

Detailed Implementation Plan

Child Survival XV

Catholic Relief Services
Community-Based Child Survival
Intibuca, Honduras

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TABLE OF CONTENTS

SECTION 1: Program Description	1
A. Field Program Summary	1
B. Program Location	2
C. Program Goals and Objectives	8
D. Baseline Assessments	13
E. Program Design	15
F. Strengthening the Local Partner	18
G. Strengthening of CRS	18
H. Sustainability	19
I. Training	20
J. Behavior Change Communications	21
SECTION 2: Program Management	23
A. Workplan	23
B. Human Resources	24
C. Financial Management	30
D. Monitoring and Evaluation	31
E. Budget	36
F. Technical Plan	50
SECTION 3: Detailed Plans by Intervention	50
A. Control of Diarrheal Disease	50
B. Pneumonia Case Management	55
C. Maternal and Newborn Care	61
D. Breastfeeding Promotion	63
E. Integrated Child Survival Program and IMCI	64
Annex 1	i
KPC Documents	
ANNEX 2	ii
IMICI Document	
ANNEX 3	iii
LSS	
ANNEX 4	iv
CV's	
ANNEX 5	v
Location Maps	

Section 1.

Program Description

A. Field Program Summary

PVO/Country: CRS Honduras

Program duration (dates): 9/30/99-9/29/2003

1. ESTIMATED PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention	% of Total Effort	AID Funds in \$
Safe Motherhood and Newborn Care	35%	\$349, 921
LAM	15%	\$149,966
Pneumonia Case Management	25%	\$249,943
Diarrhea Case Management and Prevention	25%	\$249,943
Total	100%	\$999.775

2. Program Site Population: Children and Women

Population Age Group	Number in Age Group
Children < 1 year	1,675
Children 1-4 years	9,649
Total Children < 4 Years	11,324
Total Women 15-49 Years	11,310

- Source of the population estimates above: Censo Familiar de Salud, 98-99, SOH
- Estimated annual number of live births in the site: 489
- Estimated annual number of pregnancies: 562
- Estimated annual number of complicated pregnancies: 225
- Estimated annual number of complicated pregnancies requiring referral per year: 84

B. Program Location

This project targets marginalized regions of Intibucá where CRS has had an established presence since the late 1980s on the Salvadoran border and expands north to areas where CRS carries out development programming. The municipalities that will participate in the project are Intibucá, Colomoncagua, Camasca, Concepción, Santa Lucia, and San Antonio (see Appendix 5).

The project area has an estimated population of 36,878 persons.

Numbers for Beneficiary Populations

Women 12-49 yrs.	11,310
Children <1 year	1,675
Children 1-4 years	9,649
Others	22,973
Total Population	45,607

The Secretariat of Health (SOH) is responsible for the provision of public health services in Honduras. The country is divided into 8 health regions. The Department of Intibucá forms part of the SOH's Region II and is considered to have the poorest rating in the country in terms of meeting its population's basic needs. Basic health services in particular are lacking. According to UNICEF and the SOH, Intibucá has only one doctor and 6 nurse auxiliaries for every 10,000 people. At between 80 to 100 per 1000, infant and maternal mortality rates in this area are more than double national rates. In response to this reality and in recognition of the need to strengthen the capacity of the SOH to respond to the critical health situation in the project area, special importance will be placed upon forging close links between COCEPRADII and the SOH, emphasizing information sharing and technology exchange. This partnership will allow for lasting project impact and will provide ongoing benefits for the target population.

Potable water and sanitation have dramatically improved due to CRS and other water projects funded by USAID, yet target villages for this project are still ranked as extremely poor on the basis of income and health status. According to the Honduran Central Bank, agricultural day laborers earn approximately US\$ 1.50 per day. The Honduran Secretariat for Planning estimates that 71% of Hondurans in rural areas live in extreme poverty in terms of their capacity to purchase the basic food basket.

The economy in the proposed project zone is agriculture-based with families renting land (on average 3.5 hectares) and relying on annual basic grain production of corn, sorghum, and beans. Given the mountainous terrain, the quality of land is poor. The

usual practice for the farmers in this region is to keep half of what they produce for their own subsistence and to sell the remaining half

Through the implementation of over 130 water projects in Intibucá, CRS has strongly emphasized education in the areas of health, hygiene, and community organization in an effort to overcome some of the built-in inadequacies of the formal educational system.

The project zone is targeted for these reasons:

- The project builds on nearly a decade of cooperation and investment between CRS and USAID in potable water and sanitation in the country's poorest and least accessible Department.
- CRS works in partnership with an established and highly credible indigenous counterpart which operates a network of 81 village level organizations, all democratically elected and highly participatory. The project therefore does not require a prior investment in community organization as this human infrastructure is already in place.
- The project will strengthen, in a highly complementary way, an established integrated community organization structure. The existence of potable water and basic hygiene services, existing COCEPRADII programs in adult literacy, the CRS-European Union Food Security project, and the high degree of credibility and respect both CRS and COCEPRADII enjoy in the project zone all contribute to the likelihood of project success.
- CRS and COCEPRADII both have veteran staff familiar with the project zone that will be employed in this project. This project draws together diverse actors to work on health problems common to all. The project fosters continuing cooperation between CRS, COCEPRADII, SOH and municipalities through their mayors, Municipal Development Boards and the Health Plans they develop.
- The project responds to key problems in the community. Central to the strategy is setting in place communication points/resource persons where basic health messages are disseminated and through which information and support is available.
- This project promotes the further empowerment of communities with a particular emphasis on women, who make up at least 50% of the membership on COCEPRADII Water Boards and who will find their role enhanced via active participation in this project.

Epidemiology of the Region

Infant and Child Mortality

Despite improvements in overall mortality rates, desegregated data show that much of this reflects a drop in urban rates and that IMR rates for populations in rural areas are still high, particularly in the southwestern mountainous areas that include the project area (UNICEF). In the project area, post-neonatal mortality and child mortality continues to be high (80 to 100 per 1000) for children. The IMR for the Republic of Honduras was found in the 1996 National Family Epidemiological and Family Health Survey (ENESF-96) to be 42 per 1000 live births, and the under-five mortality rate (U5MR) to be 53 per 1000. However, the same survey points out that there are significant differences between urban and rural areas. In 1989, a comparative study was done among municipalities based upon the proportion of Unmet Basic Needs (UBN) indicators (PAHO Scientific Publication # 549, p. 255). This study showed that among municipalities which exhibited an UBN of 80% or higher, the Infant Mortality Rate (IMR) was estimated to be 100 per 1000. According to reports from the Secretariat of Health, 26% of municipalities of Region 2 (where Intibucá is located) show an UBN of 60% or higher. The southwestern region where the project is located is one of the areas of Region 2 with the least access to governmental social programs and high UBN indicators.

ENESF-96 findings cite that more than 50% of infant mortality occurs within the first month of life and 3/4 of these occur in the early neonatal period (0-7 days after birth). The Honduran perinatal death rate is 25 per 1000 deliveries. Major causes of infant deaths are respiratory infections, peri-natal complications, and diarrhea. The same study reports that in the neonatal period (0-28 days after birth), the leading causes of death are: birth trauma/asphyxia (30%) and prematurity/low birth weight (28%). In the post-neonatal period (28 days to 1 year), the main causes of death are diarrhea/dehydration and Acute Respiratory Infection (ARI), 32% each.

Diarrhea and Respiratory Infections

The prevalence of diarrheal disease is still a problem in the project area with 53.1% of mothers interviewed in a CRS KPC survey taken in August 1998 stating that their under 2 year old child had diarrhea in the past two weeks. This figure is 2.8 times higher than the diarrhea national prevalence (19.3%) and 2.5 times higher than the prevalence of Region 2 (21.5%) as reported by the ENESF-96. National Nutrition Surveys (UNICEF 1987) demonstrate that child growth patterns are relatively normal for the first few months of life and then show a sharp increase in both acute and chronic malnutrition between age 3 months to two years. This drop in nutritional status most likely corresponds to early introduction of other fluids and foods, abrupt halting of breast-feeding and repeated episodes of diarrhea and respiratory disease suffered by children.

In the project area, the 1998 KPC reported an estimated prevalence of 33.7% of ARIs in children under 2 in the two weeks before the survey. Of these, less than half sought help and only a third went to a medical facility. Of all mothers interviewed, only 49% could cite a symptom of pneumonia as reasons to seek medical help. The ENESF-96 found nationally and regionally that 39.9% of children under 5 had ARIs. It also estimates that less than 45% of the cases of ARI are treated with antibiotics nationally, and less than 40% in the project region.

The high incidence of death resulting from diarrhea and respiratory infections is mainly attributable to low levels of health education among mothers, delays in seeking appropriate medical attention for children with diarrhea, and a lack of access to health services and medicines. Through ongoing water projects, CRS provides basic hygiene and health education to the community, expands water and sanitation infrastructure and combats diarrheal disease through its village level Water Boards and Health Committees. This Child Survival Project will reinforce preventive activities, emphasize basic home management and care seeking behaviors, work on linking the existing community structures to health services, seek to improve quality, access to, and utilization of these services and develop a strong group of first level care volunteers to serve communities.

Maternal Mortality

Maternal Mortality Rates (MMR) in Region II are extremely high, with over 388 deaths per 100,000 live births versus 221 per 100,000 nationally (ENESF-96). UNICEF estimates that this rate is even higher in the Department of Intibucá with rates of 534 per 100,000 live births (2.4 times national MMR). Nationally, causes of maternal deaths include hemorrhage (32.8%), infections (20.7%) hypertension (12.3%) and obstructed labor (4.2%) (PAHO). Two thirds of these deaths occur at home (UNICEF). Home deaths, 80% of which occur during the first week after birth, are due mainly to hemorrhages and can be prevented in many cases with improved delivery and postpartum care. Maternal death rates also reflect high fertility rates of women in the region (6.3 compared to 4.9 nationally), low birth spacing, low prevalence of prenatal care, absence of postpartum care, lack of knowledge about family planning and reproductive health and the predominance of inadequately attended child births at home. The limited training of TBAs also contribute to the risks of labor and postpartum complications.

Coverage of Basic Maternal Child Health Services

Nationally, approximately 83.9% of women received at least one prenatal visit, though only 25.5% receive two or more visits. In Region II approximately one fifth of women (20.7%) receive no prenatal care services at all.

The majority of women in the project area give birth at home. The ENESF-96 shows that regionally, 59.4% of women deliver at home. The KPC survey in the project area suggests

this to be much higher, since KPC showed that 83.5% and 87.5% of births (the region and specific locations covered by the project, respectively) are in the home and are assisted either by a family member or TBA. Another important factor in high maternal and neonatal mortality is the lack of any postpartum care. Only 34% of women nationally, 27% in the region and 10.7% in the project area (only 1% in the latest KPC) receive any form of postpartum care. This is partially due to the large distances that exist from communities to health centers.

Both access to and use of family planning services are low. Only 7% of women in the Department of Intibucá receive any education or information concerning reproductive health and family planning (SOH Region II). UNICEF estimates that more than a third of all births nationally are spaced less than two years apart. In addition, exclusive breast-feeding to 6 months is very low (below 35% according to the KPC/00). The project will include the Lactation Amenorrhoea Method (LAM), which stresses the importance of appropriate breast-feeding practices for protection from pregnancy for the mother and prevention of infection for the child.

Nationally, anemia among women is also a problem. Between 60-70% of pregnant women are anemic due to malnutrition, faulty absorption, or uncompensated iron losses (Save the Children interview, 1996). These deficiencies are most prevalent among rural populations with low socio-economic levels, such as those in the project area.

Coverage of Tetanus Toxoid (TT) for women is relatively high, with 86% of women in Region II having received at least one dose of tetanus toxoid (ENESF-96), yet in the project area only 35% of women in reproductive years received at least one dose of TT vaccine. Coordination with the SOH for completion of TT series in all women and complete coverage for pregnant women will be included in the safe motherhood component of this project.

Chart 1. Comparison of Basic Health Coverage: National-Local

Program	Level	MR	DP	ARIP	OPV3	TT	PV	HD
Infant	National	42	19.3	39.2	90.9			
	Local	100	53.1	33.7	77.4			
Maternal	National	220				90	83.9	46.2
	Local	534				35	20.4	83.5

MR = Mortality Rate; Infant (per 1000); Maternal (per 100,000)

DP = Diarrhea Prevalence (%)

ARIP = Acute Respiratory Infection Prevalence (%)

PV = Prenatal Visits (%)

HD = Home Delivery (%)

Current Health and Child Survival Infrastructure

Since 1980, the SOH has implemented a decentralized health program using an Integrated ChildCare [*Atención Integral al Niño (AIN)*] strategy that incorporates several child survival interventions. While leaving the specific design and implementation of these programs to the local health post, the core structure includes:

- Primary health care strategies, most recently incorporating the IMCI methodology
- Community participation in solving local health problems
- The establishment of training programs for health care personnel and volunteer CHWs
- The implementation of a referral system linking volunteers and their communities to the medical expertise and resources of the SOH.

