

PD-ABP-881  
95825

# DETAILED IMPLEMENTATION PLAN

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## Child Survival X

(Project # FAO-0500-A-00-4038-00)

## Kampala District, Uganda

October 1, 1994 - September 30, 1997

Submitted to:

**United States Agency for  
International Development**

April 3, 1995

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# DIP TABLE A: FIELD PROJECT SUMMARY

PVO/Country \_\_\_\_\_ ADRA/Uganda

Project Duration (mm/dd/yy): start date \_\_\_\_\_

1-Oct-94 estimated completion date \_\_\_\_\_

30-Sep-97

## 1. BUDGET SUMMARY IN U.S. DOLLARS

	(a)	(b)	(c)	(d)
<b>a. By year of project</b>	<b>USAID Contribution</b> (field + HQ)	<b>PVO Contribution</b> (field + HQ)	<b>Total Contribution</b> (field + HQ)	
Year 1	\$177,950	\$151,208	\$329,158	
Year 2	\$185,882	\$55,979	\$241,861	
Year 3	\$189,720	\$37,067	\$226,787	
<b>Country project total</b>	<b>\$553,553</b>	<b>\$244,254</b>	<b>\$797,807</b>	

<b>b. Percent of PVO Match</b>	31%
(PVO Contribution divided by Total Contribution: sum of column "c" divided by the sum of column "d")	

## 3. PERCENT OF TOTAL USAID CONTRIBUTION by INTERVENTION

Percentages must add to 100%.

INTERVENTION	Percent of Project Effort (%)	Percent of USAID Funds in US \$
a. Immunization	15	\$83,033
b. Control of Diarrheal Diseases	10	\$55,355
c. Nutrition	10	\$55,355
d. Vitamin A		\$0
e. Iodine		\$0
f. Control of Pneumonia		\$0
g. Maternal Care/Family Planning	30	\$166,066
h. Malaria Prevention & Management	5	\$27,678
i. HIV/AIDs	30	\$166,066
j. Other (specify)		\$0
k. Other (specify)		\$0
l. Other (specify)		\$0
m. Other (specify)		\$0
<b>TOTAL</b>	<b>100%</b>	<b>\$553,553</b>

## 2. SIZE OF THE POTENTIAL BENEFICIARY POPULATION

Note: POTENTIAL BENEFICIARIES are defined as those in the project area who are eligible to receive services for a given intervention, not the percent you expect to provide services to - which may be smaller than the eligible population.

	(t)
<b>a. Current population within each age group*</b>	<b>Number of Potential Beneficiaries</b>
infants, 0-11 months	2,604
children, 12-23 months	2,488
children, 24-59 months	5,787
children, 60-71 months (If Vitamin A component)	
females, 15-19 years (high risk pregnancy)	2,835
females, 20-34 years	5,902
females, 35-49 years (high risk pregnancy)	3,530
Other (specify) Children 5-14 years	16,839
Fathers of children 5-14, (mothers included above)	5,729
<b>b. Additional births</b>	
Total estimated live births, years 2 and 3	5,615

<b>c. Total Potential Beneficiaries</b>	<b>51,329</b>
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\* Note: Females (ages 15 - 49) should only be included as potential beneficiaries where they are direct beneficiaries of services (for example, TT immunizations, or family planning services), and not for educational interventions (for example, education on proper use of ORT).

## 4. CALCULATION OF USAID DOLLARS per BENEFICIARY per YEAR

a. Total USAID Contribution to Country Project (sum of column "b" in table 1, this page)	\$553,553
b. Total Potential Beneficiaries (sum of column "f" in table 2, this page)	51,329
c. USAID Funding per Beneficiary for Project (line a. divided by line b. in table 4, this page)	\$10.78
d. USAID Funding per Beneficiary per year (line c. above divided by 3 years)	\$3.59

TABLE A: FIELD PROJECT SUMMARY

5. ACTIVITIES: Circle all activity codes that apply for each intervention.

a. Immunization

- 1 = Distribute vaccines
- ② = Immunize mother/children
- ③ = Promote immunization
- ④ = Surveillance for vaccine preventable diseases
- ⑤ = Training in immunization
- Other \_\_\_\_\_  
(specify)

b. Control of Diarrheal Diseases

- 1 = Distribute ORS Packages
- 2 = Promote use of ORS packets
- ③ = Promote home-mix
- 4 = Promote SSS home-available fluids
- ⑤ = Dietary management of diarrhea
- ⑥ = ORT training
- 7 = Hand washing
- Other \_\_\_\_\_  
(specify)

c. Nutrition

- 1 = Distribute food
- 2 = Provide iron, folic acid, vitamins
- ③ = Provide scales and growth charts
- 4 = Sponsor mother-to-mother breastfeeding/promotion support groups
- 5 = Conduct food demonstrations
- ⑥ = Counsel mothers on breastfeeding
- ⑦ = Conduct group sessions
- ⑧ = Training in breastfeeding and weaning
- ⑨ = Training in maternal nutrition
- ⑩ = Training in growth monitoring
- Other \_\_\_\_\_  
(specify)

d. Vitamin A

- 1 = Vit. A deficiency treatment
- 2 = Vit. A supplementation
- 3 = Vit. A fortification
- 4 = Vit. A education
- ⑤ = Vit. A food production
- Other \_\_\_\_\_  
(specify)

e. Iodine

- 1 = Iodine deficiency treatment
- 2 = Iodine supplementation
- 3 = Iodine fortification
- 4 = Iodine education
- 5 = Iodine food production
- Other \_\_\_\_\_  
(specify)

f. Control of Pneumonia

- 1 = Promote antibiotics
- 2 = Health education
- 3 = Improve referral sites
- 4 = Training
- Other \_\_\_\_\_  
(specify)

g. Maternal Care/Family Planning

- ① = Distribute contraceptives
- ② = Promote exclusive breastfeeding to delay conception
- ③ = Promote child spacing or family planning
- ④ = Antenatal care
- ⑤ = Promote malaria prophylaxis
- ⑥ = Train TBAs in improved birth practices
- ⑦ = Family planning training
- ⑧ = Improve Referral Sites
- Other \_\_\_\_\_  
(specify)

h. Malaria Prevention and Management

- 1 = Residual insecticides
- 2 = Larvaciding
- 3 = Provision of bednets
- 4 = Provision of commodities
- 5 = Treatment
- ⑥ = Health education
- 7 = Training
- Other Prophylaxis of pregnant women  
(specify)

i. HIV/AIDS Prevention

- ① = Distribution of condoms
- ② = AIDS education
- 3 = HIV testing and counseling
- Other \_\_\_\_\_  
(specify)

j. Other

Specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

k. Other

Specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

l. Other

Specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Section B. LOCATION AND FORMAL AGREEMENTS**

### **B.1 Location Description**

The project intervention area is in Kalagala and Ziobwe sub-counties, Bamunanika County, Luwero District, Uganda. These two rural sub-counties are contiguous. Most of the population are peasant farmers. The population in the intervention area is approximately 55,000, composed mostly of Baganda ethnic peoples. Since this is an extension and expansion project, beneficiaries will be the same as those of the LCSP CS VII. The project area is in a fertile rural region, approximately 30 km. north of Kampala, which also provides the closest referral hospital.

### **B.2 Location Justification**

The project area was originally chosen for several reasons. Among these reasons, the project region was a part of the "Luwero Triangle," which was hardest hit during the civil strife of Uganda's recent past. Heavy loss of life, looting, and destruction of property greatly increased the needs of the area. During this time, society and social structures were severely disrupted and most of the population fled the area. Thus the returning and returned populations are made much more vulnerable, and must find ways of reestablishing their modes of existence. Most of the population are peasant farmers with little organized commercial agriculture.

In addition to the problems of civil strife, the project region has seen relatively little external assistance. Assistance has come only recently through *Medicins Sans Frontiers* with reconstruction of several clinics and health centers, Plan International working with schools, and the African Medical and Research Foundation (AMREF), with Child Survival Interventions in the northern portion of the Luwero district, in Semoto. There are no other health-specific external assistance projects in the two project specific sub-counties, outside the USAID funded CS VII interventions.

The project area exhibits strong preventive health care deficiencies compared with the rest of Uganda. The 1992 baseline survey showed only 55.4% of children 12-23 months of age were fully immunized (compared with a national average of 80%). Infant mortality was estimated to be 122/1000. The most recent baseline completed in 1994 shows significant improvement in immunization coverage rates (81.6% of children 12-23 months have received DPT1), however problems persist in the quality of the service offered, leading to a higher drop-out rate (14.3%) presently than was recorded in the 1992 baseline survey (7.9%). Further improvement, therefore, is needed.

Finally, the project site was chosen because of an affiliated ADRA institution in the area that provides the physical infrastructure for a base of operations. Bugema College has been operating in Kalagala sub-county since 1948. The Bugema College Dispensary and Maternity Center provides the only 24-hour medical service available in the area.

### B.3 Formal Agreements

The project under CS VII has developed a good working relationship with the DMO and the RC3, 2 and 1 councils. Initial letters of support are included in Appendix XII. This support and cooperation has continued. There are no formal agreements with these MOH or local government entities. The project has been provided permanent office space on ADRA property near Bugema College. This is under formal agreement with Bugema College. Other agreements for training and technical assistance will be made on formal contractual basis.

**C.1 Baseline Survey Results:** A comparison of the objectives as originally proposed in the project proposal and the objectives changed as a result of the baseline survey.

ORIGINAL OBJECTIVES	REVISED OBJECTIVES
<b>Control of Diarrheal Diseases</b>	
(No comparable objective in original proposal.)	Reduce the percent of children <2 years of age experiencing diarrhea in the past two weeks from 23.3% to 15%.
To increase the percentage of mothers who use ORS to treat diarrhea to 60%.	Increase the percent of mothers recognizing signs of dehydration and treating with ORT from 55.3% and 61.4% respectively to 70%.
(No comparable objective in original proposal.)	Sustainability Objective: 80% of village health committees providing support system for Hps. <i>c h w s</i>
<b>EPI</b>	
To increase complete immunization coverage among the 12-23 month age group to 80%.	To increase immunization coverage of children <2 years of age from 67% to 80%
To increase the percentage of WCBA who have had at least two TT doses to 80%.	To increase TT coverage of WCBA from 45% to 60%.
(No comparable objective in original proposal.)	Sustainability Objectives: <ul style="list-style-type: none"> <li>• Improve the quality of service at vaccine sites and provide new vaccine sites to increase access;</li> <li>• Improve the cold chain monitoring, maintenance, and vaccine supply system.</li> </ul>
<b>GM/Nutrition/Vit A</b>	
To increase the percentage of children under two who have been weighed within the last three months to 75%.	Increase the number of children <2 years of age that will have been weighed in the last three months from 67.5% to 75%.
To increase the percentage of households with kitchen gardens to 50%.	Increase the percent of households having kitchen gardens from 71.7% to 80%.
(No comparable objective in the original proposal.)	Increase the homes with food availability throughout the year by use of food storage facilities from 18.7% to 35%. ✓
(No comparable objective in the original proposal.)	Sustainability Objectives: <ul style="list-style-type: none"> <li>• 80% of RC1s will have taken consistent responsibility for monthly weighing sessions;</li> <li>• 32 contact farmers will be accessing ag. Extension support for advice;</li> <li>• Two seed cooperatives will be operating on a self sustaining basis.</li> </ul>
<b>Safe Motherhood/Family Planning</b>	
(No comparable objective in the original proposal.)	Increase the percentage of mothers who at delivery are assisted by a trained health professional from 78.3% to 85%
To increase the percentage of couples who use modern methods of child spacing to 15%.	Increase the percentage of couples using modern contraceptive methods from 12% to 25%.
<b>HIV/AIDS</b>	
To increase by 50% the under 15 year-olds who are aware of HIV/AIDS and high risk behaviors.	Decrease the transmission of HIV/AIDS in the present and future population by targeting 5-15 year olds and parents.

To increase the percentage of WCBA with a correct knowledge of HIV/AIDS transmission by 30%.	(No comparable objective in revised objectives.)
(No comparable objective in original proposal.)	Increase percent of pregnant women being screened and treated for STDs 50% from baseline.
<b>Malaria</b>	
To increase the percentage of pregnant women who receive malaria chemoprophylaxis to 30%.	Increase the percent of pregnant mothers receiving chemical prophylaxis from 41.7% to 60%.

ADRA UGANDA - SUMMARY REPORT CS VII - BASELINE DATA FOR CS X

**CSVII Interventions:**

- EPI
- CDD
- Nutrition/Growth Monitoring
- Vitamin A (kitchen gardens)
- Safe Motherhood/FP (birth spacing)
- AIDS Education/prevention

**CS-X adds:**

- Stronger FP component
- Safe Motherhood (Ante natal care, safe delivery)
- HIV/AIDS (full intervention)
- Malaria prophylaxis

Measurable project inputs/outputs:	Planned	Achieved
Health promoters trained (5/RC1)	500	706
Village Health Committees organized, trained	30	31
CHW supervisors trained	30	31
Bicycles for each CHW, HC, CBDA	32	63
Weighing scales	100	100
CBDA's trained		16
Food storage facilities in place in households		9

**Comparison of CSVII baseline with CSVII end of project/CS-X baseline results:**

Key Indicators (bold) and measurable objectives listed in CSVII DIP	CSVII baseline	CSVII objective	CSVII EOP/CS-X baseline
<b>Nutrition/Growth Monitoring</b>			
<b>1. Appropriate Infant Feeding Practices: Initiation of Breast feeding</b> Percent of children (less than 24 months) who were breastfed within first 8 hours after birth <sup>1</sup>	57.1%	None	82.9%
<b>2. Appropriate Infant Feeding Practices: Exclusive Breast feeding</b> Percent of infants less than four months, who are being given only breast milk	50%	70%	57%
<b>3. Appropriate Infant Feeding Practices: Introduction of Foods</b> Percent of infants between five and nine months who are being given solid or semi-solid foods	31% <sup>2</sup>	60%	ND <sup>3</sup>
<b>4. Appropriate Infant Feeding Practices: Persistence of Breast feeding</b> Percent of children between 20 and 24 months, who are still breast feeding (and being given solid/semi-solid foods).	ND	None	28.1%

<sup>1</sup>The CSVII baseline used the indicator "within the first 8 hours after birth", so for comparison the same was used in the EOP rather than the revised breakdown of "within one hour of birth" and "within six hours of birth".

<sup>2</sup>This is noted in the CSVII DIP as "percent of mothers giving children 4-6 months semisolid food" rather than the recent indicator of 5-9 months, or the current revision of 6-10 months.

<sup>3</sup>ND - no data

Percent of mothers who know the importance of adding food rich in iron and vitamin A	12.5 & 4.2% respective	30%	ND
Percent of children weighed at least once during the past three months	34.1%	60%	67.5%
Percent of women eating more than usual during pregnancy	14%	30%	ND
Percent of households surveyed having a food storage facility (granary)	ND	ND	18.7%
<b>Vitamin A</b>			
Number of homes with kitchen gardens growing at least 5 kinds of vitamin and/or iron rich foods	28.8%	45%	71.7% <sup>4</sup>
<b>CDD</b>			
<b>5. Management of Diarrheal Diseases: Continued Breast feeding</b> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breast-milk	61%	75%	73.8%
<b>6. Management of Diarrheal Diseases: Continued Fluids</b> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breast-milk	71%	80%	98.5%
<b>7. Management of Diarrheal Diseases: Continued Foods</b> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food	30%	45%	80%
<b>8. Management of Diarrheal Diseases: ORT Usage</b> Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT	41%	60%	61.4%
Percent of mothers who recognize the signs of dehydration as important symptoms of diarrhea (implied as important for seeking advice or treatment from a trained provider)	11.7%	30%	53.3%
Amount of diarrhea reported to have occurred in children under five in the past two weeks	46.3%	20%	23.3% <sup>5</sup>
<b>ALRI Indicator 9 - ALRI not a component of CSVII nor planned in CS-X</b>			
<b>EPI</b>			
<b>10. Immunization Coverage (Card): EPI Access</b> Percent of children 12-23 months who received DPT1	75.9%	None	81.6%
<b>11. Immunization Coverage (Card): EPI Coverage</b> Percent of children 12-23 months who received OPV3	69.9%	None	71.8%
<b>12. Immunization Coverage (Card): Measles Coverage</b> Percent of children 12-23 months who received measles vaccine. <sup>6</sup>	56.6%	80%	67%

<sup>4</sup>This percentage is in response to the simple question "Do you have a kitchen garden?" without qualification regarding vitamin and/or iron rich foods. To a subsequent question asking "Do you want a kitchen garden?" 96.7% responded "yes".

<sup>5</sup>This EOP figure is only of children 0-23 months rather than the under five noted in the DIP.

<sup>6</sup>The objective in the CSVII DIP is noted as "Increase complete immunization coverage" without definition if this is OPV3 or Measles.

<b>13. Immunization Coverage (Card): Drop Out Rate</b> Percent change between DPT1 and DPT3 coverage levels for children 12-23 months	7.9%	None	14.3%
<b>14. Maternal Care: Maternal Card</b> Percent of mothers with a maternal card for the birth of their youngest child less than 24 months of age	ND	None	51.7%
<b>15. Maternal Care: Tetanus Toxoid Coverage (Card)</b> Percent of mothers whose card shows that they received two doses of tetanus toxoid vaccine before the birth of the youngest child less than 24 months of age	40%	70%	45.7%
Percent of mothers who know that more than 2 TT are needed for protection of mother	45%	65%	91.4%
<b>16. Maternal Care: One or More Ante-Natal Visits (Card)</b> Percent of mothers who had at least one ante-natal visit (by card) prior to the birth of her youngest child less than 24 months of age	ND	None	ND
Percent of mothers who had at least one ante-natal visit (by self report) prior to the birth of her youngest child less than 24 months of age	97%	None	96.6%
<b>17. Maternal Care: Modern Contraceptive Usage</b> Percent of mothers who are not pregnant and who desire no more children in the next two years, or are not sure, and who are using a modern contraceptive method <sup>7</sup>	6.2%	None <sup>8</sup>	25.9%
Percent of mothers of children 0-23 months not presently pregnant who do not want children in the next three years			51.7%
Percent of all mothers of children 0-23 months who are using a modern contraceptive method	1.7%	12%	12%
Reasons for not using a method of contraception			
Don't know			26.2%
Religious reasons			0.6%
Husband objects			13.1%
Personal beliefs			3.3%
Side effects/safety			.6%
No local FP services			21.3%
Other (not specified)			32.8%
Percent of mothers of children 0-23 months who have received chemoprophylaxis (treatment) against malaria during the current or last pregnancy	ND	None	41.7%
Percent of mothers who at the delivery of their last child were assisted by a health professional (physician, nurse, or midwife)	ND	None	78.3%
Percent of mothers who at the delivery of their last child were assisted by a traditional birth attendant	ND	None	6.0%
Percent of mothers who at the delivery of their last child were assisted by a family member or self	ND	None	14.0%

<sup>7</sup>A modern contraceptive method is considered as: tubal ligation/vasectomy, injections, pill, IUD, barrier method/diaphragm, condom, or foam/gel (responses 1-7, question 33).

<sup>8</sup>The DIP gives a percentage objective of all women surveyed rather than only of those who desire no more children or are not sure.

<b>HIV/AIDS Education, Prevention</b>			
Percent who responded they think that people in their village are in danger of getting AIDS	43%	None	78.3%
Percent who think it is possible to get the disease themselves	18%	None	89.7% <sup>9</sup>
Percent of mothers who think the woman can pass the AIDS virus to a child before it is born	ND	None	64.7%
Percent of mothers who think it is possible to get AIDS through sex without using condoms	ND	None	90.0%
Percent of mothers who report they are taking measures to prevent themselves from getting AIDS <sup>10</sup>	ND	None	79%
Reasons for not protecting themselves from getting AIDS: Husband objects Do not know how to Doesn't know	ND	None	29.2% 26.2% 26.0%
Percent who think they can get AIDS from someone who looks healthy?	ND	None	90.0%
Percent who know the AIDS virus can be in the body for years before a person begins to feel sick	ND	None	85.3%
<b>Recommended Knowledge Indicators</b>			
<b>1. Mother's Literacy</b> Percent of mothers who are literate	68%	None	68%
<b>2. Immunization knowledge: Timeliness of Measles</b> Percent of mothers who know that measles should be given at 9 months	57.9%	80%	86.8%
<b>3. Immunization knowledge: Tetanus Toxoid Protection</b> Percent of mothers who know that tetanus toxoid protects both the child and the mother	20.8%	50%	43.7%
<b>4. Maternal Care Knowledge: Timeliness of Ante-Natal Care</b> Percent of mothers who know that pregnant women should start ante-natal care before the third trimester	89.6%	None	97.0%

<sup>9</sup>This percent is responding to the question "Do you think anybody can get AIDS?" which is seen as a reasonable comparison to the CSVII baseline question regarding the possibility of getting the disease themselves.

<sup>10</sup>Unfortunately this question was not followed by a question "if yes, what measures are you taking to prevent yourself from getting AIDS". This would have been valuable information.

## DIP TABLE B: PROJECT GOALS AND OBJECTIVES - ADRA Uganda CS-X

### PROJECT GOALS:

1. Improvement of the health status of women and children in the project target area

### OVERALL PROJECT IMPACT INDICATORS TO BE MEASURED:

1. **Maternal Mortality:** Annual maternal deaths in target area according to local vital events registry decreasing over life of project [Subcounty Vital Events Registry]
2. **Child Mortality:** Annual deaths of children under five years of age according to local vital events registry, decreasing over life of project [Subcounty Vital Events Registry]
3. **Morbidity:** Diarrheal disease cases treated in Health Centers - decreasing incidence over time [HC records]; Surveillance of immunizable diseases of neonatal tetanus, measles and polio, incidence decreasing over life of project [Health Center Records, Sub-county Vital Events Register]
4. **Food Security:** Percent of households with food available year round through utilizing food storage facilities increased from 18.7% to 35% [Survey]

### CS-X TARGET POPULATION NUMBERS

### TOTAL PROJECT AREA POPULATION:

53,734

Target age group	Percentage	1991	1994	1997 est.
0-11 months	4.5%	2,418	2,604	2,804
12-23 months	4.3%	2,311	2,488	2,680
24-59 months	10.0%	5,373	5,787	6,231
5-14 years	29.1%	15,637	16,839	18,134
15-19 year old females	4.9%	2,633	2,835	3,053
20-34 year old females	10.2%	5,481	5,902	6,356
35-49 year old females	6.1%	3,278	3,530	3,801
Total WCBA (15-49)	21.2%	11,392	12,267	13,210
Parents 5-14 year old est.	19.8%	10,639	11,457	12,338

Project Objectives by Intervention	Measurement Method - Key Indicators, How/When	Major Planned Inputs and Activities	Outputs	Measurement Method (of outputs) How/When
<b>10% CDD (focus on hygienic practices and HP sustainability)</b>				
<p>Reduce the percent of children under two years of age experiencing diarrhea in the past two weeks from 23.3% to 15%</p> <p>Increase the percent of mothers recognizing signs of dehydration and treating with ORT from 55.3% and 61.4% respectively to 70%</p>	<p>1. Percent of children 0-23 months experiencing diarrhea in past two weeks [SURVEY]</p> <p>2. Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breastmilk;</p> <p>3. given the same amount or more fluids in addition to breastmilk;</p> <p>4. given the same amount or more food;</p> <p>5. treated with ORT [SURVEY]</p> <p>6. Percent of mothers of infants/children (less than 24 months) who know two or more correct symptoms indicating the need to seek trained health care [SURVEY]</p>	<p>1. Refresher TOT training</p> <p>2. Refresher training of CHWs in CDD key messages with emphasis on:</p> <ul style="list-style-type: none"> <li>• Sanitary waste disposal</li> <li>• Clean water supply</li> <li>• Hand washing after toilet and before handling food</li> </ul> <p>3. Key messages continue to be given to mothers by CHWs</p> <p>4. Key message checklists for CHWs</p> <p>5. CHWs trained in giving deworming medicine (Albendazole, single dose)</p> <p>6. Supply deworming medicines every six months to CHWs</p> <p>7. Deworming of under 5's every six months</p>	<p>1. 8 Field Supervisors, 35 trainers trained</p> <p>2. 700 CHWs trained</p> <p>3. 11,000 (90%) mothers/WCBA receive messages</p> <p>4. 700 CHWs using checklists for communication of messages</p> <p>5. 700 CHWs trained</p> <p>6. CHWs receive deworming medicine every six months</p> <p>7. 6528 (60%) under five's dewormed every six months</p>	<p>1. [TRAINING REPORT]</p> <p>2. [TRAINING REPORT]</p> <p>3. [HP MONTHLY REP]</p> <p>4. [HP MONTHLY REP]</p>
<p><u>Sustainability objective:</u> 80% (80) of village health committees providing support system for CHWs</p>	<p>Percent of VHC's providing for all five essential components of support system:</p> <ul style="list-style-type: none"> <li>• Supervision</li> <li>• Report review</li> <li>• Recognition/status in community</li> <li>• Refresher training</li> <li>• Replacement of dropouts</li> </ul>	<p>1. Orientation of VHC's to essential components of a support system for CHWs</p> <p>2. Follow-up supervision to facilitate VHC's institutionalizing the support system</p>	<p>1. 100 VHC's oriented to components of a sustainable support system for CHWs</p> <p>2. 80% of VHC's providing for all 5 components of HP support system</p>	<p>1. [QRTLRY REP]</p> <p>2. [MONTHLY VHC SUMMARY REP, VHC INTERVIEWS]</p>

Project Objectives by Intervention	Measurement Method - Key Indicators, How/When	Major Planned Inputs and Activities	Outputs	Measurement Method (of outputs) How/When
<b>15% EPI (focus on dropouts, accessibility &amp; service quality)</b>				
To increase immunization coverage of children under two years of age from 67% to 80%	<p><u>EPI access</u>: Percent of children 12-23 months who received DPT1 [SURVEY]</p> <p><u>EPI coverage</u>: Percent of children 12-23 months who received OPV3 [SURVEY]</p> <p><u>Measles coverage</u>: Percent of children 12 to 23 months who received measles vaccine [SURVEY]</p> <p><u>Drop out rate</u>: Percent change between DPT1 and DPT3 doses for children 12-23 months [SURVEY]</p>	<ol style="list-style-type: none"> <li>1. Refresher TOT training with focus on quality monitoring, and dropout follow-up</li> <li>2. Selection of community based vaccinators by community</li> <li>3. Refresher training of CHWs and vaccinators and training of new vaccinators</li> <li>4. Provide bicycles to community vaccinators, vaccination kits to CBV's</li> <li>5. Continue IEC through CHWs on EPI key messages</li> <li>6. Follow-up of dropouts through home visits by CHWs</li> </ol>	<ol style="list-style-type: none"> <li>1. 8 Field Supervisors, 35 trainers trained</li> <li>2. 31 Community Based Vaccinators (CBV's) selected</li> <li>3. 31 CBV's trained</li> <li>4. 31 bicycles provided, 31 CBV kits (pressure stove, cooker, syringes, needles, cold box, timer)</li> <li>5. 11,000 (90%) mothers/WCBA receiving EPI messages</li> <li>6. 345 HH's visited monthly for follow-up of dropouts (14% of 90% of under one infants).</li> </ol>	<ol style="list-style-type: none"> <li>1. [TRAINING REP]</li> <li>2. [VHC RECORDS]</li> <li>3. [TRAINING REP]</li> <li>4. [PROJECT FINANCIAL STATEMENT]</li> <li>5. [HP MONTHLY REP]</li> <li>6. [HP MONTHLY REP]</li> </ol>
To increase TT coverage of WCBA from 45% to 60%	Percent of WCBA having received at least two TT immunizations	<ol style="list-style-type: none"> <li>1. Promotion of TT by CHWS to families, and by TBA's and midwives during antenatal care</li> </ol>	<ol style="list-style-type: none"> <li>1. 11,000 (90%) WCBA receiving TT promotion</li> </ol>	<ol style="list-style-type: none"> <li>1. [HP MONTHLY REP, TBA REP, MIDWIVES REP]</li> </ol>
<p><u>Sustainability objectives:</u></p> <ul style="list-style-type: none"> <li>• Improve quality of service at vaccine sites and provide new vaccine sites to increase access</li> <li>• Improve the cold chain monitoring, maintenance, and vaccine supply system</li> </ul>	<ol style="list-style-type: none"> <li>1. Number of community sites missing one vaccination day in past 6 months</li> <li>2. Number of days frig temp has not been between 0 and 8 C during the past 3 months</li> <li>3. Number of days out of stock in past 3 months</li> </ol>	<ol style="list-style-type: none"> <li>1. Training of vaccinators at HC's in cold chain monitoring of temperature and maintenance of refrigerators, gas supply</li> <li>2. HMC monitoring cold chain reports</li> <li>3. Work with RC-3's and DMO to ensure vaccine supply and gas supply, institutionalize this responsibility</li> <li>4. Mobilization of VHC's to assume responsibility for supervision and monitoring of community vaccinators</li> </ol>	<ol style="list-style-type: none"> <li>1. 5 vaccinators, 4 midwives trained</li> <li>2. Cold chain reports reviewed monthly by HMC</li> <li>3. HC's have consistent vaccine and gas supply</li> <li>4. VHC's providing support system for CBV's</li> </ol>	<ol style="list-style-type: none"> <li>1. [TRAINING REP]</li> <li>2. [HMC RECORDS]</li> <li>3. [HC COLD CHAIN RECORDS]</li> <li>4. [VHC RECORDS]</li> </ol>

Project Objectives by Intervention	Measurement Method - Key Indicators, How/When	Major Planned Inputs and Activities	Outputs	Measurement Method (of outputs) How/When
<b>10% GM/Nutrition/Vit A (focus on sustainability objectives)</b>	Mandated key indicators will be measured: <u>Initiation</u> of breastfeeding <u>Exclusive</u> breastfeeding <u>Introduction</u> of foods <u>Persistence</u> of breastfeeding			
Increase number of children under two years of age that will have been weighed in the last three months from 67.5% to 75%	Percent of children 0-23 months weighed in past three months	1. Continued promotion of GM and follow-up by CHWs 2. Monthly weighing at RC1 sites 3. Replace weighing scales as necessary 4. Key messages checklists for nutrition	1. 6,000 households receiving reinforcement of GM/Nut messages 2. 100 weighing sites monthly 3. Weighing scales provided  4. CHWs self monitoring with checklists	1. [HP MONTHLY REP] 2. [HP MONTHLY REP, VHC COMPILED REP] 3. [INVENTORY REP] 4. [HP MONTHLY REP]
Increase the percent of households having kitchen gardens from 71.7% to 80%	Percent of households having kitchen gardens	1. Contact farmers given refresher training, emphasis on year round varieties, food storage, seed supply 2. Promotion to HH's of kitchen gardens, food storage, year round varieties 3. One demonstration garden for training of contact farmers	1. 32 contact farmers trained  2. 6,000 households receiving messages  3. Demo garden providing training venue for contact farmers	1. [TRAINING REP]  2. [CONTACT FARMERS MONTHLY REP] 3. [PROJECT REP, SITE VISIT]
Increase the homes with food availability throughout the year by use of food storage facilities from 18.7% to 35%	Percent of households having food storage facility (granary)	1. Instruction in building food storage facilities	1. 2,650 HH's learn how to build food storage facility	1. [CONTACT FARMERS REPORT]
Increase the percent of mothers who report eating more than usual during pregnancy to 50%.	Percent of mothers reporting eating more than usual during last pregnancy	1. Education of mothers by CHWs, TBAs.	1. 11,000 mothers receiving key messages on nutrition during pregnancy and lactation.	1. CHW monthly report
<b>Sustainability objectives:</b> <ul style="list-style-type: none"> <li>• 80% of RC1's will have taken consistent responsibility for monthly weighing sessions</li> <li>• 32 contact farmers will be accessing ag extension support for advice</li> <li>• Two seed cooperatives will be operating on a self sustaining basis</li> </ul>	Percent of RC1's having missed one months weighing session in past 6 months  See output indicators  See output indicators	1. Mobilize RC1's and VHC's to provide ongoing support systems to CHWs 2. Contact farmers assisted to access ag extension help 3. Access technical help and training for setting up seed coop	1. 80 RC1's have not missed one weighing session in past 6 months  2. Contact farmers access ag extension help 3. Two seed coops established, locally managed	1. [VHC SUMMARY REP]  2. [CONTACT FARMERS REP] 3. [SITE VISITS, SEED COOP RECORDS]

Project Objectives by Intervention	Measurement Method - Key Indicators, How/When	Major Planned Inputs and Activities	Outputs	Measurement Method (of outputs) How/When
<b>30% Safe Motherhood/Family Planning (New components, link with HIV/AIDS/STD component)</b>				
<p>Increase the percentage of mothers who at delivery are assisted by a trained health professional from 78.3% to 85%</p>	<p>Percent of mothers assisted at delivery by a trained health professional (physician, MA, midwife, trained TBA)</p> <p>Percent of mothers with a maternal card for the birth of the youngest child less than 24 months of age (51.7% to 75%).</p> <p>Percent of mothers who received two doses of tetanus toxoid vaccine (card) before the birth of her youngest child less than 24 months of age (45.7% to 60%).</p> <p>Percent of mothers who had at least one ante-natal visit (card) prior to the birth of her youngest child less than 24 months of age. (The self report data was 97% so no objective is set, this will be monitored only).</p>	<ol style="list-style-type: none"> <li>1. TOT refresher training covering SM key messages</li> <li>2. Training of CHWs in SM key messages</li> <li>3. Key messages to mothers</li> <li>4. Refresher training of TBA's and community based midwives in antenatal care, essential home/community safe delivery practices with emphasis on recognition of danger signs and referral (Tier 1)</li> <li>5. Refresher training of HC midwives in basic emergency obstetric care (BEOC) (Tier 2) including referral to hospital comprehensive emergency obstetric care (CEOC) (Tier 3)</li> <li>6. Service quality monitoring system instituted</li> <li>7. Work with local VHC's to establish community based emergency transport alternatives to HC <ul style="list-style-type: none"> <li>• designated transport teams at each RC1</li> <li>• stretcher at each RC1 for transport</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>1. 8 Supervisors, 35 trainers trained in SM key messages</li> <li>2. 700 CHWs trained in SM key messages</li> <li>3. 11,000 mothers receive messages</li> <li>4. 65 TBA's trained</li> </ol> <p>5. a) 8 HC and community midwives trained in BEOC and referral b) BEOC services being given at two HC's</p> <ol style="list-style-type: none"> <li>6. Qrtrly facility surveys for QA by midwives themselves</li> <li>7. 80% of VHC's have transport plan in place and being used</li> </ol>	<ol style="list-style-type: none"> <li>1. [TRAINING REP]</li> <li>2. [TRAINING REP]</li> <li>3. [HP MONTHLY REP]</li> <li>4. [TRAINING REP]</li> </ol> <p>5. a)[TRAINING REP] b)[FACILITY SURVEY]</p> <ol style="list-style-type: none"> <li>6. [QRTRLY REP TO HMC]</li> <li>7. [VHC RECORDS, SITE VISITS]</li> </ol>

<p>Increase the percentage of eligible couples using modern contraceptive methods from 12% to 25%</p>	<p>Percent of women with children 0-23 months using a modern contraceptive method</p>	<ol style="list-style-type: none"> <li>1. Revise training curriculum for IEC and service delivery in FP based on analysis of barriers to usage of modern methods</li> <li>2. TOT refresher training of trainers in CBD, key messages, quality monitoring</li> <li>3. Training of CBDA's in FP key messages, counseling on all methods, service delivery of condoms, foam, pills according to checklist (protocol), and HIV/AIDS key messages</li> <li>4. Training of CHWs and TBA's in FP key messages, including messages on HIV/AIDS (Facts for Life/Uganda) and safe sex (what is safe sex, condom use, negotiating safe sex)</li> <li>5. Key messages to families through CHWs, CBDA's, TBA's.</li> <li>6. Service delivery through CBDA's</li> <li>7. Establish FP service centers at four HC's, provide services</li> <li>8. Orient RC3, RC2, RC1 members to FP for community promotion</li> <li>9. Facilitate linkage with DMO and District Community Based Health Care Assistant (DCBHA) for supplies and cost recovery through sale of condoms by CBDA</li> <li>10. Establish VSC (Voluntary Surgical Contraception) at one of the four HC's to be serviced by Marie Stopes</li> <li>11. Monitor quality of services using service quality checklists developed during training (PHC MAP guidelines)</li> </ol>	<ol style="list-style-type: none"> <li>1. Revised curriculum</li> <li>2. 8 Supervisors, 35 Trainers trained</li> <li>3. 64 CBDA's trained</li> <li>4. 700 CHWs 65 TBA's trained</li> <li>5. 6,000 (80%) HH's receiving key messages</li> <li>6. Eligible couples have service accessible</li> <li>7. 4 Service centers providing FP services</li> <li>8. RC3,2,1 members oriented and promoting FP</li> <li>9. Dependable supply of contraceptives and cost recovery through sale of condoms by CBDA's</li> <li>10. VSC center established, offering VSC services</li> <li>11. Self evaluation system doing qtrly quality monitoring</li> </ol>	<ol style="list-style-type: none"> <li>1. [CURRICULUM]</li> <li>2. [TRAINING REP]</li> <li>3. [TRAINING REP]</li> <li>4. [TRAINING REP]</li> <li>5. [HP, CBDA, TBA, MONTHLY REP]</li> <li>6. [CBDA REP]</li> <li>7. [SERVICE CENTER MONTHLY REP TO HMC]</li> <li>8. 80% RC's active in FP promotion [RC RECORDS]</li> <li>9. [FP SERVICE CENTER SUPPLY INVENTORY, CBDA MONTHLY REP]</li> <li>10. [FACILITY SURVEY]</li> <li>11. [QRTLY REPORT TO HMC]</li> </ol>
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Project Objectives by Intervention	Measurement Method - Key Indicators, How/When	Major Planned Inputs and Activities	Outputs	Measurement Method (of outputs) How/When
<b>30% HIV/AIDS (focus on education/prevention in 5-15 year olds)</b>				
Decrease the transmission of HIV/AIDS in the present and future population by targeting 5-15 year olds and parents	Percent of 5-15 yo aware of transmission/prevention of HIV/AIDS Percent of 5-15 yo exhibiting skills for resisting high risk behavior Percent of 11-15 yo adopting value of abstinence before marriage and fidelity to one partner Percent of 11-15 yo who choose to be sexually active practicing safer sex	1. Formative research on prevalence of traditional sexual practices which are high risk, sources of information and social networks related to sex, marriage, STD's & HIV/AIDS, establish indicator baselines 2. Access technical assistance in IEC design 3. Establish 4 recreational clubs 4. Recreation, education, values formation, safe sex principles promoted  5. Outreach to schools for HIV/AIDS education, prevention 6. Children's clubs organized 7. Outreach to parents through Rec centers and CHWs and TBA's  8. Counseling services through Rec centers for 5-15 year olds and parents (counseling also through FP component)  9. Condom availability through FP service providers (CBDA's, service centers)	1. Report  2. IEC methods designed  3. 4 recreation clubs established 4. Targeted messages to 5-10, 11-14, and parents  5. 16 schools receive education teams once per qtr 6. 20 clubs established 7. 8,000 parents receiving key messages  8. Counseling in communication skills (with children), values formation, correct information, safer and safe sex, protected sex negotiating skills, condom use, STD recognition/ treatment 9. Accessible condom supply	1. [REPORT]  2. [MATERIALS, OUTLINE OF METHODOLOGY] 3. [SITE VISITS] 4. 70% of 5-14 year olds involved in or impacted by recreational clubs, or HIV/AIDS educational messages [SURVEY, INTERVIEWS] 5. [REC CENTER REP]  6. [PROJECT REP] 7. 70% of parents of 5-14 year olds by HIV/AIDS IEC activities [REC CENTER REP, HP REP, TBA REP] 8. [REC CENTER REP, CBDA REP]  9. [CBDA REP]
Increase percent of pregnant women being screened and treated for STD's 50% from baseline	Percent of pregnant women screened and/or treated for STD's	1. Training of midwives in WHO syndromic screening/treatment protocol for STD's 2. Pregnant mothers screened, treated for STD's	1. 4 midwives trained  2. STD syndromic treatment provided in HC service centers	1. [TRAINING REP]  2. [FACILITY SURVEY, FP CENTER MON REP]
<b>5% Malaria (chemoprophylaxis/ treatment of pregnant women)</b>				
Increase the percent of pregnant mothers receiving chemical prophylaxis from 41.7% to 60%	Percent of pregnant mothers reporting having received chemoprophylaxis during their last pregnancy	1. Train TBA's, midwives in chemoprophylaxis 2. Establish supply of chloroquine to FP service centers, midwives, TBA's 3. Prevention/treatment for pregnant mothers	1. 65 TBA's, 8 midwives trained  2. Chloroquine supply consistent  3. 1644 pregnant mothers treated annually	1. [TRAINING REP]  2. [FP CENTER REP, TBA REP, MWIVES REP] 3. [TBA, FP SERVICE CENTER REP]

### C.3 Project design

The project is an extension of CS VII and will continue an emphasis in the interventions of CDD, GM/Nutrition, EPI, and will increase the emphasis on MC/FP and HIV/AIDS. In addition a small malaria component will be added - chemoprophylaxis of pregnant women - to support the strengthened MC initiative.

The **primary method of impacting families** will be through 700 CHWs and other community groups such as song and dance groups who have been found to communicate CS messages very effectively in the communities. In addition, this project is adding Community Based Vaccinators (CBVs), to increase the accessibility to immunizations, increasing the number of Community Based Distribution Agents (CBDAs) for basic Family Planning services since the introduction of the CBDAs was quite successful in CS VII, and training TBAs for basic maternal care in the communities. Also, parents of 5-14 year olds will be impacted directly through the recreational clubs and HIV/AIDS educational activities of the club members, and through educational meetings with parents of club members.

A **major strategy for sustainability** will be the institutionalizing of support systems for the community level workers (CHWs, CBVs, CBDAs) in the local Village Health Committee who will be trained and mobilized to provide the five key elements of a support system: 1) supervision, 2) review of reports, 3) recognition of the volunteers in the community, 4) refresher training, and 5) replacement of dropouts. In addition the subcounty Health Management Committee will assume responsibility for monitoring the cold chain and vaccine supply, and will be included as partners in implementation and monitoring the overall project activities in each of the two subcounties.

**Service delivery strengthening** will be accomplished specifically in the MC/FP area through upgrading of the MC/FP services at the health centers (including a voluntary sterilization center at one of the health centers) and the TBAs and CBDAs in the communities. Emergency obstetric transport to the health centers will be the responsibility of the local RC1s. **Service quality monitoring** will be implemented using a self evaluation method specifically in the areas of Maternal Care, Family Planning (at the health centers), STD screening and treatment, cold chain monitoring and vaccine delivery.

**Formative research**, particularly in the HIV/AIDS area, will provide further information necessary for understanding the current high risk practices, how they are "popularized" and how the project can more effectively communicate to the target groups. This will also contribute to more effective work in popularizing beliefs and values which will lead to lower risk behavior and therefore lower transmission rates.

A further key concept in the project is the **integration of the MC/FP and HIV/AIDS** components to provide a more complete reproductive health emphasis.

**Interventions and percentage of project activity:**

**10% CDD:** Continuation of the communication of key messages to families with increased emphasis on hygienic practices. Particular focus on the VHC supporting the CHWs to sustain the education of families. CHWs will be trained in providing single dose deworming medicine to under fives every six months.

**15% EPI:** Continue the IEC to families on EPI with added emphasis on increasing accessibility by adding Community Based Vaccinators. Improving the quality of services through training, and instituting a quality monitoring system for vaccinators, the cold chain and vaccine supply.

**10% GM/Nutrition:** Continue IEC to families on Nutrition and the Growth Monitoring at 100 weighing sites. Additional emphasis on family gardens, particularly using seasonally adapted seed varieties to improve year round food security. Also promotion of food storage facilities to increase the food security during the dry season. Sustainability will be encouraged through farmer's seed cooperatives and accessing the local agriculture extension agents for technical assistance.

**30% Safe Motherhood/Family Planning:** The project will address the community and health center levels of Maternal Care through refresher training of TBAs, and private and health center midwives. The health centers will be upgraded to provide the Basic Essential Obstetric Care services. TBAs will be trained in recognition of danger signs for OB emergencies. Transport to health centers will be organized. The CBDAs will be increased for FP and the health centers will become full FP provider centers including voluntary sterilization services (vasectomy and tubal ligation) at one of the centers. The FP component will include messages regarding safe sex and will include STD screening and treatment of pregnant women and others by request. Condom supply will be provided through the health centers and the CBDAs.

**30% HIV/AIDS:** Formative research will be conducted to understand the practices in the target area relating to high risk sexual behavior. Recreational clubs will be established for the target group of 5-14 year olds. Through recreational activities, group discussions, role playing, negotiating skills practice, personal counseling and values development, the objective of decreasing high risk behavior will be upheld. Key messages about safer sex will be communicated including proper condom use if they choose to be sexually active (primarily the 11-14 year olds). Parents will be included in the IEC activities. Young people will be involved in IEC to their peers in the schools. Pregnant women will be screened and treated for STDs and others by request. Condoms will be available through the CBDAs of the FP component.

The primary focus of this project will be to create sustainable systems to continue the basic CS activities. The local entities of the RC1s, the Village Health Committees, and the RC3 Health management Committee are key entities in the sustainability of the activities.

**C.4 Project evaluation**

CHWs will provide monthly reports for process indicators. These reports will be monitored by the VHC and the Project staff. The HIS coordinator will be responsible for the tabulation of the

monthly reports. Monthly reports will also be compiled from other functionaries to monitor process data for purpose of project management. Effect and impact evaluation will be through comparing the baseline survey and the end project survey. Midterm and end of project evaluations will be conducted.

#### C.5 Training/supervision plan

The overall design includes training at several levels:

- The basic training in key messages and specific added skills for the CHWs will be done by the field supervisor/trainers.
- Specific technical training (MC/FP, HIV/AIDS) will be conducted using outside technical expertise.
- Training and orientation for VHCs, RC1s and Subcounty Health Management Committees will be done by project staff (training coordinator, subcounty supervisors).

The following is a list of the various training activities planned:

1. TOT for the field supervisor/trainers
  - training and supervision skills
  - key messages for each intervention
  - surveillance for neonatal tetanus
  - deworming protocol
2. Refresher training in key messages for all interventions and additional skills noted above for CHWs
3. Refresher training for TBAs and private and HC midwives
  - antenatal, postnatal, safe delivery, malaria chemoprophylaxis
  - Basic Essential Obstetric Care at the health centers
  - FP service delivery training for midwives
  - Training in STD screening/treatment for HC staff
  - MC/FP service quality monitoring (midwives)
4. CBDA training in basic FP service delivery
5. CBV training in vaccination skills
6. Refresher training for HC vaccinators in service quality, cold chain monitoring
7. Formative research training and development for HIV/AIDS
8. HIV/AIDS skills training for project staff, recreation club staff, school teachers
  - IEC skills for HIV/AIDS
  - Counselling skills
9. Contact farmer training in seed coop management, family garden promotion, year round seed varieties, accessing ag extension services
10. HIS training for project staff in data collection and use
11. VHC training
  - Community health management
  - Support requirements for community volunteers (CHWs, CBVs, CBDAs) - supervision, reporting, recognition, refresher training, replacement of dropouts.
12. Training/mobilization of RC1s for supervising/conducting weighing sessions, emergency transport for OB emergencies.

13. Orientation of subcounty Health Management Committee

- Vaccine supply, cold chain monitoring
- Service quality monitoring of EPI

14. Project staff general upgrading in computer skills, data handling, training and supervision skills, quality monitoring, and general management skills

A number of the training activities listed above are not included in table C and will be scheduled in detail during the consultancy visit from ADRA HQ health advisor during the third quarter of the project.

## DIP TABLE C: TRAINING AND SUPERVISION SUMMARY

PVO/Country ADRA/Uganda CS-10

Project Duration, Start Date: Sept. 30, 1994

Completion Date: Sept. 29, 1997

TRAINER & JOB TITLE	TRAINEES & COURSE TITLE	NO. OF HOURS		SUPERVISOR	PER MONTH	CONTACTS INTERVENTION(S)
		PER MONTH	INSERVICE Average			
	Growth Monitoring/Safe Motherhood interventions for trainer supervisors	20	0	Israel Musoke/Project Director	4	Growth Monitoring/SM
	Malaria/EPI interventions for trainer supervisors	20	0	Israel Musoke/Project Director	4	Malaria/EPI
	CDD interventions for trainer supervisors	20	0	Israel Musoke/Project Director	4	CDD
	HIV interventions for trainer supervisors	20	0	Israel Musoke/Project Director	4	HIV
Juliet Nmazzi/Safe Motherhood, Kate Kafeero/Family planning	Community-based distribution for CBDA's	10	2	Israel Musoke/Project Director	4	Family Plannin/SM
Joseph Hayuni, Training/HIS coordinator	Health Management for Committees & RC3s	10	1	Israel Musoke/Project Director	4	All
Israel Musoke/Project Director	Gold Chain Monitoring for community vaccinators	10	1	Israel Musoke/Project Director	na	EPI
ADRA Technical staff	All interventions for trainers	20	4	Israel Musoke/Project Director	6	All interventions
ADRA technical staff & trainer supervisors	All interventions for CHWs	20	4	Israel Musoke/Project Director	4	All interventions
ADRA Agriculture/Nutrition technical person	32 contract farmers vitamen A and vegetable gardening	15	1	Israel Musoke/Project Director	2	Nutrition
Kate Kafeero, Juliet Namazzi, Family Planing, Safe Motherhood	Advices, refresher courses in SM	10	1	Israel Musoke/Project Director	4	Safe Motherhood/Family Planning
<b>TOTAL</b>		<b>175</b>	<b>14</b>		<b>40</b>	

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## C.6 Response to proposal review comments

Regarding **lessons learned** from CS VII: judging from the EOP evaluation and survey results, CS VII was quite effective in the educational components of the project. Areas needing further work were the institutionalizing of project activities and their monitoring and supervision in local entities for sustainability. This is a major emphasis of this project. Further, quality of service delivery was not a significant emphasis of CS VII. This will play a much stronger role in this project. The survey revealed the inaccessibility of services, particularly immunizations, and FP services, as key factors in not accessing these services. These points are specifically addressed in this project. Project management and technical capacity will be strengthened through more training in practical areas such as computer literacy, handling of reports, formative research, and pushing management of project finances down the project level with close supervision and controls.

