

World Vision Relief and Development

**WVRD/Honduras FY92-96
End-of-Project Report
No-Cost Extension
San Miguel Child Survival Project
Tegucigalpa, Honduras
April 30, 1996**

**Beginning Date: October 1, 1992
Ending Date: March 31, 1996**

Submitted to:

**Child Survival Grant Program
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ACRONYMS

AHLACMA	The Honduran Association of Breastfeeding
ARI	Acute Respiratory Infections
BF	Maternal Breastfeeding
CESAMO	Centro de Salud Medico , Medical Health Center
CHV	Community Health Volunteer
EOP	End-of-Project
EPI	Expanded Program of Immunization
FP	Family Planning
FUNED	National Foundation for Development
HIS	Health Information System
MOH	Ministry of Health / Honduras
NGO	Non Government Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
SMCSP	San Miguel Child Survival Project
TT	Tetanus Toxoid
WCBA	Women of Child-Bearing Age
WV/H	World Vision/Honduras
WVRD	World Vision Relief and Development

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I. EXECUTIVE SUMMARY

WVRD through World Vision/Honduras implemented a Child Survival Project (CSP) located in the Northeast marginal zone of Tegucigalpa, Honduras. The CSP, programmed for three years, began on October 1, 1992 and terminated on March 30, 1996 including a USAID-authorized six months no-cost extension. The subject of this report is a summary of activities that have occurred from the period of the Final Evaluation Report (submitted to **USAID** on December 31, 1995) to the end of the project's no-cost extension.

This CSP targeted children under five years and women of child-bearing age (WCBA) residing in twelve neighborhoods belonging to the catchment area of San Miguel Health Center (CESAMO), the national MOH counterpart in the project. Based on a 1995 neighborhood census, the target population estimates by EOP were: 8,137 under-fives (1,626 under one year and 3,252 under two years) and 11,950 WCBA, thus reaching 20,087 direct beneficiaries from a total population of approximately 50,000.

All the communities covered by the project are located in the Northeastern marginal zone of Tegucigalpa and have relatively easy geographical access to any health facility available in the city. The neighborhoods, called *colonias* are: La Esperanza, La Travesia, Estados Unidos, La Era, La Trinidad, La Sosa, 13 de Julio, Izaguirre, 30 de Noviembre, 28 de **Marzo**, Brisas del **Valle** and San Miguel.

The strategy for reaching the target population was based on training and support of community health volunteers (**CHVs**) as direct service promoters. CHVs would visit families on a house-to-house basis to promote, educate and deliver specific services/messages as well as to refer patients to the health center when needed. The interventions applied were: improvement of nutritional status, control of diarrhea, control of acute respiratory infections, vaccinations and reproductive health.

The rationale for the project's six month no-cost extension granted by **USAID** was the need to complete targeted objectives especially in control of diarrhea, control of ARI, improvement of child's nutrition through growth monitoring and exclusive breastfeeding (BF) promotion, EPI and maternal reproductive health. Other key activities such as sustainability and income generation activities were also affected and needed further implementation time. The delay in achieving the targets within the original three-year period was a result of slow start-up due to major shifts in key personnel responsible for the project implementation.

In summary, the extension period strengthened the achievements in programming and management of the efforts as reported in the Final Evaluation and contributed to the sustainability plan as well.

II. PROJECT ACHIEVEMENTS AND ACCOMPLISHMENTS

The health indicators presented in this section are based on information generated by the community-based SMCSP/HIS during the period January through March, 1996. However, they do not apply to the entire population living in the *colonias* but rather the ones followed by the project on a monthly basis.

A. Project Outcomes

1. Immunization

At the end of the no-cost extension, the complete vaccination coverage reached among children under 2 years is 98% according to HIS results. There are currently 23 children who do not have full vaccination coverage. This figure eclipses the one observed six month ago in the overall population (86%) from the Final Evaluation KPC Survey (see Table No. 1).

Table No. 1

Indicator	Baseline	Final
a. Full vaccination schedule among children < 2 years	77	86
b. % of mothers of children < 2 years who know age to administer measles vaccine	46	51

2. Control of Diarrhea¹ Diseases

In the three-year project period, the overall frequency of diarrhea among the target population has decreased. Among the population monitored in the HIS during the extension, the frequency of diarrhea among children under 2 years (during the last 15 days) is even lower (12%) for the first quarter of 1996. The frequency of children receiving antibiotics continued to decrease to **36%**, while the frequency of use of ORT among cases of diarrhea has increased to 85% in March, 1996. It is important to note that operationally speaking, ORT is defined as including not only ORS, but also other liquids such as natural juices.

