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September 29, 2010

# Annual Report

September 30, 2006 - September 29, 2007

## FY06 Child Survival and Health Grants Program

Submitted by

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## List of Acronyms and Abbreviations

<b>ANC</b>	Ante-Natal Care
<b>ARI</b>	Acute Respiratory Infection
<b>BN</b>	Breast feeding and Nutrition
<b>BNE</b>	Breastfeeding and Nutrition Educator
<b>BCC</b>	Behavior Change Communication
<b>CSG</b>	Community Support group
<b>CPR</b>	Community Poverty Reduction (NGO Partner)
<b>CS</b>	Child Survival
<b>CESVI</b>	Cooperazione E Sviluppo (Italian NGO)
<b>DIP</b>	Detail Implementation Plan
<b>DPM</b>	Deputy Program Manager
<b>FLD</b>	Farmer Livelihood Development
<b>HC</b>	Health Center
<b>HH</b>	Household
<b>IRD</b>	International Relief and Development
<b>IEC</b>	Information Education and Communication
<b>KPC</b>	Kampong Chhnang
<b>KPC</b>	Knowledge Practical Coverage
<b>LDSC</b>	Latter-Day Saint Charities
<b>LWF</b>	Lutheran World Federation
<b>MW</b>	Midwife
<b>MUAC</b>	Mid Upper Arm Circumference
<b>MPA</b>	Minimum Package of Activity
<b>NGO</b>	Non-Governmental Organization
<b>OD</b>	Operational District
<b>ORT</b>	Oral Rehydration Treatment
<b>PMT</b>	Project Management Team
<b>PHD</b>	Provincial Health Department
<b>PM</b>	Program Manager
<b>PNKA</b>	Phom Neang Kong Rei local NGO Partner
<b>RACHA</b>	Reproductive and Child Health Alliance
<b>TBA</b>	Traditional Birth Attendant
<b>ToT</b>	Training of Trainers
<b>USAID</b>	United States Agency for International Development
<b>UNICEF</b>	United Nations Children's Fund
<b>VAC</b>	Vitamin A Capsule
<b>VHSG</b>	Village Health Support Group
<b>VHV</b>	Village Health Volunteer
<b>VDC</b>	Village Development Committee
<b>WHO</b>	World Health Organization
<b>WFP</b>	World Food Program

## I. Executive Summary

This Annual Report describes the *first year* of the implementation of Child Survival and Health Grants Program in the Teuk Phos District of Kampong Chhnang Province, Cambodia. International Relief & Development (IRD) has put all its efforts at grassroots levels to mobilize the existing community resources for the implementation of the Child Survival and Health Grants Program interventions proposed in the Workplan. These target pregnant and lactating women as well as malnourished children who are living in the eighty-one villages of the eight communes in Teuk Phos administrative district, Kampong Chhnang Province (KPC). The district has a population of 54,047<sup>1</sup> people, under the catchments areas of four health centers implementing the Minimum Package of Activities (MPA) and two remote health posts.

Of the total population 23,500 are women of reproductive age and 6,000 are children under five years old (1,300 aged 0-11 months, 1,000 aged 12-23 months and 3,700 aged 24-59 months). Many children in the target area under five suffer from malnutrition related morbidity and mortality. Based on the result of a baseline survey conducted by IRD, 76% of the children under three years of age are under weight while 39% are moderately to severely malnourished.

The primary program strategy is to increase the capacity of families and communities to adequately meet the nutritional needs of young children and to prevent food and water borne infections.

The program is implementing a strategy of engaging no-cost and low cost community human resources such as Community Support Groups (CSGs), Breastfeeding and Nutrition Educators (BNEs), Village Health Volunteers (VHVs), and Traditional Birth Attendants (TBAs). These individuals then form community health networks able to provide health education on immediate and exclusive breastfeeding, nutrition, complementary food, hygiene, clean water and diarrhea prevention. These networks will make a sustainable impact by changing practices and health seeking behaviors in the community, the improved health of individuals and the reduction of the malnutrition related morbidity and mortality in children under five years of age in Teuk Phos District by the end of the program in 2010.

In addition to providing health education CSGs, BNEs and TBAs are involved with the continuous IEC/BCC campaigns promoting breastfeeding and feeding practices aimed at mothers and women of reproductive age.

The main activities of the first year were concentrated on the start-up and establishment of the IRD office in Kampong Chhnang, signing of the Memorandum of Understanding with the Provincial Health Department, conducting the Baseline Survey, completing a Health Centre Assessment, compiling Village Profiles, building the capacity of the human resources in the community via Training of Trainers sessions and trainings on various topics related to the implementation of the Child Survival Program. IEC/BCC campaigns regarding immediate and exclusive breastfeeding, complementary feeding, nutrition and micronutrients have been carried out continuously. In addition a household register and MUAC assessment of children aged 1 to 3 years were carried out in July 2007. Many educational tools such as flipcharts for breast feeding, complementary feeding,

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<sup>1</sup> The figure was extracted from the Department of Planning of Kampong Chhnang Province in 2006

nutrition and diarrhea were produced based on the existing resources of the Ministry of Health, WHO and UNICEF.

Other activities during this period included the identification and selection of forty villages where Hearth methodology will be implemented. The nutrition status of children under three years of age in these villages will be reassessed after the trainings on Hearth methodology are conducted by a technical expert in November 2007.

## **II. Introduction**

On September 30, 2006, IRD has been chosen by United States Agency for International Development (USAID) to implement a Child Survival and Health Grants Program in the Teuk Phos Administrative District of Kampong Chhnang province for a period of four years. The program is using an integrated community-based approach to achieve a sustainable decrease in child malnutrition.

The Teuk Phos District of Kampong Chhnang Province was selected over other districts because of the higher levels of infant/child mortality and malnutrition. The district covers 1,752 square kilometers and the population is estimated to be 54,047<sup>2</sup> people in 2006, including approximately 7,250 children under five.

Administratively, the district consists of eight communes and eighty-one villages:

1. Taing Krasaing Commune (population 8,608 / 12 villages)
2. Chaong Mong Commune (population 6,213 / 8 villages)
3. Khlong Popok Commune (population 5,319 / 7 villages)
4. Aphiwat Commune (population 8,379 / 9 villages)
5. Chiep Commune (population 6,007 / 11 villages)
6. Kbal Teuk Commune (population 4,163 / 11 villages)
7. Kraing Skear Commune (population 11,411 / 16 villages)
8. Tual Khpos Commune (population 3,947 / 7 villages)

Teuk Phos district has four health centers and two health posts, the latter being a facility offering the most basic of care, which serve the entire district population.

### ***A. Project Goal***

The overall goal of the project is to reduce under five malnutrition related morbidity and mortality in Teuk Phos district, Kampong Chhnang province in an integrated and sustainable manner.

### ***B. Project Objectives***

Specific objectives of this project are to:

- ❖ Decrease the prevalence of moderate and severe malnutrition among children under the age of three years to  $\leq 30\%$
- ❖ Increase the percentage of infants breastfed immediately after birth to  $\geq 60\%$
- ❖ Maintain the percentage of infants exclusively breastfed for the first six months at  $\geq 80\%$
- ❖ Improve the quantity and nutritional quality of complementary foods given to young children, operationalized to mean an increase in the percentage of:

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<sup>2</sup> Kampong Chhnang provincial department of planning

- children aged 6-23 months fed three or more times a day to  $\geq 65\%$
  - children aged 6-23 months who consume Vitamin A-rich vegetables to 60%
  - children aged 6-23 months who consume fruit to 55%
  - children aged 6-23 months who consume any oil or fat to 45.0%
- ❖ Decrease the incidence of diarrheal diseases in children under three to  $< 20\%$

### III. Main Accomplishments

#### *A. Strategy*

The overall program strategy is to increase the capacity of families and communities to adequately meet the nutritional needs of young children and to prevent food and water borne infections.

The main strategies employed are:

- ❖ Advocacy and awareness-raising
- ❖ Behavior Change Communication (BCC)
- ❖ Community mobilization
- ❖ Hearth Program of nutritional rehabilitation
- ❖ Capacity building of community support groups, BNEs, TBAs
- ❖ Improving access to services and resources

#### *B. Description of Accomplishments*

All proposed activities in the Workplan for the year one of project implementation were carried out successfully. The details of the activities and the accomplishments made in this period (October 1, 2006-September 30, 2007) are described below.

#### **Assessment of Health Centers**

The staffing, resources, functions, utilization and supplies of four health centers and two health posts in Teuk Phos administrative district were assessed. Even with greater than average transportation barriers the results of the assessments demonstrated that the HCs in Teuk Phos compare favorably overall to the national standard for health centers. Entry and analysis of data and reporting on ante-natal visits, deliveries and post-natal care commenced in January 2007.

#### **Baseline Assessment**

Two kinds of baseline assessments were carried out: a population based Knowledge, Practices and Coverage (KPC) survey of health and nutrition related indicators and “Village Profiles” developed through structured interviews with the Village Chief in each of the district’s villages. The assessments were carried out by a survey field group of seventeen people (11 enumerators, 2 supervisors and 4 anthropometrics collectors). The KPC survey focused on individual and household level indicators while the Village Profiles focused on village-level information.

The ante-natal care showed the majority (88.3%) of the mothers has received two or more anti-tetanus vaccinations prior to delivery while 40% of mothers who delivered were assisted by trained birth attendants (TBAs) and more than one fourth (27.7%) of the mothers consulted a trained health provider within three (3) days after delivery.

It was noted that almost all (92.8%) of the mothers practiced exclusive breastfeeding for six months while nearly half (48.3%) initiated breastfeeding one hour after birth. On complementary feeding 42% of children aged 6-23 months received inadequate foods both in terms of quality and quantity.

The majority of the children, received DPT1 <12 months and measles immunization, 78% and 84%, respectively. Some (37%) of the children used oral rehydration therapy (ORT) during episodes of diarrhea while 50% were given increased fluid intake and 60% had continued feeding during diarrhea. More than half (54.3%) of the households surveyed treated the water from point of use.

Four health centers and two health posts were evaluated on the delivery of health services, availability of essential drugs as well as equipment and work load of present staffing. Results showed the health services available were outpatient consultation, immunization, Vitamin A supplementation, de-worming; and ante-natal care. The weighing of children from 0-5 years is not conducted in the four health centers due to the absence of weighing scales. Only two out of six health centers have complete facilities including water, electricity, an incinerator, and latrines.

In terms of health staff no medical doctors or medical assistants reported to the centers. The available staff were primary and secondary midwives, primary and secondary nurses and volunteers. Only two health centers conducted outreach programs (health center staff visiting remote villages) with an average of 21 to 30 times per month. The most common illnesses reported in the six health centers were acute respiratory infections and a few mentioned stools with mucus or blood.

Upon the completion of the Baseline Assessment an information dissemination and brainstorming session was held to share results. This was facilitated by Sheryl Keller, the Child Survival DIP Consultant, with the participation of fourteen senior staff from IRD/Cambodia and two local NGO partners. An interactive discussion took place to ensure that all key project staff had a clear understanding of the Teuk Phos District baseline conditions, project objectives, project strategies, approaches and their rationale.

### **Detailed Implementation Plan (DIP)**

From January 30-31, 2007, at the Provincial Health Department (PHD) meeting hall, IRD conducted a workshop on the Development of a Detailed Implementation Plan (DIP) for the Child Survival Project stakeholders.

A total of fifty-six people participated in the two-day workshop. Among the participants were some distinguished guests: Mr. Soun Sokharith, Deputy Chief of Teuk Phos District, Dr. Teuk Saroeurn, Director of Kampong Chhnang PHD and Dr. Lali Chania, Senior Health Officer from IRD

Headquarters in Washington. The public health sector was represented by eleven government officials from the PHD, Provincial Maternal and Child Health (MCH) ODs and the four health centers of Teuk Phos District. In addition three participants came from the Provincial Departments of Planning, Women's Affairs and Rural Development and fourteen people came from Teuk Phos District: the District Deputy Chief with Representatives of the District Rural Development Office, District Education Office, all eight communes and four villages. Seventeen members of IRD Cambodia's staff and those of the two local NGO partners were also in attendance.



The DIP served as the guideline and reference for all planned activities from year one to year four. The DIP development process was based on a participatory approach with active involvement of project staff (both field and HQ), the consultant, local stakeholders and national/international partner organizations. The DIP contains data on the program site information, results of the baseline assessments, detailed program description from goals and objectives to strategies and training plans. The interventions for nutrition, diarrhea, and micronutrient approaches (including monitoring and evaluation strategies) are explained in the DIP. The DIP also includes the administrative component, and the organization of the program management staff.

