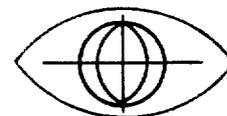


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**INTERNATIONAL EYE FOUNDATION
TEGUCIGALPA, HONDURAS
VITAMIN A FOR CHILD SURVIVAL PROJECT
ANNUAL REPORT - YEAR 3**

**USAID CHILD SURVIVAL IX
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
ARI	Acute Respiratory Infections
CESAMO	MOH Health Center
CDD	Control of Diarrheal Diseases
CHV	Community Health Volunteer
CS	Child Survival
DIP	Detailed Implementation Plan
DRF	Drug Revolving Fund
ENESEF	National Survey of Epidemiology and Family Health
ESFM	National Survey of Family Health and Women
EPI	Expanded Program on Immunization
FIS	Honduran Social Investment Fund
HIS	Health Information System
IEC	Information, Education, and Communication
IEF	International Eye Foundation
IGA	Income Generation Activities
INCAP	Nutrition Institute of Central America and Panama
KPC	Knowledge, Practices, and Coverage
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PVO	Private Voluntary Organization (see also NGO)
QA	Quality Assessment
QAP	Quality Assurance Project
TA	Technical Assistance
TBA	Traditional Birth Attendant
WHO	World Health Organization
USAID	United States Agency for International Development

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I. Overview of Year 3 Activities

The IEF Child Survival Project of the peri-urban area of Tegucigalpa has had great success in reaching the objectives set out in the DIP by the time of the mid-term evaluation. The project, which is implemented in 25 communities serves the CESAMOS (health centers) of Las Crucitas, 3 de Mayo and San Francisco, serving a population of 21,485 (project census 1994).

The project currently conducts the interventions of EPI, CDD, ALRI, PEC, IGA and HIV/AIDS. At the mid-term the majority of objectives for the interventions had been reached or exceeded. Since the mid-term, the project has changed its focus to support and train the MOH to conduct the Child Survival interventions, thus ensuring the sustainability of project objectives. The strong relationships the project has built with the MOH will serve the project to effectively implement its sustainability workplan in the final year of programming (see Annex 3).

The highly motivated and technically well versed staff of the IEF have continued to be crucial to the IEF's success in the area. As noted at mid-term the "project interventions have been applicable to the needs of the community and well coordinated with collaborating institutions. The quality of the one-on-one education provided by the CHV to the mother, by the IEF nurse to the CHVs, and by IEF staff to the CESAMOs has been excellent." IEF is further developing its strong linkages with the communities by increasing collaboration with the local "Patronatos" (civic groups, generally composed primarily of men, which deal with any local concerns).

In addition, to work with the MOH and the community, the IEF was able to secure funding outside of Child Survival to strengthen its CS interventions. AIDSCAP funding for an education video aimed at the prevention of HIV and AIDS boosts efforts to educate IEF's target communities. The collaboration with the MOH and OMNI to conduct the National Micronutrient Survey will provide valuable information on maternal and child micronutrient levels. The ongoing work of IMPACT through the MOH, USAID and IEF has yielded a 100% fortification of this year's sugar crop (for consumption) with vitamin A and will obviously have a positive effect on reducing childhood mortality. The IEF staff presented their achievements in Child Survival and related collaborations at the IVACG meeting in Guatemala City, Guatemala in March of this year. The conference was heavily attended by the Honduras staff (8 participants), reflecting IEF strong commitment to vitamin A interventions.

A. Accomplishments by Interventions

As stated above, the IEF's Child Survival Project in Tegucigalpa has been very successful in meeting the objectives as stated in the DIP. In year 3 of the project, the child survival staff was primarily concerned with addressing the recommendations of the

mid-term evaluation and with implementing and strengthening the project's sustainability plan. Since completion of the mid-term KPC survey the MOH has conducted the National Survey of Epidemiology and Family Health (ENESEF) which include data on the project's target area's providing further evidence that the project has remained on target to accomplishing the stated objectives. This information is provided by intervention as available.

Expanded Program on Immunization (EPI)

As stated in the DIP, the objectives for EPI are as follows:

1. 80% of children 0-12 months of age will be completely immunized in the impact areas during 1993-1996.
2. 70% of women of child bearing age (15-49) will receive two or more doses of tetanus toxoid in the impact areas during 1993-1996.

The mid-term KPC showed that the first objective had been fully met and exceeded by the time of the survey. However, the second objective was not met. The mid-term recommendations stressed concentration on the TTV objective.

In order to improve TT coverage of women during the reporting period, the project has emphasized the educational messages on the positive impact that TT vaccination has on women's children and on the fact that TT protects a woman from "cuts and wounds". Increased publicity has accompanied the educational messages during full and mini vaccination campaigns in local areas, as well as during national campaigns. Use of a mobile loudspeaker has been incorporated and increased during training to CHVs, IEF and MOH personnel has been implemented. CHV's have devoted more time in the past year to TTV during home visits with mothers.

Through the project, IEF has been coordinating and supporting the MOH in organizing the community vaccination mini-campaigns to improve TT coverage. The PRAF (PROGRAMA DE ASIGNACION FAMILIAR) a governmental program which gives a "maternal bonus" (vouchers which can be redeemed for cash) in exchange for positive health behaviors is expected to increase TT coverage as the TT vaccine is now a requirement to receiving the bonus.

The MOH survey in the Municipality of Tegucigalpa corroborates the high rates of immunization found by IEF at the mid-term KPC. Current coverage rates are estimated as follows:

<u>BCG</u>	<u>DPT</u>	<u>POLIO</u>	<u>MEASLES</u>
97.9%	95.9%	98.6%	98.3%

Control of Diarrheal Diseases (CDD)

The project objectives for diarrheal disease control are as follows:

1. 65% of children under 24 months of age will receive appropriate ORT fluids (ORS and home fluids) during episodes of diarrhea.
2. Decrease from 60% to 40% the number of children less than 24 months of age, who receive antibiotics and other medicines during episodes of diarrhea.

At Midterm Evaluation, both objectives had been reached. The IEF has continued with the community level education, primarily through CHVs to maintain objectives at the desired levels. Reduction in the use of antibiotics continues to be a theme taught to workers and families. The project has also incorporated education of community store owners, who generally sell other medications for diarrhea to improve coverage and sustainability of the intervention. All 113 owners within the projects 25 communities were contacted in year 3 of the project. Please refer to Annex 5 for the list of stores visited and the educational materials used during the visit.

The recent study by the MOH found that only 26.7% of children with diarrhea were given ORS in the two weeks prior to the survey. Although this figure is low, it takes into account communities that are not in IEF's target area. It is expected that the IEF areas would have higher coverage estimates.

In an ongoing effort to strengthen collaboration, the IEF has been able to establish good coordination with the MOH personnel of the CESAMOs in two of the three project areas in order to provide ORS to community store owners. In these areas the MOH assists the IEF to monitor and supervise the activity. CESAMO "Las Crucitas" has resisted working with the IEF and will only provide ORS to CHVs, not to store owners. This is because they lack confidence in the store owners' ability to properly distribute the ORS. The IEF is hopeful that if a positive experience can be documented at the final KPC with the community store owner involvement the remaining CESAMOs will reconsider their current thinking. A meeting will be held in year 4 with the Heads of the three CESAMOs, the Head of the Area, and the head of the Metropolitan Region to discuss this issue and motivate them to implement this service.

Training to IEF and MOH staff was provided with emphasis in supervisory skills, focused on proper home management of diarrhea, the proper use of antibiotics and other medication; initiation of ORS (diagnosis and treatment), as well as referral procedures.

As part of the sustainability strategy (refer to Section G. for full details), all training to new CHVs has been developed and implemented by MOH staff with technical and logistical support from IEF. In year 4, this approach will continue for the training of

CHVs. The results have been positive as the staff from MOH have welcomed the opportunity to take greater control of the training activities. The CHV's are now being recognized by the communities as belonging to the MOH rather than to IEF.

Follow-up supervision on the part of the MOH has, unfortunately, not improved in the reporting period, and continues to be performed by the IEF. In year 4 the IEF will increase attention to ensuring greater involvement by the MOH staff and will also increase to improve the MOH's supervisory capabilities. Continued training in maintaining a MIS should improve the MOH's supervise and monitor the activities of the CHVs.

All ORS distributed by CHVs in the communities continues to be provided by the MOH. During year 3 a total of 20,550 ORS sachets were distributed by the MOH to the CHVs. A total of 8,574 ORS were recorded as being distributed to mothers.

Vitamin A/Nutrition

The objectives for this intervention are as follows:

1. 35% of lactating women with children under four months of age will exclusively breastfeed their infants.
2. 80% of children 6-59 months of age will receive vitamin A supplementation every six months.
3. 60% of women will receive vitamin A supplementation within one month after delivery.

