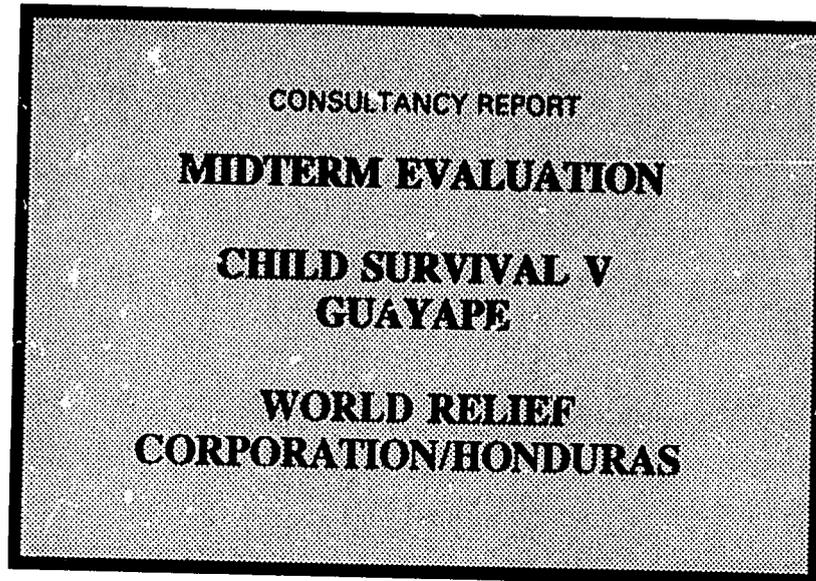


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ACKNOWLEDGMENT

When one is involved in the implementation of rural programs that provide direct care to populations that include a large number of children and mothers and after initiating the corresponding service activities, it is virtually impossible to stop and think about whether or not the initial proposals are being followed.

This is why the mid-term evaluation of Child Survival programs is so important. Undoubtedly evaluations of this nature consume time, resources and energy. It is also acknowledged that any evaluation interrupts the development of the respective program and for this reason, they should be approached in such a way that the utmost advantage may be taken of them.

It is evident that the most appropriate time to begin an evaluation process is when those responsible for evaluating a project meet in order to obtain information on the process and on the effect of its activities. Quite often during such a process, we technicians forget to ask the target population - mothers in this case - what they think of the program and the services they receive. In other words, we evaluate the structure, process and effectiveness of the project, and forget about its effect on the human being and how it responds to the needs and expectations of those people who are often not included in the agendas of eager evaluation technicians. We believe we are mistaken when we think that way. Looking at, speaking to and touching the target population of our investment is perhaps more important than analysing the project's budget or data system.

It was a great pleasure to receive an invitation to form part of the team who evaluated the World Relief's Guayape-Child Survival program in Honduras. The evaluation period went by all too quickly and involved a great many meetings, interviews and field visits. Perhaps the most important part of the visit, however, was the fact that we were able to see the faces and expressions of the mothers and children who comprise the project's target population.

I was favourably impressed by the project's human resources - highly motivated people anxious to devote themselves to relieving poverty, pain and illness, transmitting a rather unusual message of human fellowship. To all those in Campamento, Catacamas and Tegucigalpa, my grateful thanks for allowing me to dare express my desire to become like them.

A special thanks to Dr. Orestes Zúñiga for having taught me important Child Survival aspects that can only be learnt by looking out for them in a warm, caring manner, as he does. I am also grateful to Roberto Ruiz for bringing the evaluation team back to reality every time our minds wandered. Thank you also to Dr. Muriel Elmer of WRC headquarters, who invited me to form part of the team. I should like to express my grateful thanks to all the WRH staff in Tegucigalpa who helped to make my stay such a pleasant one.

This document could not have been written without the support of María Elena Umaña and Gustavo Lepe, who worked on it simultaneously in two languages. Special thanks also to Franklin and Aída Alejandra who with their laughter, games and noise livened up the tedious weekend work and constantly reminded us of the ultimate objective of our work - our children.

ABBREVIATIONS AND ACRONYMS

AID	Agency for International Development
ARI	Acute Respiratory Infection
CESAMO	Rural Health Centre with physician and dentist
CESAR	Rural Health Centre
HG	Health Guardian
EBF	Exclusive Breast Feeding
EIP	Extended Immunization Program
FP	Family Planning
GMP	Growth Monitoring and Promotion
GOH	Government of Honduras
HIS	Health Information System
HIV	Human Immune-deficiency Virus
KAP	Knowhow, Attitudes and Practice (studies)
MCH	Mother-Child Health
PHM	Public Health Ministry
NGO	Non-Government Organization
PVO	Private Voluntary Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
DIP	Detailed Implementation Plan
PAHO	Pan American Health Organization
PDO	Private Development Organization
PHC	Primary Health Care
TA	Technical Assistance
USAID	AID Mission in Honduras
USAID/DC	AID Headquarters in Washington, D.C.
WHO	World Health Organization
LHC	Local Health Committee
CS	Child Survival
CSP-G	Child Survival Project - Guayape
WRH	World Relief Honduras
WRC	World Relief Corporation, U.S. Headquarters
JHU	John Hopkins University
FHA/PVC	/Private Voluntary
CORU	Community Oral Rehydration Unit

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EXECUTIVE SUMMARY

The Guayape/Honduras Child Survival program is being implemented in two of the country's departments - Francisco Morazan and Olancho. The objectives of this program are: 1) To improve the health and child survival potential of children between the ages of 0 and 59 months and improve health and child survival practices among 15 - 45 year old women. 2) Strengthen the work carried out by the Public Health Ministry (PHM) through training, logistic support and the data system in areas of impact.

Two years after the initial implementation, a mid-term evaluation took place, with the participation of people not involved in the program. To this end, the services of an external evaluator were obtained and invitations were extended to representatives of the PHM and the International Eye Foundation (IEF) in Honduras. For 7 consecutive days, the team of 8 people visited 15 settlements and, using various techniques, interviewed 113 people involved with the design, implementation and future of the program.

The evaluation of the program led to the conclusion that WR/H is achieving the objectives proposed in the different documents negotiated with AID. The objectives and products currently being achieved are in keeping with the needs of the respective area, and the program is effective. Certain problems were observed in the implementation of the risk strategy, resulting from the design of the program which is affecting the control of infections and food. The data system works well, but more use should be made of it. It is in the area of social communication and community education that the program has made the most progress. The people working on this project are well trained and have a very special working spirit, although their workload is considerable. The program's supplies and materials are well administered, though the need for further investment in teaching materials was evident. The supervision and monitoring of the program is fairly effective, but more use should be made of available information. The need for technical assistance in such areas as information and training have been underestimated. The program must strengthen its sustainability strategies. There is an adequate budget administration and sufficient funds to complete the program with no major stumbling blocks, although more funds are required for technical assistance purposes.

The main recommendations include the following:

- 1) A more integrated involvement to improve the risk approach and make the most of existing resources.
- 2) Stronger sustainability strategies, seeking better joint planning with the MOH and improving self-management abilities of the groups that comprise the target population.

I. Background

A proposal submitted to the United States Agency for International Development (USAID) by the World Relief Corporation for funding the implementation of a five-year Child Survival Program in Honduras between September 1st 1989 and August 31st 1994, was approved in 1989. The Guayape/Honduras Child Survival Program is being implemented in two areas: Area 1 is located in the Department of Olancho (Catacamas, Santa María del Real and Dulce Nombre de Culmá), and Area 2 is located in the municipalities of Orica, San Ignacio and Marale in the Department of Francisco Morazán and the municipalities of Guayape and Concordia in the Department of Olancho.

The objectives of this program are: 1) Improve the health and child survival potential of children between the ages of 0 and 59 months and improve health and child survival practices among 15 - 45 year old women. 2) Strengthen the work of the Public Health Ministry (PHM) through training, logistic support and the data system in areas of impact.

Objectives, strategies and specific activities were designed and implementation began in the program's two areas of involvement.

Two and a half years later, it was decided to carry out the mid-term evaluation proposed in the initial proposal, with the participation of people not involved in the program. To this end, the services of an external evaluator were obtained, and representatives of the MOH and the International Eye Foundation (IEF) in Honduras were invited. (See Appendix 1).

II. Evaluation Methodology

The Mid-term Evaluation Guidelines provided by FHA/PVC USAID were used. A month before the field evaluation, members of the evaluating team began reviewing the documents to be used during the evaluation process. The officer responsible for supporting the program from Wheaton, Illinois, visited the project the previous month. Her agenda included drawing up the terms of reference for the external evaluator (Appendix 2), making local contacts for the initial evaluation, designing a tentative schedule and drafting documents and logistic material. Before travelling to Honduras, the external evaluator spent three days reviewing the 14 documents on the project and preparing documents to be used during the evaluation.

Once the team had arrived in Honduras, they reviewed the schedule, objectives and expectations of team members (see Appendix 7). All potential sources of information were identified, particularly the people involved in the implementation of the project or whose decisions could affect the project (see Appendix 9). Methods of approaching these groups of informants were

then decided and guidelines were drawn up for structured and non-structured interviews, interviews with key informants and focal groups to test their knowledge. On the second day, these guidelines were tested in a rural community, interview techniques were practiced and focal group development techniques were reviewed, although most people were aware of them. The intention was to adapt discussion and interview guidelines and standardize techniques for obtaining qualitative information.

The interviews included a review of the information used during the project's different stages, however no quantitative information was obtained.

For seven consecutive days the team of 8 people visited 15 settlements and carried out interviews to the following, using various techniques:

- 8 leaders involved in the implementation of the Program.
- 29 Voluntary Community Guardians working for the Project.
- 8 Nursing Assistants from MOH health establishments involved in the Project.
- 2 Public Health nurses in charge of supervising areas of participation in health establishments.
- 2 Head Physicians of MOH areas responsible for public health management.
- 23 health promoters hired by the project on a full-time basis for the Project's two areas.
- 2 Coordinators and supervisors of the Project's two areas of involvement.
- 1 Director of the CS Program
- 1 Director of WRH
- 2 people responsible for coordinating with other PVOs

Four of the team's members were staff directly involved in the implementation of the project, two were area coordinators, one an assistant physician and the other the Director of the CS program. Field visits and interviews were planned in such a way that directors could make contact with the target population, leaders and volunteers of their respective projects (Director with Mothers; CSP Director with Mothers and Guardians; Coordinators with Guardians, Mothers and Leaders; CSP Director with Assistant Nurses and MOH Nurses; CS international headquarters' Coordinator with Mothers, Guardians, Leaders, MOH staff and Promoters; and so on) and carry out interviews with external evaluators. At the end of each day and after the visit to each area, all the information obtained was reviewed and the findings of the different groups of informants were discussed. Information meetings were held and the information produced by evaluators was reviewed with members of the implementation team in each area.

The objective of this technique was to provide members of the evaluating team with an opportunity to clarify certain areas on which they were lacking information on the one hand, and on the other, hold immediate discussions on findings and provide feedback to the implementing teams.

The team remained in the project's implementation area. Equipment and materials were transferred to the field office in Catacamas, where findings and conclusions were discussed for two days and final recommendations were drawn up. On the next two days, the findings and recommendations were shared with the MOH and the local office of USAID in Honduras.

A draft of the evaluation report in Spanish was left behind before the external evaluator left the country.

The methodology followed proved to be one of involvement. Besides, field implementation teams were able to improve their ability to learn participative evaluation techniques, using qualitative methods of obtaining information. All members of the evaluating team participated in a number of interviews and focus groups, as did the interviewers and recipients of the qualitative information obtained. Various techniques for analysing and summarizing qualitative information were practiced, as well as for expediting group discussions.

III. Findings and Conclusions

1. Project Achievements

The project began to operate in September 1989 (34 months). Table 1 is a summary of the objectives achieved to date, containing all the objectives of the activities implemented during the first few months of 1992, as well as accumulated figures for three years. It shows that 7 out of 20 (35%) of the objectives have been exceeded or have achieved the estimates proposed for the end of the third year (full immunization for children under one year of age, two doses of tetanic toxoide vaccinations for women, oral rehydration used by women to treat children suffering from diarrhoea, children between 0 and 23 months weighed each month, women nourishing their children exclusively through breast feeding up to 4-6 months¹, mothers receiving training on child nourishment, and mothers receiving care before childbirth).

