

# **Second Annual Report**

**2002 – 2003**

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**ADRA CAMBODIA**

**CHILD SURVIVAL XVII**

**BARAY-SANTUK OPERATIONAL DISTRICT  
KAMPONG THOM PROVINCE/CAMBODIA**

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## **ABBREVIATIONS/ACRONYMS**

<b>ADRA</b>	<b>Adventist Development and Relief Agency</b>
<b>ADCOM</b>	<b>Administrative Committee</b>
<b>AD</b>	<b>Associate Director</b>
<b>APLI</b>	<b>ADRA Professional Leadership Institute</b>
<b>AI</b>	<b>Appreciative Inquiry</b>
<b>APM</b>	<b>Assistant Project Manager</b>
<b>ARI</b>	<b>Acute Respiratory Infection</b>
<b>BCC</b>	<b>Behavior Change and Communication</b>
<b>BMI</b>	<b>Body Mass Index (Kg/m<sup>2</sup>)</b>
<b>BS</b>	<b>Birth Spacing</b>
<b>BSOD</b>	<b>Baray-Santuk Operational District</b>
<b>CC</b>	<b>Commune Coordinator</b>
<b>CCB</b>	<b>Cambodian Community Building</b>
<b>CD</b>	<b>Country Director</b>
<b>CDD</b>	<b>Control Diarrhea Disease</b>
<b>CE</b>	<b>Continuing Education</b>
<b>CFVI</b>	<b>Child Friendly Village Initiative</b>
<b>CIMCI</b>	<b>Community Integrated Management of Childhood Illness</b>
<b>CRFC</b>	<b>Community Representative Feedback Committee</b>
<b>CRS</b>	<b>Catholic Relief Services</b>
<b>CS</b>	<b>Child Survival</b>
<b>CSCC</b>	<b>Child Survival Coordinating Committee</b>
<b>CMA</b>	<b>Cambodian Midwives Association</b>
<b>CSTS</b>	<b>Child Survival Technical Support</b>
<b>DHS</b>	<b>Demographic and Health Survey</b>
<b>DIP</b>	<b>Detailed Implementation Plan</b>
<b>EPI</b>	<b>Expanded Program of Immunization</b>
<b>FD</b>	<b>Finance Director</b>
<b>FGI/D</b>	<b>Focus Group Interview/Discussion</b>
<b>FS</b>	<b>Food Security</b>
<b>GAAP</b>	<b>Generally Accepted Accounting Practices</b>
<b>HC</b>	<b>Health Center</b>
<b>HCM</b>	<b>Health Center Midwife/ves</b>
<b>HCMC</b>	<b>Health Center Management Committee</b>
<b>HIS</b>	<b>Health Information System</b>
<b>HIV/AIDS</b>	<b>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</b>
<b>HKI</b>	<b>Helen Keller International</b>
<b>HQ</b>	<b>Head Quarter</b>
<b>HRM</b>	<b>Human Resources Manager</b>
<b>HRMS</b>	<b>Human Resources Management System</b>
<b>IEC</b>	<b>Information, Education and Communication</b>
<b>IFT</b>	<b>Iron Folic acid Tablets</b>

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

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## A. MAIN ACCOMPLISHMENTS

### LQAS

LQAS has not been commonly used in ADRA CS projects worldwide. In Cambodia there has been a lot of energy and enthusiasm dedicated to implementing this M&E technique, with support from ADRA International & ADRA Asia.

The first LQAS workshop was conducted by CS Project Manager, Activity Coordinator, and M&E Officer in July 2003 at the ADRA CS Kampong Thmor office. As well as project staff, the Baray-Santuk Operational District (BSOD) Director, OD MCH Director, 5 HC chiefs, 10 HCM's & Community Representative Feedback Committee members were participants. The purpose of this workshop was not only to introduce all of the above to LQAS but also to discuss how this tool would help to analyze progress towards project outputs and to give the project an early warning system, where progress was too slow or non-existent. It would also help staff to review the performance in each supervision area, so that local, as well as project wide responses, could be made where targets were not being met.

Two surveys have been completed following the training and implementation of the VHV & TBA programs in the 5 HC catchment areas. Another 5 HCs will commence activities in Phase II, which starts October 2003. The field health education program commenced in August 2002. The first LQAS was carried out on Jan 2003 and 2nd in August 2003 by the CS staff and CC's in cooperation with OD and HC staff. (Please see Appendix A, 1st actual LQAS survey report and B, 1st LQAS Results Workshop.)

#### Results: How data was used for decision-making

##### 1. Married non-pregnant women and men age 15-49 years

Indicators ↴	LQAS judgments for TT vaccination, Birth spacing knowledge use					
	Women who received at least two TT or more		Women who knew At least three MBSM		Women who are using BS method to delay or avoid pregnancy	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	20%	25%	20%	30%	35%	35%
Average coverage	52%	54.7%	30.9%	45.3%	61.9%	42.1%

Indicators ↴	LQAS judgments for birth spacing counseling, AIDS/HIV knowledge					
	Women who received counseling at HC		Women who knew at least two ways of HIV/AIDS prevention		Women who knew at least two ways of HIV/AIDS prevention	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	35%	40%	20%	35%	20%	35%
Average coverage	43.2%	39.5%	52.6%	54.7%	56.8%	56.8%

##### 2. Mothers with children 0-11 months

Table 1: LOAS judgments for nutrition practice on colostrum/ exclusive breastfeeding

Indicators ↴	Mothers initiated breastfeeding with colostrum within the first hour after delivery		Mothers breastfed exclusively up to 6 months after delivery	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	20%	20%	20%	20%
Average coverage	28.4%	48.4%	47.9%	32.2%

Table 2: LOAS judgments for mother continue giving food and liquid with illness

Indicators ↴	Mother continue breastfeeding with illness		Mothers gave water to children with illness		Mothers gave food to children with illness	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	20%	25%	20%	25%	20%	25%
Average coverage	85.3%	79.5%	82.1%	86.5%	66.6%	36.8%

Table 3: LOAS judgments for Weighed at birth, Iron and Vitamin-A provided

Indicators ↴	Babies weighed at birth within 24 hours after delivery		Pregnant women who received iron tablets		In the first two months after delivery lactating mothers received Vit-A	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	45%	55%	35%	40%	20%	20%
Average coverage	61.6%	83.2%	56.8%	71.6%	43.2%	67.4%

Table 4: LOAS judgments for prenatal, delivery care and birth spacing practice

Indicators ↴	Women who received prenatal care at least 2 times		Pregnant women were delivered by TBAs using clean birth kits		Women who initiated using modern birth spacing method within the first three months after delivery	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	20%	25%	75%	75%	25%	30%
Average coverage	42.1%	69.2%	85.3%	84.2%	12.1%	15%

### 3. Mothers with children age 12-23 months

Table 1: LOAS judgments for mother continue giving food and liquid with illness

Indicators ↴	Mother continue breastfeeding with illness		Mothers gave water to children with illness		Mothers gave food to children with illness	
Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	20%	25%	20%	25%	20%	25%
Average coverage	82.2%	87.3%	89.9%	82.7%	60.8%	56%

Table 2: LOAS judgments for vitamin-A, immunization and birth spacing practice

Indicators ↴	Children received vitamin-A at least one capsule in the last 6 months	Children who completed immunization	Women who are using BS method to delay or avoid pregnancy
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Dates monitoring data were collected	Jan 2003	August 2003	Jan 2003	August 2003	Jan 2003	August 2003
Coverage benchmark	35%	40%	35%	40%	35%	35%
Average coverage	75.5%	91.6%	47.4%	73.6%	57.3%	46.7%

## BCC workshop

To complement the project implementation process, combined with responding to the LQAS surveys, CS staffs were trained in BCC. This workshop facilitated by the PA, with assistance from the WR PM. The BCC tool taught was a synthesis of the tool used by WR, with modifications by the ADRA PA. The CS team, including the 10 CC's, gathered in Koh Kong, for a week during December 2002, where they learnt about and adapted this tool to the project indicators and objectives. Much of the time was spent in the same teams as work together in the field, which also strengthened team spirit and cooperation. The BSOD Director was also invited to maximize local MoH input. The two PHD IEC staff were also invited but, at the last moment, an IEC seminar took them away to Phnom Penh. A psychiatrist from Phnom Penh also attended and gave the team a basic understanding of psychiatric illness in the community, as well as making some valuable suggestions to the various BCC strategies that were being developed.

The BCC tool first used by the team during this workshop was later reinforced through the BCC workshop run by CORE in Phnom Penh during February 2003 which several staff were able to participate in.

## Community behavior change tools workshop

Following a CS staff Team meeting, where the BCC strategy was discussed, it was noted that most VHV's were using one to one, families or small groups, as the main medium for the transfer of knowledge, leading to behavior change. The team recognized that a larger range of BCC tools was needed, with special reference to the Khmer cultural tradition. Invitations were sent out to all CS projects and throughout ADRA, asking for participants in a one week course development workshop. The aim was to bring together experienced BCC staff members from various CS projects, as well as other non CS ADRA projects and to share and document experiences, so that at the end of the week each participant took away a series of documented generic trainings, in BCC tools that were specific to large audiences. This workshop was led by CS Activity Coordinator and assisted from Project Advisor and Manager. The process of this workshop was first to share experiences, then to identify tools, prioritize tools, develop the tools into a training program through group work, and test the training. Afterward, the compiled books were given to the Organizations who participated in the workshop. Thirteen tools were identified and 9 were developed into a training manual. (This Training Manual was prepared in the local language and is available, on request, in Khmer.)

## Child Friendly Village (CFV)

With the introduction of all of the key activities in the 5 HC catchment areas the model of a CFV has been implemented in 10 villages, two in each HC catchment area. This trial commenced with setting the CFV criteria and then selecting the appropriate villages. (See Appendix C for the specific indicators, members, and role and responsibilities.) This was followed by the selection of the CFV Committee members, who were then trained for two days

in May 2003. The participants were 4 HC chiefs, 6 HC midwives, 6 TBAs, 2 VHVs, and 29 popular people in village. The topics of this training were: “What is a child friendly village?,” communication skills, meeting preparation, and health problem solving. Training pretest scores were: <50% = 43 persons, 50-60% = 24 persons and >60% = 23 persons. For the post-test <50% = 8 persons, 50-60% = 5 persons and >60% = 77 persons. This model is being implemented with the assistance and support of the HC staff from the MoH.

## HC Facility Assessment

The HC assessment was conducted during September 2003. This assessment was scheduled earlier in the life of the project, but was delayed so that this process could be arranged in full cooperation with the BSOD Director and MoH staff. The OD Director requested that we use the same tool as has already been implemented by the MoH through a World Bank funded project. This tool was not being used as the BSOD had no financial capacity to support staff travel to the HC's for monitoring and evaluation purposes. The CS staff spent time with the BSOD staff in encouraging them to use this tool in the best manner possible. The results of these monitoring visits are then passed on to the project, as well as being used by the BSOD, thereby building local MoH capacity. The assessment took 5 days to complete for the 5 health centers in Phase I. There were 3 persons in each team, 2 OD senior officers and one CS health coordinator. The results of this assessment will be compiled during the next quarter.

In the following table, the “Yes” or “No” are based on LQAS results. If results were at or above what was expected that is signified by a “Yes”, if below a “No”.

## Project Achievements

Objectives	Yes/No	Comments/Processes
<b>Maternal and Newborn Care</b>		
Increase to 80%, HCMs able to provide quality basic pre-/post-natal and obstetric care.	Yes	All the HCMs have been trained in pre and post natal care and safe delivery .
80% of TBAs able to provide quality basic delivery care	Yes	Most TBA’s attended 2 training sessions which were led by project & HCM staff. They were also provided with home birth kits. A system of follow-up is in place.
60% of pregnant women follow through with their TBA's referral.	Yes	The TBA’s have referred pregnant women with complications to HCs, the RH, and Kunthabopha hospital in Phnom Penh. (Confirmed by monthly TBA reports)
Increase from 10% to 35% pregnant women who receive prenatal care at least two times during the pregnancy from trained HCMs.	Yes	VHV’s & CC’s are encouraging mothers to attend the HC for prenatal care. This is an ongoing process. When pregnant mothers bring sick children to the HC they are also given a prenatal check.
40% of pregnant women who have birth preparedness plan.	No	This indicator relates to the culture. Most people believe that if they are prepared in advance their babies will die or they will face problems during labor. A change in understanding is gently being encouraged here.
Increase from 70% to 80% use of clean birth kits at deliveries	Yes	TBAs attended two training sessions and ADRA provided birth kits for each TBA. Also follow-up is done every month on their knowledge and techniques and kits through a checklist.
Increase from 40% to 80% newborns weighed within 24 hours after birth.	Yes	Each TBA has been provided with a baby scale. Each TBA reports every month to the HC with their statistics .
LBW protocol practiced by mothers in 50% of cases where newborns weigh less than 2500 gms.	No	This protocol is being established by the project, in consultation with the MoH and other NGO’s.
Increase from 5% to 85% WRA with children <2 years who know at least two ways that HIV/AIDS is spread.	Yes	CCs & VHVs have provided HIV/AIDS education. This complements national programs in print, newspapers, radio and TV.
Increase from 57% (1 <sup>st</sup> LQAS result) to 85% men 15-65 who know at least two ways that HIV/AIDS is spread.	Yes	CCs & VHVs have provided HIV/AIDS education. This complements national programs in print, newspapers, radio and TV.
<b>Birth Spacing</b>		
Increase from 33% to 60% women	Yes	CCs, VHVs, and TBAs have established

receiving birth spacing methods and Counselling at HC and community level.		contact and provided education on the importance of birth spacing and counseled WRA to go to the HC.
Increase from 12% to 60% WRA who know three modern methods of birth spacing.	Yes	VHVs, CCs, and TBAs are all part of a comprehensive program of educating WRA re birth spacing.
Increase from 32% to 50% WRA who currently want to avoid pregnancy, which use a modern contraceptive method.	Yes	VHVs, CCs, and TBAs are all part of a comprehensive program of educating WRA re birth spacing
Increase from 25% to 35% WRA who initiated use of modern method of birth spacing within the first three months following pregnancy.	Yes	VHVs, CCs, and TBAs are all part of a comprehensive program of educating WRA re birth spacing

<b>Nutrition</b>		
Increase from 13% to 33% the number of mothers who initiate breastfeeding with colostrum within the first hour after delivery.	Yes	VHVs & CCs provide education to pregnant women before delivery. TBAs give them education during delivery the importance of colostrum.
Increase from 19% to 25% mothers who breastfeed exclusively up to 6 months after delivery.	No	The factors affecting this indicator relate to poverty. Women, who must also be breadwinners, are often found in markets, as sellers, or out in the rice fields as laborers etc. These women leave their babies at home with their grandmothers or older sisters.
Increase from 12% to 32% mothers of children <2 who continue breastfeeding or giving water and food to children with illness.	Yes	Project officers trained TBAs and VHVs in cooperation with OD and HC staff. The HCs have provided more education to villagers during immunization outreach.
Increase from 33% to 50% pregnant and lactating women who receive 90 IFT supplements.	Yes	The HC give iron to pregnant women during prenatal check up. Lactating mothers get their iron during the monthly immunization visits by the HC staff.
Increase from 35% to 60% children 6-23 months of age who received at least one vitamin A capsule in the last 6 mos.	Yes	The national vitamin-A campaign is conducted every six months (twice a year). The project works with the MoH to support this campaign.
Increase from 17% to 30% women who receive a VAC within 8 weeks postpartum.	Yes	The HC staff provided vitamin-A capsules to the lactating mothers during the immunization outreach. HC staff come to homes if the mothers are unable to attend the outreach.

<b>Immunization</b>		
Increase from 28% to 60% children under 2 who have complete immunization coverage.	Yes	HC staff conducted regular immunization outreach in cooperation with CCs and VHVs every month. Education was provided by volunteers, HC staff and national radio and TV.

Increase from 9% to 40% mothers who have at least two TT vaccinations in the last five years.	Yes	HC staff conducted regular immunization outreach in cooperation with CCs and VHVs every month. Education was provided by volunteers, HC staff and national radio and TV.
<b>Capacity Building</b>		
Standardized technical backstopping protocol includes standards for identification of innovative approaches and best practices that can be applied in other ADRA programs.	No	Planned at ADRA International Health Summit in January 2004.
Lessons learned/innovative approaches from CSXVII are published internally.	Yes	In Monthly and Quarterly Reports disseminated in four ADRA offices.
Lessons learned/innovative approaches from CSXVII are published/presented in at least two publications/forums external to ADRA.	No	Considerable information and ideas have been exchanged by the CS project with other CS projects within Cambodia, mainly through the Combined CS Quarterly Meetings
Documented lessons learned/best practices from CSXVII are applied to other ADRA health programs.	Yes	Cross visits with ADRA Cambodia Pursat CS project share LQAS, Training materials, etc.
LQAS system in place and functioning.	Yes	See First 2 reports in Annexes.
<b>Sustainability</b>		
Increases in percentage of community members who have adopted program promoting behaviours by end of project.	Yes	To date in the LOP, behaviors are being changed, such as documented in the Colostrum research and LQAS surveys

## B – Factors that have impeded progress

### Health Center Working Hours

HC's only operate in the mornings until 11am during the week and are usually closed on the weekends. This limits community access to the HC and also makes community members reluctant to go to the HC when illness arises, unless it is during the working hours. The limited operating hours results from poor motivation of HC staff, as they are meant to work in the afternoons and to have a 24 hour call-out system. Their low salaries mean that they usually work in their private practices in the afternoons, so that they can make enough money to live. Some HC's are not fully staffed, thereby increasing the workload for the remaining staff. The project and the BSOD have discussed this problem, as it affects the referral system that the project is trying to encourage. The project is well supported by the BSOD in trying to deal with this nation-wide problem. In several of the HCs a guard has been hired to be present during non-working hours, as of August 2003. He is then able to call in HC staff when a patient arrives for treatment. This is funded by the HC staff and the HC financial scheme.

## Health Centre Midwife Deliveries

Most HCM's have less experience and appear to be of lesser or no better quality, for a greater cost, to members of the local community. The only benefit of HCM's acknowledged by the community is that they are educated to know what to do in case of severe difficulties during delivery and have more equipment needed to deal with these. However, as women will not anticipate severe difficulties in delivery, this is not a high priority. HCM's are also less accessible than TBA's, especially for out of hours deliveries, which is when most women deliver. A home delivery is often preferred by the family as family members can assist in preparations for delivery while still being able to provide childcare and meals. There is also a traditional belief that if a baby dies during a delivery, it was due to the spirit of the previous mother taking the child back. This belief means that even though a TBA may have made a mistake during the delivery she is not blamed as the outcome was out of her control.

