PEARL S. BUCK INTERNATIONAL

PARTNERS FOR HEALTH
CHILD SURVIVAL PROJECT CSXIII
FY2000 - FY2003
FAO-0097-00041-00

In Ormoc and Merida, Leyte Province,
Eastern Visayas, Philippines

Final Evaluation Report, July 2003

Written by Joan M. Jennings, MPH
Edited by Hannah M. Gilk, MPH

Pearl S. Buck International Partners for Health Child Survival Project
CSXIII FY2000 - 2003; Final Evaluation June-July 2003

TABLE OF CONTENTS

ACRONYMS

BCLP	Basic Child Learning Package
BEOP	Barangay Emergency Obstetrical Plan
BHC	Barangay Health Committee
BHS	Barangay Health Station
BHW	Barangay Health Worker
BIG	Bio-Intensive Gardening
BNS	Barangay Nutrition Scholar
CS	Child Survival
CSTS	Child Survival Technical Support
DIP	Detailed Implementation Plan
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
FE	Final Evaluation
FGD	Focus Group Discussion
FHSIS	Field Health Surveillance Information System
FP	Family Planning
GM	Growth Monitoring
HBMR	Home Based Maternal Record
HNP	Health and Nutrition Post
IECM	Information Education Communication Motivation
IMCI	Integrated Management of Childhood Illness
KAP	Knowledge Attitude Practice
KPC	Knowledge Practice Coverage
LGU	Local Government Unit
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSG	Mother Support Group
NGO	Non-Governmental Organization
PDI	Positive Deviance Inquiry
PHDB	Purok Health Data Board
PHN	Public Health Nurse
PHO	Public Health Officer
PSBI	Pearl S. Buck International
RHM	Rural Health Midwife
SEATS	Family Planning Service Expansion and Technical Support
TA	Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development

Saying in the Philippines Region VIII, Eastern Visayas:
"The crisis of today can be laughed at tomorrow, once it is solved."

A. SUMMARY

A1. OVERVIEW

Pearl S. Buck International (PSBI) implemented a **2 year Child Survival entry planning grant** from October 1997 to September 1999 in the Ormoc and Merida health units of Leyte Island Provincial Health Office, Eastern Visayas, the Philippines. This period was spent networking and coordinating with MOH and local government to build capacities for implementing essential child survival services and for monitoring and evaluating (M&E) activities. The entry period culminated in participatory development of a Detailed Implementation Plan for future planned activities.

In October 1999, a **4 year Child Survival Grant** (CSXIII) was awarded to PSBI, for implementation until September 30, 2003. Review of the Detailed Implementation Plan produced suggestions that contributed to a revised DIP. These revisions were made to better focus activities; both in terms of the number of interventions and in terms of geographic coverage, and improvements were suggested for M&E plans.

This is the report of the final evaluation of the Partners for Health Child Survival Project.
The project goal was "to improve the health and nutritional status of children and women through the strengthened capacities of families, communities, Local Government Units (LGU) and Non-Governmental Organizations (NGO) to manage community health programs."[1] The project focused on three technical intervention areas:

- Nutrition and Breastfeeding Promotion (40%)
- Maternal Care (30%)
- Child Spacing (30%)

Note that a chart of detailed objectives and targets can be found in section B1.

The **project location** focused on 48 rural communities (*barangays*) of the Ormoc and Merida health unit areas of Leyte Island (38 in Ormoc and 10 in Merida). Project **beneficiaries** were 21,867 children 0 to 59 months of age, along with 12,617 women of childbearing age. Partners included MOH personnel, local government unit personnel and, originally, 3 local NGOs; however, the local NGOs gradually opted out of participating, primarily due to changes in their own geographic or technical area of emphasis. Participation by MOH and LGU partners was as strong as or stronger than expected during the life-of-the-project.

The **project's approach** was to build capacity at the household, community, local government, local health unit and health management levels. Extensive meetings with MOH and LGU personnel were held during the 2-year entry grant period and within the first year of this project, to update and refresh **MOH staff capacity** for implementing key child survival and maternal care interventions. **Local Government Units** in Ormoc and Merida, with health care responsibility under the on-going

[1] PSBI Detailed Implementation Plan for Partners for Health Child Survival Project, June 1999.

devolved strategy for maternal and child health outreach, were active project partners involved in all activities, including participation in workshops on technical topics and topics such as social mobilization. In addition, the project provided training in leadership and health action planning for Community (*Barangay*) Councils, to strengthen their capacities in support of community health actions.

The project provided technical training and equipment support for existing **community health volunteers**, including approximately 95 Barangay Health Workers (BHW), 35 Barangay Nutrition Scholars (BNS) and 60 Traditional Birth Attendants (TBA). They were trained in the recommended health practices and messages for nutrition and breastfeeding, maternal care, and child spacing. They also received training on the formation of Mothers Support Groups, for community group health education through the Basic Child Learning Package, and in health action planning with community Barangay Councils. All community health volunteers were provided with 3 sets of behavior change communication materials and flipcharts: Healthy Baby, Healthy Mother and Healthy Family. The project also conducted a contest for Healthy Baby, Healthy Mother and Health Family in Years 1 to 3, with photos of winners used to create calendars, with a health message for each month, that were distributed to all participating families. In 5 communities each, BHWs received additional training for new approaches for recuperation of malnourished children (the Hearth model) or for promotion of bio-intensive gardening (BIG).

Basic equipment for maternal and child health care was also provided to the Barangay Health Stations (BHS) that provide coverage for target communities and MOH referral units. This included 50 obstetric exam tables, 44 standing scales, 150 sphygmomanometers and stethoscopes, 30 gooseneck lamp and Salter hanging scales (132, including those provided to community health volunteers). Communities distant to BHS were encouraged to construct simple Weighing Posts with local materials and BHWs in 36 such communities were provided with child hanging scales to use in conducting regular growth monitoring. In a few instances, these Weighing Posts were expanded and converted into outreach clinics, or Health and Nutrition Posts, for use by visiting Rural Health Midwives based at BHS distant to these communities. The project also translated Child Health Cards and Home Based Maternal Records from English into the local language and distributed 1,500 of each.

This final evaluation report is based upon **quantitative results** from a participatory LQAS survey of mothers' knowledge and practices, along with a client satisfaction survey of the quality of care provided by Rural Health Midwives and community health volunteers (including TBAs) carried out by the project in May 2003, along with **qualitative results** from participatory field evaluation activities (focus group discussions and interviews of key informants) led by the author of this report and a local consultant in two teams of MOH and LGU local and provincial-level representatives.[2] Results were analyzed in a participatory manner and key findings were presented to project partners. Further description of final evaluation methodology can be found in Annex A, B, and C.

A2. KEY FINDINGS

[2] Final Evaluation Team Leader Joan M. Jennings, MPH; Assistant Leader, Susan Balingit, M.D.

Of the project's eleven objectives that were assessed at baseline and final evaluation by LQAS and review of project monitoring information, two-thirds of these showed significant improvement. Among the 7 objectives showing improvement, 3 did not quite meet the target while 4 exceeded the targets established in the DIP.

The technical interventions of **maternal care** and **child spacing** achieved very successful results. The percentage of women with children under 24 months of age, with at least 3 documented prenatal care visits during their last pregnancy increased from 48% to 93.2% (± 4.8). Among the same sample group, women who had received at least 2 or more tetanus toxoid vaccinations increased from 58% to 98.5% (± 1.8). Among women of reproductive age, the percentage using modern contraceptive methods increased from 25% to 66.6% (± 7.0).

Qualitative results from final evaluation focus group discussions (FGD) were triangulated with quantitative LQAS results. There was concordance that mothers that were interviewed showed the broadest and most comprehensive knowledge of recommended practices for maternal care and/or child spacing, compared to all technical intervention areas. *Barangay* Council members, mothers and fathers all specifically noted the inclusion of men in health education activities on child spacing as a key strength of the project.

LQAS found that the percentage of women who were delivered by a TBA and received quality post-partum care from that TBA increased from 57% to 81.8% (± 6.5). The quality of this post-partum advice, however, was found in FGD to be close to but not quite adequate. Conversely, there was no change in the percentage of women delivered by an MOH or project -trained TBA, among all women delivered by a TBA (90% to 84.6% ± 6.2). However, FGD results demonstrated that the quality of care had improved tremendously, with sterile technique used in 100% of recent deliveries. As roughly 40% of mothers in FGD had a delivery attended by a TBA, this underscores the continued importance of technical training for TBAs.

Objectives for promotion of **breastfeeding** showed a mix of positive improvement (continued breastfeeding increased from 46% to 66.0% ± 6.2; early initiation of breastfeeding, although not a project objective, was found to increase from 80.5% to 97.5% ± 3.6) and no change (exclusive breastfeeding for six months, 50% to 40.4% ± 4.3). Qualitative results from FGD also concurred with these results. Mothers cited increased knowledge of the benefits of colostrum as enabling them to continue and promote this traditional practice to new mothers. Positive changes in other traditional beliefs that could restrict the continuation of breastfeeding were also noted, along with increased knowledge of multiple positions for breastfeeding. Confusion still exists regarding the appropriate age to maintain exclusive breastfeeding, as the official MOH message and the project indicator changed from 4 months to 6 months during the life-of-the-project.

The two objectives for child **complementary feeding** revealed the poorest quantiative results. The percentage of children age 6 to 9 months provided with continued breastfeeding and introduction of solid foods showed no change (31.5% to 37.9% ± 4.0). The percentage of mothers giving at least one food high in Vitamin A or iron to children 6 to 24 months of age appeared to decrease, from 85% to 45.7%. However, results from FGD were the opposite of quantitative results. It is considered likely that a concern expressed by supervisors of the LQAS

may have affected quantitative results -- that surveyors were not sufficiently patient for mothers to give multiple answers during 24 hour diet recall.

In FGD, mothers repeatedly mentioned the benefits of giving children age 6 months or older "adult food". They noted the importance of adding an available source of protein, such as shredded dried fish, to the staple weaning food of porridge. The benefits of including local vegetables high in Vitamin A and/or iron also in the porridge were expressed by almost all mothers interviewed. Mothers' knowledge was weaker on the importance of including sources of concentrated calories in the weaning diet and/or of multiple cheap options for protein sources.

However, FGD and field visits during final evaluation found mothers' interest in and understanding of **growth monitoring** to be a key project achievement and may be partially attributed to community construction of 36 Weighing Posts, which are manned by BHWs or BNSs, and provide an extension of community services. These posts were promoted by the project through cross-visits to other sites in the Philippines. In addition, the project introduced the Hearth model for community-based recuperation of malnourished children in 5 communities. Evaluation found this approach to have also contributed to a new level of knowledge by mothers regarding child growth; however, final evaluation findings were similar to those of a special operations research conducted in June 2002 -- that the education component is weak and not completely based on the Hearth model of analysis of positive deviance. In response to this finding, the person providing HQ technical backstopping to the project decided to prolong her stay beyond participation in final evaluation activities, in order to support a refresher training for project partners in the Hearth model.

Results from **Client Satisfaction Surveys** also conducted at final evaluation were very positive, showing a good level of quality care and client satisfaction with care provided by MOH Rural Health Midwives, Barangay Health Workers, and Traditional Birth Attendants. The only weak aspect was revealed to be trust in the confidentiality of interactions. Assessment of **BHW, BNS and TBA technical knowledge** of key child survival and maternal care messages conducted in focus groups during final evaluation qualitative activities found a strong level of technical knowledge in all intervention areas.

It should be noted that project MOH partners were active and enthusiastic participants in the final evaluation process, conducting focus group discussions with Barangay Council and/or mothers group members during community visits. Two days were spent in participatory analysis of FGD results, and the key findings of final evaluation were presented in a workshop at the conclusion, with attendance by all key MOH and LGU partners in positions of authority and staff management. The overall level of capacity-building for project partners is seen as another key achievement of this project, especially in the area of monitoring and evaluation techniques.

B. ASSESSMENT OF RESULTS AND IMPACT OF PROJECT

The following results are based upon the project objectives and indicators submitted with the *revised* Detailed Implementation Plan in June 1999. It should be noted that a revision of the DIP was requested partly in order to strengthen the monitoring and evaluation component of the proposed project. The project has invested considerable efforts in capacity-building for M&E activities. Throughout the life-of-the-project there has been continuous improvement in the use of evaluation

methods, from KPC cluster sampling to Lot Quality Assurance Sampling techniques, and in the reformulation of objectives and definition of the criteria for calculating these objectives. Differences in criteria used for indicator calculation are explained in the "Comments" section of the Summary Chart of Results. As much as possible, final evaluation results were either calculated identically as baseline indicators, or, in many cases, even stricter and more appropriate definitions of criteria were used.

