

World Vision Cambodia

FIRST ANNUAL REVIEW

**Kean Svay Child Survival
(Follow-On) Project
(KSCSP Phase 2)**

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PVO Field Office Contact
Dr Douglas Shaw, National Health Advisor
World Vision Cambodia
Central PO Box 479
Phnom Penh, Cambodia

Asia-Pacific Regional Contact
Dr Sri Chander, Regional Health Advisor
World Vision Asia-Pacific Region

PVO Headquarters Contact:
Fe. D. Garcia, MD, MPH
WVUS Asia Pacific Team Leader
Or
David Grosz, MPH
WVUS Program Officer for Cambodia
World Vision, Inc
34834 Weyerhaeuser Way South
Federal Way, Washington 98063

LIST OF ACRONYMS

ADB	Asian Development Bank
ADD	Accelerated District Development
ADP	Area Development Program
ADRA	Adventist Development and Relief Agency
ANC	Ante-Natal Care
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
CDD	Control of Diarrhoeal Disease
COPE	Client Orientated Provider Efficient
CRS	Catholic Relief Service
DHF	Dengue Haemorrhagic Fever
DIP	Detailed Implementation Plan
FAR	First Annual Review
FGD	Focus Group Discussion
GIK	Gifts in Kind
HC	Health Centre
HKI	Helen Keller International
IDD	Iodine Deficiency Disease
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
KSCSP	Kean Svay Child Survival Project
LQAS	Lot Quality Assurance Sampling
MCH	Maternal & Child Health
MED	Micro-Enterprise Development
MoH	Ministry of Health
MPA	Minimum Package of Activities
NGO	Non Government Organisation
NIPH	National Institute of Public Health
OD	Operational District
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PHD	Provincial Health Department
RACHA	Reproductive and Child Health Alliance
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
VAC	Vitamin A Capsules
VAD	Vitamin A Deficiency
VBMC	Village Bank Management Committee
VDC	Village Development Committee
VHV	Village Health Volunteer
WHO	World Health Organisation
WVC	World Vision Cambodia
WVUS	World Vision United States

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INTRODUCTION

Following the success of the Kean Svay Child Survival Project (October 1996-September 2000) approval was granted by USAID for a three year Follow-On Project commencing October 2000.

The purpose of this First Annual Review is to review the main accomplishments, the factors that have impeded progress and action taken to address these factors, technical assistance required and to respond to recommendations made during the DIP Review in June 2001.

The Kean Svay Child Survival Project (KSCSP) is located in Kean Svay Operational District (OD) of Kandal Province in Cambodia and comprises three administrative districts: Kean Svay (the location for Phase 1), Leuk Dek and Lovea Em. Leuk Dek District is the direct impact area for the Follow-On Project (Phase 2), where child survival interventions are being implemented by project staff in collaboration with Ministry of Health staff. Capacity building and community participation in collaboration with World Vision Cambodia's Leuk Dek Area Development Program (ADP) are the other two key interventions in Leuk Dek District. In Kean Svay and Lovea Em Districts (indirect impact area) the Follow-On project will concentrate on capacity building for Ministry of Health staff.

A second indirect impact area comprises three Districts in Kompong Thom Operational District (about four hours drive north of Kean Svay). These are Prasath Ballang, Prasath Sambo and Sandan Districts and have been selected because WVC manages an ADP in each district and has helped to build a strong health infrastructure. The Follow-On Project will provide capacity building for Ministry of Health staff with child survival interventions drawn from Kean Svay Operational District, but implemented by WVC ADP staff in collaboration with MoH staff. A comparison of the outcomes from these different approaches will be an important component of the Mid-Term Evaluation of the Follow-On Project.

This First Annual Review for the Follow-On Project was conducted from 10-14 September. The Review was led by a team of four comprising Dr Sir Chander, Regional Health Advisor for World Vision Asia-Pacific Region, Dr Douglas Shaw, National Health Advisor World Vision Cambodia (WVC), Dr Ly Vanthy, Technical Support for WVC National Health Program and Dr Lim Somaly, the KSCS Project Manager. Drs Vanthy and Somaly are Cambodian nationals and also represented WVC at the DIP Review in Washington in June 2001.

2. METHODOLOGY FOR REVIEW

Over 100 people were directly involved in this Annual Review. These included those in the Annual Review Team, those interviewed and those who attended the presentation of findings on the final day of the Review. Names of all participants and members of the Annual Review Team are listed in Annexes 8.1 and 8.2 while the Schedule for the Review and Interview Team Schedule are found in Annexes 8.3 and 8.4.

The first day of the review involved preparations with WVC Project Staff. On Day 2 the Review Team assembled at the Project Office. While most of the team already had good knowledge of the project, a brief overview was provided by Dr Lim Somaly, the Project Manager. Dr Sri Chander then shared on his experience of Annual Reviews which led to small group discussions

on expectations and outcomes. While the Annual Review was structured to meet USAID requirements, the input of all participants was sought to reach consensus on goals and expectations. The results of these discussions were then shared with the whole group (see 3.1 below).

One large group discussion then followed with the purpose being to identify who needed to be interviewed, what information needed to be collected and how this should best be collected in order to meet the group's expectations. Key informants included commune, village and group leaders; Health Centre and OD staff; Village Development Club members (VDC) and village health volunteers (VHVs); fathers and mothers of children; traditional healers (kru khmer) traditional midwives (TBA); drug sellers; World Vision KSCSP staff, Leuk Dek ADP staff and senior National Office WVC staff. In addition, it was agreed that Health Centre assessments were an important part of the process. Decisions were made as to where these interviews would take place in order to be representative of the District. However, due to flooding, communes in the south of the District were not accessible.

Next, the group selected the most appropriate methods to obtain the required information from each of the above key informants. The methods selected were interviews, Focus Group Discussion (FGD), direct observation and review of records.

Tasks were then assigned to small groups to develop the questionnaires or checklists needed for each key informant using the selected method. At the end of Day 2, the tools developed by each group were presented to the whole group for review. The day concluded with logistic preparations for the field visit the following day. This whole process was conducted in the Khmer language avoiding the necessity of translating and back-translating these tools. English language translations of these questionnaires are in Annex 8.5.

On Day 3 the Team traveled to Leuk Dek district and divided into 4 groups with pre-determined tasks. Most of the field work was completed by lunchtime and the afternoon was set aside for each group to present findings and for these findings to be collated for presentation on the final day. The preparations for the presentation continued during the morning of Day 4. Interviews with other key informants not resident in Leuk Dek were scheduled for Days 4 and 5, or in some cases, early the next week. Several key informants, such as Operation District staff, were both key informants and members of the Review Team and were interviewed on Days 4 and 5.

On Day 5 the results of the field-work were presented to a larger audience including invited guests from USAID, other USAID-funded Child Survival NGOs, and central and provincial Ministry of Health staff (see Annex 8.6). Key findings were summarised, feedback actively sought and key recommendations were made.

In the following weeks this Annual Review document was prepared with additional sections to address recommendations made during the DIP Review.

3. SUMMARY OF FINDINGS AND KEY RECCOMENDATIONS

3.1 Purpose and Expectations of Annual Review

On Day 2 of the Annual Review the team met in small groups to discuss the purpose, expectations and benefits of the Annual Review.

In addition to the USAID requirements, two additional purposes were added:

- To share good experiences and continue to carry on good work
- To identify weak points and their causes in order to modify future strategies.

The expectations of the Annual Review Team were:

- To exchange experiences between PHD, OD, HC, community level and the project
- To directly observe and evaluate the actual activities of the HCs and community
- To strengthen the support from the project, national MoH, PHD, OD and community to Health Centres
- To assess the degree of improvement in Health Centre services to the community.

The expected benefits of the Annual Review were

- To compare the actual achievements with project targets
- To identify weak points in order to modify strategies
- To improve project activities
- To assess project achievements during the past last year.

3.2 Summary of Survey Results

3.2.1 Mothers and Fathers

Focus Group Discussions (FGD) were held in three villages (Kbal Chroy, Kg Poh and Spean Dek.) with mothers and separately with fathers. The results are combined and summarised here.

All participants knew the location of the nearest Health Centre (HC). The services that they knew were provided were outpatient services for children and adults and maternal and child health education. Most stated that people were using the Health Centre and that there had been changes in the last 12 months. These included a new, clean HC in one location; staff available for service including night duty; staff with the capacity to do the work; staff being friendly and polite; provision of good health education and good follow up; and the cost of service being less than private practitioners.

The main reasons stated for these changes were support to the HC provided by the NGO (WVC) and Government and people's belief in the effectiveness of treatment provided. Areas of concern included party politics with priority given to some people over others; staff not always wearing uniforms; staff not punctual; and staff on night duty difficult to contact. Suggestions for improvements included addressing the concerns noted above; the need for more support and supplies; improved relationships between staff and local authorities to encourage villagers to use the HC; the need for transportation to refer sick patients; need for electricity; and the need for the local authority to renovate the road to improve access to one HC.

3.2.2 Village and Group Leaders

Interviews with Village and Group leaders were held in Kompong Poh village of Kg Phnom commune. In the last 12 months, this group felt that HC services had improved with staff available 24 hours a day; improved punctuality; provision of village outreach services; and better relationship with patients. Services provided by the HC were stated to be outpatient services for adults and children, antenatal care, assessment of a sick child, birth spacing and immunisation. This group felt that the majority of the people in their communities would go to the HC when they were sick. Reasons for not going included distance (with a private practitioner closer) and a bad road to one HC.

Concerns included lack of an effective referral service; shortages of some drugs; the appearance of some drugs implied the drugs were not good; staff not punctual; some staff not polite; some staff not wearing uniforms; some patients having to wait a long time for service and party politics (priority service given to some); and lack of electricity. Suggestions for improvement included strengthening technical skills; having enough medicines; increased health education; collaboration with local authorities; and exemption given to the poor.

3.2.3 Village Health Volunteers

One FGD and one interview were conducted. VHVs were asked what work they had done so far related to health. Responses included the registration of all newborn children, pregnant women and under-five child deaths; participation in village immunisation activities; provision of Vitamin A capsules post-partum; health education on ARI, CDD, Vitamin A, hygiene, care of sick children, use of ORS and encouraging mothers to use HC services for sick children; distribution of abate and chloramine; monthly report to HC; and epidemic surveillance. Generally there was good communication between VHVs and HC staff – VHVs felt they were able to contact HC staff with problems; HC staff usually responded in a timely way; and VHVs themselves were provided with free services at HC.

Problems included lack of transport; lack of IEC materials; mothers who did not concentrate during health education sessions; some mothers who did not bring their children for immunisation; some mothers who did not follow instructions to bring their sick child to the HC; and the anger of some mothers and fathers if their child developed a fever after immunisation.

Since becoming a VHV knowledge and skills had improved in areas of recognising the signs of diarrhoea, DHF, ARI and VAD; birth spacing; six infections prevented by immunisation; and ability to read the yellow vaccination cards. VHVs had observed the following changes in community health knowledge and behaviour: more people coming for immunisation; more mothers accepting birth spacing; increased knowledge of how to use ORS and prevent dengue; importance of drinking safe water; more pregnant women attending the HC for ante-natal care and tetanus immunisation; and increased knowledge on the prevention of certain illnesses.

3.2.4 Village Development Club (VDC) member

One VDC member was interviewed. Local flooding prevented access to other VDC members in the three communes where VDCs presently exist. The VDC member felt that HC staff had a

good relationship with the community. The HC provided treatment and prevention services including immunisation and birth spacing services in the villages. The VDC member stated that part of his role was to report health related information to the HC.

3.2.5 Traditional Birth Attendants

One FGD was conducted with 16 TBAs attending training at Kompong Phnom HC. When asked why they had agreed to become involved with project activities, responses included: to improve knowledge and delivery technique; wanting to serve the villagers with these delivery skills; and wanting to collaborate with the project and HC. They stated that the project had provided financial support for the training and the provision of safe delivery kits. Among the tasks they would undertake following the training were to use the knowledge to serve the villagers; report numbers of newborn children to the HC; encourage pregnant women to attend the HC for ANC and tetanus immunisation; encourage women aged 15-49 years to have tetanus immunisation; disseminate information about birth spacing; refer high-risk pregnant women to the HC; and to build a close relationship with the HC, especially with the HC midwife.

Suggestions for improvements included provision of transport for HC staff to refer patients; additional training on delivery techniques; request for plastic sheets, sterilizer and gloves (these are usually provided after training); and requesting the HC to maintain good relationships with the TBA when the project finishes.

3.2.6 Traditional Healer

One Traditional Healer (kru khmer) was interviewed in Kompong Poh village of Kg Phnom commune. On average he saw five to seven patients each month and stated that most people went first to the HC before seeing him. If someone did come to him first, he would refer them to the HC for assessment. The most common problems that he treated were fractures, hemorrhoids and leukorrhoea. He used both traditional medicines and modern medicine (lincomycin, amoxicillin). He viewed modern medicine favourably and stated that HC staff played a significant role in the immediate care of sick people. He believed that people had to accept health education on hygiene, drinking water and disease prevention and stated his own family did this. He had noticed a significant improvement in HC services, including outreach health education, in the last 12 months.

3.2.7 Private Drug Sellers

Three private drug sellers were interviewed at Prek Tunloap HC. They had been selling drugs for three, eight and 18 years respectively. They prescribed drugs themselves more often than drugs prescribed from the HC or doctors. One had received a short course of training on birth spacing but had not used the knowledge, another had been trained as a Pharmacist while the third had received some unspecified health training from the government and NGO. They prescribed on the basis of their own observation, sometimes by reading the leaflet in the drug box and sometimes from a written prescription from the HC or doctor. One stated he had never been asked to see a seriously ill patient, another would advise that patient to go to the private clinic while the third would refer them to the HC.

3.2.8 Commune Leaders

Two commune leaders were interviewed at Kompong Phnom HC. One stated that the HC was always open with staff in attendance most of the time. Others stated that those close to the HC usually sought treatment there while those further away would see a private practitioner. They stated that people liked the HC because of the effective services; politeness and good relationship with patients; and no discrimination between rich and poor. Changes noted in the four to five months since WVC began active support included an improved level of health care; more people using the HC; less medicine sold at private pharmacies; and increased community support for the HC. Concerns included using inappropriate humour; availability of staff but not of some drugs; need to build staff solidarity; need to increase HC staff capacity; provision of essential drugs; and improved relationship with local authorities.

3.2.9 Health Centre Staff

A FGD was conducted with four HC staff at Kompong Phnom HC. Staff were asked what they had learned from the ARI, CDD and DHF training. Responses included knowing how to classify dehydration status; knowing not to prescribe antibiotics for uncomplicated diarrhoea; ability to treat diarrhoea with proper drugs; ability to diagnose pneumonia by observing and counting respirations rather than by auscultation; ability to diagnose DHF using the tourniquet test; and knowing how to classify the severity of pneumonia.

When asked about the role of VHVs, staff replied that VHVs provide monthly statistics to the HC and VHVs helped HC staff with outreach activities (immunisation, birth spacing and VAC distribution). However, VHVs did not have a monthly meeting with HC staff and did not regularly help in the HC.

Staff stated that the last supervisory visit from the OD Team (OD chief, Pharmacy chief and Finance Officer) was in April 2001. The OD Team used a MoH checklist (A) to review records, observed practice with another checklist (B), checked case management records and received verbal (and some oral) feedback (C). Checklist A was used every visit while Checklists B and C were used on alternate visits. WVC staff were not involved with these supervisory visits.

HC staff noted problems in referral of sick children. Often there was no letter of referral from the HC and such notes were often ignored by referral centres. Parents may not have money (5000 R) for the cost of transport and the HC had no vehicle for emergency transport.

During observation of practice (with a checklist previously used by the project) the following problems were noted:

- Did not count Respiratory Rate or look for chest indrawing for ARI
- Did not ask for Immunisation Card (Yellow card)
- Did not ask about duration of illness.
- Did not ask for frequency of diarrhea.
- Did not give specific counseling or clear counseling .
- Did not ask mothers to repeat instructions.
- Missed opportunity for immunisation and VAC
- Did not tell mothers to come back in 2 days for ARI review

- Did not tell mothers about the referral center if the condition gets worse.

During exit interviews with mothers/ caretakers the following problems were noted:

- Mother not able to name the child's illness.
- Mothers not aware of need to come back in 2 days and to complete the course of antibiotic.
- Mother not able to describe danger signs and symptoms of pneumonia/diarrhoea.

A review of Pharmacy supplies noted stockouts in the last three months of Paracetamol, Multivitamin, Amoxicillin and Antacid.

3.2.10 Operational District Team

A FGD was conducted with four senior members of the Kean Svay OD. Major achievements in the last 12 months included new or renovated Health Centres (World Bank/ ADB funded) and all HCs in the OD now receiving the Minimum Package of Activities (MPA) and training for HC staff in MPA Modules 1 and 2. Achievements specific to the Child Survival Project included case management training in ARI, CDD and DHF, training in Immunisation, Vitamin A deficiency and Birth Spacing for all HC staff. 50 VHVs and 40 TBAs in Leuk Dek had received similar training.

Factors contributing to this success included the support of the Ministry of Health and Provincial Health Department in supply of equipment, MPA, budget (Chapter 11 and Chapter 13), vaccine and VAC. WVC support included HC staff training and VHV selection and training which contributed to increased motivation and commitment of staff.

The OD had a written Supervisory Plan and Schedule for monthly visit using a core group of 10 persons and teams in each administrative district (7 in Kean Svay, 5 in Leuk Dek and 5 in Lovea Em). A supervisory checklist developed by the MoH was used. This checklist had three parts: Part A was used at every visit while Parts B and C alternated from visit to visit.

The OD Team stated that there was good collaboration between the CS Project staff and the OD. The Project had helped the OD in fulfilling responsibilities in immunisation and training. One concern was that the CS project only supported health services for mothers and children, in comparison with Kompong Tralach District in Kg Chhnang Province where NGOs (including WVC) supported health services for all age groups.

The OD Team stated that additional support was needed to strengthen the activities and services of the Referral Hospital, particularly in X-Ray, Echo and Surgical services. Health service management training was another expressed need.

The OD Team compared the start of the Kean Svay project Phase 1 with Phase 2. In Phase 1 mobile teams of HC staff and project staff were formed before VHVs were selected. In Phase 2 VHVs have been selected first and mobile teams will not be operating. The OD Deputy from Lovea Em stated that HC staff effectiveness had improved through working with VHVs, that quality of care had increased and ORT corners had been established in all HCs.

Challenges faced by the OD staff tended to focus on the short term – a MoH mass immunisation campaign (including OPV, VAC and mebendazole) in November 2001 for all children under 14 years of age. Concerns were expressed about continued MoH budget support for 2002 through the ADD scheme (Accelerated District Development), particularly related to the MoH recommendation that HC staff on outreach activities be given a per diem of 8000 R per day.

3.2.11 Child Survival Project Staff

Individual interviews were conducted with six key WVC Child Survival Project Staff. Three staff (two drivers and one administrative staff member were not interviewed). Staff were proud of the good community involvement; motivated VHVs and HC staff; and good collaboration and communication with local authorities in the last 12 months. Major project achievements in this time included training of HC staff and VHVs in immunisation, birth spacing, Vitamin A deficiency, case management of ARI, CDD and DHF; community health education; improved quality of care at HC; capacity building for Kean Svay OD staff; training and capacity building support for Kompong Thom OD and ADPs; and TBA training in Leuk Dek.

Factors contributing to this success included past experiences from Phase 1 of the project; close collaboration with OD, HC, VHVs, local authorities and communities; setting a good example; HC staff motivation; good teamwork among the project staff; and good collaboration being built with the WVC ADP in Leuk Dek

Roles and responsibilities for all project staff had changed since Phase 2 commenced. These changes included increased responsibility, especially for training and capacity building; increased monitoring and evaluation activities including community based death and disease surveillance; greater geographical area to cover both in direct impact area and indirect impact areas; and recognition of the need to respond to community needs and health issues. Staff expressed the need for more support in their areas of increased responsibility, including additional training.

All Project staff had received a variety of training in the last 12 months. Some staff were also receiving English language training in their own time. All staff stated that these various training had improved knowledge and skills in technical areas, and for some, in management areas. Additional training needs were noted. These included further technical training at higher levels, additional clinical case management training, English language skills, facilitatory skills, information management and monitoring skills, leadership skills, PLA knowledge and skills and project management and planning.

Questions were asked about how Project staff were supervised. Responses varied but included submission of weekly and monthly reports; direct planned formal and informal discussions with the project manager; direct observation of activities by supervisor; and a coaching style. In addition WVC conducts formal Performance Appraisals which included quarterly coaching meetings.

Staff were asked about their current workload. Four stated that the workload was not too much but that the time, distance and difficulty of travel to Leuk Dek were making it more difficult to

conduct project activities according to schedule. Two staff stated that the current workload was too much.

All project staff had a good understanding of the need for, and the process involved in, integrating CS project activities with the Leuk Dek ADP. This was recognised as important for sustainability of the CS health outcomes. One staff member noted that as the ADP helped to improve living standards that health benefits would also follow. Another staff member noted that the busy schedule of project activities limited the time available for working closely with ADP staff. The sharing of a project office in Leuk Dek should help improve communications.

Factors which had impeded progress towards achieving the project's goals included a schedule that was too busy; serious flooding during the wet season; difficult road travel; limited knowledge and poor motivation of some HC staff. Plans to address these limiting factors included staying overnight in the communities; safe use of a boat for access to some areas; revision of Plan of Action taking into account limitations during the wet season; improved quality of supervision (support-a-vision); regular discussions with OD and HC; and refresher training at appropriate times.

