

PEARL S. BUCK INTERNATIONAL INC.

PARTNERS FOR HEALTH CHILD SURVIVAL PROJECT

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LIST OF ACRONYMS

AdBoard	Advisory Board
ANC	Ante Natal Care
BAP	Barangay Action Plan
BHAP	Barangay Health Action Plan(ning)
BCLP	Basic Child Learning Package
BEOP	Barangay Emergency Obstetrical Plan
BHC	Barangay Health Committee or Barangay Health
Center	
BHS	Barangay Health Station
BHW	Barangay Health Worker
BIG	Bio- Intensive Gardening
BNS	Barangay Nutrition Scholar
BTL	Bilateral Tubal Ligation
CDLMIS	Contraceptive Distribution Logistical Management Information System
CHDO	Community Health Development Officer
(PHCSP staff)	
CHO	City Health Office
CSTS	Child Survival Technical Support
DA	Department of Agriculture
Dep-Ed	Department of Education
DMPA	Depo Medroxy Progesterone Acetate
DOH	Department of Health
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
ERT	Emergency Response Team
FIL	Fully Immunized (against tetanus)
FP	Family Planning
FHSIS	Field Health Service Information System
GMC	Growth Monitoring Chart
GMP	Growth Monitoring Program
HS	Health Scouts
HBMR	Home Based Maternal Record
HNP	Health and Nutrition Post
IECM	Information Education Communication Motivation
IMCI	Integrated Management of Childhood Illnesses
IRA	Internal Revenue Allotment
IUD	Intra Uterine Device
KPC	Knowledge Practice Coverage
LAM	Lactation Amenorrheal Method
LQAS	Lot Quality Assurance Sampling

LGU	Local Government Unit
MCH	Maternal Care and Health
M and E	Monitoring and Evaluation
MHS	Main Health Station
MSG	Mother Support Group
MTE	Midterm Evaluation
NERS	Nutrition Education and Rehabilitation Session
NGO	Non Governmental Organization
OCP	Oral Contraceptive Pill
OR	Operations Research
PDI	Positive Deviant Inquiry
PHCSP	Partners for Health Child Survival Project
PSBI	Pearl S Buck International
PHDB	Purok Health Data Board
PHN	Public Health Nurse
QFI	Quality Food Intake
RHM	Rural Health Midwife
RHU	Rural Health Unit
TA	Technical Assistance
TWG	Technical Working Group
TT	Tetanus Toxoid
TBA	Traditional Birth Attendant

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Attachments:

- A. Lot Quality Assurance Sampling Documentation and Results
- B. Revised Monitoring and Evaluation Plan

A. Progress towards Achieving the Objectives

1. Nutrition and Breastfeeding

Objectives	Progress Towards Objective	
	YES/NO	Comments
1. Increase from 50% to 70% the percentage of children <24 mos. who were exclusively breastfed until 6 mos. old	No	Lot Quality Assurance Sampling (LQAS) revealed that 65% was achieved in only 2 lots. This may be attributed to the series of Basic Child Growth Learning Package (BCLP), Information Education Communication Motivation (IECM) campaign and breastfeeding promotion efforts by the health workers in these 2 lots. The rest of the lots revealed that health volunteers had difficulty in changing the mother's practice of 0-4 months Exclusive Breastfeeding (EBF), especially those with children who were previously breastfed up to the 4 th month.

		Although complete analysis of the Quality Food Intake (QFI) Survey is not finished, initial findings supports LQAS findings on EBF since most mothers gave water to their children “to quench the thirst”.
2. Decrease from 31% to 10% the percentage of mothers initiating solid foods to children < 6 months old	No	Only one lot achieved the target. QFI survey’s initial finding tends to support the LQAS result since those interviewed mothers initiated solid food even before their child reached the age of 6 months with most of the mothers initiating their children to solid food at 4 months. The earliest is at age 3 months.
3. Increase from 46% to 70% the percentage of children who are continuously breastfed	Yes	LQAS: All 7 lots achieved 65%. This may be attributable to the health education campaign on continuous breastfeeding by trained health workers.
4. Increase from 22% to 60% the percentage	Yes	LQAS: All 7 lots.

of children >6 mos. up to 24 mos. provided with appropriate complementary feeding		Mothers interviewed have expressed that they value solid food for their children's nutrition.
5. Increase from 85% to 95% the percentage of mothers with children <5 years old who use at least 2 vitamin A/Iron rich foods appropriate in their daily food preparation	No	LQAS: Only 1 lot achieved the target.
6. Increase from 0 to 48 the number of <i>barangays</i> (community) with established and functional weighing posts. Note: Weighing Post is now called Health and Nutrition Post (HNP). Barangay is equivalent to community.	Yes	8 HNP in Merida 25 HNP in Ormoc City 33 total <i>barangays</i> have HNP. Since some <i>barangays</i> have more than 1 HNP, there are a total of 39 HNP with 6 undergoing renovation in Ormoc. Community-to-community approach paved the way for the community leaders to take concrete action by constructing HNP.

LQAS is a Monitoring and Evaluation (M& E) tool utilized by Partners for Health Child Survival Project (PHCSP) to determine achievement towards objectives of the project. All of the 48 PHCSP sites were divided into 7 lots based on the 7 supervisory areas of the Public Health Nurses (PHN) of Ormoc City and the Municipality of Merida. The data reflected in the tables were from latest LQAS conducted last July 22 to August 2002. In each lot, 19 respondents were to be randomly interviewed to ensure reliability (95%) of data and smaller margin of error. However, the actual number of respondents interviewed fell short of the

target i.e. fewer than 19 mothers with children within 0-24 months were interviewed for continuous breastfeeding. This makes the data weaker, as the reliability depends on the actual sample size for each question. This weakness is recognized in the results particularly for continuous breastfeeding, exclusive breastfeeding, and Traditional Birth Attendant (TBA)-related data.

B. Impeding Factors

1. Nutrition and Breastfeeding

a. Policy on EBF. In the previous years and even up to the second year of the project, health personnel focused exclusive breastfeeding promotion on 0-4 months. Since Year 2, the project partnership has been trying to undo the effect of this misinterpretation of Department of Health (DOH) policy of 0-4-6 months exclusive breastfeeding by the health personnel in the area. Because of this, there are still a number of mothers whose previous understanding of exclusive breastfeeding is the minimum 0-4 months EBF. In an effort to rectify this, the project conducted a series of meetings with the nurses, midwives and health volunteers to emphasize that EBF is up to 6 months and only in rare cases when the child refuses mother's milk or not growing appropriately will EBF be limited up to the 4th month. In addition the Basic Child Growth Learning Package (BCLP) training for caregivers was introduced to reinforce breastfeeding promotion initiatives. The healthy baby/mother/family calendars further reinforced exclusive breastfeeding. The Barangay Health Worker (BHW) IECM kit for small group health education also emphasized breastfeeding and complementary feeding of children. These efforts resulted in 65% EBF of children in two supervisory areas as against the Knowledge Practice Coverage (KPC) baseline of 50% EBF for the 48 PHCSP *barangays*. The LQAS was also a good tool in identifying specific supervisory areas where EBF is low. These 5 areas will then be the focus of intensified breastfeeding campaign that will include organizing of Mother Support Groups (MSG), conduct of MSG Classes, increasing coverage and frequency of BCLP sessions for caregivers and small group health education classes using the healthy baby/healthy mother/family IECM kit.

b. Training on Food Production using the Bio-intensive Gardening Technology (BIG). Training for other barangays has been interrupted on several occasions due to the demands for the Department of Agriculture (DA) trainers in other parts outside of the project areas in Ormoc and Merida. This has not only affected the planned training of community members in the expansion area but also the cultivation of home and communal gardens since seeds would only be distributed upon completion of the training.

In connection with this intervention an assessment was made. As of the third quarter of Year 3, 4 pilot *barangays* were trained on the BIG Technology for Backyard Food Production. The project staff in these *barangays*, (Nuevo Vista and Bayog in Ormoc City and Mat-e in Merida) conducted periodic monitoring and assessment visit. Barangay San Jose was also planned to be visited but was deferred because poor weather made the road impassable.

In the 3 areas visited by the project staff, there was generally a good application of the BIG technology. Barangay Nueva Vista was the most successful in its application of the BIG technology. The barangay is implementing their so-called “Green Belt”. Nueva Vista’s Green Belt was implemented right after the DA training on BIG in May 2001. Twenty five community members participated in the training.

By June of 2001, each *purok* (zone in the community) cultivated, maintained a communal vegetable and herbal garden and utilized by the families living within the same *purok*. Each of the 7 *puroks* in Barangay Nueva Vista has their own “Green Belt” maintained and located in the center of each *purok* for the families’ easy access. Aside from this, almost all of the families have cultivated their own backyard gardens in the barangay. The Health Information Systems Coordinator (HIS) also noted during a field visit that the 25 trainees of the BIG each have their own backyard gardens maintained.

The previously organized Caregivers Group, who also participated in the BIG training, took on the additional responsibility of advocating for BIG in the barangay. This loose group has elected their own officers to further coordinate their role as health educator in the community. In addition, these individuals strive to be local model families for health and nutrition. Perhaps they were inspired to do this because of the motivation that the Barangay Officials did regarding backyard food production.

The BHWs and Barangay Nutrition Scholars (BNS) said that this group (Caregivers Group) is providing a strong support mechanism for them in performing their duties in the health center and in assisting the Midwife in providing regular health services for the community. They also pointed out that the *Barangay Kagawad* (Community Councilor) for Health provided great support to them, as she was always present and helped to facilitate every health activity. She was a primary motivation for many of the community health workers.

Meanwhile, both *barangays* Bayog and Mat-e have conducted their own campaign of the Backyard Food Production to the families. The two communities

are currently organizing a communal garden, which is hoped to be useful for the families.

The vegetables planted in the gardens were found to be rich in iron (young *camote* [sweet potato] leaves, squash leaves, *malunggay* [horseradish], and okra); vitamin A (papaya, squash, *kangkong* [a dark green leafy vegetable]); vitamin C (guava); some Carbohydrates [taro]; some protein (string beans) and other essential food nutrients. There were also common spices planted, as well as herbal plants with medicinal benefits used for common ailments and minor illnesses.

There has been a slow response in the campaign for backyard food production in the other 2 *barangays*. The families associate this with the wet weather that the areas experienced. The frequent rains ruined the gardens and prepared beds, which prompted them to decide to re-cultivate in the summer season next year.

The project will ensure that the Barangay Council and health workers intensify the campaign on backyard food production. (While an organized group of mothers and caregivers may be able to help boost the campaign, organizing them might be redundant of community organizing, especially when the project has organized various groups in different communities, i.e., MSG, BHC.) In addition, health workers will conduct the caregivers class to families, not only to mothers and caregivers, so the BIG technology will be appreciated more in the communities. A community-to-community transfer of technology is highly recommended in the campaign for backyard food production and Nueva Vista can serve as a showcase to all the other areas, with or without the BIG training.

A. Progress towards Achieving the Objectives

2. Maternal Care

Objectives	Progress Towards Objective	
	YES/NO	Comments
1. Increase from 48% to 70% the percentage of pregnant women who have at least three Ante Natal Care (ANC) visits (1 ANC Per Trimester)	Yes	<p>City Health Office (CHO): coverage of 98.7% for ANC provided by health personnel</p> <p>Rural Health Unit (RHU): 100% coverage provided by health personnel/trained Traditional Birth Attendants (TBAs)</p>

<p>2.Increase from 58% to 75% the percentage of women who have received at least TT2+(Tetanus Toxoid)</p>	<p>Yes</p>	<p>LQAS: 5/7 lots CHO: 64% including Fully Immunized against Tetanus (FIL) RHU: 96.5% including FIL</p> <p>The low achievement of the CHO was the result of low TT vaccine supply. The CHO tried to augment supply by purchasing commercially distributed vaccines. However, due to its high cost the quantity purchased was not enough to cover their targets in some areas.</p>
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<p>3. Increase from 90% to 95% the percentage of deliveries attended by trained TBA.</p>	<p>No</p>	<p>The objective aims to improve the quality of birth attendants with trained TBA as the minimum requisite. The coverage for trained TBA was below the target with an accomplishment of 68% and 54% for Ormoc and Merida respectively. This low coverage is a result of the percentage of deliveries attended by other health professionals (doctors, nurses or midwives) [CHO, 33%; RHU, 46%]. The combined coverage of all deliveries attended by any trained provider is very high, with both areas achieving about 100%</p>
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<p>4. Increase from 57 to 75 the percentage of women who received quality post partum care from trained TBA.</p> <p>Quality Post Partum care =</p> <ul style="list-style-type: none"> • Counseling on FP, Nutrition and Breastfeeding • Maternal care i.e. hemorrhage, infection • Provision of Vitamin A <p>At least 1 home visit within 6 weeks</p>	No	<p>CHO: 42% by trained TBA</p> <p>RHU: 100% by trained TBA including provision of vitamin A and Iron supplement.</p> <p>The average of the two areas is 71%, and the quantitative target for year 3 was 70%. However, on validation most of the TBA failed to do the counseling part especially on Family Planning (FP)/EBF.</p>
<p>5. Increase from 0-48 the number of <i>barangays</i> with Barangay Emergency Obstetrical Plan (BEOP)</p>	Yes	<p>37 <i>barangays</i> as of September 18, 2002</p> <p><i>Barangays</i> were given a guide/questionnaire in the dialect. This simplified the planning process and assisted them in formulating their BEOP.</p>

B. Impeding Factors

2. Maternal Care

- a. Post Partum Care. The combined accomplishments of Ormoc City and the Municipality of Merida have achieved more than this year's target of 70% for women provided post partum care. However, validation revealed that despite this high quantitative achievement the quality of post partum care provided has not yet been achieved. Most TBAs were still unable to provide counseling on post partum family planning and exclusive breastfeeding. As a result, the TBA refresher course planned for Year 4 will include counseling

skills as well as topics on post partum family planning and exclusive breastfeeding for 0-6 months.

A. Progress towards Achieving the Objectives

3. Child Spacing

Objectives	Progress Towards Objective	
	YES/No	Comments
1. Increase from 25 to 50 the percentage of women using modern contraceptive methods	Yes	<p>LQAS: 3/7 lots using modern contraceptive methods</p> <p>LQAS: 6/7 lots with two years minimum spacing</p> <p>Contraceptive Prevalence Rate: CHO 63%, RHU 51%</p>

<p>2. Increase from 0 to 48 the number of Barangay Health Stations providing quality family planning service.</p> <p>Quality FP services =</p> <ul style="list-style-type: none"> • Minimum available services for condom, pills and DMPA • 3 months stock level of pills and condom • Proper recording of distribution of supplies • Counseling conducted with privacy and confidentiality • At least 1 Trained Personnel in FP. <p>The Contraceptive Distribution Logistical Management Information System (CDLMIS) is a DOH mandated form for commodities management.</p>	<p>Yes</p>	<p>All 16 Main health stations provide FP services with 7 able to provide Intra Uterine Device (IUD) insertion. These main health stations are located in the 48 barangays of the CSP service area. At the BHS, the 3 month stock level of condom, pills and Depo Medroxy Progesterone Acetate (DMPA) is maintained. The CDLMIS is utilized regularly to monitor stock level and dispensing of FP commodities. In addition, the FP Coordinators also conducted outreach activities at the BHS; the 8 HNP located in remote areas also provide pills and condoms re-supply to further augment FP service provision.</p>
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N.B.

