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CHILD SPACING/HIGH RISK PREGNANCY AND CHILD NUTRITION CHILD SURVIVAL PROJECT MANABI AND AZUAY PROVINCES ECUADOR

Final Evaluation Report

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ACRONYMS

APROFE	Asociacion Pro-Familia Ecuador
CHV	Community Health Volunteer
CREA	Centro de Reconversion Economica de Azuay
CRM	Rehabilitation Center of Manabi
IESS	Instituto Ecuatoriano de Seguridad Social
IEOS	Instituto Ecuatoriano de Obras Sanitarias
MAG	Ministry of Agriculture
MOH	Ministry of Health
MSH	Management Sciences for Health
MSP	Ministry of Public Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
TT	Tetanus Toxoid

INTRODUCTION

This document contains the final external evaluation and the project report of Project HOPE's child survival (CS) activities in the provinces of Azuay and Manabi, Ecuador. One section includes an analysis of the factors that favor project sustainability, starting from the development of the Detailed Implementation Plan (DIP), the objectives, interventions, strategies, and achievements. Project strengths and weaknesses will be discussed for each intervention.

The Final External Evaluation is structured as follows:

I. FINAL EXTERNAL EVALUATION

ACKNOWLEDGEMENT
INTRODUCTION
A. OVERVIEW
B. SUSTAINABILITY OF PROJECT ACTIVITIES
C. RECOMMENDATIONS TO IMPROVE SUSTAINABILITY
D. SUMMARY

The Final Report is structured as follows:

II. FINAL REPORT

A. EXECUTIVE SUMMARY
B. PROJECT IMPLEMENTATION
   1. Background
   2. Project Duration
   3. Project Location
   4. Target Population
   5. Analysis of the Interventions
C. SUSTAINABILITY

APPENDICES
   A. Map
   B. Tables
   C. Organizational Chart
   D. Communities Visited by the Evaluation Team
   E. Evaluation Schedule
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I. FINAL EXTERNAL EVALUATION

ACKNOWLEDGEMENT

The external evaluator would like to thank the officials of the Ministry of Public Health and of Project HOPE for their cooperation and support in conducting this evaluation. In particular, I express my gratitude to the Health Volunteers, Traditional Birth Attendants (TBAs), and other community representatives and informants who were interviewed in Azuay and Manabi for their valuable contribution and good will.

INTRODUCTION

At the request of Project HOPE, I assumed the role of external evaluator in conjunction with an evaluation team consisting of: Dr. Francisco Moreno, Program Director, Project HOPE/Ecuador; Angela LuTena, HOPE Center representative and responsible for the preparation of the Final Project Report; Lucia Ortiz and Teresa Narvaez, Provincial Coordinators; and the Ministry of Health (MOH) counterparts Carmen Alvarado, Chief Nurse of the MOH, Azuay; Dr. Guido Romero, Chief of Development and Prevention; and Teresa Rivadeneira, Chief Nurse of the MOH, in Manabi.

In Manabi, Dr. Jorge Toledo, Chief of the Department of Development and Prevention of the Subsecretariat of Health Region II, with headquarters in Guayaquil, joined the evaluation team. The workplan was as follows:

a) The evaluation was based on a review of the project documents, field observations, and interviews with officials, implementors, and beneficiaries of the services provided by Project HOPE in various communities of Azuay and Manabi.

b) The following ideas reflect the opinion of the external evaluator, rather than the opinions formed by the evaluation team during the field visits.

c) The external evaluator had 11 days for this evaluation (including two days for the review of documents, four days for field visits, two days for meetings with various members of the project and counterparts, and one day for the preparation of this summary report).

d) Project HOPE's program has many of the characteristics found in non-governmental organizations -- administrative autonomy (financial, direct contact with the beneficiaries, general management), flexibility to make modifications, well-defined responsibilities, and a clear mission for work at the community level.

The external evaluator's summary, including opinions and recommendations from the CS project evaluations, is presented

below:

Particular attention is paid to the plan for sustainability based on the A.I.D. Final Evaluation Guidelines provided by Angela LuTena.

The report is divided into the following sections:

A. OVERVIEW
B. SUSTAINABILITY OF PROJECT ACTIVITIES
   1. Issues Concerning Sustainability
   2. Analysis of the Sustainability Plan of the Project
      a. Technical Aspects
      b. Administrative Aspects
      c. Financial Aspects
      d. Community Participation
      e. Role of the Ministry of Health
C. RECOMMENDATIONS TO IMPROVE SUSTAINABILITY
   1. General Aspects of the Project
   2. Coordination
   3. Educational Strategy
   4. Project Staff
D. SUMMARY
   1. Strengths
   2. Weaknesses
   3. Opportunities
   4. Potential Constraints

NOTE

Although my time with this evaluation has been limited, I hope that my written suggestions and those that were provided orally are objective and useful for the implementation and sustainability of such an important project.

A. OVERVIEW

My overall impression is that in the thirty months since the project's beginning, the following results have been achieved:

- Information, education, and social communication activities about major maternal and child health areas: immunizations, control of diarrheal diseases, nutrition, child spacing, and prevention of high-risk pregnancies;
- Active participation of community representatives (TBAs, CHVs, local leaders, etc.);
- Acceptance and involvement of the beneficiaries and communities in project activities and in the institutional framework;
- A generally positive perception of the project by counterparts at the central, provincial, and health area levels, and at the local operational level;
- Support, information, and follow-up systems operating at an efficient level for management and organizational

development; and
- Highly motivated technical and administrative project staff.

Areas for continued improvement include the following:

- Sustainability plan of project activities at the organizational and community level;
- Coordination with official MOH counterparts, and intra-sectoral and inter-institutional relations to optimize impact and resources and provide support to sustainability; and
- Diagnostic programs and modules to determine coverage and provide monitoring of a micro-area (parish and community).

B. SUSTAINABILITY OF PROJECT ACTIVITIES

1. Issues Concerning Sustainability

Although it is not very explicit from the document review, project sustainability is an essential element of project success, not only for the practical reasons of technical, administrative, and financial transfer of a model to the formal counterpart in health, the MOH, but also to ensure the continuation of the activities expected by the beneficiaries at the community level.

Sustainability affects all aspects of the project: conceptual development, methodology, and implementation of the project. Sustainability is strategic in a way of demonstrating a new way for NGOs working in the country; for institutionalizing lessons-learned; justifying expenditures; and facilitating the replication and expansion of successful models in the future under the special conditions under which the project operates.

However, this is a difficult strategy to undertake. The experience of other projects has oftentimes not been replicated, due to the existing deficiencies of the health situation and the weak methods that are used to achieve an acceptable level of sustainability. Even though sustainability is a long-range objective, steps to achieve it have to be developed from the onset, and one has to persist despite initial frustrating experiences.

It is also important to consider that sustainability requires negotiation and coordination, because one cannot pretend to sustain the unsustainable or make an entire "program" acceptable even if it is good for "us". Also, from our point of view, the "other one" or "others" have problems and solutions that are equally worthy of consideration as one's own.

Taking a formal perspective, sustainability has focused primarily on the official counterpart (the MOH), because of the fundamental role that the state plays in the provision of services to the public. However, it is necessary to explore other possibilities,

such as other formal or internal community agencies with whom one can also develop viable and successful forms of sustainability.

Sustainability definitely should not be conceived as a linear process, nor focus exclusively on one level. On the contrary, sustainability entails a wide spectrum of methods of coordination at different levels, including transfer of ideas, methodologies, and activities. It basically should result in a more favorable perception on the part of the beneficiaries, possibly increasing the certainty and effectiveness of support.

2. Analysis of the Sustainability Plan of the Project

a. Technical Aspects. Even though the maternal and child survival strategies are generally simple, they require proper training, to assure that they are applied rigorously and effectively. The majority of these strategies are based on information and education, rather than medical interventions (except for vaccinations, diarrheal diseases, and growth monitoring). Therefore, results do not only depend on the implementor, but primarily on those who receive the training: mothers, TBAs, CHVs, community leaders, and the general population.

Conceptually and methodologically, the technical activities of the project have to be implemented at a satisfactory degree. The evaluator noted more difficulty in the content area and in the educational messages in the area of feeding and nutrition, probably because this is a subject area of great complexity and detail (e.g., nutritional needs by age group.)

The same observation holds true for the educational activities in the area of high-risk pregnancies and deliveries. In particular, the CHVs trained by the MOH apparently perform what they have learned only incompletely (mainly due to the limited opportunities for supervision and follow-up), e.g., giving vaccination to pregnant women, TT, checking of the placenta, and immediate breastfeeding of the newborn at birth.

However, the use of recognized technologies appropriate for the setting and the strict adherence to the norms of the MOH in MCH, assures, to a large extent, the technical sustainability of the project. As a result, at project end, the activities can be implemented by any member of the MOH health team at a local level.

Two of the technical areas that have not yet been completely developed (perhaps because they are not specific objectives of the project) are community diagnosis and local programming. (I believe that this lack of development has made it difficult to allocate and organize resources based on the criteria of equity and efficiency, to determine local coverage levels, and monitor progress and impact with groups of beneficiaries.)

Unfortunately, even though the MOH has developed all of the appropriate norms for each intervention, they are not applied by the local MOH staff -- at least not in the provinces that were visited. This could be an extremely important activity to be developed jointly by the MOH and Project HOPE as a way of supporting efforts directed at improving future opportunities for coordination and sustainability.

b. Administrative Aspects

The administrative aspects of the project have been implemented well overall, in particular, the health information system, supervision and logistical supplies, as well as the management of the project (decision-making, supervision, and programming of activities).

Without a doubt, the modus operandi of a non-governmental organization (because of its characteristics and size) includes different administrative practices than governmental agencies that are often very bureaucratic and lack efficiency and monitoring of performance. The different management styles can make it difficult to develop the necessary relationship to implement the procedures required for sustainability quickly and in a timely manner.

With respect to coordination (defined as the mechanisms which make those policies, activities, and resources directed at a common purpose compatible and more potent) of the project activities with different divisions of the MOH, as well as with other intra- and extrasectoral agencies and local organizations, one can understand that its further strengthening is necessary for the sustainability of the project.

The continuous efforts of the MOH and Project HOPE to find new ways of cooperation and coordination must be recognized (e.g., the campaign to fight cholera and EPI activities). However, tools and mechanisms to operationalize and institutionalize these efforts through agreements and specific contracts or through the implementation of joint systems (e.g., the information or programming system) have not yet been developed.