3. Acute Respiratory Infections (ARI)

The relative contribution of ARI to morbidity cases treated in the CESAMO clinic

has increased lately (Annual Report from CESAMO, San Miguel 1993-1995). This trend probably will not be reversed in the near future because of the highly contaminated environment and in some degree, to the frequent weather changes.

Consequently, early detection of pneumonia symptoms, timely referral and ambulatory treatment become practical tools to reduce clinical complications and deaths among children from marginal zones. Table No. 2 shows a promising picture: mothers are increasingly able to detect signs of pneumonia while more ARI cases are treated with antibiotics by the health center.

Table No. 2

Indicator	Baseline	Final
a. Mother recognizing rapid breathing as symptom of pneumonia	68	82
b. ARI treated with antibiotics by the Health Center	50	97

In summary, it is clear that ARI control is an area where health promotion and education seem to have an impact on mothers' behavior. And this change of behavior could mean the difference between a child's life or death.

4. Nutritional Improvement and Breast-Feeding

The central activity for the nutritional improvement of children was growth monitoring for under 2-year olds. This activity reached its peak coverage on September 1995 (62%) at the time when the project was supposed to end. Subsequent field staff reduction (from 11 down to 4) has negatively influenced the coverage. On January 1996 it fell to 40% of the targeted children but is expected to improve in the subsequent months. This recovery is expected to take place by improving field staff and CHV efficiency so that by May, 1996 a monthly coverage of 55% is expected to be achieved and maintained.

5. Reproductive Health

Access to professional care during pregnancy and TT vaccine coverage is close to 100%. However, in this project period new norms were set by the DOH. Now five instead of two antenatal visits are advised, including one in the first trimester with five doses of TT instead of two required. No community-based data are yet available using these new MOH standards.

Regarding the use of modern FP methods, there is a small improvement (up to 49% in the final KPC), which is higher than the national figures.

Table No. 3

Indicator	Baseline	Final
a. % of mothers displaying their Antenatal Care Card	42	49
b. Pregnant women with 2+ Antenatal Care visits	95	97
c. % of mothers of children < 2 years with 2+ Tetanus Toxoid doses	61	95
d % of mothers using modern family planning methods	45	49

In addition to reflecting effective educational efforts and sound changed decision-making behavior, the improvement on some of these indicators may be due to the fact that the CESAMO health services will now withhold any service unless mothers can produce a card showing they have received the **TT** vaccine.

B. Project Process and Outputs

1. Community Health Volunteers (CHVs) training

During the six-month extension 280 CHVs were trained. The breakdown is provided below:

11 workshops on Child's Growth and development for 127 **CHVs**.

2 workshops on Diarrhea1 Diseases control for 22 **CHVs**.

2 workshops on Immunization for 20 **CHVs**.

2 workshops on Breast-feeding for 22 **CHVs**.

2 workshops on Family Planning for 22 **CHVs**.

12 workshops on Vitamin A for 144 **CHVs**.

4 workshops on Popular Education and Community Participation for 39 **CHVs**.

2. **Income Generating Activities**

Aimed to improve the social and economic conditions of the target population, a fund was established to provide financial support to community organized groups. In this first phase, CHVs received priority as an incentive to keep them working in their communities.

To implement this, the National Foundation for Development (FUNED) was contacted. The aim was to reach 60 CHVs (less than 20 % of the total) . So far, **FUNED** has provided 30 loans through community banks using **US\$ 6,000** as seed money. **FUNED** is responsible for providing loans/collecting payments in the area based on a three-year contract. It is as yet too early to report the outcome of this effort.

C. Training Activities for Project Staff

After December 1995, the hired staff in the project was reduced. However, they improved in quality. In-service training was the tool used to keep them updated. The workshops/courses carried out in the extension period are summarized as follows:

- 1) three courses for 6 participants on pediatric growth and development (44hrs)
- 2) one workshop on Popular Education and Community Participation (12 hrs)
- 3) one workshop addressing the project's sustainability (64 hrs)

for a total of 138 hours. These workshops were simultaneously attended by **CESAMO's** personnel (20 persons).

D. Active Community Health Committees

There are nine recently organized local committees that meet in each neighborhood (*colonia*) on a bi-weekly basis. The core of these committees consist mainly of **CHVs**. Forty members of these committees, along with project and **MOH/CESAMO** staff, participated in two workshops addressing various issues related to sustainability.

CHVs, as part of neighborhood committees are increasingly aware of their important role in community organization. While other community leaders are scarcely participating in health committees, **CHVs** are increasingly involved in different

organizations such as the committee (pafronato) for water supply, the committee for building/improvement of a community hall, and other school and religious grass-roots organizations.

