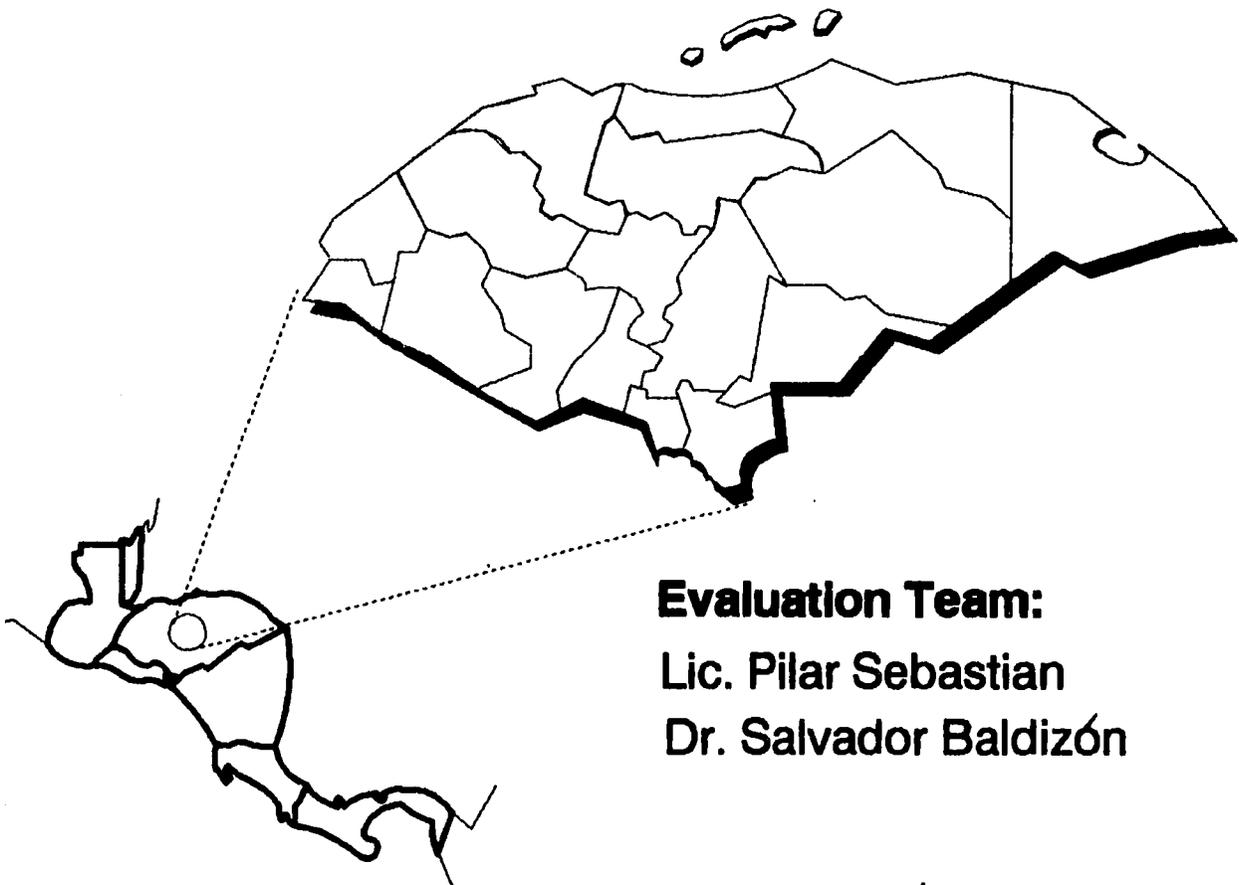


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# **CARE/Honduras**

## **CHILD SURVIVAL SIX MID-TERM EVALUATION**

**COMMUNITY HEALTH DEVELOPMENT PROJECT  
MAY 1991 - AUGUST 1992**



### **Evaluation Team:**

Lic. Pilar Sebastian

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**English Translation**

COMMUNITY HEALTH DEVELOPMENT PROJECT

HEALTH REGION NO. 5

CHILD SURVIVAL PROGRAM - VI

MID-TERM EVALUATION

Date of Evaluation: August 17-30, 1992

EVALUATING TEAM:

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## 1. EXECUTIVE SUMMARY

### INTRODUCTION

This report presents the results obtained to date by the Community Health Development Project implemented by CARE-Honduras, in Health Region No. 5, according to the agreement signed between the Honduran Ministry of Public Health and CARE-Honduras, with joint funding from USAID and CARE-USA.

The final goal of the project is to reduce the high rate of mortality and morbidity in the higher risk groups: mothers and children under 5 years of age. The specific objectives include a 20% reduction of the prevailing malnutrition rate and a 50% reduction in the prevalence of diarrheal disease and acute respiratory infections.

Per USAID guidelines, a participatory methodology was used in the evaluation. The evaluating team consisted of two persons: Pilar Sebastian, MSH Consultant, as head of the team and Dr. Salvador Baldizon, CARE's Regional Technical Advisor. The team worked two weeks, August 17 through 30, in Tegucigalpa as well as in the Santa Rosa de Copan's Health Region No. 5, with full support from project staff and the CARE-Honduras office.