3.2.12 Leuk Dek ADP staff

Interviews were conducted with the Community Development Worker and ADP Manager. Their assessment of the major achievements of the CS project in the last 12 months included training of VHVs; immunisation activities; distribution of health education materials; HIV/AIDS education; use of VHVs for distribution of abate and selected drugs (ORS); provision of medical equipment to HC; and capacity building of HC staff, VHVs and TBAs. Factors contributing to this success included the fact the VHVs were also members of the VDC in each village; good communication between project staff, HC staff, local authorities and communities; and project goals attempting to meet community needs.

There was a good understanding of the plans for integration of CS interventions into ADP activities. Opportunities for mutual learning, sharing of information, coordination of activities, sharing of resources and co-location in the same office were noted as important to the integration process.

Factors felt to have impeded progress included road conditions, initially poor communication between the CS project and ADP, concerns about the CS project providing cash incentives to community members and lack of a clear understanding of both projects goals. Actions to address these factors included strengthened collaboration and communication, regular discussion of the two project's activities, agreement on limiting cash incentives; holding a workshop to share the two project's goals.

ADP staff felt the need for Technical Assistance in veterinary services, public sanitation and safe use of insecticides.

3.2.13 Senior Management World Vision Cambodia

An informal unstructured discussion was held with WVC's Country Director and the Senior Operations Managers for ADPs and Technical Areas. The CS project was felt to be a catalyst for mainstreaming good practice in health into WVC's ADPs and this was one of the main reasons for seeking to implement Phase 2 of the project. The capacity building objectives for Kompong Thom were felt to be unclear. Benefits were felt to be considerable but needed to be weighed against costs. The challenge was felt to be how the CS interventions could be effectively mainstreamed into an "average" ADP and how this could be replicated.

The Country Director summed up the challenge of integration and sustainability by stating: "if it doesn't work in Leuk Dek it won't work anywhere".

4. ACCOMPLISHMENTS

4.1 Project Management

Since the DIP was written and reviewed, Dr Pen Sophea has been appointed to the vacant position of Training Coordinator, further strengthening the ability of the Project Team to build the capacity of project partners. His *curriculum vitae* is in Annex 8.7. There have been no other changes in staff and this stability has contributed to a strong and experienced team for Phase 2 of this project.

At the time of writing this Annual Review, the construction of the Leuk Dek ADP office in Leuk Dek District is complete. Office space will be shared between the ADP, MED and KSCSP. The KSCSP will maintain its current office in Kean Svay District, strategically located along Highway 1 and close to the Operational District offices. However the establishment of this sub-office in Leuk Dek District will contribute to more effective implementation of child survival interventions as staff will be physically based in the District. The new office includes a meeting room with sufficient space for up to 50 persons, allowing most trainings to be conducted in Leuk Dek District itself, therefore reducing travel time and costs. In addition, the process of integration with ADP and MED staff will be facilitated by sharing office space with regular meetings scheduled between these project staff. .

Based on recommendations made during the DIP Review the Workplan for the project for FY02 and FY03 has been reviewed with attention given to phasing in several activities in order to more evenly spread the anticipated workload. This Revised Workplan is in Annex 8.8.

4.2 Capacity Building/Training

The year October 2000- September 2001 has been one of transition from child survival interventions in Kean Svay District to Leuk Dek District. Some Phase 1 activities in Kean Svay District continued during this year.

A detailed list of Trainings conducted by the Project as well as Workshops attended by Project Staff is presented in Annex 8.9. The outcomes of some of these trainings is presented below.

In Kean Svay District (not Leuk Dek) between October 2000 and April 2001, a total of 199 assessments of VHV knowledge in relation to ARI, CDD, DHF, IDD and VAD were conducted.

A checklist was used where greater than 66.6% of correct responses was coded as a Good result. The range of outcomes is shown below:

ARI	93-97%	Good
CDD	90-96%	
DHF	96-100%	
IDD	92-98%	
VAD	94-98%	

During the same time in Kean Svay District, a total of 133 assessments of VHV knowledge in relation to birth spacing were conducted using a separate checklist with the same coding system. The range of Good responses was 94-99%.

During the same time in Kean Svay District, a total of 953 exit interviews were conducted with mothers using a separate checklist with the same coding system. The range of outcomes is shown below:

ARI	54-71%	Good
CDD	74-87%	
DHF	62-87%	

The results noted above were collected during the year but different samples were used on each occasion. It is therefore not possible to assess any trend in improving knowledge over the collection period.

One of the conditions of acceptance of the DIP agreed at the DIP Review was for WV Cambodia to develop a more detailed capacity building/ sustainability plan. Negotiations with WV United States have been conducted and it is anticipated that WVUS staff will travel to Cambodia to prepare this plan in collaboration with WV Cambodia. This Plan will be submitted as a separate Annex to this Annual Review.

4.3 Behaviour Change Communication

At the time of preparing this Annual Review, arrangements have been made for a Consultant to visit the Kean Svay CS Project from 29 November to 9 December for the purpose of developing a behaviour change communication plan for each of the major child survival interventions. It is anticipated that this report will be completed by 21 December and will be attached as a separate Annex to this Annual Review.

4.4 Technical Assistance

Following recommendations made during the DIP Review, the Technical Assistance Plan was revised. Technical Assistance for the next 12 months (FY02) will include:

- Behaviour Change Communication Consultancy - external
- Capacity Building/ Organizational Capacity Assessment Consultancy – external
- Nutrition Consultancy – local (HKI for micronutrients, World Relief for iron and folate supplementation, RACHA for COPE materials in Khmer and Partner’s for Development for the Hearth Model, LQAS experiences)

- Community Based Death and Disease Surveillance Consultancy –social and verbal autopsies - local and/or external
- Mid-Term Evaluation – may be combined with one of the above Technical Assistance Consultancies.
- Survey methodologies with a focus on LQAS training - local

Depending on the results of a recent UNICEF survey, the project may also seek technical assistance in the area of the role of private providers of health services.

Within World Vision Cambodia, Technical Assistance to the KSCSP is provided by WVC's National Health Advisor (Dr Douglas Shaw) and Health Technical Support Coordinator (Dr Ly Vanthy). This support includes formal and informal meeting with the Project Manager (Dr Lim Somaly) at least twice a week and specific support with implementation, monitoring and evaluation and project management. Dr Shaw subscribes to the CORE Listserve and shares relevant materials with the KSCSP staff. Additional management oversight is provided by a new position, Senior Operations Manager/ Technical, filled by Mr Andy Leigh, who also provides support to other WVC sectoral projects. The actual hours dedicated to the KSCSP are documented on a monthly timesheet by these three persons.

World Vision's Asia-Pacific Regional Health Advisor, Dr Sri Chander, provides in-country support during two scheduled visits each year (in FY01 this was during the DIP Workshop and the Annual Review). He represented WV at the DIP Review in Washington. He also facilitates regional trainings and consultancies of relevance to health issues and is available for additional technical support by email or telephone.

World Vision United States provides HQ Technical Support through Dr Fe Garcia and Mr David Grosz. In FY01 they both participated in the DIP Workshop and David Grosz in the DIP Review in Washington.

4.5 Quality Improvements

In addition to capacity building in the area of knowledge and skills the KSCSP has attempted to measure improvements in quality of service. Using a Supervisory Checklist developed during the first phase of the project, Health Centre staff in Kean Svay, Leuk, Dek, Lovea Em (all in Kean Svay OD) and in the three Districts in Kompong Thom OD were assessed before and after case management training. The assessments focused on ARI, diarrhoea and dengue and included history taking, examination, treatment plan, health education and communication. An exit interview was done with the child's caretaker. Where there were insufficient patients, role-play was used to assess quality of service. A scoring system was used to rate performance as Good, Fair or Weak. Full details are presented in Annex 8.10.

In the Kean Svay OD, the initial assessment in February demonstrated that HC staff in Kean Svay District had better performance than HC staff from the other two Districts. This was to be expected given the focus on Phase 1 of the project in Kean Svay District. In all three areas, performance improved significantly following the case-management training. For diarrhoea and dengue case-management, most HC staff scored a Good rating (63% and 62% respectively)

while for ARI 38% were Good and 50% Fair. A follow-up assessment has been planned for the first quarter of FY02.

In Kompong Thom, two similar assessments were conducted (see Annex 8.11). Following the case-management training, 60% of HC staff were rated Good for Dengue, 17% Good and 67% Fair for diarrhoea and 50% Fair and 31% Good for ARI.

During the First Annual Review, Project staff reviewed the current Supervisory Checklist used by the OD. Suggestions were made to enhance this checklist based on the findings of the Annual Review (see 3.2.9 above). However, OD staff were reluctant to make changes to the Ministry of Health approved Checklist until they had an opportunity to discuss the matter further with Provincial and Central Ministry of Health staff. In the meantime, the project will continue to support the OD in Supervisory visits to Health Centres and will use the Quality Performance Checklist as a peer-review tool for Health Centre staff to improve quality of service.

4.6 Specific Interventions

As specific child survival interventions did not commence until June-July 2000 there has been no attempt to measure achievements at the outcome level from this starting date to the time of the Annual Review. In December 2001, two USAID Child Survival partners (Catholic Relief Services and Adventist Development and Relief Agency) will be conducting a KPC/LQAS training in Cambodia in order to acquire necessary survey skills and provide both organizations with baseline data for their projects. WV Cambodia will participate in this training. In the DIP, a decision was made to conduct KPC surveys only as part of the Final Evaluation and not at each Annual Review. The project is very interested in learning more about the LQAS sampling method as a means to measure annual progress.

The Leuk Dek ADP plans to conduct a household survey in the District in December 2001 or January 2002 in all seven communes. Child Survival project staff will work closely with the ADP staff so that results from this survey can be used to measure progress in achieving CS project goals. This survey will feed into the Mid-Term Evaluation planned for April-June 2002.

However the project has been regularly monitoring performance at the output level and this data is presented in the 4th Quarterly Report (Annex 8.12) and summarized here. Based on an estimated target population for each indicator, 41% of children 0-11 months completed immunizations and 67% of mothers of young children received at least two tetanus immunizations. VAC was distributed to 86% of children 0-11 months, 10% of children 12-59 months and to 33% of eligible post-partum women. Significant achievements in health education for mothers on diarrhoea, distribution of ORS and establishment of ORT corners in Health Centres were achieved. Health education for mothers on ARI and DHF exceeded targets. Progress was made on increasing numbers of new acceptors of modern birth spacing methods.

Health Centre staff training (also noted in 4.2) met targets in Leuk Dek and Lovea Em Districts but not in Kean Svay District in Kompong Thom OD, although in both these cases well over 50% of planned trainings were conducted. All three districts in the Kean Svay OD met targets for training of midwives in birth spacing, but planned training in Kompong Thom OD did not take place.

All four health centers in Leuk Dek were provided with a motor-bike ambulance to assist with referral of seriously ill patients. Targets for training of VHVs in Leuk Dek were fully met while 40% of the TBA target population received training.

In the 12 months to September 2001, a total of 6500 kg of iodised salt was purchased and given to VHVs in Kean Svay District to sell at minimal cost to the local population.

IMCI Update (to 3 September 2001) (excerpt from WHO IMCI Update)

The adaptation of IMCI training materials was completed in August 2001. The first facilitators' training was conducted in March 2001, and currently there are 11 trained IMCI facilitators in Cambodia. The first national IMCI training course took place in the National Paediatric Hospital in Phnom Penh in July 2001. The second facilitator training course took place in the same training site from 20 to 24 August 2001.

The target for IMCI training coverage is to train at least two staff (secondary nurses and midwives, medical assistants) per health centre, selected staff from the senior district management team and technical bureau and from the provincial health department responsible for supervision of health centre staff and/or MCH, disease control and pharmacy. Three district level courses have been planned as part of the early implementation phase to train approximately a total of 40 health centre staff, representing full coverage of health personnel responsible for managing sick children in government health facilities in the pilot areas. The first one started on 27 August. Two courses for IMCI follow-up after training are also planned in 2001.

In addition, capacity building for breastfeeding counselling was initiated in 2000. Training courses involving child health staff from the pilot districts are planned for 2001/02, and policy work on infant and young child feeding and the *"International Code for Marketing of Breast milk Substitutes"* continues. In addition to the National Paediatric Hospital, Svay Rieng Provincial Hospital and possibly the Kampong Cham Regional Training Centre will be developed as IMCI training sites during the expansion phase. As part of the IMCI adaptation, the IMCI home care card has been drafted in collaboration with the National Centre for Health Promotion, and will be printed after field-testing in the near future.

With the completed national adaptation of IMCI, it is expected that the implementation of the strategy will speed up once the implementation at the district level begins. Strengthening collaboration between and support by the coordinating and implementing parties such as the CDC, National Paediatric Hospital and National Maternal and Child Health Centre and other key programmes at central level and provincial and district health departments and projects from UN and bilateral agencies and NGOs still remain critical in terms of utilizing the momentum of timely launching of IMCI in the districts. Similarly, active involvement of partners in child health and putting child health high on the development agenda need to be seen as a continued priority in rehabilitating child health services of a uniform standard of care in Cambodia.

Nutrition Update

On October 25, 2001 the Ministry of Planning released a draft Cambodia Nutrition Investment Plan (2002-2007). This plan covers both rural and urban areas with a focus on women and children, especially children under two years of age with follow-up for children 2-5 years of age.

The Plan's objectives are to reduce the levels of Protein Energy Malnutrition, virtually eliminate iodine and Vitamin A deficiencies, reduce anaemia in children under 5 years and women of child-bearing age, including pregnant women, increase coverage of ante-natal care, reduce levels of low-birth weight children and reduce malnutrition in women of reproductive age.

The KSCSP will be closely monitoring progress on this Plan and seeking to develop close collaboration with the Ministry of Health once this Plan is approved and funded.

4.7 Integration with Leuk Dek Area Development Program

As described in the DIP, one of the critical components of sustainability of positive health outcomes will be the integration of child survival interventions into community-based ADP activities.

World Vision Cambodia currently has four projects operating in Leuk Dek District. These are the Kean Svay Child Survival Project, the Leuk Dek ADP, a Micro-enterprise development project (MED) closely linked to the ADP, and, in the north of the District along National Highway 1, a HIV-AIDS prevention and care project.

Commencing in May, a series of six meetings have been conducted involving the Project Managers of these four projects together with two representatives of WVC National Health Program (Dr Douglas Shaw and Dr Ly Vanthy) and Mr Min Sor, WVC Operations Manager to whom the Leuk Dek ADP Manager reports.

The primary purpose of these meetings was to discuss how these four programs could work together, with a specific interest in how child survival interventions could be integrated into the health activities of the ADP. Key issues were identified and prioritised for these meetings. They were, in order of importance:

1. Program approach – roles and responsibilities of project staff and partners, coordination of activities, trainings, surveys, resources.
2. Financial issues – per diems for training and other activities, office space and rental.
3. Integration issues and timeline – including selection and training of Village Health Volunteers (VHVs) and Village Development Committees (VDCs).
4. Team and relationship building – including regular meetings of staff from all four projects.

A matrix was prepared summarising for each of the four projects information under the headings of activities, target groups, geographical areas covered, partners, WVC staff and management, how the project operates and the project duration. The key commonalities were that all projects plan to focus on the poor and poorest including an emphasis on mothers and children. All projects plan to eventually cover all 7 communes in the District. For three of the projects, World Vision United States is the Support Office providing opportunities to coordinate communications, including reporting. This matrix is presented in Annex 8.13.

Definitions were provided to clear confusion regarding per diems, travel allowances, accommodation costs, honorariums, incentives and gifts.

- Per-diem: money for meals given to participant for attending listed project activities. Amount based on number of hours (half or full day) and whether over night stay is needed.
- Travel allowance: Additional money for travel costs given to participants for attending listed project activities. Amount based on distance, travel time and method of travel.
- Incentive : Money given in recognition of voluntary service supporting listed project activities.
- Honorarium: Fee for services provided (eg. Facilitator, Trainer..)
- Gift : Small token of appreciation for visiting dignitary attending activities for a short while (eg . Opening/closing ceremony)
- Accommodation : WVC will pay actual costs of accommodation if needed.

In order to help determine when, who and how much per diem should be paid another table was prepared describing the role and task of the various project partners – VDC members, VHVs, VBMC members and other People’s Organisations. This Table is found in Annex 8.14.

Agreement was reached on when per diems should be paid in order to avoid inconsistencies between projects and to promote one World Vision Cambodia identity. Participants agreed to pay per diems for trainings, special surveys, regular meetings (for example of VHVs with Health Centre staff), special campaigns and cross visits to other projects in other areas. Per diems would not be paid for supervisory visits, routine field visits, routine activities and outreach activities. However the MED program does not provide per diems to Village Bank Management Committee members who instead are rewarded with 80% of the 1% service charge on loans disbursed by them. Village Development Club members will also be rewarded through this mechanism by receiving 20% of the 1% service charge.

An acceptable range for per diems was then documented with additional travel allowances paid based on distance and degree of difficulty of travel. When overnight accommodation was required, agreement was reached to pay actual accommodation costs.

In the Kean Svay Phase 1 project VHVs were given a regular payment for their cooperation with the mobile teams. However, this was felt to be unsustainable and is in process of being phased out in Kean Svay District. For Leuk Dek District, it was agreed not to give a regular financial incentive. Instead a package of incentives has been developed with the expectation that this will contribute to the motivation and commitment of VHVs. The package will comprise per diems for the activities noted above, small non-financial incentives such as mosquito nets and rain-coats given when pre-determined targets are achieved, an Annual Certificate of Appreciation, provision of bicycles for transport and the possibility of VHVs being models in their village for latrines, sand filters and wells.

4.8 Community Based Death and Disease Surveillance

A Community Based Death and Disease Surveillance system, documented in previous KSCSP documents, provides information on all births, deaths and pregnancies through registers at village level managed by VHVs in collaboration with HC staff during outreach visits. In addition to verbal autopsies for maternal and under-5 child deaths the system provides for outbreak monitoring of measles, dengue and polio cases.

During the 12 months to September 2001, a total of 54 deaths in children under 5 years of age were reported, 41 in Kean Svay (for the full 12 months) and 13 in Leuk Dek (surveillance commenced in June 2001). Of this total, where verbal autopsy was conducted, 21 deaths were attributed to ARI, seven to premature neonates, two to meningitis, one to protein-energy malnutrition, none to diarrhea, none to dengue and in 20 cases no cause could be determined.

For the full 12 months there were two maternal deaths reported in Kean Svay District – one due to post-partum hemorrhage in the village after being delivered by a TBA and the other an ante-natal hemorrhage due to a molar pregnancy. From June to September 2001 there was only one reported maternal death in Leuk Dek District with no details available.

During the year under review there were limited sporadic outbreaks of measles and one seasonally determined outbreak of dengue fever. No deaths in children were reported during this latter outbreak.

4.9 Networking and Strategic Alliances

At the OD level, the Project Manager and project staff have continued to build on the already good relationships with the OD and PHD staff through frequent formal and informal meetings and discussions. The Project Manager, Health Technical Support Coordinator and National Health Advisor for WVC have continued to strengthen relationships with the central Ministry of Health, in particular the following branches.

- National Pediatric Hospital
- National Institute of Public Health
- National Centre for Health Promotion
- National Maternal and Child Health Centre
- Department of Communicable Disease Control

Networking relationships are being developed with other CS partners in Cambodia, particularly with World Relief and Partners for Development. During the planned KPC Training Workshop it is hoped that relationships will be developed with the two new CS agencies in Cambodia – CRS and ADRA. WVC is regularly represented at Medicam meetings, a forum for exchange of information between all agencies involved in health in Cambodia. Additional links have been made with Helen Keller International in Cambodia.

A close working relationship has been developed with WHO, particularly in the area of community IMCI and there are frequent contacts with UNICEF. WVC staff also attend the local USAID Mission Partner's meetings and regular updates are provided to the local USAID Maternal and Child Health Advisor.

During the year there were two opportunities to link the project with relevant research. An independent Consultant, partly funded through WV Canada, completed a research paper on perceptions of Village Health Volunteers. This was followed by a series of feedback workshops involving active participation of VHVs. One of these workshops was conducted in Kean Svay District. A Japanese MPH student conducted field work in Leuk Dek District on "The District

Health System Reform in Cambodia and Its Influence on Health Seeking Behaviour of Local Residents”. A draft paper has been received but the completed dissertation will not be available until January or February 2002.

5. CHALLENGES AND CONSTRAINTS

This section summarises the main challenges and constraints detailed in the sections above. One of the most important challenges is to build the capacity of the project partners (OD, HC staff and local community) to the extent that effective reproductive and child health interventions continue after the project has ended. This is therefore one of the critical factors in the sustainability of project outcomes. The second critical factor contributing to sustainability, and a similarly important challenge, is the integration of reproductive and child health interventions into the Leuk Dek ADP, and subsequently, to mainstream these interventions in all WVC ADPs, with an initial focus on the three ADPs in Kompong Thom.

Related to these challenges is the importance of developing a means to compare outcomes, both in terms of health status and service indicators and cost-effectiveness, in the direct impact area (Leuk Dek) and the indirect impact areas (Kean Svay and Lovea Em Districts and the three Kompong Thom ADPs).

