

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

1993 ANNUAL REPORT
Submitted October 28, 1993

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Project Dates: September 1, 1989 - August 31, 1994

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**WORLD RELIEF HONDURAS
CHILD SURVIVAL PROJECT - GUAYAPE
ANNUAL REPORT YEAR 4**

I. OVERVIEW OF YEAR ONE

A. Progress on project objectives:

A chart showing progress on project objectives is attached in Annex A.

The Child Survival Project (CSP) has exceeded its goals for year 4 on objectives 1, 3, 7, 13, 14, 19, and 20, and has met its year 4 goal on objectives 8 and 17).

However, the CSP has been unable to meet its year 4 goals for objectives 2, 4, 5, 10, 11, 15, 16, and 18.

B. Year 4 training activities for project staff:

- * Seminar on Vitamin A and other Micronutrient, sponsored by the International Eye Foundation (IEF) on October 6, 1992. The two Area Coordinators (ACs) of Child Survival Program-Guayape (CSP-G) attended. The CSP-G Director participated as moderator of one subject.
- * Training Workshop on Acute Respiratory Infections/Control of Diarrheal Diseases (ARI/CDD) Supervision Abilities in Tegucigalpa from November 2 - 6, 1992. It was attended by ARI/CDD officials of the Ministry of Health (MOH) and by the CSP-G Director, who participated as facilitator. Both ACs of the CSP-G participated, together with representatives of 10 Non-governmental Organizations (NGOs) who work in the health area.
- * Workshop on "Operational Planning", sponsored by FOPRIDE (Federation of Private Development Organizations), on December 8, 9 and 10, 1992. The Director and the Field Assistant of the CSP-G participated.
- * Workshop on "Prevention of Deaths from Pneumonia", led by the CSP-G Area 1 Coordinator on December 14 and 15, 1992. All the Health Promoters (HPs) of this area participated.
- * Conference on "Vitamin A and other Micronutrient", sponsored by the International Eye Foundation (IEF) on January 18, 1993. The two ACs attended.
- * Workshop on "Training of Traditional Birth Attendants (TBAs) Using Focus on Risk and Participatory Methodologies", which was led by the MOH and the Pan American Health Organization (PAHO) on January 19 and 20, 1993. The two ACs, the Field Assistant and the Director of the CSP-G participated.

- * Reinforcement training on the "Prevention of Deaths from Pneumonia and CD", led by the CSP-G ACs, on February 15 and 16, 1992, using Pan American Health Organization (PAHO) materials. All of the Health Promoters (HPs) of the CSP-G participated.
- * Workshop on "Advanced Leadership", led by the Haggai Institute in Tela from May 3 to 7, 1993, in which the Area 1 Administrator, the Field Assistant and the Finance Assistant participated.
- * Workshop on "Human Reproduction, Pregnancy and Delivery", imparted by Dr. Sonia Hernández, TBA program facilitator, to 15 CSP-G HPs on April 26, 1993.
- * Workshop on "Leadership and Social Promotion", imparted to all the CSP-G personnel by Dr. David Harms and Rev. Absalon Zavala from May 26 to 28, 1993.
- * Workshop on "The Nutritional Basis for the Use of Mixtures of Vegetables and Cereals on Children Under 5 Years of Age". This workshop was given by Mario Nieto on May 27th and 28th, with the participation of the CSP-G Director, Field Assistant, ACs, 2 Facilitators and 4 HPs. This same workshop was imparted to the rest of the HPs in their corresponding area during the month of July.
- * Workshop on "Sexual Education", imparted by ASHONPLAFA (Honduran Association for Family Planning) from June 7 to 11 to all the HPs and ACs of the CSP-G.
- * Workshop on "Sustainability", sponsored by World Vision from June 2nd to 4th, in which the Facilitator for the Training of TBAs and Health Guardians (HG) of Area 1 and 2 of the CSP-G participated.

C. Technical support received in Year 4 for child survival field activities:

- * Visit of Kevin McKemey of the Central Office of WRC, from November 23 to 25, 1992, who gave managerial advice to support the direction of the CSP-G, and timely suggestions for improving the experience of the focus based on risk which was initiated.
- * During the first week of February 1993, Ken Graber of the WRC Central Office visited WRH and observed the integrated experience of Child Survival/Community Banks in the city of Catacamas, Olancho, and gave technical advice to this program.
- * Technical Assistance given by Dr. Alejandro Melara, Honduran consultant who led the revision and readjustment of the Health Information System (HIS), during the month of August 1993.

- * Literature sent by the WRC Central Offices during the whole year to support the management of the CSP-G.
- * Regular contact by phone and fax (on average biweekly) with the Child Survival staff, World Relief, Wheaton.

D. Local Health Committees organized:

A. A total of 94 Local Health Committees (LHCs) were organized by the end of Year 4. The LHCs members have been trained in the different interventions of the CSP-G, in order to focus on giving support to the HGs in their activities, which in turn gives them the confidence to start other health activities which respond to the different health problems of their communities.

The major activity which the members of the LHC have carried out is the support of the HG in his/her activities, especially in the weighing sessions. In these sessions, 5 or 6 members carry out the promotion of the activity, and during the session they divide the work: some help to weigh children, others draw the corresponding growth curve, interpret it, and discuss it with the mothers, while another member registers the data on the information sheet.

The LHCs have also collaborated in the vaccination activities. During the national vaccination campaign carried out during the month of October, 1992 and the last week of April, 1993, the LHCs participated in the promotion and organization of the people in their communities to ensure that the women and children were vaccinated. Likewise, throughout the year, they have collaborated in the vaccinations carried out by the health centers.

Another important activity of the LHCs is the transmission of basic messages to the people during weighing sessions, as well as during home visits, social gatherings and meetings in the community health center.

In addition, LHCs have carried out community cleaning campaigns of homes and streets deworming of children, by requesting the help of the personnel of the health centers. In some communities they have also facilitated the vaccination of dogs and the building of latrines.

E. Linkages made between the project and the MOH and other health and development activities in country include:

Coordination with the MOH.

As of the first quarter of the year, joint supervisory visits (CSP-G Coordinator/MOH Area Chief or Area Nurse) have been carried out. In these visits, CSP-G HIS instrument No. 20 (see Annex B) has been used as a supervisory guide. The work of the Auxiliary Nurse (AN) and the HP is evaluated, and the decisions are made as a team.

In some zones, joint supervision by the HP and AN has been carried out, but has not been consistent throughout the project, providing a goal for future improvement.

Support was given to the national vaccination campaigns from October 12 to November 12, 1992, for the campaign for the eradication of measles, and the last week of April, 1993, the national immunizations. The CSP-G participated in the promotion of the event in the organization of the community, in logistical support and application of the vaccines. The institutional personnel of the CSP-G and the community volunteers participated.

The program also contributed to the training of MOH personnel on the new focus on Acute Respiratory Infection (ARI). From May 15 to 18, 1992, the CSP-G Director was trained by PAHO (Dr. Juan Carlos Bossio, Advisor of the Program ARI/PAHO) as Facilitator for the Managerial Course on Control of Acute Respiratory Infections. From May 18 to 22, the Director of the CSP-G served as facilitator for this course at a national level with 40 participants, among them MOH Central and Regional level Technicians, Professors of the National Autonomous University of Honduras (UNAH) and two representatives of other Private Volunteer Organizations (PVOs).

On August 5 and 6, 1992, the CSP-G Director trained as facilitators in the ARI Course, the Regional Education Director and the Regional Chief of the Maternal-Child Program of the MOH Sanitary Region No. 7, including the Area Chief and the Nursing Supervisor of Area 2 of Sanitary Region No. 7 of the MOH, as well as the two ACs of the CSP-G. At the same time, this team trained, during the months of August and September 1992 and January 1993, 150 members of 20 health centers with which the CSP-G coordinates in Area 2 of Region 1.

In all the training workshops of this Sanitary Region, the CSP-G used and handed out material produced by PAHO, as well as posters of standard treatment guides of children with pneumonia, to be placed on the walls of all the health centers of the area.

Seventy percent (70%) of the training workshops of HGs have been carried out by the CSP-G HPs as a team with the MOH ANs.

The ACs (ACs) and the HPs of the CSP-G have frequently attended the meetings of the MOH area personnel, where they have discussed the joint work efforts which they have carried out and then have made outlines of work plans.

Based on the survey on "Mortality of Women in Reproductive Age and Maternal Mortality" carried out with the support of several international organizations in 1990, the MOH designed a program of training of TBAs with the purpose of contributing to the reduction of maternal and perinatal mortality, and they invited World Relief to participate in its implementation. WRH agreed to participate, using funds of the Honduran Fund for Social Investment (FHIS) for the startup of the program which is in progress.

Work has begun in the CSP-G area to train 500 TBAs.

In Area 1 of the CSP-G, all the activities carried out by the MOH on AIDS Day (December 1) were supported. Public marches were carried out in areas where written and oral basic messages appeared on the prevention of AIDS, and the AC of the CSP-G gave a talk on the subject on a local radio program.

F. Professional staff who have joined the project since the DIP was submitted:

The names, job descriptions and staff who joined the project in Years 1 and 2 included in previous annual reports. Personnel and organizational changes which have been made since Year 2 are shown in the organizational chart in Annex C.

During the year, are included in previous annual reports, as well as there have been changes in the organization of the Project, and personnel has been hired to fill in some new positions. (See the Organizational Chart in Annex C).

In effect, given that the work area of the CSP-G is large, with many population groups spread out among mountains connected by poor roads, it was necessary to make adaptations to strengthen the supervision, monitoring and evaluation systems in the field.

At the national level, the position of Field Assistant was created and it was filled by Dr. Joel Daniel Durón.

Each area was subdivided in two geographical sectors, and for each sector it was necessary to have one Health Facilitator. Two of the best HPs of the CSP-G Area 1, Iris Rodriguez and José Ursulo Suazo, were promoted as of January 1993 to these positions (resumes not included).

As the implementation of the Project has advanced, the need for administrative support has increased, for which reason Antonio Moradel was hired as Area Administrator/Accountant for Area 1 as of September 1991; and Mireya Colindres was hired as Administrative Assistant at the national level as of September, 1992.

In January 1993 Martha Elena Umaña filled the vacant position of Programmer/Analyst.

In September 1992, Nolvía de Rodríguez filled the position of Finance Assistant vacated by Sandra Chavéz. In January 1993 Guadalupe Solís replaced Silvia Hernández as Area 1 Coordinator, and in July 1993 Carlos Hernández filled the vacancy of Educational Specialist.

The descriptions of these new positions and the resumes of the different persons who filled them are attached in Annex D.

II. CHANGES MADE IN PROJECT DESIGN

A. Measurable Objectives

The chart of objectives is shown in Annex A. No revisions in project objectives were made since the second annual report, except that an error in number of women exclusively breastfeeding was corrected to reflect the number of children born rather than all fertile aged women.

During Year 4 the objectives remained the same, but we have found some problems in the way we have been evaluating the interventions which have to do with acquired knowledge.

For example, we suspect that if a change in behavior is achieved at a certain moment, it does not mean that this change is permanent. For example, when the cholera epidemic in the country started, a high percentage of the population practiced the preventive measures which were recommended. But it is possible that presently the concern for this disease has diminished, and very few people are still practicing these measures. This means that adding up registered data on behavior at different moments could give place to unrealistic data of what is currently occurring in the population.

It has been decided that instead of a routine recording of the behaviors, a periodic evaluation will be made of what is occurring with regards to community practices by means of Centennial Sites. Based on this information, we will make an evaluation of the tendencies in the behavior promoted for each intervention. This will be implemented in the HIS which will be used as of next year.

B. Type or Scope of Child Survival Interventions

When the DIP was elaborated, it was established that the community would be trained and serve basically by means of the HGs, but after several years of experience, we learned that this produces a work overload for the HG and that it is one of the main causes for their desertion.

For this reason, since Year 2 the CSP-G expanded the strategy of spreading messages to the community by means of the following media and methods: (See Annual Report 2, section I.C. in Annex E).

- 1) Carrying out social marketing of basic messages
- 2) Incorporating the public grade schools and churches as elements of transmission of basic health messages
- 3) Establishing a new work approach for HGs in communities with urban structures based on representatives of small blocks of 10 to 15 homes.

During the fourth year, as a response to the mid-term evaluation recommendations and the problems of the HGs mentioned above, the project initiated the "Work Strategy Based on Focus on Risk". See Annex F.

Besides the changes in the work strategy, there have not been any other variations in the type or scope of the interventions of child survival.

C. Location or Number of Project Beneficiaries

The geographical area of the Project remained up to the end of the first year as was originally proposed in the DIP. Nevertheless, during Year 2 the area was expanded, adding the counties of Concordia and Campamento. This situation modified the distribution, but not the number of beneficiaries, which continues to be at 18,824 children and 19,136 women, as a goal to be achieved by the end of the fifth year of the Project. Likewise, the total population within the area of the project is still approximately 104,000 inhabitants. (See Annual Report 2, Section I.B in Annex G.) There have been no changes from what was reported in Year 2.

D. Budget

No changes were made to the Budget in the past four years of the project.

III. CONSTRAINTS, UNEXPECTED BENEFITS AND LESSONS LEARNED

A. Constraints Which Have Affected Project Implementation:

- 1) The major limitations experienced in the CSP-G during the reported period, is the high desertion level or rotation observed among the HPs. The main explanation is that we have not been able to find personnel with the appropriate education level within the work area. For this reason, we have had to relocate persons from other regions of the country to work for the CSP-G and often they have returned to these regions for family reasons or for other causes which are out of the control of the administration of the project.

Towards the end of the third year, the position of Health Specialist was vacated, due to the fact that this position was budgeted for only the first 3 years. However, during the 4th year, we felt the need to fill this vacancy, especially to improve the functions of coordination, evaluation and monitoring of the training process of the CSP-G. In view of this need, and the fact that the Project had the necessary budget, we contracted a new Education Specialist at the end of Year 4.

It is appropriate to mention the resignation of the following key personnel:

- a) the Finance Assistant, who left at the end of the third year to under-take a personal project

- b) the Coordinator of Area 1, who left the Program and moved to Tegucigalpa in order to acquire a specialization in the medical field
 - c) the Programmer/Analyst, who resigned to accept a better position in another organization
- 2) The other important limitation is logistics. The photocopier was old and unable to handle the enormous photo copying load. Also, the limited capacity of the computer did not meet the accounting and reporting demands of the project has set back the CSP-G in many instances.