**CDD:** Regarding the treatment of helminthic infections, the drug of preference is albendazole. However, because of its high cost the project will need to use mebendazole unless arrangement can be made for obtaining albendazole at much lower cost. This will require additional training for administering the three day dose of mebendazole.

**Nutrition:** The gardening component will be primarily through mobilizing 32 "contact farmers" who will serve as motivators in their communities for families to have gardens growing year round varieties. Promotion of food storage facilities will increase food security during the dry season.

**MC/FP:** The inconsistency is corrected.

**HIV/AIDS Prevention:** As noted in the discussion of the intervention, males will be included both through the working with both sexes of the 5-14 year old age group and through the impact on both parents. The project is in contact with the other organizations involved in HIV/AIDS in the country and will be utilizing them for technical help. Regarding the clarity of the objectives, since the target group has been focused to the 5-14 year olds, as noted in the intervention, the objectives will be further refined based on the more extensive formative research to be conducted during the third and fourth quarter of year one. The baseline data is of the population but we will be getting more specific data on the 5-14 year group. The project has dropped the term "social marketing" and is focusing on the formative research to more accurately understand the local beliefs, traditional practices, and causative factors in the high risk sexual behavior. This is detailed in the discussion of the plan for this intervention. Specific IEC methods will be developed based on this information. Specific technical support is scheduled for this component. The project will not be mounting a broad social marketing approach. Regarding the involvement of traditional healers, this remains to be seen based on the information from the formative research. If the traditional healers are significantly involved in behaviors which continue to reinforce the

social norm of high risk behavior, then strategies will be devised to address this problem, through education, wider involvement of community elders, leaders in promoting low risk social norms and traditional practices. TBAs will be involved in basic HIV/AIDS education and encouraging pregnant mothers to be screened/treated for STDs.

**Human Resources:** Regarding the work load of the volunteers, the project agrees that 15-20 hours per week is too much to expect on a consistent basis from volunteers. 10 hours per week would be more realistic. The number of volunteers (700) should allow the workload to be within reasonable range. On the other hand, CS VII has found a strong volunteer spirit, and it is clear that many of the local communities have certainly taken ownership of the project at the community level. The project doesn't plan to consider compensation for CHWs except as the VHC can provide on a sustainable basis. ADRA sees the five components of support for the CHW being provided by the VHC 1) supervision and monthly problem solving; 2) reviewing of their monthly reports and providing feedback, and using the information for decision making at their level; 3) providing public recognition of the volunteers in the community; 4) providing for refresher training annually - per diem, transport; 5) making sure that dropouts are replaced through selection, training, and "installment" as a CHW in the community.

**Health Information Systems:** The term "surveillance" is applied in this DIP only to surveillance of the immunizable diseases of neonatal tetanus, measles and polio. Vital events will also be tracked through the existing vital events recording system. Admittedly, the term was used loosely in the proposal. The HIS section and Table B of this DIP provide the details of the HIS system and specific information to be collected and how.

**Budget:** ADRA has allocated considerable funds for technical and management consultancy. Specifically in the technical area, ADRA HQ is employing a second senior advisor for health to specifically assist in technical capacity strengthening at regional and project levels. Uganda will be the first to benefit from this added capacity at HQ through a technical visit during the third quarter of the project, specifically in the areas of HIS systems and HIV/AIDS formative research and IEC methodology design.

#### C.7 Detailed plans by intervention

See Appendix I.

#### D. 1 Sustainability plan

The following measurable objectives and indicators will be used to track progress towards sustainability. Each of the objectives listed will enhance the sustainability of a community based health care system in the area targeted, which is one of the primary goals of the project.

INTERVENTION	SUSTAINABLE ACTIVITIES	INDICATOR
General	80% of village health committees providing support system for CHWs, CBDAs, CBVs	%age of VHCs providing for all five essential components of support system: <ul style="list-style-type: none"> <li>• Supervision</li> <li>• Report Review</li> <li>• Recognition/status in community</li> <li>• Refresher training</li> <li>• Replacement of drop-outs</li> </ul>
EPI	<ul style="list-style-type: none"> <li>• Improve quality of service at vaccine sites and provide new vaccine sites for better access</li> <li>• Improve the cold chain monitoring, maintenance, and vaccine supply system</li> </ul>	<ul style="list-style-type: none"> <li>•Number of community sites missing one vaccination day in past 6 months</li> <li>•Number of days refrigerator temperature has not been between 0 and 8 C during the past 3 months</li> <li>•Number of days out of stock in past 3 months</li> </ul>
GM/Nutrition	<ul style="list-style-type: none"> <li>•80% of RC1s will have taken consistent responsibility for monthly weighing sessions</li> <li>•32 contact farmers will be accessing extension support for advice</li> <li>Two seed cooperatives will be operating on a self-sustaining basis</li> </ul>	<ul style="list-style-type: none"> <li>•Percent of RC1s having missed one months weighing session in past 6 months</li> <li>•Number of contact farmers</li> <li>•Seed co-op records</li> </ul>
MC/FP	<ul style="list-style-type: none"> <li>•Emergency transport system locally managed</li> <li>•Quality monitoring of MC locally institutionalized</li> <li>•Support system for TBAs active</li> <li>•CBDA support system from VHC active</li> <li>•FP referral center in local HC</li> </ul>	<ul style="list-style-type: none"> <li>•Number of functioning emergency transport systems</li> <li>•TBA reports</li> <li>•HC Midwife reports</li> <li>•% of VHCs providing all five essential components of support system:               <ul style="list-style-type: none"> <li>• Supervision</li> <li>• Report Review</li> <li>• Recognition/status in community</li> <li>• Refresher training</li> <li>• Replacement of drop-outs</li> </ul> </li> <li>• HC reports</li> </ul>

INTERVENTION	SUSTAINABLE ACTIVITIES	INDICATOR
HIV/AIDS	<ul style="list-style-type: none"> <li>• Responsibility for recreation clubs for 5-14 year olds institutionalized in a local school and/or church group</li> <li>• Sustainable change in traditional social values discussed between parents and children and transmitted to young people by elders</li> </ul>	<ul style="list-style-type: none"> <li>• Number of teachers/church group leaders functioning as the leaders of recreation clubs</li> <li>• End-of-Project evaluation as measured against findings of formative research component•Supervision</li> </ul>

At the end of the Child Survival grant, both personnel resources and support systems will be left in place which will continue to sustain the interventions undertaken during the duration of the grant.

The personnel resources left in place by the project are as follows:

- 700 CHWs trained in project interventions, monitoring the health of their villages, and providing basic primary health care services to women and children;
- 65 TBAs trained in maternal care and providing antenatal care, essential home/community safe delivery services, and client education in key family planning messages, and trained in chemoprophylaxis;
- Eight HC midwives trained in basic emergency obstetric care, including referral to hospital, and in chemoprophylaxis;
- Four midwives train in WHO syndromic screening/treatment protocol for STDs;
- 64 CBDAs trained in key FP messages, providing counseling on all methods, and providing service delivery of condoms, foam, pills if the client meets the necessary criteria, and HIV/AIDS key messages.

The most significant support systems which will be left in place by the project are as follows:

- 100 VHCs providing support to the CHWs and TBAs, with particular support given for CDD, EPI, Safe Motherhood/Family Planning, and GM/Nutrition/Vit A. By the end of the project, the VHCs will provide the five essential components of a support system: supervision, report review, recognition/status in community, refresher training, and the replacement of dropouts.
- An enhanced vaccination system. The training provided to the vaccinators, as well as the creation of addition vaccination sites will both improve service delivery and improve access. In addition, ADRA will provide training to HC staff in cold chain monitoring, maintenance, and vaccine supply system. Management of this system will be institutionalized within the sub-county health management committee. By putting these systems in place, ADRA anticipates a sustainable improved level of service delivery in the target area.
- Mechanisms to improve food security. 32 contact farmers will be accessing agricultural extension services for advice, strengthening the links between rural farmers and agricultural extension workers. In addition, two locally managed seed cooperatives will be operating on a

sustainable basis by the end of the project, expanding the capacity of farmers to improve their crop yields. Finally, 35% of the households in the target area will be utilizing food storage facilities which they have built. All of these activities will provide support to the GM/Nutrition intervention of the project.

- Functioning community based emergency transport alternative to HC. Working with the VHCs, the project will designate transport teams at each RC1 and each RC1 will receive a stretcher to transport emergency cases. By the end of the project, 80% of the VHCs are expected to have transport plans in place and functioning. This support system will be of particular importance for obstetric emergencies.
- Service Quality Monitoring Systems. Institutionalized in health center midwives

Significant financial resources beyond those already programmed by the MOH are not anticipated to be necessary to the sustainability of the project activities once the project has ended. Because the project emphasizes a community based health care system of trained volunteers managed by VHCs and supported by existing MOH structures, the continued costs of the activities are minimal and will not place an additional burden upon the financial resources of the MOH.

Significant nonfinancial demands, however, will be placed upon the villages targeted. These will include the time resources spent by the volunteer CHWs and TBAs in training mothers and providing primary health care to their respective communities, time resources spent by the members of the VHCs in managing and monitoring the activities of the health volunteers (CHWs/TBAs), and time resources spent by the sub-county health management committees in supervising the EPI activities. The MOH, additionally, will clearly be required to provide overall management of the health system, and will need to maintain linkages with the VHCs to monitor health trends in the target area in order to provide the most appropriate inputs.

#### D. 2 Community involvement

The VHC is the project's primary mechanism to encourage community involvement. The VHCs will assume responsibility for the community based health system through the five essential components of a support system as defined in the chart under D.1. These include supervision of the CHWs and TBAs, review of monthly reports from the CHWs, and replacement of CHW/TBA dropouts. Each VHC will supervise the work of the volunteer health personnel in each health intervention, with the exception of the HIV/AIDS intervention. The use of village based CHWs and TBAs will also ensure a grassroots level of community participation in the project activities. Finally, at a level higher than either the volunteer workers or the VHCs, ADRA is also involving the sub-county health committees in the supervision of the EPI program. At each level of implementation, therefore, significant community involvement will be present.

An example of the degree to which the communities desire child survival services may be seen in the spontaneous formation of village song and dance troupes that perform for neighboring villages, promoting the health messages introduced by the project. These groups have formed without any official support and independently of ADRA. Typically, the songs promote good hygiene, the consumption of vegetable foods, family planning, and HIV/AIDS prevention.

Community ownership of the project is implicit in its design. In CDD, for instance, the VHCs will assume chief responsibility for providing support to the CHWs, including their supervision, the monitoring of their progress (through monthly reports submitted to the VHC), official recognition of their status as CHWs in their communities, the facilitation of refresher training for the CHWs, and the replacement of dropouts. Similarly, community ownership of the EPI program will be enhanced through the selection and training of 31 community based vaccinators (CBVs). These additional vaccinators will be supervised by another key community entity, the sub-county health committee.

The broad involvement of the communities will also be encouraged, particularly by the seed cooperative component and the construction of family food storage facilities. In this way, ADRA will involve not only mothers, children, and members of the VHCs, but also male head of households too. In a similar manner, ADRA will train CBDAs, two male and two female, to provide family planning counseling and modern contraceptives to their fellow community members. This approach is designed to reach not only women of child bearing age, but also male village members as well.

Public support for the project will be monitored at various levels. CHWs, for instance, will monitor public support for their activities through their monthly reports submitted to the VHC. The VHC, similarly, will monitor public support through the CHW reports. Members of the VHC, as community members themselves, will also informally monitor public support for the project activities. The project supervisors will monitor all project activities, paying particular attention to the activities and expressed views of VHCs concerning the CS activities. Such a tiered approach to monitoring project approach will not only allow ADRA to monitor community support for the activities, but will also establish community mechanisms to monitor public support for and attitudes about health activities in the communities.

Attached to this document are a couple of letters from Ellas Owor, a parish Health committee chair, and John Kadu, RC 5 Chairman, Luwero District. These are two of the leaders who have supported ADRA throughout CS VII and in the preparation of the DIP for the current project.

Further, sub-county health management committee representation and village health committee representation assisted in the DIP planning. The field supervisor trainers have been selected from the committees and were also involved in the DIP planning workshop. Discussion from community representation during the report to the community on the baseline survey results also has fed into the planning of this DIP.

#### D. 3 Collaboration

Key collaborative relationships between the project and local entities are:

- FPAU - Family Planning Association of Uganda. Training Resources.
- DISH - Family Planning training.
- UNFPA - MOH entity concerned with family planning. Training resources.

- SYFA - (Safeguard Youth from AIDS), a UNICEF/MOH entity. Training resource materials.
- TASO - Organization training community leaders in HIV/AIDS messages. Training resources.
- EMREF - General CS collaborator.
- World Vision - General CS collaborator.
- Agricultural extension workers in sub-counties
- District Medical Office - primary relationships with District Health Educator and the District Health Visitor - Mother/Child Care/Family Planning
- RC3 - Health Committees
- RC2 - VHCs
- RC1 - GM

The key levels of cooperation are shown in the following table.

Health Department	Responsibilities
District Health Committee	<ul style="list-style-type: none"> <li>•Referral system is functioning</li> <li>•Vaccines are available</li> </ul>
RC-3 Sub-county Health Committee	<ul style="list-style-type: none"> <li>•Cold Chain monitoring</li> </ul>
Parish Development committee	<ul style="list-style-type: none"> <li>•Village health committees supervision</li> </ul>
RC-1	<ul style="list-style-type: none"> <li>•Responsible for the scales used in weighing centers</li> </ul>
Village Health Committee	Responsible for support of CHWs, TBAs, and CBVs

Additional links may be seen in the chart entitled Local Government, Community, and ADRA relationships found in Appendix X.

Significant knowledge transfer will take place between the project and the CHWs, TBAs, CBVs, HC midwives, CBDAs, VHCs, and sub-county health committees. No financial exchange is planned.

#### D. 4 Phase-over plan

Due to the immediate focus of the program upon the education of local community groups and individuals to provide health services and to manage those services, there is no distinct phase over period in the project. From the beginning, ADRA will regard the VHCs as the primary managing body of the community health care system, though their capacity to fully assume this role is expected to increase gradually over the life of the project. Thus phase over will commence immediately and will be gradual, reaching completion by the final year of the project.

The primary local institutions which will assume full responsibility for the project interventions are the VHCs, the sub-county health committees, the Parish Development Committees, the District Health Committee, and the RC-1. Their responsibilities are described in the chart immediately preceding this section.

Training to enhance the management skills of staff in these institutions are as follows:

- The Sub-County Health Committee. The members of this committee will receive training in cold chain management. There is a lack of strength in some of the local health institutions, mainly in the cold-chain for vaccines. Part of the sustainability strategy is to provide refresher training to vaccinators so that access to this program can be strengthened.

#### D. 5 Cost Recovery

The program is designed to reinforce community ownership and management of the health messages and services. As such, there are no significant direct costs to be recovered. However, minor direct costs will be incurred in the FP component. CBDAs, therefore, will charge fees for contraceptives sufficient to cover the costs of acquisition and distribution. The acceptability of this cost recovery strategy will be monitored by the project supervisors. Overall responsibility for implementing the FP cost recovery strategy will be assumed by Kate Kafeero, the Technical Specialist for Family Planning.

The seed cooperatives will be organized to be internally managed with internal cost/in-kind recovery for sustainability. No outside funding will be required for ongoing operations. The bicycles for the CBDAs, the vaccinators, and the supervisors will be assigned either to the county health committees or the Village health committees to manage. ADRA will directly work with each VHC to set up a workable plan that they and the CBDAs and CBVs agree on, which will maintain the bicycles and provide some sustainable incentive to the volunteers.

### **Section E. PROJECT MONITORING HEALTH INFORMATION SYSTEM**

#### E.1 HIS plan

A full time HIS coordinator with computer experience, Joseph Hayuni, will be responsible for the project HIS system. The biodata sheet is attached. Technical assistance on the HIS from ADRA HQ has been provided in the DIP preparation process, and further refinement of the HIS system will be included in a subsequent technical visit in the third quarter of the first year (in conjunction with the technical assistance in the formative research). This technical assistance will be provided by Mike Negere, DrPH, MPH, private consultant for ADRA HQ. Further technical evaluation and assistance will take place at the time of the mid term evaluation. Other technical assistance on the HIS will be scheduled as needed. It is expected that the HIS system will be fully operational by the fourth quarter of year one.

ADRA's focus in all its CS HIS systems is to first create a community friendly system. This simply means that the first question asked in developing the project HIS system is, "What information is needed on a regular basis at the community level for management of the local health services in that community." This question is then asked at each level (community - village health committee level), sub county - health management committee and health center management committee, and subsequently to the district medical office. This then provides the core, sustainable HIS system that will be continued after the project is completed. Other data will be gathered which will be used by the project in its project design, monitoring, and evaluation, such as: formative research, impact

measurement, KPC data from survey. As this data is useful for health management within the subcounty or district, it will be shared and the collection/analysis process institutionalized in the existing MOH or local government systems.

## E.2 Census information

The project has not and has no plans to do a complete census in the project target area.

## E.3 Data collection and use

The project will collect and utilize data in essentially four categories:

- 1) **Formative research** : further specific information particularly in the HIV/AIDS component for effective program design. (See Appendix I, Section 7g.5 for details on the HIV/AIDS formative research planned).
- 2) **Impact measurement:**
  1. **Maternal Mortality:** Annual maternal deaths in target area according to local vital events registry decreasing over life of project [Subcounty Vital Events Registry]
  2. **Child Mortality:** Annual deaths of children under five years of age according to local vital events registry, decreasing over life of project [Subcounty Vital Events Registry]
  3. **Morbidity:** Diarrheal disease cases treated in Health Centers - decreasing incidence over time [HC records]; Surveillance of immunizable diseases of neonatal tetanus, measles and polio, incidence decreasing over life of project [Health Center Records, Sub-county Vital Events Register]
  4. **Food Security:** Percent of households with food available year round through utilizing food storage facilities increased from 18.7% to 35% [Survey]

### 3) **Effect measurement:**

The primary effect measurement tool is the mandated KPC 30 cluster sample survey which has been done as a baseline and will be repeated at end of project. From this survey the 17 mandated indicators are calculated and other information provided. See the baseline survey summary report in section C.1 of this document and the separate baseline survey report document accompanying this document. For this project, indicator number nine is not responded to since there is no ALRI component planned.

4) **Process monitoring:**

Process monitoring will utilize several reporting forms:

<b>Report form</b>	<b>Reporting frequency</b>	<b>Monitoring person, entity</b>
Training reports on each training activity noting pretest/posttest information.	Per training schedule	Training coordinator
Village health committee report (summary report of CHW activities and VHC activities).	Monthly	<u>ADRA</u> : Subcounty supervisor, HIS coordinator <u>Local management</u> : Subcounty health management committee
Project reports following the standard ADRA reporting format.	Quarterly	Project director, ADRA Country director, ADRA/HQ
Project financial statements.	Monthly	Project director, ADRA Country director, ADRA/HQ
Subcounty Health Management Committee minutes.	Monthly	<u>ADRA</u> : Subcounty supervisor, project director <u>Local management</u> : Sub county chairman, DMO
Health Center midwives report which will include the TBA's report.	Monthly	<u>ADRA</u> : Family planning coordinator <u>Local management</u> : Subcounty health management committee
TBA's report submitted to the health center midwives.	Monthly	Health Center midwives
Health Center cold chain monitoring report.	Monthly	<u>ADRA</u> : Subcounty supervisor <u>Local management</u> : Subcounty health management committee
CHW's report.	Monthly	<u>ADRA</u> : Trainer supervisors, subcounty supervisor, HIS coordinator <u>Local management</u> : Village Health Committee
Contact farmers reports.	Monthly	<u>ADRA</u> : Agriculture coordinator <u>Local management</u> : Agriculture extension agent
CBDA report.	Monthly	<u>ADRA</u> : FP coordinator <u>Local management</u> : Health center FP provider
Community Vaccinators report.	Monthly	<u>ADRA</u> : Subcounty supervisor <u>Local management</u> : Village Health Committee, Subcounty Health Management Committee

Please refer to Table B where the specific effect indicators to be monitored are indicated in column two, the process indicators/targets to be monitored are indicated in column four, and how the output targets are to be monitored indicated in column five.

#### E.4 HIS training for staff

The HIS coordinator has academic and practical experience in the area of statistics. He will be responsible for training of staff in data collection.

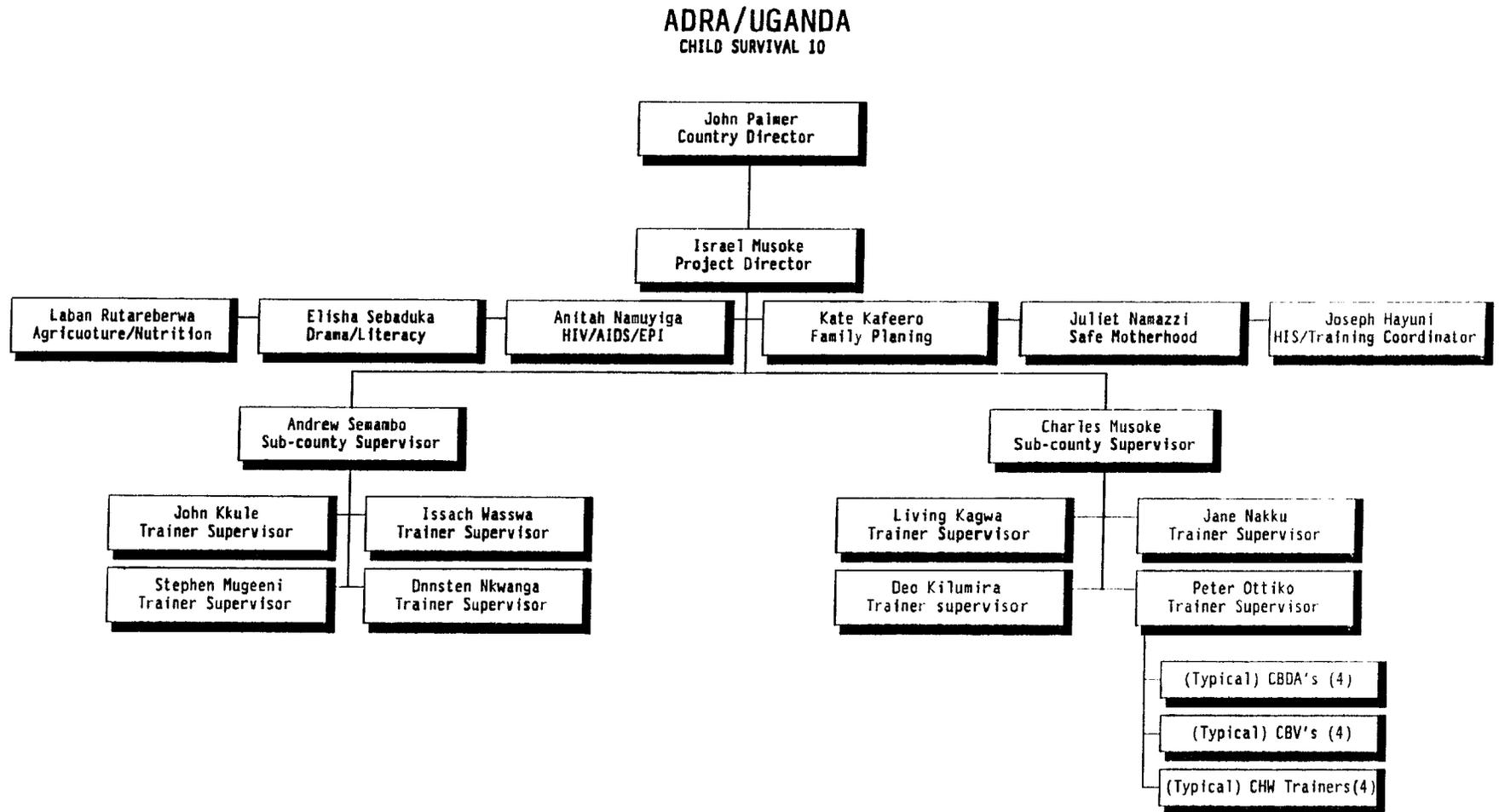
#### E.5 Baseline survey inputs

Project field staff who are from the communities in the target area were involved as interviewers in the baseline survey. The results of the baseline were shared with community representatives from the VHCs, RC1s and RC3s, and the subcounty health management committees. This discussion of the results with the community representatives has contributed directly to this DIP.

#### F.1 Organizational Chart

The following chart represents the structure of responsibility within the CSX project, including both areas of responsibility (Family Planning, HIV/AIDS, training, etc.) and lines of accountability. With the exception of the Country Director position, all staff are host country nationals. All named positions here are full-time contract workers for ADRA/Uganda.

F.1



**Notes:**

With the exception of the country directors position, all staff are host country nationals.  
All named positions here are full-time contract workers for ADRA/Uganda.

All technical staff (as indicated by area of technical expertise) are in advisory positions to the sub-county supervisors who form the direct link to the communities. The sub-county supervisors are responsible for managing the CHWs, TBAs, CBVs, and CVDAs that are part of the project. They also directly supervise the eight trainer supervisors who in turn supervise the persons who interact with the communities. These include the trainers responsible for the community health workers (CHW trainers), the Community-based Vaccinators (CBVs), and the Community based distributors (CBDs). There are 32 each at this level.

Each of the 32 CHW trainers supervises 20-25 volunteer CHWs who, in turn, are responsible for about 20 households each in the community.

All persons below the level of trainer supervisor are voluntary. The Trainer Supervisors, the CBVs and the CBDs will be given the use of a bicycle as a facilitator for their work, and as an incentive. The CHW's will receive periodic allotments of used clothing as incentives. It is expected that the bikes will be under the management of the Village Health committees.

## F. 2 Community Groups

The following table indicates the principal community groups, their relationship to the project, and the project personnel who will be responsible for supervising the relationship.

Community group	Relationship to Project	Frequency of Meetings	Person/job title of Responsible Person
Women's Groups	Trained by CHWs	weekly	8 supervisors
Farmers' Co-ops	Participate in demonstration gardens	monthly	Laban Rutareberwa, Agriculture/Nutrition
Village Health Committee	•In charge of "ADRA's" CHWs, Vaccinators, CBDs and Bicycles.	Bi-weekly	Andrew Semambo, Charles Musoke, Sub-county supervisors
Health Management committee	•Organizing and providing training sites and support	Monthly	Joseph Hayuni, HIS/Training Coordinator
Recreation clubs for 6-15 year-olds	•Formed by ADRA •Provide drama groups for message dissemination	Twice weekly	Elisha Sebaduka, Drama/Literacy

See the attached chart Local Government, Community, and ADRA relationships, for further clarification of the linkages of the project with the community.

## F.3 Community Health Workers

The total number of CHWs taking part in the project are 700. On the average the ratio of community workers to the number of households is 1:20.

#### F.4 Volunteer Turnover

The experience gained from CS VII indicates that the turnover in the area is typically very low. When drop-outs do occur, it is typically because the individual acting as a CHW has moved to another parish or sub-county. However, even in these cases, such individuals are usually absorbed by the village health committee in the new area, and are thus able to continue to use their skills gained in the project.

Upon the event of a drop-out, the village health committee is responsible for filling any vacancies which occur. The new CHW then trains with another functioning CHW until she is ready to assume her full responsibilities. The CHW trainer also trains her in key messages when he makes his supervisory visits, and gauges her progress.

A more serious constraint on the project would be the drop-out of CHW trainers. It is expected, however, that such drop-outs will be very low due to the high status and responsibility enjoyed by the CHW trainers in their communities. In the event, however, of a CHW trainer vacancy, a similar strategy will be followed as that taken for CHW drop-outs. The VHC, in consultation with the sub-county HC, will identify a replacement, who will then train with a fellow CHW trainer.

Minor incentives will be used by the project. These will include leather satchels for the CHWs identifying them to their constituent communities. By clearly identifying the CHWs, their stature in the community will be further enhanced, contributing to the long term stability of the CHW workforce. As stated earlier, a small allotment of used clothing will also be provided. While the allotment of clothes is a sustainable activity, it is consistent with the GOU norms for incentives.

#### F.5 Technical assistance

ADRA will request technical assistance in the Safe Motherhood and HIV/AIDS education components, the two programmatic sectors in which ADRA is expanding its activities under the CSX. There are various NGOs and para-governmental institutions in Uganda which have done research and implemented programs in both family-planning and in the area of HIV/AIDS. In the family-planning sector the principle source for data and educational materials will be the Ugandan Family Planning Association. Various organizations have gathered data and gained significant technical expertise in on how to approach the problem of AIDS in Uganda. These include, World Vision, AMRED, TASO, and SYFA. In the CHW and CBD training components ADRA will contract with these organizations to help craft the key messages for the CHWs and CBDs, as well as their operating methods.

ADRA has not yet formulated a detailed schedule of technical assistance, and though ADRA has met with representatives of the organizations mentioned, contractual negotiations are still ongoing. However, no obstacles to collaboration between ADRA and these organizations are anticipated.

F.6 Role of country nationals

All of the project staff are country nationals, most of whom have been in managerial/technical advisory position under CS VII for the past three years. The results of CS VII as demonstrated in the final evaluation for that project attest to the competence of these national staff. During the DIP process, ADRA International worked to build upon this expertise, further training the staff in methods of planning based upon qualitative research. In addition, ADRA International staff devised the budget with the full participation of key project staff to ensure a full understanding of budget limitations. The ADRA/Uganda country office will assume accounting responsibility for the project. The accountant there, also a national, will receive ongoing technical backstopping from both the Ugandan SDA union treasurer as well as from the HQ financial compliance officer.

A constraint in the CS VII project was that the field office and the key staff did not have ready access to computers, and as a result all lack sufficient literacy in the use of computers. The new HIS/Training technician, however, has extensive university experience in computer science and will train and provide assistance to project staff in computer use, thereby improving the efficiency of the project and the management of project data.

The staff will be working with the VHCs and the DMO to formulate cost recovery strategies for the family planning supplies and the seedbanks. This work will require some knowledge of how to project costs.

F.7 Role of headquarters staff

The table below indicates the frequency and purpose of ADRA supervision of the project.

Person	From Office	Technical Skills	Visits	Length of visit	Purpose of visit
Regional Administrator, (To be Appointed)	Harare Regional Office	Administrative	6	2 days	Systems control
Senior Health Advisor, (Dr. Jerald Whitehouse)	HQ office	Public Health	4	9 days	Training/research
Senior Manager, (Milton McHenry)	HQ office	Administrative	4	7 days	Administration & compliance
Financial Compliance Officer, (Peter Grav)	HQ office	Financial	5	10	Financial compliance & training

## Section G. TRANSPORT AND LOGISTICS

### G.1 Transport

The CHWs are assigned according to the geographical area of influence. Because of the close proximity of the households for which they are responsible, no transport constraints are anticipated. However, the CHW trainers will have to travel between villages to supervise the CHWs and to gather data. It is for this reason the project will make a bicycle available to each CHW Trainer and CBV. 62 bicycles will be purchased locally by the project for this purpose. An additional eight will also be purchased for the Trainer Supervisors. The two Sub-County Supervisors will have the use of a motorcycle to cover their territory. The field office has two 4-WD vehicles and a motorcycle to transport technical staff and the Project Director to the various training sites as needed.

### G.2 Procurement

All necessary supplies and equipment still needed by the project are listed in the budget. No further supplies or equipment will be required.

## Section H. DIP SCHEDULE OF ACTIVITIES

See Table D.

## Section I. FIELD PROJECT BUDGET

### Direct Costs

#### A. Personnel

1. **Headquarters-** In the attached detailed Headquarters budget three areas are identified as providing back-stopping to the field project: Management, Health, and Financial. These are calculated as providing approximately three weeks a year of direct back-stopping. As with almost all line items, an inflation of 3%/year is calculated. Technical support with Evaluation, accounting and general support is calculated at two weeks per year.
2. **Field, Technical -** In the attached detailed Field budget each position and pay rate per month is specified in the Narrative with the budget.
3. **Field, Other personnel -** In the attached detailed Field budget are the positions and pay rates for the other personnel. Note that this has been split into support and Administrative sections.

## **B. Travel/Per Diem**

There is no travel for HQ budgeted either domestic or International. When personnel travel from the HQ office to the field it will be as consultants.

1. **Field - In-Country** This group includes the costs of supervisory travel by the country director, and the internal travel by staff and workshop participants. As vehicle costs are covered under a different line item, travel costs are not very heavy.
2. **Field - International.** This includes the cost of the international consultants and auditors travel, as well as a line item to provide for key staff upgrading in workshops outside of Uganda.

## **C. Consultancies**

1. **Evaluation Consultants-Fees:** The cost of the external consultant for years two (ME) and three (EDP) for approximately 15 days of work each time.
2. **Other - Fees:** This is used for principally the time that HQ personnel are in the field back-stopping the program directly.
3. The personnel in the above sections have budgeted travel and per/diem. As per standard regulations, travel is done with American carriers.

## **D. Procurement**

1. **Headquarters:** No HQ supplies or equipment are budgeted.  
**Field-Pharmaceutical:** (D.4.d) Any pharmaceuticals are purchased with ADRA funds. In the budget are additional USAID funds that can be used for some of the shipping/handling costs.  
**Field-Other:** (D.4) The working budget (in appendix) details the different things that will be bought under the supplies line items. There are agricultural line items, but any seeds or chemicals, will be purchased with ADRA funds.
2. **Equipment-Headquarters:** No equipment purchases are budgeted for HQ.  
**Field:** (D, D.1,2) There are two areas of the Field budget that cover equipment purchases. There are items for the field that are purchased at HQ--much of the electronic items such as the microcomputers are bought there. In the field items are such things as the vehicles and furniture. All equipment purchases are purchased with ADRA funds, with the exception of locally-purchased office furniture.
3. **Training-Headquarters:** No HQ training costs are budgeted.  
**Field:** The training line item in the field budget is the costs of the training of the VHCs and associated personnel. As a major part of this project is training, this line

item shows heavy costs during the first two years. This line item includes registration, lodging, and foods costs for the trainees while they are being trained.

E. **Other Direct Costs**

Explained in the budget.

**Indirect Costs**

The attached agreement is for the latest negotiated indirect cost rate with USAID which is covering the agency as a whole. (Independent agreements are not done for the field.)

**DIP TABLE D: HEADQUARTERS SCHEDULE OF ACTIVITIES**  
(Check box to specify Quarter and Year)

PVO: ADRA/Uganda

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
<b>1. Personnel in Position</b>	X											
a. HQ/HO Technical	X	X	X	X	X	X	X	X	X	X	X	X
b. HQ/HO Administrative	X	X	X	X	X	X	X	X	X	X	X	X
c. Country 1 Key Staff		X	X	X	X	X	X	X	X	X	X	X
d. Country 2 Key Staff												

<b>2. Baseline Reports Completed</b>												
a. Country 1		X										X
b. Country 2												

<b>3. Training Completed</b>												
a. Country 1												
b. Country 2												

<b>4. Procurement of Supplies</b>		X										
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<b>5. Services Delivery Initiated</b>												
a. Country 1												
b. Country 2												

*Handwritten mark*

**DIP TABLE D: HEADQUARTERS SCHEDULE OF ACTIVITIES**

PVO: <u>ADRA/Uganda</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
<b>6. HQ/HO Technical Staff Visits</b>												
a. Country 1	X	X	X		X		X		X			X
b. Country 2												
<b>7. Health Info. System Functioning</b>												
a. Country 1												
b. Country 2												
<b>8. Mid-Term/Final Evaluation</b>							X					X
<b>9. A.I.D. Reports Prepared</b>												
a. Country 1		X			X		X		X			X
b. Country 2												

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DIP TABLE D: FIELD PROJECT SCHEDULE OF ACTIVITIES

PVO: <u>ADRA</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
Country: <u>UGANDA</u>												
<b>1. Personnel in Position</b>											X	X
a. Project Manager	X	X	X	X	X	X	X	X	X	X		
b. Technical Coordinator		X	X	X	X	X	X	X	X	X		
c. Health Information System Manager		X	X	X	X	X	X	X	X	X		
d. Community/Village health workers		X	X	X	X	X	X	X	X	X		
e. Other Support			X	X	X	X	X	X	X	X		

<b>2. Health Information System</b>												
a. Baseline Survey												
- Design/preparation	<X											X
- Data collection and analysis	<X	X										X>
- Dissemination and feedback to community and project management		X										X>
b. Consultants/contract to design HIS												
c. Develop and test HIS			X									
- Implementation			X	X	X	X	X	X	X	X	X	X
- Development and feed back to community and project management												

DIP TABLE D: FIELD PROJECT SCHEDULE OF ACTIVITIES

PVO: <u>ADRA</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
Country: <u>UGANDA</u>												
<b>3. Training</b>												
a. Design		X		X	X					X		
b. Training of trainers		X		X	X					X		
c. Training sessions			X	X	X	X	X	X	X		X	
d. Evaluation of knowledge of skills				X		X		X		X		X
<b>4. Procurement of Supplies</b>		X	X	X	X	X	X	X	X	X	X	
<b>5. Service Delivery to be initiated</b>												
a. Area 1-Kalagera sub-county												
- Control of Diarrheal Diseases	X	X	X	X	X	X	X	X	X	X	X	X
- Immunization	X	X	X	X	X	X	X	X	X	X	X	X
- Nutrition:	X	X	X	X	X	X	X	X	X	X	X	X
Breastfeeding	X	X	X	X	X	X	X	X	X	X	X	X
Growth Monitoring/Promotion	X	X	X	X	X	X	X	X	X	X	X	X
- Micronutrients												
- HIV		X	X	X	X	X	X	X	X	X	X	X
- Control of Pneumonia												
- Maternal Care/Family Planning	X	X	X	X	X	X	X	X	X	X	X	X
- Other - Malaria Prophylaxis			X	X	X	X	X	X	X	X	X	X

**DIP TABLE D: FIELD PROJECT SCHEDULE OF ACTIVITIES**

PVO: <u>ADRA</u>	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
Country: <u>UGANDA</u>												
<b>b. Area 2-Zirobwe sub-county</b>												
- Control of Diarrheal Diseases	X	X	X	X	X	X	X	X	X	X	X	X
- Immunization	X	X	X	X	X	X	X	X	X	X	X	X
- Nutrition:												
Breastfeeding		X	X	X	X	X	X	X	X	X	X	X
Growth Monitoring/Promotion		X	X	X	X	X	X	X	X	X	X	X
- Micronutrients												
- HIV			X	X	X	X	X	X	X	X	X	X
- Control of Pneumonia												
- Maternal Care/Family Planning	X	X	X	X	X	X	X	X	X	X	X	X
- Other-Malaria Prophalaxis												

<b>6. Technical Assistance</b>												
a. HQ/HO/Regional office visits				X			X				X	
b. Local Consultants			X		X				X			
c. External technical assistance	X	X	X		X		X		X		X	

<b>7. Progress Reports</b>												
a. Annual project reviews				X				X				X
b. Annual reports					X				X			X
c. Mid-term evaluation							X					
d. Final evaluation												X

**CHILD SURVIVAL X  
HEADQUARTERS BUDGET**

	Year one		Year two		Year three		All years		Grand Total
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	
Headquarters support									
A. Personnel									
1 Direct Backstopping									
a Grant Manager	2,750	917	2,833	972	2,917	1,030	8,500	2,918	11,410
b Health Advisor	2,750	917	2,833	972	2,917	1,030	8,500	2,918	11,410
c Financial Compliance	2,750	917	2,833	972	2,917	1,030	8,500	2,918	11,410
Subtotal direct backstopping	8,250	2,750	8,498	2,915	8,752	3,090	25,500	8,755	34,255
2 Technical support									
a Evaluation	1,750	583	1,803	618	1,857	655	5,409	1,857	7,266
b Accounting	1,200	400	1,236	424	1,273	449	3,709	1,273	4,980
c Support staff	750	250	773	265	796	281	2,318	796	3,111
Subtotal technical support	3,700	1,233	3,811	1,307	3,925	1,386	11,436	3,926	15,360
Subtotal Personnel	11,950	3,983	12,309	4,222	12,678	4,476	36,936	12,681	49,618
E. Other HQ costs									
1 Communication									
a. Telephone	600	200	618	212	637	225	1,855	637	2,491
b Fax	300	100	309	106	376	112	985	318	1,303
c Mail/express	150	50	155	53	159	56	464	159	623
Subtotal Communication	1,050	350	1,082	371	1,172	393	3,303	1,114	4,417
2 Report Preparation	450	150	464	159	477	169	1,391	478	1,868
Subtotal other HQ costs	1,500	500	1,545	530	1,649	562	4,694	1,592	6,286
<b>TOTAL HEADQUARTERS COSTS</b>	<b>13,450</b>	<b>4,483</b>	<b>13,854</b>	<b>4,752</b>	<b>14,327</b>	<b>5,037</b>	<b>41,630</b>	<b>14,273</b>	<b>55,903</b>
Uganda external field costs.	27,050	14,100	31,122		36,387	2,500	94,559	16,600	111,159
Uganda field program costs	122,491	49,250	119,287	27,420	95,156	16,645	336,933	93,315	430,248
Subtotal Uganda field costs	149,541	63,350	150,408	27,420	131,543	19,145	431,492	109,915	541,407
Total direct costs	162,991	67,833	164,262	32,172	145,870	24,182	473,122	124,188	597,310
Indirect costs	27,708	18,315	27,924	8,687	24,798	6,529	80,431	33,531	113,962
		17 %							
(17% USAID, 27% ADRA)									
10% unrecovered indirect costs		16,299		16,426		14,587		47,312	47,312
<b>Total Program Costs</b>	<b>190,699</b>	<b>102,447</b>	<b>192,186</b>	<b>57,285</b>	<b>170,668</b>	<b>45,299</b>	<b>553,553</b>	<b>205,031</b>	<b>758,584</b>
<b>Match</b>				27.03%					
Cash appropriation to field	43,200								

**UGANDA FIELD COSTS**

**Accounted for at HQ**

	Year one		Year two		Year three		All years		Grand Total
	USAID	ADRA	USAID	ADRA	USAID	ADRA	USAID	ADRA	
<b>UGANDA EXTERNAL FIELD COSTS</b>									
<b>B. International travel</b>									
1 Auditing			2,833		2,918		5,751		5,751
2 Management	2,750		2,833		2,917		8,500		8,500
3 Health	2,750		2,833		2,917		8,500		8,500
4 Finance	2,750		2,833		2,917		8,500		8,500
5 Evaluation			2,833		5,751		8,584		8,584
6 HIS			2,833		2,917		5,750		5,750
<b>Subtotal International Travel</b>	<b>8,250</b>		<b>16,997</b>		<b>20,338</b>		<b>45,585</b>		<b>45,585</b>
<b>C. Consultants/Services</b>									
1 A-133 audits			1,000		1,030	2,500	2,030	2,500	4,530
2 Management	1,750		1,803		1,857		5,409		5,409
3 Health	1,750		1,803		1,857		5,409		5,409
4 Financial	1,750		1,803		1,857		5,409		5,409
5 Training of Trainers	2,250		2,318		2,387		6,955		6,955
6 Evaluation			5,400		5,562		10,962		10,962
7 HIS	1,750						1,750		1,750
<b>Subtotal consultants/services</b>	<b>9,250</b>		<b>14,125</b>		<b>14,549</b>	<b>2,500</b>	<b>37,924</b>	<b>2,500</b>	<b>40,424</b>
<b>D. Procurement</b>									
1 Computers		7,000						7,000	7,000
2 Photocopier		1,600						1,600	1,600
3 Printers		2,500						2,500	2,500
4 Fax Machine		1,400						1,400	1,400
<b>Subtotal Procurement</b>		<b>12,500</b>						<b>12,500</b>	<b>12,500</b>
<b>E. Other Direct Costs</b>									
1 DIP orientation	2,800						2,800		2,800
3 Final baseline					1,500		1,500		1,500
4 Shipping/clearing	6,750	1,600					6,750	1,600	8,350
<b>Subtotal Other Direct costs</b>	<b>9,550</b>	<b>1,600</b>			<b>1,500</b>		<b>11,050</b>	<b>1,600</b>	<b>12,650</b>
<b>Total External Field Costs</b>	<b>27,050</b>	<b>14,100</b>	<b>31,122</b>		<b>36,387</b>	<b>2,500</b>	<b>94,559</b>	<b>16,600</b>	<b>111,159</b>

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**UGANDA CHILD SURVIVAL X  
DETAILED FIELD BUDGET**

Item	YEAR ONE		YEAR TWO		YEAR THREE		ALL YEARS		GRAND TOTAL	NARRATIVE
	AID	ADRA	AID	ADRA	AID	ADRA	AID	ADRA		
<b>A. Personnel</b>										
1 Administrative										
a Regional Director				3,863		3,979		7,842	7,842	1 pm/year @\$3750/month w 6% i
b Country Director		6,000		11,588		11,936		29,524	29,524	3 pm/year @\$3750/month w 6% i
c Project director	6,315		6,504		6,700		19,519		19,519	36 p/m @\$526/m w 6% inflation
Subtotal administrative	6,315	6,000	6,504	15,451	6,700	15,915	19,519	37,366	56,885	
2 Technical										
a Agriculture/Nutrition	5,222		5,379		5,540		16,141		16,141	36pm @\$435/m w 6% inflation
b HIV/EPI technician	3,376		5,222		5,379		13,977		13,977	32pm @\$422 w 6% inflation
c Nurse/FP	2,484		2,559		2,635		7,678		7,678	36pm @\$207/m w 6% inflation
d HIS/Training	2,736		4,223		4,350		11,309		11,309	32pm @\$342/m w 6% inflation
e Safe Motherhood	3,768		3,881		3,997		11,647		11,647	36pm @\$314/m w 6% inflation
f Literacy training/dra	2,536		3,928		4,046		10,510		10,510	32pm @\$317/m w 6% inflation
Subtotal Technical	20,122		25,191		25,947		71,260		71,260	
3 Support Staff										
a Sub-county supervisor	3,552		5,944		6,122		15,618		15,618	2 x 32m @\$222/m w 6% infl.
b Trainer supervisors	3,945		6,095		6,278		16,318		16,318	8 x .5 x 32pm @\$155/m w 6% inf
c Secretary	1,352		2,089		2,152		5,593		5,593	32pm @\$169/m w 6% infl
d Driver	1,350		1,854		1,910		5,114		5,114	33 pm @\$150/m w 6% infl.
e Demonstration gardner	600						600		600	2 x 12pm @\$25/m
f Security	2,400		2,472		2,546		7,418		7,418	2x32pm @\$150/m w 6% infl
Subtotal Support	13,199		18,454		19,008		50,661		50,661	
4 Employee benefits										
a Expat allowances		650		689		730		2,069	2,069	Portion of country directors a
b Employee benefits	4,800	17,700	1,200		1,272		7,272	17,700	24,972	3-year rent contract for 6 key
Subtotal Benefits	4,800	18,350	1,200	689	1,272	730	7,272	19,769	27,041	
<b>Total Personnel</b>	<b>44,436</b>	<b>24,350</b>	<b>51,350</b>	<b>16,140</b>	<b>52,926</b>	<b>16,645</b>	<b>148,712</b>	<b>57,135</b>	<b>205,847</b>	
<b>B Travel</b>										
1 Manager travel/national	2,400	500	2,472	500	2,546		7,418	1,000	8,418	Transportation costs for count
2 Int. Conference	750		773				1,523		1,523	Travel to International worksh
3 Staff/Volunteers	1,300		1,339		1,379		4,018		4,018	Local participant travel for w
Subtotal Travel	4,450	500	4,584	500	3,925		12,959	1,000	13,959	
<b>C. Consultancies</b>										
1 Family Planing/Vacinator	1,800		1,000				2,800		2,800	70p/days @\$40pd w 6% infl.
2 Training	200		212		200		512		512	10 p/days @\$40 w 6% inflation
Subtotal Consultancies	2,000		1,212		2,000		3,312		3,312	

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Item	YEAR ONE		YEAR TWO		YEAR THREE		ALL YEARS		GRAND TOTAL	Narrative
	AID	ADRA	AID	ADRA	AID	ADRA	AID	ADRA		
<b>D. Procurement</b>										
1 Equipment										
a Video player		2,000						2,000	2,000	Show HIV/Aids videos
c Office Furniture	800						800		800	office furniture
Subtotal office equipment	800	2,000					800	2,000	2,800	
2 Vehicles										
b 3 motorcycles		11,400						11,400	11,400	3 @ \$3800 in country
c Bicycles	5,950						5,950		5,950	70+ Bicycles @\$85
Subtotal vehicles	5,950	11,400					5,950	11,400	17,350	
3 Technical Equipment										
a Scales	2,400						2,400		2,400	100 replacement scales @\$24/scale w
b Medical Center equipm	2,000						2,000		2,000	To strengthen 4 Safe Motherhood clin
c Teaching aids	300		318		337		955		955	Flip Charts, Puppets, Training manua
Sub-total technical equipme	4,700		318		337		5,355		5,355	
4 Supplies										
a Office supplies	1,510		1,555		1,502		4,567		4,567	Paper, Cartridges, routine supplies
b Gardening Supplies	1,500	500	300	250	309		2,109	750	2,859	Seeds, tools, supplies
c Promotional Material	200		206		212		618		618	Identification and promotional mater
d Medical/family planing	500	500	515	530	530		1,545	1,030	2,575	Cloroquin, Albendesol, contraceptives,
g Recreational Center	3,500		3,500				7,000		7,000	Sports and Drama supplies for 4 Rec.
h Storage Satchels	5,400		6,500				11,900		11,900	1580 Satchels for trainers, supervisc
Subtotal supplies	12,610	1,000	12,576	780	2,654		27,840	1,780	29,620	
5 Services										
a Accounting support	5,400		5,562		5,729		16,691		16,691	Accounting/Financial support @\$450/m
c Training/Duplicating	16,500		16,995		2,000		35,495		35,495	Training costs for TBA/s CBD's HP/s
Sub-total Services	21,900		22,557		7,729		52,186		52,186	
<b>TOTAL PROCUREMENT</b>	<b>45,960</b>	<b>14,400</b>	<b>35,451</b>	<b>780</b>	<b>10,720</b>		<b>92,131</b>	<b>15,180</b>	<b>107,311</b>	
<b>E. Other Direct Costs</b>										
1 Communications	1,200		1,236		1,301		3,737		3,737	Postage, Phone, fax
2 Vehicle Operation	8,445		8,698		8,959		26,102		26,102	Maintenance, repair fuel, oil, filter
3 Vehicle Insurance	4,800		4,944		5,092		14,836		14,836	2 Vehicles + 3 Motorcycles
4 Equipment maint	2,000		2,060		2,122		6,182		6,182	Cost of equipment repair
5 Build/ equip. insurance	1,800		1,854		1,910		5,564		5,564	
7 Office rent	2,400		2,472		2,546		7,418		7,418	Central Office @\$200/m w 6% inflator
8 Utilities	1,200		1,236		1,273		3,709		3,709	Water, electricity
9 Operation center rent	3,000		3,090		3,182		9,272		9,272	Project office @\$250/month
10 Evaluation report prepar	800		1,100		1,100		3,000		3,000	Printing and mailing costs
11 CHV support		5,000		5,000				10,000	10,000	Clothing incentives for the CHV's
12 Control Diarrheal Disease		5,000		5,000				10,000	10,000	Water and Sanitation projects
Subtotal other direct Costs	25,546	10,000	26,690	10,000	27,485		79,820	20,000	99,820	Match
<b>TOTAL FIELD COSTS</b>	<b>122,491</b>	<b>49,250</b>	<b>119,287</b>	<b>27,420</b>	<b>95,156</b>	<b>16,645</b>	<b>336,933</b>	<b>93,315</b>	<b>430,248</b>	21.69%

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Country/PVO:  
 Cooperative Agreement #:  
 Original budget prepared:  
 Date submitted to USAID

ADRA/Uganda  
 FAO-U500-A-00-4038-00  
 January, 1995  
 March, 1999

**TABLE B: HEADQUARTERS BUDGET**

Check one: Original Budget  REVISED BUDGET

		YEAR 1		YEAR 2		YEAR 3		TOT. YEAR:
		AID	PVO	AID	PVO	AID	PVO	
<b>I. DIRECT COSTS</b>								
<b>A. PERSONNEL</b> (salaries, wages, fringes)	1. Headquarters-wages/salaries	11,950	3,983	12,309	4,222	12,678	4,476	
	2. Field, technical personnel-wages/salaries							
	3. Field, Other personnel wages/salaries							
	4. Fringes-Headquarters + Field							
	<b>SUBTOTAL-PERSONNEL</b>	<b>11,950</b>	<b>3,983</b>	<b>12,309</b>	<b>4,222</b>	<b>12,678</b>	<b>4,476</b>	
<b>B. TRAVEL/PER DIEM</b>	1. Headquarters-Domestic (USA)							
	2. Headquarters-International							
	3. Field-In country							
	4. Field-International							
	<b>SUBTOTAL-TRAVEL/PER DIEM</b>							
<b>C. CONSULTANCIES</b>	1. Evaluation Consultants-Fees							
	2. Other Consultants-Fees							
	3. Consultant travel/per diem							
	<b>SUBTOTAL-CONSULTANCIES</b>							
<b>D. PROCUREMENT</b> (provide justification/ explanation in narrative)	1. Supplies							
	a. Headquarters							
	b. Field-Pharmaceuticals (ORS, Vit. A. Drugs, etc.)							
	c. Field-other							
	2. Equipment							
	a. Headquarters							
3. Training								
a. Headquarters								
	<b>SUBTOTAL-PROCUREMENT</b>							
<b>E. OTHER DIRECT COSTS</b> (provide justification/ explanation in narrative)	1. Communications							
	a. Headquarters	1,050	350	1,082	371	1,172	393	
	b. Field							
	2. Facilities							
	a. Headquarters							
3. Other								
a. Headquarters	450	150	464	159	477	169		
	<b>SUBTOTAL-OTHER DIRECT</b>	<b>1,500</b>	<b>500</b>	<b>1,545</b>	<b>530</b>	<b>1,649</b>	<b>562</b>	
<b>TOTAL DIRECT COSTS</b>		<b>13,450</b>	<b>4,483</b>	<b>13,854</b>	<b>4,752</b>	<b>14,327</b>	<b>5,037</b>	
<b>II. INDIRECT COSTS</b>								
<b>A. INDIRECT COSTS</b>	1. Headquarters	2,287	17,510	2,355	17,709	2,436	15,947	
	2. Field (if applicable)							
<b>TOTAL INDIRECT COSTS</b>		<b>2,287</b>	<b>17,510</b>	<b>2,355</b>	<b>17,709</b>	<b>2,436</b>	<b>15,947</b>	
<b>GRAND TOTAL (DIRECT AND INDIRECT COSTS)</b>		<b>15,737</b>	<b>21,993</b>	<b>16,209</b>	<b>22,462</b>	<b>16,762</b>	<b>20,985</b>	<b>II</b>

CS/PJDC/99

TOTAL PRO.