As regards women identifying children and referring them for treatment of pneumonia, it is evident that only 50% of this goal was achieved. Likewise, the goal concerning the number of women trained to prepare ORS was only 5,025 (51% of the goal). Nevertheless, it is puzzling to find that nearly 6,000 women practice ORT. This tends to reflect the work carried out simultaneously by the project and by the media as well as other institutions that affect the target population.

¹ The goal is 35% of children under 1 year of age, although consideration is being given to apply this goal to the under 6 months old population. This figure was changed in the Second Annual Report.

New means of involvement were included during the implementation process, and objectives related to the Organization of Women.

Community Women's Banks were established as well as other services for women such as the goal to sterilize women which which achieved 44% success.² It should be mentioned, however, that this activity was not financed with CS WRC/AID funds.

During the interviews carried out by the evaluating team, it was concluded that the direct beneficiaries of this programme - i.e. mothers - consider the programme effective. Also evident was the almost systematic statements made by mothers in the project's different areas, concerning their expectations, particularly as far as medical treatment and food availability are concerned.

Conclusions:

- The appraisal of the different achievements depends on the level of the study/personnel WRH/community - qualitative in terms of the community and quantitative in terms of the WRH.
- The initial objectives have been expanded, e.g. women's care, women's organization and income generation.

² This figure only corresponds to two quarters, from the second quarter of the third year when this project began.

Table 1

**SUMMARY OF OBJECTIVES, INPUT AND OUTPUT PROJECT
ACHIEVEMENTS**

WORLD RELIEF HONDURAS/GUAYAPE CHILD SURVIVAL OBJECTIVES

Quarter: 3/ Fiscal Year: 1992 / Prepared by: O. Zuniga Riva Date: June 26, 1992

OBJECTIVES	Quarter 1 Actual		Quarter 2 Actual		Quarter 3 Actual		Quarter 4 Actual		Year-to-Date	Year 3 Goal	YR 3 % Realized	Total Yrs 1-3	Goal Yrs 1-3	Total % Realized
	Area 1	Area 2												
1. Children 0-11 months completely immunized	272	42	232	109	514	259			1428	425	336.00%	2,600	1,597	162.81%
2. Children 12-59 months completely immunized	853	48	768	91	902	688			3350	5,878	56.90%	6,803	9,331	72.91%
3. Women 15-45 vaccinated with two doses Tetanus Toxoid	849	69	979	141	758	687			3483	3,676	94.75%	8,420	8,611	97.78%
4. Women able to prepare and administer ORT/ORS	154	190	139	147	357	320			1307	6,216	21.03%	5,025	9,936	50.57%
5. Women evidencing regular use of ORT/ORS during diarrheal episodes in their children	632	222	546	181	325	327			2233	2,327	95.90%	5,918	5,962	99.26%
6. Children 0-23 months weighed monthly	214	79	253	112	731	301			1690	216	782.41%	4,138	2,684	154.17%
7. Children 24-59 months weighed once every three months	65	29	93	75	363	251			876	1,267	69.14%	3,461	3,852	89.85%
8. Women instructed in breastfeeding	265	181	217	220	711	298			1892	7,585	24.94%	6,230	11,923	52.25%
9. Women who exclusively breastfeed until 4-6 months*	-	-	55	179	644	221			1099	932	117.92%	1,099	932	117.92%
10. Mothers trained in weaning and nutrition	265	181	276	133	642	452			1949	4,637	42.03%	6,287	4,637	135.58%
11. Children 6-59 months receiving Vitamin A	776	177	793	203	6147	847			8943	17,883	50.01%	15,979	17,883	89.35%
12. Mothers receiving Vitamin A in the first month post-partum	130	45	104	61	113	77			530	782	67.77%	1,361	1,613	84.38%
13. Women 15-45 utilizing modern birth spacing methods	-	-	-	623	395	81			1099	1,472	74.66%	1,099	1,472	74.66%
14. Women sterilized	-	-	18	10	45	37			110	250	44.00%	110	250	44.00%
15. Number of packets of birth control pills distributed														
16. Pregnant women receiving pre-natal care	143	22	199	101	166	83			714	305	234.10%	1,820	1,411	128.99%
17. Women 15-45 instructed in prevention of death from pneumonia	371	128	319	121	159	166			1264	2,142	59.01%	3,880	4,358	91.33%
18. Women 15-45 who can identify and facilitate treatment of pneumonia in children 0-59 months	47	40	76	34	41	41			279	1,322	21.10%	1,018	2,061	49.39%
19. Health Guardians trained for inclusion into MOH Public Health System**									0	60	0.00%	126	180	70.00%
20. Local Health Committees organized	-	2	-	11	-	7			20	69	28.99%	71	120	59.17%

OBSERVATIONS:

* The goal for Objective 9 was readjusted, since the original calculation of 35% of all children under 5 years was incorrect. The goal should refer to children (0-11 months) under 1 year of age. ** 126 Health Guardians were actually involved in the CS training during Year 3.

2. Relevance of CS problems

".....Julia said - Some mothers don't come because the children are only weighed and nothing is given to them - What type of aid do you think they require? Julia said - They want food and vitamins -..."

Report on an interview with a mother in the rural community of Jamasquire, Olancho.

Acute Respiratory Infections are the main cause of morbidity in the Project Area, affecting approximately 62% of the children belonging to the women interviewed during the past two weeks³. The second cause is Diarrhoea, which affected about 30% of the children over the past two weeks, according to interviewed mothers.⁴ There are no specific statistics on mortality in the area of involvement, however the 1987 Health and Nutrition Survey found that diarrhoea (31%) and acute respiratory infections (15%) were the two main causes of death.

The project included the following participation in health promotion efforts:

1. Immunization
2. Diarrhea Control
3. Prevention of Death from Pneumonia
4. Growth Monitoring/Nutrition & Weaning Education
5. Prenatal care/Child Spacing

The program not only responded to health priorities, but also to epidemiological circumstances, such as the implementation of the vaccination program early in 1989 in the light of a widespread measles epidemic, and then in 1990, the diarrhoea control program in response to the main cause of death, which in the short term was put into effect to combat the cholera epidemic that affected the entire region.

Community participation revolved around growth control activities, which have created new expectations of children's weights and brought the community closer to the program's staff. The benefit obtained from monitoring the growth of the infant population within the context of the social and economic situation in the rural areas of Honduras where this program is being implemented, is obvious.

It is not too hasty to conclude that although the project has been effectively introduced, the

³ Basic Study of the Child Survival Project - Guayape, March 1990.

⁴ Basic Survey. Child Survival Programme - Guayape. March 1990.

enthusiasm and efforts of both the community and the project cannot continue unless new alternatives are introduced to respond to the needs felt by the population and to ensure that these are complemented by preventive aspects.

Conclusions:

- The project responds to the majority of relevant problems.
- Mothers know that the program is preventive, but they would like it to be different.
- Although some involvement has caused an impact on health aspects, a strategy to solve the **nutrition problem** has not been found, as proved by beneficiaries and volunteers of the project.

3. Effectiveness of the Program

*".....people have accepted it, they talk about it and they support the Health Guardian."
Assistant Nurse, CESAMO in Orica, Francisco Morazán.*

The progress of the project is evident, as seen from Table 1 reviewed above. The area of involvement is extremely widespread and rural, but the project's activities can be found everywhere. The most important proof of the project's effectiveness was the implementation of the activities that reflect a high level of acceptance, not only by the target population but by different levels of the MOH in the area and other organizations involved in the program. It was truly impressive to discover the amount of knowledge mothers have of the messages introduced by the project. Nevertheless, it was also evident that the target population were not entirely satisfied, as they would like to have better medical care and food.

The evaluating team identified certain problems in the management of certain aspects concerning technical knowhow and involvement in high risk groups. These are described below:

- a. There is a combination of risk factors concerning morbidity and mortality. From interviews and the observations made by the so-called Guardians (community volunteers) responsible for implementing the program in the community, it became obvious that they were aware of a long list of risk factors, however they fail to put such concepts into practice when providing services to the high risk population in order to make their involvement more cost-effective. This was also evident among the staff responsible for training the Guardians, Promoters and Assistant Nurses from the MOH.

-
- b. Some of the involvement of high risk groups was limited because their achievements were the result of decisions made by other groups or institutions (availability of contraceptives, the lack of trained personnel in the MOH to control pneumonia, etc.).
 - c. Under the current supervision and monitoring system it is impossible to identify areas of involvement in which the risk population is not receiving attention, except as far as vaccinations are concerned; or to monitor information on the development of interventions aimed at risk groups.
 - d. Certain diarrhoea control messages are rejected by children and create a lack of confidence among mothers regarding the effectiveness of ORS, mainly because ORS are introduced before patients are affected by dehydration and thirst. This often leads to inadequate treatment of diarrhoea and dehydration.
 - e. The growth control program does not use suitable risk criteria for making the most of volunteers who have a considerable workload.
 - f. The response to the demand for family planning services generated by education, is limited. Methods suggested depend on availability and on how quickly the MOH and ASHONPLAFA can supply the communities. The only method under CSP-G's control is sterilization and Project staff work hard to detect and refer women. This focus on sterilization is dangerously prominent.

Conclusions:

- There is a problem concerning the practical emphasis of the risk approach. This problem is determined by the vertical nature of the involvement and the unyielding data system.
- The direction/message/training regarding the treatment of diarrhoea generates a lack of confidence in ORS.
- As regards the teaching of eating habits and growth/nutrition control practices, no difference was noticed between the activities/messages /procedures of the normal population and the risk population.
- As far as ARIs are concerned, there is some discrepancy between the messages, standards and risk groups promoted by the MOH and the community activities affected by pneumonia, which is causing confusion.
- With respect to pregnancy control and spacing between pregnancies, emphasis is

indiscriminately placed on obstetric risk and not on reproductive risk. More attention is paid to pregnant women than to women with reproduction risks.

4. Effects of the Development of Communities and their Population

Certain aspects affecting the development of the project were pointed out by mothers, leaders, guardians and the staff of the program, and are summarized below:

- Social changes taking place in the population as a result of the economic adjustments in the country that affect the population, causing families to live with an economy of subsistence and a shortage of food.
- Numerous paternalistic programs that have affected community vision and participation and continue to affect the implementation of programs that tend to have a sustainable effect on free service policies are still maintained by the MOH administration.
- Cultural practices and literacy levels tend to influence the population's participation in preventive programs, such as the control of infections and food.

The project is promoting the development of women's skills in various areas that are affecting the development of the community and the survival and standard of living of their children, by means of:

Community Mobilization Activities:

Community Banks, which are encouraging the participation of women and generating skills and income which is being invested in food, medication and others.⁵

The program forms women leaders who reach out to, organize and educate others.

Over 95% of the community Guardians and Volunteers are women.

5. WRH Competence in the Implementation of the CSP/Guayape.

⁵ Report on Focal Group with Mothers of Community Banks. Catacamas, Honduras. July 1992

5.1 Design of the Program

The project is being implemented in an extremely large area and activities were introduced in a vertical manner, simultaneously. The objectives and achievements are clearly evident and the project has been extremely flexible in responding to changes in the design strategy throughout the program, in an effort to respond to past experiences or evidently necessary circumstances. Nevertheless, the introduction of five areas of involvement simultaneously and almost vertically, have placed an added burden on the workload of volunteers and promoters and some of them (food counselling on growth control, control of pneumonia and FP) are frequently cast aside.

Conclusion:

- The fact that participation in all areas of involvement was introduced simultaneously, has made it difficult to discriminate between priorities and efforts that should be put into different sites or areas. This has weakened the project's effectiveness.