B. Strategies Which Have Been Used to Overcome these Constraints:

- 1) To diminish the rotation of Health Promoters, we have tried to incorporate local people who have finished high school into the CSP-G work, if they meet the other requirements for the position.

At other levels, we have immediately filled the positions vacated by personnel who have left the CSP-G area.

- 2) To revitalize the logistics support, a new photocopier and computer were bought with WRC funds.

C Circumstances Which May Have Facilitated Implementation and/or Produced Unexpected Benefits.

The atmosphere of peace which has been generated in the Central American region, and especially in Honduras, has been a factor which has facilitated the implementation of the CSP-G.

The continuous devaluation of the Lempira (local currency) against the U.S. dollar which was observed during the life of the project has produced an unexpected benefit of an increase in the money available. Consequently, we have had an underexpenditure in the project which allowed us to create and fill some needed positions and, at the same time, consider a training program for TBAs. (We are presently awaiting approval for the addition of the TBA training program from USAID.)

D. Steps taken to institutionalize lessons learned.

The lessons learned since the beginning of the project have been summarized in Chapter V of the Mid-Term Evaluation (MTE). (Annex H.)

- 1) In order to institutionalize the lessons learned for the HGs, we have implemented the strategy of "Volunteer Block Representatives in the Urban Communities" and the "Focus on Risk" in all CSP areas as described in Item II.B of this document and in Annex F.

- 2) Lessons have been learned about supervision, monitoring and evaluation. Instruments (supervisory check lists) were designed and incorporated as forms (#14 - #20) in the HIS. These checklists are currently in use in the program. See Annex B.
- 3) In order to educate the community, the leaders of schools and churches of the different communities of the CSP-G have been recruited as new volunteers besides the HGs. Together they are carrying out a systematic work plan with the CSP-G personnel in order to disseminate the basic health messages the communities.
- 4) To strengthen the sustainability based on a greater commitment by the MOH in the development of the activities of the CSP-G, we initiated new joint supervision trips with officials of the different levels of the MOH. The selection, training and follow-up of the volunteers has been carried out as a team with the nurse of the local health center.

With this purpose, we are also holding a monthly meeting with HPs, nurses and community volunteers to analyze information, make decisions, and to reinforce the knowledge and practices of the volunteers.

- 5) School children have been incorporated as educators, training them in the CSP-G interventions in order to transmit basic health messages to their parents and neighbors.
- 6) To strengthen the effectiveness of the birth spacing intervention, the program is working more closely with the Honduran Association of Family Planning (ASHONPLAFA) so that they can open more family planning posts in the work area of the CSP-G. These posts will be managed by the HGs.

IV. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

A. Characteristics and Effectiveness of the HIS

Being conscious of the need to revise the HIS which had been used through the second year, project personnel completed an internal revision of the HIS during the second quarter of the third year. The strategy involved input from all the personnel and volunteers in the project, and followed these basic steps:

- 1) Each HP met with the HGs and MOH personnel in their influence zone in order to make the corresponding revisions at their operational level.
- 2) The HPs then met with their AC for the corresponding revision and analysis, in which mid-level MOH personnel also participated.
- 3) The process of revision and adjustment was completed with the personnel of the central office and with the ACs. Each HIS format was validated at field level before finally adopting it.

The participation at the community level and the response from the entire project staff has been characteristic of the HIS from the start.

When the revised system was implemented, a greater simplicity and effectiveness was achieved for generating and processing the information. However, the HIS allowed us to collect the data on high-risk women and children, it was still not easy to identify the at risk groups, in such a way that it would obligate the field personnel to take appropriate and timely steps.

B. Collection of HIS Data:

- 1) At community level, the HGs register the data of their activities in the corresponding forms (001-004A). (See Annex B.) This information is shared with the AN in a monthly meeting in the health center, where all the volunteers in the area participate. To make this monthly meeting more effective, (as in the last quarter of this year) we have started a process in which the HP participates actively. In this manner, it is hoped that the AN will take advantage of this meeting in order to give training reinforcement to the HGs, as well as encouraging them to participate more in the analysis, decision making, and implementation.
- 2) Using the data registered by the HGs and the documentation of their own activities, the HPs complete their monthly report, which they hand in and discuss at the monthly meeting of all the HPs with their AC. At this meeting, decisions are also made on the basis of the analysis of the reported information.
- 3) The AC elaborates a quarterly report which he/she hands in and discusses with the CSP-G team in a quarterly meeting that is held for this purpose.

C. Needs for Further Refinement of the System

Despite the aforementioned internal revision of the HIS, it was evident that a need existed for a further revision with the help of an external consultant, in accomplish to carry out at least the following:

- 1) "Clean" the system to simplify it and leave only the recording formats which are absolutely essential for the routine collection of data.
- 2) Make the system more sensitive to the communities need for information in order to make decisions at the community level.
- 3) Identify the high-risk groups more readily in order to strengthen interventions targeted to them.

HIS forms now being utilized by the CSP-G since the consultancy are attached in Annex B.

V. BUDGET AND EXPENDITURES

A. Major Budget Revisions

There have been no major budget revision on USAID funds since the Cooperative Agreement was signed.

B. Financial Pipeline Analysis

The CSP-G 1993 Pipeline analysis (1993 Annual Report Form A) is attached in Annex I.

C. Unit Costs

Project outputs cannot be readily quantified to cost data to compute unit costs. Therefore, this section is not applicable.

D. Explanation of Cost Overruns or Higher Unit Costs

With regards to the AID funds, there are currently no cost overruns.

The cost overrun on WRC expenditures on procurement (specifically equipment) was made to replace a broken photocopier and computer with limited capacity as described above in section III. A.2. There are no other cost overruns on the major cost elements.

VI. FOLLOW-UP OF DIP REVIEW AND MID-TERM RECOMMENDATIONS

For the "Response to the Technical Revision of the USAID to the DIP" see Annex J. The responses in Annex J have all been incorporated into the project.

Implementing the "New Focus on ARI" centered in the standard treatment of the child with pneumonia was slow and costly since WRH had to train MOH personnel, as was reported in Item I.E. of this report.

Likewise, the suggestions made in the "Technical Revisions of the Nutrition", "Diarrhea and ARI Curricula" have been incorporated into the ongoing curriculum.

The recommendations made in the MTE were very important for improving the quality and effectiveness of the CSP-G. Following is a summary and a follow-up of these:

To ensure the fulfillment of the objectives, goals and their sustainability the following steps have been taken:

1. Integrate all the interventions around Growth Control, and generate a work plan based on the formal community structure on which the HG depends, and that both of these have a direct relationship with the health center. This work must be carried out under the

focus on risk, it must incorporate HGs with a specific task and include all the interventions of the Project.

2. Reinforce and redesign strategies to increase the capacity of the community for helping themselves, and in this manner generate community structures that work as a counterpart of the health center in each community.

In order to implement these recommendations, a pilot experience called "Work Strategy Based on Focus on Risk" was designed to improve the applicability, competence and quality of the project which is described in Annex F.

3. Jointly design, along with the MOH and the community, a reference/counter-reference system for each community of the project.

To implement this suggestion, reference and counter-reference forms designed by the MOH in 1985 have been used, but they are no longer in use since there are none in stock and the MOH has not been able to reproduce.

Consequently, the Project reproduced both forms in order that they be used by the HGs and the ANs. The HGs have been instructed on how to use these forms, and at the same time have been motivated to use them. Likewise, they are working with the nurses of the health centers so that the nurses will consider these reference forms to be important and so that they will send counter-reference forms to the HGs. This keeps the communication flowing and enables team work to assist mothers and their children.

4. Review the supervisory instruments at the different levels. Reinforce and ensure the joint supervision and monitoring, WRH/MOH, at all levels. Ensure a process of promotor/community supervision which uses the information system.

To respond to this recommendation, the CSP-G is coordinating with the MOH Area Chiefs and the health centers. At area level, the CSP-G and MOH Coordinators, since October 1992, have made official monthly visits to the field with supervisory and monitoring purposes, during which they make joint decisions.

Together with the ANs of the health centers, a monthly meeting with the HGs is carried out, where the data that they record is interpreted together, and then used to monitor their activities and decision making at the local level. A review of the HIS has also been carried out to facilitate this process.

5. Review the HIS, allowing the health center to be the place where the data is centered. Adapt the collection/use of data at community level, giving more emphasis to the participation of the MOH in the whole process. Use simple and appropriate systems to return the information to the community.

To respond to this recommendation, a review and readaptation of the HIS was made with the help of an external consultant. The new HIS will be implemented during this coming year.

6. With regards to the technical aspects of the interventions:

The CSP-G will: review and reduce the criteria of risk for each intervention, leave only the factors of risk due to illness, review the component of food counseling and concentrate on the risk population, develop pilot experiences of more individualized feeding practices, review the treatment of diarrhea, introduce dietetic handling, limit the use of ORS to dehydration, and reinforce the MOH initiative of having Community Oral Rehydration Units (UROCs) in each community.

As far as maternal health, concentrate on the attention of risk groups, ensuring their access to family planning services within the community, trying to include a medical visit as part of primary care. Study ways of self-financing these community services. In control of pneumonia, identify alternatives of identification and handling of cases in each community. In coordination with the MOH, implement a policy of the handling of cases by the community.

The criteria of risk were revised, and they now read as follows:

A. High Risk Children

1. After two consecutive weighing sessions, the child has not gained or has lost weight.
2. The child is not covered by Vitamin A (from foods rich in Vitamin A or supplements).
3. Children under 6 months of age who do not exclusively breastfed.
4. Children with incomplete vaccinations for his age or totally uncovered by vaccines.

B. High Risk Women of Reproductive Age, Pregnant or Not

1. Women with incomplete vaccinations of tetanus toxoid or none at all.
2. Women with husbands and who are under 18 years or over 35 years of age.
3. Women with three or more previous children.
4. Pregnant women with a birth interval of under two years.

C. High Risk Families

High risk families are considered those with children and/or women who have one or more of the aforementioned criteria.

It was decided that food counseling would only be given individually to the mothers of children who do not gain weight, by means of home visits in which the HG, together with the mother, respond to a series of questions which lead to increasing the frequency of feeding, to adding fat to the food and to using mixtures of cereals and legumes which the mother has at home (rice, corn and beans). (See Annex F.) Food counseling has also been reinforced in order to promote the feeding of the child with diarrhea and ARI, both during and after his illness.

The treatment of the child with diarrhea was reviewed: the dietetic handling of diarrhea was introduced, and the use of ORS promoted, especially for dehydration (but considering ORS as an additional liquid when the child is not dehydrated). It is hoped that the work strategy based on risk groups which has begun to be implemented reinforces the implementation of UROC which the MOH has started. It is also desired that it responds to the suggestions on maternal health and the prevention of deaths by pneumonia.

7. Coordinate with PAHO in the development of three training workshops for the joint WRH and MOH personnel, within the following six months: "Abilities in the Supervision of Diarrhea Control", "Control of ARIs", and "Basic Principles of Epidemiological Control of Illnesses".

CSP-G coordinated with PAHO Honduras and MOH for the suggested training. As was reported under I.B, the training workshop on ARI and Control of Diarrheal Diseases was carried out from November 2 to 6, 1992, where representatives of 10 PVOs which work in the area of health also attended.

The training on "Epidemiological Supervision" has not yet been able to be carried out due to time limitations of the MOH personnel, who are the official training facilitators required by PAHO.

8. Coordinate joint efforts of WRH/MOH/USAID Honduras in order to develop operational surveys on:
 - a. Calculations of recurring costs of the project
 - b. Mechanisms for documenting the impact of community banks in the health of the families
 - c. Cost recovery by means of pharmacies community family planning services and others, managed by formal community structures

- d. Assignment of budget items which the MOH could use for community health care in the communities where the CSP-G works
- e. Revision of the actual educational materials which uses messages validated by the users

The pertinent contacts were made on this recommendation with the corresponding officials, but it was not possible to actually carry out the implementation of any short-term investigation. Nevertheless, there is a good chance in the future of carrying out investigations on the assignment of budget items of the MOH for community health, the impact of the community banks on family health, cost recovery by means of popular pharmacies and validation of educational materials.

- 9. Ensure the Coordination between WRC and USAID in order to identify the possibility of technical assistance for the HIS and Nutrition.
- 10. Identify funds, from the budget and from external sources, for the development of the necessary technical assistance.

These recommendations were implemented when the revision process of the HIS was carried out, and when the training on "Nutritional Basis for the Use of Vegetable Mixtures in Children under 5 Years" was carried out, as mentioned in I.B.

VII. OTHER (Report any significant project-related information which has not been requested elsewhere in these guidelines.)

A. Revision and Adjustment of the Present HIS

In attention to the needs and objectives presented in Numeral IV.C, at the end of this year we hired Dr. Alejandro Melara as a local consultant, who led the new revision of the HIS with the participation of all the CSP-G personnel, of key MOH officials at all levels, and of community volunteers. The new HIS forms are shown Annex B of this Report.

B. National and International Visitors to Health Programs

Using financing from other sources, the CSP-G Director visited other health programs within the country, such as: the health program of the Church of God and the health program of the Philadelphia Church, which are in the northern area of the country. During these visits, he shared on the functioning of the CSP-G and prepared a plan of action with them which included reciprocal visits for sharing and for support.

Responding to invitations received, the CSP-G Director also travelled to Peru, Dominican Republic, El Salvador, Nicaragua, Mexico and Guatemala, with similar purposes as mentioned above. The final event of this effort was the "Workshop for the Exchange of Experiences in Community Health", which was sponsored by WRH, and was carried out

in one of the work areas of the CSP-G during the last week of July 1993. Representatives of national and international programs with which the program had previous contacts participated. This workshop was funded by the Chatlos Foundation.

Outcomes from this interchange are as follows:

- 1) The two aforementioned national programs modified their approach from a curative one to the implementation of child survival activities;
- 2) Programs outside of Honduras were strengthened, specially those of the Luke Society in Peru and Dominican Republic; OPRODE in El Salvador; World Relief Nicaragua; Covenant Church of Mexico; International Medical Ambassadors and ASIDE of Guatemala. Simultaneously, the CSP-G was greatly enriched.

