

**Mid-term Evaluation**  
Matching Grant 1985-1987  
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Honduras

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This report is the result of work by the entire evaluation team. The final written document is the product of the Project evaluator, who is solely responsible for its contents. This report would not have been possible without the generous cooperation and support of the ADRA/HONDURAS staff who freely shared their time and knowledge with us. We also appreciate their generous hospitality during our visit.

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ABBREVIATIONS AND GLOSSARY

ADRA	ADVENTIST DEVELOPMENT AND RELIEF AGENCY
ADRA/I	ADRA INTERNATIONAL, WASHINGTON D.C.
ADRA/IAD	ADRA INTERAMERICAN DIVISION, CORAL GABLES, FL
ADRA/H	ADRA HONDURAS
CARE	COOPERATIVE FOR AMERICAN RELIEF EVERYWHERE
LEMPIRA	HONDURAN CURRENCY. 1 LEMPIRA=US\$0.50
LDC	LESS DEVELOPED COUNTRY
MCH	MATERNAL AND CHILD HEALTH
MGP	MATCHING GRANT PROGRAM
NGO	NON-GOVERNMENTAL ORGANIZATION
OVI	OBJECTIVELY VERIFIABLE INDICATOR
PAHO	PAN AMERICAN HEALTH ORGANIZATION
PVO	PRIVATE VOLUNTARY ORGANIZATION
RDA	RECOMMENDED DAILY ALLOWANCE
SDA	SEVENTH-DAY ADVENTIST CHURCH
USAID	U.S. GOVERNMENT A.I.D. OVERSEAS MISSION
WHO	WORLD HEALTH ORGANIZATION

## I. EXECUTIVE SUMMARY

The ADRA/HONDURAS Matching Grant program is an integrated community development program. The focus is on improving the health status of people in the target communities. The originators and administrators of ADRA/H recognize that many factors contribute to community development and in this project have tried to deal with those most important and most changeable at the community/personal level. Some of the desired/necessary improvements will only be evident after several years of changed lifestyle but others can be observed in less time. In some cases intermediate goals have been established which should produce the ultimate goals. This evaluation looks at the intermediate goals as indicators of ultimate success.

There have been some changes in the program from the original proposal. These changes are the result of community factors and project developments. Two communities demonstrated strong resistance to the project and were dropped from the project. The time needed to obtain supplies, train project workers, conduct baseline studies, organize the community, and implement the programs is as scheduled but the starting date is later than scheduled because the funds were not available as planned. If the entire time schedule is moved back to match the release of funds, the project is on schedule and meeting its intermediate goals.

Mothers are attending health courses. Many are practicing the principles they have learned in the courses. Children under five years of age are receiving daily food supplements and their body weight is being recorded as a measure of improved nutritional status. Some children have "graduated" from the program by virtue of age and some have dropped out or attend irregularly but those who participate fully are showing the desired improvements. Latrines are being built and used. Waste water around the homes is being channeled into drainage pits to decrease the spread of disease and insects. Land is being terraced to reduce soil erosion. Farmers are using fertilizers and other improved management practices. Families are raising goats, chickens, and bees as a source of food for improved nutrition and income. People are operating and patronizing small markets as a source of basic supplies for the home. The integration of several activities as opposed to specialized intervention is evident and the results display the importance of an integrated approach.

Problems or lack of results are primarily related to lack of staff availability. The promoters are involved in many communities and don't have enough time to do more than is now being done. Each community is visited weekly but each visit requires one to two hours of travel time each way and homes are often 30 minutes from each other. The promoters have set some priorities for action and these priorities are good.

Unreached goals are more a result of planning too much, rather than inadequate action. Three major shortcomings are evident. The first is the most significant because it is most crucial. Community workers are not being developed and utilized. Unless community leaders are involved in the projects, continuity after the end of funding is questionable. The other two shortcomings are lack of literacy education and lack of fish pond development. These are both a result of lack of staff time.

The impact of this project on the community is obvious, significant, and positive. Needed and wanted improvements are visible in the lives of the recipients. Many people involved in the project appear to have internalized the changes. More emphasis now needs to be put on the development of active community leadership and expertise.

## II. BACKGROUND

### A. Evaluation Description

In 1985 ADRA/I contracted with USAID to operate a food production and nutrition education project in Honduras. One requirement of the grant was that ADRA/I would provide an external evaluation during the course of the project and this evaluation would be submitted to USAID in addition to ADRA/I's internal periodic evaluations. ADRA/I contracted with Douglas Havens, Chairman of the Agriculture Department at Loma Linda University and Associate Professor of Agriculture and International Health to lead the external evaluation.

The evaluation involved 10 days of site visit in Honduras plus the time for preparation, travel, and final document processing. While in Honduras the team visited the project headquarters in the township of Lepaera, Department of Lempira, Honduras, and 11 of 12 of the project satellite sites in the surrounding region. At each site, interviews were conducted with directors and assistants at the satellite centers. Program participants were also interviewed along with community leaders and other interested parties.

