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FY91 ANNUAL REPORT

Child Survival
and
Applied Nutrition

CRS/Ecuador

Changes in Project Design

A. Statement of Country Project Objectives

As a result of the mid-term evaluation conducted in October 1990 several adjustments were made in the project objectives in order to focus on interventions where nonmedical personnel could have greatest impact, and rely on coordination with the MOH for those components requiring medical expertise:

- Activities to control parasitosis within the beneficiary population were discontinued as a direct project activity. During FY90 activities included the distribution of Zentel to children over two years of age participating in the project. The experience was unsatisfactory for the following reasons:

  - For effective results, all members of the family must be treated.
  - The initial lot of medication was received as a donation to the project. Additional doses required to achieve desired results were found to be extremely costly.

  The project now refers suspected cases, particularly when associated with malnutrition, to the local health ministry facility for testing and treatment.

- Similarly, immunization activities are based on coordination with the MOH. Educational activities within the communities include explaining the importance of complete and timely immunization coverage. Project staff and/or community promoters review each child's health card control to alert mothers when vaccinations should be obtained, and to verify that the schedule is being completed. As of September 1991, over 98% of the beneficiary population had fulfilled the immunization program (PAI) established by MOH norms.

- Control of acute respiratory illnesses is also now implemented primarily in coordination with the Ministry of Health. MOH personnel train Child Survival community promoters in ARI prevention, and diagnosis. In some cases, they also provide direct training to community mothers. When cases requiring medical intervention are detected, children are referred to the nearest rural health post.

During FY91, the following activities were emphasized:

- Transfer to mothers of all growth monitoring skills: weight taking, data reading, data registration, graph design and interpretation.

  This practice gave mothers the opportunity to directly evaluate and understand their children's growth and nutritional progress. At the same time promoters were able to devote more time to other project activities.

- Performance of post-weighing individual nutritional education activities according to specific cases based on growth monitoring data results (age, weight gain, non weight gain). To carry out this activity, specific material was designed (14 illustrated sheets - counselling charts - with nutritional key messages for different audiences, including messages for pregnant and nursing mothers and sick children as well as messages for the use of FUERSAN and the avoidance of nursing bottles). To transfer these messages, educator mothers were trained in each diocese. In Portoviejo 20 fathers also received nutritional education training.

  The addition of these post-weighing educational activities to the project interventions allowed mothers to know "<u>what to do now</u>" to improve their children's nutritional status. This mechanism raised great interest among project mothers.

- As a response to the strong tendency towards use of nursing bottles and lack of motivation to breast feed children, breast feeding and the avoidance of nursing bottles were promoted, especially in the coastal region (Portoviejo) where bottle feeding is more prevalent. Nutritional, immunological and economic advantages of mothers milk were highlighted.

  Breast feeding as a means for family planning and birth spacing was not promoted within the Child Survival project because two of the dioceses initiated separate family planning activities based on other natural methods. In addition, during FY91 the European Economic Community donated PG/53 Fertility Testers via the Ministry of Health and the dioceses have signed agreements to promote and distribute these natural family planning devices. These devices will also be promoted in selected Child Survival communities during FY92 on a test basis to determine their effectiveness and appropriateness.

- Concrete activities were emphasized to prevent diarrhea and to assure the proper use of oral rehydration solutions to treat dehydration symptoms, in order to keep the tendency towards decreasing diarrhea prevalence reached during the four year project implementation period, as showed:

DIOCESES	1986* (Oct-Dec)	1990** (October)	1991** (August)
Cuenca	72.5%	11 %	7.1%
Latacunga	43.5%	4 %	3.1%
Portoviejo	63.5%	9 %	2.1%
TOTAL	61.0%	8.3%	4.7%

* Diarrhea presence in the last month (1-4 episodes)
** Point prevalence

The focus of the diarrheal illnesses control component was broadened when a cholera epidemic appeared in Ecuador in February 1991. Results reflected that the project communities were prepared to confront this epidemic and were also provided with enough oral rehydration salts.

Currently, the cholera epidemic is defined as an endemic condition which can not be eradicated through educational measures alone. It is extremely important to improve sanitary conditions in the rural areas of the country.

- During FY91 the phase out process was strengthened in the 85 project communities which are now carrying out the project activities by themselves. Initial implementation activities for 60 new communities were already started.

- Considering the importance of spacing births, specially in those communities with higher rates of malnutrition, church statements and the necessity of assuring successful interventions for family planning, the Child Survival Project has been performing professional and institutional contacts and approaches.

Currently, the child survival project owns a fertility tester "PG/53" which in combination with breast feeding and the Billins natural family planning method can assure more successful results. This fertility tester will be tested as a pilot plan before spreading its use.

B. Location and Size of the Priority Population Living in the Child Survival Impact Areas

The project was initially implemented through Mother Child Health groups who received Title II food donations. When the program was phased out in FY89 many mothers left the project, reducing the number of beneficiaries. Participation rates have been partially restored, but during FY91 the project took additional steps to increase its coverage within the existing communities. This was principally in response to the midterm evaluation finding that the project beneficiaries did not reflect the normal age distribution of the population as whole, with children under two years of age being significantly underrepresented.

Home visits were made to all families in the communities in order to explain the purpose of the project and encourage families to participate. Particular emphasis was given to recruiting pregnant women, and mothers with children under two years of age. As a result, a total of 310 new mothers were incorporated into the project between January-June 1991. Total coverage as of September 1991 was 2,367 families.

A census carried out by the project in July 1991 revealed the following data on the beneficiary population and on the coverage percentages of all the population:

Entire Project Area	Target Population	Coverage %	
58,949	33,350		Total population.
1,182	695	58.7%	children under 12mos.
1,549	1,014	65.0%	" 12 - 23 mos.
5,504	3,593	65.0%	" 24 - 59 mos.
10,028	6,922	69.0%	" 0 - 72 mos.
3,229	1,878	58.0%	women 15 - 19 yrs.
4,251	2,475	58.0%	women 35 - 49 yrs.
13,884	8,283		women 15 - 49 yrs.
856	515	60.0%	# of births in 1990.

These actual figures differ significantly from the projections included in the project DIP. For example, the number of children 0-59 months was projected at 12,000.

Regarding priority target groups for the project, during FY91 two important decisions were made:

- Training previously oriented to all the beneficiaries was focused more specifically towards the higher risk group of pregnant mothers and children under two years of age in the participating communities.

- The priority target group for all Child Survival interventions was children under two years of age.

