DETAILED IMPLEMENTATION PLAN

July 15, 2005

Siem Reap Integrated Child Health Project (CS-20)

Siem Reap Province, Cambodia
2004 – 2008

Funded by the United States Agency for International Development
Bureau for Global Health
Office of Health, Infectious Disease, and Nutrition

FY-2004 Child Survival and Health Grants Program (CSHGP)
Grant No. GHS-A-00-4-00007-00

American Red Cross

CAMBODIAN RED CROSS

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ACRONYMS

AD	Administrative District
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARC	American Red Cross
ARCHI	African Red Cross Red Crescent Health Initiative
ARI	Acute Respiratory Infection
BCG	Bacillus Calmelle-Guérin tuberculosis vaccine
BF	Breastfeeding
BFHI	Baby Friendly Hospital Initiative
BTC	Belgium Technical Cooperation
CSSA	Child Survival Sustainability Assessment
CATCH	Core Assessment Tool on Child Health
CBSS	Community-based surveillance systems
C-IMCI	Community Integrated Management of Childhood Illness
CNM	National Malaria Center
CR	Cambodian Riel
CRC	Cambodian Red Cross
CRS	Catholic Relief Services
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CVCG	Community Volunteer Care Group
DfID	Department for International Development
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
DTK	Diarrhea Treatment Kits
FGD	Focus Group Discussions
FY	Fiscal Year
GH	Global Health
GMP	Growth Monitoring and Promotion
HKI	Helen Keller International
HMIS	Health Management Information System
HIV	Human Immune-deficiency Virus
ICH	Integrated Child Health Project
IFRC	International Federation of Red Cross Red Crescent
IR	Intermediate Result
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPTT	Indicator Performance Tracking Table
ITN	Insecticide Treated Nets
IYCF	Infant and Young Child Feeding
JICA	Japanese International Cooperation Agency
KPC	Knowledge, Practices and Coverage

LAM	Lactation Amenorrhoea Method
LLIN	Long Lasting Insecticide Treated Nets
LOE	Level of Effort
LRA	Local Rapid Assessment
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MPA	Minimum Package of Activities
MR	Mortality Rate
MRD	Ministry of Rural Development
OD	Operational District
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHD	Provincial Health Directorate
PPM	Parts Per Million
PSI	Population Services International
PVO	Private Voluntary Organization
RACHA	Reproductive and Child Health Alliance
SD	Standard Deviation
SO	Strategic Objective
TAPE	Technical Assistance and Program Evaluation Unit
TBA	Traditional Birth Attendants
TRM	Technical Reference Materials
USAID	United States Agency of International Development
UNICEF	United Nations Children's Fund
URC	University Research Corporation
VAC	Vitamin A Capsule
VHSG	Village Health Services Group
VMW	Village Malaria Workers
VSO	Volunteer Services Overseas
WHO	World Health Organization
WUHE	Water Use and Hygiene Education

A. EXECUTIVE SUMMARY

Grantee and sub-grantees: The American National Red Cross (ARC) is the primary recipient of this grant. The Cambodian Red Cross (CRC), a separate legal entity from ARC, is the local partner and sub-grantee and will serve as the implementing organization.

Program name: Integrated Child Health (ICH) Project

Category of CSHGP grant and level of funding: Standard Category, $1.5 million USAID; $500,096 cost share.

Start and end dates: October 1, 2004 to September 30, 2008.

Program Location and Beneficiaries: The project site is in Angkor Chum Operational District (OD) in Siem Reap Province. The site contains three Administrative Districts (ADs): Pourk, Angkor Chum, and Varin. The estimated 2004 project site population is 213,749. The project will serve estimated average populations of 43,610 U5 children and 52,744 women of reproductive age (WRA).

Problem Statement: Cambodia has among the highest rates of child morbidity and mortality in Southeast (SE) Asia with an infant mortality rate (IMR) of 93 per 1,000 live births and an under-five mortality rate (U5MR) of 122 per 1,000 live births. After decades of civil war, the public health system is still nascent, and community-based health service delivery is woefully inadequate to meet public needs. Consequently, most Cambodians lack education about the most appropriate treatments and thus self-medicate or use unqualified and expensive private practitioners. In addition, essential child health products are not available in communities.

The national Cambodian U5MR increased by 17% between 1990 and 2000 in contrast to an 11% decline in the least-developed countries of the world. Only five other countries – Iraq and four sub-Saharan African countries – experienced a greater increase during this time. Acute respiratory infections (ARI), diarrheal disease, malaria, and vaccine-preventable diseases are the major causes of pediatric deaths, with malnutrition a primary co-factor.

Goals, Objectives, and Strategies: The project's goal is to reduce child morbidity and mortality in a sustainable fashion. The goal will be reached by achieving measurable improvement in the following three strategic objectives (SO) and eleven intermediate results (IR): **SO 1:** *Improved nutritional status of children under two*. IRs related to: (1) Antenatal Care; (2) Initiation of breastfeeding and exclusive breastfeeding; and (3) Complementary feeding. **SO 2:** *Immunization*. IRs related to: (4) Improved routine immunization rates; (5) Improved Vitamin A rates; and (6) Improved community participation in immunization. **SO 3:** *Community management of the sick child*. IRs related to: (7) Improved home management; (8) Early identification and referral for danger signs; and (9) Improved malaria prevention and treatment. **SO4:** *Partner Project Management Capacity.* IRs related to: (10) Improved coordination with health community; (11) Improved project management policies and skills; and, (12) Improved volunteer network.

The project interventions will be implemented through the following four major cross-cutting strategies: (1) Health education/coaching for behavior change through an extensive network of CRC volunteers; (2) Community mobilization for behavior change achieved by engaging opinion leaders and motivating community-based activities to reinforce health communication through the CRC volunteers; (3) Coordination and continued involvement of other implementing partners to ensure synergistic program approaches; and (4) Community-based surveillance systems that complement and support existing Health Management Information Systems (HMIS) while enhancing broader community participation in monitoring basic health statistics at the village level.

Interventions and LOE: The technical interventions are (1) nutrition (LOE: 15%) and breastfeeding (LOE: 20%) with specific focus on immediate and exclusive breastfeeding, and complementary feeding and maternal and newborn care (LOE: 10%), (2) immunization with a focus on raising immunization coverage rates for the leading vaccine-preventable child diseases and Vitamin A and improved community participation (LOE: 25%), and (3) community management of the sick child with specific focus on pneumonia management and control of diarrheal disease and malaria (LOE: 30%).

Local Partner: The CRC is the project's local implementing partner. The CRC has a nationwide structure with branch offices in all 24 of the country's provinces and a nationwide system of 5,773 Red Cross volunteers. CRC has a unique advantage in its broad geographical reach. As an indigenous organization that serves as an auxiliary to the government, CRC can mainstream its primary health care (PHC) experiences into the government health system at national and subnational levels. CRC currently has funding support from a wide range of donors to implement PHC, dengue hemorrhagic fever, HIV/AIDS, safe water, blood donor, and first aid programs. CRC also has the history, authority, and capacity to generate internal political and financial support.

ICH will collaborate with USAID, the MOH, CARITAS, ADRA, PLAN, URC, the Belgian Technical Cooperation (BTC) and RACHA all of whom support health and development programs in the project area to ensure synergistic program approaches.

Proposed Operations Research: The project proposes to undertake three operations research studies: (1) The use of bed nets during the rainy season (as the baseline survey was conducted during the dry season, when malaria is less common); (2) The provision of other fluids before the onset of breastfeeding; and, (3) Understanding the difference in immunization rates between the three administrative districts.

Name and position of the loca l USAID Mission representative: Mark White, Chief, Office of Public Health, USAID/Cambodia.

Main writers of the DIP document: Robert Kolesar, Health Delegate ARC/Cambodia, Dr. James Ricca, Senior Health Advisor, ARC/Washington, Dr. Alice Willard, Senior Monitoring and Evaluation Advisor, ARC/Washington, Nick Edwards, ARC/Cambodia Sujata Ram, Maternal Child Health Advisor, ARC/Washington.

Contact person at PVO headquarters: Sujata Ram, Maternal Child Health Advisor, ARC/Washington.

B. CSHGP DATA FORM

Child Survival and Health Grants Program Project Summary

Jul-15-2005

American Red Cross International Services Cambodia

General Project Information:

Cooperative Agreement Number:	**GHS-A-00-04-00007**
Project Grant Cycle:	**20**
Project Dates:	**(9/30/2004 - 9/29/2008)**
Project Type:	**Standard**

ARC HQ Backstop: **Sujata Ram**

Field Program Manager Information:

Name: **Robert Kolesar**
Address:

Phone:
E-mail: robertkolesar@hotmail.com

Alternate Field Contact:

Name: **Nicholas Edwards**
Address: No. 19, Street 352, Boeung Keng Kang
Phnom Penh
Phone: 855-23-211-996
E-mail: nedwards.amcross@everyday.com.kh

Funding Information:

USAID Funding:(US $): $1,500,000 **PVO match:(US $)** $500,096

Project Information:

Description:

The project goal is to reduce the high morbidity and mortality through Nutrition (LOE 15%) and Breastfeeding (20%), Immunization and Vitamin A (LOE 25%),and Community management of the sick child (LOE 30%) and Maternal Newborn Care (LOE 10%).
The project interventions will be implemented through the following four major cross-cutting strategies: (1) Health education/coaching for behavior change through an extensive network of CRC volunteers; (2) Community mobilization for behavior change achieved by engaging opinion leaders and motivating community-based activities to reinforce health communication through the CRC volunteers; (3) Coordination and continued involvement of other implementing partners to ensure synergistic program approaches; and (4) Community-based surveillance systems that complement and support existing Health Management Information Systems (HMIS).

Partner Name	Partner Type	Sub Grantee $
Cambodian Red Cross	Subgrantee	$501,051
Ministry of Health	Collaborating Partner	
RACHA	Collaborating Partner	
Population Services International	Collaborating Partner	
Plan International	Collaborating Partner	
Belgium Technical Cooperation	Collaborating Partner	
CARITAS	Collaborating Partner	
University Research Cooperation	Collaborating Partner	

General Strategies Planned:

Social Marketing

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners

Behavior Change & Communication (BCC) Strategies:

Social Marketing
Interpersonal Communication

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community

(None Selected)	(None Selected)	(None Selected)	(None Selected)	Other CBOs CHWs

Interventions:

Immunizations (15 %)
** IMCI Integration
** CHW Training
*** Classic 6 Vaccines
*** Vitamin A
Nutrition (15 %)
** IMCI Integration
** CHW Training
*** Comp. Feed. from 6 mos.
*** Cont. BF up to 24 mos.
*** Growth Monitoring
Vitamin A (10 %)
Pneumonia (10 %)
** IMCI Integration
** CHW Training
*** Recognition of Pneumonia Danger Signs
Control of Diarrheal Diseases (10 %)
** IMCI Integration
*** Hand Washing
*** ORS/Home Fluids
*** Feeding/Breastfeeding
*** Care Seeking
*** Case Mngmnt./Counseling
Malaria (10 %)
** IMCI Integration
** CHW Training
*** Access to providers and drugs
*** ITN (Bednets)
*** Care Seeking, Recog., Compliance
Maternal & Newborn Care (10 %)
** IMCI Integration
** CHW Training
*** Recog. of Danger signs
Breastfeeding (20 %)
** IMCI Integration
** CHW Training
*** Promote Excl. BF to 6 Months

Target Beneficiaries:

Infants < 12 months:	**6,362**
Children 12-23 months:	**6,238**
Children 0-23 months:	**12,600**

Children 24-59 months:	17,966
Women 15-49 years:	48,521
Population of Target Area:	213,749

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	122	342	35.7%	8.1
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	16	38	42.1%	25.9
Percentage of children age 0-23 months whose births were attended by skilled health personnel	27	177	15.3%	7.8
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	106	177	59.9%	13.5
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	43	112	38.4%	14.6
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	49	60	81.7%	24.9
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	48	141	34.0%	12.4
Percentage of children age 12-23 months who received a measles vaccine	151	170	88.8%	14.9

Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**6**	**347**	**1.7%**	**1.9**
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**201**	**347**	**57.9%**	**9.5**
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**65**	**121**	**53.7%**	**15.8**
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**22**	**170**	**12.9%**	**7.4**
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**1**	**170**	**0.6%**	**1.6**

Comments for Rapid Catch Indicator

C. DESCRIPTION OF DIP PREPARATION PROCESS

1. Background information

In May 2003, ARC and CRC decided to partner on the resubmission of the Integrated Child Health (ICH) Project for the FY04 CSHGP. After consulting with the ministry of health, the north central province of Siem Reap was targeted for the project. This decision was made based on the area's dire public health statistics, USAID's geographic focus, and the proposed establishment of the BTC-funded, health-sector-strengthening program in the province. Interventions were selected following a comprehensive assessment that considered core organizational strengths of both ARC and CRC, priority public health problems of the targeted operational district, and the potential for impact.[1]

In August 2003, field visits were undertaken to review the proposed interventions with provincial authorities. Specifically, the ARC/CRC team met with the first deputy provincial governor, the provincial health director, the director of Siem Reap operational district, six district governors, and five health center (HC) directors. The team discussed the proposed community-based program to solicit input on how it could relate with other child health programs currently operating or under development.

Community health education, social mobilization, social marketing, community-based surveillance, and referrals to health centers were all discussed and agreed upon as overreaching project strategies. All government officials strongly endorsed an ARC/CRC child survival project concept and grant application, particularly the district governor and health center director of Varin who cited the desperate health conditions in the district and the absence of viable health services. The Siem Reap provincial health district director recommended that the project work in the new Angkor Chum operational district. The team also consulted with RACHA, BTC, the World Food Programme, Handicap International, and SEILA (UNDP's government decentralization program). These stakeholders all were supportive of the project concept.

Although the grant was awarded in April 2004, the reorganization of the International Services Department of the American Red Cross resulted in new policies and procedures related to risk mitigation and grants compliance. As a consequence, the grant was not signed until January 2005.

2. Detailed Implementation Planning Process

In December 2004, the project's proposed interventions were reviewed against the Cambodia "scorecard" that had been agreed upon as key priority interventions during the December, 2004 Child Survival Partnership Workshop in Phnom Penh. With the exception of iodized salt promotion, all proposed project interventions reflect the Cambodia "scorecard" selections.

[1] Potential for impact was quantified based on recommendations from "The Summary of The Lancet Child Survival Series, The Second Child Survival Revolution ," published by BASICS II

In January and February 2005, ARC assembled a core team, mobilizing human resources from three program regions (Africa, Americas, and Asia) as well as the Technical Assistance and Program Evaluation (TAPE) Unit and other in-country projects to undertake the planning and organization of the detailed implementation planning process. The CRC also mobilized critical human resources from other projects to complement and support this process over an accelerated timeline. Core team members are listed in the matrix below.

Table 1: Core DIP team members

Name	**Title**
American Red Cross Headquarters	
1. Mark Preslan	Acting Asia/Pacific Regional Director
2. Dr. Alice Willard*	Senior M&E Advisor
3. Dr. James Ricca	Senior Health Advisor
4. Sujata Ram*	Child Survival Backstop Officer
5. Kevin Mitchell	Senior International Financial Analyst
American Red Cross Cambodia Delegation	
6. Nicholas Edwards	Head of Delegation
7. Robert Kolesar*	ICH Project Officer
8. Ven Sarith	ICH Project Manager
9. Chum Sophal	Administrative Manager
Cambodian Red Cross	
10. Hum Sophon	Director, Program Department
11. Dr. Kem Darasophea	Head of Health Sub-Department
12. Hang Chan Sana	ICH Project Liaison Officer
13. Sum Sam An	Director, Siem Reap Branch
Angkor Chum Operational District	
14. Mak Sam Oeun	Director, Angkor Chum Operational District

*Designates a key position

2.1 Baseline and preliminary feedback sessions

In January 2005, survey instruments were reviewed concurrently with survey coordination and logistics planning. In late February 2005, KPC baseline survey planning meetings were completed with the provincial health director, operational district director, and the administrative district governors. Enumerator training was conducted from March 9 to 11; field level data collection was undertaken from March 12 to 20. A closing ceremony (including a debriefing) was held on March 21 with the survey team. A summary of the baseline survey findings is provided in Section 1; the complete baseline report is included as Annex W.

A preliminary data dissemination meeting was held eight days following the completion of data collection on March 28. ARC and CRC coordinated the meeting, which was attended by officials from the CRC branch office, Angkor Chum Operational District (including the three administrative district governors), provincial health department officials, and several midwives who had taken part in the survey.

The provincial level dissemination meeting was then expanded during the following week with feedback sessions in each of the three administrative districts to: (1) share the preliminary baseline findings, (2) motivate conversation on community action to promote improved health, and (3) solicit ideas on the project design. A discussion guide was used to standardize these sessions. Administrative district governors coordinated the meetings and involved commune leaders, village chiefs, community leaders, health center staff, school directors, and Buddhist monk leadership. Feedback was recorded, compiled, and analyzed to further inform the detailed implementation planning process.

Preliminary baseline findings were also shared with USAID/Phnom Penh on 21 March, and then with USAID/Washington and ARC senior leadership through a brown bag lunch on April 14.

2.2 Other studies

From March 30 through June 1, focus group discussions (FGDs) were conducted with key project constituency groups to solicit their input on the project design. Midwives (one FGD), Cambodian Red Cross (CRC) volunteers from Pourk (one FGD), and village mothers (two FGDs) were organized into separate focus groups.

A market study was undertaken from March 28 through June 1. Availability and pricing for iodized salt, oral rehydration salt, and mosquito nets (both treated and untreated), which were products identified for social marketing in the proposal were all investigated. Data collection tools and findings are provided in Annex S.

Five of the 12 health facilities with the minimum package of activities (MPA) were visited from March 28 through June 1 to validate findings from the University Research Corporation's "Comprehensive Health Facility Assessment in Seven Provinces of Cambodia" (including Siem Reap). A summary of the findings is included in Section 1; a more detailed summary with the data collection instrument is included as Annex P.

A Red Cross branch capacity assessment was completing using a modified branch assessment tool developed by the ARC Organization Development Unit. Summary information from the assessment is included in Section 1 and the completed assessment is included as Annexes B and E.

2.3 Stakeholder and Implementing Partner Meetings

In addition to ongoing consultation with the USAID mission, the operational district director, the provincial health director and administrative district governors, ARC and CRC met with numerous NGOs and PVOs in Phnom Penh, Siem Reap/Angkor Chum from February through May to discuss best practices, programming options, and coordination. A list of all contacts and organizations follows.

Table 2 Phnom Penh and Siem Reap Stakeholder Meetings

Name Title,	Affiliation
Phnom Penh	
Cambodian Government	
1. Professor Dr. Koum Kanal	Director, National Maternal and Child Health Center, MOH
2. Dr. Duong Socheat	Director, National Center for Parasitology, Entomology and Malaria Control, MOH
3. Dr. Chhorn Veasna	National ARI/CDD/Cholera Control Program, Vice Chair of IMCI Working Group, MOH
4. Dr. Hong Rathmony	Vice-Director, Communicable Disease Control Department, MOH
5. Dr. Svay Sarath	Deputy Director, National Immunization Program, MOH
6. Chhim Knin Dareth	Deputy Director, Ministry of Rural Development
Multi-lateral	
7. Dr. Chhin Lan	Project Officer Nutrition, UNICEF
8. Dr. Severin von Xylander	Child and Adolescent Health and Development Officer, WHO
Bi-lateral	
9. Mark White	Director, Office of Public Health, USAID
10. Dr. Chantha Chak	Family Health Team Leader, USAID
11. Dr. Hen Sokun Charya	Development Assistance Specialist for MCH/RH, USAID
NGO/PVO	
12. Joan Schubert	Senior Technical Advisor, Linkages Project, Academy for Educational Development
13. Dr. Pheng Meas	MCH Technical Advisor, ADRA
14. Leonard Uisetiawan	Provincial Program Advisor, ADRA
15. Ingebord Roorda	MCH Technical Advisor, CARE
16. Yim Sovann	Senior Program Officer MCH, CARE
17. Richard Balmadier	Country Representative, Catholic Relief Services
18. Natalie Kruse-Levy	Technical Advisor for HIV/AIDS, Catholic Relief Services
19. Michelle Lang	Country Director, Helen Keller International
20. Dr. Sin Somuny	Executive Director, MEDiCAM
21. Dr. Hun Ratana	Advocacy Coordinator, MEDiCAM
22. Julie Foster	Country Health Advisor, PLAN
23. Andrew Boner	Country Representative, PSI
24. Jaqueline Devine	Deputy Country Representative, PSI
25. Dr. Chan Ketsana	Child Health / M&E Team Leader, RACHA
26. Peng Vanny	Technical Advisor, Planning, Monitoring and Supervision, URC
27. Andrew Butler	Programme Capacity Builder, VSO
28. Pann San	Programme Support Officer, VSO
29. Geof Bowman	Health Advisor, World Relief Cambodia
Siem Reap/Angkor Chum Operational District	
Cambodian Government	

30. Dr. Dy Bun Chhen	Director, Provincial Health Department
31. Mak Sam Oeun	Director, Angkor Chum Operational District
32. Tas Chan Kiri	Governor, Pourk Administrative District
33. Chhimb Tun	Governor, Angkor Chum Administrative District
34. Em Vath	Governor, Varin Administrative District
NGO/PVO	
35. David Cowled	Provincial Program Advisor, ADRA
36. Dr. Georges Dallemagne	Project Co-Director, Belgian Technical Cooperation
37. Kim Sour	Program Manager, Buddhists for Development
38. Samrith Sambo	Administrator and Accountant, Caritas Cambodia
39. Thorng Sikeak	Provincial Program Manager, PSI
40. Dr. Kong Visal	Assistant Provincial Coordinator, RACHA

Meetings were also requested with Partners for Development, World Vision, and Save the Children, but were not possible due to scheduling conflicts. National core team members plan to visit the World Relief and CRS Child Survival projects to benefit from lessons learned in implementing that project upon return from the mini-university. Scheduling conflicts prevented this from occurring prior to DIP submission.

2.4 Detailed Implementation Planning Workshops

The DIP workshop was planned in three phases to maximize participation from stakeholders and implementing partners in Phnom Penh, Siem Reap, and Angkor Chum. Phase I was jointly organized by ARC, CRC, and the MOH and took place in Phnom Penh on April 29 in the MEDiCAM conference room.[2] The objectives of this first phase workshop were to share baseline findings and to solicit feedback on project options in support of the detailed implementation planning process, primarily from Phnom Penh-based stakeholders. The workshop was held in English.

This workshop had broad participation from the Cambodian government (including representatives from the MOH, MRD, and Angkor Chum operational district), UNICEF, WHO, USAID, other PVOs and NGOs, CRC, and ARC. Professor Dr. Koum Kanal, Director, National Maternal and Child Health Center and Chairman of the Child Survival Working Group, Professor Dr. My Samedy, Secretary General, CRC and Nicholas Edwards, Head of Delegation, ARC-Cambodia, presided over the workshop. Feedback received during this workshop was used to further develop the project strategies and activities. The workshop agenda and presentations as well as a complete participant list and summary proceedings are included as Annex Q. Five local television news programs broadcast reports about the workshop.

The second-phase workshop was jointly organized by ARC, CRC, and the Angkor Chum Operational District. This workshop was conducted at the Provincial Health Department meeting room in Siem Reap town from May 10 to 12. The workshop's objective was to

[2] MEDiCAM is a local, membership-based, non-governmental organization that advocates for the advancement of child survival and health policy advancement. Both ARC and CRC are members.

finalize the design of the integrated child health project by engaging stakeholders and implementing partners. A participatory, but highly structured, workshop agenda was developed to provide participants with options to stimulate discussion and ideas and to build consensus on key aspects of the project design including:

- Planning the sustainability, strategies, and activities;
- Developing the work plan;
- Planning the volunteer structure at the village level; and
- Developing coordination and communication.

The workshop was held in Khmer with simultaneous translation to English with an audio recording of both languages to enable review of the proceedings.

Workshop participants included the USAID, the administrative district governors from Pourk, Angkor Chum and Varin, key constituency group representation from each of the administrative districts, including commune leaders, village chiefs, midwives, school directors, monks and nuns. Partner NGOs, including RACHA, PSI, BTC, VSO, Caritas, PLAN and Buddhists for Development, were all in attendance. The workshop agenda as well as a complete participant list are included as Annex R.

The third-phase workshop was held on May 13 at the Siem Reap Branch of the Cambodian Red Cross. This was an internal ARC-CRC workshop with the objective of reviewing and revising the project's human resource requirements, operational structure, management plan, and budget. The workshop agenda and participant list is included as Annex X.

All of the above activities served as critical inputs for the DIP development including definition of the interventions and activities, work plan, and organizational structure.

2.5 Additional Activities

Relevant Cambodia policy and strategy documents were reviewed to ensure that the planning process supported national practices. Documents reviewed included:

- Ministry of Health - Health Sector Strategic Plan 2003 to 2007;
- National Centre for Parasitology, Entomology and Malaria Control, Policy of Malaria Prevention and Control;
- Ministry of Education, Youth and Sport – Draft Policy of School Health;
- Cambodia Child Health Strategy Development – Delivery Modalities and System Constraints: Immunizations;
- Policy on Community Participation in the Development of Health Center, 2003; Guidelines for Outreach Services from Health Centers, 2001;
- Draft USAID /Cambodia Strategy Statement;
- Cambodian Red Cross Volunteer Policy, 2005;
- Cambodian Red Cross Volunteer Policy Implementation Guide, 2005.

Annexes H, I, and M detail policies and strategies for each document relevant to the ICH project. Additionally, ARC participated in the USAID/Cambodia Strategy presentation on May 9 at the Ronald Reagan Building in Washington D.C.

Core team members participated in three technical workshops in Phnom Penh with direct implications on the strategy and activity design for the integrated child health project. The Academy for Educational Development (Linkages Project) coordinated two workshops on March 15 to 17 and 24 to 25 that resulted in the development of *draft* breastfeeding communication strategy and operational plans.[3] Population Services International/Cambodia coordinated a workshop on March 30 to introduce the diarrhea treatment kit and to initiate discussion on the integration of this new health product into child survival projects. Helen Keller International coordinated a one-day workshop on maintenance strategies and future direction of the vitamin A capsule distribution program on May 3.

Workshop outputs were integrated into the preliminary draft of strategy and activity options (Annex X) used during the second-phase workshop to stimulate discussion among Siem Reap and Angkor Chum operational district stakeholders and constituency groups (see section 2.4 above).

To discuss monitoring and evaluation, a consultation was set up with the Angkor Chum operational district during their health management information system (HMIS) data processing day. Data collection procedures and forms from the village through the health centers to the OD administration office was reviewed and discussed for the design of the project's monitoring and evaluation plan detailed in section 3.

Finally, core team members participated in the USAID Rules and Regulations training in Bangkok, Thailand on April 18 to 20 to refresh their understanding of and prevent future issues with compliance.

[3] Due to scheduling conflicts, core team members were only able to participate in the second workshop, but spent time interviewing both Joan Schubert and the Linkages consultant about findings before and after the workshops.

D. REVISIONS

The detailed implementation planning process resulted in four programmatic revisions to the ICH Project: (1) removal of iodized salt social marketing as an intervention, (2) reclassification and reorganization of interventions, (3) expansion of community-based volunteer network, and (4) increase in the volunteer to beneficiary household ratio. Each revision is further detailed below.

D.1 Removal of Iodized Salt Social Marketing

The KPC baseline survey revealed a dramatic change in HH use of iodized salt. The 2000 DHS data for Siem Reap/Oddar Meanchey provinces showed children U5 living in HHs with adequately iodized salt to be 4.1 percent. The KPC baseline survey recorded the current rate at 64 percent, and a further data analysis revealed that all but one cluster had presence of adequately iodized salt. Complementing this information with the market study (see Section 1), it is clear that iodized salt availability and access are no longer of pressing importance in Angkor Chum OD. This is likely attributable to the Royal Government of Cambodia's adoption of the sub-decree on iodized salt. Therefore, social marketing of iodized salt was dropped as a project intervention.

D.2 Reclassification and Reorganization of Interventions

ICH Project components were reclassified from 'components' to 'Strategic Objectives'; 'objectives' were reclassified as 'Intermediate Results'. This change was made to broaden the number of indicators used for tracking each intervention area, thus permitting a more logical integration of Rapid CATCH, HMIS, and "Cambodian Scorecard" indicators into one comprehensive performance tracking plan (see Section 3).

Additionally, interventions were reorganized from technical area to delivery mechanism in order to maximize integrated health promotion. To that end, promotion of vitamin A supplementation was moved from *SO1: Nutrition* to *SO2: Immunization* as both interventions are delivered through HC outreach and activities related to increased HC outreach turn-out are mutually reinforcing. Likewise, tetanus toxoid vaccination was moved from *SO2: Immunization* to *SO1: Nutrition* as it was linked with a more comprehensive package of coaching and service delivery related to antenatal care, including preparation for early and exclusive breastfeeding during pregnancy.

D.3 Expand Community-based Volunteers

The ICH Project proposal described female Village Health Support Group (VHSG) members as being primarily responsible for the projects health promotion activities. However, as defined in the MOH *Policy on Community Participation in the Development of the Health Center,* the primary role of the VHSGs is to ensure the regular flow of information between the community and the HC. This role has already been taxed with the additional responsibilities by other NGOs and government authorities. In effort to avoid overburdening VHSG volunteers, the ICH Project will work with the VHSGs and other community opinion leaders to identify new CRC volunteers to complement and support the work of the VHSGs, effectively expanding the reach of the existing health service delivery chain. Existing and newly recruited CRC volunteers will form

Community Volunteer Care Groups (CVCGs). Each CVCG will consist of approximately 10 CRC volunteers and will have one designated CRC volunteer leader.

D.4 Increase in the Volunteer to Beneficiary Household Ratio

The ICH Project proposal specified a volunteer to household ratio of 1 to 50. Following stakeholder input on best practices in Cambodia and a time/work analysis, it was determined that 1 volunteer to 50 households would require monthly schedule in excess of the 8-10 hour threshold agreed upon during the Phase III DIP workshop and detailed in the *CRC Volunteer Policy Implementation Guide*. Ten hours of volunteer work may be comprised of two one-hour and a half hour women's support/discussion groups and 21 home visit contacts averaging 20 minutes each. The volunteer-household ratio was adjusted so that each volunteer would be responsible for health promotion with no more than 20 beneficiary households. This adjustment increased the planned number of volunteers from 769 to 2,218 (including volunteer leaders and CVCG members).

D.5 Application of the CSSA

Given that there were already a number of elements of sustainability planning in place in the original proposal (organizational development of the Cambodian Red Cross, partnership with Ministry of Health, and strengthening of community structures), project staff decided to more explicitly plan for sustainability. The process of applying the Child Survival Sustainability Assessment (CSSA) framework was begun during DIP preparation. As part of the Phase III DIP workshop, a visioning exercise was completed and the elements to be included in each of the Component and Dimensions were also done.

D.6 Project Budget

Preparation of the DIP has provided an opportunity to refine the associated cost inputs. This refinement has resulted in a $39,093 increase in the size of the total project budget. This budgetary increase has been added to ARC's cost share.

In addition to the increase in the project budget, there has been some movement within each object class category of the budget. As a result, a revised budget and budget narrative have been prepared and can be found in Annex Y. Per the DIP guidance, a revised form SF-424 has been prepared as well and can be found in Annex Z.

E. DETAILED IMPLEMENTATION PLAN

1. Summary of Baseline and Other Assessments

a. Methodology of baseline assessments conducted by the project

KPC – Community Based Maternal and Child Health Survey

A. Survey Instruments: Questionnaires, Anthropometry, and Iodized Salt Assay

Two instruments were used for the survey. One tool collected information on children 0 to 11 months. The second tool focused on children 12 to 23 months. Both instruments were adapted from the KPC questionnaires developed by Catholic Relief Services (CRS)

for its FY-2001 Child Survival project in Battambang Province, Cambodia. The revised instruments were pre-tested in the project area and modified for validity (necessary as the Khmer spoken in different areas of the country is not exactly the same.).

Both instruments collected information on basic demographics, nutrition, immunization status, childhood illness, diarrhea case management, acute respiratory infections, fever/malaria, mosquito net use and maintenance, health contacts and sources of information. The instrument for 0 to 11-month children also included separate modules on maternal and newborn health (MNH) and breastfeeding. The instrument for 12 to 23-month children included separate modules on household water and sanitation and HIV/AIDS knowledge, as well as additional childhood immunization questions.

The split in questionnaires was done to reduce the time needed to complete each interview. This was accomplished by having age-appropriate modules that in a single instrument would otherwise have simply been skipped (MNH, breastfeeding, immunizations) or modules that needed only to be applied to a valid subset of mothers where sample size considerations did not dictate that a full 300-person sample was necessary (HIV knowledge and water/sanitation).

Additionally, the youngest child in each interviewed household was weighed and measured. Electronic weigh-reweigh *AND UC-300* scales and standard metric child measuring boards were rented from Helen Keller International. A salt sample of approximately 30 grams was also collected from each household in a plastic bag and tested for iodine content. Samples were tested using the semi-quantitative assay manufactured by MBI International (Mumbai, India) and supplied by the UNICEF Cambodia field office. This test gives results in 25 parts per million (ppm) increments.

The interview time varied from 30 to 80 minutes depending on whether the child was reported to have diarrhea, acute respiratory infection, or fever within the two weeks prior to the interview. Caregivers with children who were reported sick during this period were asked additional questions about care seeking and illness management in reference to the reported illness. Supervisors ensured that skip patterns in the survey questionnaire were appropriately followed by all enumerators.

B. KPC Indicators

The survey was primarily concerned with collecting data for construction of Rapid CATCH indicators, indicators in the draft program matrix, and indicators included in the Cambodia "Scorecard." Following technical review of the instruments by various stakeholders, additional questions were added to support the development of project activities and strategies. All indicators are expressed following standard definitions according to the *KPC2000+ Toolkit* unless otherwise indicated. Provisional baseline proportions and targets were taken from the original project matrix.

C. Sampling Design

The *KPC 2000+ Field Guide* was used to establish the sampling design. Standard sample size for a 30-cluster sample survey of 10 (total 300) was checked against the most restrictive indicator (stunting) to ensure adequate data collection to achieve a level of precision (alpha error) of 0.05 and power of 80 percent (beta error of 0.2). The value of 137 was computed. This was then rounded up to 150 per cohort (0 to11 month olds and 12 to 23 month olds) to ensure sufficient robustness in the event of refusals (estimated at 10 percent). Therefore, all indicators, including those only in one of the questionnaires, had sufficient sample size by these standard criteria.

The master list of villages was used as the sampling frame for selection of clusters. This master list was constructed from three different population lists provided by the OD administrator during a planning and coordination visit before the survey. These lists were cross-checked and found to be mostly consistent. Four villages previously identified in other ADs were recategorized to Pourk AD. A master list with cumulative population totals was constructed to include all villages on all three lists. Discrepancies in population numbers were resolved by using the numbers from one list that had more detailed information that generally had slightly higher populations and was assumed to be more recent and more accurate (as the initial estimate was from early 2004). The number of households within each cluster was increased to 11 to obtain a total sample of 333. This was done to arrive at an estimated 300 final usable questionnaires, taking account of possible refusals or incorrectly completed surveys. The total estimated population of the AD in the sampling frame (199,828) was then divided by 30, giving a sampling interval of 6,661. A start number was randomly selected and 30 clusters were identified using the sampling interval.

Following the selection of the 30 clusters, two additional clusters were selected in the Varin Administrative District (AD) to permit more precise and therefore meaningful inter-AD comparisons of some indicators (see data analysis section below). During data collection, it was discovered that two clusters were in villages too small to have enough households with children targeted by the survey. The total number of surveys completed was 347 (out of a possible 352).

Before beginning the field level data collection, a second round of meetings was held with all AD governors to review the selected villages and to identify their location on a detailed map. Each AD governor recommended a routing and visit schedule for each survey team. Each AD governor assumed responsibility to notify each selected village of the survey and schedule.

At the village level, the supervisors met with the village chief to sketch a village map or used one provided by the commune administrator. Each team divided into two or three sub-teams (depending on supervisor coverage) and was assigned to begin work according to the most visually logical beginning, end, and center points of the village. Each enumerator team of two people went to its starting point, skipped two houses, and interviewed the members of the next house that had a child less than 24 completed months of age (either the 0 to 11 or the 12 to 23-month cohort). This procedure was followed until each enumerator team completed its assigned number of interviews for that

village. Each two-person sub-team was tasked to complete five interviews per cluster. The supervisor was responsible for completing the remaining interview. Teams with three sub-teams divided the work by having two teams complete four interviews and the third team complete three interviews.

D. Training

The ARC senior monitoring and evaluation technical advisor was the survey team leader and oversaw all aspects of the survey planning, training, and fieldwork. Survey supervisors all had previous experience with community-level data collection and survey interviewing. All enumerators were literate and minimally had a high school education; all except one were female.

The enumerator training was conducted for three full days from March 9 to11 at the Angkor Chum OD offices. The training agenda included project background, survey objectives, review of questionnaires, practice sessions, demonstration, and logistics/scheduling. Two midwives withdrew after the first day of training because of family obligations. Two staff members from the OD replaced them, and were paired with CRC supervisors during the remainder of the training to ensure comprehension.

Following the completion of the survey, all teams participated in a joint debriefing session that included a discussion of lessons learned and best practices. Feedback from this session has been transcribed and supported the planning process.

E. Data Collection

A field data collection schedule was developed with the AD governors to organize teams and assign villages according to geographic proximity. Note that geographic proximity refers to the relative distance between the selected villages and a logical sequence for traveling without retracing routes, rather than simply those villages that were most convenient to the road. Three supervised teams were deployed in separate vehicles to each of the targeted administrative districts to complete household interviews following the schedule; data collection was undertaken from March 12 through March 20, 2005. Each team had two supervisors, one national staff member, and one international staff member, plus the designated enumerators. Supervisors and national staff members also conducted interviews on an as-needed basis and to reinforce the survey training methods.

Field teams participated in coordination and debriefing meetings, which were held each afternoon following that day's data collection. This gave each team the opportunity to correct forms and review any questions or concerns. After the first day, survey teams had progressively fewer questions about how to ask questions or code responses. The overall survey team leader had regular communication with all team supervisors to ensure progress and respond to questions generated during data collection, either via phone, radio, or in person, depending on communication technology limitations.

F. Data Entry and Analysis

Data was entered, processed, and analyzed using EPI-INFO 3.2.2. ARC headquarters staff prepared the electronic questionnaires. An independent consultant entered the data from March 23 to 26, 2005. The ARC health project officer cleaned, recoded, and analyzed the data, a process that took approximately seven days after the completion of data entry.

Administrative District (AD) level statistics were calculated by separating the additional clusters from Varin to check for statistical differences. When no statistical differences were detected (using 95 percent confidence interval), the data was pooled to further improve the level of precision of the point estimates.

Health Facilities Assessment

Because of the wealth of available information from recent, comprehensive, and high-quality health facilities' assessments covering Siem Reap, it was agreed that there would be limited primary data collection done by the project for the assessment of the health facilities.[4] Data from existing reports was reviewed. In particular, the most useful sources of information were:

- PLAN 2003 HFA of several ODs in Siem Reap
- URC 2004 HFA of seven provinces including Siem Reap
- RACHA 2000 HFA focusing on family planning services

To validate relevant findings from the HFAs cited above, five of the twelve minimum package of activities (MPA) HCs in Angkor Chum OD were visited from March 28 through June 1. The HCs visited were Pourk, Char Chhouk, Angkor Chum, Suay Sor, and Teuk Vil. The results are further discussed in Annex P.

Qualitative Studies and Key Informant Interviews

Relevant qualitative studies were reviewed to further develop appropriate behavior change communication strategies. These studies included the following:

- *Draft* Formative Research Report on Breastfeeding Practices in Cambodia, Creative Brief, and trip report documents, Linkages/IYCF Working Group Linkages IYCF preliminary documents generated from 12/04 and 3/05 field visits
- Community Terms and Beliefs Regarding Childhood Illness, RACHA
- Summary Report of Community Based Interventions for Nutrition, CRS
- Immunization Delivery Modalities and System Constraints, PATH
- Cultural Perceptions of Diarrhea, Dehydration, and Diet: Factors Influencing Health Seeking Behavior in Cambodia, Hollis DL

Drawing on the wealth of CS project implementation experience in Cambodia, key informants from the MOH, PVOs, and NGOs were interviewed to better understand best practices and lessons learned as they relate to sustained health behavior change. Feedback was also solicited from local stakeholders to better understand the challenges to

[4] BTC is finalizing a HFA which included all HCs in Angkor Chum OD. The report was not available at the time of writing the DIP for inclusion.

improving health in Angkor Chum OD including availability and access to health services and products.

Market Study

The ICH Project targeted three health products that ICH for increased utilization:

- Iodized Salt
- Oral Rehydration Salts (ORS)
- Bednets and Insecticide Treated Nets (ITNs)

A brief market study was undertaken to better understand availability and access of each of these products through private retail outlets. The market study was not meant to be an exhaustive or definitive examination of the salt, ORS, and ITN market in Siem Reap, but rather a rapid assessment to corroborate findings from the KPC and reports from local stakeholder key informant interviews.

Three modules were developed – one for each of the products in question (iodized salt, ORS, and bednets). Other agencies and PVOs were consulted in the construction of the instruments. The survey instruments have been included in Annex S along with the tabulated results. Two interviewers from the Cambodian Red Cross were trained in the use of the instruments. In April 2005, a convenience sample was chosen by going to the market area of various towns and villages in the project area. Vendors of varying sales volumes and in various parts of the project area were surveyed. The interviewers applied one module for each product sold among each vendor interviewed. Ten vendors were surveyed. The results were tabulated by hand.

b. Comparison of baseline findings to previous data

The most complete and reliable data source for comparison of the KPC data is the DHS 2000. There was a separate analysis within the DHS 2000 for Siem Reap and Oddar Meanchey provinces. The findings from the DHS 2000 were discussed in the situation analysis in the proposal. A summary table included in the proposal is reproduced in part below and supplemented with data from the KPC to compare baseline findings with the expected values from the assessment. The DHS 2000 data is for U5 and the KPC for U2, but similar values would still be expected.

Overall, the data collected in the KPC gives a substantially better impression of the health situation than was expected. Child immunization rates, insecticide-treated bed net coverage, and access to sanitation were among those indicators which remained at low values. A range of other indicators were substantially improved – child nutritional status, vitamin A supplementation, breastfeeding, and care of the sick child. These data suggest that there has been a substantial underlying improvement in the population's health. One of the most radical indicator shifts was in the consumption of iodized salt (from 4 percent to 64 percent). This data is undeniably reliable as it comes from a simple, rapid, quantifiable chemical test. The DHS 2000 data comes from a time only one year after the central government was able to assert control over this territory and establish public health institutions. There was also very little commerce with areas outside of the area at the time, explaining the lack of iodized salt in 1999. The booming tourist industry

in Siem Reap town and concentrated efforts of several NGOs and the MOH have undoubtedly had an impact on public health in Angkor Chum OD. The project will track the expected improvements in human development in the area as part of the establishment of the Child Survival Sustainability Assessment framework. This will aid in assessing attribution of any health gains during the project period to the specific project interventions. In any case, the targets for several key indicators were changed after reviewing the changed situation indicated by the KPC data.

Table 3: Health and nutrition statistics from KPC compared with data from DHS 2000 (all figures are %'s)

	KPC (U2)	**Rural Siem Reap (U5)**	**Cambodia National (U5)**
Nutrition and Breastfeeding			
Children ≤ –2SD weight for age	35.7	74.1	45.0
Children who received VAC in past 6 months	48.3	8.5	28.5
Children living in households with adequately iodized salt	64.0	4.1**	12.2
Infants who started breastfeeding within one hour of birth	42.8	7.3**	11.0
Infants under 6 months exclusively breastfed	38.4	19.6*	11.2
Immunization			
Children 12-23 months fully immunized	34.1	33.8	39.9
Births in past 12 months, mother received 2+ TT in pregnancy	59.9	14.9	30.0
Child Health			
Children with diarrhea who received ORS	32.2	10.3	17.8
Children ill with fever and/or ARI*** treated in medical sector	67.0	27.8	34.5

Data Source:
CDHS 2000, Secondary Data Analysis and Tables 12.5, 12.17, 12.19, 12.23, 13.1, 13.9, 13.12, and 13.9
* Province-wide statistic as sample sizes are too small to disaggregate by rural-urban residence.
** Statistic for combined Siem Reap/Oddar Meanchey provinces
*** Defined as cough accompanied by short rapid breathing

c. Constraints to achieving program objectives

Quality of services at the HC level is a major determinant of care seeking behavior. HC quality issues were identified by multiple stakeholders throughout the detailed implementation planning process and documented in the URC, PLAN, and RACHA health facility assessments. The sustained success of improved care seeking at the HC will be largely dependent on improvements in service quality. Both RACHA and BTC are supporting programming which focuses on quality at the HC level.

The baseline HFA data from URC indicates that Siem Reap has some of the best infrastructure, trained and supervised staff in terms of delivering the MPA services relevant to the project. Also, BTC will be working on overall health services quality improvements and RACHA in rolling out clinical IMCI, complementing the access and behavior change interventions of the ICH project.

The PLAN HFA, done in neighboring ADs of Siem Reap, also specified in more detail the exact nature of sorts of constraints that the issue of perceived low quality of services can have on the project and the solutions proposed by the project:

- *Problem:* Many are inappropriately "jumping the queue" and going straight to the Siem Reap City Hospital.
  Solution: Improving the quality of care and the *perception* of the quality of care at peripheral facilities will be critical to rationalizing health care utilization. This will be taken account of in the community-based communications materials for IMCI that are used through the volunteer network.
- *Problem:* 4 in 5 initial contacts with the health system are not through the MOH but rather with private drug sellers or other private providers.
  Solution: Market sellers are being trained by RACHA in appropriate first line treatment and social marketing of selected health products through their shopkeepers program.
- *Problem:* User fees have acted as a barrier to care seeking.
  Solution: The Belgian Technical Cooperation Agency and others in the project area are addressing this problem by using mystery clients to test for standard fees. HCs which are found to be charging outside of the fee schedule set by the VHSGs will be docked from the monthly HC cash incentives, as per the signed contract. The ICH project will coordinate closely with BTC.

d. Disease surveillance data

Health facilities data from 2003 for two other similar ADs in Siem Reap analyzed by PLAN show that the following were the most common reasons for consultations for 0-4 year olds: lower ARI, simple diarrhea, dysentery, upper ARI, and malaria. KPC data confirm the frequent nature of ARI, diarrhea, and malaria/fever. A full 1/3 of children sampled had had symptoms of one of these three conditions in the last two weeks. These are the target conditions whose improvement will give the most impact.

e. Up-to-date coverage estimates / Quality of existing services

Coverage for most services is quite low. Outreach activities for nutritional interventions like growth monitoring and promotion (GMP) and breastfeeding promotion (BF) were found to be variable across ADs in the KPC and HFA data analyzed, but are not considered adequate in any of them. According to the Baseline KPC, vaccination coverage in the project area is 34 percent (complete vaccination rate for 12-23 month olds). In terms of sick child interventions, RACHA has begun to roll out its health worker training for IMCI and is planning on completing this training by the end of 2005. Table 4 summarizes the MPA Health Center data for Siem Reap as a whole. This data was extracted from the URC HFA done in 2004 and recorded several inputs including HC equipment, infrastructure, supplies and essential drugs as adequate. Combining this with the planned improvements in staff knowledge and practice that will occur through the BTC and RACHA projects, ICH project staff does not expect health services quality to be a serious constraint to improved services delivery, especially for those facility-based services for which the project expects to increase demand (pneumonia and malaria treatment). In any case, community-based case management for pneumonia and malaria is not an option as this would run counter to MOH policy.[5]

[5] However, the OD director stated that he is looking into the possibility of equipping VHSGs with a limited, emergency supply of ARI and malaria drugs to improve access.

Table 4 – Summary of HFA Data from URC for Siem Reap MPA HC services

URC HFA Table	Area of Assessment	% HC in SR to norm	SR Better/ Worse than Avg.	Comments
	INPUTS: GENERAL			
A-1	% MPA HC – **infrastructure** (elec., water, toilet)	88-100%	=	
A-81	% MPA HC – **essential equipment** (scale, stethoscope, fetoscope, thermom., etc.)	63-100%	–	No otoscopes
A-80	% MPA HC – **essential supplies** (injections, solutions, gloves, etc.)	38-100%	=	38% partographs
A-2	% MPA HC – **norms and manuals** (management., ARI, diarrhea, TB)	88-100%	+	
A-5	% MPA HC – **initial training**	63-100%	+	No HIV
A-82	% MPA HC – **IEC materials available for posters** (Imm., Nut., ARI, W/S)	75-100%	+	
A-83	% MPA HC – **IEC materials available for leaflets** (Imm., Nut., ARI, W/S)	13%	=	Imm75% /others13%
A-84	% MPA HC – **IEC materials available for flipcharts** (Imm.,Nut.,ARI, W/S)	13%	=	No Nut., ARI
A-4	MPA HC – **avg. no. staff** providing health services	9.3	–	
	INPUTS: STAFF KNOWLEDGE			
A-7	% MPA HC staff – correct knowledge of **immunization schedule** (all EPI vaccines)	100%	+	
A-8	% MPA HC staff – correct knowledge of **filling immunization card**	100%	+	
A-9	% MPA HC staff – corr. knowl. of how to **identify malnourished child**	13 – 75%	=	Weight/Age 75% MUAC 13%
A-10	% MPA HC staff – corr. knowledge - **providing vitamin A to children**	63 – 75%	+	
A-11	% MPA HC staff – correct knowledge of **assessing child with diarrhea**	38 –100%	+	Lacking in several areas
A-12	% MPA HC staff – correct knowledge of **treating child diarrhea** (without dehydration)	50 –100%	+	Need for F/U weak
A-13	% MPA HC staff - correct knowledge of **assessing a child with ARI**	63 –100%	=	Count RR 100% Resp. distress 63%
A-14	% MPA HC staff – corr. knowledge of **treating child with pneumonia** (simple)	63 –100%	+	Antibiotics 100% Home care/F/U 63%
A-15	% MPA HC staff – corr. knowledge of how to **assess child for malaria**	63 – 88%	=	Generally good
A-16	% MPA HC staff – correct knowledge of **treating child for malaria**	25 – 88%	+	AM3/AM2 88% Quinine 25%
A-17	% MPA HC staff – correct knowledge of **prevent child malaria**	100%	+	
A-32	% MPA HC staff – correct knowledge of **advantages of EBF** (exclusive breastfeeding)	38 –100%	=	Prevent diarrhea 38% Prevent illness 100%
A-33	% MPA HC staff – corr. knowl. **advantages of breastfeeding post- del.**	100%	+	
A-34	% MPA HC staff – correct knowledge of **IEC after delivery**	25 – 88%	–	Low – HIV/vit A High – BF, imm., nut
A-105	% MPA HC staff – know **mon. and eval. of comm. outreach activities**	63 – 88%	+	

URC HFA Table	Area of Assessment	% MPA in SR to norm	SR Better/ Worse than Avg.	Comments
	PROCESSES			
A-3	% MPA HC – **annual plan & monthly reports** complete/updated (annual plan, child consults, ANC, EPI, Birth Spacing)	100%	+	
A-63	% MPA HC – **received PAP funding** (Priority Action Pgms.)	100%	+	
A-62	MPA HC – avg. **amount of user fee** generated per mo.	0 – 90 K Riel/mo.	=	No HC recd. > 90K ($25)
A-64	Avg. no. **supervision visits** received from OD in last 6 mo.	8.0	+	Higher than PP (5.8)
A-65	% MPA HC – **received feedback from the OD** during supervision	25%	–	Quite poor. Little prob. solving
A-6	% MPA HC – **received refresher training**	0 – 13%	–	Very poor
A-69	% MPA HC – **available drug stocks**	88 –100%	+	Except Tetracyc. (25%)
A-70	% MPA HC – **stock-out of essential drugs**	25 – 75%	+	
A-73	% MPA HC – **available anti-malaria drugs**	50 – 88%	+	AM2,3,4 = 88% Quinine 50%
A-74	% MPA HC – **stock-outs of anti-malaria drugs**	13 – 50%	+	AM2,3,4 13% Quinine 50%
A-85	% MPA HC – **assets management**	low	–	Maintenance pgm. in place but no $$
A-87	% MPA HC – **infection control**	±	=	Handwash good Disposal poor
A-92	% MPA HC staff – **correctly asks and checks during ANC**	72 –100%	+	72% illness Hx 100% clinical check
A-93	% MPA HC staff – **provides iron, folate, TT and make next appt.**	±	=	**29% TT** 86% Fe/folate
A-94	% MPA HC staff – **provide maternal health IEC during ANC**	±	+	Good:nut,BF,deliv Poor: vit A,HIV
A-95	% MPA HC staff – giving **maternal health education during ANC**	57 – 86%	+	Poor: F/U Good: Anemia, danger, TT
	OUTPUTS			
A-96	Avg. no. **ANC, delivery, and PNC clients** per month	57 ANC visits/mo.	+	Highest volume of all provinces
A-97	% **WRA covered by FP services** by HC per month	19%	+	Mainly OC (11%)
A-99	**Couple Years Protection** (CYP) per WRA per HC	11.7	–	
A-100	Avg. no. **child illness clients** per month	7.3 – 10.8	–	7.3 diarrhea 21.1 ARI
A-101	Avg. no. **micronutrients provided** (Fe, vit. A) per month to children	340.2(vitA) 3,457 (Fe)	=	Svc. stats c/w 25% covg. (vit. A)
A-104	% MPA HC – **community outreach activities** in each village	38 –100%	+	CO more likely if NGO present

f. MOH policies and strategies for each intervention

Relevant Cambodian government strategies are outlined in the matrix included as Annex K. The project has incorporated the Cambodia "Scorecard" as an integrated part of the indicators against which it will report. This scorecard cuts across all ICH interventions. The MOH strategy includes coverage of catchment areas surrounding health centers (HC) with a minimum package of activities (MPA), interfacing with those communities through the Village Health Support Group (VHSG). The ICH Project aims to strengthen the community component of the MPA mainly through strengthening the outreach component through with growth monitoring and promotion (GMP) and vaccinations are delivered. This can act as a platform for BCC activities for care of the sick child as well. The volunteer structure built up by the ICH project will be an auxiliary to the VHSG. This auxiliary role is already contemplated for the CRC in MOH policy.

The project is supporting other policy initiatives in each of the strategic objectives. In SO1 (Nutrition), the MOH policy for IYCF is to implement the WHO Baby Friendly Hospital Initiative (BFHI) and a community-based IEC/BCC strategy. For the former, the project will coordinate with other actors working at that level. In terms of the BCI and communication strategy for IYCF, the ICH project team participated in the most recent meetings on IYCF with Linkages, the MOH, and other PVOs. GMP is another MOH strategy that is central to the ICH project. The MOH immunization strategy for increasing EPI coverage is through village outreach and NIDs, both supported by the project. In terms of care of the sick child (SO3), the MOH adopted IMCI in 2001 but has yet to implement it in the project area. ICH Project will be coordinating with RACHA as it rolls out IMCI in the districts.

g. Discussion of Rapid CATCH Indicators

The 13 Rapid Catch indicators of the KPC are collected by all USAID Child Survival grantees. The Siem Reap ICH Project has selected 11 of these indicators to target for project impact as summarized below. All values were lower than corresponding national 2000 DHS data.

Table 5 ICH Strategic Objectives and corresponding Rapid Catch Indicators

Strategic Objective	**Rapid Catch Indicators**
SO1: Nutrition	1-Stunting 2-Child spacing 3-Skilled birth attendant 5-Exclusive breastfeeding 6-Complementary feeding
SO2: Immunizations	4- Tetanus toxoid 7-Full vaccination 8-Measles vaccination
SO3: Sick Child/C-IMCI	9-ITNs 12-Danger signs 13-Increased feeding during illness

In terms of child spacing, RACHA is supporting modern family planning methods to improve access through the HCs and outreach activities. The ICH Project will support child spacing through promotion of LAM as it relates to early and exclusive breastfeeding. The child spacing data from DHS 2000 shows that 79% of women had a birth interval of 24 or more months, versus the KPC finding of 42%. For skilled birth attendance, the DHS 2000 data gives a value of 32% versus the KPC finding of 15%. Finally, in the DHS 2000 69% of women could cite two or more methods for preventing HIV transmission, versus the KPC finding of 13%.

Table 6 - Rapid Catch Indicators and Results

No.	Intervention	Indicator	Num.	Denom.	Statistic	CI
1.	All	Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	122	342	35.7%	± 8.1%
2.	Child Spacing	Percentage of children 0-23 months who were born at least 24 months after the previous surviving child	16	38	42.1%	± 25.9%
3.	MNC	Percentage of children age 0-11 months whose births were attended by skilled health personnel	27	177	15.3%	± 7.8%
4.	MNC	Percentage of mothers with children age 0-11 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	106	177	59.9%	± 13.5%
5.	Nutrition	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	43	112	38.4%	± 18. %
6.	Nutrition	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	49	60	81.7%	± 24.9%
7.	Immunization	Percentage of children age 12-23 months who are fully vaccinated before first birthday	48	141	34.0%	± 17.9%
8.	Immunization	Percentage of children age 12-23 months who received a measles vaccine	151	170	88.8%	± 14.9%
9.	Malaria	Percentage of children age 0-23 months who slept under an insecticide treated net the previous night	6	347	1.7%	± 1.9%
10.	HIV/AIDS	Percentage of mothers with children age 12-23 months cite at least 2 known ways of reducing risk of HIV infection	22	170	12.9%	± 7.4%
11.	CDD	Percentage of mothers with children age 12-23 months who report that they wash their hands with soap/ash at all appropriate moments	1	170	0.6%	± 1.6%
12.	All	Percentage of mothers of children age 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment	201	347	57.9%	± 8.9%
13.	All	Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	65	121	53.7%	± 15.8%

2. Program Description by Objective, Intervention, and Activities

Figure 1. ICH Project Goal, Strategic Objectives, and Intermediate Results

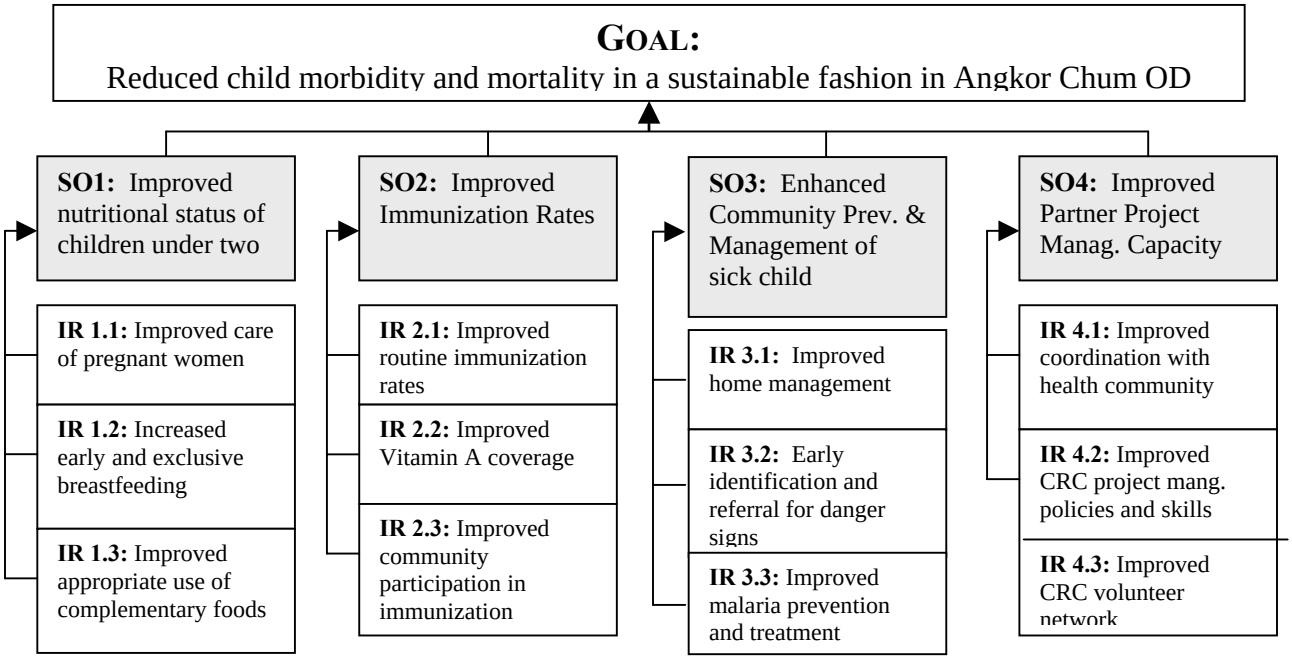
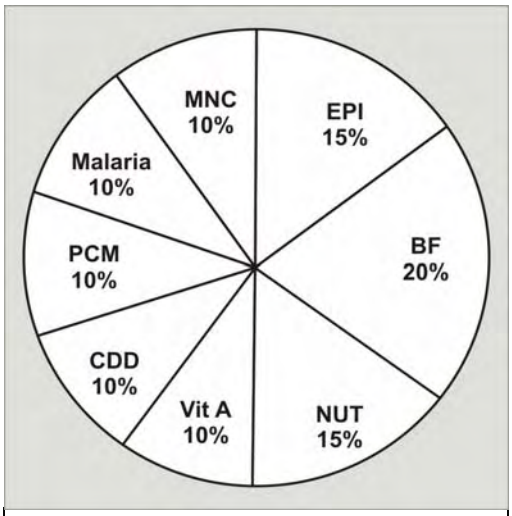


Figure 2. ICH Project Intervention Areas, ICH community-centered strategies will focus on the following intervention areas, with indicated levels of effort:



1. Immunization (EPI)
2. Breastfeeding (BF)
3. Nutrition (NUT)
4. Vitamin A (Vit A)
5. Control of Diarrheal Diseases (CDD)
6. Pneumonia Case Management (PCM)
7. Malaria
8. Maternal and Newborn Care (MNC)

These interventions will be implemented through the following four major ICH cross-cutting **strategies**:

1. **Health education/coaching for behavior change** will be achieved through an extensive network of CRC CVCGs. The ratio of one volunteer to every 20 target households is intended to create a near saturation effect of interpersonal health communication at the village level.
2. **Community mobilization for behavior change** will be achieved by engaging opinion leaders and motivating community-based activities to reinforce health communication through the CVCGs.
3. **Coordination and (continued) involvement** of other implementing partners to ensure synergistic program approaches and local ownership.
4. **Community-based surveillance systems (CBSS)** have been designed to complement and support the existing HMIS while enhancing broader community participation in monitoring basic health statistics at the village level. CBSS will empower communities with information necessary to recognize their accomplishments and identify areas for improvement.

2. Program Description by Objective, Intervention, and Activities

A. SO1: Improved nutritional status of children under two will be achieved through improved antenatal care (IR1), increased early and exclusive breastfeeding (IR2), and improved appropriate weaning with complementary foods (IR3). SO1 will succeed by training and coaching CRC volunteer leaders and community volunteer care groups (CVCGs) to develop strong communication and coaching skills, strengthen knowledge of correct breastfeeding practices, develop skills to help mothers overcome difficulties when breastfeeding, and maintain continuous support through ongoing contact. The ICH Project will build on the breastfeeding training previously provided to VHSG members by RACHA. Trained VHSG members (1 female per village) will support the training to the CVCGs in their respective village.

A.1 Training

Relevant training modules from the *Training Curriculum for Cambodian Community Health Volunteers on IMCI Key Family Practices* are Module 8-Communication skills, Module 1-Breastfeeding and complementary feeding, Module 9-Antenatal care, and Module 10-Breastfeeding, complementary feeding refresher.[6] All modules are comprised of short (30 minute to 2 hour) sub-sessions detailed below.

<u>Module 8: Communication Skills Refresher</u>[7]
8.05 Communication Skills Refresher Role Plays

<u>Module 1: Breastfeeding and Complementary Feeding</u>
1.11 BF Introduction and pre-test
1.12 CHV experiences with BF
1.13 Colostrum
1.14 Exclusive breastfeeding
1.15 Problems with bottle feeding
1.16 Problems with BF and how to solve them
1.17 BF misconceptions
1.18 Complementary feeding
1.19 Using IEC materials and skills practice
1.20 Wrap-up and post-test

<u>Module 9 Antenatal Care</u>
9.01 Introduction and pre-test
9.02 Importance of ANC visits at the HC
9.03 Antenatal danger signs
9.04 Using IEC materials and skills practice
9.05 Wrap up and post-test

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[6] The original module numbering has been used for easier reference to the source document.
[7] Due to the sequencing of activities, volunteers will have received a more complete training on adult learning and communications skills (see SO4) before training on BF, therefore a communication refresher is planned as part of the BF training cycle

Refresher Training Sessions

Module 10: Feeding Refresher
10.01 Introduction and pre-test
10.02 BF review
10.03 Complementary feeding review
10.04 Managing nutritious rice porridge
10.05 Wrap-up and post-test

Module 12: Antenatal Care Refresher
12.04 Antenatal care review
12.05 Nutrition and food taboos during pregnancy
12.06 ANC poster contest

Additionally, support statements developed by the Infant and Young Child Feeding (IYCF) working group in Cambodia will be integrated into breastfeeding training and promotion. These include:

- Breast milk contains antibodies that help the child to fight disease and prevent illnesses such as diarrhea.

- Breast milk alone has all the water and nutrients that the baby needs for the first six months. During this time nothing else is needed to quench the baby's thirst or satisfy hunger, not even water.

- The mother's body will produce as much breast milk as the baby needs. The more the baby is allowed to suckle at the breast the more the mother's body will produce milk. The same thing happens if a mother expresses her milk on a regular basis.

- Breast milk does not have to be purchased from a shop. It can be expressed and stored up to eight hours without refrigeration giving working mothers an economical and healthy option for feeding their young children when they cannot be there.

- Exclusive breastfeeding or LAM is a good birth spacing option for some couples for the first six months after birth. When practiced correctly, the method is at least 99 percent effective at preventing pregnancy.

This training curriculum will be reviewed and supplemented with training on the Lactation Amenorrhoea Method (LAM) of birth spacing and the *Growth Monitoring Training Curriculum and Lesson Plans*[8]. The latter will support community-based weight monitoring to be linked with health center outreach services. Relevant lesson plans are detailed below.

[8] Helen Keller International/Cambodia and The United Nations World Food Programme, 2002

Growth Monitoring
3. Importance of the yellow card
4. Recording information on the yellow card
5. Nutrition education
6. How to weigh the child
7. The growth chart, birth weight, and birth month
8. Plotting the child's weight
9. The growth curves and color interpretation
10. Interpreting the growth curves
11. Interpreting the direction and position of the growth curve

A.2 Interventions and Activities

A.2.1 Improved care to pregnant women

The ICH project will work to influence change in behaviors that negatively impact on nutritional status through intensive (at least bi-weekly) visits by CRC CVCGs and trained TBAs to households with pregnant women and newborns. CRC field officers and village opinion leaders will also conduct follow-up visits to these households as determined necessary and appropriate. Additionally, CVCGs will convene mothers to promote improved health practices related to antenatal care and breastfeeding through sharing of experiences and mutual support. Through home visits and mothers' groups, pregnant women will be repeatedly counseled to:

(1) improve attendance for ante-natal care;
(2) receive at least two tetanus toxoid injections before child birth (TT2)[9];
(3) receive iron folate;[10]
(4) consume Vitamin A rich foods;
(5) recognize pregnancy danger signs;
(6) plan and arrange for skilled health personnel (see below) to attend the delivery;
(7) understand the benefits of immediate and exclusive breastfeeding following birth (including skin-to-skin messages);
(8) plan for immediate and exclusive breastfeeding following childbirth.

ICH project staff will work with HC staff to set up a system to provide free or highly subsidized ITNs to pregnant women as an incentive for seeking ANC care (see Section C.2.3), with distribution following completion of two shots of TT as recorded on the pink index card currently used to track ANC services. CVCG members will promote ANC

[9] Women will be counseled that they need two doses of TT prior to delivery but they need only five doses over the course of their reproductive life.
[10] Both TT2 and iron folate for pregnant women are included in the basic outreach package for near villages as detailed in the *Guidelines for Outreach Services from Health Centers.*

attendance and awareness of this incentive to newly pregnant women among their catchment households during regular home visits.

In relation to planning and arranging for skilled health personnel, HC staff will be promoted as definitive first choice to attend delivery. Trained TBAs with clean delivery kits will be recommended as an alternative if skilled health personnel cannot be arranged from the HC.[11] Delivery by non-trained TBAs will be discouraged at all levels of the ICH project.

Post-partum women will be encouraged to continue consumption of Vitamin A-rich foods in addition to seeking Vitamin A supplementation during routine health center outreach (within eight weeks of childbirth). For special cases, provision of VAC in the home will be explored through the VHSG.

A.2.2 Early and exclusive breastfeeding; appropriate weaning for children six to nine months of age

Pregnant women will receive ongoing coaching for improved breastfeeding practices through both home visits and mothers' groups. Counseling during pregnancy will prepare mothers for the challenges of early and exclusive breastfeeding and help them to alleviate stress and family pressure, which can lead to poor breastfeeding choices and post-partum practices (see Khmer Beliefs, Knowledge, and Practices as Barriers to Behavior Change below). All households with newborns will be targeted for a visit within one day of delivery to follow up exclusive breastfeeding counseling. These households will be targeted for intensive visits by CRC CVCGs to continue support for exclusive breastfeeding for six months.

Breastfeeding messages will focus on addressing the many cultural barriers to early and exclusive breastfeeding (see Khmer Beliefs, Knowledge, and Practices as Barriers to Behavior Change below). For example, the Lactation Amenorrhoea Method (LAM) of birth spacing will be promoted for mothers of newborn children as a strategy to prevent breastfeeding cessation, which follows from the belief that breastfeeding should not continue during pregnancy. CVCGs will promote appropriate introduction of complementary feeding from six to nine months of age through coaching during continued home visits following the training modules detailed above.

The pink index card, sometimes used to track services for pregnant women, will be promoted. Home visits, different counseling sessions about pregnancy danger signs, tetanus toxoid injections, and VAC distribution can all be noted on the previously printed card by a hole puncher, kept by the mother or an older child in the household. Households with perfect coverage would qualify for incentives (flying the model household flag) and be witnesses to recording the information on the village recording forms.

[11] Trained TBAs with clean delivery kits are mostly available in Angkor Chum OD, resultant of RACHA's work.

Community growth monitoring for U2s will be conducted by CRC volunteer leaders and CVCGs to supplement services provided during health center outreach. CRC volunteer leaders will interview mothers of children who have not gained weight since the previous measurement to identify underlying reasons and to negotiate solutions. CRC volunteer leaders will record notes from these interviews and review these with CRC field officers during monitoring and coaching visits. Households with children U2 who did not attend outreach services or are not gaining weight will be targeted for more intensive (at least bi-weekly) visits by the CVCG to ensure monitoring and weight gain.

The ICH Project will work with television, radio, and newspapers to publicize exclusive breastfeeding 'model mother' success stories and testimonials. The ICH project will explore the possibility of launching small (five villages) pilot projects to test and apply formative research recommendations of the Infant and Young Child Feeding (IYCF) Working Group to overcome the barrier of work outside of the home to exclusive breastfeeding.

B. ***SO2: Improved immunization rates*** includes intermediate results (IRs) relating to improved routine vaccination of measles, DPT3, Polio3, and BCG, improved Vitamin A coverage, and improved community participation for immunization. Currently, each health center provides outreach services to all villages within its catchment area monthly or bi-monthly.[12] The basic outreach package for near villages[13] includes immunization, Vitamin A, health promotion focusing on key family practices including dengue hemorrhagic fever, distribution of ORS, iron folate, birth spacing services, bi-annual de-worming and follow-up on defaulters for TB and leprosy. The expanded outreach package for remote villages also includes antenatal care and symptomatic malaria treatment.

SO2 will focus on community education for behavior change, community participation, and mobilization to enhance demand for and use of routine health center outreach services.

B.1 Training

The relevant training modules from the *Training Curriculum for Cambodian Community Health Volunteers on IMCI Key Family Practices* is Module 7-Immunization and one section of Module 2-Micronutrients. These modules will be preceded with a review of communication skills (Module 8). Relevant module sub-sessions are detailed below.

[12] As per the *Guidelines of Outreach Services from Health Centers*, outreach once every two months is considered acceptable for remote communities during the rainy season when access to the village by HC staff is exceedingly difficult; outreach activity was independently reported to be high by OD staff and midwives

[13] Near villages are defined as within 10 kilometers of the health center.

Module 8: Communication Skills Refresher[14]
8.05 Communication Skills Refresher role plays

Module 7: Immunization
7.01 Introduction and pre-test
7.02 Immunizations and side effects
7.03 Yellow Card
7.04 Visit to immunization outreach session
7.05 Making household visits
7.06 Using IEC materials and skills practice
7.07 Wrap-up and post-test

Module 2: Micronutrients
2.03 Vitamin A
2.04 Iron deficiency anemia in children

Refresher Training Sessions

Module 12: Immunization refresher
12.02 Immunization review and immunization myths
12.03 Handling immunization dropouts

B.2 Interventions and Activities

B.2.1 Immunizations

CRC volunteer leaders will support VHSGs to disseminate information about planned health center outreach to the community through the CVCG home visits and mothers' group meetings. In coordination with the VHSGs, CVCGs will complete mapping exercises to identify pockets of non-vaccinated children. Once identified, CRC field officers will work with the VHSG and the CVCG to jointly investigate the causes of partially or non-vaccinated children using the WHO *Guidelines for Community Feedback on Immunization Services* to understand barriers and resistances to access. A joint action plan will be developed among local stakeholders to remove barriers and address resistances with the aim of improving access to and utilization of routine vaccination outreach services.

CVCGs will provide information and education to their communities with special attention to geographic clusters of non-vaccinated children. Education and information will include promotion of yellow cards, vaccination outreach scheduling, and child eligibility criteria while promoting an awareness that vaccines are free, safe, protective, and should be repeated. CVCGs will also provide information on the benefits of vitamin A supplementation in advance of enhanced outreach activities that include Vitamin A capsule (VAC) distribution in March and November.

[14] Due to the sequencing of activities, volunteers will have received a more complete training on adult learning and communications skills (see SO4) before training on BF; therefore a communication refresher is planned as part of the BF training cycle

Health center outreach days will be announced through schools, pagodas, and farmers associations. The use of flags, banners, and megaphones will be explored to further encourage turn out.

Following a highly successful model in Indonesia[15], the ICH project will promote student competitions to improve vaccination and Vitamin A supplementation coverage. Each student will be asked to locate and register two children U1 and follow them throughout the immunization schedule to ensure that they attend outreach each month. Students will copy each registered child's vaccination card onto a fresh blank card and update immunizations given.

CVCG members will track outreach attendance through a series of cards, stickers, yarn knots, flags, and other visible measures that allow schoolchildren and other members in the community to help motivate and manage community performance. CRC volunteer leaders will support the village chief or VHSG to maintain a vaccination defaulter follow-up registration book for all children. This book will be shared with the HC outreach team as a 'due' list so that the team knows who need to be vaccinated. The registration book will be linked to PLAN's birth registration project at the village level.

B.2.2 Vitamin A

The benefits of VAC and iron folate will be promoted by CVCGs through regular home visits. Pregnant women will be coached to improve consumption of Vitamin A rich foods. Post-partum women will be targeted for Vitamin A supplementation to ensure that they receive a capsule within eight weeks following delivery. This will be accomplished through the intensive home visit intervention described in Section A.1 above.

Following health center outreach activities, CRC volunteers will discuss lessons learned with the VHSG to improve coordination, and so that feedback may be communicated to the health center as appropriate.

C. ***SO3: Enhanced community prevention and management of the sick child*** will be achieved through improved home management of sick children, early identification and referral for danger signs, and improved malaria prevention and treatment. SO3 will focus on increasing knowledge and recognition of danger signs in the home, community monitoring of sick children, referral from the village to the HC, improving coverage and use of insecticide treated bed nets, as well as improving handwashing practices during critical moments.

C.1 Training

The relevant training module from the *Training Curriculum for Cambodian Community Health Volunteers on IMCI Key Family Practices* is Module 3-Home Care. Module 3 is comprised of eleven short sub-sessions detailed below. These modules will be preceded

[15] World Health Organization, Imaginative Ways of Raising Immunization Coverage, August 1997

with a review of communication skills (Module 8). Relevant module sub-sessions are detailed below.

Module 8: Communication Skills Refresher[16]
8.05 Communication Skills Refresher Role Plays

Module 3: Home Care
3.01 Introduction and pre-test
3.02 Home care for a sick child or child with a slight fever
3.03 Home care for a child with a high fever
3.04 Home care for a child with diarrhea
3.05 Identifying severe dehydration
3.06 Making/mixing oralit (ORS)[17]
3.07 Review
3.08 Home care for child with cough or cold
3.09 Recognizing danger signs
3.10 Using IEC materials, role-play, and review
3.11 Wrap-up and post-test

Module 5-Malaria
5.01 Introduction and pre-test
5.02 Malaria transmission cycle
5.03 Insecticide treated bed nets
5.04 Malaria danger signs
5.05 Malaria review game and practice
5.06 Wrap-up and post-test

Handwashing[18]
1. Transmission routes (F-diagram activities)
2. Blocking transmission
3. Handwashing critical moments
4. Use of soap and ash
5. Handwashing correct practice
6. Addressing misperceptions and resistances

[16] Due to the sequencing of activities, volunteers will have received a more complete training on adult learning and communications skills (see SO4) prior to training on prevention, therefore a communication refresher is planned as part of the prevention training cycle
[17] ORS training will be supplemented with information on zinc to provide volunteers with complete information concerning the PSI Diarrhea Treatment Kit (DTK)
[18] The *Training Curriculum for Cambodian Community Health Volunteers on IMCI Key Family Practices* has no modules related to handwashing. Training and IEC material is currently being compiled by the Ministry of Rural Development's Department of Rural Health Care and will be presented at a Water Use and Hygiene Education Workshop in Phnom Penh from July 27-29, 2005. Training subjects listed here are illustrative and will be reviewed in detail and revised following the workshop.

Training Refresher Sessions

Module 11: Home Care Refresher
11.02 Review of home care for child with cough or cold
11.03 Review of recognizing danger signs
11.04 Seeking care and following health workers' advice

These sessions will be complemented by PSI training on sales techniques, cash, and stock card management related to social marketing activities described below.

C.2 Interventions and Activities

C.2.1 Improved home management of sick child

CRC CVCG members will provide basic education on home care for the sick child to each of the 20 households for which they are responsible through home visits and mothers' group meetings. CVCGs will monitor all households for sick children with special focus on children U2. Households with sick children will receive a visit within two days of illness onset and a follow-up visit, scheduled in accordance with the severity of the illness.

To support improved home management of diarrhea, the ICH project will sell Diarrhea Treatment Kits (DTK) using a social marketing scheme currently under development by PSI/Cambodia. The DTK will bundle 2 packs of low osmolarity ORS with 10 tablets of 20 mg. dispersible zinc and a consumer insert containing information on correct use, danger signs, prevention and messages on continued feeding. The DTK will offer a "1-2 punch": rehydration and reduction of severity. DTK will be sold by CRC volunteer leaders and CVCGs with the intent of making DTK more available then antibiotics and antidiarrheals. RACHA is planning on selling DTK through its shopkeeper program. Pricing will be fixed so that neither initiative undercuts each other's sales. CRC volunteers will keep a small profit margin for each DTK as an incentive for their work. Currently, the OD is supplying VHSGs with ORS for free emergency distribution. Guidelines will need to be agreed upon among the OD, RACHA, and ARC/CRC in order to limit free distribution of ORS for true emergency situations.

Zinc is a new product in Cambodia. The concept of water-soluble tablets is not common, especially in the rural areas. Additionally, the treatment recommendation (one tablet dissolved in water for children 6 months to 5 years of age for 10 consecutive days even if diarrhea episode has stopped[19]) is not consistent with the treatment recommendation for ORS (continuous until diarrhea episode has stopped). These issues complicate communication for correct and concomitant use of both products. PSI/Cambodia has undertaken formative research (in Siem Reap) to make the packaging and insert easily understandable with minimum text. Although it is recognized that only 23 percent of

[19] ZinCfant 20mg information sheet, www.nutriset.fr, last update 11/2004

mothers have more than three years of schooling[20], some text is required to support illustrations included in the consumer insert. Launching of the DTK by PSI/Cambodia in Siem Reap Province will be complemented with local radio and television broadcasts, education through mobile video units, training of shopkeepers (via RACHA), and training of CVCGs via the ICH Project.