This approach has led to measurable improvements in health coverage and mortality rates in many areas of Honduras. However, in the Department of Intibucá, this strategy has not been fully developed or implemented due to financial and human resource constraints. Therefore, a key value-added aspect of this program is to more fully develop the AIN/IMCI strategy with CRS support. Through this project, CRS will build upon both the basic SOH infrastructure and the existing community health service model to improve access to and the quality of health services for women and children. CRS contributes to this effort through its counterpart COCEPRADII's network of village level organizations, which include Water Boards and health committees and through the provision of 15 Community Educators with years of experience in the project zone. The project also assigns resources for training current personnel and bringing in highly qualified new staff in the community, counterpart, and SOH levels. The aim of these activities is to improve access to health services and education among the target population.

The health service infrastructure in the Department of Intibucá consists of one hospital located in the departmental capital of La Esperanza, two clinics (one each in Camasca and Santa Lucia) and health centers in the municipalities, all under the coordination of the SOH. This system has been hampered by a shortage of medical personnel, inadequate training of health workers, and shortages of basic medicines. The project will work with the SOH and with communities to address these problems and strengthen the ability of the system to respond to the health needs of the project zone population.

A small network of SOH CHWs and TBAs supplements the traditional SOH system. Due to financial constraints, these CHWs and TBAs have received limited training and consequently have focused primarily on helping to organize vaccination campaigns and supply Oral Rehydration Salts (ORS). However, use of the Community Health Worker model in other parts of Honduras demonstrates that with effective training and support,

CHWs can provide a broad range of essential health services currently not covered by the SOH, thereby improving access to these services, especially among the rural population.

CRS has worked closely with the SOH in designing this program. CRS also met with Save the Children, CARE, WFP, UNICEF, and PAHO, all of whom support the project's programmed activities. CARE and WFP will manage limited food assistance programs in the region associated with the project zone.

C. Program Goals and Objectives

Goal: To reduce maternal and perinatal/neonatal mortality and child Mortality in children under 24 months in the target area over a Four year period.

Safe Motherhood and Newborn Care (50% of time)

Objectives	Indicator*	Data Source	Major Activities
To improve the ability of women, families and TBAs to recognize/prevent, and respond to obstetric complications.	Increased % of families correctly performing Obstetric First Aid	MTE Final	Design/adapt and implement a training intervention for women and families.
	Increased % of TBAs correctly performing Obstetric First Aid	MTE final	Design/adapt and implement a training intervention for TBAs.
	Increased % of women receiving follow up care by TBAs at 6, 24, and 72 hours and 1 week postpartum	MTE Final	Idem
To improve the ability of women, families, and TBAs to access first-level referral facilities in the event of obstetric complication.	Increased % of timely referrals	Facility Data	Develop means of communication and coordination between community and referral facility.
	Increased % of TBA accompanied referrals	Monitoring system	
	Increased % of families having a ready action plan for transportation	MTE Final	Develop community feasible means of transportation for complicated obstetrical cases to referral facilities. Develop and implement a quality assessment of facility service delivery and action response.

To promote and increase the utilization of LAM/exclusive breastfeeding during the first six months post-partum.	50% of children under 6 months of age will be exclusively breastfed	KPC (pre/post)	Design/adapt and implement an education strategy for pregnant women
	30% of women in their reproductive age will have knowledge regarding LAM	KPC (pre/post)	Design/adapt and implement an IEC strategy for LAM

- *Exact percentage goals for this component will be determined after application of KPC*

Pneumonia Case Management (25% of time)

Objectives	Indicator	Data Source	Major activities
Improved Pneumonia case-detection at the community level	60% of mothers of children <24 months will be able to identify signs of pneumonia	KPC	Design/adapt and implement a training (IMCI strategy based) intervention for women and families.
Improved pneumonia care-seeking behavior	60% of mothers of children <24 months presenting rapid and difficult breathing will have sought medical care.	KPC	Design/adapt and implement a training (IMCI strategy based) intervention for women and families.
Improved ability of CHWs to use pneumonia SCM at the community level	60% of children < 24m w/fast breathing in the past two weeks will receive treatment and/or referral by CHW	KPC	Design/adapt and implement WHO SCM training for CHWs
Improved ability of community to access first level facilities in the event of pneumonia	Increased % of timely referrals	facility data	Develop means of communication and coordination between community and referral facilities.

Diarrhea Case Management and Prevention (25% of time)

Objective	Indicator	Data source	Major activities
Improved ability of women/family to recognize and prevent dehydration	45% of children under 24 months with diarrhea in the past two weeks will have received an increased amount of home-based fluids.	KPC	Design/adapt and implement a training (IMCI strategy based) intervention for women & family.
	50% of children under 24 months with diarrhea in the past two weeks will have received food during and after the illness	KPC	“
	40% of mothers will be able to identify signs of dehydration.	KPC	“
Improved ability of CHW to recognize & treat “some dehydration”	50% of children <24m w/dehydration in the past 2 weeks will be treated w/ORS	KPC/ monitoring system	Design/adapt and implement a training intervention (IMCI strategy based) for CHWs.
	90% of mothers of children w/diarrhea in the past 2 weeks will know how to correctly prepare ORS	KPC	“
Improve ability of community to access first level facility in the event of severe dehydration	Increased % of timely referrals	Facility Data	Develop means of communication and coordination between community and referral facility

Capacity Building Objectives

Objective	Indicator	Data source	Major activities
To enable CRS HQ And Honduras staff To implement innovative CS interventions	program implementing CRS' framework for CB-IMCI and HB LSS	Final evaluation	Protocol development, training monitoring/supervision
To facilitate implementation of FB-IMCI by Area departamental de Salud de Intibuca	health facilities in the area are implementing FB-IMCI	Final Evaluation	adaptation of protocols, training follow-up, evaluation
To increased number Of villages with an Organized structure Addressing health	50% of villages within the area of influence will have an organized structure	COCEPRADII's information system	
To facilitate COCEPRADII institutional development	evaluation of inter institutional relation COCEPRADII-CRS	study report	

Sustainability Objectives

Objective	Indicator	Data source	Major activities
To increased number Of villages with an Organized structure Addressing health	50% of villages within the area of influence will have an organized structure	COCEPRADII's information system	
To facilitate COCEPRADII institutional development	evaluation on inter institutional relation COCEPRADII-CRS	study report	
To promote project Ownership by SOH	100% of health facilities will have an educator from the Project assigned	HIS	community visits, systematization of supervision process, maintenance of community HIS
	SOH staff participates In every activity of project	monthly reports	

D. Baseline Assessments

The project staff in coordination with the Ministry of Health and COCEPRADII, conducted a series of baseline assessments which included a KPC survey, focus groups, in-depth interviews with key informants, and exit interviews. The joint CRS-MOH-COCEPRADII team analyzed the information collected, selected health priorities for the area and strategies to address them. Likewise, indicators were defined to monitor and evaluate the project. Also, the results of these surveys were presented to the community at large.

KPC Survey: The project used an adaptation of the instrument developed by the JHU CSSP staff and followed the 30-cluster sampling technique. Both are described fully in the Baseline Survey report in Annex 1 along with complete results. As a result of the KPC survey, the objectives of the project were re-examined and the level of effort adjusted for the different interventions to more clearly reflect the needs identified. The indicators to be used throughout the life of the project and its pre-implementation results are the following:

KPC 2000 Safe motherhood Indicators Results

Indicator	Percent
Danger Sign Knowledge/Recognition	13.4%
Risk factors Knowledge/Recognition	2.7%
Post-natal Control	1 %
Maternal Coverage	51.7%
Quality of Service	SO4FE2 + TT2
Prevalence of Exclusive Breastfeeding/ LAM	32.2%

KPC 2000 ARI Indicators Results

Indicator	Percent
Case Detection	38.3%
Care Seeking Behavior	53.4%

Prevalence of IRA	56.3%
Prevalence of Pneumonia	44%

KPC 2000 Diarrhea Indicator Results

Indicator	Percent
Prevalence of Diarrhea	32.3%
Children <24 months with diarrhea who received an increased amount of home-based fluids	7%
Children <24 months with diarrhea who received food during episode	26.8%
Children <24 months with diarrhea who received increased ration of food after episode	7.2%
Children <24 months with diarrhea treated with ORS	26.8%
Mothers who can identify signs of dehydration	10%

Qualitative Surveys:

During the last two months of 1999, the project completed three focal groups with TBAs, two focal group and thirty in-depth interviews with VHWs, and two focal groups with mothers of children less than five years of age. The main objective of this qualitative research was to obtain a general profile of community health providers, and a general understanding of the expectations from their main clients. Thus, for the TBA group the main findings were the following:

- the great majority has not received any formal training
- the majority of complications during pregnancy arise during delivery
- no community, to their knowledge, has an emergency evacuation plan in place
- the majority of complications are related to hemorrhage during delivery or in the immediate post-partum
- they do not carry out prenatal control regularly
- they do attend the majority of deliveries in their respective communities
- their main limitations are related to lack of training, supervision, and supplies
- they receive a monetary compensation for their services
- they submit a monthly report to the MOH

The main findings among the VHW were the following:

- 75% of them were selected by the community

- their motivation for becoming a VHW were related to either the acquisition of health related skills, or altruistic motives
- the majority is literate
- 88% has received formal training, most of them from the MOH
- the average training time is 3 days
- Their main activities are related to health education and community mobilization, although when part of a PVO program their activities go beyond these areas.
- Voluntary work tends to be once a week
- Main limitations are related to lack or insufficient training, time, supervision, and educational supplies
- Main incentives for their work will be a greater resolution capabilities (for instance knowledge on drugs), increased training and supervision, and economic incentives
- 84% submit a monthly report to the MOH

The main findings among the mother's groups in relation to maternal health were:

- the great majority do not attend prenatal care, the main reason being lack of time
- for the great majority pregnancy and delivery are "hard times"
- as a rule post partum control is not a norm nor a felt need, usually they have their first post partum control 40 days after delivery
- almost all of them do not use FP methods because of religious reasons
- none of them have heard about LAM or the billing method before
- the main felt needs regarding their children health were related to home treatment and nutrition
- in general they held low expectations on VHWs because their poor capacity to solve health problems

E. Program Design

This project is designed to extend health services to 106 marginalized communities by building on the existing relationships and strengths of each of the project actors and by maximizing local management and involvement in health care provision.

The overall strategy aims to increase access and quality of health care for the population of children less than two years of age and women in their reproductive years. Access and quality will be focus at two levels: community and health facility.

At the community level access will be improved through the strengthening of local organizational structure and capacity. The project will build upon the organizational structure and capacity of COCEPRADII; thus supporting the local agency to develop a network of community health providers, increase their resolution health capacity, and promote its linkages with the formal health system. The quality and resolution capacity of services will be improved through the implementation of IMCI (Integrated Management of Childhood Illness) methodology and Home Based Life Saving Skills methodology (see Annex 2) by community health providers at the community level. The

implementation of these methodologies will entail training, supervision, and logistical support. These activities will be supported and exerted by CRS/COCEPRADII in close coordination with the Secretary of Health at the regional level.

At the health facility level, access will be improved through the strengthening of links with the community health network and the local design, adaptation, and implementation of a referral system. Quality of care will be improved through support for the implementation of facility based IMCI, and the implementation of the new MOH Maternal Health norms (LSS methodology will build upon these norms) (CRS will support the training of MOH personnel of all health centers included in the area of influence for these two new initiatives). See Annex 3

Based upon the epidemiology of the locality the health areas to be prioritized are safe motherhood, acute respiratory infections, and diarrhea.

In the maternal/neonatal care area, the main problems are:

- High incidence of congenital birth defects (according to anecdotal and observational data almost 80% of defects are related to neural tube defects)
- High incidence of perinatal and early neonatal mortality due to trauma/asphyxia during labor, prematurity/low birth weight.
- High incidence of maternal mortality (33% due to hemorrhages [80% of which occur during early postpartum and at home]; 21% due to infections, and 12% due to pre-eclampsia/eclampsia).

In the project area, 83.5% of births occur in the home. Untrained persons attend the majority of these births (82% of total deliveries), and some are unattended. Most maternal deaths in this area are due to postpartum hemorrhage and infections (54% of total MMR). Indeed, the greatest proportion of all deaths cluster within 24 hours of birth, with the vast majority (80%) occurring during the first week.

Although increasing awareness of signs and symptoms of obstetric complications among community members and strengthening of referral networks are important interventions, they are not sufficient in and of themselves to achieve an impact on maternal and neonatal health. This has been demonstrated by several studies. In order to reduce high levels of maternal and neonatal mortality, then strategies that include the implementation of obstetric emergency measures at the community level by TBAs and/or family members need to be implemented. A key activity in the maternal/neonatal component of this project is to adapt training interventions developed by ACNM in relation to Phase I (delay in the decision to seek care) and Phase II (delay in arrival to care facility) of the Delay Model (Thaddeus-Maine). This will be achieved through a partnership with The American College of Nurse-Midwives (ACNM), who will provide assistance to CRS in developing a maternal and neonatal program with special emphasis on Life Saving Skills (LSS) programs at the community level. This

program will enable TBAs to recognize and respond to obstetrical complications and emergencies.

While the intervention will focus on first aid in the case of obstetric complications, it will also include activities on preventive measures such as micro-nutrient supplementation (vitamin A, Iron, and Folic Acid), TT immunization, child-birth spacing (LAM methodology), and others. CRS Honduras' alliance with Georgetown University will enable identification of birth control spacing methods appropriate to the region. This information will be used to refine programming activities for child spacing that ensure greater success.