As a counterbalance to the above the project has supported the MoH in training the HCM's in MPA module 11, which covers pre and post natal care and MPA module 12, which covers safe delivery. The project is also planning to support the OD to send the HCMs to practice in large hospitals where they can obtain more practice in delivery in a short period of time. As the HCM's display an increased quality of care, through better practices the project expects to see a slow movement away from TBA's towards the HCM's. With the project using HCM's in the training of TBA's and then following this up with regular monthly meetings, this relationship is also strengthening and we expect to see more deliveries with the TBA and HCM present.

## Hearth Program

The implementation of the hearth program has been delayed as the project was waiting for PFD to complete its first trial of hearth. Hearth is new to Cambodia and it seemed practical and realistic to take this approach. In August the projects Activity Coordinator, and a Nutritionist from the CBFS project, a partner/match ADRA project in Kampong Thmor focusing on improved nutrition, attended a hearth training by PFD, representatives were also sent from the CRS and World Relief CS projects. Using the tools and lessons learned from PFD a course was designed and the TOT for relevant project staff is due to be held in October 2003. In preparation for the hearth program regular growth monitoring for children under two years has been established in all the CFV's.

(See Appendix D: Report on Hearth Training Study Visit)

## C - Technical Assistance Required

The CS project staff will need ongoing technical assistance in the area of program implementation as new programs are implemented, such as Mothers Clubs, and current strategies are reviewed and improved, such as the LQAS monitoring program. This assistance will primarily come from the new Project Advisor, who will be commencing shortly. In the meantime the previous Advisor has been giving ongoing assistance to the project, since leaving in May. It is also planned that the ADRA Cambodia Finance staff will further assist the project, at field level, in the area of cash management. As the nearest bank is one hours drive, accurate daily and future cash management is essential to maintain the smooth running of the project,

especially in periods of intense field training, where cash demands are unusually high. Outside assistance may be needed as the project implements and reviews the Hearth program.

## **D - Program Change**

Due to recent information from the OD Director and the Sralao HC, we are changing one of the five health center's that the project will be working with in Phase II. A Child Rights NGO began working in 2002 to support the Sralao HC doing many of the same interventions as the CSP. Since the Sralao HC chief who participated in DIP workshop and was a member of Child Survival Coordinating Committee died in a traffic accident, it appears that there was some miscommunication regarding development plans for the Sralao HC.

The Sralao HC does not have a midwife on staff to coordinate MCH, ANC, Delivery and PNC, etc., so most of the people living in this HC catchment area travel to another HC nearby to consult about CS issues. Since the Goal and Objectives of CSP are to reduce morbidity, mortality of WRA and Children fewer than 5, we can not expect that HC can work towards to reach our objectives. The BSOD Director informed us that they will not be able to solve the lack of human resources by hiring a midwife. They recommend that we change the HC to Prasat.

The change from the Sralao HC to the Prasat HC has already been approved by USAID and involves the following change in beneficiaries:

	<b>Sralao HC (OLD)</b>	<b>Prasat HC (NEW)</b>
<b>Total Villages</b>	<b>18</b>	<b>10</b>
<b>Total Population</b>	<b>12,972</b>	<b>8,724</b>
<b>WRA</b>	<b>5,449</b>	<b>3,996</b>
<b>Children &lt; 5</b>	<b>1,736</b>	<b>1,168</b>

## **VHV/CC Approach**

Towards the end of Phase 1, where the project has implemented all activities in half of the project area, all field staff met to discuss the lessons learned and suggested modifications for the future. One key area that came under close scrutiny was the CC and VHV programs. All CC's were present at this meeting. As the CC's live and work in the villages they highlighted an issue, one that the project had been trying to grapple with for some time. Although the VHV attrition rate was low there was a significant number that were not working to the standard required by the project, which is the equivalent of 2 days a month. There were VHV's that were working very well but around 30% were not giving adequate time to their volunteer responsibilities, as their primary focus was in generating family income. This may have seemed larger at this time because it was rice planting time and many of the VHV's were involved with this and would have worked less in recent months. It did not appear that being a VHV gave any

significant improvement to status in the village and so once the training was over their enthusiasm gradually waned. Towards the end of Phase I special VHV celebrations were held in every HC catchment area to try and boost the local status of the VHV's and to give them further encouragement, as we move into Phase II. One of the key project strategies to give ongoing support to the VHV's has also been to connect them closely to the HC, where they attend monthly meetings and get further training. This is the key to their sustainability, while the extra layer of CC's allows the project to closely monitor VHV activities, as well as being a ready source of motivation and knowledge to the VHV's. The CC's have worked well and are highly respected by CS staff and VHV's alike. Their closeness to daily village life enabled them to highlight the depth of this problem.

There are many factors influencing this situation, arising from the individual VHV, (where people seek to get rather than to give), the village environment, (where they are undervalued and there is little sense of community), and the HC (where staff are poorly trained, paid and motivated). There is no simple answer to this situation as it requires significant changes to the MoH system and staff, and a major shift in community and individual attitudes. All of these are part of the legacy left behind by the many years of internal destruction the country and Cambodians endured. The project will organize a survey of the active and less active VHV's, doers and non-doers, to further analyze and respond to this problem.

For Phase II the project staff would like to make a number of changes to the CC/VHV strategy implemented in Phase II, to strengthen BCC at the field level. It was noted, through staff field visits, that whenever CC's were present, they became the ones villagers asked questions of, following an IEC presentation, as the VHV knowledge level gave them a limited ability in this area. By the nature of the VHV system, i.e. large numbers with limited ability and training, they were able to give basic messages to the target population but were unable to answer some of the more complex questions that sometimes followed. As there were only 10 CC's and over 300 VHV's, a CC could not be present to assist every VHV in every presentation. This led the team to question the ability of VHV's to impact a population, once a number of basic messages had been delivered. There were also many anecdotal instances where CC's had been able to impact behaviour change, where VHV's had been unsuccessful, as the CC's have a much higher level of education and are more highly trained by the project. A comparison was made of the benefits of each group, see below:

	VHV	CC
Knowledge	Small	Large
Skill	Small	Large
Implementation of Skill	Small	Large
Area of Impact	Large	Small (As in there are many more VHV's than CC's, so they are able to contact more people.)
Quality of Impact	Small	Large
Cost per VHV/CC	Small	Large

The team then suggested that maybe it was better to have less VHV's but choose people who were better educated. Each VHV would have to cover more households, from the current number of 1:30 increasing to 1:50 to 70, depending on the size of the village. The CC layer would then be deleted as less VHV's could be directly overseen by project staff, thereby

deleting the middle layer. These new VHV's would then be taught BCC techniques that could be used in larger groups, instead of using the current 1:1 and small group techniques. A new training technique of 'drip feeding' would also be implemented along with this change, so that the VHV's had many small and frequent trainings by project staff, rather than widely spaced and concentrated trainings, as was done in Phase I. This is important as training helps to maintain enthusiasm, as well as increase knowledge. As the CC layer was removed there would be money available for extra training of the VHV's and non-direct incentives, t-shirts, competitions etc. The team will continue the original model in the Phase I area, while using the new model in the Phase II area, and, using LQAS, study any differences in impact. For some special programs, like the hearth program, the VHV's involved would need to be paid a small per diem, as this program requires full time work over an extended period of time. This is a special circumstance and is beyond their normal duties as a VHV. This situation only applies to CFV's, not all villages. Through these program changes the team believes that the program will be more effective in encouraging and maintaining positive behaviour change in the target population. To signify that this is a different approach the new VHV's will be called 'Community Health Educators'.

## **E. PROGRAMS 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 on-going staff capacity building in financial management at the PROJECT and ADMIN level through continued education and mentoring. 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 or Associate 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 ADMIN and when preparing the bi-monthly drawdowns from USAID and other project donors. This is also used as a tool to monitor expenditure against budget.

The project maintains four bank accounts to be able to operate the project smoothly. The first (1) located at the bank closest to the project site, is used for petty cash replenishment, payroll, and specific larger field check payments. Signatories include the PM, PA, Administrative Assistant, ADMIN Chief Accountant (as an alternate) and all checks must be countersigned. Project petty cash is limited to \$6,000 total with up to \$500 of this in cash held in the project safe. The second and third accounts are for holding incoming funds, paying out project costs in Phnom Penh, and transfers to the field petty cash account. These checking (2) and saving (3) accounts in Phnom Penh have the following signatories; Country Director, Associate Country Director, Chief Accountant, Gov./HR officer, and a Board Representative – all checks must be countersigned. The Associate Country Director and Chief Accountant are the normal signatories. The fourth account (4) is an account in Washington D.C. for receipt of project funds from USAID transfers to Cambodia as well as payment of any US-based expenses. The majority of funds from this account are immediately transferred into the project account (#3) upon receipt. 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 and SF-272 are 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 (PWC). 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 Cambodia 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 follows the Human Resources Management System (HRMS) set up by ADRA Cambodia HR policy and facilitated by the Human Resources Manager (HRM) and Country and Associate Directors. HR documents such as job contracts, position profiles, personnel health information, etc. are prepared by the PM and HRM with approval from the PMC, PA, AD and ADCOM as per policy.

## **Lines of Command developed**

The CSXVII project HR lines of command are set up according to the CSP organization chart.

### **Supervision**

At field level, supervision starts with visits from the AD. These visits focus on financial and programmatic areas, as well as monitoring the implementation of ADRA Cambodia policies. The AD visited the project once a month, providing some advise to senior project staff as well to the CS team members. If needed, the AD has visited the project more often. PM, AC and MEO observe/supervise field staff at work two or three times a week (some times more often than this). The PA also visits the team members in the field as often as possible. 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 the ADRA International level both the Assistant Director for Health, Becky de Graaff, and Reproductive Health Advisor, Debbie Herold, have shared the backstopping of this project, first Becky being the main backstop and now Debbie. Both Becky and Debbie Herold assisted the project during the DIP, visited the project on monitoring visits in 2003, and are in regular e-mail contact with the project. Becky's visit was during January 2003 while the project needed more technical assistance on the regular monitoring process (LQAS) and observed what program activities had occurred so far. She gave some advise along with the program consultant from ADRA Asia, Satish Pandey.

### **Reporting**

Firstly, the CSP field team collects monthly reports from supervised volunteers (TBAs, VHV chiefs and CCs). On a quarterly basis, all teams have meetings with all VHVs. Most of the TBAs are illiterate women so they give their reports verbally using pictures and cards. The VHVs, all are literate people, so they report all health information using checklists every 4<sup>th</sup> week of the month

Secondly, Field teams (MCH & Nutritionist Officers) compile the data and information obtained from the volunteers and share with HCs partners and the Activities Coordinator (AC) every 27<sup>th</sup> – 30<sup>th</sup> of the month. As well team members submit, monthly and weekly activities schedule. The AC works with the MEO to compile reports from 5 teams and transfers these to Project Manager who reviews and adjusts them as needed. Lastly the PM sends reports to AD and sends copies to the PA, CD and Administrative Assistant in Administration by the 3<sup>rd</sup> of

each month. Quarter reports are summarized by the AC, PM, PA, and AD and sent to ADRA International each quarter. The same team prepares the Annual Report such as this one.

### **Staff turnover**

One staff, a Reproductive Health Officer (RH), worked with ADRA after her graduation from medical school. She is a MoH employee, but was able to work with ADRA during the 23 months while they were in the process of assigning her to a territory. She resigned as of October 10, 2003 because she has been appointed by the MoH to work in the Eastern province, Mondul Kiri. We plan to select new staff from the local field to replace her that already knows the geographical area and deeply understands the human behavior in her/his home district.

## **Communication System and Team Development**

Since there are no phone landlines in Kampong Thmor, both the PA and PM have portable computers and hand phones for communication via e-mail. 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. The project also provides all staff with handheld radios, 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.

### **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. This is encouraged through staff meetings that are held at least once per month, sometimes twice if needed. During the recent selection process for a new Project Advisor, staff were able to join in the process interviewing.

Throughout the life of the project to date, time has been invested in team building and in-group outings. The CCs have also been included, due to their intimate knowledge of village life and behaviors and also to reinforce their integration into the CS team. Early in the second year of the project, the CCs along with representatives from the HC and OD staff joined the CS project staff in the BCC workshop described in Section 1.2 above. This reinforced teamwork among the project staff, CCs and HC & OD staff. Since then the CCs have also participated in the LQAS workshop and other project management trainings and activities.

The project does not only focus on staff and CCs in team building, but also works to ensure that other volunteers, such as TBAs and VHV's are part of the team. A TBAs follow up meeting is held every month at each of the five HCs. Along with the checklists for TBA reports and kits during the meeting, lessons learned are discussed and feedback given. A similar meeting is held monthly with each VHV chief.

The Child Survival Coordinating Committee (CSCC) and Community Representative Feedback Committee (CRFC) meet every two months with the main aim to strengthen the relationships between the project and the local MoH partners to maximize cooperation and synergy. During the meeting the the group discusses the coordination of project activities and deal with any issues raised by any of the meeting participants.

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.

## **PVO in country coordination/collaboration**

### **CS Projects Coordination Workshop**

This CS project has been at the forefront of CS collaboration in Cambodia. Staff not only went to visit other CS projects, soon after project commencement, they also initiated and organized 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. The next three meetings have been coordinated by PFD, WR and CRS focusing on IEC, Behavioral Change, Sustainability of VHVs and the Hearth Program.

### **MEDICAM Monthly Meeting**

ADRA is an active member of MEDICAM, a non-profit, non-partisan membership organization which includes 110 members, both local and international NGOs. The main objectives are 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 it's steering committee. Through this forum, health policy issues can be raised and presented with a strong representative 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. More specifically, this project's innovative experiences with the Child Friendly Village (CFV) initiative, hearth, birth preparedness cards and monitoring tools for low-literate village-based volunteers are to be shared with other PVOs, again through presentation in Medicam and other conferences.

## **District Technical Health meeting**

Early every month, the OD director invites representatives of NGOs that work in health sector to join the meeting with OD, HC chiefs, other department's chief such as EPI, Malaria, TB, STD& HIV/AIDS, and etc. The purpose of this meeting is to strengthen collaboration, share current issues faced, broadcast circulars from the MoH or PHD and solve problems encountered.

## **Relevant Management System**

The Project Management Committee (PMC) has met as needed throughout the project year. The first provincial joint PMC meeting was established with the separate match home gardening project in July 2003 and has been conducted 3 times already. Although the PMC members had no previous experience with a joint PMC and the learning curve was expected to be steep, this has not had a negative effect on the Project management. 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 organizational capacity.

ADRA Cambodia has established a Programs Committee (ProCom) where all project management and advisory staff meet tri-annual to share project management strategies, successful development experiences and discuss & solve administrative issues. (See Appendix E)

## **Organizational Capacity Assessment**

The Country Director (CD) and Associate Country Director (AD) have provided support and supervision to Project Management throughout the current project year. While no formal organizational capacity assessment has been conducted, an ongoing informal assessment was carried out throughout LOP.

Through formal and informal feedback on the monthly Project and Management reports, communication via email, phone and face to face meetings the CD/AD were able to assess and provide feedback on the organizational capacity of the Project management.

Financial monitoring required by ADRA International's A-133 audit occurred during October 2003. The report will be prepared later in 2003.

## F- Health Programs Work plan

Program Component	Work plan Activity	Performance Indicator	Timeline				Person Responsible
			Qtr 1 2003	Qtr 2 2004	Qtr 3 2004	Qtr 4 2004	
Maternal & Newborn care, Birth Spacing Nutrition and Immunization	HC Assessment for new 5 HCs	HC Assessment & report completed	X				OD, MEO, & HC coordinator
Nutrition	Hearth training (CC and HC chief)	Training Completed	X				PA, PM, AC and CBFS staff
Nutrition	Conduct Hearth Program at 10 Child Friendly Villages	Hearth Program completed	X	X	X		PA, PM, AC, CC and CBFS staff
Sustainability	HC Management committee Training	5 committees are trained	X				HC Coordinator and MEO
Maternal & Newborn Care, Nutrition, birth spacing, Immunization	Child Friendly Village (CFV) Selection and organize it committee	CFV committees established and local activities implemented.	X				The 5 teams, HC partners and local authorities

Program Component	Work plan Activity	Performance Indicator	Timeline				Person Responsible
			Qtr 1 2003	Qtr 2 2004	Qtr 3 2004	Qtr 4 2004	
Maternal & Newborn care, Birth Spacing Nutrition and Immunization	HC Assessment for new 5 HCs	HC Assessment & report completed	X				OD, MEO, & HC coordinator
Maternal & New born care, Birth spacing Immunization and Nutrition	Recruit TBA and VHV	TBA and VHV are selected	X				PA, PM, AC, the 5 teams, HC partners
Maternal & New born care, Birth spacing, immunization and Nutrition	CFVC Training	All CFVC are trained		X			PA, PM, AC and 5CS teams

Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	CFV assessment	10 CFVs are assessed by using questions related to the CFV criteria		X			PM, PA, AC, MEO and 5 teams
Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	HC Staff and CS staff VHV and TBA Refresher training	10 HC staff and CS staff attend the training		X			OD, PHD, AC and some CS staff
Maternal & Newborn care	HC Midwives training 1	HC mid wives of 5 new HC attend the MPA module12 (ANC &PNC)		X			PM, AC, OD, and PHD

Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	VHV Training1	Training completed		X			PA, PM, AC and the 5 teams
Nutrition	Hearth training Phase I (CC and HC chief)	Training completed			X		PA, PM, AC and CBFS staff
Nutrition	Conduct HP in CFVs of HC catchments area Phase II	Hearth Program completed				X	PA, PM, AC, CC and CS staff
Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	TBA Training1	Training completed		X			PA, PM, AC and the 5 teams
Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	Mid Term Evaluation	Survey and report completed		X			PA, PM, AC, M&E officer and the 5 teams
Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	LQAS Survey 2 for 5 HC in Phase I	Survey and report completed			X		PA, PM, AC, M&E officer and the 5 teams
Maternal & Newborn care	HC Midwives Assessment	Completed assessing and report			X		PM, AC, OD, M&E officer and HC Coordinator
Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	VHV Training 2	Training completed			X	X	PA, PM, AC and the 5 teams

Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	LQAS Survey 1 for 5 New HC	Survey and report completed			X		PA, PM, AC, M&E officer and the 5 teams
Maternal & Newborn care, Birth Spacing, Immunization and Nutrition	TBA Training 2	Training completed				X	PA, PM, AC and the 5 teams
Maternal & Newborn care	HC Midwives Training 2	HC midwives of 5 new HC attend MPA module11 (Delivery)				X	PM, AC, OD,PHD

## **G - Key issues Results, Success and Plans for scale-up:**

### Research on Colostrum

As part of an Analyzing Development Issues (ADI) training course, the CS project manager did a small research project within the CS target work area. This research took place in early 2003 and was compared with the baseline survey done in December 2001 (KPC). Prior to the research VHV's were trained in the importance of early breastfeeding. Each VHV is responsible for 10-15 households and using the mechanism of family visits the VHV's taught each mother in their area about the importance of early breastfeeding and encouraged them to practice it.

