

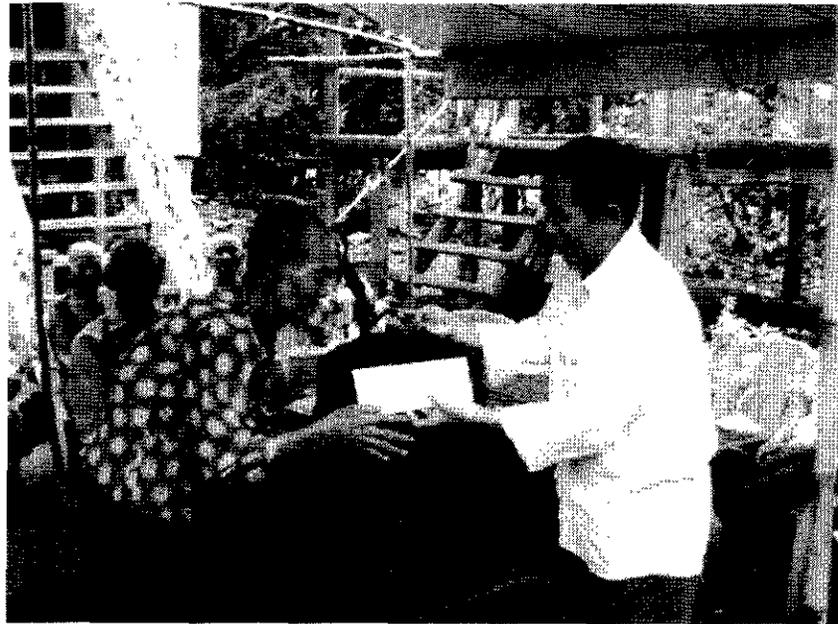
First Annual Report

2001 – 2002

CHILD SURVIVAL XVII

BARAY-SANTUK OPERATIONAL DISTRICT KAMPONG THOM PROVINCE, CAMBODIA

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ABBREVIATIONS/ACRONYMS

ADRA	Adventist Development and Relief Agency
ADCOM	Administrative Committee
AD	Associate Director
APLI	ADRA Professional Leadership Institute
AI	Appreciative Inquiry
APM	Assistant Project Manager
ARI	Acute Respiratory Infection
BCC	Behavior Change and Communication
BMI	Body Mass Index (Kg/m²)
BS	Birth Spacing
BSOD	Baray-Santuk Operational District
CC	Commune Coordinator
CCB	Cambodian Community Building
CD	Country Director
CDD	Control Diarrhea Disease
CE	Continuing Education
CFVI	Child Friendly Village Initiative
CIMCI	Community Integrated Management of Childhood Illness
CRFC	Community Representative Feedback Committee
CRS	Catholic Relief Services
CS	Child Survival
CSCC	Child Survival Coordinating Committee
CMA	Cambodian Midwives Association
CSTS	Child Survival Technical Support
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
EPI	Expanded Program of Immunization
FD	Finance Director
FGI/D	Focus Group Interview/Discussion
FS	Food Security
GAAP	Generally Accepted Accounting Practices
HC	Health Center
HCM	Health Center Midwife/ves
HCMC	Health Center Management Committee
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HKI	Helen Keller International
HQ	Head Quarter
HRM	Human Resources Manager
HRMS	Human Resources Management System
IEC	Information, Education and Communication
IFT	Iron Folic acid Tablets
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
KPC	Knowledge, Practices and Coverage

KPT	Kampong Thom Province
LAM	Lactation Amenorrhea Method
LOP	Life of Project
LQAS	Lots Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MMR	Maternal Mortality Rate
MNC	Maternal and Newborn Care
MoH	Ministry of Health
MRD	Ministry of Rural Development
MPA	Minimum Package of Activities
NGO	Non-Governmental Organization
NMC	National Malaria Center
NMCHC	National Mother and Child Health Center
NHPC	National Health Promotion Center
OD	Operational District
PA/PM	Project Advisor/Project Manager
PFD	Partner For Development
PHC	Primary Health Care
PHD	Provincial Health Department
PMC	Project Management Committee
PRA	Participatory Rural Appraisal
ProCoCom	Provincial Coordinating Committee
PVO	Private Voluntary Organization
PWC	Price Waterhouse Coopers
RACHA	Reproductive and Child Health Alliance
RGC	Royal Government of Cambodia
STI/D	Sexually Transmitted Infection/Disease
TBA	Traditional Birth Attendant
TOT	Training Of Trainer
USAID	United States Agency for International Development
VDC	Village Development Committee
VHV	Village Health Volunteer
VN	Viet Nam
WFP	World Food Program
WHO	World Health Organization
WRA	Women of Reproductive Age
WR	World Relief
WVI	World Vision International

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EXECUTIVE SUMMARY

Project Location

The Adventist Development and Relief Agency (ADRA) Cambodia is implementing Child Survival (CS) activities in ten health center catchment areas of the Baray-Santuk Operational District (BSOD) of Kampong Thom Province, Kingdom of Cambodia. The ten HCs are: Tang Kok, Protong, Kreul, Boeung and Balang, in Phase 1; and Srah Banteay, Sralao, Baray, Kampong Thmor and Cheung Deung in Phase 2). The project office is situated in Kampong Thmor, 135 kilometers northeast of Phnom Penh, on the main road to Siem Reap. The ADRA Cambodia office is in Phnom Penh, two and a half hours drive from the project office (see Appendix E for project map).

Problem Statement

The health status of women and children in Cambodia generally, and Baray-Santuk Districts in particular, are among the poorest anywhere. The most recent DHS 2000 estimates an IMR of 95 in 1,000, U5MR of 124 in 1,000 and MMR of 437 in 100,000, demonstrating this. Causes of death among children include malnutrition, diarrhea, ARI and vaccine-preventable diseases. Over 20% of overall deaths of women in Cambodia are attributed to maternal causes. Sixty percent of these are directly attributable to obstetric complications, contributing to the high MMR. The causes of death among women and children are linked to poor access to health care facilities and professional health care providers, as well as the poor economic status of many members of the community. Most importantly there is almost no knowledge of the human body and how it functions, in relation to health, leading to a high level of superstition and unsafe health practices.

The use of modern methods of birth spacing is low, with a contraceptive prevalence rate of around 13%, leading to large poor families with children they cannot afford to feed. Statistics related to the nutritional status of women and children are among the poorest in Asia, particularly in rural areas. For example, the baseline survey found that 41.6% of children 0-23 months are underweight, comparable with other nutritional surveys conducted in Cambodia.

Some of the culturally specific health issues are that mothers do not breast feed in the first three days after delivery, *roasting* (being kept above a bed of hot coals) of mothers for 1-7 days post delivery, and incorrect treatment of childhood diarrhea.

Estimated Number of Beneficiaries

Program resources available, combined with the potential for impact, were key factors in deciding where in Baray-Santuk the project would be based. Also, an assessment of current PVO activity within Baray-Santuk indicated a number of areas where there was little or no NGO input. These areas were then chosen as the project target sites. For this reason, ADRA proposes to serve roughly half of the eligible beneficiary population in the BSOD and does so by targeting ten of the nineteen health center catchment areas exhibiting the greatest need and which have not received substantial assistance from the organization's previous health projects or other PVOs. The current population of the project's targeted ten HC catchment areas of the BSOD is approximately 116,640 of which some 20,762 (17.8% of total pop) are women of reproductive age (WRA) and nearly 16,095 (13.8% of total pop) are children below the age of five (Census, March 2001). The estimated number of project clients by the end of the project is 41,497 individuals living in 21 villages.

Project Goal and Objectives

To improve the quality of health and reduce the morbidity and mortality of women of reproductive age and children under five in the target sites in Baray-Santuk Operational District, Kampong Thom Province, The Kingdom of Cambodia.

General Objectives for Maternal and Newborn Care (MNC) – 40% Effort

- Reduce maternal deaths by providing pre-/post-natal care and appropriate delivery practices.
- Reduce maternal deaths by improving access to emergency obstetric care.
- Reduce neonatal deaths through appropriate postpartum and neonatal care.
- Raise awareness about the deadliness and prevention of HIV/AIDS.

General Objectives for Birth Spacing (BS) Intervention – 20% Effort

- Ensure that families are able to make informed choices regarding the use of safe birth spacing methods
- WRA utilize birth spacing methods in a timely fashion and continuously.
- Families are successful in birth spacing plans.

General Objectives for Nutrition Intervention – 30% Effort

- Improve the nutritional status of infants through appropriate breastfeeding practices.
- Improve the nutritional status of infants through consumption of nutritious foods.
- Improve the malnutrition status of children <3 years of age.
- Decrease anemia in pregnant and lactating women.
- Improve the vitamin A status of women and children <5 year of age.
- Families are experiencing improved household food security through home gardening.

General Objectives for Immunizations Intervention – 10% Effort

- Improved immunization coverage for children <2 years of age.
- Improved maternal TT vaccination coverage for the prevention of tetanus.

Project Strategies

Four main strategies will be used to implement project interventions (see Appendix F for detailed project implementation timeline):

- 1) Use of village-level volunteers, existing community health providers and traditional care structures in multiple capacities to do health promotion and perform surveillance
- 2) Community-based village-level initiatives (mothers' clubs, village health days, hearth groups, home gardening, Child Friendly Village Initiative)
- 3) Health system capacity building and support (health center staff and Health Center Management Committee training, HIS supervision and management support)
- 4) Partnerships with PHD, BSOD, CMA, RACHA, GTZ, other PVOs, local associations, etc.

ACCOMPLISHMENTS

The first year has been an important year for ADRA Cambodia CS Project as it laid the foundation for the implementation of its initiatives, including the baseline survey, DIP, research using Fads, the first group of trainings for TBAs, CCs, VHV's and HC Midwives, as well as the training of HC In-charges, who have a key role to play in the training program as trainers. A description of the major accomplishments follows.