PSI/Cambodia is also developing a training curriculum to ensure consistency in messaging. ICH Project staff will be trained in and use this curriculum with village-based training. Additionally, the DTK insert will be a training tool for the CVCG; ICH Project field officers will review the insert with CVCG leaders and volunteers in addition to practicing in role-plays with CVCG members to ensure that they understand how to communicate appropriate and effective use to their catchment households.

Until the DTK is released in 2006, mothers have access to ORS through village shops. RACHA has reported that at least two shops in each village have been trained in correct ORS use and linked with private wholesaler to ensure supply. Additionally, the Village Health Support Groups (VSHGs) are supplied with ORS to be used for emergency cases which is supplied by their respective HC. Visits to five of the 12 HCs visited as part of the detailed implementation planning process revealed that all had ORS in stock.

Improved handwashing practices

CVCGs will promote improved handwashing practices at critical moments. Handwashing has been shown to significantly reduce both diarrhea and ARI incidence[21]. The KPC baseline survey revealed that less than one percent (0.6 percent) of mothers of children age 12-23 months reported washing their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. Segregating reported handwashing by critical moment reveals a significant opportunity for improved handwashing to interrupt the fecal transmission as only 41.8 percent reported handwashing after defecation and only 0.6 percent reported handwashing after attending to a child who has defecated. In contrast, report of handwashing before food preparation only was near universal (94.1 percent).

This discrepancy suggests an enormous potential for the ICH to impact hygiene behavior change among mothers. However, additional formative research will be undertaken to determine misperceptions and/or resistances to handwashing following fecal exposure. Research findings will be incorporated into the handwashing improvement strategy.

MEDiCAM is organizing a national workshop on Water Use and Hygiene Education (WUHE) from July 27-29, 2005. This workshop will include a presentations on WUHE training and IEC materials as well as highlight best practice in Cambodia. Materials

[20] KPC Baseline Survey Report, Siem Reap Integrated Child Health Project, April 2005
[21] Curtis V., Cairncross S. (2003). *Effect of Washing Hands with Soap on Diarrhea Risk: A Systematic Review.* Lancet Infectious Diseases, 3(5): 275-281.

presented at this workshop related to appropriate handwashing during the five critical moments will form the bases of the handwashing training curriculum.

C.2.2 Early identification and referral for danger signs

The Baseline KPC survey revealed that only 35 percent of mothers were able to identify three or more danger signs. CVCGs will provide basic education on identification of the danger signs indicating need for immediate referral to a health facility. All sick children will be monitored for the danger signs through CVCGs. Dangers signs are fast or rapid breathing, diarrhea, high fever and convulsions. Mothers will be coached through mothers' groups and home visits to identify danger signs. Mothers with children who present danger signs and do not seek care outside the home within 24 hours will receive a follow-up visit from the CRC volunteer leader, VHSG, or village chief as appropriate to monitor the illness and to discuss and resolve the barriers and resistances to immediate care seeking. Referrals will be made from the village to the HC and tracked by the VHSG.

Performance incentives will be provided to CVCGs following the successful completion of group targets. Each CVCG will choose its preferred incentive. The purchase of a bicycle or boat to reduce transportation as a barrier to referral or the establishment of a community managed transportation fund for referrals will all be suggested as possible performance incentives.

A rapid assessment of the referral system[22] will be undertaken as part of the ICH project mid-term evaluation to determine the strengths and weaknesses of this system. Findings will be incorporated into the community-based referral strategy.

C.2.3 Improved malaria prevention and treatment

The ICH project will also support malaria prevention with the goal of increasing effective use and coverage of insecticide-treated bed nets (ITNs). A segmented and sequenced approach will be used (see Section 5 Work Plan). Considering that 75 percent of households with children U2 own a mosquito net, but only 1.7 percent of those have been treated in the past 12 months, the first priority will be to support treatment campaigns that will be linked to the bi-annual expanded health center outreach activities. Expanded health center outreach is done every March and November[23] and includes provision of Vitamin A and de-worming treatment. As bed net insecticide treatment is effective for at least 6 months, re/treatment in March and November will protect the bed net users in the malaria transmission seasons from June to August and December to January.[24] This supports the MOH policy of treating bed nets once every 6 months or at least once a year, in advance of the transmission season.[25] Community

[22] This assessment will follow the *Rapid Assessment of the Referral System: A Guide for Program Managers,* published by BASICS II.
[23] Cambodian MOH, *Guidelines for Outreach Services from Health Center*, 2004
[24] WHO, Integrated Management of Childhood Illness, *Malaria Study Report in Cambodia*, July 2000
[25] MOH National Centre for Parasitology, Entomology and Malaria Control, Annual Progress Report, 2004

mobilization through CVCG home visits and mothers' groups will be complemented by information dissemination through pagodas, schools, and village leaders to ensure that the entire village brings its mosquito nets to the expanded health services on outreach days for re/treatment. ICH project staff will coordinate closely with OD, AD, and HC staff as well as village malaria workers put in place by the National Center for Malaria to organize an insecticide re/treatment station near to the health center's outreach site.

Social marketing of retreatment kits will be piloted in several project villages to test for feasibility (including sales and correct use) and acceptable treatment coverage outcomes. Following the successful pilot testing, social marketing of standard KO tablets will be scaled-up to appropriate project areas (determined through zone/vulnerability classification). Additionally, following WHOPES approval and PERSUAP clearance for use in Cambodia, long-lasting KO retreatment kits will be promoted and either sold at a subsidized rate through social marketing or used for retreatment campaigns to convert the existing batch of mosquito nets into long-lasting insecticide-treated nets (LLINs).

The Cambodian malaria control ITN distribution program applies the strategy of "total coverage" of entire village populations to achieve protection levels in high transmission areas. This is feasible only because of the low population density in forested areas.[26] The National Malaria Center (CNM) classifies villages into vulnerability 'zones' based on the distance from forest areas. Zones 1 and 2 are considered to be hyperendemic for malaria and are priority areas for the free distribution of ITNs. The Angkor Chum OD office has identified 3,629 vulnerable households (with pregnant women or children U5) classified as Zone 1 (1,850) and Zone 2 (1,779) that are eligible for a free ITN in accordance with CNM policy. The OD office has also identified 4,981 vulnerable households in Zones 3 and 4 that are considered more appropriately targeted for subsidized sales of ITNs at approximately half the procurement cost.[27] PSI/Cambodia is planning on launching a subsidized ITN in June 2006.[28] The ICH project will support achievement of these targets set out in the Operational District *draft* 2006 Annual Operation Plan as summarized in the following table.

As described in Section A.2.1, ICH project staff will work with HC staff to set up a system to provide free or highly subsidized ITNs to pregnant women as an incentive for seeking ANC care, with distribution following completion of both shots of TT as recorded on the pink index card currently used to track ANC services. CVCG members will promote ANC attendance and awareness of this incentive to newly pregnant women among their catchment households.

[26] http://www.pathcanada.org/english/malaria_news7.cfm, retrieved March 15, 2005
[27] Final pricing will be set following a rapid willingness-to-pay survey to be carried out in Zones 3 and 4.
[28] Borima Chann, PSI Advisor, personal communication, May 24, 2005

Table 7 Insecticide-treated net provision by vulnerability zone and donor

Malaria Zone	**Vulnerable HHs**	**MOH**	**ICH**
1	1,850	1,000	850
2	1,779	0	1,779
Sub-total free ITNs	*3,629*	*1,000*	*2,629*
3	3,030	0	3,030
4	1,951	0	1,965
Sub-total social marketing	*4,995*	*0*	*4,995*
Total ITNs	**8,624**	**1,000**	**7,624**

In relation to malaria treatment, suspected cases will be referred to the village malaria worker or the VHSG for treatment or referral to the HC as described in Section C.2.2 above.

D. ***SO4: Local partner project management capacity*** will focus on improving coordination with the health community, improving CRC project management policies and skills, and improving the CRC volunteer network.

D.1 Coordination with the Health Community

At the village and commune levels, ICH project staff will work in close coordination and collaboration with the many stakeholders. The ICH's cross-cutting strategies of community mobilization for behavior change (see Section 2.1.2) and coordination (see Section 2.1.3).

At the HC level, each FO will attend the monthly VHSG meetings at the HC to ensure that all village level data is also presented and by the respective VHSGs to be integrated into the HMIS. The FO will provide coaching support to a volunteer to aggregate all village level information for the HC.

At the project level, regular coordination meetings will be held with provincial, OD, and health center officials as well as other NGO implementers in Angkor Chum OD (see Project Coordination Team identification, Annex D. Organizational Chart). There have been preliminary discussions about institutionalizing coordination meetings through the OD office. There have also been preliminary discussions about requesting MEDiCAM to open a Siem Reap provincial committee, similar to that in Battambang. ICH project staff will advocate for both of these options.

ICH project staff will distribute a monthly progress update to improve the flow of information, transparency, and coordination among the many Angkor Chum OD stakeholders. ICH project staff members will maintain regular contact with all stakeholders, and they have discussed scheduling of joint village monitoring visits with RACHA, HC, OD, and AD staff. Village-level training and coaching sessions will be coordinated with all stakeholders to solicit their expertise and participation, as described in Section 2.1.

At the national level, CSHGP grantee project sites will be visited including CRS, World Relief, and Partners for Development. A site visit will also be completed at two CRC primary health care projects. Such visits will serve to improve the coordination and dialogue between CRC and CS community as well as help to compare different approaches and best practices that may be applied to the ICH project and other primarily health care projects implemented by CRC.

CRC will become an active member of MEDiCAM and join and participate in at least one national level technical working group (but no more than two, due to time constraints) directly related to the ICH project. Participation will enhance CRC's exposure to the CS community and provide an opportunity to participate in and influence national policy and strategy initiatives that may be tested and incorporated into the ICH project.

Success stories, particularly those relating to coordination and partnerships with the health community, will be documented by the CRC information officer. These will be distributed to all stakeholders to strengthen partnership work. ARC will compile a PVO resource document highlighting the project's partnership success stories. Inclusion of other partnership success stories in the resource document from other ARC partnerships will be explored.

D.2 Improved Project Management Policy and Skills

At the CRC policy level, increased CRC involvement and coordination with the child survival community in Cambodia will facilitate adoption of alternative/best practices, thus strengthening CRC's project implementation throughout its national network of branch offices. Exchange visits, technical resource sharing, and participation in working groups, with the opportunity to 'field test' alternative/best practices through the ICH project will maximize the potential for the adoption and standardization of implementation strategies for the CRC.

ARC will hold brown bag lunch presentations every two months at CRC headquarters to share and discuss child survival literature and best practices as it relates to the ICH project. Publications will include *The Second Child Survival Revolution, Community Health Worker Incentives and Disincentives: How they affect motivation, retention, and sustainability* and the *ARC Volunteer Tool Kit*. Publications will be translated into Khmer, as needed.

These efforts will be coordinated with the International Federation of Red Cross and Red Crescent Societies (IFRC) CRC organizational development strategy. The coordinated effort will support the planned development of a *CRC Volunteer Reward and Recognition Plan* and a *Volunteer Management Training Curriculum* to be adopted as CRC national policy and used as part of the ICH project. These resources will be shared with the larger health NGO community to forward the development of a national volunteer strategy.

ARC will improve CRC's financial management skills through a combination of training and sub-recipient monitoring. ARC will perform a rigorous financial assessment of CRC at the start of the project. In addition, ARC will conduct an ongoing review of CRC's internal controls to determine if its financial management and accounting systems are able to account for program funds. ARC will assist CRC in the recruitment and training of its project finance staff to ensure professional competence, organizational transparency and regulatory compliance. Finally, ARC will help CRC build its long-term financial management capacity by developing skills in areas such as procurement, budgeting, reporting, and auditing.

Improving CRC's project management skills will be achieved through continuous on-the-job coaching by the ARC health project officer and ARC project coordinator. Additionally project management training will be explored, as needed, for the CRC ICH Project management team. All project staff will receive training in volunteer management, adult learning, and communication skills.

D.3 Improved CRC Volunteer Network

The ICH Project will activate and recruit a total of 2,218 village-based volunteers (including 202 volunteer leaders and 2,016 CVCG members). They will participate in village-based training in the Red Cross fundamental principles, adult learning and communication skills. CRC volunteer leaders will also be trained in volunteer management and motivation.

D.3.1 Training

Training in the fundamental principles of the Red Cross will include humanity, impartiality, neutrality, independence, voluntary service, unity, and universality. This will support the development of the *CRC Volunteer Management Training Curriculum*.

Training in adult learning, and communication skills will include Module 1 of the *Training Curriculum for Cambodian Community Health Volunteers on IMCI Key Family Practices*. Relevant sections of this training module are detailed below.

Module 1 Adult learning and Communication Skills

1.01 Things I like
1.02 Training aims and objectives
1.03 Roles and responsibilities of CHV's
1.04 Importance of CHV's
1.05 Seeing the same thing in different ways
1.06 Creating a good learning environment
1.07 Two-way communication
1.08 Steps in good communication
1.09 Getting to know your HC and HC staff
1.10 Project specific tasks (monitoring, meetings, and activity plans)

The curriculum for training in volunteer management will include relevant sections of the *ARC Volunteer Management Toolkit* including:

1. Volunteer record keeping
2. Personnel management
3. Volunteer mobilization
4. Volunteer motivation
5. Supportive supervision and intangible incentives
6. Problem solving

D.3.2 Interventions and Activities

The CVCG structure is the primary delivery mechanism of the ICH project. Each CVCG will be formed of approximately 10 CRC volunteers and one CRC volunteer leader. Each CVCG member will assume responsibility for working with approximately 20 target households (those with children under fives years of age and/or women of reproductive age). The volunteer ratio of one volunteer to every 20 households is intended to create a saturation effect of interpersonal health communication at the village level. The activation/recruitment plan for the development of this volunteer structure is detailed in Section 2.1.1. Specific intervention and activities are described under each IR. Below is detailed the volunteer incentive strategy which will support and sustain the improved CRC volunteer network.

The care group model relies primarily on intangible incentives to motivate participants, prevent volunteer burnout and ensure sustainability of the interventions. Volunteers are asked to commit to approximately 10 hours of volunteer work per month to prevent them from becoming overwhelmed and burning out. Intangible incentives which will be fostered over the life of the ICH project will include: public and private respect and recognition of work by project staff, community leaders and high ranking government officials, increased health knowledge for personal development, organizational affiliation (CRC), group affiliation (CVCG), community respect, understanding of the impact of their work through group review and analysis of monthly statistics included as part of the community-based surviellance system

Material incentives will include a light snack during village-based training session; a CRC identification badge as well as project tee-shirts and scarves will be provided over the life of the project to promote a sense of organizational and group identity. Each CVCG member will receive a certificate of completion signed by the provincial health director, operational district director, and administrative district governor following successful completion of each training cycle.

Performance based incentives for achievement of CVCG developed targets will be decided upon by the respective CVCG. These incentives will be awarded to the CVCG and not individuals to promote group cohesion and will likely include umbrellas to all members (making it easier for the volunteer to visit households during the rainy season), exchange visits to nearby villages (to share best practices), and/or matching funds for the establishment of a community managed transportation fund for medical emergencies.

All material incentives (except the light snack) will be provided in a public forum to reinforce community recognition.[29,30]

The ICH project will also apply lessons learned from the African Red Cross and Red Crescent Health Initiative (ARCHI), which was launched in 1998 and involves over 50 National Societies. ARCHI focuses on building the strength of Red Cross Societies to implement more focused, priority health activities through networks of longer-term community volunteers, coaches and trainers. ARCHI have developed volunteer support structures at the national, branch and community levels for a comprehensive management program. Various technical toolkits, training and supervision plans and volunteer retention plans that include incentives and recognition programs have been developed and field tested to identify success elements of a volunteer program. The ICH will work closely with the ARCH initiative to replicate these elements in Cambodia.

ICH Project Strategies Support CSHGP Intermediate Results

Program Result 1: Increased use, coverage, and quality of child and matenial health, and nutrition and infectious disease programs implemented by PVOs and their local partners will be supported through the ICH project's cross-cutting health education/coaching and community mobilization for behavior change strategies. The ICH project will mobilize a CRC volunteer force exceeding 2,200 members, a roaming BCC team, and a cross-section of local opinion leaders to saturate the three participating administrative districts. Ubiquitous, coordinated health promotion will improve selected household practices and increase the demand for routine, high-quality health services from the health center.

Program Result 2: Increased sustainability of child and maternal health and nutrition and infectious disease programs/interventions initiated by PVOs and their partners will be achieved through a high level of local stakeholder participation in the project design (see Section IV.C.), implementation, and monitoring and evaluation. Local participation throughout each stage of the project is critical to foster ownership and shared responsibility beyond the project's life. Community-level behavior changes will be motivated through the successful Community Volunteer Care Group (CVCG) model[31], shown to retain activity following the formal end of project. At the individual level, behavior changes are expected to be sustained as improved practices are adopted and prove to be beneficial.

Best practices and lessons learned are expected to be institutionalized by the ICH's local implementing partner, the Cambodian Red Cross. Adoption of improved policies and best practices will likely be applied through similar primary health care projects, largely funded through other Red Cross societies (e.g. Danish, British, etc.).

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[29] Laughlin M. The Care Group Difference: *A Guide to Mobilizing Community-Based Volunteer Health Educators,* World Relief/CORE, 2004

[30] Bhattacharyya K., BASICS II. Arlington, Virginia, October 2001

[31] Morrow M. et al. *Retention of community health volunteers using care groups*, The 130th Annual Meeting of APHA, Abstract #44795

Program Result 3: Child and maternal health and nutrition and infectious disease program strategies, tools and approaches developed/adapted, tested and applied will be supported through: (1) social marketing of PSI's new diarrhea treatment kits (DKT). Lessons learned from promotion of this product will be applied to improve the project design and national scale-up. Second, following their WHOPES approval and PERSUAP clearance for use in Cambodia, long-lasting KO retreatment kits will be promoted and sold at a subsidized rate as part of the malaria prevention activities. Approaches will need to be adapted from the standard KO Tablet re/treatment kits, tested and applied for improved impact. Lessons learned will be documented and shared with the child survival community. Third, recommendations from the IYCF Working Group will be piloted, including testing the feasibility of breast milk expression for mothers who work outside of the home. Finally, the development of a volunteer reward and recognition plan and volunteer management training curriculum will be shared with the broader CS community to further national dialogue on these issues.[32] This will further permit CRC to fulfill its role as an auxiliary to the Royal Government of Cambodia.

2.1 Cross-cutting strategies

The ICH Project will address priority MCH needs in the intervention areas detailed above through the implementation of four cross-cutting strategies. These strategies are designed to support the Ministry of Health's Health Sector Strategic Plan 2003-2007 and the *draft* Angkor Chum OD 2006 Annual Operational Plan, while complementing health and development interventions implemented by other organizations in Angkor Chum OD. The ICH project focuses on the *third element* of the community Integrated Management of Childhood Illnesses (C-IMCI) implementation framework: integrating key family practices critical to child health and nutrition. Each cross-cutting strategy is detailed below.

1. **Health education/coaching for behavior change** will be achieved through an extensive network of village-level CRC Community Volunteer Care Groups (CVCGs). Each CVCG will be formed of approximately 10 CRC volunteers and one CRC volunteer leader. Each CVCG member will assume responsibility for working with approximately 20 households. The volunteer ratio of one volunteer to every 20 target households is intended to create a saturation effect of interpersonal health communication at the village level. The ICH project will recruit more than 2,200 CRC volunteer leaders and CVCG members, with a density proportional to the population. The table below details the estimated number of CRC ICH project volunteers by AD.

[32] The need to develop a national volunteer incentives policy has been repeatedly expressed at the Child Survival Partnership Workshop in December, 2004 in Phnom Penh and by the secretary of state for health.

Table 8 Households, population, CRC volunteers and supervision by Administrative District

Division	Administrative Districts			
	Pourk	Angkor Chum	Varin	**Total**
Communes	16	7	5	**28**
Villages	154	84	25	**263**
Households	24,501	10,963	4,866	**40,330**
Population (2006)	129,855	58,105	25,788	**213,749**
CRC Field Officers	8	4	3	**15**
CRC Volunteer leaders	123	55	24	**202**
CRC CVCG members	1,225	548	243	**2,016**

Activation and expansion of the CRC volunteer base in Angkor Chum OD will be undertaken by building on the participation and relationships strengthened during the participatory baseline survey and detailed implementation planning process (see Section IV.C.). A schedule will be developed with the OD director, AD governors, health center staff, and commune leaders to visit each village chief and VHSG with the objectives of (1) introducing and discussing the ICH project, (2) identifying existing community resources (including VHSG and CRC volunteers), and (3) scheduling a meeting with the entire village with expressed involvement from both women and men. ICH project staff, including the CRC field officers, will conduct follow-up meetings with each village to (1) introduce and discuss the ICH project, (2) discuss the roles and responsibilities of CRC volunteer leaders and CVCGs, and (3) elect new CRC volunteer leaders and volunteers as needed to form CRC Community Volunteer Care Groups (CVCGs). CRC volunteer leaders are preferred to be literate and female; CVCG members are preferred to be female as much of their work will focus on ante and post-natal care and breastfeeding.

Following the election of volunteers, a bi-weekly visit schedule will be agreed upon among the field officer, village chief, VHSG, and CRC volunteers. Bi-weekly visits will facilitate follow-up, village-based training, and strengthening of CVCG group cohesion to improve mutual support and sustainability. The first bi-weekly visit will involve a discussion about health priorities in the village, identification of community resources, and participation in a village mapping exercise to identify all households with women of reproductive age (WRA) and children under five (U5s). The second visit will include a CRC volunteer induction as detailed in the *CRC Volunteer Policy Implementation Guide* (Annex H). The induction will include completion of a volunteer registration form, orientation with the organization, review of the Red Cross, Red Crescent Fundamental Principles, Code of Conduct and expectations as a CRC volunteer. Each CVCG member will be asked to contribute no more than 10 hours per month and assume responsibility for working with approximately 20 targeted households (those with WRA or U5s) through home visits and mothers' groups.

The third visit will focus on the development of a CVCG work plan including setting targets related to activity as well as improvements in health status. Section 5, the Work Plan, provides an overview of the technical training schedule by strategic objective. Village-based technical training and coaching will be scheduled in 2 to 3 hour sessions following the relevant modules and sub-modules of the *Training Curriculum for Cambodian Community Health Volunteers on IMCI Key Family Practices*[33] and other curriculum as described above. Shortened training and coaching sessions will facilitate learning for the primarily non-literate volunteer base. Each session will focus on 2 to 3 simple messages or skills, as well as participant practice with dissemination of messages to households within their sphere of responsibility. This training will build local capacity by providing an expanded CRC volunteer network with clearly defined roles and basic skills that will contribute to measurable improvements in health at the village level.

CVCGs will be trained by the CRC field officer, VHSG member (already trained in several child survival technical skills by RACHA), and one implementing partner. According to their specific expertise and availability, implementing partners will be asked to participate in village-level training to improve collaboration, coordination, and sustainability. Implementing partners participating in village-level training will include staff from the health centers (including village malaria workers), OD, RACHA, Caritas, Plan International, ADRA, and PSI.

2. Community mobilization for behavior change will be achieved through continued engagement in ICH project activities of all opinion leaders, including AD directors, commune and village leaders, VHSG members, school directors and teachers, and Buddhist monks and nuns as well as health center staff, village malaria workers, and traditional birth attendants. Continued stakeholder participation will build social capital at the community level, which will facilitate implementation as well as develop ownership and responsibility for project activities among local leadership. Maximum feasible stakeholder participation is a guiding principle of ICH project implementation.

Local leadership participation will include: (1) monthly work plan development at the village, commune, and AD levels, (2) review of monthly monitoring statistics and progress reports and provision of feedback, and (3) participation in village-level BCC activities. Specific BCC activities for different opinion leaders have been identified and validated through the detailed implementation planning process. These activities are summarized by opinion leader below.

- <u>OD, AD, and health center staff</u> will participate in joint visits with CRC field officers to monitor progress following the monthly work plan development. OD, AD, and health center staff will also be requested support village-based training and coaching sessions according to their expertise and availability.
- <u>Village malaria workers (VMWs)</u> will support disseminating quality information, education, and communicationas well as assist with the re/treatment and distribution of ITNs.

[33] Draft, World Health Organization, UNICEF, June 2004

- Village Health Support Group (VHSG) main role is to ensure the regular flow of information between the community and the health center.[34] To support this role, VHSGs will be requested to monitor community health statistics collected by the CRC volunteer leaders. Additionally, VHSGs will be requested to support village-based training and coaching sessions according to their expertise and availability.
- Commune leaders and village chiefs will facilitate the election of new CRC volunteers and provide support for home visits and referral when deemed appropriate. Village chiefs will also be invited to participate in village-based training and coaching sessions.
- School directors and teachers will incorporate health messages into their curriculum, announce HC outreach days to students, and facilitate contests to support improved vaccination coverage as detailed in Section B.2 above.
- Buddhist monks and nuns will play pre-recorded health messages through the pagoda loud speaker system that relate to each of the project interventions, including announcements of health center outreach days. Monks and nuns will also form a study group to review Buddhist dharma as it may relate to health promotion with the aim of developing a message booklet as a reference and health promotion guide for monks and nuns. Additionally, monks and nuns can promote health messages through their ongoing contact with the villagers.
- Traditional Birth Attendants (TBAs) will be recruited as CVCG members to fully engage them in SO1 activities related to antenatal care, delivery and breastfeeding.

CRC will also establish a mobile behavior change communication (BCC) team to organize BCC activities including dialogue, coordination, and motivation of the many and varied key opinion leaders detailed above. The BCC unit will be staffed with a VSO volunteer and three CRC staff. CRC field officers will facilitate recruitment of energetic and dynamic Red Cross Youth volunteers[35] from the villages to work with the BCC team staff. The BCC unit will develop a monthly program of meetings with key opinion leaders and community-based activities.

Community-based activities identified and validated during the detailed implementation planning process included shadow puppet shows, public recognition of 'model' mothers, school contests, choirs, award ceremonies, high-level visitors, and radio and television interviews with 'model' volunteers. All activities will be coordinated with the village-based training and coaching schedule to reinforce interpersonal health communication transmitted through the CVCGs.

3. Coordination with non-governmental organizations supporting health and development programming in Angkor Chum OD will ensure synergistic program approaches. USAID, Caritas, ADRA, PLAN, URC, BTC, and RACHA are all supporting programming in Angkor Chum OD. These organizations were involved throughout the detailed implementation planning process (see Section IV.C. and Annexes

[34] *Policy on Community Participation in the Health Center, 2003*
[35] *Cambodian Red Cross Volunteer Policy Implementation Guide*, 2005

Q and R-DIP Workshop summary proceedings) to ensure that the ICH project will complement and programming that they are supporting or plan to support. A summary of each organization's activities follows.

Caritas established its ongoing health program in Siem Reap province in 1995. Caritas support for three health centers in Angkor Chum OD focuses on improving the quality of care, developing and extending health education activities in target villages of these health centers, running a nutrition program with WFP support in 15 villages for U5s, pregnant and lactating mothers in food-insecure areas in addition to having school feeding programs in four schools. Caritas also runs a home-based care program for people living with HIV/AIDS. Through its community development program, Caritas also supports water and sanitation, agriculture, small animal husbandry, irrigation, and fish pond and road construction in Angkor Chum OD.[36] These activities support the *multi-sectoral platform* to optimize child health and nutrition.

Adventist Development and Relief Agency (ADRA) runs an integrated rural development project in Angkor Chum and Varin Administrative Districts of Angkor Chum OD that began in 2000 with expansion in 2002. This project works primarily with the development of farmers' associations in micro-credit, cow and rice banks and literacy. ADRA has also done considerable work in water and sanitation and has constructed more than 1,500 hand-dug wells since 1989. ADRA's water and sanitation project currently has plans to complete an additional 500 wells and 500 latrines.[37] ADRA's work focuses on the C-IMCI *multi-sectoral platform* to optimize child health and nutrition.

PLAN International has a national birth registration project as part of its child rights program that is functioning in several villages of Angkor Chum OD. PLAN is planning on expanding its community-based health programming to Angkor Chum OD in late 2005 or early 2006. PLAN will likely focus on improving access to water and sanitation as well as road construction in the OD.[38] These activities focus on the C-IMCI *multi-sectoral platform*.

University Research Corporation (URC) is operating a three-year Health Systems Strengthening in Cambodia (HSSC) cooperative agreement awarded in October 2002. The project's overall aim is to support both the Ministry of Health's strategic plan and USAID/Cambodia's three-year interim health strategy. The objective is to strengthen the capacity of the Ministry of Health (MOH) in Cambodia to plan, manage, and implement programs addressing HIV/AIDs, tuberculosis, and family health in seven provinces.

The URC team provides technical assistance to the MOH by applying a comprehensive systems approach to strengthen the capacity of the Cambodian health system to better

[36] Caritas/Cambodia Program briefing sheet, 2005; Personal communication with Bernadette Glisse, Community Health and Community Development Programs, AIDS Home Care Program Coordinator, May 2005
[37] Personal communication with David Cowled, Provincial Program Advisor Siem Reap, April 2005
[38] Personal communication with Julie Ann Forder, Country Health Advisor, April-May 2005

plan, finance, and deliver the basic package of reproductive and child health services. In addition, the project team is working to link these system improvements to the achievement of key health outcomes.[39]

In Angkor Chum OD, URC support is limited to the annual operational planning process following the MOH guidelines.[40]

Belgian Technical Cooperation's (BTC) Provision of Basic Health Services Project (June 2004- June 2008) in Siem Reap and Oddar Meanchey provinces supports the delivery of health services. The project has five major activities:

> (1) Development of free, high-quality health care for the poor through health equity funds to pay for the hospital expenses of the poor;
>
> (2) Promotion of better health behavior through a periodic medical newsletter, road safety campaign, better marketing of public health services, and a health education training course;
>
> (3) Strengthening health services through incentives and bonuses paid to the health centers according to their performance and activity (HC contracting). HC officials sign contracts to maintain official service fees; not remove or sell HC drugs, materials, or equipment for personal benefit; complete a 40 hour work week; and work in accordance with medical ethics;
>
> (4) Support for quality improvement initiatives and training through the development of quality standards and incentives to health facilities for reaching quality criteria; and,
>
> (5) Strengthen management and capacity building through planning, monitoring and supervision, and the computerization of resource management and the health information system.[41]

The table below summarizes BTC's current or planned programming, related ICH planned programming, and comments on how these activities are complementary and mutually supportive.

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[39] http://www.urc-chs.com/services/health/HSSC.html, retrieved May 19, 2005

[40] Personal communication with Peng Vanny, Technical Advisor- Planning, Monitoring & Supervision, April-May, 2005

[41] BTC Provision of Basic Health Services in Siem Reap and Oddar Meanchey provinces brochure, 2004; Personal communication with Dr. Georges Dallemagne, Project Co-director, April 2005

Table 9. Complementarity of BTC and ICH activities

BTC Activity	ICH Activity	Complementarity
Improved Hospital Access		
Development of free, high-quality health care for the poor through health equity funds to pay for the hospital expenses of the poor.	1. Improve awareness of the fund through thru the community-based early identification and referral mechanism. 2. Possible provision of emergency transport seed funds as a performance-based incentive to villages.	Early identification and referral of emergency cases thru the HC's to the SR hospital will improve timely provision on care and lead to improved survival rates. Emergency transport funds will remove the cost barrier of transport to the
Health Promotion thru Medical Community		
Promotion of better health behavior through a periodic medical newsletter, road safety campaign, better marketing of public health services, and a health education training course;	1. ICH success stories submitted for publication in the medical newsletter. 2. Development and submission a series of articles relating to improved BF practices to encourage medical/HC staff to promote exclusive BF practices (no water). 3. Collaborate on the development of the health education training course.	Research in Cambodia suggests (see Table 11) that positive influences appear strongest in areas where the community has been exposed to a combination of change agents, all promoting the same message
Improved HC Access		
Strengthening health services through incentives and bonuses paid to the health centers according to their performance and activity (HC contracting). HC officials sign contracts to maintain official service fees; not remove or sell HC drugs, materials, or equipment for personal benefit; complete a 40 hour work week; and work in accordance with medical ethics;	1. Create awareness at the community level of improved services at HCs. 2. Increase demand for HC services through community-based early identification and referral mechanism. 3. Organize communities for HC outreach activities. 4. Joint monitoring (BTC/ICH) of increase in	Increased quality of services at HC will reduce resistances to health care seeking; increased use of services by communities will reinforce HC staff motivation (thru more appropriate referrals and increased activity); CVCGs will organize communities for HC outreach activities, making more efficient use of HC staff time; improved community monitoring and feedback on HC services

	demand for service. 5. Improve community feedback to HCs.	will further improve quality.
Improved quality		
Support for quality improvement initiatives and training through the development of quality standards and incentives to health facilities for reaching quality criteria	1. Improve community feedback to HCs. 2. Information sharing between ICH/OD/PHD/BTC on quality issues raised by communities.	Community perceptions are critical in the development of quality, improved feedback from communities to HCs will permit HCs to identify areas for quality improvement; information sharing will highlight HC quality strengths to be used as models as well as weaknesses needing management involvement.
Planning, Monitoring, HMIS		
Strengthen management and capacity building through planning, monitoring and supervision, and the computerization of resource management and the health information system.	1. Joint monitoring visits 2. Participate in the annual operational planning process. 3. Strengthening of HMIS.	Joint monitoring visits will permit standardization of monitoring tools, information sharing, and cross-fertilization; participation in the annual planning process will strengthen community perspective during planning (currently dominated by clinicians); as the ICH builds on the existing HMIS, it will community-based data collection and provide monitoring of some additional basic health indicators to complement and corroborate the HMIS

Reproductive and Child Health Alliance's (RACHA) work in Angkor Chum OD focuses on IMCI components one (improving case management skills of health workers) and two (improving the health system supports for high-quality care for children coming to health facilities or outreach sites). Activities related to these two IMCI components planned by RACHA for FY2006 include: (1) conducting OD planning for IMCI into annual OD planning prior to technical training course; (2) organizing clinical training course on IMCI provided TA by MOH IMCI team (11 day course); (3) organizing TOT and follow-up courses for the provincial health department, OD staff who have attended 11-day and

TOT course; (4) continuing to support and strengthen existing IMCI HC focus RACHA OD (IEC materials, checklist); (5) organizing follow up and supervision to all existing IMCI health centers and provide feedback on practical issues; and, (6) payment of staff per diem and travel.

In support of the third IMCI component[42] (improving household and community practices related to child health, nutrition and development), RACHA focuses on *second element activities* to increase appropriate and accessible health care from community-based providers. These activities include improving supply of essential health products in the village as well as providing technical training of TBAs in the use of the home birth kit.

The ICH Project focuses on *third element activities*, integrating key family practices critical to child health and nutrition. The ICH project will focus on the third element of the community-integrated management of childhood illnesses (C-IMCI) implementation framework: integrating promotion of key family practices that are critical for adequate child health and nutrition. ICH Project interventions and activities are focused at the community level. Other organizations are concentrating efforts and resources at the facility level (URC, BTC and RACHA). Additionally, RACHA supported training of VHSGs and continues support for health center outreach as well as training for community-based health providers through its village shopkeeper program.

The table below summarizes RACHA's current or planned programming, ICH planned programming, and comments on how these activities are complementary and mutually supportive.

Table 10. Complementarity of RACHA and ICH activities

RACHA Activity	**ICH Activity**	**Complementarity**
Safe motherhood		
ANC, TBA, home birth kit and syphilis testing	Pregnant women will be counseled to improve attendance for ante-natal care, receive both tetanus toxoid (TT2), recognition of pregnancy danger signs, encouraged to seek skilled health personnel (including trained TBA with clean birth kit) for delivery, and counseled on the benefits of immediate and exclusive breastfeeding following birth (including skin-to-skin messages)	Improved quality of services will facilitate demand generation for these services; increased client/patient demand will maximize the cost-effectiveness of health provision. Both improved supply and increased demand will have the net effect of improving health among service users.

[42] The third IMCI component is the community component of IMCI and is also known as C-IMCI.

Birth spacing		
IUD, Condoms, Calendar and Birth Spacing Good condom availability through shopkeepers	Lactation Amenorrhoea Method of family planning (LAM)	Modern birth spacing products can be complemented with LAM to provide an additional child spacing option for mothers with infants
Child Health-Iodized Salt		
Conduct training to shopkeepers and VHSGs by OD and HC staff; follow up and HP to the areas trained; continue support TA and IEC material and strengthening to all village shopkeepers, VHSGs have been trained.	Monitor iodized salt use and availability for baseline, mid-term and final evaluations.	Information from ICH's baseline and final surveys will support monitoring iodization coverage and usage to guide geographical targeting for RACHA's activities.
Child Health-Breastfeeding		
Conduct training on BF to nuns/women's groups by HC and OD staff; conduct follow-up and supervision to all trained villages; continue TA and IEC material and strengthening to all villages. (catchment area for 6 HCs)	Engage N/WG members in BF training to CRC volunteer community care groups; ongoing interpersonal communication, support group and community activities targeting all households with pregnant women and infants to promote behavior change in the household.	Joint training for N/WG/CVCG; involvement of VHSG in training to CVCG, joint supervision/follow-up visits.
Vitamin A		
Support on supervision to OD staff on VAC distribution day; Continue to support TA and IEC material for refresher course; staff per diem and travel	Community mobilization for improved turn-out on VAC distribution days; follow up with HHs with VAC-eligible children who have not received VAC on distribution. Refer these mothers to VHSG or outreach	Improved quality of services will facilitate demand generation for these services; increased client/patient demand will maximize the cost-effectiveness of health provision. Both improved supply and increased demand will have the net effect of improving health among service users.
Early identification, correct home care and referral for danger signs for sick children		
Clinical IMCI trainings (described above); conduct training on C-IMCI to village	Engage HC and OD staff in training CRC volunteer community care groups in	Early identification of danger signs in the home is critical for prompt care

shopkeeper by HC and OD staff; conduct follow-up supervision to all trained village shopkeepers; continue to support TA and IEC material to all trained shopkeepers; staff per diem and travel	correct home care as well as early identification and referral for danger signs; ongoing interpersonal communication and community activities targeting all households with U5s and WRA to promote correct home treatment and prompt care seeking.	seeking. (According to the baseline KPC, mother's knowledge of illness danger signs was exceedingly low.) Mothers' knowledge can be reinforced by shopkeepers as they are often consulted for advice and treatment for sick children.
Acute Respiratory Infection		
Conduct training on ARI to VHSG, N/WG by HC staff; follow-up supervision to all areas trained; staff per diem and travel (catchment area for 4 health centers)	Engage VHSG, N/WG in training CRC volunteer community care groups in early identification and referral for cough and rapid breathing	Joint training for N/WG/CVCG; involvement of VHSG in training to CVCG, joint supervision/follow-up visits.
Child Health-Control of Diarheal Disease(CDD)		
Conduct training to VHSG, N/WG, and village shopkeepers by HC staff; follow-up supervision to all areas trained; continue support of TA and IEC materials to all areas trained; staff per diem and travel (catchment area for 6 HCs); social marketing of DTK through village shopkeepers (catchment area for 13 HCs).	Engage VHSG members in CDD training to CRC volunteer community care groups; ongoing interpersonal communication, support group and community activities targeting all households with U5s and WRA to promote behavior change in the household; social marketing of DTK through CRC volunteers to improve access and availability of ORS.	Joint supervision/follow-up visits; maximize community outlets to improve access and availability; DTK pricing will be standardized by PSI to avoid under selling; joint advocacy to enforce free distribution norms by VHSGs (supplied with ORS by HCs for emergency situations). .

Other planned RACHA activities include support for community directly observed therapy (DOTS) for tuberculosis treatment, and HIV/AIDS. The ICH will not work with TB nor HIV/AIDS prevention. RACHA also plans to continue its work with capacity building including credit and logistics. The ICH project does not work with these interventions, but will benefit from an improved supply of health services, which is a likely outcome of these interventions. Finally, RACHA plans capacity building with the HIS and VHSGs.

ICH will undertake malaria prevention activities including education and behavior change to improve use of insecticide-treated mosquito nets. ICH will support re/treatment campaigns, provide free and socially marketed ITNs and explore social

marketing of retreatment kits. RACHA is planning to introduce malaria treatment activities on a wider scale than currently (in the Pourk AD), which will be coordinated as they are introduced.

Overall, RACHA focuses on supply side activities to improve the quality and availability of health services through training, supervision, and financial support for outreach; ICH focuses on demand generation activities to improve utilization of services as well as improved health practices in the home through interpersonal communication and community mobilization.

4. Community-based surveillance systems (CBSS) have been designed to complement the existing HMIS (including the VHSG main role to facilitate communication between the community and the health center) while enhancing broader community participation in monitoring basic health statistics at the village level. CBSS will empower communities with information necessary to recognize their accomplishments and identify areas needing further attention. CBSS data, including nutritional surveillance, vital statistics, and monthly activity reports will be tabulated and reviewed by each CVCG with the FO to ensure progress, analyze the results and develop an action plan as needed. The CBSS forms part of the overall Monitoring and Evaluation Plan detailed in Section 3. The CBSS is summarized below.

Nutritional surveillance, through monthly growth monitoring of U2s, will be added as a service conducted by CRC volunteer leaders and CVCG members during health center outreach visits with follow up to households that do not attend outreach or households with children that show weight loss during weighing.

Health Management Information System (HMIS) indicators related to the ICH project have been included in the M&E Table (Section 3). CRC volunteer leaders will support the VHSG in the collection and summarizing of data to ensure a regular flow of information between the community and health center. Additionally, CVCG members will verbally report on vital events and disease prevalence among their assigned households once every two weeks. This information will be recorded by the CRC volunteer leader and reported to the FO and VHSGs.

Home visit logs will be kept by the CRC volunteer leader to see that each CVCG member is maintaining monthly, bi-weekly, or more intensive contact with each household for which they are responsible. The home visit log will also document questions and issues that arise between CRC field officer monitoring and training and coaching visits.

The complete M&E Table is included in Section 3.

A. Behavior Change and Communication

Identifying Khmer beliefs, knowledge, and practices by technical intervention and how the ICH project will work to influence behavior change

The cross-cutting strategies of health education, coaching, and community mobilization described above were carefully designed to facilitate behavior change and communication both as a process and a product. Khmer specific beliefs, knowledge, and practices relating to each technical intervention were identified from several studies. The table below summarizes each identified barrier to behavior change and the corresponding ICH Project strategy to be employed. Additional formative research that will be undertaken during implementation is described under Section 3.1.

Table 11 Beliefs, knowledge and practices as barriers to behavior change and corresponding project strategies by technical intervention.

Source	**Beliefs, knowledge or practices**	**ICH BCC Strategy**
Ante/post natal care		
ARC/CRC, ICH KPC Baseline Survey, April 2005	60% of mothers received TT2 during last pregnancy	Intensified home visits to pregnant women (at least bi-weekly) to encourage attendance at HC outreach; provision of free or highly subsidized ITN following completion of both shots.
ARC/CRC, ICH KPC Baseline Survey, April 2005	31% of mothers don't know symptoms--indicating need to seek health care during pregnancy	Intensified home visits to pregnant women (at least bi-weekly) to discuss symptoms
HKI, Present Status of VAC Distribution Program, presentation, May 2005	VAC coverage lower among post-partum mothers	Intensified home visits to pregnant women (at least bi-weekly) to encourage VAC supplementation, possible provision in the home by VHSG
Early and exclusive breastfeeding		
Doyle S. Infant and Young Child Feeding Formative Research on Breastfeeding Practices in Cambodia, March 2005	Main motivational factor reported for exclusive breastfeeding is that respondents are experiencing the benefits of changing their practices	Recruitment of "model" mothers that have had success with exclusive breastfeeding to act as advocates; integration of self-reflection questions about infant health during home visits/coaching
Ibid	Positive influences appear strongest in areas where the community has	Cross-cutting strategies of health education and

	been exposed to a combination of change agents, all promoting the same message	community mobilization for behavior change will engage a combination of change agents, all promoting the same message of early and exclusive breastfeeding.
Ibid	First time mothers were very nervous about initiating breastfeeding and frequently experience problems in getting started.	Encouraging skin-to-skin contact will help promote a relaxed atmosphere, build the psychological bond between mother and baby, and encourage the baby to suckle within the first hour of birth, which helps deliver the placenta
Ibid	Becoming pregnant is a major reason why mothers stop breastfeeding. A major disadvantage, reported by respondents, of breastfeeding for a longer period of time is that it makes the mothers weak and thin. This clearly suggests that optimal infant and young child feeding cannot be promoted in isolation. Maternal nutrition messages, including addressing the iron deficiency anemia issue, and effective birth-spacing programs need to be integral parts of any strategy aimed at improving breastfeeding practices in Cambodia. In addition, promoting the lactation amenorrhoea method of family planning will promote exclusive breastfeeding.	Simple, accurate, and repeated messaging to promote continued breastfeeding during pregnancy; identification of "model" mothers who have successfully breastfed while pregnant. Post partum mothers will be encouraged to take iron folate through HC outreach Promotion of lactation amenorrhoea method (LAM) of family planning
Literature Review of Eleven Qualitative Studies, February 2005; Key beliefs and traditions that impact on breastfeeding initiation and continuation. (Appendix II of Infant	Belief that mother has no milk immediately after birth, leading to delay in initiating breastfeeding	Repeated counseling during pregnancy and immediately following child birth to discuss delay in first milk as normal and not necessitating provision of other liquids including water

and Young Child Feeding Formative Research on Breastfeeding Practices in Cambodia)		
Ibid	Belief that mother has no milk immediately after birth and colostrum is “bad” or of no nutritional value leads to mothers give pre-lacteal feeds (water, Khmer tea, sugared water, diluted sweetened milk, rice water)	Simple, accurate, and repeated information and coaching about the benefits of colostrum before and immediately following child birth.
Ibid	Belief that colostrum is “bad” or of no nutritional value leads to colostrum not being given to the baby and may be squeezed out and discarded	Simple, accurate, and repeated information and coaching about the benefits of colostrum before and immediately following child birth.
Ibid	Believing that water is essential for life leads to water being given to wash the baby’s mouth after breastfeeding and when baby get thirsty	Simple, accurate, and repeated information and coaching about the risks of introducing water (including LAM) before and immediately following child birth
Ibid	Belief that hot milk causes diarrhea	Simple, accurate, and repeated information and coaching about the benefits of breast milk as protection from diarrhea
Ibid	Belief that the breast milk turns sour and will make the baby sick leads to ceasing breastfeeding when the mother gets pregnant	Promotion of lactation amenorrhoea method (LAM) of family planning
Ibid.	Not producing enough breast milk or not of good enough quality leads to supplementation of breast milk with, e.g., cows milk, sweetened tinned milk, formula milk	Simple, accurate, and repeated information and coaching about the benefits of breast milk and its superiority to artificial milk
Immunization		

PATH, Delivery Modalities and System Constraints, Immunization, May 2004.	Success factors seem to have been the application of effective local area communication strategies	The cross-cutting strategies of health education and coaching and community mobilization for behavior change will work together to saturate communities with focused communication to improve turn out for HC outreach services
Ibid.	Experience demonstrates the significance of linking VHSGs, volunteers, village chiefs and HC Management Committees in an effective social mobilization effort	The cross-cutting strategy of community mobilization links all stakeholders to work together with the common goal of improving immunization rates
Ibid.	Strategies for sustaining support from village volunteer networks needs development and scale-up	Application of the CVCG model to maximize potential for sustainability
CVP PATH/NIP, Knowledge, Attitude, Practice Study on Immunization, 2003 and CVP PATH Immunization Coverage Survey Kampong Cham Province, 2004 *Draft* report	Reasons for immunization failure identified by parents: Economic priorities of families Fear of making child sick	Communicate that vaccination is free and available in the village through outreach services. Communicate that vaccination protects children from life-threatening disease
Vitamin A		
HKI, Strategic Workshop on Maintenance Strategies and Future Direction of Vitamin A Distribution Program in Cambodia, Background Information, May 2005	VAC maintenance support is required for previously assisted ODs; more community-based approaches need to be explored	Community mobilization to increase support for routine HC outreach
HKI, Present Status of VAC Distribution Program, summary findings from survey data in 8 ODs, May,	Belief that child was too young for VAC	Provision of accurate information about age eligibility for VAC following national guidelines

2005		
Early recognition and referral for children with danger signs		
ARC/CRC, ICH KPC Baseline Survey, April 2005	27% of mothers were not able to recognize any danger signs	Education through home visits, CVCG monitoring of sick children
ARC/CRC, ICH KPC Baseline Survey, April 2005	33% of mothers did not seek care outside the home for cough and rapid breathing 43% of mothers did not seek care outside the home for fever	CVCG monitoring and community involvement; referral for children presenting danger signs
Diarrhea Management		
RACHA, Community Terms and Beliefs Regarding Childhood Illness, Report of Qualitative Research Studies, undated	Tea made from boiling guava tree bark is a common first-line treatment in the home; children are encourage to consume as much as possible; kapok and cashew tree bark teas are also used for diarrhea treatment, both of which are prepared by soaking and not boiling water	Encourage increased liquid intake (including teas) during and following diarrhea for children not exclusively breastfeeding Emphasis on use of boiled water for all tea preparation
PSI, Thinking Zinc, Drinking ORS: Diarrhea Treatment Kit, presentation, March 2005	ORS alone faces low adherence as caregivers resort to using antibiotics and anti-diarrheals; marketing zinc only may send conflicting or difficult messages	Promotion of bundled diarrhea treatment kits (DTK)
ICH Market Study, April 2005	Ubiquitous availability of antibiotics and anti-diarrheals; limited availability of ORS	Increase demand for ORS through simple, accurate, and repeated education Create ubiquitous availability of DTK thru CVCGs, complementing RACHA's shopkeeper program Price DTK at or below cost of antibiotics and anti-diarrheals.
RACHA, Community Terms and Beliefs Regarding Childhood Illness, Report of Qualitative Research Studies, undated	Local drug sellers are the preferred first source of care outside the home; second choice was private practitioners; health center and referral hospital were the third choices when care seeking outside the home	Improved community referral and follow-up system to health centers

	the home	
Hollis DL. Cultural Perceptions of Diarrhea, Dehydration, and Diet: Factors Influencing Health Care Seeking Behavior in Cambodia, August 1992	The notion of balance, drawn primarily from metaphysical and naturalistic theories, is pervasive in mothers' and child caretakers' explanations about illness, including perceived etiology and symptomatology, treatments used to manage diarrhea and dehydration, and feeding practices during a diarrheal episode.	Message diarrhea management practices in the context of reestablishing balance Re-validate the relative influence of the notion of balance as it relates to illness management and explore how it may be used to reinforce other health practices
Ibid.	Identification of diarrhea as either "normal" or "serious". Diarrhea is culturally accepted as a normal condition because "all children get diarrhea." Even though considered normal, diarrhea is still perceived as a serious threat to infants and young children and worrisome for mothers.	Reinforce perception that all diarrhea is a threat if not properly managed
Malaria prevention and treatment		
WHO, Integrated Management of Childhood Illness, Malaria Study Report, July 2000	Re-infections in communities where bed nets have been distributed are not due to non-use or misuse, but the habit of people to venture out from under the net for smoking tobacco or having a chat around the fire and rice wine jar. Some mothers who smoke make nightly rounds carrying their infants on their backs.	Integrate messages about protecting children by leaving children under the ITN all night
MOH National Centre for Parasitology, Entomology and Malaria Control, Annual Progress Report, 2004	More than 80% of Cambodian people did not seek treatment at the public health facilities because of transportation problems (bad road or far, no transportation means, travel cost very expensive)	Preliminary discussions with the OD director revealed plans to provide VHSGs with Malarine for emergency treatment in the most remote and hyper-endemic areas
Ibid.	Even though Malarine was sold [at a] subsidized price, this drug was not available at the affected community and the price is out of the affordability of those poorest	See above

	communities	

(Please see the section above on ICH strategies for discussion of these approaches.)

How information from assessments will be used to change behaviors

Specific strategies designed to address findings from available assessments is detailed in the table above. Additional formative research relating to each technical intervention will be validated and integrated into the ICH project, as appropriate, to maximize the potential for sustained behavior change. Focus group discussions will be conducted periodically over the ICH project's life to answer questions that will arise through implementation, thus enabling the 'fine tuning' of behavior change interventions.

Describe activities that will be carried out to facilitate change in behavior at each level from policy to community to individual.

As described above, the cross-cutting strategies of health education, coaching, and community mobilization were carefully designed to facilitate behavior change and communication both as a process and a product. At the policy level, formative and evaluation research findings will be shared with the CS community to guide future programming and policy decisions at both the national and provincial levels. Exchange visits to the ICH project site will also be encouraged to further support this aim.

At the community level, the ICH project will support social cohesion among CVCG members with the aim of forming a lasting community structure that will persist beyond the project's life. This social cohesion will be achieved through the development of relationships around the common goal of improving their community's level of health[43] and supported by maximum feasible participation from key local leaders. At the community level, the CVCG will work to infuse the development of community norms for universal antenatal care, exclusive breastfeeding, nutrition monitoring, vaccination, Vitamin A supplementation, home management of sick children, knowledge of danger signs, and prompt referral for care at the health center, as well as ITN use. The establishment of community norms can only be achieved through individual behavior change. As individuals adopt and appreciate the benefits associated with each health behavior they will become advocates. The individual behavioral changes will lead to sustained, community-level changes in behavior.

BCC-related training and supervision

Please see the section above on the ICH strategy of joint training and supervision.

[43] Morrow M. et al. "Retention of community health volunteers using care groups," Abstract #44795 The 130th Annual Meeting of APHA

Discuss which behavior changes are to be sustained and how the interventions may contribute to their sustainability

Please see the section above on the facilitating behavior change at each level from policy to community to individual

B. Quality

How quality will be addressed in the partnerships that are formed

BTC and RACHA are supporting the improvement of service quality in health centers in Angkor Chum OD. BTC is supporting quality improvement initiatives and training through the development of quality standards and incentives to health facilities for reaching quality criteria. Through its HC contracting scheme, BTC will be monitoring each health center for quality improvements. Table 9 above details how the ICH project will support quality initiatives of BTC.

RACHA has begun clinical IMCI training (11-day course) and is planning to continue training to reach the Minimum Package of Activities (MPA) standards. RACHA supported training is expected to improve use of standard diagnosis and treatment guidelines as well as improved child screening following IMCI guidelines. Selected ICH project staff will participate in the clinical IMCI training course to ensure constancy and complementarity between the clinical and community IMCI.

The ICH Project focuses on community-based health promotion, including early identification and referral. The ICH Project staff will support communication of health center quality improvements to the villages. This is expected to facilitate confidence in care seeking at the health center by mitigating present concerns about quality issues.[44]

To ensure that quality is consistently evaluated during joint monitoring visits, checklists will be developed with staff from RACHA, the PHD, the OD, and the HC. The quality of village-based training/coaching session will be evaluated using pre and post-tests (see Section 3).

C. Access

Essential commodities and services for the success of the intervention

Diarrhea Treatment Kits (ORS with zinc), ITNs, and insecticide retreatment are essential commodities for the success of the intervention. The primary essential service is routine outreach services provided by the health centers.

According to the URC assessment and interviews with the provincial health director, OD director and health center midwives, outreach services are functioning according to the official MOH guidelines with periodic/minor stock outs of essential supplies.

Reliability of essential commodities supply and services now and over the project life

DTK supply is expected to come on-line through PSI/Cambodia by the end of 2006. Mosquito nets are widely available on the commercial market and PSI/Cambodia is expecting to launch a subsidized ITN in June 2006. Bulk insecticide retreatment is reportedly available through the MOH at the request of the OD through the PHD.

[44] During the Phase II workshop in Siem Reap, HC service quality was repeatedly mentioned as an issue.

Insecticide retreatment kit (KO-trine) supply is currently limited in Siem Reap Province, but available in Phnom Penh

Outreach services are currently reported to be conducted on a regular basis following the MOH guidelines. With funding from USAID, RACHA is currently paying per diem and transport in support of outreach. The OD director monitors outreach activities to ensure their completion and quality. Minor stock-out issues are expected to be corrected as BTC is sponsoring the OD director to complete a Health Service Management Training Course through the MOH National Institute of Public Health. The course is comprehensive and will cover:

- Concepts of Public Health and Management
- Health System Analysis and Community Health Needs Assessment
- Operational Planning
- Human Resource Management
- Physical Assets Management and Rational Drug Use
- Financial Resource Management and Budgeting
- Supervision, Monitoring, Evaluation, and Quality Management
- Discussion of likely constraints to the success of "supply" activities and approaches to overcome these constraints.
- Discussion about how sustaining the supply after the program's end.

Likely constraints to the success of "supply" activities and approaches to overcome identified constraints

As mentioned previously, ICH focuses on demand generation activities to improve the utilization of services as well as improve health practices in the home through interpersonal communication and community mobilization.

How supply will be sustained after the end of the project

DTK is expected to be adopted by the MOH with a subsidy to support its continued social marketing. Insecticide treatment is available through the MOH and is expected to continue to be available. Bed nets are widely available on the market, although cost is an issue for very poor families.

Describe how the quality of supplies will be monitored

Quality control of bed nets and ORS will be primarily assumed by the supplier. For example, a sample bed net will be sent to the supplier to perform an insecticide analysis to determine effectiveness. The supplier will follow UNICEF's standards for ITNs and ORS. The ICH project will also conduct community-based quality control for bed nets during health center outreach activities. As they wait for vaccinations and other outreach activities, beneficiaries will be asked to respond to a brief questionnaire regarding bed net retreatment, the number of mosquito bites of children who have been sleeping under a net, and fever incidence of these individuals.

Discuss how the program will ensure safety

Re-dipping nets in insecticides will be done, using the MOH guidelines and following training provided by the National Malaria Center (CNM), and will be supervised by village malaria workers.

How improved access will be sustained in selected interventions

Access will be sustained through the CVCGs' continued efforts as described above.

3. Program Monitoring and Evaluation Plan

Introduction: ARC Project M&E Philosophy

There are a number of approaches that ARC uses in developing M&E plans with partner societies:

- Necessary and sufficient
- Integration
- Community-based
- Management capacity building.

The first approach is the idea of 'necessary and sufficient' – numerous M&E systems come up with far too many indicators that duplicate information already collected, or else collect far more information than the project requires to manage its performance effectively and efficiently. We do not collect information for its own sake. The second approach is integration: determining the core requirements for reporting on the project; how they fit with international standards; and how they reflect national standards. In Cambodia, much of this integration has already occurred in the strong PVO collaborations with the line ministries and USAID, especially in the Child Survival programs. The third approach is community responsibility for the data collection. This process both feeds into higher analytical frameworks in the health system and back into community performance. The fourth approach builds on both quality assurance and supervision, where checking data collection and supporting the use of that information is to be an integral part of enhancing our local partner's management capacity.

i. Timing of M&E events

We conducted the baseline during the second quarter of year one. The endline will be conducted during the second quarter of year four (the final year). The mid-term review will be conducted during the fourth quarter of year two, and will include a rapid assessment of the referral system. We will conduct a final evaluation during the fourth quarter of year four, to ensure that we have the completed analysis of the endline prior to the evaluation. This keeps to a schedule of final quarter for evaluation events, and also spreads out the workload for staff. The mid-term review will be conducted primarily by Red Cross staff and some external technical staff, preferably from within the other child survival grantees in-country if possible. The final evaluation will be led by an external consultant; although, the Cambodian Red Cross, Angkor Chum OD Health Department, and American Red Cross staff (project and NHQ) will have considerable involvement.

ii. Monitoring and Evaluation Table Variation

With past projects, we have determined what information collection mechanisms are already in place locally. Indicators currently used (and their frequency of collection) are presented on Table 11, together with core CS indicators by intervention that the project proposes using. As we use a relatively discrete array of strategies to achieve our targets,

we have modified the M&E table somewhat (see Annex U). Each primary strategy is presented immediately following the goal.

The indicators by strategy include the technical indicators of performance as well as the monitoring and quality assurance indicators used to supervise performance and inform management. Each of these is then coded with initials, and used as appropriate for each of the design elements in the work plan. This is a way of streamlining the table and reducing repetition. Discrete indicators (for example, stunting) that are not part of these strategies are treated subsequently and thoroughly. In line with our emphasis on management capacity, the person responsible for the task is also matched with his or her respective supervisor and with the purpose for that specific data element (annual report, quarterly report, etc). This allows us to create more functional work plans that include a time-bound element for measuring performance as well as contain more detailed schedules for timely submission of required reporting elements.

a. Current Area HIS and Integration

The organizational district (OD) currently collects information at the village health support group level, commune health center level, and referral hospital level and sends the data directly to the Provincial Health Department.

Routine Reporting

There is an organized system of information collection in the organizational district. The Village Health Support Group (VHSG) keeps records and reports these monthly to the health center during a monthly meeting at the health center, where at least one member of the VHSG is supposed to report. The VHSG also keeps a record of cases, and they are the ones who encourage the villagers to come to outreach days. It is up to the health center to determine if it needs the monthly report before the meeting, or if it is acceptable to turn it in at the meeting. There is not 100 percent compliance on this reporting, however. RACHA trains the VHSG on the proper completion of this form.

The health center maintains daily case records, and updates these ledgers with the reports from each outreach visit. Each health center holds a monthly staff meeting. The health center is also tasked with reporting to the OD monthly, and there is 100 percent compliance on this. The report (HC1) is turned in on the third day of every month, and an OD meeting is then scheduled on the seventh day of each month (except for weekends). This form includes the compilation of village statistics as well as the daily case records. The referral hospital also has a standard report (RH2) that goes to the OD monthly. These monthly meetings are sometimes an opportunity for training. OD records are tallied quarterly in a separate report (DO3) sent to the Provincial Health Department. The Ministry of Health trains the OD and health center staff together on the proper completion of these forms.

The Angkor Chum OD maintains their records on a computer using Microsoft Excel. Basic reports, including frequencies and the creation of statistical graphs, are printed out

for submission to the Provincial Health Department (PHD). Not every OD has computers or the necessary skills to produce these reports.

Each year the OD produces an annual operations report that includes the summary statistics for the year and plans for the following year. OD staff members do not set targets for performance, but they do plan for different campaigns, interventions, and training activities for their staff in this report. The OD maintains a roster of staff, trainings attended, and when they should be trained (or have a refresher training) based on the recommendation of the health center chief. This goes into the OD training plan, part of the annual report. Many of the details for the OD annual report derive from each health center's annual plan.

The health center also maintains a weekly record of cases of vaccine-preventable diseases, such as measles. The OD is notified (and notifies, in turn, the PHD) if there are any cases caused by direct contact, and a written record is kept on the case report form for subsequent collection and compilation. In the event of contagious diseases, the presence is separately verified by a team from the OD.

Routine Supervision & Outreach

In addition to monthly meetings, which are used for information collection and dissemination (for upcoming immunization campaigns or training opportunities), the OD deputy director visits all the health centers once a month. If problems were identified on the previous month's report (discrepancies or simple errors), the head of that program visits with the deputy director to review the information and make any necessary corrections. The OD also does supervisory visits every month to different villages, at which time any concerns the village has with the health center staff performance are aired. This is done on a less regular schedule than other supervision visits. The OD checks to see if people come to the health center and does spot checks of the village ledgers to determine if they match health center records.

The health center staff goes once a month to every village closer than 20 kilometers in their catchment area, and every other month for villages farther away than 20 kilometers. During the outreach visits, they conduct routine examinations, catch up on some immunizations, notify the VHSG of any upcoming health outreach (national campaigns or NGO activity), and make home visits to cases identified by the VHSG.

Chief issues

The health center and the VHSG are closely linked. When the health center works well, the VHSG usually does as well. The reverse is also true. Getting qualified staff (with a four-year college degree) is a challenge and keeping qualified staff even more of one. Incentives to encourage performance help. Some NGOs 'top off' the base salary of staff, or pay per diems for accompanying staff on their own outreach activities. In a similar manner, even very small incentives at the village level are important. Providing a transportation allowance of even 3000 riels a month (about 75 cents) makes attendance at the monthly meetings far more likely. It is also important for the OD to be very

transparent about their own operating budget, as the health centers often feel that the OD is somehow keeping funds that should belong to the centers.

The various health staff levels do not conduct growth monitoring, as they feel it takes too long to do. Yellow cards are completed for immunizations, but the reverse of the card (with the growth curves) is completely blank. Weight at birth is unknown as is any indication of growth faltering. The only possible point of reference for this would be the number of times the child was referred to the health center. Growth monitoring is a powerful way for the community to own and use data for improving child health. However, it has also backfired in Cambodia where mothers fed their children less to qualify for food supplementation and additional resources. The project will proceed cautiously and ensure that the community understands the benefits of tracking weight gains and losses before beginning to weigh children.

Operational District Health Management Information System

Information from the administrative districts is then aggregated by each of the four operational districts and onwards to the provincial level, which feeds into national statistics. This information up to the OD has been roughly grouped into a separate table by intervention by responsible level, with the understanding that most information is collected monthly (see Table 12). Information highlighted in blue on this table either feeds directly into project indicators (see the project IPTT, Annex X) or could contribute to an expansion of the community-based surveillance system (described in the following section). New information to be collected will be presented on the M&E table and highlighted in green to indicate materials to be developed (again, described in the following section).

Table 12: Operational District Health Information System Indicators

Intervention/indicator	**Responsible Level**
Nutrition and breastfeeding	
no. of deliveries at health center	HC
no. of deliveries at home attended by HC staff	HC
no. of deliveries at home attended by TBA	VHSG
Immunizations and VAC	
no. BCG	HC
no. DPT3 Hep B	HC
no. DPT1 Hep B	HC
no. measles vaccinations	HC
no. women receiving 2 doses of tetanus toxoid	HC
Community management of sick child	
no. cases ARI	VHSG
no. cases dengue fever	HC

no. cases coughing >21 days (presumptive TB)	VHSG
no. cases measles	VHSG
no. cases diarrhea	VHSG
no. cases conjunctivitis	VHSG
no. cases psychological problems	HC
no. cases Hansen's disease	HC
no. cases other diseases	HC
Hospital and Financial Administration (not a project intervention, but part of PHD reporting)	
Population	HC, RH
outpatient department:	HC, RH
no. of new cases	HC, RH
total consultations	HC, RH
no. of referral cases	HC, RH
return rate	HC, RH
no. of new cases in health center annually	HC, RH
Inpatient department	HC, RH
total beds	HC, RH
TB beds	HC, RH
total discharges	HC, RH
total deaths	HC, RH
no. of deaths from TB	HC, RH
bed occupancy rate (non-TB)	HC, RH
bed occupancy rate (TB)	HC, RH
Hospitalization rate	HC, RH
no. of ANC1	HC, RH
no. of ANC2	HC, RH
no. of ANC total	HC, RH
at risk pregnancies referred	HC, RH
ANC1 coverage	HC, RH
total income	HC, RH
Received funds from MOH	HC, RH
Received material/equipment	HC, RH
Received funds from NGO	HC, RH
% of new cases of outpatient department without fees	HC, RH
% of total income of outpatient department lost	HC, RH

As more information is collected routinely by the community on breastfeeding, nutritional status, or disease incidence, it can be added to the existing health center records with minimal change to the current reporting forms.

b. Monitoring Methods and Tools

The M&E table lists the indicators for which the project will track and measure performance. In previous projects in Cambodia, ARC has used a simplified reporting form beginning at the village level that is aggregated at each next higher level, with report submission deadlines. Submission of complete and timely reports then becomes part of the work plan for supervisors at each level.

For each of the major strategies of community education, growth monitoring promotion, community-based surveillance system, coordination, and social marketing, we describe the feeder indicators (such as pre/post-tests) on the M&E table. For many of the community education modules, other resources already exist that the project will be adapted (such as HKI's nutrition education training materials, which include TOT, exercises, etc.).

A Local Rapid Assessment (LRA) will be used an M&E tool for both field officers and project leadership. The LRA is a simplified survey methodology which will measure changes in knowledge and behavior (relevant questions extracted from the baseline survey tool) for a particular training module among beneficiary household of one, randomly selected CVCG for each field officer.[45] As the LRA permits disaggregated analysis, field officer (FO) catchment areas (communes) the tool will assist in identifying FOs needing additional support. An LRA will be conducted every three to four months, following dissemination of every training module to the beneficiary households. This methodology will monitor of the effectiveness of message dissemination to the beneficiary level.

c. Process of data collection

There are five general mechanisms for collection project data:

1. Formal quantitative surveys at baseline and final
2. Annual meetings with project representatives to review annual reports and indicators tracked annually, together with the health center staff and their records
3. Community-based surveillance system outlined below as a monitoring tool.
4. Community work plans, tied to performance of community-initiated outreach and social mobilization activities
5. Supervision work plans for staff.

<u>Community Outreach</u>
The community already collects much of the necessary health information monthly, as described in section a. above. Increasing the number of people attending HC outreach visits and helping the HC staff to locate and track candidates for key outreach activities (see section 2.B.2) will be included as part of the annual community work plan targets.

[45] Laughlin M., *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*, World Relief/CORE, Baltimore, Maryland, 2004

Community-based Surveillance System (CBSS)
The primary monitoring tool will be the community-based surveillance system (CBSS). CBSS will empower communities with information necessary to recognize their accomplishments and identify areas needing further attention. CBSS data, including nutritional surveillance, vital events and selected disease incidence, and monthly activity reporting will be tabulated and reviewed by each CVCG with the FO, VHSG and other community leaders to ensure progress, analyze the results and develop an action plan as needed. This process will hold CVCG members accountable to their communities in fulfilling their agreed upon roles, improve awareness of the health situation among community leaders and facilitate joint action for improvement. Information will be aggregated by each FO. Each FO will attend the monthly VHSG meetings at the HC to ensure that all village level data is also presented and by the respective VHSGs to be integrated into the HMIS. The FO will provide coaching support to a volunteer to aggregate all village level information for the HC. AD level data will be aggregated by each operations manager. Monthly, ICH project-wide data will be compiled and disseminated by the M&E technical officer to all project staff and stakeholders. This information will be reviewed by the project management team to ensure progress, analyze results and used to for management decision making over the course of the project. FOs will share selected project-wide data CVCGs to motivate improved performance.[46]

Nutritional surveillance, through monthly growth monitoring of U2s, will be added as a service conducted by CRC volunteer leaders and CVCG members during health center outreach visits with follow up to households that do not attend outreach or households with children that show weight loss during weighing. Growth monitoring promotion indicators to be tracked are % of timely and accurate completion of growth monitoring forms and % of children 0-23 months less than 2 standard deviations below the median weight-for-age.

Vital events and disease incidence will be tracked by verbal report of CVCG members during monthly meetings. Pregnancies, births and deaths as well as new cases of fever, diarrhea and rapid/difficult breathing will be recorded and aggregated by CRC volunteer leaders and discussed with the CVCG, VHSG and community leaders as described above. The VHSG is responsible for providing this information to their respective HC. CRC volunteer leaders will support the VHSG in the collection and summarizing of data to ensure a regular flow of information between the community and health center. Additionally, CVCG members will verbally report on vital events and disease prevalence among their assigned households once every two weeks. This information will be recorded by the CRC volunteer leader and reported to the FO.

Activity reporting including the number of monthly home visits, number of CVCG meetings held and referrals will be kept by the CRC volunteer leader to see that each CVCG member is maintaining monthly, bi-weekly, or more intensive contact with each household for which they are responsible. The activity report will also include a home

[46] Time constraints will prohibit review of all project-wide data on a monthly basis.

visit log to document questions and issues that arise between CRC field officer monitoring and training and coaching visits.

Additionally, CVCG members will be mobilized to track HC outreach attendance through a series of cards, stickers, yarn knots, flags, and other visible measures that allow schoolchildren and other members in the community to help motivate and manage community performance. The communities will have annual work plans, developed by the community with project support. Having the community take responsibility for performance – rather than the record of performance, which will still be managed by the VHSG – should minimize the possibility of misrepresenting data. Having simple, concrete markers, rather than more forms also increases the possibility of use through different members in the highly illiterate communities of Angkor Chum OD.

For example, a pregnant woman could keep a laminated pink index card for the duration of her pregnancy. Home visits, different counseling sessions about pregnancy danger signs, tetanus toxoid injections, and VAC distribution can all be noted on the previously printed card by a hole puncher, kept by the mother or an older child in the household. Households with perfect coverage would qualify for incentives (flying the model household flag) and be witnesses to recording the information on the village recording forms.

Volunteer Management and Supervision

The project team will develop the monitoring tools with technical assistance from the American Red Cross national headquarters' TAPE Unit, adapting existing tools from other projects both in Cambodia (and from the Child Survival community here) and elsewhere in the world. In particular, elements of volunteer management, supportive supervision, and volunteer multiplier effects will be pulled from existing PEPFAR grants. Additional monitoring tools and processes, such as during the midterm review or prompted by operations research, will be developed on an as-needed basis. These additional tools may include LQAS or PRA; selection will be based on the information needs at the time.

The responsible parties for different indicators and data collection at different levels are included in the M&E table. Supervisory responsibilities, frequency, definitions and sub-definitions are also included on this table. In past projects, we have used this table to generate individual staff work plans at different levels of the project hierarchy. Population reference points will use the OD statistics, and will be adjusted annually following the production of the OD Annual Operations Plan (but still tracked monthly as part of the routine coordination meetings conducted for all HCs in the OD).

d. Data analysis and improvements to project performance

Depending on the frequency of data collection (monthly, quarterly, etc.), the analysis will fall to the project staff and the network of community workers working in coordination with the health center staff. Many of the indicators are part of the routine health management information system.

Information Interaction at the Community Level

Additional indicators that will form the community-based surveillance system as well as those specific to volunteer management will comprise the bulk of the work for the community/volunteer supervisor cadre. Data aggregation, review and analysis will begin at the community level as previously described. The CRC operations managers and CRC project manager with support from ARC staff will provide additional oversight for these processes as needed. Annual meetings to review performance of the community work plans against overall project targets and performance will keep ownership of data grounded at the community level.

Information Interaction with Provincial Health System (village, health center, OD, PHD)

Project staff will attend the monthly HC meetings, described above, and support the aggregation of community-based data for use by the HC staff. Information on community work plan performance, including CBSS activities, will be appended to the monthly reports turned into the health centers.

Aggregated project data will be shared with project stakeholders including the OD and PHD for review and discussion. Project staff may also work with the operational district staff in analyzing data to determine trends, especially in target villages/non-target villages. The project plans to cover the entire operational district, but this coverage may be phased in different modalities (by universal coverage for immunization campaigns, by administrative district, by nodal commune, by model health centers, etc.) depending on the intervention. Discussions of differences in performance among the villages will be discussed initially at the village level, and then through routine meetings with the administrative and operational district authorities. Project staff will also attend provincial health department quarterly NGO meetings. More informally, the provincial health department director and the provincial governor are both board members of the Siem Reap Branch of the Cambodian Red Cross, which enhances access and coordination.

Information Interaction with National Health System and International Community

As members of MediCam, ARC and CRC participate in regular meetings that provide a forum for sharing experiences with other PVOs in Cambodia. The Child Survival Partnership working group, other ministry initiatives, and regular participation in provincial level health update meetings will ensure the dissemination of project results, lessons learned, best practices, coordination with other health messaging initiatives, and increased opportunities for project exchange visits and other collaborations. Cambodian Red Cross has routine meetings by technical sectors with other donor societies and the International Federation of Red Cross and Red Crescent Societies, which encourages exchange of successes.

Information Interaction at National Headquarters

ARC collects project information through quarterly reports, based on the indicators presented on the IPTT, and adding financial reporting. Project staff members complete these reports, subsequently aggregated for internal management review by region, the

TAPE unit, and for donor annual reports. Our finance department also reviews the budget BVA quarterly to help in maintaining compliance with grant requirements. Country desk officers and regional management at NHQ have routine communications with all country representatives and project managers to discuss successes, concerns, and provide updates on NHQ processes.

The NHQ Child Survival backstop attends CORE working group meetings and disseminates any key reports and updates to the project staff in Cambodia. In the past, ARC has attended several professional conferences where staff members have presented processes and results from other projects. These conferences have included the American Evaluation Association annual meetings, the Global Health Council, and the American Public Health Association annual meetings. When possible, we have had local staff members attend the conferences to make presentations. These are valuable opportunities for sharing of lessons learned as well as technical networking.

e. Quality of Service / Health worker and facility performance

The project works primarily at the community level, and our primary vehicle for project activities will be through community education and outreach. However, the community members' use of health facilities is directly associated with the performance of the health staff and the services provided at the health center. Baseline findings suggest that the referral system is relatively frail as a consequence of poor performance/services. The URC health facility assessment conducted in 2004 provides a detailed analysis of the current state of health facilities, subsequently validated by field visits to health centers by the project staff. Currently, there are two NGOs working in Siem Reap Province that focus on improving health facility services and staff performance: Belgian Technical Cooperation and Population Services International. Our project will assist ongoing interventions by RACHA in providing community and health staff training on health education. Conducting technical update meetings for health staff and sharing experiences from other health projects in Cambodia and elsewhere contribute to a general improvement of skills.

The project aims to improve community management of the sick child, through prevention education--determining what home-based care is appropriate--and through referrals to the health center via the existing mechanisms. The improvements in nutritional status and neonatal health, together with increased immunization coverage, will support the existing health outreach services. Ensuring that the technical skills of the outreach teams match the overall IEC messages will help reinforce the basic training that ARC will provide at the community level and complement the existing programs aimed at improving the health-specific skills (such as clean delivery, etc.).

The supportive supervision model reinforces the quality of programming and the retention of volunteers. Using the six-month ex-post test for training allows us to examine both the basic knowledge retention and the relative effectiveness of the trainer.

f. Improving M&E skills of local staff and partners

ARC conducts routine training in project design, including the basics of M&E. There is a great demand to conduct additional training with the national society partners on M&E, specifically. During the production of the M&E system and the individual work plans, ARC will provide basic training in M&E. We expect that partners at different levels of the health system will also attend to validate that our M&E system fits with the existing reporting requirements. As we move into the villages, we will work closely with the community care groups to develop their own work plans. Annual village meetings on performance reinforce achievements also present an opportunity to reinforce basic data collection and analysis techniques that are part of the existing HMIS.

ARC is also collaborating with CRS on the production of a number of practical M&E modules, and these will be available for dissemination worldwide (and as part of routine technical assistance visits already planned for LOP) to partners. Training on individual modules takes between two to four hours each, and the dissemination strategy would engage either CRS or ARC as trainers--depending on availability.

g. Operations research plans

Following the baseline study, several questions immediately emerged. The first of these is the use of bed nets during the rainy season (as we conducted the survey during the dry season, when malaria is less common). The second is the provision of other fluids before the onset of breastfeeding. There has been some recent qualitative work by Linkages on breastfeeding practices that indicates a reduction in the old practice of 'roasting' (secluding the mother for three days following the birth). The baseline showed that every child received some other type of fluid first, and we need to understand why mothers do this before we can modify that behavior. The third is understanding the difference in immunization rates between the three administrative districts.

