

World Vision Relief & Development Inc.

**RAWALPINDI
URBAN CHILD SURVIVAL PROJECT
FIRST ANNUAL REPORT
RAWALPINDI MUNICIPAL CORPORATION
PAKISTAN**

**Beginning Date: October 1, 1989
(Original) Ending Date: September 30, 1992**

Submitted to:

**Child Survival and Health Division
Office of Private and Voluntary Cooperation
Bureau for Food and Humanitarian Assistance
Agency for International Development
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KEY TO ABBREVIATIONS

AKU	Aga Khan University
ARI	Acute Respiratory Infections
BCG	Bacillus Calmette Berin
CS	Child Survival
CDD	Control of Diarrheal Diseases
CHN	Community Health Nurse
CHW	Community Health Worker
CMD	Chief Medical Officer
CV	Community Volunteer
DHO	District Health Officer
DIP	Detailed Implementation Plan
DTP	Diphtheria, Tetanus, Pertussis (vaccine)
DVF	Domiciliary Visit Form
ECI	Entrepreneurship and Center Institute
EPI	Expanded Program on Immunization
GOP	Government of Pakistan
HIS	Health Information System
ICT	Islamabad Capital Territory
IMR	Infant Mortality Rate
LB	Live Birth
LBW	Low Birth Weight
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NHC	Neighborhood Health Committee
NIH	National Institute of Health
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PVO	Private Voluntary Organization
RMC	Rawalpindi Municipal Corporation
RUCSP	Rawalpindi Urban Child Survival Project
SED	Small Enterprise Development
SenSurSite	Sentinel Surveillance Site
SSS	Sugar Salt Solution
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHW	Village Health Worker
WCBA	Women of Childbearing Age
WHO	World Health Organization
WV	World Vision
WVI	World Vision International
WVP	World Vision Pakistan
WVRD	World Vision Relief & Development, Inc.

EXECUTIVE SUMMARY

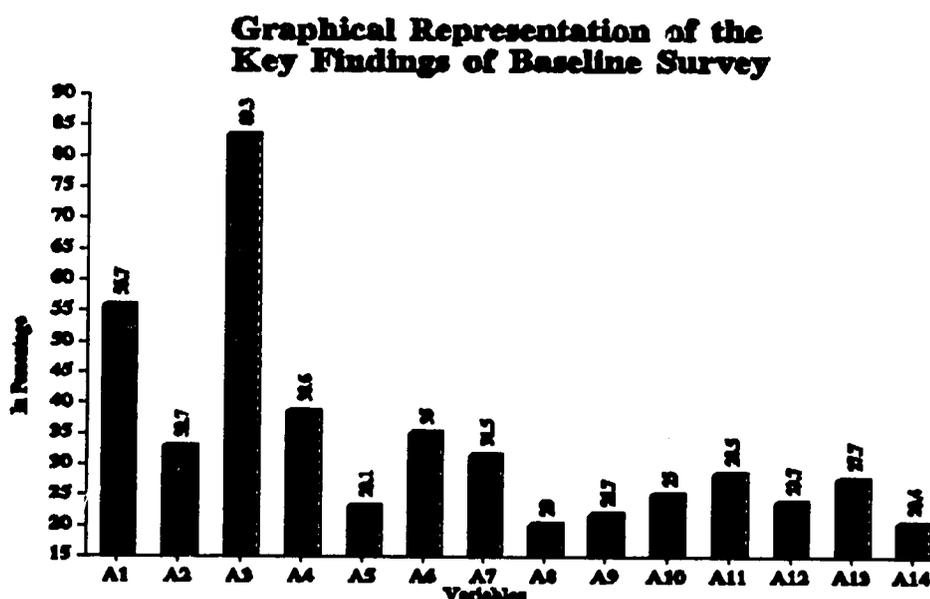
The Rawalpindi Urban Child Survival Project is a three-year project with a total USAID funding of \$491,650. WVRD's funding match is \$250,438. The original proposed site was Islamabad Capital Territory, but due to circumstances beyond WVRD's control, continuation of the project at that site was not possible. The alternative site suggested by government leaders was Rawalpindi, the sister city of Islamabad.

The project site is located in four periurban slum wards of Rawalpindi - Wards 29, 30, 31 and 32. The estimated beneficiary population is approximately 35,234 with an estimated 45 percent comprising of women 15 - 45 years and children 0 - 59 months old.

Project interventions include immunizations, control of diarrheal diseases including ORT, nutrition, maternal care, birthspacing, and pneumonia control.

Presently, the project has hired its full complement of technical and administrative staff. Only the guards and despatch persons need to be hired. Most of the supplies and equipment have been procured. The baseline survey has been done and the management information system is in place. The project has slowly but effectively mobilized a diverse constituency to facilitate ownership of project goals.

The project's major activity was the implementation of the baseline survey. The major findings of the survey are given in the figure below:



- A1 = Children 12-23 months fully immunized with six EPI vaccines before first birthday (card and history).
- A2 = Women 15-45 years immunized with at least two doses of TT.
- A3 = Mothers who are practicing exclusive breastfeeding during first three months of infancy.
- A4 = Bottle-feeding practice of mothers among infants 0-11 months.
- A5 = Supplementary feeding introduced for children at four months of age.

- A6 = At least one person in a family can prepare ORT at home.
- A7 = Children 0-59 months with diarrhea in last two weeks treated with ORT.
- A8 = Normal food given during diarrheal episode.
- A9 = Extra feeding given during diarrhea recovery.
- A10 = Eligible couples in union currently using modern methods of contraception.
- A11 = Mothers with children 0-59 months who know how to recognize at least two out of three major life-threatening ARI signs.
- A12 = Children 0-59 months who had ARI signs in last 12 months taken in for treatment.
- A13 = Pregnant women who had been followed up with at least three antenatal visits.
- A14 = Mothers after delivery (up to six weeks) who had been followed up with postnatal visit.

The survey revealed low tetanus toxoid 2 coverage among women of childbearing age. EPI coverage among infants is still low to achieve herd immunity. A significantly large number of mothers bottle-feed their infants (38.8 percent). Over 25 percent of respondents know how to recognize at least two out of three major life-threatening signs of acute respiratory infections. The respondents' practice is low for the following behaviors: (1) oral rehydration therapy, (2) correct dietary management during and after diarrhea episodes, and (3) use of modern methods of contraception. The results were shared with ward residents, local leaders, and health staff of the Rawalpindi Municipal Corporation.

Because of the delay in project start-up, the project was considerably underspent.

On September 30, 1991, instructions to suspend project activities were received from USAID. WVRD, however, is committed to continue the project with private funds, although it might be on a reduced scale.

I. CHANGES IN PROJECT DESIGN

A. Project Objectives

There have been changes made in the objectives since the submission of the original proposal for the Islamabad Capital Territory (ICT) Rural Areas. A Safe Motherhood component has been incorporated into the DIP.

The end-of-project objectives with corresponding benchmarks are as follows:

1. Eighty-five percent of children (12-23 months) will have been fully immunized by age 12 months with BCG, DPT3, OPV3, and measles vaccines. FY91: 60 percent; FY92: 75 percent; FY93: 85 percent.
2. Sixty percent of women (15-45 years) who delivered in the last 12 months will have received two doses of tetanus toxoid vaccine. FY91: 35 percent; FY92: 45 percent; FY93: 60 percent.
3. Sixty-five percent of registered households (at least one person per household) will be competent in Oral Rehydration Therapy (ORT) usage (can demonstrate proper ORS mixing procedures and administration; continue feeding during diarrhea episodes; give extra feeding during recovery; and know where to refer children with serious diarrheal dehydration). FY91: 35 percent; FY92: 45 percent; FY93: 65 percent.
4. Seventy percent of mothers with children (0-59 months) with diarrhea in the last two weeks will have been treated with ORT. FY91: 35 percent; FY92: 45 percent; FY93: 65 percent.
5. Eighty percent of mothers with children (0-23 months) will know correct weaning and infant feeding practices (viz; exclusive breastfeeding if less than three months, breastfeeding throughout infancy, introduction of weaning foods at fourth month and no bottle feeding). FY91: 25 percent; FY92: 40 percent; FY93: 80 percent.
6. Thirty-five percent of eligible couples in union will be using modern methods of contraception such as condoms, oral contraceptives, intrauterine devices, and sterilization. FY91: 28 percent; FY92: 35 percent; FY93: 40 percent.
7. Sixty percent of mothers with children 0-59 months will be able to name two out of three pneumonia signs (rapid respiration, indrawn chest and/or inability to drink) which indicate need for treatment or referral. FY91: 30 percent; FY92: 45 percent; FY93: 60.
8. Sixty percent of all pregnant women will have had at least three antenatal and one postnatal checkups by a trained health professional. FY91: 20 percent; FY92: 40 percent; FY93: 60 percent.

B. Location and Size of the Priority Population

The original site for the project was in Rural Islamabad Capital Territory. In December 1990, after a tedious process of negotiation, the government advised the project to change its site to the four wards of Rawalpindi City—Ward Nos. 29, 30, 31, and 32 of Rawalpindi Municipal Corporation. The population is squeezed into three square kms. of land. About 10 percent live in slums, their shanty homes built on the open sewers of the city. Most of them belong to the Muslim Pathan or Punjabi communities.

Approximately 5,505 families representing 35,235 people are project beneficiaries. An estimated 1,762 infants 0-11 months, 1,585 children 12-23 months, 4,052 children 24-59 months, and 4,651 women are targeted on a phased basis.

C. Health Problems

The problems addressed by the project in the DIP have not changed:

- High prevalence of diarrhea among children 0-59 months;
- Low vaccination coverage rate among under-fives and pregnant mothers;
- Lack of maternal protection services such as prenatal care;
- Very low practice of contraception;
- High incidence of acute respiratory infections (ARI);
- Lack of knowledge and practice among mothers in the recognition and home management of ARI and diarrhea; and
- Poor access to clean water.

The health problems could be attributed to the following factors: a very low literacy rate especially among women, the existence of a sociocultural structure which does not empower women educationally and economically, and a lack of community involvement in health and development activities which are sustainable.

D. Child Survival Interventions

The interventions remain the same as described in the DIP.

E. High-Risk Strategies

1. Immunization

Community Health Workers (CHWs) and Community Volunteers (CVs) will educate mothers on the value of immunization during their home visits. Immunization defaulters will be visited especially the day before the next immunization session. A list of defaulters will be given to NHC members to reinforce follow-up and to persuade families of defaulters.

Each child 0-11 months will be visited five times to ensure full immunization coverage.

The immunization card will be used to record each immunization. Data from this card will be entered into the project base's computer, where quarterly updated immunization coverage for each ward is maintained. The Monitoring and Evaluation (M&E) Coordinator will provide Community Health Nurses (CHNs) a list of beneficiaries with immunization due dates. The CHNs thus will have backup data in the event of card loss.

2. Control of Diarrheal Diseases

During the baseline census, CHWs will enroll beneficiaries through home visits using Domiciliary Visit Form (DVF) developed from the baseline survey questionnaire (Appendix 1). A separate master list of children 0-23 months and 24-59 months will be compiled by CHWs in each ward. In this list, a special mark will indicate if the child is at high risk. High-risk children will include:

- Those with moderate/severe diarrheal dehydration;
- Children with more than two diarrhea episodes per month;
- Children with blood/mucous-stained stools; and
- Children with family history of diarrhea-related deaths in a sibling within the last five years.

Mothers with an index child will be visited by the CHW initially, then followed up at least once a week for one month. During this face-to-face encounter, the CHW will facilitate the mother's understanding of the causes of diarrhea in her own environment and help her to think of ways to manage/prevent it. The CHWs will also monitor the child's improvement and nutritional status by weighing the child every week. The CHW will emphasize the nutrition-diarrhea cycle.

3. Nutrition

Children at high risk for malnutrition will be identified through the DVF. Those are children whose mothers fall under any of the following categories:

- Mothers who did not give colostrum or immediately breastfeed their newborns.
- Mothers who did not exclusively breastfeed their infants for the first three months and/or are not continuing breastfeeding throughout infancy.
- Mothers who did not introduce supplementary feeding to their infants by the fourth month.

The CHW will visit these mothers and hold neighborhood meetings and demonstration kitchens weekly for at least two months. The Public Health Nurse (PHN) will conduct intensive face-to-face, one-to-one sessions with women found to be resistant to the nutrition session. The DIP describes other strategies.

4. Prevention of High-Risk Births

Enrollment of pregnant women will be done using the DVF. The CHWs will be trained to identify and follow up women with the following characteristics:

Spacing: Mothers whose birth intervals are too short, i.e., less than 24 months.

Maternal age: Mothers who are too young (below 20 years) or too old (above 34 years).

Parity: Mothers with five or more babies.

Low birth-weight babies: Mothers with history of low birth-weight babies or stillbirth or neonatal deaths.

High-risk pregnancies will be screened during antenatal checkups and recorded on the antenatal cards for referral. The other strategies are given on page 16 of the DIP.

II. HUMAN RESOURCES AND COLLABORATION

A. Staffing

All technical staff are in place. Only the guard and dispatch person need to be recruited. A copy of the job descriptions of newly hired staff and the project organization is in Appendix 2.

B. Technical Assistance

1. Dr. Sri Chander, WV South-Asia Regional Health Consultant visited the project each quarter to assist in program planning, staff recruitment and development. He also helped identify the new site, build relationships, plan program components, design baseline survey, develop HIS and, write the DIP.
2. Ms. Sandra Jenkins, Field Financial Coordinator, WVRD, trained the staff in grant accounting in July 1991.

3. The Project Manager and Operations Coordinator participated at the Asia Regional PHC Management Workshop co-sponsored by WVRD in Pontianak, Indonesia, in April/May 1991.
4. Mr. Abdul Hye, Monitoring and Evaluation Officer of the USAID-funded Kamalapur CSP, and Dr. Iqbal, Project Manager, Mohammadpur CSP, from Bangladesh, trained the project staff on the baseline survey in May/June 1991. They also assisted in the development of the HIS.
5. The two project public health nurses attended a ten-day field training and supervision workshop for grassroots-level health workers at the Sialkot Memorial Christian Hospital PHC project in July 1991.
6. World Vision Pakistan staff trained CHWs on community preparation.
7. The Operations Coordinator visited the USAID-funded Kamalapur CSP in Bangladesh.

C. Community Activities

1. Dialogues were held with the Mayor, CMO, other municipal staff, local councilors and neighborhood leaders including pesh-Imams, women's groups, and traditional health practitioners. These discussions allowed the project staff the opportunity to maximize contact, gain a better understanding of the community's viewpoint, and capitalize on the contributions of key informants.
2. Visited homes and interviewed families.
3. Worked closely with the CMO, municipal staff, and project beneficiaries in planning and decision making to enable them to prioritize their health problems.
4. Mapped out communities with ward leaders; collected population-based data through the registration of project families. The community actively participated in these activities.

D. Linkages to Other Health and Development Activities

No new linkages were formed since the submission of the DIP.

III. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

A. Baseline Survey

The survey was conducted from May 28 to June 8. The final report was completed in ten days. Survey costs amounted to \$3,800 only, against the

original estimated cost of \$4,290. The reduction in cost was due to the use of two WV Bangladesh staff—Dr. Iqbal Anwar, Project Manager of CSP, Mohammadpur, Dhaka; and Mr. Abdul Hye, M&E Coordinator for CSP Dhaka. Dr. Anwar and Mr. Hye provided technical assistance in the design, sampling, data collection, data entry, tabulation, and writing of the results. They also assisted in developing the HIS including the design of HIS tools. Technical assistance was very useful because of the lack of experience of project staff in survey methodology, tabulation, and report writing.

Four hundred sixty-six households constituting 515 women with children 0-59 months of age and women 15-45 years of age were interviewed. It took an average of five minutes to interview one mother.

Major findings of the baseline survey have been mentioned in the DIP. These findings were formally shared with the Rawalpindi Municipal Corporation staff, community leaders and project health workers on July 12, 1991, in a ceremony held at Jinnah Hall RMC, Rawalpindi. Key findings were presented graphically. Community leaders actively participated in the discussion.

A safe motherhood component has been included due to the need for enhancing the awareness for antenatal and postnatal care and safe delivery by trained health professionals. A copy of the baseline survey report is attached as Appendix 3.

B. Routine Data Collection

Registration in Ward No. 32 has been completed. The Domiciliary Visit Form used for registration of families and collection of vital information helped in identifying the high-risk beneficiaries. A list of beneficiaries is given to the CHNs who keep a register of beneficiaries and those at high risk needing follow-up service at the sub-center.

Two CHNs supervise the CHWs during home visits on a regular basis. The CHNs also review the monthly reports submitted by the CHWs. The CHNs use these reports to assess their work, to provide technical inputs, and to prepare plans for the next week/month. The CHNs provide aggregate reports to the Operations Coordinator who in turn submits her report monthly to the Project Manager.

Due to a delay in recruitment of a qualified and experienced finance administrative officer, the project faced difficulty in managing the financial records. The WV office Finance Officer assisted in the administration of project finances in the interim.

The M&E Coordinator supervises the data collection in the field. He conducted six training sessions on the use of the DVF and checked each form turned in. He discusses with staff necessary corrections, weak areas, and re-

orients staff when necessary. Surprise field visits were made by the Project Manager to ensure quality of data.

The project does not as yet monitor service performance and sustainability indicators as actual delivery of services has just started.

No active surveillance system is yet in place. The CHWs collect data using the DVF under supervision of the M&E Coordinator and CHNs. Compilation and analysis of data is done by Raheel Sheraz, M&E Coordinator, who also monitors the quality of data.

Feedback is given to CHWs during weekly staff meetings, and to the NHCs during their monthly meetings. Since October 1990, approximately 1 percent of total expenditures has been spent on the HIS.

IV. IMPROVEMENT IN PROGRAM QUALITY AND TECHNICAL EFFECTIVENESS

The Rawalpindi Urban Child Survival Project (RUCSP), having started-up activities late, has not had much experience in the actual implementation of CS interventions.

Lessons Learned

- A. All staff should be in place before activities are initiated. This allows staff to gel and to have unity of purpose. Recruited staff should be oriented and trained to achieve A.I.D. standards. Training of Trainers should be done well in advance of project startup. This ensures the quality of work and technical effectiveness in the early stages of the project.**
- B. Staff should be conversant with their job descriptions and supervisory roles. Misconceptions will result in loss of technical effectiveness. Leadership must be exercised from the inception to facilitate work and smooth flow of communication.**
- C. Social mobilization to enhance awareness of CS activities is an indispensable step to acceptance. Strategies must be well planned and executed—this should start with the baseline survey. Communities should be made aware of its relevance and subsequent benefits to their families and the community.**
- D. Communities expect visible results soon after project starts. Some development activities such as building toilets or construction of garbage disposal units, are visible activities which should be initiated early on so as to sustain the communities' interest. Once interest is aroused, it should not be allowed to wane, otherwise, it will be difficult to re-activate.**
- E. Contrary to popular belief, Muslim women in urban areas can be motivated to become community volunteers despite cultural and religious barriers. However, staff should be ready to overcome difficulties in persuading them to become**

members of NHCs and persuading the men to accept women's legitimate role in CS and Safe Motherhood programs.

- F. CS projects will continue to deviate from the path to sustainability if donors lay down rigid schedules. More time should be given for startup of project activities and for community sensitization.

V. WORK SCHEDULE

Due to the late start and inadequate staffing, the baseline survey was conducted with much difficulty. The staff was newly recruited and was pressured by the burden of field work in temperatures well above 40C in June 1991. A CHN and one CHW dropped out as a result. We plan to come up with a more flexible schedule in future surveys.

The CHNs recruited had little exposure to field work as Pakistani nurses are clinically oriented. They lack management and supervisory skills. It took time for them to understand their leadership role. One-to-one counseling and training in management/supervision is being planned for them to upgrade their skills. They will have to spend more time in the field to understand their role of health providers at the community level.

Work Plan

This is no longer relevant since the donor agency has terminated project activities beginning October 1, 1991. However, World Vision Pakistan is committed to continue activities it helped begin.

VI. BUDGET EXPENDITURES AND JUSTIFICATION

Because of the delay in project startup, this project was significantly underspent in FY91. A copy of the country project pipeline analysis is given as Appendix 4.

By October 1, 1991, the project will cease its operation per instruction from the donor agency (Appendix 5).

VII. SUSTAINABILITY

A. Recurrent Costs

The projected costs and revenues which should be maintained annually are the following:

<u>Item</u>	<u>Amount</u>
Sentinel Surveillance Site	\$ 500
Contraceptive Supplies	\$ 1,000
Printed health charts, cards, materials	\$ 1,000
Teaching aids	\$ 1,000
Salaries of 8 CHWs	\$11,542
Honorariums for CVs	\$ 3,744
Facilities Rentals & Fees	\$ 700
Social Mobilization	<u>\$ 1,000</u>
Total	<u>\$20,464</u>

Project components which the community and government will not be able to sustain include personnel, vehicles, and project office maintenance and a sophisticated HIS. In lieu of the latter, a simple community-based HIS will be designed.