Administrative

Office Set up and Logistics

ADRA Cambodia/CS Project has rented an office in Kampong Thmor Commune and has all the necessary logistics system in place for full operation, although one of the key items, the project vehicle, arrived just recently, the delay being caused by the Cambodian Government Committee (CDC) that processes tax exemptions for PVOs. Vehicle and motorcycles will be used in accordance with ADRA Cambodia policy. The office is appropriately furnished with each field team having a desk, filing space and access to a laptop computer. Each team member has a new Honda Dream motorcycle for travel to project operational sites, as well as two way radios, for efficiency and security, helmets and raincoats are also provided. There is a large radio network that covers Operational District Offices, Referral Hospitals and HCs, which our staff can access as well as our own internal system utilizing a base station in the project office. Each motorcycle is also fitted with rear view mirrors and staff have been instructed on their use, as these are not common in Cambodia. Most major items are procured in Phnom Penh, with assistance from PP office staff, while small items and photocopying is done locally. A standard numbering system for filing has been implemented at the project so that all files, whether filed by field or office staff, follow a set filing number system.

Staff recruitment

As planned, ADRA Cambodia CS had its entire technical and administrative staff in place until the resignation of the Training Facilitator in August (see staff turnover below). This includes the Program Manager and one Activities Coordinator [as Assistant Project Manager (APM)], also responsible for all training and technical assistance to the field team. One Training Facilitator who is responsible for developing training curriculum and teaching methodology. One Monitoring and Evaluation Officer, responsible for the development, implementation and ongoing supervision and reporting of the project M&E. Five MCH Officers responsible for safe delivery training of TBAs and birth spacing training and support for VHVs. Five Nutrition Officers responsible for VHV training and later for Hearth training. One Accountant/Assistant Administrator and three other support staff (1 cleaner and 2 office guards). An expatriate Project Advisor is also based on site in Kampong Thmor.

In addition to the core CS team, young, well-educated women, were selected (two from each HC catchment area), to work with the CS project. They are called Commune Coordinators. Each field team will consist of an MCH officer, a Nutrition Officer and two CCs. These CCs are paid a traveling allowance, significant by local standards, and are expected to work full-time for the project. This is the first time a health project has taken this approach in Cambodia. During the life of the project the CCs will be taught the same course as the VHVs as well as further training in supervision, support, monitoring and evaluation of VHVs. They will also take a leading role in the development and ongoing support of Child Friendly Villages as well as the Hearth Program. Choosing these young women for this role has given them an opportunity for employment within their village environments that would otherwise not exist. It will also mean that after the project is complete, a cadre of well-trained young women who have the potential and skills to be future leaders in their communities will remain in place.

Programmatic/ Planning (in chronological order)

The project has been split into a two implementation phases followed by a consolidation phase. The first six months of the project was the start-up phase and included the Baseline Survey and preparation of the DIP. The next 18 months of the project were designated Phase 1. During this phase all project activities began to be implemented in five of the ten HC catchment areas. In Phase 2, again 18 months, all of the project activities will be implemented in the remaining five HC catchment areas, while there will be ongoing support, supervision and monitoring of the initial five areas. The next 12 months is the Consolidation Phase, where there will be refresher training, for the various groups of volunteers. The last phase, Project Wind-Down, is for six months and includes final survey and community and health service handover.

Training / Workshops for Project Staff

- Four CS Project staff attended an ADRA Professional Leadership Institute (APLI) Financial Management Workshop in November 2001. The Senior Financial Management Team of ADRA International and ADRA Asia facilitated this workshop.
- Knowledge, Practice and Coverage Workshop (KPC) took place in two different provinces: Pre-survey in Battambang Province and the second session after completion of baseline survey, each training session lasted one week. This workshop was facilitated by Sandra Bertoli (CSTS) and presented by two specialist trainers, Tom Davis and Julie Mobley, during late November and into December 2001.

The participants of the workshop were:

- ADRA Cambodia CS team
- World Vision, Cambodia
- World Relief, Ponhea Krek
- Partners for Development (PFD), Kratie
- Catholic Relief Services, (CRS), Battambang
- World Vision, Indonesia
- MoH staff as represented by Provincial Health Department staff (PHD), Operational District staff (OD) and Health Center staff (HC)

A training of the KPC Supervisors and Interviewers was held in Kampong Thmor, following the KPC training, under the watchful eye of Joseph Hayuni, an M&E expert from ADRA International Office. The primary trainers were the Program Manager and the M&E officer, as all training was conducted in Khmer, using a questionnaire translated into Khmer. All members of the interview teams consisted of health staff with previous interview experience, including OD and HC staff and previously trained VHVs (in the preceding ADRA health project). The baseline survey was conducted using the KPC 30-cluster method. The method entails a random sample of 30 villages (clusters) selected proportionally according to the population size of the villages.

- ADRA Asia organized a Human Resources workshop in Thailand during March 2002. The ADRA Cambodia CD, Human Resources Manager and CS Project Advisor all attended this workshop, which was primarily based on the 22 Keys to Creating a Meaningful Workplace by Tom Terez.
- ADRA Cambodia held a Strategic Management Workshop for one week in September 2002. The PA and PM actively participated in this workshop run by Murray Millar from the ADRA Asia Office.

Exposure study visits

As none of the project staff had previously worked in a CS project it was seen to be of the utmost importance for staff to get exposure to other CS projects in Cambodia. These tours were conducted in January 2002, so as to precede the DIP. Three of five CS projects in Cambodia were visited, as the other two were unable to facilitate visits in the time we had available. Each visit took approximately three days and was done in late December and early January. Each visit began with an orientation presented by the host field staff and included observations of actual project implementation in the field. CS projects visited were PFD in Kratie, World Relief in Ponhea Krek and a CARE C-IMCI Pilot Project in Pursat. Different members of the CS team went to different locations and then presented their findings to the full group, giving the main emphasis of each CS project, interventions, strategies, strengths and weaknesses and how successes might be incorporated into the new CS project.

Detailed Implementation Plan (DIP) workshop

This workshop was held in Kampong Thom in early February 2002. In the weeks prior to workshop activities, preliminary visits were made with selected and potential partners and community representatives to confirm their attendance and participation. The project sought out participants from all levels from the various communes and villages where the project would be implemented, as well as appropriate local representatives from the PHD, OD and local PVOs, as well as a male and female monk. The project was also careful to make sure there was an equal division of the sexes from the community. Other specific preparations for the workshop included agenda, revisions and refinements, project staff introduction to selected workshop methodology (1 week), venue set up, logistics, material translation and preparation, etc.

ADRA CS selected the Appreciative Inquiry approach as the main theme for the DIP workshop. This is a highly participatory approach that enables attendants to engage in strategic planning by focusing on the positive aspects and strengths of their experience, communities and organizations. These experiences were brought forward in an open atmosphere, where all members input were considered of value.

The majority of the workshop was implemented with the participants arranged in five different working groups according to their expertise and interest in the selected project interventions (nutrition, MNC, child spacing, sustainability and others). The composition of these groups was changed for days 4 and 5 as it was found that some senior participants were not adequately considering suggestions and ideas from community members of lower status (this is a Cambodian issue in a hierarchical based culture). This was overcome by dividing the groups into people of similar status. This led to some community members becoming much more forthright with their ideas, even when reporting back to the group as a whole, and increased the effectiveness of the AI approach.

The five-day workshop was organized according to the four “Ds”: Discovery, Dreams, Design and Demonstration. This workshop was run by two senior health officers from ADRA International, Becky de Graaff, Assistant Director for Health and Debbie Herold, MCH Advisor, in close collaboration with the CS team and supported by the ADRA Cambodia Country Director.

The DIP Report has been distributed to the ministry of Health (MoH), Provincial Health Department, Baray-Santuk Operational District (BSOD), and other PVOs. The key areas of the DIP will be

translated into Khmer and distributed by Feb 2003. Meetings have also been held with key stakeholders to explain the DIP Report.

Training of Trainers (TOT)

This training was held over two weeks in March 2002, in the CS office. The participants for the training included the PHD/MCH trainer, Director and Deputy Director of BSOD (a trainer), the CS team and local HC partners. The main purpose of this course was to help trainers understand clearly, what appropriate teaching methods were to be used with each different level of trainees, proper use of visual aids, seminar preparation and how to communicate with local authorities or appropriate community members, etc. (see Appendix A for course details).

Focus Group Discussions (FGD)

After the DIP workshop, a suggestion was received from the OD Director to change one of the targeted HC catchment areas (which was quite large), and replace it with two smaller ones, equaling the same population. This was done and written into the DIP document, which has since been approved. Because there had not been a baseline survey in these two new areas it was decided to hold FGDs in these new areas to have a general comparison of health issues compared with the other area. Staff conducted five FGDs over six days during May 2002. As the sample size is smaller with a different methodology, FGDs are not as accurate, or as comprehensive, as a 30-cluster survey and one needs to be circumspect in drawing strong conclusions from this comparison.

Prenatal care and birth spacing

The number of pregnant mothers who have attended antenatal visits is estimated to be higher than in the original KPC survey. Possible influencing factors is that Balang HC is situated close to the local market and at the intersection of two main roads. This increases access to the HC and so shopping visits can easily include a HC visit. There are still TBAs in this area, that were trained by a previous ADRA health project, and who still work and have regular monthly meetings with HC staff. The HC midwife is known for her pleasant disposition and friendliness towards clients. These two points may also be contributing to the large number of antenatal visits.

Again the previous ADRA health project had trained Birth Spacing Volunteers in the Balang HC catchment area. Many of these volunteers still work and have monthly meetings with HC staff. The higher estimates in mothers who know modern birth spacing methods and who use these contraceptive methods, can be attributed to the ongoing work of these Birth Spacing Volunteers and their continued cooperation with the local HC.

Nutrition

Here there are variances, both positive and negative. Considering that there has already been a presence of trained VHVs in this area one would expect some higher estimates. One of the most significant differences was the low response to the practice of exclusive breastfeeding. This corresponds with the indication that mothers do give complementary food *and* continue to breastfeed their children 6-9 months. This could apparently mean that weaning begins a lot earlier than six months. Mothers did seem to know the importance of continued fluids and feeding during illness, more than would have been expected compared to the low results of the KPC survey. Many women also responded positively to receiving iron supplements, which would correspond with the high response to antenatal visits.

Immunizations

Since mothers were merely reporting from memory whether or not their child had received a measles vaccine, this could attribute for the low response gained from this question during FGDs. The project will continue to observe this indicator through the HC HIS and project LQAS to decide if special action is required in this area.

