



**CATHOLIC RELIEF SERVICES
CAMBODIA PROGRAM**

**CRS/BATTAMBANG
COMMUNITY-BASED
PRIMARY HEALTH CARE
CHILD SURVIVAL
PROJECT**

Award No. HFP-A-00-01-00042-00

**Fourth Annual Report
OCTOBER 1, 2004 – SEPTEMBER 30, 2005**

Submitted to

USAID

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ABBREVIATIONS

ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BF	Breast Feeding
CB-IMCI	Community-based Integrated Management of Childhood Illness.
CBPHCP	Community-Based Primary Health Care Program
CDD	Control Diarrhea, Dysentery, Cholera
CS	Community Health Structures
C-IMCI	CORE Integrated Management of Childhood Illnesses
CRS	Catholic Relief Services
F/IMCI	Facility Based Integrated Management of Childhood Illness
HC	Health Center
HCMC	Health Center Management Committee (new name for CMCF – Co-Management and Co-Financing Committee given by MOH)
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IEC	Information, Education, Communication
KPC	Knowledge, Practice and Coverage Survey
LQAS	Lot Quality Assurance
MCH	Mother-Child Health
MIS	Management Information System
MOH	Ministry of Health
MPA	Minimum Package of Activities
ND	New Districts
NIP	National Immunization Program
NGO	Non-Governmental Organization
OD	Operational District
OPD	Out Patient Department
ORS	Oral Re-hydration Solution
ORT	Oral Rehydration Therapy
PAA	Performance Activity Assessment
PHD	Provincial Health Department
PVO	Private Voluntary Organization
TA	Technical Assistance
TT	Tetanus Toxoid
TBA	Traditional Birth Attendants
TOT	Training of Trainers
USAID	United States Agency for International Development
USCC	United States Catholic Conference
VDC	Village Development Committee
VHC	Village Health Committee
VHV	Village Health Volunteer
WBW	World Breast feeding Week

FOURTH ANNUAL REPORT
Period October 2004 – September 2005
Catholic Relief Services Child Survival Program in Cambodia
Award No. HFP-A-00-01-00042-00

Objectives:	Results:
Increase to 80 % children under 2 years of age fully immunized in Bovel District and 60% fully immunized in the New Districts	Fully Immunized: Bovel :90 % children Samphov Loun: 85% children
Increase to 65% pregnant women who have 2 TT before the birth of their baby by recall and 55% by card	Pregnant women TT 2: Bovel: 50% Samphov Loun: 47%
Increase to 60 % mothers who recognize at least two signs of pneumonia.	55% recognized at least two signs of pneumonia
Increase to 55 % mothers who recognize 2 signs of dehydration as danger signs of diarrhea	45% recognized two signs of dehydration as danger sign of diarrhea.
Increase to 60% mothers who recognize 2 signs of malaria in the malaria zone.	81.6% recognized fever and 79.3% chills as danger signs of malaria.
Increase to 45% women of children <2, who sought appropriate medical treatment when their child experienced rapid and/or difficult breathing	33% of women of children< 2 sought appropriate medical treatment when their child experienced rapid and/or difficult breathing.
Increase to 50% mothers who sought appropriate medical care for her child <2 years for diarrhea, dehydration, bloody diarrhea or persistent diarrhea.	53% mothers sought appropriate medical care for her child <2 years for diarrhea, dehydration, bloody diarrhea or persistent diarrhea.
Increase to 50 % mothers whose child <2 experiencing fever sought appropriate medical care in the malaria zone.	33% mothers whose child <2 experiencing fever sought appropriate medical care in the malaria zone
Increase to 40% mothers of children under 2 years experiencing diarrhea in the last two weeks who treated their child with Oral Rehydration Therapy	29.6% of mothers used ORS and 13% home based fluids when their child had diarrhea .
Increase to 30% mothers who practice exclusive breastfeeding for the first six months	28% mothers practiced exclusive breastfeeding for the first six months
Increase to 45 % children from age 6 months to 2 years intake of Vitamin A and iron rich foods.	50 % children from age 6 months to 2 years intake of Vitamin A and iron rich foods.
Increase to 90% children <2 sleeping under impregnated bed nets in the malaria zone.	99.3% children <2 and pregnant women slept under impregnated bed nets in the malaria zone.
Increase to 90% pregnant women sleeping under impregnated bed nets in the malaria zone	

USAID 2005 Annual Report

A. The main accomplishments of the program:

1. Implementation of an improved Behavior Change Communication (BCC) strategy:
 - Outside consultation for CRS managers and staff on recommendations of the Midterm Evaluation (MTE).
 - Targeting focused on women of reproductive age 15 – 49 years of age.
 - Improved training to community structures (Village Health Volunteers (VHVs), Village Health Committees (VHCs), Traditional Birth Attendants (TBAs), & Health Center Management Committees (HCMCs) using adult learning techniques, instruction in use of participatory methodologies, increased practice session including community practice sessions during training and breaking information for training into smaller parts with clear key messages.
 - Expanded use of participatory methods for BCC in the communities including role plays, stories, case studies, demonstrations, problem trees, drawing, decision making using pictures.
 - Expanded use of various media including leaflets and posters, video in the HC, audio messages in the community, campaigns with interactive participation, and radio spots.
 - Development of Mother's Group Leaders (1,714) in 141/194 villages to assist the VHVs & TBAs in mobilizing and ensuring that mothers come for BCC sessions.
 - Change from providing education to a general group to development of Mother's Groups (1,045) of 20 mothers to a group in 141/194 villages.
 - Improvement of education to Health Center (HC) clients during waiting periods and consultation through use of video and participatory methods.
 - Improved counseling of women during Antenatal Care (ANC) and the use of the Facility Based Integrated Management of Child Illness (F/IMCI) mother's counseling.
 - Identifying and addressing barriers to participation and improved scheduling.
 - Development and use of a new checklist for monitoring and supervision.
 - Increased coverage of mothers who know two danger signs of pneumonia to 55% up from 24.5%.
2. Increased access of families and communities to safe water and improved sanitation through:
 - Water and Sanitation projects:
 - 1) Pump well projects: 38 wells for 1057 families in 5 villages.
 - 2) Latrine projects: 2,756 latrines for 2,771 families in 16 villages.
 - Water/sanitation project BCC reached 3,828 families and focused on hand washing, protection of safe water, use of latrines, and hygiene.
 - Annual planning in 50 VHC villages included improvement of village sanitation
3. Improved availability and use of data at the community level:
 - Use and development of a uniform format for the Village Health Record (VHR) negotiated with the Provincial Health Department (PHD), Operational District (OD), HC and Community Structures (CS).

- 217 VHVs and 9 HC staff in 9 HCs provided training and technical assistance on data collection, recording and use of the revised VHR. VHVs, VHCs and & HC staff already using the revised VHR in 7 HC coverage areas received technical assistance.
 - Recording of deaths and births were added to the village health record.
 - Mobilization and coverage of children and pregnant women for the National Immunization Program (NIP) and Vitamin A capsule were improved.
 - The VHR was used in the VHC semi-analysis and annual health planning.
4. Increased sustainability of VHCs ensured through the revision of the self-management training and activities in the communities:
 - Development of community annual health planning with semi-annual analysis by 50/50 VHCs.
 - Revisions of training, scheduling and methods of provision of self-management training and guidelines for VHC procedures was based on lessons learned.
 - Integration of VHC annual plans with HC and Commune Council (CC) plans in 10/50 VHCs.
 5. Coverage for fully immunized children under 1 year reached 90% in Bovel and 85% in Samphov Loun :
 - Post Activity Assessment in Sampov Loun OD identified the real practices and coverage by the health center staff for outreach immunizations and was used to solve problems and improve planning by the PHD, OD, CRS and HC.
 - Counseling by F/IMCI by staff at 16 /16HCs increased access to immunization for children and pregnant women.
 - Mother's with children under 2 years of age keeping their immunization card increased to 97%.
 - Outreach Management Training (including NIP) in Samphov Loun OD was provided to 58 staff.
 6. Coverage of the key messages for immediate and exclusive breast feeding in the entire project area expanded through routine and World Breast Feeding Week campaigns, radio spots, videos at the health center and counseling during ANC and IMCI visits.
 7. Vitamin A coverage and mother's knowledge increased through training to HC and CS, improved mobilization by Mother's Group Leaders and VHVs using VHRs and education to mothers groups:
 - Vitamin A capsule distribution coverage reached 84% in November, 2004, and 85.5% in March, 2005.
 - Results of the LQAS monitoring survey in December, 2004 showed that 50% of mothers with children from 6 months to 2 years provided Vitamin A and iron rich food.
 8. Health Center Management Committees developed in 11 new health centers established community agreed upon fees and exemptions for the poor and assisted the health center in improving the quality and transparency of services at the health centers.

9. Improved quality of assessment, classification, treatment, counseling and referral for children 0 – 5 years of age through support for F/IMCI development, training, and technical assistance:
 - Maintenance of the quality of Bovel District HCs through CRS technical assistance and support for supervision (8 HCs) resulted in an average supervision score of 92%.
 - F/IMCI expansion to Samphov Loun OD 8 HC reached the MOH target of training of 60% of the staff and an average supervision score of 86%.
 - F/IMCI expansion to Thmor Kor OD 9 HC with training of 30% of health center staff occurred in September of 2005. Technical assistance is being provided to establish F/IMCI.
 - TOT and supervision training for 7 OD supervisors and support and involvement for F/IMCI regular (1 – 2 month) supervision provided.
 - IMCI mother's counseling improved through 4 trainings focused on the review of counseling techniques, practice and technical assistance for 34 health center staff in Bovel district and 32 staff in Sampov Loun Operational District.
 - Increase in utilization of the health centers by children with common illness increased by 57% in Bovel and 74% in Samphov Loun after IMCI instituted.
 - Exit interviews with mothers after the training showed an increase in satisfaction and knowledge as shown in the change in the mother's exist interview scores from 57% to 77%.
 - Campaigns to provide communities information about IMCI held in 81/83 villages, reaching 6,952 mothers.
 - Interest of Provincial, OD and HC in implementing F/IMCI increased as a result of a CRS/ MOH/PHD workshop disseminating the F/IMCI strategy and lessons learned from the Bovel and Samphov Loun OD F/IMCI experience.
10. Collaboration and coordination between operational district, health center staff, local authorities and community health structures improved health center and community health services, coverage and information to the community on IMCI, NIP and other health topics through 11 Linkage workshops with participation of 7 OD, 83 HC staff, 116 local authorities and 616 Community Structures for a total of 822 participants.
11. Malaria case management for severe in patients, outpatients and pregnant women improved at the RH and 10 HCs through training and technical assistance including the reinforcement of F/IMCI malaria treatment, out-patient and in-patients case management for 39 RH staff and 22 HC staff in the Samphov Loun OD and Bovel District.
12. OD managers improved skills in training, planning and monitoring and supervision through support, TOT training, technical assistance for quarterly, semi-annual and annual analysis and planning and supervision.
13. Referral hospital, health center, and community structures increased quality of services and capacity through support, training and technical assistance.

14. Increased technical and management capacity of CRS managers and staff through self - reflection and utilization of experiences, analysis and planning, training and technical assistance.
15. Development of draft Constitution, bylaws and policy and procedures were completed relating to the transformation of the CRS Battambang Health program into a local organization, AHEAD, Cambodia.

▪ **What the project has done well.**

1. Facilitated and supported development of linkages between health facilities and community structures, community structures within communities and communities.
2. Increase health education coverage and behavior change through change in BCC strategy.
3. Facilitated and supported the development of VHC self-management: community diagnosis, community health problem identification, proposal development, water and sanitation project development, implementation, monitoring, evaluation and maintenance, annual planning and analysis, and village water and sanitation projects.
4. Supported, provided technical assistance and collaborated with health center, OD and PHD managers and staff to improve health services through quarterly analysis and planning.
5. Collaborated with and supported the PHD and OD to perform and utilize the Post Activities Assessment for Immunization to improve the health center and community practices for outreach immunizations.
6. Developed and implemented a BCC strategy to improve immediate and exclusive breastfeeding with OD and HC midwives, TBAs, VHVs and other NGOs.
7. Developed Health Center Management Committees in collaboration with HC, Community structures, OD and Commune Councils.
8. Established and maintained quality F/IMCI in 16/16 health centers.
9. Collaborated and supported government (MOH, PHD, OD, HC, Village Chief, Village Development Committees, and Commune Councils), community structures and communities.
10. Integrated HIV/AIDS and Water & Sanitation into the Community-Based Primary Health Care Program (CBPHCP).