1. Each Rural Health Midwife (RHM) covers a catchment of an average of 5-6 BHS and one is designated as her Main Health Centers (BHC) Station.
2. The term BHS in the objective was used as a generic name for all health centers/stations located outside of the City Health Office and Rural Health Unit

A. Progress towards Achieving the Objectives

4. Institutional Development and Capacity Building

Objectives	Progress Towards Objective	
	YES/No	Comments
1. Increase community participation in community health planning, implementation, monitoring and evaluation from 0% to 50% of the families in the PHCSP <i>barangays</i>	No	As observed in meetings, planning sessions, and communities' involvement in surveys etc., the number has not yet reached the desired target for this year. But there is an increasing trend in families participating in community activities. Planning, implementation and M&E is not anymore limited to elected <i>barangay</i> officials. Some mothers and fathers are now members of the different Barangay Health Committee (BHC). The latest LQAS survey team also involved even non-BHW/BNS.

<p>2. Increase from 0-48 <i>barangays</i>, participation among the key players (barangay council members, BHWs, BNS and TBA) in community health assessment and designing community health programs, initially focusing on the three technical interventions.</p>	<p>Yes</p>	<p>Community leaders and health volunteers from all barangays are participants in the annual barangay health action planning/assessment, LQAS and other project assessment activities.</p>
<p>3. Increase by 25% the current budgetary allocation and resources for health in 24 <i>barangays</i></p>	<p>No</p>	<p>34 barangays had budgetary allocation on health but did not meet the goal of 25% due to low Internal Revenue Allotment (IRA) provided to barangays by the LGU. Fourteen barangays tried to source funds through community members' contribution and other fund raising activities i.e. raffles. These activities are not regularly conducted and funds generated are not sufficient.</p>
<p>4. Increase from 0-48 barangays with organized and functional health committees.</p> <p>Organized= membership open to other members of community including parents, youth, BHWs, BNS, TBA, purok leaders, etc.</p> <p>Functional = participates in health planning and implementation, conducts BCH meetings at least once per month</p>	<p>Yes</p>	<p>Of 20 BHC, 16 are functional; the rest in different stages of organizational development. An additional 28 work through Barangay Council Health Committee. (See note at end of table.)</p>

<p>5. Increase by 50% the current level of families and communities with access to health information</p>	<p>Yes</p>	<p>All Households provided with health calendars annually; BCLP conducted in 46 barangays throughout the year by health volunteers; and BHWs trained in IECM Kit utilization for small group health education sessions. All elementary schools provided with flipcharts to be used during classes.</p>
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<p>6. Increase technical skills of city and municipal health personnel and barangay health workers on the three interventions in terms of quality of care, including efficiency and effectiveness, conduct of behavior change communication, record keeping, analysis and utilization, and reaching out to missed opportunities.</p>	<p>Yes</p>	<p>All health personnel were trained on basic and comprehensive family planning, Integrated Management of Childhood Illnesses (IMCI), refresher on handling deliveries, conducting hearth nutrition, and BCLP and health education classes. These trainings equipped them with the necessary skills to provide quality nutrition, maternal care and child spacing services. They were also oriented on the new M&E tools that they used in keeping track of cases and missed opportunities in their areas. In addition, nurses were trained on Basic Management to upgrade their skills in supervision through the use of supervisory tools for monitoring the efficiency and effectiveness of the RHM in delivering quality care and services. BHWs received training on hearth nutrition, Growth Monitoring and breastfeeding counseling through the BCLP training. They were also</p>
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<p>7. Increase capacity of three Non Government Organizations (NGO) partners in managing high quality and sustainable child survival project activities</p>	<p>No</p>	<p>and analysis and utilization of Purok Health Data Board (PHDB). Additional efforts to improve the skills of partners in these areas are ongoing.</p> <p>Only one NGO remains with the partnership and has not shown capability to manage quality PHCSP activities despite series of attendance in capability building activities of the partnership.</p>
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N.B. Difference between BHC and Barangay Council Health Committee (BCHC):

- BHC is composed of non-elected community leaders. This is a community-based/managed group. It is an expanded version of the BCHC where the Barangay Councilor for Health sits as ex-officio.
- The Barangay Council Health Committee is the health council of elected barangay officials. In reality it is a committee of one (the Barangay Councilor for Health) in most cases. It is re-organized every election time (every 3 years).

B. Impeding Factors

4. Institutional Development and Capacity Building

a. Community Livelihood Activities. Although there is an observable increase in number of families and community members participating in planning, implementation, monitoring and evaluation, this has not reached the target for this year. A major impediment is that many community members work in the sugar plantation or in farms, livelihoods that are very demanding of time and energy. It should be noted though that ordinary community folks are invited and do participate during the annual assessing and planning or the Barangay Health Action Plan formulation. Several have also been involved in the KPC and LQAS surveys. The increasing community participation resulted in the drafting of a community plan; a resolution requesting for financial assistance in constructing

HNP and PHBD; a resolution to encourage cultivation of home and communal gardens; a resolution requiring the RHM to hold clinic at the HNP at least once a month; and request for health budget from municipal and city officials. In year 4, other participatory learning activities will be introduced with the primary aim of encouraging community members to think about and discuss importance of health in their lives and how they might be more involved. The project will use PLA methodology (Participatory Learning in Action). We intend to use pair –wise ranking and the causal impact analysis (or problem tree) as the primary tools. The Pair-Wise Ranking is a technique use to analyze preferences, prevalence and the decision making process while Causal-Impact Analysis will be useful to understand the causes and impact of an event, problem or activity on people’s lives.

b. Low Internal Revenue Allotment (IRA). The Barangays are still not able to increase their budget allocation due to low IRA from the local government units. This situation is further compounded by the lesser priority and attention given by the barangays officials to health activities as compared to infrastructure projects since they equate health with what the CHO/RHU can provide. As a remedy to improve budget allocation for health, the PHCSP in coordination with the City/Municipal Councilor for health, President of the Association of Barangay Councils and the Department of Interior Local Government agreed that the BHAP of the 48 barangays would be used as basis for their IRA. With the BHAP as an official budget document, some health activities identified, if not all, were considered in the annual budget preparation of the city or municipality.

c. Organization of Barangay Health Committees. The existing Barangay Health Committees in the 48 project barangays are composed of one Barangay Kagawad (Community Councilor) who sits as chairperson of the committee and 2 other *Kagawads* as members. All of the members of the BHC are also members of the Barangay Council, the highest and usually the only, legislative body in each community. This was documented through the Participatory Rapid Appraisal which the project conducted during the planning phase. In the implementation phase, the project introduced the concept of an expanded BHC, to improve facilitation of the health activities in the communities. These expanded BHC have opened their membership to representatives of the farmers’ group, health workers, active mothers, active youth and a few of the members of the Barangay Council. The Barangay Kagawad for Health sits as the Advisor of this Expanded BHC.

In 2002, PHCSP conducted an assessment to determine progress on organizing this community support structure. Project staff visited established 4 Barangay Health Committees in Lao, Mabini, Manlilinao (in Ormoc City), and Tubod in Merida. Each of these barangays had initiated expanding the existing Barangay

Health Committee in terms of membership, roles and responsibilities in the community and capabilities of the organization.

During the field visit, the project learned that this Expanded BHC were in the organizing stages, in that target members were being invited to join in the BHC and the membership requirements were still being discussed. However, Barangay Lao had advanced one stage; they were able to assemble 18 definite members and have agreed to meet monthly on every 4th Sunday. They also scheduled the election of officers in the week following the field visit.

The initial members of the Expanded BHC said that as a group, they could facilitate identifying health needs in the communities as well as solutions to address these needs. Given enough capabilities and skills they can also provide support to the barangay council to implement health activities. They can also extend assistance to the health workers in health education and information dissemination.

Some of the identified members of the Expanded BHC have long been involved in various health activities such as the *Garantisadong Pambata* (National Micronutrient Supplementation), Expanded Program on Immunization (EPI) clinic with the RHM and other barangay activities on health. They participated in these activities as individuals and not as a group in the Expanded BHC.

It is worth noting that the health professionals assigned in the communities such as the RHM and the PHN have not yet participated in many of the organizing activities of the Expanded BHC. The sole exception is that the RHM of Barangay Lao attended one BHC meeting in April 2002; she has not joined them in succeeding meetings and other activities as a group.

Challenges Encountered

The communities are facing many challenges in their efforts to organize the Expanded BHC. The initial members who have attended the first few meetings said that there is a need for the Barangay Council to support them as an expanded group. Scheduling remains a constant conflict among members; except for Barangay Lao, the Expanded BHC have not yet agreed upon a schedule of convening the members regularly. Another challenge identified was the scarcity of skills to build the capability of the members, so that the group is able to perform their roles and responsibilities in the community.

There is also the challenge of making the families understand the importance of community health and that their contribution can help attain a healthy environment. Some of the mothers and caregivers do not participate in the regular

health activities in the community, which are mostly provided in the health center. There has also been a very low involvement among the men in the communities. The BHC members insist that community health should not only concern the women but the men as well.

Actions to be taken

A basic capability building and skills training is planned to strengthen the Expanded BHC as a group and develop their potential to facilitate the implementation of health activities and programs in the community. In addition, the Expanded BHC will be encouraged to get the involvement of and coordinate with the Midwife and the Nurse assigned in the barangay. The participation of a health professional is a venue to strengthen the group's capabilities to more effectively address community health issues.

During her visit, the HIS Coordinator noted the over-reliance of the communities towards the project staff, particularly towards the Community Health Development Officers (CHDO), in organizing the Expanded BHC and conducting the meetings. Leadership training is therefore planned for all the Expanded BHC in order to increase their self governance skills.

c. Decline in NGO Partner. From three NGO partners the PHCSP is down to one, the Philippine National Red Cross (PNRC) Ormoc Chapter. The Action for Development Foundation has ceased its operation in the area while Rural Development Institute for Leyte (RDI) has focused its work on agrarian reform. On several occasions RDI was invited but failed to send a representative. On the other hand PNRC regularly attends PHCSP activities and is active as a major partner in Health Scouting together with the Department of Education (Dep-Ed).

Other Factors that impeded overall project implementation

a. Scheduling. It has been experienced by the partnership that agreeing on a common date for a specific activity by all partners caused a great difficulty. Some trainings had to be postponed several times, affecting the implementation of other activities. The LQAS and Supervisory Training as well as the last part of the OR on Hearth Nutrition had to be deferred for this reason.

b. Field Work of RHM. At the onset of year 3, the majority of RHM continued to confine their fieldwork at the main health center or the Barangay Health Station. As a remedy, barangay councils were mobilized to initiate dialogues with their respective RHM, encouraging them to render service at the Health and Nutrition Posts (HNP), in order to reduce the missed cases. It took a while before this was implemented since there was some resistance from the

RHM. Some Councils passed resolutions officially requesting that their RHM render services at the HNP.

c. Lack of water and power supply. In some BHS/Main Health Stations IUD insertion cannot be provided due to lack of water and power supply. The project is discussing tactics to overcome this.

d. Partisan Politics. At one point, there was an effort to remove BHWs and BNS from the roster of health volunteers who are given honorarium for their voluntary work. However, due to the timely intervention of the BHW Federation, those removed were later re-instated. This same problem cropped up after the election for barangay officials. With this development the partnership conducted an orientation for the newly elected official and tackled this particular issue of the BHW/BNS.

C. Required Technical Assistance

The project has addressed the M&E recommendations of the Midterm Evaluation (MTE) through the technical backstopping provided by the Health Programming Specialist. However, the project still needs monitoring and evaluation assistance in quantitative analysis of surveys and Field Health Service Information System (FHSIS) data, client satisfaction surveys and quality of care research on trained TBA. There is also a need to assess the revised M&E system during the first quarter of year 4.

D. Changes from the DIP

Regarding the nutrition and breastfeeding indicator of increasing the number of Purok Health Data Board (PHDB) to have one per barangay, the project has decided to no longer pursue this target. Although this target is currently on schedule with 37 barangays having PHDB, only 20 of them are regularly updated and used for planning. The project has decided that instead of continuing to encourage the remaining 11 barangays to establish PHDB, efforts are better spent on encouraging its active use among the existing but inactive 17 barangays.

E. Activities Undertaken/Being Undertaken on Midterm Evaluation (MTE) Recommendations

Activities Undertaken on MTE General Recommendations

1. Over-all Project Plan.

An over all project plan for the remaining two years of the project was developed and a more detailed one for Year 3 was also formulated. The project also addressed this recommendation by formulating the M and E plan that details the objectives, indicators, measurement tool and major planned activities of the project. For Year 3 this has been the guide for the project in implementing M&E activities and in ascertaining accomplishment towards targets. It is also regularly updated in terms of accomplishments made for the specific month or quarter. The Communication Plan is another document developed by the IECM Task Force that embodies the specific IECM activities and materials to be implemented in Years 3 and 4.

2. Exit Strategy

In preparation for phase out, Project Staff were deployed to partners' institution offices for closer and better coordination. This strategy ensured constant sharing of PHCSP technology implemented during the first two years of the project and regular mentoring of nurses and midwives by field staff. The Partnership also identified Hearth Nutrition Model, MSG, Health and Nutrition, Barangay Health Committee, and BEOP as activities they would like to strengthen and continue after the project. During the last annual assessment planning of the PHCSP, it was also agreed that the Local Government Unit (LGU) partners would now take the lead in all aspects of program management.

In addition, Phase-out Indicators for each activity were identified as follows.

Intervention	Phase Out Indicators	Status
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Nutrition and Breastfeeding		
Health and Nutrition Post (Weighing Post)	HNP to inaccessible purok	All HNP constructed were in puroks far from the BHS. Two HNP near BHS were transferred to another purok
	Available funds for HNP construction	All HNP established were community cost share
	Services such as regular weighing, caregivers' class, pill/condom dispensing, FP counseling, pre-natal, BP taking	Some still do not provide pill, FP counseling and pre-natal care
	Internal Revenue Allocation for maintenance	Maintenance is through community members' contribution i.e. materials, labor and food for the workers
	Equipped with weighing scales, IEC materials, Growth Monitoring Chart (GMC) and Home Based Maternal Record (HBMR)	All HNP provided with these equipment and materials
	Records of updated master lists	All masterlists but there is still a problem on regularly updating of masterlists in some HNP
	Monthly monitoring visit of RHM	Monthly visit by RHM was found to be not feasible. Latest agreement is to do it on a quarterly basis
	BHWs and mothers operating the HNP on a regular basis	Opening of HNP is dependent on activity to be conducted.

Mother Support Group	Trained MSG members capable of conducting MSG training to other barangays with support from CHO/RHU	MSG members in pilot barangays still lack the confidence to act as trainer. The revised curriculum orientation will be used to expose/equip them with necessary skills as trainer
	Barangay resolution passed to establish and recognize MSG members	Still being worked out and coordinated with the barangay council
	Regular supervision of RHM	This is done during barangay visit.
	MSG members represented in the Barangay Health Committee	MSG members are part of the BHC
	Regular monthly meetings	Meetings are convened based on need and not yet on a monthly basis
	Capable to conduct breastfeeding and counseling, caregivers or mothers class	MSG are able to conduct and participate on caregivers and mothers' classes that includes activity on breastfeeding and counseling
	Trained and oriented in livelihood projects	The Merida group was linked with the Department of Social Welfare and Development and was provided training on dressmaking.
	Capable to establish linkages with Department of Labor and Employment and National Economic and Development Authority to provide potential training	Still being worked out with the representatives of these agencies
Food Production (Bio-intensive Gardening)	Access to training from DA	Training is being provided by the DA

Technology)	Community has capability and skills to do BIG	Communities trained are able to implement BIG technology
	Each family have a backyard garden	Families maintain home gardens.
	Barangay is able to produce material counterparts	Community provides organic fertilizer and meals for training while seeds and seedlings are provided by the DA
Hearth Nutrition Model	BHWs/BNS are capable to train other communities	Selected BHWs/BNS are included in training team but still lack the exposure and skills as trainers.
	Trained communities to conduct hearth sessions	Trained BHWs/BNS and mother volunteer manage hearth sessions.
Maternal Care	Continuous ANC, TT immunization, Iron supplementation to women and health education	These are continuously provided by the CHO and RHU.
	Funds allocation by CHO/RHU to supply ferrous sulfates and TT vaccine	Supplies are provided to CHO/RHU by the DOH. CHO is also capable of augmenting these supplies through their own budget
TBA Training	TBA trained for quality service	TBA Training was conducted by Provincial Health Office /CHO/RHU. Another training (refresher/new training) is scheduled in year 4. TBA kits were also provided to those trained and will be provided to those newly identified TBA who will be trained.