It has to be pointed out that the described limitations are more evident at the health area level where the project (which is highly decentralized to the cantons and communities) has not been able to develop well-defined counterparts in the MOH to establish a better history of coordination. This is related to the fact that the "health areas" have not yet implemented a decentralized management system of the necessary human and material resources, in part due to the inability of the MOH to begin decentralizing its activities.

In summary, the primary concern is that Project HOPE implements some activities in coordination with the MOH and other organizations (IESS, CARE, CREA, APROFE), for which there are no

systematic procedures that promote joint implementation of activities. This is particularly true for the MOH, the official counterpart of the project and results in a lack of practical common experiences in the area of sustainability to facilitate the institutionalization of project activities through a modality of joint implementation.

C. Financial Aspects

The financial sustainability of the project is one of the most critical points. Officials of the MOH always state that the lack of financial resources is the major obstacle that prevents them from accomplishing and taking on new tasks. (Due to the present financial crisis of the Government of Ecuador, social expenditures have drastically declined, particularly in the health sector).

Given this financial situation and because of the MOH norm of providing basic health services free of charge (since 1981), the project has not developed alternatives in financing with the MOH. This contributes to the difficulty of making basic activities sustainable, such as supervision and follow-up of staff trained by the MOH, and, even less supervision and follow-up of those trained by the project.

On the other hand, and because of the serious economic crisis faced by the country, the idea of a financial contribution by beneficiaries of the project services does not seem feasible: the target population of the project has a very low income. In addition, preventive health care practices are easily abandoned at the first financial obstacle. (Furthermore, we should ask ourselves: should we charge someone attending a health education talk in the schools? Can vaccinations or ORS be sold? Can we charge for participating in a training course for CHVs or for receiving training in home gardening?)

Without a doubt, it is more logical to explore other alternatives for financing promotional and educational health activities that certainly are not very costly, e.g., with contributions from other local development agencies, the development of community insurance schemes, a change in the MOH budget to promote better implementation of primary health care, and support from the private sector.

d. Community Participation

The community has not participated in the design or the implementation of the project. Sporadic activities by the members of the community do not imply community participation. Furthermore, educational and cultural factors limit active and responsible participation.

Despite these limitations, the training of CHVs and TBAs as implementors of project activities has increased coverage levels

in very remote communities. It has spread education messages at the community level that increase the potential for sustainability of some of the child survival activities (immunizations, breastfeeding, family planning, personal hygiene are the most viable), while at the same time increasing the communities' acceptance of MOH services.

At a community level, more work is required to collaborate with community leaders who can, to a large extent, accelerate the process of conscientization in the area of health through their influence and acceptance by their communities.

Organizations, such as the "Mothers' Clubs", "Women's Clubs" and the "Health Committees", have not yet demonstrated their full potential to assist in the implementation of project activities. Their capabilities to sustain project activities on their own should be assessed.

In summary, the communities are definitely interested in the continuity of the project activities and are willing to participate more as long as they are not manipulated and feel that their needs are met consistently.

e. Role of Ministry of Health

The Ministry of Health, as the principal agency responsible for policies and norms in health care, has the important role of formal counterpart of the project and is one of the cornerstones for sustainability.

After a superficial analysis, it can be concluded that the relationship between the project and the MOH has been variable (according to the technical staff). It has improved with increasing coordination between the two institutions, and as jealousies have decreased due to the diplomatic efforts of Project HOPE staff, emphasizing that the project is here to assist the MOH in its work rather than demonstrating "competence" vs. incompetence.

At the central level, the knowledge and interest in the project is more general than at the provincial or area level. Basically, the central MOH refers to the cooperative agreement between the two institutions. There is an understanding about the difficulties in achieving project sustainability, primarily due to budget limitations, and suggestions are made to develop alternative ways for financing and joint management.

At a provincial level, more interest in the presence of the project is evident, and it is a good strategy that project offices in Azuay and Manabi are located in the MOH buildings. At this level there is a need for more coordination with the project, and a willingness to take on new commitments and sign agreements that further define the administrative and operational responsibilities to improve the coordination of activities in the

province.

At the health area level, the knowledge and interest in the project depends upon the existing relationship with the health area chiefs. In the areas where the project has a good reputation, cooperation is well accepted. This positive disposition facilitates the project activities because the benefits of the health activities within the context of the service delivery of the health area are more tangible. (Unfortunately, the health areas do not yet function in a decentralized fashion with substantial autonomous management. Therefore, many decisions about operations and financial management depend strongly on the provincial level).

The relationship of the project at the "micro" level -- the operational units at the primary health care level -- is variable. This is due to the fact that the rural physicians and nurses who are completing their rural service change annually. (This is one of the most worrisome operational difficulties affecting the planning for sustainability). Local staff were not present during the field observations (in Azuay), and several are relatively indifferent about the project activities.

The TBAs and CHVs play a very important role in the project activities at this level. The TBAs and CHVs trained by the project are greatly appreciated by the community and have a cooperative attitude. However, they are not considered members of the local health team. In fact, MOH staff consider CHVs as competing with them, an attitude that would, without a doubt, improve if staff had a better overall understanding of the community health system.

C. RECOMMENDATIONS TO IMPROVE SUSTAINABILITY

1. General Aspects of the Project

Because of the project achievements, the evaluator recommends that the project maintains its basic characteristics of community focus, education, and prevention, targeting the most deprived social groups, as a model of assistance to the MOH.

- With respect to the development and expansion of the project the following should be considered:

  If the project is expanded to additional areas, the number of staff should be increased to avoid a negative impact on program quality, and to derive the expected benefits from the investment made into the project. Presently, the number of staff are insufficient to expand the project and to improve the supervision of the CHVs whose contribution could be more productive with ongoing supervision and training. This would also reduce premature losses of volunteers at the same time.

If the project still would like to expand into other areas, I would suggest that the project select and prioritize activity to achieve a better balance between the number of communities served and the technical resources without endangering the commitment to complete coverage (for example, focusing on areas with a higher prevalence of malnutrition, diarrheas, and ARIs in children, or areas with a larger number of women not participating in prenatal care).

- Information should be classified by level of urgency for local programming jointly with the MOH to assess coverage levels by intervention. This will make it possible to target activities by areas and groups of highest bio-social risk and would help to continue to develop a family registration system with the purpose of looking at the family as the basic unit for analysis and intervention.

- The monitoring system should be consolidated on the basis of progress indicators (outputs = efforts and resources to achieve objectives and benchmarks), in conjunction with indicators that "measure" the impact of the interventions (impact = evaluation of whether the outputs are actually utilized).

- Promote initiatives to link health with income-generating projects, especially in the area of nutrition. This should be achieved through coordination with other NGOs, training, micro-enterprise, and credit oriented towards increasing income-generating opportunities, organization and participation of women in the work-force as part of a maternal survival strategy.

- The important activity of promoting family and community gardens should not be neglected, not only for home consumption but also for sale (this topic is not mentioned much in the role-plays, songs, and poems that were heard and seen during the field observations in Manabi). Groups of consumers and distributors of basic foods or community stores could be organized where possible, desirable, and justifiable.

2. Coordination

- The relationship with the MOH at all levels should be strengthened, in particular with respect to strengthening and developing local "health areas". Also, the project should continue and expand the positive coordination with the MOH and the Civil Registry (Manabi) and establish "internship" opportunities for MOH staff in the project. Ideally, the project would also coordinate all field visits with the MOH to increase opportunities for exchange of ideas and joint supervision.

- The project should take advantage of work sessions with MOH staff, community leaders, and other organizations that are potential collaborators to address the criteria for sustainability of the project's activities, prior to developing transition methodologies, from Project HOPE as "implementor" to "facilitator," as the first stage of phaseover.

- Increase activities and mechanisms for developing intra-sectoral coordination (especially with IESS -- social security for farmers) and inter-institutional and regional development agencies (CREA - Azuay, CRM - Manabi, and agencies that provide community services (MAG, IEOS), and NGOs such as CARE, Nature Foundation, religious missions, etc.

- The coordination of family planning activities with APROFE is positive because APROFE supports the same objective of preventing unwanted pregnancies, and promoting the appropriate use of family planning. (Confusion in the role and image of CHVs trained by the project in CS has to be avoided when they collaborate in the sale of contraceptives for a small profit).

- Project HOPE should pay special attention to coordinate its activities with the national child survival project, that is implemented by MSH and determine points of mutual interest for coordination with the MOH at the central, provincial, and health area levels. One major point of common interest could be the implementation and strengthening of local programming.

- At the local level, one could incorporate new social actors, such as youth clubs, sports clubs, and neighborhood associations and community development committees, in addition to mothers' clubs and health committees at the local level, to improve the legitimacy and representation of these organizations in health promotion and education.

- It is also suggested that the project develop a relationship with other local developmental agents, such as teachers and secondary community leaders (e.g., peasant leaders) to stimulate their interest in health as part of their overall agenda and to help them in the development of their organizational structures and in the development of commissions for health for a more permanent involvement.

3. Educational Strategies

- The project should continue to review and refine its messages, methodologies, and materials for health training and education, developing a different focus for young children, youth, and adults, using proven popular education methodologies.

- Social communication strategies in health for volunteers and other local leaders should be improved. The project could also assist in equipping units that produce materials, including in the area of production of audiovisuals. The evaluator also suggests exploring the production and emission of radio programs to strengthen health education efforts.

- The project should continue to review training contents (including workshops with experts) periodically and to expand follow-up of training activities and their application by the CHVs and TBAs, with the purpose of maintaining quality and effectiveness of the messages.

- The project should forge a strong working relationship with the health educators of the provincial MOH and prepare a joint plan for health education in the province (involving the Ministry of Education, OTIDES, municipalities, NGOs, etc.) with the support of the private sector, particularly focusing on the most permanent organizations in each province.

- The efforts to develop and strengthen mechanisms which make health education a continuous and systematic process, and avoid the programming of single "disconnected" events which have proven to be ineffective in transmitting education messages should be emphasized.

- The project should expand on multiplier effect of long-term education in this population, working with nursery and school-age children. These children can be effective "health promoters" in their families. In addition, their own potential for change is more immediate and sustained.

4. Project Staff

- Conduct workshops for the coordinators/supervisors and for the field staff about community development, social participation, the socio-economic context, health and disease theories, prevention, integrated development, and family and poverty in the rural areas, etc., to strengthen knowledge and reduce the likelihood of misinformed theoretical notions.

- Improve the infrastructure of the office in Manabi so that the technical and administrative staff have more adequate work space.

- Instruct the field staff to mention the name of "Project HOPE" less frequently in their presentations and services. This could be counterproductive for achieving sustainability in the medium run, and reduce jealousy by the MOH.