All objectives were met or exceeded by the mid-term evaluation. With this in mind the project focused on improving general feeding practices, especially exclusive breastfeeding which was identified as a problem area during the mid-term (only 23.5% of mother's with 0 to 4 month olds report exclusive breastfeeding).

At the time of this report the IEF in conjunction with the MOH and La Leche League(no longer working in the area), have established 23 breastfeeding support groups and have trained 33 "madres consejeras" (group leaders), distributed amongst the 25 communities. La Leche League developed the educational materials for the trainings and also provided training and follow up in conjunction with IEF and the MOH. They were initially in charge of visiting these groups to support their activities and continue providing more education to the Madres Consejeras. La Leche League is no longer working in the project area, but nurses from each CESAMO have been assigned to monitor, supervise, and lead these breastfeeding groups on a monthly basis.

Mothers have been taught the importance of exclusive breastfeeding during the first four months of infancy, how to appropriately breastfeed and they are given emotional

support in order to increase the practice. A total of 328 CHVs have been trained in how to educate mothers in basic nutrition and the importance of breastfeeding. See Annex 6 for location of the breastfeeding support groups.

Vitamin A

The IEF and MOH continue to conduct mini-campaigns for vitamin A supplementation at community level every three months. Year-round distribution of capsules also has been maintained through the use of CHV's at the household level. CHV's continue to be monitored, supervised, and evaluated by IEF and MOH staff. Vitamin A capsules have been provided by IEF to CESAMOS and the Mother and Infant Hospital for post-partum supplementation.

Vitamin A was provided to IEF through the kind donations of the Task Force Sight and Life in Basel Switzerland. In year three the IEF was provided with 250,000 capsules of which 150,000 were donated to the MOH for hospitals and CESAMOs.

In collaboration with the Quality Assurance Project (QAP), the IEF has performed quality assessments of several components of its vitamin A distribution system. The project has been able to use this information to increase coverage to mothers and children (See section F. for details).

Acute Lower Respiratory Infections (ALRI)

The objectives for this intervention are as follows:

1. 80% of MOH CESAMO staff, IEF staff, and CHVs can correctly cite the MOH-ALRI case management protocol by the end of the project.
2. 70% of mothers with children 0-24 months of age can correctly identify danger signs of pneumonia and explain when to refer their children to the nearest CESAMO in the impact area.

The mid-term evaluation found the project to be ahead of schedule for both ALRI interventions. Efforts to improve this intervention were oriented to improving the skills of CHVs and all the MOH and IEF staff in the referral system. In addition a loudspeaker was used in the community to transmit key messages to keep mother's knowledge at desired levels.

The Project is considering, in conjunction with MOH and Save the Children, drug revolving funds which would make antibiotic treatments available for severe cases of pneumonia at night and on weekends when the CESAMOs are closed.

Prevention of HIV/Aids

The objective for this intervention is as follows:

90% of parents (both men and women) identify condom use as a principal mean of preventing AIDS in the impact areas.

Preliminary results of the joint MOH/USAID National Survey of Family Health and Women (ESFM) indicates that 99.7 % of women of child bearing age can identify the link between condoms and AIDS prevention. The project with therefore emphasize education on med and distribution of condoms through the CHV's. This is also in accordance with the mid-term recommendations. In the past year, the IEF has included work with teachers to educate adolescents in the schools regarding AIDS prevention and, in conjunction with the MOH, the IEF is also targeting "patronatos" (community groups).

The IEF is also creating an AIDS awareness video with funding provided by AIDSCAP. The video is based on a soap-opera format which is popular in Honduras. It is aimed at housewives and adolescents.

Primary Eye Care (PEC)

75% of children under five years of age are provided with annual eye examinations and treatment referrals.

One screening eye campaign took place in each of the 25 communities in year 3, as in previous years. Any one in need of a referral for glasses was sent to the San Felipe Eye Clinic during the Optometrists Brigade that visited Tegucigalpa in July 1996. Three hundred and two persons received glasses during the campaigns.

Two Auxiliary Nurses from the MOH/CESAMO of Las Crucitas were trained by Dr. Alberto Ehrler, Ophthalmologist to provide primary eye care. This was done to offset the need for eye care services created when a part-time IEF Ophthalmologist finished his work contract and left the area. The MOH was unable to provide a replacement due to a lack of funds. The CESAMO of Las Crucitas is particularly well equipped with a Slit lamp provided by the IEF. The IEF is also trying to make arrangements with the Universidad Nacional Autonomas (National University) residency program to have an ophthalmology resident visit at least once a week to provide services.

In accordance with the mid-term recommendation to transfer greater responsibility of this intervention to the MOH, the IEF has joined this intervention with its ChildSight program. Through the program, children are screened at elementary schools by trained teachers. The program is implemented in conjunction with one of the project CESAMOs for sustainability.

Income Generating Activities (IGA)

a. Fruit Tree Nurseries:

The objectives for Fruit Tree Nurseries are as follows:

1. Increase availability of food sources of Vitamin A by establishing six tree nurseries.
2. Over 200 families plant and maintain fruit trees.

The Project established one pilot fruit tree nursery that served for demonstration, education, and practice to all the persons involved in this activity. Once these persons are fully trained in the pilot nursery, they will establish a small nursery at their house, with fruit seedlings of mangoes, papayas, marañoes, maracuyá, provided by IEF. Trainings included care and maintenance of the fruit trees, accounting procedures and marketing. At the time of this report, 14 persons had been trained and 8 nurseries were in full operation.

Two fruit trees have been distributed to each CHV as an incentive for their work, as well as to improve the consumption of Vitamin A.

b. Community Banks:

The objective of the community banks is to increase family income by assisting with the establishment of 15 Community Banks to assist women with small business development in Project Communities.

The project planned to establish 15 community banks in the three years. To this date the objective has been exceeded and 24 community banks have been established in 19 communities. Collaboration with Project HOPE has facilitated progress towards the objective. Health education messages are given to all the participants of the banks, as well as accounting and microenterprise training. Project HOPE will continue to give financial and technical support to these banks when the Child Survival Project ends.

B. Training Activities

Please refer to Annex 2 for all trainings conducted by the IEF during this reporting period. The project has increased the amount of effort that it devotes to training the MOH in a wide variety of topics, in order to better prepare the MOH to handle the responsibilities of the project interventions.

C. Other Activities

"The Doctor and your Health"

The IEF was able continue its successful partnership with the popular Honduran radio show, "The Doctor and your Health" to transmit key messages related to all child survival interventions. The program was initially brought to the attention of IEF after receiving a UNICEF award as a leader in the promotion of health among children. The show has a call-in format, to which a Doctor answers medical questions and expounds on current health issues. Since IEF's involvement the show has aired health messages regarding the child survival Interventions at the end of the program.

IVACG

The IEF/Honduras Child Survival Project along with IMPACT were selected to deliver one oral presentation and one poster at the International Vitamin A Consultative Group Meeting, held in Guatemala City, Guatemala. Both presentations dealt with sugar fortification in Honduras, a theme of the Conference. Eight members of the staff including the Country Director and the Child Survival Project Manager (submitted two abstracts for presentation) participated in the Conference, reflecting IEF's strong commitment to their vitamin A and nutrition interventions. (Annex 4)

D. Technical Support

The following technical assistance was received:

- Mrs Liliana Clement, the new IEF/Headquarters Child Survival Coordinator, made two visits to the project to evaluate progress, construct a year 4 work plan, deal with personnel issues and restructuring of the project for the sustainability plan and to review instructions for the annual report.
- Personnel from the MOH assisted project staff during all the trainings of field personnel and CHVs in the child survival interventions to focus on sustainability.
- Two persons from Project LUPE assisted IEF staff in training the fruit tree nursery managers and in the establishment of the nurseries.
- Personnel from project HOPE trained two IEF personnel in community banking (promotion, establishments, monitoring, supervision, evaluation and credit benefits).
- Save the Children provided IEF with technical support related to the formation of Drug Revolving Funds, which IEF is considering for the ALRI intervention. At this time it is not known if IEF will venture into this activity as indications from the CDD intervention are that the communities do have very good access to antibiotics and a willingness to use them.

E. Community Health Committees

During this period the project reinforced and established, where needed the community health committees. In total the IEF has established one committee in each of the 25 communities of the project. Each committee has a variety of members including community leaders and CHVs. Generally, four to six CHVs can be found in a given committee. Committees meet once per month with the assistance of an Auxiliary Nurse from IEF, and sometimes with the assistance of CESAMO staff.

In the project's final year of activities, the goal is to incorporate the president of each committee as a member of the local patronato. This will not only bring more respect to the health committee but it will ensure that the "patronato" is kept abreast of the work the health committee is doing.

F. IEF Linkages with MOH, PVOs, NGOs and Others

PVO Child Survival Coordination Committee

The PVO Child Survival Coordination Committee meets every two months to share work experiences, conduct joint activities, and to coordinate joint proposals. This committee is composed of PVOs with CS projects, including: Save the Children, World Vision, Project Hope, ADRA, La leche League, World Relief and IEF.

