

WORLD RELIEF



LIGHT FOR LIFE

CHILD SURVIVAL PROJECT



Districts of Ponhea Kriek - Dumbai, Kampong Cham Province
Kingdom of Cambodia

Cooperative Agreement #: FAO-A-00-98-00051-00

October 1, 2003 – September 30, 2008

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ACRONYMS

ADB	Asian Development Bank
ARI	Acute Respiratory Illness
BCC	Behavior Change Communication
CC	Commune Council
CDD	Control of Diarrhea Disease
CG	Care Group
CHIS	Community Health Information System
EPI	Expanded Program on Immunization
FC	Feedback Committee
HC	Health Center
HFS	Health Field Supervisor
LRA	Local Rapid Assessment
MOH	Ministry of Health
MTE	Midterm Evaluation
OHD	Operational Health District
PD	Positive Deviant
SCA	Save the Children Australia
TOT	Training Of Trainer
TT	Tetanus Toxoid
VDC	Village Development Committee
VL	Village Leader
WHE	Women Health Educator
WR	World Relief

A. MAIN ACCOMPLISHMENTS:

The first and major key success of the project this year has been shown in the Mid Term Evaluation findings, relayed by an independent evaluator, Dr. Henry Perry, that all of the mid term project goals have been met and exceeded (see Mid Term Evaluation Report).

A second key success has been a stronger sense of community ownership, and stronger relationship and partnership with the health center. The village and care group (CG) leaders have been supported by the commune councils (CC) and the health centers to work in the role of a bridge between the community and the health centers enhancing communication and mutual accountability (see Mid Term Evaluation Report).

A third key accomplishment has been the success by the “Cambodia Staff” to grow community leadership and ownership. The staff has been working to impact community leaders and care group leaders with a focus on community empowerment.

A fourth key accomplishment has been building the capacity of, and empowering women in the project area. Women have responded to training through the women health educator (WHE) structure with a significant increase in health knowledge and behavior change (see LRA#7 – ANNEX 1), as well as becoming more self confident, self assured and team oriented. A sense of community ownership and leadership has been developed in each village throughout the project area.

The factors that have contributed to achieving these accomplishments:

1. Cambodia Child Survival Project (CSP) Staff.

From the beginning, the CS project staff has been trained in using adult participatory education techniques, role modeling and showing respect for the local human resource, to transform the key persons in the community. Staff development takes place in the office weekly, and the staff then go out to mentor the care group leaders through role modeling. They also help to empower the volunteers to reach their village neighbors. As a result, the care group leaders have become more responsible and confident in leading their groups.

2. Empowering community women through health education of 2,500 volunteers.

After each health education training, the WHEs conduct home visits to reach all the households in their groups, averaging 15 households per WHE. The women are empowered, through an increase in health knowledge, enabling them to make the right decisions about their children’s health and becoming local community role models. One test of this self assurance and empowerment is when outside/overseas visitors and Mid Term Evaluation team talked to CGs. Previously the women in newly established groups were shy and reserved and the primary spokesperson for the group was the CG leader. Now, the volunteers have become more active as spokespersons and interact and respond to visitors and

Mid Term Evaluation (MTE) team. The women are now more outgoing, self confident and all women actively interact and respond to visitors' questions and the MTE team, while proudly displaying the strong, fat (as babies should be) and healthy babies in their communities, each one fully immunized. The WHEs that have now been with the project 3 years are already showing significant improvements in self confidence and self esteem and are making good progress towards having the strong confidence that the WHEs (from the original project area) now have after 6 years with the project. Through gaining knowledge and learning how to teach and interact with people, especially women and village leaders (VL) in their communities, their status and confidence has changed and will continue to show significant improvement over the life of the project. (Sustainability++)

3. Building Teamwork amongst WHEs and increasing support from village leaders.

WHEs are grouped into Care Groups; each group has an average of 8 members. The project promotes the CG meeting as a forum for discussion, to encourage each other, and reinforce health messages. A WHE's performance is not assessed individually but the performance of each CG is assessed collectively. This encourages and increases teamwork and a spirit of mutual support and comradeship. The village leaders encourage the WHEs by joining the monthly meeting to work with them and increase community participation and awareness of healthy lifestyle changes they can make in their lives and those of their children. This mechanism helps CGs and the village leaders to see themselves as a group/team, and it is the interdependence of these key players that is leading to substantial change in health behaviors. The village leaders also encourage and praise the WHEs in their work and encourage the villagers to learn from the WHEs. This mechanism is an important step towards building a sense of community, which was so cruelly destroyed by Pol Pot's regime, where every individual was primarily concerned with his/her own survival – even families lost their importance in the degradation and the battle for survival. (Sustainability++)

4. Community involvement.

Life modeling by mothers who exhibit positive behavior change, has led to improved health for themselves during pregnancy and their baby, during and after delivery. The ongoing encouragement of these women and by using them as a frame of reference for other mothers, has created a rapid response from other mothers, as well as community leaders, who have quickly seen the benefits of the health education and behavior change and become strong supporters of project activities and encouragers to village women. This has led to a sense of community ownership, with health becoming a community issue.

The HFS provides the monthly village statistics (CHIS) to village leaders. Then the BCC staff (male) help village leaders interpret and analyze the statistics, thereby helping them to understand the impact of the WHEs and behavior change

within the village, as well as highlighting issues that may require the village leader's support or intervention. Two VL checklists have been designed to facilitate this process. The first checklist is for village leaders when they are first starting to work with the statistics and the second is for those that have gained an understanding of the process and the statistics. Each checklist is designed to help them to focus their thinking and act on health issues. (See annex 2 for checklists.). These checklists are constantly being revised and improved so that they are enabling and relevant for the VLs. This builds a sense of partnership in strengthening each community (village) using health as the facilitating mechanism.

The Village Leaders and the WHEs are the catalysts for a change in community dynamics and a sense of community ownership in the area of health. (Sustainability ++)

Workshops of the MTE findings were held for all commune councils in the project area. The project supervisors have worked alongside the commune council members so that they understand and support the Care Group Model. As a result the commune councils have agreed to sign the identity card for WHEs, as a local incentive.

5. Supply from the drug sellers.

The trained shop vendors continue to sell iodized salt and are helping to support change in healthy eating in their communities. Local community private providers have little knowledge about their products and most welcome the opportunity to help the community, and their profits, through the supply of products that they know will be purchased from their shops. As they are local providers many are happy to be responsive to local community health issues, as they are often women of reproductive age, whose families will also benefit from the new products. (Sustainability++)

6. Relationship and partnership between the community and the MOH through the HC feedback committee (FC).

The project encourages the MOH to partner with the community through the HC feedback committee. The committee consists of one person selected from among the CG leaders and another person selected from the village leaders and the HC in-charge. Meetings are held monthly at the HC. The purpose of these meetings is to provide opportunity for both the HC and community to discuss health issues, problem solve and create better understanding and partnership between the community and the HC.

Through this committee the WHEs have motivated the HC staff to reach all villages for immunizations and more people now come to the HC for health care and the health status of the community is improving.

The HCs have also agreed to provide support to the WHEs by signing an identity card for each WHE, which entitles them to free health care at the HC. This card is a prized local level incentive and contributes to WHE and Care Group sustainability, beyond the life of the project.

Because both the MOH and the community are key project partners for project sustainability; the project works with both very closely to facilitate dialogue between them, in order to help them to be interested in each other and to build a good long term relationship that will outlast the project.

Behavior change requires a multi faceted approach, both of community building, active village leader support, private provider participation, WHEs and WHE teams (CGs), combined with the training, support and encouragement from the project staff. These all combine to build a sense of community, using health and behavior change as the catalysts. These are the 'unquantifiables' and yet they are essential to project success and future sustainability. These approaches have been successful in promoting community participation, and have led to behavior change of families and communities.