Barangay Emergency Obstetrical Plan	Organized and trained Emergency Response Team (ERT)	Still loosely organized. A training curriculum is being developed and will be implemented in Year 4
	BHC established and recognized BEOP as a major activity	Barangay Health Action Plan (BAHP) developed incorporated BEOP

Child Spacing		
IUD Insertion Service at the Health Center	PHN/RHM trained on IUD insertion, equipped with IUD kits and providing IUD insertion services	All PHN/RHM trained and equipped with IUD Kits. IUD service is provided at the CHO, RHU and main health centers. Some RHM in Ormoc are still undergoing apprenticeship with the FP Coordinator to develop confidence and enhance their skills.
	Increase number of mothers who are using IUD	IUD as a FP method is one of the top three preference
Pill and Condom Dispensing	Health Workers are trained in dispensing pill/condom and use of the medical eligibility checklist	BHWs are trained on the basic of FP and were doing the re-supply of pills/condom. They will be trained in Year 4 on community-based FP competency to further improve their skill to do assessment of clients and provide initial pill supply.
Voluntary Surgical Sterilization	Continue networking with Marie Stopes, CHO/RHU, and hospitals.	Partnership with Marie Stopes, RHU/CHO was disrupted due to DOH's cease and desist order on Marie Stopes FP activities
Cross Cutting and Support Activities		

Health Scouts (HS)	Partnership with Department of Education	Dept-Ed is the lead partner in this activity. Training is done through their schools, nurses and field personnel
	Integrate health lessons in curriculum. HS motivate/train other children	HS are given 15 minutes during the Health and Science subject to do child-to-child class
	HS are sentinel and motivators	HS refer cases within the household and immediate neighborhood to BHWs/RHM
Purok Health Data Board	Community members are trained and aware on the application of PHDB at each purok	Level of understanding and awareness is limited to the health workers and formal leaders. Ground work has commenced by initiating purok meetings using data from PHDB. During the BHAP planning PHDB was also used.
	Quarterly updating of PHDB	This was found out to be not practical since there were not much difference seen between two quarters. The new policy of Advisory Board (AdBoard) is to update PHDB twice a year.

IECM	4 sets of IECM materials (health baby, mother, family and community) available at the HNP and Health Centers	Only three (healthy baby, mother and family) have been developed so far by the project and is made available at the HNPs and Health Centers. The IEC on healthy community will be distributed on December 2002. On top of these, other IECM materials on nutrition and breastfeeding, Child Spacing and Maternal Care developed by DOH are also available at the health centers and HNP.
Barangay Health Committee	Organized and recognized BHC	BHC leads the annual BHAP, implementation of activities i.e. BCLP, community mobilization and M&E i.e. LQAS, KPC, PHDB

3. Monitoring and Evaluation

In June 2002 the HIS Coordinator and the Health Programming Specialist revised the monitoring and evaluation system. The indicators and measurement method for each of the technical interventions were clarified and measurements and proxy indicators discussed. The revised plan is attached. In addition, the Monthly Monitoring Form which a BHW from each barangay completes was also revised. The Quarterly Monitoring Form which the CHDO complete for each of their covered barangays was also revised. In the revised forms, unneeded information was deleted and needed information was clarified. In November 2002 the backstop and the new HIS Coordinator again reviewed the forms. The latest revision is even more succinct and clear. These forms were then presented to the other PHCSP staff for comments and approval.

In addition to the work of the staff, the Technical Working Group/M&E Task Force discussed the monitoring and evaluation system. Monitoring tools were reviewed and modified. All members agreed that monitoring the project was a role that must be conducted by the partnership, LGU, PHO and the Center for Health Development of the DOH, rather than by PSBI alone.

The revised version of these tools considered the project indicators, real needs, priorities and standardized forms including the masterlists for all interventions. It also emphasized the use of an active masterlist, as compared to the current practice of a clinic-biased data generation system. These tools are the ones currently used and implemented in the 48 barangays. To systematize flow of information, each barangay designated a monitoring officer from among their health workers, who was in-charge of collecting, consolidating and submitting the data. In addition documentation was strengthened with the conduct of assessments by the partnership of its healthy family/calendar activities, Purok Health Data, Health and Nutrition Post, Barangay Health Committee, MSG Curriculum, BIG for food production, utilization of GMC and barriers to FP.

4. Integration of Project Activities

The revised version of the Mother Support Group Curriculum has incorporated discussion of breastfeeding, exclusive breastfeeding and LAM. It also utilized the BCLP manual and counseling cards during its pre testing, which was found to be complementary to the new MSG Curriculum. The BCLP training is more general than the MSG, in that it covers food production and other topics affecting child health. The Purok Health Data Board is used as an entry point for explaining the importance of child spacing, maternal care, nutrition, immunization and environmental health. Integration is noticeable in service facilities like the Weighing Post which is now appropriately called the Health and Nutrition Post. The HNP now provide health, maternal care and FP services on top of weighing children.

5. Technical Assistance Recommended During the Midterm Evaluation

The majority of the identified Technical Assistance (TA) needs have already been met. The Health Programming Specialist provided technical assistance on monitoring and evaluation through her networking with Child Survival Technical Support (CSTS), actual visits in the field and hands-on training of project staff. Email was also intensively utilized for follow up and further technical inputs. Reading materials and electronic magazines were also forwarded from the Head Office to field personnel. The University of San Carlos in Cebu City provided TA on qualitative research methodology in assessing the IEC materials developed by the project. Johns Hopkins University was also on hand to guide the partnership in formulating the Communication Plan. The plan identified the major IECM activities for Year 4 as follows:

- Nutrition and Breastfeeding
 - Intensification of breastfeeding counseling by the MSG
 - Health education sessions using IEC kits and flipchart on healthy baby

- Maternal Care
 - Counseling sessions including pre-marriage counseling on Maternal Care and Health (MCH) messages, mothers' and fathers' classes, TBA meetings using IEC materials developed by the project.
 - Barangay Assembly with officials and health personnel sharing MCH messages

- Child Spacing
 - FP counseling to walk-in and referred clients
 - Health education session on FP messages in the IECM Materials
 - Satisfied users to talk about benefits of FP during bench conferences and caregivers classes.

The production of the final calendar, themed healthy community, will occur in year four. Six winners from the healthy community competition will serve as models. The chosen barangays were selected because of their high immunization coverage both for mothers and children, low malnutrition rate, high FP coverage, number of families/barangays with vegetable and herbal gardens, and the existence of a potable water source and clean environment.

Activities Undertaken on Specific Recommendations for each Technical Intervention

I. Nutrition and Breastfeeding

a. Health and Nutrition Post

A periodic monitoring and assessment on the Health and Nutrition Posts established in the PHCSP covered communities was conducted in the second quarter of Year 3. The HIS Coordinator visited eight barangays- Mas-in, Nasunogan, Can-untog, Patag, Cabingtang and Sto. Niño (all in Ormoc City), and Lundag and Mat-e in Merida.

Every barangay had at least 1 HNP established and maintained. Out of the 8 visited, 7 were functional in that they were currently well utilized by the communities. The last post had recently been destroyed by a typhoon and was not yet rebuilt, although it had been utilized prior to the typhoon. All posts provided the same variety of services, such as monthly weight monitoring of children, dispensing of vitamin A during the *Garantisadong Pambata* (National Micronutrient Campaign) Week conducted twice a year, dispensing of the oral Polio vaccine during the *Balik-Patak*, (National Immunization Day) taking of blood pressure level and conducting of health education sessions or caregivers

classes. One barangay also utilized their HNP for health implementation with 9 children. A few of the barangays dispensed pills and condoms to the families in the purok.

It was also found that none of the HNP in Ormoc had a clinic schedule where a health professional is providing health services. The Midwives or Nurses provided their regular monthly health services only in the Barangay Health Center. Only the BHWs and other volunteers provided the services in the HNP in Ormoc.

In contrast, the HNP in Merida have been providing health services to the families in their purok with the Midwives present. However, these barangays have no Barangay Health Centers where the Midwife can provide the regular health services, except in the Barangays where the Main BHS is located. The HNP have served this purpose since they were established in Merida. In HNP, prenatal and family planning services were also provided by the Midwives.

The Barangay Councils established these HNP with support from the health workers and the PHCSP. The structure was either an old chapel or waiting shelter that has long been unused, converted into a Health and Nutrition Post. Barangays that had no unused old structure had to build a small HNP made of mostly light materials; the community helped by donating either materials or labor.

The communities owe the success of establishing these HNP to everyone's cooperation in building the structure and for the health workers and professionals in providing the services. The communities valued the health equipment that the project donated for the established HNP, such as the weighing scales for children and women, BP apparatuses with stethoscopes, tables for prenatal examinations, and various IECM materials designed by the project for its IECM strategy.

A few of these barangays experienced slow responses and support from the barangay council in their campaign to establish the HNP. The health workers have associated this with the barangay officials' lack of prioritization of community needs and that most of the barangay funds go to infrastructure, with little to nothing left for health programs and services. Other barangays have also encountered the lack of cooperation from the barangay council and even the community members in the maintenance of the HNP established.

The health workers also said that there was a lack of support from the community members for safeguarding the equipment. In most cases, the health workers brought the equipment to their houses. Some, however, preferred to lock it in a cabinet at the barangay health clinics, and some brought it to a purok leader's

house near the HNP for safe-keeping. This became a burden for the health workers in transporting the equipment as well as keeping it from damage.

The HNP is viewed as a center of community health, as it is located within a small community, or purok, which maintains the structure and provides the services. The project's aim has been that a holistic health education scheme is conducted in all the HNP, and that IECM materials are available for all health programs. There remains, however, a pressing need in Ormoc for the Midwives to provide health services in the HNP, thus greatly increasing the accessibility of free health services. The project can facilitate the advocacy of this concern. However, a faster and more meaningful impact can be attained when this need is expressed and led by the communities.

Since the HNP is the center of community health, it is the responsibility of that community to maintain the structure as well as the equipment. Hence, the project recommends that each community should develop a plan to maintain and safeguard the equipment and other important materials within the HNP's parameter.

b. Micronutrients supplementation

The two LGU, through the City Health Office, Rural Health Unit, Barangay Health Stations and HNP, provided iron capsules to women 15-49 years old during regular consultation while post partum women were also given vitamin A. During the Department of Health *Garantisadong Pambata* Day, which is conducted twice a year, vitamin A and iron supplements were given to children under 5. PSBI assisted with these activities.

Micronutrient supplies were procured by the LGU and at times the supplies of the CHO were augmented by the Center for Health Development-8; Merida receives its supplies from the Provincial Health Office.

c. Mother Support Group Curriculum Revision

As recommended by the MTE team, the MSG Curriculum needs to be streamlined by dropping non-essential topics such as therapeutic massage and community organizing. From its original ten modules it was reduced to its current revised version of three modules. The major reasons for the reduction in the number of modules were to better emphasize breastfeeding promotion and to improve attendance by mothers. The revised modules incorporated child spacing through the inclusion of LAM.

These revised modules (Module 1: Breastfeeding; Module 2: Complementary Feeding; and Module 3: Counseling) were pre-tested in two pilot barangays of Ormoc and Merida with 24 MSG members as participants. The local dialect was used as the medium of instruction during the pre-testing, which encouraged an increased level of interaction among the participants and between the trainees and trainers. An assessment was done at the end of September with the following results:

- Content and Clarity

The use of the dialect as the median of instruction as well as visual aids facilitated the easy understanding of the topics on BF i.e. EBF, colostrum and flow of milk. The participants also demonstrated understanding in the 3 basic food groups, complementary food mix and the definition of interpersonal communication. The trainers, though, met some difficulty in the explanation of technical terms like oxytocin and prolactin. It is recommended that technical details such as these be deleted. Another finding is the need for a more thorough discussion on the milk production, milk code, and the difference between breast milk and infant formula.

- Training Methodologies

The revised modules utilized a number of training methodologies and all were found be effective and encouraged active participation. In addition, role-play and demonstrations were used to assess the level of understanding and skills of participants. Lecture-discussion was helpful in explaining technical terms prior to every demonstration.

- Time Allotment

When MSG was first introduced by the project, the major impediment to implementation was the long training that stretched up to 10 months, with three days per module and an average of five hours per day per session. As a result, the project decided to reduce the number of days to three for the whole MSG Training, with an average of three hours per session.

- Visual Aids and Reference Materials

With integration as a major direction for year three, visual aids and reference materials of other interventions were utilized in pilot testing the revised modules. These additional materials included the BCLP counseling cards, Healthy Baby Flipchart, BHW IEC Kit, BF Counseling manual and Executive Order 51 Manual (or the Milk Code). Several topics were added to the materials, including illustration of BF position, flow of milk production, breast anatomy, difference between breast milk and infant formula and the 3 basic food groups. The midwives found these visual aids and materials convenient to use, and the trainees understood them. However, it was recommended that the illustrations used be transferred to a more durable material, such as heavy grade paper, and preferably colored. There is also a need to maximize use of the BHW IEC kit for healthy babies since it is a good material for small group health education classes with very appropriate themes on breastfeeding and infant care. This kit was developed by PHCSP in year 1.

- Participation and Attendance

In the previous years, attendance was very erratic and the majority of the participants were unable to complete all sessions and modules. With the revised modules, the dropout rate has greatly improved with only three dropping from the training due to transfer of residence, illness and one delivered her baby. Composition though was limited to women, thus the need for the project to campaign for male involvement. The lack of participation of the council officials in the MSG formation and training was noticeable thus the project will advocate in mitigating this.

Overall the pilot testing was a success due to good teamwork of project staff, RHM and community volunteers coupled with the use of the dialect, good visual aids, resource materials and time management.

Actions to be taken by the project:

- Organize training teams and convene them at least a day before the training to prepare materials and allow familiarity with them.

- Ensure support of barangay council through provision of snacks
- Develop monitoring form and orient MSG/RHM on it
- Conduct practicum on BF counseling within a week post training
- Standardized visual aids to ensure integrity of health messages
- Develop an MSG Manual or Guide Book
- Share findings to RHMs and PHAB/TWG
- Record counseling sessions conducted
- Explain benefit of BF especially EBF in simple terms

d. Test of IEC materials

Among the IEC Materials produced, only the calendar was assessed so far. The results revealed that the health calendar is well accepted and its message understood. The most remembered message from the healthy baby calendar was breastfeeding and immunization, and the care of pregnant women in the case of the healthy mother calendar. During this assessment it was determined that a handful of households were unable to get their copy of the calendar due to distance from the village centers or at times the failure of the BHW/BNS/kagawad in-charge to distribute this despite provision of the household masterlist for easy tracking. Among those who received it, there were some who used the previous health calendars as “wallpaper” that provided them with year-round access to health information. Messages provided were also consistent with the annual theme and easily comprehensible because of the use of the Cebuano language.

Assessment on BHW IEC Kit, Flipchart and Health Scouts is still on-going and will be completed by the end of November 2002.

e. Growth Monitoring Activities

On behalf of the project, a student at the University of Heidelberg conducted an assessment to determine understanding and acceptance of the growth monitoring program by community health workers based on their utilization of the GMC. Fifty community health workers participated in the structured exercise, and 24 of them were interviewed to assess problems on their experience in the growth monitoring activity. Observations on the weighing sessions were conducted in five barangays, including two outreach sessions and in one at the RHU of Merida. Five mothers were interviewed in each weighing sessions except in one barangay where six mothers were interviewed. Health professionals, including three medical doctors, five midwives two nurses and one nutrition coordinator were also interviewed to assess their view of the growth monitoring program.