### **Establishment of the Project Management Team (PMT)**

The PMT was formed and is serving as a supporting body to (1) ensure the smooth running of project; (2) monitor the progress of the project; and (3) provide technical and managerial support, feedback, suggestions and recommendations for programming. The PMT consists of eleven people (The Program Manager, the Deputy Program Manager, three Team Leaders, two Coordinators of IRD and the Directors of CPR and PNKA). The PMT has convened its regular meetings in the afternoon of every first Thursday of the month.

### **Formation of Community Support Groups (CSG) and Selection of Breast Feeding and Nutrition Educators (BNE)**

The CSGs and BNEs are an essential part of the program in as much as they provide the most effective approach to behavior change through their work with mothers on breastfeeding, child care, nutrition, hygiene and seeking health care.

Armed with the approval of local authorities in Teuk Phos administrative district IRD and its two local NGO partners carried out the field activities organizing and selecting BNEs and CSGs. Key village stakeholders (village chiefs and deputies, Village Development Committees (VDC), Village Health Support Groups (VHSG) Village Health Volunteers (VHV), school teachers, Achars "senior members of pagoda committee" and the village elders) were invited to meet and select their village CSGs and BNEs. As a result, an average of 2-3 BNEs and 4-5 CSGs per village were identified from each village resulting in a total of 213 BNEs and 341 CSGs being formed to serve the eighty-one villages in Teuk Phos administrative district.



### **Training on Nutrition and Malnutrition Awareness**

The Training of Trainers (TOT) on malnutrition awareness was conducted on April 5, 2007 for two staff from the PHD, two from KPC OD, one from Boribo OD and six staff members from the health center.

The master trainers then conducted thirty-one training sessions between April 9-12, 2007 on nutrition and malnutrition awareness for 210 local government officials, 224 VDC members and 146 VHSGs. The average pre- and post-test results of those trained can be seen in the table below:

Participants	Pre-Test			Post-Test		
	Excellent	Good	Poor	Excellent	Good	Poor
N = 580	87	292	201	232	304	44
Percentage	15%	50%	35%	40%	52%	8%

### Training on Breastfeeding and Nutrition

The Training of Trainers on Breastfeeding and Nutrition was conducted on May 2-3, 2007 for fifteen participants (two from the OD, six from the HC, three from IRD, and four from the LNGO partners). The training covered general nutrition, micronutrients and breastfeeding. The training was facilitated by IRD's Nutrition and IEC Coordinators.

Master Trainers conducted ten training courses on immediate and exclusive breastfeeding, nutrition and complementary food during two consecutive periods (June 14-15 and 19-20) in close collaboration with the health centers (Krang Skea, Cheap, Tang Krasang, and Apiwat). Over 200 CSGs/BNEs from eighty-one villages were trained in:

- Food groups
- Protein energy malnutrition
- Iodine
- Vitamin A
- Iron deficiency
- Immediate and exclusive breastfeeding
- Complementary foods
- How to use IEC materials and conduct BNE education
- Diarrhea
- BNE reports
- Social marketing



The trainings went well in all aspects. The table below shows the average result of the theoretical knowledge in pre/post-test of all trained CSGs/BNEs in ten courses.

Participants	Pre-Test			Post-Test		
	Excellent	Good	Poor	Excellent	Good	Poor
N = 202 <sup>3</sup>	85	86	29	182	18	2
Percentage	42%	43%	14%	90%	9%	1%

### Training on Household Registration and Community Mobilization

The ToT on household (HH) registration and community mobilization was conducted from May 17-18, 2007 by the Nutrition and IEC Coordinators for four IRD staff and eight LNGO partner staff (PNKA, CPR and CESVI). The participants were trained to mobilize mothers to participate in health center outreach services to assess the nutritional status of children less than 3 years with Mid-Upper Arm Circumference (MUAC) measurement and register the families with target children.

<sup>3</sup> The figure is the number of those who sat for the post test while 200 sat for the pre-test.

There were fifteen sessions of HH registration and community mobilization training conducted 15 different locations on May 22-June 1, 2007 with 270 community support groups (CSGs) participating. The result of the training is shown below:

Participants	Pre-test			Post-test		
	Excellent	Good	Poor	Excellent	Good	Poor
N = 270	1	64	205	171	76	23
Percentage	0%	24%	76%	63%	28%	9%

### IEC/BCC Campaign

As of September 30, 2007 a total of sixty campaigns on immediate and exclusive breastfeeding, nutrition and complementary food feeding had been held in villages of the eight communes in Teuk Phos district. A total of 2,170 community members (173 men, 179 women, 1,662 lactating women and 156 women of reproductive age (WRA)) participated in these events.



Period	# of Sessions	# of Villages	# of CSGs/ BNEs	Men	Preg. women	Lact. women	WRA	Total
3rd Quarter	28	28	71	91	65	844	36	1,036
4th Quarter	32	32	95	82	114	818	120	1,134
Total	60	60	166	173	179	1662	156	2,170

### Follow up with CSGs/BNEs on HH Registration and MUAC

By July of 2007 a total of 3,230 households in eighty villages had been registered. During July 939 households were visited and with that household registration follow-up activities were concluded. MUAC follow-up activities in July involved 67 households where 804 children's nutritional status was checked. Of these children 21 were considered severely malnourished, 157 moderately malnourished and 486 children were well nourished. The table below shows the data for household registration



and MUAC in June and July 2007 after data collection and data entry was completed.

Month	# of HH Regist.	# of Villages	# of HH Visited	# of CSGs/ BNEs	# of Visits	# of Child. Visited	Categories of Child		
							Red <sup>4</sup>	Orange	Green
June	2,538	60	808	58	35	499	21	116	362
July	692	56	939	73	67	804	21	157	486
Total	3,230	1165	1,747	131	102	1,303	42	273	848

### Quarterly Meeting with CSGs and BNEs

Quarterly meetings were organized for all trained CSGs and BNEs to review the health messages learned, roles and responsibilities as well as getting feedback and resolving constraints. A total of 233 of the 287 trained CSGs/BNEs attended the meetings. During the meetings new items and tools, such as the reporting form, were introduced to the volunteers. The majority of the CSGs/BNEs demonstrated that they were retaining their knowledge gained from the trainings and were quickly able to grasp the new information presented.

### Traditional Birth Attendant (TBA) Training

Nine TBA two-day training courses were conducted from August 7-10, 2007. The training curriculum was reviewed and finalized to fit the needs of the TBA population which is highly illiterate. The handouts, textbooks and other IEC materials which were provided to the TBAs were pictorially based.



The trainings focused on the following topics:

1. Importance of Colostrums
2. Importance of Exclusive Breastfeeding
3. Importance of Complementary Food
4. Importance of Three Food Groups
5. Importance of Micronutrients
6. Importance of Immunization
7. Reporting

After the training each TBA was given a kit comprised of a shoulder bag with nutrition hand outs, IEC materials, and posters for use during community education sessions. The result of the pre/post test of TBA training is shown in the table below:

# of Participants	Pre-Test			Post-Test		
	Excellent	Good	Poor	Excellent	Good	Poor
N = 103	21	39	43	70	23	10
Percentage	20%	39%	42%	68%	22%	10%

<sup>4</sup> The Red represents the child with severe malnutrition and the Orange represents the child with mild malnutrition while the Green represents the child in normal nourishment.

<sup>5</sup> Some villages have been visited more than one time. The actual number of villages is 81.

### **CSGs, BNEs and TBAs Reporting Data**

The program collected reporting data monthly from village CSGs and BNEs to determine the numbers of community members that received breastfeeding and nutrition messages from the CSGs and BNEs. The data demonstrated that 1,577 HH education sessions were conducted by 174 CSGs/BNEs while 374 group education sessions were also conducted where audiences received the same messages. The table on the next page illustrates the number of beneficiaries that received health messages from CSGs/BNEs and TBAs.

Table 1: CSGs Report on Household Education Sessions:

# of HH Registered	# of Visits	# of CSGs Involved	# of HH Education Sessions	Beneficiaries		Status of Women			Health Messages				
				New	Old	Preg. Women	Lact. Women	Child < 3 Yrs	BF	Nutrition	Hygiene	Water	Other
3,910	28	174	1,577	634	945	260	257	1,233	1091	1307	381	383	966

Table 2: CSGs Report on Group Education Sessions:

# of HH Registered	# of Visits	# of CSGs Involved	# of Beneficiaries	Status of Women			Health Messages				
				Preg. Women	Lact. Women	Child < 3 Yrs	BF	Nutrition	Hygiene	Water	Other
3,910	28	174	374	71	64	224	189	270	169	107	27

Table 3: TBAs Report on Household Education Sessions:

# of Visits	# of TBAs Involved	# of HH Education Sessions	# of Preg. Women	# of Referrals	# of Vaccines	# of Colostrums	# of Exclusive BF	Compl. Food	3 Food Groups	Vit.A	De-worming
13	44	126	114	78	114	116	86	78	87	28	49

<sup>6</sup> Of 96 cases, 26 ANC, 59 vaccination and 11 birth spacing were referred to HC by CSGs.

<sup>7</sup> Two (2) cases referred by CSGs for immunization.

### **Training on Solar Water Disinfection (SODIS) for all IRD staff**

With financial support from the Latter-Day Saints Charities (LDSC) and with technical assistance from the Solar Water Disinfection (SODIS) specialist from ADRA the IRD Program Manager of the USDA-funded “Better Foods for Better Lives Project”, Mr. Son Siveth, in close collaboration with the Program Manager and the Deputy Program Manager of the Child Survival Program, conducted a 3-day ToT on SODIS for all IRD and partner staff (total of 13 participants) on August 21-23, 2007. IRD and its partner staff will conduct a ToT on SODIS for all CSGs in the next year of the Child Survival Program.

The aim of the SODIS training was to introduce a new and simple way to treat unclean water making it safe for consumption and preventing diarrheal diseases in poor communities. The training of the IRD and partner staff went well with the only setback being that the microscope for water testing did not work.

### **Training on Soap Making For CSGs**

With technical and financial assistance from LDSC the ToT on soap making was conducted for seventeen CSGs and twelve IRD and partner staff. The participants were trained in making two types of soap, one for scabies and another for lice and hand washing. These soaps have a good market in the community and are allowing the CSGs to generate part of their income from the production and sales of the soap. At the end of the training all trained CSGs were provided the equipment, materials and ingredients to produce solid soap. The trained CSGs are currently producing the soap and selling it in the community.

### **Training on Home Gardening For IRD and Partner Staff**

A former IRD team leader, Mr. Khun Bunseng, conducted an in-house ToT on home gardening for IRD and partner staff. The training focused on the practical experience of planting edible green leafy vegetables and selecting varieties of seeds that have quick harvesting time and use less water. Home gardening training for CSGs will be conducted in the first or second quarter of year two of the program. Equipped with this knowledge the CSGs can train community people on how to plant selected vegetables and their nutritional benefits. Home gardening will complement the CS program in the selected Hearth villages.

### **Malaria/Dengue Fever Campaign**

The Program Manager and the Deputy Program Manager of IRD, with support from LDSC and in close collaboration with the Chief of Anlong Kangan HC in Phnom Penh, organized a malaria and dengue fever campaign on September 28, 2007 drawing over 1,000 participants from eight villages. Additionally Village Volunteers selected the poorest participants to receive mosquito nets resulting in the distribution of six hundred (600) mosquito nets to the community one day after the campaign.



## Organize World Breastfeeding Week

As planned, World Breastfeeding Week events were organized in three consecutive periods (September 7, 12, and 14) in three different locations. The events were organized by the PHD of Kampong Chhnang, in close collaboration with IRD, drawing over 2,000 participants (pregnant and lactating women, children and teenagers). The events were held successfully with involvement of key stakeholders such as the Deputy Chief of PHD, Chiefs of the three Administrative Districts, OD staff, health center staff, representatives of Commune Councils, Village Chiefs, IRD staff and those from other NGOs. The Child Survival Program Manager and the Deputy Program Manager were invited by the three health centers to share the breastfeeding messages with the participants. IRD also supported the event by providing snacks, t-shirts and other items for the operational districts.



