CATHOLIC RELIEF SERVICES
CAMBODIA PROGRAM

CRS/BATTAMBANG COMMUNITY-BASED PRIMARY HEALTH CARE CHILD SURVIVAL PROJECT

Award No. HFP-A-00-01-00042-00
OCTOBER 1, 2001 – SEPTEMBER 30, 2006

Midterm Evaluation Report
(June 14 -25, 2004)

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Submitted to

USAID

ABREVIATIONS

AIDS	Acquired Immunodeficiency Deficiency Syndrome
ARI	Acute Respiratory Infection
CBPHCP	Community-Based Primary Health Care Program
CDD	Control of Diarrheal Disease
C-IMCI	Community Integrated Management of Childhood Illnesses
CMCF	Co-Management and Co-Financing Committee (now HCMC)
COCOM	Coordination Committee (Provincial)
CRS	Catholic Relief Services
CS	Community Health Structures
DIP	Detailed Implementation Plan
DOTS	Direct Observation Treatment Short Course
GOC	Government of Cambodia
HC	Health Center
HCMC	Health Center Management Committee (formerly CMCF)
HE	Health Education
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Results
IRCM	Intermediate Results – Community Mothers
IRCS	Intermediate Results – Community Structures
IRHC	Intermediate Results – Health Center
IRCHC	Intermediate Results – Community and Health Center
IRCHCODCRS	Intermediate Results – Community, Health Center, Operational Districts and Catholic Relief Services
IROD	Intermediate Results Operational Districts
KPC	Knowledge, Practice and Coverage Survey
KM	Key Mother
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MIS	Management Information System
MOH	Ministry of Health
MPA	Minimum Package of Activities
ND	New Districts
NIP	National Immunization Program
NGO	Non-Governmental Organization
OCA	Organizational Capacity Assessment
OD	Operational District
OPD	Out Patient Department
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy

PHD	Provincial Health Department
PRA	Participatory Rural Appraisal
PQSD	Program Quality and Support Department
PVO	Private Voluntary Organization
SCM	Standard Case Management
TA	Technical Assistance
TT	Tetanus Toxoid
TB	Tuberculosis
TBA	Traditional Birth Attendants
TOT	Training of Trainers
USAID	United States Agency for International Development
USCC	United States Catholic Conference
VDC	Village Development Committee
VHC	Village Health Committee
VHV	Village Health Volunteer
VR	Village Register
WHO	World Health Organization

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A. Executive Summary

The goal of the five-year Child Survival project is to reduce morbidity and mortality in mothers and children by improving the capacity of communities and the health care system to manage and sustain primary health care. The total population of the four districts is 154,147, of which 40,078 are women of reproductive age and 21,272 are children under five years of age. The total number of expected births during the life of project is estimated at 14,640. The project is addressing the principal causes of child morbidity and mortality through Prevention of Immunizable Diseases (25%), Improved Case Management of Acute Respiratory Illness (20%), Improved Control of Diarrheal Diseases (30%), and Improved Control of Malaria (25%).

To date, the main accomplishments of the program include successfully implementing IMCI at the health centers in Bovel District; successfully implementing case management in Samphov Loun Operational District, with training and implementation of IMCI about to begin imminently; successfully developing the community structures used to implement the program; and beginning the processes necessary for localization.

The overall progress made in achieving program objectives to date revolves around IMCI and improving management at the health center level, and community health education and mobilization through community structures for increasing utilization and improving behavior change at the community level.

The project is using IMCI to strengthen health worker performance. Observation checklists, pre and post testing, and supervision are being used to appropriately and cost-effectively assess performance, which has been very effective. Assessment results have guided additional training and supervision in order to continue increasing quality of care in health facilities, and to bridge the gaps between performance standards and actual performance. IMCI is working well in the health centers in Bovel District in terms of assessment, classification and treatment. Once counseling has been strengthened, Bovel District could be used as a living university to capitalize on hard won success and ensure future sustainability of quality health services.

The community component of this program is built on a foundation of community structures. VHV and HCMC are mandated by the Government of Cambodia (GOC), and established in the project areas with the assistance of this child survival project. TBA are independent private practitioners that are accepted by the government. VHC, established with the assistance of the child survival project and CRS, have been accepted by the government as a sub-committee of the VDC, and thereby recognized by the Ministry of Rural Development as a village development structure. To date most of these structures have now been established, and are working on various levels of governance issues including bylaws and other management topics.

The project is following the work plan in the DIP very closely, and almost all activities are on schedule as planned, including the very extensive training plan.

The main constraints, problems and areas in need of further attention include a weak referral system, the counseling component of IMCI in Bovel District, the development of IMCI in Samphov Loun Operational District, the challenges of establishing a new local NGO, and the behavior change strategy which has been identified as the weakest component of this program. The management information system also continues to be problematic.

The CRS staff is very committed, hard-working, loyal and open to learning and growing. They have all increased their capacity considerably since the inception of the program, and will continue to do so for the remaining life of the project. In the field, they work very closely as a team, toiling in a very harsh environment with rain, mud, almost impassable roads, land mines, and under extremely difficult circumstances for very long hours often 6-7 days a week with little time off. Having been refugees themselves, this external evaluator was amazed and in awe of the incredible hardship that the staff of this program routinely face. There was nothing to do but applaud their amazing tenacity, and support them in their efforts to learn and grow personally and professionally. They will surely triumph in the face of sheer drive!

CRS demonstrates a nice, healthy relationship with the government, and it is apparent that everyone has worked for a long time to build these strong relationships. To date, the institutional capacity of the government is in the process of being strengthened through this project. The quality of services has begun to increase, as has the management capacity of the Operational District staff and the health center staff. The project has begun developing the groundwork for an exit strategy with project staff and local partners. However, no approaches have been implemented to build financial sustainability, nor has the community been involved in a dialogue regarding sustaining project services through alternative funding sources at the close of the project.

Priority recommendations include rapidly scaling up IMCI, redesigning the behavior change strategy, exploring various social marketing tools and resources (including investigating possible income generating activities), pre-positioning health commodities in villages, strengthening the referral system, revising the management information system, and developing an exit strategy (including building financial sustainability) that will ensure sustainability of essential activities and health services for improved child and maternal health, and successful localization.

B. Assessment of Progress Made Toward Program Objectives

1. Technical Approach

a. Project Overview

CRS Cambodia is in its third year of implementing a five-year USAID centrally funded child survival project in the province of Battambang. The program is being implemented in four rural districts: the "New Districts" refer to three districts including Kam Rieng, Phnom Prick and Sampov Loun combined as the Samphov Loun Operational District. The fourth district is Bovel District in Thmor Kol Operational District, and is so named throughout this report.

The goal of the five-year Child Survival project is **to reduce morbidity and mortality in mothers and children by improving the capacity of communities and the health care system to manage and sustain primary health care**. The total population of the four districts is 154,147, of which 40,078 are women of reproductive age and 21,272 are children under five years of age. The total number of expected births during the life of project is estimated at 14,640.

The Battambang Community Based Primary Health Care Child Survival Project has a two-pronged approach which includes:

A) Building village level community structures to improve community management of disease prevention and health promotion including home care, seeking care, behavior change communication techniques and village health activities including water and sanitation projects.

B) Increasing quality of the Minimum Package of Activities (MPA) services at health centers to improve health center management and clinical assessment, classification, treatment and counseling.

Strong linkages between the community and facility levels are being developed to sustain the improved overall health status of the communities by emphasizing community management and community ownership.

To further sustain this approach, the project has developed the following cross-cutting strategies:

1. **Build technical and management capacity at Health Center, Operational District, community and CRS level, including phasing in of facility-based IMCI.**
2. **Health Center, community structure and household IEC and counseling activities for behavior change.**

3. **Develop sustainable community and facility health services and complementary linkages.**
4. **Joint planning, monitoring and evaluation using participatory assessments and quality assurance tools.**
5. **Transformation of CRS/Cambodia health staff into a Cambodian health NGO.**

The project is addressing the principal causes of child morbidity and mortality, which include:

Prevention of Immunizable Diseases (25%) – Project efforts increase immunization coverage for children under two years of age through the establishment, improvement and maintenance of Health Center National Immunization Program (NIP) services, including outreach, and the development of community immunization support systems through community health structures.

Improved Case Management of Acute Respiratory Illness (20%) – Activities improve Health Center case management using an integrated strategy (IMCI) and referral systems, and strengthen the ability of caretakers to recognize pneumonia danger signs, seek appropriate/timely care and to provide appropriate home care including completing treatment and recommended follow up for their children.

Improved Control of Diarrheal Diseases (30%) – Interventions improve case management at Health Centers using an integrated strategy (IMCI) and increase the capacity of caretakers to prevent diarrhea, provide home treatment, ORT, recognize danger signs of dehydration, and seek prompt appropriate treatment.

Improved Control of Malaria (25%) – Project efforts are improving capacity in pregnant women and caretakers to recognize signs/symptoms of malaria and seek appropriate treatment, and to prevent malaria through the use of impregnated bed nets. Activities also improve Health Center case management through the use of an integrated strategy (IMCI).

Along with this child survival project, complementary projects and activities funded by other donors have been integrated into the overall Battambang Community Based Primary Health Care Program, including water and sanitation activities, prevention and treatment of dengue fever, HIV/AIDS, and maternal and child health.

Local partners involved in the program implementation include the Battambang Provincial Health Department and the Thmar Kol and Samphov Loun Operational Districts, as well as the staff of 16 Health Centers and one referral hospital that serve the project area.

Partners at the community level include health center management committees, village health committees, traditional birth attendants, village health volunteers and community members. Several additional community structures exist, and the project is collaborating with several of them including the School Parent Association, Village Development Committees, Elderly Groups, and the Pagoda Association.

CRS health staff who will transform into a Cambodian Health NGO will also become a partner during the course of project implementation.

The program implementation started on October 1, 2001 and will end on September 30, 2006. The level of funding is $1,300,000 from USAID and cost sharing of $632,957 from CRS and $108,313 from other donors for a total funding level of $2,041,270 (DIP revised budget). The annual cost per direct beneficiary is $6.60.

b. Intervention Areas – Progress Report

The following section provides detailed information on the technical approach of the program in a results framework.

For the community level, results, intermediate results, indicators, data collection methods, use of data, activities, and data presented from the 2000 DHS, the 2001 KPC baseline survey, the 2003 LQAS monitoring survey, and the CRS MIS data levels is compiled for Bovel and the new districts (Sampov Loun Operational District).

In additional tables, the facility level is represented through results, intermediate results, indicators, data collection methods, use of data, activities, HIS data from the health center level, and health facility assessment (HFA) data presented for the 2001 HFA baseline survey and the 2003 HFA survey.

While the project has generated a lot of data, it is not possible to compare any of these data sets against one another for a number of reasons including:

- A number of different questions were used to complete the 2001 baseline KPC and the 2003 LQAS survey. While most of the questions were the same, the changes were meant to capture the information that was not included in the KPC.

- The program was implementing different strategies (IMCI in Bovel District, and case management in SL OD) in the various project areas due to the timing of the MOH basic training for primary and secondary nurses and midwife certification in the Samphov Loun Operational District.

- The 2001 baseline KPC did not disaggregate various data for the different districts the project was operating in, thus some disaggregated baseline data is not available. When data for both districts was similar, it was not disaggregated in the KPC report tables, but is available in the body of the KPC report.

- The 2003 LQAS survey did not disaggregate some data for the different districts the project is operating in, thus some disaggregated LQAS data is not available. When data for both districts was similar, it was not disaggregated.

- The 2001 baseline KPC was not adequately adapted to include questions for some of the indicators in the DIP, thus no baseline data is available for a few indicators.

- The 2003 LQAS monitoring survey sample size was not adequate to provide information for some indicators. (It was reported that supervisory areas and sample size for the 2003 LQAS monitoring survey were set up on the recommendation of the CRS PQSD Senior Technical Advisor).

- Some different tools were used to complete the 2001 HFA and the 2003 HFA. (It was not longer appropriate to use ARI, CDD and Malaria checklists in Bovel District, so IMCI was used instead. However, the ARI, CDD, Malaria, IC and breastfeeding checklists used in the 2001 HFA in Samphov Loun OD were the same in 2003. The NIP checklist was different).

- The 2001 HFA was completed using interviews, while the 2003 HFA was done by observation

Immunization (25%)
Community Level Focus – Mothers

RESULT 1 - *To Improve Prevention of the Six Immunizable Diseases in Children Less Than 2 Years of Age and Pregnant Women (BCG, Polio, DPT, Measles)* ***This was provided already in the evaluation.***

Intermediate Results	Indicators	Collection Method	Use of Data	Activities	DHS 2000	Baseline KPC 2001		LQAS 2003		HIS & MIS Data	
						Bovel	SL OD	Bovel	SL OD	Bovel	SL OD
IR CM1.1 Increase in mothers and pregnant women who keep immunization cards **IR CM1.2** Improved vaccine coverage for children < 2 YO **IR CM1.3** Improved TT coverage for pregnant women	1. Increase to 80% mothers with children < 2 YO who keep immunization cards 2. Increase % of children < 2 YO fully immunized to Bovel = 80% SL OD = 60% 3. Increase to 65% pregnant women who have 2 TT before birth of baby - by recall 4. Increase to 55% pregnant women who have TT2 before birth of baby – by card	NIP Data from HC HIS VHR Data from VHC and VHV	Monthly and quarterly analysis of results and development of action plan at CRS and with HC to improve coverage Monthly and quarterly analysis of results and action planning with CS	Registration of < 1 YO and pregnant women by CS Health Education, counseling, campaigns and peer education on immunizations by CS Organization and mobilization of the community and assistance to HC by CS for immunization activities	**48%** **31%** **NA** **32%**	**56%** **66%** **45%** **-**	**55%** **27%** **46%** **-**	**100%** **-** **-** **-**	**90%** **-** **-** **-**	**-** **2002 – 55%** **2003 – 65%** **-** **2002 – 35%** **2003 – 41%**	**-** **2002 – 50%** **2003 - 63%** **-** **2002 – 47%** **2003 – 45%**

Acute Respiratory Infections (20%)
Community Level Focus – Mothers

RESULT 2 - *To Improve Control of Acute Respiratory Disease Focused on Pneumonia*

Intermediate Results	Indicators	Data Collection Method	Use of Data	Activities	DHS 2000	Baseline KPC 2001		LQAS 2003		HIS & MIS Data	
						Bovel	SL OD	Bovel	SL OD	Bovel	SL OD
IR CM2.1 Improved mothers' knowledge and practices for ARI prevention	1. Increase to 60% mothers who recognize at least two signs of pneumonia	KPC baseline and final	Monthly and quarterly analysis of results and development of action plan at CRS and with HC to improve coverage	Qualitative assessment of mothers' practices for prevention and management of ARI	-	Fever – 86% Rapid/ difficult breath – 27/%	same	Fever – 44% Rapid Breath 44%, difficult breath 28%	Fever – 38% Rapid breath – 46% Difficult breath – 46%	-	-
IR CM2.2 Improved mothers' knowledge and practices to manage pneumonia	2. Increase appropriate care seeking for child < 2 YO with rapid and/or difficult breathing to 45%	ARI Data from HC HIS		Health education, counseling, peer education, and campaigns provided by CS on ARI prevention, danger signs, home care and compliance	12.7%	22%	25%	ARI - 38%	ARI 40%		
IR CM2.3 Improved mothers' practice to seek appropriate care for child with pneumonia	Sample size for ARI, CDD and malaria were small in the LQAS 0f 2003	Annual assessment using LQAS Proxy – Village Register	Monthly and quarterly analysis of results and action planning with CS	Consumer education on drugs and care seeking	-	-	-	ARI, CDD & Malaria 36%	40%	-	-

Control of Diarrheal Diseases (30%)

Community Level Focus – Mothers

RESULT 3 - *To Improve Control of Diarrheal Diseases*

Intermediate Results	Indicators	Data Collection Method	Use of Data	Activities	DHS 2000	Baseline KPC 2001 Bovel	Baseline KPC 2001 SLOD	LQAS 2003 Bovel	LQAS 2003 SLOD	HIS & MIS Data Bovel	HIS & MIS Data SLOD
IR CM3.1 Improved mothers' knowledge and practices for diarrhea prevention **IR CM3.2** Improved mothers' knowledge and practices to manage diarrhea **IR CM3.3** Improved mothers' practice to seek appropriate care for child	1. Increase to 55% mothers who recognize two signs of dehydration as danger signs of diarrhea	KPC baseline and final ARI Data from HC HIS	Monthly and quarterly analysis of results and development of action plan at CRS and with HC to improve coverage	Qualitative assessment of mothers' practices for prevention and management of diarrheal diseases Health education, counseling, peer education, and campaigns provided by CS on diarrhea prevention, danger signs of dehydration, home care, ORT, and hygiene practices Consumer education on drugs, ORT and care seeking	-	-	-	Irritable – 9% Sleepy – 31% Dry mouth/skin – 13% Sunken eyes – 18% Thirsty – 4.5% Diarrhea worse – 45%		-	-
	2. Increase to 40% mothers of children < 2 YO experiencing diarrhea in the last two weeks who treated their child with ORT	Annual assessment using LQAS Proxy – Village Register	Monthly and quarterly analysis of results and action planning with CS		16%	5.6%	same	18%		-	-
	3. Increase appropriate care seeking for child < 2 YO with bloody, persistent diarrhea, dehydration to 50%				20%	20%	same	11% ARI, CDD, & Malaria 36%	46% 40%	-	-

Control of Malaria (25%)

Community Level Focus - Mothers

RESULT 4 - *To Improve Control of Malaria*

Intermediate Results	Indicators	Data Collection Method	Use of Data	Activities	DHS 2000	Baseline KPC 2001		LQAS 2003		HIS & MIS Data	
						Bovel	SL OD	Bovel	SL OD	Bovel	SL OD
IR CM4.1 Improved mothers' knowledge and practices for malaria prevention	1. Increase to 60% mothers who recognize two signs of malaria in the malaria zone	KPC baseline and final	Monthly and quarterly analysis of results and development of action plan at CRS and with HC to improve coverage Monthly and quarterly analysis of results and action planning with CS	Qualitative assessment of mothers' practices for prevention and management of malaria Health education, counseling, peer education, and campaigns provided by CS on malaria prevention, fever, and home care Consumer education on drugs, bed nets and care seeking	-	-	-	Bovel not Malaria Zone	Fever – 84% Chills – 77%	-	-
IR CM4.2 Improved mothers' and pregnant women's practices to use impregnated bed nets	2. Increase to 90% children < 2 YO sleeping under impregnated bed nets in the malaria zone	Malaria Data from HC HIS			-	Not malaria Zone	97%	Not malaria zone	98%	-	-
IR CM4.3 Improved mothers' and pregnant women's knowledge and practices to manage malaria	3. Increase to 90% pregnant women sleeping under impregnated bed nets in the malaria zone	Annual assessment using LQAS			-	Not malaria zone	97%	Not Malaria Zone	98%	-	-
IR CM4.4 Improved mothers' practice to seek appropriate care for child/pregnant with malaria	4. Increase appropriate care seeking for: child < 2 YO with fever = 50% pregnant = 45%	Proxy – Village Register and number of bed nets impregnated			-	Not malaria zone	Child – 16%	Not malaria zone	child - 40% Pg – 12%	-	-

Cross Cutting Results: R2.0 Improve ARI Case Management, R3 .0 Improved Control of Diarrheal diseases and R 4.0 Improved control of malaria (Both Districts – together – Information not available by District)

Intermediate Results	Indicators	DHS	KPC Baseline	LQAS Survey 2003
Community-level focusing on Mothers IR CM5.1 Increased practice of exclusive breastfeeding for first six months IR CM5.2 Improved complementary feeding with special focus on Vitamin A and iron rich foods	1. Increase to 30% mothers who practice exclusive breastfeeding for the first six months. Increase to 45 % children from age 6 months to 2 years intake of Vitamin A and iron rich foods.	**11%** **Not obtained**	**12%** **26%**	**6.8 % (Sample Small)** **69%**

Cross Cutting Results: 2.0 Improve ARI Case Management, 3 .0 Improved Control of Diarrheal diseases and R 4.0 Improved control of malaria (Both Districts together – not available separate)

Intermediate Results	Indicators	DHS	KPC Baseline (For Diarrhea only)	LQAS Survey 2003 (For ARI, CDD, Malaria)
Community level focusing on Mothers IR CM5.3 Improved feeding practices during illness and recovery.	1. Increase to 60% mothers giving the same or increased amounts of fluid and food during illness.	**Fluid:** **Same -40%** **More – 53 %** **Food** **Same – 33%** **More – 8%**	**Fluid:** **Same – 31%** **More – 42%** **Food;** **Same -26%** **More – 12%**	**Fluid:** **Same – 40%** **More – 35%** **Food:** **Same - 23%** **More – 22%**

Linkages Community and Health Center

Intermediate Results	Indicators	DHS	KPC Baseline	LQAS Survey 2003	CRS MIS (collected @ HC and Community	
					Bovel	SL OD
IR HCCS 1.1 Improved surveillance of disease	1.Increases to 80% children 12 – 23 months who receive Vitamin A in the last 6 months.	Coverage rates not obtained	55% (Both Districts together)	Not collected	Child 6 – 59 mon – 89 %	Child 6 – 59 mon – 77%

Community level focusing on community structures

Intermediate Results	**Indicators**	**CRS MIS (collected @ HC and Community)**	
		Bovel	**SL OD**
IR CS1 Improved management capacities of the village health structures including Community SCM/Community Based IMCI	1. 10% increase in pre and post test scores. 2. 50% Community structures reach acceptable level (70%) on HE check list	Average – 24%	Average – 20%

Cross Cutting Results: R3.0 Improved Control of Diarrheal diseases and R 4.0 Improved control of malaria

Intermediate Results	**Indicators**	**MIS (Collected at Community or HC)**	
		Bovel	SL OD
Community level focusing on Community Structures **IR CS 3.**4 Improved community water, hygiene and sanitation	1. 75% of VHC Villages have regular village cleaning schedules or systems 2. 90% of VHC Villages have water or sanitation projects.		

Health Facility Assessment
Baseline and 2004

Health Center Level (NIP – All HC)

Intermediate Results	**Indicators**	**Health Facility Assessment Base- line areas**	**Average Scores for District HCs by interview – 2002 per area**		**Health Facility Assessment 5/2004 (observation)**	**Average Scores for District HCs – 2004 per area**	
			Bovel	SL OD		Bovel	SL OD
IR HC1. Improved management and technical quality of NIP (National Immunization Program) at the Health Center. IR HC1.2 Improved coverage of immunizations for children and pregnant women.	85% of health centers will have an acceptable level (75%)of quality of EPI service as measured by quality assurance checklists.	1. Explain Vaccine 2. Vaccine Schedule 3. Side Effects 4. Cold Chain 5. Counseling Average Score 85% of HC reach 75%	100% 80% 38% 71% 56% 71% 2 /7 28% HC	100% 100% 83% 37% 51% 76% 4/8 50% HC	1.Vaccine Care/supply 2. Analysis/Plan 3.Organization/ Mobilization 4. Techniques 5.Mother's Interview 6. Pregnant woman Interview **Average Score** 85 % of the HC had a score of over 75%	84% 74% 85% 88 % 78% 81% 81% 5/7 71% HC	84% 72% 72% 68% 49% 37% 65% 2/8 25% HC

Health Center Level (Infection Control)

Intermediate Results	**Indicators**	**Health Facility Assessment Base- line areas**	**Average Scores for District HCs by interview – 2002 per area**		**Average Scores for District HCs – 2004 per area (Observation)**	
			Bovel	SL OD	Bovel	SL OD
Management IR HC 5 Improved Health Center MPA Management and Standard Case Management	. 50% of health centers will have an acceptable level (75%) of management quality as measured by management checklists.	1. Universal Precautions: 2. Hand Washing 3. Decontaminate of work surface 4. Decontaminate of equipment 5. Sterilization 6. Care and maintain of sterilizer 7. Waste Disposal Average Score 50% of HC with 75% score	57% 89% 85% 100% 48% 38% 44% 73% 0/7 HC with 75%	52% 100% 87% 81% 52% 63% 63% 62% 0/8 HC with 75%	67% 61% 80% 80% 75% 63% 53% 66% 3/7 HC 42% with 75%	78% 41% 77% 77% 80% 70% 78% 71% 4/8 HC 50% with 75%

Health Center Level (Breast Feeding)

Intermediate Results	**Indicators**	**Health Facility Assessment Base- line areas**	**Average Scores for District HCs by interview – 2002 per area**		**Average Scores for District HCs – 2004 per area (Observation)**	
			Bovel	SL OD	Bovel	SL OD
<u>Clinical</u> IR HC5.1 Improved counseling and Health Education at health center for all interventions	70% of health centers in the project site have an acceptable level (75%) of performance in case management of ARI, CDD, Malaria/ IMCI as measured by quality assurance checklists	1. History	40%	28%	62%	35%
		2. Education	48%	40%	76%	36%
		3. Nutrition Messages	48%	40%	79%	53%
		4. Weaning Food	54%	39%	75%	58%
			NA	NA	61%	61%
		5. Mother's Interview	46%	34%	69%	40%
		Average Score 70% of HC have score of 75%	0/7 HC with 75% score	0/7 HC with 75% score	1/7 HC 14% with 75% score	0/7 HC with 75% Score

Health Center Level - ARI Case Management

Intermediate Results	**Indicators**	**Health Facility Assessment Base- line areas**	**Average Scores for District HCs by interview – 2002 per area**		**Average Scores for District HCs – 2004 per area (Observation)**	
			Bovel	SL OD	SL OD	Bovel (IMCI)
IR HC2 Improved quality of Health Center ARI Case Management	70% of health centers in the project site have an acceptable level (75%) of performance in case management of ARI, CDD, Malaria/ IMCI as measured by quality assurance checklists	1. History 2. Physical Exam 3. Classify/RX 4. Education Average Score 70% of HC have score of 75%	74% 59% 74% 58% 64% 2/7 28% HC have score of 75%	70% 75% 70% 61% 61% 0/8 HC have score of 75%	68% 55% 24% 20% 40% 0/8 HC have score of 75%	Did not do ARI

Health Facility Assessment
CDD, and Malaria

Health Center Level - CDD Case Management

Intermediate Results	**Indicators**	**Health Facility Assessment Base- line areas**	**Average Scores for District HCs by interview – 2002 per area**		**Average Scores for District HCs – 2004 per area (Observation)**	
			Bovel	SL OD	SL OD	Bovel (IMCI)
IR HC2 Improved quality of Health Center CDD Case Management	70% of health centers in the project site have an acceptable level (75%) of performanc e in case manageme nt of ARI, CDD, Malaria/ IMCI as measured by quality assurance checklists	5. History 6. Physical Exam 7. Classify/R X 8. Education 5. Interview Mother Average Score 70% of HC have score of 75%	70% 59% 54% 56% 56% 0/7 HC have score of 75%	78% 68% 75% 65% 72% 2/7 28% have score of 75%	62% 52% 37% 28% 62% 47% 0/7 HC have score of 75%	Did not do CDD

Health Center Level - Malaria Case Management

Intermediate Results	**Indicators**	**Health Facility Assessment Base- line areas**	**Average Scores for District HCs by interview – 2002 per area**		**Average Scores for District HCs – 2004 per area (Observation)**	
			Bovel	SL OD	SL OD	Bovel (IMCl)
IR HC2 Improved quality of Health Center Malaria Case Management	70% of health centers in the project site have an acceptable level (75%) of performance in case management of ARI, CDD, Malaria/ IMCI as measured by quality assurance checklists	1. History 2. Physical Exam 3. Classify/R X 4. Education 5. Interview Mother Average Score 70% of HC have score of 75%	94% 68% 80% 65% 71%	60% 62% 77% 53% 63%	68% 43% 35% 53% 57% 53% 0/7 HC have a score of 75%	Did not do CDD

However, the following discussions and recommendations are based on qualitative information collected during focus group discussions and the participatory process and activities implemented throughout the midterm evaluation. The goal of this evaluation was not quantitative in nature, but rather qualitative and a thorough review of the processes and systems currently in place and being used for implementation of the DIP toward achievement of results, as measured through the indicators for baseline figures against the final KPC which will be done at the end of the program in 2006.

For a more detailed discussion of the management information system and program monitoring, please see the Information Management Section below under Program Management.

The following is a discussion of the interventions, the processes and activities used to implement them, their effectiveness, and the progress made to date for each one. Next steps for follow-up are also outlined, as are recommendations from this midterm evaluation.

Health Facility Activities and IMCI

When the child survival program began in 2001, the Ministry of Health was in the process of working with WHO to adapt IMCI as the integrated approach for health facilities in Cambodia. However, only facility-based IMCI was eventually accepted. (C-IMCI is currently being developed, but will focus on key family practices and not on the use of the algorithm by Community Structures, as outlined in the CRS C-IMCI manual).

When this child survival project started up, IMCI had still not been approved, and so standard case management for ARI, CDD and Malaria was used in all the districts. CRS also worked with the health facilities on implementing the National Immunization Program (NIP). However, in the 3rd quarter of 2002, IMCI was endorsed by the MOH, and so the program switched to doing IMCI in Bovel District, while continuing with standard case management in Samphov Loun OD. This was due to the implementation of MOH basic training for nurses and midwife certification in Samphov Loun OD health centers, which made the addition of training on IMCI impossible during that time since the staff was not available. The MOH plans to train 60% of its health worker force nationally within the next five years.

Currently, there is a loosely functioning referral system between communities and health facilities in Bovel and Samphov Loun Districts. Patients are sometimes being referred from the community to the health center with a referral form, but the health centers do not yet have a system in place to send referral information back to the community structure once the patient has been seen. The Health Centers also refer patients to the Referral Hospital, but the return of information back to the Health Centers is inconsistent. CRS has developed a system in SL OD for the referral hospital to provide written information back to the health center through a mailbox system, and in-person feedback at the health center OD meeting for specific cases. Radio contact between the health center and the referral hospital is used for special cases only.

In Bovel District (this region of Cambodia is socio-economically deprived), the health infrastructure consists of health centers established in rural areas to serve 8,000 to 12,000 people according to the MOH Health Reform Plan, staffed in the great majority with primary and secondary nurses and midwives who provide primary care services, and clinical work with children under five is provided through the use of IMCI tools. There are no physicians in these health services. The personnel of this district received the standard facility-based IMCI training (11 days) from the MOH, CRS and the Operational District, and have been implementing the approach for the last 12 months.

Health staff perception (primary and secondary nurses): according to staff interviews, IMCI is seen as a very useful tool, which has achieved in a relatively short time a substantial increase in clinical skills for treating children under five. Use of the IMCI tool has improved credibility of health services by community members, and thus somewhat increased health facility utilization rates. By following the algorithm, staff is required to use a comprehensive view of the child. This has increased the amount of time that health providers spend on each child, which is good. One of the main advantages of this approach is the improvement of quality of health services demonstrated through accuracy of classification and treatment of childhood diseases, and by counseling provided to the mothers or primary caregivers.

Overall, it was the PQSD's impression that the current health environment will benefit significantly through the implementation of IMCI. It was also his impression that the CRS program had been a fundamental partner in this process. The good working relationship between health workers and CRS personnel was palpable, and the importance that district level health personnel placed on this relationship was excellent. Nonetheless, at times there was the sense that MOH personnel expect too much (financial and technical) support from the program, and that this might lead to dependency in the future.

Clinical use of the IMCI tool in general was very good. The registration forms observed were completed in their totality and correctly. Health personnel followed the order dictated by the form, and assessed the child correctly. The classification part was done correctly, and although some over-treatment was witnessed, this would probably not vary much from those done by physicians anywhere. It was evident how counseling skills have been improved from normal standards, however, health staff skills need to continue to be improved in order to secure client confidence and satisfaction over time, and to also significantly increase not only follow-up but future utilization. IMCI communication aid tools were used and complemented with dialogue between patient and child care provider, however this activity could be improved. The time spent on each child varied from 15 to 25 minutes, which is much longer than the norm in most developing countries, however, this could be due to the fact that they were being observed.

Several exit interviews were done to explore client satisfaction with client reception, clinical care provided, and pharmacy attention. The waiting time varied between 20 and 30 minutes, the reception received reported was in all cases adequate, clinical care was

reported by all mothers as very satisfactory with the exception of explaining procedures and illnesses. As with pharmacists' attention, the explanation of drug prescriptions was provided but not probed.

The district has a cold chain in place in each of the health facilities, and thus the NIP activities are being fully integrated into IMCI through routine immunization at the health facilities and through outreach.

Samphov Loun Operational District Health Centers are more socially deprived than Bovel District, but economically they may be better off due to agricultural potential and cross-border trading. However, there is significant poverty due to the migration of people from other provinces in Cambodia to these areas in search of land or jobs which often leads them to end up doing farm labor or cross-border work. Health infrastructure is restricted to areas with a high concentration of population, since the majority of dwellers split their time between living in more populated areas and farms depending on the season, with many new villages being established in farming and forested areas. Most of the population lacks access to health services. Health centers are staffed in the great majority by primary and secondary nurses and midwives who provide primary care services. However, in all health centers the health center chief is a medical assistant, and the health center with beds has one doctor. Other than that, there are no additional physicians in these health services.

At the time of this MTE, the Samphov Loun OD and its health centers had just completed their first group of staff training on IMCI, and implementation had not yet begun. The second group had not yet completed their training. While some staff had already received training and were attempting to use the information and algorithm, the majority of the staff was still awaiting training and technical assistance from CRS and the OD to be able to implement IMCI in the health centers.

During the MTE, both the HQ Technical Backstop (PQSD) and the external consultant evaluated (through observation, FGD and semi-structured interviews with MOH staff) the technical implementation of clinical services, management issues related to the health information system, health planning, and the referral system in the health centers.

A performance assessment of health personnel (using the MOH IMCI form) was done through observation during the delivery of health services, and through review of the IMCI registry form after child assessment. During delivery of health care to children under five, the health provider observed used the IMCI approach to assess the child, although IMCI has not officially started in Samphov Loun OD health centers where they are still using case management of ARI, CDD and Malaria. Thus, the following assessment is on current capacity of health personnel in the health center in an attempt to use the IMCI tools.