E. Coordination with MOH and Other Health-Related Organizations

1. MOH Coordination

During the extension period, the CSP has been able to improve its coordination with the MOH at different organizational levels. Specifically with the CESAMO, accomplishments in various areas have been met. Brief illustrations are provided in:

a) Training

The SMCSP staff have worked with CESAMO's personnel in several different ways, both as trainers and trainees. CESAMO staff have provided training for CHVs in CS interventions. In turn, they have attended workshops where the SMCSP staff acted as trainers and both parties have attended as trainees courses in Popular Education and Health Data Analysis (including use of Epi-Info).

b) Monitoring and Evaluation

Both partners, SMCSP and CESAMO personnel, have reviewed the design of the community HIS; have reviewed the **process** of data collection and have shared the information generated by the system. Starting two months ago, a process of combined supervision was set-up so that a specific neighborhood receives a visit from both institution's supervisors.

c) Service Delivery

Both institutions share the service structure at the community level. CESAMO is currently providing ORS sachets and condoms to CHVs, who in turn distribute them to each house visited as needed. In relation to vaccination and other interventions, the CSP promotes health messages, detects problems and refers patients to the health center. Lastly, they

provide follow-up on cases seen at the CESAMO.

2. Other Agencies

Several health institutions have exchanged letters of understanding with WV/H aimed at sharing resources and providing specific and qualified services to the targeted population in the areas of reproductive health, BF and community health education. This work is expected to expand next year. Also there are agreements with the National School of Nursing/University of Honduras, the Honduran Association of Breast-Feeding (AHLACMA), the Honduran Association of Family Planning, and the Foundation for National Development (FUNED) for continued collaboration. These interactions with WV/H are a result of the SMCSP-related collaborations.

F. Staff Turnover

As a result of budget restrictions the technical, field and support staff were sharply reduced in December 1995. Technical personnel were reduced to two full-time persons; field staff, to four full-time workers and support personnel to five persons. Five months ago, Ms. **Aida** Bustillo was hired as Administrative/Financial coordinator. Her administrative background and skills are expected to help sustain the project's operation after USAID funds have terminated.

G. Technical Support Received for Child Survival Field Activities

During the extension period Technical support was received from various sources:

1. **Larry Casaua:** as WVRD Child Survival Director, provided assistance in reviewing the Final Evaluation Report as well as the extension plan and its objectives. He constantly provided direction and advice especially in monitoring, evaluation and reporting. He helped to develop a new CS proposal which is now under USAID consideration.
2. **José Angel Girón:** acting for FY96 as LACRO evaluator, provided direct support in several issues such as evaluation of the HIS: team review of CHV

service provision, training, review of health strategies, and reporting. He proved to be a good source of sound and problem-specific advice.

3. **Christopher Hogue:** acting as **WVRD** financial advisor helped to organize figures and procedures, and was especially helpful for the newly hired Financial and Administrative Assistant.
4. **Rolando Godoy:** acting as a consultant, led the review and evaluation of CSP performance especially in reference to the HIS, training, community participation and planning and evaluation. As part of a team, he has proposed a transitional plan to maintain and improve current community health activities and to link them to broader, sustainable objectives.
5. **World Vision/Honduras :** has provided technical support to the project in various areas related to management, administration and finance and system analysis.

III. MONITORING AND EVALUATION (INFORMATION SYSTEM)

Facing the need to provide an easy-to-use monitoring and evaluation system which is reliable and low cost, the SMCSP designed and developed a system to collect and process data from each target neighborhood on a monthly basis. Based on this information, the CHV coordinators are able to decide where to focus attention in their respective neighborhoods without depending on the CSP staff to decide for them. This reflects the HIS staff training which encourages the use of data collected at all levels of operations. The SMCSP/HIS coordinator then receives all tabulated reports and after quality control checks of the data, generates ratios and percentages to compare neighborhoods and measure the overall trend. This information can be compared with the intermittent KPC survey results to define progress toward attaining objectives.

During the extension period, a careful review of the system led to some changes in the data collection process to ensure that: a) Data quality control is carried out at each neighborhood site; b) tabulation and processing is simplified and made easy-to-do by the community personnel; c) analysis and interpretation of results are improved ; d) proper decisions are taken at the various levels and feedback provided down to the

“end-of-the-line” worker; e) comparability of results with other sources, (for example Health clinic statistics, KPC surveys, rapid assessment survey) becomes feasible.

The SMCSP-based community HIS has been analyzed by the CESAMO and the Metropolitan Region, who seek to standardize information systems at the community level.