Community leaders, four barangay captains and three barangay councilors, were also interviewed to assess their view on the Growth Monitoring Program (GMP).

All community health workers who participated in the structured exercise were literate as it was one of their requirements as volunteers. The result of the structured exercise showed more than half of the community health workers (56%) plotted the children's weight in the GMC very well and more than half of them demonstrated that their ability to fill in additional information on the GMC was either good (44%) or moderate (42%). However, more than half of them (54%) showed low ability to interpret the child's growth curve.

In the weighing sessions observed, weighing of the children was done either by the community health workers (BNS, BHWs), councilor in charge, or the mothers, fathers or caregivers. Their accuracy in reading the weights varied from 50% categorized as good, 12.5% moderate, and 37.5% low. The plotting of children's weight in the GMC was done by the community health workers, midwives or nurses. Their accuracy in plotting the weights was better with 80% categorized as good and 12.5%, low.

One of the weakest aspects about the GMP observed during the weighing sessions was the appropriate actions taken by the community health workers for the children weighed based on their current weight and nutritional status. The community health workers sometimes did not tell the mothers about the weight status of the child. Only when a child was malnourished did they inform the mother clearly about the child's weight and nutritional status. The community health workers were more concerned about the child's nutritional status rather than the direction of the children's growth. They have also varied ways in plotting the weights in the appropriate lines and boxes. The BNS, for example, used the weight-for-age table to determine the nutritional status of the child instead of the GMC. The table's cut off point to determine normal status is higher than the GMC.

Most of the children (95%) that were brought to the weighing sessions were between the ages of 1 to 12 months. Five percent were over 1 year old; none were older than 24 months. Most of their mothers and caregivers (73.7%) said that it was not necessary to bring the older children to the weighing sessions because their immunization was complete. Some of these mothers (17%) do not know the purpose of the weighing session. Most of the mothers and caregivers (68.3%) refer to the GMC for the child's immunization records. However, 63.4% did say that the GMC is a tool to record the weight of the child.

The community health workers viewed the GMP as a very important activity to determine or monitor the weight and growth of the children and know who are

malnourished and well nourished. However, they enumerated the following problems on their implementation of the GMP: mothers may not come to the weighing session, either because they go to work or due to bad weather, while some mothers refuse to bring their children for weighing. The health workers also complained of lack of supply of medicine and vitamins for children; that they do not have enough time for their families because of their duty as volunteers; and that the incentive they receive is not enough.

The researcher cited the need for the project to develop a clear guideline and manual for growth monitoring. Since the BHWs and BNS have a basic training on their specific duties in the community and how this should be conducted, a refresher course might be needed to re-orient them on the growth monitoring activities especially in the interpretation of the child's growth curve and the appropriate action that should be done regarding the child's condition.

The researcher also stated that either the GMC or the weight-for-age table should be revised so that both use the same weight and nutritional status standards to determine malnourished from well-nourished children. However, this would need a major policy pronouncement from the DOH Central Office. In relation with this study the project is convening a meeting among nutritionists and nutrition coordinators to review the nutrition protocol of the DOH and the possible publication/re-orientation of health personnel and community health workers on these protocols. It is also the intention of the project to share this study with DOH once we receive the official copy from the University of Heidelberg.

f. Research on Quality of Breastfeeding, Complementary Feeding Practices and 24-hour diet recall

This was already partially addressed by the LQAS survey. Nonetheless an in-depth inquiry research is in progress and the result will be available by mid-December. The results will be discussed by the AdBoard and Technical Working Group (TWG)

g. Hearth Nutrition Model.

There were five barangays that initially implemented this intervention. In preparation for scaling up hearth nutrition to other interested barangays, as well to ensure current quality, an operation research was conducted.

The Hearth Nutrition Program is currently being implemented in the 5 pilot barangays namely, Sto. Niño (pre-pilot area), Patag, RM Tan and Lao in Ormoc City and Lundag in Merida. These 5 communities enrolled 42 children in the program and monitored monthly their weights and nutritional progress. The

project facilitated the recording-keeping of the weights in the communities, as well as the periodic assessment and collection of qualitative information of the processes of hearth implementation.

An operations research (OR) on hearth was conducted by the project staff in June 2002. The overall goal of this OR hearth was to “state definitively the best practices regarding quality processes, use of data and sustainability of Growth Monitoring and Hearth Nutrition Program”. Seven objectives were formulated, including:

1. Review the current hearth framework/plan for clarity and quality
2. Review the current Growth Monitoring framework/plan for clarity and quality
3. Review and document the current implementation of Growth Monitoring and Hearth Nutrition Program
4. Test assumptions and uncover remaining barriers in current hearth practices and modify the plan for hearth nutrition program when necessary
5. Determine factors that affect the rehabilitation of children
6. Determine the capability of the community, LGU and family to support the scale up of the hearth implementation during the duration of the project
7. Determine necessary factors in replication of the hearth nutrition program after the project life

Because of the limitations of time and human resources, the group agreed to conduct the OR for the first four objectives in June 2002, and the remaining three (Objectives 5, 6, 7) later in the year.

The group conducted focus group discussions, key informant interviews, field observations and reviewed various documents on hearth to collect the data needed for the OR. Several tools were developed for the purpose of these methodologies, which were used in the field and for review of the documents.

Generally, the group found that the strong points of the hearth implementation were the active participation of the caregivers as well as the maximized use of indigenous food resources and knowledge based on the Positive Deviant Inquiry (PDI) results. Most caregivers appreciated the food contribution, and that they all practiced the various tasks in rotation. The supervision and competence of the health workers were also highly appreciated by the community, the partner LGU (especially among RHM assigned in the areas) and the project.

After 12 months, 50% of the children enrolled (excluding transferees) were either rehabilitated or improved their nutritional status. A monthly weight monitoring of

the children is conducted in each community by the health workers and records of these weights are kept and maintained.

A major weak point of the hearth pilot implementation was the documentation of the activities. The health education sessions that were conducted during the Nutrition Education Rehabilitation Session (NERS) were either unclear or did not occur at all. In addition, there is no documentation regarding the follow up home visits hence, there is reason to believe that most BHWs did not conduct them.

The GMC were also not plotted with the children's previous and current month's weight. This was especially true for children older than 9 months. The health workers said that the mothers/caregivers do not usually bring the cards of these children because their immunizations are already completed. On this note, the project believes the GMC is viewed by the caregivers and BHWs mainly as a tool for recording immunization services received.

The communities pointed out that the contribution of food items that needed to be bought was a major barrier. On days when families were unable to buy their food, they were usually absent due to the embarrassment. The project will look into this and emphasized the use of local indigenous food sources for the heart sessions.

The health education component for the caregivers is very important. This will be provided additional consideration in the plans of scale up to other children in the pilot barangays. Along the same lines, follow up home visitations are essential to the rehabilitation of the malnourished children. Health workers, barangay officials and even the RHM can conduct these home visits. During these visits, the health worker or other key player can reinforce the behaviors learned during the 12 NERS session.

In the five pilot barangays, it is noticeable though that few barangay officials and RHM demonstrated some support for the hearth implementation in the communities. The project will assess the barriers for the barangay officials and RHM involvement in the hearth activities and implement action steps to strengthen their participation.

2. Maternal Care

a. Training and follow up of TBA

Non-TBA who were recommended to be trained were removed from the roster and their kit retrieved and transferred to those previously trained prior to the project but had an incomplete OB kit.

The TBA Coordinators of Ormoc and Merida facilitate regular monthly meeting with TBA. A TBA Monitoring tool was devised to document the activity of the trained TBA. This is currently in use. According to the TBA Coordinators it helped them keep track of the performance of the TBA in terms of caring practices and maintenance of the OB kit. A TBA training and refresher course is also scheduled in Year 4.

b. Use of Home-Based Maternal Record (HBMR) by TBA

The CHO and RHU TBA Coordinators oriented and trained TBA on this form. Unfortunately, due to their age, poor eyesight and low literacy, accomplishing the form is quite taxing on the TBA. It was then decided that it be retained as the RHM responsibility.

c. Development of Standard Format for Masterlisting

This is addressed in the new M&E tools used in the 48 barangays. Please refer to M&E Portion of this section.

d. Reach out activities to trace missed clients

Missed opportunities were difficult to track down since masterlisting was passive, only those whom the BHW knew and those who came for consultation were listed. Now with the implementation of the new M&E System coupled with the training/orientation and the institutionalization of the Barangay M&E Officers, active masterlisting of clients, and tracking down missed opportunities was easier for the nurse and RHM.

In addition, the partnership is considering conducting a monthly Maternal Care caravan to track down and provide health services to the remaining missed cases not responded to during the regular monthly visit of the PHN and RHM. This will be a sort of a mapping out activity to further lessen number of missed cases. Again the masterlists of clients will be utilized for this purpose. The Maternal Care Caravan will be conducted at least once a month as a follow through of the nurse-midwife monthly schedule in the field. It will deliver different maternal care services such as prenatal and post partum care, provision of iron supplements, and TT as minimum package of the caravan. The focus of this activity will be the City of Ormoc where Maternal Care service is quite low. The project has initiated initial discussions with the CHO.

e. Formative research on ANC, Client Satisfaction Survey, Quality of Care of Trained TBA

Originally, these were supposed to be conducted by the medical students of the University of the Philippines. However, they were not able to complete these due to the sudden change in their research focus on the advice of their thesis tutor. The staff and the HIS Coordinator was also occupied with doing other studies and assessments also programmed for Year 3. These are then scheduled for Year 4.

f. Conduct of Continued/Regular Health Facility Assessment

This is being done in the course of the project staff's field activity. Findings such as lack of vaccines, FP supplies and double delivery of equipment were immediately relayed to the City and Municipal Health Officers for appropriate action.

The DOH *Sentrong Sigla* (Center of Wellness) initiative is another mode in which health facilities are assessed for availability of basic health equipment, physical set-up of the clinic and quality of care. During the life of the project the City Health Office of Ormoc, the Rural Health Unit of Merida and the Main Health Center of the San Pablo Catchment in Ormoc have all been accredited as "*Sentrong Sigla*" Centers. This accreditation guarantees quality health service from these centers of wellness. The San Pablo catchment was the first ever accredited Barangay Health Station in Region 8.

g. Assessment of Barangay Emergency Obstetrical Plan

The project visited 4 covered barangays - Cabintan, Mabini, Manlilinao (all in Ormoc City) and Mat-e in Merida to assess the Barangay Emergency Obstetrical Plans. PHCSP introduced BEOP in the aim to formulate plans and strategies which would enable communities to locally respond to obstetrical emergencies, and to improve referrals. In the course of the formulation of the plans, the BEOP was adapted by the communities into a guide for general health emergencies, including death in the family.

Each community organized a loose Emergency Response Team (ERT) who will be in-charge of leading the action to families in need. The ERT is composed of the volunteer health workers, purok president, purok treasurer and a few barangay officials. The community set criteria for selecting the members of the ERT. These criteria varied in each community, depending on their needs and capabilities. Generally, the membership was for key individuals who have active involvement in community activities and who live strategically in the community. One other important consideration was the individual's willingness for public service when emergencies happen.

The barangay leaders and volunteers formulated the BEOP in June 2001. As of the end of Year 3, there were 37 barangays with emergency plans. However, no evidence was seen that these emergency plans were presented to the families and that they understood its implementation scheme and objectives. The project then will work with the barangay officials to increase the awareness of the residents on the plan and how they can participate in its realization. It is worth noting though that families who were provided with emergency assistance were satisfied with the response and had positive outcome.

An important challenge to implementation is that no major obstetrical emergencies happened in most of the communities to see the impact of the BEOP. However, for those who have had families with obstetrical needs, the ERT of the communities were able to respond and provide support either financially or in kind.

The communities have experienced that there were insufficient funds to address all the emergency needs of the families. Even with a monthly contribution, this was not sufficient to sustain the funds. To address this, the communities appropriated a small amount so they can provide support to more families when emergencies arise.

Communities saw the need for the ERT to have First Aid skills so they can provide better service and produce more positive outcomes. This training can be handled by partner agencies like PNRC or the local health offices of the LGU.

The original concept of the BEOP has several components that are ideally to be included in the plans. However, not all of these components were readily adapted by the communities. Some communities have no health care financing scheme while others could not even use radio sets for communication because of the lack of it or the absence of communication range. The community views health care financing scheme as a valuable aspect of the BEOP. Once again, health care financing training will be conducted through the project in partnership with other agencies.

The project also observed during the monitoring visits that no records were kept of the services and assistance provided to the families in the community. The project will emphasize that these records should be considered as an important tool in the implementation of the BEOP.

3. Child Spacing

a. Inclusion of Vasectomy

This was favorably considered by the partnership. PSBI coordinated with Engender Health and visits were conducted by the country representatives. The project has identified doctors interested in the training. However, the sudden resignation of Dr. Jonathan Flavier from Engender Health put a halt to this initiative. Secondly, there are not enough clients available so that training can proceed. It is therefore necessary to intensify information campaign at the grassroots level to overcome the false notion of loss of virility after vasectomy. The campaign will take the form of health education to be conducted by health personnel. By Year 4, the partnership will reopen the interrupted negotiation for a partnership on vasectomy promotion and services.

b. Male involvement

As recommended by the MTE Team, a Project Coordinator was sent on an exploratory visit to the KANIB project in Mindanao. This project, however, is still in its infancy, thus not much learning can be derived from its first year of operation. Currently, fathers are included in FP session by the RHM but attendance is still low. The project will further explore other possibilities to encourage male involvement in FP.

c. BHWs As Oral Contraceptive Pill (OCP) and Condom Dispensers

Initially, this was met with a lot of resistance by professional health personnel due to their lack of confidence in the capability and knowledge of BHWs to assess potential OCP clients. Recently though, the City Health Office FP Coordinator and the Municipal Health Officer of Merida attended a DOH-sponsored one week training on the mobilization of BHWs as pill dispensers and not merely re-suppliers. It is hoped that this will make pills more accessible to the people.

F. Review DIP Phase Out Plan

Excerpt from the DIP

“A phasing in and phasing out mechanism to ensure sustainability will be implemented within the four year period. Year 1 will be closely facilitated by PHCSP staff focusing on technical support, training and community mobilization. Most instances during this period, the CHDO will be taking the lead as the primer of community activities. It is expected, however, that this period will also be the apprenticeship period for all the partners more especially in activities that are relatively new to them. In the second, partners LGU and NGOs will assume some major responsibilities in project implementation of activities that they have developed and acquired the basic knowledge and skills. By the end of year 2, the

partnership will decide in a meeting the number of CSP staff to remain in the project. It is projected, if things will go on as planned, that there maybe only two CHDO left to do community activity. As the project enters year three, more activities will be assumed by the partners. And during the last year, only the PD, Coordinators and Administrative Personnel will remain with the project. At this point the partner NGOs, LGUs and communities (BHC/BHW/TBA/BNS) should be now doing all the project activities with minimal technical support”

Except for maintaining the same staffing pattern throughout the four years, the phasing in and phasing out of responsibility between PSBI and partners as originally envisioned was followed. The rationale for maintaining the same number of project staff was influenced by the inaccessibility and distance of most of the 48 barangays. The partnership was in agreement that reducing the number of CHDO would imply less interaction with community people. As the project entered Year 2, training and project activities at the barangay levels were already being conducted by the LGU personnel or by trained health volunteers as in the case of growth monitoring, production of IEC materials, selection of healthy mothers. As the project entered Year 3, more responsibilities were assumed by the partners, such as assisting with the LQAS survey.

During the Year 3 annual planning the phase out indicators were developed by the partnership. These indicators define the parameters of phase out. During this year, project staff were also re-deployed to the partner institutions’ offices for closer coordination, easy sharing of PHCSP learning and the enhanced possibility of conducting field visit in tandem. Some equipment, office furniture and supplies were also donated to the partner institutions in preparation to phase out.