- Develop incentives for the CHVs and the TBAs based on performance (for example, every three months identify the community where the pre-natal care, growth monitoring (weight gain), or community gardens have increased the most), in addition to other more academic incentives (e.g., help volunteers who want to become auxiliary nurses).

D. SUMMARY

In this summary, the evaluator will attempt to provide a brief qualitative impression about some of the major components of the project.

1. Strengths

- Targeted community action, with active participation of community representatives and other local leaders and the development of self-sustaining social mobilization processes focusing on community health problems and strategies for child and maternal survival.

- Educational focus with a high potential for promotion and prevention of the primary MCH problems.

- A multidisciplinary technical team with high motivation and capability for work at the community level, composed primarily of nurses, social workers, and nutritionists.

- An innovative work model between an international NGO and the government, which is based on a cooperative working relationship directly within the provincial MOH.

2. Weakness

- Weak coordination with the institutional structure of the counterpart (MOH), particularly in joint activities at the operational level, the primary level of care of the MOH.

- Lack of integrated local programming of health activities, in accordance with existing coverage models.

- No provision of direct medical care by Project HOPE, and, therefore a need for the support of other institutions to develop an integrated health service model.

- Difficulty in applying a sustainability plan in the short term.

3. Opportunities

- Expansion and replication to other areas with concrete support of the MOH and community organizations.

- Coordination of some of the activities with the MSH Child

Survival Project to avoid a duplication of efforts and resources and in some cases with a joint purpose of coordination with the MOH.

- Coordination with local development organizations (municipalities, regional development agencies, and other public sector agencies -- Ministry of Agriculture, Ministry of Education and Culture-IEAS, and NGOs, etc.) to empower multi-sectoral development activities.

- Assistance in the development of a multi-institutional provincial plan of information, education, and social communication relating to health problems.

4. Potential Constraints

- Substantial changes in the health policies of the MOH in terms of program priorities, operating procedures of the service delivery units, or in the relationship with assistance organizations, including PVOs.

- Competition with the MSH child survival project, particularly in the area of coordination at a central, provincial, or health area levels.

- Rejection of Project HOPE by the community or rejection of some of its activities.

II. FINAL REPORT

A. EXECUTIVE SUMMARY

1. Evaluation Team

Azuay. The evaluation team consisted of Dr. Ramiro Echeverria, External Evaluator; Dr. Francisco Moreno, Program Director, Project HOPE; Lcda. Carmen Alvarado, Ministry of Health (MOH) Chief, Azuay; Lcda. Lucia Ortiz, Provincial Coordinator, Azuay, Project HOPE; and Lcda. Angela LuTena, headquarters representative, Project HOPE.

Manabi. The evaluation team consisted of Dr. Jorge Toledo, Region II Chief of Promotion and Protection, MOH, Guayaquil; Dr. Guido Romero, Chief of Promotion and Protection, MOH, Manabi; Lcda. Teresa Rivadeneira, Head Nurse, Promotion and Protection, MOH, Manabi; Teresa Narvaez, Provincial Coordinator, Project HOPE, Manabi; Dr. Francisco Moreno; and Lcda. Angela LuTena.

2. Schedule of Activities

Three Days, review of documents (DIP, Quarterly Reports 1991, and first Annual Reports); review of the HIS and Baseline Surveys; Midterm Evaluation; project response to the Midterm Evaluation; and results of the final surveys. **Five Days**, field visits. **Two Days**, meetings with officials of the MOH and project staff. **Three days**, preparation of a draft report. **Two days**, meetings with counterparts to discuss preliminary findings and recommendations. Total number of days: **15 days.**

3. Evaluation Design

The evaluation methodology was based on a review of documents, field observations, and interviews with officials, implementors, and beneficiaries of the services provided by Project HOPE in the communities visited in the Provinces of Azuay and Manabi. In order to assess the project outputs, data for the calendar year 1991 were used as the point of reference.

4. Results

- Project HOPE's CS project has the characteristics usually attributed to a project developed by a non-governmental organization (NGO), i.e., administrative and financial autonomy, direct contact with the beneficiaries, management, flexibility, well-defined responsibilities, and a clear mission for work at the community level.

- The impressions of the MOH counterparts at the central, provincial health area, and local operational level, is predominantly positive.

- Training of institutional and community staff is a part of

each intervention.

- Project HOPE has a great ability to channel community involvement and promote active participation of community representatives, leaders, traditional birth attendants (TBAs), and community health volunteers (CHVs).

- The project has successfully promoted the involvement of women in health and development activities through Mothers' Clubs.

- The project has provided information, education, and social promotion in the major CS activities: immunization, control of diarrheal diseases (CDD); nutrition, growth monitoring, breastfeeding, and weaning; child spacing; and prevention of high risk pregnancies.

5. Recommendations

- To provide strong support to the MOH, the project should try to maintain its primary focus on the community and on education, and prevention, targeting rural areas with limited access to services.

- In the design of the CS-VIII DIP, the project should be more realistic in considering the size of the target population, the number of communities to cover, and individuals to be trained in relation to the human resources of the project.

- The project should increase the coordination and integration of the MOH staff in its field activities through a better definition of responsibilities and implementation of local programming with MOH staff. This will make it possible to refine the targeting of the highest risk groups.

- The project should improve the social marketing strategies of health messages transmitted by volunteers and community leaders and explore the production of CS radio messages to strengthen community education.

- The health information system (HIS) should be improved to permit a better monitoring and assessment of the impact of project interventions.

B. PROJECT IMPLEMENTATION

1. Background

Project HOPE initiated its activities at the request of the MOH on January 5, 1990 after having signed an "Agreement of Technical Cooperation Between the Government of Ecuador and The-People-to-People Health Foundation, Inc." The objective of this agreement is to "combine the efforts of the MOH and The Foundation to promote and improve health education programs and health services

provided to the People of Ecuador, and directed with priority at improving the health of mothers and children".

In January 1990, Project HOPE began to implement its CS-V activities in the provinces of Azuay and Manabi with the overall goal of reducing the morbidity and mortality of mothers and children under three years through health education at the community level and at the local operational level of the MOH. To achieve a stronger impact and foster the sustainability of the project, activities are directed at progressively involving those responsible for health services in the rural areas in activities at the community level and in promoting the participation of the population in health prevention.

The project is implemented with funds from the Agency for International Development (AID/FHA/PVC) and Project HOPE. The contributions by the government of Ecuador are: US $200.00 in Sucres annually, office space in the MOH of Azuay and Manabi, and the assignment of central, provincial, and local staff from the MOH to act as counterparts to project staff.

2. Project Duration

Project HOPE started its CS activities first in Azuay, in January 1990, and phased in activities in October 1990 in Manabi, for a total project duration of 29 months in Azuay and 24 months in Manabi.

3. Project Location

The Ministry of Health requested that Project HOPE work in one of the mountainous and one of the coastal provinces. As a result, project activities were implemented in the rural communities of the cantons Paute, Gualaceo, Sigsig, Girón, and Santa Isabel in the Province of Azuay, and the cantons of Bolívar, Junin, Monte Cristi, and Pichincha in the Province of Manabi. The project area in Azuay encompasses an area of 3,176 km2 (39% of the total province) with a population of about 125,000 living in about 404 communities; in Manabi, the project area of 2,692 km2 encompasses a population of about 122,000 in 380 communities. (See Map, Appendix A).

4. Target Population

See Table 1, Appendix B.

5. Analysis of the Interventions

a. Summary

Strengths

The following training activities were completed:

- 90 MOH auxiliary nurses and 233 CHVs received training in maternal care, child spacing, growth monitoring, nutrition and breastfeeding, diarrheal disease control, hygiene, immunization, and home gardening.

- 182 TBAs were trained and received follow-up in child-spacing, clean delivery practices, care of pregnant women and the newborn, and immediate referral of the newborn (149 had never received training, and 30 had been trained more than 12 years ago by MOH staff).

- Training modules and manuals for auxiliary nurses and CHVs were developed and serve as guidelines for training and program implementation.

Weaknesses

- The project works at the cantonal rather than the health area level. This does not help in the institutionalization of the project in the health areas, nor supports their development under the concept of "Integrated Local Planning."

- MOH staff are still not sufficiently involved in the implementation of activities at the community level.

- Volunteer loss is significant, primarily for economic reasons (migration).

Objective 1: Improvement in the vital statistics system.

This objective was partially achieved. In Manabi this activity had more support from the MOH and other involved agencies, such as the Civil Registry and the Institute of Statistics and Census (INEC) and has resulted in the development of the Inter-Institutional Committee of Vital Statistics."

Strengths

- The formation of an inter-institutional committee, consisting of Project HOPE, the MOH with its Departments of Promotion and Prevention and Statistics, the Civil Registry Office, and INEC, made it possible to achieve this objective, particularly in Manabi.

- Joint planning of the training and supervision activities of the individuals responsible for recording vital events--the auxiliary nurses, statistical staff of the operational unit of the MOH, and officials of the Civil Registry System -- made the planning process effective.

- Coordination between staff of the MOH and the Civil Registrars at the local operational level has improved.

- Sharing the financing of training and providing follow-up to the MOH staff with the provincial MOH contributes to the sustainability of these activities.

- The promotion of a timely registration of births and deaths, and the distribution of information pamphlets about the fact that registration is free of charge has resulted in an increase in the registration of vital events at the local and provincial level.

- Staff involved in recording vital events in Manabi have benefited from three training courses of 24 hours consisting of three different modules. A total of 164 individuals were trained (70 auxiliary nurses, 24 MOH statisticians, and 70 civil registrars). According to the DIP, it was planned to train only 27 registrars in Year 3. However, a total of 70 registrars were trained because the involved agencies requested that training be provided for the whole province of Manabi to assure consistency of data collection throughout the province.

- 182 TBAs were trained to immediately refer families with a newborn to the civil registry for recording (149 new TBAs were trained and supervised by the project, as well as 33 old TBAs).

Weaknesses

- The monitoring and supervision at the field level is inconsistent because the involved institutions have difficulty coordinating time that should be allocated to those activities.

- In Azuay, progress to achieve this objective has been slower due to a number of factors, including strikes of the various institutions at different points in time which resulted in cancelation of programmed training activities, and weakened the interest of the involved agencies.

- Only 40% of the auxiliary nurses specified in the DIP were trained due to an overestimation of this output.

<u>Objective 2</u>: **Implement a statistically significant baseline survey in the target areas.**

Strengths

- The implementation of two qualitative studies about health, nutrition, and weaning, utilizing a focus group methodology (Azuay, August 1990; Manabi June 1991) provided information about the knowledge, attitudes, and practices of mothers. The results were helpful in the preparation of the training curricula.