Others

Many participants were able to mention the use of mosquito nets. This is attributable to the fact that the OD was doing a distribution program for impregnated nets, in conjunction with the National Malaria Centre, at the time of the FGDs. Handwashing was a focus of the previous health program implemented in this area and so participants were also a little more aware of this health practice compared to the KPC estimate of the other area (see Appendix B for full FGD report).

Training at the Community Level

Volunteer selection process and training

The CS team had comprehensive discussions with local partners, authorities and HC staff on the criteria, job descriptions and selection of three main types of volunteers the project will be working with: CCs, TBAs and VHVs. The CS team members selected the CCs. After visiting each village and asking the village chief which of the young women met the criteria and had the respect of local villagers, they then asked if those selected individuals if they were interested. Once this process was complete the potential candidates were interviewed by the two CS staff working in that area; looking at the applicant's ability, commitment, interest and current education.

For the VHVs, project staff visited the local village chief and using predetermined criteria (see Appendix C for volunteer selection criteria), asked who may be suitable to be a VHV. Staff then visited each potential VHV and asked if they were available and willing, as well as discussing potential candidates with the local HC staff. Then groups of local villagers met, and using colored cards, they had a secret ballot to choose the VHVs. Most VHVs are women, with a wide age range along with a few male VHVs. There are fewer men since they are usually occupied as the provider and household member generating income for the family. The number of VHVs was set according to the ratio 1 VHV/30 households.

TBA training

Seventy-four TBAs of five different HC catchment areas were recruited and trained in phase one of the project by the CS team with assistance from HCMs. The project set criteria for TBA selection, so that TBAs that were no longer practicing or were no longer able to practice would not be included in the training. Each training, of one week, is separated into two parts, within each phase, so that initial training outcomes can be monitored and the second course can reflect areas where behavior change has not occurred or other areas of need have been highlighted. (See Appendix D for course details).

CC training

For Phase 1 ten CCs were recruited and trained for two weeks at the project office. The CCs were given the same training as the VHVs they will be supporting, plus further training in the support, monitoring and evaluation of those VHVs. As all of these CCs had completed high school, they were quick and interested to learn, as well as being interactive when asked to do group work. They were enthusiastic to learn, so that they could return and be of help in their villages. Even when talking about STDs and HIV/AIDS, issues which young Khmer women would never discuss in public or

with men, these young ladies were not afraid to go to their villagers and pass on their new knowledge to young and old of both sexes (see Appendix D for course details).

VHV training

Three hundred and seventy-one VHVs from five different HC catchment areas were recruited and trained in Phase 1 by the CS team with assistance of local HC chiefs and CCs. Each group was trained in a local facility, such as a school or HC, and was limited to a maximum of 25 participants. Hence each HC catchment area had three consecutive training sessions: Balang had four sessions, so the Boeng team, who only had two sessions, completed one of their sessions. Training lasted two weeks, the first week being theory and the second week was field practice. The CCs were not only very helpful during the VHV training, especially where participants were slow to understand, but they were also able to organize and assess groups of VHVs during the field training. This enabled the 25 participants to be broken into 4-5 groups for field work, depending on the availability of the HC chief (see Appendix D for VHV Training Report).

Information, Education and Communication Materials

There has been extensive production of new IEC materials in Cambodia over the last five years. Hence the project has utilized the already developed posters, flip charts and pamphlets. Project staff visited the IEC database at the National Centre for Health Promotion and chose appropriate materials from their list. IEC materials were then purchased from HKI, NMC, RACHA and the National Centre for Health Promotion. Each VHV has been given a comprehensive selection of IEC materials as part of their kit and is currently utilizing their range of presentation skills in disseminating corresponding health messages. In December 2002, the project team, including CCs, will be meeting to formulate the project's BCC strategy, which will then be taught to VHVs in their second Phase 1 training in January 2003. In the first training they have gained basic information and dissemination skills, while the second training will see them focus these skills with specific interventions for behavior change. The development of the BCC strategy, after the first year of the project, has given the staff time to learn and understand local village behaviors. With the inclusion of the CCs in this process, who have an even more intimate knowledge of local behaviors, the project believes that a realistic BCC strategy can be formed based on a thorough understanding of local behaviors.

Strengthening Local Partners

The BSOD HCs are ADRA's key implementing partners. The partnership concentrates primarily on HCMs, Immunization staff, HCMCs and HC (specifically cost recovery schemes). Health center In-charges are also regularly asked to help with trainings. The initial project strategy is to include appropriate HC staff in any trainings, either held by the MoH or the project, to enhance their skills and ability specific to their position and the goals of the project. Throughout the project, CS staff will work in unison with the relevant HC staff and then during Phase 2 a specific handover strategy will be designed to give responsibility back to the government. This strategy will then be implemented in Phase 3. Due to the dynamic changes that have been happening in health care in Cambodia over recent years, it is better to wait until late in Phase 2, rather than devise a strategy, which could easily become outdated over the next two years.

The HC In-charges were trained with the CS staff, in the project's first ToT, to enable them to assist as trainers in our various training programs. The HCMs also attended the project's ToT, as well as being trained for six days during September 2002 in Module 12, Antenatal, Postnatal Care and Birth Spacing, the latest training for midwives to come from the Ministry of Health. The project also ran a five-day course in the basics of monitoring and evaluation, and the forms that the project will be

using. The HCMs and HC In-charges attended this course as they will be assisting the project in this area, as well as encouraging them to realize the importance of M&E and increasing their skills and knowledge in M&E.

CS Coordinating Committee (CSCC) and Community Representative Feedback Committee (CRFC)

It was the project's original intent to establish two committees to maintain ongoing input from the OD Health Service and the villagers it serves. These two committees were established: 1) the CSCC consists of the BSOD Director, the BSOD MCH Director, 11 HC Chiefs, 11 HCMs and 3 CS staff; 2) the CRFC consists of a District Chief, the local Rural District Development Officer, Commune Chief, Village Chief, VDC member, CC, TBA and VHV, plus 3 CS staff. All CRFC members were also at the DIP workshop, and so already had a good understanding of the CS project and its indicators and activities. These Committees were brought together in June, 2002, for their first meeting. This was held as a joint meeting so that all participants could be introduced to the aims of their respective committees and how they fit into the participative approach of the project. At this meeting it was decided to meet every three months and they wanted to continue to meet as a joint committee. At their next meeting, in September, 2002, the joint committee decided that there were so many project interventions and activities occurring since their last meeting that they will now meet every two months, to allow more input and feedback on project activities and interventions.

CONTRIBUTING FACTORS for ACCOMPLISHMENTS

Support of National and Local Government Officials and the Community

This CS project is the second health project ADRA has implemented in the BSOD, as well as an already completed well digging project and the soon to be completed Community Building for Food Security. Throughout the life of these projects ADRA has built up strong links with the local communities and leaders, as well as the BSOD and the MRD. This local network has minimized CS implementation problems and enabled a smooth and cooperative implementation process. Throughout the implementation of the activities, ADRA Cambodia CS project benefited from the support of national and local government. Community and local government officials are keen to see improvement in the health and living conditions of their community and were very pleased to have a CS project in BSOD. Government officials and community members actively participated in the development of the DIP, monthly and quarterly meetings. In the field, local government participated not only in community mobilization efforts but also in activity planning and monitoring project activities. ADRA's strength, as an organization, which has had a long history of taking a participatory approach when implementing projects, has maximized community and local government support for the CS project. This approach, and the dissemination of the findings of the Baseline Survey, has highlighted to local communities and government bodies the health needs of their communities.

Competence and Dedication of Project Staff

The competence and dedication of project staff have also been another important contributing factor to these accomplishments. Even though 2/3 of the CS staff came from different provinces outside of Baray-Santuk, they are committing all their energy to help the people in our target areas, in the same way they would help people in their hometown. ADRA has three core values of Integrity, Respect and Compassion, which the staff exhibit, even when there is a personal cost involved. There have been many instances where project staff, CCs and VHVs have given money from their own pockets

to help very sick children. Up to now, four children have been sent to PP for medical treatment, at the expense of staff, while many others have been helped in their villages, with some receiving ongoing support. All of this work is outside of their job description and that of the project but reflects a heart commitment to helping the people that the project works with. These small acts have given the project a good reputation at village level and have helped project staff gain the respect and cooperation of village leaders and members.

Good Collaboration/Partnership

This CS project has been at the forefront of CS collaboration in Cambodia. Staff not only went to visit other CS projects, they also initiated the first joint CS meeting in Cambodia. This initiative was well supported by the USAID Mission and all CS projects. The inaugural meeting was held on July 29, 2002 in the World Vision building. The meeting was opened by USAID, followed by project summaries, including lessons learned, from almost all CS projects. The pilot C-IMCI project by CARE was also presented. In addition, there were presentations by Save the Children - France on some new IEC materials they had developed and an update from the Government IMCI Committee and a presentation from the Ministry of Rural Development. At the conclusion of the meeting, PFD volunteered to be the main organizer of the next joint CS meeting to be held in three months, with the theme being IEC.

CONSTRAINTS and ACTIONS TAKEN TO ADDRESS THEM

Project Vehicle

Up to now there have been no significant factors that have impeded the progress of the project. For instance the late delivery of the project vehicle did not limit any project activities, as local transport was hired when needed. All staff have motorcycles, and this is generally the preferred means of travel and access to project areas was not compromised.

Wet Season

Starting the volunteer selection and training during the wet season was not ideal but staff were equipped with raincoats and by traveling slowly and carefully all areas were reached, volunteers selected and trained. Staff often returned wet and tired but each day's work was completed. This problem in timing is a consequence of starting the project in October, combined with the time needed for office set-up, staff training, baseline survey etc., that needed to occur pre- volunteer selection and training. Due to limited facilities available in local communities for training, the VHV training program was brought forward by a week so that school buildings could be utilized while local children were on holidays.

Staff Computer Skills

Computer skills of some staff are limited or non-existent. The commencement of an ADRA volunteer as a computer specialist in July, made it possible for staff to be trained and mentored in computer use. He has also helped the project to set up appropriate backup and virus update protocols and maintain its computers and printers.

