ANNUAL REPORT 2016

ASSOCIATION FOR COMMUNITY DEVELOPMENT (ACD)
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Abbreviations

ARV	Anti-Retro Viral
BCC	Behaviour Change Communication
CHBC	Community and Home Base Care
DMC	Directorate of Malaria Control
DOTS	Directly Observed Treatment Short Course
FLCP	First Line Care Facility
GB	Gilgit Baltistan
GSM	Green Star Social Marketing
HCP	Health Care Providers
IUATLD	International Union against TB and Lung Diseases
LLIN	Long Lasting Insecticidal Nets
MC	Mercy Corps
MDR	Multi-Drugs Resistance
NACP	National AIDS Control Programme
NTP	National TB Programme
NWA	North Waziristan Agency
PLHIV	People living with HIV
PPM	Public Private Mix
PTP	Provincial TB Programme
RDT	Rapid Diagnostic Test
SWA	South Waziristan Agency
TBCP	TB Control Programme

Executive Summary

Association for Community Development (ACD) is a non-governmental humanitarian organization established in year 2000 and registered in Pakistan under the societies Act XXI of 1860. Currently we are working in the field of health focusing on prevention and control of Tuberculosis, Malaria and HIV/AIDS. During the year 2016, we worked in Khyber Pakhtunkhwa, Federally Administered Tribal Agencies (FATA) and Gilgit Baltistan (GB) province. Our projects were funded by the Federal Directorate of Malaria Control (DoMC), National TB Control Programme (NTP), National AIDS Control Programme (NACP), National Ministry of Health Services Regulation and Coordination, Islamabad (M/o NHSR&C), Government of Pakistan and an International partner Mercy Corps (MC) being the principal recipient of The Global Fund grant.

All projects were implemented in close collaboration and coordination with the National and provincial programmes, Directorates of Health and district health authorities. The programmatic and financial performance of the projects was monitored by the health authorities and donors for transparency, accuracy and timeliness

Performance of the projects was measured and rated against the criteria's set by the donors. Performance updates were shared at the district, provincial and national level in the quarterly review and planning meetings. During the year 2016 TB, Malaria and HIV projects were implemented with the following objectives;

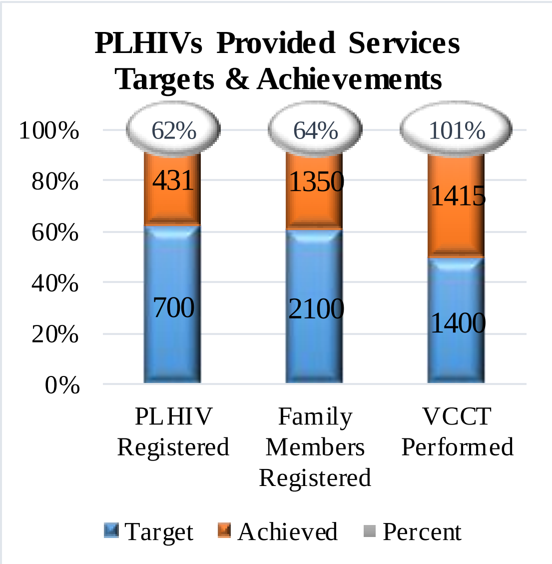
For Malaria project the objectives were to ensure universal coverage of multiple prevention for at risk population in FATA Agencies, provide diagnostic and treatment services to over 80% of the population and create awareness on the benefits of early diagnosis, treatment and Malaria preventive measures among the FATA population by the year 2017

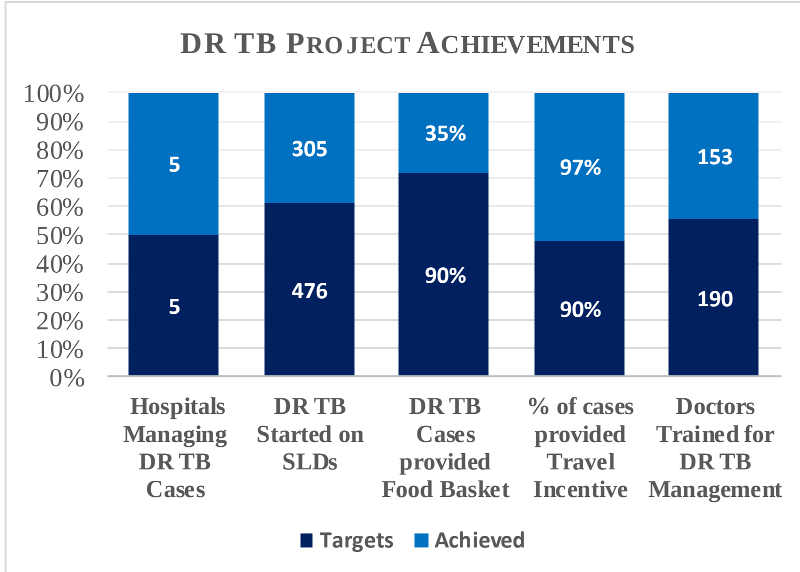
For Drug Resistant TB project the objective was to enhance MDR-TB enrollment from 21 % of estimated cases in 2014-15 to 32% by the year 2017.

For Public Private Mix project to enhance TB DOTS services the objective was to offer quality care to TB patients through a network of enabled private sector clinics and laboratories.

Following table and Figures gives annual achievements against set indicators of all the project. Achievements of individual project are given in the relevant sections

