

CLASSIFICATION
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE 5199791281501 PL 480, TITLE II	2. PROJECT NUMBER PL 480, Title II	3. MISSION/AID/W OFFICE EL SALVADOR
	4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 78-103 <input type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING A. Total \$ 30 millones B. U.S. \$ 30 millones	7. PERIOD COVERED BY EVALUATION From (month/yr.) January 1973 To (month/yr.) May 1978 Date of Evaluation Review December 1978	
A. First PRO-AG or Equivalent FY 62	B. Final Obligation Expected FY (cont.)	C. Final Input Delivery FY (cont.)			

B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
Implement all recommendations regarding program policy, development, and operation as described in Section VII B of the evaluation. The recommendation to translate the evaluation into Spanish has already been implemented.	Dale Gibb	June 30, 1979

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9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT	
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change	
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T		B. <input checked="" type="checkbox"/> Change Project Design and/or	
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)	<input checked="" type="checkbox"/> Change Implementation Plan	
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P		C. <input type="checkbox"/> Discontinue Project	

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles) Dale Gibb, Chief Health & Population Division USAID	12. Mission/AID/W Office Director Approval Signature: <i>Aldelmo Ruiz</i> Typed Name: Aldelmo Ruiz USAID Director Date: 12/20/78
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EVALUATION OF THE PL 480 TITLE II PROGRAM

IN

EL SALVADOR

1978

J.Q. Cotten: USAID Evaluation Officer

E. Brineman: USAID Nutrition Advisor

May 17, 1978

El Salvador



Revision No. 353
December 1974

EVALUATION OF THE PL 480 TITLE II PROGRAM

IN EL SALVADOR

1978

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I. INTRODUCTION

A. Purpose

The purpose of this evaluation was to identify or corroborate objectives of the PL 480 Title II program in El Salvador, to determine with what degree of effectiveness they are being achieved, and to make recommendations for improving program implementation.

B. Scope

The evaluation was limited to a review of the MCH program at the level of the local centers where food is distributed. The primary focus was on distribution center operations and management, and compliance with the PL 480 Title II policies concerning targeting and nutrition education.

C. Methodology

In conformity with AID's increasing emphasis on "collaborative style" and involvement of intermediaries, the design and implementation of the PL 480 Title II program evaluation was undertaken as a joint effort of all agencies involved in supplementary food distribution in El Salvador. Unlike some previous USAID evaluations, which were conducted by outside contractors ^{1/} with the participation of Mission and AID/W personnel only, the current evaluation involved USAID, GOES and CRS/CARITAS personnel directly in all phases of the evaluation.

The collaborative process included a number of activities. First, a Scope-of-Work and implementation plan were prepared and discussed by USAID and CRS. The implementation plan called for the establishment of a working group composed of personnel from all implementing agencies. (See Table I) In the initial meetings the working group developed illustrative Logical Frameworks as a means of identifying and corroborating program objectives. The original intent of this exercise was to develop a Multi-year Plan, using the Logical Framework as the common vehicle for organizing information and standardizing design concepts. This objective was not achieved, partly because of the diversity of the agencies involved, and partly because of the limited planning experience of the participating personnel. However, the design exercise did serve as a pedagogical tool which contributed to a better mutual understanding of the policies and objectives of the Title II MCH program on the one hand, and the objectives and operations of the implementing agencies on the other hand. In the course of the initial meetings, held in November and December 1977, it was determined that, given the resources available, the scope of the evaluation would be limited to a survey of MCH program management practices at the level of the local distribution center.

^{1/} In July 1971, Robert R. Natham Associates, Inc. carried out a four week evaluation of the PL 480 Title II program in El Salvador at a cost to

Next, a questionnaire was designed and a random sample of distribution centers was selected. Supervisory personnel from CRS/CARITAS, the Ministry of Health and USAID staff participated in field testing the questionnaire prior to launching the full survey.

The survey was done in two phases during January and February of this year. The information collected pertained to program operations during the 1977 Calendar year. Phase I involved interviews with available personnel at 40 distribution centers operated by the five regional Dioceses, the Ministry of Agriculture (MAG), the Instituto Salvadoreño de Transformación Agraria (ISTA), and the Office for Improvement of Marginal Communities (OMCOM) of the Ministry of the Presidency. 1/ Phase II involved a survey of 24 Ministry of Health facilities in all five health regions of the country.

TABLE I

EVALUATION COMMITTEES

<u>Expanded Committee</u>		<u>Working Group</u>	
Joel Cotten	AID	Joel Cotten	AID
Elena Brineman	AID	Elena Brineman	AID
Sylvie Kulkin	AID	Sandra Callier	MOP
Sydeny A. Chernenkoff	AID	Anthony Nolan	CRS
Sandra Callier	AID/MOP	Laura Guzman	CRS
Anthony Nolan	CRS	Sandra Jimenez	CARITAS
Laura Guzman	CRS	Tatiana Osegueda	MOH
Ana Mercedes Martinez	CRS	Elizabeth de Barahona	ISTA
Sandra Jimenez	CARITAS	Blanca Rosa de Lemus	OMCOM
Alberto A. Reyes R.	CARITAS	José A. Bolaños	UCS
José A. Bolaños	UCS		
Nicolás A. Navarrete	ISTA		
Elizabeth de Barahona	ISTA		
Tatiana Osegueda	MOH		

Field Team

Joel Cotten	AID	Pedro A. Casco	CARITAS
Elena Brineman	AID	Tatiana Osegueda	MOH
Laura Guzman	CRS	Cladyz Martinez	MOH
Sandra Jimenez	CARITAS	Kye de Arrivillaga	MOH
Orlando Gonzalez	CARITAS	Rosa E. Hernández	MOH

1/ The Unión Comunal Salvadoreña (UCS), which has been distributing food under the agreement with CARITAS, was eliminated from the survey because its program was terminated.

D. The Survey Sample

Phase I

CARITAS distributes Title II foods through 382 centers nationwide including facilities of the Ministry of Agriculture, OMCOM and ISTA under separate working agreements. The Phase I survey sample was stratified by the number of organizations working under formal agreement with CARITAS as shown in Table 2.

TABLE 2

<u>Organization</u>	<u>Number of Centers</u>	<u>Sample Size</u>
Diocese San Miguel	111	11
Diocese San Salvador	62	6
Diocese Santa Ana	97	8
Santiago de María	42	4
Diocese San Vicente	37	4
OMCOM	29	3
ISTA	4	4
	<hr/>	<hr/>
TOTAL	382	40
	=====	=====

Phase II

CARITAS also has an agreement with the Ministry of Public Health (MOH) to distribute food through its 242 health centers. For health service delivery administration purposes the country is subdivided into five health regions. Therefore, the Phase II (MOH) survey sample is stratified by health region as shown in Table 3.

TABLE 3

<u>Region</u>	<u>Number of Centers</u>	<u>Sample Size</u>
I Occidental	40	4
II Central	56	6
III Para-Central	47	5
IV Oriental	75	8
V Metropolitan	24	2
	<hr/>	<hr/>
TOTAL	242	25
	=====	=====

The total survey sample including both Phase I and Phase II, consists of 65 centers representing about 10% of the approximately 624 centers, public and private, involved in the distribution of Title II foods throughout El Salvador.

Lists of centers surveyed and maps showing their geographic distribution are contained in Annex A.

II. THE NUTRITION PROBLEM IN EL SALVADOR AND DESCRIPTION OF THE TARGET POPULATION

In 1974, the F.A.O. ranked El Salvador, along with such countries as Haiti and Bangladesh, among the countries most seriously affected by malnutrition. Recent studies by the Ministry of Health (MOH), and CARS/CDC support this conclusion and demonstrate an increase in the absolute number of malnourished children in the last ten years although percentages have not changed substantially

INCAP data, show that 74% of the children under five have some signs of protein-calorie malnutrition (PCM) as measured by the Gomez Classification (weight for age) 1/. Even more critical is the finding that 22.1% may have acute PCM as measured by Gomez grades two and three. 2/ INCAP estimates that in 1976 close to 156,000 Salvadoran children, from six months to five years of age, suffered from acute grade two and three malnutrition, while an additional 371,000 suffered from a chronic lack of food.

Differences occurring among the regions of El Salvador are more important for their variation in causes than in actual levels of malnutrition. Levels throughout range from 15.3% to 24.9% second and third degree malnutrition. The lowest occur in the urban areas and the highest in the marginal agricultural areas where most of the small subsistence farmers are located.

Infant mortality rates are generally considered to be an indirect indicator of nutritional status in developing countries, and in El Salvador they are high. According to data provided by the Ministry of Health, infant rates nationally were approximately 58 per 1,000 live births per year between 1971 and 1975. These figures are high despite the effect of known sub-registration of infant deaths, especially prominent in rural areas. The Inter-American Investigation of Infant Mortality, 1968-1970, 3/ revealed that 86% of the infant deaths in El Salvador were caused by diarrheal diseases, respiratory diseases and nutritional deficiencies. In 1974, avitaminosis and other nutritional deficiencies still ranked third after diarrhea and respiratory diseases in the five major causes of illness in children one to four years of age. 4/

In addition to PCM, anemias and vitamin deficiencies, especially vitamin A and riboflavin, affect a substantial portion of the Salvadoran population. Ministry of Health- CARS/CDC estimate that 18% of the population have low or deficient hematocrits (a test for anemia) with the greatest concentration occurring in the teenage and adult populations, both male and female.

1/ Functional Classification of Nutritional Problems in El Salvador, INCAP, 1976

2/ Gomez grade one (75-90%); grade two (60-74%); grade three (less than 60%) of the weight for age standard.

3/ Puffer, R. and C. Serrano, Patterns of Mortality in Childhood, Pan American Health Organization, Scientific Publication No. 262, 1973.

4/ Data from Ministry of Public Health, Department of Statistics.

Food Balance sheets indicate an overall deficit in both calorie and protein availability in the country. According to 1976 figures 5/ the per capita caloric consumption was estimated to be 1890 per day and the protein intake 43 grams. This compares with a country specific recommended per capital minimum of 2300 calories and 47 grams of protein.

These data when combined with income and expenditure data from the 1976 household survey 6/ suggest that at least 60% of Salvadoran families have caloric and protein intakes significantly below recommended levels. (See Mission Nutrition Sector Assessment for more detailed description of Nutritional Status).

The Target Population

The national nutritional target population are the 63% of Salvadoran families with a monthly income of less than \$300. This income ceiling includes those families living below the poverty level as defined by the U.S. Congressional Mandate and below the income level which can reasonably meet the basic needs of the average size family. There are approximately 490,209 households in the target population, 150,257 of them urban and 339,952 rural, and they include about 2,645,128 people. The target families are generally those of landless agricultural workers, small subsistence farmers, unemployed heads of households, both urban and rural, and migrants newly arrived in the marginal urban areas. This population tends to have a low educational level, poor housing, and limited access to clean water, sanitary facilities and health and educational resources.

Entire families are considered to be in the nutritionally vulnerable target population because PCM, anemias and vitamin deficiencies are distributed throughout families and are not unique to any particular sex or age group. In addition, anemia and even marginal PCM in the principal wage earner can substantially reduce work capacity and thus affect the entire family income and nutritional status. Within the family the most vulnerable to all nutritional deficiencies are the pregnant and lactating mother and the pre-school child. This special group constitutes the target population of the MCH program.

The MCH program currently administered by CRS/CARITAS distributes Food to about 110,000 MCH beneficiaries, about four percent of the national nutrition target population, and less than 15% of the approximately 927,000 economically high-risk, maternal child target group.

5/ Hoja de Balance Alimentario - El Salvador, 1976, Ministerio de Planificación del Desarrollo Económico y Social (Unidad de Alimentación y Nutrición).

6/ Encuesta Nacional de Presupuesto Familiar, Agosto-Octubre 1976.

III. HOST GOVERNMENT RESPONSE TO NUTRITION PROBLEM TO DATE

Prior to 1976 nutrition interventions were generally limited to those under the direction of the Ministry of Health, emphasizing Maternal Child Health. Rehabilitation of malnourished children and Title II food distribution in cooperation with Catholic Relief Services (CRS) and CARITAS have been the most important programs. In addition, some initial attempts at nutrition education have been made through health centers and in cooperation with home educators in the Agricultural Extension Division. Other related MOH activities have included training of food service personnel for hospital and institutional facilities, vaccination campaigns, disease control and sanitation improvement programs.

