

**Midterm Evaluation Report
Partners for Health and Child Survival Project
Pearl S Buck International**

Submitted by

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GLOSSARY OF ACRONYMS

AdBoard	Advisory Board
ANC	Ante-Natal Care
BCLP	Basic Child Learning Package
BEOP	Barangay Emergency Obstetrics Plan
BHAP	Barangay Health Action Plan
BHC	Barangay Health Center
BHW	Barangay Health Worker
BHS	Barangay Health Station
BHNC	Barangay Health and Nutrition Committee
BIG	Bio-Intensive Gardening
BNS	Barangay Nutrition Scholar
BP	Blood Pressure
CBMIS	Community-Based Monitoring and Information System
CDD	Center for Diarrheal Disease
CDLMIS	Contraceptive Delivery & Logistics Management Info. System
CHO	City Health Office®
CHDO	Community Health and Development Officer
CO	Country Office
DA	Department of Agriculture
DECS	Department of Education, Culture and Sports
DILG	Department of Interior and Local Government
DIP	Detailed Implementation Plan
DMPA	Depo-medroxyprogesterone acetate
DOH	Department of Health
FGD	Focus Group Discussion
FHSIS	Field Health Surveillance Information System
FNRI	Foundation for Nutrition Research Institute
FP	Family Planning
GMC	Growth Monitoring Chart
GMR	Growth Monitoring Record
GP	Garantisadong Pambata
HBMR	Home-Based Mother's Record
HIS	Health Information System
HKI	Helen Keller International
HO	Home Office
IEC	Information, Education, Communication
IECM	Information, Education, Communication and Motivation
IGD	Informal Group Discussion
IRA	Internal Revenue Allotment
KI	Key Informant
KPC	Knowledge, Practice and Coverage
LAM	Lactational Amenorrhea Method
LGE	Local Government Executive
LGU	Local Government Unit
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MGP	Matching Grant Program
MSG	Mother Support Group
NCP	Nutrition Council of the Philippines
NGP	Natural Family Planning

NGO	Non-Government Organization
OB Kits	Obstetrical Kits
ODH	Ormoc District Hospital
PDB	Purok Data Board
PDI	Positive Deviance Inquiry
PFNFP	Philippine Federation of Natural Family Planning
PHAB	Partners for Health Advisory Board
PHDB	Purok Health Data Board
PHCSP	Partners for Health and Child Survival Project
PHN	Public Health Nurse
PHO	Provincial Health Office®
PNRC	Philippine Nutrition Research Council
PRA	Participatory Research Action
PSBI	Pearl S Buck International
PVO	Private Voluntary organization
RDI	Rural Development Institute
RHA	Reproductive Health Awareness
RHM	Rural Health Midwife
RHU	Rural Health Unit
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOP	Technology of Participation
TOT	Training of Trainers
TWG	Technical Working Group
TT	Tetanus Toxoid
UP	University of the Philippines
USAID	United States Agency for International Development
VAW	Violence Against Women
VSC	Voluntary Surgical Contraception
VSS	Voluntary Surgical Sterilization
WSMMP	Women's Health and Safe Motherhood Project
WP	Weighing Post

TRANSLATIONS

Hilot	Traditional birth attendant
Barangay	Smallest unit of government (community)
Kagawad	Councilor or member of local government council
Purok	subsection of a barangay
Sentrong Sigla	“Center of Wellness” (quality certification program)
Garantisadong Pambata	Children's health outreach program occurring twice a year

**Midterm Evaluation
Partners for Health Child Survival Project
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A. SUMMARY

1. Brief Description of Program and Objectives

The PHCSP is a 4-year USAID funded project that aims “to improve the health and nutritional status of children and women through the strengthened capacity of families, communities, local government units and nongovernmental organizations to manage community health programs.” The long-term goal of the project is to *reduce infant and child mortality and improve maternal health*. The program has trained community partners and program managers to plan, manage, and carry out the activities of the project in two areas, Ormoc City and Merida. The program covered three major intervention areas, namely, 1) Nutrition and Breastfeeding, 2) Maternal Care, and 3) Child Spacing.

The project’s Detailed Implementation Plan (DIP) and Work Plan have listed activities grouped according to these three intervention areas. Cross cutting activities were carried out as a strategy to strengthen the implementation of activities under the three intervention programs. In addition, the project developed strong partnerships with local stakeholders, emphasizing participatory planning with all partners.

2. Main Accomplishments of the Program

The project has successfully set up the basic groundwork for the project and activities have been commenced in capacity building, community mobilization and testing of innovations. Critical intervention models such as Hearth, Mother Support Groups (MSG), Weighing Posts (WP), and the Basic Child Learning Package (BCLP) have been tested. Necessary trainings have been conducted. The project deserves commendation for building on existing structures and taking a deliberate policy not to replicate or add new structures and protocols that can result in overloading the local health system. The more innovative interventions such as Hearth Nutrition Model and WPs attempted to adjust to the local context and paid attention to local requirements and limitations.

3. Overall Progress Made in Achieving Program Objectives

Training activities have established service delivery competencies in all three of the interventions. The project has achieved notable progress in establishing weighing posts in a majority of the project barangays¹. Barangay Health Action planning has been conducted, encouraging the ownership of activities among the community.

Examination of 2001 KPC results show that breastfeeding and nutrition indicators compare well with midterm targets set by the DIP. Maternal Care indicators did not fare as well, but in general, the Child Spacing indicators show positive results compared to their mid-term targets. Using Ministry of Health Field Health Surveillance Information System (FHSIS) data, the number of new family planning acceptors for all methods have significantly increased in project areas.

¹ Barangay is the smallest government unit

4. Main Constraints, Problems and Areas in Need of Further Attention

Despite the positive findings on the progress towards achieving project objectives, there are several areas that still need to be strengthened. One of these areas is the monitoring and evaluation component of the project. Related to the problem of monitoring and evaluation is the inadequate documentation, lack of operations research studies and a poor analysis of these studies. There has been no coordinated exit strategy that has been noted at this point to prepare for the eventual phasing out of the project, although the Advisory Board is in place to assist with this.

5. Summary of Capability-Building Effects of the Program

With the participation of local officials and service providers in the training program, there was a discernible increase in the sense of ownership in CSP activities. In the area of service delivery, health providers, particularly midwives and Barangay Health Workers (BHWs) were trained in counseling on breastfeeding, nutrition, and family planning. For facility upgrading, health centers were provided with additional equipment. As a capability building as well as a sustainability strategy, the multi-sectoral advisory board that had been set up to oversee the implementation of the projects has formally linked up the barangays to a potential pool of local consultants. Many of these individual members are capable of providing technical assistance to the project.

6. Summary of the Prospects of Sustainability

The capacity building strategies that have been employed by the project all help to strengthen the prospect for sustainability, as managerial and technical skills have been emphasized in many of the early training workshops. Equipping health centers and service providers with IEC and medical equipment also help ensures the facilities' readiness to provide necessary health services. However a more difficult issue is in the area of financial sustainability.

7. List of Priority Recommendations

A general recommendation is that the project management team assess the status of interventions overall and within specific barangays. There is a need to strengthen documentation, research utilization, and application of lessons learned from the pilot experiences. A review of staff capacities is also in order, so that the need for technical assistance can be planned. The team's general recommendations are as follows:

- The Need for an Overall Project Plan
- Planning for an Exit Strategy
- Monitoring and Evaluation.
- Need for Technical Assistance and Staff Development
- Sustainability Strategies

B. ASSESSMENT OF THE PROGRESS MADE TOWARD ACHIEVEMENT OF PROGRAM OBJECTIVES

1. Technical Approach

1a. Brief Overview of the Project

The Partners for Health Child Survival Project (PHCSP) began as an entry grant in 1997 to Pearl S Buck International (PSBI) in Ormoc City and Merida, Leyte Province. This period was devoted to intense planning and consultation between partners and major stakeholders in the

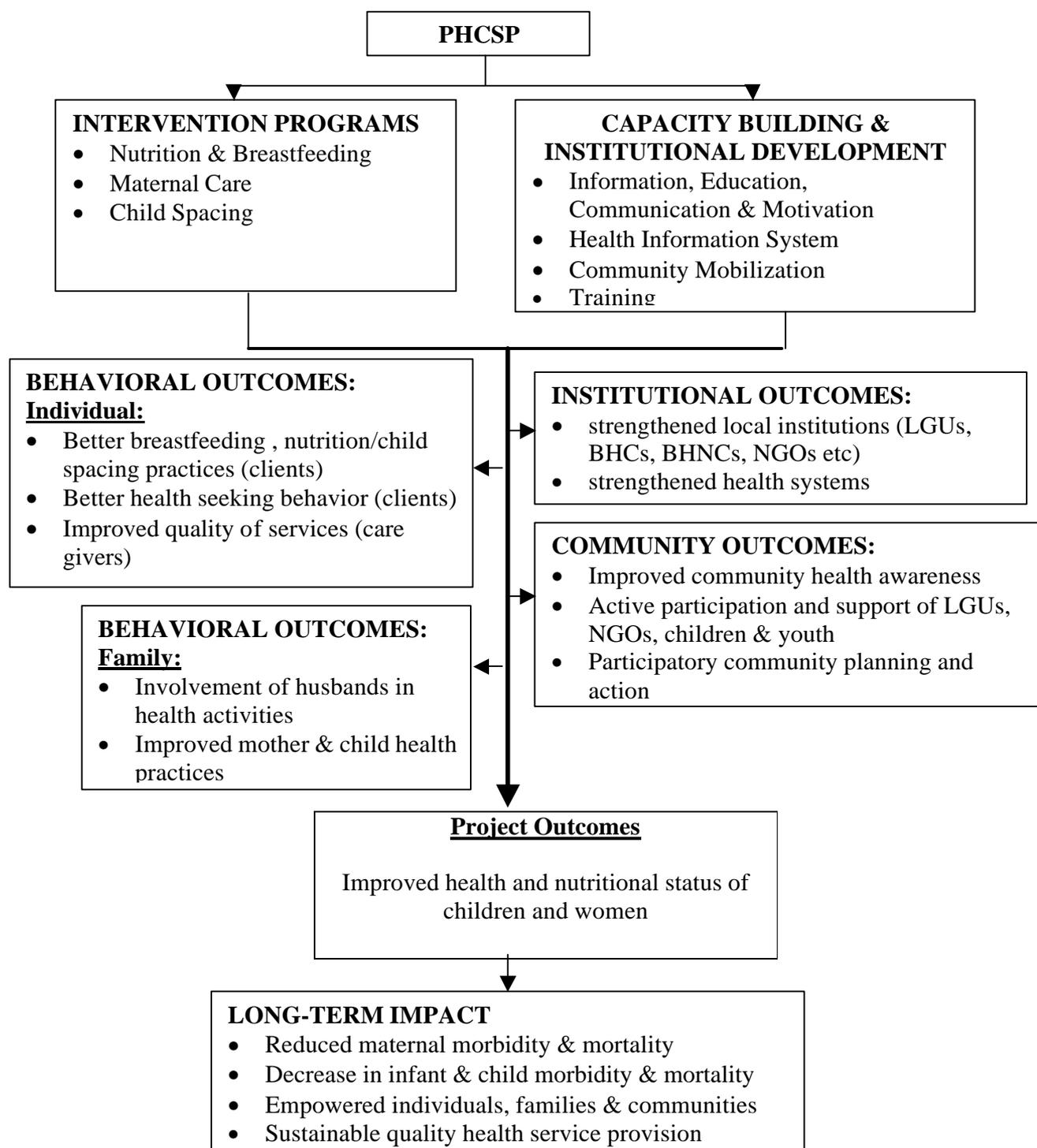
development of a Detailed Implementation Plan (DIP) for the project. After a review of the DIP, a number of revisions were made in response to reviewers' comments. PSBI subsequently received a four-year grant from USAID beginning in September 1999. The project is now in its second year of implementation in 48 barangays of Ormoc City and the municipality of Merida, Leyte Province and undergoing a midterm review. This document constitutes the report of the evaluation team.

Objectives The PCHSP aims “to improve the health and nutritional status of children and women through the strengthened capacity of families, communities, local government units and nongovernmental organizations to manage community health programs.” The long-term goal of the project is to *reduce infant and child mortality and improve maternal health*.

Location and Coverage Forty-eight rural barangays of Ormoc City and Merida (10 in Merida and 38 in Ormoc) were selected as project sites for child survival intervention activities of PHCSP. Ormoc is a component city with a total population of over 160,000, while Merida is a fifth-class municipality with more than 25,000 population located in Eastern Visayas Region.

Framework of Project The selection of specific programs was decided after consultation with the local partners during the entry grant period. Three major interventions were identified, namely: (1) Nutrition and Breastfeeding, (2) Maternal Care, and (3) Child Spacing. These program intervention activities have built in capacity building and institution development support. This support includes training, community mobilization, and development of Information Education Communication Motivation (IECM) materials and a health information system. Figure I shows the conceptual interrelationships of the different components of the program, their expected effects (on the individual, the family, the institution, and the community) and links them with the immediate and long term impacts of the project:

Figure 1. Partners for Health Child Survival Project (PHCSP) Conceptual Framework



This formulation illustrates that the project’s long-term goal of “improving the health and nutritional status of children” works through improvement in breastfeeding, nutrition, maternal care and child spacing programs. By strengthening the capacity of families, communities, local government units and non governmental organizations, the partnership will be capable of managing health programs under devolution.

Intervention Mix A mix of interventions and activities has been specified in the DIP within each of the three intervention areas. The implementation of these activities followed an operational yearly work plan. Activities outlined in the DIP and the Workplan were clustered by the evaluation team under the following groupings:²

A. Nutrition and Breastfeeding:

- 1) Creation of Mother Support Groups (MSG) to support exclusive and continued breastfeeding practice in the community
- 2) Training of Rural Health Midwives (RHMs), BHWs and Traditional Birth Attendants (TBAs) to conduct breastfeeding counseling sessions with the use of Basic Child Learning Package (BCLP)
- 3) Initiating Hearth Model using Positive Deviant approach and assessing experience for scaling up
- 4) Advocating for creation of more Weighing Posts as a nutrition strategy with the provision of weighing scales
- 5) Activating the transformation of Health Stations as Mother and Child-Friendly Facilities according to the Milk Code
- 6) Training for the implementation of Bio-intensive Gardening (BIG) for fathers and youth groups
- 7) Implementation of the “Healthy Baby, Mother, Family and Community Program”
- 8) Micronutrient supplementation support for women and children

B. Maternal Care:

- 1) Training of TBAs and RHMs on enhancing skills for delivery of services and provision of basic obstetric & delivery instruments and supplies
- 2) Information Campaigns for early and regular prenatal visits and promotion of Tetanus Toxoid (TT) immunizations
- 3) Emphasizing and strengthening the use of Home-Based Mother’s Record (HBMR)
- 4) Strengthening of Barangay Health Stations (BHS) through provision of basic equipment (e.g. BP apparatus, examination tables, weighing scales, lamps, etc) and supplies (e.g. iron tablets)
- 5) Development of Barangay Emergency Obstetric Plan (BEOP)

C. Child Spacing:

- 1) Training of doctors, RHMs and Public Health Nurses (PHNs) on Basic Comprehensive Family Planning, including separate training of volunteers on Natural Family Planning (NFP)
- 2) Provision of IUD kits to ensure competency in IUD insertion
- 3) Ensuring regular and sufficient availability of FP supplies in health facilities
- 4) Strengthening of Voluntary Surgical Contraception (VSC) service provision and establishing the critical referral system
- 5) Enhancing male involvement in reproductive health
- 6) Establishing of a community-based commercial contraceptive dispensing station

D. Other Crosscutting Strategies and Activities:

- 1) Setting up the Health Information System (HIS)
 - Strengthening of FHSIS working in tandem with the Rural Health Unit (RHU) and City Health Office (CHO)

² Only major activities are included in this list.

- Mobilizing communities to set-up Purok Data Boards (PDB)
 - Master listing women and children to identify clients and other needs for services
 - Adoption of the Community-Based Monitoring and Information System (CBMIS) (not in the DIP)
 - Monitoring and evaluation activities through conduct of small formative studies; Focus Group Discussions (FGDs) to evaluate pilot interventions, diagnostic studies on barriers to antenatal care (ANC), etc.
- 2) Information, Education, Communication and Motivation (IECM)
- Production of Health Calendars with cross-cutting messages for distribution to partners and community members (at least one per household in the 48 project barangays)
 - Production of Flip Charts for groups counseling sessions and/or bench conferences; IEC Kits for BHW for individual counseling sessions; and Counseling Guides
 - Community Theater Production and Puppetry Training
 - Organization of Health Scouts and working with science teachers to integrate health into the curriculum and train children as health advocates in the school, family and community
 - Implementation of the Health Future's Group IEC message designed for Healthy Baby in year 1, Healthy Mother in year 2, Healthy Family in year 3 and Healthy Community in year 4.
- 3) Community Mobilization
- Working with BHCs on Healthy Baby & Mother IEC message initiatives, training and development of the Barangay Health Action Plan and support for setting up structures e.g. Weighing Posts, Data Board, Backyard Gardens, Hearth
 - Establishing partnerships with local NGOs (Rural Development Institute [RDI], Philippine Nutrition Research Council [PNRC], University of Philippines [UP] Medical School, Leyte Institute of Technology, Marie-Stoppes) and creation of inter-agency committees such as Advisory Board, Technical Working Group, IEC Task Force
 - Conduct of cross-cutting activities such as master listing, PDB installation and CBMIS implementation
 - Advocacy work on FP support from Local Government Executives, special health campaigns such as Garantisadong Pambata (GP) and other IEC campaigns
- 4) Capacity Building, Sustainability, Training and Research Activities
- Conduct of Institutional Assessment and Development
 - Training of Partnership on program management and competency based skills
 - Skills training for mothers, TBAs, volunteers and NGO partners
 - Translation and production of GMC and HBMR into Cebuano (the local language) for use in the community and training for use of health providers
 - Working with health officials to strengthen capacities particularly in updating information system (FHSIS), setting-up monitoring and evaluation systems and computer literacy and computerization of operations
 - Provision of Computer facilities to CHO and RHU

- Conduct of FGDs to support up scaling of specific interventions (e.g. Hearth and MSG)

General Program Strategy. In line with project objectives, PHCSP developed strong partnerships with local stakeholders. These partners consisted of officials of the Local Government of Ormoc and Merida, the DOH regional office, the City and Municipal Health Offices, the Barangay Health and Nutrition Councils, the Federation of Barangay Health Workers, local NGOs, Department of Education, Culture and Sports (DECS), Department of Interior and Local Government (DILG), health providers and mothers in the community. In order to achieve greater community involvement and enhance the project’s sustainability, participatory planning with all partners was emphasized.

The DIP enumerated different methods of capacity building. A systematic assessment of each partner using the Institutional Assessment Instrument and follow-up implementation of the Institutional Development Plan were undertaken. The project also allowed for the possibility of undertaking “intervention in the areas of governance management and operating systems resource mobilization and financial management”. Training was a major strategy used for capacity building. These trainings were intended to enhance both organizational and technical skills.

Community mobilization approaches consist primarily of engaging local government officials to conduct barangay health action planning, organizing mothers and providers to promote and support exclusive breastfeeding, as well as involving mothers and members of the community on planning and implementing projects such as BEOP, Hearth, etc.

Another project strategy that was adopted was the creation of an Advisory Board, Technical Working Group and IEC Task Force composed of partner representatives - Regional Health Office, Provincial Health Office, City Health Office (Ormoc), Municipal Health Office (Merida), DECS, NGO, Barangay Captain, Barangay Health worker, and City Planning Office. The multi-sectoral membership of the Ad Board allowed for a broad representation of stakeholders.

For its information needs the project has committed to using the enhanced FHSIS of the DOH in monitoring the progress towards project objectives. The DIP states that the project will “strengthen the FHSIS system in terms of its reliability, timeliness, data utilization and information feedback.”

1b. Progress by Intervention Areas

The following section of the report highlights the evaluation team’s findings, in terms of the three health program intervention areas. Each intervention area will be evaluated using the following outline:³

- i) Activities related to specific interventions as proposed in the DIP
- ii) Progress toward benchmarks and effectiveness of the interventions
- iii) Changes in the technical approaches outlined in the DIP and rationale
- iv) Special outcomes, unexpected successes or constraints
- v) Follow-up and next steps

³ Based on the Guidelines for Mid-Term Evaluation (Issued May 2000) from USAID/BHR/PVC PVO Child Survival Grants Program

1) Nutrition and Breastfeeding

Health sector partners strongly supported the need to include nutrition and breastfeeding as a priority intervention area in child survival, mainly because of the high prevalence of malnutrition in the project sites. It was felt that the state of malnutrition made children more susceptible to the major causes of morbidity and mortality in the area, including diarrheal diseases and acute respiratory infections.

(i) Activities Related to Nutrition and Breastfeeding as proposed in the DIP

The DIP lists nine activities to be undertaken by the project under Nutrition and Breastfeeding. These range from mobilizing support groups for breastfeeding among mothers, to providing monitoring and evaluation in support of these activities. Table 1 presents the findings and analysis of each activity. The table has four columns; the first shows activities as set forth in both the DIP and the 2-year work-plans. The third column specifies the dates that these activities are scheduled in the work plan and the fourth column notes the current status giving the major highlights of the activities. Analysis of the other two program interventions (maternal care and child spacing) will also follow this sequence of presentation of findings.

Table 1: Nutrition and Breastfeeding Activities Specified in the DIP, Workplans, and Assessment of Progress towards Benchmarks, September 2001

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>1. Organization/Training of the Mother Support Groups</p> <p>a. BHW/BNS and MSG visit, counsel lactating mothers on exclusive breastfeeding</p> <p>b. MSG/BHW/BNS train and counsel mothers on solid food initiation,</p> <p>c. Knowledge and skills upgrading of MSG addressed by RHM, CHDO</p> <p>d. MSG/BHW/BNS conduct cooking demos</p>	<ul style="list-style-type: none"> ○ On-site training in pilot barangays ○ Promotion of Breastfeeding at WPs and Health Stations ○ Conduct of first MSG's 9 modules ○ Conduct of three remaining modules ○ Plans for Replication ○ Reach out to other barangays 	<p>2/00</p> <p>3/00 to 9/00</p> <p>1/01to 9/01</p> <p>10/00 to 12/00</p> <p>10/00 to 12//00</p> <p>1/01; 03/01; 05/01; 7/01; 09/01</p>	<p>Piloted in Masumbang and Biliboy.</p> <p>Eight of the nine training modules were implemented in Biliboy and only 7 modules were done in Masumbang. Participants perceive the training as useful but mentioned reasons other than its main purpose (IGD finding).</p> <p>From the experience, the training modules have been revised cutting it down from 8 to 6 estimated to run for 3-4 months. This will be tested in the expansion areas.</p> <p>Replication has not been done but plans are underway. Four barangays, one from each cluster, have been identified as areas for replication.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>2. Training of RHMs, TBAs and BHWs and BNSs to conduct Breastfeeding Counseling</p> <p>a. Trained TBAs conduct BF counseling during pre/post natal visits and assist mothers to initiate BF within 24 hrs post delivery</p> <p>b. Train RHMs/BHWs/BNSs and MSG on exclusive breastfeeding</p> <p>c. Train TBAs on how to conduct breastfeeding counseling</p>	<ul style="list-style-type: none"> ○ Identification of pilot barangays (Masumbang and Biliboy) and contact Arugaan and HKI ○ Development of training design ○ Conduct of training of trainers ○ Training of BHWs/ TBAs/BHNs by RHMs, Nurses and CHDOs ○ Conduct of cooking demonstration ○ BCLP (3rd level Caregivers' class) given by BHWs/BNS (field visited by HKI and RHMs) ○ Quarterly Assessment Meeting ○ BHNs/BNS/TBAs conduct Counseling on Breastfeeding and Complementary Feeding 	<p>11/99 to 12/99</p> <p>12/99 to 1/00</p> <p>1/00</p> <p>3/00; 1/01</p> <p>4/00; 7/00</p> <p>10/00 to 9/01</p> <p>12/00; 3/01; 6/01</p> <p>4/00 to 9/00; 2/01 to 9/01</p>	<p>44 of the 48 barangays have implemented the BCLP.</p> <p>Training of trainers and community facilitators was done. Problems of lateness and absenteeism were encountered both in the TOT (refer to HKI report) and community-based training. The latter was addressed by shifting venue from health station to the purok. Confidence of Care Givers increased after the training.</p> <p>Lack of advance scheduling, causing the health workers to be away from their jobs too long and conflicting schedules were among the concerns raised by some health officials and partners (RHO, PHO, RDI).</p> <p>RHMs, BNS, BHWs were trained on Breastfeeding Counseling in the BCLP. Breastfeeding is also taken up in the Hilot's (TBA) and MSG training but the counseling aspect is not given equal emphasis.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>3. Piloting the Hearth Nutrition Model</p> <p>a. BHC implements in 2 barangays with 30% moderate and severe malnutrition</p> <p>b. CHDOs/RHMs share lessons on progress of Hearth</p> <p>c. Partners for Health Advisory Board (PHAB) shares lessons of Hearth Nutrition Model to other barangays</p>	<ul style="list-style-type: none"> ○ Identification of sites and data gathering ○ Pre-pilot in Sto. Nino (12 days) and assessment ○ Training on Hearth in 2 barangays ○ Conduct of PDI survey and analysis ○ Implement the Hearth Model ○ Monitoring and Evaluation 	<p>9/99 to 10/99</p> <p>10/00</p> <p>11/00 to 12/00</p> <p>12/00 to 1/01</p> <p>2/01 to 9/01</p> <p>2/01; 4/01; 6/01; 8/01</p>	<p>Pre-pilot activities were done in one barangay, Sto. Nino. This was delayed for almost a year because of the unavailability of a consultant to introduce the Hearth activity. Pre-pilot activities in Sto. Nino were well documented. There was an observed improvement in the nutritional status of three of the five second-degree malnourished kids after participation in the Hearth. A closer look at the data indicate that weight increase tapered after the first two weightings, and number of attendance in Hearth Sessions was found not to be associated with magnitude of weight increase</p> <p>Piloting of Hearth was done in four barangays - R.M. Tan, Lao, Lundag and Patag.</p> <p>This intervention is well appreciated by both mothers and barangay officials. Many other beneficial effects other than nutrition were enumerated in the IGDs. It has reportedly mobilized mothers to exchange experiences and discuss other issues. Hence, Hearth can be an entry point for other health interventions.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>4. Establishment of Weighing Posts “primary purpose is nutrition-related but shall provide equally important health services like family planning . . . in the long run it will be transformed to CSP centers where other services will converge...”</p> <p>a. Advocacy activity to encourage adopting of WP as nutrition strategy by LGUs</p> <p>b. IEC and GMC provided at WPs</p> <p>c. Establishment of WPs at the purok level</p>	<ul style="list-style-type: none"> ○ Advocacy activities for community leaders ○ Passage of resolutions endorsing WPs construction ○ Identification of sites and negotiation with owners ○ Provision of Nutrition, MCH, FP services in WP ○ Replication of WPs in other barangays ○ Resource generation activities for replication (BHC) 	<p>10/00 to 9/01</p> <p>11/99 to 12/99;</p> <p>11/00 to 2/01</p> <p>11/99 to 1/00;</p> <p>10/00 to 2/01</p> <p>10/00 to 9/01</p> <p>10/00 to 9/01</p> <p>11/00 to 12/00</p>	<p>35 WPs have been constructed in 31 barangays. The exposure trips to Hilongos (25-30 pax/ trip) were instrumental in bringing this about. Community members have a very strong sense of ownership of the facility possibly because they fully financed the construction (see section on Crosscutting Approaches - Community Mobilization)</p> <p>In the field visits, one barangay that was not targeted for (and not oriented on) WP constructed a WP facility located too near the BHS. In another WP the weighing scale was missing because it was kept in the Kagawad’s house for safekeeping.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>d. BHC meet to assess WP activities</p> <p>e. BHC conduct quarterly assessment meeting of WP activities</p>			<p>Functions of the WPs have expanded from just a nutrition post to a post which offers FP services. Four WPs that were visited had examining tables to be used for IUD insertion. However it was also observed that the structure offered little to no privacy. The team was informed that curtains were hung and used as screens during scheduled IUD insertion or prenatal examination days. Nevertheless auditory privacy is still compromised in this set-up.</p> <p>It was gathered from the field visits that the WPs are opened weekly if managed by the BHW and monthly if staffed by the RHM & BHWs Kagawad in charge in two barangays expressed their willingness to upgrade the facilities (increase space, painting, etc).</p>
<p>5. Activate Mother-Baby Friendly Health Stations according to the Milk Code</p>	<ul style="list-style-type: none"> ○ Milk Code Orientation for BHC/BHWs/BNS and TBAs ○ Assessment of Health Centers and Weighing Posts based on Sentrong Sigla Standards and Milk Code 	<p>5/00 to 8/00</p> <p>2/01; 4/01; 6/01; 8/'01</p>	<p>The Milk code is reported to have been discussed during the MSG, however, since the MSG was only done in two areas (Biliboy and Masumbang), this still needs to be extended to other project barangays.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>8. Advance Micronutrient Supplementation for Mothers and children</p> <p>a. Conduct quality food intake survey</p> <p>b. MSG train on Vitamin A/Iron rich food source</p> <p>c. MSG /BHWs/BNSs train on Vit A and iron and their proper preparation</p>	<ul style="list-style-type: none"> ○ Review of Data on pregnant or lactating women and children below 5 years old ○ TWG review policy on master listing, develop standard format ○ Orientation and re-orientation of Health Workers ○ Distribution of iron supplements ○ Distribution of Vit A supplements ○ Monthly iron dispensing report ○ Monthly Vit A dispensing report ○ BHWs/BNS/TBAs reach out to those who failed to attend using master list info. 	<p>11/99; 1/00; 3/00; 5/00; 7/00; 9/00;</p> <p>10/00</p> <p>1/00 to 2/00; 10/00; 1/01; 4/01; 7/01</p> <p>3/00 to 9/00; 11/00 to 9/01</p> <p>11/00 to 9/01</p> <p>3/00 to 9/01</p> <p>10/00 to 9/01</p> <p>2/00; 4/00; 6/00; 8/00; 12/00; 3/01; 6/01; 9/01</p>	<p>The review of master list is done at the RHU and CHO level once a year.</p> <p>PSBI purchased and distributed Ferrous sulfate for pregnant and lactating women in 48 barangays to augment the low supply in the health centers of project sites. 20,085 capsules have been purchased and delivered to Merida and 80,515 capsules have been purchased and released to Ormoc for Year 2. Clients were limited to those in the master list and follow-up was not done to those who failed to show up.</p> <p>The study on the quality of food intake was not undertaken nor scheduled in the work plans.</p> <p>Monthly Dispensing reports are the responsibility of health personnel at the health facility. It is not clear if the project collects this information; much less utilize information from this report. No documentation was provided to the team on this, as well as any documentation on the CBMIS data utilization.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work Plans	Progress Towards Benchmarks
<p>9. Monitoring and Evaluation on Nutrition and Breastfeeding</p> <p>a. HIS conduct survey to establish baseline for year 1</p> <p>b. CHDO conducts FGD to determine factors contributing to early solid food initiation</p> <p>c. KPC at the end of the project</p> <p>d. Monthly recording on GMC and review of FHSIS</p> <p>e. Monthly barangay visit report of CHDO</p> <p>(The DIP cites that monitoring and evaluation must be done at four levels: Technical, intervention, project and community levels)</p>	<ul style="list-style-type: none"> ○ Monthly review of FHSIS by HIS and presentation to TWG/PHAB for action ○ HIS/Partners conduct baseline and data regeneration from KPC 2001 with children below 5 years old who use at least 2 Vit A/iron rich foods and are provided appropriate complimentary feeding ○ Assessment of FGDs/key information interview to determine quality of breastfeeding and appropriate complementary feeding counseling services. ○ HIS Coordinators/Health Partners conduct 24-hour diet recall ○ Monthly GMC use ○ UP Medical Interns conduct research on quality of breastfeeding practices, complementary feeding and counseling services ○ Meeting to address issues 	<p>11/99 to 9/00</p> <p>1/00; 4/01</p> <p>5/00 to 6/00</p> <p>10/00; 12/00; 3/01; 9/01</p> <p>10/00 to 9/01 2/01 to 4/01</p> <p>6/00; 6/01</p>	<p>KPC conducted for 2000 and 2001, and analysis of basic indicators done. Baseline analysis was done only for children two years and below.</p> <p>KPC data set, not maximally analyzed to get critical information on intermediate effects of intervention. For example do we know the % of mothers who can name at least two sources of Vit A and iron rich foods in addition to breast milk for children for children <24 months? Answers to this question will tell us impact of messages on mothers' awareness. An in-depth well-thought out re-analysis of KPC may be in order, beyond the analysis of end line indicators. The same can be said of FHSIS data.</p> <p>Monthly monitoring of GMC use not done.</p> <p>Students from UP Medical School were approached by the Project Director to undertake studies relevant to the project. They were offered support in terms of free use of computer facilities and printing of their studies. This never materialized because the students did not avail of the offer of support.</p>

Organization & Training of Mother Support Groups The work plan on this activity has basically followed the activities listed in the DIP. The project contracted a national NGO, the

Arugaan,⁴ to provide the technical assistance in training the members of the mother support group. The MSG was piloted in two project barangays: Masumbang and Biliboy. The Mother Support Groups (MSG) is intended to strengthen the breastfeeding behavior of mothers and support nutritional activities of the project. The training sessions consisted of 8 modules (all of which were conducted in Biliboy but only 7 were carried out in Masumbang), on an average of three days duration per module. The first module was conducted in January 2000 and the whole course was completed in October 2000. Although there was a module on gender and violence against women (VAW) this was subsequently dropped from the design because of unavailability of a consultant on this component. The table below shows the schedule for the conduct of these modules.