Access to treatment for pneumonia in the project area was 3.5 times less than the national average (19.2% of children with symptoms related to pneumonia did not receive any treatment, in comparison with 5.5% at the national level). Studies have shown that the only effective way to reduce mortality from pneumonia is through prompt and effective treatment of pneumonia episodes rather than through prevention or home care of ARI. For this reason, the focus of community educational activities will be on prompt recognition of signs of pneumonia and prompt care seeking. Delivery of services will be provided using "Standard Pneumonia Case Management," which is already being adopted and implemented through the IMCI strategy by the Secretariat of Health. Adequate access of households to SCM will be achieved through the implementation of strategies defined by the community in conjunction with the nearest first level facility.

Diarrheal disease prevalence in the project area exceeds the national average (2.8 times), access to service delivery is limited (45%), and case management at home is deficient (20% of households increase home fluids intake on any given diarrhea episode, 42.7% use antibiotics or anti-diarrheics, and only 1.8% increase food intake). The strategy of the program will focus on enhanced home management of diarrhea, mainly in the prevention of dehydration and malnutrition. It will also enhance management at the community level through training of CHWs and strengthening their links to health facilities.

The level of effort dedicated to "Pneumonia Case Management" has been decreased from 35 to 25%; and "Diarrhea Case Management and Prevention" has been increased from 15 to 25%. Due to the findings of the KPC in terms of community knowledge and practices in the home treatment of diarrhea, the health project team considered these changes to be needed to match the design of the project to the local reality. The number of communities to be included in the project was decreased from 113 to 106 by the exclusion of the municipality of San Francisco de Opalaca. This decision was taken in conjunction with all partners involved, by taking into account the difficulty in reaching the above municipality due to difficult geographical access and high dispersion of communities.

This project will implement a new strategy to address maternal mortality developed by ACNM: Home Based Life Saving Skills (HB LSS). This methodology aims to help women and their new babies who risk suffering and death because they lack access to health care or do not know how to prevent death and illness. The objective is to improve the performance of women, family caregivers, and home birth attendants (HBAs) in key preventive practices, knowledge for survival, and critical responses to life threatening complications. The training concentrates on clean and safe birth techniques, prevention of infection, resuscitation of the newborn and first aid response to hemorrhage.

This project will also implement Community IMCI and support the implementation of Health Facility IMCI. For the present proposal Community Based IMCI is defined as the community based management of child health using integrated approaches for health promotion, prevention, and treatment of childhood illness. The approach to be utilized will be " Integrated Approach to Child Health at the Community: Community Based IMCI". See Annex 2

F. Strengthening Local Partner Organizations

CRS will work in partnership with the Secretariat of Health (SOH) of Honduras and COCEPRADII in the implementation of this proposal. At the end of the project implementation we expect that 100% of SOH health facilities will have improved their quality of health services through the implementation of facility based IMCI, and will have strengthened its links to the community through its partnership with COCEPRADII. COCEPRADII, in turn, will have expanded its services to include health components in their community work, and at the same time will expand from 25 to 50% of villages, included in the grant, with some type of community health organized structure. Each of these village-organized structures will become integrated within the organizational structure of COCEPRADII, hence, strengthening its role as an advocate for civil society development.

G. Strengthening of CRS

Headquarters as well as the Honduras office will have acquired new skills through the implementation of two new child survival interventions in the areas of maternal health and pneumonia and diarrhea case management at the community level. At the same time these well-documented experiences will be shared with the international PVO community for their advancement in these areas. The health unit of CRS-Honduras will use this application to test their potential and act as a springboard to build its capacity. Once the health unit's potential is fully realized CRS Honduras will have created the core competence to continue to develop, manage, and implement quality and high impact health projects in Honduras. Another goal of the CRS health unit is that the experience from the CS project will allow CRS to become a regional leader among NGOs in the development and implementation of IMCI strategies at both the community and facility level. CRS will develop IMCI lessons learned and best practices from the project and

later collaborate with the SOH and other NGOs in their implementation throughout Honduras. In addition, CRS will develop key lessons learned from the project in how best to strengthen linkages for sustainability between communities, health facilities, and local and municipal governments. These lessons will be transferable to other technical fields, and will be especially important because of the new municipal development strategies of the Honduran government.

Currently, CRS Honduras health unit counts with experienced health professionals in the implementation and management of centrally funded child survival grants. The team demonstrates a wide range of technical skills including health education, MIS, supervision; in addition the CS project manager will be trained in Facility Based and Community Based IMCI and Home Base Life-Saving skills. In addition to the core technical and managerial staff, the unit also counts on quality administrative and financial support that has management experience with USAID grants.

The capacity building objectives will be monitored through monthly revisions of the project activity plan, and measured through the mid-term and final evaluation.

H. Sustainability

Sustainability for this project is understood as the process by which a local development program achieves total or partial programmatic and/or financial self-sufficiency which in turns promotes the local ability to exert influence upon the forces which shape local reality. The sustainability strategy for this project will be focus on programmatic and organizational capacity at the community and institutional level.

At the institutional level the focus will be on promoting ownership of the activities of the project by the health facility and regional (SOH) level; and strengthening the organizational capacity at the community (COCEPRADII) level. Hence, at the EOP we expect that the quality and resolution capacity of health services at the community level will have improved. Likewise, a systematic supervision system for the community health providers will exist and it will be linked to the health facility; and a community health information system will be in place and utilized for management purposes by the community and the formal health system.

The activities to be implemented to promote ownership will be:

- An educator (project personnel) will be assigned to each health center included in the geographical area of the project. There are 15 health centers within the project's area and 15 project's educators. Its role will be to support the community works that is implemented by the health facility personnel. The main activities within this area will be community visits with the health facility personnel; participate in the design and systematization of a supervision process for community health providers, and revise and support the development and maintenance of a simple and manageable community HIS. These set of activities lead to a process of community reflection and promotion of a community dialogue with the SOH.

- The project manager will promote a strong relationship with the health region (SOH). This will be done through the promotion of SOH's participation in every phase and activity of the project, participation of project personnel in SOH activities, and project's support for SOH activities related to the project goals.

The activities to be implemented to empower the institutional capacity of COCEPRADII are the following:

- Implementation of an evaluation of the inter-institutional relationship between COCEPRADII and CRS, its strengths and weaknesses. After several field visits and interviews with COCEPRADII's leaders, there was a general consensus that, in order to assure a positive effect on the organizational strength of COCEPRADII (as a result of project's implementation), there is a need to review the current status of the relationship, its impact on social development, and possible improvements.
- To increase the number of villages with an organizational structure integrated into COCEPRADII's organization. (currently only 25% of villages covered by the project form part of COCEPRADII's organization)
- To promote the systematic community health profile presentation by the community volunteer in the monthly community meeting. Currently, the villages, which are part of COCEPRADII, held a monthly meeting that revolves only around their water system. The presentation will aim at a process of reflection/action around community health issues.

I. Training

Training will be done at three levels:

1. Secretary of Health

The project will support the SOH health department area (area departamental de salud de Intibuca) through the implementation of training and follow-up workshops on the different health interventions included in the project. Special emphasis will be place on the implementation of IMCI in the health facility as well as in the community. Another area of emphasis will be maternal health. All the health personnel from three CESAMOS (health center which includes a physician and nurse personnel), 11 CESARES (health center which includes only nursing personnel), and a MCH clinic will be included in training activities.

2. Community

Training will be done at two levels:

- a. Community health providers

The community health providers' network will be supported through workshops in the areas of CB-IMCI and obstetric emergencies (LSS methodology). The number of community health providers will be increased and trained by personnel from the SOH and CRS/COCEPRADII.

b. Mother and family

The community health provider (CHV/TBA) will educate the mother and family level through home-visits, mother groups, pregnant women groups, and community assemblies.

3. Project Staff

All project staff (CRS/COCEPRADII) will be trained in two areas, CB-IMCI and LSS for obstetric emergencies. In addition the program manager and her assistant will be trained on FB-IMCI. The initial training will be done during the first year of the project, follow up workshops will follow throughout the life of the project.

Monitoring process

This process will be implemented at two levels, each level using its own methodology. Training at the institutional level will be monitored through the application of a pre-post test methodology, and on-going supervision. At the community level the monitoring will be done through the application of checklists and focus groups.

Training Material

FB-IMCI modules	Honduras Secretary of Health
CB-IMCI modules	PAHO
Obstetric emergencies LSS protocols	American College of Nurse-Midwives

J. Behavior Change Communication

The BCC overall approach will be develop in close coordination with the CONSAID initiative. This initiative is a collaborative effort between SOH-BASICS-NGO with support from the USAID mission, to develop a national IEC plan for child survival programs in Honduras. The process will be implemented in several phases using a participatory approach with all the organizations involved. Presently, the initiative has determined to focus upon the following behaviors:

Behaviors related to Pneumonia

- To seek and identify fast breathing and chest inward as a sign of pneumonia

- Early care seeking behavior

Behaviors related to diarrheal disease

- To increase early home liquids ingestion
- To promote healthy feeding practices during diarrhea episode
- To promote early care seeking behavior
- Early recognition of signs of dehydration
- To promote healthy feeding practices during the convalesce period

Behaviors related to maternal and newborn care

- To promote breastfeeding initiation within one hour after delivery
- Early identification of risk factors and danger signs by women, families, TBAs, and facility health personnel
- Early care seeking behavior
- To promote early post-partum care
- To promote micronutrients supplementation, with emphasis on folic acid and iron
- To promote prenatal care (two visits at least)

CRS-COCEPRADII will actively participate in the developing and testing of health messages in the geographical area of the project through the national IEC plan.

Section 2

Program Management

A. Work Plan for Life of Project

A work plan is outlined with 106 communities participating in the project since Year 1. Training activities will be implemented in a progressive manner, dividing the total of communities into three sectors with one coordinator each.

CHWs and TBAs will be trained in each community and will work with Community Educators, SOH Health Center personnel and COCEPRADII Water Boards and Health Committees to ensure complete coverage of community health needs.

Activity	1999-2000				2000-2001				2001-2002				2002-2003			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Staff Recruitment	X															
KPC and other studies	X	X														
DIP		X														
Development of Protocols		X	X													
Training CRS/Cocepradii				X												
Training Follow-up					X	X	X	X		X		X			X	
*SOH Personnel Training (FB-IMCI, Integrated Maternal Health)			X	X	X											
SOH personnel training on CB-IMCI						X										
SOH Training Follow-up						X	X	X	X		X			X		
Training TBA/CHW 1 st group						X										
TBA/CHW Training Follow-up						X	X	X	X		X			X		
Community Activities				X	X	X	X	X	X	X	X	X	X	X	X	X
COCEPRADII organizational Strengthening			X		X		X		X		X					X
Midterm Evaluation								X								
HIS strengthening			X		X											
Monitoring/supervision					X	X	X	X	X	X	X	X	X	X	X	X
Training TBA/CHW 2 group							X									
Final Evaluation (KPC)																X

Implementation Schedule:

Year 1: Hiring of staff, conduct baseline survey, Rapid Health Facility Assessments, development of detailed implementation plan, development of protocols (LSS-IMCI) and HIS. Training of SOH IMCI facilitators, training of health center personnel on IMCI. Training for Educators, TBAs, and CHWs, COCEPRADII organizational strengthening.

Year 2: Training SOH personnel, training follow-up, training TBA/CHW, community activities, Start, mid-term evaluation, COCEPRADII organizational strengthening, monitoring and supervision.