B. Strategies for Reducing Sustainability Concerns

At the municipal level, the CMO agreed to provide EPI vaccines, immunization cards, an ice-lined refrigerator, syringes, needles, oral contraceptives, condoms, iron tables, and basic medicines. At the Ward level, the four Ward counselors agreed to assist in surveys and formation of NHCs.

The Ward 30 municipal dispensary and the MCH Bahbood Women's Welfare Clinic will service all project referrals. The Entrepreneurship and Career Institute, a local NGO, will train project area. The project will co-fund the construction of four garbage disposal points—one in each ward.

A sustainability action plan has been developed right from the design stage. Indicators to track progress in achieving sustainability are found in Appendix 5. These indicators will be refined through ongoing discussions with NHCs, women's groups, and community members.

The project will create, maintain, and link community demand for health services to the following health facilities: Ward 30 Municipal Dispensary, Bahbood Women's Welfare Clinic, local private clinics, Ward 33 MCH Center, and the Civil Hospital. Community demand will be enhanced through empowering NHCs and women's groups. The project, through its strong community health training component, will invest in people to gradually liberate them from negative lifestyles and health behaviors. Project social workers, CHWs, and CVs will reinforce and institutionalize these health behavior changes through regular NHC and women's meetings, focus group discussions, intensive home visits, and health fairs.

On the supply side, it is envisioned that the RMC will convert the subcenter into fixed EPI/MCH centers by the end-of-project life. The RMC will also be assisted to request for the introduction of a new category of paid cadre—the Auxiliary Health Workers, a functional equivalent of the project CHW. This paid cadre has been sanctioned in the GOP's current five-year plan for 1988-1993.

The NHCs in each ward will be encouraged to form a Ward Health Committee to negotiate with the RMC to introduce the above-mentioned government health facilities and worker category. In line with GOP policy, TBA's role will be expanded by facilitating the recruitment and training of the TBAs to become CVs. Traditional practitioners, such as hakims and homeopath, will be approached to train and promote ORS. Chemists will be targets of social marketing efforts related to ORS, EPI, and ARI. Consultant firms, private firms, and NGOs will be used to help develop and produce training materials, media messages, and social marketing materials. These proposed linkages with the private sector should help reduce the burden to government health institutions by encouraging additional actors to play greater and more effective roles in maternal and child health.

The Project Manager attended the Costing Exercise at Dhaka (USAID-funded) in April 1990 to enhance his understanding of organizational costs and improve skills in cost recovery and price setting.

C. Cost-Recovery Activities

The June 1991 Baseline survey showed that 40 percent of the households have a monthly income of less than Rs 1000 (US \$40). With large families, the women cannot afford proper medical care and medicines for their children when they become ill. World Vision Pakistan has decided to start income-generating activities in FY92 to enhance the income of women by exploring the following:

1. Sources of seed money for a revolving loan fund for five women's groups in one ward initially.
2. Technical assistance from the Entrepreneurship and the Career Institute in Islamabad and the Rawalpindi Industrial Home for Women to test the feasibility and acceptability of training women to become self-confident and help microentrepreneurs through:
 - a. Identification of Small Enterprise Development (SED) by a market survey;
 - b. Advice on marketability of products;
 - c. Selection of small businesses for loans;
 - d. Training in marketable technical and managerial skills; and

- e. Accessing credit from the First Women's Bank, the small Business Finance Corporation for loan schemes.**
- 3. Establishing a policy for revolving funds.**
- 4. Tapping local funds from companies, community organizations, and affluent individuals to help pay for SED activities. Training of CDWs and CHWs has already begun on SED issues.**

**BASELINE SURVEY QUESTIONNAIRE
RAWALPINDI URBAN CHILD SURVIVAL PROJECT**

I N D O	MARITAL STATUS	DMON. WITH TT	BIRTH SPACING			ARI		SAFE MOTHERHOOD (ANTE-NATAL/POST-NATAL)						MOTHER OF CHILDREN 0-59 MONTHS				SOCIO-ECONOMIC STATUS				
			PRAC FP	NAME OF FP METHODS	CAUSE FOR FAILURE OF BIRTH SPACING	KNOWS ABOUT SYMPTOMS OF ARI (AT LEAST TWO OUT OF THREE)	WHAT TO DO FOR CHILDREN 0-59 MOS. WITH ARI	KNOWS ABOUT THE NEED FOR MEDICAL CHECK-UP DURING PREGNANCY	IF YES, BY WHOM/ WHEN	PLACE OF DELIVERY	DEATH DUE TO PREG/ DELIVERY IN LAST 5 YEARS	NO. OF CHECK-UPS DURING PREGNANCY	MOTHER AFTER DEL. (UPTO SIX WKS.) NEEDS CHECK- UP FOR HERSELF AND/OR BABY	IF YES, BY WHOM/ WHERE	WHERE YOUR LAST CHILD WAS DE- LIVERED	DURING YOUR LAST PRE- GNANCY, DID YOU HAVE ANC	IF YES, BY WHOM/ WHERE	AFTER DEL. (UP TO 6 WKS.) DID YOU HAVE POST-NAT- TAL CARE FOR YOU AND/OR BABY	IF YES, BY WHOM/ WHERE	MOTHER'S EDUCATION FORMAL	MONTHLY INCOME OF THE FAMILY	SOURCE OF IN- COME
	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
1																						
2																						
3																						
4																						
5																						
6																						
7																						

- (27)
- 1 = Unmarried
 - 2 = Married (Non-preg.)
 - 3 = Married (Pregnant)
 - 4 = Div./Sep./Widow

- (28)
- 1 = Yes, 1 dose
 - 2 = Yes, 2 doses
 - 3 = Yes, > 2 doses
 - 4 = No

- (29)
- 1 = Yes
 - 2 = No
 - 3 = N/A

- (30)
- 1 = Pill
 - 2 = Condom
 - 3 = Injectable
 - 4 = IUD
 - 5 = Foam Tab/Jelly
 - 6 = Ligation
 - 7 = Vasectomy
 - 8 = More than one
 - 9 = Others
 - 0 = N/A

- (31)
- 1 = Relig. Restrict.
 - 2 = Husband doesn't like
 - 3 = Don't need
 - 4 = Affects health
 - 5 = Don't have children
 - 6 = Want more children
 - 7 = No reason
 - 8 = Other
 - 0 = N/A

- (39, 32 & 34)
- 1 = Yes
 - 2 = No

- (33)
- 1 = Seek treatment from nearby health pers.
 - 2 = Take the child to nearby hospital/clinic
 - 3 = Don't know
 - 4 = Other
- (36)
- 1 = Home
 - 2 = Clinic/Hospital
 - 3 = Other

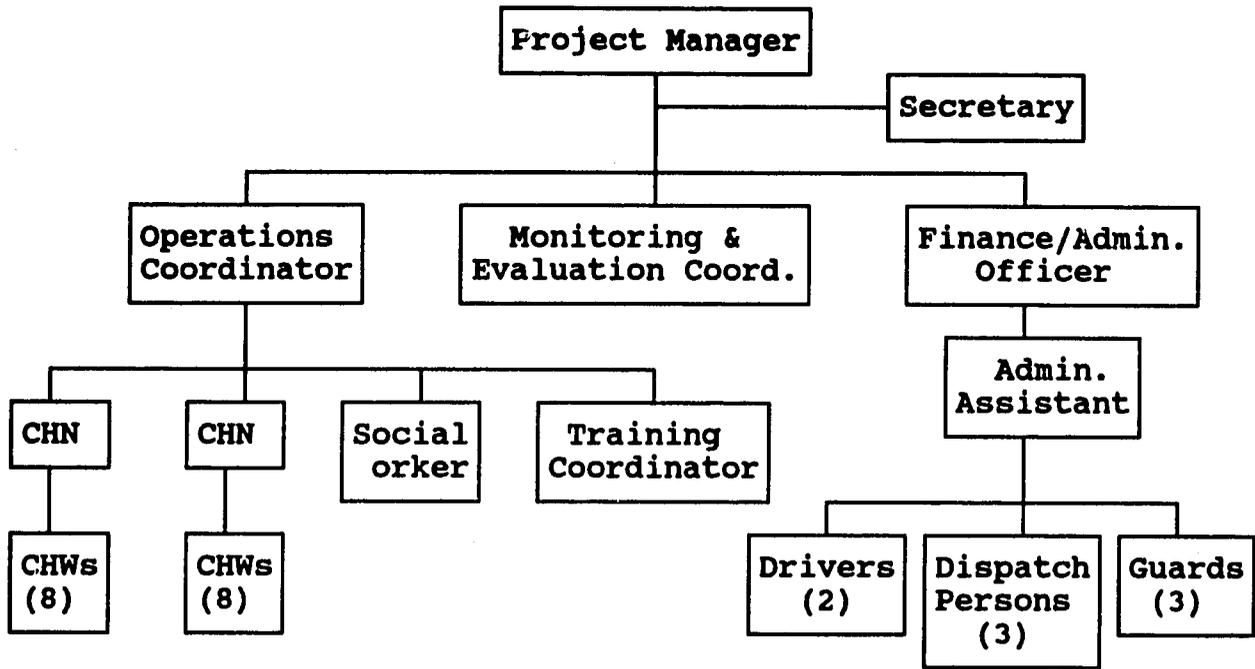
- (35, 40, 43 & 45)
- 1 = TBA
 - 2 = Urg. Local Doctor
 - 3 = Qualified Doctor
 - 4 = Relatives
 - 5 = Hospital/Clinic
 - 6 = Others
 - 0 = N/A

- (37)
- 1 = 1 death
 - 2 = 2 deaths
 - 3 = 2 + deaths
 - 4 = No death
- (38)
- 1 = 1 time
 - 2 = 2 times
 - 3 = 3 times
 - 4 = 4-5 times
 - 5 = 6 times
 - 6 = 6 + times
 - 7 = When there is a problem
 - 8 = No
 - 9 = Don't know

- (41)
- 1 = Home
 - 2 = Clinic/Hospital
 - 3 = Other
 - 0 = N/A
- (42 & 44)
- 1 = Yes
 - 2 = No
 - 0 = N/A
- (48)
- 1 = Cultivation
 - 2 = Odd job/labor
 - 3 = Service
 - 4 = Business
 - 5 = Tonga Driver
 - 6 = Other

- (47)
- 1 = <1,000 Rs.
 - 2 = 1,001-2,000 Rs.
 - 3 = 2,002-5,000 Rs.
 - 4 = 5,001-10,000
 - 5 = 10,000 plus
 - 6 = Don't know
- (46)
- 1 = Class 1-5
 - 2 = Class 6-8
 - 3 = Class 9-10
 - 4 = Class 11-12
 - 5 = Class 12+
 - 6 = Nil

PROJECT ORGANOGRAM



APPENDIX 2B

JOB DESCRIPTION PROFILE: Finance and Administrative Officer

Job Summary: Responsible for planning, leading, implementing and controlling the financial and administrative support service of the Child Survival Project over a three to five year period. The Finance and Administrative Officer will supervise the purchase and maintenance of capital assets, inventory control of equipment/supplies, and security of property and records.

Responsibilities:

1. Manages the project administrative and support services aspect of the project.
2. Manages the financial requirements of the project by developing policies, procedures, and standards to ensure accountability, and the administration of project finances in consultation with the project manager.
3. Interprets and clarifies financial and administrative policies and procedures to staff and donors. Keeps the project manager informed of financial transactions and any irregularity and alerts him to take corrective action if variances are excessive (+/- 10%)
4. Prepares management and financial reports in accordance with the standard set by WVI and USAID.
5. Maintains separate financial accounts and records for WVRD and donors, using the prescribed forms.
6. Procures capital assets such as equipment, and ensures these are appropriately maintained.
7. Develops and implements a system for inventory control of supplies and capital assets.
8. Provides maintenance and security for facilities rented by the project and ensures project documentation is in place.
9. Performs other specific duties as assigned by the project manager.

Qualifications:

1. 14-16 years' education: College degree with M.B.A. or B. Comm.
2. Minimum three years' experience as a financial officer or business manager, preferably with grant accounting experience with international organizations or A.I.D. agency.
3. Fluency in English, Urdu, and Punjabi.
4. Knowledge of Community Development and or Child Survival preferable.

5. Knowledge of WordStar, WordPerfect, Lotus 1-2-3, preferred.
6. Committed to WVI Core Values.

Work Relationships:

1. Reports directly to the WV Pakistan Child Survival project manager.
2. Supervises support staff of the project.

N.B. This job description is subject to periodical review.

JOB DESCRIPTION PROFILE: Community Health Worker

Job Summary: Responsible for implementation of project health activities at the community level. He/she will be the crucial link between the project and the community, facilitating the work and meetings of health workers. He/she will mobilize the community to participate in project activities and remain responsible for the interventions.

Responsibilities:

1. Supervises Voluntary Health Workers (VHWs) under his/her supervision and map the wards assigned to them.
2. Assists the Social Worker and the CHN in his/her ward to achieve the ward's goals.
3. Maintains an updated register of children 0-59 months and women 15-45 years.
4. Conducts an assessment after each outreach session on immunization, ORT, ARI, antenatal, and gynecological care.
5. Assists in pre-service training and the on-the-job training of the Community Health Volunteers (CHV).
6. Assists in all surveys and evaluations.
7. Keeps an inventory of all supplies received and issued by him/her.
8. Knows correctly and practices/implements the appropriate measure to the following:
 - a. Adverse reactions to immunizations;
 - b. ORT usage;
 - c. Correct weaning and infant feeding practices;

- d. How to classify identifiable clinical signs of ARI for two management decisions; whether or not to refer patients to a higher-level health facility and whether or not to prescribe antibiotics;
 - e. Life-threatening ARI symptoms in children (0-24 months) that require immediate referral;
 - f. Birth spacing;
 - g. Other topics of interest to the community;
 - h. Record keeping; and
 - i. Relationship with the community and other NGOs operating in the area.
9. Performs other duties assigned to him/her by the Community Health Nurse.

Qualifications:

- 1. At least Matriculate (ten years' education).
- 2. Must have some experience working in an urban setting.

Working Relationships:

- 1. Reports directly to the Community Health Nurse.
- 2. Supervises the Voluntary Health Worker (VHW).

JOB DESCRIPTION PROFILE: Community Health Nurse

Job Summary: Responsible for the operational and technical services the Rawalpindi Urban Child Survival Project over a three- to five-year period. The Community Health Nurse will maintain proper records and implement the reporting system as described in the job responsibilities.

Responsibilities:

- 1. Trains and supervises the Community Health Workers (CHWs) and Community Volunteers to accomplish project's objectives for his/her area of operation, and namely:
 - a. Increase immunization coverage of children under one with EPI vaccine and of women of childbearing age (15-45 years) with tetanus toxoid to 85 percent.
 - b. Train one person in at least 80 percent of registered households to be competent in ORT usage.
 - c. Help select and train Community Workers and Volunteers.
- 2. Assists government officials and Neighborhood Health Committees to select and train at least two Community Volunteers for each committee.
- 3. Provides first aid and deals with minor ailments when applicable; refers and follows up as needed.

4. Assists in pre-service and on-the-job (OTJ) training of Community Volunteers.
5. Assists with surveys and evaluations.
6. Makes arrangements for logistics related to the technical aspects of the project and maintains inventory records.
7. Assists in designing and maintaining a technical reporting system.
8. Assists the Operation Coordinator in ongoing reviews of job responsibilities and performances of CHWs.
9. Works in Rawalpindi bustees/other areas outside the project area as required.
10. Knows and practices method of contraception and assists deliveries.
11. Performs other duties assigned by the Operations Coordinator.

Qualifications:

1. Must have "A" Grade Nursing Training Certificate from any authorized nursing school/college and/or possesses a diploma in Public Health/Nutrition/Family Planning.
2. Minimum three years' work in Public Health and Basic OBS.
3. Committed to WVI Core Values.
4. Speaks Punjabi and Urdu.
5. Good working knowledge of English, able to write reports in English.

Work Relationship:

Reports directly to the Operations Coordinator of the Rawalpindi Urban C/S Project WVP.

JOB DESCRIPTION PROFILE: Monitoring and Evaluation Coordinator

Job Summary: This job entails the design, analysis and preparation of project progress and evaluations, quantitatively and qualitatively. He/she will ensure that project objectives are being met on time. He/she will design and conduct quarterly, annual, midterm, and final evaluations.

Responsibilities:

1. Designs, conducts, and analyzes evaluations (annual, midterm, and final).
2. Monitors the project through analysis and reporting of the following:

- 20

- a. managerial indicators based on the project's action plan;
 - b. domiciliary visits of Community Health Workers (CHWs);
 - c. service statistics;
 - d. special surveys, sample surveys (baseline, midterm, and end-of-project) to measure progress towards objectives; and
 - e. supervisory visits and sample checks in the different wards.
3. Designs, implements, monitors, and refines, a family registration system to ensure that:
 - a. All target families in the project area are registered;
 - b. Deaths, immigration, and emigration are recorded; and
 - c. A continually updated master list is established that:
 - (1) Picks up each new cohort of newborns and pregnant women.
 - (2) Records the number of children under one year, and women of child-bearing age 15-45 years who are eligible for immunization. Identifies unvaccinated "at-risk" children and mothers, as well as "at-risk" pregnant women.
 - (3) Includes the number of eligible couples for birth spacing by contraceptives.
 4. Ensures accurate and relevant data are gathered, aggregated, banked in a computer, analyzed and fed back to WordPerfect and Lotus 1-2-3.

Work Relationships:

1. Reports directly to the project manager.

N.B. This job profile is subject to periodic review.

JOB DESCRIPTION PROFILE: Training Coordinator

Job Summary: This job involves the planning, organizing, and evaluation of training seminars/workshops for the professional development of staff. He/she will develop a curriculum for training of each member of the project staff based on their needs. He/she will be responsible for the development of training materials and ensure training standards and expectations are met. He/she will continually review the training program to ensure that it is appropriate and updated.

Job Responsibilities:

1. Develops training events and coordinates training schedules.
2. Coordinates with external organizations on training resources and secures trainers to meet specified needs of the staff.

3. Helps develop and organize pre-service and on-the-job training courses for the following:
 - a. Project Manager, Operations Coordinator, Social Worker, Monitoring and Evaluation Coordinator, Finance and Administrative Officer.
 - b. Other technical and administrative support staff, three Public Health Nurses, ten Community Health Workers, and health staff of the ICT.
 - c. Community Volunteers in cooperation with and inputs from UNICEF, WHO Basic Health Services Cell, NIH, etc.
4. Assists Community Development Workers in community organization and participation especially in formation of neighborhood health committees and the selection, training, and follow-up of community health volunteers.
5. Assists in developing, field-testing, and producing a basic training course for mothers on correct ORT usage for implementation by Community Health Volunteers in their neighborhood.
6. Performs other duties as assigned by the Project Manager.

Qualifications:

1. College graduate with major in Education, Psychology, and/or Public Health.
2. Two years' experience as trainer/facilitator with experience in nontraditional training methods/techniques.
3. Committed to WVI Core Values.
4. Fluent in English and Urdu.
5. Ability to design and produce training materials.

Work Relationships:

1. Reports directly to the Operations Coordinator.

JOB DESCRIPTION PROFILE: Secretary

Job Summary: This job is responsible for performing secretarial functions to relieve superior of clerical and routine administrative details. In addition, performs clerical or administrative duties required in a department where assigned.

Responsibilities:

1. Prepares reports, correspondence, documents from prepared drafts following prescribed formats.
2. Takes dictation, transcribes, and types notes in standard or appropriate format.
3. Receives, screens, and sorts mail reports, faxes, telexes, and other related matters addressed to superior; records and routes incoming and outgoing communications. Ensures all confidential matters are treated sensitively.
4. Answers, screens, and refers phone calls to superior or party concerned; makes outgoing calls for superior; provides routine information to inquiries; receives and/or transmits messages as requested.
5. Arranges and keeps appointment schedules as requested and reminds superior of same; attends to change in schedules.
6. Receives and attends to visitors desiring to see superior.
7. Keeps and maintains an orderly filing system, and assures that confidential papers are kept secured.
8. Assists superior in preparing reports by gathering and consolidating data or making computations as necessary; distributing assignments or following up work progress of department/field personnel as required.
9. Attends to housekeeping chores in superior's office to make sure it's always kept clean, orderly, and provided with supplies.
10. Makes travel reservations and arranges for meetings. Ensures that all pertinent documents for the meeting are prepared beforehand.
11. Performs secretarial or clerical functions for other departments as requested or act as receptionist in the absence of assigned staff.
12. Performs other related functions assigned by superior.

Qualifications:

1. College graduate 14 years with major in secretarial sciences preferably.
2. One year experience as a secretary (preferably).
3. Fluent in English.
4. Computer literacy in Word Star and WordPerfect.