In order to reach the above objectives, the project, designed with an integrated health educational focus, addresses the following interventions:

1. Growth and Development (growth monitoring)
2. The control of diarrhoeal diseases
3. The control of acute respiratory infections

### ACHIEVEMENTS MADE TO DATE:

- Recruiting and training a motivated team of community health education trainers
- Reinvovement of existing community volunteer personnel, previously trained by the Ministry of Health.
- Establishment of 94 growth monitoring posts
- Establishment of 87 Oral Rehydration Centers
- Implementation of Community Level Information System as a complement to the MOH Health Information System
- Funding and start-up of an independent Family Planning component, as a complement to Project activities

- A good level of coordination with MOH Health Centers, MOH region headquarters, with other project staff and the community volunteers

#### WEAKNESSES

- Loss of the staff's global vision of the project's goals and objectives
- Under utilization of the health information system, a lack of feedback and analysis of the information that allows taking concrete decisions.
- Lack of a Supervision-Support System for the project's health educators.
- Lack of a systematized training program.

#### RECOMMENDATIONS

1. Carry out a seminar with project staff to analyze the project as a whole and define the logical framework that relates objectives, goals and concrete activities as well as allows planning, monitoring and evaluation of achievements.
2. Add two educators, to have a maximum of 12 communities for each one; or study the possibility of reducing the number of communities in order to have greater impact, with the existing 7-person team.
3. Define and implement an efficient Supervision-Support System for the project's health educators.
4. Improve the information collection tools, preferring quality to quantity. The creation of a "Unique Information Form" is suggested.
5. Hold information and feedback analysis meetings on a quarterly basis with all project staff and participants.
6. Implement a systematized training approach and design an Operating Training Plan by Level. Strengthen the project's health educators abilities.
7. Actively involve the MOH field health centers (FHC) in activity planning and implementation, strengthening it's training and supervisory abilities. Determine costs according to type of community personnel, identifying funding sources for allocation of resources that the FHC can use for this purpose. Gradually phase over the project to the FHC personnel under MOH Region No. 5 supervision.

8. Make necessary efforts to continue the project for at least three more years. The benefits of this extension are countless. Given actual interest of the MOH, the same activities could be replicated in a larger geographical area.

LESSONS LEARNED:

- 0 It is very important to invest time in negotiations with the Ministry of Health in order to define clearly the project. This way, the sustainability of the project can be assured to a certain extent.
- 0 Community health volunteers previously trained by the MOH are greatly motivated and respond positively to new training, leadership stimulus and supervision.

## II. THE PROJECT BACKGROUND

The Community Health Development Project (CHDP), also known as Child Survival VI, was programmed to be implemented from October 1, 1990 to September 30, 1993 in 85 rural communities in three departments of Western Honduras which correspond to Health Region No. 5.

CHDP's final objective is to "Reduce the mortality rate in infants and children ages 0-4 in the Health Region No. 5" and has as intermediate objectives: a) 20% reduction in malnutrition in children under 5; b) 50% increase in hygienic practices and the use of oral rehydration therapy (ORT) in diarrheic episodes in children under the age of 2; c) 30% increase in the number of families that adopt preventive practices and proper handling of acute respiratory infections.

The project's target population is children under five years of age and women of reproductive age in approximately 8,000 rural families. The project's total budget is US\$513,500: USAID contributes US\$385,000 and CARE-USA US\$128,500.

CHDP was presented to the International Development Agency in Washington, D.C. (USAID) for approval and funding in December, 1989. It was approved in June, 1990 and funds were made available October, 1990.

Activities, however, were initiated in May 1991 after a seven-month delay. Though procedures were started seven months in advance, the agreement between CARE and the MOH was not signed until December 1990. A second delay occurred in hiring a Project Manager because the Honduran Doctors' College demanded a long bureaucratic procedure before approving the current Project Manager. An additional element that has affected project development is the resignation of four of its seven health educators at the beginning of 1992.

The project now has a project manager (a medical doctor), a training supervisor/coordinator, 7 health educators, a statistician, an administrative assistant, and a driver. A second doctor has recently been added to the project staff, who will be in charge of coordination of the reproductive health and family planning activities to be implemented with financial support from the Population Council. The project staff receives periodic technical support from CARE's Assistant Director and the CARE-Honduras staff nutritionist.

Given this and rural conditions under which the project has operated, it is necessary to consider that the mid-term evaluation is being carried out after only 15 months of real work in the field and with only 13 months remaining to complete their original funding period.

### III. EVALUATION METHODOLOGY

The evaluation of CARE/Honduras' Community Health Development Project is based on USAID's mid-term evaluation guidelines. The evaluating team regrets not being able to include a representative from the Ministry of Health to represent the counterpart. The person appointed resigned at the last minute.

The evaluating team used different methods during the evaluation process, the participatory methodology being the most used. All project staff were involved in the evaluation exercise. Key MOH Region 5 employees were interviewed and their opinions are included in this report. The Project Manager and Training Coordinator accompanied the team during the headquarter and field health center visits and to the communities. The evaluating team interviewed auxiliary nurses, area supervisors and community health volunteers.

The USAID format 1992 MID TERM EVALUATION GUIDELINES FOR CSV FIVE YEAR PROJECTS AND CS VI THREE YEAR PROJECTS was used as a reference for investigations and report writing.