The Breastfeeding Week is an important advocacy campaign to encourage all mothers to practice breastfeeding. This breastfeeding week was celebrated with the theme, “Breastfed immediately after birth and exclusively breastfed within the first six months means a healthy baby”. IRD participated in all committee meetings at the national, provincial and district levels to plan the breastfeeding week activities. The event was also an opportunity for IRD to strengthen its partnership with the Ministry of Health in planning activities for mothers and children.

## Workplan Development

As scheduled, the Child Survival Annual Workplan review workshop was held on September 18-20, 2007 at IRD’s Kampong Chhnang office involving all IRD and partner staff in the province and facilitated by the Program Manager, the Deputy Program Manager and the Nutritional Advisor.

During the workshop the participants actively brainstormed to develop the realistic and doable activities and/or interventions that reflected the problems identified and the needs of the community.

The Project Objectives and Project Outputs remain unchanged while some of Strategic Objectives and Main Activities were dropped and some were modified to reflect the real situation and problems identified over the past year. The strategic objectives were reduced from 19 to 13 as listed below and still reflect the proposed strategies elaborated in the Detail Implementation Plan.



1. Advocacy with health system (HC/OD/PHD) to ensure the basic services are available.
2. Malnutrition awareness raising/advocacy with commune, village leaders, and influential community members.
3. Community HC transportation scheme.

4. Community mobilization for attendance at immunization, VAC, De-worming outreach session by CSG.
5. Social marketing.
6. Capacity building of MWs, TBAs, and CSGs/BNEs on BF and Nutrition.
7. BF behavior change communication by CSGs/BNEs, and TBAs.
8. BCC through drama show and mobile video show on BF, Nutrition, Hygiene, and Diarrhea.
9. BCC infant/child feeding behavior change communication by CSGs/BNEs, and TBAs.
10. Hearth program (NERS and Growth Monitoring).
11. Food security intervention in Hearth villages.
12. IEC/BCC on hygiene, point-of-use water disinfection, and diarrhea preventions
13. Wells/Rain water catchments system (Hearth villages).

As a result of the workshop a new realistic and achievable workplan was developed. All participants understood clearly the project implementation plan, its indicators and the importance of monitoring and evaluating each activity. It is important to note that the new workplan developed is consistent with the limitations of the program budget.

### C. Key Activities Table

Table 1.1: Key activities for project objectives

Project objectives	Key Activities	Status of Activities	Comments
Decrease the prevalence of moderate and severe malnutrition among children under the age of three years to $\leq 30\%$ ---	IEC/BCC	IEC/BCC campaigns on immediate and exclusive breast feeding, complementary food and diarrhea prevention were conducted in 60 villages. 2,170 people participated including, pregnant and lactating women and WRA.	Progressing as planned in the DIP Workplan. Staff and partner training completed. Community IEC started in second quarter of the first year and is continuing in the community.
Increase the percentage of infants breastfed immediately after birth to $\geq 60\%$ ---	Capacity-building of traditional birth attendants	103 TBAs received 2 days training on all CS interventions including appropriate breast feeding, colostrums and nutrition. Training was facilitated by IRD and HC staff (August 2007).	All TBAs are up to date in training and can apply the knowledge learned to provide education to mothers and pregnant women.
Maintain the percentage of infants exclusively breastfed for the first six months at $\geq 80\%$	TBAs educate mother and pregnant women on BF, nutrition and make referrals	<ul style="list-style-type: none"> <li>• 126 households visits</li> <li>• 114 pregnant women educated on vaccination, colostrums, exclusive breast feeding, complementary food, 3 food groups, Vit A and de-worming</li> <li>• 78 referrals of mothers to HC</li> </ul>	Education to mothers and pregnant women is on going.
	Capacity-building of BNEs and CSGs	202 BNEs/CSGs received 2 days training on nutrition, BF, CF, Vit A, iodine, iron deficiency and diarrhea prevention. Training was facilitated by IRD, PHD, OD and HC staff (June 2007).	All BNEs/CSGs are up to date in training and can apply the knowledge learned to provide education to mothers, pregnant women, WRA and the community. Refresher training required at least once a year but with the current budget it might not be possible.

Project objectives	Key Activities	Status of Activities	Comments
	BNEs/CSGs educate mothers	<ul style="list-style-type: none"> <li>1577 households visits</li> <li>374 group education sessions on BF, nutrition, hygiene and water and sanitation</li> </ul>	Education activities continue in the community
<p>Improve the quantity and nutritional quality of complementary foods given to young children:</p> <ul style="list-style-type: none"> <li>❖ children aged 6-23 months fed three or more times a day to &gt; 65%</li> <li>❖ children aged 6-23 months who consume Vitamin A-rich vegetables to 60%</li> <li>❖ children aged 6-23 months who consume fruit to 55%</li> <li>❖ children aged 6 – 23 months who consume any oil or fat to 45.0%</li> <li>❖ Decrease the incidence of diarrheal diseases in children under three to &lt; 20%</li> </ul>	IEC/BCC	IEC/BCC campaigns on immediate and exclusive breast feeding, complementary food and diarrhea prevention were conducted in 60 villages and ongoing to cover 81 villages	Progressing as planned in the DIP Workplan. Staff and partner training completed. Community IEC started in second quarter of the first year.
	Hearth Program	To commence in year 2	Monique Sternin, Hearth Model Consultant, to travel to Kampong Chhnang in November to support the CS project staff on the development of a training program and materials for the introduction of the Hearth Nutrition Model
	Improved access to food and safe water	In progress	Collaboration with Rain Water Cambodia and support by LDSC. The assessment and construction of tube wells and rain water catchments system is in progress.
	Capacity-building of HC staff, midwives,	6 HC midwives received 2 days training on nutrition counseling and breast feeding (May 2007).	HC midwives require more training on nutrition counseling skills but funding is not available.
	Community mobilization	270 CSGs received 2 days training on HH registration, community mobilization and MUAC (May 2007). HH registration and MUAC completed in July 2007. A total of 3,230 HH in 81 villages were registered.	CSGs carry out this activity on a monthly basis to mobilize the community to attend HC outreach services for immunization, Vitamin A, ANC, PNC and de-worming.
	Advocacy with local leaders	Malnutrition awareness conducted for 210 local authorities, 224 villages	IRD staff continue to raise awareness of community members.

Project objectives	Key Activities	Status of Activities	Comments
		development committee members and 146 VHSGs (April 2007).	
❖ Decrease the incidence of diarrheal diseases in children under three to < 20%	IEC/BCC on hygiene and POU	IEC/BCC campaign on immediate and exclusive breast feeding, complementary food and diarrhea prevention were conducted in 60 villages. 2,170 people participated including, pregnant and lactating women and WRA.	Progressing as planned in the DIP Workplan. Staff and partner training completed. Community IEC started in second quarter of the first year and continues in the community.
	Improved Access to Soap and year round water supply	20 out of 270 CSGs received training in soap making in the first week of September 2007. Soap production is now in place in ten villages.	Many CSGs requested to be given training in soap making. This was not possible because the budget has no allocations for additional training. The soap making training was scheduled in the DIP to start in Q2 of year 2 but due to the request of the CSGs the project brought the training forward to September 2007.
	Social Marketing of POU materials, ORS, zinc, soap	Social marketing of locally made soap is available in ten villages	Marketing of POU materials, ORS and zinc has not yet commenced. These activities are due to start in Q2 and Q3 of Project year 2.
	Community mobilization for outreach services (VAC etc)	270 CSGs received in 2 days training on HH registration and community mobilization and MUAC (May 2007). HH registration and MUAC completed in July 2007. A total of 3,230 HH in 81 villages were registered.	CSGs carry out this activity on a monthly basis to mobilize the community to attend HC outreach services for immunization, Vitamin A, ANC, PNC and de-worming.
<b>Capacity Building Objectives</b>			
Identify strengths of IRD's Health Team and its backstopping of child survival field programs	Staff Performance development plan developed to address staff needs for capacity	Senior staff (Program manager, Deputy Program Manager, Nutrition Advisor, and Coordinator) to provide in-service training and coaching to	Senior staff continue to provide coaching to field staff.

<b>Project objectives</b>	<b>Key Activities</b>	<b>Status of Activities</b>	<b>Comments</b>
	improvement	staff on relevant topics vital to CS project.	
Identify and agree on areas of challenge that require further strengthening	Staff training needs assessment conducted	Training needs assessment report completed in May 2007	Regular in-service training on topics relating to CS conducted on the first and third Friday of the month.
Identify priority needs for local Cambodian NGOs	Capacity assessment of local NGOs conducted	Capacity assessment completed in March 2007.	Needs identified for capacity building in child survival, breast feeding, hygiene, health seeking behavior, and the ability to implement M&E in a Child Survival program.
Prepare plans for making improvements in the areas needing further strengthening	Formal training plan	In process of developing proposal for the formal training plan.	Staff development, with an allocated budget, was not planned for in the DIP. Based on the organizational capacity assessment, it was identified that technical capacity building of staff is needed but would require an additional budget.
Identify how changes and their results will be monitored during the life of the grant	Performance appraisal, In-service training and coaching	In progress and ongoing	We do have a problem with staff attrition due to limited qualified personnel in Cambodia and competition with other agencies for good individuals. This is not uncommon for all INGOs operating here but remains, nevertheless, a challenge.
<b>Sustainability Objectives</b>			
Increase knowledge and awareness of appropriate infant and child feeding among WRA and mothers	IEC/BCC campaign through puppet shows, drama and video shows	Ongoing	With support from the District Education Director and School Head Masters a school drama group was established in two communes. The group performs during IEC/BCC campaigns to disseminate messages about nutrition, BF and complementary feeding. This is to

Project objectives	Key Activities	Status of Activities	Comments
			promote community participation and ownership of activities.
Increase capacity of the CSGs/BNEs to provide effective health education	Training and refresher training every year	202 CSGs/BNEs trained and ongoing post training supervision conducted	The CSG /BNE is a group of existing community volunteers drawn together for a common purpose (similar to the “Care group” concept).
Increase capacity of local NGO partners to implement the CS child nutrition intervention	In-service training and coaching	Ongoing	More time is required to teach and coach the local NGO partner staff as they have limited knowledge about CS programs.
Increase malnutrition awareness of the local authorities	Awareness raising campaign	Campaign conducted and ongoing	Local authorities are an essential part of the project implementation plan. Collaboration with these key stakeholders raises awareness and creates a supportive environment for the project.

**Table 1.2: Key Activities for Technical Intervention Area**

Technical intervention	Key Activities	Status of Activities	Comments
Nutrition	Training of CSGs/BNEs	Completed	Refresher training is planned for the third year due to lack of budget for annual trainings.
	Hearth Model	To start in Q2 of year two	External consultant and nutrition advisor to assist and train project staff.
	Growth monitoring	Part of Hearth program to start in Q2 year 2	External consultant and nutrition advisor to assist and train project staff.
	Complementary feeding	Commenced in Q2 of year one	Ongoing training and education to community members.
	Home food production training	Held on October 22-26, 2007	Technical assistance from HKI training specialist.

Control of Diarrheal Diseases	Training of CSGs/BNEs on diarrhea prevention and management, the use of ORS and IEC materials related to diarrheal disease prevention	Formal training conducted. Ongoing supervision and monitoring carried out monthly.	CSGs/BNEs will use IEC materials and participatory activities to stress the importance of appropriate diarrhea care.
	Education and promotion of ORT	Formal training conducted. Ongoing supervision and monitoring carried out monthly.	CSGs/BNEs will stress the importance of giving extra fluids if a child has diarrhea.
	POU treatment of water; provision of clean water sources	Ongoing education carried out. With support from LDSC some tube wells and Rain Water Harvesting systems have been built in select villages and at the HC.	CGS/BNEs will promote household hand-washing stations and encourage the practice of solar disinfection to obtain potable water.
	Soap making and promotion of the importance of hand washing	Soap making training conducted. Ongoing promotion carried out in the community to encourage people to change behavior.	Soap making for home use is available in some villages. There is a high demand for the soap from the community as it is readily available and inexpensive.
Micronutrients	Promote the use of Iodine salt	Ongoing activity	Iodine salt and fish sauce are available in the local market and HC.
	Promote adequate vitamin A intake for infant and young children	Ongoing activity	CSGs/BNEs are mobilizing the community to attend HC outreach services for Vitamin A distribution. They are also promoting the importance of increased dietary intake of Vitamin A rich food for children under five years of age.
	Fortified Mee Dara noodles	Available at all 4 HC of Kampong Chhnang Operational District	There is keen interest in Mee Dara as it is wide spread in Teuk Phos district.