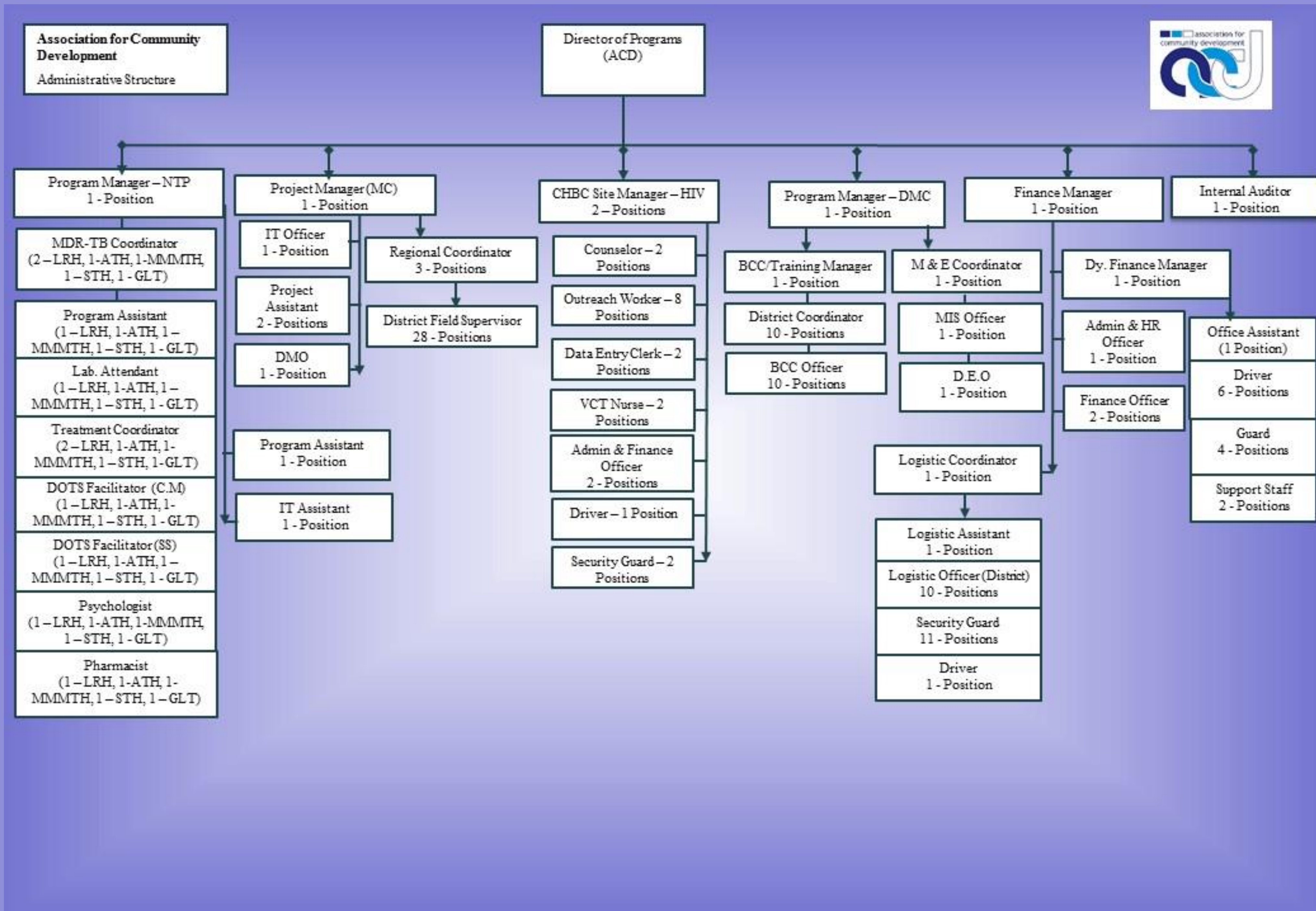
MALARIA PROJECT ACHIEVEMENTS	Target	Results	Achievement
Proportion of malaria cases treated in public sector health facilities	80%	81%	101%
Proportion of malaria cases treated in private sector health facilities	70%	79%	113%
Number of health facilities upgraded and functioning in FATA	399	370	93%
Proportion of health facilities without stock-outs of key commodities	370	351	95%
Number of long-lasting insecticidal nets distributed to at-risk populations	420,474	171,516	41%
Health Care providers Trained on Malaria Case Management & outbreak response	1015	966	95%
Behavior Change Communication Session Conducted	2,991	3,011	101%
People reached through Behavior Change Communication sessions	90.258	87,156	97%
Proportion of facility reports received over the reports expected during the reporting period	4,026	3,813	95%
Monthly Review Meetings at district level	160	160	100%





PPM PROJECT ACHIEVEMENTS	Targets	Achieved	% Achieved
Number of GPs clinics enabled to provide TB DOTS	299	273	91%
Number of Private Laboratories enabled for TB DOTS	62	62	100%
Number of health care providers trained on TB DOTS through Basic and Refresher Trainings	664	535	81%
Number of Community Gatherings Conducted	58	53	91%
Number of Chest Camps conducted	58	53	91%
Number of Meetings conducted with Area Notables	58	53	91%
Number of TB Cases Registered and treated	4,625	4,462	96%
Number of QRMs conducted	56	56	100%
Number of SR Staff meetings conducted	4	4	100%

ACD Organogram



2 About ACD

Association for Community Development (ACD) is a non-governmental humanitarian organization established in year 2000, registered in Pakistan under the societies Act XXI of 1860. ACD is also registered with FATA Secretariat Directorate of Social Welfare under the Voluntary Social Welfare Agencies (Registration and Control) Ordinance 1961 (XLVI of 1961) and with FATA Disaster Management Authority.

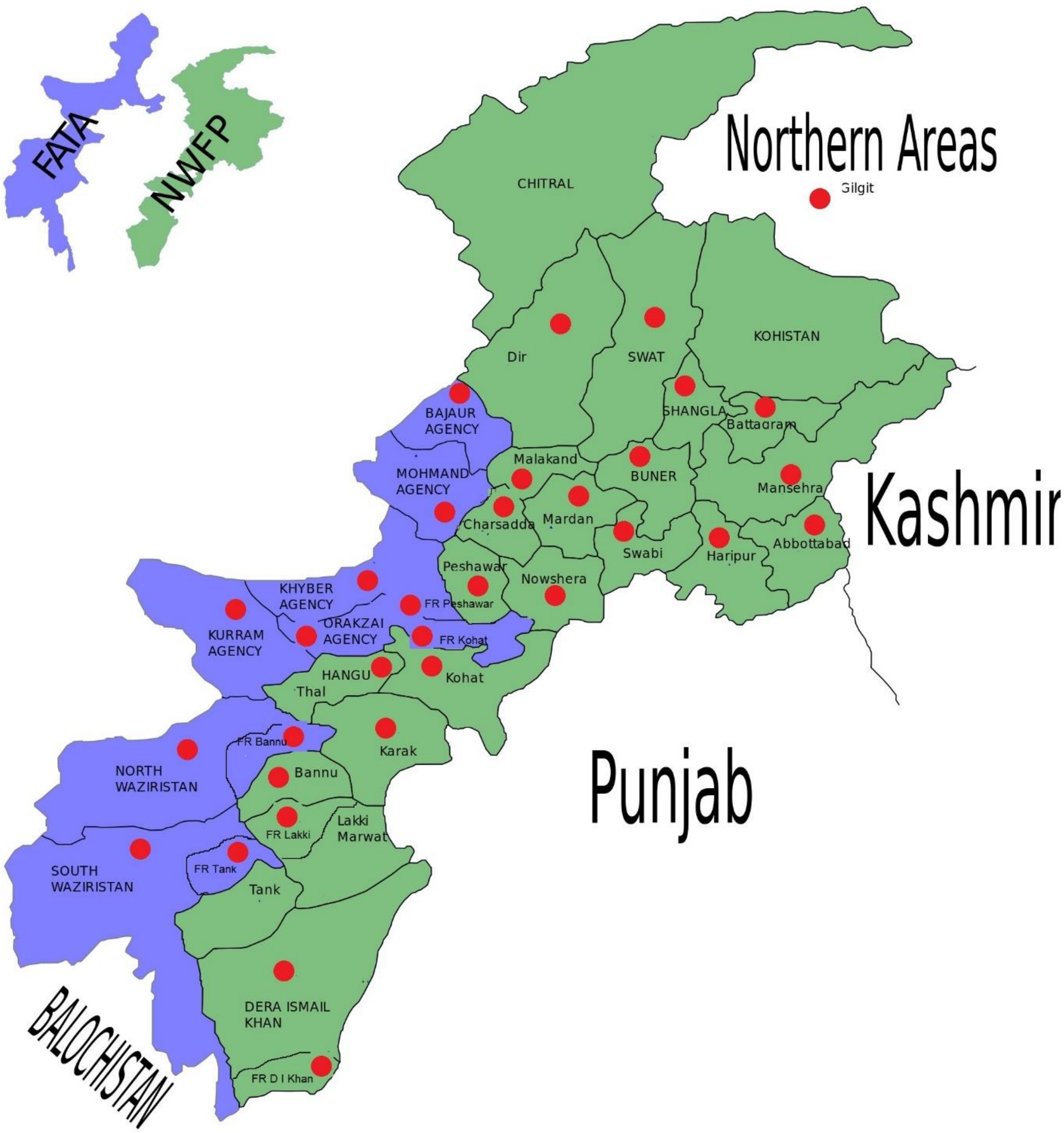
The aim of the society is “to improve preventive, promotive, curative and rehabilitative health services for the people living in Pakistan regardless of race, religion or political affiliations.