- In the final survey of the project, a methodology developed by the Johns Hopkins University Child Survival Support Program was used, as recommended by A.I.D. This will make it possible to compare and contrast the results for the different CS interventions at onset and end of the CS-VIII extension project (see Final Survey Report).

- The short duration required to complete the final survey made it possible to provide instant feedback to the counterparts and the communities.

- The results of this survey are being used in the development of the DIP for the CS-VIII project.

Weaknesses

- The different design of the baseline survey and the final survey in the two provinces made it difficult to evaluate and compare the impact of the project.

<u>Objective 3</u>: **Increase by 50% the use of child-spacing methods in women of fertile age.**

The baseline survey noted that, on the average, 30.6% of women of fertile age used a family planning method. In the final survey, 26.4% of women with children under 2 years of age stated that they were using a method for family planning. These two percentages are not comparable because the respondent groups are not comparable (women of fertile age vs. women with children under two years).

Strengths

- Child spacing is a strong component of the training curriculum of the TBAs.

- The coordination and involvement of APROFE (Ecuadoran private family planning agency) in the education of health staff and in the promotional activities at the community level has promoted a better understanding and acceptance of family planning methods at the community level.

- 20 community-based distribution posts for contraceptives, provided by APROFE, were established at the community level.

Table 2 in Appendix B summarizes the activities in child spacing for the year 1991.

Weaknesses

- One difficulty with this intervention is that, in some communities, there is a strong resistance to artificial family planning methods due to the strong influence of the church. Women in these communities prefer to use the less

reliable natural family planning methods. According to the final survey, 19.4% women in Azuay use the rhythm method.

Objectives 4 and 5. **Improve training materials and train 75% of TBAs by project end.**

According to the final evaluation, an average of 40% of births are attended by TBAs (for outputs, see Table 3, Appendix B).

Strengths

- Training modules and manuals for TBAs were developed with an emphasis on detecting high risk women, clean delivery practices, and timely referral; the TBAs also improved their knowledge and practices in maternal and infant care.

- Coverage rates in pre-, peri-, and post-partum care and care of the newborn by MOH staff have increased through referral of cases by project-trained TBAs.

- Pictorial referral forms for TBAs were redesigned and printed.

- The coordination between the project and the MOH at all levels has increased the mutual acceptance and respect between trained TBAs and the staff of the MOH facilities.

- The coordination of TBA training with the MOH and UNFPA, as well as the joint funding of course expenditures and supplies, has been very effective and will promote the sustainability of this intervention in the future.

- The increasing participation of MOH staff in training, follow-up, and supervision (every three months) has strengthened the potential for sustainability.

- The TBAs help with other health-related activities in the community, such as identification of children with diarrhea, oral rehydration, and referral of children to the health facilities strengthens child survival activities.

- Regular follow-up training (every three months) has maintained the TBAs active and motivated. These meetings are also used to restock TBA supplies, collect information, and strengthen their knowledge.

- The existence of the HIS which compiles data of TBA activity makes it possible to monitor outputs. 80% of TBAs and volunteers provide activity reports.

Weaknesses

- After discussions with the MOH, the project did not conduct any KAP survey with the TBAs to modify training materials

because the MOH had planned to conduct such a study nationwide in 1992.

- About 20% of TBAs seem to have difficulty in reporting and referral.

<u>Objective 6</u>. **Immunize 50% of women of fertile age with TT2 by project end.**

Strengths

- The continuous promotion and education at the community level about the importance of the TT vaccine has increased the acceptance and demand for TT immunizations. Initially the MOH only immunized pregnant women, despite the fact that MCH norms recommend the immunization of pregnant women and women of fertile age.

- TT immunization is a priority activity of the project which has resulted in increased coverage.

- The importance of immunizing pregnant women and women of fertile age with TT is emphasized in the training curricula of health staff, TBAs, and CHVs.

Weaknesses

- Despite existing MOH norms, the immunization of women of fertile age with TT is still poorly accepted at the health facilities, in part due to lack of resources and supplies (syringes).

See Tables 4 and 5 in Appendix B.

<u>Objective 7</u>. **Conduct growth monitoring of 50% of children under three by project end.**

See Table 6 in Appendix B for growth monitoring outputs.

Strengths

- As a result of the training courses for MOH staff, some operational units reinitiated and others improved the growth monitoring activities of young children.

- Project staff used growth monitoring sessions for individualized nutrition counseling of mothers.

- CHVs promote and assist in the growth monitoring sessions and in the education of mothers; this increases the mothers' trust and credibility of the CHVs.

- Growth monitoring and the child's growth curve make it possible to identify children at risk for malnutrition and

refer them to the health facilities for treatment and inclusion in complimentary feeding programs.

- The participation of mothers in the growth monitoring process make them aware of the importance of the relationship between NUTRITION-WEIGHT-HEALTH.

Weaknesses

- Growth monitoring events are not recorded by the health information system of the MOH.

Objectives 8 and 9. Training of 172 auxiliary nurses of the MOH health facilities in basic nutrition and breastfeeding and strengthening of their capabilities in the training and supervision of TBAs, CHVs, and mothers in appropriate nutrition practices.

See Table 7 in Appendix B for information about the outputs of nutrition education, home gardening, and breastfeeding.

Strengths

- Results of focus groups provided information about the education needs of mothers and helped in focusing the training content.

- Training sessions for mothers' clubs and mothers using different dynamic teaching methodologies have been more effective than the regular course modules provided to CHVs. Methodologies have included the planning of special health days with focus on nutrition and competitions on preparing the most nutritious dish, etc. at the end of such training sessions. 741 mothers and women of 21 mothers' clubs were trained in this way in different communities of Manabi.

- Dynamic training materials and methodologies for the different CS interventions have increased the active participation and interest of community members.

- A further component of the nutrition strategy that promotes active participation is the development of family, community, and school gardens and training of the beneficiary families in the utilization and consumption of the produce.

- Technical assistance from the Ministry of Agriculture, INIAP, CEMADEC, and CREA has been effective in implementing the home gardening component in both provinces.

- Ninety volunteers in Azuay and 64 in Manabi were trained in home gardening in a 24-hour course. This component will be strengthened in 1993.

- Breastfeeding and appropriate weaning are important components of the nutrition education strategy.

Weaknesses

- Only 90 auxiliary nurses (52% of the figure provided in the DIP) were trained; however, these are all the auxiliary nurses with whom the project was in direct contact. Despite the progress made in developing training methodologies further development is needed in that area to improve the training provided to the communities.

<u>Objective 10</u>. **Reduce infant/child mortality due to dehydration by 10%.**

See Table 8 in Appendix B for outputs of this project component.

Strengths

- 142 oral rehydration units were established at the community level. They are managed by the CHVs who help mothers in assuring that their children do not become dehydrated. The final survey indicated that 58% of mothers increased, or at least no longer decreased liquids during a diarrheal episode. In 1991, 13,332 ORS packets were distributed.

- The ORT component was strengthened further through intensive educational efforts of the MOH and Project HOPE to reduce the impact of the cholera epidemic.

- Communities with CHVs were well prepared to confront this situation. Project staff rehydrated 767 children and CHVs 2,813.

- Communities improved environmental hygiene through the efforts of community groups, e.g., construction of latrines, improvement in water supply, community collection of refuse, etc.

Weaknesses

- Some of the CHVs trained to manage community rehydration units are no longer active. Strategies to motivate and train others have to be developed.

<u>Assistance Provided to the EPI and ARI Programs of the MOH</u>

The outputs are listed in Table 9 in Appendix B.

Strengths

- The CHVs' promotion of EPI activities at the community level has increased the acceptance and participation in immunization campaigns.

- MOH staff recognize the valuable contributions of project field staff and volunteers during immunization activities.

Weaknesses

- Because the project is only providing general support to the MOH, the DIP did not specify specific objectives and outputs for immunization.

- Health units frequently do not have vaccines, and staff are often absent. This has made it impossible to increase coverage levels.

In summary, in Azuay, the project has worked in 199 communities (49.2%) and has trained 125 CHVs (41.6% are still active); in Manabi, the project worked in 195 communities (51.3%) and has trained 108 CHVs (83% are still active).

C. SUSTAINABILITY

(Response to the A.I.D. Guidelines)

A. SUSTAINABILITY STATUS

A1. Project funding ended on or about October 31, 1992. The project has been extended with CS-VIII funding until March 1995.

A2. The CS activities are not ending. The short duration of the project and other factors have made it impossible to achieve the project objectives. It is hoped that some or most of the CS activities can be phased over to the MOH and the communities during/at the end of the CS-VIII project.

A3. Some activities and responsibilities are progressively assumed by the MOH. In some of the cantons, the MOH has assigned staff to participate in the supervision and follow-up of the TBAs and volunteers. Training costs for TBAs and CHVs are shared by Project HOPE and the MOH. The health units distribute supplies to the TBAs and ORS packets to the CHVs.

CHVs are becoming increasingly involved with MOH operational staff in training and promotional activities at the community level.

B. ESTIMATED RECURRENT COSTS AND PROJECTED REVENUES

B1. The project considers the following activities effective and would like to see them sustained:

- Training, follow-up, and supervision of TBAs, and

strengthening the relationship "operational units-TBA-community."

- Training and assistance to community groups (e.g., mothers' clubs, health committees, etc.) as a major way of educating a large number of community members in key child survival messages.

- Strengthening of the inter-institutional committees to improve the collection of vital events.

- Increased inter-institutional collaboration to address the comprehensive development needs of communities.

- Training and increased coordination with the MOH rural health teams of physicians and auxiliary nurses to serve inaccessible communities and improve quality of services.

B2. Per diems for MOH staff responsible for training and follow-up of TBAs and CHVs.

The TBAs and CHVs do not receive any stipends from the MOH. However, to assist training courses, they need to be reimbursed for transport, food, and lodging, where appropriate.

B3. It is estimated that the MOH would need about $20,000 to support the above expenditures, $10,000 in each province.

B4. These costs are reasonable, given that the CS activities are a component of national, provincial, and health area programming.

B5. No revenues are projected.

B6. Repair and maintenance of equipment (e.g., computers, vehicles, etc.) are difficult for the MOH to provide given the very serious economic constraints of the MOH.

The absorption of project staff (45 individuals) similarly will be difficult for the MOH.

B7. Counterpart contributions should be clearly defined at project onset. In particular, counterparts need to allocate the necessary amount for per diems of their staff involved in community work.

In kind contributions (e.g., office space) are easier to obtain than cash contributions. Minimal contributions that were mutually agreed upon (cash contribution of $200 per year) have been difficult to obtain.