Table 2 Training Workshops on Mother Support Group as Conducted by ARUGAAN Foundation January–April 2001

Dates	Topics covered	Composition and number of Participants
1. January 23-25 and 26-28, 2000 2. February 15-17 and 21-23, 2000	Module 1: Food Security and Healing Foods	Mothers and other community members Masumbang=25 Biliboy=25
3. July 23-26, 2000 4. July 27-30, 2000	Module 2: Therapeutic massage	MSG members Masumbang=15 Biliboy=10
5. August 7-9, 2000 6. August 10-12, 2000	Module 3: Early Childhood Development	MSG members Masumbang=15 Biliboy=12
7. August 21-23, 2000 8. August 24-26, 2000	Module 4: Creation of MSG Module 5: Involvement in Health Campaigns: Community theater	MSG members Masumbang=10 Biliboy=10
9. September 11-13, 2000 10. September 14-16, 2000	Module 6: Breastfeeding Counseling Techniques Module 7: Visual arts Rehearsals and Props Preparations	MSG members Masumbang=12 Biliboy=12
11. October 23-25, 2000	Module 8: Establishment of Mother Baby Friendly Station/ “Crèche”	BHWs, BNS, MSG members Biliboy=12 ⁵

An examination of the topics covered by the modules reveals that breastfeeding per se was not focused on until Module 6 (conducted in September). Furthermore, the intervals between

⁴ The idea of hiring Arugaan for the first year only was for the PHCSP staff to learn about the technology in order for them to be able to provide this technical assistance in further replication of the MSG.

⁵ The module on Gender and Violence Against Women (VAW) was no longer included because of unavailability of consultant to extend technical assistance to the project. This will be deleted from the revised set of modules.

sessions were too long and can break up the momentum that was built up in the previous session. However, members of the MSG are appreciative of the training because “it helped them correct many of their misunderstandings and superstitions about breastfeeding”. They see their role as one of “supporting community-organizing activities organized by the CSP project”.

The group members also saw the MSG as a general health education intervention, rather than as a support group to promote breastfeeding for mothers. However, when asked what they wish to recommend for the next step in their activities for MSG, the women conveyed a need that did not have any bearing with the intervention. They made known to the evaluation team their request for PSBI to help link them to an outlet or market for their finished products once they have started an income generating project. Although this request is hardly related to their role in promoting breastfeeding, this is an interesting development because in this case, the MSG appeared to have empowered the women to begin thinking of other activities that can help them improve themselves.

In a later interview with the PSBI project team members, it was found that an FGD was already conducted with members to evaluate the MSG training. The conclusion of the study was that there was a need to compress the modules, and develop a new set of training protocols. The CSP staff members have recently completed this new set of protocols which is a training curriculum made up of 6 modules. These modules are to be piloted in 4 barangays (choosing one site in each of the 4 sets of barangay groupings, or clusters, under the supervision of the 4 CHDOs). This is certainly a laudable initiative as this makes for better planning of MSG replication. After reviewing the new protocols, however, the evaluation team has determined that the newly developed materials may still need further review by a person trained in breastfeeding counseling, before these are tested in the four identified sites.

RHMs/TBAs/BNSs trained to Conduct Breastfeeding Counseling. This activity is intended among others, to promote breastfeeding initiation within 24 hours post delivery. A training of trainers was conducted for PHCSP and LGU partners to “enhance their capability to effectively deliver specific nutrition interventions”. Helen Keller International was contracted to facilitate the training, which consisted of four modules: (1) review of PHCSP; (2) establishment of WPs, growth monitoring and the promotion of nutrition education; (3) conduct of in-house and field visits; 4) development of training design. Team building activities were also incorporated in the training. (For a detailed assessment, see Helen Keller International documentation). To date, 44 barangays have started with BCLP activities.

The participants were knowledgeable and aware of basic concepts of ANC, nutrition, breastfeeding, complementary feeding and growth monitoring. Two of the midwives said that the training improved their communication skills and the BCLP materials were quite useful for reference. The training has evidently shifted service providers’ orientation towards a focus on teaching mothering skills. There were, however, some unclear areas in the minds of some trainees with regard to the skills that they received from the training, particularly the mothers. They were not sure whether they were being trained for their own personal benefits or so that they can be trainers to other women.

A point that was also brought up had to do with the issue of frequent and overlapping training activities that require the same set of participants. This observation came from both health providers, including barangay health workers pointing to a possible “lack of advance planning”, conflicting schedules, and training duration which takes participants too long away from work.

In situations where the participants had to pay for transportation, local officials expressed concerns about these expenses.

Piloting the Hearth Nutrition Model The Hearth Nutrition Model was introduced for the first time in the Philippines by PSBI in Ormoc on the strength of the success that this model had in other countries, notably in Vietnam. The Positive Deviance Inquiry was conducted by first undertaking a wealth ranking activity in the barangay to identify families at the bottom of the community's socioeconomic strata. Extremely poor families who have healthy children were then identified, in order to determine the positive practices of these mothers that contributed to the well being of their children. Several menus using foods identified in the PDI, were developed emphasizing the use of "free food" to minimize cost. In order to track progress, the children who participated in the Hearth program were weighed before, during each visit/session, and after the conduct of the 12 sessions.

The Hearth Nutrition Model was pre-pilot tested in Barangay Sto. Nino. An orientation session on the Hearth model was conducted for barangay officials, BHWs and BNS. The training of the community was conducted for two weeks. A plan for the 12-session Hearth program was formulated and negotiations with the participating families were made to gain their support and commitment. One cycle of 12- day hearth sessions was completed in barangay Sto. Nino and a second cycle was planned in the same purok because of the fluctuating nutritional status among the participants.

Based on the documentation of the Hearth experience in Sto. Nino, a positive change was observed in the number of children who were originally second degree malnourished: Five out of 8 were malnourished before and only 3 out of 8 were malnourished afterwards. A closer look at the individual weight increases show that the improvements in weight gains tapered off after the second or third weighing. Also the degree of weight gains did not correlate with attendance in the sessions. Hence, there is a need for more quantitative and qualitative analysis of the process to fully assess and appreciate the effectiveness of this model. Learnings from this pre-pilot stage will be useful for refining succeeding Hearth sessions.

Mothers and the community, including a group of barangay officials, have positive reports of the Hearth sessions. Because Hearth has been successful in mobilizing mothers, it provides an opportunity to start other interventions (such as the MSG) by building on the Hearth sessions. This approach is similar to the recommendation made regarding the linking of different interventions to reinforce behavioral changes that are being promoted.

Weighing Posts The rationale for the establishment of the posts was to respond to the outlying communities' lack of access to basic nutrition and health services. The posts were meant to be satellite health stations. To date, 31 barangays have weighing post established and 35 posts have been successfully installed. The community contributed the materials and labor for building the posts. The project provides equipment and materials for the WPs such as weighing scales, examining table, BP apparatus, stethoscope, and iron capsules.

Preliminary activities started with educational trips arranged for members of the partnership to visit Hilongos, Leyte and Surigao in Mindanao in order to observe how this particular intervention had been operationalized in these areas. The DIP describes this strategy as "bringing nutrition and health services closer to the people. It shall provide services that cover at least 20-25 households or the neighborhood within its vicinity. Although its primary purpose is nutrition related, it shall also provide equally important health services like family planning. In the long

run, this shall be transformed to CSP centers, where all other services such as immunizations and hearth sessions will converge”.

Although the community support for WPs is quite impressive, there are a few observations that were made by the team during their visit to nine posts in 10 barangays. One WP did not have a weighing scale (we were later told that it was with the Kagawad or BHW for safe keeping); one was under construction; and one was constructed too near the BHS. (We were later told that the latter was not yet oriented but the barangay captain wanted to be able to show the evaluation team that her barangay has a weighing post). Of those seen, two are opened weekly by a BHW, while two others are opened monthly by RHM and BHW.

It was also observed that IEC posters (e. g. family planning, gender messages, etc) were not strategically arranged to provide clients an appropriate appreciation for the messages on nutrition. Secondly, one post has a rather large examining table that takes up most of the WP. Because almost all the WPs have bamboo slats for their walls, this raises issues of privacy for female patients being examined. The health providers are apparently aware of this problem and had to cover the walls with curtains and Manila paper. This is an improvement, however, auditory privacy also needs to be maintained and service providers have to be sensitive to this need.

A strong point of the WP intervention is the overwhelming support extended by the community towards the setting up of the facility, as mentioned earlier. People were mobilized in all the WP visited to provide construction materials and free labor to build the WP facility. This, in turn, created a strong sense of community ownership of the WPs that will hopefully contribute to its sustainability.

Activate the Mother Baby Friendly Health Stations In consonance with the Milk Code, this initiative was instituted to provide an appropriate environment for the promotion of exclusive breastfeeding for 6 months. There were no clear-cut activities that were observed by the team that indicated on-going efforts in this regard, except for the information gathered that there was a discussion of the Milk Code during the MSG training and the certification of the City Health Office and the RHU of Merida as Sentrong Sigla Centers⁶.

Backyard Food Production Bio-intensive gardening in the forms of “backyard gardens” was originally intended to promote the cultivation of Vitamin A and iron-rich vegetables in order to ensure food availability in the community. Three two-day training sessions (one in March, the other two in May and July 2000) were conducted for the men of two *barangays* of Merida (Mat-e and San Jose) and two barangays of Ormoc City (Nueva Vista and Bayog). A total of 53 participants attended the training conducted by an agriculturist of the LGUs. After the training, they were expected to start cultivating their communal garden primarily for propagating seeds for distribution to the community. They were supposed to teach other households the benefits and methods of bio-intensive gardening (BIG).

The team visited some of the sites in the pilot barangay (Mat-e) which implemented backyard food production. Six out of 11 mothers interviewed in Mat-e said they implemented backyard gardens. It seems, too, that the idea has spread beyond the pilot sites because in at least two non-BIG barangays (Sto. Nino and Lundag) that were visited by the team, backyard gardening has been identified as an activity as set forth in their BHAP, with a few households having actually

⁶ Sentrong Sigla, or Center of Wellness, is a comprehensive MOH quality of care accreditation program.

initiated the project on their own. However, since these farmers have not yet attended any training, the concept of BIG with its emphasis on small-scale backyard garden using organic fertilizers and natural insect repellent plants has not been fully adopted. In Barangay Sto. Nino, one farmer had implemented a relatively large vegetable garden intended for commercial purposes rather than a small, backyard garden. In Barangay Lundag, the garden is solely owned and intended for commercial purposes. It is clear, however, that these two barangays have shown a readiness to the idea of BIG and may therefore be good candidates for BIG training during the second phase of the training.

Mobilizing Community to undertake Healthy Baby/Mother/Family and Community Campaigns. This activity is described by the DIP as a motivational strategy to encourage families to properly take care of children and mothers' health and nutrition. For example, holding baby and mother contests in the community rewards good nutritional practices. This campaign adopts new themes each year--Healthy family for year 3 and Healthy Community for the fourth year. The winners will become photo models for the health calendars as an incentive for joining the campaign. This activity is quite popular, with the Barangay Health Councils and Barangay Health and Nutrition Committees providing active support for these activities.

A Healthy Baby Contest was held in all 48 pilot barangays. Out of 17 baby finalists 12 were chosen as winners to be featured as models in the Health Calendar for the year. For the period of October 2001 to September 2001, the contest for Healthy Baby and Healthy Mother has already been held. There were 24 models (12 babies and 12 mothers) chosen they were the models for the 2001 calendar. Calendars are currently being displayed in the homes, BHS, WPs and schools. The team received very positive reviews from users of the calendars, and the fact that "they recognized the faces of the models" added to the attraction to the calendars. As of June 2001, preparatory and information dissemination activities for the Healthy Family Selection have already commenced.

Advance Micronutrient Supplementation for Mothers and children The DIP specifies conducting a quality food intake study to begin this intervention but it was not really undertaken by the project. A major input of the project in this regard is the purchase and distribution of Ferrous Sulfate for pregnant and lactating women. A total of over 100,000 capsules were purchased and distributed both in Merida and Ormoc project sites.

It is recommended that the project documents the number of ferrous sulfate and Vitamin A capsules distributed to women in order to get a better sense of the intermediate impact of this intervention. The sustainability aspect of this activity should be considered and advocacy for support of this through inclusion in the budget should be done early as part of the project's exit plan.

(ii) Progress toward Benchmarks and Effectiveness of Intervention

Table 3 examines the progress in the basic indicators for the nutrition and breastfeeding program using the KPC results for 2001 as assessed vis-à-vis the midterm targets and end of project targets.

Table 3. Nutrition and Breastfeeding Interventions Indicators Compared with Midterm and End of Project Targets, September 2001

Indicators	KPC 2001	Midterm Target	End of Project Target
Percent of children <24 mos. who were exclusively breastfed until 6 mos.	66.4	60	70
Percent of children < 6 mos. initiating solid foods	23.3	20	10
Percent of children continuously breastfed	69.4	60	70
Percent of children < 5 years old who have 2 Vit. A & Iron-rich foods in their daily diet	79.4	80	95
Percent of children > 6 mos. to 24 mos. provided with appropriate complimentary foods	69.1	30	60

Based on the KPC 2001 results, all the breastfeeding and nutrition indicators shown in Table 3 compare favorably with the DIP targets. In fact, the KPC 2001 results show that three out of five midterm targets have been surpassed with the last two almost the same level as the midterm targets. However, preliminary LQAS results from the 3 out of the 7 lots conducted to date show contrary results. According to these, exclusive breastfeeding is under target. This discrepancy cannot currently be explained.

As far as specific nutrition/breastfeeding interventions are concerned, it is difficult to give definitive statements about their effectiveness given the relative lack of documentation on these initiatives. So far, there seems to be a general appreciation on the part of mothers and even of barangay officials who were interviewed about the MSG (even given some limitations that have been mentioned). Service providers report their knowledge on breastfeeding counseling has been enhanced, and indeed, the team noted mothers' high awareness of key breastfeeding issues, when a group of these mothers were asked knowledge questions during the IGDs. The Hearth documentation reports positive changes in the nutrition status of 3 out of the five children recorded who had been second degree malnourished, and there were discernible increases in weights observed after the first cycle of the Hearth sessions. Certainly the WPs have been successful in generating participation by the community as evidenced by the local donations towards the construction of these health posts. Micronutrient supplementation initiatives seem to be moving along well, with 1,000 ferrous sulfate capsules having already been distributed. What is unknown is if the WPs are the cause of these positive changes.

(iii) Changes in Technical Approaches in the DIP and Rationale

There are several changes in the operationalization of activities that departed from the DIP's description. For example, the MSG training was too broad in its coverage, which has watered down the original intent of the MSG. A revised set of modules was prepared by the TWG compressing the materials into 6 modules and to last for only 3 months as opposed to the original of 9-10 months. Activities in between training sessions have also been incorporated so that the interest of the participants would be captured and sustained.

The monthly review of FHSIS by the Health Information System Coordinator was not found to be feasible so this has now become the responsibility of the TWG and is done on an annual rather than monthly basis.

(iv.) Special Outcomes, Unexpected Successes or Constraints

There are a number of special outcomes and unexpected successes identified by the team and partners during the course of implementation in the first 2 years of the project. In the Hearth Model, there was an added benefit of bringing women together. The discussions of culinary secrets resulted in greater interaction among them, and led to other noteworthy endeavors not part of the original design of the project, such as income-generating projects and community improvement projects. The empowerment of local leaders is another point. They have started to think of projects that would improve the community situation and even asking the evaluation team to help them identify possible external funding for such initiatives. In most instances, community volunteers aided by IECM tools that were developed by the project now have greater confidence to undertake health teachings and conduct BCLP sessions on their own, no longer requiring the presence of the midwife.

The major constraints identified by the team are the challenges posed by the terrain of the surrounding barangays and their inaccessibility particularly during rainy season. This inherent difficulty in reaching mothers and the community during particular times of the year should be considered in future work plans and schedule development, allowing for wide adjustments in schedules during such times when typhoons and heavy rains are expected. Another important constraint repeatedly identified in project implementation is the constant delays and adjustment in work schedules due to unavailability of external consultants. It is hoped that project staff become less dependent on Manila-based experts and try to identify local sources of technical assistance, or create local expertise for particular skills that are needed. The project may wish to develop a directory for local experts for their use, as well as the partners' use once the project phases out.

(v) Follow-Up and Next Steps

The evaluation team concludes that in the area of nutrition and breastfeeding there were too many activities identified, reducing the ability to focus and follow through with the major interventions, and learn lessons from them such as doing documentation and monitoring and evaluation. There is a need to examine existing activities, evaluate the chances for success, and determine which activities have not moved in the two years. The midterm point is a good time to do this, rather than starting new activities or trying to revive a dying activity. It is time to concentrate efforts on strengthening existing activities, paying attention to quality implementation, consolidating gains, rather than undertaking new ones.

IEC materials have been developed and seem to have been quite successful in bringing the messages clearly to the target audiences. However, there is still a need to identify the behavior change objectives, identify different sets of audiences so that messages can be formulated, worded, and disseminated appropriately for maximum impact. A number of innovative media are being tested, be it Community Theater, health scouts, and others. Documentation or operations research should support these existing strategies in order to fine tune their implementation and avoid costly mistakes in the future. For example, one can test the effectiveness of the calendar vis-à-vis the IEC kit.

The concept of expanding the Weighing Post to provide other services must be studied further. It may not be feasible to perform all task identified in the DIP in these satellite health facilities, for which the structure may not be suited due to its current size, structure, and lack of privacy. It is also best to find out when is a good time for the WP to open, for how long, and who the best person to manage the facility is.

It is noted that many activities that were put forth in the work plans are really more under the direct control of local partners because these are part of their regular responsibilities (e.g. monthly requisition and allocation of FP supply; or, monthly inventory of supplies at the health center), and not deliverables of project staff. Hence, work plans must be stated clearly specifying the role of project management in them. Activities in the work plan should be re-stated as to identify the technical assistance role of PSBI in conducting/ implementing such activities (many of which are coordinative and monitoring) vis-à-vis the role of local partners as managers and implementers.

There is a need likewise to encourage community groups to modify certain community interventions (with TA from the partnership) so that these closely fit the context and the felt needs of the community. Using local names and titles would give community members a sense of local identity and ownership of the initiative.

2. Maternal Care

The decision to include maternal care as an intervention area of the PHCSP stems from the analysis of KPC results that shows that more than 70% of births in the 48 barangays selected for the project were attended by traditional birth attendants (TBAs), very few women had home-based maternal records, and less than 50% of pregnant women visited the health facility at least three times for pre-natal check-ups. Interestingly, the maternal mortality ratio is relatively low compared to regional or national averages. Ormoc registered less than 17 maternal deaths in the past five years and Merida registered even less, however, this might be a function of recording rather than what is the reality out there.

(i) Activities Related to Maternal Care as proposed in the DIP

The following activities have been identified in the work plan, which will serve to strengthen the delivery of maternal care services at the barangay level:

1. Training of traditional birth attendants (TBAs), BHWs and midwives on the provision of “quality” pre-natal, delivery and post-partum services and provision of essential obstetric equipment and supplies to perform these
2. Information dissemination activities on the importance of early and quality prenatal services including tetanus toxoid injections
3. Emphasizing and strengthening the use of HBMR
4. Strengthening of Barangay Health Stations through provision of basic equipment and kits to local health workers e.g. BP apparatus, examination table, weighing scale (adult), lamps, and supplies e.g. iron tablets
5. Development of Barangay Emergency Obstetric Plan

Table 4 examines these activities in terms of the progress they have made vis-à-vis the Benchmarks and schedules set by the Workplan.

Table 4. Maternal Care Activities Specified in the DIP and Workplans, and Assessment of Progress towards Benchmarks, September 2001

DIP Guideline of Activities (4 years)	Activities in Work Plans: Years 1 & 2	SubActivities scheduled by work plan	Progress towards benchmarks
<p>1. Training of TBAs on Maternal care</p> <p>a. Training of TBAs/ BHWs/ RHMs in providing quality maternal care</p> <p>b. TBAs provided with HBMR forms and trained on how to use them</p>	<ul style="list-style-type: none"> ○ Preparation and training of TBAs by a team from municipal/city/provincial offices ○ Provision of basic obstetrical instruments to TBAs ○ Advocacy on MCH (introduced in yr 1, not identified in yr 2) ○ Identification of untrained TBAs ○ RHMs conduct small Group and modular training to Untrained TBAs ○ MCH distance learning education (for partner LGUs) 	<p>12/00 to 3/00</p> <p>2/00</p> <p>10/00 to 12/00</p> <p>1/01 to 6/01</p> <p>11/00; 2/01</p> <p>5/01; 8/01</p> <p>3/01 to 9/01</p>	<p>4 batches of training for TBAs (Feb- March 2000) 69 participants attended training and were provided with kits</p> <p>Trained TBAs confirming knowledge and skills enhancement after training as elicited from the informal group discussions</p> <p>Criteria for identifying untrained TBAs was not followed in all barangays. Instead, some barangays chose BHWs who have no experience in delivering babies to be trained</p> <p>Community campaigns reportedly done but not documented</p> <p>On distance learning, negotiations are being made with radio station but this is not in the planning stage and not implemented</p>
	<p>Ensure safe delivery of mothers in the barangays</p> <ul style="list-style-type: none"> ○ BHW/TBAs identify and refer High risk pregnancies ○ PHO provides RHMs with OB kits ○ Meetings with RHMs/CHDOs ○ Training on quality maternal care and safe motherhood for community leaders, TBAs and BHWs ○ Training coordinator and PHN review TBA trng curriculum ○ Post training follow-up within a month from training by RHM/ 	<p>10/00 to 9/01</p> <p>1/01</p> <p>6/00; 9/00; 10/00</p> <p>1/01</p> <p>12/99</p> <p>3/00</p> <p>10/00 to 9/01</p> <p>3/01; 9/01</p>	<p>Coordinators observed that referrals are hardly done</p> <p>The project provided the OB kits to Merida because midwives stay in the barangays</p> <p>Training on quality MCH and safe motherhood not yet done</p>

	<p>BHW/TBAs to identify high risk pregnancy to RHM/PHN/ doctors</p> <ul style="list-style-type: none"> ○ Trained TBAs/RHMs handle prenatal/ deliveries/post partum services and records on HBMR ○ Refresher course for TBAs by RHMs/PHNs 		
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DIP Guidelines Activities (4 years)	Activities in Work Plans: Years 1 & 2	Sub Activities scheduled by work plan	Progress towards benchmark
<p>2. Information campaigns on early prenatal and TT injections</p>	<ul style="list-style-type: none"> ○ EPI (TT) promotion and campaign ○ PSBI purchase vaccine carrier and with LGU distribute to all BHS/MHC ○ Monthly inventory of vaccine stock by RHM ○ Immunization provision ○ BHW/TBAs/health scouts Mobilize women & children who missed immunization schedule ○ Immunization done in WP 	<p>9/99 to 11/99 1/00 9/01</p> <p>10/00 to 9/01</p> <p>10/99 to 9/01 11/99 to 9/01</p> <p>10/00; 12/00; 2/01; 4/01; 6/01; 8/01</p>	<p>There are no reports available to the team or indications that these activities have been carried out</p> <p>PSBI did not purchase carriers because it was found out that they were available but not used because of size</p> <p>On-going immunization and Case finding by BHWs. Health scouts not yet involved since they just completed the module</p>
<p>3. Strengthening of health facilities and supplies</p> <p>Note: this activity was not explicitly cited by the Dip but emphasized in the work plans</p>	<ul style="list-style-type: none"> ○ Health facility assessment ○ PSBI purchase and turn over of equipment to LGUs ○ Distribution of equipment to 48 barangays ○ PHN orient RHMs, BHWs, TBAs on how to use and properly maintain equipment 	<p>9/99; 11/00; 2/01; 5/01; 8/01</p> <p>9/99; 11/99</p> <p>12/99 to 1/00</p> <p>12/99 to 1/00</p> <p>11/00; 5/01</p>	<p>Equipment delivered to 48 barangays include:</p> <ul style="list-style-type: none"> ● Exam table ● Stand type detecto weighing scale ● Salter weighing scale ● BP apparatus ● Stethoscope ● OEC materials ● Goose neck lamps <p>Local executives and BHS personnel acknowledge this assistance with great appreciation, which enhances PSBI's credibility</p>

DIP Guideline (Activities (4 years))	Activities in Work Plans: Years 1 & 2	Sub-Activities scheduled by work plan	Progress towards benchmarks
<p>4. Emphasizing the use of the HBMR</p> <p>a. Translation of HBMR into Cebuano and made available at BHS</p> <p>b. TBAs provided with HBMR and trained how to use it</p>	<ul style="list-style-type: none"> ○ Translation of HBMR into Cebuano ○ BHS and Main health center are provided with Cebuano version ○ Re-orientation of TBAs/BHWs On HBMR by trained TBAs and RHMs ○ TBAs/RHMs provide pregnant women with HBMR ○ Monthly accomplishment of HBMR by trained TBAs and RHMs ○ Trained TBAs and RHMs Conduct prenatal, handle delivery and post partum services and record in HBMR 	<p>10/99 12/99 to 1/00</p> <p>12/99</p> <p>12/99 to 9/00</p> <p>10/99 to 9/01</p> <p>10/00 to 9/01</p>	<p>HBMR and GMC forms Translated and used. Cards available in most BHS, except in one barangay visited by the team. Shortages of translated forms are experienced in some barangays. Clients bring HBMR when they go for check up</p>
<p>c. RHMs Conduct ANC and record in HBMR and BHS logbook</p> <p>d. Monthly review report of HBMR by RHMs</p> <p>e. Pregnant women provided with HBMR and bring copy to next visit</p> <p>f. CHDO spot checks HBMR recording for completion</p>	<ul style="list-style-type: none"> ○ CHDO/BHW/RHM conduct Home visits to mothers and randomly check HBMR for completeness and regularity in updating the form 	<p>no date specified in workplan</p>	<p>Some loose their copies. HBMRs are now home based, but before the project they were clinic based</p> <p>All TBAs are oriented on HBMR but only selected TBAs are trained to use it</p> <p>CHDOs are said to check for completeness – monitoring is said to be done through KPC</p>

DIP Guideline of Activities (4 years)	Activities in Work Plans: Years 1 & 2	Sub-Activities scheduled by work plan	Progress towards benchmarks
<p>5. Development of Barangay Emergency Obstetrical Plan (BEOP)</p> <p>Note: The DIP was not explicit about this approach but it was emphasized in the work plan as a major intervention to be adopted in year 1 and followed up in year 2. Interviews with staff indicate that it has been challenging to implement, as it requires advocacy and training at different levels.</p>	<ul style="list-style-type: none"> ○ Meeting of BHC to develop BEOP ○ Disseminate plan to community Barangay Assemblies ○ Review of plan by Barangay Health Committee (BHC) and council ○ Finalize plan after BHC review ○ Joint Planning: Assoc. of Barangay Councils, ODH, CHO, RHU, PNRC on emergency obstetrical services, use of radio, access to ambulance ○ BHCs and barangay councils implement BEOP ○ Municipal and city level EOP planning session ○ Development of municipal/city Level EOP 	<p>11/99 to 2/00 3/00 to 9/00</p> <p>5/00; 8/00; 3/01 8/01</p> <p>10/00 to 11/00 1/00</p> <p>12/00</p> <p>1/01</p> <p>1/01</p>	<p>Only 11 out of 48 had not developed BEOP. Still very much in the planning stage</p> <p>Conceptually this started as a response to address emergency situations for complications arising from pregnancy in remote areas. But after community deliberations, the concept has expanded to address not just obstetrics but all types of emergencies. This expanded approach might be more practical, given the lack of any facility nearby for any kind of emergency health need. This, however, needs more planning since a wider range of services will be required. It should be noted that not all barangays have chosen to implement the expanded concept, and have remained with the obstetrical focus.</p>

DIP Guideline of Activities (4 years)	Activities in Work Plans: Years 1 & 2	Sub-Activities scheduled by work plan	Progress towards benchmarks
<p>6. Monitoring and Evaluation Maternal Care</p> <p>The DIP cites that monitoring and evaluation must be done at 4 levels: technical, intervention, project and community level</p>	<ul style="list-style-type: none"> ○ Monthly FHSIS by RHMS ○ Accomplishment of HBMR by TBAs and RHMS ○ Formative research on ANC ○ Client satisfaction study of midwifery students and CHDO ○ HIS Coordinator's baseline Survey on deliveries and post partum cases of trained TBAs ○ Quarterly review of maternal mortality ○ Quality of care research on Trained BA service provision by UP Medical interns in Merida 	<p>10/99 to 8/01 10/99 to 9/01</p> <p>2/00; 3/01 3/00; 7/00</p> <p>2/00</p> <p>1/01; 4/01; 7/01 2/01 to 4/01</p>	<p>No document to indicate That formative research has been undertaken, nor has there been any report reviewed on the baseline survey of TBA assisted deliveries</p> <p>HIS Coordinator did this by review of KPC data</p> <p>All scheduled research activities were not done. Two FGDs were conducted to evaluate pilot interventions: MSG and Hearth. There were clear indications of data utilization here, but this is more of an exception than the rule</p>

Training of TBAs on Maternal Care Given that a majority of women in the project sites still prefer to deliver their babies with the TBAs, the DIP has correctly identified this intervention. This ensures that TBAs are updated on the current technology for ensuring safe deliveries of mothers, including aseptic procedures. This intervention also includes the training of TBAs in filling up the Home Based Maternal Record forms. Initial activities specified by the work plan consist of identifying untrained TBAs in the community. Four batches of training (with 69 participants) were conducted between February and March 2000, as scheduled in the work plan. A series of activities are identified under the advocacy component of this intervention, including a campaign to increase the number of women who avail of services of trained TBAs. Also included are distance learning education, provision of OB kits, reviewing TBA training curriculum, post training follow-up and refresher courses. The project staff clarified that the project provided the OB kits and not the Provincial health Office.