Table 1: Objectives, Activities and Relevance to CSHGP Intermediate Results

A. Capacity Building and Sustainability Objectives

Light for Life Objectives	Progress made?	Comments (Option)
1. 75% of salt vendors in the two largest market places will have iodized salt for sale and be able to tell why it is better.	Yes	Salt vendors trained. The project staff did ask the questions related to the iodized salt, 75% of salt vendors in the two largest market places (Stung market and Chimon market) knew that it prevent goiter, prevent difficult learning of a child and help the health of a child.
2. Community members will advocate for consistent outreach services (e.g. EPI) to district level authorities.	Yes	Currently EPI outreach activity ranges from 98.4% to 100% in the original and new areas.
3. Attrition rate of trained volunteers for reasons other than death, disability or movement out of the project area will be less than 30%.	Yes	The current volunteer attrition rate is 3% in the original area, and 4.9% in the new area.
4. To integrate the WHEs and CG system into a lasting community structure: a) At least 75% of CGs will have 70% attendance at two of their last three meetings. b) In the final two years of the project, at	Yes	a) 89-94% attendance in July, August & September 2005 b) The project is working towards the project goals and plans to withdraw the health field staff from the Original Area to test it.

Light for Life Objectives	Progress made?	Comments (Option)
least 65% of CGs will meet even when a HFS is absent. c) Integration of CG structure into the community via links with the village leader and FC.		c) All CGs work closely with the local VLs and, the VLs attend the monthly CG meeting when available. Some FCs have been established. Each FC consists of a male and a female, the latter is always a WHE. VDCs and CCs are also being trained to support CGs and WHEs, so that they see them as a permanent part of the village/community.
5. 80% of EPI outreach sessions will be conducted according to schedule.	Yes	Currently EPI outreach activity ranges from 98.4% to 100% in the original area and new areas.
6. Build mutual accountability between communities and the MOH as indicated by increased service utilization and the functioning of feedback committees.	Yes	Feedback committees are functioning. Two representatives per village have been selected to participate in this committee.
7. Integrate WR's community-based system with that of the MOH.	Yes	The project works with the community and MOH as it seeks to improve program sustainability.

B. Objectives for Technical Interventions

Light for Life Objectives	Progress made?	Comment (Option)
Immunization	Yes	See MTE and LRA#7 (Annex 1) 80% at MTE
1. Increase to 60% children age 12-23 months who are fully vaccinated before the 1 st birthday.		
2. Increase to 60% pregnant women who will receive at least 2 TT doses before the birth of their child	Yes	See MTE and LRA#7 (Annex 1) 64% at MTE
Hygiene and CDD	Yes	See MTE and LRA#7 (Annex 1) 99% at MTE
3. Increase to 60% (80% old area) mothers who wash hands with soap in conjunction with at least two of the following: before preparing food, before feeding children, after defecation, & after attending to a child who has defecated.		
4. Increase to 80% children with diarrhea who receive ORT.	Yes	See MTE and LRA#7 (Annex 1) 100% at MTE

Pneumonia Case Management 5. Increase to 40% the percentage of children with suspected pneumonia (rapid, difficult breathing) who were taken to a trained provider within 24 hours.	Yes	See MTE and LRA#7 (Annex 1) 97% at MTE
<i>Sick Child</i> 6. Increase to 50% mothers who know at least 2 danger signs of childhood illness that indicate the need for treatment.	Yes	See MTE and LRA#7 (Annex 1) 98% at MTE
Nutrition 7. Increase initiation of breastfeeding within 1 hour of delivery to 40% (50% in old areas).	Yes	See MTE and LRA#7 (Annex 1) 90% at MTE
8. Increase to 30% the use of iodized salt	Yes	See MTE and LRA#7 (Annex 1) 89% at MTE
9. Increase to 60% (80% in original villages), caretakers who will give more fluids and continue feeding a child who is ill.	Yes	See MTE and LRA#7 (Annex 1) 98% at MTE
10. 60% of children who completed the <i>Hearth</i> program achieve and sustain adequate or catch-up growth per month during at least 2 months after period of supervised feeding.	Yes	See <i>Hearth</i> assessment (Annex 3). 1) 64.8% at <i>hearth</i> assessment
11. Increase to 20% pregnant women taking iron tablets at least 60 days during their most recent pregnancy.	Yes	See MTE and LRA#7 (Annex 1) 78% at MTE

TRAINING AND MONITORING ACCOMPLISHMENTS IN THE THIRD YEAR:

2004

October to December:

- LRA #5 completed for all the project interventions.
- Reviewed the lesson on immunization and diarrhea to the care groups.
- TBA training on pre and post natal care, immunization, cord care, and breastfeeding.
- BCC teams teach the children and other community members on diarrhea. They also facilitated the village leaders to use the monthly village health statistics (CHIS) to review the current health situation in their villages.

2005

January to March:

- Reviewed all the lessons to care groups.
- LRA #6 completed for the MTE of the project.
- HFS introduced the community feedback persons to the HC staff.
- Got the approval for the household drug practice on ARI treatment to train the WHEs in health center Kandual Chrum #I, from the provincial health department for the project pilot.
- Trained WHEs on drug practice for ARI treatment and how to do home visits in pilot area.
- Facilitated feedback meetings in the health centers.

March to June:

- Reviewed all the lessons to the care groups.
- Project Mid-Term Evaluation.
- Workshop on the MTE finding in Phnom Penh.
- Completed LRA#1 on the household drug practice for pneumonia in the pilot area.
- Workshop on MTE finding, discussion to get feedback from the commune councils for planning in the next two and a half years, in the original area.
- Staff retreat.
- Started implementation of Hearth program in 4 villages that have the highest mortality rate of children under 5, as determined by care group monthly mortality statistics.
- Joined monthly meeting with health centers and community feedback committees.

July to September:

- Weighed the child in hearth program for monitoring and assessment.
- Planning with the Operational Health District (OHD) & HC's to take responsibility for all future training of the care group leaders and village leaders on nutrition with child growth monitoring and drug practice at the household level for pneumonia. Then CG leaders take the responsibility to train CG members.
- Reviewed all the health lessons to the care groups.
- Joined monthly meeting with health centers and community feedback committees.
- Did a baseline survey on household drug practices in the remaining project area.
- Met with the commune council and the OHD to discuss about making the HC ID card for WHEs, as an incentive for their voluntary work.
- TOT was provided to the project HFS and health centers staff on nutrition, child growth monitoring and drug practices at the household level for pneumonia.
- The health center staff and HFS trained care group leaders and village leaders on nutrition, growth monitoring and drug practices for pneumonia.
- Prepared the project LRA#7 questionnaire for all interventions.
- HFS and BCC team reviewed dengue fever lessons with all care groups as it is the dengue fever season.

II. THE CONSTRAINTS AND FACTORS THAT HAVE IMPEDED PROGRESS TOWARD ACHIEVEMENT OF OVERALL GOALS AND OBJECTIVES:

1. Although there is improvement in community values through the community empowerment and ownership, led by the village and care group leaders, the process of reinvigorating a sense of community faces other obstacles outside of project control, such as corruption, local power and political forces which community members perceive themselves as powerless against.
2. Mutual accountability between the MOH and community is improving but the problems of lack of appreciation and encouragement for HC staff by the community continues to create a low sense of self esteem and morale of these staff.

ACTIONS BEING TAKEN BY THE PROGRAM TO OVERCOME THESE CONSTRAINTS:

1. The project works with village leaders, CC leaders and members, using the issue of health as a means of bringing all parts of the community together. Health is presented as an individual, family and community issue, with differing responses required by each of these parts, according to the intervention/health issue. HFS work closely with CC leaders and members. CG leaders work closely with WHEs and VLs. BCC staff work with VLs and their BCC activities are complimentary to the messages being presented by the WHEs. Through this multi faceted approach, individuals, families, villages and communes' capacities are built, and they all become enlisted in improving health beliefs and practices. The other areas mentioned above, such as corruption, are rarely impacted by the project's community building interventions.

To further strengthen post project sustainability, and continue to build a sense of community, the project has commenced a health training program for CC leaders and members. This approach is unique in Cambodia and has the potential for community empowerment and impact by using the political system recently established in all communes throughout Cambodia. The CCs are elected by community members, have received training in assessing and planning for community needs, and have been given some funding to implement some of their programs. The project attends the planning meetings and notes that health has become a priority issue. Prior to this training, health was not even on the CC planning agenda, and was poorly understood. Since then the project has undertaken a program of training and working closely towards the project goals.