In this context, the project as a whole extended the definition of the potential beneficiary population to include families in the entire community, rather than focusing on participants in the original MCH groups.

C. Health Problems Which the Project Addresses

During FY91 a cholera epidemic affected Ecuador, particularly in rural areas with inadequate sanitary services such as those which the project serves. In order to confront the spread of the epidemic, and enable beneficiary communities to respond adequately

in the event cholera cases presented themselves, CRS expanded the educational curriculum to include the following topics:

Cholera Prevention.-

- Community hygiene: waste disposal, separation of animal and human spaces,
- Personal/family hygiene: home cleanliness, washing of hands before and after food preparation and consumption, washing hands after defecation, proper preparation of all foods, avoidance of street vendors, use of latrines.

Cholera Treatment.-

- Identification of cholera related diarrhea as opposed to common diarrhea;
- Need for immediate rehydration therapy;
- Need to seek immediate medical attention.

CRS reproduced and distributed 1,200 copies of a simple educational pamphlet in comic book format within the beneficiary communities. Health promoters participated in training workshops focusing on the above topics which were later transmitted at the community level. Community training materials produced in Peru with support from CRS were also distributed via the Child Survival network.

UNICEF also donated 8,000 packets of ORT salts to CRS which were distributed in Child Survival communities to ensure an immediate treatment capacity. A special shipment of cholera supplies and medication valued at $208,000 was obtained from the Catholic Medical Mission board and arrived in country in October 1991. Distribution will take place in FY92.

These activities were coordinated with the Ministry of Health, and the country's National Committee to Fight Cholera. Although some cholera cases in Child Survival beneficiary communities were reported in the early months of the epidemic, no deaths occurred within families participating in the project.

D. Child Survival Interventions

1. Nutrition Education

Among the project's accomplishments during its 4 years of implementation, has been a significant reduction in the incidence of diarrhea and resulting dehydration. This was confirmed by the October 1990 mid-term evaluation, demonstrating that the project's educational activities related to diarrhea prevention and treatment have produced the desired changes in mothers' knowledge, attitudes, and practices related to diarrhea. Current rates of diarrhea are 8.8% (approximately 5 episodes per child per year), with 8.2% of these cases showing at least one symptom of dehydration.

A much more difficult and persistent problem, however, has been the prevalence of malnutrition among children in the project's target group. Figures for August 1991 showed that 45.8% of the children suffered some degree of malnutrition, which represents almost no improvement from the beginning of the project.

In order to focus more directly on this problem, particularly given that FY91 was the phase-out period for the original communities, CRS developed a specific nutritional education strategy and methodology based on the following principles:

1. The nutritional strategy is based on the monthly growth monitoring performed by the promoters.

2. Nutritional education advice must be easy to perform, involve no additional cost and demand little time from mothers and other caretakers.

3. This strategy is based on social marketing techniques to reinforce positive feeding practices and discourage negative ones.

4. Nutritional advice is based on the knowledge, attitudes, and practices of beneficiary mothers.

5. All the educational messages were standardized for the three project areas.

6. The strategy was implemented through interpersonal as well as group level activities.

7. Appropriate and specially designed material was used by personnel responsible for carrying out the educational activities.

8. All the participants received proper training and supervision.

Among the new interventions in the nutritional component, was the consumption of FUERSAN, a highly nutritional blend, prepared with bean and barley flour. (100 grams of FUERSAN provide 395 calories, 13 grams of protein with a protein score of 85%) Given that beans and barley are produced in the highland provinces of Cotopaxi and Azuay, FUERSAN is prepared with locally available products, while in Manabí (coastal region) mothers have organized a wholesale buying scheme for this purpose.

A copy of the nutrition education messages is included as Annex A to this report.

2. Decentralization

After three years of project implementation, the majority of participating communities demonstrated that they were able to carry out the project activities by themselves. Taking this into consideration, during FY91 a phase out process involving the following steps was carried out in the communities:

- Reducing the frequency of staff visits to those communities with more capacity of self-sustainability and lower rates of malnutrition.

- Performance of the following project tasks by the community personnel and promoters:

  . Education to mothers
  . Administration of credit through credit committees.
  . Analysis of growth monitoring results.

E. Strategies for Identifying and Providing Services to Individuals at Higher Risk

The adjustments in project methodology implemented as a result of the mid-term evaluation included the following:

- **Identifying new beneficiaries within the target communities, particularly pregnant mothers and children with nutritional deficiencies, and incorporating into project activities.** This was accomplished by the diocesan project teams, by making household visits to all families in the communities, explaining the purpose and activities of the project, and inviting them to participate in the project.

- **Adjusting the frequency of growth monitoring sessions, according to the age of the child.** Children from 0-12 months continue to be weighed on a monthly basis, while older children, from 13-72 months, are now weighed quarterly. Children with nutritional deficiencies are also weighed monthly until their weight/age reaches acceptable levels. This shift has enabled greater attention to be placed on children whose growth is at a more critical phase, and has made growth monitoring sessions less mechanical.

- **Conducting individual nutrition education sessions with mothers whose children show inadequate growth .** When a growth deficiency is identified during a growth monitoring session, the health promoter conducts a follow up home visit during the month to discuss appropriate feeding practices in order to overcome the problem. This has enabled the nutritional component of the project to focus more specifically on high risk children.

- The symbol to identify the <u>weight gain</u>, was selected as the indicator to identify malnutrition risks. This is noted on the Child Health Charts as follows:

  / gains weight

  - does not gain weight

  \ high risk

II. <u>Human Resources and Collaboration</u>

A. New Staff.-

In November 1990 CRS contracted Dr. Yolanda de Grijalva as manager of the Child Survival/Applied Nutrition project. She is

a recognized national authority in child health and nutrition programs. In addition to working for over 20 years for the Ministry of Health, she has frequently served as a consultant to UNICEF and other international organizations. A copy of her resume is included as Annex B to this report.

B. Technical Assistance.-

In its continuing efforts to improve the project information system, CRS contracted a systems analyst who reviewed the existing data base and made necessary modifications in order to enable its utilization with the CDC software package EpiInfo.

In addition, professionals from Peace Corp and the Ministry of Public Health provided the diocesan teams with technical assistance during a three day workshop on community organization and participation.

C. Community Activities.-

During FY91, a total of 85 community groups in the Provinces of Azuay, Manabí, and Cotopaxi participated in the Child Survival project. These groups met on an average of twice each month to participate in growth monitoring, health and nutrition education, and agricultural production activities.