Project HOPE did not expect Ecuador's economic situation to

deteriorate to this extent.

C. SUSTAINABILITY PLAN

C1. All staff with more than two months of work with the project were interviewed. Their involvement in implementation, monitoring, and evaluation varies.

C2. The project works in accordance with MOH policies and program guidelines, strengthening the MOH and assisting it to achieve its CS objectives.

One major purpose of the project is to train MOH staff so they can jointly with project staff implement the community outreach activities and assume the responsibility for implementing the training courses, follow-up, and supervision of CHVs and TBAs.

All project staff are country nationals to increase the availability of trained staff at the community level and facilitate their absorption by the MOH, thereby assuring sustainability of the CS activities.

C3. The project addresses needs identified and valued by the communities and operates with appropriate technologies and costs. This promotes and achieves substantial community participation.

Conscious community organization and participation promotes self-management.

Project staff program their activities monthly with their local counterparts.

The project closely coordinates and implements its activities with the programs of other agencies and NGOs, such as the MOH, Seguro Social Campesino, APROFE, CREA, Ayuda en Accion, Peace Corps, World Vision, CRS, Fundacion Nino a Nino, Ministry of Agriculture, Instituto Nacional de Investigaciones Agropecuarias, CEMADEC, and COOPIBO-SENDAS.

The project also participates in the development of a support group for U.S. PVOs.

C4. The project has achieved acceptance and integration into the MOH structure at the provincial and local level.

The communities have responded positively with community development and improvement activities through organized community groups and trained human resources of the communities.

The project has coordinated with other agencies and NGOs in

the programming and implementation of specific activities at the community level.

Slowly, MOH staff are becoming involved in the implementation of activities at the community level.

The implementation of community based information and distribution sites for family planning was not considered in the DIP. It has provided good results and is important for sustainability.

C5. In the agreement with Project HOPE, the MOH has made a commitment to provide an office and furniture in both provinces. This commitment has been fulfilled. In addition, the MOH promised to pay $200 annually as a cash contribution. This amount of money has been paid, with some delays.

The MOH provides vaccines and supplies for immunization, as well as ORS packets for the community oral rehydration units.

In the agreement, the MOH stated its willingness to absorb trained project staff to the extent possible given its financial and human resource planning constraints. This will not become an issue until the end of the extension project.

C6. The observation of the project successes and the evaluation of specific project achievements, particularly at the community level, has motivated the MOH to better fulfill its commitments.

The fact that Project HOPE takes its commitments to the MOH and the communities seriously also has increased counterpart commitment.

Involvement of counterparts in the evaluation process has been important to strengthen local ownership of project activities.

Lack of financial resources for transport and per diems is one of the most frequent reasons given for the inability of the counterparts to keep their commitment. Labor problems (e.g., frequent and lengthy strikes, also resulting in changes in provincial leadership in the MOH) have also affected the continuity in the working relationship between Project HOPE and the MOH.

D. MONITORING AND EVALUATION

D1. Because of continued developments in the area of child survival and, in particular in the survey technologies, project indicators are not consistent from the initial

baseline surveys to the final surveys in each province, making comparisons difficult.

The DIP has objectives, activities, outputs, and benchmarks for each intervention to facilitate monitoring and evaluation, e.g., # of auxiliary nurses trained; # of TBAs trained vs. # of TBAs reporting and # of TBAs referring; # of CHVs trained vs. # of CHVs active and reporting; # of mothers' clubs organized vs. # of clubs active; # of home gardens implemented vs. # of gardens producing vegetables; etc. In addition, the surveys look at CS knowledge and practices at the community level.

Coverage data analyzed quarterly and annually are used for planning and programming for each subsequent quarter.

Quarterly and annual reports and the midterm evaluation have been used to monitor project progress and make any necessary program adjustments.

Provincial and local health area chiefs receive monthly activity reports.

D2. The involvement of the MOH has to increase further and become more consistent during the extension project to increase the likelihood of sustainability of the project activities.

D3. Provincial MOH staff understand the need for decentralized programming, as implemented by Project HOPE, and is interested in continued assistance from Project HOPE.

Demand for maternal and child health services has increased continuously due to the community education activities of the project.

Maternal behaviors are changing: e.g., before taking a child with diarrhea to a health facility, mothers have already administered home available liquids or ORS. Physicians at the health facilities have observed these changes and commented about them to Project HOPE. Similarly, during the project's midterm evaluation, health facility staff remarked upon the improvement of the relationship of TBAs with health facility staff and increases in the referral of high risk patients.

The project has attempted to strengthen the process of regionalization through joint programming, assistance, and integration of project activities with MOH activities at the local level.

Ayuda en Accion! Coordination of activities at the community level. One representative participated in the baseline/final survey and the hand tabulation of the data.

D4. MOH: Coordination and implementation of CS activities; participation in both evaluations;

Peace Corps: provision of two volunteers in Azuay and two in Manabi;

CARE: Assistance to environmental hygiene and latrine activities; one representative participated in the final survey, another in the presentation of the data;

CRS: Coordination in implementing community education meetings; one representative participated in the discussion of the final survey results;

CREA (Centro de Reconversion Economica del Austro): assisted in the development of home gardens;

Ministry of Agriculture: provided technical assistance to the home gardening component;

SECAP (Servicio Ecuatoriano de Capacitacion Popular): Coordinated and assisted with provision of training in handicrafts for women;

Seguro Social Campesino: coordinates health activities at the community level;

INNFA (Instituto Nacional del Nino y la Familia): Coordinates in providing education for mothers about care of the young child;

APROFE (Asociacion Profamilia del Ecuador): Has assisted in staff training, community promotional meetings about family planning, and in setting up community-based distribution systems of contraceptives;

Ministerio del Bienestar Social: Networking in the area of social services for young children;

COOPIBO-SENDAS, Plan International, and Fundacion Nino a Nino: Coordination of activities at the community level and participation in the discussion of the final survey results.

D5. The project used the comments of the technical reviewers of the proposal in the design of the DIP. Recommendations of the technical reviewers of the DIP were addressed in the first annual management review. A detailed response of Project HOPE is attached in the First Annual Report as Appendix A. Similarly, recommendations of the Midterm Evaluation were used in the development of the extension proposal.

D6. The Midterm Evaluation contributed much toward strengthening the relationship between Project HOPE and the MOH. The highly participatory process (during the evaluation and during discussions of its implications at the provincial and health area level) has strengthened MOH ownership of the project activities and resulted in a gradual increase in involvement in the implementation of activities at the community level. Coordination and networking with other public and private agencies has also increased as a result of the Midterm Evaluation. These changes will increase the likelihood of sustaining CS activities at the end of the extension project.

E. COMMUNITY PARTICIPATION

E1. The following community leaders were interviewed:

25 community leaders of the Proyecto Norte (Sta. Isabel, Azuay);

40 members of various mothers' clubs in Sevilla de Oro (Azuay);

About 50 representatives of mothers' clubs and community leaders of the communities of Guyabal, San Jose, La Sequita, El Pueblito, and Bajos de la Palma (Manabi);

80 women and community representatives of Pichincha (Manabi).

The following CHVs and TBAs participated in Azuay:

Ester Ordonez - TBA, Salinas, Santa Isabel;
Irene Calle - CHV, Sarar, Sigsig;
Narcisa Benalcazar - CHV, San Alfonso, Santa Isabel;
Segundo Llivisupa - CHV, Guayara alto;
Alfonso Jimenez - CHV, Salinas

E2. Community leaders perceive the following activities as effective for meeting current maternal and child health needs:

- Community-based health education;
- Training of volunteers and TBAs;
- Assistance in how to contact public and private agencies to address community development issues;
- The improvement in the relationship between the community and the respective health facility/provider.

E3. The following activities were carried out:

- Promotion of community organization, particularly mothers' clubs that act as multipliers of the CS messages to their communities;

- Multi-sectoral coordination with other public and private agencies to assist in addressing specific problems of various communities;
- Fostering the communities' capabilities to resolve their own problems;
- Project HOPE attempts to optimize the resources of other NGOs that work in related activities in the same communities (CARE, World Vision, Ayuda en Accion, APROFE, COOPIBO, and Peace Corps).

E4. The communities participated in the various aspects of the project through their representatives (CHVs, TBAs, and mothers' clubs). They have also participated in the surveys and focus groups conducted by the project.

Several community volunteers were interviewers in the final survey. In both Manabi and Azuay, popular presentations of the data were made at the community level using puppets and involving community members in socio-dramas.

In the project extension, community volunteers will participate in the elaboration of the DIP.

E5. Presently, there are 11 health committees and 59 mothers' clubs in existence. They meet once a month, on the average. Women of fertile age, adolescents, young children, and sometimes other community members come to the meetings of the mothers' clubs, depending on the purpose of the meeting. The health committees are representative of their communities.

E6. The following topics are being discussed by the health committees and mothers' clubs: health promotion, environmental sanitation, community organization, organization and maintenance of community pharmacies, and specific CS interventions, etc. Mothers' clubs organize courses in handicrafts and organize other events of interest to the community.

E7. One of the major contributions of the communities are the volunteers. In addition, community members contribute time to participate in project activities and land for the development of home gardens. The communities also replicate activities that promote community development, e.g., health days, the construction of day care settings and community assembly halls, etc. Some communities provide accommodations and food for MOH and project staff during community visits.

E8. Community groups tend to contribute resources when they are motivated to do so by project staff; because of their involvement in the home gardening activities; and because project staff take their own commitment to the communities serious.

Failure to commit more resources is due to the overall high level of poverty in the target area; the high migration rates for economic reasons; and differences in opinion among community committee members. Sometimes the presence of other organizations that are not interested in coordinating multi-sectorial efforts creates tension in these committees.

F. ABILITY AND WILLINGNESS OF COUNTERPART INSTITUTIONS TO SUSTAIN ACTIVITIES

F1. The following individuals were interviewed:

Ministry of Health:
Dr. Angel Racines -- Chief, Maternal and Child Health Programs;
Mrs. Consuelo Bejarano -- Obstetrical Nurse in charge of training TBAs at the central level;
Dr. Ruth Andrade -- Consultant, UNFPA.

Interviews in Azuay:
Dr. Galo Ochoa -- Chief of the MOH, Azuay;
Ms. Carmen Alvarado -- Head of Nursing, MOH, Azuay;
Lcdo. Ramiro Proano -- MSH Provincial Consultant;
Dr. Manuel Cedillo -- Head of the Health Area of Sigsig;
Ms. Betty Quishpe -- representative of the Catholic Church;
Dr. Jorge Bejerano -- PHC Coordinator;
Lcda. Olga Ochoa -- President of the Association of the Handicapped of Azuay;
Isabel Medoza -- Community health nurse, Sarar, Sigsig.