Table 13: M&E Table

Indicator Shorthand and Underlying Activities	**Indicator**	**Reporting Requirements**	**Frequency**	**Responsible Person**	**Supervisor**	**Reporting Function**	**Intervention**
Goal: Reduced child morbidity and mortality in a sustainable fashion in Angkor Chum Operational District							
C-IMCI training (C-IMCI)	*training completion rates; pre/post -test scores; % scoring 80% or higher on post-test; % scoring 65% or higher on ex-post test (six month interval)*	pre/post-test; training tracking matrix; monthly TO&PC report, field officer & operations manager checklists	after training; quarterly	TO; C-IMCI trainers	M&E Officer	ARC QPR; donor annual report	All
Growth monitoring and promotion sessions (GMP)	*% of timely and accurate completion of growth monitoring forms; annual trend analysis (for seasonal or district level changes)*	growth curve card; commune analysis	monthly report to OD & M&E officer; quarterly report to PC	field officer; operations manager M&E	Officer	ARC QPR; donor annual report All	
Pro-active home visits (HV)	*# pro-active HVs (disaggregated by reason for visit); % community care group members doing home visits per project guidelines; # communities where pro-active home visits occur*	volunteer leader reporting form; field officer reporting form	monthly report to operations manager & M&E officer; quarterly report to PC	field officer; operations manager	M&E Officer	ARC QPR; donor annual report	All
community volunteer support groups (CVSG)	*# community volunteer support group meetings held; % of villages where CVSGs are held routinely (2 times or more /month)*	volunteer leader reporting form; field officer reporting form	monthly report to operations manager; quarterly report to PC	field officer; operations manager	M&E Officer	ARC QPR; donor annual report	All
community social mobilization (CSM)	*# commmunity mobilization activities (disaggregated by wat/school/cvsg); annual trend analysis (for seasonal or district changes, especially in immunization coverage)*	volunteer leader reporting form; field officer reporting form	monthly report to operations manager; quarterly report to PC	field officer; operations manager M&E	Officer	ARC QPR; donor annual report All	

community based surveillance system (CBSS)	*multiple; antenatal care, growth monitoring, bednet, immunization*	household tracking tools	monthly report to VHSG & field officers; quarterly report to M&E Officer	field officer; operations manager	M&E Officer	ARC QPR; donor annual report	All
Training on essential actions for nutrition and micronutrients (NM)	*training completion rates; pre/post-test scores; % scoring 80% or higher on post-test; % scoring 65% or higher on ex-post test (six month interval)*	pre/post-test; training tracking matrix; monthly TO report, volunteer leader & field officer supervisory checklists	after training; quarterly	TO; NM trainers	M&E Officer	ARC QPR; donor annual report	Nutrition
Objective-1: Improved nutritional status of children under two							
Stunting	Percent of children aged 0-59 months who are less than 2 standard deviations below the median height-for-age of the reference population	population based survey	baseline, endline	project officer	ARC NHQ	baseline, final evaluation	All
GMP; CVSG; CBSS; CSM							
Underweight	Percent of children aged 0-23 months who are less than 2 standard deviations below the median weight-for-age of the reference population	community growth monitoring (CBSS)	monthly weighing; annual report	field officer; operations manager	M&E Officer	annual report	All
GMP; CVSG; CBSS; CSM; HV							
IR 1.1: Improved care of pregnant women							
birth spacing	percent children 0-23 months who were born at least 24 months after the previous surviving child	population based survey	baseline and endline	Project Officer	ARC NHQ	baseline and endline surveys	MNC

antenatal care		percent women with 2 or more ANC visits	HMIS; CBSS?	monthly	health center staff; operations manager	M&E Officer	ARC quarterly report; annual report	MNC
tetanus toxoid 2		percentage of women receiving at least two tetanus toxoid injections before the birth of their last child	HMIS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	MNC
careseeking behavior		percentage of women who can recognize three or more danger signs of pregnancy	ex-post test	annual	field officer; operations manager	M&E Officer	annual report	MNC
community outreach		percent women counselled at least twice during pregnancy by community care group	volunteer leader checklist	monthly	field officer; operations manager	M&E Officer	ARC quarterly report; annual report	MNC
delivery		**percentage of births attended by skilled health personnel of mothers who had received appropriate community counseling visits**	HMIS with volunteer leader checklist	annual	operations manager	M&E Officer	annual report	MNC
		percentage of children age 0-11 months whose births were attended by skilled health personnel	HMIS annual		health center staff; operations manager	OD director; project coordinator	annual report	MNC
		percentage of children age 0-11 months whose births were attended by trained TBAs	HMIS with volunteer leader checklist	annual	health center staff; operations manager	OD director; project coordinator	annual report	MNC
		percentage of deliveries at home not attended by a skilled health personnel	volunteer leader checklist	annual	volunteer leader; field officer	M&E Officer	annual report	MNC
HV; CVSG; CBSS; HMIS; CSM								
IR1.2 Increased early and immediate breastfeeding								
breastfeeding	initiation	percentage of children breastfed within the first hour of delivery	CBSS; volunteer leader checklist	monthly	field officer; operations manager	M&E Officer	ARC quarterly report; annual report	Nutrition
		percentage of children breastfed within the first day of delivery	CBSS; volunteer leader checklist	monthly	field officer; operations manager	M&E Officer	ARC quarterly report; annual report	Nutrition

		percentage of children given other fluids prior to initiation of breastfeeding	CBSS; volunteer leader checklist	monthly	field officer; operations manager	M&E Officer	ARC quarterly report; annual report	Nutrition
	exclusive breastfeeding	**percentage of children exclusively breastfed for six months**	survey; rapid assessment at midterm	baseline, midterm, final M&E	Officer	Project Officer	baseline/endline reports; midterm & final evaluations	Nutrition
		percentage of children 0-5 months exclusively breastfed during the last 24 hours	CBSS; volunteer leader checklist	monthly	field officer; operations manager	M&E Officer	ARC quarterly report; annual report	Nutrition
	community outreach	percentage women counselled within one day of delivery by community care group	volunteer leader checklist	monthly	field officer; operations manager	M&E Officer	ARC quarterly report; annual report	
	CBSS; HV; CVSG							
IR1.3: Improved appropriate use of complementary foods								
complementary foods		percentage of children age 6-9 months who received breastmilk and complementary foods within the last 24 hours	survey	baseline and endline	M&E Officer	Project Officer	baseline/endline reports	Nutrition
		percentage of children 12-23 months who ate three or more food groups within the last 24 hours	pre/post-test; ex-post test	annual	field officer; operations manager	M&E Officer; TO	ARC quarterly report; annual report	Nutrition
community outreach		percentage of mothers who complete community care-group sponsored nutrition education sequence	volunteer leader checklist	quarterly	field officer; operations manager	M&E Officer; TO	ARC quarterly report; annual report	Nutrition
		percentage of mothers who can name five or more vitamin-rich foods	pre/post-test; ex-post test	monthly	field officer; operations manager	M&E Officer; TO	ARC quarterly report; annual report	Nutrition
CBSS; HV; NM; CVSG								
Objective 2: Improved immunization rates								

full immunization	percentage of children 12-23 months who are fully vaccinated before first birthday (# children in appropriate age group in target villages, # children fully vaccinated)	volunteer leader checklist	annual	volunteer leader; field officer	operations manager; M&E Officer	annual report	Immunization
	percentage of households with yellow cards	volunteer leader checklist	monthly	volunteer leader; field officer	operations manager	ARC quarterly report;	Immunization
CBSS; HMIS; CSM; HV							
IR2.1: Improved routine immunization rates							
routine immunization	percentage of children 12-23 months who received a measles vaccine	HMIS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	Immunization
	percentage of children 12-23 months who received three DPT vaccination	HMIS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	Immunization
	percentage of children 12-23 months who received three polio vaccinations	HMIS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	Immunization
	percentage of children 12-23 months who received BCG vaccinations	HMIS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	Immunization
HMIS; CBSS; CSM; HV; CVSG							
IR2.2: Improved Vitamin A coverage							
child VAC	percentage of children less than 23 months who received a VAC dose (# children who received VAC dose; # eligible children in target villages)	HMIS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	
pregnant women VAC	percentage of pregnant women who received at least one VAC dose	HMIS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	

HMIS; CBSS; CSM; HV: CVSG							
IR2.3: Improved community participation in immunization campaigns							
community care group outreach	percentage of children eligible vaccinated in campaign	CBSS; HMIS	campaign schedule	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	Immunization
community record-keeping	percentage of children eligible with household marker (# children in marked households; # children eligible for vaccination campaigns in target villages)	CBSS; volunteer leader checklist	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	Immunization
CSM; HV; CBSS; CVSG							
Objective 3: Enhanced community prevention & management of sick child							
overall prevalence	percentage of children with symptoms of illness (cough, diarrhea, fever) during the last two weeks	CBSS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	All
	no. of cases of childhood illnesses referred appropriately to health center	HMIS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	All
CBSS; HV							
IR3.1: Improved caregiver knowledge of childhood illnesses							
community outreach	percentage of mothers age 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment	survey	baseline; endline	M&E Officer	Project Officer	baseline/endline reports; final evaluation	All
	percentage of mothers with children age 12-23 months who can cite at least 2 ways of reducing risk of HIV infection	survey	baseline; endline	M&E Officer	Project Officer	baseline/endline reports; final evaluation	HIV/AIDS
	percentage of mothers who complete community care-group sponsored child health education sequence	volunteer leader checklist	quarterly	field officer; operations manager	M&E Officer; TO	ARC quarterly report; annual report	

	percentage of mothers who can name any signs of childhood illness	pre/post-test; ex-post test	quarterly	field officer; operations manager	M&E Officer; TO	ARC quarterly report; annual report	
CVSG; HV; CIMCI							
IR3.2: Improved caregiver home management of childhood illnesses							
careseeking behavior	percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks	survey	baseline; endline	M&E Officer	Project Officer	baseline/endline reports; final evaluation	All
	increased percentage of mothers of children 0-23 months who seek care for their child with cough or fast/difficult breathing	CBSS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	All
	increased percentage of mothers of children 0-23 months who seek care for their child with diarrhea	CBSS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	All
	increased percentage of mothers of children 0-23 months who seek care for their child with fever CBSS		monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	All
CVSG; HV; CBSS; CIMCI							
IR3.2: Improved prevention & treatment of childhood illnesses							
diarrhea	percentage of mothers with children age 12-23 months who report that they wash their hands with soap/ash at all appropriate moments survey		baseline; endline	M&E Officer	Project Officer	baseline/endline reports; final evaluation CDD	
	number of cases of diarrhea during the last month	CBSS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	CDD
	percentage of children age 0-23 months who had diarrhea during the last two weeks	CBSS monthly		health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	CDD

	percentage of children age 0-23 months who had diarrhea and were treated with ORT	CBSS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	CDD
ARI	number of cases of cough or rapid/difficult breathing during the last month	CBSS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	ARI
	percentage of children age 0-23 months who had cough or rapid/difficult breathing during the last two weeks	survey	baseline; endline	M&E Officer	Project Officer	baseline/endline reports; final evaluation	ARI
malaria	percentage of children age 0-23 months who slept under an insecticide treated net the previous night	volunteer leader checklist	annual	volunteer leader; field officer	operations manager; M&E Officer	annual report	malaria
	number of cases of fever during the last month	CBSS	monthly	health center staff; operations manager	OD director; project coordinator	ARC quarterly report; annual report	malaria
	percentage of children age 0-23 months who had fever during the last two weeks	survey	baseline; endline	M&E Officer	Project Officer	baseline/endline reports; final evaluation	malaria
CBSS; HV; CVSG; CIMCI							
Objective 4: Improved partner management capacity							
capacity	improvement on organizational capacity assessment (financial, HR, etc.)	capacity assessment	annual	M&E Officer	Project Officer	annual report	
IR4.1: Improved coordination with health community							
Use of data collection tools	no. joint trainings held	project monthly report	annual	TO Officer	Project Officer	annual report	
MOH activiities	% meetings held with MOH initiated by CS management team	project monthly report	annual	Project Coordinator	Project Officer	annual report	
	attendance record at monthly OD meetings	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	

	no. meetings held with MOH	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	
Stakeholder Participation	no. working group meetings attended	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	
	no. working group memberships	project monthly report	annual	Project Coordinator	Project Officer	annual report	
Docummentation and dissemination	no. professional papers or peer reviewed publications	project monthly report	annual	Project Coordinator	Project Officer	annual report	
IR4.2: Improved project management policies and skills							
project information management	% reports turned in correctly and on time	project monthly report	annual	Project Coordinator	Project Officer	annual report	
	no. reports turned in on time	project monthly report	quarterly	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report
	no. reports turned in completed correctly	project monthly report	quarterly	quarterly	Project Coordinator	Project Officer	
	no. trained in reporting procedures	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	
finance	% reports turned in correctly and on time	project monthly report	annual	Project Coordinator	Project Officer	annual report	
	no. reports turned in on time	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	
	no. reports completed correctly	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	

	no. trained in reporting procedures	project monthly report	quarterly	Finance Officer	Project Officer	ARC quarterly report; annual report	
training	no. trained in project management	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	
	% staff retained for more than one year after training	project monthly report	annual	Project Coordinator	Project Officer	annual report	
volunteer strategy development	volunteer structure options developed	project monthly report	annual	Project Coordinator	Project Officer	ARC quarterly report; annual report	
volunteer management	no. new volunteers recruited for project	project monthly report	quarterly	Project Coordinator	Project Officer	ARC quarterly report; annual report	
	% volunteers retained for more than one year	project monthly report	annual	Project Coordinator	Project Officer	annual report	

4. Management Plan

The ICH Project's staffing and management plan were designed following the primary roles and responsibilities of both ARC and CRC as described below.

American Red Cross (ARC) is responsible for ensuring the achievement of the ICH project's goal and objectives through the strategies and activities specified in the final and USAID-approved Detailed Implementation Plan (DIP). To that end, ARC is responsible for providing oversight for all aspects of the project and reporting to all stakeholders including USAID. ARC will also provide technical and financial support and ensure compliance with USAID regulations.

The Cambodian Red Cross is responsible for implementing the ICH project. Specifically, ARC is responsible for recruitment, management, and training of all CRC staff and volunteers who will work towards the achievement of the ICH project's goal and objectives. CRC is also responsible for reporting project and financial activities to ARC and is responsible for compliance with USAID regulations.

Both ARC and CRC are responsible for ensuring that project activities comply with related laws, policies, strategies, and guidelines of the Royal Government of Cambodia (RCG). Both ARC and CRC are responsible for ensuring that ICH project activities complement other activities implemented by the RGC, local authorities, and other NGOs. CRC has a defined role to serve as an auxiliary to the RCG.

The table below outlines the project staffing structure, roles and responsibilities, lines of authority, and level of effort. Resumes of key personnel and job descriptions are included as Annex V. The ICH project's organizational chart is included as Annex D.

Table 14. Management Table

Staff Roles	**& Responsibilities**	**Authority Level**	**of Effort**	**Status**
American Red Cross-Headquarters				
Asia Pacific Director	• Assumes the overall management responsibility of the project	Senior Director of International Relief and Development	10%	Mark Preslan
Senior International Financial Analyst (finance officer)	• Provides project financial management oversight in financial planning, analysis and internal and external reporting • Provides technical assistance to ARC field finance team to ensure compliance with USAID	Finance Manager	10%	Kevin Mitchell

	and ARC regulations and subrecipient monitoring of CRC			
M&E Technical Advisor	• Provides monitoring and evaluation technical assistance	TAPE Director	20%	Dr. Alice Willard
CS Technical Backstop	• Primary point of contact from NHQ and serves as the point of contact for USAID • Provides technical assistance to ensure best practices	Senior Health Advisor	20%	Sujata Ram
American Red Cross-Cambodia				
Head of Delegation	• Represents ARC and the project in PP • Responsible for all financial aspects of the project including sub-recipient training and monitoring • Provides support and liaises with ARC NHQ on administrative and financial matters • Provides support and acts as liaison with CRC senior leadership on partnership, organizational development, and non-technical project issues • Serves as liaison with USAID	Asia Pacific Director	25%	Nicholas Edwards
Health Program Officer	• Ensuring project design and implementation follow best practices and technical standards to achieve maximum impact • Ensures project resources – human, financial, and physical – are allocated to ensure project success and expended following donor and ARC regulations • Ensures activities are implemented as planned through supervision of ARC project staff and ongoing coordination	Head of Delegation	100%	Rob Kolesar

	with CRC project manager • Ensures accurate and timely project reporting to all stakeholders including USAID • Reviews financial reports and budgets, ensures implementation in line with budget with support from the HOD and ARC NHQ finance • Oversees operations research and integrates findings into project as appropriate, disseminates reports to CS community in Cambodia • Represents ARC and the ICH Project on coordination and technical working group meetings in SR and PP			
Finance/Admin. Officer	• Ensures project cash flow including monthly expense reporting and cash requests • Manages project bank account in SR • Pays staff salaries and allowances, invoices, and supplies • Summarizes expenses by account code and reporting in Quicken • Ensures compliance with donor and CRC regulations, policies, and procedures • Supports social marketing officer with financial record keeping	HOD/Health Project Officer	100%	A/Navy
Project Coordinator	• Coordinates technical support from ARC to CRC management and volunteer structure • Develops and monitors monthly work plan with CRC project manager • Support CRC project manager as requested • Recruits and trains staff in coordination with	Health Project Officer	100%	vacant, currently recruiting

	CRC • Monitors overall project performance • Monitors overall ARC staff performance • Represents project to stakeholders with CRC project manager • Ensures compliance with USAID, ARC, and CRC financial policies and procedures			
Training Technical Officer	• Oversees all project training to build capacity • Organizes and coordinates training for all project staff • Engages local expertise in training (ARC, CRC, PSI, RACHA, HC, etc.) • Provides TA and support to FOs for village-based training • Monitors training quality and skills development of trainees • Provides on-the-job coaching to project staff needing additional support	Health Project Officer	100%	Vacant, currently recruiting
M&E Technical Officer	• Ensures collection of data identified in the M&E plan on a timely basis; compile information for project reporting including HMIS and project specific data • Ensures the project's data monitoring system supports the HMIS • Verifies accuracy of data • Reviews and analyzes data to monitor achievement of targets with communities and project management • Acts as liaison with Angkor Chum OD and HCs on HMIS data collected by VHSGs and compiled by the HC outreach teams • Identifies gaps and	Health Project Officer	100%	Vacant, currently recruiting

	redundancies in data collection systems; makes recommendations to improve the system • Participates in OD, provincial, and national M&E meetings as required • Builds capacity of CRC and OD staff through one-on-one coaching • Conducts operational research in coordination with CRC and the ARC health program officer • Facilitates efforts of internal and external evaluators			
VSO Volunteer	• Provides technical support to CRC BCC team • Motivates team and CRC volunteer activities • Organizes monthly work plan with BCC Promotions Manager • Completes monthly progress reports	Health Project Officer	100%	Vacant, (not to be filled until Q1 Year 2)
Cambodian Red Cross- Headquarters				
Program Department Dir.	• Represents CRC and the project in PP • Ensures fulfillment of all CRC responsibilities as detailed in the project agreement	Secretary General	15%	Hum Sophon
Information Officer	• Write-up project success stories, especially those relating to partnerships with other implementing partners • Mobilize media to broadcast success stories and model mothers • Maintain an electronic photo library of project activities • Organize media events including press releases for signing, volunteer certificate, and inauguration ceremonies with participation from all project stakeholders • Interview technical		50%	Vacant, candidate identified

	experts to write articles relating to health promotion undertaken by the ICH Project			
Liaison Officer	• Briefs head of the health sub-department and director of the program department concerning project activities on a regular basis • Participates in PP-based technical working group • Supports project implementation as requested by the project manager (approximate travel = 50%) • Coordinates CRC HQ travel to the field • Serves as liaison with CRC communication department to write monthly story on the project • Serves as liaison with administration and finance department to ensure that cash requests from the project finance officer are processed in a timely manner	Program Department Dir.	100%	Vacant, currently recruiting
Cambodian Red Cross- Siem Reap Branch				
Branch Director		Secretary General	10%	Hum Sam An
Cambodian Red Cross- Angkor Chum Sub-branch				
Project Manager	• Manages overall ICH project implementation in accordance with the work plan • Directs supervision and performance monitoring of CRC project management staff • Recruits and trains staff in coordination with ARC policies • Facilitates ARC technical support to CRC management and volunteer structure • Maintains ongoing coordination with ARC • Reports activities to ARC and CRC leadership • Represents project to	Program Department Dir./ Branch Director	100%	Candidate identified

	stakeholders • Ensures compliance with donor and CRC financial policies and procedures			
Finance Officer	• Ensures project cash flow including monthly expense reporting and cash requests • Manages project bank account in SR • Pays staff salaries and allowances, invoices, and supplies • Summarizes expenses by account code and reporting in Quicken • Ensures compliance with donor and CRC regulations, policies, and procedures	Project Manager	100%	vacant, currently recruiting
Operations Managers (2)	• Supervise FOs; train and coach FOs on communication skills and health messages • Develos monthly work plans with FOs • Complets village visits with FOs • Revies and compile reports	Project Manager	100%	vacant
Field Officers (FOs) (15)	• Introduce project at village level with local authorities • Recruit and activates project CRC volunteers • Lead villages meetings to discuss health priorities, identify community resources, map beneficiaries, and develop village work plan with targets • Train/coach VLs and CVCGs on communication skills and health messages • Plans monthly activities with VLs including CBSS, home visit and WGs, and promotion activities • Monitors and motivates volunteer activity • Prepares progress reports	Project Manager	100%	Vacant

	• Acts as liaison with HC outreach teams • Coordinates with BCC team			
Volunteer leaders (VLs) (202)	• Coach volunteers in health message dissemination and communication skills • Monitor and motivate volunteer activity • Complete CBSS activities in their village • Coordinate with project promotion activities and other stakeholders working in their villages • Serve as liaison with the VHSG and TBAs in their village to facilitate HC referrals when appropriate and to help disseminate outreach activity schedule	Field Officers	15%	Some existing CRC volunteers identified
Community Volunteer Care Group members (2,016)	• Mobilize families for HC outreach activities • Conduct home visits and facilitate WGs to coach mothers for improved health practices • Complete intensive home visits with pre and post natal women • Monitor sick children as part of the CBSS	Volunteer leaders	10%	vacant
BCC Promotions Manager	• Manages all activities of the BCC team • Acts as liaison with ARC training officer and VSO volunteer to ensure BCC message accuracy and consistency • Ensures regular radio and TV coverage of project activities • Works with FOs, local authorities and opinion leaders to engage them in promotion of health messaging	Project Manager	100%	Vacant
Communications Officer	• Works with FOs, local authorities, opinion leaders and communities to engage	Promotions Manager	100%	vacant

	them in promotion of health messaging • Motivates participation from CRC volunteers in organizing community-based activities			
Social Marketing Officer	• Works with FOs, local authorities, opinion leaders and communities to engage them in promotion of health messaging	Promotions Manager	100%	vacant
BCC Unit volunteers	• Motivate and organize peers and participate in community-based activities including puppet shows, dramas, games, etc.	Project Manager	25%	vacant
Ministry of Health				
Provincial Health Director	• Provides guidance on implementation of project activities in support of PHD initiatives and plans • Supports training of project staff • Makes periodic joint monitoring visits	Secretary of State for Health	5%	Dr. Dy Bun Chhem
OD Director and staff	• Coordinate project activities with other implementing partners under OD jurisdiction • Facilitates coordination with HCs, ADs, and local leadership • Perform data processing for HMIS • Support training of project staff • Make joint monitoring visits • Coodinate counterpart ITNs and insecticide	Provincial Health Director	10%	Mak Sam Oeun
HC staff and outreach teams	• Support training of project staff • Communicate outreach visit schedule • Monitor community-initiated referrals	OD Director	5%	Various
Village Malaria Workers	• Support training of project staff and volunteers • Support village-based BCC activities	Provincial Health Director/OD Director	10%	Various

	• Support ITN distributions • Support insecticide re/treatment of bed nets			
VHSGs	• Support village-based training of CVCGs • Facilitate communication between HC and village	HC staff	5%	Various
TBAs	• Support SO1 activities related to antenatal care, delivery, and breastfeeding	HC staff	10%	Various
Local Leadership				
AD Governors (3)	• Facilitate introduction of project staff and activities in villages • Conduct joint monitoring	OD Director	10%	Tas Chan Kiri Chhimb Tun Em Vath
Commune leaders	• Facilitate introduction of project staff and activities in villages • Conduct joint monitoring	OD Director	15%	Various
Village Chiefs	• Facilitate introduction of project staff and activities in villages • Facilitate election of volunteers (CVCG members) • Oversee community-based monitoring of sick children • Support viillage-based training sessions	Commune leaders/ villages	15%	Various
Buddhist Monks and Nuns	• Play pre-recorded health messages over loudspeaker • Review Buddhist dharma as it may relate to health promotion and develop booklet for distribution to pagodas • Support BF WGs (nuns)	Department of Religion and Cults	5%	Various
School Directors and Teachers	• Incorporate health messages and announcements into lesson plan • Facilitate contests to support improved vaccination coverage	Department of Education	5%	Various

5. Table 15 - Work Plan Table

ICH Workplan Overview and Operating Environment Calendar

Activities	Year 1				Year 2				Year 3				Year 4				Personnel
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Overview																	
1. Baseline survey		X															ARC, CRC, OD
2. Stakeholder engagement/DIP Workshops		X X															ARC, CRC
3. DIP Preparation			X														ARC
4. Sign agreements and MOUs			X X														ARC, CRC, OD, PSI, VSO
5. Identification and hiring of staff		X	X	X													ARC, CRC
6. Angkor Chum Sub-branch office set-up			X	X													ARC, CRC
7. Recruitment, induction, and activation of volunteers/CVCGs			X	X													CRC, communities
8. Training of project staff		SO	4	SO4/ SO3	SO4/ SO2		SO4/ SO1		SO4/ SO2/3		SO4/ SO1		SO4/ SO3/2		SO4/ SO1		ARC, CRC
9. Village-based training of CRC volunteer leaders and CVCGs				X	X X X			X	X	X	X	X	X	X X			CRC, ARC
10. Formative research to fine tune training/interventions				X	X X X			X	X	X	X	X					ARC
11. BCC Unit community mobilization activities					X X X			X	X	X	X	X					VSO, CRC, opinion leade
12. Quarterly progress review meetings and reports				X	X X X			X	X	X	X	X	X	X X		X	All partners
13. Stakeholder coordination		X	X	X	X X X			X	X	X	X	X	X	X X		X	All partners
14. Supportive supervision and monitoring			X	X	X X X			X	X	X	X	X	X	X X		X	ARC, CRC, RACHA, HCs
15. Mid-term evaluation									X								ARC, CRC
16. Endline evaluation																X	ARC
Operating Environment Calendar																	
1. Rainy season																	
June-October	X		X	XXX	X		X	XXX X			X XXX X				X XXX		
2. Hot season																	
February-May		XX	XX			XX	XX			XX	XX			XX	XX		
3. Diarrhea season (follows rainy and hot seasons)																	
March-April and June-December	X X		X X XXX		X	X	X X XXX		X	X	X X XXX		X	X	X X XXX		
4. Malaria season (follows rains)																	
June-August and December-January	X X		X	XX	X	X	X XX		X	X	X	XX	X X		X	XX	
5. HC Vitamin A and de-worming outreach (MoH schedule)																	

March and November	X X				X		X		X		X		X		X		

Detailed Activities by Intermediate Result

Interventions: MNC (10%), BF (20%), NUT (15%)

SO1: Improved Nutritional Status of children under 2

IR1: Improved care of pregnant women

IR2: Increased early and exclusive breastfeeding

IR3: Improved use of complementary foods

Major Activities	Year 1				Year 2				Year 3				Year 4				Personnel
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
1.1 Staff TOT training BF							X				X				X		ARC, CRC, HCs, TBAs
1.2 Village-based training in BF							X	X			X	X			X	X	CRC, ARC, RACHA
1.3 Staff TOT training in antenatal care							X				X				X		ARC, CRC, HCs, TBAs
1.4 Villlage-based training in antenatal care							X	X			X	X			X	X	CRC, ARC, RACHA
1.5 Pre and post-partum visits / women's groups							X	X	X	X	X	X	X	X	X	X	CRC CVCGs, TBAs
1.6 Staff TOT training in growth monitoring								X			X				X		CRC, ARC, HCs
1.7 Village-based training in growth monitoring								X	X			X				X	CRC, ARC, HCs
1.8 Growth monitoring linked to HC outreach								X	X	X	X	X	X	X	X	X	CRC CVCGs, HCs
1.9 Related community-based BCC activities								X	X	X	X	X	X	X	X	X	VSO, CRC, opinion leade
1.10 Supportive supervision and monitoring							X	X	X	X	X	X	X	X	X	X	ARC, CRC, RACHA

Interventions: EPI (15%), Vit A (10%)

SO2: Improved Immunization Rates

IR1: Improved routine immunization rates

IR2: Improved Vitamin A coverage

IR3: Improved community participation in immunization

Major Activities	Year 1				Year 2				Year 3				Year 4				Personnel
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
2.1 Staff TOT training in immunization and micronutrients					X				X				X				ARC, CRC, HCs
2.2 Village-based training in immunization					X	X			X	X			X	X			CRC CVCGs, VHSGs
2.3 Village-based training in micronutients						X								X			CRC Field Officers
2.4 Home visits and women's groups to improve turn-out					X X X			X	X	X	X	X	X	X X		X	CVCGs, TBAs,

2.5 Follow-up visits with outreach no-shows																	CRC VLs, VHSGs, opinion
2.6 Coordination meetings with VHSG (pre and post outreach)					X X X			X	X	X	X	X	X	X X		X	CRC VLs, VHSGs
2.7 Intensified outreach for enhanced HC outreach (VAC)						X		X		X		X		X		X	CVCGs, VHSGs
2.8 Community-based BCC activities						X	X	X	X	X X		X	X	X	X	X	VSO, CRC, opinion leade
2.9 Supportive supervision and monitoring					X	X	X	X	X	X	X	X	X	X	X	X	ARC, CRC, HCs, OD
Interventions: CDD (10%), PCM (10%), Malaria (10%)																	
SO3: Enhanced Community Prevention and Management of the Sick Child																	
IR1: Improved home management																	
IR2: Early identification and referral for danger signs																	
IR3: Improved malaria prevention																	
Major Activities	Year 1				Year 2				Year 3				Year 4				Personnel
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
3.1 Staff TOT training in home care, DTK, and malaria				X					X				X				PSI, ARC, CRC
3.2 Village-based training in home care, DTK, and malaria				X	X				X	X			X	X			CRC, PSI
3.3 Home visits and WGs to improve home management					X	X	X	X	X	X	X	X	X	X	X	X	CVCGs
3.4 Home visits and WGs for early identification and referral					X	X	X	X	X	X	X	X	X	X	X	X	CVCGs
3.5 Community monitoring for early identification and referral					X	X	X	X	X	X	X	X	X	X	X	X	CRC VLs, opinion leaders
3.6 Community-based DTK promotion and sales					X	X	X	X	X	X	X	X	X	X	X	X	CVCGs
3.7 Mosquito net re/treatment linked to enhanced outreach					X	X			X	X			X	X			CVCGs, VLs, HC, VMWs
3.8 ITN vulnerability targeting					X	X											CVCGs, VLs, opinion lead
3.9 Mosquito net free distribution to most vulnerable					X	X											VLs, HC, VMWs
3.10 Mosquito net social marketing (promotion and sales)					X	X	X	X	X	X	X	X	X	X	X	X	VLs, CVCGs
3.11 Related community-based BCC activities						X	X	X	X	X X		X	X	X	X	X	VSO, CRC, PSI, opinion l
3.12 Supportive supervision and monitoring				X	X	X	X	X	X	X	X	X	X	X	X	X	ARC, CRC
Interventions: Local Capacity Building (integrated)																	
SO4: Improved Partner Project Management Capacity																	
IR1: Improved coordination with health community																	
IR2: Improved project management policies and skills																	
Major Activities	Year 1				Year 2				Year 3				Year 4				Personnel
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
4.1 Coordination meetings with stakeholders (PP, SR, and AC)		X	X	X	X X X			X	X	X	X	X	X	X X		X	All
4.2 Progress reporting with stakeholders			X	X	X X X			X	X	X	X	X	X	X X		X	ARC health officer
4.3 Joint village-based training and monitoring visits			X	X	X X X			X	X	X	X	X	X	X X			ARC, CRC, RACHA, HCs

4.4 Participation in technical working groups	X	X	X	X	X	X			X	X	X	X	X	X	X		X	ARC, CRC
4.5 Exchange visits		X	X								X			X				ARC, CRC, CRS, PFD
4.6 Technical resource sharing	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	ARC
4.7 Support development of Volunteer Management Training Curriculum and Volunteer Reward and Recognition Plan	X	X	X	X		X												ARC, CRC, IFRC
4.8 On-the-job training/coaching	X	X	X	X	X	X			X	X	X	X	X	X	X		X	ARC, CRC
4.9 Adult learning, communication and volunteer manag. training		X	X	X				X		X		X		X		X		ARC, CRC

6. Organizational Development / Sustainability

Although this section is not required for standard category grantees, it has been included to highlight the importance of organizational development for both the American and Cambodian Red Cross. Correspondingly, *SO4: Improved Partner Project Management Capacity* focuses on organizational development. SO4 OD activities are detailed in Section 2. This section includes an overview of the OD project indicators that will be tracked to evaluate OD and capacity building. Also included here are several elements of the Child Survival Sustainability Assessment (CSSA) framework that were incorporated into the detailed implementation planning process. The results of these activities are described below.

Organizational Development

Organizational development of the Cambodian Red Cross is integrated into all aspects of the ICH project. The project aims to strengthen CRC's capacity to implement and manage community health programming. Health center community outreach activities supported by VHSGs are central to the MOH's strategy for expanding access to services. As CRC is recognized as an auxiliary to the MOH, OD activities untaken with the CRC support the strengthening of the MOH's efforts to improve access by expanding the reach of health services further into the villages through an enhanced CRC community volunteer base.

As described in Section C., a branch capacity assessment was undertaken and is included as annex E. The assessment was used to establish a baseline for organizational development indicators detailed in the *Indicator Performance Tracking Table* (IPTT- see Section 3- SO4). Indicators to be tracked under *IR4.2 Improved project policy and management skills* span the spectrum of organizational competencies necessary for the effective management of primary health care projects: information and financial management, training, and personnel management, especially volunteer management. Indicators tracked under *IR4.1 Improved coordination with the health community* will strengthen CRC's profile as a primary health care service provider in Cambodia. This IR will also facilitate the adoption of alternative and best practices through increased exposure to the Cambodian Child Survival community--inevitably strengthening CRC's technical capacity and project implementation throughout its national network of branch offices.

Clear and attainable OD targets have been laid out in the IPTT. Some of these will be tracked by the project manager through the regular monthly reporting mechanism (mainly, the ability to submit quality reports as well as recruit sufficient volunteers). Other indicators will be tracked quarterly, corresponding to the quarterly written reporting that is sent from the field to ARC headquarters. Capacity assessments (mainly self assessments) will be done annually to track progress on OD

Sustainability Assessment

The CSSA is a six-step process developed by CSTS and the CORE group:

1. Define the system to be assessed, its vision, and its goals.

2. Identify elements for the local system.
3. Choose indicators and identify scales you will use.
4. Measure the status of the individual indicators.
5. Create map indicators along the scales to define progress and, as needed, combine the indicators into indices.
6. Review results and propose programmatic intervention

The ICH project team has begun this process and will complete it over the next several months. During the Phase II DIP workshop, with participation from each of the key stakeholder organizations, the team facilitated a visioning exercise whose results are shown in Annex T. The system being analyzed for this vision is the community, Red Cross and Ministry of Health. The participants split into five groups, each of whom identified what they thought should be key elements of the vision. These key elements all belonged to the domains of community competence and responsibility, health service quality, improved community volunteer networks (especially the VHSGs). The elements identified in this visioning exercise were pulled together by the facilitators afterwards and made into a unified vision that was reflected back to the group for confirmation and refinement. This vision is that:

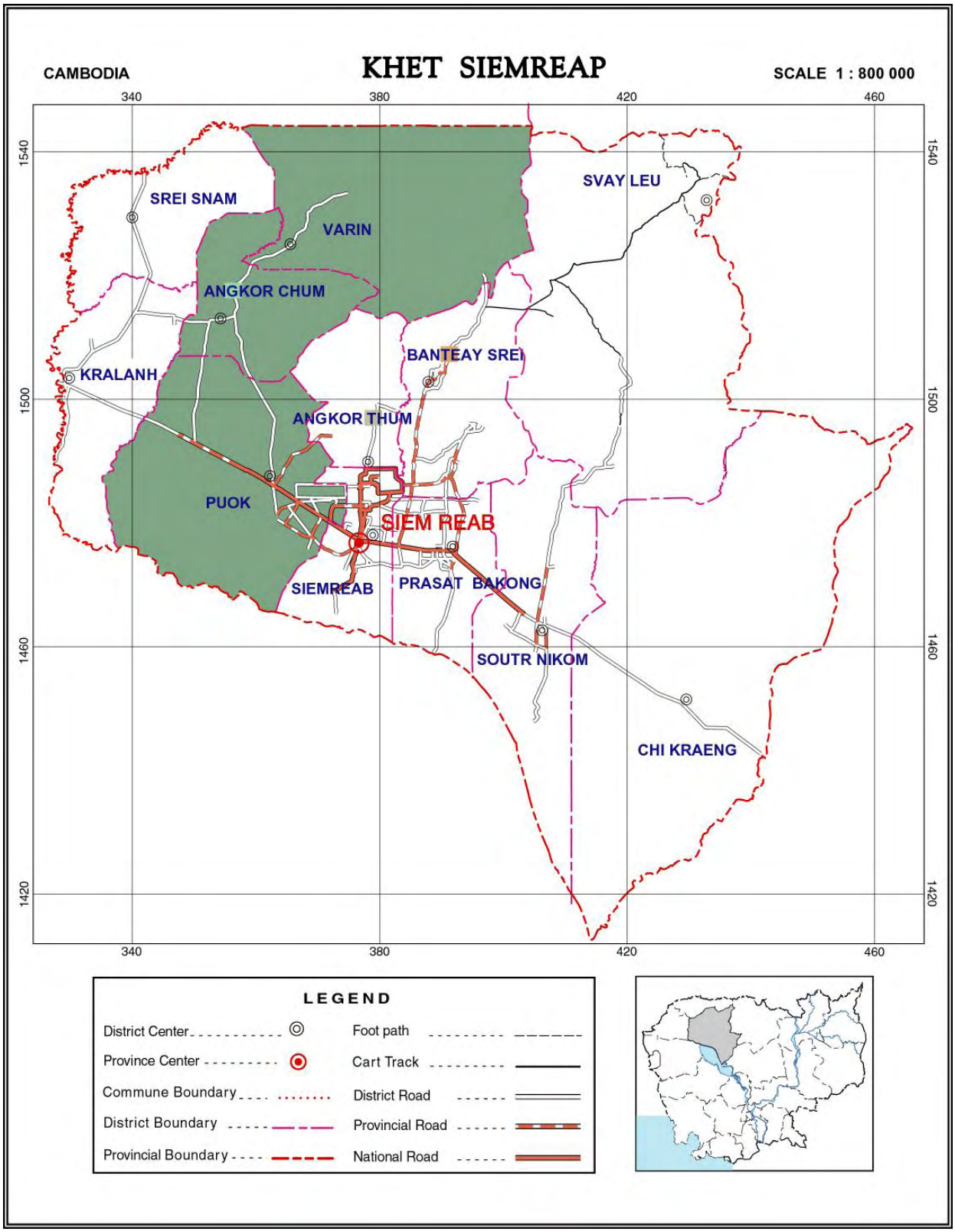
> Children under five and their mothers in the three administrative districts of Siem Reap (Pourk, Angkor Chum, and Varin) will be healthy and well-nourished as a result of:
> - Improved key family health behaviors;
> - Strengthened community structures (vhsgs and crc volunteer structure);
> - Improved coordination between the community and the authorities;
> - Improved delivery of priority health services.

A preliminary outline of the project's sustainability measurement framework is outlined in Table 15 below. The project coordination team will be consulted to complete and finalize the elements to be included in each of the six components detailed in the CSSA framework.

Table 16 – Outlines of CSSA Framework for ICH Project

Comp. #	Component Name	Description of Elements to be Included	Comments
1.1	Health outcomes	Those indicators from the KPC that are relevant to the three focus areas (nutrition, immunization, care of the sick child).	Outlined in M&E Section 3
1.2	Health services approach	• Strengthening the VHSGs • Improve the quality of facility based health services through coordination with other actors.	Outlined in M&E Section 3
2.1	Organizational capacity	CRC ability to manage community health projects (managerial, technical, financial areas)	See IPTT table in Section 3
2.2	Organizational viability	Connection of CRC to MOH and other actors	See IPTT table in Section 3
3.1	Community competence	Measured through strengthened volunteer groups associated with the VHSGs	
3.2	Ecological and policy environment	Adoption of a Volunteer Incentives Policy; other indictors yet agreed upon	There was recognition that the landscape is changing radically in the three ADs because of economic development in Siem Reap driven by tourism.

Annex A: Map of Project Site



Annex B

Cambodian Red Cross
Branch Assessment Tool

	Background Information
Questions	Answers
Branch Name	Siem Reap
Branch Manager's Name	A. First (Surname): SUM
	B. Last (Family name): SAM AN
Branch Address	Mondol I, Khum Svay Dangkum
Branch Telephone Number	063-964-492 Mobile phone: 012-948-127
Date of Interview (dd/mm/yyyy)	9 / 05 / 2005

	Section 1: Governance	
Questions	Answers	Notes
When was your branch established?	Month: |0|7| Year: |1|9|7|9 Don't know: □	
How many members does your branch have (do not include paid staff)?	Number of members: |0|4| Not applicable: □ Don't know: □	
Is your branch registered?	Yes: □ No: □ ✓ Don't know □	
If yes, with whom is your branch registered?	National government □ State / regional government □ Provincial government □ Other (specify)…… □ Don't know □	
Does your branch have bylaws or statues that govern its operations?	Yes: □✓ (done every year by branch committee) No: □ Don't know □	Get a copy
Do you have a community advisory board or another mechanism for ensuring community involvement?	Yes Yes, other, (specify) branch committee □✓ PHD, Provincial governor □ No □ Don't know	

What role/function does the community advisory board have?	Provides advice on all operations □✓ Provides project-specific advice □ Other (specify) policy □✓ Don't know □ □	
How often does it meet?	Twice a year □ Quarterly □✓ Monthly □ Infrequently □ Don't know □	
Who is on the board? Check all that apply.	Local government officials □ Religious leaders □ Members of target population □ Youth □ Other (specify) businessmen □✓	

Section 2: Human Resources		
Questions	Answers	Notes
How many paid staff does your branch have?	Number of paid staff: 19 professional, 7 guards/cleaner |2|6| Not applicable: □ Don't know: □	
How many regular volunteers does your branch have? (A volunteer is defined as an individual who has given an average of 2-4 hours/week over the last 3 months.)	Number of volunteers: |4|3|0 Not applicable: □ Don't know: □	
Do job descriptions exist for all key staff positions?	Yes: □✓ No: □ Don't know: □	Get a Copy ✓
Does your branch have an organizational chart?	Yes: □✓ (draft) No: □ Don't know: □	Get a Copy
Does your branch conduct regular performance reviews of all staff?	Yes: □✓ anuually No: □ Don't know: □	
Does your branch have a Human Resources policy?	Yes: □✓ based on HQ No: □ Don't know: □	Get a Copy ✓
Does your branch have a volunteer policy?	Yes: □✓ draft, pending approval No: □ Don't know: □	Get a Copy ✓ there is a rational policy

Does your branch have written position descriptions for its volunteers?	Yes: □✓ No: □ Don't know: □	Get a Copy ✓
Does your branch organize regular training for volunteers?	Yes: □✓ (not regular) No: □ Don't know: □	Get a Copy of Training Guides ✓
Does your branch have a written code of conduct for its volunteers?	Yes: □ No: □✓ Don't know: □ just roles and responsibities	Get a Copy

Section 3: Financial Management		
Questions	Answers	Notes
How large is your current annual budget?	US $30,000	
Does your branch have a bank account?	Yes □✓ No □ Don't' know □	
Do you develop annual budgets?	Yes □✓ No □ Don't' know □	
Does your branch produce monthly financial reports?	Yes: □✓ No: □ Don't know: □	Get a Copy ✓ April
Are internal financial audits conducted on a regular basis?	Yes, regularly □ Yes, BUT not regularly □ No, not conducted □✓ Don't know □	
Are external financial audits conducted on a regular basis?	Yes, regularly □ Yes, BUT not regularly □✓ OD just does PHC, not possible to get copy No, not conducted □ Don't know □	Get a Copy
Does your branch receive regular funds from CRC NHQ?	Yes: □ No: □✓ Don't know: □	
What percentage of your funds are derived from international donors?	% of funds from international donors:(only PHC Danish Red Cross	
Has your branch received any grants over the past year?	Yes: □ No: □✓	

	Don't know: □	
If yes, how many grants did your branch receive? From which organizations?	No. of grants received:…… From which organization?:……	
Does your branch conduct any fundraising activities?	Yes: □✓ No: □ Don't know: □	
If yes, what kind of fundraising activities do you do? Select all that apply.	Public events (one time or ad hoc events): □✓ branch assembly and Red Cross Day Income-generating activities: □ Requesting pledges/donations: □ Other (specify) boxes: □✓	

Section 4: Strategic Planning		
Questions	Answers	Notes
Does your branch have a mission statement describing its long-term goals and objectives?	Yes: □✓ No: □ Don't know: □	Get a Copy
Does your branch conduct annual (regular) strategic planning?	Yes: □✓ No: □ Don't know: (one year) □	Get a Copy ✓
Do you have a work plan that describes the activities to be implemented over the next several months?	Yes: □ No: □✓ Don't know: they keep it flexible and fill in as needed □	Get a Copy

Section 5: Monitoring and Evaluation		
Questions	Answers	Notes
Does your branch have a monitoring and evaluation (M&E) plan?	Yes: □ No: □✓ Don't know: □	Get a Copy
Does your branch submit monthly reports to ERCS NHQ?	Yes: □✓ No: □ Don't know: □	Get a Copy
Does your branch conduct an annual (regular) customer satisfaction survey?	Yes: □ No: □✓	Get a Copy

	Don't know: □	
Does your branch use indicators to measure implementation of its activities and its objectives?	Yes: □ No: □✓ Don't know: □	
Does your branch track the number of direct beneficiaries through its interventions?	Yes: □✓ No: □ Don't know: □	
If yes, how frequently do you measure how many people you are reaching?	Monthly □✓ Quarterly □ Semi-annually □ Annually □ Other (specify)_____ □ Don't know □	

Section 6: Service Delivery		
Questions	Answers	Notes
What are your branch's MAIN target populations?	1. victims of dissaster 2. handicapped 3. poor 4. HIV patient (full-blown AIDS) 5. widow/orphan 6.	
What kind of services do you provide to these target populations? How many clients are provided each service? monthly	Services provided/# of clients: copy coming 1. poor, OD HH kit / (varies by month) 2. handicapped/wheel chair/20/year 3. food/(varies by month) 4……/…… 5……/…… 6……/……	
What areas in the district/province are you working? (List all states/regions, provinces, or communities)	1. PHC Danrun Commune; Sonikum District 2. entire province 3. depending on request 4…… 5…… 6…… 7…… 8…… 9…… 10……..	

Section 7: Partnerships		
Questions	Answers	Notes
Who are your main partners? Give names of partners.	1. PHD 2. MOED 3. Danish Red Cross	

	4. CRC 5. GIPA (HIV NGO) 6…… 7…… 8…… 9…… 10……	
With which partners does your branch have a signed MOU? Give names of partners.	1. none at branch, only at NHQ 2…… 3…… 4…… 5……	

Annex C

I. DESCRIPTION OF PVO APPLICANT

ARC's **global operations** now include more than 40 community-based health projects in 30 countries in Asia, Africa, Eastern Europe, the Caribbean, and the Americas. The Measles Initiative and the IMCI Healthy Children Initiative are examples of two major multi-country international community-level programs with a child health focus in which ARC has major design, implementation, and monitoring and evaluation (M&E) contributions. The Measles Initiative has vaccinated 120 million children in 24 African nations, saving an estimated 272,000 lives. The IMCI Healthy Children Initiative is a five-year community-based initiative geared to save the lives of 100,000 under-five (U5) children in 10 countries in the Americas. Working through national and subnational steering and technical committees, it mainstreams policies and implementation guidelines into national IMCI programs. The Measles Initiative and the IMCI Healthy Children Initiative have forged strong working relationships with multiple organizations, including the Centers for Disease Control, the United Nations Foundation, the World Health Organization (WHO), United Nations Childrens Fund (UNICEF), national Ministries of Health, RC movement partners, and NGOs.

USAID recently awarded ARC a five-year CSHGP for Albania (2003-2008). The Albania interventions include nutrition and micronutrients (breastfeeding, complementary feeding, vitamin A supplementation, and iodized salt promotion), control of diarrheal disease, pneumonia case management, and reproductive health (iron supplementation during pregnancy, promotion of prenatal visits, and family planning). The ARC CSHGP for Cambodia will implement several, though not all, of these activities and add activities, such as immunization and malaria control. Ample opportunities thus exist for the two projects to exchange ideas and lessons learned, particularly in the important areas of (1) building the institutional capacity and financial sustainability of national and subnational RC societies, (2) fostering complementary and durable linkages between RC societies and Ministries of Health, and (3) designing, implementing, monitoring, and evaluating shared technical interventions.

ARC's **current operations in Cambodia** are in the safe water and hygiene, disaster preparedness, and disability sectors, and it has current agreements with a private foundation and the Mekong River Commission (MRC) to implement these activities. ARC now furnishes project design, project implementation, compliance, and technical assistance, as well as funding support, to CRC's NE Province Community Hygiene and Water Purification Project, an 18-month activity that runs from July 2002 to December 2003. Exercising a participatory planning approach and receiving design and implementation inputs and feedback from government, UN agency, and NGO stakeholders, this project strengthens provincial CRC management, training, and monitoring capacities and provides simple hygiene messages and effective and affordable household ceramic water purifiers (CWPs) to impoverished and illiterate villagers, many of whom belong to highland forest tribes. The project has also conducted (1) professional quality improvement for CWP production and marketing, and (2) monitoring research using a Knowledge, Practices, and Coverage (KPC) survey. Lessons from this project show that an effective community-based activity geared toward poor Cambodians requires (1) simple technologies; (2) simple, frequently repeated messages; (3) continuous monitoring; and (4) community ownership. These lessons are highly relevant for the ARC CSHGP for Cambodia.

ARC now implements a flood early-warning system project in two eastern provinces with an Office of Foreign Disaster Assistance (OFDA) subgrant from MRC. Carried out by provincial branch offices and CRC community-based workers with ARC financial oversight and TA, this project adapts MRC flood monitoring and forecasting systems to the local context. It will expand to all provinces along the Mekong River in 2004.

ARC received over seven million dollars, primarily from USAID and AusAid, from 1991 to 2002 to furnish physical rehabilitation services, community social and education services, and information and referral services to persons with disabilities, particularly persons disabled by landmines. It currently has funding from the Freeman Foundation to continue rehabilitation services through June 2004.

G. Partner Organization and Reasons for Selection: The CRC is ARC's local implementing partner. CRC was founded in 1955 and joined the Federation in 1960. After a gap caused by decades of civil strife, the CRC was readmitted to the Federation in 1994. As of mid-2002, CRC had 65,428 paying members, 5,773 RC volunteers, and 317 paid staff. It has branch offices and volunteer networks in all 24 of Cambodia's provinces. CRC's 1998 to 2001 total income was $16,456,854, 36% of which was generated from membership fees. CRC's 2002 to 2006 Strategic Plan includes the following four goals relevant to the ARC CSHGP: (1) capacity building at national and subnational levels; (2) increasing self-reliance; (3) improving the quality of life, health, and social welfare of the most vulnerable; and (4) strengthening internal, national, and international relations.

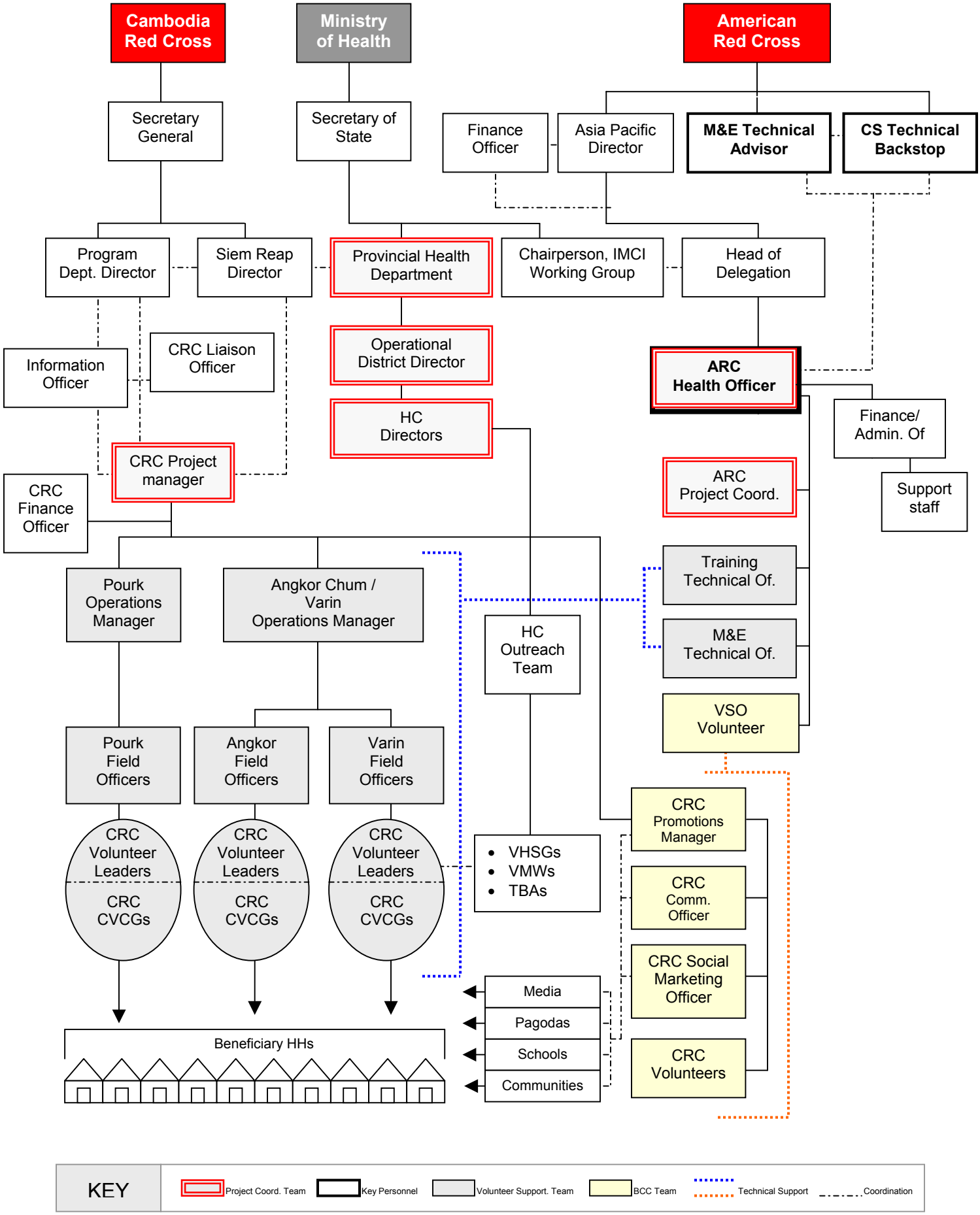
CRC implements an impressive array of multisectoral health programs. They include the community-based PHC Pilot Project supported by the British RC in Chong Kal District, Oddar Meanchey Province (bordering on Siem Reap); the Sothnikum PHC Project supported by the Danish RC in southern Siem Reap Province; the Community Health and Water Purification Project supported by ARC in four NE provinces; the Community-based First-Aid Program supported by the Federation nationwide, the HIV/AIDS Education Project supported by the Australian RC in seven provinces; the Community-based Dengue Hemorrhagic Fever Prevention Program supported by the Federation and the New Zealand RC in four provinces; and a national blood donor recruitment program supported by the South Korean RC. CRC also routinely conducts disaster management, emergency response, and landmine awareness activities.

CRC's partners and donors include the Federation; sister RC societies; AusAid; CIDA; UNESCO; OPEC, Family Health International; and Handicap International. CRC has also received USAID funding under ARC subgrants for community-based disaster preparedness and emergency relief.

Reasons for selecting CRC include the following: (1) As an organization with a national structure, a constitution, and a national governing board, it enjoys complete institutional sustainability. It generates its own internal funding and draws upon diverse financial donors and resources, thus ensuring a degree of financial sustainability; (2) As an indigenous organization operating as an auxiliary to the government, the CRC maintains a close professional relationship with national and local government authorities and line ministries, including the MOH; (3) As an internationally recognized member of the Federation, CRC can – and does -- draw on the expertise and resources of the international RC movement. CRC holds monthly health coordination meetings with its in-country RC sister societies and encourages linkages between them. For example, the ARC CSHGP

will adopt the basic management model and the community-based surveillance system (CBSS) established in the Chong Kal PHC project, and the Danish RC will use ceramic water filters pioneered by ARC in NE Cambodia; (4) As an organization with an institutional presence in all 24 provinces, CRC can rapidly scale up successful models and programs, including those supported by USAID; and (5) Over the past nine years, CRC has demonstrated an ability to carry out successful health and relief activities in PHC, HIV/AIDS, water and sanitation, blood donor recruitment, and disaster preparedness and management.

Annex D - Integrated Child Health Project Organizational Chart



Annex E

Cambodian Red Cross
Branch Assessment Tool

	Background Information
Questions	Answers
Branch Name	Siem Reap
Branch Manager's Name	A. First (Surname): SUM
	B. Last (Family name): SAM AN
Branch Address	Mondol I, Khum Svay Dangkum
Branch Telephone Number	063-964-492 Mobile phone: 012-948-127
Date of Interview (dd/mm/yyyy)	9 / 05 / 2005

	Section 1: Governance	
Questions	Answers	Notes
When was your branch established?	Month: |0|7| Year: |1|9|7|9 Don't know: □	
How many members does your branch have (do not include paid staff)?	Number of members: |0|4| Not applicable: □ Don't know: □	
Is your branch registered?	Yes: □ No: □ ✓ Don't know □	
If yes, with whom is your branch registered?	National government □ State / regional government □ Provincial government □ Other (specify)…… □ Don't know □	
Does your branch have bylaws or statues that govern its operations?	Yes: □✓ (done every year by branch committee) No: □ Don't know □	Get a copy
Do you have a community advisory board or another mechanism for ensuring community involvement?	Yes Yes, other, (specify) branch committee □✓ PHD, Provincial governor □ No □ Don't know	

What role/function does the community advisory board have?	Provides advice on all operations □✓ Provides project-specific advice □ Other (specify) policy □✓ Don't know □ □	
How often does it meet?	Twice a year □ Quarterly □✓ Monthly □ Infrequently □ Don't know □	
Who is on the board? Check all that apply.	Local government officials □ Religious leaders □ Members of target population □ Youth □ Other (specify) businessmen □✓	

Section 2: Human Resources		
Questions	Answers	Notes
How many paid staff does your branch have?	Number of paid staff: 19 professional, 7 guards/cleaner |2|6| Not applicable: □ Don't know: □	
How many regular volunteers does your branch have? (A volunteer is defined as an individual who has given an average of 2-4 hours/week over the last 3 months.)	Number of volunteers: |4|3|0 Not applicable: □ Don't know: □	
Do job descriptions exist for all key staff positions?	Yes: □✓ No: □ Don't know: □	Get a Copy ✓
Does your branch have an organizational chart?	Yes: □✓ (draft) No: □ Don't know: □	Get a Copy
Does your branch conduct regular performance reviews of all staff?	Yes: □✓ anuually No: □ Don't know: □	
Does your branch have a Human Resources policy?	Yes: □✓ based on HQ No: □ Don't know: □	Get a Copy ✓
Does your branch have a volunteer policy?	Yes: □✓ draft, pending approval No: □ Don't know: □	Get a Copy ✓ there is a rational policy

Does your branch have written position descriptions for its volunteers?	Yes: □✓ No: □ Don't know: □	Get a Copy ✓
Does your branch organize regular training for volunteers?	Yes: □✓ (not regular) No: □ Don't know: □	Get a Copy of Training Guides ✓
Does your branch have a written code of conduct for its volunteers?	Yes: □ No: □✓ Don't know: □ just roles and responsibities	Get a Copy

Section 3: Financial Management		
Questions	Answers	Notes
How large is your current annual budget?	US $30,000	
Does your branch have a bank account?	Yes □✓ No □ Don't' know □	
Do you develop annual budgets?	Yes □✓ No □ Don't' know □	
Does your branch produce monthly financial reports?	Yes: □✓ No: □ Don't know: □	Get a Copy ✓ April
Are internal financial audits conducted on a regular basis?	Yes, regularly □ Yes, BUT not regularly □ No, not conducted □✓ Don't know □	
Are external financial audits conducted on a regular basis?	Yes, regularly □ Yes, BUT not regularly □✓ OD just does PHC, not possible to get copy No, not conducted □ Don't know □	Get a Copy
Does your branch receive regular funds from CRC NHQ?	Yes: □ No: □✓ Don't know: □	
What percentage of your funds are derived from international donors?	% of funds from international donors:(only PHC Danish Red Cross	
Has your branch received any grants over the past year?	Yes: □ No: □✓	

	Don't know: □	
If yes, how many grants did your branch receive? From which organizations?	No. of grants received:…… From which organization?:……	
Does your branch conduct any fundraising activities?	Yes: □✓ No: □ Don't know: □	
If yes, what kind of fundraising activities do you do? Select all that apply.	Public events (one time or ad hoc events): □✓ branch assembly and Red Cross Day Income-generating activities: □ Requesting pledges/donations: □ Other (specify) boxes: □✓	

Section 4: Strategic Planning		
Questions	Answers	Notes
Does your branch have a mission statement describing its long-term goals and objectives?	Yes: □✓ No: □ Don't know: □	Get a Copy
Does your branch conduct annual (regular) strategic planning?	Yes: □✓ No: □ Don't know: (one year) □	Get a Copy ✓
Do you have a work plan that describes the activities to be implemented over the next several months?	Yes: □ No: □✓ Don't know: they keep it flexible and fill in as needed □	Get a Copy

Section 5: Monitoring and Evaluation		
Questions	Answers	Notes
Does your branch have a monitoring and evaluation (M&E) plan?	Yes: □ No: □✓ Don't know: □	Get a Copy
Does your branch submit monthly reports to ERCS NHQ?	Yes: □✓ No: □ Don't know: □	Get a Copy
Does your branch conduct an annual (regular) customer satisfaction survey?	Yes: □ No: □✓	Get a Copy

	Don't know: □	
Does your branch use indicators to measure implementation of its activities and its objectives?	Yes: □ No: □✓ Don't know: □	
Does your branch track the number of direct beneficiaries through its interventions?	Yes: □✓ No: □ Don't know: □	
If yes, how frequently do you measure how many people you are reaching?	Monthly □✓ Quarterly □ Semi-annually □ Annually □ Other (specify)_____ □ Don't know □	

Section 6: Service Delivery		
Questions	Answers	Notes
What are your branch's MAIN target populations?	1. victims of dissaster 2. handicapped 3. poor 4. HIV patient (full-blown AIDS) 5. widow/orphan 6.	
What kind of services do you provide to these target populations? How many clients are provided each service? monthly	Services provided/# of clients: copy coming 1. poor, OD HH kit / (varies by month) 2. handicapped/wheel chair/20/year 3. food/(varies by month) 4……/…… 5……/…… 6……/……	
What areas in the district/province are you working? (List all states/regions, provinces, or communities)	1. PHC Danrun Commune; Sonikum District 2. entire province 3. depending on request 4…… 5…… 6…… 7…… 8…… 9…… 10……..	

Section 7: Partnerships		
Questions	Answers	Notes
Who are your main partners? Give names of partners.	1. PHD 2. MOED 3. Danish Red Cross	

	4. CRC 5. GIPA (HIV NGO) 6…… 7…… 8…… 9…… 10……	
With which partners does your branch have a signed MOU? Give names of partners.	1. none at branch, only at NHQ 2…… 3…… 4…… 5……	

Annex F

PROJECT AGREEMENT #4
Concerning Siem Reap Integrated Child Health Project
issued under
Memorandum Of Understanding
between
The Cambodian Red Cross Society
and
The American National Red Cross

This Project Agreement is entered into by The American National Red Cross and the Cambodian Red Cross Society (collectively the "Parties"), pursuant to the Memorandum of Understanding (MoU) dated dated July 1, 2004.

The terms and conditions contained in the MoU apply to this Project Agreement (hereafter: Agreement) as if they were included herein and are made an integral part of this Agreement.

1. Project Description

The purpose of this Agreement is to specify the roles and responsibilities of The American National Red Cross (hereafter: American Red Cross) and the Cambodian Red Cross Society (hereafter: CRC) for the implementation of the Siem Reap Integrated Child Health Project (hereafter: the Program) to ensure the commitment by the Parties to working effectively and in an efficient manner towards the implementation of the Program in the interests of the direct beneficiaries of the Program.

USAID has awarded a cooperative agreement to American Red Cross to implement the Siem Reap Integrated Child Health Project (USAID Grant Award No. GHS-A-00-04-00007-00, hereafter: Award). Under this Award and pursuant to this Project Agreement, American Red Cross hereby provides a sub-grant to CRC for the purpose of implementing the Program. The CRC is considered a sub recipient of USAID funding and agrees to follow all terms and conditions that apply as described in this Agreement and the Annexes 1-11, attached hereto and made an integral part hereof. American Red Cross will provide technical support to the CRC and oversight for the Program in accordance with the Work Plan set forth in Annex 1.

2. Period of Agreement

This Agreement forms an integral part of the MOU between American Red Cross and CRC and covers the period beginning October 1, 2004 and continuing until September 30, 2008 or the end date of the Program, whichever comes last.

3. Role and Responsibilities of the Cambodian Red Cross Society

The CRC will:

3.1 Undertake the planning and implementation of the Program in accordance with the agreed upon Program Description ("Program Description") and Budget ("Budget") set forth in Annexes 1 and 2. Specifically, CRC will:

3.1.1 Recruit, select, and supervise qualified CRC paid staff and volunteers for the positions listed in the Budget and Program Description, to carry out the activities described in the

Program. All staff hired by CRC will be employees of CRC and as such, CRC agrees to comply with all local labor laws, pay all appropriate local taxes and comply with all other applicable laws, rules and regulations.

3.1.1.1 Maintain a record of all time spent by CRC paid staff members working on the Program by completing Timesheets (Annex 3). These timesheets must be available for onsite verification by American Red Cross or USAID personnel, with copies submitted to the American Red Cross Finance and Administration Delegate as part of the Monthly Financial Report.

3.1.1.2 Develop a system for maintaining record of all volunteer time for reporting on cost share to the program. These records must be available for onsite verification by American Red Cross or USAID personnel, with copies submitted to the American Red Cross Finance and Administration Delegate as part of the Monthly Financial Report.

3.1.2 Organize participatory planning sessions with the Siem Reap branch office.

3.1.3 Develop detailed implementation plan and detailed budget.

3.1.4 Orient the Office of the Provincial Governor, MOH, local government officials, local UNDP & UNICEF offices, sector NGOs, & Health Center personnel about project.

3.1.5 Develop training and communications materials and survey methodologies.

3.1.6 Adapt, translate and distribute existing training materials to meet Program objectives.

3.1.7 Provide technical assistance (TA) to village health support group members in all project interventions.

3.1.8 Participate with the MOH to train on the following areas: adult learning, social marketing, community-based surveillance, customer surveys, KPC surveys, immunization, nutrition, breastfeeding, diarrheal disease control, pneumonia case management, malaria control, dengue hemorrhagic fever prevention, birth spacing.

3.1.9 Co-ordinate and implement the training and activities involved in the Program implementation as set forth in the Program Description.

3.1.10 Work with CRC branches to train and provide ongoing technical support.

3.1.11 Develop and implement a plan for monitoring and evaluating Program activities and results.

3.1.12 Conduct site visits and participate in ongoing Program evaluation with American Red Cross.

3.1.13 Collect and interpret data for presentation to American Red Cross Technical Delegate and for feedback to the community.

3.1.14 Inform American Red Cross of other assistance, financial support and events influencing Program implementation.

3.1.15 Co-ordinate with the American Red Cross Technical Delegate on quarterly Program reviews and the baseline, mid-term and final evaluations of the Program.

3.1.16 Provide, through its good relations with the relevant national and local authorities, administrative and other support to the Program to allow the achievement of Program objectives.

3.1.17 Ensure that the Program is coordinated with other non-governmental organizations (NGOs) to enhance effectiveness and avoid duplication of effort.

3.2 Sign and be solely responsible for administering all contracts necessary to implement and monitor the Program, including but not limited to contracts necessary for training and surveys. CRC retains sole liability for all contracts and sole responsibility for ensuring that all contracts comply with local laws, rules and regulations.

3.3 Maintain appropriate property management and procurement systems to ensure adequate safeguards, records and maintenance for all purchases made in support of the Program.

3.3.1 Acquire and use equipment, supplies, office space, and furniture for this Program within the limitations of the Budget and according to the procurement standards referenced in 22 CFR 226.31-37 "Property Standards" (Annex 10), attached hereto and an integral part hereof. The authorized Geographic Code 000 applies to this Agreement. Deviations beyond 10% of the cost indicated in the Budget must be pre-approved in writing by American Red Cross.

3.3.2 Provide property insurance protecting the office space, equipment, and furniture. Insurance policies on property purchased with program funds should name American Red Cross as the beneficiary.

3.3.3 Conduct an annual physical inventory of all equipment purchased for the Program. The inventory must include at a minimum: description, serial/model number, source, acquisition date and cost with unit acquisition cost, condition and location of equipment.

3.3.4 Maintain a fixed asset listing available to American Red Cross or USAID representatives upon request.

3.3.5 Title to all property purchased with funds received under this Agreement will be vested with the CRC. Title to all non-expendable property, supplies and other expendable equipment remains vested in CRC, until such time as USAID issues disposition instructions. CRC is responsible for ensuring its use in accordance with USAID requirements according to Property Standards (Annex 10). CRC agrees to maintain a control system to ensure adequate safeguards to prevent loss, damage or theft of the equipment as well as to implement adequate maintenance procedures to keep the equipment in good condition. Equipment use should be limited to Program related activities. When no longer needed for the Program, the equipment shall be disposed in coordination with American Red Cross and USAID.

3.3.6 CRC agrees to register all vehicles provided to CRC in full compliance with local laws, rules and regulations. In addition, CRC agrees to provide physical damage and comprehensive loss insurance on all vehicles provided to CRC as well as auto liability insurance meeting all legal and compulsory requirements of the government of Cambodia. Vehicle use should be limited to Program related activities. When no longer needed for the Program, the vehicles shall be disposed in coordination with American Red Cross and USAID.

3.4 When requested by USAID, periodically brief the USAID Mission representative in Cambodia. All significant contacts with USAID must be conducted with the knowledge of the American Red Cross Technical Delegate. The CRC does not have the authority to negotiate or amend any of the terms and/or conditions of the Program Description or Budget directly with USAID.

3.5 Obtain prior approval in writing from American Red Cross for the following actions:

- Change in Program scope or objectives.
- Purchase of equipment equal to or greater than USD $1,000 unit cost and not described in the Budget.
- Deviation in excess of 10% of the cost of equipment indicated in the Budget.
- Modification of line item allocations in the Budget.
- International travel.
- Sale or disposition of equipment or supplies valued at USD $1,000 individually or cumulatively at the time of sale.
- Transferring work to a third party.
- Any activity restricted by the Budget or Standard Provisions set forth in Annex 8.
- Extensions of report due dates.

4. Role and Responsibilities of American Red Cross

The role of American Red Cross is to provide funding and appropriate resources to support implementation of the Program and to ensure appropriate monitoring and evaluation of the Program. American Red Cross will:

4.1 Integrate the Program within International Federation of Red Cross Red Crescent Societies (Federation) Delegation in Cambodia. The Country Support Agreement signed by the American Red Cross and the Federation allows the American Red Cross and its delegates to benefit from the Federation's Status Agreement in Cambodia, providing it with a legal personality to work in Country, including the ability to open bank accounts, as well as, affording the minimum protections for the American Red Cross and its Delegates. The American Red Cross Delegates for all practical purposes are considered agents of the Federation in Cambodia and adopt the legal identity of the Federation.

4.2 Provide the services of a Technical Delegate to support and provide assistance for the administration, planning, monitoring and evaluation of Program implementation. The Technical Delegate will work with the CRC counterpart to coordinate CRC, USAID and American Red Cross activities.

4.2 Provide the services of a Finance Officer based in Phnom Penh, Cambodia for oversight of financial disbursements, monitoring of expenditures and follow up on monthly reporting. The details of the activities of the Finance Officer are outlined in section 7.1.

4.3 Provide other technical assistance (TA) as required and/or requested by the CRC and any necessary TA for implementation of the activities and for compliance with USG regulations. Other TA may be provided based on American Red Cross' assessment and CRC' requests. This TA must be agreed upon by both Parties.

4.4 Make funds available electronically for deposit directly into a CRC bank account specifically set up for this Program. American Red Cross shall advance to the CRC funds for expenses to be incurred by the CRC in the implementation of Program activities certified by the Technical Delegate in accordance with the Budget and with US Government rules and regulations (see Section 9). American Red Cross shall advance funds to the CRC on a monthly basis after receipt and approval by American Red Cross of CRC' monthly financial reports. In no event shall the costs reimbursed exceed the budgeted amounts under this Agreement.

4.4.1 Following the signing of this Agreement and the receipt and approval of the initial Monthly Forecast/Cash Request, American Red Cross will advance funds for the first month of forecasted Program expenses to the CRC. Thereafter, additional funding will only be advanced following approval by American Red Cross of CRC' Monthly Forecast/Cash Request (Annex 7) and Monthly Financial Reports (See section 7.3.6).

4.4.2 Remit payment to the CRC no later than thirty (30) days following approval of the Monthly Forecast/Cash Request.

5. Key Personnel

5.1 CRC personnel identified in subsection 5.3 below shall report and coordinate Program activities described in Annex 1 with American Red Cross.

5.2 If CRC key personnel for whatever reason become, or are expected to become, unavailable for work under this Agreement for a continuous period exceeding 20 work days, or are expected to devote substantially less effort to the work than indicated in Work Plan and Budget, CRC shall immediately notify American Red Cross and, subject to the concurrence of American Red Cross, shall promptly replace such personnel with personnel of substantially equal ability and qualifications. Such personnel must be approved by American Red Cross prior to providing services in support of the Program.

5.3 For purposes of this Agreement, the following positions are identified as CRC key personnel:

Program Office Director, TBD
Primary Health Manager, TBD
Finance Officer, TBD

Personnel for positions that are not filled at the time of signing of the Agreement must be approved by American Red Cross prior to providing services in support of the Program.

6. Budget

6.1 The approved budget for this Agreement is $331,757 as per the attached Budget (Annex 2). The Budget is subject to change after Detailed Implementation Plan (DIP) is finalized and approved by USAID.

The estimated Budget ceiling of this Agreement may change during the Term of the Agreement or in accordance with any USAID approved changes in the workplan or budgets.

6.2 It is understood that work pursuant to this Agreement is subject to the availability of USAID funds and that such funds are not assured for the Term of the Agreement. In the event that American Red Cross fails to receive funds from USAID adequate to enable American Red Cross to fulfill its obligations to CRC under this Agreement, American Red Cross shall so inform CRC. American Red Cross shall not be liable for costs incurred by CRC subsequent to American Red Cross' provision to CRC of such notice, nor shall CRC be obligated to complete any work in progress initiated prior to receipt of such notice, nor any subsequent work.

6.3 CRC will ensure that all funds provided by American Red Cross under this Program are used solely for Program activities in strict accordance with the Budget. All expenditures and reimbursements will be in accordance with the line item allocations established in the Budget. Any changes to these line item allocations must be pre-approved in writing by American Red Cross. CRC agrees to immediately repay any portion of the funds not used for Program activities.

6.4 CRC has agreed to make a cost-share contribution of $127,740 over the life of the Agreement. CRC intends to use time of CRC volunteers, value of the Social Marketing product kits purchased by CRC from Population Services International (PSI), and value of the office rental of the main office to fulfill this cost share requirement. CRC will provide adequate documentation in Monthly Cost Share report.

7. Financial Support and Reporting Requirements

7.1 The American Red Cross Finance Officer to be based in Phnom Penh, Cambodia will:

7.1.1 Verify that the charges incurred and documented by CRC have supporting documentation according to the standard provisions and US Government rules and regulations.

7.1.2 Upon review and verification of the Monthly Financial Reports and Monthly Forecast/Cash Request, American Red Cross will provide written notification to CRC to that effect and process the advance of funds.

7.1.3 Conduct monitoring and technical assistance site visits to the Program on a quarterly basis. These visits will be coordinated with CRC staff in order to ensure their availability and participation.

7.2 The CRC will:

7.2.1 Open and maintain a bank account for the exclusive use of this Program.

7.2.2 Maintain a financial management system that provides for accurate, current, complete and separate disclosure of financial information (income and expenses) for this Program.

7.2.3 Participate in quarterly monitoring and technical assistance visits and will provide American Red Cross Finance personnel with information and support necessary to conduct said visits.

7.3 CRC will submit and/or contribute to Program reports. Specifically, CRC will:

7.3.1 Provide Quarterly Narrative reports to American Red Cross which shall describe activities, a comparison of actual accomplishments with the inputs/outputs/goals established for the period, problems encountered, actions taken to resolve the problems, and activities planned for the subsequent period. Other pertinent information should be included, such as reasons why established goals were not met, and an analysis and explanation of costs significantly over or under the amounts projected for the period. Quarterly narrative reports should be submitted to the American Red Cross Technical Delegate. These reports are due by the 15th of the month following the end of the quarter. The quarters defined by the US Government are as follows:

- January through March
- April through June
- July through September
- October through December

Therefore, Quarterly Narrative reports are due on the 15th of April, July, October, and January.

7.3.2 Contribute to the Annual Performance Report which is due within 30 days after the end of each project year (October 31, except for those years when Mid-term or Final Report is submitted).

7.3.3 Contribute to the Mid-Term Evaluation Report which is due within 30 days after the end of the project year (October 31).

7.3.4 Contribute to American Red Cross' Final Performance Report no later than 60 days prior to the end of the Term of the Agreement. It will cover the entire period of the Program and include all information shown in this section of this Article including, but not necessarily limited to: (1) a summary of the Program's accomplishments or limitations; (2) an overall description of the activities under the Program; (3) a description of lessons learned and future steps.

7.3.5 Provide Monthly Financial Reports to the American Red Cross Finance Officer within thirty (30) calendar days after the end of the month. These reports must be according to American Red Cross guidelines and formats based on the forms contained in Annexes 4 through 8.

7.3.5.1 Monthly Financial Reports must include the following: Monthly Statement of Cash (Annex 4), Monthly Statement of Expenses (Annex 5), Monthly Summary of Expenses (Annex 6), Detailed General Ledger Report, copies of invoices, and Bank Advices of funds received (including exchange rate used).

7.3.5.2 Monthly Forecast/Cash Request (Annex 7) has to be submitted with the Monthly Financial Report. The Monthly Forecast/Cash Request must list total cash receipts and expenditures for the Program to date and anticipated cash requirements by budgeted line item for the next two months.

7.3.5.3 As a part of the Monthly Financial Report, submit a Monthly Cost Share Report reporting volunteer time in the field with supporting documentation. Documentation will include number of volunteers, time spent, and an hourly or

daily value of such time with total value of volunteer work for the reporting month and the program year to date; value of the Social Marketing product kit received from Population Services International; and value of the office rental. See Annex 11 for cost share report forms and detailed instructions.

7.3.5.4 These monthly financial reports must be submitted with copies of supporting documentation and receipts. Financial reports and original copies of supporting documentation and receipts must also be available for onsite verification by representatives of American Red Cross and USAID.

7.3.6 Submit a Final Financial Report within forty-five (45) days of the expiration or termination of this Agreement.

7.3.6.1 Upon submission of the Final Financial Report, remit any outstanding advance or surplus funds immediately to American Red Cross. Interest amounts up to USD two hundred and fifty ($250) per fiscal year may be retained by the CRC for administrative expenses.

7.4 Requests by the CRC for approvals or to extend any due date (including reporting requirements) must be submitted in writing to the American Red Cross not less than 20 days prior to the due date and must be confirmed by a written Agreement between the Parties before such approvals or extensions are effective.

8. Audit

8.1 In the event when CRC expends more than $300,000 of US government funds in CRC' fiscal year, CRC must obtain an annual audit by an independent Certified Public Accountant of the funds advanced under this Agreement. An independent firm should be approved by the USAID mission or the US Embassy. If this is not possible, the American Red Cross Technical Delegate or American Red Cross Headquarters must approve the firm. The completed audit report is to be submitted to American Red Cross Headquarters.