▪ **The factors that contributed to achieving these accomplishments.**

1. Community structures are available 191/196 villages in the program area.
2. Mother's Groups exist in 77 % of the villages.
3. Good communication, collaboration and linkage between communities, community structures and health centers established and functioning well.
4. Good community participation (by mothers and community in general).
5. CRS staff and managers have the capacity to strengthen health center and community activities.
6. Good collaboration between CRS and counterparts in the government and the community at all levels with few exceptions.
7. CRS managers able to solve problems with their counterparts when they exist.

8. Refrigerators now available in all health centers.
9. Capacity building through training and regular technical assistance/monitoring support by CRS to OD, HC and community structures.
10. Timely problem solving.
11. Managers and staff commitment to the program.
12. Availability of complementary funds for bed net impregnation, water and sanitation projects, VHC development and MCH interventions.

- **Projective interventions, objectives, Key Activities and Status of Activities for 2005. An LQAS monitoring survey was done in November 2004. This will be repeated in November 2005.)**

Project objectives	Key Activities (as outlined in the DIP)	Status of Activities
Intervention: Immunization – 25%		
Increase to 80% mothers with children under 2 years of age who keep their immunization card.	<ol style="list-style-type: none"> 1. Post Activities Assessment (PAA) with PHD, OD and HC to identify NIP coverage and quality and knowledge of the mothers. 2. Health education during outreach by health center staff and community structures. 3. Health education at the health center using a CD spot with participatory methods 1 time per week. 4. HC staff educates mothers to bring their children's and their immunization cards to the HC when they come for any illness. 	<ol style="list-style-type: none"> 1. 4,425 people provided with by HE by HC staff and community structures during outreach. 2. 2,044 people reached by HC education. 3. 94% IMCI staff inform mothers about immunizations, keeping and bringing their cards with mothers during the visits 4. PAA results: Assessment in random villages of 8 HC in 1 OD showed an increase of mothers keeping immunization cards to 97%.
Increase to 80 % children under 2 years of age fully immunized in Bovel District and 60% fully immunized in the New Districts (Samphov Loun, Phnom Prick, and Kam Reang)	<ol style="list-style-type: none"> 1. Common Activities: 2. Annual Planning and Quarterly analysis at HC and OD with planning to improve NIP coverage. 3. Support Health center staff routine NIP Outreach activities 4. Health education at health center by use of CD spot 1 time per week. 5. Community structures collect data in VHR on children and pregnant women and mobilize them for NIP activities. 	<ol style="list-style-type: none"> 1. CRS technical assistance to HC and ODs to analyze NIP coverage quarterly, semi-annual and annually to identify strengths and weaknesses and develop plans to solve problems to improve NIP for children and pregnant women in 16 HCs in 1 ½ ODs. 2. PAA conducted in 8 HC in 1 ODs identified problems and plans to improve the NIP activities and coverage. 3. NIP checklist performed every 3 month for each health center to identify and solve problems. 4. Integrated Outreach in 21 distant villages. 5. 6,952 people received information about

<p>Increase to 65% pregnant women who have 2 TT before the birth of their baby by recall and 55% by card</p>	<ol style="list-style-type: none"> 6. Community structures provide health education at village. 7. Health centers have schedule for immunization at the health center and identify and immunize children and pregnant women through the F/IMCI protocol. 8. Use of NIP quality checklists to improve NIP technical and management quality and coverage. 9. Conducted training to TBAs on the important of tetanus and announcement for vaccine availability the at health center. 10. Training of new VHV in basic course 11. Integrated Outreach to distant villages. <p><u>Activities for Fully Immunized children:</u></p> <ol style="list-style-type: none"> 1. TBAs inform mothers at delivery to obtain BCG and Hepatitis B Birth doses. 2. Hepatitis B training 3. Hepatitis B information to CS and local authorities during linkage workshop and to mothers through IMCI campaign and mothers group education sessions. 4. Post Activities Assessment <p><u>Activities for TT2 for pregnant women only:</u></p> <ol style="list-style-type: none"> 1. TBAs and MWs counsel pregnant women to obtain TT2. 2. National Campaign activities to provide Tetanus to all pregnant and reproductive age women. 	<p>hepatitis B through the F/IMCI campaign</p> <ol style="list-style-type: none"> 6. 63 new VHV trained on NIP in the Basic VHV course. 7. 13 CRS staff trained on Hepatitis B vaccine and how to provide technical assistance to HC and CS for outreach activities. 8. 90 % children under 1 yr. fully immunized in Bovel and 85% in Samphov Loun. 9. 50% pregnant women recieve TT2 in Bovel and 47% in Samphov Loun. 10. 1,638 children received immunizations at the HCs during IMCI visits.
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	3. Train TBA on the important of tetanus and announcement for vaccine available at health center.	
Interventions – ARI (20%) , CDD 30%, Malaria 25% (Activities at the facility level are combined for these into use of the F/IMCI strategy which is the accepted strategy in Cambodia) and a common BCC strategy is used at the community level.		
Recognition of danger signs: ARI, CDD, Malaria		
<p><u>ARI</u> Increase to 60 % mothers who recognize at least two signs of pneumonia.</p> <p><u>CDD</u> Increase to 55 % mothers who recognize 2 signs of dehydration as danger signs of diarrhea</p> <p><u>Malaria</u> Increase to 60% mothers who recognize 2 signs of malaria in the malaria zone.</p>	<p><u>Key Common Activities</u></p> <ol style="list-style-type: none"> 1. Qualitative assessment of mothers’ practices for prevention and management of ARI, CDD and Malaria through CS and Mothers Groups discussion and use of the problem tree. 2. Participatory BCC training to VHVs by HC & CRS. 3. Mobilization of Mothers by MGL 4. VHVs educate Mother’s Groups using participatory methods such as correct and incorrect picture, case study, and group discussions, etc. 5. Every two month analysis of HE result and planning by the HC with VHVs to increase coverage 6. Danger signs key messages to mothers for the specific problem of their child as part of F/IMCI counseling during their HC visit. <p><u>Special Activities:</u></p> <p>ARI: 1. None</p> <p>CDD: 1. Education by VHCs during water and sanitation project implementation</p> <p>Malaria: 1. Education by HC & CS</p>	<p><u>ARI</u></p> <ol style="list-style-type: none"> 1. ARI BCC trained to VHVs 276/459=60%. 2. ARI BCC HE coverage reached to 17,851/20507 = 87%% 3. LQAS 2004 results: 55% mothers recognized at least two sign of pneumonia. <p><u>CDD</u></p> <ol style="list-style-type: none"> 1. Part 1 of the new CDD BCC curriculum (Prevention, danger signs, seeking care) trained to VHVs 226/459=49%. (Additional VHVs to be trained in Oct. 2005.) 2. VHVs in the process of providing BCC to Mother’s Groups. 3. LQAS 2004 results: 45% of mothers recognized two sign of dehydration as danger sign of diarrhea. <p><u>Malaria (only in Malaria Zone – 9 HC)</u></p> <ol style="list-style-type: none"> 1. New malaria curriculum developed. 2. Malaria trained to VHVs 201//287 =70%. 3. HE coverage reached to 10,951/11,428 = 96%. 4. LQAS 2004 results: 81.6% mothers recognized fever and 79.3% chills as danger signs of malaria. <p><u>ARI,CDD, Malaria F/IMCI:</u></p> <ol style="list-style-type: none"> 1. Staff at16/16 HC use F/IMCI to assess, classify, treat and provide counseling to mothers with ill children. 2. 66 staff at 16/16 HCs received a refresher course on counseling of mothers for IMCI. 3. 5,095 mothers educated on ARI at the HC. 4. 2,240 Mothers educated on CDD at the HC.

	during mosquito bed net impregnation.	<p>Special Activities:</p> <ol style="list-style-type: none"> 5929 families received HE by VHCs during Wat/San project implementation. 16,408 families received HE during mosquito bed net impregnation.
Seeking Care for ARI, CDD & Malaria		
<p>Increase to 45% women of children <2, who sought appropriate medical treatment when their child experienced rapid and/or difficult breathing</p> <p>Increase to 50% mothers who sought appropriate medical care for her child <2 years for diarrhea, dehydration, bloody diarrhea or persistent diarrhea.</p> <p>Increase to 50 % increase mothers whose child <2 experiencing fever sought appropriate medical care in the malaria zone.</p>	<p>Common Activities:</p> <ol style="list-style-type: none"> Facility IMCI Linkage workshops to disseminate IMCI strategy to CS and local authorities Community IMCI campaigns Development of HCMCs with community agreed upon fees and exemptions for the poor. Information about HC services by HCMC to the community. BCC strategy utilized for the key messages of recognizing danger signs and seeking appropriate care See Danger signs for community BCC strategy. 	<ol style="list-style-type: none"> Facility IMCI improved in all HC: <ul style="list-style-type: none"> Supervisory checklist scores: <ul style="list-style-type: none"> Bovel: 85% to 96% Samphov Loun: 76% to 84% CRS checklist scores: <ul style="list-style-type: none"> Bovel: 66% to 86% Samphov Loun: 55% to 83% Linkage work shops in 11 HC reach 616 CS and 116 local authorities from 127 villages, 83 HC staff. and 7 OD managers. Community IMCI campaigns reached 6,952/9737 (71%) in 81/83 Villages Mothers exist interviews show increased satisfaction scores: <ul style="list-style-type: none"> Bovel: 58% to 75% Samphov Loun: 49% to 77% 11 HC developed HCMCs with 105 members trained on the basic course. <p>6. See results from danger signs above.</p>
Other CDD, Malaria objectives		
<p>Increase to 40% mothers of children under 2 years experiencing diarrhea in the last two weeks who treated their child with Oral Rehydration</p>	<ol style="list-style-type: none"> ORS is provided and instructions on how to mix and how to use ORS and HBFs are provided through F/IMCI counseling to mothers of children who come to the HC with diarrhea. 16/16 HC have an ORT corners 	<ol style="list-style-type: none"> CDD curriculum developed. Part 2 of the curriculum includes ORT and will begin to be trained to VHV's in November. System for positioning ORS in the community is being discussed and developed with the OD, HC and VHV's. LQAS 2004 results: 29.6% of mothers used ORS and 13% home based fluids when their child had diarrhea.