#### IV. Constraints

The IRD Child Survival Project has been fortunate to have very few constraints. Of the constraints we have faced, most did not impede the programs ability to carry out activities. All constraints are listed below:

1. Some activities proposed in the DIP were not allocated enough funds in the budget.  
**The solution:** Relocate some funds from other budget lines and/or try to seek some assistance from other NGOs such as LDSC and ADRA.
2. Some trained CSGs/BNEs were not very active and even resigned after the training.  
**The solution:** Provide additional counseling to the volunteers to determine what issues they are facing. If the issues cannot be addressed by the project, or the volunteers are not willing to work with the program further, we need to find replacements.
3. Limited budget to conduct the ToT for the CSGs/BNEs.  
**The solution:** Trainings were shortened from 5 days to 2 days. Every effort was taken to provide the trainees with the most important key messages and abilities to provide those messages to the community. To ensure that the CSGs/BNEs are fully capable to educate the community, the IRD and local partner staff are providing continuous on-the-job coaching keep building capacity.
4. During the rainy season, the majority of community members are in their fields planting rice. The CSGs/BNEs have a difficult time providing BN education to the target groups at this time.  
**The solution:** The CSGs/BNEs make every effort to access the farmers in their fields. If they are unable to connect with the farmers, due to weather and road conditions, they will re-schedule the visits to a more accessible time.
5. During the rainy season the accessibility to some of the target areas (11 villages in the Krang Skea commune, the very remote area of Teuk Phos district) is very limited due to the roads being flooded.  
**The solution:** The IRD field staff, and CSGs/BNEs use all means of transportation available to them (motorized vehicle, bicycles, ox-carts, and Bamboo trains) to reach the target areas. If they are still unable they will re-schedule the visit to a more accessible time.
6. Targeted community members have limited knowledge of best nutrition practices for infants and children. Behavior change in the short term will be very difficult.  
**The solution:** The CSGs/BNEs provide intensive and long term IEC/BCC education continuously in their villages to increase the awareness of best nutrition practices in the communities. The more activities and presence the CSG/BNE has in the community the more likely that the community members will begin to change their behaviors.
7. The literacy levels among the Village Health Volunteers are much lower than had been presumed during initial planning.  
**The solution:** The Village Health Volunteers will be provided longer periods of training, and simplified training curriculum. In addition, if the budget allows, refresher trainings will be held twice a year and post training supervision and coaching will be carried out regularly.

## **V. Required Technical Assistance**

The following technical assistance needs were identified in the DIP and/or as part of the annual review by the project team.

1. **Hearth Program:** A Hearth Consultant will be contracted in November 2007. The consultant will work closely with the IRD Cambodia staff in Kampong Chhnang for the development of a training program and materials for the introduction of the Hearth Nutrition Model. The training will include Positive Deviance Inquiries, Nutrition Education and Rehabilitation Sessions and a Growth Monitoring Program. In addition the consultant will develop guidelines for the implementation of the Hearth Program as well as the reporting format for monitoring and evaluation.
2. **Relationship with MOH and INGOs:** IRD has a very collaborative relationship with the Cambodia MoH staff and other NGOs. ADRA has already provided full support for the training of IRD and partner staff on SODIS, and LDSC has provided support to the program on soap making and the development of puppet shows.
3. **Home Food Production:** Helen Keller International will provide technical assistance to the program in the conduct of the Home Food Production training for IRD staff. Trained IRD staff will in turn conduct Home Food product trainings for community members.
4. **Staff Capacity:** Based on the results of the needs assessment for technical assistance to field staff, IRD plans to strengthen staff capacity in project management and monitoring and evaluation. A staff development proposal will be developed in December of 2007 and an external consultant will be hired to conduct the training for IRD staff. IRD recruited a short term Nutrition Advisor in July 2007 to develop the nutrition training plan to strengthen capacity of IRD staff and partners in nutrition. Currently, she is working on the plan and has conducted in-service training twice a month.
5. **Mid-term and Final Evaluations:** IRD will contract an external consultant to lead the mid-term evaluation at the end of year two and the lead the final evaluation at the end of the project.

## **VI. Modification of Cooperative Agreement**

IRD did not make any substantial changes to the Project Objectives, Indicators, Intervention Mix (including the level of effectiveness), Specific Activities, Location of Project, Number of Beneficiaries, Local Partners, or Budget. They remain as stipulated in the DIP. No modification is required at this time.

## **VII. Progress, Gaps and Responses**

Program monitoring is carried out on a monthly basis using the developed and tested monitoring form (Annex II). The objective of monitoring and supervision is to track the achievements of the BNEs and TBAs. The program staff is currently developing the database system that will store and analyze the data collected. The data collected will include demographic inputs on the target populations, MUAC screening results, number of trainings held, number of home visits and village education events performed by the BNEs, etc. The program teams provide daily monitoring and supervision support to the CSG and BNEs. In addition the Project

Management Committee reviews the data on a quarterly basis and analyzes the progress and constraints, provides feedback to the field teams, and resolves any issues.

### VIII. Sustainability

The behavior changes the Project has designed are intrinsically self-sustaining to the extent that they are adopted as the social norm. The Project will work on both ends of the demographic spectrum tapping into the traditional influence of older women in the community as well as capitalizing upon the rising dominance of the “baby boom” generation.

The programs main strategy is to work closely with the community in order to increase the families capacity to adequately meet the nutritional needs of young children and to prevent food and water borne infection. Sustainability in this context for IRD is the transfer of knowledge and skills to the community members to enable them to perform activities and change behaviors that result in better outcomes and self reliance.

The Child Survival program has also recognized that government health facilities are also a critical part of the community referral system. Therefore, strengthening capacity and improving service delivery at the health facilities is also essential.

Sustainability Plan	Steps Taken	Target Reached/ To be Reached	Comment/ Constraint
Increase capacity of LNGOs to successfully implement child nutrition interventions.	<ul style="list-style-type: none"> <li>Provide training and coaching.</li> <li>Involvement in key activities.</li> <li>Provide regular feedback and problem solving support.</li> </ul>	# of LNGO staff able to implement all key activities effectively	Some LNGO staff resigned after being trained making it difficult to maintain the momentum of the program implementation
Building the capacity of the CSGs/BNEs, so that they will be able to continue to help the community after the program is ceased.	<ul style="list-style-type: none"> <li>Provide training, monitoring and coaching.</li> </ul>	# of trained CSGs/BNEs continuing to do their volunteer job after the program ceased. * The MoH’s Health Information System (HIS) collects data on health service provision.	Some CSGs/BNEs have limited knowledge and resign.
Increase the knowledge and awareness of appropriate infant/child feeding practices among WRA and mothers.	<ul style="list-style-type: none"> <li>Mass education and IEC/BCC campaigns.</li> <li>Puppet and Video shows</li> </ul>	<p># of WRA and Mothers receiving all health key messages.</p> <p># of WRA and Mothers practicing proper infant/child feeding.</p>	Some of target group may not follow the new technology due to their beliefs and food taboos.

## **IX. Additional DIP Information**

With respect to IRD's Detail Implementation Plan (DIP) for the USAID funded Child Survival program in Cambodia, IRD has carefully analyzed the comments received from the USAID reviewers: Ms. Frances R. Davidson, USAID Global Health Bureau; Ms. Jennifer Yourkavitch, Child Survival Technical Support Project; Ms. Janis Lindsteadt, Medical Teams International; and Mr. Sek Sopheanarith USAID Mission in Cambodia. We have grouped the reviewers comments by thematic areas and addressed them accordingly.:

### **1. CSGs and Other Community Volunteers**

**Reviewer:** Consider already existing community groups that can be further capacitated to take on health and nutrition related tasks before developing new cadres of implementers such as the CSGs proposed.

**Reviewer:** Use as much as possible the exiting community structures such as pagoda committee, farmer groups which were created by their own initiatives and the existing MoH volunteers named as village health support group (VHSG). However, the number of VHSG is not appropriate to ensure the effective implementation of the project. In case of the absence of the above mentioned groups in the target areas, the creation of the community support group (CSG) as mentioned in the DIP is be an option.

**IRD:** As noted in the DIP p. 41, the Community Support Group (CSG) contains the Village Development Council, VHSG, Village Chief, and members of any other existing community structure (note that in only 15% of villages are there any groups other than the VDC and VHSG). The CSG is a group of existing community volunteers drawn together for a common purpose (similar to the "Care group" concept). In some cases additional people may belong if the numbers of VHSG, VDC... etc. are not adequate.

**Reviewer:** on page 7, the VHSG is described as typically one person who is challenged in mobilizing villages for outreach sessions. Page 15: VHSGs are described as active in all villages. Has there been a strategy identified for revitalizing the VHSGs if needed?

**IRD:** VHSGs are active in all villages, but due to their numbers (one man and one woman per village) are limited in their ability to mobilize attendance for outreach sessions and follow up missed cases, especially in large villages. We do not identify a need to "revitalize" the VHSGs but rather a need to provide them with other volunteers to help share the work, which is exactly what the CSG structure will provide.

### **2. Lack of Knowledge versus Other Constraints**

**Reviewer:** The intended intervention of education may not make a difference since there is no basis to assume that lack of information is the critical stumbling block. Education and awareness are not necessarily the missing resources. There is an over emphasis on knowledge being the key to behavior change despite the extensive literature to the contrary.

**IRD:** The Project assumes that both "lack of knowledge" and "lack of resources" are factors and attempts to address both, the latter through interventions to sustainably improve food security. "Knowledge" in this context means not only theoretical information but also what people have learned to do based on what they have seen and experienced, even though no conscious thought may go into it. The child-rearing practices in particular tend to be imitative.

The Project's BCC will involve considerably more than provision of information. Older women have been selected to provide one on one BCC to tap into the traditional reliance on grandmothers for advice, and these women will be trained in interactive counseling techniques. The Hearth model will allow mothers to learn by seeing with their own eyes the effect of improved feeding practices, not only on the child's weight but also on the child's alertness, level of activity and general health. The Hearth education sessions will be based on participatory learning and the sessions interactive in nature.

**Reviewer:** In the context of improving breast feeding practices, the strategy is to target messages about health benefits and importance of immediate and exclusive breastfeeding to the mother and child. However, no data has been presented to show that ignorance of this is the constraint to practicing exclusive and immediate breast feeding. All too frequently is assumed that knowledge will lead to different practices without factoring all the other influences, e.g., traditional beliefs, influential family members, realistic expectations of time commitments...etc into the equation.

**IRD:** The data show that knowledge of the health benefit of colostrums is high (although the nature of the benefit is little understood) and that giving of colostrums is also high. Knowledge of the maternal health benefit of immediate BF is virtually nil and immediate (i.e. within 1 hour) BF is much, much lower than is BF within 24 hours. Knowledge of the need for exclusive BF for 6 months is high and so is the practice. In other words, the practices reported follow the knowledge measured. The only area of BF that has a substantial need for change is in immediate initiation of BF, where both knowledge and practice are low (88% begin BF within 24 hours but only 48% do so within 1 hour of delivery). There are no traditional beliefs in Cambodia that would cause a woman to initiate BF on the day of delivery but not within the first hour. There are beliefs in some parts of the country that a child should not be fed at all for a couple of days after delivery but this does not seem to be the case in the Project area based on the very high percent of mothers who initiate BF within 24 hours and also the high percent who know that early initiation of BF is beneficial to the infant. We analyze the constraint to *immediate* BF to be 1) lack of knowledge, and 2) lack of its promotion by birth attendants who, given how tired and weak a woman is immediately post-delivery, are key decision makers regarding immediate post-partum behavior. In the latter respect, it is notable that immediate BF was *not* higher among women who had a trained delivery attendant than those who delivered with a TBA. The reasons for this are unclear and will be probed during the planned midwife/TBA training.

**Reviewer:** The importance of feedback to the caretaker is critical in ensuring the various interventions have an impact. I would suggest that the various tasks to be undertaken such as measuring MUAC by volunteers be part of hands on experience for the caretaker rather than simply a research or clerical process. Having the caretaker know what this means and how it can improve by them and their families could have a large role in behavior changes.