8.2 USAID, the Comptroller General of the United States, American Red Cross, and their duly appointed representatives reserve the right to conduct or facilitate internal and independent audits of the Program and to have access to program related records and financial statements, verification and review of the documentation, internal controls and accounting systems in order for American Red Cross to practice its due diligence in assuring the allowability of related costs and the completeness of required documentation.

8.3 CRC must ensure that appropriate corrective action is taken within six (6) months if there are any audit findings related to the Program, and must specify the contact person responsible for the corrective actions and the anticipated completion date.

8.4 American Red Cross reserves the right to conduct or facilitate external reviews of the Program's progress. American Red Cross will make every effort to ensure that any such reviews or evaluations take place at a time convenient to the CRC staff and to include the CRC in the process.

8.5 All financial and programmatic records pertinent to the Program shall be retained and reasonably accessible for a minimum of three (3) years from the date of submission of the American Red

Cross' final financial reports to USAID, or such longer period of time as required by law, rule or regulation.

9. US Government Rules and Regulations

9.1 The US Government rules and regulations pertaining to the Program are set forth in the following publications: Standard Provisions for Non-US, Non-Governmental Recipients, A-122 (Cost Principles), and 22 CFR 226.31-37 (Property Standards) as set forth in Annexes 9-11 and must be adhered by CRC throughout the term of this Agreement.

9.2 The CRC is reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the CRC to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts/subawards issued under this Agreement.

CRC warrants compliance today and throughout the term of this Project Agreement with all U.S. economic sanctions, anti-terrorism laws and anti-money laundering laws, including but not limited to the USA PATRIOT Act, the laws administered by the United States Treasury Department's Office of Foreign Assets Control, Executive Order 13224, and any local laws that apply in the jurisdiction in which the CRC is operating.

9.3 Any violation of Section 9 shall be grounds for unilateral termination of the Agreement prior to the end of its Term. This section must be included in its entirety and verbatim in all lower tier subcontracts/grants under this Agreement.

10. Publications and Intellectual Property

10.1 CRC will ensure that all publications, journal articles and other written materials, including manuals, brochures, and posters, produced for this Program bear an acknowledgement and disclaimer, as appropriate, such as: "This publication (journal article, etc.) was made possible through support by the U.S. Agency for International Development, under the terms of the Award No. GHS-A-00-04-00007-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of U.S. Agency for International Development and the American Red Cross." Further guidance on publications relating to USAID funded projects can be found in the USAID Standard Provisions for Non-US Non-Governmental Recipients (Annex 9).

11. Final provisions

11.1 The Parties agree to consult each other as soon as possible to resolve any difficulty in implementing the terms of this Agreement and, if necessary, the Parties may ask an independent arbiter for support in resolving such matters.

11.2 If any Party wishes to end its association with the Program, then it must give 60 days prior written notice to the other Parties.

11.3 This Agreement may be terminated, in whole or in part, for any of the following reason providing written notice to the other party:

11.3.1 Mutual: By mutual agreement of the parties, this Agreement may be terminated in whole or in part. The parties must agree upon the effective date of termination and any portion to be terminated.

11.3.2 Default: Either Party may terminate this Agreement, in whole or in part, if the other has failed to fulfill any one of its obligations under this Agreement (the "Breaching Party") after providing written notice and a 30 day cure period. The Agreement will terminate, in whole or in part as applicable, if the Breaching Party fails to cure the breach after the expiration of the requisite cure period. The cure period shall not apply to breaches or failure to comply with Section 9 of this Agreement.

11.3.3 American Red Cross may terminate this Agreement at anytime in the event that (i) its agreement with the USAID is terminated; (ii) CRC violates provisions in Section 9; or (ii) the scope of the Program or the budget is changed by CRC without American Red Cross'written approval.

11.3.4 Remedies for Noncompliance. If CRC materially fails to comply with the terms and conditions of this Agreement, including federal laws and regulations applicable hereto, American Red Cross may impose any of the special conditions, as appropriate in the circumstances, such as:

11.3.4.1 Temporarily withhold cash payments pending correction of the deficiency by the CRC.
11.3.4.2 Disallow all or part of the cost of the activity or action not in compliance.
11.3.4.3 Wholly or partly suspend or terminate the current Agreement.
11.3.4.4 Withhold further funds for the Program.
11.3.4.5 Take other remedies that may be legally available.

11.3.5 Effects of suspension and termination. Costs of obligations incurred during a suspension or after termination of this Agreement are not allowable unless American Red Cross expressly authorizes them in the notice of suspension or termination.

11.4 The CRC hereby discharges and releases American Red Cross, its governors, directors, officers, employees and volunteers from any and all liabilities, costs, claims, losses, damages or expenses arising from, or connected with, CRC's implementation of the Program. CRC agrees to indemnify, defend and hold American Red Cross, its governors, directors, officers, employees, volunteers and agents harmless from and against any claim, costs, losses, liability and expense (including court costs and reasonable attorneys' fees) resulting from liability, obligations, losses, damages, assessments, claims, demands, judgments, costs and expenses (including but not limited to court costs, attorneys' fees and fees of expert witnesses) which American Red Cross may incur, suffer, become liable for, or which may be asserted or claimed against American Red Cross as a result of the acts, errors or omissions of CRC, or of any other entity in Cambodia, public or private, connected with this Project Agreement and their respective directors, officers, employees, agents, contractors and subcontractors as a result of (1) the implementation and performance by CRC, its contractors and subcontractors and their respective directors, officers, employees and agents of the Program and the obligations described in this Project Agreement and its Annexes and related materials; (2) any breach or violation by CRC, and its directors, officers, employees or volunteers of any of the terms and provisions of this Project Agreement or its Annexes and related materials or while performing its obligations hereunder and; (3) damages, fraud and theft related to the American Red Cross funds provided under this Project Agreement. CRC further

agrees to indemnify, defend and hold harmless American Red Cross, its governors, directors, officers, employees, volunteers and agents against any cost, liability, expense, allegation or claim for damages incurred by American Red Cross arising in any manner from failure of CRC, its directors, officers, employees, contractors, subcontractors or agents to comply with any applicable laws, regulations, standards or rules in their conduct of the Program. In no event shall these indemnifications of American Red Cross by CRC apply to the extent and proportion such losses are caused by the negligence or willful misconduct of American Red Cross.

11.5 CRC represents and warrants to American Red Cross that to the extent required by Cambodia law or customary practice in Cambodia, the potential liabilities that may arise from this Agreement, including the liabilities assumed in this Indemnification, are fully insured by a policy or policies of applicable insurance and that the full limits of such policy or policies are available to protect the CRC and American Red Cross from such liabilities.

11.6 This Section 11.4 on Indemnification shall survive the expiration or other termination of this Agreement indefinitely.

11.7 Neither party will assign, or transfer any of its rights or obligations hereunder without prior written consent of the other party. Any attempt to so to assign or transfer any of its rights and obligations without the prior written consent of the other party shall be null and void and render this Agreement subject to immediate termination without any obligation or liability attaching as a result of such termination.

11.8 For any technical or programmatic questions, please contact Mark Preslan, the American National Red Cross Regional Manager for Asia, at preslanm@usa.redcross.org
American National Red Cross
International Services, Asia Region
2025 E Street, NW, 2nd Floor
Washington, DC 20006
Attn: Asia Desk Officer

For any financial or compliance questions, please contact Kevin Mitchell, the American National Red Cross Regional Financial Analyst for Asia at mitchellk@usa.redcross.org
or:
American National Red Cross
International Services, Asia Region
2025 E Street, NW, 2nd Floor
Washington, DC 20006
Attn: Asia Finance Associate

Attachments: The following attachments are hereby made an integral part of this Agreement:

Annex 1, Program Description
Annex 2, Budget
Annex 3, Timesheet Format
Annex 4, Monthly Statement of Cash Form
Annex 5, Monthly Statement of Expenses Form

Annex 6 Monthly Summary of Expenses Form
Annex 7, Monthly Forecast/Cash Request Form
Annex 8, Standard Provisions for Non-US, Non-Governmental Recipients
Annex 9, OMB Circular A-122 (Cost Principles for Non-profit Organizations) at
http://www.whitehouse.gov/omb/circulars/a122/a122.html
Annex 10, 22 CFR 226.31-37 Property Standards
Annex 11, Cost Share Guidelines for Non-US Organizations

IN WITNESS WHEREOF, the Parties hereto, acting through their duly authorized officers, have executed this Agreement as of the date first above written.

Signatories:

The Cambodian Red Cross Society:	**The American National Red Cross:**
Name:	Alan McCurry
Position:	Executive Vice President, Chapter and International Operations
Date:……..	Date:……..
Signature:……	Signature……..

Witness:

The International Federation of Red Cross and Red Crescent Societies – Cambodia Delegation:

Name:

Position: Head of Delegation

Date:……..

Signature:……

Annex G

Memorandum of Understanding
between
Cambodian Red Cross,
The American National Red Cross ,
International Federation of Red Cross and Red Crescent Societies,
and
International Committee of the Red Cross
concerning
COOPERATION AGREEMENT STRATEGY

1. Introduction

The Cambodian Red Cross (CRC), the American Red Cross Participating National Society (AmCross) mentioned above, the International Federation of Red Cross and Red Crescent Societies (Federation) and the International Committee of the Red Cross (ICRC), hereafter collectively referred to as "the Parties," agree to the following:

1.1 This MoU records the agreement between the CRC, the AmCross, the Federation, and the ICRC to cooperate in supporting the development of CRC and strengthening its capacity to effectively deliver quality program and services.

1.2 The framework for this cooperation shall be the CRC updated 5-year Development Plan 2002-2006 attached hereto as Attachment 1 (CRC Plan), and individual bi- or multilateral project agreements mutually agreed upon by the Parties as needed.

1.3 The Parties recall that the Fundamental Principles and Statutes of the International Red Cross and Red Crescent Movement, the decisions of the General Assembly of the Federation and resolutions of the International Conference will be applicable in all circumstances. The Federation's Development Cooperation Policies attached hereto as Attachment 2 are an integral part of this MoU and are respected by all Parties.

1.4 The Agreement on the Organisation of the International Activities of the Components of the International Red Cross and Red Crescent Movement signed in November 1997 (Seville Agreement) will be used as a reference for international activities requiring coordination among various components of the Movement.

2. Background

Based on a common concern for ensuring adequate capacities of National Societies to manage and deliver quality services, and in the spirit of solidarity within the Movement, the Parties have agreed that a coherent and well coordinated approach to development assistance is required.

3. Purpose

3.1 The Parties agree that the overall aim of this MoU is to define roles and responsibilities in supporting the CRC with technical and financial resources in order to ensure the development and long term sustainability of effective structures and programs described in the updated CRC Plan

4. Duration of the MOU

The validity of this MOU begins on the date of the last signature by the CRC, the AmCross, the Federation and the ICRC and will remain in effect for three (3) years, unless terminated by the Parties. The Parties may mutually agree in writing to extend the term of this MoU by execution of an amendment.

5. General

5.1 The Parties agree that support to the CRC will be in accordance with individual project agreements mutually agreed upon by the Parties. Such project agreements will include mutually agreed upon budgets. Support to CRC programming depends on the availability of funding from the Parties.

5.2 The Parties agree to consolidate their existing relationship in accordance with their respective areas of competence to ensure coherence and complimentarily to the CRC Plan. The CRC will keep all Parties informed of the progress of such relationships.

5.3 For each programme/project to be supported, the Parties agree that a programme/project agreement, as mutually agreed upon by the Parties, will be signed. Such programme/project agreement will set out the specific objectives, the roles and responsibilities of each Party, the funding arrangements, reporting requirements, and evaluation and auditing provisions. It should be based on this MoU and on relevant programme/project documents.

5.4 The Parties agree to assist the CRC in its efforts to ensure effective standardisation as well as exchange of comprehensive information among the different Partners.

6. The Cambodian Red Cross

The CRC will:

6.1 *Hold* the primary responsibility for planning, implementing, monitoring, reporting, and evaluating all its activities in co-operation with and supported by the Parties;

6.2 *Be responsible* for ensuring efficient operational and financial management of the programmes/projects;

6.3 *Be encouraged* to forge additional relationships as may be deemed necessary and which are in support of the CRC Plan. The CRC will keep the all Parties informed of such relationships.

6.4 *Update/prepare* detailed annual plans and budgets, using the Federation standardised project proposal format adopted by CRC in 1999, for each or current programmes/projects (19 in January 2002) under the five programme categories namely disaster preparedness, disaster response, health and care in the community, humanitarian values and organisational and resource development at the end of the second quarter (end of June) of each year.

6.5 Update the 5-Year Development Plan on annual basis as needed and disseminate it to all Parties.

6.6 *Develop* a CRC Strategy 2010 in addition to the 5-Year Development Plan and disseminate it to all Parties.

6.7 *Inform* about the progress made on organisational development, identify organisational weaknesses yet to be addressed through the work of the Organisational Development (OD) Council and inform all Parties through regular reporting.

6.8 *Provide* regular quarterly and annual reports in accordance with the international standards as per programme/project contracts and with the support of technical advisors in each sector.

6.9 *Ensure* that programmes/projects are monitored and that evaluations are initiated and co-ordinated as per progamme/project contracts.

7. AmCross

AmCross will:

7.1 Support the CRC in the implementation of its updated 5-year Development Plan 2002 – 2006 when possible. Through the Country Agreement Strategy, AmCross will identify specific programme areas in which AmCross may be able to provide support and will provide assistance to the CRC according to their specific requirements as set forth in a mutually agreed upon programme/project agreement;

7.2 Will consolidate their programme support to the CRC through the establishment of programme/project agreement mutually agreed upon by the parties.. The Federation will be consulted on the drafting of these agreements and will sign them as a witness in the spirit of the serving leader for CAS process facilitation;

7.3 Recognise the Federation's assistance to the CRC in coordinating and facilitating all ongoing and future AmCross-supported programmes in Cambodia in the spirit of the CAS and in accordance with the Federation Status Agreement in Cambodia since 1995 and its mandate as a serving leader;

7.4 Contribute to the planning, implementation, monitoring, evaluation and reviewing of the Cooperation Agreement Strategy (CAS) on annual basis as needed;

7.5 Seek the Federation coordination in disaster response in case of a major disaster requiring international assistance (to be further clarified in terms of roles and responsibilities).

8. The Federation

The Federation will:

8.1 Assist CRC in the coordination of international development and disaster response support and facilitation of all ongoing and future AmCross supported programmes/projects in Cambodia through the Cooperation Agreement Strategy (CAS) 2002 - 2004 and which are linked to the CRC 5-year Development Plan and Programme/Project Contract signed separately with each Party;

8.2 Continue to provide technical assistance to the CRC in capacity building through the organisation and resource development projects with a focus on:

- striving to obtain the Characteristics of a Well-Functioning National Society
- strengthening governance and management co-operation
- strengthening the resource development capacity
- strengthening disaster preparedness, disaster response, health and youth sectors through assistance to CRC on policy and strategy development
- ensuring continued implementation of statutes (or structures and systems where needed)
- observing, in close cooperation with the ICRC, the implementation of the Red Cross Royal Decrees on Recognition of the NS and the Use and Protection of the Emblem (yet to be adopted by the Government)
- facilitation in the strengthening of human and financial resources
- facilitation of improvement of planning and reporting procedures and skills to meet the international requirements
- facilitation of monitoring and evaluation of development programmes and emergency operations
- launch international emergency appeals on behalf of the CRC for natural disasters as needed
- assisting the CRC in the standardisation of procedures
- advocating for the Federation key messages such as HIV/AIDS and disaster preparedness
- harmonising the approach of the various components of the Movement involved in programming support to the CRC.

8.3 Assist the CRC in the setting of basic narrative and financial reporting standards to meet international donor accountability requirements;

8.4 Will facilitate, in close cooperation with the CRC, the international resource mobilisation and sharing of information on progress made of overall capacity building.

9. The International Committee of Red Cross (ICRC

The ICRC will contribute to the development of the CRC in the following areas, in coordination with the Federation

9.1 Support of the CRC Information and Dissemination Programme for disseminating knowledge of international humanitarian law and the Fundamental Principles;

9.2 Support to the Tracing and Message Service of the CRC and its participation in the international tracing network;

9.3 Involvement of the CRC in measures taken to promote international humanitarian law and ensure its implementation;

9.4 In armed conflict situations and internal strife, the ICRC may expand its cooperation with the CRC in order to strengthen its operational capacity. In such cases, the ICRC shall coordinate its plans with the plans of the CRC and the International Federation.

9.5 Contribute to the planning, implementation, monitoring, evaluation and reviewing of the Co-operation Agreement Strategy on annual basis as needed.

9.6 The ICRC and the CRC will conclude written agreements on specific programme/project support in close consultation with the Federation.

10. Financial Management and Auditing

10.1 The CRC will assume responsibility for effectively managing funds transferred by the respective Parties for programmes/projects within the framework of the CAS cooperation and based on the updated CRC Plan.

10.2 Funds made available for specific programmes/projects will only be used for this purpose.

10.3 The financial management will be in accordance with "The Principles and Rules for Red Cross and Red Crescent Disaster Relief" (approved at the 26th International Conference, Geneva, 1995).

10.4 The CRC will identify its financial and in-kind contribution to each of its programmes/projects supported by the Parties.

10.5 Specific requirements for narrative and financial reports for each programme/project supported will be specified in Programme/Project Contracts between the CRC and the Party.

10.6 As a usual practice since 1998, the CRC will contract an external auditor for a consolidated annual audit. Specific audit procedures will be defined in the Programme/Project Contracts if necessary.

11. Monitoring and evaluation

11.1 Federation Southeast Asia Partnership meetings will be held on annual basis and will serve as a forum for all Parties to meet on a periodic basis. These meetings should include country specific sessions on:

- Discuss the progress of the implementation of the CRC Plan and individual development programmes/projects
- General review of CAS
- Discuss the implementation of CAS cooperation and coordination and challenges faced and decide the plan of action for addressing them.

11.2 The CRC Plan will be updated on annual basis as needed to meet the changing needs of the fast developing Cambodian society.

11.3 The CRC Strategy 2010 *(yet to be developed)* will be reviewed periodically and evaluated towards the end of 2010. The cost of the evaluation will be covered by the Parties on a mutually agreed-upon cost-sharing basis.

11.4 The individual programmes/projects included in the updated CRC Plan will be evaluated in accordance with the programme/project agreement.

11.5 An evaluation of the impact of CAS on the overall capacity building of the CRC should take place and be coordinated by the Federation at least once every three (3) years. The cost of the evaluation will be covered by the Parties on a mutually agreed-upon cost-sharing basis.

11.6 Quarterly review meetings, chaired by CRC, will be held between the CRC, the Federation and other Movement Party representatives present in Cambodia to monitor the progress of the CAS and implementation of the CRC Plan, individual programmes/projects contained therein, and of this MoU. The meetings will be clearly documented and the minutes will be shared with all Movement Parties included in this MoU.

12. Modifications

12.1 The provisions of this MOU can only be amended or modified with the mutual written consent of the partners concerned, and with three (3) months advanced notice;

12.2 In the event of any difficulty in implementing the terms of this MoU, the Parties will consult each other promptly. If a solution is not found, then a mediator will be appointed by mutual consent of the Parties. In case of discrepancy, the English language text is considered as the only official text.

12.3 If any of the Parties decides to terminate this agreement earlier than the contract period, they must serve formal notice in writing three (3) months in advance to the other Parties.

This MOU is signed and dated in four (4) copies.

13. Signatures:

Cambodian Red Cross Society

_____

Professor My Samedy Date
Secretary General

The American National Red Cross

_____

xxx Date

International Federation of Red Cross and Red Crescent Societies

_____ _____

xxx Date
Head of Delegation
International Federation
in Cambodia

International Committee of the Red Cross

_____ _____

xxx Date
Head of Regional Delegation
SEA Regional Delegation

Attachment 1 -- CRC updated 5-year Development Plan 2002-2006
Attachment 2 -- Development and Development Cooperation Policies

Cambodian Red Cross

RED CROSS VOLUNTEER POLICY IMPLEMENTATION GUIDE

2005

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1. *Volunteer Management Structure*
2. *Sample Tasks and Functions of Volunteers*

I . INTRODUCTION

Inherent in the provision of services of the Red Cross and Red Crescent Movement around the world is the involvement of volunteers. At present, the Cambodian Red Cross (CRC) have around 6,000 trained volunteers nationwide carrying out relevant tasks in their respective communities, assisting the vulnerable through the provision of health services, disaster management and promotion of humanitarian values. This demonstrates CRC's adherence to the Movement's overall mission which is "to improve the lives of vulnerable people **by mobilizing the power of humanity."**

This document will facilitate the national society's volunteer recruitment plans, will foster a more systematic way to instruct, prepare, attract and retain volunteers at different levels, while at the same time assisting to maintain a more systematic structure at the national and provincial levels for their network of volunteers.

This Volunteering Policy Implementation Guide hopes to further elaborate on the CRC Volunteer Policy that defines the Code of Conduct and Fundamental Principle of Voluntary Service.

Free will is important for volunteering. People should not be forced to volunteer by external pressures, but rather volunteer because they want to do the work, and not because they want to earn money or other privileges, such as trips abroad and generous allowances.

CRC is committed to promoting volunteering because it strengthens the individual volunteer, the communities and develops civil society. Volunteers are specially recruited for the following services:

II . VOLUNTEER MANAGEMENT

Volunteer programme management is the design, development, management and evaluation of a programme in which volunteers are involved. A critical part of this includes the design of volunteer tasks to meet programme needs, and the training and support of volunteers in their tasks.

Volunteer management refers to the human resource process that recruits and motivates suitable volunteers to carry out these defined tasks.

Volunteers give a considerable amount of their time to the Movement. CRC needs to recognize that it must support its volunteers, and treat them with dignity.

2.1-The Central Committee and branch committee responsibilities include:

1. Being responsible for making sure that CRC management implements the volunteer policy
2. Ensuring that management prepares an effective and realistic implementation plan

3. Ensuring that management reports to the central committee on the progress of implementation, as appropriate
4. Approving changes of the volunteer policy, if needed

2.2- The Management and Administration

Cambodian Red Cross must set up its own national and provincial planning and implementation of their volunteer resources. A long-range volunteer development plan must be prepared, specifying goals, objectives, strategies and expected output, as well as a short-term or annual plan that will show specific objectives, activities, timetable, person/office responsible and the corresponding budget.

To facilitate effective development of volunteer service, listed below are the different phases:

➢ Job description	➢ Recruitment	➢ Selection
➢ Screening	➢ Orientation	➢ Training
➢ Placement	➢ Supervision	➢ Promotion and recognition
➢ Appraisal of work performance		➢ Monitoring and Evaluation

Cambodian Red Cross must create and equip themselves with the necessary internal structure, within their means, for the improvement and organization of their voluntary services so that they will be able to provide the services identified by the Cambodian Red Cross as priorities.

New expertise should be brought in to enable the Cambodian Red Cross to make the necessary adjustments and changes to be able to cope and respond to changing needs in today's world.

If new services or activities are being planned, the experience of the traditional services should be taken into consideration in order to reap the benefits of their successful implementation.

Cambodian Red Cross NHQ shall support their Branches in their work with volunteers. It shall identify and support projects that will help to strengthen Red Cross Branch activities that promote volunteering and share this information systematically. It shall also be purposive in establishing visibility and solid image in the community.

The **Human Resource Department (HRD)** of the CRC NHQ is responsible for the overall management of the volunteering development program. It will:

1. Be responsible for the implementation of the Red Cross Volunteer Policy and its Implementing Guidelines
2. Maintain a database for RCV and disseminate the same to other departments
3. Conduct the Training of Trainers of RCV
4. Be responsible for curriculum development of trainings for RCVs
5. Monitor and evaluate the RCV Program

The **Program Department** is responsible for the conduct of basic and advanced trainings of volunteers and their active utilization in the delivery of Red Cross services.

The **Administration/Finance Department** shall integrate the RCV plans and budget in the annual plan and budget of CRC.

The **Disaster Management Department** shall provide the necessary logistical requirement of the volunteers for them to be able to function effectively.

The **Communications Department** shall disseminate information about the RCVs and ensure visibility of RCV involvement in CRC programmes and projects. It is also responsible to provide training on the movement, principle, international humanitarian principal, and information dissemination towards promoting voluntary services.

2.3-The Red Cross Branches and Sub-Branches

Each Red Cross Branch and Sub-Branch is responsible for the overall management of volunteers at their own level.

They are responsible for:

1. The development of a plan (annual and long-term), its implementation and evaluation
2. The development of a clear list of tasks and functions of volunteers, and provide copy to them
3. The recruitment of volunteers
4. The direct supervision of volunteers
5. Encouraging volunteers to continue volunteering
6. Visiting the volunteers quarterly and monitoring their activities
7. Maintaining a record of volunteer activities and time spent
8. Submit reports regularly to National Headquarters

The Red Cross Volunteer Leader should:

1. Lead the community volunteers by example
2. Provide encouragement and support to volunteers
3. Hold monthly meeting with volunteers to discuss community problems where they can be of help
4. Record volunteer services and time spent
5. Report the same to the Red Cross Branch Office

III . VOLUNTEER RECRUITMENT

Volunteers are found in many different roles in the CRC and at all levels.

- Volunteer at the governance level
- Volunteer at the offices and
- Volunteer in the communities

They are active in:

- ***Policy-making and monitoring*** (for example: board members and delegates to General Assemblies)
- ***Management and administration*** (planning, accounting, office work and membership drives)
- ***Organizing and delivery services/programs*** (voluntary services, team leaders and trainers)
- ***Fund-raising*** (collecting money, organizing bazaars, income generation)
- ***Advocacy*** (campaigning and dissemination)
- ***Giving advice and solving problems*** (expert or advisory volunteers).

Of all these, volunteers serving vulnerable people in their own communities are the main work force of the Cambodian Red Cross especially in the following services:

1. **Promotion of the Movement's Fundamental Principles and Humanitarian Values**
   - Disseminate Principles and Values
   - Disseminate proper use of Red Cross emblem
2. **Disaster Management**
   - Disaster Preparedness
   - Disaster Response
3. **Health and Care in the Community**
   - Primary Health Care
   - Health care in emergency situation
   - Communicable Disease Control
4. **CRC Governance, and Management and Administration**

3.1- Volunteers at Governance level (Central & Branch Committees)

The Central Commi ttee of the Cambodi an Red C ross is c omposed p rimarily of volunteers. It establishes policy for the Cambodian Red Cross, with the approval of the General Assembly.

Thus, the Central Committee members be nominated and elected for their knowledge, expertise, respect within the community, respect of fellow members the ability to lead and their sufficient time to do the job. The same is true with the Branch Committee.

Thus, when proposing a volunteer candidate to serve in this (governance) capacity, the following qualities and qualifications should be taken into consideration:

1. Whether s/he has a track record of effective Red Cross service, or with other voluntary or humanitarian organizations;
2. Whether s/he knows Red Cross/Red Crescent Movement well, and believes in its vision and mission;
3. The selection of central committee and branch committee will be implement according to adjusted CRC statue that have been approved in the third General Assembly in Auguest,2002.
4. Whether the candidate has the knowledge and expertise in the area of service
5. Whether the candidate has the respect of people in the community and of fellow members in governance; and
6. Has the ability to lead

(For the rules in the election of members of governance, please refer to the CRC statutes revised and approved in year 2002)

3.2- Volunteers at the Community level

As mentioned above, the volunteers serving vulnerable people in their own communities are the main work force of the Cambodian Red Cross. Therefore, it is important that care must be taken in the recruitment and selection.

Having volunteers with a mixture of ages, ethnic groups, religious beliefs, and balance of men and women is a positive advantage of CRC. Considering that half of the population in Cambodia is less than 21 years of age, it is desirable to motivate and recruit the youth to volunteer.

Broadly, the way to recruit volunteers is to have a specific task or role in mind, and then find people to volunteer for the task. When recruiting volunteers you should be looking out for these qualities:

- The person's commitment to the work
- The potential for developing and learning the skills needed
- The existing skills and experience that they can bring to the Movement

When recruiting volunteers it is important to recognize that in most cases volunteers will require some form of training. Selection becomes easier if you have direct interaction with them and be able to discern their qualities.

3.3- Red Cross Youth

Red Cross Youth (RCY) are being developed to become dedicated volunteers for the delivery of services to the most vulnerable. They are a special group of human resource being tapped to provide voluntary Red Cross services, especially in areas of:

- **Health Education**
- **Disaster Prevention and Response**
- **Promotion of Humanitarian Values**

Care and attention shall also be given to the RCY to retain or continue their services as volunteers beyond age 25, if they so desire. A system should be put in place to invite and encourage them to become Red Cross Volunteers.

IV. REGISTRATION OF VOLUNTEERS

All Red Cross Volunteers must be registered. A Registry of Volunteers must be maintained by the Red Cross Branch Office and Sub-Branch.

The Registry process is as follows:

1. Each volunteer will complete an individual registration form (containing basic information about the volunteer (e.g. name, age, sex, religious belief, residence), type of service to be rendered and duration of volunteer work with their photo attached
2. The registry will be regularly updated
3. A profile of the volunteers of each branch will be submitted to the CRC NHQ Human Resource (HR) Department by the end November of each year
4. Red Cross Branch Office shall issue Identification Cards (ID) to all Red Cross Volunteers, indicating name and expiry date.

V. RESPONSIBILITIES OF VOLUNTEERS

Each volunteer has the following responsibilities according to the RCV Policy :

5.1- Red Cross Volunteer should:

1. Remember that when one is working for the Red Cross s/he is representing the movement and its ideals.
2. Familiarize oneself with the Code of Conduct, the Fundamental Principles and Red Cross/Red Crescent Philosophy of Voluntary Service, the Four Geneva Conventions and the two additional Protocols
3. Be attentive to the needs of others, at all times.
4. In case of doubt, seek advice on Red Cross matters from the Cambodian Red Cross before making any decision.
5. Help others to help themselves.
6. Be ready to assume responsibilities and try to be accessible.
7. Be realistic about one's availability and limitations.
8. Seek to serve at the level of one's capacity, but be flexible and persevering in undertaking one's task.
9. Be able to provide feedback and evaluation of the task undertaken;
10. Seek to strengthen Cambodian Red Cross by being fully informed of its goals, objectives and policies.
11. Try to be positive and enthusiastic.
12. Establish a positive working relationship with one's co-volunteers by improving communication and being aware of the importance of interaction and consultation.

5.2- Red Cross Volunteers should not:

1. Commit resources of the Red Cross without prior mandate
2. Misuse his/her Red Cross position for personal advantage
3. Take advantage of his/her status to perform private transaction or sales from which a profit can be derived for himself/herself or for a third party.

5.3- Opportunities for Volunteers

Opportunities for Red Cross Volunteers are varied within the broad range of services and activities of the Cambodian Red Cross. Listed below are a few that can be seen as ideal. Some, of course, are more achievable than others.

- To offer one's skills and talents for the benefit of the movement
- To learn and develop new skills and knowledge
- To participate in course(s) of your interest
- To choose among tasks in the line of services available and to familiarize oneself as to where one could best serve and enjoy the services being rendered. This may be in Disaster Preparedness and Relief, Community Based First Aid, Red Cross Youth, Dissemination, Blood Donor Promotion, Mine Awareness, HIV/AIDS Peer Education or any other activities and programmes of the Cambodian Red Cross
- To learn to assist others through the Cambodian Red Cross's community services
- To participate in disaster relief operations at the local, national and even in the international level
- To represent the Cambodian Red Cross at meetings, workshops, conferences or seminars
- To take an active role in problem-solving of issues and concerns of the community where the volunteer lives.

5.4- Time spent volunteering

The amount of time that volunteers spend working for an organization can vary greatly. Research suggests that most volunteers in successful, long-term programmes work for around 10 hours per month. Therefore, care must be taken in determining the number of hours a volunteer should put in a month.

People can only volunteer for a large amount of time each week if they have enough free time. If this becomes a culture, CRC may close itself to other groups – such as skilled professionals, mothers, students, etc., who have only a limited time to donate. These people may well have skills which CRC needs for its programmes. By encouraging volunteers to work for a short period of time per week, say, 3 hours/week or 12 hours/month, CRC makes itself more accessible to all parts of society. At the same time, it reduces the risk of volunteer "burn-out", as individual workloads become more sustainable.

The time (number of hours) the volunteer renders for Red Cross activities must be recorded.

VI. TRAINING OF VOLUNTEERS

It is important that before volunteers are recruited, CRC identifies the sorts of skills that are required, plans for the training to take place, and ensure that it has money to pay for the training. This is an important part of fulfilling CRC's legal and moral duty both to volunteers and beneficiaries.

Volunteers must be given opportunities to learn, develop their skills and their potential. Education, training and administration of volunteers are extremely important and therefore, must be properly handled.

Active Red Cross Volunteers invigorates the Cambodian Red Cross. Therefore, CRC must establish appropriate training, support, projects, incentives and leadership opportunities to volunteers.

6.1- Basic Training/Orientation

This may be induction to familiarize volunteers with the organization, the Fundamental Principles, the Code of Conduct, with the kind of work they will be doing, and with any procedures they have to follow.

6.2- Advanced Training

Advanced training may be given as needed. This may include communication skills, community development, and technical skills such as:

- First aid
- Community-based disaster preparedness
- Primary health care
- HIV/AIDS
- Land Mine Awareness
- Tracing
- Recording & reporting
- Fund raising for volunteers in governance
- Membership drive and management

VII. LOGISTICS SUPPORT

Volunteers often have to pay for expenses out of their own pockets. They may have to pay for transportation or lunch when they are doing their volunteering work. When this is the case, CRC should refund these expenses, if the volunteer so wishes. This is to remove any financial barriers to volunteering for those who, otherwise, might not be able to afford it.

CRC should also provide necessary equipment to volunteers for the task they are asked to carry out. They should also be aware of the security and safety of their volunteers and the equipment they need to do their work.

CRC may establish contract with companies for support or assistance in providing the necessary equipment or instruments for the volunteers.

VIII. REWARD AND RECOGNITION

Saying 'thank you' is one of the most important aspects of working with volunteers. CRC shall ensure that all the staff and volunteers who are responsible for managing volunteers are aware of the need to thank their volunteers, know how to do it appropriately, and have sufficient resources to be able to do it. If volunteers feel that they are not recognized for their contributions, they leave.

By 2005, CRC shall have developed a "Volunteer Reward and Recognition Plan" that should serve as guide for all the Red Cross Branches.

IX. MONITORING and EVALUATION

The Volunteer Development Program (VDP) shall be monitored and evaluated at various levels. An annual review and evaluation of the implementation plan of the VDP shall be spearheaded by the CRC National Headquarters.

The follow up system was developed to improve Red Cross Volunteer activities.

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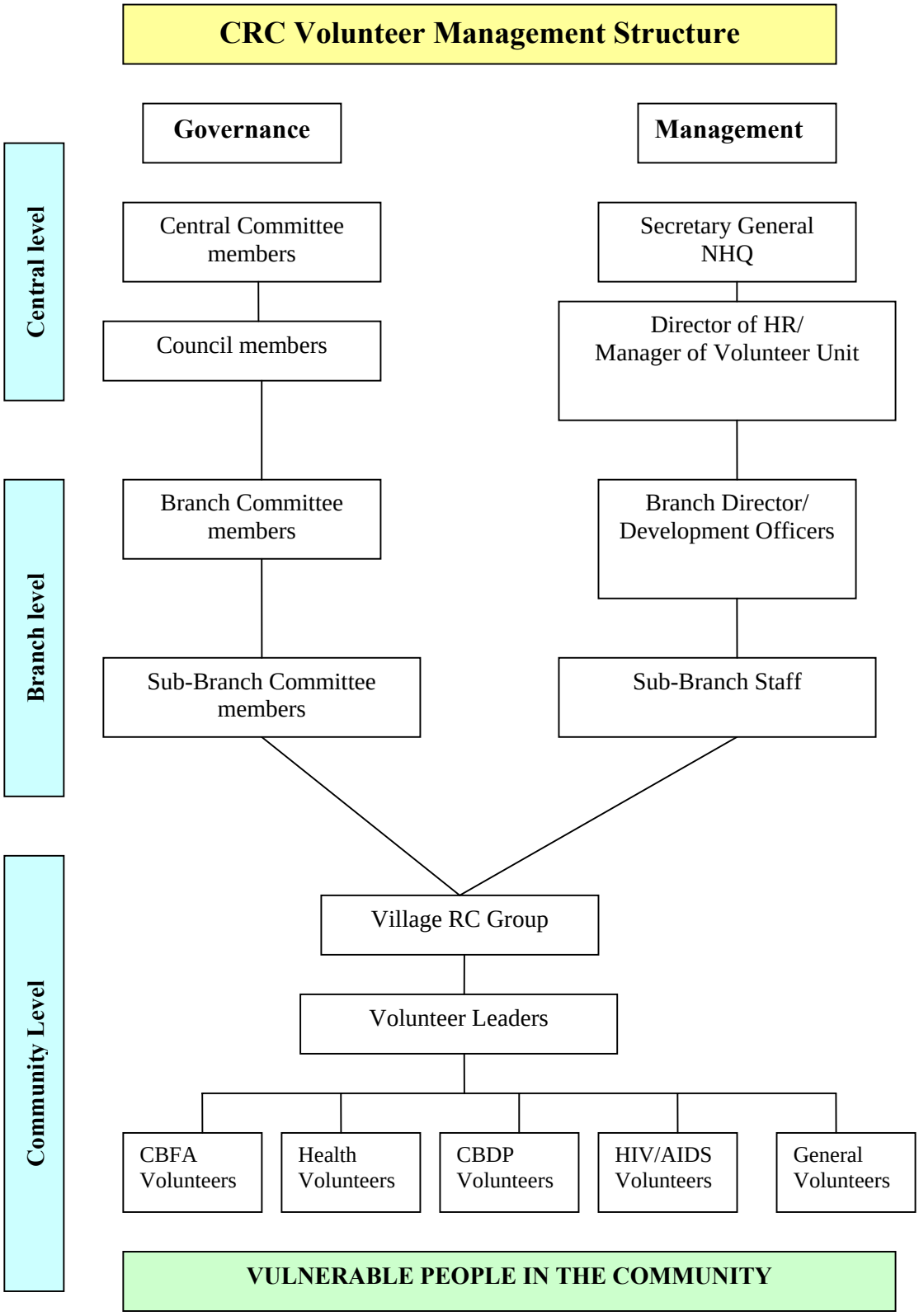
ANNEX 1:
Volunteer Management Structure



ANNEX 2 :

Functions of Volunteers

Community Based Landmine/UXO Risk Education Project (LMRE)

The program trained 500 RCVs for the following purposes :

1- **Gather information in community.**
2- **Providing First Aid in community.**
3- **Providing health education in community.**
4- **Disseminate Red Cross and Red Crescent movement International Human Italian Laws to community.**
5- **Assist the community in the cage of Disaster.**
6- **Dissemination on the awareness of Mine/ UXO to community.**

Annex J

	Section B: Partnership Report **Name partner:**
The organisation	
Background	
Aims and objectives	
Main activities	
Staff structure (organogram)	
Strengths and weaknesses	
Organisation's needs	
Organisational context/other information	
History of partnership	

Current status partnership (including length of partnership)
How does the partnership contribute to programme objectives?
VSO: **Partner organisation:**
Draft partnership objective
Agreed partnership strategy
How does the partnership address the programme's gender issues?
How does this partnership link into other partners/organisations?
Participants to the Participatory Partnership Appraisal

< If volunteer support has been agreed, the following form will be completed >

At the request and agreement of (name partner organisation), (hereafter referred to as the **partner organization)** VSO will provide support through the following VSO Volunteer Professional(s):

1) Job Title:
Location:
Duration:

2) Job Title:
Location:
Duration:

The success of this partnership largely depends on the relationship between the partner organisation, the VSO Professional(s) and the VSO Programme Office. The purpose of this agreement is to clarify the role and responsibilities for each party and to set the terms and conditions under which the VSO Professional(s) will work with the partner organisation.

This partnership plan follows the preparation of a placement outline, which was drawn up by the partner organisation and the VSO Programme Office and which describes the Roles and Responsibilities of the VSO Professional(s).

1. RESPONSIBILITIES

The partner organisation is the employer of the VSO Professional(s), not VSO. The VSO Professional will be line managed/supervised by:

Name:
Position:

The responsibilities of the line manager include:

Before the arrival of the VSO Professional(s):

- Ensure that the placement outline is accurate
- Prepare colleagues and beneficiaries for the arrival of the VSO Professional(s) and make sure that everyone understands his/her role
- In addition, the line manager is required to attend a VSO 'employers workshop' in Phnom Penh to help them to prepare for management of the VSO Professional(s).

When the VSO Professional(s) is in the workplace:

- Provide orientation, introduction to staff, and direction during the first few months of placement
- Ensure that the VSO Professional(s) has designated colleagues to work with
- Meet with the VSO Professional(s) regularly to discuss progress and workplans
- Discuss in advance with the VSO Professional(s) any significant changes that will affect their role, schedule or workload
- Work with VSO to review the outcomes/impact resulting from the placement
- Manage the VSO Professional(s)'s annual leave requests

The responsibilities of the VSO Professional(s) include:

- To work with the line manager to review objectives, develop workplans, and monitor and evaluate the placement
- Work with colleagues as part of a team to achieve the agreed objectives
- Discuss in advance with the line manager and VSO any significant changes that will affect their role, schedule or workload
- Accommodate reasonable requests from the line manager regarding job responsibilities, leave, dress and behaviour

The responsibilities of the VSO Programme Office include:

- Preparation of an accurate placement outline based on discussions with the partner organisation
- Provide and facilitate an 'employers workshop' (if necessary) for the partner organisation and VSO Professional(s)
- Organise visas and assist with medical/emergency evacuations for the VSO Professional(s)
- Provide orientation training to the VSO Professional(s) (including language training)
- Provide on-going advice on VSO procedures/policies (including security) to the VSO Professional(s)
- Provide opportunities for the partner organisation and VSO Professional(s) to make links with other VSO partner organisations/Professionals
- Visit the placement to provide support to the partner organisation/VSO Professional(s) and to assist in monitoring and evaluation of the partnership.
- Provide support in resolving problems between the partner organisation and VSO Professional(s) (see below)

Resolving problems:

- The line manager and the VSO Professional(s) should speak directly to each other in a respectful and professional manner if either has any problems with the placement
- If the situation is not resolved the line manager or VSO Professional(s) should contact the VSO Programme Office
- If the situation is still not resolved, a meeting should be held between all three parties to discuss the situation and agree any changes if necessary.
- If the situation can not be resolved and either the partner organisation or the VSO Professional(s) wishes to end the placement, at least one months written notice must be given to the other parties with a clear explanation of the reasons why

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2. Reviewing effectiveness of the partnership

- The partner organisation will work with the VSO Professional(s) and VSO Programme Office staff to review and modify the placement objectives and establish a monitoring and evaluation plans 2-4 months after the start of the placement.
- The partner organisation and the VSO Professional(s) should monitor and evaluate the outcome/impact of the placement on an on-going basis
- VSO Programme Office staff will conduct at least one visit a year to discuss with all stakeholders the progress of the partnership. The partner organisation and the VSO Professional(s) should prepare a presentation of progress made towards partnership objectives in order to discuss the way forward.

- The VSO Professional(s) and the partner organisation are expected to identify and document a significant change in a participatory way at the end of each placement and send this to VSO Programme Office.

3. ANNUAL LEAVE:

Annual leave entitlements for the VSO Professional(s) will be[1]:

- 15 working days annual leave, plus 12 days National Holiday in accordance with the partner organisation's staff policy

The normal working day will be 8-hours, but the VSO Professional(s) will need to work flexi-time and some weekends due to the nature of the project.

The VSO Professional(s) should make requests for annual leave to the line manager at least 1-month in advance of the requested period of leave.

In addition, they will be entitled to the following number of days for:

- Sick leave: 8 days/year - in accordance with the partner organisation's staff policy
- Wedding leave: 3 days/year in accordance with the partner organisation's staff policy

4. ATTENDING VSO OFFICIAL BUSINESS:

In addition to annual leave, VSO requests that the VSO Professional(s) attends VSO workshops and a VSO Annual Conference each year (up to 10 days per year). The VSO Programme Office will write to the partner organisation to request the release of the VSO Professional(s) from their place of work to attend each workshop/conference. The VSO Programme Office may also request for the VSO Professional(s) to be released from their work for other VSO official business.

In addition to that, VSO requests the partner organisation to attend one partnership review session and to send one report to feed into VSO's programme area review every year. VSO also expects that the relevant staff will attend a one-day visit by the VSO Programme Manager after the first three months of every placement.

5. FUNDING/SUPPORT:

The partner organisation agrees to provide the following support to the VSO Professional(s):

Item	Yes/No (and description where possible)
Office space	
Management support	
Access to a computer	
Access to email	
Work-related travel/accommodation/subsistence costs[2] (when volunteers leave their duty station)	
Provision of stationary and work	

[1] Please note that VSO insists on a minimum of three weeks annual leave, excluding public holidays

[2] Please note that it is against policy for VSO Professionals to accept per diem payments. Advance payment or re-imbursement of actual expenditure for work-related travel costs is acceptable.

related materials	
Translator	
Transport	
Volunteer Allowance	
Volunteer Accommodation	
Related volunteer pre-departure costs.	

6. THE CONTENTS OF THIS DOCUMENT AND THE PLACEMENT OUTLINE HAVE BEEN READ AND AGREED BY:

Signed (on behalf of partner organisation) .....……

Position in organisation …….

Date ..... (Official stamp)

Signed (on behalf of VSO Cambodia Programme Office)
…….....……

Position in organisation …….

Date ..... (Official stamp)

Please Return to:	**For VSO use only:**
VSO Programme Office Address: #19, St 214, Sangkat Boeung Rang Phnom Penh, Cambodia P.O Box No 912, CCC Box No 65 Tel / Fax: 855 23 426734 Email:	**Employer/job codes:**

Annex K

National Strategies	Consistency (Strategies supported by Siem Reap Integrated Child Health Project)
1. Ministry of Health - Health Sector Strategic Plan 2003 - 2007	**Health Service Delivery:** - Strengthen the management of cost-effective interventions to control communicable diseases. -Strengthen the management and coverage of support services such as laboratory, blood safety, referral, pharmaceuticals, equipment and other medical supplies and maintenance of facilities and transport. **Behavioral Change:** - Empower consumers, especially women, to interact with other stakeholders in the development of quality health services through mass media and inter-personal communication. - Promote healthy lifestyles and appropriate health seeking behavior through advocating for healthy environments and implementing counseling and behavioral change activities. **Quality Improvement:** -Develop and implement minimum and optimum quality standards for the public and private sectors incorporating pro-poor and gender issues through the use of appropriate tools. **Human Resource Development:** - Enhance the management and technical skills and competence of all Ministry of Health workforce through quality, comprehensive training, education, retention and support measures. **Institutional Development:** - Effective public private partnership to improve accessibility, quality and affordability through the promotion of private sector participation and enforcement of regulations. - Enhance Ministry of Health capacity to address chronic diseases and emerging public health problems through raising awareness and developing comprehensive plans.
2. National Centre for Parasitology, Entomology and Malaria Control, Policy of Malaria Prevention and Control	**1. Policy of Malaria Prevention** **1.1:** Free distribution of ITNs to the population at risk living in villages situated in forested areas and forest fringes. **1.2:** Making available through social marketing approach insecticide required for treating hammock nets for people who are in temporary transit to the forest areas **1.3:** Treatment of bednets and hammock nets once every 6 months or at least once a year, in advance of the transmission season. **2. Policy of Malaria Case Management** **2.2:** [Referral to] village malaria workers for detecting and treating malaria patients in high endemic areas for patients who have no access to health services at public or private sectors. **Strategy 3:** Prevent and control malaria outbreak **Strategy 4:** Promote effective prevention measures **Strategy 5:** Increase capacity building to all partners

3. Ministry of Education, Youth and Sport – *Draft* Policy of School Health	**Objective A:** To improve the health status of school children, students and education staffs of all public and private education institutions. **Objective B:** To improve the capacity and skill for prevention of accidents and of communicable diseases which affect the lives of the students and education of staffs of all public and private education institutions. **Policy 1:** Provision of health services to the teachers, school children, students of all public and private school institutions is essential in ensuring the equity on physical, mental and social development **Strategy 3:** Enhance appropriate immunization which will be given by medical personnel to school children and students especially young girls and female students, disable children or vulnerable children or students and children in remote area from pre-school up to university, to reduce communicable diseases. **Strategy 4:** Timely interventions will occur to prevent the spread of communicable diseases and to assist school children, teachers during the health crisis such as food poisoning, disease outbreak, and environmental disasters to reduce serious health problems. **Policy 2:** Health education is an important way to provide information, knowledge, skill and behavior changes for achieving conformability, safety and responsibility. **Strategy 2:** More effective media messages on health, hygiene, sexual health and reproductive health, accidental and communicable disease prevention will be delivered using billboards, leaflets, posters, learning games and newspapers within other existing programmes such as sport education and competition, workshops, training courses and conferences. **Strategy 6:** Health education must place a high priority on communicable diseases, which occur in all communities, regardless of geographical location and demographics. **Strategy 8:** Controlling and evaluating the quality and efficacy of health education will be occurred by strengthened behavior change communication in reduction of communicable diseases and accidents. **Policy 4:** The participation from private sectors, association, relevant institutions, donors, national and international organizations on school health provides essential resources to improve hygiene, beauty, safety and conformability of the schools, communities and public places. **Strategy 1:** Strengthen the coordination mechanism inter-ministries and working group on health promotion in schools from national level to individual educational institution with the participation of relevant departments including health, agriculture, rural development, planning, finance, local authorities, international organizations, donors and non governmental organizations working on school health. **Strategy 3:** Strengthen the collaboration with relevant partner to improve ownership on health promotion by regularly sharing information during the meetings on action plan development, experience exchange and monitoring of activity implementation.

	Strategy 4: Appeal to private sectors for help in maintaining hygiene, health and disease prevention, to reduce the school dropout rate and the need for students to reduce school year repetition. **Strategy 5:** Encourage the community, especially school support committee, student parent association, students and teacher to contribute their active participation in hygiene and prevention of diseases, including HIV/AIDS and helping poor and other at risk children. **Strategy 6:** Provide opportunity for students and their parents to be involved in health promotion through sharing their idea in workshop and meeting on action plan development as well as health monitoring.
4. Cambodia Child Health Strategy Development – Delivery Modalities and System Constraints: Immunizations	**Service Delivery:** NGOs also play an important role in the success of immunization. Through support of outreach activities they improve performance in delivery of immunization, family planning, nutrition and other health services. The role of the private sector in immunization has potential for future development, particularly in relation to establishing public/private partnerships for health through information sharing. **Communication and Social Mobilization:** Communication strategies are vital for immunization – 1. High dependence on outreach to achieve program objectives requires that community leaders and volunteers mobilize populations to village posts. 2. It is necessary to inform populations of the benefits of immunization. 3. Health workers need improved capacity to communicate effective immunization messages to populations.
***5. Draft* USAID /Cambodia Strategy Statement**	**Strategic Objective 1:** Improved health services in HIV/AIDS and infectious diseases as well as in maternal, child and reproductive health. ***Program Component 2:*** Prevent and control infectious diseases of major importance. ***Program Component 3:*** Improve maternal and child health and nutrition.
6. Policy on Community Participation in the Development of Health Center, 2003	**2.4.1 Scope of Work for Community Participation in Health Center** (1) Communication between HC and Community-promote a beter understanding of the health problems of the community by HC on the one hand and a better understanding of the HC services and activities by the community on the other hand. (2) Support to the HC activities-mobilizing community commitment to assist HC team I their efforts to deliver a good quality basic health services and to carry out health activities organized in the community such as health education campaigns, outreach sessions. 3.4 Linkages between HC Management Committee/Village Health Support Group and Other Community-Based Health Activities. *Examples of Community-Based Health Activities:* Red Cross Volunteers: put in place by the Cambodian Red Cross

7. Guidelines for Outreach Services from Health Centers, 2001	Improved community feedback to improve outreach through Village Health Support Groups; mobilize communities to improve turn out for outreach activities following: Annex III: National Immunization Program Policy Annex IV: Protocols for universal vitamin A capsule supplementation Annex VII: Oral Re-hydration Salt Protocol for Outreach Activity

Annex L

	Section B: Partnership Report **Name partner:**
The organisation	
Background	
Aims and objectives	
Main activities	
Staff structure (organogram)	
Strengths and weaknesses	
Organisation's needs	
Organisational context/other information	
History of partnership	

Current status partnership (including length of partnership)
How does the partnership contribute to programme objectives?
VSO: **Partner organisation:**
Draft partnership objective
Agreed partnership strategy
How does the partnership address the programme's gender issues?
How does this partnership link into other partners/organisations?
Participants to the Participatory Partnership Appraisal

< If volunteer support has been agreed, the following form will be completed >

At the request and agreement of (name partner organisation), (hereafter referred to as the **partner organization)** VSO will provide support through the following VSO Volunteer Professional(s):

1) Job Title:
Location:
Duration:

2) Job Title:
Location:
Duration:

The success of this partnership largely depends on the relationship between the partner organisation, the VSO Professional(s) and the VSO Programme Office. The purpose of this agreement is to clarify the role and responsibilities for each party and to set the terms and conditions under which the VSO Professional(s) will work with the partner organisation.

This partnership plan follows the preparation of a placement outline, which was drawn up by the partner organisation and the VSO Programme Office and which describes the Roles and Responsibilities of the VSO Professional(s).

1. RESPONSIBILITIES

The partner organisation is the employer of the VSO Professional(s), not VSO. The VSO Professional will be line managed/supervised by:

Name:
Position:

The responsibilities of the line manager include:

Before the arrival of the VSO Professional(s):

- Ensure that the placement outline is accurate
- Prepare colleagues and beneficiaries for the arrival of the VSO Professional(s) and make sure that everyone understands his/her role
- In addition, the line manager is required to attend a VSO 'employers workshop' in Phnom Penh to help them to prepare for management of the VSO Professional(s).

When the VSO Professional(s) is in the workplace:

- Provide orientation, introduction to staff, and direction during the first few months of placement
- Ensure that the VSO Professional(s) has designated colleagues to work with
- Meet with the VSO Professional(s) regularly to discuss progress and workplans
- Discuss in advance with the VSO Professional(s) any significant changes that will affect their role, schedule or workload
- Work with VSO to review the outcomes/impact resulting from the placement
- Manage the VSO Professional(s)'s annual leave requests

The responsibilities of the VSO Professional(s) include:

- To work with the line manager to review objectives, develop workplans, and monitor and evaluate the placement
- Work with colleagues as part of a team to achieve the agreed objectives
- Discuss in advance with the line manager and VSO any significant changes that will affect their role, schedule or workload
- Accommodate reasonable requests from the line manager regarding job responsibilities, leave, dress and behaviour

The responsibilities of the VSO Programme Office include:

- Preparation of an accurate placement outline based on discussions with the partner organisation
- Provide and facilitate an 'employers workshop' (if necessary) for the partner organisation and VSO Professional(s)
- Organise visas and assist with medical/emergency evacuations for the VSO Professional(s)
- Provide orientation training to the VSO Professional(s) (including language training)
- Provide on-going advice on VSO procedures/policies (including security) to the VSO Professional(s)
- Provide opportunities for the partner organisation and VSO Professional(s) to make links with other VSO partner organisations/Professionals
- Visit the placement to provide support to the partner organisation/VSO Professional(s) and to assist in monitoring and evaluation of the partnership.
- Provide support in resolving problems between the partner organisation and VSO Professional(s) (see below)

Resolving problems:

- The line manager and the VSO Professional(s) should speak directly to each other in a respectful and professional manner if either has any problems with the placement
- If the situation is not resolved the line manager or VSO Professional(s) should contact the VSO Programme Office
- If the situation is still not resolved, a meeting should be held between all three parties to discuss the situation and agree any changes if necessary.
- If the situation can not be resolved and either the partner organisation or the VSO Professional(s) wishes to end the placement, at least one months written notice must be given to the other parties with a clear explanation of the reasons why

2. Reviewing effectiveness of the partnership

- The partner organisation will work with the VSO Professional(s) and VSO Programme Office staff to review and modify the placement objectives and establish a monitoring and evaluation plans 2-4 months after the start of the placement.
- The partner organisation and the VSO Professional(s) should monitor and evaluate the outcome/impact of the placement on an on-going basis
- VSO Programme Office staff will conduct at least one visit a year to discuss with all stakeholders the progress of the partnership. The partner organisation and the VSO Professional(s) should prepare a presentation of progress made towards partnership objectives in order to discuss the way forward.

- The VSO Professional(s) and the partner organisation are expected to identify and document a significant change in a participatory way at the end of each placement and send this to VSO Programme Office.

3. ANNUAL LEAVE:

Annual leave entitlements for the VSO Professional(s) will be[1]:

- 15 working days annual leave, plus 12 days National Holiday in accordance with the partner organisation's staff policy

The normal working day will be 8-hours, but the VSO Professional(s) will need to work flexi-time and some weekends due to the nature of the project.

The VSO Professional(s) should make requests for annual leave to the line manager at least 1-month in advance of the requested period of leave.

In addition, they will be entitled to the following number of days for:

- Sick leave: 8 days/year - in accordance with the partner organisation's staff policy
- Wedding leave: 3 days/year in accordance with the partner organisation's staff policy

4. ATTENDING VSO OFFICIAL BUSINESS:

In addition to annual leave, VSO requests that the VSO Professional(s) attends VSO workshops and a VSO Annual Conference each year (up to 10 days per year). The VSO Programme Office will write to the partner organisation to request the release of the VSO Professional(s) from their place of work to attend each workshop/conference. The VSO Programme Office may also request for the VSO Professional(s) to be released from their work for other VSO official business.

In addition to that, VSO requests the partner organisation to attend one partnership review session and to send one report to feed into VSO's programme area review every year. VSO also expects that the relevant staff will attend a one-day visit by the VSO Programme Manager after the first three months of every placement.

5. FUNDING/SUPPORT:

The partner organisation agrees to provide the following support to the VSO Professional(s):

Item	Yes/No (and description where possible)
Office space	
Management support	
Access to a computer	
Access to email	
Work-related travel/accommodation/subsistence costs[2] (when volunteers leave their duty station)	
Provision of stationary and work	

[1] Please note that VSO insists on a minimum of three weeks annual leave, excluding public holidays

[2] Please note that it is against policy for VSO Professionals to accept per diem payments. Advance payment or re-imbursement of actual expenditure for work-related travel costs is acceptable.

related materials	
Translator	
Transport	
Volunteer Allowance	
Volunteer Accommodation	
Related volunteer pre-departure costs.	

6. THE CONTENTS OF THIS DOCUMENT AND THE PLACEMENT OUTLINE HAVE BEEN READ AND AGREED BY:

Signed (on behalf of partner organisation) .....……

Position in organisation …….

Date ..... (Official stamp)

Signed (on behalf of VSO Cambodia Programme Office)
…….....……

Position in organisation …….

Date ..... (Official stamp)

Please Return to:	**For VSO use only:**
VSO Programme Office Address: #19, St 214, Sangkat Boeung Rang Phnom Penh, Cambodia P.O Box No 912, CCC Box No 65 Tel / Fax: 855 23 426734 Email:	**Employer/job codes:**

Annex M

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CAMBODIAN RED CROSS

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The Seven Fundamental Principles of the International Red Cross and Red Crescent Movement

Each volunteer is responsible for acting in accordance with the Fundamental Principles of the International Red Cross and Red Crescent Movement, as proclaimed in 1965 by the XXth International Conference of the Red Cross in Vienna and adapted in Geneva in 1986, at the XXVth International Conference of the Red Cross:

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavors, in its international and national capacity, to prevent and alleviate human sufferings wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, co-operation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, sex, class or political opinions. It endeavors to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, whole auxiliaries in the humanitarian service of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary Service

It is voluntary relief movement not promoted in any manner by desire for gain.

Unity

There can be only one Red Cross or one Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is world wide.

1. INTRODUCTION

The Cambodian Red Cross (CRC) is a national voluntary aid society officially recognized by the Royal Government of the Kingdom of Cambodia. It is part of the International Red Cross/ Red Crescent Movement (the Movement). The new vision of the CRC is "Contributing to poverty reduction and the protection of humanitarian values of vulnerable people" and its new mission is "To be a leading humanitarian organization assisting the vulnerable through the provision of health services, disaster management and promotion of humanitarian values." It supports the Movement's overall mission which is "To improve the lives of vulnerable people by mobilizing the power of humanity." And as such, CRC is governed by the seven (7) Fundamental Principles of the Movement, one of which is "voluntary service."

The principle of voluntary service means that the voluntary relief movement is not prompted in any manner by desire for gain. Volunteers are valuable assets of the Movement; they are responsible for much of the local service delivery and play an important part in strengthening communities by learning skills and developing social ties. Volunteering is a way of helping communities to build capacity to cope with crises.

The strength of the Cambodian Red Cross lies in its ability to meet many needs and to integrate volunteers in the most varied of circumstances. The national society's mission is a unique one, and the wide variety of services it renders constitutes evidence of its adaptability.

This Code of Conduct and Fundamentals of Voluntary Service is directed to all the volunteers who commit themselves to the humanitarian mission of the national society and of the movement, in whatever capacity.

The present code, and its contents, attempts to compile and update in an informative and systematic way guidance and inspiration to those who carry and share the responsibilities of the Cambodian Red Cross, in particular, and the Movement, in general.

2. DEFINITION OF VOLUNTEERING, VOLUNTEER AND MEMBER

Volunteering in the Red Cross and Red Crescent Movement is an **activity** that:

1. is motivated by the free will of the person volunteering, and not by a desire for material or financial gain or by external social, economic or political pressure;
2. is intended to benefit vulnerable people or their communities; and
3. is organized by recognized representatives of a National Society.

A ***Red Cross Volunteer*** is a person who carries out volunteering activities occasionally or regularly; who reaches out beyond the confines of his/her paid employment and other normal responsibilities to contribute in different ways without expectation of profit or reward, in the belief that their activity is beneficial to the community as well as satisfying to themselves. A registered Red Cross Volunteer is also classified as "active member".

A **Red Cross Member** is a person who has formally agreed to the conditions of membership as required under the Cambodian Red Cross stabilities or Rules, and is usually entitled to elect representatives of governing bodies, and to stand for election *(Please refer to Chapter III, Articles 7 – 9 of the CRC Statutes*.)

3. BASIC PRINCIPLES OF VOLUNTEERING

Volunteering is a means for an individual or group to put into practice the Movement's Fundamental Principle of Voluntary Service. To live up to this fundamental principle, the Cambodian Red Cross adheres to the following principles of volunteering:

1. The CRC is committed to promoting volunteering as a significant and positive contribution to improving the lives of vulnerable people, and to strengthening communities and civil society;
2. CRC recognizes and values volunteering as a means of creating and supporting a network of people who are available to work for the CRC in an emergency;
3. CRC values all volunteers primarily for their individual contributions, enthusiasm and commitment, as well as for the experience and skills they can bring;
4. CRC is aware of and value informal volunteering in communities, outside the formal organization of the CRC program and activities.

4. RIGHTS AND RESPONSIBILITIES OF CAMBODIAN RED CROSS

The Cambodian Red Cross has a measure of responsibilities nationally while the society must adhere to the Red Cross/Red Crescent Movement universally. The national society has an important role to mobilize people's will to help in this changing world.

It follows, as with any other organization, that the performance of the national society may well be judged publicly by the attitudes and actions of any volunteer operating in the name of Cambodian Red Cross.

a) The governance (Central Committee and the Branch Committee of the Cambodian Red Cross)

The Central Committee and the Branches Committee of the Cambodian Red Cross is composed primarily of volunteers. It establishes policy for the Cambodian Red Cross, with the approval of the General Assembly.

Thus, the Central Committee members be nominated and elected for their knowledge, expertise, respect within the community, respect of fellow members and the ability to lead.

b) Responsibilities towards volunteers

The Cambodian Red Cross is responsible for the recruitment, training and development of its volunteers in order to meet the humanitarian needs of their clientele in Cambodia. The national society's responsibilities are herein outlined with the hope that they facilitate understanding.

Cambodian Red Cross should:

1. Provide volunteers with the Code of Conduct and Fundamentals of Voluntary Service;
2. Recruit volunteers for specific, explicitly described roles or tasks; make sure that the job description corresponds as closely as possible to the tasks assigned; explain functions and tasks;
3. Provide clear guidelines to volunteers performing technical assignments;
4. Recruit volunteers on the basis of their commitment and potential;
5. Actively seek to recruit volunteers irrespective of their race, ethnicity, class, sex, disability, age, religious beliefs, and political affiliation;
6. Ensure that there is appropriate participation of men and women in CRC volunteer programs for effective and gender-sensitive delivery of services and activities;
7. Make volunteers feel welcome; orient all new volunteers and arrange for their necessary courses; emphasize the importance of collaborating with others in assigned tasks.
8. Provide appropriate training that will enable a volunteer to meet his or her responsibilities towards the Movement, the specific task or role they were recruited to carry out, and for any emergency response activity they may be asked to carry out;
9. Provide appropriate equipment for the task or role they are asked to carry out; provide volunteers with adequate material to keep them informed and updated on Red Cross/Red Crescent matters.
10. Reward and recognize active volunteers whenever possible and appropriate, and provide appropriate personal development opportunities (e.g. exchange program in-country and abroad);
11. Ensure that volunteers' views and ideas are actively sought and acted upon at all stages of programme design, development, implementation and evaluation;
12. Reimburse reasonable expenses incurred by volunteers in the course of carrying out approved volunteering tasks;
13. Ensure that volunteering work does not substitute for, and lead to loss of, paid employment;
14. Ensure that, when people need to be paid to perform a task or work, they are recognized as employees, contract workers or casual labor. As such, they should be covered and protected by any relevant employment legislation applicable, such as minimum wages, contract protection and other legal rights and responsibilities;
15. Provide appropriate training and development opportunities for existing and potential governance volunteers;
16. Seek to promote cooperation and partnerships with organizations in civil society and public and private sectors that encourage volunteering;
17. Define the conditions under which the national society or the volunteer will end his/her commitment.

Cambodian Red Cross NHQ shall support their Branches in their work with volunteers. It shall identify and support projects that will help to strengthen Red Cross Branch activities that promote volunteering and share this information systematically.

5. RIGHTS AND RESPONSIBILITIES OF VOLUNTEERS

a) Fundamentals of Voluntary Service:

All Red Cross Volunteers are expected to:

1. Act in accordance with the Fundamental Principles of the National Red Cross and Red Crescent Movement and promote their dissemination;
2. Respect the regulations on the use of the emblem and to prevent its misuse;
3. Strive and work for the highest standards of quality service;
4. Sign, and behave in accordance with the CRC's code of conduct for volunteers, rules and/or the Federation's code of Ethics and Fundamentals of voluntary services;
5. Be available in an emergency, as agreed with the CRC, and according to their skills and abilities;
6. Respond to the needs of beneficiaries and strengthen their capacity for self-help and active volunteering;
7. Fulfill duties without discrimination of nationality, race, class, sex, political views or religious belief;
8. Respect each individual and the confidentiality of those being assisted;
9. Promote mutual understanding through consultation;
10. Respond to the needs of others in a humanitarian and compassionate way;

b) All Red Cross Volunteers are entitled to:

1. Choose to become a Member of CRC, as defined by the statutes;
2. Have appropriate training or personal development to be able to undertake their agreed tasks or role;
3. Have appropriate equipment provided to be able to undertake their agreed tasks or role;
4. Accept or refuse any task or role in accordance with the Code of Ethics and Fundamentals of Voluntary Service.

Red Cross Volunteers must not:

1. Commit resources of the Red Cross without prior mandate.
2. Misuse his/her Red Cross position for personal advantage.
3. Take advantage of his/her status to perform private transaction or sales from which a profit can be derived for himself/herself or for a third party.
4. Use information gained outside of Red Cross / Confidentiality

ANNEX: N

BUDGET INFORMATION

Weaknesses

- If would be useful if, in the detailed budget, the costs associated with each project and support staff (in the field) were identified, rather than lumped together (item number 51991).

- Attention should be paid, also, to the reconciliation of costs described in the detailed budget, compared with the budget narrative. For instance, during year one, the total cots for national project staff, according to the detailed budget, amounts to $35,454. However, the sums associated with the budget narrative (itemizing the costs involved for each staff person), do not correspond. According to the budget narrative, the total cost for project staff in year one amounts to $39,885, revealing a discrepancy.

- Ideally, the budget narrative would not simple provide the calculations involved but would also reveal the total amounts, the show how these correspond with amounts itemized in the detailed budget.

DESCRIPTION OF THE PVO APPLICANT OR PROGRAM

Weaknesses

- Although the proposal describes well the Measles Initiative and the IMCI Healthy Children Initiative, as examples demonstrating ARC past performance, it would be useful to include a discussion on ARC and/or Cambodia Red Cross (CRC) technical experience in Cambodia.

PROGRAM STRATEGY AND INTERVENTIONS

Comment

Greater consideration should be given in the proposal to describe how program activities will affect behavioral change. While the proposal provides same discussion about the use of flipchart pictures to encourage change at the household and community level, and alludes to other BCC messages, greater attention is required of this issue. It is unlikely, for instance, that flipchart pictures, in and of themselves, will foster positive change.

Response

As described in *Section 2. Program Description by Objective, Intervention and Activities, sub-section A. Behavior Change and Communication*, the ICH Project will employ a comprehensive behavior change communication strategy focusing on interpersonal communication through home visits and women's group discussions. Interpersonal communication will be reinforced with social mobilization (through a high level of participation from stakeholders and local opinion leaders) and mass media (primarily radio and television coverage highlighting 'model mothers' or positive deviants).

Relevant quantitative and qualitative research has been reviewed and Khmer specific beliefs, knowledge, and practices relating to each technical intervention were identified. Health messaging strategies were designed to capitalize on positive beliefs as well as address resistances. Formative research relating to each technical intervention will be validated through FGDs as needed. FGDs will be conducted periodically over the project life to answer questions which will arise through implementation, thus enabling the 'fine tuning' of behavior change interventions in order to maximize the potential for sustained behavior change.

Comment

Furthermore, no specific attention is paid to how BCC activities might impact behavior change at the health worker and health facility levels.

Response

RACHA and BTC are funding initiatives that focus on behavior change at the health worker and health facility levels (see *Section 2. Program Description*). The ICH Project will engage HC staff including midwives in supervision and training activities to the greatest degree possible. However, we are sensitive to the reality of competing demands placed on understaffed HC's by other NGOs, the OD, and the PHD.

Comment

How the capacity of ARC volunteers to deliver services and effect change could also use some further detail. The use of RC volunteers, while innovative, poses questions- especially since it is believed that capacity of volunteers to deliver CS services is low.

Response

ICH project volunteers are CRC volunteers. CRC volunteers will be activated or recruited from each of the 263 villages of Angkor Chum OD. They will be elected by their villages to serve as volunteers, thus ensuring community support for their work. These mothers already have intimate knowledge of the child health issues affecting their peers. Their social, economic, and geographic proximity to the beneficiary households will further facilitate their work. It is recognized that the large majority will have very limited or no formal education. The ICH Project's village-based training/coaching strategy addresses this reality. Short two to three hour adult based learning sessions will 'teach' information or skills by emphasizing how they relate to current knowledge and practices. Practice and application will be integrated into each session. Finally, training of village-based CRC volunteers supports local capacity building.

Comment

Applicant mentions that program area would be inaccessible during the rainy season when major flooding would be expected leading to displaced communities and increased risk of diarrhea, malnutrition, malaria and difficulty accessing care from trained providers for ARI. ARC and its partner CRC are best equipped to manage this type of situation and the implementation plan needs to incorporate the appropriate actions.

Response

The effect of rainy season on each of the proposed interventions and activities was thoroughly discussed during the Phase II DIP workshop in Siem Reap. Representatives from each of the three participating ADs stated that under normal rainy season conditions, transportation and access is more difficult. However, it was not thought that normal rainy season conditions would prevent access nor suspend project activities in areas except Varin. Varin may be inaccessible during the rainy season. In the event of a major flood or other natural disaster, ARC and CRC will complete an emergency assessment and design an action plan in coordination with all stakeholders.

PERFORMANCE MONITORING AND EVALUATION

Weaknesses

- Given the program's concern for identifying low performing villages and the need, if required, to take remedial action, the proposal should consider the type of sampling method to be applied to the KPC. Given the specific localities of the project districts and the focus on community level health, consideration should be given to the use of LQAS as the sampling method. A suggestion is also to include seasonal variations in health care utilization patterns such as in the rainy/flood season.

Response:

The project chose to use the classic KPC survey and a 30 cluster sampling frame, rather than LQAS. This meant that results could be directly compared both with other child survival projects in Cambodia, and provided a more generalizable training for field staff than the use of one method. In addition, per the CSTS document that compared cluster sampling and LQAS, the approximate costs for LQAS (increased sample size & thus increased amounts of time spent conducting the survey) also contributed to the decision to use the more classic method. LQAS is likely to be used at the mid-term review to assess the overall quality of training provided through the cascade models,

With respect to low performing villages, the project monitoring system includes considerable elements for quality control and health indicator review (see the M&E plan in the DIP). Key elements from that plan include the CBSS, volunteer leader workplans, quarterly reports, and the monthly OD health meetings. All of these are elaborated in the M&E plan, excerpted in the following two paragraphs:

> The project team will develop the monitoring tools with technical assistance from the ARC NHQ TAPE Unit, preferably adapting existing tools from other projects both in Cambodia (and from the Child Survival community here) and elsewhere in the world. In particular, elements of volunteer management, supportive supervision, volunteer multiplier effects may be pulled from existing PEPFAR grants. Additional monitoring tools and processes, such as during the midterm review or prompted by operations research, will be developed on an as-needed basis.

These additional tools may include LQAS, PRA, based on the information needs at the time.

Information Interaction with Provincial Health System (village, health center, OD, PHD).

It is anticipated that project staff will attend the monthly OD meetings, described above, and provide amplification of community-based data. Project volunteers will participate in the monthly meetings conducted at each health center, and in routine meetings with members of the VHSG. Information on community workplan performance, including CBSS activities, will be appended to the monthly reports turned in to the health centers. Project staff may also work with the Operational District staff in analyzing data to determine trends, especially in target villages/non-target villages. The project plans to cover the entire Operational District, but this coverage may be phased in different modalities (by universal coverage for immunization campaigns, by Administrative District, by nodal commune, by model health centers, etc.) depending on the intervention. Discussions of differences in performance among the villages will be discussed initially at the village level, and then through routine meetings with the Administrative and Operational District authorities. Project staff will also attend provincial health department quarterly NGO meetings. More informally, the Provincial Health Department Governor and the Provincial Governor are both board members of the Siem Reap Branch of the Cambodian Red Cross, which enhances access and cooperation.

Finally, seasonal variations can be captured through both the CBSS and the monthly health meetings (where the monthly statistics are presented). The project already plans to conduct operational research on seasonality on bednet use. The OD currently plans campaigns based on when different diseases tend to occur, and to run education programs in the months immediately prior to the disease outbreaks. The project would coordinate their efforts with the existing timeframes.

Annex O - Rapid Catch Indicators and Results

No.	Intervention	Indicator	Num.	Denom.	Statistic	CI
1.	All	Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	122	342	35.7%	± 8.1%
2.	Child Spacing	Percentage of children 0-23 months who were born at least 24 months after the previous surviving child	16	38	42.1%	± 25.9%
3.	MNC	Percentage of children age 0-11 months whose births were attended by skilled health personnel	27	177	15.3%	± 7.8%
4.	MNC	Percentage of mothers with children age 0-11 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	106	177	59.9%	± 13.5%
5.	Nutrition	Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	43	112	38.4%	± 18. %
6.	Nutrition	Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	49	60	81.7%	± 24.9%
7.	Immunization	Percentage of children age 12-23 months who are fully vaccinated before first birthday	48	141	34.0%	± 17.9%
8.	Immunization	Percentage of children age 12-23 months who received a measles vaccine	151	170	88.8%	± 14.9%
9.	Malaria	Percentage of children age 0-23 months who slept under an insecticide treated net the previous night	6	347	1.7%	± 1.9%
10.	HIV/AIDS	Percentage of mothers with children age 12-23 months cite at least 2 known ways of reducing risk of HIV infection	22	170	12.9%	± 7.4%
11.	CDD	Percentage of mothers with children age 12-23 months who report that they wash their hands with soap/ash at all appropriate moments	1	170	0.6%	± 1.6%
12.	All	Percentage of mothers of children age 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment	201	347	57.9	± 8.9%
13.	All	Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	65	121	53.7%	± 15.8%

Appendix P

Health Facilities Assessment: Summary of Analysis of Secondary Data and Other Recent Reports and Brief Confirmatory Primary Data Collection

I. INTRODUCTION

Because of the wealth if available information from recent, comprehensive, and high quality health facilities assessments covering Siem Reap, it was agreed that there would be little extra primary data collection done by the project for assessment of health facilities. Instead, the data from key reports was reviewed. In particular, the most useful sources of information were –

PLAN 2003 HFA of several ODs in Siem Reap

URC 2004 HFA of seven provinces including Siem Reap

RACHA 2000 HFA focusing on Family Planning Services

Additionally, key strategy documents were consulted. These included, among others:

Linkages IYCF preliminary documents generated from 12/04 and 3/05 field visits

RACHA, Community Terms and Beliefs Regarding Childhood Illness

Summary Report of Community Based Interventions for Nutrition, CRS

Immunization Delivery Modalities and System Constraints

Cultural Perceptions of Diarrhea, Dehydration, and Diet: Factors Influencing Health Seeking Behavior in Cambodia

IMCI Strategy for Cambodia, Ministry of Health, 2001

This information was confirmed and supplemented through a brief primary data collection process in April 2005. ICH project staff conducted interviews, focus groups, and observations at five major health centers in the project area (Pouk, Char Chhouk, Angkor Chum, Suay Sor, and Teuk Vil Health Centers) and among health officials and VHSGs in the project area. The areas of inquiry for this confirmatory data collection were perceived health problems and priorities, health seeking behavior, and health services inputs.

II. SUMMARY OF NATIONAL HEALTH SERVICES AND STRATEGIES (FROM PLAN 2003)

Health Services in Cambodia

There is a wide variety of health services available in Cambodia, including public and private, formal and informal, modern and traditional, for profit and non for profit. Public health services are provided by the MoH facilities and hence, these services are funded by the government and provided by government health staff.

Externally funded health projects are usually concerned with and put most emphasis on strengthening public health services, despite the fact that less than 1 out of 5 patients (18.5% - CDHS 2000) uses these services for first treatment.

The public health sector consists of health facilities at national, provincial and district levels:

- The country has been divided in 76 Operational (Health) Districts (ODs), each with an office responsible for management of public health services, consisting of a Referral Hospital and several Health Centers.
- Each province consists of 1 or more Operational Districts and has a Provincial Health Department (PHD), which is responsible for management of public health services as well as for other public health activities and issues in the province.
- At national level, there are a number of national hospitals that are either general hospitals (e.g. Calmette) or specialized hospitals (e.g. the National Pediatric Hospital or the National Maternity Hospital). In addition, there are a number of national programs (e.g. National Tuberculosis Program, National Immunization Program, National Malaria Program, etc.) and national institutes (National Center for Health Promotion and the National Institute of Public Health). Final responsibility for the delivery of public health services lies with the central Ministry of Health.

The MoH document that specifies the location of public health facilities and the level of services provided is called the Health Coverage Plan. The Health Coverage Plan includes 76 Operational Districts, 942 Health Centers and 69 Referral Hospitals and is based on rational criteria such as population covered (a population of 100,000 per Operational District and approximately 8,000 to 12,0000 people covered by 1 Health Center) and distance (within 10km or maximum 2 hours walk from the Health Center)

Health Centers provide a basic package of services called the Minimum Package of Services (MPA), which consists of a number of curative and preventive services:

- Primary curative consultation for treatment of the most common health problems, such as malaria, respiratory infections, diarrheal disease, sexually transmitted infections, etc.
- Emergency care and simple (minor) surgery
- Treatment of chronic diseases: Tuberculosis and Leprosy
- Consultation for healthy children, including vaccinations, management of malnutrition, prevention of Vitamin A deficiency
- Care for pregnant women, including antenatal and postnatal care, vaccination against tetanus, prevention of anemia, delivery, and referral of complicated deliveries
- Birth spacing
- Referral of patients
- Outreach activities

By the end of 2003, 823 Health Centers (87% of all planned Health Centers) were functioning. It should be noted, however, that due to a lack of qualified staff only 24% of these Health Centers are able to provide the full package of MPA services. Many Health Centers in more remote areas are not able to provide all MPA services and the lack of qualified midwives is the most acute problem.