<p>Rehydration Therapy</p>	<p>to provide rehydration to children with diarrhea.</p> <ol style="list-style-type: none"> 3. All mothers with children under 5 seen in the HC receive the IMCI mother's card that includes information on mixing and use of ORS and HBF. 4. HCs use a video on diarrhea that shows how to mix and use ORS. 5. HC and community provide leaflets for diarrhea prevention and treatment including ORT. 6. VHV's provide information on use of ORT to mothers with children with diarrhea who consult them in the communities. 	<p>when their child had diarrhea.</p>
<p>75% of VHC Villages have regular village cleaning schedules or systems</p>	<ol style="list-style-type: none"> 1. VHC annual plans include a plan to improve sanitation in the villages. 2. Sanitation for safe water, latrine use and maintenance of projects is part of water and sanitation projects. 	<ol style="list-style-type: none"> 1. 50/58 VHC annual plans include plans for improving sanitation in the village. 2. Semi-analysis of plans conducted to determine progress in 50/58 villages 3. LQAS results: <ul style="list-style-type: none"> ▪ Disposal of babies feces: <ol style="list-style-type: none"> 1) Latrine: 24% 2) Bury: 47% ▪ Disposal of garbage: <ol style="list-style-type: none"> 1) Burn: 84% 2) Closed pit: 1% 3) Open pit: 13%
<p>90% of VHC Villages have water or sanitation projects.</p>	<ol style="list-style-type: none"> 2. VHC expansion to 16 villages. 3. VHC community diagnosis, problem identification and community meeting conducted 4. Proposal developed. 5. Community environment, water and/ or sanitation projects for prevention of diarrhea developed, implemented, monitored and evaluated by the VHC and the community. 6. Education provided use, maintenance, and rehabilitation of water and sanitation projects. 	<ol style="list-style-type: none"> 1. 21/21 VHCs scheduled to developed and implemented water and sanitation project this year. 2. 50/ 58 VHC villages(86%) have implemented water and sanitation projects during this project to date 3. Family latrine project (2005): 2,955 latrines benefiting to 2,971 families with in 16 villages. 4. Pumping well projects (2005): 36 wells benefiting 1057 families in 5 villages. 5. LQAS 2004 results for hand washing: <ul style="list-style-type: none"> ▪ Before prepare food: 75% ▪ Before feeding child: 46%

	<p>7. Education to change community hygiene & sanitation practices:</p> <ul style="list-style-type: none"> ▪ Hand washing with soap. ▪ Safe water ▪ Food hygiene. ▪ Sanitation. 	<ul style="list-style-type: none"> ▪ After defecating: 20% ▪ After cleaning child: 28% ▪ Using soap for washing hands: 89%
<p>Increase to 90% children <2 sleeping under impregnated bed nets in the malaria zone.</p> <p>Increase to 90% pregnant women sleeping under impregnated bed nets in the malaria zone</p>	<ol style="list-style-type: none"> 1. Development of BCC curriculum for malaria including bed net impregnation. 2. Qualitative assessment of community practices for use of bed nets through mothers groups, discussions with local leaders and CS. 3. Education and planning with CS and local leaders emphasizing how to reach migrants and those living in distant villages. 4. HE through mother's groups & group education to the community by community structures and local leaders. 5. Information and organization, and implementation for bed net implementation activity in coordination with local leaders, PHD, OD, HC, and CS for each village. 	<ol style="list-style-type: none"> 1. 201/287 (70%) CS trained on malaria BCC/bed net impregnation. in 9 HC in the malaria zones. 2. Team of 43 people including CS, HC and OD staff trained on technical aspects of bed net impregnation. 3. 39,534 bed nets impregnated for 16,408 families in 126 villages, 18 communes and 4 districts for a coverage of 79.8 % 4. LQAS 2004 results: 99.3% children and pregnant women, mothers slept under impregnated mosquito bed net.
<p>Increase to 45% pregnant women in the malaria zone experiencing fever and/or other signs and symptoms of malaria during recent their most recent pregnancy who sought appropriate medical care.</p>	<ol style="list-style-type: none"> 1. Training to RH and HC staff on dangers, screening and treatment for pregnant women with malaria. 2. Screen all pregnant women during ANC visits. 3. Health education and counseling provided by MWs to pregnant women during ANC and out reach activities. 4. Training to TBA/VHVs on dangers of malaria and need for refer to the HC. 5. TBA/ VHVs provide health 	<ol style="list-style-type: none"> 1. 81% pregnant women come for ANC 2. Training on malaria in pregnant women: <ul style="list-style-type: none"> ▪ 59 TBAs ▪ 201 VHVs ▪ 61 HC & RH staff 3. HE coverage through: <ul style="list-style-type: none"> ▪ HC to 2,638 women. ▪ VHV to 10,951 ▪ TBAs to 359 4. Results: 91 pregnant women with malaria treated at the health centers.

	education to pregnant women individually and in small groups in the community.	
Cross Cutting Themes		
Increase to 30% mothers who practice exclusive breastfeeding for the first six months.	<ol style="list-style-type: none"> 1. Focus Group Discussions (FGD) to determine present practices and constraints for immediate and EXBF. 2. Capacity building to health center midwives on counseling and Behavior Change for immediate and EXBF including use of CD and participatory methodologies for HE at the HC. 3. HC MW counseling during ANC. 4. Capacity building to TBAs Behavior change behavior for immediate and EXBF. 5. Breast feeding campaigns by CRS MW, TBAs and VHV.s. 6. World Breast Feeding Week campaigns. 7. Radio announcement on key messages for immediate and EXBF. 8. TBA and Midwives education on BCC breast feeding key messages to mothers at villages through the mothers groups. 9. IMCI staff at 16/16 HC provide counseling to the mothers on EXBF and CF during visits. 10. Mothers receive IMCI counseling card with ExBF information to take home during IMCI visits. 	<ol style="list-style-type: none"> 1. Key messages for immediate and EBF developed from FGDs conducted in 16 HCs/ 20 villages with 20 pregnant women and 260 mothers with children less than 2 year of age. 2. 35 HC MWs provided counseling to pregnant and post partum women during ANC and used a CD on immediate and EXBF with participatory methods at 15 HCs. 3. 166 TBAs trained on BCC for Immediate and EXBF in 15 HCs. 4. Routine breast feeding campaigns conducted in 9 HCs, 17 villages reached 300 pregnant women and 428 mothers. 5. WBFW campaigns in 15 health centers reached 245 pregnant women and 1,488 mothers in 35 villages located far from the HCs 6. Radio announcements reached accessible areas in two ODs. 7. LQAS 2004 Results: <ul style="list-style-type: none"> ▪ Exclusive BF: 28% ▪ Immediate BF: <ol style="list-style-type: none"> 1) Within 1 hour: 48% 2) After 1 hr, (1st day): 41%
Increase to 45 % children from age 6 months to 2 years intake of Vitamin A and iron rich foods. Increase Vitamin	<ol style="list-style-type: none"> 1. Training on Vitamin A to CRS, HC and CS. 2. Collaboration between HC, CS, Local authorities and other organizations for education and mobilization of children and pp women. 	<ol style="list-style-type: none"> 1. Training on Vitamin A to: <ul style="list-style-type: none"> ▪ 6 CRS staff ▪ 32 health center staff in 16 health centers. ▪ Outreach training on management and organizing to integrate outreach activities to 34 staff from 8 health center

<p>A supplement coverage for children 6 – 59 months and post partum women to 80%.</p>	<ol style="list-style-type: none"> 3. Community structures provide health education and inform mothers of the importance of Vitamin A in their diet and supplements & for the date of activities. 4. Monitoring and supervision by PHD, OD and CRS distribution. 5. Post activity analysis and planning. 6. Vitamin A provided during routine integrated outreach. 7. Assessment and provision of Vitamin A to children and women during F/IMCI at the HC. 	<p>activities to 34 staff from 8 health center in Sampov Loun OD.</p> <ol style="list-style-type: none"> 2. 2,447 mothers received Vitamin A education. 3. LQAS 2004 Results: <ul style="list-style-type: none"> ▪ 50% of mothers have children from 6 months to 2 years provide Vitamin A and iron rich food. 4. Results of Vitamin A campaign for children 6 – 59 months: <ul style="list-style-type: none"> ▪ November 2004: 84% ▪ March 2005: 85.5% 5. Postpartum Vitamin A: <ul style="list-style-type: none"> ▪ November 2004: 80% ▪ March 2005: 92% 6. Vitamin A provided during IMCI: 2,756 children. 																			
<p>Increase to 60% mothers giving the same or increased amounts of fluid and food during illness.</p>	<ol style="list-style-type: none"> 1. The same or increased breast feeding, fluids, and food for children during illness and during recovery from illness incorporated into ARI, CDD and Malaria BCC curriculums. 2. Training by HC and CRS to VHVs 3. The key message for increased breast feeding, fluids and food for children during illness and during recovery from illness provided by: <ul style="list-style-type: none"> ▪ VHVs to mother’s groups as part of ARI, CDD and Malaria training. ▪ HC education. ▪ Counseling during IMCI visits. 4. Refresher training for HC staff on F/ IMCI Counseling. 	<ol style="list-style-type: none"> 1. VHVs Trained on: <ul style="list-style-type: none"> ▪ ARI: 276/455(60%) ▪ Malaria: 201/287 (96%) ▪ CDD: 226/459 (49%) 2. Community HE coverage for: <ul style="list-style-type: none"> ▪ ARI: 1785/20507 (87%) ▪ CDD: 2495/20507 (12%) (CDD BCC HE only started in Sept.2005) ▪ Malaria: 10951/11,428 (96%) 3. HC education on: <ul style="list-style-type: none"> ▪ ARI: 5,561 ▪ CDD: 2789 ▪ Malaria: 2,763 4. IMCI counseling refresher course provided to 64 IMCI staff for 15 HCs. 5. 60% of all HC staff in Samphov Loun and Bovel trained in F/IMCI. 6. Counseling on feeding during and during recover after illness provided during IMCI counseling in 16/16 HCs 7. LQAS 2004 Results: <table border="1" data-bbox="927 1566 1479 1875"> <thead> <tr> <th rowspan="2">Illness</th> <th colspan="2">Same</th> <th colspan="2">Increase</th> </tr> <tr> <th>Fluid</th> <th>Food</th> <th>Fluid</th> <th>Food</th> </tr> </thead> <tbody> <tr> <td>ARI</td> <td>41%</td> <td>29%</td> <td>21%</td> <td>24%</td> </tr> <tr> <td>CDD</td> <td>26%</td> <td>37%</td> <td>53%</td> <td>25%</td> </tr> </tbody> </table>	Illness	Same		Increase		Fluid	Food	Fluid	Food	ARI	41%	29%	21%	24%	CDD	26%	37%	53%	25%
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Capacity Building / Sustainability		
20% increase in pre and post test scores.	1. Pre and post tests conducted for VHV, HC and RH trainings to assist OD, HC and CRS in determining weaknesses that need continued support to ensure the quality of the planned education or activity.	1. Average increase in pre and post test scores for: <ul style="list-style-type: none"> ▪ VHV's between 20% - 30% ▪ TBAs between 21% - 28% ▪ HC staff between 23% - 30%
50% Community structures reach acceptable level (70%) on HE check list.	1. Revision of HE checklist to reflect the new BCC curriculums. 2. Training to CRS HC staff on use of the checklist. 3. HE checklist used to provide feed back to VHV's on education provided to Mother's Groups.	1. HE checklist revised. 2. HE checklist conducted in 9 HC areas with a numbers of VHV's. 3. The average checklist score was 76%. 4. HE coverage is reported by VHV's to the HC monthly.
70% of health centers in the project site have an acceptable level (75%) of performance in case management of ARI, CDD, Malaria/ IMCI as measured by quality assurance checklists	1. Use of IMCI supervision checklist by OD supervisors on a regular schedule to improve the quality of F/IMCI by HC staff. 2. CRS staff use IMCI checklist to provide technical assistance to HC staff to improve the quality of IMCI. (Frequency depends on the HC staff need.) 3. Exit interview are conducted with mothers of children who have been seen using the IMCI strategy.	1. OD IMCI supervision scores have increased from: <ul style="list-style-type: none"> ▪ Bovel: 85% to 96% ▪ Samphov Loun: 76% to 84% 2. IMCI Mother Exist Interview scores increased from: <ul style="list-style-type: none"> ▪ Bovel: 58% to 77% ▪ Samphov Loun: 49% to 81% 3. CRS IMCI monitoring checklist average: <ul style="list-style-type: none"> ▪ Bovel: 86% ▪ Samphov Loun: 83%
85% of health centers will have an acceptable level (75%) of quality of EPI service as measured by quality assurance checklists.	1. Quality performance checklists used to provide technical assistance and to monitor the technical/ management and sustainability for NIP at the HC and community. 2. Meeting and feed back on weak areas with planning for sustainability	1. 14 out of 16 HC (87%) of health centers conduct every 3 month checklists. 2. The average checklist score is 79%.
50% of health centers will have	1. HC Management Quality/sustainability is	1. Accounts and Infection Control checklists conducted with HC staff at 16/16 HC