The project health educators' evaluations were done in groups, using the FODA (Group dynamic for evaluation) as an instrument. The group was able to analyze achievements, strengths, weaknesses, opportunities and obstacles with this auto-evaluation methodology. Joint group participation allowed evaluation of the high degree of motivation, team spirit and true disposition towards reaching project objectives. It also allowed identifying some immediate areas of improvement.

The team had access to all the project's statistic information. This greatly facilitated the analysis and discussion of the weaknesses and strengths of the information systems. The analysis was made with the project statistician, who made important suggestions to increase the efficiency of different data collection instruments.

The results of the Base Line Investigation and the Study of Nutrition Practices were consulted. The assistant country director gave the team ample explanation on the project. It was not possible to interview key central level MOH personnel, because the person in charge of PVO project coordination was not available.

The evaluation team was able to participate in an important community personnel training session, which allowed for interviews with many of the participants. The training methodology used, and project education aids were evaluated.

Two crucial elements prevented the evaluating team from making more visits to the communities where the project is being implemented: the short period of time designated for the evaluation (2 weeks) and the long distances needed to travel to the rural communities.

#### IV. FINDINGS AND DISCUSSION:

##### 1. ACHIEVEMENTS:

To date the project has obtained the following positive results:

- Team spirit and very high staff motivation
- Good level of coordination with MOH Region No. 5 technical personnel
- High level of community personnel motivation (94 Health Guardians and 87 Counsellors on Diarrhoea)
- Establishment of 94 growth monitoring and promotion centers at the community level
- Establishment of 90 community Oral Rehydration Units
- Initial contact and coordination with traditional birth attendants
- Participation of MOH field health center auxiliary personnel in meetings with guardians and use of community registers
- Implementation of a fairly efficient Management Information System
- Initial Base Line survey and a follow-up Community Nutrition Practices study to help design activities
- Continuous project staff training

##### POPULATION COVERAGE

Groups	No.
Women of child bearing age	7,575
Under 1 year of age	1,111
Children 1-4 years of age	4,288
General Population	30,748

##### COVERAGE OF MOTHERS AND CHILDREN WITH CHILD SURVIVAL INTERVENTIONS TO DATE:

(according to report: Comparative Data, June, 1992)

1.	<u>Growth Monitoring and Promotion:</u>		
	Talks given	141	
	Children under Supervision		72%
2.	<u>Vaccinations:</u>		
	Talks given	127	
	3rd. Doses Polio Vaccination		79%
	3rd. Doses DPT		79%
	Measles		70%
	BCG		87%
3.	<u>Diarrhoea and Cholera:</u>		
	Talks given	290	
	Diarrhoea control		(no data available)
4.	<u>Acute Respiratory Infections:</u>		
	Talks given	175	
	ARI control		(no data available)
5.	<u>Breast Feeding:</u>		
	Talks given	95	
6.	<u>Family Planning:</u>		
	Talks given	36	
	Referrals	45	
	New Users	5	

A total of 538 talks on health education have been given, benefiting 6,649 persons, including men, mothers and youngsters.

## 2. RELEVANCE OF CHILD SURVIVAL PROBLEMS:

Maternal mortality as well as infant mortality in Region No. 5, where the project is being implemented, is considered the highest in the country.

- Diarrhoea and acute respiratory infections continue to be the two main causes of infant morbidity and mortality.
- The project's baseline showed that only 4.2% of the women with children under 2 years of age are using some type of family planning method; the most often used being: pills (50%), condoms (18.8%), feminine sterilization (18.8) and IUD (6.3%).

- The investigation also demonstrated that breast feeding is practiced for less than 6 months in 71% of the cases, and only 8% of the mothers increased feeding of the child after diarrhoea or ARI episodes; only 36% of the families own and use the latrine; less than 50% of the mothers used oral rehydration salts to treat the last diarrhoea episode; and only 18% of the mothers reported having increased ingestion of liquids in the last episode of ARI.

Though the project's agreement was limited to only three interventions (malnutrition, diarrhoea and ARI), it now includes a total of six interventions. The following have been added: reproductive health and family planning, breast feeding and immunization. Though it may appear that the project is more ambitious than is reasonable, the set of interventions is justified by several reasons:

- a) In working closely with the MOH, the ministry insists that all priority interventions be covered;
- b) The baseline study showed an urgent need to include the family planning component;
- c) By doing so, the project deals with the mother-child aspect in a more integrated manner;
- d) Since all the interventions are educational and not actual delivery of services, the project does not require a massive increase of its resources.

The complete set of interventions is considered necessary to face the most relevant maternal and infant health problems.

The interventions have been prioritized according to the community's health situation and are set within the guidelines established by the MOH.

### 3. PROJECT EFFECTIVENESS:

The project does not seem to be moving as quickly as necessary to meet objectives and goals. The actual pace has been set by the development of the infrastructure necessary to make the project work at the community level and in coordination with the Ministry of Health.

Various factors have contributed to this situation:

- a) The time required to sign the agreement in December, 1990, though CARE initiated negotiations seven months in advance;
- b) The time needed to hire the project manager due to bureaucratic procedures of the Honduran Doctors' College;
- c) The lengthy process needed to agree on implementation details and adjustments with MOH Region No. 5;
- d) Difficulties encountered with the selection and hiring of staff due especially to the scarcity of certified nurses;
- e) The resignation of more than 50% of project staff at the end of 1991.