Referral Hospitals provide services that cannot be provided by the health centers, called the Comprehensive Package of Activities (CPA). There are three variants of CPA:

- CPA-1 is the lowest level of hospital based services and excludes surgery
- CPA-2 is the full package of hospital services, including surgery
- CPA-3 is the full package of hospital services plus certain specialized services such as ophthalmology, specialized surgery, etc.

By the end of 2003, 30 hospitals were classified as CPA-1, 21 hospitals as CPA-2, and 18 hospitals as CPA-3. In special cases, i.e. when a considerable number of people are living too far away from the nearest Health Center and do not have access to MPA services, Health Posts can be established. Health Posts function as an outpost of the Health Center, provide only the most crucial MPA services (but never the full package), and some Health Posts provide services only a few days per week.

Ministry of Health policies and guidelines promote community participation in the Health Centers. In order to establish a link with the community, Health Centers are encouraged to establish Village Health Support Groups (VHSG), which consists of 1 woman and 1 man from each village covered by the Health Center. The main purpose of the VHSG is to facilitate the exchange of information between community and Health Center. A second and much smaller committee, which is intended to be actively involved in management of the Health Centers, is the Health Center Management Committee (HCMC). This committee includes Health Center staff, Khum officials, and community representatives.

Since the introduction of the Health Financing Charter in 1997, most health facilities charge a fee for services. At Health Center level these user fees are generally low, but the fees for hospital services are considerably higher. In order to guarantee access to public health services for the poor, the Charter specifies that the poor should be exempted from paying user fees. The user fees form an important source of income for health facilities, which can be used to buy materials and supplies (50% of income from user fees), but also to supplement staff salaries (49%). In order to make sure that the poor have access to health services and that health facilities do not loose essential income by exempting the poor, the MoH has started piloting equity funds. Equity funds are typically funded and managed by NGOs/IOs and pay the fee for services to the health facility on behalf of the poor.

Private Health Services

Most Cambodians will use private health services for first and subsequent treatment. According to the CDHS 2000, almost one third (32.9%) of the ill or injured sought first treatment from a qualified private provider, while 35.1% sought care from the non-medical (non-qualified or traditional practitioners). In other words, more than two thirds sought first treatment in the private sector.

As mentioned, the private sector includes a wide range of health services:

- Qualified or trained providers:

- Private hospitals and clinics; Mostly in Phnom Penh and in provincial capitals
- Private providers with private practice at home or providing house calls; Many of them government health staff
- Qualified pharmacies; Mostly in Phnom Penh, provincial capitals and in some of the larger district towns

- Non-qualified or non-trained providers:
  - Providers that are diagnosing and treating patients, but do not have any medical training to do so
  - Drugs store (pharmacy without qualified staff)
  - Shops/market stalls selling drugs

- Traditional medicine:
  - Kru Khmer (traditional healer or herbalist)
  - Shops or market stalls selling traditional and herbal medicines
  - Spiritual healers
  - Bonesetter
  - Traditional Birth Attendants (TBAs)

It should be noted that not all private providers are motivated by profits. Some NGOs provide highly subsidized or even free of charge services. Examples are the RHAC reproductive health clinics in Phnom Penh and in several provincial towns, the Kantha Bopha hospitals in Phnom Penh and Siem Reap, and the Angkor Hospital for Children in Siem Reap. It is also quite common for a Kru Khmer, a spiritual healer, or a TBA to charge according to the patient's ability to pay or to accept payments in kind.

There is sufficient proof that the care provided in the private (for profit) sector is generally of poor quality, which is especially true for services provided by non-qualified and non-trained providers. The result is that patients pay relatively large sums of money for poor quality and inappropriate and sometimes even dangerous care, and delay seeking appropriate and adequate care until the moment a relatively simple illness has progressed into a serious health problem.

National Health Policies and Strategies

The Ministry of Health's mission and policies are reflected in the Health Sector Strategic Plan 2003-2007, which was launched in August 2002. This section also discusses several other government policies and strategies that are aimed at child health and child survival, including early childhood care and development and school health.

Box 2.1: Mission and Policy Statements of the Ministry of Health

Mission Statement
Commitment to ensure sector wide equitable, quality health care for all people through targeting resources, especially to the poor and to areas in greatest need.

Policy Statement
All people in Cambodia, of whatever gender, age, place of residence or ability to pay, should have equal access to good quality, basic and essential specialized health services, staffed by competent health professionals and at a cost people can afford. They should have information that empowers them to make informed choices about matters affecting the health and well being of themselves and their families

Source: Health Sector Strategic Plan 2003-2007

The Health Sector Strategic Plan 2003-2007

The Strategic Plan was developed in an effort to make progress towards achievement of the MoH mission and policies and to focus resources and actions of the MoH and of other health partners during the years 2003-2007.

The Strategic Plan gives a very honest and realistic overview of the key challenges in further development of the health sector and in improving the health of the population.

In summary, the key challenges are:

- The urgent need to reduce the present high rates of infant, child and maternal mortality through improved coverage of and access to critical child and maternal health services. Critical child and maternal services include:
  - Immunization services
  - Access to and utilization of trained providers for treatment of childhood illnesses, especially for acute respiratory infections
  - The use of oral re-hydration solution for children with diarrhea
  - Promoting exclusive breastfeeding and reducing inappropriate complementary feeding practices
  - Measures to reduce the very high prevalence of malnutrition and micronutrient deficiencies
  - Access to and use of trained midwives, especially in remote areas
  - Availability of emergency obstetric care, especially in remote areas
  - Birth spacing (contraception) services
  - Access to safe abortion services
- Health services are often of poor quality, both in the public and in the private sector, and need to be improved
- Related to the quality of care, providers need to be sensitized on professional ethics and build their skills in interpersonal communication and counseling.
- There is a need to improve household health practices with regards to nutrition, the use of preventative measures, and healthy lifestyles. More efforts are needed to promote behaviors such as immunization, contraceptive use, breastfeeding, the use of

oral re-hydration solution, the use of trained providers for delivery and for treatment of childhood illnesses, etc.

- In order to address these key challenges and to effectively deliver the necessary services and interventions, a number of key challenges with regard to building a well functioning health system (systems issues) need to be addressed:
  - The health sector is under-funded with the national health budget amounting to 1.2% of GDP (2003) and low public health expenditures due to limited budget access. By 31 December 2003, only 61% of the annual health budget had been released and spent.
  - As a result of the low government salaries, health staff cannot afford to work full-time and need to do private practice in order to earn a living wage.
  - There is a lack of qualified staff, especially in remote areas. This is partly caused by a lack of qualified staff (especially midwives), but also due to the mal-distribution and poor management of existing staff.
  - The price of health care is a major barrier for the poor to access health services. Out of pocket expenditure amounts to $24 per capita per year and 80% of those who sought care had to use savings, borrow, or sell assets to meet the health care costs.
  - There is a thriving and largely unregulated private sector with a wide range of providers, the majority of which is believed to provide poor quality and relatively expensive health care.

Box 2.2: The Key Areas of Work and Core Strategies

1. Health Service Delivery
- **Further improve coverage and access to health services, especially for the poor and other vulnerable groups through planning the location of health facilities.**
- **Strengthen the delivery of quality basic health services through health centers based upon the minimum package of activities (MPA)**
- **Strengthen the delivery of quality care, especially for obstetric and pediatric care, in all hospitals through measures such as the complementary package of activities (CPA)**

2. Behavioral change
- **Change for the better the attitudes of health providers sector wide to become more responsive to consumer needs, especially of the poor through sensitization and building interpersonal skills**

3. Quality Improvement
- **Introduce and develop a culture of quality in public health, service delivery and their management through the use of MoH quality standards**

4. Human Resource Development
- **Increase the number of midwives through basic training and strengthen the capacity and skills of midwives already trained through continuing education**

5. Health Financing
- **Ensure regular and adequate flow of funds to the health sector, especially for service delivery, through advocacy to increase resources and strengthening financial management**

6. Institutional Development
- **Organizational and management reform of structures, systems and procedures in the MoH to respond effectively to change**

Source: Health Sector Strategic Plan 2003-2007

The goal of the Strategic Plan is to address these key challenges and "to enhance health sector development in order to improve the health of the people of Cambodia, especially mothers and children, thereby contributing to poverty alleviation and socio-economic development."

The outcomes for the goal are:

- Reduced infant and child mortality rates
- Reduced maternal mortality ratio
- Improved nutritional status among children and women
- Reduced total fertility rate
- Reduced household expenditure, especially among the poor
- More effective and efficient health system

The Strategic Plan includes 20 strategies grouped according to 6 key areas of work. The strategies aim to address the key challenges and to achieve the goal and outcomes of the Strategic Plan. Box 2.2 lists the 6 key areas of work and the 8 core strategies, which are believed to be most urgent, cost-effective and feasible.

Child Health Strategy / Priorities

The Ministry of Health does not have a separate policy on child health. Nevertheless, the Health Sector Strategic Plan 2003-2007 identifies child health as one of the main priorities for the years 2003-2007, and the MoH and its partners are currently in the process of formulating a plan of action for child health in an effort to refocus commitment and resources.

The main strategies with regard to child health are:

- Immunization of children under the age of 1 year against 6 vaccine preventable diseases
- Distribution of Vitamin A capsules to children aged 6-59 months
- Integrated Management of Childhood Illnesses (IMCI)

<u>Immunization</u>

The routine immunization is carried out by the Health Centers through monthly outreach visits to the villages. In addition, certain immunizations are carried out through campaigns. The eradication of polio was achieved through campaigns and presently the National Immunization Program (NIP) is implementing regular campaigns to vaccinate children against measles.

Routine immunization includes BCG, DTP, Polio, and Measles vaccinations. The NIP has piloted Hepatitis B vaccination in a limited number of provinces and is now expanding this to cover more provinces.

The MoH has implemented routine immunization for many years and has received considerable support for International Organization such as UNICEF, WHO, and more

recently GAVI. Nevertheless, CDHS 2000 reports a full immunization coverage of 39.9% which is low and lags behind coverage rates reported by some other countries in the region.

The NIP is about to start piloting fixed-site immunization at some Health Centers. As part of this pilot, parents living within 10 km from the Health Center are asked to bring their children to the Health Center for vaccination, while the monthly outreach visits are continued to villages further away than 10 km from the Health Center.

Vitamin A

The distribution of Vitamin A capsules to children aged 6 to 59 months started in 1995 and is linked to the immunization program. The capsules are distributed twice per year: Round 1 takes place in March and coincides with the measles vaccination campaign, and the second round is in November through routine immunization.

In the year 2003, the National Immunization Program reported coverage of 70% of the targeted children for round 1, while coverage during round 2 was reported at 47%.

There are indications that the reported coverage is too high, and the results from CDHS 2000 show that only 29% of targeted children had received a Vitamin A capsule in the six months preceding the survey.

Integrated Management of Childhood Illnesses (IMCI) / Care of Sick Child

IMCI is an integrated approach to child health, which aims to reduce death, illness and disability and to promote improved growth and development among children under 5 years of age. IMCI includes both preventative and curative elements that are implemented by families and communities as well as by health facilities.

In health facilities, IMCI promotes the accurate diagnosis of childhood illnesses, ensures appropriate combined treatment of all major illnesses, strengthens the counseling of caretakers and speeds up the referral of severely sick children. At the family and community level, IMCI promotes appropriate care seeking behaviors, improved nutrition and preventative care, and the correct implementation of prescribed care.

The IMCI strategy has three components:

- Improving case management skills of health staff
- Improving overall health systems
- Improving family and community health practices (community IMCI)

IMCI was introduced in Cambodia approximately 5 years ago and activities have focused on adapting the standard IMCI clinical guidelines to the Cambodian context, and on upgrading diagnostic and treatment skills of Health Center staff.

The IMCI training for Health Center staff (also called MPA Module 3) consists of an 11 days theoretical and practical training course and two follow-up or supervision visits after completion of the training. The National Pediatric Hospital in Phnom Penh and the

Angkor Hospital for Children in Siem Reap are the only two training sites in the country. The lack of regular supervision (i.e. after and beyond the 2 initial follow-up visits) is generally seen as a shortcoming.

By the end of the year 2003, only 95 Health Centers had been trained in and were implementing IMCI. The slow progress in the implementation is contributed to the relatively high costs of the training (estimated at $7,000 to $10,000 per course for 18 to 24 Health Center staff) and the fact that the funding largely depends on the willingness of NGOs to support the training for the Health Centers supported by them.

Community IMCI consists of 12 key family practices (see box 2.3) to improve child survival, growth and development. In order to provide this care, families need knowledge and skills, mothers and other caretakers need to be motivated to try and sustain these practices, and finally, they need support from their respective communities as well as from the health system. Several of the key family practices are part of MoH policies and strategies, and have been promoted for many years, mostly by NGOs as part of community based health projects. Usually, the focus is on one or several of the family practices, using various vehicles to deliver health education messages at community level.

The MoH Communicable Disease Control (CDC) Department, which is in charge of the implementation of IMCI, is presently collecting existing health education messages and putting these together as a package in support of community IMCI.

Box 2.3: Community IMCI – 12 Key Family Practices

- **Exclusive breastfeeding for at least 6 month**
- **At 6 months, start introduction of complementary foods, while continuing to breastfeed**
- **Ensure adequate intake of micro-nutrients**
- **Sanitation: Safe disposal of feces; Washing hands**
- **Full immunization before first birthday**
- **Use of bednets in malaria endemic areas**
- **Promote mental and social development of the child**
- **Continue to feed and offer more fluids when children are sick**
- **Appropriate home treatment for infections**
- **Recognize when treatment outside the home is required and seek care from appropriate providers**
- **Follow health worker's advice about treatment, follow-up and referral**
- **Ensure that every pregnant woman has adequate antenatal care (at least 4 visits and including tetanus toxoid vaccinations)**

Source: Child and Adolescent Health and Development Website; WHO

Nutrition

Since the publication the CDHS 2000, which showed high levels of both protein-energy malnutrition and micronutrient deficiency malnutrition in children under 5 years of age, efforts to develop sound nutrition policies and strategies have been stepped up. Two

documents need to be mentioned in particular: The National Policy on Infant and Young Child Feeding Practices (MoH, January 2002) and the Cambodia Nutrition Investment Plan 2003-2007 - CNIP (National Council for Nutrition, December 2002).

The National Policy on Infant and Young Child Feeding is based on the following three conclusions:

- Present breastfeeding practices are poor: No less than 76% of mother do not give the colostrums to their babies, only 6% of mothers start breastfeeding within 1 hour following birth and 50% do not breastfeed for the first 24 hours or more, and only 15% of mothers breastfeed exclusively during the first 3 months.
- Improved breastfeeding practices could contribute to a reduction in infant malnutrition and hence, infant mortality and morbidity.
- Health workers have insufficient knowledge and skills in this subject to help mothers.

The national policy consists of a number of directives (15 in total):

- Mothers should start breastfeeding with colostrum as soon as possible after birth, preferable within the first hour.
- No other fluids should be given shortly after birth and before starting breastfeeding with colostrum.
- All infants should be exclusively breastfed for the first 6 months of life.
- At the age of 6 months, mothers should start giving home made complementary foods in addition to breast milk.
- Breastfeeding should continue for at least 2 years.

The main purpose of the CNIP is to identify and cost a number of strategies to reduce both protein-energy malnutrition and micro-nutrient deficiency malnutrition. The proposed strategies approach malnutrition in the context of poverty and promote solutions that are multi-sectoral and largely community based.

Proposed community based strategies and activities account for 80% of the proposed $41.1 investment plan for nutrition and aim to ensure that households are the basic unit for promoting good nutrition. Proposed activities focus on promoting the following behavior to improve nutrition:

- Care for pregnant and lactating women
- Breastfeeding and safe complementary feeding practices
- Positive psychosocial behaviors
- Food storage and safe preparation behaviors
- Hygiene behaviors
- Health Promotion including growth monitoring and promotion of young children health seeking behaviors.

Proposed national level strategies focus on strengthening relevant institutions through capacity building and improved coordination, but also include strategies to control micro-nutrient deficiencies and the promotion of appropriate breastfeeding and complementary feeding practices. In recent years, nutrition activities have focused on three strategies with varying degrees of success:

- Growth Monitoring and Promotion (GMP), which aims to prevent malnutrition through early detection of growth failure and intervention, is implemented with varying degrees of success by several NGOs and IOs. The MoH, however, does not yet implement GMP and most health workers do not know how to manage growth faltering and malnutrition. As a result, large parts of the country are not covered by GMP
- Infant and Young Child Feeding (IYCF) activities have focused on policy development, the development of BCC materials, and the development of regulations on the marketing of products for infant and young child feeding. Training in breastfeeding counseling for health personnel and community health workers is taking place, but the coverage to date is limited.
- Vitamin A supplementation is included in the outreach services provided by Health Centers and consists of distribution of vitamin A capsules to all children aged 6-59 months (twice a year) and to lactating women within 8 weeks of delivery. There are strong indications that about two-thirds of the target children do not receive these supplements, while just over 20% of lactating women are believed to have receive Vitamin A supplements in the year 2003

III. SUMMARY OF FINDINGS FROM HFAs (URC 2004, PLAN 2003, Supplementary and Confirmatory Primary ICH data)

Background for URC HFA: Goal, Objectives, Methods

The overall goal of the HFA was to collect important qualitative and quantitative information on key services provided at MOH facilities in selected provinces for use by the ministry and its partners, and USAID. USAID strategy's evaluation design includes community and household data from the 2000 CDHS, the 1998 National Health Survey, the HSS, BSS, the ADB/NCHADS Baseline Health Facility Survey, the CDC-GAP survey in Benteay Meanchey and KAPC surveys conducted by implementing partners. The core set of indicators agreed to by all USAID-supported implementing partners, guided the selection of HFA measures, as well as other methodologies for performing health facility assessments.

Units of analysis consist of Health Centers with MPA services (82), VCCT services (9), PMTCT services (2), TB wards (27), STI units (12) and HIV/AIDS inpatient care units (5). The content of data collected from each type of health service is described below. The MPA HC and TB ward data provide central and provincial level indicators of health services. Other health services (VCCT, PMTCT, STI clinics, and HIV/AIDS care units) involved smaller samples; thus data are provided in this report for PP and "other provinces".[1] No effort was made to stratify the units of analysis (health facilities and specific services) by urban/rural, public/private/NGO, volume of patients, and so forth. Given the limited time and resources for the HFA, it is not feasible to implement a large survey of MPA Health Centers that would permit OD level measures of health services. In order to derive provincial measures, no attempt was made to weight data from MPA Health Centers based on the population served in the Health Center's catchment area, nor

[1] If provincial and site level measures are desired, they can be readily obtained and used for provincial level strategy meetings and planning.

the number of Health Centers in the OD. Each Health Center is equally weighted to derive provincial level HFA measures. Former District Hospitals are now included in the universe of MPA Health Centers for the purpose of obtaining MPA Health Center measures. For the assessment of inpatient TB wards, former District Hospitals with TB wardss are examined along with TB wards in Provincial and Referral Hospitals.

Instruments used were:

Survey or inventory using a checklist of infrastructure, staffing, drugs, equipment, and supplies.

Record review (or audit) of service outcomes (number of consultations by CoC, and coverage).

Questioning of selected health providers/support staff regarding their knowledge of clinical norms and other procedures).[2]

Direct observation of service performance (i.e. provider-client interaction to measure compliance with technical and IPC/C norms).

Discussions facilility managers or coordinators.[3]

Table 1 – Areas of Analysis of URC HFA (7 provinces including Siem Reap)

Inputs: preparedness to provide service	
Infrastructure	
Clinical norms and guidelines	
Planning	
Human resources	Staffing (numbers) Training initial Training refresher (12 months)
Knowledge of staff (technical competence)	
Service fees and PAP funds to support services	
Clinic records (complete and up-to-date)	
Supervision (from outside the facility)	
Drugs (in stock and stock outs)	• In-stock (e.g. availability of vaccines, contraceptives and drugs for TB, malaria, and STI) • Stock-outs (of the above drugs) during the last 6 months
Supplies and equipment (essential for service)	

[2] Knowledge of MOH staff will be measured through face-to-face interviews (without probing).
[3] Management information will also be measured through face-to-face interviews with the facility manager or coordinator.

service)	
IEC materials (types, topics and use)	
Infection control (control of sharps and sterilization)	
Service delivery processes: provider-client interactions	
Technical performance (compliance with clinical norms and provision of information)	
Outcomes: clients served, coverage and Continuum of Care	
Service outcomes (number of clients served, coverage and CoC)	• Maternal health: ANC, delivery, PNC, Birth Spacing • Childhood illness • EPI
Linkages and referrals of clients (to and from the facility)	• To the MOH facility: the referral sources of clients coming to the facility • From the MOH facility: to other MOH services, care networks, NGOs, community groups and private providers

Major Findings from HFAs

Inputs: Access

Access remains limited in remote areas. Outreach services are provided to remote areas if additional funding and resources are available to support HC staff. Many areas of the country do not have easy access to HC, thus outreach services and the number of HC need to be expanded and receive adequate support. Access to existing services is also limited by the number of hours that HC are open; thus many clients prefer to rely first on local drug vendors and pharmacies.

Inputs: Infrastructure

Although many of the health facilities were not well maintained, the number of consultation rooms was usually adequate. More concern should be given to privacy and ability to discuss health concerns with the provider. The MOH should consider the expansion of HC in remote areas, with linkages to hospitals and community services. Overall there are an adequate number of consultation rooms. Nevertheless, consultation rooms lack privacy for STI and ANC consultations. There is often a queue of patients waiting to receive a consultation (for most HC services) sitting in the proximity of the health care provider, mitigating the possibility of discussing private issues and expressing emotions.

Inputs: Equipment and Supplies

10% to 25% of HC did not have basic consultation tools: stethoscope, sphygmomanometer. Although most essential supplies were available, 25% do not have blank partographs, and 50% lack IV supplies and tongue depressors (required for throat examinations).

Inputs: Norms and guidelines

Health facilities should have a full set of training manuals, technical norms and guidelines to serve as a reference for supervisors, managers and health providers. MPA (1 & 2) manuals and Guidelines on Health Center Management were missing in a number of HC.

Inputs: Staffing and training

Staff receives initial training, but yearly refresher training focusing on competency gaps depends on the specific health service. Staff competency and gaps can be filled with facilitative supervision and on-the-job training using structured training/learning methods. Gaps in provider coverage existed for TB, STI and birth spacing services. Other health services are generally well-staffed.

Inputs: Staff Knowledge

Staff competence was mixed, strong in some content areas and weak in others. Further examination of strengths and weakness is required to target training and other support activities. Job aids and other IEC/C materials such as flipcharts would help fill gaps in knowledge (and mean that all of the content does not need to be recalled from memory by health providers). Other learning and training techniques involving periodic reviews and assessments by peers groups should be considered. Knowledge of providers regarding birth spacing methods, ANC, PNC and child health is relatively high but still have some weak areas (e.g. side effects of birth spacing methods, STI/HIV/AIDS prevention).

Inputs: IEC materials

The availability and effective use of IEC/C materials (as job aids and provision to clients) should be improved across most of the six health services. Compliance with clinical and IPC/C norms would be substantially improved through the use by providers of well-designed job aids, particularly where the content to be covered is complex (e.g. VCCT and PMTCT). The MOH should review the need for IEC/C materials; inventory existing materials that have been validated or under development; close existing gaps by developing new materials or adapting them from a similar setting; print and disseminate to user groups; then train both providers and support staff to effectively use the job aids and other IEC/C materials for clients and caregivers. IEC/C materials consist largely of posters that are not appropriately placed for use as job aids during consultations. The availability of leaflets/brochures and flipcharts in HC varied by content: only 17% had leaflets and 16% had flipcharts for ARI. In comparison flipcharts for birth spacing counseling clients were available in most HC.

Inputs: Drugs

Although essential drugs for the various services were found during the HFA, stock-outs of drugs and contraceptives occur resulting in improper treatment and birth spacing discontinuation. When stock-outs occur, clients must depend on private vendors, if they have funds available to pay for the required drug/contraceptive method. Stock-outs in HC, during the last six months, occurred for 1) essential HC drugs (ranging from 17% to 44% depending on the drug), and 2) TB drugs (10%). Drugs for common STI such as syphilis, gonorrhea and Chlamydia had the highest levels of stock-outs (ranging from 63% to 92% of the HC).

Inputs: Infection control

Major problems with infection control are related to the absence of functioning incinerators, and disposal of sharps on the grounds of HC. Although boxes for sharps were available, they were often disposed on the HC grounds, and incinerators were not in working condition. Water and soap was often missing in the consultation rooms.

Processes: Supervision

In general supervision and quality control visits are made, but the use of structured checklists, problem solving, and facilitation remain mixed. Supervision visits focus largely on weak areas that that need improvement. There is no evidence that information from supervision visits are compiled and used at higher levels. Much of the supervision occurs when lower level staff meets with a higher level managers (e.g. HC staff meet with OD supervisors). HC managers report regular supervision visits. There now appears to be less funding available from the MOH and donor groups to support supervision visits. Supervision with the use of a standard checklist, and meeting with the HC staff for problem-solving and planning needs to be further emphasized by OD and PHD managers.

Processes: Compliance with technical norms and procedures

Data from the HFA identifies both strengths and weakness in complying with norms of the seven health services. A review of each health service is required to identify opportunities for improvement that could be addressed by a variety of means: training, on-the-job learning and coaching, job aids, quality improvement efforts, and changes in the norms (more integrated case management).

Integrated management of childhood illnesses is minimal in MPA HC.

ANC services were more integrated compared to child health services.

If the provider assessed one of three common childhood illnesses (ARI, diarrhea and DHF) by asking questions and checking for signs/symptoms, the majority of assessments did not comply with the clinical norm. For example, only 24% of ARI assessments counted respirations.

Provision of iron/folic acid during visits was high (87%), but giving TT was only 61% (perhaps because the client already received their TT during previous visits or outreach activities).

Only 44% of the ANC visits reviewed the illness history of patients, and 21% checked for STI. Other opportunities for improvement during ANC visits include providing information regarding the vitamin A schedule (14.8%) and child immunization schedules (36.1%), and breast feeding (44.3%).

Information focuses more on the prenatal period and less on the post partum phase (in particular care of the child).

Outputs

Birth spacing is universally low (for all contraceptive methods) with the average HC providing 224 Couple Years of Protection (CYPs). Pills and injectables contraceptives are the primary methods while IUD use is almost nil.

HC staff report regular outreach visits to each village in their catchment area on a monthly basis. The regular coverage of villages through outreach requires additional examination and depends on the availability of resources for staff to travel (resources often dependent on support from NGOs working in the area). Outreach activities focus largely on preventative care (e.g. immunizations and vitamin A for children, plus IEC/C about seasonal illnesses) with little curative care due to the national guidelines.

Summary of Private Provider Services Available (from PLAN 2003)

Participants of the VHSG workshops listed a wide range of private providers available in the villages, both trained/qualified and non-trained/unqualified providers of western medicine, as well as providers of traditional medicine. In total, the participants identified 10 different types of private providers and listed 480 providers available in the 35 villages represented in the VHSG workshops.

Annex 6 gives a detailed overview of the different private providers available in the villages. It should be noted that the VHSG workshops were organized for 4 Health Centers only and that the villages covered by Rum Chek Health Center are not represented in this overview of private providers.

The most common private providers are sellers of modern drugs and traditional birth attendants. Especially sellers of modern drugs are common, with on average 4 providers per village. Another 31 villages (89% of all villages) has other qualified providers.

Surprising is the limited importance of Health Center staff doing private practice. Only 5 villages in the area covered by Preas Dak Health Center mentioned Health Center staff doing private practice as a source of health care, while 3 villages mentioned Health Center midwives doing private practice. The VHSG members of the remaining three Health Centers did not list Health Center staff doing private practice as an available source of health care.

Providers of traditional health care are very common; 30 villages (86% of all villages) have access to spiritual healers, 24 villages (two thirds of all villages) have a Kru Khmer,

almost half of all villages have a bone-setter, and just over half of all villages have sellers of traditional medicine.
Although difficult to draw conclusions due to the fact that only 15 out of 36 villages in Banteay Srey District were represented in the VHSG workshops, it seems that private health care providers are more abundant in Angkor Thom District. There are more other qualified providers (34 providers in 19 villages, against 20 providers in 12 villages in Banteay Srey District), and there are many more providers of traditional health care in this district: 61 Kru Khmer in 19 villages (against 10 Kru Khmer in 5 villages in Banteay Srey); 47 spiritual healers in 19 villages (against 24 spiritual healers in 11 villages in Banteay Srey); 61 TBAs in 20 villages (against 34 TBAs in 15 villages in Banteay Srey); 14 bone-setters in 12 villages (against 5 bone-setters in 5 villages in Banteay Srey).

Despite the abundance of private providers, most participants in the workshops and focus group discussions failed to mention the use of these providers when asked about care seeking behavior (see next section). The exception is sellers of modern drugs and TBAs, which were both frequently mentioned.

This assessment did not attempt to review the quality of care provided by the various private providers. Although it is generally believed that the private health services provide poor quality of care and are relatively expensive, we should be careful to draw conclusion. Services provided by qualified private providers may be of doubtful quality, but this does not automatically mean the services provided in the public sector are of better quality. In addition, it is difficult to draw conclusions regarding traditional health care, especially the use of traditional and herbal medicine.

On the other hand, there is sufficient evidence regarding the quality of services provided by the two most common types of private providers; TBAs and sellers of traditional medicine:

- Most of the TBAs in Angkor Thom and Banteay Srey Districts have undergone basic training provided by NGOs. Training has focused on reducing inappropriate practices, recognition of danger signs, and improving hygiene. Regarding the latter, most of the TBAs appear to be using the RACHA home birth kits, which include items like gloves, plastic sheets, disinfectants, etc. International literature, however, provides ample evidence that basic training for TBAs does not result in considerable reductions in maternal mortality, which requires access to services provided by trained midwives and access to emergency obstetric services. This is supported by the findings of population based surveys in Cambodia, which show gradual reduction in a still high maternal mortality ratio (MMR)
- Sellers of western medicine are small village shops or market stalls that sell a small selection of western drugs in addition to groceries and other goods. The sellers have no training and do little more than selling the drugs that are requested by the customer or prescribe drugs based on the complaints described by the patient. Another concern is the quality of the drugs as there is sufficient proof of fake and expired drugs being sold.

Health Seeking Behavior Findings (from PLAN 2003)

During the VHSG Workshops quite a different pattern of health seeking behavior emerged, putting much more emphasis on private providers and on the children's hospitals in Siem Reap Town.

The majority of the participants stated that the first line of treatment for sick children is within the communities and consists mostly of buying drugs from a local drugs seller. There are drugs sellers in each village and hence, it's easy to use this type of private provider. The most common drug bought from the drugs sellers appears to be paracetamol, but no doubt other drugs are used as well. It was generally agreed that buying drugs from a drugs seller is more expensive than the fees charged by the Health Centers, but it should be noted that this does not take into account travel costs.

It was difficult to establish how long parents will continue buying drugs before seeking care from a qualified provider. It is very clear, however, that few parents will go to a Health Center when there is no improvement after several days of self-treatment. Only those living in the vicinity of a Health Center will go there first, while the majority is believed to take their child to one of the children's hospitals in Siem Reap.

The reasons for not going to the Health Centers were mostly stated in terms of reasons for taking a sick child to one of the children's hospitals. On the other hand, some participants complained that Health Centers do not provide effective treatment, lack drugs, and that staff are often absent, especially during lunch and throughout the evening and night.

When a child is severely ill, the majority of the parents don't hesitate to take their child to one of the children's hospitals. Only respondents from Khum Leang Day and from Khum Peak Sneng in Angkor Thom District mentioned that some parents will first go to the Health Center, mainly to get IV fluids administered before going to Siem Reap Town.

Both children's hospitals in Siem Reap Town are very popular and parents are aware of the fact that these hospitals provide excellent care and are free of charge. In addition, both hospitals provide additional support to poor families in the form of food or money to buy food and in the form of travel costs for the journey back home.

The focus group discussions with mothers with young children paint a relatively straightforward picture of mothers buying drugs from drugs sellers in the village as the first line treatment for sick children. When the child doesn't get better, mothers will take their child to one of the children's hospitals.
There appears to be a preference for the Angkor Hospitals for Children, although several of the mothers had been to Jayavarman VII hospital as well. Mothers who preferred the Angkor Hospital for Children stated the following reasons:

- Staff are friendly
- Family members accompanying or visiting a hospitalized child can come and go as they like (no strict visiting hours)
- The hospital has cooking facilities, where accompanying family members can cook
- The hospital is believed to take smaller quantities of blood for blood tests.

None of the 40 mothers who participated in the focus group discussions mentioned taking a sick child to the Health Center. A number of reasons were mentioned for not going to a Health Center:

- Drugs prescribed by the Health Centers are believed to be less effective.
- Several mothers mentioned that the Health Center is too far away
- One mother mentioned that patients don't get a proper examination in the Health Center, not like in the children's hospitals in Siem Reap Town.

Some mothers in Kandal village (Khum Svay Chek) mentioned that a spiritual healer must be consulted before taking a sick child to Siem Reap Town, while one mother mentioned that injections cannot be given without having consulted a spiritual healer first.

Only a few mothers mentioned having sought care from a qualified private provider. In one case the private provider concerned was a Health Center staff, while in another case a staff of the Angkor Hospital for Children living in the same village had been consulted.

During the discussions with Health Center staff it was confirmed that most mothers will first buy drugs and treat the child at home. In one Health Center the staff mentioned that on average parents will treat a sick child at home for 3 to 5 days, before seeking care elsewhere. Also the use of spiritual healers was mentioned several times as an important source of first line care for sick children.

Not surprisingly, staff give more importance to the use of Health Center services. Staff in 2 Health Centers mentioned that those living relatively near are likely to use the Health Centers instead of buying drugs from drug sellers. Staff in all Health Centers agreed that when a child does not get better after several days of self-treatment, many mothers will decide to take the child to a Health Center. Given the travel costs involved, only the better off families will decide to take the child to one of the children's hospitals.

Health Center staff stated that severely sick children will be taken to one of the children's hospitals in Siem Reap Town. At least one of the Health Centers (Rum Chek) mentioned that in the majority of these cases, parents will still go to the Health Center first in order to get a referral letter. With such a letter, it is believed to be easier to get access to the children's hospitals, while RACHA pays the travel costs for poor patients using interest accumulated by its micro-credit scheme.

In summary:

- The majority of mothers will first buy drugs from a drugs seller and only those living near a Health Center are likely to take a sick child there for first line treatment.
- It is less clear what happens when a child does not get better. Commune officials and Health Center staff state that many mothers will go to the Health Center when a child does not get better, but none of the mother that participated in the focus group discussions mentioned going there with a sick child.
- In case of a severely sick child, it is quite clear that the majority of children go to one of the children's hospitals in Siem Reap Town.

Determinants of HSB: Quality of Care

The main determinants of health seeking behavior are the quality of care as perceived by the population, and the time, effort and costs involved in using a certain type of provider. Obviously there are several other factors that play a role, but most of these will ultimately influence the perceived quality of care and the time, effort and costs involved in seeking care. The quality of care was mentioned by many of the participants in workshops and focus group discussions, especially with regard to the Health Centers and with regard to the children's hospitals in Siem Reap Town.

Several participants (especially of the VHSG workshops and the focus group discussions with mothers) mentioned that Health Center staff are not always there, that the Health Centers lack equipment and drugs, and that available drugs are not effective. The Jayavarman VII Hospital and the Angkor Hospital for Children are believed to provide good medical care, to have all medical equipment required, and to have sufficient and effective drugs. In terms of quality, it appears that the Angkor Hospital for Children is generally the preferred hospital. VHSG members mentioned that the staff is friendlier in this hospital and several VHSG members and mothers brought up that the Jayavarman VII Hospital requires too much blood for tests. On the other hand, at the Angkor Hospital for Children the waiting time is considered to be longer than in the Jayavarman VII Hospital.

Determinants of HSB: Costs of Seeking Care

The costs involved in seeking care include several factors, including the fee charged for services. With regard to care seeking for sick children it should be noted that services at the Health Centers and at the children's hospitals are either modestly priced or even for free and hence, other costs are believed to be much more important.

Other (indirect) costs include travel costs, the cost of food for family members that accompany a hospitalized child, and the costs of being away from home and not being able to do ones regular work (opportunity costs).

Travel costs and the costs and effort of leaving ones house and village in search of health care are mentioned as the main reasons why people prefer to find treatment close to the house in the form of buying drugs from drugs sellers. Its importance is also illustrated by the fact that the majority of the patients using Health Centers come from nearby villages. Travel costs are a very important component of health care expenditures of households in Angkor Thom and Banteay Srey Districts. Obviously, travel costs differ with the distance traveled, but are also much higher in case of a seriously sick patient and during the night. Those without their own means of transport will go by motor taxi, motor remork, or even rent a car. Travel costs quoted by participants range from just a few thousand Riels in case of a relatively short distance traveled, to as high as Riels 50,000 to 60,000 for those further away and in case of a medical emergency.

Both children's hospitals reimburse part of the travel costs for the poor. The hospitals provide money to travel back home when a child is discharged from the hospital, and the

amount is based on the distance traveled. In addition, both hospitals provide some support in terms of food and/or money to buy food to family members that accompany a hospitalized child.

The time and effort involved in going to a Health Center or to Siem Reap Town cannot always be expressed in money. The difficulty of leaving ones house and village and to arrange for someone to take care of children that stay behind was mentioned by several VHSG members and mothers with young children. These factors cannot be underestimated as important reasons for buying drugs from drugs sellers and delaying seeking treatment from a qualified provider.

Finally, it should be realized that the proximity to both children's hospitals, with high quality and cheap health care, is the major factor shaping health seeking behavior for sick children in these two districts. Health seeking behavior for adults should be expected to be quite different, while care seeking for sick children in other provinces is likely to be more similar to care seeking in general.

IV. DISCUSSION - KEY FINDINGS AND PROGRAMMATIC IMPLICATIONS

Health Problems (from PLAN. See also Annex 3)

Child Health

- Acute respiratory infections, and diarrhea and diarrheal disease are common health problems for all age groups and for both women and men. For young children, skin disease and eye infections are also mentioned as frequent health problems.
- While Health Center service statistics show only few cases of malaria and dengue amongst young children, VHSG members listed both diseases as main health problem for young children.
- The PLAN baseline survey in the neighboring Angkor Thom District clearly indicates that malnutrition was a serious health problem for children in 2003.

Women's Health (ANC, Gynecological Consults, Family Planning)

- While Health Center service statistics do not specify diseases diagnosed and treated for women, VHSG members indicated vaginal discharge, irregular menstruation, anemia, and complication related to pregnancy and delivery as main the health problems facing women.
- Birth spacing is universally low (for all contraceptive methods) with the average HC in the URC HFA providing 224 Couple Years of Protection (CYPs). Pills and injectables contraceptives are the primary methods while IUD use is almost nil.

Health Seeking Behavior and Access (from PLAN)

- Many are inappropriately "jumping the queue" and going straight to the Siem Reap City Hospital. Improving t he quality of care and the *perception* of the quality of care at peripheral facilities will be critical to rationalizing health care utilization.
- Because 4 in 5 initial contacts with the health system are not through the MOH but rather with private drug sellers or other private providers, including them in any strategy is critical.
- It is critical that user fees not act as a barrier to care seeking. Other organizations in the project area are working on this and the ICH project will coordinate with them.

Health Services Inputs (mainly from URC)

Access

- Access to health services is limited geographically in remote areas. On the other hand, the KPC found that there seemed to be appropriate "compensatory behavior" on the part of the MOH in Varin which is the most geographically isolated of the three ADs in the project area. There were more outreach visits there.
- Access also limited by limited hours of operation; thus many clients prefer to rely first on local drug vendors and pharmacies.

Infrastructure and Supplies

- The number of consultation rooms is generally adequate and Siem Reap HC's have almost all the basic needs (electricity, water, working toilet). Maintenance of HC infrastructure is generally poor. Client privacy is generally a concern.
- 10-25% HC did not have basic supplies and equipment. None had tongue depressors or otoscopes.

IEC materials and usage

- Although IEC materials were present in many HC, they were not appropriately placed to either act as reminders for the provider or as information sources for clients. Often were placed in hallways or used to cover walls. URC team felt that donor organizations have focused too much energy on developing posters and not enough on practical job aids for consultations. There should be emphasis on practical IEC materials and job aids. As these are developed at the HC level, there should be coordination and linkage with materials used at the community level.

Knowledge of Clinical Protocols

- Knowledge of norms is generally quite high, and Siem Reap HC staff scored among the best. Relatively weaker areas of knowledge were assessment of the child with malaria, post-natal care, and home care of the child with pneumonia.

Health Services Processes (mainly from URC)

- The clinical norms for three key child illnesses (ARI, diarrhea, DHF) was not followed in the majority of clinical encounters.
- ANC visits focus very little on the postpartum phase (in particular, the care of the child) or birth spacing.
- Community outreach activity level is quite high, but is also associated with NGO support for such activities. Outreach is limited by lack of personnel to carry it out and lack of transport.
- Health promotion (growth promotion, EPI) knowledge and activity level is relatively low in health facilities, as this is seen as appropriate mainly for outreach activities.

Health Services Outputs / Outcomes (mainly from URC)

- The practice of IMCI is minimal. No one was trained in IMCI in Siem Reap at the time of the HFA. Linking improvements in the health facility objectives of IMCI (clinical training and health system improvements) will be key to project success in the community level aspects of these same areas. As RACHA, URC and others roll out clinical IMCI, coordination will be crucial.
- ANC coverage is quite high. Although this is quite positive, this can also be viewed as a missed opportunity as certain key services that can and/or should be delivered during this contact are not, in fact, delivered. For instance,
    - TT coverage appears to be quite low, even from service statistics. This agrees with the KPC results (59.9% mothers with 0-11 mo. olds with $\geq$ 2TT at last pregnancy). This is not surprising given the number of missed opportunities during ANC documented in the URC observations of clinical practice.
    - There is little or no discussion of post-partum concerns like breastfeeding and neonatal warning signs.

- There are no immediate post-partum visits (i.e., in the 7-10 days following birth when the large majority of severe Maternal and Neonatal problems tend to occur).

- EPI coverage is relatively high for many vaccines individually, but because of inconsistent implementation, full vaccination coverage is not high. Additionally, coverage rates are clearly overestimated by service statistics.
- HC staff report regular outreach visits to each village in their catchment area on a monthly basis. The regular coverage of villages through outreach requires additional examination and depends on the availability of resources for staff to travel (resources often dependent on support from NGOs working in the area). Outreach activities focus largely on preventative care (e.g. immunizations and vitamin A for children, plus IEC/C about seasonal illnesses) with little curative care due to the national guidelines. Appropriately, where there are fewer facilities (Varin), the KPC seemed to confirm that there is greater reliance on outreach activities. Attention needs to be paid to linkage of community activities with health promotion activities at HC level – supervision, follow-up, referral/counter-referral.

Annex 1 - Tabular Summary of URC HFA Data for Siem Reap MPA Health Centers

URC HFA Table	Area of Assessment	% HC in SR to norm	SR Better/ Worse than Avg.	Comments
	INPUTS: GENERAL			
A-1	% MPA HC – **infrastructure** (elec., water, toilet)	88-100%	=	
A-81	% MPA HC – **essential equipment** (scale, stethoscope, fetoscope, thermom., etc.)	63-100%	–	No otoscopes
A-80	% MPA HC – **essential supplies** (injections, solutions, gloves, etc.)	38-100%	=	38% partographs
A-2	% MPA HC – **norms and manuals** (management., ARI, diarrhea, TB)	88-100%	+	
A-5	% MPA HC – **initial training**	63-100%	+	No HIV
A-82	% MPA HC – **IEC materials available for posters** (Imm., Nut., ARI, W/S)	75-100%	+	
A-83	% MPA HC – **IEC materials available for leaflets** (Imm., Nut., ARI, W/S)	13%	=	Imm75% /others13%
A-84	% MPA HC – **IEC materials available for flipcharts** (Imm.,Nut.,ARI, W/S)	13%	=	No Nut., ARI
A-4	MPA HC – **avg. no. staff** providing health services	9.3	–	
	INPUTS: STAFF KNOWLEDGE			
A-7	% MPA HC staff – correct knowledge of **immunization schedule** (all EPI vaccines)	100%	+	
A-8	% MPA HC staff – correct knowledge of **filling immunization card**	100%	+	
A-9	% MPA HC staff – corr. knowl. of how to **identify malnourished child**	13 – 75%	=	Weight/Age 75% MUAC 13%
A-10	% MPA HC staff – corr. knowledge - **providing vitamin A to children**	63 – 75%	+	
A-11	% MPA HC staff – correct knowledge of **assessing child with diarrhea**	38 –100%	+	Lacking in several areas
A-12	% MPA HC staff – correct knowledge of **treating child diarrhea** (without dehydration)	50 –100%	+	Need for F/U weak
A-13	% MPA HC staff - correct knowledge of **assessing a child with ARI**	63 –100%	=	Count RR 100% Resp. distress 63%
A-14	% MPA HC staff – corr. knowledge of **treating child with pneumonia** (simple)	63 –100%	+	Antibiotics 100% Home care/F/U 63%
A-15	% MPA HC staff – corr. knowledge of how to **assess child for malaria**	63 – 88%	=	Generally good
A-16	% MPA HC staff – correct knowledge of **treating child for malaria**	25 – 88%	+	AM3/AM2 88% Quinine 25%
A-17	% MPA HC staff – correct knowledge of **prevent child malaria**	100%	+	
A-32	% MPA HC staff – correct knowledge of **advantages of EBF** (exclusive breast feeding)	38 –100%	=	Prevent diarrhea 38% Prevent illness 100%
A-33	% MPA HC staff – corr. knowl. **advantages of breastfeeding post- del.**	100%	+	
A-34	% MPA HC staff – correct knowledge of **IEC after delivery**	25 – 88%	–	Low – HIV/vit A High – BF, imm., nut
A-105	% MPA HC staff – know **mon. and eval. of comm. outreach activities**	63 – 88%	+	

URC HFA Table	Area of Assessment	% MPA in SR to norm	SR Better/ Worse than Avg.	Comments
	PROCESSES			
A-3	% MPA HC – **annual plan & monthly reports** complete/updated (annual plan, child consults, ANC, EPI, Birth Spacing)	100%	+	
A-63	% MPA HC – **received PAP funding** (Priority Action Pgms.)	100%	+	
A-62	MPA HC – avg. **amount of user fee** generated per mo.	0 – 90 K Riel/mo.	=	No HC recd. > 90K ($25)
A-64	Avg. no. **supervision visits** received from OD in last 6 mo.	8.0	+	Higher than PP (5.8)
A-65	% MPA HC – **received feedback from the OD** during supervision	25%	–	Quite poor. Little prob. solving
A-6	% MPA HC – **received refresher training**	0 – 13%	–	Very poor
A-69	% MPA HC – **available drug stocks**	88 –100%	+	Except Tetracyc. (25%)
A-70	% MPA HC – **stock-out of essential drugs**	25 – 75%	+	
A-73	% MPA HC – **available anti-malaria drugs**	50 – 88%	+	AM2,3,4 = 88% Quinine 50%
A-74	% MPA HC – **stock-outs of anti-malaria drugs**	13 – 50%	+	AM2,3,4 13% Quinine 50%
A-85	% MPA HC – **assets management**	low	–	Maintenance pgm. in place but no $$
A-87	% MPA HC – **infection control**	±	=	Handwash good Disposal poor
A-92	% MPA HC staff – **correctly asks and checks during ANC**	72 –100%	+	72% illness Hx 100% clinical check
A-93	% MPA HC staff – **provides iron, folate, TT and make next appt.**	±	=	**29% TT** 86% Fe/folate
A-94	% MPA HC staff – **provide maternal health IEC during ANC**	±	+	Good:nut,BF,deliv Poor: vit A,HIV
A-95	% MPA HC staff – giving **maternal health education during ANC**	57 – 86%	+	Poor: F/U Good: Anemia, danger, TT
	OUTPUTS			
A-96	Avg. no. **ANC, delivery, and PNC clients** per month	57 ANC visits/mo.	+	Highest volume of all provinces
A-97	% **WRA covered by FP services** by HC per month	19%	+	Mainly OC (11%)
A-99	**Couple Years Protection** (CYP) per WRA per HC	11.7	–	
A-100	Avg. no. **child illness clients** per month	7.3 – 10.8	–	7.3 diarrhea 21.1 ARI
A-101	Avg. no. **micronutrients provided** (Fe, vit. A) per month to children	340.2(vitA) 3,457 (Fe)	=	Svc. stats c/w 25% covg. (vit. A)
A-104	% MPA HC – **community outreach activities** in each village	38 –100%	+	CO more likely if NGO present

Annex 2 - Tabular Results of ICH Confirmatory HFA for Five Health Centers

Inputs – Equipment and Essential Medicines					
	Teuk Vil	**Suay Sor**	**Angkor Chum**	**Char Chhouk**	**Pouk**
Do you have an ice box for vaccines? (permanent freeze, portable ice box, other)	freezer	freezer	freezer	freezer	freezer
Today, do you have polio vaccine in stock?	Y	Y	Y	Y	Y
In the past 6 months how many times have you not had the polio vaccine in stock?	9	3	10	N/A	0
Today, do you have DPT (DTC) vaccine in stock?	Y	Y	Y	Y	Y
In the past 6 months how many times have you not had the DPT (DTC) vaccine in stock?	9	6	27	N/A	0
Today, do you have measles vaccine in stock?	Y	Y	Y	Y	Y
In the past 6 months how many times have you not had the measles vaccine in stock?	7	2	12	N/A	N/A
Where do you get your vaccines? (OD, NGO, Other)	OD	OD	OD	OD	OD
How often do you receive vaccines?	monthly	monthly	monthly	monthly	monthly
Today, do you have Vitamin A in stock?	Y	Y	Y	Y	Y
In the past 6 months how many times have you not had Vitamin A in stock?	N/A	N/A	N/A	N/A	0
Today, do you have Mebendazole in stock?	Y	Y	Y	Y	Y
In the past 6 months how many times have you not had Mebendazole in stock?	N/A	53	N/A	N/A	N/A
Today, do you have ORS in stock?	Y	Y	Y	Y	Y
In the past 6 months how many times have you not had ORS in stock?	330	9	N/A	175	82
Today, do you have mosquito nets in stock?	N	N	N	N	N
In the past 6 months how many times have you not had mosquito nets in stock? Never in stock...99	never	never	never	never	never
Are the mosquito nets treated with insecticide or have a treatment tablet?	N	N	N	N	N
Has this health center ever participated in a mosquito net re/treatment campaign?	N	N	Y	Y	N
When was that campaign?	N/A	N/A	?	2003	N/A
How many mosquito nets were treated during that campaign?	N/A	N/A	?	?	N/A
Who sponsored that campaign?	N/A	N/A	?	WB/ MOH	N/A
Do you have a growth measuring board to measure height for small children?	Y	N	N	Y	Y
Do you have a tape measure to measure height for older children?	N/A	Y	Y	Y	N
Do you have a scale that is working today?	Y	Y	Y	Y	Y

Information, Education and Communication Materials					
	Teuk Vil	**Suay Sor**	**Angkor Chum**	**Char Chhouk**	**Pouk**
Do you have any health promotion posters?	Y	Y	Y	Y	Y
Please show me your health promotion posters. (those in **bold** are present)	**Imm.** **ANC** PNC **Fam Plan** **Nutrition** **ARI** Malaria **Iodine** **ORS** **BF** **TB**	**Imm.** **ANC** PNC **Fam Plan** **Nutrition** **ARI** **Malaria** **Iodine** **ORS** **BF** TB	Imm. **ANC** PNC **Fam Plan** **Nutrition** **ARI** Malaria Iodine **ORS** **BF** TB	**Imm.** **ANC** PNC Fam. Plan **Nutrition** **ARI** **Malaria** **Iodine** **ORS** **BF** **TB** **Vit. A**	**Imm.** ANC PNC Fam. Plan **Nutrition** ARI **Malaria** **Iodine** **ORS** **BF** TB
Do you have any health promotion brochures that you give out to clients?	Y	Y	Y	Y	Y
Please show me your health promotion brochures. (those in **bold** are present)	**Imm.** **ANC** PNC Fam. Plan **Nutrition** **ARI** **Malaria** **Iodine** **ORS** **BF** **TB**	**Imm.** **ANC** PNC **Fam Plan** **Nutrition** **ARI** **Malaria** **Iodine** **ORS** **BF** TB	**Imm.** **ANC** **PNC** Fam. Plan **Nutrition** **ARI** **Malaria** **Iodine** **ORS** **BF** TB	**Imm.** **ANC** PNC Fam Plan **Nutrition** **ARI** **Malaria** **Iodine** **ORS** **BF**	**Imm.** ANC PNC Fam Plan **Nutrition** ARI **Malaria** **Iodine** **ORS** **BF**
Do you have any health promotion flip charts?	Y	Y	N	Y	Y
Please show me your health promotion flip charts. (those in **bold** are present)	Imm. **ANC** PNC Fam. Plan Nutrition ARI Malaria Iodine ORS BF **TB** **STI**	Imm. **ANC** PNC **Fam Plan** Nutrition ARI Malaria Iodine ORS BF TB STI	N/A	**Imm.** **ANC** PNC **Fam Plan** Nutrition ARI Malaria Iodine **ORS** **BF** TB STI	?

Annex 3: Main Diseases Diagnosed and Treated by Health Centers of Siem Reap Province (PLAN 2003)

Main Diseases Diagnosed and Treated by Health Centers - All Patients

	Phlong HC		Peak Sneng HC		Banteay Srey HC		Preas Dak HC		Rum Chek HC		Siem Reap OD	
	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Upper ARI	4.5%	5	-	-	31.4%	1	20.9%	1	4.7%	5	14.6%	1
Lower ARI	20.2%	1	11.3%	2	6.5%	4	11.7%	2	9.7%	1	10.9%	2
Cough > 21 days	-	-	-	-	-	-	-	-	7.3%	2	-	-
Diarrhea with mucus & blood	-	-	5.7%	4	8.7%	3	2.9%	5	6.7%	3	9.6%	3
Simple Diarrhea	6.2%	3	4.8%	5	-	-	-	-	-	-	-	-
Malaria	10.4%	2	13.2%	1	11.0%	2	5.6%	3	5.6%	4	6.4%	4
Injury	-	-	8.8%	3	5.0%	5	3.7%	4	-	-	-	-
Vaginal Discharge	4.9%	4	-	-	-	-	-	-	-	-	5.3%	5
Total number of patients	5,520		4,665		6,912		4,864		5,674		153,334	

Main Diseases Diagnosed and Treated by Health Centers - Children 0-4 years

	Phlong HC		Peak Sneng HC		Banteay Srey HC		Preas Dak HC		Rum Chek HC		Siem Reap OD	
	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Upper ARI	4.2%	4	4.6%	4	42.4%	1	30.3%	1	3.1%	4	19.0%	2
Lower ARI	38.0%	1	32.1%	1	14.8%	3	23.4%	2	25.9%	1	26.0%	1
Diarrhea with mucus & blood	4.6%	3	5.3%	3	17.4%	2	12.7%	3	8.3%	2	13.1%	3
Simple Diarrhea	17.6%	2	9.3%	2	8.5%	4	4.6%	4	6.8%	3	7.3%	4
Malaria	0.9%	5	-	-	-	-	-	-	-	-	-	-
Skin Infection	0.0%	-	3.8%	5	-	-	2.8%	5	-	-	5.4%	5
Injury	-	-	-	-	3.7%	5	-	-	-	-	-	-
Eye Infection	-	-	-	-	-	-	-	-	2.6%	5	-	-
Total number of patients	802		1,065		1,095		1,220		1,672		23,308	

Main Diseases Diagnosed and Treated by Health Centers - Children 5-14 years

	Phlong HC		Peak Sneng HC		Banteay Srey HC		Preas Dak HC		Rum Chek HC		Siem Reap OD	
	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Upper ARI	4.3%	4	4.7%	5	42.0%	1	29.9%	1	4.7%	3	17.7%	1
Lower ARI	31.6%	1	10.7%	3	5.2%	4	7.7%	2	9.8%	1	12.9%	2
Diarrhea with mucus & blood	-	-	-	-	6.4%	3	5.7%	3	5.5%	2	8.4%	4
Simple Diarrhea	5.4%	3	6.2%	4	-	-	-	-	4.6%	4	-	-
Malaria	12.7%	2	14.0%	1	12.3%	2	-	-	4.0%	5	8.8%	3
Skin Infection	3.6%	5	11.2%	2	-	-	5.2%	4	-	-	-	-
Injury	-	-	-	-	4.7%	5	3.3%	5	-	-	5.2%	5
Total number of patients	576		731		934		853		1,138		20,707	

Annex Q

Summary Proceedings
Detailed Implementation Planning Workshop, Phase I: Phnom Penh Stakeholders
29 April 2005, MEDiCAM Meeting Room

In attendance:

Name	Title, Affiliation
Cambodian Government	
1. Professor Dr. Koum Kanal	Director, National Maternal and Child Health Center/MoH
2. Dr. Chhorn Veasna	National ARI/CDD/Cholera Control Program, Vice Chair of IMCI Working Group, MoH
3. Dr. Svay Sarath	Deputy Director, National Immunization Program, MoH
4. Chhim Knin Dareth	Deputy Director, Ministry of Rural Development
5. Mak Sam Oeun	Director, Angkor Chum Operational District
Multi-lateral	
6. Dr. Chhin Lan	Project Officer Nutrition, UNICEF
7. Dr. Severin von Xylander	Child and Adolescent Health and Development Officer, WHO
Bi-lateral	
8. Dr. Chantha Chak	Family Health Team Leader, USAID
9. Dr. Hen Sokun Charya	Development Assistance Specialist for MCH/RH, USAID
NGO/PVO	
10. Leonard Uisetiawan	Provincial Program Advisor, ADRA
11. Ingebord Roorda	MCH Technical Advisor, CARE
12. Dr. Sin Somuny	Executive Director, MEDiCAM
13. Dr. Hun Ratana	Advocacy Coordinator, MEDiCAM
14. Julie Foster	Country Health Advisor, PLAN
15. Chann Borima	Marketing and Communications Manager, PSI
16. Dr. Chan Ketsana	Child Health / M&E Team Leader, RACHA
17. Thach Lykhann	Siem Reap Provincial Director, RACHA
18. Peng Vanny	Technical Advisor, Planning, Monitoring and Supervision, URC
19. Pann San	Programme Support Officer, VSO
20. Andrew Butler	Programme Capacity Builder, VSO
Red Cross	
21. Scott Tindsimmoul	Head of Delegation, International Federation of Red Cross and Red Crescent Societies
22. Soong Choi	Head of Delegation, Korean Red Cross
23. Jytte Roswall	Country Director, Danish Red Cross
Cambodian Red Cross	
24. Professor Dr. My Samedy	Secretary General, CRC
25. Dr. Nguon Sakhon	Second Deputy Secretary General, CRC
26. Hum Sophon	Director, Program Department, CRC

27. Mak Thang	Human Resource and Volunteer Manager, CRC
28. Dr. Kem Darasophea	Head, Health Program Sub-Dept., CRC
29. Dr. Narin Piseth	Primary Health Care Programme Officer, CRC
30. Hang Chan Sana	Integrated Child Health Project Liaison, CRC
31. Chhun Vanary	Executive Secretary, CRC
32. Sum San Am	Siem Reap Branch Director, CRC
33. Liv Lorn	Siem Reap Branch Project Officer, CRC
American Red Cross	
34. Nicholas Edwards	Head of Delegation, AmCross-Cambodia
35. Robert Kolesar	Integrated Child Health Project Officer, AmCross-Cambodia
36. Dr. Alice Willard	M&E Technical Advisor, AmCross-Washington D.C.
37. Ven Sarith	Integrated Child Health Project Manager, AmCross
38. Sean Nhoung	Finance Manager, AmCross
39. Chhour Navy	Deputy Finance Manager, AmCross
40. Chum Sophal	Administrative Manager, AmCross
Press Corps	
41. Peng Sih	Reporter, TV Bayon

Summary proceedings:

Mr. Nick Edwards, Head of Delegation of the American Red Cross in Cambodia, gave the introduction and welcoming remarks. He discussed the long history between AmCross and CRC as well as the combined experience of both organizations in community-based child health programming. Mr. Edwards also expressed AmCross' commitment to support related national strategies by working within national policies, guidance and best practices.

Professor Koum Kanal, Director of the National MCH Center and Chair of CS Working Group/Cambodia presented an overview of the child health situation in Cambodia in relation to the Millennium Development Goals, the Cambodia "score-card" and recommended interventions including interventions related to the health system, maternal and child health and infectious disease.

Professor Dr. My Samedy, Secretary General of the Cambodian Red Cross discussed challenges faced by midwives and other health center staff, emphasizing the need to follow the path outlined by Professor Koum Kanal. He also highlighted the commitment of the CRC to expand the Integrated Child Health Project in Angkor Chum OD to a national level through the CRC's national branch, membership and volunteer network.

Rob Kolesar, Integrated Child Health Program Officer of the American Red Cross, reviewed the agenda and workshop objectives. The workshop objective were to (1) sharing the baseline findings and (2) soliciting feedback on project options in support of the detailed implementation planning process.

Three presentations followed to provide essential background/contextual information in relation to health in Siem Reap Province and Angkor Chum OD, conclusions from the Child Survival Partnership workshop in December, 2004 and a progress report on the detailed implementation planning process.

Dr. Mak Sam Oeurn, Director, Angkor Chum OD described the current health service delivery situation in Siem Reap Province and Angkor Chum Operational District. His presentation included information on health coverage, staff distribution, health partners, selected health outputs and the results of a SWOT analysis which identified low use of public health services, poverty and illiteracy as weaknesses/threats to health service delivery in the province.

Dr. Sin Somuny, Executive Director of MEDiCAM presented a summary of the proceedings from December, 2004 CS Partnership Workshop. He highlighted key lessons learnt, participant consensus on public-private mix, M&E framework and improving the health systems as well as roles, responsibilities and coordination. Dr. Somuny summarized key messages from the MoH, NGO representatives, UNICEF, ECHO, WHO and USAID.

Mr. Hang Chan Sana, Child Survival Project Liaison Officer of CRC introduced the project goal and components, provided a progress report on detailed implementation planning and reviewed the C-IMCI framework.

Mr. Sana stated that the project goal is to reduce child morbidity and mortality in a sustainable fashion. This will be achieved through the project's four components: (1) nutrition and breastfeeding, (2) immunization, (3) community management of the sick child, and (4) local capacity building. The core CS interventions in Cambodia and their corresponding "score-card" indicators were related to each of the project's components.

In relation to the DIP process, Mr. Sana reviewed the various activities over the past two months that have served as inputs for the detailed implementation planning including: stakeholder meetings, the baseline survey, feedback sessions, the market study, health center visits, focus group discussions and the DIP workshops.

In relation to C-IMCI, Mr. Sana explained the three elements of C-IMCI:

1. improving partnerships between facilities or services and the communities they serve;
2. increasing appropriate and accessible care and information from community based providers; and,
3. integrated promotion of key family practices critical for child health and nutrition.

These three elements build on the multi-sectoral platform for sustainable child health and nutrition including water and sanitation, education and livelihoods.

Dr. Alice Willard, Senior M&E Technical Advisor of the American Red Cross presented the summary baseline findings including the KPC and qualitative research. She described methods, questionnaires, sample design, training, data collection and summary results which are detailed in the draft KPC survey report. The draft KPC report was included as a handout for all workshop participants.

During discussion, there were suggestions to consult with PFD and ADRA to build on successes with positive deviance (including 'model villages' and 'model caregivers' and a modified hearth model. It was noted that the standard hearth has not worked so well in Cambodia.

In the afternoon, Mr. Ven Sarith, Child Survival Project Officer of the American Red Cross reviewed the project's components and outlined general strategies for each technical intervention. The general strategies included increasing health education through families, schools, wats and community activities, behavior change communication, community-based surveillance systems, community mobilization, improve access and availability of ORS and zinc through coordination with RACHA and PSI as well as social marketing of ITNs and mosquito net treatment and retreatment campaigns.

Complementary programming from the multi-sectoral platform (including sanitation and food security) were mentioned as needing additional discussion to identify partners and/or additional resources.

Dr. Alice Willard organized breakout groups to perform SWOT analysis on the presented project options for three of the project components. Following group work, each group presented its analysis and/or recommendations. Small group presentations are annexed to these minutes.

Presentations were followed by a discussion on volunteer incentives. Professor Koum Kanal noted that the MoH policy is that volunteers are not paid. There was a suggestion to look for sustainable mechanisms to fund volunteer incentives. Health center service fees were cited as being one possible source. It was also noted that non-monetary incentives can be highly effective such as recognition of volunteers and provision of free health services at the health center.

A summary of the day's proceedings were reviewed by Rob Kolesar.

Closing remarks were provided by Dr. Nguon Sakhon, Second Deputy Secretary General, CRC.

May 7, 2005
rjk

Annex 1. Component 1: Breastfeeding and Nutrition Breakout Group Report

Strengths and Opportunities

IYCF Working Group Creative Brief just developed (key messages: exclusive BF as a priority, reduce distance between mother and child for continued breastfeeding throughout the day and express breast milk.

Post-partum visits to discourage water giving

Organize CM activities World Breastfeeding Week, health fairs, award ceremonies, high level visits

Identify and recognize "model mothers" whom have exclusively breastfed for 6 months:

- -public announcements
- -community bulletin board
- -Pagodas/wat grannies

"Model mothers" to give testimonials

Community opinion leaders including TBA, grand mothers, village chiefs and fathers are all resource people and can facilitate behavior change for improved practices

Promote safe and locally available foods for children 6 months of age for timely and appropriate weaning practices

High prevalence of iodized salt, no promotion or social marketing necessary at this time

Use baseline survey results to demonstrate MoH policy impact, creating momentum for additional health policies

Barriers and Weaknesses

Message consistency: advocacy and education to HC staff and private providers to discourage water giving (mixed messages cause confusion among mothers).

Lack of model in Cambodia to overcome work/employment outside the home as a barrier to exclusive BF

TV use is low in rural areas

TV spots not on all channels

Resistance to exclusive BF from health professionals (advise to give water)

Difficult for working women to exclusively breastfeed

Artificial milk is being promoted

Annex 2. Component 2: Immunization and Vitamin A Breakout Group Report

Strengths and Opportunities

Existing HC staff and VHSGs in place
NGO support
Trained staff
Existing and strong relationship between CRC and MoH
Community Social Mobilization-HC has clearly defined role and plan through network of VHSGs

Weaknesses and Threats

Community busy with other activities/life
Lack of IEC material and media
Irregular outreach to villages
Inaccessibility of many villages (especially during rainy season)
Displacement of people to new areas
Limited knowledge of VHSG on case definition of many diseases (Community based Surveillance systems)
Lack of clarity on reporting systems
No incentive support (MoH policy)
VHSG not well trained on data management
Moving of VHSG (attrition)

Annex 3. Component 3: Community Management of the Sick Child

Strengths and Opportunities

Many IEC materials available
Many lessons learned and qualitative research from partners
Village health volunteers work well in Cambodia
Partnerships already exist
Health staff are knowledgeable
Edu-tainment successful (mobile video units, community theater, etc.)
Media is supportive (TV and radio)
Use positive role models
Village takes ownership of health issues if involved/engaged in CBSS
Important to begin project with well developed CBSS

Weaknesses and Threats

Limited knowledge among existing village health volunteers
No incentives for volunteers (MoH policy)
Lack of relevant peer education curriculum/model
Geographic barrier
Service providers need to improve quality
Lack of knowledge about barriers to behavior change (need for more qualitative research)
No clear MoH policy on CBSS
High rate of illiteracy
Resource intensive, potentially distractive
Quality of information may be limited

Annex R

Summary proceedings of the Detailed Implementation Planning Workshop: Phase II Siem Reap Stakeholders, May 10-12, 2005

In attendance:

Name	Title, Affiliation
Cambodian Government	
1. Chan Sophal	Siem Reap, Deputy Governor
2. Dr. Dy Bun Chhem	Director of Provincial Health Department Siem Reap
3. Mak Sam Oeun	Director, Angkor Chum Operational District
4. Rath Chum	AD Governor, Angkor Chum District
5. Tah Chan Kiri	AD Governor, Pourk District
6. Em Vath	AD Governor, Varin District
Bi-lateral	
7. Dr. Chantha Chak	Family Health Team Leader, USAID
NGO/PVO	
8. Thorng Sikeak	Program Manager, PSI
9. Bernadette Gliss	Community Health and Community development Program Coordinator/Siem Reap, CARITAS Cambodia
10. Julie Foster	Country Health Advisor, PLAN
11. Ir Por	Provincial Health Officer BTC
12. Sun Nasy	Deputy Executive Director, RACHA
13.Ung Kim Sour	Home Care Coordinator, Buddhists for Development
14. Pann San	Programme Support Officer, VSO
15. Andrew Butler	Programme Capacity Builder, VSO
16. Peou Hun	Project Coordinator, URC
17. Touch Narong	Project Coordinator, CARITAS Cambodia
Cambodian Red Cross	
18. Professor Dr. My Samedy	Secretary General, CRC
19. Dr. Nguon Sakhon	Second Deputy Secretary General, CRC
20. Hum Sophon	Director, Program Department, CRC
21. Dr. Kem Darasophea	Head, Health Program Sub-Dept., CRC
22. Chroeung Darin	Primary Health Care Project Manager, CRC
23. Hang Chan Sana	Integrated Child Health Project Liaison, CRC
24. Chhun Vanary	Executive Secretary, CRC
25. Sum San An	Siem Reap Branch Director, CRC
26. Liv Lorn	Siem Reap Branch Project Officer, CRC
27. Chan Cham Roeun	Pourk District, Vice-Director of Pourk CRC Branch
28. Chea Ven	CRC Volunteer, Pourk District
29. Dek Sum	CRC Volunteer, Pourk District
30. Chhoarm Sam	CRC Volunteer, Pourk District
American Red Cross	
31. Nicholas Edwards	Head of Delegation, AmCross-Cambodia
32. Robert Kolesar	Integrated Child Health Project Officer, AmCross-

	Cambodia
33. Dr. Alice Willard	M&E Advisor, AmCross-Washington D.C.
34. Ven Sarith	Integrated Child Health Project Manager, AmCross
35. Chum Sophal	Administrative Manager, AmCross
Community Leaders	
36. Sith Hart	Angkor Chum District
37. Peng Thang Dy	Angkor Chum District
38. Sun Dara	Angkor Chum District
39. Pring Teng	Angkor Chum District
40. Seng Khai	Angkor Chum District
41. Leav Vina	Varin District
42. Ven Sorn	Varin District
43. Rim Chan Seng	Varin District
44. Ty Tha	Varin District
45. Norm Phath	Varin District
46. Min Hao	Nun, Pourk District
47. Chea Phoeuy	Community member, Pourk District
48. Moeun Chhourt	Community member, Pourk District
49. Rush Sovannarith	Vice-Director of Pourk College, Pourk District
50. Seang Son	Community member, Pourk District
51. Rath Bun Han	Community member, Pourk District
52. Chhea Kim Chhat	Midwife, Pourk District
53. Chan Sinoun	Midwife, Pourk District
54. Sourm Sereiy Rithy	Monk, Pouk District
Press Corps	
55. Peng Sin	Reporter, TV Bayon

Day 1: May 10, 2005

Dr. Kem Darasophea, Head of Health Sub-Department of CRC and workshop Master of Ceremony, reviewed the **workshop objective to finalize the design of the ICH project by engaging stakeholders and implementing partners**.

Mr. Nicholas Edwards, Head of Delegation in Cambodia, American Red Cross, highlighted the 10 year collaborative history between CRC and ARC. He asked for collaboration from all workshop participants to help in the design and implementation of the project.

Mr. Chan Sophal, Siem Reap Deputy Provincial Governor, welcomed the project and the appreciation for selection of Angkor Chum OD for inclusion in this project which will permit a broader public health intervention through coordination with other initiatives implemented by the MoH with support for from other collaborating organizations and donors. Mr. Sophal noted the common aim of all workshop participants to improve child health to reduce infant and child morbidity and mortality.

Professor Dr. My Samedy, Secretary General Cambodian Red Cross, emphasized the need to address the urgent child health problems documented in the recent survey completed by ARC/CRC with support from the PHD and OD. He called for local leaders, including Buddhist monks and nuns, government authorities, village chiefs and commune leaders to take action to promote improved breastfeeding practices, vitamin A supplementation, malaria prevention, prompt referral for deadly illnesses, and vaccination. He concluded by stating that the Integrated Child Health project will serve as a pilot for expansion to other CRC branches throughout Cambodia.

Mr. Hang Chan Sana, Child Survival Project Liaison Officer of CRC facilitated participant introductions. This was followed by reviewing the **project goal and components, summary results from the baseline survey and described the detailed implementation planning process**.

Mr. Sana stated that the project goal is to reduce child morbidity and mortality in a sustainable fashion. This will be achieved through the project's four components: (1) nutrition and breastfeeding, (2) immunization, (3) community management of the sick child, and (4) local capacity building.

In relation to the DIP process, Mr. Sana reviewed the numerous activities undertaken over the last two months that have served as inputs for the detailed implementation planning including: stakeholder meetings, the baseline survey, feedback sessions, the market study, health center visits, focus group discussions and the DIP workshops.

Mr. Sana also summarized the baseline findings. The baseline executive summary was distributed to all project participants.

Dr. Dy Bun Chan, Director of Provincial Health Department, described the **current health service delivery situation in Siem Reap Province and Angkor Chum Operational District**. His presentation included information on health and staff coverage, and partners. He stated that the PHD identified low use of public health services, poverty and illiteracy as weaknesses/threats to health service delivery in the province. He also emphasized the importance of community involvement in health service delivery.

Mr. Hang Chan Sana, CRC Child Survival Project Liaison Officer, led workshop participants in a **visioning exercise to initiate sustainability planning.** Mr. Sana described the general purpose of the visioning exercise which is to define what participants expect to achieve and what changes they hope to see over the project life. Mr. Sana organized five small groups to discuss and prepare feedback in relation to the above questions. The results of the visioning exercise are included as Annex A to this report.

Following lunch, Dr. Kem Darasophea, CRCHead of Health Sub-Department led participants in a **community mapping exercise to identify human resources and relationships in the community.**

Dr. Darasophea asked participants about existing human resources and relationships among the different decision makers and opinion leaders relating to child health at the community-level. Five groups were formed to draw a map representing human resources and relationships in their community.

Mr. Sum Sun An, CRC Siem Reap Branch Director, provided an overview of the CRC and its work in Siem Reap Province, highlighting that CRC is committed to improving the health of Cambodians. CRC manages programming in primary health care, HIV/AIDS, community-based first aid as well as disaster preventions and response.

Day 2: May 11, 2005

Dr. Darasophea reviewed the workshop objective, provided a summary of the May 10 proceedings, and reviewed the day's agenda.

Mr. Sana reviewed project strategies and proposed activities. He presented a matrix which summarized the project's overall strategies: (1) education and behavior change, (2) coordination, and (3) community follow-up/surveillance. The matrix is included as Annex B to this report. The matrix of proposed activities was taken from activity suggestions received during feedback sessions, focus group discussions and Phnom Penh stakeholders. Proposed activities were organized by project component, strategy and implementation level (village, pagoda, school and HC). Mr. Sana instructed workshop participants to review the proposed activities and add new activities to the matrix in three small working groups (one for each administrative district).

Each group discussed the strategy/activity matrix and reported out on recommendations for each activity. Each report was prepared on flip chart paper and included: (1) recommendation or not for each activity, (2) recommendation of additional activities, (3) feasibility of recommended activities during the rainy season, and (4) responsible parties for each activity. Small group reports were the foundation for the work plan development on May 12. Group work continued for the entire day. The results of this exercise formed the basis of the consolidated ICH work plan included as part of the Detailed Implementation Plan (DIP).

Day 3: May 12, 2005

Dr. Darasophea reviewed the workshop objective, provided a summary of the May 11 proceedings, and reviewed the day's agenda.

Dr. Sun Nasy, RACHA Deputy Director, presented an overview of its work in Cambodia. Activities include safe motherhood, capacity building to midwives, provision of ANC and post-natal care to women, improved awareness thru TBAs and VHSGs, monks and nuns to provide peer education at the village level, post-abortion/miscarriage care sensitization to TBAs and midwives including clinic training of HC staff in complicated

delivery. Birth spacing (condoms and pills) services promotion in compliance with national policies.

Dr. Nasy also described the RACHA shopkeeper program which includes support/training for medicines, iodized salt, ORS, and condoms and pills to shopkeepers for retail sale to the villages. Also, RACHA Vitamin A and de-worming medicine through community outreach programs. RACHA coordinates with national TB control program for community level TB and malaria (primarily through detection and treatment kits in coordination with PSI.

RACHA also supports HIV/AIDS and STI prevention, volunteer testing and counseling (Pourk), vertical transmission program including provision of navaripine to HIV positive pregnant women in addition to support to HCs for management of STI symptoms.

In the area of capacity building and quality improvement, RACHA uses the client orientated and efficiency/ quality improvement method, strengthening HMIS and promotion of accountability of data collection in addition to use of data for decision making.

In relation to BCC, RACHA supports outreach activities through agreements with the OD and HCs for motorcycles to support outreach activities. RACHA's micro-finance program works in cooperation with micro-credit groups with interest collected going to support RACHA's health programming including a loan program to health staff. RACHA establishes agreements between HC and communities with the aim of promoting awareness at the community level in relation to health services. RACHA cooperates and coordinates with PHD as demonstrated by their shared office with MCH office at PHD. RACHA also supports drugs management and provision of equipment to ODs.

Angkor Chum OD Director, Dr. Mak Sam Oeun, presented the *draft* 2006 OD Operational Plan. He expressed the need to integrate the ICH project work plan into the draft OD operational plan citing that the ICH work plan will support the broader OD objectives and work plan.

Dr. Oeun cited that the first goal of the work plan is related to health service delivery; specifically, the OD will put 2 more HCs into operation. Specific objectives were highlighted as follows:

- strengthen HC delivery at the HC level to improve MPA health services;
- increase distribution of vitamin A and de-worming medicine for children U5 thru primary school on a bi-annual basis;
- exclusive BF and food supplementation to post-natal mothers
- thru RC, distribute ORS thru village volunteers;
- Increase U1 immunization;
- reduce infectious diseases include dengue, leprosy and malaria (including increasing ITN coverage).

Dr. Oeun cited the need to think about CRC volunteers and VHSG expanding their roles to reduce the burden on HC staff to mitigate the issue of understaffing.

Dr. Oeun also discussed the need for administrative and logistics support to HCs, plans for a survey to investigate the illegal sale of anti-biotics in Angkor Chum OD through grocers and shopkeepers as well as the recruitment of midwife training from Varin will provide support staff at the HC level. BTC will sponsor this training planned for Battambang. Also noted was that health financing, strengthen financial management, activities are severely under-funded in addition to the need for institutional development, maintenance and repair OD and HC equipment.

Dr. Nguon Sakhon, CRC Second Deputy Secretary General, delivered a presentation on CRC volunteer recruitment, motivation and structure options. He explained that the CRC volunteer policy is currently under revision. Dr. Sakhon stated that incentives (not payment) are important to motivate volunteers, especially performance based incentives that facilitate the completion of volunteer work (bicycles, boots, etc.).

Dr. Sakhon described the Red Cross organizational structure including the HQ, branch and sub-branch level. Development Officials are responsible for programming at the branch level. At the sub-branch level that are on permanent duty that supervise community level volunteers.

In relation to volunteer structure options, three volunteer structure models were presented: (1) a model with a volunteer to household ratio of 1:80 based on CRC's Primary Health Care project; (2) a model with a volunteer to household ratio of 1:50 that was proposed in the original project design; and, (3) a model with a volunteer to household ratio of 1:4 based on the World Relief Child Survival in Cambodia. Advantages and disadvantages of the three models were discussed in plenary.