2. Since June 2004 Save the Children Australia (SCA) has taken the responsibility for the OHD, through a MOH/ADB contracting agreement. SCA is working to deal with the above problems and there is an expectation that HC and outreach services will improve under their management. They have already implemented a HC salary, user fee and incentive scheme, based on work hours and fulfillment of their duties; such as timely completion of all outreach services and meeting or exceeding targets, e.g. complete immunization of children under 1 year of age. The supply of materials, such as motorbike

fuel and cold chain boxes etc, is no longer a problem; since these, and other HC needs, are part of the SCA contract. An assessment of knowledge and practice of all HC staff is to be implemented and this will be followed up with the necessary training, where gaps are found. Eleven new HCs have been built in areas which have been designated by the government as eligible for a HC. The contracting, and subsequent strengthening of health services, has created excitement and renewed enthusiasms among HFS and WHEs, as the opportunities for synergy, leading to further behavior change by individuals, families and communities, and improved health access and quality of care, enable a poor community to reassign their personal resources rather than spending large amounts of money on transport to access health care facilities. (In the MTE WHEs spoke of how their families were now wealthier and healthier because they were spending less on health care and were using this money to improve their family business. Healthy children mean more expendable income.)

III. NEED FOR TECHNICAL ASSISTANCE

Technical assistance is required in the form of a program trainer and promoter in curriculum development and adult participatory education techniques. Also, assistance is needed to develop strategies for the sustainability of care groups. Financial management and English skills are also considered as needs for the program managers.

Table 2: Technical Assistance

Priority	Program Application
1. Technical assistance on the research of the sustainability of the care groups in the original area.	To help the project prepare for meeting the end of the project goals.
2. Financial management	To improve project financial management.
3. Curriculum development	To strengthen the skill of the staff in term of job aid for their teaching manual.
4. English	To enable the managers to do international communication such as report writing, attend regional workshops etc.

IV. DESCRIBE ANY SUBSTANTIAL CHANGES FROM THE PROGRAM DESCRIPTION AND DIP:

No changes in the third year.

ANNEX 1: LRA#7

World Relief Cambodia Light for Life Child Survival Cost Extension Project Ponhea Kriek – Dumbai Operational Health District, Kampong Cham Province, Cambodia

Fifth Local Rapid Assessment on Micronutrient Nutrition, Immunization, Diarrhea, ARI, IMCI
September 2005

I. Objectives of the Local Rapid Assessment Survey

The purpose of this mini-survey is to help the project focus on goals and achievements for reflection and discussion. It is primarily to help locate problem areas at both the project level and among the Health Field Staff (HFS). It is also used to provide feedback to the project volunteers, Ministry of Health (MOH) staff, and leaders of villages and communes in the project area.

II. Selection of the Sample

Each HFS had three care groups chosen at random by drawing their number from a box. To avoid bias, each HFS was randomly selected to interview the mothers from another HFS's care group. Three Women Health Educators (WHEs) were randomly selected from each of the selected care groups. The first and the second WHE selected had two women with children under 2 years in her area interviewed, the other one WHEs had three women with children under 2 years in their area interviewed. This gave a total of 7 women interviewed in each care group, with a total of 21 women interviewed per HFS. In order to have enough sample size to measure the immunization coverage for each health center and each commune, other care groups were selected to be added, and to be at least 21 women with children under 2 years for any health center and commune that not enough sample size.

III. Method of Data Analysis

Data entry and processing was done by Phan Seang Theun, Phan Buntheng, and Oun Sivan with EPI Info 6.

IV. Survey Results

The following answers were given for the survey questions. The total number of this survey in LRA#7 was 420, including 147 in the original area (OA) and 273 in the extension area (EA). There is only one kind of the survey form. In both areas, the knowledge, practice and coverage questionnaires were given to the mothers to measure the knowledge, practice, and coverage has been done so far.

Demographic Data

1. Do you know your volunteer?

Responses	Both areas N = 420		LRA#7 Original Area N= 147		LRA#7 Extension Area N= 273	
	N	%	N	%	N	%
a. Yes	420	100%	147	100%	273	100%
b. No	0	0	0	0	0	0

In the original area, there are 5 communes in the north of Ponhea Kriek district such as Kandual Chrum, Po Pel, Kong Kang, Veal Mlou, and Kriek.

In the extension area, there are 10 communes (including 3 communes of Ponhea Krek district in the south and 7 communes of Dam Be district) such as Don Tey, Kok, Tropaing Plong , Dam Be, Se Da, Tropaing Pring, Chung Cheag, Tuk Chrouv, Koc Srok, Neang Teut.

2. Name, age of the mother

Age range of women			Age mean of women		
Both Areas	Original Area	Extension Area	Both Areas	Original Area	Extension Area
16-45 years	16 – 43 years	17- 45 years	25.948 years	25.973 years	25.934 years

3. Name, age, and sex of a youngest child.

In Both Areas: Male = 222 = 52.9%, Female = 198 = 47.1%, N = 420

In Original Area: Male = 72 = 49%, Female = 75 = 51%, N = 147

In Extension Area: Male = 150 = 54.9%, Female = 123 = 45.1%, N = 273

Age range of women			Age mean of women		
Both Areas	Original Area	Extension Area	Both Areas	Original Area	Extension Area
0- 23 months	0- 23 months	0-23 months	9.526 months	10.109 months	9.212 months

4. When you were pregnant with this child (Name), did you receive any iron tablets?

Responses	Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%
a. Yes	383	91.2%	144	98%	239	87.5%
b. No	36	8.6%	3	2%	33	12.1%
c. Don't know	1	0.2%	0	0	1	0.1%

5. How many days did you take the iron tablets?

Responses	MTE - Both Areas N=462		Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%	N	%
a. Receive 60+ days	361	78.1%	338	80.4%	131	89.1%	206	87.5%

6. May I test your salt for iodine?

Responses	MTE Both Areas N=462		Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%	N	%
a. Iodine is present	413	89.4%	400	95.2%	143	97.3%	257	94.1%
b. Iodine is not present	49	10.6%	20	4.8%	4	2.7%	16	5.9%

7. Ask for immunization card of (Name) and record it below. Record children are 12- 23 months?

Responses	MTE-Both Areas N=164		Both Areas N= 140		Original Area N= 53		Extension Area N= 87	
	N	%	N	%	N	%	N	%
a. No card/lost	12	7.3%	7	5%	3	5.7%	4	5.2%
b. BCG	152	92.7%	134	95.7%	50	94.3%	84	94.8%
c. OPV1	152	92.7%	133	95%	49	92.5%	84	94.8%
d. OPV2	152	92.7%	133	95%	49	92.5%	84	94.8%
e. OPV3	148	90.2%	131	93.6%	49	92.5%	82	92.2%
f. DPT1	150	91.5%	132	94.3%	48	90.6%	84	93%
g. DPT2	150	91.5%	132	94.3%	48	90.6%	84	93%
h. DPT3	146	89%	129	92.1%	47	88.7%	82	90.4%
i. Measles	140	85.4%	129	92.1%	49	92.5%	80	86.1%
j. Complete	137	83.5%	124	88.6%	46	86.8%	78	83.5%
k. Complete before one year of age	131	79.9%	119	85%	43	81.1%	76	80%
Vitamin A of children over 6 months of age, record the recently dosage in the yellow card.	83 N=301	27.6%	134 N= 294	45.6%	40 N = 107	37.4%	94 N = 187	30.3%

8. Look at the maternal health card or other immunization cards and record the date for each TT show on the card below:

TT2 for women in the reproductive age (15 years – 49 years)

Responses	MTE-Both Areas N=462		Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%	N	%
a. No card/lost	44	9.5%	62	14.8%	15	10.2%	47	17.2%
b. TT1	418	90.5%	358	85.2%	132	89.8%	226	82.8%
c. TT2*	408	88.3%*	346	82.4%*	126	85.7%	220	80.6%
d. TT3	330	71.4%	346	82.4%	106	72.1%	169	61.9%
e. TT4	103	22.3%	121	28.8%	52	35.4%	69	25.3%
f. TT5	59	12.8%	45	10.7%	35	23.8%	10	3.7%