5.2 Management and Use of Data

The data system is obtaining information that is generated in the communities with no major problem and is shared with the MOH (health centre, health post), streamlined in each area and then concentrated at a central level. Some information is especially used for reporting and solving local problems. Quantitative methods predominate in the data collection system. Two quantitative surveys have taken place, one basic and another on knowledge and experience, the latter following the model provided by the John Hopkins University, who also provided advice. The information obtained from these surveys was used to perfect the project's objectives and also to redesign such involvement as the control of pneumonia and food. It is worth mentioning that the MOH, the Buen Pastor Clinic, and a local NGO are using this data to design proposals and draw up comparative analyses with the information contained in their own data systems.

The information generated by the project is handled exclusively by local staff who have suitable technical and administrative abilities. Information obtained in the field is usually shared with local information. Local information is not analysed in depth at health area levels. There is a certain amount of analysis in the coordination of the project, however its use is limited. The process is restricted to ensuring a flow of the same information that is reported to USAID Washington, throughout the different levels. There is no evident need of different information either in the community or in coordination activities with the MOH.

There was little evidence of information aimed at sharing the analysis of data obtained at local or national levels. The lack of monitoring instruments and information analysis to improve control and supervision, was evident.

Conclusions:

- There is a need to improve the local ability to analyse and respond, particularly as regards coordination with local health establishments and within the MOH area.
- The need to improve the monitoring process is evident, to enable the promoter/coordinator to take more systematic decisions.
- The information system is geared towards generating information for a report that must be written.
- Information/indicators are available at a community level, but no good system to collect and process such information.

5.3 Community Education and Social Promotion

*"The nurse tells the guardian that he (the guardian) belongs to the MOH, but that World Relief will train him".
Focal Group Promoter, Area No. 2.*

The project is fully oriented towards communication and community education. Excellent examples of technical skills have been identified among the staff as far as informal and participative methods of education are concerned.

The education program is implemented by the WRH and services are provided by communities or the MOH. Nevertheless, a certain lack of coordination was noticed particularly as regards providing medical care to the affected population and referring people for medical treatment. There is a lack of balance between the direct services provided to the population, as these are provided by the MOH and other private organizations, where the project has contributed little and has hardly any influence or control over such activities. This is clearly perceived by the population and was constantly repeated by the different groups evaluated, mainly at community and reference levels.

The MOH's health establishments encounter a number of problems, including the lack of medication and duly trained technical staff.

In general, education messages were implemented in a centralized manner. There is no evidence of the use of a systematic updating of materials, since most of them come from other institutions. Materials were implemented for volunteers in most areas of involvement. There

is no permanent production of suitable quantities of teaching materials for the population or for the volunteers.

Conclusions:

- The process is effective and the demand generated needs to be compensated with the services of other institutions.
- There is no systematic way to update the messages/materials because they come from other sources. This is critical in the case of the material for guardians.
- Sufficient teaching materials are not available to mothers.

5.4. Human Resources

Full-time staff includes 3 physicians, 1 clinical clerk, 23 promoters, 250 guardians, and 7 people in charge of administrative and logistic support.

It was noticed that these people have a heavy workload because of the characteristics of the area, the number of people to be supervised and the number of interventions they are required to participate in. Certain activities such as filling in forms which take up a volunteer's valuable time, tend to reduce his motivation and enthusiasm.

The added workload of field personnel has led to an operational investigation in one project area to make the families/volunteers ratio more manageable, reducing it from 1:40 to 1:25 or 10. This would also affect promoters, whose supervision work would increase. The actual work burden is 1 promoter for every 10.8 volunteers.

Personnel training appears to be adequate, though limited. Tests on technical knowhow resulted in an average of 70% of suitable replies. It was evident that this staff needs a refresher training course. There was no evidence of a systematic evaluation of training needs based on future tasks; this ties in with the characteristics observed on the supervision forms that were analysed.

Results of the knowledge tests to community staff proved the excellence of the training methodology used and the careful planning involved. The lack of training materials and references to maintain the technical information level of the project was also observed.

One effect of this partial lack of materials was observed in the level of knowledge of promoters, guardians and mothers. Promoters were trained for two months and health guardians attended yearly workshops for 2 or 3 days each month, during which they received teaching materials.

Mothers were given talks or education through participative or practical techniques, e.g. the preparation of LITROSOL. Most of these meetings did not include the distribution of reference materials, printed matter or any other material. In their replies to interviewers of the evaluating group, mothers still included a number of cultural aspects related to their own traditions and environment, which often include negative practices that were mentioned during their training period (e.g. the use of medication for diarrhoea, food, etc.). This was evident in the food component, for which promoters require additional knowledge, as their lack of it is reflected in the message transmitted to guardians and in the methods mothers use to feed their children.

Conclusions:

- Guardians, Mothers and Promoters are overworked, the former because of the number of interventions (5 or more) and the handling of forms.
- The technical content is adequate, however there is little emphasis on procedures to instrument the process.
- The training process requires more systematic updating.

5.5. Supplies and Materials for Local Staff

Community staff in the different project areas visited by the evaluating team, showed an interest in additional supplies of materials for treatment of the population and more teaching materials.

A consistent message transmitted by different members of the communities was the need for medicinal products and food. Although these were not demanded, after the "adequate" preventive reply, they were included as an evident need that had neither been considered nor satisfied by the project.

Guardians encountered problems in handling certain equipment (scales), particularly in sorting equipment by size and handling measuring units.

Conclusion:

- The equipment (scales) used for weighing purposes were not in pounds/ounces which is the system used by mothers.

5.6. Quality of the Project

WRH promoters took knowledge tests on various CS areas and meetings were held with focal groups of 6 promoters. The purpose of these meetings and interviews was to discover the level of knowledge and experience of voluntary promoters and guardians, and find out the areas in which technical knowledge and skills were being poorly transmitted. The evaluating team discovered that the level of knowledge was limited (70% of the replies to the knowledge tests were adequate). As regards food, there was little information on infant nutrition, weaning practices and feeding sick children. With respect to growth control, a systematic approach to diagnosing malnutrition took preference over monitoring growth. As regards family planning/spacing between pregnancies, more emphasis was placed on obstetrical risks than on reproductive risks. Moreover, the emphasis placed on the use of LITROSOL in cases of diarrhoea without dehydration, was exaggerated. These matters, which were discussed in detail with the evaluating team and the project's management and coordinating staff, indicate the need to standardize criteria with the MOH, which should probably be done jointly and in routine fashion.

Conclusions:

- Although the project's development process was handled by knowledgeable promoters/guardians, a more systematic approach is required to monitor the ability and knowhow of those responsible for implementing the project.

5.7 Supervision and Monitoring

There is a supervision system and instruments available, which promoters and guardians relate to quite well. The instruments are fairly specific insofar as the administrative process is concerned, or for checking specific aspects of the process (coordinator to promoter). There was no evidence of specific supervision formalities among decision-makers, nor of any specific formalities and procedures for the individual work carried out by the promoter or the guardian.

Supervision standards are too flexible. Generally speaking, Area Coordinators view supervision as going along to see what needs doing - "...to support whatever work must be done". Available information is not used to identify areas of potential involvement in monitoring and supervision activities, which is so necessary considering the workload of coordinators and promoters. Most supervision work involves counselling and assistance. There was no evidence of any evaluation of performance, in-service training or administrative monitoring. Auditing and financial control in the field is superficial and involves no documents.

During the interviews with MOH staff, it was noticed that the MOH and WRH have parallel supervision systems, both encountering problems with the handling of information, logistics and transport. Both the MOH and WRH stated that one of the factors that could give the project

some continuity was the possibility of the MOH supervising the voluntary staff in areas under the WRH's sphere of responsibility.

Conclusions:

- The existing supervision and monitoring system is no longer systematic at certain levels (Coordination > promoter and promoter > guardian). There is a lack of sufficient viewpoints for decision-making purposes.
- A review of supervision instruments/viewpoints/strategies is required.
- There is a need to establish the monitoring and supervision system jointly between WRH/MOH at all levels.

5.8 Use of Central Funds

The support obtained from the WRH headquarters has been very important for the development of the Project. WRC CS staff have visited the offices and WRH field operations on six occasions. WRC management staff have visited almost bimonthly. Technical and administrative visits have been key factors in various stages of the project, particularly the initial one. The information material and a permanent monitoring of the implementation were also important. To date the sum of US\$115,946.00 has been spent in the main office to support field operations. The sum of US\$ 64,603.00 was budgeted for the two remaining years of the project.

Conclusion:

- The technical and financial assistance during the implementation of the Project was both effective and efficient, particularly during critical periods.
- There is a need to re-program the international headquarters' aid funds, to ensure a continued support, particularly for the technical assistance recommended in this evaluation and to carry out the final evaluation survey.

5.9 Use of Technical Assistance

The program has not used external technical assistance for the implementation of the Project's key areas. External assistance from JHU was used to implement a survey on knowledge and experience in 1991.

The assistance provided by JHU was most adequate and led to the reconsideration of certain aspects of the program. Nevertheless, it was interesting to observe that some of the information required at the time which could have been obtained through the survey, was not included in the latter, particularly matters concerning the amendment of certain educational messages to make the community work process more suitable. More emphasis should have been placed on the use of this information and technical assistance so that the project's progress could have been reviewed a year ago and certain aspects identified which are now being reviewed in the mid-term evaluation.

There is a need for planned technical assistance for organizing supervision and monitoring systems, reviewing teaching materials and training staff.

When analysing the budget for technical assistance, it is evident that the need for technical assistance in key areas was underestimated. Moreover, there is no budget for any technical assistance after the mid-term evaluation.

Conclusions:

- Access to the source of technical assistance with foreign financing in the KAP survey, was both timely and fruitful.
- It is evident that the need for funds for immediate technical assistance (6 months) to ensure the implementation of the recommendations resulting from the mid-term evaluation, was underestimated.

5.10 Relations with Counterpart Organizations

Counterpart organizations such as "El Buen Pastor" and "Obreros Cristianos" which would be responsible for implementing the project according to the proposal and the detailed implementation plan, have not followed the proposed implementation plan. In fact, whilst there is coordination and assistance at the present time, there is no evidence of implementation.

The relationship with the MOH is strong as far as field operations are concerned, particularly between promoters and assistant nurses in health posts and health centres (CESAR and CESAMO). With respect to middle-management and general management levels, however, coordination is still weak. This is mainly due to the fact that little priority and political importance is given to the WRH in the Health Sector, but this problem is being solved gradually. The technical presence of the MOH's Health Region No. 7 Mother-Child committee as a member of the mid-term evaluation team, is proof of the growing interest that could be beneficial for the future of the program.

Hopefully in this case the initiative will come from the WRH and not the other way round. There is no detailed plan nor specific strategies for implementing joint work with the MOH. There is no key person in WRH whose responsibility is to keep permanently in touch with the MOH on a central and regional basis. So far, this job has been carried out by the CS Director, but he has such a heavy work burden that such duties have now become mere formalities.

One aspect that causes much concern as regards the weak relationship with counterpart organizations, is the fact that the responsibility for sustaining the program depends on the independent work carried out by the MOH's nursing assistants. This is worrying because the level of coordination between them depends on the area nurse and also because it is evident that to understand the management of the WRC's CS program, certain technical and administrative limitations must be overcome.

Conclusions:

- Relationships with local NGOs have concluded. The WRC is now fully responsible for the implementation of the project.
- There was been a certain amount of cooperation and coordination with the MOH, mainly in the field: assistant nurses > promoters - MOH/WRH.
- The relationship with the MOH in regional and central areas is still weak. There is no specific working plan nor any objective or tangible results with the MOH that could arouse the interest of either the WRH or the MOH.
- Coordination with the MOH must be re-designed and specific resources should be allocated for this purpose.

5.11 Relations with Referral Services

"Nurses now depend too much on guardians"
Focal Group Promoter, Area No. 2.

"The nurse tells the guardian that he (the guardian) belongs to the MOH, that that World Relief will train him".
Focal Group Promoter, Area No. 2.

All guardians stated that as far as they were concerned, the best place to refer patients was the Health Centre and that they had good relationships with the nurses who were willing to receive their patients. An attempt is being made to strengthen this nurse > guardian relationship and coordination is taking place to train basic staff.