National Aids Association

The National Aids Association meets every month. IEF is the liaison between the Association and all PVOs and NGOs working in the Metropolitan Area. The Medical Advisor and the CS Project Coordinator are playing active roles in this Association. Recently, they took part in the development and revision of the Aids statutes and in the presentation of the new strategies to the MOH.

Collaboration for Reproductive Health

The IEF continues its coordination with the Fondo de Población, Save the Children, and Population Council to support CESAMOS in reproductive health activities.

Collaboration with the MOH

A strong working relationship with the MOH especially at the CESAMO level has been established for the implementation, monitoring, supervision and evaluation of all project activities.

Quality Assurance Project (QAP)

Coordination with the Quality Assurance Project (QAP) has continued through ongoing assessments of vitamin A services in the all three CESAMOS of the project area and at the antenatal clinic of the Hospital Escuela. During the past few years the IEF has worked closely with the QAP to train IEF and MOH staff in the assessment

methodologies. The project has been successful in identifying several areas that required attention and worked to correct existing problems. In the final year of programming, the project will expand its QA activities to examine interventions other than vitamin A.

Task Force Sight and Life

The Task Force Sight and Life, a project of Hoffman La Roche, Ltd. has provided all the vitamin A capsules utilized by the project and donated to the MOH.

IMPACT

Since 1993, IEF has been supporting the MOHs micronutrient strategies through the management of the IMPACT Project. Funding for the project is provided by USAID. The following is a review of national level activities that have been realized through the project:

1. **Vitamin A Supplementation:** Developed protocols, registration forms and monitoring system, introduced vitamin A capsules to the MOHs Essential Drugs List.
2. **Fortification of sugar with vitamin A:** Support the MOH at Central and Regional levels to implement the Honduran law regarding fortification (100% of sugar production should be fortified). In fact, 100% of sugar production for human consumption has been achieved in this year sugar harvest. A quality of control and monitoring system is being implemented in coordination with INCAP (Instituto de Nutrición de C.A. y Panamá).
3. **Fortification of Salt with Iodine.**
In a joint effort with UNICEF, the MOH, USAID and others a preliminary survey of all the salt producers has been completed. The Association of Salt Producers, was then established. A monitoring system for iodine and retinol had been established through schools to monitor household levels of the fortificants.
4. **Education:**
Through the Division of Health Education of the MOH, the IEF has trained the MOH Regional Staff and the communities regarding vitamin A food consumption, sugar and salt fortification, signs and symptoms of vitamin A and iodine deficiency.

OMNI

In the past year the IEF has managed the National Micronutrient Survey of OMNI and the MOH. The survey measured serum vitamin A levels in children up to 5 years old, and hemoglobin levels in children and their mothers. Results of the survey will be available in January 1997.

Children First, A Global Forum

The Country Director of IEF/Honduras, Dr. Raúl Gómez, was invited to attend the Children First Forum in Atlanta, in April of 1996. Invitations were on the behalf of Mr. and Mrs. Jimmy Carter. The forum convened leaders in children's issues from around the world. The objective of the meeting was to build a new model to create change and improve the lives of children around the world. The "Promise of Atlanta" is a mandate generated at the conference to call international attention to children and to demand that children's issues are put first.

Upon his return to Honduras, Dr. Gómez appeared on a television news program to call for action regarding the Promise of Atlanta. The Government of Honduras has been very active implementing actions to the benefit of children. In August, the National Congress passed a New Law for the Protection of Children (Código de la Infancia y Protección al Menor).

G. Response to Mid-Term Recommendations

The following recommendations were suggested at the mid-term evaluation for the areas of management and sustainability. Other recommendations have been addressed in Section Ia. under their respective interventions.

In general, it is important to note that the evaluator found the project to have met the vast majority of its objectives. The project, therefor was seen to be shifting emphasis to sustainability rather than implementation of the interventions. "The development and sustainability of these activities," it was stated, "require the provision of a great deal of training and technical assistance, on-going supervision and supplies, and coordination among participating organizations." As the IEF entered its final phase of programming, efforts have in fact shifted to educating communities, and to training community leaders, CHVs, and MOH workers to provide and supervise the services at that time provided by the IEF. The function of IEF staff therefore, has shifted to advising and monitoring what is done by others.

Supervision

As recommended, the IEF has increased the amount of supervisory training that it provided to the MOH. The IEF is working to coordinate the management system used by the three CESAMOs to leave in place a single supervisory protocol for the area.

Training

As noted at the mid-term evaluation, training is a major key to meeting project goals, particularly with the shift in focus requiring the transfer of responsibilities from IEF to the CESAMOs for implementation of field activities. Therefore, as recommended, training topics have expanded beyond the standard child survival interventions to include managerial topics such as supervision, referral, information systems, use of data for

decision making, and human relations. Lessons are integrated with technical lectures on the interventions for efficiency. Leadership training, with a focus on individual and social transformation, will be given in the upcoming months to all levels of workers, to achieve community self-initiative and MOH management of interventions.

The recommendation to provide all staff (IEF, MOH and CHVs) with training and technical assistance in methods and techniques of adult, non-formal education, i.e. training of trainers (TOT) for community learning, will be addressed in the final year of the project.

The project has continued with the participative educational methodologies and use pre and post tests to evaluate all training events. Improvement of the trainings is ongoing, in terms of content and methods, based on the results of the testing.

Information Systems

The IEF has made an effort to prepare the CESAMOs for the end of project activities. Staff have worked in conjunction with community leadership to conduct training activities, promote the regular reporting of health related activities and data by the CHVs and MOH field personnel to the local patronato. The final year of activities will focus on training to use this data for analysis and informed decision-making by the CESAMO's and communities.

Sustainability

At the time of the mid-term evaluation a "Workplan for Sustainability" was prepared and presented. A new workplan has since been developed to expand activities to reflect the change in project brought about by the one year extension. (Please refer to Annex 3) It is the goal of the MOH and the IEF to hand-over all project activities to the MOH by the end of the extension period.

Empowerment of the local community is also key to the IEF sustainability strategy for Honduras. IEF continues to work with the local patronatos, the only community organization which has power to negotiate with public and private agencies on behalf of the community. The patronato could provide support of the CHVs by serving as an official link between the community and the CESAMO. IEF has followed the recommendation to strengthen the relationship between CHVs and the patronato, in addition to the connection between the patronato and the CESAMO. Since the patronatos are highly politicized, care needs to be taken so that CHVs do not become identified with any one political party.

Staffing

Although it was recommended at the mid-term evaluation that IEF not make any changes in personnel during the final year of operation, the reduction in funding for the extension period has required a restructuring and downsizing of the project. (Please refer to Annex 1: Organogram). As the amount of effort expended on actual

implementation of interventions has decreased and supervision, management and monitoring activities have increased, the restructuring is appropriate. By consolidating the Medical Advisor and Project Manager positions into one, still titled Project Manager, the project was able to promote one of its most highly valued employees.

As noted at mid-term, "...current child survival staff have developed excellent relationships with collaborating institutions, communities and CHVs, and their continuity will enhance the success of the transfer of program responsibilities." Acknowledgement that the IEF staff have served the community and the project well made the consolidation of the positions difficult.

Financial Management

The IEF has continually made efforts to improve the degree of knowledge that all levels of staff have regarding the financial management of the Child Survival Project budget. It was suggested during the mid-term evaluation, that IEF administrative staff receive greater responsibility in handling budgetary issues for the project and that different staff levels should receive further training in financial management including: analysis of financial reports, cash flow, cost structures (recurrent and fixed), budget management (preparation, control and projections) and financial decision making. A local expert will be contracted during the extension period to provide this training based on the needs identified by IEF headquarters, the mid-term evaluator, and field staff.

II. Constraints, Unexpected Benefits, and Lessons Learned

A. Constraints affecting project implementation

Supervision

The project interventions have been implemented in conjunction with the MOH. However the MOH's lack of manpower continues to be a stumbling block to improving their supervisory abilities. Personnel have adequate skills and the knowledge and are willing to perform the work, however, the high rate of absenteeism, trainings and labor meetings, cause the shortage in manpower. When CESAMO staff are out, their roles have to be filled by field personnel, abandoning the community outreach work. IEF staff are able to fill this gap, but finding a sustainable solution is difficult.

The CESAMOs suffer from a lack of supervision (only one person per CESAMO). One person is not sufficient to oversee the activities within the health center and surrounding communities. Again, it is usually the field work which suffers from this understaffing.

Training:

The project has spent considerable time to identify and train community members interested in developing fruit tree nurseries. The activity has been difficult however because the initial enthusiasm generated wains over time and participants drop out. Also, participants spend the money generated from the nursery and resist reinvesting it in a second round of planting.