The topic of research was, "The Impact of MCH program, Breastfeeding Section of ADRA KPT CS Project in 4 Muslim Villages." The Objectives of this research were 1) to assess the knowledge of the target women on breastfeeding at 4 villages and 2) to identify the factors/actors that were behind this constraint. Due to the limited time frame, we interviewed only 20 women that have children under 12 months old and had at least 2 children. Two CS team members, 2 CCs, 20 women (5 x 4 villages), 4 VHV's (1 per village), 4 TBAs (1 per village) and 8 VDC members assisted and contributed ideas in this research. The results showed a significant increase in a short period of intervention compared with the Baseline result that correspond with the project's January LQAS improved results in this area as well. Eighteen women (90%) responding to the question about early breastfeeding gave the answer: birth within 1 hour. During the Baseline the result was only 12.7% (but the sample size was 300 Households (30 clusters) in the Baseline

### HC Capacity Building

We have hired a qualified HC chief as the part-time employee to be in charge of organizing, training and monitoring the HCMC and CFV and to co-ordinate with other HC related activities. The HC chief attended a workshop on Developing BCC tools in Kompong Thmor which was facilitated by ADRA. After the workshop the HC chief developed a set of puppet shows regarding the hazards of mosquitoes (malaria and dengue fever). These shows were demonstrated in September 2003 on Volunteer Celebration Days. By using a member of the Ministry of Health part-time, both the project has benefited, through the establishment and training of HCMC and the HC's Chief's input into the Child Friendly Village (CFV) program. In addition, the MOH has been able to gain through the extra capacity building that has been given to the HC Chief, who continues to work for the MoH. This has also helped to strengthen the partnership between the project and the MOH, instead of a project taking away MoH staff to work full-time in the project, thereby depleting, what are often the best, human resources from the MoH.

### Behavior Change Communication Strategy

In December 2002, the project team, including CCs, met to formulate the project's BCC strategy for each intervention. In the first training they have gained basic information and dissemination skills, while the second training had them focus these skills and also cover new

areas not trained in the first course. 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 more realistic BCC strategy was formed based on a thorough understanding of local behaviors. The team put this strategy to use in dealing with the areas that had shown a low response on the first LQAS report. This demonstrates how the team had developed, not just in technical understanding of two different project tools, but in how to use each tool to complement the other and so help to improve the potential for meeting project targets. As was mentioned above, ADRA facilitated BCC workshop which was not only for ADRA staff, but also was attended by staff from two other US funded CS projects in Cambodia. Since the workshop, ADRA has been requested to translate the workshop and has developed a BCC trainer manual in the local language.

### Child Friendly Village Committee Training (CFVC)

Following completion of the VHV Phase 1 training the CS staff, with the assistance of the CC's, set up criteria and chooses potential villages for the Child Friendly Village program. The CFV program aims at increasing village participation in the various project interventions and could become a model for the future. In May, 2003, the CFVC selection and subsequent committee training was held at appropriate local sites, such as a school, pagoda, CC's house and the CS office. Each CFVC is composed of one village chief, a HC chief, one HC midwife, one CC, one school teacher, a representative of women association, one VHV chief, and one or two key informant people. These committees have agreed to set up certain interventions to improve the health status of WRA and children less than 2 years. After VHVs received basic training, ADRA also conducted monthly growth monitoring for children up to 24 months, recorded results on the master plan by the in-charge and the results will be discussed with the CFVCs at the next regularly scheduled bi-monthly meeting.

### Child Survival Projects Collaboration

This CS project has been at the forefront of CS collaboration in Cambodia. Staff not only went to visit other CS projects, soon after project commencement, they also initiated and organized 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. The next three meetings have been coordinated by PFD, WR and CRS focusing on IEC, Behavioral Change, Sustainability of VHVs and the Hearth Program. This collaboration is being reinforced by cross trainings, such as the Hearth training that PFD is doing for ADRA and other US funded CS projects in Cambodia in September 2003.

**Appendix A**

**1<sup>st</sup> LQAS Survey**

**January 2003**

**ADRA CAMBODIA**

**CHILD SURVIVALXVII**

**BARAY-SANTUK OPERATIONAL DISTRICT  
KAMPONG THOM PROVINCE/CAMBODIA**

**Prepared by  
Sin Samai Monitoring/Evaluation Officer  
Meas Pheng Project Director**

## ACRONYMS

ADRA	Adventist Development and Relief Agency International
CBD	Community-based Distribution
CPR	Contraceptive Prevalence Rate
CSTS	Child Survival Technical Support
HCC	Health Center Chief
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
LQAS	Lot Quality Assurance Sampling
M&EO	Monitoring and Evaluation Officer
NGO	Non-Governmental Organization
PVO	Private Voluntary Organization
SA	Supervision Area
STI	Sexually transmitted infection
TA	Technical Assistance
TTV	Tetanus toxoid vaccination
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## ACKNOWLEDGEMENTS

This report is the culmination of the hard work of many people who the Baray-Santuk CS project wants to thank. Becky de Graaff, ADRA International Assistant Director for Health; Ann Marie Stickle, Associate Country Director; and Satish Pandey, a consultant from ADRA Asia who reviewed some parts of the LQAS processes and instructed the overall supervision area supervisors and other senior staff how to tabulate (data entry by hand tabulation sheets).

Dr. Meas Pheng, Child Survival Project Manager, who directly organized and supervised data collection in the field and also ensured the smooth implementation of the activity.

Mrs. Huth Sokleang, Activity Coordinator, who perfectly facilitated the whole training and provided technical assistance.

Baray-Santuk CS project would like to take this opportunity to thank all those (supervision area supervisors and commune coordinators and HCC) who made this report possible before compilation. Your work and feedback have greatly contributed to this in the discussion. Your patience, understanding, and dedication have made working with you a great pleasure. We hope you all take well-deserved satisfaction. Also Baray-Santuk Operational district MCH director who have a great active participation in the training and recognition

## I. BACKGROUND

### A. Introduction

This document reports the results from the first LQAS survey of five health center supervision areas of the Baray district supported by the ADRA Child Survival XVII Project in Phase I. The activities were organized as two separate implementations. Balaing and Boeung health center supervision areas were implemented first, the remaining three HC Supervision Areas (SAs) were implemented second. The supervision area supervisors and interviewers were rotated from their own respective supervision area.

### B. Project description

The Child Survival XVII project is located in Kampong Thom Province, approximately 140 kilometers northeast of the capital city, Phnom Penh. The project is implemented in Baray-Santuk Operational District (BSOB), where ADRA has an established presence. This target area was selected based upon the identification of local needs.

The Child Survival XVII project carries out activities in ten HC supervision areas. In Phase I of the project, the project worked only in five HCs of the 10 supervision areas of the project's catchments area in Baray district. Each team organized its respective supervision area (SA) follow LQAS guidelines. This survey covered five supervision area, seven communes and 63 villages. Table 1 below lists the supervision areas where the survey took place.

Table 1. Target Population Groups and Catchments Areas

NO	Target group	Supervision Area
1	<input type="checkbox"/> Non-pregnant women age (15-49 years) 19 individuals <input type="checkbox"/> Mothers with children age 0-11 months 19 individuals <input type="checkbox"/> Mothers with children age 12-23 months 19 individuals The total <b>57 respondents</b> .	<input type="checkbox"/> Balaing health center supervision area 12 villages were interviewed
2	<input type="checkbox"/> Men and women of reproductive age (15-49 years) 19 individuals <input type="checkbox"/> Mothers with children age 0-11 months 19 individuals <input type="checkbox"/> Mothers with children age 12-23 months 19 individuals The total <b>57 respondents</b> .	<input type="checkbox"/> Boeung health center supervision area 5 villages were interviewed
3	<input type="checkbox"/> Men and women of reproductive age (15-49 years) 19 individuals <input type="checkbox"/> Mothers with children age 0-11 months 19 individuals <input type="checkbox"/> Mothers with children age 12-23 months 19 individuals The total <b>57 respondents</b> .	<input type="checkbox"/> Kreul health center supervision area villages were interviewed
4	<input type="checkbox"/> Men and women of reproductive age (15-49 years) 19 individuals <input type="checkbox"/> Mothers with children age 0-11 months 19 individuals <input type="checkbox"/> Mothers with children age 12-23 months 19 individuals The total <b>57 respondents</b> .	<input type="checkbox"/> Protong health center supervision area villages were interviewed
5	<input type="checkbox"/> Men and women of reproductive age (15-49 years) 19 individuals	<input type="checkbox"/> Tang Kork health center supervision area 13 villages

	<input type="checkbox"/> Mothers with children age 0-11 months 19 individuals <input type="checkbox"/> Mothers with children age 12-23 months 19 individuals The total <b>57 respondents</b> .	were interviewed
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**C. Project Establishment**

The ADRA Cambodia Child Survival XVII project is sponsored by the United State Agency for International Development (USAID). The project period is five years beginning October 2001.

**D. Catchment Area**

Adventist Development and Relief Agency (ADRA) Cambodia implements Child Survival Project (CSP) activities in ten Health Center Supervision Areas (HCSAs) of 19 in the administrative district of Baray-Santuk of Kampong Thom province. These ten HCSAs are located in Baray-Santuk, Kampong Thom Province, approximately 140 kilometers northeast of the capital city, Phnom Penh.

**E. Project Goal and objectives**

**General Objective**

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

**Specific objectives**

- Reduce maternal deaths by providing pre-/post-natal care and appropriate delivery practices.
- Reduce neonatal deaths through appropriate postpartum and neonatal care.
- Reduce maternal deaths by improving access to emergency obstetric care.
- Raise awareness about the deadliness and prevention of HIV/AIDS.
- 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.
- 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 years of age.
- Families are experiencing improved household food security through home gardening.
- Improved immunization coverage for children <2 years of age.
- Improved maternal TT vaccination coverage for the prevention of tetanus.

**F. Purpose of LQAS Survey**

- To measure the changes of women’s knowledge, attitudes, and practices related to the project’s indicators for the program area
- To know how much improvement has been made in the different health center supervision area
- To establish baseline data for HIV/AIDS related men respondent indicators

## **G. Survey Schedule**

On January 27-28, 2003 the CS Project Advisor (PA), Project Manager (PM) and senior staff with Becky de Graaff, ADRA International Assistant for Health (AH), Ann Marie Stickle, ADRA Associate Country Director (AD), and Satish Pandey, ADRA Asia Consultant (AAC) discussed through the project's indicators and determined what information was needed for the LQAS survey.

On the following day late in the morning, the Monitoring and Evaluation Officer (MEO) discussed with the AAC how to improve the survey instruments and monitoring plan. Next the draft questionnaires were verified and revised both in Khmer and English. Also the MEO developed both the tabulation table and summary results table for each supervision areas. The AAC reviewed the survey training technique and etiquette with the CSP staff and Commune Coordinators (CCs) while the MEO was doing all the above.

By noon time, the survey instruments were done, and were discussed and revised again with the CSP field staff and CCs again. Around 3pm all the group assignments were given to the teams for different villages which were situated in nearby towns to find out the intended target group for pre-test. After they were all back from the field, feedback was given between the survey teams, MEO and AAC. The feedback focused on estimate data collection requirements such as amount of time, sequence of question and others.

On the next day, January 30<sup>th</sup>, 2003 the data collection was carried out in only three supervision areas, because the AAC required the raw data to train the team how to tabulate the fields. And the following day on Jan 31<sup>st</sup>, 03 the AAC and MOE trained all the field staff and CCs in the techniques of how to do useful manual tabulation during the morning. For the next activities the team conducted the data collection for one more day on Feb 03<sup>rd</sup>, 2003 to finish the two remaining supervision areas. They did the hand tabulation on their own during the third day of the first week of February 2003.

## **II. METHODS**

### **A. Questionnaire Development**

At first, the CS team determined which indicators for each intervention should be used for question construction, and then decided which specify population the project wanted to study. The MEO facilitated this activity and was assisted by the PM and PA.

Secondly, the questionnaires were revised with CSP field staff, HCMs, HC chiefs, MCH program officer and OD director in the LQAS training. Therefore, the draft questionnaires were prepared before the AAC arrived in-country.

At last, the acceptable questionnaires were revised by the previous participants and assisted by the AAC. The five health center chiefs were absent, as they attended the malaria national training at the provincial health department. There were many key people involved with this questionnaire development and they seriously provided a great comment for the pre-implementation, carrying out and post-implementation. Those people were CS PM, PM, AD, and AH.

Firstly the questionnaires were developed in English and then translated into Khmer by the MEO, a native Khmer speaker. Next, the Child Survival Team verified the questionnaires on January 5<sup>th</sup>. 2003 during the review training. The questionnaires were then pre-tested with the intended target group and also revised

after field testing. The questionnaires were divided into three types with various modules. These are shown in the paragraphs below.

Three types of survey instruments were developed. The first was for men and non-pregnant women age 15-49 years, this consist of 4 modules as respondent's background, Immunization, Birth spacing knowledge and use, and HIV/AIDS.

The second questionnaire was for mothers with children 0-11 months. This questionnaire has 4 modules; they are the respondent's background, nutrition, birth spacing, and prenatal/delivery care. The last questionnaire was mothers with children 12-23 months; this contains four modules as well, the respondent's background, nutrition, TT vaccination, and birth spacing and use.

More detailed

**Table1. Types of Respondents and Questionnaire Modules Included in the Survey**

Questionnaire module	Type of Respondent		
	<i>Women (non-pregnant) and Men Age 15-49 years</i>	<i>Mothers with children 0-11 months</i>	<i>Mothers with children 12-23 months</i>
Background	X	X	X
Nutrition		X	X
Immunization	X		X
Birth Spacing	X	X	X
Prenatal/Delivery Care		X	
HIV/AIDS	X		

### **B. Training of Survey**

The MEO worked together with the training activity coordinator on the training for ten field officers and ten CC, five HC chiefs and an OD MCH chief. During this training the participants were divided into ten teams with each team consisted of 2 persons. One person was a moderator and another was a note taker. At the same time the CS field officers were selected to change their supervision areas except CCs. Therefore, the CCs guided the CS field officers, for they did not know the geographical supervision area of the others very well. This training was carried out in response to the technical assistance needs of the project staff and relevant stakeholders.

### **C. Data Collection**

The existing map of each village, which was drawn by the CSP staff and key persons in communities (teachers, village leader, and the old popular people) for appointing VHVs's household responsibility, was used to select the households. These maps were divided into the sections depend upon the number of VHVs. Each section of VHV's responsibility is 35-50 households on average. The number of VHVs varies according to how big the village is. At first the interviewer wrote VHVs' names on the small piece of papers, put them into a cap and then randomly selected a section of sections. So a VHV section that the interviewer picked was used for the first interview. After that an interviewer wrote the number of each household on the small piece of paper, and then put them all into a cap again. An interviewer just took one out; this number in paper was the first starting point for household selection. If the respondent resides

in the first house, she/he was interviewed. If not, the interviewers went to the next door (next nearest) and continued this process until they find all informants that they are looking for.

#### D. Tabulation

Firstly five supervision area teams collected data from three supervision areas (Balaing, Boeung, and Kruel). This took a one-day period to collect the 36 sets of data in these supervision areas. Following data collection, tabulation was held to train supervisors and commune coordinators on how to hand tabulate results using tabulation sheets. Supervisors tabulated data by hand for several key variables; this was supervised by the MEO and assisted by the AAC. The MEO and supervision area supervisors made decisions of each supervision area and calculated the overall coverage estimate for each supervision area. The tabulation lasted half a day, on February 7<sup>th</sup> 2003 for three supervision areas. Two days later, the five teams finished interviews in the two remaining supervision areas (Protong and Tang Kork) during one day and tabulation the following day.

### III. RESULTS OF FINDINGS

This section includes results of responses to questions asked of three different types of respondents: Men and non-pregnant women (15-49 years of age), Mothers with children age 0-11 months and Mother with children age 12-23 months). This report presents data on health behaviors and knowledge within the entire program area and supervision area.

#### A. Demographic Characteristics

This section presents basic demographic information about women and men including marital status, educational level, literacy, and religious affiliation. In addition, youth were asked about their sources of income.

#### B. Non-pregnant Women and Men Age 15-49 years

##### 1. Women received Tetanus Toxoid

\* Red star means project's indicator

Denominator 95

Received TT	Numerator	Percent
Women who have TT vaccination card	60	63.2
* Mothers who have at least two TT vaccinations	49	51.2

This project indicator is 9-40% of the mothers with children age 0-23 months received at least two TT injections before delivery. At the time of this LQAS survey, the average coverage of women who received at least two TT vaccinations was 51.2% among 63.2% who had cards. This figure was from the TT cards of the 95 women surveyed. The coverage target for this indicator is defined as 20%, so it was 32% higher than the coverage target. When the supervision areas were broken down into the respective supervision area the result seems to be completely different between two and three supervision areas. Boeung and Kreul failed to achieve the average coverage decision rule (ACDR) and Balaing, Tang Kork, and Protong met their achievements. But none failed the coverage target.