Gender

Rob Kolesar, ICH Program Officer, initiated a discussion on gender issues and the role of women in the project, noting that most people in leadership positions in Cambodia are men. Comments included were: women are needed to promote BF; women are important and have the most influence over the health of the children; men are also responsible for looking after children's health; women should not have all the burden of caring for the children; children are the shared responsibility of both men and women. However, it was also noted that most responsibility for child health falls upon the women; men need to get more involved in women's health for pregnant women; and, the need to talk about gender. Additionally, it was said that: men need to provide opportunity to women at local and commune levels; any times women are reluctant to take leadership roles; there is a need to ensure that women play a greater role at every level. Barriers include habit, social norms, capacity, etc. It was suggested that 60 percent of project staff be women.

Closing remarks

Nicholas Edwards, ARC Head of Delegation, highlighted the **workshop objective to finalize the design of the ICH project by engaging stakeholders and implementing partners.** He summarized the process that has lead to the achievement of this objective over the past three days, including the visioning and mapping exercises, review and comment on proposed objectives, development of AD level work plans, review and discussion of three volunteer structure options, as well as discussion on gender issues and involvement of women in the implementation of this project. He concluded by noting that input from the workshop participants has been recorded and will be integrated into the overall project design.

Vice-governor of Siem Reap Province expressed appreciation for the planned implementation of the ICH project in Angkor Chum OD building on the CRC's historic support to the PHD to forward maternal and child health in Siem Reap and poverty reduction for the Cambodian people.

Dr. Shakon, CRC Vice Deputy Director, thanked the workshop participants. He noted the excellent participation from the workshop participants and the importance of their continued involvement throughout implementation. Emphasizing the importance of all stakeholders working together to improve health at the village level and highlighting the role of the CRC as an auxiliary to the Cambodian Government.

Annex S: Market Survey for Health Products (Iodized Salt, ORS, Bednets)

INTRODUCTION

The Siem Reap Integrated Child Health Project (ICH) has prioritized increasing access to healthy products through the private market. Private market mechanisms can be utilized through social marketing and/or educational interventions with market sellers. The intervention areas that ICH will focus on are nutrition, immunization, pneumonia, malaria, and diarrhea. There are three critical products that ICH has targeted for increased utilization:

- Iodized Salt
- Oral Rehydration Salts (ORS)
- Bednets (in particular, Insecticide Treated Nets (ITNs))

This market survey was not meant to be an exhaustive or definitive examination of the market in Siem Reap for these products, but rather a "quick and dirty" assessment that could confirm or cause the project staff to modify its activities with respect to these critical products that could have an impact on health and nutrition of under fives in the project area. This report describes the methods, survey instruments and tabulated results, summary of the results by product, followed by a brief discussion.

The project manager reviewed literature and available reports in Cambodia on these products, especially iodized salt. Previous ARC personnel had gathered information on iodized salt for a concept paper written in 2003, showing a very low consumption of iodized salt in all but border areas of Cambodia, making it highly likely that the only iodized salt available was from bordering countries.

METHODS

Three modules were developed – one for each of the products in question (iodized salt, ORS, and bednets). Other agencies and PVOs were consulted in the construction of the instruments. In particular, the instruments were based on instruments developed by Population Services International (PSI) and used in several other countries. The survey instruments have been included after a discussion of the findings. Two surveyors from the Cambodian Red Cross were trained in the use of the instruments. In April 2005, a convenience sample was chosen by simply going to the market area of various towns and villages in the project area. In order to get a more or less representative sampling of the vendors in the project area, vendors of varying sales volumes and in various parts of the project area were surveyed. The interviewers applied one module for each product sold among each vendor surveyed. Ten vendors were surveyed. The results were tabulated by hand. This report was prepared by the senior health technical advisor in Washington D.C.

SURVEY INSTRUMENTS AND TABULATED RESPONSES

Module 1: Iodized salt

Question	Responses	No.	%
Type of retail outlet	Large community-based vendor (over 40 products) Medium community-based vendor (10-40 products) Small community-based vendor (<10 products) Open market Other	3 6 0 0 0	33% 67%
Do you know what causes goiter?	Iodine deficiency Other Don't know/blank	3 1 5	33% 11% 56%
How many kinds of salt do you sell?	None 1 2 3	2 3 2 2	22% 33% 22% 22%
May I see each kind of salt you sell?	Yes No	7 1	88% 12%
How is this salt stored in the outlet?	Bulk Individually	5 5	50% 50%
The packaging is…	Unlined woven material Lined, impervious material Other	2 11 0	15% 85% 0%
Package indicates iodization, meets national standards or minimum standards for iodine fortification?	Yes No	5 5	50% 50%
How long has this salt been kept at your outlet?		Range: 2-120 days	
How much does one unit cost?		Range: 300 – 1,000 Riels ($0.08 - $0.25)	
Where is this salt produced?	Imported Locally produced Don't know	0 7 6	0% 54% 46%
Estimated quantity of salt sold per month in Cambodian Riel?		Range: 8,000 to 300,000 ($2 - $77)	
In the past 6 months, how many times have you had a stock out?		1 9	10% 90%
Estimated amount of salt sold in a month?	Quantity (kg)	Range: 10–60kg	
Do customers have a preference for their salt purchasing?	Yes No	9 3	75% 25%
If yes, which salt is preferred and why?		- Preferred salt - TV promotion - Powdered salt	
Do you recommend this salt?	Yes No	3 9	25% 75%
If yes, why do you recommend it?		No responses	
Iodine content of salt sample in ppm	0 25 50 75 100	1 2 4 1 5	8% 15% 31% 8% 38%

Module 2: Oral Rehydration Salts (ORS)

Question	Response	No.	%
Type of retail outlet	Large community-based vendor (over 40 products) Medium community-based vendor (10-40 products) Small community-based vendor (<10 products) Open market Other – Pharmacy	3 6 0 0 1	30% 60% 10%
Do you sell diarrhea management products?	Yes No	6 4	50% 40%
What kind of diarrhea management/treatment do you sell?	ORS Imodium Other (3 are "pills")	4 1 7	40% 10% 70%
How many kinds of ORS do you sell?	None 1 2	6 2 2	60% 20% 20%
May I see each kind of ORS you sell?	Yes No	2 2	50% 50%
Estimated number of sachets/packets sold in one month?		1 packet 300-500 packets	
How much does one sachet/packet cost?		100 – 500 Riels $0.03 - $0.14	
In the past 6 months, how many times have you had a stock out?		0 – 2 times	
Do you sell Imodium?	Yes No Blank	1 2 7	10% 20% 70%
How much one Imodium treatment cost?		80 ($0.02) Riels/tablet	
Estimated number of Imodium treatments sold in one month?		600 – 1,000 tablets	
Do you sell any other diarrhea treatment?	Yes No Blank	6 2 2	60% 20% 20%
What kind?	Patardium Tetracycline Loperamide	4 4 2	67% 67% 33%
How much does one treatment cost?		100 – 400 Riels $0.02 – $0.09	
Estimated number of treatments sold in one month?		10 – 1,000 tablets	
What diarrhea management product do you recommend to your customers?	Patardium Tetracycline ORS	4 3 1	67% 50% 17%
Why do you recommend that product?		-For rehydration -Patardium recommended by doctor -recommendation from market seller/suppliers	
What are customers concerned about when they buy diarrhea management/treatment products?		-Access - recommendations from shop owners	

Module 3: Bednets

Type of retail outlet	Large community-based vendor (over 40 products) Medium community-based vendor (10-40 products) Small community-based vendor (<10 products) Open market Blank	3 4 1 0 2	30% 40% 10% 0% 20%
What is malaria?	Disease caused by mosquitoes Cold/fever/shivering Don't know/blank	2 4 4	20% 40% 40%
How do you prevent malaria?	Use a mosquito net Clear brush from compound Blank	6 2 4	60% 20% 40%
What products do you sell to prevent malaria?	Mosquito net Other (mosquito coil) Blank	2 2 6	20% 20% 60%
How many types of mosquito nets do you sell?	1 2	1 1	50% 50%
May I see one of each type of mosquito net you sell?	Yes No	0 2	 100%
How many of each type of net do you sell in one month during the dry season?		5/month and 0-10/month	
How many of each types of net do you sell during the rainy season?		6-7/month and 0-10/month	
How much does each type of mosquito net cost?		6,000–15,000 Riel $1.53 - $3.84	
In the past 6 months, how many times have you had a stock out?		0 – 2 times	
Which of these nets are pre-treated with insecticide?		0	
Which of these nets comes with an insecticide treatment tablet?		The merchant who sold one type of nets had nets with tablets	
Which mosquito net do you recommend to your customers?		Merchant who sold one type recommended the only type he sold.	
Why do you recommend that product?		- For forestry - Useful for lots of people	
What are customers concerned about when they buy a mosquito net?		Ease of use	
Do you sell mosquito net retreatment kits (KO tabs, K-Otrine)?		All blank	
How much do they cost?		N/A	
How many do you usually sell in one month during the dry season?		N/A	
How many do you usually sell in one month during the rainy season?		N/A	

RESULTS

Although small retail vendors (less than 10 products) are omnipresent, their product range is mostly limited to prepackaged crackers and snacks, vegetables, and cigarettes. Therefore, the vendors surveyed were a sampling of large and medium sized businesses where most people do their purchasing.

Iodized salt

- Iodized salt is *widely available*
  - 8/10 (80%) of salt vendors had iodized salt available.
  - Retail outlets carried 1-3 kinds of salt
  - 9/10 (90%) of vendors have not run out of salt in the last six months
  - Cost is not likely to be prohibitive for most beneficiaries in the project area. One unit of salt costs 300 to 1,000 Riels ($0.08 - $0.25).
  - Over half of all iodized salt available among these vendors was reported to be produced locally. This is a dramatic change from only 3-5 years ago when almost no iodized salt was available and what was available was not produced locally.

- The *quality* of the iodized salt is generally sufficient to prevent IDD:
  - 11/13 (85%) of salt among vendors surveyed was in a container likely to preserve iodine content (a lined, impervious material).
  - Salt was reported to be kept at retail outlets from 2 days to 4 months.
  - Half of all salt packages indicated iodization, meeting national standards or minimum standards for iodine fortification.
  - 12/13 (92%) of salt samples tested had an iodine content of at least 25%, and 5/13 (38%) had a content of at least 100 PPM.

- Customer *utilization and preference*:
  - An estimated amount of 10 – 60 kg of salt was sold each month by the surveyed vendors
  - Customers (75%) generally have a preference for their salt purchasing.
  - Retail outlets do not generally recommend a certain type of salt. There seems to be a preference based on advertising and for finer grained salt.

- *Knowledge of IDD is poor:* Only one-third of vendors identified iodine deficiency as the cause of goiter. However, they did identify iodized salt as a preferred product.

Oral Rehydration Salts (ORS)

- Diarrhea products are easily available but are generally not appropriate
  - 6/10 (50%) of vendors surveyed sold diarrhea management products.
  - 4/10 (40%) reported selling ORS, and two of these had two types available. One of the vendors had a very low volume of ORS sales (1 sachet per month).
  - Non-ORS products are more available – partardium, tetracycline, and Imodium.
  - None of the vendors surveyed had zinc available.

- Vendors are much more likely to recommend non-ORS treatments for diarrhea – 7/7 (100%) report recommending non-ORS treatments versus 1/7 (17%) ORS. One vendor reported that he recommended Partardium because of advice by a doctor.
- Wholesale suppliers are a source of health information for venders. When venders were asked why they recommend a treatment 1/10 (10%) cited because it was recommended by their supplier. In turn, venders are a source of health information for some customers – 1/10 (10%) reported that customers base their buying on the opinion of the vendor.

Bednets

- *Knowledge about malaria is low:* Only 2/10 (20%) of vendors identified malaria as a disease caused by mosquitoes. However, 6/10 (60%) of vendors surveyed identified using a bed net as malaria prevention.
- *Availability* of bed nets is low and ITNs is nil:
  - Only 2/10 (20%) of vendors surveyed carried bed nets
  - ITNs were not sold by any of the vendors surveyed.
  - Of the 2 merchants who sold bed nets, only one sold nets with an insecticide treatment tablet (and he was out of stock at the time of the survey).
- *Cost of nets* sold was quoted as 6,000 – 15,000 Riel (about $1.50 to $4.00).

DISCUSSION

Iodized salt

The wide availability of iodized salt, mainly locally produced, corroborates findings from the KPC survey which documents a major improvement in the availability and consumption of this product in the project area. This is attributable to the National Sub-decree on Iodized Salt which established fortification standards for Cambodia. The sub-decree was adopted in 2004 and is enforced by the Federal Ministry of Health. The combined findings of the KPC survey and market study confirm that the promotion of iodized salt is no longer necessary and therefore should no longer be included as an intervention area of the Siem Reap ICH project.

Oral Rehydration Salts (ORS)

ORS does not seem to be available in the majority of retail outlets. It is certainly less available than other useless or harmful diarrhea remedies, and is much less likely to be recommended to consumers than these other remedies. Zinc is not available in the market.

One vendor reported that the reason he recommended Partardium was because of advice from a doctor. This needs to be investigated further and compared with information from the URC Health Facilities Assessment (HFA). There is need for much activity in changing the knowledge and behavior of shopkeepers (and likely, health providers and beneficiaries) in the project area with regard to the recommended treatment for diarrhea. There is also need for further qualitative research on the beliefs about diarrhea and barriers to ORS use among beneficiaries.

Zinc is likely to be a “blank slate” in terms of peoples’ beliefs about and preferences for it, as it is not currently available. There may likely be no current beliefs about it. It may be easier to introduce its use than it will be to increase the use of ORS alone, given the likelihood that zinc will be seen as a “pill” or “treatment” equivalent to other more common forms of diarrhea treatment. This would be similar to the experience of introducing zinc in other countries (e.g. Nepal (Adam Slote, USAID, personal communication)). If so, then linking ORS to zinc sales as a bundled product, as proposed with the Diarrhea Treatment Kit (DTK) currently under development by Population Services International Cambodia is likely to be a very effective strategy to increase demand for ORS quickly.

Bednets

There is a vague and moderate level of knowledge that mosquitoes are the cause of malaria and that bednets can prevent this. The results of the market survey confirm the results of the KPC. Bednets are indeed available and at a reasonably low price; however, ITNs are not widely available. Retreatment kits to convert bednets to ITNs also seem not to be widely available. Introduction of either KO tabs or ITNs will occur in a market with little to no availability of either product. There is probably little knowledge of the increased efficacy of ITNs over non-treated bednets for malaria control, so BCC activities will be a crucial complement to increasing access to either ITNs or KO tabs.

Annex T

Detailed Implementation Plan
Phase II: Siem Reap Stakeholders
Visioning Exercise

Mr. Hang Chan Sana, CRC Child Survival Project Liaison Officer, led workshop participants in a **visioning exercise to initiate sustainability planning.** [This exercise was developed using the CSTS draft tool for sustainability planning.] Mr. Sana described the general purpose of the visioning exercise which is to define what participants expect to achieve and what changes they hope to see over the project life. Key questions related to defining the vision were reviewed:

1. Describe the health situation of mothers and children as well as the health services that they receive in the community.
2. Describe the ability of institutions and partner organizations providing health services. What can be done to strengthen collaboration with those partners?
3. Develop methods which villagers will implement in their communities and how villagers will collaborate with partner organizations in relation to their current situation/environment.

Mr. Sana organized five small groups to discuss and prepare feedback on the above key questions. Groups recorded their ideas on flipcharts and presented these ideas to in plenary. Each groups presentation is shown below.

Group 1
To have a healthy community focus on health, community and VHSG.

1. Health
    - Availability of proper facilities
    - Adequate supplies and drugs
    - Availability of trained staff
    - Quality services- provide 7 items: vaccines, VAC, iodized salt, iron, de-worming, delivery, birth spacing
    - Health education, health info., technical,
    - Feedback from communities
2. Community
    - Parents receive health education
    - Participation and cooperation
    - Aware of literacy campaign
    - Adequate road networks
    - Adequate clean water
    - Availability of nutritious food
    - Mothers and children receive quality services (preventive and curative)
3. Community
    - Local authorities cooperate
    - Red Cross established volunteer networks
    - NGO support: technical and material

Group 2

- Contribute to the reduction of U5 mortality rate in the target OD by encouraging children and women to use existing health services
- Improve the quality of the six-disease immunization
- Improve the quality of prenatal, ante-natal and post-natal services; promote breastfeeding
- Strengthen preventive services and provide quality, curative services for such diseases as ARI, diarrhea and malaria
- Promote the involvement of villagers and local authorities in responding to project objectives
- Ensure smooth running of the VHSG structure and strengthen existing local feedback committees
- Ensure customers have easy access to HC services (transport and food)
- Provide support for volunteers in implementing the project in their respective communities/areas
- Effective and broad communication (messaging)
- Promote dissemination of information relating to project activities to communities thru village volunteers, HCs, partner and other relevant organizations and community involvement.

Group 3

- Children need complete immunization
- Good roads
- Sufficient staff (HC)
- Availability of transport (bicycles and motorcycles)
- Sufficient materials
- RC volunteers help promote awareness
- VHSG help collect children
- Good relationship with local authorities = good communication

Reduce maternal and child mortality

- Women attend ANC
- Women receive TT2
- Midwives have sufficient skills in delivery
- Availability of nearby HC
- Women practice birth spacing
- Availability of referral mechanism from HCs to referral hospital
- Adequate drugs

To ensure good health

- Proper facilities
- Adequate equipment, materials and drugs
- Women receive services along with education

- Promote women's awareness

Community and people
- Believe in health staff and participate
- Help spread knowledge to others

Collaboration with partners, good relations with communities
- Village and commune authorities
- TBAs
- VHSGs
- Volunteers

Reduce maternal and child mortality
- Convince women to use existing services
- Promote women's awareness of health care and hygiene
- Collect children in order to ensure they receive full immunization
- Encourage pregnant women to receive ANC and post-natal services
- Encourage pregnant women to deliver at HC

<u>Group 4</u>
- Mothers will understand the importance of immunizations for children and for women aged 15-49
- Mothers will understand the importance of breastfeeding from 0-6 months and supplementary feeding
- Reduce maternal and child mortality
- Child safety in community

Cooperation with local authorities
- Collaborate with relevant organizations, HCs and community
- Educate VHSGs on health so that they will do the same with communities
- Availability of equipment and skilled health staff
- Availability of HC services
- Educate women on breastfeeding
- Educate mothers on dangerous symptoms before and after delivery
- Educate women on ANC and TT immunization
- Promote birth spacing services
- TBAs must have adequate skills and materials
- Availability of means of referral
- Build capacity of TBAs
- Collaboration with relevant institutions
- Villages, communes, schools and community
- Children know traffic rules
- Promote children's awareness
- Ensure all children attend school

<u>Group 5</u>

Children receive full immunization

Availability of roads, sanitary toilets, school, adequate clean water system
Availability of nutritional food
No domestic violence
Availability of quality health services

Children enjoy well being, good health (mental, physical and social health)

Work responsibility
Coordinate and communicate for funds
Provide nutritious food for children
Correct education messages
Provide preventive and care services
Prevent illegal sale of drugs thru law enforcement
Help educate students on hygiene and diseases

Responsible persons
Local authorities (provincial, district, commune)
National and international NGOs
Health workers
VHSGs and CRC volunteers
Religious groups

Children receive full immunization
Mothers receive TT2
Safe motherhood
Correct breastfeeding and nutrition
Birth spacing and prevention of communicable diseases

Develop action plans together: meetings, reporting and monitoring

During pregnancy: HC staff (TBAs), nuns, clergymen, father and siblings

During and after delivery: TBA, midwives, grandmothers, siblings and fathers, mother, private providers, VHSG, teachers, NGOs, monks, nuns and clergymen

Villagers must seek right services
Behavior change
Impart knowledge to others
People can communicate with all partners thru a village development center (give information and some drugs for emergency)

Annex U

Component 1: Immunization and Vitamin A

Objective 1: Improve attendance for routine outreach for improved Vit. A supplementation

Objective 2: Improved attendance during routine outreach for improved routine vaccinations

Level	Education	BCC	Coordination	CBSS
Village	IEC materials (leaflets, flipcharts, posters) Use flags, banners and megaphones to let people know about vaccination days. Train volunteers in motivational interviewing techniques	Give stickers to children who have received VAC/immunization. Incentives linked to achievement of village targets (e.g. bicycles, latrines, exchange visits to other villages to share success stories). Home visits (especially to remote households).	Coordinate and organize outreach/ VAC distributions/immunization thru local authorities, HC staff, VHSG and volunteers as part of the monthly feedback meetings. Feedback meetings with village chief, volunteers and VHSG following VAC distribution round/immunization day to process lessons learned to improve performance for the next round/day. VHSG to provide feedback to HC to improve outreach through monthly meetings. Link with growth monitoring	Distribution/assignment of numbers/coding before VAC/immunization day to identify all eligible children which will serve to identify missed children following VAC distribution/immunization. Identification of pockets of unvaccinated children and assessment of barriers and resistances. Establish coverage targets with village and commune leadership and certify villages/communes that have consistently attained coverage targets. Annual performance review meetings at the village level Link with PLAN birth registration project. Monitor yellow cards and tally sheet. Record VAC on HC1 / HO2 forms, DO3 then Pro4 to support

				the HIS and NNP.
Schools	IEC materials (leaflets, posters) Involve school children to promote awareness of VAC distribution/vaccination day.	School-based contests for improved routine coverage		
Pagoda	IEC materials (leaflets, posters)	Prerecorded messages and songs announcing VAC distribution/immunization days thru wats. Identify Buddist Dhamma relevant to vaccination and compile message booklet for pagodas.		
Health Center	IEC materials (leaflets, posters)		Coordinate and organize outreach/ VAC distributions/immunization thru local authorities, HC staff, VHSG and volunteers as part of the monthly feedback meetings.	

FORMATIVE RESEARCH: Formative research to pin-point barriers and resistances to VAC distribution (see HKI research): outreach not outreaching (EPI team did not come to village 11%); or, community not mobilizing for outreach; mother did not take child to HC 54% (people don't perceive HC as providing preventive services rather curative)

Objective 3: Improve neonatal attendance for improved tetanus toxoid vaccination

Level	Education	BCC	Coordination	CBSS
Village	Train volunteers in motivational interviewing techniques. Education and promotion of use of pink card	Develop home visit strategy immediately following delivery to promote VAC during outreach	Involvement of TBAs to promote TT and post-partum VAC: TBAs as referral agents to HC and outreach for TT Attendance at monthly HC meeting/ report to VHSG for HC monthly meetings.	Community mapping of all pregnant women Identification of pockets of unvaccinated women and assessment of barriers and resistances
Schools				
Pagoda				
Health Center		Use highly subsidized or free ITNs as an incentive for completion (2 shots) during outreach or visit to HC Provide VAC to PPM during BCG, Hep. B outreach. Provide VAC thru HC/ hospital when they deliver at facility.		

Component 2: Nutrition and breastfeeding

Objective 4: increase infant breastfeeding within first hour after birth
Objective 5: increase six month exclusive BF
Objective 6: increase continued breastfeeding with appropriate and timely introduction of complementary foods

Level	Education	BCC	Coordination	CBSS
Village	IEC materials (leaflets, flip charts, posters) Recruit "model mothers" as volunteers and train in breastfeeding and motivational interviewing Educate on the growth monitoring curve	Post-partum visits to encourage early and exclusive breastfeeding as well as discourage giving water or other liquids as well as weighing of children immediately following birth to record on growth monitoring card Organize CM activities around World Breastfeeding Week, health fairs, award ceremonies, high level visits Design pilot to overcome work/employment outside the home as a barrier to exclusive breastfeeding; building on the IYCF Working Group Creative Brief (key messages: exclusive BF as a priority, reduce distance between mother and child for continued breastfeeding throughout the day and expressing breast milk.	Involve community opinion leaders including grand mothers, nuns, monks, village chiefs and fathers. Link with PLAN birth registration project. Link growth monitoring with vaccination outreach	Identify and recognize "model mothers" whom have exclusively breastfed for 6 months: -public announcements -community bulletin board -Pagodas/wat grannies Growth monitoring using yellow cards

		“Model mothers” to give testimonials, tee-shirts, identification of houses (e.g. flags, stickers, name plates)		
Schools				
Pagoda		Identify Buddist Dhamma relevant to exclusive breastfeeding for inclusion in message booklet for pagodas.		
Health Center	Message consistency: advocacy and education to HC staff and private providers to discourage water giving (mixed messages cause confusion among mothers). IEC materials (leaflets, flip charts, posters)			

Component 3: Community prevention and management of childhood illness
Objective 7: increase proportion of caregivers who seek care for their children with cough and rapid/difficult breathing
Objective 8: increase proportion of caregivers who seek care for their children with fever

Level	Education	BCI	Coordination	CBSS
Village	IEC materials (flipcharts, leaflets, posters) Train volunteers on recognition of danger signs Train volunteers in motivational interviewing techniques. Training on appropriate home treatment and referral	Social marketing of malaria diagnosis kits "Mala-check" through VHSG or village chief	Involve community opinion leaders including grand mothers, nuns, monks, village chiefs and fathers. Link with outreach activities for referrals	Send referred patients with referral forms (through village chiefs, VHSG or volunteer) as tracking mechanism and disease surveillance system
Schools				
Pagoda		Prerecorded messages and songs educating on danger signs thru wats. Identify Buddist Dhamma relevant to care seeking for inclusion in message booklet for pagodas. Develop mediation chants which repeat/reinforce the danger signs.		
Health Center	IEC materials (flip charts, leaflets, posters)			

Objective 10: increase proportion of caregivers who use DTK or other home fluids
Objective 11: increase proportion of children in malaria risk areas who slept under an insecticide treated net last night

Level	Education	BCI	Coordination	CBSS
Village	Education on diarrhea management including: increase fluid intake (including breast milk) during and after diarrhea episodes; discourage home treatment with pills and syrup from private providers; use of DTK Demonstration of preparation of DKT Education on use of ITNs (demand creation) IEC materials (flipcharts, leaflets, posters) Train volunteers in motivational interviewing techniques.	Social marketing of Diarrhea Treatment Kits thru volunteers Free "promotional" distributions Diarrhea/malaria edutainment videos during outreach and health fairs Social marketing of ITNs/ K-Otrine treatment tablets thru Red Cross Volunteers Mosquito net treatment/re-treatment campaigns Free "promotional distributions" to volunteers and most vulnerable Home visits shadow puppet shows, dramas/skits, choirs village performance certificate	Involve community opinion leaders including grand mothers, nuns, monks, village chiefs and fathers. Coordinate with RACHA shopkeeper program and HC distribution Link with outreach days to provide health education and retreatment of mosquito nets thru VHSG Coordinate with PSI	Establish coverage targets with village and commune leadership and certify villages/communes that have consistently attained coverage targets. Annual performance review meetings at the village level

Schools	IEC materials (flipcharts, leaflets, posters)	School poster/drawing competition		
Pagoda		Prerecorded messages and songs promoting prevention of malaria and proper home treatment of diarrhea thru wats. Identify Buddist Dhamma relevant to malaria and diarrhea for inclusion in message booklet for pagodas.		
Health Center	IEC materials (flipcharts, leaflets, posters)			

Annex V

CURRICULUM VITAE

Name: **KEM DARASOPHEA**, Sex : **MALE**, Nationality : **CAMBODIAN**
Date of birth : [redacted]
Place of birth : [redacted]
Address : # 168Eo, Street 13, Sangkat Chey Chom Neas, Khann Donn Penh, Phnom Penh City.
Telephone: 855(0)12 307 878 / 012 965 012

Address reference person:

- Mr. Doung Elite, Director of Protocol of Cambodian Red Cross, Tel: 012 243333
- Dr. Mean ChanYada, Director of Human Resource Department of Cambodian Red Cross, Tel. 012941188
- Dr. Sok Long, Manager HIV/AIDS Programs of Cambodian Red Cross, Tel: 012 688081
- Mr. Hout Cheng Chhay, Head of Public Relations of Cambodian Red Cross, Tel:012715341

I - General Education

- 1979-1997: Diploma of Bac. II at High School of Bac Touc (Phnom Penh)

II - Special Education

- 2002-2005: Master Business Administration (BBU-Phnom Penh)
- 1994-1998: Diploma of Medical Doctor (University of Sciences for Health Phnom Penh)
- 1983-1988: Diploma of Medical Assistant (Medical Faculty Phnom Penh)

III - Certificate or Other training

For abroad Certificate (outside Country)

- May-June 2005 (3 weeks): USA
  Workshop DIP (Detail implementation Plan) Child Survival (13 countries, 53 participants) in USA at Jonh Hopskin University, Baltimore Maryland, Washington DC sponsor by American Red Cross (USAID), and visit Chapter American Red Cross in Boston and Long Beach.

- October 2004 (1 week): Thailand
  Workshop Health Strategy for Southeast Asian Red Cross and Red Crescent at Regional Health Unit of IFRC in Bangkok Thailand (11 countries of National Societies Red Cross in Southeast Asian participated) supported by IFRC.

- September 2004 (2 weeks): Thailand
  Certificate Project Monitoring and Evaluation at Asia Pacific Development Communication Centre in University DhuRakij Pundit (Bangkok Thailand) supported by British Red Cross.

- March 2004 (1 week): Thailand
  Certificate Logical Frame Work Approach at Asia Pacific Development Communication Centre in University DhuRakij Pundit (Bangkok Thailand) supported by IFRC.

- January 2004 (2 weeks): Laos
  Certificate workshop Institutional Development and Organization Strengthening in Loas Country / Laung Prabang Province supported by Danish Red Cross.

- October 2000 (1month): French
  Attestation Formation Continue in French / Lyon by Handicap International:
  Module TRONC COMMUN of HI
  Module COORDINATEURS PROGRAMMES of HI

For Office / Divers Certificates

- 2004 (2 days): Obtained training Gender by GDC sponsor by IFRC.
- 2004 (5 days): Certificate Report Writing process by CRD sponsor by IFRC.
- 2003 (5 days): Certificate Project Planning Process (PPP) by IFRC / CRC
- 2003 (3 days): Certificate Orientation to Accountability Training Course at NGO VBNK/HAP NGO
- 2002 (5 days): Certificate Participatory Rural Appraisal at CRD NGO.
- 1998 (3 months): Certificate Foundation of Management (WIN: Working Internationally) by REGENT COLLGE, Phnom Penh.
- 1997 (3 months): Attestation Writing professional (letter of administration, review, synthetic, summery) by CCF/CCCL.

- 2004, Certificate database at ICS in PP: Certificate Access basic-advance
  Certificate Visual basic-advance
- 1999/ 3 months and 1995/ 3 months: Certificate Proficiency of Computer: Microsoft Word, Excel, power point and Typing skill by ICS in Phnom Penh and by ABC in Siem Reap Province.

For Health Certificates

- 2005 (14 days): Certificate of Appreciation conducting KAP baseline survey Cambodia Child Survival in Siem Reap Province supported by USAID-American Red Cross.
- 2005 (4 days): Certificate Mainstreaming Gender in Multisectoral Responses to HIV / AIDS
- 2003 (5 days): Obtained Training Courses M / E of WVC for Health
- 2003 (3 days): Certificate Training Human Right Related testing HIV/AIDS by CHHRA NGO.
- 2002 (5days): Certificate Community Counselling on HIV/AIDS at CRD NGO.
- 2001 (5days): Certificate Growth Monitoring and Nutrition Education by HKI and WFP
- 2000 (10 days): Certificate Community Health Promotion Management by NCHP (National Center Health Promotion).
- 1999 (5 days): Obtained Recycling (Refresher) for the activity EPI by Health Unlimited and National Programme of EPI.
- 1999: (3 days) Certificate (ISC) Use of Integrated Supervision Checklist by Health Unlimited.
- 1999: (2 weeks) Certificate MPA module I : Minimum Package of Activity by Health Unlimited.
- 1997 (10 days): Certificate Method of health education for child to child by Institute Health Development of Paris and Enfants du Cambodge.
- 1997 (1 week): Certificate Teaching Techniques for Health Education by CHED-NGOL.
- 1996 (1 week): Obtained Training first Aid by Cambodian Red Cross and EnfantsduCambodge.
- 1992 (3 months): Certificate Paediatric Refresher Training Course by World Vision and the National Paediatric Hospital.
- 1989 (10 days): Obtained TOT of Health Education by Unicef and Kandal's Province Health Department.

For Agriculture Certificate

- 1999: Certificate Improved Vegetable Production for Vulnerable Household by AAH.
- 1999: Certificate TOT of Agricultural Extension Methodologies by AAH.

IV - Working experiences

For NGO

- **2003 to 2005: Head of Health and Social Welfare for Cambodian Red Cross.**

Specific Duties:

Manage the implementation of Primary Health Care, Health in Emergency and Communicable Disease Projects HIV/AIDS. Make sure these projects are well functioning.

Develop concepts and proposals for new: Primary Health Care, Health in Emergency and Communicable Disease Projects, HIV/AIDS.

Prepare and editing reports such as monthly, quarterly, bi-annual and annual, Translation Health Documents, Proposal writing and Draft a letter to respond to domestic and overseas.

Review and Analyze Database to determine effectiveness of programme performance and make needed changes for program improvement. Develop and Review budgets.

Developing policies, strategy and guidelines for Health and Social Welfare activities with CRC.

Provide technical support to all CRC Health/Social Welfare related activities with CRC such as design training curriculum and editing translation training or workshop report.

Carrying out general offices duties as necessary such as daily office management, draft a letter to respond to the local and international. Translation projects health documents.

- **2003 (6monts): Health Coordinator of OD Kampong Chhang, Kampong Leng District, Kampong Chhang Province for NGOI – WORL VISION:**

***Duties:**

-To facilitate the Community Health Development, process in target area and will present WV in OD and 4 HC.

-Coordinate with OD office and Programme Health Coordinator and of necessary with national programme.

-Review the project plan and activities related to health activities with the community people.

-Monitor the progress of health activities according to the set standards and indicators of strategy planning of Area Development Programme and submit progress report to ADP Manager and Programme Health Coordinator.

-Seek regularly advice from Program Health Coordinator.

-Assist ADP health worker counterparts in the target area.

-Assist Programme Health Coordinator and National Health, Advisor in developing concept paper.

-Coordinate workshop on Training in the target area on health activities for 4 health centres , Village Health Volunteers, Traditional Birth Attendance etc.

- **1999 to 2002:** Health Project Coordinator as well as Health Project Manager of OD Kralanh / Siem Reap Province for NGOI – HI: (work with 1 Operational District and 7 Health Centers)

***Duties:**

-Aspect internal relationship:

-Responsible: Management, Administration, Coordinating, Planning (PAP, PAI),
-Staffing, recruitment staff, organising, controlling, monitoring, evaluation, supervision, and recommendation.
-Budgeting, fundraising,
-Organised visit of Donors, Delegations visitors.
-Report Monthly-Quarter-semester-annual for Donors/Headquarter in Phnom Penh / Headquarter in LYON.
-Training: pre-plan training, report-recommendation training,
-Created database analysis.
-Make the contracts with partners involve.
-Responsible for 20 local staffs.

-Aspect projects:

-Nutrition Food Security (Donors from WFP): Activities like as
  -Health Education,
  -Mother and Child Health (EPI: Extended Programme Immunization)
  -Grow monitoring children < 5 years,
  -ANC for pregnancy, lactating and birth spacing and
  -Reinforce Community Health/Nutrition Committee (VNV).
-Health Community (Donors from Canada Fund): Activities like as
  -Co-financing System,
  -Contribution money community for Child Health care (children < 5 years)
  -Incentive system for HC staff
  -Income generation for HC staff.
-Mother and Child Health (Donors from Racha): Activities like as
  -Traditional Birth Attendant (TBA),
  -Home Birth Kits (HBK),
  -Health massage for community health committee (VHSG),
  -Self Improvement System (SIS),
  -Client Oriented Provider Efficiency (COPE),
  -Health Information System (HIS),
  -Health Centre Performance Contracting (contracting motorbike for HC staff) and
  -Health message prevention HIV/AIDS for men and women.

-Aspect external relationship: with partners like authorities, ministries, NGOs, Authorities, Governor provincial, districts, communes, villages and communities committees, Ministries : Departments of Health (Ministry of Health), Department of Health (Ministry Rural Development), NGOs: MEDICAM, HACC, RACHA, WFP, Canada Fund, UNICEF, CRD, CHED etc.

- **1999 (6 months):** Program Officer Health Center of Koulen/ Preah Vihear Province for NGOI – Health Unlimited, project for reinforce health public sector of Health Center.

***Duties:**

-Aspect internal relationship:

-Coordinating, planning, with HC staff
-Organizing, controlling, monitoring, evaluation, supervision, recommendation to HC staff
-Organised visit of Donors, Delegations visitors.
-Report monthly to project manager
-Training: pre-plan training, report-recommendation training,
-Created database analysis.
-Make the contracts with partners involve.

-Aspect projects:

-Health Community: Activities like as

-Co-financing System,

-Income generation for HC staff.

-Health Education,

-ANC for pregnancy, lactating and birth spacing and

-Mother and Child Health (EPI: Extended Programme Immunization)

-Reinforce Community Health (FBC)

-Health massage for community health committee (FBC),

-Aspect external relationship: with partners like authorities, ministries, NGOs, Authorities, Governor provincial, districts, communes, villages and communities committees, Provincial Health Department

- **1996 - 1998:** Assistant Program Health Education for Primary School for NGOI PARTAGE, project for primary health care using method child to child.

***Duties:**

-Aspect internal relationship:

-Coordinating, planning, with Teachers at 6 primaries schools.

-Organising, monitoring, evaluation, supervision, recommendation

-Organised visit of Donors, Delegations visitors.

-Report monthly to country representative.

-Training: pre-plan training, report-recommendation training,

-Created database analysis.

-Make the contracts with partners involve.

-Aspect projects:

-Primary Health Care for children at primaries schools: Activities like as

-Using method Child to Child for Health Education,

-Activities Child Club for health (Theatres of child, Health tooth care for child, Health practice at home, home visit to families of child ...).

-Latrine construction for villagers

-Aspect external relationship: with partners like authorities, ministries, NGOs, Authorities, Governor provincial, districts, communes, villages and communities committees, Directors and teachers of 6 primaries schools, HC staff

- **1994 (6 months):** Part-time worker for program of library for NGOI Save the Children Australia,

Duties:

-Sticking books translation English to Khmer

-Project support book for library primary school.

- **1993 (6 months):** Personnel UNTAC (United Nation Transitory Authority in Cambodia) for election of district Chamkaloeu / Kampong Cham Province,

Duties:

-Mission to supervisor and control fair the day voting.

-Translation French – Khmer for 2 Observers of election.

-Assist working for 2 Observers.

For Health public sector

- **1990-1994:** Medical Assistant for treatment of Hospital Reussey Koe district (Phnom Penh):

Duties:

-Children Consultation (Sickness and EPI: Extended Programme Immunization)

- **1988-1990:** Medical Assistant for treatment of Hospital Kandal Stoeung district (Kandal Province).

Duties:

-Chief services of Consultation:

-Adult sickness

-Children sickness and EPI: Extended Programme Immunization

-Gyneco-obsttric

V - Other languages

English

- 2003-2005: Ongoing for English training at English Language Training Institute (ELT)

Spoken	Read	Written
Good	Good	Advanced

French

- 1996: - Certificate DELF: 1, 2, 3 Units by CCF/CCCL.
- 1991-1995: - Diploma: Finished studying French language by CCF/CCCL (3 years=540 hours).
- 1993/3 months: - Certificate Interpreter local for election by UNTAC and CCF/CCCL.

Spoken	Read	Written
Advanced	Advanced	Advanced

Annex V

Nicholas Edwards

PROFESSIONAL EXPERIENCE

Head of Delegation
American Red Cross (AmCross) Cambodia Delegation 2004 - Present

Develop and maintain relationships with donors, Red Cross partners, implementing partners, and governmental partners, including USAID, OFDA, World Bank, CRC Secretary General and deputies, HE Dr. Eng Hout Director of Health and other key MOH counterparts, with ICRC and MOSALVY to hand over Kampong Speu rehabilitation center to ICRC, and most importantly work regularly with CRC counter-parts in disaster management, water/sanitation, and health to strengthen programming and organizational development.
Ensure project implementation by reviewing work plans and reports, and meeting with staff and partners regularly.
Advise, inform, and liaise with desk officers on program and program support issues, including MOUs with World Bank and the Mekong River Commission, and Project agreements for Child Survival, Prey Veng Safe Water and Early Warning System programs.
Ensure compliance with financial, legal, risk management, labor, and local government regulations, policies and procedures. Develop policy as AmCross works in new areas and conducts new activities.
Guide strategic direction of AmCross Cambodia and explore new funding opportunities.
Recruit, train, and supervise consultants and staff. -Ensure compliance with and update of security policy.

Finance Administration Delegate
American Red Cross (AmCross) Cambodia Delegation 1997 – 2004

Manage all aspects of accounting procedures for disability sector, disaster preparedness, water sanitation, and health education grants. Work closely with project managers and Head of Delegation to prepare financial component of several successful funding proposals that yielded over $ 4 million. Work with program managers to ensure convergence of work plans, budgets, and actual activities by providing feedback on variance of budgeted and actual income and expenditures. Supervise accounting/ bookkeeping associated with the administration of program grants and sub-grants. Ensure compliance with US and Australian government and other donor regulations. Administer day to day activities of the program including personnel, procurement, and logistics and supervise local staff; have been able to delegate much to senior Cambodian staff. Train AmCross and partner organization staff in finance and management so they can assume greater levels of responsibility. Maintain appropriate internal control to ensure safe custody of assets and minimize risk to the organization. Ensure compliance with donor and AmCross financial reporting requirements. Successfully facilitate work of external auditor. Make decisions, represent the program, communicate with partners, and coordinate security on behalf of the Head of Delegation in his absence.

Finance Manager
International Rescue Committee (IRC), Battambang, Cambodia 1996-1997

Managed the accounting system, compiled financial statements, instituted internal controls, monitored and evaluated income and expenditures, reviewed and tested procurement procedures. Tracked expenditures by grant against budgeted amounts, managed cash flow, reconciled bank accounts, and trained staff in accounting functions. Advised a local NGO on internal control procedures, reviewed transactions, and recommended reporting mechanisms. Improved communication so managers could better understand financial information relevant to them. Prepared budgets for project proposals. Acted on behalf of the Country Representative in her absence.

General Ledger Reconciler
United States National Bank, Seattle, WA and Portland, OR, USA 1995-1996

Reconciled general ledger accounts for the Automated Clearinghouse (ACH) department, identifying items that created an out of balance for each account. Researched these items and made corrections to prevent their reoccurrence.

Board Member
Board of Inquiry, United Nations Transitional Authority in Cambodia (UNTAC) 1993-1994

Analyzed evidence, determined details and causes in each of 60 incidents and accidents presented by the Legal Advisor, and drafted conclusions and recommendations to the Head of Mission to allow the UN to recover assets and settle liabilities.

Financial Controller
UNTAC Civil Administration, Sihanoukville, Stung Treng, and Preah Vihear, Cambodia 1992-1993

Evaluated the neutrality and regularity of Provincial Government monthly expenditures and negotiated with officials to resolve differences of opinion on specific requests in order to minimize partisan abuse of the governmental structure during the electoral process. Trained government staff in budgeting, accounting, and auditing techniques. Identified rehabilitation priorities and developed proposals that repaired district schools and hospitals. Provided cultural insight to the Provincial Director who had no previous experience in Cambodia.

Field Coordinator
Repatriation Logistics Unit, CARE International in Cambodia 1992

Established field operations under a tight deadline to transport 300,000 Cambodian refugees home from camps to district sites. Developed and implemented administrative support activities: reporting, procurement, inventory and asset management, payroll, petty cash, and budget monitoring procedures. Managed international and local staff responsible for scheduling/maintaining a trucking fleet and receiving/distributing food and shelter material.

Program Administrator
Khao-I-Dang Refugee Camp Hospital and Supplementary Feeding and Health Education Program
CARE International in Thailand 1987-1990

Managed and trained 200 Cambodian staff responsible for purchasing, receiving, storing, preparing, and distributing food commodities and equipment in proper quantity and quality under stressful conditions in a camp of 40,000 Cambodian refugees. Trained staff in management and teaching techniques.

Project Manager
Northern Kordofan Integration Project, CARE International in Sudan 1989

Designed, budgeted, and managed a resettlement project to provide transportation, food, water, and shelter materials to southern Sudanese (Dinka and Nuer) returnees moving from camps to farming areas in the north. Consulted with Provincial Government and local leaders to ensure project acceptance by local population

Teacher
Phnat Nikhom Refugee Camp, The Consortium/Save the Children, Thailand 1985-1987

Developed curriculum, lesson plans, and materials for students with little formal education. Taught cross-cultural skills to US bound refugees from Laos and Cambodia in the context of an American high school.

EDUCATION

Master's of Science Degree in Management Sciences, Finance and International Business, School of Management, University of Manchester, United Kingdom 1991

Bachelor's of Arts Degree, Economics and Business, Macalester College 1984

LANGUAGES

Conversational Cambodian, Conversational Thai, native English speaker

Strong skills in Quickbooks, Quicken, Excel, and Word computer programs, proficient in PowerPoint and Project. Familiar with SPSS and various computerized accounting software.

Annex V

CURRICULUM VITAE

APPLICANT'S NAME : **Hang Chan Sana**
SEX : Male, Married.
DATE OF BIRTH : [redacted]
BIRTH PLACE : [redacted]
Telephone Nº : **(855) 12 201 455 /729 812, E- mail:**

PROFESSIONAL EXPERIENCES

01/2001- Present : Working for Cambodian Red Cross, in different 4 positions below:

1. Integrated Child Health Project Liaison Officer.
2. Senior Blood donor Recruitment Officer (Senior BDR Officer).
3. Dengue Hemorrhagic/Dengue Hemorrhagic Fever (DH/DHF) Coordinator
4. Health in Emergency Monitoring Officer (HEMO).

Responsible for:

- To collect and analyze reports on health activities and DH/DHF from affected provinces.
- To assist the Head of Health and Social Welfare Sub-Department in Health and the Health in Emergency activities after flood as required.
- To work with Program Department Team in planning a response to health related issues during and after floods including DH/DHF.
- To develop and strengthen the planning process for health related problems during flooding including establishment monitoring systems and follow up.
- To promote the good relationship between CRC and Communities and relevant Ministry (especially MoH) related to health activity monitoring.
- To prepare work plan for monitoring and evaluation activities related to CRC's Health in Emergency intervention and BDR project.
- To promote BDR activities in target groups.
- Coordinate and maintain the relationship with related ministries as well as target groups.
- Carry out the general office duties as necessary.

10/1999 – 10/2000 : Working for Health Unlimited (HU) International Organization in Ratanakiri Province.

Title : Program Assistant Strengthening Health Center (PASHC).

Responsible for :

- Providing Technical Skills (on the job training) to Health Center staff.
- Improving Management (In – Outreach Activities) and Administration of OYADAO health center in Ratanakiri province.
- Assist and motivate health center staffs/chief to set up the Feedback/Support Committee, to make plan and conduct outreach activities focusing on E.P.I, M.C.H., T.B Program.
- Participating in health center chief meeting at Provincial Health Department (PHD) and HU staff meeting for every month.

03/1996 – 09/1999 : Official of Ministry of Health base in Mondulkiri Province.

Title : Out- patient Consultation Section chief of Senmonorom Health Center.

Responsibilities :

- Provide medical consultation and treatment to the outpatient's clinic of Health Center.
- Assign and transfer hard sickness patients to the referral hospital for further treatment.
- Organizing and managing cycle planning of pharmaceutical supply and consumption for the health center.
- Provide training program to subordinators and village health workers.
- Serve as mobile clinic part time staff for MDM (Medecine Du Monde), an International NGOs, based in Mondulkiri Province.
- Assist CAP ANAMOUR, an International NGOs to conduct health development program in Mondulkiri province.
- Help translate occasionally English - Khmer/ Khmer – English for specific program run by International NGOs above.

EDUCATION

09/91 – 04/96 : Faculty of the Medicine, Diploma of Medical Assistant.
09/90 – 06/91 : Faculty of the Medicine, Formal Preparation Class for Medical Study.
09/80 – 06/90 : Santhormok High School, Certificate of High School diploma.

TRAINING

04/05 - 04/05 : One week training workshop on USAID Rules and Regulation, Bangkok,Thailand**.**
11/04 - 11/04 : One week traninig workshop on Voluntary Blood Donor Recruitment in Singapore.
09/04 - 09/04 : One week training workshop on Human Resource Management in Phnom

		Penh, Cambodia.
03/04 - 03/04	:	One week study tour to Korean National Red Cross, (South Korea)
07/02 - 08/02	:	One week training on Internaet and E-mail in Cambodia.
05/02 - 05/02	:	One week training workshop on East and East Asia Region Sphere Project in Hanoi, Vietnam.
02/02 – 02/02	:	Two weeks Training on Family Latrine and Community Organizing, in Stung Treng Province.
02/02 - 04/02	:	Three months Training on Driving Course in Cambodia.
11/01 - 12/01	:	Two weeks Health in Emergency Training Workshop in Philippines.
10/00 – 02/01	:	Computer Training Course (M.S. Word and M.S. excel Typing)
08/00 - 09/00	:	On week training on Facilitation Skill for community Development in Ratanakiri province
02/00 - 03/00	:	Two weeks Training Program on TOT and Facilitation Skills for Community Development in SVAY RIANG.
10/99–11/99	:	Two weeks Training Program on Training of Trainer (TOT) for Minimum Package Activities(MPA) module II in Phnom Penh.
05/99 – 05/99	:	Two weeks Training Program on Elimination of "HENSIN" at Cambodia Center of Disperse of uberculosis.
02/98 – 02/98	:	One-week seminar on MPA module I required for Health Center at Mondulkiri Referral Hospital.
03/98 – 03/98	:	One week training on EPI program including practical implementation at Senmonorom Health Center.
04/98 – 04/98	:	One week training on Preventive and Curative of Malaria in Mondulkiri.
12/97 – 12/97	:	One week training program for Elimination of sickness caused by lack of Iodine.

LANGUAGES

- English : Good in writing , reading and speaking.
- French : Good in writing, reading and speaking
- Khmer : Native language.

HOBBIES/ INTERESTS

- Reading/Travel/ Sport.

REFERENCE

1 – Dr. Hun Ratana
Advocacy Coordinator, MEDICAM
Tel : (855) 11 858 584 OR (855) 23 211 486

2 – Ms. Krong Chanthou
PSW Field Manager, America Red Cross (Am R.C)
Tel: (855) 12 917 342.

ANNEX V

ROBERT JOHN KOLESAR, MPH

rkolesar.amcross@everyday.com.kh
815-012-201-297

EXPERIENCE

Health Program Officer **American Red Cross-International Services**
March, 2005-present Siem Reap/Phnom Penh, Cambodia

- Supervised administrative district baseline survey team; completed data analysis, and authored KPC survey report.
- Designed and coordinated the participatory detailed implementation planning process including: feedback session with local authorities and opinion leaders, key constituency focus group discussions, stakeholder and implementing partner meetings and DIP workshops.
- Co-authored the Detailed Implementation Plan.

Head of Programs American Red Cross-International Services
February, 2004-February, 2005 Addis Ababa, Ethiopia

- Set-up country office, supervise local and expatriate staff, provide technical assistance to the Ethiopian Red Cross Society to develop local capacity in project management, reporting, budgeting, public relations, monitoring and evaluation; quickly resolved pre-existing audit findings.
- Co-authored concept paper; led field data collection and proposal development in Tanzania for an HIV/AIDS program resulting in a three country, $7.1 million Presidential Emergency Plan for AIDS Relief (PEPFAR) grant.
- Oversaw the development and implementation of a food-for-agricultural recovery operation implemented through employment generation schemes used as a model activity by local government; supervised commodity forecasting, logistics and warehousing.
- Oversaw implementation and evaluation of an OFDA funded $.5 million water, sanitation and hygiene project; completed quantitative data analysis, authored quantitative survey and final results reports.
- Led the monitoring and evaluation committee for a national handwashing campaign implemented by a diverse donor and NGO consortium; completed the sample design, survey team training and data analysis.
- Coordinated participatory proposal development process engaging all stakeholders including the Ethiopian government; authored a multi-organizational expanded impact application for the 2005 Child Survival and Health Grants program focusing on malaria, immunizations and hygiene.

Health Delegate American Red Cross-International Services
August, 2003-January, 2004 Lilongwe, Malawi

- Hired and trained eight district level staff in community mobilization and joint programming with MOH to build capacity in the technical areas of HIV/AIDS prevention, drug revolving funds, malaria prevention and early identification, referral and treatment of common childhood illnesses.
- Completed a community Integrated Management of Childhood Illnesses (C-IMCI) needs/stakeholder assessment including review of MOH work plans, district health officer in-depth interviews and community focus groups to determine program priorities.
- Refocused proposed C-IMCI program design to address identified priorities; presented assessment findings and new program design to stakeholders; authored corresponding project document and budget resulting in the approval of a $.7 million C-IMCI program component.
- Supervised district team to complete a comprehensive health facility quality assessment including facility audit, patient-client observation and client exit interviews.

Health, Water and Sanitation Program Manager **U.S. Agency for International Development**
March, 2000-March, 2002 Santo Domingo, Dominican Republic (DR)

- Managed $10.5 million health portfolio as part of the Hurricane Reconstruction Special Objective.
- Administered 25 integrated primary health, water and sanitation grants to NGOs/PVOs: proposal review and selection; monitored financial and program implementation; oversaw monitoring completed by the support unit; prepared monthly and quarterly reports; coordinated with other projects to set-up General Accounting Office audit visits; prepared program presentations; drafted scopes of work, speeches, press releases and briefing papers; oversaw all program evaluations.
- Supervised extensive quantitative socioeconomic and health survey resulting in the focusing of national attention and resources on the most marginalized population in the DR.
- Oversaw formative research in hygiene behavior change resulting in the development of a hygiene module within the community-level Integrated Management of Childhood Illnesses (C-IMCI) strategy.
- Designed health guidelines for the development of USDA Global Food for Education Initiative proposals including HIV, water and sanitation activities; reviewed NGO project proposals.
- Coordinated Centers for Disease Control (CDC) hurricane reconstruction activities in the DR.

Food Aid Manager **U.S. Agency for International Development**
February, 1999-March, 2000 Santo Domingo, DR

- Managed $10.3 million Title II Emergency Food Program including direct relief and food-for-work programming: coordinated partners and linked food programming to HIV/AIDS effected populations; prepared presentations as well as monthly and quarterly progress reports; supervised local staff.
- Represented USG on the Program Executive Committee which oversaw WFP administration and coordination of over 130 implementing NGOs; including performance monitoring and reprogramming.
- Hired, coordinated and supervised Food Security Analysis Team to determine the need for continuing Emergency Title II assistance; resulting in the addition of $1.4 million program resources.
- Oversaw the development of a multi-province nutritional surveillance system implemented by MOH.
- Monitored implementation and supervised overall program evaluation.

Child Survival/Relief Coordinator **U.S. Peace Corps/Crisis Corps**
October, 1996-February, 1999 Santiago/Santo Domingo, DR

- Co-designed the Peace Corps emergency health response following Hurricane Georges in the DR; solicited and received USAID grants totaling $50,000; managed a 20 person volunteer team to implement emergency health, water and sanitation interventions immediately following the hurricane.
- Launched a school-based neighborhood HIV/AIDS behavior change campaign: educated over 900 students, coordinated a design contest producing an internationally circulated AIDS poster, led World AIDS Day vigil with over 2,000 participants. The final result was a 400 percent increase in local condom sales.
- Established community health department within the Santiago branch of the Dominican Red Cross: recruited, trained, supervised and guided 42 health educators who trained over 1,800 youth in hygiene and HIV prevention in 20 high schools.
- Coordinated community health worker breastfeeding master trainer program with UNICEF and Leche League International.

Family Advocate and Medical Social Worker **Social Development Commission**
December, 1991-June, 1996 Milwaukee, WI

- Managed health clinic; coordinated preventive services including vaccinations, HIV/STI/TB voluntary counseling and testing, follow-up and referral, nutrition education, growth monitoring and advocacy.
- Counseled clients to resolve presenting, underlying and working problems.
- Assessed needs of homeless families to identify housing, social and health priorities; worked with other organizations to link families with HIV/AIDS support services and resolve child rights issues including parental abandonment.
- Analyzed service statistics and completed monthly, quarterly, and annual program evaluation reports; designed cross-reference system which reduced reporting time by 50 percent.

Chairman of the Board **Resource Center for Justice and Peace**
April, 1991-April, 1995 Menomonee Falls, WI

- Spearheaded marketing strategy of a new NGO: coordinated, pilot tested and executed radio, billboard and newspaper advertising and publicity; initiated complementary fundraising strategy; produced and edited newsletter.
- Directed a volunteer force of 108 persons that provided services to 10 NGOs: recruited, trained, and supervised volunteers; identified and developed volunteer placements; established and maintained NGO coordination.
- Implemented three central city neighborhood clean-up projects mobilizing a coalition of volunteers, schools, community groups and the private sector; total participation ranged between 200-500 personnel.

EDUCATION

Johns Hopkins University Bloomberg School of Public Health
Master of Public Health, 2003 Department of International Health
Baltimore, MD

University of Wisconsin-Milwaukee School of Social Welfare
Bachelor of Science, Social Work, 1995 *cum laude* Milwaukee, WI

LANGUAGE & COMPUTER

- Bilingual English/Spanish, proficient French, conversational Ethiopian Amharic.
- Skilled in Word, Excel, PowerPoint, EpiInfo, STATA.

Annex V

Sujata S. Ram

12503 Livingston Street **202-303-5015**
Silver Spring, MD 20906, USA **RamS@usa.redcross.org**

PROFESSIONAL EXPERIENCE

Maternal and Child Health Advisor, Technical Assistance, Planning & Evaluation Unit, American Red Cross, Washington, DC 6/05-Present

- Serve as the maternal and child health advisor for all projects including two USAID funded child survival projects.

Regional Manager, Americas Region, International Relief and Development, American Red Cross, Washington, DC 12/04- 6/05

- Provide on-going technical expertise and overall quality control in HIV/AIDS, tuberculosis, child health including IMCI and water sanitation programming by reviewing and finalizing proposals and project workplans and reports and conducting evaluations and supervisory visits.
- Act as the Regional Director with supervisory and management responsibilities of all National Headquarter regional personnel and field delegates when the Director is out of the office.

Associate, Americas Region, International Relief and Development, American Red Cross, Washington DC 8/03-12/04

- Responsible for the development and management of health programs and funding strategies in the Americas region.
- Develops and maintains relationships with Red Cross Movement partners, donor organizations and regional partners.
- Develops and designs funding proposals to donor agencies for child survival, tuberculosis control and HIV/AIDS prevention programs.

Team Leader to Develop a Detailed Implementation Plan (DIP), Curamericas, La Paz, Bolivia 2/03-4/03

- Responsible for the development of a detailed implementation plan for a USAID funded child survival grant.
    - Led a participatory planning and analysis workshop, which analyzed baseline data with project staff and partners from key project sites.
    - Conducted key informant interviews and developed project goals, objectives, and a monitoring and evaluation plan that includes results-based indicators.
    - Developed interventions, activities, and a detailed time line of the project's first two years.
    - Wrote and finalized report for the client.

USAID Child Survival Proposal Writer, Plan International, La Paz, Bolivia 11/02

- Actively participated in a team that wrote a USAID funded community-based child survival proposal that focused on the Integrated Management of Childhood Illness (IMCI) strategy. Responsible for revisions prior to submission to USAID Washington.

Evaluation Consultant, Project Concern International (PCI), San Diego, California
10/02-12/02

- Conducting a final evaluation of PCI's USAID funded Institutional Strengthening Assistance grant that provides resources to strengthen the capacity of the organization to better manage its food security or Title II programs in Bolivia and Nicaragua.

Program and Policy Analysis Consultant, Development Associates, USAID Ukraine, Kiev, Ukraine
9/02-10/02

- Developed a results framework and a performance monitoring plan, which included indicators and data reference sheets for the Social Protection and Health Strategic Objective for USAID Ukraine.

Evaluation Consultant, Title II Project -- Project Concern International, Cochabamba, Bolivia
8/02-9/02

- Conducted an evaluation of a food security program that assessed the validity of assumptions underlying three key implementation strategies. Also examined the sustainability of activities associated with the strategies and their results and distilled lessons learned that will be useful to the food security community.

Proposal Writing and Project Design Consultant, ADCI/VOCA, Santa Cruz, Bolivia 5/02-8/02

- Wrote a proposal that designs a safe drinking water and health education project for a community-based project in rural Potosi, Bolivia.

Health Policy Consultant, Abt Associates, Bethesda, MD 3/02- 5/02

- Assisting in the development of program manager guidelines for conducting a community health impact assessment for Shell International.
- Analyzing a household dataset using the statistical data program Stata 6.0 for an applied research project that is developing tools to assess the equity of resource allocation for two districts in Mali.

Volunteer, CARE/Bolivia, Santa Cruz, Bolivia 12/01- 12/02

- Collaborating on a community health project and also provided technical assistance in designing data collection instructions and performing data analysis.

Social Market Demand Consultant, Population Services International, La Paz, Bolivia 9/01-11/01

- Conducted a feasibility study that assessed the market demand and earning potential of four public health products in Bolivia. Results of study will be used by Prosalud, a Bolivian non-government organization, in the development of a long-term strategy for sustainability.
    - Developed survey questionnaires and conducted interviews with providers, vendors and producers.
    - Produced financial projections and cash flow statements to determine products' earning potential.
    - Produced a final report and presented results to Prosalud.

Senior Program Officer, Development Associates, US AID funded Partnerships for Health Reform (PHR) Project, Bethesda, MD 3/01-4/01

- Analyzed a household dataset using the statistical data program Stata 6.0 for an applied research project that developed tools to assess the equity of resource allocation for two districts in Mali (Phase I of the project).

Data Analysis and Report Writing Consultant, Abt Associates, USAID funded Zambia Integrated Health Project (ZIHP-Sys) Project, Bethesda, MD 2/00- 3/1/01

- Produced a synthesis report that highlighted and summarized child survival, reproductive health and HIV/AIDS program statistics from the 1999 ZIHP Baseline Survey.

Health Financing & Policy Consultant, TVT Associates, USAID funded Synergy Project, Washington, DC 10/00-11/00

- Authored a paper entitled "Summary of resource transfer mechanisms" for the UNAIDS conference "The Role of Debt Relief in Financing of HIV/AIDS Programs," in Lilongwe, Malawi November 13-16, 2000.

Logistics Consultant, Abt Associates, Bethesda, MD 10/00

- Provided logistics and technical support for study tour of PROSALUD, a Bolivian non-government organization in Santa Cruz, Bolivia.

Senior Program Officer, Development Associates, US AID funded Partnerships for Health Reform (PHR) Project, Bethesda, MD 5/98 – 3/31/01

- Coordinated and managed four activities in PHR's Child Survival Special Initiative focusing on child health, nutrition and infectious diseases.
  - Managed and participated in development of study design and methodology.
  - Participated in field data collection, data analysis, and report write-up and dissemination.
  - Collaborated with researchers from World Health Organization, World Bank, UNICEF, Centers for Disease Control, U.S. Agency for International Development and others.
  - Assured timely preparation and monitoring of project reports and budgets totaling over $800,000.
  - Supervised and monitored the workload of two program assistants and external consultants.

Research Analyst, Development Associates, USAID funded PHR Project, Bethesda, MD 6/97 – 5/98

- Analyzed health care utilization by socioeconomic and demographic characteristics for a franchising feasibility study.
- Performed a cost analysis for second medical opinions for Cesarean sections in Ecuador; results presented at the 11/98 American Public Health (APHA) conference.
- Analyzed a 1994 Burkina Faso Household Survey for PHR's Applied Research Program in equity of resource allocation and resource generation; results presented at the 11/98 APHA conference.
- Trained local data collectors for a maternal health cost study in Accra, Ghana, 8/98.

Research Associate – BASICS/USAID, Arlington, VA 5/96 - 8/96 and 12/96 - 5/97

- Researched and compiled data on the child health status of selected West African countries.
- Produced briefing packages that included information on basic indicators, health sector analyses and child health program plans and evaluations of other organizations.
- Researched the design and implementation of micro-credit and health programs.
- Conducted an extensive literature review on decentralization and health service delivery.

Budget Analyst – US Environmental Protection Agency, Washington, D.C. (Grade 11) 7/93 - 8/95

- Designed and implemented an Agency-wide payroll projection and analysis system to monitor headquarters and regional resource utilization.
- Developed issue papers for senior management analyzing current budget trends and identified the long-term cost implications for Agency-wide programs.
- Analyzed costs and benefits of converting contractor employees to federal employees.

- Prepared briefing materials for EPA's senior management, US Office of Management and Budget and Congress on Agency budget issues.
- Presented status of Agency's payroll at Annual Regional Technical Workshop.
- Served as a liaison between regional and headquarter offices to ensure that pertinent procedures and policy issues were disseminated on a timely basis.
- Designed and produced graphic presentations for the Agency's Budget Press Conference.

Secondary School Business Teacher – US Peace Corps, Apia, Western Samoa 11/90 - 12/92

- Designed curriculum, created visual aids, and devised innovative role-play activities as an accounting and economics teacher.
- Created examinations in accounting, economics, and business studies for all class levels.
- Directed a school theatrical production that involved students and their communities.
- Assisted in the revision of the Samoan National Accounting Curriculum.

Head of the Business Department – Leulumoega Fou College, Western Samoa 11/90 - 12/92

- Conducted monthly staff meetings to evaluate performance, allocate resources, and discuss effective teaching methods.
- Counseled and advised Samoan adolescents and encouraged academics.
- Introduced economics as a new course offering. Outlined a syllabus and class project as a teacher's guide.
- Served as an examiner for the Western Samoa's 1992 Secondary Accounting Examination.

EDUCATION

Emory University, Atlanta, GA
Master of Public Health, Health Policy and Management, December 1996

Bucknell University, Lewisburg, PA
Bachelor of Science, Business Administration, Major in Accounting, June 1990

PROFESSIONAL AFFILIATION

American Public Health Association, Secretary of the International Health Section – November 2000- November 2002

LANGUAGES

Proficient in Spanish, Hindi and some knowledge of Samoan.

Annex V

DETAILS CURRICULUM VITAE

SUMMARY OF EXPERIENCE:

- Project management for Early Warning System project
- General staff management
- Report writing skills
- Work plan development and budgeting
- Community development
- Administration/Finance
- Eight years health experience in border camps working in areas including Adult, Pediatric, Surgery, Malnutrition wards.
- Public health experience

Work Experience:

January 2003-present
ARC EWS Project Manager
American Red Cross/Cambodia
Responsible for:
1. Prepare progress reports and work plan
2. Coordinate with CRC EWS Officers to plan and manage EWS project
3. Develop work plan and budget plans with CRC EWS Officers for donor submission.
4. Ensure EWS activity conducted according to work plans
5. Routine monitoring to ensure EWS activities are being conducted as plans
6. Ensure quarterly activity schedule developed by CRC-EWS, CRC-Branch staff & RCVs received.

February 1998-2003
Program Assistant
American Red Cross/Cambodia
Responsible for:
1. Provide programmatic support to project areas
2. Train staff or seek out side training
3. Updating staff Term and Condition, Contract and Rules of Conduct etc.
4. Supervision and evaluations of subordinates
5. Assisted vehicle and patient arrangement for Kompong Speu Rehabilitation Center
6. Provide and coordinate vehicles
7. Petty cash management for day to day expenses
8. Attending meeting and produce a minute to Head of Delegation
9. Assist budgeting for staff development training
10. Developed staff training plan for all staff working in American Red Cross.

October 1996-1998
Chief of Administration
CAPE KANDAL Province
Responsible for:

1. Management of support staff (Finance officer, Secretary, Interpreter/Translator, Drivers, Guards and Maids).
2. Coordinate vehicles use and maintenance
3. Make all payments/purchasing for office/workshop supplies
4. Preparing materials for teacher training workshops
5. Oversee the proper use of computers and general office management related to policy and approving perdiems and overtime/ sick and holiday leave.
6. Maintain personnel files for local staff, including tracking of sick and annual leave
7. Produce and implement logistical plans and arrangements for all the designated project activities including those for transporting of personnel, lodging and board during residential training and the use of materials for various training.
8. Assist members of the CAPE technical teams to facilitate the sharing of resources both within and between sites.
9. Ensure that vehicles and motorcycles allocated to the project are used for their intended purpose and are properly maintained and serviced.
10. Participate in meetings and decisions concerning the project
11. After July 5-6 with the absence of expatriate staff, as Chief of Administration was requested to assume additional responsibilities.
12. Approving all payments for resource construction centers and day to day expenses at the office
13. To ensure the safety of CAPE properties, the continuation of resource center construction and the financial management.
14. Implementing training course in computer and English during the suspension period

February 1995-September 31 1996
Administrator/Finance Officer
CONCERN Kompong Chhnang
Responsible for:

1. Management of support staff (Admin. Assistant, Interpreter/Translator, Drivers, Guards, Maids and Cooks).
2. Salary payment to staff
3. Purchasing all supplies including for the projects
4. Oversee the proper use of computers and general office management related to regulation and policy
5. Recording and preparing monthly account and submitting to Central office
6. Attending NGO, and ministry meetings on behalf of program manager or with the program manager
7. Preparation of minutes/reports and report to the program manger
8. Developed appropriate administrative systems
9. Prepared Budget comparison for project managers and program manager
10. Trained eleven CONCERN staff to use MAC. Computer
11. During the absence of the Program Manager for two months (July to September, 1996, assume additional responsibilities that included compiling monthly reports from different projects, day to day management and decision making to meet the requirement of the program.

July 1993 - February 1995
Senior Translator/Computer operator
CONCERN Pursat
Responsible for:

1. Translating document in the office for natural resources project as well as interpreting in the field
2. Oversee the proper use of computer
3. In charge of Village Live stock agent for stock control and revolving fund
4. Data entry and book keeping for Animal Health Project. Field visits as and when needed to follow up on the instrument used, and to restock drugs.
5. Produced and submitted report to the Project Manager on a monthly basis

6. Information gathered using participatory rural appraisal

August 1992- June 1993
Translator/Interpreter
UNTAC, Pursat province
Responsible for:
1. Translating/Interpreting for UNTAC District Electoral Office in Pursat town, prior, during and after election.
2. Assisted District Electoral Officer during giving policy presentation to voter registrar teams
3. Translating and assisting people coming to vote

1987 – 1992
Working in Hospital
Consultant/Medical Assistant
Responsible for:
1. Management of health workers/nurses in the ward
2. Teaching health workers/ nurses
3. Take care of the patients
4. Make rounds with doctors
5. Referred patients to referral hospital
6. Continue teaching to health workers, nurses and patients
7. Explain patients the causes, treatment and prevention of diseases
8. Responsible for examining, explaining the cause of disease, the transmission of diseases and the important of bringing the children or the family members to come to a hospital in early stage of sickness.
9. Instructed about danger of taking private medications and the side effects of the drugs
10. A patient instructed to remember the cause, the treatment, and the prevention of the disease
11. Make the management plan for prolonged treatment
12. Rotated on six- monthly basis to different wards (Adult, Pediatric, Surgery and Malnutrition wards)

1986 – 1987
Working in Out Patient Department pharmacy (OPD)
Responsible for:
1. Responsible for giving instruction to patients how to take medicines and tell about the side effect of drugs.
2. Tell patient to come back after three days of antibiotics for follow up
3. Referred patient to see a consultant if patient still complained the disease not responding to the treatment.

April 1984 -1986
Mother and Child Health (MCH)
Responsible for:
1. To give/ inject the vaccinations for children under five years of age
2. Referred and followed up malnutrition children at Malnutrition Center and followed up after discharged home.
3. A house visit for health education to encourage mothers understanding of the importance of the vaccinations.
4. Encouraged parents to bring their children to get vaccinated till complete the course
5. Health education was also done prior and after vaccination to the children on the prevention of diseases (worms, the pathway of infection, the skin diseases and the causes of malnutrition).

Other information:

- Fluent in written & spoken Khmer & English
- Experience in reports/minutes writing skills

- Willing to learn more, working hard and flexible

Reference:

1. Bernie Orneil Adviser tel: 012-840-771
2. Om Yapin Admin. Manager Concern Worldwide Phnom Penh, telephone: 023- 214-891/214-879
3. Chhoun Vuthy Program Advisor SKIP Phnom Penh, telephone: 023-217-807

Annex V

Alice Willard

2217 Leeland Drive
Falls Church, VA 22043
Phone: 703/533-3126

AREAS OF EXPERTISE AND COUNTRIES OF EXPERIENCE

Expertise: Monitoring and Evaluation, Quantitative and Qualitative Analysis, Strategic Planning, Training Design and Implementation.

Countries: Bulgaria, Burkina Faso, Cambodia, Cameroon, Cote d'Ivoire, El Salvador, Ethiopia, The Gambia, Haiti, India, Liberia, Kazakhstan, Kenya, Macedonia, Madagascar, Malawi, Mali, Mauritania, Morocco, Mozambique, Niger, Portugal, Senegal, Sri Lanka, and Vietnam.

WORK EXPERIENCE

Senior Technical Advisor, Monitoring and Evaluation/ Monitoring and Evaluation Manager

American Red Cross, August 2001 – present.

Within the International Services Department, manager responsible for unit tasked with technical assistance in planning, monitoring and evaluation to all American Red Cross (ARC) projects and programs worldwide, including projects in food programming, primary health care, child survival, HIV/AIDS, TB, organizational development, water/sanitation, psychosocial, and disaster planning/preparedness. Manages professional staff, provides technical assistance to headquarters and field staff based in the Asia/Pacific, Europe/Central Asia/Middle East, Americas, and Africa regions, and on an as-needed basis to other programs and staff worldwide and at national headquarters. Develops materials and trains ARC headquarters and field staff in integrated planning (including strategic planning, project design, proposal development, monitoring and evaluation). Develops and implements monitoring and evaluation standards and templates for project managers, and designs monitoring and evaluation systems for projects. Conducts evaluations of programs and designs scopes of work for sector assessments and other evaluation studies. Conducts reviews of past performance in targeted sectors or cross-cutting areas. Reviews proposals and other field reports for technical merit, and collaborates on the development of other proposals and field reports (successful proposals include US government-funded proposals for two Child Survival grants and a Title II DAP, OFDA, USDA, GPRM, as well as numerous public and private foundations). Oversees the monitoring and evaluation of tsunami relief-funded programs and projects, including those implemented with the Movement and

partner organizations. Collaborates with peer organizations on technical issues and trainings, including FFP/ICBA grant materials generation for monitoring and evaluation. Serves as technical liaison with International Red Cross/Red Crescent (ICRC) and International Federation of the Red Cross/Red Crescent Societies counterparts in Geneva, Switzerland. Served on the FFP Strategic Plan sub-working group on strategic performance indicators.

Monitoring and Evaluation Specialist

Academy for Educational Development, August 1999 – June 2001.

With the Food and Nutrition Technical Assistance Project (FANTA), reviewed and refined monitoring and evaluation plans and development assistance proposals for Title II (P.L. 480, Food Aid) programs for AID's Bureau of Humanitarian Response/Office of Food for Peace. Provided technical assistance, training and guidance on monitoring and evaluation, results reporting and donor requirements for a portfolio including eleven West/Central Africa region Title II programs (including Africare, CRS, OICI, CARE, Counterpart and ACDI-VOCA) and all fourteen Institutional Support Assistance grants. Designed, managed and facilitated a week-long francophone workshop on Monitoring and Evaluation for Title II Programs in Bamako, Mali. Managed indicator refinement and clustering for Title II consortium (of four PVOs) in Niamey, Niger, and drafted monitoring and evaluation outline and six month workplan for consortium. Drafted Performance Monitoring and Evaluation Plan for FANTA, responsible for results reporting to donor(s). Developed workplan for USAID/Antananarivo and coordinated indicator clustering exercise for Madagascar Title II programs. Responded to client requests for technical assistance on monitoring & evaluation, training and reporting requirements. Edited numerous technical documents.

Independent Consultant

o *AMA Technologies, Inc. May - July 1999.*

Updated Evaluation Guide for AID/PVC's Office of Matching Grants. Guide included strategic planning, linkages between Planning Matrix and evaluation, audience information needs, guidance on developing indicators and an overview of the available methodologies.

o *The Mitchell Group. November 1998 - February 1999.*

Technical proposals for USAID/Mali Strategic Objective for Youth, USAID/Guinea Performance Measurement Management, USAID/Jamaica Basic Education. Prepared and oversaw overall technical approaches, workplan, performance milestone and evaluation plans.

o *The Mitchell Group. July 1996 - October 1997.*

Technical proposal for USAID/Senegal for series of Strategic Planning workshops as part of ongoing technical proposal work under USAID Strategic Planning IQC.

Facilitated Health Strategic Objective workshop in Dakar. Member of four-person team that provided technical assistance in strategic planning, methodology, causal linkages and USAID requirements. Designed workshop sessions for PVO, USAID and Ministry partners for Private Enterprise, Health and Democratization workshops, presented workshop sessions for Health workshop, advised small groups and assisted in workshop management. Workshops conducted entirely in French. Principal author/editor of final report.

o *Aguirre International. November 1994.*

Conducted a final assessment of the Haitian Educational Policy Reform Training Program of the International Management & Development Institute, University of Pittsburgh, an element of the Caribbean-Latin America Scholarship Program (CLASP). Francophone training program for Ministry of Education personnel in education policy and methods required an examination of training methods used, outcomes for personnel trained and overall success of activity. Assessment methods included focus group interviews, surveys and in-depth interviews with activity staff and Ministry personnel as well as document review. Assessment conducted primarily in French.

o *Investment & Trade Resources Intl. May - July 1994.*

Conducted a mid-term evaluation for USAID of the Environmental Business Exchange Program of the World Environment Center, a component of the U.S.- Asia Environmental Partnership (USAEP). Program provided short-term training and orientation to American business practices and potential partners for Asian businesses. Assessment techniques included remote survey protocol (phone interviews), analysis of goodness of fit among prospective partners, in-depth interviews with project staff and extensive document review.

o *Helen Keller International. February - April 1994.*

Team leader for mid-term evaluation for USAID of Expanding Vitamin A Supplementation and Nutrition Education for the Prevention and Control of Vitamin A Deficiency in Eight Provinces of Burkina Faso, a Child Survival Grant activity. Activity entailed extensive nutrition education components at all levels of Ministry of Public Health personnel and evaluation used focus group interviews, interview protocols, in-depth interviews with Ministry and NGO personnel at sampling of field

sites. Conducted entirely in French, with translators for More and Gourmantche into French.

o *Helen Keller International. October 1992 - June 1993.*

Impact assessment for USAID of Vitamin A Technical Assistance Project (VITAP), a Child Survival Grant activity. This was the field component of an impact study that included the Philippines, Indonesia, Niger, Burkina Faso and Mali that evaluated effects of training and technical assistance to PVOs worldwide. Part of two person team in Niger, Burkina Faso, and Mali that used survey protocol, in-depth interviews, exhaustive recipient coverage and comprehensive document review among PVO and Ministry partners of outcomes and initiatives based on the technical assistance. Wrote evaluations for African field visits and edited overall evaluation report.

Senior Systems Analyst

Executive Resource Associates, Inc., October 1986 - July 1990.
Computer Data Systems, Inc., June 1986 - October 1986.

Under contract to the Information Resources Management/Mission and Project Support division of the U.S. Agency for International Development (USAID). Tasks included training and on-site technical assistance to missions in Mali, Niger, Mauritania, Senegal, the Gambia, Cameroon, Liberia, West Africa Regional Office (REDSO/WCA), the African Development Bank and the Moroccan Ministry of Commerce & Industry; providing off-site technical assistance to sub-Saharan missions, including analyzing and evaluating configurations for automated systems; and overseeing USAID automation procurements and programs for sub-Saharan missions.

Evaluation Specialist

Evaluation Technologies, Inc. June 1985 - June 1986.

Evaluated grant programs for the National Endowment for the Arts. Tasks included assessing grantee project management; designing and applying data collection and analysis instruments; and supervising data entry and analysis.

Consultant

USAID Africa Development Policy Division, March - October 1985.

Conducted a review and analysis of USAID programs in thirteen African countries (Cape Verde, Central African Republic, Congo, Equatorial Guinea, the Gambia, Guinea, Guinea-Bissau, Malawi, Mali, the Seychelles, Sierra Leone, Swaziland). Tasks included analyzing financial and evaluation data to assess program impact; and

comparing USAID and other donor programs for level of contribution and potential impact for Annual Budget Submission meetings.