<p>an acceptable level (75%) of management quality as measured by management checklists.</p>	<p>measured by the use of performance quality checklists for:</p> <ul style="list-style-type: none"> ▪ IC checklist ▪ Accounts checklist <p>2. Monitoring and technical assistance is provided for drug management (No checklist)</p>	<p>according to the need of the HC.</p> <p>2. Average Checklist Results:</p> <ul style="list-style-type: none"> ▪ Account checklist score: 89% ▪ Infection Control checklist score: 83%
<p>90% OD reach an acceptable score for IMCI</p> <p>(The OD managers receive TA from the MOH after receiving supervision training)</p>	<ol style="list-style-type: none"> 1. CRS and OD plan supervision schedules and emphasis. 2. OD managers with CRS staff provide supervision to HCs for IMCI 3. Post supervision OD supervisors provide feed back to HC staff at each HC. 4. OD managers present and discuss results of IMCI supervision during monthly OD or IMCI meetings to address areas for improvement. 	<ol style="list-style-type: none"> 1. IMCI supervision is conducted every month to every 2 months depending on the HC need. 2. OD/HC meetings are held monthly 3. OD/HC IMCI meetings are held every two months.
<p>75% of Operational District supervisors use IMCI or SCM Quality Assurance check lists for supervision.</p>	<ol style="list-style-type: none"> 1. OD supervisors receive training on use of the IMCI supervisory checklist from the MOH. 2. OD supervisors also use the MOH integrated supervision checklists for general supervision which includes management quality. 	<ol style="list-style-type: none"> 1. 100% OD supervisors use the IMCI supervision checklist and use it 100% of the time. 2. 100% of OD supervisors use the integrated supervision checklist for supervision 100% of the time.
<p>100% of CRS staff have 90% technical competence score</p>	<ol style="list-style-type: none"> 1. Training to CRS staff by MOH, consultants, advisor and managers. 2. Technical assistance provided to staff by managers 3. Technical assistance to managers by health advisor. 	<ol style="list-style-type: none"> 1. Training to CRS staff: 2. 11 on F/IMCI clinical management. 3. 10 TOT and supervision. 4. 8/11 CRS staff chosen by MOH to be trainers for IMCI. 5. All CRS staff trained on BCC by consultant. 6. MOH, PHD, and OD accept CRS as co-trainers and supervisors. 7. 13 on NIP technical and management. 8. 10 on revised VHR, VHC guidelines.

		<p>9. 10 on ARI, CDD and Malaria BCC curriculums.</p> <p>10. 4 on BCC for BF</p> <p>11. Program manager and area managers have taken on management of the program with limited support from the advisor.</p>
<p>95% of CRS staff uses checklists appropriately for monitoring and improving IMCI/SCM at HC and community.</p>	<ol style="list-style-type: none"> 1. CRS staff use checklist for monitoring and improving IMCI. 2. CRS staff use checklists to monitor management at the HC. 3. CRS staff use checklists to provide technical assistance to the VHVs for BCC to mother's groups. 	<ol style="list-style-type: none"> 1. 100% of CRS staff use checklists to monitor HC management: Accounts and Infection. 2. 100% of CRS staff use IMCI and Mother's Exist interview checklists. 3. 62% of CRS staff use HE checklists to monitor and assist VHVs
<p>Circulated lessons learned on use of LQAS for baseline and monitoring</p>	<ol style="list-style-type: none"> 1. CRS staff conducted a LQAS survey in November 2004, analyzed the results and used them to review and develop their annual and quarterly planning. 2. LQAS results were shared with health center and OD staff in quarterly, semi and annually analysis and planning. 3. The results related to interventions were shared and analyzed with VHVs, VHCs and TBAs during ARI, CDD, Malaria and breastfeeding training and during development of annual planning. 4. Results were shared with the CRS SEAPRO regional counterparts. 	<ol style="list-style-type: none"> 1. 100% of the CRS staff involved with LQAS survey, analysis and planning. 2. 16/16 health centers and 2 ODs used the LQAS results to analyze and develop their quarterly and annually planning to improve the activities. 3. 308/368 VHVs in 16 health centers were involved in analysis of ARI, CDD and CDD results from LQAS monitoring survey and used them to develop plans for BCC and other activities. 4. 50 VHCs utilized the results of the LQAS survey to analyze their progress toward their objectives in their annual plans and to develop their annual plans. 5. 166/216 TBAs with 35 MW in 15 health centers used the LQAS data to analyze their progress toward their objectives for BF, CF, and Vitamin A, Danger signs of pregnancy, and TT2.
<p>5. Circulated lessons from midterm and final evaluation</p>	<ol style="list-style-type: none"> 1. Review and response of midterm evaluation recommendations 2. Development of revision of program plans. 	<ol style="list-style-type: none"> 1. Midterm Evaluation recommendations have been implemented. 2. Lessons learned have been shared.

	3. Lessons learned shared with other organizations doing Child Survival projects.	
Sustainability Objectives		
HCMC (CMCF) developed in 100% of coverage areas)	<ol style="list-style-type: none"> 1. HCMC developed through elections in 11 health centers. 2. Basic training to HCMCs 3. Regular HCMC meetings conducted with health centers. 4. HCMC conducted information gathering in communities to collect information about acceptable health center fees for each type of service from the community. 5. A contract and agreement was signed by local authorities and health officers. 6. Activities for existing HCMCs maintained. 	<ol style="list-style-type: none"> 1. 15/16 (94%) of the health centers have HCMC (one is the health post which is not approved to develop the HCMC). 2. 105 Health Center Management Committee members at 11 health centers elected and trained on the basic course. 3. Bylaws developed for all HCMC. 4. New HCMC at 11 health centers have official recognition and are supported by the local authorities. All submitted their request to get final official approval from the MoH. 5. HCMC in 15 health centers conducted meeting every month to address problems, improve transparency of services and increase access for the poor to use the health center services.
90% of villages have Community structures	<ol style="list-style-type: none"> 1. CRS community project officers and health centers mobilized the community with support from the local authorities to elect new VHVs to replace those who had left. 2. VHVs elections were done in 2 health centers that had no existing VHVs. 3. 8/14 VHCs expanded through community election. 	<ol style="list-style-type: none"> 1. 25 VHVs elected in 17 villages of 2 health centers by communities to replace VHVs who had stopped working. 2. 92 VHVs completed training on the basic VHV curriculum in 44 villages for 2 health centers. 3. 191/196 (97%) villages in the program areas have Village Health Volunteers. 4. 191/196 villages with existed VHVs in 16 health centers. 5. 8 VHCs expanded through community election with 48 members. 6 VHCs are going to develop.
50% of VHCs reach Level 3 development	<ol style="list-style-type: none"> 1. VHCs trained on self management from the beginning of the VHC development. 2. VHCs conducted annual assessment, developed annual health planning and analysis and developed action plans every 6 months. 	<ol style="list-style-type: none"> 1. 10 VHCs are in the process to become level 3 and 40 VHCs are in level 2. 2. 50/58 VHCs developed, analyzed and used health planning to improve the health for their community and 10/58 VHCs integrated annual health planning with health center planning. 3. 58/58 VHCs linked with other community structures.

	<ol style="list-style-type: none"> 3. VHCs integrated annual health planning with health center planning. 4. CRS continue to provide technical assistance to improve the weak areas for VHCs. VHCs are taking on more responsibilities without CRS assistance as part of the phase down process. 	<ol style="list-style-type: none"> 4. 58/58 VHCs received self management training and technical assistance from CRS and health center staff. 5. 21/21 VHCs managed, implemented and monitored the village water and sanitation projects.
50% of HCMC (CMCF) function without support	<ol style="list-style-type: none"> 1. CRS facilitated HCMC chiefs to develop and prioritized agendas for their meeting. 2. CRS provided technical assistance and feedback to the HCMC chiefs in each meeting to focus on the facilitation process, decision making and minute taking. 	<ol style="list-style-type: none"> 1. 4/15 (27%) HCMC are able to perform their roles as the HCMC such as conducting meetings, facilitating meetings, and decision making through participatory approaches.
50% of the VHCs sustain community PHC	<ol style="list-style-type: none"> 1. CRS provided self management training to VHCs immediately after development. 2. Regular technical assistance to VHCs on water and sanitation projects including maintaining the existing projects. 3. CRS provided technical assistance to VHCs to develop, use and analyze the village health register and health planning. 	<ol style="list-style-type: none"> 1. 58/58 VHCs trained on self management according to the procedures set up and stage of the VHCs. 2. 50/58 VHCs developed annual health planning, analysis and 10 VHCs integrated annual health planning with health center planning.
50% of HC will provide the MPA	<ol style="list-style-type: none"> 1. CRS staff worked with health center staff to provide technical assistance, monitoring and supervision to the health center on management and clinical services. 	<ol style="list-style-type: none"> 1. 16/16 health centers provide MPA services (health planning, staff meeting, HIS, Account System, Infection Control, training to community structures, drugs, OPD, ANC, PNC, NIP, Outreach activities, health education).
50% of the HC receive at least one supervisory visit from the TAG in the last 3 months	<ol style="list-style-type: none"> 1. CRS provided technical assistance to the OD technical advisory group assisting them to develop a plan for each integrated, 	<ol style="list-style-type: none"> 1. 16/16 health centers received integrated supervision from the OD TAG and feedback to improve health center management and clinical services. Supervision was done every month.

	<p>facility IMCI supervision and drug supervision.</p> <ol style="list-style-type: none"> 2. CRS assisted the OD TAG to provide feedback to health center staff during supervision. 3. CRS provided technical assistance to the OD TAG to identify and prioritize the agenda for each health center and OD meeting after supervision. 	<ol style="list-style-type: none"> 2. 16/16 health centers received facility IMCI supervision, feedback and facility IMCI meetings to address the problems and improve the services. The supervision was done every 2 months at Bovel and every month at Sampov Loun OD. 3. 13/16 health center supervisions were done in the last 3 months by the OD TAG and 3 health centers were done by the PHD drug supervisors.
100% of the HC have representation at the OD quarterly meeting	<ol style="list-style-type: none"> 1. Health center staff attended regular meetings at the OD every month. 2. Health center staff attend the quarterly, semi and annual analysis and planning at the OD. 3. CRS staff provided input into the monthly meeting and analysis and planning at the OD. 	<ol style="list-style-type: none"> 1. 16/16 health centers attended the monthly meetings and quarterly, semi and annually analysis and planning. 2. CRS regular provided input and joined the decision making with health centers and ODs at the monthly meeting and quarterly, semi and annual analysis and planning.
Improved technical and management competence of CRS staff	<ol style="list-style-type: none"> 1. CRS staff and managers trained on BCC from external consultant including marketing and adult learning techniques 2. CRS staff trained on interventions to increase the knowledge and skills to provide support and technical assistance to partners. 3. CRS staff and managers involved and provided input to the working group to develop strategy and sharing the lesson learned to MoH and NGOs 4. CRS management team conducted the meeting to address the problems and increased the management skills with Advisor. 5. CRS staff and managers conducted the quarterly, semi 	<ol style="list-style-type: none"> 1. 18 staff and managers trained on BCC including the marketing and adult learning techniques by the consultant and used the knowledge and skills to train to VHVs and TBAs to improve the behavior change of the mothers on interventions. 2. All CRS community project officers trained on Facility IMCI clinical management, supervisors and trainers to train to health centers with MoH and OD trainers. 3. Staff and managers provided input into the workshop and working group at the notational level to develop the plan and strategies such as immunization, hepatitis B, Infant Child feeding, C-IMCI. 4. CRS staff and managers quarterly, semi and annual analysis and planning conducted regularly and improved. 5. The management teams (managers) improved the skills to manage the