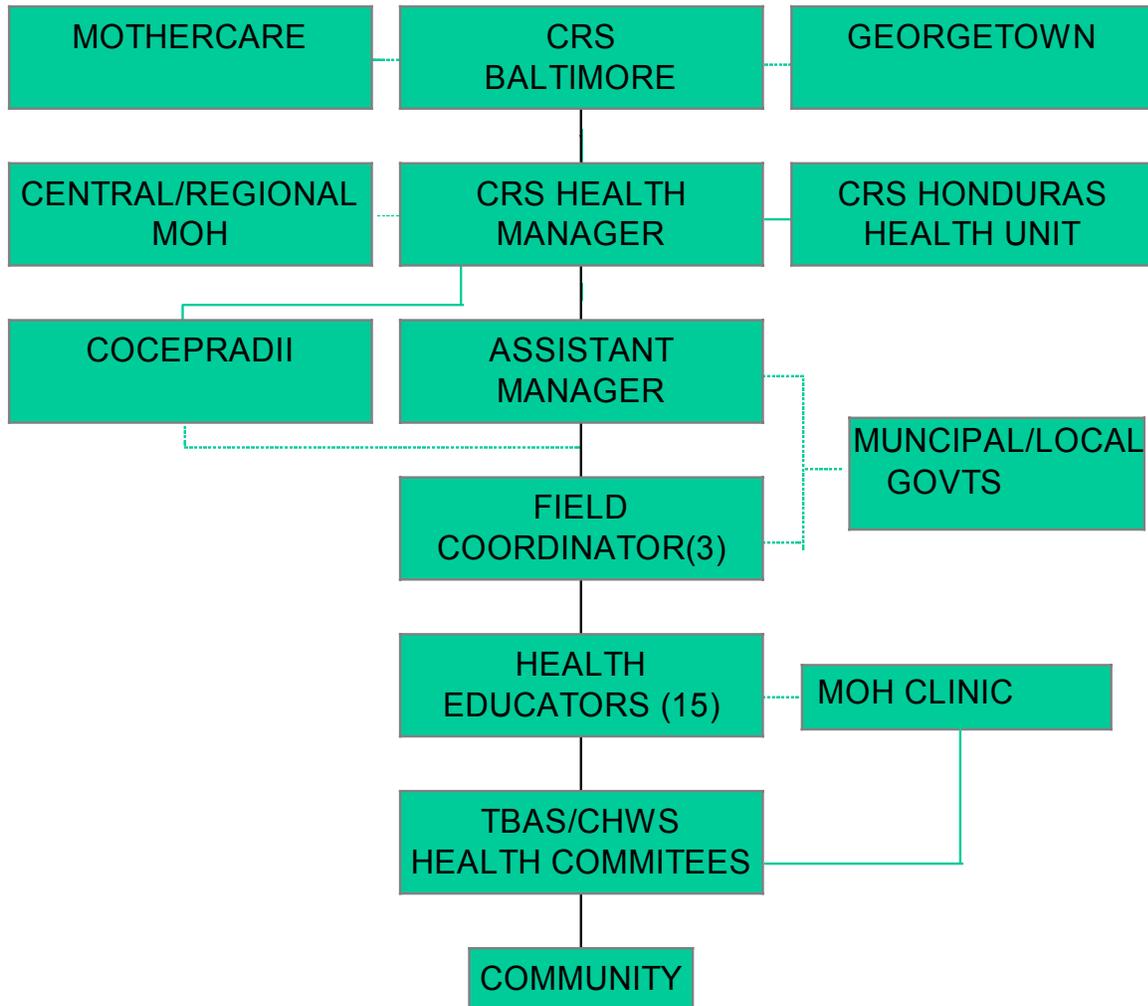
Year 3: Training follow-up for all training activities, community activities, COCEPRADII organizational strengthening, monitoring and supervision activities.

Year 4: Community activities, training follow-up, monitoring and supervision activities, Final CRS KPC Survey and Evaluation.

B. Human Resources

B.1 Organizational Chart

ORGANIZATIONAL CHART



B.2 Personnel

The following is a list of personnel who will be directly linked to project design, implementation, monitoring and evaluation.

- *CRS Baltimore:*

The PQSD Health Technical Advisor, Dr. Alfonso Rosales, will provide HQ-based technical and management backstopping for this project. He will spend 33% of its time on this program. His responsibilities will include: monitoring and supervision of the overall project, technical assistance to local grant manager and counterparts, one

annual field visit per year, review and approval of annual reports, midterm and final evaluation technical assistance and review and approval of final reports, and focal point for USAID Washington and CRS communication.

- *CRS Honduras Health Unit*

The CRS Honduras health unit will provide management, technical, and administrative support to the child survival project. The CRS Honduras health unit consists of the **health sector coordinator** who provides overriding supervision, monitoring and evaluation, and quality control of project strategies, budget, workplans, and advancement towards goals and objectives for all health projects managed by CRS Honduras. The health sector coordinator has an MPH and will spend approximately 25% of his time supporting the project. The other member of the CRS Health Unit that will support the project is the **CRS Administrative Assistant/Accountant**. This person will have a technical degree in finance and accounting and be acquainted with USAID financial reporting systems. She will provide technical assistance in project financial monitoring and reporting as well as accounting procedures. She will also work with both the project manager and health sector coordinator to facilitate project purchasing and other administrative support. Lastly, the project accountant will provide technical assistance to the project counterpart COCEPRADII in financial and administrative issues. She will spend 100% of her time supporting the project.

- *Project Grant Manager*

The Grant Manager will be an employee of CRS and be a public health professional (MD) with extensive experience in the management of community based child survival projects. The Project Grant Manager will be responsible for the oversight of all project operations including the development and quality control of project strategic planning, DIP, mid-term, and final evaluations, and the development and monitoring of project workplans according to project strategies, goals and objectives. She will also be responsible for the development, implementation, and follow-up of project monitoring, evaluation, and health information systems, and the provision of monthly, quarterly, and yearly project reports. In addition the Project Grant Manager will be responsible for ensuring effective coordination between CRS, COCEPRADII, and the SOH. The Project Grant Manager will be the direct link between the project and the SOH as well as the COCEPRADII Central Committee. She will spend 100% of her time supporting the project, and will be based in Tegucigalpa with 60-75% of her time in the field.

- *Assistant Project Manager*

The assistant project manager will be a nurse with over five years' experience in coordinating and managing field level community based child survival programs. The assistant project manager will be based in the field to provide timely supervision and management of day to day project activities. She will ensure the quality implementation of project interventions, and monitor the project's progress towards targeted goals and objectives. She will also provide direct supervision of field coordinators and project health educators, and coordinate project team training. The assistant project manager will coordinate closely with the project manager to develop project plans as well as project monitoring systems. The assistant project manager will also manage the project HIS and IEC systems and their subsequent dissemination with the SOH and participating communities. The assistant project manager will be the direct link between the project and the local SOH and municipal governments. She will be an employee of the project counterpart COCEPRADII, be directly supervised by the project manager, and spend 100% of her time supporting the project.

- *Field Coordinators (4)*

The project will incorporate four field coordinators who will have an educational background of a nurse auxiliary with experience in community based health programs, or a degree in community health. Each of the three field coordinators will be assigned two municipalities where they will coordinate the implementation of project strategies, plans, and field activities in the communities in their assigned municipalities. Overall each field coordinator will coordinate project activities in approximately **24** of communities and five health centers. In addition each field coordinator will be responsible for the direct support, guidance, supervision, and on the spot training of five health educators who will directly implement project activities in the targeted communities. The project field coordinators will be responsible for coordinating health educators in the implementation of the project HIS system and providing monthly progress reports on progress towards project goals and objectives in their assigned area. The field coordinators will be the direct link between the project and the health centers in their assigned municipalities. The field coordinators will be employees of COCEPRADII, be directly supervised by the assistant project manager, and spend 100% of his or her time supporting the project.

- *Health Educators (15)*

The project will hire 15 community health educators who will be from the region and have extensive community based health promotion experience. Each health educator will be assigned approximately **6** of communities where she/he will be responsible for the implementation and promotion of project strategies and activities

at the community level. This will include working in close collaboration with the local health facility in the training and supervision of TBAs, community health workers, and community health committees. The health educator will also be responsible for the implementation, supervision, and integration with the SOH of the project HIS and IEC systems at the village level. The health educator will be the direct link between the project and the community and local community governments, and work to catalyze community ownership of project activities and strategies. The health educators will be employees of COCEPRADII, be directly supervised by the field coordinator, and spend 100% of their time in support of the project.

- *COCEPRADII Administrative Support Administrative Assistant:*

The COCEPRADII administrative assistant will have a technical degree in accounting and experience in data analysis, financial management, and project logistics. He will have extensive experience in project and CRS accounting procedures. The administrative assistant will monitor and report on all project expenditures managed by COCEPRADII. He will also work with both the project manager and health sector coordinator to facilitate project purchasing and other administrative support. The administrative assistant will be an employee of COCEPRADII and be directly supervised by the assistant project manager for project activities. He will also receive support, training, and supervision from the CRS Health Unit accountant. The administrative assistant will spend approximately 75% of his time directly supporting the project, and about 25% of his time with the COCEPRADII central committee in institutional capacity building activities.

Driver

The project will also hire a local driver to drive the project vehicle assigned to COCEPRADII. The driver will have mechanical skills and experience driving in the rough roads of the project area. He will be an employee of COCEPRADII, be supervised by the assistant project manager, and spend 100% of his time supporting the project.

- *Local SOH Health Centers*
- *TBA (Traditional Birth Attendants) (100)*

TBAs will be volunteers selected by the local communities. Through project training in Basic Life Saving Skills TBAs will be responsible for attending and ensuring safe and hygienic births at the community level, the provision of home based pre-natal and post partum care, and the promotion of immediate breastfeeding. The TBA will be responsible for

the identification of an obstetric or neo-natal emergency and referral to the hospital. In addition the TBA will be a focal point in the provision of maternal and newborn health education at the community level, advocacy of a community supported emergency transport system, and assist families in the development of a birth plan. The TBA will be trained by the project health educators and be supervised by a combination of SOH health facility personnel and local community leaders. The amount of time spent supporting the project will depend on the number of pregnant women and births in the community.

- *Community Health Workers (CHW) (163)*

CHWs will be volunteers who are selected by the local communities. Through project training CHWs will be responsible for the provision of community based health care services at the community level. This will include the community based case management (detection, treatment, and referral) of pneumonia and diarrhea. In addition to supporting the implementation of project activities in the targeted communities the CHW will also be the focal point for the dissemination of key project IEC messages at the community level. She/he will also be the key link in the community based HIS, and coordinate project activities with local governments and other community based organizations. The CHW will be jointly supervised by the project health educators, SOH health facility, and supported by local community leaders. Each CHW will spend on average about 4 hours per week supporting project activities.

- *Community Health Committee (CHC)*

The community health committee will be volunteers selected by the local community to support health activities in the community. The CHC will assist in the planning and promotion of health activities in the community and provide oversight and supervision of CHWs and TBAs activities with the SOH and project staff. The CHC will also support the project in conducting evaluations of project interventions and provide key data for the project HIS. The CHC will form a part of the local community government and advocate project activities and strategies at the municipal level. The CHC will meet on a regular basis with project and SOH staff to discuss project sustainability and the progress to meeting project and community goals and objectives.

B.3

There are an estimated **50** of beneficiary families per community health worker.

B.4

Key project CVs can be found in **Annex 4**.

Dr. Alfonso Rosales CRS-HQ Senior Health Technical Advisor will be responsible for backstopping this project, he will make one visit each year, for a minimum of a week, to the project to assess progress, assist staff in analyzing efficacy of efforts, and to provide informal training in any area needed.

B.5

The project will ensure that project staff and other project partners will receive sufficient training and supervision utilizing the following two approaches. First the project has already conducted a training needs assessment for the project team and a partial assessment for the SOH, TBAs, and CHWs. The project will further refine these assessments and where needed and develop a training program that takes into consideration regular in-service refresher courses. Secondly the project will develop monitoring indicators that will be incorporated into the project's regular M&E and supervision plans that will gauge weak points in project activities and help define where further training is needed. To complement the project strategy of monthly supervision, reporting, and evaluation meetings, the project will also develop a complete supervision plan and schedule that incorporates simple and easy to use supervision tools for all project levels.

C. Financial Management

All project funds will be called forward from CRS headquarters in Baltimore. Funds will be called forward on a quarterly basis according to project plans and budgeted expenses. Once the cash call is approved in Baltimore the requested funds are forwarded to CRS's bank account in Honduras.

Once the funds are in the Honduras account CRS will either directly utilize the funds for project activities, or transfer the funds to the project counterpart to support project activities. CRS Honduras will manage project funds for larger project expenses, payments of consultants, and payment of CRS employee salaries. Funds turned over to the counterpart will be utilized to manage smaller local level field expenses and payment of project staff directly employed by the counterpart.

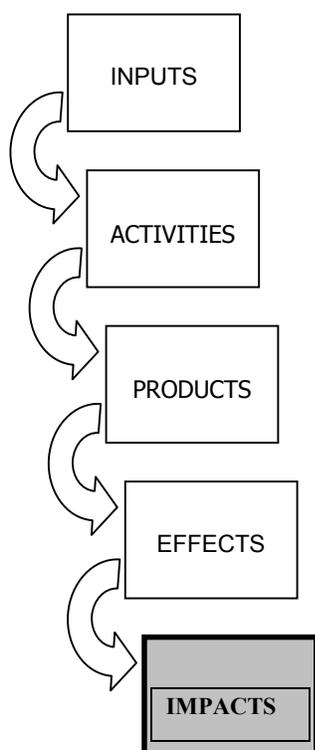
CRS Honduras has developed and trained counterpart administrative support staff in a budget and expenses tracking system that is uniform for all CRS projects in Honduras, and complies with USAID standards. In order to closely monitor the project budget and connect it to project plans and activities the following procedures are carried out on a monthly basis.

- At the end of every month the project manager meets with the rest of the project team to revise and evaluate the past month's activities, and to plan project activities for the following month.
- The project manager and assistant project manager then meet with the COCEPRADII central committee to review the project plans, discuss project progress, and develop a working budget for the following month.
- The CRS health sector coordinator then revises and approves the previous monthly expenditures and following month's budget and together with the COCEPRADII accountant submits them to CRS Honduras finance. In a participatory process involving both the COCEPRADII and CRS accountant the previous month's expenditures are liquidated with the required receipts and signatures, and the funds for the following months expenses that correspond to the counterpart are forwarded to the counterparts bank account.

The turnaround for this three-step process takes 3-4 days and is utilized as a tool for both CRS and COCEPRADII to monitor the overall project budget and spending rhythm. In addition, the system will help create counterpart ownership of the project and be a "hands on" tool that will assist COCEPRADII to build its institutional capacity to properly manage a large budget and connect it to project plans and activities.