In addition, two nutritionally related food for work projects, one in community development and the other in promotion of basic grains production, are being implemented through cooperation between the World Food Program and the Ministries of Interior and Agriculture respectively.

Although the treatment of malnutrition is within its jurisdiction the MOH could not be expected to control, as no single state agency could, the major causes of the country's food and nutritional problems. Attempts were made in the early 1970's to create a national food and nutrition planning unit but these were met with little success.

Early in 1976, however, a former Minister of Health with more than thirty years experience in the nutrition field in El Salvador became nutrition advisor to the Minister of Planning and began drafting a multisectoral National Food and Nutrition Plan with the help of a Nutrition Planner from the New Transcentury Foundation. In March 1977, a Nutrition Unit was formed in the Ministry of Planning, and the first task of the Unit was the development of the First National Food and Nutrition Seminar held in September 1977. From this multisectoral seminar and prior work by the Nutrition Unit, a National Food and Nutrition Program was developed which was incorporated into the Five Year Plan (1978-1982). The Program emphasizes the following target areas:

- a. Increasing availability of basic foods for internal consumption;
- b. Commercialization of basic foods;
- c. Industrialization of enriched tortilla flour;
- d. Food and nutrition education;
- e. Health programs affecting food and nutrition;
- f. Assistance through direct feeding programs.

A multisectoral executive committee and coordinating office for the National Food and Nutrition Program have been established in the Ministry of Planning. These bodies will be responsible for execution of the National Program, planning and coordination of effective food and nutrition interventions and making recommendations on program policy and proposed legislation affecting the country's food availability and nutritional status.

IV. OTHER DONOR ACTIVITIES

To date the only other donors active in nutrition programs in El Salvador have been the UN and its related agencies, PAHO and INCAP. The United Nation's World Food Program (WFP) has functioned in the country since 1974. Its major activity has been the provision of commodities for food-for-work projects through FOCCO (Fomento y Cooperación Comunal), a government agency responsible for community development activities in the country. Recently this agency has been restructured under the Ministry of the Interior, as the Dirección de Desarrollo de la Comunidad. The future of its involvement with WFP, is now under consideration.

The WFP has just approved a MOH proposal to use UN commodities in an expanded feeding program throughout its health centers, to begin in 1979. Over a three year period, this program will gradually replace commodities currently dispensed by the MOH under its agreement with CARITAS.

The commodities imported by the WFP program include basic grains (corn and beans) which are also produced locally and thus, it is argued, have a better chance of being replaced by domestically produced grains when production reaches sufficient levels in the future to permit such a substitution. In addition the WFP ration size is twice the maximum Title II ration and thus is likely to have a greater nutritional impact even if the ration is consumed by all members of the family, as is often the case.

V. THE PL 480 TITLE II PROGRAM IN EL SALVADOR

A) Historical Background

Between 1962 and 1977 \$30.4 million in PL 480 Title II commodities have been distributed to needy people in El Salvador through School Feeding, Food-for-Work, and Maternal Child Health Programs. The school lunch program started in 1963 and was discontinued on October 9, 1974 after it was determined that the GOES did not wish to assume responsibility for the program after a two year phase-out period. Food-for-Work activities were initiated by CARITAS in 1966 and terminated June 30, 1973 due to a general worldwide scarcity of PL 480 commodities, the decision of WFP to begin a FFW activity, and the decision to reorient the CRS/CARITAS program to address the needs of the high risk MCH target population instead of older children and adults.

Over the past years the PL 480 Title II program has averaged about \$1.9 million annually. The approved program for FY 77 called for 8,580,000 lbs. of PL 480 commodities including WSB, Bulgur and Oil valued at \$1.1 million* to be distributed to 110,000 MCH program recipients. In FY 78 the program level was increased to 15,650,800 lbs. of food including WSB, Bulgur, Oil, NFDM and Rice valued at \$2.5 million*, and the number of beneficiaries was increased to 115,000 women and preschool children.

B) Current Operations 1/

1. The Cooperating Sponsor (CRS)

Catholic Relief Services (CRS) is the cooperating sponsor for PL 480 Title II activities in El Salvador. CRS initiated the Title II program in 1962 and currently operates under an agreement with the Government of El Salvador (GOES) signed by the Ministry of Foreign Affairs on January 21, 1969. Under the terms of the Agreement the GOES agrees to duty-free entry as well as exemption from internal taxation of Title II food commodities and other relief supplies and equipment.

The CRS staff consists of a Program Director, a Program Assistant, and Administrative Assistant, two Secretaries and a Driver/Orderly. The Program Director is a U.S. citizen and is new to the program having just assumed the position in October 1977. He has full responsibility for all CRS' activities in El Salvador and spends less than 50% of his time on PL 480 Title II matters. The Administrative Assistant, a local hire, spends full time managing Title II operations. The Program Assistant is not involved in Title II matters.

As the Cooperating Sponsor, CRS is responsible under the terms of a world-wide agreement with AID for Title II program development and operations including proper use of commodities and/or funds from the time it acquires control of them until they are properly utilized.

* Excluding ocean freight.

1/ As of the close of Calendar Year 1977

2. The Counterpart Agency (CARITAS)

CARITAS of El Salvador is the indigenous, counterpart agency of CRS. The responsibilities of CARITAS for implementing the Title II program are outlined in a separate agreement signed between CRS and CARITAS on April 30, 1963.

CARITAS, in turn, has individual working agreements with the five regional Catholic Dioceses in El Salvador, as well as with the Unión Comunal Salvadoreña (UCS), Instituto Salvadoreño para Transformación Agraria (ISTA), the Office for Improvement of the Ministry of the Presidency (OMCOM), and the Ministry of Public Health (MOH). (A sample agreement is contained in Annex C).

The work agreements are renewable annually, however, the most recent agreements between the five Dioceses, ISTA and UCS date from 1976. A new agreement for 1978 between CARITAS and the MOH was signed March 14, 1978.

The agreements describe the objectives of the PL 480 Title II MCH program, the obligations of the parties, the ration size and number of beneficiaries for which each agency is responsible, record keeping, monitoring and reporting requirements, minimal staffing requirements and other arrangements for carrying out the program.

CARITAS also distributes food through Ministry of Agriculture (MAG) Centers but does not have a formal agreement with MAG since that Ministry does not have an office directly responsible for supplementary feeding activities and uses CARITAS transportation and warehousing facilities. The supplementary feeding activities of MAG centers are thus managed as through they were Diocesan centers.

The five Dioceses and MAG distribute food through approximately 350 centers to some 73,000 beneficiaries.

The staffing patterns for the National Office of CARITAS and the five regional Dioceses are contained in Annex E.

3. The GOES Agencies

a. The Ministry of Health (MOH)

The Ministry of Health provides health services through approximately 242 health facilities in the country including 14 hospitals, 8 health centers, 85 health units and 131 health posts.

The health posts are usually located in remote villages and provide primary health care. They are normally staffed by an auxiliary nurse and are serviced on a rotating basis by a registered nurse and a doctor. The health unit has a full time doctor, registered nurse and auxiliary nurse and generally provides basic outpatient services. The health centers are usually more fully staffed and provide a full range of both in-patient and out-patient services.

Supplementary feeding activities are carried out through all of these types of facilities by existing MOH staff and are normally used as an incentive for participation in other health programs such as vaccination campaigns and educational activities. Approximately 22,000 women and pre-school children receive Title II food through MOH facilities.

b) The Office for Improvement of Marginal Communities (OMCOM)

OMCOM is an office within the Ministry of the Presidency. Its primary objective is to create the conditions for integrating poor urban families into the social and economic mainstream of the country.

Under its agreement with CARITAS, OMCOM distributes Title II foods to about 1,600 beneficiarias through 29 centers located in marginal zones of metropolitan San Salvador.

The objectives of its feeding program is to improve the nutritional and health status of children under five and pregnant and lactating women within its jurisdiction.

The present staffing pattern of OMCOM's Department of Nutrition includes one Chief of Section, one supervisor position currently vacant, six nutrition promoters, and one promoter of small home gardens. The chief is responsible for planning and programming projects, administering, supervising and evaluating the program and training personnel. The supervisor is responsible for implementing the nutrition program in all its stages, periodic evaluation of programs and personnel training. The nutrition promoters organize clubs for mothers, give educational talks on family planning, nutrition and other subjects, conduct surveys of selected communities and tabulate data, distribute supplementary food and weigh children to establish their nutritional status.

The garden promoter teaches families how to increase production of food, distributes plants, coordinates activities with other agriculture agencies and holds meetings periodically with community groups.

c) Instituto Salvadoreño de Transformación Agraria (ISTA)

ISTA is an autonomous agency of the GOES established to carry out, in coordination with other agencies, the agrarian transformation policy of the National Agrarian Transformation Commission. It is thus involved in resettling rural families.

The supplementary feeding program is used by ISTA as a means of organizing and consolidating groups, particularly women, for the purpose of providing educational talks on diverse subjects such as family planning, home gardens, home improvement, etc.

ISTA distributes food to about 1,200 beneficiaries through four rural centers. There are two promoters responsible for the supplementary feeding program at the present time.

d) The Ministry of Agriculture (MAG)

The Ministry of Agriculture, through its rural extension centers, organizes women's clubs for disseminating information and carrying out various community development activities. Eligible members of the women's clubs participate in the supplementary feeding program.

VI. ANALYSIS OF SURVEY DATA

A. Phase I - CARITAS/MAG/OMCOM/ISTA

1. Center Operations and Management

a) Staffing, Supervision and Training

All CARITAS centers are operated primarily by volunteers ranging in age from about 13 to 65, including students, campesinos, clergy and others working mostly on a part-time basis. Each center has a Junta Directiva or Comité of five to ten people who manage the program. The educational level of the average volunteer is quite low; some are illiterate.

Agreements between CARITAS and the Regional Dioceses require that Diocesan supervisory personnel visit all centers once a month. At present there are two national level supervisors and four regional supervisors one for each Diocese except San Miguel which has six "educators" on its staff. With this level of manpower it is virtually impossible to provide adequate regional coverage. For example, in the case of the Santa Ana Diocese which operates about 97 centers, a single supervisor would have to visit about five centers per day - an obviously impossible work load.

Analysis of the survey data show that twenty three percent of the centers surveyed indicated that during 1977 their staff received no training at all in the operation of the Title II MCH program. The remaining respondents said that they received some training on record keeping, management and preparation of food, and other subjects only once during the year or during supervisory visits.

Twenty eight percent of the sample centers indicated that during the last year they never received a visit by a supervisor either from the national or regional level. The remaining centers received supervisory visits from one to four times during the year.

Although the size of the sample when stratified by geographic region or organizational entity is too small to permit statistically sound judgements as to the comparative performance of the regional Diocese or organizations, nevertheless, the responses to questions regarding the need for improvement in personnel training, orientation and supervisory visits have a discernible pattern.

Of the six respondents who felt the worst problem with their program was inadequate training or supervisory visits, three were from the Santa Ana Diocese and the remaining three were ISTA personnel.

It is also noteworthy that of twelve respondents who believed that their program could be most improved through better training and orientation of center personnel and more frequent supervisory visits and coordination with CARITAS, four were from the Santa Ana Diocese (33% of the Santa Ana sample), three were from the San Miguel region (19% of the San Miguel

sample), two were from San Vicente (25% of the San Vicente sample), and the remaining three were ISTA personnel which constitutes the entire sample of that organization.

b) Physical Facilities, Services and Logistics

Title II foods are distributed through a variety of centers. The majority are parochial centers usually operated by a Catholic priest under the jurisdiction of one of the five regional Diocese. Others are private centers including farmacias or private homes in remote areas which provide a centralized point for food distribution. CARITAS also has agreements with distribution centers operated in rural areas by the Ministry of Agriculture. In these centers women are organized in Housewives Clubs (Amas de Casa) which provide nutrition and family planning education as well as supplementary feeding services. The Clubs are also involved in activities to improve the home and in the development of cottage industries for women.

Currently Title II food is being distributed through both public and private Day Care Centers (Guarderías) as well. In these centers food is prepared on the premises, and usually some health services are provided.

The majority of Phase I centers surveyed were located in small villages and very remote rural areas. Many were accessible only by four-wheel drive vehicle and some only by foot. There is little question that CARITAS is more than meeting new legislative requirements to distribute food to the most remote areas and without a doubt surpasses the performance of the MOH in this regard.