B1. SUMMARY CHART OF QUANTITATIVE RESULTS

Table No.1

Project Objectives	Baseline	FE	Comments
Nutrition and Breastfeeding Promotion (40%)			
1. Increase from 50% to 70% the percentage of children <24 mos. who were exclusively breastfed until 6 mos.	50%	40.4% ± 4.3	NO CHANGE: Baseline was calculated as present practice among mothers of children 0 to 4 mos. of age; FE came from retrospective question for children 6 to 24 mos. as LQAS contained few mothers with children <6 mos. of age.
2. Decrease from 31% to 10% the percentage of mothers initiating solid foods to children <6 months of age.	31%	n/a	NOT ASSESSED: determined to be inappropriate in its focus on only solid food, not including liquids.
3. Increase from 46% to 70% the percentage of children who are continuously breastfed (age 20 to 23 mos.).	46%	66.0% ± 6.2	IMPROVEMENT: FE numerator includes children age 18 to 23 mos. to achieve sufficient sample size.
(n/a) Percentage of mothers Immediately breastfeeding at childbirth (colostrum).	80.5%	97.5% ± 3.6	IMPROVEMENT: Not included as project objective but assessed at baseline and FE.

Project Objectives	Baseline	FE	Comments
4. Increase from 22% to 60% the percentage of children age 6 to 24 mos. provided with appropriate complementary feeding. [3]	31.5%	37.9% ± 4.0	NO CHANGE: Criteria for baseline and FE includes: ▪ continued breastfeeding ▪ introduction of any solid food Numerator includes children age 6 to 9 mos. of age.
5. Increase from 85% to 95% the percentage of mothers with children <5 years old who gave	85%	45.7%	DECREASE. Criteria includes consumption of any food high in Vitamin A or iron among children

[3] Note that objective would be better written as "the percentage of children age 6 to 9 months with continued breastfeeding and consumption of solid food". Note also that Baseline value had been reported as 22%, but this incorrectly included only children age 6 mos. within the numerator, while KPC survey recommendations are for age 6 to 9 months (KPC+ 2000).

children at least 2 Vitamin A / iron rich foods.[4]			age 6 to 24 mos. (Questions exist as to surveyor technique.)
6. Increase from 0 to 48 (100%) the number of communities with established and functional weighing posts.	0	32 (66.7%)	IMPROVEMENT: Criteria includes regular growth monitoring activities by community health volunteers; source is project monitoring data.

Project Objectives	Baseline	FE	Comments
Promotion of Appropriate Maternal Care Practices			
7. Increase from 48% to 70% the percentage of women who have at least three prenatal care visits.	48%	93.2% ±4.8	TARGET EXCEEDED: Criteria for baseline included only 2 or more *documented* PNC visits, while FE criteria is 3 or more.
8. Increase from 58% to 75% the percentage of women who received at least 2 Tet.Tox.	58%	98.5% ±1.8	TARGET EXCEEDED: Includes only *documented* vaccination among those with health cards.
9. Increase from 90% to 95% the percentage of deliveries attended by a trained TBA.	90%	84.6% ±6.2	NO CHANGE: Denominator is total number deliveries attended by any TBA, trained or untrained.
10. Increase from 57% to 75% the percentage of women who receive quality post-partum care from a trained TBA.	57%	81.8% ±6.5	TARGET EXCEEDED: Denominator includes only births attended by trained or untrained TBAs. Criteria for defining "quality" were not included in survey questions baseline or FE.
11. Increase from 0 to 48 the # of communities with an Emergency Obstetrical Plan.	0	47	IMPROVEMENT: Information from project monitoring system.

[4] Note that objective would be better written as "children 6 to 24 mos. of age given any food source high in Vitamin A or iron."

Project Objectives	Baseline	FE	Comments
Promotion of Child Spacing			
12. Increase from 25% to 50% the percentage of women using modern contraceptive methods.	25%	66.6% ± 7.0	TARGET EXCEEDED: Criteria include only modern methods such as condoms, pills, injection, IUD or sterilization.
13. Increase from 0 to 48 the number of Barangay Health Stations providing quality family planning service.	0	n/a	NOT ASSESSED: Project complemented efforts of MOH and other projects to improve access to quality FP services. Health facilities were not assessed by this project.

Of the project's eleven objectives that were assessed at baseline and final evaluation, two-thirds of these showed significant improvement. Among the 7 objectives showing improvement, 3 did not quite meet the target while 4 exceeded the targets established in the DIP. The most successful results were achieved in the technical interventions for **maternal care** and **child spacing**. Objectives for promotion of **breastfeeding** showed a mix of positive improvement (continued breastfeeding; early initiation of breastfeeding) and no change (exclusive breastfeeding). The two objectives for child **complementary feeding** revealed the poorest results (and may reflect a weakness in survey technique rather than actual results; see section B2b for more information).

B2. RESULTS: TECHNICAL APPROACH

B2a. PROJECT OVERVIEW

Pearl S. Buck International (PSBI) implemented a **2 year Child Survival entry planning grant** from October 1997 to September 1999 in the Ormoc and Merida health units of Leyte Island Provincial Health Office, Eastern Visayas, the Philippines. This period was spent networking and coordinating with MOH and local government to build capacities for implementing essential child survival services and monitoring and evaluating activities.

In October 1999, a **4 year Child Survival Grant** was awarded to PSBI, for implementation until September 29, 2003. A revised Detailed Implementation Plan was submitted in June of 1999. Revisions were made to better focus activities, both in terms of the number of interventions and in terms of geographic coverage.

The **project goal** was "to improve the health and nutritional status of children and women through the strengthened capacities of families, communities, Local Government Units (LGU) and Non-Governmental Organizations (NGO) to manage community health programs."[5] The project focused on three technical intervention areas:

[5] PSBI Detailed Implementation Plan for Partners for Health Child Survival Project, June 1999.

- Nutrition and Breastfeeding Promotion (40%)
- Maternal Care (30%)
- Child Spacing (30%)

The **project location** focused on 48 rural communities (*baranagays*) of the Ormoc and Merida health unit areas of Leyte Island (38 in Ormoc and 10 in Merida). Project **beneficiaries** were 21,867 children 0 to 59 months of age, along with 12,617 women of childbearing age. Partners included MOH personnel, local government unit personnel (LGU) and, originally, 3 local NGOs; however, the local NGOs gradually opted out of participating, primarily due to changes in their own geographic or technical area of emphasis. Participation by MOH and LGU partners was as strong as or stronger than expected during the life-of-the-project.

The **project's approach** was to build capacity at the household, community, local government, local health unit and health management levels. Extensive meetings with MOH personnel were held during the 2-year entry grant period and within the first year of this project, to update and refresh MOH staff orientation and capacity for implementing key child survival and maternal care interventions.

Local Government Units in Ormoc and Merida, with health care responsibility under the on-going devolved strategy for maternal and child health outreach, were active project partners involved in all activities, including participation in workshops on technical topics and topics such as social mobilization. In addition, the project provided training in leadership and health action planning for Community (*Barangay*) Councils, to strengthen their capacities in support of community health actions.

The project provided technical training and equipment support for existing community health volunteers, including approximately 95 Barangay Health Workers (BHW), 35 Barangay Nutrition Scholars (BNS) and 60 Traditional Birth Attendants (TBA). They were trained in the recommended health practices and messages for nutrition and breastfeeding, maternal care, and child spacing. They also received training on the formation of Mothers Support Groups, for community group health education through the Basic Child Learning Package, and in health action planning with community Barangay Councils. All community health volunteers were provided with 3 sets of behavior change communication materials and flipcharts: Healthy Baby, Healthy Mother and Healthy Family. The project also conducted a contest for Healthy Baby, Healthy Mother and Healthy Family in Years 1 to 3, with photos of winners used to create calendars, with a health message for each month, that were distributed to all participating families.

Basic equipment for maternal and child health care was also provided to the Barangay Health Stations (BHS) that provide coverage for target communities and MOH referral units. This included 50 obstetric exam tables, 44 standing scales, 150 sphygmomanometers and stethoscopes, 30 gooseneck lamp and Salter hanging scales (132, including those provided to community health volunteers). Communities distant to BHS were encouraged to construct simple Weighing Posts with local materials and BHWs in 36 such communities were provided with child hanging scales to use in conducting regular growth monitoring. In a few instances, these Weighing Posts were expanded and

converted into outreach clinics, or Health and Nutrition Posts, for use by visiting Rural Health Midwives based at BHS distant to these communities. The project also translated Child Health Cards and Home Based Maternal Records from English into the local language and distributed 1,500 of each.

B2b. PROGRESS BY INTERVENTION AREA

B2b1. NUTRITION AND BREASTFEEDING PROMOTION INTERVENTION

In summary of the quantitative results presented in section B1: LQAS results did not show improvement in the indicator of **exclusive breastfeeding**. This concurs with results from the qualitative final survey. It may be partly due to confusion that remains as the official MOH message , as did the project indicator, from 4 mos. to 6 mos. during the first few years of the project.
The project did not quite meet the target (66%) for **continued breastfeeding**, but significant improvement was found since baseline, with positive practice increasing by 20 percentage points. This is an important accomplishment, considering that large national studies have shown the median length of breastfeeding to be 13 months.[6]

Early initiation of breastfeeding (colostrum) was not included as a project objective as it was among the more positive findings at baseline (80%); however, it was assessed at final evaluation and revealed statistically significant improvement (97.5%).

As seen in Text Box No.1, results from focus group discussions with mothers supported quantitative LQAS results, with a strong emphasis by mothers on the importance of colostrum and multiple comments supporting new techniques that enable a mother to continue breastfeeding.

Text Box No.1[7]

Open-ended question: What *changes* in breastfeeding practices have occurred due to the project?
▪ New knowledge to continue support for a traditional practice -- that colostrum has antibodies that protect against childhood diseases. ▪ New knowledge on a variety of positions for breastfeeding. ▪ Rejection of traditional beliefs that breastmilk can become "old". ▪ New knowledge about expressing breastmilk, to be given by spoon. ▪ New knowledge on hygiene of cleaning nipples with warm water.

[6] National Demographic Health Survey, 1998.
[7] Note that in the Text Boxes, only those comments that were made "frequently" or "very frequently" in final evaluation focus group discussions are presented.

Mothers stated that early initiation of breastfeeding is a traditional practice (although it should be noted that the percentage increased from 80.5% to 97.5%) but were enthusiastic that their new knowledge of the detailed benefits of colostrum justified the validity of this practice and enabled them to feel capable of promoting it to new mothers. They stated that **Mothers Support Groups**, organized by a BHW or BNS leader, were an effective strategy for disseminating information on the benefits of breastfeeding. However, final evaluation did note that these groups appeared to be more general "community health education mothers groups" rather than groups that achieve all of the objectives for mutual support as outlined in the MSG model promoted by La Leche League and others.

There was also frequent mention of a traditional belief that a mother must express breastmilk and throw it away, if she had left the home without the child for a few hours, as the breastmilk would become "old". This practice could decrease a mother's ability to **continue breastfeeding**. Mothers were also enthusiastic about their new knowledge that breastmilk could be expressed and given to a child by spoon. Most stated that the breastmilk would be fine at room temperature for about "8 hours to a day". A common obstacle to continued breastfeeding up to age 24 months is the need for many mothers to engage in temporary work, such as selling things at market. Expressing breastmilk for use during a mother's short-term absence can greatly assist in prolonging the period of
continued breastfeeding. Mothers were also enthusiastic about their new knowledge of a variety of positions for breastfeeding, although they did not correlate this with a decrease in nipple problems or other factors.

Among the messages for breastfeeding promotion that could benefit from further strengthening are **promotion of exclusive breastfeeding** and education on the **management of breastfeeding problems**. In focus group discussions, mothers were clearly confused as to whether exclusive breastfeeding should be continued until 4 months of age or 6 months of age. Many mentioned introducing soups at 4 months. Several of the younger mothers noted strong influences from in-laws to introduce cereal-based commercial formulas at an early age and a few confidently recommended practices that are discouraged, such as giving liquid vitamins to babies before 6 months of age. A few mothers mentioned problems that prevented their breastfeeding, such as inverted nipples, without any of the other mothers commenting on ways to prevent or manage such problems.

Final evaluation LQAS did not show improvement in **child complementary feeding** (introduction of solids and continued breastfeeding among children age 6 to 9 months); however, final evaluation qualitative results were at odds with these quantitative results. Focus group discussions with mothers of children age 6 to 24 months consistently revealed increased knowledge and report of improved practices in **diversifying the diet of children** and no resistance to the recommended practice of introducing solid foods at 6 months of age was detected. (See Text Box No.2 for more information.)