Budget reports are then sent to CRS headquarters on a quarterly basis as a part of the regular project quarterly report.

D. MONITORING AND EVALUATION



In analyzing the establishment of the project's monitoring and evaluation (M&E) framework, CRS has determined that the thrust of efforts in the area of monitoring will be on measurement of change in indicators related to knowledge, attitudes and behaviors (KAB) of project participants. Assessment of movement in these **effect** indicators will enable project staff, counterparts and participants to determine the degree to which the interventions are producing the postulated changes in KAB. Achievement at this effect level is contingent on the attainment of **product** targets, both in terms of quality and quantity, thus the monitoring system will gather the necessary information to review progress in these areas. Products are the results of **activities**, measurement of whose quantity and quality will form part of the monitoring system. Finally, the success of the entire project depends on the timely availability of appropriate types and amounts of **inputs**. The project will therefore devote sufficient effort to review of performance in this key area.

The project’s evaluation strategy will focus at the **impact** level, with some **effects** also to be reviewed. In the three moments of evaluation – baseline, mid-term evaluation, and final evaluation – the project will gather principally quantitative information with respect to impact and selected effect indicators. At the mid-term and final evaluations, emphasis will be placed on examining the relationship between the effects achieved in terms of KAB and their impact on the health status of participants.

1. Monitoring:

The following monitoring table presents the principal effect level indicators, the periodicity with which data will be collected on them, the source of these data, and the person(s) primarily responsible for their collection.

INDICATORS	PERIODICITY	DATA SOURCE	RESPONSIBLE
<i>Safe Motherhood and Newborn Care</i>			
% of pregnant women who receive at least 2 prenatal consultations and TT by trained personnel.	Monthly	Service records	TBAs Project Trainers
% of pregnant women who deliver with a trained attendant.	Monthly	Service records	TBAs
% of women who begin breastfeeding within the first hour after delivery		MTE	MTE team
% of women who receive a post partum follow up within 48 hours of delivery	Monthly	Records	TBAs Project Trainers Health Center personnel
% of TBAs trained in HBLSS		MTE	MTE team
% of pregnant women in need of referral is referred	Monthly	Facility records	TBAs Project Trainers Health Center personnel
% of communities with functioning referral and emergency transport system or plan		MTE	MTE team
% of TBAs who received at least one supervisory visit		MTE	MTE team

during the previous 4 months			
% of health facility personnel trained in LSS		MTE	MTE team
<i>Pneumonia Case Management</i>			
# of children <24 months with ARI	Monthly	CHW report	CHW
# of children <24 months with fast breathing	Monthly	CHW report	CHW
% of children <24 months referred with positive signs of pneumonia	Monthly	Facility report	MOH staff
% of mothers with children <24 months who can identify signs of pneumonia		MTE	MTE team
# of children less than 2 years old with ARI	Monthly	VHW report	Project staff MOH staff
% of children <24 months w/fast breathing in last two weeks will have received treatment and/or referred by VHW.		MTE	MTE team
% of health facilities personnel trained in IMCI		MTE	MTE team
% of VHW who received at least one supervisory visit in the last 4 months		MTE	MTE team
# of health facilities incorporating IMCI and AIN protocols for pneumonia		MTE	MTE team
<i>Diarrhea Case Management and Prevention</i>			
# of children <24 months with diarrhea	Monthly	VHW report	VHW
# of children <24 months with dehydration	Monthly	VHW report	VHW
% of children <24 months referred with positive signs of dehydration	Monthly	Facility report	Facility personnel
% of children <24 months with diarrhea in the past two weeks and received an increased amount of liquids		MTE	MTE team
% of children <24 months with diarrhea in the last two weeks		MTE	MTE team

and received normal or extra amount of food during and after the illness			
% of mothers able to identify signs of dehydration		MTE	MTE team
% of children <6 months with exclusive breastfeeding		MTE	MTE team
% of mothers with children <24 months know how to correctly prepare ORS		MTE	MTE team
Capacity Building			
CRS Successful implementation of CRS framework for CB-IMCI and HB-LSS	Baseline MTE Final Evaluation	Baseline MTE Final Evaluation	Project Staff
MOH # of health facilities in the project area successfully incorporating IMCI strategies		MTE Final Evaluation	Evaluation team
Community % communities in project area with organized health committees that form a part of the larger water and development committee		MTE Final Evaluation	Project and COCEPRADII staff
COCEPRADII Institutional capacity assessment		Study report	CRS/consultant
Sustainability			
Community # of communities with operational emergency transport system		Final Evaluation	Project Staff
Community # of communities with community health committee that forms part of larger water and development committee		Final Evaluation	Project Staff
Community # of communities that have successful revolving community medicine funds		Final Evaluation	Project Staff

<u>MOH</u> # of health facilities with functioning village health supervision system		Final Evaluation	Project Staff
<u>MOH</u> # of health facilities implementing clinical IMCI strategies emphasized by the project.		Final Evaluation	Project Staff
<u>COCEPRADII</u> COCEPRADII has develop an institutional development plan		Final Evaluation	Project Staff
<u>COCEPRADII</u> COCEPRADII has developed plans and proposals for the continuation of project interventions		Final Evaluation	Project Staff

The project will utilize adult-education strategies that emphasize “learning by doing” to deliver the health messages. Standard lectures on health subjects might be complemented by community level visits to discover positive deviance, field trips to hospitals to observe different medical conditions, or other activities designed to facilitate learning. As these innovative approaches are perfected, the project will develop the monitoring necessary to assess their effectiveness.

As the project will base its interventions on the IMCI program, it will develop its monitoring tools on the basis of this content. In order to do this, CRS will work closely with the Ministry of Health in harmonizing the project-monitoring scheme with the existing MOH system. The idea is to avoid creating an alternative system not recognized by the MOH and therefore not sustainable over the long-term.

An additional component of project monitoring will be client satisfaction. During the midterm evaluation, the project will carry out focus group interviews with participants – VHWS and community members alike – to determine the degree to which interventions are responding to their needs. Project staff will use the results of these interviews to make necessary adjustments in implementation approach. CRS believes that this constant reminder of participant preferences will enable the project not to lose its focus on people as it strives to reach numerical performance targets.

While there are indicators for which the project will be responsible to USAID, CRS recognizes that these considerations may not be the ones of greatest interest to community members. This situation has two implications for monitoring. First, CRS will not make the mistake of assuming that all project-level indicators can be collected from

community members via VHWs. CRS, counterparts, and participants will determine which information can be generated by the community, and which information needs to be collected by project staff. Second, and of greater importance, CRS will work with participants in developing community-level health information systems reflecting their priorities. The idea of this initiative is to promote systems for monitoring health conditions that outlive the current project, and can provide an on-going flow of information for decision-making.

The primary information flow will be at the local level, between communities via VHWs and health centers. Data generated by the project will be analyzed jointly by the VHWs and health center personnel, facilitated by CRS staff. The results of the analysis will be reported to regional levels of the MOH by health center staff. Information will be returned to the community through local government structures (municipal authorities, Community Development Committees, *patronatos*) with which the project coordinates. In this way, project information will be made available to other actors for use in municipal or community planning.

One of the specific areas for monitoring of inputs is the supply of drugs to VHWs. CRS will be examining the lessons learned from the unsuccessful UNICEF pilot project in the zone, and adapting its own positive experiences in other countries in order to create an effective model.

The project will implement a midterm and final evaluation following USAID/BHR/PVC CS-XIII, 1997-2001 guidelines. The midterm evaluation will be implemented during the fourth quarter of the second year (FY2001) during the months of July and August. Likewise, the final evaluation will be done during the fourth quarter of the last year (FY2003), in the month of August.

E. Budget

	YEAR 1		YEAR 2		YEAR 3		YEAR 4		TOTAL	
	USAID	CRS	USAID	CRS	USAID	CRS	USAID	CRS	USAID	CRS
FIELD										
1.- Personnel										
CRS CS Grant Manager	16,414.00	-	17,235.00	-	18,097.00	-	19,002.00	-	70,748.00	-
Asst. Project Manager	9,655.00	-	10,138.00	-	10,645.00	-	11,177.00	-	41,615.00	-
CRS Admin. Support	-	6,759.00	-	7,097.00	-	7,452.00	-	7,825.00	-	29,133.00
CRS Field Coordinator (3)	23,172.00	-	24,332.00	-	25,548.00	-	26,824.00	-	99,876.00	-
CRS Health Educators (15)	57,930.00	-	11,788.00	49,037.00	63,870.00	-	23,312.00	43,753.00	156,900.00	92,790.00
CRS Admin Support	-	4,828.00	-	5,070.00	-	5,324.00	-	5,590.00	-	20,812.00
Driver	2,449.00	1,413.00	-	4,055.00	953.00	3,305.00	-	4,471.00	3,402.00	13,244.00
Guard	-	2,414.00	-	2,535.00	-	2,662.00	-	2,795.00	-	10,406.00
Office Cleaner	-	1,352.00	-	1,420.00	-	1,491.00	-	1,566.00	-	5,829.00

TOTAL PERSONNEL	109,620.0 0	16,766.0 0	63,493.0 0	69,214.0 0	119,113.0 0	20,234.0 0	80,315.0 0	66,000.0 0	372,541.00	172,214.00
2.- Fringe & Benefits										
Social Security/RAP	64.00	800.00	-	907.00	-	952.00	-	1,000.00	64.00	3,659.00
Life Insurance	6,624.00	-	-	6,955.00	-	7,303.00	-	7,668.00	6,624.00	21,926.00
Health Insurance	3,312.00	-	-	3,478.00	-	3,652.00	-	3,835.00	3,312.00	10,965.00
Severance Payment	-	9,957.00	-	10,434.00	-	10,958.00	-	11,506.00	-	42,855.00
TOTAL FRINGES	10,000.00	10,757.00	-	21,774.00	-	22,865.00	-	24,009.00	10,000.00	79,405.00
3.- Travel										
Consultants	1,800.00	-	3,600.00	-	3,600.00	-	3,600.00	-	12,600.00	-
Grant Manager	1,440.00	-	1,440.00	-	1,440.00	-	1,440.00	-	5,760.00	-
Asst. Project Manager	720.00	-	720.00	-	720.00	-	720.00	-	2,880.00	-
FC/HE	600.00	-	600.00	-	600.00	-	600.00	-	2,400.00	-
COCE Admin. Asst.	1,200.00	-	1,200.00	-	1,200.00	-	1,200.00	-	4,800.00	-
CRS Health Unit										

	864.00	-	864.00	-	864.00	-	864.00	-	3,456.00	-
Driver	960.00	-	960.00	-	960.00	-	960.00	-	3,840.00	-
TOTAL TRAVEL	7,584.00	-	9,384.00	-	9,384.00	-	9,384.00	-	35,736.00	-
4.- Minor Equip. & Expend.										
Computer/printer/Software		7,000.00	-	-	-	-	-	-	-	7,000.00
Office Furniture/Equipment	2,622.00	4,913.00	-	-	-	-	-	-	2,622.00	4,913.00
Main/repair office furniture	500.00	-	-	500.00	-	500.00	-	500.00	500.00	1,500.00
Office Renovation	6,000.00	-	-	2,000.00	-	-	-	-	6,000.00	2,000.00
Rental	1,800.00	-	-	1,980.00	-	2,178.00	-	2,396.00	1,800.00	6,554.00
Tel/fax/email	1,000.00	-	-	1,000.00	-	1,000.00	-	1,000.00	1,000.00	3,000.00
Other	1,000.00	-	-	1,000.00	-	1,000.00	-	1,000.00	1,000.00	3,000.00
TOTAL EQUIPMENT	12,922.00	11,913.00	-	6,480.00	-	4,678.00	-	4,896.00	12,922.00	27,967.00
5.- Supplies										
TBA birth equipment	2,062.00	688.00	-	2,750.00	-	-	-	-	2,062.00	3,438.00
Rehydration equipment	-	1,283.00	-	1,282.00	-	-	-	-	-	2,565.00
Pneumonia timers										

	858.00	-	-	858.00	-	-	-	-	858.00	858.00
Supplies/equip. HC	-	-	-	8,000.00	-	4,000.00	-	-	-	12,000.00
Supplies/drugs community	-	13,339.00	-	15,000.00	-	10,000.00	-	10,000.00	-	48,339.00
Maternal cards	600.00	-	-	600.00	-	600.00	600.00	-	1,200.00	1,200.00
Scales	-	-	-	6,600.00	-	-	-	-	-	6,600.00
Office Supplies	1,200.00	-	-	1,200.00	-	1,200.00	1,200.00	-	2,400.00	2,400.00
Printing reproduction	4,000.00	-	-	5,000.00	-	3,000.00	2,136.00	864.00	6,136.00	8,864.00
Didactic materials	2,400.00	-	2,400.00	-	2,400.00	-	2,400.00	-	9,600.00	-
Audio-visual equipment	-	1,666.00	-	334.00	-	-	-	-	-	2,000.00
Potable generators (4)	-	1,200.00	-	-	-	-	-	-	-	1,200.00
Other	2,000.00	-	-	2,000.00	-	2,000.00	2,000.00	-	4,000.00	4,000.00
TOTAL SUPPLIES	13,120.00	18,176.00	2,400.00	43,624.00	2,400.00	20,800.00	8,336.00	10,864.00	26,256.00	93,464.00
6.- Contractual Services										
Baseline Consultant	1,250.00	-	-	-	-	-	-	-	1,250.00	-
Baseline Surveyors										