The health worker who was being observed used the IMCI tool incorrectly. His assessment did not follow all the sections required by the tool, and some sections were ignored. Classification showed inadequacies in almost all case classification sections. In

addition, treatment did not follow the defined classification. The counseling section was done poorly in content and insufficient is scope. In conclusion, quality of care according to IMCI standards did not reach acceptable levels of performance. Health centers in this area will need strong supervision and follow-up support during IMCI implementation, as CRS and the OD are planning to provide.

Since the inception of the program, the Samphov Loun OD had only two cold chains set up, one in the referral hospital, and one in the Trang Health Center with beds. They were using cold boxes to transport vaccines to the other health centers for facility-based routine immunization and outreach. However, at the time of the MTE the health centers in the Samphov Loun OD were all in the process of establishing cold chains, with equipment and supplies being transported and set up for operation. The staff of these health centers will receive full training on policies and procedures for operating the cold chains next month.

Issues Raised

Health centers receive monthly monitoring and supervision visits from OD staff. There are currently two supervisory teams composed of three supervisors each. One team supervises three health centers and the other four health centers. Each supervisory team visits one health center per month.

In lengthy discussions with Provincial Health Department (PHD) and Operational District (OD) management and health center staff, the issue of supervision was repeatedly raised as a problem which the MOH was having difficulty dealing with in Samphov Loun OD due to a lack of resources (capacity, financial, material and staff). It was also made clear that the OD staff were not operating in the most efficient manner to fully utilize their potential. In Bovel, supervision was reported to be less of a problem since the OD has received training on IMCI supervision from the MOH, and supervision is done regularly, along with routine meetings to discuss and solve problems and to improve skills for IMCI.

Recommendation

CRS could continue working closely with the OD to help facilitate a reorganization of OD supervisory systems for health facilities, ensuring efficient and effective use of resources to provide maximum coverage on a continuing basis for phase out and sustainability.

The issue of drug supplies and periodic shortages was raised as an ongoing problem, given that the health facilities can only request additional supplies once they have used the stock in their possession. When they do make requests, drugs are often not received in a timely manner, and stock-outs occur, which interrupt service provision and quality of care.

Recommendation

CRS could continue working closely with the OD to help facilitate a possible reorganization of the OD drug supply management system, and the policies around stocking adequate supplies of pharmaceuticals at the health centers to bridge time gaps.

During the MTE it was reported that government staff morale at the health centers is a serious problem due to extremely low salaries and very little incentive to report for duty on time, or at all, let alone provide quality care. Although it is prohibited (but accepted as the "norm"), many staff engage in private practice as health workers outside of their government jobs in order to cover their monthly expenses. Salaries are "topped up" at the health facilities on a monthly basis through receiving a percentage (49%) of the money collected from client fees. The other 51% is distributed as follows: 50% is used to cover health facility operational costs, and 1% is retained by the government. Client fees are established by the Health Center Management Committee (made up of villagers and health center staff) through meetings held to assess how much people can afford to pay according to their socio-economic situation, and then a set fee is established for each catchment area. The client fees may therefore be different in each catchment area. The HCMC is a system that assists the health center staff in managing the health center to improve transparency and quality and solve problems between the community and the health center.

As reported during the MTE, the problem of low salaries caused some health facility workers to fraudulently charge fees higher than those set by the HCMC in order to increase their personal income. Increased monitoring and supervision will help relieve part of this nefarious activity, but the problem of low salaries still remains.

As utilization increases, so will salary top-ups which are considered an incentive for the health center staff. However, it would be in the best interest of all parties if the program might find a way to have some income generating activities set up that could cross-subsidize the health facilities and provide further financial remuneration to staff. Various types of projects might be considered including for example cottage industries, internet cafes and other sales ventures. It is prohibited for health facilities to engage in this type of income generating activity, so it would need to be done through a local NGO or group such as the health center management committee. CRS might also explore having other groups such as NGOs (ex. PSI) who are currently working in the area, or who are currently in Cambodia and might come into the area expand these types of activities independently.

Recommendation

CRS is encouraged to work closely with the microfinance department of their organization and other NGOs, and with the PHD, OD and local groups / community structures to investigate possible income generating activities that might cross-subsidize health center services and staff.

Accelerated Scale-Up of IMCI – Facility Level

Due to the fact that the project has already been operating for 2 ½ years and has only that amount of time remaining, and given the project goals (and indicators) and the need for phase-out during the final year of the project, the project may wish to consider an aggressive scale-up operation in order to achieve the objective of having IMCI operating independently and effectively by 2006 in both Bovel and Samphov Loun Districts.

Allowing for a three-month planning phase, the evaluator suggests a six-month scale-up plan. This will increase quality of care at the health centers, however it will not, by itself, increase demand for services and utilization of the health facilities. The project may wish to consider doing a large-scale campaign for accelerated scale-up at the health facility and community levels simultaneously. For a discussion on increasing demand and utilization, please see the sections below on complementary activities for scale-up at the community level, and redesign of the behavior change strategy and health education activities, tools and resources.

Recommendation

The project may wish to consider allowing for a three-month planning phase, followed by an accelerated six-month scale-up plan for IMCI at all health centers in Bovel and Samphov Loun Districts.

Bovel

The project may wish to consider using Bovel District health centers as "living universities" for IMCI in Cambodia. This would provide multiple opportunities for the Bovel health center staff to train other district health staff throughout the country, starting with the Samphov Loun District health centers, and thereby scaling up IMCI in Cambodia. Teaching and modeling IMCI could be the most effective way for the staff to institutionalize their skills and behavior. If there is a constant parade of clinicians from around the country coming to view their work and learn from them, not only will it give them pride in what they are accomplishing, but it will also reinforce their positive practices. Providing them with opportunities to go to other district health centers and give technical assistance will be an incentive for them by instilling a sense of importance in the work they are doing. Lastly, it could be a very effective means of ensuring some sustainability for IMCI. It will be important to document their work in local newspapers, on television, and with other organizations and donors.

Samphov Loun OD Health Centers

In the next three months these health centers will have all their staff complete the 11-day IMCI training course, and have their cold chains fully installed and operational. After that has been accomplished, it is suggested that the following schedule be used as a model for scale-up by Operational District (OD) and CRS staff working closely together

to provide technical assistance, monitoring and support to health facility staff in the following timeframe:

Over 16 weeks (4 months) – work side by side with health center staff on the following schedule:

5 days / week for 4 weeks
4 days / week for 3 weeks
3 days / week for 2 weeks
2 days / week for 3 weeks
1 day / week for 4 weeks

What this will do is ease the health facility staff into daily excellence in IMCI performance, institutionalizing the process during a routine schedule, providing strong support and then slowly phasing out. By having CRS staff work with OD staff for this period of time, it will also ensure a high level of quality by the OD staff for future project monitoring and problem solving, thereby facilitating sustainability for supervision by the government, and phase out by CRS.

Referral System

Referrals **from the community** to the health facility and from the health facility **back to the community** are an essential component for successfully implementing community-based primary health care. The project is already working with a referral system between the health centers and the referral hospital, and this will be further strengthened. However, during the MTE conflicting information was received regarding the use of referral forms to/from the community/health center. Developing and maintaining a functional referral system includes:

- Developing referral protocols
- Specifying when and where to refer
- Developing a tool for referrals (ex. From community – red card; From facility – blue card; and different shapes for different diagnosis/treatment)
- Establishing an emergency transport system
- Having a functional link with the referral center
- Positive reception of referred cases in referral center
- Quality of referral care provided
- Positive reception of referred cases back to community health worker for follow-up and rehabilitation
- Supervision and monitoring of system – community and facility levels
- Continuing education through feedback on cases and formal in-service training sessions to help build the links (trust and confidence) between the community health workers and health facility staff; with feedback loop to community on identification of system barriers and improvements for sustainability

Recommendation

The project may wish to establish and/or strengthen a functional referral system between communities and health centers which incorporates the above list of items.

No Missed Opportunities

A campaign for scale up could happen simultaneously at both the health center and community levels. The following are examples of activities and tools that could be used to improve present activities and message delivery to clients.

Waiting Area – Use every opportunity to provide information to patients

- Kids: games, toys, songs, books, posters, printed material, etc.
- Adults: tutorials, key messages, demonstrations, flannel grams

Counseling - Use the IMCI tools

- Method: explain the information and have the mother repeat it, then when she gets back to her village have her again repeat the information to the village health worker who does the follow-up visits with her

Exit interviews - For 4 months, at least 5 mothers with child < 5 YO/week who are seen at the health center for pneumonia, CDD, malaria or dengue

Have mother explain:

- F/U @ home
- When to return to HC
- Key messages
- Drug prescriptions provided (what, how often, for how long, etc.)

Outreach – Design new methods for doing more creative, integrated activities during outreach by improving participatory methods to fully engage communities in their own learning and behavior change, and having them more fully participate in vaccination and other health activities

Homework – Develop homework assignments that community members and caregivers can do at home prior to outreach activities and health education sessions, and after returning from the health clinic (ex. Clean and cover water containers, burn/bury garbage, etc.)

Campaign – Arrange for various activities at the health center and community levels including introducing competition (and prizes) such as free bed nets!

- Between health centers to see which can vaccinate the most number of children or pre-position the most number of ORS packages or get the highest scores on IMCI supervision checklists, etc.

- Between households and/or villages, for example, to see who can have the cleanest environment, the most children vaccinated, the most families with an emergency transportation plan, a caregiver who provided ORS to

her child the last time s/he had diarrhea, the most kids sleeping under a bed net, the VHV who gives the most health education sessions or covers 100% of their target population, etc.

Community Structures and Activities

The community component of this program is built on a foundation of community structures. Village Health Volunteers (VHV) and Health Center Management Committees (HCMC) are mandated by the Government of Cambodia (GOC), and established in the project areas with the assistance of this child survival project. Traditional Birth Attendants (TBA) are independent private practitioners that are accepted by the government. Village Health Committees (VHC), established with the assistance of the child survival project and CRS, are an accepted sub-committee of the Village Development Committee (VDC) which is recognized by the Ministry of Rural Development as a village development structure.

Community Structure	Bovel Planned	Bovel (2004)	Samphov Loun OD Planned	Samphov Loun OD (2004)
TBA	NA	108	NA	122
VHV	189	189 (in 8 HC)	192 (in 8 HC)	152 (in 6 HC)
VHC	41	242 (in 22 villages)	37	116 (in 12 villages)
HCMC	8	2	7	2

(HC = Health Center)

Each of these structures has a clearly defined role, responsibilities, and methods for their establishment and governance. The DIP states that "community structures will receive training and technical assistance on self-management to develop, implement, monitor, evaluate and sustain community-based primary health care/CB-IMCI and child survival interventions in the community, and on health topics and IEC methodologies and other methodologies for achievement of the expected outcome for the interventions".

To date, as reported during the MTE, most of these structures have now been established, and are working on various levels of governance issues including bylaws, and how to interact with other existing community structures, with the community at large, and with the health center in their area. They are also dealing with issues such as how to replace members who leave the structure voluntarily, as well as those who are not high functioning in their roles.

Key Mothers were originally listed as one of the community structures in the DIP, however, a decision was made based on recommendations from another donor to discontinue key mother development and change key mothers groups to VHCs through community elections. In light of the challenges in the community aspect of this project, CRS may want to reconsider using Key Mothers. Also discussed was the possibility of developing Mother's Groups, which the project reported it has been considering.

CRS continues to provide technical assistance to these structures through the use of monitoring tools such as observation checklists and through monthly meetings where data is exchanged and training on additional governance and health education issues is provided. While an attempt has been made to ensure that the outcome from these trainings is highly knowledgeable community structures and staff, this has not resulted in the desired impact of significantly improved home care, increased utilization of health centers or considerably higher use of community health care workers.

Although utilization of the health centers has increased, the community continues to use private practioners on a regular basis prior to or instead of seeking care at government health centers. While anecdotal, during several home visits at the time of the MTE it became apparent that women with small children may not necessarily be receiving key messages through health education from VHV or TBA. Instead the women interviewed received messages from their mothers, from neighbor women, and from other sources. During the MTE, focus group discussions with groups of mothers revealed that at least half of the mothers in the group in both areas received health education, information and referrals from VHV, TBA and VHC. It is suggested that the project conduct the formative research detailed in the DIP in order to further understand where people get information, how they receive that information, and what they do with it – if it changes their behavior.

The project to date has been targeting the entire population in the project area, rather than focusing on WRA and children < 5 years. They have been discussing the possibility of changing the target group for the second half of the project.

Recommendation

- The project may wish to consider refocusing their efforts exclusively on WRA and children < 5 years in order to achieve the objectives set out in the DIP.

The functions for TBA, VHV and VHC overlap considerably for some specific tasks including health education, community mobilization and referrals to the health center.

Traditional Birth Attendants (TBA) have additional roles for ANC, delivery and PNC. Their monthly meetings are held at the health center.

Village Health Volunteers (VHV) are the most versatile of this group, having a mandate to basically facilitate this project at the community level, including community mobilization, documentation and record keeping, home care, health education and counseling, and care seeking for children <5, pregnant women and those with chronic diseases. While they could be playing a pivotal role in referral and follow-up, the program does not currently have a well defined or well functioning referral system. The primary methods and tools currently being used for health education are pamphlets and posters in focus group discussions/lectures, occasional demonstrations, and some house-to-house education. The VHV meet with CRS and health center staff at the health center every month, alternating monthly between training and having a meeting.

CRS provides management and technical support, and the health center staff facilitate the meeting.

Village Health Committees (VHC) have the additional task of facilitating community based water and sanitation schemes, funded through CORDAID and AADC. They also work with other existing community organizations on problem solving skills for health issues, health planning integrated with health center management, village health register monitoring, community mobilization, and they support ANC, delivery and chronic disease activities. The VHC have a monthly meeting with CRS, villagers and sometimes health facility staff comes as well. VHC receive training on health and self-management topics from CRS and health center staff. The meetings take place in their villages.

The Health Center Management Committee (HCMC) does not do health education in the community, but rather is the conduit for exchanging information and solving problems between the community and the health center, and coordinating, mobilizing and facilitating service delivery at both ends. They are responsible for the management of the health centers, including financial and other resources. They advocate for quality and equitable service delivery for the community, and they determine client fees at the health center. The HCMC has a monthly meeting with CRS and health center staff at the health center, facilitated by the HCMC chief or deputy, with CRS providing management and technical support.

All of these structures are successfully being established, however once they get organized, they are underutilized and not operating at their full potential.

The project may wish to consider significantly scaling up community-based activities during the second half of this project. The project could continue to utilize these potentially strong community structures, however significant emphasis could be placed on increasing their skills, motivating them through supportive supervision and income generation activities, refocusing their efforts on WRA and children < 5, and designing a campaign to accelerate community activities on a larger scale for at least six months to begin institutionalizing the changes in health behavior the project is seeking to impact.

Training the community structures on the use of adult learning techniques (not just TOT), and providing them with more interactive materials and tools will help them move in the right direction toward their goal of significantly affecting behavior change at the community level. For more details on all of these issues, please see the Communication for Behavior Change Section below under Cross-Cutting Approaches.

Recommendation

The project may wish to consider training community structures on adult learning techniques, and providing them with more interactive materials and tools.

Currently, only TBA and midwives are involved in commodity sales (home-safe birthing kits) at the community and health center levels. There are no other commodities pre-positioned in the villages. Nor is there any social marketing of health commodities being done by the project. ORS, bed nets, re-treatment chemicals, soap, condoms, water purification tablets, and other items can only be found in urban and semi-urban centers.

Recommendation

The project may wish to consider pre-positioning health commodities in villages through HCMC/VHC/VHV/TBA (and mother's groups) to greatly increase access, use and healthy behaviors. This can be done as an income generating activity to provide incentive to community health workers.

There are no changes in the technical approaches for this program from those outlined in the DIP.

Constraints include the SL OD health center staff being preoccupied with basic nursing and midwife training from October 2003-May 2004, making them unavailable to do their routine work or participate in project activities. Health centers were operating with only half of the usual number of staff during that time.

Migration into the area was also greater than expected, increasing the population denominator and making it more difficult to provide adequate coverage for project activities. The openness of the border between Thailand and Cambodia resulted in excess mobility of the population making it more difficult to mobilize people to participate in project activities.

Accelerated Scale-Up of Community Based Primary Health Care

The project could consider engaging all community structures in a scale-up campaign aimed at quickly increasing home care, care seeking and health education and counseling for the beneficiary population. **People need to know that services exist, what they are, that they are quality services, and that they can afford them.** Community structures could increase their interaction with target groups by increasing the number of activities, key messages and community members involved, and significantly scaling up a campaign in order to reach the level of impact that the project has stated in the DIP. For additional information please refer to the Strategies for Behavior Change Section under Cross-Cutting Approaches.

Recommendation

The project may wish to work intensively with community structures to provide additional training on HOW to interact with and deliver key messages to target beneficiaries.

Recommendation

The project may wish to work intensively with community structures to supervise them with THEIR provision of supervision and support for follow-up with target beneficiaries on key messages.

Referral System

Referrals **from the community** to the health facility and from the health facility **back to the community** are an essential component for successfully implementing community-based primary health care. Please see the discussion above for more details.

c. New Tools and Approaches Discussion

This program has adapted a wide range of check lists for quality assurance, monitoring purposes and periodic evaluation. However, while the tools have been successfully adapted, there remains a need to use these tools more fully and effectively as memory aids for health center and community structures and staff. These tools can provide a built-in source of continued support for sustaining both quantity and quality of services and activities.

> *Recommendation*
>
> The project may wish to consider using the checklists as memory aids for health center and community structures and staff to facilitate a sustained level of high quality and quantity of services.

IMCI is being implemented for the first time in Cambodia, beginning just one year ago. CRS is doing a very good job of providing technical assistance, training and support to the health centers in Bovel District, where health center staff are demonstrating competency with the IMCI algorithm, including assessment, classification and treatment.

Counseling has lagged behind the other three activities for a number of reasons as discussed in this report. This could be improved in order to help increase quality of services, demand for services and ultimately to increase utilization.

Once counseling has been improved, rapid scale-up of IMCI in Bovel District can potentially be taken to scale in other districts of Cambodia, with this CRS project being used as a model.

> *Recommendation*
>
> The project may wish to consider using the Bovel health centers as living universities where health staff from other districts may come to learn, practice and observe facility-based IMCI in action.

No current operations research activities are underway however, the program plans to address several behavioral questions through field research during the second half of the program.

2. Cross-Cutting Approaches

The following section provides detailed information on the various approaches and strategies that are being used to implement the above technical interventions. These include community mobilization, communication for behavior change, capacity building, and sustainability, all of which are framed around additional activities as part of a suggestion to implement a larger campaign for accelerating and scaling-up IMCI in the project areas.

a. Community Mobilization

The following discussion provides an overview of the community mobilization activities that have been done to date, as well as future suggestions.

This project has been involved in doing community mobilization through the various community structures that now exist, including HCMC, VHC, VHV and TBA. The activities that have been done mostly revolve around focus group discussions to deliver health education key messages and to arrange for outreach activities, and loud speaker announcements and house-to-house checks for rounding up families (and pregnant women as identified by the village register) for NIP outreach. The materials used for delivering health education key messages include posters, pamphlets, and some video and audio tapes. For a complete discussion of health education methods, tools, and resources, please see the Communication for Behavior Change Section below.

The community has been somewhat responsive to these activities however, the project has not been directly targeting WRA and children < 5, and thus is not reaching a majority of the population that the DIP (project indicators) has identified for behavior change.

Community mobilization has been carried out as described in the DIP, and it has not been necessary to refine program implementation plans so far. However, as the project evolves in terms of its behavior change strategy, it may wish to reconsider some of the community mobilization efforts it is currently engaged in.

The following three issues were raised during the MTE focus group discussions as effecting community mobilization and participation in health education sessions and outreach activities. The issue of timing for mobilizing community members as most people work in their fields for a large part of the time, and their fields are often located in distances far away from their villages. This has presented a barrier for participation. Childcare was also an issue effecting attendance and participation in health education sessions. Lastly, the roads are very difficult during the rainy season and can present difficulty for some people.

Recommendation

The project may wish to investigate the major and minor barriers for community participation and mobilization, and rectify them wherever possible through creative programming (doing outreach mobilization in the fields where people are working!) and problem solving.

Currently, the project is not using mass media, theater, or other types of creative and interactive programming. Please see the discussion below under the Communication for Behavior Change Section.

Recommendation

The project may wish to explore the use of various tools and resources to integrate as many different types of media as possible for key message delivery to affect behavior change.

It was reported during the MTE that for the most part, security no longer presents a problem in the project areas during the daytime, except on remote stretches of roads where bandits continue to attack lone individuals. The political situation is stable and does not seem to interfere with project implementation or community participation except around election time. During elections, people do not feel comfortable gathering in large numbers for fear of being seen as a political meeting, and thus community education is being done in small groups at that time. This demonstrated excellent problem-solving skills on the part of CRS, the OD, and the community structures.

b. Communication for Behavior Change

The behavior change strategy developed at the time of the DIP utilized the PRECEDE Model, which the staff received some training on, but never fully made operational due to the model being perceived as “too theoretical”.

At the time of this MTE, the behavior change strategy of the project was identified as the weakest component.

There is no regular schedule for community structures to provide health education in the villages. Health education sessions are not organized in each area on a certain day and/or time each week, nor are they drawing more than a handful of people for each session. There is no systematic process of ensuring that all WRA in a given village receive each and every key message or attend at least one health education session per week/month.

The project is using observation and checklists to evaluate how well the community structures are doing health education. However, there is no regular monitoring system for health education sessions (by CRS staff) to ensure that key messages are

consistently being given. The only follow-up by community structure staff (VHV and TBA) is for sick home visits. The CRS and government staff meet with VHV/TBA on a monthly basis at the health center to monitor progress, provide additional information and materials, and assist with problem solving. Monthly meetings are also held with the VHC, where they exist, and with the HCMC (who are not involved in providing health education).

> *Recommendation*
>
> CRS and government staff need to provide the community structures with a regular schedule for supervision IN THE COMMUNITY to ensure consistent, quality message delivery.

The use of community structures for this project is a good idea, however, the training and health education activities, materials, tools and media are not as effective as they need to be, and are thus not accomplishing significant behavior change at the community level. While all the key messages have been included and are technically correct in the material and curriculum produced to date, the project was predominantly using posters, leaflets and lecture/focus group discussions. It was reported that audio/video tapes and campaigns were minimally used as well. Key mothers were identified in the DIP as one of the community structures, however it was determined that VHC were more relevant for this project, as per donor recommendations.

> *Recommendation*
>
> CRS could consider working with the community structures to develop a regular schedule for delivery of health education sessions for target beneficiaries, including occasional well home visits to households.

> *Recommendation*
>
> CRS may consider working with community structures to ensure that they are reaching 100% of the target beneficiaries with health education on key messages ON A REGULAR BASIS.

The data collected on these training sessions specifies the number of people trained, but does not look at qualitative information for follow-up in terms of practice to determine if the messages are having an impact on behavior, and how to change the delivery system to ensure better attendance and responsiveness.

As per the DIP, this project did not choose to use the positive deviance model to showcase mothers who are demonstrating positive household health practices for key messages. Nor is it using demonstrations, modeling, practicing with on-site activities (learning by doing), or any other interactive exercises on a regular schedule. The issue of literacy has been addressed to some extent through the use of leaflets and posters

for non-literate and semi-literate populations. Small- scale audio and video tapes have been developed for dengue and malaria.

Regarding the information system flow, it seems like the most important points at which decisions for behavior change can have the most impact have been either left out or insufficiently involved in the process.

> *Recommendation*
>
> The project may wish to consider reviewing the type, quality, amount and consistency of data and information that is being collected from the community and provided back to the community on a regular basis for facilitating behavior change.

Information is systematically fed back into the community so they can make community health decisions and facilitate additional behavior change, however additional guidance is needed in non-VHC villages. Villages with VHC do community diagnosis and health problem identification and planning for health problem solving. This information is then shared with the community, who then make an action plan to solve the health problems that have been identified, and take action. CRS provides KPC and LQAS feedback information to the community structures for use in health planning. For a detailed discussion of the MIS, please refer to the Information Management section under Program Management below.

> *Recommendation*
>
> The project may wish to consider teaching non-VHC communities how to interpret, analyze and use their data for informing their own processes and for community health decision-making and behavior change activities.

The project is in the process of adopting the BEHAVE Model and some of the staff participated in an intensive training in Siem Reap, Cambodia during a CRS regional training earlier this year. They have subsequently developed an agenda to share this training with the rest of the CRS staff, however only part of that training has been accomplished to date. It was reported that the remaining items will be covered in the next few weeks. While this model is a good choice for this project, due to the weak capacity of the staff in the area of BCC, there remains a question as to whether the staff will be able to apply this model to their current work. Thus it is suggested that they receive additional training and support on BCC.

Regardless of the model chosen, the overall strategy could be reworked in order to effect the sustainable behavior change that the project is attempting to secure. While the staff is trying their best to utilize the skills and materials they have, there is still a need for significantly increasing the types of media and the methods for delivery with community members.

It is suggested that the project consider hiring an expert BCC consultant to help rework the behavior change strategy and train the staff in how to implement it, including use of new types of tools, media and adult training techniques.

> *Recommendation*
>
> The project may wish to consider using a social marketing approach to scale up project activities.

Social marketing makes use of marketing principles and strategies to achieve social goals, such as better health, hygiene and sanitation. A social marketing approach may involve a partnership between the public sector and manufacturers to both expand the product market and promote improved health and hygiene.

Social marketing strategies would really enhance the project's strategy for behavior change. Below is some information from the CDC website on social marketing. PSI also does extensive social marketing, and it might be helpful to meet with them in Cambodia and discuss possible applications of social marketing within this project.

Centers for Disease Control and Prevention, U. S. A.
http://www.cdc.gov/communication/practice/socialmarketing.htm
"To "sell" healthy behavior, social marketing starts with audience research that leads to the segmentation of the target audience into groups with common risk behaviors, motivations, and information channel preferences. Key audience segments can then be reached with a mix of intervention strategies informed by the "4 P's" of marketing:

- **Product:** what the consumer is asked to "buy" (often a behavior),
- **Price:** the actual cost or something the consumer must give up/ do in order to obtain the product,
- **Place:** how and where the product reaches the consumer, and
- **Promotion:** how information about the product is disseminated.

The idea is to make the product attractive, reasonably priced, and conveniently accessible. These product characteristics are promoted to consumers with persuasive messages sent through channels of information that are popular with the target audience. The "marketing mix" is continually refined on the basis of consumer feedback.

Many of the campaigns summarized on the Campaigns-at-a-glance chart on the CDC website employ social marketing strategies. In addition, CDC developed its own brand of social marketing, *Prevention Marketing*. *Prevention Marketing* involves community representatives and stakeholders in all steps of the marketing process."

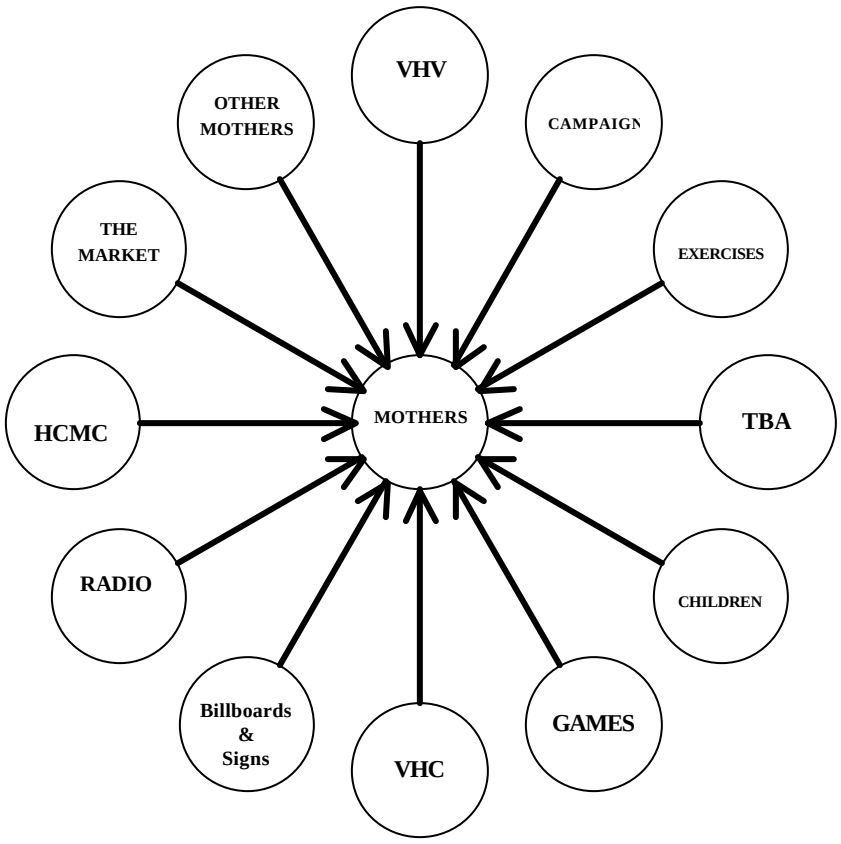
For accelerated scale-up, the project could ensure that beneficiaries are receiving the key messages in a plethora of formats, media and from every direction. The idea is to "bombard" mothers and children with key messages everywhere they go…when they are washing clothing, listening to the radio, attending health education sessions, visiting with other mothers, watching community theater, singing educational songs, going to the market, listening to their children when they come home from school or when they

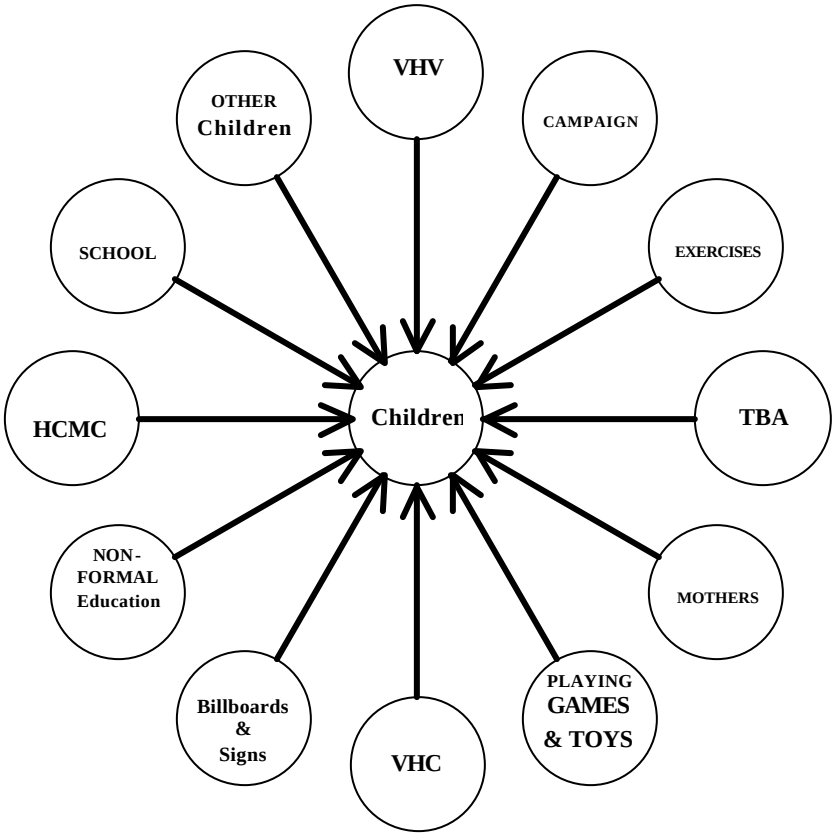
have participated in non-formal education sessions, going to the health center, receiving a home visit by a VHV or TBA, etc.

Wherever they go, they are receiving messages, both overtly and subliminally. They are seeing the desired behaviors modeled by other community members, and they are practicing them at health education sessions. For several months at a time, this activity could be directed at mothers and primary caretakers so the messages begin to become automatic and "known".

Recommendation

The project may wish to consider "bombarding" target beneficiaries with key messages using various media so that they taste it, see it, smell it, feel it, hear it so often it becomes "the norm", and becomes integrated into daily behavior at the household level.


VHV
OTHER MOTHERS
CAMPAIGN
THE MARKET
EXERCISES
HCMC
MOTHERS
TBA
RADIO
CHILDREN
Billboards & Signs
VHC
GAMES


VHV
OTHER Children
CAMPAIGN
SCHOOL
EXERCISES
HCMC
Children
TBA
NON-FORMAL Education
MOTHERS
Billboards & Signs
VHC
PLAYING GAMES & TOYS

Pre-positioning health commodities within the community will also help to reinforce these messages, so that when a child has diarrhea, everyone **knows** that they need to go to the VHV or VHC and get some ORS, even the children.

Interaction and delivery of key messages is accomplished by assessing:

- Methods, materials
- If the messages are getting through
- What message is getting through
- When are they getting through
- Where does it get through
- Why is it getting through
- Results, impact, behavior change

Examples of activities and roles of community structures for scale-up are summarized below.

HCMC – Campaign mobilization related to health center services including IMCI, fees, and increasing utilization of the health center

VHC – Campaign, WATSAN projects, health education, problem solving and community planning, modeling key behaviors, facilitating youth involvement (perhaps have youth as members of VHC to help organize the children – it gives them something to do, gets them organized, provides early training for them, and provides a measure of sustainability), pre-positioning of health commodities (ORS, bed nets and re-treatment chemicals, condoms, etc.), community mobilization

VHV and TBA – health education, home visits for both well and sick kids, referral and follow up (to and from health center), modeling key behaviors, pre-positioning of health commodities, checklists, community mobilization

Mother's Groups – Peer to peer and group training and sharing, possibly using positive deviants and modeling key behaviors, demonstrations (learning by doing), community mobilization

Children's Groups – Child to child learning, positive deviants and modeling key behaviors, demonstrations, delivery of key messages to community through songs, drama, theater, role play, playing, health toys, etc.

Recommendation

The project may wish to consider adding mother's groups and children's groups to the community structures, and targeting them with key messages using various media and formats on a regular basis.