IV. SUSTAINABILITY

A. World Vision / Honduras Compromise

The WV/H national office, legally established as a Honduran NGO, has assumed full responsibility for conducting the activities and tasks formerly assigned to the CS project. W/H is committed to strengthening the scope and extent of health activities in these communities; facilitating the organized efforts of the community to assume the responsibility for health care management and improvement, and acquiring the support of national and international donors when needed.

In order for **WV/H** to assume this responsibility, it carried out a thorough review and system evaluation of the SMCSP activities executed over the last three years. Based on this analysis WV/H has changed the approach to more effectively serve the community. Some of the areas to be newly-addressed are: improve community participation, expansion of CHV training, monitoring and evaluation, and overall management and administration skills.

To initiate the national take-over after **USAID** funding lapses, **WV/H** has developed a work-plan to be carried out through December 1996. The work-plan will initially be fully funded by **WV/H** in a program called “Family Health and Development”. This program is designed to generate income for its own operations by marketing locally various health services, and training and evaluation skills.

B. Progress and Achievements in the last six months

In order to establish CS sustainability, WV/H has carried out specific activities in various areas over the last six months of the extension. They are:

1. Training

- a) Training of 202 CHV was completed covering various CS topics.
- b. Four workshops were developed in Popular Education and Community Participation to ensure the new model will reach the grass-roots level. This training included all SMCSP staff, CESAMO staff and CHV coordinators.
- c. Selection and training of CHV coordinators was started, who will take over some of the current facilitators tasks. Once this process is complete, they will be responsible for coordinating and facilitating the various CSP interventions in their respective neighborhoods.
- d. Continued training of SMCSP and CESAMO staff in information systems and data processing (including a basic course in Epi-Info).

2. Community Participation

- a. The community has constantly participated through the efforts of more than 200 CHVs and 20 CHV coordinators.
- b. Community participation by grass-roots organizations has been promoted, but tangible accomplishments are still limited. So far, initial promotion and training of potential organization participants has been carried out. A wide umbrella organization is expected to be formed to include local and specific sectoral committees such as water, environmental improvement, and church groups. The first meeting took place in mid-March, 1996 and the CESAMO staff has promised to provide follow-up on this activity.

V. LESSONS LEARNED

The problems encountered in the last six months are not exclusive to the extension period but are related to those described in the Final Evaluation. The following conclusions are presented:

- A. A careful, realistic and participatory program diagnosis and design should precede project execution. The problems faced by the project were related to this limitation which stems from the short time period available to engage the community and counterparts in the proposal preparation step. For instance, the extension period showed that when **CESAMO's** support is timely and properly promoted, they fully respond and provide the needed collaboration.
- B. Activities bound to promote project's sustainability should be started as soon the project implementation begins.
- C. Successful project sustainability should integrate the following areas: community participation, institutional coordination and participation, integration between strategy and operations, and funds and resources availability.
- D. Project staff should pay increased attention to factors affecting **CHVs'** participation and performance.

VI. FINANCE

For finance information, please see attached Pipeline Analysis (Attachment A).

PVO/COUNTRY

WVRD/Honduras

COOPERATIVE AGREEMENT NO:

FAO-0500-00-2042-00

FINANCIAL REPORT

	Agreement Budget 8/31/92 to 03/31/96		Actual Expenditures 8/31/92 to 03/31/96		Spending Variation 10/01/92 to 03/31/96	
	USAID	PVO	USAID	PVO	USAID	PVO
1. DIRECT COSTS						
A. PERSONNEL	181,488	0	175,957	438	5,531	(438)
B. TRAVEL PER DIEM	69,622	0	118,261	0	(48,639)	0
C. EVALUATION	26,354	0	19,058	3,690	7,296	(3,690)
D. PROCUREMENT	45,146	99,065	39,380	94,548	5,766	4,517
E. COMMUNICATIONS	16,620	0	7,213	389	9,407	(389)
F. FACILITIES	2,500	0	4,377	0	(1,877)	0
G. OTHER DIRECT COSTS	27,390	0	4,874	0	22,516	0
TOTAL-DIRECT COSTS	369,120	99,065	369,120	99,065	0	0
II. INDIRECT COSTS						
1. HQ Indirect Costs (20%)	71,880	5,209	71,880	2,258	0	2,951
2. Field Administrative Support	0	159,540	0	154,260	0	5,280
TOTAL INDIRECT COSTS	71,880	164,749	71,880	156,518	0	8,231
GRAND TOTAL	441,000	263,814	441,000	255,583	0	8,231