## 2. Birth Spacing Knowledge and Use

Indicators	Numerator	Denominator	Percent
*WRA knew three modern birth of birth spacing	29	94	30.9
WRA desire no children in the next 2 years	62	95	65.3
*WRA who want to avoid pregnancy, who use BSM	52	84	61.9
*Women received birth spacing method counseling	41	95	43.2

Of the women aged 15-49 years who were asked on knowledge of modern birth spacing, 30.9% (29/94) respondents responded to the correct question. It was slightly higher than the coverage target was set up at 20%. Balaing supervision area was not able to achieve its own expectation. The team has now identified it as a first priority supervision area that now will receive extra effort, because it did not meet the average coverage either the coverage target decision rule. (Please see summary tabulation table regular monitoring: Non-pregnant women age 15-49 years)

Most of the mothers, 61.9% (52/84), are using modern birth spacing methods to delay their pregnancies. The coverage target was 35%, so the result was a gain nearly over half of the coverage target for this indicator. It was almost equal to 65.3% of women who desire no children in the next 2 years. Two of the health center supervision areas (HCSA) did not reach the average coverage decision rule. Both HCSAs are now identified as second priority. In spite of this, there are many women now using birth spacing methods, but only 45% received the birth spacing counseling. So 20% of women among women are using birth spacing methods did not receive birth spacing method counseling. For this indicator all HCSAs were successful.

## 3. Knowledge of HIV/AIDS

### 3.1. Female

Indicator	Numerator	Denominator	Percent
Women have ever heard of AIDS	89	95	93.7
*WRA with children < 2 years who knew at least two ways that HIV/AIDS is spread	50	95	52.6

Mothers provided verbal reports that 93.7% (89/95) heard of HIV/AIDS and 52.6% (50/95) knew at least two ways of HIV/AIDS is spread. This result overachieved the coverage target was defined 20% for the first LOAS. But the Balaing HCSA failed to achieve the average coverage decision rule, the Balaing HC supervision area. A reason why the average is so high is that the villagers are gradually learning every day and also are giving up their bad behavior. They have seen people living with HIV/AIDS, they have heard of HIV/AIDS from the education campaign of the provincial health department which uses question and answers during dancing at dusk, and Radio or TV shows sponsored by PSI.

### 3.2. Male

Indicator	Numerator	Denominator	Percent
Men have ever heard of AIDS	88	95	92.6
*Men age 15-65 who knew at least two ways that HIV/AIDS is spread	54	95	56.8

Most of the female respondents 92.6% (88/95) have heard of HIV/AIDS, but among the men who knew, only 56.8% knew at least two ways that HIV/AIDS is spread. The percentage difference between female and male knowledge was not very different, the female percentage was only slightly lower than men. Because, men are always out of community, they received more interpersonal communication either mass communication, whereas most of the women do not have much freedom to go out and also usually have lower education. HIV/AIDS education rarely reaches remote rural areas. The coverage target for the men indicator was set up at 20% as same as women. The one supervision area that did not overcome the average coverage decision rule was Balaing HC supervision area again.

### C. Mothers with Children Age 0-11 months

#### 1. Breastfeeding

Indicator	Numerator	Denominator	Percent
Mothers have breastfed to their children	92	95	96.8
*Mothers who initiate breastfeeding with colostrums within the first hour after delivery	27	95	28.4
Children were not given food or liquid in the last 24 hours	35	72	48.6

When the survey was conducted, most of the mothers said that they have ever breastfed their children 96.8% (92/95) except 3.2% (3/95) never breastfed their children. The percent of mothers who have ever breastfed is higher than those who have never breastfed. Exactly 28.4% (27/95) of mothers who put their children to the breast within the first hour after delivery and 48% (35/73) were exclusively breastfed within the last 24 hours of data collection took place. The coverage target was 20%, so this result almost achieves the project's indicator, except for the Kreul HCSA. This HCSA is now identified as a second priority HCSA, because it did not reach the average coverage decision rule. The percent of children who were not given food or liquid in the last 24 hours was 48.6% (35/72). However, this result was acceptable, but three HCSAs were under the average coverage decision rule, so they are not identified as second priority HCSA.

There are many poor families in communities and they have been so very busy from daytime to night. This, according to their seasonal activities, such as dry season men collect palm juice and women collected fire-wood, rainy season spouse were at the rice field for whole day worked in their owns or other rice field for income generation, the benefit that they got 3000 or 3500 riels per day. Permanently they can afford their living only day to day. They left their babies with mothers or elder daughters. Another thing, mothers still not understand clearly how important of breast-milk at age 0-5 months.

## 2. Food or liquid given during illness

Indicator	Numerator	Denominator	Percent
*Mothers continue breastfeeding the same or more than usual during illness	58	68	85.3
*Mothers continue giving water the same or more than usual to drink during illness	32	39	82.1
*Mothers continue giving food the same or more than usual to eat during illness	26	39	66.7

Most mothers reported that they breastfed their babies during illness 85.3% (58/68), gave water 82.1% (32/39), and gave food 66.7% (26/39), this figure were very high from the project's indicator and coverage target either. Even though these results quite high different, but all the HCSA failed to reach the average coverage decision rule, so they are all now identified as second priority. Normally the mothers always breastfed and gave water even healthy or illness. But when the children were sick the mothers gave less food, for that they thought the food caused more illness.

## 3. Weight at birth, Iron and Vitamin-A distribution

Indicator	Numerator	Denominator	Percent
*Babies weighed at birth within 24 hours after delivery	58	95	61.1
*Pregnant women who receive iron tablets	54	95	56.8
*Mothers received vitamin-A dose in the first two months after delivery	41	95	43.2

### 3.1. Weight at birth

61.1% (58/95) weighed at birth. This result was very suddenly increased; for the project distributed the TBAs the babies scale before conducting LQAS survey. Only the Kreul HCSA did not meet the ACDR.

### 3.2. Iron for pregnancy

Of the 95 mothers interviewed, 56.8% (54/95) received iron tablets during their pregnancies with last child. They received the tablets from an immunization outreach site and VHVs, mothers said. The Protong HCSA failed to achieve the ACDR.

### 3.3. Vitamin-A for lactating mother

Of the mothers who were asked, 43.2% (41/95) received a vitamin-A capsule in the first two months after delivery. Almost all supervision areas met their achievement except the Boeung HC with average coverage DR.

#### 4. Prenatal/Delivery Care

Indicator	Numerator	Denominator	Percent
Pregnant women received prenatal care while were pregnant	54	94	57.4
*Pregnant women who received prenatal care at least two times	40	95	42.1
*Pregnant women were delivered by TBAs through clean birth kit	81	95	85.3

Of the mothers asked, 57.4% (54/94) reported that they received prenatal care check up during their pregnancy. And also there were pregnant women who received at least two prenatal cares during their pregnancies by HCMs was 42.1% (40/95). Therefore, 15.3% of women received less than two checks up. This indicator, two SAs were not able to meet their average coverage DR. Those SAs were Boeung and Tang Kork. Even though, most of the mothers went to the HC to receive prenatal visits. But the result showed that less of women delivered with HCMs. Some of the reasons why did they have not receive prenatal visits and afterwards why they did not come to deliver are that they faced difficulties such as poor care, no guard at night, higher costs than TBAs, difficulties in travel or in a place to stay, etc. So, there were 27.9% out of 85.3% delivered by TBAs with clean birth kits, and no prenatal visits.

#### 5. Birth Spacing Uses

Indicator	Numerator	Denominator	Percent
Women started using birth spacing method after birth.	23	85	27.1
*Women started using birth spacing method within the first three months after delivery	10	83	12.1

Percent of women who were interested in using birth spacing method after delivery was 27.1% (23/85) and whereas, 12.1% (10/83) was the women who started using birth spacing method within the first three months after delivery among women are using birth spacing method. The result indicated that, 15% it was a bit over half of percent that used birth spacing method after three months. This figure, it was broken down into the individual supervision area. It showed that, Kreul and Tang Kork were inclined to their achievement, for that is why they couldn't reach the average coverage either coverage target DR. The average coverage was not applicable. It was very low, so it could not use in assessment for an HCSA.

### D. Mothers with Children Age 12-23 months

#### 1. Continued breastfeeding

Indicator	Numerator	Denominator	Percent
Mothers have breastfed to their children	78	95	82.1
The children experienced with disease in the last two weeks	79	95	83.1

For mothers that have breastfed their children at age 12-23 months the figure was 82.1% (78/95), fewer than 14.7% of age 0-11 months. And they experienced with disease in the last two weeks 83.1% (79/95). So it showed that, it was a large difference.

## 2. Food or liquid given during illness

Indicator	Numerator	Denominator	Percent
*Mothers continue breastfeeding the same or more than usual	65	79	82.3
*Mothers continue giving water the same or more than usual to drink	71	79	89.9
*Mothers continue giving water the same or more than usual to eat	48	79	60.8

The percent of mothers continue giving food or liquid to their children during illness, was above in table 2. If compare to table 2 of children age 0-11 months, and children age 12-23 months. There were not a large difference.

## 3. Vitamin-A distribution

Indicator	Numerator	Denominator	Percent
*Children received vitamin-A at least one capsule in the last 6 months	71	94	75.5

Mothers were asked about vitamin-A distribution every 6 months of national campaign for children. The vitamin A coverage was 75.5% (71/94). It was quite high coverage for the catchment area. The Balaing HCSA did not meet ACDR.

## 4. Immunization

Indicator	Numerator	Denominator	Percent
Children have had vaccination cards	66	95	69.5
*Completed immunization	45	95	47.4

Of mothers who directly reported that they have had their children's vaccination card the coverage percentage was 69.5% (66/95). So, 47.4% (45/95) of children did not complete vaccination at age 12-23 months. 22.1% of children who have had cards still not did complete vaccination. Boeung HCSA was not able to overcome its ACDR. It has been identified as second priority for this indicator. Informal individual discussion conducted HC chiefs and villagers conveyed that mothers feel scared that their children can received high fever and poliomyelitis from vaccines. Also mothers missed vaccinations because of poor schedules.

## 5. Birth Spacing Knowledge and Use

Indicator	Numerator	Denominator	Percent
Women desire no children in the next 2 years	75	95	79
* Women who currently want to delay or avoid pregnancy, who use BS method	43	75	57.3

Women were asked on use of modern birth spacing. 57.3% (43/75) of respondents directly answered to the correct question who are using birth spacing to delay or avoid pregnancy among 79% (75/95) women who desired no children in the next 2 years. Therefore, 21.7% women who desired no children were unable to use birth spacing. Even so, the result indicated a large increase; but the Balaing and Protong HCSA failed into achieve the ACDR. For this indicator both HCSA are not identified as second priority HCSAs and need special assistance. They did not meet the average coverage, they passed only the coverage target.

#### IV. CONCLUSION AND RECOMMENDATION

Mothers were always less interested in taking care of their cards and children's. This was an obstacle which led some of supervision areas fall short of the indicator. So the manager and SA supervisors should find the way to solve this with the team work. (OD, HC, CS staff, CC, VHVs, and TBAs etc)

Balaing supervision area had an existing CBD structure. The figure for this, very extremely low no one could answer to the correct response on what birth spacing do you know. Therefore the SA supervisors should identify the root causes of this priority problem through non-structured interviews.

The accomplished indicators showed that, for the whole program area was 58.4% and 41.6% which failed into indicators. The result indicators 41.6% indicate that related health services should be improved.

The questions and pre-codes should be improved before starting the 2<sup>nd</sup> LQAS

#### V. APPENDICES

##### Appendix A: Survey team Assignment

###### 1. Overall Supervisor

Mr. Geoffery James Bowman, CS Project Advisor

###### 2. Survey trainer or Facilitator:

Mr. Sin Samai, Monitoring/Evaluation Officer

###### 3. Supervisors

Dr. Meas Pheng, Project manager

Mrs. Huth Sokleang, Activity Coordinator

###### 4. Interviewers and Note taker (CS staff are Interviewers)

##### Balaing HC supervision Area

<u>No</u>	<u>Name</u>	<u>Sex</u>	<u>Position</u>
1.	Leng Ponlok	M	Nutrition Officer
2.	Sieng Nara	F	R H Officer
3.	Chuy Chim	F	Commune Coordinator
4.	Heng Kimhouth	F	Commune Coordinator

**Boeung HC supervision Area**

5. Hing Sarann	F	R H Officer
6. Sor Chheng	F	Nutrition Officer
7. Om SomOoeurn	F	Commune Coordinator
8. Moun Ra	F	Commune Coordinator

**Kruel HC supervision Area**

9. Hang Sroeur	M	Nutrition Officer
10. Sun Ny	F	R H Officer
11. Huang Kunthear	F	Commune Coordinator
12. Noun Bopha	F	Commune Coordinator

**Tang Kork HC supervision Area**

13. Mom Pachika	F	R H Officer
14. Orn Sothea	F	Nutrition Officer
15. Hor Sokuntheary	F	Commune Coordinator
16. Ven Sopheap	F	Commune Coordinator

**Protong HC supervision Area**

17. Yun monyroth	F	Nutrition Officer
18. Khun Poch	F	R H Officer
19. Om Phallyn	F	Commune Coordinator
20. Pen Dany	F	Commune Coordinator

**Appendix B: Questionnaires (English Version)**

B1. Married Non-pregnant women

**Child Survival Project XVII  
Baray-Santuk Operational District  
LQAS Survey**

SA \_\_\_\_\_

*Questionnaires for Married Non-pregnant women*

<b>éƒŋsmÖas</b>	Interview date _____/_____/_____
<b>mNÐlsuxPaB</b>	HC _____
<b>PUmi</b>	Village _____
<b>XuM</b>	Commune _____
<b>Rsuk</b>	District _____
<b>eQµa³GñkeFVlsmÖas</b>	Interviewer's name _____
<b>eQµa³GñkRtYtBinitü</b>	Supervisor's name _____























**Appendix C: Results Tabulation Table for Supervision Area**

C 1: Female and Male age 15-49 years

Result Tabulation Table for a Supervision Area: Baseline Survey and Regular Monitoring																					
Females 15 – 49 Years																					
Supervision Area: _____														Supervisor: _____				Date: _____			
CORRECT = 1			INCORRECT = 0					SKIPPED = S					MISSING = X					Total Correct in SA	Total Sample Size (all '0's and '1's)		
#	Indicator	Correct Response Key	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15			16	17
<b>Section2: Immunization</b>																					
4	Do you have TT Vaccination card?	1 (if 2, Q 5 automatic incorrect)																			
5	Women with more than 2 TT Vaccination according to the TT vaccination card.	1 if 2 or more TT recorded																			
<b>Section 3: Birth Spacing Knowledge and Use</b>																					
6	What spacing methods do you know?	At least 3 answers reported from 1-6																			
7	Do you want another	2																			







10	(Only for child 6-11) When (name) was sick, did you offer less, the same amount or more than usual to eat?	2, 3 (S if child age 0-5 months)																		
11	Was (Name) weighed at birth within 24 hours after delivery	1																		
12	When you were pregnant with (Name), did you receive or buy any iron tablets or syrup?	1																		
13	In the first two months after delivery, did you receive a vitamin-A dose?	1																		
<b>Section 3: Prenatal/Delivery Care</b>																				
14	Did you see anyone for prenatal care while you were pregnant with (Name)?	1 or 2 (if 3,4,5 Q15 automatic incorrect)																		

15	How many times did you see someone for prenatal care during the pregnancy?	2 Times or more= 1																		
16	Was a birth kit used during delivery of the child (name)?	1																		
<b>Section 4: Birth Spacing Use</b>																				
17	(>6 wks children) After birth of (Name) did you start using this birth spacing method?	1(if 2, Q18 automatic incorrect)																		
18	When did you start?	<3 months=1																		

**C3. Mothers with Children Age 12-23 years**

<b>Result Tabulation Table for a Supervision Area: Baseline Survey and Regular Monitoring Children 12 – 23 Months</b>			
Supervision Area: _____		Supervisor: _____	
Date: _____			
<b>CORRECT = 1</b>	<b>INCORRECT = 0</b>	<b>SKIPPED = S</b>	<b>MISSING = X</b>

#	Indicator	Correct Response Key	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Total Correct in SA	Total Sample Size (all '0's and '1's)
<b>Section2: Nutrition</b>																							
4	Are you still breastfeeding?	1																					
5	Did (name) experience any of the following in the past 2 weeks?	Any answer from 1-9 (if 10, Q 6, 7, 8, automatic skip)																					
6	When (name) was sick, did you offer less, the same amount or more than usual breast-milk?	2, 3																					
7	When (name) was sick, did you offer less, the same amount or more than usual to drink?	2, 3																					
8	When (name) was sick, did you offer less, the same amount or more than usual to eat?	2, 3																					





Vaccination according to the TT vaccination card.	8	1	8	1	8	1	8	1	8	1									
<b>ection 3: Birth Spacing Knowledge and Use</b>																			
What spacing methods do you know?	0		7		9		8		5		29	19	1	1	1	1	94	30.9%)	20%
	4	1	4	1	4	1	4	1	4	1									
Do you want another child in the next 2 years?	14		16		14		16		2		62	19	1	1	1	1	95	65.3%	25%
	11	2	11	2	11	2	11	2	11	2									
Which of the following birth spacing methods are you using to delay or avoid pregnancy?	9		13		11		10		9		52	14	1	1	1	1	84	61.9%	35%
	10	4	10	4	10	4	10	4	10	4									
	10		14		9		10		7										

Did you receive birth spacing method counseling?	6	4	6	4	6	4	6	4	6	4	6	4	41	19	1	1	1	1	9	9	9	9	95	43.2%	35%
--	---	---	---	---	---	---	---	---	---	---	---	---	----	----	---	---	---	---	---	---	---	---	----	-------	-----

**Section 4: HIV AIDS**

0	Have you ever heard of AIDS?	17		18		18		18		18		89	19	1	1	1	1	9	9	9	9	95	93.7%	
		16		16		16		16		16														
1	How is HIV AIDS prevented?	5		12		10		11		12		50	19	1	1	1	1	9	9	9	9	95	52.6%	20%
		8	1	8	1	8	1	8	1	8	1													

**QUESTIONNAIRE FOR MEN Section 4: HIV AIDS**

Indicator	Total Correct In each SA/Decision Rule										Total Correct in Program	Sample Size				Total sample Size in Program	Average Coverage = $\frac{\text{Total Correct}}{\text{Sample Size}}$	Coverage Target					
Have you ever heard of AIDS?	17		18		17		18		18		88	19	1	1	1	1	9	9	9	9	95	92.6%	
	16	1	16	1	16	1	16	1	16	1													
How is HIV AIDS prevented?	6		14		9		14		11		54	19	1	1	1	1	9	9	9	9	95	56.8%	20%



foods or liquid in the last 24 hours?	7		7		7		7		7										
Exclusively breastfeeding	1		13		4		3		14		35	18	19	9	8	19	73	47.9%	20%
	7	1	7	1	7	1	7	1	7	1									
Did (name) experience any of the following in the past 2 weeks?	17		15		10		13		14		69	19	19	19	19	19	95	72.6%	
	1	2	1	2	1	2	1	2	1	2									
When (name) was sick, did you offer less, the same amount or more than usual breast-milk?	14		13		8		11		12		58	17	14	10	13	14	68	85.3%	20%
	1	5	1	5	1	5	1	5	1	5									
When (name) was sick, did you offer less, the same amount or more than usual to drink?	10		3		4		8		7		32	11	4	6	10	8	39	82%	20%
	1	4	1	4	1	4	1	4	1	4									