Research Associate

TRITON Corporation, September 1982 - November 1984.

Managed a comprehensive study of USAID's Project Evaluations. Tasks included designing, testing and revising data collection instruments; reviewing 346 evaluations for quality, completeness and clarity; conducting qualitative and quantitative analyses of findings; and training and supervising two interns and three consultants.

Teacher

Peace Corps, Liberia. December 1978 - December 1980.

As an education volunteer, primary task was high school English/French instruction. Secondary projects included developing material generation and curriculum for adult literacy program; teaching literacy and numeracy; and coordinating methods workshops for teachers.

EDUCATION

Ph.D.	The Johns Hopkins University, Sociology, December 1998. Methodology and World-Systems Analysis. Dissertation: "Rivers of Gold, Oceans of Sand: The Songhay in the West African World-System."
M.A.	The Johns Hopkins University, Sociology, December 1991. Methodology and Development.
M.A.	The American University, International Development, May 1985. Rural Development and Economics. Thesis: "AID Evaluations: Present Orientation and Possible Directions."
B.A.	SUNY/Albany, French and Latin, May 1978. Magna cum laude.

Languages:

French (fluent), Latin, Italian (speaking/reading), basic Portuguese, Spanish, German, Greek and Mano.

References available upon request.

Alice Willard

Annex W

Baseline Survey Report (KPC)
Siem Reap Integrated Child Health Project

Angkor Chum Operational District
Siem Reap Province, Cambodia

Funded by the United States Agency for International Development
Bureau for Global Health
Office of Health, Infectious Disease, and Nutrition

FY-2004 Child Survival and Health Grants Program (CSHGP)
Grant No. GHS-A-00-4-00007-00

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American Red Cross

CAMBODIAN RED CROSS

April 2005
Phnom Penh, Cambodia

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The authors would like to thank the Siem Reap Provincial Health Department for its support through the participation of 12 midwives who comprised the majority of enumerators. Their dedication, meticulous attention to detail and buoyancy throughout the training and field work are unparalleled. We would also like to thank the Operational District for providing excellent counterpart staff to support the data collection. Without their participation, the quality of the data presented in this report would not have been possible. Their commitment to improving community health is commendable.

We also gratefully acknowledge the participation the Cambodian Red Cross Headquarters and Siem Reap Branch Office in facilitating the training and supervising field work. Specifically, Dr. Kim Dara Sophea and Nang Chan Sana from the Cambodian Red Cross provided invaluable support throughout training and data collection.

Additionally, we appreciate the involvement of the governors of Pourk, Angkor Chum and Varin who provided assistance in identifying the randomly selected villages and notifying the villages prior to data collection.

Mr. Ven Sarith of the American Red Cross office in Phnom Penh was detailed to this effort on short notice. He gracefully managed multiple aspects of the survey from training through logistics, and provided a calm center through the whirlwind of data collection.

Finally, the authors would like to acknowledge the efforts of Mark Preslan, American Red Cross Asia Region Manager and Nick Edwards, American Red Cross Head of Delegation in Cambodia, who facilitated the overall coordination and logistics of the survey.

A note on spelling conventions: Khmer words are approximately spelled using the English alphabet. However, many Khmer sounds do not transliterate exactly and multiple spellings can be found. For the purpose of this report, names of places were spelled by the Administrative District governors.

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Abbreviations and Acronyms

AD	Administrative District
AIDS	Acquired Immune Deficiency Syndrome
ARC	American Red Cross
ARI	Acute Respiratory Infection
BCG	Bacillu Calmelle-Guérin tuberculosis vaccine
BF	Breastfeeding
CATCH	Core Assessment Tool on Child Health
C-IMCI	Community-Integrated Management of Childhood Illnesses
CR	Cambodian Riel
CRC	Cambodian Red Cross
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
DfID	Department for International Development
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
FY	Fiscal Year
GH	Global Health
HIV	Human Immune-deficiency Virus
JICA	Japanese International Cooperation Agency
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
KPC	Knowledge, Practices and Coverage
LOE	Level of Effort
MoH	Ministry of Health
MR	Mortality Rate
PHD	Provincial Health Directorate
PPM	Parts Per Million
OD	Operational District
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
SD	Standard Deviation
TRM	Technical Reference Materials
USAID	United States Agency of International Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

I. Executive Summary

Background

Cambodia has one of the highest under five mortality rates in the world at 122 per 1,000 live births.[1] Additionally, the rate actually rose 17 percent from 1990 to 2000. These facts prompted the declaration of Cambodia as a Child Survival Partnership country in order to focus international attention and resources on this severe and worsening problem.

American National Red Cross (ARC), along with its partner the Cambodian Red Cross (CRC), was awarded a Child Survival and Health grant in the CS-20 cycle, named the Siem Reap Integrated Child Health Project in one of the areas of Cambodia with the worst health statistics, the Angkor Chum Operational District. As part of its baseline assessments, the project carried out a Knowledge, Coverage, and Practices (KPC) baseline survey. The survey was undertaken by ARC in partnership with the CRC and with strong support from the Operational District Administration and Siem Reap Provincial Health Directorate.

Overall, the results of this survey show the child health situation in Angkor Chum Operational District in March 2005 to be better than comparable data for the region, extracted from the Cambodia Demographic and Health Survey (DHS) in 2000 for the provincial level.[2] Specifically, the survey documents remarkable progress with coverage for iodized salt consumption, Vitamin A, and measles immunization. Despite these accomplishments, much work remains to be done to achieve several of the 2007 targets detailed in the Cambodia Health Sector Strategic Plan.

Results and Discussion

The mean age of primary caregivers interviewed in this survey is 29 years. They are overwhelmingly uneducated with fifty-two percent having had no formal education; twenty-eight percent having attended school for 1 to 3 years; and, sixteen percent attended school for 3 to 6 years. Only five percent have over 7 years of schooling.

There was a strikingly high level of morbidity, even though the survey was carried out in the dry season. Nearly fifty-eight percent of children had one of the following illnesses in the two weeks preceding the survey: acute respiratory infection (cough with rapid breathing), diarrhea or fever. Two week period prevalence for acute respiratory infection (ARI) was 19 percent, diarrhea 35 percent, and fever 38 percent. Thirty-five percent had two of these illnesses and 7.2 percent had all three within the past two weeks.

Thirty-one percent of mothers recognized fast or rapid breathing as a sign of illness needing treatment. Fifty-six percent recognized diarrhea. High fever (presumptive malaria) was cited by nearly 70 percent of all surveyed mothers as a danger sign needing treatment. Twenty-seven percent of surveyed caregivers were not able to identify any

[1] Cambodia DHS 2000

[2] The DHS reported pooled data for both Siem Reap and Otdar Mean Chey Provinces. Also, note that DHS data is for children under five years of age; this survey collected information for children 0-23 months.

danger sign indicating the need for care and treatment (rapid breathing, diarrhea, high fever and convulsions).

Overall, 75.5 percent of household had a mosquito net in the home. However, only 1.7 percent of households had a net that was insecticide treated within the past 12 months.

Over one third of children were severely or moderately underweight (weight-for-age). Thirty-six percent of children were severely or moderately stunted (height-for-age).

Twenty-one percent of mothers stated that they exclusively breastfed for at least six months. Thirty-eight percent of children 0-5 months were exclusively breastfed during the last 24 hours. Eighty-two percent of children age 6-9 months received breast milk and complementary foods during the last 24 hours.

When caregivers of children with diarrhea were asked what they used to treat the diarrhea less than one-third reported giving packaged Oral Rehydration Salts (ORS). The most common treatment (58.7 percent) was a pill or syrup.

Forty-eight percent of mothers reported that their child received a Vitamin A capsule within the past six months. Nearly two-thirds of interviewed households had salt that tested positive for iodine.

Sixty percent of mothers received a tetanus toxoid injection two or more times during their last pregnancy. Eighty-four percent said they gave birth at home; 4.5 percent delivered at a public hospital and 7.9 percent delivered at a private hospital.

Sixty-one percent of respondents were able to show their child's vaccination card. Total immunization coverage (vaccination card and verbal reporting) reached 87.1 percent for BCG, 68.8 percent for DPT3, 52.4 percent for Polio 3 and 88.8 percent for measles.

Over half of interviewed households reported an open public well as their primary water source. Nearly 32 percent cited having an open well in their yard or plot. Ninety-two percent of households reported having no sanitation facility.

Reported handwashing before food preparation was nearly universal (94.1 percent). Handwashing before child feeding was only cited by 30 percent of mothers, after defecation was cited by 41.8 percent. Fifty-eight percent of mothers reported using soap when they wash their hands and had soap in the household at the time of the interview.

Ninety percent of mothers stated that they heard of an illness called AIDS. Seventy-one percent responded positively when asked if there is anything a person can do to avoid getting AIDS or the virus that causes AIDS. Over 59 percent of mothers identified condom use as an HIV/AIDS infection prevention measure. Less than five percent cited abstinence and less than 14 percent identified faithfulness to one partner as prevention strategies.

Nearly 42 percent reported not getting health information at present via inter-personal communication. However, the most common source of information is from a village health volunteer (21 percent). Mothers were asked if they received health messages from any other sources over the past month. Over 47 percent cited the television as a source of information; nearly 31 percent noted the radio. Other sources were village health volunteers (21.6 percent), traditional birth attendants (13.3 percent) and village health committees (8.6 percent). Print media (newspapers) was only identified by 1.4 percent of mothers.

II. Background

The American Red Cross, in partnership with the Cambodia Red Cross, was awarded a grant from the United States Agency for International Development (USAID) Child Survival and Health Grants Program (FY-2004). The grant supports the implementation of the Siem Reap Integrated Child Health Project. This report details the methodology and results from a two stage cluster sample KPC baseline survey undertaken in Angkor Chum Operation District, Siem Reap Province from March 12-20, 2005.

The primary objectives of the KPC survey detailed in this report are to:

(1) adjust and validate the project's planned objectives and strategies, focusing on the most pressing public health problems within the targeted Operational District
(2) better understand the current knowledge, practices and coverage of the planned intervention areas, establishing baseline statistics
(3) strengthen the partnership among the Provincial Ministry of Health, Cambodian Red Cross and the American Red Cross

The background information provided below is presented with the purpose of informing the reader of the overall operational environment and the initially proposed project goal, objectives and strategies. This report follows the *Writing the KPC Survey Report* guidance detailed in the *KPC 2000+ Field Guide* (October 2000).

Problem Statement: Cambodia has among the highest rates of child morbidity and mortality in Southeast Asia with an infant mortality rate (IMR) of 93 per 1,000 live births and an under-five mortality rate (U5MR) of 122 per 1,000 live births. Following decades of civil war, the public health system is still nascent, and community-based health service delivery is woefully inadequate to meet public needs. Consequently, most Cambodians lack education about the most appropriate treatments and thus self-medicate or use unqualified and expensive private practitioners. In addition, many essential child health products are not available in communities.

The national Cambodian U5MR increased by 17% between 1990 and 2000 in contrast to an 11% decline in the least-developed countries of the world. Only five other countries – Iraq and four sub-Saharan African countries – experienced a greater increase during this time. Acute respiratory infections (ARI), diarrheal disease, malaria, and vaccine-preventable diseases are the major causes of pediatric deaths, with malnutrition a primary co-factor.

National Policies & Strategies: In Cambodia a high level consultation on child survival was held in June 2004 bringing together for the first time all national partners in health around the common goal of child mortality reduction. As a result, the Royal Government of Cambodia has established a Child Survival Steering Committee under direct supervision of the Director-General for Health, as well as a Child Survival Secretariat for day-to-day operations and coordination among partners. In collaboration with the Commission on Macroeconomics in Health, a child survival investment plan is under development while a costing exercise supported by the World Health Organization

(WHO) will provide information on the most cost-effective interventions to reduce child mortality in Cambodia. Various partners have made new commitments including the Cambodia Ministry of Health, the Asian Development Bank, the World Bank, UNICEF, WHO, USAID, DfID, the European Commission, JICA, and an alliance of national NGOs.[3] In December 2004 a National Child Survival Partnership Workshop was held in Phnom Penh. This workshop moved the CS agenda forward by building consensus and support around:

(1) a programmatic focus on the major causes of child mortality and on the core interventions outlined in the "score card" (see Annex 3);
(2) the definition of roles and responsibilities of the CS partners in Cambodia; and
(3) the commitment of the MoH to draft a National CS strategy.

Program Location and Beneficiaries: The project site is in Angkor Chum Operational District (OD) in Siem Reap Province. The site contains three Administrative Districts (ADs): Pourk, Angkor Chum, and Varin. The estimated 2004 project site population was 199,952. The project will serve estimated average populations of 33,537 U5 children and 52,744 women of reproductive age, including 31,147 married women of reproductive age. Angkor Chum and Varin in particular are characterized by extreme poverty and illiteracy and are hyper-endemic for malaria. Until 1998, Varin was under Khmer Rouge control and its population was deprived of fundamental human rights. More recently, the main road running through Angkor Chum OD has been under reconstruction and can be expected to improve the economic situation of the area. Additionally, the recent expansion of Siem Reap town from a booming tourism industry may be expected to directly benefit Pourk AD by generating employment in the tourism sector.

Goals, Objectives, and Strategies: The project's goal is to reduce child morbidity and mortality in a sustainable fashion. The goal will be reached by achieving measurable improvement in the following three component areas and eleven objectives:

Component 1: *Nutrition and Breastfeeding*. Objectives related to:
(1) Vitamin A supplementation;
(2) Iodized salt use;
(3) Initiation of breastfeeding;
(4) Exclusive breastfeeding; and
(5) Complementary feeding.

Component 2: *Immunization*. Objectives related to:
(6) Fully-immunized children; and
(7) Tetanus toxoid immunization.

Component 3: *Community management of the sick child*. Objectives related to:
(8) Pneumonia management;

[3] http://www.childsurvivalpartnership.org/Ethiopia-Cambodia.asp *retrieved April 9, 2005*

(9) Control of diarrheal disease; and
(10) Control of malaria.

Objective 11 concerns building CRC's organizational, programmatic and human resources capacity at all levels so that it can manage and sustain a successful community-based child health program.

The project strategies include the following:

(1) Increase community access to health information, services and products that address leading causes of child illness and death through a network of community volunteers;

(2) Positively modify home health practices and care-seeking behavior through health education and behavior change communication;

(3) Establish community-based social marketing through sales of essential child health products;

(4) Transfer successful health education, social marketing, and community-based surveillance knowledge and experience to CRC;

(5) Develop durable linkages between HC outreach teams and the community through social mobilization activities and campaigns;

(6) Strengthen partnerships between the CRC and MoH at national and sub-national levels by linking with health systems strengthening projects and mainstreaming CRC experiences;

(7) Establish a community-based disease surveillance system (CBSS) to collect real-time data for local decision-making; and

(8) Enhance CRC management, monitoring, communications, and sustainability through partnership with ARC.

(9) At the community level, the program will strategically focus on establishing and improving health education, social mobilization, social marketing, community-based surveillance, and referrals to Health Centers.

Interventions and LOE: The technical interventions are (1) nutrition and breastfeeding (LOE: 40%) with specific focus on vitamin A and iodized salt supplementation, immediate and exclusive breastfeeding, and complementary feeding, (2) immunization with a focus on raising immunization coverage rates for the leading vaccine-preventable child diseases (LOE: 30%), and (3) community management of the sick child with specific focus on pneumonia management and control of diarrheal disease and malaria (LOE: 30%).

III. Process and Partnership Building

Project stakeholders were engaged throughout the survey process including revision of the questionnaires, training, field level data collection, data interpretation, as well as reviewing, editing and disseminating this report. Table 1 lists the stakeholders consulted during the survey development process. Following the review of the tools, recommendations were integrated into the final instruments.

Table 1 - Stakeholder consultation and review

Consultation	Review of Tools
Adventist Development & Relief Agency Cambodian Communicable Disease Control Department Cambodian Ministry of Planning Catholic Relief Services Helen Keller International National Maternal Child Health Center National Nutrition Program Population Services International USAID/Phnom Penh World Health Organization (IMCI and Nutrition Officials)	Angkor Chum Operational District Catholic Relief Services Linkages Project Siem Reap Provincial Health Directorate USAID/GH/HIDN

The KPC training and supervisory team was comprised of both ARC and CRC staff. The Pourk Provincial Health Director engaged 12 midwives from project area health centers to be trained as enumerators for survey data collection. Additionally, two Operational District staff and one CRC volunteer from the project area participated in the training and data collection. Although primary supervisory and technical oversight was the responsibility of the survey team leader with support from the supervisory team, CRC leadership from the branch and headquarters also completed supervisory field visits.

A preliminary data dissemination meeting was held eight days following the completion of data collection. This meeting was coordinated by ARC and CRC and involved officials from the CRC branch office, Pourk Operational District (including Administrative District governors) and the Provincial Health Directorate as well as the midwives who had taken part in the survey. The provincial level meeting was followed-up with feedback sessions in each of the three ADs using a discussion guide to motivate conversation on community action to promote improved health. Administrative District (AD) governors coordinated these sessions and involved commune leaders, health center staff, school directors, Buddhist monk leadership and community leaders. Feedback on the preliminary survey results was solicited, recorded, compiled and analyzed to further inform the detailed implementation planning process.

IV. Methods

A. Survey Instruments: Questionnaires, Anthropometry, and Iodized Salt Assay

Two instruments were used for the survey. One tool collected information on children 0-11 months. The second tool focused on children 12-23 months. Both instruments were adapted from the final KPC questionnaires developed by Catholic Relief Services (CRS) for its FY-2001 Child Survival project in Battambang Province, Cambodia. The revised instruments were pre-tested in the project area and modified for face validity. This was necessary as the Khmer spoken in different areas of the country is not exactly the same. English versions of both instruments are included as Annexes 8 and 9 to this report. The final Khmer questionnaires have not been included as annexes to this report, but are available electronically from both ARC and CRC.[4]

Both instruments collected information on basic demographics, nutrition, immunization status, childhood illness, diarrhea case management, acute respiratory infections, fever/malaria, mosquito net use and maintenance, health contacts and sources of information. The instrument for 0-11 month children also included separate modules on maternal and newborn health (MNH) and breastfeeding. The instrument for 12-23 month children included separate modules on household water and sanitation and HIV/AIDS knowledge, as well as additional childhood immunization questions. The split in questionnaires was done to reduce the time needed to complete each interview. This was accomplished by having age-appropriate modules that in a single instrument would otherwise have simply been skipped (MNH, breastfeeding, immunizations) or modules that needed only to be applied to a valid subset of mothers where sample size considerations did not dictate that a full 300 person sample was necessary (HIV knowledge and water/sanitation).

Additionally, all children were weighed and measured. Electronic weigh-reweigh *AND UC-300* scales and standard metric child measuring boards were rented from Helen Keller International. A salt sample of approximately 30 grams was also collected from each household in a plastic bag and tested for iodine content. Samples were either tested immediately at the household or later the same day. Samples were tested using the semi-quantitative assay manufactured by MBI International (Mumbai, India) and supplied by the UNICEF Cambodia field office. This test gives results in 25 parts per million (ppm) increments.

The interview time varied from 30 to 80 minutes depending on whether the child was reported to have diarrhea, acute respiratory infection, or fever within the two weeks prior to the interview. Caregivers with children reported sick during this period were asked additional questions about care seeking and illness management in reference to that illness. Supervisors ensured that skip patterns in the survey were appropriately followed by all enumerators.

[4]Khmer script documents require special language software for electronic transmission.

B. KPC Indicators

The survey was primary concerned with collecting data for construction of Rapid CATCH indicators (Section IV.A), indicators in the draft program matrix (Annex 2), and indicators included in the Cambodia "Scorecard" (Annex 3). Following technical review of the instruments by various stakeholders, additional questions were added to support the development of project activities and strategies. All indicators are expressed following standard definitions according to the *KPC2000+ Toolkit* unless otherwise indicated. Provisional baseline proportions and targets were taken from the original project matrix (Annex 2).

C. Sampling Design

The *KPC 2000+ Field Guide* was used to establish the sampling design. Standard sample size for a 30 cluster sample survey of 10 (total 300) was checked against the most restrictive indicator (stunting) to ensure adequate data collection to achieve a level of precision equal (alpha error) of 0.05 and power of 80% (beta error of 0.2). The value of 137 was computed. This was then rounded up to 150 per cohort (0-11 month olds and 12-23 month olds) to ensure sufficient robustness in the event of refusals (estimated at 10 percent). All indicators, including those only in one of the questionnaires, therefore, had sufficient sample size by these standard criteria.

The master list of villages was used as the sampling frame for selection of clusters. This master list was constructed from three different population lists provided by the OD administrator during a planning and coordination visit prior to the survey. These lists were cross-checked and found to be mostly consistent. Four villages previously identified in other ADs were recategorized to Pourk AD. This resulted in the following distribution by AD: 15 in Pourk, eight in Angkor Chum and seven in Varin. A master list with cumulative population totals was constructed to include all villages on all three lists. Discrepancies in population numbers were resolved by using the numbers from one list that had more detailed information which generally had slightly higher populations and was assumed to be more recent and more accurate (as the initial estimate was from early 2004). The number of households within each cluster was increased to 11 in order to obtain a total sample of 333. This was done to arrive at an estimated 300 final usable questionnaires, taking account of possible refusals and/or incorrectly completed surveys. The total estimated population of the AD in the sampling frame (199,828) was then divided by 30, giving a sampling interval of 6,661. A start number was randomly selected and 30 clusters were identified using the sampling interval.

Following the selection of the 30 clusters, two additional clusters were selected in Varin Administrative District (AD) in order to permit more precise and therefore meaningful inter-AD comparisons of some indicators (see data analysis section below). Two clusters were in villages too small to have enough households with children targeted by the survey. The total number of surveys completed was 347 (out of a possible 352). A list of selected villages is included as Annex 4, together with their estimated populations in the master sampling frame.

Prior to beginning the field level data collection, a second round of meetings were held with all AD governors to review the selected villages, and to identify their location on a detailed map. Each AD governor recommended a routing and visit schedule for each survey team. Each AD governor assumed responsibility to notify each selected village of the survey and schedule.

At the village level, the supervisors met with the village chief to sketch a village map or used one provided by the commune administrator. Each team divided into two or three sub-teams (depending on supervisor coverage) and were assigned to begin work according to the most visually logical beginning, end and center points of the village. Each enumerator team of two people went to their starting point, skipped two houses and interviewed the next house with a child less than 24 completed months of age (either the 0-11 or the 12-23 month cohort). This procedure was followed until each enumerator team completed their assigned number of interviews for that village. Each two-person sub-team was tasked to complete five interviews per cluster. The supervisor was responsible for completing the remaining interview. Teams with three sub-teams divided the work by having two teams complete four interviews and the third team complete three interviews.

D. Training

The ARC senior technical advisor for monitoring and evaluation was the survey team leader and oversaw all aspects of the survey planning, training and fieldwork. Survey supervisors all had previous experience with community level data collection and survey interviewing. All enumerators were literate and minimally had a high school education; only one enumerator was not a woman.

The enumerator training was conducted for three full days from March 9-11 at the Pourk AD offices. The training agenda (Annex 5) included project background, survey objectives, review of questionnaires, practice sessions, demonstration and logistics/scheduling. Two midwives withdrew after the first day of training, due to family obligations. Two staff from the OD replaced them, and were paired with CRC supervisors during the remainder of the training to ensure comprehension.

Following the completion of the survey, all teams participated in a joint debriefing session which included a discussion of lessons learned and best practices. Feedback from this session has been transcribed and is included in the Detailed Implementation Plan.

E. Data Collection

A field data collection schedule was developed with the AD governors to organize teams and assign villages according to geographic proximity. Note that geographic proximity refers to the relative distance between the selected villages and a logical sequence for traveling without retracing routes, rather than simply those villages that were most convenient to the road. Three supervised teams were deployed in separate vehicles to each of the targeted administrative districts to complete household interviews following the schedule; data collection was undertaken from March 12 through March 20, 2005. Each team had two supervisors, one national and one international.

Field teams participated in coordination and debriefing meetings, which were held each afternoon following that day's data collection. This gave each team the opportunity to correct forms and review any questions or concerns. After the first day, survey teams had progressively fewer questions about how to ask questions or code responses. The overall survey team leader had regular communication with all team supervisors to ensure progress and respond to questions generated during data collection, either via phone, radio or in-person, depending on communication technology limitations.

F. Data Entry and Analysis

Data was entered, processed and analyzed using EPI-INFO 3.2.2. Electronic questionnaires were prepared by ARC headquarters offices. Data was entered by an independent consultant from March 23-26, 2005. Data was cleaned, recoded and analyzed by the ARC Field Project Manager. This process took approximately seven days after completion of data entry.

Operational District (OD) level statistics were calculated by separating the additional clusters from Varin to check for statistical differences. When no statistical difference were detected (using 95 percent confidence interval), the data was pooled to further improve the level of precision of the point estimates. The analysis is presented in the Results section below.

V. Results

This section details the statistical findings of the KPC survey. Following the Rapid CATCH indicators, results have been grouped by topic. Confidence intervals (CIs) have been provided when it was considered that this information would enhance interpretation of the frequency point estimates.

A. Rapid CATCH Indicators

The Rapid Core Assessment Tool on Child Health (CATCH) detailed in the *KPC 2000+ Toolkit* was integrated into the survey questionnaires. Analysis of Rapid CATCH indicators was done following the tabulation plan specified in the guidance and is presented in Table 2 below. These results are described in more detail on the following pages, where we highlight the major queries and compare these results with national values.

Table 2 - Rapid Catch Indicators and Results

Intervention	Indicator	Statistic	CI
Nutrition	1. Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	35.7%	28.6 – 42.9%
Child Spacing	2. Percentage of children 0-23 months who were born at least 24 months after the previous surviving child*	44.1%	36.7 – 51.5%
MNC	3. Percentage of children age 0-11 months whose births were attended by skilled health personnel	15.3%	7.8 – 22.7%
MNC	4. Percentage of mothers with children age 0-11 months who received at least 2 tetanus toxoid injections before the birth of their youngest child	59.9%	49.7 – 70.1%
All	5. Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	38.4%	25.7 – 51.1%
Breastfeeding CDD/Nutrition Immunization	6. Percentage of children age 6-9 months who received breast milk and complementary foods during the last 24 hours	81.7%	67.8 – 95.5%
Intervention	**Indicator**	**Statistic**	**CI**
Immunization	7. Percentage of children age 12-23 months who are fully vaccinated before first birthday	34.1%	24.0 – 44.2%
Immunization	8. Percentage of children age 12-23 months who received a measles vaccine	88.8%	82.1 – 95.5%
Malaria	9. Percentage of children age 0-23 months who slept under an insecticide treated net the previous night	1.7%	0.0 – 3.7%
HIV/AIDS	10. Percentage of mothers with children age 12-23 months cite at least 2 known ways of reducing risk of HIV infection	12.9%	5.8 – 20.1%
CDD	11. Percentage of mothers with children age 12-23 months who report that they wash their hands with soap/ash	57.1%	46.5 – 67.6%
All	12. Percentage of mothers of children age 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment	57.9%	50.6 – 65.3%
All	13. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	53.7%	41.2 – 66.3%

*calculated using the assumption that any household with more than two children under five are not properly birth-spaced.

B. Background Information

The mean age of primary caregivers (almost entirely mothers) interviewed in this survey is 29 years with a range from 15 to 62 years. Approximately two-thirds (65.1 percent) of mothers are over 25 years of age; all primary caregivers are female.

Fifty-six percent of households had only one child under five years of age; 39 percent had two children under five and five percent had three children under that age. The survey population is overwhelmingly uneducated: fifty-two percent have no formal education. Twenty-eight percent reported having attended school for 1 to 3 years; and, sixteen percent attended school for 3 to 6 years. Only five percent have over 7 years of schooling.

Over 55 percent of mothers work outside of the home to earn money. The primary economic activities reported were harvesting (15.3%) and handicrafts (11.8%). All of the mothers worked (non-salaried) within the home or farm compound.

Table 3 - Work outside of the home

Type of Work	Baseline		
	n	N	%
None	189	347	54.5
Handicrafts	41	347	11.8
Harvesting	53	347	15.3
Sell food	24	347	6.9
Shopkeeper/Street vendor	8	347	2.3
Salaried worker	3	347	0.9
Other	29	347	8.4

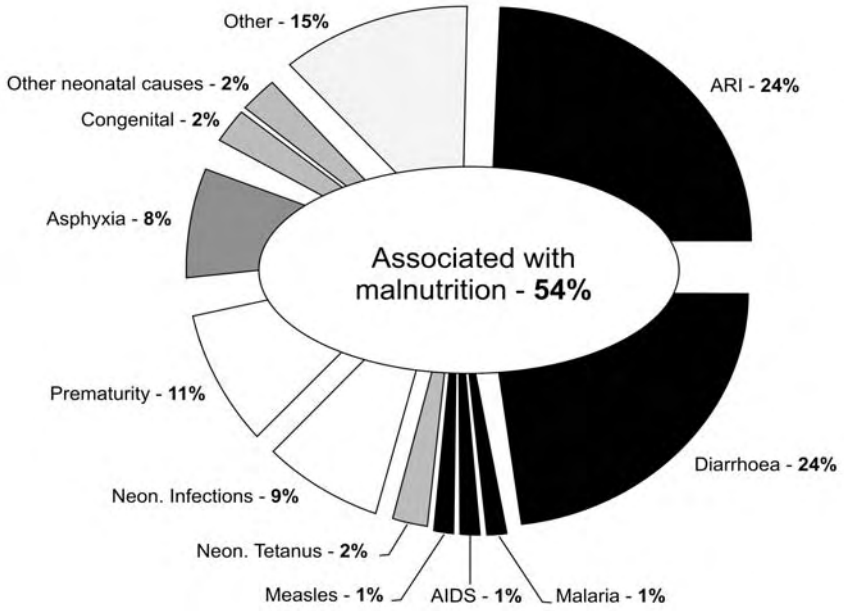
When asked who takes care of the child if they leave the home, five percent reported that they do (presumably that they take the child with them when they leave the home), five percent cited their husband, 11 percent other children 20 percent other relatives, and four percent neighbors and friends. All respondents (100 percent) reported that they also leave their child with a non-paid housekeeper.

Consumption of porridge and/or wild foods is a proxy indicator for hunger and food insecurity as they are foods of last resort. Fifty-seven percent of households reported that they ate porridge and/or wild foods for their meals at least one month in the past year. Nine percent stated that they ate porridge and/or wild foods six months or more. Average number of months of eating porridge and/or wild foods was 2.15.

C. Infant & Childhood Illness

Nationally, acute respiratory infection (24 percent) and diarrhea (24 percent) account for nearly half of death among children under five years of age in Cambodia. Measles, malaria, and acquired immune deficiency syndrome (AIDS) each contribute one additional percent to U5MR. Malnutrition is associated with 54 percent of all childhood mortality.

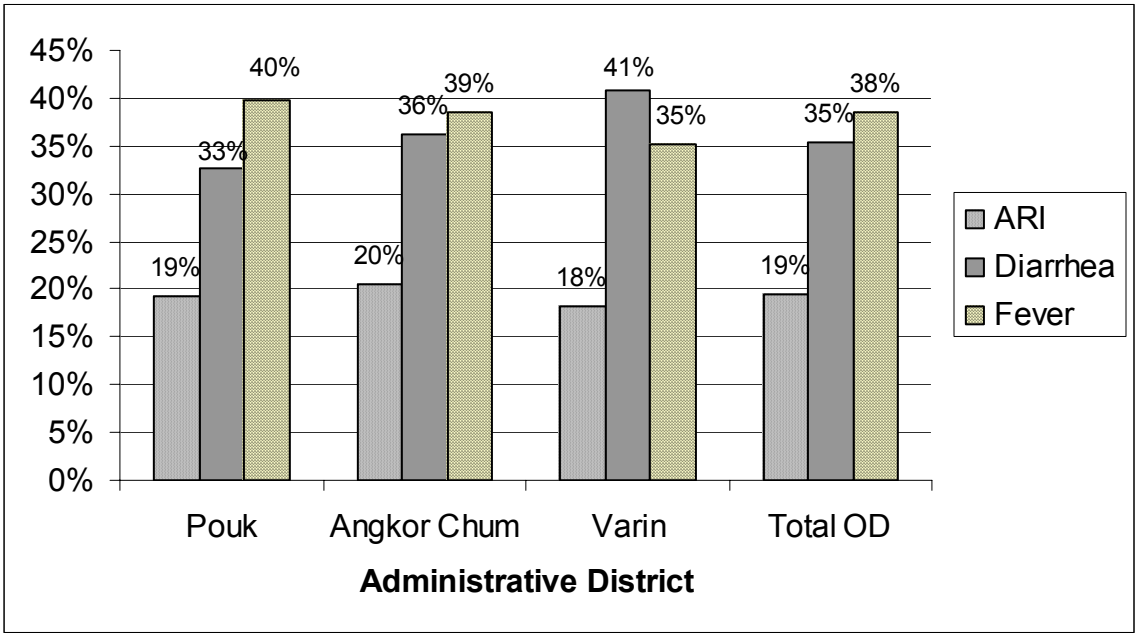
Graph 1 - Causes of under five deaths: Estimated distribution in Cambodia 2000



Source: Millennium Development Goal 4: Reducing Child Mortality in Cambodia, Child Survival Partnership High Level Consultation, Phnom Penh May 31-June 2, 2004

Predictably, corresponding morbidity among Cambodia's children is high. According to the Cambodia Demographic and Health Survey 2000, two week period prevalence for children under five years of age for acute respiratory infection (ARI) was 20 percent, diarrhea 18.9 percent, and fever 35 percent. The prevalence statistics in Angkor Chum OD for children under two years of age are equivalent or worse for all these illnesses. Acute respiratory infection (ARI) prevalence was 19 percent. Overall, diarrhea was 35 percent, with small, non-statistically significant increases from each AD south to north (and progressively further from the national highway): Pourk (33 percent), Angkor Chum (36 percent) and Varin (41 percent). Conversely, fever prevalence decreased from each AD south to north: Pourk (40 percent), Angkor Chum (39 percent) and Varin (35 percent). Likewise, these differences were not statistically significant. The overall fever prevalence was 38 percent. During the rainy season, it is expected that these prevalences would increase significantly.

Graph 2 - Acute Respiratory Infection, Diarrhea and Fever by Administrative District



Nearly fifty-eight percent (57.6) of children had at least one of these conditions (acute respiratory infection (cough with rapid breathing), diarrhea or fever). Thirty-five percent had two of these illnesses and 7.2 percent had all three within the past two weeks.

Early recognition of the signs of serious illness is a key community IMCI household practice. Recognition of danger signs is a precursor to seeking prompt care and treatment which can greatly improve chances for child survival. For example, the major impact on pneumonia mortality is achieved through prompt and effective treatment of pneumonia episodes, rather than through prevention.[5] Recommended home case management for diarrhea includes early use of food-based fluids and/or Oral Rehydration Solution (ORS), continued breastfeeding and recognition of danger signs requiring immediate care from a provider.[6] Universal treatment of diarrhea with ORS is expected to reduce mortality of children under five years of age by 15 percent.[7] Likewise, children with uncomplicated malaria must be given prompt treatment with an effective anti-malarial drug to avoid subsequent progression to severe malaria.[8] At the same time, most of these could be prevented, and complementary health education using a behavior change approach can contribute to reducing the incidence of diarrhea, as well as early treatment seeking behavior, thus reducing illness duration and severity.

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[5] Technical Reference Materials Pneumonia, PVO Child Survival and Health Grants Program, revised 2004
[6] Technical Reference Materials Control of Diarrheal Disease, PVO Child Survival and Health Grants Program, revised 2004
[7] Jones G. et al. How many child deaths can we prevent this year?, *The Lancet* 2003; 262: 65-71
[8] Crawley, J. Reducing deaths from malaria among children: the pivotal role of prompt, effective treatment in Technical Reference Materials Malaria, PVO Child Survival and Health Grants Program, revised 2004

Enumerators asked mothers "What are the signs of illness that would indicate your child needs treatments?" Interviewers read all possible answers and recorded all responses. Thirty-one percent of mothers recognized fast or rapid breathing as a sign of illness needing treatment. Fifty-six percent recognized diarrhea. High fever (presumptive malaria) was cited by nearly 70 percent of all surveyed mothers. However, only 26 percent recognized convulsions as a symptom indicating the need for care or treatment. Given the educational level of the mothers, it is possible that some of the more clinical terms elicited a 'don't know' response.

Stratification by mothers' age revealed that younger mothers (<25 years of age) report diarrhea as an illness needing care or treatment less frequently (46.3 percent; CI 37.2 – 55.6) when compared to 61.1 percent of older mothers (CI 54.4 – 67.5). No differences were found in reporting when stratifying by child's gender.

Table 4. Mothers' recognition of signs of illness

Sign of Illness	Baseline		
	n	N	%
Fast or rapid breathing	108	347	31.1
Diarrhea	194	347	55.9
High fever	241	347	69.5
Convulsions	90	347	25.9
Looks unwell/not normal play	64	347	18.4
Not eating or drinking	73	347	21.0
Lethargic or difficult to wake	77	347	22.2
Vomits everything	148	347	42.7
No signs	95	347	27.4
One sign	51	347	14.7
Two signs	79	347	22.8
Three or more	122	347	35.2

Twenty-seven percent (27.4) of surveyed caregivers were not able to identify any the danger signs indicating the need for care and treatment (rapid breathing, diarrhea, high fever and convulsions). Nearly 15 percent were able to recognize one of these signs, 22.8 percent knew of two signs and 35.2 percent were able to identify three or all four.

Recognition of rapid breathing, diarrhea, high fever and convulsions were each stratified by AD. Knowledge among mothers in Varin, the most remote AD of the three surveyed, proved to be consistently and significantly higher. Only 14.3 percent of mothers in Angkor Chum were able to identify rapid breathing as a sign of illness needing treatment as compared to 33.3 percent in Pourk and 44.2 percent in Varin. Likewise, knowledge of diarrhea as a sign needing treatment was identified by 39.3 percent of mothers in Angkor Chum as compared to 57.5 in Pourk and 70 percent in Varin. High fever and convulsions were cited by 46.4 percent and 9.5 percent in Angkor Chum, respectively. In Pourk,

69.6 percent and 21 percent were able to identify these symptoms. Recognition of these symptoms in Varin was 93.5 percent and 55.8 percent respectively.

Table 5. Mothers' recognition of selected signs of illness by Administrative District

AD	Rapid Breathing		Diarrhea		High Fever		Convulsions	
	%	CI	%	CI	%	CI	%	CI
Pouk	33.3	26.6 - 40.6	57.5	50.1-64.7	69.9	62.8 - 76.4	21.0	15.4 - 27.5
Angkor Chum	14.3	7.6 - 23.6	39.3	28.8 - 50.5	46.4	35.5 - 57.6	9.5	4.2 - 17.9
Varin	44.2	32.8 - 55.9	70	58.6 - 80	93.5	85.5 - 97.9	55.8	44.1 - 67.2
Total	31.1	26.3 - 36.3	55.9	50.5 - 61.2	69.5	64.3 - 74.3	25.9	21.5 - 30.9

Table 6 below summarizes care seeking practices and influences for children who were reported sick over the last two weeks. Sixty-seven percent of mothers sought advice or treatment outside of the home for ARI (cough with rapid breathing) as compared to 70 percent for diarrhea and 57.1 percent for fever. Of those sick children brought for care, over half were brought to the health center for advice and treatment irrespective of illnesses (ARI, diarrhea and fever). Reported care seeking at hospitals and private practitioners was more common than at the pharmacy or market (see Table 6).

Providers were selected based on cost, familiarity/trust and distance. Distance seems to be less of a consideration for diarrhea care seeking (30 percent response) as compared to fever care seeking (48.7 percent response). Of further interest in relation to diarrhea care seeking is that cost seems to more of a factor (50 percent response) than distance (30 percent response). This may be a result of the seeming omni-presence of diarrhea medication available from small shopkeepers.

Table 6. Care seeking for ARI, Diarrhea and Fever

Care seeking	ARI	Diarrhea	Fever
Sought advice or treatment	67.0	70.0	57.1
Service provider			
Health Center	56.9	53.4	53.0
Hospital	15.7	20.5	15.2
Private practicioner	13.7	16.4	19.7
Pharmacy/market	9.8	8.2	9.1
Unidenfied provider	3.9	0.0	1.5
Provider preference			
Cost less	45.5	50.0	43.0
Known or trusted	41.0	40.0	42.0
Distance 39.0		30.0	48.7
Follow-up visits			
Requested to return by provider	47.7	10.7	38.4
Actual return to provider	18.1	5.5	15.1

D. Acute Respiratory Infections (ARI)

Nineteen percent of mothers reported that their child had cough with rapid breathing in the last two weeks. These mothers were asked more detailed questions concerning treatment and care seeking for this illness.

Although the sample proved to be too small to make statistically significant conclusions, stratification by gender showed that girls are slightly less sick with ARI: 17.2 percent compared to 21.1 for boys. Similarly, mothers under age 25 reported more ARI (24.8 percent) compared to mothers 25 or older (16.4).

Table 7. Two week acute respiratory infection prevalence by child gender, mother's age and administrative district

Background Charateristic	n	N	%	CI
ARI	67	347	19.3	13.4 - 25.2%
Child's gender				
Female	30	174	17.2	9.3 - 25.2%
Male	36	171	21.1	12.4 - 29.7%
Mother's Age				
<25 years	30	121	24.8	13.9 - 35.7%
25 years and over	37	226	16.4	9.5 - 23.2%
Administrative District				
Pouk	36	186	19.4	11.3 - 27.4%
Angkor Chum	17	84	20.2	8.1 - 32.4%
Varin	14	77	18.2	6.0 - 30.4%

Sixty-seven percent of mothers (45 cases) reporting a cough and fast breathing over the past two weeks sought advice or treatment (Table 6). Nine percent of those seeking care did so the same day they noticed symptoms; 40.9 percent sought care the next day, 18.2 percent after two days and 31.8 percent did so only after three or more days (not shown).

In deciding to go for care, nearly all (93.2 percent) stated that they make the decision, although 39 percent mentioned their husband. Only 12 percent identified the grandmother or mother-in-law. Seven percent noted that friends and neighbors also participate in the decision-making process.

Walking was most common (40.9 percent) means of getting to a health provider. Thirty-two percent cited taking a moto-taxi, 15.9 percent stated that they took their own transportation and 2.3 percent (1 case) reported hiring a car taxi. Sixty-one percent stated that they paid no transportation cost. Thirty percent of mothers paid less than 300 Cambodia Riels (CR) (~US$.08). One case reported paying 3000CR (~US$.75) and one case reported paying 12000CR (~US$3.00) (the car taxi cost).

The standard consultation fee at the health centers as reported by local authorities is 500 CR (~US$0.13). Seventy-nine percent of care seekers paid for the consultation and treatment. Thirty-nine percent of these mothers paid 500 CR (~US$0.13) or less. Fourteen percent paid more than 500 and less than 1000 CR. Twenty-five percent paid more than 1000 CR for the consultation and treatment.

During the consultation the provider asked 47.7 percent of mothers to return for a follow-up visit. Only 38 percent of those mothers returned to the same provider as instructed. Treatments were paracetamol (52.3 percent), unknown tablets (31.8 percent), amoxicillin/ampicillin (22.7 percent) and unknown injection (6.8 percent). These are potentially inappropriate treatments for ARI.

E. Diarrhea Case Management

Thirty-five percent of mothers reported that their child had diarrhea in the last two weeks. These mothers were asked more detailed questions concerning treatment and care seeking for this illness.

Stratification by gender showed diarrhea prevalence for girls (32.6 percent) to be less than for boys (38.5 percent). This finding, however, is not statistically significant. Likewise, a non-significant increase trend was found among the ADs. Diarrhea prevalence was 32.6 in Pourk was 32.6 percent as compared to 36.1 percent in Angkor Chum as compared to 40.8 percent in Varin.

Table 8. Two week diarrhea prevalence by child gender, mother's age and administrative district

Background Charateristic	Baseline			
	n	N	%	CI
Diarrhea	121	343	35.3	28.1 - 42.4%
Child's gender				
Female	56	172	32.6	22.7 - 42.5%
Male	65	169	38.5	28.1 - 48.8%
Mother's Age				
<25 years	41	118	34.7	22.6 - 46.9%
25 years and over	80	225	35.6	26.7 - 44.4%
Administrative District				
Pouk	60	184	32.6	23.0 - 42.2%
Angkor Chum	30	83	36.1	21.5 - 50.8%
Varin	31	76	40.8	25.2 - 56.4%

Caregivers reporting child diarrhea were asked what they used to treat the diarrhea. The most common treatment (58.7 percent) was a pill or syrup. Packaged Oral Rehydration Salts (ORS) was cited by nearly one-third (32.2); only 1.7 percent (two cases) reported

making a sugar-salt solution in the home. "Other" responses included tree bark (2), coconut milk (2), proaxium (2) and antibiotics (7). The Health Sector Strategic Plan 2007 target for Oral Rehydration Therapy (ORT) is 80 percent of children with diarrhea in the last two weeks received ORT.

Table 9. Diarrhea treatment

Treatment	Baseline		
	n	N	%
Nothing	10	121	8.3
ORS	39	121	32.2
Home-made fluid	2	121	1.7
Pill or syrup	71	121	58.7
Injection	10	121	8.3
IV	4	121	3.3
Home remedies/herbal	21	121	17.4
Other	27	121	22.3

Caregivers were asked about breast milk, fluid and food intake during the reported diarrhea episode. Fifteen percent (14.9) reported decreasing breastfeeding; 33.9 percent continued the same level and 42.1 percent increased breastfeeding. In relation to other fluids, 14 percent of caregivers stated that they decreased other fluids, 21.5 percent reported that provision other fluids remained the same. Nearly 55 percent cited increasing other fluids.

Table 10. Breast milk, fluid and food intake during diarrhea episode

Frequency	Baseline		
	n	N	%
Breast milk			
Less	18	121	14.9
Same	41	121	33.9
More	51	121	42.1
Child not breastfed	10	121	8.3
Don't know	1	121	0.8
Other fluids			
Child not yet drinking	11	121	9.1
Less	17	121	14.0
Same	26	121	21.5
More	66	121	54.5
Nothing to drink	1	121	0.8
Food			
Child not yet eating	20	121	16.5
Less	46	121	38.0
Same	31	121	25.6
More	18	121	14.9
Nothing to eat	6	121	5.0

Food intake during last diarrhea episode was reduced for 38 percent of children, remained the same for 25.6 percent and was increased for 14.9 percent.

Caregivers were also asked about fluid (including breast milk) and food intake during the child's recovery from the last diarrhea episode. Seven percent (6.6) reported giving less fluids, 52.9 percent cited providing the same amount and 38.8 percent stated that they increased fluids. Food intake during recovery for diarrhea was less for 5.8 percent of children, the same for 42.9 percent and more for 29.8 percent.

Table 11. Fluid (including breast milk) and food intake during recovery from diarrhea

Frequency	Baseline		
	n	N	%
All fluids (including breast milk)			
Less	8	121	6.6
Same	64	121	52.9
More	47	121	38.8
Nothing to drink	1	121	0.8
Don't know	1	121	0.8
Food			
Child not yet eating	20	121	16.5
Less	7	121	5.8
Same	58	121	47.9
More	36	121	29.8

For reported diarrhea over the past two weeks 70 percent of respondents (50 cases) stated that they sought advice or treatment from someone outside of the home (Table 6).

In relation to decision-making about where to go for care, nearly all (94 percent) stated that they make the decision. However, forty-four percent also mentioned the husband, and 24 percent cited their mother or mother-in-law.

The primary mode to travel to the health care provider was walking (42 percent). Twenty-six percent of mothers cited taking a moto-taxi. The remainder either used their own transportation (16 percent) or hired a car taxi (6 percent). Fifty-six percent of interviewees stated that their travel to the provider was free. Twenty-three percent reported paying more than 2000 CR (~US$0.50).

Most respondents (70 percent) reporting having to pay for the consultation and treatment. Over three-quarters (77.8 percent) paid less than 500 CR (~US$0.12). The remainder stated they paid between 500 and 7000 CR (~US$0.12 - US$1.75).

Only 10.7 percent of mothers were asked to return for a check up. Slightly more than half (55 percent) complied with that request.

F. Fever

Thirty-eight percent of mothers reported that their child had fever in the last two weeks. These mothers were asked more detailed questions concerning treatment and care seeking for this illness.

Stratification by gender showed fever prevalence for girls (35.6 percent) to be less than for boys (40.6 percent). This finding, however, is not statistically significant. Likewise, a non-significant decrease trend was found among the ADs. Fever prevalence was 39.8 in Pourk as compared to 38.6 percent in Angkor Chum as compared to 35.1 percent in Varin.

Table 12. Fever by child's gender, mother's age and administrative district

Background Charateristic	n	N	%	CI
Fever	133	347	38.3	31.3 - 45.6%
Child's gender				
Female	62	174	35.6	25.6 - 45.7%
Male	69	170	40.6	30.1 - 51.0%
Mother's Age				
<25 years	43	121	35.5	23.5 - 47.8%
25 years and over	90	225	40.0	30.9 - 49.1%
Administrative District				
Pouk	74	186	39.8	29.8 - 49.7%
Angkor Chum	32	83	38.6	23.7 - 53.4%
Varin	27	77	35.1	20.0 - 50.1%

When asked about seeking advice or treatment for reported fever within the past two weeks, 57.1 percent (76 cases) of respondents stated that they did so (Table 6). One-third of these children were brought for care the same day symptoms of fever were recognized. Thirty-six percent went for care the next day, 20 percent after two days and 10.7 percent did so only after three or more days.

G. Mosquito Net Use

Insecticide-treated mosquito nets (ITNs) have been shown to reduce the incidence of malaria episodes by half and in malaria endemic areas the widespread use of ITNs can be expected to reduce all cause child mortality by about one fifth.[9] All caregivers were asked about malaria knowledge as well as mosquito net ownership, use and maintenance.

[9] Technical Reference Materials Malaria, PVO Child Survival and Health Grants Program, revised 2004

Over three-quarters of respondents identified mosquito bites as a cause or transmission risk for malaria. As the survey was conducted during the end of dry season, it is expected that mosquito net use would increase during the more malarious rainy season.

Table 13. Reported cause of malaria

Cause	Baseline		
	n	N	%
Mosquito bites	263	347	75.8
Witchcraft	4	347	1.2
Intravenous drug use	2	347	0.6
Blood tranfusion	8	347	2.3
Injection	1	347	0.3
Sharing razor blades	7	347	2.0
Home remedies/herbal	21	347	6.1
Not adapted to one's environment (environmental immunity)	7	347	2.0
Unboiled or dirty water	7	347	2.0
Don't know	84	347	24.2

Overall, 75.5 percent of household had a mosquito net in the home that was seen by the interviewer. Mothers under 25 years of age are slightly more likely to have a net in the home (79.3 percent) when compared to mothers 25 years and older (73.5).

Stratification by AD showed that surveyed households in Pourk are more likely (86 percent) than those in Angkor Chum (67.9) or Varin (58.4) to have a mosquito net.

Table 14. Mosquito net in home by child gender, mother's age and administrative district

Background Charateristic	n	N	%	CI
Mosquito net in home	262	347	75.5	69.1 - 81.9%
Child's gender				
Female	127	174	73.0	63.7 - 82.3%
Male	133	171	77.8	69.0 - 86.6%
Mother's Age				
<25 years	96	121	79.3	69.1 - 89.5%
25 years and over	166	226	73.5	65.3 - 81.6%
Administrative District				
Pouk	160	186	86.0	79.0 - 93.1%
Angkor Chum	57	84	67.9	53.7 - 82.0%
Varin	45	77	58.4	42.9 - 74.0%

Of those households with a mosquito net, 71.8 percent had the mosquito net hanging over the bed at the time of the interview. Four percent (11 cases) stated that they never use their mosquito net.

The vast majority of mosquito nets are not insecticide treated. Only 3.9 percent of mosquito nets (CI 1.9 – 7.0%) were reported to have been soaked or dipped in a liquid to repel mosquitoes or insects. Of these 10 mosquito nets, four were treated more than 12 months before the interview. Thus, reducing the rapid CATCH indicator for "percentage of children 0-23 months who slept under an insecticide treated net to 1.7 percent. The Health Sector Strategic Plan 2007 target is 100 percent for people living less than 200 meters from forested areas.

Frequency of mosquito net washing was reported at 30.2 percent once a week, 51.2 percent once a month and 18.5 percent less than once a year.

H. Nutrition (Anthropometry, Breastfeeding and Micronutrients)

i. Anthropometry

Height, age and weight data were collected for all children (under 24 months) to calculate underweight, stunting and wasting. Less than three (3) standard deviations (SD) below the mean is considered to be severe, under 2SD is considered moderate and under 1SD is considered mild malnutrition. Treatment for severe malnutrition is therapeutic feeding and rehabilitation, generally at a feeding center; however, mild to moderate malnutrition is reversible through improved feeding and care practices in the home. Stratification by child's gender yielded no significant differences between girls and boys.

Over one third of children (35.7 percent) were severely or moderately underweight (weight-for-age). Data from the DHS in 2000 recorded this same statistic for Siem Reap and Otdar Mean Chey at 49.9 percent.

Stunting (height-for-age) is a reflection of chronic malnutrition and thus one of the strongest indicators of overall child health. Thirty-six percent of children were severely or moderately stunted in Angkor Chum OD as compared to 50.7 percent for Siem Reap and Otday Mean Chey (DHS 2000).

Table 15. Nutrition Z Scores: Weight-for-age, Height-for-age and Weight-for-height

Nutrition Indicator	Standard Deviation					
	<3SD	<2SD	<1SD	80%	>1SD	>2SD
Weight-for-age						
National DHS	12.6	32.6	na	na	na	na
Siem Reap/Otdar Mean Chey (DHS)	10.9	39.0	na	na	na	na
Angkor Chum OD (KPC)	15.0	20.7	26.4	33.8	2.2	1.9
Female	14.7	21.8	30.8	29.5	1.3	1.9
Male	15.2	19.6	22.2	38.0	3.2	1.9
Height-for-age						
National DHS	20.5	24.1	na	na	na	na
Siem Reap/Otdar Mean Chey (DHS)	21.0	29.7	na	na	na	na
Angkor Chum OD (KPC)	10.8	15.4	27.7	40.0	4.9	1.2
Female	14.4	16.3	27.5	36.3	3.8	1.9
Male	7.3	14.5	27.9	43.6	6.1	0.6
Weight-for-height						
National DHS	3.9	11.1	na	na	na	na
Siem Reap/Otdar Mean Chey (DHS)	0.8	9.8	na	na	na	na
Angkor Chum OD (KPC)	5.5	11.1	24.8	52.1	4.9	1.6
Female	5.3	11.3	26.0	52.7	2.0	2.7
Male	5.7	10.8	23.6	51.6	7.6	0.6

Severe and moderate wasting (weight-for-height) was found to be 16.6 percent in Angkor Chum OD, as compared to 10.6 percent in Siem Reap/Otdar Mean Chey (DHS 2000).

Although vaccination cards have a growth monitoring chart on one side, this chart was blank (not used) for all observed vaccination cards.

ii. Breastfeeding

Breastfeeding is the most effective way to protect infants and children from common childhood illnesses. Universal coverage of the optimal breastfeeding practices can be expected to reduce mortality of children under five years of age by 13 percent.[10]

Caregivers were asked about breastfeeding practices following child birth. Forty-three percent (42.8) stated that they put the child to the breast within the first hour. Sixteen percent (15.7) did so after the first hour, 19.5 percent breastfed before the end of the first day and 22 percent breastfed after the end of the first day.

Although not statistically significant, stratification by gender showed that girl babies are more often breastfed within the first hour (50 percent) as compared to boy babies (35.1 percent).

[10] Jones G. et al. How many child deaths can we prevent this year?, *The Lancet* 2003; 262: 65-71

Table 16. Time lapse before putting infant to the breast following birth by child's gender

Stratification	Baseline			CI
	n	N	%	
Operational District				
Immediately/within first hour	68	159	42.8	31.9 - 53.6%
After first hour	25	159	15.7	7.7 - 23.7%
Before the end of the first day	31	159	19.5	10.8 - 28.2%
After the end of the first day	35	159	22.0	12.9 - 31.1%
Child's gender				
Female				
Immediately/within first hour	41	82	50.0	34.7 - 65.3%
After first hour	13	82	15.9	4.7 - 27.0%
Before the end of the first day	14	82	17.1	5.6 - 28.6%
After the end of the first day	14	82	17.1	5.6 - 28.6%
Male				
Immediately/within first hour	27	77	35.1	20.0 - 50.1%
After first hour	12	77	15.6	20.0 - 50.1%
Before the end of the first day	17	77	22.1	9.0 - 35.2%
After the end of the first day	21	77	27.3	3.2 - 41.3%

Eighty-nine percent of mothers reported giving the liquid that came from their breasts within three days after delivery (not shown). Of these mothers, 74.6 percent stated that they did not give any other liquids or food before feeding breast milk; conversely, 25.4 percent did provide other liquids or food before feeding breast milk. These mothers (44) were asked what other liquids they provided in addition to breast milk.

All mothers introducing liquids before breastfeeding within three days following birth cited giving sugar-salt water solution; over seventy percent reported giving plain water. Twenty-seven percent stated they had given powdered milk, fruit juice, rice soup or coconut milk.

Table 17. Other liquids given to infants within first three days of life before breastfeeding

Other liquids	Baseline		
	n	N	%
Sugar-salt water solution	44	44	100.0
Plain water	31	44	70.5
Powder milk	4	44	9.1
Fruit juice	4	44	9.1
Rice soup/coconut milk	4	44	9.1
Sugar water	3	44	6.8
Infant formula	0	44	0.0
Tea 0		44	0.0
Traditional herb	2	44	4.5
Sweetened condensed milk	1	44	2.3

In relation to exclusive breastfeeding, 39.3 percent of caregivers reported no months of exclusive breastfeeding. Twenty-one percent (21.4) stated that they exclusively breastfed for at least six months. The Health Sector Strategic Plan 2007 target for exclusive breastfeeding (percentage of infants under 6 months exclusively breastfed) is 25 percent.

Table 18. Exclusive breastfeeding[11]

Number of Months	Baseline		
	n	N	%
0	57	145	39.3
1	17	145	11.7
2	10	145	6.9
3	10	145	6.9
4	10	145	6.9
5	10	145	6.9
6 or more	31	145	21.4

Thirty-eight percent of children 0-5 months were exclusively breastfed during the last 24 hours. Eighty-two percent of children age 6-9 months received breast milk and complementary foods during the last 24 hours.

iii. Micronutrients

Micronutrients are highly cost-effective and have a substantial impact on health and well being. Vitamin A supplementation can reduce mortality in children between 6 and 59

[11] During data collection it was discovered that one team understood that this question was asking about knowledge and not actual practice, a clarification was made with enumerators after this error was detected. Effected clusters (9-13) were not used in the findings presented above.

months of age by 23 to 34 percent. Providing vitamin A supplements to this age group every 4 to 6 months is recommended by the World Health Organization and may be feasible through many child survival and health programs. Iodine deficiency during pregnancy increases the risk of spontaneous abortions and stillbirths and causes impaired fetal brain development and infant death. It is the cause of goiter and of cretinism, a birth defect involving severe mental and physical impairment. Promoting and monitoring the consumption of iodine-fortified products, such as salt, may be practical for some child survival and health programs and could have a measurable impact on mortality and morbidity. Fortification of salt with iodine has proven highly effective in preventing iodine deficiency disorders.[12]

a. Vitamin A

The Cambodia "Scorecard" cites existing vitamin A coverage at the national level to be 47-70 percent; the Health Sector Strategic Plan target is 80 percent coverage by 2007. Survey respondents were shown a vitamin A capsule and asked if their child received a supplement during the last six months; forty-eight percent (48.3) responded positively. Stratification by Administrative District (AD) reveals a non-significant downward trend in vitamin A supplementation coverage from Pourk (56.5%) to Angkor Chum (41%) to Varin (36.4%).

Table 19. Vitamin A supplementation coverage of children under two years of age by child's gender, mother's age and Administrative District.

Stratification	Baseline			CI
	n	N	%	
Operational District	167	346	48.3	40.8 - 55.7%
Child's gender				
Female	77	173	44.5	34.0 - 55.0%
Male	89	171	52.0	41.5 - 62.6%
Mother's Age				
<25 years	54	120	45.0	32.4 - 57.6%
25 years and over	113	226	50.0	40.8 - 59.20%
Administrative District				
Pouk	105	186	56.5	46.4 - 66.5%
Angkor Chum	34	83	41.0	26.0 - 55.9%
Varin	28	77	36.4	21.2 - 51.6%

Although not statistically significant, stratification by mother's age and child's gender shows that children of mothers over 25 years of age and male children are more likely to have received a vitamin A supplement. Table 19 above details these findings.

[12] Technical Reference Materials Nutrition and Micronutrients, PVO Child Survival and Health Grants Program, revised 2004

b. Iodine

The recommended minimum iodine content of fortified salt is 15 parts per million (PPM) to adequately prevent iodine deficiency disorders. According to the 2000 Cambodia DHS, under five children living in households with adequately iodized salt in Siem Reap/Oddar Meanchey provinces was 4.1 percent. All households were asked to provide a salt sample for iodine testing; all but two households provided salt. Approximately two thirds (64%) of households had salt that tested 25 PPM or higher. Over 43 percent of households had salt registering 100 PPM.

Table 20. Iodized salt test results by increments of 25 PPM.

0		25		50		75		100	
n	%	n	%	n	%	n	%	n	%
124	35.9%	43	12.5%	8	2.3%	20	5.8%	150	43.5%

With one exception, all clusters had some households with salt testing positive for iodine (not shown). Only one cluster had no positive tests for iodine (Varin OD). This strongly suggests that, with limited pockets of unavailability, iodized salt is available throughout Angkor Chum AD.

A second iodine test was performed on all salt samples in attempt to determine if either "course grain" salt commonly used for general cooking or "fine grain" commonly used for preparing fish was more likely to contain iodine (at any detectable level). Iodine fortification rates for both types of salt was statistically the same: 76 percent of course salt had detectable iodine as compared to 70 percent of fine grain salt.

I. Maternal and newborn care (0-11 months)

Mothers with children less than one year of age were asked about maternal and newborn care. Questions related to pre-natal care including tetanus toxoid vaccination, place of delivery and assistance with delivery.

In relation to pre-natal care, 26 percent of mothers saw no one for care during their last pregnancy. According to the 2000 DHS, 27.7 percent of mothers received at least one tetanus toxoid (TT) injection during pregnancy. In Ankgor Chum OD, 74 percent of mothers reported having received at least one TT injection during their last pregnancy; 59.5 percent received a tetanus toxoid injection two or more times. TT vaccination is indicative that pregnant women are coming into contact with the formal health sector. The OD has outreach activities that include immunizations and other health services. It is possible that these mothers do not consider this type of outreach as a prenatal visit.

Table 21. Prenatal tetanus toxoid injection

Frequency	Baseline		
	n	N	%
Once	25	177	14.1
Twice	51	177	28.8
More than twice	55	177	31.1
Once or more	131	177	74.0
Twice or more	106	177	59.9

Caregivers were asked about symptoms during pregnancy that made them recognize the need to seek health care or treatment. Twenty-eight percent reported fever, 7.3 percent cited shortness of breath, 16.4 percent identified bleeding and 19.8 percent reported swelling. However, the greatest percentage did not know (30.5 percent).

Table 22. Symptoms during pregnancy indicating need to seek health care

Symptom	Baseline		
	n	N	%
Fever	50	177	28.2
Shortness of breath	13	177	7.3
Bleeding	29	177	16.4
Swelling	35	177	19.8
Don't know	54	177	30.5

Mothers were asked where is the first place they would go for care if they had these symptoms. Seventy-eight percent said they would go to a formal health service provider: 55.4 percent responded they would go to the health center, 13.6 said they would go to a private practitioner, and 9 percent mentioned they would go to a public hospital.

Table 23. First choice for health care during pregnancy

Provider	Baseline		
	n	N	%
Public hospital	16	177	9.0
Health Center	98	177	55.4
Traditional Birth Attendant	13	177	7.3
Private practitioner	24	177	13.6
Traditional healer	3	177	1.7
Community distributer	1	177	0.6
Friend/relative	2	177	1.1
Other	6	177	3.4
No response	14	177	7.9

"Other" responses included a mission doctor who came to the village (4) and market (2).

Mothers were asked to identify the birth location of their baby. Eighty-four percent (83.6) said they gave birth at home; 4.5 percent delivered at a public hospital and 7.9 percent delivered at a private hospital.

Table 24. Location of last birth

Provider	Baseline		
	n	N	%
Home	148	177	83.6
Other home	3	177	1.7
Public hospital	8	177	4.5
Private hospital	14	177	7.9
No reponse	4	177	2.3

All mothers who reported home birth also reported to be assisted by a Traditional Birth Attendant during that birth.

Table 25. Assistance with last birth

Provider	Baseline		
	n	N	%
Traditional Birth Attendant	148	177	83.6
Mid-wife	18	177	10.2
Doctor	1	177	0.6
Medical Assistant	1	177	0.6
Nurse 1		177	0.6
Other	7	177	4.0

Reviewing the previous three tables shows the difference between knowledge and practice. Mothers know they should seek care, but the vast majority deliver at home.

J. Immuniz ation

Child immunization is one of the most cost-effective public health interventions for reducing child morbidity and mortality. The goal of immunization programs is to reduce the incidence of vaccine-preventable diseases in children by means of high coverage with potent vaccines administered at the appropriate age. The "original" six target diseases are poliomyelitis, diphtheria, pertussis, and tetanus (DPT), tuberculosis (BCG), and measles.[13]

All caregivers were asked to show their child's vaccination card. Information on specific vaccinations was only collected for children 12-23 months. Caregivers were also asked if their child received any other vaccinations that were not recorded on the card in attempt to determine total coverage rates for each immunization, regardless of documentation.

Table 26 below details immunization coverage proportions by vaccination type and source of information (card, verbal reporting and cumulative). This information has been stratified by child's gender, mother's age and administrative district. Note that the rapid CATCH numerator for fully vaccinated children is defined as number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card. Only 34.1 percent of children were able to meet this more restrictive indicator for fully vaccinated.

Sixty-one percent of respondents were able to show their child's vaccination card, leaving no written record of any immunization surpassing herd immunity levels. Stratification by AD revealed Angkor Chum to have a lower (51.8 percent) immunization card availability than Varin (61 percent) and Pourk (66.1 percent). The later difference was statistically significant (between Pourk and Angkor Chum only). Recorded vaccination was significantly lower in Angkor Chum compared to Pourk for BCG, DPT1-3, Polio 1-3 and measles.

This finding occasioned much discussion during the initial debriefing and feedback sessions. The midwives felt that this difference may be due to several possible causes:

1. higher ratio of health care providers to population in Pourk and Varin;
2. proximity to urban environment for Pourk and thus an increase in healthcare seeking behaviors;
3. the population in Varin more accustomed to outreach activities, and thus greater turn-out for National Immunization Days, due to the dearth of health facilities in Varin;
4. the population of Angkor Chum has lost both the 'outreach habit' and this has not been compensated by health center coverage.

[13] Technical Reference Materials Immunization, PVO Child Survival and Health Grants Program, revised 2004

Table 26. Ever vaccinated as recorded on vaccination card and verbal report

Background Charateristic	Vaccination card seen	BCG	DPT			Polio				Measles	Mebendazole
			DPT1	DPT2	DPT3	Polio 0	Polio 1	Polio 2	Polio 3		
Vaccination card	61.4	58.2	57.6	54.7	51.2	16.3	57.6	54.7	51.2	48.8	22.4
Child's gender											
Female	61.3	60.2	59.0	53.0	50.6	2.4	59.0	53.0	50.6	49.4	18.1
Male	62.7	56.5	56.5	56.5	51.8	9.4	56.5	56.5	53.0	48.2	25.9
Mother's Age											
<25 years	64.2	58.3	56.3	54.2	54.2	10.4	54.2	54.2	54.2	47.9	25.0
25 years and over	60.2	58.2	58.2	54.9	50.0	4.1	59.0	54.9	50.0	49.2	21.3
Administrative District											
Pouk	66.1	64.5	63.4	63.4	61.3	6.5	63.4	63.4	61.3	57.0	34.4
Angkor Chum	51.8	43.6	41.0	38.5	33.3	10.3	41.0	38.5	33.3	30.8	10.3
Varin	61.0	57.9	60.5	50.0	44.7	0.0	60.5	50.0	44.7	47.4	5.3

		DPT			Polio				Measles	Mebendazole
	BCG	DPT1	DPT2	DPT3	Polio 0	Polio 1	Polio 2	Polio 3		
Verbal reporting	28.8	27.1	24.7	17.6	28.2	24.7	17.6	1.2	40.0	52.4
Child's gender										
Female	32.5	28.9	24.1	16.9	28.9	24.1	12.0	0.0	22.9	45.8
Male	25.9	25.9	24.7	53.3	27.1	25.9	18.8	2.4	23.5	58.8
Mother's Age										
<25 years	31.3	27.1	20.8	14.6	27.1	20.8	14.6	0.0	22.9	56.3
25 years and over	27.9	27.0	26.2	18.0	27.9	26.2	18.9	1.6	23.0	50.8
Administrative District										
Pouk	26.9	25.8	21.5	16.1	26.9	22.6	16.1	2.2	24.7	66.7
Angkor Chum	28.2	23.1	23.1	10.3	23.1	23.1	10.3	0.0	10.3	27.4
Varin	34.2	34.2	31.6	28.9	34.2	31.6	28.9	0.0	31.6	26.3
Totals										
Total vaccine recorded on card and verbal report	87.1	84.7	79.4	68.8	44.5	82.4	72.4	52.4	88.8	74.7
Siem Reap/Otdar Mean Chey DHS 2000	43.3	60.8	63.1	55.9	49.8	23.1	68.7	57.7	50.4	51.0	na
National DHS 2000	47.5	71.4	68.0	58.2	48.5	29.8	74.7	64.1	51.5	55.4	na

Verbal reporting revealed that documented and undocumented to coverage to reach 87.1 percent for BCG, 68.8 percent for DPT3, 52.4 percent for Polio 3 and 88.8 percent for measles.

K. Water, sanitation and hygiene (12-23 months)

Water quantity and quality as well as access to sanitation have been shown to significantly reduce the diarrheal disease burden by 20 percent, 15 percent and 36 percent, respectively.[14] Handwashing has also been repeatedly demonstrated to significantly reduce diarrhea

[14] Esrey SA et al. Effects of improved water supply and sanitation on ascariasis, diarrhea, dracunculiasis, hookworm infection, schistosomiasis, and trachoma. Bulletin of the World Health Organization, 69(5): 609-621 (1991) Reprint No. 5216

prevalence. More recently, handwashing was found to reduce diarrhea prevalence by an average of 40 percent.[15]

Households were asked to identify their primary water source and all responses were recorded. Primary water source is sometimes seasonal. Some hand-dug wells were reported to be dry at the time of the survey and may be considered the primary source when they have water, but a dry season primary source is also identified. For this reason, multiple answers were recorded.

In Angkor Chum OD, over 50 percent of households reported an open public well as their primary water source. Nearly 32 percent of households cited having an open well in their yard or plot. Twenty-eight percent of households cited rain harvesting as their primary source. Nearly 15 percent use sources that are highly prone to human and animal fecal contamination (especially considering high reporting of unsafe fecal disposal detailed below) including springs, rivers, streams, ponds, lakes or dams.

Table 27. Primary water source

Water Source	Baseline		
	n	N	%
Open well in dwelling/yard/plot	54	170	31.8
Open public well	87	170	51.2
Protected well in dwelling/yard/plot	9	170	5.3
Protected public well	13	170	7.6
Pumping well in dwelling/yard/plot	10	170	5.9
Pumping public well	5	170	2.9
Spring/river/stream	15	170	8.8
Pond/lake/dam	8	170	4.7
Rain water	48	170	28.2

Over 92 percent of households reported having no sanitation facility.

Table 28. Sanitation facilities and feces disposal

Facility	Baseline		
	n	N	%
Water seal latrine	8	170	4.7
Traditional pit	3	170	1.8
Ventilated Improved pit	2	170	1.2
No facility/bush/field	157	170	92.4

[15] Curtis V, Cairncross S. Effect of washing hands with soap on diarrhea risk in the community: a systematic review. The Lancet Infectious Diseases 2003; 3: 275-81

When asked about waste disposal, most households (89.4 percent) reported burning their garbage. Over one-third of mothers stated that they dispose of it anywhere, implying that there is no formal disposal and it becomes litter.

Table 29. Disposal of garbage

Waste Disposal	Baseline		
	n	N	%
Open pit	5	170	2.9
Closed pit	2	170	1.2
Anywhere	60	170	35.3
Burning	152	170	89.4

Mothers were asked when they wash their hands, they were not prompted with potential answers, but asked "anything else?" until responses were exhausted. Reported handwashing before food preparation was nearly universal (94.1 percent). Before child feeding was only cited by 30 percent of mothers, after defecation was cited by 41.8 percent.

Table 30. Handwashing

Moment	Baseline		
	n	N	%
Never	4	170	2.4
Before food preparation	160	170	94.1
Before feeding child	51	170	30.0
After defecation	71	170	41.8
After cleaning child defecation	1	170	0.6

Respondents were asked if they use soap when washing their hands. The presence of soap was verified by the enumerator. Fifty-eight percent of mothers reported using soap when they wash their hands and had soap in the household; conversely, forty-two percent did not report to use soap or did not have soap at the time of the interview.

L. HIV/AIDS knowledge (12-23 months)

Ninety percent of mothers stated that they heard of an illness called AIDS. Seventy-one percent responded positively when asked if there is anything a person can do to avoid getting AIDS or the virus that causes AIDS.

Over 59 percent of mothers identified condom use as an HIV/AIDS infection prevention measure. Less than five percent cited abstinence and less than 14 percent identified faithfulness to one partner as prevention strategies.

Table 31. HIV/AIDS infection prevention

HIV Prevention Measure	Baseline		
	n	N	%
Abstain from sex	8	170	4.7
Be faithful to one partner	23	170	13.5
Use condoms	101	170	59.4
Limit number of partners	6	170	3.5
Avoid sex with sex workers	13	170	7.6
Avoid sex with persons who have many partners	11	170	6.5
Avoid same-sex sex	2	170	1.2
Avoid sex with persons who inject drugs	3	170	1.8
Avoid blood transfusions	12	170	7.1
Avoid kissing	1	170	0.6
Avoid mosquito bites	3	170	1.8
Seek protection from Traditional healer	1	170	0.6
Avoid sharing razors	22	170	12.9

M. Health Contacts and Sources of Information

Contact with formal and informal health service providers is important to understanding care and treatment seeking behavior. Similarly, understanding sources of health information is critical to identify opportunities and strategies for enhancing health communication with caregivers.

Mothers were asked about contact with various health care providers over the past month. All answers were read and multiple responses were recorded. The most common contact was with a nurse (15.9 percent). In relation to community level services, interviewees reported contact with midwives (13 percent), community health workers (14.4 percent), traditional birth attendants (12.4 percent) and, less frequently with traditional healers (7.5 percent).

Table 32. Contact with health care providers in the past month

Health Contact	Baseline		
	n	N	%
Doctor	29	347	8.4
Medical Assistant	36	347	10.4
Nurse	55	347	15.9
Mid-wife	45	347	13.0
Community Health Worker	50	347	14.4
Traditional Birth Attendant	43	347	12.4
Private practicioner	48	347	13.8
Traditional Healer	26	347	7.5

Respondents were asked where they usually get general information or advice on health and nutrition. Nearly 42 percent reported not getting health information at present via inter-personal communication. The most common source of information is from a village health volunteer (21 percent). Nurses (19.9 percent), midwives (17.6 percent) and traditional birth attendants (13.3 percent) are not uncommon health and nutrition resource people. Family members (husband, mother, mother-in-law, sister, grandparent and aunt) collectively are recognized by only 5.9 percent of mothers as sources of health and nutrition information.

Table 33. Source of health information

Source of Health Information	Baseline		
	n	N	%
No one	145	347	41.8
Doctor/Medical Assistant	15	347	4.3
Nurse	69	347	19.9
Mid-wife	61	347	17.6
Traditional Birth Attendant	46	347	13.3
Village Health Volunteer	73	347	21.0
Village Health Committee	22	347	6.3
Private practicioner	5	347	1.4
Husband	2	347	0.6
Mother/Mother-in-law	8	347	2.3
Sister	4	347	1.2
Grandparent	2	347	0.6
Aunt	4	347	1.2

Mothers were asked if they received health messages from any sources over the past month. All answers were read and all responses were recorded. Over 47 percent cited the television as a source of information; nearly 31 percent noted the radio. Other sources were village health volunteers (21.6 percent), traditional birth attendants (13.3

percent) and village health committees (8.6 percent). Print media (newspapers) was only identified by 1.4 percent of mothers.

