

**FIRST ANNUAL REPORT**  
**Period October 2000-September 2001**  
**Catholic Relief Services-Maguindanao Child Survival Project**  
**Cooperative Agreement FAO-A-00-00-0037-00**

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**Introduction**

This is the first annual report of the **CRS-Maguindanao Child Survival Project** (Cooperative Agreement FAO-A-00-00-0037-00) covering the period October 2000-September 2001. The report highlights the major accomplishments of the project and lessons learned towards a more effective strategizing of activities in meeting the project goals and objectives.

The report is divided into 5 major parts: **a)** Part 1-Background Information; **b)** Part 2-Accomplishments; **c)** Part 3-Changes from the Program Description and DIP; **d)** Part 4-Issues raised during DIP review; and actions taken; and, **e)** Part 5-Main Thrusts for Year 2 (Oct 2001-Sep 2002).

**PART I. BACKGROUND INFORMATION**

**A. Why Maguindanao**

Maguindanao, one of the five provinces that make up the Autonomous Region in Muslim Mindanao (ARMM), forms a pocket of poverty in the Philippine archipelago. The region's Child Mortality Rate of 97.6 per 100,000 live births is twice the national average, and health facility utilization rates are three times lower than the national norm. Decades of violent conflict between the rebel groups and the national government have disrupted the province's health service network, and have resulted in some of the highest morbidity rates in the nation. Further, while no reliable literacy figures are available, the Provincial Health Office of Maguindanao estimates that 34% of the province has received no formal schooling, a rate that is 8 times higher than the country average. Health service delivery coverage is the lowest in the country, with the percentage of households utilizing health facilities falling 75% below the national average. A demographic health survey reported that a trained doctor, nurse or midwife attended to only 15.5% of births (DHS 1998). The MCSP will complement other CRS projects in the area, especially peace and reconciliation efforts between the majority Muslim population and the Christian population.

**B. Goals and Objectives**

The Maguindanao Child Survival Project (MCSP) is a four-year (October 2000-September 2004) special project of the Catholic Relief Services assisted by USAID in partnership with the Maguindanao Integrated Provincial Health Office (IPHO) and Kaduntaya Foundation, Inc.

(KFI). The goal of the Project is to reduce morbidity and mortality among children under five. The overall strategic objective of the MCSP is to enhance the capacity of the IPHO, KFI and, other stakeholders like the LGUs and the communities to implement health services designed to decrease the major causes of infant and child mortality in the target population. The Project will be piloted in five (5) municipalities of Maguindanao initially working with 76 barangays (9/municipality).

The two major partners (IPHO and KFI) will be directly responsible in the implementation of the project with CRS providing technical and financial assistance. A team of four multi-disciplinary CRS-MCSP staff was formed and established in Cotabato City to coordinate the overall implementation of the project with the partners

The four year MCSP seeks to improve the health status of 13,948 children under the age of five and 24, 049 women of reproductive age in 76 communities (or barangays) in five municipalities of Maguindanao. The project will address the principal causes of child mortality (concentrating efforts on under two-year old children) through Pneumonia Case Management, Diarrhea Case Management, Breastfeeding and Nutrition and Expanded Program on Immunization.

The MCSP is designed to complement and enhance the Integrated Provincial Health Office's (IPHO) plan to introduce a facility-based strategy for the Integrated Management of Childhood Illness (IMCI) over the next five years. The project will promote what the World Health Organization identifies as the third component of IMCI: "Improving family and community practices." The IPHO recognizes its institutional constraints in successfully fulfilling this component of IMCI, and emphasizes the important potential role of the PVO/NGO sector in this activity.

### **C. Project Interventions**

MCSP has four (4) project components that will directly improve the rate of survival of children in covered communities as follows:

- Pneumonia Case Management (PCM) - The objective of the PCM intervention is to reduce mortality in children under 5 years of age from Pneumonia (with special emphasis on the very young infant), using Standard Case Management (SCM)
- Care of Diarrheal Diseases (CDD) - The objectives of the Diarrhea intervention are to prevent cases of child diarrhea, prevent dehydration by providing prompt treatment at the household for diarrhea cases, prompt care seeking for complicated cases and prevention of malnutrition through appropriate feeding of the child during and after illness.
- Expanded Program on Immunization (EPI) - The objective of the EPI intervention is increased vaccine coverage of children under the age of 24 months, and pregnant women.

- Nutrition and Breastfeeding - The objectives of this intervention are increased early initiation of breastfeeding and exclusive breastfeeding, and increased coverage of children and mothers with micronutrient supplements and prevention of malnutrition related to poor feeding practices and illnesses.

#### **D. Strategies**

The long-term impact of the above intervention will be enhanced through capacity building of the partner organizations and a sustainability strategy designed to continue the child survival activities after the life of the project. The Project adapts four strategies as follows:

- Community Mobilization for Health – The ultimate goal of all the project’s interventions is for the community to eventually adopt behavior change and improved practices beneficial to the overall health condition of the household especially among children under 5. All the project’s activities at the community level shall serve as an opportunity or venue of the households and the community to increase their awareness on improved health practices as well as learn the skills in managing the overall health of the community. Specifically, the Project will facilitate communities develop strategic plans to confront the causes of poor health and implement basic health projects prioritized in their plans. By participating in a structured learning process (i.e., planning exercises, project monitoring, skills training, etc.), communities are expected to adopt behaviors that improve health and gain control over their own health. With the increased awareness, communities are likewise expected to advocate to authorities for improved services.
- Health Education/IEC at the Community Level – The health education strategy is aimed at bringing about behavioral change in individuals, groups and larger populations from behaviors detrimental to health, and promotes the behaviors conducive to present and future health. The project will provide resources and program activities to ensure that health education for behavior change becomes a central component of all community-level interventions.
- Promoting Public/Private Partnership - The MCSP implementation will provide opportunity for partnership interaction between IPHO, KFI and other potential organizations thereby increasing their technical capacity and optimize their resources in health-delivery services. It is also anticipated that the experience would develop into partnerships model for the sustainability of the project.
- Capacity Building - This is the overall strategy of the Project aimed at institutionalizing effective health delivery systems among partners but as well as enhancing their technical and skills. This strategy is considered as a major intervention for the sustainability of the project. The capacity building is at two levels: The strengthening of the institutional and organizational management capacity of partners and, enhancement and/or development of technical knowledge and skills of individuals in the organizations.