Throughout the project, the MOH is the referral institution. The establishments we visited were always crowded, however many of the people interviewed mentioned inadequate care, a shortage of medication and other problems. The presence of well-trained staff for attending to referred patients is fairly limited in such establishments. Most pneumonia cases, for example, are referred to hospitals located far away in the capital city. One important problem is the lack of a systematic reference and counter-reference system. Patients are transferred with no reference instrument. It was also noticed that the volunteer referring the patient and the nurse at the receiving end, speak a different technical language. Their relationship is limited to sharing information and attending some talks given by MOH personnel to volunteers. Most of the field work - follow-up, training, logistic support - is done by the WRH promoter, thus adding to the lack of coordination. The isolated participation of assistant nurses in certain aspects of volunteer training is not enough to develop an effective reference and counter-reference system.

The need for detailed reference formalities, joint training for assistant nurses and volunteers and permanent communication between these and other reference centres, is essential for changing the population's points of view that the program does not fulfil their health-care expectations. A Child Survival program that merely increases the demand for services and does not ensure an adequate supply, must be considered incomplete.

In one area, patients are mainly referred for treatment and services to a local clinic in Catacamas - "El Buen Pastor" - where the attention is good and a good supply of donated medicinal products is available. However, this clinic is located in an urban area that is not accessible to all rural areas. It is evident that the presence of medical staff and medication improves the concept that such services are useful and ensures that these are protected by the local population who may, if possible, help to finance them.

During the last few months, these aspects have been observed by the management, and certain measures are currently being taken to improve relationships and organization between the community, primary health care services and secondary services. Even at a third level (Catacamas hospital), the heads of medical services have shown much interest and are eager to participate in developing an adequate system to handle health-care problems in the communities.

The Director of the Buen Pastor Clinic also mentioned that the program should be more balanced as regards increasing the demand for services, improving services and making them more effective, reducing the participation of promoters and making use of other education and communication mechanisms; establishing closer relationships with the MOH for training and follow-up purposes, and establishing closer relationships with services providing medical treatment, which the population are most in need of.

Conclusions:

- A progressive improvement was observed in the dialogue, coordination and services rendered at the MOH's reference establishments and at the Buen Pastor Clinic.
- Joint training plans are available to support MOH personnel and to incorporate and standardize service regulations and procedures.
- There is no evidence of a counter-reference system between services and communities.
- More emphasis should be placed on the population's access to MOH establishments in the area of involvement, and on the quality of these services, supporting the joint organization of current referral services with the MOH.

5.12 Project Contact Network

The relationship with other NGOs was adequate. Since the CS Workshop sponsored by USAID FHA/PVC and implemented by JHU in 1991, communication with other NGOs has been permanent with similar organizations. Material belonging to other NGOs was used, and there is a rather unsystematic exchange process.

There is a network of organizations referred to as "Inter-Agency Committee of PDOs that have CSPs" financed by USAID/Washington, which is a good contact network to support the project.

Conclusions:

- The effects of these relationships has been mostly positive.
- Materials/documents are exchanged between PDOs that are similar to WRH.

5.13 Budget Administration

The total amount spent by June 30, 1992, amounts to US\$491,454.88 i.e. 42% of the overall budget for the same period, equivalent to US\$562,169.00, . If the remaining 58% is properly administered it should last until the end, although some heavy expenditure is envisaged because all promoters were hired at once in 1991 instead of gradually as originally planned. It would be difficult to spend less than the remaining budget.

Whilst it is true that certain items have small budget allocations, other items have sufficiently high allocations that provide flexibility if necessary, i.e. evaluation or technical assistance. The latter item was underestimated on the budget during the initial stages of the project and is now

practically drained.

Conclusion:

- Sufficient funds are available to complete the project. Nevertheless, due to certain design adjustments, there are certain areas in which additional funds are required for activities that would improve the quality and effectiveness of the project.

6. Sustainability

*"With the community bank's activities, my children don't suffer as much as they used to."
Mother, CESAR Guayabito, Naranjal Community.*

All mothers, volunteer guardians and community leaders mentioned that there was a pressing need for the CS program and that they were willing to continue it even if the WRH were to terminate its operations. The great incentive was not money or goods, but the organization, socialization and participation of the population in caring for children and mothers which was achieved thanks to the project. It is worth mentioning, however, that the driving force behind these incentives is the project's staff. It is mainly thanks to the promoters that all this organization and participation was achieved. Evidently this motivation activity will not continue if the project comes to an end. The great question is, who will assume the role.

The project staff, the MOH and many others, consider the MOH as the most likely entity to continue these health-care activities, however this is mainly wishful thinking, in view of the current economic and social circumstances in Honduras. The MOH has a small budget, more than 79% of which covers recurrent expenses, mainly staff. The difference is spent on hospital maintenance and medication, mainly in urban areas. The MOH budget for CS actions fully relies on foreign donations, mainly from USAID through the Health Sector II Program, which should be completed in 1994.

In the area of involvement there is no evidence of any emphasis on a public health policy aimed at financing CS programs in rural areas. The limited activities depend entirely on the role of CESAR's nursing assistants and a few activities of the public health sector. The MOH places more emphasis on the care provided in establishments, and there are no mechanisms for increasing the community's participation in controlling public health and CS problems.

From the point of view of the MOH's Area Head, the project would not continue if WRH were to leave, although there is a possibility the Ministry could absorb it. According to the MOH, the nurse > promoter > guardian relationship is crucial as far as sustainability is concerned. It is worth mentioning that the MOH give special consideration to this project, but this interest

does not materialize in combined plans or actions. It is evident that the community work carried out by WRH is most effective for the MOH, who view the WRH's actions as a goal they should achieve.

In the light of such circumstances, problems are bound to affect the sustainability strategy or expectations.

On the other hand, the project's success in organizing women to take CS actions, has a greater sustainability potential. There is practically a consensus (leaders, mothers, MOH, WRH, etc.) in the sense that it would be very difficult for the beneficiary to pay for their services, since they may afford a consultation or material benefits, but not education. As regards the exchange of knowhow and experiences as a sustainability criterion, this cannot be relied upon because it is a well-known fact that once a communication and education project is discontinued, the experiences are reverted and it takes generations to absorb them.

Financing is definitely a crucial factor as far as sustainability is concerned. A possible alternative could be for community banks to finance the preventive project; however, most community banks are urban.⁶

Another alternative would be for part of the money people pay the Ministry of Health for medical treatment, to be allocated for prevention purposes. However, the MOH's income from health services is insignificant and does not remain within the communities, although the MOH is prepared to study the possibility of recovering costs, even for treatment purposes.

It is very obvious that consideration should be given to strengthening the communities that already exist, rather than to increase the number of communities.

It would appear that there are few possibilities, however all these involve not only supporting a community with a guardian, but forming formal organizations/committees in each community as a link with the MOH and other institutions so that community participation in solving their basic health problems may continue.

Conclusions:

⁶ Community Banks are an activity that began in the project area to increase women's income in the hope that this would benefit the mother-child population, particularly as regards food and access to health services. These have mainly been implemented in urban areas and there are now 14 of these banks.

- It would be difficult to sustain the financing of this project after 2.1/2 years, however there is a good relationship with the MOH, the exchange of knowhow and experiences is likely to continue for some years, community banks will sustain mothers to a certain extent, WR will not abandon the project altogether although it will be involved in a different way, and a good relationship has been established with the churches in each community.
- The achievements obtained so far could be maintained to a certain extent, providing local structures become more solid and more organic. Equal relationships must be sought with communities and finance and technology facilities, rather than "providing them with a guardian to help them".

7. Recurrent Expenses and Expense Recovery Mechanisms

"If we ask mothers for money, they would not come. That is why they come. We tell them it's for their own good. It's difficult to find money these days."

Guardian of San Ignacio (Focal Group)

"No, I don't think some women would pay for the project's services. They would say they were too poor and we are going through hard times. When I get a headache, I can't afford an aspirin."

Julia de Aguilar, Madre Jamasquire.

Project administrators have a fairly realistic viewpoint of the project's effectiveness and the amount of financial, material and human resources to implement it. Little emphasis has been placed on periodic estimates of the operational expenses of specific involvement or expenses incurred in specific geographical areas, i.e. a community or an area under the influence of a reference centre. Recurrent expenses of various operations or of the entire project are not estimated periodically either. When there is no record of the real or current expenses incurred in each community, it is difficult to judge whether or not the MOH could continue with the Project.

Whether or not the community can afford to pay some or all of the expenses related to the project, has not been established, nor the type of expenses they would be willing to pay for health services in general in relation to their income. The results of meetings and interviews indicate that the community are reluctant to face health-care expenses. Funnily enough however, a demand for certain pharmaceutical products and services was observed, which are permanently used in these communities. Many of these medicines and services are expensive, ineffective and incomplete (i.e. antibiotics to treat diarrhoea).

It really would not be too difficult for the MOH to include items on its budget to finance the continuation of some of the project's areas of involvement, because they already have the infrastructure as well as a budget for such activities which is often not used, consequently the funds return to the public treasury.

USAID's mission in Tegucigalpa is very interested in these financing aspects and cost recovery mechanisms for health services. They are financing a number of activities and research work that have had little effect on the MOH staff, mainly due to their limited contact with the population and the lack of technical assistance. If WRH were interested in sharing this interest, they would be willing to mediate with the MOH to carry out joint activities and research work on these aspects.

Conclusion:

- It is considered that in the communities and through the MOH, there is a potential to absorb certain basic recurrent expenses. More information is required on local costs and expenses so that local strategies and specific projects may be developed.

IV. Main Recommendations**To ensure that the objectives, goals and sustainability of the project are achieved:**

1. Ensure that all participation revolves around Growth Monitoring and generates an integrated community response, based on a formal community structure that has direct relations with the MOH and on which the health guardian depends. Such participation must be based on the current aid and supervision structure and the same activities carried out by the project, focused on risk groups. Participation in actions currently under implementation should be included, i.e. a Change of Eating Habits, Control of Diarrhoea and Pneumonia, and the supply of Vitamin A and Vaccinations.

Volunteers should play a specific role in such services as growth control and ORUs. The objective of this strategy is to reduce the present workload of volunteers, sharing it with other members of the community and generating support networks for different sectors of the population in need of preventive services and adequate information.

CS Support Networks:

Vaccinations: Under the responsibility of an individual who is interested in vaccinating his/her own children as well as the other children in the neighbourhood or community. This person must be trained to: 1) identify newborn babies and provide a vaccination card for them; 2) pinpoint the children who require vaccinations each month; 3) make sure the children are vaccinated; and 4) once they have been fully vaccinated, remove their names from the list at 11 months.

Diarrhoea Control: A mother who has gone through the experience of rehydrating her child, needs additional training in oral rehydration and the dietary management of diarrhoea. She should: 1) Set up a table in a corner of her home for preparing ORS; 2) put up a notice offering ORT for REHYDRATION; 3) stock ORS; 4) make time to encourage mothers to resort to ORS and teach them how to use them.

Activities that unite guardians/mothers/promoters should be encouraged, so that they may all strive towards the same goal and project an overall view of the project's intentions. This could be achieved through local planning meetings with specific goals. The promoters should **PAVE THE WAY** to this end.