	<p>and annual analysis and developed the planning with assisted from the Advisor.</p> <p>6. Monthly and 2 weeks plan from staff and managers.</p>	<p>program, problem solving, planning including budget management improved.</p> <p>6. CRS staff and managers were recognized and accepted by the MoH to provide the technical assistance, monitoring and supervision to OD and health center staff for improving Facility IMCI, health strengthening and training.</p>
CRS staff transforms into a Cambodian Health NGO (HB)	<p>1. CRS staff and managers and Advisor conducted the workshop to develop the localization.</p> <p>2. Localization committee developed and moved the localization process forward</p>	<p>1. 29 CRS staff and managers attended the localization and reflection on previous activities and develop the plan and step to achieve the plan.</p> <p>2. Vision, goals, mission statement, name and objectives developed and approved by all staff and CRS Country representative.</p> <p>3. The bylaw and personnel policy developed and translated to the local language.</p> <p>4. The official registration with the Ministry of Interior of Cambodia will be submitted to get approval in November 2005.</p>
The transformed Cambodian Health NGO's staff successfully manages and completes the Child Survival Project (HB)	<p>CRS managers conducted meeting as the management team</p> <p>CRS managers provided monitoring and technical assistance to CRS staff and financial monitoring and management</p> <p>CRS staff provided monitoring and technical assistance to health center, OD and community structures</p> <p>2 weeks and 1 month plan developed by staff and managers</p> <p>quarterly, semi and annual analysis and planning</p>	See the result above
The Cambodian Health NGO replicates the CBPHCP strategy with CS interventions and obtains funding for sustaining the	<p>1. CRS staff and managers using and replicated the strategy of child survival to obtain funding to sustain the CBPHCP through Child Survival Bundled Proposal and HIV/AIDS project</p>	<p>1. USAID local mission funded 3 years HIV/AIDS project to obtain and sustain the CBPHCP.</p> <p>2. Child Survival Bundled project are in developing the proposal to get funding to maintain and sustain the Child Survival CBPHCP and replicate and expand to</p>

CBPHCP (HB)	submitted to USAID local mission for funding.	others operational district in Battambang Province.
Improved capacity for advocacy for community health needs and resources at all levels. Indicator: 50% of the communities access resources to meet the needs of the communities	<ol style="list-style-type: none"> 1. CRS developed trained and technical assistance to VHVs to provide the health messages to the community on the interventions. 2. CRS support the health centers to provide outreach services to community. 	<ol style="list-style-type: none"> 1. 97% of the villages access the health information from VHVs. 2. 50/196 villages have access to water and sanitation including the messages through VHCs.
Participate in policy development and change Indicator: National Policy and strategies developed and changed with input from CRS/Cambodia Health NGO	<ol style="list-style-type: none"> 1. CRS staff was invited to attended the national working group for CIMCI, NIP, Vitamin and young child feeding practices provided input into the National 2. CRS was selected to be a member of the CSWG at Medicam. 	<ol style="list-style-type: none"> 1. CRS provided input and field experiences of the interventions to the national activities and working groups. 2. CRS provided input in the CSWG to advocate to the MoH level to improve the interventions of child survival.

B. Factors that impeded progress toward achievement of overall goals and objectives and what actions are being taken by the program to overcome these constraints.

1. Migration:

In Sampov Loun Operational District and 3 health centers in Bovel District large numbers of people including whole families moved into the areas from other provinces to seek land; do seasonal work, engage in cross border trading between Thailand and Cambodia and cross into Thailand for temporary work. Migration causes a rapid increase in population, which is difficult to track, as well as an increase in the numbers of new villages that are located very far from health facilities. This makes it difficult to reach the people and ensure the coverage for their basic health care such as immunization, health education, Vitamin A, and bed net impregnation to prevent malaria. It is difficult for these people to use the health facilities when they get sick due to distance and lack of knowledge.

Action Plan: Village health records are maintained by VHVs, TBAs and VHCs to record all the new mothers and children under 5 years of age. Mother Group leaders register the new mothers and children into their groups, provide them with information and include them when they mobilize their groups for outreach activities such as immunization, Vitamin A, ANC and health education.

2. Difficult to access areas (about 40% during the rainy season) :

Many villages in Sampov Loun Operational District and some villages in Bovel District are difficult to access due to distance and poor road conditions, especially in the rainy season. This creates a problem both for health providers to go to these areas to provide the services to people and also for the people to come to the health facilities.

Action Plan: Health staff plan and conduct more intensive outreach services for difficult to access villages during the dry season attempting to reach high coverage of services during this time. Community structures are and continue to be developed to provide health education to people in these areas to assist in disease prevention.

3. Duplication of plans and different incentive support to local partners from NGOs and government:

Schedules for trainings and other activities had to be changed many times due to scheduling conflicts with trainings and other activities that had been decided at the MoH and PHD levels and by other NGOs without coordination with each other (both USAID funded and non-USAID funded). Trainings and other activities were often communicated to the Operational District level with no flexibility or consideration of other plans that the Operational District had made with other partners, and CRS plans were often changed .

NGOs working in the program areas often provide different support to the local partners (Operational District, Referral Hospital, Health Center and Community Structures) and have different philosophies of development. The partners are happy to work with NGOs who provide more incentives rather than the NGOs. Due to the long-term nature of the CRS program, which has a set level of support, and CRS' concern for the sustainability of the health activities, these differences regarding incentives created difficulties in dealing with partners and also some other NGOs.

Action Plan: CRS maintains regular and constant communication with the MoH, PHD and Operational District regarding their plans for trainings and other activities. At the PHD, OD and HC levels CRS regularly attends coordination meetings. CRS assists, participates and incorporates the CRS objectives and plans into quarterly, semi-annual and annual analysis and planning with health centers, Operational District, PHD and NGOs.

Collaboration and coordination is actively maintained with other NGOs such as the USAID Mission partners and other NGOs working in Battambang with the same local partners to discuss plans, incentives and do problem solving through regular and special meetings.

4. Community structures continue to need support to provide BCC to Mother's Groups.

Although the Community structures find the new methods of providing education easier, it is new to them and they need support. CRS and HC staff have limited time to provide support and supervision to all community structures.

Action Plan: More time is scheduled during the training to practice providing HE to the mothers including practice in the villages. A new checklist to assist CRS and health center

staff in monitoring VHV education was developed and is being used. Village Volunteers develop a plan with the health center and CRS to assist in monitoring and technical assistance

5. Linkages between local authorities, community structures and health facilities still need strengthening:

Community structures sometimes do not communicate within the community and local authorities although they were involved in election of VHVs and VHCs do not provide sufficient support to them. Health Center staff do not have sufficient time to provide all the support and supervision that the Community Structures need.

Action Plan: Linkages workshops attended by health center, local authorities and community structures provided an opportunity for all to share roles and responsibilities, discuss problems and plans. Development of the HCMCs provided a communication mechanism between the health center and the community.

C. Areas of the program for which technical assistance was required.

1. Technical assistance obtained by the project in 2005 was:
 - BCC consultation (outside consultant) to provide training to CRS staff on adult learning, participatory BCC methodologies and development of a revised Behavior Change Strategy.
 - Consultation for revision of the Management Information System.
 - The health program advisor continued to provide support for management, data analysis and planning, program implementation for new areas, problem solving, reporting, localization and fund raising.
2. For 2006 technical assistance needed from the health program advisor:
 - Analysis of data and planning with focus on ensuring that objectives and indicators for the project are met and on phase down and sustainability.
 - Improving the BCC strategy especially for support monitoring and supervision to community structures to ensure quality, effective BCC to mothers in order for behavior change to occur.
 - Annual Child Survival report
 - Review and support for implementation of sustainable strategies and phase down and phase out of program activities.
 - Obtaining funding to maintain, strengthen and expand Child Survival Interventions after the end of this project.
3. Technical Assistance from outside consultant:
 - Final KPC data analysis and final report.
 - Final Child Survival program Evaluation.

D. Changes from the original program description and DIP made in this time period.

1. Facility IMCI in Thmor Kol District the remaining half of the Thmor Kol Operational District was expanded through training of 28 health center staff in 9 health centers and

CRS managers and staff technical assistance to health center staff and supervisors to establish Facility IMCI clinical, management, and supervision. In the DIP, the plan was only to provide support and training for F/IMCI to the Bovel District health centers in Thmor Kol District. The decision to expand was done at the recommendation of Susan Youll, USAID Washington during her visit to the CRS Cambodia program who suggested this given the success of the program's IMCI component, the support of the Battambang Provincial Health Department and Thmor Kol Operational District, and the availability of funds in the project at that time.

2. Cambodia added Hepatitis B to the immunizations in conjunction with DPT provided to children under 1 year of age. The key messages for Hepatitis B were added to key messages and education for immunizations. This did not require any new resources.
3. Other program changes were made on the recommendation of the Midterm Evaluation:
 - Mother's group leaders were developed and trained for all villages to mobilize newly formed mothers groups formed to improve targeting of mothers for health education and outreach activities.
 - CRS managers and staff were trained on adult learning, behavior change methodologies and social marketing. The Village Health Volunteers and Traditional Birth Attendants were trained using the new methods and provided BCC to the mothers using the new methods.
 - Regular breastfeeding campaigns and activities for World Breastfeeding Week were added to the BCC strategy conducted in the program areas.
 - IMCI campaigns were conducted in the communities to share the information about IMCI and to increase the utilization of the health center by children less than 5 years of age.
 - A workshop was held to disseminate lessons learned from the implementation of Facility IMCI in Samphov Loun OD and Bovel District Health Centers to the PHD, other OD directors and managers and other NGOs in Battambang.

Use of the program's monitoring plan to monitor and describe progress, gaps and the programmatic responses proposed:

Village Health Volunteers and Village Health Committees collect data on children, pregnant and postpartum women, births and deaths, chronic disease and health education. This information is used by the community and health center for mobilizing for immunization, Vitamin A and other outreach activities, monitoring mortality, and health education coverage. Health centers collect data for their health information system with reports to the Operational Districts. CRS collects data from both the Village Health Records and from the health center HIS reviewing it every month and analyzing the data to monitor progress and re-plan to address weakness every three months. A LQAS monitoring survey is done every year. The last survey was done in November 2004 and another survey is planned for November 2005. This data is shared with the community structures and communities and health facilities and used for planning at all levels. CRS supports the communities, health center and operational district with annual planning and to analyze their data on a quarterly, semi-annual, and annual basis with revisions of action plans as appropriate to reach objectives and with annual planning.

E. The sustainability plan, steps taken and/or to be taken, targets reached or to be reached:

The sustainability strategy of the project consists of three components: (1) the organizational development of communities and community structures, (2) strengthening the institutional capacity of health centers and operational districts for the improvement of management and quality of the health services, and (3) investing in the capacity of CRS national staff to continue to develop, maintain and expand the Community Based Primary Health Care Program through transforming the present CRS program into a viable local organization.

Steps taken/ and or to be taken:

Household/ Community:

1. VHV have been elected by the communities and trained for 97 % of the villages in the project. They are in the process of developing bylaws that will give them a means for sustainability.
2. VHCs have been trained in a variety of techniques for self-management. The self-management curriculum, guidelines and schedules have been revised to start the process earlier and speed up the process of self-management. Ten VHCs are nearing Level Three of the VHC development (ability to function by themselves). CRS plans to have 25 VHCs reach Level Three in 2006.
3. Training and technical assistance will continue to be provided to increase the VHCs capacity for self –management and attainment of Level 3 capacity.
4. The Behavior Change Strategy of the program was revised after the midterm evaluation to improve targeting, training and use of an expanded variety of methodologies. Household/community behavior change has occurred for a variety of practices that is improving health status of children, women and communities.
5. Training and technical assistance provided to community structures has improve their capacity to self manage community-based health activities including identification of health problems and determining solutions, health surveillance, data analysis, health education and promotion activities, village health projects, and linking with the health centers for integrated planning and for obtaining continued training on health topics. Capacity building will continue to complete the self-management curriculum.
6. Advocacy is one of the self- management trainings that are provided for the VHCs. 68% of the HCMCs advocated with the health centers for fees acceptable to the community.