IGDs with TBAs indicate that they were quite happy with the training and confirmed that they have learned many new things. Still, there are a few problematic areas. For instance the distance learning never took off the ground, despite the negotiations made with a local radio station, and the quality of care training for community leaders never materialized, etc. It is clear that the work plan activities were intended to keep on giving follow-ups on skills development, but no activity was identified to determine whether TBAs are now practicing new skills learned, whether the campaign to train TBAs have resulted in near 100% trained TBAs in the area, etc. Clearly the role of monitoring and evaluation is important in these activities.

Information Campaigns This educational activity focused on ways to communicate the importance of early prenatal care, as well as getting the TT2+⁷ immunization for women. The activity is intended to utilize RHMs in conducting TT2+ immunizations and monthly updates by outreach workers. Whether immunizations are being regularly conducted is measured by the stock levels of the vaccine, the number of orders made to restock the barangay and how often vaccine carriers are used for delivery in the barangay. The team noted short supply of TT vaccines. This was most likely due to problems with the national distribution system, which seems to plague the program nationwide.

Home-Based Mother's Record This advocacy activity consists of revising previously existing health forms by translating them into the local dialects, so these can be more efficiently used by mothers and filled out at home. Translation and reprinting of the forms have been completed, and the forms are now available in most barangay clinics. Women are using these forms, which encourages them to visit the clinic more regularly for prenatal care. There are indications that women do use this form, but we have also encountered women who say that they have lost their card. It is noteworthy to point out that the need for postpartum check up for women is not well-emphasized in the project. This is a significant lapse because one of the major reasons for maternal mortality is due to postpartum complications.

Provision of Basic Equipment and Supplies This activity had the goal of improving community health stations by providing basic equipment, to enhance its readiness to provide health services. The following were purchased by the project after the facility assessment survey:

- An examination table
- Stand-type detector weighing scale
- Salter weighing scale (for infants)
- BP apparatus
- Stethoscope
- Goose-neck lamps

It must be noted that this activity resulted from the facility assessment that was conducted by the project. It was not an identified activity by the DIP but was found in the work plan. Local government executives visited by the team were fully aware of this donation, and were very appreciative. The challenge however, is how to make the local partner aware that this entails the responsibility of the local health center to maintain this equipment in good working condition.

As far as supplies of TT vaccines are concerned, there were indications that there have been instances of stock outs reported by health providers. Lack of Vitamin A supplies were also noted which will certainly affect the coverage of micronutrient supplementation programs.

Development of Barangay Emergency Obstetric Plan The Barangay Emergency Obstetrics Plan has been discussed in almost all the project sites. This activity has been accomplished in 37 of the targeted 48 barangays, thus the midterm target of 24 has been exceeded. Only a remaining 11 barangays have yet to undertake this activity. However, even as the Barangay Health Action Plan had identified this activity, there is no guarantee that it will be operationalized. An advocacy plan is supposed to support the intervention. At present the barangays have just been barely organized to plan for an advocacy strategy that addresses the concerns of different stakeholders. In Sto. Nino, the Barangay Captain reported that the Council wishes to launch the project, but they still have to determine what are the requirements including cost. In the

⁷ There is discrepancy in the DIP and in other project documents regarding TT2 and TT3. We have used TT2 in this document. However, in the future, it is recommended that the project use TT3.

meantime, there are some misgivings among the local officials that Sto. Nino might not be given support from the city because of political reasons.

A development that evolved in the planning of the BEOP is its change from a strategy to deal with maternal emergency to one of dealing with general emergencies. This may be a practical conceptualization of this intervention, given the lack of any facility to deal with all types of emergencies in removed barangays. However, if this is the case, a new name will have to be devised, just like the case of the weighing post. Some barangays, however, have maintained the original idea of the BEOP.

Monitoring and evaluation of Maternal Care Activities under this heading consist of collection of FHSIS, accomplishment of HBMR forms, (both are responsibilities of the health providers), conduct of formative research on ANC, client satisfaction survey, study of delivery and postpartum cases of trained TBAs, and a quarterly review of maternal mortality and quality of care among trained TBAs. Except for the activities which are clearly outside the project's direct responsibility (FHSIS, HBMR), it can be said that not one activity has been undertaken. In fact the monitoring and evaluation portion of the project is quite weak and will need improvement in the next year. This is not to say that the HIS coordinator has not done her job; it is more a function of just too many activities being planned and implemented.

(ii) Progress toward Benchmarks and Effectiveness of Intervention

The four major activities are found in the DIP, but the work plan has identified additional activities under this intervention area: advocacy on MCH, ensuring safe delivery of mothers, and the introduction of the Barangay Emergency Obstetrical Plans.

Again, it is very difficult to ascertain the effectiveness of any one intervention given the short time of implementation and the lack of data from the project. However, five indicators of maternal care were identified to ascertain the effects of the mix of interventions at different points in the life of the project, namely:

1. Percentage of women having at least 3 prenatal visits
2. Percentage of pregnant women who receive the TT2+
3. Percentage of deliveries attended by trained TBAs⁸
4. Percentage of women who received "quality post-partum" care from trained TBAs
5. Number of barangays with BEOPs.

Table 5 below examines the results from 2001 on the indicators and compares these with midterm and end of project targets.

⁸ The team recommends that this indicator be modified to % of TBA deliveries attended by trained TBAs.

Table 5 Maternal Care Output Indicators Compared with Midterm and End of Project Targets, September 2001

Indicators	KPC 2001	Midterm Target	End of Project Target
1. Increase percentage of women who have at least 3 prenatal visits	46.6	60.0	70.0
2. Increase the percentage of pregnant women who have received TT2+	55.4	70.0	75.0
3. Increase the percentage of deliveries attended by trained TBAs	92.0	95.0	98.0
4. Increase the percentage of women who receive “quality postpartum” care	41.3	60.0	70.0
5. Increase number of Barangays with BEOP	37*	24	48

* This means only that BEOP has been planned in the community and does not indicate the presence of an operational BEOP.

It is noted that there is a lag in reaching mid-term targets for all the indicators. Even though the number of BEOPs is more than the number specified for the midterm target, the number only refers to planning BEOP, not functional BEOPs. Preliminary LQAS results are mixed for all of the indicators in this intervention. Program management might want to consider placing more focus on maternal care in year 3 given the lackluster performance shown so far. On the other hand, it may be too early to look for changes considering that intervention activities have recently been put in place, the margin of difference expected among deliveries attended by TBAs is extremely small, and complete LQAS results are not yet available.

The KPC figures above for maternal care indicators are not looking as good as those for nutrition and breastfeeding, but the figures are understandable considering that the project sites are among the most depressed in the province. The prenatal care coverage with at least 3 visits (one per trimester) is below the national average of 81%⁹. The post-partum care coverage is also below national average of 63%. National authorities have yet to determine what qualifies as quality antenatal care. In the team’s interview with the mothers in the 10 barangays selected for the review, it was well documented that mothers were given services that can be considered “quality”. Answers of the mothers were consistent in all areas visited, which speak of the standards set by the project during its capability building for health providers. TT2+ figure is again below the national average of 72% based on 1999 MCHS Survey. However, when compared to the baseline of 5.4%, a TT2+ coverage of 55.4% after two years implementation is a remarkable achievement in itself.

Based on the responses to questions posed during informal discussions, it is noted that that both service providers and clients view the inputs of the project as significant in improving the health of mothers. It is their observation that more women are coming for pre-natal check-ups and receiving TT injections and ferrous tablets. It is the observation of service providers that women come to the health facility early on during pregnancy, usually after several weeks of missed

⁹ MCH Survey of 1999.

menses, in contrast to previous practice where women usually come in during the 5th month of pregnancy.

(iii) Changes in Technical Approaches in the DIP and Rationale

Major changes identified in technical approaches from the original DIP were the inclusion of additional objectives for Maternal Care intervention. These include improving post-natal service coverage, increasing attendants at birth by trained TBAs and increasing the number of barangays with Obstetric Emergency Plans. Another major change was to qualify the pre-natal and post-natal care services as “quality” services.

In addition, technical changes are observable between the objective that was outlined in the DIP and its corresponding activity. The first technical change occurred in the first activity discussed above --- the Maternal Care Training for TBAs. The TBAs are an understandable alternative for pregnant women who prefer the individualized care inside their homes by one they know well. There are also possible financial benefits for opting for a TBA rather than a health professional like a midwife, nurse or doctor who are rather impersonal and may charge for services. For these reasons, this was a major activity identified in the DIP for improving maternal health. The training was intended to teach aseptic delivery as well as to improve coverage for pre-natal and post-natal care.

However, during the recruitment of TBAs to be trained, the TWG expanded recruitment of participants to non-practicing TBAs, (e.g. a daughter of TBAs who was too old to continue as TBA and a very active and committed BHW who was interested to provide this service in her community). This was pointed out by the team as a major infraction that should not be repeated in future interventions. A five-day training course cannot make TBAs of any individual woman. The advantage of training practicing TBAs is that they have already acquired the needed skills and knowledge beforehand which are drawn out from their long experience in the trade.

Some activities that were identified in the original DIP were not carried out. Among these were the use of IECM and capacity building for identifying missed opportunities and fine tuning strategies that are related to improving immunization coverage and clinic scheduling.

(iv) Special Outcomes, Unexpected Successes or Constraints

The project was able to undertake a significant number of activities in a fairly short period of time. There was a lot of collaboration and networking with key stakeholders as well as partners outside of project areas (such as health officials at provincial/regional and national levels, and other NGOs and consultants/ firms hired for technical assistance) that were observed by the team. The DIP was useful in organizing the activities but there were several overlapping and overloading of activities that were noted. Some partners interviewed during mid-term evaluation commented on the “continuous barrage of activities” that was being scheduled. Still, there were activities cited in the DIP that were missed and not followed up in the workplan, including:

- Resource generation activities for replication
- Activation of Mother-Baby Friendly Health Stations
- Development of standard format for masterlisting by the TWG
- Reach out activities to trace missed clients using the masterlist
- Conduct of research on quality of breastfeeding and complimentary feeding practices by UP Medical Interns in project sites
- Conduct of 24-hour diet recall study by partners
- MCH distance learning education by LGU partners

- Conduct of continued/regular health facility assessment
- Development of municipal and city level emergency response and obstetric emergency plan
- Formative research on ANC practices
- Conduct of Client satisfaction surveys by midwifery students
- Conduct of quality of care research on trained TBAs by UP Medical Interns in Merida

A major constraint identified in this intervention is the dependence on the national system for the provision of supplies such as the TT vaccines. As long as this arrangement is not straightened out, it will be difficult to achieve the benchmark in this program on TT. Another constraint is the amount of activities that are being carried out. It was recommended that with the many activities, it will serve the project well to revisit each intervention and see which needs strengthening and which ones needs to be closed down in order to be able to focus on interventions that have greater potential for making an impact.

Some of the BCLP classes were temporarily suspended because of the weather and poor road system that became muddy pathways that were difficult to access. The lack of budget of local governments, particularly in Merida, has also been identified as a barrier in implementing some of the planned activities. How these LGUs are able to generate additional funding to address the health needs of the community will always pose as a major challenge in areas with limited resources such as the case for Merida and Ormoc City.

(v) Follow-up and Next steps

HIS will need to focus on monitoring the effectiveness and performance of the interventions that have been put in place. It is important to know how effective the use of HBMR is in terms of increasing and improving ANC practices. However, it is also important that postpartum care be focused alongside with interventions to improve prenatal care.

For participants who are not practicing TBAs, it is recommended that OB kits be retrieved, particularly if there are no trained RHMs who can supervise them during deliveries. They can become regular BHWs who help to facilitate transport and referrals of pregnant women to trained service providers. Furthermore, the team recommends instead for the community to identify birth attendants, or other qualified candidates who can be sponsored for midwifery training.

A refresher course for TBAs has been identified in the DIP. This should be implemented but the curriculum should be improved to hone the skills of the TBAs and in particular increase knowledge on breastfeeding, complimentary feeding, nutrition and care of the infant.

Perhaps a major concern that the project will be faced with in the next two years will be the competing demands of following up activities that have been initiated while starting replications in other project areas. In the case of the maternal care intervention, the usefulness of integrating multiple objectives with one activity has to be maximized. Monitoring and supervision of RHMs and TBAs on a regular basis must be implemented as proposed.

3) **Child Spacing**

(i.) Activities related to child spacing as proposed in DIP

The third set of intervention activities is child spacing. The activities under this program are the following: training of service providers in FP service provision, ensuring the availability of different methods of FP, strengthening VSS, involving men in the program, strengthening community commercial contraceptive dispensing, and monitoring and evaluation.

Table 6 shows the DIP guidelines vis-à-vis the work plan that were developed for year 1 and 2 and the progress of these intervention activities. The activities under child spacing that are listed below consist of those that were completed during the first year of implementation (Work plan 2000) including newly identified activities during the second year (Work plan 2001). Activities that were listed in Work plan 2001 are those on-going and carried over from the previous year (such as management of FP supplies, and voluntary sterilization). The provision of FP services (temporary methods), an activity identified in WP 2000 served as a preparation for the Community-based Contraceptive Commercial Dispensing, a major activity listed in Work plan 2001. In addition, two new activities “Involvement of Fathers” and “Partnership with the DECS” were added in the second work plan.

Table 6 Child Spacing Activities Specified in the DIP and Workplans, and Assessment of Progress Towards Benchmarks, September 2001

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work plans	Progress Towards Benchmarks
<p>1. Train Doctors, RHMs and PHNs on Basic/Comprehensive Family Planning</p> <p>Training of RHMs on Basic Comprehensive Family Planning following DOH Protocol</p>	<ul style="list-style-type: none"> ○ Coordination of PHO for conduct of training for RHMs and actual conduct ○ RHMs provision of FP services ○ Assessment and Coaching sessions to RHMs 	<p>2/00; 3/00</p> <p>4/00 to 9/00</p> <p>3/00; 6/00; 9/00</p>	<p>Training conducted was on competency-based approach (10 days) rather than basic comprehensive training specified in the DIP. This is the new DOH plan, endorsed and recommended by the PHO. One training session on Competency- Based FP was completed between March and April, and attended by 21 participants - 4 doctors, 4 nurses, 13 RHMs.</p> <p>There was a marked increase in FP utilization, based on analysis of FHSIS.</p>
<p>2. Provision of IUD Kits to trained RHMs</p>	<ul style="list-style-type: none"> ○ Provision of IUD Kits to ensure Competency in IUD insertion <p>Note: The DIP did not specify other activities under this heading</p>		<p>21 IUD kits distributed to trained service providers.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work plans	Progress Towards Benchmarks
<p>3. Ensuring the availability of FP contraceptives, supplies and services</p> <p>a. RHMs provide regular service on modern methods of FP at the barangay health stations</p> <p>b. Training of health personnel/BHWs and TBAs on interpersonal communication, problem management, referral system and Family planning counseling</p>	<ul style="list-style-type: none"> ○ Monthly inventory of supplies and requisition using CDLMIS ○ Advocacy of activities to Local Chief Executive to allocate FP funds ○ Train/Mobilize BHW/TBAs to provide condom and pill re-supply in 48 barangays) ○ Pill dispensing ○ Natural Family Planning Training for CSP ○ 48 barangays providing Natural Family Planning 	<p>9/99 to 9/01</p> <p>9/99 to 9/01</p> <p>1/00 to 2/00; 10/00 to 9/01</p> <p>2/00 to 3/00 2/01 to 4/01</p> <p>10/00 to 9/01</p>	<p>Inventory is being done in three BHS visited (Boroc, Lundag and Liberty).</p> <p>Ormoc: 16 BHS & Satellite Bgys. with 1 month FP supply as reported Merida: All 5 BHS have 3 months FP supplies</p> <p>Stocks on pills and condoms meet the set requirements.</p> <p>Trained 65 health volunteers and service providers on NFP for community members and service providers. Volunteers came from 13 barangays. Participants are expected to adopt and/or teach others (PFNFP expected to monitor and provide PSBI a report on performance).</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work plans	Progress Towards Benchmarks
<p>4. Strengthening Voluntary Surgical Sterilization (VSS) Services</p> <p>a. Quarterly coordination meeting of CHO/RHU and Ormoc District hospital regarding VSC service</p> <p>b. Ormoc District hospital provides VSC service at least once a week</p>	<ul style="list-style-type: none"> ○ Link up with Ormoc DH .re availability of VSS services. ○ Identification of VSS clients and referrals ○ CSP, CHO/RHU, PHO and RHO provide BTL Pack, medicines, supplies ○ RHO to Accredite Marie Stoppes ○ VSS Outreach by Marie Stoppes 	<p>1/00</p> <p>1/00; 4/00; 6/00; 8/00</p> <p>11/00</p> <p>1/01</p> <p>3/01; 6/01; 9/01</p>	<p>Referral system is now established with Ormoc District hospital.</p> <p>Has already partnered with Marie Stoppes to provide outreach services for VSS, Ormoc hospital charges high professional fees (P3,000) for special patients (e.g. obese patients</p> <p>Accreditation of Marie Stoppes was not pursued because the present set-up seems to work well for Marie Stoppes.</p>
<p>5. Ensuring Involvement of Fathers in Family Planning and Health Activities</p> <p>Conduct sessions on FP with fathers by BHWs, RHMs and CHDO.</p>	<ul style="list-style-type: none"> ○ Curriculum development for fathers classes ○ Organize fathers classes (1 in Merida; 3 in Ormoc) ○ Establish men’s clinics in 2 barangays 	<p>11/00</p> <p>1/01; 3/01; 5/01; 7/01; 9/01</p> <p>4/01</p>	<p>Except for the inclusion of husbands in the NFP training, no other activity to promote male involvement has been undertaken. Father’s classes are planned to build on this training. CSP Staff members report that this will be included in curriculum development in Year 3 workplan.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work plans	Progress Towards Benchmarks
<p>6. Establishment of Community-based Commercial-Contraceptive Dispensing Station (CDS) in 4 Barangays (1 in Merida and 3 in Ormoc)</p>	<ul style="list-style-type: none"> ○ Development of criteria for piloting Community-Managed Commercial Family Planning Dispensing Stations ○ Discuss tie up and signing of MOA with DKT ○ Piloting of Family Planning Dispensing Stations ○ Plan for replication ○ Provision of condoms and pills in BHS ○ Assess Family Planning Program and Feasibility Study (Barriers to Family Planning Services and Client Satisfaction Survey) ○ Management Training in Commercial Dispensing with Use of Medical Eligibility Checklist ○ BHCs establish/manage Dispensing Station ○ Meeting with DKT to tie up with DOA ○ Initial stocks at Dispensing Stations 	<p>1/00</p> <p>1/00</p> <p>2/00 to 9/00</p> <p>8/00-9/00; 8/01 to 9/01</p> <p>3/00 to 9/00</p> <p>3/01</p> <p>5/01</p> <p>6/01</p> <p>11/00</p> <p>6/01</p>	<p>At negotiating stage with DKT. Project Director wants to explore collaboration with John Snow for setting up Well family midwife clinic in Ormoc.</p> <p>There has been a delay in implementing this activity. Rescheduled from Sept 2000 to Sept 01. No training in commercial dispensing had been scheduled.</p> <p>These activities had been postponed. Contact was made with DKT.</p> <p>The team recommends that the activity be put on hold given the fact that the project sites are depressed areas (a basis for their inclusion in the project sites), and the prospect for setting up a commercial dispensing system at this point will not prosper from a business point of view. The same is true with the proposed setting up of the well-family midwife clinic.</p>

DIP Guidelines of Activities (4 years)	Activities in Work Plans: Year 1 and 2	Sub activities scheduled by Work plans	Progress Towards Benchmarks
<p>7. Monitoring and Evaluation on Child Spacing</p> <p>Conduct formative research on barriers of family planning by HIS</p> <p>Note: The DIP cites that monitoring and evaluation must be done at four levels: technical, intervention, project and community levels</p>	<ul style="list-style-type: none"> ○ Monthly Accomplishment Report of CHDOs ○ Monthly CDLMIS/FHSIS reports by RHMS and PHN ○ Client satisfaction survey ○ Formative Research on Barriers of Family Planning ○ Feedback of Analysis of FHSIS to PHAB/TWG/PD 	<p>10/99 to 9/01</p> <p>10/99 to 9/01 4/00</p> <p>2/00</p> <p>11/99 to 9/00; 11/00 to 8/01</p>	<p>CDHOs provide updated and regular accomplishment reports.</p> <p>HIS coordinator was successful in influencing the City health Office to segregate the performance data from the 38 project barangays. The problem of disaggregating data was only encountered in Ormoc. For Merida this was not a problem because it only has a total of 22 barangays and data can be easily segregated for the 10 pilot barangays. This data are not currently analyzed to assess performance, but can be done in a relatively quick way. May require TA from data analyst.</p> <p>Not yet pushed through with university. Recommend looking at CBMIS on FP.</p>

Training of Doctors, RHMs, and PHNs on Basic Comprehensive Family Planning The first activity is the training of service providers. The training was supposed to be coordinated by the PHO and includes the assessment and coaching of RHMs. This is a very important intervention given that there is a dearth of service providers who are able to insert IUD. The training that was conducted was a competency-based training. This was completed in 10 days, and included the use of models and a practicum. The basic comprehensive training uses a similar format, but requires 28 days to complete. Twenty-one participants composed of 4 doctors, 4 nurses and 13 RHMs completed the training between March and April. The trained providers were also given IUD kits after the training session.

Ensuring the availability of FP contraceptives, supplies, and services This intervention consisted of an inventory of supplies in the health center; advocacy to LGU executives to support FP and to allow TBAs and BHWs to re-supply pills; and introduction of NFP and provision of IUD kits. The “Contraceptive Delivery and Logistics Management Information System” (CDLMIS) is crucial in ensuring the availability of a 3-month stock of pills in the Barangay Health Station, which is also a key indicator in measuring the progress and effectiveness of the intervention. Of the 10 barangays visited, a team member checked the stock status of three Barangay Health Stations, finding that the CDLMIS forms and records are being regularly filled out by the Rural Health Midwife. Furthermore, the available stocks of pills and condoms met the set requirements.

NFP training was conducted by The Philippine Federation of Natural Family Planning, an NGO based in Manila with networks in selected areas of the country. It will be interesting to conduct an operations research allowing outreach workers to supply pills to first time users after training as another strategy for reaching more women in the community.

Strengthening of voluntary surgical sterilization services This intervention consists of strengthening the link with the Ormoc District Hospital (ODH) and identification of potential clients to refer to this hospital. This referral system has now been established, but some issues arose regarding the high professional fees at ODH being charged for special cases. The partnership project also linked up with Marie Stoppes and there seems to be a potential for collaboration with this NGO. The project aims to conduct advocacy for the accreditation of Marie Stoppes by the regional office. However, it seems that there are some major barriers to this outcome and therefore the project for now may just wish to pursue an outreach VSS activity with Marie Stoppes.

Ensuring Involvement of Fathers in FP and Health Activities This objective aims to motivate men to participate and make responsible decisions related to child spacing. The “Father’s Classes” is a proposed activity as suggested during the Barangay Action Planning in order to increase the level of men’s awareness on the issue of child spacing. Interestingly, male members of the Barangay Council reacted during the IGD to this approach, citing the possibility that men will not feel good about being “singled out”. In this regard, the team recommends using the “couple approach”, a strategy that will involve both husband and wife in any program that relates to reproductive health.¹⁰ (However, use of this strategy does introduce some concerns, such as

¹⁰ This can begin by including men in the service protocols during prenatal, delivery and postpartum, as well as during counseling for breastfeeding, nutrition, and child spacing. A similar approach has been tested by KANIB, an NGO based in Bukidnon, which used the RHA approach (developed with the Institute for Reproductive Health, Georgetown University) for involving men. Cf. “Enhancing Male Involvement Through NGO-LGU Collaboration, *Frontiers in Reproductive Health*”, Population Council, Manila, 2001.

bias towards married users, as well as the possibility of dis-empowering women in front of their husbands. These concerns should be addressed prior to implementation.)

Establishment of “Community-based Commercial Contraceptive Dispensing Stations” This intervention was conceived to address the need to offer a wider range of options to clients in their choice of FP methods in the community, particularly in the light of the project’s concern for providing a sustainable source of FP supplies. What have been initiated at this point are preliminary meetings of the project director with representatives of DKT to develop the mechanisms of linkage, and plans to link up with Johns Snow’s Well Family Midwife network of NGOs. Scheduling of training on commercial dispensing had been put on hold.

The team felt that the establishment of the commercial dispensing station within the WPs, as originally conceived, is difficult to justify. The Health Centers offer free contraceptives, and the clientele are mostly from disadvantaged communities. Although the government has recently enacted a policy towards cost recovery and strengthening private and commercial contraceptive provision, the evaluation team feels that this is inappropriate to implement at this point. It would be better to first have a working program like the Indigency program of Philhealth which is now in place in some areas, which is not the case here.

Monitoring and Evaluation on Child Spacing For the monitoring and evaluation component of this intervention, the project has been putting its efforts toward providing technical assistance in terms of monitoring the regular accomplishment of the Field Health Service Information System. This had enabled the FP Program Coordinator to further segregate the data to generate information from the 10 project sites in Ormoc, thereby installing a mechanism to track down information on current use of FP. One interesting follow-on activity would be the comparison of performance between project and non project sites in the same province.

(ii) Progress towards Benchmarks and Effectiveness of the Interventions

Aside from the analysis of program performance using data from the FHSIS, Table 7 shows the status of two child spacing indicators that were specified in the DIP: percent of women using modern contraception and number of barangays offering “quality” family planning services. The KPC data show that during the past two years the project has seen a remarkable increase in the percent of women using modern contraceptives. In fact, KPC figures surpassed the midterm target by 6 percentage points. Preliminary LQAS data demonstrated a similar finding.

Table 7. Status of Child Spacing Output Indicators based on KPC and compared with Midterm and End of Project Targets, 2001

Indicators	KPC 2001	Midterm Target	End of Project Target (2003)
1. Percent of modern contraceptive use	41	35	50
2. Number of barangays providing quality FP services	12	24	48

The second indicator pertains to the establishment of health stations providing FP in all the 48 project sites. KPC results show that 12 such health stations now exist which is still a way off the target of 48 at the end of the project. How “quality” is defined, however, is not clear. It must be pointed out that definitions of quality differ for different individuals and depends on whose

perspective it is being evaluated. Hence in completing this target, the project may want to consider clarifying what are the objective criteria that can be used for determining one health service as providing quality care or not.

It was clear that FP use increased after the training, as determined by a quick look at the FHSIS data that were analyzed by the team during the field visit. Since the project was able to segregate the data for project sites (an accomplishment that deserves commendation) FP utilization (new acceptors) was computed per method in Ormoc city. Table 8 shows the number of new acceptors for six months (Jan-Sept 2001) compared to what it looked like the year before. The accomplishment for Intervention 3 in particular is further corroborated by the data from the records of the City Health Office in Ormoc on Family Planning method use.

Table 8. New FP acceptors by Method, 1998-2001

FP Method	1998 *	1999**	2000***	2001****
Pills	898	853	219	278
Condom	213	282	130	135
Ligation	52	8	5	15
IUD	245	210	203	170
DMPA	162	77	71	84
LAM	463	297	318	378
TOTAL	2034	1727	946	1060

*Annual Performance for all barangays in Ormoc City

** Annual Performance for all barangays in Ormoc City

***Annual Performance of 38 PHCSP barangays only

**** Performance of 38 PHCSP barangays only as of August 31, 2001 only

The data from the City Health Office indicated a general improvement in family planning acceptance and use. There is already a 22% increase in the total number of new acceptors for FY 2000 compared with only the first half of 2001 for all methods. If this trend continues, it is expected that by the end of the year the accomplishment of acceptance rate would be more than double the total 2000 figure. This increase is noteworthy considering that the main child spacing intervention consists of training service providers and equipping them. Although there appear to be impressive increases in the numbers of new acceptors in this table, it would be interesting if this analysis could be extended to non-project areas, to see how performance in the non-project areas compares with project areas. In addition, a partnership with Marie Stoppes has also been initiated during the year to improve voluntary surgical services. The reason for the decline of some methods from 1998 to 1999 is not clear.

(iii) Changes in the technical approaches outlined in the DIP

As far as changes in the technical approaches are concerned, the project has essentially been led to start the commercial contraceptive dispensing as a separate activity. The DIP originally conceived this to be a modest and complementary initiative to the weighing post, which is the major intervention. Another shift that has emerged is the stronger project link that is being established with Marie Stoppes as a main referral group for VSS, despite their lack of accreditation with the DOH, given the problems that are cited by the project about high fees at the ODH. This shift was perceived as better for the program, not only for cost consideration but the flexibility of Marie Stoppes in providing community outreach.

(iv) Special outcomes, unexpected successes or constraints

What stands out at this point in child spacing intervention is the relative success in increasing new acceptors in the program given the minimum inputs that have been put by the project into family planning. The case of the community commercial distribution system which, did not really get off the ground, is an example of a constraint. The socioeconomic situation in the area is not conducive for commercial distribution of the pills or condoms. Sustainability strategies should be limited to community participation efforts which do not require any outlay of financial resources. This observation underscores the need to assist LGUs in obtaining external resources if they are not yet able to absorb some of the more promising interventions. The participation of local leaders in planning their programs in the community has “forced” them to face the needs of their health system and become aware of their limitations in this area. This has helped to bring out their sense of ownership of their programs.

A constraint faced by the project is the predominance of men in the barangay councils. In most cases, they are not at the center of the issues regarding maternal health and nutrition, and there is still a need to orient them to needs related to maternal health. To accomplish this, initial orientations and training can begin with the predominantly male memberships of the barangay health and nutrition committees.

(v.) Follow up and next steps

The follow-up steps that have been identified are the inclusion of vasectomy training and the need to follow-up this intervention in the RHUs and BHS. Another follow-on activity is shifting the focus of the male involvement activities towards couple approaches. The project will be studying lessons learned based from experience here and abroad on this area. A possible local contact is the KANIB group in Bukidnon province which recently implemented a reproductive health awareness education campaign in the community, using locally developed modules assisted by another local NGO.

Another activity that should be pursued is the conduct of operations research on the issue of allowing BHWs to dispense pills to first time users. To allow the barangay health workers to do this will be truly bringing health services at the doors of women. However, the project will have to study and address quality of care issues associated with this strategy.

The team recommends that there be a stronger focus on providing gender-balanced interventions. In this regard it is recommended that VSS training and service provision pay closer attention to providing training for vasectomy, and supports this with stronger support from the IECM section of the project. Many misconceptions regarding vasectomy exist not only among men but also among women. These have to be addressed and the IEC support will be crucial.

The provision of vasectomy is a practical addition to services in the health centers given that this procedure, unlike ligation, can be done in an RHU or a BHS setting. An added bonus to this initiative is that it can be used as a component of the intervention to involve men in reproductive health concern, which is another activity of this project.

Like the other two intervention areas, monitoring and evaluation are areas that need strengthening. A strategy of hiring short-term help will be well worth the investment as it allows the partnership to assess the effectiveness of their initiatives and determine the gaps in their implementation so that corrective measures could be put in place.

2. Cross-cutting Approaches

2a. Community Mobilization

The communities were mobilized for several activities as listed in Table 9 below. The table also shows accomplishment based on targets.