When (name) was sick, did you offer less, the same amount or more than usual to eat?	9		3		4		6		4		26	11	4	6	10	8	39	66.6%	20%
	1 1	1																	
Was (Name) weighed- at birth within 24 hours after delivery	12		15		7		14		10		58	19	19	19	19	19	95	61.1%	45%
	1 0	6																	
When you were pregnant with (Name), did you receive or buy any iron tablets or syrup?	16		11		11		7		9		54	19	19	19	19	19	95	56.8%	35%
	9	4	9	4	9	4	9	4	9	4									
In the first two months after delivery, did you receive a vitamin-A dose?	10		5		7		9		10		41	19	19	19	19	19	95	43.2%	20%
	6	1	6	1	6	1	6	1	6	1									
<b>ction 3: Prenatal/Delivery Care</b>																			
Did you see anyone for prenatal care while	18		10		10		7		9		54	19	18	19	19	19	94	57.4%	

prenatal care while you were pregnant with (Name)?	9		9		9		9		9										
How many times did you see someone for prenatal care during the pregnancy?	15		5		8		5		7		40	19	19	19	19	19	95	42.1%	20%
	6	1	6	1	6	1	6	1	6	1									
Was a birth kit used?	17		18		15		15		16		81	19	19	19	19	19	95	85.3%	75%
	1	1	1	1	1	1	1	1	1	1									

**Action 4: Birth Spacing and Use**

(>6 wks children) After birth of (Name) did you start using this birth spacing method?	4		5		6		5		3		23	16	15	19	19	16	85	27.1%	
	3		3		3		3		3										
When did you start?	3		2		1		1		3		10	16	15	17	19	16	83	12%	25%
	N	2	N	2	N	2	N	2	N	2									

**Summary tabulation table: regular monitoring  
Mother with children age 12-23 months**

Indicator	Total Correct In each SA/Decision Rule					Total Correct in Program	Sample Size					Total sample Size in Program	Average Coverage= $\frac{\text{Total Correct}}{\text{Sample Size}}$	Coverage Target						
	1	2	3	4	5		1	2	3	4	5									
<b>Indicator 2: Nutrition</b>																				
Are you breastfeeding now?	12		14		17		17		18		78		19	19	19	19	19	95	82.1%	
	1 4		1 4		1 4		1 4		1 4											
Did (name) experience any of the following in the past 2 weeks?	18		18		13		17		13		79		19	19	19	19	19	95	83.1%	
	1 4		1 4		1 4		1 4		1 4											
When (name was sick, did you offer less, the same	16		13		9		15		12		65		18	18	13	17	13	79	82.3%	20%

less, the same amount or more than usual breast-milk?	1 4	1	1 4	1	1 4	1	1	1 4	1	1 4	1								
When (name) was sick, did you offer less, the same amount or more than usual to drink?	17		16		11		17		10		71	18	18	13	17	13	79	89.9%	20%
	1 5	1	1 5	1	1 5	1	1	1 5	1	1 5	1								
When (name) was sick, did you offer less the same amount or more than usual to eat?	10		14		10		10		4		48	18	18	13	17	13	79	60.8%	20%
	1 0	1	1 0	1	1 0	1	1	1 0	1	1 0	1								
Mothers who gave same as usual or more fluids and food to a sick child	10		13		9		10		4		46	18	18	13	17	13	79	58.2%	
	9		9		9		9		9										
Has (name) taken a vitamin A capsule during the last 6 months?	12		15		15		15		14		71	18	19	19	19	19	94	75.5%	35%
	1 3	4	1 3	4	1 3	4	1 3	4	1 3	4									

**Section 3: Immunizations**

Do you have a card where (name)'s vaccinations are written down?	9		13		13		15		16		66	19	19	19	19	19	95	69.5%	
	1	1	1	1	1	1	1	1	1	1									
Complete Immunization	7		6		9		9		14		45	19	19	19	19	19	95	47.4%	35%
	7	4	7	4	7	4	7	4	7	4									

**Section 4: Birth Spacing Use**

Do you want another child in the next 2 years?	13		16		17		16		13		75	19	19	19	19	19	95	79%	
	1	3	1	3	1	3	1	3	1	3									
Which of the following birth spacing methods are you using to delay or avoid pregnancy?	5		13		11		10		4		43	13	16	17	16	13	75	57.3%	35%
	9	4	9	4	9	4	9	4	9	4									

## Appendix B



CSXVII, Baray-Santuk Operational District  
Kampong Thom Province, Cambodia

# ADRA Cambodia Child Survival Project XVII Baray-Santuk Operational District Kampong Thom Province

Workshop Report On

LQAS Survey

July 07-10, 2003

**Prepared by:** *MA. Sin Samai, Monitoring and Evaluation Officer*

**Facilitated by:** *Dr. Meas Pheng, Project Manager*  
*Mrs. Huth Sokleang, Activity Coordinator*

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- ❑ Miss. Yim Chheng Sim, BSOD MCH program officer
- ❑ Mr. So Sopeap, Administrative Assistant
- ❑ CS field officers
- ❑ HC chiefs and HCMs
- ❑ Commune Coordinators from the five supervision areas

■ Again would like to take this opportunity to thank all those people who gave great feedback and contributed of your lovely experience by sharing construction ideas during the group-work and the whole class discussion which made the training workshop more enjoyable.

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## Acronyms

LQAS	Lot Quality Assurance Sampling
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
CSP	Child Survival Project
SA	Supervision Area
HC	Health Center
BSOD	Baray-Santuk Operational District
MCH	Maternal and Child Health
RHC	Road to Health Card
TT	Tetanus Toxoid
MBSM	Modern Birth Spacing Method
WRA	Women of Reproductive Age
CC	Commune Coordinator
BS	Birth Spacing
RM	Regular Monitoring

## 1.0 Introduction

### Workshop Background Information

The ADRA (Adventist Development Relief Agency) Cambodia is an International Non-Governmental Organization (NGO) in Cambodia. The Cambodia Child Survival XVII Project (CSP) is one of its health programs that covers ten Health Center Supervision Areas (HCSA), including 12 communes and 122 villages of the Baray-Santuk Operational District, Kampong Thom Province. The CSP organized this workshop held from July 07-10, 2003 at the ADRA Kampong Thom Office. This is the first LQAS training workshop held in the local Khmer language and most of the written documents were translated into Khmer.

## 2.0 Objective

The major objective of this workshop was to improve the quality of the Lot Quality Assurance Sampling (LQAS) in five supervision areas of Santuk district, Kampong Thom Province.

### Specific objectives

The participants will be able to:

- 1) Define the coverage average by using the LQAS table through the summary tabulation table of BS
- 2) Define the program goals/coverage targets of the LQAS regular monitoring
- 3) Define goals/coverage targets by using the LQAS table through the summary tabulation table of RM
- 4) Analyze data
  - a. Priorities among supervision areas for each indicator
  - b. Priorities within one supervision area among a group of related indicators
- 5) Understand how data is used for decision-making
- 6) Develop action plans for individual supervision and five HCSAs

## 3.0 Content Covered to the workshop

- 3.1 Review of LQAS
- 3.2 Summary Tabulation baseline
- 3.3 Defining program Goals/Annual and Six months Targets
- 3.4 Summary tabulation regular monitoring
- 3.5 How to analyze data
  - a. Priorities of supervision Areas for each indicator
  - b. Priorities within one supervision area among related indicator
- 3.6 How data used for decision-making
- 3.7 Action Plans

## 4.0 Training Workshop Methods

### Presentation

The workshop used a participatory approach with interactive lectures. Facilitators made verbal presentations using transparencies and exercise sheets for summary tabulation tables and coverage targets.

### Document handed out to

Some of the written documents, translated from English into Khmer were handed out to the participants at the end of session. The facilitators were responsible for collecting group work-sheets and materials used in the workshop as well as outputs from group work

### Self-learning opportunities

Self learning opportunities were offered to the participants through exercise, group work, questions and answers, and experience sharing. Short joke and stories were also used to make the training workshop more enjoyable. The experiences of the participants in their own HCSA area were used in-group discussion to elaborate issues and problems. This encouraged the participants to participate more actively and learn from their own and each other's experiences. The facilitators observed the participants' response in the workshop and recorded this in a daily record sheet. The participants were encouraged to give frank comments for the best solution of the workshop opportunities. They did this through class and group discussion and as well as individual feedback.

## 5.0 Schedule

### Training workshop schedule

From July 07-10, 2003

Date/Time	Monday 07 July	Tuesday 08 July	Wednesday	Thursday
8:00-8:30	Opening	Hand tabulate regular monitoring	Analyze data and identify priorities	Action plans (Continue)
8:00-8:50	Self-introduction			
8:50-9:30	Overview of LQAS			
9:30-9:45	<b>Tea break</b>			
9:45-11:30	Tabulation baseline Survey	Hand tabulate regular monitoring (Continue)	Analyze data and identify priorities (Continue)	-Summary -Closing 30 ms
11:30-1:30	<b>Lunch Break</b>			
1:30-3:30	Defining program Goals/Targets	Identify priorities of supervision areas	Action plans	

3:30-3:45	<b>Tea break</b>			
3:45-4:30	Defining program Goals/Targets (Continue)	Identify priorities supervision areas (Continue)	Action plans (Continue)	

## 6.0 Facilitators

There were 3 facilitators, all of which were Khmer (Cambodian). They each have facilitated many trainings, workshops, and meetings at the provincial and community level. Please see the table below.

*Table 1: Facilitators*

No	Name	Position	Address
1	Dr. Meas Pheng	Project Manager	ADRA CS BSOD
2	Mrs. Huth Sokleang	Activity Coordinator	ADRA CS BSOD
3	MA. Sin Samai	Monitoring and Evaluation Officer	ADRA CS BSOD

## 7.0 Participants

32 participants showed their interest and intention by participating in this workshop. The participants included: 1 Operational district director, 1 Operational maternal child health program officer, 5 health center chiefs, 5 health center midwives, 10 commune coordinators and 11 Child Survival staff (See Annex 2)

## 8.0 Workshop Monitoring and Evaluation

### 6.1 Daily attendance

Participants signed an attendance sheet twice a day, in the morning and afternoon.

### 6.2 Daily review

The facilitator reviewed the previous achievements before starting the new session. This was done regularly at the beginning of the morning and before starting after noon.

### 6.3 Daily session record

Facilitator for the day completed a Daily record sheet in which she/he recorded what was done during each session for the day and indicated her/his observations on participants response during different sessions.

### 6.4 Informal feedback

Informal discussions were held with participants during tea break in order to gather information and what problems to be solved for the workshop improvement.

### 6.5 Facilitators' review meeting

At the end of each day, the Monitoring and Evaluation Officer and Activity Coordinator discussed what happened during the day. This

was done informally trying to find the way to facilitate the participants opposite ideas and reactions.

## 9.0 Results of training workshop

Day 1:

### Summary tabulation table: Baseline Survey

Initially, a facilitator explained the summary tabulation table of the baseline survey and the LQAS table (Decision rule) to the participants by using transparencies with an overhead projector. Then they practiced individually. Next, the participants were divided into three groups such as group one worked on married female non- pregnant questionnaire, group two worked on mother with children age 0-11 months questionnaire, group three worked on mother with children age 12-23 months questionnaire. The results of the three groups above were in detailed results, Please see 1<sup>st</sup> LQAS Survey Report.

### Defining the program goals/ annual and six months targets

The facilitator divided the participants into three groups. The first group was responsible for the married non-pregnant women indicators, the second group was responsible indicators for mothers with children 0-11 months, and the third group was responsible indicators for mothers with children 12-23 months. See **Annex 3**.

Day 2:

### 1. Summary tabulation table: regular monitoring

At first, a facilitator explained the summary tabulation table of the regular monitoring and the LQAS table (Decision rule) to the participants by using transparencies with an overhead projector. Then their respective HC supervision area practiced individually. Next, the participants were divided into the three groups identified above. They did the actual activities each group such as group one worked on married female non- pregnant table, group two worked on mothers with children age 0-11 months table, and group three worked on mothers with children age 12-23 months table. The results of the three groups above were in detailed results table; please see the 1<sup>st</sup> LQAS Survey report.

### 2. How to analyze data

#### a. Priorities among supervision areas for each indicator in a group of related indicators

This work was discussed in elaboration regarding how to prioritize of supervision areas by the formulary table of the LQAS survey on the first and second priority.

The facilitator explained to the whole-class how to identify the priority supervision areas by using the summary table of regular monitoring.

## See Annex 6

### Day 3:

#### *b. Priorities within one supervision area among a group of related indicators*

Priorities were identified within one supervision area for each indicator in a group of related indicators.

The facilitator divided the participants into their own respective supervision area in the group to determine which indicators were below average. The composition of each group was the HC chief, HCMs, CS staff, and the Commune Coordinators. Each of groups discussed what caused the indicators to be below average **See Annex 3.**

#### *c. Problems Analysis*

<i>Indicators discussed</i>	<i>Causes</i>	<i>Possible solution</i>
Women who received at least two TT vaccinations	<input type="checkbox"/> Lost cards <input type="checkbox"/> Miss the HC's schedule <input type="checkbox"/> HC did not find the ones who missed TT vaccination. <input type="checkbox"/> Mothers are scared of needles.	<input type="checkbox"/> Renew cards <input type="checkbox"/> Give a copy of the HC's TT record to VHV of her/his households <input type="checkbox"/> Schedule informed through VHVs, As to mothers <input type="checkbox"/> Make sure who are on the list of those missing TT vaccinations follow-up with those who are missing <input type="checkbox"/> Increase education by using both home-education and education at the TT vaccination post.
Women who know at least three modern method of birth spacing	<input type="checkbox"/> Interpersonal and mass communication still limited <input type="checkbox"/> They were not interested	<input type="checkbox"/> Provide more education though volunteers and HCMs
Women are using birth spacing method to delay or avoid pregnancy	<input type="checkbox"/> Most of farmer families need many people's power to replace them when they are getting old <input type="checkbox"/> Bleeding <input type="checkbox"/> No child forever <input type="checkbox"/> Affect to their health <input type="checkbox"/> They are shy	<input type="checkbox"/> Increase education by using both home-education and at HCs through TBAs, VHVs and HC staff
WRA initiate use modern method of birth spacing within first three months after delivery	<input type="checkbox"/> Waiting for menstrual period <input type="checkbox"/> Hot breast-milk for baby <input type="checkbox"/> Thick and viscous breast-milk <input type="checkbox"/> Husband not allow to use	<input type="checkbox"/> Increase education by using both home-education and at HCs through TBAs, VHVs and HC staff
Women who know at least two ways of AIDS/HIV is spread	<input type="checkbox"/> Interpersonal and mass communication still limited <input type="checkbox"/> Traditional barrier	<input type="checkbox"/> Increase education by using both home-education through TBAs, VHVs
Mothers initiated breastfeeding with colostrum within first hour	<input type="checkbox"/> No breast-milk at first <input type="checkbox"/> Had diarrhea <input type="checkbox"/> Had fever <input type="checkbox"/> Difficult roasting (uncomfortable) <input type="checkbox"/> Did not understand importance	<input type="checkbox"/> Increase education by using both home-education and at HCs through TBAs, VHVs and HC staff
Mothers who breastfed exclusively to their children	<input type="checkbox"/> Mothers went away <input type="checkbox"/> Not enough breast-milk <input type="checkbox"/> If they fed the baby food water	<input type="checkbox"/> Increase education by using both home-education and at HCs.

	she/he slept comfortably	
Mothers continue breastfed, water, and food to their children during illness	<input type="checkbox"/> Baby is getting more serious <input type="checkbox"/> Mothers did not know how to take care theirs.	<input type="checkbox"/> Increase education by using both home-education and at HCs.
Women who received vitamin-A in the first two months after delivery	<input type="checkbox"/> Some HC staff did not find the lactating mothers <input type="checkbox"/> HC are distant	<input type="checkbox"/> List lactating mothers with children age < 2ms <input type="checkbox"/> Vitamin-A distribute at health post
Children who are completely immunization	<input type="checkbox"/> Scared her child has fever <input type="checkbox"/> Became poliomyelitis <input type="checkbox"/> Lost cards <input type="checkbox"/> Miss the HC's schedule <input type="checkbox"/> HC did not find the ones who missed vaccination.	<input type="checkbox"/> Renew cards <input type="checkbox"/> Copy HC's TT record to VHV of her/his households <input type="checkbox"/> Inform mothers about schedule through volunteers <input type="checkbox"/> Make sure who are in a list miss vaccination <input type="checkbox"/> Find out who are out of a list <input type="checkbox"/> Increase education by using both home-education and at the vaccination post.
Newborns weighed within 24 hours after birth	<input type="checkbox"/> Delivered with untrained oldest TBAs	<input type="checkbox"/> Train oldest TBAs
Pregnant women who received iron tablets	<input type="checkbox"/> No service in villages <input type="checkbox"/> Distant between HC and village <input type="checkbox"/> No card to record	<input type="checkbox"/> Distribute iron tablets to mothers during EPI outreach <input type="checkbox"/> Record into TT card

#### Day 4:

*How data is used for decision-making (See Annex 4)*

## 10.0 Action Plans

The participants were divided into five groups, those working in their own health center supervision area. The respective HCSA discussed how to find possible solutions and develop action plans. Detailed action plans were developed in Annex 5

## 11.0 Conclusion and Recommendation

- The interviewers improperly collected the information for a few survey questions because they misunderstood what responses to fill in for the indicators. ADRA should revise the questionnaires and interview technique.
- Most of the mothers did not remember when they received vitamin-A as their own children. The interviewers should record from RHC/TT cards for the next survey
- Because mothers lost their TT cards, HC staff should make new cards and record all vaccinations into new ones and explain carefully about how to keep the cards properly.
- Several mothers always loose their cards and or their children's cards. To avoid all this, the HC staff should give each VHV a copy of TT and 6 childhood immunization record.