MoH Staff

According to the National Health Coverage Plan there should be at least six staff in each HC, so that the Minimum Package of Activities can be delivered to the local community. Of the five HCs currently targeted, Protong only has three MoH staff and two floating staff and Boeung has four

MoH staff and one floating staff. The concept of floating staff is a peculiarity seen throughout the health care system in Cambodia. Where HCs do not have adequate MoH staff they use non-MoH staff who are called floating staff. Of the extra two floating staff in Protong, one is a primary midwife and one has no medical background and has been trained by the HC staff. The floating staff in Boeung is a primary nurse. These floating staff receive no salary from the MoH and they are not included in any MoH organized skills update training. This unusual situation has occurred because the MoH has an excess of staff and so it has a cap on taking any new staff. Unfortunately for Cambodia the extra staff are mostly in the cities and refuse to work in the countryside. This is an issue that the MoH has not been willing to deal with, as this requires national action. At the project level we will include these staff in any training that we hold which is relevant to their role in the HC. Through the initiation of HC cost recovery schemes, these staff will be able to receive a small salary. The BSOD Director is well aware of the problem and its consequences but appears helpless to resolve the staff shortage, being bound by MoH policy. Some projects have introduced payments for these staff but this is an unsustainable option and provides a false sense of security during the life of the project. The CS project will continue to work with the BSOD in responding to this problem but there is no immediate solution on the horizon.

Artificial Feeding

Since the commencement of fieldwork, project staff, CCs and VHV's have found some children with severe malnutrition (kwashiorkor and marasmus), with secondary infections of the skin and chest, which have required treatment in Phnom Penh National Pediatric Hospital. These children had lost their mothers at birth, or soon after, and were being bottle-fed. In all cases they were not being adequately fed as caretakers could not read instructions on the cans of powdered milk, use watered down condensed milk, rice water and sugar water and did not use appropriate hygiene or clean water. As these were mostly under 6 months the project needs to establish a preventative program, where bottle-feeding is necessary. It has been suggested that the project train one of the support staff, who is intelligent, has had two children herself (breast fed), and whose time could be better utilized. She would be trained in milk preparation, use of clean water and hygiene of bottles. An assessment checklist would be devised for her to complete at the beginning of her visit, and her education and training would then follow to fill the gaps noted. There could be a follow-up visit two weeks later to reinforce new behaviors and to assess changes in behavior. If this problem was found to be widespread then the VHV's and/or TBAs would also be trained to take over this activity. Further assessment of bottle-feeding numbers and practices will be included in the first project LQAS in December.

TECHNICAL ASSISTANCE NEEDED

Hearth Program

To prepare for the Hearth Program, two staff, the Program Manager and a nutritionist visited the Hearth Program of the Australia Foundation for Asia-Pacific (AFAP) in Vietnam. During the week and a half spent in Vietnam, in July 2002, they also visited other government and non-government agencies, collecting nutrition and Hearth information. The staff raised some key issues in cultural differences that would impact the introduction of a Hearth Program in Cambodia such as: 1) the communist system enforces parental involvement in the Hearth Program; and 2) the Vietnamese were very hard working and produced good quality crops and a better variety of food than in Cambodia, at least in the area visited. PFD has been the first organization in Cambodia to introduce the Hearth Program. They have found that the program is very labor intensive and required many

modifications for the Cambodian context. The CS project has been negotiating with PFD, over the last six months, to have PFD staff train the CS nutrition and CC staff in Hearth. This training is expected to occur before the end of the year.

Financial Management System

The CS project is constantly looking for ways to improve financial management. With the coming of the new ADRA Cambodia Associate Director in October 2002, who was previously the Senior Financial Administrator for Health at ADRA International, we expect to gain from her experience and knowledge as we further assess, monitor and revise our financial management systems, both at the project site and in Phnom Penh.

Monitoring and Evaluation

This area continues to be a growth curve for the project, especially as the time will soon come to do our first LQAS survey. ADRA Nepal has a manager with previous experience in LQAS and Child Survival and will shortly be hired to visit the project and strengthen this crucial area.

PROJECT MONITORING and EVALUATION SYSTEM

Program Approach

Monitoring and evaluation activities are keys being used to build on the successes of the staff and communities, for refining strategies, strengthening weaknesses and for providing stakeholders and donors with progress reports. The program commits to accomplishing this through a variety of means. Thus far, community systems and project processes are still being established making it a little early to report on progress. Monthly reporting with the Country Office and another donor office has been working well as a communication tool.

Reports

- Monthly internal reports
- Annual report
- Component reports
- CC reports
- VHV activity reports
- TBA activity reports

Meetings

- Quarterly meetings with VHVs.
- Bi-monthly meeting with CSCC/CRFC (at the last meeting it was suggested by this joint committee that ID cards be given to VHVs to confirm their identity within communities and so that they can use these cards to get free services at their local HC. The project is now looking into the costs and best means of implementation of these cards.)
- Monthly PROCOCOM at the Provincial Department of Health (This allows us to update the Provincial Health Department on project activities as well as discussing the best mechanism for the project to work with the MoH in the implementation of its local health plan.)
- Monthly meetings of project staff. (e.g. All per diems for VHVs & TBAs were decided by the team.) Where the contents are relevant all CCs are also invited to these meetings, for instance in the upcoming project activities planning meeting in November.
- PMC (This committee of senior project staff gives the opportunity to review local management issues, as well as make recommendations to ADRA Cambodia. This committee has the responsibility for staff education and agreed to send the M&E Officer to an M&E course in Phnom Penh, for the benefit of the project.)

- PROCOM (PROCOM is a quarterly meeting held by ADRA Cambodia, of all senior officers and field staff, to discuss policy and general management issues. At the last PROCOM meeting the ADRA Cambodia staff health policy was completely revised and has since been implemented.)

Schedules

- Staff weekly Schedule
- CC weekly schedule
- VHV monthly Schedule

Other Methodologies

- Field Observation
- KPC and LQAS surveys
- Focus group discussions
- PRA and Mapping

Mapping (PRA Tool)

Maps have been created by CS staff of all villages in their HC supervision areas, in cooperation with community members, HC staff, village leaders, teachers, older generation popular villagers, etc. The purpose of these maps is to know the variety of different features and resources in each village. For example the available land that could be used for home gardens, availability of safe water, key community facilities like pagodas, schools, households and HCs. Target groups that were included in the maps were children 0-23 months, 24-59 months, pregnant women and family planning users. This mapping is currently 60% complete and will be completed by the end of October.

Component Monitoring Detailed Forms

The M&E officer created a variety of forms. These forms were discussed with the CS team, CCs, HC staff, OD MCH staff. Modifications were then made to the forms, training conducted in their use and the forms are now being used. These forms are listed below:

1. Nutrition

- 1.1. Monthly growth monitoring for children <24 months. This form will be used by VHVs during weighing of children in the villages, under supervision of HC staff/CCs/project staff.
- 1.2. Monthly summary growth monitoring of children <24 months for each village.
- 1.3. Monthly growth monitoring summary statistic of children <24 months for HCs. CCs and project staff will use both forms.

2. Traditional Birth Attendants

- 2.1 TBA individual monthly checklist (this form the TBA trainers are using for checking the equipment/delivery kits).
- 2.2 Monthly reports (this form was created to support the existing health center information system and is used by TBAs → CCs → HC → ADRA MCH Officer.

3. Birth Spacing

- 3.1 BSA monthly report, this form was created and supports the existing health center information system and is used by VHVs → CCs → HC → ADRA MCH Officer.

4. Other relevant forms

- 4.1 VHV health education schedule report. VHVs → HC → CCs → CS staff.

Future plans

The first project LQAS will be conducted in December, 2002 in the current project districts. Also in December there will be a second LQAS which will cover the complete project catchment area to gain baseline data on new HIV/AIDS & MNC indicators, as well as covering clarifications and changes to original project indicators covered in the Baseline Survey. An M&E expert from ADRA ASIA will be coming to the project in December to help local staff finalize these issues prior to the survey.

MANAGEMENT SYSTEM

Financial Management System

To ensure that the program runs smoothly, ADRA has established a multi-level financial management system. These levels include the project onsite team (PROJECT), the in-country support team (ADMIN), and the US based support team (HQ). The core elements include authorization of transactions, recording of transactions, production of reports, and review of those reports for accuracy, reasonableness, and comparison to budget and project scope. The authorization of transactions is done mainly at the PROJECT level, with administration support expenses incurred by the ADMIN and HQ support teams authorized at their respective levels. The recording of transactions is started at the PROJECT level which operates a petty cash system; however, review and monthly reports are done in ADMIN.

Factors that have made a positive impact on financial management include the financial management and USAID regulations workshop. Internal control was identified as an important area and efforts have been made to set up a strong system since the inception of the workshop. The PROJECT follows the ADRA Cambodia Policies which include segregation of duties at the PROJECT and ADMIN level and includes a Project Management Committee (PMC). The PMC is composed of the Project Manager (PM), Project Advisor (PA), Activity Coordinator, M&E Officer and Administrative Assistant; and must authorize all major project transactions up to \$1,000. The PM or PA can authorize expenditure or purchases up to \$500, the PMC up to \$1000, Country Director up to \$3,000, ADCOM up to \$10,000, above which the ADRA Country Board approves items. A cash flow projection chart is maintained at project level to help senior project staff when requesting cash from the Phnom Penh office and when preparing the 3 monthly draw downs from USAID and other project funders. This is also used as a tool to monitor expenditure against budget.

The ADRA Cambodia Financial Director conducted a training in Kampong Thmor (January 14/15, 2002) on the use of forms relevant to the project. Other monitoring visits by the Country Director highlighted some issues relating to cash management and procedures relating to the use of the safe. This was corrected with the purchase of a project safe where the Administrative Assistant is the only member of staff to know the combination and the Program Manager holds the key. Thus two people must be present to open the safe. A backup key and the combination are held in a safe in Phnom Penh.