## **PART 2. DISCUSSION OF ACCOMPLISHMENTS**

The discussion of accomplishments is divided into four sections:

- Highlights of Year 1 – Provides a glimpse of the Project’s main accomplishments.
- Pre-implementation phase. This consists of all preparatory activities before full implementation of the Project such as logistical preparation and pre-planning process.
- Implementation phase. This is the full implementation phase that highlights major accomplishments at two levels – the Partnership and Community level; strengths and factors that contributed to these accomplishments; factors which impeded progress and actions taken; and, areas needing technical assistance. This section also includes discussion and/or analysis on the constraints of project implementation.
- Challenges and Issues. These are the challenges perceived by the project based on its analysis of the accomplishments and factors affecting project implementation.

### **A. Highlights of Year 1**

The first year was mainly spent in setting-up the overall mechanism and systems for the full implementation of the Project. As reflected in the Detailed Implementation Plan, the planned major activities were accomplished such as: a) setting-up the Cotabato Office and staff complementation; b) conduct of the KPC and OCA survey; c) formulation of DIP; d) procurement of equipment and, e) initial institutionalization for a Partnership approach to project implementation. Moreover, ten (10) priority trainings for IPHO were also facilitated with a total participants of 263 (*Note: Most of the participant have attended two or more training*) mostly IPHO staff and RHU-level health care givers involving 64 days. The KFI, on the other hand, successfully laid the groundwork for a community-based development approach to project implementation with the formation of 45 community-based core groups and 5 Municipal level support teams. The Project was successfully launched with the 45 pilot communities and ensured the full participation of the overall community. Likewise, a teamwork approach between KFI-COs and the RHMs (for the IPHO side) in the implementation of the community mobilization strategy for the 45 pilot communities was established with the formulation of a joint plan of action and defined roles and responsibilities. Generally, the Project is now ready for the full community mobilization phase (i.e., implementation of community-based projects) with the 45 pilot communities (i.e. organization building and implementation of priority community-based micro-health projects. Likewise, with the initial institutionalization of the Partnership (i.e., leveling-off on MCSP’s community development framework, monitoring process, community-level coordination process and criteria in project selection), the Project is assured of a coordinated process and/or real partnership approach to project implementation between the CRS/IPHO/KFI/LGUs. On the other hand, with most of the planned training activities of IPHO conducted, the project is now looking forwards for some changes or improved knowledge, attitude and skills of health care givers in the delivery of community or children’s health care services.

## **B. Pre-implementation phase**

This phase comprised of major activities implemented in preparation for the full implementation of the Project at the community level, as follows:

- *Setting-up the MCSP Cotabato office, completed the staffing requirement and procurement of equipment*

In the first few months, the setting-up of Cotabato Office and complement-staff were accomplished. For the **CRS-MCSP**, a Project Manager, a Community Development Specialist, Bookkeeper and Driver were hired. Due to limited qualified applicants, the Health Education Specialist position was not filled-up on the first year. Likewise, the NGO partner, (KFI) completed its staffing requirement for the Project such as; a CO-Coordinator and five Community Organizers. On the other hand, the IPHO has designated their respective Program Coordinators to directly facilitate the implementation of the four Project's interventions such as; CDD, Pneumonia, EPI and Nutrition / Breastfeeding. Aside from the Program Coordinators, the IPHO has also assigned Area Coordinators for each of the Municipality covered by the Project. At the end of first year, MCSP has total of 10 full time staff (KFI-6 and CRS-MCSP-4). Hopefully, the MCSP-Health Education Specialist will be hired early part of year 2. The part time staff (meaning, on the average, 10-30% of their time shall be devoted to MCSP) numbers around 45, as follows:

- ✓ 3-KFI: Executive Director, Finance Officer and Driver
- ✓ 37-IPHO: PHO(1), RHM(19), MHO(5), PHN(5), Program Coordinators (6) and, 1 driver
- ✓ 5-CRS: Country Rep, Senior Program Manager, Health Program Manager, Regional Finance Officer, and Accountant.

In the first few months, series of consultative meetings and planning were facilitated by CRS-MCSP defining the roles and interaction among partners. These activities also resulted in creating a good climate of coordination and work relationship among all levels of partnerships.

In the early part of the year, most of the needed equipment and supplies were procured. Among the major items bought and distributed to partners are: 3 units of 4x4 vehicle, motorcycles, a pump-boat, computers and printers, photocopiers and other basic office equipment and furniture.

- *Completed Studies on the Health Condition of Target Communities and Organizational Capacity of Partners*

Two major assessment studies were conducted during the second quarter of the year. These were the quantitative and qualitative study on the health Knowledge, Practice and

Coverage (KPC) of households and health care givers and, the Organizational Capacity Test of the three partners, IPHO, KFI and CRS.

- ✓ The KPC was conducted with sample households in the Municipalities using the Lot Quality Assurance Sampling method. The study has two-fold objectives: training the partners on a scientific methodology in assessing the health condition of communities and, arriving a concrete understanding or picture on the overall health condition and practices of households in caring for their children age 0-2 years old. Likewise, the results of the study provide ample basis in the formulation of plans and implementation strategies of the Project (i.e., the formulation of a comprehensive Behavior Change Communication Plan).

The KPC revealed that there is an urgent need to improve the health care practices of households especially in the following areas: care for diarrhea disease specifically in sanitation and feeding of children; health seeking behavior and/or utilization of services; detection on danger signs of pneumonia; and, in giving complete vaccination.