ACD has a rich history of managing Public Health Projects in collaboration with provincial and national health programmes. Our core focus has been TB DOTS, MDR TB management, Malaria prevention, care and control and Harm Reduction for People Living with HIV/AIDS. Our interventions are coordinated with Public Sector Health Programmes and willing private health sector partners. All interventions are implemented as per National Health Guidelines of Government of Pakistan. We have been working in Khyber Pakhtunkhwa, FATA, Balochistan and Gilgit Baltistan.

To achieve our objectives, we work with national health authorities and other stakeholders to establish effective health services and systems. We provide technical support, train health care providers, improve infrastructure of laboratories, and implement behavior change communication and awareness programmes by working with general communities, key advocates, media representatives and volunteers advocating for improved health, increase community awareness of health issues, promoting health seeking behavior and ensuring provision of quality basic health care. To a limited extent, ACD has also responded to natural disasters occurring in Khyber Pakhtunkhwa during the previous years

3 Geographical Coverage of the Project

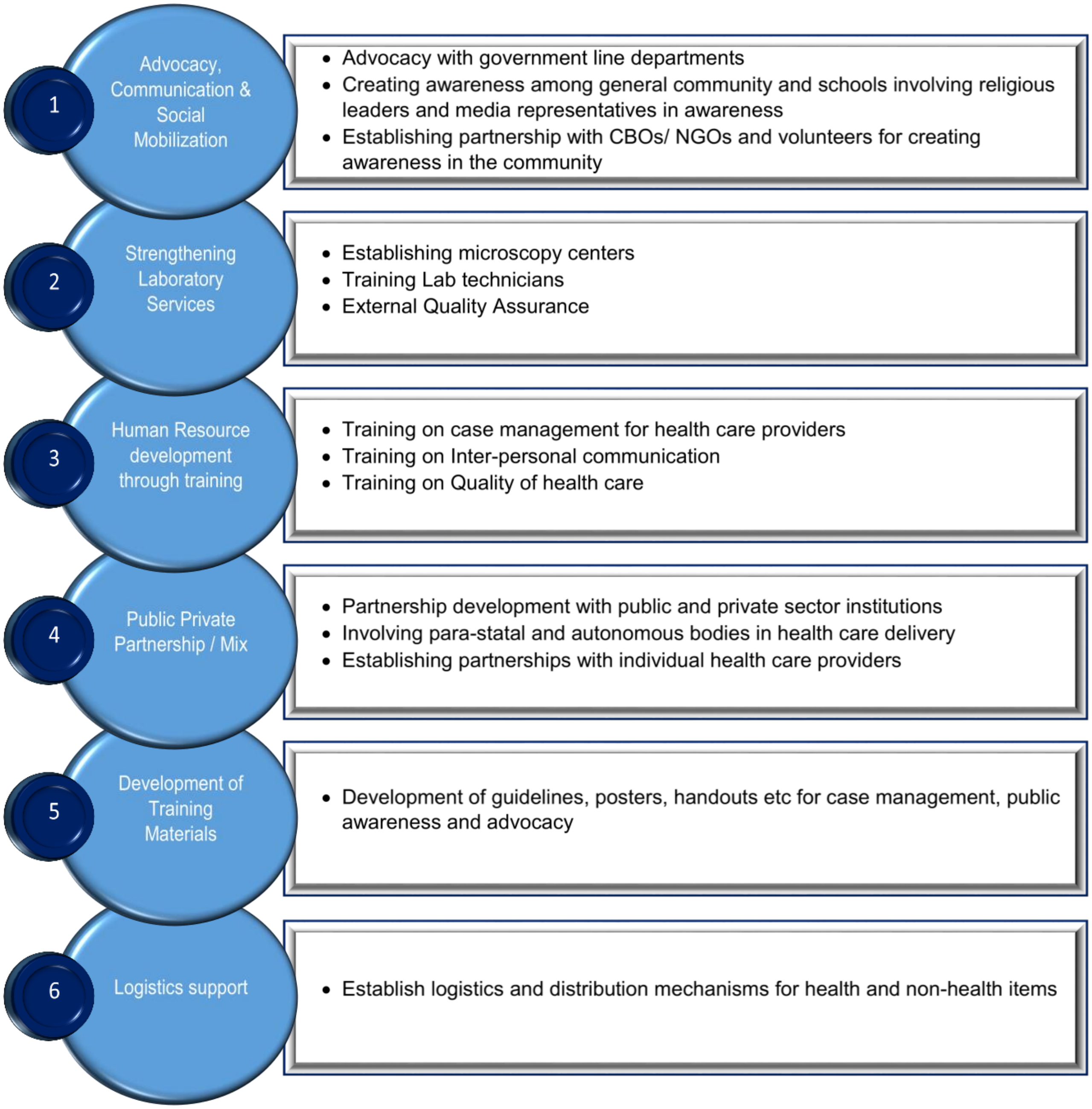
Geographical Coverage of the Projects



4 Areas of Interest

Areas of Interest

ACD has broad based objectives and expectations to get involved in multidisciplinary interventions for the benefit of its target communities; however, currently it is working in the following areas of its interest.



5 Malaria NFM Component

5.1 Malaria Project Background:

Pakistan has a population of 180 million inhabitants of which 177 million are at risk of Malaria. With 3.5 million presumed and confirmed malaria cases annually Pakistan contributes 22% of total malaria disease burden in the Eastern Mediterranean Region (EMRO). The majority (80%) of malaria in Pakistan is caused by Plasmodium vivax, while the remaining 20% is caused by P. Falciparum.

The malaria indictor survey (MIS) was conducted in 2013 in 43 (GF R-10) highly endemic districts of the country showing highest prevalence rates in the region of Federally Administered Tribal Areas (FATA) (13.9%) followed by Balochistan (6.2%), and Khyber Pakhtunkhwa (KP) (3.8%). The DoMC 2012 data shows that the highly endemic districts are located in Balochistan with an average API of 7.68 ranging from 7 to 27, FATA with average API of 6.83 ranging from 6 to 11.8, Sindh with average API of 2.92 ranging from 5.2 to 12 and KP with average API of 2.76 ranging from 6 to 32, Punjab with average 0.19 and AJK 0.10. Malaria is typically unstable (seasonal) in Pakistan, with a peak starting from August to November for both P. vivax and P. Falciparum. The PV:PF ratio from 43 highly endemic districts is 84:16

Malaria endemicity is heterogeneous in Pakistan. Thirty-seven percent of malaria cases are reported from the districts and agencies of Federally Administered Tribal Areas (FATA) and Balochistan bordering Afghanistan and Iran. Malaria transmission is seasonal, with peaks in summer (June-September) for Vivax Malaria and late-summer and winter (August-November) for Falciparum Malaria. The Government of Pakistan is implementing Malaria Control Program (MCP) in 72 malaria endemic districts of Pakistan with the public sector resources and in 43 highly endemic districts with the support from the Global Fund (Round 10).

5.2 Project Objectives:

Following table gives objectives of the project.