No Missed Opportunities

The project may wish to ensure that there are NO MISSED OPPORTUNITIES for health education and message delivery to clients in order to achieve the objectives set out in the DIP. This means that every opportunity is used to provide information, education and health services to community members.

> *Recommendation*
>
> The project may wish to focus on NO MISSED OPPORTUNITIES for health education and key message delivery to project beneficiaries.

When clients come to the health center, the average wait is around 30 minutes to see a health care provider. However, during the waiting period, information is not currently being provided to the public other than for triage. In the health centers we visited during the MTE, approximately 8 - 10 mothers and 15 children were in the waiting area. There exists an excellent opportunity to develop a strategy to fully utilize this time and provide health education and commodities to mothers and children during this waiting period.

One of the mothers we interviewed stated that she has been living about 20 kilometers from the health center for the last three years. She was working in the field with her husband and children when one of the children became ill with fever. She walked 10 kilometers to her village, where she tried to care for her sick son. When he did not recover within 2-3 days, she walked another 10 kilometers (upon the advice of a neighbor woman) to the closest town with a health facility. She didn't know where the health center was located, and so when she arrived at the town she saw a sign for the health center and came directly here.

It was pouring rain outside, with roads so muddy that the vehicles were slipping and sliding, and this mother walked 10 kilometers to this site with her sick child on her back and two additional children in tow. She reported having never received previous information from a health care worker or community structure (VHC, VHV, TBA), and she didn't know what to do when her child was sick and so received information from a neighbor. Luckily somehow this neighbor had received appropriate care seeking information, and was able to advise this mother correctly.

This is an interesting case study and the project may wish to consider doing some *market research* on how people in the area get information, where they go for information, how they hear about news and happenings, and what influences them to act on this information. This mother obviously cares deeply for her child and went through the mud and rain many miles to seek care for her sick son. This is the kind of behavior that the project may wish to affect in order to increase appropriate home care and care seeking behavior.

The project may want to consider addressing the issue of reaching these difficult to access populations who were previously refugees but who have now returned to this

area to live and farm. They are existing in extremely remote areas where land is still available (albeit with land mines), but where no infrastructure or health services are currently available. The project might wish to consider assisting the health facilities to develop and extend outreach opportunities to deliver services to this population in desperate need – perhaps through market days or other activities that don't endanger the CRS or health center staff.

Health Education Methods, Tools and Curriculum

During the MTE it was reported that the staff spends a large amount of time engaged in curriculum development and lesson planning. They have a basic training plan for teaching community structures how to provide effective health education, including identifying predisposing factors, enabling factors, and reinforcing factors, topic selection, role play, practice, demonstration, case study, group mobilization, process evaluation, impact evaluation, and lesson plan development.

While this is a really good start, it could be continued and reinforced considerably. It was reported that most community structures were not yet able to use this information fully and develop their own lesson plans around the key messages, or assist the community in identifying enabling factors through role play.

The MTE also revealed that the CRS staff is mostly just doing FGD and not engaging in other forms of education including those listed above. Examples of potential options include Flannelgraphs, Child-To-Child Resources, Tools for Community Participation (PHAST), Community Mapping, Community Theater, among others. These and many more are available from various projects and from TALC (Teaching Aids at Low Cost - http://www.talcuk.org/).

visual aids - something seen e. g. posters, flannelgraphs, slides, flip charts
audio aids - something heard e. g. songs or stories
audio-visual aids - something seen and heard e.g. films, video, drama
models and games - something touched or played with

One of the midwives sang several songs for this consultant, stating that she had developed them with others and was encouraging uptake and utilization of this medium at the community level.

Songs by Chantorn

VHV *We are VHV working for the health center to provide health education with our income/incentive to help the people to refer and report the disease to health center and educate mothers how to take care of their children, and collect children for vaccination.*
TBA *We are TBA working as TBA we should always wash our hands before touching patients. Materials and supplies should be clean. We are TBA, we work in communities successfully since 2001 in the new district and now we have experience on how to decrease mortality and morbidity in the communities.*
Infection Control *For infection control we work with HIV/AIDS infected people and the song we want to sing is the information about transmission of this disease and that there's no medicine for treatment, and people will spread the disease by prostitution, needles and sexual encounters with many partners, and mother to child. We share with people information on how to prevent the spread of HIV/AIDS.*
Philippines *It's me, it's you, it's us who build community* *It's me, it's you, it's us who build community* *It's me, it's you, it's us who build community* *La la la la, roll over the ocean, roll over the sea* *Go and do your part to build community!*

Recommendation

The project may wish to expand its use of tools and resources for message delivery, and may want to consider those mentioned in this report, as well as other available materials.

c. Capacity Building Approach

This section discusses the progress made in implementing the capacity strengthening plans outlined in the DIP. This includes plans for the PVO, the government partners, and community-based partners, and how this progress affects the project's vision of and plans for sustainability as described in the DIP.

The project has a very extensive training plan in the DIP, and to date they have achieved most of what was scheduled for the first 2 ½ years.

Government Partners

This external consultant was impressed with the amount of work that has been accomplished to date. This project is fortunate to be implementing in an area where CRS has already been working for years, which provided a great foundation to facilitate success.

CRS demonstrates a nice, healthy relationship with the government, and it is impressive that three government health officials participated in this evaluation for the duration! It

was a big advantage to have them with us. It is apparent that everyone has worked for a long time to build these relationships, and the benefits are now showing.

During the MTE it was reported that there are still some problems between the government and CRS at times, however, both sides seem to solve these conflicts without issue. Both CRS and the government staff expressed an interest in learning more skills for conflict resolution to ensure smooth functioning in the future, especially in light of the potential accelerated scale-up of project activities followed by a phase out of CRS staff and full handover to government staff and community structures.

CRS staff may wish to play an assertive role in working with the OD to improve the quality of supervision and possibly help them look at redesigning their supervision activities, and then to provide technical assistance and training to OD staff so that each supervisor has the skills and ability to fully function independently, and to provide comprehensive supervision and support on all issues for example to two health centers each on a weekly basis, and to possibly provide occasional support to the health centers when they do supervision with community structures. The government may also initially need some financial assistance to facilitate this change.

The project is using IMCI to strengthen health worker performance. Observation checklists, pre and post testing, and supervision are being used to appropriately and cost-effectively assess performance, and this has been very effective. Assessment results have guided additional training and supervision in order to continue increasing quality of care in health facilities, and to bridge the gaps between performance standards and actual performance.

IMCI will be established and could be rapidly scaled up in the Samphov Loun OD health centers. These health centers may wish to consider implementing a six-month acceleration scale-up plan to ensure quality services at all health facilities.

The facility IMCI is working well in Bovel District in terms of assessment, classification and treatment, however counseling could be improved. Once counseling has been strengthened, Bovel District could be used as a living university to capitalize on hard won success and ensure future sustainability of quality health services.

Community Partners

The community component of this program is built on a foundation of community structures. VHV and HCMC are mandated by the Government of Cambodia (GOC), and established in the project areas with the assistance of this child survival project. TBA are independent private practitioners that are accepted by the government. VHC have been established by the child survival project and CRS, and are an accepted sub-committee of the VDC, recognized by the Ministry of Rural Development as a village development structure.

Each of these structures has a clearly defined role, responsibilities, and methods for their establishment and governance. The DIP states that "community structures will receive training and technical assistance on self-management to develop, implement, monitor, evaluate and sustain community-based primary health care/CBIMCI and child survival interventions in the community, and on health topics and IEC methodologies and other methodologies for achievement of the expected outcome for the interventions".

To date, most of these structures have now been established, and are working on various levels of governance issues including bylaws, and how to interact with other existing community structures, with the community at large, and with the health facility in their area. They are also dealing with issues such as how to replace members who leave the structure voluntarily, as well as those who are not high functioning in their roles.

CRS continues to provide technical assistance to these structures through the use of monitoring tools such as observation checklists and through monthly meetings where data is exchanged and training on additional governance and health education issues is provided. While an attempt has been made to ensure that the outcome from these trainings is highly knowledgeable community structures and staff, this has not resulted in the desired impact of significantly improved home care, increased utilization of health centers or considerably higher use of community health care workers.

The community PHC could continue to use the structures it has built, however it could use a new and more assertive behavior change strategy that includes multimedia and multifaceted approaches to change behavior, in order to increase demand for and utilization of quality health services from both village health workers and health centers.

PVO

The CRS staff of this project is extremely interested in learning and growing professionally. They are committed to putting in the time necessary to build their capacity.

However, while they have made tremendous progress to date, there are still some areas where they need to make significant improvements in fairly quickly in order for them to be able to function more effectively, demonstrate significant impact, generate future funding, and design additional projects. For a list of CRS staff training needs please refer to the Staff Training Section under Program Management.

The project recently hired a local NGO to conduct an organizational assessment of the Battambang Community Based Primary Health Care Program. The program was not satisfied with the results of this assessment and has subsequently requested revisions of the final report due to problems with how the assessment was completed and their feeling that the report was of poor quality. It was felt that the local NGO did not have the

skills required, nor did they complete the necessary evaluative activities in order to have drawn the conclusions they did.

Localization, while an important goal of the program, could continue in areas of staff growth and capacity building. However, it may be necessary to scale down the pace of other activities at this point in order to focus on achieving successful project impact (measured by the indicators in the DIP).

Staff capacity is still low in some areas that will be important for an independent NGO to function successfully in, especially given the very competitive funding environment in Cambodia. Additional time and resources may be needed in the future to fully accomplish this goal. For more details, please see the Staff Training Section.

In the meantime, this project can continue to provide a training ground for the staff to learn and grow, ultimately leading them to successful localization.

To fulfill this goal, the program may wish to consider external assistance in a potential reorganization of the structure of the project and ultimately the NGO. It would be advantageous to decentralize the authority and decision-making responsibilities in order for the project/organization to function more effectively and efficiently, thereby accomplishing much more in a shorter period of time, without sacrificing quality.

As discussed and suggested by the staff during the MTE, the project may want to consider establishing and/or moving a project office (management) closer to the field, thereby having a functional office much closer to the sites where the project wants to demonstrate impact. The issue of staffing may need to be reassessed in light of the suggested changes for program implementation during the second half of the life of this project. It may be more advantageous to move staff from Bovel to Samphov Loun District, and to relocate staff to the field for varying lengths of time in order to provide more concentrated technical support to each community. For additional information on these issues, please see the Program Management Section.

d. Sustainability Strategy

As stated in the DIP, “The sustainability strategy of the project consist of three components: (1) the organizational development of communities and community structures, (2) strengthening the institutional capacity of health centers and operational districts for the improvement of management and quality of the health services, and (3) investing in the capacity of CRS national staff to continue to develop, maintain and expand the Community Based Primary Health Care Program through transforming the present CRS program into a viable local organization”.

To date, most of the community structures have been established and are minimally functional, however, they need to be strengthened considerably if they are to have a significant impact on behavior change at the community level and be sustained in the future.

To date, the institutional capacity of the government is in the process of being strengthened through this project. The quality of services has begun to increase, as has the management capacity of the Operational District staff and the health center staff.

To date, the project has invested in the training and capacity building of CRS national staff, however improvements in capacity are still needed in order for the staff to be able to expand the program and transform itself into a viable local organization.

Due to the large number of activities the project has taken on, it is suggested that a review of activities and a prioritization exercise be undertaken in order to successfully achieve the targets (indicators) stated in the DIP. This could mean slowing down localization activities at the current time and focusing on child survival project activities. Localization activities could then take priority once CRS begins to phase out of project activities in the final year of the project.

The project has begun developing the groundwork for an exit strategy with project staff and local partners, but this will need to be refined into a specific plan in the second half of the project. Currently, the strategy revolves around developing OD skills for training and supervision of health center staff, developing capacity of health center staff for service delivery including IMCI, and building capacity of the community structures to manage PHC activities in their communities and obtain health center services as well.

> *Recommendation*
>
> The project could now begin developing the groundwork for an exit strategy with project staff and local partners.

No approaches have yet been implemented to build financial sustainability (ex. local level financing, cost recovery, resource diversification, or corporate sponsorships).

> *Recommendation*
>
> The project may wish to consider developing and implementing an approach to build financial sustainability (ex. cost recovery, micro-enterprise, income generation).

To date, the community has not been involved in a dialogue regarding sustaining project services through alternative funding sources at the close of the project.

> *Recommendation*
>
> The project may with to consider engaging the community in a dialogue regarding sustaining project services through alternative funding sources at the close of the project.

C. Program Management

This section provides an overall discussion of program management issues, at HQ, within the field program, with partners and with the community. An assessment of the strengths and weaknesses of the management support systems, i.e., planning, financial management, information management, personnel management, supervision, training, and logistics are detailed below, along with recommendations on how these systems can function more effectively.

As has been previously articulated in this report, the project was very ambitious and attempted to not only complete the activities listed in the DIP, but to add several additional cross-cutting activities funded by other donors. At the time of this MTE, it was generally discussed and agreed that the project has taken on too much and can not possibly complete everything with the same desired level of quality and depth.

Therefore, the project needs to make some decisions about what can be dropped, those activities that can be scaled back, and those that need to be scaled up in order to reach the project objectives detailed in the DIP. All of the following sections have been written in light of the need for a possible accelerated scale-up of child survival project activities over the next eighteen months, followed by a systematic phase-out of CRS staff from these activities that government and community structure staff will then completely assume by the end of the life of this project.

1. Planning

As reported in the DIP, and subsequently by project and government staff during the MTE, all levels of CRS project staff and PHD, OD, health facility staff and members of community structures have been actively involved in project planning. This includes participation in the DIP process, and subsequent involvement in annual, quarterly, monthly, bi-weekly and often daily planning.
For a more detailed discussion of the MIS and data use for planning, please refer to the Management Information Section.

During the MTE, it was reported that the CRS staff spend anywhere from 15 minutes to 1 hour every morning meeting on issues for the day, issues from the previous day, logistics and transportation for the day, and any other issues that need to be shared with the staff.

While the program does copious amounts of planning, they do not always stick to these plans for a number of reasons, and must constantly readjust the schedule on a regular basis to ensure that all structures receive the information, training and technical assistance they need to function effectively in their roles. It was reported that the system for working with field staff is erratic and changeable daily, weekly and monthly, and that it is difficult to evaluate how the field project officers and the area managers do their jobs because they are constantly changing their schedules. It was felt that a more

consistent approach to working would produce better results in a more timely and efficient manner. The staff is very capable, knowledgeable, and clear on their jobs and responsibilities, however they stated that the lack of consistent working methods was found to be difficult, de-motivating and frustrating.

It is unclear why plans need to change so much that a bi-weekly plan is not sufficient to manage this project, especially given that the project has already been in operation for 2 ½ years. It was reported that government staff and community members sometimes have other commitments (meetings, harvesting, etc.) and so they are not available for CRS staff to work with as previously scheduled.

However, if this is the major cause of daily changes in the work plan, then CRS may wish to find more creative and reliable planning methods with their counterparts. If weather and roads cause major disruptions in project implementation, then contingency planning could become a permanent part of the planning process, thus eliminating the need for constant revisions, which are both time consuming and disruptive. If contingency plans were used, then project staff would refer to the contingency plan in this case and implementation would continue without disruption. It would be more effective to do less planning and more implementing.

If staff need to attend weekly meetings, it might, for example, be more advantageous to have one staff member from Samphov Loun OD (or Battambang District if a field office is established in that project site) come to the Battambang staff meeting and then report back to the rest of the field staff, who would remain in the field and continue working. This might be feasible if staff were to spend two weeks in the field and then return for 4-5 days off, combining both weekends into a long furlough every other weekend. The program staff may wish to consider trying different options to see what works best for different people and/or project sites and activities.

Recommendation

CRS staff may wish to consider a bi-weekly plan that is a general guide for the activities needing to be accomplished during the following two-week period of time, and then adjust this plan according to the daily realities encountered in the field and the contingency plan in place.

Recommendation

CRS staff may wish to consider creating a weekly logistics and transportation plan and stick to it as closely as possible, allowing for the above necessary changes as adjusted for daily realities in the field, and relying on the contingency plan when necessary.

Recommendation

CRS staff may wish to consider having a regular staff meeting once a week for 1-2 hours depending on the agenda and the amount of information that needs to be covered and/or shared. Meetings each morning are redundant and take precious time away from fieldwork.

As reported during the focus group discussions from the various partners included in the project, it appears that government staff, community members and CRS staff all understand the objectives of the child survival project. However, some of the community members were not aware that CRS was responsible for this project. While CRS staff understands the objectives of the project, there seems to be a lack of clarity on how to achieve the project objectives and this appears to be more of an issue with staff capacity building than project planning. All project partners reported having a copy of the project objectives in English and the objectives and indicators translated into Khmer, the local language.

The project is following the work plan in the DIP very closely, and most activities are on schedule, as planned.

2. Staff Training

The staff of this project is extremely interested in learning and growing professionally. They are committed to putting in the time necessary to build their capacity. However, while they have made tremendous progress to date, there are still some areas where they need to make improvements in for them to be able to function more effectively, demonstrate significant impact, generate future funding, and design additional projects.

Throughout the MTE, the issue of language was raised to ensure that all participants fully understood the directions, discussions and outcomes. In spite of this effort, on numerous occasions the results produced during small group work did not match the directions provided. Clarification was requested to evaluate whether the issue was language or lack of capacity. While the staff often refused the offer for translation to clarify directions and discussions, after several of the exercises there was a general complaint that the instructions provided were not clear.

After the MTE field work was completed, and upon returning to the Battambang Office, all further discussions were translated. For successful localization, it will be important for the staff to be proficient in both oral and written English. Proficiency in English will also help the staff better utilize the child survival and health tools and resources that are currently available through this program, through the internet, and often free of charge through other donors.

The Technical Advisor, through her long-term relationship with the staff for the past 5+ years has provided strong leadership, training and capacity building for the staff. She has strong skills in several areas, and has provided much of the necessary TA for the first 2 ½ years on this project as she provides 50% of her time on the Community Based Primary Health Care Program. Almost no other child survival project has benefited from having an external Technical Advisor assigned at 50% time to a project.

There remains a need for technical assistance on behavior change, community mobilization, social marketing, and other areas as identified in the findings from the MTE. The issue of increasing staff capacity to self-manage, and to become independent as a local NGO will also need to be addressed. The project may wish to consider phasing out the role of the Program Advisor and assuming increasing responsibility over the program themselves.

> *Recommendation*
>
> The project may wish to consider phasing out the role of the Program Advisor and assuming increasing responsibility over the program themselves.

With several issues remaining problematic, it is recommended that for additional technical assistance the project consider using short term contracts with specialists in the areas where specific needs have been identified and where technical assistance, training and/or tools are required.

> *Recommendation*
>
> For future technical assistance on very specific technical, programmatic and management needs, the project may wish to consider hiring short-term consultants and/or specialists to provide training and TA.

CRS staff has already been trained on the following areas:

- KPC, LQAS and PRA
- Data Entry and Analysis
- Facility IMCI (and supervision)
- Standard Case Management (ARI, CDD, Malaria)
- Technical Assistance and Monitoring
- Financial Management
- Training of Trainers
- Drug Management
- National Immunization Program (new policies and the cold chain)
- Bed Net Impregnation
- Health Planning (quarterly and annually) (Facility and Community)
- Behavior Change Communication (in process)
- Vitamin A
- Information Gathering and Problem Solving – Community Diagnosis

Performance is monitored through supervision using checklists and observation of skill sets.

However, staff capacity is still low in some areas that are needed for this child survival project to demonstrate significant impact, and will also be important for localization as well. Wherever possible, government staff could be included in learning, as they exhibit the same capacity building needs.

Recommendation

The project may wish to consider additional training and/or TA in the following areas for CRS and government staff:

- Data Analysis and Use
- Behavior Change
- Teaching Methods for Adults and Children
- Computer Systems, Windows, WORD, and EXCEL or another spreadsheet
- Social Marketing
- Internet Use for Development and Distance Learning
- How to Adapt and Use Information and Technical Resources (applied)
- Program Management
- Conflict Resolution
- English Language Skills (Oral and Written)

Additional financial resources may need to be shifted in order to fulfill the needs of the staff in these capacity areas.

3. Supervision of Program Staff

Supervision of project staff is done through a tiered process.

- The Program Advisor is responsible for providing overall technical assistance to the project. (50% time)

- The Program Manager has overall responsibility for the child survival project. (80%)

- There are three area managers, each with a special focus (community, facility, and MCH/HIV/AIDS) – and they all cover both Bovel and Samphov Loun OD. (100%) C/I Manager – 85%, Village Activities Manager – 85%, MCH/HIV/AIDS – 55%, and Admin/MIS – 80%

- The project has two Senior Project Officers in Samphov Loun District, who take responsibility for HIV/AIDS 80% and child survival/MCH 20%. One works at the Referral Hospital and the other at the health center with beds. One of these team leaders assists with coordination

- The two field teams (one team in Bovel and one team in Samphov Loun OD) each consist of two Midwife Project Officers and four Field Project Officers. Project Officers are 75% child survival, while the Midwife Project Officers are 70% child survival. Both project officers also work for the HIV/AIDS Project

The Field Project Officers work independently, with guidance and support from the Area Managers. The Senior Project Officers provide leadership in the field to coordinate among the team, for urgent matters and when problems arise. The Area Managers provide feedback on planning tools and activities, and occasional technical assistance

and supervision in the field. During the MTE, it was reported that they also provide direct technical assistance (along with CRS Field Project Officers) to government staff at health facilities and with community structures. However, the Field Project Officers feel that they need more help from the Area Managers. The Area Managers feel they need to spend more time in the field supervising, supporting and providing technical assistance to the Field Project Officers. Everyone is in agreement, and yet the information was not being communicated between these two groups.

It was reported that currently, the Area Managers spend anywhere from 30 – 50% of their time in the office, and the remaining time in the field, while Field Project Officers spend about 90% of their time in the field and 10% in the office.

In light of the need for accelerated scale-up of project activities, rather than providing direct technical assistance to health facility staff, for example, it might be more effective for the Area Managers to work exclusively with CRS Field Project Officers who would then provide direct technical assistance to government staff at health facilities, and to community structures for mobilization, health education and other activities.

Perhaps the project may wish to consider changing how the Area Managers function, so that they become 100% trainers of CRS staff, increasing capacity, supervising, providing support and helping them do their jobs with 100% quality and quantity. This would improve the capacity of the CRS staff tremendously and ensure sustainability during localization. It would also make the Field Project Officers better able to work with the project partners for greater impact. The Area Managers could "shadow" the Field Project Officers after providing training, to observe them in action, and later provide feedback to improve performance. They could also jump in and help out when issues arise, or when additional hands are needed for training and partner capacity building.

Recommendation

For the duration of this project, the project may wish to consider having Area Managers spend 80% of their time in the field providing (direct) support, supervision and technical assistance to the Field Project Officers.

Recommendation

The project may wish to consider reviewing and revising the supervision strategy for the project, including workload, time management, communication, tools, and resources/logistics. A thorough review and indexing of staff needs and skills could also be included, so peer-to-peer supervision and other creative approaches may be considered where appropriate, cost effective and where they can contribute to sustainability.

The Field Project Officers, while able to work independently on activities where they posses good capacity, still have areas of low capacity where they need more support and reinforcement from Area Managers. The Area Managers need to be able to provide this support and reinforcement, but they don't necessarily have all the skills and capacity they need in order to support the Field Project Officers.

Recommendation

The project may wish to consider additional training on supervision and management skills for Area Managers and Field Project Officers for capacity building of staff and partners.

It continues to be important for field staff to feel empowered to do their jobs and make decisions about their work, while also receiving guidance and redirection when they demonstrate a lack of capacity, skill or results. This is equally as important with the Area Managers and the Program Manager.

4. Human Resources and Staff Management

Given the low capacity of the staff in several areas at the start of the project, it appears that the Program Advisor, while in theory was supposed to be providing technical assistance only, in reality has been managing much of the project for the duration. Given the situation, this was a logical role to play. However, in relation to the goals of the project for localization and increased staff capacity, the project may now wish to consider phasing out the Program Manager position and assuming increased responsibility over the project management and activities.

During the MTE, all project staff were interviewed regarding their jobs, how they did them, the training they received, workload, and many other questions around roles, responsibilities and how the project functioned. Based on interviews and observation of the group in action for two full weeks, the following issues were identified:

- Empowerment
- Staff Capacity and Skills
- Decentralization of Decision-Making Authority
- Field Offices Needed
- Workload

The project recently hired a local NGO to conduct an organizational assessment of the Battambang Community Based Primary Health Care Child Survival Project. The project was not satisfied with the results of this assessment and has subsequently requested revisions of the final report due to problems with how the assessment was completed. During the MTE it was stated that the staff felt the NGO who did the assessment did not have the skills required, nor did they complete the necessary evaluative activities in order to have drawn the conclusions they did. A copy of the initial report was made available during the MTE, however the final version is still not available. A request for the recommendations from that report were not forthcoming to be included in this MTE report. Upon review of the initial report during the MTE, this consultant agreed with the recommendations drafted therein.

In light of the need for accelerated scale-up of project activities, and due to the need for the staff to feel empowered and increase their management capacity for this project as well as their future local NGO, the project may want to bring in a management review team relatively soon to help them work through what they want their NGO management structure to look like.

Recommendation

The project may wish to consider decentralizing the organization chart so that the Area Managers have authority for decision-making equal to the Program Manager, while each continues to have their own responsibilities commensurate with their skills and expertise.

All key personnel policies and procedures are in place and there are job descriptions for all positions in this child survival project, for CRS staff, for the PQSD, for government partners, and for community structures.

There has been very little staff turnover in this project, with only one person being replaced to date. Staff retention has not been an issue during this project.

The project has as one of its goals to become a local NGO. The main reason for the goal is to sustain the work of the managers and staff for the continuation of the CBPHC Program in Cambodia, which will facilitate staff transition to another paying job when this child survival project ends.

5. Financial Management

This project has been extremely ambitious and has obtained funding from several donors for various activities which have all been integrated in to the CRS/Battambang Community Based Primary Health Care Program. These include water and sanitation, HIV/AIDS, MCH, child survival and dengue fever. Implementing the integration of these various activities into one program has been challenging in terms of financial management due to each of the several different funding sources requiring completely unique reporting formats and time frames. It was reported that the project was audited within the last year, however, the report is not yet available from the auditor.

During the MTE, comments were repeatedly made regarding a lack of available resources in order to make changes or for follow-up on recommendations for the child survival project. The project may wish to review the budget line items and possibly move funding within line items to free up resources for necessary project changes and activities.

The Program Manager is ultimately responsible for all financial management in the CRS Battambang Office. He spends at least 1 – 2 hours per day dealing with financial issues. He also has an accountant and a cashier who both work full time on the CBPHCP.

How the Money Flows

The field project officer requests advances of money for field activities (as detailed in the project plans), and the request goes through the area manager to ensure it is an appropriate expense and for subsequent approval, and then to the program manager for approval, and then sent to the accountant for preparing the voucher. Then it goes to the Admin/MIS Administrator to verify the amount, etc., then the goes back to the program manager for final approval and signature and then it goes to the cashier who prepares a withdrawal slip against the proper account, then sends it back to the program manager (or advisor in the absence of the Program Manager) a third time for a final review and recalculation to assure correctness and then he signs the withdrawal slip and sends it back to the cashier with the bank book and then the bank book and withdrawal slip to the bank and withdraws the money. Using three different currencies makes things confusing and sometimes difficult to balance the budget due to exchange rates. Support also comes from the CRS Phnom Penh Office.

Cash is used for per diems for training participants in the field, and by field project officers to purchase some urgent supplies in the field. Most supplies are purchased in Battambang and taken out to the field. Sometimes project officers are reimbursed for expenses if they need something urgently in the field.

After the money has been used, a liquidation form is completed against expenses by the field project officer, and then send it to area manager for verification, and then it's sent to the program manager for verification and final approval. The Admin/MIS Officer approves requests for office supplies from the Admin staff. Then it is sent to the accountant to put into a template. The template is reviewed weekly by the Admin Manager (with spot checks by the program manager) to check expenses against accounts. Books are closed monthly, reports are compiled and sent to Phnom Penh, original kept here and photocopy sent.

Recommendation

The project may wish to consider reviewing the financial management system with the CRS country office in Phnom Penh, and revising the system so that it fully meets the requirements of CRS AND the needs of an independent local NGO with financial accounting requirements and audits of its own. The system should be safe, efficient and streamlined, dispensing with unnecessary duplication, but ensuring accountability.

6. Logistics

The only logistical issue that has impacted the implementation of the DIP budget to date was the purchase of a vehicle that the government refused to give tax exemption for.

The program reported that they are not experiencing any problems with the procurement of equipment and supplies.

The program has a system for distribution of supplies and equipment, along with stringent documentation procedures for both CRS and the health facilities. Information on distributions is also provided to the OD, PHD and community structures.

Logistics challenges the program will face during the remainder of the project include the following:

Samphov Loun is supposed to get ADD budget, but this is not always consistent. Bovel health centers do not get ADD.

NIP – Bovel does not have a budget from the MOH to support outreach, which could become a problem. With past funding, CRS has been able to provide some support for this, but these funds will be depleted by the end of this year. This raises a serious issue regarding sustainability, which the program should review.

Bed net impregnation – CRS had funding for this activity up until the present time, but will have to find new funding for this activity for the remainder of the project. The issue of sustainability also needs to be addressed here.

Funding for water and sanitation decreased due to the completion of a contract with one donor. This donor is ceasing to provide funding in Cambodia to any NGOs.

Requests from community structures for transportation equipment can not be met as CRS does not have available funds. However, CRS should attempt to help communities address the need for transportation in more sustainable ways.

7. Information Management

In September 2003, Alfonso Rosales PQSD-Health Unit Technical Advisor visited the CRS/Battambang Community Based Primary Health Care Child Survival Project to provide technical (TA) support on the revision of the Management Information System. His findings concluded the following, which the MTE consultant is in full agreement with.

- Currently, the MIS is collecting data which is included in the health center information system. Community data is not being included in the project monitoring system. Instead, this information is being collected through period surveys including LQAS, KPC and occasional focus group discussions.

- Regarding the information system flow, it seems like the most important points at which decisions can have the most impact have been either left out or insufficiently involved in the process. Information is systematically fed back into the community, but without substantial guidance as to how to use the information. Therefore, in practice the community is limited in the decision making process.

- For information usage purposes, the elaboration of procedures in the decision making process would be something useful and relevant. This would imply the definition of health event indicators by operational level. Thus, there would be a set of simple health indicators to be assessed by community members, and upon this appraisal a decision would be taken. The same would be done for the management level. This would facilitate the behavior of analyzing the information and acting upon it. Decision taking, at certain levels, is a norm that has to be learned.

- Data collection tools currently being utilized at the community level need to be adapted to the level of population literacy. It was reported that there were problems evidenced by this evaluation in terms of validity of the information collected due to inability to use the collection tools.

- It is suggested that the project consider implementing follow-up sessions on data collection tools utilization for field program officers.

Therefore, it is suggested that the project hire a monitoring and evaluation consultant to review the current HIS, and provide recommendations on how to simplify the system and make the data more manageable and usable for program management.

Communities

For community structures, various reporting forms are now in place collecting large quantities of process data regarding the numbers of trainings that have taken place, the number of people trained, the number of topics trained on, and other variables. The collection of this data is a huge accomplishment, and fills the MIS with data, however, the program does not fully utilize this data in the most efficient or effective way.

The project has not yet completed any additional assessments, however, it plans to do so in the second half of the life of this project.

8. Technical and Administrative Support

The project is supported at 50% time by the Regional Program Advisor.

The CRS Cambodia Country Director provides 20% support to this program, and visits the program site every three months. He also provides assistance with reporting, financial management, networking, collaboration and problem solving with the local USAID Mission, and with other NGOs.

In light of the need for accelerated scale up of project activities over the next eighteen months, the project will require the following additional technical assistance and may wish to consider hiring short-term consultants or specialists to fulfill these needs:

- Data Analysis and Use

- Behavior Change
- Teaching Methods for Adults and Children
- Computer Systems, Windows, WORD, and EXCEL or another spreadsheet
- Social Marketing
- Internet Use for Development and Distance Learning
- How to Adapt and Use Information and Technical Resources (applied)
- Program Management
- English Language Skills (Oral and Written)

The headquarters technical backstop or PQSD provides technical assistance to this child survival project. That person has changed since the inception of the program, however HQ has provided consistent backstopping throughout the life of the project to date (Dr. Anwar to Dr. Alfonso Rosales). A technical backstop has visited this project three times in 2 ½ years. A backstop was involved in the writing of the application, and actively involved in preparing the DIP. A backstop provided training to the staff on various topics, and facilitated CSTS to provide training on LQAS and the KPC. Currently, Alfonso Rosales keeps in close contact through regular emails, and sends technical material on a monthly basis. He will visit the project at least two more times, and will be involved in facilitating the Final Evaluation in August 2006.

D. Other Issues Identified by the Team

This external consultant was impressed with the amount of work that has been accomplished to date. This project is fortunate to be implementing in an area where CRS has already been working for years, which provided a great foundation to facilitate success. CRS demonstrates a nice, healthy relationship with the government, and it is impressive that three high-ranking government staff have been participating in this evaluation for the duration! It is a big advantage to have them here with us. It is apparent that everyone has worked for a long time to build these relationships, and the benefits are now showing.

There are still some problems between the government and CRS at times however both sides seem to solve these conflicts without issue. Both CRS and the government staff expressed an interest in learning more skills for conflict resolution to ensure smooth functioning in the future, especially in light of the need for accelerated scale up of project activities followed by a phase out of CRS staff and full handover to government staff and community structures.

CRS has demonstrated the ability to work at the policy level informing national, provincial and district health policy in Cambodia. This is of tremendous importance to the credibility of the CRS Battambang Office, and of the future role the local NGO can play in the policy arena. The following are a few examples of CRS health policy involvement.