At the level of health service delivery, one major challenge is to enhance the quality of services provided which will in turn increase utilization of public health services. Supervision is an essential element in improving quality of care. A recurring challenge will be to keep up-to-date and actively contribute to Ministry of Health policies and practices in reproductive and child health.

Given the number of interventions, current workload and travel distance and time, the need to develop strong links with other child survival projects in Cambodia will need to be given a greater priority.

In Leuk Dek District, the difficulty of access to the southern communes during the wet season is a constraint, with serious flooding in 2000 and 2001. More widespread seasonal flooding could disrupt project activities in much of the District. Related to this is the need to develop an effective referral system and to build the capacity of the referral hospital to respond appropriately to cases referred from Health Centres. The role of private providers of health care, including public Health Centre staff who also conduct private practice, is a challenge to improving quality of care. The southern communes of the district share a border with Vietnam and many people seek health care in Vietnam, especially when road access to the north is limited.

Finally, the commune elections in February 2002 will be closely monitored, both for opportunities to enhance community participation in project activities and for potential threats that may impact on health services.

6. CHANGES IN PROGRAM DESIGN

There have been no substantial changes in Program Design since the DIP was written. However, in response to issues raised during the DIP Review the following actions have been taken (and are reported on in more detail elsewhere in this Review)

- The Workplan has been reviewed to show how activities will be phased in both chronologically and geographically
- The Technical Assistance Plan has been updated (including the addition of technical assistance for BCC and nutrition)
- A Consultancy has been arranged to prepare a BCC plan for each major intervention
- Plans for Technical Assistance from WVUS in the area of capacity building have been made.

7. KEY RECOMMENDATIONS

This section will follow the order of accomplishments presented in Section 4 and does not therefore list finding and recommendations in order of priority.

	Key findings	Recommendations
1.	Project Management – problems with travel distance/ time and workload for KSCSP staff	Revise Workplan to phase activities both geographically and chronologically (done) Consider staying overnight in Leuk Dek
2.	Project Management – strengthen linkages between HC and VHVs, VDCs and community	Facilitate formation of Health Centre Management Committees following MoH Guidelines Encourage VHVs and VDCs to regularly attend HC staff meetings and participate in planning as well as working Develop a package of non-financial incentives for VHVs
3.	Capacity Building – Case Management practices of HC staff does not yet meet quality standards	Provide training or refresher training (see also below on Quality Improvements)
4.	Capacity Building- OD staff need additional training/skills as master trainers of Demo site.	Support MoH organised training opportunities for OD staff Support funding for Health Services Management training through NIPH for OD staff Strengthen clinical and management skills and expertise in reproductive and child health to Kean Svay Referral Hospital staff. Provide Training of Trainer Skills to OD staff, including presentation skills and establish a training team at OD. Conduct COPE exercise for OD staff
5.	BCC - Lack of IEC materials at HC and Village Level	Provide three TV/VCR units to share among the four HC (done) Obtain IEC materials from HKI (breast feeding), UNICEF/MoH Disseminate 16 Community Practices for IMCI Prepare a VHV IEC “kit” with key IEC materials
6.	Technical Assistance – identify TA needs and resources – externally and in-country	See Section 4.4
7.	Quality Improvements – Case Management practices of HC staff does not yet meet quality standards	See 3. above. Regularly supervise and monitor through Supervision Team comprising PHD, OD and the project staff (provide limited supplementary funding from the project for supervision activities) Work with OD, PHD and central MoH to enhance supervisory checklists to strengthen quality of service delivery OD should establish a technical mobile team to assist some health center

		where the capacity of staff is limited Conduct COPE exercise for HC staff (see 4. above)
8.	Quality Improvements - HC staff not always available 24 hours/day or punctual for clinic hours	Chief of HCs should conduct a meeting focusing on working hours and staff on duty. Staff have to decide and agree among themselves on working hours and staff on duty (Bottom up approach). Chief and vice chief of the OD should participate in the meeting. Strengthen the unity between chief of HC and his staff. Provide training on leadership and management styles which will encourage teamwork and loyalty in each HC. Consider appropriate rewards to staff as well as to HC that are open 24 hours per day and punctual for clinic times - HC, OD and the project will discuss the rewards. Conduct missed opportunity survey at HCs
9.	There is a lack of some Essential Drugs/supplies at HC level	OD and HC need to demonstrate transparency and accountability in management of drugs and supplies. The project will then be able to effectively support the HC through the provision of buffer stock. Begin long term planning to address the issue of insufficient drugs/supplies from MOH in anticipation of the Project phasing out support. Strengthen the cost-recovery system (with strong advocacy for free drugs for those clearly defined as poor). Use 50% of these funds to address drug/ supply shortages. Advocate for increased support from MoH, World Bank, ADB where needs are clearly identified.
10	Quality Improvements – inadequate trained staff, equipment and supplies at Referral Hospital to support Project interventions	Explore possibilities for using WVUS GIK matched funds to strengthen reproductive and child health services at the referral hospital, particularly where cases are referred from HC for management. Discuss with OD, referral hospital and HC an effective means of documenting referral from HC to the referral hospital (referral letter)
11	Quality Improvements – no effective system exists to refer patients to the referral hospital	Provide motorbike-ambulances to each of the four HC to facilitate affordable transport at least in the dry season (done) Advocate with the ADP to support infrastructure repairs to key roads, culverts and bridges
12	Quality Improvements – no reliable power source to provide lighting for 24 hour service	Provide generators to all four HC (done)
13	Specific Interventions – need to keep up-to-date with MoH programs regarding IMCI and Nutrition	See 4.6 above – IMCI update and Nutrition update
14	Project in process of integration with ADP	Joint planning - checking for overlapping activities. Regular meetings in new ADP project office Conduct Lessons Learned/ Best Practice Workshops for direct and indirect impact areas Plan for cross-visiting of ADP staff, including Kg Thom Based on KSCSP experiences, develop standard health status and service indicators, quality of care indicators and capacity and sustainability indicators to be introduced in all ADPs in Cambodia
15	Surveillance- need to strengthen Health Information System	Provide training on HIS to HC staff, facilitated by PHD and OD TA – see 4.4.
16	Networks – need to strengthen links with other USAID funded CS projects in Cambodia	Plan regular meetings with other CS project staff and seek other opportunities for joint training/ sharing of experiences

ANNEX 8.1 LIST OF RESPONDENTS FOR FIRST ANNUAL REVIEW

1. Fathers and Mothers

N°	Health Center	Address	Mothers	Fathers	Remarks
1	Prek Tunloap	Spean Dek	Chhorn Srey Phal	Veng Ith.	
2			Ros Hoeurn	Nem Mos.	
3			Samreth Narun..	Yet Moa.	
4			Aun Mom	Samreth Seila	
5			Khen Mach	Muon Uon.	
6			Bin Sok	Doeurk Samnang	
7			Noy Siron		
8	Kg Phnom	Kbal Chroy	Soy Ny	Ven Lon	
9			Kim Thy	Run Poly	
10			Y Yoeurn	Sath Sinath	
11			Koen Chrep	Huon Vong	
12			Phoeurn Roeurn	Heng Soy Try	
13			Dy Heng	Hay Nay	
14			Kan Phally	Saray	
15			Pan Chrep	Seang Peng Heang	
16			Puth Soben	Sok Tek	
17			Khom Neath	Muong Sameth	
18			Puk Pon		
19		Kg Poh	Keo Leakhena	Horn Phean	
20			Sem Ron	Sar Hoeurn	
21			Sok Khoeurn	Soeur Sar	
22			Bo Srey	Soth Pring	
23			Kang Khen	Lun Thon	
24			You Saveth		
25			Chamroeun Ry		
26			Chea Sroy		

2. Village and Group Leaders.

N°	Commune	Village	Name
1	Kg Phnom	Kg Poh	Tep On
2			Kim Ly
3	Prek Tunloap	Spean Dek	Ros Rin

3. Village Health Volunteers

N°	Health Center	Address	Name	Remarks
1.	Kg Phnom	Kbal Chroy	Van Sarin	
2			Heang Nan	
3		Kg Poh	Khuon Sarom	
4			thim Chhan	
5			Sok Oh	
6			Tep On	
7			Keng Try	
8			Hem Saman	
9	Prek Tunloap	Spean Dek	Son Neang	
10			Sok Samnang	
			Ros Rin	

4. TBAs

N°	Health Center	Address	Name	Age	Remarks
1.	Kg Phnom	Kbal Chroy	Rin Ang	48 y	
2			Ros Tob	55 y	
3		Kg Poh	Mith Savorn	62 y	
4			Yet Han	42 y	
5			Hok Tem	65 y	
6		Ampil Tuek	Uth Sreang	49 y	
7			Hem Chhang	65 y	
8		Koh Chamroeun	Lun	65 y	
9			Hen Sophany	35 y	
10	Prek Tunloap	Prek Tauch	Sreang Kimhay	45 y	
11		Prek Bak	Mey Ngeth	65 y	
12			Mith An	56 y	
13		Spean Dek	Chuop Pok	51 Y	
14			Srun Vy	38 y	
15		Kg Chamlong	Thach Vy	40 Y	
16			De Toeur	40 y	

5. Drug Sellers -Interview at Prek Tunloap Health center

1. Ok Kimly Kg Chamlong Village , Prek Tunloap Commune.
2. Narin. Kg Chamlong Village , Prek Tunloap Commune
3. Puth Sary Kg Chamlong Village , Prek Tunloap Commune

6. Commune Leaders.

1. Suon Chin. Kg Phnom Commune leader
2. Bou Saborn. Prek Tunloap Commune Leader.

7. Health Center staff

Kg Phnom Health center.

1. Mrs. Sun Neang
2. Mr. Prum Vannak
3. Mr. Snguon Sovann
4. Mr. Mon Phen

8. Operational District Staff/ Provincial Health Department

- | | |
|---------------|------------------|
| 1 Tuy Saroeun | 3 Yi Sophoanrith |
| 2 Ben Samrith | 4 Phan Samnang |

9. Kean Svay Project Staff

- 1 Dr Lim Somaly, Project Manager
- 2 Keo Sereivuth, M&E Coordinator
- 3 Dr Pen Sothea, Training Coordinator
- 4 Hout Sokda, Public Health Officer
- 5 Huy Dany, Public Health Officer
- 6 Kan Chamroeun, Public Health Officer

10. Leuk Dek ADP Project Staff

- 1 Sil Sineng, Project Manager
- 2 Ngoun Pheap, Community Development Worker

11. WVC Senior Management

- 1 Justin Byworth, Country Director
- 2 Andy Leigh, Senior Operations Manager/ Technical
- 3 Talmage Payne, Senior Operations Manager/ ADPs

ANNEX 8.2 FIRST ANNUAL REVIEW TEAM

Nº	Name	Title	Remarks
1	Dr Sri Chander	Regional Health Advisor	
2	Dr Douglas Shaw	National Health Advisor	
3	Dr. Ly Vanthy	National Health Program	
4	Phan Sam Nang	PHD , EPI Chief	
5	Tuy Saroeurn	Kean Svay OD Chief	
6	Hor Veng Nay	Kean Svay OD EPI Chief	
7	Bin Samreth	Kean Svay OD Vice Chief/LD	
8	Thang Seng	Sandar HC Chief	
9	Mak Sakhoeurn	Prek Tunloap HC Chief	
10	Teang Sarath	Prek Dach HC Vice Chief	
11	Yun Sa-Eng	Kg Phnom HC Chief	
12	Chan Sam Deth	Kandal/Takeo Health Cluster	
13	Mok Aura	Leuk Dek ADP CDW	
14	Yin Yorn	VDC/ Village leader.	
15	Hem Sa Man	VHV	
16	Dr Lim Somaly	KSCSP Staff	
17	Huy Dany	KSCSP staff	
18	Huot Sokda	KSCSP staff	
19	Kan Chamroeun	KSCSP staff	
20	Keo Sereivuth	KSCSP staff	
21	Dr Pen Sophea	KSCSP staff	

ANNEX 8.3. SCHEDULE FOR FIRST ANNUAL REVIEW

DAY/TIME	ACTIVITY
<i>Monday 10 September</i>	
1100	Arrival Dr Sri Chander
1100-1200	Briefing in National Office
1200-1230	Travel to Kean Svay Project Office
1230-1330	LUNCH
1330-1630	Meeting with Project Staff to finalise timetable for Annual Review
1630	Return to Phnom Penh
<i>Tuesday 11 September</i>	
0800-0830	Dr Lim Somaly. Welcome and Introductions, Summary of KSCSP to date
0830-0850	Dr Sri Chander. Purpose/ Outcomes of First Annual Review
0850-0935	Dr Ly Vanthy. Small group discussion on participants expectations and understanding of purpose of Review
0935-1005	Dr Ly Vanthy. Presentation of small groups
1005-1020	BREAK
1020-1130	Dr Lim Somaly. Large group discussion on what information is needed? who to ask? and how to get this information?
1130-1200	Dr Sri Chander. Tools available for Annual review
1200-1330	LUNCH
1330-1530	REVIEW TEAM Work groups to develop tools, questionnaires
1530-1600	REVIEW TEAM Finalise tools
1600-1700	REVIEW TEAM Finalise logistics for field visit
<i>Wednesday 12 September</i>	
0700-0800	Travel to Leuk Dek District in 4 groups
0800-1200	Teams in four locations – interviews, focus groups, observations, review of records according to Team workplans
1200-1330	LUNCH
1330-1400	Travel back to Project Office
1400-1700	Collate results from Field Visit
<i>Thursday 13 September</i>	
0800-1200	Preparation for Presentation of Findings
1200-1400	Lunch
1400-1700	Interviews with Key Informants not in Leuk Dek (OD staff, WVC National Office Staff, Project Staff)
<i>Friday 14 September</i>	
0830-1200	Presentation of Findings, discussion on Recommendations
1200-1400	LUNCH
1400-1500	De-brief, Action Plan for preparation of Annual Review Report

ANNEX 8.4 INTERVIEW TEAM SCHEDULE

Group One	Group two	Group three	Group four
Kg Phnom Health Center	Kg Poh Village	Prek Tunloap Health Center	Spean Dek Village.
1. Tuy Saroeurn	1. Bin Samreth	1. Phan Sam Nang	1. Hor Veng Nay
2. Keo Sereivuth	2. Hem Saman	2. Yin Yorn	2. Huy Dany
3. Huot Sokda	3. Kan Chamroeun	3. Mok Aura	3. Mak Sakhoeun
4. Thang Seng	4. Pen Sophea	4. Yun Sa-Eng	4. Teang Sarath
5. Dr. Sri Chander	5. Dr. Douglas	5. Ly Vanthy	5. Lim somaly



Interviewees	Interviewees	Interviewees	Interviewees
Commune Leader . I	VHV F.I	Village Leader I	VHV F.I.
HC Staff . OS.IF	Villager Leader I	HC Staff . OS. I.F	Villager Leader I
VHV . F.I	Group Leader I	VDC I	Commune Leader I
Father F	Father F	Father F	Father F
Mother F	Mother F	Mother F	Mother F
TBA I	Traditional Healer I	Drug Seller I	

ANNEX 8.5 QUESTIONS FOR ANNUAL REVIEW

1. Questions for Mothers and Fathers

1. Do you know the Health Center?
2. Do you know what services are provided at the HC?
3. Are there people using the health services at the HC at the moment?
4. Have you seen any changes in HC service?
5. If yes, what are the changes?
6. What are the factors that can bring about changes in the health center?
7. Do you see any weak points which need to improve?
8. Do you have any suggestion in order to improve or have the health center worked better?

2. Questions for Village and Group Leaders

1. How is the health center service today?
2. What are the health center services?
3. Do the people go to the health center when they get sick?
4. If they do not go to health center - why?
5. What are the differences in health center service at the moment compared to the past?
6. What are the weak points you think that the health center should change?
7. Do you have any suggestions for the health center in order to improve health services?

3. Questions for VHVs

1. What have you done so far in terms of health related work or activities?
2. Is it possible for VHVs to contact health center staff?
3. If it is possible, in what ways do you make contact with HC staff?
4. What problems have you encountered in doing the work?
5. What do you know in terms of health since you became a VHV?
6. Have you seen or noticed any changes in the community in terms of health?

4. Questions for VDC Members

1. Is there a health center in your community?
2. Do the health center staff have a good relationship with the community?
3. What are the services provided at the health center?
4. In what ways does the VDC make contact with the Health Center?

5. Questions for TBAs

1. Why have you agreed to be voluntarily involved with project activities?
2. What type of support you have received from the project?
3. What do you feel about the project implementing activities in your community ?
4. Do you have any ideas or suggestions for the health center and project?

6. Questions for Traditional Healers

1. What is the average number of patients you seen in a month?
2. Who do people like to see first, HC staff or Krou khmer?
3. What are the common problems you have treated?
4. Do you treat with traditional medicine or magic?
5. What do you think about modern techniques and medicine used to cure patients?

7. Questions for Drug Sellers

1. How long have you been selling drugs ?
2. Do you prescribe drugs yourself or follow prescriptions. Which do you do most often?
3. Have you been trained in terms of health knowledge ?
4. If you have not been trained, how do you prescribe ? (by notice or by prescription)
5. What do you do if you see severely ill patients.?

8. Questions for Commune Leaders

1. Is the health center always open and are there staff?
2. From whom do people seek help when anyone in the family gets sick - Private practitioner or Health center?
3. Since the project started activities 4-5 months ago, are there any changes in the health center services? - If Yes. What are the changes?
4. Have you seen or noticed any weak points that the health center needs to change in order to make health center service better?

9. Questions for Health Centre Staff

1. What have been the outcomes of the ARI, CDD and DHF training?
2. Use of data from VHVs and Community (CBDDS, pregnancy, death, birth registers)
3. Nature of supervisory visits from OD.
4. Problems in referring sick children
5. Observation of Practice . ARI/CDD.
6. Exit interview of mothers/caretaker.
7. Record Review

10. Questions for Operation District Staff

1. In the last 12 months, what do you think have been the major accomplishments of the KSCSP (Phase 2)? What has the project done well?
2. What factors do you think have contributed to this success?
3. Do you have a plan for supervisory visits to Health Centres?
4. Do you do these visits in collaboration with KSCSP staff?
5. How has the KSCSP helped with these visits?
6. How often to you do these supervisory visits?
7. How many visits have you made in the last three months?
8. Do you have a Supervisory Checklist?
(obtain blank copy and also look at recent completed copies).
Check whether there are the same arrangements for Kean Svay, Leuk Dek and Lovea Em
9. How has the Project helped you in fulfilling your roles and responsibilities as Operation District leaders?
10. What support has the project provided to assist you in carrying out these roles and responsibilities?
11. What additional support do you need to help you better carry out your roles and responsibilities?
12. In what areas do you think the project needs Technical Assistance?
13. Have your roles and responsibilities changed since the commencement of activities in Leuk Dek District?
14. What are the greatest challenges for you in working with the Project?

15. How can these challenges be dealt with or what changes should be made to the project to deal with these challenges?

11. Questions for KSCSP Staff

1. What have you done in the last 12 months that you feel proud about?
2. In the last 12 months, what do you think have been the major accomplishments of the KSCSP (Phase 2)? What has the project done well?
3. What factors do you think have contributed to this success?
4. How have your roles and responsibilities changed since the commencement of activities in Leuk Dek District?
5. How do you feel about these changes?
6. What training have you received in the last 12 months?
7. Has it been helpful for your work?
8. In what ways?
9. What additional training do you feel you need to better meet your roles and responsibilities?
10. In what areas do you think the project needs Technical Assistance?
11. How are you supervised? What tools? What style of supervision?
12. Is your current workload – just right/ as expected, too much, too little?
13. What is your understanding of the plans for integration of the KSCSP with the Leuk Dek ADP?
14. What factors have impeded progress towards achieving the project's goals?
15. What action do you think needs to be taken to overcome these factors?

12. Questions for Leuk Dek ADP staff

1. In the last 12 months, what do you think have been the major accomplishments of the KSCSP (Phase 2)? What has the project done well?
2. What factors do you think have contributed to this success?
3. What is your understanding of the plans for integration of the KSCSP with the Leuk Dek ADP?
4. What factors have impeded progress towards achieving the project's goals?
5. What action do you think needs to be taken to overcome these factors?
6. In what areas do you think the project needs Technical Assistance?

13. Questions for World Vision National Office Senior Management

1. In the last 12 months, what do you think have been the major accomplishments of the KSCSP (Phase 2)? What has the project done well?
2. What factors do you think have contributed to this success?
3. What is your understanding of the plans for integration of the KSCSP with the Leuk Dek ADP?
4. How do you think this project can serve the 4 ADPs (Leuk Dek and three in Kg Thom)?
5. How do you think this project can serve all of WVCs ADPs?
6. In what areas do you think the project needs Technical Assistance?
7. What factors have impeded progress towards achieving the project's goals?
8. What action do you think needs to be taken to overcome these factors?
9. What additional questions/ concerns do you have about this project?