Each community designates two promoters, who dedicate an average of 10-15% of their time to project activities. In some cases both focus on health and nutrition, while in others one assumes responsibility for this component while the other specializes in the agriculture and animal raising activities.

There is also a Credit Committee in each community, which includes two people who are responsible for managing the revolving loan fund for agricultural production. Funds disbursed by the project, and repayments of capital plus interest are kept in a savings account in the nearest bank.

D. Linkages to Other Health and Development Activities.-

- The principal entity with which the project coordinates activities is the Ministry of Health at the provincial level. Child Survival diocesan staff actively promote participation in the Ministry's immunization programs, resulting in almost 100% coverage of the beneficiary population. In addition, project components such as deparasitization and treatment of respiratory infections requiring medical personnel are implemented via the local Ministry facilities.

  In October 1991 a formal agreement was signed between CRS/Ecuador and the Minister of Health to specify the obligations of each party in the new project extension. A translation of this Agreement is attached as Annex C.

- To a more limited extent, local coordination has been established between the CRS Child Survival project and other health activities in the same areas. These include Project HOPE, Red Comunitaria of the Social Welfare Ministry and the Child Day Care Program of INNFA.

- During February-March 1991 UNICEF carried out a worldwide evaluation on Growth Monitoring Strategies. Ecuador was one of the six countries where this evaluation took place and the CRS Child Survival Project was selected as one of the programs under study.

  The main conclusion of the evaluation was that Growth Monitoring is the best strategy to fight child malnutrition. Nevertheless, it is possible to take advantage of this strategy only when there is active participation and formal commitment by the communities and mothers to evaluate child nutritional status and to identify the causes that prevent adequate growth and their practical solutions.

  This experience gave CRS the opportunity to share the project's achievements and lessons learned with other institutions

III. Progress in Health Information Data Collection

A. Baseline Survey

Perhaps the most important finding of the midterm evaluation was the strong correlation found to exist between project impact and low socio-economic status of the beneficiaries. That is, the participants who demonstrated the greatest difference as compared to the evaluation control group (no project benefits) were those with the lowest socio-economic level as inferred by mothers' educational level. The conclusion for maximizing project impact was therefore to ensure that services were targeted to sectors with the greatest need.

In preparing the FY92 project extension to 60 additional communities, a three phase selection process was carried out in order to ensure the target area had demonstrable need in terms of health and nutritional indicators. CRS and project staff from the implementing dioceses developed a list of preconditions which included the following:

- High malnutrition rates
- Lack of basic services and illiteracy
- Deficit in health services (distance and access)
- Existence of or potential to establish community organization.
- Population size: communities with an average of 100 families per community.
- Minimal presence of other development programs.
- Proximity to other communities, enabling zonification of project coverage.

Then, parish priests proposed areas which, based on their direct contact with local residents, apparently met these conditions. Project staff then interviewed key informants in each community to determine the total number of families, average number of family members, existence of electricity, water, and waste disposal services. After analyzing this information, a provisional selection of communities was made, with the following characteristics:

- There is an average of 40 families per community.
- There is an average number of 6 members per family.
- 55% of the families have electricity.

- Only 30% of the families have piped water for home consumption and 70% use streams or rain water.
- 70% of the families have no waste disposal facilities for defecation or household refuse.
- Approximately 60% of the mothers are illiterate or have low educational levels (second grade or less).

Anthropometric data on all children under 7 years of age in the preselected communities were then registered, data on mothers' educational levels were also collected. These data will serve as the basis for the final selection. Final results on all communities are not yet available, but the following preliminary nutritional data have been reported by the diocesan teams for the entire population surveyed:

	Prevalence of Malnutrition		
Age Group	Weight/Age (Overall)	Height/Age (Chronic)	Weight/Height (Acute)
0-24 mos.	38.0%	49.8%	6.8%
0-60 mos.	47.4%	60.4%	4.1%
0-72 mos.	49.1%	62.2%	4.5%

The total range of malnutrition rates, depending on the community, was between 15-80%.

In October 1991 CRS began the design of a full baseline study of the selected communities to collect the following information:

- Family size and composition: sex, age, educational level and kind of employment for each family member.

- Child health knowledge and practices regarding: vaccinations, growth graphs, diarrhea, use and episodes , presence of colds, cough, fever or other kind of illnesses.

- Hygiene practices: water, garbage and human waste disposal facilities.

- Feeding practices:
  . Pregnant, nursing and mothers with children under two years of age.
  . Breast feeding and weaning periods: frequency,

quantity, variety, consistency and feeding for sick children.

- Dietary patterns: family, children under two years of age and pregnant and nursing mothers.

- Animal raising and agricultural production: land holdings, amount of arable, cropping patterns, kind of animals, soil conservation practices, availability of credit and technical assistance.

- Community organization and participation: belonging to other associations, ability to be a leader, ability to work in community tasks.

Technical assistance will be contracted to finalize the survey instrument and sampling methodology. The final results of this survey will be available in December 1991.

B. Routine Data Collection

After analyzing the October/90 evaluation results, CRS and the diocesan teams decided to modify the information system as follows:

Community level: Records data on individual child weight gain and nutritional status. Two health charts are used, the first in charge of the health promoters, and the second for the mothers. Both charts register whether children have diarrhea by writing **diarrhea 1**. When children have dehydration the number is circled. If children have two diarrheal episodes in the same month **diarrhea 2** is written instead of diarrhea 1; for dehydration symptoms the number is also circled. This step must be followed according to the number of diarrheal episodes.

Educational contacts are registered at the top of the community chart. Educational contacts with pregnant mothers are registered in the lists used by the promoters.

Diocesan level:	Uses summary forms registering child nutritional status and the incidence of diarrheal illnesses per community.
CRS level:	Uses summary forms registering nutritional status and incidence of diarrheal episodes per diocese, including quantitative and qualitative analyses.

During FY91 additional steps were taken to improve data collection, processing, and analysis. These improvements will serve also for the FY92 expansion phase, and include:

- Acquisition of computer equipment for each of the three dioceses, including technical training to the diocesan teams.
- Utilization of the EpiInfo5 Program, and the provision of technical training to the diocesan teams on data entry and analysis.

It is important to point out that the diocesan teams are now using computer equipment for the first time. The analysis of nutritional prevalence is therefore a key activity for which they have now assumed responsibility.