Final evaluation LQAS also oddly revealed a reduction in the percentage of mothers giving children foods high in **Vitamin A or iron**. This result is also completely contrary to results from focus group discussions with mothers (Text Box No.2). It may unfortunately reflect a concern expressed by final evaluation LQAS supervisors -- that interviewers were not giving mothers

sufficient time for multiple answers during the 24 hour diet recall section of the questionnaire. This is considered to be the likely explanation as values were found to be lower at final evaluation for ALL food categories, yet there has been no dramatic change in household livelihood security during the life of the project.

Text Box No.2

Open ended question: What *changes* in child feeding practices have occurred due to the project?
▪ New knowledge on the importance of a balanced diet. ▪ New knowledge of the value of available vegetables as sources of vitamins. ▪ New knowledge on the importance of feeding a child 5 times a day. ▪ New knowledge that small children can "eat adult foods". ▪ Strengthened knowledge on the importance of healthy snack foods. ▪ Better knowledge on improved hygiene during food preparation. ▪ Decreased traditional beliefs that consumption of fruit is harmful for small children.

Results from final evaluation focus group discussions on complementary feeding were consistent among all 10 communities visited. Responses to open-ended questions repeatedly emphasized that the communication and discussion of recommended complementary feeding practices had been a strong element of the project, and that mothers had now internalized these messages.

FGD results revealed that mothers understand most of the key messages of the Philippines Nutrition Council for a balanced diet: "**Rice plus Go, Grow, Glow foods**". Almost all mothers noted the need to have a variety of locally available sources of complex carbohydrates in the diet, most frequently mentioning cassava and noodles and occasionally taro and/or bread. Most mothers mentioned the importance of including small amounts of shredded fish in the staple weaning diet of porridge; a few also mentioned eggs or meat. All mothers noted the importance of including locally available vegetables high in Vitamin A and iron, chopped up into the weaning porridge. In FGD, both older and younger mothers noted that they had come to agree that the traditional belief that fruits were harmful to small children was inappropriate. The words mothers used in FGD to describe their opinions reflected a commitment to recommended practices, rather than a "parroting" of nutrition messages.

> "*We have learned that you must try a variety of foods mixed into the porridge, until you figure out which the child prefers. But you must not give up trying to give this food again, as children's tastes will change day by day and it is important they learn to eat all vegetables. Children should eat the same foods as adults, but mothers must make sure the foods are soft and chopped up so the child can swallow them.*
>
> *Comment by mother in Tubod, Merida*

There were two areas of complementary feeding knowledge found to be weak: other cheaper options for sources of vegetable protein, such as beans or nuts; and the importance of fats and oils as sources of concentrated calories among the "Go" foods. In addition, mothers in FGD did not specifically mention active feeding practices, nor the importance of a child having his own separate bowl of food.

The project supported the promotion of Vitamin A supplementation for children through community volunteer trainings. In FGD, mothers demonstrated awareness of the importance of Vitamin A supplementation for children and specifically cited its importance for vision. The percentage of children receiving supplements was not assessed at final evaluation, as it was not one of the key project indicators. In interviews with MOH staff, they noted that supplies of Vitamin A are usually sufficient; however, MOH staff also noted frequent changes in health policy that determines the selection of sub-regional areas for increased emphasis in micronutrient campaigns and subsequent receipt of supplies.

> *"Even if my child is below the curved line printed on the growth chart, the most important thing is that the line showing her weight each month is going up. I can also continue to give her extra food so that she can get closer and closer to the curve."*
> *Comment by mother in Santo Niño, Ormoc*

Although the project did not meet its target (67% of 100%, or 32 of 48 communities) for establishing **Weighing Posts**, a new approach for this area, focus group discussions and field visits revealed a fairly good quality of service available in these posts. The Weighing Posts were built by community Barangay Councils with community participation. The posts are managed by community health volunteers, with occasional supervisory visits by local health personnel. Most of the weighing posts are small single rooms constructed of locally available materials. A few, over time, were expanded and converted into outreach clinics, or Health and Nutrition Posts, for use by visiting Rural Health Midwives based at health units distant to these communities. The promotion of regular growth monitoring through Weighing Posts is an important strategy when trying to reduce child malnutrition[8], as mothers must pay close attention to a child's weight for immediate and additional action at the point at which growth faltering occurs.

Mothers interviewed stated that BHW and/or BNS not only discuss growth monitoring results with them, but also have taught them how to chart their child's growth; they are able to describe a correct understanding of the chart and of growth trends and tendencies. ***Mothers' interest in and comprehension of growth monitoring activities was determined by final evaluation to be an important project accomplishment.***

B2b2. MATERNAL CARE INTERVENTION

The project **exceeded targets for both prenatal care indicators** (99% with ≥TT2; 93% with 3 or more PNC visits); this is indicative of the high degree of collaboration between the project and its key partner, MOH personnel, in coordination with community health volunteers. These are very important achievements for maternal health, especially as national statistics had shown TT2 levels to be *decreasing* between 1993 and 1998, from 42% to 38%[9].

These project achievements also reflect the importance of a Home Based Maternal Record, in order to better evaluate these indicators. Few mothers possessed a HBMR at baseline. The

[8] DOH data for Ormoc in 1998: 28% mild malnutrition, 7% moderate, <1% severe; weight-for-age.
[9] DIP 1999.

project provided not only for the distribution of HBMR, but also had these translated into the local dialect to promote better knowledge of maternal health care recommendations. More than 70% of mothers were found to have HBMR in the final evaluation LQAS, while only a negligible number had these at baseline.

Results from focus group discussions with mothers concurred with quantitative results, finding the greatest positive change in knowledge to be in the technical intervention area of maternal health care (Text Box No.3). The greatest number of mothers expressed the most comprehensive knowledge of recommended prenatal care practices, among all of the technical intervention topics.

Text Box No.3

Open-ended question: Why is **prenatal care** important?

Frequency of comment	Comment
▪ Very frequent	▪ Check weight
▪ Very frequent	▪ Check status of the fetus, including position
▪ Very frequent	▪ Receive tetanus toxoid vaccination
▪ Moderate frequency	▪ Check blood pressure
▪ Moderate frequency	▪ Get iron tablets

Mothers described confidence in and comfortableness with Rural Health Midwives at the local health unit, and a close relationship between RHM, TBAs and pregnant women. Final evaluation with Client Satisfaction Surveys of prenatal care by Rural Health Midwives also found very positive results, with good quality of care and a high level of client satisfaction (see section B3c4, Health Worker Performance, for more information).

Among TBAs attending childbirth, the percentage of these found to be MOH-trained TBAs remained similarly high between baseline and final evaluation (85-90%). However, results from qualitative focus group discussions found the use of **appropriate practices during childbirth by TBAs**, as reported by mothers with a TBA attended birth, to be of excellent quality in all cases (Text Box No.4). When mothers were questioned about TBA practices during childbirth, **sterile techniques** had been used during every childbirth attended.

Text Box No.4

Open-ended question: (for those attended by TBA)
What techniques were used by the TBA to protect your health and the baby's during **childbirth**?

Frequency of comment	Comment
▪ Mentioned by all	▪ Sterilize equipment
▪ Mentioned by all	▪ Wash hands or use gloves
▪ Very frequent	▪ Cut cord with sterilized scissors, use betadine
	▪ Place clean plastic sheet under lower body

▪ Very frequent ▪ Moderate frequency	▪ Wash perineal area with warm water

At 82%, the project **exceeded its target for post-partum care by trained TBAs.** All mothers whose childbirth had been attended by a TBA had also been visited by the TBA during the post-partum period, even though this was not a traditional practice previous to the project. Qualitative results (Text Box. No.5) show post-partum care to have improved in quality, though room for improvement remains.

Text Box No.5

Open-ended question: (for those visited post-partum by TBA) What advice was given **post-partum**?	
Frequency of comment	**Comment**
▪ Very frequent ▪ Moderate frequency ▪ Moderate frequency	▪ Importance of breastfeeding ▪ Visit health unit for Vitamin A capsule ▪ Visit health unit for iron tablets

Post-partum counseling topics found to show positive results were on the importance of breastfeeding and the need for the mother to visit the health unit to receive Vitamin A and iron tablets. However, the overall quality of counseling remains weak, similar to that found at midterm evaluation. Counseling topics that could be strengthened include some of the most important elements of post-partum care, such as signs of infection for mother or baby, the importance of immunization for the newborn and discussion of child spacing. It should be noted that in final evaluation FGD with TBAs for assessment of their level of technical knowledge, all recommended post-partum counseling messages were mentioned by TBAs; however, FGD with mothers revealed the above results.

The project supported the promotion of MOH messages for iron supplementation during pregnancy and receipt of Vitamin A supplement post-partum. As MOH supplies of ferrous sulfate were inadequate, the project utilized private matching funds for the purchase of this micronutrient several years during the life-of-the project. Receipt of micronutrients by women of childbearing age was not assessed in LQAS at final evaluation. However, in FGD and interviews with MOH staff, supplies were said to be adequate due to the project's support.

The project came very close to meeting its target for **community emergency obstetric plans**. It should be noted that community leaders interviewed during qualitative fieldwork noted the infrequent need for such a plan to be a hindrance in motivating community involvement and therefore modified it to an emergency transportation plan for any community health problem.

B2b3. CHILD SPACING INTERVENTION

The project exceeded its target for use of **modern contraceptive methods**. This is indicative of the potential of collaborative efforts between more than one NGO and the local MOH partner.

The local MOH has been promoting child spacing and family planning techniques for many years previous to the project. In addition, another NGO (Marie Stoppes) provides support, especially for voluntary surgical sterilization.

The PSBI project focused on **complementary activities** by providing support and equipment for the training of Rural Health Midwives in the technique of IUD insertion. In addition, the strong focus of the PSBI project on community mobilization also provided complementary activities for message dissemination and discussion for behavior change (Text Box No.6). Although an **increased involvement of husbands** and other male community members in maternal and child health care community activities was mentioned several times during final evaluation focus group discussions, it was most strongly noted during discussion of the topic of child spacing. ***Women, men and local government councils interviewed stated that this was one of the strengths of the PSBI project.***

Text Box No.6

Open-ended question: In regards to child spacing, what *changes* have occurred due to the project?
▪ increased access to a greater variety of methods ▪ community members better-informed on types of methods ▪ more involvement of husbands in community activities and personal discussions

B2b4. LESSONS LEARNED

▪ **Collaboration with MOH partners**: Project management staff learned several important lessons related to partnership with other actors. First and foremost, the strong participation of local MOH personnel throughout the life-of-the-project validated the project's early emphasis in participatory planning with MOH partners and the focus on capacity-building in all project areas of activities.

▪ **Partnership with other agencies**: Although partnership with local NGOs initiated with exploratory discussions and participatory planning, over time it became apparent that the partnerships were not functional. A more structured process to detail and compare partners goals, objectives, key strategies and expectations would be recommended for any future PSBI activities. Some difficulties, however, were most likely inevitable as a few of the partners altered their technical or geographic area of focus during the life-of-the-project.

▪ **Value of technical assistance from experienced providers:** PSBI sought input from NGOs with experience in child survival projects throughout the life-of-the-project and staff note the benefit this provided in strengthening capacities.

B2b5. CONSTRAINTS

- ***Constraints at the Community Level***: An important potential constraint mentioned by multiple project participants and partners during qualitative final evaluation fieldwork was that some of the mothers with the highest needs for health and nutrition education do not have much time available for these community activities as they must work outside the community. In most cases, this was addressed by the community health volunteers' willingness to hold activities on Saturdays, with compensatory time permitted for PSBI field staff. In addition, communities have multiple health volunteers and these volunteers also conduct home visits in the evening or on weekends.

Another potential constraint mentioned by project staff and partners during final evaluation interviews was a concern that re-elections of Barangay Council members would negatively impact the work of community health volunteers. However, final evaluation found this potential constraint to have had minimal to no effect to-date on community health activities. Many BHWs were asked about the length of time they had been active and most had extensive years of service that had continued during multiple changes in Council structures. Although they agreed that this potential constraint exists, they stated that truly active community health volunteers are valued by the community.

- ***Constraints at the Institutional Level***: Review of project Annual Reports found that project partners consistently mentioned budget constraints as an impediment to increasing or modifying supervisory activities.

B2c. NEW APPROACHES AND OPERATIONS RESEARCH

B2c1. THE HEARTH MODEL

In support of local response to child malnutrition, PSBI decided to undertake the Hearth model of community-based recuperative activities for malnourished children in 1 pilot barangay in September 2000. The Hearth model is based on the identification of child health care and feeding practices among "positive deviants", or well-nourished children, discovered within families of similar economic status within a community. An international consultant with experience in this model assisted in the design of the pilot intervention and accompanied project staff through the key steps for implementation, including inquiry into positive deviance, analysis of these results and determination of menus based on these results. The intervention was expanded to an additional 4 communities in 2001.