As a consequence of all these factors, real project implementation was initiated in May, 1991, which implies a 7-month delay and only 15 months of effective implementation to date.

Project effectiveness may have also been diluted for two reasons:

- a) Sufficient care has not been observed the targetting of mothers as required by the project. The entire community that attends the talks has been accepted as the target audience;
- b) Because efforts have been concentrated on the registration of all children under 1 year, follow up of children older than 1 year has not been done. These children constitute the age group with a higher risk of malnutrition.

#### 4. IMPORTANCE/PERTINENCE TO COMMUNITY DEVELOPMENT:

There are many problems in the communities that affect the health and the quality of the children's lives particularly. Among the principal barriers that prevent proper care are the following:

- a) Low level of education of the mothers that allows that myths, beliefs and "external propaganda" to have a strong influence on child care practices;

- b) A scarcity of resources combined with a low education level and a certain degree of fatalism, influence the quality of life and hinder adoption of proper health practices at the community level.
- c) Difficult geographical (up to six hours on the road from one place to another) and psychological barriers (people are not always nice; indifference and a perceived lack of medicines) make community access to health services very difficult.
- d) The size of the family that reduces the resources available at home level and causes severe wear on the mother.

The project responds directly to the previously mentioned barriers as follows:

- a) Community education and development the ability to locally manage health problems, and breaking of certain myths and beliefs;
- b) Promotion of Family Planning to give the couple the option of spacing pregnancies and the decision of how many children they want;
- c) Transfer of certain preventive health services to the community;
- d) Strengthen, through training, the organization and community participation for the local identification of, and search for solutions to, the principal health problems.

## **5. RESPONSIBILITY OF PROJECT IMPLEMENTATION:**

### **5.1 Evaluation of Project Design:**

The project design clearly establishes the target population and the geographical area for implementation. However, it is obvious that the selection of such disperse areas has contributed to the dilution of efforts due to the time needed for start-up and logistical support.

Working with only a group of communities from each field health center makes project evaluation of impact at health center level more difficult and creates two types of community personnel (CARE-supervised and others).

From the geographical point of view, the project was ambitious in initiating simultaneously in all the areas to be covered. However, when you only have three years to implement and reach the objectives and goals, its not possible to develop a pilot area that allows the interventions to be refined prior to their being implemented as a whole.

Implementation of Child Survival interventions has been gradual and has responded to the needs of the community as well as to the priorities of the MOH.

The project has clearly defined and measurable objectives. However, a well established relation does not exist between objectives, products and activities that allow, on one hand, that all staff have a clear vision of the project and on the other, make it possible to monitor the advances in relation to the objectives in a more effective manner.

It is evident that management has been open to suggestions and changes needed in the project. Though only three interventions were planned for child survival, the project is actually implementing six.

Conversely, the project has dedicated a large portion of time and resources to respond to the MOH's interest to introduce and use the "under-one" beneficiary registers at community level. However, the attention given to these registers has resulted in less attention to follow up with children older than one year which is also necessary to achieve the project's stated objectives.

It bears mention that the most difficult of the project's three objectives is the one which intends to reduce malnutrition by 20%. This is due to the short time frame and the way the project is being implemented actually which does not allow for monitoring of children over one with growth deficiencies; it also does not facilitate advising mothers of the proper care of children under one year.

## 5.2 Management Evaluation and Use of Information:

The project does not have its own Health Information System. It is interesting to observe that, contrary to other such projects, CHDP adapts

the MOH's existing Health Information System to its needs, creating its own monthly and quarterly information collection forms.

The forms allow for collection of data from the under-one registers that function at community level, educational activities and data on diarrhoea, which are obtained from the Community Oral Rehydration Units. In addition, information generated by field health centers where the project is implemented is collected every month on services delivered.

#### Quarterly Information:

- Information is obtained from the registers filled in by the community volunteers and therefore one must assure that the information is complete and accurate. On one of the registers seen by the evaluators, at least 50% of the children under one year were missing (Pastoreadero community).
- The same register is filled in by the Project Health Educator and field health center, which indicates a further duplication of effort. This situation can lead to too little attention being given to the community volunteers' list since the educator and auxiliary nurse have their own independent information.
- The information obtained in the quarterly form covers all project aspects of child survival. However, data on diarrhoea, ARI and referrals, are too vague to be of use when making decisions. The form also collects unnecessary information on growth monitoring and maternal high risk.

#### Monthly Education Activity:

- Allows monitoring of visits to villages, number of talks and subjects covered, number of participants, number of groups formed and quantifies the new community leaders. However, it does not distinguish the total number of women trained in each of the project's specific target subjects.
- The evaluating team considered it unnecessary to collect all this information on a monthly

basis especially as the required information can be collected in a more integrated manner in a quarterly form. (Number of talks, subjects covered, number of women trained number and type of community groups formed).