**IRD:** Agree and will do, both in the MUAC screening and in the Hearth GMP. Cambodian mothers are usually eager to have their children weighed (an opportunity they seldom have) and we will tap into that to provide feedback to them. Also, the Hearth education sessions will, as described in the DIP pp 67-68, be highly participatory and draw on the mother's own experiences and observations to help them make the linkage between feeding practices, nutritional status, and health.

### 3. Monitoring and Evaluation

**Reviewer:** IRD might consider using the more recently developed descriptors of malnutrition whereby moderate and mild are considered together.

**IRD:** Agree in principle; our constraint here is sheer numbers, since only 24% of children in the project area are of normal nutritional status. Although the Project objective is worded in terms of reduction in moderate/severe malnutrition, we will examine the effect upon mild as well and have the necessary baseline with which to do so. In the Hearth villages, children with mild malnutrition may be included if the numbers permit

**Reviewer:** We would suggest that IRD should appropriately monitor and collect information about breastfeeding, complementary feeding, vitamin A distribution, vaccination, diarrhea control and insecticide treated net utilization regarding the Cambodian child survival scorecard intervention indicators of the Cambodian Child Survival Strategy.

**Reviewer:** Vitamin A supplementation is missing from data form.

**IRD:** All of these indicators were collected in the baseline survey and will also be collected in the year four KPC survey.

**Reviewer:** How will the *effectiveness* of the CSGs be monitored?

**IRD:** *Process indicators:* number of and attendance at village educational events, social marketing sales, and development of HC transport system.

*Impact/Coverage Indicator:* Changes in HC utilization (source: HIS) and immunization/VAC coverage (source: KPC survey).

**Reviewer:** The project places a great emphasis on process and leaves analysis of impact until the end of the project. It may be advisable to use LQAS for mid-term monitoring of key process and impact indicators.

**IRD:** The original proposal included a mid-term survey for this purpose; it was deleted on recommendation of CSTS that the mid-term focus instead on process indicators. In addition, the resource constraints are such that conducting a survey at mid-term would reduce inputs available for implementation. We will, however, have impact-level data available for the Hearth villages from the Growth Monitoring Program. This will clearly tell us whether or not the prevalence of malnutrition has declined in the villages where Hearth is being implemented.

**Reviewer:** How will control of diarrheal disease and micronutrients be tracked?

**IRD: Process Indicators:**

- BCC on hygiene and safe water (% villages with village educational events held on these topics and number of people attending; number of BNE counseling visits on these topics.
- ORS, water filter, solar disinfection set, soap sales
- Sales of fortified foods (noodles, bread, salt)
- Number of rain water catchments units and combination wells built
- Number of CSGs trained in soap making

**Impact/Coverage Indicators:**

- Prevalence of diarrheal disease

- ORT treatment rate
- Prevalence of POU disinfection esp. among families utilizing an unsafe water source
- Hand-washing (presence of a location with soap within the house or yard)
- VAC coverage

**Reviewer:** The CSGs are gathering a lot of valuable information, including registers and nutritional information. To whom do they submit their reports? What happens to this information? This can be used to track morbidity and mortality if CSGs could also record child and maternal deaths and causes. This is part of the project HIS that would be appropriate to continue after the project ends. This information would feed into the MoH HIS.

**IRD:** The CSGs will undertake a one time mass screening with MUAC in order to select which villages will be targeted for Hearth, otherwise no nutritional data will be collected by them. The Household registers, that will be developed by the CSGs, are for their own use in mobilizing attendance at HC outreach sessions and also for use by the BNEs in identifying target households. There is no vital registration system in Cambodia and the MoH HIS does not track deaths, only births. The CSGs will share their information on births with the HCs for inclusion in the HC HIS form.

#### 4. Range of Interventions

**Reviewer:** Is the project specifically addressing prolonged breastfeeding?

**IRD:** No, because there is no need to do so, either in this project site or in Cambodia as a whole. Breast-feeding is already prolonged; the mean duration in rural areas nationally is 21 months and in the Project area it is 27.7 months. There are no factors in place in the Project area which would threaten this.

**Reviewer:** It may be useful to include more evidence and explanation on how ARI will be addressed at the village level through project efforts (in addition to improved nutrition) or through other initiatives such as treatment outreach from the HC.

**Reviewer:** What about ARI? Can NEs and CSGs learn danger signs and make referrals, since it is the top killer of children <5 in this area?

**IRD:** MoH policy does not permit curative treatment on an outreach basis. ARI treatment is available at HCs and widely utilized by villagers living within easy transport to a HC. In the baseline survey, 74% of children with ARI were treated by a trained provider overall. However, this is 84% for children living within 5 km from HC and over 90% for those within walking distance. The project will address the problem of lack of transport/cost of transport for more remote villages through community based transportation schemes. Until such transport is available, making referrals is of little value.

**Reviewer:** Page 9 mentions the “perception that health workers ‘look down’ on the un-educated poor.” How is this being addressed by the project?

**IRD:** As noted in the DIP, this perception is “widespread in the country (but) was not specifically noted in the Project area during the baseline assessment”. The MoH has a nationwide effort underway to improve Provider-client interactions. The IRD Project does not work at facility level. However, it will provide training to Health Center staff on nutritional counseling

which will include inter-personal techniques to minimize class barriers and use of interactive rather than lecture-style approaches.

**Reviewer:** Since BNEs are in contact with pregnant women, will they counsel on maternal nutrition? There is no description of the maternal nutrition component. Presumably, there is a behavior change aspect to this component, as well.

**IRD:** The Project focuses on child nutrition, specifically nutrition during the critical period of 6 – 35 months where behavior change is sorely needed. It does not have a specific maternal nutrition component, but addresses ensuring iron/folic supplementation and post-partum VAC through mobilization for outreach services and development of transportation mechanisms to the HC. It also addresses food security, which more than behavioral factors is what limits adequate intake during pregnancy and lactation in rural Cambodia.

## 5. Partnerships

**Reviewer:** There appears a very large percentage of non MoH health care resources (traditional healers, private practitioners, etc.). Will these personnel continue to be regarded as competition, or recruited for assisting in interventions?

**IRD:** They are not regarded as “competition” by either the MoH or the Project. The Traditional Birth Attendants and private trained midwives will be specifically recruited and trained to help promote appropriate BF.

**Reviewer:** Based on the information provided the choice of CPR as a partner seems questionable, given their exclusive experience with HIV/AIDS. It was not clear how CPR and PNKA will manage their responsibilities for this project. Will they shift their current activities to focus on this project, or add to their existing portfolio? What is their capacity to implement? What specific changes will be made/capacities built and sustained within the partner organizations?

**Reviewer:** I would suggest that in identifying ways forward, IRD consider already existing community groups that can be further capacitated to take on health and nutrition related tasks before developing new cadres of implementers such as the CSGs proposed.

**IRD:** There is a marked absence of LNGOS based in or even near the Project location, and also of any nationwide with experience in nutrition. Our selection was based quite frankly on what was available. We recognize that both LNGOs are quite new to child survival and nutrition. IRD has recently completed a capacity assessment of both CPR and PNKA and it is working towards strengthen their capacity.

## 6. Child Nutrition

**Reviewer:** Will BNEs counsel on feeding sick children?

**IRD:** Yes, this will be included in the nutritional counseling provided, both by BNEs and in the Hearth program.

**Reviewer:** Could IRD consider adding a peer component for the non-Hearth villages?

**IRD:** This is what the BNE group sessions are...a convening of mothers to discuss common issues.

**Reviewer:** Should complementary feeding message 4, about the container, be referencing meal size, rather than daily intake?

**IRD:** It references portion (meal) size.

**Reviewer:** I still have concerns about the message regarding frequency of feeding solids. Would like to see evidence from other organizations working on complementary feeding in Cambodia that supports or refutes the principle of two messages, one for children 6-8 months and the other for children 9-23 months. Before simplifying the guidelines, please learn how others have handled this.

**IRD:** This Project is being implemented with an unusually uneducated population even by rural Cambodian standards. In addition to concern about the complexity of two messages about frequency (based on age) there is the fact that most mothers in this area do not off hand know how old their child is, as was very apparent during the baseline survey when interviewers had to spend a great deal of time helping them calculate the age in months. A double message on frequency based on exact age in months is just not appropriate under these circumstances. It is also not our understanding from the WHO guidelines that feeding a 6-8 month old infant 3 times a day is considered less desirable than only twice a day. The guidelines say 2-3 times and do not indicate 2 as preferable. Given the extremely small portions being given there is not a risk of overfeeding.

## 7. Miscellaneous

**Reviewer:** IRD should explain how HEARTH links to school feeding program. If the IRD tries to link HEARTH to school feeding program, we concern about dependency to food provided by IRD. There won't be any food supply initiated by community.

**IRD:** There is no linkage or connection between the school feeding program and Hearth. The school feeding program provides on site feeding to primary school children (ages 6 years and up); there are no take home rations.

**Reviewer:** IRD presents a very interesting discussion of innovation and replicability of interventions. My concern is that some of the ideas, e.g., dairy production run counter to earlier information on traditional cultural practices.

**IRD:** It is true that dairy production is not a traditional cultural practice, but there are not cultural or religious prohibitions against it. It will be promoted initially as a source of cooking oil (ghee) since Cambodians do normally fry foods if they can obtain oil or fat with which to do so, so it does not involve a change in cuisine. We understand that there is a chance of failure with this as with any really innovative effort, but believe it is worth a try given its potential for sustainably increasing access to an energy-dense foodstuff.

**Reviewer:** I can't tell how many people are on the Field Teams, but they may be overstretched with monitoring CSGs, NEs and Hearth. You might consider hiring Hearth coordinators

**IRD:** There are three people on each of the three Field Teams. In addition, there is a fulltime Nutrition Coordinator in charge of Hearth and a fulltime IEC/BCC Coordinator. The budget is already badly overstretched and we do not have the resources to hire additional staff.

**Reviewer:** Why has ORS not been well received in Cambodia?

**IRD:** Because it does not decrease the diarrhea, and mothers tend to gauge efficacy in terms of whether or not the diarrhea abates. To date only conventional ORS has been used. The MoH is soon going to introduce low osmolarity ORS plus zinc and it is anticipated that this will be much better received, as it has been in other countries, since it will decrease the duration and severity of the diarrhea.

## **X. Baseline Data and Social and Behavior Strategy**

Baseline data results and the full social and behavior change strategy were completed at the time of the DIP.

## **XI. Management System**

The Child Survival team has a proper organigram and each staff member is given a job description detailing their roles and responsibilities. Per agreement with the Global Health Office of USAID Washington part of the Child Survival Project's budget was sub-granted to two local NGOs (PNKA and CPR) working in Kampong Chhnang. The Child Survival management staff meets regularly every first Thursday of the month. Since July IRD Cambodia's senior management has met every Monday morning, alternating between the Phnom Penh and Kampong Chhnang offices. General staff meetings, to share progress and ideas, are held monthly. The CS management style (and that of IRD Cambodia in general) is collaborative, open to all suggestions, comments and/or criticisms made by its staff, partners and/or other sources. All suggestions and proposals regarding the improved effectiveness of IRD's CS program are thoughtfully, and openly, considered.

### **A. Financial Management System**

The financial management of the Project is managed by the Kampong Chhnang-based Finance Officer in coordination with the Phnom Penh-based Administration & Finance Manager using the QuickBooks systems to record and monitor all financial transactions. At the end of each month original receipts and ledgers are submitted to the Country Office for review with which the Administration & Finance Manager prepares expenditure statements for the project to submit to IRD HQ. Since the arrival of the new CD this summer we also submit nightly cash counts to the Phnom Penh office, participate in the drafting of a Schedule of Cash and Bank Accounts for all Cambodia programs every Friday evening, and have instituted random cash counts on a monthly basis. Also recently introduced has been a system of handling payroll by bank transfer, which has increased efficiency and decreased the financial management workload.

### **B. Human Resources**

The CS program has one expatriate Program Manager assisted by a National Deputy Program Manager, Nutrition Advisor, Nutrition Coordinator, IEC/BCC Coordinator, three field Team Leaders, an Admin/Finance Officer, a receptionist, and six team members from the two partner LNGOs with support from the Country Director and Program Officer at the Phnom Penh office as well as IRD Headquarters in Washington.

### ***C. Communication System and Staff Development***

The Kampong Chhnang office maintains its daily communication with the Phnom Penh office and HQ in Washington, through internet, email, and telephone (desk phone and cell phone). Senior Management meets weekly to share information and discuss problems. In addition all program staff meet monthly to be updated on all program achievements and ongoing activities.