- ✓ The OCAT was conducted generally to determine the management and technical capacity of three partners to implement MCSP and their organizational capacity building needs to sustain the project. The results of the OCAT presented an overview on the present capacities of the partnerships in the overall implementation of the project. This includes their management capacity, expertise, present programs, systems and strategies and present manpower and logistical resources. Some areas needing training and technical assistance were also identified by the study and, plans to fill these gaps were formulated.

The participants of the assessment were the management and field staff of the three organizations.

As summed-up, the three common strengths and weaknesses of the three organizations fall under the 3 categories: governance, service delivery and sustainability as shown in the table below:

Partner	Strengths			Weaknesses		
	<i>Governance</i>	<i>Service Delivery</i>	<i>Sustainability</i>	<i>Management</i>	<i>Service Delivery</i>	<i>Sustainability</i>
IPHO	Mission, Goal and leadership	Sectoral expertise	Strategic thinking, efficiency of operation	Structure, Planning, M&E	Community participation	Alternatives to donor financing, Income generating enter. Marketing function
KFI	Board, Mission, Goal and leadership	Sectoral expertise	Strategic thinking, alternatives to donor financing	Structure, Planning, M&E, Prog. Devt.	Community participation Impact assmt.	Reliance on donor support, Marketing function, Efficiency of operation
CRS	Board, Mission, Goal	Sectoral expertise	Commitment and strategic thinking	M&E, Prog. Devt.	Community participation Impact assmt.	Alternatives to donor financing, Income generating enter., Efficiency of operation

**On strengths**, generally, the three partners cited clear understanding on the mission and goals of their organization and effective leadership. They also mentioned that the organization have enough expertise on specific fields of services and commitment. As to sustainability, the common response relates to the ability of the organization for strategic thinking efficiency of operation and commitment.

**On weaknesses**, the three partner organizations commonly cited the following: ensuring community participation, appropriate organizational structure, coordination between units in the organization, effective planning, monitoring and evaluation process and appropriate management styles (i.e., centralized decision-making). Some specific weaknesses were pointed-out on the dependency for funding assistance from donors, inadequate field allowances (i.e., per diem and transportation), financial management systems and lack of logistics and facilities.

- *Joint Formulation of the Detailed Implementation Plan*

Series of workshops and meetings were facilitated with partners in the development of the Detailed Implementation Plan. The process started with the conduct KPC and OCAT, presentation of highlights of the two studies and, a 5-day planning workshop detailing targets and strategies and roles and responsibilities of the partnerships in the overall implementation of the project.

The significant achievement on this aspect is the common understanding on the overall development framework of the project (i.e., vision, goals, objectives, targets and strategies) by

partners at all levels. Specifically, the partners were able to set their targets and plan of action according to their pace and expertise. They were able to internalize how they are going to contribute to the overall implementation of the project.

- *Initial Institutionalization of the Partnerships*

The Project ensured that the partners have understood their roles and responsibilities in the implementation of the Project. Series of workshops and meetings were facilitated to discuss specific roles and coordination process specifically at the community-level health and development interventions. A Health Working Group (HWG) composed of ten (10) members (IPHO-3, KFI-3 and MCSP-4) was formed. The HWG was perceived as the overall coordinating body that will provide direction of project implementation specifically in planning, monitoring and evaluation. The HWG shall also serve as a regular venue for interaction and sharing of lessons and experiences of project implementation. The group agreed to meet on a quarterly basis of which the first meeting was held on May 5 2001.

- *Preparation for Barangay Entry/Mobilization Phase*

Series of meetings were facilitated with the Partners in the preparation of Barangay entry. A 2-day workshop was also facilitated to define the community development framework or process for MCSP and the coordination and/or complementation process specifically at community-level activities. During a two-day Barangay Entry Planning Workshop, the partners agreed that KFI shall be mainly in community organizational building and/or strengthening of community organizations for community health and development mobilization. The IPHO shall provide the needed technical (medical) skills in the implementation of various health activities (i.e., as resource persons in training, immunization, health education, etc.) according to the overall health and development direction of the community. In the process the IPHO is expected to enhance their health delivery systems toward a sustainable and community-based manner. The KFI-CO shall be mainly responsible in ensuring that community activities are not fragmented that it should generally relate in meeting the health goals of the community. The CRS, apart from ensuring timely release of funds, shall provide overall technical assistance and direction of project implementation according to the Detailed Implementation Plan. Specifically, it shall provide technical assistance, constant advise and, strategies on community health mobilization and development process and health education (i.e., for behavioral change).

The number (45) was decided by the partners mainly on the limitation of capacity of the KFI-COs to undertake the community organizing/community development process (i.e., ensuring community participation in project implementation and management). The KFI-CO is expected to work or coordinate closely with the Rural Health Midwives (RHMs) of the IPHO. One RHM usually covers 4-5 Barangays as their catchment areas. With a partner CO, it is perceived that both can cover on the average 9 Barangays per municipality thus the number of 45 Barangays. The actual number of Barangays per municipality was proportionately selected following the formula below:

No. of Barangays Per Municipality <hr style="width: 30%; margin: 0 auto;"/>	x 45 Pilot	= No. of Barangays for
Total No. of Barangays in 5 Municipalities	Barangays	Comm. Mobilization
For MCSP Implementation (76)		

The table below shows the total number of Barangays for overall MCSP health interventions and for community health and mobilization:

Municipality	MCSP Health Interventions	For Community Health and Mobilization
1. Sultan sa Barongis	21	12
2. Talitay	11	7
3. Kabuntalan	22	13
4. Mamasapano	15	9
5. South Upi	7	4
6.		
<b>Total</b>		<b>45</b>

The 45 pilot Barangays were selected based on some criteria established and agreed by the partners. Among the criteria used in the selection process were: a) prevalence and degree of child's mortality and morbidity and other vital health data; b) acceptance and commitment of the community to participate and share resources; c) evident absence of basic health facilities and services; d) topographical condition and accessibility (i.e., it is not practical to cover communities that are hard to reach even on foot); and e) presence of active barangay health workers or potential community health volunteers. The criterion on peace and order condition was not given much weight since the peace and order condition of the entire province is always fragile.