To increase the applicability, competence and quality of the project, the following is required:

3. A joint MOH/WRH/Community design of a reference/counter-reference system for each individual community within the scope of the project.
4. A review of the supervision instruments at all levels:
 - Strengthen and ensure a joint WRH/MOH supervision at all levels.
 - Ensure a promoter > community supervision process that uses the data system.
 - Monitor the joint WRH/MOH implementation of Child Survival activities at a management and coordination level in selected communities.
 - Produce joint supervision reports for distribution to all WRH and MOH establishments.
5. Review the Data System, as follows:
 - Ensure that the data collected is concentrated in CESAR (Health Post), from where the promoter and the nurse may obtain the information they require for their reports on communities and volunteers.
 - Review the data handling process at a community level (data collection/data use), placing

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- more emphasis on MOH coordination, production, and monitoring.
 - Help the population to objectively appreciate the project's achievements in the different communities. Simple, adequate systems should be used for feeding back the information to the community. Specific goals must be monitored as well as all-embracing activities.
 - Systematically share periodic achievements by areas (News Bulletin), using information that proves the benefits of the project and the MOH's achievements, in terms of coverage, reduced MOH expenditure and community involvement in the MOH's objectives.
 - Promote the exchange of information on recommendations and experiences obtained from other local and international PDOs.
6. Technical aspects of the participation:
- Review and reduce risk population criteria for each participation. Concentrate efforts on the risk of ill-health.
 - Review the growth control component of the food counselling program, concentrating its implementation on the high-risk population, carrying out pilot experiences involving individual eating practices.
 - Review the treatment of diarrhoea, introducing dietary management practices. Limit the use of ORS to cases of dehydration, as recommended by local regulations. Strengthen the MOH's initiative to set up Community Oral Rehydration Units (ORUs) in each community, once the WRH and MOH staff have been duly trained.
 - As regards mothers' health, particularly during pregnancy, concentrate on high risk groups, ensuring their access to a Family Planning centre within their community which should be linked (reference/counter-reference) to CESAMO or another medical centre. The initial medical care of a woman or a couple should include a medical consultation. Study self-financing alternatives for these community services, i.e. locally controlled Community Medical Centres for Women and Couples.
 - With respect to Pneumonia, study different alternatives for identifying and managing cases in each community. In coordination with the MOH, implement a community case-management policy.
7. Coordinate the development of three joint training courses for WRH and MOH staff with PAHO/Washington D.C. and Tegucigalpa, within the next six months: Supervisory Skills for Diarrhoea Control; Supervisory Skills for ARI; and Basic Principles of Epidemiological Disease Control.
8. Make joint efforts (WRH/MOH/USAID-Honduras) to carry out operational research work on:
- The project's estimated recurrent expenses and the population's expenses on health

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- services in each community.
- Mechanisms for recording the impact of community banks on family health.
 - The recovery of expenses through drug stores, community family planning services and others, managed by formal community structures.
 - The allocation of the MOH's budget items for providing health care to support the communities under the project's sphere of influence.
 - Review the existing education materials, using suitable messages for users.
9. Ensure coordination between WRC and USAID/DC, to identify possible technical assistance for the Health Information System and Nutrition.
10. In the budget and from foreign sources, identify funds for implementing a technical assistance program in the short and medium terms, to provide the necessary technical assistance. The program should include:
- Technical Assistance for training MOH and WRH staff. PAHO's contribution of training materials for the supervision and epidemiology courses could be included.
 - Operational Research. It is possible to carry out research work to improve the program. The local USAID mission and the MOH have regional resources available through the Health Sector II program, for operational research work that could be used with the MOH establishments.

To USAID FHA/PVC:

11. Suggest that USAID PVC/FHA introduce qualitative methods of implementing the mid-term evaluation process.

V. Lessons Learned

1. The development of an adequate management and surveillance system is vital for obtaining the best results from a CSP.
2. If Health Guardians have to visit over 20 families, they cannot be expected to be efficient.
3. The food strategy must be considered a priority in any Child Survival project if good results are to be expected.
4. The development of human resources at a community level is effective because it is easier to envisage problems and find solutions to them.

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5. Field supervision should be carried out systematically with the help of simple but safe instruments to ensure that problems are solved as quickly as possible at all levels of the CSP-G structure.
 - 6.A Unless each aspect of the program is jointly implemented with the MOH (health messages, structures, supervision policies, the data system, the reference system, costs) sustainability cannot be expected.
 7. Any NGO willing to implement a CS program must ensure the participation and commitment of the Ministry of Health in all stages of the project, starting with the initial proposal.
 8. In order to establish a close relationship with the MOH, a strategy is required to encourage and promote joint operation and volunteer training as well as new areas of interest which have been very effective for the MOH staff.
 9. As a result of the lack of initial involvement, different institutional objectives and different structures, the relationship with counterpart NGOs is based on coordination rather than on continuous implementation.
 10. It is more effective to train community volunteers when the educational strategy and content are adapted to their own organic structure and their real context.
 11. Local Health Committees that initially operated as support groups working hand-in-hand with the Health Guardian, are very important for ensuring community participation, however to make them more effective, roles should be reverted and Guardians should depend on the Committee.
 12. Health Promoters should have well-defined working guidelines regarding who they should work with, i.e. teachers or churches, etc.. If the choice is left open, they find it difficult to start work and they achieve little.
 13. It is a good approach to educate the community through community volunteers, but it is not too effective if the work depends exclusively on one type of volunteer, such as a Health Guardian. They should be helped to integrate their actions with other networks of responsible individuals involved in other areas within the community (Community Oral Rehydration Units, Support Networks for Breast-feeding Women, Community Family Planning Centre, etc.).
 14. With respect to Public Health structures, Nursing Assistants are the most suitable people to teach the community. Once the community actively participates in the selection and

- training of community volunteers (design and implementation of follow-up workshops), then there should be an effective Health Centre-Health Volunteer integration as far as community activities are concerned.
15. The Data System must be designed from the initial stages of the project so that no valuable information is lost. Field personnel should be encouraged to participate in reviewing and adjusting the information.
 16. Any educational task that does not include a supply of the input or element promoted (e.g. contraceptive methods) will not effectively improve community practices.
 17. The educational activity should not be limited to transferring knowhow, but should include practical work, e.g.: health volunteers should not only teach mothers how to prepare ORS, they should have a supply of ORS and prepare the solution with the mother and administer the first dosage to the patient, making a house call to ensure that the ORS are being used at home.
 18. Not only should spacing between pregnancies be taught, but the community should have methods available to which users may be referred.
 19. Children are easy to teach because adults tend to love and respect them. In the process, tomorrow's adults are being educated.
 20. Health volunteers who have been trained to apply medical treatment do not carry out preventive practices, despite their training. Even medical staff of higher levels find it difficult to become involved in preventive actions.
 21. Participative methodology and techniques are effective in community volunteer training, as they make learning easier and develop skills for training others.
 22. A community volunteer's work should be planned within a formal community structure to prevent a heavy workload: he should have a small, well-defined area of influence; have a limited number of interventions; be treated gently and courteously; be visited constantly so that he may be sufficiently motivated to carry out a more effective job, etc.
 23. Local primary schools are effective means of promoting community health education.
 24. Weighing sessions are numerous but ineffective, mainly due to the fact that mothers have no time to be taught about their children's growth process, and also because they wear out the health volunteer. Weighing sessions should involve between 5 and 8 children.

25. The careful recruitment of volunteers and initial training on the characteristics and duties of the health volunteer are important factors for determining whether or not a volunteer is likely to continue his work. These two aspects should therefore be included in every trainign process.

26. The motivation of the wage-earning Health Promoter is crucial for establishing his commitment to the cause and the results of his work over and above the material working tools he may possess.

VI. Appendices:

1. Evaluation Team

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2. Terms of Reference

**WORLD RELIEF CORPORATION/HONDURAS
GUAYAPE CHILD SURVIVAL V PROJECT**

**MIDTERM EVALUATION
SCOPE OF WORK**

PURPOSE

To evaluate the accomplishments and management of WRC's Child Survival Project in accordance with the guidelines established in their Cooperative Agreement (#9380WRC.01) and Detailed Implementation Plan (DIP).

EVALUATION OUTPUTS

The evaluator will be responsible for preparing and delivering an original unbound copy and four bound copies of the final report, in English, to USAID/Washington and one unbound copy to WRC/Wheaton by September 4, 1992.

Prior to this, the evaluator will present a rough draft in Spanish, with tentative recommendations, to the evaluation committee and Guayape Child Survival field staff for discussion on July 29, 1992. A second draft in Spanish will be sent to the Guayape Child Survival staff in Honduras by August 12, 1992 for their final review. This draft will be returned to the evaluator with comments by August 17, 1992.

The report should provide the following:

1. An assessment of WRC's progress towards meeting the goals of the Grant Agreement and the DIP.
2. An assessment of the problems and constraints that are influencing progress towards the established goals as well as the potential of the project for reaching its stated objectives by the end of the project (September 1994).
3. Recommendations to WRH for actions to improve the project in the remaining two years.

The body of the report should follow the USAID Mid-Term Evaluation Guidelines (attached) and contain the following:

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- Table of Contents
 - Executive Summary
 - Key Findings and Recommendations
 - Team Composition and Study Methodology
 - Annexes
 - Scope of Work
 - List of Documents Consulted
 - List of Individuals/Organizations Consulted

METHODOLOGY

The evaluation team will conduct its assessment based on the following:

1. WRC Cooperative Agreement with FHA/PVC, DIP, annual reports and technical reviews.
2. WRC/s responsiveness to recommendations in the various technical reviews of project documents.
3. Other documents considered relevant by the evaluation team.
4. Interviews with Guayape Child Survival Project staff, beneficiaries, MOH, USAID and other individuals considered relevant.

ISSUES TO BE ADDRESSED

The Guayape Project staff have designated the following areas as areas of emphasis in the evaluation prioritized as follows:

1. The Acute Respiratory Infections Intervention and ways to improve mothers' practices.
2. The Birth Spacing Intervention and ways to improve the mothers' practices.
3. The Health Information System (monitoring and evaluation).

Attachment: USAID MTE Guidelines

cc: Jaime Henriquez, Project Officer, USAID/FHA/PVC/CSH
Dr. Dory Storms, Coordinator, PVO CSSP, JHU

Roberto Ruiz, WRH Country Director
Dr. Orestes Zuniga, CSP-G Director
Bas Vanderzalm, WRC International Director

3. Documents Consulted

1. Calendario Detallado de Actividades
2. Talleres para el Personal del PSI-G
3. Investigacion Sobre Conocimientos y Prácticas en Supervivencia Infantil 1991
4. Investigación de Base 1990
5. Ayuda Memoria - Cuarto Seminario/Taller de Capacitación PSI-G, 10-14 de junio de 1991
6. Ayuda Memoria - Quinto Seminario/Taller de Capacitación PSI-G, 20-24 de enero de 1992
7. Revisión de los Mensajes de Nutrición en Supervivencia Infantil - Una evaluacion del curriculum de capacitación, Junio de 1991
8. Guías para la Evaluacion a Medios de los Proyectos de SIV de Cinco Anos y Proyectos de SIVI de Tres Años
9. Análisis sobre Deserción de Guardianes (Area 1)
10. Informe Actualizado sobre Deserción de Guardianes de Salud (Area 2)
11. Lecciones Aprendidas del PSI-G a Junio de 1992
12. Revisión Técnica por AID de Curricula de Nutrición PSI-G
13. Datos estadísticos del proyecto (3 cuadros)
14. Objetivos PSI-G (inglés) (1 cuadro)
15. Sistema de Información en Salud (SIS), PSI-G
 - Descripción del PSI-G (5 páginas)
 - 9 formularios para registro, cada uno con su respectiva guía para llenarlo
16. Respuesta a Revisión Técnica de USAID al DIP

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17. Plan Detallado de Implementación (DIP) (ingles)
 18. Plan Detallado de Implementación (DIP) (español)
 19. Primer Informe Anual, PSI-G, Septiembre 1, 1989 a Agosto 31, 1990 (inglés)
 20. Segundo Informe Anual, PSI-G, Septiembre 1, 1990 a Agosto 31, 1991
 21. Proyecto de Supervivencia Infantil - Guayape (propuesta - español)
 22. Material Educativo
 - a. La Planificación de Actividades
 - b. La Evaluacion Realizada con la Participación de la Comunidad
 - c. Comites Locales de Salud
 - d. La Importancia de la Organización Comunal
 - e. Guía de Preparación de Alimentos con Productos de Huerto y su Valor Nutritivo
 - f. Recetas con Frijol Soya
 - g. Algunas Cosas que Debemos Saber sobre el Crecimiento y Desarrollo del Niño Menor de Cinco Años
 - h. Como Aprende el Adulto
 - i. Aprendamos Sobre la Importancia de la Vitamina A
 - j. Ayudemos a Prevenir las Muertes por Neumonía
 - k. Promotores de Salud
 - l. Hablemos Mas a Fondo Sobre Algunas Enfermedades del PAI
 - m. Manual para Personal Voluntario de Salud (Proyecto Hope)
 - #1 - "Control de Enfermedades Diarréicas"
 - #2 - "Programa Ampliado de Inmunizaciones"
 - #3 - "Infecciones Respiratorias Agudas"
 - #4 - "Nutrición"
 - n. Folleto de Conocimientos Básicos "Lo Que Tu Debes Saber Para que Tu Hijo No Muera"