TT2 for pregnancy women:

Responses	MTE-Both Areas N=462		Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%	N	%
a. No card/lost	44	9.5%	62	14.8%	15	10.2%	47	17.2%
b. TT1	337	72.9%	325	77.4%	119	81%	206	75.5%
c. TT2	297	64.3%	325	77.4%	115	78.2%	201	73.6%
d. TT3	122	26.4%	316	75.2%	78	53.1%	111	40.7%
e. TT4	62	13.4%	82	19.5%	43	29.3%	39	14.3%
f. TT5	25	5.4%	36	8.6%	29	19.7%	7	2.6%

9. How did you take care of umbilical cord for (Name) when he/she was a baby?

Responses	Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%
a. Clean with wine	26	6.2%	6	4.1%	20	7.3%
b. Clean water and soap	45	10.7%	16	10.9%	29	10.6%
c. Beta dine preparation	362	86.2%	136	92.5%	226	82.8%
d. Did nothing	20	4.8%	4	2.7%	16	5.9%
e. Wasp nest poultice	3	0.7%	2	1.4%	1	0.4%
f. Other ash	17	4%	3	2%	14	5.1%
g. Black pepper	2	0.5%	2	1.4%	0	0

10. Does your household have a special place for hand washing?

Responses	Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%
a. Yes	419	99.8%	147	100%	272	99.6%
b. No	1	0.2%	0	0	1	0.4%

11. Ask to see the place most often used for hand washing and circle the follow items that are present?

Responses	MTE-Both Areas N=462		Both Areas N= 419		Original Area N=147		Extension Area N=272	
	N	%	N	%	N	%	N	%
a. Water	462	100%	417	99.5%	147	100%	270	99.3%
b. Soap	453	98.1%	403	96.2%	144	98%	259	95.2%
c. Ash or other	11	2.4%	21	5%	4	2.7%	17	6.3%
d. Basin	455	98.5%	409	97.6%	146	99.3%	263	96.7%
e. Can with a hole	4	0.9%	2	0.5%	0	0%	2	0.7%
f. Have 3 items (a,b,c,d and e)	455	98.5%	401	95.7%	144	98%	257	94.5%

12. When do you wash your hand with soap?

Responses	MTE-Both Areas N=462		Both Areas N= 420		Original Area N=147		Extension Area N=273	
	N	%	N	%	N	%	N	%
a. Before food preparation	412	89.2%	373	88.8%	132	89.8%	241	88.3%
b. Before eating	422	91.3%	381	90.7%	134	91.2%	247	90.5%
c. Before feeding children	389	84.2%	345	82.1%	122	83%	223	81.7%
d. Before going to bed	32	6.9%	21	5%	10	6.8%	11	4%
e. After eating	106	22.9%	80	19%	54	36.7%	26	9.5%
f. After defecation	403	87.2%	358	85.2%	131	89.1%	227	83.2%
g. After attending a child with defecation	384	83.1%	332	79%	119	81%	213	78%
h. After working in the field or clean the house	82	17.7%	15	3.6%	8	5.4%	7	2.6%
i. With a bath	19	4.1%	10	2.4%	4	2.7%	6	2.2%
j. When dirty	72	15.6%	31	7.4%	6	4.1%	25	9.2%
k. Don't know	0	0%	1	0.2%	0	0%	1	0.4%
l. Know at least 2 of (a,c,f,g)	457	98.9%	416	99%	146	99.3%	270	98.9%

13. In the last two weeks, have (Name) had diseases below:

Responses	MTE-Both Areas N=462		Both Areas N= 420		Original Area N=147		Extension Area N=273	
	N	%	N	%	N	%	N	%
a. Cough	80	17.3%	105	25%	38	25.9%	67	24.5%
b. Difficult breathing/fast breathing	40	8.7%	48	11.4%	14	9.5%	34	12.5%
c. Chest drawing and nostril flaring	22	4.8%	23	5.5%	6	4.1%	17	6.2%
d. High fever	55	11.9%	47	11.2%	21	14.3%	26	9.5%
e. Light fever	96	20.8%	99	23.6%	36	24.5%	63	23.1%
f. Cold	137	29.7%	107	25.5%	39	26.5%	68	24.9%
g. Diarrhea	71	15.4%	30	7.1%	16	10.9%	14	5.1%
h. Convulsion	1	0.2%	0	0%	0	0%	0	0%
i. None	223	48.3%	223	53.1%	81	55.1%	142	52%

14. When (Name) was sick, what signs/symptoms did you see that prompt you to see treatment or advice immediately?

Responses	MTE-Both Areas N=239		Both Areas N= 197		Original Area N= 66		Extension Area N= 131	
	N	%	N	%	N	%	N	%
a. Lethargic	180	75.3%	141	71.6%	46	69.4%	95	72.5%
b. High fever	223	93.3%	189	95.9%	66	100%	123	93.9%
c. Difficult breathing/fast breathing	189	79.1%	151	76.6%	48	72.7%	103	78.6%
d. Chest drawing and nostril flaring	104	43.5%	86	43.7%	31	47%	55	42%
e. Vomiting	101	42.3%	71	36%	11	16.7%	60	45.8%
f. Convulsion	91	38.1%	60	30.5%	22	33.3%	38	29%
g. Not eat	21	8.8%	21	10.7%	5	7.6%	16	12.2%
h. Cry hard and not stop	14	5.9%	6	3%	3	4.5%	3	2.3%
i. Gave medicine but not recover	5	2.1%	0	0%	0	0%	0	0%
j. Blood in stool	61	25.5%	48	24.4%	15	22.7%	33	25.2%
k. Sign of dehydration	76	31.8%	37	18.8%	23	34.8%	14	10.7%
l. Prolong diarrhea	79	33.1%	59	29.9%	22	33.3%	37	28.2%
m. Don't know	0	0%	1	0.5%	0	0%	1	0.8%
n. Know at least two signs/symptoms of (a,b,c or d, e and f)	235	98.3%	193	98%	65	98.5%	128	97.7%

15. When child (Name) had pneumonia (difficult breathing/fast breathing), when did you seek treatment or advice?

Responses	MTE-Both Areas N=41		Both Areas N=48		Original Area N=14		Extension Area N=34	
	N	%	N	%	N	%	N	%
a. Immediate	34	82.9%	44	91.7%	14	100%	30	88.2%
b. 1 day (within 24 hours)	6	14.6%	4	8.3%	0	0%	4	11.8%
c. 2 days	0	0	0	0	0	0	0	0
d. 3 days or more	1	4%	0	0	0	0	0	0
e. Don't know	0	0	0	0	0	0	0	0
f. Seeking treatment within 24 hours (a+b)	40	97.5%	48	100%	14	100%	34	100%

16. How many days of antibiotic treatment for a child with pneumonia?

Responses	MTE-Both Areas N=41		Both Areas N= 48		Original Area N= 14		Extension Area N= 34	
	N	%	N	%	N	%	N	%
a. At least 5 days	21	51.2%	38	79.2%	12	85.7%	26	76.5%
b. At least 7 days	16	39%	9	18.8%	2	14.3%	7	20.6%
c. At least 10 days	4	9.8%	0	0%	0	0	0	0
d. Less than 5 days	0	0	1	2.1%	0	0	1	2.9%
e. Don't know	0	0	0	0	0	0	0	0

17. When (Name) had diarrhea, what treatment, if any, did you use?

Responses	Both-Areas N=71		Both Areas N= 30		Original Area N= 16		Extension Area N= 14	
	N	%	N	%	N	%	N	%
a. Nothing	0	0	0	0	0	0	0	0
b. ORS packets	52	73.2%	26	86.7%	15	93.8%	11	78.6%
c. Homemade sugar-salt solution	9	12.7%	3	10%	3	18.7%	0	0
d. Cereal based ORT	61	85.9%	23	76.7%	13	81.3%	10	71.4%
e. Tea, other available fluid	62	87.3%	29	96.7%	15	93.8%	14	100%
f. Breast milk	66	93%	28	93.3%	15	93.8%	13	92.9%
g. Diarrhea medicine pill	16	22.5%	0	0	0	0	0	0%
h. Traditional medicine	1	1.4%	0	0	0	0	0	0
i. Injection	1	1.4%	0	0	0	0	0	0
j. Intravenous infusion	0	0%	0	0	0	0	0	0
k. Get to health center/hospital	3	4.2%	0	0	0	0	0	0
l. Use ORT	71	100%	30	100%	16	100%	14	100%