- ❑ Some of the cards are recorded only in the HC's register but were not in mothers' and children' cards. This makes the project indicators difficult to reach. Therefore, the HC staff should record both register and cards.
- ❑ Many mothers still need the eldest untrained TBAs for their delivery, so this situation affects the survey on weighing and kits. ARDA should include the eldest TBAs in the training of phase II.

#### **Annex 1: List of participants were From July 07-10, 2003**

<b>No</b>	<b>Name</b>	<b>Position</b>	<b>Address</b>
1	Dr. Meas Chim	BSOD director	Baray-Santuk Operational District
2	Yim Chheng Sim	MCH Officer	Baray-Santuk Operational District
3	Sieng Nara	MCH Officer	ADRA CS BSOD
4	Mom Pachka	MCH Officer	ADRA CS BSOD
5	Sun ny	MCH Officer	ADRA CS BSOD
6	Hing Sarann	MCH Officer	ADRA CS BSOD
7	Kun Porch	MCH Officer	ADRA CS BSOD
8	Sor chheng	Nutrition Officer	ADRA CS BSOD
9	Leng Ponlork	Nutrition Officer	ADRA CS BSOD
10	Orn Sothea	Nutrition Officer	ADRA CS BSOD
11	Yum monyroth	Nutrition Officer	ADRA CS BSOD
12	Hang Saroeun	Nutrition Officer	ADRA CS BSOD
13	Lim Sareth	HC chief	Tang Kork
14	Tep Som arth	HC chief	Protong
15	Ban Sombarth	HC chief	Balaing
16	Sok Som Oeurn	HC chief	Boeung
17	Kong Chan Tha	HC chief	Kreul
18	Chuy chim	Commune Coordinator	Balaing
19	Heng Kim Houth	Commune Coordinator	Balaing
20	Om Som Oeurn	Commune Coordinator	Boeung
21	Moun Ra	Commune Coordinator	Boeung
22	Houng Kunthear	Commune Coordinator	Kreul
23	Noun Bopha	Commune Coordinator	Kreul
24	Om phally	Commune Coordinator	Protong
25	Men Dany	Commune	Protong

		Coordinator	
26	Kuntheary	Commune Coordinator	Tang Kork
27	Ven Sopheap	Commune Coordinator	Tang Kork
28	Va Sroev	HC midwife	Balaing
29	Im Chhorn	HC midwife	Boeung
30	Kirt Sokha	HC midwife	Kreul
31	Yim Sophally	HC midwife	Protong
32	Thoung Sim Chheng	HC midwife	Tang Kork

**Annex 2: Defining program Goals/Targets**

**Table 1: Married non-pregnant women of reproductive age**

<b>NO</b>	<b>INDICATORS</b>	<b>Jan 03</b>	<b>July 03</b>	<b>April 04</b>	<b>Jan 05</b>	<b>Oct 05</b>
1	Women who received at least 2 TT vaccination	20	25	30	35	40
2	Women who know three modern method of birth spacing	20	30	35	40	60
3	Women want another child in the next 2 years	25	30	35	40	50
4	Women are using birth spacing method to delay or avoid pregnancy	35	35	40	45	50
5	Women received birth spacing method counseling	35	40	45	50	60
6	Women who know at least 2 ways of HIV/AIDS is spread	20	35	55	70	85
7	Men who know at least 2 ways of HIV/AIDS is spread	20	35	55	70	85

**Table 2: Mother with children 0-11 months**

<b>NO</b>	<b>INDICATORS</b>	<b>Jan 03</b>	<b>July 03</b>	<b>Apr 04</b>	<b>Jan 05</b>	<b>Oct 05</b>
1	Mothers initiated breastfeeding with colostrums within first hour	20	20	30	30	33
2	2 Mother who breastfeed exclusively	20	20	25	25	25
3	Mothers continue breastfeeding children with illness	20	25	30	32	32
4	Mothers continue giving water to children with illness	20	25	30	32	32
5	Mothers continue giving food to children with illness	20	25	30	32	32
6	Newborns weighed within 24 hours after birth	45	55	65	70	80
7	Pregnant women received Iron tablets	35	40	40	45	50
8	Women received Vitamin-A in the first 2 months after delivery	20	20	20	25	30
9	Pregnant women received pre-natal care at least 2 times during pregnancy	20	25	30	35	35
10	Clean birth kits used	75	75	75	75	80
11	WRA initiated use of MMof birth spacing within first three after delivery	25	30	30	30	35

**Table 3: Mother with children 12-23 months**

<b>No</b>	<b>INDICATORS</b>	<b>Jan 03</b>	<b>July 03</b>	<b>Apr 04</b>	<b>Jan 05</b>	<b>Oct 05</b>
1	Mothers continue breastfeeding children with illness	20	25	30	32	32
2	Mothers continue giving water to children with illness	20	25	30	32	32

3	Mothers continue giving food to children with illness	20	25	30	32	32
4	Children received vitamin-A at least one capsule in the last 6 months	35	40	45	50	60
5	Children who completed immunization	35	40	45	50	60
6	Women want another child in the next 2 years	25	30	40	45	50
7	Women are using birth spacing method to delay or avoid pregnancy	35	35	40	45	50

**Annex 3: How to Analyze Data**  
**Priorities with One Supervision Area among a Group of related Indicators**

**3.1- Balaing health center supervision area**

*A. Married non-pregnant women and men age 15-49 years*

<b>No</b>	<b>Indicators</b>	<b># of Correct</b>	<b>Coverage Estimate</b>	<b>Decision Rule</b>	<b>Equal to or Above? Yes or No</b>
1	Women who received at least 2 TT vaccination	12	55%	8	Y
2	Women who know three modern method of birth spacing	0	35%	4	N
3	Women want another child in the next 2 years	14	70%	11	Y
4	Women are using birth spacing method to delay or avoid pregnancy	9	65%	10	N
5	Women received birth spacing method counseling	10	45%	6	Y
6	Women who know at least 2 ways of HIV/AIDS is spread	5	55%	8	N
7	Men who know at least 2 ways of HIV/AIDS is spread	6	60%	9	N

*B. Mother with children age 0-11 months*

<b>No</b>	<b>Indicators</b>	<b># of Correct</b>	<b>Coverage Estimate</b>	<b>Decision Rule</b>	<b>Equal to or Above?</b>
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					Yes or No
1	Mothers initiated breastfeeding with colostrums within first hour	6	30%	3	Y
2	Mother who breastfeed exclusively	1	50%	7	N
3	Mothers continue breastfeeding children with illness	14	90%	15	N
4	Mothers continue giving water to children with illness	10	85%	14	N
5	Mothers continue giving food to children with illness	9	70%	11	N
6	Newborns weighed within 24 hours after birth	12	65%	10	Y
7	Pregnant women received Iron tablets	16	60%	9	Y
8	Women received Vitamin-A in the first 2 months after delivery	10	45%	6	Y
9	Pregnant women received pre-natal care at least 2 times during pregnancy	15	45%	6	Y
10	Clean birth kits used	17	90%	15	Y
11	WRA initiated use of MMBS within first three after delivery	3	12%	NA	N

**C. Mothers with children age 12-23 months**

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers continue breastfeeding children with illness	16	85%	14	Y
2	Mothers continue giving water to children with illness	17	90%	15	Y
3	Mothers continue giving food to children with illness	10	65%	10	Y
4	Children received vitamin-A at least one capsule in the last 6 ms	12	80%	13	N
5	Children who completed immunization	7	50%	7	Y

6	Women want another child in the next 2 years	13	80%	13	Y
7	Women are using birth spacing method to delay or avoid pregnancy	5	60	9	N

### 3.2- Boeung health center supervision area

#### A. Married non-pregnant women and men age 15-49 years

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Women who received at least 2 TT vaccination	6	55%	8	N
2	Women who know three modern method of birth spacing	7	35%	4	Y
3	Women want another child in the next 2 years	16	70%	11	Y
4	Women are using birth spacing method to delay or avoid pregnancy	13	65%	10	Y
5	Women received birth spacing method counseling	14	45%	6	Y
6	Women who know at least 2 ways of HIV/AIDS is spread	12	55%	8	Y
7	Men who know at least 2 ways of HIV/AIDS is spread	14	60%	9	Y

#### B. Mothers with children age 0-11 months

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers initiated breastfeeding with colostrums within first hour	10	30%	3	Y
2	Mother who breastfeed exclusively	13	50%	7	Y
3	Mothers continue breastfeeding children with illness	13	90%	15	N
4	Mothers continue giving water to children with illness	3	85%	14	N
5	Mothers continue giving food	3	70%	11	N

	to children with illness				
6	Newborns weighed within 24 hours after birth	15	65%	10	Y
7	Pregnant women received Iron tablets	11	60%	9	Y
8	Women received Vitamin-A in the first 2 months after delivery	5	45%	6	N
9	Pregnant women received pre-natal care at least 2 times during pregnancy	5	45%	6	N
10	Clean birth kits used	18	90%	15	Y
11	WRA initiated use of MMBS within first three after delivery	2	12%	NA	N

**C. Mother with children age 12-23 months**

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers continue breastfeeding children with illness	13	85%	14	N
2	Mothers continue giving water to children with illness	16	90%	15	Y
3	Mothers continue giving food to children with illness	14	65%	10	Y
4	Children received vitamin-A at least one capsule in the last 6 ms	15	80%	13	Y
5	Children who completed immunization	6	50%	7	N
6	Women want another child in the next 2 years	16	80%	13	Y
7	Women are using birth spacing method to delay or avoid pregnancy	13	60	9	Y

**3.3- Kreul health center supervision area**

**A. Married non-pregnant women and men age 15-49 years**

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Women who received at least 2 TT vaccination	7	55%	8	N
2	Women who know three modern	9	35%	4	Y

	method of birth spacing				
3	Women want another child in the next 2 years	14	70%	11	Y
4	Women are using birth spacing method to delay or avoid pregnancy	11	65%	10	Y
5	Women received birth spacing method counseling	9	45%	6	Y
6	Women who know at least 2 ways of HIV/AIDS is spread	10	55%	8	Y
7	Men who know at least 2 ways of HIV/AIDS is spread	9	60%	9	Y

**B. Mother with children age 0-11 months**

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers initiated breastfeeding with colostrums within first hour	2	30%	3	N
2	Mother who breastfeed exclusively	4	50%	7	N
3	Mothers continue breastfeeding children with illness	8	90%	15	N
4	Mothers continue giving water to children with illness	4	85%	14	N
5	Mothers continue giving food to children with illness	4	70%	11	N
6	Newborns weighed within 24 hours after birth	7	65%	10	N
7	Pregnant women received Iron tablets	11	60%	9	Y
8	Women received Vitamin-A in the first 2 months after delivery	7	45%	6	Y
9	Pregnant women received pre-natal care at least 2 times during pregnancy	8	45%	6	Y
10	Clean birth kits used	15	90%	15	Y
11	WRA initiated use of MMBS within first three after delivery	1	12%	NA	N

**C Mothers with children age 12-23 months**

No	Indicators	# of	Coverag	Decisio	Equal to or Above?
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		Correct	Estimate	n Rule	Yes or No
1	Mothers continue breastfeeding children with illness	9	85%	14	N
2	Mothers continue giving water to children with illness	11	90%	15	N
3	Mothers continue giving food to children with illness	10	65%	10	Y
4	Children received vitamin-A at least one capsule in the last 6 ms	15	80%	13	Y
5	Children who completed immunization	9	50%	7	Y
6	Women want another child in the next 2 years	17	80%	13	Y
7	Women are using birth spacing method to delay or avoid pregnancy	11	60	9	Y

### 3.4- Protong health center supervision area

#### A. Married non-pregnant women and men age 15-49 years

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Women who received at least 2 TT vaccination	12	55%	8	Y
2	Women who know three modern method of birth spacing	8	35%	4	Y
3	Women want another child in the next 2 years	16	70%	11	Y
4	Women are using birth spacing method to delay or avoid pregnancy	10	65%	10	Y
5	Women received birth spacing method counseling	10	45%	6	Y
6	Women who know at least 2 ways of HIV/AIDS is spread	11	55%	8	Y
7	Men who know at least 2 ways of HIV/AIDS is spread	14	60%	9	Y

#### B. Mothers with children age 0-11 months

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above?
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					Yes or No
1	Mothers initiated breastfeeding with colostrums within first hour	4	30%	3	Y
2	Mother who breastfeed exclusively	3	50%	7	N
3	Mothers continue breastfeeding children with illness	11	90%	15	N
4	Mothers continue giving water to children with illness	8	85%	14	N
5	Mothers continue giving food to children with illness	6	70%	11	N
6	Newborns weighed within 24 hours after birth	14	65%	10	Y
7	Pregnant women received Iron tablets	7	60%	9	N
8	Women received Vitamin-A in the first 2 months after delivery	9	45%	6	Y
9	Pregnant women received pre-natal care at least 2 times during pregnancy	5	45%	6	N
10	Clean birth kits used	15	90%	15	Y
11	WRA initiated use of MMBS within first three after delivery	1	12%	NA	N

**C. Mothers with children age 12-23 months**

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers continue breastfeeding children with illness	15	85%	14	Y
2	Mothers continue giving water to children with illness	17	90%	15	Y
3	Mothers continue giving food to children with illness	10	65%	10	Y
4	Children received vitamin-A at least one capsule in the last 6 ms	15	80%	13	Y
5	Children who completed immunization	9	50%	7	Y

6	Women want another child in the next 2 years	16	80%	13	Y
7	Women are using birth spacing method to delay or avoid pregnancy	10	60	9	Y

### 3.5- Tang Kork health center supervision area

#### A Married non-pregnant women and men age 15-49 years

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Women who received at least 2 TT vaccination	12	55%	8	Y
2	Women who know three modern method of birth spacing	5	35%	4	Y
3	Women want another child in the next 2 years	2	70%	11	N
4	Women are using birth spacing method to delay or avoid pregnancy	9	65%	10	N
5	Women received birth spacing method counseling	7	45%	6	Y
6	Women who know at least 2 ways of HIV/AIDS is spread	12	55%	8	Y
7	Men who know at least 2 ways of HIV/AIDS is spread	11	60%	9	Y

#### B. Mothers with children age 0-11 months

No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers initiated breastfeeding with colostrums within first hour	5	30%	3	Y
2	Mother who breastfeed exclusively	14	50%	7	Y
3	Mothers continue breastfeeding children with illness	12	90%	15	N
4	Mothers continue giving water to children with illness	7	85%	14	N

5	Mothers continue giving food to children with illness	4	70%	11	N
6	Newborns weighed within 24 hours after birth	10	65%	10	Y
7	Pregnant women received Iron tablets	9	60%	9	Y
8	Women received Vitamin-A in the first 2 months after delivery	10	45%	6	Y
9	Pregnant women received pre-natal care at least 2 times during pregnancy	7	45%	6	Y
10	Clean birth kits used	16	90%	15	Y
11	WRA initiated use of MMBS within first three after delivery	3	12%	NA	N

C. *Mothers with children age 12-23 months*

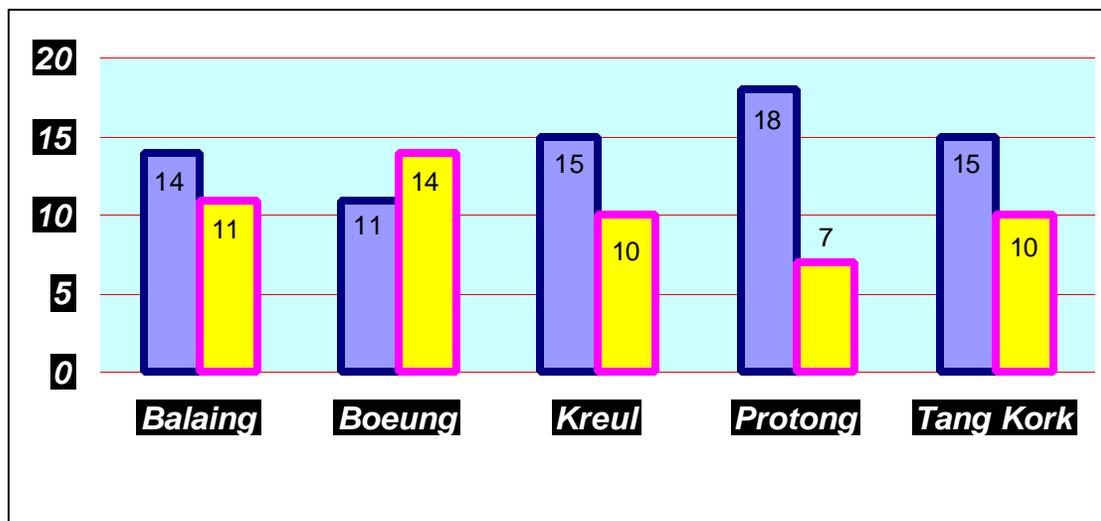
No	Indicators	# of Correct	Coverage Estimate	Decision Rule	Equal to or Above? Yes or No
1	Mothers continue breastfeeding children with illness	12	85%	14	N
2	Mothers continue giving water to children with illness	10	90%	15	N
3	Mothers continue giving food to children with illness	4	65%	10	N
4	Children received vitamin-A at least one capsule in the last 6 ms	14	80%	13	Y
5	Children who completed immunization	14	50%	7	Y
6	Women want another child in the next 2 years	13	80%	13	Y
7	Women are using birth spacing method to delay or avoid pregnancy	4	60	9	N

**Total Yes and No for Each Supervision Area**

No	Supervision Area	Yes	No	Total
1	Balang HC Supervision Area	14	11	25
2	Boeung HC Supervision Area	11	14	25
3	Kreul HC Supervision Area	15	10	25
4	Protong HC Supervision Area	18	7	25

<b>5</b>	<b>Tang Kork HC Supervision Area</b>	<b>15</b>	<b>10</b>	<b>25</b>
		<b>73</b>	<b>52</b>	

**Yes** means reached Coverage average decision rule  
**No** means not reached coverage average decision rule



**Blue color represents yes**  
**Yellow color represents No**

#### Annex 4: How Data Were Used for Decision-Making

#### 4.1 Married non-pregnant women and men age 15-49 years

#### LQAS Judgments for TT vaccination, Birth spacing knowledge and use

Indicators	Women who received at least two TT vaccinations or more	Women who know at least 3 modern BSM	Women who are using BS method to delay or avoid pregnancy
Date monitoring and data collected	Jan-2003	Jan-2003	Jan-2003
Coverage Targets	20%	20%	35%
Decision rule	1	1	4
Average coverage	52%	30.9%	61.9%
Decision rule	8	4	10
Supervision Area	Correct responses		
SA1	12	0 ☆	9
SA2	6	7	13
SA3	7	9	11
SA4	12	8	10