Barangay entry plans were also jointly formulated with KFI-COs and their RHMs counterparts at the RHU level. The RHMs were considered as the main partners of KFI-COs at community level activities.

- *Conducted Health Facility Assessment*

The Health Facility Assessment was conducted to provide baseline data on the availability and adequacy of drugs, supplies, and services in the target municipalities. A total of 19 out of 23 facilities in the five target municipalities were assessed. Four of the facilities were not accessible at the time of the survey due to the impassable roads caused by heavy rains. A

checklist was used to assess the facilities' capability to deliver the basic health services. Information on the facility's staff complement, health services offered, type of equipment, available, drugs, medicines and IEC materials were gathered. Results of the HFA revealed inadequacies on staff complement, physical infrastructures, supplies, drugs, medicines and IEC materials in the facilities surveyed.

### **C. Implementation Phase**

The implementation phase of the project started from the actual community entry and capacity building activities and/or training interventions for IPHO and KFI partners. The milestone accomplishments during this phase are as follows:

- *KFI-COs immersion, barangay orientation and formation of community health core groups or volunteers*

One KFI-CO is assigned per municipality handling nine or more communities except South Upi, which has only 4 pilot communities. From May to June 2001, the COs started the community organizing process through initial immersion in the communities. The COs met with the local leaders and introduced the project and, initially discussed with them the role and participation of the community in the overall project implementation. Community volunteers to form as the community health core group were also identified and organized during the immersion process. The community volunteers totaled to over a hundred members averaging 2-3 per community. These volunteers are mostly Barangay Health Workers and some women local leaders selected by the community. They are expected to assist the COs and the RHMs in the overall community mobilization activities of the project. Also during the period, the COs completed the Barangay project orientation of which the general community was briefed on the overall purpose and strategy of the Project. All the 45 pilot communities signified their willingness to participate with the project.

- *Municipal orientations and formation of municipal support teams*

The Project was successfully launched and introduced with all the five Municipal Local Government Units (MLGUs) through the Mayors, council members and heads of agencies. The MLGUs were happy that a health and development project will be implemented in their Municipality noting the need to improve the overall health condition and welfare of children. The Mayors and some council members have manifested their cooperation with the project and appointed 2-3 MLGU staff to closely coordinate and assist the implementation of the project at the community level. These MLGU staff is mostly coming from the Planning, Agriculture, and Social Services and from the Mayor's Office itself. This MLGU staff will form part as the Municipal Project Support Teams who will coordinate in the overall implementation of the project and eventually serve as a channel for the integration and sustainability of the project at the Municipal level.

- *PRA training for core group member*

Participatory Rapid Appraisal training was conducted with a total of 100 selected community core group members and 25 RHU staff mostly RHMs and PHNs. The training was a 5-day activity that taught the participants the various methodologies in gathering basic health data in a rapid but participatory manner. The data that were organized and designed for PRA pertained to child's health care, access to health services, source of living of the households and community organizations information.

The first 3 days was spent for classroom discussions and the last 2 days for practicum and re-entry planning. The PRA training was designed to ensure community participation in gathering of basic health data as aid to community health planning. During the re-entry planning, the participants formulated strategies in facilitating the PRA in their respective communities. The actual PRA for all 45 communities was scheduled for completion by January 2002 followed by community health planning process.

- *IPHO trainings conducted*

The over-all goal of the project will only be materialized if mainly the entire technical system supporting the manpower of the partners is improved. One of the major strategies of the project is to enhance the technical capacity and skills of IPHO partners especially the Municipal level health care givers to effectively contribute to the improvement of the health status of the target communities.

For IPHO, a total of 10 trainings have been conducted for this year commencing with a five day training on Breastfeeding Counseling last July 9-13, 2001. This highlighted the local situationer on Breastfeeding as well as its importance and the steps, ways of the proper practice of Breastfeeding. 27 participants attended the training from IPHO (nurses, midwives & MHOs). This was followed by Total Quality Management (TQM), as IPHO's way to establish client satisfaction in delivering quality health care services. Twenty-five health personnel attended this 5-day training last August 27-29, 2001. Disease Surveillance came next as priority training last August 30-31, 2001. This focused more on establishing EPI surveillance system, Polio eradication, Neo-Tetanus elimination and Measles control.

As the MCSP is designed to complement IPHO's plan to introduce a facility-based strategy for the Integrated Management of Childhood Illness, a Training of Trainers for Community Integrated Management of Childhood Illness (ToT-IMCI) was conducted last August 6-10, 2001 for 11 IPHO personnel.

The following Table describes the training facilitated from July to September 2001.

Table : TRAININGS CONDUCTED BY IPHO

TITLE	DATE CONDUCTED/ DURATION	PARTICIPANTS	CONTENTS	METHODS USED	EVALUATION METHODS
Breastfeeding Counseling	5 days July 9-13,2001	27 nurses, MHOs, midwives	<ol style="list-style-type: none"> <li>1. Local breastfeeding situation</li> <li>2. Importance of BF</li> <li>3. How BF works</li> <li>4. Assessment</li> <li>5. Positioning</li> <li>6. Building support</li> <li>7. Breast conditions</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecture-discussion</li> <li>2. Clinic practicum</li> <li>3. Small Group Discussions</li> <li>4. Role plays</li> <li>5. Reading exercises</li> </ol>	Use of Questionnaire
Total Quality Management	3 days August 27-29,2001	25 participants	<ol style="list-style-type: none"> <li>1. Implementing total quality</li> <li>2. Real meaning of quality</li> <li>3. Personal leadership</li> <li>4. Personal insights profile</li> <li>5. Continuous improvement</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecture-discussion</li> <li>2. Group sharing</li> <li>3. Group presentation</li> </ol>	<ol style="list-style-type: none"> <li>1. Processing</li> <li>2. Use of questionnaire</li> </ol>
Disease Surveillance	2 days August 30-31, 2001	30 participants	<ol style="list-style-type: none"> <li>1. Establishing EPI surveillance system</li> <li>2. Polio eradication</li> <li>3. Neonatal Tetanus elimination</li> <li>4. Measles control</li> <li>5. Prioritizing surveillance activities</li> <li>6. Supplemental immunization activities</li> </ol>	<ol style="list-style-type: none"> <li>1. Pretest</li> <li>2. Lecture-discussion</li> <li>3. Small group discussion</li> <li>4. Practical exercises</li> <li>5. Case studies</li> </ol>	Use of Questionnaire