Operations research was conducted in June 2002, led by the HQ technical support staff member. The operations research activities were participatory with project partners, as another strategy for capacity-building. The key findings of this operations research were that, although the appropriate tools were available and the initial steps were followed in establishing the Hearth intervention, the education component was quite weak. An unexpected success, however, was in forging stronger bonds between mothers for community health action.

During qualitative final evaluation visits to two of the communities that implemented Hearth, results similar to those found during operations research were again encountered. Participants did not fully understand some of the key elements of the model, such as that the promoted

actions were those of local mothers in similar economic situations. The feeding recommendations also had not clearly been based upon the findings of the inquiry into practices of mothers with children that were positive deviants for nutritional status.

However, mothers that had participated revealed a **good level of knowledge about growth monitoring**, along with understanding of the growth monitoring graph on the Child Health Card. Increased concern and **focus on their child's nutritional status** and eating behaviors had clearly been motivated through participation in Hearth.

Participant mothers interviewed also stated their children were no longer malnourished, although this could not be verified as their children were not present. Many participant mothers continued meeting, cooking together and feeding their children on a regular basis for almost a year after the initial 12 week cycle of activities. However, BHWs, BNSs, and mothers did not demonstrate a capacity to repeat the Hearth cycle of activities on their own. It was decided during final evaluation that the project would have one last refresher training for MOH partners on the Hearth model, and that the PSBI headquarters staff that provides technical backstopping (and was present for participation in final evaluation) would remain two weeks longer to provide technical support during the training.

B2c2. BIO-INTENSIVE GARDENING (BIG)

The initial focus of the bio-intensive gardening activities was to promote backyard food production, especially of locally available vegetables and fruits rich in Vitamin A and iron, through methods based on the use of organic fertilizer and natural insecticides and planting in sacks or other small containers that make up locally available refuse. Training from the Department of Agriculture specialists was provided in four pilot communities. These trainers were unavailable for future trainings, as they were busy in other areas of the country. Project staff assisted interested Barangay Councils, BHWs or BNSs to replicate these activities in their communities.

Over the life of the project, the bio-intensive gardening activity morphed into community interest in several different types of gardening activities: individual backyard gardens, communal gardens, and model community gardens managed by the Barangay Council and community health volunteers. Almost all of the communities participating in the Child Survival project had initiated some type of new gardening activity by Year 4 of the project.

During final evaluation fieldwork visits to 10 communities with any type of gardening activity, it was found that the most sustained model was that of community gardens (except for a few individual backyard gardens). However, all models were found to have **strongly promoted the value and benefit of local fruits and vegetables**.

The BIG model did not focus very heavily on vegetable sources of protein, such as beans, and based on garden size observed, it is doubtful that the gardens were providing significant amounts of fruits or vegetables for family consumption. However, produce from these gardens was reported to be used in **diversifying the diet of small children**, whenever available. In a few instances, fathers that were interviewed noted that they were able to sell small amounts of

produce and **purchase other foods** for the family with the income, primarily animal sources of complete protein.

Many of the model gardens were also promoting local herbs used for medicinal purposes. All were known and still in common use among community members; evaluation consultants saw no potential harm in any of the herbal medicine promoted.

B3. CROSS-CUTTING APPROACHES

B3a. COMMUNITY MOBILIZATION

The project strategy for community mobilization was:

a) To increase the capacities of community health volunteers to provide maternal-child health education and promotion within a context in favor of behavioral change, while

b) Also strengthening collaboration and mutual support between health personnel, community health volunteers and community Barangay Councils for community health actions.

More information on the capacity of community health volunteers to provide maternal-child health education and promotion can be found below, in section B3b, Communication for Behavior Change.

In terms of coordination with committees and community members, partners received **technical training** on community organization, advocacy and social mobilization. BHWs and Barangay Council members were trained in the development of health action plans. In addition, one round of leadership training for Barangay Council members was conducted in Year 3 of the project. Another round is scheduled to take place during the final months of the life-of-the-project.

Final evaluation found the project approach for building the capacity of community health volunteers for the dissemination of maternal-child health messages to be a very effective approach. (See section B3b, Communication for Behavior Change, for more information.)

The approach for community mobilization through Barangay Council Health Committees was found to be either fairly effective in those communities with Health Committees, or ineffective due to the non-existence of Health Committees. Among the 10 communities visited during final evaluation field visits, the 5 Barangay Councils that had active Health Committees described a good degree of coordination with and support for community volunteer activities and community health actions. This result concurs with that noted in the project's Year 3 Annual Report, in which approximately half of Barangay Councils are noted to be actively supporting health activities through Health Committees.

During focus group discussion with Council members in those communities with active Health Committees, frequently mentioned comments in regards to a description of this coordination included:

- The Council **monitors project activities** through BHW reports to the Council.
- The Council **allocates funds**, such as for transportation to trainings, in support of community health volunteer activities
- The Council **organized community support** for construction of Weighing Posts.
- The Council and BHWs **address community health problems jointly**.
- The Council **informs community members** of health education activities and meetings.
- The Council holds **community meetings** to discuss health problems and report on progress in addressing such problems.

It should be noted that Barangay Councils coordinated support for the achievement of the construction of 32 Weighing Posts in the project's 48 target communities. The fact that Barangay Councils receive allocations from Local Government Units strengthens the likelihood that actions will be sustained among those Health Committees actively collaborating with community health volunteers at present.

The establishment of **Purok Health Data Boards** was a key mechanism for promoting community health action. PHDBs were organized by the Barangay Council members and community health volunteers and had project support.

The use of a Purok Health Data Board (PHDB) builds upon an existing practice of having a community level map of key landmarks, resources and geographic boundaries posted in a central location. The PHDB is a map of a smaller section of a community (the Purok) and is color-coded to reflect each household's health status in terms of appropriate water and sanitation practices, existence of bio-intensive garden, etc. During final evaluation field visits to communities, the PHDB was found to exist in at least one or more Purok in 7 of the 10 communities visited. In FGD with the Barangay Councils with active Health Committees, frequently mentioned comments on the usefulness of the PHDB included the following:

- Enables the community and the Council to see the **health situation** of the community
- Enables the Council to **monitor status** by color-coding
- Functions as a basis for **decision-making** by the Council
- Aids decisions by the Council for **budget allocations**
- Creates **social pressure** to comply with good health practices
- Helps the community know of **health dangers**

It was also noted by one Barangay Council that the PHDB also functions as a guide for visitors -- especially visits by other organizations with potential resources for community projects. Barangay Council members interviewed during final evaluation expressed a willingness to sustain the PHDB through regular up-dates to the information. However, MOH personnel interviewed expressed doubt that the PHDB would be updated without project impetus.

Among the Barangay Councils with active Health Committees, final evaluation FGD encountered multiple **positive impacts and effects attributed to the project**, including:

- More regularity in health service availability

- Less sickness in the community
- Better information on child spacing options
- More participation by men (husbands) in community health activities
- Less or no malnutrition among children
- Better relations among the community members
- Increased community mobilization for health actions
- Better availability of equipment for community health activities

See section B3d, Sustainability Strategy, for further discussion.

B3b. COMMUNICATION FOR BEHAVIOR CHANGE

The project promoted "communication for behavior change" at the institutional and community level -- by providing training on communication for behavior change to all partners, by organizing participatory training based on adult learning methods for all project partners, and by providing Information, Education, Communication and Motivation (IECM) materials to all community health volunteers and Barangay Health Stations.

On a large scale, the project initially stimulated community interest in child health by having a **Healthy Baby contest**. A set of 12 winners were chosen on the basis of the number of recommended child health care practices followed by the mother. Winners received small prizes. Photos of these children, along with a key health message, were then incorporated into calendars distributed to all participating families in the project coverage area. This activity was so successful that it was adapted as a Healthy Mother Contest (Year 2) and a Healthy Family contest (Year 3).[10] Final evaluation found project partners and community members to have had a very positive experience with this approach. Mothers clearly felt that "winners" were from their peer group, and that anyone could be a winner if they learned and implemented all of the recommended health care practices. MOH partners were concerned that they may not be able to continue to provide prizes, as they are legally prohibited from soliciting small businesses; however, in spite of this constraint, they were optimistic that they will find a solution and be able to sustain this activity that is so clearly valued by families.

On the level of one-to-one or small group counseling, the BHWs were provided with an **IECM kit** on each of 3 topics: Healthy Baby, Healthy Mother, and Healthy Family. A series of half-page size flipcharts were packaged as a set enclosed in a carrying case. The case converts into a tripod-like support for the flipcharts. The flipcharts are colorful, with appropriate drawings and messages in the local language. Messages provide some additional technical information for greater depth of understanding of recommended behaviors, along with comments to stimulate discussion of constraints to behavior change. For larger group education activities at the Barangay Health Stations, the BHS were provided with large cloth flipchart versions of the IECM kit materials.

[10] Year 4 was initially going to be "Healthy Community", but, being the final year of the project, it become a recognition of the efforts of all project partners.

Final evaluation shows the project approach to communication for behavior change to have been an essential element contributing to all of the project's accomplishments. Repeatedly in focus group discussions (FGD), mothers would mention that "*now we know why*" a recommended practice is important. Mothers clearly felt that BHWs and BNSs communicated useful technical information to them, while Mothers Support Groups and Basic Child Learning Groups offered a forum for discussing constraints. Another frequent comment in FGD was that "*now we have the knowledge to challenge some of the practices recommended by our mothers or in-laws*". In final evaluation LQAS results, ***81% of mothers sampled stated they had acquired information through the health network of project participants***, while 63% also cited project posters and/or calendars as a source of health information.

The high level of internalization by BHWs, BNSs, mothers and fathers of recommended child survival practices detected during final evaluation field visits supports the perception that positive behavior change will be sustained even after the project ends. The confidence level of BHWs and BNSs and their familiarity in using the IECM materials, along with the sturdy construction of the materials, makes it likely that community health education activities will also be sustained.

B3c. CAPACITY BUILDING APPROACH

The project included measurable **objectives for capacity-building** in the DIP. However, early on project staff determined that this was overly ambitious. At baseline the project focused their efforts on ensuring the quality of several important monitoring and evaluation elements: the KPC Survey, (self) Institutional Assessment, and an Equipment and Supplies Assessment. For monitoring purposes, the project regularly conducted participatory Lot Quality Assurance Sampling. At final evaluation, LQAS and a set of 4 Client Satisfaction Surveys comprised the quantitative inputs to final evaluation.

Qualitative information from final evaluation focus group discussions revealed good results for almost all of the capacity-building objectives presented in the DIP. Each objective is presented below, with comments from field visits and a note on other sections of this report with additional relevant information.

No.1: Increase community participation in community health assessment, planning, implementation, monitoring and evaluation, from 0 to 50% of families.

No.2: Increase knowledge and skills of 168 Barangay Council members, 50 BHWs, 35 BNSs and 20 TBAs in community health assessment and designing community health programs.

The project did not achieve the target of having 50% of families participate regularly in community organization for health. However, through use of the Purok Health Data Board as a tool of Barangay Councils and Health Committees, almost every family obtained some level of knowledge regarding the health status of their community and awareness of community health action plans. Additional information on the PHDB can be found in section B3a, Community Mobilization.

In regards to the second objective, the project was successful in building the capacity of Barangay Council members, BHWs, BNSs and TBAs. The numbers of BHWs and TBAs trained were higher than expected, due to improved assessment and identification of community health volunteers during project implementation. Approximately 100 Barangay Council members have been trained to-date (more than 1 per community); another training was planned to occur during the final months of project implementation.

No.3: Increase from the current level to 25% the health resources of 10 communities.

This objective was not assessed during final evaluation. The project's Annual Report for Year 3 notes: "34 (of 48) barangays had budgetary allocation on health but did not meet the goal of 25% due to low Internal Revenue Allotment provided by the LGU." Per informal discussions with project partners during final evaluation, it is not expected that results for Year 4 were different than that reported for Year 3.

No.4: Increase from 0 to 48 the number of communities with functional health committees.

Of the 10 communities visited during final evaluation qualitative investigation, half had active Health Committees. This concurs with information from the Annual Report for Year 3, in which half of Councils in project communities had active Health Committees. Additional information can be found in section B3a, Community Mobilization.

No.5: Increase the capacity of three NGO partners in managing high quality and sustainable child survival programs.

The capacity of the NGO partners was not assessed at final evaluation as they were no longer actively participating in the project due to changes in their area of technical or geographic focus.

No.6: Increase the technical skills of city and municipal health personnel and Barangay Health Workers in three interventions in terms of quality of care, efficiency and effectiveness, conduct of behavioral change communication, records keeping, analysis and utilization, and reaching out to missed opportunities.

Qualitative final evaluation found ***this objective to reflect one of the key accomplish-ments of the program***. The positive results found in the Client Satisfaction Surveys at final evaluation, presented below in section B3c4 - Health Worker Performance - further support the qualitative finding.