ACRONYMS

AC	Area Coordinator
AN	Auxiliary Nurse
ARI	Acute Respiratory Infection
ASHONPLAFA	Honduran Association of Family Planning
CDD	Control of Diarrheal Diseases
CSP	Child Survival Project
CSP-G	Child Survival Program - Guayape
DIP	Detail Implementation Plan
FOPRIDE	Federation of Private Development Organizations
HG	Health Guardians
HIS	Health Information System
HP	Health Promoter
IEF	International Eye Foundation
IEF	International Eye Foundation
LHC	Local Health Committees
MOH	Ministry of Health
MTE	Mid-term Evaluation
NGO	Non-governmental Organization
ORS	Oral Rehydration Salt
PAHO	Pan American Health Organization
PVO	Private Volunteer Organization
TBA	Traditional Birth Attendants
UNAH	National Autonomous University of Honduras
UROC	Community Oral Rehydration Unit
WRC	World Relief Corporation
WRH	World Relief Honduras

ANNEX A

**WORLD RELIEF HONDURAS
CHILD SURVIVAL PROJECT - GUAYAPE
ANNUAL REPORT 4**

OBJECTIVES - STATUS ENDING YEAR 4

WORLD RELIEF HONDURAS/GUAYAPE CHILD SURVIVAL OBJECTIVES - STATUS ENDING YEAR 4

OBJECTIVE	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
	9/89--8/90	9/90--8/91	9/91--8/92	9/92--8/93	9/93--8/94
	Baseline	Actual	Actual	Actual	Projection
1. Children 0-11 months completely immunized	592 (40%)	1,036 (50%)	2,224 (83%)	2,930 (90%)	3,078 (80%)
2. Children 12-59 months completely immunized	5,184 (90%)	7,258 (90%)	8,975 (69%)	10,772 (85%)	13,478 (90%)
3. Women 15-45 vaccinated with two doses Tetanus Toxoid	4,048 (55%)	6,182 (60%)	9,610 (73%)	12,954 (80%)	16,265 (85%)
4. Women instructed in preparation and administration of ORS/ORT	2,944 (40%)	7,522 (73%)	9,936 (75%)	12,424 (78%)	15,309 (80%)
5. Women evidencing regular use of ORT/ORS during diarrheal episodes in their children	2,208 (30%)	3,709 (36%)	6,881 (52%)	8,960 (55%)	13,395 (70%)
6. Children 0-59 months weighed monthly	2,027 (28%)	---	---	---	---
7. Children 0-23 months weighed monthly	---	1,658 (40%)	3,240 (61%)	5,203 (80%)	6,157 (80%)
8. Children 24-59 months weighed once every three months	---	2,397 (40%)	2,982 (39%)	5,640 (60%)	7,790 (70%)
9. Women 15-45 instructed in breastfeeding, weaning, nutrition for children 0-59 months	2,208 (30%)	---	---	---	---
10. Women 15-45 instructed in breastfeeding	---	9,274 (90%)	11,923 (90%)	14,573 (90%)	17,222 (90%)
11. Women 15-45 who exclusively breastfeed their children until four months of age	---	622 (30%)	986 (37%)	1,302 (40%)	1,924 (50%)
12. Women 15-45 instructed in weaning and nutrition	---	---	7,319 (55%)	10,720 (68%)	17,222 (90%)
13. Children 6-59 months receiving Vitamin A	1,448 (20%)	3,041 (30%)	4,237 (55%)	9,782 (68%)	11,294 (60%)
14. Mothers post-partum receiving Vitamin A	(0%)	157 (10%)	1,328 (50%)	2,362 (73%)	2,330 (80%)
15. Women 15-45 utilizing modern birth spacing methods	3,680 (50%)	1,192 (16%)	3,376 (25%)	2,306 (14%)	2,208 (30%)
16. Pregnant women receiving pre-natal care	750 (67%)	1,098 (70%)	966 (36%)	1,898 (58%)	2,038 (70%)
17. Women 15-45 instructed in prevention of death from pneumonia in children 0-59 months	(0%)	2,782 (27%)	6,059 (46%)	6,890 (43%)	8,096 (50%)
18. Women 15-45 who can identify and facilitate treatment of pneumonia in children 0-59 months	(0%)	1,546 (15%)	2,385 (18%)	4,209 (20%)	5,740 (30%)
19. Health Guardians trained for inclusion into MOH Public Health System	60	98	252	343	343
20. Local Health Committees organized	10	50	75	118	130

ANNEX A

ANNEX B

**WORLD RELIEF HONDURAS
CHILD SURVIVAL PROJECT - GUAYAPE
ANNUAL REPORT 4**

**HEALTH INFORMATION SYSTEM FORMS
(HIS)**

PRIMER CONSOLIDADO DEL LINVI

NOMBRE DEL PROMOTOR:

COMUNIDAD:

SECTOR:

UPS:

AREA: REGION: MES: AÑO:

#	Nombre de la Comunidad	# Niños nacidos	FACTORES DE RIESGO MATERNOS					ESTADO VACUNAL				APLICACION VIT "A"		MORTALIDAD Y CAUSAS				
			Edad Madres <18 >35	Paridad > 4 Emb.	Esp.Int < 2a	Cri-ster	0-11m Comp	12 a 59m Com	12-59m	Número	Diarrea	Neumonia	Parto	Otras				
1		2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		

SEGUNDO CONSOLIDADO DEL LINVI

NOMBRE DEL PROMOTOR:

COMUNIDAD:

SECTOR:

UPS:

AREA:

REGION:

MES:

AÑO:

#	Nombre de la Comunidad	COBERTURA		CONTROLES REALIZADOS				NIÑOS EN CONTROL				
		0 - 11Meses 2 Nuevos Acum3	12-59Meses Nuev Acum4	Crecimiento Adecuado 5	Crecimiento No Creciendo6	Inadecuado Decreciendo7	Subtotal Crec Inadec8	Total de Controless9	Niños Cap tados 10	Niños en Ctrl 11	Niños Con Ctrl Inad12	Niños DPC13
1												

CONSOLIDADO DEL LISEM

NOMBRE DEL PROMOTOR:

COMUNIDAD:

SECTOR:

UPS:

AREA:

REGION:

MES:

ANO:

#	Nombre de la Comunidad	E M B A R A Z A D A S				MUJERES USANDO METODOS PLANIFICACION FAMILIAR										
		Vacunadas Con T 2 ₃ Con TT5 ₄		En Control Nuevas Subsigs		MUJERES			Tipo de Metodo							
1	2	3	4	5	6	7	Nuevas	8	Subsig.	9	Total	10	Cirugia ₁₁	Pildoras ₁₂	Otras ₁₃	Total ₁₄

MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
BASE DE DATOS: LAS INTERVENCIONES PSI-G006

Edad de las Madres
Número de Embarazo a que corresponde los niños
Espacio Intergénésico
Tendencia del Crecimiento por mes de edad
Situación Nutricional por mes de edad
Causa de no Crecimiento
Cobertura con Vitamina A
Cobertura con DPT
Cobertura con Sabin
Cobertura con Antisarampión
Cobertura con BCG
Promedio de Madres con Lactancia Materna Exclusiva
Desvinculación de Voluntarios y causa
Mortalidad Infantil y causa
Mortalidad Materna y causa
Mortalidad General y causa

MINISTERIO DE SALUD PUBLICA
AUXILIO MUNDIAL
PROYECTO SUPERVIVENCIA INFANTIL GUAYAFE

FORMULARIO PSI-G 007

ENCUESTA EN SITIOS CENTINELAS

1	QUE EDAD TIENE UD?
2	TIENE NINOS< 6 MESES?
3	QUE LE DIO DE COMER AYER?
4	LE DIO ALGO MAS?
5	HA TENIDO UD O SU NINO DIARREA?
6	CON QUE LO TRATO?
7	SABE PREPARAR EL LITROSOL?
8	QUIEN LE ENSENO A PREPARARLO?
9	NINO MAL DEL PECHO!QUE QUIERE DECIR?
10	RECIENTEMENTE HA VISTO ALGUNO?
11	QUE HIZO CON EL?
12	HA RECIBIDO CONSEJOS DE NUTRICION?
13	QUIEN LE DIO LOS CONSEJOS?
14	LE SIRVIERON DE ALGO?
15	PARA QUE LE SIRVIERON?

LA ENCUESTA SE APLICA A LA MUJER QUE ESTA
COMO JEFE DE CASA O QUE ES LA CONYUGE

MINISTERIO DE SALUD PUBLICA\AUXILIO MUNDIAL
 PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE

FORMULARIO PSI-G 008

FORMULARIO PARA RESUMEN DE LA ENCUESTA EN SITIOS CENTINELAS

#	VARIABLES	SITIO 1	SITIO 2	SITIO 3	TOTAL
1	MUJERES ENTREVISTADAS				
2	NINOS< 6 MESES				
3	LACTANCIA MATERNA EXCLUSIVA				
4	LACTANCIA COMBINADA				
5	NINOS CON DIARREA				
6	USO DE LITROSOL				
7	CONOCE COMO PREPARAR EL LITROSOL				
8	INSTRUIDA POR VOLUNTARIO				
9	INSTRUIDA POR AUXILIAR DE ENFERMERIA				
10	INSTRUIDA POR PROMOTOR DE AUX. MUND.				
11	CONOCE LAS SEÑALES DE PELIGRO				
12	NINO CON SOSPECHA DE NEUMONIA				
13	REFERENCIA DE NINOS CON NEUMONIA				
14	INSTRUIDA EN ALIMENTACION Y DESTETE				
15	INSTRUIDA POR VOLUNTARIO				
16	INSTRUIDA POR AUXILIAR DE ENFERMERIA				
17	INSTRUIDA POR PROMOTOR DE AUX. MUND.				
18	UTILIDAD DE LOS CONSEJOS				
19	USOS MAS FRECUENTES				
21					
22					
23					
24					

LA ENCUESTA SE APLICA A LA MUJER QUE ESTA COMO JEFE DE CASA O QUE ES LA CONYUGE

MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
BASE DE DATOS: GUARDIAN DE SALUD PSI-G009

Nombre del Guardian	Fecha de Nacimiento		
Nombre del Conyuge	Fecha de Nacimiento		
Número de Hijos	Edad de cada Uno:		
Comunidad donde Vive:			
Fecha de Inicio	Fecha de Finalización/G.S.		
Causa:			
Fecha	Tipo de Incentivos Recibidos		
Escolaridad	Fecha de Capacitaciones		
Tipo de Capacitaciones	Fecha de ReCapacitaciones		
Tipo de ReCapacitaciones			
Condición Religiosa y desde Cuando:			
Católico	Desde Cuando	Mormón	Desde Cuando
Evangélico	Desde Cuando	Otra	Desde Cuando
Condición Laboral:			
Oficios Domesticos	Con Apoyo de Banco Comunal		
Trabajo Remunerado en Casa	Remunerado fuera de Casa		
Destrezas Adicionales			
Supervisiones Recibidas Número y Fechas			

REGISTRO DE COMITE DE APOYO AL GUARDIAN DE SALUD

Comunidad: _____
 Fecha de Organización: _____
 Fecha de Desintegración: _____
 CAUSA: _____

MEMBROS:

Presidente: _____
 Vice-presidente: _____
 Secretario: _____
 Tesorero: _____
 Fiscal: _____
 Otros: _____

REUNIONES POR MES:

Año: _____

Mes:	Enero	Febrero	Marzo	Abril	Mayo	Jun.	Jul.	Ago.	Sept.	Oct.	Nov.	Dic.
Nº:												

EVENTOS REALIZADOS:

Enero:	_____
Febrero:	_____
Marzo:	_____
Abril:	_____
Mayo:	_____
Junio:	_____
Julio:	_____
Agosto:	_____
Sept.	_____
Octubre:	_____
Nov.	_____
Dic.:	_____

MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL - PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
INDICADORES DE SOSTENIBILIDAD

PSI-G 011

NOMBRE DEL PROMOTOR:

COMUNIDAD:

SECTOR:

UPS:

AREA:

REGION:

MES:

AÑO:

#	Comunidad	Guardianes de Salud					COMITES DE SALUD															
		ACTIVIDAD			CAPACITACION		ACTIVIDAD			REUNION CON			ACTIVIDADES POR INTERVENCION									
		Nº	Activo	Desvin	A/E	PAM	TOT	EXIS	ACT	TOT	A/E	PAM	TOT	CyD	PAI	LME	TRO	CP	ESPEC	VIT A	OTRAS	TOT

MINISTERIO DE SALUD PUBLICA \ AUXILIO MUNDIAL PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE PSI-G012

FORMULARIO PARA RESUMEN DE LA ENCUESTA EN SITIOS CENTINELAS

NOMBRE DEL FACILITADOR: _____ SECTOR: _____ AREA: _____ REGION: _____ CICLO: _____ AÑO: _____

#	VARIABLES	Z O N A # 1				Z O N A # 1				Z O N A # 1				Z O N A # 1				T O T A L				
		S1	S2	S3	TOT	S1	S2	S3	TOT													
1	MUJERES ENTREVISTADAS																					
2	NINOS< 6 MESES																					
3	LACTANCIA MATERNA EXCLUSIVA																					
4	LACTANCIA COMBINADA																					
5	NINOS CON DIARREA																					
6	USO DE LITROSOL																					
7	CONOCE COMO PREPARAR EL LITROSOL																					
8	INSTRUIDA POR VOLUNTARIO																					
9	INSTRUIDA POR AUXILIAR DE ENFERMERIA																					
10	INSTRUIDA POR PROMOTOR DE AUX. MUND.																					
11	CONOCE LAS SEÑALES DE PELIGRO																					
12	NINO CON SOSPECHA DE NEUMONIA																					
13	REFERENCIA DE NINOS CON NEUMONIA																					
14	INSTRUIDA EN ALIMENTACION Y DESTETE																					
15	INSTRUIDA POR VOLUNTARIO																					
16	INSTRUIDA POR AUXILIAR DE ENFERMERIA																					
17	INSTRUIDA POR PROMOTOR DE AUX. MUND.																					
18	UTILIDAD DE LOS CONSEJOS																					
19	USOS MAS FRECUENTES																					

MINISTERIO DE SALUD PUBLICA\AUXILIO MUNDIAL\PROYECTO DE SUPERVIVENCIA INFANTIL GUAYAPE PSI-G013

Trim: _____ Mes: _____ Año: _____ Preparado por: _____ Fecha: _____

	N a c i m i e n t o s						M u e r t o s				
	Nº	de Madres -18 A.	de Madre + 35 A.	de 40 o + embarazos	Antes de 2A. del UP	Con 1 o + criterios	Nº	Causas			
								Diarrea	Neumonia	Polio	Otros
Zona 1											
Zona 2											
Zona 3											
Zona 4											
Zona 5											
T o t a l											