	500.00	-	-	-	-	-	-	-	500.00	-
Midterm Evaluation Consult.	-	-	3,000.00	-	-	-	-	-	3,000.00	-
Midterm Evaluation Team	-	-	1,500.00	-	-	-	-	-	1,500.00	-
Final Evaluation Consultant	-	-	-	-	-	-	3,500.00	-	3,500.00	-
Final Evaluation Team	-	-	-	-	-	-	2,000.00	-	2,000.00	-
HIS Design Consultant	-	-	3,000.00	-	-	-	-	-	3,000.00	-
HIS Follow-up	-	-	-	-	2,000.00	-	-	-	2,000.00	-
Healthy Mother/Newborn	10,000.00	-	-	-	-	-	-	-	10,000.00	-
Project best practices	-	-	-	-	-	-	1,500.00	-	1,500.00	-
Organization Self-Assessment	4,000.00	-	-	-	-	-	-	-	4,000.00	-
MOH IMCI trainers	1,000.00	-	2,000.00	-	1,000.00	-	-	-	4,000.00	-
Community training	-	2,000.00	-	-	-	-	-	-	-	2,000.00
TOTAL CONT.SERV.	16,750.00	2,000.00	9,500.00	-	3,000.00	-	7,000.00	-	36,250.00	2,000.00
7.- Other										
Quality Asses/Facility Assessment	1,000.00	-	-	-	-	-	-	-	1,000.00	-
Project Monitoring										

	1,000.00	-	480.00	520.00	1,000.00	-	1,000.00	-	3,480.00	520.00
Baseline Evaluation	750.00	-	-	-	-	-	-	-	750.00	-
Mid-term Evaluation	-	-	1,500.00	-	-	-	-	-	1,500.00	-
Final Evaluation	-	-	-	-	-	-	2,000.00	-	2,000.00	-
4x4 vehicles (2)	-	38,000.00	-	-	-	-	-	-	-	38,000.00
Motorcycles (10)	-	24,000.00	-	-	-	-	-	-	-	24,000.00
Fuel vehicles	7,200.00	-	-	7,200.00	7,200.00	-	7,200.00	-	21,600.00	7,200.00
Fuel motorcycles	6,000.00	-	-	6,000.00	2,913.00	3,087.00	3,135.00	2,865.00	12,048.00	11,952.00
Fuel Generator	590.00	370.00	-	960.00	-	960.00	-	960.00	590.00	3,250.00
Oil vehicle	-	840.00	-	840.00	-	840.00	-	840.00	-	3,360.00
Oil Motorcycle	-	2,400.00	-	2,400.00	-	2,400.00	-	2,400.00	-	9,600.00
Repair/main. Vehicle	-	3,000.00	-	3,000.00	-	3,000.00	-	3,000.00	-	12,000.00
Repair/main Motorcycle	-	1,500.00	-	1,500.00	-	1,500.00	-	1,500.00	-	6,000.00
Repair/main.Generators										

	-	500.00	-	500.00	-	500.00	-	500.00	-	2,000.00
Battery/tires	1,500.00	-	-	1,500.00	-	1,500.00	-	1,500.00	1,500.00	4,500.00
Insurance/Lic/Reg.	-	2,500.00	-	2,500.00	-	2,500.00	-	2,500.00	-	10,000.00
Toner photocopier/printer	-	500.00	-	500.00	-	500.00	-	500.00	-	2,000.00
TOTAL OTHER	18,040.00	73,610.00	1,980.00	27,420.00	11,113.00	16,787.00	13,335.00	16,565.00	44,468.00	134,382.00
8.- Training										
Training Project Personnel	7,000.00	-	7,000.00	-	3,000.00	-	3,000.00	-	20,000.00	-
CHWS	10,000.00	-	10,000.00	-	15,000.00	-	5,000.00	-	40,000.00	-
TBAS	10,000.00	-	10,000.00	-	15,000.00	-	5,000.00	-	40,000.00	-
SOH	5,000.00	-	5,000.00	-	3,000.00	-	3,000.00	-	16,000.00	-
Training Exchange	3,000.00	-	3,000.00	-	3,000.00	-	3,000.00	-	12,000.00	-
TOTAL TRAINING	35,000.00	-	35,000.00	-	39,000.00	-	19,000.00	-	128,000.00	-
TOTAL FIELD										

DIRECT COSTS	223,036.00	133,222.00	121,757.00	168,512.00	184,010.00	85,364.00	137,370.00	122,334.00	666,173.00	509,432.00
HEADQUARTERS										
Personnel	20,000.00	-	21,000.00	-	22,050.00	-	23,153.00	-	86,203.00	-
Benefits	6,600.00	-	6,930.00	-	7,277.00	-	7,641.00	-	28,448.00	-
Travel	1,485.00	-	1,559.00	-	1,637.00	-	1,719.00	-	6,400.00	-
TOTAL HEADQUARTER	28,085.00	-	29,489.00	-	30,964.00	-	32,513.00	-	121,051.00	-
TOTAL DIRECT COST	251,121.00	133,222.00	151,246.00	168,512.00	214,974.00	85,364.00	169,883.00	122,334.00	787,224.00	509,432.00
INDIRECT COST@27%	67,802.67	-	40,836.42	-	58,042.98	-	45,868.41	-	212,550.48	-

* Program income is not anticipated, however in the event that funds are generated they will be used to further the objectives of this program.

E.1 Budget Notes

Introduction:

This budget reflects the revised costs needed for the implementation and management of the project. The budget is based on an exchange rate of \$1 USD = 14.5 Honduran Lempiras.

1) Personnel:

All salaries are national staff who will spend 100% of their time supporting the project. The salary year is based on a 14-month salary calendar that is standard law in Honduras.

2) Fringe Benefits:

Fringe benefits for Honduran national staff include severance payment reserve equal to one salary per month per year of service, approximately \$138 USD a year for health insurance, approximately \$275 USD per year for life insurance, and a social security payment that is proportional to the salary earned.

3) Travel:

Travel costs include hotel, per diem, transport, and miscellaneous costs associated with travel to project sites in the field, or to meetings and events. The project manager will spend approximately 60% of her time in the field, and other project staff will live in the area where they work. Project personnel assigned to the field will only receive travel costs when travelling outside their normal work area (ex. Tegucigalpa or other municipalities). Both CRS and COCEPRADII daily per diem rates are approximately \$10 USD, local transport at cost, and the cost of a mid-range hotel where available.

4) Minor Equipment or Expenditures:

All major purchases of equipment will follow the established CRS purchasing policies and procedures. Whenever and wherever possible CRS will explore alternative funding sources or options to lower costs.

- *Computers, Printers, and Software:*
The project will purchase two desktops computers at \$2,540 USD each, one laptop computer at \$2,050, and two printers at \$910 USDs each, and \$1,500 USD for software and other accessories.

- *Office Furniture and Equipment:*
Includes the costs of desks, chairs, file cabinets, tables, photocopier for the project office in Intibuca and in part for the office in Tegucigalpa.
- *Maintenance and Repair of Office Furniture and Equipment:*
Repairs of office furniture and equipment.
- *Office Renovation and Conditioning:*
Includes the reconditioning of the counterpart field office to accommodate the new staff and to upgrade office space. Funds will also be utilized to recondition meeting and training rooms at the COCEPRADII offices that will be utilized by the project.
- *Rental:*
Funds will be utilized to rent a house in the field where the project manager, CRS Honduras health unit staff, and other visitors will stay while visiting the project in the field to conduct training exercises or project supervision. This is due to the fact that there are no hotels in the project area. CRS Honduras will equip the house.
- *Telephone/Fax/E-mail/Courier:*
The project will utilize approximately \$83 USD per month in telephone, fax, e-mail, and courier services.
- *Other:*
Miscellaneous equipment and expenditures not specified or foreseen at this time.

5. Supplies:

- *TBA Birth Kits:*
110 kits at an estimated \$50 USD each.
- *Rehydration Equipment:*
Equipment for 95 communities estimated at \$27 USD for each community.
- *Pneumonia Timers:*
110 timers at an estimated cost of \$15.60 USD each.
- *Supplies and Equipment for Health Centers:*
CRS funds will be utilized to purchase key project related equipment lacking in participating health centers, or minor renovations that will enhance project related services at the clinic. The average amount spent on each clinic will be \$800 USD and the funds will be utilized in conjunction with other community or government funds that support the initiative.

- *Supplies and Drugs to be Utilized at the Community:*
CRS funds to be utilized to purchase drugs, supplies, and other support for community based health initiatives of the project. This includes the supply of drugs and ORS to CHWs to treat ARIs and diarrhea at the community level, and other Honduran SOH approved drugs and supplies that will support CHW and TBA activities in the community. Funds will also be utilized to purchase basic materials such as paper, pencils, table, and chair that will be utilized by the CHW and TBA in her/his work in the community. Average cost per community will be around \$500 USD. CRS Honduras will work to obtain support from the *Catholic Medical Mission Board* to obtain donations of drugs whenever and wherever possible.
- *Maternal Cards:*
Funds will be utilized to support the local SOH health centers in the reproduction of maternal cards for the area.
- *Scales:*
110 scales will be purchased at \$60 USD each to support growth-monitoring activities at the community level.
- *Office Supplies:*
\$100 USD per month to support the purchase of needed office supplies.
- *Printing/Reproduction:*
Includes printing or re-printing of developed or already produced guides, references, and health education materials for project activities. Examples include community and clinical IMCI training materials.
- *Didactic Materials:*
Includes manuals or guides for best practices, protocols, or other training materials to be utilized in the field as resource references or training guides for community or facility participants.
- *Audio Visual Equipment:*
Includes the purchase of TVs, VCRs, slide projector, overhead projector, screen, etc. that will support project activities.
- *Portable Generators:*
Four portable generators will be purchased and be utilized for select health education activities in villages where electricity is not available.
- *Other*
Miscellaneous supplies and equipment not specified or foreseen at this time.

6) Contractual Services

- *Baseline, Mid-term, and Final Evaluations:*
Includes fees, hotel, per diem, and other expenses for outside consultants that participate in the evaluations.
- *HIS Design and Follow-up:*
Includes fees, hotel, per diem and other expenses for outside consultant who will assist CRS in developing and monitoring a project health information system that complements the SOH system.
- *Healthy Mother/Newborn:*
Includes fees, hotel, per diem, and other expenses for representatives from the ACNM to provide a training of trainers workshop for SOH and community personnel in Basic LSS and obstetric emergencies.
- *Best Practices Document:*
Covers the cost of a consultant to define and document project best practices and lessons learned and consolidate the findings into a training tool.
- *Organizational Audit:*
Covers the cost of an external consultant to undertake a participatory institutional audit of COCEPRADII that will identify administrative, financial, and managerial strengths and weaknesses, and suggest how these may be improved through fortified linkages with CRS.
- *IMCI Training:*
Covers the travel, per diem, and hotel costs of SOH personnel who will train project and other area personnel in IMCI.
- *Community Health Training:*
Covers the cost of a local consultant who will provide a training workshop for project personnel in approaches to community organization in health.

7) Other

- *QOC and Facility Assessments:*
Funds utilized to undertake qualitative community and facility level assessments and evaluations to obtain information for project planning.
- *Yearly Monitoring Activities:*
Funds to support normal project monitoring activities throughout the year. Activities include small focus groups, interpersonal interviews, etc.

- *Baseline, Mid-term, and Final Evaluations:*
Funds to be utilized to pay interviewers, photocopying, transport, etc. to undertake evaluations.
- *4X4 Vehicles:*
The purchase of two 4 X 4 pick-ups that will support project activities in the field.
- *Motorcycles:*
The purchase of ten motorcycles that will be utilized by project field coordinators and health educators to conduct project activities at the community level.
- *Fuel for Vehicles, Motorcycles, and Generator:*
Fuel costs estimated at \$300 USD per month for vehicles, \$50 USD per month for each motorcycle, and \$40 USD per month for the generators.
- *Oil for Vehicles and Motorcycles:*
Oil for vehicles estimated at \$35 USD per month per vehicle, and \$20 USD per month per motorcycle.
- *Repair and Maintenance for Vehicles, Motorcycles, and Generators:*
Taking into road conditions of the project area, normal maintenance and repair costs at \$1,500 USD per vehicle per year, \$1,500 for all motorcycles, and \$500 USD a year for the generator.
- *Battery and Tires:*
Costs associated with the purchase of tires and batteries for the vehicles and motorcycles.
- *Insurance/License/Registration Fees:*
Costs associated with insurance for the vehicles, license plates and registration as dictated by Honduran law.
- *Toner:*
Costs associated with toner cartridges or other minor parts for the project photocopier and 2 project printers.

8) Training:

Funds will cover the cost of training exercises and follow up with project personnel, training exercises and follow up with community-based training with CHWs and TBAs, and training activities and follow up with the SOH. Specific training activities are outlined in the training segment of section 2. Training costs include materials, lodging, per diem, transport, and in some cases food.