B3c1. STRENGTHENING THE PVO ORGANIZATION

As this Child Survival project built upon an entry-level grant, PSBI continuously invested in building capacity of both local staff and partners. The technical support person from **PSBI headquarters** visited the project at least twice a year, and three times yearly at baseline, midterm and final in order to also participate in project evaluation activities. In fact, upon

presentation of the key findings of this final evaluation, the technical support person changed her plans in order to remain an additional 2 weeks to assist in a refresher training course on the Hearth model, to ensure transfer of capacities to local partners before the end of the project.

The technical support person from HQ also regularly participated in Child Survival activities, such as CORE Group meetings, researched materials available through such agencies as CSTS, and networked with those NGOs implementing new tools or approaches in child survival interventions. During the final evaluation interview, local project management staff notes that a continuous stream of information, tools and linkage with technical assistance was provided to field staff from PSBI headquarters.

The project received **technical assistance** from a regional resource staff member of World Vision for implementation and data analysis of the baseline KPC survey. Helen Keller International also provided assistance in developing project indicators and input into monitoring plans. Experienced international consultants assisted in the development of the DIP (for which CSTS covered the expenses), and in launching the Hearth nutrition model.

Health Futures International, a local NGO led by a former Under-Secretary of Health for the Philippines, provided technical assistance in developing and field-testing the Information, Education, Communication and Motivation (IECM) materials for community health volunteers. (See section B3b, Communication for Behavior Change.) Arugaan Inc., a member of the World Association for Breastfeeding, provided technical assistance in establishing Mothers Support Groups and in providing refresher training to MOH staff and community health volunteers on key messages in the promotion of breastfeeding. They also conducted follow-up visits and refresher training at the community level. Helen Keller International provided technical assistance in micronutrient initiatives and a Basic Child Learning Package for community groups.

PSBI not only networked in order to build their capacity for child survival project implementation, but also in order to **share their experiences** with other groups. PSBI Philippines sponsored a Child Survival conference among NGOs with child survival programs in the region. This included participation by World Vision, Catholic Relief Services, and Helen Keller International, among others. Participants at the conference also visited PSBI child survival activities in the field. A PSBI project staff member participated in a final evaluation of a World Vision child survival project, while CRS participated in the midterm evaluation of this PSBI project. PSBI staff also trained CRS to implement Hearth.

B3c2. STRENGTHENING THE LOCAL PARTNER ORGANIZATIONS

The project formed an **Advisory Board,** composed of Ormoc and Merida health management personnel, Local Government Unit leaders, representatives from Ormoc and Merida of the

Barangay Health Worker Federation and members of partnering NGOs[11]. **Technical Working Groups** were also formed among these participants or others assigned, such as from the MOH provincial level.

Per final evaluation interview with AdBoard representatives, and separately with project personnel, this strategy was described as having been highly effective for implementing the project in a participatory manner. MOH personnel especially noted that this ensured that all activities fit into their strategic plans and promoted the transfer of capacities. As an example, they cited participation in the design of IECM materials.

BHW Federation representatives noted that participation in the AdBoard enabled them to disseminate information on the project to their members and thereby promote community support for the project. They also mentioned that project staff and AdBoard members had supported them in lobbying before Local Government bodies in favor of the stipend that is assigned for BHWs and allocated from funds that are provided to Barangay Councils by the LGU.

The project heavily invested in **technical training** for MOH personnel, especially in the entry-level period and in the first year of this project. (See information on Institutional Assessment in section B3c3.) In final evaluation interviews with MOH personnel from Ormoc and Merida health units and Provincial Health representatives, this was reported to have been a key element for building capacity for community-based child survival actions.

There was also a strong focus on the provision of training on **monitoring and evaluation techniques**, such as: KPC survey; Participatory Rural Assessment; and Lot Quality Assurance Sampling. Project partners were able to put their new knowledge into action with practical field experience through their participation in all project monitoring and evaluation activities. ***A key finding of the final evaluation is the strong level of participation by MOH partners in project monitoring and evaluation activities.***

In addition to training on technical topics, MOH partners also received training on community organization, advocacy and social mobilization techniques. ***The final evaluation found that partner capacity for community mobilization appeared to have been strengthened by a broadening of expectations for health action by community members.***

Project partners, including MOH staff and community health volunteers, also noted in final evaluation interviews the benefit of cross-visits to other child survival sites in the Philippines. This enabled them to learn from **other approaches**, such as Weighing Posts, in action and replicate these activities. The Provincial Health Officer (PHO) of Leyte also attended, with the PSBI CS Project Manager, a SEATS-sponsored workshop in Bangladesh on the integration of reproductive health activities into maternal-child health programs. Not only did the PHO find this beneficial, but other MOH staff also noted the feedback from this visit as useful.

[11] Note that each of the local NGOs partners (Rural Development Institute, the Action for Development Foundation, and the Philippine National Red Cross Ormoc Chapter) dropped out of participating in the AdBoard at the time when each decided to no longer partner in the project, due to changes in their technical or geographic focus. No final evaluation interviews were conducted with these NGOs.

Although the MOH had a history of working with BHWs, BNSs and TBAs, the on-going devolution strategy has meant that there is little or no money assigned for **refresher training for community health volunteers**. Support from this project enabled all community health volunteers to be brought up-to-date with the most recent recommendations for appropriate maternal-child health practices and to receive technical training in new approaches, such as the Hearth model.

See key findings from client satisfaction surveys below, in section 3C4 - Health Worker Performance - for information on community health volunteer performance. See section B3a - Community Mobilization - for more information on capacity-building activities with local community partners, the Barangay Councils and Health Committees.

B3c3. HEALTH FACILITIES STRENGTHENING

In Year 1 of the project, MOH and LGU partners, along with PSBI staff, received training in Institutional Assessment, including elements of the technique for Appreciative Inquiry. MOH and LGU partners then conducted self-assessments, with assistance from PSBI staff. Results from these assessments were used to develop Institutional Development Plans. Plans for training of MOH staff concurred with plans in the project project and were primarily implemented as intended in the work plan of the DIP.

Per review of the project's Annual Reports and discussion with project management, formal project plans for strengthening the **supervision systems** of the MOH and relevant LGU partners never quite solidified. In Year 2, Helen Keller International was brought in to provide recommendations on improving monitoring systems, but these were ultimately determined by project partners to be too cumbersome. Later, the project's HIS coordinator convened an M&E task force, which provided recommendations on improving systems and adapted existing supervision tools. However, this task orce did not remain extremely active. Project partners repeatedly noted budgetary constraint, with little or no financial support for supervision activities.

Project support for provision of **basic equipment and supplies** was based upon an Equipment and Supplies Assessment conducted in 1999. Major findings of this assessment were that vaccine and contraceptive supplies were adequate while micronutrient supplements were not. Some CS grant matching funds were used to provide a limited supply of ferrous sulfate (approximately 1,000 small bottles). A limited amount of equipment was provided to Barangay Health Stations, primarily standing scales for monitoring maternal weight gain during pregnancy, and replacement blood pressure cuffs, stethoscopes and exam tables. Hanging scales for child weighing were provided to BHS and to those communities that had established Weighing Posts.

More than 60 Traditional Birth Attendants were provided the Unicef -established standard TBA Kit. Blood pressure cuffs and stethoscopes were provided to those BHWs and TBAs that demonstrated capacity to use these instruments correctly. All community health volunteers (BHW, BNS, and TBA) were provided with IECM Kits for community education. (See section Bcb, Communication for Behavior Change.)

B3c4. HEALTH WORKER PERFORMANCE

As another input into final evaluation activities, **client satisfaction surveys** were conducted with at least 30 respondents in each of the two project MOH areas in each of four different topic areas: prenatal care, family planning counseling, growth monitoring, and care by Traditional Birth Attendants. Results of client satisfaction survey for prenatal care and/or family planning counseling, as provided by MOH-salaried Rural Health Midwives, demonstrated positive results regarding the quality of care as perceived by clients. Highlights from these surveys include the following:

Prenatal Care (by Rural Health Midwives)

- 84-89% of providers ask if client is having any problems[12]
- 87-92% of clients feel provider gives the right amount of information to client
- 95-98% of clients feel comfortable asking questions
- 96-100% of providers discuss family planning
- 98-100% had visual privacy during exam
- 42-54% waited less than 15 minutes to be seen
- ~100% state provider treated them "well" (~75%) or "very well" (~25%)

Family Planning Counseling (by Rural Health Midwives)

- 73-87% asked if client was having any problems with method
- 60-100% were satisfied with the advice given by the provider
- 88-98% explained how to use the method effectively
- 89-90% gave instructions on when to return
- 60-86% waited less than 15 minutes to be seen
- 94-96% received the method of their choice
- 60% of providers encouraged simultaneous use of condoms
- ~100% stated that provider treated them "well" (~85%) or "very well" (~15%)

The area in which results were less than desired was in regards to auditory privacy during prenatal exam or family planning counseling (48-60%) and belief that the provider would treat information as confidential (42-67%).

Results of client satisfaction with child growth monitoring by Barangay Health Workers or Barangay Nutrition Scholars, assisting health personnel at local health units, was found to be equally positive. Highlights include:

Child Growth Monitoring (by community health volunteers)

- 84-90% asked if child was ill or had other problems
- 87-100% feel comfortable asking questions

[12] Note that results were tabulated separately for the two health areas of Ormoc and Merida, for MOH management purposes.

- 100% were informed of child's weight
- 71-90% received an explanation of what child's weight means
- 87-95% were instructed when to return
- 92-100% received counseling on breastfeeding and/or complementary feeding
- 100% stated that provider treated them "well" (~75%) or "very well" (~25%)

The weakest result was the above-noted 71% for explanation of what the child's weight means.

Results of the client satisfaction survey of TBA care provision were also positive. Highlights include:

TBA Maternal Care

- 70-87% ask if client is having any problems
- 90% feel comfortable asking questions during session
- 70-90% received information on family planning
- ~100% stated provider treated them "well" (~75%) or "very well" (~25%)

However, it is important to note that only 17% felt that the TBA provided sufficient information to the client (as compared to 87-92% for prenatal care visits with Rural Health Midwives) and less than 15% cited "better quality of care" as a reason for choosing TBA care. The most frequently cited reason was "closer to home" and/or "conducts home visit" (48-53%).

Client satisfaction with the level of confidentiality provided by a TBA was similarly low as that for Rural Health Midwives, at 47-67%. Results for auditory privacy were equally low (52-66%), most likely due to the fact that the visits are conducted in the home.

Until all pregnant women have easy access to institutional health services for childbirth, it will continue to be important to strengthen the quality of care provided by Traditional Birth Attendants. These positive results from client satisfaction survey, in conjunction with the overwhelmingly positive results for safe childbirth techniques by TBAs as found during focus group discussion, reveal the value of the project's investment in TBA training and involvement in community mobilization for maternal-child health care.

B3d. SUSTAINABILITY STRATEGY

During the project design phase and preparation of the Detailed Implementation Plan, project partners were active participants in developing a **sustainability plan**. The DIP noted three levels of actions to achieve sustainability:

- financial support for community health activities
- skills transfer to partners
- behavior change

The **project objectives for capacity-building**, section B3c, are directly related to the first two levels of sustainability. The third, **behavior change**, was addressed through the key objectives and indicators in the project monitoring and evaluation plan for technical interventions (see section B1). In addition, the sustainability plan included two additional objectives:

- Trained community health volunteers continue to render service of high quality.
- Advocates and support groups for project technical intervention areas (nutrition and breastfeeding, maternal health and child spacing) are organized in all communities.

During the final evaluation, individual focus group discussions were conducted in a central location with participation by each of the three different types of community health volunteers: Barangay Health Workers, Barangay Nutrition Scholars, and Traditional Birth Attendants. They were asked not only open-ended questions as to the effects of the project and level of coordination and support from non-PSBI partners, but also their **knowledge of the key messages for technical interventions** was assessed as a group. The results of two FGD with a total of 25 BHWs can be seen in Text Box No.7:

Text Box No.7

FGD Assessment of Technical Knowledge of BHWs		
Excellent	**Good**	**Weak**
▪ General messages for child health ▪ Recommended breastfeeding practices ▪ Advantages of appropriate breastfeeding practices ▪ Importance of regular growth monitoring ▪ Methods of child spacing (CS) ▪ Key benefits of CS	▪ Recommended complementary feeding practices	▪ Key risk factors during pregnancy ▪ Recommended prenatal care practices ▪ Importance of post-partum visit and recommended counseling topics

As can be seen, the level of **technical knowledge among BHWs** was very high in the topics of general child health, breastfeeding, growth monitoring and child spacing. The level of technical knowledge was good in the topic of recommended complementary feeding practices, although some additional training could be useful. Last of all, BHW knowledge in the area of maternal health was weak (i.e. only half of BHWs could easily recall only half of the key practices). In final evaluation activities to analyze results with partners, it was noted by MOH staff that recommended prenatal and post-natal health practices is not a topic that is emphasized in BHW training.