- Development of the Cambodian Primary Health Care Policy and Guidelines as representative of MEDICAM (NGO coordinating body)

- Development of Community Participation Guidelines for MEDICAM
- CRS has been actively involved in the Working Group on IMCI assisting the government (national, PHD, OD and health facility levels) to develop IMCI as the integrated approach to child health in Cambodia
- Participation in working group on C-IMCI
- Participation in development of VHV criteria for Battambang Province
- Participation in development of national protocol for Vitamin A
- Participation with government and NGOs in development of TBA curriculum

For localization, it will be important to develop a strategy to continue influencing policy in the province, country and even at the region level. This can easily become one of the commodities which the NGO can "sell" as a prime activity bringing in funding and helping to expand both services and reach. The government is very receptive to learning, and clear about their capacity and their resources, and they are looking to CRS for technical and financial support.

CRS should continue to work closely with the government to provide assistance with their processes in order to make them more efficient and effective. Currently, CRS is a little reluctant to challenge the government on some of its processes. However, without CRS assistance (or some other donor), the government will not be able to make substantial changes and dramatically move forward with expanding IMCI and other approaches for sustainable health impact of the population. This consultant is challenging CRS to be more assertive in the policy work they do with the government. She believes that the government will not only be receptive, but thankful for the assistance, technical support and bright ideas, as the government is looking to CRS to bring these resources and information that they do not otherwise have access to. For example, during the MTE it was learned that in Samphov Loun District, the OD has two teams of supervisors with three people on each team. Together the team visits each health center once a month. However, the government stated that supervision was a problem and needed to be increased to be more effective.

PVOs have an important role to play in influencing policy to improve health and decrease morbidity and mortality in every developing country, including Cambodia.

Recommendation

The staff may wish to consider developing a strategy for influencing policy at all levels once they have achieved localization.

E. Conclusions and Recommendations

Conclusions

The CRS/Battambang Community-Based Primary Health Care Child Survival Project has just completed the first half of the project. To date, the project has completed a tremendous amount of work, and has accomplished nearly everything they set out to do within the first 2 ½ years of the DIP.

During the MTE general discussion, however, there was agreement that the project has taken on too much and can not possibly complete everything with the same desired level of quality and depth. Therefore, the project needs to make some decisions and prioritize the activities that will be scaled up during the next eighteen months, followed by phase-out during the final year of the child survival project. It was reported that the other donor activities (WATSAN, HIV/AIDS) are being evaluated independently on a regular basis.

This project may wish to focus on accelerated scale-up of IMCI at the facility level, and the development and implementation of a behavior change strategy for both the health facilities and community structures. It will also need to decide at what level localization activities can proceed in light of the health center and community needs of this project.

The CRS staff is very committed, hard-working, loyal and open to learning and growing. In the field, they work very closely as a team, toiling in a very harsh environment with rain, mud, almost impassable roads, land mines, and under extremely difficult circumstances for very long hours often 6-7 days a week with little time off.

For almost all of the staff, Battambang, where they are all located for this project, is very far from their homes and their families, and most of them only see their families for a few days per month. One of them joked that his children didn't know his face when he returned home once a month for just a couple of days. Another one stated that each time she came home her child asked when she was leaving again.

Unfortunately, Cambodians have few employment options where they are able to choose more comfortable and convenient work environments. Having been refugees themselves, this external evaluator was amazed and in awe of the incredible hardship that the staff of this program routinely face. There was nothing to do but applaud their amazing tenacity, and support them in their efforts to learn and grow personally and professionally. They will surely triumph in the face of sheer drive!

The project has three goals:

1. Health Center IMCI

2. Community PHC

3. Localization/NGO Status

The **facility IMCI** is working well in Bovel District in terms of assessment, classification and treatment, however counseling is weak. Once the issue of counseling is strengthened, Bovel District could be used as a living university to capitalize on hard won success and ensure future sustainability of quality health services.

IMCI will be established and could be rapidly scaled up in Samphov Loun OD. Samphov Loun OD may wish to consider implementing a six-month accelerated scale-up plan to ensure quality services at all health facilities.

The **community PHC** could continue to use the structures it has built, however it needs a new and more assertive behavior change strategy that includes, for example, multimedia and multifaceted approaches to change behavior, in order to increase demand for and utilization of quality health services from both village health workers and health facilities. In order to accomplish this, the staff suggested that it may be necessary to move a project office (management) closer to the field, thereby having a functional office much closer to the sites where the project wants to demonstrate impact. The issue of staffing could be reassessed in light of the suggested changes for program implementation during the second half of the life of this project. It may be more advantageous to move staff from Bovel to Samphov Loun OD, and to relocate staff to the field for varying lengths of time in order to provide more concentrated technical support to each community.

Localization, while an important goal of the program, could continue in areas of staff growth and capacity building. However, it may be necessary to scale down the pace of other activities at this point in order to focus on achieving successful project impact (measured by the indicators in the DIP). Staff capacity is still low in some areas that will be important for an independent NGO to function successfully in a very competitive funding environment. Additional time and resources may be needed in the future to fully accomplish this goal. In the meantime, this project can continue to provide a training ground for the staff to learn and grow, ultimately leading them to successful localization. To fulfill this goal, the program may wish to consider external assistance in a potential reorganization of the structure of the project and ultimately the NGO. It would be advantageous to decentralize the authority and decision-making responsibilities in order for the project/organization to function more effectively and efficiently, thereby accomplishing much more in a shorter period of time, without sacrificing quality.

Recommendations

Program

- CRS could continue working closely with the OD to help facilitate a reorganization of OD supervisory systems for health facilities, ensuring efficient and effective use of resources to provide maximum coverage on a continuing basis for phase out and sustainability.

- CRS could continue working closely with the OD to help facilitate a possible reorganization of the OD drug supply management system, and the policies around stocking adequate supplies of pharmaceuticals at the health centers to bridge time gaps.

- CRS is encouraged to work closely with the microfinance department of their organization and other NGOs, and with the PHD, OD and local groups / community structures to investigate possible income generating activities that might cross-subsidize health center services and staff.

- The project may wish to consider allowing for a three-month planning phase, followed by an accelerated six-month scale-up plan for IMCI at all health centers in Bovel and Samphov Loun Districts.

- The project may wish to establish and/or strengthen a functional referral system between communities and health centers which incorporates the above list of items.

- The project may wish to consider refocusing their efforts exclusively on WRA and children < 5 years in order to achieve the objectives set out in the DIP.

- The project may wish to consider training community structures on adult learning techniques, and providing them with more interactive materials and tools.

- The project may wish to consider pre-positioning health commodities in villages through HCMC/VHC/VHV/TBA (and mother's groups) to greatly increase access, use and healthy behaviors. This can be done as an income generating activity to provide incentive to community health workers.

- The project may wish to work intensively with community structures to provide additional training on HOW to interact with and deliver key messages to target beneficiaries.

- The project may wish to work intensively with community structures to supervise them with THEIR provision of supervision and support for follow-up with target beneficiaries on key messages.

- The project may wish to consider using the checklists as memory aids for health center and community structures and staff to facilitate a sustained level of high quality and quantity of services.

- The project may wish to consider using the Bovel health centers as living universities where health staff from other districts may come to learn, practice and observe facility-based IMCI in action.

- The project may wish to investigate the major and minor barriers for community participation and mobilization, and rectify them wherever possible through creative programming (doing outreach mobilization in the fields where people are working!) and problem solving.

- The project may wish to explore the use of various tools and resources to integrate as many different types of media as possible for key message delivery to affect behavior change.

- CRS and government staff need to provide the community structures with a regular schedule for supervision IN THE COMMUNITY to ensure consistent, quality message delivery.

- CRS could consider working with the community structures to develop a regular schedule for delivery of health education sessions for target beneficiaries, including occasional well home visits to households.

- CRS may consider working with community structures to ensure that they are reaching 100% of the target beneficiaries with health education on key messages ON A REGULAR BASIS.

- The project may wish to consider reviewing the type, quality, amount and consistency of data and information that is being collected from the community and provided back to the community on a regular basis to facilitate behavior change.

- The project may wish to consider teaching non-VHC communities how to interpret, analyze and use their data for informing their own processes and for community health decision-making and behavior change activities.

- The project may wish to consider using a social marketing approach to scale up project activities.

- The project may wish to consider “bombarding” target beneficiaries with key messages using various media so that they taste it, see it, smell it, feel it, hear it so often it becomes “the norm”, and becomes integrated into daily behavior at the household level.

- The project may wish to consider adding mother's groups and children's groups to the community structures, and targeting them with key messages using various media and formats on a regular basis.

- The project may wish to focus on NO MISSED OPPORTUNITIES for health education and key message delivery to project beneficiaries.

- The project may wish to expand its use of tools and resources for message delivery, and may want to consider those mentioned in this report, as well as other available materials.

- The project could now begin developing the groundwork for an exit strategy with project staff and local partners.

- The project may wish to consider developing and implementing an approach to build financial sustainability (ex. cost recovery, micro-enterprise, income generation).

- The project may wish to consider engaging the community in a dialogue regarding sustaining project services through alternative funding sources at the close of the project.

Management / Staff

- CRS staff may wish to consider a bi-weekly plan that is a general guide for the activities needing to be accomplished during the following two-week period of time, and then adjust this plan according to the daily realities encountered in the field and the contingency plan in place.

- CRS staff may wish to consider creating a weekly logistics and transportation plan and stick to it as closely as possible, allowing for the above necessary changes as adjusted for daily realities in the field, and relying on the contingency plan when necessary.

- CRS staff may wish to consider having a regular staff meeting once a week for 1-2 hours depending on the agenda and the amount of information that needs to be covered and/or shared. Meetings each morning are redundant and take precious time away from fieldwork.

- The project may wish to consider phasing out the role of the Program Advisor and assuming increasing responsibility over the program themselves.

- For future technical assistance on very specific technical, programmatic and management needs, the project may wish to consider hiring short-term consultants and/or specialists to provide training and TA. This could be done with the funding saved by reducing the % of the Technical Advisor.

- CRS and government staff could receive additional training and/or TA in the following areas:
  - Data Analysis and Use
  - Behavior Change
  - Teaching Methods for Adults and Children
  - Computer Systems, Windows, WORD, and EXCEL or another spreadsheet
  - Social Marketing
  - Internet Use for Development and Distance Learning
  - How to Adapt and Use Information and Technical Resources (applied)
  - Program Management
  - Conflict Resolution
  - English Language Skills (Oral and Written)

- For the duration of this project, the project may wish to consider having Area Managers spend 80% of their time in the field providing (direct) support, supervision and technical assistance to the Field Project Officers.

- The project may wish to consider reviewing and revising the supervision strategy for the project, including workload, time management, communication, tools, and resources/logistics. A thorough review and indexing of staff needs and skills could also be included, so peer-to-peer supervision and other creative approaches may be considered where appropriate, cost effective and where they can contribute to sustainability.

- The project may wish to consider additional training on supervision and management skills for Area Managers and Field Project Officers for capacity building of staff and partners.

- The project may wish to consider decentralizing the organization chart so that the Area Managers have authority for decision-making equal to the Program Manager, while each continues to have their own responsibilities commensurate with their skills and expertise.

- The project may wish to consider reviewing the financial management system with the CRS country office in Phnom Penh, and revising the system so that it fully meets the requirements of CRS AND the needs of an independent local NGO with financial accounting requirements and audits of its own. The system should be safe, efficient and streamlined, dispensing with unnecessary duplication, but ensuring accountability.

- The staff may wish to consider developing a strategy for influencing policy at all levels once they have achieved localization.

F. Results Highlight

Malaria Prevention:

The Samphov Loun Operational District (OD), population **81,198**, in **131** villages poses a problem for impregnated bed net malaria prevention due to the large numbers of migrants seeking seasonal and cross border work. However, CRS, working with village health workers, local authorities, health center and OD staff with additional focus on migrants and residents living in the fields, in May 2004, impregnated 34,633 bed nets for 14,140 families for 84% of the families. CRS' November 2003 LQAS survey found that 98% of pregnant women and children under 5 were sleeping under impregnated bed nets at night.

Improved Health Care Service for children under 5 through Facility IMCI

Use of facility-based IMCI has improved health care for children under five for common illness and has increased health center utilization in 8 Bovel District Health Centers serving 12,830 children under 5. Prior to this, assessment and classification of patients was incomplete, too many medicines in inadequate amounts were provided and little counseling was done. In collaboration with the Communicable Disease Department (CDC) of the MOH, CRS supported the training of PHD and OD directors and Technical Advisory Group and CRS as trainers in November 2002 and as supervisors in March 2003. PHD, OD and CRS with the MOH trained 30% of the Bovel staff in 2003 and the OD began doing monthly supervision. Monthly meetings are held with the Thmor Kol Vice-Director and CRS with health center staff to solve problems. CRS provides technical assistance using their IMCI checklist. The remaining 30% of Bovel staff completed training in September 2003. Although, there is still room for improvement, assessment, classification, treatment and counseling have all progressed. In July 2004, the training of the staff from the 8 Samphov Loun OD health centers will be completed and implementation will be started. CRS will use lessons learned in Bovel in the implementation of IMCI in Samphov Loun.

CBPHC model:

The CBPHCP model combines capacity building and support for the community structures and community while strengthening health center management and services in a good model for improving child health services and care and support for PLHA. Through the model of an integrated approach, MPA health center management (accounts, infection control, drug management, HIS, and health planning) as well as care for children through IMCI and for PLHA through prophylaxis and treatment of OIs, counseling, referral and support for home care can be improved. At the same time target groups in communities through community structures receive C-IMCI key messages, awareness for the general public and those at most at risk for HIV (youth and migrants) but also develop the capacity to solve their own primary health problems, provide community based home care and support for PLHA. BCC can be carried out as water and sanitation needs are addressed by the community. Community input into health center management increases utilization and community –health center solidarity and income. Linkages between community structures and health centers, including support for outreach activities strengthens all the activities. CRS acknowledges that

there is still a lot of work to do and some changes need to be made to improve especially the behavior change communication within the model however feel that the model has already shown it potential.

ANNEXES

Annex 1

Summary of Baseline Assessments from the DIP

The summary findings are presented in narrative and CSTS format.

Vaccination

- 55% of mothers reported that their children received a dose of vitamin A in last six months.
- 46% of children 12-23 months had complete vaccinations having a card. However, it dropped down to 24% if all children 11-23 months are considered.
- 64% of children 12-23 months with a card had received measles vaccine. Coverage for measles dropped down to 34% if all children 11-23 months with or without cards are considered.

Prevalence and practices of common health problems

- 50% of the mothers were able to identify at least two signs of childhood illness that indicate need for treatment.
- 67% of children were reported to have a cough in past two weeks.
- 47% of children experienced cough with difficult breathing/fast breathing/short, quick breaths symptoms.
- 47% of the children reported to have diarrhea.
- 6% of mothers of children age 12-23 months reported that they wash their hands with soap/ash before food preparation, after defecation, and after attending to a child who has defecated.
- 20% of mothers reported that they increased fluids and gave same or more food during diarrhea in the past two weeks.
- 58% of children reported to have experienced fever.
- 97% of children age 0-23 months who slept under an insecticide-treated mosquito net the previous night in New districts which are malaria zone.

Maternal Care

- 45% of mothers of children age 0-11 months recalled that they received at least two TT injections before the birth of their youngest child.
- 42% of births were attended by skilled health personnel.

Nutrition

- 28% of children suffered from –2SD from the median weight of the WHO/NCHS reference.
- 97% of mothers reported that they are currently breastfeeding. Fifteen percent of mothers reported initiating breastfeeding immediately or within first hour. 81% of mothers reported that they fed the liquid that comes out of the breast during the first three days after delivery.
- 75% of mothers reported that they had given something to their infants to drink before initiating breastfeeding.
- 12% of mothers exclusively breastfed in last 24 hours (among 0-5 months old infants).
- 89% of infants age 6-9 months received both breast milk and complementary food.

Health Contact and Source of Information

- One-third of mothers get their general information or advise on health from husband, mother/mother-in-law and elders. Another 20% from various types of health providers, while 50% reported no consultation.
- In the past month, major sources for health messages for mothers were radio (33%), TV (35%) and TBAs (14%).

Key Findings Health Provider Competencies Survey

- All of the respondents have a full knowledge of types of vaccination and their schedule.
- 50% or less of health providers had a competency score of 50% for history taking from mothers having a child with cough, indicating that they were performing half of their required tasks.
- A median score of 67% for examination competence for cough symptoms showed that 50% or more health providers checked about 2/3 of the required signs during examination.
- A median competency score of 50% for counseling for respiratory infection indicated that 50% of the providers gave half or less of the messages to the mothers.
- 52% of the health providers stated that they had enough supply of antibiotics during last month, indicating that insufficient supply of antibiotics could hinder their ability to treat pneumonia.
- An average competency score to take history from mothers having child with diarrhea was 75%, indicating 25% of the tasks were not performed.
- 65% was the mean score for competency in assessing signs of dehydration.
- On average, health providers gave 2 out of 4 (50%) messages during counseling for diarrhea management
- 50% or more of the workers asked 70% of the required questions during malaria history taking and conducted tasks during examination.
- 50% or more of the health providers gave 6 out of ten messages during malaria counseling.
- 50% or more of the health providers told that they received malaria supplies 60% of the times.
- Forty-eight percent of the health providers stated that mothers should exclusively breast feed for four months
- 50% or more of the respondents could describe 2 out of 5 questions for history taking on breastfeeding. None asked about the history of taking medicine or alcohol as well as asking her to repeat message for increased understanding and memory.
- 73% of the providers said that vitamin A is part of the nutritional counseling message
- 95% of the health providers described availability f place, water, soap and clean towel for hand washing.
- 50% or more health providers described availability of chloramine and other disinfecting material.
- 50% or more health providers described half the number of tasks for sterilization by autoclave.
- 50% or more health providers described 60% of the tasks for waste disposal at health centers

Annex 2

Team Members and Their Titles

(all participants were interviewed and/or contacted)

The following individuals participated in the midterm evaluation and many were involved in writing and/or editing the midterm evaluation report:

1. Della Dash	Consultant, External Evaluator
2. Alfonso Rosales	CRS PQSD/Health
3. Lori Dostal	CRS Health Program Advisor/Regional Health Tech. Advisor
4. Heng Bunsieth	CRS CBPHCP Health Program Manager
5. Mop Pheun	CRS Clinical / Institutional Area Manager
6. Moul Vanna	CRS MCH/HIV/AIDS Area Manager
7. Mok Samoeun	CRS Village / Community Area Manager
8. Sok Buntoeun	CRS MIS/Admin Manager
9. Chhoun Sovann	CRS Senior Project Officer/Samphov Loun OD Team Leader
10. Rith Saray	CRS Senior Project Officer
11. Thlang Sovann	CRS Community Project Officer
12. Ly Chhean	CRS Community Project Officer
13. Touch Sam Ol	CRS Community Project Officer
14. Hun Youm	CRS Community Project Assistant
15. Siv Kosal	CRS Community Project Officer
16. Song Chanthy	CRS Community Project Officer
17. Mai Hong	CRS Community Project Officer
18. Heng Hean	CRS Community Project Officer
19. Sim Sophea	CRS Midwife Project Officer
20. Bou Sakun	CRS Midwife Project Officer
21. Kong Chanthorn	CRS Midwife Project Officer
22. Oum Buntha	CRS Midwife Project Assistant
23. Dr. Koy Sok	Vice Director, Provincial Health Department, Battambang Province
24. Dr. Saint Chinhan	Vice Director, Thmor Kol Operational District, Battambang Province
25. Dr. Pann Sam Kol	Vice Director, Sampho Loun Operational District, Battambang Province
26. Dr. Andre Tanoe	Health Program Manager, CRS Indonesia
27. Dr. Meas Pheng	Project Director, Child Survival Project, ADRA Cambodia

Annex 3

Assessment Methodology

The midterm evaluation was conducted using a fully participatory approach which included all project staff in the design, implementation, analysis and recommendation phases of the evaluation. A full schedule and daily agendas can be found in the annexes of this report, along with a list of exercises, activities and games used to facilitate the work.

The purpose of choosing a completely participatory method for conducting this midterm evaluation was twofold.

a. The project has as one of its goals to become an independent NGO
b. The project aims to establish and strengthen facility and community structures

It was determined that the most effective way to evaluate the capacity of the local CRS staff to plan, implement, monitor and evaluate the program was to involve them in each of these steps and determine their strengths and weaknesses, and make recommendations on how to improve their ability to manage the challenges they will face as a new and independent organization.

Evaluating the processes being used to achieve the objectives set out in the DIP was the second goal of this evaluation.

The evaluation was initiated using various team building exercises and activities aimed at breaking down barriers and encouraging full and honest participation by everyone involved. There was a continuous effort to include the entire team throughout the evaluation. Specific exercises were developed and implemented in small group work for each of the following areas, for both the community and facility levels. See results of small group exercises in the annexes below.

Expectations: identify weak points, strengths, where are we now? Where do we want to go? What needs to be done? What are the constraints? How to make it better, participation, enough time to collect all info, complete the evaluation as planned, recommendations, personal and professional growth.

Ground rules: start and finish on time, participation, silence mobile phones, listening and respect each other, questions for clarification, feel safe and trust each other, constructive criticism, no interruptions, translate as needed, talk slow.

Battambang Team Presentations: Format: mapping, data against targets, strengths, weaknesses, constraints and challenges, recommendations, discussion.

a. First presentation by Heng Bunsieth (health program manager): an overview of Battambang health program. Program areas in Battambang.

b. Second presentation by Map Phoeun (clinic manager): an overview of clinical intervention of the program.
c. Third presentation by Mok Samoeun (Village activity manager): an overview of community activities.
d. Fourth presentation by Moul Vanna (MCH/HIV-AIDS manager): an overview of immunization intervention/MCH activities/HIV-AIDS activities.

Discussion of presentations: The group decided to break into 4 groups (2 community and two facilities) to define the Implementation process in the community related to behavioral change for preventive related activities, care-seeking behavior, and home-care behavior; the facility group would concentrate in defining the process in terms of behavioral change of health personnel. Based upon implementation process, external evaluator would develop focus groups guidelines for community and HF. Health facility would use checklists already developed by MOH.

Process definition: during this process the participants would define and describe the various process implemented at health facility and community level. The health facility definition process is described in the last section done the previous day.

Research question development: the participants broke into four groups. Two groups were asked to identify process-related information needs at the health facility level; and two groups at the community level. After the team presentations, the consultant with the group synthesized information needs into a table with three main themes for each level: governance, communication/training process, and practices. A smaller group then analyzed the information presented by participants and using the synthesis chart developed by consultant in the previous session developed the FGD guide. Research teams to conduct and collect information during the FGD would use this guide. The consultant led the presentation, discussion and practice of FGD guidelines with the research teams. The research teams (community and facility) had the opportunity to practice with the tool and comment/ clarify any doubts on its application.

Field Work – Focus Group Discussions (FGD) and Home Visits

Data Compilation and Translation of Field Work by CRS staff and government partners

Data Analysis (FGD, Home Visits, HFA, KPC/LQAS X2) – in small groups of staff.

Development of Recommendations – using the HFA, LQAS and FGD data in small groups, then as a plenary.

MTE Presentation for Program Partners, and Feedback, with small group work.

The issue of language was raised repeatedly to ensure that all participants fully understood the directions, discussions and outcomes. In spite of this effort, on numerous occasions the results produced during small group work did not match the directions provided. Clarification was requested to evaluate whether the issue was

language or lack of capacity. While the staff often refused the offer for translation to clarify directions and discussions, after several of the exercises there was a general complaint that the instructions provided were not clear. After the field work was completed, and upon returning to the Battambang Office, all further discussions were translated. Where appropriate, information from each of these sessions is included in the discussion and/or recommendations for each objective of the program.

Recommendation

The project should consider providing English language training for all staff members to ensure proficiency and facilitate effective functioning within the wider development community

Annex 4

Midterm Evaluation Agenda

Day 1 – Monday, June 14, 2004

AM

Introductions
Expectations
Ground Rules
Consensus and Decision-Making
Trust
Inspiration and Challenge
Presentation of Current Program – by Area Managers

PM

Discussion of Presentation
Defining Implementation Processes (related to behavior change)

Day 2 – Tuesday, June 15, 2004

AM

Problem Identification
Problem Analysis

PM

Development of Research Questions
Preparation for Field Work

Day 3 – Wednesday, June 16, 2004

AM

Preparation for Field Work

PM

Field Work – Focus Group Discussions and Home Visits (see attached schedule)

Day 4 – Thursday, June 17, 2004
Field Work – Focus Group Discussions and Home Visits (see attached schedule)

Day 5 – Friday, June 18, 2004
Field Work – Focus Group Discussions and Home Visits (see attached schedule)

Day 6 – Saturday, June 19, 2004

AM

Travel back to Battambang

PM

Data Compilation and Translation

Day 7 – Sunday, June 20, 2004
Data Compilation and Translation

Day 8 – Monday, June 21, 2004

Data Compilation and Translation

Day 9 – Tuesday, June 22, 2004

AM

FGD Debrief
Data Analysis (FGD, Home Visits, HFA, KPC/LQAS)
Development of Recommendations

PM

Data Analysis (FGD, Home Visits, HFA, KPC/LQAS)
Development of Recommendations

Day 10 – Wednesday, June 23, 2004

AM

Data Analysis (FGD, Home Visits, HFA, KPC/LQAS)
Development of Recommendations

PM

Team Leader Presented Overview of Preliminary Findings and Recommendations

Day 11 – Thursday, June 24, 2004

AM

Presentation Preparation

PM

MTE Presentation for Program Partners, and Feedback

Games

- Human Knot
- Yurt Circle
- Stand Off
- Helium Stick
- Killer
- Shoe Factory
- Circle Sit
- "A What"
- Pass the Apple
- Back to Back

Supplies Needed

- Flip chart paper
- Colored markers
- White board and markers
- Candy and goodies

Resources

1. Quicksilver: Adventure Games, Initiative Problems, Trust Activities and a Guide to Effective Leadership by Karl Rohnke
2. Group Process by Corey and Corey
3. Technical Resource Materials By CSTS
4. Request for Applications (RFA) by USAID
5. The New Games Book by The New Games Foundation
6. More New Games Book by The New Games Foundation

Annex 5

Program Presentations by Area Managers

MCH/HIV/AIDS Component Presentation
Immunization Intervention for Child Survival - 25%

1. Why chosen -

- Coverage for fully immunized and TT2 still low in Cambodia and in the project areas. (A national survey showed that on 1/3 of children age 0 – 23 months had received all of their immunizations.) High drop out rates.
- In 3/4 districts routine immunizations for women and children did not exist until the MOH and Battambang PHD started polio and measles campaigns in 1997. CRS provided some support for these campaigns. Routine immunization activity did not really start until 1998. The whole process of managing and providing immunizations to women and children was new to the staff and to the community.
- Activities in the Bavel district were disrupted by limited access due to the war, land mines and difficult to access areas due to bad roads and rain.

2. KPC/DHS results:

Table 4.2.5: Immunization with Card - Comparison Cambodia DHS 2000 with CRS Survey 2001

Vaccines	DHS data	Combined districts	Bovel district	New districts
Cards	48%	56.2%	56.8%	55.7%
BCG	45.9%	82.9%	98.6%	68.7%
DPT 3	35.8%	65.1%	82.7%	48%
MEASLES	36.4%	63.9%	70.6%	57.3%
FULL IMMUNIZATION	31.6%	46%	66.6%	27.7%

TT Coverage by Number of TT Received before or during last Pregnancy Comparison of Cambodia DHS 2000 with CRS KPC Survey 2001

VACCINES	*DHS DATA*	COMBINED DISTRICTS	BOVEL DISTRICT	NEW DISTRICTS
TT1	14.3%	16.1%	13.1%	18.7%
TT2	30.0%	25.2%	31.4%	20.0%
TT2+	N/A	19.8%	14.5%	24.3%
Total	44.3%	45.1%	45.9%	44.3%
Total 2 & 2+ only	30.0%	45.1%	45.9%	44.3%

3. DIP Plan:

Result 1: Improved prevention of immunizable diseases.

Community Level:

IR 1: Increased percentage of mothers and pregnant women who keep immunization cards.

IR 2: Improved vaccine coverage for children < 2 years of age.

IR 3: Improved tetanus toxoid coverage for pregnant women.

Health Center Level:

IR 1: Improved management and technical quality of NIP (National Immunization Program) at the Health Center.

IR 2: Improved coverage of immunizations for children and pregnant women.

Indicators (Community and Health Center):

1. *Increase to 80% mothers with children less than 2 years of age who keep their immunization card.* **(KPC Result: 56%)**
2. *Increase to 80 % children under 2 years of age fully immunized in Bovel District* ***(KPC Result: 66%)*** *and 60% fully immunized in the New Districts (Samphov Loun, Phnom Prick, and Kam Reang)* **(KPC Result: 27%)**
3. *Increase to 65% pregnant women who have 2 TT before the birth of their baby by recall.* **(KPC Result: 45%)**
4. *Increase to 55% pregnant women who have TT2 before the birth of their baby by card.* **(KPC did not look at cards for TT2)**
5. *Increase 80% children 12-23 month who receive vitamin A the last 6 month*

Indicators (Community – only)

1. *Community structures show increase in knowledge of immunization management and health education messages by an increase in pre and post test scores by 20%.*
2. *50% Community structures reach acceptable level (70%) on HE checklist for providing health education on immunization to the community.*

Indicators (Health Center only)

1. *85% of health centers will have an acceptable level (75%) of quality of NIP service as measured by quality assurance checklists***.**

4. Strategy:

- Establishment of NIP systems in areas of migration and new settlement in the project site where immunization services did not exist.
- Health Center:
    1) Provision of technical assistance to Health Center - training, monitoring, evaluation, and follow-up for development and maintenance of management and technical skills.
    2) Strengthening the capacity of health center staff to collect and analyze immunization data and to formulate effective plans.
    3) Technical assistance to improve supervision of health center NIP activities.
    4) Provision of immunizations at selected health centers.
    5) Assist health center staff in the planning and organization of integrated community outreach activities.
- **Community level:**
    1) Develop the capacity of village health structures such as Village Health Committees (VHCs), Village Health Volunteers (VHVs), and Traditional Birth Attendants (TBAs) to organize and mobilize and provide education to their communities for immunization activities.
    2) Develop the community's capacity to obtain and analyze and monitor data needed for effective village level NIP management and community mobilization through the use of Village Health Registers and Records.
- **Linkage between Health Center and Community**:
    1) Health Center and Community work on increasing immunization coverage plan and activity together.
    2) Monthly meeting, Report

5. What has been done?

Health Center and Community:

- Education about importance of NIP

- Meeting every 2-month to analyze the coverage and solving problem.
- Finding misses children and record the problem during NIP activities.

Health Center:

- Annual, semi-annual, quarterly analysis and planning.
- Training on New guideline and Policy including refrigerator cold chain for NIP on management and technique
- Technical assistance by using checklist every 3 month.
- Check immunization card for all children less than 5 year and provide counseling to mother for keeping card and next immunization.
- Record miss children and send to community structure to find out.
- Integrate outreach for far distant village to provide NIP to children TT2, Iron to pregnant women.
- Vaccine is available in 8 HC for provide NIP and TT2 to children and pregnant women in HC.
- Monitor cold chain and request vaccine on time
- Provide information 3 days before hand to community structure
- Monthly report to OD
- Training on Vitamin A.
- CRS Support transportation and perdiem
- CRS Support IEC materials
- CRS Support equipment/ supply and medicine when MOH shortage
- CRS Support training and technical assistance
- CRS Support planning

Community:

- Village Health Register/ Village Health record to gather numbers of children and women who need immunizations in the community, organize, mobilize, analyze and plan for NIP activity.
- Training on NIP management
- Training on Vitamin A
- Report new child and new pregnant women to HC during NIP activity.
- Provide information to community and make sure information reach to community.

6. Results:

Description	**2002**	**2003**
Fully immunize	52%	60%
TT2 pregnant	40%	55%
Vitamin A	72%	88%
Keep card		97%

7. Strengths:

1. Regular routine and integrated activities (Immunization, Vitamin A, Iron and Mebendazole)
2. Vaccine available at 8 HC and reach to children for miss opportunity at village.
3. Most mothers and pregnant women bring card to immunize and using service in HC.
4. Mother and pregnant women participation.
5. Community structure link with HC staff on participation during activities.
6. Collaboration between PHD, OD, HC, CS and authority.

8. Constraints

1. New District started immunize on 1998.
2. Need continue to support provide technical assistance to HC.
3. Migrations difficult and in accessible during raining season.

4. Staff work by rotation

Complementary MCH Activities:

1. **Why important?**
   - High maternal mortality rates (437/100,000)
   - Infant mortality rates (95/1000)
   - Midwifes and TBA activities contribute to accomplishment of Child Survival and CS interventions:
     1) Immunizations
     2) Breast feeding
     3) Complementary Feeding
     4) Infant and child's health – safe delivery, newborn care, etc.
     5) Pregnant and post partum women's health – ANC, Delivery and Postpartum care and education
2. **What done:**

1. Training and providing technical assistance to Midwives on ANC, BF, and PNC by using checklist to improve quality services.
   Average scores: ANC: 78%
   PNC: 72%
   BF: 69%
2. Support and technical assistance to Midwives to improve effective health education and counseling to pregnant women on foods reach of Iron.
3. (210 TBA) in the program. Health center Midwives work with TBAs as partners.
4. Meeting and continue training every 2 month.
5. TBAs report activity to the health center what did they do in village # refer # birth # death # provide health education # use SHBK and problem that face in village in the meeting.
6. TBAs provide health education to mother, pregnant women on BF, ANC, PNC, complementary feeding, NIP, food reach of Vitamin A and Iron.
7. TBAs identify high-risk pregnant women and complicated delivery to refer to health center.
8. Existing Safe Home Birth Kit in 7-health centers to improve safe delivery.
9. CRS, health center and TBA conduct home visit with TBA to see behavior change after training by using checklist.
10. Support safe delivery supplies and Home Safe Birth kit to TBAs and HC.
11. Malaria screening to pregnant women in malaria zone.