18. When child (Name) was sick, where did you seek treatment or advice first?

Responses	Both Areas N= 197		Original Area N= 66		Extension Area N= 131	
	N	%	N	%	N	%
a. Take care at home, don't use antibiotic	1	0.5%	0	0	1	0.8%
b. Health center	172	87.3%	61	92.4%	111	84.7%
c. Private clinic	5	2.5%	0	0	5	3.8%
d. Village injectionist	11	5.6%	3	4.5%	8	6.1%
e. Traditional healer	1	0.5%	0	0	1	0.8%
f. Hospital	8	4.1%	2	3%	6	4.6%
g. Pharmacy/shop keeper	1	0.5%	0	0	1	0.8%
h. Volunteer	9	4.6%	4	6.1%	5	3.8%
i. TBA	0	0	0	0	0	0

j. Relative	2	1%	0	0	2	1.5%
k. Village leader	0	0	0	0	0	0

19. When (Name) was sick, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?

Responses	MTE-Both Areas N=239		Both Areas N= 197		Original Area N= 66		Extension Area N= 131	
	2	0.8%	N	%	N	%	N	%
a. Less than usual	3	1.3%	0	0	0	0	0	0
b. Same amount	234	97.9%	3	1.5%	0	0	3	2.3%
c. More than usual	0	0	194	98.5%	66	100%	128	97.7%
d. Nothing	0	0	0	0	0	0	0	0
e. Don't know			0	0	0	0	0	0

20. When (Name) was sick, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?

Responses	MTE-Both Areas N=239		Both Areas N= 197		Original Area N= 66		Extension Area N= 131	
	N	%	N	%	N	%	N	%
a. Less than usual	1	0.4%	3	1.5%	2	3%	1	0.8%
b. Same amount	0	0	2	1	0	0	2	1.5%
c. More than usual	238	99.6%	192	97.5%	64	97%	128	97.7%
d. Nothing	0	0	0	0	0	0	0	0
e. Don't know	0	0	0	0	0	0	0	0

21. After (Name) was sick, what did you do to help her/him recover?

Responses	Both Areas N= 197		Original Area N= 66		Extension Area N= 131	
	N	%	N	%	N	%
a. Give extra food (more than usual, frequent)	132	67%	49	74.2%	83	63.4%
b. Give food as usual	1	0.5%	0	0	1	0.8%
c. Give food high caloric content (such as sugar, oil, fat)	140	71.1%	49	74.2%	91	69.5%
d. Withheld certain food to prevent further diarrhea	1	0.5%	0	0	1	0.8%
e. Give soft food (such as bobor, banana, or egg)	182	92.4%	60	90.9%	122	93.1%
f. Increase breastfeeding	175	88.8%	59	89.4%	116	88.5%
g. Give vitamin	2	1%	0	0	0	0
h. Don't know	0	0	0	0	0	0

22. Are you breastfeeding child (Name)?

Responses	Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%
a. Yes	406	96.7%	142	96.6%	264	96.7%
b. No	14	3.3%	5	3.4%	9	3.3%

23. Did you used to breastfeed child (Name)?

Responses	Both Areas N= 14		Original Area N= 5		Extension Area N= 9	
	N	%	N	%	N	%
a. Yes	13	92.9%	5	100%	8	88.9%
b. No	1	7.1%	0	0	1	11.1%

24. After delivery, when did you breastfeed (Name) for the first time?

Responses	MTE-Both Areas N=462		Both Areas N= 419		Original Area N= 147		Extension Area N= 272	
	N	%	N	%	N	%	N	%
a. During the first hour after delivery	418	90.5%	388	92.6%	137	93.2%	251	92.3%
b. From 1-8 hours after delivery	26	5.6%	16	3.8%	5	3.4%	11	4%
c. More than 8 hours after delivery	12	2.6%	11	2.6%	5	3.4%	5	1.8%
d. Second day	4	0.9%	3	0.7%	0	0	3	1.1%
e. Three days or more	2	0.4%	3	0.7%	0	0	3	1.1%
f. Don't know	0	0	0	0	0	0	0	0

25. I would like to ask you about the type of fruit and food that (Name) consumed yesterday during the day and at night. How many times yesterday did he/she drink or eat them?

READ EACH OF THE FOLLOWING AND PLACE NUMBER OF TIMES IN BOX NEXT TO EACH ITEM CONSUMED.

Responses	Both Areas N= 420		Original Area N= 147		Extension Area N= 273	
	N	%	N	%	N	%
a. Plain water	302	71.9%	111	75.5%	191	70%
b. Infant formula	19	4.5%	9	6.1%	10	3.7%
c. Cow's milk	8	1.9%	4	2.7%	4	1.5%
d. Fruit juice	49	11.7%	23	15.6%	26	9.5%
e. Any other liquids such as sugar water, tea, soda, bobor water	202	48.1%	80	54.4%	122	44.7%
f. Can sweet condense milk	16	3.8%	8	5.4%	8	2.9%

g. Any food from grain (bobor, corn, rice, bread)	285	67.9%	102	69.4%	183	67%
h. Pumpkin, red or yellow sweet potatoes, carrot	204	48.6%	204	48.6%	132	48.4%
i. Any other food made from root or tuber	74	17.6%	26	17.7%	48	17.6%
j. Any green leafy vegetables	268	63.8%	96	65.3%	172	63%
k. Any yellow fruit such as mango, papaya, jackfruit, durian	42	10%	19	12.9%	23	8.4%
l. Any other fruit and vegetables	173	41.2%	64	43.5%	109	39.9%
m. Meat, poultry, or fish	283	67.4%	283	47.4%	180	65.9%
n. Any food made from with legumes	57	13.6%	23	15.6%	34	12.5%
o. Any food made from with from fat or oil	246	58.6%	92	62.6%	154	56.4%
p. Eggs with yolk, liver, or small fish with liver	202	48.1%	76	51.7%	126	46.2%
r. Exclusive breastfeeding for child with 4 months old	18 N=23	78.3%	9 N=12	75%	9 N=11	81.8%
s. Exclusive breastfeeding for child with 6 months old	3 N=20	15%	0 N=6	0	3 N=14	21.4%

V. DISCUSSION/RECOMMENDATIONS

1. Age of the mothers and children:

The exact age of the mothers and children were often unknown. Approximate age of women and children were determined with the help of a local calendar (major holidays, etc). The interviewers were already trained to calculate the child's age in months by determining the number of months completed between the child's birth date and the interview date.

It is good to see that 100% of the mothers know their volunteers.