### B. The Seventh-Day Adventist Church and ADRA

The Seventh-Day Adventist Church has been sending workers around the world for more than 120 years. These church workers, often called missionaries, have carried the Gospel of Christ with a two part objective. First was demonstrating the love of God through programs which assist the people they work with and second, carrying the good news of God's plan for the future. From the earliest days of the SDA church there has been a strong emphasis on health and lifestyle. Healthful living holds a near theological importance in the church, and hospitals, clinics, schools, health education, nutrition, and food production have been the core of the church's outreach activities.

Adventists are represented in 190 of the 218 countries recognized by the United Nations. The church operates 345 medical institutions, thousands of elementary schools, and nearly 500 schools above the primary level outside of the United States.

The Adventist Development and Relief Agency (ADRA) was organized in 1956 as the Seventh-Day Adventist World Service (SAWS). (Because of a name change in 1983, some documents refer to SAWS and some to ADRA.) The agency is responsible for coordinating all development and relief work conducted by the church. ADRA has its headquarters in Washington, D.C., at the world headquarters of the Seventh-Day Adventist Church.

In its early years SAWS was primarily involved in disaster relief, but beginning in the 1970's the church recognized the need to get involved in development on a larger scale, and since that time ADRA has provided more development assistance than disaster relief. ADRA works through the organization and structure of the Seventh-Day Adventist Church world wide, but its programs are open to all, without regard to race, color, creed, religion, sex, national origin, or politics.

ADRA programs are generally oriented to the neediest sectors of the people in developing countries, "the poorest of the poor". In addition to its traditional role of providing short-term relief for victims of disasters, it now provides a wide range of material and technical resources for projects in agriculture, community development, nutrition education, environmental health, maternal/child health, literacy, housing, and economic development. ADRA is one of the ten largest private voluntary organizations in the US and is one of 6 agencies authorized to distribute PL 480 Title II commodities in Honduras. ADRA's thirty year record of distributing commodities in disaster relief and "food for work" programs gives it great organizational strength and experience.

ADRA funds come from the SDA church and from outside grants. AID grants have included ASHA grants, OPG's, Outreach Grants, Ocean Freight Reimbursements, and since 1981, Matching Grants.

### C. The ADRA Matching Grant

The ADRA matching grant was initiated in 1982 for three years and was refunded in 1985 for an additional three years. The grant funding period ends 30 June, 1988. The matching grant currently funds projects in 10 countries.\* The two volume matching grant report, prepared in 1987, gives a detailed report of the scope and goals of the grant plus a summary of each project.

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\*The ADRA Matching Grant was approved in October, 1981. The LOP funding level was US \$4.3 million, one-half provided by USAID, the other half by ADRA. Implementation was authorized for 14 countries (ADRA/I, October, 1982). These countries were, by region: (Africa) Ghana, Kenya, Rwanda, Tanzania, Zimbabwe. (Asia) Sri Lanka. (Latin America/Caribbean) Barbados, Dominica, Guyana, Haiti, Honduras, Jamaica. St. Lucia (Pacific) Philippines.

The problems which exist in the target communities are common in most poor communities--lack of potable water; lack of adequate irrigation water; poor environmental health conditions; malnutrition in children under five; ignorance of health principles; ignorance of improved agricultural practices; lack of access to resources; lack of trained experts to provide assistance; lack of commercial business expertise and opportunities.

ADRA saw an opportunity to utilize the existing institutions and its own infrastructure as resources to address the problems and improve the communities. ADRA decided on an integrated development approach in which many specific interventions such as nutrition education, potable water development, and increased food production would be integrated to reach the desired outcomes. ADRA also recognized that much needed to be done to develop and strengthen the capacity for decision making, planning, and program management in the parent organization and in its field organization.

"The goal of the MG was to improve the health, nutrition, and economic conditions of the population within a defined radius of health-care and educational institutions in targeted countries. The purposes were: to adapt, test, and implement community-based integrated health and nutrition methodology in selected communities in target countries; to support new community-based programs in designated communities in six countries; and to expand community-based programs in ten countries with a package of primary health care and nutrition services."

According to the original proposal, several components would be integrated to achieve the goal. The communities needed to be organized to participate in all phases of the project from needs assessment through intervention activities and evaluation and improvement. Community organization consisted of establishing community committees. These community committees would be the focal point for all activity and would be the contact between the project employees and the recipients. These committee members would establish community goals, gather baseline data, plan the project in their community, and serve as "board of directors" for the project. Local SDA institutions were to serve as sites of technical and logistical support. Community volunteers, approved or selected by the community were to be trained as community technical leaders. As many factors as possible were to be involved in achieving the goals. For example, improved health would be fostered by: nutrition education, increased food supply, immunizations, potable water, and any other components needed in the community.