The key area of **technical knowledge assessed for Barangay Nutrition Scholars** was their knowledge of child health messages and correct growth monitoring technique. Their level of knowledge of the key recommended messages for nutrition and breastfeeding and the importance of growth monitoring was similar to that found for BHWs. Their knowledge of the key steps involved in growth monitoring was excellent, from hanging the scale at eye level and calibrating,

to determining if the child is growing properly and giving nutrition counseling to the mother. BNS did admit that the removal of all of a child's clothing is not culturally accepted in their communities. They emphasized that they were careful to remove as much clothing as possible and especially replace any wet cloth or diaper.

The results of two FGD with a total of 17 **Traditional Birth Attendants** (Text Box No.8) were considered to be satisfactory for achieving sustainability of the strategies for the promotion of behavior change by women in their communities. Although the area of post-partum counseling is weak, it must be remembered that the total amount of information a new mother receives will be combined with that provided through post-partum referral to the local health unit (see positive results noted for client satisfaction with care by MOH staff at BHS -- Rural Health Midwives -- in section B3c4).

Text Box No.8

FGD Assessment of Technical Knowledge of TBAs		
Excellent	**Good**	**Weak**
▪ Recommended prenatal care practices ▪ Risk factors during pregnancy ▪ Key practices for safe and clean childbirth	▪ Recommendations for mothers health during post-partum visits	▪ Recommendations for child health during post-partum visits

Although final evaluation did not verify project monitoring results showing all 48 target communities to have active Mothers Support Groups and/or Behavior Child Learning Groups, in all 10 communities visited during final evaluation field visits, self-confident and knowledgeable mothers and fathers that had been active participants in these groups were encountered in FGD. The **key constraint to sustainability** of project activities is likely to be the limited MOH budget for community health volunteer refresher training and supervisory visits.

C. PROGRAM MANAGEMENT

C1. PLANNING

The project conducted a series of **participatory baseline assessments** (including KPC Survey and Participatory Rapid Appraisal) and planning workshops based on these assessment results to **jointly develop a Detailed Implementation Plan**. Multiple representatives participated from all project partners groups. In final evaluation interviews with project staff and MOH and LGU partners, this was reported as being a key strategy for facilitating project implementation while building capacity for long-term sustainability of project activities.

Per final evaluation results, the DIP work plan appears to have been a bit ambitious, but the key elements of progress as planned for all technical intervention areas were achieved. (See section C3, Supervision, and C7, Information Management, for more information.) The project developed annual work plans and reviewed results based upon these plans. Project management

staff demonstrated flexibility in addressing any obstacles encountered during implementation while remaining within the goals, objectives and budget as proposed in the DIP.

C2. STAFF TRAINING

The project devoted **considerable resources to organizing training and orientation** activities for project partners. Consultants or the HQ backstop led these workshops and project field staff also participated in these activities as students, improving their capacities along with partners. In final evaluation interviews with project staff, they cited increased knowledge of the key messages and recommended behaviors for technical interventions, noting that their previous education and work experience had primarily been on community organization. MOH partners interviewed cited new knowledge in evaluation processes, including the KPC Survey and LQAS techniques. The project training plan and level of resources dedicated appears to have been appropriate to transfer capacities to project partners while providing skilled assistance by project staff throughout the life-of-the-project. (More information can be found in section B3c, Capacity Building Approach.)

C3. SUPERVISION OF PROJECT STAFF

In final evaluation interviews, project staff reported **regular visits to the field office by management staff,** from both the central office for PSBI in the Philippines and from PSBI headquarters. These supervision visits included review of project systems and reports, meetings with project partners, and field visits to communities. PSBI Philippines central office staff and/or PSBI HQ staff participated in all key project activities, such as project planning, initiation of new approaches, key workshops, and midterm and final evaluation.

Per review of project Annual Reports, the DIP appears to have been a bit ambitious in plans for making institutional changes to strengthen local **MOH systems for supervision** of community outreach. The key obstacle was a lack of funds to support visits to communities by health unit supervisors, as noted by MOH partners. However, per final evaluation interview, project staff felt MOH capacity for supportive supervision of community health activities was achieved through the process of accompaniment by PSBI field staff in all activities. In final evaluation interviews with MOH partners, achievements in the area of supervision systems were not specifically noted or recognized by partners.

C4. HUMAN RESOURCES AND MANAGEMENT

Pearl S. Buck International country offices have **previously existing systems**, policies and procedures for human resource management and program operations. Per final evaluation interview with project staff, no constraint in this area was noted.

Staff morale and working relationship appeared satisfactory, and no problems in this area were encountered. **Staff turnover**, however, had been high. By Year 4, the project had a new HIS Coordinator, no longer had a Coordinator for Training nor a Coordinator for Community Health Development, and the two field staff (Community Health Development Officers) were both new. These new staff, when interviewed during final evaluation, reported having received

sufficient orientation to support on-going project processes and activities; however, a lack of organizational memory was encountered during the final evaluation process. Documentation of previous processes and activities was good, but new staff did not seem thoroughly familiar with the content of project documentation. The Country Office supervisor and Project Manager stated they had considered youth and a desire to grow professionally as criteria for hiring field staff that would be motivated and enthusiastic about community development and health improvement. They consider staff turnover to have been due to a typical pattern in the Philippines of young professionals encountering new opportunities (all staff had left for new education or work opportunities). They did not feel this level of staff turnover had hindered project implementation, but rather felt it had increased the transfer of capacity to project partners. There had also been turnover of the HQ backstop in the early years of the project

No formal plans for assisting staff in finding new jobs were encountered at final evaluation. However, staff has informally supported each other by networking and sharing contacts and information on future opportunities.

C5. FINANCIAL MANAGEMENT

PSBI follows **approved accounting procedures and standards**, as mandated by the Child Survival Grant Program. The field office is responsible for basic documentation and accounting of project expenditures and for submission of regular financial reports to the Country Office. These financial reports are reviewed at the Country Office level, before being forwarded to PSBI headquarters. At PSBI HQ, a final review is conducted.

The project appears to have budgeted **adequate resources** and to have essentially remained within the budget as planned. The project anticipated the potential for approximately US$50,000 in unspent funds and explored the possibilities for a no-cost extension. This was determined by PSBI HQ to be an inefficient use of resources, and the project has since planned for the disbursement of these funds during the final quarter of project implementation. Plans for the use of these funds include increasing the number of partner training workshops planned for the final quarter, increasing project activities for documentation of processes and experiences, and supporting partners with the purchase of a limited amount of essential equipment. During final evaluation, it was recommended that the project replace those child weighing scales provided to community health volunteers that were not the recommended brand (Salter) and were damaged at present. It was suggested these might be available through the Unicef office in Manila.

C6. LOGISTICS

Project management at the field level did not report any obstacles to project implementation based upon logistics. The level of resources dedicated to logistics appears adequate and extremely cost-efficient. For example, the project has no assigned vehicles, but rather all staff rely upon public transportation. Field staff interviewed during final evaluation state that there is sufficient and multiple public transportation options available for visiting any project community and returning within the same day. This was confirmed by observation during final evaluation field visits.

C7. INFORMATION MANAGEMENT

One of the key positive results found at final evaluation is the level of effort the project invested in developing partner capacity for using recognized evaluation techniques, including the KPC Survey at baseline and Lot Quality Assurance Sampling annually, and basing decisions upon assessment results. Several people in key positions within each of the partner units participated in every step of project evaluation activities, including analysis and discussion of key findings. This was documented in baseline, midterm and annual evaluation reports, and observed first-hand during final evaluation. Between 8 and 10 personnel from MOH management and supervision at the area and provincial level not only participated in conducting focus group discussions during daily visits to 10 communities, but also participated in two full-day sessions to tabulate and analyze results of qualitative final evaluation.

Beyond the project and partners, project management staff have been active participants in a **collaborative group of PVOs** with child survival projects in the Philippines. They have shared evaluation results and also invited and received participation by other PVO staff in project evaluation activities.

At the community level, development and analysis of the **Purok Health Data Board** was the key health information management strategy utilized by the project. Final evaluation found the effectiveness of this strategy to vary from strong to weak, depending on each community's individual idiosyncrasies (see section B3a, Community Mobilization, for more information). In communities with good use of this technique, community council leaders specifically cited this information as a basis for council allocation of resources on an annual basis.

At one point, the project intended to invest significant effort into adapting and improving the MOH computerized **Field Health Surveillance Information System** (FHSIS). Several computers were provided, technical assistance was obtained, and potential modifications were discussed. However, in the end, agreement among all partners and the project could not be achieved. The productive outcome of this activity was that the local coordinators of the FHSIS system did agree to and provide the project with annual information disaggregated at the community level.

The project provided for the **translation of a Child Health Card and Home Based Maternal Record** into the local language, along with replication and distribution of the cards (1,500 each) within the project area.

C8. TECHNICAL AND ADMINISTRATIVE SUPPORT

Final evaluation interviews with project management and field staff revealed a more than adequate degree of **timely and appropriate technical assistance and administrative support**. (See section B3c1, Strengthening the PVO Organization, for more information.) In a few instances, significant modifications were made to the technical assistance received. For example, the training plan for Mothers Support Groups developed by Arugaan, Inc., was altered to reduce and concentrate the focus on breastfeeding topics. In another instance, a plan for

modifying MOH monitoring and supervision systems developed with the assistance of Helen Keller International was also altered by project partners. This effort might have been better invested in more pre-planning and collaboration between technical assistance providers and the project and partners.

Per final evaluation interview, project staff would have requested, upon looking back at the early development of the project plan, assistance in a few areas. They would have benefited from an experienced international consultant on the entire process of **determining project objectives and defining criteria** for calculating the indicators of success in meeting such objectives. Assistance on designing survey questionnaires and tabulating these results indicators would also have been useful.

C9. MANAGEMENT LESSONS LEARNED

Project management did not report any lessons learned in this area; however, it is suggested that more analysis be given to criteria for hiring field staff for any future projects. Back-up plans to ensure the transfer of organizational memory to new staff could be developed, if high turnover is considered to be unavoidable in order to attain the level of technical skill and individual enthusiasm appropriate for a community development project.

D. OTHER ISSUES

No other issues were identified by the final evaluation team.

E. CONCLUSIONS AND RECOMMENDATIONS

Final evaluation shows the project to have achieved excellent to satisfactory results in the technical intervention areas of nutrition and breastfeeding promotion, maternal health care and child spacing. A key accomplishment has been the transfer of capacity to project partners at all levels. Among new approaches of the project, the establishment of Weighing Posts in communities distant to health units appears to have been the most successful.

Project MOH partners were active participants in the final evaluation process, not only conducting focus group discussions but also analyzing results. MOH and LGU representatives and key staff attended a presentation of final evaluation findings, and recommendations regarding a few specific technical message areas that could benefit from further strengthening were shared.

In conclusion in regards to project management, overall systems and procedures appear more than adequate. The only recommendation for PSBI to consider internally when developing future maternal-child health projects would be in relation to the criteria for selection of field staff and backup plans for staff turnover. It is also possible that additional HQ support or review of procurement plans for key equipment would avoid the purchase of non-recommended brands of such items as child weighing scales.

Although it is difficult to tell if any different procedure would have given different results in terms of partnering with local NGOs, it might be useful for PSBI to promote the use of available tools for analyzing concordance between potential NGO partners in detail.

F. RESULTS HIGHLIGHT[13]

In the Ormoc and Merida area of Leyte Island in the Philippines, the Partners for Health Child Survival project implemented by Pearl S. Buck International found that at least 40% of childbirths are attended by Traditional Birth Attendants (TBA). This is not due to a lack of confidence in the formal health care system. Client satisfaction surveys at final evaluation found more than 90% of respondents to rate the level of maternal health care provided by Rural Health Midwives as "good" or "excellent". The main reason given by respondents for preferring a TBA to attend the birth of their child was "closeness to home". Although there are fairly extensive road systems and available public transportation in this region, it is understandable that a woman in labor might hesitate to spend an hour on a *very* bumpy dirt road, in order to reach accessible services.

In discussion of baseline survey results and analysis of the causes of maternal mortality in the region, which is at least 180 per 100,000 births or higher (due to under-reporting), the PSBI project partners decided that support for MOH training, refresher trainings and equipment kits for local TBAs would be one of the key project activities. In final evaluation focus group interviews in 8 diversely located communities with over 25 mothers whose recent childbirth had been attended by TBAs, every single mother interviewed stated that the TBA attending their birth had used **all of the key techniques for preventing infection** during childbirth. These include sterilizing instruments, washing hands with special attention to clipping and cleaning fingernails, and use of sterile instruments to cut the umbilical cord.