Interviews in Manabi:
Dr. Jorge Toledo -- Chief of Protection and Prevention, MOH, Region II;
Dr. Humberto Moreno -- Chief of the MOH, Manabi;
Sra. Aspacia de Equez -- Head of Nursing, MOH, Manabi;
Dr. Guido Romero -- Head of Protection and Prevention, MOH, Manabi;
Dr. Jorge Lozada -- Chief of the Health Center of Montecristi;
Lcda. Teresa Rivadeneira -- Nurse, Protection and Prevention, MOH, Manabi;
Lcda. Miriam Mera -- Provincial Nurse Supervisor, MOH, Manabi;
Dr. Julio Villacres -- Head of Health Services, MOH, Manabi;
Dr. Lilario Cedeno -- Health of the Health Area of Sta. Ana;
Srta. Mariana Garcia -- nurse of the Health Area of Pichincha;
Dr. Eduardo Ibarra -- MSH Provincial Advisor;
Sra. Miriam Santana -- Representative of the MOH Department of Statistics;
Lcda. Teresa Delgado -- Head of Nursing, Health Area II;
Srta. Gladys Garcia -- Nurse, Manta;

Dr. Maria Elena Gonzales -- Chief, Health Area, Pichincha;
Sra. Maria Pacheco -- Auxiliary Nurse of the Sub-Center San Sebastian;
Sr. Roberto Casanova -- Representative of INEC;
Sr. Bolivar Barcia -- Representative of the Civil Registry Office;
Sr. Magno Ramirez -- APROFE Coordinator of Region II;
Sr. Jorge Pinargote -- APROFE Supervisor, Manabi.

F2. The primary counterpart relationship is with the MOH. However, Project HOPE coordinates with local development agencies at the community level in both provinces. Direct financial exchange is not involved. However, resources (e.g., transport, community time, etc.) are shared with other development agencies at the operational level.

F3. The key local institutions to participate in sustaining project activities are the MOH, the Seguro Social Campesino, and APROFE in the area of family planning.

F4. The MOH, NGOs, and other counterparts are considering the following project activities as effective:

- Training of MOH auxiliary nurses;
- Training and follow-up of TBAs and CHVs;
- Community organization and education; and
- The Inter-institutional Committee of Vital Statistics (in Manabi).

F5. By training 90 MOH auxiliary nurses, the project has assisted these MOH staff to perform their duties more effectively. This includes practical demonstrations on how to train and supervise CHVs and workshops in adult education techniques.

Project HOPE also provided training to counterparts in adult education and communication.

MOH counterparts are invited to participate in the training, follow-up, and supervision of CHVs and TBAs, as well as in community outreach and education. Even though level of participation of MOH differs across the involved operational units, MOH staff that have participated actively have benefited by increasing their technical skills and capabilities of working with community volunteers and groups in community outreach activities.

F6. The ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities is still limited. This is not surprising taking into account the short duration of the project and the increasingly scarce resources of the main project counterpart, the MOH. Even though progress has been made in increasing the MOH staff's

involvement in working directly with the communities, frequent labor problems (e.g., strikes, frequent staff turnover at all levels of operation and its impact on staff motivation, etc.) disrupt the continuity of work and the level of trust of the communities. The number of salaried staff of the MOH is decreasing, and necessary supplies are frequently lacking. On a more positive note, Project HOPE's participation in the development of provincial health plans with the MOH and the MSH Provincial Advisors has been helpful for emphasizing the importance of community-based activities.

F7. Additional activities perceived as effective by the counterparts are local programming and the immunization of women with TT.

G. PROJECT EXPENDITURES

G1. The pipeline analysis will be submitted independent of this report.

G2. Due to a number of reasons (see past project reports), expenditures for salaries (and, therefore the indirect cost of the project which is calculated based on salaries and benefits) was much higher than expected. Project staff turnover was excessively high in the first two project years due to Project HOPE's policy of paying salaries not higher than 10% above the rate paid by the MOH to facilitate their later absorption by the MOH and enhance sustainability. Due to the demands of key positions -- the projects community nurses serve a very large number of communities and are expected to live in their assigned cantons -- nurses were lost to the MOH and the Social Security system where they may have positions "for life" in more comfortable settings (work within a hospital or health center, rather than moving among disperse rural communities). Several nurses also have emigrated to the U.S. and Spain for better paying positions.

In the second year of the project, the MOH raised local salaries significantly after a very lengthy labor strike. In order to not lose further staff, project salaries had to be raised simultaneously.

The expatriate program director was replaced later than expected by a country national at the specific request of the central MOH.

G3. Project HOPE maintains its accounting on an accrual basis. Revenue is accounted for by source (i.e., public, private, service agencies, and in-kind), and monies become fundable upon deposit. Expenditures are controlled for in budget controlled cost centers, and account titles are functionally descriptive. Financial reports are prepared monthly for Foundation management, comparing actual with budgeted

performance (and on a regular, less-frequent basis for the Board of Directors). Project HOPE's financial statements are audited annually by Deloitte & Touche, an internationally respected firm of independent certified public accountants. Selection of the auditors is made based on the recommendations of the Audit Committee of the Board of Directors. Functional responsibilities of employees are structured to ensure sound internal control of Foundation resources.

Accountability for the receipt and expenditure of Project HOPE funds at program sites is through an imprest system. Each country office is provided a cash fund of $1,300 to $20,000 from which local operational expenses and foreign national salaries are paid and into which host country contributions are deposited. Each site submits to HOPE Center a monthly report of account receipts and expenditures. All expenditures are supported with vendors' vouchers. HOPE Center issues reimbursement checks on a monthly basis to restore on-site bank accounts to the imprest level. From the monthly financial report, the headquarters accounting department compiles a summary of transactions, including budget comparisons, journal entries, accounts payable, and cash receipts. Accounting records at the program sites consists of duplicate financial reports and local bank records. Project HOPE has established procurement procedures accepted and approved by A.I.D.

G4. Major changes in local salaries are difficult to predict and difficult to plan for in budgets. Additional internal and A.I.D. funding may be needed in situations where the size of the project staff cannot be reduced, or program duration may have to be reduced in order not to jeopardize program quality. Local salaries have to remain competitive with the salaries of the major counterparts if high quality staff are to be attracted and maintained. High staff turnover is very expensive in terms of resources required for training and orientation of new staff, in developing a good counterpart relationship, and in maintaining the trust of the communities.

H. ATTEMPTS TO INCREASE EFFICIENCY

H1. Training courses for CHVs and TBAs were held in small groups in or close to their respective communities. In addition, training proceeded in single modules over a span of time to reduce the need to pay for lodging of the trainees.

Local materials and local human resources were used as much as possible. The only expatriate consultant to the project resides in Ecuador, reducing the need to pay for inter-country travel expenditures. He also is available on a "by need" basis and for short duration.

Project staff attempt to share resources (e.g., transport) with other local agencies and coordinate closely at the local level to avoid duplication of effort.

H2. A large proportion of project costs are staff salaries. Costs in that area could not be reduced, as explained above. Because of the large number of highly disperse communities, it is not possible at this point to reduce the number of staff without impeding project effectiveness and staff productivity.

H3. In the extension project, efforts will be increased to obtain a larger commitment from the MOH to work at the community level with project staff to facilitate phaseover.

I. COST RECOVERY ATTEMPTS

I1. Cost recovery is not a part of the project. The project receives $200 per year as a contribution of the MOH, as well as free office space.

The project charged a fee for one of its workshops for health professionals to offset cost.

I2. $390, or about 50% of the workshop cost, was recovered.

I3. The cost recovery attempt did not negatively impact on Project HOPE's image.

I4. Not applicable

I5. Cost recovery strategies for health education and preventive services are difficult to implement in an environment where these services are provided free by the MOH. However, given an environment of increasingly scarce resources, new strategies need to be explored with public agencies.

J. HOUSEHOLD INCOME GENERATION

No income generation activities were implemented during the CS-V project. Recently, Project HOPE initiated an income-generation project in Manabi, funded by a Project HOPE-A.I.D Matching Grant. Project activities have commenced in several of Project HOPE's CS target communities.

K. SUMMARY

K1. The project has accomplished the following in enabling communities to meet their basic health needs, and in promoting sustainability of effective child survival activities:

- Changed maternal health behavior has resulted at the community level.

- Communities have learned how to organize and to self-manage their activities increasing their ability to address community development needs in health and non-health areas.

- CHVs and TBAs have strengthened their skills, improved the quality and demand for their services, and increased referral to the MOH health system.

- The MOH staff has been trained strengthening their skills to provide quality services.

- General demand for MCH services has increased due to increased numbers of referral and improved quality of services.

- Demand for family planning services has increased with the establishment of information and community-based distribution posts for modern contraceptive methods.

- Knowledge about home gardening techniques have been disseminated and replicated.

- The project has carried out its sustainability promoting activities in a highly competent manner. The technical competence, motivation, and commitment of project staff have increased the MOH's cooperation and collaboration thereby improving the chances for sustainability.

Lessons Learned

Counterpart contributions should be clearly defined at project onset. In particular, counterparts need to allocate the necessary amount for per diems of their staff involved in community work.

In-kind contributions (e.g. office space) are easier to obtain than cash contributions.

Budgeting and sustainability plans must consider the deteriorating economic conditions and decreasing human and financial resources available to the public sector in developing countries due to structural adjustment economic policies. These conditions make sustainability with MOH counterparts increasingly more difficult.

The use of country nationals as project staff to facilitate their absorption by the MOH increases sustainability.

Involvement of counterparts in baseline and evaluation strengthens local ownership of project activities.