Table 9 Community Mobilization Activities, DIP Targets, and Status

ACTIVITY	DIP TARGETS	PROGRESS
○ Organization of MSG	2 pilot barangays	<ol style="list-style-type: none"> 1. Two MSGs organized in two pilot sites: Masumbang and Biliboy. 2. One of the two barangays was visited by the team; IGD conducted for MSG in Masumbang.
○ Establishment of WP	48, 1 per barangay	<ol style="list-style-type: none"> 1. 35 WPs have been established 2. Nine of the 10 sample barangays visited by the team have established WPs, the status of which has been described in detail in the Nutrition and Breastfeeding section of this report. 3. Community resources were mobilized from the establishment to the maintenance of the facility. During the construction, the community donated the lot, building materials, labor and food for the workers. 4. BHWs also give time in managing the WP at least once a month not to mention the physical upkeep of the facility. The DOH and/or LGU provide supplies, IEC materials, personnel (RHM). 5. PSBI provided equipment, e.g. weighing scale, and IEC materials which were accessed from the Provincial Population Office (Tacloban), Nutrition Council of the Phil (NCP) and Food and Nutrition Research Institute(FNRI). 6. Facilitating factors include political will and cooperation of local (barangay) leadership and exposure trip, e.g. Hilongos

ACTIVITY	DIP TARGETS	PROGRESS
<ul style="list-style-type: none"> ○ Involvement of children in community health activities 	Health Scouts Puppety	Two of 6 Health Scout Groups and one of the Puppety Groups were visited by the team. The Health Scouts related what they have been taught, particularly on nutrition. Both groups just finished their training on the Nutrition Module. The Puppety group has not yet made any public performance in these areas, but the other groups in Mabini and Cauntog have performed 7 times.
<ul style="list-style-type: none"> ○ Barangay Health Action Planning (BHAP) 	48 barangays have increased participation in community assessment, designing community health programs Training on BHAP	<ol style="list-style-type: none"> 1. 48 barangays have BHAPs. Of all 10 barangays visited by the team, 4 barangays had a plan for <u>both</u> 2000 and 2001. 2. Training of trainers (TOT) on Technology of participation (TOP) in support of BHAP Ormoc: 18 participants, 9 of whom came from 5 brgys Merida: 19 participants from 10 brgys 3. Subsequent community-based BHAP Planning was done in 33 barangays of Ormoc led by the PSBI staff; those who were trained during the TOT e.g. RHM, DILG, BHW, facilitated the sessions. 4. As per account of staff, the plans emanated from a situational assessment and for the second round accomplishment results. 5. Participants were mostly the Kagawad For Health, Barangay Capt. and the BHWs. In some barangays, mothers, the youth and TBAs were also involved. 6. Participants in planning: mostly Kagawad for Health and BHWs. In some visited areas, the Barangay Capt., Barangay Council also took part. Many of the Barangay Council members interviewed were not aware of the BHAP content nor the reason why some activities in the first plan were deleted in the second plan.

ACTIVITY	DIP TARGETS	PROGRESS
<ul style="list-style-type: none"> ○ Purok Data Board 	<p>Empowerment of brgys to generate data, utilize and feedback info to community for community action</p> <p>Regular (quarterly) updating</p> <p>After each survey the BHWs report to Council results for appropriate action</p>	<ol style="list-style-type: none"> 1. Trained were: <ul style="list-style-type: none"> -36 participants from Merida (10 barangays) -2 batches of 63 participants from Ormoc (7 barangays) (based on Project training report) 2. Six of the 10 visited barangays had at least one Purok Health Data Board. In most of these areas the BHWs are aware of the color codes and the board is updated quarterly. However in one barangay the barangay captain does not know the codes. Cost was the reason for the non-replication in other puroks. The marine plywood is expensive according to the respondents.
<ul style="list-style-type: none"> ○ Healthy Baby / Mother Contest 	<p>Healthy Baby – Yr. 1</p> <p>Healthy Mother – Yr. 2</p>	<p>A community-based Search & Selection committee was formed composed of the Barangay Capt., BHWs, RHM, Kagawad for Health, DECS representative and an NGO representative working in the area. After being oriented on the criteria, they selected qualified nominees from their barangay. The Search & Selection Committee accompanied the finalists to Ormoc for a final screening by a group composed of the PHO, RHO, CSP staff and DECS. Plaques were awarded the barangays who had winning entries, besides framed photos, etc.</p>

The team was able to visit only one site of the MSG-Masumbang. A more detailed assessment of the functioning of the group is discussed in the section on nutrition and breastfeeding. As a form of community mobilization strategy, the MSG has potential but at this point much of the issues have to do with simply putting the components in place. At present the “energy” of the group, aside from the visits of the CHDO lies with the barangay health workers who are also members of the MSG. The challenge as far as community mobilization is concerned is how to get regular mothers in the community to participate actively in the MSG. A system for monitoring and evaluation that allows the members to report their accomplishments and activities will need to be set up to support the initiatives for sustainability.

On the Weighing Posts, as based on interviews in the 10 sample barangays, it was determined that response to the establishment of WPs varied from active to low participation. The degree of responsiveness of these barangays did not necessarily correlate with the number of activities

initiated. However, it is very clear that the setting up of the WPs in the project sites has mobilized the community from the local leadership down to the mothers in the community. The WP has the potential to become the center of other community mobilizing strategies such as the MSG, the Hearth, and BEOP if there is a deliberate effort on the part of program management to organize the activities with the WP as the entry point for the latter activities.

Community participation in health assessment and development of the Barangay Health Action Plan (BHAP) is one important DIP indicator for capacity-building and successful community mobilization. From the staff's account, the process followed was a sound one--the conduct first of a situational assessment before planning was done. However, documentation of this process is weak, and the participants of the BHAP were not given copies of the health assessment. Although the output is complete, participation in the planning and awareness of the plans seem to be limited.

The plans seem not to have been monitored and assessed. In one barangay that was visited the barangay captain admitted that he did not know exactly what transpired because he left the meeting early. In the Barangay Council of a few areas visited, many were not aware of the contents of their BHAP. In instances where two plans have already been drawn, the reasons for why some activities were dropped and others continued are not known. In addition, it was noted by a member of the team that the BHAPs did not contain any objectives. In community planning, activities are means to attain specified objectives and not the end. The CHDOs are currently assuming the task of monitoring the plans. The documentation of status of implementation is lodged mainly at the PVO level. Since assessment and planning are critical processes in building people's capacity, these steps must be strengthened.

The following are what have been perceived as barriers which prevent members of the community from benefiting from the program:

- Communication problems; for example, the contact person (Barangay Captain) did not relay the messages to Kagawads on time.
- Low IRA (Merida barangays) inadequate to support even transportation expenses of trainees. Cost is high when training is held in Ormoc City.
- Some training packages dilute the main messages by including many ideas and activities that are not too central to the objectives of the training (e.g. MSG training package). Before any module is adopted, this must be thoroughly reviewed and approved by the appropriate technical staff or committee.
- The project seemed to have identified beforehand a series of intervention activities to be implemented in all areas, regardless of what problems are most severe in these areas (for example, why is BEOP determined as the intervention of choice to be implemented in all areas, when in fact some areas may have easier access than others to emergency services such as being located near better roads, or nearer a health facility?). There is therefore a need to prioritize the intervention that is most needed to implement based on the actual assessment of health needs of a particular barangay, rather than having these predetermined.

Because community mobilization activities have not been well documented, it is difficult to ascertain if there were activities that were "used to refine program implementation plans".

2b. Communication for Behavior Change

The Health Calendar, BHW kit and flipcharts are the major IEC materials developed by the project. Other materials like the BCLP counseling cards are also used as aides for the “bench conferences”. Health Scouts and MSG are among the channels utilized to disseminate the information.

On the whole, most of the approaches clearly identified messages for the entire project duration with technically sound messages and progression of messages. However, there are insufficient tools to gauge the effects of the approaches listed. In the IGDs conducted, the Calendar and IEC kits were the most popular among both mothers and service providers.

The creation of calendar messages is probably one of the more successful project activities. The messages were clear and easily remembered by clients, especially mothers. This type of IEC support, which included the local language translation of clinic forms (e.g. GMC and HBMR), is very important in reinforcing the overall program objectives. The use of community members in the pictures for the calendar has very positive effects in the utilization of the calendar. The mothers and caregivers (as determined from IGDs) easily identified with the personalities and modeling is attained. However, there is the question of sustainability of this component as the cost for use of local talents, reproduction in small scale and the use of quality materials are quite high. However, the hope is that these outputs will be durable, albeit not sustainable.

The active involvement of the IEC Task Force was claimed by the project staff to be a rewarding experience for everyone. The Task Force appreciated the long, meticulous process of reviewing materials and identifying messages from the recipients and the partners at the health facilities. They confirmed that there was transfer of technology to partners in terms of messages and materials development. As a result, the process has empowered partners in adapting local materials for their message development.

Although mentioned in the document under Training Program and IEC component, there is no documentation of a comprehensive Communication Plan. This is critical for the measurement adjustment of behavior change approaches. It has been claimed that data sources were utilized as inputs in developing the IEC messages and materials, e.g. KPC, FGD, vital statistics. However in the annual review and planning, only quantitative data is used as inputs. Again, the need to optimize the use of data generated by the project, including FGDs, cannot be overemphasized.

2c. Capacity Building Approach

(i) PVO Strengthening

Capacity building objectives for the PVO are not developed in the DIP. It is an assumption that staff possess the competencies and technical capacity necessary to implement the project. There were efforts, however, to enhance competencies of project staff. In all activities of the project and where appropriate, the organic PSBI staff as well as project staff have been involved in planning, monitoring, training and evaluation activities. For training, in particular, the Project Director attended the Organizational Capacity Assessment and a training of PSBI staff on Reproductive and Maternal health; the Training Coordinator was sent to attend the LGU-IEC Capability training and IMCI workshop; the HIS Coordinator attended the training on FHSIS and Qualitative Assessment on Health Programs using FGD.

Technical support was provided by PSBI Head Office (HO) on a “per need basis”. Most of the HO’s involvement has been in ensuring that the implementation adheres to the DIP and the proposal, and providing technical assistance in the introduction of new approaches (e.g. Hearth, IMCI) as well as in providing technical support in installing the KPC and the LQAS. She also maintains communication with USAID and CSTS, and has made regular visits to the project.

The CSP project has helped to improve PSBI’s organizational capacity in some ways particularly when there are regular PSBI program activities that overlap with the CSP. An example is the PSBI Health Academy Sessions where the CSP project shared their best practices, and provided the CSP an opportunity to influence further PSBI’s paradigm shift (in the words of a CHDO) from a dole-out approach to one of a more development-oriented approach (i.e., “health in the hands of the people”). PSBI staff from the other branches were exposed to CSP activities and trainings, i.e., PRA, BCLP, KPC, Purok Health Data Board, IEC Kit and Hearth. From the feedback, PRA was the most utilized among the trainings.

(ii) Strengthening Local Partner Organizations

Local partners are representatives of government and non-government organizations who are also members of the Project Advisory Board, Technical Working Group, IEC Task Force.

There is a strong involvement of professional health workers (at the level of the CHO, RHU, PHO, RHO) in capacity building activities of the project. This is largely due to their involvement in capacity building trainings and activities since the beginning of the project. After the early trainings which were done mainly as capacity building strategy, subsequent workshops focused on the transfer of technical skills to enhance quality of care in service delivery.

One of the weakest links in the partnership is probably the one forged between PSBI and other NGOs. PSBI has originally engaged three NGOs for the project, but only two NGO partners remained at the time of the evaluation. Some NGO drop-outs were unavoidable. However, there are some constraints that NGOs (particularly the RDI) have on project implementation which needs to be reviewed by the project staff and addressed appropriately.¹¹

Among the NGO partners, the relationship with PNRC is the most successful particularly regarding the Health Scouts. Content of training was modified to respond to the agenda of both the project and PNRC. Another partner (ACTION) ceased to participate with the project because their operations have been discontinued in the project barangays.

There is evidence of strong linkages and capacity building of the health sector partners, especially with the PHO which has now trained both the service providers and the BHWs. Strong LGU linkages exist for the City/ Municipal levels but weak at the Barangay level. Except for the BHAP training, there has been no capacity building for local government executives and officials for improved program management. Of the 48 barangays, 15 BHCs have been organized. Twenty-three more need to be organized and made functional. Additionally, there is a need to ensure quality of the community assessment and planning process and better participation of all related sectors. It is important to mainstream this as a Barangay Health Committee function.

¹¹ The partnership with Rural Development Institute (RDI) had some difficulty due to RDI’s perception that there was a lot of waste of resources as a result of bringing participants out of their barangays for training. RDI prefers that Merida people be trained in the locality rather than bringing them to Ormoc so that funds expended would benefit Merida. PSBI’s position is that this was done only for the planning stage, and subsequent training workshops were scheduled locally. Hence, undefined roles, failure to level expectations at the start, and irregular coordination were among the de-motivational factors identified in the seeming failure of the PSBI NGO partnership.

An Institutional Assessment was done but the results did not outline the needs for capacity building per partner organization and as a whole. In the DIP, the assessment would have been followed by a capacity building plan.

Again, an area for capacity building which needs to be strengthened at all levels is in the area of monitoring and evaluation and setting of guidelines for project management, particularly with regard to the role and functions of the Ad Board.

(iii) Health Facilities Strengthening

The first activity for improving service delivery is to ensure facility readiness and technical competence. Accordingly, the activities that the project undertook for this purpose (training of service providers in breastfeeding counseling and FP, provision of equipment, including IUD kits, computers, translation of GMC and HBMR, etc) were quite appropriate and laudable. Computers were provided for Merida RHU and Ormoc CHO. The printer was agreed to be the LGUs counterpart, which was not fully complied with, at least on the part of Merida. BHS and WP are provided with forms, IEC materials, and micro- nutrient supplementation supplies. Supervision is one activity that has been adversely affected by devolution, as there was no travel allowance being provided for this activity.

In view of this, the project conducted a monthly visit to assess the health facilities during the second year, with the idea that the health sector will be part of this monitoring and supervision activity, along with an LGU representative and PSBI. Prior to the Mid-Term evaluation this was tested in five months – one barangay in Merida and Ormoc per month. The health sector representatives were supposed to come from the RHO for Ormoc, and the PHO for Merida. However, in actual conduct, it appears that there was no health sector representation as visits were conducted only by the LGU and PSBI.¹²

Two tools were used during the visits – Program Management, and Operation & Maintenance of Health Facility. These are existing DOH tools which the advisory board decided to field test. However, examination of these tools led the team to conclude that these are not adequate to monitor all the critical aspects of the project. Hence these tools will need further refinement in their content, choice of indicators, as well as format. Regarding links between the facilities and the communities, weighing posts are an excellent example.

(iv) Strengthening Health Worker Performance

Enhancing performance of professional and volunteer health workers was done through on-the-job training, exposure trips and the provision of kits (TBA, IUD insertion) and IEC materials (BHWs, RHM). Assistance has so far been effective in addressing identified needs of providers. Training activities have been flexible and adjusted to the concerns of the health providers.

The resulting improvement in performance after the training could not be shown since there are no written performance standards or tools to measure actual performance. Competencies of service providers at the different levels need to be identified and assessed. The New Performance Appraisal (NPA), an assessment tool which the DOH has developed, could be reviewed and enhanced based on identified competencies.

¹² CSP staff members reported that CHO, PHN, and Program coordinators participated in joint supervisory visits.

(v) Training

Training has been conducted for different aspects of program implementation. To date, training activities have reached a total of 1378 individual participants.¹³ Training activities are planned carefully by the IEC and Training Coordinator, but there is no overall Training Program to show how the different trainings contribute to the attainment of the project objective of capacity building. This training plan should be able to indicate how many should be trained, who will be trained, what kinds of training different target clientele need, how will the training be phased, provisions for an assessment of skills/knowledge transfers, quality of care standards that are put in place, etc. With this system the program would be able to describe the selection and training of participants vis-à-vis the objectives of the different interventions. Phasing and sequencing of training activities to clearly address the competencies identified for the service providers could not be gleaned from documents. For example, Quality Assurance is identified as a separate training activity which could have been integrated in the Training for Competency-Based FP.

In some instances the criteria for selection of participants to the training workshops was agreed upon but not implemented due to problems with miscommunications (e.g. TBAs included those who were non-practicing TBAs or new TBAs). Or in another case, more than 30 participants arrived for TBAs training, a number that cannot be accommodated in one training session. This resulted in having to send home some participants and asking them to return when the next training will be scheduled. These could have been avoided if the guidelines have been set clearly beforehand.

New training on other programs was conducted in the second year. The criteria for the prioritization of these training activities are not clear. It is noted, for example, that training for an externally funded program on Integrated Management of Childhood Illness (IMCI) was conducted by the project, but this is not an identified training need that is directly related to program implementation. Although initiatives like these are laudable because it builds on existing programs, these activities must be weighed against other more critical training needs of the project.

Needs Assessments were allegedly undertaken during the entry grant and were used to identify the types of training needed. This is a missing document and thus could not be referred to during the design of the specific trainings. In the absence of information on performance, IGD with project trainees was done to get an idea of their self-assessment of perceived changes in their competencies. The feedback received by the team was positive, e.g. they were more confident about their IUD insertions; TBAs no longer practice fundal pressure, and BCLP participants report that they have become “better communicators”.

2d. Sustainability Strategy

As per the DIP, the goal of sustainability of interventions is to improve communities', LGUs' and partner NGOs' capacity to manage and deliver MCH services which the project will address in terms of financing, skills transfer and sustained behavior change in the target population. The capacity to deliver services in terms of skills has improved, as discussed in detail in the earlier portions of this report under the section on training.

Regarding management, the Ad board and the TWG are beginning to take on the responsibility for managing the systems that have been put in place by the project. These groups are also beginning to participate actively in the concerns of the project. The remaining two years will be

¹³ Some of these individuals are counted more than once because they have attended more than one training session.

crucial in institutionalizing the role of these groups in terms of providing the technical and advisory functions at the local level.

However, financing is not as strong yet and should be given attention particularly at the barangay level. Presently, the budget for health is already stretched. In fact one need identified by the local government office in Merida is how to generate other sources of grants to help sustain the activities started by the CSP. Financial sustainability and cost recovery schemes are areas that still need strengthening in the remaining two years of the project.

The community mobilizing aspect of the project also contributes to the sustainability of the project. A full discussion of this can be had under the community mobilization section.

C. PROGRAM MANAGEMENT

1. Planning

In keeping with the participatory nature of the project implementation, key partners were invited to participate in planning the PHCSP. Planning started with the development of the Detailed Implementation Plan (DIP), and included in these early discussions were the following representatives from different key institutions and partner agencies:

- The Provincial Health Office - the PHO, Program Coordinators (MCH, FP, ARI, CDD, Nutrition, WHSMP)
- DOH Regional Office, DOH Representatives
- From the municipality of Merida: the Municipal Health Officer, (MHO), the Public Health Nurse (PHN), the Rural Health Midwives (RHMs), Maternal and Nutrition Action Officer, President of ABC, and *Kagawad* for Health
- From Ormoc City: the City Health Officer (CHO), Asst. CHO, Medical Officer 3, Coordinators of FP, Nutrition and other Health Coordinators, 16 RHMs, 8 PHNs, Representative of CPDO, Association of Barangay Captains (ABC) President, Representative of PNRC, Representatives of Action Inc. (has since ceased to operate) and Rural Development Institute of Leyte (RDI)
- Program Coordinators (MCH, FP, ARI, CDD, and Nutrition) and the Chief of Technical Division
- Action Inc.: Executive Director and 1 CO worker
- PNRC: Administrator and 2 PNRC nurses
- RDI: Executive Director, CO worker and an administrative Staff
- At the community level: Barangay Captains, *Kagawad* for Health, Barangay Health Workers (BHWs), Barangay Nutrition Scholars (BNS), and the *Sangguniang Kabataan*.

Essentially the same people and institutions were again represented in the development of the project's yearly work plan. At year 2, three additional partners were identified to join in the planning: representatives from the Department of Agriculture, Department of Education, Culture and Sports (DECS), and Department of Interior Local Government (DILG).

The attempt to ensure the participation of different sectors is quite impressive. Because those who were involved in the development of both the DIP and the work plan were major stakeholders, it was an opportunity for them to contribute and have first-hand knowledge of the program planning process. This strategy was adopted to bring about a sense of ownership of the project among the local leadership.

During the implementation of the plans, a number of unavoidable constraints and scheduling conflicts cropped up. Some of these constraints included unavailability of resource persons (e.g. Hearth, and to some extent the MSG), lack of local resources, as well as conflicting schedules with other programs (within CSP or outside, as other projects compete for the time of local partners), or inclement weather. However, the Project Director is pleased with the schedules of the activities and claimed that about 90% of these were implemented as scheduled. Schedules for training encountered more problems because these involved the participation of many more individuals. In this case, only about 75-80% was carried out on schedule.

Project objectives are fairly well understood by the different stakeholders, given the orientations, information dissemination, and training activities that were sponsored by the project for this purpose. All participants in these activities had been provided with copies of the DIP and the work plans. The major challenge however, lies at the local level, where some misconceptions and suspicions persisted even among responsible members of the Barangay Council regarding the project objectives. One such official questioned the motives of PSBI regarding the program on child nutrition because of rumors that in Camotes Islands “children were taken away from their parents and sent abroad”. Hence more IEC needs to be done at the local or barangay level.

The DIP states that the monitoring scheme has “utilized various sources from both LGU and community levels”. Examples of these sources include the FHSIS, the KPC, the CDLMIS, the GMC, and at the community level, the Purok Data Board. The LQAS (which was just introduced in August 2001), other small studies (most of which were not conducted to date), the master list, monthly accomplishment reports, and IECM documentation are also monitoring and evaluation tools. The CBMIS came later as the MGP began to establish its program in the 38 barangay sites of PSBI. Once this system is fully adopted by the program, it also can be an important monitoring and evaluation tool.

The team notes that there are no overall plans that state that there are project resources or systems in place (except having one personnel, the HIS coordinator) that would ensure that data are being analyzed, and that results are being utilized for future program development and implementation.

A few examples of program monitoring activities that resulted in the refinement of the program implementation relate to the FGDs done for the MSG and to some extent, the Hearth. In the first example, it was determined that the training was too long; hence a new module was developed to compress the topic and shorten the duration of the sessions. In the Hearth, it was found that there are drop-outs in the middle of the 12 sessions. Strategies for improving attendance are now being considered by the project staff.

Helen Keller International was brought in as a consultant to produce the report on “Monitoring and Evaluation Component of the PHCSP”. The reaction of the partnership to the HKI report was that the design was too cumbersome. In addition, they felt “there is already an existing M & E system in place”—the Field Health Service Information system (FHSIS) which they claim is working, and already answers their information needs. However, the utility of this system has not been demonstrated to date because of reporting delays at the facility level, and because of the manner in which this data is aggregated. A thorough review of the FHSIS was discussed during the years two and three action planning. Fortunately, because of the project’s success in getting the health system to present data by barangay, FHSIS’s potential for generating relevant barangay level information have now been greatly enhanced. However, it must be emphasized

that FHSIS alone will not suffice as the project's monitoring and evaluation system, since it was not developed to capture the nuances of the CSP objectives.

2. Staff Training

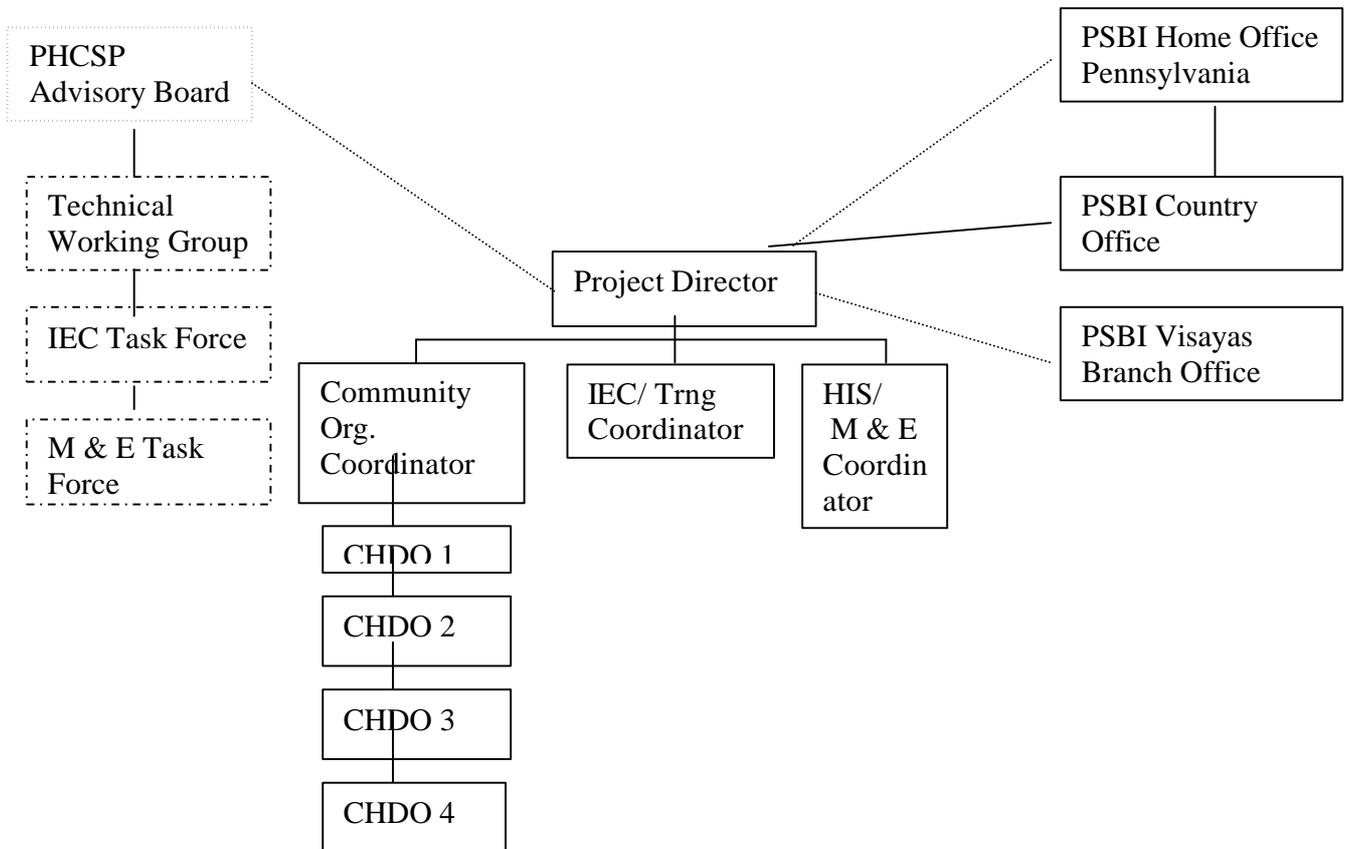
With regards to staff training, the project director explained that no project resources are allotted for staff training, given that theirs is a short-term assignment, and because management is operating under the assumption that the staff is already technically capable. However, when there were opportunities for training or updating of skills that come along, such as the JHU-sponsored IEC training, the staff were encouraged to attend these training (see section on PVO strengthening). There are also a number of in-house opportunities in this regard, including various trainings being given by consultants or the backstopper (e.g. BCLP, Hearth, LQAS, and IMCI). In addition to this, the performance of the staff is reviewed during regular annual performance assessments.

Specific areas for skills/competencies trainings have been noted. (For a full discussion, refer to section on capacity building). The HIS coordinator indicated that she will need further training in data analysis (quantitative and qualitative approaches), the IECM coordinator expressed a need for training on strategic communication, and the Community Development Coordinator indicated a need for her to update her knowledge on new developments in community organizing. These are quite realistic assessments of their training needs, and the project may wish to consider these concerns in its plan for future staff development. In addition to this, the two coordinators do not have training in public health, so this could also be another area for further development.

3. Supervision of Program Staff

The Project Director is the overall coordinator and supervisor of the implementation of the project. The link between him and the Ad Board, the TWG and IEC Task Force are represented by a broken line in Figure 2 in order to emphasize the fact that the project director does not report directly to these Ad Hoc committees. The relationship is one of partnership. However, the Advisory board still needs to be brought up to the point where it begins to function truly as an advisory and policy making body for the project. Project management at PSBI currently calls the meetings to assess project performance or for undertaking annual planning. In contrast, however, the TWG's roles and functions are much clearer.

Figure 2: Organizational Structure of PHCSP



The project is set up in such a way that there is system of technical backstop and coordination from the PSBI headquarters in Pennsylvania, with the country office in Quezon City (Manila) down to the field office in Leyte. Ms. Nancy Obias, the former PSBI Country Director, contributed significantly to the planning and development of the project since the entry grant. About six months ago, there was a change of leadership in the country office when Ms. Obias took on a regional position. The new Country Director has just familiarized herself with the project but now provides the needed supervisory role over the Project Director. The previous Country Director felt that the technical support function coming from the headquarters is essential, especially in areas which involved bringing in cutting-edge technology on child survival, given that this is a public health intervention and that this is a new program that the country office has engaged in.

There seems to be in place a system of regular supervision of staff as mentioned in the DIP. Communication is maintained via 2 monthly meetings – one for all CSP staff, including the 4 CHDOs, the finance and general support staff - and another with just the Project director and the three coordinators. Reports are expected of each coordinator so that needs for assistance are determined. The Project director makes monthly field visits accompanied by the CHDO assigned to the particular areas. The annual Performance Appraisal is also conducted where the staff’s self-appraisals are contrasted with supervisor’s appraisal of her/his performance. Staff describe the supervisory style as one of facilitative supervision where the supervisor gives instantaneous feedback when he sees something that needs to be immediately corrected in the field. This approach has been found to be effective in building competence and allows also for quick action

on the part of the supervisee. However, the question of whether there are supervisory tools – in addition to the system described above - remains unanswered.

4. Human Resources and Staff Management

Hiring is conducted with the involvement of representatives from the health offices of the CHO and RHU. The personnel manual was developed with staff participation. The staff expressed satisfaction with their work arrangements. There was a break during the entry grant with the project director leaving the post midstream. Despite this one event, staff turnover has not been a problem at the field level. However, there were some interruptions with staff turnover in the headquarters with technical assistance delayed on several occasions.

At this juncture, no plans have yet been made with regard to staff's transition to other paying jobs when the project ends. This should however be part of the exit strategy that the project should be paying attention to during the next two years.

5. Financial Management

There is a PSBI financial system in place that governs the way finances are handled within the program. The finance staff of the project coordinates with the PSBI Visayas Branch office located in the same building where the project staff also holds office. Funds are directly paid for each completed activity. Financial reports are submitted prior to release of funds. The financial management may be described as efficient. According to the project director, there were occasions when the total amount of funds requested to finance field operations is not fully released. In the event that this occurs when there is a need to conduct the activities, they have good credit lines with suppliers and venues.

6. Logistics

The project director conveyed to the team that there has been no major issue in logistics because there were not significant purchases or distributions that were entailed in the project. The purchase of equipment for the BHS proceeded smoothly, and there were no serious reports of delays or difficulty in transporting these to the intended beneficiaries. The distribution proceeded quickly because there are no storage facilities provided in the PSBI office for big equipment such as the weighing scales.