In the just concluded annual work planning for Year 4, the partnership revisited the phase out indicators developed in the previous year by community representatives and further improved on this by identifying phase out strategies. An example of this is the convening of a Finance Sustainability Committee, as well as the documentation and production of a book on all lessons learned from the PHCSP.

G. Factors that Impacted on Overall Management of the Program

- Financial

The project utilized PSBI’s existing Accounting System and Procedures that sets in place the regular submission of the Monthly Financial Report from the field to the Country Office. This document is reviewed by the Finance and Administrative Manager and Country Director before it is submitted to the Head Office in USA. It is also the basis for budget tracking and requesting funds for the

succeeding month. The Accounting System guidelines incorporate procedures on project funds disbursements, records keeping, canvassing and bidding, material allocation, petty cash management as well as the inventory of project assets.

As a way of financial control, two co-signatories were identified for withdrawing project funds or when disbursing it through check issuance. Delegated special power of attorney is regularly reviewed and limited only for a specific period.

The overall finance system in place positively supported project implementation.

- Human Resources

Health personnel are now better trained and equipped with the skills to provide health services when compared to their skill status prior to the project. At the community level, leaders and volunteers provided the link between their community and the project. The health workers played a big role in filling the gaps in the health care service delivery system. There are more trained TBAs who are available to provide quality service to mothers during the absence of the midwives. BHWs are very cooperative and active in project implementation as well as monitoring and evaluation. The Barangay Health Committee worked closely with the Barangay Captain in the formulation of the annual Barangay Health Action Plan.

The capacity of project staff has also increased over the life of the project. The Health Programming Specialist regularly attends CORE and CSTS meetings, workshops and relevant trainings. For example, in September of 2002 she attended the workshop entitled Data for Action (where she also presented the results of the operations research on hearth that the project conducted). Field staff have also been capacitated. Carlo Valiente, the Project Director has attended workshops on IMCI, reproductive health and institutional assessment. Jane Bahian, The IECM and Training Coordinator, attended training on IEC management. Ava Barientos, the Health Information Systems Coordinator, attended trainings on FHSIS and on qualitative research (which the remaining CSP field staff were later briefed on.) All field staff have also participated in trainings on vaccinations (EPI), hearth, LQAS and OR. The Health Programming Specialist, was able to conduct the above trainings on LQAS and OR, based on her learnings from CORE and CSTS.

Carlo Valiente has shared the learnings and best practices gained from PHCSP with other PSBI(non-CSP) staff in the Philippines, as well as in Vietnam and Thailand.

- Communication

Communication in the project areas have improved in the three years of the project life. Meetings at the barangay level are the major forum where community health issues are discussed amongst leaders and volunteers. These meetings are either the barangay assemblies, which the barangay Captain occasionally calls, or the monthly Barangay Council Session. Usually the RHM, CHDO and BHWs attend the Council Session. Prior to the project, Council Sessions were exclusive to elected barangay officials. There is also more interaction now between the Kagawad for health, BHW/BNS as well as the RHM. In addition, the Kagawad for Health is usually present during training and health activities to lend support to PHCSP. Finally, the IEC activities also increased the communication between the community, BHWs and the RHM.

In order to improve management of the Child Survival project, communication between the Ormoc CSP office, the Manila Country Office, and the Pennsylvania home office was also improved through frequent use of electronic and surface mail, phone calls and fax. All communication between these offices ensures that major players, health specialist, International Program Manager, CD and PD, are provided copies of the communication. This improved communication relates to technical assistance and financial management, as well as at the organization's executive management level.

- Local Partner Relationships

The factor that binds together the partnership is the existence of the different sub-groups that facilitate planning, implementation and M&E, specifically:

- a. The Advisory Board provides direction and policy formulation.
- b. The Technical Working Group reviewed and finalized the monitoring and evaluation forms
- c. The IECM Task Force developed IECM materials for PHCSP, formulated the Communication Plan, facilitated conduct of the healthy baby, healthy mother, healthy family and healthy community selection. In addition, the group also conducted assessment of the health calendars.
- d. The 48 Barangay Councils supported and actively participated in planning sessions both at the barangays and at the PHCSP annual planning conference. They have been instrumental in establishing health and nutrition posts, and providing travel allowance and honorarium to BHWs.
- e. The Department of Education/Philippine National Red Cross actively supported the health scouts initiatives.

- PVO Coordination/Collaboration

- a. Marie Stopes provided free BTL service to women in the project area. However, in October 2002, the Department of Health issued a cease and desist order to Marie Stopes as private FP service provider for failure to submit to the accreditation requirements of the government. But despite this, the Provincial Governor of Leyte also issued an order to all health personnel in the province to cooperate with Marie Stopes' activities. This conflicting order has already created confusion in the field.
- b. CSTS – The Home Office Technical Backstop gained technical assistance from CSTS. As a result, the LQAS survey and Hearth Nutrition Operation Research were successfully conducted.
- c. USAID Mission – We are regularly invited to the monthly Cooperating Agency Meeting where current trends in health programming and management are shared amongst the Cooperating Agencies. As part of our active involvement, the project presented its experience in Hearth Nutrition Model. The project also hosted USAID personnel during their project field visits.

- Cooperating Agencies

- a. Johns Hopkins University provided free technical assistance which helped the partnership formulate the Communication Plan.
 - b. Engender Health – initial coordination on Non-scalpel Vasectomy Training was initiated but the details had not yet been finalized.
 - c. Catholic Relief Services – PHCSP provided training and technical assistance in hearth nutrition model to USAID funded Catholic Relief Services child survival staff and their Government Organizations /NGO partners.
- If an organizational capacity assessment of any kind has been conducted during the LOP, including a financial or management audit, describe how the PVO/program has responded to the findings.

Internal and external audits were conducted during this period without any major violations on the Accounting Systems and Procedure. All recommendations were immediately addressed to both at the country office and project levels. PSBI conducted an ISA in September 2002. This was facilitated by the Health Programming Specialist through the guidance of CSTS. Results will be finalized internally by the end of 2002, and actions taken will be included in final evaluation report.

H. Opportunities for Scale Up

The Partners for Health Child Survival Project has constructed and activated Health and Nutrition Posts as its key strategy, or the vehicle through which most activities have been implemented. These HNP act as the foci for community based health, in that many basic services, such as prenatal care, family planning, and nutrition education are available locally. The Barangay Health Committee may meet there, hearth sessions may take place there, and IEC occurs there. Government trained health workers and community health workers man these posts. The HNP are providing support structure for these health workers to make accessible essential child and maternal care services. These local posts also provide a starting point for community empowerment in health, in that the facility is constructed using local materials and labor. The total cost of construction averaged less than \$100, and the community shouldered these costs, either through donation of materials or financial contributions. However, in some instances, there was an existing structure that could be adapted, thereby minimizing if not eliminating the costs. The fact that the primary provider is a local resident may also facilitate empowerment.

The Health and Nutrition Posts work within the national system, in that the posts are located in the smallest unit of government and new health volunteers do not

need to be identified. Scale up nationally is thereby feasible, given that district support is present and if the process is adapted to fit the national system.

Attachments:

Attachment A. Lot Quality Assurance Sampling Documentation and Results

Attachment B. Revised Monitoring and Evaluation Plan

Attachment A. Lot Quality Assurance Sampling Documentation and Results

**Pearl S. Buck International
Partners for Health Child Survival Project
Leyte, Philippines**

**LOT QUALITY ASSURANCE SAMPLING DOCUMENTATION AND RESULTS
July – August 2002**

Introduction

PHCSP focuses on three major interventions: Nutrition and Breastfeeding, Maternal Care and Child Spacing. These interventions are implemented in 48 barangays covered in the two LGUs, which are mostly in the upland and remote areas and are inaccessible by regular transportation.

The project is currently concluding its third year of implementation and initiating activities to commence the fourth and final year of PHCSP. It has recently conducted the LOT QUALITY ASSURANCE SAMPLING (LQAS) survey to generate data on project status and accomplishments. The data that will be gathered will be utilized during the Annual Planning and Assessment Sessions set in the first week of September 2002.

The LQAS survey was conducted in the covered areas of the project wherein three modules were developed and utilized to assess project status and identify priorities in improving program coverage. The three modules were as follows: (1) Nutrition and Breastfeeding; (2) Maternal Care; and (3) Child Spacing. The LQAS survey utilizes simple random sampling wherein 19 sampling units were used for each module, interviewing 19 respondents from among the target population of the project.

The area was divided into 7 lots where in at least one Public Health Nurse is assigned in supervising a cluster of barangays.

LOT #	Supervising PHN	Barangays Covered
Lot 1	Delsa Pañares/ Erlinda de Leon	San Isidro
		Mahayag, Merida
		Masumbang
		Lundag
		Cambalong
		Mat-e
		San Jose
		Tubod

LOT #	Supervising PHN	Barangays Covered
Lot 2	Ma. Lily Flores	San Vicente
		Nueva Vista
		Mahayag, Ormoc
		Mabato
		Donghol
		Cabaon-an
		Bagong
Lot 3	Connie Codilla	Manlilinao
		Patag
		RM Tan
		Alta Vista
		Nueva Sociedad
Lot 4	Vivian Martizano/ Susan Codilla	Lao
		Mas-in
		Domonar
		Green Valley
		Esperanza
Lot 5	Brenda Penserga	Lake Danao
		Tongonan
		Cabintan
		Gaas
		Liberty
Lot 6	Evelyn Romero	Sto. Niño
		Labrador
		Kadauhan
		Nasunogan
		Hibunawon
		Leondoni
		Monterico
		Biliboy
		Bayog
Lot 7	Luz Calipayan	Boroc
		Sumangga
		Can-untog
		Quezon Jr
		Mabini
		Hugpa
		Mahayahay

The PHCSP trained community leaders, community health workers and volunteer youth in conducting the LQAS Survey. The same trained partners joined the two teams in the

actual survey in 46 barangays, out of the 48 covered communities of the PHCSP, as drawn out using simple random sampling.

Objectives

Generally, the Lot Quality Assurance Sampling (LQAS) Survey is intended to measure progress of the PHCSP based on project objectives and track project indicators by specific Supervised Areas.

Specifically, the LQAS Survey aims to:

- Capacitate project partners of the PHCSP and PSBI Staff to conduct LQAS Survey.
- Determine if project objectives for PHCSP Year 2 have been achieved.
- Determine what change took place in the covered areas using selected indicators.
- Measure the coverage of each Supervised Areas in terms of PHCSP Interventions at Mid-Term.
- Feed back Results to project partners.

PROGRAM OF ACTIVITIES

Date	Activity	Facilitator
July 22	Orientation for Interviewers	
	- Briefing on the Questionnaires	Ava Barientos
	- Dividing Team Members	Ava Barientos
	- Random Sampling Process	Joseph McDonough & Jared Bandalan
	- Pointers in Interviewing	Ava Barientos
	- Open Forum	Jared Bandalan & Ava Barientos
July 23-26	Data Gathering in the communities	Team Leaders: Jared Bandalan (Team 1), Ava Barientos (Team 2)
July 29 to Aug 2	Data Gathering in the communities	Team Leaders: Jared Bandalan (Team 1), Ava Barientos (Team 2)
Aug 5-9	Data Analysis; Submission of first draft of process documentation	Ava Barientos Jared Bandalan
Aug 12-16	Review of process documentation	Ava Barientos
Aug 19-23	Revision and submission of process documentation report	Jared Bandalan

PROCESSES

Day 1: Orientation with Interviewers

Morning Session

The Orientation for the Lot Quality Assurance Sampling (LQAS) survey was conducted at the Old Function Room, Pongos Hotel, Ormoc City. Registration started at exactly 9:00 o'clock in the morning. There were 28 participants who attended the orientation. They were the volunteers interviewers for the LQAS survey from the different Barangays of Ormoc City. The volunteers consisted of BNS, BHW, Punong Barangay, Barangay Kagawad, and youth volunteers.

These participants have already undertaken the training for conducting the LQAS survey last November 2001. There were 89 volunteers trained in conducting the LQAS survey and expected to join this year's survey.

#	Name of trained participant	Designation and Barangay
1	Dorothy Dawa	BHW, Boroc
2	Fe A. Bornasal	BHW, Sto. Niño
3	Martina L. Nahine	BHW, Sto. Niño
4	Susana L. Polido	BHW, Sto. Niño
5	Elenita Rosauro	BNS, Nasunogan
6	Jovelyn Arnaiz	S.K. Chair, Bayog
7	Francisca Cape	BNS, Bayog
8	Arili Castañeda	BNS, Labrador
9	Nelia Grabillo	BNS, Can-untog
10	Bernadette Seledio	BHW, Can-untog
11	Ma. Rosa Jacinto	BHW, Quezon Jr
12	Rosa G. Parilla	BHW, Quezon Jr
13	Lorenzo P. De Leon	Barangay Kagawad, Can-Untog
14	Julita Cape	BHW, Labrador
15	Eulalia Cabilus	BNS, Quezon Jr
16	Lourdes Abellana	BHW, Biliboy
17	Marcela Ycoy	Barangay Kagawad, Biliboy
18	Caridad Nuñez	Barangay Kagawad, Biliboy
19	Yolando Tomada	Barangay Kagawad, Mabini
20	Jojo Polenio	SK Chair, Mabini
21	Julita Huerta	BHW, Mabini
22	Violeta Ringor	BNS, Mahayahay
23	Estelita Bayo	BNS, Tongonan
24	Esperanza Cabalican	BHW, Lake Danao
25	Aurora Albarido	BHW, Hibunawon

26	Marivic Gabor	Barangay Kagawad, Hibunawon
27	Analinda Paquiao	SK Member, Cabintan
28	Emelinda Guy-ab	BHW, Cabintan
29	Raquel Rivera	BNS, Cabintan
30	Mirasol Quimpano	BHW, Cabintan
31	Aniceta Tumampo	BHW, Nasunogan
32	Rustica Sotelo	BHW, Sto. Niño
33	Bernardina Gasatan	BNS, Sto. Niño
34	Virgenia D. Quisagan	BHW, Sto. Niño
35	Loreta C. Mendoza	BHW, Sto. Niño
36	Marlyn Canonigo	BHW, Sto. Niño
37	Manuel Laurente	Punong Barangay, Lake Danao
38	Jeffrey Tomada	SK Chair, Hibunawon
39	Amelita Ablen	BNS, Hibunawon
40	Juliana V. Agrade	BHW, San Isidro
41	Flora Amabao	BHW, Mahayag, Merida
42	Arleen Luzano	BNS, Canbantug
43	Avelina Pening	BHW, Canbantug
44	Lanelia Bacusmo	BHW, Canbantug
45	Marciana Pening	BHW, Canbantug
46	Josefina Tantiado	BHW, Canbantug
47	Elizabeth Repolio	BHW, Canbantug
48	Justina Maudó	BHW, Mahayag, Merida
49	Maribel Macapobre	BNS, Mahayag, Merida
50	Elena Amabao	BHW, Mahayag, Merida
51	Vicente M. Claros	Barangay Kagawad, San Isidro
52	Marita S. Ochang	BHW, Masumbang
53	Sherlita Cartagena	BHW, Mat-e
54	Emelita Pino	BHW, Masumbang
55	Julieta Roble	BNS, Mat-e
56	Jonathan S. Jordan	SK Member, Mat-e
57	Charlene S. Matugas	SK Member, Mat-e
58	Felix Tantiado Jr	Barangay Kagawad, Canbantug
59	Editha Garcitos	BHW, Lundag
60	Jenia Pingos	SK Chair, Lundag
61	Ritchie Perez	SK Kagawad, Lundag
62	Melita Giango	BHW, Lundag
63	Rosa Rhea Pañares	BNS, Lundag
64	Nida Anonat	BHW, Cambalong
65	Desideria Roble	BHW, Mat-e
66	Transita A. Sosmeña	Rural Health Midwife, Merida

67	Lucia C. Pedra	BSPO, Masumbang
68	Gaudiosa Borja	BNS, Masumbang
69	Adela Linggas	Rural Health Midwife, Merida
70	Rolinda B. Garciano	BHW, Tubod
71	Myrna De La Cruz	BHW, Tubod
72	Maria P. Lapinig	SK Chair, San Isidro
73	Emylene Panis	BNS, San Jose
74	Editha Araño	BHW, San Jose
75	Feladelpia Alvarez	BHW, Calunasan
76	Perpetua Colanggo	BHW, Calunasan
77	Leony Nodalo	SK Member, Calunasan
78	Teresita Nodalo	BNS, Calunasan
79	Delia Bautista	BNS, Tubod
80	Artemia Jordan	BNS, Cambalong
81	Marcelina M. Ayud	BHW, Cambalong
82	Lucila Jordan	BHW, Cambalong
83	Leonida T. Roble	BHW, Cambalong
84	Benjie Matugas	SK Chair, Cambalong
85	Arlene Repolido	BNS, San Isidro
86	Elmer Pingos	SK Chair, Tubod
87	Berlito Jordan	Barangay Kagawad, Tubod
88	Gina Alipan	BHW, Tubod
89	Beatriz Formentera	BHW, San Isidro

However, only 28 were able to attend. One of the reasons for this low turn out of participants is the recently concluded Barangay Election. Trained Volunteers from the Municipality of Merida were also unable to come for similar reasons

The sessions were facilitated by Joseph M^cdonough (PSBI Volunteer) and PSBI's Health Information System Coordinator Ava Bariantos, with Jared Bandalan as documenter and co-facilitator.