### ***D. Local Partner Relationships***

IRD has built very good relationships with local partner organizations (PNKA and CPR). Six staff members from these local partners work on the IRD CS project and the LNGO Presidents are active members of the Project Management Team.

### ***E. NGOs Coordination/Collaboration in Country***

IRD maintains close relationships with various NGOs and government agencies in Cambodia. IRD is actively participating in the CS technical working group and is continuing to establish additional relationships with NGOs. IRD liaises closely with HKI, ADRA and RACHA to share expertise on IEC materials, home food production as well as social marketing. The team made a program visit to RACHA to discuss and learn about their experiences in CS programs.

### ***F. Organizational Development***

IRD developed its own internal rules and regulations including financial policies to govern its operations in country. IRD is registered as a legal entity with the Ministry of Foreign Affairs and International Cooperation of the Royal Government of Cambodia.

#### *Internal Audit*

An internal audit of the programs in Cambodia was carried out by from the HQ auditor during July 2007. Recommendations from this audit included minor changes in internal management, financial procedures, and IT procedures. Both Cambodia and HQ management have already responded and addressed these recommendations.

#### *Organizational Capacity Assessment*

An organizational capacity assessment was done in March 2007 and the priority challenges identified are being addressed in an ongoing, life of project, action plan.

## **XII. Mission Collaboration**

The project is maintaining good collaboration with the USAID Mission. IRD Cambodia is in routine contact with Dr. Sek Sopheanarit (the designated local contact at USAID) as well as Kate Crawford, the Director of the Office of Public Health. The mission's strategic objective is "Increased use of high impact HIV/AIDS and Family Health Services and appropriate Health-Seeking Behaviors". The IRD Child Survival program directly contributes to this strategic objective by improving child health and nutrition.

The program will substantially increase access to information on appropriate nutrition during pregnancy, BF, proper weaning practices, infant/child feeding, and hygiene, areas where knowledge is currently very low and where incorrect beliefs are rampant. In addition, through creation of the linkage between HCs and communities and development of the community mobilization mechanism to increase services utilization, the program will increase access to essential preventive services such as immunization, Vitamin A supplementation, and deworming. Village-level social marketing of health related commodities also creates an additional service channel in remote rural areas where such products are otherwise unavailable.

The program is using the existing community structures such as the pagoda committee and farmer groups, which were created by their own initiatives, and the existing MoH volunteers Village Health Support Group (VHSG) which is in line with the Mission recommendations.

The project activities are being fully implemented to promote immediate and exclusive breastfeeding and complementary food feeding. The program also supports the Cambodian Child Survival 12 Scorecard Interventions (Initiation of Immediate and Exclusive Breastfeeding, Complementary Food Feeding, Oral Rehydration Therapy (ORT), Insecticide Treated Net Use, Measles Vaccine, and Tetanus Toxoid Vaccine) through which the Mission plays a major supporting role.

On May 22, 2007, Dr. Hen Sokhun Charya and Dr. Sek Sopheanarith from the USAID Mission, and IRD's Country Director visited the IRD CS activities including a CSG training, IEC/BCC campaign, and a puppet show performed by the LDSC team at Kdol, Koh Kandal and Taphorn villages. Mission representatives were very impressed with the activities and results.

### XIII. Timeline of Activities

The timeline of activities for the coming year remains unchanged. All keys activities planned in the first year were carried out successfully. Please see the Activities Timeline for the coming year in the table below.

No.	Activities	Year 2 (Oct. 07-Sept. 08)											
		10	11	12	1	2	3	4	5	6	7	8	9
<b>Objective I. Decrease Prevalence of Moderate and Severe Malnutrition Among Children Under 3 Years</b>													
<b><i>Strategy 1. Advocacy with Health System (HC/OD/PHD) to Ensure Basic Service Availability</i></b>													
1	Participate in the regular monthly meeting with OD and the Provincial Health Department Technical Working Group for Health (PHDTWGH) to present IRD CS activities and results and request PHD/OD to ensure the HC is providing outreach services.	x	x	x	x	x	x	x	x	x	x	x	x
2	Regular meeting with HC to update on activities and results and resolve any problems identified.	x	x	x	x	x	x	x	x	x	x	x	x
<b><i>Strategy 2. Malnutrition Awareness Raising/Advocacy with Commune, Village Leader and Influential Community Member</i></b>													
1	Continue to disseminate nutrition messages to the community through CSGs/BNEs and TBAs.	x	x	x	x	x	x	x	x	x	x	x	x

2	Continue to conduct community IEC/BCC campaigns to cover 81 villages.	x	x	x	x	x	x	x	x	x	x	x	x	x
3	Participate in the regular monthly meetings with the communes.	x	x	x	x	x	x	x	x	x	x	x	x	x
<b>Strategy 3. Community HC Transportation Scheme</b>														
1	Discuss the feasibility of organizing community transport systems with local authorities and community.				x	x	x							
<b>Strategy 4. Community Mobilization for Attendance at Immunization, VAC, Deworming Outreach Session by CSG</b>														
1	Meet with HC staff to obtain outreach schedule.	x	x	x	x	x	x	x	x	x	x	x	x	x
2	Integrate CS plan to coincide with HC plan.	x	x	x	x	x	x	x	x	x	x	x	x	x
<b>Strategy 5. Social Marketing</b>														
1	Encourage CSGs to produce soap in the village.	x	x	x	x	x	x	x	x	x	x	x	x	x
2	Follow-up and support the CSGs in soap making.	x	x	x	x	x	x	x	x	x	x	x	x	x
3	Train new batch of CSGs in soap training - Q4 2008 or Q1 2009.											x	x	x
<b>Objective II &amp; III. Increase Percentage of Infant Breastfeed Immediately After Birth and Maintain Percentage Breastfeed Exclusively More Than 80%</b>														
<b>Strategy 1: Capacity Building of TBAs and CSGs/BNEs on BF</b>														
1	Conduct follow up and supervision to all trained MWs, TBAs and CSGs/BNEs on BF.	x	x	x	x	x	x	x	x	x	x	x	x	x
2	Hold quarterly meetings with TBAs and CSGs/BNEs.			x			x			x				x
3	Conduct refresher courses for MWs, TBAs and CSGs/BNEs.													x
4	Conduct BF and Nutrition contests among all trained CSGs/BNEs.						x							x
<b>Strategy 2. BF Behavior Change Communication by CSGs/BNEs and traditional birth attendants</b>														

1	Conduct health education on immediate and exclusive BF and Nutrition and distribute IEC materials to all pregnant and lactating women and WRA in 81 villages.	x	x	x	x	x	x	x	x	x	x	x	x
2	Collaborate with OD/PHD to organize annual World Breastfeeding Week.												x
<b>Strategy 3. BCC Puppet Show and Mobile Video Show on BF, Nutrition, Hygiene, Diarrhea</b>													
1	Form drama show team and make costumes for the show.		x	x									
2	Develop scripts for drama shows.	x											
3	Conduct trainings to drama team.		x	x									
4	Conduct community drama shows and video shows.		x	x	x	x	x	x	x	x	x	x	x
5	Collaborate with LDSC to conduct puppet shows.	x	x	x	x	x	x	x	x	x	x	x	x
<b>Objective IV. Improve the Quantity and Nutritional Quality of Complementary Food Given to Children 6-35 Months</b>													
<b>Strategy 1. BCC Infant/Child Feeding Behavior Change Communication by BNEs.</b>													
1	Conduct health education sessions on immediate and exclusive BF and nutrition and distribute IEC materials to target groups.	x	x	x	x	x	x	x	x	x	x	x	x
2	Conduct community contests after finished complementary feeding sessions.						x						x
<b>Strategy 2. Hearth Program (NERS and Growth Monitoring )</b>													
1	Conduct training for IRD staff and CSGs in Hearth program, Nutrition Education Rehabilitation Session (NERS) and Growth Monitoring Program (GMP).		x	x	x								x
2	Select target groups for Hearth Program.												

3	Conduct Positive Deviance Inquiry (PDI).				x	x	x	x						
4	Conduct NERS.					x	x	x	x	x	x	x	x	x
5	Conduct GMP.					x	x	x	x	x	x	x	x	x
6	Follow up visit to drop outs, non-weight gainers, non-normal status clients after 3rd or 4th round of NERS.							x	x	x	x	x	x	x
7	Update HH register for children under 3.												x	x
8	Organize village mapping (15 villages).	x	x											
<b>Strategy 3. Food Security Interventions in Hearth Villages</b>														
1	Conduct ToT on food production for all IRD staff.	x												
2	Holding meetings with villagers to discuss food security in Hearth villages.					x	x							
3	Identified households to implement food security.					x	x							
4	Conduct home gardening training for CSGs/BNEs and selected HH.					x	x							
5	Identify and provide a variety of seeds to HH.	x											x	
6	Conduct follow up and provide technical support to CSGs/BNEs.		x	x	x	x	x	x	x	x	x	x	x	x
7	Develop proposal for food security to be submitted to potential donors.		x											
<b>Objective 5. Decrease the Incidence of Diarrheal Diseases in Children Under 3 Years</b>														
<b>Strategy 1. IEC/BCC on Hygiene (2) Point-of-use Water Disinfection (3) Diarrhea Preventions</b>														
1	Print IEC materials about personal hygiene and diarrhea prevention.			x	x									
2	Train CSGs about hygiene and sanitation including SODIS in collaboration with HC as observer.								x	x				



## Indicators for Reporting

Objectives	Indicators		Means of Verification	Frequency	Baseline Value	Target
Decrease the prevalence of moderate and severe malnutrition among children	1	% of children 0-35 months old who are <-2 SD weight for age	KPC Survey	Year 1 & 4	39.6	30%
	2	% of children enrolled in Hearth who are discharged with weight for age within 1.5 SD of the mean	Project Database	Quarterly in Y 2-4	-	80%
Increased rate of immediate breastfeeding	1	% of children aged 0-23 months who were breastfed within one hour of birth	KPC Survey	Year 1 & 4	48.3%	60%
	2	% of villages with at least one birth attendant trained in importance of immediate breastfeeding.	Project Database	Quarterly	-	90%
High rate of exclusive breastfeeding is maintained.	1	% of children aged 0-5 months who received only breast milk in previous 24 hours	KPC Survey	Year 1 & 4	92.8%	80%
	2	% of villages which held at least one educational event on the importance of exclusive breastfeeding.	Project Database	Quarterly	-	90%
Improved quantity and nutritional quality of complementary foods given to young children	1	% of children aged 6-23 months fed 3 or more times in the past 24 hours.	KPC Survey	Year 1 & 4	55.8%	65%
	2	% of children aged 6-23 months who ate Vitamin A rich vegetables in the past 24 hours.	KPC Survey	Year 1 & 4	46.3%	60%
	3	% of children aged 6-23 months who ate fruit in the past 24 hours.	KPC Survey	Year 1 & 4	39.4%	55%
	4	% of children who consumed fat or oil in the past 24 hours	KPC Survey	Year 1 & 4	32.9%	45%
	5	% of villages with active Nutritional Educator.	Project Database	Quarterly	-	90%
	6	% of villages held at least one educational event on complementary feeding.	Project Database	Quarterly	-	90%
	7	% of Hearth villages receiving food security input.	Project Database	Quarterly	-	TBD
Decrease incidence of diarrheal disease	1	% of children aged 0-35 months who had diarrhea in the past 2 weeks.	KPC Survey	Year 1 & 4	27.1%	20%
	2	% of villages which held at least one educational event on hygiene and water.	Project Database	Quarterly	-	90%

## XIV. Results Highlights

### Success Stories

The child survival project is fortunate to work with many dedicated community volunteers who are willing to help and assist their communities. Below are some success stories from the volunteers:

#### **Breast feeding and Nutrition Educator (BNE) Success Story**

Son Leap is a 40 years old woman, married with five children, living in Kokpeng Village, Teuk Phos District, Kampong Chhnang, Cambodia. She is an IRD trained BNE. Prior to her BNE post, she was a member of the Village Health Support Group (VSHG). Upon invitation to the BNE training she readily accepted the challenges knowing that this will help improve the community.



Son Leap shows how to use the flipchart

Son Leap completed the three day training in June 2007 during which she learned, for the first time, about the malnutrition problems within her own community and the consequences of such malnutrition amongst children. The training made her aware that malnutrition can be prevented through proper feeding practices like early and exclusive breastfeeding as well as complementary feeding. Son Leap was very excited at being given this opportunity to be a part of the BNE group within her community.