MINISTERIO DE SALUD PUBLICA \ AUXILIO MUNDIAL PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE PSI-G014
 FORMULARIO PARA RESUMEN DE LA ENCUESTA EN SITIOS CENTINELAS

NOMBRE DEL FACILITADOR: _____ SECTOR: _____ AREA: _____ REGION: _____ CICLO: _____ AÑO: _____

#	VARIABLES	SECTOR 1				SECTOR 2				SECTOR 3				TOTAL			
		S1	S2	S3	TOT	S1	S2	S3	TOT	S1	S2	S3	TOT	S1	S2	S3	TOT
1	MUJERES ENTREVISTADAS																
2	NINOS < 6 MESES																
3	LACTANCIA MATERNA EXCLUSIVA																
4	LACTANCIA COMBINADA																
5	NINOS CON DIARREA																
6	USO DE LITROSOL																
7	CONOCE COMO PREPARAR EL LITROSOL																
8	INSTRUIDA POR VOLUNTARIO																
9	INSTRUIDA POR AUXILIAR DE ENFERMERIA																
10	INSTRUIDA POR PROMOTOR DE AUX. MUND.																
11	CONOCE LAS SEÑALES DE PELIGRO																
12	NINO CON SOSPECHA DE NEUMONIA																
13	REFERENCIA DE NINOS CON NEUMONIA																
14	INSTRUIDA EN ALIMENTACION Y DESTETE																
15	INSTRUIDA POR VOLUNTARIO																
16	INSTRUIDA POR AUXILIAR DE ENFERMERIA																
17	INSTRUIDA POR PROMOTOR DE AUX. MUND.																
18	UTILIDAD DE LOS CONSEJOS																
19	USOS MAS FRECUENTES																

MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
BASE DE DATOS: COMUNIDAD PSI-G015

1. Número de Viviendas:
2. Número de Habitantes y su distribución por sexo:
3. Número de Niños menores de cinco años:
4. Número de niños menores de un año:
5. Número de Mujeres de 12 a 49 años:
6. Promedio de Hijos por Familia:
7. Tipo y Número de Organizaciones Locales:

Iglesias

Escuelas:

Patronatos:

Comites de Salud:

Listado de OPD's trabajando en la comunidad:

8. Escolaridad de la Población:

9. Servicios Públicos
Cobertura con Agua:

Cobertura con Letrina:

Disponibilidad Horas/Luz:

10. Fuentes de Ingreso (Patrimonio Principal):

11. Condicion Predominante de la Vivienda:

12. Distancia a la sede de Zona y via de Comunicación:
(En tiempo y Kilometros)

13. Número de Voluntarios en Salud.

WORLD RELIEF (AUXILIO MUNDIAL) DE HONDURAS
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
Para Supervisar el Manejo de Casos de Diarrea

	Necesita <u>Mejorar</u>	Bueno	Muy <u>Bueno</u>
I. <u>Contenido Básico de Capacitación</u>			
1. Enseñanza sobre el uso de líquidos caseros a base de cereales como arroz en aquellos casos de episodio diarreico sin deshidratación.	_____	_____	_____
2. Enseñanza sobre continuación de lactancia materna y/o alimentación del niño durante el episodio de diarrea.	_____	_____	_____
3. Enseñanza sobre añadir una ración más de comida al niño una vez que haya pasado el episodio diarreico durante al menos 2 semanas.	_____	_____	_____
4. Enseñanza sobre identificación de señales de deshidratación	_____	_____	_____
5. Demostración práctica de cómo preparar el Litrosol	_____	_____	_____
6. Demostración práctica de cómo utilizar el Litrosol	_____	_____	_____
6.1 Niño menor de 2 años, media taza de Litrosol cada vez que defeca	_____	_____	_____
6.2 Niño mayor de 2 años, 1 taza de Litrosol cada vez que defeca	_____	_____	_____
6.3 Cuando el niño está deshidratado se le da Litrosol hasta quitarle la sed, mientras se lleva inmediatamente al Centro de Salud.	_____	_____	_____
II. <u>Utilización de la Metodología Participativa</u>			
1. Utilización de dinámicas y técnicas participativas.	_____	_____	_____
2. Planificación de actividades para aplicación de lo aprendido.	_____	_____	_____
3. Fomento de solidaridad y relaciones humanas.	_____	_____	_____
III. <u>Conocimiento del Guardián de Salud</u>			
1. Manejo de niño con episodio diarreico			
1.1 Recomienda el uso de líquidos caseros en los casos de diarrea sin deshidratación.	_____	_____	_____
1.2 Fomenta la continuación de lactancia materna y/o alimentación en el niño con diarrea.	_____	_____	_____
1.3 Recomienda a las madres sobre la práctica de dar una ración extra de comida al niño en su período de convalecencia.	_____	_____	_____
2. Identificación de señales de deshidratación	_____	_____	_____
3. Preparación del Litrosol	_____	_____	_____
3.1 Se lava las manos con agua y jabón	_____	_____	_____
3.2 Mide un litro de agua (preferiblemente hervida)	_____	_____	_____
3.3 Echa el sobre de Litrosol en el litro de agua	_____	_____	_____
3.4 Vota el Litrosol sobrante después de 24 horas de prepararlo	_____	_____	_____
4. Uso de Litrosol	_____	_____	_____
4.1 Media taza en niños menores de 2 años	_____	_____	_____
4.2 1 taza en niños mayores de 2 años	_____	_____	_____
4.3 De acuerdo a la sed que tiene el niño cuando está deshidratado	_____	_____	_____
4.4 Cuando el niño está deshidratado lo lleva inmediatamente al Centro de Salud	_____	_____	_____
IV. <u>Logística</u>			
1. Disponibilidad de sobre de Litrosol y materiales para prepararlo	_____	_____	_____
2. Disponibilidad de materiales educativos	_____	_____	_____
3. Local	_____	_____	_____

NOTA: De considerarlo necesario, discuta y concerte un plan de acción para seguimiento.

Firma del Supervisor: _____ Fecha: _____

Firma del Promotor de Salud: _____

MINISTERIO DE SALUD PUBLICA\AUXILIO MUNDIAL
 PROYECTO SUPERVIVENCIA INFANTIL GUAYAPE
 RESUMEN DE CUMPLIMIENTO DE OBJETIVOS CUALITATIVOS POR ZONA/SECTOR/AREA
 FORMULARIO PSI-G 017

1	2	3				4
		SITIO SEGUN NIVEL DE ACCESIBILIDAD				
Nº	OBJETIVOS	SITIO	CON MAS Y MENOS ACCESO		GRAN	
		SEDE	MAS	MENOS	SUBTOTAL	TOTAL
1	MUJERES CAPACITADAS EN TRO					
2	MUJERES USANDO TRO					
3	MUJERES CAPACITADAS LACTANCIA MATERNA					
4	USANDO LACTANCIA MATERNA EXCLUSIVA					
5	MUJER CAPACITADAS ALIMENTAC Y DESTETE					
6	USANDO CONOCIMIENTOS ALIMENT. Y DESTETE					
7	CAPACITADAS EN NEUMONIA					
8	IDENTIFICAN SEÑALES DE PELIGRO					
9	MUJERES Q'REFIEREN NINOS CON NEUMONIA					

MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
BASE DE DATOS: PROMOTOR PSI-G018

Nombre del Promotor
Fecha de Nacimiento
Nombre del Conyuge
Fecha de Nacimiento
Número de Hijos
Edad de cada Uno:
Comunidad donde Vive:
Casa Propia
Fecha de Inicio/Promotor
Años de servicio
Nivel Academico
Destrezas Adicionales
Condición Denominacional
Experiencias en Otros trabajos
Número de Capacitaciones Recibidas y Tipo
Responsabilidad sobre:
de Voluntarios,
de Aldeas,
de Localidades,
de Barrios
Aspiraciones Laborales

MINISTERIO DE SALUD PUBLICA\AUXILIO MUNDIAL\PROYECTO DE SUPERVIVENCIA INFANTIL GUAYAPE PSI-G019

Trim: _____ Mes: _____ Año: _____ Preparado por: _____ Fecha: _____

	N a c i m i e n t o s						M u e r t o s				
	Nº	de Madres -18 A.	de Madre + 35 A.	de 40 o + embarazos	Antes de 2A. del UP	Con 1 o + criterios	Nº	Causas			
								Diarrea	Neumonia	Polio	Otros
Area 1											
Area 2											
T o t a l											

Observaciones:

MINISTERIO DE SALUD PUBLICA\AUXILIO MUNDIAL

PROYECTO DE SUPERVIVENCIA INFANTIL GUATAPE

RESUMEN DE CUMPLIMIENTO DE OBJETIVOS CUANTITATIVOS FORMULARIO PSI-G 020

1	2	3	4	5	6	7
Nº	OBJETIVOS	MES ACTUAL	MESES ANTERIOR	TOTAL ACUMULADO	META ANUAL	PORCENTAJE REALIZADO
1	<11m INMUNIZADOS COMP.					
2	12-59m INMUNIZAD COMP.					
3	MUJERES CON 2 DOSIS TT					
4	< 11m PESADOS					
5	12-59m PESADOS					
6	<1a VIT "A"					
7	11-59m VIT"A"					
8	TOTAL NINOS CON VIT A					
9	MADRES CON VIT "A"					
10	USUARIAS P.F.					
11	PAQ PILD DISTRIBUIDOS					
12	MUJERES EN CTRL PRENAT					
13	G.S. ENTRENADOS PARA INCLUIR EN EL SISTEMA DEL MSP					
14	COMITES LOCALES ORGANIZADOS					
15	COMITES LOCALES ACTIVOS					

MINISTERIO DE SALUD PUBLICA\AUXILIO MUNDIAL
 PROYECTO SUPERVIVENCIA INFANTIL GUAYAPE
 RESUMEN DE CUMPLIMIENTO DE OBJETIVOS CUALITATIVOS
 CONSOLIDADO DEL PROYECTO
 FORMULARIO PSI-G 021

1	2	3				
		SITIO SEGUN NIVEL DE ACCESIBILIDAD				
Nº	OBJETIVOS	SITIO	CON MAS Y MENOS ACCESO			GRAN
		SEDE	MAS	MENOS	SUBTOTAL	TOTAL
1	MUJERES CAPACITADAS EN TRO					
2	MUJERES USANDO TRO					
3	MUJERES CAPACITADAS LACTANCIA MATERNA					
4	USANDO LACTANCIA MATERNA EXCLUSIVA					
5	MUJER CAPACITADAS ALIMENTAC Y DESTETE					
6	USANDO CONOCIMIENTOS ALIMENT. Y DESTETE					
7	CAPACITADAS EN NEUMONIA					
8	IDENTIFICAN SEÑALES DE PELIGRO					
9	MUJERES Q'REFIEREN NINOS CON NEUMONIA					

MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
BASE DE DATOS: COORDINADOR/FACILITADOR PSI-G022

Nombre:
Fecha de Nacimiento
Nombre del Conyuge
Fecha de Nacimiento
Número de Hijos
Edad de cada Uno:
Comunidad donde Vive:
Casa Propia
Condición Actual
Area o Sector donde trabaja
Fecha de Inicio como Coordinador/Facilitador
Años de servicio en Auxilio Mundial
Nivel Academico (Profesión u Oficio)
Destrezas Adicionales
Condición Denominacional
Experiencias en Otros trabajos
Número de Capacitaciones Recibidas durante su trabajo
actual y Tipo
Incentivos Recibidos y Tipo
Número de Facilitadores/Promotores a su cargo

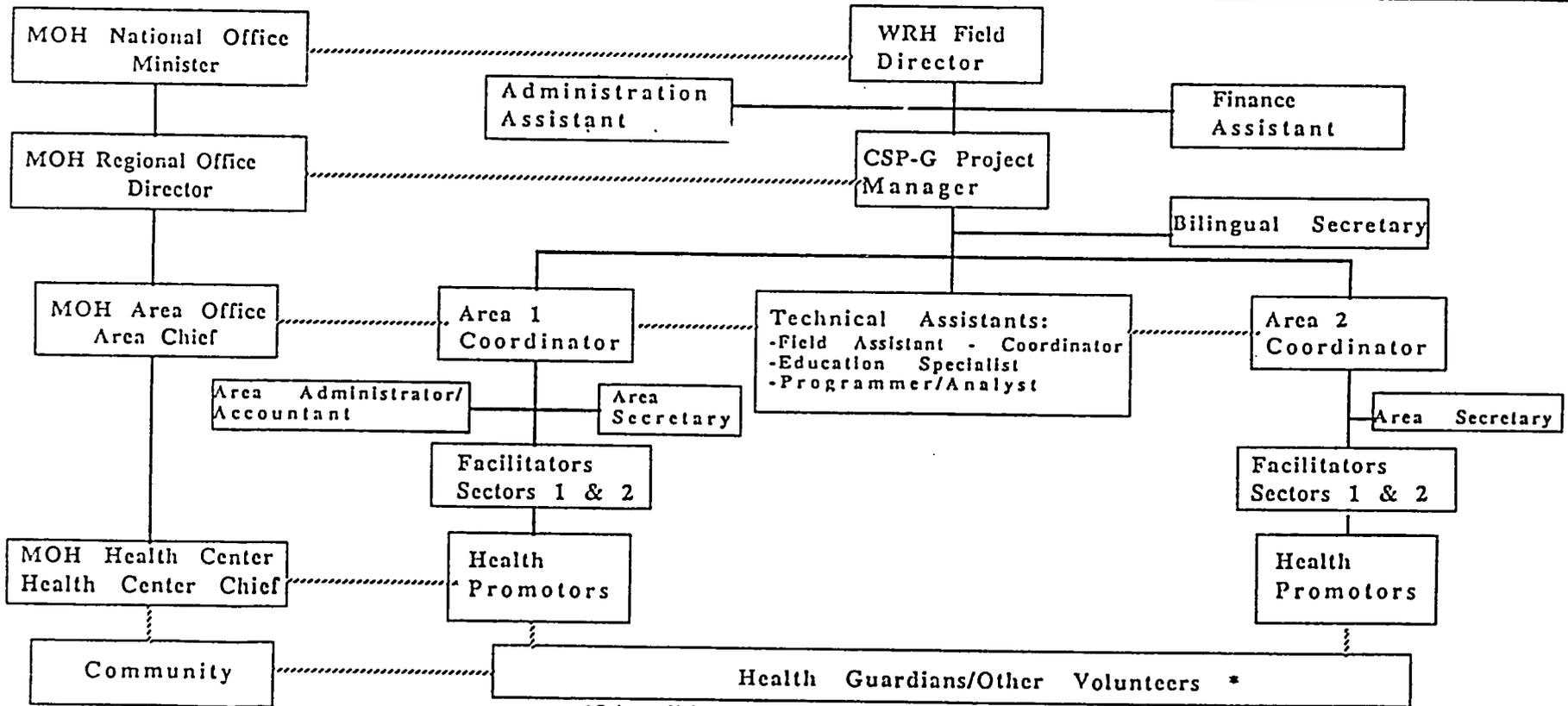
MINISTERIO DE SALUD PUBLICA/AUXILIO MUNDIAL
PROYECTO DE SUPERVIVENCIA INFANTIL - GUAYAPE
Sistematización del Informe Narrativo PSI-G023