In spite of the remoteness of the centers and extremely poor roads, which in some cases are nothing more than foot paths, it is surprising to note that, without exception, all centers reported that supplies of Title II foods arrived regularly each month. In some cases they have to be brought in by burro or horse. Only three centers (8%) reported that in a few cases food (WSB) arrived in poor condition.

The distribution centers are often located in the private home of the person in charge of the program (encargada) or other member of the Junta Directiva. In many cases the house is made of sticks with a thatched roof and dirt floor. Under these circumstances the usual criteria for appropriate storage could not be applied. However, in most cases the food was kept in a dry relatively clean place. Furthermore, commodities brought in are normally fully distributed each month, and storage time is minimal. Commodities are generally brought in one to three days before the scheduled distribution.

Only about one third of the centers surveyed said they provided some kind of health service to mother and children in the program.

Twenty percent of the centers had periodic medical consultation either by an M.D. or a nurse.

Twenty three percent provided periodic services for detection and treatment of parasites and a few (8%), generally day care centers, indicated that vaccinations were made available through coordination with the Ministry of Public Health facilities nearby.

It is noteworthy that about 25% of the centers provided some medicines and vitamins which in some cases were purchased with the proceeds of the Title II program.

c) Beneficiary Participation

The Phase I centers surveyed reported a total of 9,227 inscribed beneficiaries of which 643 or 7% were women and the remainder children mostly under six years of age.

The average number of women inscribed per center is about 25 ranging from 1 to 110, while the average number of children under 6 is 393 ranging from 28 to about 900.

When asked if the number of beneficiaries could be increased, about 73% of the respondents answered in the affirmative. The main reasons given were the large number of people requesting food assistance who were not yet inscribed in the program, or simply the general impression of need in the community.

Those who said that the number of beneficiaries could not be increased gave a variety of reasons, including (1) the existence of other food programs in the area (Santa Ana), (2) lack of understanding about the proper use of the foods, (3) lack of attendance, (4) increased distances that the beneficiary would have to travel, (5) small size of the community or adequacy of the present program, and (6) that no more beneficiaries could be attracted because of the increased monetary contribution being solicited (San Vicente)

Ninety three percent of the Phase I respondents said that they applied some kind of criterion for termination of beneficiaries.

Only 10% indicated recuperation as a reason for cessation. Forty-five percent indicated that pregnant women were discontinued after parturition. Ninety three percent said the age of the child was a factor which determined continuing eligibility. The most common age of cessation was six but a few centers terminated the child at 5 and 7 years of age.

Beneficiaries were also terminated in some cases for non-attendance at distributions and talks. In a few cases misuse of food was also mentioned as a reason for terminating the recipient.

d) Food Distribution

Eighty five percent of the centers surveyed said that food was distributed to beneficiaries regularly on a monthly basis. The six remaining centers, including all three of the OMCOM centers surveyed, said they missed an occasional distribution. Three centers indicated that only one distribution was missed, two reported that three were cancelled and one center missed four. The reasons given included fumigation of the center, vacation, internal office problems, need to repair the warehouse, and food received in poor condition.

All centers except the two day-care centers (guarderías) included in the sample indicated that the food was not consumed at the center but was carried home by the mother in bulk and consumed there.

Ration

The ration size, as described in the agreements between CARITAS and the implementing agencies, is 6.5 pounds of Title II commodities, consisting of 5 pounds of WSB or CSM, one pound of Bulgur and one half pound of oil. Other commodities such as non-fat dry milk are also distributed when available.

About 63% of the Phase I centers distributed the specified ration. Twenty three percent distributed a double ration of oil, and about 10% doubled the bulgur ration.

Almost all centers also included one pound of dried milk in the ration. A few provided additional commodities such as sugar, purchased locally, and commodities supplied by FOCCC. In only three cases did the respondent indicate that the ration of oil was reduced to one quarter pound per beneficiary.

In summary, no significant deviation from the prescribed ration was noted.

e) Recordkeeping

Basic records on receipt of food, distribution of food, attendance at food distributions, initial and subsequent weights of children, and collection and use of money donated by beneficiaries were checked at each center surveyed to determine the adequacy of record maintenance. Analysis of the survey data indicates that, in general, records are poorly maintained, if at all.

Only about 40% of the centers surveyed had well maintained records on the receipt of food. About 60% either did not have this type of record at all or had records which were poorly maintained.

With regard to food distribution only 30% of the centers maintained good records, 40% did not have distribution records and the remaining 30% were poorly maintained.

Records on attendance at food distribution were also poorly maintained by 42% of the centers while 31% did not have any attendance records that could be verified by the interviewer. 27% had well maintained attendance records.

Records on the weight of children at time of inscription into the program were well maintained by 21% of the centers, while 12% maintained adequate records of subsequent weights. Over 60% of the centers surveyed did not have any weight records which could be verified by the interviewer.

Financial records were no exception. Only 30% of the centers kept records on receipt and disbursement of money contributed by beneficiaries. Failures to find financial records in over 60% of the centers surveyed may be accounted for in part by the fact that in some cases financial records were maintained outside the center or were locked up and inaccessible at the time of the interview.

f) Voluntary Contributions (Cuota)

PL 480 Title II regulations (Regulation 11, Section 211.5) permit implementing agencies to solicit voluntary contributions from program beneficiaries so long as the money is used to improve the implementation of the program. Money may be used for such things as transportation costs, storage improvement and payment of indigenous or third country personnel involved in the program. However, it is not legitimate to use the money to purchase land for sectarian use or to construct or improve church buildings.

According to the FY 79 Program Plan, individual contributions for 1977 amounted to the equivalent of \$218,000. Estimates made from the survey data on voluntary contributions by recipients of the food distributed at the sampled centers, corroborate this amount as the probable annual contribution to the program by beneficiaries.

Respondents to the questionnaire indicated that contributions ranged from 50 centavos in 20% of the centers surveyed to one colon in one case. Forty six percent of the centers asked 60 centavos per ration and the remaining 20% collected 75 centavos from each recipient.

In most cases the money was used for legitimate program purposes such as transportation or program personnel costs; however, there were sufficient cases of inappropriate or questionable use of funds to warrant remedial action to establish criteria of appropriate use and to make sure these standards are adhered to. Some examples of inappropriate or questionable uses cited by respondents to the survey were: (1) costs of the church, (2) celebrations or fiestas (unless the celebration includes educational or promotional activities related to the MCH program), (3) purchase of toys for children, etc.

g) Major Problems in the Management of the Program

The two problems cited most often by residents to the Phase I questionnaire were (1) non-attendance of mothers at scheduled food distributions, and (2) lack of orientation and training for center personnel on program operations.

Other problems mentioned were the lack of forms for maintaining records, the small size of the ration, poor help or lack of help at distributions, inadequate amount of commodities, the requirement to pay for the food, the requirement to weigh children, too much paperwork, and inadequate budgets.

2. Compliance with PL 480 Title II Policy

a) Targeting

Agency policy with respect to targeting of Title II beneficiaries remains flexible, but legislative requirements are becoming more rigorous. AID Handbook 9, Chapter 8, Section 8.3, which deals with Maternal Child Health programs, states that, "the target groups in these programs are the most vulnerable groups; i.e., the high-risk categories of women of child-bearing age and their children under the age of six with emphasis on children up to the age of three". It is further stated that "it is also important to attempt to reach these groups in terms of poverty and/or nutritional status."

This obligation is further strengthened by AIDTO Circ. A-352, dated 9/29/77, which cites recent changes in PL 480 policy incorporated in the International Development and Food Assistance Act of 1977. The Circular states that "Title II distributions shall be made to those suffering from malnutrition by such means as giving priority to malnourished children within food programs for preschool children and that in implementing this" each child should be examined to determine the extent of its malnutrition." Legislative intent is thus clear with respect to the targeting requirement and the objective of reaching the most severely malnourished children with the limited resources available.

There are, however, other policy statements which appear to be contradictory. For example, AID Handbook 9, Chapter 8, Section 8B3b (3) states that "activities targeted to the rehabilitation of the most severely malnourished children should be undertaken only in facilities staffed and equipped to service, treat, and follow-up such cases effectively. As a practical matter, commodities should be directed generally toward systematic preventive work among vulnerable groups through health clinics, nutrition centers, etc."

On the other hand, the new legislation, cited in Circular A-352, requires preference to be given to indigenous, non-profit voluntary agencies rather than agencies from developed countries for implementing Title II programs, which implies in most cases less developed planning and management capabilities. The new legislation also requires that food distribution programs be conducted in the "the most remote villages".

In most developing countries, even those with relatively well developed health delivery systems such as El Salvador, the facilities which are staffed to "service, treat, and follow-up" cases of malnutrition are usually only found in cities and small towns, not in "the most remote villages". Under this conflicting guidance either Title II commodities would be distributed to the most remote villages where there are no facilities, in which case the

targeting requirement would have to be modified, or commodities would be distributed to clinics and nutrition centers in small towns where better controls could be applied, in which case a much smaller portion of the target group would be reached.

Of course a third alternative, resulting from a liberal reading of these apparently conflicting requirements, is to distribute both to health centers in small towns and remote rural areas, with the clear understanding that the objectives and requirements for measuring results are different in each case.

Food distribution programs to the most remote areas should be recognized by AID and all cooperating agencies for what they are, namely humanitarian activities undertaken as a palliative until such time as public health services can improve their outreach capabilities and provide the necessary complement to feeding programs which enhance the probability of rehabilitating the malnourished child.

Of course, even programs in the most remote areas should not be relieved of the requirements to manage the program effectively and to account for the use of the commodities. As a minimum, all distribution centers in the CARITAS program should be required to target within the high-risk category by age and some criterion of need. That is, food should go to children under six with emphasis on those who are three years old and under.

Applying the least rigorous criterion, to inscribe children from 0-6 years of age without emphasis on those 0-3, nor those in any particular state of malnutrition, all of the centers comply. On the average, 84% of the children inscribed were in the age group 0-6. However, if the requirement to "emphasize" children 0-3 is applied, only 16% of the centers sampled in Phase I of the survey could presently be considered to be in compliance. National census data from 1975 indicate that children in age groups 0-3 and 4-6 constitute approximately 14 and 9 percent of the total population respectively. 1/ It is assumed that children in these age groups, selected purely on a random basis (without targeting) would thus be in a ratio of 14 to 9 or 1.56. Any ratio greater than this would indicate that some judgmental factor has entered into the selection process in the favor of children in the 0-3 group and that the center is thus making an effort to "emphasize" this age group.

The 16% figure cited is derived from the number of centers (5) with a ratio = 1.56, divided by the number of centers (31) which maintained records of beneficiaries by age $5/31 = 16$.

<u>1/</u> Total estimated 1975 population:	4,075,000	
Children 0-3 years of age	: 576,500	(14%)
Children 4-6 years of age	: 380,500	(9%)
Ratio	: 14/9	= 1.56

With regard to other selection criteria, analysis of the Phase I survey data shows that 18 and 30 percent of the respondents did not consider pregnancy and lactation respectively as criteria for inscription into the program. All Phase I respondents appeared to understand that the age of the child was a consideration, but there was some variation as to the upper age limit for inscription or retention of a child in the program. Seventy-five percent of the Phase I centers considered 6 years of age to be the upper limit. Ten percent admitted and/or retained children beyond the age of six, while 18% used age 5 as the cut off. Only 23% of the respondents indicated that children were selected on the basis of degree of malnutrition determined by age/weight relationships.

The economic status of the family and place of residence were used as selection criteria in 40% and 53% of the centers respectively. Economic status was most often determined by observation of the physical condition of the home, personal appearance of the mother and/or family possession of a cow or other livestock, rather than income. In some cases employment status of the bread winner was taken into consideration.

Other criteria for selection cited were, membership in an organization such as a mother's club in the case of Ministry of Agriculture (MAG) centers and OMCOM. In a few cases children over six who were invalids and old people with no means of support were given rations.

Should the more stringent requirement of targeting by degree of malnutrition be imposed, the evaluation would show that even a smaller percentage of CARITAS (Phase I) centers would be in compliance. Only 5% of the centers in the sample could be said to be given any priority to selection of malnourished children. 2/

2/ Centers are considered to be in compliance if at least 75% of the children inscribed in the program exhibited some degree of malnutrition. This percentage is used because independent nutrition surveys have shown that 74% of children under 5 in El Salvador have some signs of protein-calorie malnutrition as measured by the Gomez classification (weight for age). Levels of malnutrition were computed from actual age/weight records maintained by the centers surveyed. The assumption used in this analysis is that 74% of the children selected on a purely random basis would be expected to have some degree of malnutrition. Any percentage significantly above this would imply that some factor other than chance has intervened in the process of selecting malnourished children.