Community Health Volunteers Turn Over:

Women in Honduras, like in other developed countries, need to work out of their houses in order to earn income for their families. This is especially noticed in the peri-urban areas where manufacturing and other non-agricultural jobs are available. Given that the majority of CHVs are women, this economic reality affects retention of the volunteers. Also considering that the work is not remunerated, women stay with the project until a paying opportunity arises. The project is constantly training new volunteers to keep population coverage steady.

Lack of Coordination with Patronatos

Project staff have worked diligently trying to integrate the health committees into the Patronatos in order to generate joint health activity efforts; however the Patronatos still offer resistance in some cases, consider the volunteers as competition to their authority.

In order to establish a good relation with the members of the Patronatos it is necessary for staff to work during their meeting hours; at night and during the weekends, which requires the willingness of the MOH personnel, since they expect per diems and the MOH only recognize compensatory time, this has been a limitation in the sustainability of this intervention.

B. Strategies to overcome constraints**Supervision:**

During meetings with the CESAMO personnel, we have obtained a letter of agreement from the Directors and Nurse Supervisors, agreeing to reduce the use of field personnel by encouraging them to reduce absenteeism at the CESAMO level.

To enhance supervision, IEF has encouraged members of the CESSAMO other than the Medical Director, to assist with these duties. Addition of more personnel is not a possible alternative, as the MOH does not have sufficient staff for new positions.

Training:

New community members were chosen for the second round of fruit tree nurseries. Care has been taken to select people who understand the long term potential of the activity and value the nursery as a sustainable means of generating income.

Community Health Volunteers Turn Over:

In order to overcome this problem the IEF has attempted to use volunteers that both work outside the home and those that don't, but to use them in a different capacity. CHVs who do not work are given a full range of activities. CHVs that are employed are asked only to distribute Litrosol, condoms, vitamin A and to give referrals to the CESAMO as needed. The IEF auxiliary nurse visits them during weekends to provide supervision and material and educational reinforcement.

Lack of Coordination with Patronatos

In order to consolidate the CHV and Patronato's work, and to avoid further conflict over roles, the IEF established meetings with the Patronato Board (oversees the work of all Patronatos) to inform them of the CHVs duties and benefits to the community. The information is presented to them during their general community meetings. The IEF also takes this opportunity to give health education talks and to provide condoms (boards are predominately male).

C. Circumstances facilitating implementation

Coordination with Other Organizations:

The Family Assistance Project (PRAF), through the maternal bonus, requires that every child under five years of age have complete immunizations and that all women of child bearing age receive their full tetanus toxoid vaccination. This program has helped the IEF to increase vaccination coverage. The IEF also takes advantage of the fact that PRAF convenes groups of women, and has arranged to give health education lectures at these times.

The IEF has collaborated with Project HOPE in order to benefit from their experience with IGAs and community banks. With their assistance the IEF has been able to establish 23 community banks. IEF CHVs have been integrated into the banks in order increase their income and provide and incentive for their volunteer work.

The Project has taken advantage of activities offered by the Municipal Government, such as occupational workshops. The IEF was able to assist mothers and CHVs to receive training in IGAs (manual craft, beauty, sewing, bakery).

The IEF field staff have taken part in all health trainings provided by the MOH. This in turn has increase the technical expertise of the staff and has strengthened the MOH/IEF relationship.

III. Changes in Project Design

A. Personnel Changes

Project Staff and Organization, and Changes in Project Staff:

Changes in Project staff include firing of an Administrative Assistant (Ruth N. Rubio), an Ophthalmologist (Francisco A. Ehrler), and one Auxiliary Nurse (Wilfredo Banegas). No substitutions were hired for these persons. One Garden and Community Bank Promotor was hired (Renato Well). Please refer to Annex 1: Organizational Chart for the current listing of positions.

A restructuring of the organization has taken place since receiving the no-cost extension to reflect the decreased need for IEF support of interventions and move to increased sustainability. Positions were consolidated and/or removed to lessen the amount of staff dedicated to each intervention. A phase out of all employees will take place by the end of the project (see Annex 3: Workplan for year 4).

IV. Budget

The project was awarded a one year extension in the amount of \$110,000 to continue program activities through September of 1997. The original budget was sufficient to carry the project for two months beyond the originally end date as slight underspending had occurred. The current monthly burn rate of \$17,200 will carry the project to September of 1997. Please refer to Annex 7 for details of spending to date.

V. Annexes

Annex 1: Organogram of IEF Honduras

Annex 2: Training

Annex 3: Work Plan for Sustainability, Year 4

Annex 4: IVACG Abstracts

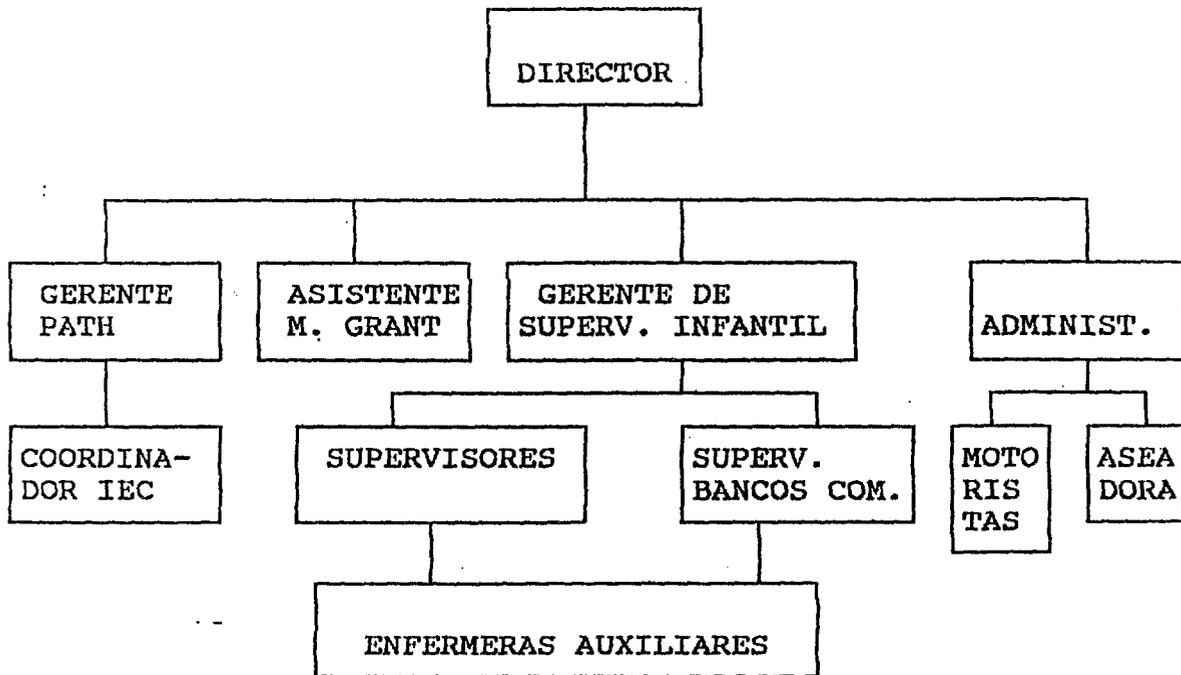
Annex 5: ORS - Local Drug Stores Visited & Educational Material Provided

Annex 6: Breastfeeding Support Groups

Annex 7: Budget Pipeline Analysis

ANNEX 1: ORGANOGRAM OF IEF HONDURAS

ORGANIGRAMA
FUNDACION INTERNACIONAL DE OJOS



ANNEX 2: TRAINING

TRAINING TO INSTITUTIONAL STAFF
SEPTEMBER 1995-SEPTEMBER 1996

No. Part.	Fecha	Tema	Duracion	Metodologia
31	26-10-95	Toxoide Tetanico (CESAMOS San Francisco y Las Crucitas)	8 horas	Participativa
18	Nov. 1995	Taller sobre Vitamina A a personal A/E, Enfermeras Profesionales y Medico de la Sala Materno Infantil	4 horas	Expositiva
20	16-12-95	Taller Motivacional personal FIO	2 dias	Participativa
21	31-1-96	Toxoide Tetanico (CESAMO 3 de Mayo)	4 horas	Participativa
12	15-1-96	Capacitacion sobre el uso de Mimeografos de madera y manejo de tecnicas parlamentarias (a personal de FIO)	4 horas	Demostrativa/ Participativa
30	1-3-96	Control de Enfermedades Diarreicas (3 CESAMOS)	8 horas	Participativa
18	Marzo 1996	Visita a Palo Blanco - capacitacion sobre SAIN	8 horas	Observacion Demostrativa
11	Abril 1996	Jornada de Educacion Continua para Personal Docente y de Asistente	4 dias	Participativa
10	Abril 1996	Cuidado Primario de Ojos (Personal de FIO)		Participativa Demostrativa
4	Mayo 1996	Taller para redefinir el rol y desempeno del Voluntario de Salud (HOPE, FIO, Save the Children)	1 dia	Participativa
12	Mayo 1996	Jornada y Capacitacion del Dengue (Campana a nivel nacional MSP-FIO)	1 dia	Participativa
12	Junio 1996	Reforzamiento IRAS	8 horas	Demost-part
2	Junio 1996	Taller Abordaje de la Enfermedad VIH/SIDA	5 dias	Participativa
22	Junio 1996	Planificacion Familiar y Riesgo Reproductivo	2 dias	Participativa
22	Julio 1996	Taller Motivacional		Participativa
12	Ag.-Sept. 96	Primeros Auxilios a A.E. de los CESAMOS San Francisco y Las Crucitas	8 horas	Participativa Demostrativa
27	Agosto 1996	Trabajo en Equipo y Toma de Decisiones (Personal de Campo FIO)	8 horas	Expositiva
16	Sept. 1996	Relaciones Humanas (Personal Campo FIO)	8 horas	Participativa
12	Julio 1996	Gerencia en salud	3 dias	Participativa