The project maintains four bank accounts to be able to operate the project smoothly. The first located at the bank closest the project site, is used for petty cash replenishment, payroll, and specific larger field check payments. Signatories include the PM, PA, Administrative Assistant, Country Finance Director (as an alternate) and all checks must be countersigned. Project petty cash is limited

to \$4,000 total with up to \$500 of this in cash held in the project safe. The second account is for holding incoming funds, paying out project costs in Phnom Penh, and transfers to the field petty cash account. This account in Phnom Penh has the following signatories; Country Director, Associate CD, Finance Director, Gov./HR officer, and a Board Representative – all checks must be countersigned. The Country Director and Finance director are the normal signatories. The third account is a single account that ADRA Cambodia uses to receive all project funds from abroad. It is at the Foreign Trade Bank of Cambodia where the lowest transfer rates are charged. Funds from this account are immediately transferred into the project account (#2) upon receipt. A fourth project account is in Washington DC for receipt of project funds from USAID, transfers to Cambodia as well as payment of any US-based expenses. All bank accounts are maintained in US Dollars.

Roles and Responsibilities Ensuring Accountability

Monthly financial statements are sent to the ADRA HQ office. There the Financial Analyst who refers potential problems to the Senior Finance Administrator traces expenditures. This helps to avoid misuse of funds and aids in tracking project activities. Regular direct communication between the HQ Finance administrator, CD, FD, PM, and PA is easily performed through emailing and follow-up.

Both SF-269 and 272 reports are prepared quarterly by the HQ grant accountant and posted on line. In addition hard copies SF-269 are SF-272 sent to the project CTO at USAID Washington and Dept of Health and Human Services, respectively.

ADRA Cambodia participates in the overall institutional audit of ADRA International. The scope (range) of the A-133 audit includes all centrally funded Federal projects and is conducted annually by the accounting firm of Price Waterhouse Coopers. Audits of implementing offices are scheduled based on availability of audit providers and other logistic considerations. Any material findings associated with the implementation of projects in Guinea are reflected in the overall audit report provided by PWC to ADRA International. In that report the implementing field office associated with each finding is specifically identified. ADRA International works with those field offices and donor agencies to resolve all findings. Audit findings from previous audits have been addressed and resolved, and at present there are no outstanding issues from those findings.

Human Resources

The project Human Resources Management System (HRMS) follows the ADRA Cambodia HR policy. When employing project staff at project commencement, the PA and PM initially interviewed candidates. If they felt the person was appropriate the new candidate then went and spent a day in Kampong Thmor, with already employed team members. If, at the end of that day, the team members wanted to employ that candidate, they were employed. This system, devised by the PM, helped to ensure a cohesive team that was committed to each other, from the commencement of the project.

Reporting

Field reports are initially collected from VHVs and TBAs at the monthly HC meetings. The CCs, who attend these meetings, then pass the reports to the CS team, and each team makes a report. Five teams equals five HC catchment areas. The Activities Coordinator compiles these reports. The report is then passed to the PM for review and then to the CD.

Supervision

At field level, supervision starts with visits from the CD. These visits focus on financial and programmatic areas, as well as monitoring the implementation of ADRA Cambodia policies. The PA stays on site and continuously monitors project implementation, use of finances and staff performance. Field visits are made weekly, more frequently when training is in process. The PM continuously oversees the technical implementation of the project, and is often found in the field, especially encouraging and mentoring weaker team members. The Activities Coordinator makes frequent field visits when training is in progress and the M&E Officer makes regular field visits to monitor correct use of data collection forms. CS team members oversee the activities of the CCs who support the VHVs. The HCM and the CS MCH officers monitor the VHVs. Each project team makes up a weekly plan, as well as writing on the office board their daily movements when out of the office. Through these mechanisms, and the project radios all staff carry in the field, the whereabouts of each team member is known at all times. For security purposes the on-duty guard keeps in radio contact with team members who arrive after working hours.

At international level the Assistant Director for Health is the project backstop. Becky de Graaff assisted the project during the DIP, is in regular email contact with and is expected to visit again early in 2003.

Staff turnover

The Training Facilitator resigned in August, because he wanted to live with his family in Phnom Penh. Half of the project staff are not from Kampong Thom Province, so there is always a risk of losing staff to the city, especially to other PVOs, even some local staff would leave their home if a suitable job became available. We may yet lose more staff during the project life, but the maintenance of a strong cooperative team spirit is our main means of minimizing this risk. One of the main initial roles of the Training Facilitator was to establish the VHV training curriculum and this was almost complete when he left. The Activities Coordinator finished the task. The other aspects of the job require skills in working with and supporting HCs and HC Committees. As such a new Personal Performance Contract will be written and this position will probably be filled locally.

Communication System and Team Development

The project has taken a synergistic team-based approach since its inception--from an open approach to staff employment to the participatory system used in team meetings and in relating to the community. Staff are encouraged to give their ideas and opinions, as well as given permission to make mistakes, and then learn from those experiences. During the workshop to develop the BCC strategy, time will also be spent in team building, and in-group outings, prior to the workshop. The CCs have also been included in the workshop, due to their intimate knowledge of village life and behaviors and also to reinforce their integration into the CS team.

As has been mentioned previously, hand held radios have been purchased for all staff, which they keep with them at all times in the field. This gives them access to the base station at the CS office, other CS staff and also the BSOD/Referral Hospital/HC radio network. The network not only increases field efficiency but also acts as a security backup, should a breakdown, accident or incident occur.

The core values of ADRA Cambodia, compassion, integrity and respect, are frequently discussed when making decisions, and in team meetings as the team try to reflect these values in their work,

both in the office and in the field. There have been many instances of the team demonstrating compassion, when in the field, as well as demonstrating integrity when dealing with money and respect when dealing with each other and the community.

The PA and PM have portable computers and hand phones for communication via email, since there are no landlines in Kampong Thmor. This allows rapid problem solving where many parties can have input, as well as clarification of the many day-to-day issues that arise in the running of the project.

PVO In-country Coordination/Collaboration

ProCoCom Meeting

Every month in Kampong Thom (provincial capital) there is a Provincial Coordinating Committee meeting (ProCoCom). The members of the ProCoCom are:

- Provincial Health Department (PHD) Director, the Chairperson
- Heads of the various PHD departments, including MCH
- Other government departments that deal with health issues
- local/international PVOs working in health or related areas

The CS project sends a senior member of project staff to each of these meetings whenever possible. The objectives of the meeting are to report on activities, share experiences, solve problems, make future plans and enhance collaboration between all agencies and the government.

MEDICAM Monthly Meeting

MEDICAM is a non-profit, non-partisan membership organization with 110 members, both local and international PVOs. The main objective is to facilitate the diffusion of health related information between NGOs, the Royal Government of Cambodia (RGC) and all other health actors in Cambodia. ADRA Cambodia has been actively represented at MEDICAM since 1994, including participation on its steering committee. Through this forum, health policy issues have been raised and presented, with a strong voice, to the MoH and UN agencies who are then able to affect public health policy change. It also presents opportunity for dialogue on lessons learned and technical updates.

Capacity Assessment

The Project Management has been supervised and supported by the Country Director (CD) throughout the first year of the project. While no formal organizational capacity assessment has been conducted, an ongoing informal assessment is being carried out throughout the LOP. Through formal and informal feedback on the monthly Project and Management reports, communication via email, phone and face-to-face meetings the CD was able to asses and feedback on the organizational capacity of the project management. Two formal project-monitoring reports have also occurred. These two monitoring reports have been welcomed by the Project Management and used to further improve the project management. Recommendations given were acted upon within an appropriate time and shared with the PMC. The project management has approached any issues or challenges as a team and thereby ensured a broad input on the matter while using these opportunities to build the organizational capacity.

APPENDIX A: TRAINING OF TRAINERS

REPORT ON TOT REFRESHER COURSE

for
ADRA CS and HC Staff
for
Teaching VHVs and TBAs



Rationale

The aim of ADRA CS is collaborating with health center staffs to disseminate health information to communities in order to change dangerous behaviors that affect women's and child health. To achieve this goal, ADRA CS collaborated with the BSOD and Kampong Thom Provincial Health Department to develop a curriculum. The first training course was held April 8-12, 2002 and the second course April 22-26, 2002.

Aim of Training

The training aims to build the capacity of HC and CS staff to enable them to teach VHVs and TBAs about maternal and child health (including: prenatal care, normal delivery, postnatal care and birth spacing).

How the Course was carried out

The participants had classroom training for two weeks. The contents were divided into two sections:

- Theories: There are 56 hours and 30 minutes for theories including pre- and post-tests. In this section the trainers us participated learning by brainstorming, group discussion, demonstration, role paying, do exercise. All participants was asked to share ideas, knowledge, and experiences each other's.
- Practice: there are 11 hours and 30 minutes for practice. During practice each Participant had practiced on teaching 30 minutes the topic that appropriate for them (contents for TBAs or VHVs). The trainer used checklist to marking and give feed back.

How the Course was evaluated

Writing the two weeks training there are two parts of evaluation. Theory and practice evaluation. Theory was evaluated by pre- and post-tests. This evaluation purpose to assess the knowledge of participants relating to course contents and also assess their improvement (see Table 2 results).

At the end of each day participants were asked to evaluate the teaching to find out the contents that they didn't understand for discussing the next morning. At the completion of the training each participant was asked to evaluate the course about: course organizing, course contents, trainers' capacity and recommendation.

Constraints and Recommendation

Some out side trainers are well prepare for their teaching. But there are a few constrain for some OD trainers who had not receive guideline for preparing lesson plan because lack of communication and follow up from training coordinator. The result is that the trainers had not clear objectives for their topic as project need for the course. On the other and the participants had not hand out for learning.

Though these constraint for the next training the training should have enough time to contact with all trainers at least one week before the course start to make sure that the trainers receive guideline about topic and learning objectives for their teaching. To ensure that the contents and objectives are appropriate for course requirement training coordinator should discuss and find out the resources for teaching with trainers and prepare hand out for participants.