Computation: Seven (7) centers, of the 20 surveyed who maintained age/weight data, showed percentages of children with some degree of malnutrition exceeding 75%. These seven constitute 18.5% of the total sample of 40 centers. However, when these seven centers are cross checked with those indicating that they consciously classified children according to degree of malnutrition, only two centers meet both criteria (2/40 =5%).

Although 90% of the centers indicated that they weighed children at least once, only 28% of the respondents said they actually used the weight information to classify the nutritional status of the child. Further analysis of the survey data indicates that of those centers classifying children according to degree of malnutrition, only two could actually demonstrate, by means of weight charts or other records, that the percentage of malnourished children in their program significantly exceeded the percentage of malnourished children one would expect to find if they were selected on a purely random basis.

This poor performance cannot be ascribed entirely to ignorance of the use of the data, because 43% of the respondents gave a reasonably adequate reply when queried as to the reason for weighing children. The explanation lies rather in the quality of personnel supervising and staffing Phase I centers and the adequacy of training provided as already discussed above.

Another factor affecting compliance with the weighing requirement, which is a concomitant of those already mentioned, is obviously the existence of equipment and materials for weighing children and maintaining adequate records.

Survey data indicates that 73% of the sample centers had bathroom scales in working order ^{3/}. Considering the fact, already mentioned, that only 28% of the centers actually use weight information to classify children as to degree of malnutrition, there appears to be a great deal of wasted effort weighing children to meet an arbitrary requirement imposed across the board with no consideration of the relative capabilities of each center to utilize the data thus gathered.

Only 55% of the centers had weight charts for computing and recording the degree of malnutrition of individual children, while only 13% maintained records on initial and subsequent weights of the child for determining progress toward rehabilitation.

b) Nutrition Education Requirements

AID Handbook 9, Section 8B3B (3) (b) states that "continued evaluation should be undertaken where bulk distribution for home consumption is considered the most cost effective method to reach the target group. In such a project a nutritional education component (which might also include elements of health and/or family planning) should be considered essential. "The lack of an educational component would give rise to consideration for discontinuing future support"

^{3/} The variance between the centers indicating that they weighed children (90%) and those with scales (73%) can probably be accounted for by the fact that some centers use scales carried by the supervisor or supplied by other means.

Analysis of the survey data indicates that the educational program of CARITAS is inadequate. Of those centers who responded to the question on education for mothers of beneficiaries, twenty five percent indicated that they never had formal talks and only 10% of the centers provided any kind of printed educational materials. Those centers that did have talks for the mothers did so with varying degrees of frequency ranging from every week (10%) to once in the life of the program. The most common frequency for talks as indicated by about a third of the centers sampled was once a month. Talks usually lasted from thirty minutes to two hours. Subject matter was also diverse but usually included a discussion of the use and preparation of the Title II foods and in some cases personal hygiene, child care, family planning and sanitation.

As already noted, the size of the sample, when stratified by region and/or organization, does not permit attaching any degree of confidence, in a statistical sense, to inferences drawn from the data. Nevertheless certain patterns are noteworthy which contain information as to the relative performance of the regional organizational entities represented in the sample.

With respect to education for mothers, of the eight respondents who said that they had no education program, three were from centers in the San Vicente region (38% of the San Vicente sample), two were from Santa Ana (17% of the Santa Ana sample), and one each from San Miguel, Santiago de Maria, and San Salvador.

In response to question #22 of the questionnaire on how to improve the program, of the six respondents who believed that an educational component would most improve the program four were from San Vicente (50% of the San Vicente sample), two were from Santa Ana (17% of the Santa Ana sample) and one was from San Salvador.

B. Phase II - MINISTRY OF HEALTH CENTERS

1. Center Operations and Management

a) Staffing, Supervision and Training

The MOH centers are staffed by paid, professional personnel including doctors, nurses, nurses auxiliaries and other professionals and para-professionals. The type of staff and the kind of services provided by the three different types of facilities which were included in the survey sample, are described on page 10 above.

Thirty seven percent of the MOH respondents said that center personnel did not receive any special training on record keeping, management of food or implementation of nutrition education activities.

There was no apparent difference in the amount of training provided the three types of MOH facilities. There were only two "Centers" in the sample. One reported that they did provide training for their staff and the other that they did not. Of the ten health "Units" in the sample, 60% said they had training in 1977, while 64% of the health "Posts" in the sample, which are the smallest and usually the most remote health facilities, reported that they had some training for their personnel.

When stratified by region there is also no significant difference in terms of training provided. The Occidental, Para Central, Oriental, Central and Metropolitan health regions showed respectively that 75%, 67%, 63%, 50% and 50% of the centers surveyed in those regions had training programs for some of their personnel.

In most cases the training was given by the regional nutritionist, the regional supervisory nurse or the central educator. The cursillos usually lasted about a day.

With respect to supervision only 42% of the centers indicated that they received a visit by a national level supervisor during 1977. However, regional supervisors visited 83% of the centers surveyed during that period. Frequency of visits ranged from one a month in about 46% of the centers to once every three to six months in about a third of the centers. In one case the Regional Supervisor made only one visit.

The survey data does indicate that coverage by supervisors, especially those from the national level, tends to diminish with the size and/or remoteness of the facility. From the standpoint of good management the opposite should be the case. The smaller, more remote health posts, staffed by part-time, para-medical personnel, are in greater need of supervisory support and should be given priority.

b) Physical Facilities, Services and Logistics

The Ministry of Health distributes Title II Food through 242 health facilities to approximately 22,000 MCH program beneficiaries. The types of facilities and services provided are described on page 10 above.

All MOH centers provide medical services to the mother and children inscribed in the MCH program. Services by a doctor or a nurse include immunizations, treatment for parasites, and prescription of medicines. Larger centers also provide dental care, diagnostic services and minor surgery. The frequency of medical consultations vary according to the age of the child and/or need.

Regarding logistics, only 67% of the MOH centers surveyed said that the Title II food arrived on a regular basis. In only two cases did food arrive

regularly on a monthly basis. Food distribution at most MOH centers is bi-monthly. Forty four percent of the centers responding to the question regarding delivery of food said they received deliveries every two months. A third of the centers reported delivery every three months and two centers indicated that food arrived every four months. The reasons most often cited for irregular delivery of food were non-availability at the regional level or lack of transportation.

According to the agreement signed between CARITAS and the Ministry of Public Health, the latter is responsible for picking up the food from the port warehouse and delivering it to regional warehouses upon being advised by CARITAS in writing of the data and quantity allotted.

A recent CRS internal audit, covering the period July 1, 1975 through November 1, 1976, indicates that in the past the MOH has not allocated Title II commodities according to programmed center need, nor has it reported deliveries on a timely basis. This problem apparently has still not been rectified.

Approximately 90% of the MOH centers has storage facilities which were secured and of an adequate size. Roughly the same percentage of centers provided adequate rodent and insect control and protected the commodities from moisture damage.

However, about a third of the storage areas were found to be unclean and disorderly.

Twenty seven percent of the centers reported arrival of damaged commodities one or more times during 1977.

c) Description of the Beneficiary

The MOH centers surveyed reported a total of 4,491 beneficiaries of which 627 (14%) were women, 3,131 children less than three years of age (70%), 520 children from three to six years of age (12%), and the remainder, children over six or adults. The average number of women per center was 26, ranging from 1 to 169, while the average number of children under six was 152, ranging from 145 to 400.

When asked if the number of beneficiaries could be increased, all of the Phase II respondents answered affirmatively. The main reasons given were the large number of malnourished children, mothers' soliciting food assistance, and the generally poor economic conditions in the community. Two respondents suggested that food assistance be expanded to include infants and older children of normal weight as a preventive measure. Another pointed out the value of the supplementary food program as a means of orienting people to other programs and to the availability of other services, such as vaccinations and family planning.

All centers indicated that they have criteria for terminating beneficiaries. Nearly 90% discontinue children after they reach a specific age or are rehabilitated. In sixty seven percent of the centers the age limit was five. Three of the centers surveyed discontinued children at age 4.

About 80% of the centers applied MOH norms for terminating beneficiaries after a fixed period of time. Most indicated that it was common procedure to inscribe pregnant and lactating women for a period of four months.

Children were retained for periods of from 8 to 12 months depending on their age. If they do not recuperate during this initial period they are continued in the program for eight more months.

With respect to non-attendance by mothers participating in the program, 83% of the respondents said that this was a cause for termination but differed as to the number of times (2-6) that the women did not attend before termination.

Forty-six percent of the centers indicated that misuse of food was also a reason for termination of a beneficiary.

Most MOH centers mentioned that a standard procedure was followed when a beneficiary failed to attend. This included talking to the person, sending a note in some cases via the cantonal commissions, visiting the mother, and finally termination of these measures are unsuccessful.

d) Food Distribution

Only 67% of the MOH centers had a fixed date for food distribution while only 54% actually distributed the food on a regular basis during 1977. Eighty three percent of the centers distributed every month. The main reasons given for failure to distribute food on a regular basis was the non-availability of food in the regional warehouse and/or non-availability of transportation to deliver food to the center. Forty six percent of the centers surveyed reported non-availability of food for anywhere from one to three distribution periods. All centers in the sample indicated that the food was distributed in bulk and consumed at home.

Ration Size

MOH centers distributed only WSB and dried milk. Seventy-one percent distributed only WSB, while the rest supplemented the ration with dried milk. Those centers distributing food every eight weeks gave each beneficiary eight pounds of WSB and four of dried milk, - double the normal monthly ration. All but two of the MOH centers survey reported no change in the size of the ration during 1977.

e) Recordkeeping

All MOH centers maintained records on receipt and distribution of food, initial and subsequent weights of children, and attendance during distribution. None of the centers maintained separate financial records on contributions of Title II beneficiaries, since no money was collected for the food except, in some cases to cover the cost of a plastic bag to put the flour in if the mother did not bring her own container. In these cases funds were controlled using standard MOH records. Between 70 and 80 percent of the surveyed centers maintained all records surveyed in good condition.

f) Voluntary Contribution (Cuota)

Most MOH centers do not collect voluntary contributions from Title II beneficiaries. However, about one third of the centers did ask a nominal fee, ranging from 10-25 centavos, to cover the cost of a plastic bag for carrying the ration, a small notebook for each mother to keep personal records and to note distribution dates, and in some cases to buy additional food used in food preparation demonstrations.

g) Major Problems in the Management of the Program

Forty six percent of the Phase II centers surveyed indicated that the major problem in running the MCH program was related to either insufficient ration size, inadequate amount of food assigned to a given center, or irregularity of delivery due to non-availability of food in the region or lack of transportation.

The next most frequently cited problem (25% of the respondents) was non-attendance or tardiness of the beneficiaries at scheduled food distributions and demonstrations.

Another problem noted was the rigidity of program norms for inscription of beneficiaries. In this regard one respondent thought that normal children should be inscribed, and another believed that nurses should be given the authority to inscribe beneficiaries as well as doctors. Apparently it is MOH practice to inscribe beneficiaries into the program only after examination by a doctor. This was believed by some to be an unnecessary constraint to meeting programmed beneficiary levels.

In a few cases misuse of food in the home, inadequate storage space at the center, lack of scales to weigh children, and lack of training for the entire staff of the center were cited as major problems. Concerning the latter, apparently in some cases, only the "encargada" is given training in the operation of the MCH program.

2. Compliance with PL 480 Title II Policy

a) Targeting

Analysis of Phase II (MOH) data with respect to targeting shows that all MOH centers emphasize the 0-3 years old. Seventy two percent of the MOH beneficiaries in the sample fall into this age groups as compared to 42% in the Phase I (CARITAS) sample.

Regarding targeting by degree of malnutrition (applying the test described on page 18) 100% of the MOH centers surveyed were able to demonstrate that they selected children on the basis of degree of malnutrition. All had scales, weighed children about every two months, and classified the degree of malnutrition.

The proportion of malnourished children ranged from 80 to 100 percent of the total number of children inscribed. Fifty percent of the centers had no "normal" children listed as beneficiaries of the program. It is also noteworthy that the percentage of children with second and third degree malnutrition inscribed in the MOH program exceeded the national average of 22% in 100% of the centers. In fact, 71% of the centers had twice this percentage of acute cases inscribed. To a large degree this is of course a natural consequence of a preselection of the population of children arriving at the MOH clinics for treatment. Because a large percentage of those children with second or third degree malnutrition are recognized as such a much larger percentage will be seen in the clinics than were in the population at large. Nevertheless it is clear that the MOH centers are reaching the targeted most malnourished children.