ANNEX 8.6 LIST OF PERSONS INVITED TO FIRST ANNUAL REVIEW PRESENTATION

Nº	Name	Title	Remarks
1	Dr Sri Chander	Regional Health Advisor WV	
2	Dr Douglas Shaw	National Health Advisor WVC	
3	Pat Le Blanc	Partners for Development	
4	Dr. Ly Vanthy	National Health Program	
5	Dr. Prak Phan	PHD Vice chief	
6	Phan Sam Nang	PHD Chief of EPI.	
6	Dr. Svay Sarath	Deputy Director of National Immunisation Program	
7	Kim Phon	Leuk Dek District governor	
8	Tuy Saroeurn	Kean Svay OD Chief	
9	Hor Veng Nay	Kean Svay OD EPI Chief	
10	Bin Samreth	Kean Svay OD Vice Chief/LD	
11	Thang Seng	Sandar HC Chief	
12	Mak Sakhoeurn	Prek Tunloop HC Chief	
13	Teang Sarath	Prek Dach HC Vice Chief	
14	Yun Sa-Eng	Kg HC Chief	
15	Chan Samdeth	Kandal/Takeo Health Cluster	
16	Sil Sineng	ADP Manager, Leuk Dek	
17	Mok Aura	Leuk Dek ADP . CDW	
18	Yin Yorn	VDC/Village Leader.	
19	Hem Saman	VHV	
20	Lim Somaly	KSCSP Staff	
21	Huy Dany	KSCSP staff	
22	Huot Sokda	KSCSP staff	
23	Kan Chamroeun	KSCSP staff	
24	Keo Sereivuth	KSCSP staff	
25	Pen Sophea	KSCSP staff	
26	Seng Chhuon Leng	NHP Assistant	
27	Ngudup Paljor	MCH Advisor USAID	Apologies
28	Kay Hansen	World Relief	Apologies
29	Lori Dostal	Catholic Relief Service	Apologies
30	Mark Schwisow	ADRA	Apologies

ANNEX 8.7 CURRICULUM VITAE OF TRAINING COORDINATOR

Name: [REDACTED]
Sex: Male
Date of Birth: [REDACTED]
Place of Birth: [REDACTED]

Formal Education.

- Diploma of Secondary School
- Medical Doctor (University of Health Science, Phnom Penh 1990-1997)
- Bachelor of Law (Faculty of Law and Economic Science 1995-1999)

Other Training

- Computer training – Microsoft Word, Excel
- Reporter training
- Human rights training

Employment History

1999-current Ministry of Health – Infectious Diseases Department

- 1.1 Ministry of Health, Kompong Chhnang Provincial Health Department – staff of Technical Unit responsible for infectious diseases and STDs, trainer and supervisor of health staff at community level.
- 1.2 Vice-President of Youth and Development Association (local NGO) – youth training in information technology and English language, also Director-General Neaksang Ketkat Thmey News (New Observer News)– political and economic analysis
- 1.3 General Editor of Inter-Faculty Khmer Student News – medical research writing, social life and law commentary
- 1.4 Steering member of SODECO (Association de Solidarite et de Development Communautaire – local NGO) – rural development activities

Languages

- Khmer (mother tongue), English (good) and French (reasonable)

Special interests:

- football and other sports, travel to other areas (rural)

ANNEX 8.8 REVISED WORKPLAN

Kean Svay Child Survival Workplan Revised Following Follow-on Project Dip Review

Description	Target Group	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ACTIVITIES													
Childhood Illness Mgmt													
District Health Staff Trg	Kean Svay OD		X			X				X			
	Kg Thom OD		X			X				X			
Health Center Staff Trg	Leuk Dek District		X			X				X			
	Kean Svay District		X			X				X			
	Lovea Em District		X			X				X			
	Kg Thom - 3 Districts		X				X			X			
Assess quality of care	Leuk Dek District			X			X				X		
	Kean Svay District			X			X				X		
	Lovea Em District			X				X			X		
	Kg Thom - 3 Districts		X			X				X			
ORT corner established at HC	Leuk Dek District			X	X								
	Kean Svay District	X											
	Lovea Em District				X								
	Kg Thom - 3 Districts				X								
Village Health Volunteers Trg	Leuk Dek District			X		X				X			
	Kean Svay District			X		X							
Pharmacists Trg	Leuk Dek District						X				X		
Traditional Healers Trg	Leuk Dek District						X				X		
Immunization/Micronutrients													
District Health Staff Trg	Kean Svay OD			X			X				X		
	Kg Thom OD			X				X			X		
Health Center Staff Trg	Leuk Dek District			X			X				X		
	Kean Svay District			X			X				X		
	Lovea Em District			X			X				X		
	Kg Thom - 3 Districts			X				X			X		
Assess quality of care	Leuk Dek District				X			X				X	
	Kean Svay District				X			X				X	
	Lovea Em District				X			X				X	
	Kg Thom - 3 Districts				X				X			X	
Village Health Volunteers Trg EPI/VitA	Leuk Dek District			X			X				X		
	Kean Svay District			X			X						
Conduct IDD survey	Leuk Dek District						X						
Birth Spacing/Maternal Health													
District Health Staff Trg	Kean Svay OD			X				X			X		
	Kg Thom OD			X				X			X		
Health Center Staff Trg	Leuk Dek District			X				X			X		
	Kean Svay District			X				X			X		
	Lovea Em District			X				X			X		
	Kg Thom - 3 Districts			X				X			X		
Assess quality of care	Leuk Dek District				X				X			X	
	Kean Svay District				X				X			X	

Description		FY01				FY02				FY03			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Lovea Em District				X				X			X	
	Kg Thom - 3 Districts				X				X			X	
STI training for HC staff	Leuk Dek District							X				X	
	Kean Svay District							X				X	
	Lovea Em District							X				X	
Village Health Volunteers Trg - STI	Leuk Dek District							X			X		
Traditional Birth Attendant Trg- STI	Leuk Dek District				X				X		X		
Nutrition/Breast Feeding													
District Health Staff Trg	Kean Svay OD								X			X	
Health Center Staff Trg	Leuk Dek District								X			X	
	Kean Svay District								X			X	
	Lovea Em District								X			X	
Assess quality of care	Leuk Dek District									X			X
	Kean Svay District									X			X
	Lovea Em District									X			X
Village Health Volunteer Trg	Leuk Dek District								X			X	
TBA Trg	Leuk Dek District								X			X	
Growth monitoring <5 yrs	Leuk Dek District						X				X		
Monitoring & Evaluation													
Annual Surveys	Leuk Dek District					X						X	
District Health Staff Trg	Kean Svay OD								X				
Health Center Staff Trg	Leuk Dek District								X				
	Kean Svay District								X				
	Lovea Em District								X				
VHV Trg	Leuk Dek District								X				
PLA Training													
District Health Staff	Kean Svay OD						X			X			
Health Center Staff	Leuk Dek District						X			X			
VHV	Leuk Dek District						X			X			
Community Leaders	Leuk Dek District						X			X			
Project management trg													
Communication/ Facilitation	Kean Svay OD								X				X
Program Mgmt Skills- NIPH	Kean Svay OD						X						
Health Center Mgmt - NIPH	Kean Svay OD						X						
Financial Mgmt - NIPH	Kean Svay OD						X						
Workshops/Meetings													
Lessons learned?Emerg. Issues W'shop	Kean Svay OD				X				X				X
	Kg Thom OD								X				X
	Leuk Dek District				X				X				X
	Kean Svay District				X				X				X
	Lovea Em District				X				X				X
	Kg Thom - 3 Districts								X				X
Community Mtgs	Leuk Dek District			X	X		X		X		X		X
Review/Planning Mtgs	Kean Svay OD		X	X	X	X	X	X	X	X	X	X	X

Description		FY01				FY02				FY03			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Int'l CS Workshop	Project Staff					X							
Grant Compliance Workshop	Project Staff						X						
Community Organization													
Select VHV's/Feedback committee	Leuk Dek District			X									
Select HC Management Committee	Leuk Dek District						X						
Establish mother's groups, children groups	Leuk Dek District					X		X					
Establish traditional healer groups, TBA groups	Leuk Dek District					X							
TRAVEL													
Local Travel													
Local Exposure Trips	Kean Svay OD							X			X		
	Kg Thom OD							X			X		
	Leuk Dek District							X			X		
	Kean Svay District							X			X		
	Lovea Em District							X			X		
	Kg Thom - 3 Districts							X			X		
International Travel													
DIP Review	Project Staff			X									
International Exposure Trip	Project Staff									X			
Technical Assistance													
LQAS training	Kean Svay OD					X							
BCC Consultancy - external						X							
Capacity Building Consultancy - external							X						
Nutrition Consultancy - local								X					
Mid-term Eval. (Consultant) - external	Consultant							X					
CBDDS Consultancy - local									X				
Final Eval. (Consultant) - external	Consultant												X

ANNEX 8.9 LIST OF TRAININGS COURSES AND WORKSHOPS

Dates	Topic	Trainers	Participants
10-12 & 17-19 Oct	Workshop on Perceptions of VHVs in Cambodia	Independent Consultant	2 Proj Staff, 2 from OD, 5 from HC & 5 VHVs
13-17 Nov	Child Focused Development Workshop	WV Cambodia	Project Manager
15 Nov	M&E Workshop	Partners for Development	Project M&E Coordinator
20-30 Nov	KPC Survey in Leuk Dek and Lovea Em Districts	Project staff, NHP	Project staff, OD & HC staff
4-9 Dec	Breast feeding counseling workshop	National Maternal and Child Health Centre	Project Manager
12-16 Dec	KPC Survey in Ksach Kandal District (comparison area)	Project staff, NHP	Project staff, OD & HC staff
20-21 Dec	PLA baseline exercises in Leuk Dek District	Project staff, NHP	Project staff, OD & HC staff
5-8 Jan	Focus Group Discussions and Key Informant Interviews in Leuk Dek District	Project staff, NHP	Project staff, OD & HC staff
21-23 Feb	Health Facility Assessment in Kean Svay, Lovea Em and Leuk Dek	Project staff, NHP	Project staff, OD & HC staff
Feb	DIP Preparation Consultancy	Dr Stan Foster	All Project Staff and partners
26 Feb-2 Mar	Case Management Training in ARI, CDD & DHF	NPH Training team	32 Health Centre staff from Leuk Dek, Kean Svay and Lovea Em
12-16 Mar	National Immunisation Program Integrated Supervisory Skills Workshop	NIP	One Project Staff, one HC staff
12-16 Mar	Case Management Training in ARI, CDD & DHF	NPH Training team	29 Health Centre staff from 3 Districts in Kg Thom
24-25 Apr	Follow-up on Case Management Training	Project Staff, NHP	16 Health Centre staff from Leuk Dek, Kean Svay and Lovea Em
Jun	VHV Workshop	Local Consultant	46 VHVs from Kean Svay
Jun	DIP Review Washington	USAID/ WVUS	Project Manager, National Health Program Tech Support Coordinator
Jun	National Immunisation Program training	NIP	Health Centre staff, Leuk Dek 35, Kean Svay 23, Lovea Em 39, OD 1
Jun	VHV Training - Diarrhea	Project Staff, OD	49 VHVs from Leuk Dek
July	VHV Training - DHF	Project Staff, OD	49 VHVs from Leuk Dek
July	Case Management Training in ARI, CDD & DHF	NPH Training Team	13 HC staff Leuk Dek, 12 Lovea Em, 9 Kean Svay, 3 from OD
Aug	Birth spacing training	PHD, Project Staff, OD	20 HC staff Leuk Dek, 18 Lovea Em, 21 Kean Svay, 3 from OD
Aug	Workshop in Kg Thom to discuss capacity building	WV Cambodia	Project Manager, WVC Kg Thom staff
Aug	VHV Training – Birth Spacing	Project Staff, OD	49 VHVs from Leuk Dek
Aug	Vitamin A Deficiency Training	PHD, Project Staff, OD	31 HC staff from Leuk Dek, 31 Lovea Em, 20 Kean Svay, 5 from OD
Aug	VHV Training - VAD	Project Staff, OD	49 VHVs from Leuk Dek
Aug	Lessons Learned Workshop	Project Staff, OD	OD and mobile teams from Phase 1 KSCSP
Sep	VHV Training - ARI	Project Staff, OD	50 VHVs Leuk Dek, 62 Kean Svay
Sep	VHV Training – Birth Spacing	Project Staff, OD	29 VHVs Leuk Dek

Sep	VHV Training - VAD	Project Staff, OD	63 VHV's Kean Svay
Sep	VHV Training - DHF	Project Staff, OD	62 VHV's Kean Svay
Sep	VHV Training - CDD	Project Staff, OD	62 VHV's Kean Svay
Sep	VHV Training - EPI	Project Staff, OD	64 VHV's Kean Svay
Sep	TBA training	Project Staff, OD	16 TBAs Leuk Dek
Sep	Health Information System training	Project Staff, OD	18 VHV's, 2 HC staff Leuk Dek

ANNEX 8.10 QUALITY OF CARE - KEAN SVAY OD

Comparison the performance appraisal of health workers in Kean Svay OD, Kandal Province on ARI, Diarrhea and DHF case management

(February and April, 2001)

Performance appraisal of HC staff on ARI, Diarrhea and DHF disease								
ARI Assessments	Kean Svay		Leuk Dek		Lovea Eam		Total	
	February	April	February	April	February	April	February	April
Good	3(25%)	3(50%)	0	1(17%)	1(9.1%)	6(43%)	4(12.5%)	10(38%)
Fair	1(8.3%)	1(17%)	1(11.1%)	4(66%)	1(9.1%)	8(57%)	3(9.4%)	13(50%)
Weak	8(66.7%)	2(33%)	8(88.9%)	1(17%)	9(81.8%)	0	25(78.1%)	3(12%)
Total	12	6	9	6	11	14	32	26
Diarrhea Assessments								
Good	3(25%)	3(50%)	1(11.1%)	3(43%)	2(15.4%)	9(82%)	6(17.6%)	15(63%)
Fair	3(25%)	2(33%)	1(11.1%)	4(57%)	1(7.7%)	1(9%)	5(14.7%)	7(29%)
Weak	6(50%)	1(17%)	7(77.8%)	0	10(76.9%)	1(9%)	23(67.7%)	2(8%)
Total	12	7	9	7	13	11	34	24
DHF Assessments								
Good	1(14.3%)	2(40%)	1(16.7%)	5(72%)	1(14.2%)	6(67%)	3(15%)	13(62%)
Fair	4(57.1%)	2(40%)	1(16.7%)	1(14%)	3(42.9%)	2(22%)	8(40%)	5(24%)
Weak	2(28.6%)	1(20%)	4(66.6%)	1(14%)	3(42.9%)	1(11)	9(45%)	3(14%)
Total	7	5	6	7	7	9	20	21

NB:

- *."ARI:" Actual:19, Role Play: 7
- *. Diarrhea : Actual 13, Role Play: 11
- *. DHF : Actual : 0 , Role Play: 21

**Comparison the performance appraisal of health workers in Kean Svay OD,
Kandal Province on ARI, Diarrhea and DHF case management by
administrative districts**
(February and April, 2001)

Performance of health center staff on ARI/CDD and DHF by districts									
<i>District</i>	<i>HCS</i>	<i>DHF</i>		<i>ARI</i>		<i>Diarrhea</i>		<i>Total</i>	
Kean Svay district		February	April	February	April	February	April	February	April
	Koki Thom	F	<i>F</i>	GG	<i>W</i>	GG		FGGGG	<i>FW</i>
	Samrong Thom	<i>FG</i>	<i>G</i>	<i>GW</i>	<i>G</i>	<i>GW</i>	<i>FW</i>	<i>FGWGW</i>	<i>GGFW</i>
	Bantey Dek	<i>F</i>	<i>GF</i>	WW	<i>GF</i>	WW	<i>GF</i>	FWWWW	<i>GFGFGF</i>
	Dey Eth	<i>F</i>		WW	<i>G</i>	FF	<i>G</i>	FWWFF	<i>GG</i>
	Kbal Kos	<i>W</i>	<i>W</i>	WW	<i>W</i>	WW	<i>G</i>	WWWWW	<i>WWG</i>
	Prek Eng	<i>W</i>		<i>WF</i>		<i>FW</i>		<i>WWFFW</i>	
Leuk Dek district	Prek Dach	<i>W</i>	<i>G</i>	WW	<i>F</i>	WWW	<i>GG</i>	WWWWW	<i>GFGG</i>
	Sandar	<i>WW</i>	<i>W</i>	WW	<i>FFF</i>	<i>W</i>	<i>GF</i>	WWWWW	<i>WFFFGF</i>
	Prek Tunlap	<i>W</i>	<i>G</i>	WW	<i>W</i>	WW		WWWWW	<i>GW</i>
	Kg. Phnom	<i>FG</i>	<i>GG</i> <i>F</i>	<i>FWW</i>	<i>GG</i> <i>F</i>	<i>WGF</i>	<i>FFF</i>	<i>FGFWWWGF</i>	<i>GGFGGF</i> <i>FFF</i>
Lovea Eam district	Sarika Keo	<i>F</i>	<i>GG</i>	WW	<i>GG</i>	WW	<i>W</i>	<i>FWWWW</i>	<i>GGGGW</i>
	Arey Ksath	<i>W</i>	<i>GF</i>	<i>FW</i>	<i>FFG</i>	<i>WF</i>	<i>GGG</i>	<i>WFWWF</i>	<i>GFFFGG</i> <i>GG</i>
	Tek Klang	<i>W</i>	<i>GG</i>	WW	<i>FG</i>	WW	<i>GG</i>	WWWWW	<i>GGFGGG</i>
	Peam Ouknha Ong	<i>F</i>	<i>F</i>	<i>W</i>	<i>F</i>	WWW	<i>F</i>	<i>FWWWW</i>	<i>FFF</i>
	Kos Keo	<i>GF</i>	<i>GW</i>	<i>GW</i>	<i>FF</i>	<i>GG</i>	<i>GG</i>	<i>GFGWGG</i>	<i>GWFFG</i> <i>G</i>
	Prek Russey	<i>W</i>	<i>GG</i>	WW	<i>FG</i>	WW	<i>GG</i>	WWWWW	<i>GGFGGG</i>

NB: *. G : Good; F: Fair; W: Weak
 *. "ARI:" Actual:19, Role Play: 7
 *. Diarrhea : Actual 13, Role Play: 11
 *. DHF : Actual : 0 , Role Play; 21

ANNEX 8.11 QUALITY OF CARE – KOMPONG THOM AND STONG OD

Performance Appraisal of health workers in Kampong Thom, Stong Operational District Kampong Thom Province, on ARI, Diarrhea and DHF Case Management

(Follow Up date: May 14 and September 4, 2001)

	Kampong Thom OD	Stong OD (September 4, 2001) ⁽²⁾	
	<u>May 14, 2001⁽¹⁾</u>	<u>September 4, 2001⁽²⁾</u>	
<u>ARI Assessment</u>			
Good	2(25%)	5(31.3%)	0
Fair	6(75%)	8(50%)	0
Weak	0	3(18.8%)	1(100%)
Total	8	16	1
<u>CDD Assessment</u>			
Good	1(20%)	2(16.7%)	1(100%)
Fair	3(60%)	9(66.7%)	0
Weak	1(20%)	2(16.7%)	0
Total	5	12	1
<u>DHF Assessment</u>			
Good	0	6(60%)	0
Fair	3(80%)	2(20%)	1(100%)
Weak	2(20%)	2(20%)	0
Total	5	10	1

NB:

- | | |
|--|---|
| <p>1. * ARI: Actual: 7, Role Play:1
 * Diarrhea : Actual: 3, Role Play: 2
 * DHF : Actual : 0 , Role Play; 5</p> | <p>2. ARI: Actual: 16, Role Play:1
 Diarrhea: Actual: 8, Role Play: 5
 DHF: Actual: 2, Role Play: 9</p> |
|--|---|

Performance Appraisal of health workers in Kampong Thom, Stong Operational District Kampong Thom Province, on ARI, Diarrhea and DHF Case Management

(Follow Up date: May 14 and September 4, 2001)

Performance Appraisal of health center staff on ARI, CDD and DHF case management									
District	HCs	DHF		ARI		Diarrhea		Total	
		Ma y	Septe mber	May	Septembe r	May	Septembe r	May	September
Kampong Thom	Taing Krasau	FF	F W	GG	FF W	G	FF	GGG FF	FFFFF WW
	Mean Chey	FW	GGG G	FF	GG FFF	FW	G FFF	FFFF WW	GGGGGGG FFFFFFF
	Chhouk	W	W	F	FF W	F	FF W	FF W	FFFF WWW
	Salavisey		F		F W		F W		FFF WW
	Sambo		GG	FFF	GGG	F	G	FFFF	GGGGGG
	Stong	Dong		F		W		G	