BEST AVAILABLE COPY

Country/PVO:  
 Cooperative Agreement #:  
 Original budget prepared:  
 Date Submitted to USAID

ADRA/Uganda  
 FAO-0500-A-00-4038-00  
 January, 1995  
 March, 1995

**TABLE C: FIELD BUDGET**

Check one: Original Bu  X

REVISED BUDGET \_\_\_\_\_

		YEAR 1		YEAR 2		YEAR 3		TOTAL YEARS 1-3
		AID	PVO	AID	PVO	AID	PVO	
<b>I. DIRECT COSTS</b>								
<b>A. PERSONNEL</b> (salaries, wages, fringes)	1. Headquarters-wages/salaries							
	2. Field, technical personnel-wages/salaries	20,122		25,191		25,947		71,260
	3. Field, Other personnel wages/salaries	19,514	6,000	24,958	15,451	25,707	15,915	107,545
	4. Fringes-Headquarters + Field	4,800	18,350	1,200	689	1,272	730	27,041
	<b>SUBTOTAL-PERSONNEL</b>	<b>44,436</b>	<b>24,350</b>	<b>51,350</b>	<b>16,140</b>	<b>52,926</b>	<b>16,645</b>	<b>205,847</b>
<b>B. TRAVEL/PER DIEM</b>	1. Headquarters-Domestic (USA)							
	2. Headquarters-International							
	3. Field-In country	3,700	500	3,811	500	3,925		12,436
	4. Field-International	750		773				1,523
	<b>SUBTOTAL-TRAVEL/PER DIEM</b>	<b>4,450</b>	<b>500</b>	<b>4,584</b>	<b>500</b>	<b>3,925</b>		<b>13,959</b>
<b>C. CONSULTANCIES</b>	1. Evaluation Consultants-Fees			5,400		5,562		10,962
	2. Other Consultants-Fees	11,250		9,937		9,087	2,500	32,774
	3. Consultant travel/per diem	8,250		16,997		20,338		45,585
	<b>SUBTOTAL-CONSULTANCIES</b>	<b>19,500</b>		<b>32,334</b>		<b>34,987</b>	<b>2,500</b>	<b>89,321</b>
<b>D. PROCUREMENT</b> (provide justification/ explanation in narrative)	1. Supplies							
	a. Headquarters							
	b. Field-Pharmaceuticals (ORS, Vit. A. Drugs, etc)	500	500	515	530	530		2,575
	c. Field-other	12,110	500	12,061	250	2,123		27,044
	2. Equipment							
	a. Headquarters							
	b. Field	16,850	25,900	5,880		6,066		54,696
	3. Training							
b. Field	16,500		16,995		2,000		35,495	
<b>SUBTOTAL-PROCUREMENT</b>	<b>45,960</b>	<b>26,900</b>	<b>35,451</b>	<b>780</b>	<b>10,720</b>		<b>119,811</b>	
<b>E. OTHER DIRECT COSTS</b> (provide justification/ explanation in narrative)	1. Communications							
	a. Headquarters							
	b. Field	1,200		1,236		1,301		3,737
	2. Facilities							
	b. Field	6,600		6,798		7,001		20,399
3. Other								
b. Field	27,395	11,600	18,656	10,000	20,683		88,334	
<b>SUBTOTAL-OTHER DIRECT</b>	<b>35,195</b>	<b>11,600</b>	<b>26,690</b>	<b>10,000</b>	<b>28,985</b>		<b>112,470</b>	
<b>TOTAL DIRECT COSTS</b>	<b>149,541</b>	<b>63,350</b>	<b>150,408</b>	<b>27,420</b>	<b>131,543</b>	<b>19,145</b>	<b>541,407</b>	
<b>II. INDIRECT COSTS</b>								
<b>A. INDIRECT COSTS</b>	1. Headquarters							
	2. Field (if applicable)	25,422	17,105	25,569	7,403	22,362	5,169	103,031
<b>TOTAL INDIRECT COSTS</b>	<b>25,422</b>	<b>17,105</b>	<b>25,569</b>	<b>7,403</b>	<b>22,362</b>	<b>5,169</b>	<b>103,031</b>	
<b>GRAND TOTAL (DIRECT AND INDIRECT COSTS)</b>	<b>174,963</b>	<b>80,455</b>	<b>175,977</b>	<b>34,823</b>	<b>153,905</b>	<b>24,314</b>	<b>644,437</b>	

TOTAL PROJECT



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# Appendix I

## Detailed Plan by Intervention

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## DETAILED PLANS BY INTERVENTION

### Section C.7a - DIP for Immunization (EPI)

#### 7a.1 Coverage Estimates

Immunization coverage of children 12-23 months of age is fairly high in the target area. 81.6% of children under two have received DPT1, while 71.8% have received OPV3, and 67% have received measles vaccine. These represent rather minor gains from previous levels of 75.9%, 69.9%, and 56.6% respectively.

There do appear to be weaknesses in the service delivery system in place for EPI. The drop out rate for DPT immunizations in the target area has risen from the CSVII baseline level, from 7.9% to 14.3%. One possible explanation of this increase may be poor service delivery. The high numbers of children receiving DPT1 indicate a high level of awareness among mothers of the importance of vaccinations for children under two. Poor service delivery, however, may discourage mothers from returning for further vaccinations, and thus the higher drop out rate.

There is a similarly high level of knowledge concerning the importance of receiving two TT vaccinations for mothers. 91.4% of the mothers surveyed indicated that they knew that more than two TT are necessary to protect the mother. However, this high level of awareness is in contrast to the percentage of mothers whose maternal card show that they have received two doses of TT vaccine. Only 45.7% of the mothers surveyed had received the necessary dosages of TT before the birth of their youngest child less than 24 months of age. Again, this disparity between knowledge and practice is likely due to poor service delivery.

#### 7a.2 Knowledge & Practice

As mentioned above, the high levels of immunization coverage in the target area, particularly for DPT1, indicate a high level of knowledge by mothers of the importance of immunization for the health of their young children. It seems, however, that the quality of service delivery is adversely effecting the practice of mothers in relation to EPI. This is indicated by the higher drop out rate for DPT1, and the gap between an awareness of the importance of TT vaccinations and the actual number of mothers who received TT dosages before the birth of their youngest child less than 24 months of age.

#### 7a.3 Immunization Objectives

- a) Children under two: To increase immunization coverage of children under two years of age from 67% to 80%.
- b) Women of Child Bearing Age: To increase TT coverage of WCBA from 45% to 60%.
- c) Sustainability objectives: (see Table B for specific indicators of these objectives)  
Improve quality of service at vaccine sites and provide new vaccine sites to increase access  
Improve the cold chain monitoring, maintenance and vaccine supply system

#### 7a.4 Approach

Because of the baseline survey results which show access (DPT1) of 81.6%, with a dropout rate of 14.3% resulting in a measles coverage of 67% (OPV3 of 71.8%) this project will focus on two main issues.

First, increasing the accessibility to 90%. The MOH role presently extends to the health center level and 12 established vaccination outreach sites. There are currently two vaccination sites at the two health centers, as well as the 12 outreach vaccination sites from those centers (Five from Kalagala and seven from Ziobwe) as already mentioned. ADRA plans to work with the communities to expand the number of vaccinators providing services, as well as the number of vaccination sites. To this end 31 additional community based vaccinators will be selected by and from the community, trained, provided bicycles, and given responsibility to conduct monthly vaccination days in the 31 new rural sites.

These 31 sites and attendant vaccinators will correspond to the 31 village health committees. The village health committees (VHCs) will assume primary managerial responsibility for the community based vaccinators. To equip the VHCs to provide such management, each VHC will be given training in five components of a support system: supervision, monthly report reviews, recognition in the community, refresher training, and the replacement of dropouts. The VHCs will be expected to assume responsibility for monitoring the regular function of the vaccination sites. The MOH will provide support for the new sites, including timely deliveries of vaccination supplies as required.

Second, ADRA will focus on the dropout problem as revealed in the baseline survey results. As noted, the dropout rate for children under two years of age for DPT1 has risen from the previously established level in CSVII, even though knowledge levels have improved significantly. The baseline information seems to indicate a breakdown in the service delivery system. For a further discussion of the dropout problem and ADRA's strategy in dealing with it, please see 7a.7.

The vaccine supply from the DMO to the Health Center is generally reliable, though there are occasional problems. Please see 7a.9 for a further discussion of the supply system.

TT coverage: Mobilization of women of child bearing age to get at least two TT immunizations will be continued by the CHWs. Also, TBAs and midwives will be trained to encourage mothers during antenatal visits to get TT immunizations. These will be recorded on their antenatal (mothers) card.

#### 7a.5 Population

The number, by age, of the beneficiary population for immunizations is as follows. Included is the estimated number of newborns each year, and the number of visits required to reach full coverage for children by 12 months of age.

##### Population by Age

- EPI beneficiary population - 0-11 months: 2,604 (1994 estimate).
- Estimated number of newborns each year (crude birth rate of 51 per 1000 population): 2740
- Number of visits to achieve full coverage: (5 visits including BCG, 3 DPT/OPV, Measles)

##### Number of Visits Required

- 100% - 2740 x 5 visits = 13,700
- 90% - 2466 x 5 visits = 12,330
- 80% - 2192 x 5 visits = 10,960

#### 7a.6 Individual Documentation

The project will use the standard MOH growth monitoring card to also record the immunizations. An immunization register is kept by each vaccinator which can serve as backup in the event of loss of the growth monitoring/EPI card.

#### 7a.7 Drop-outs - Children

Analysis of the baseline data, discussions with project staff and sub-county health management committee members, indicate that CS 7 did relatively well in community mobilization (as evidenced by a DPT1 of 81.6%), although this will be further increased as noted above.

However, the dropout rate is a problem, with baseline data showing a rise in the number of children who do not receive their full vaccinations. This increase in the dropout rate can be explained by deficiencies in the service delivery quality (missed opportunities at health centers and missed days in the outreach centers), and simply lack of follow-up of dropouts by the CHWs.

ADRA will address service delivery quality through refresher training of Health Center vaccinators, and training of the RC3 Health Management Committee in monitoring the vaccination program. Refresher training of the CHWs will concentrate on follow-up of dropouts through home visits. CHWs will be present at vaccination sites during vaccination days and will note dropouts from their area and make follow-up home visits within the following month.

#### 7a.8 Drop-outs - Women

There is a high level of knowledge concerning the importance of receiving two TT vaccinations for mothers. 91.4% of the mothers surveyed indicated an understanding that two TT are necessary to protect the mother. However, this high level of awareness is in contrast to the percentage of mothers whose maternal card show that they have received two doses of TT vaccine. Only 45.7% of the mothers surveyed had received the necessary dosages of TT before the birth of their youngest child less than 24 months of age.

This disparity between knowledge and practice is likely due to poor service delivery. The problem of drop-outs among women will be dealt with through the network of CHWs and TBAs who are in weekly contact with the women, and who serve as the main key message promoters within the villages. These volunteer workers will monitor the progress of their constituents, including the number of TT vaccinations which pregnant women within their area of influence receive. If pregnant women fail to receive two doses of the TT vaccine, and also fail to respond to the encouragement of the CHW and TBA to receive the full dosage of TT, the CHW will then refer the case to the VHC for that village.

#### 7a.9 Cold Chain Support

The supply of vaccines from the DMO to the Health Center is generally reliable. Transport of the gas cylinders presents a problem occasionally. The project will endeavor to reach an agreement with the RC3s and the DMO to ensure the consistency of the vaccine supply and gas supply for the refrigerators.

Training in cold chain monitoring of temperature (twice daily recording of temperature and movement of vaccines to emergency cold box if refrigerator exceeds acceptable range) and maintenance of refrigerators will be given to vaccinators in the health centers. The monitoring

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responsibility will be institutionalized in the RC3 Health Management Committee, including vaccine supply and monitoring of the cold chain. This will be accomplished through training workshops for the HMC and follow-up supervisory visits by project sub-county supervisors. Additional portable cold boxes, and immunization kits for the community based vaccinators will be provided through the DMO's office.

#### 7a.10 Surveillance

Each sub-county has a well kept Vital Events Registry, and Health Center records are quite complete. Information regarding most deaths comes from the Health Centers. The project disease surveillance will utilize these two sources of information (routine reporting system) to track the incidence of three immunizable diseases - neonatal tetanus, measles and polio. The standard WHO case definitions will be utilized: (Disease Surveillance, WHO/EPI/MLM/91.4, revised 1991)

- Neonatal tetanus: History of normal suck and cry for the first 2 days of life, and history of onset of illness between 3 and 28 days of age, and history of inability to suck followed by stiffness and/or "convulsions" and often death.
- Measles: History of a generalized blotchy rash lasting 3 or more days and history of fever and history of any one of the following: cough, runny nose, red eyes.
- Polio: A case of polio myelitis is defined as any patient with acute flaccid paralysis (including any child less than 15 years of age diagnosed to have Guillain Barre syndrome) for which no other cause can be identified.

Lay definitions for these diseases: (same source)

- Neonatal tetanus: History of normal suck and cry first two days of life, and History of onset of illness between 3 and 28 days of life, history of inability to suck followed by stiffness and/or jerking of the muscles.
- Measles: History of fever and rash and any one of the following: cough, rash, red eyes.
- Polio: History of sudden onset of weakness and paralysis of the leg(s) and/or trunk, and history that paralysis was not present at birth or associated with serious injury or mental retardation.

The WHO case definitions for all three diseases will be reviewed with the Health Center staff responsible for diagnosis and reporting of these diseases. In addition, the 35 CHW trainers will be trained in case investigation follow-up of neonatal tetanus only using the standard WHO case investigation form. ADRA will train the 35 CHWs in case investigation and follow-up only of neo-natal tetanus because it is targeted by the MOH for eradication, and because it is relatively easy to recognize disease symptoms and verify the incidence of the disease.

### **Section C.7b - DIP Control of Diarrheal Disease (CDD)**

#### 7b.1 Baseline

The incidence of diarrhea among children under five within the past two weeks has fallen significantly in the target area, from 46.3% down to 23.3% currently. Data on the number of episodes of diarrhea per child, per year is unavailable, as is the length of each episode. While diarrhea incidence has fallen significantly, ADRA and the local health authorities still consider it to

be a problem in the project area.

#### 7b.2 Knowledge & Practice

The level of maternal knowledge about diarrheal disease and methods of treating it are generally high. Mothers' ability to recognize the signs of dehydration as an important symptom of diarrhea is 53.3%, a rise of 41.6% from previously measured levels. Current practice also shows significant improve. 73.8% of infants/children less than 24 months of age with diarrhea in the past two weeks were given the same amount or more fluids other than breast-milk. Similarly, 80% of children less than 24 months with diarrhea in the past two weeks were given the same amount or more food. Finally, 61.4% of children less than 24 months who were suffering from diarrhea in the past two weeks were treated with ORT. These figures represent improvements of 12.8%, 27.5%, and 20.4% respectively as measured against CSVII baseline levels.

#### 7b.3 MOH Protocol & Practices

The MOH protocol for case management of diarrheal diseases follows the standard WHO guidelines (see appendix XX for copy of WHO guidelines). In the refresher training for Health Center staff these protocol will be reviewed. However, the primary focus of this project will be on home management of diarrheal cases and prevention through hygienic practices.

Presently, significant success in controlling diarrheal disease appears to have been achieved. As already mentioned, a reduction in the reported incidence of diarrheal episodes within the last two weeks among children under 5 from 46.3% to 23.3% has been achieved. Anecdotal evidence concurs with the baseline evidence, with health staff and the Health Centers indicating a significant observed reduction in the number of diarrheal cases received.

#### 7b.4 Diarrheal Disease Control Objectives

Project objectives for diarrheal disease control:

Reduce the percent of children under two years of age experiencing diarrhea in the past two weeks from 23.3% to 15%.

Increase the percent of mothers recognizing signs of dehydration and treating with ORT from 55.3% and 61.4% respectively to 70%.

#### 7b.5 Approach

The project will continue to education mothers through the CHW\_s in the standard home management of diarrhea, including: (1) early initiation of fluids, (2) increased frequency of fluids, (3) proper preparation and administration of home made cereal based OR fluids, (4) more frequent small feedings during diarrheal episodes, and (5) more feeding after diarrheal episodes so the child can regain weight. The standard WHO protocol for home management of diarrhea and key messages for mothers is attached in appendix XX.

In addition to continuing these messages the project will also emphasize prevention through education of mothers by the CHWs in common hygienic practices: sanitary waste disposal (latrines), clean water supply, hand washing after toilet use and before handling food. CHWs will be instructed to follow-up with home visits families who have more frequent diarrheal episodes.

Mothers will be taught to seek care at the health center for bloody diarrhea or dysentery.

#### 7b.6 Population

Beneficiary population (0-23 months): 5092

To reach 70% coverage of ORT knowledge and use of ORT will require approximately 3564 home contacts.

#### 7b.7 ORS

ORS packets are available at the health centers and in commercial outlets in the communities. The key messages to mothers will include the correct use of ORS packets. Mothers knowledge and practice of ORT is already quite high according to the baseline. This will be tracked again in the end of project survey.

#### 7b.8 Home Available Fluids

Recipes for home based fluids have been locally adapted as follows: XXXXXXXXXXXXThe project does not intend to assess the exact chemical composition of these fluids.

#### 7b.9 Health Education

The CSVII end of project survey (CSX Baseline) data indicate a good percentage of KPC regarding home management of diarrheal disease episodes. (73% continued breastfeeding, 98.5% continued fluids, 80% continued foods, 61.4% ORT usage, 53.3% recognition of dehydration signs). This project will continue the education of mothers that has been successful in CSVII, including the following key messages:

- Give the child more fluids during diarrheal episodes (including how to mix ORS from packets but special emphasis on home made starch based fluids (see recipes in appendix XX);
- Continue breastfeeding;
- Continue feeding during diarrheal episodes - small frequent feedings;
- Give an extra meal each day for two weeks following the diarrhea to catch up on weight loss;
- Seek care from a trained health worker if the child does not get better in 3 days or develops: many water stools, repeated vomiting, marked thirst, eating or drinking poorly, fever, blood in the stool;
- Medicines should not be used for diarrhea, except on the advice of a qualified health worker;
- Diarrhea can be prevented by breastfeeding, by immunizing all children, by using latrines, by keeping food and water clean, and by washing hands before touching food.

The methods of communication used have been through monthly mothers groups, and song/drama presentations. Measurement of mothers knowledge, practices and usage of ORT is done through baseline and end of project surveys.

#### 7b.10 Other Strategies

In addition to continuing these messages the project will emphasize prevention through education of mothers by the CHWs in common hygienic practices: sanitary waste disposal (latrines), clean water supply, hand washing after toilet use and before handling food. CHWs will be instructed to follow-up with home visits families who have more frequent diarrheal episodes.

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## Section C.7c - DIP for Nutritional Improvement

### Nutritional Improvement for Infants and Children

#### 7c.1 Baseline

Presently, GM information is used to identify and follow-up the faltering or underweight child. As of submission of this DIP, ADRA/Uganda does not maintain information on malnutrition levels within the target area. The baseline does indicate that seasonal food insecurity is a problem in the project area. Only 18% of the households surveyed indicated that they possessed a food storage facility (granary). Therefore, it is likely that over 80% of the households in the project area suffer from food shortage at least four months out of the year.

Statistics for the Luwero area in which the project site is located indicate that 2% of the children under five years of age suffered from moderate to severe malnutrition in 1981-88. It is unlikely that the rate is as high currently.

#### 7c.2 Current Practices

Knowledge and practice of breastfeeding and child nutrition is fair, though mixed. The percentage of children who are breastfed within eight hours after birth is 82.9%, an improvement of 25.8% from the baseline conducted at the beginning of CSVII. On the other hand, only 28.1% of children between 20 and 24 months were still breastfeeding while they were being introduced to solid/semi-solid foods.

Basic food security data similarly seems to be somewhat mixed. A significant 71.1% of homes have kitchen gardens, though no qualification was given regarding vitamin A and/or iron rich foods in the survey questions. In a follow-up question, 96.7% of the respondents indicated that they wanted a kitchen garden, demonstrating a fairly keen interest in the topic. Efforts to educate mothers in the importance of adding food rich in iron and vitamin A during CSVII may have increased the number of households growing such food in their kitchen gardens, though no data has been gathered indicating such an effect.

Food storage appears to be a serious problem in the target area affecting food security. Only 18.7% of households surveyed had a food storage facility. It may thus be concluded that moderate to severe crop loss is occurring due to inadequate or improper storage methods, weakening the food security of the household.

#### 7c.3 Nutrition Objectives

- Increase the practice of exclusive breastfeeding under four months to 80%.
- Increase the percent of households having kitchen gardens from 71.7% to 80%.
- Increase the homes with food availability throughout the year by use of food storage facilities from 18.7% to 35%.

Objectives for sustainability:

- 32 contact farmers (growing vegetable gardens) will be accessing agriculture extension support for advice.
- Two seed cooperatives will be operating on a self sustaining basis.

#### 7c.4 Approach

Nutritional status improvement will be addressed through:

a) Continued nutritional education of mothers by CHWs in nutritional key messages:

- Exclusive breastfeeding 0-3 months.
- Early initiation of breastfeeding (in first hour).
- Breastfeeding is protective against various dangerous diseases
- Introduce solid/semisolid foods between four and six months, continue breastfeeding into the second year of child's life.
- Breastfeeding does assist in spacing of pregnancies.

b) Increasing household food security through promotion of kitchen gardens and food storage facilities. 31 "contact" farmers will be trained and encouraged to become model farmers in their area for dissemination of information and promotion of family gardens. This is to transfer the demonstration garden model from a central location to the contact farmers gardens in the villages. These farmers will essentially act as agriculture extension assistants as they access help of the government agriculture extension agents and in turn promote vegetable gardening in their areas. Key messages will include: improved gardening techniques, encouraging growing of vitamin A rich foods, year round varieties (including during dry season), and improved food storage.

c) Growth monitoring for education of mothers and monitoring of nutritional status.

The primary nutritional problems seem to center not around general food availability but lack of variety (particularly micronutrient containing foods), unequal distribution within the family, and seasonal food deficits due to poor storage. Breastfeeding practices need continued improvement also. Therefore, the focus of this project will be on these points as noted above.

#### 7c.5 Low Birth Weight Babies

This project is not directly addressing this issue except through encouraging adequate maternal nutrition during pregnancy.

#### **Growth Monitoring**

#### 7c.6 Baseline

A total of 67.5% of children were weighed at least once during the three months preceding the survey, indicating a rise of 33.4% from the CSVII baseline.

#### 7c.7 Knowledge & Practices

GM practices in the target area have improved significantly from CSVII baseline levels. In the CSVII baseline it was estimated that 34.1% of children were weighed once during the past three months. In the CSX baseline/CSVII EOP this figure had risen to 67.5%. This increase indicates an increased level of interest in GM sessions, and a greater level of understanding about how to ensure that their children are growing properly.

#### 7c.8 Growth Monitoring Objectives

Increase the number of children under two years of age that will have been weighed in the last three

months from 67.5% to 75%.

#### 7c.9 Approach

Growth monitoring will be conducted monthly at 100 weighing sites. Each RC1 is responsible for the custody of the weighing scales and the conduct of the monthly weighing days in their area. The actual weighing, recording of weights, and education of mothers is done by the CHWs. They are expected to keep a list of underweight or faltering children among their households and follow-up with not only on site discussion of the problem with the mother but also home visits. In addition to the underweight and/or faltering child, families with more than five children, immunization defaulters, families with frequent child illnesses, and single parent families will be considered high risk and followed up with home visitation. Intervention will consist of personal education/discussion with the families of causative factors and alternative solutions.

No major constraints to the approach are anticipated. ADRA has used a similar approach in CSVII with success, raising the total percent of children weighed at least once during the last three months from 33.4% to 67.5%. In CSX, ADRA will simply continue to improve the existing system.

#### 7c.10 Population

The total number of the population which is eligible for growth monitoring (children 1-32 months of age) is 5,092. If each of these children are weighed monthly a total of 61,104 visits would be required. However, as the objective is for 70% of under twos to be weighed monthly, this brings the total number of under 2s to be weighed down to 3,564 (70%). Hence, the total number of visits required will be 10,692 annually.

#### 7c.11 Follow-up on Children

CHW\_s conduct the monthly weighing at the 100 sites and will list the faltering children in their area. Home visits will be made to these families as noted above.

#### 7c.12 MOH Protocol & Practices

- 0-23 months - monthly
- 24-59 months - quarterly

The project will conduct monthly weighing days and encourage monthly weighing of 0-23 month olds and quarterly weighing of 24-59 months.

The project is using the standard Salter scales.

#### 7c.13 Individual Documentation

The standard MOH growth monitoring card is being used on this project and is attached in Appendix XX. Each of the 100 growth monitoring sites has a master record which will be used as backup in the event the growth monitoring card is lost.

### **Nutrition Improvement for Pregnant & Lactating Women**

#### 7c.14 Nutritional Objectives

Increase by 50% the percent of mothers who report eating more than customary during pregnancy

68

by the end of the project.

#### 7c.15 Approach

The project addresses the nutritional issues of pregnant and lactating women through the key nutritional messages the CHW\_s are transmitting to women, which includes the message that all women need more food and rest during pregnancy.

#### 7c.16 Population

Beneficiary groups eligible for any nutrition interventions:

- 0-11 months 2,604
- 12-23 months 2,488
- 15-49 year old Females 12,267
- Pregnant women 2,740

As noted above the primary method of education of these groups in nutrition will be by CHWs through women's groups and community meetings.

#### 7c.17 Food Availability & Security

Overall availability of food doesn't seem to be a significant problem except for occasional seasonal drought periods. The primary nutritional problems are inequitable distribution within families, inadequate variety particularly of foods rich in micronutrients, and seasonal shortages due to poor storage facilities. The project addresses food security on a household basis by promoting family gardens, including utilizing different varieties throughout the year to provide some garden produce even during dry season, and by improving the household storage facilities.

#### 7c.18 Supplementary Foods

The project will not be supplying supplementary foods.

#### 7c.19 Health Messages

Continued nutritional education of mothers by CHWs in nutritional key messages:

- Exclusive breastfeeding 0-3 months.
- Early initiation of breastfeeding (in first hour).
- Breastfeeding is protective against various dangerous diseases.
- Introduce solid/semisolid foods between four and six months, continue breastfeeding into the second year of child's life.
- Breastfeeding does assist in spacing of pregnancies.
- Pregnant and lactating women need extra food and rest.

The CHWs are transmitting these messages to mothers through informal discussion in women's groups, and at weighing and immunization sessions. Also, local songs composed by the people and sung with local instruments and dance will continue to be used to reinforce key messages.

#### **Prevention of Vitamin A Deficiency**

#### 7c.20 Baseline

This project does not directly address Vitamin A. Indirectly it is dealing with this intervention through the promotion of kitchen gardens, especially of Vitamin A rich foods.

- 7c.21 Knowledge & Practice
- 7c.22 MOH Protocol
- 7c.23 Population
- 7c.24 Vitamin A Objectives
- 7c.25 Approach
- 7c.26 Individual Documentation

## **Section C.7d - DIP for Maternal Care and Family Planning**

### **7d.1 Baseline information**

The maternal mortality ratio for Uganda is 300/100,000 live births (UNICEF, *State of the World's Children*, 1994). Causative factors, ranked in descending order, are hemorrhage, hypertensive disorders of pregnancy, sepsis, unsafe abortion, and obstructed labor.

The following birth attendants, ranked in descending order of utilization, were cited by baseline survey respondents as persons consulted for maternal care at the time of delivery: trained biomedical professional (78.3%), family member or none (14%), trained TBA (6%).

The baseline survey indicated that a moderate number (51.7%) of mothers possessed maternal cards for the birth of their youngest child less than 24 months of age. A significant percentage of women appear to have had at least one ante-natal visit prior to the birth of her youngest child less than 24 months of age. 96.6% of the mothers surveyed indicated that at least one such visit had occurred, roughly the same level as reported in the CSVII baseline survey.

A moderate 41.7% of mothers of children 0-23 months had received chemoprophylaxis (treatment) against malaria during their current or last pregnancy.

Contraceptive use is fairly low, though significantly higher than the baseline for CSVII indicated. The percentage of mothers who were not pregnant and who desired no more children in the next two years, or who were not sure they wanted more children in the next two years, and who were using a modern contraceptive method<sup>1</sup> was 25.9%, up from 6.2% as indicated by the CSVII baseline. The percentage of mothers of children 0-23 months of age who were using a modern form of contraception was lower at 12% than the more general group of mothers in which the age of their youngest child was not specified. However, this figure too represents a very significant increase from the previous baseline level of 1.7%. A higher percentage of mothers (51.7%) of children 0-23 months who were not pregnant when surveyed and were not necessarily using a modern contraceptive method said they did not want children in the next three years, indicating a fairly significant demand for modern contraceptive methods.

21.3% of the mothers surveyed said that they do not currently use a method of contraception because no local family planning services are available to them, while 26.2% simply said they

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<sup>1</sup>A modern contraceptive method is considered as: tubal ligation/vasectomy, injections, pill, IUD, barrier method/diaphragm, condom, or foam/gel.

didn't know why they were not using contraception. 13.1% claimed their husbands objected to the use of contraception. 3.3% did not use contraception because of personal beliefs, while a small 0.6% indicated that religious beliefs discouraged the use of contraception. Similarly, 0.6% cited concerns of safety and side effects as the reason for not using contraception. The largest group, 32.8%, did not indicate their reasons for not using a method of contraception.

#### 7d.2 Maternal Care Objectives

Project's objectives for maternal care and family planning:

- Increase the percentage of mothers who at delivery are assisted by a trained health professional from 78.3% to 85%.
- Increase the percentage of eligible couples using modern contraceptive methods from 12% to 25%.

#### 7d.3 Description of Current Maternal Care Capabilities

##### **Prenatal care facilities:**

There are 4 health centers where prenatal clinic is conducted on a weekly basis:

(1.)	Bugema	1 Midwife
(2.)	Kalagala	2
(3.)	Degeya	0
(4.)	Zirobwe	2

Private Midwives - 1 in Kalagala, 5 in Zirobwe  
TBAs - Kalagala - 31, Zirobwe - 34

Activities involved are:

- Blood pressure monitoring is done routinely. Counselling and intensive monitoring is given to those with raised B/P, referral if it remains high.
- Iron supplements are routinely given. Vitamins are given to selected cases due to limited supply.
- Tetanus toxoid vaccinations are carried out weekly on the antenatal day.
- Weight monitoring is done on every visit
- STDs are rarely reported by pregnant women. Most STDs are detected on vaginal examination during labor. There is no routine vaginal exam on 1st visits and rarely are mothers asked about abnormal vaginal discharge. Urinary tract infections are treated promptly when reported.
- With the promotion of trained TBAs by the Government, knowledge regarding problem pregnancies and detection of danger signs in pregnancy are being emphasized during training of TBAs.
- No malaria prophylaxis given

**Intrapartum delivery care facilities available:** The only intrapartum service units available at this time are the four health centers listed above. None of these provide blood transfusion or surgery services. In fact, services which may be considered Basic Essential Obstetrical Care (BEOC) such as Oxytocin for bleeding, labor management using a partograph, treatment of incomplete abortion, syphilis screening, and special care of the low birth weight infant are not presently being offered. According to the baseline survey 78.3% of mothers responded that a health professional (physician, nurse, or midwife) had tied the cord at their last delivery. A family

member or self assisted in 14% of mothers delivery of their last child. 6.0% were assisted by a TBA. At present the on going supervision of each of these trained health workers is weak. Training of TBAs and refresher training of midwives is being encouraged, but follow-up supervision is not being implemented.

**Referral and transport capabilities for obstetric emergencies:** Obstetric emergencies requiring blood transfusion, care for bleeding, or surgical intervention must be transported to Kampala, a distance of about 40 km. Transport for obstetrical emergencies relies on public transportation at this time.

**Postpartum care services:**

- Nutrition advice is given to mothers before discharge from maternity by midwives in H/C. Iron-folate supplements given to mothers with anaemia.
- Postpartum infections are treated as mothers come with complaints -- No specific post natal clinics carried out.
- The common breast problems are cracked nipples and breast abscesses.
- Perineal tears are examined and repaired by midwives if 1st and 2nd degrees 3rd degrees are repaired in hospital. TBAs refer mothers to H/C for repair.

All these services are provided by the Medical Assistants and midwives at H/Cs.

**Family planning services currently available:**

(a) 700 CHWs give health messages on

- Breast feeding
- Antenatal care
- Nutrition during pregnancy and lactation
- Family planning

(b) 16 CBDAs (community based distribution agents), trained during CS VII give family planning education to families. They also provide modern family planning contraceptives which include - Pills (if the client meets the screening criteria), condoms, and foaming tablets. They are presently supervised by an ADRA sub-county supervisor.

(c) The ADRA Family Planning technical supervisor has been providing Family Planning Services at the four health centers during the last few months of CS VII. This level of services has included:

- General physical exam
- Counselling on available methods (pills, condoms, foaming tablets, jellies, injectables, tubal ligation, vasectomy)
- Referral to Marie Stopes clinic in Kampala for those choosing tubal ligation or vasectomy.

The main constraints to maternal care in the project area are:

- Reliance on public transport in emergency.
- Accessibility of CEOC (Comprehensive Essential Obstetric Care) to distant - 40 km to Kampala.
- Health centers presently are not providing complete BEOC (Basic Essential Obstetric Care).

#### 7d.4 Population

State the number, by age, of the potential beneficiary population for the maternal care and family planning components.

- Women of child bearing age (WCBA) - 12,267
- Family planning eligible couples - 8,255 (67.3% of WCBA married or living together - DHS-Uganda)

#### 7d.5 Approach

The project approach emphasizes a three tiered system for Maternal Care and the linkages between them, beginning with the Home and Community, then the Health Center and finally the Hospital. This project will focus on upgrading quality of services at the first two tiers (home & community, and health center), transport from community to the health centers, and on referral relationships with the referral hospital in Kampala.

#### **Prenatal Care and Delivery Care**

The project will not be training new personnel but will give refresher/upgrading training to 5 HC midwives, 6 private midwives, and 65 TBA\_s in pre and perinatal care as follows:  
HC midwives will be trained to provide Basic Essential Obstetric Care (BEOC) at the Health Centers. This will include:

##### **Routine obstetric care:**

- Family planning
- Iron-folate
- Risk assessment
- Recognition of danger signs
- Tetanus toxoid
- Medication for HDP
- Labor management using partograph
- Malaria case management
- Syphilis screening/treatment
- Counselling
- Special care of the Low Birth Weight infant
- Establishing breathing
- Keeping neonate warm, dry
- Exclusive, immediate (within 1 hr) breastfeeding
- Clean cord care
- Eye care

##### **BASIC Essential Obstetric Care:**

- Parenteral antibiotics
- Parenteral oxytocic drugs
- Parenteral sedatives for toxemia
- Manual removal of the placenta
- Removal of retained products of the conceptus

This is in distinction to COMPREHENSIVE Essential Obstetric Care which will be reserved for referral hospitals in Kampala and would include:

- All basic EOC
- Surgery (C[section, curettage)
- Blood transfusion
- Sepsis
- Preeclampsia/eclampsia
- Sick neonate care

**Private midwives** will be trained in the same items as the HC midwives so that they can be integrated into the three tiered referral system being developed.

TBAs will be trained in Routine antenatal and obstetric care to include:

- Family planning
- Iron-folate education
- Malaria prophylaxis education
- Tetanus toxoid education
- Risk assessment
- Recognition of danger signs
- Clean, safe labor and delivery
- Organization for referral transport\* (See section below Emergency Care)
- Establish breathing of neonate
- Keeping neonate warm and dry
- Exclusive breastfeeding beginning immediately (within 1 hour)
- Clean cord care
- Eye care

**Active screening** will be done at the home and community by the TBA\_s and private midwives, and in the HC by the HC midwives. These will include risk assessment during prenatal care:

- Mother age 15-19 or 35+
- History of births less than two years apart
- More than five children
- Small size mother

**and** recognition of danger signs for immediate referral:

- Fever and other signs of infection, such as severe headache or vomiting
- Failure to gain weight
- Extreme pallor
- Edema (especially in face or limbs)
- Vaginal Bleeding
- Labor longer than 12 hours
- Prolapse of cord or limb
- Malpresentation
- Convulsions

**STD screening and treatment** at the Health Centers will be implemented through training and follow-up of Health Center staff (including the Medical Assistants). The WHO protocol for syndromic case management of STD\_s will be taught (see Appendix XX) since it is judged impractical to institute laboratory screening with the numbers involved.

## Emergency Care

Obstetric emergencies will be handled through the three tiered system. TBAs and private midwives will refer to the Health Center on recognition of danger signs and the Health Center midwife will then either handle the emergency if it is appropriate or refer on to hospital in Kampala if necessary.

The project will work with local village health committees and RC1s to organize local transport teams for emergency transport to the Health Centers using locally available hand carried equipment. Further discussion with RC3 level Health Management Committees will be necessary to discover alternatives for transport to the hospital when necessary. It is estimated that by addressing the home/community to Health Center emergency care approximately one half of obstetric emergencies will be appropriately cared for.

## Postpartum Care

TBAs, private midwives, and HC midwives will be trained in post partum care including:

- Post partum hemorrhage
- Puerperal sepsis
- Care of the LBW infant
- Basic sick neonate care
- Exclusive breastfeeding.

## Family Planning Services

Family Planning services will concentrate on: a) increasing demand, b) improving access, c) assuring client centered quality, d) increasing range of methods available at health center level, e) building a sustainable system of Family Planning services, f) integrating FP, MC and HIV/AIDS activities.

**Demand:** The present demand is considerably higher than the usage - 51.7% indicated not wanting children in the next three years, while only 12% of the total sample of women interviewed were using a modern method of contraception. This implies a significant gap between supply and demand. In looking at the reasons given for not using a modern method of contraception, 26.2% either don't know why they are not using contraceptives, or are not aware of the options. The next most frequently stated reason was "no local FP services" (21.3%). This was followed by "husband objects" (13.1%), and personal beliefs (3.3%). Religious reasons, and side effects/safety each were 0.6%. "Other" reasons (not specified) were given by 32.8% of respondents.

This will be investigated further through focus group interviews as part of the training of the CBDAs to try to understand the "other" reasons. The information cited, however, seems to point out two key areas needing attention: 1) education (the "don't know" response, and "husband objects" response), and 2) accessibility ("no local FP services").

**Education:** In addressing the demand issue the project will continue general FP education through the 700 CHWs. They will then refer interests to the Community Based Distribution Agent (CBDA). Most of the CHWs are women. The second method to be used to increase knowledge/acceptance will be the training of additional CBDAs. A total of 64 CBDAs will be selected by the communities, trained, and then provide services in each local parish (4 to a parish). Every effort will be made to have half men and half women with a balance of 2 men and 2 women

in each parish so as to address the issue of husbands' acceptance. The CBDAs use a combination of home visits and presentations at community (RC1) meetings to communicate key messages on Family Planning. Singing/dance troupes will also be enlisted to communicate FP messages as has proven effective during CS VII.

**Accessibility:** Accessibility will be addressed on three levels. First, by significantly increasing the number of CBDAs and striving to balance the male/female ratio, the community level accessibility to information and basic commodities, and the either gender accessibility will be increased significantly. This level will provide the education and counselling on available methods, provide basic services including, pills according to qualifying checklist, condoms, foaming tablets, and referral to the Family Planning provider at the health center.

Second, at the health centers, the midwives will be trained to a Family Planning Provider level and Medical Assistants to be able to counsel men on FP options, so as to provide all barrier, reversible, or short term contraceptive methods (pills, condoms, foaming tablets, jellies, injectables).

Third, negotiation has begun with Marie Stopes clinic to upgrade one of the health centers in the project area into a voluntary sterilization center to be serviced weekly by Marie Stopes. This would be a referral center for tubal ligation and vasectomy. A line item has been included in the budget ("medical center equipment") for this purpose. Marie Stopes services are subsidized so that costs to client are minimal.

**Quality:** Quality of services will center on 1) providing a consistent supply and access to a choice of methods to the clients, 2) training and refresher training for each cadre (CHWs, CBDAs, midwives and TBAs), 3) providing adequate information to clients through general education, home visits, personal counselling, 4) emphasizing personal relationship skills win clients in the training and follow-up of FP workers, 5) providing other integrated reproductive health services at the health centers also (STD screening and treatment, maternal care, HIV/AIDS prevention), and 6) developing a sustainable consistent service. In addition to refresher training, the project family planning coordinator will work with the health center staff and the CBDAs in setting up an internal self evaluation system that will provide an ongoing service quality assurance mechanism.

**Range of methods:** As noted above with the addition of the voluntary sterilization center facility in the target area, the full range of methods will be accessible to the target population.

**Sustainable system:** The CBDAs will provide condoms at an affordable price and thus be able to sustain the condom supply and their transportation costs. The family planning providers at the health centers will be responsible for technical support of the CBDAs including supervision, and in-service training. The Village Health Committees will be trained in monitoring of the activities of the CBDAs in their area including supervision, reporting, recognition, refresher training, replacement of dropouts. The supervision and monitoring of the health center level family planning services will be institutionalized in the RC3 level health management committee. At present the supply of FP commodities is adequate (USAID has provided sufficient supplies to the central MOH stores) but at times there are difficulties in accessing these at the district level. The project will work with the RC3 Health Management Committee and the DMO to coordinate the delivery of FP supplies with the EPI supplies to the health centers.

**Integration of FP, MC, HIV/AIDS:** With the aim of providing a more comprehensive reproductive health service at both the community and health center level, the project will endeavor to integrate FP, MC and HIV/AIDS activities. In practice, the integration between FP and MC will take place at all levels. CHWs, TBAs, and CBDAs will be giving reinforcing messages in both FP and MC. Health center midwives will be trained and providing services in both FP and MC. The supply of condoms and screening and treatment for STDs, which are important components of the HIV/AIDS intervention, will be provided through the MC/FP interventions. General education regarding HIV/AIDS transmission/prevention will also be given by the MC/FP workers.

#### 7d.6 Health Education Messages

The following health promoting behaviors and practices will be taught to mothers by CHWs, TBAs and midwives:

##### **Prenatal period:**

- Increase the quantity and quality of their intake of nutritious foods.
- Reduce their work load and rest more often.
- Consume iron-folate tablets daily to prevent anemia.
- Recognize danger signs of pregnancy and follow instructions for referral.
- Community groups should consider emergency funds, and a transportation system for complicated deliveries.