3. **Results:**

Description	**2002**	**2003**
ANC	41%	47%
DL by TBA	72.3%	68.26%
DL by MW	25.7%	29.2%

LQAS Results:

- Keep ANC cared
  1) Have – 24%
  2) Lost – 30%
  3) Never had – 45.9%
- Knowledge of Danger Signs
  1) Fever, SOB, Bleeding, Edema – 42%
- Where seek care for danger signs
  1) Hospital – 19.5%
  2) HC – 55.16%

- Breast feeding
  1) First hour – 19.5%
  2) EBF - 6.4% (Sample too small to be significant)
- Pregnant women seek care for signs/symptoms of malaria
  1) 68.4% stated that they would seek care at the public facilities.
  2.8% at the hospital and 55.6% at the health centers.

HIV/AIDS Integrated Interventions:

1. Present situation in Cambodia/BTB

- Prevalence (2.6%)

	Cambodia	Battambang
ANC	2.8%	5.3%
Police	3.1%	2.3%
TB	8.4%	21%
IDSW	14.8%	12.3%
DSW	28.8%	10.1%

- Transmission (sexual and mother to child)
- Situation for prevention, care and support
  Health services not prepare well

2. Needs

- For decreasing HIV/AIDS
  1) Knowledge for prevention
  2) Behavior change
  3) Gender balance
  4) Reduce violence and women and child trafficking
  5) Dissemination information to Education, Women affair, Association.
- Health System needs
  1)Knowledge and skills for OD, hospital, HC
  2)Update information.
  - Community needs
    1) Knowledge
    2) Empowerment
  - PLHA/PAA /OVC
    1) Information about testing, OI prophylaxis and treatment
    2) Care and support
    3) HIV/AIDS Human rights
    4) Self support group
    5) Community suppor

3. Why CRS integrates?

CRS believe in utilization existing community structure and institutions instead of creating separate and unsustainable that can foster discrimination and dependency,
disrupt other health services and create unrealistic expectations regarding continued high level of support for HI/AIDS care.
When effectively integrated into existing community-based health programs HIV/AIDS interventions can provide people living with or affected by HIV/AIDS access to quality care that is affordable and comprehensive without disrupting the other care services.

4. How integrates – refer to HB diagram

5. What done?

HIV/AIDS Interventions:
Collaboration with NCHADS, PHD (PAO), OD, HC and local authorities to develop and support. Develop COC with District governors, Commune councils, OD, HC, Hospital, PLHA

Focus of the project:

1. HIV/AIDS awareness to community on prevention and reduce discrimination through community HE
2. Special events such as World AIDS Days and candlelight.
3. PRA for identify and education for risk group – youth, drug, migrants
4. Support to PLHA/ PAA and OVC
5. Self support group
6. Develop CBHCT
7. VCCT/PMTCT – pre and post test counseling, referral
8. TB/HIV/AIDS- identification and care
9. STI – education, treatment
10. OI treatment and prophylaxis
11. Build capacity at all levels
12. Community-based home care
13. Care and support at the HC, community, hospital and home

Referral Hospital and HC Activities:

Capacity building:

- Counseling
- Opportunistic infection
- STI symptomatic treatment at HC
- Lab for HIV
- Provide support and supervise to CBHCT members
- Assist in facilitating PRA with Community structure to identify and provide peer education to risk groups

Activities:

- Counseling in HC to identify suspected case and refer to VCCT
- Pre counseling and Post counseling
- Admitted for treatment of OI and prophylaxis
- Set up drug system for HC and RH
- Provide health education to patient come to use services.
- Assist and support for developing CBHCT, monitor, refill supplies, coordinate and facilitate meeting, training, problem solving, provide treat and care for severe ill patients at home and receive suspected case referred from CBHCT at HC and provide counseling and referral for VCCT.
- Technical assistance on classification and treatment for OIs and STI including partner treatment.

Community:

Capacity building:

- CBHCT receive basic training 8 days divide by 3 part and continue training and meeting every 2 month.

Activities:

- Community awareness and reduce discrimination through CS activity

- Special events World AIDS Days and candlelight
- PRA for identify and education on risk behavior.
- Selected key risk behavior training and support for peer education – youth, drug, migrants
- CBHCT – provide care, support, refer, teach families how to care, education to the community exist in 5 HC and in process 2 HC
- CBHCT identify the chronic and suspected cases and assess the situation of the patients and family for support/ care.

Linkages:

- NCHADS –
- PHD (PAO)
- OD
- HC and community
- COC
- HACC
- NGO

Health Facility Component Presentation

CRS is working in 2 Operational Districts (OD) in Battambang province
Thmor Kol OD (there are two districts Thmor Kol and Bovel district) but CRS is working with 7 MPA health centers and 1 health post in Bovel district. (Khnach Romeas, Bovel I, Bovel II, Prey Kpos, Lovea, Ampil Pram Deum, Kdol Tahen and Klang Meas)

Sampao Luon Operational District consisted of 3 administrative district: Kam Reang(Takrey, Kam Reang and Trang health center), Phnom Prik(Pichenda, Barang Thlak health centers and Chakrey Health Post) and Sam Pov Loun(Serey Mean Chey and Angkor Ban health centers) (Sampao Luon was a former Khmer Rouge area. CRS started work there since the end of 1996.

Total 16 health centers (14 MPA health centers including 2 Health centers with beds and 2 health posts)
CRS is also working in Sam Pov Loun Referral Hospital with 75 beds, adult 25 Pediatric 17, TB 10, surgery 13, delivery 10, laboratory service, X- ray

MPA Health center (Minimum Package of Activities) is the Health Care Reform with an emphasis on the implementation of Primary Health Care at health center level.

CRS work in health center focuses on:
- **Child Survival Project(ARI, CDD, malaria and NIP)**
- **Clinical/Technical Assistant services at Health Center**
- **Management services at health center**
- **Provision of materials and equipment**
- **Supervision**
- **Working collaboration / two prong approach strategy**
- **Provide health education at health center**
- **Strengthening health center (Develop HCMC)**
- **Integrated Management for Child Illness (IMCI)**
- **Phase out HC**
- **Successful program**

A. <u>Child Survival Project (ARI, CDD, Malaria and NIP)</u>
CRS health program in Battambang got Child Survival grand from USAID. Started in Oct 2001 – 2006.
Child Survival Project has four interventions in the CS project (ARI, CDD, Malaria and NIP).
CRS completed KPC survey, tabulation and results analysis.
CRS completed LQAS survey tabulation and analysis result.
CRS completed development of DIP and started to integrate the CS activities in to the quarterly health planning.

B. <u>Clinical/Technical Assistant services</u>

<u>Technical assistance:</u>
- Training of trainer at Operational District and health center level
- Training of health center staff on clinical and management topic
- Use checklist list to develop, monitor and maintain quality clinical care.
- Assistance to set up, maintain and monitor management system.
- Support to develop the effective outreach and health education.
- Training and Technical assistance to OD technical advisory group to improve training and management.
- CRS work to support health center staff to monitor and follow up to find out how HC staff use the knowledge and skills after training.
- CRS monitor and follow by using quality management checklist for staff performance.
- Demonstrate and practice with HC staff.
- Regular supervision base to the HC staff performance e.g. Infection control, the average score of checklist is 70%, if the score less than 70% CRS need to monitor more often than usual, when the score is 70% or higher CRS need to monitor every month 2 months.

- HC activities and results through Health Information System (HIS) report. The Health Information System including:
- Out Patient consultation (new case and number of consultation).
- Health Problem (new cases malaria ARI, CDD, DF, Chronic diseases, TB, skin infection, UTI, traffic accident, injury, mental health problems, anemia and malnutrition).
- Inpatient activities for referral hospital and Health center with beds

C. Management services

- Health planning and analysis
- Modules training
- Drug management.
- Health information system.(HIS)
- Linkage (health facility and community)
- Collaborate with government and NGOs.
- Account, drug, infection control management system

D.Provision of materials and equipment

- CRS provide technical assistance to Health center staff and provide equipment and materials only when OD or PHD do not affordable.
- CRS continue to replace the broken equipment if OD, PHD did not have available equipment.

E. supervision

- OD do Monthly supervision by using integrate checklist
- IMCI supervision every month.
- CRS staff always participated in OD supervision. The purpose to participate is to find out the results of supervision, problems solving and what can CRS help to solve or make improvement of the weakness.

F. Working collaboration / two prong approach strategy

- PHD / OD and HC level
- CRS share of CRS health planning including goal, objective, activities and discuss together to feedback and the agreement.
- CRS share the whole of the planning with PHD and OD if they understand they can't implement and support our plan.
- When CRS develop the new proposal we invited the community people, HC staff, OD and PHD to participate and input in to the proposal.
- After proposal approved by donor CRS worked together again to develop the plans.
- CRS participated and trained to HC and OD staff to develop health planning and analysis for quarterly, semi-annual and annual. Now all HC and OD able to do by themselves.
- CRS work together with staff to improve the working relationship with community through village health volunteer, traditional birth attendance and health center management committee. Through training, meeting and report.
- Organize linkage workshop with health center and community.
- Regular meeting for planning and problem solving between HC and community
- Collaborate of HC with local authority, other NGO within and outside are working in the community.
- Transparency and accountability of HC to community.
- HCMC development.
- HCMC basic and continued training.
- HC continue to train community structure
- HC and community integrated planning with quarterly analysis and action plan.

G. Provide health education at health center

- All HC trained on module 7 health education and how to use I.E.C.
- CRS provided health education to health center staff and develop the health education schedule, lesson plan and health education topic (ARI, CDD, Malaria)

H. Strengthening health center

Development of Health Center Management Committee (HCMC)

- Sustain the HC quality services and management

- Improve communication and linkages between HC and community
- Increases HC's resources and motivation
- Improve access to the poor
- There are 4 HC's that strengthened and developed HCMC and the other 3 new HC's are going to develop HCMC July 2004.

HCMC development process

1-Conduct meeting with OD

- CRS conducted meeting with vice OD director to explain the purpose, objective and process of HCMC development. During the meeting we shared the PHC guideline policy, MOH HCMC policy and CRS HCMC development model.
- After the meeting CRS and OD made the plan to meet with HC staff, the district governor and commune chief.

2- Conduct meeting with HC staff

- CRS and OD conducted the meeting with all HC staff to explain the purpose, objective and process of HCMC development, go through the PHC guideline policy, MOH HCMC policy and CRS HCMC development model.
- Meet district governor. Two objectives that we bring to discuss:
- Share the purpose, objective and process of HCMC development go through the PHD guideline policy, MOH HCMC policy and CRS HCMC development model.
- Asked support from district governor to set up the temporary election committee and to inform to commune and village authority about the HCMC election in commune.
- When district governor agreed to the plan and ask him to send the agreement letter to commune authority office.

3- Conduct meeting with commune counsel

- CRS and HC chief met with commune counsel. Three objectives that we'll be brought to discuss with commune counsel:
- Share the purpose, objective and process of HCMC development, go through the PHC guideline policy, MOH HCMC policy and CRS HCMC development model.
- Discuss to find out who is the best person should we invite to participate the workshop.
- Develop village level workshop plan
- We invite the commune counsel authorities to participate in the meeting. After the meeting the commune authorities agreed with the plan. When the plan is agreed, make the plan to invite village chiefs, VDC chief and VHV, VHC, TBA from each village to participate the workshop (set up a date for workshop)

4- Conduct village workshop/ Methodology:

- Organize the village workshop for one day to:
- Share the purpose, objective and process of HCMC development; go through the PHC guideline policy, MOH HCMC policy and CRS HCMC development model.
- Share the information of HCMC development to all families in the village.
- Organize place and villager for election
- Develop the leaflet to inform the information to villager.
- After the workshop finished for one day we conducted spot check to all villages to find out did villager received the information and how do they understand about the election of HCMC. All the villages received the information and know when to do the election of HCMC.
- Develop the schedule for election

5- Compile the election result:

- The election must include village name, candidates' name both male and female, age, average of people participation and the score result of each candidate.

6-The goal of HCMC development:

1. Improve quality of HC services
2. Provide quality control for delivery of MPA services
3. Improve overall management
4. Set CMCF policy agreeable to health provider and the user of HC services

5. Promote of transparency of HC budget operation and income
6. Increased sustainable of HC
7. Increased HC utilization
8. Increased resources for HC operation
9. Increased motivation of HC staff
10. Facilitate information flow from community to HC
11. Facilitate information from HC to community
12. Create system for community "OWNERS" of HC to participate in management and financing of their HC.

HCMC training topic

1. Health orientation
2. Role and Function
3. Bylaws
4. Report
5. Account system
6. Contract
7. Meeting
8. Problems analysis
9. Facilitation skills
10. Information gathering

Role of HCMC members:

1- Monitor health centeractivities, finance and provide community feedback to HC staff
2- set up HCMC policy, bylaw and contract including fee cost for health care services that are agreeable between health center and community.
3- Monitor and provide feedback on condition of HC facility and equipment.
4- Help to solve the problem at health center.
5- Promote HC service including the out reach activities.
6- Promote community feedback on quality health care services at health center.

IMCI Strategy:

- The MOH has decide to implement IMCI as the national strategy to improve care for children at health center level.
- CRS has been talking with MOH and WHO about implementation of IMCI in the project area and discuss with PHD and OD feel that it would be better to start with IMCI in some health center.
- CRS Support IMCI basic training course to 60% = 54 of health center staff in Bovel district, 25 health center staff in Sampov Loun district, IMCI TOT training to 1 PHD, 5 OD and 10 CRS trainers.
- IMCI is a strategy activities to take care the children under 5 years old, focus on child assessment, classification, treatment and mother/ care taker teaching/ counseling.
- CRS will support second IMCI basic training course on July 2004 for Health center staff in Sampov Loun district and will send some key staff to attend IMCI supervision training course in June 2004.
- MOH performed first IMCI supervision at Bovel district and OD continue to do every month.

Non strengthening health center

- CRS works to support them to provide the MPA health care services to the community as well as the strengthening HC..
- CRS and OD need time to build the staff capacity to manage and provide services quality and we need to have the system. Example: Account, Infection control and HIS first.

Phase out HC

- CRS phased out the activities at 4 health centers in Banan district by the end of 2003, the reason for phase out because HC staff are able to operate the services themselves and OD Battambang is able to provide support to HC regularly e.g. training, budget support, supervision and general problem solving.

Successful program

- HC able to conduct health planning and analysis
- HC able to work with HCMC, VHV and TBA
- HC able to generate income for operation
- **OD able to facilitate HC staff supervision and train to HC**

Constraints

- The IMCI did not start in New District because the staff (primary nurse, primary midwives, SN, SM) came to MOH Regional Training School in Battambang in order to have official certificate recognize by MOH.(MOH made this plan).

Community Based Primary Health Care Program
Mid term evaluation Presentation
by Mok Samoeun, Village Activities Manager
Date June 14, 2004

The CBPHCP (Child Survival Project) emphasis the importance of community involvement in health promotion, disease prevention and primary health care activities through

* Developing sustainable community structures
* Building the capacity of community structures (VHV, VHC, TBA) to carry out sustainable primary health care activities in the community
* Building the knowledge, skills and capacity of the community
* Linking community activities with health care services.

Village Activities – Specific Activities

* Develop VHVs and VHCs
* Capacity building for VHVs, VHCs, and TBAs
* Community awareness health promotion/Disease prevention by VHV, VHC, TBA
* Outreach Activities
* Village HIS
* Community Structures
* Village Projects
* Outbreak response
* Advocacy

Role of VHC

* Data collection and record in VHR
* HE – Key message – C-IMCI
* Referral
* Village Projects
* Relate to community and authorities about health problems Identify and address in the community
* Obtain and maintain resources
* Make Annual plans/Analysis
* Report to HC every month through VHV meeting
* Involve with out reach activities with HC staff in the community
* Participated meeting and training at the community

Role of VHV

* Data collection and record in VR (Identify chr0nic Dz HIV/AIDS)
* HE – Key message – C-IMCI
* Referral

* Information sharing to HC and from HC to Community
* Report to HC every month through VHV meeting
* Involve with out reach activities with HC staff in the community
* Participated meeting and training at the HC level
* Collaborate with existing committee and LNGOs & NGO

VHV Development

* Plan with authorities, HC, OD, Key people
* Share objective with community
* Identify candidate – 2/3 women (Use Venn Diagram)
* Election – at least 50% community participation

VHV Capacity Building

* Basic course
* Every two month training and health topic trained: Dengue, Malaria, NIP, Nutrition, ARI etc…
* Every two month meeting – objective of meeting: Analysis HE coverage, NIP, VR check and feedback and action plan for next month.

VHV Activity

- Provided HE ARI Malaria NIP and Bed net impregnation in malaria zone
- Participated in bed net impregnation activity
- Report monthly activity to HC
- Participated in organizing Candle light ceremony and world HIV day.
- Data collection of children < 1 year # preg and identify chronic Dz and referred to HC

VHV Results

- Average # of VHV attend meeting
- Average # of VHV attend Training
- Topic trained
- HE coverage???
- Special Activities done???
- Number stop to work??
- Scores on pre and post test
- HE checklist

VHC Development

- Information for village selection according to village selection criteria

- Plan with authorities, HC,VHV, TBA and Key people
- Share objective with community
- Identify candidate – 2/3 women (Use Venn Diagram)
- Election – at least 50% community participation

VHC Capacity Building

- On health Topic:
  1. NIP
  2. Malaria
  3. ARI,
  4. Dengue Fever
  5. HIV/AIDS,
  6. Nutrition
  7. Breast Feeding
- On Self-management training:
  1. Role/ Function
  2. Bylaw facilitated,
  3. Community diagnosis,
  4. Health Planning
  5. Effective health education
  6. effective meeting
  7. Simple proposal
  8. VHR
  9. Latrine construction, used and maintain latrine and hend washing

VHC Activity

- Community Diagnosis
- Health planning
- Analysis
- Data collection/record in VHR and analysis
- Develop Village project:
  1. Latrine project development and implementation
  2. HDW project development and implementation
  3. Canal project development and implementation
- Participated with NIP activity in the community by mobilizing mothers and child for immunization.
- Health Education
- Link with existing committee, community and HC

VHC Results

- HE coverage 2002:

Topic	By VHV	By VHC
HIV/AIDS	8514	8032
ARI	1218	4104
DF	6821	9269
CDD	3531	4967
NIP	7907	2234
Nutrition	375	00
Malaria	5402	3887
ANC	644	87
Nutrition for pregnant women	444	263
Viti A	57	1272
Latrine use and safe water use	250	1605

VHC Results

- HE coverage 2003:

Topic	By VHV	By VHC
HIV/AIDS	1867	1052
ARI	3357	7773
DF	***22772***	***36077***
CDD	3768	12813
NIP	18829	6145
Malaria	18078	5404
ANC	193	482
Nutrition for pregnant women	121	263
Viti A	10806	1272
Latrine use and safe water use	503	410
Bed net impregnation	ed net impregnation	924

- Develop Village project 2002:

1. Latrine project with 6 village 1059 latrine and 1087 fs benefits
2. PMR school latrine 1 village 3 rooms 620 students benefits
3. Pump well with 2 village 8 Wells and 274 families benefits VHC
4. Pump well with 6 village 12 Wells and 454 families benefits
5. HDW project with 1 village 10 HDW and 204 families benefits
6. Canal project with 1 village 45 culverts 1050 ms canal 56 FB
7. Slow send filter project with 1 village 102 Jars 1050 102 FB

VHC Results Continue

- Develop Village project 2003:

1. Latrine project with 10 villages 1291 latrine and 1296 fs benefit
2. PMR school latrine 1 village 4 rooms 712 students benefits
3. Pump well with 5 villages 26 Wells and 779 families benefit VHC
4. Pump well with 12 villages 21 Wells and 454 families benefits
5. HDW project with 1 village 10 HDW and 204 families benefits
6. Canal project with 3 villages 231 culverts 6973 ms canal 715 FB

- Level of VHC all of them are level 2
- VHR developed and data collection and at the community.
- HE checklist score in average 80 %
- Score on pre-post-test in average
with 53 % and post-test with80 %

Linkages

- VHC & VHV & TBA and others
- VHC with health center
- VHV with HC
- VHC with CBHCT
- Linkages workshop

- Integrate health planning between community and HC

Strength and constrains

Strength :

14/16 HC coverage area existed VHV for link between community and HC.

- CS involve with HC out reach activity at community
- Meeting for activity analysis and planning
- Village project development to support diarrhea intervention.
- *Constrains:*
- *CS movement related to the family condition*
- Low of educated
- Community not willing to work for the community

related to the poverty

ARI: Intermediate Results:

IR CM2.1 Improved mothers' knowledge and practices for ARI prevention.

IR CM2.2 Improved mothers' knowledge and practices to manage pneumonia

IR CM2.3 Improved mothers' practices to seek appropriate health care for child with pneumonia.

Indicators:

1.Increase to 60 % mothers who recognize at least two signs of pneumonia.

2.Increase to 45% women of children <2, who sought appropriate medical treatment when their child experienced rapid and/or difficult breathing

3.Community structures show increase in knowledge of ARI Standard Case/ Community-Based IMCI management and health education messages by an increase in pre and post test scores by 20%

4.50% Community structures reach acceptable level (70%) on HE checklist for providing health education on ARI to the community

KPC and LQAS Results

1. (KPC Results: 86.7% recognized fever and 24.5% recognized rapid or difficult breathing) (LQAS Results: 78% recognize fever, 52.6% recognize rapid breathing, 38.3% recognize difficult breathing.)
2. . (KPC Results: 25%) (LQAS Results: 42.9% (Sample to small to be significant)
3. (Score increase was looked at during training, monitored through the monthly MIS and analyzed quarterly. Average increase in test scores was at least 20%)
4. .(Checklist scores were obtained when checklist was completed through the Monthly MIS Results: Insufficient Health Education Checklists were done to determine if the increased scores are really significant)

Intervention/Indicators/Results

CDD

1. IR CM3.1 Improved mother's knowledge and practices for prevention of diarrhea
2. IR CM3.2 Improved mothers' knowledge and practices to manage diarrhea
3. IR CM 3.3 Improved mothers' practices to seek appropriate health care for diarrhea, dehydration, bloody diarrhea and persistent diarrhea.

Indicators

Increase to 55 % mothers who recognize 2 signs of dehydration as danger

signs of diarrhea.
Increase to 40% mothers of children under 2 years experiencing diarrhea in the last two weeks who treated their child with Oral Dehydration Therapy
Increase to 50% mothers who sought appropriate medical care for her child <2 years for diarrhea, dehydration, bloody diarrhea or persistent diarrhea.
Community structures show increase in knowledge of ARI Standard Case/ Community-Based IMCI management and health education messages by an increase in pre and post test scores by 20%
5.50% Community structures reach acceptable level (70%) on HE checklist for providing health education on ARI to the community

Results of KPC and LQAS
(Multiple answer)

1. Blood in the stool - 22.7%, Diarrhea getting worse - 45.5%, Diarrhea continuing more than 3 days- 18.2%, Fever- 22.7%, Vomiting – 9.1%, Very sleepy – 31.8%, Irritable – 9.1%, unable to eat or drink – 13.6%, Dry mouth and skin – 13.6%, Sunken eyes – 18.2%, Very thirsty – 4.5%

Summary: 86.4% recognize signs of diarrhea which need assessment at the health center. 57.5% recognize general danger signs, 36.3 recognize signs of dehydration. (However, the sample size was small as this was only asked of those mother's whose children had diarrhea in the last two weeks. Parallel sampling was not done.)

2. LQAS Results (question was asked of all about what they would do not what they did) LQAS ORS – 18.2%, Home based fluid – 6.8%)
3. 45.4% stated that they sought care at the public facilities; 4.5% at the hospital and 40.9% at the health center. (Sample was too small to be significant)

Intermediate results, Indicators, Results
Malaria

Intermediate Results:

1. IR CM4.1 Improved mother's and pregnant women's knowledge and practices for prevention of malaria
2. IR CM4.2 Improved mothers' and pregnant women's practices to use
3. impregnated bed nets
4. IR CM4.3 Improved mothers' and pregnant women's knowledge and practices to manage malaria

IR CM4.4 Improved mothers' and pregnant women's practices to seek appropriate health care

Indicators

1.Increase to 60% mothers who recognize 2 signs of malaria in the malaria zone.
2. Increase to 90% children <2 sleeping under impregnated bed nets in the malaria zone.
3. Increase to 90% pregnant women sleeping under impregnated bed nets in the malaria one.
4. Increase to 50 % increase mothers whose child <2 experiencing fever sought appropriate medical care in the malaria zone.

5. Increase to 45% pregnant women in the malaria zone experiencing fever and/or other signs and symptoms of malaria during recent their most recent pregnancy who sought appropriate medical care.

Results KPC & LQAS

(KPC Results: The KPC did not ask specifically about mothers' knowledge of signs of malaria)
(LQAS Results: Fever – 84.2%, chills – 77.4%)
(LQAS Results: 97.5%). (LQAS Results: Pregnant 98%)
(KPC Results: 20%) (LQAS Results: 80% stated that they sought care from the public facilities. 40% from the hospital and 40% from the health center. However, the sample size was too small to be significant.
(LQAS Results: 68.4% stated that they would seek care at the public facilities. 12.8% at the hospital and 55.6% at the health centers.

Improved community water, hygiene and sanitation
Intermediate /Results

Indicators:
1. 75% of VHC Villages have regular village cleaning schedules or systems
2. 90% of VHC Villages have water or sanitation projects

Village Project: 43 % VHC village project related to water and sanitation.

LQAS Results related to diarrhea prevention/ Water/San

1. Washing hands: Before preparing food – 77.4%
After defecation -16.5% After attending to a child who has defecated – 30.1Before feeding a child – 31.5
2. Disposal of babies stools:Latrine – 15.8%Bury – 40.6Left on the ground – 44% Thrown in the water-
3. Garbage Disposal Closed pit – 1.5% Burn – 82.7% Open pit – 19.5%Anywhere – 1 Throw into the canal of water – 2.25%

Annex 6

Defining Implementation Processes

Facility Level

1. Training/refresher (IMCI ToT) on
    a. How to assess
    b. Classification
    c. Treatment
    d. Counseling
2. Monitor/supervision of quality
    a. Patient assessment
    b. Patient Hx
    c. Patient physical examination
    d. Provide classification
    e. How to give mother counseling
    f. Filling patient card and keep card
    g. How to use protocol
    h. How to counsel the mother
3. Health education
    a. How to organize place/room
    b. IEC materials prepared and in place
    c. How to weight child/temperature
    d. Check yellow card when child come the HC
    e. Organize ORS room and material
    f. How referral system
    g. Follow/return when child get grave or need refill medicines
    h. Vaccination at HC and organizing cold chain for outreach
    i. Conduct training to VHV, TBA
    j. Monitor activity by work and checklist
    k. Develop health plan
4. Cross-cutting
    a. Linkages between health center and community
    b. Staff attitude
    c. Acceptable facility services
    d. First demonstration in facility
    e. ORT corner
    f. Integration of Hep B
    g. Quarterly/semi-annual analysis and planning (developing graphic)
    h. Access to water system in HC
    i. Material for washing hand
    j. Midwife conduct training to TBA, VHV on breastfeeding, complementary feeding
    k. Provide education to pregnant women during ANC, PNC
    l. Use quality checklist for IMCI, account, IC, drug, NIP, BF
5. Strengths
    a. Work commitment
    b. Increased facility utilization
    c. Improved facility management
    d. Regular monitoring and supervision
    e. Cold chains all being installed
    f. Participatory planning and analysis
    g. Integrated outreach
    h. HIS
    i. 60% of staff trained in IMCI
    j. IMCI supervision every 2 months

   k. Staff meeting every 2 months
   l. Material is appropriate and in place
6. Limitations
   a. 30% of staff in ND not yet trained in IMCI
   b. Low salary and benefits cause low commitment
   c. Access (geographical/time)
   d. Referral system
   e. Drug supply
   f. Health education/counseling

Community Level

Community process:

1. ToT to health staff
   a. Develop lesson plans (target groups, key messages, methods, IEC)
   b. Develop key messages
2. Training to community structures
3. Develop action plan for health education (select target groups)
4. Community structures provide health education
5. HC/CRS monitor community structures to provide health education
   a. Use health education checklist
   b. Provide feedback
   c. Evaluate coverage of health education sessions
6. Meeting at the health center
   a. Report coverage
   b. Problems/difficulties during health education activities
   c. Analyze results/continue plan to provide health education if coverage was not reached

Strengths:
- VHV existed in 14/16 HCs
- Community structures trained on ARI, Malaria, projects
- HC staff becomes CS trainers
- Technical assistance to CS by HC/CRS
- VHV commitment
- Work with community
- VHV commitment
- IEC materials/tools (VHR,VR, report, referral forms)
- Meeting/analysis with CS plus HC every 2 months

Weakness:
- Coverage less than 50%
- Limited counseling skills (home care, care seeking)
- Limited monitoring on mother practices
- Irregular health education visits
- CDD not yet developed
- 2 HC not yet included (no community structures)
- Health education methods need to be improved
- Key message development, health education plan

Annex 7

Problem Identification and Analysis

Community VHC:

- Information about VHC development process (from election until structure development)
- Information about role/function development process and implementation
- Bylaw development process and use/purpose
- VHR development process and purpose
- Health planning development process and its purpose
- Proposal development process and use

Community Mothers:

- VHV: mothers know VHV/TBA in villages, have they receive messages from VHV, what type of message, how often, for how long, what is the level of confidence/satisfaction of mothers with VHV, perception of importance and relevance of message.
- Seeking care: when child is sick, what do mothers do? Do mothers know about HC service delivery? Quality perception about services? Do mother know about danger signs? Referrals?
- Home care: Do mothers receive advice about home care? Mother practices at home when child is sick? About VHC development, roles, and project development in the village.

Community VHV/TBA:

- Capacity building
- Process of training
- Action plan after training
- Recording information
- Activity of TBA/VHV in community
- Problems happening in the community

Health facility HCMC:

- How to conduct organize a meeting
- How to deal w/problems between HC and community
- Information sharing with HC and community
- Record keeping
- Meeting minutes/report
- Facilitate/coordinate HC activities and financial
- Participate in bylaw development
- Disseminate HC services information to the community
- Set up fee cost with community and feedback to HC
- How HCMC links with other community structures
- How to manage HC
- HCMC training

Health Facility management:

- HC utilization coverage
- Health planning
- Monitoring table
- HIS
- Staffing
- Drug management system
- Account system
- Infection control
- Watsan system in HC
- Cold chain/vaccine/NIP
- Patient flow
- Service provision
- Consultation materials

- National protocols
- IEC material
- Chronic care
- Referral system

Annex 8

Development of Research Questions

Annex 7 was then synthesized into the following categories:

Facility

Health Center

- Management and Clinical
  - Governance
    - Communication
  - Training
  - Practice

Health Center Management Committee

- Governance
  - Communication
- Training
- Practice

Community

VHV/TBA

- Governance
- Communication
- Training
- Practice
  - Referral System

VHC

- Governance
- Communication
- Training
  - Capacity Building
- Practice
  - Referral System
  - Project Development
  - Education
    - Delivery
    - IEC Material

Mothers

- Knowledge
- Education
  - Content – key messages
  - Process – how they get information
- Practices (behavior)
  - Referral
  - Communication and Mobilization
  - Home Visits
  - Care Seeking
  - Home Care
  - Relationships (satisfaction regarding health services)
- Attitudes and Beliefs
  - Satisfaction

Annex 9

Guidance for Focus Group Discussions

TIME: 1-2 hours (1 ½ is optimal)
Participants: 6-10 people (8 is optimal)

The Moderator

1. Be sensitive to the needs of the participants
2. Be non-judgmental about the responses from the participants
3. Respect the participants
4. Remain open-minded
5. Practice good listening skills
6. Practice good leadership skills
7. Practice good observation skills
8. Be patient and flexible
9. Make eye contact with participants
10. Make participants feel welcome and included
11. Make sure everyone speaks – even if it means going around the circle and having each person provide some of the answers
12. Encourage participants to discuss issues together, either agreeing of disagreeing with each other
13. Choose an appropriate environment without distractions to conduct the session
14. Be polite but firm
15. Probe, Probe and probe some more – you want to dig deep and try to get as much information as possible.
16. KEEP PARTICIPANTS FOCUSED ON THE TOPIC!!!

The Note-Taker

1. Record the key issues emerging in the session
2. Record other key factors that may be important in analysis and interpretation of the results
3. Write down the participants' responses
4. Observe and record non-verbal responses that may assist in understanding how participants' feel about particular issues

(non-verbal include facial expressions, body language such as approval, interest, boredom, impatience, resentment and anger

5. Get permission from group if/when recording the session

Mothers' FGD

1. Ultimately you want to know if mothers and children are benefiting from this program, so all of your probing is about getting at that question/answer.
2. You want to find out why there is low coverage for health education sessions in the village
3. You want to know if the VHV/VHC/TBA are doing their jobs, which include things such as referrals, communication, mobilization, home visits for sick children, etc.

4. You want to get information on the level of satisfaction the mothers feel about the program activities, including how they feel about the village health workers
5. Try and assess if/how mothers are using the health education and IEC materials that they are being given

Community – VHC FGD

1. You want to know if they understand their role, the reason why their job is important to the smooth functioning of the program
2. What would help them do their job better?
3. You want to know if they understand their role in project development, and if they are satisfied with the outcomes? What is the process they use?

Community – VHV/TBA

1. Find out if they know their roles, the reason for their position and the importance of it to the overall program.
2. What would help them do their job better?
3. Are they able to help with problem solving in the community?
4. What problems do they face in doing their jobs?
5. How is mobilization done? Is it effective?

Health Center – HCMC

1. Find out if they know their role, why it is important, and how they contribute to the overall program
2. What kind of training and information do they receive in order to help them do their job better? Where and how?
3. How do they use this information?
4. What would help them do their job better?
5. The result if they don't do their job – who suffers?

Health Facility

1. Find out how to improve the project
2. What do they value most in their relationship with CRS?
3. You want to understand how they see the different roles of CRS and HC and their relationship to each other and to the program
4. Try to get information on the areas of support provided by CRS to the HC in terms of training, technical assistance (and what this means), material and financial assistance, and monitoring and supervision, etc.
5. How does what you do impact beneficiaries (mothers and children)?