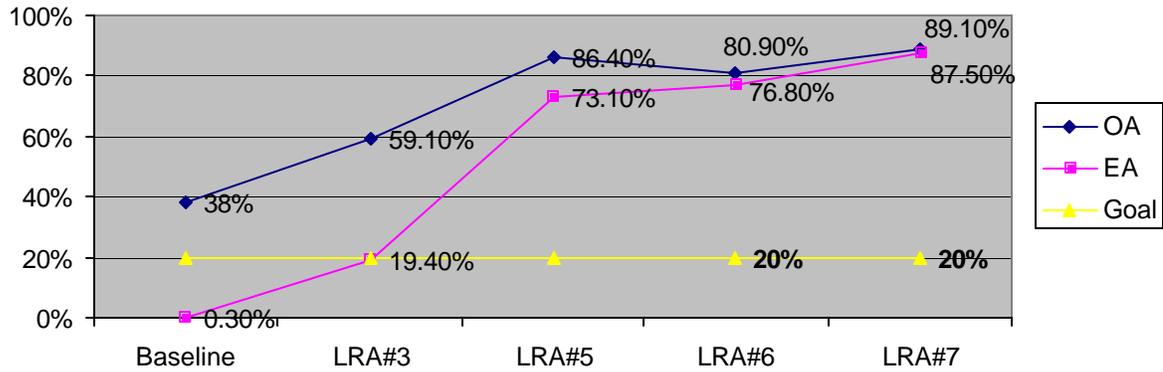
2. Micronutrient:

OA= Original Area

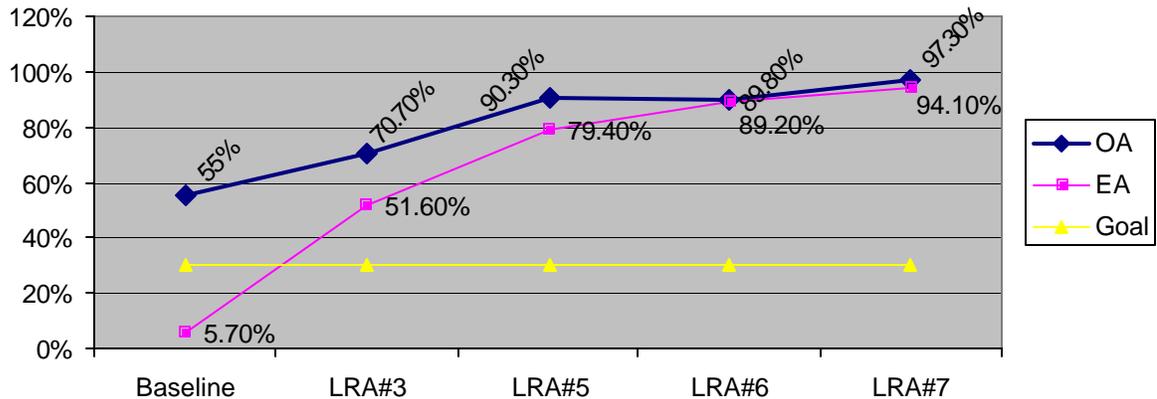
EA= Extension Area

EOP= End of project

Pregnancy woman took iron tablet for 60+ days



Salt was tested and saw iodine was present:

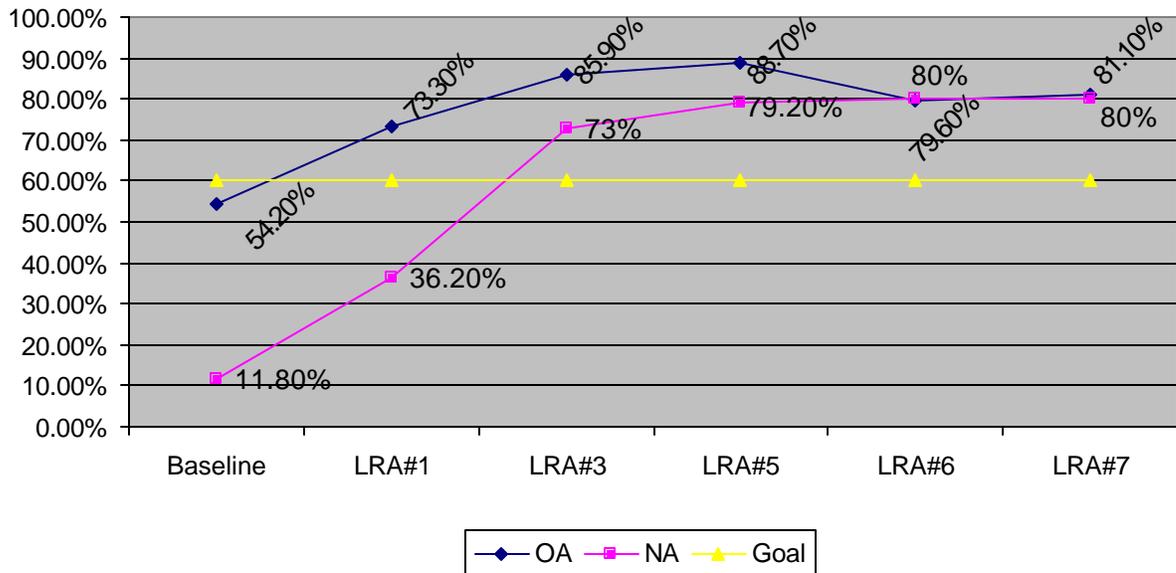


In this survey, the graphic shows that the woman used iron tablets for 60+ days during her pregnancy this child. It increases very significantly from the baseline 38% (OA) and 0.3% (EA) to LRA#6, 80.9% (OA) and 76.8% (EA) to LRA#7, 89.1% (AO) and 87.5% (EA). It both exceeds the project goal of 20%.

The use of iodized salt, evidenced by UNICEF Test Kit during this survey, it is also tremendously increasing as well from the baseline of 55% (OA) and 5.7% (EA) to LRA#6 of 89.8% (OA) and 89.2% (EA) to LRA#7, 97.3% (OA) and 94.1% (EA). The micronutrient has been exceeded EOP goal of 30% in both areas.

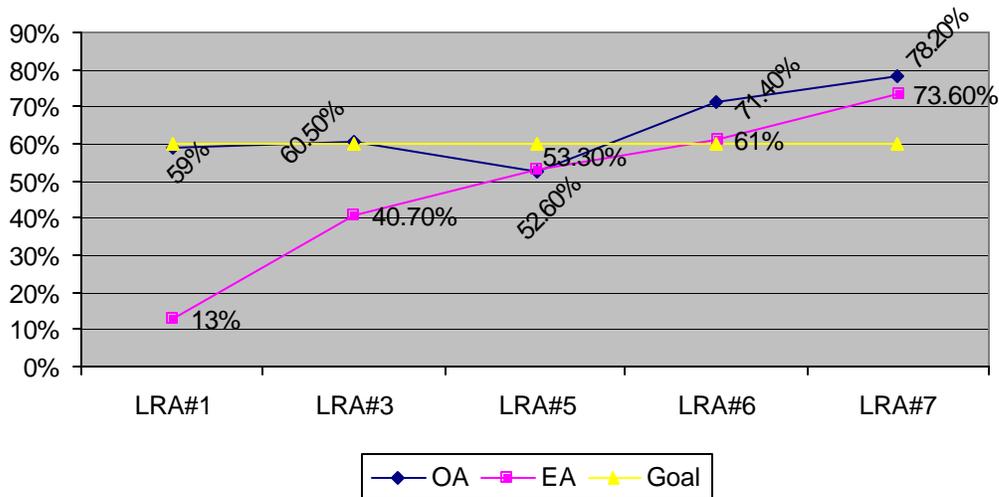
3. Immunization:

Child completes immunization before one year of age:



In the graphic, the result of this survey shows that children got completely immunization before one year of age is still exceeded the goal of 60% in both areas and sustain.

Woman's TT2 before the birth of her last child:



In this graphic, the result shows that there is a lot of improvement from LRA#1 of 59% (OA) and 13% (EA) to LRA#6 of 71.4% (OA) and 61% (EA); and up to 78.2% (OA) and 73.6% (EO). Both areas meet EOP goal (60%).

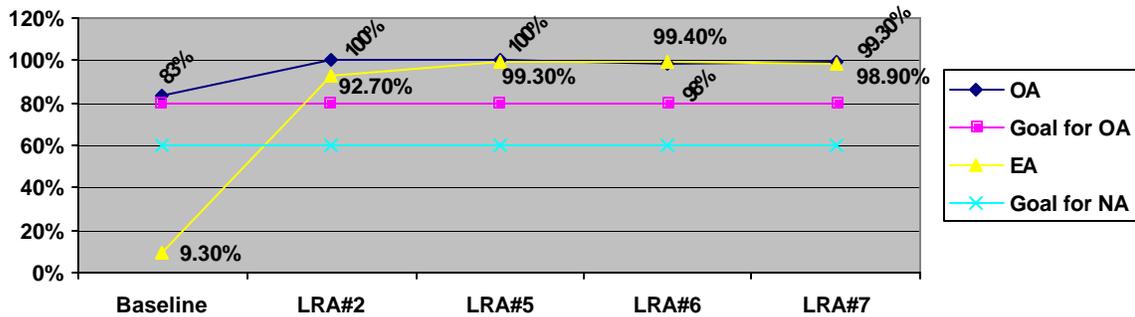
Newborn Cord Care

It is good to see the mother use more Beta dine preparation for baby cord care 73.5% (OA) and 74.9% (EA); and to LRA#7, 92.5% (OA) and 82.8% (EA) in this survey.