TRAINING TO COMMUNITY HEALTH VOLUNTEERS
SEPTEMBER 1995-SEPTEMBER 1996

No. Part.	Fecha	Tema	Duracion	Metodologia
280	Octubre 1995	Toxoide Tetanico (3 CESAMOS)	38 horas	Participativa
11	Diciembre 1995	Diarrea (CESAMO Las Crucitas)	2 horas	Demostrativa Participativa
212	Enero 1996	PAI (3 CESAMOS)	38 horas	Demostrativa Participativa
20	Febrero 1996	Toxoide Tetanico (CESAMO Las Crucitas)	4 horas	Demostrativa Participativa
253	Marzo 1996	Diarrea (3 CESAMOS)	38 horas	Demostrativa r
149	Abril 1996	Nutricion (3 CESAMOS)	35 horas	Demostrativa Participativa
150	Mayo 1996	IRA (3 CESAMOS)	29 horas	Demostrativa Participativa
129	Junio 1996	Revision Mensajes basicos sobre las Intervenciones (3 CESAMOS)	19 horas	Participativa
22	Junio 1996	Taller Prenatales En cada reunion mensual se da una actualizacion a V.S.	2 semanas 1 - 4 p.m.	
	Sept. 1996	Primeros Auxilios (3 CESAMOS)	16 horas	Participativa

IEF Workshop Participation

ASISTENCIA A TALLERES 1995 -1996

- . Reunión para la Conformación de la Red Nacional de Lucha contra el SIDA. OPS 5,6/10/95
- . Reunión sobre Salud Reproductiva Patrocinado por Population Council. 25/10/95
- . Taller sobre Estrategias de del SIDA en Honduras. OPS y Red Nacional de ONG vde Lucha contra el SIDA. 27/10/95
- . Reunión Mensual de Salud Reproductiva Tema: Abordaje de la Sexualidad en el dolescente. Population Council. 29/11/95
- . Taller sobre la Mujer y el SIDA Patrocinado por Centro de Estudios de la Mujer. 1 /12/95
- . Conferencia del Ministro de Salud Dr. Samayoa con motivo de la celebración del Día Mundial del SIDA. 1/12/95
- . Reunión de Coordinación con OPS para la preparación del Primer Taller de la Red Nacional de ONG de Lucha contra el SIDA. 11/12/95
- . Reunion de Salus Reproductiva 22/02/96
- . Taller sobre Producción de Alimentos IMPACT. ZAMORANO. 08/03/96
- . Reunión Anual del Grupo Consultivo Internacional de Vitamina "A" IVACG. 18-24/03/96
- . Taller de La Red Nacional de Lucha contra el SIDA a desarrollarse en Tela, Atlántida para discusión y aprobación de estatutos de la Red. 06,07/05/96
- . Reunión TPC - INOPAL III USAID Washington y TPC Mexico. en Population Council, Tegucigalpa 19/04/96

- . Reunión de Salud Reproductiva 23/5/96
Agencias de Cooperación Externa
patrocinado por Population Council.

- . Analisis sobre el Perfil del Voluntario de Salud. Patrocinado por FIO, HOPE, ADRA. y MSP. 31/05/96

- . Reunión con Región Metropolitana y las OPD sobre la Implementación de Normas de Atención Integral al Niño. 03/07/96

Summary of All IEF Training by Category

TECHNICAL SURVIVAL INTERVENTION

N PART	MOH	IEF	OTRO	TALLER
31	19	12	-	Toxoide Tetánico (CESAMO San Francisco y Crucitas)
18	18	-	-	Taller sobre Vitamina "A" A/E Enfermeras Profesionales y Médico de la Sala Materno Infantil.
21	19	2	-	Toxoide Tetánico (CESAMO 3 de Mayo)
30	18	12	-	Control de Enfermedades Diarreicas, (3 CESAMOS)
18	4	10	4 (ADRA PVO)	Visita a Palo Blanco - Capacitación sobre SAIN
10	0	10	-	Cuidado Primario de Ojos
12	10	2	-	Capacitación sobre el Dengue
12	-	12	-	Reforzamiento en IRA
2	-	2		Taller Abordaje de la Enfermedad VHI/ SIDA
22	10	12	-	Planificación Familiar y Riesgo Reproductivo
12	10	2	-	Primeros Auxilios a AE de los CESAMOS San Francisco y Crucitas

Leadership

N Part	MOH	IEF	Otro	Talleres
27	15	12	-	Trabajo en Equipo y Toma de Decisiones
16	4	12	-	Relaciones Humanas
12	12	-	-	Gerencia en Salud
20	8	-	-	Taller Motivacional
11	11	-	-	Jornada de Educación continua para Personal Docente y Asistente
12	-	-	-	Capacitación en Uso de Mimeografo de madera y Manejo de Técnicas Parlamentarias.
22	10	2	-	Taller Motivacional

SUPERVISION / MONITORING

N	MOH	IEF	otro	Taller
9	-	8	1 (OPS)	Taller de Computacion EPI INFO

ANNEX 3: WORK PLAN FOR SUSTAINABILITY, YEAR 4

ACTIVIDADES POR OBJETIVO

	Sept. 1996	Oct. 1996	Nov. 1996	Dic. 1996	Ene. 1997	Feb. 1997	Mar. 1997	Abril 1997	Mayo 1997	Jun. 1997	Jul. 1997	Agos. 1997	Sept. 1997
OBJETIVO NO. 1													
El Ministerio de Salud Pública mantendrá las coberturas de las intervenciones													
1. Reorganización del personal de FIO (contratación de personal)		X											
2. Reunión con el personal contratado		X											
3. Reunión con autoridades del MSP para exponer el Plan de Sostenibilidad y los resultados de la evaluación de medio término		X											
- Directora Regional y Jefes de Área		X											
- Jefes de los tres CESAMOS		X											
- Personal clave de los tres CESAMOS		X											
4. Realización de CAP											X		
5. Presentación resultados del CAP												X	
6. Envío de resultados de Evaluación de Medio Término a MSP	X												
OBJETIVO NO. 2													
Establecer la garantía de calidad para el monitoreo de distribución de Vitamina A, así como la adición de TRO y PAI a los protocolos, así como para evaluar los talleres de capacitación													
1. Reorganizar los grupos de Control de Calidad y fortalecerlos en la metodología de control de calidad			X										
2. Realizar las actividades y establecer protocolos nuevos durante y después de los talleres de capacitación administrativa			X	X	X	X	X	X	X	X	X	X	X
OBJETIVO NO. 3													
Capacitar a personal de MSP para realizar encuestas CAP (2-3 personas de la Región Metropolitana de Salud y un representante de cada CESAMO será involucrado en el CAP de julio 1997. Durante el CAP de julio 1995, una persona de cada CESAMO y una del equipo regional, participarán en la realización del mismo, por lo que en el CAP de 1997 se incluirá una persona de la Región Metropolitana, una persona del Área de Salud y una persona de cada CESAMO)													
1. Organización y preparación de papelería del CAP										X			
2. Realización del CAP										X			
3. Presentación de resultados al MSP y comunidades											X		

ACTIVIDADES POR OBJETIVO

	Sept. 1996	Oct. 1996	Nov. 1996	Dic. 1996	Ene. 1997	Feb. 1997	Mar. 1997	Abril 1997	Mayo 1997	Jun. 1997	Jul. 1997	Agos. 1997	Sept. 1997
2. Sesiones de capacitacion para los representantes de los patronatos y de los Voluntarios de Salud			X	X									
3. Establecimiento de fechas para reuniones bimensuales con los Voluntarios de Salud patronatos y CESAMOS				X									
4. Transferir la responsabilidad de las reuniones con la comunidad a los CESAMOS. La FIO funcionara solo como evaluador de las reuniones					X	X	X	X	X	X	X	X	X
OTRAS ACTIVIDADES													
<i>Enfocadas a dar seguimiento a las recomendaciones de la evaluacion de Medio Termin</i>													
1. Fomentar la creacion de grupos de apoyo de Lactancia Materna a ocho comunidades que aun no los tienen (*)													
2. Visita del Director Nacional a La Paz, Bolivia, para estudiar el sistema de cobros por servicio que actualmente se realiza en el sistema de salud de Bolivia	X												
3. Realizar grupos focales para determinar las percepciones comunitarias respecto al uso de antibioticos					X								
4. Evaluacion Final												X	
5. Transferencia del Proyecto de Arboles Frutales a la comunidad		X	X	X	X	X	X						
6. Continuar apoyo a los bancos comunales y transferencia gradual a Project HOPE		X	X	X	X	X	X						

ANNEX 4: IVACG ABSTRACTS

ABSTRACT

FORTIFICATION OF SUGAR WITH VITAMIN A IN HONDURAS. PROGRESS, PROBLEMS AND LESSONS LEARNED.