9) Headquarters Direct Costs:

- *Personnel:*
Grants funds from USAID will cover 33% of the salary for the Child Survival Coordinator in the technical unit at CRS headquarters in Baltimore.
- *Fringe and Benefits:*
Includes life, health, social security, and other benefits for Child Survival Coordinator in Baltimore.
- *Travel:*
The USAID portion of the budget will cover the Child Survival Coordinator travel cost to Honduras to assist in project monitoring. Each year he will travel for approximately two weeks to Honduras for monitoring purposes.

F. Technical Assistance Plan

The program will count with the technical support of Dr. Alfonso Rosales. Dr. Rosales has more than 15 years of experience in international health, 12 years of which were gained at the field level in various countries of Latin America and Africa. Dr. Rosales is a physician with a master in public health and tropical medicine, and training in ob-gyn and IMCI. He is member of the "Community IMCI-interagency working group" and co-chair of CORE IMCI Working Group.

The country program manager (physician) and the assistant manager (nurse) will be trained during the first year of the project on IMCI and LSS methodologies. The program will also be technical assisted by the American College of Nurses and Midwives in "LSS" methodology for obstetric emergencies to improve the obstetric quality of care provided to pregnant women at the facility and community level. ACNM will train a group of "core" trainers for facility health workers during the first year of the project, and a group of "core" trainers for community health workers during the second year. Georgetown University Institute will technically support the "LAM" methodology for Reproductive Health.

Section 3: Detailed Plans By Intervention

➤ **Control of Diarrheal Disease**

Incidence

According to ENESF-96, Diarrheal diseases constitute the second and third cause respectively for infant morbidity and mortality in Honduras. In the area of Intibuca, each child under five years of age presents as average three diarrhea episodes per

year. Last year the health area #2, in which the project is located, reported 6,606 cases; 120 cases more than in 1998. In this area of Honduras, the prevalence of diarrhea shows a seasonal variation with increments in the number of cases during the months of May through October. The majority of cases are of the acute watery type. There is no documented data regarding antibiotic resistance, but with a community utilization of antibiotics in the treatment of diarrhea cases of 58.7% (KPC 00) we could infer problems in this area.

SOH Policies

MOH has three different treatment plans depending on the type of diarrhea, and level of dehydration (see Annex 5). The general approach of these protocols is aimed at prevention of dehydration and mortality. These protocols coincide with IMCI algorithm and have been adapted into the IMCI protocols. Home liquids (atoles, te de canela, te de manzanilla) and ORS use are promoted for the prevention of dehydration. Vitamin A supplementation is not contemplated.

Antibiotics such trimethoprim-sulfa or metronidazole are recommended in the case of dysentery. Antidiarrheals are not indicated at any time. Notwithstanding, among the population surveyed by the KPC-00 the utilization of antibiotics and/or antidiarrheals is conspicuous as noted above.

Knowledge and Practices

According to data produced by KPC-00, only 19% of caretakers provided more than usual amount of liquids during a diarrhea episode. On the other hand, notwithstanding the great majority of mothers (74.5%) know how to prepare ORS (litrosol) most of them use it when the child is not dehydrated with the subsequent high rejection rate. At the same time, only 10% of caretakers recognize signs of dehydration. Self-medication and limited knowledge about healthy practices are widespread among the population surveyed. Many caretakers fear that increasing feeding times per day during an episode of diarrhea will have a deteriorating effect on the disease; thereby, only a minority (27%) increases or maintains the amount of food during the diarrhea episode. The protocols recommend keeping or increasing frequency and amount of food during the episode. Likewise, it is recommended to increase one feeding time during the recuperation period; nonetheless, only 7% of children under five followed this practiced in the area surveyed.

Approach

The approach utilize by this project will concentrate on activities that facilitate the provision of health care closer to the user and improve quality of service, thus, activities related to the diarrhea component will be divided into various levels:

Household: appropriate case-management with emphasis in early treatment with home liquids (rice-water, te de manzanilla, te de canela) , appropriate feeding practices during and after a diarrhea episode, promotion of breastfeeding, ORS preparation and

appropriate use, early recognition of danger signs, and early care-seeking behavior. Preventive messages will be concentrated on exclusive breastfeeding, and sanitation practices.

Community: establishment of focal points (unidades de rehidratacion oral) for evaluation, classification and treatment of mild cases of dehydration, and referral of moderate to severe cases. Community volunteers, previously trained in community IMCI will manage these focal points according to MOH protocols; at the same time, these volunteers will provide education to caretakers on home case-management. Especial emphasis will be place on early recognition of danger signs and use of referral-counterreferral system, and the link between health facility and community. ORS packs will be provided by the SOH-region, COCEPRADII will support logistical distribution; and they will be provided to the client free of charge.

Health facility: through the implementation of the IMCI methodology in the health centers case management and health education will be improved. Prior to the IMCI training, the staff from this project in coordination with the health region will implement a "quality of care" assessment to determine particular deficiencies which must be addressed. Another area of emphasis will be the strengthening of links between the health facility and the community, on this line a health educator from the project will be appointed to each health facility in the area.

Resumen del Manejo de las Enfermedades Diarreicas

Según Protocolo de la Secretaría de Salud de Honduras

Signos y Sintomas	A	B	C
Observe Condicion: Ojos Lagrimas Boca y lengua Sed Explore : Signo del pliegue	Bien alerta Normales Presentes Húmedas Desaparece rapidamente	Intranquilo, irritable Hundidos Ausentes Secas Sediento, bebe agua con avidez Desaparece lentamente	Comatoso,hipotoni co* Muy hundidos y secos Ausentes Muy secas Bebe mal o no es capaz de beber* Desaparece muy lentamente
Decida	No tiene signos de deshidratacion o solo un signo en la columna B	Presenta 2 o mas signos de la columna B	Presenta dos o mas signos de la columna C
Clasificar como:	Diarrea sin	Diarrea con algun	Diarrea con

	deshidratacion	grado de deshidratacion	deshidratacion grave.Ademas si tiene uno de los signos marcados * tiene deshidratacion o choque
Plan de tratamiento	Use Plan A	Use Plan B	Use Plan C

Plan de Tratamiento

Plan A

- Promoveer el uso de liquidos tradicionales (té de manzanilla, atole de arroz, te de canela, jugos ,etc) y evitar el uso de refrescos embotellados y jugos artificiales.
- Entregar 3 sobres de litrosol
- Indicar a los padres la forma correcta de preparar el litrosol
- Orientar a la madre para que den los liquidos tradicionales y el litrosol frecuentemente en cantidades pequeñas y en particular despues de cada evacuacion y / vomito, utilizando de preferencia una taza o cuchara
- Indicar la continuacion de la lactancia materna y de la alimentacion habitual durante el episodio diarreico.
- Indicar la importancia de dar por lo menos una comida adicional durante dos semanas despues del episodio diarreico.
- Orientar a los padres en el reconocimiento de las señales de peligro ,la importancia de acudir al Centro de Salud
- Orientar a los padres sobre medidas de prevencion como el lavado de manos, hervir el agua, uso abundante de agua, disposicion de excretas y basura, higiene personal , preparacion y conservacion de los alimentos , lactancia materna y vacunacion.
- Orientar a las amdres para que no den purgantes o aceites al niño con diarrea.
- Referir en caos de que el niño presente dos o mas signos de deshidratacion, diarrea con sangre, diarrea con vomitos incontrolables , diarrea persistente (mas de 14 dias) , diarrea con distensión abdominal.

Plan B

- Dar litrosol en dosis de 50 – 100 ml / kg .
- Tiempo : 4 horas
- Fraccionando cada 20 –30 minutos , o de acuerdo a la tolerancia y voluntad del niño.
- Con taza y cucharita

- Mantener la lactancia materna y la alimentación del niño
- Hacer que la madre participe en el cuidado del niño.

Plan C

En las UPS donde no haya posibilidad de aplicar rehidratación intravenosa, el personal responsable de la atención del niño con deshidratación grave y / o shock hipovolémico le indicará las medidas de urgencia encaminadas a mantener la vida del niño, iniciar su rehidratación y favorecer su referencia en las mejores condiciones posibles

- Iniciar lactato ringer o solución salina normal 50ml /kg en una hora I.V.
- Repetir si continúa en choque
- Continuar con lactato ringer o solución salina normal de 50ml/kg en dos horas.
- Retirar venoclisis previa prueba de tolerancia y aceptación de la vida oral
- Completar hidratación con litrosol : 50 – 100 ml/kg en 4 horas vía oral. (Plan B)
- Reiniciar lactancia materna y alimentación habitual , si se ha suspendido por el choque.

Resumen de Manejo de Diarrea persistente (más de 14 días

- Indicar examen de heces (wright y / coprocultivo) para identificar posibles agentes etiológicos como : G. Lamblia, Shigella , E Coli.
- Indicar trimetoprim con sulfametoxazol = 8mg/ kg /día vía oral por 10 días o ampicilina , vía oral , 100 mg/kg/día en 4 dosis (cada 6 horas) vía oral, cuando se identifica (o el cuadro clínico es compatible con) shigella o E. coli.
- Indicar metronidazol 15 – 20 mg de peso x día vía oral durante 5 –7 días cuando se identifique cuadro compatible con Giardia Lamblia
- Recomendar la suspensión de aquellos alimentos en forma temporal que de acuerdo con la historia clínica , sean responsables de la persistencia de la diarrea o intolerancia de los mismos.
- Indicar alimentos sustitutos para mantener el aporte nutricional

Manejo de la Diarrea con Sangre :

- Indicar examen de heces y / coprocultivo para identificar agente etiológico
- Indicar trimetoprim / sulfametoxazol : 8mg /kg peso/ día , vía oral, durante 5-7 días cuando se identifique o el cuadro es compatible con giardia lamblia.

Behavioral Change Communication

The messages to be promoted by the child survival program in this area are being developed in close collaboration and coordination with the COSAIN initiative (BCC approach section). The messages will be consequent with the national IEC plan.

➤ Pneumonia Case Management

1. MOH ARI case management policies

Acute Respiratory Infections (ARI) is one of the main causes of death among children under five in Honduras. The 1996 National Family Epidemiological and Family Health Survey (ENESF – 96) reported that only 40 % of children under five with Pneumonia received appropriate treatment with antibiotics. According to data produce by the Intibuca department of health during 1999, the number of pneumonia cases that received treatment is as follow:

Year	Pneumonia cases in children < 1 year	Pneumonia cases in children 1-4 years
1998	1802 cases	1386 cases
1999	1200 cases	2275 cases

The current approach to this disease has been incorporated within the IMCI strategy. The main emphasis includes:

- Early identification of risk factors
- Early and appropriate treatment to avoid complications and decrease mortality
- Rational use of antibiotics and other drugs
- Growth and development maintenance of children suffering from ARI
- Health education to the community through interpersonal communication for prompt pneumonia sign recognition and early care seeking behavior

MOH Protocol for ARI (Manual de Normas y Procedimientos para las acciones de Control de las IRA, 1997, Secretaría de Salud Pública, Honduras.

Signos	Diagnostico	Tratamiento	Nivel de Atención
Frecuencia Respiratoria > o igual 60por min y /	Neumonía Grave	Penicilina Cristalina Gentamicina y otroa	Hospitalario

o tiraje subcostal moderado o severo		raminoglicosido	
Tiraje Subcostal	Neumonía Grave	Penicilina Cristalina u oxacilina mas ceftriaxone o cloranfenicol	Hospitalario
Ausencia de tiraje subcostal, aumento de frecuencia respiratoria : ➤ Mayor o igual 50 vece por minuto en niños < 2meses a 1 año. ➤ > o igual de 40 veces por minuto de 1-5 años	Neumonía	Amoxicilina ó ampicilina ó penicilina procainica ó trimetropin /sufametoxazol .	Nivel ambulatorio: CESAMOS y CESARES . Voluntarios de salud capacitados pueden iniciar tratamiento , referir al centro de salud y dar seguimiento posterior.

2. Quality of case management services in the program area

Management of pneumonia cases is the responsibility of all the health workers assigned to the health units of the MOH. The area of intervention of this project currently counts with 3 CESAMOS (center staffed with physician and nurse) and 10 CESARES (center staffed only with auxiliary nurse personnel), these units provider of health services are responsible for clinical care of pneumonia cases. According with the health facility assessment carried out by this project some health personnel, specialty auxiliary nurses showed serious deficiencies in pneumonia case management. Currently, the health area has not implemented IMCI training to its health personnel. This will be one of the priorities of the project, to support IMCI training for MOH health personnel.

The ministry of health also has a network of health volunteers (163) in the area. These personnel activities include early detection of ARI cases in the community, management of mild cases, and referral of moderate/severe cases. According to qualitative data produced by the project, the impact of these volunteers on ARI, specifically on pneumonia detection and management, is extremely limited due to inadequate training, lack of support and follow up. Theoretically, health volunteers in Honduras are allowed to distribute antibiotics (Trimethropin-sulfa) for case management of mild cases of pneumonia. The study showed that in practice these personnel lacks the knowledge and the means to fulfill this activity; likewise, the referral system is inadequate and ineffective.