TABLE 2: RESULT SHEET

N	Name	Sex	Place of Work	Theory			Practice %
				Pre Test %	Post Test %	Improvement %	
1	Sieng Nara	F	ADRA	66	83	17	82
2	Orn Sothea	F	ADRA	56	66	10	73
3	Mam Pachhika	F	ADRA	59	86	27	74
4	Sor Chheng	F	ADRA	58	85	27	84
5	Yun Monyrath	F	ADRA	62	73	11	70
6	Sun Ny	F	ADRA	63	100	37	81
7	Hang Saroeun	M	ADRA	65	83	18	83
8	Leng Ponlok	M	ADRA	68	94	26	75
9	Khun Poch	F	ADRA	61	77	16	70
10	Ban Sambath	M	HC Balaing	51	73	22	80
11	Yim Sophaly	F	HC Protong	63	89	26	80
12	Lim Sareth	M	HC Tang Kork	71	80	9	83
13	Var Sreav	F	HC Balaing	59	84	25	81
14	Sim Thorn	F	HC Boeung	51	90	39	65
15	Thong Kimchheng	F	HC Tang Kork	65	88	23	73
16	Sok Sam Oeurn	M	HC Boeung	63	86	23	77
17	Kit Sokkha	F	HC Kreul	52	83	31	60
18	Tep Sam At	M	HC Protong	75	86	11	72
19	Kong Chantha	M	HC Kreul	68	82	14	84
20	Hing Sarann	F	ADRA	?	86	?	?

APPENDIX B: FOCUS GROUP DISCUSSIONS

Purpose of the Focus Group Discussions

The main purpose of these FGDs is to assess health status of mothers and children less than 24 months. The findings from this FGD will be used and compared with upcoming monitoring and evaluation activities such as the LQAS monitoring and midterm and final evaluations.

Focus Group Discussions

Seventy-seven questions were selected from the 92 questions of the first baseline survey questionnaire. It was divided into three sections. The first section had 31 questions, the second 26 questions, and third 20 questions. The field test was carried out in the three nearest villages in the HC supervision areas, where the intended interview target groups were. The average size of one FGD was 6-10 interviewees. 5 focus group discussions were held by each field team. The average length for one FGD was around two hours, including a 15 minute debriefing. The targeted area consists of two communes and 22 villages. Nine villages were randomly selected from the 22 villages. There was a total of 123 interviewees and 15 FGDs.

APPENDIX C: VOLUNTEER SELECTION CRITERIA

Criteria for Commune Coordinator Selection

- 1) Female
- 2) Age: 25-45 years
- 3) Education background: grade 9-12
- 4) Live permanently in her commune , but not farther than 5 km from HC
- 5) Good health
- 6) Not involved with any political party
- 7) Willing to volunteer and has permission from her family
- 8) Good facilitator, communicator and problem solver
- 9) Commitment to perform the tasks
- 10) Medium living condition

Criteria for VHV selection

- 1) Age: 25-45 years
- 2) Women are encouraged to select
- 3) Single or Widow or Mother who has older children.
- 4) Can read, write and calculate (Khmer language)
- 5) Lives permanently in her / his village
- 6) Willing to volunteer and has permission from her/his family
- 7) Not involved with any political party
- 8) Good communicator

Criteria for TBA selection

- 1) Age: 30-65 years
- 2) TBA living far from HC catchment areas
- 3) TBA who is active in the village, especially with deliveries
- 4) TBA who is involved in health activities in the village
- 5) Good health (including eyes and ears)
- 6) Willingness to learn something new for improved services
- 7) Has basic literacy skills

APPENDIX D: TRAINING of CCs, TBAs and VHVs

REPORT ON COMMUNE COORDINATORS TRAINING

**Hold on 16th to19thJuly2002 and
5th to13th August2002**

Rationale

Project goal, objectives and main strategies is to improve the quality of health and reduce the morbidity and mortality of women of reproductive age and children under five in the Baray-Santuk Operational District, Kompong Thom province. The above strategies will be used within the context of four project interventions: 1-Maternal and new born care, 2-Nutrition, 3-Birth Spacing and 4-Imminazation. To reach the project goal we will use Commune Coordinators (CC) to run the four interventions.

Aim of Training

The training aimed to build the capacity of CCs, to be able to supervise the VHVs and to do evaluation and monitoring. They are also to understand all content that VHVs will learn and they will be able to provide health education related to ANC, PNC, birth spacing, nutrition, hygiene and communicable disease.

How the course was running

The participants had learnt in classroom for 11 days. The contents were divided into 2 parts; part one was taught about Monitoring and Evaluation and part two was taught about the contents that the VHVs would learn. Part 1 took 4 days of period and part 2 took 7 days of period including health education practice in the classroom. The teaching Methods used by the trainers were: Short answer question, Brainstorming, Demonstration, Group discussion, Exercise, Lecture and Role-play. Every morning, before starting new lessons, the trainers lead the participants to review the lessons. Every afternoon, after the class was finished, the trainers had to attend a short meeting with activity coordinator to discuss on problems that happen during the training and find the ways to sole the problems.

How the course was evaluated

For theory we use pre- and post-test to evaluate the CCs' knowledge. All CCs passed and/or improved (see pre- and post-test results below).

For Practice we use checklist to evaluate the CC health education skills. So during practicing, each CC had to practice health education 2 times with different topic in the classroom. After CC practicing health education, the trainers had to give feedback to them immediately.

No	Name	Place of work	Pre Test (%)			Post Test (%)			Change (%)
			1st Wk	2nd Wk	Total	1st Wk	2nd Wk	Total	
1	Chuy Chim	HC Balaing	70	80	75	76.7	100	88.3	13.3
2	Heng Kim Hourt	HC Balaing	66.7	86.7	76.7	83.3	100	91.7	15.0
3	Mourm Ra	HC Boeung	53.3	56.7	55.0	60	100	80	25.0
4	Um Sam Oeun	HC Boeung	40	46.7	43.3	50	100	75	31.7
5	Nourn Bopha	HC Kreul	56.7	33.3	45.0	86.7	97	91.8	46.8
6	Hourng Sokunthea	HC Kreul	60	56.7	58.3	60	83	71.5	13.2
7	Penn Dany	HC Protong	46.7	66.7	56.7	66.7	100	83.3	26.7
8	Sam Samrith Phallin	HC Protong	56.7	60	58.3	63.3	100	81.7	23.3
9	Venn Sopheap	HC Taing Kauk	53.3	53.3	53.3	66.7	100	83.3	30
10	Hor Sokuntheary	HC Taing Kauk	63.3	70	66.7	91.7	100	95.8	29.2

REPORT ON TRADITIONAL BIRTH ATTENDANT TRAINING

8 -12 July 2002

Rationale

Project goal is to improve the quality of health and reduce the morbidity and mortality of women of reproductive age and children under five in the BSOD, Kampong Thom Province. To reach the project goal, TBAs will have an important role in providing primarily health messages and maternal services related to the four interventions of 1) maternal and newborn care, 2) nutrition, 3) birth spacing and 4) immunizations.

Aim of Training

The training aim is to build the capacity of TBA to be able to practice clean and safe deliveries and to provide health education on ANC, PNC and birth spacing.

How the course was running

The participants had learnt in classroom for 5 days. There were 26 hours including pre- and post-tests. The teaching methods used by the trainers were: short answer question, demonstration, group discussion, exercise, lecture and explain by using pictures. Every morning, before starting the new lesson, the trainer led the participants to review the lessons of the day before. The day ends with a short meeting with the Activity Coordinator to discuss any problems and find the ways to solve the problems.

How the course was evaluated

Before starting the training each TBA had to do pre-test and after a post-test. All TBAs passed and/or improved. A total of 74 TBAs were trained. The average pre-test score was 50.6 and the average post-test score was 86.3 for an average change of 35.7.

Constraint and recommendation

The trainers complained that they had some difficulties in teaching some TBAs who cannot read and write, they need to explain many times and the training was finished every late afternoon.

REPORT ON VILLAGE HEALTH VOLUNTEERS TRAINING

19th August - 27th September 2002

Rationale

Project goal is to improve the quality of health and reduce the morbidity and mortality of women of reproductive age and children under five in the BSOD, Kompong Thom Province. The above strategies will be used within the context of four project interventions: To reach the project goal, the project will use VHVs to engage in four interventions: 1) maternal and newborn care, 2) nutrition, 3) birth spacing and 4) immunizations.

Aim of Training

The training aims to build the capacity of VHVs to be able to provide health education about pre-and post-natal care, birth spacing, immunizations, nutrition, hygiene and prevention of communicable diseases.

How the course was run

Each of the five training sites had about 25 VHVs with a total of about 125 VHVs in attendance overall. Each session was divided into two stages: five days for theory and five days for practice.

- Theory: There are 26 hours including pre- and post-tests. The teaching methods used by the trainers included short answer questions, brainstorming, demonstration, group discussion, exercise, lecture and role-plays. Every morning, before starting new lessons, the trainer led the participants through a review of the previous day's lessons. The day ends with a short meeting with the Activity Coordinator to discuss any problems and find the ways to solve the problems.
- Practice: For five days of practice, VHVs were divided into four groups. Each group had a trainer or assistant trainers to help facilitate. Each VHV first takes one day to learn about their catchment households for which they will be responsible. This is accomplished by collecting information on the maternal and child health situation using the MCH Situation form.