Elementos a Incorporar en el Informe

1. Principales Logros
 - 1.1 Visitas
 - Visitas Realizadas
 - Visitas Recibidas
 - 1.2 Capacitación
 - 1.2.1 Capacitación a Capacitadores
 - a. Capacitación del Personal del PSI-G
 - 1.2.2 Capacitación de Guardianes de Salud
 - a. Nuevas Promociones:
 - Número de Guardianes Nuevos
 - Total acumulado
 - Grado de Capacitación
 - Tipo de Participación
 - b. Seguimiento a Promociones Anteriores
 - Tipo de Participación
 - 1.3 Comites Locales de Salud
 - Número de Comites Nuevos
 - Total acumulado
 - Grado de Capacitación
 - Tipo de Participación
 - 1.4 Trabajo con Escuelas
 - a. Nivel Primario
 - Numero de Escuelas y Tipo de Actividades realizadas
 - b. Nivel secundario
 - Numero de Escuelas y Tipo de Actividades realizadas
 - 1.5 Trabajo con Iglesias
 - Numero de Iglesias y Tipo de Actividades realizadas
 - 1.6 Actividades de Coordinación
 - a. Con el Ministerio de Salud Pública
 - b. Con Otras Instituciones del Sector Público
 - c. Con Otras Instituciones No Gubernamentales
 - 1.8 Actividades de Evaluación y Planificación
 - 1.9 Felices Resultados
2. Planes para el Proximo Trimestre
3. Observaciones o Análisis sobre lo informado

WORLD RELIEF HONDURAS - CHILD SURVIVAL PROJECT
ORGANIZATIONAL CHART

LEGEND
Advisory
Supervisory _____



*Other Volunteers includes members of the Community Health Committees

ANNEX C

ANNEX D

**WORLD RELIEF HONDURAS
CHILD SURVIVAL PROJECT - GUAYAPE
ANNUAL REPORT YEAR 4**

JOB DESCRIPTIONS AND RESUMES

JOB DESCRIPTION

1.0 POSITION NAME

Health Facilitator, Child Survival Project - Guayape.

2.0 NATURE OF THE POSITION

The work consists in carrying out activities of supervision, implementation, monitoring and evaluation of the accomplishment of the objectives and goals of the CSP-G, supporting the Health Promoters and the voluntary personnel in community activities. Will report to the Area Coordinator of the CSP-G.

3.0 POSITION QUALIFICATIONS

3.1 Education

Have a high-school degree careers such as: nursing, elementary education, social promotion or other similar careers.

3.2 Experience

Have at least two years of experience in the implementation of activities of child survival or similar, at field level, have motivational and communication abilities an evident comprehension of the skills required for the community development.

3.3 Other

- Availability to live in the work area
- Good health conditions
- Ability to work as a team

4.0 FUNCTIONS

In close collaboration with the CSP-G Coordinator Area, the Health Facilitator will participate in the following basic functions:

4.1 Ensure an effective control of the quality of information, in order that real, timely and useful data be generated in the direction of the CSP-G.

4.2 Analyze and use the information, for decision making which will facilitate the solutions of problems and improve the execution of the activities within his work area.

- 4.3 Monitor the training of the Health Guardians and the rest of the community leaders.
- 4.4 Give follow-up to the training of the Health Promoters who depend on his area of work.
- 4.5 Encourage the good administration of human and material resources under his responsibility.
- 4.6 Assure the accomplishment of the activities planned monthly in each community, giving support in this manner to every promoter.
- 4.7 Report monthly to the Area Coordinator and follow his instructions.
- 4.8 Develop and maintain relationships with the Ministry of Health coordination and other PVOs at community level.
- 4.9 Any other function which the Coordinator assigns.

5.0 WORKING CONDITIONS

- 5.1 The nature of his functions demands that he live full time in his headquarters work area. Each Health Facilitator will have a place from where he will commute to his zones of influence.
- 5.2 The work schedule is flexible, adapting to the needs presented by the nature of his functions.

JOB DESCRIPTION

1. NAME OF THE POSITION:

Field Assistant of the Child Survival Project.

2. NATURE OF THE POSITION:

Consists of assisting the CSP Director in carrying out the functions of coordination, implementation, monitoring and evaluation of the accomplishment of the objectives and goals of CSP-G , supervising and supporting the personnel in the health activities and in the process of information and participatory evaluation.

Also includes the development and maintain relationships with other Public Health authorities and other similar agencies. Will report to CSP-G Director.

3. POSITION QUALIFICATIONS:

3.1 Education:

Professional with university degree level in the areas of health such as: Public Health, Health Educator, Nursing or Medicine.

3.2 Experience:

At least two years of experience in the implementation of development projects or community health projects; proven administrative and management abilities, experience in handling personnel, and proven motivational and communication abilities and proved communication abilities and evident comprehension of the skills required for the development of the communities.

3.3 Other:

- Availability to commute in the work area as needed.
- Good health conditions
- Preferable that know how to drive and have driver license in use.
- Ability to work as a team
- Possibility to work full time for the Organization
- Very good knowledge of English language desirable.

4.0 Functions:

In close coordination and collaboration with the CSP-G Director and, as a team with the rest of personnel, will participate in the following basic functions:

- 4.1 Work closely with the area coordinators to assure the efficient handling of the program in each area.
- 4.2 Assure that the requirements and guidelines presented in the guiding documents of the CSP-G (The Agreement, DIP, Annual Reports, Work Plans, and adaptations as we have been operating) be incorporated in the execution of field activities.
- 4.3 Facilitate and support the integration and coordination of the Child Survival activities with other field activities carried out by WRH.
- 4.4 Identify technical and material resources, local or external, which can be utilized in the implementation and strengthening of the child survival activities.
- 4.5 With the support of the Finance and Administration Departments, assure that the field requirements be obtained and sent on time for the appropriate implementation of activities.
- 4.6 Assist in the development and maintenance of an appropriate information and monitoring system and supervising the collection, documentation, analysis and use of the information produced.
- 4.7 Develop and maintain relationships with Ministry of Health officials of different levels, and other PVOs for the exchange of information, identify successful experiences which may be adapted and establish relationships of mutual collaboration, which can ensure a successful work for WRH.
- 4.8 Assist in the identification, interviewing and selecting of candidates to the different positions which could be needed in the development of CSP-G.
- 4.9 Participate in all the process which leads to the Mid Term Evaluation, Final Evaluation and others which may need to be accomplished.

4.10 Prepare and send on the stipulated time the quarterly and annual activities report which are under his responsibility, as well as the action plans and other reports requested.

4.11 Other activities that may appear in the course of the development of the project.

5. WORKING CONDITIONS

5.1 The nature of his functions demand that he stay at least 50% of his time within the CSP-G geographic area.

5.2 The work schedule is flexible. It will be adapted to the needs presented by the nature of his functions.

CURRICULUM VITAE

NAME: FRANCISCO ANTONIO MORADEL

DATE AND PLACE OF BIRTH:

PROFESSION: FORESTRY SPECIALIST

EDUCATION:

Primary School: "Pedro Nufio" School
Catacamas, Olancho
1964-1969

High School: Catacamas Institute
Accountant
1973-1978

University Studies: National School of Forestry Sciences
(ESNACIFOR) 1979-1981
Forestry Specialist Degree

EXPERIENCE:

- Chief of Forestry Management Unit
Honduran Corporation for Forestry Development (COHDEFOR)
Catacamas, Olancho - June 1990 - September 1991
- Coordinator of Credit Program (PAPAPRO)
World Relief de Honduras
La Mosquitia
March 1987 - June 1988
- Supervisor of Credits
Institute for Honduran Development (IDH)
Tegucigalpa, Choluteca, Danlí
May 1984 - February 1987
- Forestry Extensionist
Natural Resources Management Project
Choluteca
July 1982 - April 1984
- Cashier and in charge of payroll
Meat Packing Company (CISA)
1974-1978

CURRICULUM VITAE

NAME: LIZZETTE IZAGUIRRE

DATE AND PLACE OF
BIRTH:

PROFESSION: Bilingual Secretary

EDUCATION:

Primary School: United States of America School
1968-1973

Seconday Education: Bilingual Secretary
Evangelical Institute
1977-1979

Accounting Degree
"Alfonso Guillén Zelaya" Institute
1980-1982

EXPERIENCE:

- Bilingual Secretary
Agriculture and Rural Development Office
Agency for International Development (AID)
October 1991 - June 1992
- Administrative Assistant
Office of Development Programs
Agency for International Development (AID)
June 1985 - April 1990
- Secretary for Technical Director
Foundation for Business Research and Development (FIDE)
June 1984 - May 1985
- Assistant Purchaser
World Relief (Honduras)/ACNUR
November 1982 - May 1984
- Bilingual Secretary I
Export Promotion Department
General Directorate of External Trade
Ministry of Economy
February 1980 - October 1982

CURRICULUM VITAE

NAME: MARIA ELENA UMAÑA

DATE AND PLACE OF BIRTH:

PROFESSION: Programmer/Analyst

EDUCATION:

Primary School: Tela American School
Tela, Honduras (1958-1965)

High School: Madonna High School
Wichita, Kansas (1965-1970)

University Studies: American University, Washington, D.C.
Studies in Computer and Business Administration.
Northern Virginia Community College
Alexandria, Virginia
Studies in Early Childhood

EXPERIENCE:

- EVANGELICAL HOSPITAL
Siguatepeque, Honduras
Assistant of the Director and Public Relations
1987-1992
- THE NAVIGATORS
Siguatepeque, Honduras
The 2:7 Series
1986-1987
- INTERAMERICAN DEVELOPMENT BANK (IDB), Washington, D.C.
1976-1985
Executive Secretary, Office of Vice-President (1983-1985)
Executive Secretary, Chief, Evaluation Operations Office,
(1981-1983)
Executive Secretary, Recruitment Chief (1976-1981)
- NATIONAL ELECTRICITY COMPANY (ENEE)
Tegucigalpa, Honduras
Executive Bilingual Secretary for the Assistant Manager
(1974-1976)
- CONSEJEROS BERTRAND, Guatemala City, Guatemala
Bilingual Computer Codifier (1972-1974)
- TABACALERA NACIONAL, S.A. Tegucigalpa, Honduras
Executive Bilingual Secretary Manager (1970-1972)

CURRICULUM VITAE

NAME: GUADALUPE SOLIS

DATE AND PLACE OF
BIRTH:

PROFESSION: NURSE

EDUCATION:

Primary School: Escuela República de México
1963-1967
Escuela Benigno Estrada
1968 - Cortés

Secondary Education: CENAR - 1975
Auxiliar Nurse Degree
"Alfonso Guillén Zelaya" Institute
1978-1982

Advanced Studies: National University of Honduras
Tegucigalpa, M.D.C. 1983-1987
Bachelor's Degree in Nursing
National University of Honduras
Tegucigalpa, M.D.C. 1990-1991
Post-Bachelor Studies

EXPERIENCE:

- Chief of Services, Newly Born Ward
Honduran Institute of Social Security Hospital
Comayaguela, M.D.C. - March 1990 to January 1993
- Rotating Nurse
Unit of Pediatrics Intensive Care
Honduran Institute of Social Security Hospital
Comayaguela, M.D.C. - February 1989-February 1990
- Nursing Assistant, Newly Born Ward
Honduran Institute of Social Security Hospital
Tegucigalpa, M.D.C. January 1978-January 1989
- Nursing Assistant, Health Center
Trinidad, Santa Bárbara
Ministry of Health
February 1976 - October 1977

CURRICULUM VITAE

NAME: JOEL DANIEL DURON RODRIGUEZ

DATE AND PLACE OF
BIRTH:

PROFESSION: MEDICAL DOCTOR

EDUCATION:

Primary School: "Francisco Morazán" Grade School
1967-1972

High School: Escuela Normal de Varones
"Centro América"
Primary School Teacher
1976-1978

University Studies: Faculty of Medical Sciences
National University of Honduras
Medical Doctor
1980-1988

EXPERIENCE:

- Teacher and Director of
"Luis Ernesto Táborá" Grade School
Los Bejucales, El Paraíso
1979

- In charge of Medical Program
"Friends of the Americas"
(International Organization)
Las Trojes, El Paraíso
February 1991 - June 1992

CURRICULUM VITAE

NAME: NOLVIA VILLANUEVA DE RODRIGUEZ

DATE AND PLACE OF BIRTH:

PROFESSION: ACCOUNTANT

EDUCATION:

Primary School: Escuela José Cecilio del Valle
Tegucigalpa, M.D.C.
1964-1969

High School: "Vicente Cáceres" Institute
Comayaguela, M.D.C.
Accounting Degree
1970-1975

EXPERIENCE:

- ACCOUNTANT
CARE International
January 1983 - September 1992
- ACCOUNTANTING ASSISTANT
Comercial Company Schmid & Tentori
October 1976 - August 1982

OTHER SKILLS:

- Handling of IBM personal computers
- Handling of all office machines

CURRICULUM VITAE

NAME: CARLOS ALBERTO HERNANDEZ
AGE: 25 years old
NATIONALITY: Honduran
PROFESSION: GRADE SCHOOL TEACHER
BACHELORS DEGREE IN EDUCATION

EDUCATION:

Primary Education: Alvaro Contreras School
Los Planes, Sonaguera, Colón
1975-1981

High School: Escuela Normal Mixta
Trujillo, Colón
Teaching Degree
Grade School Teacher Degree
1985-1987

University Studies: National Autonomous University of Honduras
Bachelor in Education Degree

EXPERIENCE:

- Regional Coordinator of Training Program
CEDEN (Evangelical Committee for National Emergencies)
February, 1993 - July, 1993
- Coordinator of Training Program
FEPROH (Local development organization)
March 1988 - January 1993
- Coordinator of Education Department
Region No.6
Ministry of Public Health
March 1987 - September 1987

CURRICULUM VITAE

NAME: LESBIA MIREYA COLINDRES ROSALES

DATE AND PLACE OF
BIRTH:

PROFESSION: ACCOUNTANT

EDUCATION:

Primary Education: Mixta Esteban Guardiola School
La Lima - 1976

High School: Patria Institute
Accounting Degree
La Lima - 1982

University Studies: 6 years of Accounting Studies at
National Autonomous University of Honduras

EXPERIENCE:

- General Accountant
Board of Mechanical and Chemical Engineers of
Honduras (CIMEQH)
July 1991-October 1992
- Accounting Assistant
CREDOMATIC of Honduras
Tegucigalpa - 1990-1991
- Administrator
Christian Institution "Power of God"
Tegucigalpa - 1989-1990
- Administrator and Accountant
INCEL - Tegucigalpa
1986-1989
- General Accountant
CENTRAH - San Pedro Sula
1985-1986
- Accounting Assistant
TROMETAL - San Pedro Sula
1983-1985

ANNEX E

**WORLD RELIEF HONDURAS
CHILD SURVIVAL PROJECT - GUAYAPE
ANNUAL REPORT YEAR 4**

CSP EXPANDED STRATEGY TO DISSEMINATE HEALTH MESSAGES

C. HEALTH PROBLEMS WHICH THE PROJECT ADDRESSES

There are several problems which have emerged in the project that CSP-G personnel have begun to focus on. These problems are listed below:

1. The Health Guardians have been unable to meet the objectives for coverage of the community in many of the interventions.
2. Due to the heavy workload of the Health Guardians, many of them drop out of the program. The drop out rate for the CSP-G has been 30% since the first year.