NB: * G : Good; F: Fair; W: Weak

ANNEX 8.12 FOURTH QUARTERLY REPORT FOR KEAN SVAY CHILD SURVIVAL PROJECT FY01

FY01	Goal	Target Population	est population	Times/yr	Benchmark total	Quarter 4	Quarter 4 Projected	Total Projected	Total Actual	Total % achiev
	EPI									
75%	children completed immunizations	age 0-11mo, 7 communes	1891	1	1418	355	239	1418	576	41%
40%	mothers received TT2	mothers giving birth	1891	1	756	189	1321	756	510	67%
	VAC								0	
40%	infants children 6-12 months rec VAC	infants 6-12 months	1114	1	446	111	267	446	384	86%
40%	children 12-60 mo	children 12-59 months	7239	2	5791	1448	488	5791	560	10%
40%	mothers received VAC within 2 months of delivery	mothers giving birth	1891	1	756	189	87	756	247	33%
	DIARRHEA									
60%	*children with diarrhea treated with ORT.	children <2, 7 communes	1891	4	4538					
60%	*children with diarrhea given same amount or more of fluids		1891	4	4538			4538	0	0%
60%	*children with diarrhea given same amount or more of food		1891	4	4538			4538	0	0%
60%	CDD health education	mothers children <2, 7 com	1891	1	1135	284	4035	1135	5532	487%
60%	ORS packets distributed	children <2, 7 com	1891	4	4538	1135	3400	4538	4700	104%
60%	cases dehydration treated in ORT corners	children with dehydration (10%)	189	4	454	113	335	454	473	104%
	ARI								0	
70%	*sought treatment for child difficult breathing	pneumonia episodes/yr; <2 yrs, 7 com	1891	2	2647					
70%	ARI health education	mothers children <2, 7 com	1891	1	1324	331	4035	1324	5532	418%
70%	ARI treated by WV & district staff	children <2, 7 com	1891	2	2647	662	440	2647	2017	76%
	DHF									
30%	*mothers know danger sign DHF									
30%	DHF health education	mothers children <2, 7 com	1891	1	567	142	4035	567	5532	976%
	BS									
10%	*mothers ...using a modern contraceptive method									
10%	# new BS acceptors WVI + HC	women entering	11140	1	1114	279	247	1114	273	25%

		childbearing								
10%	#BS acceptors - WVI + HC	mothers of child <2 (4 HC)- preg&want child	1891	4	756	189	841	756	1350	179%
	Dist MCH - training in teaching techniques, clinical supervision	classes/year								
	Training in ARI/CDD/DHF,EPI,Micronutrient,									
60%	Kean Svay District MCH & HC staff -	HC staff -	57	3	103	26	36	103	67	65%
100%	Leuk Dek HC staff -	HC staff -	27	3	81	20	44	81	91	112%
60%	Lovea Em HC staff -	HC staff	46	3	83	21	43	83	94	113%
	Training in ARI/CDD/DHF.									
60%	Kg Thom HC Staff -	HC staff in 3 ADPs	65	3	117	29	33	117	67	57%
	*Cases diarrhea, ARI at HC correctly diagnosed and treated	4 clinics	6	1						
	HC midwives received training in BS									
100%	Kean Svay District MCH & HC staff -	HC staff - 7 HC	21	1	21	5	24	21	24	114%
100%	Leuk Dek HC staff -	HC staff - 4 HC	16	1	16	4	20	16	20	125%
100%	Lovea Em HC staff -	HC staff - 6 HC	18	1	18	5	20	18	20	111%
100%	Kg Thom HC Staff -	HC staff in 3 ADPs- 8 HC	24	1	24	6		24	0	0%
100%	HC have means of transporting severely ill	4 Health Centers	4	1	4	1	4	4	4	100%
100%	VHV's - trained and functioning .	2 VHV's/ villages	50	4	200	50	197	200	247	124%
100%	Community Health Deve Mgt Team - formed and functioning.	4 Health Centers	4	1	4	1		4	0	0%
100%	Traditional Birth Attendance		41	1	41	10	16	41	16	39%
60%	Traditional Healers			1	0	0		0	0	0%
60%	Drug Sellers			1	0	0		0	0	0%

* assessed annually

0

Refreshment training for VHV's of Kean Svay administrative district for 6 sessions: ARI/CDD/DHF/EPI/Vit A /BS in Q 4 (62/72 each Session)

Direct involvement of outreach activities since Q 3 (Q 1& Q 2 was in preparation : Baseline survey, DIP)...

ANNEX 8.13 WORLD VISION CAMBODIA PROJECTS IN LEUK DEK

	Leuk Dek ADP	MED	KSCSP	STAR 1 HIV-AIDS Project
Activities	16 integrated outputs – health (currently relief basis only), education, veterinary, family econ. devel (=MED), leadership devel, surveys/research, water deve, infrastructure devel, increased crop production	credit & savings services, loan fund from WV	MCH interventions – Immunisation, Vit A, Birth Spacing, Health Education, Micronutrients, Capacity building	Home-based care, Counselling and Testing (Ksavay & Neak Leung) HIV-AIDS education through mass media
Target groups	All, but focus on women, (including CIP 3-12 years) and the poor.	poorest, focus on women	Mothers & children 0-5 years	HIV-AIDS families, uniform personnel and residents
Geography	3 communes intially (Sandar, Kpob Ateav & Peam Rang). Same as MED. FY03 to Kompong Phnum, FY04 to Prek Tunlap, Prek Dach and Kham Samnor	initially Sandar, Kpob Ateav & Peam Rang but extending north if insufficient clients	all 7 communes, all 4 Health Centres (Kampong Phnum, Prek Tunlap, PrekDach & Sandar)	Highway 1 from Mean Chey to Neak Leung in Prey Veng province.
Partners	Multisectoral: CDC, Provincial CRD, Commune DC, VDC. Sectoral: MRD, Provincial DRD, Agriculture, Forestry & Fisheries District: Education, Youth & Sport, Rural Development, Water Resources & Meteorology, Health Community: Community DC, other NGOs and grassroot organisations	VDC for initial comm..meeting s (per diem given) then VBMC (3 to 6 persons in charge of member savings & recruitment) Selected from Village Bank members	OD, HC staff, VHV's, CHDMT, TBAs, Kru Khmer, Mother's groups, ?other private health providers	Health Centers, Operational District Hospitals & Provincial health officials
WV staff, management	organisational chart (not included in this report)	WV ADP staff + one MED staff respons. for Leuk Dek (Credit Agent) sup'd by Field Facilitator)	organisational chart (not included in this report)	organisational chart (not included in this report)
How program operates	Five Year Design – includes baseline Household Survey. Triangulation of PLA, HHS and Secondary data -> problem tree -> objective tree	Streamline ADP credit manage., new consistent sys., aimed at self-suffic/ sustain	see Activities – through OD and HC staff with WVC staff as support-a-visors	Cooperation with OD and HCs in the area
Donors.	WVUS private sponsorship funds	WVUS – private non-sponsorship funds	WVUS/USAID	WV Japan, POSIVA (PO Savings Internat'l Voluntary Aid)
Project Duration	15-18 years	Life of ADP	USAID grant to 30 September 2003	Yearly funding FY 01 completed FY 02 funding confirmed

ANNEX 8.14 PROJECT PARTNERS IN LEUK DEK – ROLES AND RESPONSIBILITIES

VDC	VHV	VBMC	OTHER PO
<ul style="list-style-type: none"> . Collect information from community . Provide reports to CDW . Identify village problems . Facilitate/arrange village meetings . Help design village plan of action . Mobilize local resources. . Facilitate implementation of village plan of action . Attend regular meetings . Facilitate child sponsorship information. . Develop village project proposals 	<ul style="list-style-type: none"> . Support HC staff during outreach activities . Community health education. . Report health information from the community. . Special campaigns . Simple case management and referral to health centers or referral hospital. 	<ul style="list-style-type: none"> . Coordinate with members for regular meetings . Assist with loan release and collection. . Manage savings (simple bookkeeping). . Help trouble shoot VB problems . Help in recruitment of new members . Help in loan utilization checks 	<ul style="list-style-type: none"> . Identify and prioritize community problems . Design project framework . Facilitate project implementation . Provide regular reports to project staff . Arrange regular meetings . Develop project proposals
Time: 2-3 days/wk 4-6 hrs/d = 8-18 hrs/wk	Time: 2-3 days/wk, 2-3 hrs/ d = 4-9 hrs/wk	Time: 1-2 hrs/wk	Time: 2-3days/wk 4-9 hrs/wk.
Incentive: none (20% of 1% service charge where VBMC operating)	Incentive: KS Phase 1=10 000-12 000 /mth (2.5-3\$/mth) LD (50 VHV _s) – no payment but Free consultations/ medicine at HC	Incentive: 80% of 1% service charge.	Incentive: None

Annex 8.17

**Adapting a Behavioral Approach
*to the Child Survival Interventions
of the Kean Svay Follow-On Project***

Introduced by Elli Leontsini, MD, MPH
Behavior Change Consultant
Kean Svay, Kandal Province
Cambodia

November 29 to December 9, 2001

Consultancy Report
Prepared December 21, 2001



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Adapting a Behavioral Approach to the Child Survival Interventions of the Kean Svay Follow-On Project

Introduced by Elli Leontsini, Behavior Change Consultant, Kean Svay, Kandal Province, Cambodia, November 29 to December 9, 2001. **Prepared December 21, 2001**

Summary/Introduction

The Kean Svay Child Survival Project has been implementing several major child survival interventions for the last four years, both as the primary (non-governmental) provider and through strengthening of the governmental health service network of Village Health Volunteers, Health Centers and Referral Hospitals. The interventions implemented are immunizations, Vitamin A supplementation, birthspacing, home care of diarrheal disease, and treatment seeking for severe diarrhea, pneumonia and dengue hemorrhagic fever at a formal health care facility. Evaluation indicators measured by KPC surveys show a significant improvement of mothers' knowledge and reported behavior. Actual behavior change, however, is more difficult to measure. Project staff has identified a number of problematic areas that could benefit from a behavioral approach. To address this need, the consultant introduced a behavior change framework and demonstrated its application to voiced problems with birthspacing behaviors, early and exclusive breastfeeding, weaning and children's feeding, home care of diarrheal disease and antenatal care visits, through a series of (6) half-day workshops. This report concludes with the consultant's recommendations on formative research to be undertaken for the design of a behavior change strategy for each problem, as well as suggestions on how to integrate those strategies in a client-centered way and throughout the year. A managerial plan on who will be responsible for next steps, accompanying budget, should new BCC materials be developed, training required on the methodology to be applied, along with time table were addressed but further work is needed.

A. Behavior Change Framework introduced:

The consultant walked project staff and partners through the next 5 steps of a behavior change framework.

1. Start with Community IMCI (cIMCI) as a basis for crosscutting behaviors versus vertically defined disease-centered behaviors

The initiative on Integrated Management of Childhood Illness (IMCI) and esp. its community component provides an excellent starting point for adapting a behavioral approach to child survival interventions. Community IMCI has agreed on 16 key family practices (See Table 1) sorted into those promoting physical growth and mental development, practices for disease prevention, appropriate home care and for seeking care from appropriate providers, and not according to which disease they help prevent or manage. This crosscutting, horizontal way of sorting key behaviors is more useful from a behavioral point of view, compared to vertically defined disease-centered sorting of behaviors.

A first step, then, during our workshop was to map the behaviors addressed by the project and partners during the follow-on period, under the 4 major interventions or under a pilot project, onto the Community IMCI Family Practices Table (See Table 1, ❖ sign).

The rationale for selecting these key behaviors as a focus for project activities is based on factors such as local epidemiology (survey or other data), what is feasible locally, likelihood of change based on the project’s experiences or data, strategic importance for the project, and what local communities or decision makers want. The rationale is detailed in the initial grant proposal and the follow-on DIP, and will, therefore, not be repeated here.

2. Sort project-selected cIMCI behaviors into client-centered behavioral categories

Sorting criteria to use include frequency, periodicity or seasonality of behavior, social space in which it is performed, according to each role that the client plays: e.g. parent, partner, homemaker (See Table 2). Sorting often points to the implementation of a common/linked behavior change strategy for two or more medically separate conditions:

Example 1. In administering Vitamin A at the same time as Immunizations, the project is already implementing a common behavior change strategy for two medically separate behaviors that share periodicity and delivery systems.

Example 2. Handwashing for diarrhea control and safe water storage to reduce *Aedes* mosquito production for dengue control can be viewed by the householder as model hygiene practices that characterize ideal homemaking. The two medically separate behaviors then could perhaps be promoted in a common behavior change strategy, as best cleanliness and neatness practices without necessarily mentioning the diarrhea or the dengue threat, which typically concern the public health expert.

What we did next then was to select priority behaviors to focus upon, according to project staff and partners’ expressed difficulties in sustaining behavior change during a rating exercise (see below) and to mark them within a client-centered framework (see ? arrows in Table 2).

Rating results by 5 KS staff and 2 OD (MOH) reps of 6 Child Survival areas, according to having had most difficulty with behavior change		
Immunizations	12 seeds	
Birthspacing	27.5 seeds	
Treatment seeking	14	
Micronutrients	8	
Infant feeding	10.5	
ANC->PNC	18	N=7, 10 seeds/ea

3. Introduce Behavioral Approach¹ to Program Planning for each priority problem mentioned

¹ Drawn upon ecological behavior change models, models emphasizing skills and USAID’s BEHAVE framework

The approach is described in Table 3 and it was illustrated with an example of a behavior change strategy for *Aedes aegypti* control and dengue prevention in the Dominican Republic (MOH/Change Project/John Hopkins University). It was later illustrated many more times when the behavior change framework was applied to each priority problem selected.

Features of a behavior change strategy stressed during the workshops:

- Explicitly spell out each behavioral objective for each target group/audience segment and make it the focus of the effort.
- Explore the context in which each key behavior is to be practiced, local knowledge, language and words used, current practices and ideal practices (formative research). If initial formative research already conducted, explore barriers to and benefits of currently promoted behaviors, review current behavior change communication shortcomings and strengths.
- As part of formative research, include a trial step: conduct small trials of candidate improved behaviors and modify accordingly before launching a large-scale effort. Introduce candidate behaviors through negotiation: listen, suggest, monitor, problem-solve.
- Come up with final list of perhaps negotiated and modified but still effective and feasible behaviors to promote in the behavior change strategy.
- Design improved behavior change communication (BCC) plan, in line with the overarching behavior change strategy, as a key facilitating factor to behavior change. In general, hands-on skills are best provided via interpersonal communication aided by small media (e.g. flyers with pictorial sequence of instructions); larger media (radio and TV ads) are more appropriate for increasing demand for better services, awareness raising, cues and reminders, positive reinforcement of VHVs' work. Any BCC support materials to be developed need a budget and need to be field-tested before reproducing in large numbers.
- Besides BCC, work on other key facilitating factors, such as: product/kit availability, facility-based improvements, institutional changes at all levels and skill-based training of all providers (e.g. VHV, HC, OD, RH, project staff). Coordinate with other partners to implement a common strategy using the same BCC materials, and seek assistance from non-health sectors, such as development projects, credit mechanisms and industry, among others.

4. Integrate behavior change strategies in a client-centered way and throughout the year

Do after applying behavioral approach to each priority problem mentioned.

As of December 2001, best practice examples include:

- Season-specific promotion - multipurpose home calendar reminding seasonal behaviors, showing immunization days, providing a way for VHV/HC staff to mark upcoming appointments
- Umbrella themes, e.g. "theme of the month" anemia, healthy nutrition, etc.

- Use of community IMCI counseling card – currently under preparation in Cambodia, as a tool for integrated counseling for the caretaker and integrated training for VHV, TBAs and other providers, and the community itself.
- Use of mass media to increase demand, provide awareness, cues, honor role of VHV, etc.
-

5. Adjust evaluation indicators to measure actual behavior change, to the extent possible

Versus only reported behavior change, versus mere knowledge increase. Example: card-confirmed immunizations (already used by the KSCS Project) or VHV-confirmed Oralte administration versus reported by mother only. It is harder to assess frequently performed behaviors. How can handwashing be evaluated, for example? Structured observation of activities in the home at varying time points during the day maybe needed. A proxy would be presence of soap and/or amount of soap remaining, compared to that distributed a month earlier, e.g.

The selection of appropriate behavior change indicators can be the topic of a whole different workshop and is a concern by all child survival projects. Ideally, the behavior change strategy should be designed first, during the development of the DIP and before the baseline KPC survey is conducted, so that behavioral indicators can be included and measured at baseline and not only at the end of the project.

B. Application of Behavioral Framework to selected priority problems mentioned

Done during 4 half-day and one full-day workshop at Kean Svay Project with staff and partners. 5 specific behavioral frameworks are presented in Tables 4 – 8. The tables are structured in the same way that Table 3 is, showing each step to take, only the columns in Table 3 appear as rows in Tables 4-8. Improved or negotiated behaviors, key facilitating factors and activities/interventions to support the behavior change strategy currently listed in the tables will have to be finalized after formative research is conducted, and are preliminary at this point.

C. Recommendations on formative research needed towards the development of behavior change strategies

1. Review of formative research methods that the staff has interest in applying

Done for the staff in the course of the workshops for PLA/PRA techniques, Hearth/TIPs for nutrition and social autopsies. A summary of what was discussed on each method is presented below:

PLA/PRA are participatory techniques that the staff has had most experience with. PVOs, including WV, with a strong community development component beyond health have the longest tradition with using these methods. Their application creates expectations on the part of the community from community leaders or health services staff, present at the PRA session and binds all parties to respect the community's point of view voiced during the session and to take decisions to implement the changes implied. When for this purpose, then, they should continue to be applied, by all means.

When the research question is more exploratory in nature and not at the decision-making point yet, individual and/or group in-depth exploratory discussions, depending on the topic, maybe more appropriate. Let take the issue, for example, of the men's/partners'/ fathers' greater involvement in birth spacing as well as care seeking for their child outside the home, that repeatedly came up during the workshops. To find out what men of various types think and why, what suggestions they might have to address the problem and what they might be willing to do to solve it, exploratory in-depth individual interviews, perhaps conducted by a male interviewer, should be conducted first, reserving a PRA session for a later date when decision-making and binding at the community level needs to take place.

The Hearth model and Designing by Dialogue for nutrition interventions. Both approaches have a strong formative or consultative research component, heavy on observation of cooking practices, with the purpose to find actual recipes and menus of locally available yet nutritious foods to promote for weaning and child feeding. The interventions that follow the formative research go beyond simply recommending a series of healthy foods for mothers to offer to their children, to actually teaching mothers hands-on skills on how to prepare these foods and in what quantity, and, therefore, have a strong behavioral approach.

The Hearth model ² is based on *positive deviance* where the cooking practices of equally disadvantaged mothers but without malnourished children are compared to those with malnourished children. If a specific kind of food or recipe given by the model mothers is discovered during the formative research, it is then promoted as part of the behavior change strategy for all mothers. This was the case in neighboring Vietnam where positive deviants were giving their children a kind of shrimp growing in the flooded rice fields that the mothers of malnourished children were not taking advantage of. Shrimp was subsequently promoted as a protein-rich food for all mothers to give to their children.

Trials for Improved Practices (TIPs) form a large component of the Designing by Dialogue³ approach. The term TIPs was coined in the respective manual as a key step before promoting ideal behaviors at a large scale. But TIPs should not be and in fact are not limited to nutrition interventions. It is highly recommended to conduct small-scale detailed trials of candidate behaviors before finalizing behavior change strategies in any field, not just in nutrition. In Designing by Dialogue for nutritional interventions, consultant mothers in a group setting are first asked to cook a tasty meal containing as many locally available nutritious foods as possible without taking price into consideration (project bought and paid for the foods) (ideal behavior). They then experiment with modifying the ideal recipe to still include the best/richest but more expensive foods but in smaller more affordable quantities (negotiated candidate behavior). An initial recipe agreed upon by the consultant mothers (dialogue) is drafted and subjected to TIPs by a new small group of mothers taught the recipe and asked to try it out and give their opinion. During frequent home visits, the cooking process is observed and the perceived benefits and

²Wollinka, Olga, Erin Keeley, Barton R. Burkhalter, and Naheed Bashir, eds. 1997. *Hearth Nutrition Model: Applications in Haiti, Vietnam, and Bangladesh*. Published for World Relief Corporation and the US Agency for International Development by the Basic Support for Institutionalizing Child Survival (BASICS) Project. Arlington, VA 111 pp.

³Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding'. By Dickin K, Griffiths M, Piwoz E. 1997. Manual produced by the SARA Project/AED/Manoff Group.

difficulties of preparing this recipe mentioned by the mother are recorded and extensively discussed with her (dialogue). Further modifications of the recipe to respond to the difficulties voiced are suggested and tried out (more dialogue). Based on the data, a single final negotiated recipe or several equally acceptable alternatives are promoted at a larger scale, always through a negotiation (continuing dialogue), mutually respectful approach as opposed to a one-way top-down directive.

In the case of Peru, the only instance in which both sugar and grease mixed was in preparing a dessert type of drink for grown-ups, not for kids. Mothers experimented and came up with a “watered-down” recipe appropriate for weaning that contained both sugar and grease. In the case of Ecuador, when taught how to encourage more eating for their children, mothers were amazed at the quantity of food that a young child was capable of consuming if he or she liked it and if encouraged appropriately.

Project staff mentioned their interest in piloting nutritional interventions and asked for the consultant’s opinion on which of the two approaches to use. The consultant’s opinion is that either approach has merit. The project can mix and match elements to best fit their needs. Initial ideas for healthy meal preparations can come from observing positive deviants, for example, and later tested, negotiated and modified during TIPs. In fact all the cooking sessions which form part of the Hearth model can be viewed as a form of TIPs. Some times no obvious difference between positive and negative deviants is observed but bringing the mothers together to learn good cooking skills from each other is positive. Either approach will require strong observation and negotiation skills first on the part of staff and then on the part of VHV’s involved.

During a meeting with Partners for Development, we learned that this PVO already received training for the Hearth model and is about to apply it. It might make sense for the KSCS Project to perhaps try the Designing by Dialogue methodology, and compare experiences, as both PVOs are at the pilot stage right now. The consultant has ordered the respective manual from AED to be directly shipped to the Phnom Penh office, so that the staff can take a look and decide if it is feasible to apply.