This level of achievement (100%!) exceeded project expectations. This result, in combination with other very positive results for maternal health care found at final evaluation (including an increase in the percentage of recently pregnant women with at least two or more recorded vaccinations with tetanus toxoid, from 58% to 98.5%), has contributed to the project goal to reduce maternal mortality for the 12,617 women of childbearing age in the project target area -- a benefit also for their 21,867 small children ages 0 to 59 months.

[13] Note that this is submitted in the final report as a separate tear-away page.

Annex A
Participants in Final Evaluation
Pearl S. Buck International Child Survival Project FY2000-2003, Philippines

A. Consultants:
- Joan M. Jennings, MPH; Team Leader
- Susan Balingit, MD; Assistant Team Leader

B. Pearl S. Buck International Headquarters:
- Hannah Gilk, MPH; Health Programming Specialist

C. Project Partners:

Region VIII, Department of Health, Center for Health Development
- Ms. C. Singco, Nurse Coordinator for Breastfeeding
- Ms. F. Modesto, Nurse Coordinator for Family Planning and E.P.I.
- Dr. N. Navales, DOH representative assigned to Ormoc City Health Office
- Dr. C. Sabulao, Coordinator for Maternal and Child Health

Leyte Provincial Health Office
- Ms. G. Pijo, Nurse Coordinator for Family Planning and E.P.I.
- Ms. V. Fernandez, Nurse Coordinator for Women's Health and Safe Motherhood
- Ms. C. Panao, Coordinator for Nutrition

Ormoc City Health Office
- Dr. R. Marson, MPH, City Health Officer II
- Dr. V. Espina, MPH, City Health Officer I
- Dr. M. Lampong, Medical Officer III
- Ms. N. Adolfo, Nurse Supervisor and EPI Coordinator
- Ms. E. Romero, Nurse Coordinator for Family Planning
- Ms. L. Calipayan, Nurse Coordinator for Barangay Health Workers and TBAs
- Ms. R. Nastor, Coordinator for Nutrition

Merida Rural Health Unit
- Dr. J. Solana, Municipal Health Officer
- Ms. D. Panares, Nurse Supervisor
- Ms. T. Sosmena, Rural Health Midwife

Local Government Unit
- Dr. R. Omega, City Councilor of Ormoc
- Ms. D. Corbo, City Planning and Development Office
- Ms. N. Cubilla, Municipal Nutrition Action Officer

Community Partners
- Ms. R. Caraca, President of the BHW Federation of Ormoc City
- Ms. A. Lubaton, President of the BHW Federation of Merida Municipality

Annex B
Final Evaluation Methodology
Pearl S. Buck International Child Survival Project FY2000-2003, Philippines

A. Activities conducted by project staff and partners from May to June 2003

1. 3 LQAS surveys in 4 lots of 24 mothers each (total = 96):
   - Breastfeeding and Nutrition
   - Maternal Care
   - Child Spacing

2. 3 Client Satisfaction Surveys with an average of 100 mothers in each of two MOH health geographic units:
   - Quality of care for Family Planning provided by Rural Health Midwives
   - Quality of care for Growth Monitoring by Barangay Health Workers
   - Quality of care for Maternal Health provided by Traditional Birth Attendants

B. Activities conducted by final evaluation team, June 30 to July 11, 2003

1. Focus group discussion in 10 communities:
   - With 6 mothers participating in project activities
   - With 6 fathers participating in project activities
   - With 3 to 5 members of community local government

C. Activities conducted by final evaluation consultants, June-July, 2003

1. Review of project documents:
   - Project Detailed Implementation Plan
   - Project Annual Reports
   - Midterm Evaluation Report
   - Operations Research on the Hearth Model
2. Review of LQAS and Client Satisfaction Survey results
3. Review of project BCC materials:
   - Healthy Baby and Healthy Mother Calendars
   - Community health volunteer kits: Healthy Baby, Healthy Mother, Healthy Family
   - Flipcharts provided to health units: Healthy Baby, Healthy Mother, Healthy Family
4. Focus group discussions with community health volunteers in two groups each:
   - 33 Barangay Health Workers from 25 communities
   - 17 Traditional Birth Attendants from 15 communities
   - 14 Barangay Nutrition Scholars from 14 communities
5. Interviews with key informants (see Annex C)

NUTRITION: BREASTFEEDING AND COMPLEMENTARY FEEDING

Date: _____ Community: _____

No. Participants: _____ Project role: _____

(Females _____ Males _____) _____

Materials: Toy baby doll; Poster of Child about 1 year old; tape or tacks for poster.

Introduction: The .....local name.....project is ending and this evaluation hopes to find out what elements of the project have been most useful for community members, providing benefits for the health and nutrition status of women and small children.

Participatory Techniques: Conduct icebreaker for participant introductions.

Assessment of Knowledge, Attitudes and Practices of BREASTFEEDING:

Moderator: Use a toy doll to stimulate participation, by passing the Doll from mother to mother. Explain that you would like 3 mothers to participate and ask for or select volunteers. Explain that you will tell each mother what age her child is, and then she should tell the group:

- what the child's name is
- when she began to breastfeed this child and whether she continues
- why she (does or doesn't) breastfeed the child
- what other foods or drinks she gives to this child
- why or why not she gives other foods or drinks to this child

MOTHER #1: (.....NAME.....) AGE OF CHILD = 4 MONTHS

When began BF: _____ Continues? Yes____ or No _____

Why or not BF: _____

Other liquids or foods: _____

Why other foods: _____

MOTHER #2: AGE OF CHILD = 6 MONTHS

When began BF: _____ Continues? Yes____ or No _____

Benefit of BF: _____

Other liquids or foods: _____

Benefit liquids or foods: _____

MOTHER #3: AGE OF CHILD = ABOUT 18 MONTHS, OR 1-1/2 YEARS OLD

When began BF: _____ Continues? Yes____ or No _____

Benefit of BF: _____

Other liquids or foods: _____

Benefit liquids or foods: _____

Assessment of KAP of <u>COMPLEMENTARY FEEDING</u>:

Moderator: Display a poster with a picture of a child approximately 1 year old. Ask the following questions and uses methods to promote participation by many mothers.

Repeat each question for TWO DIFFERENT MOTHERS.

1. WHAT FOODS WOULD YOU GIVE THIS CHILD FOR BREAKFAST? WHY?

a. FOOD: _____ WHY: _____

FOOD: _____ WHY: _____

FOOD: _____ WHY: _____

b. FOOD: _____ WHY: _____

FOOD: _____ WHY: _____

FOOD: _____ WHY: _____

2. HOW MANY TIMES EACH DAY WOULD YOU FEED THIS CHILD? WHY?

a. # TIMES: _____ WHY: _____

b. # TIMES: _____ WHY: _____

3. WHAT WOULD YOU GIVE THIS CHILD BETWEEN MEALS (SNACKS)? WHY?

a. FOOD: _____ WHY: _____

FOOD: _____ WHY: _____

b. FOOD: _____ WHY: _____

FOOD: _____ WHY: _____

Discussion of NEW KAP: Focus Group discussion, open to all participants. Moderator asks the following questions:

- Since this project started, have there been any changes in the typical BREASTFEEDING practices of mothers in .....name of barangay.....?

NOTE CHANGES MENTIONED BY MOTHERS:

1. _____

2. _____

3. _____

4. _____

- Since this project started, have there been any change in the typical COMPLEMENTARY FEEDING practices of mothers in .....name of barangay.....?

5. _____

6. _____

7. _____

8. _____

- What influenced these changes to occur? (Look for influence of BHW, local health staff, radio or other media campaigns, Mothers Support Groups.)

How did (?) influence practices? (For example, was trust in the message established? How? Did discussion promote messages? By groups? Family? Other?
What was the opinion of "others of influence", such as husbands, mothers-in-law, etc.?

Influence: _____ How: _____

Influence: _____ How: _____

Influence: _____ How: _____

Impact and Sustainability: Use of the DEBATE technique. Moderator divides the group in half and assigns one group to the POSITIVE side and one to the NEGATIVE side. They are asked to debate, in turns, the following question. KEEP TRACK OF TIME and limit debate to FIVE MINUTES.

QUESTION: When the project ends, will the positive changes that have occurred in CHILD FEEDING PRACTICES for the health of mothers and children in your community continue on? How and why?

YES	**NO**
_____	_____
_____	_____
_____	_____
_____	_____

CONCLUSION: Moderator explains that the Focus Group session is about to close with two final questions.

1. In your opinion, what has been the BEST or MOST IMPORTANT part of the project?

2. Are there any other comments?

THANK THE PARTICIPANTS
AND ANSWER ANY FINAL QUESTIONS.

MATERNAL CARE AND CHILD SPACING

Date: _____ Community: _____

No. Participants: _____ Project role: _____

(Females _____ Males _____) _____

Introduction: The .....local name.....project is ending and this evaluation hopes to find out what elements of the project have been most useful for community members, providing benefits for the health and nutrition status of women and small children.

Participatory Techniques: Conduct icebreaker for participant introductions.

Assessment of KAP of ANTE-NATAL CARE:

TECHNIQUE:
TWO QUESTIONS to whole focus group

1. Why do pregnant mothers go to Rural Health Midwife for Ante-Natal Care (also include question on Tetanus Toxoid if not mentioned)?

2. Why not?

POST-NATAL CARE

WHY ANTE-NATAL CARE?	**WHY NOT?**
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____

Assessment of KAP of CHILDBIRTH AND POST-NATAL CARE:

TECHNIQUE:
GUIDED STORY TECHNIQUE to discuss recent CHILDBIRTH and POST-NATAL CARE in the family.

Ask for 3 people to participate and guide them with the following questions

Experience Number 1:

Age of mother: _____ Number of pregnancies: _____

Age of youngest child: _____ Attended by TBA alone or with RHM? _____

- What did TBA do to make sure there was good **HYGIENE** during childbirth?

_____

_____

- Did anyone give you advice about what to do within a month to six week after childbirth (POST-PARTUM) for:
    - Good health for MOTHER?
    - Good health for BABY?

HEALTH FOR MOTHER	**HEALTH FOR BABY**
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____

- Did you follow advice? Why or why not?

_____

_____

Experience Number 2:

Age of mother: _____ Number of pregnancies: _____

Age of youngest child: _____ Attended by TBA alone or with RHM? _____

- What did TBA do to make sure there was good HYGIENE during childbirth?

_____

_____

- Did anyone give you advice about what to do within a month to six weeks after childbirth (POST-PARTUM) for:
  - Good health for MOTHER
  - Good health for BABY

HEALTH FOR MOTHER **HEALTH FOR BABY**

1._____ 1._____

2._____ 2._____

3._____ 3._____

4._____ 4._____

- Did you follow advice? Why or why not?

_____

Experience Number 3:

Age of mother: _____ Number of pregnancies: _____

Age of youngest child: _____ Attended by TBA alone or with RHM? _____

- What did TBA do to make sure there was good HYGIENE during childbirth?

_____

_____

- Did anyone give advice POST-PARTUM for good health for:

HEALTH FOR MOTHER **HEALTH FOR BABY**

1._____ 1._____

2._____ 2._____

3._____ 3._____

4._____ 4._____

- Did you follow advice? Why or why not?

_____

Assessment of KAP of <u>CHILD SPACING</u>:

TECHNIQUE:
Uses of the HOT POTATO TECHNIQUE until ALL participants have given at least one comment on:

THE BENEFITS OF CHILD SPACING

_____ _____

_____ _____

_____ _____

_____ _____

Discussion of NEW KAP: Focus Group discussion, open to all participants.

- Since this project started, have there been any changes in the typical **ANTENATAL, OR CHILDBIRTH OR POST NATAL** practices of mothers in .....name of barangay.....?

_____

_____

_____

- WHO influenced these changes to occur? HOW? (Look for influence of BHW, local health staff, radio or other media campaigns, Mothers Support Groups.)

Influence: _____ How: _____

Influence: _____ How: _____

- Since this project started, have there been any changes in the typical **CHILD SPACING** practices of mothers in .....name of barangay.....?

_____

_____

_____

- What influenced these changes to occur? (Look for influence of BHW, local health staff, radio or other media campaigns, Mothers Support Groups.)

- How did (?) influence practices? (For example, was trust in the message established? How? Did discussion promote messages? by groups? Family? Other? What was the opinion of "others of influence", such as husbands, mothers-in-law, etc.?

Influence: _____ How: _____

Influence: _____ How: _____

Influence: _____ How: _____

SUSTAINABILITY:

FOCUS GROUP QUESTION:
Ask ONE QUESTION to the whole focus group.

QUESTION: When the project ends, **HOW** will the positive changes that have occurred in MATERNAL CARE AND CHILD SPACING PRACTICES for the health of mothers and children in your community continue on?