4. Control of diarrhea disease:

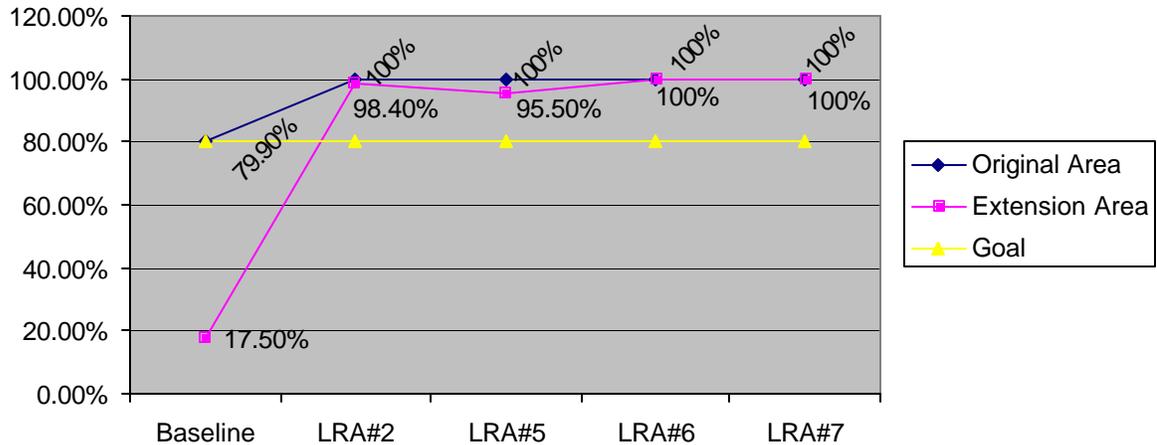
Hand washing to prevent diarrhea:

In this survey, the mothers who wash their hands with soap/ash in conjunction with at least 2 of the following (such as before preparing food, before feeding children, after defecation, and after attending a child who has defecated) is 99.3% in the original area with the baseline was 83%; and 98.9% in the extension area with the baseline was 9.3%.



The graphic shows that it exceeded EOP 80% in the original area, and 60% in the extension area.

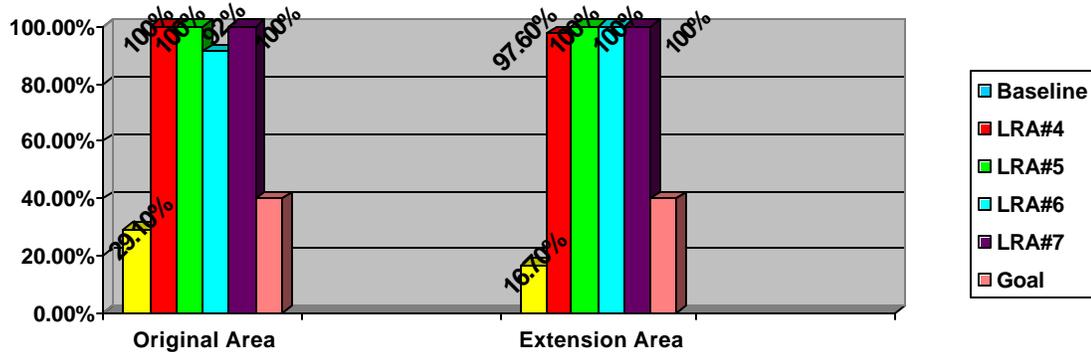
Use ORT to treat diarrhea:



The graphic of this survey shows that ORT (oral rehydration therapy) use for treatment diarrhea is very good in both areas since it was known by the mothers that it helps to prevent death of dehydration and it exceeded EOP goal of 80%. It is excited to see 100% of the mothers who have children with diarrhea used ORT at LRA#6 and LRA#7.

5. ARI and sick child:

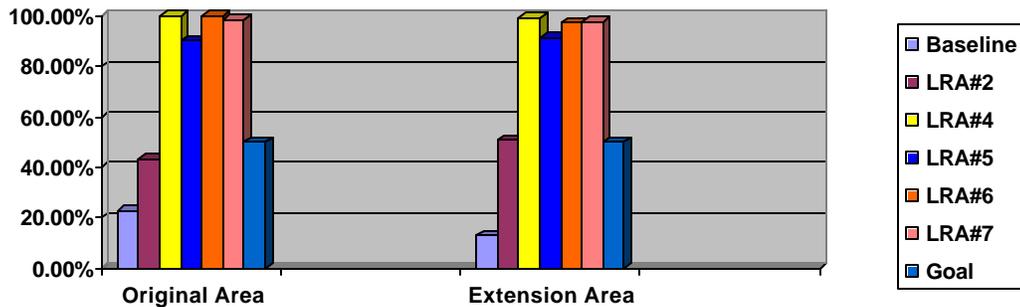
Care seeking for fast/difficult breathing within 24 hours in the health trained providers:



It is very excited to see that the mother seeks health care within 24 hours when a child has fast/difficult breathing.

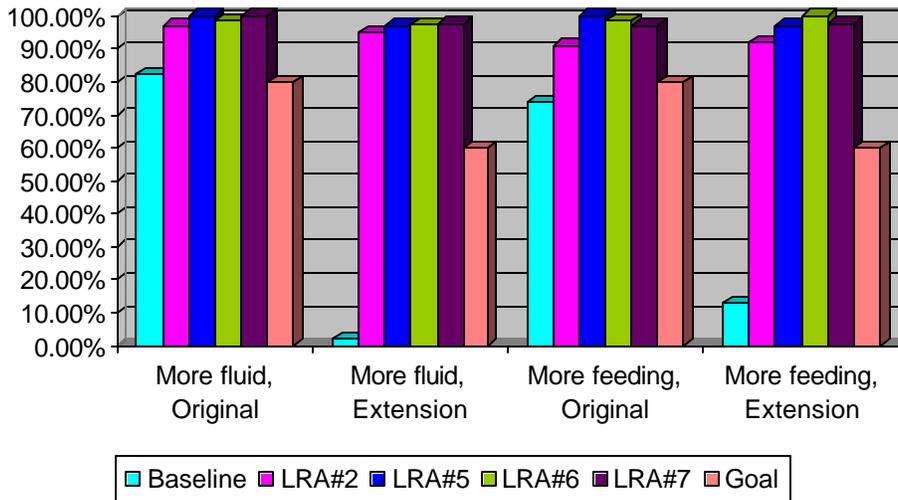
Danger signs/symptoms for sick child:

Know at least two of the following danger signs/symptoms such as lethargic, high fever, difficult/fast breathing, chest drawing and nostril flaring, vomit every things, convulsion.



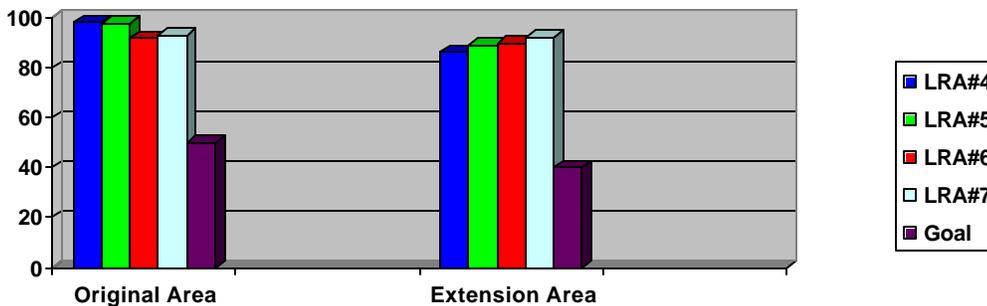
In this survey, the finding shows that there is some drop in LRA#5 but it increases again in LRA#6 of 100% (OA) and 98% (EA); and LRA#7 is 98.5% (OA) and 97.7%.