5. **Positive attitude and friendly.**
6. **Mature outlook and able to handle pressure situations.**
7. **Trustworthy and able to handle sensitive matters.**
8. **Committed to WV Core Values.**

Work Relationships:

1. **Reports directly to CSP Project Manager.**

N.B. This job profile is subject to periodic review.

APPENDIX 3

RAWALPINDI URBAN CHILD
SURVIVAL PROJECT

OCT 1990.....SEPT 1993

(A PROJECT OF WORLD VISION PAKISTAN)

BASELINE SURVEY
REPORT

JUNE 1991

25

LIST OF ABBREVIATIONS

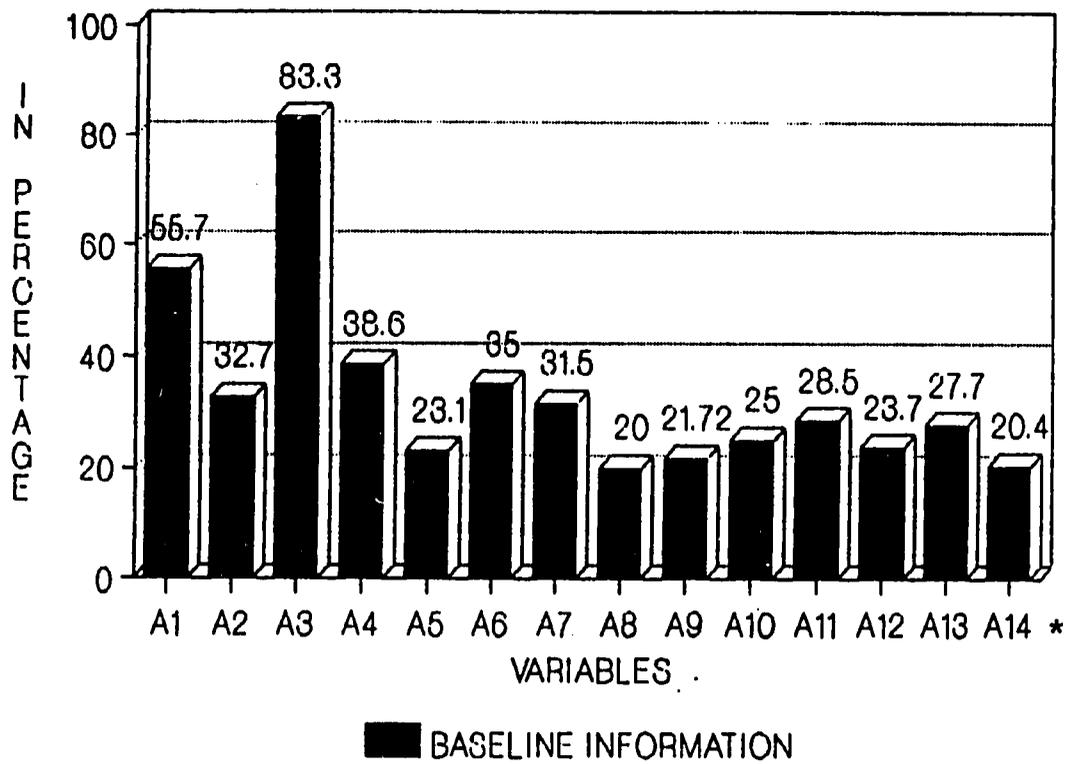
ARI. ACUTE RESPIRATORY INFECTIONS
ANC. ANTENATAL CARE
BCG. BACILLUS CALMETTE GUERIN
CHN. COMMUNITY HEALTH NURSE
CHW. COMMUNITY HEALTH WORKERS
CDW. COMMUNITY DEVELOPMENT WORKER
DPT. DIPHTHERIA, PERTUSSIS, TETANUS
EPI. EXPANDED PROGRAM ON IMMUNIZATION.
EBF. EXCLUSIVE BREAST FEEDING.
OPV. ORAL POLIO VACCINE
ORS. ORAL REHYDRATION SALT.
ORT. ORAL REHYDRATION THERAPY
PNC. POSTNATAL CARE.
RMC. RAWALPINDI MUNICIPAL CORPORATION.
TT. TETANUS TOXOID.
WV. WORLD VISION.

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GRAPHICAL REPRESENTATION OF THE KEY FINDINGS OF BASELINE SURVEY



* Please see Executive Summary for description of variables (Next Page)

EXECUTIVE SUMMARY

The project is located in Wards No. 29, 30, 31, and 32 of Rawalpindi Municipal Corporation in the District of Punjab, and it is 15 km. distant from Islamabad. The approximate area of the Project is 3 sq.km. and the population is about 35 thousand.

The aim of CSP Rawalpindi is to reduce the morbidity and mortality of the priority target population in the project area by strengthening promotive and preventive health care services at the neighbourhood level.

Keeping this aim in mind, the project conducted the Baseline Survey from 29 May to 9th of June 1991.

A total No of 466 families were interviewed from Wards No 29, 30, 31 & 32 by applying the methodology of 30 cluster sampling to get desired target children and mothers/women.

The major findings of this study which are related to the interventions of the project are given as follows:

A1. Children (12-23 months) fully immunized with 6 EPI vaccines before their first birthday (card & history)	55.7%
A2. Women (15-45 years) immunized with at least 2 doses of TT	32.7%
A3. Mothers who are practicing Exclusive Breast Feeding during first 3 months of infancy.	83.3%
A4. Bottle feeding practice of mothers among the infants (0-11 months)	38.6%
A5. Supplementary feeding introduced for children at 4 months age	23.1%
A6. At least one person in a family can prepare ORT at home	35.0%
A7. Children (0-59 months) with diarrhoea in last 2 weeks and treated with ORT	31.5%
A8. Normal food should be given during diarrhoeal episode	20.0%
A9. Extra feeding was given during diarrhoea recovery.	21.72%
A10. Eligible couples in union currently using modern methods of contraception	25.0%
A11. Mothers with children (0-59 months) know how to recognize at least two out of three major life threatening ARI signs.	28.5%
A12. Children (0-59 months) had ARI signs in last 12 months and taken for treatment	23.7%
A13. Pregnant women had been followed-up with at least 3 antenatal Visits	27.7%
A14. Mother after delivery (upto 6 weeks) had been followed-up with postnatal Visit.	20.4%

FROM THE COUNTRY COORDINATOR-WORLD VISION PAKISTAN.

I am very pleased to introduce the Rawalpindi Urban Child Survival Project Baseline Survey Report. This document clearly presents the context which this project will address, and shows the great need for Ministry by World Vision in these communities.

The goals of this project are clear, realistic and measurable. The level of community involvement is high. The cooperation from Government officials continues to be excellent. All of this together promises to achieve a significant impact within the selected wards. It is our desire that the results of this project will multiply and benefit many other people as well.

I commend this baseline survey report, and the vision that it represents. It is more than just a report - It is the foundation for a better life for all the beneficiaries. It also represents a professional approach to achieving health objectives in a community. With this information, all the participants will have clear understanding of the needs of the people, the steps to solving the needs, and the end results that are desired. This should give us hope that the goals will indeed be met, and that the future indeed will be better.

I congratulate all those involved in this worthy Survey, and extend my full support for the success of the Rawalpindi Urban Child Survival Project.



R. Boyd Johnson
Country Coordinator
World Vision Pakistan

ACKNOWLEDGEMENT

The Rawalpindi Urban Child Survival Project, is the first endeavour of World Vision Pakistan to address the issue of "Child Survival and beyond" on a large scale. In fact, it is the largest current Project of WV Pakistan in terms of population impacted, budget etc. Despite many constraints, and the necessity of shifting sites from rural Islamabad to urban Rawalpindi, we were able to conduct the Baseline survey from 29th May 1991 to 9th June 1991.

Firstly, I would like to extend my sincere appreciation and thanks to John Key, South Asia Regional Director, for his keen interest and active support in launching this project. His commitment to the issue of Child Survival and Safe Motherhood has given us strength through our darkest days.

Our grateful thanks to R. Boyd Johnson, Country Coordinator for WV Pakistan, for his encouragement and all-out support for this program. Under his leadership we developed confidence and grew together as a team.

We are especially grateful to Dr. Sri Chander, South Asia Regional Director for Health, World Vision International. His brain-child, this project's Baseline Survey was planned by him.

Our sincere thanks to the Mayor, Mr. Rashid Jillani; Chief Medical Officer Dr. Ghulam Mohenuddin Khan and other staff of the Rawalpindi Municipal Corporation, for their valuable inputs.

Our extreme gratitude to Dr. Iqbal Anwar Project Manager of CSPM Dhaka, and Mr. Abdul Hye, Monitoring and Evaluation Coordinator both of WV Bangladesh, without whom it would not have been possible to conduct a successful Baseline survey.

I would like to thank James Hilton/Field Director and Dr. Kabiruddin Ahmed of WV Bangladesh for allowing us to use their experts to do this Survey and develop a viable Health Information System for this project.

I would like to take cognition of the commendable work done by Dr. Zari John, Operations Coordinator of RUCSP both in the field and in the office, to conduct this survey.

My sincere gratitude goes out to all those Community Development Workers, Nurses, CHWs and Raheel Sheraz, Pansy Asghar & Mrs Wanchoo who toiled hard with us even during weekend holidays.

Finally, my sincere appreciation and thanks to the 4 ward Councillors, and the project community people themselves in helping to make this survey a success.

With best regards



Dr. Fred Griffiths
Project Manager
Rawalpindi Urban Child Survival
Project

INTRODUCTION

Pakistan comprises of 4 major Provinces, each with different languages, 18 divisions and 84 districts.

Pakistan has a dynamic economy, but socio-political problems exist. With an agriculture-based economy and large population of over 110 million, Pakistan is basically a poor country. 21% of the population comprise children under 5 years of age. Annual population growth rate is 3.1%. The rapid growth in population (4 million children are born yearly) cuts across all sectors of the economy, slowing down the process of development.

Unmet needs are large. The gross National product per capita is about \$ 380. 30% of the population employed has to provide for the need of the whole nation.

The fast - growing economy has not helped the lowest income groups to substantially improve their quality of life. 60% of the population comprise small farmers, tenant cultivators and landless labourers. Urban migration from villages is high resulting in urban slums. Lack of access to public services by the poor majority compounds the situation.

In low-income households high density of people per room, poor design of houses, inadequacy of water supply and latrines, shortage of fuel etc. affect women's health more than men.

About 900,000 children die annually. One out of 7 children born dies by the age of 5 years, mostly due to tetanus of the newborn in the first year of life. In older children, the major killers are:

- Diarrhoea	: 300,000	deaths	per	year
- Neonatal Tetanus	: 109,000	-	-	-
- Pneumonia	: 80,000	-	-	-
- Measles	: 35,000	-	-	-
- Malaria	: 50,000	-	-	-
- Accidents etc.	: 75,000	-	-	-

About 172,000 children die annually from diseases that can be controlled by vaccination.

Approximately 60% children are malnourished, mostly due to lack of knowlege of proper infant feeding, not due to lack of food.

27% of infants born are of low-birth weight while 41% of the population is anaemic.

Life expectancy at birth is 58 years.

Considering the prevailing situation in Pakistan and the annual urban population growth rate of 48% overburdening the already crowded hospitals, WV Pakistan decided to plan a Child Survival Project in Rawalpindi City.

The Mayor and Chief Medical Officer of the Rawalpindi Municipal Corporation oversee health related activities within Municipal limits. The Mayor, Mr. Rashid Jillani welcomed World Vision and we were invited to select the sites for the proposed project. After extensive ground survey, it was decided to select wards No 29, 30, 31, and 32, of the old city, namely the localities of Dhok Ratta, part of Ratta Umral, Bhoosa Godam and Shaitan Garhi slums, Hazara Colony, Quaidabad and Mazharabad localities. The open sewage canal draining Islamabad and Rawalpindi traverse these areas and many houses are built along this "nala". With a total population of 35,235 (WV Baseline Survey 1991), this is a very congested area with an average of 6.4 people per family living in a three square Km. area. Sanitary conditions are poor, and most people are of the labour / working class of Pathan and Punjabi Muslims. Only one Municipal Dispensary serves the entire area providing basic medical treatment and EPI vaccinations. Most people consult local practitioners when they fall ill and are referred to the District Headquarters (Civil) or other hospital of Rawalpindi in case of emergency.

As a consequence, considering the need in these areas, we finalised the sites and sent in our teams to demarcate the wards, prior to the conduct of a Baseline survey.

This Baseline Survey will elicit the prevailing Knowledge and Health Practices of mothers with children 0-59 months of age, and the immunization status of children 12-23 months of age. Findings from this survey will be used as the "yard - stick" to measure progress of the program with regard to the changes in the knowledge and practices of women 15-45 years of age and the EPI coverage. It will also help in the planning of program interventions and writing of the Detailed Implementation Plan, setting the priorities and targets over the next two and a half years.

OBJECTIVES

The main objective of this study was to assess the base of existing knowledge, attitude and practice on immunization, Oral Rehydration Therapy, infant feeding, Birth spacing, Acute Respiratory infection, Antenatal and Postnatal check-up, Education, income, as well as pattern of morbidity and mortality of the priority age groups of Ward Nos. 29, 30, 31 and 32 of Rawalpindi Municipal Corporation.

The baseline information will also be used as the "milestone" to measure or evaluate the achievements/progress of different components of the project.

METHODOLOGY

Having considered the important aspects of the project area, it was decided to conduct the survey by using the technique of cluster sampling. A total of 14 teams were engaged in data collection. Each team consisted of one supervisor and one Community Health Worker (CHW). The data was collected from 7th to 9th June 1991. The Survey was undertaken with the direct involvement of Drs. Frederick Griffiths and Zari John of World Vision Pakistan and Dr. Iqbal Anwar and Mr. Abdul Hye of World Vision Bangladesh and a list of personnel associated directly/ indirectly as shown in the Appendix B. By using standard WHO/EPI cluster sampling techniques, the whole process of the survey from the preparation of the questionnaire to the writing of this report took less than one month.

★ **STUDY UNIVERSE:**

The Survey was conducted in 30 out of 100 clusters of Wards No. 29, 30, 31 and 32 of Rawalpindi Municipal Corporation, which no doubt represents the project area both in terms of geographical and socio-economic cultural conditions.

★ **SAMPLING PROCEDURES:**

A three-stage sampling procedure was adopted. One set of 30 clusters was selected from the prepared list of 100 clusters from all the four Wards with the total number of households and population by using the random sampling technique recommended by WHO. The ultimate sampling unit in the target households was the third stage of selection.

★ **SAMPLE SIZE:**

The primary target population were children aged 12 - 23 months and mothers aged 15 - 45 years having children 0 - 11 months of age. In finding out this target population, other women of 15 - 45 years and/or mothers with children of other age groups (24 - 59 months) of under five who came in contact

with data collection teams were also interviewed.

As such, a total of 515 women/mothers (15 - 45 years) of 466 households were interviewed for data collection.

★ **SURVEY INSTRUMENTS:**

The information was collected through a precoded questionnaire. The questionnaire was finalized after getting feedback through field tests and valuable inputs from the experienced persons who are involved with Child Survival Projects of World Vision Bangladesh.

★ **SELECTION OF FIELD WORKERS AND SUPERVISORS:**

The data was collected by the CHWs under the direct supervision of people like physicians, social workers Community Development Workers (CDWs) and Community Health Nurses (CHNs).

★ **ORIENTATION/TRAINING OF INTERVIEWERS AND SUPERVISORS:**

A two-day-long orientation/training session was arranged for the people who were directly involved with the survey. In order to ensure the quality and accuracy of data collection, a field test was also included in the training. 13 CHWs, 3 CHNs, the Monitoring and Evaluation Coordinator, the Operations Coordinator of RUCSP and 5 CDWs of WV Pakistan participated in the training. The training was facilitated by Dr. Fred Griffiths, Project Manager RUCSP of WVP, Abdul Hye, and Dr. Iqbal Anwar of WV Bangladesh.

★ **THE FIELD DATA COLLECTION:**

The data was collected by 14 teams, each of which was formed with one CHW and one supervisor. The period of data collection was from 7th to 9th June, 1991.

★ **REPEATABILITY CHECKS:**

In order to maintain the accuracy of data, three steps of editing/checking were maintained, as follows:

- Information was checked by the respective Supervisors of the team in the field during data collection.
- Filled up questionnaires were checked manually by the Project Manager and Operations Coordinator of RUCSP and Abdul Hye and Dr. Iqbal of WV/BGD. The questionnaires which were found with mistakes were given back to the respective team for necessary correction.
- Edited by the computer through checklist program.

★ **DATA MANAGEMENT AND PROCESSING:**

By applying all the steps of data cleaning/editing, the data of the survey were cleaned and banked into the computer for analysis. Analytical work was done by using a Statistical Package for Social Sciences (SPSS) of the computer.

TABLE-1: IMMUNIZATION STATUS OF THE CHILDREN
(12-23 MONS) BY WARD NO.

IMMUNIZATION STATUS OF CHILDREN (12-23 MNS)	WARD NO.				TOTAL
	29	30	31	32	
FULLY IMMUNIZED BEFORE 1ST B.DAY (WITH CARD)	40 (44.0)	28 (66.7)	19 (67.9)	15 (30.6)	102 (48.6)
FULLY IMMUN. BEFORE 1ST B.DAY (WITHOUT CARD)	4 (4.4)	0	0	11 (22.4)	15 (7.1)
FULLY IMMUNIZED AFTER 1ST B.DAY (WITH CARD)	4 (4.4)	4 (9.5)	2 (7.1)	0	10 (4.8)
FULLY IMMUNIZED AFTER 1ST B.DAY (WITHOUT CARD)	0	4 (9.5)	0	0	4 (1.9)
NOT IMMUNIZED/PARTIALLY IMMUNIZED	43 (47.2)	6 (14.3)	7 (25.0)	23 (46.9)	79 (37.6)
TOTAL	91 (100)	42 (100)	28 (100)	49 (100)	210 (100)

TABLE-2: CAUSES OF FAILURE OF IMMUNIZATION OF THE CHILDREN BY WARD NO.

CAUSES OF FAILURE OF IMMUNIZATION	WARD NO.				TOTAL
	29	30	31	32	
LACK OF INFORMATION	7 (16.3)	0	0	5 (21.7)	12 (15.2)
LACK OF MOTIVATION	8 (18.6)	0	3 (42.9)	5 (21.7)	16 (20.3)
PLACE OF IMMUNIZATION IS TOO FAR	7 (16.3)	0	0	4 (17.4)	11 (13.9)
TIME OF IMMUNIZATION IS INCONVENIENT	3 (7.0)	0	0	0	3 (3.8)
MOTHER IS TOO BUSY	11 (25.6)	0	0	4 (17.4)	15 (19.0)
FAMILY PROBLEMS	0	0	4 (57.1)	0	4 (5.1)
LONG WAITING TIME	3 (7.0)	2 (33.3)	0	0	5 (6.3)
FEAR OF SIDE EFFECTS	4 (9.3)	4 (66.7)	0	5 (21.7)	13 (16.5)
TOTAL	43 (100)	6 (100)	7 (100)	23 (100)	79 (100)

TABLE-3: IMMUNIZATION STATUS OF THE WOMEN (15-45 YEARS) BY WARD NO. (With card & history)

IMMUNIZATION STATUS OF WOMEN (15-45 YEARS)	WARD NO.				TOTAL
	29	30	31	32	
YES, 1 DOSE	11 (7.3)	6 (5.5)	4 (3.3)	5 (3.8)	26 (5.0)
YES, 2 DOSES	45 (29.8)	34 (30.9)	57 (46.3)	18 (13.7)	154 (29.9)
YES, >2 DOSES	3 (2.0)	3 (2.7)	2 (1.6)	6 (4.6)	14 (2.7)
NO	92 (61.0)	67 (60.9)	60 (48.8)	102 (77.9)	321 (62.3)
TOTAL	151 (100)	110 (100)	123 (100)	131 (100)	515 (100)

IMMUNIZATION :

IMMUNIZATION STATUS OF CHILDREN (12-23 MONTHS)

According to this study, among the 466 families, 210 children (12-23 months) were found which is the target group to assess the coverage of immunization of children. Table-1 shows that out of 210 children, 102 (48.6%) were found to be immunized with 6 EPI vaccines (BCG, DPT, OPV and Measles) before their first birthday and they had immunization card in their home . Another 15 (7.1%) children were also immunized full before their first birthday but their mothers failed to show the immunization card or any other document as evidence of full immunization. Only 10 (4.8%) children were immunized with the same after their first birthday and they had the immunization card. Another 4 (1.9%) children were also immunized fully but their mother could not show any card in favour of full immunization. A total No. of 79 children were found who were not immunized which represents 37.6% of the total sample (210).