7. Information Management

Information management lies in the office of the Health Information System Coordinator. As mentioned in earlier sections, the major source of information for monitoring and evaluation is the FHSIS which has occupied much of the coordinator's time up to this point. There is still a lot of work needed to update and get the system functioning down to the level of the barangays. This is essential for this project because the implementation of the activities takes place at the barangay level. The project is making headway in this direction, but the next step is to analyze and utilize information derived from this system in conjunction with other MIS that have been put in place by the project such as the PDB, the KPC and lately the LQAS. The CBMIS, which is a component of a Matching Grant (MGP) which the Ormoc City Health office holds, has the potential for providing another source of information. The MGP and CSP overlap in some barangays.

At this point, it is also essential to identify indicators that can be obtained from each of these systems in relation to the project, and to determine the frequency in which these indicators can be collected and analyzed. It is also essential that the HIS Coordinator is not overburdened with the project's demand for information. Data analysis is weak and there is a definite need in this

area for technical assistance. Furthermore, it is also not too clear how information had been utilized by the project for program improvement; hence this concern also needs to be addressed.

The problem with the KPC, which to date has provided much of the current data is that it measures long-term effects of the projects. The project needs intermediate indicators that can be derived from small studies or surveys for monitoring purposes. The LQAS may be able to serve this purpose, but since it has just started, its utility cannot be assessed at this point.

The perennial issue about the inadequate utilization of data in many programs seems to also plague this project. The KPC data have shown that in most instances the target or benchmarks have been achieved during the first two years of implementation. However, there is virtually no reference to this analysis in any project document. Were the observed increases in the indicators due to the intervention being implemented? One cannot answer this question as yet unless there are other sources that can be had to make comparisons about the results observed from the KPC. Furthermore, even though it can be assumed that the project is responsible for the positive effects that have been observed, one still cannot determine which intervention has made this kind of difference.

This observation implies the need to undertake operations research for the pilot projects that are being implemented. It is important to know what intervention is working and how cost effective or sustainable these interventions are. This is true, for instance, with Hearth, the Health Scouts and BCLP, which have been piloted in certain areas. At this point, the evaluation team cannot give concrete assessment of these interventions as their impact have not been uniformly documented and established.

8. Technical and Administrative Support

A number of individuals have provided the project with technical and administrative assistance:

Home Office (Pennsylvania):

- Kristine Brunkow (backstop entry planning Grant and DIP 1)
- Linda Arbogast (DIP2) - as replacement for Ms. Brunkow
- Hannah Gilk- as replacement for Ms. Arbogast
- Joanne Fairley

Country Office (Philippines):

- Nancy Obias-Country Director from entry planning grant to March 2001
- Ana Maria Locsin-Country Director from March 2001 to the present
- Adelfa Garcia- Finance and Administrative Manager
- Femia Baldeo-Program Manager

International Consultants:

- Donna Espuet of CSTS – KPC
- Waverly Rennie – Freelance Consultant on Hearth Nutrition Model
- Donna Sillan – Freelance Consultant on DIP 2 (revision)

National and local consultants:

- Dr. Melchor Lucas – Freelance Consultant now with MSH on Quality Assurance
- Dr. Jimmy Tan – Health Futures Inc. - IEC
- Helen Keller International – BCLP, Advocacy and M & E

- Inez Fernandez, Executive Director, ARUGAAN – MSG
- Tito Aure, Freelance Consultant-Puppetry
- Drs. Salinas and Angulo, Eastern Visayas Regional Medical Center, IMCI– Puppetry
- Amy Bernardo, Lorna Caminforte – IMCI Core facilitators
- Divine Word College of Tagbilaran – Technology of Participation
- Zeny Aran, PHC Federation of Surigao City-Purok Data Board

Visayas Branch of PSBI:

- Rose Sequitin, branch Manager, assists in the day to day operation of regular PSBI Branch staff
- Dona Oloroso, Finance and Administrative Officer-Technical and Personnel Support

Technical assistance received was, in most cases, timely and relevant. A few exceptions with regard to the issue of timeliness were noted in the text of this report.

Other anticipated needs for technical assistance include the advice on the establishment of an overall monitoring and evaluation plan. This plan should assess the existing sources and tools and how these can be used to monitor progress and evaluate effectiveness of specific interventions. Community-Based Monitoring and Information System (CBMIS) is a tool that was introduced to the 38 barangays in Ormoc by the Matching Grant Program. It is implemented by master listing women 15-49 and children less than 5 years old as a first step. This list forms the basis for identifying women and children in need of particular health services. They are subsequently prioritized according to their unmet health needs so that they are followed up and linked to services in either the fixed clinics or in an outreach activity. This model overlaps with preexisting master listing that is done in the barangays of Leyte. However, current master listing is frequently biased towards women that seek services at health facilities. Possibilities for integrating these activities with the Purok Data board will need to be explored.

There are new intervention areas that are still starting and may need further strengthening. One of these is in the area of male involvement. A suggested strategy would be to seek assistance from KANIB (an NGO in Bukidnon province) to share their experience in their successful implementation of the couple approach to reproductive health awareness.

D. Other issues Identified by the Team:

1. **On Indicators Chosen for the Project.** An indicator for one of the benchmarks for maternal care of the DIP was, “increasing the percentage of births attended by trained TBAs”. If interpreted without any sort of qualification, the statement could be understood to mean that the project would like more births to be attended by TBAs rather than by health professionals. This objective needs to be clarified to state that, of all deliveries attended by TBAs, the project’s goal is to have all of these attended by trained TBAs. In other words, the desire is that all of these deliveries would be attended by trained health providers (including TBAs). It should be pointed out that the numerator should be the number of deliveries attended by trained TBAs divided by all deliveries attended by TBAs. There has been confusion in the computation of this indicator.
2. **Inclusion of Non-practicing “TBAs” in TBA trainings conducted.** Related to this issue is the rather flawed practice of including non-practicing birth attendants to the TBA training (e.g. getting BHWs to become TBAs). The training is intended to tap practicing birth attendants so that they will practice aseptic delivery and post-partum techniques. It

was not the desire of the training course that non- practicing TBAs could become “trained” birth attendants only after 5 days. If there is a felt need for more trained TBAs, one option is that the project locate internships for women wishing to become TBAs with currently practicing midwives or trained TBAs.

3. **Supervisory role of Midwives over TBAs.** This is a sticky issue because the TBAs are community- based and not really officially linked with the health system. What kinds of system of supervision can be made in this situation? The project has to address this and document the relationship between midwives and TBAs in the community. How does the project know that all TBAs have been reached by the training program? For trained TBAs, what are mechanisms in place to ensure that they are practicing what they have learned in the training? What are the indicators to measure quality of care at this level? These have to be defined and measured.
4. **Addressing Critical Issues Related to Maternal Care.** Other interventions to address major causes of maternal deaths have not been considered by the project. In particular, some of the major causes of maternal deaths are due to hemorrhage and post-partum/abortion complications. The project might consider an intervention that includes ensuring safe blood supply as well as post abortion care.
5. **Inclusion of LAM as a major component of the FP intervention, as well as in the IEC and training support.** It makes a lot of sense to include LAM within a program where there are already strong initiatives on breastfeeding. It takes minimal effort to include this under the breastfeeding initiatives (particularly in MSG and BCLP training modules). There is hardly any mention of the method perhaps because of the persistent misconception that “breastfeeding equals LAM”. It is not well understood that LAM has its own set of well-developed protocols. A separate training can be planned just to introduce the method to both providers and clients. The IEC materials that have been developed have not emphasized this point either.
6. **Development of Work Plans and Assignment of Areas of Responsibility among the Members of the Partnership.** In the development of work plans, activities are listed without any clear indication as to who among the partnership is responsible for implementing, documenting, supervising and assessing progress of activities. In this way, there is no clear accountability for completion of activities. At the very least, the role of PSBI in the activities listed in the work plan must be clearly specified.
7. **Regular Reporting of Progress.** Reporting of activities does not consistently include whether the work plan has been adhered to, or that there are departures from the plans or delays encountered and why these occurred. Hence the follow-through suffers, and there are activities that “get in between the cracks,” because of numerous activities that are being initiated, followed up and monitored (e.g. the case of the formative studies and the commercial contraceptive dispensing system initiatives).
8. **Adding more Progress or Intermediate Indicators for Child spacing.** At present, there are only two indicators cited in the DIP for child spacing. Other indicators, such as % increase in new acceptors of Family planning, or % of women (who want to space or limit their children) practicing exclusive breastfeeding up to 6 months who choose a modern method of FP may be added to the list. Since IUD and ligation are major

emphases of the intervention, this can also be measured, including vasectomy acceptors, once vasectomy has been installed in the VSS intervention.

9. **Start up of Upcoming Initiatives.** CBMIS provides the opportunity to bring about the convergence of current activities, such as master listing and the Purok Data Board. Since the CBMIS begins with a master listing activity, the current purok specific master listing can just be enhanced so that this satisfies the requirement of the CBMIS. CBMIS can be used to update the Purok Data Board – which are meant to be updated quarterly, as well as the identify mothers and children who are in need of services. If integrated in this manner, the institutionalization of CBMIS will become more manageable, as will be master listing and the PDB. The CHO who coordinates the MGP work in Ormoc is a potential source of TA in this regard. It is also recommended that the project invite the project investigators of “Impact of Quality of Care” Project Province (C/O Dr. Agapito Hornido, PHO and the Ateneo de Davao University) to share their well-documented experience on the successful implementation of the CBMIS in Davao, funded under the FRONTIERS Project of Population Council, and Rockefeller Foundation.

Secondly, **Increasing Male Involvement** should begin with an examination of other models or approaches that have been tested. There are some initiatives in the country and the project will be served well to contact agencies such as KANIB in Bukidnon and the Institute of Reproductive Health to provide the needed technical assistance to the project. More gender sensitive IEC will be needed for this project, involving in particular the development of information on vasectomy as a method for men. In this regard, Engender Health can provide technical assistance in training doctors in vasectomy. The advantage of this operation is that it can be done in a rural health unit, or even in a barangay health station.

10. **Setting Criteria for Scheduling Particular Training Activities.** Connected to the observation of the need for a training plan, it is noted that training on some programs that were not specified in the DIP were conducted in the second year. In particular, training for Integrated Management of Childhood Illness (IMCI) was conducted by the project. Although initiatives like these are laudable because they build on existing programs, they should be weighed against other more critical training needs of the project.
11. **Other activities arising from the project activities that may not be in the DIP or in the workplan.** In the case of the MSG, members have indicated a need to use the MSG as an opportunity to generate some common income generating activities (e.g. sewing) and they expressed the desire to get connected with a “market” for their products. They have requested assistance from PSBI in this regard. Similarly, the Vice Mayor of Merida is seeking assistance from PSBI to help them get external funding to support their health program (e.g. purchase of ferrous sulfate capsules and maintenance of health center equipment) in anticipation of project phase-out. In what ways these requests can be responded to might be considered by program management during the next phase of the project.

E. Conclusion and Recommendations

It is the evaluation team’s assessment that much was accomplished by the project during the first two years of its implementation. Certainly, the essential groundwork preparations for the project have been completed. Critical intervention models have been tested (Hearth, MSG, WPs, and BCLP). Necessary training for program implementers, health service providers (including

TBAs), and clients (mothers) has been conducted. The project also deserves commendation for building on existing structures and taking a deliberate policy not to replicate or add new systems, structures or protocols that can result in overloading the local health system. In fact, the project has gone out of its way to sponsor existing training activities of the local health system that are directed towards the achievement of project goals (e.g. IMCI training). The more innovative interventions (e.g. Hearth, WPs) attempted to adjust to local realities and paid attention to the requirements of sustainability and local needs.

Despite these strengths of the project that have been mentioned, some gaps have been noted and listed below with accompanying recommendations:

A. General Recommendations:

The Need for an Overall Project Plan This plan will serve to connect the Work plan with the DIP as well as the specific and long-term objectives of the project. This is needed for the different components of the project during the remaining two years of the project, including a monitoring and evaluation plan, an IEC and training plan, a research plan, as well as a technical assistance plan for each intervention and crosscutting activities. The details of these needs have been discussed in the text of this report. In drawing up this plan, it will do well for management to undertake a tracing exercise linking the activities with their potential impact on the benchmarks.

Planning for an Exit Strategy An exit strategy will have to be consciously and deliberately planned by the project during the next two years. At this juncture, no plans have been made with regard to staff's transition to other paying jobs when the project ends. This could be part of the exit strategy. In this regard, it is important that the Advisory Board be involved in planning for the exit strategy of the project, especially since their technical and policy making roles will constitute an important part in the exit strategy. The recommended approach of reviewing existing activities and choosing to strengthen activities that hold promise for success would fall under this strategy.

Monitoring and Evaluation There are major gaps identified in the areas of monitoring and evaluation, data analysis and utilization of information. These are either not done in a systematic fashion, information is generally not utilized to refine program implementation, and/or to influence policy. This utilization must be done at different levels. The regional level would include logistical issues, such as regular supply of vaccines and contraceptive supplies, and accreditation of Marie Stoppes. The provincial level includes the role of provincial support of trainings, either at the CHO and RHU, (especially in the areas of supervision, monitoring and evaluation), or the LGU (in terms of budget support and local planning). Process documentation of pilot interventions will help to identify best practices, and problems of implementation. This information is very important for replication and scaling up, particularly for cost efficiency reasons. In this regard one cannot overemphasize the role of process documentation and assessments. These types of evaluations should become standard activities when piloting interventions, so lessons can be utilized to fine tune, and if need be, redirect the implementation of replications.

PSBI needs to make an extra effort to involve the RHU or CHO in supervision and monitoring of health clinics, emphasizing supportive supervision, with the use of an effective monitoring tool to review clinic performance.

Need for Technical Assistance and Staff Development Technical assistance needs have been identified especially in the areas of evaluation and process documentation. Another area that requires technical assistance is financial sustainability. A review of the different capacities of staff for these particular challenges in the next two years of the project is in order, so that technical assistance can be systematically planned.

The team has therefore recommended the provision of short term technical assistance in the areas of project evaluation and process documentation, setting up of innovative programs (e.g. male involvement) or strengthening of existing ones (CBMIS), as well as in the analysis of FHSIS, KPC, and the LQAS to assess impact of specific interventions. Additional TA might be needed for conducting evaluations using both qualitative and quantitative methodologies.

In the past, program implementation had been constrained by the unavailability of identified consultants at the time when the project needed them. In order to address this problem, and in anticipation of the TA needs of the project, it is important to begin to identify a pool of local technical consultants to assist in the implementation of programs, particularly in the area of evaluation, research, and documentation.

Sustainability Strategies In order to enhance existing efforts for sustainability, quality partnerships with NGOs should be strengthened. To date, the partnership with these groups is largely faltering. We recommend that the project make a conscious effort to include this in the exit strategy. As for financial sustainability, the project can be guided by the DIP which states that it should undertake intervention in the “areas of governance management and operating systems for resource mobilization and financial management”. In line with this, the request for technical assistance coming from the local government of Merida mentioned in the text of this report can be properly addressed.

Another area to consider is the establishment of a mechanism to build or encourage self-help. The MSG members’ request for technical assistance on setting up income generating activities can fall under this effort. The PhilHealth Indigency model used in Aklan can also be studied to see how this can be applied in the project sites.

B. Specific Recommendations on Particular Intervention Programs:

- 1. Strengthening the Activation of Mother-Child Friendly Health Station.** Since supporting breastfeeding interventions is an important aspect of the project, the team wishes to recommend beginning discussions with the regional Office of DOH to orient the health personnel about the Milk Code, and to disallow milk ads in the health centers or any health facility.
- 2. Strengthening of Maternal Care Interventions.** It is the team’s assessment that while the breastfeeding/nutrition intervention activities are relatively sufficient to effect impact in the project benchmarks, the interventions on maternal care are rather weak. This is reflected in the rather lackluster accomplishment in this area’s indicators as shown by the KPC results.

To be specific, the BEOP, an activity identified under maternal care, is still in the planning stage. In some instances, this approach had been widened to address emergencies of general nature. Since it needs to be pilot tested, it is recommended that for a stronger implementation, an evaluation activity be built into the pilot testing of this model.

The team recommends the strengthening of micronutrient supplementation initiatives (Ferrous Sulfate and Vitamin A), the prenatal and post-partum program for mothers, and service provider's capacity to deal with post-partum complications.

3. **Adding LAM as an Integral Part of Breastfeeding/Nutrition and Child Spacing Interventions.** The team's major recommendation is that LAM should be included in training and IEC development support plans, in order to integrate this method within existing interventions (such as MSG, BCLP, and Hearth). Again monitoring, evaluation and operations research have to support these initiatives.
4. **On IEC Activities.** IEC activities that go beyond the general messages currently in place may be considered as next steps. For example, a more intervention-focused IEC strategy for FP could be the development of instructions for health workers in providing basic information on appropriate use of FP methods. There is also a need, to include vasectomy messages to support the VSS intervention, LAM messages in order to support breastfeeding and child spacing interventions, and gender and male involvement in reproductive health to support new initiatives of the project.
5. **Introducing Vasectomy in VSS intervention.** The team has recommended that there be stronger efforts to provide gender-balanced interventions. In this regard it is recommended that VSS training and service provision pay closer attention to providing training for vasectomy, and support this with IEC materials. Many misconceptions regarding vasectomy exist among both men and women. These have to be addressed and the IEC support will be crucial. The provision of vasectomy is a practical addition to services in the health centers given that this procedure, unlike ligation, can be done in an RHU or a BHS setting. An added bonus to this initiative is that it can be used as a component of the intervention to involve men in reproductive health concern.
6. **Encouraging the Convergence of Different Interventions.** Some activities may be integrated with others (MSG in the Hearth; CBMIS with master listing and PDB) that are on going in order to consolidate strengths and minimize duplications and missed opportunities. Because Hearth allows for mothers to get together for weighing, cooking and feeding sessions, this could become an excellent entry point for introducing the MSG. This consolidation of activities into clusters of interventions can help to increase cost efficiency in introducing the new interventions, and at the same time will help to reinforce the impact of the messages and lessons that can be derived from each of the interventions. The same is true here for the consolidation of LAM within Nutrition and breastfeeding intervention.

In conclusion, a more general reminder at this point will be for project management to assess the project interventions' status overall and within specific barangays. This will determine which set of interventions or activities holds promise for impact, considering the community's reception and support for these activities, as these are important elements for sustainability. These are the projects that will need to be followed up and strengthened. The rest of the activities may be integrated with others, or may have to be concluded immediately in order to consolidate strengths and minimize further losses. The active involvement of the Advisory Board is essential in making this decision. This approach will constitute part of the exit strategy that will have to be consciously and deliberately planned by the project at midstream.

Highlights of the PHCSP Project: Hearth is Introduced in Leyte, Philippines

Among the more successful initiatives that the Partners for Health Child Survival project has introduced is the Hearth Nutrition model. Being a new concept in the Philippines, PHCSP, through the guidance of a consultant, decided to initially implement the Hearth on a small-scale basis. One community was chosen as a pilot. This site was chosen because of its proximity, cooperative leaders, committed health personnel, and relatively high incidence of malnutrition.

A wealth ranking activity was facilitated in preparation for the Positive Deviant Inquiry (PDI). The PDI identified the positive practices of the mothers that contributed to the well being of their children, despite their economic status. This also included examining the caloric value and availability of foods, and the feeding preferences and practices of the caregivers. Leonila (or Nila), who was identified as one of the Positive Deviant mothers, has been a widow for almost two years and has maintained the health of her two children by herself. She is unable to find a stable job. She perseveres, however, by working odd jobs. She keeps a vegetable garden in her backyard. Her understanding of maintaining proper hygiene is reflected inside her home, despite the scarcity of water, which can only be fetched in a public faucet about 200 meters away. Nila's story and health practices have served as a source of inspiration and basis for the Hearth Program which hopes to bring her experience and practices to others.

Based on the information obtained during the PDI study, the team proceeded to develop several menus for the program. Each menu was specifically created to meet the required 600 calories or more per serving, and emphasis was placed on utilizing locally available free food. Some of the mothers involved said that their children were not used to eating several kinds of food included in the menus. However, a dry run yielded positive results, hence proving that the mothers' apprehensions were merely misconceptions.

Following the making of menus, the team then conducted weighing sessions for children 6-18 months old. After assessing the results of these sessions, and following negotiations with the parents on their responsibilities (i.e. bringing food contribution, attendance for the Hearth sessions), 11 children who were diagnosed as either 1st or 2nd degree malnourished were selected to be "Hearth children".

Twelve Hearth nutrition sessions were spent preparing meals, feeding the children and planning the menus for the following day. The participant mothers in the program exhibited great diligence and dedication to the program. They were so enthusiastic that the 2-hour sessions would almost always extend up to four or five hours. It was also noted that the supervision of the local health workers gradually lessened as the mothers became more responsible and creative in handling menu planning, food preparation and feeding.

A comparison of the weights of eight of the participating children before and after the Hearth program showed that all the children gained weight a month after the start of the Hearth sessions. Two children who were initially diagnosed as 2nd degree malnourished were able to climb up to the 1st degree after the program.

During a focus group discussion that was conducted among 6 mothers and caregivers that participated in the program, it was reported that the children were now more active and playful. It was also observed that the children now ate more, and were willing to eat certain types of food and vegetables which they wouldn't before. The mothers and caregivers also added that their children were not as prone to skin diseases as before. The mothers had earlier stated that the

activity provided them with a new support system. One of the mothers, Emma, stated that “I’ve learned that food can be cheap or readily available from our neighborhood and doesn’t have to be bought”. The mothers added that they had become more aware of proper feeding practices such as washing the children’s hands before feeding and making sure the utensils were washed thoroughly. They said that they were also encouraged to make their own backyard gardens.

Conclusion and Recommendations

The evaluation team’s assessment is that the Hearth Nutrition Program offers great potential as a venue for combating malnutrition in the barangays. The program has yielded positive results, such as the weight gain experienced by the children, and the behavioral changes of the mothers. The activity’s success will depend on the willingness of the participants to continue with the program even after the conclusion of the Hearth sessions. In this project, there is a need to do a qualitative follow-up study to determine behavioral changes that occurred in the home after the completion of the 12 Hearth sessions. Future steps will include the expansion of the Hearth to other members of the community and to disseminate the benefits of the programs to the other project sites.

BASELINE INFORMATION FROM THE DIPs

A. Field Program Summary

PVO: Pearl S. Buck International Inc.

Country: Philippines

Program Duration: October 1999 to September 2003

1. Estimated Program Effort and USAID Funding by Intervention

INTERVENTION	% OF TOTAL EFFORT	AID FUNDS IN \$
Nutrition / Breastfeeding Promotion	40%	471,103
Maternal Care	30%	353,327
Child Spacing	30%	353,328
Total	100%	1,177,758

2. Program Site Population: Women and Children

Population Age Group	Number in Age Group*
Infants (0 - 11 months)	5,568
Children (12-23 months)	10,552
Children (24-59 months)	5,747
Total Children (0 - 59 months)	21,867
Women (15 - 49 years)	12,617

* The above data are estimates provided by health offices in the project area. Data from the Municipal Planning and Development Office show higher numbers of population in each category. The Partners for Health Child Survival Project (PHCSP) will work with both offices to reconcile and verify population statistics.

Estimated number of live births per year:

- Ormoc City 3,849 (Source: City Health Office (CHO) Statistician, for 1999)
- Merida 503 (Source: Rural Health Unit (RHU) Merida Average within 5 years from 1992-1997)

Source of population estimates:

- Ormoc CHO Report, 1998
- Merida RHU Report, 1997

B. Program Goal and Objectives

B.1 Goal

To improve the health and nutritional status of children and women through the strengthened capacity of families, communities, local government units and non-governmental organizations to manage community health programs.

The goal of the Partners for Health Child Survival Project (PHCSP) is to improve the health and nutritional status of children and women through the strengthened capacity of families, communities, LGUs, and NGOs to manage community health programs. The project addresses a substantial health problem in the area, and will greatly reduce infant and <5 mortality and improve maternal health. Pearl S. Buck International (PSBI) will play a very important role in meeting the goals and objectives of the project partnership as the provider of technical assistance in state-of- art strategies and technologies in child survival programming and will serve as link and bridge the gap between the community and health services. Being experienced in community organizing and with established close relationships with the community and other major partners, PSBI also offers opportunities for innovations and strategies to bring health into the hands of the people under the devolved set up. With its strategic partnering with existing health providers and building capacity for on-going support mechanisms, it is contributing its resources for full capacity building and institutional development of partners in the project, to improve their management, systems and human resource capacities. Additionally, its good relationship with the DOH and its support to the DOH policies, strategically sets PSBI as a PVO that can make a difference in the health of children and women. Lastly, PSBI's Mission and program goals are strongly consistent with the Philippine USAID Mission's strategic objectives in child and maternal health.

B.2. Objectives

B.2.1 Nutrition and Breastfeeding

The Nutrition and Breastfeeding intervention was strongly recommended by the workshop participants. The group argued that malnutrition makes the infants more vulnerable to illnesses and infections. Baseline source for this intervention were the results of the participatory rapid appraisal and the KPC surveys of 1998, and NDHS of 1998. The result of the KPC survey in so far as it relates to objectives was only limited to the knowledge level of mothers as to sources of vitamin S and iron rich foods and not as to whether the daily food intake of their children includes foods rich in Vitamin A and iron. So in the first year, the establishment of the baseline will form as an initial activity of the nutrition intervention. It is only after the partnership is able to determine this that benchmark will be decided a meeting of the technical working group and advisory board.

It must be noted that the objectives on decrease on malnutrition rate was dropped and instead replaced with objectives on appropriate complementary feeding, continued breastfeeding and use of Vit. A and iron rich foods by mothers in the food preparation for children. The partners realized that decrease malnutrition rate is difficult to measure when the use of weight for age standard is questionable. Hence, objectives that would respond and hopefully bring about improved nutrition of children were identified.

Monitoring and evaluation will be done through monthly FHSIS report of the RHM, monthly weighing of children <5 yrs. Old and accomplishing the growth monitoring chart by the BNSs and BHWs and FGDs facilitated by the CHDOs.

PHCSP will focus its nutrition and breastfeeding intervention on the following objectives:

1. Increase from 50% to 70% the percentage of children <24 mos. who were exclusively breastfed until 6 mos. old
2. Decrease from 31% to 10% the percentage of mothers initiating solid foods to children <6 mos. old
3. Increase from 46% to 70% the percentage of children who are continuously breastfed
4. Increase from 22% to 70% the percentage of children >6 months up to 24 months provided with appropriate complementary feeding (Baseline established by KPC 2000 Survey)
5. Increase from 84.9% to 90% the percentage of mothers with children <5 years old who use at least 2 vitamin A / iron rich foods appropriate in their daily food preparation (Baseline established by KPC 2000 Survey)
6. Increase from 0 – 48 the number of barangays with established and functional weighing posts

Objectives	Indicator	Measurement Method	Major Planned Activities
<p>1. Increase from 50% to 70% the percentage of children <24 months who were exclusively breastfed (EBF) until 6 mos. old (Data based on KPC)</p> <p>Year 1- 55%</p> <p>Year 2- 60%</p> <p>Year 3- 65%</p>	<p>Percentage of children <24 months who were exclusively breastfed until 6 mos.</p>	<p>Monthly recording in and review of Growth Monitoring Chart (GMC)</p> <p>Monthly/Quarterly Field Health Service Information System (FHSIS) reported by the Rural Health Midwife (RHM)</p> <p>KPC at the end of the project</p>	<p>Updating of master list (newly delivered mothers, newborn and children <24 mos.) by TBA/BHW/BNSs</p> <p>Organizing and training of Mother Support Group (MSG) on exclusive breastfeeding</p> <p>Train TBAs on how to conduct breastfeeding counselling sessions</p> <p>Trained TBAs conducts breastfeeding counselling during pre/post natal visits</p> <p>TBAs assist mothers to initiate breastfeeding within 24 hours post delivery</p> <p>BHW/BNSs and MSG visit and counsel lactating mothers on exclusive breastfeeding</p> <ul style="list-style-type: none"> - end of week one - end of first month post delivery - Monthly for 6 mos. <p>Barangay Health Committee (BHC) implement information, education, communication plan i.e. healthy baby contest once a year</p>

Year 4-70%			<p>BHC distributes health calendars with exclusive</p> <p>Youth theatre and puppetry groups conduct popular education activities to promote exclusive breastfeeding</p> <p>BHC make existing Health Stations baby and mother friendly according to the Milk Code</p> <p>CHDOs conduct FGDs to determine quality of exclusive breastfeeding counselling done by the TBA/BHW/BNSs and MSG</p> <p>Develop and use checklist on determining quality counselling sessions at the weighing posts.</p> <p>Train RHM/BHW/BNSs and MSG exclusive on breastfeeding</p> <p>BHC/RHM/CHDO meet to address issues on EBF, knowledge and skills upgrading of MSG and review accomplishments towards achieving objectives and strategic actions</p> <p>BHC publicly acknowledge breastfeeding mothers during community activities</p>
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Objectives	Indicator	Measurement Method	Major Planned Activities
<p>2. Decrease from 31% to 10% the percentage of mothers initiating solid foods to children <6 months</p> <p>(KPC Data)</p> <p>Year 1-25%</p> <p>Year 2-20%</p>	<p>Percentage of mothers initiating solid foods to children at age after 6 months</p>	<p>Monthly recording in and review of Growth Monitoring Chart (GMC) by BHW/BNSs</p> <p>KPC at the end of the project</p>	<p>MSG/BHW/BNSs train on initiating solid foods</p> <p>MSG/BHW/BNS counsel mothers/caregivers on solid food initiation</p> <p>BHW/BNSs and CHDOs facilitate sharing sessions with mothers on initiating food to infant</p> <p>MSG/BHW/BNS conducts cooking demonstration on solid food preparation</p> <p>BHC distributes calendar w/ solid food initiation messages</p>

Year 3-15%			CHDO conducts FGD to determine factors contributing to early solid food initiation to improve intervention
Year 4 -10%			<p>Train BHWs & TBAs on maternal care, interpersonal and behavioral change communication, counseling and referral</p> <p>Provide TBA kit and conduct monitoring/coaching sessions with them.</p> <p>Conduct LQAS to assess skills after the training once in 6 months</p> <p>Students conduct FGD and Key Informant interview on the quality of care provided by health workers twice a year</p>

Objectives	Indicator	Measurement Method	Major Planned Activities
<p>3. Increase from 46% to 70% the percentage of children who are continuously breastfed up to 24 months</p> <p>yr 1 – 55%</p> <p>yr 2 – 60%</p> <p>yr 3 – 65%</p> <p>yr 4 – 70%</p>	Percentage of children who are continuously breastfed up to 24 months	<p>Masterlisting by BHW/BNS</p> <p>GMC recording</p> <p>FHSIS collected by RHM</p>	<i>Unclear in DIPs</i>

Objectives	Indicator	Measurement Method	Major Planned Activities
4. Increase from 22% to 60% children 6 months to 24 months who are provided with appropriate	Percentage of children 6- 24 months provided with appropriate comple-	<p>Masterlisting by BHW/BNS</p> <p>GMC recording</p> <p>FHSIS collected by RHM</p>	<i>Unclear in DIPs</i>

complementary feeding	mentary feeding		
yr 2 – 30%			
yr 4 – 60%			

Objectives	Indicator	Measurement Method	Major Planned Activities
5. Increase from 85% to 95% the percentage of women with children <5 years old who use at least 2 vitamin A/Iron rich food appropriate in their food preparation	Percentage of mothers with children <5 years old who use at least 2 vitamin A/Iron rich food in their food preparation	Baseline Survey by HIS Quarterly Food Intake Survey by HIS Coordinator and partners Hearth Nutrition Model Project Report KPC at the end of the project	HIS Coordinator conducts survey to establish baseline for year 1 HIS Coordinator conducts Quality Food Intake Survey quarterly MSG/BHW/BNSs train on vitamin A/iron rich food source MSG/BHW/BNSs counsel mothers on indigenous food rich in vitamin A and iron and its proper preparation BHC pass ordinance on BIG/backyard gardening and launch BIG contest Conduct a one-day training on Bio-Intensive Gardening to fathers and youth BHC source of seeds from DA and Nutrition Center BHC implements the Hearth Nutrition Model in 2 barangays and later to the rest of the barangays with at least 30% moderate and severe malnutrition CHDOs/RHMs facilitate quarterly sharing sessions on the progress of the Hearth Model Partners for Health Advisory Board (PHAB) shares lessons on Hearth Nutrition Model with other barangays
Year 1 - 85%	Percentage of children		
Year 2 - 90%	who meet the weight for age standards		
Year 3 - 95%	of the DOH		
Objectives	Indicator	Measurement Method	Major Planned Activities
6. Increase	Number	Monthly	BHC conducts advocacy activity with the

<p>from 0 to 48 barangays with established and functional weighing posts</p> <p>Year 1 – 12</p> <p>2 – 24</p> <p>3 – 36</p> <p>4 - 48</p>	<p>of barangays with at least 1 WP</p> <p>Number of barangays conducting weekly/monthly weighing of children under 5 years old</p> <p>Number of barangays establishing additional WP by the end of year 1</p> <p>Number of Municipal /City resolution and barangay ordinance approved adapting WP as a nutrition strategy</p> <p>Percentage of children under 5 years old who meet the</p>	<p>barangay visit report by the CHDOs/RHMs</p> <p>Quarterly supervisory visit report by PHNs and Community Development Coordinator (CDC)</p> <p>Bi-annual Monitoring Field Visit Report of City Health Officer (CHO), Municipal Health Officer (MHO) and Project Director</p> <p>Annual Project Report</p> <p>Recording and review of GMC</p>	<p>support of CHDO to encourage LGUs to adapt weighing post as nutrition strategy</p> <p>Establishment of weighing post at purok level</p> <p>IEC and GMC provided at weighing posts</p> <p>BHC conduct quarterly assessment meeting of weighing post activities</p>
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	weight-for-age standard		
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B.2.2 Maternal Care

Maternal Care was selected as an intervention due to low coverage of ANC visits (48%) and TT 3 coverage (58%). Initially, these were the two major activities under this intervention. However, during the action planning workshop, the partners realized the merits of the DIP reviewers' comments and included quality delivery, post partum care and emergency obstetrical plan.