Vitamin A deficiency (VAD) is a significant public health problem in Honduras. Vitamin A intake has been systematically found to be grossly deficient, particularly among children under 5 years of age, 18% of whom had serum retinol levels < 20 ug/dl in 1987.

Legislation on sugar fortification with vitamin A was passed in 1976 and the program initiated in 1978. However, sugar producers reluctantly abided by the legislation and fortification coverage declined after the 1978/79 harvest. No sugar was fortified in 1980/83 and 1986/88. New regulations issued in 1987 allowed "production of unfortified sugar to be sold only to industries with permission from the Ministry of Health (MOH) and not to be marketed through commercial outlets" which, in practice, restricted fortification to table sugar.

It was not until 1987 that some limited regular monitoring of sugar samples at retail stores was initiated. Efforts to implement fortification largely failed, even for table sugar, up until 1992 when the MOH shifted from merely law enforcement to a negotiation process intended to reach consensus with sugar producers on increased coverage levels for table sugar. Technical and financial assistance, including training, was requested from PAHO/INCAP, UNICEF and USAID. The government donated premix preparation equipment that was installed at one of the sugar plants from which the vitamin A premix is distributed to other plants.

Periodic government-producers meetings are used to set quality and coverage goals for table sugar and to review progress made. A fortification monitoring system, initially designed in 1993, has been tested and progressively modified over time. Coverage and quality of fortification has generally increased. Major problems that had to be resolved or are still present include:

1. Political commitment, particularly from sugar producers, has been relatively weak. Fortificant supplies are not yet ordered early enough for timely initiation of premix preparation, some of the premix is not used but left to be used one year later, and manual addition of the fortificant premix is still practiced. Law enforcement and monitoring have not been systematic and imports of unfortified sugar have been allowed;
2. Quality of fortification at the plant level is uneven, with large variation and a median content of 10.8 ug of retinol per gram of sugar in 1994/95;
3. Fortification monitoring has been difficult due to uneven MOH commitment, human resource constraints, unfortified sugar imports and government's decision to allow production of unfortified sugar for industrial use;
4. About half of the rural population in the western region do not consume white sugar thus further reducing the coverage of fortified sugar; and
5. Conflicting information provided by producers have precluded accurate coverage estimates. Annual coverage estimates based on fortificant imports amounted to 41% (1991/92),

125% (1992/93), 52% (1993/94) and 110% (1994/95) of the estimated demand for table sugar, as derived from recent dietary surveys. The 1994/95 coverage figure is equivalent to 48% of the sugar intended for domestic use (about 50% of it goes to industry) and 44% of the total harvest.

A simple but functional monitoring system is now in place which targets five critical points in the sugar production and marketing process, as follows:

1. verification by the MOH of fortificants ordered and actually imported by producers;
2. quality control by producers and inspection by the Food Control Division of the MOH at the premix preparation plant and at sugar production plants;
3. MOH inspection at central warehouses (fortified sugar should be stored separately with proper labeling), semiquantitative check-ups (4-tube kits) and confiscation of inadequately fortified sugar (< 5 ug/gram);
4. MOH inspection at supermarkets and wholesale outlets and confiscation of sugar not labeled as fortified; and
5. periodic monitoring at the household level using ongoing national surveys implemented by the health or other sectors (qualitative analysis of all sugar samples collected and quantitative analysis of those containing retinol).

Lessons learned with practical implications for other countries are:

1. **Building a positive and mutually rewarding public/private sector partnership is essential.** Food producers should be sensitized and involved in the process from the very beginning, including preparation of legislation. Industry commitment after legislation is less likely if they have not been involved. Profits, rather than social concern, are the driving force of industry. The government should be ready to provide training, assistance and timely information to producers, and to implement systematic monitoring.
2. **Legislation is not enough. Monitoring and law enforcement are critical.**
3. **Fortification of all sugar for domestic use should be enforced.** Waiving fortification of some sugar imposes serious constraints on monitoring systems, facilitates leakage of unfortified sugar and dilutes accountability.
4. **National legislation needs to be enforced to prevent imports of non fortified sugar.** Regional legislation on this matter would be extremely useful.
5. **Provisions should be made for timely supplies and premix preparation by sugar producers in a strategically located sugar mill.** Installation and operation of the premix preparation plant need not to be costly.
6. **Quality control and systematic monitoring are always required.** Quality control should be the responsibility of the producers. The monitoring system should be tailored to the specific features of the production, distribution and marketing process.
7. **Political, financial and institutional sustainability need to be carefully considered.** Political commitment is critical to ensure financial sustainability, although public resources required are usually limited to the cost of proper monitoring. Systematic training promotes institutional sustainability.

FORTIFICATION OF SUGAR WITH VITAMIN A IN HONDURAS:
PROGRESS, PROBLEMS AND LESSONS LEARNED. Vilma
Estrada, Anne Swindale and Jose O. Mora. Food Security and Nutrition
Monitoring Project (IMPACT), 1655 N. Fort Myer Dr. Suite 300,
Arlington, VA 22209.

The implementation process for sugar fortification with vitamin A in Honduras is described, including problems encountered, lessons learned and approaches to sustainable solutions. Dietary and biochemical assessments in 1965 and 1987 revealed that vitamin A deficiency (VAD) was a serious problem in Honduras. Sugar fortification legislation passed in 1976 was not regularly implemented for many years; law enforcement failed and an effective monitoring system was not developed. In the early 1990s, awareness of the VAD problem and its functional implications generated stronger government commitment. In 1992, the government initiated negotiations with the sugar industry that eventually led to reactivation of fortification, and USAID began to support efforts to address VAD through technical and financial assistance. By 1995, fortification was implemented regularly with high coverage: more than 90% of the projected demand of sugar for direct consumption was fortified at the industry level, compared with only 13% in 1994 and even less in previous years. Monitoring of fortification at the consumer level is important because sugar for industrial use is not fortified, leakages of fortified and unfortified sugar occur and imports of unfortified sugar are permitted. The government has instituted household level monitoring of fortification levels at low cost through intersectoral collaboration in the gathering of sugar samples.

XVII IVACG Meeting Abstract Form

STRATEGIES OF CARE SERVICES TO THE PROBLEM OF VITAMIN A IN HONDURAS. Vilma Estrada, IMPACT/USAID, International Eye Foundation, MOH, Honduras. According to the National Nutrition survey of 1987, 73% of the families in Honduras consume less than half of the nutritional requirement of vitamin A. This situation stimulated the interest of regulating the sugar fortification and supplementation of vitamin A to children under 5 years of age and women in the first month of post partum. It was not until 1992 that as an initiative of the MOH the political support was generated to implement some of the activities to solve this problem of vitamin A deficiency. Since that time a Plan of Action and a strategy has been developed to prevent and control of vitamin A deficiency under the support of USAID/ VITAL and later USAID/IMPACT in close implemented by MOH. The private sector such as a the industry of sugar has also been participating. Up to date, the activities achieved have been the following: Training of MOH staff, community program for the sugar fortification, its coverage has improved from 40 to 91% of the total of the sugar producer for human consumption, spread of information, provision of technical assistance to the industry of sugar, establishing of a surveillance system at the industries of sugar, commerce and households, reviewing and spreading of the acquire vitamin A, register of date, supervision and monitoring, implementation of epidemiological surveillance, a designed and implemented system of epidemical surveillance.

Abstracts must be submitted on this form on or before 22 July 1995. Accepted abstracts will be reproduced for publication directly from this form. The information on this form will also be used for the final program if the abstract is accepted. Prepare your abstract in English. For optimum results, please follow instructions.

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2. Use a 10- or 12-point type size.
3. Single-space all copy within the box. Leave a margin within the box. Type should NOT touch the outside border, or go beyond the border, of the box.
4. Begin with the title in capital letters, followed by a period. Continue with: all name(s), affiliations, and address(es) (city and country) of author(s), followed by a period. Underscore the name of the individual who will give the presentation. See example on other side.
5. Begin abstract on a new line, indented 3 spaces. Abstracts must contain sufficient specific data to enable evaluation by the selection committee. (See "Tips for Writing Abstracts"; Proofread your abstract for accuracy.
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Please list below the name of the author who will present abstract, if accepted. All future correspondence about this abstract will be sent to this person.