IV. Improvements in Program Quality and Technical Effectiveness

A. Lessons Learned

- During FY 1991, administrative and financial decentralization took place, giving greater responsibility and autonomy for implementation decision s to diocesan project teams. Some of the difficulties which were encountered initially during this process ca n be attributed to insufficient technical preparation of diocesan personnel. This in turn contributed to a certain degree of insecurity regarding diocesan responsibilities, and also limited the degree of creativity in the new atmosphere of greater independence. CRS increased the frequency of visits in order to reinforce technical skills, instill greater confidence in the diocesan staff, and ensure the completion of the project objectives.

- After the communities become familiar with the basic project activities, particularly growth monitoring and educational sessions, there is a strong tendency for these to become routine and mechanical. It was therefore increasingly difficult to maintain the mothers' level of interest in attending meetings, and attention spans during the meetings began to drop. To overcome this problem, the project assigned responsibility for an increasing number of activities to the mothers themselves, and diversified the types of activities carried out during each meeting. Similarly, it was necessary to develop new educational materials in order to reduce repetition and keep interest levels high.

- The CRS project used the same Child Health card as the Ministry of Public Health during the first two years of the project. Subsequently, however, the Ministry modified its form, which meant that Child Survival project mothers needed to be familiar with two formats. This caused considerable confusion, and as a result CRS has decided to adopt the official MOH version for the FY92 extension. It will be also important to standardiz e the use of health messages and materials to simplify project activities and enable closer coordination with the Ministry.

- The use of monetary incentives for community promoters can have unanticipated negative effects. The CRS/Ecuador project initially covered transportation and incidental expenses for promoters when making home visits to outlying areas. This was later the cause of criticism by community members who accused promoters of taking advantage of the project for personal gain. For the coming period incentives to promoters, on either an in-kind or cash basis, will be provided by the communities themselves.

B. Steps Taken to Strengthen Technical Quality.-

Growth Monitoring:

- Practical guidance on specific feeding practices is now given to mothers during post-weighing interpersonal nutritional education activities. Previously, nutritional messages were communicated primarily at the group level, and were found to be too general to have the desired impact.

- Use of the weight gain indicator to determine appropriate corrective actions.

- Training has been provided to new community agents such as mothers and fathers who will work as nutritional educators.

Production/credit:

- Greater correlation has been established between production activities promoted by the project and the nutritional requirements of the beneficiary population. Thus, emphasis is being placed on increasing the number of different crops and animals within the family's production scheme, in order to increase the diversity and quality of food available for home consumption.

V. Work Schedule

A. Problems and/or Constraints to Implementation.-

1. Project activities focused on nutritional recovery of children with severe malnutrition, especially those between 4 and 5 years of age.

In attempting to understand the persistence of malnutrition levels within the beneficiary population, CRS staff identified the priority being given to the group with severe malnutrition as an apparent methodological error. It is now felt that the problem of malnutrition can be better addressed by preventive interventions, giving priority to children under two years of age, before malnutrition becomes established.

2. High turnover of community promoters.

In some cases this has been the result of other programs, such as the Ministry of Social Welfare's rural day care program, entering the community and offering paid positions to Child Survival project promoters. In other cases promoters have moved or gotten married and their husbands would not allow them to continue participating in the project.

CRS/Ecuador feels that to some extent these problems are unavoidable when voluntary personnel are used. To mitigate the effects of turnover, however, the following activities were carried out:

- Training was provided to new promoters
- Training for new types of community agents, especially for the performance of nutritional education activities (men and women).
- For the extension phase cash or in-kind incentives for promoters will be required of all participating communities.

3. Inefficient use of technical staff time.

At the diocesan level, the three team members have been responsible for all the communities. The nutritionist, the agronomist and the social promoter visited each community on the growth monitoring meeting day. At the beginning of the project, this methodology enabled the staff to develop a common approach and shared knowledge of the beneficiary communities. Since this need has now been met, it is no longer necessary to make such a heavy investment of technical staff time in having all three professional staff visit each community. For the extension phase, each staff member will have primary responsibility for a specified number of communities, receiving technical support from the other team members as required.

CRS staff time is also being used more efficiently as a result of administrative and financial decentralization. The focus of CRS' relationship with the diocesan teams is now on technical support concerns and monitoring fulfillment of approved annual operational plans.

B. Work Plan for FY92

The key activities to be carried out during the FY92 project extension are:

1. Analysis of anthropometric results (weight, height, age) of all children under 7 years of age in all the preselected communities, including:

   - Determining prevalence of acute (weight/height), chroni c (height/age), and overall (weight/age) malnutrition.

   - The malnutrition prevalence will be analyzed by using the Z score corrected for positive and negative false amounts (Mora's method).

   - Height of all 7 year old children.

   - Analysis of other important data gathered in the communities prior to the final selection of the communities: community size, number of family members, availability of electricity, water and defecation disposal facilities, and mother educational level.

2. Design of the annual operational plan with active participation of the communities. In preparation for this step, CRS organized and implemented a seminar for diocesan project staff on community organization and participation in October 1991.

3. Definition of local level agreements with Ministry of Health.

4. Selection and training of voluntary personnel.

5. Design of training and educational material.

6. Follow-up and evaluation.

A Gantt chart of key activities is included as Annex D.

VI. Changes in Project Expenditures and Justification for Budget Changes

A. Pipeline Analysis.-

The Pipeline Analysis has been included as Annex E.

B. Justification for Budget Revisions.-

A Budget Comparison sheet is attached as Annex F. The following categories require significant adjustments as a result of extending the project for one additional year to 60 new communities.

I. PROCUREMENT

A. Supplies:	An increase of $59,965 will be required to bring the agricultural production component during FY92 to $90,000. This is the minimum budgetary level needed to undertake this component in 60 additional communities.
B. Local Consultants	The amount originally budgeted for local consultants included diocesan agronomists, who were to be hired on a contract basis. The total will not be required in this item since this is now considered a staff position and is charged to salaries.
II. Evaluation	Only $3,000 was originally budgeted to evaluate a project valued at $850,000. This item was overspent during the midterm evaluation. An additional $4,000 has been budgeted for the final evaluation in FY92.

IV. Other Program Costs

A. Personnel	An increase in this category is required to continue project staff during the FY92 extension period.

B. Travel — Budgetary levels for in-country travel can be significantly reduced without negative consequences for the project.

c. Other Direct — Actual expenditures charged to this line item have been minimal, so the total amount budgeted can be reduced.

VII. Sustainability

A. Recurrent Costs.-

Recurrent costs for maintaining the three diocesan project teams (salaries, transportation, office expenses) are approximately $45,000 per year. Currently, the only source of revenue for project activities is the interest payments made by beneficiaries on loans received for production activities. At the existing interest rate of 36%, this income is projected to be approximately $29,000.