Give more fluid and more food to a sick child:



The graphic shows, it is very good for a sick child, the mother say that she gives more fluid and more food for a child to drink and to eat. It is encouraged that the mother keeps giving more fluid and more food to a child when he/she was sick in both areas.

6. Nutrition BF: The mother says that she breastfed the child within one hour of delivery.



In this survey, it shows that the mother reported that they start breastfeeding early within one hour after delivery of her last child. It also encourage that the result shows that 93.2% (OA) and 92.3% (EA) it works very well in this area.

7. EXCLUSIVE BREASTFEEDING:

In this survey shows that 75% (OA) and 81.8% (EA) of mothers with children 4 months old said that she breastfed her child and never gave any things else besides breast milk. For exclusive breastfeeding up to 6 months old, there is 0% (OA) and 21.4% (EA). Because it impact to the health of the baby, the project keeps promote it to the mothers.

Overall the objectives of the project are met, and sustain the result, the project keep up the good work to encourage the mothers to continue practicing the new behavior and maintain it toward the healthy life style for the next generation.

For sustainability, the project will use these data to share with care groups, village leaders, commune council's members, the communities and the health centers, encourage them and help them to see how much achievement we have accomplished through their involvement and participation to build up the relationship, ownership and leadership.

ANNEX 2

World Relief Cambodia “Light for Life” Cost Extension Child Survival Project October 2002- September 2007

Facilitation Checklist1 for village leaders

BCC team:

Name of the village:

Name of the commune:

Name of the village leader:

Date:

Questions	Answers		Teaching provided to the village leader as needed
	Yes/positive	No/negative	
1. How many children born last month?			
2. Why do you need to know the number of birth last month?			
3. How many children under 5 years die last month?			
If the answer NO for #3, How many children die in the last three months?			
4. What are the causes of death?			
5. Can these causes of deaths be preventable?			
6. What is your idea for reduce the deaths of children under 5 years in your village?			
7. What kinds of diseases or health problems of the children do you have in your village?			
8. Can these kinds of diseases be preventable?			
9. If the answer YES, How/What could you and your community do for it?			

**World Relief Cambodia “Light for Life” Cost Extension Child Survival Project
October 2002- September 2007**

Facilitated checklist 2 for village leaders

BCC team:

Name of the village:

Name of the commune:

Name of the village leader:

Date:

Questions	Answers		Teaching provided to the village leader as needed
	Yes/positive	No/negative	
1. How many children born last month?			
2. How many children die last month?			
3. What can you do to help your people to be healthier?			
4. What are the benefits of the volunteers working in your village?			
5. What are the benefits of the care group monthly meeting for your village?			
6. Do you want to keep the care group into your village structure?			
7. If the answer YES, what are the plan or idea for the care group sustain?			
8. What are the training do you need for helping you become a good village leader?			

**World Relief Cambodia “Light for Life” Cost Extension Child Survival Project
October 2002- September 2007**

Facilitation check list for village leaders

BCC team:

Name of the village:

Name of the commune:

Name of the village leader:

Date:

N		Teach Village leader		Village leader- Knowledge
1		-Did you attend the care group meeting?		
2		-What did they discuss about?		
3		-What is the benefit of the care group meeting?		
4		-Do you want to keep these care groups into your village lasting infrastructure?		
5		-If you want to keep it, do you have any idea or plan to help these care groups?		

ANNEX 3

World Relief Cambodia Light for Life Child Survival Cost Extension Project Ponhea Kriek-Dumbai Operational Health District, Kampong Cham Province, Cambodia

Hearth Program in 4 villages May-June 2005

I. Objectives of Hearth Program:

The purpose of Hearth program is to rehabilitate identified malnourished children in order to reduce the mortality and morbidity associated with malnutrition in the villages that have the highest frequency of child deaths. In addition, it helps mothers identify malnourished children and learn appropriate care and rehabilitation techniques.

II. Selection of villages:

Villages are evaluated according to monthly statistics collected by WHEs, and those with the highest frequency of child deaths are selected for hearth intervention. This is used as a proxy for severe malnutrition rates, since malnutrition is known to be an underlying morbidity in over half of under-five deaths that occur globally. In addition, villages with under-three malnutrition rates exceeding 30% are selected to implement Hearth.

III. Hearth process:

Hearth is carried out in 4 villages by the project staff with help from WHEs, village leaders and mothers' involvement. The process of Hearth involves:

1. Weight assessment of all children under three years.
2. Situational analysis of current feeding practices for children and food security in selected villages through focus group discussion.
3. Wealth ranking exercise with community members to determine 'positive deviant (PD)' families.
4. Conduct Positive Deviance Inquiry and observe PD homes.
5. Discover PD foods and feeding, hygiene, and other healthy practices.
6. Cooking demonstrations.

IV. Results Assessment:

In 4 villages, a total of 155 children under 3 years were weighed and 103 of them were well nourished, 47 were moderately malnourished, and 5 were severely malnourished.

The baseline assessment compared to the result, shown by village is shown below:

Village	Baseline		Result	
	N=# of malnourished children	%	N= # of malnourished children	%
Angkor Leu N=31	11	35.48%	9	29%
Kansomsat N=30	9	30%	2	6.66%
Chambok N=51	25	49%	18	35.2%
Taream N=43	14	32.5%	11	25.5%

Villages	Baseline			Result	
	# of children <3y	# of children moderately malnourished	# of children severely malnourished	# of children moderately malnourished	# of children severely malnourished
Angkor Leu	31	10	1	8	1
Kansomsat	30	9	0	2	0
Chambok	51	22	3	15	3
Taream	43	13	1	10	1

In this assessment for Hearth program in 4 villages, among 54 malnourished children who completed the Hearth program, 35 of them (64.8%) achieved and sustained adequate or catch-up growth every month for at least 2 months after period of supervised feeding.

Child Survival and Health Grants Program Project Summary

Nov-01-2005

World Relief Corporation (Cambodia)

General Project Information:

Cooperative Agreement Number: FAO-A-00-98-00051-02
Project Grant Cycle: 18
Project Dates: (9/30/2002 - 9/29/2007)
Project Type: Cost XT

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Funding Information:

USAID Funding:(US \$): \$1,250,000

PVO match:(US \$) \$333,376

Project Information:

Description:

The goal of the Light of Life cost extension is to improve the health status of the women and children through families making of timely and appropriate health choices based on sound knowledge and to strengthen the capacity of the health system. The interventions are in immunization; hygiene and control of diarrheal disease; pneumonia; and nutrition. Strategies for these interventions will include; community advocacy; training of volunteers and caretakers; & the promotion of ORT through EPI teams and drug sellers; training of volunteers and caretakers; drug sellers, shopkeepers; Hearth—community-based nutritional rehabilitation, Vitamin A, maternal iron supplementation and iodized salt use. The CE CSP will introduce critically needed new interventions and further the framework for sustainability with the MOH and project communities including the PD-Hearth program, and integrate HH/C-IMCI strategies for CDD and pneumonia case management. It will also expand the BCC strategy.

General Strategies Planned:

Advocacy on Health Policy
 Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
 Health Facility Assessment
 Organizational Capacity Assessment with Local Partners
 Organizational Capacity Assessment for your own PVO
 Lot Quality Assurance Sampling
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
 Peer Communication
 Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
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Women 15-49 years:	46,128
Population of Target Area:	184,642

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	74	297	24.9%	7.5
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	49	71	69.0%	22.1
Percentage of children age 0-23 months whose births were attended by skilled health personnel	33	300	11.0%	5.2
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	34	300	11.3%	5.2
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	12	106	11.3%	8.8
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	37	38	97.4%	31.8
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	5	125	4.0%	4.9
Percentage of children age 12-23 months who received a measles vaccine	21	125	16.8%	9.7

Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	185	300	61.7%	10.5
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	47	244	19.3%	7.4
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	179	276	64.9%	11.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	16	300	5.3%	3.6
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	252	0.0%	0.0