Training of Trainers for Community Integrated Management of Childhood Illness (ToT-IMCI)	5 days August 6-10,2001	11 IPHO staff	<ol style="list-style-type: none"> <li>1. Introduction of Facilitators Guide</li> <li>2. Module: Introduction</li> <li>3. Assess &amp; classify the sick child age 2 mos-5 yrs</li> <li>4. Identify Treatment</li> <li>5. Treat the child</li> <li>6. Counsel the mother</li> <li>7. Management of sick young infant</li> <li>8. Follow-up</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecture-discussion</li> <li>2. Group participation &amp; presentation</li> </ol>	Immediate Feedbacking and Processing
Control of Diarrheal Diseases (CDD) Home Management	2 days/ 2 batches August 30-31,2001 September 6-7,2001	35 BHWs	<ol style="list-style-type: none"> <li>1. Patho-physiology of acute diarrhea</li> <li>2. Epidemiology and causes</li> <li>3. Preventive measures</li> <li>4. 3 Fs on treating diarrhea</li> <li>5. Use of ORT</li> </ol>	<ol style="list-style-type: none"> <li>1. Use of instructional modules</li> <li>2. Lecture</li> <li>3. Group discussion</li> <li>4. Demonstration</li> <li>5. Role play</li> </ol>	Use of Questionnaire
Pneumonia Management	3 days/3batches August 27-27,2001 September 3-5,2001 November 5-7,2001	15 BHWs/batch	<ol style="list-style-type: none"> <li>1. Assessment</li> <li>2. Classify the illness (2 mos-5yrs)</li> <li>3. Classify the illness (less 2 mos)</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecture-discussion</li> <li>2. Exercises using videotapes, other visuals like chart</li> </ol>	<ol style="list-style-type: none"> <li>1. Use of Questionnaire</li> <li>2. Evaluation checklist/tool</li> <li>3. Immediate feedbacking</li> </ol>

Basic IMCI	11 days September 17-28,2001  14 days October 16-30,2001	24 participants - MHOs, PHNs, RHMs  20 pax	<ol style="list-style-type: none"> <li>1. Introduction IMCI</li> <li>2. Assess &amp; classify the sick child</li> <li>3. Identify treatment</li> <li>4. Treat the child</li> <li>5. Counsel the mother</li> <li>6. Management of sick young infant (1 week –2 mos)</li> <li>7. Follow-up</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecture-discussion</li> <li>2. Exercises for clinical information</li> <li>3. Use of videos &amp; photographs</li> <li>4. Use of other visuals, flipchart, booklets, modules</li> <li>5. On-site visit &amp; observation to health centers</li> </ol>	<ol style="list-style-type: none"> <li>1. Immediate feedbacking</li> <li>2. Use of Questionnaire</li> </ol>
EPI Basic Skills	3 days November 5-7, 2001	30 IPHO staff	<ol style="list-style-type: none"> <li>1. EPI thrusts 2001-2004</li> <li>2. Introduction</li> <li>3. Cold chain &amp; Logistics management</li> <li>4. How to give vaccines</li> <li>5. Preparing the immunization</li> <li>6. Conducting immunization session</li> </ol>	<ol style="list-style-type: none"> <li>1. Group discussion</li> <li>2. Brainstorming</li> <li>3. Role playing</li> <li>4. Modular reading</li> <li>5. Exercises</li> <li>6. Demonstration &amp; return Demonstration</li> <li>7. Case study</li> <li>8. Practicum to health centers</li> </ol>	Use of Questionnaire
Cold Chain Management	2 days November 7-8, 2001	25 IPHO staff	<ol style="list-style-type: none"> <li>1. Provincial cold chain status</li> <li>2. Managing effective cold chain system</li> <li>3. Vaccine calculation</li> <li>4. Vaccine Vial Monitor</li> <li>5. Safety of injection</li> <li>6. Modification of local refrigerator</li> <li>7. CFC effect on cold chain</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecture-discussion</li> <li>2. Workshop</li> <li>3. Demonstration &amp; Return-Demonstration</li> </ol>	Use of Questionnaire

<p>Basic BHW Training</p>	<p>5 days November 12-16, 2001</p>	<p>23 pax</p>	<ol style="list-style-type: none"> <li>1. Problems of Women &amp; Child &amp; the role of BHW</li> <li>2. Care during Pregnancy/ Post Partum Care</li> <li>3. Family Planning</li> <li>4. Adolescents Fertility</li> <li>5. Sexually Transmitted Diseases</li> <li>6. Women's Health</li> <li>7. Growth Monitoring &amp; Promotion</li> <li>8. Breastfeeding</li> <li>9. Health Care of Children Food &amp; Nutrition</li> <li>10. Expanded Program on Immunization</li> <li>11. Control of Diarrheal Diseases</li> <li>12. CARI</li> <li>13. Common Illness &amp; Social Problem among Children</li> <li>14. Knowing &amp; Supporting the People I Serve</li> </ol>	<ol style="list-style-type: none"> <li>1. Lecturette</li> <li>2. Group work discussion</li> <li>3. Demo/Return Demo</li> <li>4. Role Play</li> <li>5. Presentation</li> </ol>	<ol style="list-style-type: none"> <li>1. Use of Questionnaire</li> <li>2. Immediate Feedbacking</li> </ol>
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- *Health Education*

Health Education is one potent vehicle of MCSP to achieve sustainable impact in the community. Through this strategy, the project stakeholders hope to see positive behavior change among the members of MCSP targeted communities within four-years of project implementation. To make this more relevant, appropriate and attune to the reality of the communities, a quantitative and qualitative study was conducted last February-March 2001 to gain insights from mothers and caregivers and also from the health workers regarding their beliefs, perceptions, attitudes and behaviors in relation to the identified child survival interventions. The LGUs and Barangay Leaders were also included in the study in order to gain information regarding their capability to manage health and nutrition project in their respective areas of responsibility.