Annex 10

Focus Group Discussion Questionnaires (Originals in English)

Health Center Management Committee

1. Role and function of the HCMC?
   - Who do they relate to
   - Who are they responsible to (Accountability)
   - Status in the community?
2. Major Accomplishments of the HCMC?
3. How does the CRS Child Survival Project support the HCMC to accomplish their job?
   - Training/information
     1) Where do they get it ?
     2) How do you get it?
     3) Is it enough?
     4) Is it useful?
     5) Is it too much?
     6) How do they use the information?
   - Technical assistance
     1) Meeting
     2) Community information gathering
     3) Fee setting
     4) Develop contract
   - Support
   - Financial
4. How does the CRS Child Survival Project limit the HCMC in what they want to do?
   - Are they doing what they think they should do?
   - What else do they think they should be doing?
5. What would happen if they did not do their job?

VHC FGD

1. What is the role of the VHC?
   - Who do they relate to?
   - Who are they responsible to? (Accountable)
   - Status in the community?
2. What do they do? What have they accomplished? (Ask them to talk mo re about what they do? Why successful? What now accomplished? Why?
   - How do they feel about what they do
     1) Able to do?
     2) Get enough support?
     3) Doing what they feel they should do?
     4) Think that they should do other things
     5) Think their role is useful or not?
     6) Doing too much?
   - How could they do it better?
   - What are the problems to do the job?
   - Why do they do their job? What would happen if they did not do their job?
3. Where do they get information to do their job?
4. How do they get information to do their job>
   - Useful
   - Given in a useful way
   - Information consistent

- Information useful
- Too much
- Not enough
- What more do they want?
- What support after get information?
- How do they use the information?

VHV/TBA FGD

1. What is the role of the VHV/TBA?
   - Who do they relate to?
   - Who are they responsible to? (Accountable)
   - Status in the community?
2. What do they do? What have they accomplished? (Ask them to talk more about what they do? Why successful? What now accomplished? Why?
   - How do they feel about what they do
   7) Able to do?
   8) Get enough support?
   9) Doing what they feel they should do?
   10) Think that they should do other things
   11) Think their role is useful or not?
   12) Doing too much?
   - How could they do it better?
   - What are the problems to do the job?
   - Why do they do their job? What would happen if they did not do their job?
3. Where do they get information to do their job?
4. How do they get information to do their job>
   - Useful
   - Given in a useful way
   - Information consistent
   - Information useful
   - Too much
   - Not enough
   - What more do they want?
   - What support after get information?
   - How do they use the information?

Health Center FGD

1. What is your relationship with CRS?
   - What do you value most about your relationship with CRS and why?
2. If CRS was not here what would you not be able to do or would be doing differently?
3. What is the role of CRS in this partnership? What is the role of the HC in the partnership?
   - How could this be improved?
   - What else is needed?
   - What does CRS provide?
     1) Financial
     2) Material
     3) Training/TA – improve Clinical? Improve management?

4. What do they see as the goal of this program?
5. What is the effect if they do not do their job?

Mother FGD

1. Why do you come for HE from the VHV, VHC, TBA?
   - Why do you think that other women do not come?

1) Timing
2) Access
3) Interest
4) Useful
5) Aware
6) Mobilization

2. What doest the VHV/ VHC/RBA do for you?
   - What do they do on a regular basis?

   1) communicate information
   2) provide education
   3) mobilize people

   How do they do these activities?
   How do you use the information that you get?
   What happens if you do not use the information ?
   - What do they do when your child is sick?
     1) Referral
     2) Home visit

   How do they do these activities?
   - What else do you think that they should do?

3. Do they know that their village is part of the CRS CS program?
   - If so what does that mean to them?
   - How does this impact their life or the life of their family?

Annex 11

Field Work Logistics

Evaluation Teams
Date: June 16-18, 2004

Bovel District	New District
Health Facility Team: • Mop Pheun • Dr. Saint Chinhan	**Health Facility Team:** • Moul Vanna • Dr. Pann Sam Kol
VHC Team: **Team 1:** • Ly Chhean • Dr. Meas Pheng **Team 2:** • Touch Sam Ol • Hun Youm • Mok Samoeun	**VHC Team**: **Team 1:** • Siv Kosal • Dr. Andre • Rith Saray **Team 2:** • Song Chanthy • Mai Hong • Heng Bunsieth
VHV/TBA Team: • Thlang Sovann • Sim Sophea • Bou Sakun	**VHV/TBA Team:** • Heng Hean • Kong Chanthorn • Oum Buntha

Notes:

- Dr. Alfonso and Della will involve in Khnach Romeas Health Center on June 16, 2004.
- Dr. Alfonso will travel to New District at afternoon of June 16, 2004
- Della and Dr. Koy Sok will travel to New District at afternoon of June 17, 2004
- Lori Dostal will also involve with field evaluation either at the health center or at the village.

Bovel District

Wednesday		Thursday		Friday	
AM	**PM**	**AM**	**PM**	**AM**	**PM**
HC (1 team) HC Observation HC FGD at **Khnach Romeas Health Center**	HC (1 team) HCMC FGD at **Khnach Romeas Health Center**	HC HC Observation HC FGD at **Bovel II Health Center**	HC HCMC FGD at **Bovel II Health Center**	HC HC Observation & FGD at **Prey Kpos Health Center**	(stay for HC VHV/TBA FGD) see below
Village (VHC) (2 teams) VHC – FGD **at: Roung Ampil & Khanch Romeas village**	Village (VHC) (2 teams) Mothers FGD Home visit to mothers at: **Roung Ampil & Khanch Romeas village**	Village (VHC) (2 teams) VHC- FGD at **Sang Rang and Prey Totoeung I village**	Village (VHC) (2 teams) Mother FGD Home visit to mothers at **Sang Rang and Prey Totoeung I village**	Village (VHC) (2 teams) VHC – FGD at **Soun Sla and Khlang Village**	Village (VHC) (2 teams) Mothers FGD Home visit to mothers at **Soun Sla and Khlang Village**
Village (VHV/TBA) Mother FGD Home visit to mothers **at Prey Sangha village**	HC (1 team) VHV/TBA FGD at Khanch Romeas HC	Village(VHV/TBA) at Bovel II HC Mother FGD Home visit to mothers **at Bovel II village**	HC VHV/TBA FGD at Bovel II health center	Mother FGD Home visit to mothers **at Tamath village**	HC VHV/TBA FGD at Prey Kpos Health Center

New District

Wednesday		Thursday		Friday	
AM	PM	AM	PM	AM	PM
Team Travel to New District	HC (1 team) HC FGD at **Pich Chenda Health Center**	HC HC Observation HC FGD at **Takrey Health Center**	HC HCMC FGD at **Takrey Health Center**	HC HC Observation CHMC FGD at **Serey Meanchey Health Center**	HC HCMC FGD at **Serey Meanchey Health Center**
	Village (2 teams) (1) VHC FGD (1) Mothers FGD Home visit to mothers at **Pich Chenda village**	Village VHC- FGD at **Dey Krahorm & Beng Sa Art village**	Village Mother FGD Home visit to mothers at **Dey Krahorm & Beng Sa Art village**	Village VHC – FGD at **Lovea Tee & Damnak Khsan village**	Village Mothers FGD Home visit to mothers at **Lovea Tee & Damnak Khsan village**
	HC (1 team) VHV/TBA FGD at Pich Chenda HC Mother FGD Home visit to mothers **at Pich Chenda Village**	Village Mother FGD Home visit to mothers **at Dey Krahorm and Beng Sa Art village**	HC VHV/TBA FGD at Takrey HC and Kampong Chamlorng village	Village Mother FGD Home visit to mothers **at Damnak Khsan village**	HC VHV/TBA FGD at Serey Meanchey HC and Mother FGD and Home visits at Chambork village

Annex 12

Debriefing Discussion on FGD Process

Upon returning from the field work, the group had a discussion about the process of doing the FGD in the field, how it went, the problems encountered, ways to overcome these issues in the future, and how it felt to do the FGD.

The staff stated that there was some confusion regarding the FGD tools (questions) they used, as they had not had adequate preparation time to fully understand all the question, nor had them all been precisely translated. They stated that it would have been very helpful to have pre-tested the tools prior to going out to the districts to use them. They also complained about the rushed atmosphere of going out to the field so quickly, and having to prepare the logistics in a rush, but then being late for the first morning sessions on Wednesday morning, making people wait after they had asked them to be there.

The following observations were recorded by the consultant while observing several FGD sessions in the field.

1. The three interviewers sat on one side of the table, and the 6 HC staff sat on the other side of the table, like an interrogation.

It would have been better for everyone to sit interspersed so that it was really a more group atmosphere.

2. They got everyone to speak up fairly easily. The group was very receptive, everyone smiling, talking, lots of agreement and not much dissention noted.

The CRS staff did a good job of encouraging dialogue and keeping it going.

3. One CRS staff asking the questions basically asked all of the questions to the head of the HC, not to the whole group, so the head person always answered first. The head was taking photos of the group process, and kept getting up and walking around the table. Then at 1:30 he walked out of the room, coming back a few minutes later.

Ask questions to the group at large, and if one person always answers first, then say something like, "this time we are going to start the answers with so-and-so first, and start with a different person each time".

4. Through translation, it became apparent that the CRS leader of the FGD did not single out the child survival project in terms of CRS assistance, but instead was receiving information about all the material assistance that CRS has previously provided. The participants were approaching this from an integrated perspective, thus the answers were skewed.

Make sure that when you are asking about a specific program, activity or issue, your questions and tone reflect this, and when the group strays, redirect them in order to ensure the consistency of your data.

At the end of the session, the CRS note-taker correctly summarized the notes from the session, asked for clarification and/or additions, and then thanked everyone for their participation – **good job!**

5. The choice of venue is very important to ensure the comfort of the participants and a quiet place with as few distractions as possible. Please see the FGD guidelines for more information on how to plan a FGD.

Annex 13 FGD and Home Visits - Compiled Data

BOVEL - Health Center Focus Group Discussion
Date: June 16-18, 2004(Compilation)

Health Center's Name: Knach Romeas, Bovel II, Prey Kpos — Note Taker:
Moderator: Map Pheun — Date of Data Collection:16-18/06/04
Note Taker: Dr. Saint Chinhan — Participants: 23 people

Question #	Health Center's Questions	Health Center's Answers
1.	What is your relationship with CRS?	1. Knach Romeas HC made relationship with CRS since 1991(Knach Romeas) 2. CRS provided T/A, budget for training to the community, health center staff and transportation (3/3) 3. CRS support materials, train on technical assistance, community raining (3/3) 4. CRS support HIV/AID (3/3) **5.** Support medical supplies e.g. blood pressure cuff, help consultation, material, office supplies, photocopy, pump wells, 6. support budget at the beginning of health finance scheme at HC (2/3 Knach Romeas, Bowel II) 7. CRS support minor surgery supplies(2/3 Bovel II, Knach Romeas) 8. Provided autoclave, suture stick, building the center (1/3 Knach Romeas) 9. Help facility in planning (1/3 Bovel II) 10. Support shortage drugs (3/3) 11. Support IMCI training and strengthen IMCI clinical management activities (3/3) 12. Support infection control (1/3 Prey Kpos) Comments: CRS stay far away, the arrival at HC too late due to have a short time to meet with TBA and VHV (1/3 Prey Kpos).
	• What do you value most about your relationship with CRS and Why?	1. Collaboration and strengthen the works(1/3 Bovel II) 2. Have enough material for HC(1/3 Prey Kpos) 3. More children come to use HC services (IMCI) (3/3) 4. CSR help since has no building till to have a building (1/3 Knach Romeas) 5. From no technical experience to have experience(1/3 Knach Romeas) 6. Held HC to have better operation such as meeting, because if we do not have meeting, training, the communication between community is slow (1/3 Bovel II) 7. Health staff and CRS have good collaboration and friendship (1/3 Bovel II) 8. TBA and VHV understand the jobs of HC. (1/3 Bovel II) 9. People Living With AIDS (PLWA) comes to use HC easily. (1/3 Bovel II) 10. HCMC function well (2/3 Knach Romeas& Bovel II) 11. The mother received tetanus more than before. (1/3 Prey Kpos) **Comment: Some case of suspected HIV/AIDS sent to VCCT with their family but CRS support the patient only (1/3 Prey Kpos)**
2.	1. If CRS was not here what would you not be able to do or would be doing differently?	1. Still continue to do the same jobs, but will not do in the community development project because no budget (3/3) 2. Might be have some difficulty because CRS used to support document photocopy, will obstruct training activities and replace broken equipment. (1/3 Knach Romeas) 3. Will not have OI drug, supplies for HIV/AIDS patient such as: bed nets, mats, rice that CRS used to help. (3/3) 4. No community training activities. (3/3) 5. HC can continue until the government has budget.(The government give budget 12 millions riels per year) to replace CRS or use health center income from patient fees for support the meeting but the meeting/trining need to be reduced every 2 months, HC could not find the money from other resources. (1/3 Bovel II)
3.	2. What is the role of CRS in this partnership? What is the	CRS roles 1. Supporter and follow up the material, supplies that provided to HC (3/3).

	role of the HC in the partnership?	2. Support community structure such as: culvert and wells (3/3). 3. Problem solving at community, train to community when variety diseases out break.(3/3) 4. Provided IEC material, leaflets (breast feeding, ANC, health education)(3/3) 5. Monitor, correct clinical IMCI and Support IMCI materials(3/3) 6. Held Infection control (1/3 Prey Kpos) 7. Check the vaccine site in the villages(1/3 Knach Romeas) 8. Strengthen; bring the problem from HC to higher level to help to solve the problem.(1/3 Bovel II) 9. CRS support the budget for community works (HIV/AIDS)(3/3). 10. Provided drugs when shortage, made photocopy drug documents (3/3) 11. Training to VHV, TBA and encourage them to continue to work in the community about child diseases (2/3 Bovel II, Prey Kpos) 12. Facilitate the process for TBA, VHV training. (3/3) HC role 1. Meet and discuss for problem solving, training, prepare lesson plan with CRS.(3/3) 2. Give monthly report to CRS (2/3 Bov el II& Knach Romeas) 3. Work on annual health planning together (1/3 Knach RFomeas) 4. Created the easy atmosphere (communication) between local authority (commune, village) and CRS (3/3) 5. Discuss and solve the problem with CRS when the problem cannot solve by them.(1/3 Bovel II) 6. Implementation the activities according to OD guideline.(1/3 Bovel II) 7. Made shortage drugs request to CRS. (3/3)
	• How could this be improved?	1. CRS should continue the project longer for further community development works.(1/3 Knach Romeas) 2. Should have clear plans for continuing work, because the plan needs the budget from CRS support. (1/3 Knach Romeas) 3. Encourage the mother to bring the child to get vaccination in order to reach the goal/ if the mother bring yellow will not ask to pay (exemption) (1/3 Bovel II) 4. Training and service dissemination on health services to VHV, TBA. (1/3 Bovel II) 5. CRS should have office close to HC (Bovel district) in order to have easy way for communication and have more time to facilitate the works at HC.(1/3 Prey Kpos) 6. CRS staff should spend more time at HC (2 times/week). .(1/3 Prey Kpos)
	• What else is needed?	1. Delivery room(1/3 Knach Romeas) 2. HIV/AIDS training building(1/3 Knach Romeas) 3. Transportation facility (motor) (1/3 Knach Romeas) 4. Refresher new technical 5. assistance (1/3 Knach Romeas) 6. Modern Document for clinical 7. consultation (1/3 Knach Romeas) 8. Grass cutting machine(1/3 Bovel II) 9. CRS support another staff in out reach group for(3 staff) to provide health education and availability services at health center(1/3 Bovel II) 10. Need $100.00/month for operational activities at HC. (1/3 Bovel II) 11. Strengthening of VHV to have proper report on number of children in the houses, and make sure the time that they received vaccine (how many time) and the process how to get children and women statistic in the community. (1/3 Prey Kpos) 12. Ask CRS to support VHV when they go out for out reach activity. (1/3 Prey Kpos)
	• What does CRS provide? Financial Material Clinical Training T/A- improve Clinical? Improve management?	1. CRS provided IMCI case management training and materials support (scale, chart, ORT corner) (3/3) 2. CRS provided Building (1/3 Knach Romeas) 3. Supported material, office supplies, photocopy document, Technical Assistance, Replace broken material (3/3) 4. CRS provided budget for training/meetingf, VHV, TBA) and budget for NIP activities (3/3)

		5. OI drugs and support material for HIV/AIDS patients, transportation for VCCT 3/3) 6. Prepare HCMC re election for second time.(1/3 Knach Romeas) 7. CRS supported water pump machine, water filter and one old motor bike (1/3 Bovel II)
4.	What do they see as the goal of this program?	1. Development of community health, Improvement of health facility (1/3 Khnach Romeas) 2. Reduce mortality and morbidity of children and mother.(3/3) 3. Decrease poverty in the community (2/3 Prey Kpos & Knach Romeas.
5.	What is the effect if they do not do their job?	1. Increase the number of sick children(1/3 Khnach Romeas) 2. No place for rescue / survive(1/3 Khnach Romeas) 3. Did not provide proper care/ consultation to the child. (1/3 Khnach Romeas) 4. The child need to go far away (Seam Reap) (1/3 Khnach Romeas) 5. Affect to the family and social economy(1/3 Khnach Romeas) 6. Affect HC, PHD and OD(1/3 Bovel II) 7. .Dangerous for population especially the poor people, elderly people, handicaps, widows and especially children.(3/3) **Request: -** CRS support campaign activities for giving tetanus, Mebendazole and Iron to girl school students >15 years. -Outreach for sputum screening for suspected TB.(1/3 Knach Romeas)

Bovel - Health Center Management Committee Focus Group Discussion
Date: June 16-18, 2004 (compilation)

Health Center's Name: Knach Romeas/Bovel II
Moderator: Map Phoeun — Date of Data Collection: 16/06/04
Note Taker: Dr. Saint Chin Han — Participants: 12 people

Question #	HCMC's Questions	HCMC's Answers
1.	Role and function of HCMC?	1. Set up fee cost for each service (2/2) 2. Attended HCMC meeting every month. Meet every month for problem solving (2/2) 3. Monitor HC activities(1/2 Bovel II) 4. Monitor drug shortage, check for shortage of equipment and condition of building(1/2 Knach Romeas) 5. Bring information from HC to community about health center service, fee cost and from community to HC about diseases in the community.(2/2) 6. Check income and expenses at HC (2/2) 7. Collaborate with HC in case of special cases happen such as disease out break(½ Knach Romeas) 8. Develop HCMC Bylaw(2/2 Knach Romeas) 9. Made meeting minutes and send to commune counsel office and OD. (½ Knach Romeas) 10. Discussion at HC if any problem happens e.g emergency happened the meeting will be called before appointment(½ Knach Romeas) 11. Check inventory system at HC. (½ Knach Romeas) 12. Encourage the population come to use HC(½ Knach Romeas)
	Who do they relate to?	1. TBA, VHVVHC and health center staff.(2/2) 2. Local authorities commune, village (1/2 Bovel II) 3. Traditional healer(1/2 Knach Romeas)
	• Who are they responsible to (accountability)	1. They responsible for the people in coverage area in the community e.g. disseminated the health information to community and referred the patient to health center.(2/2) 2. Responsible for HC especially the condition of the building, in order to have better improvement of utilization than before.(2/2)
	• Status in the community?	1. Better than before, the population came to use the public, health exemption policy and dissemination about other diseases in the community.(2/2) 2. The people known the HC services and fee cost. (2/2) 3. The minority of population still used private services.(1/2 Knach Romeas) 4. The people shared their ideas on services delivery at HC.(1/2 Knach Romeas) 5. The relationship between HC and community has more quicker than before. More people come to use service, provided health information happens every month such as sputum screening for TB, referral case from community to HC faster than before. .(1/2 Knach Romeas) 6. The people made indirect criticized to HC via HCMC and HC solve the problem via HCMC. .(1/2 Knach Romeas) 7. The sanitation condition is better e.g. family latrine. .(1/2 Bovel II) 8. People used boiled water.(1/2 Bovel II) 9. The mothers known the date to bring their child for vaccination. .(1/2 Bovel II)
2.	Major accomplishment of the HCMC?	1. Majority of the people came to use HC(1/2 Knach Romeas) 2. Conduct HCMC monthly meeting and take proper minutes(2/2) 3. Disseminate the free of charge for TB treatment, and TB can be cured by treatment. (1/2 Knach Romeas) 4. Youth counseling for HIV/AIDS (blood test at VCCT) (1/2 Knach Romeas) 5. Good collaboration with HC. (1/2 Knach Romeas) 6. Health center used income from patients' fees to operate the activities.(before CRS used to supported 50$/month) (1/2 Knach Romeas) 7. Identify fee cost and monitor HC income and expenses (2/2) 8. Develop roles and function of HCMC (1/2 Bovel II)

		9. Gather information from community to HC (1/2 Bovel II)
3.	How does the CRS Child Survival Project support the HCMC to accomplish their jobs?	1. Trained role and function and support training/meeting budget for HCMC.(2/2). 2. Support materials/training document and instructed how to use document (IEC). (2/2) 3. Disseminate the new strategy IMCI information by using microphone. (1/2 Knach Romeas) 4. Monitor and check the ledger book . (1/2 Bovel II)
	• Training/Information Where do they get it? 2 >How do they get it? Is it enough? Is it useful? Is it too much? How do they use the information?	1. From community structure VHV,VHC, other people .(2/2) 2. From health center and CRS (2/2) 1. Lecture/ discussion in the classroom/role play (1/2 Bovel II) 2. Provide document about role and function, information gathering, communication, conduct meeting, facilitation skills and how to do the information gathering for fee cost. (1/2 Bovel II) ***Information*** 1. The information is enough (1/2 Knach Romeas) 2. Received information 50% (1/2 Bovel II) ***Training*** 1.The training is not enough (1/2 Knach Romeas) 2. The training is enough (1/2 Bovel II) 1. It is useful (2/2) 1. Enough not too much (2/2) 1.Use information from health center to VHV, VHC (1/2 Knach Romeas) 2. After Information gathering ? meet and discussion ? decide what each strategy e.g. the child did not come to get(2/2)
	• **Technical assistance** Meeting Community information gathering?. Fee setting Develop contract	1)Meeting 1. HCMC chief conducted the meeting. (1/2 Knach Romeas) 2. HC chief and CRS conducted the meeting because HCMC just begin.(1/2 Bovel II) 3. The agenda take from village and HC.(disease outbreak and other problems and new problem happened at HC) (2/2) 4. Made minutes (2/2) 1. Any thing happened in the village always known by HCMC members(1/2 Knach Romeas) 2. Organize by CRS and HCMC members go out for getting information themselves.(1/2 Bovel II) Fee setting 1. . Identify fee cost(1/2 Knach Romeas) 2. Went to community and ask for possible price that they can pay then come back to discuss in HCMC meeting. (2/2) 3. Fee cost information gathering in the village, at least >50% of family in the village (1/2 Knach Romeas) 4. HCMC member set up the meeting to identify the fee cost. (1/2 Knach Romeas) 1. Develop contract then submitted to MOH (2/2)
	• Support	1. CRS support Technical assistance (2/2)
	• Financial	1. CRS support budget for running HCMC activities (Meeting, election, training)(2/2)
4.	How does the CRS Child Survival Project limit the HCMC in what They want to do? • Are they doing what they think they should do?	1.Child Survival, New IMCI strategy, bring yellow cart. (1/2 Knach Romeas) 2. None (1/2 Bovel II) 1.Yes, They should do because to reduce mortality rate of children (IMCI) (1/2 Knach Romeas)

	• What else do they think they should be doing?	2.HCMC are doing thing according to the job description. (1/2 Bovel II) 1. Organize referral system from HC to RH (1/2 Knach Romeas) 2. None (1/2 Bovel II)
5.	What should happen if they did not do their jobs?	1. The activities of HC will decrease (2/2) 2. Affect to the poor, widow, handicaps and elderly people especially children.(2/2).
Addition	Where do you get the information?	1. Community structure and other people.(1/2 Knach Romeas)
	2) How do you feel about HCMC re election?	1.Very happy because it is a democracy way. .(1/2 Knach Romeas) 2. When I was elected I will continue to work.(1/2 Knach Romeas)
	3) What do you do with new member?	3. Share experiences with them until CRS organize training. (1/2 Knach Romeas)

Bovel - VHC FGD for MTE June 16-18, 2004

Name VHC village: Roung Ampil, Khleang, Sang Rang, Soun Sla, Prey TotoeungI and Khnach Romeas VHC
Date Implemented From June 16-18, 2004
CRS PO 1 Mok Samoeun 2 Hun Yourm 3 Ly Chean 4 Touch Samol 5 Thlang Sovann

Question #	VHC FGD Question	Answers from VHC FGD
1	What is the role of the VHC?	1. Provided HE to community (Provide food to the child, Exclusive Breastfeeding, Sanitation, Dengue Fever, and Project maintain Hand Dug Well, Latrine and canal, Malaria, HIV/AIDS, NIP and safe water used and how to do latrine construction (5/6 VHC) 2. Provide health education (2/6 VHC) 3. Village project planned and implementation * Identified health problem in the community * Proposal development process * Accessing / managing out and inside resources for project implementation (Wells, Latrines, Canal, Village cleaning) (5/6 VHC) 4. Mobilized mothers who has children < 1 year and Pregnant women for received immunization (4/6) 5. Develop and use Village Health Register (Pregnant women, NIP, Health education, Patient referred record and chronic diseases. (5/6 VHC) 6. Referred community people to used HC (6) 7. Conducted community meeting, VHC meeting (5) 8. Attend the training (2) 9. Collaboration between VHC and TBA,VHV, authority. (2) 10. F/U people referred, what medicine they get and assumed not for poor family and did home visits and check to see they get better or not. (1) 11. Communication/Report with health center through VHV (3) 12. Identified seasonal diseases (1) 13. Health Center services dissemination (1) 14. Participation in Key youth development process (1)
	Who do they relate to?	1. Communication with VHC members 2 2. Communication with CBCHCT 1 3. Communication with community 6 4. Communication with CRS 6, and others 5. Communication with Private practitioners 1 6. Communication with HC staff 5 7. Communication with Local authority 4 8. Communication with NOG who is working in the community. NOG who is working in the community.
	Who are they responsible to? (Accountable)	1. VHC member responsible 28-30 families for VHC member 3 2. Referred sick patients to HC, pregnant woman to received TT and children 1 years to immunization. 1 Encourage and support materials, money, rice and home visit with PLWA. 1 3. To reduce number of dead and of diseases in the community 1 4. Communicated with village chief for statistic 2 5. Villagers know, recognize and believe VHC. 1 6. People change behaviors from surface defecation to using latrine. 1 7. Target children and target women and community 3
	Status in the community?	1. Status in the community was reducing diarrhea disease. DF, ARI, not bad smell in the village, good environment, reduce poverty. 5 2. Status in the community people still lack of health knowledge Lack of sanitation and living condition still limited. 1 3. Villagers know, recognize and believe VHC.1 4. Improved sanitation People change behavious from surface defecation to using latrine.2 5. Children get immunization then before, large of numbers of mother seeking at the HC. . 6. Refer pregnant women with problem for delivery at HC. 1

2	What do they do? What have they accomplished?	1. Willing to work for community because of all VHC members were elected by communities. (1) 2. Developed health in the community, Reduce diseases in the community. Increases self-knowledge. (1) 3. HE coverage 50-60 % such as (Provide food to the child, Exclusive BF, Sanitation, DF. Malaria 70 % Bed Net impregnation 90 %, ARI reach to 40 %, Diarrhea and HIV/AIDS reach to 80 %, referred to VCCT with 3 people, NIP health education reach to 80 %, pregnant women to HC for ANC reach to 47 %, children received fully immunized with 37 children (5) 4. Completed Latrine 547 benefited 547 families (3) 5. HDW 15 (1) 6. Canal project 1418 ms, public culverts 11 places and private culverts 49 places. 7. Primary school latrine 1 building with 3 room with 7 teachers and educated students how to used and maintain the latrine (1) 8. Village project developed Such as latrine project, Canal project, HDW project and primary school latrine project (6) 9. Organize people to attend the meeting small or big group (3) 10. VHC meeting (1) 11. Participated training (1) 12. NOG meeting with in 2 times (1) 13. Follow-up chronic patients.(1) 14. Referred cases to HC.(1) 15. Mobilized children and pregnant women for immunization.(1) 16. Participated in Vitamin A campaign. (1)
	Why successful?	1. Community participation (6) 2. Supported by CRS (4) 3. Supported by village chief, commune council. (2) 4. They know their role, commit to work with community (4) 5. Available IEC 50 % for health education, has knowledge to do, well communicated with village chief (3) 6. Supported by HC (1) 7. Learning by direct implementation (1) 8. Good collaboration with CRS, HC and village chief (1)
	How do they feel about what they do	1. VHC Feeling family living condition still limited. (1) 2. Willing and happy to work for community, but thinking more about family condition. (2) 4. They are happy with village benefit and willing to participate. Better community health status People increase awareness on health issue KRM 5. Feel happy due to being supported by community. Feel warm up when seeing community's participation. 6. Having some difficulty at the beginning of starting the work because of, not having knowledge. We are willing to work due to having recognition and identification from the community. We have knowledge and benefits for family and community.

Question #	VHC FGD Question	Answers from VHC FGD
	Able to do?	1. Able to do such as health education, refer sick people, mobilized children and pregnant women for immunization. 2. Impossible to do such as the process of village project development 3. We are able to carry out our role because we have already done them so far. 4. This job does not make us busy all the time. 5. Because we believe in our work . 6. Because of full involvement of Authorities and community. 7. We have knowledge to do.