FAILURE OF IMMUNIZATION :

It has been found from this study that out of 210 children, 79 were found who did not receive any vaccine. Mothers of these unimmunized children mentioned various reasons for not immunizing their children which is shown in table-2. Among them 12 (15.2%) mothers said that due to the lack of proper information they failed to immunize their children. Another 16 (20.3%) mothers mentioned, they did not feel the necessity of vaccinating their children which enumerates the highest percentage in the list. 11 (13.9%) mothers said, due to the long distance of immunization center they could not immunize their children. Only 3 mothers said, time of immunization was inconvenient. A total No. of 15 mothers mentioned they did not have time to take their children for vaccination which represents 19% of the children who were not immunized. Only 4 (5%) mothers said, due to the family problem and their illness they could not immunize their children. Due to the long waiting time 5 (6.3%) mothers did not take their children for vaccination and 13 (16.5%) mothers said they are afraid about the side effects of immunization.

IMMUNIZATION STATUS OF WOMEN (15-45 YEARS):

From Table-3 it has been found that out of 515 women (15-45 years), 26 (5%) were found who received one dose of Tetanus Toxoid (TT) in the last 3 years. 154 (30%) women were immunized with 2 doses of TT and only 14 (2.7%) women said they received more than 2 doses of TT in the last 3 years from the date of Survey. A total of 321 women said they did not receive even a single dose of TT in the last 3 years which represents 62.3% of the total (515) women (15-45 years).

TABLE-4: BREAST FEEDING/BOTTLE FEEDING PRACTICE OF INFANTS (0-11 MONS) BY WARD NO.

INFANT FEEDING PRACTICES		WARD NO.				TOTAL
		29	30	31	32	
BREAST FEEDING PRACTICE OF INFANTS (0-11 MONS)	YES, EBF PRACTICED DURING FIRST 3 MONTHS	32 (40.0)	33 (63.5)	17 (43.6)	27 (69.2)	109 (51.9)
	YES, EBF FIRST 3 MONTHS & STILL CONTINUING	26 (32.5)	16 (30.8)	15 (38.5)	9 (23.1)	66 (31.4)
	YES, BUT NOT EBF	17 (21.3)	0	0	0	17 (8.1)
	NO	5 (6.3)	3 (5.8)	7 (17.9)	3 (7.7)	18 (8.6)
	TOTAL	80 (100)	52 (100)	39 (100)	39 (100)	210 (100)
BOTTLE FEEDING PRACTICE OF INFANTS (0-11-MONS)	YES	34 (42.5)	29 (55.8)	11 (28.2)	7 (17.9)	81 (38.6)
	NO	46 (57.5)	23 (44.2)	28 (71.8)	32 (82.1)	129 (61.4)
	TOTAL	80 (100)	52 (100)	39 (100)	39 (100)	210 (100)

**TABLE-5: WOMEN PRACTICING SUPPLEMENTARY FEEDING TO THEIR CHILDREN
(4-23 MONS) BY WARD NO.**

SUPPLEMENTARY FOOD WAS INTRODUCED	WARD NO.				TOTAL
	29	30	31	32	
AT 4 MONTHS AGE	45 (32.4)	13 (15.9)	16 (22.2)	9 (13.6)	83 (23.1)
AT 5 MONTHS AGE	15 (10.8)	2 (2.4)	11 (15.3)	9 (13.6)	37 (10.3)
AT 6 MONTHS AGE	15 (10.8)	19 (23.2)	10 (13.9)	9 (13.6)	53 (14.8)
AT 7-11 MONTHS AGE	29 (20.9)	30 (36.6)	31 (43.0)	12 (18.2)	102 (28.4)
AT AGE 12 MONTHS AND ABOVE	16 (11.5)	11 (13.4)	4 (5.6)	9 (13.6)	40 (11.1)
NO	19 (13.7)	7 (8.5)	0	18 (27.3)	44 (12.3)
TOTAL	139 (100)	82 (100)	72 (100)	66 (100)	359 (100)

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B. NUTRITION

BREAST FEEDING/BOTTLE FEEDING PRACTICE OF INFANTS (0-11 MONTHS)

If has been revealed from Table-4 that out of 210 mothers, 109 (52%) said they are practicing breastfeeding exclusively and will continue it till 3 months age of the child. 66 mothers mentioned, they practiced the same for the first 3 months of their baby and still continuing which represents 31.4% of the total 210 respondents. Only 17 (8.1%) mothers said they practice breastfeeding for their infant, but not exclusively and 18 (8.5%) mothers mentioned they don't practice breast feeding.

It is also found from this Table that mothers of 81 (38.6%) infants were found to feed their infants with bottle and the rest 129 mothers said they did not practice the same for their infants which represents 61.4% of the total mothers who had infants.

AGE OF CHILDREN OF STARTING SUPPLEMENTARY FOOD:

From this study, a total of 359 children were found whose ages were in between 4 to 23 months. Mothers of those children were asked at what age of their infant/children they started to give extra foods. In reply to this question from table-5 it has been found that out of 359 mothers, 83 (23.1%) started to give extra food to their infant/children from the age of 4 months. 37 (10.3%) mothers gave the same when the age of their infant/ children was 5 months. At the age of 6 months 53 (14.8%) gave the extra foods. Another 102 (28.4%) respondents mentioned that they started to give extra foods when the age of their infants/ children was in between 7 to 11 months. 40 (11.1%) mothers started the same when their children became 12 months and above. A total No. of 44 (12.3%) mothers did not give any extra foods to their infants/children which represents 12.3% of the total respondents (mothers of infants/children 4-23 months).

TABLE-6: KNOWLEDGE OF WOMEN (15-45 YEARS with children o-59 months). ABOUT ORT BY WARD NO.

KNOWLEDGE ABOUT ORT		WARD NO.				TOTAL
		29	30	31	32	
HEARD ABOUT ORT	YES	85 (62.0)	35 (35.4)	24 (21.6)	80 (67.2)	224 (48.1)
	NO	52 (38.0)	64 (64.6)	87 (78.4)	39 (32.8)	242 (51.9)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
CAN PREPARE ORS	YES	83 (60.6)	36 (36.4)	28 (25.2)	16 (13.4)	163 (35.0)
	NO	54 (39.4)	63 (63.6)	83 (74.8)	103 (86.6)	303 (65.0)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)

TABLE-7 CHILDREN (0-59 MONS) WHO HAD DIARRHOEA (IN LAST TWO WEEKS) AND TREATED WITH ORT BY WARD NO.

CHILDREN (0-59 MON) HAD DIARRHOEA IN LAST TWO WEEKS & TREATED WITH ORT		WARD NO.				TOTAL
		29	30	31	32	
HAD DIARRHOEA IN LAST TWO WEEKS	YES	78 (43.8)	64 (48.9)	76 (52.8)	74 (47.7)	292 (48.0)
	NO	100 (56.2)	67 (51.1)	68 (47.2)	81 (52.3)	316 (52.0)
	TOTAL	178 (100)	131 (100)	144 (100)	155 (100)	608 (100)
IF YES, TREATED WITH ORT	YES	35 (44.9)	18 (28.1)	22 (28.9)	17 (23.0)	92 (31.5)
	NO	43 (55.1)	46 (71.8)	54 (71.1)	57 (77.0)	200 (68.5)
	TOTAL	78 (100)	64 (100)	76 (100)	74 (100)	292 (100)

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TABLE-8: KNOWLEDGE OF THE WOMEN (15-45 YEARS) ABOUT THE DIETARY MANAGEMENT OF DIARRHOEA PATIENT BY WARD NO.

KNOWLEDGE ABOUT DIETARY MANAGEMENT & REFERRAL OF DIARRHOEA PATIENT		WARD NO.				TOTAL
		29	30	31	32	
DIETARY MANAGEMENT DURING DIARRHOEA	NO FOOD SHOULD BE GIVEN	11 (8.0)	11 (11.1)	3 (2.7)	35 (29.4)	60 (12.9)
	SELECTIVE FOOD SHOULD BE GIVEN	103 (75.2)	46 (46.5)	61 (55.0)	59 (49.6)	269 (57.7)
	NORMAL FOOD SHOULD BE GIVEN	23 (16.8)	11 (11.1)	36 (32.4)	21 (17.6)	91 (19.5)
	OTHERS	0	3 (3.0)	3 (2.7)	0	6 (1.3)
	DON'T KNOW	0	28 (28.3)	8 (7.2)	4 (3.4)	40 (8.6)
TOTAL		137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
DIETARY MANAGEMENT AFTER DIARRHOEA	NO FOOD SHOULD BE GIVEN	0	2 (2.0)	0	9 (7.6)	11 (2.4)
	SELECTIVE FOOD SHOULD BE GIVEN	27 (19.7)	21 (21.2)	9 (8.1)	10 (8.4)	67 (14.4)
	EXTRA FOOD SHOULD BE GIVEN	32 (23.4)	26 (26.3)	39 (35.1)	4 (3.4)	101 (21.7)
	NORMAL FOOD	73 (56.9)	32 (32.3)	55 (49.5)	92 (77.3)	257 (55.2)
	DON'T KNOW	0	18 (18.2)	8 (7.2)	4 (3.4)	30 (6.4)
TOTAL		137 (100)	99 (100)	111 (100)	119 (100)	466 (100)

WHERE TO TAKE CHILD WITH SEVERE DIARRHOEA	NEARBY DOCTOR / CLINIC/H.CENTRE	96 (70.0)	49 (49.5)	72 (64.9)	96 (81.0)	313 (67.2)
	NEARBY HOSPITAL	37 (27.2)	36 (36.4)	32 (28.8)	23 (19.02)	128 (27.5)
	NO WHERE	2 (1.4)	0	0	0	2 (0.4)
	DON'T KNOW	0	5 (5.2)	5 (4.5)	0	10 (2.1)
	OTHERS	2 (1.4)	9 (9.0)	2 (1.8)	0	13 (2.8)
TOTAL		137 (100)	99 (100)	111 (100)	119 (100)	466 (100)

C. ORAL REHYDRATION THERAPY (ORT)

KNOWLEDGE ABOUT ORT:

According to table-6, out of 466 respondents, 224 (48%) were found who heard about ORT and the rest 242 respondents never heard about the same which represents 52% of the total respondents.

All the respondents were asked how to prepare the correct mixture of Oral Rehydration Saline (ORS) at home in order to see their in-depth knowledge about the preparation of ORS. From this table it has been found that 163(35%) respondents could prepare ORS mixture with correct proportions of salt, sugar/ molasses and safe water and other 303 (65%) respondents did not have idea about the preparation of ORS correctly.

CHILDREN (0-59) HAD DIARRHOEA AND TREATED WITH ORT:

According to the findings of the study, 608 children (0-59 months) were found in the 466 visited families. Mothers of those children were asked whether their children had diarrhoea within last 2 weeks from the date of survey or not. In reply to this question from table -7 it has been found that 292 children got sick with diarrhoea in last 2 weeks which represents 48% of the total children (0-59 months)

TREATMENT OF DIARRHOEA:

The households in which sick (had diarrhoea in last 2 weeks) children were found, respondent of those families were asked what did they do when the child got sick with diarrhea in order to study the usage of ORT.

According to the findings of the table-7, out of those 292 children with diarrhoea, only 92 (31.5%) children were treated with ORT and the rest 200 (68.5%) were not treated with the same.

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DIETARY MANAGEMENT AND REFERRAL OF DIARRHOEA PATIENT

All the respondents were asked to express their opinion about the diet of a patient during diarrhoea and just after the recovery of diarrhoea. They were also asked where to take diarrhoea patient with severe dehydration.

DIETARY MANAGEMENT DURING DIARRHOEA:

From table-8 it has been found that a total number of 60(13%) women expressed their opinion that it is better not to give any food during diarrhoea. 269(58%) respondents said, some selective food should be given to the diarrhoea patient which is the highest percentage in the list.

Only 91 respondents expressed their opinion in favour of giving normal food which represents 19.5% of the total respondents and other 40 (9%) women were found who have not any idea about the food of diarrhoeal patient.

DIETARY MANAGEMENT AFTER DIARRHOEA:

A total No. of 11 (2.4%) respondents mentioned no food should be given just after the recovery of diarrhoea. 67 (14.4%) expressed their opinion in favour of giving selective foods. 101 (21.7%) respondents said that some additional food should be given for quick recovery. Another 257 women mentioned that to give normal food which represents 55.4% of the total respondents and rest 30 (6%) said they don't have any idea about this subject.

WHERE TO TAKE DIARRHOEA PATIENT WITH SEVERE DEHYDRATION:

In reply to this question 313 (67.2%) respondents said to take the patient to a nearby doctor/clinic/Health Center. 128 (27.2%) respondents expressed their opinion in favour of Hospital and other 10 (2.1%) women said they don't know where they should take their child for the treatment of diarrhoea with severe dehydration.

**TABLE-9 MARITAL STATUS OF THE WOMEN (15-45 YEARS)
BY WARD NO.**

MARITAL STATUS OF THE WOMEN (15-45 YEARS)	WARD NO.				TOTAL
	29	30	31	32	
UNMARRIED	31 (20.5)	19 (17.3)	22 (17.9)	24 (18.3)	96 (18.6)
MARRIED (NON-PREGNANT)	95 (63.0)	81 (73.6)	90 (73.1)	89 (67.9)	355 (68.9)
MARRIED (PREGNANT)	18 (12.0)	10 (9.1)	11 (9.0)	18 (13.7)	57 (11.1)
DIVORCE/WIDOW / SEPARATION	7 (4.5)	0	0	0	7 (1.4)
TOTAL	151 (100)	110 (100)	123 (100)	131 (100)	515 (100)

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TABLE-10: DISTRIBUTION OF ELIGIBLE COUPLES
PRACTICING BIRTH SPACING BY WARD NO.

PRACTICE BIRTH SPACING. NAME OF THE METHODS		WARD NO.				TOTAL
		29	30	31	32	
PRACTICE BIRTH SPACING	YES	27 (23.9)	30 (33.0)	32 (31.7)	14 (13.1)	103 (25.0)
	NO	86 (76.1)	61 (67.0)	69 (68.3)	93 (86.9)	309 (75.0)
	TOTAL	113 (100)	91 (100)	101 (100)	107 (100)	412 (100)
NAME OF THE METHOD OF BIRTH SPACING	PILL	3 (11.1)	8 (26.7)	13 (40.6)	3 (21.4)	27 (26.2)
	CONDOM	10 (37.0)	5 (16.7)	7 (21.9)	0	22 (21.4)
	INJECTABLE	2 (7.4)	3 (10.0)	0	3 (21.4)	8 (7.8)
	LIGATION	4 (14.8)	2 (6.7)	0	0	6 (5.8)
	IUD	2 (7.4)	0	0	4 (28.6)	6 (5.8)
	FOAM TABLET/ JELLY	0	0	4 (12.5)	0	4 (3.9)
	MORE THAN ONE	0	3 (10.0)	0	0	3 (2.9)
	OTHERS	6 (22.2)	9 (30.0)	8 (25.0)	4 (28.6)	27 (26.2)
	TOTAL	27 (100)	30 (100)	32 (100)	14 (100)	103 (100)

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TABLE-11: CAUSES OF FAILURE OF BIRTH SPACING
BY WARD NO.

CAUSES OF FAILURE OF BIRTH SPACING	WARD NO.				TOTAL
	29	30	31	32	
RELIGIOUS RESTRICTIONS	6 (7.0)	6 (9.8)	8 (11.6)	0	20 (6.5)
HUSBAND DOES NOT LIKE	12 (14.0)	19 (31.1)	25 (36.2)	10 (10.8)	66 (21.4)
DON'T NEED	29 (33.7)	6 (9.8)	5 (7.2)	48 (51.6)	88 (28.5)
AFFECTS HEALTH	6 (7.0)	0	3 (4.3)	0	9 (2.9)
WANT MORE CHILDREN	11 (12.8)	2 (3.3)	0	0	13 (4.2)
NO REASON	18 (20.9)	24 (39.3)	28 (40.6)	10 (10.8)	80 (25.9)
OTHERS	4 (4.7)	4 (6.6)	0	25 (26.9)	33 (10.7)
TOTAL	86 (100)	61 (100)	69 (100)	93 (100)	309 (100)

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D. BIRTH SPACING

BIRTH SPACING PRACTICE OF ELIGIBLE COUPLES:

In this study 515 women have been found among the 466 households who were interviewed for data collection. Of them, the total No. of eligible couples were 412 who were asked about birth spacing. From table-10, it has been found that among them only 103 women were practicing birth spacing which represents 25% of the total eligible couples and the rest 309 (75%) did not practice the same.

METHOD BEING PRACTICED FOR BIRTH SPACING BY THE RESPONDENTS:

According to the table-10, a total 27 (26.2%) women mentioned that they use pill for birth spacing which is the highest percentage in the list. 22 (21.4%) women mentioned that condom is being used by their husbands for birth spacing. A total No. of 8 (7.8%) women said they are practicing injectable, 6 (5.8%) mentioned they are using IUD and another 27 said they are practicing other methods beyond the mentioned methods which represents 26.2% of the total eligible couples.

CAUSES FOR NOT PRACTICING BIRTH SPACING:

According to findings of this study 309 eligible couples were not practicing birth spacing.

According to the Table-11, among them 20 (6.5%) women mentioned they do not practice birth spacing due to the religious restrictions, A total No of 66 (21.4%) women said they don't practice the same because their husband don't like this, 88 (28.5%) women said they don't need to practice birth spacing. Another 9 (2.9%) women said, they don't practice it because of some adverse effects on health. 13 (4.2%) respondents mentioned they want more children and 80 (25.9%) women could not give any specific reason for not practicing birth spacing.

**TABLE-12 DISTRIBUTION OF THE WOMEN'S KNOWLEDGE
ABOUT ARI BY WARD NO.**

KNOWLEDGE OF WOMEN ABOUT ARI		WARD NO.				TOTAL
		29	30	31	32	
KNOWS ABOUT SIGNS OF ARI AT LEAST 2 OUT OF 3	YES	41 (29.9)	37 (37.4)	38 (34.2)	17 (14.3)	133 (28.5)
	NO	96 (70.1)	62 (62.6)	73 (65.8)	102 (85.7)	333 (71.5)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
WHAT TO DO FOR CHILDREN (0-59 MN) WITH ARI	SEEK TREATMENT FROM NEARBY HOSPITAL/CLINIC	49 (35.8)	12 (12.1)	38 (34.2)	9 (7.6)	108 (23.2)
	TAKE THE CHILD TO NEARBY HOSPITAL/CLINIC	86 (62.8)	63 (63.6)	68 (61.3)	92 (77.3)	309 (66.3)
	DON'T KNOW	2 (1.4)	21 (21.2)	5 (4.5)	9 (7.6)	37 (7.9)
	OTHERS	0	3 (3.0)	0	9 (7.6)	12 (2.6)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)

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TABLE-13: DISTRIBUTION OF THE CHILDREN (0-59 MONS) WHO HAD ARI IN LAST 12 MONTHS & TAKEN FOR TREATMENT BY WARD NO.

CHILDREN (0-59 MONS) HAD ARI IN LAST 12 MONTHS & TAKEN FOR TREATMENT		WARD NO.				TOTAL
		29	30	31	32	
HAD ARI SYMPTOMS IN LAST 12 MONTHS	YES	42 (23.6)	42 (32.1)	39 (27.1)	21 (13.5)	144 (23.7)
	NO	136 (76.4)	89 (67.9)	105 (72.9)	134 (86.5)	464 (76.3)
	TOTAL	178 (100)	131 (100)	144 (100)	155 (100)	608 (100)
IF YES, WHERE THE CHILDREN TAKEN FOR TREATMENT / REFERRAL	NEARBY DOCTOR / CLINIC/HEALTH CENTRE	38 (90.5)	24 (57.1)	26 (66.7)	9 (42.9)	97 (67.4)
	NEARBY HOSPITAL	4 (9.5)	13 (31.0)	10 (25.6)	6 (28.6)	33 (22.9)
	OTHERS	0	3 (7.1)	0	0	3 (2.1)
	NO WHERE	0	2 (4.8)	3 (7.7)	6 (28.6)	11 (7.6)
	TOTAL	42 (100)	42 (100)	39 (100)	21 (100)	144 (100)

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F. ACUTE RESPIRATORY INFECTION (ARI)

KNOWLEDGE ABOUT THE SIGNS/SYMPTOMS OF ARI:

In order to study the in-depth knowledge about ARI, all the respondents were asked to tell at least 2 signs/symptoms of ARI.

From table-12 it has been found that only 133 respondents had knowledge/idea about the sign/symptoms of ARI which represents 28.5% of the total respondents and the rest 333 (71.5%) women did not have any proper understanding/ idea about ARI.

WHAT TO DO FOR THE TREATMENT OF ARI:

It has been revealed from. table-12 that 108 (23.2%) respondents expressed their opinion in-favour of seeking treatment from the health personnel if their children get sick with ARI. A total No of 309 (66.3%) respondents mentioned they feel the necessity of taking the children to hospital/Clinic and another 37 women said they don't have any idea what to do for the treatment of ARI which represents 7.9% of the total respondents.