At 9:45 a.m., an invocation led by Mrs. Estelita Bayo, a participant from Barangay Tongonan, formally commenced the orientation. Afterward, Ms. Bariantos welcomed all the participants and discussed the significance of volunteerism, particularly for health programs and projects such as the PHCSP. A brief comparison on the LQAS survey from the KPC surveys, especially in terms of the methodology and the bulk of questions under each interview questionnaires, were presented to the participants as an overview. The facilitator cited that the LQAS provides information on which areas, as divided into lots, are performing better and which areas need more focus and prioritization on each of the project objectives, with which the KPC cannot provide. The LQAS survey is also faster than the KPC because it has fewer questions for each module.

Ms. Bariantos presented the three modules of survey questionnaires to each of the volunteers. These are the modules for *Child Spacing*, *Maternal Care*, *Breastfeeding and Nutrition*. The participants were instructed to check the number of pages for each set of questionnaires.

Each of the items of the survey questionnaires were read and carefully explained by the HIS Coordinator. She also stressed out the need of consistency of information from each respondent. “If one answer is inconsistent with another, try to clear up the confusion”.

The questionnaires were written in Cebuano dialect for the volunteers to easily comprehend and read each item to the mothers and providing clearer ideas for the respondent. The volunteers agreed that the use of the local dialect made it easier for them to interview their respondents because there is less repetition and less probing is needed during the actual field visit.

Each module has a specific group of respondents needed to be interviewed individually and this was explained thoroughly by the HIS Coordinator. The Module for *Child Spacing* is intended for women in their reproductive age (15-49 years old), *Maternal Care* is for mothers with a children aged 6 weeks to 3 months, whereas *Breastfeeding and Nutrition* is for mothers with children aged 0 to 24 months old.

The Morning session ended at 11:45.

Before lunchtime, participants were instructed to check in for hotel accommodation for the activity.

Afternoon Session

The orientation resumed at exactly 1:45 in the afternoon with discussion centered more on the LQAS process. The target barangays identified were clustered based on the supervisory area of the Public Health Nurses assigned in Ormoc City and the Municipality of Merida.

Each cluster of barangays was assigned to a specific Lot Number. Lot No. 1 consists of ten PHCSP barangays in the municipality of Merida while lot 2-6 consists of barangays in Ormoc City.

The participants were divided into two teams of volunteers with Jared Anthony A. Bandalan assigned as the team leader for Team 1 and Ava Bariantos for Team 2. The participants requested that the Team Leader for Team 1, Jared Bandalan provide a brief introduction about himself. He was hired by PSBI as a documenter for the LQAS activity and new to the group.

Afterwards, the volunteers were given the choice on which team to be with during the survey. Team 1 was assigned to lot 1, lot 4, and Lot 5 while Team 2 was assigned to lot 2, lot 3, and lot 6. The grouping also ensured that each volunteer would not be assigned in the barangays where they originated to reduce the bias in the actual survey.

Ms. Bariantos gave a brief and concise explanation on why Lot Quality Assurance Sampling (LQAS) survey was used. “LQAS survey was utilized because it makes use of simple random sampling as a survey technique as compared to the KPC which uses cluster sampling. LQAS, in contrast to other random sampling survey, uses only a fix number of 19 respondents per lot. A sample of 19 provides an acceptable level of error for making management decisions and higher number of samples are said to have practically the same statistical precision as 19 but costs more.

By implementing simple randomization correctly, every qualified respondent is given an equal chance of being chosen, thus, minimizing sampling bias. Sampling is utilized to the ‘few’ to describe the ‘whole’. It enables the investigation of a large population and it also reduces cost of research/study since sampling enables the completion of study within a reasonable period of time.

Mr. McDonough, reiterates at this point, that “choosing any respondent you like, because of the convenience of finding that respondent along the way, would practically make our sampling survey ineffective thus, making the analysis useless.”

Ms. Bariantos also discussed the proper conduct of an interviewer in the area where interview is to be conducted. She said “The first thing to do is to have a courtesy call with the Punong Barangay. Then, identify the respondents for each module of questionnaires. Each volunteer should go to the randomly selected barangay location (e.g purok or sitio) for him or her to find and interview the respondents. Above all, the volunteers should not forget to give thanks to the respondents after the interview. The team leader ensures that each accomplished questionnaire is properly filled out and that responses are providing the information asked in each question, before the team leaves the barangay. This will help each team in ensuring that each interview will be useful for the survey and that no questionnaire will be discarded because of improper or incomplete data filled out.

Each team planned out the schedule of each barangay covered in every lot wherein they are assigned to visit and conduct the interviews. Below was the output of each team:

Schedule of interviews and actual field visit:

Team #	Day	Lot #	Barangay
Team 1	Day 1	Lot 1	Mat-e
			Tubod

			Masumbang
			Mahayag
	Day 2	Lot 1	Cambalong
			San Jose
			San Isidro
			Lundag
	Day 3	Lot 5	Liberty
			Gaas
			Lake Danao
			Cabintan
			Tongonan
	Day 4	Lot 4	Mas-in
			Esperanza
			Lao
			Domonar
			Green Valley
Team 2	Day 1	Lot 6	Labrador
			Sto. Niño
			Kadauhan
			Biliboy
			Nasunogan
			Bayog
			Hibunawon
			Leondoni
			Monterico
	Day 2	Lot 3	Mahayag
			Donghol
			Bagong
			San Vicente
			Mabato
			Nueva Vista
			Cabaon-an
	Day 3	Lot 2	Nueva Sociedad
			RM Tan
			Manlilinao
			Patag
			Alta Vista
	Day 4	Lot 7	Mabini
			Mahayahay
			Quezon Jr
			Can-untog

			Hugpa
			Sumangga
			Boroc

Finally, the facilitator reviewed for each team the important things that are needed before going out to the actual survey in the barangays for the next days of the week. Participants enumerated that these include: 1) Complete and correct copies of questionnaires of each module, 2) Meals and snacks, 3) Schedule of areas to be visited, and 4) List of Interview Location.

The orientation concluded at 4:45 PM.

Day 2 to 5: Data Gathering/LQAS Survey in the Covered Barangays

Randomization of Respondents

At 6:45 to 8:30 in the morning of Day 2, in the PSBI office, the documenter and the HIS Coordinator made the randomization to determine the number of respondents per barangay per lot with the aid of the computer software and a scientific calculator. Using an MS Excel software spreadsheet, in each lot, barangays were enumerated in a column with each corresponding total population in the second column. The corresponding cumulative population was calculated in the third column.

Afterward, sampling interval was calculated by dividing the Total Cumulative Population by 19. With the use of the random # function of a scientific calculator, random number was obtained. It was made sure that the random number identified should not go beyond the sampling interval.

Interview locations were then identified. The location of the first respondent is the first Barangay in the list with the cumulative population larger than the random number. The second respondent is in the barangay in the list whose cumulative population is greater than the *sum of the random number and the sampling interval* (or the interview location no. 2). The third respondent is in the barangay in the list whose cumulative population is equal or greater than the *sum of interview location no. 2 and the sampling interval* (interview location no. 3). The 4th respondent is in the barangay, whose cumulative population is equal or greater than the *sum of interview location no. 3 and the sampling interval* (interview location no. 4). The process was repeated to identify the 5th to 19th interview location. The same procedure applied to all the lots covered.

Tables of Interview Location:

LOT 1

Barangay	Population	Cumulative Population	Interview Location Number					
San Isidro	1209	1209	24	468	912	1356	1800	2244
Cabantug	1300	2509						
Mahayag	945	3454	2688	3132				
Masumban g	729	4183	3898					
Lundag	639	4822	4342	4786				
Calunasan	350	5172						
Cambalong	799	5971	5230	5674				
Mat-e	894	6865	6118	6562				
San Jose	917	7782	7006	7450				
Tubod	653	8435	7894	8338				

Sampling Interval: 444

LOT 2

Barangay	Population	Cumulative Population	Interview Location Number				
San Vicente	970	970	352	716			
Nueva Vista	1671	2641	1080	1444	1808	2172	2536
Mahayag	376	3017	2900				
Mabato	1116	4133	3264	3628	3992		
Donghol	1628	5761	4356	4720	5084	5448	
Cabaon-an	556	6317	5812	6176			
Bagong	610	6927	6540	6904			

Sampling Interval: 364

LOT 3

Barangay	Population	Cumulative Population	Interview Location Number					
Manlilinao	2141	2141	138	515	892	1269	1646	2023
Patag	1832	3973	2400	2777	3154	3531	3908	
RM Tan	1427	5400	4285	4662	5039			
Alta Vista	1206	6606	5416	5793	6170	6547		
Nueva Sociedad	563	7169	6924					

Sampling Interval: 377

LOT 4

Barangay	Population	Cumulative Population	Interview Location					
Lao	2482	2482	313	694	1075	1456	1837	2218
Mas-in	1617	4099	2599	2980	3361	3742		
Domonar	1423	5522	4123	4504	4885	5266		
Green Valley	1057	6579	5647	6028	6409			
Esperanza	675	7254	6790	7171				

Sampling Interval: 381

LOT 5

Barangay	Population	Cumulative Population	Interview Location Number				
Lake Danao	1546	1546	105	445	785	1125	1465
Tongonan	1387	2933	1805	2145	2485	2825	
Cabintan	1360	4293	3165	3505	3845	4185	
Gaas	1300	5593	4525	4865	5205	5545	
Liberty	884	6477	5885	6225			

Sampling Interval: 340

LOT 6

Barangay	Population	Cumulative Population	Interview Location Number		
Sto. Niño	1858	1858	483	1065	1647
Labrador	1601	3459	2229	2811	3393
Kadauhan	1260	4719	3975	4557	
Nasunogan	1252	5971	5139	5721	
Hibunawon	1197	7168	6303	6885	
Leondoni	1044	8212	7467	8049	
Monterico	1009	9221	8631	9213	
Biliboy	985	10206	9795		
Bayog	864	11070	10377	10959	

Sampling Interval: 582

LOT 7

Barangay	Population	Cumulative Population	Interview Location Number				
Boroc	2009	2009	156	608	1060	1512	1964
Sumangga	1441	4018	2416	2868	3320	3772	
Can-untog	1232	5250	4224	4676	5128		

Quezon Jr	1202	6452	5580	6032			
Mabini	869	7321	6484	6936			
Hugpa	818	8139	7388	7840			
Mahayaha y	466	8605	8292				

Sampling Interval: 452

At the Field

The planned survey duration was from July 23-26, 2002 but was extended to August 2, 2002 due to the insufficient number of volunteers. On the second week of the survey, numbers of volunteers were reduced to half thus compelling the two teams to merge. On August 1, 2002 four volunteers from Barangay Mas-in were added.

From 8:00 to 8:30 am, the interviewers start out from Pongos Hotel to their respective barangays. Before the team left for their respective assigned barangays, each team leader gave a brief overview on what must be accomplished for the day. Meals, snacks, and water were provided for the two teams.

Before the volunteers proceeded to locate the respondents, courtesy call to the Punong Barangay or any of the barangay officials present was done. The team also sought out help from the Barangay Health Workers or from the Barangay Nutrition Scholar for the list of respondents especially for mothers with children aged 6 weeks to 3 months. Since there were problems in the master-listing of target mothers, as experienced before, each team reviewed the list and asked the BHWs or BNS in the barangay if there were other mothers not listed and have not been availing services of the Barangay Health Center. This is one measure (among others) of ensuring that ALL of the target mothers are considered in the random sampling process.

After getting the list, simple random sampling was done to identify the corresponding respondents. Each team did this by using random numbers drawn from a calculator. To make certain that the interview was properly conducted, the team leaders carefully checked every filled-out interview questionnaires before leaving each barangay visited.

Various experiences were feedback by each team at the end of the day. Volunteers from Team 1 shared the ordeal of reaching the Barangay of San Isidro and San Jose by trekking steep and slippery terrain. At San Jose, the Punong Barangay, Renato Wenceslao, kind-heartedly provided Team 1 with a “*lamaw*” (a snack from coconut juice and coconut meat). In Gaas one of the volunteers encountered an unfriendly husband of the respondent with whom he showed his bolo during an argument over an unspecific issue on health delivery systems of the government. The volunteer, Mrs. Aurora Albarido, however, respectfully and calmly explained that the purpose of her interview is

to merely see the status of the project in the barangay. The respondent's husband just brushed aside his arguments later on.

Despite these experiences, the LQAS survey was a general success and that the needed respondents have been interviewed in the areas visited. The interviews were also swift for each interviewer and that the respondents did not find a difficulty in answering because each question was very specific and easy to understand.

Limitations During The Survey Period

Limited Volunteers

As earlier cited in this report, the survey schedule in the barangays from July 22-26, 2002 was extended to August 2 due to the low turn out of trained volunteers. There were a total of 89 LQAS trained volunteers who were invited for this year's survey. However, only 28 from among them were able to participate for various reasons.

Some of the volunteers we met only in the barangays when the teams went out for the actual survey, shared that because of the recently concluded barangay elections, most of them were unable to respond to the invitation because of the exhaustion of the long preparations from the said election. Others said that they had decided not to come for the activity because they were not provided with any travel allowance from the incumbent barangay officials due to the barangay election that has just been concluded in the week before, but could not elaborate further the cause of this. Invited volunteers from the Municipality of Merida claimed that they were not able to receive the invitation letters from PSBI and said that it was probably received by the incumbent officials who might have lost from the recent barangay election.

The team, however, were unable to verify these claims at the time of the survey. This is because of the priorities in conducting the activity on field, on one hand, and the absence of the concerned barangay officials, in another.

Limited Number of Respondents for Maternal Care.

Modification from the sampled respondents was resorted to due to the limited number of respondents for *Maternal Care* module. In Brgy. San Isidro, six respondents with children aged 6 weeks to 3 months were randomly chosen. Unfortunately, there were only 4 respondents qualified that was identified. The team decided to make a census for the Maternal Care respondents to substitute for the 19 sampling units in Lot 1. The survey period ended with only 14 respondents interviewed instead of the desired 19.

Unavailable updated population list.

Statistically, to have desirable results of the survey, it is a must to have a list of population of the barangay. Population list of respondents for each set of modules (questionnaires) should have been identified. Nevertheless, the agency like the City Civil Registrar does not have the updated list of population. Many of the mother's do not register their child immediately after birth, or at least within the same month. Some of the mothers only register their child after 4 to 5 months.