The baseline data used were the 1998 KPC survey and the 1997 FHSIS Report of the DOH. Currently, there is no baseline on the postpartum cases attended by TBAs. On the other hand, KPC data on deliveries attended by TBA reveal a 73% coverage but without the specifics of whether they are trained or not. Considering that training of TBAs is not any more done as frequent as it was prior to devolution of the DOH, the PHCSP decided to include the objectives on deliveries and post partum since cases attended by untrained TBAs exposes both the mothers and infants to a great risk. Corollary to this is the conduct of a baseline survey by the HIS Coordinator in Year 1.

Monitoring and evaluation will primarily use the HBMR and the FHSIS which will be generated monthly/quarterly by the BHWs, TBAs and RHMs and KPC at the end of the project.

The PHCSP will focus its maternal care intervention on the following:

1. Increase from 48% to 70% the percentage of pregnant women who have made at least three ANC visits (1 ANC per trimester)
2. Increase from 58% to 75% the percentage of women who have received TT2+
3. Increase from 91% to 95% the percentage of deliveries attended by trained TBAs
4. Increase from 57% to 75% percentage of women who received quality post partum care from trained TBAs (Baseline for establishment)
5. Increase from 0 to 48 the number of barangays with Emergency Obstetrical Plan

Objectives	Indicator	Measurement Method	Major Planned Activities
1. Increase from 48% to 70% the percentage of women who have made at least three ante-natal care (ANC)	Percentage of pregnant women with 3 ANC visit (1 visit per trimester)	Monthly review report of Home Based Maternal Records (HBMR) by RHM Monthly validation	Monthly updating of master list of pregnant women by BHW/TBAs Translation of HBMR in Cebuano and made available at BHS Training of TBAs/BHWs and RHM in providing maternal care services

<p>visit (KPC Data)</p> <p>Year 1 – 55%</p> <p>Year 2 – 60%</p> <p>Year 3 – 65%</p> <p>Year 4 – 70%</p>		<p>validation report of RHM's target client list</p> <p>Monthly/Quarterly FHSIS report by RHM and HIS Coordinator</p> <p>KPC at the end of the project</p>	<p>Conduct of formative research on the barriers and motivations for attending antenatal care</p> <p>BHWs and TBAs conduct case findings of pregnant women</p> <p>Health Scouts assist BHW/TBAs in case finding within their immediate neighborhood and submit list to BHW/TBAs</p> <p>TBAs provided with HBMR forms and trained on how to use it</p> <p>BHWs refer pregnant women to TBAs and RHM's for ANC</p> <p>Production of IECM kit for BHW/TBAs</p> <p>BHWs and TBAs conduct home visits and counsel on ANC and maternal care services using the IECM kit</p> <p>RHM conducts ANC and record in HBMR and BHS logbook</p> <p>TBAs trained on quality ANC</p> <p>Pregnant women provided and keep copy of HBMR and bring it for next ANC</p> <p>CHDOs validates 10% of pregnant women in the Masterlist and spot check HBMR recording for completeness</p> <p>Quarterly RHM supervisory meeting with TBAs</p> <p>Quarterly quality assurance conference on maternal care services</p> <p>Youth theatre and puppetry groups conduct quarter popular education presentation to promote importance of ANC</p>
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Objectives	Indicator	Measurement Method	Major Planned Activities
<p>2. Increase from 58% to 75% the percentage of pregnant women who have received at TT2+</p> <p>(1997 and 1998 records of City Health and Rural Health I\Units)</p> <p>Year 1 – 65%</p> <p>Year 2 – 65%</p> <p>Year 3 – 70%</p> <p>Year 4 – 75%</p>	<p>Percent-age of pregnant women who have receive TT2+</p>	<p>Monthly/Quarterly review of target client list</p> <p>Monthly/Quarterly FHSIS Report of RHM</p> <p>KPC at the end of the project</p>	<p>Improve distribution system of TT vaccines at barangay level through regular monitoring of stock, requisition for re-supply of TT and provision of vaccine carriers per barangay</p> <p>Conduct monthly case findings/master listing and referral of pregnant women by BHWs, Health Scouts and TBAs</p> <p>BHWs conduct IECM on TT vaccination and other maternal services</p> <p>RHM conducts TT immunization once a month at the health center/stations</p> <p>BHW/TBAs and Health Scouts report mothers who missed scheduled immunization to RHM and motivate them to avail of the service</p> <p>RHM conducts outreach TT immunization once a month for missed opportunities</p> <p>Recording of TT immunization given to pregnant women in HBMR and reflected in the FHSIS</p> <p>Quarterly quality assurance conference on maternal care services</p>

Objectives	Indicator	Measurement Method	Major Planned Activities
<p>3. Increase from 91% to 95% the percentage of deliveries attended by trained TBAs</p> <p>(Baseline for establishme</p>	<p>Number of trained TBAs on quality delivery management</p> <p>Percent-age of deliveries attended</p>	<p>Training and post training follow-up report of the Training Coordinator</p> <p>Monthly/Quarterly FHSIS Report of the RHM</p>	<p>HIS Coordinator conducts baseline survey on deliveries attended by trained TBAs</p> <p>Training of TBAs on quality delivery management and basic obstetrical kit provided</p> <p>Training on quality maternal care supervision by the Provincial Health Office</p> <p>TBAs and RHMs provide clinic-based or domiciliary obstetrical services and recorded</p>

nt)	by trained TBAs	Client satisfaction interview by CHDO and RHM once a month	domiciliary obstetrical services and recorded in the HBMR
Year 1 – 55%	Number of TBAs provided with basic obstetrical kit	Review of HBMR by RHM/HIS Coordinator	Quarterly TBA meeting and bi-annual performance assessment
Year 2 – 60%			Development of client satisfaction interview design by HIS Coordinator
Year 3 – 65%			Orientation of CHDO/RHM on client satisfaction interview tool
Year 4 – 70%			CHDO and Midwifery students conduct satisfaction interview to mothers

Objectives	Indicator	Measurement Method	Major Planned Activities
4. Increase from 57% to 75% the percentage of women who received quality post partum care from trained TBAs (Baseline for establishment)	Number of trained TBAs Percentage of women who received quality post partum care from trained TBAs	Training and post training follow-up report of the Training Coordinator Client satisfaction interview by CHDO/RHM every month Review of HBMR by RHM/HIS Coordinator	HIS Coordinator conduct baseline survey of post partum cases attended by trained TBAs Master listing of postpartum cases by BHWs and TBAs Training of TBAs in quality post partum care TBAs and other health personnel conducts post partum visit to mother and infant within 24 hours from delivery and thereafter weekly for a period of one month and recorded in the HBMR Development of client satisfaction interview design by HIS Coordinator
Year 1 – 60%		Monthly/Quarterly FHSIS report of RHM	Orientation of CHDO/RHM on client satisfaction interview tool
Year 2 – 65%			CHDO/RHM/BHW conduct home visit and client satisfaction interview to mothers re: child delivery management
Year 3 – 70%			
Year 4 – 75%			

Objectives	Indicator	Measurement Method	Major Planned Activities
5. Increase from 0 to 48 the number of barangays with Emergency Obstetrical Plan	Number of barangays with emergency obstetrical plan	Quarterly review of obstetrical emergency plan by the BHC	BHC develops Barangay Emergency Obstetrical Plan with assistance from CHDOs
Year 1 – 12	Number of emergency obstetrical cases assisted and referred to hospital/clinics on time	BHC report on emergency obstetrical cases attended to	BHC conducts quarterly review of emergency plan and report to community
Year 2 – 24			Planning session of BHC and Barangay Council re: OB emergencies
Year 3 – 36			Planning session of Association of Barangay Council Federation, Ormoc District Hospital, City Health Office and Rural Health Unit re: OB emergencies, access to radio communication network and ambulance
Year 4 – 48			

B.2.3. Child Spacing

Child Spacing was chosen as an intervention due to a big gap between need for FP and actual FP acceptors. This was revealed in the KPC survey wherein 89.1% of women stated that they either did not want to have children in the next two years. Of those who do not want to have a child in the next two years, 50.8% were not using any FP method. Baseline data used under this intervention aside from the KPC.

The monitoring and evaluation of the project will be done using the Contraceptives Distribution and Logistics Management Information System (CDLMIS) for logistic monitoring, target client listing, survey and FHSIS report.

PHCSP will focus its child spacing intervention on the following:

1. Increase from 25% to 50% the percentage of women using modern contraceptive methods
2. Increase for 0 to 48 the number of Barangay Health Stations providing quality family planning service

Objectives	Indicator	Measurement Method	Major Planned Activities
1. Increase from 25% to 50% the percentage of women using modern contracep-	Percentage of women using modern contraceptives (CPR)	Target Client List FP acceptors record and report of the RHM	Monthly updating of target client list by the RHM Training of RHM's on Basic and Comprehensive Family Planning following DOH protocol

<p>contraceptive method (KPC Data)</p> <p>Year 1 – 30%</p> <p>Year 2 – 35%</p> <p>Year 3 – 40%</p> <p>Year 4 – 50%</p>	<p>(CPR)</p> <p>Number of new acceptors</p>	<p>Client Satisfaction Survey conducted by Midwifery Students of UPSHS and HIS Coordinator</p> <p>Monthly CDLMIS Report of RHM</p> <p>Monthly supplies and assessment report of the RHM</p> <p>Formative Research Report on barriers of FP</p> <p>KPC at the end of the project</p> <p>Monthly/Quarterly FHSIS Report of RHMs</p> <p>Performance Improvement Review Report (developed by initiatives)</p>	<p>Provide RHM with IUD insertion kit</p> <p>RHM provide regular service on modern methods of FP at the Barangay Health Stations</p> <p>Quarterly coordination meeting of CHO/RHU and Ormoc District Hospital re: VSC service</p> <p>Ormoc District Hospital provides VSC service at least once a week</p> <p>Training of health personnel, BHWs and TBAs on interpersonal communication, problem management, referral system and FP counselling</p> <p>Conduct session on FP with fathers by BHWs/RHMs/CHDOs</p> <p>Conduct formative research on barriers of FP by HIS Coordinator</p> <p>Conduct FP workshop among health staff/NGO/BHC and health workers adapting the Integration Workshop on FP into existing programs</p> <p>TBAs and BHWs conduct FP sessions during home visits and group sessions</p> <p>BHWs visit new acceptors within three months interval and conduct counseling and problem solving session</p> <p>Orient TBAs on the benefit of child spacing and counsel mothers during pre and post natal contacts</p> <p>Conduct quality assurance conference among RHM/PHN</p>
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Objectives	Indicator	Measurement Method	Major Planned Activities
2. Increase from 0 to 48 the number of Barangay Health Stations providing quality FP services	Number of BHS with 3 months stock level of pills, condoms, DMPA	Monthly CDLMIS Report of the RHM	RHM provide FP services at the BHS that can't be provided by the dispensing stations i.e. Pelvic Examination and IUD insertion
Year 1 – 12	Number of BHS providing FP service at least once a week	FP records and reports of the RHM	Improve pills and condom supply availability at the health centers and weighing post/dispensing station
Year 2 – 24		Monthly Progress Report of Commercial Contraceptives Dispensing Stations	Pilot testing of the medical eligibility checklist protocol in 2 barangays and later expand application to the rest of the CSP areas
Year 3 – 36	Number of community-based/managed commercial contraceptive dispensing stations established	Minutes of monthly meeting of dispensing operators, CHDOs and RHM	Organizing and training of commercial dispensing station operators
Year 4 – 48	Number of BHWs extensively trained on oral contraceptive pill dispensing using the medical eligibility checklist	Annual Project Report	Pilot testing of community-based/managed commercial dispensing stations in 4 barangays and later implemented in other barangays
	Number of BHWs dispensing commercial contraceptives (pill/		Conduct quality assurance conference among midwives and nurses

	condom) using medical eligibility checklist Number of facilities meeting the minimum set of require- ments in providing FP services Percentage of clients expressing satisfaction with the referral services and health care provider		
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B.2.4. Institutional Development and Capacity Building

PHCSP had only conducted an initial assessment of the current capacities of partners. The matrix below will be finalized after the more in-depth assessment using state-of-art institutional assessment tools such as the Institutional Assessment Instrument (IAI). Nonetheless, the partners agreed to address the objectives below and indicated plans on how to address these objectives.

Objectives	Indicator	Measurement Method	Major Planned Activities
<p>1. Increase community participation in community health assessment, planning, implementation, monitoring and evaluation from 0 to 50% of the families in the barangay</p> <p>yr 1 – 2-% yr 2 – 30% yr 3 – 40% yr 4 – 50%</p>	<p>No. of community members who participated in community health assessment, planning, implementation, monitoring and evaluation</p>	<p>Attendance sheet during community assemblies</p> <p>Activity report</p> <p>Focus Group Discussion report</p> <p>Key Informant Interview report</p>	<p>Barangay Council and Community Health Workers trained on conducting creative and participant friendly health assessment and planning sessions like the Participatory Learning and Action methodology</p> <p>Barangay Council and health workers trained on motivational techniques, communication skills and facilitating meetings</p> <p>Barangay council members, BHWs/BNSs/TBAs and selected mothers, caregivers, fathers and leaders exposed to successful community – managed child survival projects in the country</p> <p>Barangays with excellent community participation submitted entry to the annual HAMIS/DOH contest on successful community health projects</p>

Objectives	Indicator	Measurement Method	Major Planned Activities
<p>2. Increase knowledge and skills of 168 barangay council members and 50 BHWs, 35 BNSs and 20 TBAs in community health assessment, designing community health programs, initially focusing on</p>	<p>Number of community health plans developed and passed the quality requirements</p> <p>Number of BHWs/BNSs/TBAs and barangay council members</p>	<p>Training and monitoring report three months after training</p> <p>Community health plans</p> <p>Minutes of meetings</p> <p>Follow-up sessions/coaching minutes/report</p> <p>FGD/ key informant interview</p>	<p>Partners trained on community health assessments and planning using PLA methodology, FGDs, review of barangay health workers and midwives' records</p> <p>Community health assessments and planning sessions conducted</p> <p>Communities coached and monitored during the community meetings and health plans preparation</p>

the three technical interventions	who participated in the development of the health plan	reports	
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Objectives	Indicator	Measurement Method	Major Planned Activities
3. Increase from the current level to 25% the health resources of 10 barangays Year 2 - 3 barangays 3 - 3 barangays 4 - 4 barangays	Percentage of funds at the municipal and barangay level allocated for health Funds raised from resource mobilization and advocacy efforts In-kind resources and services channelled to health activities	Municipal and barangay budget and expenditure for health Fund raising and resource mobilization reports for each activity/project Inventory of received in-kind resources, receipts/receiving reports of donations of supplies and equipment, deed of donations, acknowledgment reports.	Partners trained on alternative resource mobilization scheme (i.e., community health financing, peso for health, user fee and other cost recovery measures, cost sharing, partnering with business sector, landowners and civic groups) and advocacy for health and development of resource mobilization plan per barangay and municipality. Partners trained on proposal writing and negotiating skills. Partners participated in the Lakbay-Aral (educational trips) to successful resource mobilization projects in the country. Developed, with the barangays, recognition and incentive package for barangays who can meet benchmarks for resource mobilization.

Objectives	Indicator	Measurement Method	Major Planned Activities
4. Increase from 0 to 48 barangays with organized and functional health	Number of barangay health committee regularly conducting meeting	Minutes of Health Committee meetings Project Completion Reports	Key leaders/youth and community members mobilized for the organization of the health committees. Barangay health committees trained on primary health care, their roles and responsibilities, community health assessments, planning, advocacy and

<p>committees.</p> <p>Year 1 - 10 barangays 2 - 25 barangays 3 - 40 barangays 4 - 48 barangays</p>	<p>Number of health activities planned and implemented with success</p> <p>Number of community members participating in health activities</p> <p>Number of health-related barangay ordinances issued and enforced</p> <p>Number of representation made with the municipal councilor on health/ municipal/ city councils for health-related issues such as medicine supply and distribution, more budget for health, support</p>	<p>Attendance Sheet</p> <p>Barangay Ordinances</p> <p>Letters and excerpts of meetings with municipal/city councils</p>	<p>resource mobilization, monitoring and evaluation.</p> <p>Barangay health committees trained on negotiating skills, writing ordinances and resolutions, motivational techniques, communication, and facilitating meeting.</p>
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	for barangay health activities		
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Objectives	Indicator	Measurement Method	Major Planned Activities
5. Increase capacity of three NGO partners in managing high quality and sustainable child survival programs	<p>Number of NGO staff demonstrating knowledge and skills in designing and implementing the three interventions based on skills and knowledge checklist.</p> <p>No. of NGOs/ staff able to write proposal for health and according to donor standards and are submitted</p> <p>No. of NGOs/ staff able to financially and administratively manage</p>	<p>Knowledge and skills evaluation report for NGOs and staff</p> <p>Proposals submitted</p> <p>NGO program and financial report</p> <p>Institutional Assessment results on the 2nd and 4th years.</p>	<p>NGOs trained on the technical interventions, community health assessments and planning, and advocacy for resource mobilization, and implementation plan for their respective covered barangays prepared</p> <p>NGOs trained in proposal writing and negotiating skills</p> <p>NGO trained on fiscal and administrative management of child survival projects (financial and reporting requirements)</p> <p>Institutional assessment and capacity building plan completed</p>

	their child survival activities according to quality requirements/ standards		
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Objectives	Indicator	Measurement Method	Major Planned Activities
6. Increase technical skills of city and municipal health personnel and barangay health workers on three interventions in terms of quality of care, efficiency and effectiveness, conduct of behavioural change communication, records keeping, analysis and utilization, reaching out to missed opportunities.	<p>No. of respondents who replied that they are satisfied with the quality of care on the three interventions based on quality of care checklist.</p> <p>No. of BHWs/BNs/TBAs conducting quality behavioural change communication and using the materials properly based on quality checklist.</p> <p>No. of caregivers who are satisfied with the</p>	<p>Small survey on assessing quality of care of health workers six months after the training and on an annual basis if still needed.</p> <p>No. of supervisory visit report for BCC activities every quarter</p> <p>Follow-up sessions reports</p> <p>Report of actual observation using observation checklist</p> <p>FGD results</p> <p>Small survey on the effectiveness of IECM materials and activities</p> <p>Project quarterly</p>	<p>Partners trained on the three interventions and how to deliver efficient, effective and quality care services</p> <p>Partners provided with IECM materials and trained on how to use them</p> <p>Partners trained on community-based information system, with emphasis on its utilization</p> <p>Partners trained on monitoring progress and in identifying problem areas/red flags for problem solving</p> <p>Quarterly assessment and planning sessions with partners conducted</p> <p>Quarterly meeting of Project Advisory Board and Technical Working Group conducted.</p>

	<p>IECM activities and are motivated to attend more.</p> <p>No. of families who can express and explain the content of IECM materials given to them during IECM activities of health workers.</p> <p>No. of community based information system set in place and properly used for planning and decision-making and resource mobilization activities</p> <p>No. of LGU and health workers who are trained</p>	<p>monitoring and evaluation plan</p>	
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	<p>and consistently follow protocols for the three interventions</p> <p>No. of BHWs/BSNs and TBAS trained who remained in their post and follow protocol and guidelines</p>		
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C. Program Location

Demographics

The Partners for Health Child Survival Project (PHCSP) will be implemented in Ormoc City and in the municipality of Merida, Leyte. Both project areas are found in the province of Leyte, one of the three major islands of Region VIII, the Eastern Visayas region in the Philippines. Roman Catholicism is the dominant religion.

Ormoc City is found in the southwestern part of Leyte. It is a coastal city bounded on the north by the municipality of Jaro, on the east by the Municipality of Burauen, on the west by the municipality of Merida and on the south by Ormoc Bay. The municipality of Merida is an hour away by public utility vehicle from Ormoc.

Ormoc City’s land area is 459.72 square kilometre (sq. km.) and it has a population density of 495 persons/sq. km. There are 110 villages called barangays. Ninety-six are located in the upland areas and 14 are in the urban areas. The estimated total population is 227,686 (Ormoc City Planning & Development Office, 1997). The adult literacy rate is 88.81% (Statwatch National Survey Office (NSO), 1996). The dominant language is Cebuano. Some people in the area understand Tagalog, Waray-Waray and English; however, few people speak anything but Cebuano.

The municipality of Merida has a land area of 122.7 sq. km. and a population density of 201 persons/sq. km. There are 22 barangays located either on the coast or in the rural upland areas. Merida has an estimated total population of 24,678 (Merida Municipal Planning and Development Office (MPDO)). The dominant language is Cebuano.

Leyte’s rainy season extends from November to January. The driest months are from April to August. However, there is little distinction between rainy and dry seasons. The area produces

abaca hemp, copra, corn, rice, tobacco, banana and pineapple. The coastal shore abounds with various marine life while rattan and timber are grown in the mountains.

While Merida is a very typical rural municipality, Ormoc is fast becoming industrialized. There are four major industries in the city namely, Tongonan Geothermal Power Plant, Ormoc Sugar Company, AA Alcohol and Occidental Leyte Dairy Primary Multi-Purpose Cooperative. Three firms, Philippine National Oil Company, California Energy and Ormoc Philippines Inc., run the seven geothermal power generation plants which supply power to Luzon and Visayas islands. The strategic location of Ormoc City also serves to make it a jump off point for Cebu City, called the Manila of the South, the rest of the Visayas, and Mindanao.

The Target Population

The estimated potential participants in the program site include: 5,568 infants between 0-11 months; 10,552 12-23 months children; 5,747 24-59 months children; and 85,802 women of childbearing age. The total population reached by the project may increase with the increased capacity of existing health personnel, such as Rural Health Midwives (RHM). The extent to which increased coverage can be attained will become clear as the project is implemented. Approximately 41% of the total population in Ormoc and Merida are children under the age of five years.

The 48 barangays covered under the program are predominantly sugar and coconut plantations owned by a few old and rich families in the city and the municipality. The families in the barangay are either sugarcane plantation workers or tenants of coconut plantations. Most tenants pay at least 25% of their produce from each production cycle to the landowners. On the average, these families earn \$50 a month, which includes income from vegetable production and small animal raising. Sugarcane plantation workers are either daily wage earners (\$2.65/ day for adults and \$.50 /day for school age children) or a family who offers its services to the owner to do farm work on a per activity or contract basis. For example, one family will harvest 2 hectares of sugarcane in 5 days and get paid \$26. For the family to finish the contract ahead of time and get more contracts, women and school age children, or even those as young as five years old contribute to the labour pool. These families earn an average of \$40 a month including income from other sources such as vegetable production and small animal raising. Coconut and sugarcane are perennial crops and farming activities are done year round, with peak months for harvesting in June and January. Vegetable production peak months are July to September. During other months when demand for farm work is less, adult and adolescent men seek construction and other odd jobs in the town centres or other cities in Visayas and Luzon while adolescent women seek domestic work, locally or in the cities.

The Knowledge, Practice and Coverage (KPC) survey confirmed that 44.7% of women are engaged in income generating activities to augment family income. These women are engaged in making handicrafts (2.8%); harvesting (28.3%); selling agricultural products, preparing home made foods, buying and selling goods (24%); raising livestock (16.6%); and the rest are manicurists, domestic helpers, tailors and laundrywomen.

The KPC survey indicated that 83.5% of mothers could read and 16.6% could not. Specifically, 2.4% of mothers had no formal education and could not read, 14% reported that they had attended primary school and can not read, 53% have completed primary school and can read and 30% reported that they either had a secondary or higher level of education. The National Demographic Health Survey (NDHS) data however, presented a higher level for the whole country. 72.2% of women interviewed had attended secondary education or higher.

The KPC survey further indicated that 24% of mothers reported they were generally away from home during the day while the remaining 76.5% said otherwise. 98% of the mothers interviewed responded when asked “Who takes care of the children when you are out?”. Almost nineteen percent (18.8%) reported that older children take care of the child, 24.3% left their children with relatives, 27.7% took the child when they left home, and 28.4% left the children with the husband. Others left the child with the neighbours (2%) and took the child to the nursery (1%). Participatory Rural Appraisal (PRA) results validated the above KPC findings.

D. Program Design

The Partners for Health Child Survival Project (PHCSP) is designed in such a way that it will be able to respond to three major groups of actors: the family, community, and formal institutions, including PSBI. The PHCSP aims to improve the health and nutrition of women and children by building and strengthening the capacities of these groups. The progress within these tiers will result in a more effective and sustainable health program.

The PHCSP Management Team and Partners

The PSBI Country Director is the overall team leader of the Program. She will be supported by the PHCSP field team composed of a Project Director, three Coordinators, four Community Health Development Officers, a Finance and Administrative Assistant, and a General Support Staff person. Also lending support are the personnel of the PSBI Visayas Branch and Country Office. In addition, technical back-stopping will be provided by the Home Office through the Assistant Program Director.

At the field level, the Project Director (PD) will have overall responsibility for program management. The PD will be responsible for facilitating resources and services that will make the Local Governmental Rural Health Units, the City Health Office and NGO partners efficient and effective in health service delivery.

To set the direction and supervise the partnership among the major implementing partners, a Project Advisory Board (PAB) was organized. It is composed of the Health Officers of Ormoc (Dr. Rogelio Marson) and Merida (Dr. Jane Solana); Dr. Gemeliano Retulla, the Provincial Health Officer; Dr. Lilia Arteché, the Regional Health Officer, and the following members, Timotheo Lagahit (Barangay Captain), Arele Lubaon (BHW Federation President of Merida), Remedios Caraca (BHW Federation President of Ormoc) Noel Pesquera of ACTION and Delia Corbo of the City Planning and Development Office of Ormoc. The roles of the Advisory Board which were identified by consensus during the first organizational meeting are: 1) to set the overall operational direction, policies and guidelines in the planning, implementation, monitoring and evaluation of the PHCSP; 2) to generate support and commitments for the PHCSP within the sphere of work influence; 3) to set qualification standards for project staff hiring and the award of consultancy contracts; 4) to keep the agencies/groups represented in the partnership informed and updated on the PHCSP and their roles in the project; 5) to review the annual work plan and participate in the annual assessment and evaluation of the PHCSP; 6) to undertake field /monitoring visits; 7) to hold regular meetings every quarter (3rd Friday of the first month of the quarter in the morning); and 8) to represent the PHCSP in meetings, training programs or workshops called by other organizations or PSBI relevant to PHCSP, in the Philippines or abroad.

To provide technical backstopping to the project at the partnership level, a technical working group (TWG) was organized. The members (14) are program coordinators of the different Child Survival (CS) programs of the DOH and health personnel at the LGU level (nutritionist, RHM, PHN). Their roles are: 1) to review the technical soundness of the CS interventions according to

DOH protocols and other international standards (WHO, UNICEF); 2) to provide technical support in the implementation of the CS interventions; 3) to ensure integration/coordination of CS interventions in the regular health programs of DOH and LGUs; 4) to participate in the capacity building components, particularly those on the technical aspects of the project; 5) to recommend technical advice to the PAB; 6) to participate in the planning, implementation, monitoring and evaluation of the project; 7) to participate in the screening and review of the technical consultancy agreements; 8) to attend and or facilitate TWG meetings; and 9) to represent PHCSP in the technical training, meetings and workshops

Family

The BHW/BNS/TBAs will be the primary link between the professional health care providers and the families. They will be tasked with ensuring that health information and messages are delivered to the families through the conduct of household teachings sessions during home and neighbourhood visits. During this encounter they will also try to identify household members who are potential family health care givers. During the training, priority will be given to those families with existing health deficits and threats such as malnutrition, young age of parents, pregnant and lactating household members as well as large family size.

The curriculum for the family health care giver will be the development of skills in simple household remedies such as management of sick children, first aid, and identifying danger signs of pregnancy.

Initially the midwives shall be tasked with training the first few batches of participants side-by-side with the BHW/BNS/TBAs. As the project progresses, this arrangement will then be reversed until such a point that the latter is confident and capable to assume the role of health educator.

The methodology of the family health care giver training will follow adult learning principles. It will utilize structured learning experiences, demonstration and return demonstration, visual aids and fewer lectures. It will also be done on-site in the house of a trainee. In order to make learning more conducive, the number of participants will be limited to approximately 5 to 7 trainees.

Community

The main strategy at the community level is the greater involvement of the different sectors and age groups. Community groups and leaders shall be mobilized to take an active role in the whole project cycle.

Children

The project would like to change the traditional notion that children are too young to be involved in community health activities. In order to reverse such a view and to create a situation where children can prove their value in community endeavours, the project will organize PHCSP Health Scouts. Initially, there will be at least five health scouts per purok or sitio, (a geographical subdivision of a barangay). Recruitment and training, however, shall continue as long as there are interested children to participate in this activity. The membership, though voluntary, shall also be guided by these additional criteria: physical and mental health, the capacity of the individual to read and write, the children of parents in their reproductive age, and individuals who are siblings of a malnourished child. In order to discern an individual's interest, a one day orientation as to their role and responsibilities in the project shall be conducted by the partnership, either by the midwife in the case of the RHU and CHO, or the community worker of a partner NGO. It is only after their orientation that the formal training will commence. The training will focus on the following three CSP interventions:

Nutrition

The emphasis here will be on identifying malnourished children, indigenous food sources of nutrition, importance of breastfeeding and related issues, and how to accomplish a growth chart.