OBJECTIVES

- To ensure and sustain universal coverage of multiple prevention to population at risk in 10 target Agencies-FATA
- To ensure and sustain > 80% coverage for the provision of quality assured early diagnosis and prompt treatment services to population at risk in target districts by 2017
- To increase community awareness upto 80% on the benefits of early diagnosis, prompt treatment and Malaria preventive measures using health promotion, advocacy and BCC interventions by 2017
- To ensure availability of quality assured strategic information (epidemiological, entomological and operational) for informed decision making
- To enhance technical and managerial capacities of malaria control programs in planning, implementation, management and M&E

5.3 Activities Description

5.3.1 Strengthen Existing Diagnostic Services:

ACD have supported the selected health facilities from existing public sector health facilities for diagnosis and treatment of Malaria. The support includes provision of microscopes, medicine, laboratory reagents, trainings and minor renovation of centers where needed. This support has enhanced the capacity for health centers for provision of Malaria programme services to the target communities.

5.3.2 Establishment of Rapid Diagnostic Test (RDT) Centers at First Level Care Facilities (FLCFs)

ACD supports the existing First Level Care Facilities (FLCFs) designated as Rapid Diagnostic Test (RDT) Centers for Malaria diagnosis and treatment. These centers were provided RDT kits and anti-Malaria medicine for early diagnosis and prompt treatment.

5.3.3 Prompt and Effective Anti-Malaria Treatment

ACD provides support to 399 Malaria diagnosis and treatment centers in FATA. Free of charge quality assured anti-malarial medicine are provided to patients needing Malaria treatment. The anti-malarial drugs include: tab. Chloroquine, tab. Primaquine, tab. Quinine, tab. ACT (Artesunate + SP), tab. Artemether + Lumafentrine. Provision of early diagnosis & prompt treatment with effective Anti- Malarial drug is the most efficient intervention in reducing parasite reservoir & overall morbidity & mortality.

5.3.4 Enhancing the Capacity of Healthcare Providers in Proper Malaria Case Management Treatment

Malaria Case Management Treatment according to National Malaria guideline is essential for the provision of standardized and effective Anti- Malarial drugs & to avoid development of resistance. ACD has trained health care providers working in the public sector health facilities on the National guidelines and protocols for managing Malaria. These trainings are provided on Malaria Case management, rapid diagnostic test (RDT), Microscopy, Malaria information system (MIS).

5.3.5 Involvement of Private sector in Malaria diagnosis & treatment

Approximately 80% of patients in Pakistan are catered by private sector. However, 50% of Malaria patient in high endemic districts seek services of private sector (MIS 2013). Majority of Malaria cases in private sector are treated on clinical grounds without confirmatory tests. To involve private sector in malaria diagnosis and treatment ACD has established 90 RDT centers from the target of 100 private RDT centers in the target agencies and FRs of FATA.

5.3.6 Prevention through universal coverage of LLlNs in target Agencies/FRs

According to WHO Long Lasting Insecticidal Nets (LLlNs) is the most effective mean of vector control in highly endemic areas. LLlNs distribution outlets established in the agencies and FRs have been used for smooth and timely distribution of the LLlNs to the neediest populations. LLlNs have been distributed on mass scale to achieve universal coverage so that more than 80% of population in stratum IA agencies i.e. Kurram, Khyber, North Waziristan, FRS are covered.

5.3.7 Behavior Change Communication

To enhance Malaria awareness, case detection and adherence to treatment, ACD has implemented the National Malaria Program Advocacy, Behavior change communication (BCC) strategy through a coordinated approach in the FATA region. The activities included community, awareness sessions, health education & distribution of IEC materials. These activities have been carried out through LHWs, CBOs & ACD staff.

5.3.8 Monitoring and Supervision

Regular Monitoring and Supervision of the field activities

was carried out by the senior program management and monitoring team dedicated for the purpose. Monthly and quarterly review meetings at the national, provincial and district level were conducted for data validation and performance updates. The monitoring visits are conducted to all levels of health care facilities from the districts as well as from the central level. The district and provincial health officials regularly monitor project implementation for quality assessment and data validation.

5.4 Programmatic Achievements Malaria Prevention and Control Project

Table 1: Programmatic Achievements Malaria Programme

July, 2015- June, 2016			
Activity Description	Target	Results	Achievement
Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national policy at public sector health facilities	80%	81%	101%
Proportion of confirmed malaria cases that received first-line antimalarial treatment according to national policy at private sector sites	70%	79%	113%
Number & percentage of upgraded and functioning health facilities, microscopy and RDT Centers Public in 10 Agencies of FATA-Pakistan	399	370	93%
Proportion of health facilities without stock-outs of key commodities during the reporting period	370	351	95%
Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns	420,474	171,516	41%
Health Care providers Trained on Case Management	345	334	97%
Malaria Technician trained on Malaria Diagnosis: RDT & Microscopy	271	263	97%
Health care providers Trained on MIS and outbreak response	399	369	92%
Behavior Change Communication: Advocacy and Awareness Session Conducted	2,991	3,011	101%
Behavior Change Communication: People reached through Advocacy and awareness through LHWs, NGO/CBOs/ and Religious leaders.	90,258	87,156	97%
Proportion of facility reports received over the reports expected during the reporting period	4,026	3,813	95%
Monthly Review Meetings at district level	160	160	100%

5.5 World Malaria Day:

The day was initially adopted as Africa Malaria Day in 2001, a year after the historic Abuja Declaration was signed by 44 malaria-endemic countries at the African Summit on Malaria. It was aimed at providing education and understanding of malaria as well as spreading information on implementation of national malaria-control strategies, including community-based activities for malaria prevention and treatment in endemic areas. It was later adopted by the World Health Assembly, World Health Organization (WHO)'s decision-making body, in its 60th session in May 2007.

The theme of this year's World Malaria day commemoration was '**End Malaria for Good'**. The theme reflects the vision of a malaria-free world set out in the "Global technical strategy for Malaria 2016- 2030" and adopted in May 2015 by the World Health Assembly. This strategy aims at dramatically reducing the global malaria burden over the next 15 years. It targets reducing the rate of new malaria cases as well as reducing malaria death each by at least 90 percent; eliminating malaria in at least 35 countries; and preventing a resurgence of Malaria in all countries that are Malaria-free. The timeline of 2016-2030 is aligned with the "2030 Agenda for sustainable development", the new global development framework endorsed by all UN member states.

6 TB Component

6.1 TB Project Background:

Pakistan ranks 5th amongst the 22 High Burden Countries (HBCs) and 4th among 27 MDR high burden countries in the world. Pakistan contributes about 65% of the tuberculosis burden in the Eastern Mediterranean Region. According to national prevalence survey results (2010-11), the incidence of 'all type' TB cases in Pakistan is 276/100,000 per year or around 420,000 new cases each year. The prevalence of the disease is much higher and is estimated at 348/100,000 population or 670,000 cases. Additionally there are an estimated 3.4% and 19% Multidrug Resistant TB cases respectively among the new and retreatment cases. In the year 2013 Pakistan notified 298,446 TB cases (WHO Global TB Report 2014). TB is responsible for 5.1 percent of the total national disease burden in Pakistan and its impact on socio economic status is substantial as about 75% of TB cases fall in productive age (15-45 year) group.

Since the expansion of the WHO Direct Observed Treatment Strategy (DOTS) in 2001 NTP has followed the policy of reducing the prevalence, incidence and mortality of tuberculosis to achieve the Millennium Development Goal 6-3 (MDG-6). With the financial support from the Global Fund to fight AIDS, TB and Malaria and other international donors, National TB Programme is implementing TB prevention and control interventions in the country through its national and international operational partners that includes public sector provincial programmes and private sector civil society organizations, institutions and health care providers. In the provinces of Khyber Pakhtunkhwa and Gilgit Baltistan ACD is collaborating with the National TB Programme is implementing a project for the Management of Drugs Resistant TB.