1. _____

2. _____

3. _____

4. _____

CONCLUSION: Moderator explains that the Focus Group session is about to close with two final questions.

1. In your opinion, what has been the BEST or MOST IMPORTANT part of the project?

2. Are there any other comments?

THANK THE PARTICIPANTS

AND ANSWER ANY FINAL QUESTIONS.

BARANGAY HEALTH WORKERS FOCUS GROUP

Date: _____ Facilitator:_____ (circle) Merida or Ormoc

TOTAL PARTICIPANTS: _____ BHW (Female _____ Male _____)

Barangays Represented: _____

GENERAL

1. Who have you received training from? How many times? When? What were the topics?

(WHO, # TIMES, WHEN, TOPICS)

2. Do you feel you have received sufficient training to provide care to your community or do you need more training?

3. What was good about the training you received?

4. What could be improved about the training you received?

5. Please describe your responsibilities as a (Barangay Health Worker, TBA, other):

6. Do you have all the supplies and materials you need to fulfill your responsibilities? What do you have? Where do supplies come from? What is missing?

7. What is the attitude of people in your community towards what you do and the good health practices you promote? Do they support you? Is your work difficult or easy?

Technical Information

1. What messages do you promote for good health in general for children <2 years old?

- ❑ Complete immunization
- ❑ Good hygiene
- ❑ Breastfeeding
- ❑ Other: (note)_____
- ❑ Good nutrition (Vitamin A and iron)
- ❑ Growth monitoring
- ❑ Complementary feeding

2. What are the recommended practices for breastfeeding?

- ❑ Immediately after birth (colostrum)
- ❑ Exclusive until 6 months of age
- ❑ Continued until 24 months of age
- ❑ Frequent breastfeeding throughout the day
- ❑ On demand breastfeeding

3. What are the advantages of appropriate breastfeeding for mothers and children?

- ❑ Natural immunity for baby
- ❑ "Breast is best", contains best nutrients for growth
- ❑ Immediate breastfeeding helps to expel the placenta
- ❑ Exclusive breastfeeding until 6 months old reduces illness from contamination
- ❑ Other: (note)_____

4. What feeding practices are recommended after a child is 6 months old?

- ❑ Always give breast-milk
- ❑ Frequent feedings 3-5 times/day
- ❑ Child has own bowl
- ❑ Good hygiene in food preparation
- ❑ Give foods rich in vitamins and micronutrients (Go, Grow, Glow) (EXAMPLES)
    - Food:_____ Nutrient: _____
    - Food:_____ Nutrient: _____
    - Food:_____ Nutrient: _____

5. What is the importance of regular weighing and monitoring of a child's growth?

- ❑ Identify any problems in growth early
- ❑ Opportunity to give nutrition advice to mothers
- ❑ Can detect a child with illness and refer for treatment
- ❑ Other (note): _____

6. What are the key risk factors for a pregnant woman?

- ❑ Age (younger than 20, older than 40)
- ❑ Less than 2 years since last childbirth
- ❑ Greater than _____ total number of childbirths

- ❑ Headache
- ❑ Dizziness or short of breath
- ❑ Unusual bleeding
- ❑ Pale in color (inner eyelid)
- ❑ Swollen feet or hands
- ❑ Fever

7. What prenatal care practices are recommended for pregnant women?

- ❑ Immunization with at least two doses of Tetanus Toxoid
- ❑ At least 3 prenatal care visits (or 1 per trimester)
- ❑ Good nutrition
- ❑ Taking iron and folic acid supplements as recommended
- ❑ Decreased work load in the final months of pregnancy

8. What methods of family planning are available for spacing the birth of children, and where can you get these?

- ❑ Abstinence or rhythm method
- ❑ Standard Days Method (SDM)
- ❑ Lactational amenorrhea method (LAM)
- ❑ Condoms
- ❑ Pill
- ❑ Injections (depoprovera)
- ❑ IUD
- ❑ Tubal ligation
- ❑ Other (note): _____

9. Why should a mother and baby have an exam during the month after childbirth?

- ❑ Check mother for infection
- ❑ Check that mother has no problems breastfeeding
- ❑ Give baby first immunization
- ❑ Check health and growth of baby
- ❑ Other (note): _____

10. What are the key benefits of spacing childbirth?

- ❑ Better health for the mother
- ❑ Better health for the baby
- ❑ Less chance of low birth weight of baby
- ❑ Easier economic situation for family
- ❑ Other (note): _____

Sustainability

1. What is your link with the Barangay Health Station/Center? How often do you have meetings? When was the last time health personnel supervised your work within your community? Do you feel you are supported by the health office?

2. Do you receive any support or collaboration from other groups (community or Local Government Unit, etc.)? Who? How?

3. When this project finished, will the activities of the BHWs continue? Why or how?

4. When this project finishes, what will be the difficulties to continue your work?

5. In your opinion, what was the best part of the project?

6. In your opinion, what part of the project could have used more emphasis?

7. Do you have any final suggestions for the project or for the project partners?

BARANGAY Nutrition Scholars FOCUS GROUP

Date: _____ Facilitator: _____ (circle) Merida or Ormoc

TOTAL PARTICIPANTS: _____ BHW (Female _____ Male _____)

Barangays Represented: _____

GENERAL

1. Who have you received training from? How many times? When? What were the topics? (WHO, # TIMES, WHEN, TOPICS)

2. Do you feel you have received sufficient training to provide care to your community or do you need more training?

3. What was good about the training you received?

4. What could be improved about the training you received?

5. Please describe your responsibilities as a Barangay Nutrition Scholar.

6. Do you have all the supplies and materials you need to fulfill your responsibilities? What do you have? Where do supplies come from? What is missing?

7. What is the attitude of people in your community towards what you do and the good health practices you promote? Do they support you? Is your work difficult or easy?

Technical Information

1. What messages do you promote for good health in general for children <2 years old?

- ❑ Complete immunization
- ❑ Good hygiene
- ❑ Breastfeeding
- ❑ Other: (note)_____
- ❑ Good nutrition (Vitamin A and iron)
- ❑ Growth monitoring
- ❑ Complementary feeding

2. What are the recommended practices for breastfeeding?

- ❑ Immediately after birth (colostrum)
- ❑ Exclusive until 6 months of age
- ❑ Continued until 24 months of age
- ❑ Frequent breastfeeding throughout the day

- ❑ On demand breastfeeding

3. What are the advantages of appropriate breastfeeding for mothers and children?

- ❑ Natural immunity for baby
- ❑ "Breast is best", contains best nutrients for growth
- ❑ Immediate breastfeeding helps to expel the placenta
- ❑ Exclusive breastfeeding until 6 months old reduces illness from contamination
- ❑ Other: (note)_____

4. What feeding practices are recommended after a child is 6 months old?

- ❑ Always give breastmilk
- ❑ Frequent feedings 3-5 times/day
- ❑ Child has own bowl
- ❑ Good hygiene in food preparation
- ❑ Give foods rich in vitamins and micronutrients (Go, Grow, Glow) (EXAMPLES)
    - Food:_____ Nutrient: _____
    - Food:_____ Nutrient: _____
    - Food:_____ Nutrient: _____

5. What is the importance of regular weighing and monitoring of a child's growth?

- ❑ Identify any problems in growth early
- ❑ Opportunity to give nutrition advice to mothers
- ❑ Can detect a child with illness and refer for treatment
- ❑ Other (note): _____

6. What are the steps in weighing a child correctly?

- ❑ Scale should hang at eye level
- ❑ Calibrate the scale to "ZERO"
- ❑ Find out the birth date and determine the child's age
- ❑ Use a "sling" for babies and hanging pants for children
- ❑ Make sure the child is secure when hanging the child on the scale
- ❑ Wait until the needle on the scale stops moving
- ❑ Record the weight to the nearest "tenth".
- ❑ Mark the child's weight on a graph
- ❑ Determine if the child is growing properly and inform the mother
- ❑ Give nutrition counseling to mother
- ❑ Other answers? _____

_____

8. How do you plot the child's weight on the graph?

9. Why do some children not grow properly?

10. What can a family that is poor do to feed their child properly?

Sustainability

1. What is your link with the Barangay Health Station/Center? How often do you have meetings? When was the last time health personnel supervised your work within your community? Do you feel you are supported by the health office?

2. Do you receive any support or collaboration from other groups (community or Local Government Unit, etc.)? Who? How?

3. When this project finished, will the activities of the BNSs continue? Why or how?

4. When this project finishes, what will be the difficulties to continue your work?

5. In your opinion, what was the best part of the project?

6. In your opinion, what part of the project could have used more emphasis?

7. Do you have any final suggestions for the project or for the project partners?

BARANGAY Traditional Birth Attendant FOCUS GROUP

Date: _____ Facilitator: _____ (circle) Merida or Ormoc

TOTAL PARTICIPANTS: _____ BHW (Female _____ Male _____)

Barangays Represented: _____

1. Who have you received training from? How many times? When? What were the topics?

WHO: # TIMES:

WHEN: TOPICS:

2. Do you feel you have received sufficient training to provide care to your community or do you need more training?

3. What was good about the training you received?

4. What could be improved about the training you received?

5. Do you have all the supplies and materials you need to fulfill your responsibilities? What do you have? Where do your supplies come from? What do you do when you need more supplies?

6. What is the attitude of mothers and their families to the good health practices you promote? Do they agree with you and follow your advice? Is your work difficult or easy?

Technical Information

1. What messages do you promote for mothers during their pregnancy?

2. What are some of the danger signs that a pregnancy is HIGH RISK?

3. What do you do when you attend a child birth to protect the health of the mother and baby?

4. Why should a mother and baby have an exam within 4 to 6 weeks after childbirth? What do you check for during that visit?

5. What good practices do you suggest to mothers for the health of their newborn baby?

6. Why should mothers visit the health clinic within a month after the birth of their child?

Sustainability

1. How do you coordinate and work with the Rural Health Midwife at the Barangay Health Station/Center?

2. Do you feel you are supported by the Rural Health Midwife and the City or Municipal health office?

3. Do you feel welcome to stay with a mother during a prenatal exam at the health center? Are you welcome to stay with a mother during childbirth at the local hospital? Do you feel you are treated as part of the "health team" that is attending to the mother?

4. When this project is gone, will that have an effect on any of your work as a TBA? Why or why not? How?

5. In your opinion, what was the best part of the project?

6. In your opinion, what part of the project could have used more emphasis?

7. Do you have any final suggestions for the project or for the project partners?

BARANGAY HEALTH COMMITTEE OR COUNCIL _____

Date: _____ Facilitator: _____

TOTAL PARTICIPANTS: _____ (MALE ____ FEMALE _____)

1. Please describe the responsibilities of your (committee or council) for the health of women and children:

2. What do you think are the GOALS of this project and do you agree with these? How does the project help your community?

3. What does your COMMITTEE or COUNCIL do to support the project?

4. How do the HEALTH WORKERS (BHW, TBA, BNS, etc.) coordinate with the committee or council? Does this coordination work well or could it be improved?

5. Does your community have a PUROK HEALTH DATA BOARD? If yes, how does this help the community?

6. What positive changes do you think the project has achieved for the health of MOTHERS and CHILDREN in the Barangay? (How and why?)

7. What is the attitude of the community in general (NOT the BHW, etc.) to the goals of this project and the work of your committee/council to improve health?

8. What is the link between the community and other HEALTH care providers?

9. When this project finished, will the activities to improve the health of mothers and children continue without the project support? Why or why not? How?

10. In your opinion, what was the best part of the project?

11. In your opinion, what part of the project could have used more emphasis?

12. Do you have any final suggestions for the project or for the project partners?

Annex C
List of Persons Interviewed
Pearl S. Buck International Child Survival Project FY2000-2003, Philippines

Focus Group Discussions with Project Partners as Key Informants:

AdBoard Representatives
- Dr. R. Marson, MPH, City Health Officer II
- Ms. G. Pijo, Nurse Coordinator for Family Planning and E.P.I.
- Ms. D. Corbo, City Planning and Development Office
- Ms. R. Caraca, President of the BHW Federation of Ormoc City
- Ms. A. Lubaton, President of the BHW Federation of Merida Municipality

Ormoc City Health Office
- Ms. N. Adolfo, Nurse Supervisor and EPI Coordinator
- Ms. E. Romero, Nurse Coordinator for Family Planning
- Ms. L. Calipayan, Nurse Coordinator for Barangay Health Workers and TBAs
- Ms. R. Nastor, Coordinator for Nutrition
- Dr. N. Navales, DOH medical representative assigned to Ormoc City Health Office

Merida Rural Health Unit
- Dr. J. Solana, Municipal Health Officer
- Ms. D. Panares, Nurse Supervisor
- Ms. T. Sosmena, Rural Health Midwife