In order to begin to achieve greater coverage levels and to minimize the loss of Health Guardians, the CSP-G project will begin to utilize several new methods by which to reach the target population.

Social Marketing of Health Messages

To reinforce and compliment the education given by the Health Guardians, CSP-G has begun to place posters in public areas such as corner stores, schools, churches and health centers in the third quarter of Year 2. These posters highlight the benefits of oral rehydration, the warning signs of pneumonia and other CS interventions. CSP-G plans to continue the use of posters for the duration of the project.

In addition, mobile car speakers will be used to disseminate educational messages to the population. WRH vehicles with loud speakers will be driven through the streets announcing health messages. Popular folkloric music will be played prior to each message to draw the attention of those listening. These spoken messages alternating with the music will be repeated frequently so that they will become imprinted in the minds of those listening.

Other methods such as theatrical groups, social dramas, and puppet shows which are common forms of entertainment in Honduras will be performed by school children and church groups and will also be used to give educational messages to the communities.

Health Education Focus in Schools and Churches

Some CSP-G Health Promoters have utilized the school in order to reach parents through their children. This has been found to increase the coverage of the educated population in the communities. The same has occurred through the local evangelical churches and has been an excellent means by which to multiply the contexts for CS messages. Utilizing structures which already exist in the community promotes

sustainability in the dissemination of health messages by actively involving many different community groups in the CSP-G interventions.

Beginning in the third quarter of Year 2, elementary school teachers were trained in CS interventions. The teachers then relay these basic health messages to the students in an orientation class that is mandatory for all students at the beginning of each school year. In this way the students can be taught, while at the same time they are motivated to get the participation of their parents.

For example, a health promoter named Nahum Cruz utilized this method in El Coyol. He educated one of the teachers about vaccinations. This teacher then taught the students about vaccinations. The students' homework was to repeat what they learned each day to their parents and to tell their mothers when vaccinations would be given at the health centers.

It is hoped that this type of activity will draw the mothers to the health centers, at which time the monthly meetings given by the Health Guardians are held and vaccinations and educational messages given. It is also hoped that meetings could be held with the parents of school children much like a Parent/Teachers Association meeting, but be focused on health.

In some communities "parades for health" have been organized whereby school children carry posters with written messages through the streets, while periodically repeating the message aloud. CSP-G also plans to motivate teachers to form groups of students to perform in theatrical groups. The same will be done in local evangelical churches utilizing local leadership to organize groups of children to relay health messages through various forms of communication.

Health Education Focus in Marketing Centers

Marketing centers are towns which are larger than rural villages and smaller than cities, usually composed of 2,000 or more inhabitants. These centers draw people from neighboring villages to sell products. Furthermore, these centers are organized like cities, with homes arranged into city blocks rather than being dispersed throughout the countryside.

As a result of a workshop held among CSP-G Health Promoters and staff, the conclusion has been reached that it is very difficult for the Health Guardians to adequately care for such a large number of people. In working with the Health Guardians, the Promoters often observed that the Health Guardians did not have adequate time to sufficiently reach the number of families to which they were assigned (usually 50). Thus, a new strategy will be employed, whereby a block representative will replace the Health Guardian and will be responsible only for the

neighbors which live on her block. The number of housing units on each block is about 10 to 15.

The method will be piloted in a town called San Ignacio and if successful will be adapted to other areas. It follows a model which has been employed in the Monterrey subdivision of Tegucigalpa and has improved all CS interventions taking place there.

In this model, which MOH officials and CSP-G jointly designed, the community is first divided into four sectors. A coordinator would then be assigned from the MOH health center to each sector. The coordinator of each sector will act as a health promoter and will report to the MOH auxiliary nurse who is in charge of the health center.

Each sector is divided into blocks of 10 to 15 housing units and each block will elect a representative who will hold monthly growth monitoring sessions and will educate the block about CS interventions. This will permit the block representative (a voluntary worker) to work in a concentrated area. In this way the representative will be able to perform the educational work in a shorter time and with less effort. Since she will already have a relationship with her neighbors, she will also be motivated to share the education she receives with them.

The block representatives will be trained in groups utilizing a participative methodology which employs interactive methods such as discussions, games and songs to train the volunteers. Each block representative will make a sketch of their small area of influence and mark the houses where children under five years of age and high-risk mothers live. This sketch will serve the representative and aid the MOH in their census. The block representative will visit the high-risk families every week which will increase the community's confidence in her.

This working model for marketing centers of the CSP-G is in the planning phase with the MOH for implementation at the beginning of Year 3.

D. CHILD SURVIVAL INTERVENTIONS

There have been no changes in the type or scope of CS interventions since submission of the DIP.

ANNEX F

WORLD RELIEF HONDURAS WORK STRATEGY OF THE CHILD SURVIVAL PROJECT - GUAYAPE, BASED ON FOCUS ON RISK

1. STATEMENT AND BACKGROUND OF THE STRATEGY

Since the elaboration of the proposal of the Child Survival Project Guayape (CSP-G) in December 1988, it was established that the criteria of risk would be key elements for the successful implementation of the Child Survival interventions (Immunizations, Control of Illnesses from Diarrhea, Growth/Nutrition Control, Acute Respiratory Infections, Prenatal Care/ Birth Spacing).

The criteria for risk which are used are:

A. High-Risk Children

1. After two consecutive weight sessions, the child has not gained weight or has lost weight.
2. Has not been given Vitamin A (food rich in Vitamin A or supplements).
3. Younger than 6 months of age who are not receiving Exclusive Breast-feeding.
4. The child has a vaccination chart incomplete for his age, or the child has never been vaccinated.

B. High-Risk Women

Women in reproductive age, pregnant or not pregnant, with:

1. Tetanic toxoid vaccinations incomplete or nonexistent..
2. Younger than 18 or older than 35 years old.
3. With 3 or more previous children.
4. With intergenetic interval less than 2 years.

C. High-Risk Families

Families with children and/or women who have one or more of the before-mentioned criteria.

The implementation strategy consisted in the first place of training World Relief Honduras (WRH) field personnel, known as Health Promoters (HP), in each intervention, using participative methodologies. Simultaneously, each HP received a commitment zone where he/she trains health volunteers (Health Guardians - HGs).

In this process, the HG, among other things, learned to highlight the high-risk women and children in red, in order to visit them in their homes and pay more attention to them.

Despite this, in the biannual evaluations which have been carried out with all the CSP-G personnel, it became evident that there was a progressive work overload for the HG. For this reason, it was decided that as of the second semester of 1991 the work strategy would be expanded, incorporating, in a systematic manner, the schools and churches of the work zone; in order that, after training the teacher and church leaders, they carry out health training activities. In this way it will be avoided that the HGs carry all the responsibility.

The Mid-Term Evaluation (MTE) which was carried out in July 1992, showed that the HGs still show signs of a work overload, which does not allow for the risk on focus to be applied effectively.

Following the Mid Term Evaluation, and after reflecting on this matter with all the field personnel, we saw the need for improving the implementation strategy, and a decision was made to make a stronger emphasis in the following basic elements:

- 1) Train volunteers to have a more specific role in each intervention, in order to reduce the workload of the previously trained HGs.
- 2) Conduct follow-up in each community according to risk groups.
- 3) Integrate all the interventions around growth control.
- 4) Keep strengthening the formation of local grupos which can eventually function as counterparts and have a close relationship with the Ministry of Health (MOH).
- 5) Manage to have every volunteer in each intervention be part of a support network in Child Survival.
- 6) Strengthen the System of Reference/Counterreference with the MOH.
- 7) Concentrate the activities of the program of food counseling in the risk population, and develop more individualized pilot experiences of feeding practices.
- 8) Support the initiative of the MOH of installing Community Oral Rehydration Units (UROC).

The draft of the experience to be implemented was designed and it was refined as it was shared with regional, area and local level officials of the MOH; the same as with community volunteers and with representatives of other NGOs which also work in Child Survival.

During the month of February the area teams of the CSP-G and the MOH planned the implementation of the work to be carried out during 1993, deciding to start as of March as an initial experience in only one community in every area of influence of each of the Health Centers.

II. DESCRIPTION OF THE IMPLEMENTATION STRATEGY

Each month the HGs carry out weighing sessions with the children under 5 years of age of the community. In one-third of the communities where the CSP-G works, besides the HGs there are Support Groups to the HG, formed by women of the community who assist monthly with their children to the weighing sessions.

The people who form part of these support groups have been trained in all the CSP-G interventions, and have formed a team with the HGs in all their activities. In principle, they will be the volunteers who, after being retrained, will be responsible for one of the different interventions of the CSP-G.

The key intervention is growth control, which serves as the head of the spear to open up the doors of the community, and as an integrating axis of the other activities.

Based on the periodic weight of each child obtained in the weighing sessions, the children are classified in two groups: children who gain weight, and children who do not gain weight. This classification is made exclusively based on the weight tendency without taking into account the nutritional level.

Each of the groups will be led by a different volunteer trained for such a purpose.

1) The group of children who do not gain weight is the group of nutritional risk. A child is included in this group when he/she does not gain weight (the weight decreases or remains the same) for two consecutive sessions.

The volunteer with the greatest experience will be in charge of this group (for example, the present Health Guardian) and he/she will concentrate all his/her efforts in closely following up the children in this group.

The Health Guardian, together with the child's mother, will answer all the following questions, which are a guide to the kind of response the Health Guardian will give:

- * Does the child eat frequently enough?
(It must be ensured that the child eats 6 times a day.)
- * Does the food which the child receives have enough energetic ingredients?
It must be ensured that the child receives mixtures of legumes (such as beans, soybeans) with cereals (rice, corn, wheat); that they increase the use of oils or grease (more fried food or butter) in each meal; the same as more sugar in the form of candy, brown sugar.

The HG will pay home visits to give food counseling and will carry out demonstrations of food preparation to the mothers of high-risk children, using the food which they have in their own home.

- * Is the child frequently sick?
(Make sure that the mother looks for the health personnel to obtain treatment and/or to evaluate if the child needs or not to be attended in a more complex health installation.)
- * Did the child reject food while he was sick?
(It must be ensured that the child receive one more meal a day, at least for two weeks after the illness.)
- * Does the child receive enough Vitamin A?
(Make sure the child receives Vitamin A supplement and that he/she eats fruits and vegetables every day.)
- * Is the child being bottle fed?
(Breastfeeding should be promoted; since it is possible that the bottle and the water are not clean, or that the mothers are substituting the milk for rice water or sugar water.)
- * Is the cleanliness of the food and the water being watched over?
(If that is not so, the child will frequently suffer from diarrheal diseases.)

- * Is excrement deposited in latrines or buried?
(If this is not so, the child will frequently be ill.)
- * Does the child have intestinal parasites?
(If so, make sure that he is treated for parasites at the Health Center.)
- * Is the child alone too often?
(The child needs to receive more stimuli and greater attention in order that he/she can have a healthy development.)

In the risk group there will be a more frequent growth control, according to age, in the following manner: Children 0 to 11 months of age will be weighed every 15 days; those between 12 and 59 months will be weighed monthly. In this manner the parents will be able to evaluate the results of the care they have given their child.

The HG should make sure that each child of this group has a complete vaccination record, that he receives Vitamin A, that his mother is trained in control of diarrheal diseases and prevention of deaths from pneumonia; and that she ideally practice or get to practice birth spacing methods.

When the children of this group have an increase in weight during at least six consecutive sessions, independently of their nutritional level, they will be ready to pass to the group of children who increase weight.

2) The Group of Children Who Increase Weight

In this group will be the children who show an increase in weight. There will be a volunteer dedicated exclusively to this group. The mothers will take their children to the monthly weighing session if they are less than 24 months of age, and quarterly if they are between 24 and 59 months of age.

In each meeting the mothers will receive educational messages on the different interventions of the program, and other subjects as is deemed necessary.

If a child does not gain weight after two consecutive sessions, he will be transferred, with a transmission note, to the risk group corresponding to his community in order to continue his control.

3) Attention of the Child with Diarrhea

One more volunteer will be in charge of assisting the children with diarrhea. He/she will have packets of Oral Rehydration Salts in his/her home, which will be provided by the MOH Health Center.

This volunteer will be trained in two stages: in the first stage he will be taught how to handle a child with diarrhea in order to prevent its consequences; and, in the second stage, he will be trained on how to rehydrate a dehydrated child.

In the handling of the child with diarrhea to prevent its main consequences, it is taught that the two main dangers of diarrhea are DEATH and MALNUTRITION. Death by acute diarrhea is usually caused by DEHYDRATION.