4. Institutions and persons Interviewed

Mothers

Ana Betty Mayen	El Naranjal
Martha Pérez	Sta. María del Real
Silvia Hernández	Sta. María del Real
Xiomara López	Sta. María del Real
Gladis Aguilar	Sta. María del Real
Silvia R. Pavon	Sta. María del Real
Rosa Argentina Castro	Sta. María del Real
Lilian Crisanta Zavala	Jamasquire
Elsa Rosario Mejía	Jamasquire
Betty Aguilar	Jamasquire
Rosa Martinez	Jamasquire
Igna Concepción Bertrand	Jamasquire
Antonia Rodriguez	Jamasquire
Rosario Hernández	Jamasquire
María del Carmen Ayala	El Naranjal
Nidia O. Padilla	La Guadalupe
María O. Verde	La Guadalupe
María M. García	La Guadalupe
Irma S. Rodas	La Guadalupe
Briselda de Díos	Sta. María del Real
Evangelina Mólina	Sta. María del Real
Julia de Aguilar	Jamasquire
Hilda Ramona de Aguilera	Jamasquire
Juana de Dios Santos	Jamasquire
Xiomara Mendoza	Jamasquire
Rosa O. Pavon	San Marquitos
Inedina Rosales Verde	Orica
María N. Idiáquez	San Marquitos
Lesbia Maribel Rivas	Catacamas
Leonor Zelaya	Catacamas
Vilma Isabel Hernández	Catacamas
Virginia Aguilar	Catacamas
María Mercedes Varela	Catacamas
Erica Suazo	Catacamas
Miriam Isabel Banegas	Catacamas

Health Volunteers (Guardianes de Salud)

Alma Leticia Vallecillo	San Ignacio
Margarita Padilla	San Marquitos
Dorita Zelaya	La Concepción
Argelia Avila	La Concepción
Dunia Amador	La Concepción
Miriam Pineda	La Concepción
Olivia Avila	La Concepción
Gloria Díaz	Sta. María del Real
Francis Gómez	Catacamas
Amanda de Erazo	Sta. María del Real
Rosario de Orellana	Catacamas
Mery de Romero	Catacamas
Concepción Soto de Colindres	Catacamas
Tomasa de S. Carranza	Siguaté
Lucía Ermelinda Ochoa	El Encino
José Manuel Gálvez	Siguaté
Reyna Dilia Hernández	Jamasquire
Nohemy del Carmen Lobo	Gualiqueme
Sara Medina	Jamasquire
Gloris Amanda Mayén	Sta. María del Real
Ana Orestila Rodriguez	El Naranjal
Margarita Flores	San Ignacio
María I. Lóñez	San Ignacio
Rosalinda Soto	San Ignacio
María S. Castro	San Ignacio
Adaminda Escobar	San Ignacio
Griselda Torres	San Ignacio
Eva Estrada	San Ignacio

Area Nurses

Leticia Díaz	Area 1
Miriam Carpio	Area 2

Nurses

Juana Martinez	El Guayabito
Gloria Díaz	Sta. María del Real
Angela Pineda	Catacamas

Olga Esmeralda López	San Ignacio
Anarda Agurcia	Orica
Alba Luz Murillo	Orica
Manuela Amador Acosta	La Concepción
Gloria Isabel Mayén	Sta. María del Real

Chiefs of Area

Dr. Hector Luis Escoto	Area 1
Dr. Orlando Rivera	Area 2

Leaders

Cristina Hortencia Landa	Comite Apoyo, San Marquitos
José Alfredo Mejía	Junta de agua, Col Agricola
José Manuel Matute	Director escuela, El Naranjal
Celina Castellón	Club Amas de Casa, Col Agricola
Julia Bú	Club Amas de Casa, Col Agricola
Juan Pablo Torres	Subdirector esc., San Ignacio
Elvia Meza	Maestra, escuela, San Ignacio
Sara Hernández	Lider Com., Sta. Ma. del Real
Irma I. Rodriguez	Comité de Apoyo, El Naranjal
Juana Adilia Pinot	Comité de Apoyo, San Marquitos

Promotors

Jairo Torres	El Pataste
María Leoneris Cruz	Catacamas
Lesly Suyapa Juarez	Catacamas
José Ursulo Suazo	Culmí
Iris Rodriguez	Sta. María del Real
Harby Barahona	Siguate
Ana Bertha Zavala	Las Mesetas
Teodoro Hernández	Urrutia
Ildefonso Hernández	Orica
Luis A. Landero	Guatemalita
Aura Patricia Verde	San Ignacio
Rene Adalid Barahona	Guayape
Rebeca Jackelin Martinez	Orica

Private Voluntary Organizations

Dr. Nestor Salavarría

Clínica El Buen Pastor

World Relief Honduras/Wheaton Staff

Roberto Ruíz
Orestes Zúniga
Joel Durón
Sandra Chávez
Muriel Elmer

Director WRH
Director PSIG WRH
Asistente de Campo PSIG WRH
Jefe Finanzas WRH
Especialista en Salud WRC

Community Banks Members

Medea Esperanza Canales
Sandra Maribel Mejía
Lesbia Maribel Rivas
Miriam Isabel Banegas
María Rogelia Solís
Dilma Isable Hernández
Virginia Aguilar
María Leonor Zelaya

Catacamas
Catacamas
Catacamas
Catacamas
Catacamas
Catacamas
Catacamas
Catacamas

Area Coordinator WRH

Héctor Luis Velásquez
Silvia Hernández

Area 2
Area 1

5. Guides Used in Interviews

Guías de evaluación para: DIRECTOR DE WRC

- Es apropiada la mezcla de las intervenciones del proyecto para dirigirse a los problemas claves, dados los recursos humanos, financieros y materiales disponibles al proyecto y a la comunidad?
- Ha habido progreso suficiente par alcanzar los objetivos y metas anuales ?
- Cuales son las principales barreras comunitarias para alcanzar las necesidades de los niños
- Ha limitado el proyecto su área de intervención o el tamaño de la población de impacto ?
- Ha habido una expansión cuidadosa de las actividades de servicio del proyecto
- Ha llevado a cabo el proyecto actividades de acción comunal, educación o comunicación ?
- Ha sido creativo el proyecto en el enfoque de la educación comunitaria, como por ejemplo incorporar actividades participativas de educación o no tradicionales ?
- Cuántas personas están trabajando en este proyecto de sobrevivencia infantil ?
- Tiene este proyecto un numero adecuado y mezcla de personal para satisfacer las necesidades técnicas, administrativas para le funcionamiento de este proyecto ?
- Tiene este proyecto contraparte locales ?
- Están tomando parte de este proyecto voluntarios comunitarios ?
- Son los trabajadores voluntarios multiuso o se concentran en una sola intervención ?
- Es suficiente su cantidad de trabajo ?
- Ha sido apropiado el apoyo técnico y monitoreo administrativo de las oficinas regionales o centrales de su organismo en términos de tiempo, frecuencia y necesidades de personal ?
- Sino, que obstáculos se enfrenta el proyecto para obtener un adecuado apoyo técnico y monitoreo de las oficinas regionales o centrales de su organismo ?
- Tienen estos fondos una función critica ?
- Tienen estas funciones mas de los fondos o menos de los fondos necesarios ?
- Hay aspectos particulares del financiamiento de AID a la oficina central de su organismo que pueden tener un efecto positivo o negativo para alcanzar los objetivos de sobrevivencia infantil ?
- Que tipos de ayuda técnica externa ha necesitado el proyecto hasta la fecha y que tipo de ayuda técnica ha obtenido el proyecto ?
- Fue adecuado y claro y de mérito el nivel de ayuda técnica obtenida por el proyecto ?
- Tiene el personal de contrapartida la capacidad técnica y administrativa para tomar eventualmente las funciones necesarias para operar efectivamente en las actividades de sobrevivencia infantil ?
- Como se comparan los gastos hasta la fecha con el presupuesto del proyecto ?
- Se esta administrando el presupuesto de una manera flexible pero razonable y puede el organismo justificar los cambios que puedan haber ocurrido en el presupuesto ?

Puede el proyecto lograr sus objetivos con los fondos restantes ?

Hay posibilidad de que se gaste menos de lo presupuestado en la propuesta al final del proyecto ?

Son significativos los incentivos recibidos por los voluntarios de la comunidad, el personal y las contrapartes en su compromiso con el proyecto ?

Continuación de estos incentivos una vez que termine los fondos de AID ?

Cuales son los pasos que el proyecto ha llevado a cabo para promover la sostenibilidad de actividades efectivas de sobrevivencia infantil una vez terminados los fondos ?

Hay algunos planes concretos para que el MSP continúe las actividades particulares del proyecto después de que se terminen los fondos ?

Tienen los administradores un buen entendimiento de los gastos humanos, materiales y financieros requeridos para sustentar actividades efectivas de SI ?

Cual es el monto de dinero que el proyecto calcula que se necesitara para recuperar gastos

Que estrategias esta implementado su organismo para reducir gastos y hacer el proyecto mas eficiente ?

Que mecanismos específicos de recuperación de fondos se están implmentando para compensar los gastos del proyecto ?

Son razonables los gastos dado el ambiente en que opera el proyecto; es apropiado el costo por beneficiario ?

Guías de evaluacion para: ENFERMERAS DE AREA Y SECTOR

¿Sabe Ud. de los resultados obtenidos por las investigaciones hechas por el proyecto?

¿Que opina Ud. de la metodología utilizada para la capacitación de los Guardianes de Salud?

¿Cree que la duración de la capacitación para preparar Guardianes de Salud es suficiente para realizar su trabajo?

¿Creé Ud. que los promotores están adecuadamente preparados para entrenar y supervisar a los Guardianes de Salud asignados a ellos? ¿Podría dar ejemplos?

¿Creé Ud. que los Guardianes están adecuadamente entrenados para desempeñar sus responsabilidades en la comunidad? ¿Ha oído Ud. de algún problema?

¿En que manera, cree Ud. que los promotores, son una ayuda a las madres de la comunidad?

¿Ha oído Ud. de algún problema?

¿Esta Ud. recibiendo información que necesita del Guardián a través de la enfermera?

¿Esta Ud. informado acerca de las actividades que lleva a cabo Auxilio Mundial para la supervisión y control de Guardianes y Promotores?

¿Que incentivos de los que se dan al Guardián puedan continuar una vez que termine el proyecto?

¿Que actividades se han llevado a cabo con el propósito de que el proyecto continúe una vez que Auxilio Mundial se retire?

Guías de evaluación para: GUARDIANES DE SALUD

- Que materiales educativos han sido distribuidos a ustedes?
- Son estos materiales apropiados para hacer su trabajo?
- Estos materiales que les dan son importantes para ustedes? Lo usan?
- Tiene el personal del proyecto los conocimientos, habilidades necesarias para llevar a cabo su trabajo en el proyecto?
- Crean ustedes que las madres de la comunidad reciben el apoyo y consejo necesario por parte del Guardián y promotor?
- Cuenta usted con el apoyo, consejería, educación y evaluación de su trabajo por parte del personal del proyecto?
- A donde envía usted a un niño o madre que necesita ser atendida? Como es la atención que se le brinda?
- Cree usted que el proyecto ha utilizado adecuadamente estos servicios?
- Cual es la relación que tiene el proyecto con los lugares de referencia?
- Son significativos para ustedes los incentivos que el proyecto les brinda?
- Crean ustedes que el proyecto puede continuar una vez que Auxilio Mundial se retire de su comunidad?
- Ha participado la comunidad en el desarrollo del proyecto?
- Los miembros de su comunidad ven como efectivo este proyecto?
- Esta de acuerdo la comunidad en pagar cualquier parte de los gastos de las actividades de prevención y promoción de salud?
- Como se siente usted al trabajar con Guardianes de Salud?
- Que actividades ha logrado, usted, realizar como Guardián de Salud en su comunidad?
- Que beneficios producen los bancos comunales en la salud y nutrición de su familia?
- Que información esta usted recolectando? Como la usa? Puede mostrármela?
- Piensa usted que la información que recoge es fácil de obtenerla? La considera importante?