Staff retention is enhanced through competitive salaries and creating incentives for professional development (participation

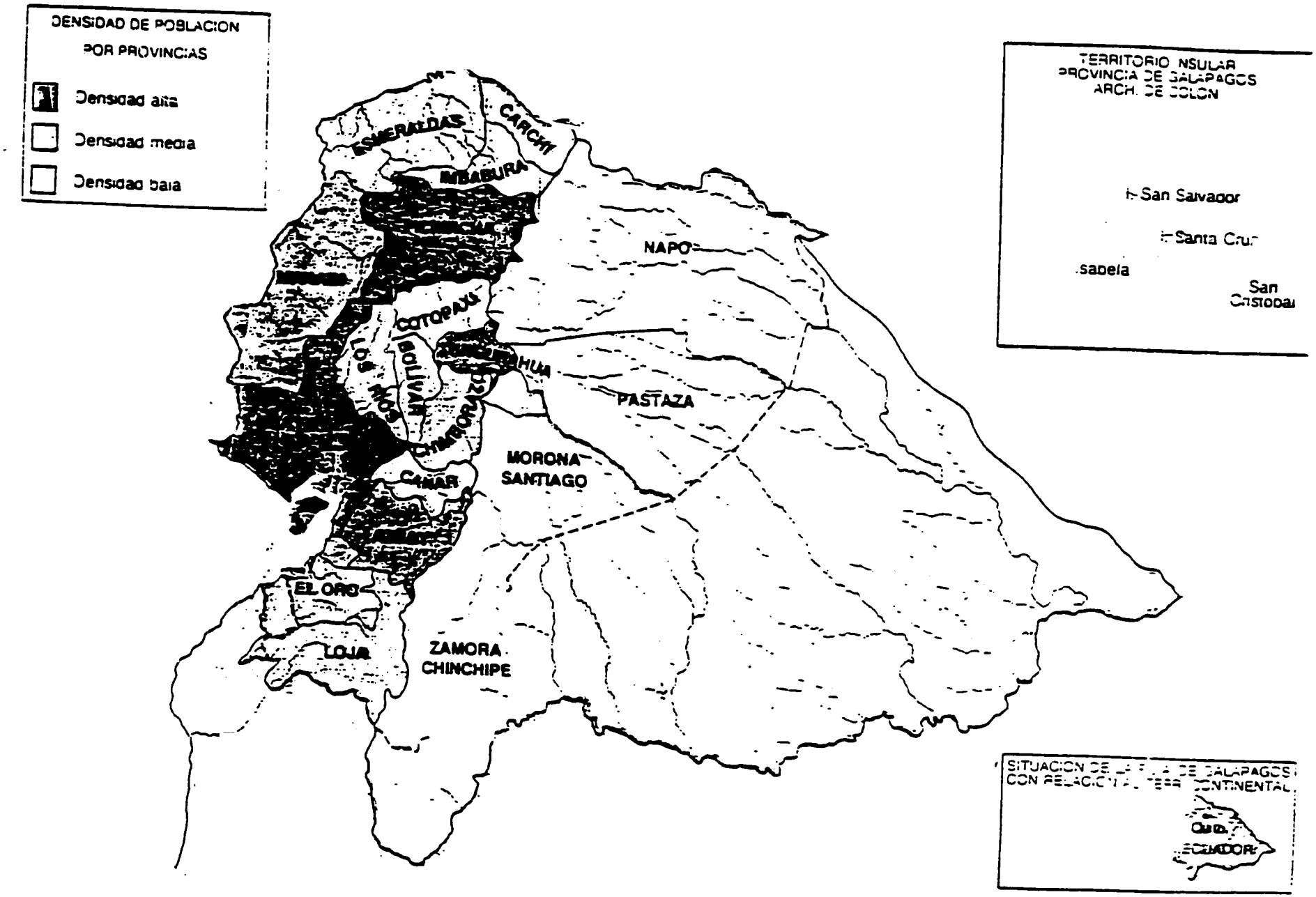
in professional conferences and relevant training workshops and language lessons). These opportunities further motivate project staff.

When projects target difficult to reach disperse communities of underserved rural populations in Latin America costs will generally be much higher than in densely populated rural or urban CS projects.

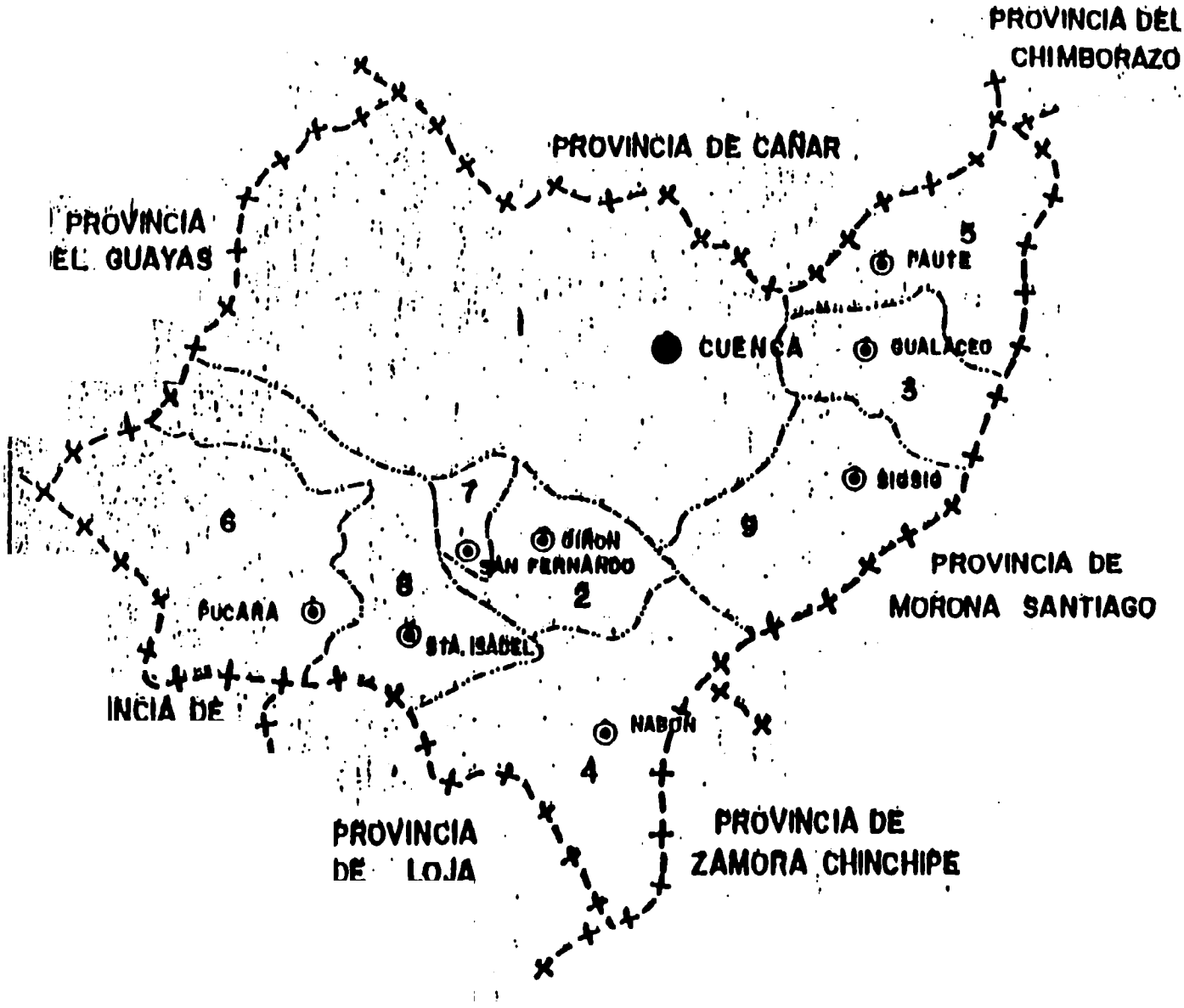
APPENDIX A

MAP

Densidad de poblacion



PROVINCIA DEL AZUAY



SIMBOLOGIA

- LIMITE INTERNACIONAL
- LIMITE DE PROTOCOLO
- LIMITE PROVINCIAL
- LIMITE CANTONAL
- CAPITAL PROVINCIAL
- CABECERA CANTONAL

APPENDIX B

TABLES

Table 1

TARGET POPULATION

PROVINCES	DIP			ACTUAL POPULATION		
	AZUAY	MANABI	TOTAL	AZUAY	MANABI	TOTAL
Women of fertile age	29,943	30,172	60,115	24,145	26,662	50,807
Children 0-3 years	14,993	12,163	27,156	10,785	10,090	20,875
High Risk Pregnancies	4,436	4,036	8,472	4,082	4,208	9,203
Communities to Serve	148	344	492	404	380	784

Table 2

OUTPUTS, 1991
CHILD SPACING

ACTIVITIES	Project HOPE Staff		Trained Volunteers	
	EVENTS	NO. OF PERSONS	EVENTS	NO. OF PERSONS
Education and Promotional Meetings	248	6,283	85	669
Individual Counseling and Home Visits	966	1,175	133	133
Referrals	280	280	156	156
TOTAL	1,494	7,838	374	958

Table 3

OUTPUTS, 1991
MATERNAL CARE

ACTIVITIES:	Project HOPE Staff		Trained Volunteers	
	Events	No. of Persons	Events	No. of Persons
Education and Promotional Meetings	167	2,043	16	261
Individual Counselling and Home Visits	1,145	1,185	616	616
Prenatal Care	-	-	4,440	-
Deliveries	-	-	1,851	1,851
Post-Natal Care	-	-	2,167	-
Care of Newborn	-	-	7,357	-
REFERRALS:				
Prenatal Care	560	560	1,026	1,026
Delivery	40	40	281	281
Post-Natal Care	-	-	77	77
Referral of Newborn	36	36	254	274

Table 4

OUTPUTS, 1991
TT IMMUNIZATIONS

ACTIVITIES:	Project HOPE Staff		Trained Volunteers	
	Events	No. of Persons	Events	No. of Persons
Education and Promotional Meetings	220	4,207	117	366
Individual Counseling and Home Visits	3,067	3,067	268	423
Referrals	-	-	155	155

Table 5

OUTPUTS, 1991
TT COVERAGE

ACTIVITY:	AZUAY			MANABI		
	Planned	Achieved	%	Planned	Achieved	%
Women of Fertile Age	24,145			26,662		
TT1		7,891	32.3		8,709	32.7
TT2		5,096	20.8		5,575	20.8
Pregnant	4,082			4,208		
TT1		2,575	63.1		1,687	40.1
TT2		1,571	38.5		1,477	35.1

Table 6

OUTPUTS, 1991
GROWTH MONITORING

ACTIVITIES:	Project HOPE Staff		Trained Volunteers	
	Events	No. of Persons	Events	No. of Persons
Education and Promotional Meeting	332	5,801	71	1,125
Individual Counseling and Home Visits	1,884	1,884	196	196
Children Monitored	9,259	3,086	-	-

Table 7

NUTRITION, HOME GARDENS, AND BREASTFEEDING

ACTIVITIES:	Project HOPE Staff		Trained Volunteers	
	Events	No. of Persons	Events	No. of Persons
NUTRITION:				
Education and Promotional Meetings	411	8,208	80	1,273
Individual Counseling and Home Visits	2,269	2,269	110	110
Children Referred	1,404	1,404	162	162
HOME GARDENS:				
Education and Promotional Meetings	180	2,612	143	1,007
Individual	635	1,056	187	187