In the last KPC (Feb-00), caretakers reported that 77.5% of children under 5 with ARI presented an increase in their respiratory frequency. Seventy three percent of

these children were taken to the health center. According to a revision of local health data, during the time-period included in the KPC, health centers of the area did not reported pneumonia cases. In other words, pneumonia case recognition by caretakers presents serious flaws with its overburdening consequence of health centers.

3. Monitoring, Improving, and sustaining the quality of case management

The project intervention strategy aims to reduce mortality in children under 5 by providing SCM (standard case management) early in the illness for a large proportion of all episodes of suspected pneumonia. This will be achieved by promptly providing appropriate antibiotics to children with signs of pneumonia and by teaching care givers to refrain from using antibiotics or other inappropriate drugs for most other ARIs.

The activities will focus mainly in addressing household, community and health facility needs regarding pneumonia, thus:

Household: priorities at this level will be early recognition of pneumonia and danger signs, and prompt care-seeking behavior. This will be accomplished through the implementation of an educational curriculum based upon the IMCI methodology; the target group of this intervention will be mother of children under two years of age, and the intervention will be executed by community volunteers, and supervised by the project's health educators. These activities will address the main HH flaws found in our qualitative survey: limited pneumonia case recognition, drug misuse, and overburdened health services.

Community: priority at this level will be to improve the ability of the health volunteer to use pneumonia SCM. This will be achieved through community IMCI training, supervision and logistical support. SCM for pneumonia is already being adopted and implemented in other regions by the Secretariat of Health. The educational material and methodology will follow PAHO's guidelines. Logistical support will be achieved through strengthening of coordination with, and supervision from the SOH. It is expected that through the appropriate implementation of the methodology, the current antibiotic utilization by the community and health facility will decrease, liberating current constraints for community supplies. At the same time, the project in conjunction with SOH will study the feasibility of implementing a community drug revolving fund. The project is also in the process of a joint developing with BASICS of an IEC strategy for the region. Another priority for the project will be the facilitation and strengthening of a referral-counterreferral system. This will be done through the promotion of the analysis of data produced by the health volunteers at the local and regional level, and the utilization of this data in the health planning process at local and regional level. Also the emergency referral system will strive to become effective and efficient through the participation of the community in its planning and implementation.

Facility: the project will support and coordinate with the SOH the training and implementation of IMCI in all health facilities included within the geographical area influenced by the Project. The Honduras SOH has adopted the strategy at the national level, currently the implementation of the strategy has not occurred at this region of the country due to lack of resources. Thus, increasing access to quality health services and satisfying the demand created by the community and household interventions.

All the above interventions will be monitored through monthly meetings, activity reports, and the HIS.

4. Counseling for antibiotic use, home care and referral:

The volunteer health worker will do counseling at home visits, during service delivery, and community meetings. Referral protocols will follow the IMCI methodology.

5. Follow-up of children treated for pneumonia:

See protocol above.

6. Assessment of access and increasing access:

As stated previously, according to ENESF-96 nationally only 40% of children under 5 with pneumonia received appropriate treatment with antibiotics. In our area of influence we found that only 53% of children under 5 with suspicion of pneumonia were seen at the health facility. This fact, notwithstanding indicates limited access to health care, does not measure access to adequate treatment. We estimate, based upon the health facility assessment done that access to adequate treatment in this area of Honduras is under national average.

Access for our project is defined as the possibility that a sick child has to receive adequate treatment and counseling from a trained health worker or volunteer for his/her disease.

After the implementation of project activities at the household and community level we estimate that access to health care will be improved by more than 20%, and the proportion of children under 5 receiving adequate treatment for pneumonia will be above 60%.

7. Beliefs, practices, and vocabulary.

The most common word for fast breathing in this part of Honduras is "cansancio". The two main signs recognized by caretakers in this area of Honduras are fast breathing (38%) and chest indrawing (18%). The main barrier to prompt recognition is limited knowledge on respiratory signs, which in addition to geographical barriers constitute the greatest constraints to health access in the region of Intibuca.

8. Communications for recognition and care seeking.

Sign recognition: the main focus on sign recognition will be placed upon recognition of fast breathing plus cough in children 2 months old and up; the targeted group will be their mothers. In children under 2 months old the messages will be concentrated on recognition of fast breathing, cough, breastfeeding poorly or stopped feeding well, and fever; the targeted group will be pregnant and post-partum women.

➤ Maternal and Newborn Care

The maternal mortality in the department of Intibuca is estimated at 534 per 100,000 live births, significantly higher than the national rate of 221 per 100,000 live births. Hemorrhage during delivery or in the postpartum period is the cause of maternal death in more than 80% of cases. Issues of particular concern are the low coverage of prenatal and postpartum services and the absence of health care personnel attention during childbirth. According to the latest KPC (February 2000), only 35% of mothers interviewed received prenatal care, 97% did not recall any risk factor, 86% could not mention a danger sign, more than 72% of deliveries were attended by TBAs, and less than 1% received post-partum care.

According to data collected by the health region during 1999, the neonatal mortality rate was 27 per 1000, apparently more than 60% of these deaths occurred during the early neonatal period (less than seven days after birth). The main causes are birth asphyxia, and sepsis. Currently, there is a total lack of information from the community. All deaths reported are the ones, which occurred at the health facility level. The BCG coverage in the area is near 90%.

MOH Policies and Current Public and Private Services

The strategy of the Secretary of Health includes:

1. A reproductive risk approach that promotes and facilitates an integral approach to maternal morbidity and mortality.
2. A non-obstetric reproductive risk approach that allows the identification of non-pregnant women with reproductive risk factors and their subsequent enrollment into FP programs.
3. An obstetric reproductive risk approach, which promotes prenatal control according to level of obstetric risk.

The project area counts with 14 health facilities in the municipalities of Colomoncagua, Santa Lucia, Concepcion, San Antonio, Magdalena, and Camasca (MCH clinic). In the municipality of Santa Lucia there is a private clinic that provides prenatal care and delivery services. All the facilities provide prenatal care, but only one (MCH clinic in Camasca) provide delivery services for normal deliveries. The only facility with capacity to manage obstetric emergencies is the regional hospital located in La Esperanza. Notwithstanding, the policy of SOH is for all pregnancies to have a facility based delivery, it is acknowledge by health regional authorities that due to high rate of home-delivery in the area there is a need to increase the resolution capacity of TBAs. Region has expressed a strong commitment to maternal health.

Knowledge and Practices

In the geographical area covered by the project, the nearest health facility with capacity to manage obstetrical emergencies is located 3 to 5 hours by bus or car. This is one of the main barriers for prompt care- seeking for obstetric emergencies because limited transport availability. On the other hand, there is a culture of home delivery, and very limited knowledge about risk factors and danger signs among the population. Women and their families do not perceive post-partum care as a need; traditionally, the newborn is brought to the health facility until 40 days after birth. Observational data leads to believe that health facility personnel capacity is poor in this area. Traditional birth attendants lack train in safe delivery techniques, and neonatal care. Their links to the formal health system is weak, as demonstrated by the absence of supervision and reporting system.

Approach

The objectives of the strategy are to increase quality of maternal health community delivery services and access to essential services outside the community. This will be achieved through the development of mainly two community-based interventions and one facility based intervention.

The major training objectives for the community interventions are to improve the ability of

- 1) Women, families and TBAS to recognize and prevent obstetric complications, as well as practices that may inadvertently contribute to complications;
- 2) families and TBAS to respond to obstetric complications in a safe and effective manner; and
- 3) women, families, and TBAs to access first level referral facilities in the event of obstetric complications where these facilities already exist.

At the community level, the project will be using two training manuals developed by ACNM which use LSS principles and teaching techniques. " Healthy mother healthy newborn" will focus on women and their families, includes clean and safe delivery,

prevention and treatment of hemorrhage, and post partum care for the mother and newborn. "Home based life saving skill" will focus on TBAs; this approach concentrates on clean and safe birth techniques, prevention of infection, immediate care of the newborn and first aid response to hemorrhage. ACNM will train project staff (COCEPRADII) to be master who would in turn train TBAs, women and their families. Auxiliary Nurses from the health centers will serve as supervisors of this network, thus strengthening links between community and health facility.

At the facility level, personnel will be trained in LSS (life Saving Skills) for management of obstetric complications. Life-saving Skills (LSS) programs help midwives improve the quality of care they provide. For this purpose a manual of protocols developed by ACNM/MotherCare will be used. These protocols were designed to enable midwives to give prompt, emergency treatment for life threatening conditions in order to reduce maternal and perinatal mortality. The protocols also enable health and maternity centers to establish standards of practice for the management of eight potentially life-threatening obstetrical conditions. At both levels the project will be developing programs for care of the post-partum woman and prenatal care. The expected outcome is to develop a common understanding of obstetric emergencies, their recognition and prevention, training in obstetric first aid, which integrates knowledge, problem solving, and psychomotor skills, developing an awareness of decision making process in obstetric emergencies, and strengthening referral networks and emergency transportation systems.

This intervention will count with the technical support from the American College of Nurses and Midwives (ACNM). The objective of ACNM technical assistance during the first year of the project will be to train facility based health staff in life saving midwifery skills. The LSS training is designed to revise, review, and update midwifery skills and to improve the ability to perform additional life-saving skills. In the case of Honduras, where there are no midwives, facility based nurses are the ones performing midwifery skills and therefore are the ones who will be receiving the LSS training.

➤ **Breastfeeding promotion**

Knowledge & Practices

According to the latest KPC (February 2000) done in the influenced communities, 87% of children less than 24 months are currently being breastfed; of these only 32% are presently receiving exclusive breastfeeding. Breastfeeding in these communities is initiated in 63% of the cases within one hour after delivery. In some communities is a regular practice to initiate with what is known as "chupon" which is a mix of herbs and oils, this with the purpose of "cleaning" the newborn; thereafter exclusive breastfeeding is instituted.

Exclusive breastfeeding, according to focal groups done by the project, is not related as a method to space births; only 4% of the mothers interviewed have heard about the LAM methodology.

SOH Policies

The general policy of the Secretary of Health is to recommend exclusive breastfeeding during the first 6 months after birth; thereafter the SOH recommends the introduction of complementary meals.

Approach

Breastfeeding will be integrated into the activities of two main interventions, diarrhea control and maternal health. The approach will be focus upon:

- immediate breastfeeding after delivery
- exclusive breastfeeding as a nutritional approach and diarrhea prevention for the first six months after delivery
- exclusive breastfeeding as part of LAM methodology for birth spacing

TBAs, community volunteers, and health facility personnel will be trained in the LAM methodology. These personnel in turn will promote the LAM method among women in their reproductive age through home visits, mother's groups, community meetings, and prenatal care. This component will count with technical assistance from Georgetown University Institute of Reproductive Health.

Behavior Change Communication

Breastfeeding promotion will be done in close collaboration with the project COSAIN, which is an initiative of SOH-BASICS-USAID to develop a national IEC plan.

The key behaviors to promote under this intervention are:

- breastfeeding initiation within one hour after delivery
- exclusive breastfeeding during first 6 months after birth
- breastfeeding plus complementary food after 6 months of age

➤ Integrated Management for Childhood Illness

Presently, IMCI in Honduras is in the early implementation phase. All IMCI generic materials have been adapted nationally. The main elements of the case management/health staff skill component of IMCI are diarrhea, ARI, and nutrition. A core group of trainers have been formed, and training of health facility personnel has begun in some regions of the country. Region II, where the project is located, is lacking behind the rest of the country and training has not yet begun, due mainly to lack of

resources. According to regional plans, in coordination and support mainly from CARE and CRS, the region will initiate training of a regional core group of trainers in the first semester of the year, and subsequently during the second semester will start the training of health facility personnel from the region. It is foreseen, that the south part of the department of Intibuca will be implementing facility based IMCI during the first semester of next year.

The child survival program will support the training in IMCI of personnel of health facilities located in the municipalities included in the project. The project manager, assistant manager and field coordinators will also be trained in IMCI, and will also support IMCI activities in the area. This team during the second semester of this year, in coordination with SOH regional staff, will adopt the "community based IMCI" protocols to the locality. Also, will take responsibility of training community health educators and community health volunteers in the area of project implementation, and measuring the impact of this initiative.

The community-based model to be promoted by the child survival program will concentrate mainly in two elements: preventive services delivered by health care providers and local activities that promote a healthier environment and lifestyle. In this approach, the first level of health care services is located at the household, with the child caretaker as the provider. The second level of health care delivery is located at the community; at this level the provider will be the community health volunteer. This community health volunteer will be the focal point linking community with facility IMCI.

The preventive services provided at the household level are:

- early recognition of illness and danger signs
- early care-seeking behavior
- improvement of nutritional habits
- improvement of home treatment

The preventive services provided at the community level are:

- promotion of immunization
- growth promotion and monitoring
- breastfeeding promotion and nutritional counseling
- management of prevalent diseases without complications
- referral of complicated cases to health facility

In promoting a healthier environment and lifestyle the main activities will be:

- promote community participation in the definition, analysis, and prioritization of health problems
- advocacy of healthy public policies
- development and implementation of emergency evacuation plans
- promotion of LAM methodology
- inter-sectoral collaboration

ANNEX 1

ANNEX 2

ANNEX 3

ANNEX 4

ANNEX 5