With regard to other selection criteria, the economic situation of the family was taken into consideration by 79% of the centers surveyed. Economic status is determined by observation, surveys of the community or interviewing the mother. No specific income level is used as a criterion of selection.

b) Nutrition Education

All of the MOH centers provide talks on a variety of health and nutrition subjects to mothers inscribed in the MCH program. Seventy five percent of the centers give talks on the same day that food is distributed, thus assuring maximum participation by mothers. The talks are given either on an individual or group basis depending upon the health facility policy. In most cases talks are given by a nurse and cover such topics as nutrition, food preparation and use, sanitation and personal hygiene, family planning, prevention and treatment of diarrhea, immunization and other related subjects. The most commonly offered subjects were nutrition and food preparation, offered by 71% of the centers surveyed and sanitation and personal hygiene, offered by 67%.

Forty two percent of the respondents said they gave talks daily, 50% said they offered them on a weekly basis and the remaining 8% indicated that they gave talks less frequently. Seventy five percent of the centers offered printed educational materials to beneficiaries.

In spite of the apparent adequacy of MOH nutrition education activities, it is interesting to note that 63% of the respondents believed that the education program could be improved. Some thought that the courses ought to be expanded to include others in the community besides Title II food recipients, while others said that more audio/visual materials and equipment were needed to improve the quality and impact of the cursillos.

c) Program Impact on Malnutrition

Although the primary purpose of the PL 480 Title II survey in El Salvador was to evaluate the performance of the executing agency, CARITAS, in managing the MCH program at the level of the local distribution center, provision was also made for the collection of data which would permit an objective judgement as to the impact of the program on the problem of malnutrition.

For the purposes of this analysis "impact" will be defined simply in terms of the percentage of children rehabilitated or more specifically, the percentage of children gaining weight at normal or better than normal rates. No attempt has been made to isolate, by means of a controlled experiment, the influence of supplementary feeding from other factors which would affect rehabilitation, such as provision of medical services, seasonal variances in the incidence of enteric diseases which are known to contribute to malnutrition, or other factors.

Nevertheless, the data may serve as a crude baseline for measuring progress in performance as it relates to the rehabilitation of cases of malnutrition within the Title II program.

In the case of the Phase I centers (CARITAS, MAG, OMCOM and ISTA) 67% of the children on the sampled beneficiary lists were recorded as having some degree of malnutrition. From a sample of 50 children, on whom there was data available on both initial weight at inscription, and a subsequent weight to measure change, 41% gained weight at equal to or greater than growth rates that would be expected of a normal child of the same age over the same period of time.

With regard to the Phase II (MOH) centers, 94% of the children listed had some degree of malnutrition. Out of a sample of 70 children, for which there was longitudinal weight data available, 55% showed normal or better than normal weight gains.

Given the nature of the data and the absence of any control, it cannot be said that children are being rehabilitated due to supplementary feeding. As already indicated, the above statistics could only serve as a baseline measure for comparing performance over time. Even if the data were used for this purpose, one would still have to qualify the results with a precautionary caveat concerning the accuracy of the raw data. As data maintenance improves

and weighing becomes more prevalent and accurate, apparent changes in performance may be found to be simply due to error in data collection.

VII. SUMMARY OF FINDINGS AND RECOMMENDATIONS

A. Summary of Findings

Given the resources at its disposal, CARITAS appears to be doing a commendable job in distributing supplementary food to needy people in El Salvador. However, in terms of achieving the specific objectives of a Maternal Child Health Program, for which PL 480 Title II Commodities are donated, CARITAS is much less effective.

Among the findings of the Phase I survey which support this judgement are the following: i) Nutrition/Health Education activities are inadequate, or, as is the case of 25% of Phase I centers surveyed, completely lacking; ii) Personnel are inadequately oriented, trained and supervised; Twenty-three percent of the centers surveyed received no training at all during 1977, while twenty-eight percent never had a single visit during that period by a supervisor from either the national or the regional level; iii) Basic records, essential to effective program management and control, are inadequate and in a significant number of cases are not maintained at all; iv) Although all centers comply with minimal MCH beneficiary selection requirements, a significant percentage of the centers surveyed do not comply with nutritional targeting requirements. Only sixteen percent of the centers could demonstrate that any emphasis was given to the vulnerable 0-3 year age group in beneficiary selection, while only 18.5% could be said to be giving any priority to malnourished children in the selection process, beyond what could be expected if children were simply randomly chosen from the community.

The findings of the Phase II survey on the other hand show that the Ministry of Health is doing a good job in carrying out the objectives of the MCH program, but is still having problems in assuring the timely delivery of adequate quantities of Title II Commodities to its distribution centers and in providing adequate program logistic support, personnel training and supervision.

Based upon these and other findings cited in the foregoing analysis, as well as general observations made in the course of conducting this evaluation, the following recommendations are made in the spirit of improving the overall management of the PL 480 Title II Program in El Salvador.

B. Recommendations

1. Program Policy

1.1. Ration Size. Since completion of the field survey, the official ration size has been increased from 6.5 pounds to 10 pounds per month per beneficiary. AID considers this ration is an adequate supplement to rehabilitate a malnourished child or supplement pregnancy and lactation assuming that the entire ration is eaten and assimilated by the target beneficiary, and that it does not replace his/her normal diet. However, in a program such

as El Salvador's where the ration is consumed at home there is no way to control intra-family food distribution. If an improvement in levels of nutritional status is to be expected, the unit of treatment must be the entire family, not only the specific MCH target individuals.

The problem of intrafamilial distribution can be approached in one or a combination of three ways: a) by increasing the total ration size so that an equal distribution among the entire family will still allow sufficient food for the target beneficiaries to significantly affect their nutritional status; b) by the selection of foods that are culturally more appropriate for consumption by small children or pregnant and lactating women than by the rest of the family; and c) through a strong education program aimed at the entire family on the importance of special feeding of small children, the increased needs of pregnant and lactating women and the way in which commodities can best be used to fulfill these special needs.

The current PL 480 program policies, commodities and education programs should be reviewed by AID/W, the USAID/Mission, and the implementing agencies to see how they could be adjusted to confront this major problem.

1.2. Targeting. All Centers should focus greater attention on selection of children in the 0-3 year age group who are most vulnerable to the affects of malnutrition in their future growth and development. Greater effort is also called for to identify and inscribe in the program on a priority basis high risk and malnourished cases. A system should be developed by CARITAS National to help center personnel in more appropriate beneficiary selection such as the use of a nutritional status screening technique or a point system to identify high risk families.

2. Program Development

2.1. OPG. USAID should give prompt consideration to an OPG to help CARITAS improve the effectiveness of its supplementary feeding program. Technical assistance should be solicited to assist in the preparation of the proposal. The draft should be completed by the end of July 1978 and the final agreement by the end of August 1978.

The OPG should focus on improvement of the educational component of the MCH program and should also address operational problems cited in the above analysis.

The OPG should provide Technical Assistance for the development of a Procedures Manual to be used by all agencies distributing food under agreement with CARITAS. The Manual should include but not necessarily be limited to a full description of the following program functions:

- Program promotion and enrollment
- Ordering, dispatching and delivering commodities

- Collecting and administering recipient contribution
- Making end-use checks
- Nutrition education and motivation
- Reporting and evaluating results
- Personnel administration and supervision

2.2. Program Level. Until such time as subsequent USAID/CRS evaluations indicate significant improvement in the logistic support, the operation of nutrition centers and compliance with PL 480 Title II policy regarding the management of MCH program, the number of beneficiaries should not be increased over FY-78 levels nor should any new activities be approved. In order to encourage local initiatives and avoid undue delays in justified program expansion, evaluations might be conducted on a regional basis at the request of individual Dioceses or other organizations.

2.3. Program Coordination. It is recognized that each of the five Catholic Diocese and other cooperating agencies are autonomous in their general operations. However, in order to assure effective management of the PL 480 Title II Program each diocese or agency wishing to participate in the Title II Program must follow established guidelines and norms.

As much as possible the National Office should take into consideration the needs and desires of the participating dioceses and agencies.

It is therefore, recommended that CRS and CARITAS national assure that meetings are arranged at least twice each year to review the operations of the PL 480 Title II program. These meetings should involve the regional managers of the feeding programs.

In addition, it is recommended that CARITAS National hold a meeting at least once a year with each of the JUNTA DIOCESANA (Diocesan Committee) and decision making authorities of participating agencies to discuss the program objectives, activities and operational plans and to review the Agreements between CARITAS National and each Diocese and participating agency.

3. Program Operations

3.1. USAID/CRS ^{FINANCIAL REVIEW} ~~audit~~. A USAID/CRS ~~audit~~ financial analysis should be undertaken to determine costs by region of operating the PL 480 Title II program at current and proposed level of activity as a basis for ascertaining the adequacy of current funds to cover program operating costs.

The ~~audit~~ analysis should investigate the adequacy of financial records at Diocesan and participating agencies headquarters and distribution centers and the appropriateness of funding and expenditure.

3.2. Supervision. It is recommended that a minimum of one supervisory visit should be made to each center every two months by the regional supervisors. Each visit should be for a full day and should include the

following activities:

1. performance of end-use checks
2. review and updating of all records
3. orientation and training of all people in the community who have responsibilities for operation of the program
4. review of the educational component of the program to see that talks are given and materials available.

The supervisors should also receive training at least twice a year.

The supervisory staff in each region must be sufficient to carry out the above workload.

In the case of CARITAS, given the number of centers in each region (See Tables 2 and 3 Pages 4 and 5), and the number of supervisors/educators presently working in each (See Annex E), it would appear that all Dioceses, except perhaps San Miguel, should increase the number of supervisors as soon as possible.

The MOH and OMCOM should review and if necessary adjust their supervisory staff and schedules to assure adequate supervision of all centers particularly those in the remote areas.

3.3. Recordkeeping. More attention must be paid to maintenance of records. Supervisors should be responsible for checking, updating and assuring the accuracy of all records maintained at the Center. Non-compliance with this requirement should be grounds for termination of the program of the delinquent center.

The following monthly records should be maintained at each distribution center:

1. Receipt of Title II commodities
2. Distribution of Title II commodities
3. Beneficiary lists
4. Weights of children or other method of nutritional screening
5. Financial records if cuotas are collected.

3.4. Beneficiary Records. It is suggested that each center should be given an annual program cuota or maximum number of beneficiaries.

The number of recipients during a given month should not exceed the program cuota. Monthly beneficiary records should contain the following information:

1. Number of individuals eligible (registered or inscritos) continuing from previous month.
2. Number of individuals added to eligible list during month.
3. Number of individuals withdrawn from eligible list during month.

4. Number of actual recipients (servidos) of food during month.
5. Number of indirect beneficiaries of food during month, i.e. number of non-eligibles in the household of the recipient.

The active beneficiary lists should include at a minimum the name of the mother and her condition (pregnant/lactating), the number, age and nutritional status of each child, date of inscription/termination.

In addition, to the active beneficiary lists, which should never exceed the annual program quota, the center should also maintain a waiting list of eligible applicants containing the same information as the active list. These two lists should be reviewed and certified by the supervisor every two months and should serve as the basis for the annual request for commodities.

3.5. Nutritional Screening. All centers should be required to weigh children or use some method of nutritional screening as an educational tool as well as for targeting and evaluation.

3.6. Nutrition Education. All centers should strengthen the nutrition education component of the MCH program. Failure to provide any education for mothers on a regular basis will be grounds for termination of the program of the delinquent center.

Centers should consider the feasibility of increasing the number of distributions as a means of reducing the number of beneficiaries at each center in order to permit more effective education of mothers.

Attendance at all talks should be a condition of eligibility to receive food.

3.7. Training. People in charge of bodegas, particularly those operated by the Ministry of Health, should receive training on care and handling of food, rotation of stock, etc.

3.8. Logistics. The Ministry of Health should determine the cause of chronic non-availability of Title II commodities at regional warehouses and failure to distribute food to distribution centers on a timely basis, and take remedial action to correct poor performance in this area.

3.9. Agreements CARITAS must negotiate new agreements annually with all cooperating agencies, including each of the five Dioceses, as called for in the existing agreements.