Results of the study revealed the importance of information, education and communication (IEC) in meeting the objectives of the project. The MCSP has considered IEC as one of the MCSP interventions. IEC can help promote child survival, growth and development among identified target audiences. Recognizing the importance of IEC in changing the behaviors of caregivers, health workers and local leaders, a workshop on the development of Behavior Change Communication (BCC) Plan was conducted by Helen Keller International for the MCSP. This gave the participants an opportunity to work together and analyze the health and nutrition situation in the five municipalities utilizing the results of the study and the secondary data. The workshop allowed them to identify communication problems and objectives and develop messages for the identified target audiences. They were also able to describe IEC materials to be developed as well as develop timeline for the implementation of BCC Plan. The prototypes of these IEC came out in October and subsequently pre-tested on the same month.

- *Enhanced team approach to project implementation through partnership meetings and team-building activities.*

Aside from workshops and meetings during the pre-implementation phase, a total of 7 meetings and workshops were facilitated with partners. The meetings were intended to define further the interaction/partnership approach and, the systems and mechanisms to project implementation. Among the most important workshop facilitated was the Management Information System (MIS) workshop. The workshop clarified the various tools and methodologies in tracking progress of health interventions/services at the community level. It was clarified during the workshop that MCSP will pattern and enhance the monitoring tools already used by IPHO. The tools include the Midwife's field records as to immunization coverage, monitoring of child's growth, maternal care, etc. These records are the main bases in the monitoring and consolidation of reports from RHU level up to the IPHO level. A supervisory check-list was also discussed during the workshop and could be further enhanced based on key capacities expected to be improved

during the life of the project. On the other hand, only one HWG meeting was facilitated. The meeting established the role of the HWG as the overall coordinating body and a venue for sharing of field-level project implementation experience.

- *Procured drugs, medicines and supplies*

For year 1, most of the basic medicines and supplies were procured to beef up the project implementation. All these medicines and supplies were distributed to the five (5) RHUs and BHS. The medicines are expected to complement with the supplies of IPHO to reach to the most needy families in the target communities particularly to prevent Pneumonia and Diarrhea.

- *Inter-project visits at project-related organizations at Visayas and Luzon.*

Two inter-project visits were facilitated during the year, such as: for health finance schemes and, the hearth nutrition model and community weighing post. The visit was aimed at gathering insights and knowledge from various health organizations particularly on their experience to institutionalize finance schemes for sustainability in the delivery of basic health services for their members and, the community organizing/mobilization process in the establishment of hearth nutrition and community weighing post. The CRS-MCSP organized the visit participated by project partners and MCSP staff. The main objective of the visit was to provide participants the opportunity to interact with the key staff and implementers of the organizations and learn from them their methods and strategies in the implementation of their program and identify replicable models for MCSP communities. The organizations visited for the health finance schemes were; 1)Philhealth; 2)Pasay Health Passport; 3)Tarlac Health Maintenance Cooperative (THMC); 4)Mother and Child Community Based Integrated Project; and, the 5)Bayawan City Peso for Health at, Negros Oriental. For the Hearth Nutrition and Community Weighing Post, the Pearl S. Buck Foundation at Ormoc City was visited.

Generally, as gathered from the participants, the following programs could be replicated at MCSP communities:

- ✓ The Peso for Health Model – Basically, this model encourages the community to put family health as one of the priorities for the household's budget and/or concerns. The scheme involves application for membership and paying regular contribution in cash or in-kind. The amount of the contribution depends on the category of health services that the members can avail. However, all members can avail of the basic health services such as regular medical check-up and immunization for children. This model is basically a health insurance scheme adjusted according to the capacity of members.

- ✓ The Tarlac Health Maintenance Cooperative (THMC) and the Mother and Child Community Based Integrated Project – These two schemes again are another type of health insurance in a cooperative and community-based manner. The scheme is to gather or encourage formal membership and regular contribution. The health services that the members can avail of depend on the category of the members and, can be availed at any accredited hospitals and private clinics.

Generally, the participants noted that the success of the various health finance schemes and, the hearth nutrition and community weighing post largely depends on education campaign, community understanding and participation and, support of the local government units. It was further noted that the health finance schemes could be very difficult to introduce especially in communities that are used to the dole-out system of health services.

- ✓ The Hearth Nutrition and Community Weighing Post – These particular community health interventions are mainly intended for children. The Hearth Nutrition is a feeding activity with organized mothers using indigenous foods and improved preparation. The weighing post is the establishment of highly accessible physical center equipped with basic supplies and equipment where the growth and health of children are monitored. The center shall be established with high community counterpart or participation.

Generally, the adoption of these two models requires parallel community organizing process where the community shall be facilitated to understand and feel ownership of the activity through active participation from planning, implementation to monitoring and evaluation.

- *NGO networking and complementation meetings*

One NGO complementation and networking meeting was facilitated during the year. Three NGOs who were also working in one of the target Municipalities of the project attended the meeting. The NGOs agreed to coordinate and complement expertise and resources for the alleviation of the health condition of children. KFI was tasked to for the continued coordination meeting.

- *Continuing project monitoring and partnership meetings*

The MCSP with the partners (IPHO and KFI) conduct regular field monitoring and provide technical assistance to partners at the municipal level. The field monitoring enables the partners to gather immediate lessons and insights of field level implementation.