	Get enough support?	1. Was supported from community and community participated in implementation for community development and received benefit all people and families in the community. 2. Enough supported from community, local authority and CRS staff (CRS staff supported how to develop village project proposal) and HC staff as well (HC staff accepted for patients referred by VHC to HC) 3. 70 % enough support by community for health education 4. Still need support from outsider on IEC and project resources 5. We still need more support.
	Doing what they feel they should do?	1. VHC want to do thing in the community especially to remove standing water to the rice field. 2. VHC feeling to work, what is related to health for the community? 3. They are happy and willing to participated 4. Build Health Post due to far distance from HC 5. Continue carrying out H. education to community and problem re-analysis for other needed project development 6. Feel happy due to being supported by community. 7. Feel warm up when seeing community's participation. 8. Learn on HIV/AIDS /STI knowledge. 9. Learn sanitation and hygiene 10. Encourage non active members to be more active. 11. Need some motivation to work. 12. Need more trainings. 13. Need ID card for members. 14. Select key families for being standard families for health care. 15. Need support garbage tin in public use.
	Think that they should do other things	1. VHC want to do village project (with 15 HDW more) 2. Willing to continue to develop village project related to sanitation such as Canal project. And VHC as to support such as bed net for using and kettle for Boiled water for dinking for community. 3. Project maintenance, more health education to reach the coverage 4. Material for announcement during an activity (Loudspeaker)
	Think their role is useful or not?	1. It is useful for them in-term of reduce diseases in the Community. 2. It is useful for them in-term increase health knowledge for VHC members and community, to reduce Malaria ARI and Dengue Fever in the community 3. They are important to help people 4. Useful for themselves and community. 5. Save money for family. 6. Implemented our role for joint benefits of community.
	Doing too much?	1. According to the activity been done so far is appropriate for them. 2. All VHC said not too much base on the time, Labor, energy and leading the people 3. Not as much (9/10 members and 1/10 said that doing too much).
	How could they do it better?	1. Increase they capacity to provide health education to community 2. Supported each other in-term of sharing information to others who absent during training or meeting. 3. More explanation, education demonstration to community 4. Communication to get more benefit 4. Additional training for continue education. 5. They want to learn more for more health education to community 6. Having the appropriate material 7. Learn more on knowledge and skills to implement our role.
	What are the problems to do the job?	1. Not enough safe water used in the village, not enough latrine for Using for new family and people lack of knowledge how to used Safe water and used latrine. 2. The problem is same mothers not participated in NIP activity because mothers Still think that, her child get fever and same pregnant women not get TT related to belief, related to the village project some families not Accomplished as plan related to the family condition. Community people

		lack of health knowledge. 4. lack of belief, understanding, commitment, resources and labors work in the project implementation and impact, health education process busy with other job. 5. HC staff come to give vaccination late in the village Mothers are busy with other work at home and in the field 6. Some people still not believe in VHC's work.. 7. VHC members live far apart from each other in the village. 8. We are also busy with our seasonal fieldwork.
Question #	VHC FGD Question	Answers from VHC FGD
	Why do they do their job?	1. To increases self-knowledge about health, and community, 2. Because they want to reduce number of dead and number of Disease in the community, and they know they role. 3. HC, CRS support and think about village benefit still limited 4. We want to have more knowledge and sanitation in village. 5. Because of the health situation in our village is not good. 6. Reduced money expense on health issue.
	What would happen if they did not do their job?	1. If they did not do their job community not understand about health knowledge such as DF, Malaria and Diarrhea prevention. 2. No Health providers in the Village 3. Lack of sanitation 4. The child and pregnant women have not receive immunization 5. Don't have the coverage plan of the mothers and children for immunization and health education. 6. VHC has no knowledge and skills in health. 7. Sanitation is still bad in the village.
3	here do they get information to do their job?	1. They get information to do their job from CRS staff, health center staff and other NGO. 2. Lost a lot of money, Resources and people face more problem 3. The village has no sanitation 4. VHV, TBA 5. From CRS and HC through attending training. 6. Radio. 7. TV, Meeting, Workshop.
4	How do they get information to do their job?	1. Get information to do their job through participated training for every month form CRS and health center staff, and received IEC material for health education form health center staff and CRS staff. 2. Training in the village by CRS and Health Center staff 3. Learning from Group discussion and implementation the project 4. Meeting .
	Given in a useful way	1. Reduce diseases, through provide more health knowledge to community and reduce poverty 50-65 %. 2. Select importance information such as prevention, transmission and not transmission. 3. Yes, It is changed a lot before the people behave surfaces defecation and now they behave latrine use. 4. Yes, we are learned from training support by HC, CRS and working experience during project implementation 5. Useful for us to share with the others. 6. useful for us to implement our role.
	Information consistent	1. No any health information change 2. Health information was change such as NIP before 6 diseases and knows change to 7 diseases. 3. Decreased case incidences of illness in the village 4. Access to Latrine use, safe water for drinking and drainage system 5. Knowledge for disease prevention practicing 6. Feeling of working commitment changed.
	Information useful	1. Health prevention better then cure according to community has more health knowledge. 2. It is useful, people use that information such as slept under bed net to prevent Malaria and Dengue Fever and drinking boiled water to prevent

		diarrhea. 3. Yes, It is useful Because people change the behavior 4. More using Health Center 5. . More access to latrine use 6. . Not much disease happen 7. . Not much disease happen make the women and children healthy 8. . Village sanitation/ Hygiene 9. . Build up their own capacity to solve the problem on time 10. VHC has knowledge . 11. Villagers received benefit from practicing health care.
	Too much	1. All information they not too much and not less 2. We need more training and supporting for more health education to reach the coverage 3. We still need more work and supports to carry out our role. 4. Too much
	Not enough	1. Information they get still not enough and they activity still limited related to the family condition. 2. Information they get still not enough around 50 %. 3. We still need support from outsiders. 4. We still need report from far distant members
	What more do they want?	1.They want to continue to develop village project in they village because of new family more grow in the village. 1. Want to learn more often than now for efficient capacity 2. More knowledge and skills. 3. Practicing skills. 8. More information from villagers.
	How do they use the information?	1. VHC members referred information to VHC chief such as health education result to health center and CRS staff. 2. Record in Village Health register and selected importance of health inform for health education to community according to the season. 3. For sharing to community 4. Used for analysis and comparison. 5. Prioritize key information for sharing with others 6. Reporting to HC

Bovel - VHV & TBA FGD for MTE June 16-18, 2004

H/C: BOVEL II, KRM and PKP
Name of CRS PO collected the data: 1 SIM SOPHEA, 2 BOU SAKUN
Participants: #VHV 5 , # TBA 4 KRM #VHV 4 and 3 TBA, PKP 4 VHV TBA 5 Total 13 VHV and 12 TBA

Question #	VHV & TBA FGD Question	Answers from VHV & TBA FGD
1	What is the role of the VHC?	➢ Mobilize mother who have child and pregnant women for get vaccination ➢ Provide education to mother as C Breast feed immediately and breast without give water, weaning food C awareness and leaflet distribution for DF, ARI, TB, CDD ➢ Identify chronic disease, # baby die <28 days and follow up chronic DZ ➢ Involve meeting & training at health center every other month ➢ Get information from health center to community and from community to health center ➢ find out children who are far miss and child < 5year to get Vit A ➢ Delivery baby only normal ➢ Refer DS of pregnancy with anemia and child sick ➢ List the # of new born baby, pregnant women ➢ Report to health center every month ➢ Encourage pregnant women to get ANC visit at health center ➢ Mobilize mother who have child and pregnant women for get vaccination and check yellow card to know the mother keep it or what kind of vaccine they need to get. ➢ Provide education to mother as C Breast feed immediately ,Nutrition, Dengue Fever, ARI, TB, CDD, Malaria, food rice of Vit A, 6 diseases, ante-natal care ➢ Identify chronic disease, health problem , ➢ Involve meeting & training at health center every other month and have report ➢ Delivery baby only normal ➢ Refer danger sign of pregnancy and home visit ➢ Report to health center every month ➢ Encourage pregnant women to get ANC visit at health center ➢ Awareness on health in community by small group ➢ Mobilize mother who have child and pregnant women for get vaccination ➢ educate mother to take care child on C with diarrhea, DF, HIV/AIDS, 6 disease, nutrition, BF ➢ Received information from HCMC and health center to disseminate to community. ➢ Need to know chronic disease, # delivery baby, # baby die, # of health education, # disease happened in the village and report to health center every month. ➢ Involve meeting & training at health center every other month ➢ 1/6 said if they have time he attend training or meeting ➢ Involve village cleaning day ➢ Involve Dangue fever campaign and world AIDS day, Candle light memory, ➢ F/U chronic diseases ➢ seasonal Education ➢ find out children who are far Delivery baby only normal with edema, bleeding
	Who do they relate to?	➢ CRS ➢ VHV ➢ Health center staff ➢ Village Authority ➢ mothers who have child < 5yrs and women 15-45 ➢ Community (VHC ,TBA, VHV) ➢ CRS ➢ Community ➢ Health center staff ➢ women who have problem ➢ district hospital ➢ HCMC ➢ VHV ➢ Health center staff ➢ Village Authority

		➢ mothers & pregnant women
	Who are they responsible to? (Accountable)	➢ Post-natal women, children, pregnant women, chronic diseases as hypertension ➢ Refer patient and DS of pregnancy as anemia ➢ Target group in the community by seasonal education ➢ Mother who have children, pregnant women, women to get vaccine ➢ VHV : children, pregnant women, women 15-45 year, chronic diseases ➢ TBA: PNC, pregnant women, women 15-45 year, Delivery baby on normal ➢ VHV : children, pregnant women, women 15-45 year, chronic diseases ➢ TBA: PNC, pregnant women, women 15-45 year, Delivery baby on normal
	Status in the community?	➢ Decrease of diarrhea, DF, Measles ➢ The women have more understand of health, eg. care cord without put something not good ➢ The people good condition living ➢ good hygiene in their village ➢ The community know the important of vegetable for healthy Reduce 6 diseases after provide awareness on important of vaccination in community Hygiene problem in their village as surface defecation Reduce diseases as Dangue fever, dangerous sign of pregnancy The community bring the child to health center ➢ Decrease of diarrhea, DF, CDD, typhoid, malaria, TB Decrease of diarrhea, DF, CDD, typhoid, malaria, TB
2	What do they do? What have they accomplished?	➢ educate to mother and pregnant women on C ANC visit at H/C at 4 time C PNC women on reduce fire, did not drink salt & water, good hygiene as take a bath after DL C Important of immediately of BF (reduce bleeding, stimulate breast milk, to stop the fist stool) C how to care breast and make more milk C Advice to mother who has more child to get birth spacing method ➢ mobilize/encourage mother who have child and pregnant women for get vaccine ➢ Refer with suspected TB to health center ➢ TBA did delivery baby never has problem ➢ The mother understand Danger sign and go to health center ➢ Refer patients , Danger Sign of pregnancy to health center, ➢ Awareness/educate on Dengue Fever , typhoid, HIV/AIDS, side effect of vaccine 1. Provide education on C ANC visit C BF on exclusive C Nutrition C Clean around the house to prevent mosquito growth 2. mobilize/encourage mother who have child and pregnant women for get vaccine 3. Refer patient to health center 4. TBA did delivery baby never has problem and delivery only normal ➢ educate to mother and pregnant women on C ANC C Nutrition C take the child to get vaccine and tetanus for pregnant women C hygiene and Remove source of mosquito growth ➢ Involve latrine project, wells, canal project in village ➢ Encourage mother to take child and pregnant women for get vaccine ➢ Refer to health center with referral form ➢ Mobilize and find out miss child to get vaccine ➢ Dangue fever campaign and world AIDS day, Candle light memory
	1. Why successful?	➢ people participation due to reduce diseases in the village ➢ community belief , understand ➢ Relationship, communication, greeting, well come ➢ women get educate on birth spacing

		▪ The community understand how to prevent the mosquito growth ▪ The community follow them and use health center service and clean village for good hygiene ▪ Participant or mobilize the mothers who has children to get vaccine . ➢ people participation due to reduce diseases in the village
	How do they feel about what they do	➢ Sometime they bored due to some mother did not follow them and to much work ➢ They feel happy if they did accomplish ➢ They able to do ➢ community and mother participation ➢ community belief to CS ➢ It our responsible job ➢ They happy because Reduce of diseases, reduce Danger sign of pregnancy 1. the job has affected their family, but they have to help the community to reduce diseases. 2. feel happy if the mothers follow what they provide to them If have disease out break in the village they ➢ They feel happy because the C mother participation C people in the village reduce poverty C the mother follow what they give advice C decrease 6 diseases fell happy to continue
Question #	VHV& TBA FGD Question	Answers from VHV& TBA FGD
	Able to do?	➢ They can do this job because it not much time to do ➢ They can do this job because it not much time to do They can do this job because it not much time to do
	Get enough support?	➢ community participation ➢ support material as leaflet, poster ➢ community participation collaborate from key people, VHC, HCMC, Village authority
	Doing what they feel they should do?	➢ continue to do education ➢ lean to get more knowledge to be able education to the mother no information ➢ TBA said they should continue to education to pregnant women as C BF, Nutrition, Nip, C mobilize mother who have child to get vaccine C refer Danger sign of pregnancy ➢ Provide normal delivery
	Think that they should do other things	➢ Provide education by seasonal diseases Latrine, canal, wells project and family garden ➢ Provide education by seasonal diseases
	Think their role is useful or not?	➢ they get knowledge and be able to provide education 1. This job have useful for CS and community Reduce family spent for health due to the community get knowledge Good activities, People belief, people bring the child to get vaccine still less at before but now still increase number of children to get vaccine
	Doing too much?	➢ no problem
	How could they do it	➢ get more knowledge to be able provide education

	better?	➢ They want health center staff work/ technical to do education at the village 2. Encourage the community use health center service Provide more education to who did not receive information ➢ get more knowledge ➢ want the people more participant then before ➢ they want CS collaborate each other ➢ IN Svay Sor village has people participation 100% for Nip activities TBA said need to provide education to all pregnant
	What are the problems to do the job?	➢ The mother not happy with VHV or TBA relate to the child get fever ➢ Some mother did not belief due to VHV haven't children ➢ Difficult to mobilize mother to get vaccine Some mother did not take the child to get vaccine ➢ 1/6 Said Some mother complaint why they need to pay for immunization 5/6 said no problem with their work
Question #	VHC FGD Question	Answers from VHC FGD
	Why do they do their job?	➢ They want the mother understand more on health and improve health status in their village ➢ They said that our role responsible /job 1. They want to knowledge and recognize from community 2. They want the community understand the health problem 3. The community use health center by themselves without CS help to go to health center 4. Reduce discrimination Reduce poverty ➢ They want the people to understand more on health and improve health status in their village. ➢ Reduce diseases infection in their village and reduce spent for illness ➢ They think this job not so busy, so they can do their personal job. ➢ TBA said they pity to pregnant women and women confident to them. Help to reduce midwife work at night and to save mother life.
	What would happen if they did not do their job?	➢ The health center staff cannot collect information from the community ➢ Diseases happen in their village ➢ Health status in community getting worse ➢ Living condition problem 1. Health problem in the community growth up 2. The community lack of knowledge health problem and affect to the child have malnutrition. 3. The community did not know the health ➢ Diseases happen in their village as C diarrhea, DF, 6 diseases, ➢ The people lack of knowledge, so they surface defecation ➢ Pregnant women not receive education (lost opportunity who has first pregnancy) ➢ The pregnant difficult to find the midwife for delivery The women lack of knowledge by themselves
3	Where do they get information to do their job?	➢ From health center staff ➢ CRS ➢ VHC HCMC
4	How do they get information to do their job?	➢ Training ➢ Meeting ➢ Communication 1. Television 2. Poster
	Given in a useful way	➢ no information 1. use the message in leaflet or poster for education ➢ The people belief

		➢ People participation as like Nip activities ➢ Reduce diseases in their village ➢ The people did follow what they tell
	Information consistent	➢ Don't know no problem
	Information useful	➢ it useful for provide education and dissemination ➢ we have knowledge to provide education to the mother for change behavior for community Don't know
	Too much	➢ no problem 1. They lean more but they did not remember well ➢ it useful for them and for mother
	Not enough	➢ no problem no problem, it enough information
	What more do they want?	➢ The need encourage from community ➢ They want health center staff work with or technical them and awareness at the village ➢ Need support more for safe Delivery supply and IEC ➢ Continue training ➢ 9/9 VHV& TBA ask to support bicycle ➢ They want health information awareness by television or radio 1. They want to get regular new information by CRS and health center staff 2. Continue training 3. Need more leaflet and poster 4. 9/9 want to have appropriate cost for transportation to health center in this time due to gasoline more prices now ➢ They want to have more knowledge to provide education to mother in their village They want to support more medicine to health center.
	What support do they get after get information?	**We did not use this question** ➢ materials as leaflet, poster ➢ collaborate from CS, key people
	How do they use the information?	➢ Provide education by small group or go house by house by using leaflet, during Nip activities. ➢ . use leaflet for education by small group (5-6) or go house by house or women come to TBA house ➢ Provide education by small group or go house by house by using leaflet, Poster

Bovel – Mother's FGD

Question #	**Mother's Questions**	**Answers from FGD (KR Village)**
Lead Quest	Have your received any HE from CS?	Mothers ever received H .Education (6)
1.	(VHV) (VHC) (TBA) Why do you come for HE from the VHV, VHC, TBA?	1. Want to know the information for disease prevention 8/10(4) 2. Mothers feel it's important/ useful 3. Mothers want to know how to take care when the child get sick(2) 4. Mother wants to do good sanitation 5. Mother wants to have the child get healthy Mother wants to know how to provide food and how to provide breastfeeding to the children.Because of no health knowledge
Additional	If you have not received any HE from CS why not?	1. Never received health education due to being busy with the field work(3) 2. Busy with family's work 3. Family member getting sick nobody takes care him at home 4. Never attended just come from Thailand 5. Her husband not available at home 6. Not interested (2) 7. Not belief Think that, they are healthy Don't Know (4)
	Why do you think that other women do not come?	1. Some time they are busy with field work(6) 2. They don't know when they organized (3) 3. No belief on the importance of disease prevention (3) 4. Not understand 5. Not interesting (2) 6. Not accessible Nobody looks after the house instead especially the spouse have no children (3)
	(VHV) (VHC) (TBA) What does the VHV/ VHC/TBA do for you?	1. Providing health education in the village by using IEC material such as leaf lets , posters for demonstration and explanation(on DF, ARI, NIP,ANC, HIV/AIDS,VCCT, BF, Food, Follow up chronic disease, Safe delivery)(5) 2. Mobilizing children and pregnant women for immunization every month(2) 3. Referred patient and pregnant women to get ANC /TT at HC.(3) 4. Mobilizing children and pregnant women for immunization every month house by house. 5. HC services dissemination DF campaign, burry items that can stand clear rain water to reduces the growth of Tiger mosquito
	What do they do on a regular basis?	1. Mobilized mothers for immunization every month(4) 2. Provide health education (5)
	How do they do these activities?	1. Go through house by house for mobilizing pregnant women and children monthly routine vaccination (3) 2. Mobilizing small group and individual for education by using leaflets and poster (5) 3. Data collected in each area responsible (Child < 1 year and Pregnant women) 4. Doing campaign by direct collecting garbage, burying or burning garbage and remove items that can stand clear water to stop the growth of Tiger mosquito

	How do you use the information that you get	1. Take child to Health Center when the child gets sick (3) 2. Spend less for services but get high quality 3. Know how to taking care the child 4. Know how to prevent from sickness and tell others(4) 5. Read leaf lets and stick on the wall dengue prevention picture, vaccination (3) 6. For practicing and changing the behavior as educated by CS. 7. Share to the neighbor about safe water use Don't know (2)
	What happens if you do not use the information	1. Spend a lot money when someone get sick in the family (3) 2. Spend more time for families 3. Lost labor for other income generation 4. Death 5. Mothers said that the child not get fully immunized, they will develop illnesses and 6 preventable diseases(6) 6. Have more serious illnesses and danger to cause death of the children . No knowledge how to take care the child
	What do they do when your child is sick?	1. Mothers take the child to HC (5) 2. Mother takes child to Angkor Hospital 3. Mothers take the child to find the medical care 4. Mothers take the to private clinic 5. Mothers take the child to meet with grand mother / old people and TBA,VHC. Referred by community structures
	How do they do these activities?	1. Telling direct to mothers to take the child to HC(4) 2. Referred to HC(3) 3. Do home visit 4. Provide leaflet through house by house. Mobilized children < 1 year of age to received immunization and pregnant women to received TT and referred pregnant women to HC for
	What else do you think that they should do?	1. Mothers said that they should increase more education activity in the Villages(2) 2. Mothers want Community structure to continue working as usual forever(2) 3. Provide counseling and consultation when someone get sick. 4. Mothers want Community Structure to continue learning from and CRS so that they can provide health education to us.(2) 5. Community structure should continue to identify other problems for further solving

	Do they know that their village is part of the CRS CS program?	1. Yes, known when CRS did projects in the village (4) 2. Known when CRS did dengue campaign in the village 3. Mother said CARE, CMAC, 4. CRS working in the village for bet net impregnation (2)
	If so what does that mean to them?	1. CRS did Wells, Latrines, Canals and safe water (6) 2. Village sanitation 3. Providing education on disease prevention on DF, Malaria, ARI NIPand HIV/AIDS.(4) 4. Mother feel warmness relate to health when they have problem 5. Conducting community meeting for VHV election
	How does this impact their life or the life of their family?	1. Have a good sanitation (safe water use, latrine use and no polluted water in the village)(6) 2. Prevent the spread of disease in the village(2) 3. Good health status(4) 4. Gain family money income and time for other work.(6) 5. Reduces case incidence of common disease(2) 6. Seek appropriate care(3) 7. Child have time for going to school 8. Able to do seasonal vegetation and home gardening 9. Prevent 6 preventable disease in the village Mothers can communicate with community structures and ask for help.
2.	(VHV) (VHC) (TBA) What does the VHV/ VHC/TBA do for you?	1. Providing health education in the village by using IEC material such as leaf lets , posters for demonstration and explanation(on DF, ARI, NIP,ANC, HIV/AIDS,VCCT, BF, Food, Follow up chronic disease, Safe delivery)(5) 2. Mobilizing children and pregnant women for immunization every month(2) 3. Referred patient and pregnant women to get ANC /TT at HC.(3) 4. Don't know when they organized (3) 5. No belief on the important of disease prevention(2) 6. Not understand 7. Not interesting 8. Not accessible 9. Busy with other work(4) 10. No body look after the house instead especially the spouse have no children Want to know the information for disease prevention 8/10(4) 11. Mothers feel it's important/ useful 12. Mothers want to know how to take care when the child get sick(2) 13. 7. Because of no health knowledge 14. Mobilizing children and pregnant women for immunization every month house by house. 15. HC services dissemination 16. DF campaign, burry items that can stand clear rain water to reduces the growth of Tiger mosquito

New Districts - Health Center Focus Group Discussion
Date: June 16-18, 2004

Health Center's Name: Pichida, Takrey and Serey Meanchey
Moderator: Moul Vanna
Note Taker: Pan Samkol
Note Taker:
Date of Data Collection: 16 to 18 June 2004
Participants: 14HC staff

Question #	Health Center's Questions	Health Center's Answers
1.	What is your relationship with CRS?	1. HC relationship since 2001(pichinda) 2000(Takrey) 1998(Serey Mean Chey) (3) 2. HC staff and CRS ask question and answer.(1) 3. As friendly working(1) 4. Work as supporter as not a boss. (1) 5. Good communication during working.(3) 6. CRS focus more in community than HC (2) 7. CRS and HC not yet good relationship well ex. Some time CRS go down to the village not inform to HC as select community structure than after select they inform to HC. (1)
	What do you value most about your relationship with CRS and Why?	1. Develop community structure to make community to understand health service and use services in HC and to problem solving.(3) 2. Community change behavior. (1) 3. Build capacity to increase knowledge and skill to HC staff and community.(3) 4. Community structure dissemination on health service in HC to community. (1) 5. Support to HC when HC not available material and equipment and drug.(1) 6. Refer suspected case and chronic disease to VCCT.(1) 7. Help to people in community to serve life to mother and children.(2) 8. Training IMCI (1) 9. Immediate support as NIP outreaches activity when GAWI not support CRS provide support they don't want to HC stop activity.(1) 10. Encourage to support HC staff to improve activity.(2) 11. Provide building.(1)
2.	If CRS was not here what would you not be able to do or would be doing differently?	• HC staff can do as activity regularly in HC.(3) • HC not yet real know plan from OD support so they can not said what they can do.(1) • HC can not do as community meeting and training and outreach because government no budget.(2) • Not enough material and equipment to do activity in HC.(1)
3.	What is the role of CRS in this partnership? What is the role of the HC in the partnership?	<u>CRS role:</u> 1. Support and strength to HC and community.(3) 2. Provide technical assistance.(3) 3. Training.(3) 4. Support budget and material to HC when needed.(1) 5. Provide health education to community on water sanitation.(1) 6.Solving problem for health issue.(2) 7. Collaboration and communication between HC and community structure.(2) 8. Make to community understand and use HC services.(1) 9. Improve quality in HC services.(1) <u>HC role</u>: 1. Serve health services for community.(1) 2. Communicate and collaboration between CRS and HC to improve health services.(3)

		3. Solving problem to improve activity.(1) 4. Inform the health problem in community to OD and CRS.(1) 5. Share information for meeting from OD to CRS.(1) 6. Direct implementation activity in HC.(1) 7. Provide health services to community.
	• How could this be improved?	1. Continue to collaboration and communication with HC and community to smoothly.(1) 2. HC staff should commit to work as regularly and enough staff in each service in HC. (1) 3. CRS should photo document as expenses for material and equipment and drug and budget to HC regularly.(1) 4. CRS should develop schedule and post it in HC or inform to HC when CRS absent.(1) 5. CRS should check for inventory every 6 month easy to HC know what lost, what broken and need to request on time.(1) 6. CRS should inform what CRS do in community to HC.(1) 7. CRS should work with HC at least 2 time per week.(2) 8. Provide feed back what weakness or work with HC to improve.(1) 9. CRS should participate regularly on monthly meeting with HC and community structure.(1) 10 HC should inform to CRS for monthly meeting.(1)
	• What else is needed?	1. Develop HCMC as soon as if possible.(1) 2. Transportation for outreach in community.(3) 3. Add more per diem to community structure during training right now CRS provide $1.5 so they need $2.00 at least.(1) 4. Add more per diem to HC staff during training or workshop at OD and place for stay.(1) 5. Training on IMCI.(1) 6. Training on OI drug management.(1) 7..Training on management of keeping documentation.(1) 8.Training and technical to Midwife.(1)
	• What does CRS provide? Financial Material Clinical Training T/A - improve Clinical? Improve management?	1.Financial (3) 2.Training (3) 3.Support(3) 4.Material and equipment and drug(3) 5.Motorcycle(2) 6..Strengthen on management(3) 7..Technical assistance(3) 8. Building (2)
4.	What do they see as the goal of this program?	1.To reduce mortality and mobility especially for pregnant and children.(3) 2. Strengthen health services.(3) 3. Water sanitation (1) 4. Strengthen and increase capacity to HC (1)
5.	What is the effect if they do not do their job?	1. Effect to health problem to community.(1) 2. Effect to public health.(1) 3.. Suffering to life of people.(2) 4. Effect to health problem to community especially mother and children.(2) 5. Effect to poor people will not access to health service.

New Districts - Health Center Management Committee Focus Group Discussion
Date: June 2004

Health Center's Name: Takrey and Serey Meanchey
Moderator: Moul Vanna
Note Taker: Pan Samkol
Note Taker:
Date of Data Collection: 17 and 18 June 2004
Participants: 12 men 7 and 5 women

Question #	HCMC's Questions	HCMC's Answers
1.	Role and function of HCMC?	1. Push people in community to use HC services.(1) 2. Provide information from HC to community and from community to HC.(2) 3. Collaboration and communication to community structure.(2) 4. Control HC activity and material and equipment.(2) 5. Solving problem from HC to community and from community to HC.(2) 6. Identify chronic disease and refer to HC.(1) 7. Set up fee cost.(2) 8. Encourage people to use HC service. (1)
	Who do they relate to?	1. Village health volunteer (2) 2. Village health committee(2) 3. HC(2) 4. TBA(2) 5. Village and commune authority(1)
	• Who are they responsible to (accountability)	1. Health center(2) 2. Community(2) 3. Community structure(1)
	• Status in the community?	1. People in community come to use HC service more then before.(2) 2. Raining season people in access to use public health they use private practitioner.(1) 3. Some people said some HC staff not good attitude.(1) 4. Some people in community said HC staff takes money more than fee cost in HC Ex. For delivery fee cost only 200Bath but they take 1000Bath.(1) 5. HC staff takes money from HCMC member when they use service in HC.(1) 6. Poor people access to use services.(1) 7. People understand HC services.(1) 8. People in community said they don't want to go to the referral hospital because referral hospital staff need money if no money they don't take care even severe sick.(1) 9. Community understand on immunization services.(1) 10. Village authority not so participate because his new.(1)
2.	Major accomplishment of the HCMC?	1. Set up fee cost(2) 2. They come with poor people to HC(1) 3. Dissemination of HC services to community and fee cost.(2) 4. Problem solving between HC and community.(2) 5. Provide health education to community during Village heath volunteer not active and busy.(1) 6. Identify chronic disease and refer to HC(1) 7. Training(1) 8. Meeting(1)
3.	How does the CRS Child Survival Project support the HCMC to accomplish their jobs?	1. Training every 2 month(2) 2. Meeting every month(2) 3. Get information and provide to community to understand the health services in HC.(2)
	• karbNþúHbNþal¼Bt''man • Training/Information	1. Training at HC every 2 month.(2) 2. Training with topic on role and function, Account, Contract and

	Where do they get it? Is it enough? Is it useful? Is it too much? How do they use the information?	facilitation skill. (1) 3. They get information from HC and CRS.(2) 4. The training is enough for them.(2) 5. It is useful for to serve community health and increase knowledge to community.(2) 6. The training is not too much for them they can catch.(2) 7. They use information by dissemination during village meeting.(2) 8. They use information through ceremony in village. (2) 9. They use information thought public event. Walk through house by house. (2)
	• **Technical assistance** Meeting Community information gathering? Fee setting Develop contract	1. Meeting every month. They take minute every month and keep in HC.(2) 2. Collect information from community and report to HC what happen in community.(2) 3. Conduct meeting with HC and send fee cost to community to decide that appropriate or not.(2) 4. Participate to develop bylaw that agree together between HC and HCMC than training.(2)
	• Support	o IEC(2) o Technical assistance(2)
	• Financial	1. Meeting(2) 2. Training(2
4.	How does the CRS Child Survival Project limit the HCMC in what They want to do? • Are they doing what they think they should do? • What else do they think they should be doing?	1. HCMC said not too much for them they can take time to do for CRS program.(2) 2. They do as disease outbreak in village happen.(1) 3. Help to dissemination information and collaboration during HC do activity at community.(2) 4. Ask village authority when has meeting to add agenda that relate to health services in HC.(1)
5.	What should happen if they did not do their jobs?	1. People will increase health problem in community.(1) 2. Effect the health to pregnant women and children(2) 3. Effect to poor people because they did not understand of health services in HC and fee cost.(2) 4. People will use private practitioner(2)

New District MTE - VHC Compile data - In 5 VHC Villages

The VHC Focus Group Discussion conducted for 5 VHCs in Sapov Loun Operational District on the June 16-18, 2004. The total of the members attended the focus group discussion is 36 VHC members (8 males and 28 females).

1. **Damnak Khsan VHC:** 6 VHC members (1 male and 5 females) in Chakrey Health Center
2. **Beng Sa Art VHC:** 6 VHC members (1 male and 5 females), in Barang Thlak Health Center
3. **Pich Chenda VHC:** 6 VHC members (1 male and 5 females) and 2 CBHCT (1 male and 1 female), in Pich Chenda Health Center.
4. **Dey Krahorm VHC:** 8 VHC members (2 males and 6 females), in Trang Health Center.
5. **Lovea Tee VHC:** 8 VHC members (2 males and 6 females), in Trang Health Center.

Question #	VHC Questions	VHC Answers
1	What is the role of the VHC?	1. Training (2) 2. Provide Health education on: • Sanitation, • Safe water use e.g. use water from well, boiling water, and do not use contaminated water from stream can causes diarrhea, people burry feces if no latrine use • Vitamin A • HIV/AIDS • Latrine maintenance and how to use latrine (2) • Garbage and rubbish disposal for both and new residents (2) • Breastfeeding • Sleep under bed nets to prevent malaria (2) • Diarrhea (2) • Drink boil water and safe water (3) • Sanitation and hygiene (2) • Maintenance wells • Common Cold (2) • Pneumonia (2) • Dengue fever (2) • Typhoid fever (2) • Home care 3. Mobilize children <1 year, Pregnant women, and women 15-49 years old of age in community for immunization to prevent 6 diseases e.g. Measles, Poliomyelitis, TB etc (5) 4. Monthly meeting to identify the problem and problem solving (2) 5. Record the number of target group for vaccination, Coverage of health education and chronic diseases. 6. Refer pregnant women to health center or hospital for taking care or ANC visits (2) 7. Refer the patients to health center (3) 8. Monthly report to village chief and HC. 9. Conduct villagers meeting to build the latrines 10. Develop health planning 11. Disseminate the health center services to community.
	• Who do they relate to?	1. Village chief (4) 2. Mothers and People in the community (4) 3. Commune chief (4) 4. CRS (3) 5. Health center (3) 6. Village Health Volunteer 7. Other NGOs 8. Community Based Home Care Team 9. TBA 10. Women Association 11. Private Practitioner
	2. Who are they responsible to? (Accountable)	1. Mothers, Pregnant women and women 14-49 years. 2. Villagers, especially Mothers and children (4). 3. Refer sick persons to health center 4. Health Center staff 5. Village, Commune and district and CRS working in the village

	Status in the community?	1. Improving of diseases prevention (the children and other people will not get sick more often as before) 2. Most mothers understand the vaccination and take the children to get immunization. 3. Community have safe water to use from the pump wells 4. Pregnant women increase knowledge of ANC and go to health center for ANC visits. 5. Mothers take the children to health center when their children get sick because it spend less money and get better. 6. Mothers provided immediate breastfeeding, exclusive breastfeeding and adding the additional foods when the child is 6 months old. 7. Many poor people in the village 8. More people have: • Diarrhea and vomiting (2) • Common cold (3) • Typhoid fever • Malaria (2) • Chest pain • Difficulty Breathing 9. All villagers have toilets and used latrines to reduce diarrhea (2). 10. Hygiene and sanitation in the village is still poor (2). 11. Villagers do not have enough water to use 12. Villagers do not have latrines to use 13. CRS provided latrines to community 14. Dengue Fever is not happen in the village
2	What do they do? What have they accomplished?	1. Register the target group in VHR, VR such as children less then 1 year old and pregnant women for immunization (2). 2. Identify the problems and solution and develop proposal, submit to CRS for supporting of the projects (3). 3. Develop planning 4. Mobilize all mothers to take the children for the immunization. 5. Provide health education on: • Bed net impregnation (3) • Immunization • Malaria • ARI • HIV/AIDS • Vitamin A • Hygiene and sanitation (2) • Latrine use (3) • Safe water use and drink boil water • Breastfeeding • Washing hands • Field defecation with burry 6. Attend training on: • Immunization (2) • Bed net impregnation • Malaria (2) • ARI (2) • HIV/AIDS (2) • Vitamin A • Dysentery • TB • Dengue Fever 7. Develop seasonal chart 8. Mobilize people and provide bed net impregnation to community (3). 9. Conduct meeting with villagers and reported to CRS (2) 10. Refer the patients to health center (2)

		11. Organized VHC election 12. Attending the meeting (2) 13. Attending training 14. Home Visits and follow up (2) 15. Participated Candle light Ceremony to remind the death spirit from HIV/AIDS 16. Mobilize people for meeting and health education 17. Decreased mobility and motility rates in village. 18. The people increased understanding on hygiene, hone care, drink boiled water and using the latrines.
	Why successful?	1. CRS supported latrine materials and provide monitoring and activities (4). 2. Community and authority trust and participate to VHC activities. 3. VHC meeting was done 4. Hand-pump proposal was discussed with people and submitted to the villagers and commune chief to check and giving agreement 5. Good communication with local authorities 6. VHC members have knowledge and some skills to do their jobs. 7. Many mothers take their children for immunization. 8. People received bed net impregnation (2) 9. VHC members understand their roles. 10. Community participated to implement the project. 11. CRS provided training and technical support for health education to mothers.
	How do they feel about what they do	1. Happy and satisfy with the accomplished works and other extra jobs that asked to do (4). 2. CRS recognized and supported VHC. 3. Even if, CRS finished the project the VHC will continue the work. 4. The villagers believe and respect to VHC because the community have safe water to use. 5. The diseases are reduced such as: • Malaria • ARI 6. VHCs continue to provide health education to the community to improve more knowledge to mothers and mother practices (2). 7. VHCs feel that, they did not do much their activities because they are busy with their own daily activities. 8. The training that VHCs got can help them and help them to continue to do health education for new married people to increase their knowledge the same as the old married. 9. VHC feels that, they should implement activities according to the need of the people because they were elected by the communities.
	• Able to do?	1. Able to mobilize and organize people to build latrines and accomplish the jobs (2). 2. Can do other things if continuous supporting from NGOs (CRS) 3. They able to do all jobs that asked to do and as written on the job description (2). 4. Can follow VHC `s bylaw **Notes: This question was answer by 3/5 VHCs**
	• Get enough support?	1. Enough technical support for health education. 2. Not enough material support for latrine construction. 3. People requested to have water seal latrines and CRS suggested to contribute some money and materials to build water seal latrine. 4. All members of VHC said they don't have enough knowledge and skills to provide health education 5. VHC said no incentive for their work. 6. The community needs more hand-pump well, drainage system and road in the village **Notes: This question was answer by 3/5 VHCs**
	• Doing what they feel they should do?	1. VHC members feel that, their roles and activities are the right things to do to help the community. 2. Continue meeting amongst VHC and meeting with the people in

		village. 3. Continue to identify and follow up the chronic ill persons in village and refer them to HC. 4. Receive training 5. Keep documents 6. Look for and record orphanage children affected from AIDS. 7. Analyze the results 8. Suggest to CRS to support to pump feces from full latrines. 9. Educate to people and maintenance and follow up the latrine use. 10. Construct more hand pump wells in the village. 11. Develop the drainage system in the village. 12. Construct the road in the village **Notes: This question was answer by 3/5 VHCs**
	Think that they should do other things	1. Suggestion to have more hand-pump wells and drainage system in the village (3). 2. To have a post for VHC meeting and immunization (2). 3. Build latrines for the other families 4. Build the latrines and hand pump wells for the primary school. 5. Construct the road in the village. 6. Educate about hygiene and sanitation in the village **Notes: This question was answer by 3/5 VHCs**
	Think their role is useful or not?	7. Useful for VHC (2) 8. Useful for people to get understand the health knowledge, healthy and using latrines (2). 9. VHC members understand and take responsible to their roles. **Notes: This question was answer by 3/5 VHCs**
	Doing too much?	10. Not too much, they can tolerate with their works (3). 11. The jobs is too much work **Notes: This question was answer by 3/5 VHCs**
	How could they do it better?	1. Learned from the result what they have done if it is not accomplished or not good, they discuss amongst VHC members to find other ways to improve it 2. Continue to do the work that is not finished yet. 3. Giving more training to VHCs such as: • Malaria • Diarrhea • Common cold • Communication skills • Home care skills • Hygiene and sanitation • Diseases prevention (2) 4. Refresher what VHCs have learned from the before. 5. Conduct regular VHC meeting (3). 6. Find out the problems and problem solving together. 7. The VHCs need to continue to provide health education to mothers and increase the number of education to improve the knowledge of the community (2). 8. VHC members should participate and involve with meeting, training, health education and NIP to improve the activities
	• What are the problems to do the job?	1. Difficult to educate community to finish the projects as soon as we want (most villagers were busy with their own works, when VHC advised the same idea in many times they disappointed to VHC). 2. No transportation supports for VHC to do their jobs such as go in the village to mobilize people for education and home visits. 3. Raining 4. Some of VHC members did not participate the meeting due to message and invitation for meeting was not reached and some of them are busy with their field (2). 5. Some of the mothers do not take their children to get immunization as VHC provided heath education because they are not interest (2).