##### **Intrapartum period:**

- Ensure cleaner and safer delivery by requesting a trained TBA if delivering at home or deliver at the Health Center.
- Consume as much water as they want during labor and urinate frequently.
- Recognize and seek help for complications, especially retained placenta, obstructed or prolonged labor, excessive bleeding and malpresentation.
- Immediately put the newborn to the breast and begin exclusive breastfeeding.

##### **Postpartum period:**

- Increase the quantity and quality of their intake of nutritious foods.
- Reduce their work load and rest more often.
- Recognize that excessive bleeding or prolonged fevers (2 days or more beginning after the first 24 hours post-birth) require immediate attention from clinical personnel.
- Breastfeed the newborn exclusively for four to six months, beginning within the first hour of life.
- Consume iron-folate tablets daily.
- Seek family planning counseling. If fully or nearly fully breastfeeding, use of family planning may be delayed until any of the following occur: mother begins supplementing infant's diet regularly; menses return; or six months postpartum, whichever comes first.
- Contraceptives used by breastfeeding women should be low in estrogen or nonhormonal. If not fully breastfeeding then begin a family planning method at six weeks postpartum.
- Ensure the newborn is well nourished by exclusive breastfeeding, warm and clean to prevent such problems as acute respiratory infections and diarrhea.

##### **General messages:**

- Spacing pregnancies at least two years apart, and avoiding pregnancies below the age of 18 or above the age of 35, drastically reduces the dangers of child-bearing.
- Girls who are healthy and well fed during their own childhood and teenage years have fewer problems in pregnancy and childbirth.

- If a woman who is pregnant smokes, or takes alcohol or drugs, her child may be damaged in the womb.

HIV/AIDS and safe sex messages:

- Aids is an incurable disease which is passed on by sexual intercourse. In Uganda about 85% of people with AIDS became infected through sex. AIDS can also be passed on by infected blood and by infected mothers to their unborn children.
- Safer sex means being sure that neither partner is infected, remaining faithful to each other, and using a condom if there is the slightest doubt.
- People suffering from other sexually transmitted diseases (STDs) like ulcers on the genitals and gonorrhoea should seek urgent treatment. The presence of other STDs makes it much easier to transmit and/or become infected with HIV.
- Any injection or cut with an unsterilized needle, syringe, razor blade or other skin-piercing instrument is dangerous.
- Women infected with HIV should think carefully about having a baby, and seek advice.
- All parents should talk with their children about how to avoid getting AIDS.
- People with AIDS need love, care, understanding and support.

Equipment needed for upgrading the Health Centers:

7d.7 Documentation

The project will use the standard maternal card used by the MOH at the health centers. The health centers have a backup registry system in event of loss of the card. In addition a simplified form is being developed for use by the TBAs. The standard partograph for monitoring labor will be introduced at the health centers.

**Section C7.e - DIP for Case Management of Childhood Acute Lower Respiratory Infections/Pneumonia (ALRI)**

ALRI is not an intervention in this project.

**Section C.7f - DIP for Control of Malaria**

7f.1 Baseline

ADRA's emphasis upon malaria is relatively minor compared to other interventions in the project. Therefore, in its baseline study, ADRA focused upon the use of chemoprophylaxis among pregnant women, discovering a current usage level of 41.7% in the target area. This population group will be targeted particularly, complementing the project's major focus on improved maternal health. Further data was not collected regarding the incidence of malaria among young children due to the limited scope of the intervention in the project.

7f.2 Population

Pregnant mothers - 2740 annually

7f.3 Malaria Control Objectives

Increase the percent of pregnant mothers receiving chemical prophylaxis from 41.7% to 60%.

#### 7f.4 Knowledge & Practice

Drug treatment of malaria is fairly high in the target area, at 41.7%.

#### 7f.5 Approach

The malaria intervention in this project will be limited to chemoprophylaxis and treatment in pregnant mothers, as well as the promotion of key messages to families. Regular treatment of malaria episodes in children is currently being provided at the health centers. TBAs and midwives will be trained in chemoprophylaxis and a supply of chloroquine be provided through the health centers (the MC/FP service) to the TBAs also. The TBAs will then be able to provide the chloroquine to the pregnant mothers.

#### 7f.11 Health Education

Key messages regarding malaria to be transmitted to families by CHWs, and TBAs include:

- Young children and pregnant women should be protected from mosquito bites at all times, but especially at night.
- Families and communities should destroy mosquito larvae and prevent mosquitoes from breeding.
- It is advisable for pregnant women to take anti-malaria tablets throughout pregnancy.
- A child who has a fever should be taken immediately to a health worker. If malaria appears to be the cause, the child should take a full course of an anti-malaria drug.
- A child with a fever should be kept cool but not cold.
- A child recovering from malaria needs plenty of liquids and food.

### **Section C.7g - DIP for HIV/AIDS Prevention**

#### 7g.1 Baseline information

There is a fairly high level of knowledge about the means of transmission of the AIDS virus and the ways of preventing HIV/AIDS infection, which seems to have resulted in a commensurate sense of caution. 78.3% of the survey respondents believed that people in their village are in danger of contracting AIDS, while 89.7% think it is possible for them to get the disease themselves. Previous CSVII baseline levels for these two questions revealed that 43% believed people in their village were in danger of getting AIDS, and 18% of the respondents believed themselves to be in danger of contracting the virus. 90% of survey respondents indicated that they could contract AIDS from a person who appears to be healthy, and 85.3% said that they know that the AIDS virus can be present in the body for years before a person begins to feel sick.

Mothers demonstrated a fairly good knowledge of the particular danger AIDS poses to them and the unborn child. 64.7% of the mothers surveyed believe that a woman can pass the AIDS virus to a child before it is born. 90% of the mothers think it is possible to become infected by the AIDS virus through sex without a condom. Finally, 79% of the mothers surveyed reported that they were taking measures to prevent themselves from getting AIDS.

The reasons given by women who are not protecting themselves from infection were as follows: 29.2% claimed their husband objected to methods of protection; 26.2% explained that they do not know how to protect themselves from infection; while 26% did not know why they were not using methods of protection against HIV/AIDS infection.

7g.2 Objectives for the prevention of HIV/AIDS

**Decrease the transmission of HIV/AIDS in the present and future population by targeting 5-15 year olds and parents.**

Admittedly this objective is not specific enough. However, at this point we do not have specific indicator data on the 5-15 year old age group as a baseline, so are not able to establish percentage objectives for key indicators. This data will be gathered during the third and fourth quarter of year one and reported in the first annual report with updated percentage objectives for each indicator.

Currently defined indicators are:

- Percent of 5-15 year olds who know common modes of transmission of HIV.
- Percent of 11-15 year olds who know 1) modes of HIV transmission, including mother-to-child; 2) methods of HIV/AIDS prevention; 3) principles of safer sex.
- Percent of 5-15 year olds practicing skills for resisting high risk behavior (saying no to "sugar daddies", saying no to high risk sex.
- Percent of 11-15 year olds who choose to be sexually active practicing safer sex (reporting condom use during last act of intercourse).
- Percent of 11-15 year olds adopting value of abstinence before marriage and fidelity to one partner.

**Increase percent of pregnant women being screened and treated for STDs 50% from baseline.**

7g.3 Current activities related to HIV/AIDS prevention in the project area

National policy related to the 5-15 year old age group is embodied in the SYFA Movement jointly developed by UNICEF, Ministry of Health and the Uganda AIDS Commission. SYFA (Safeguard Youth From Aids) is now a national initiative under the aegis of the Uganda AIDS Commission. (See Appendix XX for a copy a description of the implementation strategy of SYFA.) This HIV/AIDS component of the Child Survival Project draws heavily from the concepts, research and subsequent strategies developed in the SYFA initiative.

At present there are no other HIV/AIDS activities in the project area.

Staff who will be involved in the HIV/AIDS component of this project have had experience primarily in Family Planning activities during CS VII and HIV/AIDS education. The skills developed during FP and HIV/AIDS activities in CS VII will be a basis for expanding further into HIV/AIDS and integrating the two interventions in this project. Specific skills of the two coordinators for HIV/AIDS include one being a nurse midwife with good relational skills to youth, and the other brings drama skills to the team and good relational skills to youth.

The baseline survey indicates that during CS VII due to general education and to HIV/AIDS awareness education which was begun under CS VII, there is a high degree of awareness of HIV/AIDS and willingness to discuss the topic among community members. Song and dance groups have created songs and skits for communicating HIV/AIDS messages which have been well received in the communities. This provides a positive basis for a targeted HIV/AIDS intervention as planned in this project.

Obstacles to an HIV/AIDS intervention in the community identified by staff include:

- There is still a reluctance to discuss sexual issues in the community.
- Parents still find it difficult to talk about sex with their children.
- Local traditions, expectations for sexual activity at traditional ceremonies, frequency of polygamous marriages, wife sharing within the family all of which demonstrate the social value placed on having more than one sexual partner in contemporary Uganda life.
- Role understanding between men and women.
- Dissatisfaction with using condoms for various perceived reasons: diminishes sexual pleasure and disrupts lovemaking, is embarrassing - both to buy them and to use them, implies STDs, prostitution, promiscuity, and distrust of one's sexual partner; and does not prevent pregnancy or STDs effectively.

#### 7g.4 Population

Planned beneficiary population:

5-14 year olds	16,839
Parents of 5-14 yo	11,457

#### 7g.5 Approach

The project plans the following components to its HIV/AIDS intervention:

- Formative research.
- Recreation clubs for 5-15 yo age group.
- Education and counselling of 5-15 year olds in recreation clubs.
- Education in schools by members of recreation clubs.
- Counseling and education of parents through parent meetings (similar to parent-teacher conferences).
- Condom availability through the FP component of the project (CBDAs).
- Screening and treatment of pregnant mothers for STDs.

**Formative research:** Formative research will be conducted during the third and fourth quarter of year one to gather baseline data on the indicators noted above. In addition, for purpose of further refinement of the behavioral change strategies, further information is needed specifically about the 5-15 year old age group and family factors that influence sexual behavior. Specific technical assistance for this purpose is presently scheduled for the third quarter of the project. The primary methodology will be through small group discussion. Since will be difficult to structure formal focus group interviews with this age group a more informal discussion approach will be tested using a previously developed list of questions. This will require more time, however, than more structure focus group interviews. More structured focus group interviews will be conducted with selected parents to obtain information from their perspective. The report of this research and strategies subsequently developed will be reported in the first annual report. In preparation for this, project staff have identified a number possible factors in the society which influence sexual behavior and this will form the basis for the discussions in order to find out prevalence of certain practices or other contributing factors in the target area.

- Displacement of families in recent years due to war, famine, poverty.
- Social disintegration due to war, poverty forcing fathers/mothers to be away from families, or young girls into prostitution to earn money for the family.

- Presence of "sugar daddies" who entice young girls into sexual activity.
- Local beer brewing and associated practices.
- School drop outs may be more prone to high risk behavior.
- Traditional ceremonies when sex is expected or allowed: naming of children, initiation, weddings, last funeral rites, night prayer meetings, beer parties.
- Women's lack of empowerment to refuse sexual advances.
- Treatment by traditional healers for infertility - sexual relations with clients.
- Wife sharing within families.
- Widow inheritance.
- Peer group/social pressure - manliness, womanliness are identified with sexual prowess, or ability to please the other sexually.

#### **Recreation clubs for 5-15 year old age group.**

Four recreational clubs will be established in the project area (two in Kalagala and two in Ziobwe) for the 5-15 year old age groups including school dropouts and non school attenders. The clubs will be organized around sports activities and life skills education and personal counselling, similar to boy/girl scouts or "pathfinders". The key messages will be targeted separately for the 5-10 and 11-14 age groups and are detailed in section 7g.6 below. The project sees these clubs as the enabling factors to establish specific health promoting beliefs and values which will result in lower risk behavior (see Appendix XX, specifically the diagram Figure 2 - "An Operational Model for SYFA Communications"). These clubs will provide the opportunity for discussion of issues relating to sexuality and sexual values, personal counselling, opportunity to learn and practice negotiating and other skills for safe sexual behavior, factual information on HIV/AIDS and information on available services.

Target behaviors for the 5-10 year old groups would include:

- Adopt and promote good personal health practices
- Resist the advances of "sugar daddies" and other unhealthy activities particularly at traditional ceremonies.
- Talk with parents and teachers about sexual matters.
- Go to school and get involved in health social and recreational activities.

Target behaviors for the 11-15 year old group would include:

- Refrain from sex until marriage
- Remain faithful to one partner
- Adopt and promote good personal health practices
- If you choose to have sex before marriage use negotiating skills for safe sex
- Stay in school and get involved in healthy social and recreational activities.
- Discuss questions of sexuality with parents and teachers.
- If you suspicion an STD, go for screening and treatment

Target behaviors for parents of 5-15 year olds:

- Talk with children regarding sexual matters
- Choose faithfulness to one partner
- Practice safe sex if you choose to have more than one regular partner

### **Education and counselling of 5-15 year olds in recreation clubs.**

Various participative educational methods will be employed to create a context for active discussion, transfer of information, testing of ideas against peers, popularizing of health promoting, low HIV risk behaviors, formation and reinforcing of values, development of negotiating skills through role playing, and problem solving skill development. The information from the formative research will assist in refining the approach to address real concerns and issues of the young people. Also the data which has fed into the development of the SYFA program will be utilized in developing the approach.

### **Education in schools by members of recreation clubs.**

These activities will provide opportunity for club members to get involved in activities which clearly identify their concern about AIDS. Based on the concept that we remember much more from what we do or actively participate in than what we are told, involvement in AIDS education/prevention programs in the schools should help the young people themselves incorporate these values into their own living. Types of activities would include: presentations, drama, skits, songs, small group discussion, role playing.

### **Counseling and education of parents through parent meetings (similar to parent-teacher conferences).**

Meetings will be held at least monthly for parents of club members in which dramas, skits, songs, group discussion, presentations will be conducted. A focus will be to not only reinforce information about HIV/AIDS but to assist parents in 1) clarifying their own values, 2) seeing the need to model those values, and 3) help parents develop the skills for transmitting those values through communication with their children. This latter point will include specific skills development for talking with their children and also in a broader scope the discussion and follow up of ways to impact the traditional belief system and general social values in the community.

### **Condom availability through the FP component of the project (CBDAs).**

Condoms will be available through the CBDA's at the community level. Education in safe sex and condom use will be targeted to the 11-14 year olds, and to parents.

### **Screening and treatment of pregnant mothers for STDs.**

This component will be implemented through the MC/FP component and is described elsewhere in this document.

### *How will the project address the obstacles to HIV/AIDS described in section 7g.3?*

By providing opportunity in a "safe" environment for discussion, by openly, factually talking about the subject in detail, by providing opportunity for role playing and skill development, by popularizing understanding and discussion of key issues and messages (through drama, skits, songs), and by utilizing both men and women in the initiative these obstacles should be overcome.

### **7g.6 Health education messages**

The following key messages will be included in the project to communicate ways of preventing HIV/AIDS infection.

HIV/AIDS Prime messages for all: (Uganda Facts for Life)

- Aids is an incurable disease which is passed on by sexual intercourse. In Uganda about 85% of people with AIDS became infected through sex. AIDS can also be passed on by infected

- blood and by infected mothers to their unborn children.
- Safer sex means being sure that neither partner is infected, remaining faithful to each other, and using a condom if there is the slightest doubt.
  - People suffering from other sexually transmitted diseases (STDs) like ulcers on the genitals and gonorrhoea should seek urgent treatment. The presence of other STDs makes it much easier to transmit and/or become infected with HIV.
  - Any injection or cut with an unsterilized needle, syringe, razor blade or other skin-piercing instrument is dangerous.
  - Women infected with HIV should think carefully about having a baby, and seek advice.
  - All parents should talk with their children about how to avoid getting AIDS.
  - People with AIDS need love, care, understanding and support.

#### Messages regarding safer sex:

- The safest sex is no sex at all or abstinence. Abstinence cannot make a person sick.
- Children and young people should delay their first sexual activity until marriage. Staying without sex will not make them ill nor will it prevent them from enjoying sex later. If and when they begin sexual activity, they should adopt safer behaviors such as use of condoms. If they have been at all sexually active, they may also get tested for HIV and ask their future partner to get a test.
- For sexually active people, the best way to avoid AIDS is to stay in a mutually faithful relationship with an uninfected partner.
- Sex without intercourse (without the penis entering the woman's body) is safer sex. This means activities such as caressing and hugging.
- Sex with a condom is also safer sex. Unless you and your partner have sex only with each other, and are sure you are both uninfected, you should protect yourselves by using a condom.

#### Messages regarding signs indicating the need to seek treatment for an STD:

- Sores, wounds, bumps and blisters on, in or near the genitals.
- Burning pain during a short call (urination).
- Swelling in the groin.
- All partners need a full course of treatment if an STD is present.
- Signs which should cause women to suspect an STD:
  - An unusual discharge or smell from the vagina.
  - Pain in the lower stomach.
  - Itchiness in the vagina or bleeding from the vagina which is not a menstrual period.
  - Pain deep inside the vagina during sexual intercourse.
- Men may also suffer:
  - A drip or discharge from the penis.
  - Painful ejaculation.
  - Swelling of the genitals especially testes.

#### Specific instruction on condom usage:

- Always check the date of manufacture. If it is less than five years since manufacture, the condom should be okay.
- Keep a good number of condoms at hand.
- Keep condoms out of direct sunlight and in a cool place.
- Use the condom for only one sexual act.
- Avoid applying a lubricant because it might weaken the condom.

- If a condom breaks during sexual intercourse, it should immediately be replaced with another one. (It is a good idea to wash the penis before replacing the condom.)
- Specific instruction for putting on a condom:
- Put the condom on after the penis becomes hard (erect).
- Put the condom on before any genital contact.
- Hold the tip of the condom between a finger and thumb of one hand, leaving space at the tip to collect the semen.
- With the other hand put the condom on the end of the penis and unroll the condom down the length of the penis by pushing down the round rim of the condom. If this is difficult, the condom is inside-out. Turn the condom the other way round, take hold of the other side of the tip and unroll it.
- When the rim of the condom is at the base of the penis (near the pubic hair), penetration can begin.
- Specific instruction for taking off a condom:
- Soon after ejaculation, withdraw the penis while it is still hard, holding the bottom rim of the condom to prevent it from slipping off the penis.
- Do not let the penis go soft inside the partner because the condom may slip off and spill semen in or near the vagina.
- Do not allow semen to spill on hands or other parts of the body, and wash hands and other body parts if contact with semen occurs.
- Wrap used condoms in waste paper before disposing of them safely by flushing them down a toilet, throwing them down a pit latrine, burying them or burning them.
- Wash hands to remove vaginal secretions or semen.

**Sample negotiating skills conversation::**

- **If the man says:** "I know I don't have any disease. I haven't had sex for a long time."  
**The woman can say:** "As far as I know, I don't have any diseases either. But I still want us to use a condom since either of us could have an infection and not know about it."
- **If the man says:** "What an insult! You think I'm the sort of person who gets AIDS?"  
**The woman can say:** "I didn't say that. Anyone can get an infection. I want to use a condom to protect us both."
- **If the man says:** "I love you. Would I give you an infection?"  
**The woman can say:** "Not deliberately. But most people don't know they are infected. That's why this is best for both of us."

**Specific messages/beliefs for 5-10 year old - preadolescent:**

- Looking after myself makes me strong and bright
- Good friends help each other stay well
- When I respect myself others respect me
- Adults have more experience in health/sex matters - talk to your parents and teachers about health/sex matters.
- Say no to Sugar Daddies
- Resist and help others to resist unhealthy activities

**Specific messages/beliefs for adolescents - 11-15 years old:**

- In addition to the prime messages and messages regarding safe sex and condom use, other key beliefs will be emphasized such as:
- Looking after myself makes me strong and bright - I must take responsibility for my own

health.

- Good friends help each other stay well - peer pressure for healthy behavior and safe sex.
- Sex is best when we are in control of ourselves - recognizing and dealing with sex urges.
- You can talk with parents and teachers about sexual matters.
- Career and motherhood are too important to place at risk - premarital sex places these at risk.
- When I respect myself, others respect me - say no to irresponsible behavior.

#### **Section C.7h - DIP for Other Project Interventions**

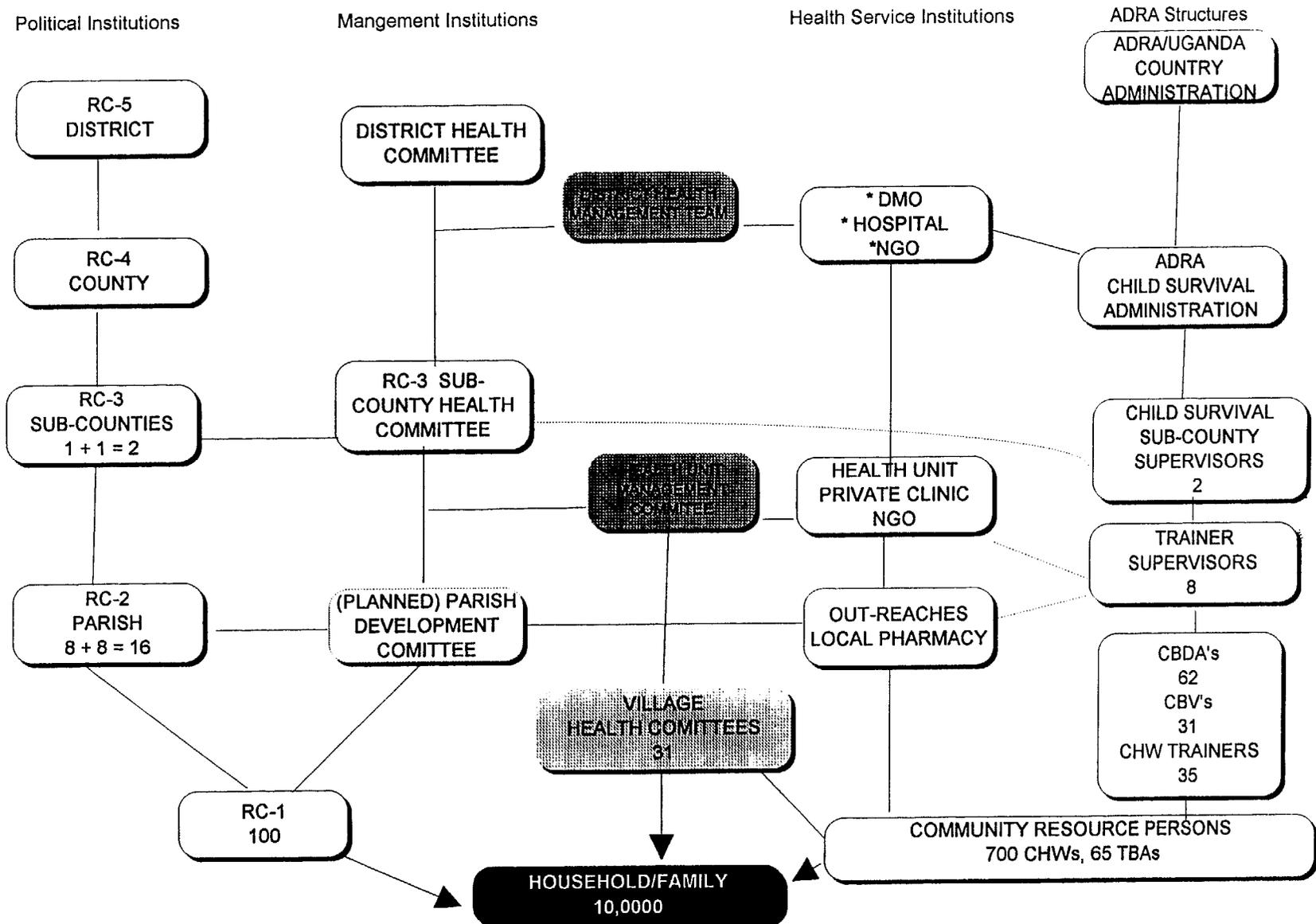
No other project interventions are planned beyond those already described.

# Appendix II

Charts: Government Community and ADRA  
Relationships;

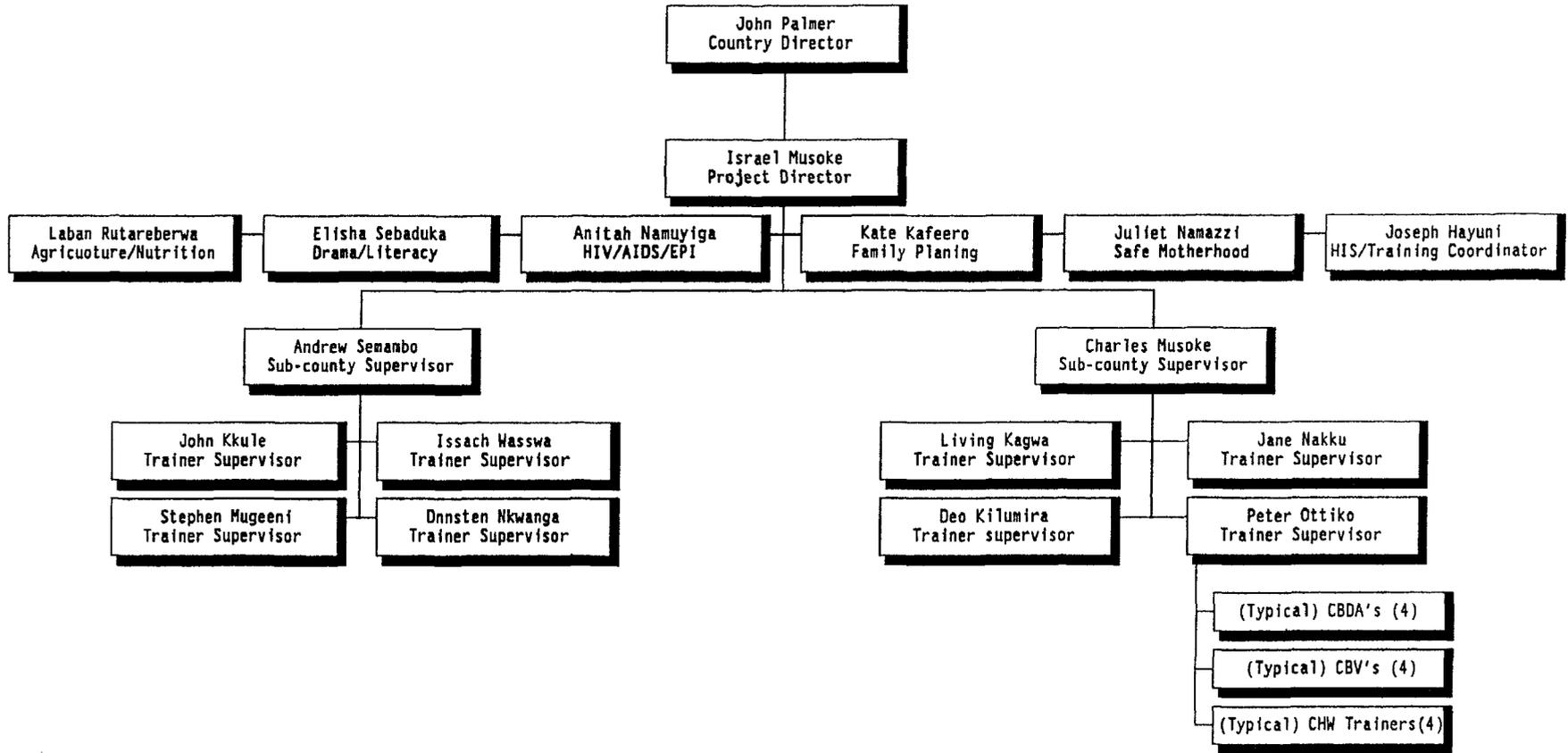
ADRA Organizational Chart

### LOCAL GOVERNMENT, COMMUNITY, AND ADRA RELATIONSHIPS



F.1

ADRA/UGANDA  
CHILD SURVIVAL 10



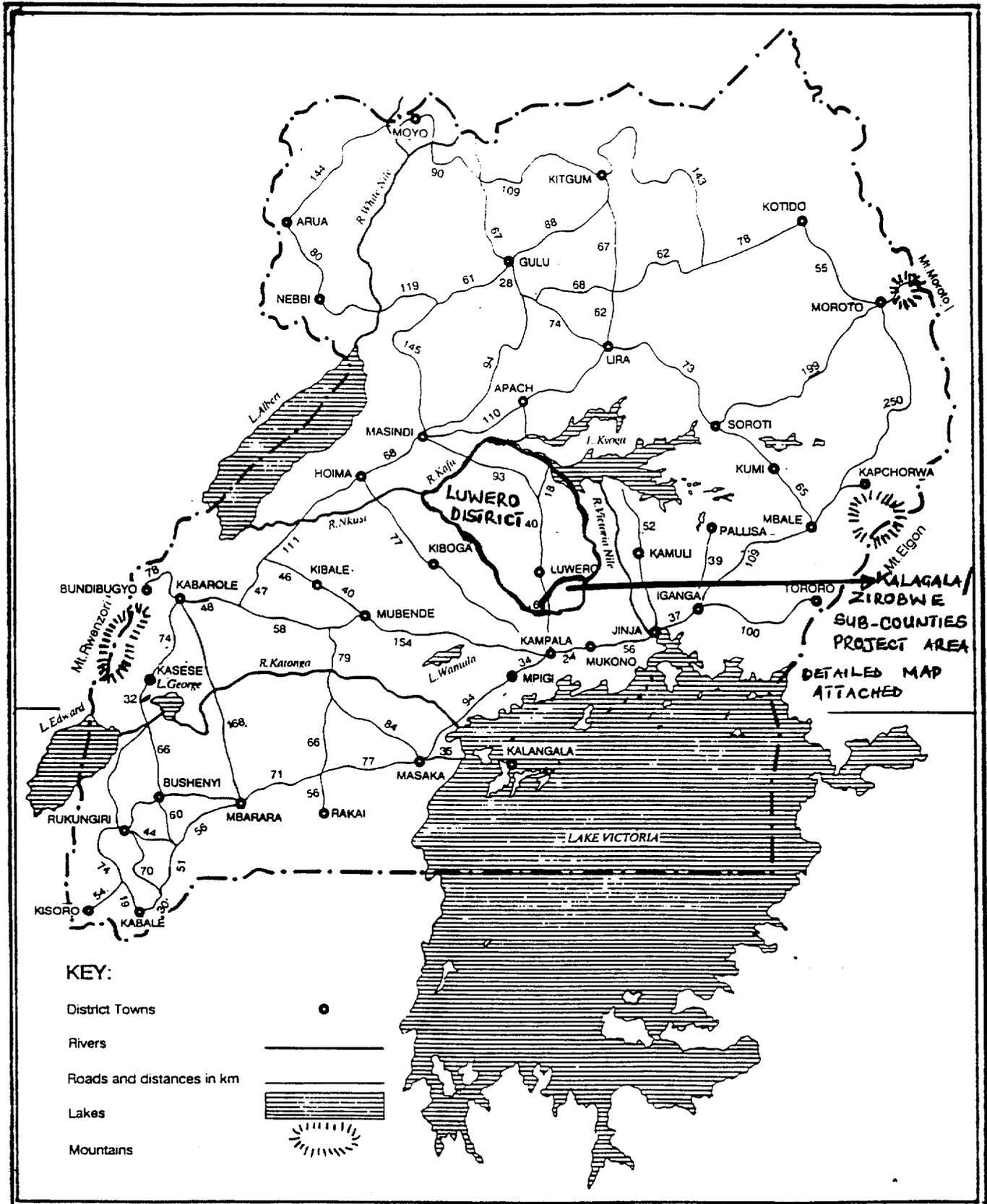
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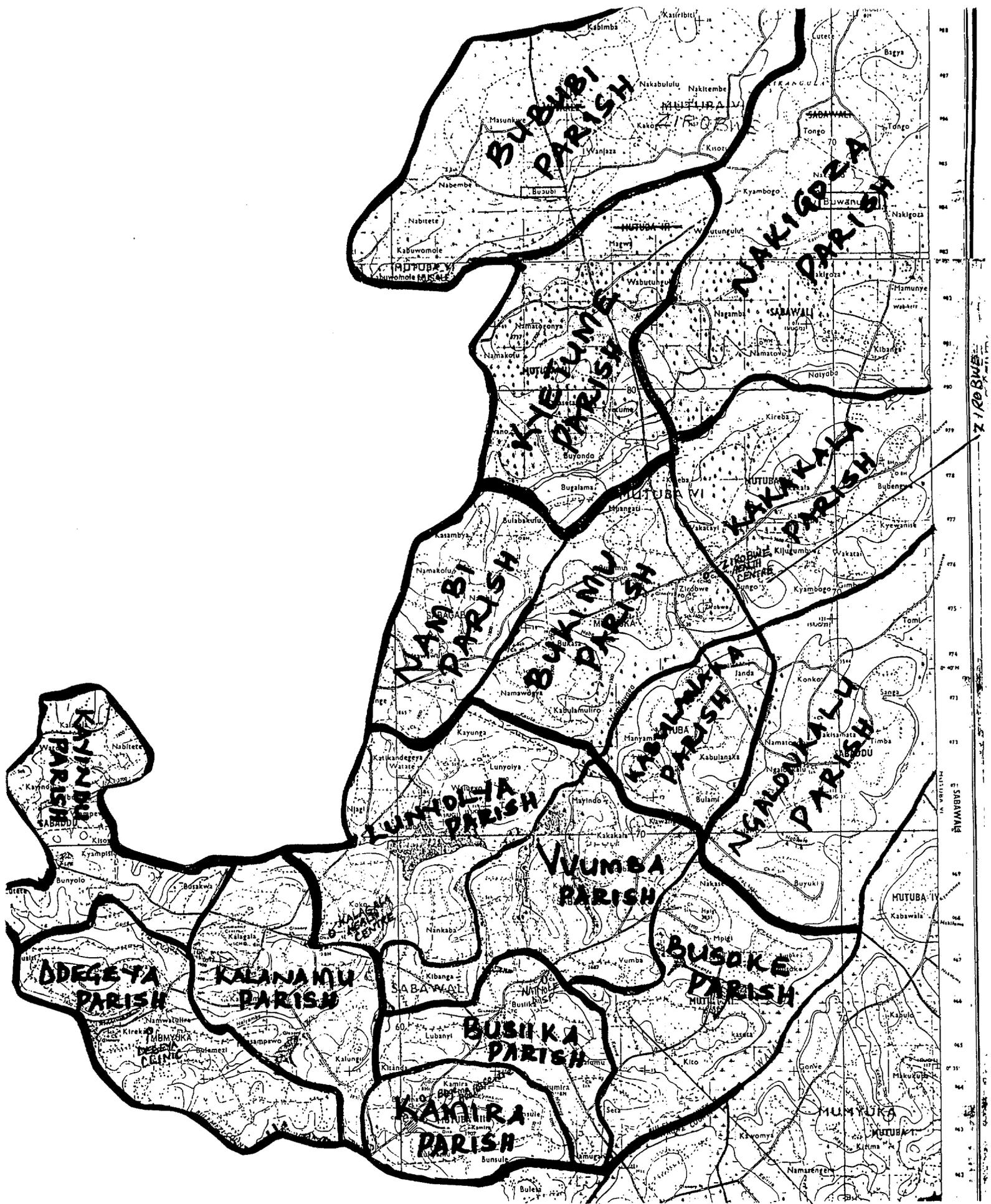
With the exception of the country directors position, all staff are host country nationals.  
All named positions here are full-time contract workers for ADRA/Uganda.

# **Appendix III**

Project and Area Maps

# UGANDA: DISTRICT TOWNS & ROAD DISTANCES MAP





BEST AVAILABLE COPY

SCALE- 1:50,000

KALAGALA SUB-COUNTY

# Appendix IV

Population Breakdown - CS X Uganda

## ADRA UGANDA, CS-X TARGET POPULATION NUMBERS

KALAGALA				ZIROBWE			
PARISH	MALE	FEMALE	TOTAL	PARISH	MALE	FEMALE	TOTAL
BUSIIKA	1,315	1,287	2,602	BUBUUBI	1,216	1,161	2,377
BUSOKE	1,496	1,449	2,945	BUKIMU	2,466	2,634	5,100
DDEGEYA	1,972	1,974	3,946	KABULAN/	1,301	1,331	2,632
KALANAMU	1,675	1,647	3,322	KAKAKAL/	2,227	2,240	4,467
KAMIRA	1,089	925	2,014	KYETUME	1,271	1,259	2,530
KAYINDU	1,761	1,738	3,499	NAMBI	1,442	1,497	2,939
LUNYOLWA	1,892	1,965	3,857	NAKIGOZA	1,773	1,721	3,494
VVUMBA	1,935	1,992	3,927	NGALONK.	2,026	2,057	4,083
<b>TOTAL</b>	<b>13,135</b>	<b>12,977</b>	<b>26,112</b>	<b>TOTAL</b>	<b>13,722</b>	<b>13,900</b>	<b>27,622</b>

Total project area **53,734**

### Population by target age group

group	Percentage	1991**	1994*	1997*
0-11 months	4.50%	2,418	2,604	2,804
12-23 months	4.30%	2,311	2,488	2,680
24-59 months	10.00%	5,373	5,787	6,231
60-71 months	2.90%	1,558	1,678	1,807
5 - 14 years	29.10%	15,637	16,839	18,134
15-19 females	4.90%	2,633	2,835	3,053
20-34 females	10.20%	5,481	5,902	6,356
35-49 females	6.10%	3,278	3,530	3,801
Parents 5-14 yo est.	19.80%	10,639	11,457	12,338
<b>Total</b>	<b>91.80%</b>	<b>49,328</b>	<b>53,121</b>	<b>57,205</b>

**\*\* Estimates using 1991 population census**

**\* An average population growth rate of 2.5% has been assumed for all age groups.**

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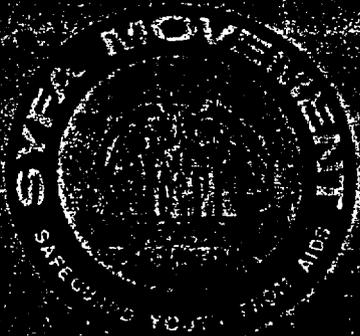
# Appendix V

Strategies for Behavior Change in AIDS Control -  
Uganda;

What Every Family & Community Has a Right to Know  
About AIDS - Uganda;

How to Use Condoms

# Strategies for behaviour change in AIDS control



**"Safeguard Youth from AIDS":  
the project and movement  
in Uganda**

Prepared for the  
Government of Uganda  
and UNICEF-Kampala



THE REPUBLIC OF UGANDA



unicef

November 1993

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# **BEHAVIOUR CHANGE IN AIDS CONTROL**

Implementing SYFA  
in Uganda

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## FOREWORD

Along with so much else that has recently improved in Uganda - national security and economic stability included - some features of the HIV/AIDS situation merit attention. Till 1991, reported AIDS cases doubled every year. The trend begins to show welcome signs of levelling out. But the disease still is the leading cause of adult deaths. The number of AIDS orphans and children with HIV is increasing rapidly, the situation of young girls being especially tragic. In the 15 - 19 age group, there are perhaps five or six times as many girls with AIDS as boys.

But there is hope. Much progress has been made in spreading knowledge of the disease, its causes and consequences. In every district of the country, in every Ministry, in countless church groups, Islamic bodies and non-government and voluntary organisations, projects are underway to stem the tide of infection and to care for those living with AIDS.

It is a matter of satisfaction for us in UNICEF to be part of a lot of these activities and to see them growing and succeeding. The newest phase of UNICEF cooperation with the Government of Uganda is, in fact, a Window of Hope: this is SYFA, an acronym of the project and movement, "Safeguard Youth From AIDS". It is also a matter of pride for UNICEF, after collaborating with the Ministry of Health and the Uganda AIDS Commission in its conception and project preparation, that SYFA should now have been adopted by different implementing elements of government under the aegis of the Uganda AIDS Commission.

SYFA departs from evidence that children between 5 and 15 years are virtually AIDS-free, according to the monthly reports of the AIDS Control Programme of the Ministry of Health. This is therefore the time when SYFA could apply to itself the wisdom of tradition, "The best time to bend the tree is when it is green". The project has been described in several

other UNICEF publications. This booklet concentrates on the implementation strategy.

What is notable in this description is the conceptual approach to behaviour change and strategy formulation, the heart of the SYFA task. It may be of interest to others confronting challenges like ours.

We owe the conceptual and advocative thrust of the approach to Gerson da Cunha, a now retired UNICEF staff member who was with us on a brief assignment. He brought us much experience in Programme Communication and Social Mobilisation derived in Latin America, India and New York Headquarters. We are grateful to him for catalysing much good thinking and development of an innovative framework for implementation.

Hon. Manuel Pinto, Director General of the Secretariat of the Uganda AIDS Commission, while noting that youth make up half of the country's population, has said, "Very simply, to save the future of Uganda, we must Safeguard Youth From AIDS". He said this before signing a Memorandum of Understanding with UNICEF on implementing SYFA. The occasion was one of great personal satisfaction to me because of my involvement over two years in conceptualizing SYFA and helping to bring the project to life. Given the great impetus that the new thinking and effort will bring in its train, we in UNICEF look forward to realization of the Director General's vision.

Aklilu Lemma  
Representative, UNICEF Uganda

Kampala August 1993.

## INTRODUCING A WINDOW OF HOPE

"SYFA" - Safeguard Youth From AIDS - is a project conceptualized in UNICEF by its Representative in Uganda, Dr. Aklilu Lemma. His, too, was the energy that transformed the concept into a project, now taken up by the Government of Uganda through the Uganda AIDS Commission.

SYFA is the youth focus of AIDS prevention in the country. It concentrates on the ages when AIDS prevalence is virtually nil, 5 to 15 years. This is the Window of Hope, an innovative vision in AIDS control. A preventive initiative at this time has the best chance of becoming the attitudes and practices of a lifetime.

These pages are written at Dr. Lemma's urging in the belief that they may interest others who work in this field. They may even do more because the approach stresses strategy formulation and behaviour change, key elements in development communication.

The writing is largely for practitioners with some experience of development communication, or an interest in it. Communication issues will be the hot focus. Therefore, details of disease prevalence and cultural reality beyond the needs of commu-

nication analysis have been sacrificed. But, wherever possible, references are given of sources where more information may be found.

The present writer is in many ways the recorder of a working experience over three swift months in Kampala. Numerous individuals participated. They will regrettably but unavoidably be referred to as "the project group". In alphabetical order, they are: Livingstone Byarugaba, Andrew Byekwaso, Margaret Egonda, Donna Flanagan (WHO Uganda), Carol Jaenson, Paul Kaggwa (Ministry of Health), Dr. Aklilu Lemma, George Lugalambi (Department of Mass Communication, Makerere University, Kampala) Margaret Mbazira, Crispus Mundua (Ministry of Information), Ayazika Nakwagala, Bernadette Olowo-Freers, Manuel Pinto (Director General, Secretariat of the Uganda AIDS Commission), George Sengendo and Richard Ssemambo (both Ministry of Information). All those not otherwise designated are in UNICEF - Kampala.

Gerson da Cunha  
( Consultant)

August 15, 1993  
UNICEF, Kampala  
Uganda

## THE HIV/AIDS PROBLEM

Something like one in ten Ugandans is HIV positive, one in five in the sexually active age groups, totalling 1.5 million persons. Some 40,000 AIDS cases have been reported and this may actually be a gross underestimate. In 1993, Uganda expects to register ten of thousands of AIDS related deaths. There are a million orphans in the country.

Many believe it was in Equatorial Africa that the pandemic to-be had its origins in the seventies. Heterosexual coitus - the hardest cause to deal with - is responsible for about 80% of total infection and 95% of new adult infection. Perinatal transmission accounts for about 8% of all infection. Women are twice as likely as men to be sero-positive. Almost six times as many girls as boys have AIDS in the 15 to 19 age group and almost twice as many in the 20 to 24 group.

Among Ugandan children under five, AIDS is now the sixth largest cause of death, up from eighth in 1988. Over 100,000 are thought to have HIV/AIDS. AIDS will push the infant and under five mortality rates well beyond their high current levels. Child survival goals articulated by the World Summit of Children in 1990 will not, therefore, be met unless the epidemic is broken.

### THE CAUSES, THE VARIABLES\*\*

Political, social, economic and cultural factors have affected a variety of behavioural and biological variables that have determined the rate of HIV/AIDS transmission in Uganda.

Political and military disruption has caused social upheaval that has seen mass movements of people, break up of families, division of communities on

both sectarian and generational lines and rapid changes in values. The effects of internal disruption have been compounded by associated economic mismanagement and a world wide collapse in commodity prices. Restructuring the economy to reflect these altered circumstances has required a period of severe and prolonged austerity. This has produced declining salaries and the collapse of many social services.

Uganda is the fourteenth poorest country in the world. The economic situation has increased the burden on women trying to fill their traditional roles as guarantors of the family's food supply and the health and education of its children. For some women in difficult circumstances, particularly single mothers, sex has been used in order to survive.

For other women, the weakness of their position relative to men means they have no control over the behaviour of their partners. This makes them vulnerable to infection.

Although the exact form of sexual behaviour and social norms varies amongst different cultural groups, the authors of a WHO-sponsored evaluation of Uganda's AIDS Control Programme (ACP) noted in 1991 that "Sexual activity (is) strongly associated with traditional ceremonies, many of which surround important life events such as naming of children, initiation, marriage of one's own children and death... The frequency of polygamous marriages further demonstrates the social value placed on having more than one sexual partner in contemporary Ugandan life."

STDs are a key co-factor in the transmission of HIV: individuals with genital ulcer disease (GUD - chancroid, syphilis or herpes) can be ten times more

\*\* Drawn from "UNICEF's Response to HIV/AIDS in Uganda - Update" (February 1993), UNICEF Kampala.

at risk of acquiring HIV with each act of sex.

Peace has come at last to Uganda, the economy has stabilised and the long march back has begun well. But these political, social, economic and cultural factors/among others, still shape behavioural variables:

- o multiple partners
- o frequency of intercourse outside of stable relationships
- o abrasive techniques of intercourse
- o high rates of contact with groups with high rates of infection
- o an early start to sex
- o low rates of STD diagnosis and treatment

### **SYFA, THE WINDOW OF HOPE**

But then AIDS in Uganda holds a mirror up to the country's strengths as much as to its ills. Among the strengths is surely its youth, who make up half the population - which brings us to Safeguarding Youth From AIDS, the SYFA project.

The epidemiology of AIDS shows that its prevalence is very low indeed in the 5 - 15 age group. The figure rises sharply after 15 years, indicating that sex and infection have occurred earlier. Forceful preventive action in these youthful years would lead to a far smaller ingress of infected persons into the older age groups. Successful prevention now could well safeguard youth for a lifetime. This is the significance of the SYFA years, 5 to 15, and the SYFA initiative.

SYFA is thrice blessed. Firstly, these are the years before the sexual drive is well established. Secondly, attitudes and practices are not yet firmly set and can be moulded. Thirdly, these are the ages when behaviour is strongly mouldable by persons with a natural interest in, and authority over, children. Here is a combination of advantages that applies at no other age. This is the Window of Hope.

In other words, SYFA may be the most do-able part of the AIDS task in Uganda (and perhaps, the principle would apply wherever people are grappling

with the disease).

SYFA's objectives in the next five years are to reduce by a third HIV and other STD infections in sexually active youth; raise the average age of first sex by a year or more; reduce teenage pregnancies and the present sex ratio of HIV positive girls to boys aged 15 - 19 years; reduce pregnancies in HIV positive mothers and sexual contact between older men and young girls.

### **SEXUAL BEHAVIOUR IN YOUTH**

Both sexes make a sexual debut in their teens, although the average age varies with regions and between town and rural areas. In 1989-90 researchers looked at adolescent sexual behaviour in six districts. They found the average age of first intercourse to be 15 years for boys and slightly more, 15.5 years, for girls. So some sexual experience occurred even earlier. The median age for women entering some form of marriage union was 18.1 years and a fifth of those unions were polygynous. The median age of women at the time of the birth of their first child was 18.6 years.<sup>1</sup>

For girls, early sex is associated with the risks (both medical and social) of pregnancy and of infection with HIV/AIDS and other STDs. The early sexual encounters of young girls whose sex organs are still anatomically and physiologically immature, may be associated with a particularly high risk of HIV infection.