SA5	12	5	

### LQAS Judgments for birth spacing counseling, AIDS/HIV knowledge

Indicators	Women who received BS counseling at HC	Women who know at least 2 ways of HIV/AIDS prevented	Men who know at least 2 ways of HIV/AIDS prevented
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003	Jan-2003
<b>Coverage Targets</b>	35%	20%	20%
<b>Decision rule</b>	4	1	1
<b>Average coverage</b>	43.2%	52.6%	56.8%
<b>Decision rule</b>	6	8	9
<b>Supervision Area</b>	Correct responses		
SA1	10	5	6
SA2	14	12	14
SA3	9	10	9
SA4	10	11	14
SA5	7	12	11

#### 4.2. Mother with children age 0-11 months

### LQAS Judgments for nutrition practice on breastfeeding and exclusive breastfeeding

Indicators	Mothers initiated breastfeeding with colostrums within first hour after delivery	Mothers who breastfed exclusively up to 6 months after delivery
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003
<b>Coverage Targets</b>	20%	20%
<b>Decision rule</b>	1	1

<b>Average coverage</b>	28.4%	47.9%
<b>Decision rule</b>	3	7
<b>Supervision Area</b>	Correct responses	
SA1	6	1
SA2	10	13
SA3	2	4
SA4	4	3
SA5	5	14

### LQAS Judgments for practice of increasing fluid and foods

Indicators	Mothers continue breastfeeding children with illness	Mothers continue giving water to children with illness	Mothers continue giving food to children with illness
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003	Jan-2003
<b>Coverage Targets</b>	20%	20%	20%
<b>Decision rule</b>	1	1	1
<b>Average coverage</b>	85.3%	82.1%	66.6%
<b>Decision rule</b>	15	14	11
<b>Supervision Area</b>	Correct responses		
SA1	14	10	9
SA2	13	3	3
SA3	8	4	4
SA4	11	8	6
SA5	12	7	4

### LQAS Judgments for weighed at birth, Iron and Vitamin-A

Indicators	Babies weighed- at birth within 24 hours after delivery	Pregnant women who received iron tablets	In the first 2 months after delivery, lactating received vitamin-A
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003	Jan-2003
<b>Coverage Targets</b>	45	35%	20%
<b>Decision rule</b>	6	4	1
<b>Average coverage</b>	61.6%	56.8%	43.2%
<b>Decision rule</b>	10	9	6
<b>Supervision Area</b>	Correct responses		
SA1	12	16	10
SA2	15	11	5
SA3	7	11	7
SA4	14	7	9
SA5	10	9	10

### LQAS Judgments for Prenatal, delivery care and birth spacing practice

Indicators	Women who received prenatal care at least 2 times	Pregnant women were delivered by TBAs through clean birth kits	Women who started using birth spacing method after delivery
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003	Jan-2003
<b>Coverage Targets</b>	20%	75%	25%
<b>Decision rule</b>	1	12	2
<b>Average coverage</b>	42.1%	85.3%	12.1%
<b>Decision rule</b>	6	15	NA
<b>Supervision Area</b>	Correct responses		
SA1	15	17	3
SA2	5	18	2
SA3	8	15	1 *
SA4	5	15	1*
SA5	7	16	3

#### 4.3. Mother with children age 12-23 months

##### LQAS Judgments for practice of increasing fluid and foods

Indicators	Mothers continue breastfeeding children with illness	Mothers continue giving water to children with illness	Mothers continue giving food to children with illness
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003	Jan-2003
<b>Coverage Targets</b>	20%	20%	20%
<b>Decision rule</b>	1	1	1
<b>Average coverage</b>	82.2%	89.9%	60.8%
<b>Decision rule</b>	14	15	10
<b>Supervision Area</b>	Correct responses		
<b>SA1</b>	16	17	10
<b>SA2</b>	13	16	14
<b>SA3</b>	9	11	10
<b>SA4</b>	15	17	10
<b>SA5</b>	12	10	4

##### LQAS Judgments for vitamin-A, immunization and birth spacing practice

Indicators	Children received vitamin-A at least one capsule in the last 6 months	Children who completed immunization	Women who are using BS method to delay or avoid pregnancy
<b>Date monitoring and data collected</b>	Jan-2003	Jan-2003	Jan-2003
<b>Coverage Targets</b>	35%	35%	35%
<b>Decision rule</b>	4	4	4
<b>Average coverage</b>	75.5%	47.4%	57.3%
<b>Decision rule</b>	13	7	9
<b>Supervision Area</b>	Correct responses		

<b>SA1</b>	12	7	5
<b>SA2</b>	15	6	13
<b>SA3</b>	15	9	11
<b>SA4</b>	15	9	10
<b>SA5</b>	14	14	4

**Annex 5: Action Plans for  
Health Center Supervision Areas**

**5.1- Balaing HC supervision area**

<b>Activities</b>	<b>Responsible Person</b>	<b>Date</b>	<b>Location</b>
Educate mothers of exclusive breastfeeding by using Loto game			
Increase birth spacing education	Sieng Nara	Every 4 <sup>th</sup> week	HC
	Va Sreav	Every 4 <sup>th</sup> week	Village
Increase birth spacing education through TBAs, VHVs	Huth, Chim	Every month	Village

**5.2- Boeung HC supervision area**

<b>Activities</b>	<b>Responsible Person</b>	<b>Date</b>	<b>Location</b>
Renew TT cards for the women and give education of keeping cards	Mr. Sarom	Start rd week of August, 03	Villages
Record vitamin-A distribution date of children into Road to Health Card (RHC)	Mr. Sarom	Start rd week of August, 03	Villages
Copy immunization and vitamin-A records for every VHVs of Her/his block	CS	Start rd week of August, 03	HC
Regularly, educate pregnant women of prenatal care	Hing sarann	Every Thursday	HC
Distribute vitamin-A to lactating mothers	Hong Sarum	Every week	Villages

every month and record into TT immunization cards			
Encourage the pregnant women to delivery their babies with trained TBAs and HCMs through education	HCMs CC	Start August, 03 Start August, 03	HC Villages

### 5.3- Kreul HC supervision area

Activities	Responsible Person	Date	Location
Increasingly, educate pregnant and lactating women Of the first breast-milk through TBAs, VHVs	CC HCMs	Every month	Villages HC
Train the untrained old popular TBAs	ADRA	Phase II	HC

### 5.4- Protong HC supervision area

Activities	Responsible Person	Date	Location
Increase prenatal care education for pregnant women through VHVs, TBAs	CC	Every month	Villages
Increasingly, educate pregnant and lactating women Of the first breast-milk through TBAs, VHVs	CC	Every month	Village
Increasingly, educate pregnant and lactating women Of the first breast-milk (colostrums)	HCMs	Every month	HC

### 5.5- Tang Kork HC supervision area

Activities	Responsible Person	Date	Location
Increase home 3education of birth spacing all covered villages through VHVs	CC	Every month	Village
Increase prenatal care education for remote villages	HCM	Every month	-Knhhoup -Chro neang -Thnal kenh

### 5.6- For the All HC catchments Areas

Activities	Responsible	Date	Location
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	Person		
<input type="checkbox"/> Revise questionnaires	Samai	July, 03	ADRA Office
<input type="checkbox"/> Renew childhood immunization /pregnant women TT cards	HC staff	August, 03	Villages
<input type="checkbox"/> Records vitamin-A into Road to health card (RTC) and pregnant women TT card	HC staff	August, 03	Villages
<input type="checkbox"/> Copy immunization and vitamin-A records for every VHVs of Her/his block	HC staff	August, 03	Villages
<input type="checkbox"/> Train the untrained popular eldest TBAs	CS staff	Phase II	HC

## APPENDIX C

### 1) Specific Indicators for Child Friendly Villages (CFV)

- a) 40% of mothers having children under 24 months use modern Birth Spacing methods.
- b) 10%-25% of pregnant women receive at least 2 ante-natal checkups at the health center.
- c) Have established an emergency transport plan.
- d) 28%-40% of children under 24 months completed immunization.
- e) 25% of pregnant women have a birth preparedness plan.
- f) 13%-25% of mothers initiate breastfeeding (colostrum) within the 1<sup>st</sup> hour after delivery.
- g) Increase 12%-25% of the mothers with children under 24 months gave children extra fluid and food when children are ill.

### 2) Member of child friendly village committee:

- a) Commune Coordinator
- b) Vice village leader
- c) Health center staff/chief
- d) Village women's affairs staff (if available)
- e) VHV's chief
- f) TBA
- g) Priest or Key informant

**3) Role and responsibilities for Child Friendly Village Committees:**

- 1./ Facilitate activities in CFV
  - a) Mother's club
  - b) Hearth Program
  - c) Home Gardening
  - d) Village Health Days
  - e) Expanded Program of Immunization
- 2-/ Solve health problems when happen in the village before transfer if possible.
- 3-/ Provide community feedback to health center or ADRA and from health center /ADRA to community.
- 4-/ Attend CFV Committee meeting every 2months.

## APPENDIX D

### REPORT ON HEARTH PROGRAM STUDY VISIT AT PFD (Snourl district, Kratie province)

#### **I. Introduction:**

First from August 4 to 11 and then from September 8 to 9, Huth Sokleang, Activity Coordinator of ADRA Child Survival XVII project (CSP), visited the PFD sponsored Hearth Program at Snourl district of Kratie province. The purpose of visited was to obtain Hearth Program experience to be able to implement the program at the 10 Child Friendly Villages in CSP as soon as possible.

#### **II. Purpose:**

The purpose of this report is to provide ADRA Cambodia country office with baseline information about Hearth Program study visit.

#### **III. Main Activities Achieved:**

Facilitated by Dul Sethea, team leader of PFD Chhlong Child Survival Project and some of his staff, Sokleang attended Hearth Program implementation at Trapaing Leak village, Snourl district, Kratie province during 6 working days and attended Hearth Training during 2 days. Normally, the Hearth Program implementation takes 15 days, 5 days for Positive Deviance Families Program and 10 days for NERP ( See following PART A and B: Hearth Program schedule).

##### **1-Hearth Training:**

Hearth training was covered by 7 Modules and took 2 days for training.

Module 1: Understanding Nutrition Situation in village

Module 2: Understanding about Positive Deviant Families

Module 3: Introduce village leader to know working group and discussion group in order to analyze common situations about community feeding, caring and health seeking practice.

Module 4: Identification of Positive Deviance Families

Module 5: Interviewing Positive and Negative Deviant Families

Module 6: Meeting with community to develop activity plan

Module 7: Study on Nutrition Education and Rehabilitation Program.

##### **2-The Process of Hearth Program implementation:**

1. Implement Growth Monitoring and Promotion (GMP) Activity
2. Identify Positive Deviant Mothers (PDM)
3. Identify successful behaviors and practices among Positive Deviant families
4. Identify successful behaviors and practice among grandmothers, mothers, fathers and older sisters or brothers
5. Present the successful behaviors and practices identified to the community
6. Train VHVs on Nutrition Education and Rehabilitation Program (NERP)
7. Conduct Nutrition Education and Rehabilitation Session (NERS) during 10 days.

#### **IV. Recommendation:**

To avoid problems occurring during running the program:

1. We should start this program in a village that is not very rural and when the people are free from work.
2. We should not run the program during the raining season because the people are busy then.
3. We should have enough and good staff to run the program (at least 4 staff), if not we will not run the program smoothly and finish on time.

Report writer: Huth Sokleang

## Appendix D Part A: Table of Positive Deviant Families Program

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	Growth Monitoring: Children weight and analyze children nutrition situation	Focus group discussion: -Mothers group -Grandmothers group -Fathers group -Elder sisters group	Present result: -Children's Nutrition Situation -Results from focus group	-Analyze data obtained from PDF and NDF	Train VHV, VDC, TBA, Mothers on NERP	Train VHV, VDC, TBA, Mothers on NERP
Afternoon	-Village Mapping -Analyze Nutrition situation in the village -Prepare for presentation	-Analyze data from focus group -Prepare for presentation	-Identify PDF and NDF -Interview with 3 PDF and 3 NDF	Meeting with VHVs to develop NERP activity plan	Continue	Continue

## Appendix D Part B: NERP Schedule

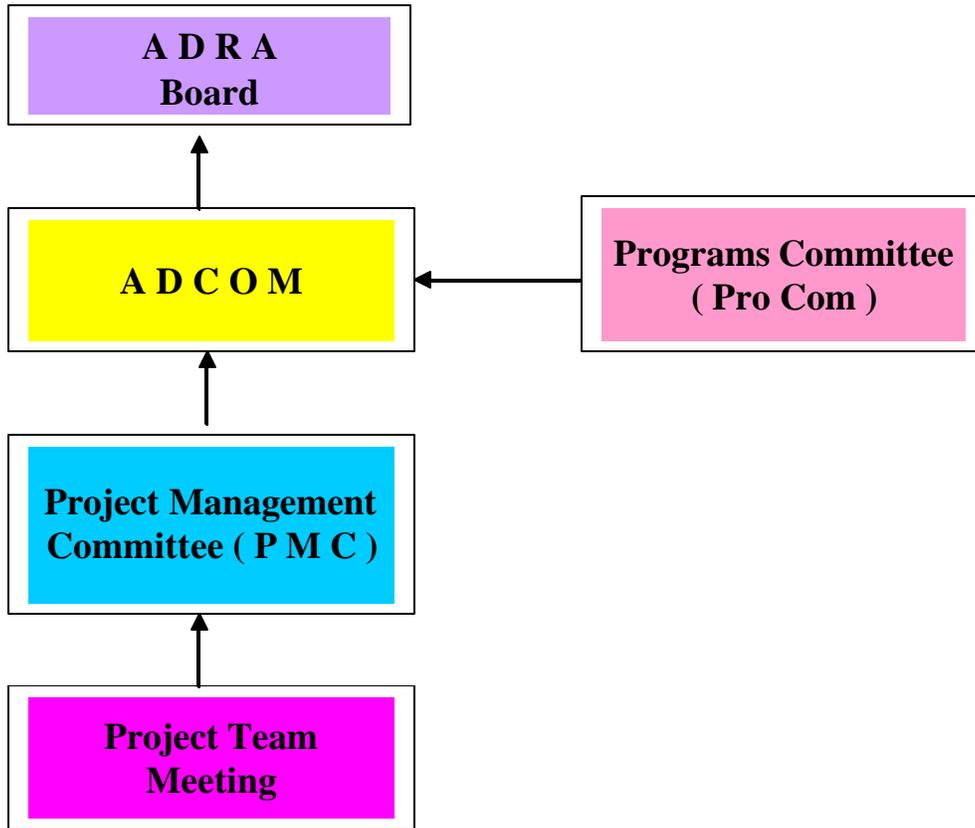
Time	Day 1	Day 2	Day 3	Day 4	Day 5
Morning	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Cooking demonstration</li> <li>-Health education: Color plate</li> <li>-Washing hands and face</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Color and Nutrient</li> <li>-Washing hands and face</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Color and Nutrient</li> <li>-Washing hands and face</li> <li>- Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Breast feeding</li> <li>-Washing hands and face</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Supplementary food</li> <li>-Washing hands and face</li> <li>-Child feeding</li> </ul>

Time	Day 6	Day 7	Day 8	Day 9	Day 10
Morning	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Diarrhea and ORS</li> <li>-Wash child' s face and hands</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Immunization and De worming</li> <li>-Wash child' s face and hands</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Personnel hygiene and Food hygiene</li> <li>-Wash child' s face and hands</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Child care during feeding</li> <li>-Wash child' s face and hands</li> <li>-Child feeding</li> </ul>	<ul style="list-style-type: none"> <li>-Collect food contribution</li> <li>-Food Cooking</li> <li>-Health education: Lessons review</li> <li>-Wash child' s face and hands</li> <li>-Child feeding</li> </ul>



## APPENDIX E

# Project Management Organogram



**APPENDIX F**

**ADRA**

**Adventist Development and  
Relief Agency Cambodia**

**REPORT ON SMALL SCALE RESEARCH**

**Impact of Early Initiation of Breastfeeding Intervention,  
Child Survival XVII Project, Kampong Thmor**

**26-28 February 2003**

**Facilitated and Compiled by:**

**Dr. Meas Pheng,  
Child Survival XVII Project Manager  
Kampong Thmor  
ADRA Cambodia**

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## Acknowledgements

This report is the culmination of the hard work and close collaboration of many people who were actively involved in conducting this research:

- ☞ Ms Hing Saran, Reproductive Health Officer of Boeung HC
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- ☞ Ms Oum Sam Oeun, Commune Coordinator of Boeung HC
- ☞ Ms Muon Ra, Commune Coordinator of Boeung HC
- ☞ Those Traditional Birth Attendant (TBA) who assisted with the interviews
- ☞ The Village Development Committee (VDC) members who allowed us to conduct the interviews
- ☞ The Village Health Volunteers (VHVs) who shared their ideas in formulating, conducting and analyzing the results
- ☞ The local authorities (village chief) who allowed us to conduct this research
- ☞ The target mothers who spent time and shared their knowledge with the interview team.

☞ I would also like to thank for ADRA Child Survival XVII, Kompong Thmor Project (CSP) for its support by supplying motorbikes for transportation.

☞ In behalf of CSP, we would like to great thank for those who are not listed above, that contribute ideas/feedback on the issue related topic of this research.

☞ Lastly, I would like to give my appreciation and thanks to ADRA Cambodia for supporting me in Analyzing Development Issues course.

### 1- PROBLEM STATEMENT:

**Kampong Thom Province is located in the centre of Cambodia where a protracted civil war has led to poverty and low literacy, particularly in rural/remote areas.**

**According to the National Government strategy strengthening the health sector is one of the key priorities in poverty alleviation. The Demographic Health Survey (DHS) in 2000 had showed a Maternal Mortality Rate (MMR) 437 in 100,000 and the under-five mortality rate of 124 in 1,000.**

**Causes of death among children include malnutrition, diarrhea, acute respiratory infection (ARI) and vaccine preventable diseases.**

**Maternal deaths accounted for 18% of all deaths to women age 15 – 49. Sixty percent of these are directly attributable to obstetric complications, of which hemorrhage comprise over half, contributing to the high MMR.**

These causes of death among women and children are linked to poor access to health care facilities and the care of trained professional health care providers. Usage of modern methods of birth spacing is generally low, with a contraceptive prevalence rate of around 24%.