6.2 Objectives of DR TB Project

2.1 Objective of the Project

To enhance MDR-TB enrollment from 21 % of estimated cases in 2014-15 to 32% of estimated by 2017.

Activities

- Enhanced capacity of hospitals and peripheral facilities to deliver and monitor in-patient and community-based treatment with Ambulatory Based Care of MDR-TB cases
- Enhancing airborne infection control and other facilities for inpatient and outpatient MDR-TB care in each hospital
- Strengthening treatment hospitals for managing MDR-TB cases
- Strengthening health facility network for community based MDR-TB care
- Number of DR TB cases Registered and treated
- Provide psychosocial support for MDR TB Patients
- Provision of free second line anti-TB drugs and laboratory investigations

The current project started in July 2015 under the New Funding Model of the Global Fund. Following paragraphs will summarize annual activities and achievements of the project.

6.3 Activities Description

- Programmatic Management of Drug Resistance TB (DR-TB) has been initiated in five tertiary care hospitals four in Khyber Pakhtunkhwa and one in Gilgit Baltistan respectively. Separate space has been provided in all the hospitals which has been dedicated for treating drugs resistant TB cases. Hospitals that are supported for the programmatic management of MDR TB Cases include; Lady Reading Hospital Peshawar, Ayub Teaching hospital Abbottabad, Saidu Teaching hospitals Swat, Mufti Mahmud Teaching hospital D I Khan and district hospital Gilgit. The selected sites in these hospitals have been provided necessary equipment, medicine and additional human resource. Infrastructure of the waiting area and wards for admitting the drug resistant TB cases have been renovated as per the national TB programme standards.
- Selected hospital staff has been trained on the national guidelines and protocols for managing MDR TB patients.
- All hospital are supported to establish linkages with the existing DOTS clinics at the district level for coordination of social support services, provision of food baskets, counseling and travel incentives to minimize loss to follow-up.
- A clinical psychologist provides psychological support and counseling to the patients not only for managing the side effects of the drugs that may occur during the course of treatment but also to encourage the patients and his family for adhering to the treatment.
- A designated Treatment Coordinator (TC) visits patient's home, arranges meeting with the DOTS clinic nearest to patients home for administering TB drugs. This arrangement facilitates patients in taking treatment regularly.
- A health workers or community volunteers is identified as a treatment support with the consent of the patient who is made responsible for ensuring treatment of the patient. The treatment supporter is also provided food basket as an incentive for his service and time.
- All health care providers managing DR TB patients are trained on the National TB programme protocols for ambulatory care model for managing DR TB.
- Patient's records are maintained in the Electronic Nominal Registrations System and reported to NTP which is included in the national DR TB database and shared with World Health Organization and donors. The reported data is later included in the Global TB report.
- During the course of treatment most of the follow up investigations are provided free of cost to the patients

6.4 Programmatic Achievements

Table 2: Programmatic Achievements Drugs Resistant TB Project

Programmatic Achievements	**Targets**	**Achieved**	**Percent**
Activity Description	Targets	Achieved	% Achieved
Number of Hospitals Managing DR TB Cases	5	5	100%
Number of cases with drug resistant that began second-line treatment	476	305	64%
Percentage of cases with drug resistant TB that were provided Food Basket vouchers	90%	35%	35%
Percentage of cases with drug resistant TB that were provided Travel Incentive	90%	97%	108%
Number of Doctors Trained for DR TB Management	190	153	81%

Picture Gallery

Site Monitoring by Project Manager

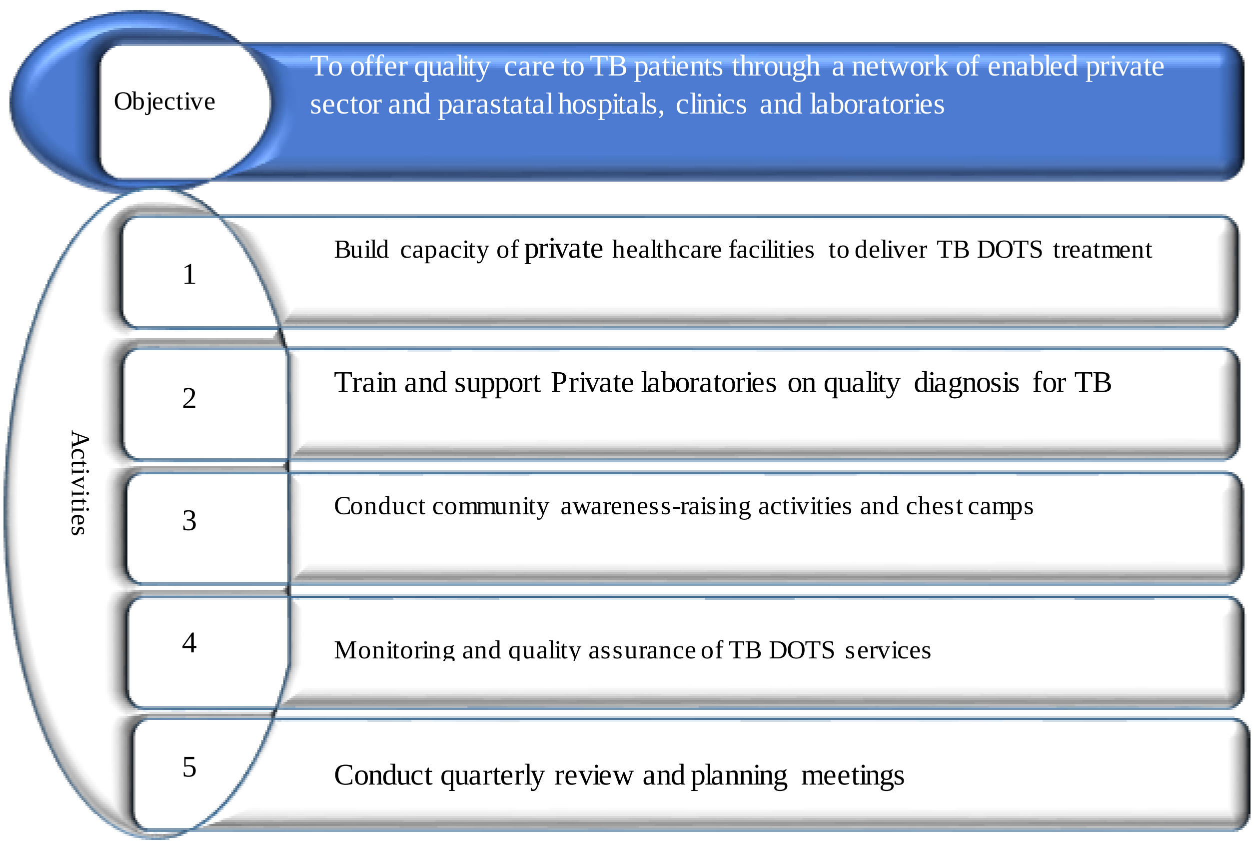
Training for the Health Care Providers

Home visit to the patient

7 Public Private Mix (PPM) for TB DOTS service delivery

After achieving countrywide DOTS coverage through a network of public sector health facilities National TB Control Programme has been focusing on improving the quality of diagnosis and care but also extending TB DOTS services to the population not yet adequately covered. These groups include mainly those who either do not "prefer to" or are not "able" to avail care from public sector facilities. The program strategy for enhanced DOTS quality and universal coverage includes integration of TB diagnosis and care within the district primary health care system (PHC), Public Private Partnerships (PPM) through engagement of private providers, parastatal run health facilities under autonomous bodies of different ministries and tertiary/teaching hospitals for establishing DOTS Linkages. The interventions under this objective were implemented through selected private health care providers and laboratories in two districts and initially nine seven parastatal health facilities managed by autonomous bodies under different Ministries. The purpose of this intervention was to introduce standardized TB diagnosis and case management protocols in the private sector. The partner private health care providers were provided laboratory reagents, microscopes and anti-TB drugs for TB DOTS.