Maternal Care

The topics for this intervention are the importance of ANC and the tetanus toxoid vaccines to children and mothers, what tetanus is and how to prevent its spread, where can one avail of ANC services and receive TT injections.

Child Spacing

As family planning is a sensitive issue in the Philippines, the discussion will be limited to the relationship of a family size, two year spacing between children and relationship of early or late pregnancy to the health of children and mothers.

Teaching Methodology

The teaching methodology will utilize visual aids, structured learning experience, games and hands-on skill enhancement techniques. In addition, the training will be conducted for three consecutive weekends, either Saturday or Sunday, at two hours per session.

Role of Health Scouts

The main task of a Health Scout will be case finding, monitoring and referral. The area of coverage of Health Scouts will be limited within their household and neighbourhood. Specifically they are to identify, refer and report children whom they suspect as malnourished; assist their mothers and neighbours in accomplishing and interpreting the growth chart; monitor household members who are exclusively breastfeeding; remind their mothers and neighbours of the schedule for weighing; remind pregnant household members and neighbours of the ANC schedule; report to BHW/BNS/TBAs which household member/s and neighbours missed their ANC appointment; report to BHW/BNS/TBAs which household member/s and neighbours are about to deliver or had threatened abortion; and report accidents or injury encountered by pregnant women in their household and neighbourhood. The responsibility to supervise rests with the health volunteers (BHW/BNS/TBAs). The midwife or community worker assigned in their area will assist the Health Scouts. As supervisors, they are to assist the children in accomplishing the tasks assigned and anticipate problems to be encountered. The supervisors shall also make a weekly follow-up of the children and discuss the progress of their work.

The regular monthly meetings of Health Scouts will be scheduled to coincide with the preparation of the monthly project report. The meeting will occur in a health camp within the Barangay. It will simulate the camps of the Boy Scouts, complete with tents and bonfires. Barangay leaders, health volunteers, the Village Health Committee and representatives of PHCSP will be in attendance to facilitate the health camp affair. There will also be a cultural presentation that will showcase the artistic talents of the children.

The uniform that the children wear shall distinguish the class of a health scout. Immediately after completing the training a scout is awarded with a neckerchief and conferred the title of Health Scout. A scout can only be promoted to the next rank which is the Junior Health Scout (neckerchief and blue cap) or the highest rank which is the Senior Health Scout (neckerchief, blue cap and white T-shirt) only after a one year cumulative mark of "pass" in the performance evaluation.

The Barangay Health Committee with the assistance of the midwife or community worker of the partner NGO shall conduct the performance evaluation on a bi-annual basis. The evaluation will be based on the regularity and accuracy in report submission, attendance in health camps, quantity and quality of referrals.

Apart from the health scouts, the child-to-child approach will also be carried out at the school. Teachers will be provided with a bigger flip chart version of the BHW health counselling kit. The concept of the child-to-child is that peers are good motivators for change. So while in school the children, grade four to six will be given lectures on good health care practices. The children are then expected to transfer this knowledge to the other children in school or their siblings at home. The teaching in school can either be organized formally through the guidance and assistance of the teacher or informally while they are playing (before school time or during class breaks). A partner NGO, Philippine National Red Cross, will implement this strategy in 10.

Adolescents

The Philippine law that created the Sangguniang Kabataan or SK (Youth Assembly) recognizes the vital role of the youth in nation building. It has also provided the Filipino youth, through their elected leaders, the opportunity to take an active part in local and national legislative bodies. It has given them the legal mandate to take the lead in sports and cultural development in their area or village. Currently, the youths' activities have been confined to the field of sports through the annual summer sports competition. However, during special occasions, such as fiestas, the youth are observed to provide the cultural talents that enliven the affair.

The youth organization (Samahang Kabataan, SK) will be mobilized to extend its activities to health rather than limiting themselves to organizing fiestas and recreational activities. In three catchment barangays, a community theater focused on health will be organized. The Cebu office of DKT International and the local Philippine Information Agency will train the youth in conducting street plays from script writing to production, using indigenous resources. The community theaters will perform from barangay to barangay, with the barangays providing the transportation and meals of the cast as their counterpart. If the youth group decides to expand to other social issues, they will be linked with the Children and Youth Foundation, an NGO providing assistance to youth groups, for further assistance in terms of youth development inputs and network with other youth groups in the country. It will also be linked with the National Youth Commission, a government agency that will provide additional assistance and project development inputs.

Considering these factors, the program will sponsor a training workshop on community theatre that will not only develop their cultural talents but will also bring this sector actively into the program as health advocates.

At the onset, Ormoc and Merida will have one Youth Theatre Group each to be composed of 15-20 members. Recruitment shall be opened both to in and out of school youth and shall be coordinated with the Municipal and City Sangguniang Kabataan.

The one week training will cover the different aspects of community theatre, such as stage production, script writing, production design, acting, stage management, costume development using available resources, directing and musical scoring as well as basics on the three CSP interventions. The workshop will be designed in such a way that at the end of the training the group will have at least three one-act play scripts on nutrition/breastfeeding, maternal care (ANC/TT) and child spacing. The nurses and midwife shall review the scripts to ensure the technical soundness of the health messages. The graduation ceremony of the two thespian groups

will be back-to-back stage presentations at the city and town centres of the Ormoc and Merida, after which they proceed with their health campaigns in PHCSP covered barangays of their respective town and city. These same theatre groups will form the core of trainers for succeeding batches of trainees.

A regular meeting will be convened every month to discuss their plans and come up with new scripts and stage materials for future presentations. Mid-way in the year another training will be conducted to upgrade their skills in other theatre form such as puppetry. The over-all supervision shall be the main responsibility of the Sangguniang Kabataan with the technical back-stopping provided by PHCSP and a partner NGO.

As a way of initiating the community to this type of activity, the DKT International Incorporated Kondom Kapers Team of Cebu will be performing in selected barangays of Ormoc City and Merida. This will be the same group that will train the youths of Ormoc and Merida in September, 1999.

As an incentive, a recognition night will be organized to choose the year's best performers, director, scriptwriter, production designer, stage manager and theatre group.

Fathers and Mothers

The roles of parents have been stereotyped and often, the man is the breadwinner and the woman is the housekeeper responsible for the care and health needs of the children. Because of this arrangement the father is often neglected and inadvertently missed by the health worker during health classes and other related activities. One example is the family planning classes where mothers are the usual target and participants.

In order to effect change in their behaviour, the program will institutionalise the fathers' forum or class. This will be convened every month at the purok level. Every session will have different topics for discussion revolving around the three interventions identified as well as health issues of interest to participants. (Refer to the sub-section on innovative strategies for greater detail).

We will also continue conducting the health education sessions with mothers on nutrition, (especially those who are pregnant and lactating), micronutrient supplementation, importance of prenatal care and tetanus toxoid.

BHW/BNS/TBAs

As cited earlier, these three health volunteers will be the link between the formal health sector of the locality and the families. Indeed, for them to provide quality service we need to continuously upgrade their knowledge and improve their skills. So we have planned a number of training sessions.

In the institutional assessments conducted, BHWs expressed the need for capacity building in motivation techniques and communication skills so mothers and caregivers will be receptive and availing of the services. These services improve social mobilization and advocacy for health resources, health problems identification, planning and implementation with full support of the barangay councils and the community members, record keeping and utilization of information for resource advocacy and planning with the barangay council, and technical skills and knowledge with quality of care in maternal care, child spacing/family planning and nutrition and breast-feeding services. The BHW/BNSs also need support on IECM materials use and need basic supplies such as blood pressure apparatus, thermometer and record-keeping supplies. The TBAs will be trained on the importance of TT immunizations and antenatal and post-partum

care, family planning, counseling mothers on the early initiation of breastfeeding and exclusive and sustaining breastfeeding up to 4-6 months.

The capacity building plan for BHWs, BNS and TBAs includes formal and informal venues for learning. A monitoring schedule and follow-up sessions with each category of participants and training will be used to monitor the progress of skills development and the knowledge and provision of quality of care at the barangay level. Each participant will be visited two weeks after the formal training and a checklist will be used for monitoring the application of learning and what difficulties were encountered in applying the learning. Appropriate IECM materials based on the communication plan developed will be distributed to the health workers with demonstration and follow up sessions on how to use them. The use of the IECM materials is also included in the monitoring checklist. Lakbay Aral (educational trips) to successful and innovative child survival strategies will be done. The plan includes an exchange visit with the World Vision ChaMPS child survival project in Sorsogon. Winners of the HAMIS best health and innovative health projects in Surigao on community health financing, social marketing of contraceptives, and weighing posts as nutrition centers are included. A checklist of what to know and ask for during the visits will serve as a guide for the participants to focus on during their visits and will make the activity productive and meaningful. A session on the last day of the visit will focus on what the participants learned and what plans are appropriate for their area.

The first training for volunteers is set for September, 1999. It will be a training on how to conduct one-on-one and small group health education and counselling sessions using the IECM kit developed during the entry grant phase. Incorporated also in this training is the module on IECM planning and development that will provide the volunteers with the knowledge and skills necessary to be able to develop a successful IECM program. Apart from this they will also be re-oriented on growth monitoring, micronutrient supplementation, family planning and maternal care. A separate training for TBAs on quality antenatal care, importance of tetanus toxoid and family planning counselling will also be conducted.

The Barangay Council and the Village Health Committee

The Barangay Council headed by a Barangay Captain is the body that takes care of the management and affairs of the barangay. The present set-up concentrates the authority and decision making in the council. Ideally, the council is the democratic representation of the community at large. It should articulate the community sentiments, and must work towards finding solutions to the problems confronting a village. Unfortunately, these skills are still lacking in the current crop of barangay leaders. The councilman assigned to chair the health committee is still unable to bring to the council important health issues since the committee membership is limited to only the officially elected members of the council. Unfortunately, health is viewed as a lesser priority program than roads, waiting sheds or basketball courts. Observable also is the lack of continuity in some programs due to changes in administration or council members almost every three years brought about by election. In addition, political manoeuvring hampers the activity of the council. Under the devolution, barangays are mandated to have health committees headed by the Health Councillor on health. PHCSP will work to make this committee organized and functional as this is the unit that is mandated to attend to health of needs of the community.

The BHC is composed of the health volunteers, purok leaders and grassroots organization representatives and the Health Councillors. The councilperson who chairs the Committee on Health in the Barangay Council is an automatic member of the BHC. This will provide him/her the forum where he/she can call opinion and determine the pulse of his/her community on

important health issues. It will be the BHCs which will ensure not only program continuity but also articulate the real health needs of the community

The institutional assessment session with the Association of Barangay Captains never mentioned health activities planned and implemented by the barangay, except for the regular tasks of RHMs and BHWs/BNS. They expressed the need for skills and knowledge in health, fiscal and operational management, community health problems assessment and planning for solutions involving the community. They also mentioned the need for getting their cooperation with health activities and advocacy for resource mobilization and sustainability of health initiatives. They also want to be aware of primary health care principles and their operations in their barangays. Their current understanding of health is limited to providing medicines, which are limited. Often, there is a delay because they must wait for supplies from the municipal unit. A death of a child due to preventable diseases and also maternal death is the least of their worries. In the series of convergence workshops conducted where all health players in the barangay were gathered, they assessed the health problems, identified solutions and discussed what each one can do to contribute to the solution of the problems. The barangay captains and councilors were not aware of the importance of primary and preventive health care. Most of them do not know what BHWs/BNS do. Hence, very little support is given to the health workers, and they are not included in the annual barangay planning and budgeting meeting. This explains why only minimal stipends for BHWs are allocated and also why there is nothing given for supplies and health. After the workshop, the barangay captains committed themselves to include the BHWs in the planning and budgeting meetings, and in the regular council meetings, especially if health will be discussed. They also committed themselves to updating BHWs on their tasks.

The barangay Health Councilor reported that almost all the barangays are not really performing their responsibility because they are not aware of their roles and they do not have the necessary knowledge and skills to act on these roles. The institutional development matrix shows how the project will enhance the technical and managerial skills of the Health Councilors (HCs) and the corresponding health committees that they will lead.

Through the CH, the formation and/or revitalization of barangay health committees will be done gradually, starting with barangays having the highest population, active BHWs, receptive communities and supportive health personnel. Barangays that are centrally located for possible replication in the neighboring barangays will also be targeted. At least ten health committees will be organized in the first year, with full training support, monitoring visits and follow-up sessions in all capacity building activities undertaken. In these barangays, the school, youth organization and children will be fully mobilized for IECM activities (community theater for youth and children). These include child to child approaches in school health education with the teachers as facilitators in elementary and in day care centers, and school grounds as one health model (food gardens, clean toilets, IECM activities, and nutrition activities).

Partners for Health Members

In coming up with this design, a series of coordination visits and meetings were carried out with the members of the PHCSP. Two DIP workshops were also conducted; the first one developed the initial DIP while the second one was for the purpose of amending the first DIP, based on the reviewers' comments. The partner members were also involved as interviewers or facilitators during the forum of the KPC surveys and the PRA, respectively. They also took part as respondents in the institutional assessment workshop.

In the development of the IECM materials and the review of FSHIS, the staff of the partnership (LGUs, RHO, PHO, CHO, RHU) as well as mothers and children were significantly involved in the series of Focus Group Discussions, Product Pre-Testing and on-site application of the IECM either as facilitator, organizer or respondents.

The results of the initial institutional assessment sessions with the key LGU health personnel demonstrated the need for: 1) strengthening municipal level LGUs' (health offices, municipal council and councilor on health, planning and development offices) capabilities to advocate for greater resources and decision making power for child and maternal health; 2) empowering the communities to understand their own health problems and plan for solutions; 3) improvement of the reporting and working relationships between LGUs, PHO and RHO; 4) institutionalizing quality care, efficiency and effectiveness in health care delivery; 5) regular refresher courses on the three interventions and transfer of these knowledge and appropriate skills to the barangay based health workers; and 6) improvement of the supply distribution system up to the barangay level. Other capacity building skill needs identified are operational management of health programs, supervision, motivation techniques and communication skills.

PHCSP, with Project Advisory Board, plans to build the technical and managerial skills of partners at the LGU level by:

1. Training the Program Coordinators, MHOs and RHMs, on the three interventions aimed at transferring appropriate technical skills to the BHWs, BNS and TBAs at the barangay level for behavioral change in the three intervention areas.
2. Training the midwives, municipal, city and barangay councils and specifically the barangay councilor on health in community organizing, advocacy and social mobilization skills for active community involvement in the planning, budgeting, and implementation of community health initiatives, more resource allocation as well as initiating innovations in implementing community health activities.
3. Training in fiscal and operational management of health programs, supervision, health financing schemes and partnering for Local Chief Executives, local health officers and public health nurses of Ormoc and Merida, the director and program coordinators from the PHO and RHO, planning and development officers, and municipal councilors on health.
4. Training in monitoring and evaluation for the MHOs, RHMs Program Coordinators of the PHO and RHO in gathering data and analyzing them for planning and decision making.
5. Training in quality care, efficiency and effectiveness of delivering maternal care, family planning services and nutrition and breast-feeding activities.
6. Training in motivation techniques and communication skills for MHOs and RHMs.

At the end of each training program, participants will develop an action plan that they will follow when they go back to their respective work areas. The PHCSP, through the Project Advisory Board, will also base their monitoring and follow up sessions on the action plan and the results thereof to be conducted, at least 3 months but not to exceed six months after the training. Specific indicators on what to look at after the training to monitor progress towards results are reflected in the institutional and capacity building objectives matrix. A training monitoring checklist for each type of training will be used for assessing the improvements of the skills and knowledge of the participants and application of acquired knowledge and skills to one's tasks.

Rationale for the Choice of Interventions

In the DIP workshop, which was attended by all the partner institutions, the choice of the CS interventions was exhaustively considered. It started with the review of the KPC results and the latest health statistics of Ormoc and Merida. The group had, at first six interventions chosen: Tetanus Toxoid immunizations, Antenatal Care, Nutrition, Family Planning, Acute Respiratory Infection treatment and Oral Rehydration Therapy. However, after considering the opinions raised in the discussion, the group finally arrived at a consensus to have only three main interventions with two incorporating additional related activities. First on the list is Nutrition and Breastfeeding. The group supporting this intervention claimed that the likelihood of getting ill is very high among the undernourished. They also claim that this is one area where service is weak and is limited to weighing, providing micro-nutrient supplements, and token health education campaigns. Statistics also show that among those introduced to breastfeeding only 50% continue to be exclusively breastfed up to 4 months. There is also a very high incidence of malnutrition among children under five with some barangays in Ormoc reaching a rate as high as 80%. Among those with growth monitoring charts, only 14% had written records of vitamin A. intake. The other two interventions are Antenatal Care/TT immunization and Child Spacing. The basis for the selection of Antenatal Care was the very low turnout of pregnant women (8%) during ANC days, high TBA assisted deliveries (73%), and low awareness of TT immunization importance (43%) as only 68% of the 8% who had ANC have TT immunizations in HBM cards. The selection of Child Spacing was prompted by the high desire of women not to get pregnant in the next two years (89%) and the low percentage of FP acceptors using the modern method (only 50% of the 49% practising contraception).

Innovations

Aside from the Health Scouts and Youth Community Theatre Group mentioned earlier, the project is also introducing innovative methods and activities in health and nutrition. The Hearth Nutrition Model, Purok Data Boards, a Quality Assurance Conference, state-of-art IECM activities and materials, Weighing Posts, Health Care Financing, and Institutional Assessment and Development programs are some of these innovations.

Hearth Nutrition Model

In the past, nutrition rehabilitation programs were implemented through the traditional supplementary feeding approach. This type of program is conducted by giving mothers a supply of milk, beans or other food commodities to be cooked at home and given to the children. A feeding centre approach was also used whereby, instead of giving out raw food, it is cooked at the feeding centre by the health worker and fed to malnourished children. The food commodities in both approaches are provided either by the Department of Health or the Department of Social Welfare and Development. This has been proven to be ineffective and not sustainable. It is for this reason that the program will be implementing the Hearth Nutrition Model. The concept will be introduced to nurses and midwives through a one-day orientation training by the first week of August 1999. This will be pilot tested first in two to three barangays. After the training, the trainees shall conduct preliminary activities such as assessment of the malnutrition prevalence in the area based on the results of the Operation Timbang (weighing of children). This shall be followed by the Positive Deviance Inquiry (PDI) aimed at identifying existing resources and solutions in the community. The PDI will also be able to identify poor families who have well-nourished children and to determine successful feeding, caring and health seeking practices which enable them to "out perform" others in their community. After completing these preliminary activities, the villagers and the staff will start preparing their own Hearth Nutrition Program, which will have two major focused activities at the neighbourhood and community level. At the neighbourhood level, there will be the monthly 12-day nutri-education and

rehabilitation session of all caretakers of identified children, and the food preparation and feeding by the health volunteers using the contribution of positive deviant foods. Meanwhile, at the community level, all children are continuously monitored using the GMC and the Village Health Committees meet on a monthly basis to review the program and develop solutions to any problems identified.

Purok Data Board

This component will focus more on the empowerment of the barangays to generate data, utilize and feedback the information to the community residents for community action and support from the LGUs. A community based information system that flows back and forth to the municipal/city level and has a strong loop between the two levels will be set up in each barangay. PHCSP will make use of the existing community health data board systems by the Philippine Government, which makes health information accessible and useful to the communities, and strengthens its utilization.

The data board is a community-based and community-managed health information system. It is an improved version of a spot map that clearly identifies the approximate location of the houses in the area. Each household is represented by a house where the different health indicators are shown and monitored. Colour-coding is employed to show the status of the household (green for good, yellow for fair and red for danger). However, for this project we will facilitate the setting up at the purok level where the leaders can easily monitor it, unlike the current ones where there is only one board for the whole barangay, usually installed near the hall or health centres. This Data Board will not only be there as a display, but will also be a reference during meetings of the purok or the barangay health committees.

Quality Assurance Conference

On a quarterly basis the PHCSP members will meet to re-assess the quality of service and project output. The conference will have three main agenda: data analysis generated by HIS, a case study on a specific intervention and updates on current trends in child survival. Prior to the conference, three member institutions will be assigned to act as presenters and discussion leaders. The tasks will be rotated among the members. Whenever feasible, resource persons from the Department of Health and other agencies will be invited as external critics of the conference.

IECM

The development of the IECM materials underwent several FGDs and pre-testing before development of the final version of the health messages for year one. There will be two types of IECM materials: the calendar and the BHW counselling kit. Both materials developed are in the local dialect. The calendar, which is to be distributed at every household, will contain pictures of community members of the PHCSP areas as models and health messages. This will be complemented by the BHW health counselling kit that was designed so that the health information given to mothers reinforces the monthly theme. The kit will be the teaching aide of the BHW in her one-to-one and small group health education class. Each year the theme changes, with year one focusing on infants and children, year two on mothers, year three on the family and year four on a healthy community.

Each year prior to the production of the calendar, a contest will be launched to select the twelve healthiest community members or community leaders. So to prepare for year one, 1999 will be considered as year zero. This will be the time to launch the healthy baby contest and the 12 lucky babies chosen will appear as the calendar babies for year 2000. The same procedure will follow during the succeeding project years.

Weighing Post

In order to increase coverage in nutrition, we are establishing a weighing post at the purok level. This will, however, not solely be devoted to weighing of children. At the start it will be the centre of nutrition activities such as the venue of the nutrition, education and rehabilitation activities. Eventually it will evolve into a CSP centre and will provide other services such as commercial dispensing of contraceptives.

Health Care Financing / Commercial Contraceptive Dispensing Station

Another innovative approach to increase service coverage is the pilot testing of a commercial dispensing station in two barangays that will be managed by the BHW Federation. A specially trained BHW will supervise the daily operation of the dispensing station. Coordination with DKT International is already on going since they are being considered as the probable trainer and supplier of family planning commodities.

Mother Support Group

In the promotion of breastfeeding, we will introduce the mothers' support group approach where peers, and in particular, other breastfeeding mothers will be organized to convince women to breastfeed babies. The Arugaan Foundation, the pioneer in this approach, has been tapped and has agreed in principle to provide the technical backup for this activity. Arugaan foundation has a long-standing track record in breastfeeding promotion and mothers' support groups. It also has linked with international breastfeeding support groups like the La Leche League and World Association of Breastfeeding. They will at first conduct a training among selected mothers on interpersonal communication, peer education and counselling as well as early childhood development. This will be initially pilot tested in two barangays and will later be replicated in other areas. During the replication phase the first batch of women trained will be the trainers. However, these women will still receive supervision and technical assistance that will be provided by the Foundation.

Integrated Management of Child Illnesses

The pilot stage of the IMCI has just been finished and the Department of Health is in the process of consolidating its pilot activity. Currently, it is assessing and planning how it will expand. We are continuously coordinating at the national and regional level of the Department. We project that if things will turn out well with the planning at the national level, we will be able to implement it in the project site in year two. Initial coordination has been done, and the national DOH and the region has welcomed the prospect of having PHCSP, through the project, extend IMCI in the region and the project areas.

Institutional Assessment and Development

A training workshop on institutional assessment was conducted last May. All partners were taught how to use the different instruments that they can use to determine gaps and capacity of their institutions. The focus in the first workshop was on human resource and service delivery capacities. We will continue to use these instruments to help the partnership ascertain the progress of the members and to determine and plan for needs in the areas of the organizations' governance, strategic management and management development, operating systems and procedures, resource mobilization and financial management.

Supplies Distribution

A major recurring issue is the problem of supplies distribution. This has been caused by the delayed deliveries either from the Provincial Health Office to the Rural/City Health Office or

from the RHU/CHO to the Barangay Health Stations. The commodities which are at times lacking are the contraceptives and vaccines. In order to remedy this problem, we are instituting the use of forecasting procedures (outlined in the Handbook Integrating Family Planning) into NGO Programs, to which one of our staff has been exposed in the workshop in Bangladesh. PHCSP will work within the CLDMIS policy and find ways to improve the distribution, even at the level of the barangay. A thorough assessment of the gaps and problems in the distribution system has not been done; PHCSP will conduct consultant with partners, (an expert if necessary) to finalize on improving the supply distribution system.

E. Partnership

PHCSP strategically chose the partners listed below as these groups are core essentials and determinants in bridging the gap between the community and the health services under the devolved set up. Building and strengthening their capacities through participatory methodologies and learning-by-doing strategies in all aspects of the project already sets in the place some sustainability mechanisms. Introducing innovative approaches and state-of-the-art child survival strategies and tools further lends support to the capacity building objective of the project.

The partnership that has started to be forged and will continue to determine the outcome of the project involves three major players and several supporting players. The three major players are: 1) 48 barangay councils, their health committees and community members; 2) two local government units and the local health offices of Ormoc and Merida, which have direct jurisdiction over these 48 barangays; and 3) PSBI Inc. The supporting players are: 1) Provincial and Regional Offices of the Department of Health; 2) three non-governmental partners: the Rural Development Institute (RDI), the Action for Development Foundation (ACTION) and the Philippine National Red Cross Ormoc Chapter (PNRC); and 3) the Academe-University of the Philippines School of Health Sciences and Leyte Western College of Ormoc.

Additionally, there are other indirect players in the project. The Catholic Church exerts a major influence on the outcome of child spacing/family planning interventions. The sugarcane plantation owners, on whose plantations most families reside and depend for a living, may support the people's initiatives on health. The existing geothermal plants and private companies open potential for community collaboration on health. PHCSP will maintain a cooperative partnership with them and involve them in areas of common interest. The possibility of a Regional Health Committee with all of these groups represented is being considered by the partners as the partnership with these players is seen to promote organizational credibility and influence.

The health infra-structure at the barangay, the municipality and the city levels are the permanent players in community health. The focal point, then, of the partnership is to build a permanent health structure at the barangay and municipal/city levels and among the community members themselves. However, it will also build the capacity of the support players in providing more effective and efficient management, and technical and logistics support to the permanent players.

The Local Health Offices of Ormoc and Merida

The LGUs of Ormoc and Merida, through their respective health offices and via the national DOH, provides TT vaccine, Vitamin A. and iron supplements, contraceptives, prenatal forms and basic health station supplies. Except for vaccines and contraceptives, the other supplies are always inadequate and LGUs barely provide additional resources of these supplies. The distribution system is also very poor even if the supplies are adequate as in the case of vaccines and

contraceptives. The Rural Health Midwives, who are the front line health workers and are in constant contact with the Barangay Health Workers and the community, conduct visits once or twice per month to the covered barangays and do the following: 1)conduct maternal care services such as ante-natal and post natal check ups, TT immunizations, Vitamin A. and iron supplementation, 2) conduct family planning services and counseling, 3) conduct the annual Operation Timbang with BHWs and BNSs, 4)implement the nationwide campaign on immunization and micronutrient supplementation, 5) refer unmanageable cases to secondary and tertiary health facilities and 6) prepare accomplishment reports and supply requisitions. The Barangay Health stations located in catchment areas of 2-5 barangays are the central primary health care services. The Municipal Health Officer visits one barangay per quarter and the Public Health Nurses visit the barangays once a month, for supervisory and technical support.

The LGUs source of funds is their share of the Internal Revenue Allotment they get from the National Government based on the income generated by each LGU. The funds may be increased by the national government based on the population and land size of the LGU. For 1999, the Ormoc City Health budget is \$668,782 with 79% going to personnel and operating expenses, leaving only 21% for direct program services. Ormoc has a total of 47 personnel directly working on child survival activities. It has 85 BHSs out of the 110 barangays. Most of these BHS are in the city proper. Merida has a budget of \$84,021 for 1999 for direct health services, excluding personnel. Merida has 8 staff directly working for child survival activities, with 4 BHSs for 23 barangays.

To support the LGUs , the Provincial Health Office and the Regional Health Offices will be organized in teams with the following responsibilities: 1) to ensure adequate supply and timely delivery of vaccines and other supplies from their own offices; 2) to provide technical support, supervision and monitoring adherence to DOH protocols and the project's indicators; 3) to advocacy for health resources and make recommendations for policy review/changes based on the results of the project; 4) to improve of the FSHIS reporting and utilization; 5) to transfer new technical knowledge and skills to other health personnel; and 6) to share project results with other LGUs and advocate replication of successful and innovative strategies. PHCSP will also facilitate the delineation of roles and tasks of the different health personnel at the different levels.

The Communities

Barangay Health Workers

The two LGUs have a total of 284 BHWs, 108 BNSs and 44 TBAs. The BHWs are federated at the municipal level and receive organizational assistance from the BHW Coordinator of the municipality/city. The federation meets once a month for submission of accomplishment reports and updates/orientation from the health personnel. On the average, each barangay has 2 BHWs, at least one BNS and only 33% presence of TBAs among the barangays. However, the situation in the 48 target barangays is quite different. In most instances, there is only one BHW who is also the BNS. These BHWs cover an average of 100-400 households and assume all the health programs of the LGUs. The BHWs are the primary health personnel at the barangay level, and ideally should be the first point of contact for the families with health concerns. However, the BHWs role is limited to assisting RHM in their regular tasks. Hence, in the absence of the RHM (who comes only once or twice a month) health activities in the barangays are paralyzed. In some barangays, the BHWs do not even have the key to the center. In instances where the key is left with the BHWs, the basic health equipment (thermometer, BP apparatus, IECM materials) are with the RHM, not to mention the health records, while the cabinet for the medicines, ORS and contraceptives are locked. The limited role of BHW/BNS in delivering responsive, timely and quality health services in the community made them less credible in the past to the

community members and the barangay officials. Hence, the limited fiscal and management support they get from the officials, while community members prefer to go to the untrained TBAs for maternal care and neighbors for health counseling needs.

The Academe

University of the Philippines School of Health Sciences (UPSHS)

The UPSHS is a medical school established in 1976 to address the need for professional health workers who are willing to work in the rural areas. The community and municipality, through screening and set criteria, select someone from the barangay and recommend the person to the school for admission. The LGU subsidize some basic expenses for the student. Then the student attends a step-ladder curriculum starting with the Barangay Health Workers program (one quarter) with community service in his/her community of origin. During the community service, the barangay councils evaluate the performance of the student and if found satisfactory, they recommend that the student pursues the next step. The next step is the Community Health Worker program (five quarters). Then the student pursues a Bachelor of Science in Community Health (two quarters) followed by another period of community service. The last step is the Doctor of Medicine degree (twelve quarters) with alternating community service. After each step, the student is assessed for qualification to pursue the next level. After completing each of the steps, students are required to go back to their community of origin. They are required to render a minimum of one year for every year of schooling to provide community health services, after which they can go to other places. Through the project, the health worker hopes to be absorbed by the barangay/municipality as a paid health worker. The advantage of this is that the health worker is a resident of the barangay and would likely remain, especially if hired by the LGU, in the barangay. The barangay will then have health workers in their midst to whom they can go to for health services. On the other hand, productive hours lost to travel time are eliminated.

The PHCSP, through the LGUs, barangay councils and health committee will coordinate with UPSHS so that students from the PHCSP areas are selected and complete at least the Bachelor of Science in Community Health. Whether a student successfully completes his/her BS in Community Health or not, it is a significant achievement if the student qualified from the barangays completes the BHW program for one quarter. After completion of the course, the barangays and the LGUs commit to provide them with a stipend for a BHW and employment if the student has completed the BSCH course and to assign them to the barangays near where the students originated. By increasing the trained health manpower from the PHCSP areas, more quality services will be provided.

The UPSHS will also be tapped for training the partners in community health management, conducting small studies required by the project and FGDs, and sharing the project results and lessons to students. On an annual basis, PHCSP will expose the UPSHS students to critical activities of the project such as evaluation of quality of care of services of BHWs, the status of the supply distribution system, family services and the mothers support group on breast-feeding.