Emphasis will be made in treating the child in his own home, practicing the following basic rules:

1. Give him a greater amount of liquids than usual.
 2. Keep feeding him as usual, i.e., continue with breastmilk if he is breastfeeding, and with other foods if the child normally receives them.
 3. Take the child to a health worker when there are signs of danger.
- (The educational content of this phase is attached.)

In order to be trained in Oral Rehydration, the volunteer will participate in educational sessions in an MOH hospital, where he will be able to observe and learn the signs of dehydration, and receive training in oral rehydration in a practical way.

Each mother who has a child with diarrhea will be taught by the volunteer the aforementioned aspects, and together they will prepare the liquids which the child should take, using whatever resources the mother has at home.

If the child must be referred to a health installation, the volunteer will make a reference note and will give indications of how to handle the child during the trip.

When the child returns from receiving care, the mother will bring a counter-reference note to the volunteer, containing the diagnosis, the treatment received and the treatment to be received. In this manner, the informed volunteer will be able to give follow-up treatment to the child.

When the volunteer is trained in oral rehydration, he will also handle dehydrated children in his community, and will administrate a system of reference/ counter-reference with the MOH Health Centers, in cases where it is necessary.

The treatment of the dehydrated child will be carried out by using the utensils found in the community, such as clay containers, pop bottles, spoons, cups, jars, etc., which will be provided by the community.

The volunteer will also be trained so that he can conduct community activities of basic sanitation which lead towards the prevention of diarrhea.

It is expected that the final result in the handling of the patient with diarrhea be something similar to what the MOH is promoting at this moment with the name of the Community Oral Rehydration Unit (UROC).

4) Prevention of Deaths from Pneumonia/Inmunizations/Vitamin A

Finally, and in direct relation to the child, there will also be a volunteer in prevention of death from pneumonia; who, besides his educational task, will have Vitamin A supplements as something concrete to offer the community, and will give follow-up of the intervention of immunizations.

This volunteer will receive training centered around the early detection and reference of pneumonia, based on an increase in respiratory frequency and withdrawal under the ribs as cardinal signs of diagnosis.

A special emphasis will be made in the detection of high risk children, and it will be ensured that their vaccination record is complete, that they receive Vitamin A, and that they receive direct food counseling.

This volunteer will receive training in immunization, and will give follow-up to women so that they receive the corresponding dosage of tetanus toxoid; and will follow up newly borns and children under 1 year of age to ensure that at the end of the first year of age they complete their vaccination plan.

He will be in charge of administrating Vitamin A each 6 months to the children under 5 years of age in his community, and of promoting that they eat foods which are rich in Vitamin A.

The volunteer will be part of the system of reference/counterreference of children with pneumonia, and will be vital in the follow-up of these children after they have received treatment in a health installation.

5) Reproductive Risk

There will be a health volunteer, preferably one who has a family planning post, in charge of detecting and educating women with reproductive risk criteria, and of offering the women alternatives of birth spacing. The volunteer will have a close relationship with the Traditional Birth Attendant and the Nurse in this task.

The family planning methods provided by ASHONPLAFA (the Association of Family Planning of Honduras) and/or the MOH will be used.

6) Birth Delivery Care under Risk Focus

The Traditional Birth Attendants (TBAs) will be trained in order that they can carry out their work using risk criteria, in such a manner that they can identify the high-risk pregnant woman and that she be referred to a health installation for her control and birth delivery care.

The TBA will also be trained in hygienic birth delivery, in administration of Vitamin A to the women at the moment of the delivery or during the first 4 weeks after delivery, in referring newly borns to growth and vaccination control; and in referring the mother to reproductive risk control.

The TBA will also be part of the system of reference/counterreference.

The Auxiliary Nurse of the corresponding Health Center will be directly involved in all this process (selection, training, and follow up of volunteers).

The purpose is that these community volunteers, together with the nurse of the Health Center, form a Health Committee which will meet once a month to share information on the activities which have been carried out, and that they make decisions as a team.

This Health Committee will represent the community counterpart of the Health Center, with whom they will work as a team in order to resolve the sanitary needs of the population (a diagram is attached).

Tegucigalpa, Honduras, May 1993

ANNEX G

Objective 17, "Women 15-45 years who can identify and facilitate treatment of pneumonia": For the same reasons as described for objective 16, the goals and final coverage for this objective were also modified to lower levels than those originally forecasted. The revised goals are as follows: 15% (Year 2), 20% (Year 3), 25% (Year 4) and 30% (Year 5).

Objective 18, "Health Guardians trained for inclusion into MOH Public Health System": This objective was met and surpassed at 63%. Instead of training 60 Health Guardians, project staff trained 98 new Health Guardians to cover the current drop out rate of 30% so that 60 (the original goal) will remain. The objectives for Years 3, 4 and 5 remain unmodified at 60, 40 and 40 respectively.

Objective 19, "Local Health Committees Organized": This objective was met this year (100%) with the organization of a total of 50 committees within the CSP-G project area. However, it is important to note that these committees are not yet fulfilling the final role envisioned for them. For the moment, the committees are organized from within each community group of mothers that is being trained in child survival (CS). These committees are functioning in the first stage of development. It is hoped that with time they will become stronger and consolidate into permanent local structures which include the involvement of community leaders so that activities such as reforestation, sanitation and income generation will be implemented in addition to CS activities.

B. LOCATION AND SIZE OF THE PRIORITY POPULATION LIVING IN THE CHILD SURVIVAL IMPACT AREAS

During the third year, a change in the location of the project is anticipated. The communities which will not be included in the CSP-G are the municipalities of Concordia, Campamento, and Cedros. The principal reason for this change is that another NGO named PREDISAN, which stands for *predicación* and *sanidad*, initiated another CS project in 1990 in Catacamas, one of the seven original CSP-G municipalities. World Relief Honduras (WRH) made an agreement with PREDISAN to divide the municipality in order to coordinate activities and avoid overlap. Upon extending its services to other municipalities, the CSP-G would compensate for the territory lost to maintain the original population size. Furthermore, we would be responding to the requests of the MOH to extend services of the CSP-G to communities in other municipalities. In summary, the location of the project will be adjusted, but the size of the population will remain the same as originally proposed.

ANNEX H

LESSONS LEARNED

1. The development of an adequate system for managing and supervising is crucial in obtaining the best results of a Child Survival project.
2. When a Health Guardian has to handle many interventions and has a population of more than 20 families, he cannot achieve his work efficiently.
3. In any Child Survival project to be implemented, it is important to keep in mind that the feeding strategy is a priority in order to get the best results.
4. The development of human resources at community level is effective because the people are able to visualize their problems and at the same time look for a solution to them.
5. Field supervision should be carried out systematically with the precise help of simple but reliable instruments in order to be able to correct the problems encountered in the least possible time within all the structural levels of the CSP-G.
6. Unless each aspect of the program (the health messages, the structures, the supervision policies, the information system, the reference system, the costs) are developed together with the MOH, there will be no hope of sustainability.
7. Any NGO that wants to develop a Child Survival program must ensure the participation and commitment of the Ministry of Health beginning with the elaboration of the proposal and in every stage of the project.
8. In order to have a close relationship with the MOH one must have a strategy which motivates and facilitates working together and training volunteers, and which furthermore will provide new areas of interest, something which has been very effective for the MOH personnel.
9. The lack of involvement from the beginning of the project, and the different institutional objectives and the different structures, causes the relationship with counterpart NGOs to develop as relationships of coordination and not of continuous implementation.
10. It is more effective to train community volunteers if the educational strategy and contents are framed within a unique organizational structure and within its real context.

11. The Local Health Committees which at the beginning function as support groups to work hand in hand with the Health Guardian are very important to ensure community participation, but to be effective the role of dependency must be inverted and the Health Guardians must be subordinated to the Committees.
12. The Health Promoters should have well defined guidelines to work with; for example, with teachers or with churches, etc.. If it is open-ended not much is achieved -- they have a hard time starting.
13. It is a good approach to educate the community by means of community volunteers, but it is not effective for all the work to depend exclusively on one type of volunteer only; for example, on Health Guardians. They must be helped to integrate their actions with other networks of persons responsible of other community interventions (Community Rehydration Units, Support Networks for Breastfeeding Mothers, Community Center for Family Planning Services, etc.)
14. At the level of Public Health structures, the Auxiliary Nurse is the most ideal personnel to carry out the work of community education; and until the Auxiliary Nurse participates actively in the selection and training (design and execution of training workshops and follow-up) of community volunteers, can we say that an effective integration of Health Center--Health Volunteer in the community activities exists.
15. The Information System must be designed from the beginning of the Project, so as not to lose valuable information, and it is more adapted to the work when the field personnel participate extensively in its revision and adjustment.
16. The educational work which does not include the provision of the product which is being promoted (for example: contraceptive methods) is not effective in improving community practices.
17. The educational activity should not be limited to only the transmission of knowledge, but instead should move more towards the initiation of practices. For example: the health volunteer should not only give instructions to the mother of how to prepare ORS, the volunteer should have the ORS, prepare the solution with the mother, give the first dose to the sick person and make follow-up visits to the mother to ensure that she is using ORS at home.

18. Not only should there be teaching on birth spacing, but methods within the community should exist in order to be able to refer the user to them.
19. Children, because they are beings who stir up the affection and respect of the adults, are excellent educators, besides educating the adults of the future in the process .
20. The health volunteers who have been trained with a curative vision, despite the training they receive, are not able to function in the preventive area. Even the health personnel at the highest level who have a curative vision of their work have serious difficulties getting involved in preventive activities.
21. Participatory methodology and techniques are effective in the training of community volunteers. They facilitate learning and the development of abilities to train others.
22. Work methods should be applied in which the community volunteer, linked to a formal community structure, is not overworked; for example: assign him a small and well-defined influence zone; limit the number of interventions in which he participates; treat him with great politeness and courtesy; visit him constantly so that he can be sufficiently motivated and that he can work more effectively, etc.
23. The local grade schools are effective means for promoting health education at community level.
24. Weighing sessions with too many participants are not very effective, especially because the mother, due to lack of time, cannot be instructed on the use of the growth chart and on how her child is developing, and furthermore, the health volunteer wears out. Weighing sessions with 5 to 8 children should be designed.
25. The careful recruiting of volunteers and the initial training on the characteristics and functions of the health volunteer are important because they are decisive on whether he continues or gives up; for which reason every training should be started with these aspects.
26. The motivation of the paid Health Volunteer is more crucial in defining his vision and the results of his work than the material work instruments which he possesses.

COUNTRY PROJECT PIPELINE ANALYSIS GUAYAQUE CSP

FIELD	ACTUAL EXPENDITURES TO DATE WRH COUNTRY EXPENSE SEP/1/89-AUG/31/93			REMAINING OBLIGATED FUNDS			TOTAL CTRY AGREEMENT BUDGET SEP/1/89-AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
PROCUREMENT									
Equipment:	6,312.42	96,293.06	102,605.48	(6,312.42)	(34,743.06)	(41,055.48)	0.00	61,550.00	61,550.00
Supplies:	14,449.39	2,055.80	16,505.19	15,050.61	7,944.20	22,994.81	29,500.00	10,000.00	39,500.00
Services:	65.43	0.00	65.43	3,934.57	0.00	3,934.57	4,000.00	0.00	4,000.00
Consultants									
1) Local:	8,657.89	0.00	8,657.89	(5,107.89)	0.00	(5,107.89)	3,550.00	0.00	3,550.00
2) Expatriate:	1,849.38	0.00	1,849.38	5,450.62	0.00	5,450.62	7,300.00	0.00	7,300.00
TOTAL PROCUREMENT	31,334.51	98,348.86	129,683.37	13,015.49	(26,798.86)	(13,783.37)	44,350.00	71,550.00	115,900.00
EVALUATION	6,151.68	0.00	6,151.68	98.32	750.00	848.32	6,250.00	750.00	7,000.00
INDIRECT COSTS	111,176.52	0.00	111,176.52	48,898.48	0.00	48,898.48	160,075.00	0.00	160,075.00
OTHER PROGRAM COSTS									
Personnel									
1) Health	194,937.12	27,254.88	222,192.00	142,142.88	57,775.12	199,918.00	337,080.00	85,030.00	422,110.00
2) Administrative	99,740.42	32,446.91	132,187.33	81,729.58	14,268.09	95,997.67	181,470.00	48,715.00	228,185.00
3) Other	17,468.66	27,780.02	45,248.69	17,996.34	19,354.98	37,351.31	35,465.00	47,135.00	82,600.00
Travel/Per Diem									
1) In Country	13,287.39	1,389.05	14,676.44	4,532.61	7,610.95	12,143.56	17,820.00	9,000.00	26,820.00
2) International	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Direct Costs	98,887.00	22,848.73	121,735.74	(15,977.00)	12,101.27	(3,875.74)	82,910.00	34,950.00	117,860.00
TOTAL OTHER PRG COSTS	424,320.60	111,719.60	536,040.20	230,424.40	111,110.40	341,534.80	654,745.00	222,830.00	877,575.00
EXCHANGE (GAIN)/LOSS	11,507.24	2,892.21	14,399.45	(11,507.24)	(2,892.21)	(14,399.45)	0.00	0.00	0.00
TOTAL EXPENSES TO DATE	584,490.55	212,960.67	797,451.22	280,929.45	82,169.33	363,098.78	865,420.00	295,130.00	1,160,550.00

HEADQUARTERS PROJECT PIPELINE ANALYSIS GUAYAPE CS

HEADQUARTERS	ACTUAL EXPENDITURES TO DATE HEADQUARTERS EXPENSE SEP/1/89-AUG/31/93			REMAINING OBLIGATED FUNDS			TOTAL HQ AGREEMENT BUDGET SEP/1/89-AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
PROCUREMENT									
Equipment:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Supplies:	168.79	46.80	215.59	1,331.21	453.20	1,784.41	1,500.00	500.00	2,000.00
Consultants									
1) Local:	44.99	75.01	120.00	(44.99)	(75.01)	(120.00)	0.00	0.00	0.00
2) Expatriate:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL PROCUREMENT	213.78	121.81	335.59	1,286.22	378.19	1,664.41	1,500.00	500.00	2,000.00
EVALUATION	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
INDIRECT COSTS	22,396.53	0.00	22,396.53	2,503.47	0.00	2,503.47	24,900.00	0.00	24,900.00
OTHER PROGRAM COSTS									
Personnel									
1) Health	56,987.56	2,431.83	59,419.39	2,980.25	288.17	3,268.42	59,967.81	2,720.00	62,687.81
2) Administrative	42,717.66	7,981.86	50,699.52	0.33	193.14	193.47	42,717.99	8,175.00	50,892.99
3) Other	494.20	18,114.19	18,608.39	0.00	510.81	510.81	494.20	18,625.00	19,119.20
Travel/Per Diem									
1) In Country	2,471.70	0.00	2,471.70	2,528.30	0.00	2,528.30	5,000.00	0.00	5,000.00
2) International	0.00	5,442.18	5,442.18	0.00	7,757.82	7,757.82	0.00	13,200.00	13,200.00
Other Direct Costs	0.00	1,273.27	1,273.27	0.00	1,476.73	1,476.73	0.00	2,750.00	2,750.00
TOTAL OTHER PRG COSTS	102,671.12	35,243.33	137,914.45	5,508.88	10,226.67	15,735.55	108,180.00	45,470.00	153,650.00
TOTAL EXPENSES TO DATE	125,281.43	35,365.14	160,646.57	9,298.57	10,604.86	19,903.43	134,580.00	45,970.00	180,550.00

NOTE: On July 14, 1992, in preparation for FY93, it was decided to move (a) \$2000 from Procurement (WRC/Supplies) to use for Personnel (WRC/Health) and (b) \$1500 from ODC (WRC) to Personnel (\$720 Health and \$780 Admin). Therefore, the Total HQ Agreement Budget was adjusted.