### **FACTORS ENCOURAGING HIGH RISK SEXUAL BEHAVIOUR AMONGST YOUTH**

#### **Socio-Cultural**

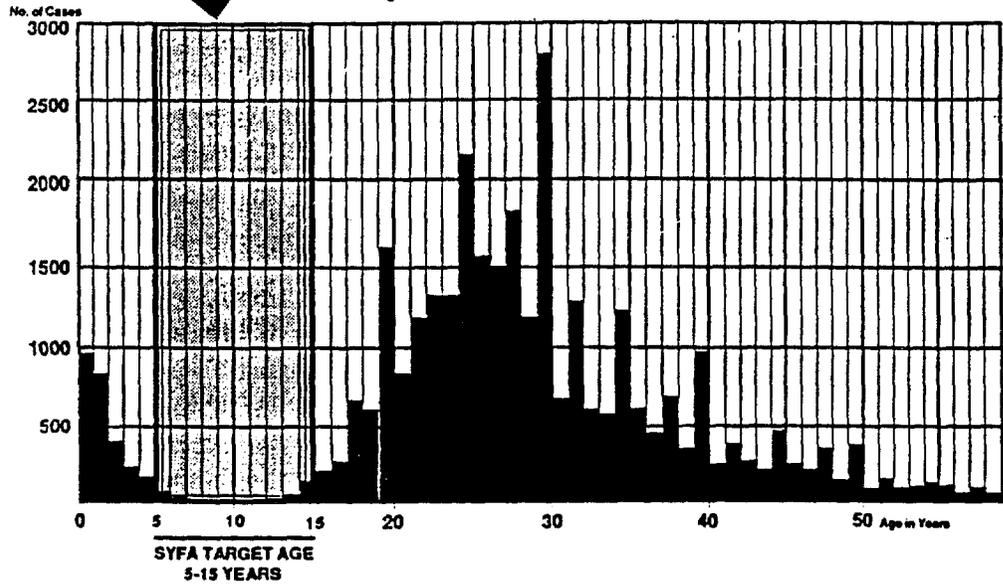
- o inadequate knowledge and support provided by the extended family

# "Window of Hope"

## for Safeguarding Youth From AIDS in Uganda

5-15 Years  
"Window of Hope"

Age Distribution of AIDS Cases

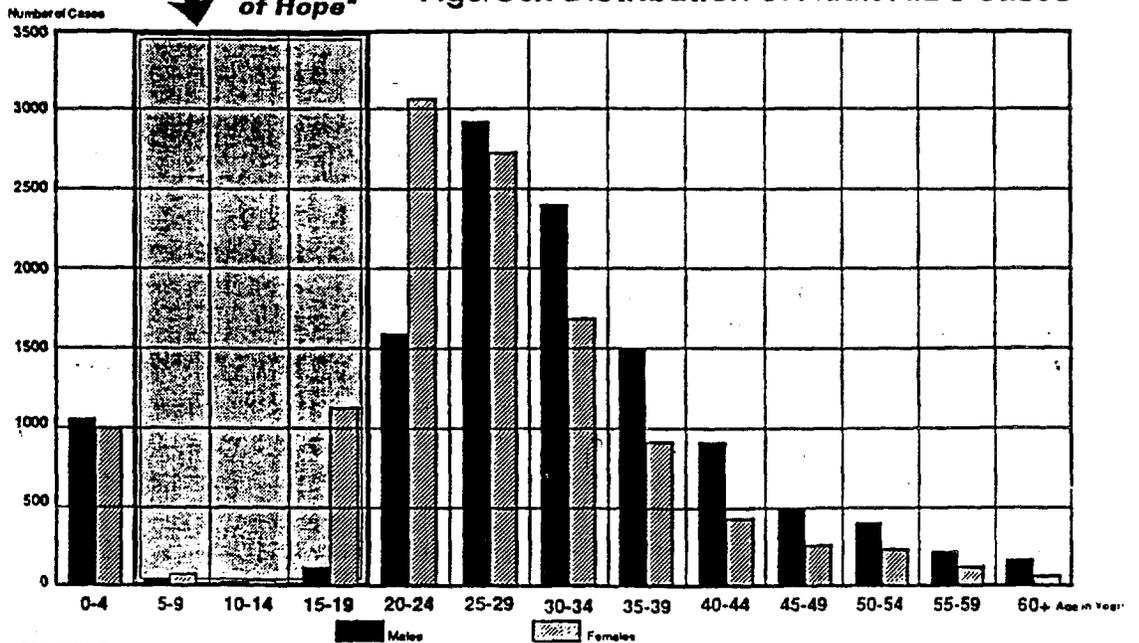


### SYFA Objectives

Through concerted and systematic education and social mobilization efforts, using children between 5-15 years as an "entry point", to reduce substantially the HIV+ rate in the sexually active 15-20 year old youth, as measured through yearly monitoring system, over an initial 5 year period.

5-15 Years  
"Window of Hope"

Age/Sex Distribution of Adult AIDS Cases



### Girl Child Focus

Note that between 15-19 year olds there are about 6 times more girls with reported AIDS cases than boys; presumably due to older men such as "sugar daddies" and others infecting the young girls.

"Children between 5-15 years are virtually AIDS free, not yet fixed in attitudes and practices. This is when prevention has the best chance".

AKU/Lemma UNICEF Representative, 1993



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- o behavioural norms amongst the adult population that include polygamy, dancing, drinking and sex at specific ceremonies, and in some areas, wife sharing, widow inheritance and treatments for barrenness.
- o subservience of women to men
- o alcohol consumption

#### Economic

- o poverty which causes women to
  - exchange sex for material gain
  - brew beer (and thus facilitate drunkenness) as a source of income

#### Psychological

- o behavioural habits that were safe in the past but, which are no longer appropriate in the face of the HIV/AIDS epidemic.
- o avoidance and resistance to behaviour change through various forms of denial and rationalisation that enable individuals to deny the immediate and personal nature of the risk
- o peer group pressure to have sex.

### **FACTORS DISCOURAGING HIGH RISK SEXUAL BEHAVIOUR AMONGST YOUTH**

In some areas of the country there are behavioural norms that will tend to inhibit high risk sexual behaviour and the associated danger of HIV/AIDS transmission. They are worth noting even though they may not always be appropriate for promotion in other parts of the country. They include:

- o faithfulness to a limited number of wives only
- o chaperoning of young girls to prevent pre-marital sexual activity
- o discouragement of adultery
- o taboos and fines discouraging sex between older men and young girls
- o high values placed on virginity of girls and some times even boys

- o early marriage to prevent pre-marital sexual activity.

The exact form of these and other factors varies throughout Uganda.

### **AN ASSESSMENT OF THE BEHAVIOURAL CHANGE TASK**

There is nothing about the AIDS prevention scene in Uganda that makes the country different from anywhere else in essential elements of the behavioural change task. The principles apply.

This means, as the project group quickly decided, that awareness of the disease, its causes, modes of transmission and consequences is no longer the problem, being well nigh universal. What lags leagues behind is practice. As in so many other fields of development, the challenge now is how to close the behavioural gap. Information/Education do not prompt behavioural change merely by being accentuated or modified. More-of-the-same does not work. In fact, as we shall see, the process and activity involved in awareness creation, on the one hand, and adoption of new behaviour, on the other, may be qualitatively different.

To sum up the relevant theory on the subject to the borders perhaps of over-simplification: messages and communication that are in conflict with an individual's current behaviour tend to be "denied", or rejected. In development programmes, this is inevitable. The message will always conflict with existing behaviour or would not be required in the first place. How is denial to be blunted?

In the present case, the basic target beliefs in young people should be: "HIV/AIDS can be fatal to me. I know how it is contracted and avoided. What's best is no sex till marriage." Resistance to these perceptions will take many forms. Some of them are these denials:

*(Taken from "UNICEF's Response to HIV/AIDS in Uganda - Update")*

- o the belief that the risk does not apply to oneself, as in "We know that AIDS is a problem of the cities and other people... we are all right here."
- o minimizing the problem as in "I have not yet seen anybody in our community who has died of AIDS... therefore there is no need to change here."
- o blaming others for the disease and for exposing him/her to risk as in "The way I behave is caused by women, they make themselves very attractive... I cannot help it as they make us feel this way and there is nothing I can do about it."
- o offering of alibis, excuses, justifications and other explanations for one's behaviour, as in "For a young man like me sex is an obligation... to fulfill cultural status."
- o giving the forbidden or curtailed activities increased prestige to justify behaviour as expressed in: "It's very difficult... sex is so sweet that people would rather die than leave it."
- o avoiding any situation or choice which is perceived to be too demanding. This is expressed as, "You are asking too much, because this has to

do with sex and to ask someone to stop something natural is too much."

Demolishing barriers and resistances of this kind needed more than an assault by information and education. The project group quickly saw we needed a new basis for planning and a new approach to implementation - that is, we needed the right conceptual model and the right strategy.

By "model" we meant a basic description or diagram of a process that facilitates understanding and action. By "strategy" we meant a sequence of action, or an approach to a problem, chosen from among several optional solutions eg Hitler's decision in World War II to attack France through the Ardennes mountains and forests, not the Maginot Line, was a war strategy. It was followed by all German armed forces, each of which set up for itself goals and objectives based on the Fuehrer's simple strategy. It was enormously difficult, as ours will be. But that strategy succeeded as, hopefully, ours will too. But first, the matter of the model.

## A BEHAVIOURAL MODEL

Since the problem is a behavioural one, familiar Information/Education models will not do. Logically, a behavioural model must be the starting point

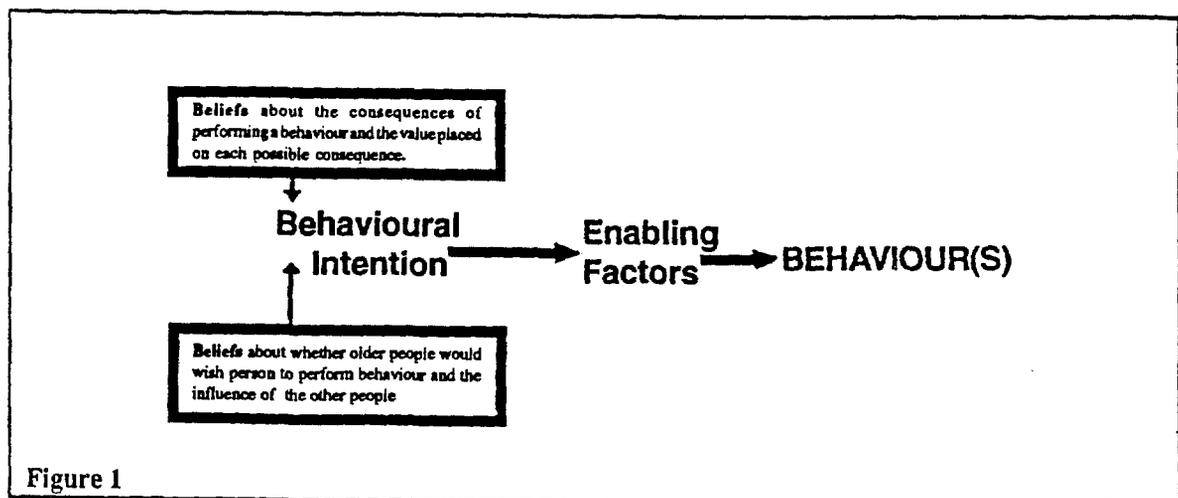


Figure 1

for understanding, analysis and strategic planning. A document search turned up Mehryar and Carballo's "Models on behavioural change" (Global Programme on AIDS, WHO-Geneva, 1990). A study of this valuable assessment and a look at a selection of books named in the Bibliography caused the project group to reach agreement. The choice settled on Hubley's BASNEF model (1988).

BASNEF is an acronym of Behaviour, Attitude, Subjective Norms and Enabling Factors. The model is, according to Mehryar and Carballo, a good combination of the outstanding features of Fishbein and Ajzen's Reasoned Action Theory and Green's PRECEDE Theory. The acronym and what it stands for along with Fig. 1 in this paper make reasonably clear what Hubley is proposing.

The model suggests that any desired Behaviour requires a prior Behavioural Intention. But this Intention is not always enough eg a young man may decide to use a condom, or a mother wish to use oral rehydration salts, but neither product may be available, or available at the right price - which will frustrate the Intention and lead to no desired behaviour.

Therefore, Enabling Factors are often essential (the condoms and ORS sachets) which imply their own train of arrangements. The right Behavioural Intention is fostered by (a) instilling in the person(s) concerned the right beliefs about the target behaviour and promoting the relevant values; (b) instilling the right beliefs/attitudes about the behaviour among those who influence our target persons; this will set up desirable subjective norms (standards) of behaviour for the young people we hope to influence.

Hubley believes that his design should be seen as a check list for programme planning rather than as a full description of the complex processes which underlie a person's action. This is how the SYFA project group has used it. Fig. 2 breaks out the model

into what needs doing, according to our best judgement of the SYFA scene: activities, materials and cooperation required of allies with regard to attitude/behaviour change among adolescents and pre-adolescents, on the one hand, and parents and teachers, on the other hand.

The BASNEF model interestingly, makes no mention of Awareness or Information or Education. These may be considered instruments to help create desired beliefs and attitudes. In other words, observing the BASNEF model transforms the behavioural change project from what is sometimes (wrongly) only an "IEC" exercise into a pursuit of the right beliefs, norms, values and enabling factors. The task is qualitatively different and immensely more complex.

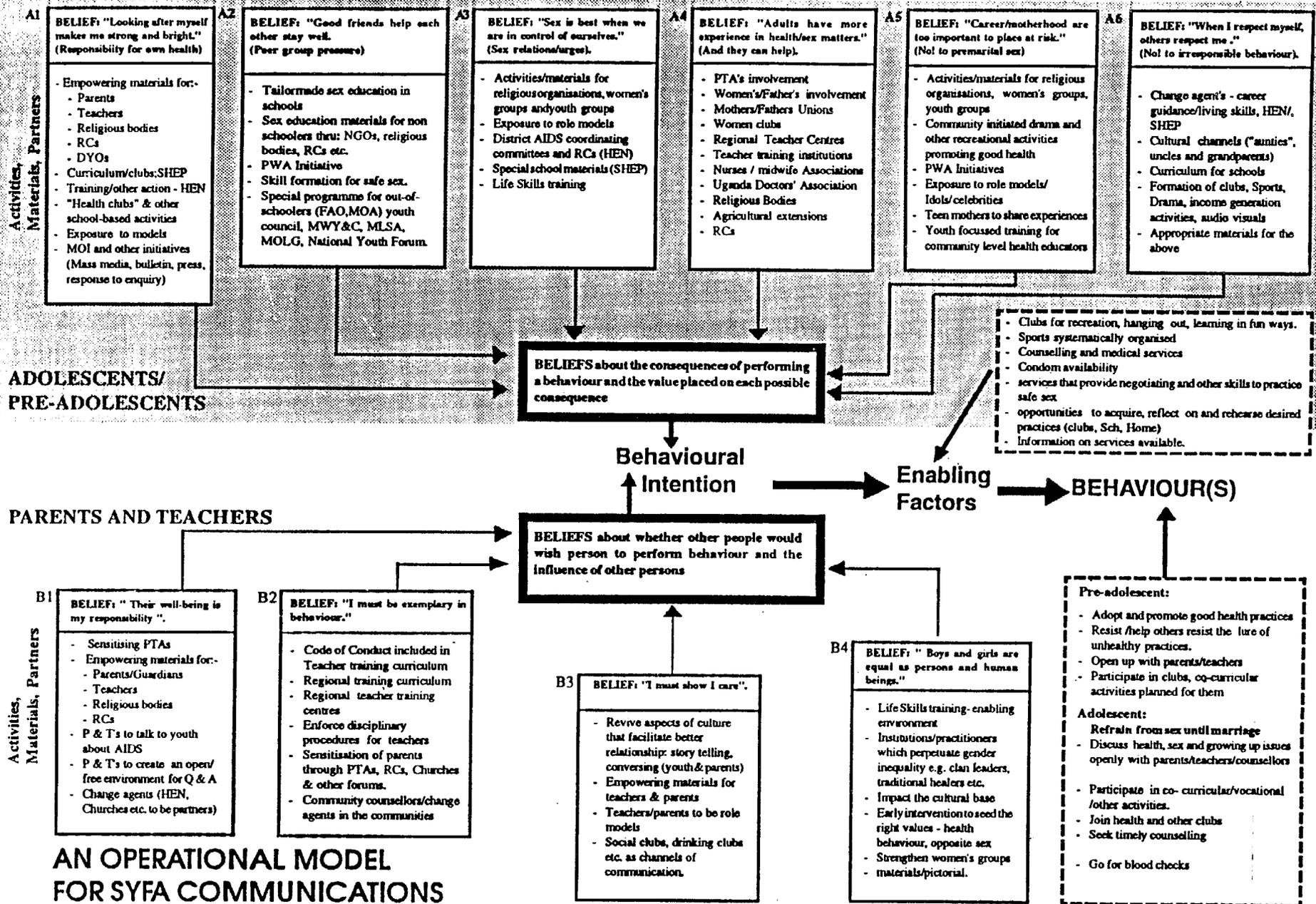
Figure 2 speaks not merely of booklets and posters but also of health clubs and sports systematically organised, not simply of mass media activities but of how they must spark response of specific types, say, in PTA's and young farmers' groups. The idea is no longer merely to batter young people with thinly disguised lectures but to help market condoms effectively, establish counselling better and facilitate role-playing/rehearsals of how an adolescent might deal with a predatory uncle.

But little of this would make sense were there not the sharpest focus on planned outcomes from each activity.

## A STRATEGY FOR THE SYFA PROJECT

The model as shown in Fig. 2 sets out some beliefs in the minds of youth, parents and teachers that, hopefully, will lead to the right Behavioural Intentions and Behaviours. But the model could give rise to a bewildering number and variety of activities/materials/partners. What are the priorities? Where is the focus to be?

Figure 2



**AN OPERATIONAL MODEL FOR SYFA COMMUNICATIONS**

□ |

We need a basic strategy to clarify these questions and supply answers. This strategy is suggested by much evidence from field experience and is summed up in the following quotation.

“Nothing jeopardizes or undermines the attempt to prevent AIDS in adolescents more than the absence in them of a sense of responsibility for their own health. Young children have been led to believe that their parents are responsible for their health. So it is difficult for youngsters suddenly to become concerned about their health at the age of 14 or 15. This concern must start at a much earlier age. In particular, the concern must be based on a set of health values derived from parents and teachers”. (Kathleen K. Reardon, in “The Potential Role of Persuasion in Adolescent AIDS Prevention” 1990, see reference below).

The first element of strategy is, therefore, that the pre-adolescent should be the project’s primary beneficiary. On judgement, the second and third priority as beneficiaries must be the 11 to 14 and the 15 to 20 year groups.

But (and this is the second element of strategy) the top priority audience for communication will be parents and teachers. It is their influence and lifelong relationship with the children that the project hopes to harness. Parents/teachers grow in importance given that the 5 - 10 year old is our primary concern. These are years when the child is still most dependent at home and in school.

Adults apart, it is well known that among adolescents and pre-adolescents the peer age groups exercise great influence on behaviour. This, then, is a force also to be harnessed.

## CATCHING THEM EARLY

The basic strategy for the SYFA project is, therefore: to activate existing parent/teacher influence or

authority as well as peer group pressure to foster the right behaviour primarily by pre-adolescents (5 - 7 years and 8 -11 years) and secondarily by adolescents (11 - 15 years) always favouring the girl child in emphasis; the desired behaviour pattern is avoidance of sex till marriage.

The strategy distinguishes between beneficiaries of the project and audiences for communication. It stresses behaviour, not awareness. This, in turn, underlines the importance of Enabling Factors. For instance, opportunities need to be provided for interaction involving parents, teachers, children/youth themselves.

The right opinions and attitudes must be helped to form. “Catchments” must be created to assemble young people with objectives and motivations that make sense to them.

The strategy will help screen the many options for project activities, perhaps eliminating some and certainly promoting others in order of importance.

The key behaviour pattern selected for adolescents (no premarital sex) will shape the content and form of much material and activity. It will also determine the brief to, or understandings reached with, strategic allies and project partners.

There is a side effect of this strategy for SYFA that will benefit the whole front of AIDS control and prevention. When parents and teachers are encouraged to safeguard their children and students, the influencers are themselves being influenced. The AIDS prevention messages are being internalised by most adults and the dangers personalised through a supremely powerful agency: the love of parents for their children.

The model and strategy evolved by the SYFA project group take three principles into account. Firstly, youth is now turned off by AIDS talk; they hear, even parrot what they hear but do not listen. Secondly,

materials and activities will be designed around what interests youth (usually, this has little to do with AIDS). Finally, everything has a single focus, working within a single design. It includes everything we plan, or maybe everything we plan has been tailored to that design.

## A COMMUNICATION RESPONSE

This exposition of the project group's thinking so far has centred on ideas for SYFA, the project. Yet the group had started out to evolve only a communication approach for the initiative. We ended up, perhaps unavoidably, with concepts and an operational outline for the SYFA project as a whole. After all, AIDS prevention (the essence of SYFA) has communication and nothing else to work with. It is the "vaccine" and a lot of the treatment, too. We discovered that communication was the SYFA project.

### A Critique of Pure Information

Properly used, therefore, communication could head off infection by triggering activity that, in turn, fosters the right attitudes and practices. But will it be used that way?

The beginning of some changes in practice can be deduced from field observations in Uganda. But there is overwhelming agreement that the current message-based, information-providing efforts have been necessary but not sufficient to affect the statistics of HIV transmission.

Apart from over-reliance on pure information and appeals to change practice, messages were almost invariably reliant on fear. This has tended to numb their audiences and may have increased both denial and fatalism. Many Ugandans believe they are already infected, or soon will be.

There is an underlying flaw in existing approaches to AIDS communication (there is virtually no systematic SYFA communication). They have failed to take into sufficient account the very high performance cost of the behaviours being required of Ugandans.

The cultures and traditions of the land favour multiple sexual partners and practices not conducive either to safe sex or abstinence. Add to this the natural power of adolescent sexuality and the usually unhelpful example of adults. Add, yet, the need to have pre-adolescents looking after themselves in a society very protective - perhaps too protective - of one's own sons and daughters. SYFA is asking a lot of its target beneficiaries and audiences.

### Value Versus Performance Cost

Now, communication that is meant to influence behaviour must be observant of a well-accepted principle: the perceived value of recommended practices must be greater than the perceived cost of performing them. Have communications woven sufficient benefit and value around the behaviours we want (fidelity to a single partner, premarital abstinence, safe sex, good health and good health in sexual behaviour), enough to outweigh the natural and cultural inducements pulling the other way? No. The problem has not been analysed this way, to begin with. It has been assumed that AIDS-related information and education were all that was required. The need to "add value" to the desired practices was not seen.

A fanciful example will illustrate the advantage. Let us suppose a nutritious biscuit is to be marketed for children in Argentina. One option to encourage purchase would be to speak of the biscuit's vitamin, protein and mineral content. A more effective option would be to have the footballer Maradona say, "This is a great biscuit. I eat some daily for health". The testimonial would add value to the product.

Briefly, then, the crucial importance of using persuasive communication has not been reflected in the methods and material for AIDS and SYFA communications.

There was much discussion in the project group about the possible manipulative effect of persuasion techniques. Also, was all this not too "vertical" and dismissive of participation by the community? Were the natural and traditional channels within the community not the right starting points?

In the end, these were seen to be invidious distinctions. Everything needed to be used. Nothing in the approach was seen to be hostile to any resource. Nor was it manipulative to wean people away from myth, gender dominance and practice destructive of family and health.

## **PERSUASION - THE KEY PROCESS IN SYFA**

The notes that follow are drawn from "The Potential Role of Persuasion in Adolescent AIDS Prevention," a contribution by Kathleen K. Reardon to Public Communication Campaigns (Editors, Rice and Alkin), Sage Publications, London, 1989. More precise references and elaboration will be available in the original article and book.

The notes support the SYFA rationale, provide a basis for strategy and ideas for implementation, outline some approaches in persuasion and suggest priorities.

These are merely jottings meant to prompt further thinking by planners.

## **A Basis for Strategy**

- o AIDS is, first and foremost, a communication and persuasion challenge. The fight must be multi-channel, multi-method and multi-disciplinary.
- o Among adults, AIDS prevention demands that settled value hierarchies be changed, a difficult persuasion task. In children, a strong value for health can be developed before they have learned to treat it with indifference. To the extent that this is done, they are more likely to take an interest in avoiding disease and to adopt behaviours that will protect them from AIDS later.
- o Nothing jeopardizes or undermines attempts to prevent AIDS in adolescents more than the absence in them of a sense of responsibility for their own health. Young children have been led to believe that their parents are responsible for their health. So it is difficult for youngsters suddenly to become concerned about their health at the age of 14 or 15. This concern must start at a much earlier age. In particular, the concern must be based on a set of health values derived from parents and teachers.
- o Parents, teachers, and youth organizations are the sources most likely to instill or fail to instill in children (a) attitudes about responsibility with regard to sex and (b) values that discourage unsafe behaviours.

## **Some needs and difficulties**

- o Several factors increase the probability of AIDS-risky behaviour by adolescents: "a sense of invulnerability, sexual exploration and experimentation, dysfunctional beliefs and attitudes towards health care services, and reliance on peer networks rather than adult sources of information" (Rotheram-Borus and Bradley 1987, p.2)

- Only 3% of the adolescents interviewed by Strunin and Hingson (1987) changed their behaviour in response to the AIDS threat. They had a reasonably high level of AIDS knowledge, but they had little personal fear of AIDS, believed in the preventability of AIDS, were confident about their ability to behave safely but were unable to simulate safe behaviours (such as asking about a partner's sexual history, or using a condom).
- A recognition of AIDS as a personal threat to youth is a necessary prerequisite to behaviour change; however, additional skills are necessary to translate this knowledge into behavioural change. Skills needed include assertiveness training (eg to help adolescents in requesting that their sexual partners use condoms or in refusing to have sex), role playing, and rehearsal of refusal skills, identifying feelings of arousal or anxiety, and problem solving with peers in a group setting.
- Additional factors of importance are the individuals' personal cost/benefit analyses of safe behaviours and access to resources (such as condoms, legal aid, or HIV testing).

### Values

- Promoting the right values is important. To the extent that children value their health, they are likely to be uncomfortable when they engage in, or even consider engaging in, health risks.
- Health is low in the value hierarchy of adolescents. This may be due to the tendency in parents to exclude children from participation in the protection of their own health. Prevention can be assured only if people place a high value on their health at an early age and throughout life.
- "Value self-confrontation" may be an effective means of encouraging young people to raise the position of health in their value hierarchy: that is, teaching them to recognize health risks as contradictory to their values. This may prove an

effective means of eliciting health-protective behaviours from adolescents.

- A communication strategy that confronts children with the discrepancy between their behaviour and values can persuade behaviour change.
- Rokeach's (1987) self confrontation approach is a robust method which can be adapted to different settings and behaviours.

### Living by one's values. Peers

- It is one thing to value your health and quite another to believe that you can actually protect it. Aside from learning to value health, children must believe they can effectively resist peer and other pressure, must learn the necessary skills and how to use them effectively. It is imperative that children come to believe that they have what it takes to resist pressure from peers to risk their health. There is a difference between having skills and being able to use them well.
- Providing specific instructions about how to perform a recommended action leads to a higher rate of acting in accordance with the recommendations.
- Sex education programs, while effective, are not as influential as peers on the level of adolescent sexual activity.
- Children initially unwilling to resist peer pressure may benefit from learning how other children found particular strategies useful in resisting pressure. Peers often have an impact greater than parents.
- Peer groups are valuable resources in health interventions. Peer counsellors, informal discussion groups, and role playing with feedback might prove useful in adolescent AIDS prevention programs (See Mantell & Schinke, 1988). A relatively non-threatening environment is important.

### The competitive factor

- o Providing children with comparative information indicating what the average achievement levels are can enhance motivation.
- o Children show increasing interest in social comparison as they mature.
- o Students benefit from reports of collective efficacy - how their school, for example, is doing in comparison to another school learning the same skills.

### Helping them to say "NO!"

- o If children are encouraged by teachers, parents, peers, and the media to engage in healthful behaviours and are also given good reasons to do so, they may convince themselves to resist health-threatening behaviours.
- o Children should feel that they chose to adopt healthful behaviours themselves and that they were not coerced into, or given excessive tangible rewards for, changing their behaviour.
- o Discover the common rationalizations used by adults and children to avoid protective measures. How might children be taught to resist such rationalizations?
- o The ACE model provides guidelines for teaching children the types of reasoning others are likely to use when pressuring them to take health risks.
- o The ACE model proposes that people do not always reason out their behaviour. When provoked to do so, they might use the criteria of Appropriateness, Consistency, and Effectiveness. Appropriateness refers to how the behavior in question fits with one's own value system and self-image. Consistency considerations respond to the question, "Is this behaviour something a person like me would do?" Effectiveness per-

tains to the likelihood that the behaviour will lead to the desired consequence or outcomes.

- o A recent study of methods used by adolescents to resist pressure by peers to smoke indicates that they prefer to use appeals to consistency (eg smoking causes cancer). Appropriateness methods (eg it's wrong to smoke) are the least preferred means of resisting pressure to smoke (Reardon, Sussman, & Flay, 1988). Teaching children to identify the reasoning patterns of others and the reasoning patterns they might use to resist pressure from others may prove a useful path in SYFA interventions.

### Instilling the right behaviour

- o Children should be given the opportunity to practice resistance behaviors without being observed by others.
- o "Children remember 20% of what you tell them and 80% of what they do." To the extent that children can be encouraged to engage in activities that clearly indicate their concern about AIDS, they are more likely to transfer that concern to their own lives.
- o Perceived self-efficacy is concerned not with what one has, but with judgements of what one can do with what one has. It is insufficient merely to teach children to value health and to provide them with rules. We must also help them to learn that they have the ability to apply these rules in their daily lives.
- o Repeated successes tend to increase self-efficacy, whereas repeated failures lower it.
- o Role playing provides children with opportunities to practice the interpersonal resistance skills and decision-making skills they learn in the classroom. Moreover, it provides opportunities for them to hear themselves publicly commit to healthful behaviours in an environment that simu-

lates actual experience. Role-playing activities have the added advantage of providing teachers and experimenters with opportunities for direct observation of behaviour that would be difficult to capture in the natural environment (Dow, Biglan, & Glaser, 1985; Hops & Greenwood, 1981).

- o A common form of strategy training is modeling, which involves encouraging individuals to adopt the behaviours of another, usually highly respected person. Considerable evidence supports modeling as an effective educational practice. (Rosental & Bandrua, 1978; Rosental & Zimmerman 1978).
- o Modelling strategies for solving problems may not have much effect on children's performances if the motivation for modelling is absent (Schunk, 1984).
- o To the extent that parents and teachers are not lenient in their own health standards, children are likely to set high standards for themselves. To the extent that mass media avoid celebrating health risks, children are likely to avoid celebrating them.

### **Mass and interpersonal media**

- o Mass media may prove especially effective in visually emphasizing to adolescents the more immediate consequences of AIDS. Adolescents who perceive the threat of death as remote from their own experience may respond to visual images of the mental problems, skin rashes and sores, and disastrous influence on a teenager's social life that accompany AIDS. Another promising approach is to emphasize the existence of these symptoms among people living in proximity to the viewer (Longshore, 1988).
- o Perhaps the most effective approach, however, is to combine these media images with interper-

sonal question-and-answer sessions. Media messages that include fear should be followed by face-to-face opportunities to discuss strategies for reducing the risk of AIDS. This, in turn will reduce fear as well as rejection of a message.

- o Meetings arranged in a non-threatening manner, during which peers discuss AIDS or are led in discussion by people who have placed themselves at risk but changed their behaviours, are alternatives that may prove useful with adolescents.

### **Use of the fear "appeal"**

- o A lot of communication about AIDS is based on creating fear of the disease and its consequences. This assumes that the message will be understood and "personalized" - that is, people will apply the threat to themselves. This often does not happen. The message and its threat are "denied" or rejected. If the fear is internalized it can serve to motivate trial of the desired behaviour, especially if the message goes with reassuring recommendations on how to avoid the threat.
- o It seems unnecessary to evoke high levels of fear about AIDS.
- o Using fear appeals with young children might have a boomerang effect.

### **Positive appeals, "illusions"**

- o Taylor and Brown (1988) suggest that everybody operates on the basis of 3 primary illusions: unrealistically positive views of self, illusions of control and unrealistic optimism. An appeal to these illusions may work better than statements of reality.
- o They propose that "illusions" may be more effective than stressing reality in persuading children into the right practices.

- o Presenting adolescents with the vivid reality of AIDS may fail to evoke desired response. Like everybody else, children wish to maintain a positive self-image, a strong sense of control and a positive view of the future. The last thing they want to hear may be that they are no different from anyone else, are highly vulnerable to AIDS and on the brink of a short and unpleasant future.
- o Instead of images of vulnerability, we might focus on how protective behaviours increase their control. Use positive models of young people who changed their behaviour, protected their health and are free of AIDS.
- o Build on their dreams for themselves, show how control will help them realise their dreams, project images of healthful and happy times ahead as a result of exercising their present powers of control today.
- o Everybody prefers to believe good things about themselves. So positive appeals may be more effective.

## OTHER COMMUNICATION CONSIDERATIONS

### Who is to be addressed?

Parents and teachers will be top priority target audiences. Teachers are not hard to reach. The schools and educational system are obvious channels. Parents are more difficult to separate out - until it is remembered that a very large proportion of all adults are parents, certainly in Uganda, or are those who can influence parents.

There are lower priority target audiences. Decision makers in Government, the religious institutions, leading NGOs, the media and the private sector have important enabling functions. For the same reason, women's groups, associations involved in child

welfare and the school's system must be addressed for specific purposes. Professionals of various kinds will need to be mobilized, those in the health and medical sector particularly. The Child-to-Child movement is an important resource.

### What will our message(s) be?

This is the crux of the communication design problem. It was clear that we need an over-arching theme for SYFA under which innumerable, more specific and objective-driven messages will need to be developed. To tackle the matter of the theme first, many meaningful options presented themselves. This is a brief discussion of the more important ones:

#### (a) Dreams

All parents nurture ambitions for their children. Children themselves voice their own dreams for themselves. The strong parental drive to make those dreams come true can help motivate them to instil the right behaviour in their children. The proposition on which a theme might be fashioned is, "Give your children's dreams a chance. Safeguard their health, protect them from AIDS by encouraging the recommended practices".

#### (b) Life is Great

At a meeting of NGO representatives, one participant said we burden children too much on the subject of AIDS. "Life is great," she said. "Let us convey that to the kids". In this we could embed the thought that to live life fully, health must be protected. The proposition for the theme might therefore be "Living life happily a healthy body and mind and following the recommended practices".

#### (c) Parent - Child Dialogue

Communication between parents and children on the subject of sexuality is virtually nil. Exaggerating to make a point, the threat of HIV to young people could vanish if well informed parents, teachers and children were to hold close and frank dialogue on

growing-up problems. This then is the goal to be pursued. So the SYFA theme might be based on this thought: "Talk freely and openly on sexuality and health to children. Listen. Tackle growing-up problems together".

There are numerous other options but these seemed the most promising. A few points about them need to be noticed.

AIDS must be discussed in the context of health and other growing-up matters. AIDS by itself, the fear appeal, is unpredictable persuasion. Whatever the theme, it needs to be appropriately dressed. Whatever the basic thought, it must be packaged in what interests parents and young people.

The most important packaging is a creative idea. The recent DHL theme is an instance. Their basic story is reliability, punctuality, and partnership in their client's business. So the theme with a twist of thought, says, "We keep your promises". The SYFA theme needs creative thought.

On balance, the recommended idea for the theme is the last one, "Talk!". It is sufficiently broad to permit matching with very many different needs. The theme also tackles a basic feature of the SYFA situation. If communication in the home is truly opened up, families are likely to come up with their own best solutions. Who understands a child better than the parents? Or the teacher? Both have different but complementary opportunities to help. Both are on the spot. Dialogue is natural and vital.

### **What channels shall we use?**

Uganda does not permit easy use of the mass media route that is so easily travelled in some countries. The reach of mass media is poor, as is literacy.

Figure 2 makes amply clear that the main communication for SYFA will be face to face. The mass media will activate word of mouth and legitimize more detailed messages; they will provoke response (e.g.

to radio, TV and press stimuli) that can then be followed up by, say, direct mail or NGO, community-based action.

By the time they reach their teens, more than half of Ugandan children are no longer attending school. In 1990, 51% of 12 year old boys and 71% of 12 year old girls were out of school according to a World Bank estimate.<sup>2</sup>

For the minority of children who are in school, education programmes can provide information about HIV/AIDS infection and a forum for follow-up discussion and reinforcement of health education messages.

For the majority of children who are not in school, communication of messages from outside the community must rely on the administrative, political, religious and social structures that have contact with the youth. Specific messages and media approaches for these groups will be tested to measure their effectiveness in achieving behavioural change. (See Annex 2: Objectives, Outputs and Activities in "UNICEF's Response to HIV/AIDS in Uganda - Update").

## **MAKING A FIST OF SEPARATE FINGERS**

Nothing could be worse than wasting resources - always scarce - in AIDS control and prevention. This is what the SYFA project group was quick to discern in the very goodwill and energy stimulated in Uganda by the infection's challenge. Multifarious activities have been prompted by different individuals and organisations working to their own well-meaning objectives and strategies. Would all of this not be more effective if the separate initiatives were mutually supportive, or at least working coherently within the same strategy? This has begun to happen. *Separate fingers are clenching into fists.*

The basic SYFA conceptual and implementation approach has been taken up by some of the numerous

toilers in the field. The strategy has been accepted by many and applied within the character and capacity of widely different organisations.

### **The Ministry of Information Initiative**

The Ministry and UNICEF have signed a Memorandum of Understanding under which radio, television and possibly press will be mobilised within the SYFA strategy.

Infact, it was in the Landcruiser carrying Ministry and UNICEF staff on a research trip to Gulu that some basic points of strategy began to emerge: the importance of parents/teachers, not young people, as the primary target audience for communication and the need to enlist peer group opinion, especially among out-of-schoolers.

The Ministry's involvement is vital. It controls radio and television in Uganda, the first being the widest reaching medium and the second being the medium that boasts 100% coverage of the country's opinion-formers and decision-makers (even while reaching no more than 3% of the population). The Ministry's participation takes two main forms and has sparked a third. Firstly, there are to be talk shows on television and radio.

### **TV/Radio Panel Programmes:**

Two panels will discuss the major issues concerning parents and youth in the prevention of AIDS eg boy-girl friendships, use of condoms, the advantages of a healthy life, the parents' problems etc. The panels, of three or four each, will be separately of adults and young people. A host will guide discussions. There will be a resident psychologist and/or doctor on the programme.

This discussion will be attended by an audience of some 30 young people and adults who, as it were, will represent viewers. They will participate in the

discussion. A live band will play appropriate music at intervals. A "Mail Bag" will answer viewer questions and encourage communication. The programme is intended to be 45 minutes long. It will be bi-weekly, starting September 1993.

There is no programme of this type on Uganda Television or radio. It will, hopefully, break new ground. The TV show recorded off-air and edited, with appropriate voicing, will become a 30 minute radio show.

The objective of the shows is to attack the barrier in homes and schools between parents/teachers, on the one hand, and adolescents/pre-adolescents, on the other. This is a significant obstacle hindering youthful understanding of sexuality, HIV/AIDS and growing up problems. The programmes will discuss a different SYFA-relevant issue each time.

In addition, it is proposed that television spots will be frequently and regularly run, urging dialogue among the principals on the SYFA stage. The spots, which radio will also transmit, will be in the form of warm and sincere testimonials by notables and People With AIDS.

Thinking of SYFA media action threw up the great need for an organ that will maintain touch among the numerous and growing body of individuals, organisations and institutions in the SYFA movement.

A bulletin will be published which, to start with, will consist of four pages inserted once a month into Uganda's main English language paper. This circulation of 40,000 copies, reaching the nation's opinion-formers and decision-makers, will be supplemented by a run of another 60,000 copies. Appearance in two Ugandan languages is visualised for a little later.

## **The Health Education Network (HEN)**

Support to this project is an on-going UNICEF commitment at the moment. Nearly 150 Health Educators have been trained in various health matters over Uganda's 39 districts.

HEN has developed a systematic plan for support of SYFA within its activities. The idea is that District Health Educators will become not just a source of information and education but also managers and mobilisers of district level resources. Animating the whole approach is the BASNEF model and the basic strategy as outlined earlier in these pages. The HEN activity stresses contact with out-of-schoolers.

## **The School Health Education Project (SHEP)**

SHEP is building into its syllabi as well as teaching and learning materials content relevant to SYFA and its strategy. In recent times, SHEP has supported the writing and production of dramas relevant to the AIDS problem. This has now taken the form of very popular drama competitions at parish, county, district, regional and national levels. This exercise has helped forge links between schools and communities.

Based on the SYFA strategy, SHEP will facilitate the formation of youth clubs in districts of concentration. The objective is to create an environment in which children can discuss and internalise the need to avoid risky sexual behaviour. It is hoped that this activity will touch youth out of school as well.

## **Sports Systematically Organised (SSO)**

There is a happy convergence between SYFA needs and the well-established outputs of SSO. The outputs go beyond those of playing and casual kicking of a football. A group in the National Youth Forum (formerly the National Youth Task Force) see SSO

as the best kind of physical education. Potentially, it could deliver healthier young bodies, greater consciousness of health and its practices as well as a healthier psyche: leadership and team qualities, self esteem and self-efficacy. Above all, this is a fun activity.

The Forum has conceived ways to build SSO into SYFA operations as exemplified in Figure 2. SSO can contribute to the right behaviours in two ways. Firstly, it could help create in young people the values that lead to the desired behaviours. Secondly, it brings parents and teachers into the picture in the right way and facilitates the relationships that SYFA is targeting.

## **The Philly Lutaaya Initiative (PLI)**

PLI assists people with AIDS to share their life experiences and counsel with others so as to influence behaviour and assist in HIV/AIDS prevention.

PLI has identified where it could play a role in the SYFA Operational Model (Figure 2). The character of the initiative enables it to make a unique impact in preventive action as much among young people as among parents/teachers.

## **The Religious Institutions**

The Church of Uganda, the Roman Catholic Church and Islamic groups are participating in the SYFA movement. They have been exposed, and have contributed, to the SYFA strategy.

The Church of Uganda has organized "SYFA Brigades" that are working at community level. The Church's outreach offers important opportunities eg youth clubs, women's groups, Sunday Schools. There are examples of action that fit perfectly into the approaches outlined on these pages.

The Catholic Church is involved, among other things,

through its Sharing Centres. These cover a wide range of activities that will effectively "package" the health/AIDS story for young people eg sports, vocational training and guidance etc.

Both Churches and participating islamic groups are conscious of the need to influence parents and teachers primarily. Briefing materials are being prepared to help ensure that the strategy is clear and all activity is suitably focussed.

### **The Scouts and Guides**

This movement, strong in Uganda, is a near-perfect ally. Membership majors on the age groups with which SYFA is concerned. Older scouts and guides could have a "parental" and teaching influence.

SYFA Clans have been formed and orientated. Units of four young people are charged with the responsibility of each person enlisting four others so that a multiplier effect is achieved. Given that scouts and guides represent an elite in motivation and abilities, the catalytic role of the movement is potentially great.

A detailed response to the SYFA strategy is being worked out. Current action is reasonably close as it stands.

### **Government Organs**

The RC system is a most powerful mechanism in Uganda and acquires even greater significance in the context of decentralization. At various levels, it provides organising capacity and a forum where elders and youth meet. A systematic plan will need to be evolved for exposure of RC elements to the behaviour change approach now being mooted for SYFA.

A development of great importance has been adoption of the SYFA strategy and operational model by the National Steering Committee for SYFA, a constituent of the Uganda AIDS Commission. The

Steering Committee has representation of all concerned ministries, major NGOs, donor organizations and implementing agencies. It will be a key coordinating and inspirational force in the SYFA movement and the mechanism through which the Uganda AIDS Commission normally relates with SYFA.

### **Donors and Resources**

Materials will soon be in preparation to mobilise the extra resources required for SYFA as it is now envisioned. Major donors already are UNICEF, USAID and SIDA.

### **RESEARCH, MONITORING AND EVALUATION**

Very little in project work will be properly focussed without appropriate formative research - qualitative and quantitative. Qualitative studies are important in message design, testing and for quick Orientation. But, because they may not have statistical significance, large-sample studies will also be necessary. Such research is also essential for evaluation-establishing a baseline and using that for an evaluation after an agreed period.

Just as important is monitoring of project activities (to check that what was planned is happening) and feedback (to facilitate correction and strengthening, where necessary). Here, selecting the right indicators will be important. How to check exactly what has been absorbed by our target audiences in such private areas as sexual attitudes? How to check relevant practices? This may require a study of projects elsewhere and existing literature on the subject.

<sup>1</sup> Demographic Health Survey 1988/89, Tables 2.2, 2.3 and 3.7. Ministry of Health with Institute for Resource Development/Macro Systems Inc, 1989.

<sup>2</sup> Table VI, 1, in "Uganda Social Sector Strategy" Volume 1, July 1992.

# What every family and community has a right to know about **AIDS**

## Note to communicators

AIDS is a very serious problem in Uganda. About 1.5 million Ugandans are thought to have HIV, the virus which causes AIDS. Most of them became infected through sexual intercourse.

Today many Ugandans know how AIDS is spread. But many do not know why other sexually transmitted diseases need urgent treatment. Many do not know that they can protect themselves through "safer sex".

The seven prime messages in this chapter can help Ugandans to protect themselves and others. They also give guidance on how to live in the midst of the epidemic.



*Poster used for "The Hydra" a national AIDS drama competition for all secondary schools in Uganda.*

## **Facts for Life**

A Communication  
Challenge



# **AIDS**

## **Prime messages**

- 1. AIDS is an incurable disease which is passed on by sexual intercourse. In Uganda about 85% of people with AIDS became infected through sex. AIDS can also be passed on by infected blood and by infected mothers to their unborn children.**
- 2. Safer sex means being sure that neither partner is infected, remaining faithful to each other, and using a condom if there is the slightest doubt.**
- 3. People suffering from other sexually transmitted diseases (STDs) like ulcers on the genitals and gonorrhoea should seek urgent treatment. The presence of other STDs makes it much easier to transmit and/or become infected with HIV.**
- 4. Any injection or cut with an unsterilised needle, syringe, razorblade or other skin-piercing instrument is dangerous.**

5. Women infected with HIV should think carefully about having a baby - and seek advice.
6. All parents should talk with their children about how to avoid getting AIDS.
7. People with AIDS need love, care, understanding and support.





# AIDS -

## SUPPORTING INFORMATION

1. **AIDS is an incurable disease which is passed on by sexual intercourse. In Uganda about 85 % of people with AIDS became infected through sex. AIDS can also be passed on by infected blood and by infected mothers to their unborn children.**

AIDS is caused by HIV, a virus which damages the body's defence or immune system. People who have AIDS die because the body can no longer fight off other serious illnesses.

Anybody with HIV can infect others.

There are no obvious signs that a person has HIV. They may look and feel perfectly normal and healthy for up to 10 years but can still pass on HIV to their sexual partners. For every person who is visibly sick with AIDS, many others are infected and can spread HIV. This is one reason why HIV has already spread to so many people.

It is also difficult for an ordinary person to know whether or not someone has AIDS or another disease. People with AIDS get sicknesses like recurrent fever, repeated rashes and continuous diarrhoea. They also lose weight. These signs may also be present in other diseases such as alcoholism, tuberculosis and malnutrition.

Anyone who suspects that he or she may have HIV should seek advice from a qualified health worker. In some towns

in Uganda it is now possible to get a test for HIV. It is best if you are counselled before the test and when you receive your result.

HIV can only be passed from one person to another in a limited number of ways. In Uganda the most important way is by sex between men and women.

- If a person has HIV, their blood and semen or vaginal fluid will contain HIV. HIV can therefore spread by sexual intercourse. It can be passed from man to woman and woman to man.

Other ways HIV can be passed are:

- By the use of unsterilised needles or syringes.
- By blood transfusions if the blood has not been tested for HIV.
- By an infected mother to her unborn child.
- By using unsterilised equipment for ear-piercing, tattooing, scarification, tooth extraction or circumcision.

If a mother is infected with HIV then there is a risk that breastfeeding may give the virus to her baby. But in countries like Uganda, where other diseases and malnutrition are a common cause of death in babies, the decision not to breastfeed is a much greater risk. Without safe water, bottlefed babies are much more likely to become ill and malnourished and to die, than babies who are breastfed. In such conditions, it is safer for the child to be breastfed even if the mother is infected with HIV. In better-off families, a mother who knows that she is infected with HIV should consider not breastfeeding her baby. She should seek advice about other methods of feeding which will ensure that the child is wellnourished and protected from the disease.

It is not possible to get HIV from being near to or touching a person with HIV or AIDS. Hugging, shaking, coughing and sneezing will not spread it. HIV cannot be spread by mosquitoes, flies, bedbugs, lice or other insects or animals. You cannot get HIV from water, latrines, toilet seats, plates, glasses, spoons, towels or sheets.

## **Facts for Life**

### **A Communication Challenge**



- 2. Safer sex means being sure that neither partner is infected, remaining faithful to each other, and using a condom if there is the slightest doubt.**

It is possible to protect yourself from HIV. It is possible to change long-standing sexual behaviour. Practising safer sex is one way to protect yourself.