7.1 Objectives of PPM Project for TB DOTS



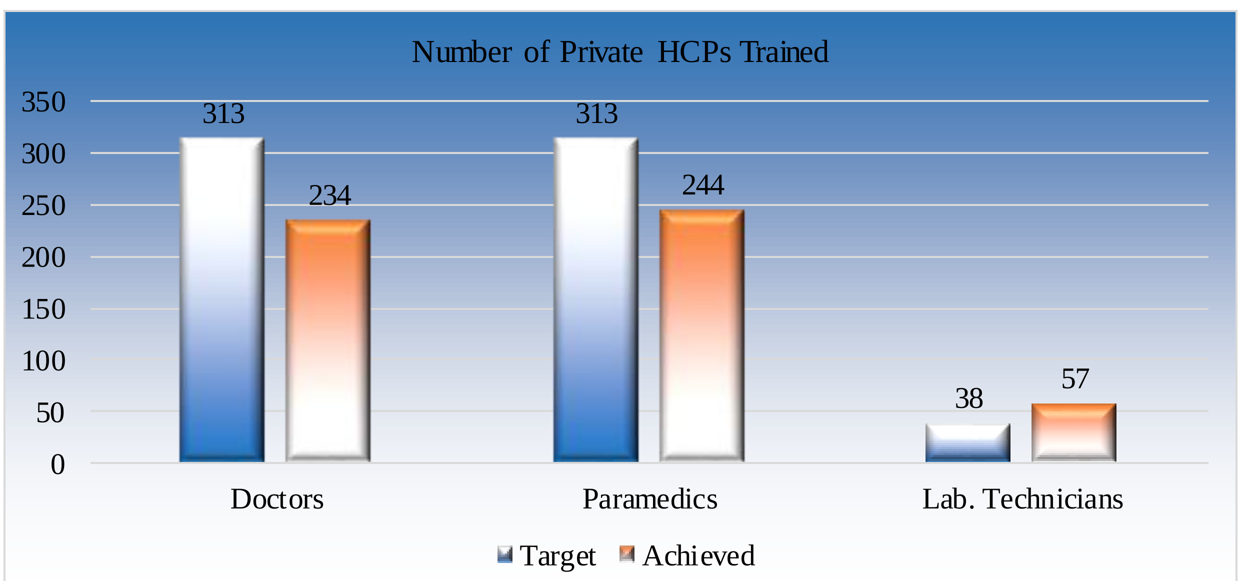
7.2 Activities Description PPM TB DOTS Project

7.2.1 Build capacity of private healthcare facilities to deliver TB DOTS treatment

Mapping exercise was conducted to identify and select private healthcare facilities in the target districts.

273 private clinics were selected with the consent of the district TB programme following a protocol approved by the National TB programme (NTP) and the Principle recipient. A memorandum of understanding (MoU) was signed between each participating healthcare provider. One doctor and one paramedic from each of the selected private health facility was trained on DOTS protocols including recording and reporting tools. Training of the private providers was conducted on the NTP standard training package for private providers. Anti-TB drugs were provided to these private healthcare providers by NTP with support from the Global Fund grant. District TB programme was given lead role in the project implementation.

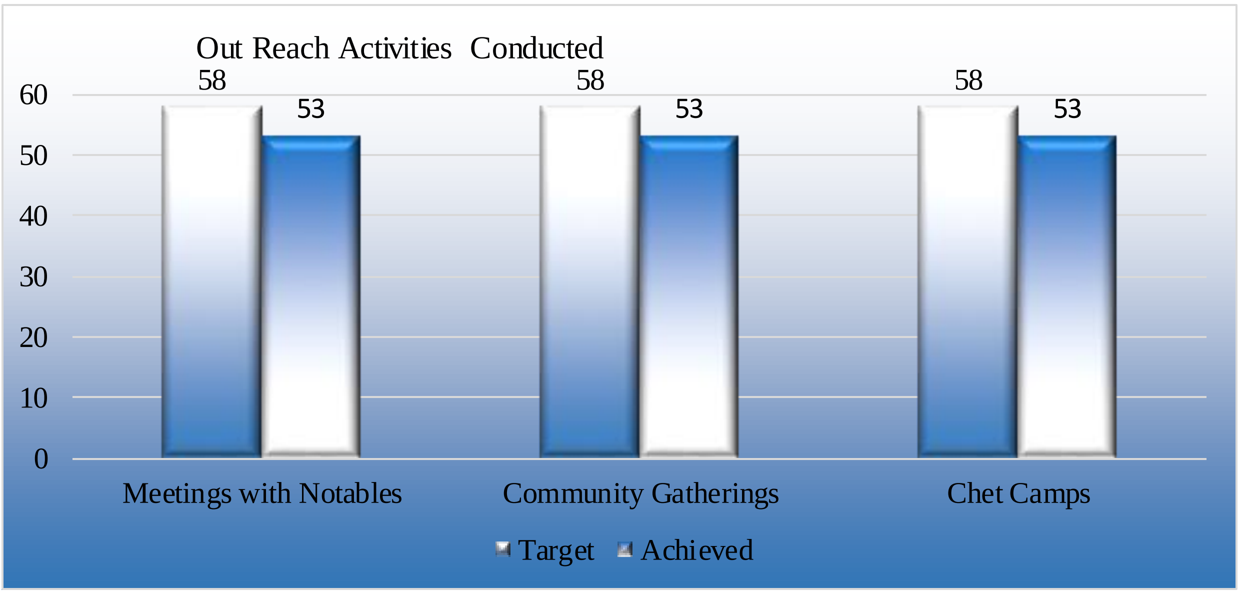
Similarly 62 private laboratories were selected and supported for sputum microscopy. Each laboratory was provided a microscope in addition to the laboratory reagents and the laboratory technician was trained to perform sputum microscopy for diagnosing TB. District TB programme has the lead role in the project implementation and monitoring. The District Laboratory Supervisor (DLS) visited each of the selected laboratories once every month to ensure the quality of sputum microscopy.



7.2.2 **Conduct community awareness-raising activities**

Community mobilization and awareness raising activities were conducted by the project dedicated district field supervisors. The purpose of these awareness activities was to encourage TB suspects to seek early diagnosis and to promote treatment adherence in confirmed TB patients.

Chest camps were conducted in the parts of the districts from where more TB patients were reporting to the district TB programme. These areas were identified with the help of District TB programme.



Two additional staff dedicated for the project implementation were deployed in each districts to facilitate TB care delivery process. The district based project staff was responsible to develop monthly activity plans in consultation with the district TB programme, coordinate activities with different stake holders, organize activities and prepare activity reports. Quarterly review and planning meetings were conducted for verification of the reported data and for assessing performance of the project.