Table 8

OUTPUTS, 1991
DIARRHEAL DISEASE CONTROL

ACTIVITIES:	Project HOPE Staff		Trained Volunteers	
	Events	No. of Persons	Events	No. of Persons
Education and Promotional Meetings	260	7,725	775	4,614
Individual Counseling and Home Visits	853	1,222	1,260	1,260
Referrals	190	190	387	387

Table 9

OUTPUTS, 1991
CHILD IMMUNIZATION AND RESPIRATORY INFECTIONS

ACTIVITIES:	Project HOPE Staff		Trained Volunteers	
	Events	No. of Persons	Events	No. of Persons
Education and Promotional Meetings	124	1,714	40	692
Individual Counseling and Home Visits	56	495	87	87
Referrals	236	236	70	70

Table 10

SUMMARY OF MAIN EVENTS IN CS
1991

ACTIVITIES:	Project HOPE Staff		Volunteers		TBAs	
	No. of Persons	Events	No. of Persons	Events	No. of Persons	Events
Meetings and Promotional Activities	2,048	40,300	1,377	11,124	—	—
Counseling & home visits	10,875	12,353	2,857	3,012	—	—
Referrals	2,746	2,746	2,046	2,356	1,374	1,374
Prenatal Care	—	—	—	—	4,440	4,440
Delivery	—	—	—	—	1,851	1,851
Postnatal Care	—	—	—	—	2,167	2,167
Care of the Newborn	—	—	—	—	7,357	7,357
TOTAL	15,669	55,399	6,640	16,492	17,189	17,189

Table 11

SUMMARY OF MAIN EVENTS IN CS/
TOTAL NUMBER OF INDIVIDUALS TRAINED
1991

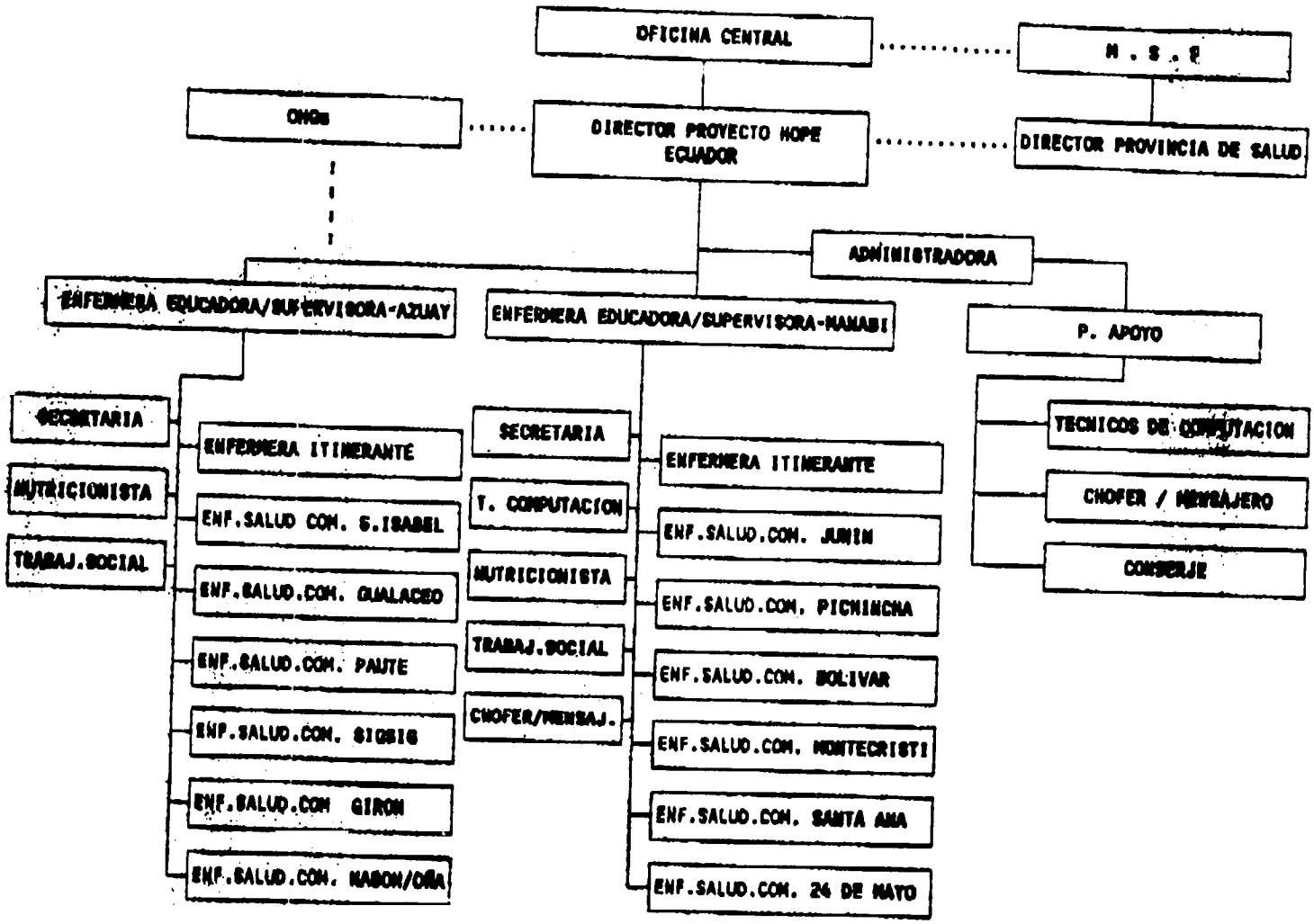
INDIVIDUALS TRAINED	PLANNED	ACHIEVED	ACTIVE
Auxiliary Nurses	172	90 (52.3%)	90 (100%)
CHVs	200	233 (116%)	142 (61%)
TBAs	200	149 (74.5%)	148 (99%)
Civil Registrars	27	70 (259%)	70 (100%)
Number of Communities Where Project Has Worked	784	394 (50%)	450 (57.4%)

APPENDIX C

ORGANIZATIONAL CHART

3 DE DICIEMBRE DE 1992

ORGANIGRAMA - PROYECTO HOPE/ECUADOR



APPENDIX D

COMMUNITIES VISITED BY THE EVALUATION TEAM

COMMUNITIES VISITED BY THE EVALUATION TEAM

EN AZUAY:

CANTON SIGSIG - PARROQUIA LUDO - Comunidad de Sarar.-
Observacion de Actividad de control de peso e interaccion del personal del MSP/HOPE y voluntaria, asi como de las limitaciones existentes a nivel local.

CANTON STA.ISABEL. - Comunidad de San Alfonso.-
Observacion de Guarderias, actividad de control de peso y actividad de la voluntaria, asi como de las limitaciones que se tiene.

EN MANABI:

CANTON MONTECRISTI	Centro de Salud Comunidad Pueblito
CANTON PICHINCHA	Comunidad San Sebastian Comunidad Pichincha

APPENDIX E

EVALUATION SCHEDULE

PROGRAMA PARA EVALUACION FINAL NOVIEMBRE-DICIEMBRE/92

Nov. 24 Lunes	Preparación de Plan Tentativo de Evaluación Final Presentación de los Resultados de la Encuesta a las Autoridades a nivel central y local - Personal del MSP y HOPE
Nov. 24 Martes	Observación de campo - Paute, Sevilla de Oro: Presentación de Resultados de la Encuesta a la comunidad.
Nov. 25-27 Miércoles Jueves Viernes	Reunión Staff Contactos con Evaluador Externo y Personal del MSP; Preparación de documentos. Análisis de Encuesta Final
Nov. 30 Lunes	Reunión Equipo Hope y MSP - Plan Local con Evaluador Externo
Dic. 1 Martes	Observación de campo: Visita a comunidad del cantón Sigsig, entrevista con líderes comunitarios y Autoridades de Salud Local.
Dic 2 Miércoles	Cantón Sta. Isabel: reunión con dirigentes comunitarios "Plan Norte"
Dic. 3-4 Juev.-Vier.	Revisión de documentos con el Equipo Evaluador, análisis de metas, coberturas y productos
Dic. 7 Lunes	<u>Quito</u> Reunión con Directivos de Salud a nivel Nacional, y viaje a Manabí
Dic. 8 Martes	Reunión en Manabí con Equipo Hope/MSP (Plan Local)
Dic. 9-10 Miérc.-Juev.	Observación de campo: entrevistas con líderes comunitarios y Autoridades Locales de Salud
Dic. 11 viernes	Retorno a Quito del Evaluador externo, y prepara sumario y recomendaciones. Retorno a Cuenca - Equipo HOPE
Dic. 14-15 Lunes-Martes	Preparación de Borrador del Informe Cuenca Equipo HOPE
Dic. 16 Jueves	Respuestas y correcciones de HOPE CENTER (Informe Final)

APPENDIX F

HUMAN RESOURCES

PRESENT STAFF

AZUAY:

- Dr. Francisco Moreno - Program Director, Ecuador
- Srta. Lucia Pena - Administrator
- Lcda. Lucia Ortiz - Project Coordinator, Azuay
- Lcda. Ruth Chalco - Traveling Nurse
- Lcda. Nelly Narvaez - Nurse, Paute
- Lcda. Lucia Albarracin - Nurse, Giron
- Lcdo. Arturo Cruz - Nurse, Sta. Isabel
- Lcda. Elsa Zhapan - Nurse, Gualaceo
- Lcda. Claudia Tello - Nurse, Sigsig
- Lcda. Gicela Palacios - Nutritionist
- Lcda. Yolanda Jacome - Social Worker
- Srta. Cumanda Tapia - Secretary
- Sr. Paul Moscoso - Computer Technician
- Sr. Pablo Mosquera - Data Entry Tech
- Sr. Kenyon Cedeno y Ruben Pacheco - Driver, Messenger
- Sr. Luis Quichimbo - Receptionist

MANABI:

- Lcda. Teresa Narvaez - Project Coordinator, Manabi
- Lcda. Fatima Garcia - Nurse, Junin
- Lcda. Sara Arias - Nurse, Bolivar
- Lcda. Yolanda Guerrero - Nurse, Pichincha
- Lcda. Wilma Garcia - Nurse, Montecristi
- Lcda. Mercedes Santana - Social Worker
- Lcda. Betty Moreira - Nutritionist
- Sr. Fernando Zambrano - Computer Tech
- Srta. Viviana Gomez - Secretary
- Sr. Jaime Zambrano - Driver, Messenger