CHILDREN (0-59 MONTHS) HAD ARI IN LAST 12 MONTHS:

According to this study, 608 children (0-59 months) were found in the 466 visited families. Mothers of those children were asked whether their children got sick with ARI in last 12 months or not.

From table-13 it has been revealed that 144 children (0-59 months) got sick with ARI in last 12 months which represents 23.7% of the total children (0-59 months) and the rest 464 (76.3%) children did not have ARI.

WHERE THE CHILDREN WERE TAKEN FOR TREATMENT OF ARI:

The households in which sick children were found, respondents of those households were asked what did they do when the child got sick with ARI.

According to the table-13, out of 144 children with ARI, 97 (67.4%) were taken to the Doctor/Clinic/ Health Center. A total No. of 33 (22.9%) were taken to the hospital and another 11 were not taken anywhere for the treatment of ARI which represents 7.6% of the total children who got sick with ARI.

TABLE-14: DISTRIBUTION OF WOMEN/MOTHER'S KNOWLEDGE ABOUT SAFE MOTHERHOOD BY WARD NO.

KNOWLEDGE OF WOMEN ABOUT SAFE MOTHERHOOD		WARD NO.				TOTAL
		29	30	31	32	
KNOWLEDGE ABOUT THE NEED FOR MEDICAL CHECK-UP DURING PREGNANCY	YES	89 (65.0)	65 (65.7)	74 (66.7)	34 (28.6)	262 (56.0)
	NO	48 (35.0)	34 (34.3)	37 (33.3)	85 (71.4)	204 (44.0)
TOTAL		137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
IF YES, BY WHOM/ WHERE	TBA	7 (7.9)	7 (10.8)	23 (31.1)	13 (38.2)	50 (19.1)
	UNQUALIFIED LOCAL DOCTORS	12 (13.5)	2 (3.1)	0	0	14 (5.3)
	QUALIFIED DOCTORS	9 (10.1)	5 (7.7)	5 (6.8)	8 (23.5)	27 (10.3)
	HOSPITAL/CLINIC	59 (66.3)	47 (72.3)	42 (56.8)	13 (38.2)	161 (61.5)
	OTHERS	2 (2.2)	4 (6.2)	4 (5.4)	0	10 (3.8)
	TOTAL	89 (100)	65 (100)	74 (100)	34 (100)	262 (100)
OPINION ABOUT THE PLACE OF DELIVERY	HOME	111 (81.0)	85 (85.9)	80 (72.1)	115 (96.6)	391 (83.9)
	CLINIC/HOSPITAL	24 (17.5)	14 (14.1)	26 (23.4)	4 (3.4)	68 (14.6)
	OTHERS	2 (1.5)	0	5 (4.5)	0	7 (1.5)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
TOTAL NO OF DEATHS DUE TO PREGNANCY IN LAST 5 YEARS		2	9	4	6	21

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TABLE-15: WOMEN'S KNOWLEDGE ABOUT ANTENATAL & POSTNATAL CHECKUP BY WARD NO.

KNOWLEDGE ABOUT ANTENATAL & POSTNATAL CHECKUP		WARD NO.				TOTAL
		29	30	31	32	
NO. OF CHECKUPS DURING PREGNANCY	1-3 TIMES	28 (20.4)	34 (34.3)	19 (17.1)	13 (10.9)	94 (20.2)
	4-6 TIMES	38 (27.8)	19 (19.2)	12 (10.8)	17 (14.3)	86 (18.5)
	MORE THAN 6 TIMES	14 (10.2)	6 (6.1)	23 (20.7)	0	43 (9.2)
	WHEN THERE IS A PROBLEM	14 (10.2)	0	32 (28.8)	7 (5.9)	53 (11.4)
	NO	35 (25.5)	32 (32.2)	20 (18.0)	78 (65.5)	165 (35.4)
	DON'T KNOW	8 (5.8)	8 (8.1)	5 (4.5)	4 (3.4)	25 (5.4)
TOTAL		137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
MOTHER AFTER DELIVERY UP TO 6 WEEKS NEEDS MEDICAL CHECKUP FOR HERSELF & /OR BABY	YES	22 (16.1)	34 (34.3)	25 (22.5)	5 (4.2)	86 (18.5)
	NO	115 (83.9)	65 (65.7)	86 (77.5)	114 (95.8)	380 (81.5)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
IF YES BY WHOM/ WHERE	TBA	3 (13.6)	0	0	5 (100)	8 (9.3)
	UNREGISTERED LOCAL DOCTORS	2 (9.1)	3 (8.8)	0	0	5 (5.8)
	QUALIFIED DOCTORS	2 (9.1)	2 (5.9)	5 (20.0)	0	9 (10.5)
	HOSPITAL/CLINIC	15 (68.2)	23 (67.6)	20 (80.0)	0	58 (67.4)
	OTHERS	0	6 (17.6)	0	0	6 (7.0)
	TOTAL	22 (100)	34 (100)	25 (100)	5 (100)	86 (100)

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TABLE-16: DISTRIBUTION OF MOTHERS WHO PRACTICED ANC DURING LAST PREGNANCY BY WARD NO.

PRACTICED ANC DURING LAST PREGNANCY		WARD NO.				TOTAL
		29	30	31	32	
WHERE YOUR LAST CHILD WAS DELIVERED	HOME	109 (79.6)	82 (82.8)	77 (69.4)	116 (97.5)	384 (82.4)
	CLINIC/HOSPITAL	28 (20.4)	17 (17.2)	25 (22.5)	3 (2.5)	73 (15.7)
	OTHERS	0	0	9 (8.1)	0	9 (1.9)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
DURING YOUR LAST PREGNANCY DID YOU HAVE ANC	YES	81 (59.1)	45 (45.5)	68 (61.3)	21 (17.6)	215 (46.1)
	NO	56 (40.9)	54 (54.5)	43 (38.7)	98 (82.4)	251 (53.9)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
IF YES BY WHOM/WHERE	TBA	4 (4.9)	3 (6.7)	25 (36.8)	9 (42.9)	41 (19.1)
	UNQUALIFIED LOCAL DOCTORS	12 (14.8)	6 (13.3)	3 (4.4)	0	21 (9.8)
	QUALIFIED DOCTORS	4 (4.9)	3 (6.7)	4 (5.9)	3 (14.3)	14 (6.5)
	HOSPITAL/CLINIC	61 (75.3)	33 (73.3)	36 (52.9)	9 (42.9)	139 (64.7)
	TOTAL	81 (100)	45 (100)	68 (100)	21 (100)	215 (100)

**TABLE-17: DISTRIBUTION OF MOTHERS WHO PRACTICED PNC AFTER
LAST DELIVERY BY WARD NO.**

PRACTICE OF PNC AFTER LAST DELIVERY		WARD NO.				TOTAL
		29	30	31	32	
AFTER DELIVERY (UP TO 6 WEEKS) DID YOU HAVE POST -NATAL CARE FOR YOUR BABY	YES	28 (20.4)	27 (27.3)	25 (22.5)	15 (12.6)	95 (20.4)
	NO	109 (79.6)	72 (72.7)	86 (77.5)	104 (87.4)	371 (79.6)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
IF YES, BY WHOM/ WHERE	TBA	4 (14.3)	2 (7.4)	3 (12.0)	1 (6.7)	10 (10.5)
	UNQUALIFIED DOCTOR	3 (10.7)	1 (3.7)	1 (4.0)	1 (6.7)	6 (6.3)
	QUALIFIED DOCTOR	1 (3.6)	1 (3.7)	2 (8.0)	0	4 (4.2)
	HOSPITAL/CLINIC	20 (71.4)	22 (81.5)	19 (76.0)	11 (73.3)	72 (75.8)
	OTHERS	0	1 (3.7)	0	2 (13.3)	3 (3.2)
	TOTAL	28 (100)	27 (100)	25 (100)	15 (100)	95 (100)

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SAFE MOTHERHOOD.

Knowledge about the need of medical checkup during pregnancy and by whom /where:

In order to study the in-depth knowledge regarding medical checkup during pregnancy all the women were asked "Do you think that the pregnant women needs medical check-up?"

In reply to this question 262 respondents expressed their opinion in favor of medical check-up during pregnancy which represents 56% of the total respondents.

According to table-14, among these 262 respondents. 50 (19.1%) opined in favour of checking up by the traditional birth attendants. Another 14 (5.3%) women felt the necessity of going to the unregistered local doctors. A total No. of 27 women said they should be checked up by the qualified physician which represents 10.3% of the total respondents. Another 161 (61.5%) respondents opined for going to the hospital/clinic for the same.

OPINION ABOUT THE PLACE OF DELIVERY:

According to the findings of the study, only 68 respondents mentioned hospital/clinic is the best place for delivery which represents 14.6% of the total respondents and other 391 (83.9%) women think that "Home" is the best place for delivery. Only 7 women mentioned for other places.

KNOWLEDGE OF WOMEN ABOUT ANTENATAL CARE (ANC)

In order to study the in-depth of knowledge of women/mothers about ANC, all the respondents were asked "What do you think about the No. of check-ups during pregnancy".

In reply to this question from table-15, it has been found that 93 (20%) respondents expressed their opinion in favour of checking up 1-3 times during the pregnancy. Similarly 86 (18.5%) women for 4-6 times and 43 (9.2%) for more than 6 times checking up in pregnancy period. 53 (11.4%) women mentioned if any complication arise, then they will go to the doctor. A very large No. of women (135) said they don't feel any necessity of medical check up during pregnancy which represents 35.4% of the total respondents and rest 26 (5.6%) said they don't have idea about this subject.

KNOWLEDGE OF WOMEN/MOTHERS ABOUT THE POSTNATAL CARE:

According to the findings of the table-15, out of 466 women only 86 felt the necessity of check-up of the mother and or baby within the last 6 weeks after delivery which represents 18.5% of the total respondents and the rest 334 (81.5%) women did not feel the necessity of checking-up after delivery.

Out of these 86 women who expressed their opinion in favour of check-up after delivery, 8 (9.3%) said to go to the TBA for check up. 5 (5.8%) women opined in favour of unregistered local physician. A total No. of 9 (10.5%) respondents said mother/baby should be checked up by the qualified physician. Another 58 (67.4%) women gave the importance of going to hospital/clinic for medical check after delivery.

WHERE THE LAST CHILD OF RESPONDENT WAS DELIVERED?

All the respondents were asked about the place of delivery of the last child.

In response to this question from table-16 it has been found that 384 mothers said that each of them delivered their child at home which represents 82.4% of the total mothers and other 73 (15.7%) mothers delivered at hospital/ clinic.

DID THE MOTHERS HAVE ANTENATAL CARE AND BY WHOM /WHERE

All the mothers of this study were asked did they receive antenatal care during the pregnancy of their last child. In reply to this question, 215 (46.1%) mothers said, they received ante-natal care during last pregnancy and rest 251 did not receive ANC during the last pregnancy which represents 53.9% of the total mothers.

According to table-16, among these 215 mothers who received ANC, 41 (19.8%) said they were under the medical care of TBA. A total No of 21 (9.8%) mentioned they were under the medical care of unregistered local Doctor, another 14 (6.5%) received medical care from the qualified physician. Other 139 (64.7%) mothers received the same from the hospital /clinic, which is the highest percentage in the list.

AFTER DELIVERY UPTO 6 WEEKS DID THEY HAVE POST NATAL CARE:

It has been revealed from table-17 that only 95 (20.4%) mothers/infants received postnatal care and the rest-371 (79.6%) did not receive the same neither for their infants nor themselves.

Among these 95 mothers, 10 (10.5%) said that they consulted with TBA. A total No of 6 (6.3%) mothers mentioned they received treatment/consultation from the unregistered local doctors. Only 4 (4.2%) said they went to the qualified physician for the treatment/consultation after delivery, and a very good number of mothers (72) went to the clinic/hospital for the same which represents 75.8% of the total mothers/babies who received postnatal care.

TABLE-18: DISTRIBUTION OF MOTHER'S EDUCATION
BY WARD NO.

MOTHER'S EDUCATION	WARD NO.				TOTAL
	29	30	31	32	
CLASS 1-5	23 (16.8)	16 (16.2)	13 (11.7)	0	52 (11.2)
CLASS 6-8	17 (12.4)	5 (5.1)	6 (5.4)	9 (7.6)	37 (7.9)
CLASS 9-10	18 (13.1)	14 (14.1)	28 (25.2)	0	60 (12.9)
CLASS 11-12	2 (1.5)	0	0	0	2 (0.4)
CLASS 12 +	6 (4.4)	5 (5.1)	3 (2.7)	0	14 (3.0)
NIL	71 (51.8)	59 (59.6)	61 (55.0)	110 (92.4)	301 (64.6)
TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)

TABLE-19: SOCIO-ECONOMIC STATUS OF THE RESPONDENTS BY WARD NO.

SOCIO-ECONOMIC INFORMATION OF THE FAMILIES		WARD NO.				TOTAL
		29	30	31	32	
MONTHLY INCOME OF THE FAMILY	<1000 RS	47 (34.3)	50 (51.0)	46 (41.0)	45 (38.0)	188 (40.0)
	1000-2000 RS	48 (35.0)	28 (28.0)	43 (39.0)	69 (58.0)	188 (40.0)
	2001-5000 RS	25 (18.2)	5 (5.0)	18 (16.0)	5 (4.0)	53 (11.0)
	5001-10,000 RS	6 (4.4)	2 (2.0)	0	0	8 (2.0)
	10,000 & ABOVE	0	8 (8.0)	0	0	8 (2.0)
	DON'T KNOW	11 (8.0)	6 (6.0)	4 (4.0)	0	21 (5.0)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)
SOURCE OF INCOME	CULTIVATION	0	6 (6.1)	0	0	6 (1.3)
	ODD JOBS/LABOR	28 (20.4)	17 (17.2)	22 (19.8)	72 (60.5)	139 (29.8)
	SERVICE	50 (36.5)	11 (11.1)	22 (19.8)	6 (5.0)	89 (19.1)
	BUSINESS	20 (14.6)	12 (12.1)	33 (29.7)	5 (4.2)	70 (15.0)
	TONGA DRIVERS	3 (2.2)	0	16 (14.4)	4 (3.4)	23 (4.9)
	OTHERS	36 (26.3)	53 (53.5)	18 (16.2)	32 (26.9)	139 (29.8)
	TOTAL	137 (100)	99 (100)	111 (100)	119 (100)	466 (100)

TABLE-20 INFORMATION OF THE BIRTHS & DEATHS IN LAST ONE YEAR BY WARD NO.

NO.OF BIRTHS & DEATHS IN LAST ONE YEAR		WARD NO.				TOTAL
		29	30	31	32	
BIRTH IN LAST ONE YEAR	LIVE BIRTH	84	29	32	12	157
	STILL BIRTH	0	6	0	0	6
DEATH OF CHILDREN (0-59 MON IN LAST ONE YEAR	DEATH IN (0-11 MONS)	10	10	0	3	23
	DEATH IN (12-59 MONS)	15	3	0	3	21
	TOTAL DEATH IN (0-59 MONS)	25	13	0	6	44
CAUSES OF DEATH	DIARRHOEA	2 (8.0)	4 (30.8)	0	0	6 (13.6)
	MALNUTRITION	3 (12.0)	0	0	0	3 (6.8)
	ARI	4 (16.0)	3 (23.0)	0	3 (50.0)	10 (22.7)
	OTHERS	16 (64.0)	6 (46.2)	0	3 (50.0)	25 (56.9)
	TOTAL	25 (100)	13 (100)	0	6 (100)	44 (100)

G. SOCIO-ECONOMIC STATUS

MOTHER'S EDUCATION:

It has been found from table - 18, that out of 466 respondents 301 who had no formal education which represents 64.6% of the total respondents, 52 (11.2%) women were found whose education level were from class 1-5, 37 (7.9%) women were from class 6-8, 60 (12.9%) respondents were from class 9-10 and education level was above class ten for only 16 (3.4%) women.

MONTHLY INCOME OF THE FAMILY:

According to the findings of table-19, out of 466 families 188 (40%) were found whose monthly income was less than 1000 Rupees. Monthly income of another 188 (40%) families is in between 1001-2000 Rupees. A total No of 53 (11%) families were found whose monthly income is in between 2001-5000 rupees. Only 16 (4%) families were found who earn monthly more than 5000 rupees and the rest 21 (5%) women did not know the monthly income of their family.

SOURCE OF INCOME OF THE FAMILY:

All the respondents were asked what is the main source of income of their family. In response to this question, from table-19 it has been found that 139(29.8%) respondents mentioned, they earn money for livelihood by odd-job/labour which is the highest percentage among all. 89(19.1%) respondents said that service is the main source of income of their family. A total 70(15%) families were found whose main source of income is business. Tonga driver is the main source of income for 23 (4.9%) families and the rest 139(29.8%) families mentioned about the other sources which is beyond the list.

BIRTHS, DEATHS (0-59 MONTHS) AND CAUSE OF DEATH

According to this study a total No. of 157 children born in last one year in the 466 families which were interviewed, only 6 mothers said they delivered still birth.

Total No. of infant (0-59 months) deaths among the 466 families were 23 in the last 5 years and 21 children of age group 12-59 died in the last 5 years.

Table-20 shows that among 44 children who died during last five years, of them 6(13.6%) died of diarrhoea. 3(6.8%) children died due to the cause of malnutrition. 10 children (0-59 months) died of ARI (22.7%) and the rest 25 children (56.9%) died of the other diseases.

APPENDIX A.

RAWALPINDI URBAN CHILD SURVIVAL PROJECT
A PROJECT OF WORLD VISION PAKISTAN.

PRECODED QUESTIONNAIRE FOR THE BASELINE SURVEY (Infants 0-59 months and Women 15-45 years)

Ward No. _____ Cluster No _____ Comp No _____ Serial No _____ Name of
CHW _____
Date of Visit _____

1. General Information of the family:

1.1 Name of the family Head.

1.2 Address

1.3 Identity of the child:

* Age

* Sex. 1. Male 2. Female.

2.1 BCG: 1. Taken + Scar
2. Taken but no scar
3. Not taken
0. Not Applicable (N/A).

2.2 DPT/OPV 1. Taken one dose
2. Taken 2 Doses
3. Taken 3 Doses
4. Not taken
0. N/A.

2.3 Measles: 1. Taken
2. Not taken
0. N/A.

2.4 Source 1. Hospital
2. Private Doctor/Clinic
3. Health Centre
4. Outreach
5. NGO
6. Other
0. N/A.

2.5 Fully Immunized:

1. Yes, with card (12-23 mos Before first Birth day)
2. Yes, without/card (12-23 mos Before first Birthday)
3. Yes, with card (12-23 mos after first birthday)
4. Yes, without card (12-23 mos after first birthday)
5. No.
0. N/A

2.6 Causes of failure of immunization:

1. Lack of information
2. Lack of motivation
3. Place of immunization too far
4. Time of immunization in convenient.
5. Mother too busy
6. Family problem including illness of mother.
7. Long waiting time
8. Fear of side effect
9. Other
10. N/A.

3. Feeding practices:

3.1 Breast feeding: Infants 0-11 mos.

1. Yes, Exclusive breast feeding during first 3 months.
2. Yes, - - - - - and still continuing.
3. Yes, but not exclusive breast feeding.
4. No.
0. N/A.

3.2 Bottle feeding 0-11 Months.

1. Yes
2. No
3. N/A

3.3 Weaning food introduced at 4-23 Months:

1. 4 mos
2. 5 mos
3. 6 mos
4. 7-11 mos
5. 12 mos +
6. No
7. N/A.

65

4. Pneumonia (ARI): (0-59 months)

4.1 Had ARI symptoms in the last 12 months., Yes 2.No

4.2 Taken for treatment / Referred to .

1. Nearby Hospital
2. Others
3. No
4. N/A.

4.3 Mother knows about the Signs of ARI (At least 2 out of 3 signs)

1. Yes 2. No

4.4 What to do for children 0-59 mos with ARI.

1. Seek treatment from nearby health person
2. Take child to nearby hospital / Clinic
3. Don't know
4. Other

5. Oral Rehydration therapy (ORT): (0-59 Months)

5.1 Had diarrhoea in the last 2 weeks.

5.2 Treated with ORT

1. Yes 2. No.

5.3 Heard about ORT

5.4 Can prepare ORS.

1. Yes 2. NO

6. Dietary management of diarrhoea: (Children 0-59 Months)

6.1 During diarrhoea

1. No food should be given
2. Selective food should be given
3. Normal food (including breast milk)
4. Others
5. Dont' know.

6.2 After diarrhoea:

1. No food should be given
2. Selective food should be given
3. Extra food should be given
4. Normal food - - -
5. Don't know.