Project components which are least likely to continue solely with resources available at the community level include training of local health promoters and the production of new educational materials.

The Ministry of Health is currently responsible for providing primary health services, including immunizations, deparasitization, ORT packages, and ARI training and treatment, to the project communities. The Cooperation Agreement recently signed between CRS and the MOH at the national level will enable this coordination, particularly of primary health care services, to be enhanced and extended. The Ministry's principal shortcomings are related to nutrition interventions: growth monitoring at appropriate intervals (currently mother and child weighing is linked to immunizations), and nutrition education, including community training and production of educational material. The MOH is also not prepared to undertake production activities, although CRS coordinates closely with the Ministry of Agriculture and some project areas, particularly in the Province of Cotopaxi, will be able to continue with MAG extensionists.

B. Strategies for Reducing Sustainability Concerns.-

1. Approach to Creating Sustainable Benefits

The issue of sustainability is understood as involving much more than financial or cost recovery considerations. Any community activity requires a stable and effective local organization in order to continue over time. Strengthening community organization is therefore an explicit focus of the efforts of the project team in each participating community, and progress in this regard is measured against objective indicators such as:

- Frequency of and attendance at meetings.
- Degree of participation in group activities.
- Internal democracy: leadership selection and rotation.
- Resource management skills
- Problem analysis and problem solving skills.

During the course of implementation, responsibility for managing project activities is gradually passed over to the communities themselves, with project staff playing an increasingly secondary role. Thus, for example, growth monitoring sessions initially require active involvement of staff to ensure that scales are properly calibrated, health cards filled out correctly, etc. Later, it is the promoter who organizes the session with project staff present for consultation purposes. Once the procedures are learned, the promoter and mothers conduct growth monitoring without project staff being present.

Similarly, the agronomist provides continuous orientation to the food production/credit component in the early phases. This includes training and practical demonstrations in horticulture and small animal raising activities, soil conservation measures, and small scale irrigation. In addition, principles of credit administration are stressed in order to prepare the community for self-management of the fund. Each community establishes its own bank account where monies from loan repayments plus interest are deposited. The agronomist plays an advisory role to the communities in the approval of new loans, gradually reducing his influence over time.

The production component is clearly one of the most important to project sustainability for several reasons. First, it serves as a strong incentive for community organization by offering tangible short run benefits which are easily understood by the

beneficiaries. Experience has demonstrated that it is often difficult to maintain community interest in preventive health and nutrition activities, because benefits are generally less immediate and visible. The CRS/Ecuador project itself suffered difficulties in this regard when the Title II program was phased out in FY89 and many mothers dropped out of the project when their monthly food rations were discontinued. Over time, participation levels have gradually been recovered, but mothers overwhelmingly report that one of the most attractive project services is food production and credit.

Agricultural production also contributes to project sustainability by increasing the variety and quality of food available for home consumption. Growth monitoring and education alone cannot alter the nutritional status of the target population unless mothers have the means by which to improve their families' dietary intake.

Since surplus production is sold on the market, the agricultural component also serves to generate complementary income for project families. This therefore constitutes the only income generating component of the project, and during the FY92 extension phase will serve as the source of for community compensation for health promoters.

2. Training to Increase Understanding

The principal focus of CRS/Ecuador's efforts in this regard during FY91 was on defining the terms for operation of the community loan funds. It is particularly difficult in Ecuador to operate a credit program in rural areas using real rates of interest because the GOE itself sponsors several programs with subsidized rates for small farmers. Nevertheless, CRS has actively pursued this issue with diocesan project staff and participating communities, stressing the need to charge interest rates that are as close to the rate of inflation as possible (currently 50%) in order to minimize decapitalization. The rate being charged by communities at the end of FY91 was 36%.

C. Cost Recovery Activities.-

During FY91 the project's principal cost recovery mechanism was the revolving loan funds being managed at the community level for agricultural production. Although loan repayments, which have been maintained at 98% of capital plus interest, are not used to cover project operating costs, the relationship of this component to sustainability of benefits via incentive to organization and improved food security, are described in Section III.B above.

The overall perception by the communities of this mechanism is highly positive, with the exception of areas where other PVO programs are operating with no repayment requirements. This community acceptance was confirmed by the FY90 midterm project evaluation. One negative finding, however, was the fact that mothers from the lowest economic strata, were often unwilling to assume the risk of credit. The project was thus faced with the dilemma of how to deliver services to those with greatest need, while also meeting the need to enhance impact by increasing the availability of resources for production activities.

No definitive solution to this problem has been identified, but certain technical adjustments have been made to give preference to production activities which involve fewer risks.

Since the beginning of the project a total of $115,000 have been invested in community managed loan funds. The current value of funds recovered and extended as new loans is $81,000. The cost of managing these funds is minimal, involving principally the time required of elected community leaders in keeping records, as well as occasional transportation costs to the bank.

These resources are used to finance new agricultural production and animal raising activities.

There is a high degree of acceptance of this project component because benefits are short term, tangible, and clearly understood to remain at the community level. As regards financial success, for the reasons cited above, it has not been possible to establish conditions which will avoid decapitalization of the funds. Under existing terms and economic conditions, the funds will decapitalize at approximately 15% per year, enabling credit services to continue to be provided at a reasonable level, and maintaining an effective incentive for community organization for several years after external funding terminates.

ANNEX A

CRS/ECUADOR
NUTRITIONAL EDUCATION STRATEGY

The CRS/Ecuador nutritional education strategy focuses on pregnant/nursing mothers and children under two years of age because gestation periods and early years of life require better nutritional intake in order to avoid nutrition problems. Dietary habits are acquired during the early years of life and are difficult to change as people get older.

AUDIENCE SEGMENTATION

For the implementation of the nutritional education strategy, the following groups were distinguished:

- Children under 4 months (0-4)
- Children from 4 to 6 months (4-6)
- Children from 7 to 12 months (7-12)
- Children from 1 to 2 years of age
- Pregnant mothers
- Nursing mothers

DEFINITION OF CONCEPTS

One of the most important aspects in a NE strategy is to decide WHAT TO SAY, which results in advices and concepts, afterward transformed in educational messages.