How the course was evaluated

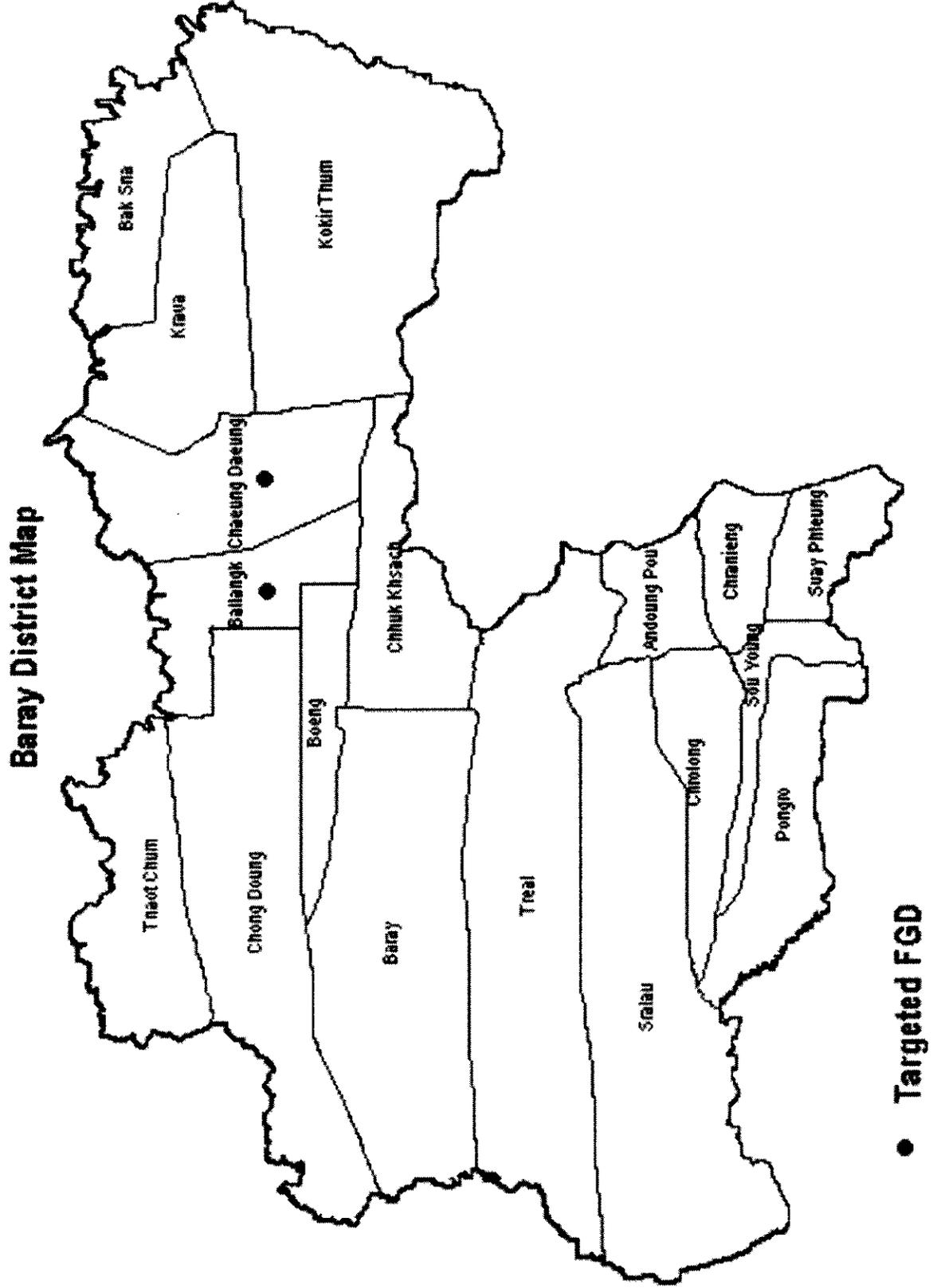
For theory we use pre- and post-tests to evaluate the VHV's knowledge. Most VHVs passed and/or improved (see below for pre- and post-test results). For practice checklists were used to evaluate the VHV's health education skills. So during practicing, each VHV had to practice health education six times with each different topic and the trainers had to give feedback on the spot.

Group	Pre test average score	Post test average score	Average change
1st session held on 19-30 August 2002	37.9%	71.3%	33.6%
2 nd session held on 2-13 of September 2002	41.2%	74.9%	34.3%
3 rd session held on 16-23 of September 2002	40.7%	72.2%	31.7%

Constraint and recommendation

The trainers had some difficulties in teaching some VHVs who have low education. Things needed to be explained numerous times causing trainings to end late. For the next phase, trainers suggest choosing more appropriate lengths of time for VHV Trainings.

APPENDIX E: MAP of TARGETED INTERVIEW AREAS



APPENDIX F: ITEMS FOR CLARIFICATION (DIP REVIEW)

Point 1: Provide specific organizational development/capacity building objectives with indicators for targeted local partners.

Capacity building objectives have already been embedded (perhaps unintentionally hidden) under other interventions. The MNC intervention includes indicators for improving the capacity of HCMs to provide quality basic pre-/post-natal and obstetric care (1.1) and improving TBA's quality of basic delivery care (1.2). Objective 2 requires capacity building of village leadership for the establishment and maintenance of a reliable emergency obstetric plan. Other capacity building objectives for local partners coincide with those under sustainability. In addition, project staff have included two more (see following table) objectives that will require training and mentoring for local partners.

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
5. HC's have regular monthly immunization visits to all catchment villages.	2.1 Each HC has an immunisation outreach calendar.	<ul style="list-style-type: none"> Mid-term and final evaluation 	<ul style="list-style-type: none"> Facilitate immunisation staff in each HC to develop outreach calendar. Encourage VHV/HC liaison in vaccination program. 	<ul style="list-style-type: none"> Improvements in the health system will continue; HSR remains on track. Continues stability/security in the BSOD. Project clients prefer home-delivery with TBAs. The effects of the Khmer Rouge period continue to present social barriers to community mobilization. Some follow-on activity will be necessary after the EOP.
	2.2 Each HC has a current list of children and vaccinations completed/requirements for each village.	<ul style="list-style-type: none"> Mid-term and final evaluation. 		
6. HC HIS accurately reflects activities.	3.1 Each HC submits accurate HIS monthly reports to BSOD.	<ul style="list-style-type: none"> BSOD HIS reports. Mid-term and final evaluation 	<ul style="list-style-type: none"> Train HC staff in the processes of a health information system and the importance of accurate records. Train HC staff in the use of HIS for decision-making, planning activities, targets and annual plans. 	

Point 2: Provide time frames with activities for the development and implementation of the proposed BCC strategy. Also consider a bottom-up approach for the bcc strategy similar to the recommendation made for the program's training plan.

The BCC strategy is to be covered in the December workshop (see *IEC* page 13).

Point 3: Clarify the development and use of any checklists to assure quality of the program's monitoring and supervision activities. It was recommended to look at the adult education tools and modules used by Food for the Hungry.

Checklists responded to under project M&E (see page 17).

Point 4: Clarify a few of the indicators presented in the Monitoring and Evaluation plan. Specifically...

1) ...provide baseline indicators for proposed MNC and HIV/AIDS objectives

See *Future Plans* page 17.

2) ...discuss with CSTS about differentiating women of reproductive age with the subgroup of women with children under 2 years of age for the MNC indicators

- BS** 1.1 Increase from 33% to 60% women receiving birth spacing methods and counselling at HC and community level.
- 1.2 Increase from 12% to 60% WRA who know three modern methods of birth spacing.
- MNC** 3.1 Increase from 5% to 85% WRA with children <2 years who know at least two ways that HIV/AIDS is spread.

All of these indicators refer to mothers of children <2 years of age. No other subgroups of women were interviewed during the baseline survey. More appropriate indicators are as follows and will be used by the project:

CORRECTED

- BS** 1.1 Increase from 33% to 60% mothers of children <2 years receiving birth spacing methods and counselling at HC and community levels.
- 1.2 Increase from 12% to 60% mothers of children <2 years of age who know three modern methods of birth spacing.
- MNC** 3.1 Increase from 5% to 85% mothers of children <2 years who know at least two ways that HIV/AIDS is spread.

3) ...consider changing the birth spacing indicator #2.2 from 0-3 months to 3-6 months

Staff consensus selects to keep the objective as is (0-3 months after delivery) to ensure that mothers are being targeted with BS messages during the time when they are most likely to come in contact with VHV's and other health staff.

The DIP review also indicated an error in the logframe:

- BS** 3.1 Increase from 29% to 50% children <24 months whose next sibling is two or more years older.

CORRECTED

- BS** 3.1 Increase from 76% to 86% children <24 months whose next sibling is two or more years older.

4) ...consider changing the exclusive breastfeeding indicator (nutrition #1.2) from a 6% increase to a minimum 10% increase for mothers who exclusively breastfed to 6 months.

Staff consensus selects to keep this indicator as is, considering the difficulty of achieving this type of objective. All efforts will be made to exceed the target in the event that it is met prior to the EOP.

5) The % children age 12-23 months who are fully vaccinated is reported as 37/133 which is 32.7% rather than 27.8 as reported...The denominator of 133 is reported for these two indicators and this information should be checked.

- 1.1 Increase from 28% to 60% children under 2 who have complete immunization coverage. The denominator of children 12-23 with cards seen is 83. So the correct value of this indicator using the Rapid Catch definition is $37/83 = 44.6\%$.

CORRECTED

- 1.1 Increase from 45% to 75% children under 2 who have complete immunization coverage.**

Point 5: Provide a detailed workplan for the first 2 years of the project and a broad stroke plan for the remaining 3 years.

Project Start Date: Mon 1/10/01

Project Finish Date: Fri 29/09/06

Name	Duration	Start Date	Finish Date
Project Start-up	138 days?	Mon 1/10/01	Fri 19/04/02
Employ Staff	1 month	Mon 1/10/01	Fri 26/10/01
Prepare Kampong Thmor office	5 days	Mon 29/10/01	Fri 2/11/01
Finance Workshop	2 wks	Mon 5/11/01	Fri 16/11/01
Christmas/New Year Holiday	1 wk	Mon 24/12/01	Fri 28/12/01
Project site visits	1.8 wks	Mon 31/12/01	Fri 11/01/02
Visit Reports	5 days?	Mon 14/01/02	Fri 18/01/02
ProCom and Field Visit	1 wk	Mon 21/01/02	Fri 25/01/02
Visit Reports	5 days?	Mon 28/01/02	Fri 1/02/02
DIP	49 days	Mon 4/02/02	Fri 19/04/02
Prepare for DIP Workshop	1 wk	Mon 4/02/02	Fri 8/02/02
DIP Workshop	1 wk	Mon 11/02/02	Fri 15/02/02
Develop Work plan	1 wk	Mon 18/02/02	Fri 22/02/02
Write DIP	6.8 wks	Mon 25/02/02	Fri 19/04/02
Phase I	381 days	Mon 1/04/02	Fri 26/09/03
Staff VHV and TBA Refresher Training	15 days	Mon 1/04/02	Fri 26/04/02
Prepare training course	1 wk	Mon 1/04/02	Fri 5/04/02
Refresher training	10 days	Mon 8/04/02	Fri 26/04/02
Qualitative Research	20 days	Mon 29/04/02	Fri 24/05/02
Recruit TBAs and VHV's	20 days	Mon 3/06/02	Fri 28/06/02
TBA Training 1	10 days	Mon 1/07/02	Fri 12/07/02
Prepare TBA training	1 wk	Mon 1/07/02	Fri 5/07/02
TBA training	1 wk	Mon 8/07/02	Fri 12/07/02
VHV Training 1	40 days	Mon 15/07/02	Fri 6/09/02
Prepare VHV training	1 wk	Mon 15/07/02	Fri 19/07/02
VHV training 1	1 wk	Mon 22/07/02	Fri 26/07/02
VHV Community Practice	1 wk	Mon 29/07/02	Fri 2/08/02
Revise VHV Training	1 wk	Mon 5/08/02	Fri 9/08/02
VHV training 2	1 wk	Mon 12/08/02	Fri 16/08/02
VHV Community Practice	1 wk	Mon 19/08/02	Fri 23/08/02
VHV training 3	1 wk	Mon 26/08/02	Fri 30/08/02
VHV Community Practice	1 wk	Mon 2/09/02	Fri 6/09/02
Community Supervisor and Hearth Training	20 days	Mon 9/09/02	Fri 4/10/02
Prepare for training	2 wks	Mon 9/09/02	Fri 20/09/02
Training	2 wks	Mon 23/09/02	Fri 4/10/02