Guías de evaluación para: LIDERES DE LA COMUNIDAD

- Cuanto tiempo dedica Ud. a su labor con el proyecto y cuanto tiempo puede piensa Ud. dedicarle en el futuro ?
- Cual es su participación en el desarrollo del proyecto ?
- Que piensa de las visitas domiciliarias ?
- Cuan importante es su participación en las actividades del proyecto?
- Ha habido suficiente progreso para alcanzar objetivos y grupos de alto riesgo ?
- Se están alcanzando los grupos de alto riesgo ?
- Como esta involucrada la comunidad en el planeamiento e implementación de las actividades del proyecto ?

- Ven este proyecto como efectivo los miembros de la comunidad ?

Esta de acuerdo la comunidad en pagar cualquier parte de los gastos de actividades en prevención y promoción de la salud ?

Guías de Evaluación para: MUJERES/MADRES

Cuanto tiempo dedica Ud. a su labor con el proyecto y cuanto tiempo puede piensa Ud. dedicarle en el futuro ?

Es apropiada la priorización de los problemas ?

Son apropiados los componentes de PSI para dirigirse a estos problemas ?

Se están alcanzando los grupos de alto riesgo ?

Sino, cuales son los problemas que evitan de que se alcancen estos grupos ?

Cuales son las principales barreras de la comunidad para que el proyecto alcance las necesidades de los niños ?

Que ha hecho el proyecto para que las familias se beneficien de sus actividades?

Que esta haciendo el proyecto par que la comunidad fortalezca su autosuficiencia y para que la mujer pueda atender mejor las necesidades de salud y nutrición de su familia ?

Sabe Ud. los datos sobre el estado de salud y los resultados logrados por las actividades del proyecto ?

Tienen consejos y apoyo oportuno del personal del proyecto ?

Como esta involucrada la comunidad en el planeamiento e implementación de las actividades del proyecto ?

Creen que el proyecto es efectivo ?

Que beneficio producen los bancos comunales en la salud y nutrición de su familia ?

Que gastos para actividades de prevención y promoción de salud puede cubrir la comunidad Que sugeriría Ud. para mejorar el desarrollo del proyecto ?

Guías de Evaluación para: ENFERMERAS AUXILIARES

Ha habido suficiente progreso para alcanzar los objetivos ?

Se estan alcanzando los grupos de alto riesgo ?

Esta su organismo fomentando un ambiente que mejore la autosuficiencia comunitaria y facilitando a las mujeres su participacion en la solucion de problemas de salud ?

Han sido compartidos los resultados de la informacion recolectada con recolectadores de datos, personal del proyecto, contrapartes y miembros de la comunidad ?

Fue apropiada la metodologia de capacitacion para la naturaleza de los trabajos de los trabajadores de salud ?

-
- Fue suficiente la duracion de la capacitacion para preparar a los trabajadores de salud ?
Que materiales educativos han sido distribuidos a los guardianes ?
Tienen suficientes materiales, suministros, y equipamiento los voluntarios locales para realizar su trabajo ?
Tiene el personal local del proyecto los conocimientos y destrezas para llevar a cabo sus responsabilidades ?
Aconsejan y apoyan el personal local a las madres en forma apropiada ?
Tiene el personal contraparte la capacidad tecnica y administrativa para asumir el PSI ?
Existe libre dialogo entre Ud. y el PSI ?
Ha hecho el proyecto uso apropiado de estos lugares de referencia ?
Cual es la continuidad de relaciones entre el lugar de referencia y el proyecto de la comunidad ?
Es adecuado el dialogo entre el proyecto y el lugar de referencia ?
Esta tomando el proyecto para fortalecer los servicios del lugar de referencia o mejorar el acceso comunal al mismo ?
Son significativos los incentivos recibidos por los voluntarios de la comunidad ?
Continuarian estos incentivos recibidos una vez que terminen los fondos de AID?
Esta involucrado el MSP en el proyecto ?

Guías de Evaluación para: COORDINADORES DE AREA PSI

- ¿Es apropiada la mezcla de las intervenciones del proyecto para dirigirse a los problemas claves, dando los recursos humanos, financieros y materiales disponibles al proyecto y la comunidad?
Es apropiado el enfoque o priorización de las intervenciones?
¿Ha habido suficiente progreso para alcanzar los objetivos y metas?
¿Se están alcanzando eficientemente los grupos de alto riesgo?
¿Cuáles son las cosas que obtienen el logro de los objetivos y alcance de los grupos de alto riesgo?
¿Cuales son las principales barreras comunitarias para alcanzar las necesidades de los niños?
¿Ha limitado el proyecto su área del proyecto o el tamaño de impacto de la población?
¿Ha habido una expansión cuidadosa de las actividades del servicio del proyecto?
¿Ha hecho su organismo objetivos medibles de logros y resultados?
¿Se ha dispuesto la Administración del proyecto a hacer cambios cuando sea apropiado y puede su organismo justificar o dar una explicación razonable de las direcciones y estrategias del proyecto que se han llevado a cabo?
¿Esta recolectado el proyecto datos sencillos y útiles?
¿Se necesita refinar los indicadores?
- ¿Cuál es el balance entre los métodos cuantitativos y cualitativos que se usan para recolectar

los datos?

¿Está usando el proyecto encuestas para el monitoreo y evaluación?

¿Cómo se están usando los datos para tomar decisiones?

¿Tiene el personal local la capacidad técnica y administrativa requerida para mantener el sistema de información en salud?

¿Han sido compartidos los resultados de la información recolectados con recolectores de datos, personal del proyecto, contrapartes y miembros de la comunidad?

¿Están las oficinas centrales de su organismo al nivel del proyecto haciendo algún esfuerzo para maximizar las lecciones aprendidas por medio de la documentación compartiendo institucionalización de sus lecciones?

¿Cuál es el balance entre promoción de salud/movilización social y provisión de servicios a este proyecto? ¿Es apropiado este balance?

¿Hay un enlace entre la educación y los servicios disponibles?

¿Ha llevado a cabo el proyecto actividades de información comunal de educación o de comunicación?

¿Ha habido un esfuerzo para utilizar datos de conocimientos y prácticas, o datos de grupos focales, entrevistas a fondo, etc. para desarrollar los mensajes?

¿Han sido los mensajes probados y refinados?

¿Cómo asegura su organismo que los mensajes dados a las madres son consistentes?

¿Fueron probados los materiales imprimidos antes de usarse?

¿Ha sido creativo el proyecto en el enfoque de la educación comunitaria como, por ejemplo, incorporar actividades participativas de educación o no tradicionales?

¿Ha valorado el proyecto el nivel de entendimiento que ha ocurrido con estos métodos o es la evidencia de efectividad anecdotal?

¿Están tomando parte en el proyecto los voluntarios comunitarios? ¿Cuántos están trabajando?

¿Son los trabajadores multiuso o se encuentran en una sola intervención?

¿Es suficiente su cantidad de trabajo?

¿Cuántos días de capacitación inicial y cuántos días de capacitación de refrescamiento han recibido desde el comienzo del proyecto?

¿Hay evidencia de que su organismo lleva a cabo una valoración de las necesidades antes de empezar una capacitación inicial o de refrescamiento?

¿Cree usted que la metodología para capacitar personal voluntario ha sido efectiva?

¿Considera usted que fue suficiente la duración de la capacitación para preparar a los trabajadores de salud para llevar a cabo sus tareas asignadas?

¿Qué materiales educativos u otros han sido distribuidos a los trabajadores?

¿Les da mucho valor el trabajador de salud?

¿Tiene suficientes materiales, suministros y equipamiento los voluntarios locales para llevar a cabo sus responsabilidades actuales?

¿Tiene el personal local del proyecto los conocimientos, técnicas y destrezas para llevar a cabo

- sus responsabilidades actuales de sobrevivencia infantil?
- ¿Aconseja y apoya el personal local a las madres de una forma apropiada?
- ¿Cuáles son las principales organizaciones, contrapartes del proyecto y qué actividades de colaboración se han llevado a cabo hasta la fecha?
- ¿Tiene el personal contraparte la capacidad técnica y administrativa para tomar eventualmente la funciones necesarias para operar efectivamente en las actividades de sobrevivencia infantil?
- ¿Hay libre diálogo entre el personal de su proyecto y su contraparte?
- Identificar los lugares de referencia y comente sobre el servicio.
- ¿Ha hecho el proyecto uso apropiado de estos lugares de referencia?
- ¿Es adecuado el diálogo entre el proyecto y el lugar de referencia?
- ¿Está tomando pasos el proyecto para fortalecer los servicios del lugar de referencia o mejorar el acceso comunal al mismo?
- ¿Puede el proyecto lograr sus objetivos con fondos restantes?
- ¿Hay posibilidad de que se gaste menos de lo presupuestado en la propuesta al final del proyecto?
- ¿Son significativos los incentivos recibidos por los voluntarios de la comunidad, el personal y las contrapartes en su compromiso con el proyecto?
- ¿Continuarían estos incentivos una vez que terminen los fondos de AID?
- ¿Cuáles son los pasos que el proyecto ha llevado a cabo para promover sustentabilidad de actividades efectivas de sobrevivencia infantil una vez que se terminen los fondos?
- ¿Cómo está involucrada la comunidad en el planteamiento e implementación de las actividades del proyecto?
- ¿Ven este proyecto como efectivo los miembros de la comunidad?
- ¿Hay una demanda en la comunidad para el sustento de las actividades del proyecto?
- ¿Está involucrado en el proyecto el Ministerio de Salud?
- ¿Hay algunos planes concretos para que el MSP continúe las actividades particulares del proyecto después que se terminen los fondos?
- ¿Cuál es el monto de dinero que el proyecto calcula que se necesitara para recuperar gastos?
- ¿Está de acuerdo la comunidad en pagar cualquier parte de los gastos de actividades de prevención y promoción de la salud?
- ¿Está preparado el gobierno para asumir cualquier parte de los gastos recurrentes?
- ¿Qué estrategias está implementando su organismo para reducir gastos y hacer el proyecto más eficiente?

Guías de Evaluación para: PROMOTORES PSI

- En el tiempo de vida del P.S.I.-G. hasta la fecha. ¿Cuanto tiempo ha estado operando?
- ¿Son adecuadas las intervenciones que incluye el proyecto para tratar los problemas claves?
- Se han dado los recursos humanos, financieros y materiales disponibles al proyecto y la comunidad para realizar estas intervenciones?

Se están alcanzando los grupos de alto riesgo; sino cuales son las causas que detienen el logro de estos grupos?

¿ Está el P.S.I.-G. fomentando un ambiente que mejore auto-suficiencia comunitaria?

¿ Se le está facilitando a las mujeres para poder dirigirse mejor a las necesidades de salud y nutrición de sus familias?

¿ Está recolectando el P.S.I.-G. datos sencillos?

¿ Han sido compartidos los resultados de la información recolectada con los mismos recolectores, con el personas del proyecto, contrapartes (M.S.P., otras O.P.V.) y miembros de la comunidad?

¿Cuál es el balance entre promoción de salud/mobilización social y provisión de servicios del proyecto? ¿ Es apropiado este balance?.

¿Cómo asegura su organismo que los mensajes dados son consistentes?

¿Están tomando parte en el P.S.I-G los voluntarios comunitarios? ¿ Cuantos están trabajando?

¿ Hay evidencia de que el P.S.I-G lleve a cabo una evaluación de las necesidades antes de empezar una capacitación inicial o de refrescamiento?