It was when the teams arrived in their respective barangays for the survey that the target respondents for each module were listed by the health workers or the Barangay Officials in the area. This took more time for each team before they can proceed to interview the respondents, which should not have been the case if given the updated population list before the survey period commenced.

The teams ensured that this list is obtained in each barangay to follow sampling procedures and reduce bias in the study.

Socials Nights

To ease the volunteers for the days of tiresome work, they were given a night of enjoyment. The activity was hosted by Joey Fiel, a youth volunteer from Brgy. Mabini, Ormoc City. Everyone apparently enjoyed the parlor games. Games, singing and dancing were done and drove away the monotony of the week. One of the volunteers sang her song composition of the activity undertaken. The Project Director and other PSBI staff also participated for the activity.

On the second week, another "socials" night was done, generally similar to the first. This activity is conducted to break the monotony of the survey and for the participants to regain a renewed motivation in completing the survey itself, without burning-out their enthusiasm for the project, as well as in their tasks in being a "volunteer".

RESULTS & ANALYSIS OF FINDINGS

A. Nutrition and Breastfeeding

EXCLUSIVE BREASTFEEDING

Majority of the mothers interviewed in this study have not practiced EBF with their youngest children aged 0 to 5 months. 2 out of 7 lots have achieved at least the Year 3 target of EBF.

For this objective, the team conducted a census instead of a survey using LQAS methodology. This is because there was a very low number of target respondents (Mothers with children aged 0 to 5 months and 29 days) in each lot at the time of the

survey. All 7 lots had less than 19 respondents. 6 out of 7 lots showed at least 50% of the coverage in EBF, to which, does not really look too far from the target of Year 3.

Triangulation of these findings from the records of the health workers in the barangays has been very difficult because of the inconsistent and unsystematic recording of information. The team found out during an inquiry with some of the community health workers (BHW and BNS) that a lot of the mothers have been practicing the 0 to 4 to 6 months EBF with their children, which was the “old” policy. Most of these mothers have already been informed that children should be exclusively breastfed up to 6 months (being the “new” policy). However, most of these mothers were already used to the old practice from their previous children. According to the health workers, informing the mothers about 0 to 6 months of EBF was quite easy but getting these mothers to practice the information takes more time especially for those who have previous children.

Indicator from M&E Plan:

of mothers with children 0 to 5 months who gave only breastmilk

Total children 0 to 5 months

LOT	Mothers with children aged 0 to 5 months	FREQ of children given only breastmilk	Year 3 Target (65%)
1	4	2	No
2	2	1	No
3	7	3	No
4	9	6	Yes
5	8	4	No
6	9	5	No
7	10	9	Yes

COLUSTRUM & IMMEDIATE LATCHING

Apparently, this study showed that many of the areas of the project have very high coverage and little difference from other lots. This objective also uses census in the visited areas for its respondents instead of the LQAS sampling size of 19.

Indicator from M&E Plan:

of Mothers with children 0 to 5 months who gave breastmilk in first 3 days

Total # of mothers with children 0 to 5 months old

LOT	Mothers with children aged 0 to 5 months	FREQ of children given breastmilk in first 3 days	%
1	4	4	100
2	2	2	100
3	7	6	86
4	9	9	100
5	8	8	100
6	9	9	100
7	10	9	90

DECREASE IN SOLID FOOD INITIATION

The LQAS survey has shown that 6 out of 7 lots still need to intensify the campaign for EBF as has been previously seen in the first objective of this intervention. Many of the mothers interviewed do not have a clear understanding of the appropriate time for initiating solid food for infants. This result confirms the data from the first objective (EXCLUSIVE BREASTFEEDING).

Indicator from M&E Plan:

$$\frac{\text{\# of Mothers with children 0 to 5 months initiating solid food}}{\text{Total \# of mothers with children 0 to 5 months old}}$$

LOT	Mothers with children aged 0 to 5 months	FREQ of children 0-5 months given solid food	Year 3 Target of Decrease (15%)
1	4	2	No
2	2	1	No
3	7	4	No
4	9	3	No
5	8	4	No
6	9	4	No
7	10	1	Yes

CONTINUOUS BREASTFEEDING (70%)

Continuous Breastfeeding has now consistently reached the target for year 3 and is expected to show higher status in the final project implementation year. Much of the

success in this objective is attributed to the continuous and enhanced health education system in the communities as implemented by the trained health workers.

Indicator from M&E Plan:

of mothers with children 6 to 24 months who breastfed in the last 24 hours

Total mothers with children 6 to 24 months

LOT	Mothers with Children aged 6 to 24 months	FREQ of children given breastmilk in the last 24 hours	Year 3 Target (65%)
1	18	15	Yes
2	19	13	Yes
3	17	13	Yes
4	19	15	Yes
5	19	15	Yes
6	16	11	Yes
7	17	13	Yes

APPROPRIATE COMPLEMENTARY FEEDING

The mothers interviewed for this objective has shown that solid food is important for their children's nutrition, complementary to breastfeeding. Practically all 7 lots have shown that appropriate complementary feeding are being practiced by families in the covered communities.

Indicator from M&E Plan:

of mothers with children 6 to 24 mos. who gave appropriate complementary feeding in last 24 hours

Total mothers with children 6 to 24 months

LOT	Mothers with children aged 6 to 24 months	FREQ	Year 3 Target (45%)
1	18	18	Yes
2	19	18	Yes
3	17	16	Yes

4	19	18	Yes
5	19	19	Yes
6	16	16	Yes
7	17	17	Yes

VITAMIN A/IRON-RICH FOOD

There are 6 out of 7 lots that needed more focus on the campaign to mothers for them to be educated on the importance of providing Vitamin A and Iron-rich food to their children.

Indicator from M&E Plan:

of mothers with children 6 to 24 months who gave at least 2 Vitamin A or Iron rich food

Total mothers with children 6 to 24 months old

LOT	Mothers with children aged 6 to 24 months	FREQ	Year 3 Target (95%)
1	18	16	No
2	19	16	No
3	17	14	No
4	19	15	No
5	19	15	No
6	16	16	Yes
7	17	16	No

B. Maternal Care

PRENATAL VISIT BY PREGNANT WOMEN

(at least once every trimester)

Many of the mothers during the survey said that they had prenatal visits to a health facility and was attended by a health professional, mostly with the Midwife in the barangay. Even though there were more than half of the mothers in 6 out of 7 lots showed their HBMR during the survey, there were still quite a big number of the respondents who had either lost their HBMR or never had one at all. The most accurate information that this study could get is the data from the HBMR of each mothers interviewed. On the other hand, the information gathered from those who were unable to show their HBMR during the survey but were able to visit the barangay health center or other facility were

triangulated with the records from the attending health professionals. However, it has been seen through this study there were a few of the HBMR from each lot that were not updated from the records of the health professionals. This has been glaring in the number of prenatal visits and the number of tetanus toxoids provided which turned that the records from the health professionals have more recent dates entered than that of the HBMR.

Through an informal inquiry with some of the Midwives and Nurses during the survey, the research team found out that some of these mothers forget to bring their HBMR during their prenatal visits at the clinic, thus, the most recent data have not been recorded. This could mean then, that some of those HBMR seen during the survey may not have provided the most accurate information for maternal care services accessed by the clients in the barangays.

Indicator from M&E Plan:

$$\frac{\text{\# of Pregnant women who received ANC at least once per trimester}}{\text{Total pregnant women (interviewed)}}$$

LOT	Sample Size	FREQ	Year 3 Target (65%)
1	16	8	No
2	19	7	No
3	19	4	No
4	19	9	No
5	19	8	No
6	19	8	No
7	19	5	No

PREGNANT WOMEN WHO RECEIVED TT2+

TT2 services showed 5 out of 7 lots that have reached the third year target, which includes those mothers who are already Protected for Life (TT5), in this study.

Indicator from M&E Plan:

$$\frac{\text{\# of Pregnant women who received at least TT2}}{\text{Total pregnant women (interviewed)}}$$

LOT	SAMPLE SIZE	FREQ	DECISION RULE
-----	-------------	------	---------------

1	16	10	Yes
2	19	11	Yes
3	19	13	Yes
4	19	13	Yes
5	19	9	No
6	19	16	Yes
7	19	10	No

DELIVERIES ATTENDED BY TRAINED TBA

Many of the mothers gave birth to their youngest child at home to which were mostly attended by TBA. 3 out of 7 lots have shown that deliveries were attended by Trained TBA practicing in the areas. In the other 4 lots, an informal inquiry with some of the mothers showed that they still avail of the services of TBA who attended their previous deliveries because they have developed confidence in their services even if they were untrained in quality delivery care.

Indicator from M&E Plan:

Of Trained TBA providing quality delivery care

Total # of deliveries by TBA

LOT	Deliveries by all TBA	FREQ	Year 3 Target (95%)
1	12	12	Yes
2	14	14	Yes
3	13	12	No
4	14	14	Yes
5	15	13	No
6	11	9	No
7	15	12	No

POST PARTUM CARE PROVIDED BY TRAINED TBA

Many of the mothers interviewed in this study said that the TBA provide post partum visit within the 6 weeks after delivery and check on their health and condition as well as the infant. However, there is no proper counseling of mothers on Nutrition and Breastfeeding, Maternal Care services provided at the health center, and Family Planning services that they can avail of in any health facility.

Indicator from M&E Plan:

of women who received post partum care from a trained TBA
Total # of post partum women attended by TBA (interviewed)

LOT	Total # of Post Partum Women attended by TBAs	FREQ	Year 3 Target (70%)
1	12	5	No
2	14	12	Yes
3	13	4	No
4	14	3	No
5	15	3	No
6	11	1	No
7	15	5	No

C. Child Spacing

WOMEN USING MODERN FP METHODS

3 out of 7 lots have achieved the year 3 target for modern contraceptive use in the project areas. In other lots, many are still practicing the traditional methods such as Rhythm and Withdrawal.

Indicator from M&E Plan:

of Women 15 to 49 who currently use modern contraceptive methods
Total # of women 15 to 49 years old

LOT	SAMPLE	FREQ	Year 3 Target (40%)
1	19	2	No
2	19	5	Yes
3	19	3	No
4	19	2	No
5	19	7	Yes
6	19	6	Yes
7	19	3	No

CHILDREN WITH 23 MONTHS MINIMUM SPACING

Apparently, the spacing among children in the project areas seemed to have shown a positive scenario for this objective.

Indicator from M&E Plan:

of children 0 to 23 months born a minimum of 23 months after previous surviving child

Total children 0 to 23 months

LOT	SAMPLE SIZE	FREQ	DECISION RULE (7)
1	19	10	Yes
2	19	8	Yes
3	19	6	No
4	19	14	Yes
5	19	12	Yes
6	19	8	Yes
7	19	9	Yes

RECOMMENDATIONS

Project Interventions

Nutrition and Breastfeeding

The priority for this intervention is Exclusive Breastfeeding and Vitamin A/Iron-rich food intake for children in their specified age group.

In this study, exclusive breastfeeding showed that majority of the project areas needed to intensify more on the campaign for such concerns to all caregivers as well as to community leaders.

Maternal Care

Keeping the HBMR is very important for pregnant women during the pregnancy and even after giving birth to their child because these are the important records that enable them to keep track of the services they accessed and the state of their reproductive health.

Community health workers and professionals must continue the campaign in promoting the HBMR as an important tool for women in accessing maternal care services. Pregnant women should be reminded always to bring their HBMR during their visit in the health center. Even though this has not been mentioned and emphasized in the IECM materials developed by the IECM task force, health education sessions should also give this issue emphasis being one of the primary concerns for the delivery of quality health services.

Child Spacing

Many of the health auxiliaries have not fully exercised counseling with women on the many options for Family Planning. Health education has improved greatly in the areas but there is still a need to intensify the one-to-one counseling for women who are not availing of family planning services in the health center.

Research Methodology

Sample Size Determination

It is imperative that the sample represents the population under study. The LQAS method has a fix sample size of 19 that makes it unique with the other sampling method. When the population under study is Children ages 0-5 months, it is a must that sample should be from the population in question.

The sample size of 19 in the LQAS survey enables researchers and program managers to see the higher performing supervision areas to learn from and the lower supervision areas that need more attention in attaining project objectives.

The first objective of the Nutrition and Breastfeeding for the *Partners for Health Child Survival Project Monitoring and Evaluation Plan* is to increase from 50% to 70% the percentage of children 0-5 months and 29 days who are exclusively breastfed. The actual sample collected in the survey for Nutrition and Breastfeeding intervention was the mothers with children ages 0-24 months. Thus, the actual sample size for the needed data unfortunately did not hit the required sample of 19 (some lots have only 2 respondents for that specific age bracket). With the inaccurate sample size, the LQAS analysis, basically will not give the real picture of the population. The same sampling error was committed for objectives 2, 3, and 4 on Breastfeeding and Nutrition of the PHCSP Monitoring and Evaluation Plan.

It is highly recommended that on the next LQAS survey, sample size should be 19 separately for mothers with children 0 to 5 months and mothers with children 6 to 24 months old, and that it must be *representative of the population under study*. If in case the population size would not reach 19, it is practical not to use LQAS or any sampling method and instead use census. Census utilizes actual population under study in the analysis. It provides a picture of the entire population under study that is more proximate to reality as opposed to survey, which uses only a sample of that population and might not be true to all of the members of that same population.

Determination of the actual population size for each intervention

In every lot, population size and population list for every *variable* in the interventions under study should be identified 3-4 days before conducting the survey so as to minimize complexity in obtaining the needed sample size. This is because the populations under study are age specific (age in months and days). This will also facilitate easier identification of respondents ahead of time.

In the absence of a population list, the most practical step to do is to ask a barangay official or a volunteer in the community to identify and list those who belong to the population under study, or the group of respondents that will be needed for the survey. A team should visit the barangays to gather this information before the actual survey will be conducted. Of course, this will require more time, resources and effort for the survey preparation, which may depend on the project's capabilities and available resources (including human and financial resources).

Determination of Respondents

If the population is available, the respondents can be easily identified before the survey commences in each area. However, in the absence of the population list, the team should conduct an informal inquiry with a barangay official or an influential leader in the area to identify those who are in the target population under study and use this list to identify the respondents.