Linkages between Community and Health Center:

1. Community structures, health center staff and local authorities participated in linkage workshops to improved coordination between health center and community structures, increased understanding of the community by the health center and of the health center by the community and joint planning for routine and emergency activities. Linkage meetings continue within the community and between the community and the health center.
2. Regular meeting between HC and community structures held resulted in planning and problem solving, improved relationships, and improved services.
3. Health Center Management Committees (previously called the CMCF) developed and trained in 11 health centers provided community input into health center management to

improve services and transparency of activities and finance, increase utilization, and a means for communication and problem solving between the health centers and communities.

4. HC trained Community Structures and will continue to train them. Plan that HC staff will develop training for Community Structures (VHVs, & TBAs) without CRS assistance delayed due to the change in training and BCC strategy.
5. Some communities and HCs integrated planning with quarterly analysis and action planning. This will continue with increased numbers of communities integrating their plans into the HC planning and also into the commune council planning.
6. Link VHC planning with commune council planning in some communes. Plan to increase number of VHC plans integrated into the commune council planning.

Health Center and Operational District Level:

1. Training and technical assistance to the Health Center staff by CRS has increased their capacity to:
 - Provide the MPA and improved quality of services at the Health Centers as shown by increases scores on Management and IMCI monitoring checklists and on IMCI supervisory checklists. Monitoring of the performance and supervisory checklists will continue. Capacity building for weak areas will be provided if needed and technical assistance will continue to be provided to improve and maintain the quality of services.
 - Provide improved Mother's counseling for IMCI and BCC at the HC. As this is still an area that needs improvement technical assistance will be continue to be focused on these areas.
 - Prepare annual plans with more accurate targeting, and realistic objectives and budgets at the HC and OD, and do quarterly, semi-annual and annual analysis with revision of the plan as needed. There are portions of the planning for which they continue to need support especially budget planning. CRS will continue to work with and provide technical assistance to the HCs and ODs to do analysis and planning.
2. Technical assistance and financial support by CRS to the ODs have increased their skills as trainers, managers and supervisors and made it feasible for them to do the supervision. Given the importance of this activity for continuing the quality of IMCI, CRS will continue to provide financial support for the supervision until the MOH can provide this.
3. Support to the ODs, HC and CC was provided for the development and training of the HCMC. Training on information gathering, role and function, health systems, financial system, and facilitation and meeting skills were provided to the HCMC. The HCMC established fees for service, exemptions for the poor and communication between the communities, HC and CC. All HC now have HCMC. CRS will continue to provide technical assistance to increase the capacity of the HCMC to communicate to the communities, provide input into HC management to improve quality of services, quality and transparency of management and increased utilization of the HCs.
4. HCs and ODs have regular meetings with staff. CRS does not support the meetings but does attempt to assist the meetings to be more effective.

5. In spite of attempts to improve the referral system through use of referral forms, boxes for return of forms, use of telephones and radios, the referral system is still mostly one way from the HC to the RH with little feedback to the HC and from the community to the HC with little feedback to the community. Discussions and planning for a more effective referral system with training to the community structure is planned in the coming year.

CRS (Local Cambodian Health NGO)

1. Training, technical assistance and experience has resulted in increased technical and management competence of CRS staff. The program manager and management team manage the program with limited and only specific assistance from the health program advisor.
2. The CRS staff has developed a mission statement, goal and objectives, bylaws and policies for their local organization, AHEAD, Cambodia. A list of potential BOD members has been prepared. A logo is being developed. The staff plan to submit their intent to become a LNGO to the local authorities in November, 2005.
3. The health program staff with CRS is in the process of developing a Child Survival expanded impact bundled proposal for submission. The program has received funds from the USAID mission for the integrated HIV/AIDS component of the project. CRS has provided technical, management and financial support for this.
4. CRS participated in the Cambodia Child Survival Conference and in the development of the NGO Child Survival Working Group (CSWG) and became a member of the Core Group. The Cambodia Child Survival Working Group will work with the MOH Child Survival Steering Committee to develop a common Child Survival strategy for the country with common indicators and a common monitoring and evaluation system. CRS will continue to participate on the Core Group of the CSWG.

Constraints:

1. Although the government Primary Health Care policy state that communities should accept responsibility to make decisions and behave in ways that will promote health and enable people to care for themselves traditionally and politically villagers feel that they have to rely on the village chief or a higher authority and to do what they say. The authorities want to maintain control and therefore do not encourage independent decision making. This dependency can easily be transferred to the NGO workers. CRS staff have to continue to look for ways to empower the people to make decisions for their own health.
2. Lack of land and job opportunities cause village volunteers and villagers to move temporarily to another area to do farm labor, cross border trade or to seek work in the neighboring country of Thailand. This disrupts village development processes.
3. Poverty causes villagers and village volunteers to focus on immediate needs of food and income for other needs rather than health.
4. Lack of sufficient salary support from the government causes OD and health center staff to seek to supplement their salaries by other part time work.
5. Inability of the health system to access the budget that is allocated to it due to problems within the system resulting in insufficient and/or late funds even for activities that are budgeted for.
6. Supplementary training for the nursing and midwife staff in Samphov Loun OD to bring them up to a higher level of capacity given their lack of formal training, has left the health

center services without adequate staff to carry out the MPA for periods of time that affects services and coverage.

7. Time constraint and conflict between taking time for improving the program and the time needed for localization has resulted in a delay in localization.
8. The distance, time needed to get to the capital, Phnom Penh where most of the working groups and national activity take place and often late notification of the time of meetings results in the CRS program not always being able to be involved as much as they would like at the national level.

F. Current expectations on progress towards phase out, how they have evolved or changed over the life of the program.

Expectations and progress toward phase out:

1. Health centers and communities link with each other to accomplish common activities thus making the activities more sustainable.
2. 50% of the HCMC in the program areas will function and perform their tasks without support from CRS.
3. The Health center management quality checklists used by CRS to provide technical assistance to the health centers will be (Account System and Infection Control) will be integrated into the Operational Districts supervision of the health centers. The Technical Advisor Group of the OD has expressed an interested and has begun to use the accounts checklist in their supervision.
4. Facility IMCI at Sampov Loun and Bovel will be done with less support and input from CRS.
5. Operational District Technical Advisory Group will able to identify, prioritize the agenda to facilitate the HC/ OD meetings without support from CRS.
6. Midwives in 14/16 health centers will able to facilitate meetings and provide technical assistance and do problem solving for TBAs without support from CRS.
7. Midwives in 9/16 health centers will have the capacity and skills to develop the lesson plans and provide continuation training to TBAs without technical support from CRS.
8. The village health volunteers and VHCs will be able to maintain regular village data collection, record in the Village Health Register, report to the health centers and use data to develop annual health planning.
9. 50% of the health centers will able to conduct regular VHVs meeting with prioritized agendas and demonstrate effective facilitation skills for the meetings without CRS providing technical support.
10. 50% of VHCs will reach to level 3 with ability to carry out the activities without technical support from CRS.
11. All VHCs will receive the self management training and technical assistance to move forward to be able to sustain the management and activities.
12. VHC health planning will integrate with commune council annual planning and VHC analyze in 6 months and action plan.

How they evolved or changed over the life of the program:

1. HCMCs development occurred more quickly due to a change in government policy related to the government's desire to have transparency regarding user fees at the health centers where health centers without HCMC could not charge any user fees.
2. It has taken more time and is more difficult for VHCs to reach Level 3 (which is the level of development where they are able to manage all activities by themselves) than had been anticipated.
3. The intermittent absence of staff at all levels in the Samphov Loun OD in order to attend trainings to upgrade their professional skills has made phase down more difficult.

G. Programs management systems and factors that have positively or negatively impacted the overall management of the program since inception.

➤ Financial management system:

The financial management system is managed by the managers and staff in the Battambang sub-office with support and oversight from the Country Program Office in Phnom Penh:

- In the Battambang sub office the budget/finance system is managed by the Program Manager, MCH/HIV/AIDS, Clinical/ Institutional, Village Activities Area Managers, and the Administrative/MIS Manager who are supported by an Accountant Assistant/bookkeeper, Cashier, and Purchaser. The Health Program Advisor provides advices and assistance as needed.
- In the Phnom Penh Country Program Office the Accounts Manager and Deputy Account Manager review the documents provided by the sub office and with the support of the finance staff enter the information into the Sun System (the financial system used by CRS). The Country Program Administration also provides support to the program as needed. The Country Representative provides oversight for the financial system and for the program.

Battambang Sub Office:

- Staff requests are verified by the Area Manager in charge of that component and sent to the Health Program Manager.
- The Account Assistant/bookkeeper prepares a Disbursement Vouchers (DV), which is verified by the Administrative/ MIS Manager and approved by the Health Program Manager.
- The Cashier prepares a bank withdrawal that is verified and signed by the Program Manager.
- The Cashier withdraws the money from the bank, disburses it to the staff according to the approved request and pays the vendors.
- After the money is used for the field activities, staff liquidate advances attaching receipts and other support documents such as exchange rates of local currency. Liquidations are verified by the Area Managers in charge of that component and approved by the Administrative Manager or the Health Program Manager. The Account Assistant/bookkeeper makes General Journal vouchers (GJ) to clear the advances that are approved by the Administrative Manager or the Health Program Manager.

- The returned money or cash income, The Cashier receives the returned money or cash income with the liquidations, makes an official receipts and sends this to the Account Assistant/bookkeeper to make the Cash receipt. The cash receipt is verified by the Administrative Manager or Health Program Manager. The Cashier deposits the case in the bank according to the fund source.
- The Account Assistant/bookkeeper keeps a daily ledger and makes a monthly financial report and bank reconciliation that is verified by the Administrative Manager and approved by Health Program Manager.
- For the monthly financial of the closing accounts, the Battambang sub office copies all documents (DV, Receipts, exchange rate receipts, GJ, CR and other support documents) and sends the copies to the CRS Phnom Penh Country program Office where they are reviewed and put into the Sun System.
- The Health Program Manager makes a Cash Forecast every 3 months and a cash request every month according to the program plan and needs and requests the funds from the Phnom Penh Country Program Office after the monthly financial closing.

Phnom Penh Country Program Office:

- The Deputy Account Manager verifies the documents and enters the data into the Sun System. Ledgers and monthly comparison reports are sent to the program for review for agreement and accuracy and to use in budget management. Cash forecasts for Three month cash forecasts are sent to the CRS Headquarters and monthly cash transfers are made to the Battambang Sub Office according to the request.
- The Senior Accounts Manager monitors and supervises all CRS finances and staff including the work of the Deputy Account manager in Phnom Penh.
- The CRS Country Representative monitors all budgets and expenditures and supervises the CRS finance managers and through them all CRS finance staff in Phnom Penh.

➤ Human resources:

- The number of staffing is adequate. The majority of the staff have been stable for the duration of the project.
- The Program Manager and Area Managers and MIS/Administrative Manager comprise a management team supported by the health program advisor (25% to 50% time). The Managers have increased their knowledge and skills to manage the Child Survival Project. The Program Manager manages the program with support only for specific needs. The Area and MIS/Administrative Manager continue to require a fair amount of support from the Health Program Manager and Advisor. Areas for which they continue to need support are managing and analyzing data, planning for new activities, reporting, programming monitoring, staff supervision, curriculum development for new topics, phase down and sustainability processes.
- Staff have knowledge and skills for working on Child Survival major and cross-cutting interventions, but need support to improve application of their knowledge, planning and prioritizing.

- The line of command is clear. Area Managers are responsible for their component. The Management team makes decisions about programming. Staff understands who they should go to for support and direction.
- Monitoring and supervision is provided by the Area Managers and Health Program Manager through monthly review of the MIS data, field staff and manager quarterly analysis of the MIS data with planning according to the findings, field supervision and monitoring, staff meetings, discussions with individual staff and review of reports. The Advisor provides training and technical assistance and contributes to the monitoring and supervision of managers, staff and program as needed.
- During this past period, the program hired a Consultant to train all CRS personnel on Behavior Change Communication (BCC) methods, adult learning and social marketing to improve the Behavior Change Communication Strategy for the program.