7. Where to take child with severe diarrhoea (0-59 Months)

1. Nearby Doctor/Clinic /Health Centre
2. Hospital
3. Nowhere
4. Don't know
5. Others.

8. Was there any birth in the last one year?

1. Yes, 1.
2. Yes, 2
3. Yes, 3
4. Still birth
5. No.

9. Death of child 0-59 months in the one year:

01. Yes, 0-11 mos
02. Yes, 12-23 mos
03. Yes, 24-35 mos
04. Yes, 36-59 mos
05. Yes, (0-11 mos) + (12-23 mos)
06. Yes, (0-11 mos) + (24-35 mos)
07. Yes, (0-11 mos) + (36-59 mos)
08. Yes, (12-23 mos) + (24-35 mos)
09. Yes, (12-23 mos) + (36-59 mos)
10. Yes, (24-35 mos) + (36-59 mos)
11. More than one death in the same age groups
12. No death.

WOMEN (15-45 YEARS)

10. Marital status:

1. Unmarried
2. Married (Non-pregnant)
3. Married (Pregnant)
4. Divorced / Separated / Widow.

11. Immunized with Tetanus Toxoid.

1. Yes, 1 dose
2. Yes, 2 doses
3. Yes, > 2 doses
4. No.

12. Practise Birth Spacing:

1. Yes 2.No. 0. N/A.

13. Name of family planning method:

1. Pill
2. Condom
3. Injection
4. IUD
5. Foam Tab /Jelly
6. Ligation
7. Vasectomy
8. More than one method
9. Others
0. N/A.

14. Cause for failure of Birth spacing:

1. Religious Restriction
2. Husband doesn't like
3. Don't need
4. Affects health
5. Don't have children
6. Want more children
7. No reason
8. Other
0. N/A.

15. Knows about the need for medical checkup during pregnancy:
1 Yes. 2. No

16. If yes, by whom / where.

1. Traditional Birth Attendant
2. Unqualified lady doctor
3. Qualified Doctor
4. Relatives
5. Hospital/ Clinic
6. Others
0. N/A.

17. Place of delivery.

1. Home
2. Clinic/ Hospital
3. Other

18. Death due to pregnancy / delivery in the last 5 years.

1. 1 Death
2. 2 Deaths
3. 2 + deaths
4. No deaths

19. No of checkups during pregnancy:

1. 1 Time
2. 2 Times
3. 3 Times
4. 4-5 Times
5. 6.Times
6. 6 + Times
7. When there is problem.
8. No
- 9 Don't know.

20. Mother, after delivery (upto 6 weeks) needs checkup for herself and / or baby.

1. Yes. 2. NO

21. If yes, by whom /where.

(as for No. 16)

22. Where your last child was delivered.

1. Home
2. Clinic/Hospital
3. Other
0. N/A.

23. During your last pregnancy did you have Ante-natal care.

1. Yes 2. No. 0. N/A

24. If yes, by whom / where.

(as for No. 16, 21)

25. After delivery (upto 6 weeks) did you have post-natal care for you and / or your baby.

1. Yes 2. No 0. N/A.

26. If yes, by whom / where.

(as for NOs. 16. 21. and 24)

27. Mother's formal education.

1. Class 1-5
2. Class 6-8
3. Class 9-10
4. Class 11-12
5. Class 12 +.
6. Nil

28. Monthly income of the family.

1. < 1000 Rs.
2. 1001-2000 Rs.
3. 2001-5000 Rs.
4. 5001-10,000 Rs.
5. 10,000 Plus.
6. Don't know.

29. Source of income:

1. Cultivation
2. Odd jobs/ Labour.
3. Service
4. Business
5. Tonga Driver
6. Other.

APPENDIX B

LIST OF CONTRIBUTORS:

SURVEY DESIGN

	<u>DESIGNATION</u>	<u>PLACE</u>
1. Dr. Frederick Griffiths	Project Manager RUCSP	WV Pak
2. Dr. Zari John	Operations Coordinator RUCSP	WV Pak
3. Dr. Sri Chander	Regional Director Health	WV Sing
4. Dr. Iqbal Anwar	Project Manager CSPM	WV BGD
5. Abdul Hye	Monitoring & Evaluation Coordinator	WV BGD
6. Dr. Ghulam Mohenuddin	Chief Medical Officer	RMC

DATA COLLECTION

1. Sajida Philip	CHW	8. Tereza	CDW
2. Nasreen	CHW	9. Pansy	CHW
3. Rubina	CHW	10. Elizabeth	CHW
4. Rehana	CHW	11. Gulshan	CHW
5. Jasmine	CHW	12. Asther	CHW
6. Asenath	CDW	13. Ghazala	CDW
7. Sajida Naz	CHW	14. Josephine	CHW

DATA CONSISTENCY CHECK/FIELD LEVEL SUPERVISION:

1. Margaret	CHN	8. Saleem Bhatti	CHW
2. Rubina Kashif	CHN	9. Daud Lal Din	CHW
3. Dr. Zari John	O.C	10. Saleem Bashir	CDW
4. Dr. Iqbal Anwar	P.M. CSPM, WV/BGD	11. Shakeel	CDW
5. Mr. Abdul Hye	M&E WV/BGD	12. Albert	CDW
6. Raheel Sheraz	M&E WV/Pak	13. Javed Masih	CDW
7. Dr. Fred Griffiths	P.M	14. Philip	CHW

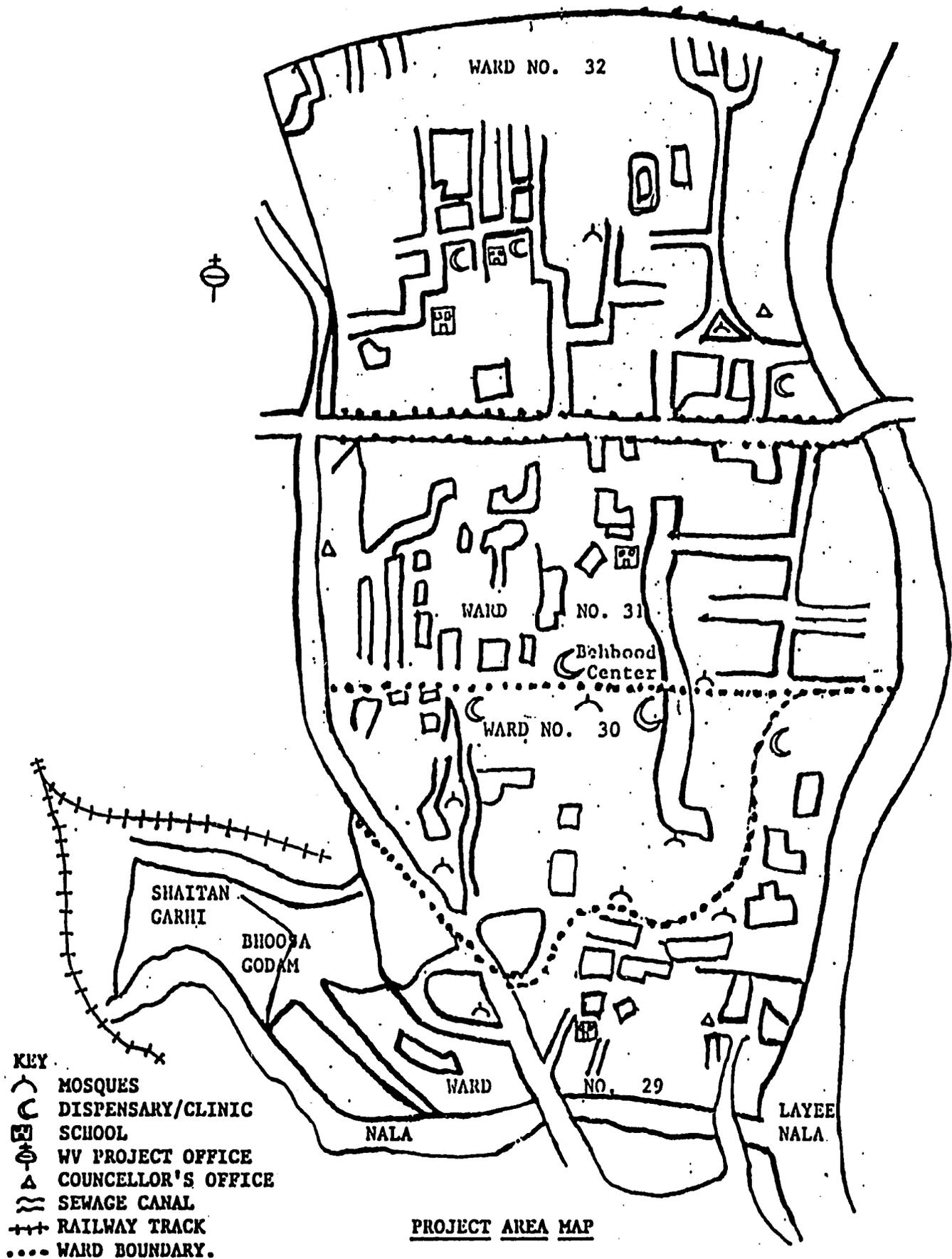
DATA ANALYSIS

1. Abdul Hye
2. Raheel Sheraz
3. Pansy Asghar

REPORT WRITING:

1. Dr. Frederick Griffiths
2. Abdul Hye
3. Dr. Iqbal Anwar

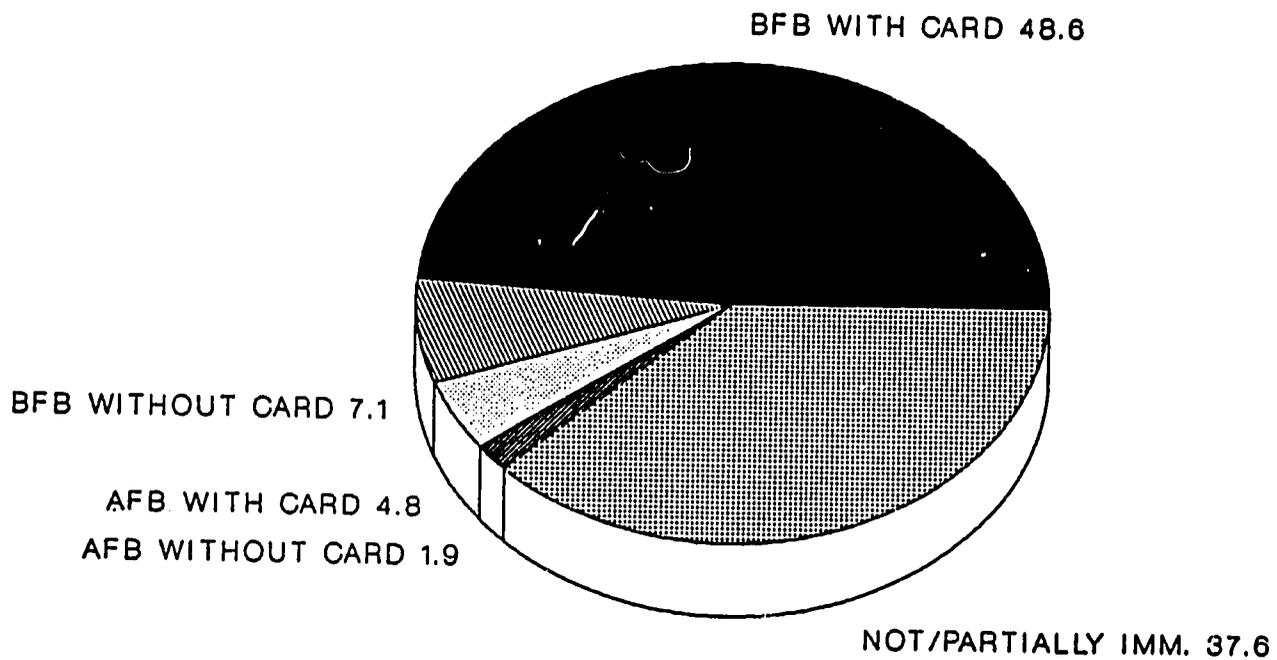
THE RAWALPINDI URBAN CHILD SURVIVAL PROJECT



PROJECT AREA MAP

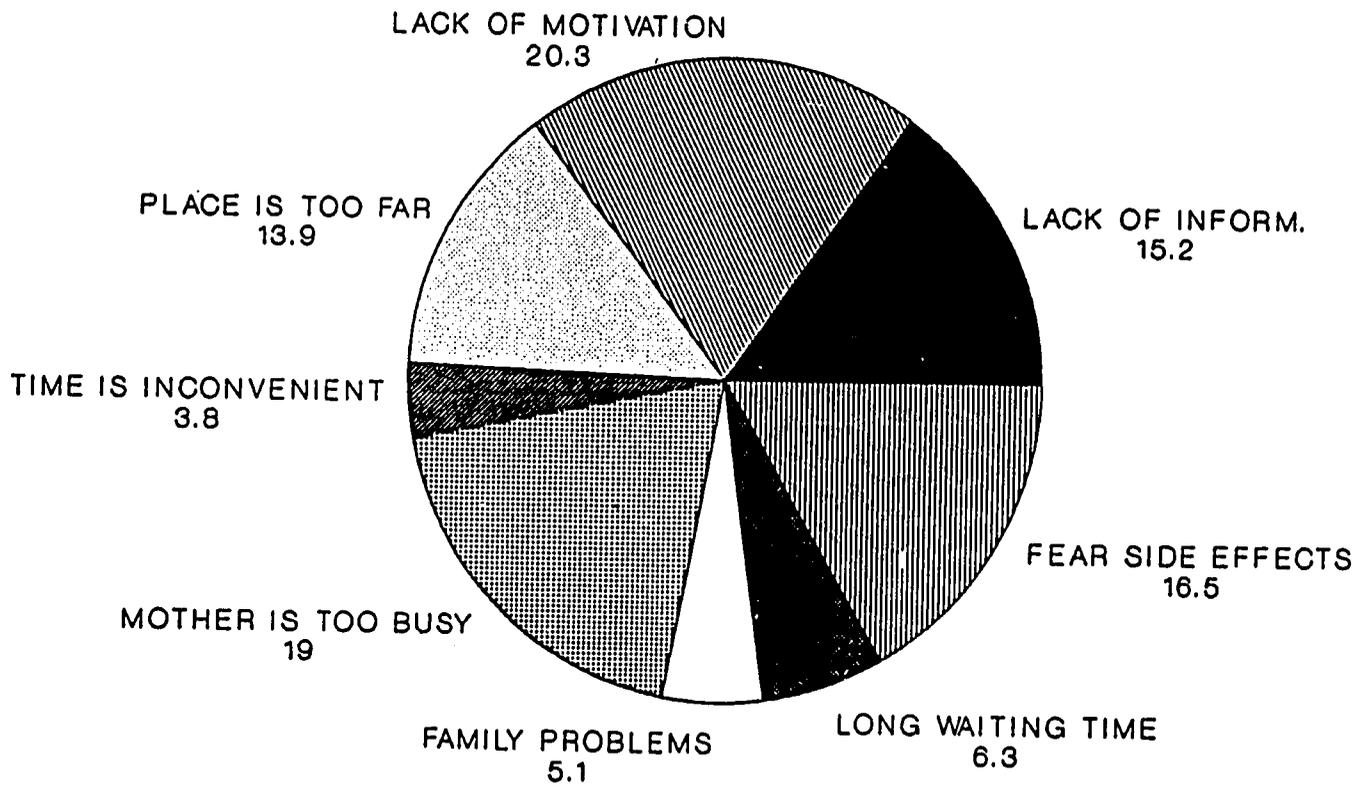
SCALE 10 MM=1 KM

IMMUNIZATION STATUS OF THE CHILDREN (12-23 MONS)

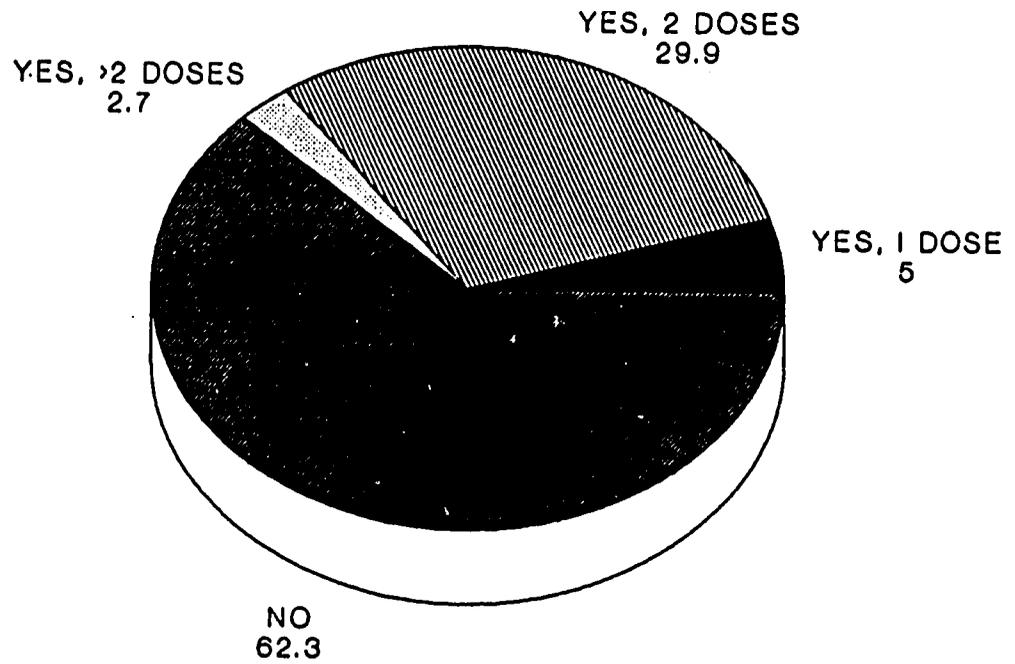


BFB = Before First Birthday
AFB = After First Birthday

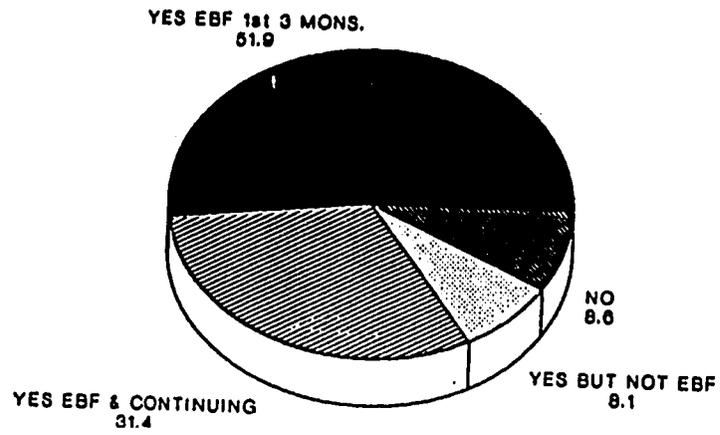
CAUSES OF FAILURE OF IMMUNIZATION OF THE CHILDREN



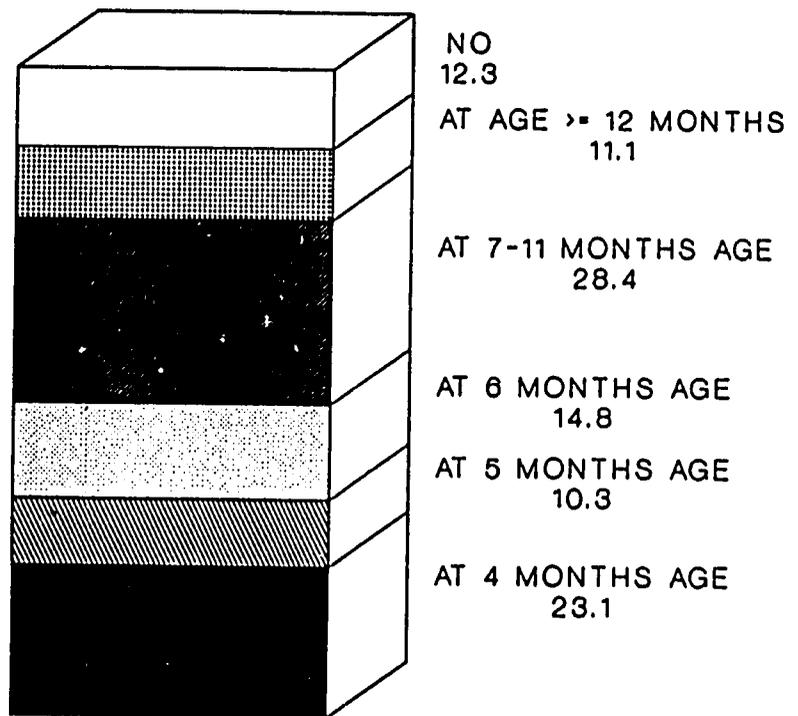
IMMUNIZATION STATUS OF THE WOMEN (15-45 YEARS)



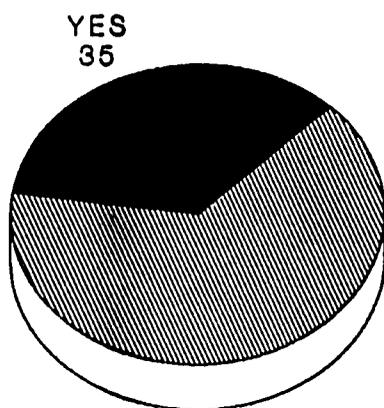
BREAST FEEDING PRACTICE OF INFANTS (0-11 MONS)