LIST OF ACRONYMS

ANC	Ante-Natal Care
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
CS	Child Spacing
EBF	Exclusive Breastfeeding
FP	Family Planning
FREQ	Frequency
HBMR	Home-based Maternal Record
HIS	Health Information System
IECM	Information, Education, Communication and Motivation
KPC	Knowledge, Practices and Coverage
LGU	Local Government Unit
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MC	Maternal Care
PHCSP	Partners for Health Child Survival Project
PHN	Public Health Nurse
PSBI	Pearl S. Buck International Inc.
RHM	Rural Health Midwife
SK	Sangguniang Kabataan (Youth Council)
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development

LIST OF PARTICIPANTS

#	Name	Position	Barangay/ Agency	Task During the LQAS Activities
1	Carmen G. Fiel	Barangay Kagawad	Barangay Mabini, Ormoc City	Interviewer
2	Julita C. Huerta	BHW	Barangay Mabini, Ormoc City	Interviewer
3	Esperanza Cabalican	BHW	Barangay Lake Danao, Ormoc City	Interviewer
4	Jovelyn O. Arnaiz	SK Chair	Barangay Bayog, Ormoc City	Interviewer
5	Aniceta C. Tumampo	BHW	Barangay Nasunogan, Ormoc City	Interviewer
6	Aurora J. Albarido	BHW	Barangay Hibunawon, Ormoc City	Interviewer
7	Julita C. Cape	BHW	Barangay Labrador, Ormoc City	Interviewer
8	Lourdes A. Abellana	BHW	Barangay Biliboy, Ormoc City	Interviewer
9	Joey Philip Fiel	SK Member	Barangay Mabini, Ormoc City	Interviewer
10	Yolando Tomada	Punong Barangay	Barangay Mabini, Ormoc City	Interviewer
11	Fe R. Dawat	Barangay Kagawad	Barangay Bayog, Ormoc City	Interviewer
12	Mirasol P. Quimpano	BHW	Barangay Cabintan, Ormoc City	Interviewer
13	Emelinda S. Guy-ab	BHW	Barangay Cabintan, Ormoc City	Interviewer
14	Lorelyn P. Visabella	Mother Volunteer	Barangay Cabintan, Ormoc City	Interviewer
15	Raquel R. Rivera	BHW/BNS	Barangay Cabintan, Ormoc City	Interviewer
16	Arili C. Castañeda	BNS	Barangay Labrador, Ormoc City	Interviewer
17	Francisca G. Cape	BNS	Barangay Bayog, Ormoc City	Interviewer
18	Estelita P. Bayo	BNS	Barangay Tongonan,	Interviewer

			Ormoc City	
19	Dorothy R. Dawa	BHW	Barangay Boroc, Ormoc City	Interviewer
20	Rustica Sotelo	BHW	Barangay Sto. Niño, Ormoc City	Interviewer
21	Virginia Quisagan	BHW	Barangay Sto. Niño, Ormoc City	Interviewer
22	Nymfa Rivera	Youth Volunteer	Barangay Cabintan, Ormoc City	Interviewer
23	Gemma Sano	BHW	Barangay Esperanza, Ormoc City	Interviewer
24	Rosita Tugonon	BHW	Barangay Mas-in, Ormoc City	Interviewer
25	Concepcion Cagang	BHW	Barangay Mas-in, Ormoc City	Interviewer
26	Adela Damayo	BHW	Barangay Mas-in, Ormoc City	Interviewer
27	Teofista Romo	BHW	Barangay Mas-in, Ormoc City	Interviewer
28	Florencia Boholst	BHW	Barangay Esperanza, Ormoc City	Interviewer
29	Jared Anthony A. Bandalan	Documenter	PSBI	Team Leader/ Interviewer/ Documenter
30	Ava Angelita A. Bariantos	Health Information System Coordinator	PSBI	Team Leader/ Interviewer/ Trainer
31	Joseph McDonough	Volunteer	PSBI	Co- Facilitator

LIST OF TRAINED VOLUNTEERS

#	Name of trained participant	Designation and Barangay
1	Dorothy Dawa	BHW, Boroc
2	Fe A. Bornasal	BHW, Sto. Niño
3	Martina L. Nahine	BHW, Sto. Niño
4	Susana L. Polido	BHW, Sto. Niño
5	Elenita Rosauo	BNS, Nasunogan
6	Jovelyn Arnaiz	S.K. Chair, Bayog
7	Francisca Cape	BNS, Bayog
8	Arili Castañeda	BNS, Labrador
9	Nelia Grabillo	BNS, Can-untog
10	Bernadette Seledio	BHW, Can-untog
11	Ma. Rosa Jacinto	BHW, Quezon Jr
12	Rosa G. Parilla	BHW, Quezon Jr
13	Lorenzo P. De Leon	Barangay Kagawad, Can-Untog
14	Julita Cape	BHW, Labrador
15	Eulalia Cabilus	BNS, Quezon Jr
16	Lourdes Abellana	BHW, Biliboy
17	Marcela Ycoy	Barangay Kagawad, Biliboy
18	Caridad Nuñez	Barangay Kagawad, Biliboy
19	Yolando Tomada	Barangay Kagawad, Mabini
20	Jojo Polenio	SK Chair, Mabini
21	Julita Huerta	BHW, Mabini
22	Violeta Ringor	BNS, Mahayahay
23	Estelita Bayo	BNS, Tongonan
24	Esperanza Cabalican	BHW, Lake Danao
25	Aurora Albarido	BHW, Hibunawon
26	Marivic Gabor	Barangay Kagawad, Hibunawon
27	Analinda Paquiao	SK Member, Cabintan
28	Emelinda Guy-ab	BHW, Cabintan
29	Raquel Rivera	BNS, Cabintan
30	Mirasol Quimpano	BHW, Cabintan
31	Aniceta Tumampo	BHW, Nasunogan
32	Rustica Sotelo	BHW, Sto. Niño
33	Bernardina Gasatan	BNS, Sto. Niño
34	Virgenia D. Quisagan	BHW, Sto. Niño
35	Loreta C. Mendoza	BHW, Sto. Niño
36	Marlyn Canonigo	BHW, Sto. Niño

37	Manuel Laurente	Punong Barangay, Lake Danao
38	Jeffrey Tomada	SK Chair, Hibunawon
39	Amelita Ablen	BNS, Hibunawon
40	Juliana V. Agrade	BHW, San Isidro
41	Flora Amabao	BHW, Mahayag, Merida
42	Arleen Luzano	BNS, Canbantug
43	Avelina Pening	BHW, Canbantug
44	Lanelia Bacusmo	BHW, Canbantug
45	Marciana Pening	BHW, Canbantug
46	Josefina Tantiado	BHW, Canbantug
47	Elizabeth Repolio	BHW, Canbantug
48	Justina Maudó	BHW, Mahayag, Merida
49	Maribel Macapobre	BNS, Mahayag, Merida
50	Elena Amabao	BHW, Mahayag, Merida
51	Vicente M. Claros	Barangay Kagawad, San Isidro
52	Marita S. Ochang	BHW, Masumbang
53	Sherlita Cartagena	BHW, Mat-e
54	Emelita Pino	BHW, Masumbang
55	Julieta Roble	BNS, Mat-e
56	Jonathan S. Jordan	SK Member, Mat-e
57	Charlene S. Matugas	SK Member, Mat-e
58	Felix Tantiado Jr	Barangay Kagawad, Canabantug
59	Editha Garcitos	BHW, Lundag
60	Jenia Pingos	SK Chair, Lundag
61	Ritchie Perez	SK Kagawad, Lundag
62	Melita Giango	BHW, Lundag
63	Rosa Rhea Pañares	BNS, Lundag
64	Nida Anonat	BHW, Cambalong
65	Desideria Roble	BHW, Mat-e
66	Transita A. Sosmeña	Rural Health Midwife, Merida
67	Lucia C. Pedra	BSPO, Masumbang
68	Gaudiosa Borja	BNS, Masumbang
69	Adela Linggas	Rural Health Midwife, Merida
70	Rolinda B. Garciano	BHW, Tubod
71	Myrna De La Cruz	BHW, Tubod
72	Maria P. Lapinig	SK Chair, San Isidro
73	Emylene Panis	BNS, San Jose
74	Editha Araño	BHW, San Jose
75	Feladelpia Alvarez	BHW, Calunasan
76	Perpetua Colanggo	BHW, Calunasan
77	Leony Nodalo	SK Member, Calunasan

78	Teresita Nodalo	BNS, Calunasan
79	Delia Bautista	BNS, Tubod
80	Artemia Jordan	BNS, Cambalong
81	Marcelina M. Ayud	BHW, Cambalong
82	Lucila Jordan	BHW, Cambalong
83	Leonida T. Roble	BHW, Cambalong
84	Benjie Matugas	SK Chair, Cambalong
85	Arlene Repolido	BNS, San Isidro
86	Elmer Pingos	SK Chair, Tubod
87	Berlito Jordan	Barangay Kagawad, Tubod
88	Gina Alipan	BHW, Tubod
89	Beatriz Formentera	BHW, San Isidro

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Attachment B. Monitoring and Evaluation Plan

**Pearl S. Buck International
Partners for Health Child Survival Project
MONITORING AND EVALUATION PLAN
Revised June 2002**

1. Nutrition and Breastfeeding

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
1. Increase from 50% to 70% of children 0-5 months and 29 days who are exclusively breastfed	# Children 0-6 months who were fed only breast-milk in <u>last 24 hours</u> Total # children 0-6 months Year 3- 65% Year 4- 70%	LQAS Monthly monitoring form	6 months	Mother Support Groups trainings – using “Checklist for key messages in BF support” Motivate BHC to implement IEC plan, in coordination with Barangay Council BCLP
2. Increase percentage of mothers with children under 6 months who gave only breast milk in first 3 days of life	# Mothers w/children under 6 months who gave only breast milk in <u>1st 3 days</u> Total # mothers w/ children under 6 months	LQAS Monthly monitoring form	6 months	MSG BCLP Training of untrained TBA in EBF and colostrum Counseling on EBF and colostrum by TBA during PNC and PP

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
				visit
3. Increase from 46% to 70% the percentage of children who are continuously breastfed to 24 months	# Mothers with children 6-24 months who breastfed in <u>last 24 hours</u> # Total mothers with children 6-24 months Year 3 – 65% Year 4- 70%	LQAS Monthly monitoring form	6 months	BCLP Hearth health education MSG
4. Increase from 22% to 60% the percentage of mothers w/ children 6- 24 months who provided appropriate ¹ complementary feeding	# Mothers w/children 6-24 months who gave appropriate complementary feeding in last <u>24 hours</u> # Mothers w/ kids 6-24 months year 3 – 45% year 4 – 60%	LQAS Monthly monitoring form	6 months	BCLP Hearth health education Backyard food production MSG
5. Increase from 0-48 barangays with functional health & nutrition posts	# Of functional ² <u>HNP</u> Total # HNP Year 3 – 36 Year 4 - 48	Quarterly monitoring tool	Quarterly	Advocacy to midwives regarding re-supply of pills and condoms During monthly meetings of BNS and

¹ Appropriate complementary feeding = feed solids first, then breast milk, child has own plate, feed solids 3-5 times/day. Solids can include kamote, mais, fish, fruit, carrots, squash, and papaya.

² Functional = minimum package of activities is monthly growth monitoring and counseling, re-supply of pills and condoms. IEC materials that should be available include: most recent calendar and IEC flip chart. Health worker should staff HNP at least 1 day per month.

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
				BHW, advocate on monthly GM, counseling, and staffing of HNP

Note: Shaded cells indicate that that indicator was added in June 2002 to serve as a proxy indicator.

2 .Maternal Care

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
<p>1. Increase from 48 to 70 the percentage of women who have had at least 1 ante-natal care visits per trimester</p>	<p># Pregnant women who received ANC by midwife at least once per <u>trimester</u> Total # pregnant women</p> <p>Year 3 – 65% Year 4 – 70%</p>	<p>Monthly monitoring form</p> <p>LQAS</p>	<p>Monthly</p> <p>6 months</p>	<p>Monthly updates of masterlist by BHW/TBA</p> <p>Training of new TBA in maternal care</p> <p>Conduct formative research on barriers and motivations regarding ANC</p> <p>BHWs and TBA conduct case findings of pregnant women (with assistance from health scouts)</p> <p>BHWs refer pregnant women to TBA and RHM for ANC</p> <p>BHWs and TBA conduct home visits and counsel on ANC and maternal care services using IEC kit</p>

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
				<p>RHM conducts ANC and records it in HBMR and BHC log book New pregnant women receive HBMR and bring it for next ANC</p> <p>CHDO spot check HBMR for validity</p> <p>Catchment meeting for TBA and BHWs conducted by RHM (monthly)</p> <p>Youth theatre and puppetry groups conduct popular education sessions to promote importance of ANC</p>
<p>2. Increase from 58 to 75 the percentage of women with children 0-23 months who have received at least TT2</p>	<p># Women with children 0-23 months who ever received <u>at least TT2</u> Total # women w/ kids 0-23 months</p>	<p>LQAS Quarterly monitoring tool</p>	<p>6 months</p>	<p>BHWs and TBA conduct case findings of pregnant women (with assistance from health scouts)</p> <p>BHWs conduct</p>

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
	Year 3 – 70% Year 4 – 75%			IECM on TT vaccination and other maternal care services RHM conduct TT vaccinations 1 time/month at BHC TT immunization given to pregnant women recoded in HBMR and FHSIS
3. Increase the percent of TBA who provide quality ³ delivery care	# Of trained TBA providing quality <u>delivery care</u> Total # TBA	WHO Safe Motherhood assessment for TBA and clients Self assessment of TBA LQAS TBA monitoring form	Quarterly 6 months	Train new TBA in maternal care Project purchases about 20 new kits and 10 partial kits for distribution to trained TBA lacking kits Refresher training on TBA supervision for RHM and nurses Quarterly TBA meeting with

³ Quality delivery care = TBAs are trained; trained TBAs have and use fully stocked kit; tools are sterilized prior to each delivery; proper delivery and immediate post partum procedures are followed

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
				nurse coordinator Orientation of CHDO and nurses on WHO Safe Motherhood assessment tool
4. Increase from 57 to 75 the percentage of women who receive quality ⁴ post partum care from trained TBAs.	# Women 0-3 months post partum who receive quality post partum care from a trained TBA Total # women 0-3 months post partum Year 3 – 70% Year 4 – 75%	WHO Safe Motherhood assessment LQAS	Quarterly 6 months	BHW and TBA Update masterlist on post partum women Train new TBA on maternal care Orientation of CHDO and nurses on WHO Safe Motherhood assessment tool
5. Increase from 0-48 the number of barangays with emergency obstetrical plan	# Project barangays with <u>BEOP</u> Total # project barangay Year 3- 36 Year 4- 48	Quarterly monitoring tool	Quarterly	Barangay Health Committee develops BEOP w/ assistance from CHDO
6. Increase	# Project	Quarterly	Quarterly	Conduct

⁴ Quality post partum = Counseling on FP, nutrition and breast-feeding, maternal care (including Vitamin A) and EPI. At least 1 home visit within 6 weeks. Mother receives check up for hemorrhage and infection.

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
the number of project barangays with effective BEOP	barangays with effective ⁵ BEOP Total # of project barangays with BEOP	monitoring tool Case study		blinded case study on emergency obstetric case during Technical Working Group meeting

3. Child Spacing

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
1. Increase from 25 to 50 the percentage of women of reproductive age using modern contraceptive method	# Women 15-49 who currently use modern contraceptive <u>method</u> Total # women 15-49 Year 3 – 40% Year 4- 50%	Monthly monitoring tool LQAS	Monthly 6 months	Monthly updating of target client list by RHM Review barriers to RHM conducting IUD insertion Conduct practicum of IUD insertion with RHM and nurse coordinator RHM provide monthly FP services at Health Center Health education for men on FP by BHWs, RHM,

⁵ Effective BEOP = Barangay has written plan and barangay residents are orientated on plan. Components of plan include financing, transport, key contacts, location of health personnel or services.

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
				<p>CHDO Conduct FGD of couples trained on NFP on ease of use of “Cycle Beads” (Standard Days Method)</p> <p>Obtain additional supplies of “Cycle Beads” as necessary</p>
2. Increase the percentage of children born a minimum of 23 months after previous surviving child	<p># Children 0-23 months born a minimum of 23 months after birth of previous <u>surviving child</u></p> <p># Total children 0-23 months</p>	<p>Quarterly monitoring tool</p> <p>LQAS</p>	Quarterly	<p>TBA and RHM conduct education on LAM during post partum care</p> <p>CHO/RHU conduct refresher workshop on EBF and LAM for BHWs</p> <p>BHWs conduct small group education on LAM</p> <p>Train new TBA in maternal care and basic child spacing</p>
3. Increase	# Of project	Quarterly	Quarterly	Conduct

OBJECTIVE	INDICATOR	MEASUREMENT METHOD	FREQUENCY	ACTIVITIES
from 0-48 number of Barangay Health Center providing quality ⁶ FP services	barangays providing quality FP <u>services</u> Total # project barangay providing FP services	Monitoring form WHO Quality FP assessment Supervisory field visit reports	Quarterly Quarterly	surveys of barriers to dispensing DMPA by RHM

⁶ Quality FP services = Minimum available services include condom, pill and DMPA. Minimum of 3 month stock of condoms and pills; all distribution of supplies must be recorded. Privacy and confidentiality must be maintained in counseling. Trained FP staff should be availability at least once per month.