**Register of Diarrhoea Information:** (includes 3 forms)

- **Monthly Summary of Activities:** This form is unnecessary since the information can be collected on the quarterly form. The columns "Diarrhoea Cases without dehydration" and "ARI" can be eliminated.
- **Daily Register of Consultations:** is adequate but should include a column on home visits for each patient.
- **Diarrhoea Referrals:** The instrument is too complicated to be used by a community volunteer and the data is not essential in handling a case. It would be more appropriate for a card to include criteria for referrals for any person (diarrhea with dehydration, complicated ARI, family planning, etc.) This card can be perforated in half and be filed with the field health center and allow community educators to quantify their monthly referrals. The other half is used by the health center as a counter-referral tool that is returned to the community volunteer.

The referrals will be monitored by the filed cards at health service level and will allow an efficient evaluation of this activity.

#### **Project Indicators:**

The project has a total of 34 indicators of which 23 require routine monitoring. Only 14 are being monitored.

For the Growth Monitoring Indicator, routine monitoring through the registers is not achieving its purpose because by doing it every two months and only for children under one year, the opportunity for an early detection of abnormal growth is lost in the children and more so in children over one year.

Of the nine indicators not being monitored, the latrine one can be eliminated if the project is not involved; the one concerning number of MOH staff trained and the one regarding health centers with medicines for treatment of moderate and serious ARI should be added to the information system; and the other six should be monitored by quick surveys and/or evaluation of knowledges and skills gained after each training session.

#### **Use of Base Line Information:**

Base line data was used, in general, to corroborate the project's work hypothesis. This data was also used to establish priorities as in the case of under utilization of family planning methods, which prompted the development of a specific family planning and reproductive health component to be funded by the Population Council as a corollary activity.

#### **Use of Management Information:**

The project generates valuable information for monitoring and readjustment of activities, which seems not to be used by field staff and much less shared with the community. For example, though only 30% of the planned talks had been given and 57% of the visits to villages in June, 1992, no action was taken to either readjust the goals or increase the necessary resources.

Though sufficient information is generated, it seems to be concentrated with the statistician who makes much effort to present it in an understandable form but without giving systematic feedback to the project staff or the communities.

A quarterly report is submitted to the regional director, but meetings to discuss advances, achievements and difficulties are not planned.

### **5.3 Community Education and Social Promotion:**

The project concentrates efforts in health promotion and limits its delivery of services to attention to diarrhoea cases. The project has framed its actions within a strong community education component.

Except for the baseline survey and a nutritional survey of feeding practices, there have been no other investigations on which to base the development of education messages. Informally, however, with the participatory training methodology that is used, educators try to develop their health messages based on their knowledge of the community. This methodology, however, needs to be improved and applied to smaller groups of participants.

The distribution of printed materials is done according to availability in the MOH. These materials are considered very valuable by the entire community who request them continuously.

The project has not systematically evaluated knowledges acquired nor the effectiveness of the methodology used. Project staff inform, in an anecdotal manner, that they can observe some changes and improvements in home hygiene, but it cannot be quantified nor is there any criteria for its monitoring.

#### 5.4 Human Resources for Child Survival:

The project has 13 full time employees of which the project manager (1), supervisor (1) and educators (7) have local counterparts. This staff is supported by two professionals (the CARE nutritionist and Assistant Country Director) on a part-time basis. Project staff show great motivation to develop their work, in some cases carrying out tasks beyond their job descriptions.

However, it bears mention that the educators are overloaded and this makes it difficult for them to give their activities sufficient attention.

In addition to the staff mentioned, volunteers chosen from their respective communities where they lend their services, participate effectively in the project. The project actually boasts a total of 181 active volunteers, 94 Health Guardians and 87 Diarrhoea Counsellors.

The project's work methodology has been to assign a specific duty to each volunteer, however, in some cases the same person carries out more than one task at a time. This distribution of duties allows each one to have a reasonable work load.

Each volunteer participates in an initial five-day training; they then receive another five-day training in filling out the registers (that includes discussion of child survival subjects) and an additional five-day training in handling diarrhoea cases. During the present evaluation, volunteers received another course on nutritional education and during each monthly visit, they receive continuous education from project staff.

The project has not yet explored the need to evaluate the level of knowledge, abilities and skills that volunteers possess. Training, therefore, has been designed considering the same should start from zero. Since training has addressed specific actions such as filling in registers, weighing children and preparation of oral rehydration salts, the methodology included all the necessary practices to augment their ability to carry out their work.

Duration of training seems to have been enough to initiate volunteers in the implementation of their programmed activities, especially when taking into account:

- a) Volunteer staff cannot be away from their community occupations for more than five days at a time, and
- b) When educators visit the volunteers in the communities, they provide follow-up training in necessary aspects.

#### **5.5 Supplies and Materials for Local Staff:**

The community volunteers have received basic materials to carry out their designated activities (weighing scales, cards, lists, pencils, rulers, rehydration salts, pamphlets on diarrhoea, etc.). This material is well appreciated and well used and is adequate for the work they carry out. However, they feel the need to have further material to support their education activities. They request posters, flipcharts, flyers and some requested the book "Where There is no Doctor".

#### **5.6 Quality Evaluation:**

Due to time limitations and great distances, it was not possible to evaluate whether the volunteer personnel have the knowledge and ability to give

adequate advice to mothers. However, through observations made during the community volunteer training event, it can be said that those abilities and knowledge are well in the process of being developed.