3.10. UCS. The feeding program implemented by UCS should be reinstated only after an audit and in-depth evaluation by USAID/CRS in order to determine that UCS is capable of implementing a supplementary feeding program.

The Audit and the evaluation will be initiated at a time mutually convenient

to USAID/CRS upon receipt of a written request from UCS.

3.11. A notice should be prepared by each diocese and implementing agency for each of the distribution centers under its jurisdiction, clearly stating program eligibility criteria, attendance requirements, penalties for non-attendance, ration size, and other pertinent administrative information and displaying the seal and/or signature of the program manager. This notice should be prominently displayed in the center during distribution for the information of all beneficiaries and as evidence of authority to avoid controversy and provide support to center or supervisory personnel in carrying out the program.

4. Other Recommendations

4.1. USAID should utilize its funds to translate this evaluation in order to facilitate presentation to our counterparts CARITAS, MOH, ISTA, OMCOM, and MINPLAN.

ANNEX A

PHASE I OF SURVEY
Sample of Caritas Centers for Title II Management Survey

<u>DIOCEESIS</u>	<u>CENTER NAME</u>	<u>CENTER LOCATIONS</u>	<u>TYPE</u>	<u>Nº BENEFICIARIES</u>
Santa Ana	1. Colonia La Fuerteza	Santa Ana	Parroquial	300
Santa Ana	2. El Tinteral	El Congo	Parroquial	100
Santa Ana	3. Valle Nuevo	Texiatspeque	Parroquial	100
Santa Ana	4. Colonia Zacamil	Masahuat	Parroquial	200
Santa Ana	5. La Isla Norte	Metapán	Parroquial	125
Santa Ana	6. Sor María Teresa Lang	Ahuachapán	Guardería	70
Santa Ana	7. El Espino	Ahuachapán	Parroquial	200
Santa Ana	8. Rev. Guido Vallardita	San Pedro Puxtla	Clínica y Parroquia	500
San Salvador	1. Antigua Cuscatlán (Sor María Saravia)		Clínica	500
San Salvador	2. Rosario de More (Sor Dionisia Hernández)		Clínica Parroquial	200
San Salvador	3. Colonia Luz (Padre Brito)		Parroquial	50
San Salvador	4. Chiltiupán (Hna. Concepción Menéndez)		Clínica	
San Salvador	5. Club de Amas de Casas de Ciudad Arce (ara. de Ayala) M.A.G.			350
San Salvador	6. Barrio El Tránsito (Sr. Merdoqueo Mata) Chalatenango		Parroquial	500
San Vicente	1. Las Delicias	Desvío Frente...	Parroquial	500
San Vicente	2. San Lázaro		Parroquial	450
San Vicente	3. San Pedro Nonualco		Parroquial	350
San Vicente	4. San Ildefonso		Parroquial	500

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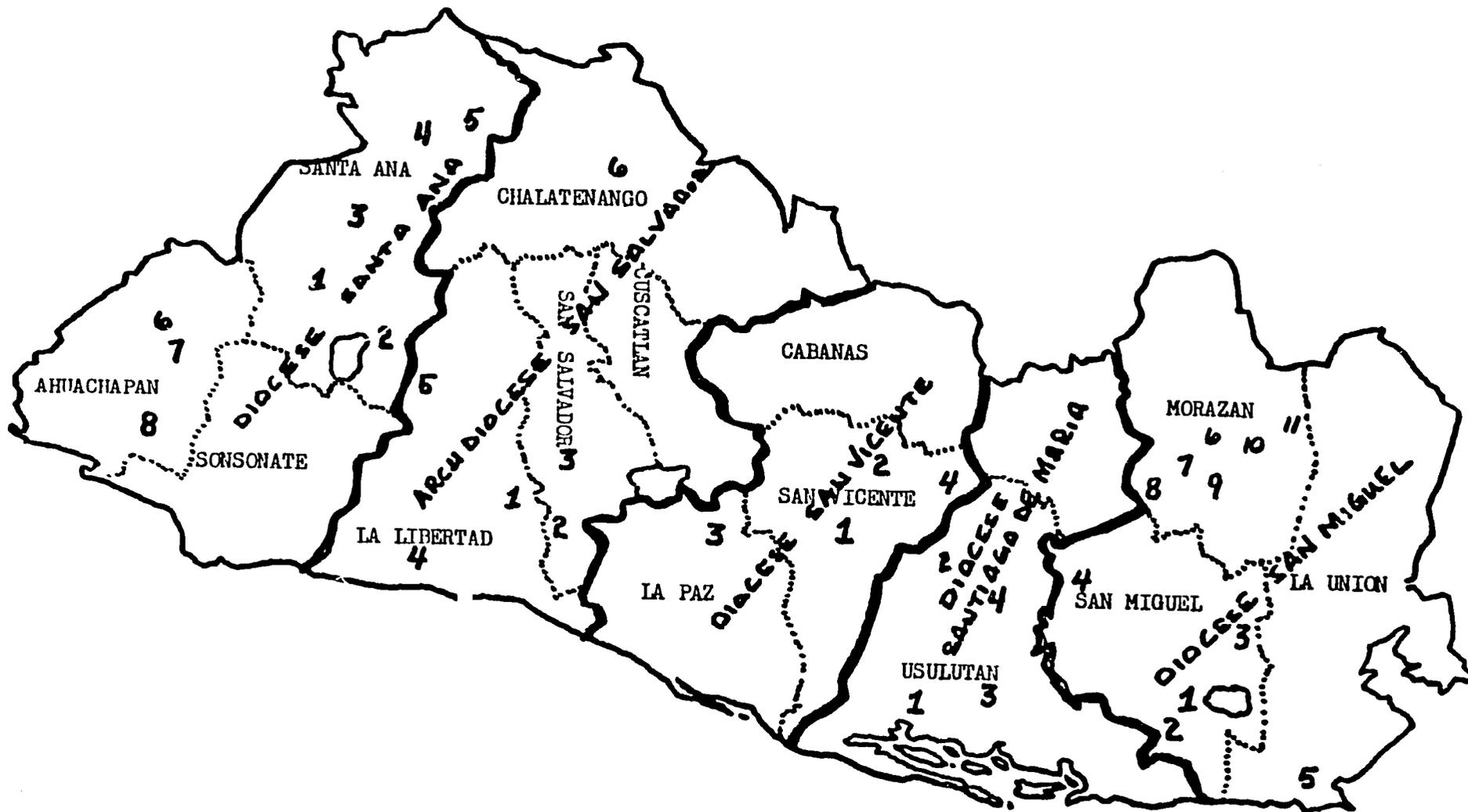
Sample of Caritas Centers for Title II Management Survey (Cont.)

<u>DIOCESIS</u>	<u>CENTER NAME</u>	<u>CENTER LOCATIONS</u>	<u>TYPE</u>	<u>Nº BENEFICIARIES</u>
Santiago de María	1. San Antonio	Tierra Blanca	Parroquial (Juana Cruz Flores)	500
Santiago de María	2. Las Mercedes	Mercedes Umaña	Parroquial (Mercedes Olivares de Henríquez)	500
Santiago de María	3. Ozatlán		Parroquial (Teresa de Médranc)	400
Santiago de María	4. San Vicente	Paul Alegría	Parroquial	90
San Miguel	1. C/El Ruso	Chirilagua	Parroquial	150
San Miguel	2. C/Nueva Concepción	Chirilagua	Parroquial	250
San Miguel	3. C/Río de Vargas	Uluazapá	Parroquia	400
San Miguel	4. C/El Conacaste	Chinameca	Parroquia	350
San Miguel	5. C/Los Patos	Conchagua	M.A.G.	150
San Miguel	6. C/El Aceituno	Yoloainuán	Parroquia	125
San Miguel	7. C/Piedra Luna	Yamabal	Parroquia	100
San Miguel	8. Pajigua	Guatajiagua	Parroquia	100
San Miguel	9. C/Cacahuatalajo	Gotera	Parroquia	100
San Miguel	10. C/Gualindo El Centro	Cacaopera	Parroquia	75
San Miguel	11. C/La Estancia	Cacaopera	Parroquia	150

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PHASE I SURVEY SAMPLE

DISTRIBUTION OF CENTER LOCATIONS
BY DIOCESE



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PHASE II
MINISTRY OF HEALTH

MUESTRA DE CENTROS

LISTA DE ESTABLECIMIENTOS DE SALUD PUBLICA Y ASISTENCIA SOCIAL

REGION I - OCCIDENTAL

1. UNIDAD DE SALUD, APANECA
2. PUESTO DE SALUD, SAN LORENZO
3. UNIDAD DE SALUD, DR. TOMAS PINEDA MARTINEZ
4. PUESTO DE SALUD, SAN ANTONIO PAJOMAL

REGION II - CENTRAL

1. UNIDAD DE SALUD, DULCE NOMBRE DE MARIA
2. PUESTO DE SALUD, SAN IGNACIO
3. PUESTO DE SALUD, SAN FRANCISCO MORAZAN
4. PUESTO DE SALUD, COMALAPA
5. UNIDAD DE SALUD, LA LIBERTAD

REGION III - PARA-CENTRAL

1. CENTRO DE SALUD, SUCHITOTO
2. UNIDAD DE SALUD, SAN JOSE GUAYABAL
3. PUESTO DE SALUD, MONTE SAN JUAN
4. CENTRO DE SALUD, SENSUNTEPEQUE
5. UNIDAD DE SALUD, APASTEPEQUE.

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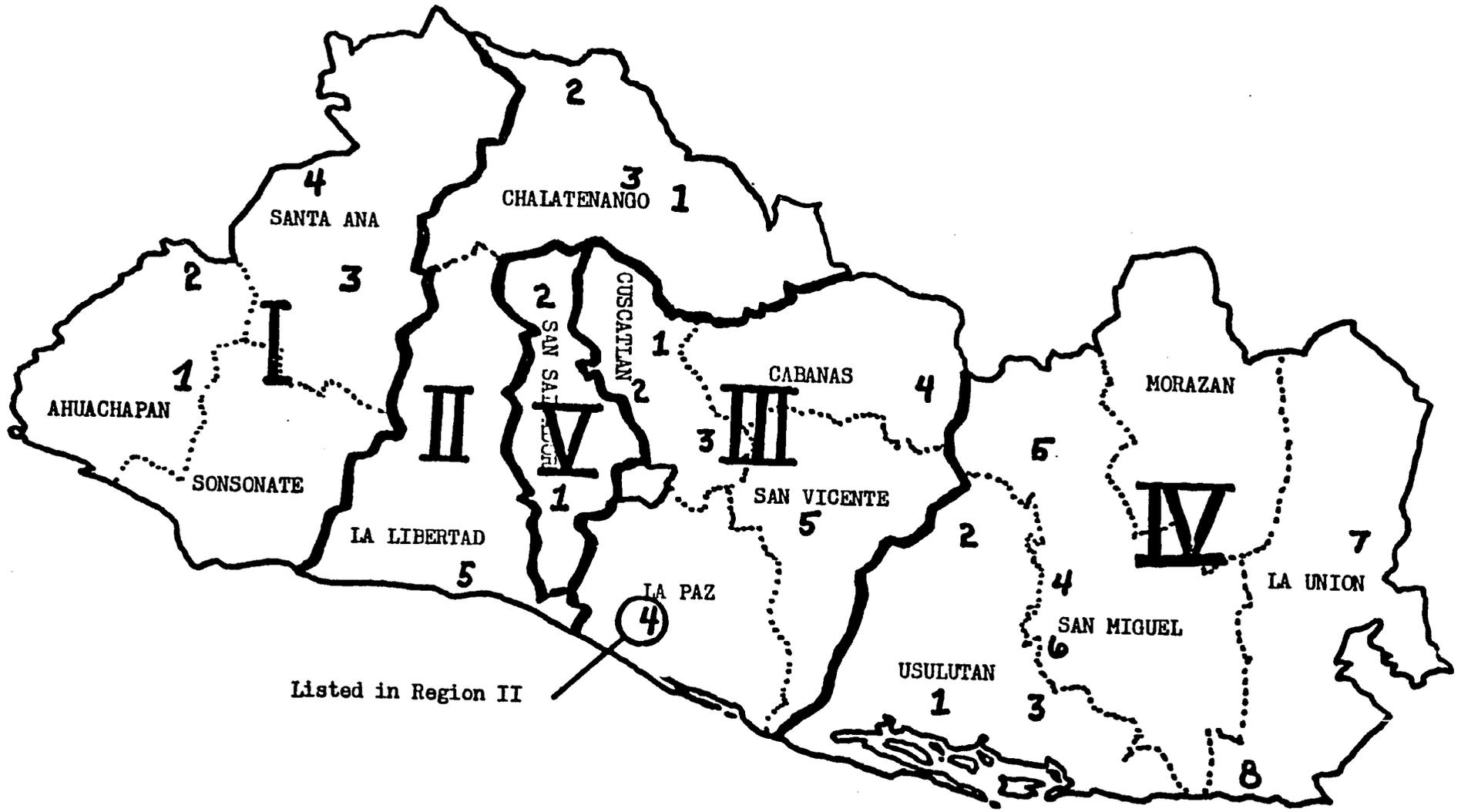
REGION IV - ORIENTAL