After the training, Son Leap conducted individual and group counseling sessions among pregnant and lactating women in the community using the BF flipchart chart and the posters provided by IRD. During her trainings Son Leap addressed the existing breastfeeding belief that colostrums is “bad milk” by providing the mothers with information on the nutritional benefits of colostrums for the babies and the importance of immediate and exclusive breastfeeding. In addition, Son Leap also provided mothers with information on the appropriate practices for infant/child feeding, nutrition during pregnancy and hygiene practices. Son Leap conducted the counseling 10-15 hours per month and was well received by the members of her community. Even when she was not acting as a BNE, Son Leap would encourage pregnant and lactating women to initiate immediate and exclusive breastfeeding and provide the right amount, and quantity, of complementary foods to the children.

Through her small, but very vital, efforts Son Leap observed many behavior changes in the community. She has observed many mothers giving colostrum to their babies after birth, early breastfeeding initiation within one hour after birth and the provision of complementary food feeding at the proper age for infants. Son Leap finds it very distressing when mothers want to feed their children but have no food stuffs available, yet she still provides important advice on proper nutrition, where to find vegetables or how to cultivate a backyard garden.

Son Leap’s husband is very supportive in her counseling work and sometimes even prepares their meals while she is conducting her counseling sessions. Son Leap affirmed that no matter what barriers she may face, she will continue to provide counseling to mothers as she realizes that many children will be saved by her efforts.

### **Community Support Group (CSG) Success Story**

Sai Som, 39 years old, is the Deputy Chief of Prey Chreu Village in the Kbal Teuk commune, of Teuk Phos district. During the formation of the village's Community Support Group (CSG), he was nominated by the other group members to be their facilitator. As facilitator, his main duty is to coordinate and support the work of the Breast Feeding and Nutrition Educators (BNEs) to provide education on malnutrition and infection, basic hygiene, breastfeeding and infant/child feeding practices.

After participating in the IRD CSG training, Sai Som became very active in working with the child survival program. He is a very committed member of the CSG and is willing to give much of his free time to assist the program and the BNEs. It is his belief that through this program his community will improve and develop.



Sai Som has proven to be very helpful with the BNEs. He consistently assists them in the completion of their monthly reports. On numerous occasions he has also supported volunteers with the use of his motorbike. His wife and children are very supportive of Sai Som and his willingness to maintain the communication flow between himself and IRD's staff. .

When IRD field personnel asked Sai Som why he continued to do volunteer work he stated that not only was this a part of his job as deputy chief of village, but he felt very lucky to have IRD working with him and helping to support the improvement of the health of his community. Sai Som's goal for his village is continued development and improving community living standards.

### **XV. Topics Not Applicable to the Program**

Items I, J and K from the guidelines are not applicable to this project.

### **XVI. Other Relevant Aspects of the Program**

*Building Capacity:* The Program objectives of this Child Survival Program does not include direct capacity building with the PHD, OD, and HC levels staff. If additional funds were available to allow for activities that would strengthen the capacity of the health center staff, it would be a very big improvement in the quality of services the communities receive. IRD would like to see the health centers able to provide quality basic health services to the communities 24 hours per day.

*Volunteer Follow-up:* Regular follow up meetings and refresher trainings need to be organized at least once or twice a year in order to maintain and enhance the BNE and TBA knowledge. In addition, they need constant support and recognition of their contribution to the program to keep them interested in being involved.

## **XVII. Publications, Presentations and Events**

In August 2007 IRD's Country Director, CS Program Manager and Nutrition Advisor met with Mr. Ram Srestha and Ms. Rae Galloway of the Technical Support Team from USAID Washington for the Infant and Young Child Nutrition Project. IRD presented an overview of IRD Child Survival Project, accomplishments, existing gaps and recommendations. The presentation used in this meeting is attached in Annex III.

## **XVIII. Recommendations**

- Provide incentives to volunteers (ex: bicycles for client follow-up)
- Free health services at the health centers
- Installation of rain water harvesting wells at health centers (with support from LDSC or other sources)
- Provide additional interventions like the homestead food production
- Follow-up training on homestead food production, HEARTH program, other income generating activities
- Provision of materials for hygiene practices (ex: food cover, soap making materials, water filters)
- If funds can be found improvements to logistics and operational capacity (such as the acquisition of additional vehicles, computers and office machines) would substantially improve program productivity and effectiveness.

## **XVIII. Annexes**

Annex I: CSHGP Project Data Form

Annex II: Monitoring form

Annex III: IRD project presentation

Annex I – CSHGP Data Form

**Child Survival and Health Grants Program Project Summary**

**Oct-20-2007**

**International Relief and Development, Inc. (IRD)  
(Cambodia)**

**General Project Information:**

**Cooperative Agreement Number:** GHS-A-00-06-00014  
**Project Grant Cycle:** 22  
**Project Dates:** (10/1/2006 - 9/30/2010)  
**Project Type:** Entry/New Partner

**IRD Headquarters Technical Backstop:** Dawn Greensides  
**Field Program Manager:** Somchit Boungnasiri  
**Midterm Evaluator:**  
**Final Evaluator:**  
**USAID Mission Contact:** Sopheanarith Sek

**Field Program Manager Information:**

**Name:** Somchit Boungnasiri  
**Address:** Mong Barang village, Phae commune  
Kampong Chhnang district, Kampong Chhnang  
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**Phone:** 011-(855) 26-989-053  
**Fax:**  
**E-mail:** somchit.ird@online.com.kh

**Funding Information:**

**USAID Funding:(US \$):** \$1,249,948

**PVO match:(US \$)** \$500,000

## Project Information:

### Description:

The program's goal is to reduce under-five malnutrition-related morbidity and mortality in a sustainable and replicable manner.

The Specific objectives of the project are to:

- Decrease the prevalence of moderate and severe malnutrition among children under the age of three years to < 30%
- Increase the percentage of infants breastfed within immediately after birth to > 60%
- Maintain the percentage of infants exclusively breastfed for the first 6 months at > 80%
- Improve the quantity and nutritional quality of complementary foods given to young children
- Decrease the incidence of diarrheal diseases in children under three to < 20%

The program will increase the capacity of families and communities to adequately meet the nutritional needs of young children and to prevent food and water borne infections. This will be done through (1) community-level education and behavior change communication to improve the quantity and quality of complementary foods, hygiene practices and breast-feeding; (2) village based nutritional rehabilitation using the "Hearth Model" to create a sustainable change in feeding practices; (3) community mobilization for the development of affordable transport mechanisms for treatment of common illnesses at the health Center, improved Vitamin A capsule distribution and immunization coverage; (4) training and promotion in point of use water disinfection and use of low-osmolarity ORS and zinc for diarrhea management, and; (5) social marketing of nutritionally fortified low cost foods, POU materials, ORS zinc and soap.

Approaches will be village-based and focus on steps that can be taken within existing resource constraints. An important hurdle to be overcome is the perception that malnutrition inevitably accompanies poverty; another is the overall lack of awareness about the extent of the problem and its impact on mortality.

The full package of the interventions, augmented by activities to improve food security and water supply, will be implemented throughout Teuk Phos District. In addition, the IEC/BCC component will be expanded throughout Kampong Chhnang Operational District in years three and four of the project.

### Location:

Teuk Phos Administrative District, Kampong Chhnang Province, Cambodia

Project Partners	Partner Type	Subgrant Amount
Local NGO - PNKA	Subgrantee	\$36,000.00
Local NGO-CRD	Subgrantee	\$24,000.00
Subgrant Total		\$60,000.00

## General Strategies Planned:

Social Marketing  
Advocacy on Health Policy

### **M&E Assessment Strategies:**

KPC Survey  
Organizational Capacity Assessment with Local Partners  
Organizational Capacity Assessment for your own PVO  
Participatory Learning in Action  
Community-based Monitoring Techniques  
Participatory Evaluation Techniques (for mid-term or final evaluation)

### **Behavior Change & Communication (BCC) Strategies:**

Social Marketing  
Interpersonal Communication  
Peer Communication  
Support Groups

### **Groups targeted for Capacity Building:**

<b>PVO</b>	<b>Non-Govt Partners</b>	<b>Other Private Sector</b>	<b>Govt</b>	<b>Community</b>
US HQ (CS unit) CS Project Team	Local NGO	(None Selected)	Health Facility Staff	Health CBOs Other CBOs CHWs

## Interventions/Program Components:

### **Nutrition (65 %)**

(CHW Training)

(HF Training)

- Gardens
- Comp. Feed. from 6 mos.
- Hearth
- Growth Monitoring
- Maternal Nutrition

### **Micronutrients (15 %)**

- Iodized Salt
- Food Fortification

### **Control of Diarrheal Diseases (20 %)**

(CHW Training)

- Water/Sanitation
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- POU Treatment of water
- Zinc

## Target Beneficiaries:

<b>Infants &lt; 12 months:</b>	<b>1,300</b>
<b>Children 12-23 months:</b>	<b>1,000</b>
<b>Children 0-23 months:</b>	<b>2,300</b>
<b>Children 24-59 months:</b>	<b>3,700</b>
<b>Children 0-59 Months</b>	<b>6,000</b>
<b>Women 15-49 years:</b>	<b>23,500</b>
<b>Population of Target Area:</b>	<b>53,000</b>

### Rapid Catch Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	278	300	92.0%	11.0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	265	300	88.0%	11.0
Percentage of children age 0-23 months whose births were attended by skilled personnel	120	300	40.0%	9.0
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within 3 days after the birth of the youngest child	83	300	27.0%	7.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	64	69	92.0%	23.0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall)	133	231	57.0%	11.0
Percentage of children age 12-23 months who received a measles vaccination	126	150	84.0%	15.0
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	127	150	84.0%	15.0
Percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	117	150	78.0%	15.0
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	73	172	42.0%	12.0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	33	87	37.0%	16.0
Percentage of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks	38	52	73.0%	26.0

Percentage of households of children age 0-23 months that treat water effectively.	<b>163</b>	<b>300</b>	<b>54.0%</b>	<b>10.0</b>
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	<b>7</b>	<b>300</b>	<b>2.0%</b>	<b>2.0</b>
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended.	<b>65</b>	<b>150</b>	<b>43.0%</b>	<b>13.0</b>
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)	<b>98</b>	<b>300</b>	<b>32.0%</b>	<b>8.0</b>
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	<b>102</b>	<b>231</b>	<b>44.0%</b>	<b>10.0</b>

### Comments for Rapid Catch Indicators

<p>* Instead of the indicator #11 we used - Child with fever receives appropriate treatment</p> <p>Notes:</p> <p>(1) Denominator is children aged 0-24 months who were reported to have had a fever in the previous 2 weeks;</p> <p>(2) Appropriate treatment was defined as taking the child to a public health facility within 24 hours of onset. Anti-malarial drugs are not routinely given for fever in Cambodia.</p> <p>(3) Responses considered as not appropriate treatment included:</p> <ul style="list-style-type: none"> <li>No treatment given = 5.8%</li> <li>Delayed onset of treatment = 8.7%</li> <li>Treated with medication bought from drug seller = 22.7%</li> <li>Treated by private (trained) provider = 30.2%</li> </ul> <p>(4) Appropriate treatment rates were similar in villages with known malaria transmission and those without. The 2 week prevalence of fever was 57.3% for the entire project area, and similar in villages endemic for malaria and those not. This plus seasonality (rains ended 2 months prior to the survey) and the fact that most cases of fever coincided with cough may indicate that most of the fevers reported in the survey were not due to malaria.</p>
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- **Annex II. Monitoring form**

<b>របាយការណ៍ត្រួតពិនិត្យការអប់រំអាហារូបត្ថម្ភ និងបម្រើសេវា BNE Report</b>				
_____	_____	_____	_____	200__
Team ប្រធានក្រុម	Commune ឃុំ	Village ភូមិ	Month ខែ	Year ឆ្នាំ

ចំនួនប្រជាជនសរុប	ប្រជាជនសរុប	ក្មេងក្រោម ៣ ឆ្នាំ	ស្ត្រីមានផ្ទៃពោះ
Population:	total:	Under 3 Years	Pregnant
	2007	_____	_____
	_____	_____	_____

ភាគរយនៃកង្វះអាហារូបត្ថម្ភ	ភូមិដែលមានគ្រួសារគំរូ ( មាន/ទេ)
% Malnourished	Hearth Village? (Y/N)
_____	_____