For this strategy the concepts were defined as follows:

MESSAGES FOR PREGNANT MOTHERS

1. PREGNANT MOTHERS MUST EAT A LITTLE MORE, SO THAT THEIR CHILD WILL BE BORN HEALTHY.

2. ALWAYS EAT: BREAKFAST, LUNCH AND DINNER AND A SNACK BETWEEN MEALS IN THE MORNING AND IN THE AFTERNOON.

3. EAT FOOD PREPARED AT HOME, BUT AS VARIED AS POSSIBLE TO AVOID UNDERNUTRITION DURING THE PREGNANCY.

4. IF YOU ARE PREGNANT, SERVE MEALS FILLING YOUR OWN DISH FIRST, BECAUSE YOU AND YOUR CHILD DESERVE MORE CONSIDERATION.

5. TO ALLEVIATE THE SYMPTOMS OF THE FIRST MONTHS, EAT SOLID FOODS, LITTLE BY LITTLE, MANY TIMES A DAY. HAVING SOMETHING IN YOUR STOMACH WILL ALLEVIATE THESE SYMPTOMS.

6. DURING THE FIRST MONTHS OF PREGNANCY, YOU MUST EAT EVEN THOUGH YOU ARE NOT HUNGRY TO GUARANTEE THE NORMAL DEVELOPMENT OF YOUR UNBORN CHILD.

MESSAGES FOR FEEDING CHILDREN UNDER TWO YEARS OF AGE

1. YOU MUST BREASTFEED YOUR CHILD IMMEDIATELY AFTER HIS BIRTH IN ORDER TO PRODUCE MORE MILK.

2. ALWAYS GIVE THE FIRST MILK TO YOUR CHILD. IT IS EXCELLENT NOURISHMENT THAT PREVENTS HIM FROM GETTING SICK.

3. UNTIL FOUR MONTHS OLD, THE CHILD SHOULD DRINK ONLY MOTHER'S MILK, THE BEST FOOD, AND ENOUGH TO SATISFY THE CHILD HIS NEEDS.

4. FROM 4 TO 6 MONTHS OF AGE, IN ADDITION TO MOTHER'S MILK, BEGIN TO GIVE THE CHILD LIGHT FOOD BECAUSE HE NEEDS MORE FOOD TO CONTINUE GAINING WEIGHT.

5. BEGIN TO PROVIDE:
   - FAMILY FOOD
   - THICK FOOD
   - 5 - 10 SPOONS EACH TIME
   - 1 - 2 TIMES A DAY

   AND CONTINUE BREASTFEEDING YOUR CHILD

6. A 6 MONTH CHILD EATS:
   - 10 SPOONS EACH TIME
   - THICK FOOD
   - FAMILY FOOD
   - TWICE A DAY

   SO THAT YOUR CHILD WILL GROW HEALTHY AND STRONG

7. A 9 MONTH CHILD EATS:
   - A HALF DISH EACH TIME AS HIS STOMACH IS BIGGER
   - LITTLE PIECES OF SOLID FOODS AS HE ALREADY HAS TEETH
   - THE FAMILY FOOD IS NOT HARMFUL FOR HIM
   - THREE TIMES A DAY BECAUSE HE NEEDS MORE

   AND CONTINUE BREASTFEEDING HIM BECAUSE MOTHERS MILK CONTINUES BEING A GOOD NOURISHMENT

8. A ONE YEAR OLD CHILD EATS:
- A FULL DISH EACH TIME TO MEET THE CHILD REQUIREMENTS
- THICK SOUPS AND SOLID FOOD AS THEY ARE NOURISHING PRODUCTS
- 5 TIMES A DAY, AS HE NEEDS MORE FOOD TO PLAY, WALK AND CONTINUE GROWING.
- HE CAN EAT BY HIMSELF THE FAMILY FOOD

AND CONTINUE BREASTFEEDING HIM

9. A TWO YEAR OLD CHILD EATS:
- EACH TIME IT IS NECESSARY SO INCREASE WHAT THE CHILD EATS FOR HIM TO CONTINUE GROWING HEALTHY AND STRONG.
- 5 TIMES A DAY AS HE NEEDS MORE FOOD
- HE CAN EAT EVERYTHING AND HE LIKES TO EAT. HE CAN EAT THE HALF PORTION OF WHAT HIS FATHER EATS.

10. NEVER USE NURSING BOTTLE BECAUSE:
- NURSING BOTTLES CAN HAVE GERMS AND PRODUCE DIARRHEA
- COMMERCIAL MILK IS VERY EXPENSIVE
- CHILDREN WHO NURSE FROM A BOTTLE CAN BECOME SPOILED AND NOT WANT TO EAT SOLID FOODS.
- IT IS HARD TO STOP USING NURSING BOTTLE, MOTHERS AND CHILDREN SUFFER A LOT.

11. TO DETERMINE IF YOUR CHILD IS PROPERLY GROWING, IT IS NECESSARY TO WEIGH HIM MONTHLY AND FILL OUT THE GROWTH MONITORING CHART.

MESSAGES FOR A SICK CHILD

1. WHEN THE CHILD IS SICK YOU MUST BREASTFEED HIM MORE FREQUENTLY THAN USUALLY BECAUSE MOTHER'S MILK IS THE BEST FOOD AND PROTECTS HIM FROM ILLNESSES.

2. BESIDES BREASTFEEDING YOUR CHILD, CONTINUE GIVING FOOD TO HIM, AS HE NEEDS FOOD TO GET WELL.

3. GIVE HIM MORE FAMILY FOOD AND PREFERABLY THICK FOOD, IN ORDER TO HELP HIM RECOVER HIS WEIGHT AND GROW HEALTHY AND STRONG.

4. THE SICK CHILD NEEDS TO EAT: "IF A SICK PERSON EATS HE DOES NOT DIE".

MESSAGES FOR NURSING MOTHERS

1. GOOD MOTHERS BREASTFEED THEIR CHILDREN BECAUSE THIS IS THE BEST MILK: NOT EXPENSIVE, DOES NOT REQUIRE PREPARATION; ADDITIONALLY, THE MOTHER-CHILD CONTACT STRENGTHENS EMOTIONAL LINKS.

2. NURSING MOTHERS MUST EAT MORE THAN USUAL TO PRODUCE ENOUGH MILK TO BREASTFEED THEIR CHILDREN.

3. THE KEY TO PRODUCE MORE MILK IS TO EAT MORE THAN USUALLY AND TO BREASTFEED THE CHILD SEVERAL TIMES DURING DAYS AND NIGHTS.

4. EAT AT LEAST 5 TIMES A DAY: BREAKFAST, LUNCH, DINNER AND TWO SNACKS BETWEEN MEALS BECAUSE WHEN MOTHERS ARE BREASTFEEDING THEY ARE HUNGRIER.