A guide to safer sex:

- **The safest sex is no sex at all or abstinence. Abstinence cannot make a person sick.**
- **Children and young people should delay their first sexual activity. Staying without sex will not make them ill nor will it prevent them from enjoying sex later. When they begin sexual activity, they should adopt safer behaviours such as use of condoms. If they have been at all sexually active, they may also get tested for HIV and ask their future partner to get a test.**
- **For sexually active people, the best way to avoid AIDS is to stay in a mutually faithful relationship with an uninfected partner.**
- **Sex without intercourse (without the penis entering the woman's body) is safer sex. This means activities such as caressing and hugging**
- **Sex with a condom is also safer sex. Unless you and your partner have sex only with each other, and are sure you are both uninfected, you should protect yourselves by using a condom.**

A condom is a sheath of rubber which a man wears over his erect penis before and during sex. Condoms reduce the chance of getting infected if they are correctly used during sexual intercourse. They should be kept on from beginning to end, and there should be no exchange of semen or vaginal fluid. A new condom should be used for each

sexual act. It should never be washed or re-used. Used condoms should be disposed of in a pit latrine or wrapped in paper and burned with rubbish. They should be kept away from children.

Condoms are so thin and strong that most men and women are not aware when one is being used. They have no negative side-effects. They cannot get "lost in the womb" or make people sick.

**Remember:**

- The more partners you have, the greater the risk of having sex with someone who is infected.
- The more partners your partner has, the greater the risk that you will be infected.

**3. People suffering from other sexually transmitted diseases (STDs) like ulcers on the genital organs and gonorrhoea should seek urgent treatment. The presence of other STDs makes it much easier to transmit and/or become infected with HIV.**

Diseases such as gonorrhoea, syphilis and genital ulcer disease are spread by sex. They are called sexually transmitted diseases (STDs). Most cause symptoms in a short time, and most are curable.

If you have sores on your genitals or any other STD, it is easier for HIV to enter your body.

For both men and women, signs of STDs are:

- Sores, wounds, bumps and blisters on, in or near the genitals.
- Burning pain during a short call.
- Swelling in the groin.

## ts for Life

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en some STDs do not cause obvious signs.  
men should suspect an STD and seek proper  
t, if their partner has an STD or if they experience:

nusual discharge or smell from the vagina.  
in the lower stomach.  
ness in the vagina or bleeding from the vagina  
h is not a menstrual period.  
deep inside the vagina during sexual intercourse.

h an STD may also suffer:

p or discharge from the penis.  
ful ejaculation.  
ling of the genitals especially testes.

ull dose of medication prescribed by a health  
will completely cure your STD. Both you and your  
should get immediate and full treatment whenever  
occurs. Condom use can prevent the spread of all  
ot just AIDS.

**ny injection or cut with an unsterilised  
eedle, syringe, razorblade, knife or other  
kin piercing instrument is dangerous.**

e or syringe can pick up small amounts of blood  
e person being injected. If that person's blood  
HIV, and if the same needle or syringe is used for  
g another person without being sterilised first, then  
n be injected.

health facilities in Uganda, health workers sterilise  
and syringes. But patients and clients can help to  
n and improve standards by insisting on sterilised  
ent.

Some injections are unnecessary as many useful medicines can be taken by mouth. It is not safe to get injections from people who are not qualified to give them.

Razorblades and knives are often used on more than one person by barbers and in circumcision ceremonies. Traditional health workers also use razorblades to cut their clients. Uganda's AIDS Control Programme recommends that every person carry their own razorblade for shaving and treatment, and that families have their own circumcision knives. The knives should be well boiled before and after use.

**5. Women infected with HIV should think carefully about having a baby - and seek advice.**

Women with HIV have about a 30 - 50% chance of giving birth to a baby who will also be infected with HIV. Most babies with HIV die before they are three years old. They also have a poor quality of life right from birth.

If a woman with HIV has a baby, the strain of pregnancy may make her weaker. She will need extra medical attention and care from her family.

Women with HIV can produce healthy babies, but they will not live to see them grow up. Babies need healthy parents to bring them up.

Deciding not to have a baby can be very difficult. Some husbands get angry with their wives if they do not bear children. Some abandon their wives. The husband's family may also put pressure on the woman.

But an understanding husband will help his wife to avoid pregnancy if she has HIV or AIDS. If a woman has trouble making her husband understand the dangers, she can ask a doctor, counsellor or relative to help. RC officials and other community leaders should advise men on the dangers of pregnancy for women with HIV. They should support women in their efforts to make sound decisions.

## **Facts for Life**

### **A Communication Challenge**



Women of childbearing age should think about having a test for HIV. Knowing their HIV status will help them and their partner to decide whether or not to have a baby.

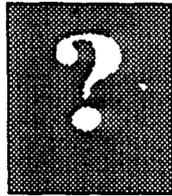
#### **6. All parents should talk with their children about how to avoid getting AIDS.**

Apart from protecting yourself and your partner, you can also help to protect your children against AIDS by making sure they know the facts about how to avoid getting and spreading the disease. It can be difficult to discuss sex with your children, but AIDS is an emergency. Parents should start sex education with their children as early as possible. One way to begin the discussion with school-going children is to ask whether they are studying AIDS in class. In Uganda, all P5, 6 and 7 pupils are now taught about AIDS in Basic Science and Health Education.

Children also need to know the facts about how HIV does not spread. They need to be reassured that they run no risk of getting the virus from ordinary social contact with HIV-infected children and adults. Children should be encouraged to be sympathetic towards people who are infected with HIV.

#### **7. People with AIDS need love, care, understanding and support.**

People with AIDS should be taken care of and helped like any other sick person. People with AIDS need to know they are not alone. They need the support of their loved ones.



## Questions about AIDS, HIV and Sex

### Q. What are the symptoms and signs of AIDS?

According to Uganda's AIDS Control Programme, some major symptoms are:

- A progressive loss of body weight
- Diarrhoea persisting for more than a month
- Fever lasting for a month or more or unexplained repeated fevers

Some minor signs are:

- Persistent cough for more than a month
- Rashes and skin infections
- Herpes zoster (shingles or *Kisipi*)
- Oral thrush (a sore coating of the mouth)
- Swelling of lymph nodes

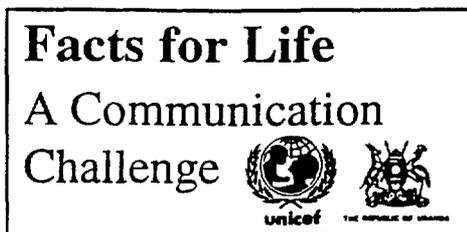
The symptoms vary between individuals and can only be confirmed by a trained health worker after testing for the virus.

### Q. How long does HIV take to make a person sick with AIDS?

Some people have been infected for 10 years and still do not show signs of AIDS. Other people, whose defence system has been weakened by other diseases common in the tropics, may show signs of AIDS within a year of being infected.

### Q. What is the "window period"?

After someone has been infected with HIV it usually takes the body two to three months to make antibodies against the virus. The HIV test looks for these antibodies. The time between infection and when antibodies can be detected is called the "window period".



**Q. Why is the “window period” important?**

The window period is important because a person may have HIV but the test cannot detect it. The test will show negative, yet the person will be able to infect other people with HIV. After the window period is over, the person will test positive for HIV.

It is for this reason that it is good to get two tests for HIV. The second test should be after about six months. In the meantime the person should abstain from sex.

**Q. Is it possible for a wife to test negative for HIV and the husband to test positive? Is it possible the other way around?**

Yes, both ways are possible. When one partner is positive and the other negative, it is said that they are “discordant”.

Discordancy is very common. In 1991 about one-quarter of the couples tested at the AIDS Information Centre in Kampala were found to be discordant. HIV is not passed with every act of sexual intercourse, and it may take time to infect a partner. For this reason, it can be good to know if you have HIV. You can protect your partner or yourself. One of you can live to take care of your children. In cases of discordancy, condoms must be used.

**Q. Is it true that to get AIDS one must be involved with many sexual partners?**

No, a single sexual encounter can be enough to pass HIV to an uninfected person. The risk of getting HIV through unprotected sexual intercourse increases:

- The more partners a person has sex with.
- With the presence of blood during sexual intercourse (due to sores, menstruation or abrasive sex).
- With the presence of other sexually transmitted diseases in either partner.

**Q. Is it possible to tell who has HIV or AIDS by their hairstyle or clothes? For example, are women with “perm on their hair” or men with jeans more likely than other people to have HIV?**

No, many people have HIV in Uganda, and they wear different types of clothing. Anybody, irrespective of what they wear or how they look, can have HIV. One infected partner is enough to transmit HIV.

**Q. How safe are condoms?**

Today’s modern condoms are as reliable as any man-made product when they leave the factory. But if they are not correctly stored or correctly used, they may not protect a person completely from AIDS, other STDs or unwanted pregnancy.

Correct use of condoms includes:

- Always checking the date of manufacture. If it is less than five years since manufacture, the condom should be okay.
- Keeping a good number of condoms at hand.
- Keeping condoms out of direct sunlight and in a cool place.
- Using the condom for only one sexual act.
- Avoiding applying a lubricant because it might weaken the condom.
- If a condom breaks during sexual intercourse, it should immediately be replaced with another one. (It is a good idea to wash the penis before replacing the condom.)

Correct use of condoms also includes putting it on and taking it off with care.

# Facts for Life

## A Communication Challenge



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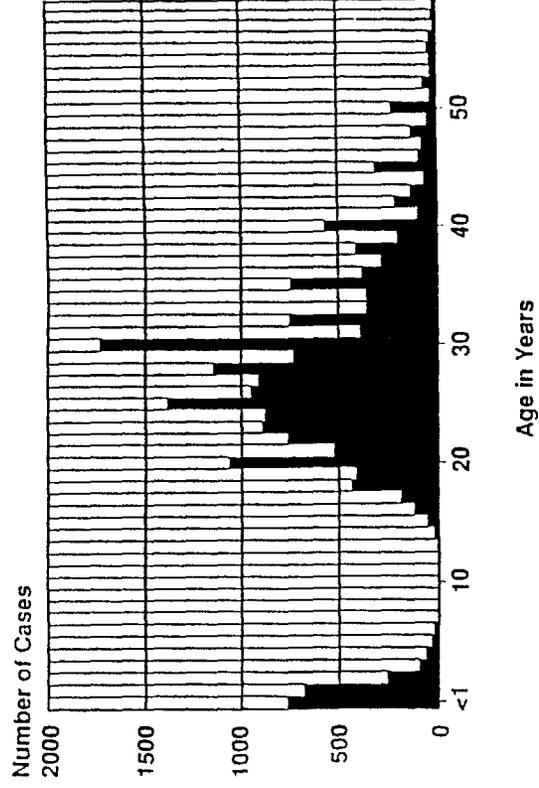
### Putting it on:

- Put the condom on after the penis becomes hard (erect).
- Put the condom on before any genital contact.
- Hold the tip of the condom between a finger and thumb of one hand, leaving space at the tip to collect the semen.
- With the other hand put the condom on the end of the penis and unroll the condom down the length of the penis by pushing down the round rim of the condom. If this is difficult, the condom is "inside-out". Turn the condom the other way round, take hold of the other side of the tip and unroll it.
- When the rim of the condom is at the base of the penis (near the pubic hair), penetration can begin.

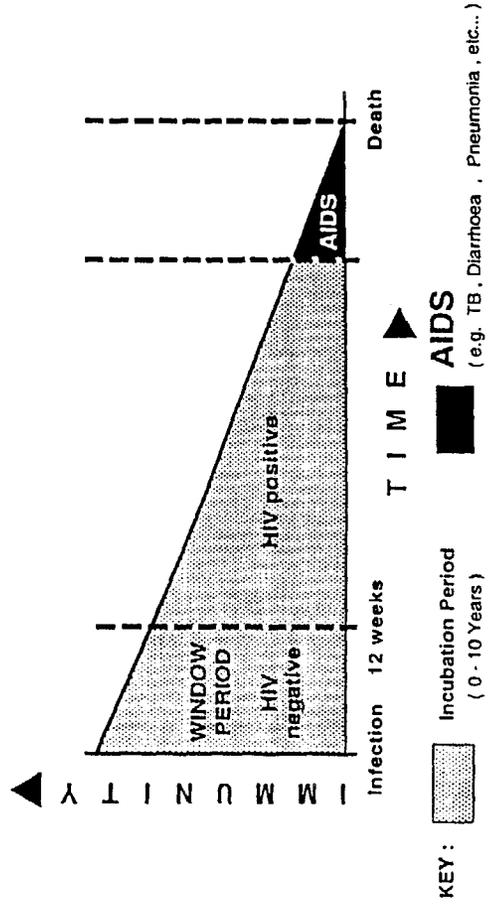
### Taking it off:

- Soon after ejaculation, withdraw the penis while it is still hard, holding the bottom rim of the condom to prevent it from slipping off the penis.
- Do not let the penis go soft inside the partner because the condom may slip off and spill semen in or near the vagina.
- Do not allow semen to spill on hands or other parts of the body, and wash hands and other body parts if contact with semen occurs.
- Wrap used condoms in waste paper before disposing of them safely by flushing them down a toilet, throwing them down a pit latrine, burying them or burning them.
- Wash hands to remove vaginal secretions or semen.

### Age of Ugandan AIDS Cases



### Stages of Infection (Maximum Periods)



# How To Use Condoms

- Be sure to have a condom *before* you need it.
- Use a condom with every act of vaginal or anal intercourse unless you are absolutely sure that you and your sexual partner have not had other partners or used intravenous drugs for at least 10 years. If you are not sure, use condoms.
- Before your penis touches your partner, place the condom on top of your erect penis—or have your partner do it. Hold the condom so that the rolled rim is on the side away from your body. If you are not circumcised, pull the foreskin back. Unroll the condom to the base of the penis. It should unroll easily and not need to be stretched.
- After ejaculation hold the condom rim to the base of your penis while you pull your penis out. This makes sure that the condom will not slip off.
- Take off the condom without spilling semen.
- Throw the used condom away in a pit latrine, or bury it. Do not use a condom more than once.
- Use another condom if the one you have:
  - Has torn or damaged packaging.
  - Bears a manufacturing date more than five years past.
  - Is uneven or changed in color.
  - Feels brittle, dried out, or very sticky.

Adapted from: WHO/GPA (436)

## Tips for Condom Care

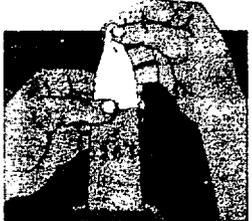
Heeding these tips will help keep condoms from breaking or leaking:

1. **Store condoms in a cool, dark place, if possible.** Heat, light, and humidity can damage condoms.
2. **If you have a choice, choose prelubricated condoms that come in square wrappers and are packaged so that light does not reach them.** The lubrication may make them less likely to tear during handling or use. Protection from light slows deterioration.
3. **Take care handling condoms.** Fingernails and rings can tear them.
4. **If you want a lubricant, use only water-based lubricants.** Lubricants made with water do not damage latex. These include glycerin and specially made products such as *K-Y Jelly*. Spermicidal jelly and foam are also good lubricants and add more protection against pregnancy and STDs. Do *not* use a lubricant made with oil; most oils damage condoms. Do *not* use cooking oils or shortening, baby oil, mineral oil, petroleum jellies (such as *Vaseline*), skin lotions, suntan lotions, cold creams, butter, or margarine.
5. **Do not unroll condoms before using them.** You may weaken them, and an unrolled condom is difficult to put on. Keep extra condoms on hand if you want to practice.

Source: Contraceptive Technology Update (71), Kestelman (189), US FDA (190), WHO/GPA (436)

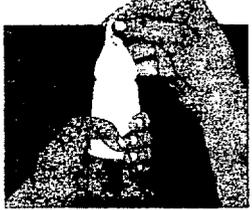
**THE RIGHT WAY TO USE CONDOMS**

1



Squeeze the air out of the tip.

2



Hold on to the tip and unroll all the way down.

3

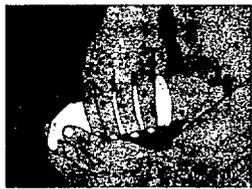
Use a water-based lubricant like KY. Don't use greases, oils, and petroleum jelly—these can make the condom burst.

4



The man should hold onto the condom at the base of the penis and withdraw while still hard.

5



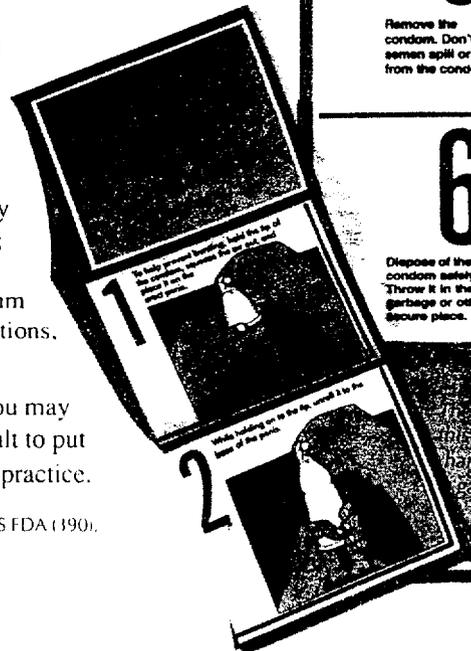
Remove the condom. Don't let semen spill or leak from the condom.

6



Dispose of the used condom safely. Throw it in the garbage or other secure place.

For more information on this instructions poster and matching handouts for condom users, local organizations can add their names and addresses so people know where to go to get help and supplies.



# **Appendix VI**

## **Discussion of Case Management of STD's**

# Diagnostic and Treatment Tips

This page may be detached and kept with the wall chart.

WHO has developed STD diagnosis and treatment flow charts—step-by-step pathways using the syndromic approach to help primary health care providers manage STD patients. The wall chart accompanying this issue of **Population Reports** displays the flow charts for the four most common syndromes caused by STDs:

- Genital ulcer in a man or woman,
- Urethral discharge in a man,
- Vaginal discharge, and
- Lower abdominal pain in a woman.

To use the flow charts, providers follow the path that corresponds to the patient's syndrome. For example, if a patient has genital ulcers and they look like small blisters, the left path under "Genital Ulcer" should be followed. If, however, the ulcer looks more like an open sore, the right path should be followed. Recommended treatments are listed below each flow chart. One side of the wall chart is used for diagnosis based entirely on syndromes. The other side of the chart is used when a microscope is available to supplement syndromic diagnosis.

The following diagnostic and treatment tips for each STD can help providers to improve their management of STD patients. They should be used along with the accompanying wall chart.

## Genital Ulcer

### Diagnostic Tips

- Lesions of syphilis and chancroid vary in appearance and may be indistinguishable from one another. If a shortage of drugs makes treatment for both chancroid and syphilis impossible, however, try to distinguish between the two. Syphilis usually produces a single painless ulcer with firm borders that feel like the tip of the nose (36, 294). Chancroid usually produces a soft, painful ulcer with an irregularly shaped border. In women the chancroid ulcer may not be painful, however. Alternatively, providers may treat for the STD that is more common in the area.

• Herpes ulcers usually differ from chancroid and syphilis ulcers. Herpes ulcers with a secondary bacterial infection, however, may resemble syphilis and chancroid ulcers.

- Syphilis and chancroid may cause enlarged lymph nodes. In syphilis, lymph nodes are enlarged and firm but painless. In contrast, chancroid, like lymphogranuloma venereum (LGV), can cause enlarged and tender lymph nodes that may burst and leak pus (185, 283).

- People with syphilis may not seek treatment until they have symptoms of secondary syphilis—rash, hair loss, sore throat, malaise, headache, weight loss, fever, or swollen lymph nodes (70, 294).
- The rapid plasma reagin (RPR) test may be falsely negative in 25% to 50% of patients who have primary syphilis (128, 283). If the ulcer could be either chancroid or syphilis and the RPR is negative, the patient should be treated for syphilis anyway.
- Donovanosis and LGV also cause genital ulcers. Donovanosis begins as nodules under the skin that erupt and form usually painless, sharply defined lesions. The lesions of LGV are small papules or shallow ulcers that look like herpes blisters and heal without treatment. LGV usually causes tender inguinal buboes that may leak pus. These buboes are the usual reason that people seek treatment (223, 283).
- Patients may also have nonulcerative genital lesions caused by human papillomavirus (HPV) and molluscum contagiosum. Human papillomavirus causes genital warts (condylomata acuminata), which often look like a cauliflower. The lesions caused by molluscum contagiosum are white, smooth pimples that contain a white, cheeselike substance (283, 333).

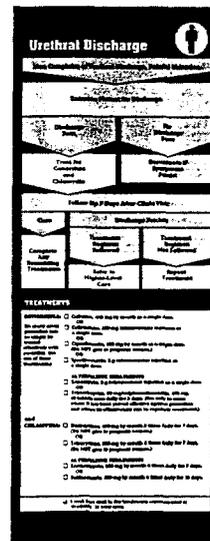
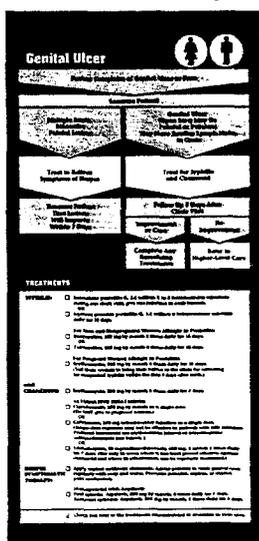
### Treatment Tips

- Make every effort to treat syphilis because it has serious sequelae.
- If possible, ask the patient to return for RPR tests 3, 6, and 12 months after the initial visit to confirm the cure.
- Treatment for LGV is doxycycline, 100 mg orally, twice daily for 14 days; OR tetracycline, 500 mg orally, four times daily for 14 days (348).
- Treatment for Donovanosis is trimethoprim, 80mg/sulfamethoxazole, 400 mg, or a comparable sulfonamide component, two tablets twice daily, orally for at least 14 days (348).
- If a patient returns because a genital ulcer has not healed, HIV infection may be the reason (306). Refer the patient for testing.

## Urethral Discharge

### Diagnostic Tips

- Identify the origin of the discharge. Urethritis causes discharge from the meatus (the opening of the penis). In uncircumcized men discharge from the glans or foreskin may appear to come from the meatus (185).
- If no discharge is visible, consider applying gentle pressure to the penis. It may be possible to observe discharge by holding the head of the penis between the thumbs and gently rolling the thumbs up and down. It may be necessary to milk the urethra: Start at the base of the penis. Place one finger or the palm of the hand beneath the penis and one or two fingers on top at the base. Applying gentle pressure, move the hands outward towards the tip of the penis. Repeat if necessary. If patients are reluc-



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tant or afraid, they may milk the penis themselves.

- If the patient urinated shortly before the examination, thus rinsing discharge from the urethra, the discharge may not reappear for several hours.

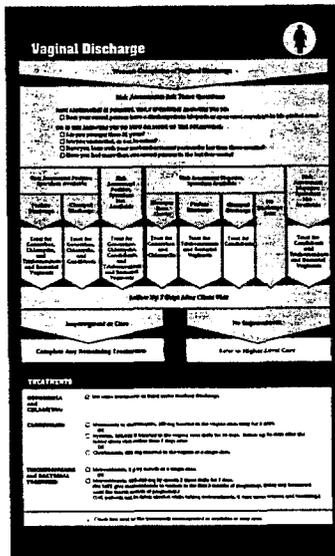
### Treatment Tips

- If the recommended drugs are not available but penicillin is available, use it only if the prevalence of gonorrhea resistant to penicillin is less than 5% in the area.
- If a patient and his sexual partner have been treated twice for gonorrhea and still have symptoms, they may be infected with a resistant strain. Refer them to an STD clinic.
- Cefixime and ceftriaxone cure incubating syphilis (a recent infection that has not produced symptoms); ciprofloxacin, spectinomycin, and kanamycin do not.

## Vaginal Discharge

### Diagnostic Tips

- The perception of abnormal vaginal discharge depends on the patient. Common complaints are new or increasing stains on underwear, a large volume of secretions, change in the color or consistency of the discharge, a foul odor, itching and soreness, painful urination, or pain during intercourse.



- The risk assessment questions, shown in the flow chart, help to distinguish sexually transmitted infections from reproductive tract infections that are not sexually transmitted. Bacterial vaginosis and candidiasis are usually not sexually transmitted. They can be caused by an overgrowth of organisms that are normally in the vagina.

- Diagnosing an STD on the basis of the consistency of vaginal discharge may be difficult. If a diagnosis cannot be based on the consistency of the discharge, check the pH of the discharge if possible. Normal

vaginal fluid has a pH between 4.0 and 4.5. Bacterial vaginosis raises the pH above 4.5. In candidiasis the pH of the discharge is usually less than 4.5. Trichomoniasis discharge usually has a pH greater than 5.0 (283). Blood in vaginal secretions or pregnancy also may make the pH greater than 4.5, however.

- Check the appearance of the vagina and vulva. If they are inflamed, candidiasis or trichomoniasis may be the cause. Bacterial vaginosis usually does not cause inflammation (121).
- Vulvar itching is also a symptom of candidiasis and trichomoniasis (121).
- The origin of the discharge can help to identify the disease. Discharge from the cervix indicates possible gonorrheal or chlamydial infection. Discharge from the vaginal wall indicates trichomoniasis, candidiasis, or bacterial vaginosis. Trichomoniasis also can cause urethral discharge. Identifying the origin of discharge in the vagina may be difficult, however. Wiping off the cervix with a swab can help. Discharge from the cervix may then be observed. Other signs of cervical infection are redness and bleeding when the cervix is touched with a swab.

- Check the patient for lower abdominal pain by doing a bimanual exam, if possible. If moving the cervix causes pain, use the flow chart for lower abdominal pain (325).
- Take the patient's temperature if possible. If the patient has a fever, use the flow chart for lower abdominal pain (325).
- Patients who return often with candidiasis may have HIV infection or diabetes (306). Refer them to a hospital for testing.

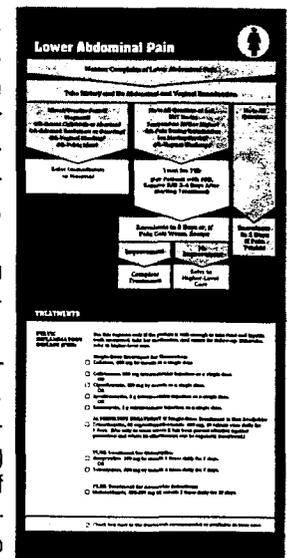
### Treatment Tips

- Treat male partners of women with trichomoniasis by using metronidazole, 2 g in one oral dose, or 400–500 mg orally, two times daily for seven days (185).
- Metronidazole crosses the placenta and may slightly increase the risk of congenital malformation. It should not be given to women in the first trimester of pregnancy. Since there are no other effective treatments for trichomoniasis, metronidazole may be used during the second and third trimesters if necessary (169, 248).
- Metronidazole passes into breast milk. Some think that breastfeeding women given the single 2 g oral dose should interrupt breastfeeding for 24 hours (169, 325). Women may not need to stop breastfeeding, however, because there is no evidence that metronidazole is harmful to babies (272), whereas disrupting breastfeeding could be harmful.
- If a speculum is available, examine patients to judge whether the discharge has diminished. Without a speculum, rely on the patients' judgment.

## Lower Abdominal Pain

### Diagnostic Tips

- Check for emergencies and refer immediately to a hospital if septic abortion, intestinal obstruction, ruptured bowel, appendicitis, or ectopic pregnancy is suspected.
- In addition to lower abdominal pain pelvic inflammatory disease can cause pain during intercourse or urination, heavy or prolonged menstrual bleeding, pain during menses, nausea, and vomiting.
- On speculum exam, an open cervix indicates pregnancy or abortion.
- Look for signs of STDs—ulcers or vaginal discharge.
- Ask the patient if she is using an IUD. Women using IUDs have a higher risk of pelvic inflammatory disease than women using no contraception, particularly if the IUD was inserted recently (106).



### Treatment Tips

- Also treat sexual partners for gonorrhea and chlamydia.
- Metronidazole treats anaerobic bacteria that may be contributing to pelvic inflammatory disease.

## **Appendix VII**

MOH Growth Card and EPI Card;

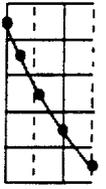
Recipe for Cereal Base/Starch ORT;

Mother's Card (TT)

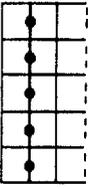


Name: \_\_\_\_\_  
 Birth weight: \_\_\_\_\_ kg

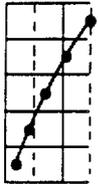
Watch the direction of the line showing the child's health.



**GOOD**  
Means the child is growing well



**DANGER**  
Find out why? and advise



**VERY DANGEROUS**  
May be ill needs extra care

**REASONS FOR SPECIAL CARE**

Birthweight less than 2.5 kg

Brothers or sisters undernourished

Birth less than 2 years after last birth

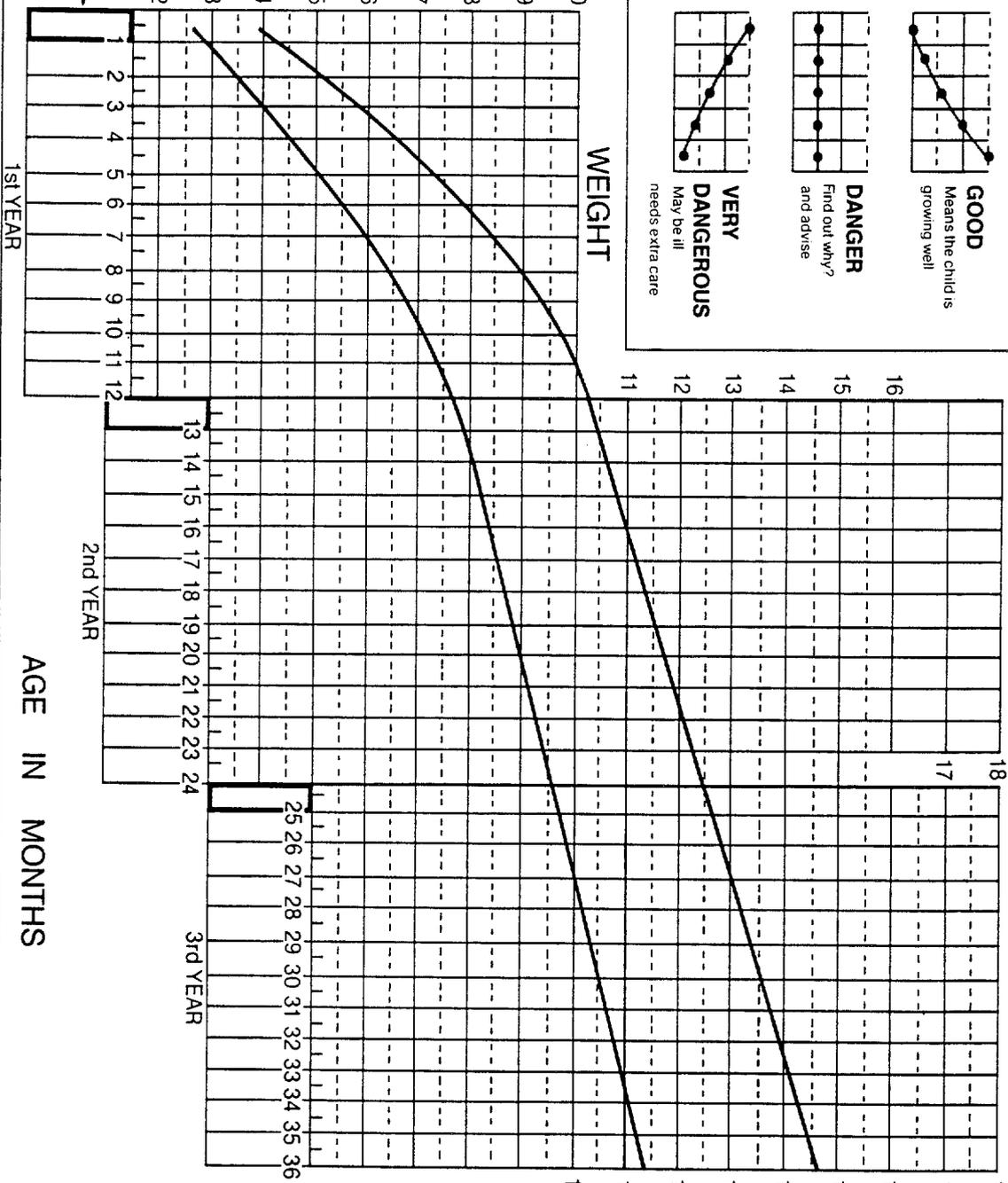
Twins

Fifth child or more

3 or more children in family died

Single Parent

WRITE THE MONTH OF BIRTH IN THE HEAVILY MARKED BOX

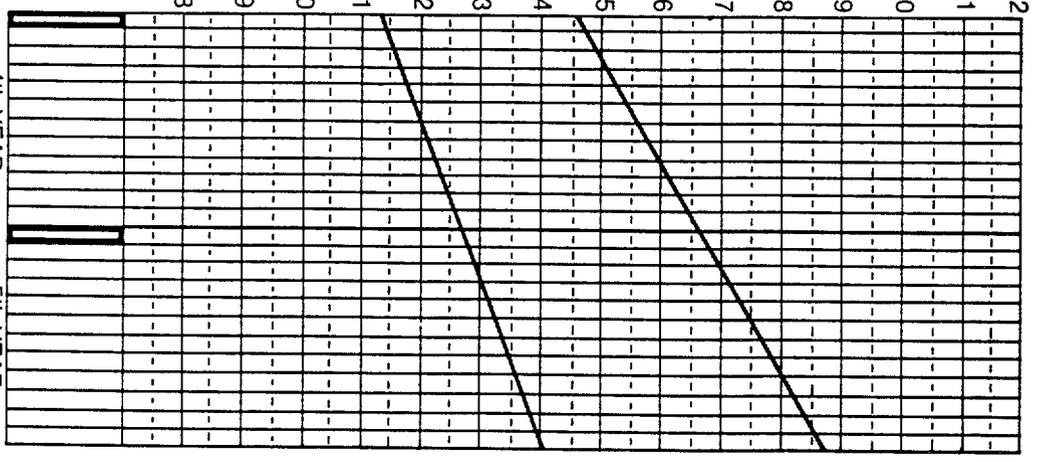


1st YEAR

2nd YEAR

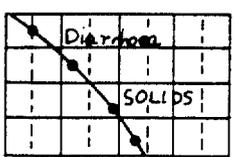
3rd YEAR

AGE IN MONTHS



RECORD ON THE CHART Like this:

- Immunisations
- Diarhoea
- Measles
- Solids introduced
- Breastfeeding stopped
- Birth of next child



Date of 1st dose
Date of 2nd dose
Date of 3rd dose
Date of 4th dose
Date of 5th dose

Name \_\_\_\_\_

Age \_\_\_\_\_

District \_\_\_\_\_

**Remarks:**

TT is given to women 15-49 years of age including pregnant women.

TT1: At first contact or as early as possible during Pregnancy.

TT2: At least 4 weeks after TT1 or during subsequent Pregnancy.

TT3: At least 6 months after TT2 or during subsequent Pregnancy.

TT4: At least 1 year after TT3 or during subsequent Pregnancy.

TT5: At least 1 year after TT4 or during subsequent Pregnancy.

1. You must receive 5 doses of TT for life long protection against Tetanus.

2. TT is for all women of child bearing age 15-49 yrs. and pregnant mothers.

3. This vaccine will protect you and your children at birth against Tetanus.



Ministry of Health  
Government of Uganda



**TETANUS TOXOID  
IMMUNISATION  
CARD**

*Keep this Card safely  
and produce it every  
visit to a Health Facility*

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## Recipe for cereal base/starch ORT

### Ingredients:

- Maize, millet, sorghum (flour) or
- Rice, millet, sorghum, maize (cereals) or
- Matooke (cooking bananas), sweet potatoes, Irish potatoes, cassava
- Salt
- Water
  
- Saucepan at least 2-liter capacity
- Mixing sticks
- Mug of 1/2 lt.
- Stove
- Charcoal/fire wood

### Preparation:

- 1.) Get a fist full of maize flour.
- 2.) Put in a saucepan.
- 3.) Pour in two mugs of 1/2 lt. Mark the level on the saucepan.
- 4.) Pour in another mug.
- 5.) Put on low fire and keep on stirring until the water comes at the level of the mark.
- 6.) Take off the fire and put in 1 level teaspoon of salt and mix.
- 7.) Wait to cool and then use as needed.

or

- 1.) Get a fist of cereal/maize or millet, etc.
- 2.) Do the same as above.
- 3.) Use only the water after cooling.

or

- 1.) Use matooke or cassava cut in small pieces.
- 2.) Put in a saucepan 1/2 way.
- 3.) Do as above.
- 4.) Serve the water after cooling.

# Appendix VIII

## Job Descriptions and Biodata Sheets

# **Job Description**

Project Director

**Reports To:** Ministry of Health, ADRA/Uganda Country Administration

**Supervises:** All General Staff, Specifically Technical Staff And Sub-county Supervisors

## **Activities**

- Supervise the overall compliance with the DIP
- Ensure the quality of technical training.
- Keep ADRA/Uganda and other relevant offices informed about the progress of the project through a regular reporting system, preferably quarterly
- Keep MOH & District Medical Office informed about project activities
- Maintain contact with other NGO's or Government ministries for the benefit of the project.
- Through regular staff meetings, ensure that project implementation and activities are optimized.

**Position filled by:** Israel Musoke

# **JOB DESCRIPTION**

Technical Advisor Drama & Literacy

**Reports to:** Project Manager

**Supervises:** Sub-county supervisors, trainer-supervisors

**Contact Schedule:**

Contacts	Frequency	Purpose
Project Manager	Weekly	Staff meetings/coordination
Sub-county Supervisors	Weekly	Orientation
Trainer Supervisors	Monthly	Review and plan activities

**Duties:** Training about the key messages about HIV/AIDS  
Promote formation of dram clubs which will spread information to the community through recreational activities.

**Position filled by:** Elisha Bireke Sebadduka

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# **JOB DESCRIPTION**

Technical Advisor, Safe Motherhood

**Reports to:** Project Director

**Supervises:** Trainer Supervisor

**Activities:**

1. Mobilizing TBA's and community based midwives on  
Ante-natal care  
Safe Delivery  
Benefits of F/P  
Facts about AIDS/HIV/STD prevention/ transmission  
Nutrition Benefits of breast-feeding  
Preventive measures for Malaria
2. Mobilizing the midwives for refresher courses on
  - a) Antenatal care
  - b) Basic emergency obstetric care
3. Work with the VHC to establish community based emergency transport alternatives to health centers

**Position filled by:** Juliet Namazzi

## **JOB DESCRIPTION**

Technical Advisor, Family Planning

**Reports to:** Project director

**Supervises:** Trainer Supervisor

**Activities:** Community mobilization through the sub-county supervisors, trainer supervisor, community-based distributors and then the health promoters

Training the trainer-supervisor in family planning.

**Position filled by:** Cate Kafeero Namuddu

# **JOB DESCRIPTION**

Technical Advisor, HIV/AIDS

**Reports to:** Project Director

**Supervises:** Trainer Supervisor

## **Activities:**

1. Community mobilization through the sub-county Supervisors, trainer supervisor, CHW trainers and the health promoters
2. Training the trainer supervisor in HIV/AIDS interventions i.e. facts about HIV/AIDS, key messages, counseling skills and models, behavioral change
3. Organize the recreation centres together with Mr Elisha Sebadduka, and work hand in hand in formation of children's clubs.
4. Be involved in mass education about HIV/AIDS's prevention and transmission--with adult drama clubs.
5. Work hand in hand with Family Planning/Safe motherhood about STD's and treatment.
6. Be involved in school education (which is school penetration) with the children's drama clubs
7. Work hand in hand with TASCOS organization about the HIV/AIDS transmission/prevention
8. Be involved in the training/formation of Village AIDS committees to gather trainer supervisors, CHW supervisors/Community leaders--which will be the same Village health communities for sustain ability.

**Position filled by : Annitah Namuyiga**

# **JOB DESCRIPTION**

Technical Advisor, Agricultural and Growth Monitoring

**Reports to:** Project Director

**Supervises:** Supervisors, Trainers, Contact farmers

**Contact Schedule:**

Person Contacted	Frequency of Contacts
Health Promoters	During Seminars
Sub-county supervisors	Weekly
Trainer supervisors	Monthly
Contact Farmers	Monthly

**Position Filled by:** Laban Rutareberwa

# **JOB DESCRIPTION**

Sub-county Supervisor

**Reports to:** Project Director

**Supervises:** 4 Trainer-Supervisors

**Contact Schedule:**

Person Contacted	Frequency of Contact`
Project director	Weekly
Technical Advisors	Weekly
Trainer Supervisors	Monthly
Health Management Committee (sub-county)	Quarterly
Village Health Committees\Trainers	Monthly
Health Promoters	As needed
Community Based Distributors	Monthly

**Filled by:** Andrew Semambo  
Charles Musoke

## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Sebakigye, Israel Musoke</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Nantabulirwa - RC1 Goma Sub-county, Mukono district P. O. Box 22, Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Project Director</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$7,600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <b>Vumba, Luwero District Ugan</b>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment  
**Ruth (wife, 32); Jonathan (son, 9); Jemimah (daughter, 7); Jovia, (daughter, 5)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (see instructions on reverse)		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Medical Training School, Mbale, Uganda	Med.	Med. Assit.	1982	English	4	4
Uganda Community-based Health Center, Entebbe		Certif	1988	Luganda	4	4
Amret Nairobi	Comun. Facilit.	Certif.	1989			

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Project Director	ADRA CS-7, Uganada	Jan-92	Oct-94	6,000
Outpatient director	Isahka Adventist Hospital	1983	1985	
Coordinator SDA Health Services	Ugandan Seventh-day Adventist Union, P.O. 6434 Kampala	1985	1989	

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION:** To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee 	Date <b>10-Mar-95</b>
---------------------------	--------------------------

**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Mukamurangwa, Louise</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>ADRA Uganda</b> <b>P O Box 9946</b> <b>Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Secretary</b>
8. Telephone Number (include area code) <b>245405</b>		6. Proposed Salary <b>\$1,906</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 100px; height: 15px;"></div>		10. Citizenship (If non-US citizen, give visa status)	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Light & Grammer Primary School				English	3S	3R
Bugema Adventist College				Luganda	3S	2R
Light Bureau of Accountancy		Diploma	1993	Kinyarwanda	2S	2R

### 14. EMPLOYMENT HISTORY

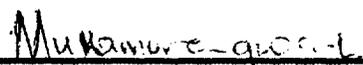
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Secretary</b>	<b>ADRA Uganda P O Box 9946 Kampala</b>	<b>1993</b>	<b>1995</b>	

### 15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

### 16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee <div style="text-align: center; font-family: cursive;">  </div>	Date <p style="text-align: center;"><b>09-Feb-95</b></p>
---	---

### 17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
--	------

## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Ndibeggamawa Annitah Namuyiga</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Lukyamu RC 1 Bugema Village Kalagala, Kamira Parish P.) box 9046 Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Technical assitant</b>
8. Telephone Number (include area code) <b>Kampala 542455</b>		6. Proposed Salary <b>\$2,813</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 100px; height: 20px;"></div>	10. Citizenship (if non-US citizen, give visa status) <b>Ugandan</b>		

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Namugongo S.S.S.	Secondary		1982	English	4S	4R
Kamuli Nursing Training School		A.S. N	1985	Luganda	4S	4R
Mingo Midwifery Training School		Certif.	1991			

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Technical advisor	ADRA Childsurvival CS-7	1992	1994	1,440

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <b>10-Mar-95</b>
---------------------------	--------------------------

**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

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Signature of Contractor's Representative	Date
--	------

## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <b>Sebadduka, Elisha, Bireke</b>		2. Contractor's Name <b>ADRA (Adventst Development and Relief Agency)</b>	
3. Employee's Address (include ZIP code) <b>Bugema, Kamira, R.C.-1 P.O. Box 9946, Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Technical Assitant</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$2,813</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <b>[REDACTED]</b>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment

**Esther, (wife); Crown (5, son), Ruth (daughter, 25 mo.) Job, (son, 7 mo.)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (see instructions on reverse)		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Emerson College (U.K.)	Ag. Deve.	Ed Dip	91	English	4S	R
National Teacher's College, Kyambogo	Teachers Certificate		1982	Luganda	4S	R
St. Henrys College, Kitovu		Certif.	1988	Lunyoro/Rutooro	4S	R

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Technical advisor GM/N	CS-& Adra Uganda	Jul-93	Sep-94	1,400
Agriculture advisor	Rural Community in Development, P.O. Box 123, Mitiyana	Jan-92	Jul-93	2,400

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <b>10-Mar-95</b>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Namazzi, Juliet Bukenya</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>ADRA Uganda</b> <b>P.O. Box 9946, Kampalla, Uganda</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Technical Assistant</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$2,813</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 150px; height: 20px;"></div>		10. Citizenship (If non-US citizen, give visa status) <p style="text-align: center;"><b>Ugandan</b></p>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Pillai's Secondary School				Luganda	4	4
Soroti Nurses/Midwifry Training School		Certif.	1975	English	3	3
				Swahili	2	2

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Health Coordinator	ADRA CS-7 Project	1993	1994	1,200
Midwife	Central Ugandan Field of SDA church. P.O. Box 22, Kampala	1979=1992		360

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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156

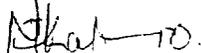
## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <b>Namuddu Cate Kafeero</b>		2. Contractor's Name <b>ADRA (Adventst Development and Relief Agency)</b>	
3. Employee's Address (include ZIP code) <b>R.C. 1, Kamira, Kamira Parish Kalagala Sub County P.O. Box 9949, Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Technical Assitant</b>
		6. Proposed Salary <b>\$2,666</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
8. Telephone Number (include area code)	9. Place of Birth <b>[REDACTED]</b>	10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	
11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment <b>Nakibuka, Margret, 24 years, Sister</b>			

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>			
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading	
Mengo School of Nursing and Midwifery		A.S. Certif.	1987	English	3S	R	
Katikamu Secondary School			1982	Luganda	5S	R	

14. EMPLOYMENT HISTORY				
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.				
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.				
POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Midwife	Mr. James Semyonjo, P.O.Box 8701, Kampala	Apr-88	Aug-94	360

15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)					
SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

<b>16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.</b>	
Signature of Employee 	Date <b>10-Mar-95</b>

<b>17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)</b>	
Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.	
Signature of Contractor's Representative	Date

## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <b>Rutareberwa, Laban</b>		2. Contractor's Name <b>ADRA (Adventst Development and Relief Agency)</b>	
3. Employee's Address (include ZIP code) <b>Bugema Adventist Secondary School Box 7500, Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Technical asstant</b>
		6. Proposed Salary <b>\$2,973</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
8. Telephone Number (include area code)	9. Place of Birth <b>[REDACTED]</b>	10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment

**Dorthy (wife, 25); Dorine (Daughter 12 mo), Bagabag (adopted son, 15)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>Mbarara High School</b>			<b>1986</b>	<b>English</b>	<b>4</b>	<b>4</b>
<b>Bukalasa National Agricultural College</b>			<b>1988</b>	<b>Luganda</b>	<b>4</b>	<b>4</b>
				<b>Runyankore</b>	<b>5</b>	<b>4</b>

**14. EMPLOYMENT HISTORY**

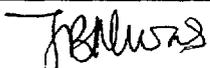
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Tech. Advisor, Agricultural</b>	<b>ADRA CS-7 project</b>	<b>1993</b>	<b>1994</b>	<b>1,440</b>
<b>Ag. Teacher, Farm Manager</b>	<b>Bugema SDA College, P.O. 7500 Kampala</b>	<b>1988</b>	<b>1992</b>	<b>1,080</b>
<b>Ag. Extension Officer</b>	<b>Bamunanika, Luwero district</b>	<b>1989</b>	<b>1992</b>	<b>480</b>

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <b>10-Mar-95</b>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

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Signature of Contractor's Representative	Date
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USAID

## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Hayuni, Joseph</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Bugema Campus</b> <b>P.O. Box 7500, Kampala</b> <b>Uganda, East Africa</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Technical Assitant</b>
		6. Proposed Salary <b>\$2,813</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
8. Telephone Number (include area code)	9. Place of Birth <div style="background-color: black; width: 100px; height: 20px;"></div>	10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

**Sarah (33, Wife), Guldba (10, son), Mutenga (9, son) David (7, son) Dorcas (5, Daughter)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Makerere University	Statistics	MA	1992	English	4S	4R
Makerere University	Statistics	Diploma	1989	Luganda	4S	4R
Makerere University	Statistics	BA	1983	Swahili	2S	2R

### 14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Director of Studies	Bugema Adventist Secondary School, P.O. 7500 Kampalla	Jan-91		2400
Statistician	Ministry of Lands and Housing, P.O 7122, Kampalla	Jan-88	Dec-90	1200
Stores Manager	Uganda Associated Industries, P.O. 3155, Kampalla	Jan-86	Dec-86	1000

### 15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars
Data Analysis	ADRA CS-7, Uganda	Aug-94		14	40

### 16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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### 17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Musoke, Charles</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <p><b>Buyuri Kajaako RC 1</b></p>		4. Contract Number <p><b>FAO-500-A-00-4038-00</b></p>	5. Position Under Contract <p><b>Sub-county Supervisor</b></p>
8. Telephone Number (include area code) [REDACTED]		6. Proposed Salary <p><b>\$1,666</b></p>	7. Duration of Assignment <p><b>Oct 1, 94 to Sept 29, '97</b></p>
9. Place of Birth [REDACTED]		10. Citizenship (If non-US citizen, give visa status) <p><b>Ugandan</b></p>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <i>see instructions on reverse</i>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
O. Level Lutete Secondary			1985	English	2	2
				Luganda	3	3