មណ្ឌលសុខភាព	_____	_____	_____	_____
Health Center:	ឈ្មោះ	ចម្ងាយ	អាចដើរ? ( បាន/ទេ)	មានណែនាំមធ្យោបាយបញ្ជូនឬទេ? ( មាន/ទេ)
	name	distance (km)	Walking? (Y/N)	Transport Scheme Introduced? (Y/N)
	_____	_____	_____	_____

ការបង្កើតក្រុមគាំទ្រសហគមន៍	ចំនួនអ្នកបម្រើសេវា/ អ្នកបណ្តុះបណ្តាល
CSG formed:	No. TBA/Midwife Trained in BF
_____	_____
(Y/N) ( មាន/ទេ)	

ការបណ្តុះបណ្តាលគ្រួសារគំរូ	កង្វះអាហារូបត្ថម្ភ	ការចុះបញ្ជីគ្រួសារ / ចលនាចូលរួម	ទីផ្សារសង្គម	ការធ្វើសាប៊ូ
CSG Training :	Malnutrition	HH registers/Mobilization	Social Marketing	Soap Making
(Y/N) ( មាន/ទេ)				

កាលបរិច្ឆេទពេលវេលាចុងក្រោយ	____/____/____
Date of Last Refresher Session:	

ចំនួនអ្នកអប់រំអាហារូបត្ថម្ភ និងបំបៅដោះ Number BNEs: _____	ការបណ្តុះបណ្តាលអ្នកអប់រំអាហារូបត្ថម្ភ និងបំបៅដោះ BNE Training				
	ផ្តល់អាហារបន្ថែម BF/Comp feeding	អនាម័យ Hygiene	ទឹកស្អាត Water	Other: _____ ផ្សេងៗ	Other: _____ ផ្សេងៗ
(Y/N) (មាន/ទេ)					

IEC Events: ការអប់រំចម្លែង			Social Marketing Commodity Sale by CSG		
សារសុខភាព Topic	កាលបរិច្ឆេទ Dates	អ្នកចូលរួម Attendance	ការលក់ទំនិញលើទីផ្សារសង្គមដោយក្រុមគាំទ្រសហគមន៍		
			Item	មុខទំនិញ	Number
ការបំបៅដោះ Breast Feeding	___/___/___	_____	IPB	មុងសុវត្ថិភាព	
ផ្តល់អាហារបន្ថែម Complementary Feeding	___/___/___	_____	Soap	សាប៊ូ	
អនាម័យ Hygiene	___/___/___	_____	ORS	ទឹកអូរ៉ាលីត	
	___/___/___	_____	Food Cover	ប្រដាប់គ្របអាហារ	
ទឹកស្អាត Safe Water	___/___/___	_____	Mee Dara	ទីតារា	
	___/___/___	_____	Water Filter	ធុងទឹកចំរោះ	
ផ្សេងៗ Other _____	___/___/___	_____	Other ផ្សេងៗ	_____	
	___/___/___	_____	Other ផ្សេងៗ	_____	
ផ្សេងៗ Other _____	___/___/___	_____	Other ផ្សេងៗ	_____	
	___/___/___	_____	Other ផ្សេងៗ	_____	



Comment / មតិផ្សេងៗ:

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ហត្ថលេខានិងឈ្មោះប្រធានក្រុម  
Signature and Name of Team Leader

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17	<input type="checkbox"/>									
18	<input type="checkbox"/>									
19	<input type="checkbox"/>									
20	<input type="checkbox"/>									
21	<input type="checkbox"/>									
22	<input type="checkbox"/>									
23	<input type="checkbox"/>									
24	<input type="checkbox"/>									
<b>Total</b>										
<b>Group Session</b>										
N°	attendance				BF	Complementary feeding	Hygiene	Water	Other	
1		-			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2		-			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3		-			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Total										

Meeting with CSG This Month: (Yes/No) \_\_\_\_\_

Comment: \_\_\_\_\_

\_\_\_\_\_  
Name and Signature of Reporter

\_\_\_\_\_  
Name and Signature of Team Leader

<b>របាយការណ៍នៃកម្មវិធីតាមដានការលូតលាស់ និងកម្មវិធីថែ/បណ្តុះបណ្តាល</b>			<b>HEARTH</b>
			200
Team ប្រធានក្រុម	Commune ឃុំ	Village ភូមិ	Month ខែ
			Year ឆ្នាំ

មានកម្មវិធីត្រួតពិនិត្យចាប់ផ្តើមឬនៅ (មាន/ទេ)	
Hearth Started (Y/N)	
បានបញ្ចប់កម្មវិធីត្រួតពិនិត្យឬទេ	
Hearth Completed (Y/N)	
មានកម្មវិធីត្រួតពិនិត្យខែនេះឬទេ (មាន/ទេ)	
Hearth This Month (Y/N)	

<b>កម្មវិធីតាមដានការលូតលាស់ GMP</b>	
លេខក្រុមតាមដានការលូតលាស់	
GMP Session#	
ចំនួនអ្នកចុះឈ្មោះ:	
Number Enrolled:	
ទំងន់:	
Number Weighed	
ធម្មតា	
Normal	
ខ្វះធ្ងន់ធ្ងរ	
Severe Malnourished	
ខ្វះមធ្យម	
Moderate Malnourished	

<b>កម្មវិធីថែនិងបណ្តុះបណ្តាល NERP</b>		
លេខក្រុមនៃកម្មវិធីថែ និងបណ្តុះ		
Nerp Session #		
ចំនួនអ្នកចុះឈ្មោះ:		
Number Enrolled:		
New ថ្មី		
Old ចាស់		
Total សរុប		
ចំនួនអ្នកចូលរួម:		
Number Attended		
ទំងន់កើន		
Gained Weight		
ទំងន់ដដែល		
Same Weight		
ចុះទំងន់		
Lost Weight		
ពីធ្ងន់ធ្ងរឡើងទៅមធ្យម		
Severe to Moderate		
ពីមធ្យមឡើងទៅធម្មតា		
Moderate to Normal		
ពីមធ្យមចុះទៅធ្ងន់ធ្ងរ		
Moderate to Severe (Worse)		
ផុតពីកង្វះអាហារូបត្ថម្ភ		
Graduated		

កុមារខ្វះសរុប Total Malnourished	_____
ពីធម្មតាចុះទៅខ្វះ Normal to Mal	_____
ពីខ្វះឡើងទៅធម្មតា Mal to Normal	_____

ហត្ថលេខានិងឈ្មោះប្រធានក្រុម

Signature and Name of Team Leader

ចំនួនក្មេងមានរលាកផ្លូវដង្ហើម # children ARI	_____
ចំនួនក្មេងមានជំងឺរាក # children diarrhea	_____
ចំនួនក្មេងត្រូវក្តៅ # children fever	_____
ចំនួនក្មេងមានជំងឺផ្សេងទៀត # children sick other	_____
ចំនួនក្មេងបានព្យាបាលនៅមណ្ឌលសុខភាព # children treat at HC	_____

# Child Survival and Health Grants Program Teuk Phos District, Kampong Chhnang Province, Cambodia



Entry Level Category  
Award Number: GHS-A-00-06-00014-00  
October 2006 – September 2010





## Project Area



- Bordering on the Aoral Mountain Range, the district covers 1,752 square kilometers, and distances between villages are considerable, especially in the forested western half.
- 56% the population is below the poverty level
- 91% of the population is engaged in subsistence agriculture (rice farming)
- Area is drought-prone
- Over half the adult female population is illiterate.
- 8 communes, 81 villages



## Project Beneficiaries



- The total population is 54,000
- 6,000 are children under the age of five
- 1,300 are aged 0-11 months
- 1,000 are aged 12-23 months
- 3,700 are aged 24-59 months
- 23,500 women of reproductive age



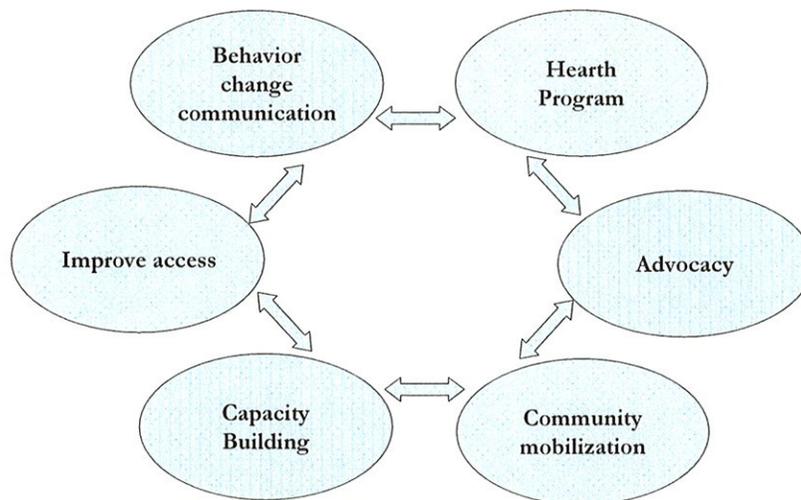
## IRD Project Partners



- MOH of Cambodia
- MOE of Cambodia
- MORD of Cambodia
- Local NGO PNKA
- Local NGO CPR
- Cambodian Red Cross
- Rain Water Cambodia
- LDS Charities
- LWF
- CESVI



## Main Strategies





## Baseline Findings



- KPC survey
- Village Profile
- Health Facility Assessment (partial)
- Analyses of previous research
- Review of policy documents
- Institutional capacity assessment (IRD and local NGOs)



## Nutrition Interventions



Capability building of  
BNEs/CSGs/TBAs on:

- BF initiation
- Exclusive BF for 6 months
- Complementary feeding
- ANC
- Immunization
- Micronutrients





## IEC/BCC Campaign



- BF initiation
- Exclusive BF
- Complementary feeding
- Vitamin A
- Iodine
- Iron
- Immunization



## Other activities



- Participate in the Child Survival and micronutrient
- Meetings with the MoH and other NGOs
- In-house training of Field staff





## Progress To Date



- Established field Office, recruited and oriented Staff
- Stakeholder meetings, project launch
- Project Management Team established
- Signed agreements with MOH, local NGO partners
- Conducted baseline studies and developed DIP
- Formed and trained CSGs
- Conducted awareness training for local leaders
- Recruited and Trained BF/Nutrition Educators/TBAs
- Household registers completed
- Hearth villages selected
- Staff ToT on SODIS and home gardening
- Ongoing coordination with INGOs, local gov. and USAID mission in Cambodia
- IRD became a member of MEDICAM, CSTWG and IYCFTWG



## Existing Gaps in the CS program



- Policies of Ministry of Health (MoH) not implemented at the village level due to limited funds
- Limited data on household profile
- Limited outreach programs in remote areas
- Lack of monitoring & evaluation supervision.



## Existing Gaps in the CS program

- Limited transport to follow up the BNEs & CSGs in remote areas for the health services
- Limited budget for food security; social marketing; and income generating activities i.e. soap making, food covers, water filters



## Recommendations

Provide incentives to outstanding/active volunteers for the delivery of the following health services:

- Household profiling
- Assist in the outreach programs
- Inform household of health services like VAC distribution; vaccines; and other supplies
- Counsel mothers on breastfeeding; complementary feeding; immunization; and ANC
- Provide income generating activities



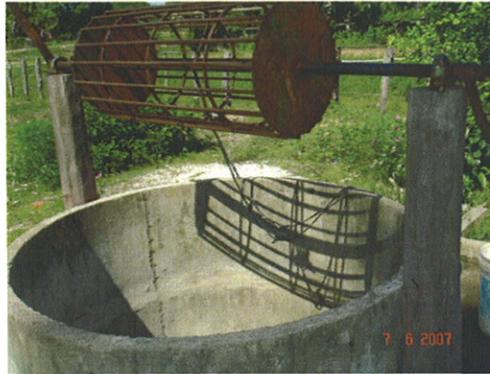


## Recommendations



Additional funds for the following:

- Provide incentives to volunteers like bicycles for following-up with clients
- Free health services at the health centers; water wells
- Provide additional interventions like the homestead food production; HEARTH program; soap making; safe water; and ITNs



## Recommendations



Additional funds for the following:

- Follow-up training on homestead food production; HEARTH program; & other income generating activities
- Materials for hygiene practices i.e. food cover, soap making, water filter