In an effort to respond to the above issues the ADRA CSP has 4 interventions: 1- Maternal and New born care, 2- Nutrition, 3- Birth Spacing and 4- Immunization, in 10 health center catchments areas of Baray- Santuk Operational District of Kampong Thom province.

**One of the aims of the nutrition intervention is to ‘increase from 13% to 33% the number of mothers who initiate breastfeeding with colostrum within the first hour after delivery’. In Cambodia the colostrum is believed to be ‘bad milk’, so mothers do not feed this**

to their babies. Mothers also undergo a ‘smoking’ process that goes for the first 3 days after delivery. This constant exposure to smoke makes it difficult to breastfeed.

To respond to this intervention, TBA’s and VHV’s were trained to educate mothers in the importance of the early initiation of breastfeeding, especially with colostrum, and specifically starting within the first hour after delivery. In Boeung Commune this education campaign started in August 2002.

To access the health knowledge of mothers on the breastfeeding and to find out the factors that inhibit the early initiation of breastfeeding, 4 villages were selected in Boeung Commune, Baray- Santuk Operational District. During this research, women of reproductive age (WRA’s), VDC’s, TBA’s and VHV’s were interviewed.

## 2- OBJECTIVES OF THE RESEARCH:

- a- To assess the knowledge of colostrum by WRA, and other key people in the village, both current and prior to project commencement.
- b- To identify the actors/factors that inhibits the mother in the breastfeeding of colostrum.

## 3- RESEARCH METHODOLOGY:

- 5 women were selected at random in each of the four villages. Each women selected had at least 2 children with the youngest being less than 12 months old.
- 6 VHV’s, 4 TBA’s and 8 VDC members were also randomly selected and interviewed.
- There were two interview teams. Each consisted of an ADRA CSP team member and a Commune Coordinator (CC). The project manager acted as survey coordinator.
- The research team used a questionnaire that was designed with input from the CSP team.
- Questionnaire development took 3 days. Motorbikes were used to access the villages and the interview process lasted two full days.

*List of Interviewees*

Description	Boeung Cheung	Boeung Tbong	Boeung Kandal	
Women with C<12M	5	5	5	
TBA	3	0	1	
VHV	3	0	3	
VDC	4	0	4	
Total	15	5	13	

## 4- SCOPE AND LIMITATION

Initially it was planned to interview 10 women in 2 villages but due to many local women being busy with various forms of income generation and some with gambling, the survey was broadened to cover 4 villages with 5 mothers being interviewed in each village. This resulted in two groups of women, with the behaviors listed above, not being interviewed.

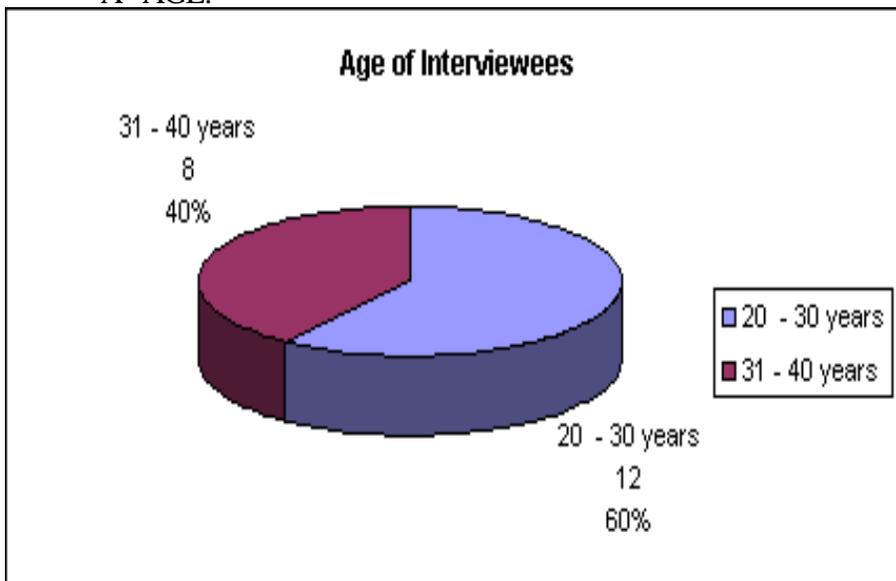
In one village there was a local celebration which was very noisy and distracting to the women who were being interviewed.

#### 5- FINDING AND ANALYSIS

- Among the 20 women interviewed, 12 women were aged between 21 to 30 and 8 women were from 31 to 40. All women interviewed were living with their husbands and children.
- 15 women had 2 to 4 children and 5 had more than 5 children.
- 9 women had low living conditions and the other 11 were average condition. This is a subjective observation based on local experience.
- 17 women had minimal literacy skills while the other 3 could read and write.

General Situation:

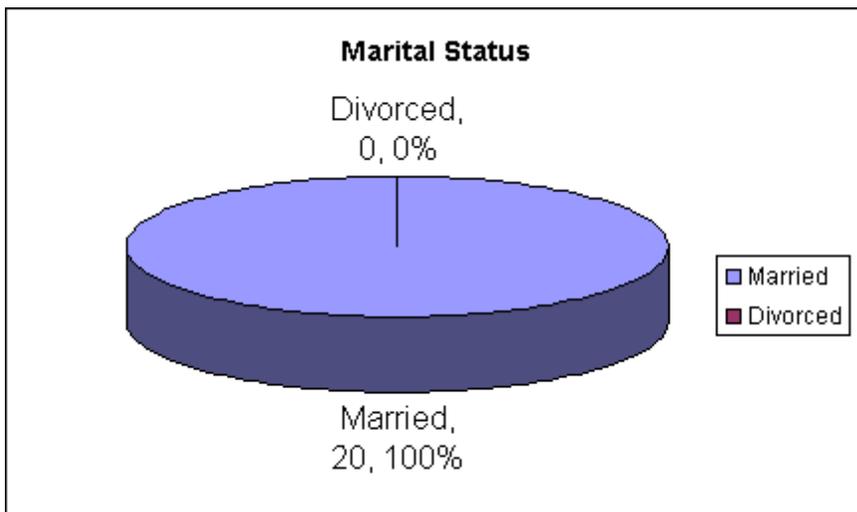
A- AGE:



#### B- MARITAL STATUS:

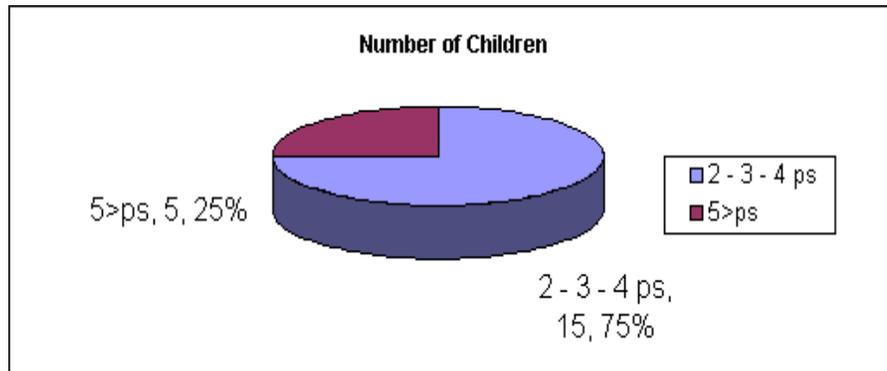
Marital	Number	Percentage
---------	--------	------------

Status		
Married	20	100%
Divorced	00	00%



### C- NUMBER OF CHILDREN

# of children	# of mother	Percentage
2, 3, 4	15	75%
5 or more	5	25%



### D- LIVING CONDITION

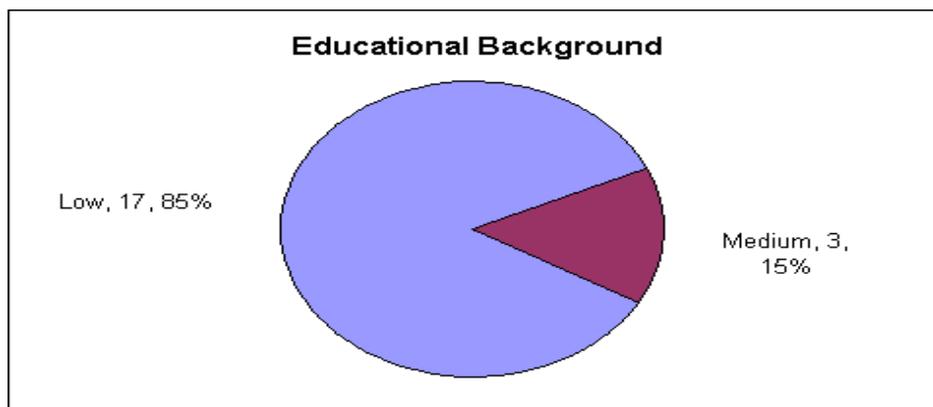
Status	Number	Percentage
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Poor	9	45%
Average	11	55%



### E- LEVEL OF EDUCATION

Level of Education	Number	Percentage
Low	17	85%
Average	3	15%

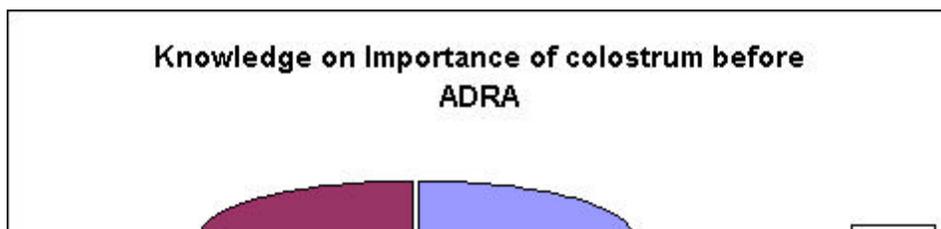


### 6-The Knowledge of the mother about colostrum

*I- Before ADRA intervention.*

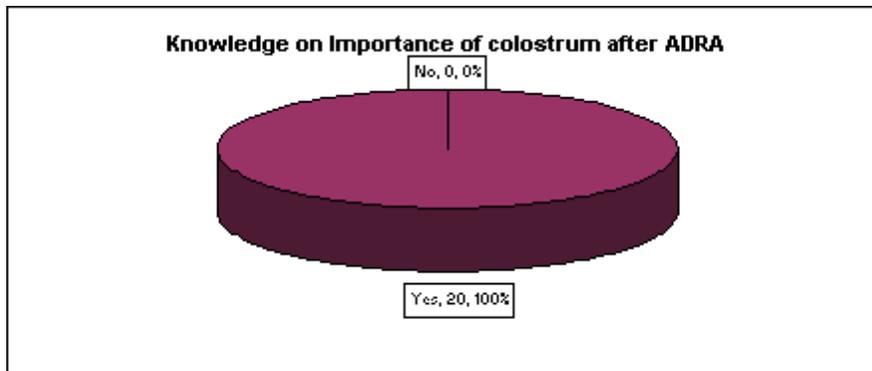
The interview showed that 50% of women already knew about the importance of colostrums but only 20% breastfeed their babies immediately after delivery, because they thought that colostrum can protect their children from diseases and also contains minerals and vitamins that cause children to grow quickly, well and healthy.

The other 50% did not know about the importance of colostrum, because their grand-mother or mother told them to squeeze the yellowish milk out and throw it away because it can cause diarrhea and fever and has no nutritional value.



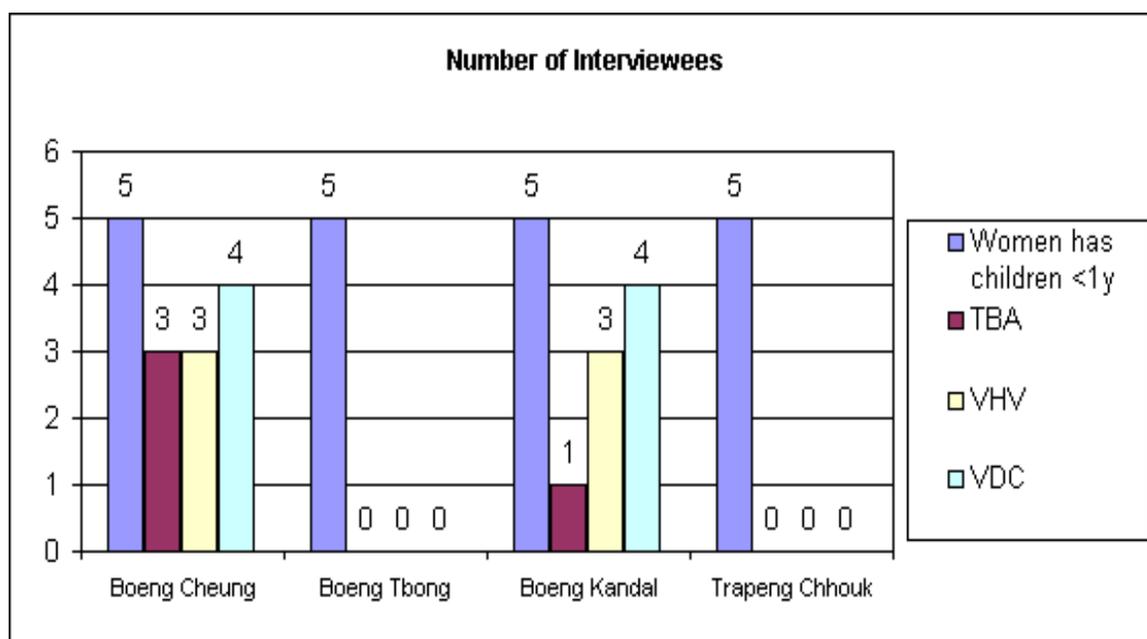
*II- After ADRA intervention.*

**100% of the interviewed women said that, they were educated about the importance of colostrum through the health program of ADRA Kampong Thom. They also knew that there were VHV's and TBA's working in their villages.**



### Number of Interviewees

Categories	Boeng Cheung	Boeng Tbong	Boeng Kandal	Trapeng Chhouk	Grand total
Women has children <1y	5	5	5	5	<b>20</b>
TBA	3	0	1	0	<b>4</b>
VHV	3	0	3	0	<b>6</b>
VDC	4	0	4	0	<b>8</b>
<b>Sub total</b>	<b>15</b>	<b>5</b>	<b>13</b>	<b>5</b>	<b>38</b>



#### a- Did your village have VHV or TBA?

Response	Frequency	Percentage
yes	20	100%
no	00	00%
Total	20%	100%

**b- Did you ever receive education about colostrums from VHV or TBA?**

<b>Response</b>	<b>Frequency</b>	<b>Percentage</b>
yes	20	100%
no	00	00%
<b>Total</b>	<b>20</b>	<b>100%</b>

<b>How often</b>	<b>Frequency</b>	<b>Percentage</b>
1 time	2	10%
2 time	3	15%
3 time	15	75%
<b>Total</b>	<b>20</b>	<b>100%</b>

**c- Do you change your breastfeeding behavior and breastfeed your baby colostrum after you learned from VHV's or TBA's?**

<b>Yes</b>	<b>Percentage</b>	<b>Comment</b>
18	90%	- Of the 50% that new of the advantages of breastfeeding with colostrums, the non-practicing 30% have now changed their behavior. - The other 50% have now also changed their behavior.
<b>No</b>	<b>percentage</b>	<b>Comment</b>
2	10%	- These women were already breastfeeding with colostrum and have continued to do so with their latest birth.

## **7- Impressions related to Traditional/Cultural norms**

Prior to the ADRA project 90% of women followed the behavioral norm from the old women in their family and have not breastfed colostrum. Traditional belief was that colostrums caused diarrhea, leading to malnutrition, and fever.

## **8- Impression of the Village Development Committee**

The VHV's were recruited in June 2002, through a local process of consultation and elections. In August the VHV's were trained for 2 weeks (1 week for theory and 1 week practicing in their village). In addition, ADRA provided 1 week training for the TBA's and also gave a birthing kit for each TBA.

The VDC members mentioned that prior to the ADRA project there were many common illnesses seen in the village children but since the implementation and training of VHV's and the training of the TBA's, there is less sickness among women and young children, showing a change of behavior.

Related to behavioral change the VDC have cooperated strongly with the VHV's in the implementation of project activities at the village level and they would like to see ongoing technical assistance to the VHV's.

## **9- Impression of the Village Health Volunteer**

The main factors in becoming a VHV was that they wanted to know “what is related to health?”, which can help the women in her village to be free from illness, reduce the rate of death and the spending on health care. They also become close to the people in their village and they gain more knowledge and experience.

They mention that they have studied the importance of breastfeeding colostrum twice and they pass this knowledge to the women. When providing health education to the local women they ask many questions and show their interest, but a small number of women are not interested as they think they know all about how to take care of their children. The VHV's tried their best to provide education and to understand women's situation.

## **10-Impression of the Traditional Birth Attendants (TBA)**

TBA's were trained by ADRA. They were motivated to join this training because they wanted to know what are the newest and best techniques, then the women will be trusted. The observation of the TBA's is that with health education most mothers are changing their behavior because they are seeing improvements in their children's health and believe that they will be cleverer.

## **11-Analysis**

The result showed that 50% of women new of the benefits of breastfeeding with colostrum, but only 20% of these women had changed their behavior, prior to the implementation of the project. These women had received their health information through radio, TV, magazines and local midwives.

On the other hand the 80% of women who practiced the old behaviors, even those with knowledge of the benefits of colostrums, were influenced by their mother or other older women from the village, in their behavior and they “squeezed out the colostrum” and threw it away.

Through health education to the community via the VHV's, TBA's and VDC member's, women have changed their behavior and breastfed their children from birth.

The results also showed that 75% of mothers have received health education a number of times. The other 25% are busy helping their families make money to survive, and so have not been exposed to health education as often.

The women also see that immediate breastfeeding has the added advantage of saving money, as they do not need to buy expensive powdered milk to use during this non-breastfeeding period. As there are many illiterate women the health education messages are mostly given verbally, supported by pictorial IEC materials.

The total result 90% have changed the old behaviors, it would be they saw that gave breastfed to new born the children have a good healthy. They understand well according to good communication and good cooperation from the trainers and trainees.

## **12- Conclusion and recommendation**

This small study showed significant change in early breastfeeding behavior of village mothers. It shows the potential impact of active VHVs, TBAs and VDC members, where all are working together, with the same message, to the same group of people.

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