Social Autopsies. This method is applied as part II of a verbal autopsy. The verbal autopsy is trying to guess what the cause of death of an infant or a child might have been, based on the mother’s recollection of symptoms and signs preceding death. The social autopsy then reviews the care that the mother took, step by step, from the moment that she recognized that her child was sick up until death occurred. The staff has already conducted many verbal autopsies and has shown how pneumonia seems to be the number one killer in the Kean Svay area (See DIP). They are now interested in conducting social autopsies and asked the consultant’s opinion on whether this would be a good method to apply.

The consultant’s opinion is that it be applied only if there is a concise plan in place, to act on the results. For example, take the results and present to the community in a PRA session and to each group of providers, e.g. formal providers, VHV’s, various kinds of healers, drug-sellers, etc. Be prepared to act on what will be demanded in those meetings, typically, better transportation, better referral system, father’s personal involvement to care seeking, better instructions on how to take the medicine, better training of all providers and so on. This will be more fruitful if applied in an area where initial steps have been already taken to improve the obvious

shortcomings (transportation, referrals, etc.) and further guidance is needed on where to focus next.

Reference for qualitative research methods needed. The consultant was asked to recommend a good reference book on qualitative research methods. There is no single book that covers all methods in a simple way but with enough detail to be meaningful. The consultant recommends a comprehensive and easy to use guide to manuals⁴ instead, to help obtain the right manual, depending on what the question is.

2. Suggestions on what behavior change strategies to focus on during the remaining project period

This was a difficult question to answer, given the brief exposure to the project and obviously the need for a project-based decision rather than coming from the consultant only.

Birth spacing - Project staff were especially vocal about their frustration with the gap between birthspacing felt need and birthspacing practice. This is in full agreement with published literature, as for example by Huff-Rousselle and Pickering, 2001⁵, stating that Cambodia has one of the highest levels of unmet need for family planning in the developing world. Further, Cambodia's suffering from the most severe STI and HIV/AIDS epidemic in Asia^{5,6} calls for better integration of birthspacing with HIV/AIDS counseling. Tarr and Aggleton, 1999 warn that a neat divide between sex workers, clients, young people and so on does not exist. The staff's idea to work with men/partners to improve birthspacing practices is a sound one. A good review to look at is cited as a footnote⁷. The consultant thinks that this should be an area to focus on. Both staff and partners mentioned how busy they were and how VHV's should take up more work. VHV's could then be the initial audience segment for study:

- Start by selecting male VHV's practicing/encouraging birthspacing with their partners and female VHV's whose partners encourage or practice birthspacing and asking them how their non-compliant colleagues might be influenced.
- Come up with support activities to encourage male involvement
- Discuss with the other HIV/AIDS WV project along the highway how to possibly integrate activities

⁴ Qualitative Research for Improved Health Programs: A Guide to Manuals for Qualitative and Participatory Research on Child Health, Nutrition, and Reproductive Health. Peter Winch, Jennifer Wagman, Rebecca Malouin, Garrett Mehl, Department of International Health, Johns Hopkins University School of Hygiene and Public Health; AED, SARA Project, Washington, DC (January 2000) 182 pp.

⁵ Huff-Rousselle, Maggie and Pickering, Helen. Crossing the public-private sector divide with reproductive health in Cambodia: out-patient services in a local NGO and the national MCH clinic. *Int J Health Plann Mgmt* 2001; 16: 33-46.

⁶ Tarr, CM and Aggleton, P. Young people and HIV in Cambodia: meanings, contexts and sexual cultures. *AIDS CARE* 1999; 11, 3: 375-384.

⁷ Male Involvement in Family Planning: A Review of the Literature and Selected Program Initiatives in Africa. Lalla Touré, AED, SARA Project, Washington, DC (November 1996) English/French version. 30 pp. Document no PN-ABY-584

Improved nutritional interventions - The staff is genuinely interested in promoting colostrum breastfeeding, (more than promoting exclusive breastfeeding, due to the long tradition of giving water to breastfeeding newborns and infants and to supplement with weaning foods early). In addition, the staff is very interested in piloting more behaviorally focused nutritional interventions. There is a judgement call here to make, as either idea requires a lot of staff training first and then a lot of exploratory and TIP work in the community.

The staff's and partners first need to be trained on the basics of breastfeeding tips. A good resource to look at with simple tips on helping mothers to breastfeed is cited at the end of the page.⁸ Best practice for breastfeeding promotion in many countries has been the formation of mother-to-mother community-based counseling support groups, pioneered by La Leche League⁹, and this should be the approach to be taken by the project. Likewise, for weaning and child feeding interventions staff needs to be trained first. As mentioned above, there is an excellent manual called *Designing by Dialogue* and should be exploited to the fullest if decided that nutritional interventions should be piloted. The consultant thinks that there is not enough time and resources to do both breastfeeding and weaning. One of the two should be selected for focus during the remaining project period.

The IMCI counseling card - Since this card is already in the works (see section below) it provides an excellent opportunity to shift from knowledge-based disease-specific print materials to an integrated, client-centered one. As always, staff and partners should be trained on how to use it first and then teach VHVs how to use it.

This is pretty much what the project could undertake in the current project period, with the possible addition of a community-based calendar on a pilot base only (see next section).

3. What shape might an Integrated Strategy take

The project already implements many elements of a behavior change approach in that it focuses on training of all actors (HC staff, VHVs, TBAs, drug sellers and traditional healers), it provides regular support-a-vision and feedback to them, it facilitates vaccine, medication and product/kit availability, it habitually works with other partners and the MOH to implement common strategies, it uses print materials and videos coming from a central MOH source.

To facilitate the integration of the new and improved strategies under development into a single cohesive one, the consultant recommended the use of the IMCI counseling card (see current draft photocopy in the Annex), about to come out sometime in the new year, during all training at all levels (at the community, VHV, drug sellers, traditional healers and health center level), during outreach, home visits for various causes, community activities, fairs and so on.

⁸ Helping Mothers to Breastfeed by F. Savage King, AMREF 1992, ISBN 9966-874-04-6. Order from AMREF, POBox 30125, Nairobi, Kenya

⁹ Maza, ICh de, de Oliva M, Huffman S, Magalhaes RS, Stone-Jimenez M and Burkhalter BR. 1997 *Sustainability of a Community-based Mother-to-Mother Support Project in the Peri-Urban Areas of Guatemala City: A La Leche League Study*. Published by the Basic Support for Institutionalizing Child Survival (BASICS) Project. Arlington, Va 60 pp.

continue to record upcoming appointments much like it is currently being done on the appointment card provided (see Annex). The opposite page should have seasonally appropriate messages. Eg.

- In March and April (or at the beginning of the hot season) provide reminders for diarrhea management
- At the beginning of the rainy season provide reminders and instructions on respiratory infections
- Show what meals to give the kids during the time that not much food is available
- Show what meals to give the kids during better times
- Remind danger signs of dengue at the beginning of the dengue season,
- and so on

As always, formative research is needed into the perception of seasons and whether to use a month per page or rather a season per page, perhaps including more than one calendar month per page. The size is important as is the durability of the material. All appearing illustrations and messages need to be pre-tested. Training of the VHVs and HC staff will be required on how to actually use this calendar with their clients. Most importantly, TIPs need to be Further, the consultant recommended a family calendar, much like the one described under best practices, to be used at home and by the VHVs and all staff during outreach. The calendar should have room for each day in order conducted to see whether this is viable at all or not.

D. Managerial plan to support behavior change strategies

The consultant discussed the need of someone to be in charge of all this proposed activity. There is no shortcut to some minimum formative research, and training, thinking and analyzing needs to happen too. The staff politely stated that they are overwhelmed in this follow-on period, because they now need to expand activities to two other operational districts, Leuk Dek and Lvea Em, further away from Kean Svay. While no solution has been found yet, some restructuring needs to take place for a staff to take charge, along with a couple of bright VHVs to become closely involved.

Training of the staff on behavior change methodology and the benefits of formative research is of high priority. There is a workshop on Social and Behavioral Interventions organized by the Core Group in South Africa, Feb 4-8, 02. Opportunities like this should be sought after to improve the staff's capacity to develop behavior change strategies. In addition, strategy-specific training needs to happen for the interventions to focus on during the project period.

E. Timetable

F. Tidbits of relevant information gathered

Office of health promotion will soon lose its funding. It finalized guidelines for PHC last week. IEC working group (should) meet every month.

MEDICAM (Association of NGOs) has irregular meetings right now. A common BC strategy plan might bring them together.

The new WHO representative for Cambodia, Jim Tulloch, is a founder of the IMCI initiative. More support to IMCI is expected at the country level.

G. Highly recommended resources and manuals to refer to

Learn to "BEHAVE": A Workshop on the BEHAVE Framework for Behavior Change Programming, February 4-8, 2002, outside of Johannesburg, South Africa. This and other workshops like this would be a good opportunity for project staff to acquire further understanding on the framework and related best practices introduced during the consultancy. Workshop description is attached in Annexes.

A Tool Box for Building Health Communication Capacity, HEALTHCOM project, AED, April 1995, Reprinted by BASICS, May 1996, ordering from Basics at www.basics.org. free of charge. Left hard copy with Dr. Ly Vanthy. Even though the term Behavior Change is not included in the title, it is implied throughout the manual. A series of work sheets guide each step (that's why it is such a thick book – but don't get scared!) and the brief summary of health behavior models was used during the workshops.

Designing by Dialogue: A Program Planners' Guide to Consultative Research for Improving Young Child Feeding. By Dickin K, Griffiths M, Piwoz E. 1997. Manual produced by the SARA Project/AED/Manoff Group. Ordered through Academy for Educational Development at \$35/ea or downloaded from www.sara.aed.org. free of charge. It is also quite thick as it contains extensive data collection instruments and examples. A copy was ordered by the consultant for the Cambodia office and apparently left Washington DC on Dec 20, 01.

Qualitative Research for Improved Health Programs: A Guide to Manuals for Qualitative and Participatory Research on Child Health, Nutrition, and Reproductive Health. Peter Winch, Jennifer Wagman, Rebecca Malouin, Garrett Mehl, Department of International Health, Johns Hopkins University School of Hygiene and Public Health; AED, SARA Project, Washington, DC (January 2000) 182 pp. Ordering through www.sara.aed.org. Document number PN-ACJ-020

H. Annexes

Annex 1. Itinerary of consultant activities

Annex 2. BEHAVE workshop announcement

Annex 3. Latest draft (November 01)of IMCI counseling card for Cambodia

Annex 4. Birthspacing calendar currently in use by the project and partners

Annex 1. Itinerary for Consultant Activities

ITINERARY FOR ELLI LEONTSINI, BEHAVIOUR CHANGE CONSULTANT

KEAN SVAY CHILD SURVIVAL PROJECT

29 NOVEMBER 2001-9 DECEMBER 2001

DATE/TIME	ACTIVITY	LOCATION	PERSON RESPONSIBLE
Thursday 29 Nov			
0925-1200	Arrive TG696 0925 Meet by Hospitality Services, assistance with Visa on Arrival, transfer to Cambodiana Hotel	Pochentong Cambodiana Hotel	Hospitality Services
1200-1400	Lunch	Cambodiana	Elli
1400-1630	Travel to Kean Svay Project Office: orientation, review Schedule, meet OD Chief. Introduction to BCC: review of health education, health communication and behavior change. Priority rating exercise	Kean Svay Project Office	Doug/ NPH Van Somaly and Project Team Elli
1630	Return to PP		Doug/NPH Van
Friday 30 Nov			
0900-1000	Meet National Centre for Health Promotion Collected several flyers and posters from various IEC campaigns.	NCHP	Doug/Somaly
1000-1100	Meet with Dr Tan Try, UNICEF Learned about the IMCI counseling card for Cambodia	UNICEF Office	Doug/ Somaly/ NPH Van
1200-1330	Lunch		
1330-1700	Travel to Kean Svay Project Office Continue introduction to BCC Review health behavioral models Discuss problems with birth spacing	Kean Svay Project Office	Somaly and Team OD representatives Elli
Saturday 1 Dec			
0830 to 1300	Review BCC docs: Training aids, posters, flyers and flipcharts used by staff in training sessions and outreach... Discussed Somaly's perceived priorities, breastfeeding & ANVs	Kean Svay Project Office	Somaly Elli
Sunday 2 Dec			
	Free Day Review relevant studies on the role of VHVs, TBAs, an anthropological study on traditional healers in Ca., other DIPs, courtesy of Doug.	Cambodiana Hotel	Elli
Monday 3 Dec			
0700-0900	Travel to Leuk Dek	Leuk Dek	Somaly/ Doug/ Project Team
0900-1200	In Leuk Dek Observed 2 outreach sessions with health education, community-based birth and death	HC, village activities, ADP Office	Somaly/ Doug/ Project Team

DATE/TIME	ACTIVITY	LOCATION	PERSON RESPONSIBLE
	surveillance, ORS distribution and mixing demonstration, birth spacing, and Vit A. Talked to VHV's, TBAs and a traditional healer		
1200-1330	Lunch at Neak Luang		
1330-1430	Return to Project Office		
1430-1700	Introduced behavioral approach for home care of diarrhea Discussed barriers and solutions		Elli
Tuesday 4 Dec			
	Writing Day of behavioral approaches and consultant report	Cambodiana Hotel	Elli
1600-1700	Meet with Partners for Development – Ann Canavan and Michelle Long Learned about their piloting with the Hearth model	PfD Office	Doug
Wed 5 Dec			
	Workshop Preparation by consultant and with consultation from Somaly	Cambodiana Hotel	Elli
Thursday 6 Dec			
0830-1200	Capacity Building Workshop for WV CS, ADP and HIV/AIDS Project Staff	Project Office	Somaly and Team, Doug, Vanthy & Elli
1200-1330	Lunch		
1330-1630	Workshop continued. Review of breastfeeding and nutritional interventions	Project office	Elli
Friday 7 Dec			
	Feedback Workshop for Project Partners. Discussed behavioral framework, illustrated it with the example of early and exclusive breastfeeding. Working groups on barriers and solutions for Antenatal visits (group 1) and early breastfeeding (group 2). Discussion and closure	Project Office	Somaly, Vanthy OD, HC, VHV Elli
1530-1630	Meet with Paljor USAID. Learned about the organization of the office into maternal and child health projects and HIV/AIDS projects.	USAID Office	Doug
Sat 8 Dec			
	Continue with preparation of final report	Cambodiana Hotel	Elli
Sun 9 Dec			
	Continue with draft report	Cambodiana Hotel	Elli
1830	Check out of hotel – pay for accommodation/meals Transport to Airport to catch TG 699 departing 2025		Hospitality Services

Annex 2. BEHAVE Workshop Announcement

The CORE Social and Behavior Change Working Group and the CHANGE Project invite you to

Learn to "BEHAVE":

A Workshop on the BEHAVE Framework for Behavior Change Programming

What is it?

Learn to "BEHAVE" is an opportunity for managers and planners of Child Survival projects to experience how a behavioral framework can aid them in planning their project strategically for maximum effectiveness. The workshop is based on the BEHAVE framework as found in the most recent version of the Child Survival Grants Program Technical Reference Materials.

Where is it?

The workshop will be held just outside of Johannesburg, South Africa.

When is it?

February 4-8, 2002

Who should come?

Headquarters backstops and managers of child survival or maternal and child health projects and their local NGO, community, or Ministry of Health partners.

What will I learn?

Participants will:

practice data-based program (or intervention) planning.

learn the four basic planning decisions of the BEHAVE framework (select an audience segment, define behavioral objectives, identify key factors influencing behavior, and plan program activities) and

practice applying the model to their program.

integrate the BEHAVE framework into their existing program approaches such as social mobilization and participatory planning.

sharpen skills in planning for and using results of qualitative and quantitative research in program development; learn what skills are necessary for various research methods.

develop indicators to monitor changes in health behaviors and outcomes

identify competencies and resources to include when writing a comprehensive behavior change budget.

What is the cost?

\$364 per participant for meals and lodging

How do I register?

Register at the CORE Group web site

<http://www.coregroup.org/conf_reg/registration.cfm>

If you are unable to access the web-based registration form, please send an email to <csts@macroint.com> and request a registration form as an email attachment.

Annex 3. Latest Draft (November 01) of IMCI counseling card for Cambodia

Only available in hard copy

Annex 4. Birthspacing calendar currently in use by the project and partners

Only available in hard copy

**Table 1. THE 16 KEY COMMUNITY IMCI FAMILY PRACTICES AS ADAPTED
BY THE KSCS FOLLOW ON PROJECT**

- ❖ Practice is part of the Project’s focus under the 4 major interventions or under a pilot project
- Practice not currently included

For physical growth and mental development
<ul style="list-style-type: none"> ❖ Breastfeed infants exclusively for at least four months and, if possible, up to six months. (Mothers found to be HIV positive require counseling about possible alternatives to breastfeeding.) ❖ Starting at about six months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to two years or longer. ❖ Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet or through supplementation. • Promote mental and social development by responding to a child’s needs for care, through talking, playing, and providing a stimulating environment.
For disease prevention
<ul style="list-style-type: none"> ❖ Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday. ❖ Dispose of feces, including children’s feces, safely; and wash hands after defecation, before preparing meals, and before feeding children. • Protect children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated bednets. ❖ Adopt and sustain appropriate behavior regarding prevention and care for HIV/AIDS affected people, including orphans.
For appropriate home care
<ul style="list-style-type: none"> ❖ Continue to feed and offer more fluids, including breastmilk to children when they are sick. ❖ Give sick children appropriate home treatment for infections. • Take appropriate actions to prevent and manage child injuries and accidents. • Prevent child abuse and neglect, and take appropriate action when it has occurred. ❖ Ensure that men actively participate in providing childcare, and are involved in the reproductive health of the family.
For seeking care
<ul style="list-style-type: none"> ❖ Recognize when sick children need treatment outside the home and seek care from appropriate providers. ❖ Follow the health worker’s advice about treatment, follow-up and referral. ❖ Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider, and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

Table 2. KS Project cIMCI key family practices sorted into client-centered behavioral categories

Priority behaviors to focus on for improvement during follow on project, according to rating exercise

Periodic Behaviors	Seasonal Behaviors	Daily/frequent behaviors inside the home			Sickness-triggered
		Feeding	Safe environment Hygiene (as homemaker)	Reproductive health behaviors (as parent and partner)	Home care of sick child (as care-taker)
Immunizations Micronutrients Ante N Visits ? Post N Visits Depo-Provera ?	Stock up with ORS packages at the onset of dry season Recognize dengue danger signs and seek treatment outside the home in dengue season	(as a mother) Early and exclusive breast feeding ? (as homemaker) Cook healthy and tasty meals ? Handwashing before cooking Use iodized salt	Clean water storage Keep house clean Use toilet Handwashing after toilet use	Take pill ? Use condoms ?	Recognize cross-cutting sickness signs Continue to feed ? Rehydrate ? Recognize cross-cutting danger signs ? Seek treatment outside the home ? Administer drugs according to instructions

Table 3. A Behavioral Approach to Program Planning

View so called key behaviors as behavioral objectives	Translate into sequence of small doable actions for each target group (ideal behaviors)	Identify barriers to performing each of these small doable actions for each target group	Conduct formative research		Agree on negotiated behavioral objectives for each target group	Translate those into small doable actions	Agree on key facilitating factors Can be at the individual, community or institutional level; private sector and other	Select activities to support behavior change (one of which is BCC) Activity can be at the individual, community or institutional level; private sector and other
			To obs. current behaviors Understand barriers to ideal behaviors To seek key facilitating factors To invent new/improved candidate behaviors More sustainable if based on existing practices	To test new/improved candidate behaviors at a small scale (TIPs = Trials of Improved Practices)				
			Methodology (Exploratory)					
			<p>Look at best practices; Observe current behaviors; Ask the staff; the target group; Ask other groups with decision-making power over the behavior; Ask each group why and what can be done to change; Apply iterative process; Obtain community input PRA/PLA Study positive deviants Conduct Social autopsies To field-test candidate behaviors you introduce them through negotiation: listen, suggest, monitor, problem-solve</p>					

Table 4. Apply behavioral approach to priority problems mentioned - birthspacing

Steps to follow:	Starting point was barriers to birthspacing
View key behaviors as behavioral objectives	Mothers of children <2 who are not pregnant and desire no more children in the next 2 years to use a modern contraceptive method
Translate into sequence of small doable actions for each target group (ideal behaviors)	Go to the HC outreach and ask for a Depo-Provera injection 1x/3mo, or Take the pill 1x/daily, or Use condoms with each intercourse Seek advise from VHV, HC staff, if side effects appear
Identify barriers to performing each of these small doable actions for each target group	Side effects of birthspacing method create fear of sickness due to bleeding; cancer, infertility later on No birthspacing until desired number of children reached Compliance issues with the pill-preference for Chinese pill Low reliability of birthspacing service, (mother does not go to HC due to lack of time, HC staff not there, HC staff does not find mother home) Husband/Partner does not agree to BS: Sickness of spouse->funds needed for care Irr periods, decreased <i>libido</i> of wife interfere with sexual activity Fear for wife's infidelity
Conduct formative research Observe current behaviors Understand barriers to ideal behaviors Seek key facilitating factors Invent new/ improved candidate behaviors More sustainable if based on existing practices Test new/ improved candidate behaviors at a small scale(TIPs =Trials of Improved Practices)	Research questions: Investigate Chinese pill: composition/dosage 1x/mo, market distribution, price, side effects How do users, VHVs, HC staff, husbands/partners, bs sellers currently deal with side effects and why What are the experiences of Chinese pill users with side effects What day and time are mothers available for outreach in each season How would husband support wife's agreement to use bs Who do husbands consult for important decisions Who do husbands consult for "male" advise How could mothers in law influence their sons and daughters in law toward bs What would support drop-outs to achieve better compliance Should condoms be given a larger role, given the sharp increase of STI and HIV/AIDS in the country Seek male VHVs who support/do not support their wife's bs and learn their arguments Test small scale counseling group to fine tune approach
Agree on negotiated behavioral objectives for each target group	Perhaps Chinese pill should be included in the recommended bs options Perhaps having desired number of children all at once and then using contraception should be an acceptable compromise Perhaps condoms should be promoted more for those who don't want to deal with side effects and as a way to protect oneself from STI and HIV at the same time. Perhaps HIV counseling and testing should be added in the birthspacing consultation
Translate those into small doable actions	
Agree on key facilitating factors Can be at the individual, community, institutional levels. Private sector and other	Increase users, VHVs, HC staff, husbands/partners, bs sellers' knowledge of side effects Increase their skill to handle them Increase husbands'/partners' support for bs methods Increase mothers' in law support for bs methods Better bridging with HIV/AIDS prevention