5. IN ADDITION TO MEALS, MOTHERS MUST DRINK LIQUIDS DURING THE DAY: JUICE, BOILED WATER, THICK JUICE CONTAINING CORN FLOUR, ETC. THESE WILL HELP HER PRODUCE MORE MILK.

6. MOTHERS MUST ALWAYS DRINK AT LEAST ONE GLASS OF LIQUIDS (JUICE, BOILED WATER, ETC.) BEFORE AND AFTER BREASTFEEDING THEIR CHILDREN, TO ASSURE ENOUGH MILK PRODUCTION TO SATISFY CHILDREN REQUIREMENTS.

ANNEX B

RESUME

Yolanda de Grijalva
Health and Nutrition Consultant
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EDUCATION:

- Central University of Ecuador. Surgeon physician. 1968
- San Carlos University of Guatemala. Public Health, MD.MPH. 1978.

In addition: Courses of Teaching Skills Improvement and Instructors Training, among others.

PROFESIONAL EXPERIENCE

- Resident pediatric physician: Isidro Ayora Maternity Hospital. 1968-1970
- Medical Director of the Clinic of Zapotillo. Province of Loja. 1970
- Medical Director of the Cotacachi Hospital. Province of Imbabura.
- Medical Director of the Health Post No. 9 in Quito. 1973 -1978.
- Physician of the Family Health Department of Provincial Health Office of Pichincha. 1979
- Physician of the National Nutrition Research Division. INIMS, 1982-1984.
- Search physician and manager project. INIMS 1984-1989

PUBLICATIONS:

- Basic Nutritional Manual. 1981
- Nutritional Epidemiological Surveillance in Ecuador.
- A System Design. Guatemala - 1978
- Nutritional System Surveillance. Prior Activities. 1982
- Nutritional Recommendations for the Ecuadorian Population. Coauthor 1983.
- Arm Circumference Tape. Coauthor. 1984.
- Use of the Weight/Height Indicator to Measure the Ecuadorian Nutritional Valuation. 1982
- Mother-Infant Feeding Guide. 1983

- Breastfeeding Studies in Urban Areas of Ecuador. 1982
- Anthropometry as Nutritional Evaluation Method. 1982
- The Ecuadorian Child Health Chart (1984). Published in 1987
- Growth Surveillance. Mother - Children Publication No. 5 / No. 3. / 1986.
- The Child Health Chart. "What is it and how to use it" 1984
- Physical Growth of Ecuadorian Children Under Two Years of Age. 1986
- Nutritional Education Editions: 1988 - 1989
  - Nutritional Education Statements
  - Qualitative Search Manual
  - Feeding Practices in Young Ecuadorian Children.
  - New Strategies on Child Nutrition.
- Newborn Weight in Ecuador. 1991
- Good Feeding Practices for Everyone. 1991

CONSULTANCIES:

- Growth Monitoring Program. "Rural Life" Foundation. Catholic University of Chile. 1987
- Social Marketing and Nutritional Education Program. Melipilla, Chile, 1988-1989.
- Workshop for Nutritional Education Material Performance. Manoff International. Inc. Bolivia. April/1987
- Education Program in "El Altiplano". International Plan, La Paz - Bolivia, 1989.
- Clinic and psychological nutritional study. "Science Foundation" 1984

HONORARY POSITIONS:

- Executive Secretary of the Ecuadorian Medical Society. 1968-1970.
- President of the Employee Association of the Provincial Health Office of Pichincha. 1973-1975
- Member of Board of Directors of the Ecuadorian Medical Association. 1975-1977
- Correspondent for Ecuador of the "Mother and Children" Publication .

LANGUAGES:

Spanish (native)
English: reading - good
speaking/writing - fair

REFERENCES:

Available upon request.

ANNEX C

(Translation)

COOPERATION AGREEMENT BETWEEN THE MINISTRY OF PUBLIC HEALTH AND CATHOLIC RELIEF SERVICES (CRS) FOR THE IMPLEMENTATION OF NUTRITION AND HEALTH PROJECTS IN RURAL AREAS OF ECUADOR

PARTIES

The Ministry of Public Health legally represented by Dr. Plutarco Naranjo and Catholic Relief Services (CRS) legally represented by Econ. Barbara Myers, sign this cooperation agreement.

FIRST CLAUSE: BACKGROUND

1.1 The Ministry of Public Health considers convenient to receive the cooperation of private institutions in the development of its health policies and the increase of its production. Furthermore, the Ministry of Public Health believes that both aspects are of great importance and require the necessary support in order to achieve satisfactory development of those Ecuadorian communities which want to improve their living conditions. Therefore, both institutions agree in the implementation of activities tending to the attainment of these objectives. CRS has worked in Ecuador since 1955 extending its cooperation under Supreme Decree of February 8, 1964.

1.2 The Ministry of Public Health through the Community Development Department of the Economic Development and Protection Division is the entity in charge of promoting activities related to the development of health, environmental sanitation, integral development including agricultural productive activities; so that this mutual participation is considered convenient.

SECOND CLAUSE: OBJECT

The object of the present agreement is to implement activities oriented to the improvement of health and nutritional conditions through Primary Health Attention activities and techniques to increase agricultural production as well as the improvement of feeding and sanitary home practices in the rural area of Ecuador.

THIRD CLAUSE: MUTUAL OBLIGATIONS

Both entities, the Ministry of Public Health and CRS, commit themselves to:

3.1 The implementation of the Child Survival project includes agricultural activities in order to allow a better social development in the population of the rural areas, with emphasis in the community participation, education, training and communities self-development. Since 1986 the Child Survival project has been implemented by the Dioceses of Cuenca, Latacunga and Portoviejo with the support of CRS. The objective of the project is to contribute to the improvement of the health and nutritional status of the beneficiary communities, especially in children under 6 years of age; through the implementation of four components: Growth monitoring, control of diarrheal illnesses, nutritional education, and production/credit activities. In October 1991 a third project phase will be initiated in 60 additional communities of the same dioceses. Three technical diocesan teams composed of one nutritionist, one agronomist and one social promoter each, have worked in the project activities implementation. At the community level the project works with trained voluntary personnel (unpaid) selected by the communities themselves. The last project evaluation peformed in October 1990 revealed that beneficiaries, especially those of poor social conditions, have a good potential.

3.2 To establish mechanisms that allow a better use of the health services and other alternatives created in each project component in order to optimize resources.

3.3 To reinforce coordination mechanisms with other local, national and international organisms to allow the development of complementary tasks.