Table 34. Source of health messages

Source of Health Messages	Baseline		
	n	N	%
Radio	107	347	30.8
Newspaper	5	347	1.4
Television	164	347	47.3
Village Health Volunteer	75	347	21.6
Village Health Committee	30	347	8.6
Traditional Birth Attendant	46	347	13.3
Key mother	3	347	0.9

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Annexes

1. Survey Team
2. Project Matrix
3. Core Child Survival interventions in Cambodia, scorecard indicators and corresponding project components
4. Selected Villages
5. Survey Training Agenda
6. Enumerator Training Plan
7. Supervisor Responsibilities
8. 0-11 Month Old Questionnaire
9. 12-23 Month Old Questionnaire

Annex 1. Survey Team

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Annex 2. Unmodified Project Matrix

Goal: **Reduce child morbidity and mortality in a sustainable fashion**			
Results-based Objective	**Indicator**	**Verification**	Major Planned Activities
Component 1: Nutrition and Breastfeeding			
Increase % of children who receive a high-dose vitamin A capsule from 11% to 80 %	% of children 6 to 59 months of age who receive high-dose vitamin A supplementation in the last 6 months	KPC; CBSS forms reviewed	**Mobilize for HC outreach sessions and micronutrient campaigns; VHSG health education; monitor high-dose vitamin A capsule supplies in HC**
Increase % of households using iodized salt from 4% to 35%	% of households using iodized salt	KPC; CBSS forms reviewed; iodized salt sales records reviewed	**VHSG health education; establish iodized salt social marketing**
Increase % of children who are breastfed within the first hour of delivery from 7% to 35%	% of children up to 6 months of age who are breastfed within the first hour of delivery	KPC; CBSS forms reviewed	**VHSG heath education**
Increase % of children who are exclusively breastfed from 10% to 35%	% of children up to 6 months of age who are exclusively breastfed within the last 24 hours	KPC; CBSS forms reviewed	**VHSG health education**
Increase % of children who receive breastmilk and appropriate complementary foods from 49% to 75%	% of children 6 to 9 months of age who receive breastmilk and appropriate complementary foods in the last 24 hours	KPC; CBSS forms reviewed	**VHSG heath education**
Increase % of children breastfed on first day of birth from 29 % to 55 %	% of children born in the past year who start breastfeeding within the first day of birth	KPC; CBSS forms reviewed	**VHSG heath education**
Component 2: Immunization			
Increase % of U1 children who receive all immunizations from 38 % to 80 %	% of children 12 to 23 months of age who are fully immunized before 12 months of age (BCG, DPT3, OPV3, measles)	KPC; CBSS forms reviewed	**Mobilize for HC outreach sessions and immunization campaigns; VHSG health education; monitor supply of vaccines in HCs**
Increase % of mothers who receive at least 2 doses of tetanus toxoid vaccine during pregnancy from 19% to 75%	% of mothers of children less than 5 years of age who receive at least 2 doses of tetanus toxoid before the birth of their last child	KPC; CBSS forms reviewed	**Mobilize for HC outreach sessions and immunization campaigns; VHSG health education; monitor supply of vaccine in HCs**
Component 3: Community Management of the Sick Child			
Increase % of caregivers who seek care for their children with cough and/or rapid or difficult breathing from 25% to 50%	% of caregivers of children less than 5 years of age who seek care for their children with cough and/or rapid or difficult breathing in the past 2 weeks	KPC; CBSS forms reviewed	**VHSG heath education; referrals to HC**
Increase % of caregivers of children with diarrhea who use ORS or other home available fluids (coconut water or rice water) from 35% to 80%	% of caregivers of children less than 5 years of age who use ORS or other home available fluids (coconut water or rice water) during their child's last diarrhea	KPC; CBSS forms reviewed; ORS sales records reviewed	**VHSG heath education; establish ORS social marketing**
Increase % of children in malaria risk areas who sleep under an insecticide treated bednet (target to be determined)	**% of children less than 5 years of age in malaria risk areas who sleep under an insecticide treated bednet**	**KPC; CBSS forms reviewed; ITN sales records reviewed**	**VHSG health education; establish ITN social marketing**

Program Matrix continued

Local Capacity Building			
Build CRC's organizational, programmatic, and human resources capacity at all levels	(1) Number of VHSG members trained in each intervention area; (2) Number of VHSG members who attend monthly HC management meetings; (3) Number of VHSG members who attend monthly HC outreach sessions; (4) Number of VHSG members who successfully fill out CB surveillance forms; (5) Number of VHSG members retained 2+ years; (6) % of mothers of U5s who receive health education from VHSG members in past 2 months; (7) No. of RCFO monitoring visits; (8) Type and number of health products socially marketed by VHSG members	(1) Training reports and post-test scores (2) to (6) RCFO activity reports; supervisory spot checks (7) RCDO activity reports; supervisory spot checks (8) Sales records	**(1) Training sessions held; (2) HC monthly management sessions held; (3) Village outreach sessions held; (4) CB surveillance carried out; (5) Regular RCFO monitoring visits; incentive mechanisms established & maintained; (6) RCFO monitoring visits conducted; (7) Social marketing system established & maintained**
ACRONYMS: CBSS = Community-based surveillance system; CRC = Cambodian Red Cross; HC = Health Center; ITN = Insecticide treated nets; KPC = Knowledge, Practice, and Coverage; ORS = oral rehydration solution; U1 = Under 1; U5 = Under 5; VHSG = Village Health Support Group			

Annex 3. Core Child Survival interventions in Cambodia, scorecard indicators and corresponding project components

Core Intervention	Scorecard Indicator	Siem Reap CS Project Component	Project Strategy Focus	C-IMCI Element
1. ORT for diarrhea	% of children with diarrhea in the last 2 weeks who received ORT	Community Management of the Sick Child	Promote ORT use in communities for improved diarrhea management	3
2. Six month exclusive BF; timely introduction of complementary foods	% of infants <6 months exclusively breastfed; % of breastfed infants 6-9 months receiving semi-solid foods	Nutrition and Breastfeeding	Improve six month exclusive BF and timely introduction of complementary foods	3
3. Antibiotics to treat pneumonia	% of children with fast or difficult breathing in the last 2 weeks who received medical care	Community Management of the Sick Child	Early identification and referral of children with fast or difficult breathing	1/3
4. Improve neonatal health	% of women who received at least two tetanus toxoid doses during pregnancy	Immunization	Improve neonatal attendance for improved tetanus toxoid vaccination	1/3
5. Vitamin A supplementation	% of children 6 to 59 months receiving one dose of Vit A in the past 6 months	Nutrition and Breastfeeding	Improve attendance for routine outreach for improved Vit. A supplementation	1/3
6. Increase routine immunizations	% of infants receiving dose of measles vaccine; % of children <1 receiving all immunizations*	Immunization	Improved attendance during routine outreach for improved routine vaccinations	1/3
7. Promote access to ITN	% of children who slept under an ITN last night	Immunization	Improve insecticide treated mosquito net ownership and use; improve access, availability and use of retreatment kits	2/3
8. Promote access to anti-malarials	% of children living in malarious areas with fever in the past 2 weeks who received antimalarials	Community Management of the Sick Child	Early identification and referral for fever	1/3
OTHER PROPOSED PROJECT INTERVENTIONS				
9. Iodized salt	% of HH using iodized salt	Nutrition & Breastfeeding		1/2
10. Build CRC capacity		Local Capacity Building		

Annex 4. Selected Villages

CLUSTER Nº	Administrative District	Health Center	Village	Population
1	Angkor Chum	Cha Chhouk	Prey Lvey	387
2	Angkor Chum	Angkor Chhum	Bay Math	234
3	Angkor Chum	Bath	Ro Kar	1369
4	Angkor Chum	Bath	Kok Chas	589
5	Angkor Chum	Nor Kor Pheas	Pong Ro	689
6	Angkor Chum	Nor Kor Pheas	Kauk They	1028
7	Angkor Chum	Kok Dong	Tum Leab	614
8	Angkor Chum	Kok Dong	Don Em	829
9	Pourk	Pourk	Prar Yuth	1174
10	Pourk	Don Keo	Peam	1288
11	Pourk	Don Keo	Prasat Chat	1313
12	Pourk	SamRong Year	Ampil	1127
13	Pourk	Keo Por (Kao Port)	Kok Russey	908
14	Pourk	Keo Por (Kao Port)	Svay Chek	645
15	Pourk	Pourk	Kom Rou	801
16	Pourk	Pourk (C. Lvea)	Steung Pra Srok	1160
17	Pourk	Pourk (C. Lvea)	Rokar	915
18	Pourk	Teuk Vill	Chey Mon	847
19	Pourk	Knart Commune	Svay Mon	608
20	Pourk	Knart Commune	Bueng Mon	827
21	Pourk	Reul	Pro Leuth	861
22	Pourk	Reul	Tro paing Tum	1101
23	Pourk	Sasar Sdam	Kauk Cheay	1565
24	Pourk	Sasar Sdam	Muk Pen	1147
25	Pourk	Sasar Sdam	Chong Thnat	1010
26	Varin	Svay Sar	Svay Sar	732
27	Varin	Varin	Rom Doul	556
28	Varin	Varin	Kok Srok	986
29	Varin	Varin	Lveau	1001
30	Varin	Varin	Prey Knol	977
31	Varin	Svay Sar	Ro Lorn	724
32	Varin	Varin	Kok Kandal	790

Annex 5. Survey Training Agenda

9 March 2005

Session	Topic	Time	Facilitator
1	Welcoming/self introduction	8:30-9:00am	Alice/Sana/Sarith
2	Project background	9:00-9:15am	Rob
3	Review learning objectives and review questionnaires	9:15-12:00pm	Alice/Sana/Sarith/Dr. Sopea
	Lunch	12:00-2:00pm	
4	Group practice and discussion using questionnaires	2:00-5:00pm	Alice/Sana/Sarith/Dr. Sopea

10 March 2005

Session	Topic	Time	Facilitator
1	Review of previous day/questions and answers	8.00-9:00am	Sarith
2	Group practice using questionnaires	9:00-11:00am	Alice/Sana/Sarith
3	Logistics/scheduling/team assignments	11:00-12:00pm	Alice/Sana/Sarith
	Lunch	12:00pm-2:00pm	
4	Group practice and discussion	2:00-5:00pm	Alice/Sana/Sarith

11 March 2005

Session	Topic	Time	Facilitator
1	Review of previous day/questions and answers	8.00-8:30pm	Sana/Sarith
2	Clarifications on data recording	8:30-10:00am	Alice/Sana
3	Weighing and measuring height of babies	10:00am-10:30am	Dr. Sopea
4	Iodine testing of salt	10:30am-11:00am	Dr. Sopea
5	Questions and Answers	11:00am-12:00pm	All
6	Practice using questionnaires	2:00pm-4:00pm	All
7	Supervisor Coordination Meeting, review of sampling methodology and random selection of households in the village	4:00pm-5:30pm	Alice

21 March 2005 Closing ceremony

Session	Topic	Time	Facilitator
1	Welcoming and congratulations	3:00-3:30pm	Alice
2	Sharing of experiences/lessons learned	3.30-4:00pm	Sana
3	Certificates of Participation	4:00pm-4:30pm	Branch Director, OD Director, AmCross Head of Delegation

Annex 6. Enumerator Training Plan

Learning Objectives:

- understand the survey
- learn how to ask the survey questions
- learn why & how to ask the survey questions consistently

1. Explain the purpose of the project and describe some of the work you are planning to do.

2. Distribute the survey form in the language in which you are going to do the survey, as well as the language of enumerator instruction. Make sure you have enough copies for everyone. You may also want to have additional copies for the practice sessions.

3. Read through (out loud or some other way) the survey form and make sure that everyone understands the questions and answers. Give yourself enough time for this, but not so much time that you are only reading through the form and not practicing how you ask and answer.

4. Note that there are different ways to answer the questions. Some questions have only one response. Others have many responses, or require a simple written response. Make sure everyone understands the instructions for each question.

5. Have the enumerators break out into pairs. Each pair asks the survey questions (or some selection of the survey questions) of each other. What were the problems, what questions seemed to need more explanations?

6. Bring the enumerators back into the group. Conduct a short analysis of the survey problems and questions. What gave everyone problems? Is there another way to phrase the questions? What should we tell the Red Cross Volunteers to help them ask these questions?

If there is time, continue onwards with steps 7, 8 and 9. Close with number ten and note the importance of this team time to review the process and make any consistent changes ONLY IF ABSOLUTELY NECESSARY.

7. Have the instructor ask questions from the survey from one person in the group (someone else notes the answer), then the instructor asks the same questions from the survey from another person in the group (someone else notes the answer on the same page as the first response). The responses should be the same (not the same answer, but the appropriate answer to each question).

8. Divide the enumerators into small groups, assign one person to ask questions (usually a selection of the survey questions) of each of two other people (out of earshot). Have two other enumerators note the questions that were different or the same, and provide feedback to the enumerator.

9. Bring back into a large group, and the observer pairs note the chief differences, and discuss how to correct the variation (less explanation, better introduction, etc.).

10. Each night of the survey, the enumerators should meet to discuss any unexpected problems or positive experiences.

10. The enumerator supervisor should monitor each enumerator at least once in a survey, preferably within the first few days and then during the last few days of the survey. The enumerator supervisor should note changes in the time it takes to administer the survey and also look at the survey responses to make sure that they are correctly written down based on what answers the respondent provided (if possible, to mark down the answers at the same time and then compare on the spot with the respondent immediately after the interview.).

Annex 7. Supervisor Responsibilities

1. label forms: a) cluster number (per the master list)
b) interview number (A for 0-11 months, B for 12-23 months)
c) total 11 for each cluster

2. label bags for salt collection:
a) date
b) cluster number
c) interview number
d) distribute with matching forms
e) collect and store at the end of the day

3. day supervision:
a) each team of two has five forms (mixed A and B; alternate quantities each day with team)
b) one supervisor goes with each team; supervisors switch teams every other day
c) supervisor team does one interview
d) teams with more supervisors can change daily goals for teams, up to five forms per supervisor team (and three each for interview team) to spell interview teams
e) supervisor may replace an interview member on a team in case of illness

4. house selection (for two teams):
a) start at opposite ends of the village
b) start on opposite sides of the street (their right side, facing the center of the village)
c) village population <1000, go to every third house
d) village population >1000, go to every fifth house
e) if houses are more than one deep on the side of the road, use a zigzag pattern to count, starting from the road side
f) if house in pattern does not have a child in either age group, go to the next house (do not skip 3-5 houses)
g) supervisors check answers, respond to questions & monitor questions

5. house selection (for three teams):
a) two teams start as per #4 above
b) third team starts from the approximate center of the village and crosses street to maintain pattern if doing three or fewer interviews
c) if third team is doing 4 or 5 interviews, this replaces one of the interview teams at the end of the village & the smaller group takes the center pattern.
d) supervisors check answers, respond to questions & monitor questions

6. night supervision:
a) collect forms
b) collect salt samples
c) review forms
d) meet with teams to go other any consistent errors or questions
e) record any questions/answers for lead supervisor resolution

f) note any new issues with completion of forms (twins, etc.)
g) set up next day's cluster schedule (and location, if teams are meeting there), ID forms and salt bags
h) check morale, workload and money business (per diems, cost of accommodation, etc.)
i) supervisors may authorize & disburse any additional gas allowance if required during the survey (otherwise, supervisors keep track of the odometer for reimbursement on closing
j) supervisors either radio in or phone to check in when possible; Varin team at 6:30, Pourk team at 7:00PM. If not possible, lead supervisor will physically check in with teams on alternating days.
k) lead supervisor checks in with delegation at 7:30PM as possible; drivers check in via Federation radio at 8AM and 5PM whenever possible.

Annex 8. 0-11 Month Old Survey Questionnaire

Cambodia Child Survival Project

Knowledge, Practices and Coverage (KPC) Survey

0 – 11 Month Olds

March 2005

INFORMED CONSENT

Hello. My name is _____, and I am working with Cambodian Red Cross. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help the Red Cross to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes about 1 to 1 1/2 hours to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

Are there children under 12 months old in the house? IF YES, THEN PROCEED

I would like to speak with the mother or the person who takes care of them. Is that you? IF YES, PROCEED.
IF NO, ASK TO SPEAK TO MOTHER OR CARETAKER

Do you want to ask me anything about the survey?

RESPONDENT AGREES TO BE INTERVIEWED 1

RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2
Note on form and go to the next designated house

CLUSTER # _____	**Health Center Name** _____
HOUSEHOLD # _____	**Village Name** _____
INTERVIEWER _____	
SUPERVISOR _____	***Interview date*** ___/___/05 ***dd/mm/yy***

I. IDENTIFYING INFORMATION			
NO.	**QUESTION**	**ANSWER……....CODE**	**INSTRUCTIONS**
ID1	Name of Mother		
ID2	Age of Mother	years	
ID3	How many children living in this household are under age five?		
ID4	How many of those children are your biological children?		
ID5	Can you please tell me the name(s), sex(es), date(s) of birth of youngest two children.	**CHILD #1** Name of youngest child less than **12 months** _____ Male……...1 Female……2 ____ / _____ / _____ Day Month Year **CHILD #2** Name of next oldest child **less than 24 months** _____ Male……...1 Female……2 ____ / _____ / _____ Day Month Year	**We want to talk about the child under 12 months in this survey, only**
ID5	What is the age of your next oldest child?	**years**	

II. BACKGROUND INFORMATION			
B1	What was the highest level of school you attended? **Ask how many years they attended school, and fill in the number; if more than seven years of schooling, write seven**		
B2	Who is the head of this household?	Self ……..……1 Husband …….2 Female relative …..…3 Other _____99	
B3	Do you work outside of the home to earn money? Anything else? **Circle all answers**	No……..…A Handicrafts……… … B Harvesting ……...… C Sell food …….……..D Shopkeeper/ Street Vendor…….…..E Household worker…. F Salaried worker …….G Other_____ __X	**If no, go to B4**
B4	If you leave **(NAME)** at home, who takes care of the child? Anything else? **Circle all answers**	Mother ……..…A Husband……. ….B Older children……C Other relatives …..…D Neighbors/ Friends……E Maid ……..F	

		Nursery school..……G Other _____ X	
B5	How many months in this year did your family eat only porridge and/or wild foods for their meals? **If none, record 0**	_____ months	

III.A. MATERNAL AND NEWBORN CARE			
MN1	How many times did you see someone for care during your pregnancy with (NAME)?	_____ times	
MN2	Before you gave birth to (NAME) did you receive an injection for tetanus in your arm?	Yes ……..…1 No……..…….….2 Don't know….....…..8	**If no or don't know, go to MN4**
MN3	How many times did you receive this injection?	Once…….……...…....1 Twice…….……...2 More than twice……...3 Don't know…….……..…8	
MN4	What are the symptoms during pregnancy indicating the need to seek health care? Anything else? **Circle all that apply. Write out any conditions for 'other'.**	Fever…….……...A Shortness of breath……..…B Bleeding…….……..……C Swelling of the body/ hands/face …….……D Other _____X Don't know……...…...Z	
MN5	Where is the first place you would go for care if you had these symptoms? **Circle one answer only**	Public Hospital……..…1 Health Center……..…...2 Traditional birth attendant……...6 Community health worker… ……..……....……..7 Private practitioner (any kind)……..... 8 Traditional healer.....9 Pharmacy …….…..... 10 Community distributor……..….11 Friend/ Relative……..….12 Other _____ 99	
MN6	Where did you give birth?	Home …….....1 Other home…….….....2 Public Hospital (NAME) _____3 Health Center (NAME) _____4 Private practitioner (NAME) _____5 Other _____99	

MN7	When you gave birth to (NAME) who assisted you with the delivery? **One answer only; if more than one person assisted in delivery, choose the most schooled**	Doctor …….....…1 Medical assistant……..…2 Nurse……....……..……3 Midwife……...…4 Traditional birth attendant……..…….. 5 Community health worker……...……..6 Family member……..…. 7 No one ……..…...8 Other _____99	

IV.A. BREASTFEEDING AND INFANT/CHILD NUTRITION			
NU1	Are you currently breastfeeding (NAME)?	Yes …….....……1 No ……....….……2	**If yes, go to NU3**
NU2	Did you ever breastfeed (NAME)?	Yes……...…….1 No ……....…….2	**If no, go to NU8**
NU3	How long after birth did you first put (NAME) to the breast?	Immediately/ Within first hour after delivery……...1 After the first hour…. 2 Before the end of the first day …….3 Other _____99	
NU4	During the first three days after delivery did you give (NAME) the liquid that came from your breasts?	Yes……...…….1 No……..…2Don't know……..…….....8	
NU5	During the first three days after delivery, did you give (NAME) anything else to eat or drink before feeding him/her breastmilk?	Yes …….....…1 No ……....……2 Don't know…...……..….8	**If no or don't know, go to NU7**
NU6	What did you give (NAME)? Anything else? **Circle all answers**	Powder Milk ……....A Plain water……...…….…B Sugar water…….……C Sugar-salt-water solution…….....D Fruit juice ……..……...E Infant formula……...…F Tea……..……..…G Traditional Herb……...H Honey…….....…....I Sweetened condensed milk	

		like Alaska…….J Other _____X	
NU7	For how long did you exclusively breastfeed (NAME)?	_____months	
NU8	Did (NAME) drink any of the following liquids yesterday during the day or at night? **Circle all answers**	Breastmilk? ...……A Plain water? ...……B Commercially prepared infant formula? ……..…C Any other milk – tinned, powered, or fresh animal milk?.……..… D Fruit juice?…….……..…E Any other liquid such as sugar water, tea, coffee, carbonated drinks, or soup broth? ……...……...F	
NU9	Now I would like to ask you about the types of foods (NAME) ate yesterday during the day and at night. Anything else? **Read the answers to the mother.** **Circle all answers.**	Any foods made from grains such as rice, porridge, corn, wheat or other local grain? …….G Pumpkin, carrots, yellow or red sweet potatoes?..... .H Any other food made from roots or tubers, e.g. white potatoes, white yams, or other? ….....I Any green leafy vegetables? …….. J Mango, papaya, orange, pumpkin, palm fruit ? .…K Any other fruits and vegetables, e.g. bananas, apples/sauce, tomatoes? …….….L Meat, poultry, fish, shellfish or eggs?…….M Any foods made from legumes [e.g. lentils, beans, soybeans, pulses, or peanuts]? …….…..……..N Any food made with oil, fat, or butter?……..... P Other _____ O No solid foods …….X	**If no solid foods, go to NU11**
NU10	How many times did <NAME> eat semi-solid (mashed or pureed) food		

	yesterday during the day or at night? **IF 7 OR MORE TIMES, RECORD '7'. DON'T KNOW = 8**		
NU11	May I take a sample of the salt that is used for cooking? Ask the Mother to put about a half teaspoon of salt in the plastic bag. Label clearly and completely with Interview number, Cluster Number, and Name of Village or Town. Store in a safe place and give to the survey supervisor at the end of the day.	Yes …...…….1 No (refused)…….…….....2	

V. IMMUNIZATIONS / CHILDHOOD ILLNESS			
IM1	Did <NAME> take a vitamin A dose like this during the last 6 months? **Show Capsule**	Yes……. .1 No……..…2 Don't Know ……..8	
IM2	Do you have a card where <NAME's> vaccinations are written down? May I see it please?	Yes, seen by interviewer...1 Not available/ lost/ misplaced ……...…..2 Never had a card …….....3 Don't know ……...…...8	
IM3	Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatments? **Read the answers to the mother.** **Circle all answers.** **Write out any 'other' responses on this form.**	Don't Know …….A Looks unwell or not playing normally……...B Not eating or drinking……... ….C Lethargic or difficult to wake ……..…….....D High fever ……E Fast or rapid breathing ….F Vomits everything ……...G Convulsions …….H Diarrhea ……I Other _____ _ J Other _____ K	
VI. DIARRHEA CASE MANAGEMENT			
DC1	Has (NAME) had diarrhea in the last 2 weeks?	Yes……...…… ….1 No…….	**If no or don't know, go to the next section AR1**

		….2Don't Know ……..8	
DC2	What was given to treat the diarrhea? Anything else? **Circle all answers.** **Write out the 'other' response.**	Nothing ……A Fluid from ORS packet ……. B Home-made Fluid …....C Pill or Syrup ..…..…... D Injection ….……..E IV ……..…….…….. F Home remedies/herbal medicines …….G Other _____ ____ _X	
DC3	When <NAME> had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more than usual?	Less ……...……1 Same……..... .2 More……..…... .3 Child not Breastfed …...4 Don't Know ……..…8	
DC4	When <NAME> had diarrhea was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	Child Not Yet Drinking …….. .1 Less……...…… 2 Same…….…… .3 More……..... …4 Nothing to Drink ……..5 Don't Know ……8	
DC5	When <NAME> had diarrhea was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	Child Not Yet Eating …….. .1 Less……...…… 2	

		Same…….…… .3 More……..... …4 Nothing to Drink ……..5 Don't Know …….8	
DC6	During the period when <NAME> was recovering from diarrhea, did you give him/her less than usual to drink, about the same amount, or more than usual to drink (includes breast milk)?	Less…… …1 Same…….. …2 More ..…….….….3 Nothing to Drink ....…..4 Don't Know ….……8	
DC7	During the period when <NAME> was recovering from diarrhea, did you give him/her less than usual to eat, about the same amount, or more than usual to eat ?	Not Eating Yet …….1 Less…… …2 Same…..…….….. .3 More…….. …4 Nothing to Eat ……..5 Don't know ….……..8	
DC8	Did you seek advice or treatment from someone outside of the home for (NAME's) diarrhea?	Yes ..……..1 No...…….…..2 Don't know……8	**If no or don't know, go to next section AR1**
DC9	Where did you <u>first</u> go for advice or treatment? **Circle only one answer.** **If 1,2,3, or 4 (Hospital, Health Center or Private Hospital, Clinic, or Practitioner)……** **Write that name here:** _____	Hospital ……1 Health Center …..……..2 Private Hospital/Clinic ……..……..…..... …3 Private Practitioner .....4 Village Health Worker/TBA/VHC…... .5 Traditional Healer	

		...….6 Market …….7 Pharmacy...……..... .8 Community Distributors …….. .9 Friend/Relative ……...10 Other _____ 88	
DC10	Why was (NAME) taken to this (PROVIDER)? Anything else? **Circle all answers.**	Cost less money ……..A Can pay on time …….…..B Practitioner known …….C Practitioner trusted …..…D Closest distance……..… E Other _____X	
DC11	Who decided that you should go there for (NAME's) illness? Anything else? **Circle all answers.**	Mother (of child) ……..…A Husband ……..…B Mother of mother …….C Mother-in-law ……..…D Friend/Neighbors ……E Others _____Z	
DC12	How was the child taken there?	Walk……. …1 Own transportation… …..2 Motor taxi…… …3 Friend…… …4 Car taxi	

		…….5 Other _____ ____96	
DC13	How much did it cost for transportation?		
DC14	Did you/they have to pay for the consultation and treatment?	Yes……...…… ….1 No…….. …2	**If no, go to DC16**
DC15	How much did you have to pay (what was the amount they asked for)?		
DC16	After the health provider saw the child did s/he ask you to bring the child back for a check in a few days?	Yes……...…… ….1 No…….. …2	**If no, got to DC20**
DC17	Did you take <NAME> back to the same heath care provider?	Yes……...…… ….1 No…….. …2	**If yes, go to DC19**
DC18	If not, why? **Write down the answers**	_____ _____ __	
DC19	When did you take the child back to the health care provider?	Same day……..1 One days …….2 Two days ……3 Three day …… 4 Other_____ __5	
DC20	Where else did you go for advice or treatment? Anything else? **Circle all answers.** **If A, B, C, or D (Hospital, Health Center or Private Hospital, Clinic, or**	Hospital….……...… A Health Center ……...B Private Hospital/Clinic ..…… C Private Practitioner	

	Practitioner)…… **Write name** _____ _____	…..D Village Health Worker/TBA/VHC/VHV…… …..E Traditional Healer ……F Market ……..……...G Pharmacy ….……H Community Distributors ……..……. .I Friend/Relative …… J No where else ……..K Other_____Z	
DC21	Did you consult with the VHV, VHC, TBA or Key Mother?	Yes…… ....1 No …….2	**If no, go to AR1**
DC22	What did they do? Anything else? **Circle all answers .**	Nothing ……...….A Refer…….B Health Education ….....C Gave Treatment …..….D Follow up …….E Other _____X	
VII. ACUTE RESPIRATORY INFECTIONS (ARI)			
AR1	Has <NAME> had an illness with a cough at any time in the last two weeks?	Yes……...…… ….1 No……. ….2 Don't Know …….8	**If no or don't know, go to MA1**
AR2	When <NAME> had an illness with a cough, did he/she have trouble breathing or breathe faster than usual with short, fast breaths?	Yes……...… ….1 No……. ….2	**If no or don't know, go to MA1**

		Don't Know …….8	
AR3	Did you seek advice or treatment for the cough/fast breathing?	Yes……...…… ….1 No……. ….2	**If no, go to MA1**
AR4	How long after you noticed <NAME's> cough and fast breathing did you seek advice/treatment? **Circle only one answer**	Same Day ……...……..0 Next Day ….……1 Two Days ……2 Three or more days …..3	
AR5	Where did you first go for advice or treatment? **Circle only one answer** **If 1,2,3, or 4 (Hospital, Health Center or Private Hospital, Clinic, or Practitioner)……** **Write the Name** _____	Hospital …...……..1 Health Center…..……...2 Private Hospital/Clinic ……..…… .3 Private Practitioner …...4 Village Health Worker/TBA/VHC ..….5 Traditional Healer ...…6 Market ...……...……7 Pharmacy…….. .8 Community Distributors …….…. 9 Friend/Relative ...……10 Other _____ 88	
AR6	Why was <NAME> taken to this <PROVIDER>? Anything else? **Circle all answers.**	Cost less money ……..A Can pay on time ……..B Practitioner known ……..C Practitioner trusted	

		……..D Closest distance ……E Other _____X	
AR7	Who decided that you should go there for <NAME's> illness? Anything else? **Circle all answers.**	Mother (self)……A Husband ……..B Mother of mother ……C Mother-in-law ……..…D Friend/Neighbors …….E Others _____Z	
AR8	How was the child taken there?	Walk ……1 Own transportation ……..2 Motor taxi ….……...3 Friend ……..4 Car taxi …….5 Other _____ 96	
AR9	How much did it cost for transportation?		
AR10	Did you/they have to pay for the consultation and treatment?	Yes……...……1 No……..…2	**If no, go to AR12**
AR11	How much did you have to pay?		
AR12	After the health provider saw the child did s/he ask you to bring the child back for a check in a few days?	Yes……...……1 No……..…2	**If no, go to AR16**
AR13	Did you take <NAME> back to the same health care provider?	Yes……...……1 No……..…2	**If yes, go to AR15**

AR14	If not, why?	_____ __	
AR15	When did you take the child back?	Same day ……..1 One days ……..….2 Two days ….…….3 Three day ……4 Other _____ _ _____5	
AR16	Where else did you go for advice or treatment? Anything else? **If A, B, C, or D (Hospital, Health Center or Private Hospital, Clinic, or Practitioner)……** **Write the Name** _____	Hospital …...……A Health Center …….....…B Private Hospital/Clinic ……..…… …C Private Practitioner ……..D Village Health Worker/TBA/VHC/VHV…… ……..…E Traditional Healer **…**……F Market …….G Pharmacy …….……H Community Distributors …… …I Friend/Relative ….....…. .J No where else ……..……K Other _____ Z	
AR17	Did you consult with the VHV, VHC, TBA or Key Mother?	Yes……...…… ….1 No…….. …2	

AR18	What did they do? Anything else? **Circle all answers.**	Nothing …...……A Refer……..……B Health Education …….C Gave Treatment ……...D Follow up ……E Other _____X	
AR19	Which medicines were given to <NAME>? Anything else? **Circle all answers.**	Nothing……...……. A Tablets – Do not know the name of medicine. ….……..…….. B Aspirin …..….…….C Paracetamol …..….…D Cotrimoxazole ……E Amoxycillin/Ampicillin……. ……F Liquid – do not know the name of the medicine…….. G Injection – Do not know name of medicine ……H Other _____ X Don't Know……Z	
VIII. MALARIA			
MA1	Has <NAME> been ill with fever in the last two weeks?	Yes……...…… ….1 No……. ….2Don't Know……..8	**If no or don't know, go to MA22**
MA2	Did you seek advice or treatment for <NAME'S> fever?	Yes……...…… ….1 No……..	**If no, go to MA22**

		…2	
MA3	*Where did you first go for advice or treatment?* **Circle only one answer.** **If 1, 2, 3, or 4 (Hospital, Health Center or Private Hospital, Clinic, or Practitioner)……** **Write the Name** _____	Hospital ……..……..1 Health Center ……....…2 Private Hospital/Clinic …...……..…...…… …..3 Private Practitioner ….....4 Village Health Worker/TBA/VHC **…...**…5 Traditional Healer ……6 Market …….……7 Pharmacy ..……8 Community Distributors …….……. ….9 Friend/Relative …….…..10 Other _____ 88	
MA4	How long after you noticed <NAME's> fever did you seek treatment from that person or place?	Same day……..0 One day ...…….1 Two days ……..……2 Three days ……...… 3	
MA5	Why was <NAME> taken to this <PROVIDER>? Anything else? **Circle all answers.**	Cost less money ……..A Can pay on time ……..B Practitioner known ……..C Practitioner trusted ……..D Closest distance ……E Other _____X	

MA6	Who decided that you should go there for <NAME's> illness? Anything else? **Circle all answers.**	Mother ……A Husband ……..B Mother of mother ……C Mother-in-law ……..…D Friend/Neighbors …….E Others _____Z	
MA7	How was the child taken there?	Walk ……1 Own transportation ……..2 Motor taxi ….……...3 Friend ……..4 Car taxi …….5 Other _____ 96	
MA8	How much did it cost for transportation?		
MA9	Did you/they have to pay for the consultation and treatment?	Yes……...……1 No……..…2	**If no, go to MA11**
MA10	How much did you have to pay?		
MA11	After the health provider saw the child did s/he ask you to bring the child back for a check in a few days?	Yes……...……1 No……..…2	**If no, go to MA15**
MA12	Did you take <CHILD> back to the same health care provider?	Yes……...……1 No……..…2	**If yes, go to MA14**
MA13	If not, why?	_____	**Go to MA15**

		__	
MA14	When did you take the child back?	Same day ……..1 One days ……..….2 Two days ….…….3 Three day ……4 Other _____ __ _____5	
MA15	Where else did you go for advice or treatment? Anything else? **Circle all answers.** **If A, B, C, or D (Hospital, Health Center or Private Hospital, Clinic, or Practitioner)……** **Write the Name** _____	Hospital …...……A Health Center …….....…B Private Hospital/Clinic ……..…C Private Practitioner ……..D Village Health Worker/TBA/VHC/VHV…….. ……E Traditional Healer ……F Market …….G Pharmacy ……..…H Community Distributors ……... ……I Friend/Relative ….....…. .J Nowhere else ……...…K Other _____ Z	
MA16	Did you consult with the VHV, VHC, TBA or Key Mother?	Yes……... ….1 No…….. …2	**If no, skip MA17**
MA17	What did they do?	Nothing …...…….A	

	Anything else? **Circle all answers.**	Refer……..…… B Health Education …….C Gave Treatment ……...D Follow up ……..…E Other _____X	
Attention! Read and follow below: ***If <NAME> was ever taken to a Hospital or Health Center → MA18*** **If <NAME> was *not* ever taken to a Hospital or Health Center → MA19**			
MA18	Was <NAME> treated with any medicine(s) before going to the Hospital or Health Center?	Yes……... ….1 No…….. …2 Don't Know ……..……8	**If no or don't know, go to MA22**
MA19	Was <NAME> treated with any medicines by you?	Yes……... ….1 No…….. …2 Don't Know ……..……8	**If yes, go to MA20. If no or don't know, go to MA22.**
MA20	Which medicines were given to <NAME> for his/her fever? **If mother cannot remember the names of the medicine, ask to see the medicine. If she does not have the medicine, show her the pictures of the medicine and ask her to identify them.** **Circle the letter next to the name of the medicine below once you have identified it.** **For each medicine checked ask:**		

	How long after the fever did <NAME> begin to take the medicine? **Circle the answer.**		
A	CHLOROQUINE	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
B	FANSIDAR	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
C	MEFLOQUINE	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
D	RECTOCAP SUPPOSITORY	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	

E	A+M2 (ENFANT)	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
F	A+M3 (ADOLESCENT)	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
G	A+M4 (ADULT)	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
H	QUININE	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
I	TETRACYCLINE	Same Day (Day 0)……..…0 Day 1…….1	

		Day 2 ……2 Day 3 + …….3 Don't know ……..8	
J	ARTESUNATE	Same Day (Day 0)……..…0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
MA21	**OTHER MEDICINES GIVEN.** **Circle all answers.**	Aspirin……...….. .A Paracetamol…….. B Co-Trimoxazole…..……..C Ampicillin/ Amoxillicin...D Other _____ E Unknown Medicine……...F	
MA22	Were any of these injections?	Yes……...…… ….1 No…….. …2 Don't Know ……..……8	
MA23	What causes malaria? Anything else? **Circle all answers, and write down any 'other' responses.**	Mosquito Bites ……A Witchcraft…… ….B Intravenous drug use ...…C Blood transfusions …...…D	

		Injections……..……E Sharing Razor Blades…....F Kissing ……...….G Other _____ W Other _____X Don't Know ……..……Z	
IX. MOSQUITO BEDNET USE AND MAINTENANCE			
BE1	Do you have any bednets in your house?	Yes……... ….1 No…….. …2 Don't Know ……..……8	**If no or don't know, go to HC1**
BE2	May I see the bednet? **Observe if bednet is hung over the bed and circle the answer.**	Hung over bed……...1 Not hung……2	
BE3	Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or insects?	Yes……...…. ….1 No…….. …2 Don't Know ……..……8	**If no or don't know, go to BE5**
BE4	**Inspect bednet for holes or tears.**	No obvious holes/tears = Good Condition ……..…1 Any visible holes/tears = Damaged ……..…2	
BE5	How long ago was the bednet last soaked or dipped? **Record answer in months** **Less than 1 month = 00** **Don't know = 99**	_____ months	

BE6	Have you or someone else in your house ever washed the bed net? **Record the number of times.** **None = 00** **Don't know = 99**	_____ times	**If none, go to BE8**
BE7	How often do you wash your bednet?	Once a week…….1 Once a month……2 Less than once a month.…3	
BE8	How long have you had your bednet? **Write down the number of months**	_____	
BE9	Who slept under the treated bednet last night? **Circle all answers.**	Child <NAME> (the one chosen for the interview)……..... …A Mother ….…..……...…B Husband ...……C Other_____ X	
X. Health Contacts and Sources of Information			
HC1	During the last month, how often have you come in contact with each of the following? **Read each response separately. Circle the letter of the response, and then circle the answer**		
A	Doctor (Public)	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
B	Medical Assistant (Public)	Never:0 times…...……1 Sometimes:1-3 times…...2	

		Frequent: 4+ times……...3	
C	Nurse (Public)	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
D	Midwife (Public)	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
E	Community Health Worker	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
F	Traditional Birth Attendant	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
G	Private Practitioner	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
H	Traditional Healer	Never:0 times…...……1 Sometimes:1-3 times…...2 Frequent: 4+ times……...3	
HC2	Who do you usually get general information or advice from on health and nutrition? **Circle all answers.**	No one …….....A Doctor(Public) ..……..…B Medical Assistant (Public) ……..……C Nurse (Public) …….……D	

		Midwife (Public) ……..…E Traditional Birth Attendant …….…… ….F Village Health Volunteer …….……..… …G Village Health Committee Member…… …H Key Mother ……...I Private practitioner …...…J Husband…… …K Mother/Mother- in-law …L Sister ……...……M Grandparent……..…… …N Aunt ……O Friend/ Neighbor ……..P Traditional Healer …...…Q Village Elder…….R Other_____ __X	
HC3	In the past month, have you received any health messages from the following? **Read each answer** **Circle all answers**	Radio…… A Newspaper…… …B Television……. C Village Health Volunteer.D Village Health	

		Committee Member……E Traditional Birth Attendant……..F Key Mother……..G	
XI. Anthropometry			
AN1	May I weigh and measure <NAME>?	Yes……...…1 No……..…2	**If no, go to the end of the survey.**
AN2	**Weigh the Child and Record Weight Below. Record to the nearest Tenth.**	_____ . _____ Kilograms	
AN3	**Measure the child and record height here**	_____ . _____ centimeters	
AN4	**Check edema with pitting.**	Yes……...…1 No……..…2	

END OF SURVEY

Thank you for taking part in this survey. This will help us begin our work of improving child health in this area.

Annex 9. 12-23 Month Old Survey Questionnaire

Cambodia Child Survival Project

Knowledge, Practices and Coverage (KPC) Survey

12 – 23 Month Olds

March 2005

INFORMED CONSENT

Hello. My name is _____, and I am working with Cambodian Red Cross. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help the Red Cross to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes about 1 to 1 1/2 hours to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important. At this time, do you want to ask me anything about the survey?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED 1	RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 Note on form and go to the next designated house.
CLUSTER # _____ **HOUSEHOLD #** _____ **INTERVIEWER #** _____ **SUPERVISOR** _____	**Health Center Name** _____ **Village Name** _____ ***Interview date*** ___/___/05 ***dd/mm/yy***

ID# _____

I. IDENTIFYING INFORMATION			
What are the ages of your children? **(All questions are to be addressed to mothers with a child less than 24 months of age.)**			
NO.	**QUESTION**	**ANSWER…….CODE**	**SKIP**
ID1	Name of Mother	_____	
ID2	Age of Mother	years	
ID3	How many children living in this household are under age five?		
ID4	How many of those children are your biological children?		
ID5	Can you please tell me the name(s), sex(es), date(s) of birth of youngest two children.	#1 Name of youngest child less than 24 months _____ – Male…….. .1 Female…… …2 ____ / _____ / _____ Day Month Year #2 Name of next oldest child less than 24 months _____ – Male…….. .1 Female…… …2 ____ / _____ / _____ Day Month Year	**Remember that you want to talk about the child between 12-23 months old in this survey only.**
ID6	What is the age of your next oldest child?	years	

II. BACKGROUND INFORMATION AND CHILD NUTRITION			
B1	What was the highest level of school you attended? **Ask how many years they attended school and fill in the number: if more than seven years of schooling, write seven**		
B2	Who is the head of this household?	Mother (self) …..……1 Husband …….2 Female relative …..…3 Other _____99	
B3	Do you work outside of the home to earn money? Anything else? **Circle all answers.**	No……..…A Handicrafts…… B Harvesting ……..… C Sell food …….……..D Shopkeeper/ Street Vendor…….…..E Household worker…. F Salaried worker…….G Other_____X	**If no, go to B4**
B4	Who takes care of **(NAME)** when you are away from home? Anything else? **Circle all answers.**	Mother……...…A Husband…….B Older children……C Other relatives …..…D Neighbors/ Friends....E Maid ……..F Nursery school..……G	
B5	How many months in this year did your family eat only porridge and/or wild foods for their meals? **If none, record 0**	_____ months	
NU9	Now I would like to ask you about the types of foods (NAME) ate yesterday during the day and at night. Anything else? **Read the answers to the mother.** **Circle all answers.**	Any foods made from grains such as rice, porridge, corn, wheat or other local grain? …….. G Pumpkin, carrots, yellow or red sweet potatoes?..... .H Any other food made	

		from roots or tubers, e.g. white potatoes, white yams, or other? …….....I Any green leafy vegetables? ……..J Mango, papaya, orange, pumpkin, palm fruit ? ……..……K Any other fruits and vegetables, e.g. bananas, apples/sauce, tomatoes? …….….L Meat, poultry, fish, shellfish or eggs?…….M Any foods made from legumes [e.g. lentils, beans, soybeans, pulses, or peanuts]? …….…..……..N Any food made with oil, fat, or butter?……..... P Other _____ O	
NU10	How many times did <NAME> eat semi-solid (mashed or pureed) food yesterday during the day or at night? **IF 7 OR MORE TIMES, RECORD '7'. DON'T KNOW = 8**		
NU11	May I take a sample of the salt that is used for cooking? Ask the Mother to put about a half teaspoon of salt in the plastic bag. Label clearly and completely with Interview number, Cluster Number, and Name of Village or Town. Store in a safe place and give to the survey supervisor at the end of the day.	Yes …...…….1 No (refused)…….……..... 2	

III.B. HOUSEHOLD WATER AND SANITATION			
WS1	What is the **main source** of drinking water for members of your household? Anything else? **Circle all answers.**	Open well in dwelling/Yard/Plot …..A Open public well …….B Protected well in dwelling /Yard/Plot ….C Protected public well …D Pumping well in dwelling/Yard/Plot …...E Pumping public well …F Spring/ River/ Stream ...G Pond/ Lake/ Dam ……H Rain water ……..I Other _____X	
WS2	Do you get your drinking water from this source throughout the year?	Yes…….1 No……..…2 Don't Know ……..8	
WS3	What kind of toilet facility do <u>most</u> members of your household use? **Circle only one answer.**	Water seal latrine ……..1 Traditional pit toilet …..2 Ventilated improved pit (VIP) latrine ……..3 No facility/ Bush/ Field ……...……4 Other _____ 96	**If 4 or 96, go to WS5**
WS4	Do you share this facility with other households?	Yes…….1 No……..…2	
WS5	What happens with the stools of babies and young children in your household who do not use the toilet facility? Anything else? **Circle all answers.**	Thrown in toilet/ Latrine……...…… A Buried in yard ……..B Not disposed of/ Left on the ground …….…….C Other _____ _____X	
WS6	What do you do with your garbage? Anything else? **Circle all answers.**	Open pit ……..…A Closed pit ……...B Anywhere ……..C	

		Burning …….….D Other _____X	
WS7	When do you wash your hands? Anything else? **Circle all answers.**	Never …….…….A Before prepare food …..B After defecation ……C After attending to a child who has defecated ……D Others _____ X	
WS8	Do you use soap? **Ask to see the soap, if you don't see it, this answer should be no (even if they say yes).**	Yes…….1 No……..…2	
IV.B. HIV/AIDS QUESTIONS			
HV1	Have you ever heard of an illness called AIDS?	Yes…….1 No……..…2	**If no, go to IM1**
HV2	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	Yes…….1 No……..…2 Don't Know ……..8	**If no or don't know, go to IM1**
HV3	What can a person do to avoid getting AIDS or the virus that causes AIDS? Anything else? **Circle all answers.**	Nothing ……...A Abstain from sex …...B Use condoms ……..C Limit sex to one partner/stay faithful to one partner …….D Limit number of sexual partners.…….…E Avoid sex with prostitutes ….....….…F Avoid sex with persons who have many partner ……..G Avoid intercourse with persons of the same sex…….……H Avoid sex with persons who inject drugs intravenously ……I Avoid blood transfusions…….J	

		Avoid kissing ……...K Avoid mosquito bites ...L See protection from a Traditional Healer …...M Avoid sharing razors, razor blades ……N Other _____ W Other _____ X Don't know ……..……Z	
V. CHILDHOOD IMMUNIZATION/CHILDHOOD SICKNESS			
IM1	Did **(NAME)** take a vitamin A dose like this during the last 6 months? **(Show Capsule)**	Yes……1 No……..…2 Don't Know ……..8	
IM2	Do you have a card where **(NAME's)** vaccinations are written down? **<u>May I see it please</u>?**	Yes, seen by interviewer……..……1 Not available/ lost/ misplaced ……..2 Never had a card ……...3 Don't know ……...8	**If not available, lost, never had it or don't know, go to IM5**
IM3	**Copy vaccination date for each Vaccine from the card.** **Write 44 in day column if card shows that a vaccination was given but no date is recorded.**		
A	BCG	__ __/_____/_____ Day/Month/Year	
B	Polio 0 (Given at birth) (P0)	__ __/_____/_____ Day/Month/Year	
C	Polio 1 (P1)	__ __/_____/_____ Day/Month/Year	
D	Polio 2 (P2)	__ __/_____/_____ Day/Month/Year	
E	Polio 3 (P3)	__ __/_____/_____ Day/Month/Year	
F	DPT 1 (DTC1)	__ __/_____/_____ Day/Month/Year	
G	DPT 2 (DTC2)	__ __/_____/_____ Day/Month/Year	
H	DPT 3 (DTC3)	__ __/_____/_____ Day/Month/Year	
I	Measles	__ __/_____/_____ Day/Month/Year	

J	Vitamin A (Most recent)	__/_____/_____ Day/Month/Year	
K	Mebendazole	__/_____/_____ Day/Month/Year	
IM4	Has (NAME) received any vaccinations that are not recorded on this card, including vaccines received in a National Immunization Day campaign?	Yes…….1 No……..…2 Don't Know ……8	**If no or don't know, go to IM6**
IM5	**Please tell me if (NAME) received any of the following vaccinations?**		
A	BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar.	Yes…….1 No……..…2 Don't Know ……..8	
B	Polio vaccine, that is, drops in the mouth?	Yes…….1 No……..…2 Don't Know ……..8	**If no or don't know, go to IM5E**
C	When was the first polio vaccine received, just after birth or later?	Just after birth ...…….1 Later ..……..…2 Don't Know ……8	
D	How many times was the polio vaccine received? **Write down the number.**		
E	**DPT** vaccination, that is, an injection given in the right upper arm sometimes at the same time as polio drops?	Yes…….1 No……..…2 Don't Know ……..8	
F	An injection to prevent measles?	Yes…….1 No……..…2 Don't Know ……..8	
IM6	Did the **(NAME)** ever receive Mebendazole tablet to treat worms?	Yes…….1 No……..…2 Don't Know ……..8	
IM7	Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatments? **Read the answers to the mother.** **Circle all answers.** **Write out any 'other' answers on this form.**	Don't Know …….A Looks unwell or not playing normally……...B Not eating or drinking…….C Lethargic or difficult to wake ……...…….....D High fever ……E Fast or rapid breathing	

		……..……F Vomits everything …...G Convulsions ……H Diarrhea________I Other _____ _____ J Other _____ __K	
VI. DIARRHEA CASE MANAGEMENT			
DC1	Has (NAME) had diarrhea in the last 2 weeks?	Yes……1 No…….....…2 Don't Know ……..8	**If no or don't know, go to AR1**
DC2	What was given to treat the diarrhea? **Circle all answers.**	Nothing ……A Fluid from ORS packet …….….B Home-made Fluid …....C Pill or Syrup ..…..….... D Injection ….……..E IV ……..…….……..F Home remedies/herbal medicines …….G Other _____ ____ _ _X	
DC3	When (NAME) had diarrhea, did you breastfeed him/her less than usual, about the same amount, or more than usual?	Less ……...……1 Same…….....2 More……..…....3 Child not Breastfed …...4 Don't Know ……..…8	
DC4	When (NAME) had diarrhea was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	Child Not Yet Drinking ……...1 Less……...……2 Same…….…….3 More…….....…4 Nothing to Drink ……..5 Don't Know ……8	
DC5	When (NAME) had diarrhea was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	Child Not Yet Eating ……...1 Less……...……2 Same…….…….3 More…….....…4 Nothing to Drink ……..5	

		Don't Know …….8	
DC6	During the period when (NAME) was recovering from diarrhea, did you give him/her less than usual to drink, about the same amount, or more than usual to drink (includes breast milk)?	Less……1 Same……..…2 More ..…….….….3 Nothing to Drink ....…..4 Don't Know ….……8	
DC7	During the period when (NAME) was recovering from diarrhea, did you give him/her less than usual to eat, about the same amount, or more than usual to eat ?	Not Eating Yet …….1 Less……2 Same…..…….…...3 More……..…4 Nothing to Eat ……..5 Don't know ….……..8	
DC8	Did you seek advice or treatment from someone outside of the home for (NAME's) diarrhea?	Yes ..……..1 No...…….…..2	**If no, go to AR1**
DC9	Where did you **first** go for advice or treatment? **Circle only one answer.** **If Hospital, Health Center or Private Hospital, Clinic, or Practitioner** **Write that name here:**_____	Hospital ……1 Health Center …..……..2 Private Hospital/Clinic ……...……..….....…3 Private Practitioner .....4 Village Health Worker/TBA/VHC…....5 Traditional Healer ...….6 Market …….7 Pharmacy...…….....8 Community Distributors ……...9 Friend/Relative ……...10 Other _____88	
DC10	Why was (NAME) taken to this (PROVIDER)? Anything else? **Circle all answers.**	Cost less money ……..A Can pay on time …….…..B Practitioner known …….C Practitioner trusted …..…D Closest distance……...… E Other _____X	

DC11	Who decided that you should go there for (NAME's) illness? **Circle all answers.**	Mother ……..…A Husband ……..…B Mother of mother …….C Mother-in-law ……..…D Friend/Neighbors ……E Others _____Z	
DC12	How was the child taken there?	Walk…… …1 Own transportation……..2 Motor taxi……3 Friend……4 Car taxi …….5 Other _____ __ ____96	
DC13	How much did it cost for transportation?_____		
DC14	Did you/they have to pay for the consultation and treatment?	Yes……... .1 No …….2	**If no, go to DC16**
DC15	How much did you have to pay?		
DC16	After the health provider saw the child did s/he ask you to bring the child back for a check in a few days?	Yes……... .1 No …….2	**If no, go to DC20**
DC17	Did you take <NAME> back to the same heath care provider?	Yes……... .1 No …….2	**If yes, go to DC19**
DC18	If Not -Why_____ **Write down the answers.**		**Go to DC20**
DC19	When did you take the child back?	Same day……..1 One days …….2 Two days ……3 Three day …… 4 Other_____	

		5	
DC20	Where else did you go for advice or treatment? Anything else? **If Hospital, Health Center or Private Hospital, Clinic, or Practitioner** **Write the Name**_____	Hospital……...…A Health Center ……...B Private Hospital/Clinic ..……C Private Practitioner …..D Village Health Worker/TBA/VHC/VHV ……..E Traditional Healer ……F Market ……...G Pharmacy ….……H Community Distributors …….……..I Friend/Relative …… J No where else ……..K Other_____ ___Z	
DC21	Did you consult with the VHV, VHC, TBA or Key Mother?	Yes……... .1 No …….2	**If no, go to AR1**
DC22	What did they do? Anything else? **Circle all answers.**	Nothing ……...….A Refer…….B Health Education …....C Gave Treatment …..….D Follow up …….E Other _____ _X	
VII. ACUTE RESPIRATORY INFECTIONS (ARI)			
AR1	Has <NAME> had an illness with a cough at any time in the last two weeks?	Yes…….1 No……..…2 Don't Know …….8	**If no or don't know, go to MA1**
AR2	When <NAME> had an illness with a cough, did he/she have trouble breathing or breathe faster than usual with short, fast breaths?	Yes…….1 No……..…2 Don't Know …….8	**If no or don't know, go to MA1**
AR3	Did you seek advice or treatment for the cough/fast breathing?	Yes…….1 No……..…2	**If no, go to MA1**
AR4	How long after you noticed (NAME's) cough and fast breathing did you seek advice/treatment? **Circle only one answer.**	Same Day ……...……..0 Next Day ….……1 Two Days ……2 Three or more days …..3	

AR5	Where did you **first** go for advice or treatment? **Circle only one answer.** **If Hospital, Health Center or Private Hospital, Clinic, or Practitioner** **Write the Name** _____	Hospital …..……..1 Health Center…..……...2 Private Hospital/Clinic ……..…….3 Private Practitioner …...4 Village Health Worker/TBA/VHC ..….5 Traditional Healer ..…6 Market ...……...……7 Pharmacy……...8 Community Distributors …….….9 Friend/Relative ...……10 Other _____ 88	
AR6	Why was <NAME> taken to this <PROVIDER>? Anything else? **Circle all answers.**	Cost less money ……..A Can pay on time ……..B Practitioner known ……..C Practitioner trusted ……..D Closest distance ……E Other _____X	
AR7	Who decided that you should go there for <NAME's> illness? Anything else? **Circle all answers.**	Mother ……A Husband ……..B Mother of mother ……C Mother-in-law ……..…D Friend/Neighbors …….E Others _____Z	
AR8	How was the child taken there?	Walk ……1 Own transportation ……..2 Motor taxi …..……...3 Friend ……..4 Car taxi …….5 Other _____ 96	
AR9	How much did it cost for transportation?		

AR10	Did you/they have to pay for the consultation and treatment?	Yes…….1 No……..…2	**If no, go to AR12**
AR11	How much did you have to pay?		
AR12	After the health provider saw the child did s/he ask you to bring the child back for a check in a few days?	Yes…….1 No……..…2	**If no, go to AR16**
AR13	Did you take <NAME> back to the same health care provider?	Yes…….1 No……..…2	**If yes, go to AR15**
AR14	If Not - Why_____		**Go to AR16**
AR15	When did you take the child back?	Same day ……..1 One days ……..….2 Two days ….…….3 Three day ……4 **Other** _____5	
AR16	Where else did you go for advice or treatment? Anything else? **Circle all answers.** **If Hospital, Health Center or Private Hospital, Clinic, or Practitioner** **Write the Name** _____	Hospital …...……A Health Center ……...…B Private Hospital/Clinic ……..……C Private Practitioner …..D Village Health Worker/TBA/VHC/VHV ……..…E Traditional Healer ……F Market …….G Pharmacy ……H Community Distributors ……I Friend/Relative …...…. .J No where else …….……K Other _____ Z	
AR17	Did you consult with the VHV, VHC, TBA or Key Mother?	Yes…….1 No……..…2	**If no, go to AR19**
AR18	What did they do? Anything else?	Nothing …...…….A Refer…….……B Health Education …….C	

	Circle all answers.	Gave Treatment ……...D Follow up ……E Other _____X	
AR19	Which medicines were given to <NAME>? Anything else? **Circle all answers.**	Nothing……...…….A Tablets – Do not know the name of medicine. ….……..……..B Aspirin …..….….…….C Paracetamol …..….…D Cotrimoxazole ……E Amoxycillin/Ampicillin ……F Injection – Do not know name of medicine ……G Other _____ X Don't Know……Z	
VIII. MALARIA			
MA1	Has <NAME> been ill with fever in the last two weeks?	Yes……1 No……..…2 Don't Know……..8	**If no or don't know, go to MA22**
MA2	**Di**d you seek advice or treatment for <NAME'S> fever?	Yes……1 No……..…2	**If no, go to MA22**
MA3	*Where did you **first** go for advice or treatment?* **Circle only one answer** **If Hospital, Health Center or Private Hospital, Clinic, or Practitioner** **Write the Name** _____	Hospital ……..…..1 Health Center ……...…2 Private Hospital/Clinic …...……..…...……..3 Private Practitioner .....4 Village Health Worker/TBA/VHC …5 Traditional Healer ……6 Market …….7 Pharmacy ..……8 Community Distributors …….……9 Friend/Relative ……..10 Other _____ 88	
MA4	How long after you noticed <NAME's> fever did you seek	Same day……..0	

	treatment from that person or place?	One days …….1 Two days ……2 Three day ……3	
MA5	Why was <NAME> taken to this <PROVIDER>? Anything else? **Circle all answers.**	Cost less money ……..A Can pay on time ……..B Practitioner known ……..C Practitioner trusted ……..D Closest distance ……E Other _____X	
MA6	Who decided that you should go there for <NAME's> illness? Anything else? **Circle all answers.**	Mother ……A Husband ……..B Mother of mother ……C Mother-in-law ……..…D Friend/Neighbors …….E Others _____Z	
MA7	How was the child taken there?	Walk ……1 Own transportation ……..2 Motor taxi ….……...3 Friend ……..4 Car taxi ……5 Other _____ 96	
MA8	How much did it cost for transportation? **Write down the amount.**		
MA9	Did you/they have to pay for the consultation and treatment?	Yes……1 No……..…2	**If no, go to MA11**
MA10	How much did you have to pay?		
MA11	After the health provider saw the child did s/he ask you to bring the child back for a check in a few days?	Yes……1	**If yes, go to**

		No……..…2	**MA14**
MA12	Did you take <CHILD> back to the same health care provider?	Yes…….1 No……..…2	**If yes, go to MA14**
MA13	If Not- Why_____		**go to MA15**
MA14	When did you take the child back?	Same day ……..1 One days ……..….2 Two days ….…….3 Three day ……4 Other _____5	
MA15	Where else did you go for advice or treatment? Anything else? **Circle all answers.** **If Hospital, Health Center or Private Hospital, Clinic, or Practitioner** **Write the Name** _____	Hospital …...……A Health Center ……...…B Private Hospital/Clinic ……...……C Private Practitioner …..D Village Health Worker/TBA/VHC/VHV ……..…E Traditional Healer ……F Market …….G Pharmacy ……H Community Distributors ……I Friend/Relative …...…. .J No where else …….……K Other _____ Z	
MA16	Did you consult with the VHV, VHC, TBA or Key Mother?	Yes…….1 No……..…2	**If no, skip MA17**
MA17	What did they do? Anything else?	Nothing …...…….A Refer…….……B Health Education …….C Gave Treatment ……...D	

	Circle all answers.	Follow up ……E Other _____X	
Attention! Read and follow below: ***If <NAME> was ever taken to a Hospital or Health Center → MA18*** **If <NAME> was *not* ever taken to a Hospital or Health Center → MA19**			
MA18	Was <NAME> treated with any medicine(s) before going to the Hospital or Health Center?	Yes…….1 No……..…2 Don't Know ……8	**If no or don't know, go to MA22**
MA19	Was <NAME> treated with any medicines by you?	Yes…….1 No……..…2 Don't Know ……8	**If yes, go to MA20. If no or don't know, go to MA22**
MA20	Which medicines were given to <NAME> for his/her fever? **Circle the letter in front of the medicine for each one the mother names.** **If mother cannot remember the names of the medicine, ask to see the medicine. If she does not have the medicine show her the pictures of the medicine and ask her to identify them. Then circle the answer she gives for each medicine.**		
A	CHLOROQUINE	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
B	FANSIDAR	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
C	MEFLOQUINE	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3	

		Don't know ……..8	
ANTIMALARIAL MEDICINES:			
D	RECTOCAP SUPPOSITORY	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
E	A + M 2 (ENFANT)	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
F	A+M 3 (ADOLESCENT)	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
G	A + M 4 (ADULT)	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
H	QUININE	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
I	TETRACYCLINE	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
J	ARTESUNATE	Same Day (Day 0)_……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
OTHER MEDICINES			

K	Aspirin	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
L	Paracetamol	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
M	Co-Trimoxazole	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
N	Ampicillin/ Amoxillicin	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
O	Other _____	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
P	Unknown Medicine	Same Day (Day 0)……0 Day 1…….1 Day 2 ……2 Day 3 + …….3 Don't know ……..8	
MA21	Were any of these injections?	Yes…….1 No……..…2 Don't Know ……8	
MA22	What causes malaria? Anything else? **Circle all answers.**	Mosquito Bites ……A Witchcraft…….B Intravenous drug use …C Blood transfusions …D Injections……E Sharing razor blades…F Kissing …….G	

		Other _____ W Other _____ X Don't Know ……Z	
IX. MOSQUITO BEDNET USE AND MAINTENANCE			
BE1	Do you have any bednets in your house?	Yes…….1 No……..…2 Don't Know ……8	**If no or don't know HC1**
BE2	May I see the bednet? **Observe if bednet is hung over the bed and circle the answer**	Hung over the bed …..1 Not hung …….2	
BE3	Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or insects?	Yes…….1 No……..…2 Don't Know ……8	**If no or don't know, go to BE5**
BE4	**Inspect bednet for holes or tears.**	No obvious holes/tears = good condition…….1 Any visible holes/tears = damaged …….2	
BE5	How long ago was the bednet last soaked or dipped? **Write down the answer in months** **Less than 1 month = 00** **Don't know = 99**	_____ months	**If don't know, go to BE5**
BE6	Have you or someone else in your house ever washed the bednet?	Yes…….1 No……..…2 Don't Know ……8	**If no or don't know, go to BE8**
BE7	How often do you wash your bednet?	Once a week ……..1 Once a month ……2 Less than once a year….3	
BE8	How long have you had your bednet?	_____ months	

	Write down the number of months		
BE9	Who slept under the treated bednet last night? **Circle all answers.**	Child <NAME> (the one chosen for the interview)……..…A Mother ……..…B Husband ...……C Other_____X	
X. Health Contacts and Sources of Information			
HC1	**During the last month, how often have you come in contact with each of the following?** **Circle the letter of the health person contacted. Then circle the number of times.**		
A	Doctor (Public)	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
B	Medical Assistant (Public)	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
C	Nurse (Public)	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
D	Midwife (Public)	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
E	Community Health Worker	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
F	Traditional Birth Attendant	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
G	Private Practitioner	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	

H	Traditional Healer	Never:0 times…...……1 Sometimes:1-3 times…2 Frequent: 4+ times…...3	
HC2	Who do you usually get general information or advice on health and nutrition? **Circle all answers.**	No one ……..A Doctor(Public)..…...…B Medical Assistant (Public) ……C Nurse (Public) ……D Midwife (Public) ……E Traditional Birth Attendant …….F Village Health Volunteer …….……G Village Health Committee Member……H Key Mother ……...I Private practitioner ……J Husband……K Mother/Mother- in-law …….……L Sister ……...……M Grandparent ……N Aunt …….O Friend/ Neighbor …….P Traditional Healer ……Q Village Elder …….R Other_____X	
HC3	**In the past month, have you received any health messages from the following?** **Circle the letter for the source of information. Then circle the answer.**		
A	Radio	Yes…….1 No……...…2	
B	Newspaper	Yes…….1 No……...…2	
C	Television	Yes…….1 No……...…2	

D	Village Health Volunteer	Yes…….1 No……...…2	
E	Village Health Committee Member	Yes…….1 No……...…2	
F	Traditional Birth Attendant	Yes…….1 No……...…2	
G	Key Mother	Yes…….1 No……...…2	
XI. Anthropometry			
AN1	May I weigh <NAME>?	Yes…….1 No……...…2	**If no, go to end.**
AN2	**If Mother agrees, weigh the child and record weight and length. Record to the nearest Tenth.**	_____ _____ . _____ Kilograms _____ _____ Centimeters	
AN3	**Check edema with pitting**.	Yes…….1 No……...…2	

END OF SURVEY

Thank you for taking part in this survey. This will help us begin our work of improving child health in the area.

Annex X: Siem Reap Child Survival Project: Indicator Performance Tracking Table																					
strategy element	performance indicator	Rapid Catch Indicator	HMIS Indicator	Cambodia Score Card Indicator	frequency of collection	baseline value	FY05 year one: target	year one: actual	year one: percnt. achieved	FY06 year two: target	year two: actual	year two: percnt. achieved	FY07 year three: target	year three: actual	year three: percnt. achieved	FY08 year four: target	year four: actual	year four: percnt. achieved	EOP: target	EOP: actual	EOP: percnt. achieved
Goal: Reduced child morbidity and mortality in a sustainable fashion in Angkor Chum Operational District																					
Strategic Objective One: Improved nutritional status of children under two																					
growth monitoring	Percent of children aged 0-23 months who are less than 2 standard deviation below the median height-for-age of the reference population				baseline and endline	36.0													32		
growth monitoring	Percent of children aged 0-23 months who are less than 2 standard deviation below the median weight-for-age of the reference population				CBSS monthly	35.7	35			32			29			25			25		
Intermediate Result 1.1: Improved care of pregnant women																					
birth spacing	percent children 0-23 months who were born at least 24 months after the previous surviving child				baseline and endline	42.1													40		
antenatal care	percent women with 2 or more ANC visits				monthly	?															
tetanus toxoid 2	percentage of women receiving at least two tetanus toxoid injections before the birth of their last child				monthly	59.9	65			75			85			90			90		
careseeking behavior	percentage of women who can recognize three or more danger signs of pregnancy				annual	?															
community outreach	percent women counselled at least twice during pregnancy by community care group				annual		15			25			40			55			55		
delivery	percentage of births attended by skilled health personnel of mothers who had received appropriate community counseling visits				annual		15			20			25			30			30		
	percentage of children age 0-11 months whose births were attended by skilled health personnel				annual	15.3															
	percentage of children age 0-11 months whose births were attended by trained TBAs				annual	??															
	percentage of deliveries at home not attend by a skilled health personnel				annual	85	85			80			75			70			70		

Intermediate Result 1.2: Increased early and exclusive breastfeeding																					
initiation	percentage of children breastfed within the first hour of delivery				CBSS monthly	42.8	45			50			55			60			60		
	percentage of children breastfed within the first day of delivery				CBSS monthly	15.7	12			9			6			3			3		
	percentage of children given other fluids prior to initiation of breastfeeding				CBSS monthly	100	95			85			75			65			65		
exclusive breastfeeding	percentage of children exclusively breastfed for six months				baseline, midterm, final	21.4							23			25			25		
	percentage of children 0-5 months exclusively breastfed during the last 24 hours				baseline, endline	38.4													60		
community outreach	percentage women counselled within one day of delivery by community care group				CBSS monthly		10			25			40			60			60		
Intermediate Result 1.3: Improved appropriate use of complementary foods																					
complementary foods	percentage of children age 6-9 months who received breastmilk and complementary foods within the last 24 hours				baseline and endline	81.7													95		
	percentage of children 12-23 months who ate three or more food groups within the last 24 hours				annual	tbd															
community outreach	percentage of mothers who complete community care-group sponsored nutrition education sequence				quarterly	tbd															
	percentage of mothers who can name five or more vitamin-rich foods				annual	tbd															
Strategic Objective Two: Improved Immunization Rates																					
full immunization	percentage of children 12-23 months who are fully vaccinated before first birthday				annual	34	36			45			60			80			80		
	percentage of households with yellow cards				monthly	tbd															
Intermediate Result 2.1: Improved routine immunization rates																					
routine immunization	percentage of children 12-23 months who received a measles vaccine				monthly	88.8	95			95			100			100			100		
	percentage of children 12-23 months who received three DPT vaccination				monthly	68.8	80			80			90			95			95		
	percentage of children 12-23 months who received three polio vaccinations				monthly	52.4	65			70			85			95			95		
	percentage of children 12-23 months who received BCG vaccinations				monthly	87.1	95			95			100			100			100		

Intermediate Result 2.2: Improved Vitamin A coverage																					
child VAC	percentage of children less than 23 months who received a VAC dose				monthly	48.3	60			75			90			95			95		
pregnant women VAC	percentage of pregnant women who received at least one VAC dose				monthly	tbd															
Intermediate Result 2.3: Improved community participation in immunization campaigns																					
community care group outreach	percentage of children eligible vaccinated in campaign				monthly	0															
community record-keeping	percentage of children eligible with household marker				monthly	0															
Strategic Objective Three: Enhanced Community Prevention & Management of Sick Child																					
overall prevalence	percentage of children with symptoms of illness (cough, diarrhea, fever) during the last two weeks				monthly	65	60			50			40			40			40		
	no. of cases of childhood illnesses referred appropriately to health center				monthly																
Intermediate Result 3.1: Improved caregiver knowledge of childhood illnesses																					
community outreach	percentage of mothers age 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment				baseline and endline	57.9													90		
	percentage of mothers with children age 12-23 months who can cite at least 2 ways of reducing risk of HIV infection				baseline and endline	59													90		
	percentage of mothers who complete community care-group sponsored child health education sequence				quarterly	tbd															
	percentage of mothers who can name any signs of childhood illness				quarterly	72.6	75			85			90			95			95		
Intermediate Result 3.2: Improved caregiver home management of childhood illnesses																					
careseeking behavior	percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the last two weeks				baseline and endline	53.7															
	increased percentage of mothers of children 0-23 months who seek care for their child with cough or fast/difficult breathing				annual	tbd															
	increased percentage of mothers of children 0-23 months who seek care for their child with diarrhea				annual	tbd															
	increased percentage of mothers of children 0-23 months who seek care for their child with fever				annual	tbd															

Intermediate Result 3.3: Improved prevention & treatment of childhood illnesses																					
diarrhea	percentage of mothers with children age 12-23 months who report that they wash their hands with soap/ash at all appropriate moments				baseline and endline	0.6													80		
	number of cases of diarrhea during the last month				monthly																
	percentage of children age 0-23 months who had diarrhea during the last two weeks				baseline and endline	35													10		
	percentage of children age 0-23 months who had diarrhea and were treated with ORT				annual																
ARI	number of cases of cough or rapid/difficult breathing during the last month				monthly																
	percentage of children age 0-23 months who had cough or rapid/difficult breathing during the last two weeks				baseline and endline	19													10		
malaria	percentage of children age 0-23 months who slept under an insecticide treated net the previous night				annual	1.7	20			50			80			90			90		
	number of cases of fever during the last month				monthly																
	percentage of children age 0-23 months who had fever during the last two weeks				baseline and endline	38													10		
Strategic Objective Four: Improved Partner Project Management Capacity																					
capacity assessment	updated monitoring and evaluation guidelines				annual		0			1			0						1		
capacity assessment	updated financial management guidelines				annual		0			0			1						1		
capacity assessment	updated volunteer policy				annual		0			0			1						1		

Intermediate Result 4.1: Improved coordination with health community																					
Use of data collection tools	no. joint trainings held				annual	0	4			6			8			8			26		
MOH activiities	% meetings held with MOH initiated by CS management team				annual	3	4			4			4			4			19		
	no. meetings held with MOH				quarterly	4	6			4			4			4			22		
Stakeholder Participation	no. working group meetings attended				annual	1	1			1			1			1			4		
	no. working group memberships				annual	1	2			2			2			2			2		
Documentation and dissemination	no. professional papers or peer reviewed publications				annual	0	0			0			0			1			1		
Intermediate Result: 4.2: Improved project management policies and skills																					
project information management (ME)	no. trained in reporting procedures according to ME guidelines				quarterly	0	10			10			10			10			10		
	% reports turned in correctly and on time				annual	0	25			35			50			75			75		
	no. reports turned in on time				monthly	0	3			4			6			9			9		
	no. reports turned in completed correctly				monthly	0	3			4			6			9			9		
ınancial managem	no. trained in reporting procedures				quarterly	0	10			10			10			10			10		
	% reports turned in correctly and on time				annual	0	25			35			50			75			75		
	no. reports turned in on time				monthly	0	3			4			6			9			9		
	no. reports completed correctly				monthly	0	3			4			6			9			9		
project managemen	no. trained in project management				quarterly	0	10			10			10			10			10		
	% staff retained for more than one year after training				annual	0	0			80			80			80			80		
Intermediate Result: 4.3: Improved volunteer network																					
volunteer strategy development	volunteer operational guidelines in place				annual	0	0			1			0			0			1		
volunteer management	no. new volunteers recruited for project				monthly	0	1000			2000			2218			2218			2218		
volunteer management	% volunteers retained for more than one year				annual	0	0			800			1600			1600			1600		

Key	
	Rapid CATCH indicator
	HMIS Indicator
	Cambodia Score Card Indicator

Note: the Cambodia Score Card also includes appropriate treatment for malaria and ARI. As the project does not provide treatment, only assists in referrals, these are the only two indicators on the score card we do not measure.

Indicators without baseline values or with zero baseline values represent new activities. Indicators in italics are the latest epidemiological data from the Operational District, but were not part of the baseline survey.

Version 7/03

APPLICATION FOR FEDERAL ASSISTANCE

		2. DATE SUBMITTED July 15, 2005	Applicant Identifier N/A
1. TYPE OF SUBMISSION: Application ☐ **Construction** ☑ **Non-Construction**	Pre-application ☐ **Construction** ☐ **Non-Construction**	**3. DATE RECEIVED BY STATE** N/A	State Application Identifier N/A
		4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: American National Red Cross		**Organizational Unit:** Department: International Services Department	
Organizational DUNS: 07583459J		Division: International Programs/Asia Pacific Region	
Address: Street: 2025 E Street, NW		**Name and telephone number of person to be contacted on matters involving this application (give area code)** Prefix: Mr.	First Name: Mark
City: Washington		Middle Name	
County:		Last Name Preslan	
State: DC	Zip Code 20006	Suffix:	
Country: USA		Email: preslanm@usa.redcross.org	
6. EMPLOYER IDENTIFICATION NUMBER *(EIN)*: 53-0196605		Phone Number (give area code) 1-202-303-5018	Fax Number (give area code) 1-202-303-0052
8. TYPE OF APPLICATION: ☐ **New** ☐ **Continuation** ☑ **Revision** If Revision, enter appropriate letter(s) in box(es) (See back of form for description of letters.) ☐ ☐ Other (specify) N/A		**7. TYPE OF APPLICANT:** (See back of form for Application Types) O Other (specify)	
		9. NAME OF FEDERAL AGENCY: USAID/BHR/PVC	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: ☐☐-☐☐☐ TITLE (Name of Program): N/A		**11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:** Siem Reap Integrated Child Health Project	
12. AREAS AFFECTED BY PROJECT *(Cities, Counties, States, etc.)*: Cambodia: Pouk Operational District, Siem Reap Province			
13. PROPOSED PROJECT		**14. CONGRESSIONAL DISTRICTS OF:**	
Start Date: October 1, 2004	Ending Date: September 30, 2008	a. Applicant N/A	b. Project N/A

15. ESTIMATED FUNDING:		**16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?**
a. Federal	$ 1,500,000.00	a. Yes. ☐ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON DATE:
b. Applicant	$ 500,096.00	
c. State	$ 0.00	
d. Local	$ 0.00	b. No. ☑ PROGRAM IS NOT COVERED BY E. O. 12372
e. Other	$ 0.00	☐ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW
f. Program Income	$ 0.00	**17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?**
g. TOTAL	$ 2,000,096.00	☐ Yes If "Yes" attach an explanation. ☑ No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Authorized Representative		
Prefix	First Name Julie	Middle Name
Last Name Reynes		Suffix
b. Title Executive Director, International Services		c. Telephone Number (give area code) 1-202-303-6748
d. Signature of Authorized Representative		e. Date Signed July 15, 2005

INSTRUCTIONS FOR THE SF-424

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0043), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

This is a standard form used by applicants as a required face sheet for pre-applications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:	Item:	Entry:
1.	Select Type of Submission.	11.	Enter a brief descriptive title of the project. If more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of this project.
2.	Date application submitted to Federal agency (or State if applicable) and applicant's control number (if applicable).	12.	List only the largest political entities affected (e.g., State, counties, cities).
3.	State use only (if applicable).	13	Enter the proposed start date and end date of the project.
4.	Enter Date Received by Federal Agency Federal identifier number: If this application is a continuation or revision to an existing award, enter the present Federal Identifier number. If for a new project, leave blank.	14.	List the applicant's Congressional District and any District(s) affected by the program or project
5.	Enter legal name of applicant, name of primary organizational unit (including division, if applicable), which will undertake the assistance activity, enter the organization's DUNS number (received from Dun and Bradstreet), enter the complete address of the applicant (including country), and name, telephone number, e-mail and fax of the person to contact on matters related to this application.	15	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.
6.	Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.	16.	Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernmental review process.
7.	Select the appropriate letter in the space provided. A. State B. County C. Municipal D. Township E. Interstate F. Intermunicipal G. Special District H. Independent School District I. State Controlled Institution of Higher Learning J. Private University K. Indian Tribe L. Individual M. Profit Organization N. Other (Specify) O. Not for Profit Organization	17.	This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes.
8.	Select the type from the following list: • "New" means a new assistance award. • "Continuation" means an extension for an additional funding/budget period for a project with a projected completion date. • "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation. If a revision enter the appropriate letter: A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration	18	To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)
9.	Name of Federal agency from which assistance is being requested with this application.		
10.	Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.		

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Headquarters	N/A	$ 0.00	$ 0.00	$ 199,906.00	$ 95,794.00	$ 295,700.00
2. Field	N/A	0.00	0.00	1,300,094.00	404,302.00	1,704,396.00
3. N/A	N/A	0.00	0.00	0.00	0.00	0.00
4. N/A	N/A	0.00	0.00	0.00	0.00	0.00
5. Totals		$ 0.00	$ 0.00	$ 1,500,000.00	$ 500,096.00	$ 2,000,096.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Federal	(2) Non-Federal	(3) N/A	(4) N/A	(5)
a. Personnel	$ 482,155.00	$ 112,997.00	$ 0.00	$ 0.00	$ 595,152.00
b. Fringe Benefits	186,226.00	49,034.00	0.00	0.00	235,260.00
c. Travel	61,581.00	60,387.00	0.00	0.00	121,968.00
d. Equipment	14,711.00	65,885.00	0.00	0.00	80,596.00
e. Supplies	84,130.00	1,080.00	0.00	0.00	85,210.00
f. Contractual	48,870.00	12,400.00	0.00	0.00	61,270.00
g. Construction	0.00	0.00	0.00	0.00	0.00
h. Other	497,062.00	198,313.00	0.00	0.00	695,375.00
i. Total Direct Charges *(sum of 6a-6h)*	1,374,735.00	500,096.00	0.00	0.00	1,874,831.00
j. Indirect Charges	125,265.00	0.00	0.00	0.00	125,265.00
k. TOTALS *(sum of 6i and 6j)*	$ 1,500,000.00	$ 500,096.00	$ 0.00	$ 0.00	$ 2,000,096.00
7. Program Income	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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Standard Form 424A (Rev. 7-97)
Prescribed by OMB Circular A-102

Previous Edition Usable

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Headquarters	$ 95,794.00	$ 0.00	$ 0.00	$ 95,794.00
9. Field	404,302.00	0.00	0.00	404,302.00
10. N/A	0.00	0.00	0.00	0.00
11. N/A	0.00	0.00	0.00	0.00
12. TOTAL *(sum of lines 8-11)*	$ 500,096.00	$ 0.00	$ 0.00	$ 500,096.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 280,959.00	$ 28,096.00	$ 56,192.00	$ 84,288.00	$ 112,383.00
14. Non-Federal	163,556.00	16,356.00	32,711.00	49,067.00	65,422.00
15. TOTAL *(sum of lines 13 and 14)*	$ 444,515.00	$ 44,452.00	$ 88,903.00	$ 133,355.00	$ 177,805.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Headquarters	$ 39,604.00	$ 40,793.00	$ 55,374.00	$ 0.00
17. Field	380,308.00	337,101.00	365,862.00	0.00
18. N/A	0.00	0.00	0.00	0.00
19. N/A	0.00	0.00	0.00	0.00
20. TOTAL *(sum of lines 16-19)*	$ 419,912.00	$ 377,894.00	$ 421,236.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: See remarks section	22. Indirect Charges: See remarks section

23. Remarks: Predetermined NICRA rate of 44% (offsite location); total estimated amount of base: $284,693; total indirect expenses: $125,265
Other Direct Costs include a sub-grant to the Cambodian Red Cross; Federal $332,304 and Non-Federal $168,747

INSTRUCTIONS FOR THE SF-424A

Public reporting burden for this collection of information is estimated to average 180 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0044), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately shown for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A, B, C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A, B, C, and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary Lines 1-4 Columns (a) and (b)

For applications pertaining to a *single* Federal grant program (Federal Domestic Assistance Catalog number) and *not requiring* a functional or activity breakdown, enter on Line 1 under Column (a) the Catalog program title and the Catalog number in Column (b).

For applications pertaining to a *single* program *requiring* budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the Catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the Catalog program title on each line in *Column* (a) and the respective Catalog number on each line in Column (b).

For applications pertaining to *multiple* programs where one or more programs *require* a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g)

For new applications, leave Column (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Columns (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase or decrease of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 - Show the totals for all columns used.

Section B Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Line 6a-i - Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount, Show under the program

narrative statement the nature and source of income. The estimated amount of program income may be considered by the Federal grantor agency in determining the total amount of the grant.

Section C. Non-Federal Resources

Lines 8-11 Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 - Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f), Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object class cost categories that may appear to be out of the ordinary or to explain the details as required by the Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
	Executive Director, International Services
APPLICANT ORGANIZATION	DATE SUBMITTED
American National Red Cross	July 15, 2005