#### **5.7 Supervision and Monitoring:**

This component is one of the weakest aspects of the project. Due to its nature, dependence on the use of the MOH supervision and information instrument does not seem pertinent. The project does not have its own supervision-support system that contains the following elements:

- a) Quality and trustworthiness of information,
- b) Program advancement,
- c) Compliance with protocols (training and referral),
- d) Presence of necessary material and equipment (for educators and community volunteers),
- e) In-service training (for staff and participants).

Efforts made to systematize supervision have not given positive results and have caused certain discomfort among supervisors. The creation of a supervision-support system based on the needs and problems of the supervised party and that systematically involves MOH personnel, in the field health centers as well as in the community, is urgently needed to assure adequate work quality.

#### **5.8 Use of Funds:**

The evaluating team did not evaluate this point because it was not considered applicable to the evaluation.

#### **5.9 Use of Technical Assistance:**

The project has received technical assistance from three sources: CARE's Latin American Regional Technical Health Advisor (in the definition of indicators, base line instruments), nutrition technical assistance from CARE-Honduras (design of training plans and nutritional survey) and Management Sciences for Health (implementation,

processing and analyses of survey results). In addition, the project was visited by the director of the CARE-New York Health Unit. All assistance was relevant and has had a positive effect on the project.

In order for the project to improve its interventions and to better reach the objectives, two types of technical assistance are required. The first is in the managerial area (including definition of a logical framework that allows staff to have a clear vision of what is meant to be obtained) and in supervision (including drafting of adequate supervision guidelines).

The second area is in training, where the project needs to (a) define a global project training plan and (b) strengthen the team in managing the participatory methodology.

#### 5.10 Relations with Counterparts:

The two project counterparts are the Ministry of Health and the community. The project geographical area was defined jointly with the MOH. Having the project's main office within the physical installations of the MOH Region 5 headquarters is an advantage since it allows better coordination. With help from the community, volunteer collaborators have been selected and other groups have been organized to help support project activities.

The Project and MOH, with volunteer personnel participation, will coordinate monthly health education activities.

There is mutual interchange and support in relation to human and material resources between the project and the MOH when the interventions require it, without going through long bureaucratic tangles.

The MOH has the managerial and technical capacity to take over the project within its operating units. However, it seems difficult for it to have an effective community projection, due to the limitations of resources and logistical support that this type of educational project requires.

Even if it were possible to manage project activities at the field health center level, MOH field personnel require reinforcement in effective supervision and training methodologies.

Though it is evident that there is a cordial relationship between project staff and MOH, which allows frequent sharing of ideas, this sharing is very informal and therefore not systematic at all. There seems to be more distance at the level of the Region's Director and Project Manager since there are no established mechanisms that allow both to analyze the project's progress in a periodic manner.

The MOH Regional Director recognizes that this situation is not CARE's sole responsibility, but that of both parties. He said he was willing to more closely coordinate activities in the near future.

#### **5.11 Referrals:**

The project implementation area has 23 MOH field health centers that deliver services. For many communities, these services are too far away to be used effectively. On the other hand, not every one of them has the ideal personnel to give medical attention nor do they always have the necessary medicines to handle specific cases. Where the project has best taken advantage of these referral places is in the immunization and family planning areas, though for the latter, achievements are still too low.

There exists already a relationship between health centers and the community since the monthly coordination meetings with volunteer personnel are carried out in these centers. The project, at the community level, is promoting the use of MOH health services, through education and referrals. However, there are no specific actions by the project to strengthen the capacity of health centers to provide better services.

#### **5.12 Coordination with Development Organizations:**

Coordination with other development organizations has been achieved on various occasions. Project staff participated in a Child Survival Program Management Seminar with other development organizations that work in the same type of project

and there is the intention to continue this type of sharing.

Coordination has also taken place with ASHONPLANFA (development organization specialized in family planning projects), who was responsible for family planning talks given to project staff.

#### 5.13 Budget Management:

To date the project has expended a total of US\$214,300, 41% of the global budget. This expenditure corresponds to a real implementation period of 15 months.

Of the total funds expended, 73% (US\$156,350) is USAID funds, and 27% (US\$57,950) CARE-USA funds. With the remaining budget, and operating under the existing structure, the project can continue operating until approximately March, 1994. However, since hiring of two new educators is being recommended, this might mean a reduction of one or two months from this extended time frame.

#### 6. SUSTAINABILITY:

The project has taken care to not give economic incentives to community volunteers. The strongest incentive to date has been the training offered by the project and the prestige that a community level position offers.

The strongest incentives at the MOH level are that the project is implementing educational programs that are part of the country's Health Policy, that it supports the community education methodology and that it follows national norms. Although community participation in project activity planning and implementation is not active, the MOH seems to think it is more effective and necessary since it responds to perceived local needs.

It bears mention, that if the project had a strong community participation component it would make its sustainability more difficult because this methodology is currently not within the MOH's reach. On the other hand, the project does require greater involvement by health personnel that work in the MOH field health centers for its sustainability.

Due to special interest shown for the project by the MOH and the possibility of involving more health personnel in the field health centers in effective supervision and training of health voluntary personnel, the possibilities for continuity of the project are very high.

**7. RECURRENT COSTS AND RECOVERY MECHANISMS:**

Though specific figures are not available at the moment on recurrent costs for community volunteers (including cost of registers, pencils, rulers, referral cards, lunch on monthly meeting days, etc.), the evaluation team considers that the project should carry out a study of these costs and the possibility of generating the funds at each field health center level or obtaining them from other sources in the region.