		6. It is difficult to go to attend the training because of bad road. 7. Some of the pregnant women do not go to health center for ANC or TT because they do not believe, even they never got immunization, and they feel that they will not get sick
	Why do they do their job?	1. Changed the village environment from bad sanitation to be good hygiene and sanitation (2) 2. Changed living condition of people to have better health (2) 3. To encourage the people to do their jobs. 4. VHCs and community benefit from the project e.g. pump well project. 5. VHCs want to improve the health and reduce the sickness and death of the people (2). 6. VHCs follow their roles and function that communities elected them as the members of VHC (4) 7. VHCs want the mothers to understand about immunization for their children, pregnant women go to health center for ANC and go to health center when they get sick.
	What would happen if they did not do their job?	1. CRS will not trust VHC. 2. Villagers will not believe to VHC or lost trust from community 3. Latrine project will not accomplished 4. VHC will lose support from CRS, other NGOs 5. Village will not develop 6. Affected to the health of people in village (2) 7. If any member of VHC does not do his job the VHC chief will look for other VHC members to work or replace the absentee. 8. Mothers and children will get sick and die from the bad health 9. CRS will not get success of their jobs 10. It will be bad in community, especially for the next young generation, they do not know and understand the diseases prevention such as malaria, ARI, Vitamin A and 6 diseases. Diseases (2) 11. Every thing that they have done will be destroyed. 12. It can be dangerous affect to the communities: Children, pregnant women e.g. after delivery the child need to get immunization but if the child did not get immunization they can have tetanus, measles poliomyelitis
3	Where do they get information to do their job?	1. CRS (4) 2. Village chief (4) 3. TBA 4. Private practitioners e.g. more people sick with DF in the village 5. Health center (3) 6. Women association 7. Villagers (3) 8. Commune chief (2)
4	How do they get information to do their job?	1. Received information from health center staff by writing (2), 2. Home visit and ask information from villagers 3. Meeting (5) 4. Planning (2) 5. Village registers (2) 6. CRS (2) 7. VHC job description (3) 8. Training (4) 9. By-Law 10. Posters and Leaflets (2)
	• Given in a useful way	1. VHCs can give health education and disseminate the messages to the villagers (3) 2. Mobilize the people to get immunization (3). 3. Conduct meeting and educate people to build the latrines. 4. VHC can refer the sick patients to health center. 5. Make the report 6. Participate meeting and training **Notes: This question was answer by 3/5 VHCs**
	• **Information consistent**	1. Information is consistent (3) **Notes: This question was answer by 3/5 VHCs**
	Information useful	1. VHC chief understand his roles such as organizing VHC monthly

		meeting, make report and someone to record the meeting when the secretary absent (2). 2. Facilitate the meeting (2) 3. VHC Deputy chief does the roles of chief when the chief absent and the secretary record all information and keep documents (2). 4. It is useful for the people in the village 5. It is important for VHCs to have knowledge and skills to improve the health of the mothers and for the children (2). 6. VHCs increase knowledge and provide education to community to reduce the sicknesses (2).
	Too much	1. The information is not too much (4). 2. The information is enough to serve the community
	Not enough	1. VHCs said they have enough information (2) 2. VHCs said they do not have enough knowledge and need more training about seasonal disease prevention (3). **Notes: This question was answer by 4/5 VHCs**
	What more do they want?	3. More training on: ▪ Malaria (3) ▪ DF (2) ▪ Pneumonia (2) ▪ Care during regency ▪ HIV/AIDS ▪ 4. Refresher what they had learned such as: • Roles of VHcs • Health Planning • Hand pump well proposal development • By law • Seasonal diseases 5. Suggest to have more hand-pump and drainage system and road construction in village in the village 6. Educate about hygiene and sanitation in the village 7. VHC want to have the latrines for people to use. 8. VHCs want to have bicycle
	• What support do they get after get information	**We deleted this question**
	• How do they use the information?	1. Provide education and disseminate messages to the villagers (2). 2. If any problems happen with doing their jobs VHC members will ask help from village and commune chiefs. 3. Report to CRS and re-conduct VHC meeting if the problem happen. 4. Use information educate to community to improve health status for mothers and children. 5. Use the information to care, prevention and treatment family and educate to community to prevent the diseases

New Districts - VHV + TBA FGD compile
For MTE June 16-18, 2004

HC: Ta Krey .
Date of DATA collected: June 17 2004 Note taker :Heng Hean Recorder: Um Buntha Recorder
Moderator: Kong Chanthorn Participants: (VHV 6 + TBA 4)

Question #	VHV + TBA FGD Question	Answers from VHV + TBA FGD
1	**What is the role of VHV/TBA?**	***VHV role*** 1. Provide health education to mothers (3) 2. Transfer patients to health center (3) 3. Involved and Mobilize the people, pregnant women, women 14-45 years and children for NIP and Vitamin A in the post (3) 4. Report monthly activities give to HC in the meeting at HC (2) 5. Attend training at HC (3) 6. Attend meeting at HC (2) 7. Collect people for health education at villages 8. Involve in meeting at villages (2) 9. Information sharing to community and in the field 10. Participate in bed net impregnation 11. Record the children less than 1 year and pregnant women, children under 5 years and chronic disease. (2) 12. Communication between HC and NGO. 13. Follow up Chronic Diseases. **TBA role** 1. Take care pregnant women and post partum women, new born baby (2) 2. Collect the pregnant, women, women 14-45 years and children for NIP in the post (2) 3. Attend training at HC (2) 4. Attend meeting at HC (2) 5. Report monthly activities give to HC in the meeting at HC (2) 6. Provide health education to mothers, breast feeding, nutrition at villages (3) 7. Refill TBA supplies from midwifes at HC (2) 8. Refer and Follow up PNC and ANC high risk danger sign (3) 9. Provide delivery 10. Communication between HC and NGO. 11. Refer patients to health center. 12. Inform to pregnant women to come to health center one time/ month
	• Who do they related to ?	1. Health center (3) 2. Village chief (3) 3. CRS (2) 4. TBA between VHV (3) 5. Old people (2) 6. Traditional kru Khmer (2) 7. Villagers (3) 8. Communication with others NGOs (2) 9. CBHCT. 10. Mothers
	Who are they responsible to? (Accountable)	1. Children and pregnant women because children have more serious than other when they got sick (3) 2. Patients illness in the village and Chronic disease (2) 3. They responsible for themselves to increase the knowledge and skills. 4. Poor villagers in their village.
	Status in the community?	1. Cut down the Children sick case in village (3) 2. Mothers have knowledge how to Prevent and take care the children eg

		Malaria(3) 3. Some of the mothers did not understand of important vaccine 4. Increase health center utilization (3) 5. Increase Immunization (3) 6. Increase ANC visit at HC (3) 7. Decrease the patient's death in the village. 8. Increase bed net impregnation coverage (2) 9. TBAs did not have enough materials for delivery at home. 10. Increase sanitation in the village and the villagers increase hygiene 11.The midwives do not reach to the far distant villages to provide services 12.The pregnant women in far distant villages have difficulty to come to health center due to the difficult road. 13. People use health center because they think low pay.
2	What do they do? What have they accomplished?	1.Provide health education -How to take care pregnant women on ANC visit, place for safe delivery (2) -How to use safe water, malaria, completed vaccination, Personal hygiene, HIV/AIDS, Breast feeding, Nutrition (3) -Provide education follow by the seasonal disease in village (2) 2. Mobilize people for immunization including TT for pregnant women. 3. Transfer patients to health center (3) - Chronic disease to health center - Pregnant women for ANC and delivery - Refer the sever case to HC - Refer high risk danger sign of pregnant women to HC - Refer patients with sign of anemia to HC - Some mother go to health center by herselves (1) 3.Villages health recording -Children less than 1 year -Pregnant women -Chronic disease patients -Health education
	Why successful?	1.Because Collaboration with HC, community health structure and others NGOs(2) 2.Received knowledge from HC, CRS then provide H education (3) 3.Involving from people in the community for health education (3) 4.They get priority topic and share to community (2) 5.VHVs are able to provide health education to mothers by using IEC 6.The villagers belief and increase thrust to VHVs, TBAs in the village 7.People increase understanding of the importance of the immunization and know the date of the immunization. 8. Increase the patients use health center
	How do they feel about what they do	1. They have felt increased knowledge through NGO on how to prevention and take care family and villagers (2) 2 Want to work and to help people in villages (3) 3 Feeling spread disease from patients????????????? 4. They are not enough time to do health education 5.They are want to work on private for their family 6.They happy to work with HC to share knowledge to people in community (2) 7. TBA got the small gift from the mothers when they gave birth to mothers.
		8. Happy to do the jobs and help the pregnant women to have safe delivery. 9. VHVs want people increase income and less spending for health care. 10.They interest to help people in community 11.Want to see the country develop
Question #	VHV and TBA FGD Question	Answers from VHV + TBA FGD

	Able to do?	1.Mobilize/ Collect mothers, children and pregnant women for immunization. (3) 2.Report activities to HC (2) 3.Provide health education (3) 4.Sharing information to the villagers of what the information that they got from the health center (2) 5. Educate and advice the sick patients to use the health center 6.Referral case sickness, high risk pregnant women for ANC to HC (3) 7.Follow up high-risk danger sign of pregnant women. 8.Provide delivery. 9.Provide ANC, Anemia, post natal care to mothers
	Get enough support?	1. They said that not enough supported transportation for far villages (2) 2. Financial for transportation from village to health center 3.They are receive training from HC (2) 4.They are have support from village chief and community(2) 5.Support from the health center. (3) 6.Health center gave exemption for TBA and VHV and the close families. 7.CRS support training, training budget and IEC for health education. 8.Problem solving 9. Provide training to TBA more than VHV 10.TBA receive technical assistant regularly in meeting at HC 11.Not enough delivery equipment as scissor, forceps 12Enough IEC material support
	Doing what they feel they should do?	1.Collect children and pregnant women for NIP (2) 2.Report activities to HC (2) 3.Provide health education (2) 4.Attend training /meeting at HC (2)
	Think that they should do other things	1. Provide more health education other topic like sexual transmitted disease 2. Collaboration with HC, NGO village chief, villager 3. Attend training and meeting at HC
	Think their role is useful or not?	1. They said very important of that role to receive knowledge (3) 2. Sharing knowledge to people in community (3) 3. Decrease disease from community (2) 4. No problem in community 5. TBAs make some of the benefits from providing delivery babies. 6 .It was useful to make income and less expenses for health in the families 7. Children get healthy
	Doing too much?	1. Enough and appropriate for them to work (3). 2. It was not too much of job and they work because, want to increase knowledge and skill
	How could they do it better?	1. They should receive more training technical from health center and Catholic Relief Services (2) 2. They should support materials IEC from health center(2) 3. They should support for transportation (2) 4. Knowledge and skill how to treat patients at villages(2) 5. If they have continuation to increase the knowledge and skills 6. If they are able to provide the basic care and giving medicines to people at home before the patient go to the health center.
	What are the problems to do the job?	1. Problem with private work to support their family (2) 2. Difficult to transport at far distance area (2) 3. Poor people busy their own work not attend in health education (2) 4. Some people did not belief did not take the child to get on vaccination (3)

		5. One child received abscess their family did not come to receive vaccine any more 6. People stay far distant from the village and could not mobilize the people for health education and immunization. 7. Delivery at night – the TBAs have difficulty to walk at night to serve people. 8. Do not enough materials use for delivery 9. No referral form for sending patients to health center. 10. New arrival use private medicine
Question #	VHV + TBA FGD Question	Answers from VHVHV +TBA FGD
	Why do they do their job?	1. People elected them to be VHV, volunteer to do the job (3) 2. To help people in community (2) 3. To change the situation in community (2) 4. Respect from community (2) 5. Because it can increase the knowledge and skills as the VHV and TBA.(2) 6. They want to see people get healthy and no one die Because the neighbor country loves their people and we as the Khmer, we have to love and help our people too.
	What would happen if they did not do their job?	1. Many people will have sick, Still have child and mother die (3) 2. People do not know on how to prevent diseases
3	Where do they get information to do their job?	1. They collected from villagers and mothers (2) 2. They get from village health recorder 3. They get from HC (3) 4. They from CRS 5. Get information NIP activity and H. education 6. Information from patients. 7. Information Village Health Record. 8. From Village chief. 9. Get information from HC and community to make plan 10. From training and meeting
4	How do they get information to do their job?	1. They get from training meeting (3) 2. They get Information when doing home visit 3. When there is the problem community.
	Given in a useful way	1. Help people to stop bleeding when they have injury 2. Regular meeting and training 3. Provide health education to people after get training 4. Provide education to people during the immunization 5. Continue information sharing or provide health education to village
	Information consistent	People living far away from health center did not receive health education not change behavior.
	Information useful	1. Can use for follow up sick disease 2. To make plan for health education 3. To make report of health situation in village 4. For sharing to community and HC
	Too much	Information that they get is enough and appropriate 1. Information appropriate and not too much
	Not enough	1. No answer
	What more do they want?	1. They want have more training to increase skill and experience (2) 2. They want to have enough support (2) 3. They want to have enough referral form 4. They want health center staff come to work on time and as schedule. 5. They want to have referral hospitals staff work for 24 hours 6. They want to have exemption to poor patient in referral hospital.

		7. They want to have exemption to VHV, TBA at health center and referral hospital. 8. 1TBA want to has delivery equipments (forceps and scissor) 9. They want to have medicine syrup 10. They want to have health center staff to classification diagnosis and treatment 11. They want to have capacity building by CRS than HC (VHV) 12. Capacity building of treatment and care by medicine Kit by VHV Well
	What support do they get after get information?	1. Posters and leaflets (3) 2.If Program can give transport support for TBA and VHV as bicycle (2) 3.CRS support transportation 4.Medicine kit 5.TA support on Village Health Record and health education. 6.Update information
	How do they use the information?	1. Collect people for meeting and provide health education (3) 2. Using poster and picture during NIP activity (3) 3. Information sharing in village chief have meeting (3) 4. Use Information during NIP activity (3) 5. Information post the poster in village and VEDEO hall (3) 6. Educate during in the shop or after rest from fieldwork. 7. Do health education by provide leaflets through small group and household

Other observation during focus group discussion

Takrey

1. No who are leaf from the group discussion, 2. One TBA not so speech out during in discussion

Pichenda : 1. VHV/TBA are very interested to learn more, 2. VHV is leaving home in the middle of process because the house is too far from HC an d difficult road, 3. 6/12 are active to give answer and other 6 are quiet

New Districts - **Mother's Focus Group Discussion, Cham Bok and Kamprong Village, Date: June 18, 2004**

Moderator: Kong Chanthorn
Note Taker Heng Hean, Oum Buntha
Participant: 20 mothers

Question #	Mother's Questions (Cham Bok Village)	Answers from FGD
Lead Quest	Have your received any HE from VHV and TBA?	1 .Mothers have received health education from VHV,TBA, (20 mothers)
1.	(VHV) (TBA) Why do you come for HE from the VHV, TBA?	1.They want to know how to care the children, diseases prevention. (2 place) 2. they said they want to know new information (2 place) 3. They want to know the immunization activity. (2 place) 4. They want to know the services at the health center (2 place)
Additional	• If you have not received any HE from CS why not?	
	• Why do you think that other women do not come?	1.The mothers busy with the field work and took the child to the field in the morning (2 place) 2. The mothers did not know the health education happen/time (2 place) 3. They said that she living far distance. (1 place) 4. No anyone give information to mothers about health education by small group (2 place) 5. women think they know and have ability to care their children and during pregnancy (2 place)
2.	(VHV) (TBA) What does the VHV/TBA do for you?	1. Mother said that they received health education from TBA,VHV,: (2 place) 2. NIP to prevent 6 diseases. (2 place) 3. Advice mother to take child for immunization. (2 place) 4. Received information about bed net impregnation. (2 place) 5. Told the mother use health center (2 place) 6. Provide leaflets for people about NIP and bed net impregnation. HIV/AIDS. (2 place)
	• What do they do on a regular basis?	1. Sharing information before NIP activity (2 place) 2. Collect children/pregnant women for immunization (2 place) 3. Sharing information during contribute VIT A activity and bed net impregnation (2 place) 4. Attended NIP activity for health education (2 place) 5. Small group not regular for health education (2 place)
	• How do they do these activities?	1. VHV told the mothers house by house to tell the mother for immunization. (2 place) 2. VHV do health education from house by house on NIP/ANC for health center staff when come to provide service in community. (2 place) 3. Provide and explain on leaflets of NIP/ANC (2 place) 4. They provide health education during village's chief meeting (1 place) 5. Use loud speaker by VHV (1 place) 6. Small group not regular for health education (2 place) 7. Provide health education in small group (1 place)
	• How do you use the	1. Share the information to other mothers who did not stay home

	• What do they do when your child is sick?	1. VHV/TBA advice mothers to take the child to health center. (2 place) 2. Advice mother to use health center less payment. (2 place) 3. Give the medicine to the child if not better need to follow up at health center. (2 place) 4. Referred child sick to the health center (2 place)
	• How do they do these activities?	1. VHV visits the child and advice mothers to take the child to health center. (2 place) 2. The mothers did not received PNC care at home TBA just take money after delivery. (1 place) 3. TBA provide health education on hygiene, breast feeding take care infant and get immunization during NIP activity during delivery. (2 place) 4. TBA advise mother eat much food. (2 place)
	• What else do you think that they should do?	1.The mothers want VHV and TBA provide health education 1 time/month (2 place) 2. Mothers want to have syrup medicine at HC during small child sick (2 place) 3. Mother want to know VHV and in each village (1 place)
3	Do they know that their village is part of the CRS CS program ?	1 All mother did not know Catholic Relief Services in the village (2 place)
		No answer from mothers. (2 place)
	information that you get?	while VHV,TBA provide education. (2 place) 2. Take the child and pregnant women card for NIP (2 place) 3. They educated mother to clean and sanitation. (2 place) 4. Put the child to sleep under bed net impregnation(2 place) 5. Saw the poster at the public area in villages (1 place)

Observation:

1: The mothers did not remember the name of agency (CRS) (2 place)
2: Mothers did know well about VHV and TBA is very clear (1 place)
3: 3 mothers leave during meeting not finished (1 place)
4: 6 mothers are very active (1 place)
5: 1 mother did not active discussion (1 place)
6. Mothers focus group discussion take time 1 hours (1 place)
7. Mothers focus group discussion take time 2 hours (1 place)
8. Mother fighting the child during meeting
9. 9 mothers are very active (1 place)

Annex 14

Staff Data Analysis, Discussions, Conclusions and Recommendations

The group broke up into four team, depending upon where they worked

Bovel		**New District**
Team 1	Team 1	
Health Center		Health Center
HCMC		HCMC
Team 2	Team 2	
VHV/TBA		VHV/TBA
VHC		VHC
Mothers	Mothers	

The groups used the following format and tools to organize their analysis, discussions, conclusions and recommendations

Facility
Assessment
Classification
Treatment
Counseling
Linkages
Community structures
Management
Planning
Drugs
NIP
Infection control
Financial
HIS
Resources – human and material
Supervision
Logistics
Technical support

Community
Care Seeking
Home Care
Behavior Change
Mobilization
Linkages
Community Structures
* Management
* Sustainability
* Roles
* Types / #

Tools Used
HFA data
DHS/LQAS/HIS data
FGD data

Group Presentations on Recommendations

Bovel - Group 1 (Health center)

IMCI

Mother counseling

- Refresher course on mother counseling for HC staff, focusing on motivation, incentive (ex. study tour to visit another IMCI area/activity)

Vaccination

- Continue support to NIP outreach activities
- Per diem support for 1 VHV in each village during activities (on a rotation basis)
- OD level take over responsibility from CRS for doing quarterly supervision using the checklist at the HC and outreach in the community,

Management:

Infection Control

- Refresher training to all HC staff on infection control

- Supervision by OD staff every 2 months using checklist

Financial System

- Refresher training on the accounting system for all HC staff by the OD staff with CRS support
- Supervision by OD staff every 3 months using checklist

Supervision

- Continue with existing plan for IMCI supervision and meetings every 2 months

Health Planning

- CRS will continue to provide support to the HC staff to develop quarterly and annual health planning, but with special focus on budget and activity plans at the HC and OD levels.

Linkage

- CRS will continue to support HC staff to organize community structures through meetings and workshops for sharing messages with communities
- Develop an integrated plan with the school system to mobilize children to come to the HC for TT (females 15 YO+) and mebendazol (7-15 YO)

Other recommendations

- CRS should facilitate with other NGOs that receive funding from the same donor sources should standardize on per diem, transportation and lodging costs/payments in the operational district
- CRS should have an office in Bovel
- CRS should spend more time in the HC – at least 2 times a week

Bovel – Group 2 (VHV/TBA)

Increase NIP coverage

- Improve VHV/TBA and HC and CRS use of village record
  - HC staff and CRS will help VHV to analyze and use VR for planning every 2 months at the meeting and for NIP activities
  - Work/train HC and VHV/TBA to use the VR (analysis, planning, etc.)
  - CRS and HC will monitor and provide TA to VHV/TBA to use the VR
- Improve health education for NIP
  - CRS and HC staff will train VHV/TBA on mothers group discussions for NIP – how to facilitate, how to organize, mobilize and deliver key messages
  - CRS and HC will help the VHV/TBA to mobilize mothers/pregnant women for group discussions around NIP
  - CRS will demonstrate how to do group discussions with mothers by going to the village and showing the VHV/TBA
  - CRS will monitor and provide TA to VHV/TBA in the village
  - Competition between mothers who have <2 yo and pregnant women on Q & A for TT2, fully immunized, keep cards

CDD – home care/care seeking/awareness
ARI – home care/care seeking/awareness

- Improve health education by VHV/TBA to follow the NIP process
  - Focus group discussions with mothers <5 yo
    - Home care practices
    - Seeking care practices
  - Analyze and develop training on key messages to be delivered by VHV/TBA

- Training for VHV/TBA on the NIP process
- VHV/TBA home visits for mothers who have sick children
- Devise/develop referral system from community to HC for use by VHV/TBA
- CRS provide training for VHV/TBA to do spot checks
- Mothers' group discussion on NIP process (mother's practice)
- Share referral system during mother group discussion
- CRS and HC to develop CDD curriculum

Bovel District – Group 1 and 2 (Mothers)

1. Conduct mothers FGC to identify " why mothers have not belief , understanding, BCC and interest on home care, care seeking and disease prevention – ARI, CDD, NIP, Malaria
   - Train CS on how to do mother's FGD
   - CRS/HC staff involve and demonstrate how to do mother FGD (Mother's feedback to CS)
   - CRS/HC monitor and provide feedback
   - CRS/HC develop questions and plan with CS to do mother FGD
2. Conduct mother's FGD to identify community support to CS to continue their work
3. Conduct CS FGD- identify what support to CS to continue their work and discuss with CRS staff to find out what support to CS to be able to continue their work/their role
4. Share CRS/CS role, activity through community w/s due to mother not knowing
5. Develop leaflet on role of CS to share to the community.

New District – Group 1 (Health Center)

Scale Up
IMCI focused TA
A
C 3 days/HC/wk for 2 months (only in the mornings) then 1x/HC/week forever
T

Counseling:
Develop a plan and tools for NIP, BF, ARI, CDD, malaria
BCS:
HC staff – increase quality of practices (in general)
Example: infection control knowledge is good
Practice is poor
Water (need to ensure that all HC have working water systems)
Linkages:
VHV/VHC/TBA Bring commodities to the villages (ex. ORS, bed nets, re-treatment supplies, vaccination cards)
Media:
Songs, drama, radio, billboard, TV, game, competition, campaign, facility forum, feedback box, mystery client, video

New District- Group 2 (VHV/TBA)

Care Seeking
Knowledge and practices of mothers on care seeking for ARI, CDD and malaria need to be improved in the community
identify the target group – not focus on general population
develop mother groups, mother leaders, in each group have about 20 mothers- if migrant mothers come in to the community, include them in the group
Community campaigns
where is the health center
the health center services available
medicines available
time open at the health center
fee charge – compare to fee charge from private practitioners

conduct community meeting
who is the VHV/TBA
roles
how to get advice or refer when children are sick
VHV/TB use referral form
CRS provides referral form to HC/VHV/TBA
HC provides information back to VHV/TBA through sending the referral back to senders
HC provides feedback in monthly meetings with VHV/TBA
Home Care
increased knowledge and practice of home care. Focus on increased fluid/food and breastfeeding
Follow up with identified danger signs of ARI/CDD/malaria
CRS/VHV/TBA provide health education to mothers groups
CRS/VHV/TBA – develop key messages
CRS assists by providing TA to VHV/TBA to provide effective health education to mothers
CRS/VHV/TBA observe mothers practices for home care when child is sick (home visits)
health education to mothers
CRS/VHV/TBA conduct home visit to sick child together – provide guidance
Develop ORS system with VHV for long distance villages
Behavior Change
CRS/VHV/TBA conduct FGD with mothers to understand what they practice related to ARI, CDD, malaria, BF and home care
CRS/VHV/TBA provide education to mothers to focus on the weaknesses on BC and encourage mothers to continue to practice what mothers do right
CRS/VHV/TBA develop home visits system to find out the behavior change (practices) after mothers received health education
CRS/VHV/TBA develop system to observe mother practices
CRS works with VHV/TBA to provide support and TA to improve BC of mothers
Mobilization
Health education, meeting, outreach activities, campaigns
Inform/mobilize through mothers group leader
Identify place/time
Identify the target group – according to issue
Information has to be shared with target groups at least 2 days before activities start
CRS conduct meeting with VHV/TBA/local authority (village chief, group leader)
Mothers group leader
Activities related to mobilization
Support from village chief/group leader
Location/time
Linkages
CRS conducts meeting at HC with VHV/TBA/HC
Report HC and community activities including utilization
Problems faced/problem solving
Feedback on referral from VHV/TBA
Shared planning
CRS conducts meeting wit VBV/TBA local authorities including group leaders
Share roles of VHV/TBA with local authorities/villagers
Share objectives and roles of CRS program in community
Get commitment from local authorities to supoort activities
CRS conducts meeting with VHV/TBA and traditional existing community structures
Share roles/objectives of all community structures
Come up with decision on how existing structures support each other to improve health for mothers/children
CRS assist, support and facilitate meeting

New District – Group 1 and 2 (Mothers)
<u>Care Seeking</u>:

1. Education on care seeking, focus to mother's with children under 5 years of age
2. Develop and group mothers with children under 5 years. Divide the mother's groups to VHV, TBA, VHC take responsible
3. Education or campaigns in the villages on seeking care focus on:
    - Danger signs of ARI, CDD and Malaria
    - Where should mother's seek care
    - Service available
    - Service charge/exemption
    - Time of HC working

4. Mother's know who they can get advice from for care seeking in the village through participation of community structures meeting to share who they are and what is their roles.

Home Care:

1. Mother's group education on Home care by selecting experienced mother's to share their experiences of home care focus on:
    - ARI, CDD, Malaria danger signs monitoring
    - Increase foods, Increased fluid and increased breastfeeding
    - Prepare and use ORS at home
    - Care the sick children at home
2. Mothers know who should they contact to get advice/opinions if they face problems with home care.

Behavior Change:

1. All pregnant women and post partum women received exclusive, immediate, complementary feeding by community structures.
2. Conduct sharing experiences among mothers who have children over 6 months
3. Mother's group discuss share and demonstrate the practices, behavior change including advantages of practices.

Mobilization:

1. Mother's group leaders mobilize mothers for H.E, group discussion, experiences sharing, outreach services.
2. Education for the mother's group members to get understanding and see the same objectives and importance of mobilization.

Linkages:

1. Mothers in each group know and support each other
2. Mothers link to the VHV, VHC, TBA and other mother's group in each village.

Annex 15

Final Presentation and Feedback with Partners

Approximately 50 people came from USAID, PHD and OD offices from Bovel and the new districts, and presentations were given by the program manager and area managers, providing information on the data set – HFA, FGD, an LQAS (baseline and 2003), and the process used for the MTE.

Participants were then divided into small groups (by district and area) and asked to discuss the data and the issues identified by the MTE, and come up with suggestions on how to address/improve them.

Bovel Health Center

Management

IMCI

1. Assessment
- All children <5 need to be assessed using the IMCI algorhythm
- Ask mothers about vaccination for 6 diseases and yellow card
- Ask if child has received Vitamin A and deworming
- Take vital signs

2. Classification
- Implement the algorithm according to the assessment findings
- Classify cases in terms of intensity of illness using the algorithm

3. Treatment
- Use the treatment table provided by the MOH IMCI program

4. Counseling and Education for mothers
- Tell the mother about the problem identified for the child (diagnosis)
- Name, dosage, time, duration for drug treatment
- Explain reasons for follow up and when to return to the HC
- Explain about side effects of drug treatment
- Ensure that the mother understands

5. Communication
- Tell the community about the services offered at the HC, working time, fee schedule and exemptions

6. Behavior Change
- Communicate with the patient by speaking respectfully
- Maintain hours of operation and ensure that health service staff are present and available
- Take only the fee that is the official rate
- Provide emotional support to mothers when they come to the HC

7. Missed Opportunities
- Ask about other problems the child may be having, beyond IMCI
- Ask about other problems the mother may be experiencing

8. Provide Important Information
- Encourage feedback from the community through supervision

New District Health Centers

1. Management
- Meetings with staff and community structures according to the plans
- Keep minutes for all meetings, and send reports to OD level, keeping copies appropriately
- Strengthen and implement the internal regulations according to MOH policy
- Assign jobs between staff clearly and evenly
- Strengthen and implement using the work schedule
- Ensure supervision from OD level

2. Assessment, Classification and Treatment
- Implement the policy of IMCI according to MOH policy
- OD and CRS support to facilitate technical, material, equipment and supplies according to IMCI program needs
- Exchange skills and experience between HC through cross visits for learning

3. Behavior Change

- Provide health education and counseling at health centers and in communities using leaflets, IMCI counseling card and other education tools

4. Communication
- Hold a workshop between HC and community structures at least once per year
- Provide clear messages between HC, community structures and CRS

5. Health Center Service Provision
- Open the doors of the health center and ensure staff are present from 0730-1130 am and 2-5 pm to strengthen and improve staff attitudes toward patient care
- Provide messages and information to communities through community structures

PHD and OD

1. Management
- Add additional indicators during planning at the HC level
- Analyze and use data that is available
- Include IMCI activities into HC and OD planning
- OD and PHD should provide appropriate supervision of HC
- Hold a meeting every 2 months at the OD level, and once a month at the HC level
- Hold a meeting every 6 months between the PHD and OD levels
- Continue IMCI training to ensure reaching more than 60% of new district HC staff by 7/04
- Provide material and equipment as needed
- Train OD supervisors to increase their capacity to function fully in their positions

2. Exchange experiences through study tours
- OD should supervise, advise and provide technical assistance to health centers

Community Structures

1. Care Seeking and Home Care
- Provide health education to mothers with children under 5 years – for danger signs of diarrhea, malaria and respiratory infections
- VHV/TBA/VHC should have medicine and commodities in the village
- Education and training material should include various media such as video and others
- Follow up with mothers is needed to ensure implementation of counseling with sick children
- Appropriate care seeking motivates mothers to increase their experience in child care and home care of sick children, and to continue sharing their experiences with other mothers
- VHC/VHV/TBA need to be role models in implementing and demonstrating good behaviors and practices for mothers in the community
- There is the need for an education campaign on care seeking for diarrhea and respiratory illness

Annex 16

Diskette with Electronic Copy of this Report in MS WORD

Annex 17

Special Reports

Progress Reports:

USAID Annual reports for Year I and Year II
CORAID Progress Reports:

- Oct. 2001 to March 2002
- April 2002 to Sept .2002
- Oct 2002 – March 2003
- April 2003 – March 2004

ASSOCIATION POUR L'ACTION DE DEVELOPPEMENT COMMUNAUTAIRE (AADC) Progress Reports:

- Monthly Progress reports from October 2001 – June 2004
- Annual Reports for 2001, 2002, 2003

Special Reports:

Summary of Feeding Practices Interventions within the CRS Cambodia CBPHCP - 2004

Summary of ARI interventions within the CRS Cambodia CBPHCP