Name Vilma Estrada

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Home phone _____ Signature/Date Vilma Estrada July 21, 1995

Email _____

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Research Foundation
1126 Sixteenth Street, NW
Washington, DC 20036
USA
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**ANNEX 5: ORS - LOCAL DRUG STORES VISITED & EDUCATIONAL
MATERIAL PROVIDED**

LIST OF STORES VISITED

PULPERIAS POR COLONIA VISITADAS PARA EDUCACION SOBRE EL MANEJO DE DIARREAS Y DISTRIBUCION DE LITROSOL.

COLONIA	PULPERIAS VISITADAS
ISRAEL NORTE	7
FATIMA	6
NUEVA OROCUINA	3
ALTOS DE LOS LAURELES	2
19 DE SEPTIEMBRE	8
ALTOS DE SAN FRANCISCO	6
SAN BUENA VENTURA	5
21 DE FEBRERO	10
RETIRO	2
SAN MARTIN	5
CAMPO CIELO	11
INDEPENDENCIA	10
FUERZAS ARMADAS	3
AYESTAS	19
RAFAEL LEONARDO CALLEJAS	7
PRIMERO DE DICIEMBRE	11

Consejos a las Madres sobre que hacer si su Niño tiene **Diarrea**



Aumente los líquidos a su hijo, con té de canela, manzanilla o atol de arroz, inmediatamente.



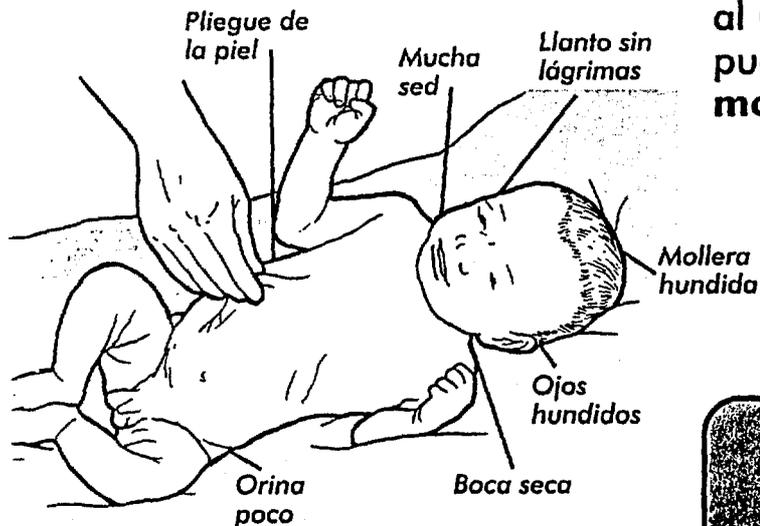
Déle de mamar a su niño más veces.



Déle de comer a su niño más veces y en menores cantidades.

Si observa alguna de éstas señales... Déle **Litrosol** y llévelo de inmediato al **Centro de Salud** pues su niño puede morir por:

Deshidratación o Desnutrición



No use antibióticos, ni otros medicamentos a menos que el médico lo indique.



Clorifique el agua que utiliza para beber y lavar los alimentos.

 *Fundación Internacional de Ojos*

* Educational material during the visit

ANNEX 6: BREASTFEEDING SUPPORT GROUPS

LOCATION OF BREASTFEEDING SUPPORT GROUP

GRUPOS DE APOYO Y MADRES CONSEJERA POR COMUNIDAD

NOMBRE CONSEJERA	COMUNIDAD	GRUPOS ESTABLECIDOS
01. PAOLA MUNOZ 02. GLORIA A. GODOY	FATIMA	1
03. SUYAPA RIVERA 04. IDALIA RODRIGUEZ	ISRAEL NORTE	1
05. ROXANA ZUNIGA	AYESTAS	1
06. MARLEN HERNANDEZ 07. CARMEN ZUNIGA	INDEPENDENCIA	1
08. MARIA D. MORENO	SAN MARTIN	1
09. MAURA HERNANDEZ	CAMPO CIELO	1
10. MIRIAN FLORES	ALTOS DEL PARAISO	1
11. ONDINA DIAZ	NUEVA DANLI	1
12. GENOVEVA ALVARENGA 13. MARTA ANDRADE 14. ANA LISETH OSORTO 15. NORMA HAYDE ZERON	ALTOS SAN FRANCISCO	1
16. KARLA BANEGAS 17. BLANCA LIDIA GALVEZ 18. LIDIA MURILLO	SAN BUENA VENTURA	1
19. OLIMPIA OSORTO 20. ANA VASQUEZ	EL RETIRO	1
21. ROSA AMELIA LOPEZ	DUARTE	1
22. DAMARIS ZUNIGA	PROVIDENCIA	1
23. MERCY MUNGUIA	SAN JUAN BOSCO	1
24. REYNA MONTECINOS	FUERZAS UNIDAS	1
25. AURORA JIMENEZ	ULLOA	1
26. CRISTINA LOPEZ 27. REGINA RIVERA	21 DE FEBRERO	1 1
28. MIRIAN SONIA FLORES	ALTOS DEL PARAISO	1
29. BLANCA ONDINA DIAZ	NUEVA DANLI	1
30. ROSA BARRAIONA	JARDINES DEL CARRIZAL	1
31. RUTH RODAS	CANTARERO LOPEZ	1
32. RAFAELA	PRIMERO DE DICIEMBRE	1
33. DEYSI RIVERA	RAFAEL L. CALLEJAS	1

ANNEX 7: BUDGET PIPELINE ANALYSIS

1996 PIPELINE ANALYSIS: PART A - HEADQUARTERS BUDGET

		Actual Expenditures to Date 09/30/95 to 6/30/96			Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99			Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99		
		AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. DIRECT COSTS										
A. PERSONNEL (salaries, wages, fringes)										
1. Headquarters-wages/salaries		12,986	13,445	26,431	(2,773)	9,968	7,195	10,213	23,413	33,626
2. Field, Technical Personnel-wages/salaries				0	0	0	0			0
3. Field, Other Personnel-wages/salaries				0	0	0	0			0
4. Fringes - Headquarters + Field		3,896	4,034	7,929	(832)	2,990	2,159	3,064	7,024	10,088
SUBTOTAL - PERSONNEL		16,882	17,479	34,360	(3,605)	12,958	9,354	13,277	30,437	43,714
B. TRAVEL/PER DIEM										
1. Headquarters - Domestic (USA)		0	70	70	375	1,905	2,280	375	1,975	2,350
2. Headquarters - International		4,600	5,428	10,028	(1,826)	(441)	(2,267)	2,774	4,987	7,761
3. Field - in country		0	0	0	0	0	0	0	0	0
4. Field - International		0	0	0	0	0	0	0	0	0
SUBTOTAL - TRAVEL/PER DIEM		4,600	5,498	10,098	(1,451)	1,464	13	3,149	6,962	10,111
C. CONSULTANCIES										
1. Evaluation Consultants - Fees		0	0	0	0	0	0	0	0	0
2. Other Consultants - Fees		0	0	0	0	0	0	0	0	0
3. Consultant travel/per diem		0	0	0	0	0	0	0	0	0
SUBTOTAL - CONSULTANCIES		0	0	0	0	0	0	0	0	0
D. PROCUREMENT (provide justification/explanation narrative)										
1. Supplies										
a. Headquarters		0	820	820	700	(670)	30	700	150	850
b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)				0	0	0	0			0
c. Field - Other				0	0	0	0			0
2. Equipment										
a. Headquarters		0	670	670	0	730	730	0	1,400	1,400
b. Field				0	0	0	0			0
3. Training										
a. Headquarters		0	70	70	0	(70)	(70)	0	0	0
b. Field				0	0	0	0			0
SUBTOTAL - PROCUREMENT		0	1,560	1,560	700	(10)	690	700	1,550	2,250
E. OTHER DIRECT COSTS (provide justification/explanation narrative)										
1. Communications										
a. Headquarters		0	2,270	2,270	0	2,605	2,605	0	4,875	4,875
b. Field				0	0	0	0			0
2. Facilities										
a. Headquarters		0	0	0	0	0	0	0	0	0
b. Field				0	0	0	0			0
3. Other										
a. Headquarters		275	977	1,252	(275)	(977)	(1,252)	0	0	0
b. Field				0	0	0	0			0
SUBTOTAL - OTHER DIRECT		275	3,247	3,522	(275)	1,628	1,353	0	4,875	4,875
TOTAL - DIRECT COSTS		21,757	27,784	49,540	(4,631)	16,040	11,410	17,126	43,824	60,950
II. INDIRECT COSTS										
A. INDIRECT COSTS										
1. Headquarters		63,116	9,071	72,187	20,320	12,851	33,171	83,436	21,922	105,358
2. Field (if applicable)										
TOTAL INDIRECT COSTS		63,116	9,071	72,187	20,320	12,851	33,171	83,436	21,922	105,358
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		84,873	36,855	121,727	15,689	28,891	44,581	100,562	65,746	166,308