HEADQUARTERS PROJECT PIPELINE ANALYSIS GUAYAPE CS

	ACTUAL EXPENDITURES TO DATE HEADQUARTERS EXPENSE SEP/1/89--AUG/31/93			REMAINING OBLIGATED FUNDS			TOTAL HQ AGREEMENT BUDGET SEP/1/89--AUG/31/94		
	USAID	WRC	TOTAL	USAID	WRC	TOTAL	USAID	WRC	TOTAL
TOTAL FIELD EXPENSE	584,490.55	212,960.67	797,451.22	280,929.45	82,169.33	363,098.78	865,420.00	295,130.00	1,160,550.00
TOTAL HEADQUARTER EXPENSE	125,281.43	35,365.14	160,646.57	9,298.57	10,604.86	19,903.43	134,580.00	45,970.00	180,550.00
GRAND TOTALS YRS 1-4	709,771.98	248,325.81	958,097.79	290,228.02	92,774.19	383,002.21	1,000,000.00	341,100.00	1,341,100.00

ANNEX J

**WORLD RELIEF HONDURAS
CHILD SURVIVAL PROJECT - GUAYAPE
ANNUAL REPORT YEAR 4**

RESPONSE TO USAID TECHNICAL REVIEW OF THE DIP

WORLD RELIEF CORPORATION (WRC) HONDURAS GUAYAPE CHILD SURVIVAL PROJECT

RESPONSE TO USAID TECHNICAL REVIEW OF THE DIP

The project staff's response to all concerns and recommendations (shown in *italic*) in the Technical Review is outlined below.

ARI

"The ARI component will concentrate on the detection and referral of complicated cases, with mild cases being treated by the family. This is a weak approach. Since ARI is the second leading cause of mortality this component needs to be developed further. What infrastructure will support referral? Are the referral centers capable of receiving children with pneumonia? In some areas it has been documented that the time between detection of pneumonia and death averages 3½ days. That means the project will have little time in which to identify the child with pneumonia and for the family to take action. The referral center must also have the necessary drugs to treat the child. The focus of WRC's ARI efforts should be to detect and to initiate the treatment of childhood pneumonia at the community level, instead of referring the child to a health center. Further, mothers should be educated in recognizing the signs and symptoms of rapid and difficult respiration, fever, and refusal to eat. Educating mothers in the treatment of mild ARI distracts the families attention away from pneumonia.

Also, ARI targets for under 24 months are needed since around 80% of pneumonia are in children under 24 months, with children under three months of age at very high risk for dying."

The project staff agreed with the USAID recommendation that the current approach to the ARI component needs strengthening. They had based their original approach on the official MOH approach which divides the problem of ARI into mild, moderate and severe cases, and promotes treatment according to the same division. Government health centers do not currently focus on the treatment of varying stages of pneumonia. After receiving the Technical Review, the Project Director took the USAID criticisms of the ARI approach to the Director of the Departamento de Atencion al Niño (Department of Attention to the Child) and discussed with him how the project's strategy might be strengthened. The Department Director suggested that project staff proceed initially with the training of mothers according to USAID recommendations. In this meeting, they learned that the MOH is reviewing and redeveloping its approach in accordance with recommendations similar to those from USAID. The MOH intends to eventually incorporate this revised approach into their nurses training program.

The current clinical referral infrastructure in the project's geographical areas is administered by the MOH through the rural health centers. These centers possess equipment and materials for the treatment of pneumonia. The project staff recognize that there are times when the life of a child with pneumonia is in danger due to the lack of personnel, drugs and adequate equipment. These factors, however, are beyond the project's control.

It would be difficult for Health Guardians to fully treat suspected cases of pneumonia at the community level. Such a strategy would require the project to equip each Health Guardian with such drugs as Penicillin, Procainica, Cotrimoxazol, or Amoxicilina. The MOH prohibits Health Guardians from carrying these drugs. Even if Health Guardians were allowed to carry them, the cost of purchasing the drugs would be very difficult for the project to underwrite. Ideally, it is the family who should be aware of and able to initiate the treatment of their children with signs of pneumonia. This is commensurate with the project's goal of enabling the community to facilitate solutions to its own health needs.

The project would therefore like to revise its approach to the ARI component by training mothers to recognize the signs and symptoms of rapid and difficult respiration, and fever and anorexia, thus facilitating early detection, treatment and/or referral of children with signs of pneumonia. The training will focus on children of 0-24 months, the most vulnerable group.

One complication in initiating this new strategy is that health center staff will need training before they can assist with treatment. The project has responded to this need by sponsoring training workshops for MOH nurses in the project areas.

Two project interventions addressing ARI were revised to reflect the recommendations in the technical review. Objective 12, "Women 15-45 instructed in prevention of ARI" was revised to read "Women 15-45 instructed in the prevention of death from pneumonia." Objective 13, "Women 15-45 who can identify ARI and facilitate treatment" was revised to read "Women 15-45 who can identify and facilitate treatment of pneumonia."

GROWTH MONITORING

"The growth monitoring target of weighing all children 0-59 months on a monthly basis is not realistic. An alternate solution could be to weigh the children 0-23 months old on a monthly basis and to weigh children 24-59 months every three months, with a monthly follow-up only for those children with inadequate weight gain."

Project staff agreed with USAID that the growth monitoring target of weighing all children 0-59 months on a monthly basis was unrealistic, but feel they used good reasoning in setting the original target. Prior to the initiation of the project, few mothers in the project regions were aware of the need for growth monitoring. Personnel, therefore, felt the strong need to motivate all mothers to develop the habit of regularly monitoring their children's growth, especially children 0-23 months of age. Since there were mothers in the project area without children under the age of 23 months and project staff want to be sure all mothers develop the habit of monitoring their children's growth, personnel decided to motivate all mothers to bring all their children 0-59 months to the growth monitoring sessions. Per the USAID recommendation, however, project personnel now weigh at each growth monitoring session only children 0-23 months and children 24-59 months who are malnourished or not gaining weight. All other children 23-59 months will be weighed quarterly.

"The plan lacks nutrition education or counseling (growth promotion) as part of growth monitoring. The nutrition education planned is set up as a separate intervention and implemented in group meetings where individual counseling is not possible. One possible solution is to integrate a growth promotion component into the growth monitoring intervention so that the mothers will get individual counseling regarding their children's growth. This practice is likely to encourage greater participation of the mothers in future growth monitoring and promotion activities while empowering them to care for and feed their children more successfully."

Project staff continue to provide nutrition education to mothers not only during group training sessions, but also to individual mothers during growth monitoring sessions and during follow-up home visits of severely malnourished children. When a child is identified as malnourished at a growth monitoring session, the Health Guardian provides on-site, individual counsel to the mother about better nutrition and feeding. During the days following the session, the Health Guardian provides follow-up counsel again to mothers, in their own homes, with severely malnourished children, children who have not gained weight in the previous two sessions, and any other children who are of concern. This process was not clearly explained in the DIP. Some higher risk children are being weighed every 15 days in some communities.

"The training for the growth monitoring component is scheduled for the first month of training, while the nutrition education component is scheduled for the seventh month of training. It would be better to connect the two training modules on growth monitoring and growth promotion to achieve a more integrated approach."

Per USAID recommendation, project staff restructured the growth monitoring and nutrition education components in a more logical sequence. This re-sequencing of the training components initiated some interesting results. Some of the Health Guardians saw more clearly the relationship between nutrition and the health of their own children, some of whom were malnourished. They immediately requested technical help in the establishment of kitchen gardens for their families and have subsequently become examples to neighbors and friends who have also established kitchen gardens.

"The benchmarks chosen to measure progress will only measure the project's use of the growth monitoring technique but not the impact of the intervention on the target population. Benchmarks reflecting the impact of the project's interventions on the target population are needed (for example, percent of children who will have adequate growth at different times during the life of the project)."

Project personnel continue to believe that it is unrealistic to set benchmarks which reflect the impact of the project's nutritional interventions. This is because there are a number of factors impacting the weight gain of each child which are beyond the project's control such as level of family income, access to food, etc.

In an attempt to have more of a direct impact on a child's health, however, project staff are experimenting with a new strategy for addressing the problem of malnutrition. This strategy more directly assists mothers in finding a solution to their children's problem. Project staff recognize it as unproductive to raise a mother's consciousness of her child's level of health without helping to facilitate a solution if the child's health is poor.

The first stage of the proposed strategy has two steps. Step one is similar to the original strategy. In step one, Health Guardians and Health Promoters make home visits to mothers/families with severely malnourished children and offer individual instruction about nutrition and the proper preparation of food for their children. In this process, Guardians and Promoters emphasize the use of locally-available foods. Step two involves the provision of a small supply of foods, such as soy beans, vegetables, etc. when the mothers/families are unfamiliar with, or are too poor to purchase the foods being promoted.

In the second stage, project staff provide the mothers/families with technical assistance and other support through the World Relief Honduras (WRH) Income Generation Matching Grant. This assistance involves the provision of seeds and tools, etc. to enable the family to start a kitchen garden, or raise chickens, or look for other sources of food and/or family income, and the technical advice necessary to get the families started. The ultimate goal is to enable families to obtain their own food.

This strategy was first developed in the villages of Vallecito and Siguate in Olancho by a small group of families with severely malnourished children. The strategy came about after one particular growth monitoring session uncovered a number of severely malnourished children in those villages. Following the growth monitoring session, the Health Guardians and Promoter in that area called a meeting of parents to explain to them the gravity of their children's condition and the potential side effects. This motivated ten of the families present at the meeting to consider how they might band together and address their children's health needs. On their own initiative, the ten families shared food with each other from their own individual resources. One family with chickens, for instance, shared eggs with families who had none. The Health Promoter and Guardians assisted in the process by visiting each of the ten families, discussing nutrition, and demonstrating better cooking procedures. After only 15 days of this process, all the children in these families improved in weight.

This success motivated project personnel to experiment with the feasibility of initiating a similar program in other areas. The experimentation is taking place in two locales of Olancho. If successful, project staff hope this improved strategy will facilitate the educational process and motivate families toward more positive change with regard to the problem of malnutrition.

The emphasis in nutrition education is to avoid allowing children to reach the level of severe malnutrition. When a child is minimally or moderately malnourished, the project counsels the mother individually at the growth monitoring session about the child's health and how it can be improved.

"There is no estimate given for the number of women or caretakers participating in nutrition education activities. An estimate of the female target population needs to be established so that progress can be measured."

The DIP included an estimate for the number of women participating in nutrition education activities on page 17, section 4c.6. See Attachment A, copy of page 17 of the DIP.

"The project uses unpaid 'guardians' for much of the work and assumes that these 'guardians' will work for the life of the project. However, other PVO CS projects have found that the drop-out rate for volunteers is likely to be high. Need to consider the additional training that will be needed for replacements of those who stop participating."

Originally, project personnel estimated there would be an annual Health Guardian drop-out rate of 25 percent. Therefore, to obtain and train 260 Health Guardians by the end of Year 5, they planned into the training program a goal of training approximately 350 Health Guardians by the end of Year 5. Staff hope this will adequately account for expected drop-out. This was not made clear in the DIP.

"More attention needs to be paid to community relations. The most significant contribution that the guardians can make is direct communication with the families."

"The project appears to have 'community cooperation' rather than 'community participation'. The project needs to strengthen the community's role in decision making and priority setting. This will greatly strengthen the project's prospect for sustainability."

The staff considers community participation essential to the project and has been advocating it since the project's initiation. The emphasis on community participation begins with the recruitment, training and integration of Health Guardians. During Year 1 alone, project personnel spent time with leaders in more than 90 communities, and made more than one visit to each community, discussing the CS project and Health Guardian recruitment process. The choice and motivation of all candidates for the position of Health Guardian was entirely the responsibility of community leadership. At the same time, project staff plan during Year 2 to obtain assistance from a specialist (consultant or staff member), who can train and motivate Health Promoters, Health Guardians, and community leaders toward a greater consciousness of community participation, how to motivate and organize groups, and the importance of improved community health.

"There is a high degree of malnutrition in the project area. The project could enlist the services of a nutritionist (as staff or consultant) to help develop the nutrition education component as well as the training of health educators. It would also be beneficial to include questions about dietary practices and weaning foods in the KAP survey to provide background information for developing the educational component."

Project personnel are concerned about the high degree of malnutrition in the project areas and desire to strengthen the project's nutrition education component. They are therefore considering the best and most financially feasible way of addressing this. There are several possible alternatives currently under consideration. One, as recommended by USAID, is to enlist the services of a nutritionist as staff or consultant. Project staff have already applied to the Instituto Nutricion for Central America and Panama (INCAP) in Guatemala for the services of an appropriate professional--someone who could provide intensive training in nutrition for select project staff and Health Guardians. Neither the MOH nor other local PVOs have trained specialists available for this service.

BUDGET

"PVO lists no breakdown of the percentage of funds allocated to different nutrition interventions. There appears to be some lack of precision in the numerical sections. The budget figures seem questionable and there appears to be errors in the figures on page two."

A more complete breakdown of the percentage of USAID funds allocated to the different nutrition interventions is attached (see Attachment B, updated DIP, Format E, Section D.II. and Attachment C, Format G, Country and Headquarters Project Budgets).