## V. CONCLUSIONS AND RECOMMENDATIONS:

In this section, the team presents specific recommendations to help obtain the desired results at the end of the project and to be able to measure their impact. In addition, recommendations are also made regarding sustainability, given the importance of the sustainability issue.

The team found evidence that allows it to state that project interventions are tending to reduce the morbi-mortality maternal-child rates and obtain achievement of its objectives and goals, although there exists some in the coverage of the target population.

### 1. Project Management:

Regardless of its late start, the project has managed to advance significantly, as is shown by the achievements previously mentioned. However, staff do not have a clear picture of the project as a whole, and the objectives and goals that should be reached at the end of the project. On-going project actions have little probability of reaching the stated objectives.

It is recommended that a seminar for all staff be organized to analyze the project and define a logical framework that relates objectives, goals and concrete activities that would allow them to have a clear vision, plan more effectively and to monitor specific project advances.

Other aspects that should be analyzed are the adjustments that the project has to do to increase its possibilities of reaching the proposed objectives. For example, if the project is limited to promoting growth monitoring in children less than one year every 2-3 months, it will be very difficult to reach the goal of reducing malnutrition (20%) in children under five years of age. The achievement of this goal requires timely identification of children with growth problems and effective advice to mothers on adequate breastfeeding and weaning practices and diet handling during episodes of illnesses.

The same type of analysis should be made of the other two project objectives.

### 2. Project Coverage:

The geographical area where the project is being implemented is too large and given the resources available, it is too difficult to cover effectively. Two factors have a negative influence:

- a) project staff have to travel long distances to places of difficult access, and
- b) they cannot concentrate their efforts in strengthening the capacities of the communities and MOH field center staff when they have to split their time between more than one field health center.

It is recommended that the project have one educator per health center and that s/he, in close coordination with the MOH field staff, cover a maximum of 12 communities prioritizing them based on health indicators.

### 3. Supervision-Support System:

The project does not have a defined Supervision-Support system nor adequate tools to cover its needs. Because of this, there is no clear distinction between the Manager's field duties and that of the Training Coordinator. There is an overlap of authority and loss of leadership of the Coordinator.

#### The following is recommended:

- 1) Technical assistance to develop a Supervision System that will allow the following elements:
  - a) Quality and trustworthiness of the information,
  - b) Program advances,
  - c) Compliance of protocols
  - d) Presence of necessary material and equipment,
  - e) In-service education.

This system should contemplate an efficient "Supervision Tool" that serves as a guide and is applicable in all levels of supervision. The same system should be used by educators when supervising community personnel.

The supervision system should generate the qualitative information that the project needs.

2. Due to lack of cooperation between the Training Coordinator and Educators, hiring a more qualified person for this position is recommended. This person should have experience and proven supervision abilities and management of training participatory methodology.

3. The information system used by the project has the advantage that it is based on the MOH's which it complements adequately. Data generated is up to date and presented adequately for analysis though the information is sub-utilized by project staff.

On the other hand, there is a disadvantage - it does not allow the project to monitor children over one year nor the coverage of mothers participating in training. In addition, it collects data that is not needed and in some cases, triplicates the same information.

The following is recommended:

- a) Use the quarterly form as the "sole instrument" to collect information periodically (in each visit to the community).
  - b) Eliminate the register currently managed by the project educators;
  - c) Eliminate the form "Monthly Summary of the Oral Rehydration Unit Activities" and integrate it into the quarterly form;
  - d) Eliminate the specific form for diarrhoea handled by the community and substitute for it a common card for all referrals;
  - e) Monitor referrals through the cards that are filed at field health centers;
  - f) Eliminate the monthly report on education activities adding pertinent data to the quarterly form (see section 5.2);
  - g) Eliminate data from the quarterly form, that is not needed for decision making;
  - h) Add to the quarterly form the two indicators (number of MOH personnel trained and number of establishments with medicines to treat moderate ARIs).
4. The information generated by the system is not analyzed systematically by the team, nor is there feedback by levels.

It is recommended that quarterly meetings be held to analyze information, evaluation of progress towards project objectives, discussions of problems and search for joint solutions and feedback.

5. The project has made significant efforts to train its staff in management of the participatory training methodology. During the training activities for community personnel, the evaluators were able to observe that staff are willing and wish to apply this methodology but frequently fall back into the classic system of training (teacher-student style, use of inadequate terminology, etc.).

Technical assistance is recommended to define the project's global Training System, design individual training plans for educators, strengthen the participatory methodology techniques, and train in evaluation techniques (quantitative and qualitative), at educators' level, as well as at community and mothers level.

6. Due to the actual implementation methodology, the project has very little chance of sustainability because it has concentrated its efforts more on the community rather than the health center level. The MOH has little probability of keeping a community-level project with dedicated educators, due to its limited resources and style of work with institutional emphasis on field health centers and curative health services.

A change in emphasis addressed towards strengthening the MOH field health centers would significantly increase the possibilities of sustainability.