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1996 PIPELINE ANALYSIS: PART B - FIELD BUDGET

		Actual Expenditures to Date 09/30/95 to 6/30/96			Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99			Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99		
		AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. DIRECT COSTS										
A. PERSONNEL (salaries, wages, fringes)										
	1. Headquarters-wages/salaries			0	0	0	0			0
	2. Field, Technical Personnel-wages/salaries	168,331	13,325	181,656	17,620	7,075	24,695	185,951	20,400	206,351
	3. Field, Other Personnel-wages/salaries	45,088	4,366	49,454	19,118	9,559	28,675	64,204	13,925	78,129
	4. Fringes - Headquarters + Field	33,222	5,128	38,350	7,641	5,657	13,298	40,863	10,784	51,647
	SUBTOTAL - PERSONNEL	246,641	22,819	269,460	44,377	22,291	66,668	291,018	45,109	336,127
B. TRAVEL/PER DIEM										
	1. Headquarters - Domestic (USA)	0	0	0	0	0	0	0	0	0
	2. Headquarters - International	0	0	0	0	0	0	0	0	0
	3. Field - in country	3,481	1,393	4,874	2,519	(1,393)	1,126	6,000	0	6,000
	4. Field - International	9,233	2,214	11,447	(1,063)	9,636	8,573	8,170	11,850	20,020
	SUBTOTAL - TRAVEL/PER DIEM	12,714	3,607	16,321	1,456	8,243	9,699	14,170	11,850	26,020
C. CONSULTANCIES										
	1. Evaluation Consultants - Fees	3,542	0	3,542	8,458	0	8,458	12,000	0	12,000
	2. Other Consultants - Fees	7,749	220	7,969	3,751	7,280	11,031	11,500	7,500	19,000
	3. Consultant travel/per diem	1,771	537	2,308	7,229	(537)	6,692	9,000	0	9,000
	SUBTOTAL - CONSULTANCIES	13,062	757	13,819	19,438	6,743	26,181	32,500	7,500	40,000
D. PROCUREMENT (provide justification/explanation narrative)										
	1. Supplies									
	a. Headquarters			0	0	0	0			0
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	0	7,360	7,360	4,700	90	4,790	4,700	7,450	12,150
	c. Field - Other	14,683	242	14,925	(6,091)	2,658	(3,433)	8,592	2,900	11,492
	2. Equipment									
	a. Headquarters			0	0	0	0			0
	b. Field	0	41,401	41,401	0	(5,101)	(5,101)	0	36,300	36,300
	3. Training									
	a. Headquarters			0	0	0	0			0
	b. Field	30,030	22	30,052	2,470	(22)	2,448	32,500	0	32,500
	SUBTOTAL - PROCUREMENT	44,713	49,025	93,738	1,079	(2,375)	(1,296)	45,792	46,650	92,442
E. OTHER DIRECT COSTS (provide justification/explanation narrative)										
	1. Communications									
	a. Headquarters			0	0	0	0			0
	b. Field	8,246	161	8,407	629	(161)	468	8,875	0	8,875
	2. Facilities									
	a. Headquarters			0	0	0	0			0
	b. Field	13,368	0	13,368	1,532	0	1,532	14,900	0	14,900
	3. Other									
	a. Headquarters			0	0	0	0			0
	b. Field	29,512	1,348	30,860	(7,712)	(1,348)	(9,060)	21,800	0	21,800
	SUBTOTAL - OTHER DIRECT	51,126	1,509	52,635	(5,551)	(1,509)	(7,060)	45,575	0	45,575
TOTAL - DIRECT COSTS		368,256	77,717	445,973	60,799	33,393	94,192	429,055	111,109	540,164
II. INDIRECT COSTS										
A. INDIRECT COSTS										
	1. Headquarters		0	0	0	0	0	0	0	0
	2. Field (if applicable)									
TOTAL INDIRECT COSTS		0	0	0	0	0	0	0	0	0
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		368,256	77,717	445,973	60,799	33,393	94,192	429,055	111,109	540,164

1994 COUNTRY PROJECT PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

		Actual Expenditures to Date 09/30/93 to 09/30/95			Projected Expenditures Against Remaining Obligated Funds 07/01/95 to 09/29/96			Total Agreement Budget (Columns 1 & 2) 09/30/93 to 09/29/96			
		AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL	
I. DIRECT COSTS											
A. PERSONNEL (salaries, wages, fringes)		1. Headquarters-wages/salaries	12,986	13,445	26,431	(2,773)	9,968	7,195	10,213	23,413	33,626
		2. Field, Technical Personnel-wages/salaries	168,331	13,325	181,656	17,620	7,075	24,695	185,951	20,400	208,351
		3. Field, Other Personnel-wages/salaries	45,088	4,366	49,454	19,116	9,559	28,675	64,204	13,925	78,129
		4. Fringes - Headquarters + Field	37,118	9,161	46,279	6,809	6,647	15,456	43,927	17,808	61,735
		SUBTOTAL - PERSONNEL	263,523	40,297	303,820	40,772	35,249	76,021	304,295	75,546	379,841
B. TRAVEL/PER DIEM		1. Headquarters - Domestic (USA)	0	70	70	375	1,905	2,280	375	1,975	2,350
		2. Headquarters - International	4,600	5,428	10,028	(1,826)	(441)	(2,267)	2,774	4,987	7,761
		3. Field - in country	3,481	1,393	4,874	2,519	(1,393)	1,126	6,000	0	6,000
		4. Field - International	9,233	2,214	11,447	(1,063)	9,636	6,573	8,170	11,850	20,020
		SUBTOTAL - TRAVEL/PER DIEM	17,314	9,105	26,419	5	9,707	9,712	17,319	18,812	36,131
C. CONSULTANCIES		1. Evaluation Consultants - Fees	3,542	0	3,542	8,458	0	8,458	12,000	0	12,000
		2. Other Consultants - Fees	7,749	220	7,969	3,751	7,280	11,031	11,500	7,500	19,000
		3. Consultant travel/per diem	1,771	537	2,308	7,229	(537)	6,692	9,000	0	9,000
		SUBTOTAL - CONSULTANCIES	13,062	757	13,819	19,438	6,743	26,181	32,500	7,500	40,000
D. PROCUREMENT (provide justification/explanation narrative)		1. Supplies									
		a. Headquarters	0	820	820	700	(670)	30	700	150	850
		b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	0	7,360	7,360	4,700	90	4,790	4,700	7,450	12,150
		c. Field - Other	14,683	242	14,925	(6,091)	2,658	(3,433)	8,592	2,900	11,492
		2. Equipment									
		a. Headquarters	0	670	670	0	730	730	0	1,400	1,400
		b. Field	0	41,401	41,401	0	(5,101)	(5,101)	0	36,300	36,300
		3. Training									
		a. Headquarters	0	70	70	0	(70)	(70)	0	0	0
		b. Field	30,030	22	30,052	2,470	(22)	2,448	32,500	0	32,500
		SUBTOTAL - PROCUREMENT	44,713	50,585	95,298	1,779	(2,385)	(606)	46,492	48,200	94,692
E. OTHER DIRECT COSTS (provide justification/explanation narrative)		1. Communications									
		a. Headquarters	0	2,270	2,270	0	2,605	2,605	0	4,875	4,875
		b. Field	8,246	161	8,407	629	(161)	468	8,875	0	8,875
		2. Facilities									
		a. Headquarters	0	0	0	0	0	0	0	0	0
		b. Field	13,368	0	13,368	1,532	0	1,532	14,900	0	14,900
		3. Other									
		a. Headquarters	275	977	1,252	(275)	(977)	(1,252)	0	0	0
		b. Field	29,512	1,348	30,860	(7,712)	(1,348)	(9,060)	21,800	0	21,800
		SUBTOTAL - OTHER DIRECT	51,401	4,758	56,157	(5,826)	119	(5,707)	45,575	4,875	50,450
TOTAL - DIRECT COSTS			390,013	105,500	495,513	56,168	49,433	105,601	446,181	154,933	601,114

II. INDIRECT COSTS											
A. INDIRECT COSTS		1. Headquarters	63,116	9,071	72,187	20,320	12,851	33,171	83,436	21,922	105,358
		2. Field (if applicable)									
TOTAL INDIRECT COSTS			63,116	9,071	72,187	20,320	12,851	33,171	83,436	21,922	105,358

GRAND TOTAL (DIRECT AND INDIRECT COSTS)			453,129	114,571	567,700	76,488	62,284	138,772	529,617	176,855	706,472
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