FOURTH CLAUSE: MINISTRY OF PUBLIC HEALTH OBLIGATIONS

4.1 The Ministry of Public Health (MPH) will name a coordinator of the project eight days after the subscription of the agreement. At the provincial level the project will have the cooperation of the Health Provincial Director, the Provincial Chief of the IEOS (Ecuadorian Institute of Sanitary Affairs) or his representative, who will carry out promotion activities, community education, and follow-up of the activities developed in the province.

4.2 The Ministry of Health commits itself to contribute in communities organization and motivation for them to actively participate in the performance of the project activities and provide with unqualified labor. Furthermore, it will

contribute in the selection of active voluntary health promoters. Health education, growth monitoring, nutritional education, control of diarrheal diseases and environmental sanitation will be emphasized.

4.3 The MPH commits itself to provide to the diocesan technical teams (Provinces of Azuay, Cotopaxi, Manabí, and Tungurahua) all the oficial materials which concern project activities: Child Health Card, educational material, oral rehydration salts, etc.

4.4 The MPH will support with technical assistance to the diocesan teams, especially in those aspects regarding communitary organization and participation through the cooperation of personnel trained at local, central and provincial levels.

4.5 The MPH personnel will assist the beneficiary communities with health attention, especially: Prenatal attention, childbirth at home, mother and child immunizations and all attention regarding morbility.

4.6 The MPH commits itself to follow-up the project basic activities at the community level. This follow-up will be carried out by the operative unities (health subcenters) in whose influence area are located the project beneficiary communities.

FIFTH CLAUSE: CRS OBLIGATIONS

5.1 CRS will name, from its local personnel, a coordinator responsible for the implementation of all the project activities. The CRS coordinator will work in close relation with the MPH coordinator. Qualified personnel will be assigned in each diocese, in order to ensure successful implementation the project.

5.2 CRS will assure that its functionaries will have all the logistic/administrative support necessary to implement the project activities; this means, transportation, per diem, office space, secretarial services, necessary supplies and office equipment.

5.3 CRS will make the methodology as well as the materials developed by the project available the Ministry of Public Health, in order for them to be used in other areas of the country. If necessary, CRS will provide technical assistance.

5.4 CRS will submit to the Ministry of Public Health an annual report on the accomplishment of the planned activities.

5.5 Financing for the implementation of the Child Survival project activities includes CRS internal funds and other external and internal funds. Therefore, the project does not require

financial support from the Ministry of Public Health.

SIXTH CLAUSE: AGREEMENT IMPLEMENTATION

To implement this agreement, CRS will coordinate actions with the Ministry of Health. To assure the accomplishment of the goals stated for each component, a schedule including the following items will be used :

- Establishment of work areas based on a prior definition with the dioceses.
- Seminars and other personnel training events in the selected communities.
- Follow-up of the planned activites.
- Motivation and education activities will be carried out during the implementation of the extension phase. They will emphasize strengthening of social organizations, and will seek active community and family participation.

SEVENTH CLAUSE: ACTIVITIES EVALUATION

The Ministry of Health and CRS agree to carry out semi-annual evaluations that will serve as the basis for a possible renewal of this agreement. The evaluation procedures will be defined between the Ministry of Health, CRS, the three dioceses and the project communities.

EIGHT CLAUSE: DURATION

8.1 This is a two year agreement, that will last from October 1991 to September 30, 1993. Both parties can restrict, extend, renew or reinforce this agreement.

8.2 In spite of the above mentioned conditions, the Ministry of Health or CRS can conclude partially or totally the present agreement by written notification that should be presented within a term no shorter that 90 days.

8.3 Any disagreements regarding implementation of the present agreement will be resolved between both parties, CRS and the Ministry of Public Health.

The two parties sign hereby six originals of the same text and legal validity in Quito at October 22, 1991.

(signed)
Dr. Plutarco Naranjo

(signed)
Econ. Barbara Myers

MINISTER OF PUBLIC HEALTH

Director
CRS/Ecuador

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ANNEX D

WORK PLAN FOR FY92

ACTIVITIES	Oct 91	Nov 91	Dec 91	Jan 92	Feb 92	Mar 92	Apr 92	May 92	Jun 92	Jul 92	Aug 92	Sept 92
. COMMUNITIES SELECTION	x	x										
. SURVEY DESIGN AND APPLICATION												
ON THE PROJECT BASELINE.		x	x									
. BASELINE RESULTS ANALYSES			x									
. POA DESIGN		x										
. PROMOTERS SELECTION AND TRAINING												
ON:			x	x	x	x	x	x	x	x	x	x
- Control of diarrheal illnesses												
- Growth monitoring												
- Nutritional education												
- Production/credit												
. DESIGN PRODUCTION DISSEMINATION												
OF EDUCATIONAL MATERIAL ACCORDING												
TO EACH COMPONENT.			x	x	x	x	x	x	x	x	x	x
. IMPLEMENTATION OF THE FOLLOWING			x	x	x	x	x	x	x	x	x	x
ACTIVITIES:												
- Control of diarrheal illnesses												
- Growth monitoring												
- Nutritional education												
- Production/credit												
. SEMIANNUAL AND ANNUAL REPORTS			x						x			x
. FINAL EVALUATION												x

CHILD SURVIVAL PROGRAM
CRS / ECUADOR

DIFFERENCES BETWEEN THE LAST PHASE AND THE EXTENTION PHASE

LAST PHASE	EXTENSION PHASE
1. Operation	
Project focused on groups of mothers and children.	Involvement of the whole community.
Criteria for the selection of the beneficiaries based on Title II Commodity Receipt.	Criteria for the selection of communities based on poverty, malnutrition, and lack of social services.
Project implementation in three phases, initiated with 10 community up to 85 ones.	Direct implementation in 60 additional communities.
Base line data insufficient for monitoring and evaluation.	Base line clearly defined including anthropometric indicators of weight/age height/age and weigh/height.
Emphasis on various aspects of child health.	Emphasis on mother/child primary nutritional education.
Emphasis on nutritional recovery (moderate-severe malnutrition) in children over one year of age.	Emphasis on malnutrition prevention (optimum physical growth) in children under two years of age.
Agricultural production activities not closely linked to specific nutritional needs.	Production activities focused on the enhancing household food security.
Community training oriented towards information delivery.	Emphasis on behavior changes (health, hygiene, practices).
Training methodology centered on group meetings.	Follow-up by community volunteers at household, especially regarding nutritional aspects.
Complex information system with data processed in central office.	A locally managed information system geared to decision making.