Communication system and team development:

A. Communication:

- Communication takes place through short daily encounters where staff report where they will go and what they will do, staff meetings, individual discussions, quarterly and semi-annual analysis and action plans, staff monitoring, field supervision and reports.
- The managers and staff develop monthly plans and 2 week plans dividing the plan into daily implementation sessions according to time, activity, distance and component plans.

B. Team Development:

- Team development takes place through participatory meetings, reflection and program development, analysis and planning, problem solving, field monitoring and supervision, management team meetings, training and technical assistance, annual performance planning and appraisals.

➤ Local partner relationships: (How is the PVO is doing as assessed by the local partner)

The program has built relationships to implement the Child Survival Interventions with the following:

- The Ministry of Health (MoH): CDC for Facility and Community IMCI, National Malaria Center, National Center for Health Promotion, National Immunization Program and the National Maternal Child Health:
 - 1) The CDC has accepted CRS as trainers and supervisors for F/IMCI. They have expressed their pleasure at the way that CRS works with the MOH at all levels stating that CRS is building the capacity of the MOH staff.
 - 2) The National Malaria Center has stated that the areas in which CRS works have better coverage for bed net impregnation than most others.
 - 3) The other ministries have allowed CRS to work with them as trainers and monitors of activities.

- The Provincial Health Department: Asked CRS to co-conduct a workshop to disseminate lessons learned from the implementation of F/IMCI in Samphov Loun and Thmor Kol ODs in order to increase the interest of the other ODs.
- Referral Hospital management and staff: State that they have improved hospital management and in patient care through technical assistance from CRS.
- Health Center staff: are interested and willing to use the F/IMCI algorithm for providing care to children even though it takes more time and have improved assessment, classification, treatment and counseling with improvement in supervisory and mother exit interview scores. Account systems are transparent and accurate and infection control has improved. NIP coverage has increased.
- Community Structures (Village Health Volunteers, Traditional Birth Attendants): Are interested in learning and using new methods for BCC in their communities. They are willing to be available for special events and regular outreach activities. They continue to work as volunteers in their communities.
- Local Authorities (village chiefs and commune councils): Are willing to listen to CRS plans, appreciate the work in the communities especially education to the communities and water and sanitation projects, provide support to CRS for activities such as bed net impregnation, Breastfeeding campaigns, World Breastfeeding Week and IMCI campaigns, participate in surveys, trainings, HCMCs and workshops.
- Communities: Participate in elections for VHVs and VHCs, mother's groups, water and sanitation projects, and other special events.

The relationships are developed and maintained through Provincial Coordination Meeting (Proccom), Technical Advisory Group (TAG) meetings at Operational District, Health center meetings, working groups, quarterly, semi and annual analysis and planning, reflection workshops, linkages workshop, training, community structures meetings, problem solving, and monitoring and supervision activities.

➤ PVO coordination/collaboration in Cambodia:

The program coordinated and collaborated with various NGOs in the country to improve Child Survival and other health interventions in the program areas and in Cambodia:

- Helen Keller International (KHI) and Reproductive Health Association Cambodia (Rhac) to increase Vitamin A Capsule Distribution.
- World Health Organization (WHO) for Facility and Community Integrated Management of Childhood Illness (IMCI).
- University Research Co. (URC) for health system strengthening, health information system review and development and health planning.
- Cambodian Health Education Development (CHED) for developing Information Education Materials (IEC).
- Reproductive and Child Health Alliance (Racha) for home safe delivery kits.
- Medicam Child Survival Working group with many Child Survival Agencies such as World Relief (WR), Adventist Development and Relief Agency (ADRA), CARE, Partner for Development (PFD) and other NGOs participated in the process of developing the Child Survival Working Group to improve child health in Cambodia.
- Family Health International (FHI) for HIV/AIDS integrated into Community Based Primary Health Care Program and Child Survival Project.

- Japan International Cooperation Agency (JICA) for integrated Facility and Community DOTS into Community Based Primary Health Care Program and Child Survival Project.
 - Association Pour L'Action De Development (AADC) for integrated Water & Sanitation project into the Child Survival Project.
- Other relevant management systems : NA
- Financial and management audit by CRS:
- A CRS internal audit done in May 2005 did not find any material weaknesses or questioned costs.
 - An annual country program management audit did not report any findings.

I. Mission Collaboration

- Child Survival is an important issue for Cambodia and a strategic objective for the USAID Mission here. CRS presented their Child Survival project at and participated in the Mission-supported Child Survival Conference. CRS worked with the Mission to co-ordinate a visit from Washington, D. C. Child Survival Representative, Susan Youll. USAID Mission-funded and centrally-funded partners met to discuss coordination and collaboration to prevent duplication and use complementarily of projects to increase results for our target population.

J. Activities for the coming year and explain any changes to the original work plan that have resulted. (See the work plan)

Changes from the original work plan:

Dissemination of Bird Flu information to the mothers and patients through health center video, to villagers through VHVs, VHCs, TBAs and through radio and TV spots. Strengthen the reporting system at the community and health center for reporting suspected cases of illness in people and poultry deaths with appropriate investigation.

Malaria case management training (assessment, classification, treatment) to Village Malaria Volunteers in 20 villages in Malaria zone (Sampov Loun OD).

Linkages workshop between health center, community structures and local authorities will focus on sustainable and phase out strategies.

IMCI campaigns to share the information about IMCI at the health center and health center's services to increase utilization for children.

Establish ORS system and provide ORS to VHVs in far distant villages to have ORS available to children who have diarrhea in the villages.

Basic facility IMCI training at Thmor Kol for one course with continues support for monitoring, technical assistance and supervision for 9 health centers and exit interview with the mothers.

Facility IMCI workshop at PHD and OD, Health Center to share the experiences and reflection on the weaknesses and strengths and problems for IMCI development and maintenance.

World Breastfeeding Week activities and breastfeeding campaign at the community to change the behavior of the mothers to increase exclusive breastfeeding and of use radio spots on breastfeeding and complementary feeding.

NIP Post Assessment Activities for Bovel and Sampov Loun OD to monitor and evaluate the coverage of the immunization and keeping immunization cards.

Continue to complete mother groups development, selecting and train the mother group leaders to improve mobilization of the mothers for health education and outreach activities.

VHVs bylaw development for 12 health centers.

Health center staff training on community IMCI focusing on Key Family messages and practices

Ceased to implement:

1. VHC training on health topics and health education on interventions by VHC was stopped so VHCs could focus on self-management for health and management of the village water & sanitation projects.
2. Key Mothers training on health topics and health education was stopped due to the recommendation of donors not to have Key Mothers (duplicate with VHVs and TBAs)

K. Child Survival project highlights:

Exclusive Breastfeeding:

Infants who receive immediate and exclusive breast feeding until 6 months of age are still the minority in Cambodia.

CRS and health center midwives conducted Focus Group Discussions to identify knowledge, practice, beliefs and barriers for Exclusive Breast feeding with 18 groups of 287 pregnant and lactating women. The FGD found that knowledge was generally low, but lower in young women and those in the rural areas. There was no difference between those delivered by TBAs or Midwives. Practice was low due to lack of knowledge, to beliefs that babies needed water to drink and to clean their mouths that mothers would not have enough milk after delivery, and unavailability of women to breast feed due to work outside the home.

A new strategy was developed to provide the key message of exclusive breast feeding in as many ways as possible with as much participation as possible to as many women as possible. The plan was to reach 5,102 pregnant women and lactating mothers with children less than 2 years old.

Thirty-five midwives and 166 TBAs in 15 health centers were trained on behavior change communication. Exclusive breast feeding messages were provided through regular breast feeding campaigns, special campaigns during World Breastfeeding Week, radio spots video spots in the health centers , and counseling by TBAs and Midwives to pregnant women during ANC visits. The TBAs and midwives were very enthusiastic, and Mother's Group Leaders assisted in mobilizing women in the communities. 15,430 women received the key messages for immediate and exclusive breastfeeding.

Behavior Change Communication:

CRS, the HC and CS found that coverage for health education and behavior change was low and the target group (Mothers) was not being sufficiently reached using the methods of small group and peer education. They decided to target women of reproductive age through development of Mother's Groups of 20 women each. Each group would have two leaders who would assist in mobilizing the women, recording attendance and finding new often migrant women. VHVs and village chiefs organized the groups who selected their leaders. CRS and HC staff provided TOT to the VHVs who trained the MGLs. At the same time CRS and HC trained the VHVs in new methods for BCC for ARI and Malaria using adult learning on intervention topics using new interactive behavior change communication methods such as problem trees, correct and incorrect pictures, use of stories, case studies, demonstrations, drawings, and role plays:

The plan was to reach 24,897 women of reproductive age (15 – 45 years) in 196 villages for key health messages for behavior change.

24,897 mothers were formed into 1,045 groups with 2,090 mother's group leaders. 63% of VHVS in 141/196 villages trained 82% of the MGL on their roles. 60% of the VHVs were trained on the method of BCC for ARI (16 HC). and 70% on Malaria (9 HC). VHVs provided BCC to mother's groups reaching 57% of the mothers for ARI and 96% for malaria in 7 months.

**DETAILED IMPLEMENTATION PLAN
OCTOBER 2005 – SEPTEMBER 2006**

Work Plan – YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmark	Persons Responsible	
	Q1			Q2			Q3			Q4					
I. Activities	O	N	D	J	F	M	A	M	J	J	A	S			
Community/Health Center Activity															
Objectives:															
<ul style="list-style-type: none"> ▪ <i>Increased % of mothers who recognize danger signs:</i> <ol style="list-style-type: none"> 1. <i>60 % at least two signs of pneumonia.</i> 2. <i>55 % - 2 signs of dehydration as danger signs of diarrhea</i> 3. <i>60% - 2 signs of malaria in the malaria zone.</i> ▪ <i>Increase to 40% mothers of children under 2 years experiencing diarrhea in the last two weeks who treated their child with Oral Rehydration Therapy.</i> ▪ <i>Increase to 90% children <2 sleeping under impregnated bed nets in the malaria zone. Increase to 90% pregnant women sleeping under impregnated bed nets in the malaria zone.</i> ▪ <i>Improved counseling and Health Education at health center for all interventions.</i> ▪ <i>50% Community structures reach acceptable level (70%) on HE checklist for providing health education to the community.</i> 															
Training of trainers for VHVs on training for mother's group leaders for 2 health centers (Angkor Ban and Trang HC)			✓											VHVs able to provide training to Mother's group leaders	CRS and Health Center staff
Training of mother's group leaders for 2 health centers (Angkor Ban and Trang HC)			✓											Mother's group leaders trained	CRS, HC and VHVs
Mother group leaders reflection workshop				✓	✓									Improved mother group leader activities	CS/HC/CRS/MGL
Community Structures Health Education sessions held with mother's groups	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	HE sessions held with mother's groups	CRS, HC and VHVs
Random interviews to monitor understanding of key messages and behavior change			✓		✓				✓				✓	Results of interviews used to monitor HE	CRS, HC and CS
Disseminate Bird Flu information to villagers through VHVs		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Bird Flu information disseminated	VHV/HC/CRS
Disseminate Bird Flu information to patients through HCs		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Bird Flu information disseminated	HC/CRS
Bird Flu TV and Radio spot		✓	✓	✓	✓									Bird Flu information disseminated	CRS

Work Plan - YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmark	Persons Responsible	
	Q1			Q2			Q3			Q4					
II. Activities	O	N	D	J	F	M	A	M	J	J	A	S			
Community															
Objectives: <i>Community structures show increase in knowledge of ARI, CDD, Malaria Standard Case/ Community-Based IMCI management and health education messages by an increase in pre and post test scores by 20%.</i>															
CDD BCC part 1 training to VHVs for 5 health centers (Pich Chenda, Serey Meanchey, Trang, Angkor Ban and Bovel I)	✓	✓												CDD BCC implemented	CRS/HC/CS
CDD BCC part 2 training to VHVs			✓	✓										CDD BCC implemented	CRS/HC/CS
ARI BCC training to VHVs for 2 health center (Trang and Angkor Ban)					✓									ARI BCC implemented	CRS/HC/CS
ARI BCC refresher course for 13 health centers					✓	✓								ARI BCC Refresher conducted	HC/CS/CRS
Refresher Malaria BCC to CS with 9 HCs						✓	✓							Improve Malaria BCC	CRS/HC
Community IMCI training to VHVs in 16 HCs				✓										Improve community IMCI	CRS/HC
Malaria assessment, classification and treatment training to VHV with 20 villages (SPL).			✓											Improved treatment for malaria	OD/CRS/HC/CS