#### **D. Strengths and Factors that contributed to these Accomplishments**

During a one-day project assessment with partners, factors cited that contributed to accomplishments are as follows:

- *Committed and skilled personnel and technical assistance*

Both the IPHO and KFI partners cited these conditions as the main contributing factors for the successful implementation of the planned activities. For IPHO, they particularly noted the long-years experience of the Municipal health staff in working with depressed and hard to reach communities. For KFI, they cited the commitment and cultural integration of its CO with the community. The KFI-COs are also very familiar with the issues and the socio-cultural condition of the community that facilitated smoothly their entry and integration with the local folks. Furthermore, for KFI, the constant technical assistance (from MCSP) added the condition in achieving the targets of the project.

- *Defined process and systems in community mobilization and training (capacity building)*

Among the systems or process cited by the partners were the roles and responsibilities of each partner at barangay level activities, the Barangay selection criteria, the Barangay entry and, the training approval flow. The KFI, particularly cited the availability of secondary data in classifying the barangays during the selection process. This according to them facilitated smoothly the implementation of activities.

- *Active participation and coordination among partners*

The KFI specifically cited the active coordination and teamwork between IPHO-KFI field staff as one of the major factors that facilitated smoothly the community-level activities. Generally, the project noted that there is now a good working relationship and coordination between KFI and IPHO at Municipal and Barangay level activities. This is a result of the constant meeting and informal discussions at the Municipal (RHU) level between the KFI-COs and the RHU personnel particularly the MHOs and the RHMs. The KFI-COs made it a practice to always update and inform the MHO on their day-to-day activities at the Barangay level. The IPHO, on the other hand, always responded positively to any assistance requested by the COs.

The Health Working Group (HWG) was also noted as a significant factor for effective coordination, planning, strategizing and monitoring. The diverse composition of the HWG provides well-thought plans, strategies and relevant inputs towards the overall project implementation and direction.

- *Merit of the Project and potential benefits that can be derived by the community*

This factor pertains to the project itself that according to the partners is a very relevant input to improve the health condition of the very depressed Muslim communities of Maguindanao. They cited that health is the only very visible development programs from the government and, that there are still many communities needing basic health services. Because of the potential benefits that can be derived from the project, the piloted communities did not hesitate to accept the project.

- *Credibility of implementing organizations*

The Kadtuntaya Foundation Inc. (KFI) is a credible and well-known development organization working with Muslim communities in the province for long years. This contributed significantly towards community's ready-acceptance to the project. On the other hand, the IPHO is the most highly visible government program in the countrysides especially at the very hard-to-reach communities.

## **E. Constraints and Actions Taken**

Among the major constraints mentioned by the partners are:

- *Time and timely release of funds*

This particular factor was cited by IPHO. They felt that with their other plan of activities in accordance with the IPHO's own targets; they are running after time particularly in the implementation of MCSP's training activities. However, as project implementation progresses, they said that they were able to cope-up with the situation by "carefully and properly" planning their activities. IPHO also cited that delayed released of funds affected the implementation of their planned activities. This was true during preparation of the DIP where series of consultations and workshops ate up much of the time of the pre-implementation phase.

Financial recording and reporting systems were enhanced with IPHO for timely released of funds in the future.

- *External factors like accessibility, political issues, peace and order, etc.*

One of the major constraints cited by the partners could be considered as external factors beyond the control of the project. This includes problems on accessibility of some communities especially during rainy season. Two of the covered Municipalities for instance are very prone to flood. The political issues are the

still unresolved mayoral position of two of the Municipalities and the constant absence of some of the Barangay Captains (some resided in town centers and in the City). These issues are also compounded with the unstable peace and order condition of the entire province.

The only action taken mentioned especially by the KFI-COs were their double-time effort, hard work and patience. As to the political issue, they “doubled-up” their effort and mobilized other leaders and personal contacts who could help them in getting support from the Municipal and Barangay officials. Careful planning and constant follow-ups also helped them in getting the necessary support from MLGU and the community.

- *Delayed formulation of some of the guidelines such as the selection criteria.*

This issue was due to the needed participatory process in coming-up with the formula and criteria in selecting the pilot Barangays. This was addressed by facilitating series of consultations and planning with the partners. An intensive workshop was also facilitated that established the process and strategies for community entry and community development activities.

## **F. Areas Needing Technical Assistance**

For IPHO, the areas needing technical assistance are:

- Conduct of TOT on Community IMCI and implementation.
- Training and facilitation of Hearth Nutrition Model.
- Facilitation of the Advocacy Training.
- Close coordination and technical assistance in facilitating the health education/IEC strategy.
- Enhancement and application of appropriate MIS

Generally, IPHO staff showed commitment, competence and skills in the implementation of the Project. What the project perceived that needs further assistance could be in terms of improving training methodologies (e.g., employing more participatory methods in the conduct of training and visuals) and monitoring. Moreover, the project perceived that technical assistance in the documentation and reporting of training conducted is also needed. Likewise, follow-up strategies and/or formulation of monitoring plan on the impact and effectiveness of training is seen to be an important input on the training program of IPHO.

For KFI, the following aspects were cited as needing technical assistance:

- Enhance the Community Organizing skills and knowledge of the COs through formal and intensive CO training. It was suggested that CRS-MCSP should organize and facilitate the training probably with some external facilitators.
- Facilitation of the Advocacy Training
- Constant technical assistance and support on community organizing/community development process (CO/CD).
- Joint field monitoring as to the CO/CD process.
- Enhancing the capacity of the MLGUs in adopting and sustaining the project through assistance in facilitating relevant training and workshops

Generally, the KFI-COs needs to internalize the community development (CD) framework for MCSP in order to tie-up all their field activities into the whole logical framework of the MCSP-CD process. This means that constant technical assistance in terms of informal meetings and workshops and monitoring should be extended for the COs. Likewise, the KFI-COs needs to be closely assisted specifically in utilizing participatory tools and methodologies in facilitating community meetings and trainings. Field level monitoring and immediate feedback shall be conducted regularly to improve CO methodologies and enhance skills.