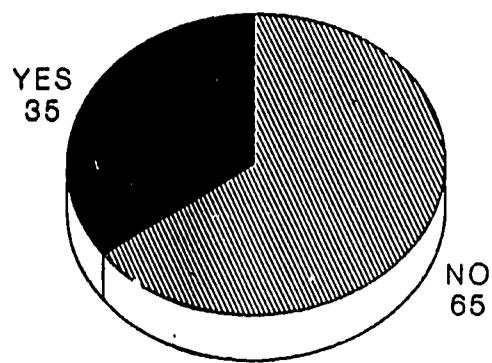
WOMEN PRACTICING SUPPLEMENTARY FEEDING TO THEIR CHILDREN (4-23 MONS)



KNOWLEDGE OF WOMEN (15-45 YEARS, WITH CHILDREN 0-59 MONTHS) ABOUT ORT

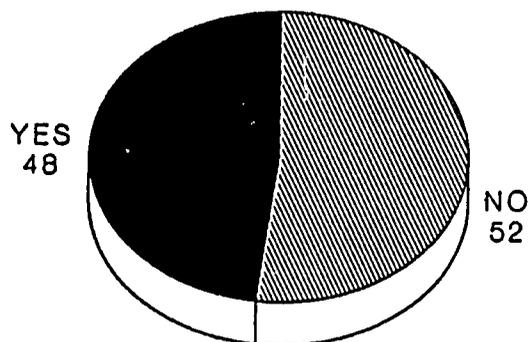


NO
65
WOMEN WHO HEARD ABOUT ORT

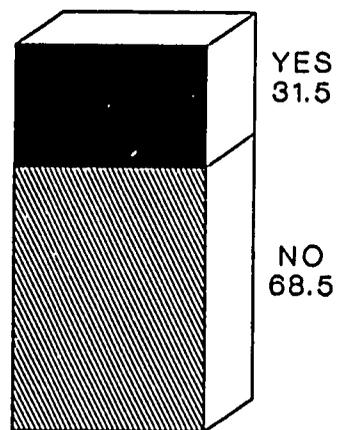


YES
35
NO
65
WOMEN WHO CAN PREPARE ORS

CHILDREN (0-59 MONS) WHO HAD DIARRHOEA (IN LAST 2 WEEKS) AND TREATED WITH ORT

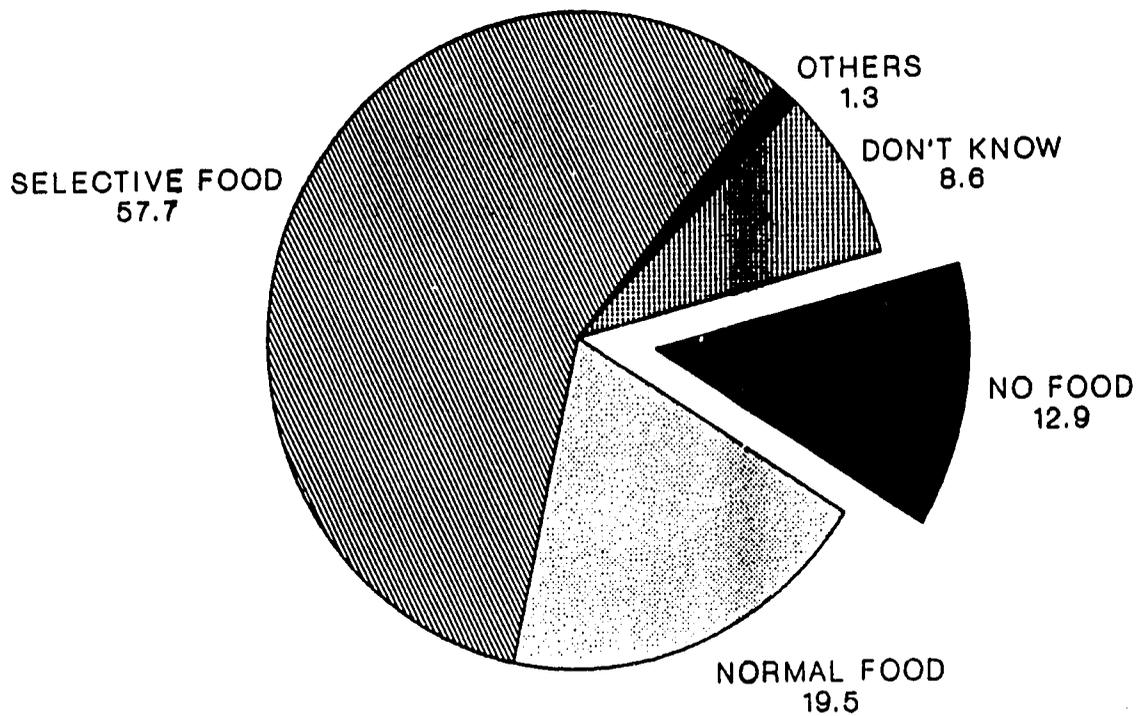


CHILDREN WHO HAD
DIARRHOEA IN LAST TWO WEEKS

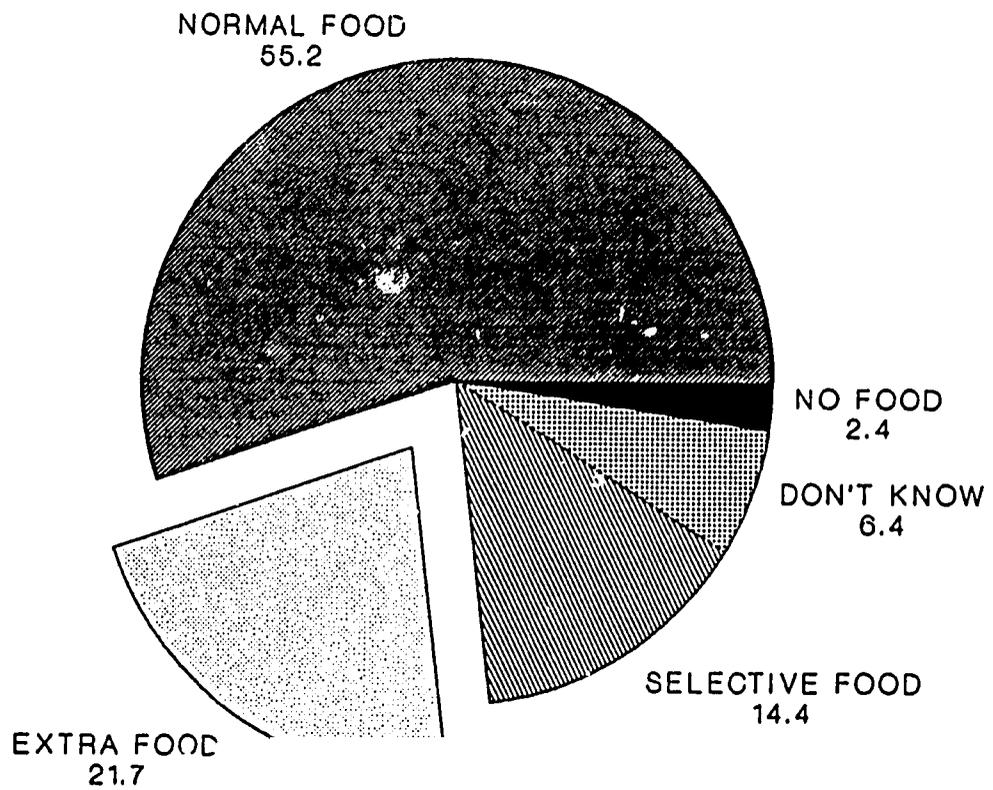


IF YES, TREATED WITH ORT

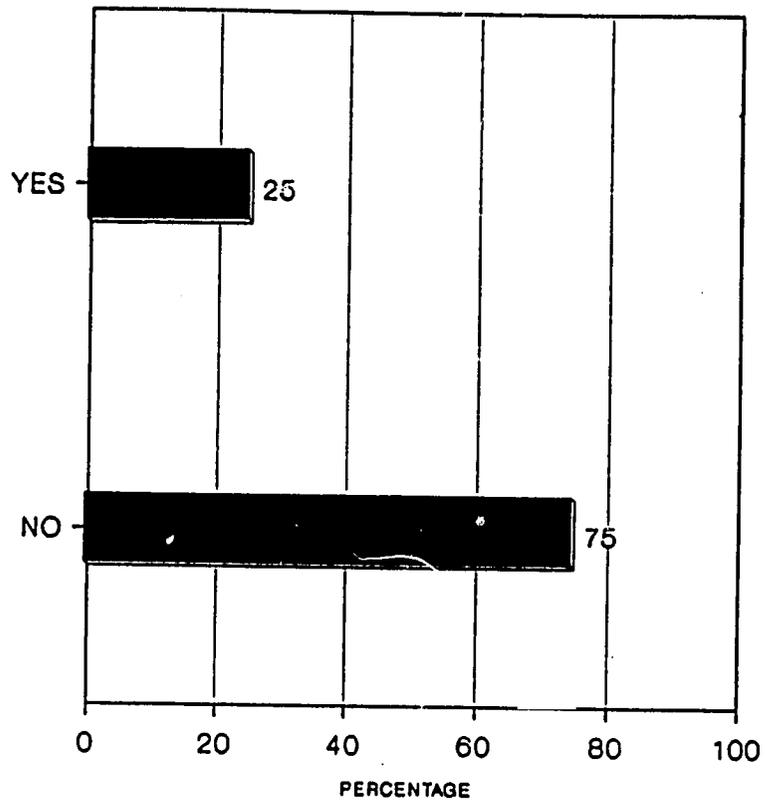
KNOWLEDGE OF THE WOMEN (15-45 YEARS) ABOUT DIETARY MANAGEMENT DURING DIARRHEA



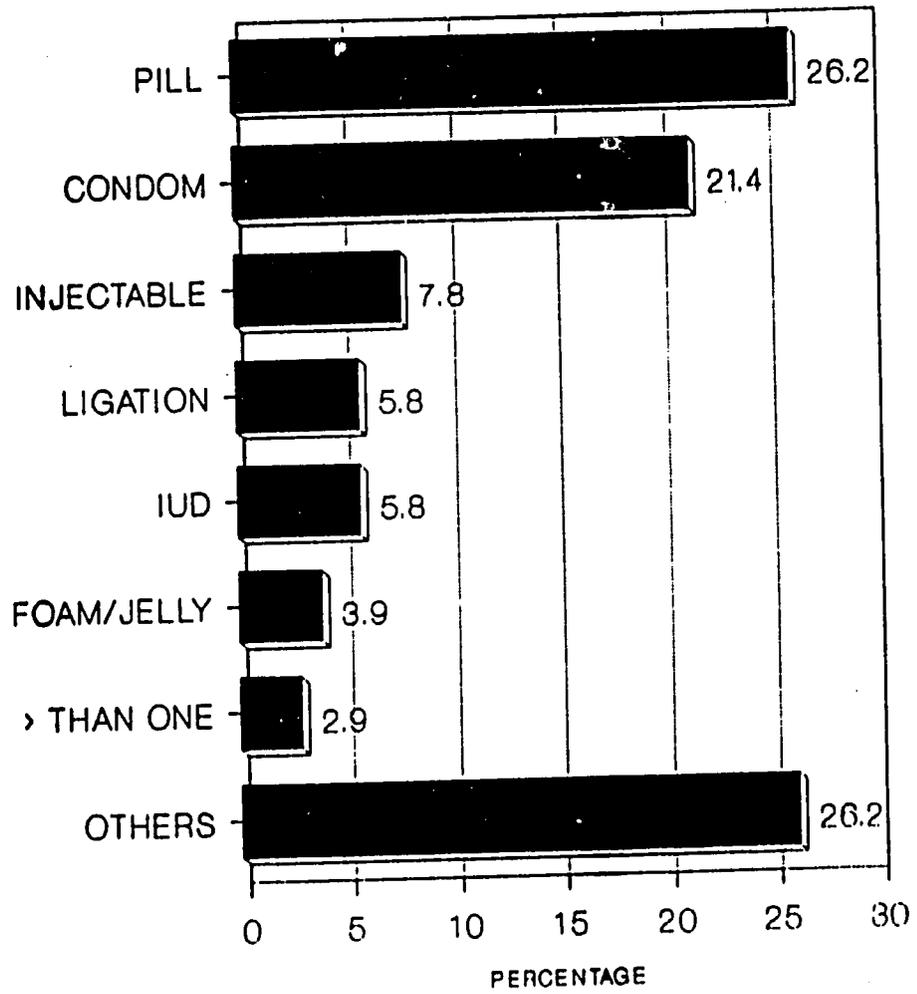
KNOWLEDGE OF THE WOMEN (15-45 YEARS) ABOUT DIETARY MANAGEMENT AFTER DIARRHOEA



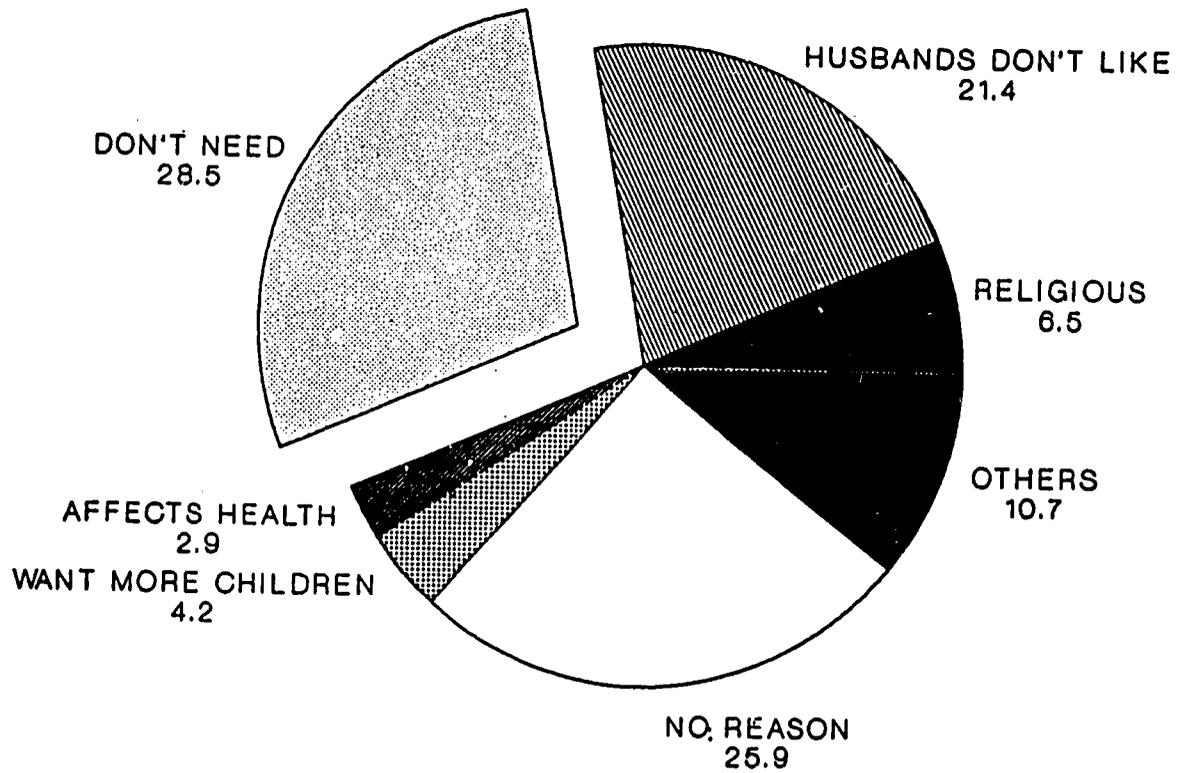
DISTRIBUTION OF ELIGIBLE COUPLES PRACTICING BIRTH SPACING



NAME/METHODS OF BIRTH SPACING

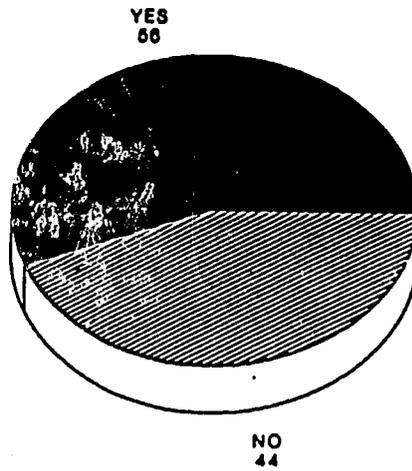


CAUSES OF FAILURE OF BIRTH SPACING

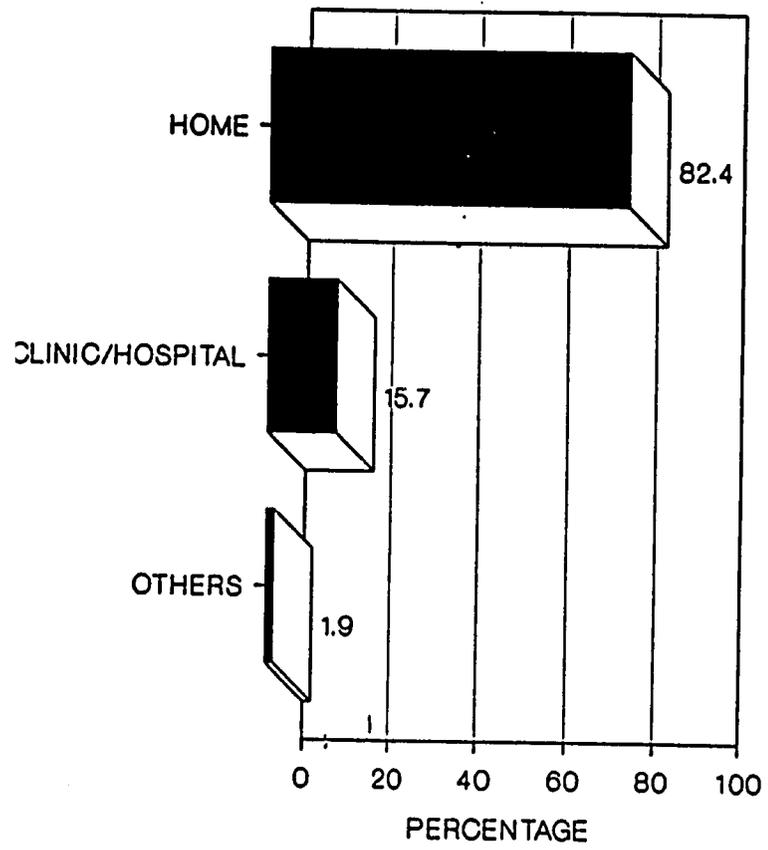


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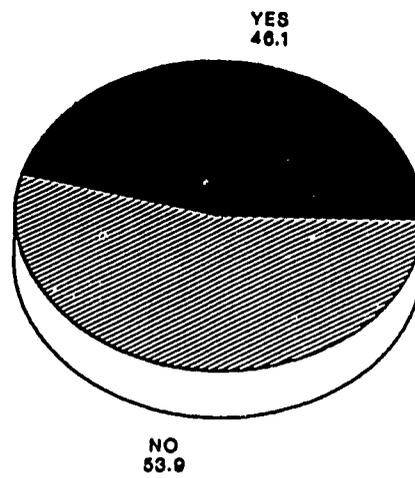
WOMEN/MOTHER'S KNOWLEDGE ABOUT MEDICAL CHECK-UP DURING PREGNANCY