<p>Select activities to support behavior change(one of which is BCC)</p> <p>Activity can be at the individual, community, institutional levels. Private sector and other</p>	<p>Training of VHVs, HC staff, husbands/partners, bs sellers' on side effects</p> <p>Print materials picturing what do with side effects</p> <p>Male bs counselors for husbands/partners</p> <p>Public Service Announcements on male support for bs</p> <p>Seek male VHVs who support bs and ask them to lead counseling sessions</p> <p>Seek female VHVs whose husbands/partners support bs and ask them to lead counseling sessions</p> <p>Complement bs with HIV/AIDS counseling</p>
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Table 5. Apply behavioral approach to priority problems mentioned – immediate and exclusive breastfeeding

Steps to follow: Starting point was barriers to **immediate and exclusive breastfeeding**

View key behaviors as behavioral objectives	Early and exclusive breastfeeding until about 6 months of age
Translate into sequence of small doable actions for each target group (ideal behaviors)	Give colostrum within one hour of birth; Continue until milk comes in Latch baby on demand, about every 2 hours day and night Do not express colostrum Do not offer water or other weaning foods until about 6 months
Identify barriers to performing each of these small doable actions for each target group	Strong tradition on expressing colostrum, as dirty, bad for baby Up to 3-day wait to initiate breastfeeding Tradition of giving water and baby foods as well as breastfeed Mother's time constrains to offer exclusive breastfeeding Tradition of rinsing mouth with water after a meal extends to breast meals Feces of exclusively breastfed babies viewed as "diarrhea" Diarrhea due to weaning causes perpetuates cycle for more water Perception that poor undernourished mothers do not have enough milk
Conduct formative research To observe current behaviors Understand barriers to ideal behaviors To seek key facilitating factors To invent new/ improved candidate behaviors More sustainable if based on existing practices To test new/ improved candidate behaviors at a small scale (TIPs = Trials of Improved Practices)	Research questions: Seek VHVs who have done early and exclusive bf and ask them how they did it, who helped them, etc. Look at appropriate cultural metaphors to use in bf promotion Study TBAs' willingness to promote colostrum Study midwives' current approach towards colostrum Pilot with small group of VHVs who are willing to give this a try on their own baby and provide them with around the clock feedback on early bf
Agree on negotiated behavioral objectives for each target group	Given the situation, it might be appropriate to concentrate on colostrum practices as easier to change Consider water an acceptable behavior for bf babies under 6 months.
Translate those into small doable actions	
Agree on key facilitating factors Can be at the individual, community, institutional levels. Private sector and other	Train TBAs and midwives on benefits of colostrum; Use traditional culture metaphors to use in a communication campaign Get experienced breastfeeders to share knowhow Increase knowledge of CS staff, HC staff, VHVs and mothers on bf basics Provide hands-on skills on how to initiate and maintain breastfeeding Promote colostrum as the first vaccine. Make room to register it on the vaccinations card

<p>Select activities to support behavior change(one of which is BCC)</p> <p>Activity can be at the individual, community, institutional levels. Private sector and other</p>	<p>TBA promotes colostrum at delivery Midwife promotes colostrum during ANC and delivery Distribute print materials with benefits of early and exl bf using local metaphors Organize mother-to-mother counseling groups for mothers willing to give early and excl bf a try Positive deviants among VHVs might be the ones to lead group</p>
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Table 6. Apply behavioral approach to priority problems mentioned – weaning and child feeding

Steps to follow:	Starting point was barriers to weaning and child feeding
View key behaviors as behavioral objectives	Mothers to offer Vit A-, protein- and energy-rich foods to their infants and young children
Translate into sequence of small doable actions for each target group (ideal behaviors)	Buy such foods at the market Grow such foods on their own Combine them in tasty recipes Offer them in adequate quantity
Identify barriers to performing each of these small doable actions for each target group	<u>Mothers lack of knowledge about nutritious foods.</u> Extreme poverty – unable to buy them There are times when nothing is available at the market “It is not that women don’t know how to cook; if they could get hold of those foods, they could all cook great meals”[partner opinion expressed at the workshop...]
Conduct formative research To observe current behaviors Understand barriers to ideal behaviors To seek key facilitating factors To invent new/ improved candidate behaviors More sustainable if based on existing practices To test new/ improved candidate behaviors at a small scale(TIPs =Trials of Improved Practices)	What are current weaning practices in terms of quality, way of preparation, quantity and frequency What is the mothers’ current level of satisfaction with the weaning foods given Given the prevailing situation of poverty, what foods are available at the market by season What foods are grown by people themselves by season List of recommended locally available healthy foods by season Current recipes for healthy meals prepared by poor women without malnourished children (positive deviants) What new recipes can be invented or old recipes can be modified to provide improved nutrition Conduct TIPs to field test them How can quantity of food per meal be increased How can number of meals be increased Conduct TIPs to field test this What are perceived benefits and difficulties with new or modified recipes. How can difficulties be resolved
Agree on negotiated behavioral objectives for each target group	Use new or modified improved recipes for weaning and infant feeding Increase the quantity of each meal Increase the number of meals per day
Translate those into small doable actions	Follow actual recipes
Agree on key facilitating factors Can be at the individual, community, institutional levels. Private sector and other	Increase knowledge of healthy foods (currently implemented) Increase buying skills for healthy foods by season Increase meal preparation skills of healthy foods by season Provide seasonal reminders for food preparation and offering to the children Increase importance of volume given

<p>Select activities to support behavior change(one of which is BCC)</p> <p>Activity can be at the individual, community, institutional levels. Private sector and other</p>	<p>Teach new/improved hands on preparation skills during counseling sessions</p> <p>Work with market to increase food availability</p> <p>Work with other development projects to increase production of healthy foods</p> <p>Public service announcements providing seasonal cues</p> <p>Print materials showing cooked ideal meals, much like restaurants do for Khmer-illiterate visitors</p>
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Table 7. Apply behavioral approach to priority problems mentioned – home care of diarrhea

Steps to follow:	Starting point was barriers to home care of diarrhea
View key behaviors as behavioral objectives	Mothers of children under 2 years of age to recognize diarrhea and treat correctly
Translate into sequence of small doable actions for each target group (ideal behaviors)	Recognize signs of diarrhea Stock up with ORS packages ahead of time Treat with oral re-hydration salts Prepare mix correctly Administer correctly Offer light tea, coconut juice Recognize dehydration Recognize danger signs and seek care from appropriate providers
Identify barriers to performing each of these small doable actions for each target group	Child does not like to drink ORS Mother prefers treating with medicines Mother prefers IV re-hydration Observation that when more fluids are given, more diarrhea Boiling process of water for ORS is time consuming
Conduct formative research To observe current behaviors Understand barriers to ideal behaviors To seek key facilitating factors To invent new/ improved candidate behaviors More sustainable if based on existing practices To test new/ improved candidate behaviors at a small scale (TIPs = Trials of Improved Practices)	What is the local knowledge around diarrheal disease: causes and cures What is the current practice of drug sellers and private providers – How can they change their practices How can be boiling of the water facilitated at the community level, e.g. can someone prepare water just for this purpose and provide to the rest of the neighborhood daily for the week? What home-based preparations can be invented/improved that provide all the salts and sugar that ORS does Conduct TIPs to field test them and improve accordingly
Agree on negotiated behavioral objectives for each target group	In the absence of boiled water, decide if it is better to mix ORS with any water vs. no water at all Provide home based ORS alternatives that are tastier yet effective and easy to prepare
Translate those into small doable actions	Provide step by step instructions on how to prepare and administer
Agree on key facilitating factors Can be at the individual, community, institutional levels. Private sector and other	Remind people of diarrhea, dehydration and danger signs using local terminology and cover all causes, biomedical and local, during the diarrhea season. Increase mothers' ORS mixing skills Increase availability of boiled or filtered water Increase ORS availability Increase mothers' skills on preparing acceptable ORS alternatives

<p>Select activities to support behavior change(one of which is BCC)</p> <p>Activity can be at the individual, community, institutional levels. Private sector and other</p>	<p>Secure ORS availability at health facilities, from VHVs and the mothers' homes, especially at the beginning of the diarrhea season</p> <p>Provide safe water for mixing</p> <p>Conduct hands-on training during outreach and by VHVs.</p> <p>Provide feedback to the mother via home visits by VHVs</p> <p>Provide hands-on skills for preparing ORS alternatives via sessions in people's kitchens</p> <p>Produce leaflets providing skills and larger media providing cues using local terminology and offering improvement for diarrhea from all causes, biomedical and local.</p>
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Table 8. Apply behavioral approach to priority problems mentioned – attend antenatal care visits

Steps to follow:	Starting point was barriers to attend antenatal care visits
View key behaviors as behavioral objectives	Pregnant women to attend four antenatal visits during their pregnancy at a formal health care facility
Translate into sequence of small doable actions for each target group (ideal behaviors)	Find funds, transportation and time to come to the clinic Come to the clinic Follow the instructions given during anc visits
Identify barriers to performing each of these small doable actions for each target group	Mothers still not clear about the quality and advantage of the service Lack of transportation to go to anc visits No habit of doing anc/ still some embarrassment in doing anc More trust to TBAs rather than professional midwives If certain to deliver at home, why go to anc Home delivery is among family, enjoys help from relatives, TBA doesn't require immediate payment and can be paid in kind. Food and care by relatives needs to be provided to the woman delivering at the clinic
Conduct formative research To observe current behaviors Understand barriers to ideal behaviors To seek key facilitating factors To invent new/ improved candidate behaviors More sustainable if based on existing practices To test new/ improved candidate behaviors at a small scale(TIPs =Trials of Improved Practices)	A common issue debated is whether to increase TBAs' antenatal care assessment skills or their referral skills only. Decide where project stands in this How can anc visits increase without necessarily discouraging a home birth How can TBAs encourage anc visits while assuring their provision of services at delivery time. How to resolve transportation issues (KSCS has recently provided ambulance tricycles for this) How to increase the quality of service offered during anc What is the sense of quality from the client's point of view How to make the visit more meaningful to the client so that the latter leaves thinking it was worthwhile. Ask future mothers what an ideal anc visit might be like Find out if TBAs would like to accompany mother-to-be to learn about potential upcoming problems How can men/partners encourage the anc visits Explore ways of offering ANC visits during outreach
Agree on negotiated behavioral objectives for each target group	The combination of an ANC visit at a clinic and a birth at home is acceptable Offer improved quality ANC visits (by health personnel) Go to an ANC visit in your own community
Translate those into small doable actions	
Agree on key facilitating factors Can be at the individual, community, institutional levels. Private sector and other	Increase training of HC staff, TBAs, VHVs Increase women's and men's awareness of service availability Increase transportation availability Increase women's and men's awareness of transportation availability Provide information on what to expect and what not to expect from an anc visit

<p>Select activities to support behavior change(one of which is BCC)</p> <p>Activity can be at the individual, community, institutional levels. Private sector and other</p>	<p>Conduct training sessions of all involved Implement BCC activities Offer improved quality anc services according to the client’s point of view Offer anc services during outreach Combine community-based birth spacing with anc counseling</p>
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Annex 8.16

WORKSHOPS ON PERCEPTION OF HEALTH VOLUNTEERS AT SIX PROJECT SITES (INCLUDING KIEN SVAY) OF WORLD VISION CAMBODIA

1 INTRODUCTION

World Vision Cambodia has supported an extensive research into the perceptions of village health volunteers, during 2000. Many different organizations supported Village Health Volunteer (VHV) programs, since as early as 1992. From 45 programs that were currently supporting village health volunteer work, 30 sites were selected. Of the 30 sites, six were supported by World Vision. Because the health director, Dr Kyi Minn, reported the six programs were dissimilar, data was collected from each of these six sites.

Valuable lessons can be learned from others' experiences, both positive and negative. The initial research project detailed the experiences of many of the VHV programs in Cambodia. This short project allowed the critical analysis of the VHV activities that World Vision is involved with and suggest recommendations for future work. Strategic planning and programming would be enhanced with the further understanding of the research results.

Two open workshops were conducted in October 2000 for all interested organisations to review the results and propose recommendations. These workshops for each of World Vision's six sites were repeated to share the individual and total results of World Vision sites as compared to the sum total of the 30 sites. These workshops allowed World Vision Cambodia to build upon the total findings. In addition, a fourth day allowed the volunteers, health center and operational district staff, along with World Vision ADP staff to understand existing or create new reporting forms.

This exercise allowed participants of the workshops an understanding of the needs of the population they serve. This project provided an in-depth understanding of the role of Village Health Volunteers within each program as compared to others in Cambodia.

2 WORKSHOP PRINCIPLES

i) **Believe in the VHV's Potential:**

The VHVs have a lot of wisdom and potential. They may not know what we know, but they know about many things necessary for working with villagers. They have long been maintaining their community and culture in their environment in their own way. We do not know about so many things the VHVs know, and those things are important when related to understanding and solving problem in community.

ii) **Recognize the importance of knowledge derived from real experience and situation in daily life:**

The VHVs have their own way of thinking, their own way of classifying, analyzing, and differentiating which is not the same as ours. Therefore it is appropriate to accept their wisdom so it can be adapted and used in solving community problem cooperatively.

iii) **Support VHVs in performing the main role of discussion:**

We must not dominate or advise them to solve the problems in our own way, but we must support them in the discussion. That is, to keep quiet and let VHVs have opportunity to think. What we can do is to facilitate by setting right questions only when necessary.

3 OBJECTIVES

The goal of this project was to share the results of community perceptions of VHV programs in six sites for World Vision Cambodia, compare the results of each site to the total findings for the nation-wide survey as well as to the total findings for World Vision Cambodia. This provided a framework for improved preventative health strategies, facilitating an improved standard of health for Cambodians in the World Vision program areas.

The purpose of this project was to determine the role of VHV programs, assist the program staff that run VHV programs to critically analyse current VHV activities and suggest recommendations for future work with VHVs, in a sustainable manner.

Methods and strategies used to overcome and meet identified needs:

- * Similarities and differences among approaches within VHV programs were evaluated by comparing individual sites with grouped results.
- * The community perception and involvement for individual VHV programs was evaluated through focus group discussion summaries and statistical frequencies compared to groups summaries and frequencies. Volunteers were able to assess their contribution to the improvement of health in their villages.
- * Program statistics with “model” VHV programs were compared.
- * The status and value of VHV programs was assessed by reviewing the grouped data and comparing with individual site. The attributes were looked at critically--both positive and negative.
- * Understanding of existing reporting forms or creation of new forms by the volunteers themselves allowed for increased ownership of the village health volunteer program. Health volunteers can use these as indicators for evaluation of village health behavior changes.
- * Recommendations for future work were suggested, with volunteers. This provides a framework for improved preventative health strategies through their community-based health volunteer program.

4 METHODOLOGY

The workshop was conducted over a period of four days. During each morning and afternoon, the data was presented. Afterwards, the participants were separated into small groups to discuss prepared questions. Then, the group came back together and a representative from each discussion group presented their discussion results. This created the opportunity for the participants to discuss issues all together.

5 RESULTS

Five workshops were conducted with staff and health staff and volunteer representatives from six ADP sites; Kampong Thom, Kean Svay and Kandal Stung, Kampong Tralach, Kampong Spue, Battambang.

Each workshop was conducted over a period of 4 days. A summary of the responses is included in the Appendix.

Mission Statement

VHVs help their communities reduce death and disease by educating, referring patients, monitoring and exchange of information between institutions and villagers.

Action Plan

The reporting forms used by the VHVs were reviewed. Suggestions for small changes were made; in some sites these suggestions were incorporated directly, in others, the decisions for changes required comment from other stakeholders. One concern raised was with “overlap” reporting. The solution reached was to hold meetings to discuss the data in the reports. In some areas, VHVs work in non-ADP villages. The monthly meetings with HCs should involve all VHVs, not just those in ADP areas.

Workshop Evaluation

Many participants reported they gained new knowledge and experience, the facilitation was clear and the workshop was prepared well. Some complained of the venue being too hot, the content difficult to understand as the time was short, accommodation was not provided and other participants talked too much during formal sessions.

Dates of workshops

Workshop	Site	Dates
1	Kampong Thom	November 2000
2	Kean Svay and Kandal Stung	5-8 June 2001
3	Kampong Tralach	12-15 June 2001
4	Kampong Spue	19-22 June 2001
5	Battambang	26-29 June 2001

Workshop participants

Site	WV staff	HC staff	OD staff	VHVs	Total
Kampong Thom				67	67+
Kean Svay	1	4	1	41	47
Kandal Stung	1	1	1	8	11
Kampong Tralach	7	6	1 +1 MRD	101	116
Kampong Spue	3	15	3	43	64
Battambang	3	12	2	32	49
Total	15	38	7	292	354+

APPENDIX

The following is a summary of the responses presented by each of the groups in the five sites.

Question 1a What are the important aspects of the vhv program?

Enable communities to understand how to prevent/ reduce diseases/ death, to get (sanitation, EPI, BS, boiled water). Build links between community members and HC (VHV can report what happens in village, including serious infectious diseases so HC can intervene on time), helping reducing poverty of people, building friendliness among villagers.

Question 2 Why is the VHV program needed to improve the community health?

Help facilitate the exchange of information between community and HC because VHV's know villagers clearly, are able to identify health needs of villagers, are able to provide health education and they become models in their villagers so people change inappropriate behaviors.

Assist with access to immunisation for children and women.

Question 3 What is good in what we are doing? Why is it good?

Weighing children to identify malnourished children because through the results they are able to know what to improve to accomplish their mission.

Health education to villagers, helping women/children to get EPI/BS, refer of patients to HC, attending monthly meeting, and monthly reporting (including deaths in village).

These are important because these activities help people to get understanding of the importance of health, women have fewer children, six kinds of diseases are prevented (EPI), diseases leading to poverty are prevented and HC staff know about what is happening in villages.

Question 4 Should VHV sell drugs in the future? Why? Why not?

VHVs should not sell drug because they do not have technical skills/capacity to advise villagers to use drug, otherwise this can destroy people's health. And this is also against the laws of Cambodia. The role of VHV's is to advise patients to go to HC. People might accuse VHV's of selling drug, which is provided by HC. However, VHV's can give out ORS and paracetamol, but not sell them, as WV provides freely.

Question 5 How have VHV's been supported?

Small amount of money, other materials, training sessions /workshops/ meeting, free treatment at HC, bicycles, other materials, per diem, latrine and cow credit.

Question 6 What do VHV's benefit their own families beside some materials and small amount of money from their work as VHV's?

Free treatment at HC.

VHV's' work enables them to build their problem solving skills that is very important to their families.

Skills in communication with other people (bravery to talk)

Knowledge to help with own families, others, decreased disease in own family, improved living condition, praise by villagers, gain merit, free treatment at HC

Question 7 Has their social status increased since they became VHVs?

Yes, villagers, local authorities and HC recognize and trust them- e.g villagers take their children to get EPI when advised by VHVs. Villagers believe in VHVs and comply with advice.

VHVs are authorized to attend training, meeting, and village development.

Question 8 What must VHVs do to improve the effectiveness of health education to villagers?

Visit villagers at home, treat villagers in a friendly manner, build good relationships with HC and villagers and local authority.

Advise villagers to go to HC or OD when sick. With a precise plan, educate villagers whenever possible about BS, diarrhea, sanitation and ANC. Provide true information to villagers, encourage villagers to get EPI and deliver baby at HC. Continue to regularly work as volunteer.

Educate villagers by setting good example (sanitation, boiled drinking water), encourage villagers who change inappropriate behavior; monitor to determine if villagers change behaviour, re-educate when they do not understand.

Question 9 What must HC and OD do to help VHVs to do even better job?

Improve relationship with VHVs. Inform VHVs first before conducting EPI sessions, and treat VHVs and patients in a friendly manner. Help solve problem of EPI side effect. Provide more education about health. Provide ORS and Paracetamol to give to villagers and health education materials (pictures).

Encourage villagers to believe in VHVs and consider poor patients.

Provide incentive such as money and free HC treatment for their families, or discount 50% of treatment fee for families of VHVs.

Conduct regular meeting with VHVs. Pay attention to report given by VHVs. Teach VHVs how to write report and give back report to VHVs (feedback). Avoid blaming VHVs when they make mistakes, rather encourage VHVs.

OD must intervene with HC staffing problems, OD must strengthen HC staff.

Increase number of VHVs per village.

Question 10 What must WV do to help VHVs to do even better job?