## **G. Challenges/Issues**

Apart from the constraints experienced by the project, some of the perceived issues and concerns of the Project that might affect the overall project implementation are:

- *Barangay and MLGUs' absorptive capacity in sustaining the Project (i.e., health development planning and IRA utilization)*

One of the major strategies of the Project is to institutionalize health programs and services at the MLGU and Barangay level. However, it is widely perceived that most of the MLGUs of Maguindanao Province lack comprehensive understanding on the planning and proper utilization of their Internal Revenue Allotment Funds. Supposedly, 20% of the IRA is intended for social development including health but most of the MLGUs spent all this to personnel and other maintenance activities (i.e., garbage collection and drainage maintenance). Likewise, there is a need to improve the overall planning process of the MLGU and the BLGU. This is going to be a tall order for KFI and the overall project itself – how to fully mobilize the local government's resources and capabilities for health and development.

- *Anticipated big or macro projects in relation to health priorities*

At initial glance and, as a result of community immersion and discussion with the local leaders and residents, major health-related and development problems already surfaced. This includes food security, access roads, health facilities, water system, drainage system, etc. This type of development activities needs referral and/or support from the LGU and other agencies. This would mean extra effort and community organizing strategies on the part of the KFI-COs.

- *Ensuring women's participation in community organizations*

In Muslim culture specifically in rural communities, most of the women are relegated at the background especially at community organizational activities. The women are assigned mostly at household chores and caring for the children. This is anticipated as a constraint especially in community mobilization and organization.

### **Part 3. Changes from the Program Description and DIP**

There were no substantial changes on the Program Description and DIP that will require a modification to the cooperative agreement.

### **Part 4. Issues rose during DIP review and actions taken**

All the issues raised during the DIP review were addressed by the Project as follows:

- *On Program Description*

All the items under the Program Description raised during the DIP review have already been corrected and incorporated in the final DIP. Among the major improvements of the DIP under this section are as follows:

- ✓ Criteria/rationale for choosing 45 out of 76 Barangays.
- ✓ Comprehensive description on the level of health facilities and staffing, including number of BHWs and proportion to be trained. The Project facilitated a health facility assessment based on a standard checklist for facilities, equipment and supplies (for RHUs and BHS).
- ✓ Results of OCAT and corresponding planned of activities
- ✓ Compilation/attachment of all training modules, maps, survey reports and tools
- ✓ Comprehensive discussion on community mobilization strategy as a process for community participation and sustainability.
- ✓ Attachments such as training manuals, survey results and tools, maps, etc.

- *Program Management*

The only modification on this section was the formation of the Health Working Group who will assist the Program Management as to the overall direction of the project. Specifically, the HWG shall serve as a venue for exchange of lessons learned and technical and social inputs in the overall implementation of the project.

- *Technical Section*

The major improvements on this section are the discussion on community-IMCI and the Behavior Change Communication Plan. On this section, major strategies and specific plan of action in the implementation of the Community-IMCI was thoroughly presented. This involves series of training and follow-through activities for the effective installation of community-IMCI. Apart from enhanced skills of field-level health workers on IMCI, it is hoped that at the end of project implementation, community-based systems and appropriate mechanism shall be installed like improvement of community-based health facilities and support from the local government units.

As to the Behavior Change Communication (BCC), a comprehensive plan was developed through a series of consultation and workshops participated by all levels of partnership. First, a 3-day workshop was facilitated with IPHO and KFI partners, selected RHMs and mothers and MLGU representatives. The workshop resulted in the development of key messages for specific audiences, type and number of IEC materials and reproduction and dissemination plan. And, second, appropriate IEC prototypes were developed and pre-tested with a sample of the target audience. Generally, the plan was developed with full participation of the partnership. It is expected that by the first quarter of the second year, the BCC plan will be fully implemented.

## **Part 5. Main Thrusts for Year 2 (Oct 2001-Sep 2002)**

Year 2 is considered to be the full implementation phase of the Project at the partnership level and community mobilization. The major thrusts are as follows:

- *Completion of all planned training programs such as:*

For IPHO: Basic IMCI second batch; T.O.T for TBAs; TBAs Training; VAD, IDA, IDD; Maternal Care; Follow-up Training on IMCI; EPI Basic Skills; Cold chain management; Total Quality Management; BHW Pneumonia management;

CDD Home Management; Community IMCI; Community IMCI for RHM for BHWs; TOT Community IMCI; and, Hearth Nutrition Model.

For KFI with communities: Community Organizing; Advocacy Training; Leadership; Participatory Planning, Implementation, Monitoring and Evaluation (PIME); and, Local Governance

- Full implementation of HE/IEC activities such as: Reproduction and dissemination of IEC materials; Caregivers class; Radio Plugging; and, Bench Conferences. In the early part of the year, all IEC materials shall be reproduced and disseminated to intended audiences as identified in the BCC plan. Likewise, continuing monitoring shall be conducted by MCSP for any appropriate improvements or changes.
- Full community mobilization activities. This includes facilitation of community health planning and implementation of priority health and development projects. Community organizational strengthening and other relevant training shall be also facilitated. Parallel with the community mobilization is the introduction of the hearth nutrition, community weighing post and, initial process for health finance mechanisms.
- Full or continuing procurement of medicines/drugs and supplies, such as: CSP supplies; Fe SO<sub>4</sub> to pregnant and lactating mothers; Vit A to UFC and lactating women
- Implementation of the hearth model and community weighing post. At the second quarter, series of consultation and community planning shall be facilitated for the introduction of the hearth nutrition model and the community weighing post. By third quarter, it is expected that these two health interventions shall be fully implemented.
- At the late part of the year, the KFI-COs shall gradually introduce the idea of health finance scheme as a community-based sustainability mechanism. This could include consultations and meetings with community leaders and organizations and, inter-project visits.
- Continuing HWG meetings and informal workshops and meetings.
- Continuing monitoring and technical assistance at the community level health activities/mobilization and strengthening of partnership and support from the MLGUs.