WHERE THE LAST CHILD WAS DELIVERED

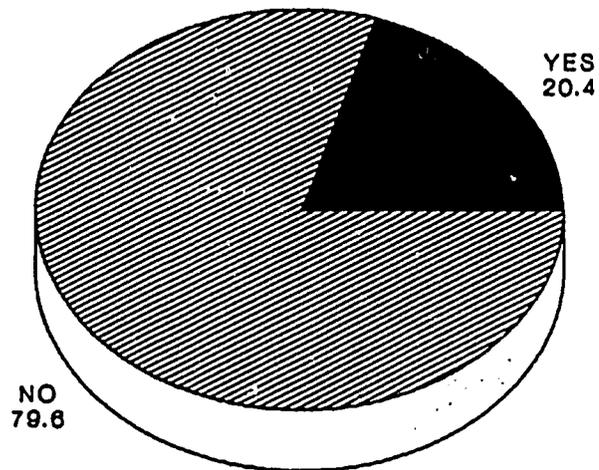


**DID THE MOTHER HAVE ANTENATAL
CARE DURING LAST PREGNANCY**

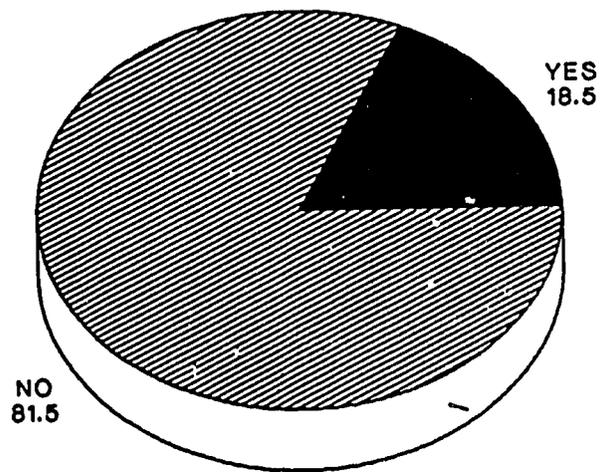


9/8

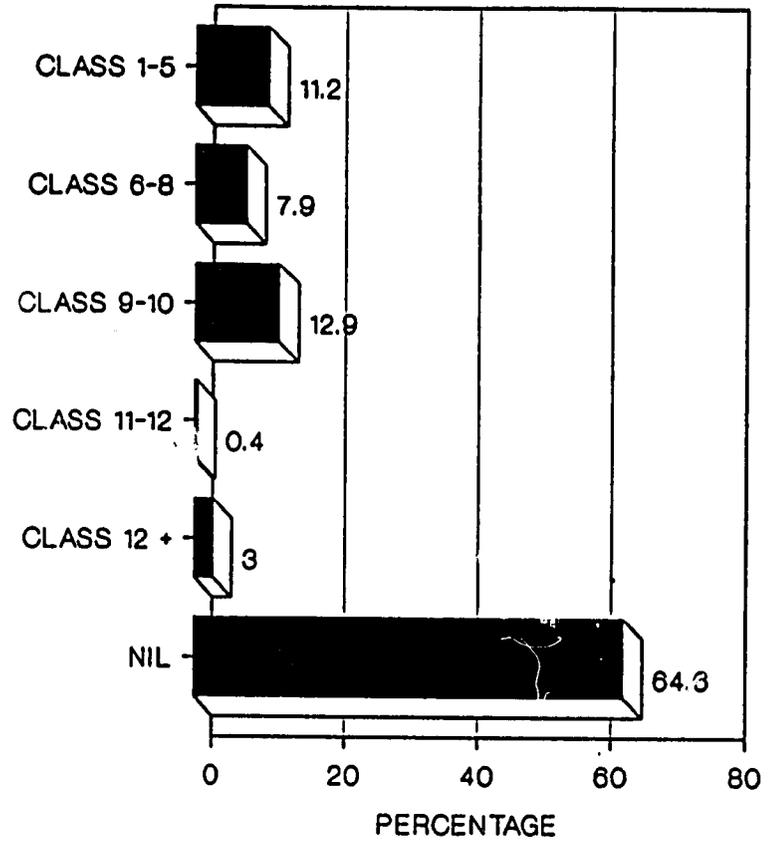
MOTHERS WHO PRACTICED PNC AFTER LAST PREGNANCY



WOMEN'S KNOWLEDGE ABOUT CHECKUPS AFTER DELIVERY UPTO 6 WEEKS

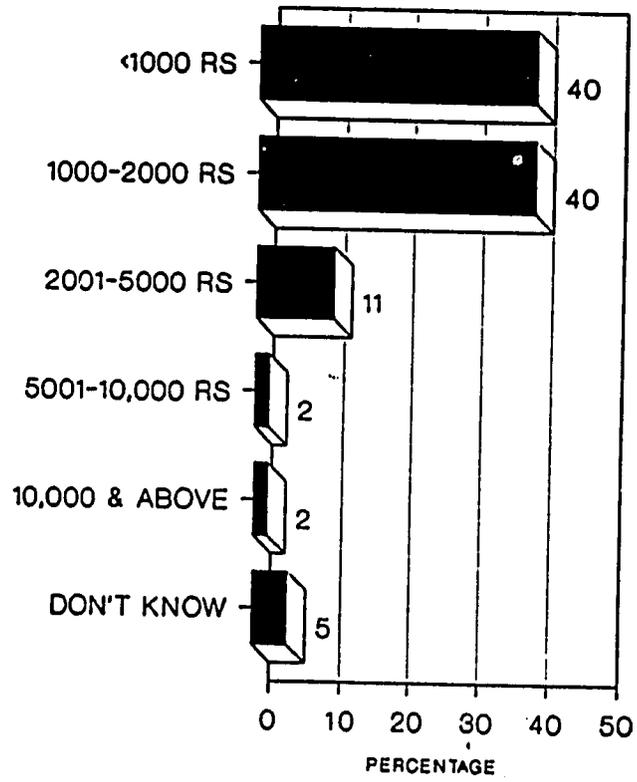


DISTRIBUTION OF MOTHER'S EDUCATION

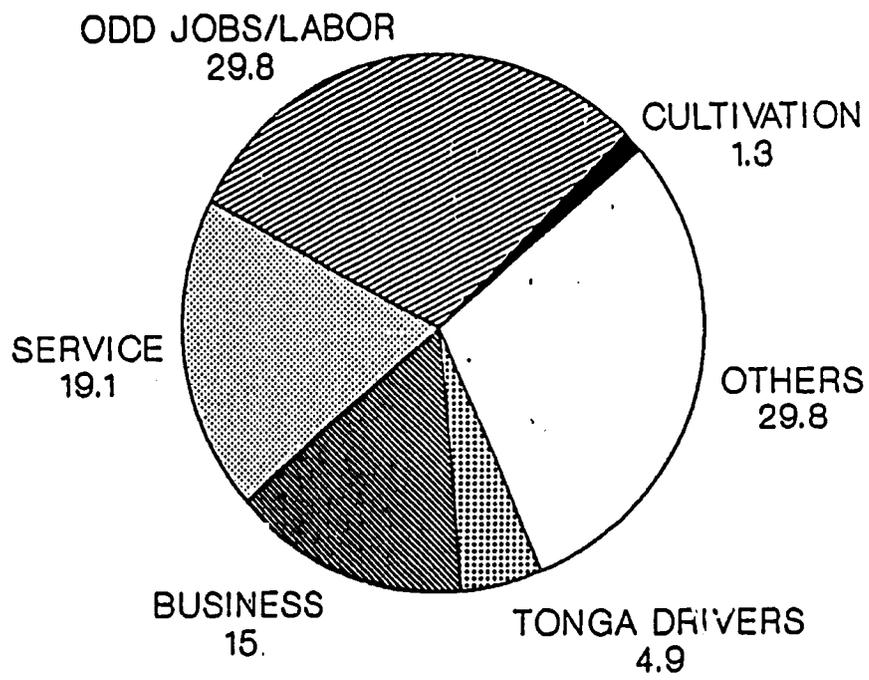


SOCIO-ECONOMIC STATUS OF THE RESPONDENTS

MONTHLY INCOME OF THE FAMILY

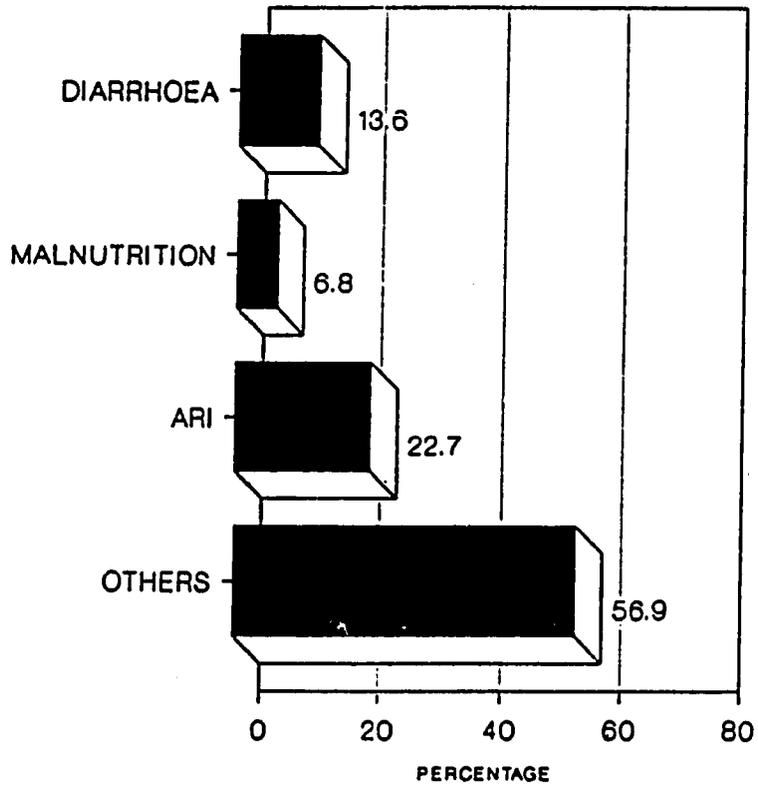


SOURCE OF INCOME



CAUSES OF DEATHS IN THE LAST ONE YEAR

CAUSES OF DEATH



APPENDIX 4

PIPELINE ANALYSIS
W.V.R.D./PAKISTAN CHILD SURVIVAL PROJECT
#OTR-0500-A-00-0105-00

FIELD	Actual Expenditures To Date (09/01/90 to 9/30/91)			Projected Expenditures Against Remaining Obligated Funds (10/1/91 to 8/31/93)			Total Agreement Budget (Columns 1 & 2) (09/01/90 to 8/31/93)		
	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
COST ELEMENTS									
I. PROCUREMENT									
A. Supplies	6,165	685	6,850	59,335	4,815	64,150	65,500	5,500	71,000
B. Equipment	789	44,652	45,441	1,801	11,818	13,619	2,590	56,470	59,060
C. Services/Consultants	3,418	0	3,418	45,082	0	45,082	48,500	0	48,500
SUB-TOTAL I	10,372	45,337	55,709	106,218	16,633	122,851	116,590	61,970	178,560
II. EVALUATION/SUB-TOTAL II	0	0	0	18,402	0	18,402	18,402	0	18,402
III. INDIRECT COSTS									
Overhead on Field (20%)	10,934	34,254	45,188	66,877	146,214	213,091	77,810	180,468	258,278
SUB-TOTAL III	10,934	34,254	45,188	66,877	146,214	213,091	77,810	180,468	258,278
IV. OTHER PROGRAM COSTS									
A. Personnel	24,081	0	24,081	151,694	0	151,694	175,775	0	175,775
B. Travel/Per diem	16,449	0	16,449	30,806	0	30,806	47,255	0	47,255
C. Other Direct Costs	4,554	2	4,556	51,264	7,998	59,262	55,818	8,000	63,818
SUB-TOTAL IV	45,084	2	45,086	233,764	7,998	241,762	278,848	8,000	286,848
TOTAL FIELD	66,390	79,593	145,983	425,261	170,845	596,106	491,650	250,438	742,088

* Note: Other Direct Costs consist of Rent, Utilities, Insurance, Training, Communications and \$2 for miscellaneous office hospitality costs. Equipment charged to AID actually consists of items which have a value of \$500 or less per unit item.(camera with flash and accessories, desktop calculator, slide projector and two tape recorders).

PLANNED EXPENSES FOR PAKISTAN CHILD SURVIVAL PROJECT #OTR-0500-A-00-0105-00

LINE ITEMS	AMOUNT	COMMENTS
I. Supplies	1,165	This represents amount exceeded in first year's budget which is needed for the first three months of the new fiscal year.
II. Salaries	62,715	All staff have been hired and are on contracts with the exception of three dispatch persons and two drivers. Original budget of \$70,475 has been reduced by \$7,760 for these positions.
III. Communications	750	The communications budget for copies, printed information, telephone, fax, courier and telex is \$5,900. Information will need to be provided over the next three months (October - December) to World Vision and local officials regarding the spending and termination of this project's AID funding and also to finalize narrative and pipe-analyses to AID/Washington. The monthly communications budget is \$250 and this request represents funding for the three months from termination date through final settlement.
IV. Rental	2,800	A lease agreement for facilities for the project has been signed and payment must be made in FY92.
V. Insurance(vehicle)	1,700	Insurance for the vehicle purchased with World Vision funds must be paid in FY92.
VI. Fuel (vehicle and generator)	1,500	The annual fuel budget for the vehicle and generator is \$5,000. This request is for funding of these costs for the three months from termination to final settlement.
Total Direct Costs	70,630	
Indirect Costs @ 20% of total direct expenses less equipment	14,126	
Grand Total Planned Funds	84,756	

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PIPELINE ANALYSIS (PLANNED EXPENDITURES)
W.V.R.D./PAKISTAN CHILD SURVIVAL PROJECT
#OTR-0500-A-00-0105-00

FIELD	Planned Expenditures Through FY92 (09/01/90 to 9/30/92)			Projected Expenditures Against Remaining Obligated Funds (10/1/92 to 8/31/93)			Total Agreement Budget (Columns 1 & 2) (09/01/90 to 8/31/93)		
	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
COST ELEMENTS									
I. PROCUREMENT									
A. Supplies	7,330	16,185	23,515	58,170	(10,685)	47,485	65,500	5,500	71,000
B. Equipment	789	45,152	45,941	1,801	11,318	13,119	2,590	56,470	59,060
C. Services/Consultants	3,418	2,700	6,118	45,082	(2,700)	42,382	48,500	0	48,500
SUB-TOTAL I	11,537	64,037	75,574	105,053	(2,067)	102,986	116,590	61,970	178,560
II. EVALUATION/SUB-TOTAL II	0	0	0	18,402	0	18,402	18,402	0	18,402
III. INDIRECT COSTS									
Overhead on Field (20%)	25,060	89,094	114,154	52,751	91,374	144,125	77,810	180,468	258,278
SUB-TOTAL III	25,060	89,094	114,154	52,751	91,374	144,125	77,810	180,468	258,278
IV. OTHER PROGRAM COSTS									
A. Personnel	86,796	0	86,796	88,979	0	88,979	175,775	0	175,775
B. Travel/Per diem	16,449	5,000	21,449	30,806	(5,000)	25,806	47,255	0	47,255
C. Other Direct Costs	11,304	26,002	37,306	44,514	(18,002)	26,512	55,818	8,000	63,818
SUB-TOTAL IV	114,549	31,002	145,551	164,299	(23,002)	141,297	278,848	8,000	286,848
TOTAL FIELD	151,146	184,133	335,279	340,505	66,305	406,810	491,650	250,438	742,088

* Note: Other Direct Costs consist of Rent, Utilities, Insurance, Training, Communications and miscellaneous office hospitality costs. Equipment charged to AID actually consists of items which have a value of \$500 or less per unit item.(camera with flash and accessories, desktop calculator, slide projector and two tape recorders).

COUNTRY PROJECT PIPELINE ANALYSIS

ANNUAL DETAIL

FIELD COST ELEMENTS -----	Actual Expenditures To Date (9/01/90 to 9/30/91)			Planned Expenditures Through FY92 (10/01/91 to 9/30/92)		
	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT						
A. Supplies	6,165	685	6,850	1,165	15,500	16,665
B. Equipment	789	44,652	45,441		500	500
C. Services/Consultants	3,418	0	3,418	0	2,700	2,700
SUB-TOTAL I	10,372	45,337	55,709	1,165	18,700	19,865
II. EVALUATION/SUB-TOTAL II			0			0
III. INDIRECT COSTS						
Overhead on Field (20%)	10,934	34,254	45,188	14,126	54,840	68,966
SUB-TOTAL III	10,934	34,254	45,188	14,126	54,840	68,966
IV. OTHER PROGRAM COSTS						
A. Personnel	24,081		24,081	62,715	0	62,715
B. Travel/Per diem	16,449	0	16,449	0	5,000	5,000
C. Other Direct Costs	4,554	2	4,556	6,750	26,000	32,750
SUB-TOTAL IV	45,084	2	45,086	69,465	31,000	100,465
TOTAL FIELD	66,390	79,593	145,983	84,756	104,540	189,296

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APPENDIX 5
Agency for International Development
Washington, D.C. 20523

SEP 20 1991

Mr. Paul B. Thompson
Executive Director
Corporate Services
World Vision Relief &
Development Organization
919 West Huntington Drive
Monrovia, CA 91016

Subject: Partial Termination of Cooperative Agreement No.
OTR-0500-A-00-0105-00

Dear Sirs:

Due to the legal prohibitions against United States assistance to Pakistan contained in Section 669 of the Foreign Assistance Act, as amended, it is necessary to suspend for changed conditions the portion of the subject agreement for which the Agency for International Development (A.I.D.) is providing direct funding for activities in Pakistan.

The effective date of the suspension of the activities will be September 30, 1991. As of that date all activities in Pakistan using A.I.D. funds must cease. Any costs incurred after that date in Pakistan citing A.I.D. funds will be disallowed. We expect that the agreement will be formally terminated 60 days thereafter.

Within 30 calendar days of the effective date of this suspension, your organization shall submit a cost analysis of all A.I.D. funds incurred and planned to be used in Pakistan. This analysis shall show both obligated and planned funds. Please note that this analysis is not the settlement claim which is due within 90 days of the effective date of termination.

Based upon a review of this analysis, A.I.D. may decide (1) to recover any obligated funds remaining and formally terminating all portions of the agreement relating to A.I.D. supported activities in Pakistan, or (2) to utilize the remaining obligated funds and any additional planned funds in one or more of the other countries included in the subject agreement. Once the aforementioned cost analysis is submitted the Grant Officer shall provide a written decision within 30 calendar days. Any recommendations from your organization would be appreciated.

In the event that the second aforementioned option is affirmed, an amendment to the agreement will be issued. In addition, any funds that your organization continues to expend in Pakistan would be considered as part of the cost share provisions of the agreement.

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You are directed to acknowledge this communication by signing in the space provided under my signature. You are requested to make a facsimile transmission of your executed copy, but in any case mail the original executed copy. Facsimile machine number is (703) 875-1107.

If you have any question please contact Mrs. Veronica Smith on (703) 875-1170.

Sincerely,

Edward H. Thomas

Edward H. Thomas
Grant Officer
Central Operations Branch
Office of Procurement

Acknowledge for: World Vision Relief and Development

NAME: *Paul B. Thompson*

TITLE: Executive Director

DATE: October 7, 1991

TIME: 8:30am

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**RAWALPINDI URBAN CSP
TRAINING CURRICULUM FOR CONTROL OF DIARRHEAL DISEASES & ORT**

	TOPIC	OBJECTIVE	PERSON RESP.
A.	Classroom Training		
1	Definition/common causes of diarrhea	To provide CHWs/CVs a better understanding of diarrhea and its causes.	Maureen (Training Coordinator)
2	Diarrheal Dehydration - Signs/symptoms - Degrees - Basic Management	To enable the CHWs to recognize degrees of dehydration and to be able to provide the appropriate treatment/referral.	Dr. Griffiths (Project Manager)
3	ORT: - Mix and administer ORS/SS - Continue feeding during diarrhea - Increase feeding after diarrhea - Refer if diarrhea persists, and if diarrhea is bloody, mucoid. Specific Messages for ORT using the Facts for Life messages.	To enable CHNs/CHWs/CVs to correctly prepare and administer ORS—the correct dietary management of diarrhea, and the indications for referral. To provide CHWs/CVs key messages in ORT. To ensure that ORT messages for mothers are targeted.	Dr. Zari (Operations Coordinator) Dr. Zari
4	Health Education - Promote breastfeeding, especially colostrum - Suggest easy recipes for semi-solid food - Sanitation	To train CHWs/CVs on the various topics.	Maureen
5	Referral - Method - Where - Record keeping	To enable the CHW to appropriately refer the child as needed.	Dr. Griffiths
6	Management of High-Risk Children: (with any or all of the following characteristics.) - Moderate/severe dehydration - More than 2 episodes of diarrhea in a month - Blood and mucous in stools * Follow-up	To underscore the importance of identifying and managing the high-risk child.	Dr. Zari
7	Special Training In Knowledge-Practice Gap - education - motivation - communication	To provide CHWs skills to enable them to influence communities' attitudes, behavior, and practice.	National Institute of Health
B.	On-the-Job Training (Two weeks)	To provide experiential training to CHWs to reinforce classroom teaching.	Maureen

**RAWALPINDI URBAN CSP
Prime Messages for Mothers**

1. Children who have moderate/severe dehydration, or who have more than two episodes of diarrhea in a month, or with blood and mucous in the stools are high risk for more serious illness and might die later if unattended and not followed up.
2. Continue breastfeeding even if the child has diarrhea.
3. Diarrhea drains fluid from a child's body. Hence, if diarrhea is not controlled and fluid is not replaced, this could lead to the child's death. It is essential to give the child plenty of liquids to drink.
4. A child with diarrhea needs food. Give extra food everyday for at least a week if a child is recovering from diarrhea.
5. Do not use pharmaceuticals unless prescribed by a health professional. Diarrhea can be prevented by breastfeeding, especially colostrum, by using latrines, washing hands before eating and after using the toilet, and by improving the nutritional status of children.

Methodologies

1. Role play
2. Films
3. Flip charts
4. Lecture/discussion

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