Review old lessons for VHVs and provide new topic in training, provide training materials, uniforms, study tour and ID card, and praise certificate for competent VHVs. Encourage VHVs with rewards or picnic during national holidays and incentive such as money.

Provide medicine (ORS) for VHVs to use with villagers, snack for meeting.

Provide transportation fee for poor patients to go to HC.

Provide VHVs with materials for well and latrine construction, and rice seed.

Cooperate with VHVs in giving education. Cooperate with OD, HC when asked by VHVs.

Monitor the report of VHVs and suggest ways to improve the report.

Question 11 What problems do you encounter, according to priority, and what solutions do you propose to solve those problems?

Why do villagers do not comply with VHV education? How could it be resolved?

Villagers are busy with their own work, do not understand about the importance of health education and they have not yet believed in VHVs so these can be resolved by trying to educate them again and again, and by encouragement. VHVs must become the model persons of villagers.

Why do villagers blame VHVs? How it could be resolved?

Because villagers get side effect from EPI or BS and they do not understand about these; the solution to the problems is to explain villagers again and again with reason why they get side effect.

Why do villagers ask for drug? How could it be resolved?

Because their villages are far away from HC; and the solution to that is to explain them to go to any nearby HC, and WV to provide first aid medicine for VHV to treat.

Why do VHVs lack transportation means? How it could be resolved?

VHVs have too many children, are poor and live far from WVC Office and HC. The solutions are to ask WVC to support transportation fee and to improve their skills in vegetable growing and animal husbandary, and do small business to generate more incomes.

Why do VHVs have low level education? How it could be resolved?

Because of war, poverty, lack of schools and the culture (people tend not to allow their daughters to school) so the best solution is to try to learn by themselves and gain more knowledge and experience from WVC and other NGOs

Why do VHVs have poor skills in education of villagers? How could it be resolved?

Because they did not have opportunity to learn as due to long-term war and poverty. The best solution is to try to learn.

Why do not villagers do not believe in VHVs? How it could be resolved?

Because the villagers do not understand the importance of health, the education skill is poor, especially VHVs have not yet become model persons of villagers. And also because of patients advised by VHVs do not meet HC staff. So the best solution to the problem is to try to learn more, try to educate them, and become the model persons. And ask HC to help patients.

Why is it difficult to educate villagers about EPI? And how could it be resolved?

Because they are afraid of disease transmission through the needles. Children got sick after EPI injection and some still got the disease after being immunised (therefore villagers do not trust EPI).

And the best solution to the problem is to educate again and again. Also, the HC should provide paracetamol for the children when they are immunised.

Question 12 Who and how should VHVs cooperate with to promote the effectiveness of community health care?

VHVs should cooperate with:

- HC, OD, WVC (by supporting technical aspect and planing), local authorities, TBA, other VHVs, villagers, school teachers, VDCs, Women Association, elderly, monks (taking time to educate villagers during religious ceremony), private drug sellers to help encourage patients.
- villagers directly by providing health education.
- HC and local authorities for EPI session and
- HC by referring patients to HC/ educate villagers to go to HC when sick.
- other VHVs solving problems, sharing experience.
- NGO in finding out education materials.

Question 13 Should Village Chiefs become VHV? Why? Why not?

Yes, village Chiefs should become VHVs because they know information clearly and live in villages (know village situation), have strong relationships with villagers (people trust them), and because they are influential and have capacity (high problem-solving skills).

No, village chiefs should not become VHVs because they do not have enough time to work as VHVs (they have many things to do as local authorities); it is better for them to cooperate with VHVs.

Monitoring System. The main objective of this discussion was to help the participants, especially VHVs, to better clearly understand/ adapt the reporting form they had already used.

Question 14a Why do we need Monitoring and Evaluation?

Monthly reports are needed because they want to know if their previous activities are good, the change in health status (if diseases occur increasingly or decreasingly), health behavior change and especially knowledge of villagers (if their plan is accomplished).

VHVs might find some ways to increase the effectiveness of the education.

Question 14b What will be included in Monitoring system?

- Numbers of children, the pregnant and men who die, numbers of children, women receiving EPI, BS, breast feeding , Vitamin A and numbers of people educated by VHVS.
- Diseases like dengue fever, cholera...
- Number of families drinking boiled water, using net, using latrine
- Health education of VHVs (what topics, how many people...)

Question 14c How will VHVs monitor?

By visiting at home, asking information from other sources, recording information (e.g. from yellow cards, during EPI session), small group meeting, direct observation and through the report form provided by HC, writing report and sending it to HC.

Question 14d How can monitoring be used?

By keeping it as the reflection of their activities as the lesson learned. Monthly reports are sent to HC and WVC and keeping information for their own use. HC will give VHVs feedback on what happened in the whole area. To compare the current month result with the previous results.

Action Plan

Kean Svay

Checklist previously developed by WVC-Kean Svay, and everybody agrees to use these forms (VHV and HC forms). One problem was raised to discuss and solve then, the overlap-reporting between Feedback Committee and VHVs. The solution to the problem is to conduct meeting altogether to solve overlap reporting.

Kampong Chhnang

HC, OD and Kompong Tralach ADP are going to cooperate each other to improve Health Program in Kompong Tralach. WVC in Kompong Tralach is going to involve HC-supporting committee selected by HCs in non-target area of WVC in VHV monthly meeting previously participated by only VHVs selected in WVC target area. All agreed to ask VHVs to report to both HCs and WVC, however this will be discussed and agreed altogether in a meeting conducted on 27 June 2001. All parties agreed to use VHV mission statement developed in the workshop as a tool to improve Health Program. WVC in Kompong Tralach will financially support Health Center to strengthen VHVs called HC-supporting committee.

Kampong Speu

The relationship and cooperation between WVC and HC is already strong. They conduct monthly meeting altogether with VHVs and VHVs report to both WVC and HCs, however the contents and the report form has been developed by only WVC in Kompong Speu. So all related sides (HCs, WVC and OD) agreed to discuss and adapt in the VHV report form to get the most benefit from the report of VHVs in the future. But the date of the meeting was not set yet.

Battambang

The workshop tried to adapt the reporting form of VHVs for use, but could not because the chairman of the OD, who developed the reporting form was not there. So the only the additional reporting form was created for use in connection to the existing form. The OD representatives who were present in the workshop and WVC staff agreed to leave the agenda to discuss and finalize later on. And the other HC representative planned to conduct their own workshop with VHVs who did not attended the workshop to finalize the reporting form in cooperation with the WVC.

Annex 8.17

Capacity/Sustainability Plan For Kean Svay Child Survival Project

Introduction

In the development of the Capacity Building plan, several factors were taken into consideration, namely:

1. **Strategy** --- a CB plan closely linked to sustainability using the Kirkpatrick Strategic Training Model of building capacities of individuals/groups to sustain their abilities that will contribute to the achievement of KSCSP goals leading to better health outcomes. Sustainability is defined as the continuous ability of individuals, and groups to make changes in behavior, policies and institutions, which have a positive effect on health and nutritional status.
2. **Focus** --- zero in on intervention areas that would contribute maximally to the achievement of the KSCSP goals as well as the geographic (direct impact area) which is most underserved and indicators lagging, given the remaining
3. **Timeframe** --- 20 months
4. **Process** --- using PLA, group discussions, and the recent result of KSCSP attainment of objectives by intervention, a participatory assessment was carried out to identify “high/low performance target achievement” jointly by key stakeholders such as mothers, fathers, village/commune leaders and health workers (TBAs, drug sellers), MOH (OD, Health center), and the KSCSP staff. Once the stakeholders identified the priority intervention, they then worked in separate groups: (#1: mothers & fathers; #2: village/commune leaders, health workers; and #3: HC staff). They discussed who are the CB participants, what role do they play in achieving goals, what they need to learn, when/how best they learn, how do they know they are learning, who should be the capacity builders, who should/how to monitor their learning, what are the CB constraints and strategies to address them. The groups then jointly presented and provided feedback to each other. The results of this process were then captured in the CB plan.
5. **Staged CB** (geographic as well as thematic) --- start with a “core” group (above stakeholders) involving representatives from one commune and the HC covering the commune. Do the same for the other communes. Once a CB plan is developed for a particular intervention, the process will be repeated for the remaining interventions.
6. **BCC application** --- following the BCC consultancy with Elli Leontsini, the KSCSP focused on the “index” behavior (in this case home management of the 3 killer diseases) utilizing the processes recommended by the consultant.

Method

A participatory method was used to develop the Capacity Building / Sustainability Plan for the Ministry of Health, community organizations, and WV Cambodia staff. Each group of participants were asked to identify the elements of the present project that were most important to sustain after the end of the project. Activities and indicators were then assigned to each element of the project to be sustained as well as the responsible party(s) and time frame. Prior to the identifying the sustainable elements of the present project by the various groups, a review of the KSCSP Detailed Implementation Plan (DIP) was made by WV Cambodia and WVUS key staff members. The sections of the DIP relating to Capacity Building and Training were carefully examined. The objectives identified in the DIP in the section on Capacity Building were either modified or retained in regard to the group process.

Three participant groups of project stakeholders were formed, and the Ten Seed Technique was used to gather information from the gathering. Each group was made up of about 20 people. The major groups were first the staff from the KSCSP, and the Kean Svay Operational District. The second group was composed of persons living and working at the community level (Village Health Volunteers, Traditional Birth Assistants, Moms & Dads, and commune leaders). Because the information from the community level is so important different groups in two separate locations met to provide their ideas. The information

from these two groups was cross-checked and combined. The third group consisted of Ministry of Health personnel who operate out of the health centers. After each group had identified the elements of the project that should remain after the end of the project, the groups were subdivided around the elements that they were most responsible for, or effected by. These subgroups identified activities that are necessary for implementation now if the priority elements are to be sustained after the end of the project. Many times the activities were based on gaps between what was presently being done, and what was needed.

The participatory method was used so that the local stakeholders in the project could express their desires and future roles of responsibility in the seeking of health, wellness, and development after the close of the project.

Capacity Building Plan for Ministry of Health and Community Organization

The information from the group participation exercise has been tabulated into the following matrices. The individual groups identified the objectives. The KSCSP staff guided a discussion on the indicators, supporting activities, who should be responsible, and the timing of implementation.

Objective	Indicators/definitions	Activities	Plan
Ministry of Health			
1. 100 % of Leuk Dek health center outreach activities managed solely by MoH (Operational District/Health Center.	1. 100% of outreach activities will be implemented and supported by the Health Center Staff in Leuk Dek Administrative District by end of project. 2. Cost recovery system in place to provide support for outreach activities by the four Health Centers in Leuk Dek Admin. District.	Training of Health Center staff in outreaches planning with emphasis on financial management and supervision. Training of Health Center staff in implementation of outreach activity. Continue of gradual phase out of outreach activities now implemented by KSCSP (Logistics, Supervision, Planning, and Supplies).	Who: MoH and KSCSP When: Beginning in FY02, Q2
2. Increased quality of Case Management of Health Center Staff in LD, LE, KS, and KgT.	“Good” performance rating in Case Management of HC staff in CDD, ARI, DHF.	Training on Case Management of CDD, ARI, DHF for HC Staff Cross supervision using the Skill Check List (DIP Annex E) Training on counseling and interpersonal communication skills. CBDDS Training including verbal and social autopsies.	Who: MoH & KSCSP When: FY02, Q2 Every six months. WVC, RACHA, UNICEF, FY02, Q4 Local Consultant, FY02, Q2 or 3.

	Area/ Disease	Baseline %	Tar get %		
	LD				
	CDD	43	80		
	ARI	17	70		
	DHF	72	90		
	LM				
	CDD	82	90		
	ARI	43	70		
	DHF	67	90		
	KS				
	CDD	50	80		
	ARI	50	70		
	DHF	40	70		
	KgT				
	CDD	17	50		
	ARI	31	60		
	DHF	60	80		
3. To strengthen the technical and managerial capacity of KS, and KgT OD to conduct quality supervision of Child Survival Interventions.	80 % of LD's HCs visited by KS OD and 50% of HCs visited by KgT OD received all five selected Supervision Quality Indicators.		Training on supervisory skills to Operational District & HC staff for Case Management		FY02, Q2
4. Health Center Management Committee (HCMC) functioning in two Health Centers in Leuk Dek. (According to MoH Guidelines, see attachment)	Two of four HCMC in Leuk Dek are able to perform according to the ten points in the MoH Guidelines (TOR for HCMC).		<p>Establish HCMC in four HCs in Leuk Dek</p> <p>Provide orientation on community CMCF in HCs</p> <p>Identify role of HCMC</p> <p>Training on problem identification and solution development.</p> <p>Orientation for HC management staff on how to conduct meetings</p> <p>Provide training on use of Health Information Systems.</p> <p>Equip and continue to support when needed.</p>		<p>Who: MoH & KSCSP When: FY02, Q3</p> <p>FY02, Q4</p> <p>Start FY02, phase out FY03</p>

<p>5. Increased organizational capacity of Kean Svay Operational District to manage and sustain child health programs.</p>	<p>Increase in organizational capacity score (OCA adapted for KS OD) from 1-2 to 4-5-6 in the KS Operational District</p>	<p>Sponsor three senior KS OD staff to attend the six-month Health Services Management training at the National Institute of Public Health.</p> <p>Three trained senior staff to conduct workshop on capacity building for OD staff.</p> <p>LQAS surveys</p> <p>Agreed Plan of Action for phased handover of management responsibilities</p> <p>Training in principles and practices of adult education.</p> <p>Training and site visit to local NGO (CRS) implementing increasing community contributions for health services, and community participation in the management of these services</p>	<p>Who: OD staff, Public Health Department & KSCSP.</p> <p>When: FY02, Q2-Q3</p> <p>When: FY03, Q1</p> <p>NHP, Partners for Development. FY02, Q2</p> <p>On-going through FY02 & 03</p> <p>WVC Staff Development Unit, KSCSP. FY 02, Q3</p> <p>NHP, FY03, Q2.</p>
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Community Organization			
<p>1. Health Center Management Committee and Feedback Committee functioning in two HCs in Leuk Dek.</p>	<p>MoH Guideline description of Feedback Committee and Health Center Management Committee.</p>	<p>Establish FBC and HCMC in two HCs in Leuk Dek.</p> <p>Provide orientation of community CMCF to community representatives.</p> <p>Identify role of HCMC and FBC.</p> <p>Equip and continue to support when needed.</p> <p>Orientation for community representatives on how to conduct meetings.</p> <p>Training on problem identification and solutions development.</p> <p>Provide training on use of Health Information Systems.</p>	<p>Who: KSCSP, MoH, HC Chief, and Public Health staff.</p> <p>When: Beginning in FY02, Q2</p>
<p>2. Families with children 0 – 23 months are practicing selected C/IMCI family practices. (Home care, men’s participation and health seeking behavior.)</p>	<p>Increased percent of mothers of children 0 – 23 months who continue to feed, provide fluids (including breast milk) to children with diarrhea.</p> <p>Increased percent of mothers who provide appropriate home treatment to children with ARI, CDD, and DHF.</p> <p>Mothers recognize when children need treatment outside the home and seek appropriate care.</p> <p>Increased percent of mothers follow the health worker’s advice about treatment, follow-up, and referral.</p> <p>Men actively participating in childcare and reproductive health in the</p>	<p>Training of caretakers in homecare, and treatment seeking in the village.</p> <p>Via Mother’s Group Model.</p> <p>Via Family Group Model.</p>	<p>Who: VHV’s, FBC, HC Staff, KSCSP, and HCMC.</p> <p>When: FY02, Q3</p> <p>Who: HC staff, and KSCSP</p> <p>When: FY02 Q 3-4</p>

<p>3. Increased capacity of nine of the forty-five VDCs in Leuk Dek, and the majority in Kompong Thom to design, manage, and implement child health activities.</p>	<p>Eight VDCs are enabled to demonstrate skill in planning, designing, implementation, and managing the essential Child survival interventions.</p> <p>Eight VDCs are able to monitor, make decisions using data from the Community Based Death and Disease Surveillance tool. And, to the problems, and develop solutions in the village.</p> <p>Eight VDCs are able to link and access other resources to support community initiatives.</p>	<p>Training of VDCs in the design, and implementation of child health activities.</p> <p>Set-up and maintain community owned registers.</p> <p>Training in CBDDS including social and verbal autopsies.</p> <p>Training in principles and practices of adult education.</p>	<p>Who: HC Chief, KSCSP, ADP staff.</p> <p>When: FY02, Q 3-4 On-going</p> <p>Local consultant, FY02, Q2 or Q3</p> <p>WVC staff development unit and KSCSP staff FY02. Q3</p>
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MoH Guideline: Operational Guidelines for Community Participation at Health Centers – Draft July 1, 2001.

Capacity Building Plan for WV Cambodia

The Capacity Building Plan for World Vision Cambodia was developed through and examination of the objectives determined for the KSCSP Detailed Implementation Plan, and a review of the present needs.

Objective	Indicators/definitions	Activities	Plan
World Vision Cambodia			
Replicate and integrate essential KSCSP interventions into WVC ADPs	8 out of 23 WVC ADPs are using KSCSP tools and training materials for delivery of “essential” elements of child survival	Operation and ADP Health Coordinators, Operation and ADP Managers involved in deciding on core and recommended health indicators and activities for WVC ADPs	National Health Program and Operation Health Coordinators FY02 Q2 - ongoing

<p>Increase competencies of WVC health and other program staff to enable successful integration of CS interventions into ADPs</p>	<p>WVC staff Performance and Development Management (PDM) plans for KSCSP staff, WVC National Health Program staff, Operation and ADP Health Coordinators, Operation and ADP Managers document increased competencies in health-specific skills through training programs specific to each individual's job description.</p>	<p>Training Refresher ToT knowledge and skills</p> <p>Introduction to IMCI principles and practices</p> <p>Community Based Death and Disease Surveillance (including Verbal and Social Autopsies)</p> <p>Behavior Change Communication principles and practices</p> <p>LQAS surveys</p> <p>Improved counseling and interpersonal communication skills</p>	<p>NHP/KSCSP</p> <p>NHP and NPH FY02 Q3 Local Consultant FY02 Q2 or Q3</p> <p>International Consultant (done)</p> <p>NHP, Partners for Development FY02 Q2 WVC, UNICEF FY02 Q4</p>
<p>Strengthen knowledge and skills of WVC staff in project design, planning, monitoring and evaluation</p>	<p>WVC staff Performance and Development Management (PDM) plans for KSCSP staff, National Health Program staff, Operation and ADP Health Coordinators, Operation and ADP Managers and CDWs document increased competencies in project design, planning, monitoring and evaluation through training programs specific to each individual's job description.</p>	<p>Training in project design and planning</p> <p>Training in M&E</p> <p>Active participation of ADP staff in KSCSP surveys, planning, implementation, monitoring and evaluation and vice versa.</p>	<p>NHP, KSCSP, ADP staff Throughout FY02 and FY03</p>

Enhance grant management skills, systems and capacities throughout WVC	KSCSP Finance/Admin staff, National Health Program Finance staff and Area Accountants from Kandal-Takeo and Kg Thom Operations have measurable increases in grant management skills. A learning network on grant accounting is established and functioning in WVC	USAID Grant Management Workshop (WVUS CYOC) Formation of learning network	WVC National Health Program FY02 Q2-3
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The goal for the WV Asia- Pacific Regional (APR) Team is to acquire requisite knowledge and skill in “essential” CSP interventions and results-based management. To achieve this goal the team is continuously involved in several activities.

- Direct involvement in CSP. Each member of the team makes site visits for evaluations, and monitoring of present CSPs. Active participation is taken in the development of reports and plans.
- Contact with the WV Technical Team. Projects involving child survival are supported by a team of medical experts trained in both treatment and prevention as adapted to different cultures, and environments. The APR Team is in constant contact with the members of this team soliciting technical advice, securing consultants, and using members of the Technical Team as evaluators.
- Attendance at workshops and seminars. The APR Team attends workshops and seminars that are sponsored such agencies as CORE, and USAID in the design and implementation of CSP.
- Individual performance appraisals. Each team member is individually assessed twice per year using a 360 – Degree appraisal tool. This tool covers several dimensions involving teamwork, communication skills, giving and receiving feedback, innovation, customer/vendor/partner relationships, systems thinking, and quality processes. In addition to the performance appraisal each team member is required to identify a set of personal development goals for which they are held accountable. Many of these personal development goals include the practical study of Child Survival interventions and management.
- Team performance appraisal. The APR Team has used the Discussion-Oriented Organizational Self Assessment tool (DOSA) to establish a baseline of measures in the areas of external relations, financial resource management, human resource management, organizational learning, service delivery, and strategic management. The assessment of these measures will indicate areas of strengths and weaknesses around which objectives and supporting activities can be developed.
- USAID Grant Management. Key members of the APR Team have been certified through an in-house training in the managing of USAID Grants. This training was intensive covering both personal study, and class instruction. A comprehensive final examination necessary to complete the course. This course was mandated by WVUS for its entire staff involved with USAID grant management.
- Graduate Level On-going Education. Three members of the APR Team are enrolled in a four-year WVUS sponsored MBA program provided though Eastern University in Pennsylvania. This program offers courses in principles of leadership, human resources, organizational development, finance and international development. Many of the courses require projects, which are of direct benefit to the organization.

Attachment (not available as electronic file)

1. Operational Guidelines for Community Participation at Health Center, Ministry of Health, Kingdom of Cambodia.