HC Midwife Training 1	10 days	Mon 7/10/02	Fri 18/10/02
Prepare for Midwife training	1 wk	Mon 7/10/02	Fri 11/10/02
Midwife training	1 wk	Mon 14/10/02	Fri 18/10/02
Hearth Volunteer Training	15 days	Mon 21/10/02	Fri 8/11/02
Prepare for Hearth Volunteer training	1 wk	Mon 21/10/02	Fri 25/10/02
Hearth Volunteer training	2 wks	Mon 28/10/02	Fri 8/11/02
TBA Training 2	10 days	Mon 6/01/03	Fri 17/01/03
Prepare TBA training	1 wk	Mon 6/01/03	Fri 10/01/03
TBA training	1 wk	Mon 13/01/03	Fri 17/01/03
VHV Training 2	40 days	Mon 20/01/03	Fri 14/03/03
Prepare VHV training	1 wk	Mon 20/01/03	Fri 24/01/03
VHV training 1	1 wk	Mon 27/01/03	Fri 31/01/03
VHV Community Practice	1 wk	Mon 3/02/03	Fri 7/02/03
Revise VHV Training	1 wk	Mon 10/02/03	Fri 14/02/03
VHV training 2	1 wk	Mon 17/02/03	Fri 21/02/03
VHV Community Practice	1 wk	Mon 24/02/03	Fri 28/02/03
VHV training 3	1 wk	Mon 3/03/03	Fri 7/03/03
VHV Community Practice	1 wk	Mon 10/03/03	Fri 14/03/03
HC Midwife Training 2	10 days	Mon 17/03/03	Fri 28/03/03
Prepare for Midwife training	1 wk	Mon 17/03/03	Fri 21/03/03
Midwife training	1 wk	Mon 24/03/03	Fri 28/03/03
Volunteer Celebration	1 wk	Mon 22/09/03	Fri 26/09/03
Phase II	385 days	Mon 6/10/03	Fri 25/03/05
Staff VHV and TBA Refresher Training	15 days	Mon 6/10/03	Fri 24/10/03
Prepare training course	1 wk	Mon 6/10/03	Fri 10/10/03
Refresher training	10 days	Mon 13/10/03	Fri 24/10/03
Qualitative Research	20 days	Mon 27/10/03	Fri 21/11/03
Recruit TBAs and VHV's	20 days	Mon 1/12/03	Fri 26/12/03
TBA Training 1	10 days	Mon 29/12/03	Fri 9/01/04
Prepare TBA training	1 wk	Mon 29/12/03	Fri 2/01/04
TBA training	1 wk	Mon 5/01/04	Fri 9/01/04
VHV Training 1	40 days	Mon 12/01/04	Fri 5/03/04
Prepare VHV training	1 wk	Mon 12/01/04	Fri 16/01/04
VHV training 1	1 wk	Mon 19/01/04	Fri 23/01/04
VHV Community Practice	1 wk	Mon 26/01/04	Fri 30/01/04
Revise VHV Training	1 wk	Mon 2/02/04	Fri 6/02/04
VHV training 2	1 wk	Mon 9/02/04	Fri 13/02/04
VHV Community Practice	1 wk	Mon 16/02/04	Fri 20/02/04
VHV training 3	1 wk	Mon 23/02/04	Fri 27/02/04
VHV Community Practice	1 wk	Mon 1/03/04	Fri 5/03/04

HC Midwife Training 1	10 days	Mon 8/03/04	Fri 19/03/04
Prepare for Midwife training	1 wk	Mon 8/03/04	Fri 12/03/04
Midwife training	1 wk	Mon 15/03/04	Fri 19/03/04
Hearth Volunteer Training	15 days	Mon 22/03/04	Fri 9/04/04
Prepare for Hearth Volunteer training	1 wk	Mon 22/03/04	Fri 26/03/04
Hearth Volunteer training	2 wks	Mon 29/03/04	Fri 9/04/04
TBA Training 2	10 days	Mon 5/07/04	Fri 16/07/04
Prepare TBA training	1 wk	Mon 5/07/04	Fri 9/07/04
TBA training	1 wk	Mon 12/07/04	Fri 16/07/04
VHV Training 2	40 days	Mon 19/07/04	Fri 10/09/04
Prepare VHV training	1 wk	Mon 19/07/04	Fri 23/07/04
VHV training 1	1 wk	Mon 26/07/04	Fri 30/07/04
VHV Community Practice	1 wk	Mon 2/08/04	Fri 6/08/04
Revise VHV Training	1 wk	Mon 9/08/04	Fri 13/08/04
VHV training 2	1 wk	Mon 16/08/04	Fri 20/08/04
VHV Community Practice	1 wk	Mon 23/08/04	Fri 27/08/04
VHV training 3	1 wk	Mon 30/08/04	Fri 3/09/04
VHV Community Practice	1 wk	Mon 6/09/04	Fri 10/09/04
HC Midwife Training 2	10 days	Mon 13/09/04	Fri 24/09/04
Prepare for Midwife training	1 wk	Mon 13/09/04	Fri 17/09/04
Midwife training	1 wk	Mon 20/09/04	Fri 24/09/04
Volunteer Celebration	1 wk	Mon 21/03/05	Fri 25/03/05
Phase III	250 days	Mon 11/04/05	Fri 24/03/06
TBA Refresher Training	10 days	Mon 11/04/05	Fri 22/04/05
Prepare TBA training	1 wk	Mon 11/04/05	Fri 15/04/05
TBA training	1 wk	Mon 18/04/05	Fri 22/04/05
VHV Refresher Training	40 days	Mon 25/04/05	Fri 17/06/05
Prepare VHV training	1 wk	Mon 25/04/05	Fri 29/04/05
VHV training 1	1 wk	Mon 2/05/05	Fri 6/05/05
VHV Community Practice	1 wk	Mon 9/05/05	Fri 13/05/05
Revise VHV Training	1 wk	Mon 16/05/05	Fri 20/05/05
VHV training 2	1 wk	Mon 23/05/05	Fri 27/05/05
VHV Community Practice	1 wk	Mon 30/05/05	Fri 3/06/05
VHV training 3	1 wk	Mon 6/06/05	Fri 10/06/05
VHV Community Practice	1 wk	Mon 13/06/05	Fri 17/06/05
Hearth Update	20 days	Mon 20/06/05	Fri 15/07/05
Prepare for training	2 wks	Mon 20/06/05	Fri 1/07/05
Training	2 wks	Mon 4/07/05	Fri 15/07/05
HC Midwife Update	10 days	Mon 18/07/05	Fri 29/07/05
Prepare for Midwife training	1 wk	Mon 18/07/05	Fri 22/07/05

Midwife training	1 wk	Mon 25/07/05	Fri 29/07/05
Volunteer Celebration	1 wk	Mon 20/03/06	Fri 24/03/06
Project M&E	1259 days	Mon 19/11/01	Fri 29/09/06
Project Reports	1229 days	Mon 31/12/01	Fri 29/09/06
Quarterly Reports to HQ	1164 days	Mon 31/12/01	Fri 30/06/06
Annual Report	1046 days	Mon 23/09/02	Fri 29/09/06
Annual Report 1	5 days	Mon 23/09/02	Fri 27/09/02
Annual Report 2	5 days	Mon 22/09/03	Fri 26/09/03
Annual Report 3	5 days	Mon 27/09/04	Fri 1/10/04
Annual Report 4	5 days	Mon 26/09/05	Fri 30/09/05
Annual Report 5	5 days	Mon 25/09/06	Fri 29/09/06
Baseline Survey	70 days	Mon 19/11/01	Mon 25/02/02
Baseline Survey	1 wk	Mon 10/12/01	Fri 14/12/01
Final Survey	4 wks	Mon 3/07/06	Fri 28/07/06
Phase I LQAS	261 days	Mon 23/09/02	Fri 26/09/03
Phase II LQAS	260 days	Mon 22/03/04	Fri 18/03/05
Phase III LQAS	130 days	Mon 19/09/05	Fri 17/03/06
Mid Term Evaluation	4 wks	Mon 1/03/04	Fri 26/03/04
Final Evaluation	4 wks	Mon 7/08/06	Fri 1/09/06

Point 6: Clarify specific changes made to the DIP budget.

Personnel

- FIELD Administrative increased by about \$20,000 per actual expenses since the start of the project as compared to the budget.
- FIELD Technical was rearranged per the revised organization of teamwork in the DIP.
- HQ Personnel decreased by about \$70,000 per review of actual cost to backstop a CS project and actual needs based on first six months experience with the project.

Fringe Benefits

Expatriate allowances are decreased by about \$30,000 due to actual allowances being lower than budgeted.

Travel

The increase of about \$45,000 is for the Commune Coordinator Volunteers travel assistance, added per the DIP.

Equipment

Amounts were shifted between equipment as it was decided that only one, instead of two, vehicles were needed and other expenses were higher.

Contractual

Technical and Financial Advisors were added per needs assessed since the start of the project.

Other

Due to the rearranging of training schedules per the DIP, training has increased by about \$40,000. Line items added include Commune Coordinator, HC Staff Training, and Field Training. An office use fee was added per actual office use with an increase of about \$8,000. Evaluation workshops that were not included in the proposal budget, resulted in an increase of \$3,000.

ADRA's provisional NICRA

ADRA's provisional NICRA rate was changed from 27% to 23.74%.