The following is recommended for Field Health Centers (FHC):

- a) Involve the FHCs more actively in planning and implementation activities,
- b) Strengthen its capacity to train and supervise community personnel,
- c) Determine the recurrent costs of training and supervising community personnel,
- d) Identify funding sources to assign the resources to the FHC for this end,

- e) Slowly delegate project duties to the FHCs,
  - f) Support the MOH in evaluation of the cost/benefit that the community personnel work represents in the extension of health services.
7. Though project implementation had advanced greatly, the time left is too short to reach objectives and address the sustainability issue.

It is recommended that CARE-Honduras make the necessary efforts to continue the project for at least an additional three years.

The benefits of this extension are incalculable if it takes into account that given the MOH's interest in the model, the same could be replicated in a greater geographical area, i.e. the rest of the rural communities of Region No. 5.

## VI. LESSONS LEARNED:

1. The evaluating team has been able to confirm the fact that the considerable time spent on negotiations with the MOH to define certain key aspects of the project, was valid, since it allowed the MOH to support the project because it considers that the project's actions conform to its priorities. This attitude helps assure, to a certain degree, the project's sustainability and expansion of its geographical areas of action.
2. In general, it has always been considered that the active life of community personnel is not too long since they lose motivation and abandon their activities. The project has demonstrated that community personnel motivation, in general, is there and only requires a small effort to revive interest and that the desire is there to serve their community, without any further type of economic incentive.

APPENDIX I

PERSONS CONTACTED

MINISTRY OF HEALTH:

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EDUCATOR - SINUAPA  
EDUCATOR - PASTOREADERO  
EDUCATOR - ERANDIQUE  
EDUCATOR - NUEVA ARMENIA  
EDUCATOR - CANDELARIA  
HEALTH GUARDIAN: EL ROSARIO  
HEALTH GUARDIAN: PLAN DEL RANCHO

CARE-HONDURAS OFFICE:

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CARE-HONDURAS ASSISTANT COUNTRY  
DIRECTOR  
PROJECT TECHNICAL ADVISOR AND CARE  
NUTRITIONIST

## APPENDIX II

### DOCUMENTS

1. CHILD SURVIVAL SIX GUIDELINES FOR EVALUATION
2. DETAILED IMPLEMENTATION PLAN 1991-1993
3. REVISED PROPOSAL (SPANISH VERSION OF DIP)
4. FAMILY HEALTH SURVEY, BASELINE SURVEY
5. EPIDEMIOLOGY AND FAMILY HEALTH SURVEY, HONDURAS, 1987
6. SURVEY OF PREGNANT WOMEN AND WOMEN WITH CHILDREN UNDER ONE YEAR OF AGE, HONDURAS, 1988
7. SIX MONTHS REPORT: JAN-JUN 1992, PROJECT PROGRESS REPORT
8. AGREEMENT BETWEEN THE MINISTRY OF HEALTH AND CARE INTERNATIONAL IN HONDURAS FOR IMPLEMENTATION OF THE COMMUNITY HEALTH DEVELOPMENT PROJECT IN HEALTH REGION # 5.
9. STUDY OF FEEDING PRACTICES IN REGION # 5, CARE CHILD SURVIVAL PROJECT, 1992

APPENDIX III  
EVALUATION ACTIVITIES  
CHRONOGRAM: AUGUST 17 - 30, 1992

MONDAY, 17	*	MEETING IN CARE OFFICE, TEGUCIGALPA
	*	INTERVIEW WITH MIKE GODFREY
TUESDAY, 18	*	TRIP TO SANTA ROSA DE COPAN
	*	INTERVIEW WITH PROJECT MANAGER
WEDNESDAY, 19	*	FIELD VISIT: PIRAERA COMUNIDAD EL ROSARIO
THURSDAY, 20	*	FIELD VISIT: SINUAPA
	*	INTERVIEW WITH FIELD HEALTH CENTER PERSONNEL
	*	INTERVIEW WITH MOH AREA # 4 PERSONNEL
FRIDAY, 21	*	INTERVIEW WITH KEY OFFICE STAFF
	*	MINISTRY OF HEALTH REGIONAL OFFICE
	*	INTERVIEW WITH CARE PROJECT OFFICE STAFF
	*	INTERVIEW WITH MANAGEMENT SCIENCES FOR HEALTH TECHNICAL ADVISOR
SATURDAY, 22	*	MEETING AND ANALYSIS WITH PROJECT TEAM
MONDAY, 24	*	OBSERVATION OF TRAINING ACTIVITIES WITH COMMUNITY PERSONNEL
	*	INTERVIEW WITH HEALTH GUARDIANS AND COMMUNITY VOLUNTEERS
TUESDAY, 25	*	OBSERVATION OF TRAINING ACTIVITIES WITH COMMUNITY PERSONNEL
	*	INTERVIEW WITH HEALTH GUARDIAN IN SAN MARCOS DE OCOTEPEQUE
WEDNESDAY, 26	*	RETURN TO TEGUCIGALPA
THURSDAY, 27	*	FIRST DRAFT OF REPORT
FRIDAY, 28	*	MEETING TO INFORM OF RESULTS OF EVALUATION
SATURDAY, 29	*	CORRECTION OF DRAFT
SUNDAY, 30	*	FINAL DRAFT
MONDAY, 31	*	DELIVERY OF FINAL REPORT

Translation by Patricia Gamero de Arce  
Tegucigalpa, D.C. September 22, 1992