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Sub-county Supervisor</b>	<b>CS7 Project, ADRA/Uganda</b>	<b>1992</b>	<b>1994</b>	<b>1,080</b>

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Semambo, Andrew</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Kyasa RC 1, Kalanamu Parish, Kalagala Sub-county</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Sub-county Supervisor</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$1,666</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 150px; height: 20px;"></div>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment  
**Milly (wife), Moses (son 15 ), Harriet (daughter 4), Betty (daughter 12), Richard (son 10)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>			
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading	
Jinja Senior Secondary School, Busoga District			1970	Luganda	3	3	
				English	2	2	

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Sub-county supervisor	ADRA Child survival 7	1992	1994	1,400

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Deo Kilumira</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Bukrasa RC1 Bukima Parish</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Supervisor</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 100px; height: 20px;"></div>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	
11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment			

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
O Level Lutete Secondary school			1980	English	2	2
				Luganda	3	3

14. EMPLOYMENT HISTORY				
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.				
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.				
POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Self Employed</b>				

15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)					
SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

<b>16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.</b>	
Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>

<b>17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)</b>	
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Signature of Contractor's Representative	Date

## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle)  <p style="text-align: center;"><b>Kule John</b></p>		2. Contractor's Name  <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code)  <b>Kyetume RC1 C/O Kyetume SDA Church Box 6529 Kampala</b>		4. Contract Number  <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract  <b>Supervisor</b>
8. Telephone Number (include area code)		6. Proposed Salary  <b>\$600</b>	7. Duration of Assignment  <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth  <div style="background-color: black; width: 100px; height: 20px;"></div>		10. Citizenship (If non-US citizen, give visa status)  <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment  
**Sarah, 18 (Wife), Moses 2 (son)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (see instructions on reverse)		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>Mpige Senior Secondary School, Luwero District</b>				<b>English</b>	<b>3</b>	<b>3</b>

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Mason</b>	<b>Nsubuga Musisi Builders, Bugema, P.O. Box 6529, Kampala</b>	<b>1992</b>	<b>1993</b>	<b>600</b>

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date  <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <b>Wasswa Isaach</b>		2. Contractor's Name <b>ADRA (Adventst Development and Relief Agency)</b>	
3. Employee's Address (include ZIP code) <b>Kalanamlu RC1 Kalagala sfc C/) Box 508, Bombo</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Supervisor</b>
		6. Proposed Salary <b>\$600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
8. Telephone Number (include area code)	9. Place of Birth <b>[REDACTED]</b>	10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

**Milly, 28,(wife); Kafeero, 13 (Son)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>Katikamu SDA Senior secondary</b>			<b>1977</b>	<b>Luganda</b>	<b>3</b>	<b>3</b>
				<b>English</b>	<b>2</b>	<b>2</b>

**14. EMPLOYMENT HISTORY**

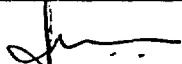
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Community based Distributor</b>	<b>ADRA CS-7</b>	<b>Apr-94</b>	<b>Sep-94</b>	<b>1,200</b>
<b>Teacher</b>	<b>Kalanamu Sxt. Secondary Box 508, Bombo</b>	<b>1988</b>	<b>Apr-94</b>	

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <b>10-Mar-95</b>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Nkwanga Dunstan Kavuma</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Kweese Village</b> <b>C/O Kayindu Primary School</b> <b>P.O. Box 135 Bombo</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Supervisor</b>
8. Telephone Number (include area code) <div style="background-color: black; width: 100px; height: 15px;"></div>		6. Proposed Salary <b>\$600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 100px; height: 15px;"></div>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	
11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment			

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>			
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading	
<b>Bombo Senior Secondary School</b>			<b>1983</b>	<b>English</b>	<b>3</b>	<b>3</b>	

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

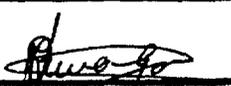
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Book Salesman</b>	<b>Central Uganda Field</b>	<b>1993</b>	<b>1994</b>	

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee <div style="text-align: center;"></div>	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Mugeni Stephen Obiang</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>RC1 Kamira, Kalagala Sub County</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>supervisor</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 100px; height: 20px;"></div>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment  
**Sam, 18 years (brother)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (see instructions on reverse)			
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading	
<b>Bombo Senior Secondary School</b>			<b>1992</b>	<b>English</b>	<b>3</b>	<b>3</b>	
				<b>Luganda/Samia</b>	<b>3</b>	<b>3</b>	
				<b>Swahili</b>	<b>2</b>	<b>2</b>	

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Teacher, Eng. Dept.</b>	<b>Amoomaya Public School, box 28, Bombo</b>	<b>1993</b>	<b>1994</b>	<b>500</b>
<b>Teacher Geography dept.</b>	<b>Amoomya Secondary School, box 28, Bombo</b>	<b>1993</b>	<b>1994</b>	<b>250</b>

15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)					
SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION:** To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) [REDACTED]		2. Contractor's Name <b>ADRA (Adventst Development and Relief Agency)</b>	
3. Employee's Address (include ZIP code) <b>Janda RC1 Kabulanaka</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Supervisor</b>
		6. Proposed Salary <b>\$600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
8. Telephone Number (include area code) [REDACTED] <b>Kkonko</b>		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <i>see instructions on reverse</i>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
O. Level Lvteetess			1979	English	2	2
				Luganda	3	3

### 14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Self Employed</b>				

### 15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

### 16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee <i>Nakku Jane</i>	Date <b>10-Mar-95</b>
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### 17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <b>Ottiko, Peter</b>		2. Contractor's Name <b>ADRA (Adventst Development and Relief Agency)</b>	
3. Employee's Address (include ZIP code) <b>Kamwano Kyetume</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Supervisor</b>
		6. Proposed Salary <b>\$600</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
8. Telephone Number (include area code)	9. Place of Birth <b>[REDACTED]</b>	10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>O Level Lutete Secondary</b>			<b>1970</b>	<b>English</b>	<b>2</b>	<b>2</b>
				<b>Luganda</b>	<b>3</b>	<b>3</b>

### 14. EMPLOYMENT HISTORY

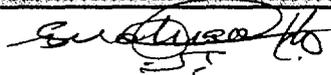
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars

### 15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

### 16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee 	Date <b>10-Mar-95</b>
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### 17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Kaggwa, Livingstone</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Nakigoza RC 1</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Supervisor</b>
8. Telephone Number (include area code)		6. Proposed Salary <p style="text-align: center;"><b>\$600</b></p>	7. Duration of Assignment <p style="text-align: center;"><b>Oct 1, 94 to Sept 29, '97</b></p>
9. Place of Birth <div style="background-color: black; width: 100px; height: 20px;"></div>		10. Citizenship (If non-US citizen, give visa status) <p style="text-align: center;"><b>Ugandan</b></p>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>Mpigi Senior Secondary School</b>			<b>1981</b>	<b>English</b>	<b>2</b>	<b>2</b>
				<b>Luganda</b>	<b>3</b>	<b>3</b>

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Teacher</b>	<b>Ministry of Eduation</b>	<b>1991</b>	<b>1994</b>	<b>380</b>

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <p style="text-align: center;"><b>10-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Byabagambi, Bosco</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Kabingo S D A Church, P O Box 30 Ibanda, Mbarara</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Security</b>
8. Telephone Number (include area code) [REDACTED]		6. Proposed Salary <p style="text-align: center;"><b>\$1,333</b></p>	7. Duration of Assignment <p style="text-align: center;"><b>Oct 1, 94 to Sept 29, '97</b></p>
9. Place of Birth [REDACTED]		10. Citizenship (If non-US citizen, give visa status) <p style="text-align: center;"><b>Ugandan</b></p>	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (see instructions on reverse)		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>Ibanda School Leavers Institute</b>			<b>1980</b>			

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Security Guard</b>	<b>Central Uganda Field SD Church</b>	<b>1992</b>	<b>1994</b>	<b>50</b>

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <p style="text-align: center;"><b>03-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Kagoda, Moses</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>Bugema dventist SS School</b> <b>P O Box 6529</b> <b>Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Janitor</b>
8. Telephone Number (include area code)		6. Proposed Salary <b>\$1,066</b>	7. Duration of Assignment <b>Oct 1, '94 to Sept 29, '97</b>
9. Place of Birth		10. Citizenship (If non-US citizen, give visa status) <b>Ugandan</b>	

11. Names, Ages, and Relationships of Dependants to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
<b>Muguluka SS School</b>	<b>S II</b>		<b>1987</b>			

**14. EMPLOYMENT HISTORY**

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
<b>Office Cleaner / Messenger</b>	<b>ADRA Uganda CS 7</b>			

**15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)**

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

**16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.**

Signature of Employee 	Date <p style="text-align: center;"><b>03-Mar-95</b></p>
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**17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)**

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Signature of Contractor's Representative	Date
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## Contractor Employee Biographical Data Sheet

1. Name (Last, First, Middle) <p style="text-align: center;"><b>Luggya Livingstone</b></p>		2. Contractor's Name <p style="text-align: center;"><b>ADRA (Adventst Development and Relief Agency)</b></p>	
3. Employee's Address (include ZIP code) <b>ADRA Uganda</b> <b>P O Box 9946</b> <b>Kampala</b>		4. Contract Number <b>FAO-500-A-00-4038-00</b>	5. Position Under Contract <b>Driver</b>
8. Telephone Number (include area code) <b>285405</b>		6. Proposed Salary <b>\$1,866</b>	7. Duration of Assignment <b>Oct 1, 94 to Sept 29, '97</b>
9. Place of Birth <div style="background-color: black; width: 100px; height: 15px;"></div>		10. Citizenship (If non-US citizen, give visa status)	

11. Names, Ages, and Relationships of Dependents to Accompany Individual to Country of Assignment  
**Zera Luggya (wife 27), Jeffrey (son 15), Denis (daughter 8), Joanita (daughter 6), Ritta (daughter 4), Dorah (daughter 3)**

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY <small>see instructions on reverse</small>		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
Bugema Primary School				Luganda	4S	4R
Kiwenda Sec School				English	2S	2R
				Swahili	2S	2R

### 14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper, if required, to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential, or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Annual Salary
		From	To	Dollars
Transport Officer	CS7 ADRA Uganda P O Box 9946 K'la	1992	1994	

### 15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE#	Date of Employment (M/D/Y)		Days at	Daily Rate
		From	To	Rate	in Dollars

### 16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee <div style="text-align: center;"></div>	Date <p style="text-align: center;"><b>09-Feb-95</b></p>
---	---

### 17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.

Signature of Contractor's Representative	Date
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# Appendix IX

## Resumes

**Maitland DiPinto**  
15511 Langside Street  
Silver Spring, MD 20905  
(301) 384-1359

**Education:**

1988                    Master of Health Administration  
Loma Linda University, Loma Linda, CA

1978                    Master of Divinity  
Andrews University, Berrien Springs, MI

1973                    Master of Science in Public Health  
Loma Linda University, Loma Linda, CA

1970                    Bachelor of Arts  
Pacific Union College, Angwin, CA

**Experience:**

1991-present           Director, Community Development  
Adventist Development & Relief Agency International, Silver Spring, MD

1984-1991             Director  
ADRA/Singapore, Far East Region

1979-1984             Director  
ADRA/Sarawak, East Malaysia

1973-1979             Minister  
North Carolina

**Milton D. McHenry**  
12309 Treetop Drive, #13  
Silver Spring, MD 20904  
(301) 680-5129

**Education:**

1968-1972 Bachelor of Science, Industrial Technology  
Pacific Union College, CA

**Experience:**

1993-present Senior Manager  
Adventist Development & Relief Agency International, Silver Spring, MD

1992-1993 Assistant Director, Community Development, Contracts Manager  
ADRA/International, Silver Spring, MD

1990-1992 Owner/Operator  
McServices Construction, Paradise, CA

1986-1990 Crew Supervisor  
Paradisewood Development, Paradise, CA

1984-1986 Country Director  
ADRA/Bolivia

1980-1984 Business Manager  
Lake Titicaca Training School, Juliaca, PERU

1975-1980 Maintenance Manager/Construction Supervisor  
Bolivian Educational Center, Cochabamba, BOLIVIA

**Mekebeb Negerie**  
Loma Linda University  
School of Public Health  
Loma Linda, CA 92350  
(714) 796-5206

**Education:**

- 1990-1993 Loma Linda University, School of Public Health, Loma Linda, Ca.,  
(DRPH Cand)
- 1985 University of the Philippines, Philippines (post Masters graduate study for  
six months)
- 1983-1985 Philippine Union College, Philippines (MPH)
- 1980-1983 University of Eastern Africa, Kenya (BS, Agriculture)
- 1978-1979 Addis Ababa University, Ethiopia (Chemistry)
- 1971-1977 Akaki Seventh-day Adventist Secondary School, Ethiopia

**Experience:**

- 1991-present Refletron lab technician and counselor, Center for Health Promotion  
Loma Linda University (part-time)
- 1990-present Circulation desk technician, LLU Library (part-time)
- 1987-1989 Project director for ADRA/Southern Sudan
- 1987 Mother and child health project consultant, Egypt (part-time)
- 1986 Mother and child health coordinator, ADRA/Sudan
- 1985 Conducted smoking cessation program for military personnel  
Philippine Union College
- 1983 Farm shop supervisor, Kenya
- 1980-1982 Painting, construction, gardening, Kenya
- 1979-1980 Music Instructor and choir director, Ethiopia
- Languages:** English, Amharic, Oromo, Arabic, Swahili

**Solomon Wako**  
11507 February Circle, # 302  
Silver Spring, MD 20904  
(301) 680-7985

**Education:**

1984 Dr. of Philosophy, Sociology  
Western Michigan University, Kalamazoo, MI

1979 Master of Social Work  
Western Michigan University, Kalamazoo, MI

1977 Master of Divinity, Andrews University, Berrien Springs, MI

1975 Master of Arts, Andrews University, Berrien Springs, MI

1973 Bachelor of Arts  
Newbold College, Bracknell, Berkshire, ENGLAND

**Experience:**

1992-present Director of Evaluation  
Adventist Development and Relief Agency, Silver Spring, MD

1990-1992 Associate Professor of Social Work and Sociology  
Walla Walla College, College Place, WA

1988-1990 Coordinator, MSW Program  
Indiana-Purdue University, Fort Wayne, IN

1987-1988 Assistant Professor of Social Work and Sociology  
Nebraska Wesleyan University, Lincoln, NE

1984-1987 Assistant Professor of Social Work and Sociology  
University of Nebraska, Kearney, NE

1979-1982 Medical Social Worker  
Michigan Department of Social Services

1978-1979 Mental Health Intern  
Kalamazoo Consultation Center, Kalamazoo, MI

1977-1978 Employment and Training Intern  
Comprehensive Employment and Training Act (CETA), Kalamazoo, MI

**Jerald W. Whitehouse, DrHSc, MPH**

11515 Sequoia Lane  
Beltsville, MD 20705  
(301) 937-6962

**Education:**

- 1977 DrHSc (Doctor of Health Science) emphasis in Clinical Preventive Care  
Loma Linda University, Loma Linda, CA
- 1977 Master of Public Health, Nutrition  
Loma Linda University, School of Public Health
- 1979 Certified Physician's Assistant  
Loma Linda University, School of Medicine
- 1965 Bachelor of Arts, Theology  
Walla Walla College, Walla Walla, WA

**Experience:**

- 1992-present Senior Advisor for Health  
Adventist Development & Relief Agency International, Silver Spring, MD
- 1988-1992 Country Director  
ADRA/Bangladesh
- 1985-1988 Chairman, Department of Health Ministries  
Weimar College, Weimar CA
- 1979-1986 Country Director  
ADRA/Sudan
- 1976-1978 Preventive Care Specialist  
Department of Preventive Medicine, Kaiser Foundation Hospital
- 1970-1973 Director, Health and Temperance  
East Mediterranean Field of SDA, Beirut, LEBANON
- 1966-1970 Director, Health Education,  
Benghazi Adventist Hospital, Benghazi, LIBYA

**Consultancies:**

- July 1988      Project Evaluation Consultancy for ADRA/International  
ADRA/Haiti, Matching Grant Program
- Jan/Feb 1992   Detailed Implementation Plan Consultant for ADRA/International  
ADRA/Indonesia, USAID, Child Survival VII
- Aug. 1992      Project Planning and Evaluation Consultancy for ADRA/International  
ADRA/Sudan, Health and Nutrition Project, USAID

**Languages:** English, Arabic

# Appendix X

HIS Forms

18

ADRA CS10 - HIS  
General Monthly Report

Page \_\_\_\_\_ of \_\_\_\_\_

Health Promoter \_\_\_\_\_ Community \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

age ranges	0 - 1	2 - 5	6 - 10	11 - 14	15 - 19	20 - 34	35 - 44	45 +
No. of people								

Household No.	Head of household	EPI dropout	At risk	Childrens weight			Key Messages										
				↑	⇒	↓	CDD	TT	EPI	GM NUTR	MAT CARE	FP	HIV AIDS	DE WORM	5 - 15 @ centre	VEG GDN	FOOD STORE
<b>TOTAL</b>																	





**Key Indicators of Child Survival Project Performance for  
USAID/BHR/PVC PVO Child Survival Projects**

1. Appropriate Infant Feeding Practices: Initiation of Breastfeeding - Percent of infants/children (less than 24 months) who were breastfed within the first hour after birth and percent of infants/children (less than 24 months) who were breastfed within the first eight hours after birth.
2. Appropriate Infant Feeding Practices: Exclusive Breastfeeding - Percent of infants less than four months, who are being given only breastmilk.
3. Appropriate Infant Feeding Practices: Introduction of Foods - Percent of infants between six and ten months, who are being given solid or semi-solid foods.
4. Appropriate Infant Feeding Practices: Persistence of Breastfeeding - Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods).
5. Management of Diarrheal Diseases: Continued Breastfeeding - Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more breastmilk.
6. Management of Diarrheal Diseases: Continued Fluids - Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.
7. Management of Diarrheal Diseases: Continued Foods - Percent of infants/ children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.
8. Management of Diarrheal Diseases: ORT Use - Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT.
9. Pneumonia Control: Medical Treatment - Percent of mothers who sought medical treatment for infant/child (less than 24 months) with cough and rapid, difficult breathing in the past two weeks.
10. Vaccination Coverage (Card): EPI Access - Percent of children 12 to 23 months who received DPT1.
11. Vaccination Coverage (Card): EPI Coverage - Percent of children 12 to 23 months who received OPV3.
12. Vaccination Coverage (Card): Measles Coverage - Percent of children 12 to 23 months who received measles vaccine.
13. Vaccination Coverage (Card): Drop Out Rate - Percent change between DPT1 and DPT3 doses  $[(DPT1 - DPT3) \div DPT1] \times 100$  for children 12 to 23 months.
14. Maternal Care: Maternal Card - Percent of mothers with a maternal card for the birth of the youngest child less than 24 months of age.
15. Maternal Care: Tetanus Toxoid Coverage (Card) - Percent of mothers who received two doses of tetanus toxoid vaccine (card) before the birth of her youngest child less than 24 months of age.
16. Maternal Care: One or More Ante-Natal Visits (Card) - Percent of mothers who had at least one ante-natal visit (card) prior to the birth of her youngest child less than 24 months of age.
17. Maternal Care: Modern Contraceptive Usage - Percent of mothers of children less than 24 months of age who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.

# **Appendix XI**

## **Quality Assurance Service Forms**

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# FIRST, ASSESS YOUR PATIENT FOR DEHYDRATION

1. LOOK AT:	CONDITION
	EYES
	TEARS
	MOUTH and TONGUE
	THIRST
2. FEEL:	SKIN PINCH
3. DECIDE:	
4. TREAT:	

<b>A</b>	Well, alert
	Normal
	Present
	Moist
	Drinks normally, not thirsty
	Goes back quickly
	The patient has NO SIGNS OF DEHYDRATION
	Use Treatment Plan A

<b>B</b>	* Restless, irritable *
	Sunken
	Absent
	Dry
	* Thirsty, drinks eagerly *
	* Goes back slowly *
	If the patient has two or more signs including at least one * sign *, there is SOME DEHYDRATION
	Weigh the patient, if possible, and use Treatment Plan B

<b>C</b>	* Lethargic or unconscious floppy
	Very sunken and dry
	Absent
	Very dry
	* Drinks poorly or incapable to drink
	* Goes back very slowly *
	If the patient has two or more signs including at least one * sign *, there is SEVERE DEHYDRATION
	Weigh the patient and use Treatment Plan C URGENTLY

## THEN, FOR OTHER PROBLEMS

### IF BLOOD IS PRESENT:

- Treat for 5 days with an oral antibiotic recommended for *Shigella* in your area.
- Teach the mother to feed the child as described in Plan A.
- See the child again after 2 days if:
  - under 1 year of age
  - initially dehydrated
  - there is still blood in the stool
  - not getting better
- If the stool is still bloody after 2 days, change to a second oral antibiotic recommended for *Shigella* in your area. Give it for 5 days.

### IF DIARRHOEA HAS LASTED AT LEAST 14 DAYS:

- Refer to hospital if:
  - the child is under 6 months old
  - dehydration is present. (Refer the child after treatment of dehydration.)
- Otherwise, teach the mother to feed her child as in Plan A, except:
  - give only half the usual amount of milk, or replace milk with a fermented milk product, such as yogurt.
  - assure full energy intake by giving 6 meals a day of thick cereal and added oil, mixed with vegetables, pulses, meat, or fish.
- Tell the mother to bring the child back after 5 days:
  - if diarrhoea has not stopped, refer to hospital.
  - if diarrhoea has stopped, tell the mother to:
    - use the same foods for the child's regular diet.
    - after 1 more week, gradually resume the usual animal milk.
    - give an extra meal each day for at least 1 month.

### IF THE CHILD HAS SEVERE MALNUTRITION:

- Do not attempt rehydration, refer to hospital for management.
- Provide the mother with ORS solution and show her how to give 5 ml/kg/yr during the trip.

### IF THE CHILD IS UNDER 2 MONTHS OF AGE:

- Rehydrate as necessary. If there is fever (38°C or above) after rehydration, refer to hospital. Do not give paracetamol or an antimalarial.

### IF THE CHILD IS 2 MONTHS OF AGE OR OLDER:

- If temperature is 39°C or above, give paracetamol.
- If there is falciparum malaria in the area, and the child has any fever (38°C or above) or history of fever in the past 5 days, give an antimalarial (or manage according to your malaria programme recommendation).

## TREATMENT PLAN A TO TREAT DIARRHOEA AT HOME

### USE THIS PLAN TO TEACH THE MOTHER TO:

- Continue to treat at home her child's current episode of diarrhoea
- Give early treatment for future episodes of diarrhoea

### EXPLAIN THE THREE RULES FOR TREATING DIARRHOEA AT HOME:

1. GIVE THE CHILD MORE FLUIDS THAN USUAL TO PREVENT DEHYDRATION:
  - Use recommended home fluids. These include: ORS solution, food-based fluids (such as soup, rice water, and yogurt drinks) and plain water. Use ORS solution for children described in the box below. (Note: If the child is under 6 months old and is not yet taking solid food, give ORS solution or water rather than a food-based fluid). Give as much of these fluids as the child will take. Use the amounts shown below for ORS as a guide.
  - Continue giving these fluids until the diarrhoea stops.

### 2. GIVE THE CHILD PLENTY OF FOOD TO PREVENT MALNUTRITION:

- Continue to breast-feed frequently.
- If the child is not breast-fed, give the usual milk.
- If the child is 6 months or older, or already taking solid food:
  - Also give cereal or another starchy food mixed, if possible, with pulses, vegetables, and meat or fish. Add 1 or 2 teaspoons of vegetable oil to each serving.
  - Give fresh fruit juices or mashed banana to provide potassium.
  - Give freshly prepared foods. Cook and mash or grind food well.
  - Encourage the child to eat, offer food at least 6 times a day.
  - Give the same foods after diarrhoea stops, and give an extra meal each day for two weeks.

### 3. TAKE THE CHILD TO THE HEALTH WORKER IF THE CHILD DOES NOT GET BETTER IN 3 DAYS OR DEVELOPS ANY OF THE FOLLOWING:

- Heavy watery stools
- Prepared vomiting
- Mashed thirst
- Blood in the stool
- Fasting or drinking poorly
- Feeding or drinking poorly
- Blood in the stool

### CHILDREN SHOULD BE GIVEN ORS SOLUTION AT HOME, IF:

- They have been on Treatment Plan B or C.
- They cannot return to the health worker if the diarrhoea gets worse.
- It is a national policy to give ORS to all children who see a health worker for diarrhoea.

### IF THE CHILD WILL BE GIVEN ORS SOLUTION AT HOME, SHOW THE MOTHER HOW MUCH ORS TO GIVE AFTER EACH LOOSE STOOL, AND GIVE HER ENOUGH PACKETS FOR 2 DAYS:

Age	Amount of ORS to give after each loose stool	Amount of ORS to provide for use at home
Less than 24 months	50-100 ml	500 mlday
2 up to 10 years	100-200 ml	1000 mlday
10 years or more	As much as wanted	2000 mlday

Describe and show the amount to be given after each stool using a local measure.

### SHOW THE MOTHER HOW TO MIX ORS.

#### SHOW HER HOW TO GIVE ORS:

- Give a teaspoonful every 1-2 minutes for a child under 2 years.
- Give frequent sips from a cup for an older child.
- If the child vomits, wait 10 minutes. Then give the solution more slowly (for example, a spoonful every 2-3 minutes).
- If diarrhoea continues after the ORS packets are used up, tell the mother to give other fluids as described in the first rule above or return for more ORS.

BEST AVAILABLE COPY

## TREATMENT PLAN B TO TREAT DEHYDRATION

### APPROXIMATE AMOUNT OF ORS SOLUTION TO GIVE IN THE FIRST 4 HOURS:

Age: *	Less than 4 months	4 - 11 months	12 - 23 months	2 - 4 years	5 - 14 years	15 years or older
Weight:	Less than 5 kg	5 - 7.9 kg	8 - 10.9 kg	11 - 15.9 kg	16 - 29.9 kg	30 kg or more
In ml	200-400	400-600	600-800	800-1200	1200-2200	2200-4000
In local measure						

\* Use the patient's age only when you do not know the weight. The approximate amount of ORS required (in ml) can also be calculated by multiplying the patient's weight (in kg) times 75.

- If the child wants more ORS than shown, give more.
- Encourage the mother to continue breast-feeding.
- For infants under 6 months who are not breast-fed, also give 100-200 ml clean water during this period.

### OBSERVE THE CHILD CAREFULLY AND HELP THE MOTHER GIVE ORS SOLUTION:

- Show her how much solution to give her child.
- Show her how to give it - a teaspoonful every 1-2 minutes for a child under 2 years, frequent sips from a cup for an older child.
- Check from time to time to see if there are problems.
- If the child vomits, wait 10 minutes and then continue giving ORS, but more slowly, for example, a spoonful every 2-3 minutes.
- If the child's eyelids become puffy, stop ORS and give plain water or breast milk. Give ORS according to Plan A when the puffiness is gone.

### AFTER 4 HOURS, REASSESS THE CHILD USING THE ASSESSMENT CHART. THEN SELECT PLAN A, B, OR C TO CONTINUE TREATMENT.

- If there are no signs of dehydration, shift to Plan A. When dehydration has been corrected, the child usually passes urine and may also be tired and fall asleep.
- If signs indicating some dehydration are still present, repeat Plan B, but start to offer food, milk and juice as described in Plan A.
- If signs indicating severe dehydration have appeared, shift to Plan C.

### IF THE MOTHER MUST LEAVE BEFORE COMPLETING TREATMENT PLAN B:

- Show her how much ORS to give to finish the 4-hour treatment at home.
- Give her enough ORS packets to complete rehydration, and for 2 more days as shown in Plan A.
- Show her how to prepare ORS solution.
- Explain to her the three rules in Plan A for treating her child at home:
  - to give ORS or other fluids until diarrhoea stops
  - to feed the child
  - to bring the child back to the health worker, if necessary.

### USE OF DRUGS

- ANTIBIOTICS should ONLY be used for dysentery and for suspected cholera cases with severe dehydration. Otherwise, they are ineffective and should NOT be given.
- ANTIPARASITIC drugs should ONLY be used for:
  - Amoebiasis, after antibiotic treatment of bloody diarrhoea for *Shigella* has failed or trophozoites of *E. histolytica* containing red blood cells are seen in the faeces.
  - Giardiasis, when diarrhoea has lasted at least 14 days and cysts or trophozoites of *Giardia* are seen in faeces or small bowel fluid.
- ANTIDIARRHOEAL DRUGS and ANTIEMETICS should NEVER be used. None has proven practical value. Some are dangerous.

## ASSESSMENT CHART FOR SEVERE DEHYDRATION

Can you give intravenous (IV) fluids immediately?

- Start IV fluids immediately. If the patient can drink, give ORS by mouth while the drip is set up. Give 100 ml/kg Ringer's Lactate Solution (or, if not available, normal saline), divided as follows:

Age	First give 30 ml/kg in:	Then give 70 ml/kg in:
Infants (under 12 months)	1 hour *	5 hours
Older	30 minutes *	2 1/2 hours

\* Repeat once if radial pulse is still very weak or not detectable.

- Reassess the patient every 1-2 hours. If hydration is not improving, give the IV drip more rapidly.
- Also give ORS (about 5 ml/kg/hour) as soon as the patient can drink: usually after 3-4 hours (infants) or 1-2 hours (older patients).
- After 6 hours (infants) or 3 hours (older patients), evaluate the patient using the assessment chart. Then choose the appropriate Plan (A, B or C) to continue treatment.

Is IV treatment available nearby, (within 30 minutes)?

- Send the patient immediately for IV treatment.
- If the patient can drink, provide the mother with ORS solution and show her how to give it during the trip.

Are you trained to use a naso-gastric (NG) tube for rehydration?

- Start rehydration by tube with ORS solution: Give 20 ml/kg/hour for 6 hours (total of 120 ml/kg).
- Reassess the patient every 1-2 hours:
  - If there is repeated vomiting or increasing abdominal distension, give the fluid more slowly.
  - If hydration is not improving after 3 hours, send the patient for IV therapy.
- After 6 hours, reassess the patient and choose the appropriate Treatment Plan.

Can the patient drink?

- Start rehydration by mouth with ORS solution, giving 20 ml/kg/hour for 6 hours (total of 120 ml/kg).
- Reassess the patient every 1-2 hours:
  - If there is repeated vomiting, give the fluid more slowly.
  - If hydration is not improving after 3 hours, send the patient for IV therapy.
- After 6 hours, reassess the patient and choose the appropriate Treatment Plan.

URGENT: Send the patient for IV or NG treatment

### NOTES:

- If possible, observe the patient at least 6 hours after rehydration to be sure the mother can maintain hydration giving ORS solution by mouth.
- If the patient is above 2 years and there is cholera in your area, give an appropriate oral antibiotic after the patient is alert.



WORLD HEALTH ORGANIZATION  
Programme for Control of Diarrhoeal Diseases

# MANAGEMENT OF THE PATIENT WITH DIARRHOEA

### USE THIS CHART FOR PATIENTS WITH:

- loose or watery stools
- loose stools with blood

1992

### PHC service quality checklist 3: Antenatal care

This checklist is intended for use in supervision and monitoring of antenatal services provided by health workers, community-based health workers, and traditional birth attendants. The list is comprehensive and includes some clinical tasks that the traditional birth attendants and other peripheral workers do not routinely carry out. The checklist should be modified and simplified according to the local situation. This checklist is intended for use in the observation of service delivery. It is recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

#### Reproductive history

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Review obstetric record or family health card?

Did the service provider update information on the following:

6. YES \_\_\_\_\_ NO \_\_\_\_\_ Age?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Date of last menstrual period?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Date of last delivery?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Number of previous pregnancies?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Outcome of each pregnancy?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Complications during previous pregnancies?<sup>1</sup>
12. YES \_\_\_\_\_ NO \_\_\_\_\_ Current or past breast feeding?

Did the service provider ask about risk factors:

13. YES \_\_\_\_\_ NO \_\_\_\_\_ Spotting/bleeding during current or past pregnancies?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Burning on urination?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Foul smelling vaginal discharge?
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Diabetes?
17. YES \_\_\_\_\_ NO \_\_\_\_\_ Cardiovascular problems?
18. YES \_\_\_\_\_ NO \_\_\_\_\_ Renal problems?
19. YES \_\_\_\_\_ NO \_\_\_\_\_ Female circumcision?
20. YES \_\_\_\_\_ NO \_\_\_\_\_ Previous injuries, especially to pelvis?
21. YES \_\_\_\_\_ NO \_\_\_\_\_ Medications currently being taken?
22. YES \_\_\_\_\_ NO \_\_\_\_\_ Smoking?
23. YES \_\_\_\_\_ NO \_\_\_\_\_ Alcoholism?
24. YES \_\_\_\_\_ NO \_\_\_\_\_ Drug abuse?
25. YES \_\_\_\_\_ NO \_\_\_\_\_ Any other problems associated with current pregnancy?

<sup>1</sup> Complications include bleeding, toxæmia, infection, prolonged labour, RH incompatibility, Cesarean section, stillbirth, and spontaneous abortion.



Ask about preventive actions taken:

26. YES \_\_\_\_\_ NO \_\_\_\_\_ Immunization against tetanus?
27. YES \_\_\_\_\_ NO \_\_\_\_\_ Malaria prophylaxis?
28. YES \_\_\_\_\_ NO \_\_\_\_\_ Plans for delivery?

#### Physical exam

Did the service provider:

29. YES \_\_\_\_\_ NO \_\_\_\_\_ Take pulse?
30. YES \_\_\_\_\_ NO \_\_\_\_\_ Take blood pressure?
31. YES \_\_\_\_\_ NO \_\_\_\_\_ Correctly measure height and weight?
32. YES \_\_\_\_\_ NO \_\_\_\_\_ Correctly examine legs, face, and hands for signs of oedema?
33. YES \_\_\_\_\_ NO \_\_\_\_\_ Calculate expected date of delivery?
34. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess adequacy of pelvic outlet?

#### Routine preventive services for pregnant women

Did the service provider:

35. YES \_\_\_\_\_ NO \_\_\_\_\_ Immunize or arrange for immunization against tetanus?
36. YES \_\_\_\_\_ NO \_\_\_\_\_ Administer or prescribe iron supplements?
37. YES \_\_\_\_\_ NO \_\_\_\_\_ Administer or prescribe nutrition supplements?
38. YES \_\_\_\_\_ NO \_\_\_\_\_ Administer or prescribe anti-malarial drugs if indicated?

#### Referral

Did the service provider:

39. YES \_\_\_\_\_ NO \_\_\_\_\_ Encourage mother to attend prenatal sessions at the local health facility?
40. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer high-risk pregnancies for additional medical attention?<sup>1</sup>
41. YES \_\_\_\_\_ NO \_\_\_\_\_ Recommend hospital birth for high-risk pregnancies?
42. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer for urine examination (sugar and protein) if medically indicated?
43. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer for blood test (glucose, haemoglobin/haematocrit or malaria diagnosis) if medically indicated?
44. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer for blood test for RH factor determination?
45. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer for syphilis serology test (per local norms or if medically indicated)?

#### Counselling

Did the service provider:

46. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the importance of continuing prenatal care during pregnancy?
47. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the benefits of weight gain during pregnancy?
48. YES \_\_\_\_\_ NO \_\_\_\_\_ Discuss the types of foods to include in diet during pregnancy?
49. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain how to take iron tablets/nutrition supplements?
50. YES \_\_\_\_\_ NO \_\_\_\_\_ Warn about dangers of alcohol, smoking, drugs?
51. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the importance of tetanus toxoid immunization during pregnancy?

<sup>1</sup> Referral is indicated if: 1) one or more high-risk factors (see reproductive history) are present; 2) there is a history of complications during pregnancy or birth; 3) the woman is older (per local norms) or has had many pregnancies (number determined by local norms). Referral is also indicated for obstetric and medical problem(s) and emergencies, ectopic pregnancy, infection or bleeding from abortion, and other prenatal problems and emergencies, especially haemorrhage, sepsis and eclampsia. Guidelines for referral should follow local norms.



52. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the importance of having delivery attended by a trained health worker?
53. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the dangers of abortions performed by unqualified individuals?
54. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain danger signs which require immediate attention?<sup>1</sup>
55. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell pregnant woman to have family seek assistance or transport her to clinic/hospital if danger signs of obstetric emergencies or complications of labour occur?
56. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell pregnant woman where and when to go for next prenatal visit?
57. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that pregnant woman understood key messages?
58. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask if she has any questions?

#### Supplies

Ask the service provider about the following supplies:

59. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a working scale (to weigh the pregnant woman)?
60. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a measuring tape?
61. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a stethoscope and blood pressure cuff?
62. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a watch with a second hand to take pulse?
63. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have tetanus toxoid vaccine?
64. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have iron tablets (per local policy)?
65. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have drugs for malaria prophylaxis (per local policy)?
66. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have forms or health cards to record the antenatal visit?

#### Interview with pregnant woman

Mark "yes" if the respondent answers correctly:

67. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you plan to have a trained health worker attend your birth?
68. YES \_\_\_\_\_ NO \_\_\_\_\_ What are the danger signs during pregnancy that require medical attention?<sup>1</sup>
69. YES \_\_\_\_\_ NO \_\_\_\_\_ When and where is your next prenatal visit?

If pregnant woman is at high-risk for any reason:

70. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you plan to seek further medical attention?
71. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you plan to have your baby at a hospital?

#### Interview with service provider

Mark "yes" if the respondent answers correctly:

72. YES \_\_\_\_\_ NO \_\_\_\_\_ What are the danger signs during pregnancy that require medical attention?<sup>1</sup>
73. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you refer high-risk pregnancies?
74. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a way of tracking high-risk pregnancies?
75. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you follow up pregnant women who do not return to prenatal sessions?

<sup>1</sup> Danger signs include swelling of hands and face, severe or prolonged dizziness, bleeding from vagina, sharp or constant abdominal pain, fever, vaginal odour or discharge.

### PHC service quality checklist 4: Safe delivery

This checklist is intended for use in supervision and monitoring of service quality as provided by clinic-based health workers, community-based health workers and traditional birth attendants. Although it is difficult to schedule observation of birth(s), performance assessment can be carried out through interviews after delivery or role play. This list includes some clinical tasks that traditional birth attendants and other peripheral workers do not routinely carry out. The checklist should be modified and simplified according to the local situation. It is recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

#### Prepare for delivery

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Sterilise needles, syringes, cord ties, scissors/razor blade, and gloves?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Prepare a clean birthing place?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess potential complications and emergencies?

#### Take labour history

Did the service provider:

8. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask when labour pains began?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about frequency of contractions?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask if and when bag of water broke?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about vaginal bleeding?
12. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about dark black/green discharge (meconium)?
13. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask when woman in labour last ate?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask when woman in labour last passed stool?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask when woman in labour last urinated and about problems urinating?
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about any medication or treatment taken?
17. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about risk factors if no information is available from prenatal records?<sup>1</sup>

#### Conduct physical examination and monitor woman throughout labour

Did the service provider:

- 1 High-risk factors include: 1) there is a history of complications during pregnancy or birth; 2) the woman is over \_\_\_ years or has had more than \_\_\_ pregnancies; or 3) the following conditions are present: spotting/bleeding during current or past pregnancies; burning on urination; foul smelling vaginal discharge during pregnancy; diabetes; cardiovascular problems; renal problems, circumcision; or previous injuries, especially to pelvis. Guidelines for defining high-risk and appropriate action should follow local norms.



18. YES \_\_\_ NO \_\_\_ Regularly take pulse?  
 19. YES \_\_\_ NO \_\_\_ Regularly take blood pressure?  
 20. YES \_\_\_ NO \_\_\_ Determine strength and length of contractions?  
 21. YES \_\_\_ NO \_\_\_ Determine position of foetus?  
 22. YES \_\_\_ NO \_\_\_ Palpate cervix to determine thickness, firmness, and openness?  
 23. YES \_\_\_ NO \_\_\_ Determine whether bag of water has broken?  
 24. YES \_\_\_ NO \_\_\_ Determine how far into the pelvis the presenting part has come (station)?  
 25. YES \_\_\_ NO \_\_\_ Determine the presenting part and its position?  
 26. YES \_\_\_ NO \_\_\_ Feel for prolapsed cord, placenta previa?  
 27. YES \_\_\_ NO \_\_\_ Regularly measure duration and frequency of contractions?  
 28. YES \_\_\_ NO \_\_\_ Regularly check foetal heart beat?  
 29. YES \_\_\_ NO \_\_\_ Regularly palpate abdomen to determine any changes in foetal position?  
 30. YES \_\_\_ NO \_\_\_ Observe perineum for crowning, opening of the vulva and/or rectum to indicate beginning of second stage of labour?  
 31. YES \_\_\_ NO \_\_\_ Regularly monitor blood loss?

#### Diagnose obstetric complications and emergencies

Did the service provider:

32. YES \_\_\_ NO \_\_\_ Diagnose dystocia if present?  
 33. YES \_\_\_ NO \_\_\_ Diagnose haemorrhage and shock if present?  
 34. YES \_\_\_ NO \_\_\_ Diagnose eclampsia if present?  
 35. YES \_\_\_ NO \_\_\_ Diagnose infection if present?  
 36. YES \_\_\_ NO \_\_\_ Diagnose cause of any maternal distress if present?  
 37. YES \_\_\_ NO \_\_\_ Diagnose cause of foetal distress if present?  
 38. YES \_\_\_ NO \_\_\_ Diagnose abnormal presentation of foetus if present?

#### Assist progress of labour

Did the service provider:

39. YES \_\_\_ NO \_\_\_ Tell woman not to bear down until fully dilated and effaced?  
 40. YES \_\_\_ NO \_\_\_ Encourage woman to urinate frequently?  
 41. YES \_\_\_ NO \_\_\_ Reposition woman in labour or increase her activities (e.g., walking) to help labour progress?  
 42. YES \_\_\_ NO \_\_\_ Administer low enema if bowel is full of stool and woman in labour cannot pass it (per local policy)?  
 43. YES \_\_\_ NO \_\_\_ Administer anaesthetic or analgesic (per local policy)?

#### Assist with normal delivery

Did the service provider:

44. YES \_\_\_ NO \_\_\_ Wash hands and mother's perineum?  
 45. YES \_\_\_ NO \_\_\_ Deliver head?  
 46. YES \_\_\_ NO \_\_\_ Support perineum to prevent tearing when foetal head is crowning?  
 47. YES \_\_\_ NO \_\_\_ Support foetus's head as it passes over perineum?  
 48. YES \_\_\_ NO \_\_\_ Feel if umbilical cord is around foetus's neck and slip it over head?  
 49. YES \_\_\_ NO \_\_\_ Suck mucus and/or meconium from infant's nose and mouth?  
 50. YES \_\_\_ NO \_\_\_ Deliver shoulders and body?



#### Seek help for obstetric problems and emergencies

Did the service provider:

51. YES \_\_\_ NO \_\_\_ For shock and haemorrhage place mother in trendelenberg position and treat (per local policy)?  
 52. YES \_\_\_ NO \_\_\_ Treat infection with antibiotics?  
 53. YES \_\_\_ NO \_\_\_ For eclamptic convulsions treat with anticonvulsants, protect physical safety of mother during convulsions, and immediately deliver infant?  
 54. YES \_\_\_ NO \_\_\_ Attempt manual manipulation of foetal head in cases of incomplete internal rotation?  
 55. YES \_\_\_ NO \_\_\_ Use appropriate technique to deliver foetus in abnormal position, such as footling, buttocks, face, brow, arm, shoulder presentations?  
 56. YES \_\_\_ NO \_\_\_ Provide other emergency care as indicated?  
 57. YES \_\_\_ NO \_\_\_ Refer obstetric problems and emergencies?  
 58. YES \_\_\_ NO \_\_\_ Perform episiotomy if indicated (per local policy)?  
 59. YES \_\_\_ NO \_\_\_ Assist with forceps, vacuum extraction, or symphysiotomy (if indicated and according to local policy)?

#### Provide immediate care for new-born

Did the service provider:

60. YES \_\_\_ NO \_\_\_ Establish respiration/loud cry?  
 61. YES \_\_\_ NO \_\_\_ Tie umbilical cord in three places with sterile ties?  
 62. YES \_\_\_ NO \_\_\_ Cut umbilical cord with sterile scissors or razor blade; leave two ties on infant's side?  
 63. YES \_\_\_ NO \_\_\_ Wrap in clean cloth and cover head to maintain warmth?  
 64. YES \_\_\_ NO \_\_\_ Determine APGAR score at 1 minute and 5 minutes after birth?  
 65. YES \_\_\_ NO \_\_\_ Give the infant to the mother to suckle?  
 66. YES \_\_\_ NO \_\_\_ Insert antibiotic eye ointment or silver nitrate drops into eyes within one hour after birth?  
 67. YES \_\_\_ NO \_\_\_ Immunize?  
 68. YES \_\_\_ NO \_\_\_ Administer Vitamin K?  
 69. YES \_\_\_ NO \_\_\_ Provide emergency care, as indicated?

#### Deliver placenta

Did the service provider:

70. YES \_\_\_ NO \_\_\_ Deliver placenta and examine for completeness?  
 71. YES \_\_\_ NO \_\_\_ Manually remove retained (partial or complete) placenta?  
 72. YES \_\_\_ NO \_\_\_ Establish breast feeding?

#### Monitor mother immediately after delivery

Did the service provider:

73. YES \_\_\_ NO \_\_\_ Regularly monitor blood pressure and pulse?  
 74. YES \_\_\_ NO \_\_\_ Massage uterus within 15 minutes after delivery and regularly thereafter?  
 75. YES \_\_\_ NO \_\_\_ Monitor blood loss?  
 76. YES \_\_\_ NO \_\_\_ Administer ergonovine 1 mg if mother is bleeding heavily (per local policy)?

#### Examine infant

Did the service provider:

77. YES \_\_\_ NO \_\_\_ Assess general appearance, alertness, tone?



78. YES \_\_\_ NO \_\_\_ Take temperature?  
 79. YES \_\_\_ NO \_\_\_ Measure respiratory rate?  
 80. YES \_\_\_ NO \_\_\_ Measure heart rate?  
 81. YES \_\_\_ NO \_\_\_ Weigh?  
 82. YES \_\_\_ NO \_\_\_ Examine head and feel for fontanelles and sutures?  
 83. YES \_\_\_ NO \_\_\_ Examine eyes for redness, discharge, jaundice, pallor?  
 84. YES \_\_\_ NO \_\_\_ Listen to chest to assess respiration and heartbeat?  
 85. YES \_\_\_ NO \_\_\_ Palpate abdomen and liver?  
 86. YES \_\_\_ NO \_\_\_ Examine genitals for normality, hernias?  
 87. YES \_\_\_ NO \_\_\_ Examine for muscle tone and Moro reflex?  
 88. YES \_\_\_ NO \_\_\_ Examine extremities and skeletal system for symmetry, movement, and broken or dislocated bones?  
 89. YES \_\_\_ NO \_\_\_ Inspect skin for sores, breaks?  
 90. YES \_\_\_ NO \_\_\_ Examine for birth defects?  
 91. YES \_\_\_ NO \_\_\_ Weigh?  
 92. YES \_\_\_ NO \_\_\_ Take temperature?  
 93. YES \_\_\_ NO \_\_\_ Refer infants with medical emergencies and birth defects?  
 94. YES \_\_\_ NO \_\_\_ Record labour and delivery information on labour charts?  
 95. YES \_\_\_ NO \_\_\_ Watch for and record first urination and bowel movement?  
 96. YES \_\_\_ NO \_\_\_ Give BCG and OPV (per local policy)?

#### Education after delivery

##### Aftercare:

Did the service provider:

97. YES \_\_\_ NO \_\_\_ Tell mother to keep her genital area clean and demonstrate how to wash her genitals?  
 98. YES \_\_\_ NO \_\_\_ Tell mother to return to clinic if gross bleeding occurs, or if lochia remains red or has foul smell, or if she develops fever or other unexpected symptoms?  
 99. YES \_\_\_ NO \_\_\_ Tell mother to refrain from intercourse for 4-6 weeks?  
 100. YES \_\_\_ NO \_\_\_ Tell mother to keep area around cord clean and dry?  
 101. YES \_\_\_ NO \_\_\_ Tell mother not to put anything (soil/salve) on the cord and not to remove the ties?  
 102. YES \_\_\_ NO \_\_\_ Demonstrate how to bathe and clean infant, especially around umbilical cord?  
 103. YES \_\_\_ NO \_\_\_ Tell mother to bring infant to clinic if any redness or discharge from cord occurs?

##### Breast feeding:

Did the service provider:

104. YES \_\_\_ NO \_\_\_ Instruct mothers in the health benefits of breast feeding?  
 105. YES \_\_\_ NO \_\_\_ Tell mother to feed colostrum?  
 106. YES \_\_\_ NO \_\_\_ Tell mother that normal milk flow will begin after 2-3 days?  
 107. YES \_\_\_ NO \_\_\_ Tell mother to breast feed infant frequently during the first few days?  
 108. YES \_\_\_ NO \_\_\_ Tell mother to use both breasts, feeding from one until it is empty, then from the other?  
 109. YES \_\_\_ NO \_\_\_ Tell mother to start feeding with the breast that is not the breast she started feeding from last time?  
 110. YES \_\_\_ NO \_\_\_ Tell mother to continue breast feeding when she or infant is ill?