1. UNIDAD DE SALUD JIQUILISCO
2. UNIDAD DE SALUD, LSTANZUELAS
3. PUESTO DE SALUD, CONCEPCION BATR
4. UNIDAD DE SALUD, CHINAMECA
5. UNIDAD DE SALUD, SESORI
6. PUESTO DE SALUD, LAS MARIAS
7. PUESTO DE SALUD, PASQUINA
8. PUESTO DE SALUD, INTIBUCA

REGION V - METROPOLITANA

1. UNIDAD DE SALUD, BARRIOS
2. PUESTO DE SALUD, EL PAISNAL

PHASE II SURVEY SAMPLE
 DISTRIBUTION OF CENTER LOCATIONS
 BY HEALTH REGION



ANNEX B

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EVALUACION DEL PROGRAMA DE SALUD

MATERNAL-INFANTIL TITULO II

EN EL SALVADOR, 1977

ENCUESTA DE ADMINISTRADORES DE CENTROS

Institución: _____

Nombre del Centro de Alimentación: _____

Localidad: Región/Departamento/Pueblo: _____

Clasificación del Centro: _____

Nombre y Cargo de la Persona Entrevistada: _____

1. ¿Cuándo empezó el programa de alimentación en esta localidad? _____

Mes _____ Año _____

Deduzca los meses y/o años de operación: _____

Verificado: _____ No verificado: _____

2. ¿Cuántas personas ^{Fueron} atendidas por el programa? (Revise los registros de asistencia) (Ponga verificado o no verificado)

Total _____

Mujeres embarazadas o amamantando que reciben alimentos _____

Niños menores de 3 años que reciben alimentos _____

Niños de 3-6 años que reciben alimentos _____

Niños de 6 años o más que reciben alimentos _____

Otros: (Especifique) _____

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a) ¿Hay personas que reciban alimentos pero no son ^{anotados} en los registros? ¿Cuántas? _____

3. ¿Cuántas personas trabajan en este programa?

a. Tiempo completo _____

Describe: _____

b. Tiempo parcial _____

Describe: _____

c. Voluntarios _____

Describe: _____

¿De los siguientes tipos de personal, qué número tiene el centro?

(Escriba el número de cada tipo. use decimales para personas de tiempo parcial, incluyendo los que cubren mas que un centro)

_____ Doctores (Frecuencia de Visitas) _____

_____ Nutricionistas (Frecuencia de visitas) _____

_____ Auxiliar de Enfermeria (Frecuencia de visitas) _____

_____ Enfermeras (Frecuencia de visitas) _____

_____ Otros para-profesionales: (Especifique) _____

¿Recibe el personal del Centro adiestramiento especial? (Sobre papelería, charlas educativas, manejo de alimentos)

_____ NC

_____ SI

(Continuación)

5a Si la respuesta es SI, favor de describir quien lo impartio, quienes lo recibieron , contenido y duracion: _____

5 b ¿Con qué frecuencia recibe visita del supervisor: Nacional _____
de cada nivel _____
Regiona _____ Fecha de última visita _____

6. ¿Cuales son los criterios en que se basa para la selección de los beneficia-
rios? Marque los criterios utilizados y escriba los detalles requeridos.

A. Tipo de beneficiario:

A.1 _____ Embarazadas

A.2 _____ Madres Lactantes

A.3 _____ Edad de los niños: los límites de edad son:
d _____ años a _____ años

B. _____ Peso de acuerdo a la edad. En qué estado nutricional se selec-
ciona a los niños? normal; _____ desnutridos _____
Grado I; _____ Grado II; _____ Grado III. _____

C. Situación económica: Si es posible, ¿cuál es el grado de ingreso
elegible? _____

D. _____ Residencia ¿Deben ser miembros de este pueblo o vivir a
_____ kilómetros de distancia?

E. _____ No tengo ningún criterio.

F. _____ Otros: Especifica _____

7. ¿Dónde son consumidos los alimentos suministrados? (Guarderías - cuantas veces dan alimentación diaria)

a. _____ En el Centro Nutricional

b. _____ Son llevados a la casa y consumidos allí.

c. _____ Las dos cosas

8. Raciones de alimentos distribuidos corrientemente a cada beneficiario:

a. Tipo de Alimento	b. Cantidad de Alimentos (Lbs.) dinero para comprar	Origen de Alimento	d. Frecuencia de Distribución a cada Persona
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEDUZCA DESPUES: Ración total por distribución _____ Lb.

Ración total por mes _____ Lb.

9. ¿Ha habido algún cambio en el tamaño de la ración durante el último año (1977) (Ver la hoja anexa 9a. para detallar)

a. _____ Ninguno

b. _____ Ha aumentado _____

c. _____ Ha disminuido _____

10. ¿Tiene el Centro los siguientes materiales?

a. Básculas _____ Tipo _____ Estado _____

b. Materiales educativos _____ Tipo y origen _____

c. Gráficos y curvas de peso _____

11. ¿Pesan ustedes a los niños? _____

Frecuencia: _____

¿Quién los pesa? _____

¿Clasifican el grado de nutrición? _____

¿Para qué utilizan los datos? _____

12. ¿Se llevan registros sobre: (Marque las respuestas que se apliquen)

(Cuando la respuesta es SI, pida que le muestren los registros).

(Si no se llevan registros, pida cada uno de los formularios de registro que se usen en el centro).

a. Recibo de alimentos _____

Llevado por _____

CODIFIQUE LUEGO COMO SIGUE:

_____ No se llevan

_____ No muy bien llevado

_____ Se llevan bien hasta la fecha

b. Distribución de los alimentos _____

Llevado por _____

_____ No se lleva

_____ registro y control _____ No muy bien llevados

_____ Se llevan bien hasta la fecha

c. Peso de los niños al inscribirse al programa _____

fi

Responsable _____

_____ No se llevan

_____ No muy bien llevados

_____ Se llevan bien hasta la fecha

d. Control de peso subsecuentes _____

Llevado por _____

_____ No se llevan

_____ No muy bien llevados

_____ Se llevan bien hasta la fecha

e. Asistencia al reparto _____

Llevado por: _____

_____ No se llevan

_____ No muy bien llevados

_____ Se llevan bien hasta la fecha

f. Registros de control de fondos _____

Llevado por _____

_____ No se llevan

_____ No muy bien llevados

_____ Se llevan bien hasta la fecha

13. Tiene día fija de reparto _____Cuál es _____

13a. ¿Llegan los alimentos oportunamente?

_____ No

_____ Si

Cada cuanto tiempo? _____

14. Fueron distribuidos regularmente los alimentos el año pasado?

_____ No

_____ Si

Si NO, cuáles fueron las razones? _____

14a. ¿Cuántas veces no pudo repartir alimentos en el último año?

15. ¿Cuáles son los mayores problemas que se encuentran en el manejo de este programa?

a. _____

b. _____

c. _____

16. ¿Podría ser aumentado el número de beneficiarios del programa?

_____ No

_____ Si

Dar razones: _____

17. ¿Dan las madres una cuota o contribución voluntaria en el programa alimenticio?

_____ NO

_____ SI

a. ¿Cuánto dan _____

b. ¿Para qué se usa el dinero? _____

18. ¿Se dan charlas a las madres? _____ NO

_____ SI

Si la respuesta es SI:

a. Al mismo tiempo del reparto de alimentos: _____ SI

_____ NO

b. ¿Quién las imparte? _____

c. ¿Con qué frecuencia? _____ Diarias

_____ Semanales

_____ Quincenales

_____ Mensuales

_____ Otros

d. ¿Qué temas se imparten? _____

e. _____ ¿Se pide a las madres que trabajen en el centro?

f. _____ ¿Se da gráficos de peso o materiales impresos a las madres?

g. _____ ¿Otros: Especifique _____

19. ¿Se da servicio Salud a las madres o a los niños?

_____ No

_____ Si

Si la respuesta es SI:

a. Que tipo de servicio es éste? (marque las que se apliquen)

(i) Inmunizaciones (vacunas) _____

(ii) Deparasitacion _____

(iii) Consulta médica _____ ¿Con qué frecuencia? Especifique

(iv) Control por enfermera _____

(v) Medicinas _____

(vi) Letrinización _____

(vii) Otras: Especifique

b. ¿Quién proporciona estos servicios? _____

(criterio)

20. ¿Existe algún límite en cuanto al tiempo que una madre o un niño puedan permanecer en el programa de alimentación complementaria?

_____ No

_____ Si

Si la respuesta es SI, favor de indicar cuándo se cesan a los participantes del programa

_____ Después de recuperarse de desnutrición

_____ Después de un período determinado. ¿Cuánto tiempo? _____

_____ Después de llegar a una edad. Edad _____

Falta de asistencia: Explique _____

Otros. Favor de explicar _____

20a. ¿Qué medida toman con los beneficiarios que no asisten regularmente? _____

21. ¿Hay lugar para el almacenaje de alimentos en el centro?

_____ No

_____ Si

Si la respuesta es SI, pida que le muestren el área. (Ver Anexo 21a. para observaciones).

21b. (Ver Anexo 21a.)

22. ¿Cómo podría mejorarse el Programa?

23. ¿Es útil el Programa para la comunidad? - Explique _____

OK _____

12 _____

Fecha de Entrevista: _____

Día _____ Mes _____ Año _____

Nombre del Entrevistador: _____

Prepared by: JCotten/EBrineman:cch

USAID/ES - P.O.

8a. ANEXO

DEDUZCA DESPUES:

8a. De la pregunta #8, resume lo siguiente:

(i) Tipo de alimentos que se usan:

- A _____
- B _____
- C _____
- D _____

(ii) Contribución de alimentos locales a la ración total:

- a. ___ Ninguna b. ___ Menos de 10% c. ___ De 10% a 25%
- d. ___ 25% a 50% e. ___ 50% a 75% f. ___ Más de 75%

(iii) Ración total por mes: _____ Lb.

(iv) Número de veces por mes que la ración se distribuye a cada persona: _____

(v) Total de calorías al día para cada beneficiario _____

(vi) Total de proteínas (en gramos) al día para cada beneficiario.

21a. ANEXO

Observaciones de Almacenamiento Anotar lo siguiente:

Limpieza: _____

Orden: _____

Seguridad: _____

Control de Insectos y roedores: _____

Precauciones contra daño por humedad: _____

Capacidad adecuada: _____

21b. ¿Con qué frecuencia llegan los alimentos dañados? _____

ANNEX C

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ACUERDO ENTRE CARITAS NACIONAL Y CARITAS DIOCESANA NA DE SAN MIGUEL SOBRE EL MANEJO DEL PROGRAMA MATERNO INFANTIL

1. INTRODUCCION

Considerando que es necesario que exista una estrecha coordinación entre Cáritas Nacional y la Cáritas Diocesana de San Miguel, en el desarrollo del Programa ~~Programa~~ "Materno Infantil", se ha creído conveniente elaborar el presente acuerdo que regula las obligaciones de cada una de las partes a fin de cumplir con el objetivo primordial del citado Programa que es el de "Reducir la tasa de desnutrición en niños pre-escolares, madres lactantes y mujeres embarazadas por medio de la educación y alimentación complementaria.

2. OBLIGACIONES DE LAS PARTES FIRMANTES

2.1.- De la Cáritas Nacional:

2.1.1- Presentará todos los años en el mes de enero, ante las Oficinas de Catholic Relief Services (CRS) la estimación anual de necesidades de alimentos para Cáritas Diocesana de San Miguel. Esta estimación se hará en base al No de beneficiarios inscritos y servidos reportados en el último informe mensual; y tomando como ración mensual por beneficiario la cantidad de 6.5 libras compuestas por los siguientes alimentos:

5 libras de W.S.B. ó C.S.M.