7.3 Programmatic Achievements PPM TB DOTS Project

Programmatic Achievements			
Activity Description	Targets	Achieved	% Achieved
Number of GPs clinics enabled to provide TB DOTS	299	273	91%
Number of Private Laboratories enabled for TB DOTS	62	62	100%
Number of health care providers trained on TB DOTS through Basic and Refresher Trainings	664	535	80.5%
Number of Community Gatherings Conducted	58	53	91%
Number of Chest Camps conducted	58	53	91%
Number of Meetings conducted with Area Notables	58	53	91%
Number of TB Cases Registered and treated	4625	4462	96%
Number of QRMs conducted	56	56	100%
Number of SR Staff meetings conducted	4	4	100%

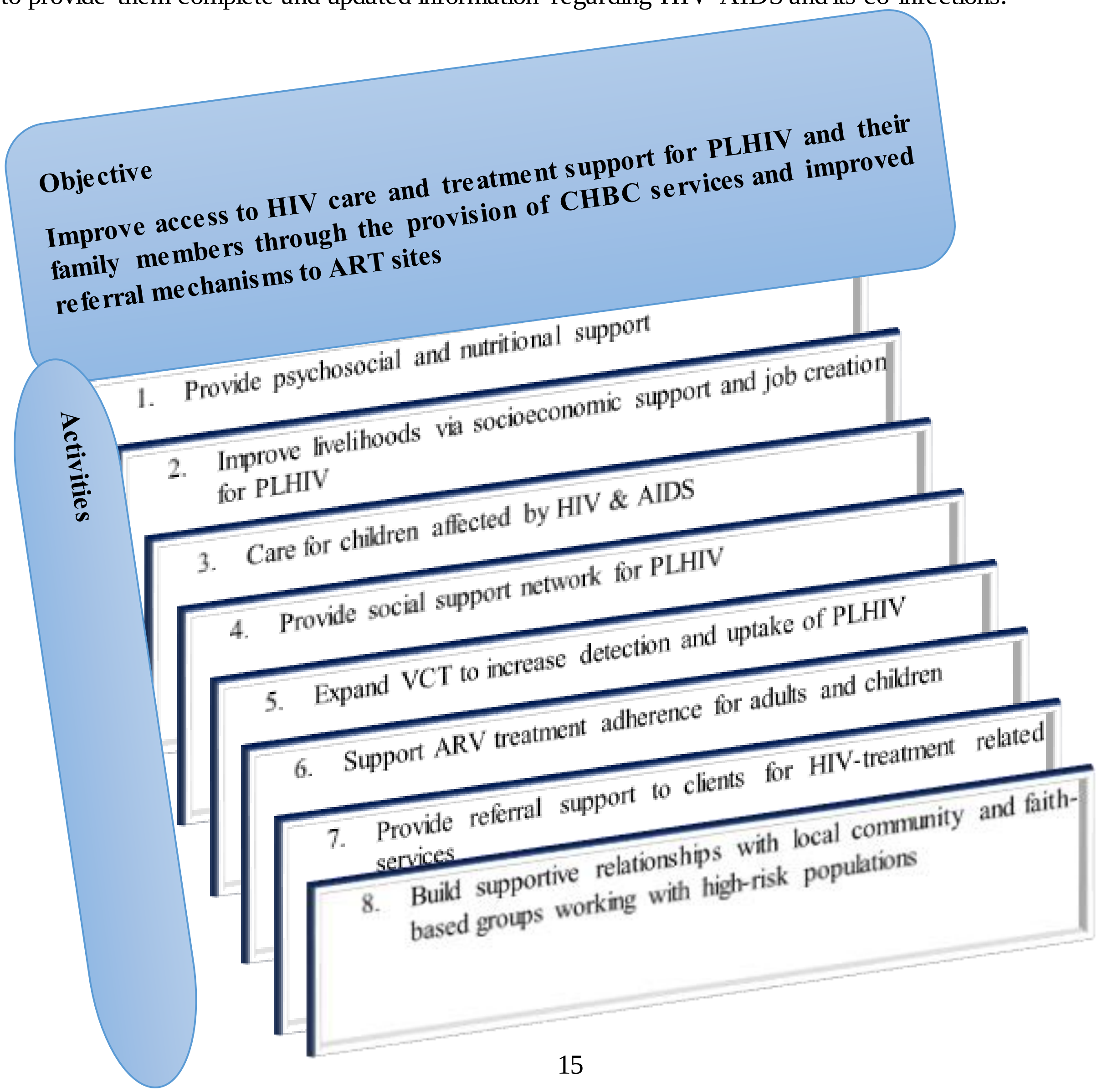
8 HIV/AIDS Component

8.1 HIV/AIDS Project Background

Pakistan is a country having a concentrated HIV epidemic, with a prevalence of **36%** among People Who Inject Drugs (PWID) (*IBBS Round IV 2011*). The main reason being the high level of needle/syringe sharing and lack of Syringe Needle Exchange Programs in the area. In the other group's prevalence is **5.2%** among Hijra (Transgender) Sex Workers (HSW), **1.6%** among Male Sex Workers (MSW) and **0.6%** among Female Sex Workers (FSW), while it is under **0.1%** in the general population. HIV prevalence is on the rise in the most at-risk population in Pakistan.

The project is based on the concept of a Public Private Partnership to improve harm reduction, Care & Support services and implementation capacity.

Association for Community Development (ACD) has established two CHBC Sites at Abbottabad and Malakand with the close collaboration of National AIDS Control Program (NACP). The project is funded by the Global Fund, The main purpose of these CHBC sites is to provide care and support, quality VCCT and comprehensive CHBC services to PLHIVs, their family members and access High Risk Groups (HRGs) to provide them complete and updated information regarding HIV-AIDS and its co-infections.



8.2 Comprehensive CHBC Services

Following Comprehensive CHBC services were provided to the PLHIVs and their family members.