111. YES \_\_\_ NO \_\_\_ Tell mother to keep nipples clean and dry to prevent cracking?  
 112. YES \_\_\_ NO \_\_\_ Demonstrate how to express breast milk to relieve congestion and prevent engorgement?  
 113. YES \_\_\_ NO \_\_\_ Demonstrate how to position infant's mouth around areola for breast feeding?  
 114. YES \_\_\_ NO \_\_\_ Tell mother to return if the infant has problems nursing?

##### Well-child care:

Did the service provider:

115. YES \_\_\_ NO \_\_\_ Tell mother about child immunization?  
 116. YES \_\_\_ NO \_\_\_ Tell mother when to return for first postpartum visit and for infant's first well-child visit?  
 117. YES \_\_\_ NO \_\_\_ Verify that the mother understands warning signs for her and/or her infant to return to clinic?  
 118. YES \_\_\_ NO \_\_\_ Verify that mother knows when to return for first postpartum visit and for infant's first well-child visit?  
 119. YES \_\_\_ NO \_\_\_ Ask mother if she has any questions?

##### Supplies

120. YES \_\_\_ NO \_\_\_ Do you have cord ties?  
 121. YES \_\_\_ NO \_\_\_ Do you have a razor or a pair of scissors?  
 122. YES \_\_\_ NO \_\_\_ Do you have gloves?  
 123. YES \_\_\_ NO \_\_\_ Do you have a watch with a second hand to take pulse?  
 124. YES \_\_\_ NO \_\_\_ Do you have a stethoscope?  
 125. YES \_\_\_ NO \_\_\_ Do you have a blood pressure cuff?  
 126. YES \_\_\_ NO \_\_\_ Do you have antibiotics?  
 127. YES \_\_\_ NO \_\_\_ Do you have anticonvulsants?  
 127. YES \_\_\_ NO \_\_\_ Do you have needles?  
 128. YES \_\_\_ NO \_\_\_ Do you have syringes?



## PHC service quality checklist 5: Postnatal care

This checklist is intended for use in supervision and monitoring of postnatal care provided by clinic-based health workers, community-based health workers, and traditional birth attendants. This list is comprehensive and includes some clinical tasks that traditional birth attendants and other peripheral workers do not routinely carry out. The list should be modified and simplified according to the local situation. It is recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

### Medical history

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother when and where she delivered?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother the outcome of the delivery?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about problems during delivery?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother about vaginal bleeding?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother about foul smelling vaginal discharge?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother if she feels pain or tenderness in the abdomen or breasts?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother if she's had a fever?
12. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother if she is taking any medications, including contraceptives?
13. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother what she is eating?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother about the infant's eating habits?

### Physical examination

*Mother:*

Did the service provider:

15. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine the abdomen for swelling, condition of caesarean incision, and to determine the size and firmness of the uterus?
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine the genitals for swelling, discharge, bleeding, tears, fistula, and episiotomy repair?
17. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine the breasts for cracked nipples, engorgement, abscess?
18. YES \_\_\_\_\_ NO \_\_\_\_\_ Take pulse?
19. YES \_\_\_\_\_ NO \_\_\_\_\_ Take blood pressure?
20. YES \_\_\_\_\_ NO \_\_\_\_\_ Weigh the mother?
21. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine eyes for signs of anaemia?



*Child (first postnatal visit):*

Did the service provider:

22. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess vital signs?
23. YES \_\_\_\_\_ NO \_\_\_\_\_ Measure height and head circumference?
24. YES \_\_\_\_\_ NO \_\_\_\_\_ Weigh child?
25. YES \_\_\_\_\_ NO \_\_\_\_\_ Monitor child's growth with growth chart?
26. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine head and fontanelle?
27. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess eyes (for opacities, jaundice, infection)?
28. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess respiration (rate, retraction)?
29. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess heart (rate, murmur)?
30. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine skin (pallor, jaundice, petechiae, infection)?
31. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine extremities and skeletal system for symmetry, movement, and broken bones?
32. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine umbilicus?
33. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess general alertness?
34. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess suction reflex?
35. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess Moro reflex?
36. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess response to brightness?
37. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess response to sound?

*Documentation:*

Did the service provider:

38. YES \_\_\_\_\_ NO \_\_\_\_\_ Record findings of history and physical examination on health record?

### Treatment, routine preventive services, and referral

*Mother:*

Did the service provider:

39. YES \_\_\_\_\_ NO \_\_\_\_\_ Provide iron and/or folic acid tablets (per local policy)?
40. YES \_\_\_\_\_ NO \_\_\_\_\_ Provide nutrition supplements (per local policy)?
41. YES \_\_\_\_\_ NO \_\_\_\_\_ Provide malaria chemoprophylaxis (per local policy)?
42. YES \_\_\_\_\_ NO \_\_\_\_\_ Give other therapeutic medications to treat medical conditions as appropriate?
43. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer maternal postpartum cases requiring special treatment?

*Child:*

Did the service provider:

44. YES \_\_\_\_\_ NO \_\_\_\_\_ Give BCG vaccination or verify that child received vaccination at birth?
45. YES \_\_\_\_\_ NO \_\_\_\_\_ Give first DPT and OPV (per local policy)?
46. YES \_\_\_\_\_ NO \_\_\_\_\_ If the child is malnourished, refer for nutritional counselling?
47. YES \_\_\_\_\_ NO \_\_\_\_\_ Refer the child for all physical conditions which need medical attention?

### Education

*Breast feeding:*

Did the service provider:

48. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to feed infant with breast milk only, for the first 4-6 months?
49. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to eat extra food while she is breast feeding?
50. YES \_\_\_\_\_ NO \_\_\_\_\_ Recommend locally available protein-rich foods?
51. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to breast feed even if she and/or infant is ill?



**Child-spacing:**

Did the service provider:

52. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to refrain from intercourse for 4-6 weeks after delivery?
53. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain that breast feeding will not prevent her from getting pregnant even if her periods have not begun?
54. YES \_\_\_\_\_ NO \_\_\_\_\_ Discuss family planning with the mother and tell her how she can obtain child spacing services?

**Well child care:**

Did the service provider:

55. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother about enrolling infant in well-child clinic?
56. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother when and where to enrol child in clinic?
57. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother when and where to take infant for first or further immunizations?
58. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that mother understands key messages?

**General:**

Did the service provider:

59. YES \_\_\_\_\_ NO \_\_\_\_\_ Provide counselling for specific medical problem(s)?
60. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother when to return for next postpartum visit, if indicated?
61. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that mother understood key messages?

**Supplies**

Ask the service provider about the following supplies:

62. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a working scale to weigh the mother?
63. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a working scale to weigh the child?
64. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a watch or time piece with second hand to measure pulse?
65. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a stethoscope and blood pressure cuff?
66. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have BCG, OPV, and DPT vaccines?
67. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have iron tablets (per local policy)?

**Interview with mother**

Mark "yes" if the respondent answers correctly:

68. YES \_\_\_\_\_ NO \_\_\_\_\_ When should your baby receive his or her next vaccination?
69. YES \_\_\_\_\_ NO \_\_\_\_\_ For how long will you breast feed?
70. YES \_\_\_\_\_ NO \_\_\_\_\_ What will you do to space your births?
71. YES \_\_\_\_\_ NO \_\_\_\_\_ Is your child growing normally?

**Interview with service provider**

Mark "yes" if the respondent answers correctly:

72. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you maintain records that identify recent mothers and infants for postnatal care?
73. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you educate mothers about postpartum care during prenatal care and delivery?
74. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you discuss family planning during the postpartum visit?



## PHC service quality checklist

### 6: Family planning services

This checklist is intended for use in the observation of delivery of family planning services. Before using it, the national treatment protocol should be reviewed in order to adapt the tool to the local situation, if necessary. It is also recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

**Medical and reproductive history (new clients)**

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask the client how old she is?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about number, spacing, and outcome of pregnancies?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about previous use of family planning methods?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about reasons for stopping or switching previous methods?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about heart disease?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about liver disease?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about high blood pressure?
12. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about history of Pelvic Inflammatory Disease?
13. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about history of suspected or confirmed venereal disease?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about history of blood clots or thromboembolism?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask if she is breast feeding?
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about date of last menstrual period?

**Physical examination**

Did the service provider:

17. YES \_\_\_\_\_ NO \_\_\_\_\_ Take blood pressure?
18. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine breast for lumps?
19. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine patient for signs of anaemia?

**Determine method**

Did the service provider:

20. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask if and when the client and her spouse would like to have children?
21. YES \_\_\_\_\_ NO \_\_\_\_\_ Describe contraceptive options to the client?
22. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about the client's preference?
23. YES \_\_\_\_\_ NO \_\_\_\_\_ Offer to discuss child spacing and methods with spouse or family?
24. YES \_\_\_\_\_ NO \_\_\_\_\_ Recommend a method that was free of contra-indications for this client?



25. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that the client is comfortable with the recommended method?
26. YES \_\_\_\_\_ NO \_\_\_\_\_ If necessary, refer the client to a doctor or midwife?

**For follow-up cases**

Did the service provider:

27. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify correct usage?
28. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about side effects?
29. YES \_\_\_\_\_ NO \_\_\_\_\_ Give advice about managing side effects?

**Counselling (for all)**

Did the service provider:

30. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the correct usage of the selected method?
31. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain possible minor side effects of the selected method?
32. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain how to manage side effects at home?
33. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain major side effects which require medical attention?
34. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain where and when to go for resupplies?
35. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain where and when to go for routine follow-up?
36. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain how to discontinue the method when pregnancy is desired?
37. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that the client understands key messages?
38. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask the client if she has any questions?

**Supplies**

Ask the service provider about the following supplies:

39. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a blood pressure cuff and stethoscope?
40. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a supply of oral contraceptives?
41. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a supply of IUDs?
42. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a supply of injectable contraceptives?
43. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have a supply of implants?

**Exit interview with client**

Mark "yes" if the respondent answers correctly:

44. YES \_\_\_\_\_ NO \_\_\_\_\_ How do you use the contraceptive you received today?
45. YES \_\_\_\_\_ NO \_\_\_\_\_ What are the possible side effects?
46. YES \_\_\_\_\_ NO \_\_\_\_\_ Where can you get more supplies?
47. YES \_\_\_\_\_ NO \_\_\_\_\_ When will you come back for a check up?

**Service provider interview**

Mark "yes" if the respondent answers correctly:

48. YES \_\_\_\_\_ NO \_\_\_\_\_ Under what conditions should you refrain from prescribing oral contraceptives?
49. YES \_\_\_\_\_ NO \_\_\_\_\_ Under what conditions should you refrain from prescribing the IUD?
50. YES \_\_\_\_\_ NO \_\_\_\_\_ Under what conditions should you refrain from prescribing injectable?
51. YES \_\_\_\_\_ NO \_\_\_\_\_ Under what conditions should you refrain from prescribing implants?



## PHC service quality checklist

### 7: Breast feeding<sup>1 2 3 4 5 6 7</sup>

This checklist is intended for use in the observation of service delivery for promotion of breast feeding. Before using it, the national treatment protocol should be reviewed in order to adapt the tool to the local situation, if necessary. It is also recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

**Medical history**

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about the mother's knowledge, attitudes and beliefs about breast feeding?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about previous use of breast feeding with each child born in the last five years?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about duration of previous breast feeding and reasons for stopping?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about use of medications and alcohol?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about any current illnesses that might affect breast feeding?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about socio-economic status and dietary habits and intake?

**Breast feeding education and counselling****Skills Training:**

Did the service provider:

11. YES \_\_\_\_\_ NO \_\_\_\_\_ Instruct mothers on the health benefits to mother and child of breast feeding?
12. YES \_\_\_\_\_ NO \_\_\_\_\_ Instruct mothers on the financial benefits of breast feeding?
13. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to feed colostrum (begin breast feeding as soon as possible)?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother that normal milk flow will begin after 2-3 days?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to breast feed infant frequently during the first few days?

1 PHC Management Advancement Programme, Module 5, User's guide

2 PRICOR Thesaurus, vol. II, p. 232, 253

3 WHO, Indicators for assessing breast feeding practices, p. 4

4 Mothercare: Interventions to improve maternal and neonatal nutrition, Working Paper # 4, November 1990 (John Snow, Inc)

5 USAID, Maternal and child health in Bolivia: Report on the in-depth DHS Survey in Bolivia 1989, p. 49

6 USAID, Media promotion of breast feeding: A decade's experience, Nutrition Communication Project, p. 45

7 Breast feeding for child survival strategy, USAID, May 1990 p. 29-30, 38



16. YES \_\_\_ NO \_\_\_ Explain the importance of feeding breast milk only, for the first 4-6 months?
17. YES \_\_\_ NO \_\_\_ Tell mother to use both breasts, feeding from one until it is empty, then from the other?
18. YES \_\_\_ NO \_\_\_ Tell mother to start feeding with the breast that is not the breast she started feeding from the last time?
19. YES \_\_\_ NO \_\_\_ Tell mother to continue breast feeding when she or infant is ill (diarrhoea, infection)?
20. YES \_\_\_ NO \_\_\_ Tell mother to keep nipples clean and dry to prevent cracking?
21. YES \_\_\_ NO \_\_\_ Tell mother to avoid using soap on nipples and to air breasts?
22. YES \_\_\_ NO \_\_\_ Demonstrate how to express breast milk to relieve congestion and prevent engorgement?
23. YES \_\_\_ NO \_\_\_ Demonstrate how to position infant's mouth around areola for breast feeding?
24. YES \_\_\_ NO \_\_\_ Tell mother to return if the infant has problems nursing?
25. YES \_\_\_ NO \_\_\_ Counsel on family planning methods with least effect on quantity and quality of breast milk (spermicides, barrier methods, progesterone only pills or injections, IUDs or abstinence)?
26. YES \_\_\_ NO \_\_\_ Teach ways to increase contraceptive benefits of breast feeding (e.g., exclusive and frequent demand feeding for the first six months)?
27. YES \_\_\_ NO \_\_\_ Use appropriate health education techniques and materials?
28. YES \_\_\_ NO \_\_\_ Encourage breast feeding among HIV positive women, if appropriate?
29. YES \_\_\_ NO \_\_\_ Explain that frequent bowel movements in the new-born indicate good milk intake and infrequent stools in the first few weeks could be a warning sign?
30. YES \_\_\_ NO \_\_\_ Ask the mother to repeat key messages?
31. YES \_\_\_ NO \_\_\_ Ask the mother if she has any questions?

**Nutritional messages:**

Did the service provider:

32. YES \_\_\_ NO \_\_\_ Tell mother to increase her total food and liquid intake or to balance her food intake and activities during lactation?
33. YES \_\_\_ NO \_\_\_ Explain to mother the administration schedule for nutrition supplements, iron and/or folic acid tablets prescribed or distributed for home administration?
34. YES \_\_\_ NO \_\_\_ Warn mothers of dangers of alcohol and drugs?
35. YES \_\_\_ NO \_\_\_ Tell mother about specific, nutritious, appropriate local foods (protein rich)?
36. YES \_\_\_ NO \_\_\_ Discourage dietary taboos that restrict important foods/food groups for lactating women?
37. YES \_\_\_ NO \_\_\_ Encourage those cultural practices that promote consumption of important foods for lactating women?
38. YES \_\_\_ NO \_\_\_ Discuss other feeding options with the mother?

**Weaning:**

Did the service provider:

39. YES \_\_\_ NO \_\_\_ Explain the importance of introducing complementary foods during a two-month transitional period (i.e., months five and six)?
40. YES \_\_\_ NO \_\_\_ Explain that children should be breastfed (not exclusively) for at least one year and preferably for up to 2 years of age or beyond.
41. YES \_\_\_ NO \_\_\_ Demonstrate preparation of weaning foods?

**Exit interview with mother**

Mark "yes" if the respondent answers correctly.

42. YES \_\_\_ NO \_\_\_ For how long will you breast feed?
43. YES \_\_\_ NO \_\_\_ Do you know the proper position to breast feed your child?
44. YES \_\_\_ NO \_\_\_ Do you know how to care for your breasts?
45. YES \_\_\_ NO \_\_\_ Do you know what/how much you should be eating during the lactation period?

**Interview with service provider**

Mark "yes" if the respondent answers correctly.

46. YES \_\_\_ NO \_\_\_ Explain the length of time that mothers should breast feed?
47. YES \_\_\_ NO \_\_\_ Explain the health and economic benefits of breast feeding?



## PHC service quality checklist 9: Immunization

This checklist is intended for use in the observation of service delivery for immunization. Before using it, the national treatment protocol should be reviewed in order to adapt the tool to the local situation if necessary. It is also recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

### Identification of needed vaccinations

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Review health records to determine which immunizations are needed today?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Review mother's health record or ask mother whether she has received tetanus toxoid immunization?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Review vaccination status of other children in the family?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Recommend vaccination even if the child is sick?

### Preparation and care of vaccine

Did the service provider:

9. YES \_\_\_\_\_ NO \_\_\_\_\_ Check the label for the correct vaccine and to be sure the vaccine has not expired?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Load the syringe without contamination?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Keep the vaccine on ice and covered during the session?

### Vaccination technique

Did the service provider:

12. YES \_\_\_\_\_ NO \_\_\_\_\_ Prepare the area of injection?
13. YES \_\_\_\_\_ NO \_\_\_\_\_ Use a sterile needle for each injection?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Use a sterile syringe for each injection?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Apply the vaccine at the right level? (BCG = dermal layer, measles = subcutaneous layer, DPT/TT = muscle)
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Properly dispose of the needle and syringe?
17. YES \_\_\_\_\_ NO \_\_\_\_\_ Was the child given all vaccinations needed today?
18. YES \_\_\_\_\_ NO \_\_\_\_\_ If the mother required TT, did the service provider vaccinate her or arrange for vaccination?

### Documentation

Did the service provider:

19. YES \_\_\_\_\_ NO \_\_\_\_\_ Record the vaccination on the child's health card?
20. YES \_\_\_\_\_ NO \_\_\_\_\_ Record the vaccination in the appropriate health centre record(s)?



### EPI education

Did the service provider:

21. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell the mother which vaccinations were given during this visit?
22. YES \_\_\_\_\_ NO \_\_\_\_\_ Inform the mother that side effects, such as fever and pain, are possible?
23. YES \_\_\_\_\_ NO \_\_\_\_\_ For BCG vaccination, explain that a scab will form?
24. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother where to go if she or the child should have a severe reaction to the vaccination?
25. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain the importance of completing the vaccination series?
26. YES \_\_\_\_\_ NO \_\_\_\_\_ If DPT #3 has been administered, stress the importance of returning for measles vaccination?
27. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain that the child can be immunized even if she/he is ill?
28. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell when to come back for the next immunization for mother or child?
29. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother to encourage other women and their children to be vaccinated?
30. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that mother understands key messages?
31. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother if she has any questions?

### Maintenance of cold chain and supplies

Observe the facility or ask health worker to determine the following:

32. YES \_\_\_\_\_ NO \_\_\_\_\_ Is the refrigerator working today?
33. YES \_\_\_\_\_ NO \_\_\_\_\_ Is there a thermometer or cold chain monitor in the refrigerator?
34. YES \_\_\_\_\_ NO \_\_\_\_\_ Is there a temperature log?
35. YES \_\_\_\_\_ NO \_\_\_\_\_ Is temperature recorded regularly according to the local schedule?
36. YES \_\_\_\_\_ NO \_\_\_\_\_ Was the registered temperature between 0 and 8 degrees (C) at all times during the last month?
37. YES \_\_\_\_\_ NO \_\_\_\_\_ Are all vials in storage unopened?
38. YES \_\_\_\_\_ NO \_\_\_\_\_ Were vaccines sufficient during the last month?
39. YES \_\_\_\_\_ NO \_\_\_\_\_ Were needles and syringes sufficient during the last month?
40. YES \_\_\_\_\_ NO \_\_\_\_\_ Were vaccination cards sufficient during the last month?
41. YES \_\_\_\_\_ NO \_\_\_\_\_ For outreach sessions, were vaccines transported in cold boxes with ice packs?

### Exit interview with mother or caretaker

Mark "yes" if the respondent answers correctly:

42. YES \_\_\_\_\_ NO \_\_\_\_\_ What immunization(s) did you or your child receive today?
43. YES \_\_\_\_\_ NO \_\_\_\_\_ When should you return to the health centre for your next immunization?

### Interview with service provider

Mark "yes" if the service provider answers correctly:

44. YES \_\_\_\_\_ NO \_\_\_\_\_ At what age should a child receive BCG vaccine?
45. YES \_\_\_\_\_ NO \_\_\_\_\_ At what age should a child receive DPT vaccine?
46. YES \_\_\_\_\_ NO \_\_\_\_\_ At what age should a child receive Measles vaccine?
47. YES \_\_\_\_\_ NO \_\_\_\_\_ At what age should a child receive OPV vaccine?
48. YES \_\_\_\_\_ NO \_\_\_\_\_ Should you vaccinate a child if she/he is ill?



## PHC service quality checklist

### 11: Diarrhoeal disease control/oral rehydration therapy

This checklist is intended for use in the observation of service delivery for oral rehydration therapy. Before using it, the national treatment protocol should be reviewed in order to adapt the tool to the local situation if necessary. It is also recommended that you review the checklist carefully before using it to be sure that you understand the questions and know how to use the form. For observation of service delivery, mark "yes" if the service provider carries out these activities during service delivery. For interview questions, mark "yes" if the respondent answers correctly.

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

#### Medical history

Did the service provider check for:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Duration of diarrhoea?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Consistency of stools?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Frequency of stools?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Presence of blood and/or mucus in stools?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Presence of vomiting?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Fever?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Home treatments?

#### Physical examination

Did the service provider:

12. YES \_\_\_\_\_ NO \_\_\_\_\_ Assess general status (alert or lethargic)?
13. YES \_\_\_\_\_ NO \_\_\_\_\_ Pinch skin?<sup>1</sup>
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Weigh child?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Determine nutritional status to be sure the child is not severely malnourished?
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Take temperature?

#### Classification and treatment

Did the service provider:

17. YES \_\_\_\_\_ NO \_\_\_\_\_ Determine the degree of dehydration (none, moderate, severe)?
18. YES \_\_\_\_\_ NO \_\_\_\_\_ Prescribe safe ORS or cereal-based ORT?
19. YES \_\_\_\_\_ NO \_\_\_\_\_ Recommend safe home treatment with ORS, or cereal-based ORT?
20. YES \_\_\_\_\_ NO \_\_\_\_\_ Refrain from using antibiotics, except when stools contain blood or mucus?
21. YES \_\_\_\_\_ NO \_\_\_\_\_ Refrain from using anti-diarrhoeals?

1 Health workers should also look for sunken fontanelle and examine the mucus membrane. These are omitted here because they cannot be observed, however they could be included if the health worker is asked to describe what he or she is doing.



22. YES \_\_\_\_\_ NO \_\_\_\_\_ If the child is dehydrated, administer ORS or cereal-based ORT immediately or refer the child to a nearby centre?
23. YES \_\_\_\_\_ NO \_\_\_\_\_ Give sufficient amount of ORS solution?
24. YES \_\_\_\_\_ NO \_\_\_\_\_ Plan to reassess child's hydration status after an appropriate interval?
25. YES \_\_\_\_\_ NO \_\_\_\_\_ Rehydrate with intravenous fluid or naso-gastric tube if dehydration is severe?
26. YES \_\_\_\_\_ NO \_\_\_\_\_ Try ORS solution, if IV or NG tube are not available within 30 minutes of facility?
28. YES \_\_\_\_\_ NO \_\_\_\_\_ NG treatment, if child cannot drink, refer/evacuate for IV?

#### ORT education

Did the service provider:

29. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother to give extra fluids during diarrhoea?
30. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother how to prepare ORS solution?
31. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother how much ORS solution to give and how often to give it?
32. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother about appropriate feeding practices during and after diarrhoea?
33. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother about at least three signs of dehydration?<sup>1</sup>
34. YES \_\_\_\_\_ NO \_\_\_\_\_ Tell mother about at least two danger signs that indicate that she should bring the child to health centre?<sup>2</sup>
35. YES \_\_\_\_\_ NO \_\_\_\_\_ Show mother how to prepare ORS solution?
36. YES \_\_\_\_\_ NO \_\_\_\_\_ Show mother how to administer ORS solution?
37. YES \_\_\_\_\_ NO \_\_\_\_\_ Verify that mother understands key information?
38. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask mother if she has any questions?

#### Essential supplies for ORT

39. YES \_\_\_\_\_ NO \_\_\_\_\_ Was the supply of ORS packets adequate for the past month?
40. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have the materials necessary (cup, spoon, water) to prepare and administer ORS solution?

#### Exit interview with the child's mother/caretaker

Mark "yes" if the respondent answers correctly:

41. YES \_\_\_\_\_ NO \_\_\_\_\_ How do you make ORS solution?
42. YES \_\_\_\_\_ NO \_\_\_\_\_ How much ORS solution will you give your child?
43. YES \_\_\_\_\_ NO \_\_\_\_\_ How often will you give ORS solution?
44. YES \_\_\_\_\_ NO \_\_\_\_\_ What danger signs indicate that you should bring your child back to the health centre?

#### Interview with service provider

Mark "yes" if the respondent answers correctly:

45. YES \_\_\_\_\_ NO \_\_\_\_\_ When you examined the child for dehydration, what physical signs did you look for?<sup>1</sup>
46. YES \_\_\_\_\_ NO \_\_\_\_\_ What was the child's degree of dehydration?

1 Signs for dehydration; 1) lethargy; 2) absence of tears while crying; 3) pinched skin retracts slow  
 2 Danger signs : 1) many watery stools; 2) repeated vomiting; 3) very thirsty; 4) eating or drinking poor  
 5) fever; 6) blood in stool; 7) child shows signs of dehydration.



## PHC service quality checklist

### 15: Sexually transmitted diseases and HIV/AIDS

This checklist is intended for use in the observation of STD-related services which are delivered by health care service providers in STD clinics, PHC centres, MCH facilities or FP clinics. It is expected that providers will have different levels of training and expertise, and have varied access to resources such as clinical, diagnostic, and treatment services. Therefore, national management and treatment protocols should be reviewed in order to adapt the tool to the local situation. PHC managers can use the checklist as a supervision tool to determine whether services are delivered according to established norms. Because of the confidential nature of the questions, supervisors may want to observe simulated visits rather than actual visits, or to use an interview with the health worker rather than observation.

NOTE: Questions included in this checklist were constructed from existing STD/HIV/AIDS medical and management protocols developed by WHO<sup>1</sup> from AIDS prevention programme materials<sup>2,3</sup> and from related studies on counselling and education<sup>4,5,6</sup> and drawn from the reported field experiences of relevant clinicians and researchers.<sup>7</sup>

1. \_\_\_\_\_ Health facility
2. \_\_\_\_\_ Service provider
3. \_\_\_\_\_ Observer/supervisor
4. \_\_\_\_\_ Date

#### Medical history

This section can be used to assess the service provider who takes the medical history. The purpose of taking the medical history is to alert the provider to possible types of infection associated with STDs.

Did the service provider:

5. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about symptoms of infection such as prolonged fever?  
     YES \_\_\_\_\_ NO \_\_\_\_\_ unexplained weight loss?  
     YES \_\_\_\_\_ NO \_\_\_\_\_ chronic diarrhoea?  
     YES \_\_\_\_\_ NO \_\_\_\_\_ persistent cough?  
     YES \_\_\_\_\_ NO \_\_\_\_\_ visual symptoms?

- 1 World Health Organization: *Management of patients with sexually transmitted diseases*. WHO Technical report series 810, Geneva, World Health Organization, 1991.
- 2 Lamptey, P, Plot, P. *The handbook for AIDS prevention in Africa*. Durham, NC, Family Health International, 1990.
- 3 World Health Organization, *AIDS prevention: guidelines for MCH/FP Programme managers*. Global Programme on AIDS, Geneva, World Health Organization, 1990.
- 4 Andrist, L., *Taking a sexual history and educating clients about safe sex*. Nursing Clinics of North America, Dec. 23(4):959-73 (1988).
- 5 Stone, D. & Kaleeba, N., *Counselling and AIDS. The handbook for AIDS prevention in Africa*, 181-190, Durham, NC, Family Health International, 1990.
- 6 World Health Organization: *Management of patients with sexually transmitted diseases*. WHO technical report series 810, 61-7, Geneva, World Health Organization, 1991.
- 7 Bernham, G., Department of International Health, Johns Hopkins School of Public Health; Brady, W., PA-C, MPH Division of STD/HIV prevention, Centers for Disease Control; Millar, M, University Research Corporation, Training programme as part of WHO Global Programme on AIDS; Neill, M., Training and Materials Development Specialist, CDC; Alwood, C., NP, AIDS Clinic, Johns Hopkins Hospital.



- YES \_\_\_\_\_ NO \_\_\_\_\_ genital ulcers?
- YES \_\_\_\_\_ NO \_\_\_\_\_ urethral/vaginal discharge?
- YES \_\_\_\_\_ NO \_\_\_\_\_ painful or difficult urination?
- YES \_\_\_\_\_ NO \_\_\_\_\_ mouth sores?
- YES \_\_\_\_\_ NO \_\_\_\_\_ night sweats?
6. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about previous exposure to STDs?
7. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about treatments administered?
8. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about follow-up and compliance with treatment?
9. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about treatment of partner(s)?
10. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask whether client has ever had transfusion of blood or blood products?
11. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask whether client has ever been exposed to non-sterile instruments such as needles or knives?
12. YES \_\_\_\_\_ NO \_\_\_\_\_ If applicable, take the medical history in private?

#### Sexual history

The purpose of taking a sexual history is to alert the service provider to possible risk behaviours associated with STDs. Due to the sensitive nature of the subject matter, the provider should be careful to explain the reason for obtaining this information and to assure the client of the confidentiality of his/her responses.

Did the service provider:

13. YES \_\_\_\_\_ NO \_\_\_\_\_ Explain why taking a sexual history is useful in identifying a condition?
14. YES \_\_\_\_\_ NO \_\_\_\_\_ Assure the client that all responses will remain confidential?
15. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask whether client is currently sexually active?
16. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask whether client is active with more than one partner?
17. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask about types of sexual practice?
18. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask whether condoms are used during sexual activity?
19. YES \_\_\_\_\_ NO \_\_\_\_\_ Ask client for questions or concerns regarding his/her sexual activity?
20. YES \_\_\_\_\_ NO \_\_\_\_\_ Take the sexual history in private?

#### Physical examination

This section can be used to assess how the physical examination is conducted given that proper equipment such as an examination table, gloves, and speculum, may not be available.

Did the service provider:

21. YES \_\_\_\_\_ NO \_\_\_\_\_ If client felt feverish, take temperature?
22. YES \_\_\_\_\_ NO \_\_\_\_\_ Weigh client?
23. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine oral cavity for signs of infection e.g., thrush?
24. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine eyes (infant) for conjunctiva?
25. YES \_\_\_\_\_ NO \_\_\_\_\_ Check for swollen glands in the neck, armpit, or groin?
26. YES \_\_\_\_\_ NO \_\_\_\_\_ For women, check for lower abdominal pain/tenderness?
27. YES \_\_\_\_\_ NO \_\_\_\_\_ For women, examine cervix, vagina, and labia?
28. YES \_\_\_\_\_ NO \_\_\_\_\_ For men, examine penis base, and scrotum, and retract foreskin?
29. YES \_\_\_\_\_ NO \_\_\_\_\_ Examine anus for ulcers or warts?
30. YES \_\_\_\_\_ NO \_\_\_\_\_ Check for possible skin infection?
31. YES \_\_\_\_\_ NO \_\_\_\_\_ Take the necessary precautions to minimise exposure to blood and body fluids during the examination?



**Case identification/treatment/referral**

Guidelines for diagnosis, testing, treatment and referral of priority diseases or syndromes will need to be reviewed in order to correctly identify and treat cases.

*With appropriate laboratory support:*

Did the service provider:

32. YES \_\_\_ NO \_\_\_ Practise universal precautions before and after drawing a sample, e.g., blood, urethral/vaginal discharge?
33. YES \_\_\_ NO \_\_\_ Draw the sample according to protocol?
34. YES \_\_\_ NO \_\_\_ Take the recommended amount of specimen?
35. YES \_\_\_ NO \_\_\_ Seal and label container of specimen?
36. YES \_\_\_ NO \_\_\_ Complete record of transfer to laboratory?
37. YES \_\_\_ NO \_\_\_ Transfer specimen to laboratory within prescribed time limit?

*After testing is complete or in the absence of laboratory support.<sup>1</sup>*

Did the service provider:

38. YES \_\_\_ NO \_\_\_ Identify disease according to established guidelines?
39. YES \_\_\_ NO \_\_\_ Inform the client of the diagnosis?
40. YES \_\_\_ NO \_\_\_ Administer/prescribe appropriate treatment according to established treatment guidelines?
41. YES \_\_\_ NO \_\_\_ Instruct client on treatment compliance and when to return?
42. YES \_\_\_ NO \_\_\_ Make the appropriate referral according to established guidelines?
43. YES \_\_\_ NO \_\_\_ Record the case according to established guidelines?
44. YES \_\_\_ NO \_\_\_ Ask for questions from the client?

**Counselling client on prevention of STD and HIV/AIDS**

Counselling the client about STDs is intended to prevent behaviours that lead to infection and to provide support to those who are infected or are caring for someone who is infected. This section can be used if the medical/sexual history indicates that the client may be at risk for STD.

Did the service provider:

45. YES \_\_\_ NO \_\_\_ Inform the client about the ways in which STDs can be transmitted within that community?
46. YES \_\_\_ NO \_\_\_ Discuss some basic ways to prevent sexual transmission of STDs?
47. YES \_\_\_ NO \_\_\_ Instruct the client on the correct and consistent use of condoms?
48. YES \_\_\_ NO \_\_\_ Teach client how to recognise some common symptoms of STDs and understand the importance of getting correct treatment?
49. YES \_\_\_ NO \_\_\_ Explain that some STDs are not curable (HIV infection; human papillomavirus)?
50. YES \_\_\_ NO \_\_\_ Explain that behaviours that may lead to STD also put client at risk of HIV infection?
51. YES \_\_\_ NO \_\_\_ Provide the client with any available brochures or handouts?
52. YES \_\_\_ NO \_\_\_ Use available educational materials to instruct the client?
53. YES \_\_\_ NO \_\_\_ Ask for questions from the client?

<sup>1</sup> When laboratory support is unavailable, the identification of STD cases may be based on the client's medical/sexual history and physical examination alone.

**Pre- and post- test counselling for HIV antibody testing or STD laboratory testing**

This section is applicable only if laboratory testing is indicated for the client and adequate laboratory protocols and facilities are available.

Did the service provider:

54. YES \_\_\_ NO \_\_\_ Explain the testing procedure to the client?
55. YES \_\_\_ NO \_\_\_ Assure the client of the confidentiality of his/her test results?
56. YES \_\_\_ NO \_\_\_ Discuss the meaning of a negative test result?
57. YES \_\_\_ NO \_\_\_ Discuss the meaning of a positive test result?
58. YES \_\_\_ NO \_\_\_ Discuss available treatment of conditions, if any?
59. YES \_\_\_ NO \_\_\_ Discuss the importance of notifying a partner?
60. YES \_\_\_ NO \_\_\_ Discuss the possibility that the infected client or partner may not yet have symptoms or show signs of being infected?
61. YES \_\_\_ NO \_\_\_ Explain about some common symptoms which may occur as a result of infection and should be reported to the provider?

*For HIV-positive women:*

Did the service provider:

62. YES \_\_\_ NO \_\_\_ Advise client of the risks to a foetus/infant?
63. YES \_\_\_ NO \_\_\_ Give contraceptive advice or, if desired, direct the client to family planning services?
64. YES \_\_\_ NO \_\_\_ Suggest any prenatal or postnatal care that may be needed?

*For mothers of HIV-infected newborns:*

Did the service provider:

65. YES \_\_\_ NO \_\_\_ Explain that the child could have many years of normal life?
66. YES \_\_\_ NO \_\_\_ Encourage breast feeding and growth monitoring of the child?
67. YES \_\_\_ NO \_\_\_ Recommend complete immunizations except BCG if the child shows clinical signs of HIV infection?

**Counselling client with diagnosed STD**

In this section, counselling is intended to provide support to clients whose laboratory testing, if available, and clinical findings indicate STD infection.

Did the service provider:

68. YES \_\_\_ NO \_\_\_ Explain how the infection may have been transmitted?
69. YES \_\_\_ NO \_\_\_ Discuss available treatments, if any?
70. YES \_\_\_ NO \_\_\_ Explain if the infection is curable, and if not, the long term effects?
71. YES \_\_\_ NO \_\_\_ Discuss complications, if any, of disease or treatment?
72. YES \_\_\_ NO \_\_\_ Discuss the possibility that infected partners may not yet have symptoms or show signs of being infected?
73. YES \_\_\_ NO \_\_\_ Explain the risk of reinfection if sex is resumed with an untreated partner?
74. YES \_\_\_ NO \_\_\_ Explain that STDs may increase the transmission of HIV?
75. YES \_\_\_ NO \_\_\_ Counsel client in private?

**Interview with service provider**

This section can be used to assess a service provider depending on his/her level of training, education, and skill in the delivery of STD-related services. A response should be judged as correct if it is in agreement with local guidelines and his/her level in these areas.

Mark "yes" if the respondent answers correctly.

76. YES \_\_\_ NO \_\_\_ What are some common examples of STDs?
77. YES \_\_\_ NO \_\_\_ How are HIV infection and AIDS defined?



78. YES \_\_\_\_\_ NO \_\_\_\_\_ How are they transmitted?  
 79. YES \_\_\_\_\_ NO \_\_\_\_\_ What are some signs or symptoms of a sexually transmitted disease? of HIV infection? of AIDS?  
 80. YES \_\_\_\_\_ NO \_\_\_\_\_ What are some risk factors for STDs?  
 81. YES \_\_\_\_\_ NO \_\_\_\_\_ What are some preventive measures against infection?  
 82. YES \_\_\_\_\_ NO \_\_\_\_\_ Which STDs may increase the transmission of HIV?  
 83. YES \_\_\_\_\_ NO \_\_\_\_\_ What treatments are available?  
 84. YES \_\_\_\_\_ NO \_\_\_\_\_ What tests should be carried out if you suspect infection?  
 85. YES \_\_\_\_\_ NO \_\_\_\_\_ Who are the people at greatest risk of being infected in your area?  
 86. YES \_\_\_\_\_ NO \_\_\_\_\_ When and to whom should you refer cases for further diagnoses, testing, or treatment?

#### Exit interview of client with STD

Mark "yes" if the client responds correctly

87. YES \_\_\_\_\_ NO \_\_\_\_\_ What is your illness?  
 88. YES \_\_\_\_\_ NO \_\_\_\_\_ How do you think you got it?  
 89. YES \_\_\_\_\_ NO \_\_\_\_\_ How do you prevent giving what you have to someone else and how do you prevent becoming infected again?  
 90. YES \_\_\_\_\_ NO \_\_\_\_\_ What treatment/medicine did you receive or will receive?  
 91. YES \_\_\_\_\_ NO \_\_\_\_\_ How much and how often will you take it?  
 92. YES \_\_\_\_\_ NO \_\_\_\_\_ When and where will you return for test results, treatment, or follow-up?  
 93. YES \_\_\_\_\_ NO \_\_\_\_\_ Were you asked to encourage your sexual partner to come for an examination?  
 94. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have questions or concerns that were not addressed by the provider?

#### Exit interview of client without STD

Mark "yes" if the client responds correctly

95. YES \_\_\_\_\_ NO \_\_\_\_\_ How are STDs transmitted in your community?  
 96. YES \_\_\_\_\_ NO \_\_\_\_\_ How can you protect yourself from getting an STD?  
 97. YES \_\_\_\_\_ NO \_\_\_\_\_ How would you know if you got an STD?  
 98. YES \_\_\_\_\_ NO \_\_\_\_\_ What would you do if you thought you had an STD?  
 99. YES \_\_\_\_\_ NO \_\_\_\_\_ Did you receive any educational brochures or handouts?  
 100. YES \_\_\_\_\_ NO \_\_\_\_\_ Do you have questions or concerns that were not addressed by the provider?











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**Rapid quality assessment checklist**  
**Oral rehydration therapy**

- 1. Health facility \_\_\_\_\_
- 2. Observer \_\_\_\_\_
- 3. Observer/supervisor \_\_\_\_\_
- 4. Date \_\_\_\_\_

**Instructions:** Mark "yes" (Y) if the service provider carries out these activities during observation.  
For interview questions, mark "yes" (Y) if the client responds correctly

Observation number/registration and documentation	1	2	3	4	5	6	7	8	9	10	TOT	Problems identified	Actions taken
<b>Medical history</b>													
5. Duration of diarrhea?													
6. Consistency of stools?													
7. Frequency of stools?													
8. Presence of blood and/or mucus in stools?													
9. Presence of vomiting?													
10. Fever?													
11. Home treatments?													
<b>Physical examination</b>													
12. Assess general status (alert or lethargic)? <sup>1</sup>													
13. Pinch skin?													
14. Weigh child?													
15. Determine nutritional status to be sure the child is not severely malnourished?													
16. Take temperature?													
17. Determine the degree of dehydration (none, moderate, severe)? <sup>2</sup>													
18. Prescribe ORS or cereal-based ORT?													
20. Refrain from using antibiotics except when stools contain blood or mucus?													
22. If the child is dehydrated administer ORS solution or cereal-based ORT immediately or refer the child to a nearby centre?													
31. Tell mother about appropriate feeding practices during and after dehydration?													
35. Show mother how to administer ORS solution or cereal-based ORT?													

<sup>1</sup> Signs of dehydration: 1. lethargy; 2. absence of tears while crying; 3. pinched skin retracts slowly; 4. dry mouth; 5. sunken eyes.

<sup>2</sup> Danger signs: 1. many watery stools; 2. repeated vomiting; 3. very thirsty; 4. eating or drinking poorly; 5. fever; 6. blood in stool; 7. dehydration persists.



# Appendix XII

## Letters of Support

CABLE ADDRESS: UNICEF Kampala  
TELEX: 61199 UNICEF Uganda



TELEPHONE 59146  
34591-3

**UNICEF**

UNITED NATIONS CHILDREN'S FUND . FONDS DES NATIONS UNIES POUR L'ENFANCE

Uganda Country Office  
P. O. Box 7047, Kampala, Uganda

YOUR REF:

OUR REF: REP. 1

30 October 1990

Mr. Keith Sherper  
The Director,  
USAID,  
Kampala.

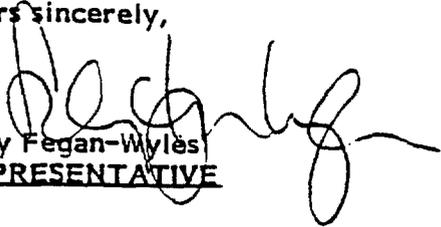
Dear Mr. Sherper,

ADRA International has referred a Project Proposal titled "Child Survival Proposal: Luwero District" for our comments and endorsement.

The Proposal is well formulated. The activities envisaged to be undertaken by the Project would complement UNICEF assisted programmes and projects as well as activities undertaken by those NGOs working in the area of child survival and development. At its present stage of development, we feel, that Uganda can benefit from Projects of this nature (especially as it hopes to use a community-based approach) to reinforce the ongoing national efforts in child and maternal health.

We wish the Project all success.

Yours sincerely,

  
Sally Fegan-Wyles  
REPRESENTATIVE

cc: Dr. William Dysinger, ADRA International  
Dr. Jack Bohanon, Chairman, ADRA Uganda Board  
Mr. Lakshman Wickramasinghe, Prog. Comm. Officer,  
UNICEF

Uganda Community Based  
Health Care Association  
P.O. Box 325  
KAMPALA.

31st October, 1990.

The Chairman  
Adra Uganda  
P.O. Box 6434  
KAMPALA.

Dear Sir,

RE: ENDORSING CHILD SURVIVAL PROPOSAL: LUWERO DISTRICT - UGANDA.

I have received your letter and photocopy of the proposal about the above subject. I have perused through it and made some suggestions for refinement.

It is indeed a well prepared document and worthy of my support and strongest recommendation for submission to the Board here and in Washington, D.C.

I have no doubt that the project will greatly benefit the communities affected in order to improve their health status as well as their social economic welfares.

Thank you for your commitment to promotion of health particularly of mothers and children. With the Aids scourge and economic decay in our midst, we surely need this kind of aggressive intervention.

Again thank you very much.

Yours sincerely,



A. M. Kyeyuna  
PROGRAMME MANAGER.

AMK/sg

Kalagala Sub-county,  
c/o Bugema Adventist College,  
P. O. Box 6529,  
Kampala.

November 5, 1990

Dr. P. Williams Dysinger,  
ADRA INTERNATIONAL,  
12501 Old Columbia Pike,  
Silver Spring,  
MD 20904,  
USA.

Dear Dr. Dysinger:

We, the community members of Lukyamu, Kamira, Kalungu,  
Bugema in Kalagala Sub-county, Luwero District wish to  
thank ADRA INTERNATIONAL for the possibility of a Child  
Survival Project proposed for our area.

We are writing this letter to express our willingness to  
support the project. As the recipients of the services, we  
promise to do everything possible to make sure it succeeds.  
We are prepared to offer the voluntary service that might  
be required.

We thank you that you chose our area for this useful project.

Please keep us informed of what we need to do in preparation  
for the implementation.

Yours faithfully,

CHAIRMAN R.C.I. Abudu Bwala.  
L. Kawenja Mutonagole Kit R.C. I Lukyamu

Edward R. C. II Hass/Mobalization  
J. Bukkoddeka m. chief of Kamira

B. mukanya R.C. II Kamira  
Deputy for health R.C. I  
for: the communities  
named above. Lukyamu

:aa

LUKYAMU R.C. I KAMIRA PARISH  
KALAGALA SUB COUNTY  
LUWERO DISTRICT  
P. O. BOX 62 NAMULONGE  
Dist. S. L. 19.9.90.

## The Uganda Protestant Medical Bureau

Chairman: Dr. H. Kasozi  
Ex. Secretary: Z. Kalega  
Tel. 70788 Office  
71776 Residence

P. O. Box 4127  
KAMPALA UGANDA

Our Ref: UM/160.....

Date 29th Oct. 1990.....

Your Ref: .....

✓ Dr. Jack Bohannon  
Chairman  
ADRA Uganda Board  
Kampala

Dear Dr. Bohannon,

### Project Proposal for Kalagala and Zirobwe Luwero District

Thank you for sending me the project proposal prepared by ADRA Uganda to cover Kalagala and Zirobwe sub counties in Luwero Districts.

In our view, this is a very good project because it is aiming at the children and family life and at the same time taking into account the income level of the people in the area.

People in Kalagala and Zirobwe sub counties suffered a great deal during the war, and now that people have come back and settled, this project comes at the right time. The people in the area are hard working and in my opinion if the project is well introduced to them as I am sure it will be, they will take it up as their own project since it affects their day to day lives. We at U.P.M.B. will give all the technical support and help possible and by copy of this letter to Ms. Grace Nakazibwe, PHC co-ordinator, I am introducing this project to her and I trust Mr. Musoke of the S.D.A. Health co-ordinator will keep in touch with us.

With all our best wishes.

I am, yours sincerely,



Z. Kalega  
EXECUTIVE SECRETARY UPMB

c.c. Ms. Grace Nakazibwe  
PHC Co-ordinator UPMB.

OFFICE OF THE  
DISTRICT ADMINISTRATOR  
LUWERO DISTRICT  
P. O. BOX 78  
LUWERO

Ref. No.: DA/DEV.

24th October 1990

The Acting Principal <sup>←</sup>  
Bugema Adventist College  
P. O. Box 6529  
KAMPALA

RE: SURVIVAL PROJECT PROPOSAL

In response to your letter dated 24th October 1990, I wish to confirm that Dr. P. William Dysinger from AEA INTERNATIONAL presented his proposal to start a project on Child Survival and Family Planning in Luwero District.

His area of interest was Kalagala and Ziropwe Sub-Countries in Kamukama County. This decision was based on the fact that Bugema Adventist College will be used as a base and the head-quarter of the project.

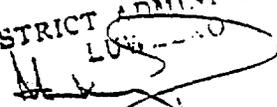
Consequently, I wish to inform you that I have no objection to starting/a useful project in the District. You can therefore go ahead and contact the relevant authorities in the District and in the Ministry of Health Headquarters in Entebbe.

/such

t:

Wishing you success in this noble objective.

Solidarity

DISTRICT ADMINISTRATOR  
  
A.H. MUKWANA (MRC)  
DISTRICT ADMINISTRATOR

- c.c. Office of  
The Prime Minister
- c.c. Hon. Minister of Health
- c.c. Permanent Secretary  
Ministry of Health
- c.c. District Executive Secretary
- c.c. District Medical Officer