Work Plan 2005:

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmark	Persons Responsible	
	Q1			Q2			Q3			Q4					
Activities	O	N	D	J	F	M	A	M	J	J	A	S			
Community/Health Center Activity															
Objectives:															
<ul style="list-style-type: none"> ▪ <i>Increase to % of women of children <2, who sought appropriate medical treatment when their child :</i> <ol style="list-style-type: none"> 1. <i>ARI - experienced rapid and/or difficult breathing – 45%.</i> 2. <i>CDD - 50% for diarrhea, dehydration, bloody diarrhea or persistent diarrhea.</i> 3. <i>Malaria - 50 % experiencing fever in the malaria zone</i> ▪ <i>Effective linkages and joint planning between community structures and the Health Centers</i> ▪ <i>85% of the Supervisory Areas have linkage activity within the community and between the CS and HC after the Linkage Workshops</i> 															
Linkage workshops for phase out and sustainability for 16 health centers (B-8 and SL-8)		S P L	S P L	B V	B V	B V								Improved collaboration between CS and HC, IMCI campaign developed	CRS, HC and CS
IMCI Campaigns for 4 8 health centers (SPL)	✓	✓	✓	✓	✓									Mothers are informed about IMCI	CRS, CS, HC
Community															
Objective:															
<i>90% of villages have Community Structures</i>															
VHC development in 13 villages									✓	✓	✓	✓		New VHCs developed	CRS
VHC Self-Management training for New VHC & existed VHC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		Improved knowledge and skills	CRS
Community Activity															
Objective:															
<i>Increase to 30% mothers who practice exclusive breastfeeding for the first six months</i>															
World Breastfeeding Week for 16 HC (including radio spot)													✓	Pregnant women/ lactating women received information on BF	CRS/HC/CS/ MGL
Breastfeeding campaign 16 HC			✓	✓	✓	✓	✓	✓	✓	✓				Pregnant women/lactating reach information on BF	CRS/HC/CS/ MGL
Breastfeeding BCC training to TBAs for 1 HC		✓												TBA provide BCC BF to mother	CRS/HC

Work Plan - YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmark	Persons Responsible
	Q1			Q2			Q3			Q4				
III. Activities	O	N	D	J	F	M	A	M	J	J	A	S		
Community														
Objective: <i>Improved management capacities of the village health structures including Community</i>														
Village Health Register monitoring and using the CHIS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Improved data collection	CRS, CS
Referral system training to CS			✓	✓									referral system existed	CRS/HC
VHC semi analysis and planning									✓				Improve health activities	CS, CC & CRS
VHC Annual Assessment	✓												Used to make plan	Community, VHC/ CRS
VHC Annual Plan	✓												Annual Plan completed	VHC/CRS
Integrated Planning HC & Community	✓												Annual Plan completed	CS/HC/CRS
Integrated Commune Council planning and community	✓												VHC planning integrated with CC	CS, CC & CRS
Strengthen Village Sanitation Systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Village Sanitation Systems in place	CS/CRS
VHC implementing the village projects	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Village project implemented with community	CRS/VHCs
VHC level 3 for 25 VHCs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	VHCs level 3	CRS
VHV Bylaws development for 12 health centers		✓	✓										VHVs bylaws in place	CRS/HC/CS
Community/Health Center														
Objective: <i>HCMC developed in 100 % of HC coverage areas. 50% of HCMCs function without support</i>														
Strengthen Health Center Management Committee through meeting every 2 months		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	HCMC functioning	HC/CRS
Basic training to HCMC at 1 health center (Barang Thlak)	✓												HCMC completed training	CRS, HC, communities

Work Plan – YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmark	Persons Responsible	
	Q1			Q2			Q3			Q4					
IV. Activities	O	N	D	J	F	M	A	M	J	J	A	S			
Community/Health Center															
Objectives: <i>Community Structures and HC coordinate collaborate and participate together in Primary Health Care activities in the community.</i>															
System for CS to provide/sell ORS in distant communities		✓	✓											CS have ORS to sell/ Provide for diarrhea pts.	CRS, HC and CS
Health Center/Community															
Objectives:															
<ul style="list-style-type: none"> ▪ <i>Increase to 80% mothers with children under 2 years of age who keep their immunization card.</i> ▪ <i>Increase to 80 % children under 2 years of age fully immunized in Bovel District and 60% fully immunized in the New Districts (Samphov Loun, Phnom Prick, and Kam Reang)</i> ▪ Increase to 65% pregnant women who have 2 TT before the birth of their baby by recall ▪ Increase to 55% pregnant women who have TT2 before the birth of their baby by card. 															
Immunization Activity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Coverage increased	HC/CS
Supplementary immunization for high risk villages (20 villages in Lovea and Prey Kpos) and 79 villages in SPL.	✓													Coverage increased	PHD/OD/HC /CRS/CS
Coverage improvement Plan (special campaign) for SPL	✓	✓	✓											Coverage increase	MOH/PHD/ OD/HC/CRS
PAA (post activity assessment on NIP (Bovel and Sampov loun)			B V		S P L									Coverage increased	PHD/OD/HC /CRS
Objective: <i>Increases to 80% children 12 – 23 months who receive Vitamin A in the last 6 months.</i>															
Vitamin A training to 8 health centers on new guideline (SPL)	✓													HC staff use new guideline to develop plan for implementation	CRS/OD
Vitamin A Training to Community Structures	✓	✓												Vitamin A training completed	CRS/HC and CS
Vitamin A activities		✓				✓								Vitamin A distribution completed	OD/CRS/HC/ PHD and CS
Health Education at health center and community during outreach	✓	✓	✓	✓	✓	✓								Health education done	HC/TBA

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October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmarks	Persons Responsible
	Q1			Q2			Q3			Q4				
V. Activities	O	N	D	J	F	M	A	M	J	J	A	S		
Community/Health Center														
Objective: <i>Increase to 90% children <2 sleeping under impregnated bed nets in the malaria zone.</i> <i>Increase to 90% pregnant women sleeping under impregnated bed nets in the malaria zone.</i>														
Training on bed net impregnation to VHVs, HCs and OD.								✓					Improve bed net impregnation	CS/HC/OD/PHD/CRS
Bed net impregnation								✓					Bed net impregnation completed	OD/CRS/HC/PHD and CS
bed net impregnation and using nets education by VHVs							✓	✓	✓				Health education done	HC/CRS/VHV
Malaria in pregnant women training for TBAs (10 HC)		✓	✓	✓									TBA increases knowledge	CRS/HC MW
TBA Provide health education and counseling to pregnant women and refer to HC		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Pregnant women reach information for prevent and seeking care	TBA/CRS
Health center midwives provide counseling and screen to all pregnant women during ANC visit and Outreach activity.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Pregnant women received appropriate care	HC/CRS
Health Center:														
Objectives: <ul style="list-style-type: none"> ▪ <i>70% of health centers in the project site have an acceptable level (75%) of performance in case management of ARI, CDD, Malaria using and integrated strategy (IMCI) as measured by quality assurance checklists</i> ▪ <i>50% of health centers will have an acceptable level (75%) of management quality as measured by management checklists.</i> 														
IMCI Provincial reflection workshop										✓			Workshop done	CRS/PHD/OD and HC
IMCI Clinical Management training to 9 health centers in Thmor Kol				✓									Health center training completed	OD/CRS/HC/MoH
Technical Assistance to HC to improve IMCI	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Checklist scores	CRS, HC

Work Plan – YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmarks	Persons Responsible
	Q1			Q2			Q3			Q4				
VI. Activities	O	N	D	J	F	M	A	M	J	J	A	S		
Health Center (continues):														
Technical Assistance to HC to improve management	✓			✓			✓			✓			Checklist scores	CRS
Refresher Training on IMCI counseling Thmor Kol								✓	✓				HC increased skills to provide counseling	OD/CRS/HC
IMCI Meeting with HC and OD	✓		✓		✓		✓		✓		✓		Improved IMCI	OD/CRS/HC
NIP monitoring use checklist every 3 months for 16 HCs	✓			✓			✓			✓			NIP techniques and management improved	CRS/HC
Health center provide education on ARI, CDD and Malaria at the HC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Increase coverage	CRS/HC
Community IMIC training to 16 HCs	✓												Improved community IMCI	PHD,OD, CRS
Mother exit interview to improve the IMCI counseling	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Mothers improved knowledge and practices	CRS
Operational District														
Objective:														
<ul style="list-style-type: none"> ▪ 75% ODs reach an acceptable score for IMCI. ▪ 75% of Operational District supervisors use IMCI or SCM Quality Assurance check lists for supervision. 														
IMCI Supervision every 3 months for Bovel	✓			✓			✓			✓			Maintain IMCI	OD/HC/CRS
IMCI Supervision every 2 months for SPL	✓		✓		✓		✓		✓		✓		Improve and strengthen IMCI	OD/HC/CRS
IMCI Supervision every month for Thmor Kol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Improve IMCI	OD/HC/CRS
HC and OD quarter, semi, annual analysis and planning	✓			✓			✓			✓			Action plan and annual planning completed	CRS/OD/ HC
IMCI health center staff meeting every 3 months (Bovel)	✓			✓			✓			✓			Improve IMCI	CRS/OD/HC
IMCI health center staff meeting every 2 months (SPL)	✓		✓		✓		✓		✓		✓		Improve IMCI	CRS/OD/HC
IMCI health center staff meeting every month (Thmor Kol)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Improve IMCI	CRS/OD/HC

Work plan – YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmarks	Persons Responsible
	Q1			Q2			Q3			Q4				
Activities	O	N	D	J	F	M	A	M	J	J	A	S		
CRS														
Objectives: <i>100% of CRS staff have 90% technical competence score.</i> <i>Technical and management capacity building by CRS to HC and CS results in project targets being met.</i> <i>Lessons from midterm and final evaluation are circulated.</i>														
CRS quarterly Analysis and planning	✓			✓			✓			✓			CRS reviews progress and plans	CRS staff & managers
Child Survival Annual Report	✓												Report completed	CRS
share lesson learned with USAID partners, CRS region and CSWG at Medicam	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Regular attended	CRS
Share lesson learned and provide input to Provincial TWG		✓		✓		✓		✓		✓		✓	Regular attended	CRS
Share lesson learned and provide input to OD TWG	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Regular attended	CRS
Localization development		✓	✓	✓	✓								Good Local NGO	CRS national Staff
Localization - Legal Registration		✓											Organization registered with government	Local Health Organization leaders
Continue strengthening of Management Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Managers continue to take on the management of the program	Advisor
Management (continue)														
Continue 2 weeks and 1 month plans	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Improved planning	CRS
Maintain every 2 week meetings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Improved efficiency, problem solving and team work	CRS

Work Plan – YEAR 5

October 1, 2005, September 30, 2006	SCHEDULE												Annual Benchmarks	Persons Responsible
	Q1			Q2			Q3			Q4				
Activities	O	N	D	J	F	M	A	M	J	J	A	S		
CRS (Continued)														
Management														
Supervisory strategy monitored and improved	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Improved supervision, plans accomplished	CRS program and area managers
LQAS monitoring survey		✓											Survey completed done	CRS
CRS continue attended the USAID partners coordination meeting													Regular attended	CRS
CRS Staff Appraisals	✓												Staff know strengths and weakness	CRS managers
Facility IMCI Survey				✓									Improve IMCI	CRS/WHO/MoH/OD/HC
KPC Final Evaluation												✓	Final KPC done	CRS/OD/HC/CS
Final Evaluation												✓	Final evaluation done	CRS/OD/HC/CS