- Voluntary Confidential Counseling and Testing (VCCT) service for the PLHIVs spouse and children, other sex partners of the PLHIV if any and for the high risk population for tracing new HIV positive cases.
- Outreach activities were conducted to identify new HIV patients, and provide approved set of services to PLHIVs and their family members.
- Nutritional Support/Food Packages was provided to those PLHIVs who don't have enough income to support their families.
- School Support packages was provided to PLHIVs children to support their education needs.
- Skill development and support was provided to selected PLHIVs to increase their income sources and for the suitability of their future.
- Peer education sessions were conducted by the CHBC Team among the PLHIVs and volunteers from the high risk groups. This activity was also used for experience sharing by the peer educator with the target community and creating awareness about preventing spread of HIV/AIDS.
- Support Group meetings were conducted for PLHIVs and their family members and high risk populations. These meetings addressed issues related to stigma & discrimination associated with HIV.
- Regular Medical referral and other medical investigations support was provided to PLHIVs for their regular medical follow-up visit to ART Centers for ARVs and other medication.
- Sessions were conducted to build supportive relationship among the PLHIVs, local community and faith based organizations working with high risk populations. The participants of these sessions were educated about HIV/AIDS and other co-infections. In this activity pre and posttest counseling is provided to those clients who are at risk and agreed for HIV testing.
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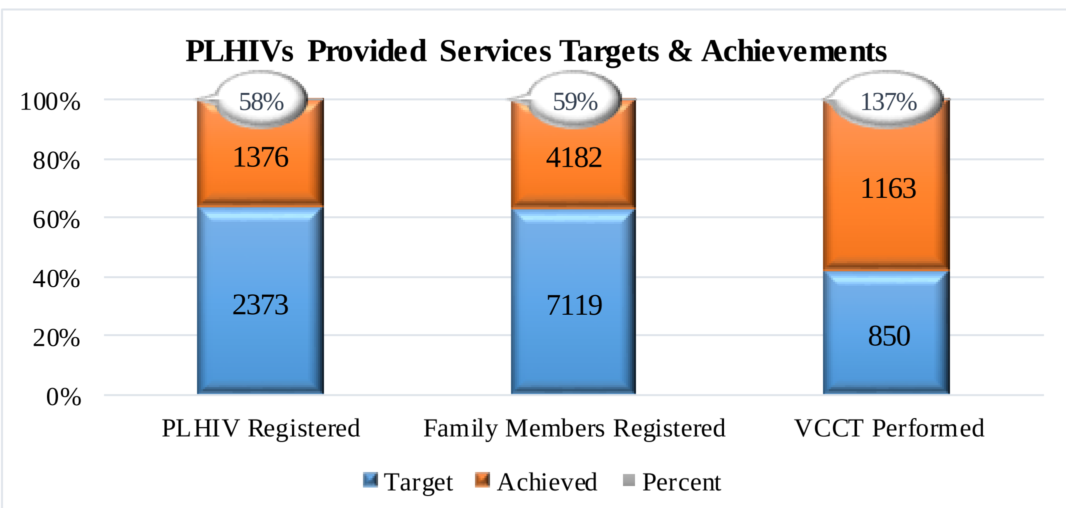
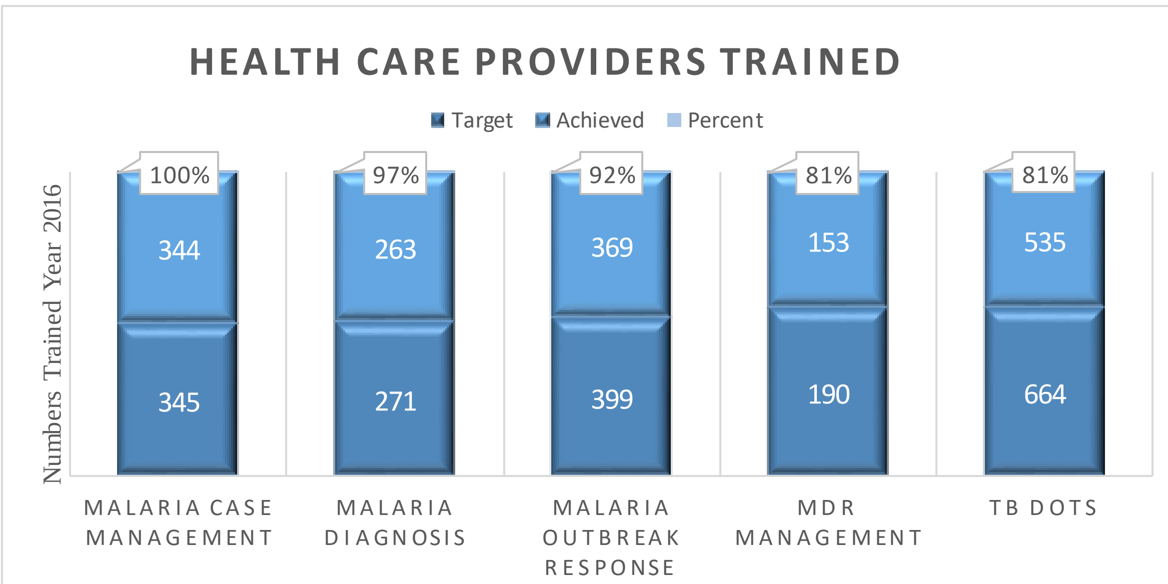
8.3 Programmatic Achievements HIV/AIDS Project



9 Human Resource Capacity Development

Trainings for building human resource capacity is an essential activity of the projects that ACD is implementing. This activity targets health care providers working in the public as well as private health care sector with the objective to enhance their technical and management capacity for responding to the infectious diseases like TB and Malaria. All activities were planned and coordinated with the provincial and district health authorities. Disease specific National programme guidelines were used for training different cadre of health care providers in the public and private sector. Due to delays in the approval of the training plans and disbursements of the funds some training targets from the previous year were brought forward and conducted in the reporting year, the achievements therefore; was higher than the planned. Following tables summarizes trainings conducted during the year.



DOCTORS AND LAB. TECHNICIANS TRAINING

10 Behaviour Change Communication

ACD conducted community gatherings and meetings to create awareness among the communities not only to raise their knowledge about communicable diseases like Tuberculosis and Malaria, but also to improve their health seeking behaviors. These interventions also focused on building supportive environment for health through public and media advocacy and involvement. ACD also worked on consensus building and commitment with the community based groups, organizations and the community through dialogue and social mobilization. In selected union councils of the districts, chest camps were conducted for identification and detecting TB patients. However, platform of chest camps were also utilized for awareness creation & social mobilization.

	Sessions Conducted			People Reached		
	Target	Achieved	Percent	Target	Achieved	Percent
Malaria Awareness	2991	3011	101%	90258	87156	97%
Tuberculosis Awareness	174	159	91%	5916	6766	114%

11 Quality Assurance

ACD gives significant importance to quality assurance of the activities performed in the field to maintain the standard of services acceptable to donors, WHO and National programme. For this purpose ACD monitoring and evaluation teams consisting of clinicians, public health and laboratory personnel regularly supervise the clinics. Supervisory visits are also utilized for on the job training, supply of materials, data collection and feedback to the field workers on the issues identified in the field. National and provincial programme representatives visit service delivery areas to monitor quality of services provided to the patients and the communities.

12 Monitoring and Evaluation

ACD uses Project performance framework for monitoring the process and outcome indicators of the project. The programme team analyzes both project monitoring and implementation data, which is monthly, reported to the donors. Senior programme and finance management also conduct field monitoring and coordination visits in the target districts where appropriate. Donors and National programmes representatives also visit project area to monitor performance.

13 Data Reporting and Validation

Data from the services delivery points was collected using donor's approved recording and reporting tools. ACD technical team validated the reported data, also representatives of the programme and principle recipients (PR) in monthly and quarterly coordination and monitoring meetings validated the reported data for correctness and completeness. The data was than collated in quarterly reports and submitted to programme and PRs. Soft record of the data was maintained in Excel based databases / formats approved by the PR. Programme performance was presented in the quarterly review meetings conducted at district, provincial and National levels and with the principle recipient in PR-SR coordination meetings.

14 Coordination

Coordination among the various partners involved in communicable disease control is very important to ensure the optimum utilization of the resources. ACD gives high priority to strengthening coordination activities with the donors and partners at the district, provincial and national levels and with the community. The coordination and functional relationship of the programme includes technical and management support in strategy and policy development, capacity building, human resource development, monitoring, quality control and supply of material required for project implementation.

ACD planned and coordinated its activities with the health authorities at district, provincial and National levels. ACD also participated in the monthly / quarterly meetings and shared its performance with the relevant stakeholders.

15 Acknowledgement

I take this opportunity to thank all stakeholders who have supported ACD financially, technically and administratively in implementing the reported project during this year and during the entire grant period. We extend our sincere gratitude to public sector officials, National and Provincial programmes, health directorates and District health management teams for their cooperation and guidance during implementation of project activities. I also thank ACD staff who despite of several challenges have put in tireless efforts to achieve the desired objectives and targets of the projects.