UPSHS technical skills will also be updated by their participation in the latest child survival assessment tools, monitoring and evaluation techniques, and the latest protocols and guidelines in child survival interventions such as IMCI via training here and abroad, as the opportunity arises. PHCSP will also support the upgrading of technical knowledge via the internet by providing them with a computer system for students to use for their school work. In order to determine whether the students are using the network effectively, a quarterly case study conference through their regular classes will be held.

Leyte Western College of Ormoc City

The school offers midwifery courses. For the students' practicum, it coordinates with the City Health Office through Ms. Nympha Adolfo, the Public Health Nurse, and one of the board members of the school. The practicum is usually hospital-based and offers no lessons on community health. PHCSP, through its partnership with Ms. Adolfo and the City Health Office, will assign the students to the 38 barangays in Ormoc. The students will provide a supportive role in community health activities such as: 1) assessment of the quality of care by the RHM/CVH according to a checklist; 2) follow-up visits to mothers without TT immunizations, and newly delivered mothers for postpartum care and FP counseling; 3) growth monitoring of children; 4) the conduct of FGDs, key informant interviews and KPC; and, 5) to monitor supply inventories of contraceptives at the barangay level. The students will also work with health committees in organizing the healthy baby and other health activities in the barangay. To prepare the students in community health, the project staff and other partners will conduct orientation sessions/workshops with the faculty and students so that everyone understands the objectives of the PHCSP, and efforts are focused on how to attain these objectives. For the school and its students, the PHCSP will offer its health resource centers for the latest in community health.

The Non-Governmental Organizations

There are three NGO partners affiliated with the project. ACTION for Development Foundation started as an NGO for agrarian programs in 1995. It is a local chapter of a national NGO on agrarian reform and rural development which started in 1985. It is funded by Christian Aid (\$131,578) and PARFUND, a government organization. ACTION has not yet committed any money for 1999. It has ten paid staff, eight of whom are directly involved in the program. It works with four People's Organizations (POs) and has 51 community volunteers. ACTION has extensive experience in community organizing and mobilization. In 1995, it included Community Health Development as a core program. It covers 21 upland communities, 3 of which are PHCSP areas. The Community Health Development Coordinator has been a regular participant in the training and workshops conducted by PHCSP. The assessment revealed that ACTION needs capacity building in community health management, advocacy for health resources, and working knowledge on the interventions and organizing of people's health committees. As an organization, assistance with financial management and funding sources, human resource management (under staffing and high staff turnover), strengthening in terms of planning and decision making, and expanding its partners and funding base are the concerns it has tentatively identified and which will be confirmed and planned for in the full Institutional Assessment. The capacity building plan focused on the management and implementation of the community health component of their organization.

PSBI will support ACTION in implementing the project in areas where they are operating now. Thus PSBI will assure that the NGOs' capacity can be built by letting them directly implement the project rather than simply training them and leaving them to implement the learning without logistical support and opportunity to apply the learning. In this manner, ACTION will also be fully responsible for the community health development implementation in three barangays with the supervision of PHCSP and according to the agreed plan. This way, ACTION will attain hands-on skills development in the three barangays and eventually replicate the experience in the other non-PHCSP covered areas of ACTION. Guiding ACTION to focus first on several interventions and really doing it well will make ACTION more confident in implementing community health and giving them more credibility among the players in the health sectors, thus increasing possibility of getting funding support to expand their health activities. The current core of POs and community volunteers of ACTION will also be tapped for health activities. In so

doing, the POs skills in planning and decision making will be enhanced. The previously formed POs will be trained in community health, problem identification and planning for resolutions through the Participatory Learning and Action method, a proven methodology of empowering communities to assess their own situation and to work toward improvement. Advocacy for health resources will also be part of the training. The community-based monitoring and action approach in the management of the health information system will be used as a feedback mechanism. In ACTION barangays, the organization of the youth community theater is planned with ACTION managing the activity and PHCSP is providing logistical and supervisory support. The partnership with ACTION is spelled out in the attached MOA.

Another partner NGO is the Rural Development Institute (RDI). RDI is an off-shoot of a national NGO focused on agrarian reform. The organization started as a separate entity in 1990 and is currently working in seven of the Partners for Health Project sites. It is funded by Christian Aid (\$9,052/year) and ICAO (\$7,894/year). RDI is a contractor for the implementation of the Women's Health and Safe Motherhood Project in selected areas of Leyte. These areas are all non-PHCSP areas. RDI has 10 staff and 6 community volunteers. The results of the institutional assessment revealed similar trends with that of ACTION. PSBI plans to build the technical and managerial capacity of RDI by involving them in the 7 barangays where they work as PHCSP project implementors. This will increase their health, managerial and administrative capacities. The attached agreement will guide the partnership. RDI understands the needs of the barangays because of their longstanding relationship with the community. RDI will first lead the implementation of the community health financing strategies and the advocacy for health resources. RDI communities have leaders that are already trained in advocacy and negotiation, hence they are the best choice for the health financing activities. RDI lessons in community health financing will be shared with other barangays who express the readiness to begin the activity.

The third NGO is the local chapter of the Philippine National Red Cross. It has seven full time staff and six volunteer doctors. It generates its funds from local sources and has an average of \$39,473 or 1.5 M. Pesos. PNRG is involved in regular first-aid training and disaster preparedness activities. They also conduct income-generating activities such as swimming lessons, bingo socials and special events. In the PHCSP, PNRG will be involved in five barangays and will implement three interventions. They will pilot the child to child approach to community health, in coordination with schools and day care centers in these barangays. Their active involvement in the PHCSP will usher in a new dimension of their work and expand their skills along child survival interventions. The attached agreement clearly spells out how the partnership will be managed.

While the three major players are central to the success of the project, the supporting players mentioned above and below will be the essential players in the project. PHCSP will also draw upon the resources of other international voluntary and support agencies for effective implementation of the project.

Management Sciences for Health, who is implementing the USAID funded LGU Performance Program in Ormoc City, is qualified for the Matching Grant portion of this project. If Ormoc applies and receives approval, more resources will be available for maternal and child health.

Helen Keller International has and will continue to assist PHCSP in the design, implementation and evaluation of effective micronutrient interventions and community-based monitoring systems.

DKT International will assist with the community theater and street play activities on family-planning and condom use.

Arugaan, Inc., a member of the World Association for Breast-feeding Action and La Leche League, will conduct a mothers support group organizing and mobilizing activities in five catchment areas covering around 20 barangays. It will train mothers in organizing breast-feeding support groups. They will conduct follow-up visits and sessions on a quarterly basis during the first year, and semi-annual after that up to the third year. It will also link the organized mothers' support group to other similar organizations in the country. Appropriate IECM media and materials for promoting breast-feeding are included in the plan.

The Department of Agriculture will assist in the areas of food production and bio-intensive gardening and will provide recognition activities for the nutrition intervention.

The Department of Social Welfare and Development will provide day-care based child to child nutrition education and care givers' health sessions while care givers are waiting for the day-care session to end.

The Philippine Information Agency will assist by providing community theater and puppet shows on health. The "Knock Out Polio" puppet show will be replicated focusing on the three interventions.

The Association of Sugar Planters will provide support for barangay initiated health activities such as recognition of health workers' performance, initiation of a healthy baby contest, and mother support group sessions.

The USAID Philippine Mission will provide monitoring, technical assistance, sharing of lessons and coordination of activities with other AID funded related programs affecting the project areas.

The National Department of Health Office will provide technical assistance and protocols, IECM resources, sharing of lessons for policy review, replication of successful innovations and reporting of project progress.

To set the operational direction and coordinate the partnership among the major players, a Partners for Health Advisory Board has been organized. To back-stop the project a Technical working Group was also organized. The roles and responsibilities of these groups are spelled out in the program design section.

F. Monitoring and Evaluation

PHCSP recognized that the current FHSIS is plagued with problems, in the advent of the devolution. These problems are: 1) unreliability and inconsistency of data; 2) delayed submission of reports, which is not very useful for identifying red flags and implementing corrective actions; 3) lack of understanding and appreciation from the report producer as to the importance and utilization of data generated; 4) lack of FHSIS forms; 5) damaged computers at the PHO level; and 6) poor mechanisms feeding back to the source of the data and for how the generated data were used. The assessment also shows that the FHSIS, from the barangay to the regional level, needs to be supplemented to reflect the other CSP indicators of the project.

To respond to the problems cited above, PHCSP conducted sessions with the BHWs/health workers, RHMs, PHN, MHO/CHO and the PHO/RHO FIS staff and identified the following

actions as necessary: 1) Conduct workshops on the importance, implementation and utilization of the FHSIS; 2) Produce forms such as Home Based Maternal Record cards, Growth Monitoring cards, EPI cards, Client Lists and others and ensure availability at the appropriate levels; 3) Ensure availability and accuracy of weighing scales at the barangay health posts; 4) PHN/MHO and PHCSP staff supervise, monitor and coach data generation at the barangay level, with memoranda from the Mayor on the guidelines and schedule of report submission. Monitoring and supervisory visits checklists will be used and 10 barangays will be covered by the concerned persons per month; 5) PHO FIS staff, with assistance from the PHCSP staff, monitor data generation at the municipal level; 6) Install computerized HIS at the municipal level. During the second year, upgrade the HIS computer at the provincial level; and 7) Have Municipal/City level data analysed and feedback provided to the Municipal/City Council by the LGU Health Officers and Health Councilor, on a quarterly basis, and plan for corrective measures and resource allocation; and 8) Barangay level data analysed and feedback to the barangay by the village health committee for action planning on a monthly basis.

The project monitoring and evaluation plan aims to: 1) empower the barangay in taking actions for their own health through the community based information system; 2) improve reliability and timeliness of the current FHSIS from the community to the municipal level; 3) convince the provincial FHSIS and even the regional FHSIS as to the improvements occurring through the project and to review its health information system and advocate for changes; 4) track the progress of the project, identify red flags and actions necessary for improvement; and 5) evaluate the attainment of the project objectives.

To meet the objectives of the Monitoring and Evaluation, there are several components:

Community-Based Information System

This component will focus more on the empowerment of the barangays to generate data, utilize and feedback the information to the community residents for action with support from the LGUs. A community based information system that flows back and forth to the municipal/city level and has a strong loop between the two levels will be set up in each barangay. PHCSP will make use of the existing community health data board systems of the Philippine Government, which makes health information accessible and useful to the communities, and strengthen its utilization. The practice will be to update the information on a quarterly basis. The PHCSP will however initiate a modification which will be the installation of a health data board in each purok instead of only at one place in the barangay, so that families far from the barangay centre have access to the information and are involved in the community health activities. Also, CSP health indicators will be added.

The FHSIS and CSP HIS data will be collected, on a monthly basis by the BHWs/CHW based on the health logbooks and a master list that they maintain. The RHM consolidates the data in the monthly BHS report (Annex F.). Each BHS covers several barangays as its catchment area, which may not be completely covered by the project. For the PHCSP barangays, the HIS coordinator will consolidate the report from each barangay on a BHS basis but reflect only the PHCSP areas. The PHN consolidates all BHS reports for the municipality while the HIS coordinator consolidates those for the PHCSP areas. These reports are submitted to the MHO on the first week of each month. The HIS coordinator discusses with the Project Director the monthly HIS reports and analyses the data generated. The results are then discussed with the MHO/CHO for improvement planning. If the results warrant the need for the Partner for Health Project Advisory Board (PAB) to meet, this will occur. Under normal circumstances, the PAB meets quarterly to discuss the quarterly project performance.

In the first quarter of the implementation of this component, a feedback and consultative workshop is planned to determine what works well, what problems were encountered and to plan for improvement. Depending on the result of the first feedback workshop, bi-annual workshops will be held until the system has been fully improved and has been internalized by the implementors, particularly at the barangay and the municipal/city levels. Since the project covers two municipalities only in the province of Leyte, the Provincial Health Office, through the Project Advisory Board will share the learnings and successes with other municipalities for replication, policy review and advocacy. The PHO will then forward its experience to the RHO for sharing of learning and policy review and advocacy.

The monthly consolidation result of the FHSIS will be presented by the village health committee to the community for the reasons cited above. The same process will occur on a quarterly and annual basis. In the third quarter of the year, the monitoring results presentation will aim to advocate to the barangay officials the allocation of the Internal Revenue Allotment for health activities based on the community health plan and monitoring results. The third quarter is the best time to advocate for resources since this is the time that the barangays and municipalities are preparing their annual plans and budgets. Advocacy to the Local Health Board at the municipal/city level through the Councillor on Health, the MHOs and the Municipal Planning and Budget Officer will follow. The BHW/health worker federation and the Association of Barangay Captains will make representation to the Municipal/City Councils for advocacy purposes.

KPC

Technical assistance is planned for the conduct of the KPC which will serve as follow-up skills building with the partners who conducted the first KPC. The succeeding KPCs, one at the end of year one, one for the midterm and one at the end of the project, will be conducted by partners with technical assistance obtained by PSBI HO staff.

KPC surveys establish a helpful scientific measurement of progress made on project objectives, useful for comparison with other CS projects and is used to track CS indicators. However, the project management needs information on the progress of the objectives as often as necessary to improve ongoing strategies. Hence, Lot Quality Assurance Sampling will be conducted.

Lot Quality Assurance Sampling

The project will conduct Lot Quality Assurance Sampling to assess coverage of the interventions, technical skills of the health workers and assessment of training conducted. It will be conducted quarterly by the community health workers. The LQAS sampling methodology and procedures will be used by the project. Depending on the results of the assessment, LQAS may not be done as frequently if the results are good and show expected progress on the objectives. The results of the LQAS will be presented to the community and LGUs for recognition of good performance and close monitoring and coaching for those lagging behind. LQAS results should identify red flags so that project management will act on these flags immediately. Actions may be to review the project design, improve scheduling and others.

Documentation of Innovative Strategies and Sharing of Best Practices

All innovations that the PHCSP will implement will have a built in documentation plan. The plan will generate baseline data, milestones in the project, success factors and hindering factors, results of each innovation and its contribution to the attainment of the objectives. Periodic assessment and planning will be held to follow the progress of the activities. The final activity report will be shared with other communities and LGUs for replication. If appropriate, a simple

newsletter or publication on project progress, lessons learned, and successes will be released on a bi-annual basis. The newsletter will be in the local dialect and distributed to families, health workers, LGU and NGO Partners, the media and the general public.

Monitoring and Evaluation Matrix

1. Increase from 50% to 90% the percentage of children <24 months who were exclusively breast-fed until 4 months old.

Indicator	Information Required	Method of Collection	Who to Collect	Frequency of Collecting	Tool Used
Percentage of children <24 months who were exclusively breast-fed until 4 months old	# of children exclusively breast-fed until 4 months # of children <24- month old.	Monthly master listing through home visits/health center records review	BHW RHM HIS Coordinator	Monthly/ Quarterly	BHW/ RHM Records FHSIS (M & Q forms) HBMR

2. Increase from 25% to 80% the percentage of mothers who can name at least two sources of Vitamin A and iron-rich foods in addition to breast milk for children 4 to 24 months

Indicator	Information Required	Method of Collection	Who to Collect	Frequency of Collecting	Tool Used
Percentage of mothers who can name at least two sources of Vitamin A. and iron-rich foods in addition to breast milk for children 4 to 24 - months old	# of mothers who have children 4 to 24-months old # of mothers who have children who can name at least two Vitamin A. and iron-rich foods	Master listing through home visits and review health center service records	BHW/ Health Scouts/ BNS RHM HIS Coordinator	Monthly and Quarterly	Master list of Mothers LQAS Report

3. Decrease from 32% to 16% the percentage of malnourished children

Indicator	Information Required	Method of Collection	Who to Collect	Frequency of Collecting	Tool Used
Percentage of malnourished children rehabilitated	# of <5 malnourished children	Annual OPT	BHW/BNS/ Health Scouts	Annual	OPT Forms
	# of 5 malnourished children rehabilitated	Monthly Growth Monitoring	BHW	Monthly	FHSIS (M&Q)
				Midterm and Final Evaluation	

4. Increase from 5.4% to 70% the percentage of women who have at least two TT immunizations

Indicator	Information Required	Method of Collection	Who to Collect	Frequency of Collecting	Tool Used
Percentage of women who have at least two TT immunizations	# of women aged 15-49	Barangay Census	BHC	Annual	Barangay Census Forms
	#of women who have at least two TT immunizations	Review of Health Center Service Records	BHW/RHM KPC team	Monthly Midterm and Final Evaluation	FHSIS (M&Q) KPC

5. Increase from 7% to 50% the percentage of women who have made at least two prenatal visits

Indicator	Information Required	Method of Collection	Who to Collect	Frequency of Collecting	Tool Used
Percentage of pregnant women who have made at least two prenatal visits	# of pregnant women	Master listing through home visits and review of health center service records	BHW/Health Scouts/TBAs	Monthly	Master list Forms
	# of pregnant women who	Review of	BHW/TBAs	Monthly/	FHSIS

	have made at least two prenatal visits	HBMR	KPC Team HIS Coordinator	Quarterly Midterm and Final Evaluation	(M&Q) KPC Survey Instrument
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6. Increase from 25 % to 50% the percentage of women using modern contraceptive methods

Indicator	Information Required	Method of Collection	Who to Collect	Frequency of Collecting	Tool Used
Percentage of women using modern contraceptive methods	# of women 15-49	Annual Barangay Census	BHC	Annual	Barangay Census Forms
	# of women using contraceptive	Review FP client list	BHW/RHM HIS Coordinator	Monthly & Quarterly	FHSIS (M&Q)
			KPC Team	Midterm and Final Evaluation	KPC Survey Instrument

ATTACHMENT B: TEAM MEMBERS AND THEIR TITLES

Team Leader:

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ATTACHMENT C: ASSESSMENT METHODOLOGY

C.1. RATIONALE

USAID Office of Private and Voluntary Cooperation (PVC) aims to build the capability of Private Voluntary Organizations (PVOs), such as Pearl S. Buck International Inc., in managing Child Survival Project. In line with this goal, PVC assisted PVOs in strengthening their Child Survival project management by undertaking evaluations, which allow a program's results to be assessed and credible program achievements to be documented. Evaluations are important tools for surfacing a program's strengths, weaknesses and gaps, in order to correct and strengthen its implementation in midstream. In line with this thinking, PSBI considered the midterm evaluation as part of its project cycle process and a learning opportunity for its members.

Evaluation Objectives

The general objective of the evaluation was to determine whether the capacity building and institutional development (CB/ID) strategies and activities implemented by PHCSP had succeeded in (a) improving the nutrition, maternal care and FP services in the project areas (Ormoc and Merida) and (b) have resulted in positive changes in the program performance as measured by indicators based on annual benchmarks set by the project. Hence, in early July, PSBI initiated plans to undertake a midterm evaluation and constituted an evaluation team composed of five members to undertake the following task:

- (1) Assess progress in implementing the Project's Detailed Implementation Plan;
- (2) Assess progress towards achieving program objectives or yearly benchmarks;
- (3) Assess whether the chosen interventions are effective in achieving desired outcomes;
- (4) Identify barriers to achieving objectives; and
- (5) Provide recommended actions to guide the program staff through the last half of the program.

C.2. EVALUATION FRAMEWORK

This PHCSP evaluation utilized the widely accepted conceptual framework of Input-Process-Output-Outcome framework (Reynolds et al., 1990). **Program inputs** included the various resources, whether those were materials, financial or human resources that were "fed into" the program. In the PHCSP, these consisted of the funds and technical assistance and training provided by PSBI on the one hand, and the contributions of the LGU or the community on the other. The latter varied among LGUs as well as projects, but were expected to include meaningful inputs in the form of personnel, supplies and possibly *barangay* allocations. **Program processes** were specific activities carried out to achieve the stated objectives of the program. Processes were intermediate, as opposed to actual outputs or outcomes. Here, various program processes were examined through retrospective interviews and a review of existing project documents and reports. **Program outputs**, which result from the combination of inputs and process, were activities or behavior that could be objectively observed and measured. In the current context, this might involve measures of service delivery (e.g. number of vaccinations administered) or service utilization (e.g. percentage of mothers breastfeeding fully or the family planning client load). **Program outcomes** were measurable results assessed empirically (using the KPC survey results or service statistics) and scientifically subsequent to program implementation. For this particular evaluation, these were defined by the indicators specified for each of the three intervention programs (nutrition and breastfeeding, maternal care and child spacing) and the available indicators related to other crosscutting strategies that were adopted to strengthen the three interventions.

In this regard, it was important to differentiate performance and impact. The type of evaluation to undertake depended on the stage of the project cycle. A midterm evaluation, such as this, is necessarily a program performance evaluation, hence the focus was largely in examining the processes and inputs described above and whatever possible measurable outcomes could be obtained from available data. Data maintained by the program were especially important because they provided suggestive information about performance and—by implication—the program’s current effectiveness. KPC data collected after program implementation can also give indications of outcome effects, according to the Project Evaluation Handbook definition of outcome effects as being “the relatively direct and immediate result of program process and output” (Bertrand et al., 1994). The Evaluation team therefore sought to examine the program based on this framework in order to systematically chart out and assess progress and relationships, if any, that could be drawn between performance and the mix of interventions that were implemented by the project.

Evaluation Questions and Sources of Data

The following table shows illustrative questions organized according to the Inputs-process-output and outcome framework to assess information derived from the evaluation activities:

Table 1. Illustrative Questions and Sources of Information as organized under the Inputs-Process-Output/Outcome Framework

Nature of Indicator	Type of Information Needed	Illustrative Questions
INPUTS	<ul style="list-style-type: none"> - financial, organizational institutional supports, including TA (source of data: project documents and reports, KIs) - manpower/personnel (existing and new); (source of data(KI)) - logistics, supplies and equipment, infrastructure upgrading & IEC (KIs, observation) - management and supervision support (project reports, KIs, IGDs) 	<ol style="list-style-type: none"> 1. What are the types of support that were provided at different stages of the program in order to operationalize the objectives of the PHCSP? 2. Who are the key players involved in the programs and their roles in the project? 3. What is the extent of manpower and personnel requirements for implementing the program? 4. What kinds of logistic and management system have been put in place in order to keep the program going?
PROCESS	<ul style="list-style-type: none"> - project activities carried out –timing, pace, coverage & reach (source of data: project reports, KIs) - standards and procedures (source of data: KI & IGDs) - collaboration with partners and other sectors (esp. NGOs) (source of data: KI & IGDs) - mechanisms for 	<ol style="list-style-type: none"> 1. What are the activities that were undertaken in order to achieve the program objectives? Are these new activities or mainly strengthening existing programs? 2. What procedures were followed in the choice of interventions and strategies? 3. Describe the pace, timing extent of coverage of project implementation. 4. What kinds of management and

	<p>sustainability (project reports, KIs & IGDs)</p> <ul style="list-style-type: none"> - service delivery (observations, project documents) 	<p>information systems are put in place?</p> <ol style="list-style-type: none"> 5. What are the extent and types of involvement of the different stakeholders in program implementation? 6. What are the strengths & constraints encountered in the implementation of the program? 7. What types and nature of collaboration are fostered with other institutions? 8. What mechanisms are employed to ensure sustainability after end of program?
<p>OUTPUT/ OUTCOME</p>	<ul style="list-style-type: none"> - Number of activities undertaken (training, outreach, IEC, service delivery) (Source of data: service statistics, project reports) - No of clients served (service statistics) - No of clinic upgraded (if any) or functional weighing posts established (observation) - Achievement of benchmarks (KPC, DIP, service statistics if applicable) - New and innovative activities undertaken (progress reports, KIs and IGDs) - Client satisfaction (KIs, IGDs) 	<ol style="list-style-type: none"> 1. How many activities (training, outreach, masterlist updating) have been carried out during the period of program implementation? What are the new services that are provided in the clinics and in the community? 2. How many clients were served under the different program activities that were implemented? 3. How many weighing posts have been established? Are they all functional? 4. To what extent have the benchmarks under each program been achieved?

C.3. EVALUATION PLAN

The evaluation was undertaken by a team composed of five members with varied experiences in the areas of maternal and child health, reproductive health and community development work. The five members belong to other agencies working in the health sector areas and community organizing. The task of the evaluation team was to come up with (a) an evidence-based examination of the interventions and support programs, (b) how they impact the beneficiaries of PHCSP, and (c) offer appropriate recommendations for strengthening the capacities of the project stakeholders in the management of these health programs.

C.3.1. Data Collection Methods

In order to get an idea of the progress that the project has made at midterm, the Evaluation Team conducted a series of key informant interviews and informal group discussions (IGDs) with implementers, partners and participants of the project. Visits were also arranged in 10 selected

pilot barangays chosen by PSBI to represent the high, medium and low performing areas. A consideration in selecting the sites was to make sure that the team would be able to visit barangays that can give them a picture of the different interventions that have been put in place by the project. The use of the different methods facilitated consistency checks of the data culled from various sources as well as strengthened data validity. The following data collection methods were utilized to analyze the project's progress:

C.3.1a. Review of Existing Materials

- Project documents (annual reports, DIP, progress reports, project activity reports & modules)
- Clinic and project records (clinic statistics)
- KPC survey reports

C.3.1b. Key Informant Interviews

- Program managers (PSBI and partners, e.g., CHO, MHO, RHO) and supervisors
- Service Providers: Midwives, BHWs, TBAs

C.3.1c. Focus Group Discussions with:

- Service providers (TBAs, BHWs, Midwives)
- Clients/beneficiaries: fathers, mothers, children
- Partners

C.3.1d. Field visits and observations

- Weighing posts
- Mother support groups in two pilot areas
- Bio-intensive gardens
- Growth Monitoring Charts
- IEC Materials

The KPC survey was the primary source of quantitative data used for this evaluation. The KPC survey was conducted using the 30 cluster sampling methodology. This has certain advantages in the relative ease - albeit extensive nature of this method. When used independently of other KPC 30 clusters surveys, the data provided has acceptably high reliability. However, there are disadvantages to the 30 cluster sample. Reliability is weakened on subsequent samplings, reducing comparability of the midterm data to the baseline data. These issues should be considered in the analysis of KPC data presented in the report.

LQAS was initiated but is to be completed at a later date. LQAS has the advantage of producing high reliability due to the stratified random sampling methodology. This also does not carry the same disadvantage that 30 cluster sampling does when repeat samples are conducted. LQAS has the disadvantage of being challenging to implement for the first time when the implementers are familiar with the 30 cluster.

C.4. SCHEDULE OF THE EVALUATION TEAM

The following table shows the detailed schedule of the evaluation team, specifying the activities that were carried out during the specified periods:

Dates	Activity	People Involved
August 6-7	First MT Evaluation Team Meeting	MT Evaluation Team, PSBI Staff – CO, Regional, Project Director
August 10	2 nd MT Team meeting	MT Evaluation Team; PSBI Staff – CO, Regional, Project Director
August 14	Team Leader Meeting with CD	Team Leader; CD
August 23-24	Consultation with Partners re: MTE	Team Leader, Project Staff
August 30-September 3	IGDs/KII * Partners * PSBI Staff	Team Members, PSBI Staff
September 4-6	- Field visits-IGDs/Ocular Inspection (10 barangays) - KII continuation	Team Members, PSBI Staff
September 7	- Presentation/Validation of Preliminary Findings to Partners - Feedback and Debriefing with PSBI Staff	MTE Team, PSBI Staff, Partners
September 15-October 14	Team Report Writing (There were 2 writing workshops (4 days each) supported by PSBI)	MTE Team
October 6-7	Review of First Draft with PSBI	MTE Team, CD, PD, HIS, Training, CD Coordinator
October 15	Submission of Final Report to PSBI	MTE Team, Project Team

ATTACHMENT D: LIST OF PERSONS INTERVIEWED AND CONTACTED

D.1. Respondents of Key Informant Interviews

- Dr. Rogelio Marson, CHO-Ormoc
- Dr. Jane Solana, MHO-Merida
- Hon. Celso Adolfo, Vice Mayor, Ormoc
- Ms. Delia Corbo, CPDO-Ormoc
- Dr. Ruby L. Gernale, PNR Chapter Manager
- Ms. Josefa Roces-Pizon, RDI Executive Director
- Ms. Ana Marie Locsin, PSBI Country Director
- Ms. Nancy Obias, PSBI Regional Coordinator
- Mr. Carlo Valiente, PHCSP Director
- Ms. Hannah Gilk, PHCSP Backstop (Home Office)
- DECS, Division of City Schools, Ormoc City
 - Dr. Violeta Alocilja, Division Superintendent; CSP Advisory Board member
 - Dr. Filomeno Maglasang, Education Supervisor 1; CSP Advisory Board & IEC Task Force member
 - Gloria Luna, Education Supervisor 1
- Rural Health Midwives
 - Sara Jane Ladia (Liberty)
 - Leisly Yap (Labrador)
 - Emalinda Abrantes (Nasunugan)
 - Marilyn Espinosa (Boroc)
 - Transita Sosmena (5 Merida barangays)
- Ms. Evelyn Romero, FP Coordinator-Ormoc
- Trained Birth Attendants
 - Mayolita Jordan (Cambalong)
 - Penita Codilla (Labrador)
 - Tenita Codilla (Lundag)
 - Rosita Mabjas (Liberty)

Informal Group Discussions were organized with project partners such as service providers (TBAs, BHWs, Midwives), local government officials, and the technical support of the PHCSP. A sample of clients and beneficiaries, particularly mothers and young children, were also brought together for a one to two-hour group discussion, facilitated by one member of the evaluation team.

D.2. Respondents of the Informal Group Discussions

- PHO Staff (CARI Coordinator, Nutrition, FP-MCH Coordinator, IECM Coordinator)
- RHO 8 Technical Support for PHCSP
(1st IGD)
 - Emily Grande, Nutrition & *Garantisadong Pambata* Coordinator; TWG
 - Fe Modesto, FP Training & Expanded Program on Immunization Coordinator
- (2nd IGD)
 - Emilie Buot, FP Service & Expanded Program on Immunization Coordinator; TWG member
 - Ma. Conchita Singco, Breastfeeding Coordinator
- PSBI Staff (8 including Carlo Valiente, Project Director)
- CHO Staff (4)
 - 2 PHN, IEC Task Force & TWG member
 - DOH Representative, Advisory Board member
- RHU Staff (4)
 - PHN Delsa Panares & Linda de Leon
 - RHM Tita Sosmena & Perla Pateros
- Barangay Councils: 10 barangays (69 participants)
- BHWs/BNS: 10 barangays (41 participants)
- TBAs: 2 barangays (5 participants)
- Mothers: 9 barangays (93)
- Health Scouts: 2 barangays (32)
- Puppeteers: 3

D.3. List of Visited Barangays

1. Sto. Nino, Ormoc
2. Labrador, Ormoc
3. Tubod, Merida
4. Nasunugan, Merida
5. Cambalong, Merida
6. Liberty, Ormoc
7. Mat-e, Merida
8. Lundag, Merida
9. Boroc, Ormoc
10. Masumbang, Ormoc

Table 1. Respondents in Community IGDs by Barangay

Groups	Areas	Number of People Interviewed
BHWs/BNS	- Tubod	3
	- Cambalong	5
	- Sto. Nino	7
	- Masumbang	7
	- Lundag	4
	- Mat-e	4
	- Boroc	3
	- Liberty	2
	- Labrador	3
	- Nasunugan	3
	SUBTOTAL	41
TBAs	- Boroc	3
	- Masumpang	2
	SUBTOTAL	5
Barangay Council	- Tubod	8
	- Sto. Nino	8
	- Cambalong	4
	- Masumbang	7
	- Nasunugan	6
	- Labrador	11
	- Lundag	6
	- Mat-e	4
	- Boroc	8
	- Liberty	7
	SUBTOTAL	69
	TOTAL	115