1 libra de Avena ó Trigor

$\frac{1}{2}$ libra de aceite.

Para el año fiscal 1976 1977, la cantidad de beneficiarios asignados a la Cáritas Diocesana de San Miguel es de 20.000

2.1.2- Hará también en el transcurso del año, asignaciones parciales para la Cáritas Diocesana de San Miguel; estas asignaciones se harán en base a la cantidad y clase de alimentos existentes en las bodegas de los Puertos de Acajutla o de Cutuco, y tomando en cuenta los saldos de alimentos en la bodega Diocesana, reportados en el informe mensual del mes anterior así como también el número de beneficiarios inscritos y atendidos.

2.1.3- Avisará inmediatamente a la Cáritas Diocesana de San Miguel, de la asignación hecha para que ésta la mande a retirar en un período de 15 días después de recibido el aviso de asignación.

2.1.4- Será el medio de enlace entre la Cáritas Diocesana de San Miguel y las Oficinas de C.R.S. y - A.I.D. en lo que al Programa se refiere, e informará - periódicamente a la Junta Diocesana y a su Gerente de las nuevas disposiciones y recomendaciones emanadas de las oficinas mencionadas.

2.1.5- Dará asesoramiento y orientación a la Cáritas Diocesana de San Miguel y efectuará supervisiones - periódicas, para comprobar el cumplimiento del Programa.

2.2- De la Cáritas Diocesana de San Miguel

2.2.1- Presentará a Cáritas Nacional el día cinco de cada mes los siguientes reportes mensuales del Programa:

- a) Estado de Alimentos
- b) Estado de Beneficiarios
- c) Daños y/o pérdidas de alimentos

- d) Resumen Mensual de Supervisiones de Uso Final
- e) Resumen Financiero
- f) Distribución de donativos en unidades.

Para esta información Cáritas Nacional, proporcionará formularios especiales.

- 2.2.2- Llevará un listado actualizado de todos sus Centros - Nutricionales, indicando:
- a) El nombre del Centro
 - b) Dirección
 - c) No. de beneficiarios
 - d) Día de reparto
 - e) Encargado del Centro
 - f) Clase de Centro (Parroquial, Privado, OMCOM, U.C.S. M.A.G., etc.)
 - g) No. de Centros por Departamento.

Este listado deberá actualizarse anualmente y mandar copia de él a Cáritas Nacional.

- 2.2.3- Firmará Contratos sobre el funcionamiento del Programa "Materno Infantil" con cada uno de los Centros Nutricionales nuevos o en funcionamiento y mandará copia de éste contrato a Cáritas Nacional para su control. Además de este contrato, llevará por cada Centro el "Cuestionario General para nuevos Centros o en funcionamiento", y el listado de los beneficiarios indicando edades y nombres de los padres y direcciones.
- 2.2.4- Se proveerá de todo el material y equipo necesario para el desarrollo del Programa, tales como, formularios, fichas, tarjetas, tarjeteros, básculas, etc.
- 2.2.5- Se proveerá del personal necesario, capacitado e indispensable que será como mínimo:

- a) Un Gerente Diocesano
- b) Una Secretaria
- c) Un Contador
- d) Un Supervisor Promotor
- e) Un Bodeguero
- f) Un Ordenanza

2.2.6- En cada Centro Nutricional solicitarán una cuota voluntaria mensual de 0.50 centavos por beneficiario.

Esta cuota se distribuirá así:

- a) 30 centavos para la Diócesis y 20 centavos para el Centro, cuando los alimentos sean transportados - por los encargados del Centro desde la Diócesis al lugar de reparto y
- b) 40 centavos para la Diócesis y 10 centavos para el centro, cuando los alimentos sean transportados de la Diócesis hasta el lugar de reparto por personal Diocesano.

Los fondos recaudados en este concepto serán para sufragar los gastos de operación; manejo e incrementación del Programa.

2.2.7- Informará mensualmente en forma detallada a Cáritas Nacional, sobre los ingresos y egresos del Programa. Por ningún motivo será permitido utilizar los fondos del Programa, en actividades ajenas al mismo. (Ver - Manual de Operaciones, Ley Pública 480, Párrafo VI).

2.2.8- Hará énfasis en la Educación Nutricional dentro del Programa, para lo cual se proveerá el material educativo necesario.

2.2.9- El Gerente Diocesano y el Supervisor Promotor, prepararán y desarrollarán adiestramientos para el personal voluntario encargado de los Centros.

- 2.2.10- El Supervisor Promotor ~~efectuara~~ efectuara supervisiones mensuales a cada Centro Nutricional, para lo cual utilizara el formato de "Supervisiones de Uso Final" y enviara copia de cada supervisión a Cáritas Nacional.
- 2.2.11- Mantendra actualizados sus controles de beneficiarios por edades y por Centros, así como los relacionados con el estado de los alimentos despachados y saldos en bodega diocesana e informara a Cáritas Nacional de las pérdidas o averías para su correspondiente descargo.
- 2.2.12- En todos los Centros, habran básculas y fichas para el control del estado nutricional del beneficiario. Debe dejarse claramente establecido en los beneficiarios que la finalidad del Programa no es el simple reparto de alimentos, sino que elevar el nivel nutricional de sus participantes.
- 2.2.13- El personal Diocesano hara como mínimo dos encuestas de peso en el año, una cada seis meses, para evaluar el rendimiento del Programa.
- 2.2.14- Dispondra de una bodega, limpia seca y bien segura, para almacenar los alimentos, los cuales estaran ordenados sobre tarimas de madera colocadas en rimeras de bolsas o sacos, dejando un espacio entre fila y fila de 50 centímetros, el mismo espacio debe dejarse de la pared, para permitir la circulación de aire, fácil acceso y desinfección.

3.- DURACION DEL CONVENIO:

El Convenio durara un año a partir de la fecha de su firma por los representantes de las partes, podra ser renovado por mutuo

acuerdo y suspendido y cancelado por incumplimiento en las obligaciones de cualquiera de las partes, pero siempre que se hayan agotado los recursos convencionales para corregir las anomalías.

4.- Revisado y aprobado por los representantes de las partes en San Salvador, a los treinta días del mes de junio de mil novecientos setenta y seis,

J. E. Alvarez Cruz

[Signature]

Presidente de la Junta Nacional
de Cáritas

Presidente de la Junta Diocesana
de Cáritas.



ANNEX D

SCOPE OF WORK

Evaluation of Title II Program in El Salvador

Purpose:

The purpose of the evaluation of the PL 480 Title II program in El Salvador is to identify or corroborate purposes and goals of the program, determine whether they are being met and, if not, to assist managers to improve the design of the program. In order to determine whether best attainable results are being achieved, it will be necessary to decide upon what indicators are most appropriate for measuring program progress.

The evaluation is intended to assist managers of the program to clarify policy issues and identify constraints to effective implementation. The evaluation is not to be regarded in any way as an audit or inspection.

The Scope of the Evaluation:

AID views Title II assistance as interim assistance to combat hunger, alleviate malnutrition, improve economic and social development and/or increase food production and improve its distribution. To meet these objectives, programs of the cooperating sponsor should be coordinated with host government nutrition plans and activities, and commitments for program support from the recipient country should be encouraged. These commitments help to assure the eventual transfer of full responsibility for the programs to the recipient country.

In this connection we need to determine what measures are being undertaken to assure that programs are coordinated and that transfer can and will occur.

In addition, AID is responsible for assuring that programs are implemented in conformity with U.S. Congressional mandates which require evidence that food resources donated by the people of the United States are reaching the poorest of the poor in the recipient country. Thus a review of the beneficiary selection and food distribution processes will be an important part of this evaluation.

Questions concerning policy, appropriateness of program objectives, effectiveness of program implementation, action agent responsibilities, interagency relationships and procedures, and program impact are all to be considered within the scope of this evaluation.

The World Food Program project proposal will also be reviewed to assure that it does not duplicate, overlap or otherwise affect the implementation of Title II activities.

Methodology:

In conformity with AID's increasing emphasis on the collaborative style, and involvement of intermediaries, responsibility for the design, implementa-

tion and evaluation of Title II programs is to be shared among three parties: the recipient country, the USAID Mission, and the cooperating sponsor. To the maximum extent feasible, representatives from all responsible parties should participate in the evaluation process. To this end a Joint Program Coordination Group (JPCG) will be organized consisting of representatives of Technical Committee for Food and Nutrition or National Commission for Social Development, CRS, CARITAS, UCS, ISTA, MOH, USAID and AID/W FFP. This group will deal with policy issues and questions dealing with the coordination of CARITAS and MOH MCH activities and GOES program responsibility. In addition, a Title II Evaluation working group will be designated to assist in data collection and other tasks of the evaluation.

A logical framework matrix will be jointly developed and used as a basis for organizing the reexamination of program design elements and for discussions among the several responsible parties. When finalized, the log frame combined with other program documentation will constitute a Multi-Year Plan to be included in the CRS Program Plan for FY 1979. Once agreed upon, the logical framework and supporting documentation may be used to communicate program objectives to field personnel responsible for implementing Title II activities, and will be used as the basis for future evaluations. The logical framework should include indicators of institutional capability of the cooperating sponsor to manage its programs and expand its outreach. A direct study of the nutritional impact of the program should be undertaken as a check on the linkages between outputs, project purpose and program goal and on the effectiveness and accuracy of monitoring procedures and reports.

The end product of the evaluation will be a report which will serve as an administrative notice to the LA Bureau AID/W that an evaluation has been undertaken, and a summary record of management decisions and recommendations for remedial action.

Implementation Plan

- | | | |
|----|---|--------------------------------|
| 1. | Prepare preliminary Log Frame and Scope of Work (USAID) | September 26 -
September 30 |
| 2. | Initial meeting with CRS to: | October 3 - |
| | - review Scope of Work and Log Frame | October 7 |
| | - Designate members of | |
| | a) Joint Program Coordination Group | |
| | Suggested representation: | |
| | USAID/MEO/GDO/Health & Nutrition | |
| | CRS | |
| | CARITAS | |
| | UCS | |
| | ISTA | |
| | GOES/MOH/Natl. Comm. for Social Dev. | |
| | AID/W/FFP | |

b) Title II Evaluation Working Group.
Suggested representation:

USAID
CRS
CARITAS
FIVE DIOCESAN REPRESENTATIVES
UCS
ISTA
MOH

3. Initial meeting of Working Group to finalize and approve Scope of Work Implementation Plan, and Logical Framework (s).
4. Prepare simple questionnaire or list of questions for survey of:
 - a) Management practices and capability of national, regional and local staffs of the cooperating agencies, and
 - b) Recipient attitudes/awareness.
 - Select survey sample in each of the above groups.
5. Undertake field review of MCH programs using sample organizations/beneficiaries. Management studies to be undertaken by USAID and beneficiary attitude/awareness study by all members of Working Group.
6. Undertake selected, in-depth studies of nutritional impact.
7. Analyze data and write draft evaluation report.
8. Final review of the evaluation report by USAID/CRS/CARITAS/MOH.

An Illustrative Table of Contents for the Evaluation Report for
the PL 480 Title II Program in El Salvador

I. The Nutrition Problem in El Salvador

This section will include a detailed description of the target population including nutritional and health status.

II. Host Government Food and Nutrition Plans, Strategies and Programs

This section will describe GOES plans and programs in food and nutrition. Should include an analysis of the national nutrient gap, the WFP MCH program, the role of IRA and an analysis of the prospect for transfer of responsibility.

III. The Title II Program in El Salvador

This section will constitute the major part of the report. It will include:

- 1) a description and analysis of the Title II program including policies, general philosophy of operation, organization and staffing, infrastructure and programs of each of the cooperating agencies,
- 2) an analysis of management and recipient survey results, and
- 3) the logical framework.

IV. Conclusions and Recommendations

This section will be a summary of the major findings and recommendations for remedial action.

V. Annexes

All statistical data and support material will be contained in annexes.

ANNEX E

ANNEX E

CARITAS STAFFING PATTERN

	National Headquarters	D I O C E S E S				
		San Salvador	Santa Ana	San Vicente	Santiago de Maria	San Miguel
Managers	1	1	1	1	1	1
Supervisors	2	1	1	1	1	
Educators						6
Nurses					1	
Accountants	1	1	1	1	1	1
Auxiliary Accountants	1					1
Secretaries	2	1	1	1	1	1
Drivers	1	1				1
Warehousemen		1	1	1	1	1
Orderlies	2		1		1	

as of May 15, 1978