¿ Fue suficiente la duración de la capacitación para preparar a los trabajadores de la salud para llevar a cabo sus tareas?

¿ Tienen suficientes materiales, suministros y equipos para llevar a cabo las responsabilidades actuales con las voluntarias? ¿Son apropiados estos materiales?

Tiene al personal local del proyecto los conocimientos técnicos y destrezas para llevar a cabo sus responsabilidades actuales de supervivencia infantil.

¿ Está la supervisión basada en el campo? ¿ Ha sido adecuada la supervisión a su nivel?

¿Es adecuado el diálogo entre el proyecto y el lugar de referencia?

¿Son significativos los incentivos recibidos por los voluntarios de la comunidad, el personal y las contrapartes para el sostenimiento del proyecto?

¿Está de acuerdo la comunidad en pagar alguna parte de los gastos de actividades de prevención y promoción de la salud?

6. Guides Used in Focus Groups

Guías de Grupos Focus para: MUJERES/MADRES

DIARREA

Que hacen las madres cuando sus niños tiene diarrea ?
Sabemos que muchas madres como Uds. conocen del uso del Litrosol pero, muy pocas la usan cuando su niño esta deshidratado, Porque creen que sucede esto ?
Que medicamentos usan para tratar la diarrea y donde los consiguen ?

IRA

Cual es la enfermedad respiratoria mas grave que han tenido sus hijos ?
Como saben Uds. que sus hijos tienen neumonía ?
Que hacen las madres cuando su hijo tiene neumonía ?

NUTRICION/ALIMENTACION

Como saben que sus hijos están creciendo adecuadamente ?
A que edad se empieza a darle otro alimento diferente a la leche materna ?
Cual es la mejor combinación de alimentos para niños menores de tres años y con que frecuencia debe recibirlos ?

Guías de Grupos Focales para: PROMOTORES

Cuales son los grupos de riesgo con los que trabaja el PSI-G ?
Creen Uds. Que se estan alcanzando los grupos de riesgo ?
Sino, cuales son las causas que impiden que se alcancen estos grupos ?
Consideran Uds. que los datos que recogen con el SIS son sencillos y claros ?
De que manera le sirves estos datos a Ud. ?
A quien le comparte la información obtenida ?
En que consiste la supervisión que Uds. hacen a los guardianes ?
En que consiste la supervicion que les hacen a Uds.
Ha sido adecuada la supervisión ?
Con lo que se ha hecho hasta ahora creen Uds. que el programa se mantendra una vez que el PSI finalice ?

Guías de Grupos Focales para: GUARDIANES

IRA

Que es lo que Ud. le recomienda a las madres sobre Infección Respiratoria Aguda ?
Que problemas tienen Uds. para identificar los signos de alarma en Neumonía y así poder referir esos niños para tratamiento ?
Porque piensa Ud. que los niños con Neumonía se mueren ?

DIARREA

Que es lo que Ud. le recomienda a las madres cuando su niño tiene Diarrea ?
Que podemos hacer para disminuir los casos de diarrea en esta comunidad ?
Sabemos que muchas madres en esta comunidad conocen de la preparación del Litrosol pero, muy pocas la usan cuando su niño esta deshidratado, Porque creen que sucede esto Que medicamentos usan para tratar la diarrea y donde los consiguen ?

NUTRICION/ALIMENTACION

Cuales son los niños a los que le presta mayor atención en las sesiones peso ?
Cual es la mejor combinación de alimentos para niños menores de tres años y con que frecuencia debe recibirlos ?
A que edad se empieza a darle otro alimento diferente a la leche materna ?

ESPACIAMIENTO DE EMBARAZOS

Cuales son los grupos de embarazadas a las que Ud. les presta mayor atención ?
Que recomienda Ud. para reducir la posibilidad de muerte en las mujeres con riesgo ?
Cual es el mejor método de anticoncepción ?

7. Evaluation Schedule

DOMINGO 19

Llegada de Evaluador Externo y Equipo de Sede Internacional

LUNES 20

Reunión de Coordinación:

Logística

Discusión de Objetivos y Expectativas

Identificación de Fuentes de Información

Preparación de Guías de Entrevistas y Grupos Focuses

AREA 2

MARTES 21

San Ignacio

Guardianes: Entrevistas (Silvia)

Auxiliares de Enfermería : Entrevistas (Hector)

Lideres Comunitarios: Entrevistas (Hector)

Practica de Entrevistas: Todo el equipo

Preparar cuestionario para Grupos Focuses sobre conocimientos & practicas de Madres

Preparar cuestionario para Grupos Focuses sobre conocimientos de Guardianes

Terminar Todos los cuestionarios

Discusión del grupo sobre cuestionarios

Discusión de grupo sobre proceso del día

MIERCOLES 22

Orica y San Marquitos

Guardianes: Entrevistas (Silvia)

Madres: Grupos Focuses (conocimientos & practicas) (Orestes)

Madres : Entrevistas (Orestes)

Auxiliares de Enfermería : Entrevistas (Hector)

Lideres Comunitarios: Entrevistas (Hector)

Discusión de grupo sobre proceso del día

JUEVES 23

Promotores: Entrevistas/Grupos focales CAMPAMENTO
Guardianes: Grupos Focales (conocimientos & practicas) (Silvia)
Madres : Entrevistas (Orestes)
Jefes de Area: Entrevista (Orestes) TALANGA
Enfermera de Area/Sector (Silvia/Muriel) TALANGA
Discusión Sobre hallazgos y conclusiones preliminares de Area 2 con Personal de Campo
Discusión de grupo sobre proceso del día
SALIDA A AREA 1: CATACAMAS

AREA 1

VIERNES 24

Discusion hallazgos y conclusiones Area 2

Santa Maria Real

Madres: Grupos Focales (conocimientos & practicas) (Orestes)
Guardianes: Entrevistas
Madres : Entrevistas (Orestes)
Auxiliares de Enfermeria : Entrevistas (Hector)
Lideres Comunitarios: Entrevistas (Hector)
Discusion de grupo sobre proceso del dia

SABADO 25

Siguete

Guardianes: Entrevistas y Grupo Focus (conocimientos)
Madres : Entrevistas y Grupo Focus (conocimientos) (Orestes)
Lideres Comunitarios: Entrevistas (Hector)

Coordinadores de Area: Entrevistas (Aida)
Discusion de grupo sobre proceso del dia

DOMINGO 26

CATACAMAS

Promotores: Entrevistas/Grupos focales
Madres : Entrevistas (Orestes)
Director de SIG: Entrevista (Victor)

Discusion de grupo sobre proceso del dia
Trabajo individual

LUNES 27

CATACAMAS

Jefes de Area: Entrevista (Orestes)
Enfermera de Area/Sector (Silvia/Muriel)
Guardianes: Grupos Focuses (conocimientos & practicas) (Silvia)

Rio Tinto/Corralitos

Madres: Entrevistas (Orestes)
Auxiliares de Enfermeria : Entrevistas (Hector)
Administrador: Entrevista (Vicky)
Discusion Sobre hallazgos y conclusiones preliminares de Area 1 con Personal de Campo
Discusion de grupo sobre proceso del dia

MARTES 28

Discusion de Hallazgos y Conclusiones: Equipo Evaluador

MIERCOLES 29

Discusion de Recomendaciones: Equipo Evaluador
Discusion de recomendaciones con Personal de Campo

JUEVES 30

Reunion con MSP/Juticalpa: Conclusiones y Recomendaciones: Compromisos en el corto y mediano plazo

VIERNES 31

Reunion con USAID/Tegucigalpa: Conclusiones y Recomendaciones: Compromisos en el corto y mediano plazo

8. Evaluation Objectives and Evaluation Team Expectatives

OBJETIVOS DE LA EVALUACION

1. Evaluar los logros del proyecto al momento actual en función de los propuesto (DIP). Obtener conclusiones y recomendaciones.
2. Estimar el potencial del proyecto para lograr los objetivos propuestos.
3. Valorar si el proceso de implementación es adecuado (capacidad de gestión y administración)
4. Identificar lecciones aprendidas y estimar su relevancia.
5. Evaluar el nivel de integración MSP/FEIG.

EXPECTATIVAS DEL EQUIPO DE EVALUACION

1. Obtener visión **REALISTA** del proyecto.
2. Identificar alternativas para mejorar **AREAS DEBILES DEL PROYECTO**.
3. Valorar la **ADECUACION DEL SISTEMA DE INFORMACION**.
4. Identificar **RECOMENDACIONES SOBRE IRA Y ESPACIAMIENTO DEL EMBARAZOS**.
5. Identificar el efecto de la **INTERACCION ENTRE SUPERVIVENCIA INFANTIL Y BANCOS COMUNALES**.
6. Continuar durante todo el proceso e implementación del proyecto (MSP).
7. Conocer el método de evaluacion.
8. Identificar alternativas para **FORTALECER EL SOSTENIMIENTO Y LOS INDICADORES DE SOSTENIMIENTO** del proyecto.
9. Conocer el desarrollo de la **PARTICIPACIÓN COMUNITARIA** y dar recomendaciones.

10. Conocer de que manera lograra la participación activa de los promotores de WRH.
11. Proveer conceptos capaces de ser transferidos a otros programas de World Relief Corporation en otras partes del mundo.

9. Pipeline Analysis

WRC/WRH GUAYAPE CS COUNTRY PROJECT PIPELINE

FIELD	ACTUAL EXPENDITURES TO DATE WRH COUNTRY EXPENSE SEP/1/89--JUN/30/92			REMAINING OBLIGATED FUNDS			TOTAL CTRY AGREEMENT BUDGET SEP/1/89--AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
PROCUREMENT									
Equipment:	(201.55)	77,164.75	76,963.20	201.55	(15,614.75)	(15,413.20)	0.00	61,550.00	61,550.00
Supplies:	9,805.47	429.62	10,235.09	19,694.53	9,570.38	29,264.91	29,500.00	10,000.00	39,500.00
Services:	65.43	0.00	65.43	3,934.57	0.00	3,934.57	4,000.00	0.00	4,000.00
Consultants									
1) Local:	8,359.10	0.00	8,359.10	(4,809.10)	0.00	(4,809.10)	3,550.00	0.00	3,550.00
2) Expatriate:	1,849.38	0.00	1,849.38	5,450.62	0.00	5,450.62	7,300.00	0.00	7,300.00
TOTAL PROCUREMENT	19,877.83	77,594.37	97,472.20	24,472.17	(6,044.37)	18,427.80	44,350.00	71,550.00	115,900.00
EVALUATION	0.00	0.00	0.00	6,250.00	750.00	7,000.00	6,250.00	750.00	7,000.00
INDIRECT COSTS	62,243.14	0.00	62,243.14	97,831.86	0.00	97,831.86	160,075.00	0.00	160,075.00
OTHER PROGRAM COSTS									
Personnel									
1) Health	129,864.53	364.70	130,229.23	207,215.47	84,665.30	291,880.77	337,080.00	85,030.00	422,110.00
2) Administrative	60,063.46	8,568.65	68,632.11	121,406.54	38,146.35	159,552.89	181,470.00	46,715.00	228,185.00
3) Other	12,786.70	19,381.29	32,167.99	22,678.30	27,753.71	50,432.01	35,465.00	47,135.00	82,600.00
Travel/Per Diem									
1) In Country	7,621.66	213.51	7,835.17	10,198.34	8,786.49	18,984.83	17,820.00	9,000.00	26,820.00
2) International	(13.16)	0.00	(13.16)	13.16	0.00	13.16	0.00	0.00	0.00
Other Direct Costs	79,313.06	13,575.14	92,888.20	3,596.94	21,374.86	24,971.80	82,910.00	34,950.00	117,860.00
TOTAL OTHER PRG COSTS	289,636.25	42,103.29	331,739.54	365,108.75	180,726.71	545,835.46	654,745.00	222,830.00	877,575.00
TOTAL EXPENSES TO DATE	371,757.22	119,697.66	491,454.88	493,662.78	175,432.34	669,095.12	865,420.00	295,130.00	1,160,550.00

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