The planned strategy to achieve the MG goal attempts: 1) to improve the social development of selected countries, and particularly the health status of children under five years of age, by using community health promoters to train mothers in nutrition and child rearing and by training communities in improved hygiene and sanitation; 2) to improve agricultural development by training agricultural workers, encouraging vegetable and kitchen gardening, and by improving marketing; 3) to improve economic development by helping establish agrobusinesses run by community health committees; and 4) to improve resource conservation by encouraging better fuel efficiency and better water management and distribution systems, planting of nurseries to produce seedlings for reforestation projects, and by exploring potential for adoption of wind and solar energy.

#### D. The Program Environment in Honduras

##### 1. The demographic-disease pattern

The problem in Honduras was defined in the proposal as follows:

"The principal causes of morbidity and mortality of children under five years of age are dehydration due to diarrhea, respiratory diseases, diseases preventable by immunization, and malaria. All of these problems are preventable and malnutrition is the major reason why these generally non-lethal maladies become life-threatening. In 1981 75% of the under five population was malnourished. 600,000 were malnourished and 240,000 were severely malnourished. Overall 67% of the population had a diet with insufficient energy supply and 43% were deficient in protein. Nationwide, more than 2,750,000 people were eating a less than adequate diet. In the 5-13 year old population 50% were malnourished. Pregnant mothers also showed a 50% malnourished rate with 20% giving birth to severely underweight babies and the same number experiencing spontaneous abortion or non-live births."

Malnutrition has many causes. Each contributes to the problem and each exacerbates other causes. The prime cause is lack of adequate food. This is caused by agronomic and economic conditions. Both of these conditions can be remedied. A secondary cause is diarrhea which prevents the child from utilizing the nutrients available. A third cause is ignorance of proper food preparation and utilization. Malnutrition is most severe and the impact of malnutrition is most devastating to children under five and pregnant women. These two groups are the primary target of the project.

## 2. The economic context

Honduras in general suffers from an economy which cannot provide adequate resources to fully feed its population and cannot provide adequate health care. The use of resources for good health are not evenly distributed in all parts of the country. The major urban centers provide better conditions than the rural areas and the more isolated the area, the less resources are available. The target communities in this project are among the most "economically isolated" in Honduras. Government provided services are very scarce. Communication is poor, health care is inadequate in both services offered and access to those services. Little help is offered in education for better health, food production, economic development, etc.

The target area has the natural resources which could provide adequate food for the population if properly managed. The lack of adequate food is attributable to economics. Families lack a source of income to purchase food and farmers lack a market for their production. Families don't know how to manage their resources to produce adequate food and some of what they produce is marketed to purchase other items. If food production is increased and families have a source of income to purchase food, the prime cause of malnutrition can be eliminated. Education can eliminate the other causes.

### E. Relevant AID, USAID, and Host-Country Policies and Strategies.

#### 1. AID

The strategic goal of AID activity in the health sector, as articulated in a May, 1983 document (AID 1983) is, through the primary health care approach, to assist developing countries to: a) reduce mortality among infants and children under five years of age, and b) reduce disease and disability in infants and children, women of reproductive age, and other members of the labor force. The rationale for the strategy is to help those groups identified epidemiologically as at highest risk and to enhance productivity and overall economic development. Participation of the private sector, in-country and offshore, is to be encouraged as appropriate.

The strategy of AID's bureau for Latin America and the Caribbean (LAC/DR, April, 1983) is to concentrate its resources on implementing AID health policy in those countries which face greatest resource constraints and which have the highest mortality and morbidity rates: Haiti, Honduras, Bolivia, Peru, and El Salvador. The largest weight in its portfolio, as projected 1982 to 1990, is to be given to: extension of health services (down from 65% to 40%); extension of water and sanitation (up from 25 to 30%); disease control (up from 5 to 15%); and technology

development and transfer (up from 0 to 10%). The share of the portfolio dedicated to planning and PVO's will remain at 5%.

The AID Nutrition Policy (May, 1982) assigns highest priority to: a) Alleviating undernutrition (inadequate food consumption and biological utilization of nutrients), and b) improving nutrition through sectorial programs in agriculture, health, food aid, population management, and education, as well as through direct nutrition programs.

Finally, the AID PVO Policy is to support PVO's "of recognized standing with discrete programs in high-priority sectors" and to give such PVO's independence and flexibility in project design, as long as AID overall policies and priorities contribute the parameters for PVO activities which use AID funds.

## 2. USAID

The core objective of USAID/Honduras' sectorial strategy in health and nutrition is to improve the basic health and nutritional status of the poorest of the population (primarily rural), especially children. Four strategy priorities were to set the guidelines for both public and private action in the sector: a) improving access to health care, with emphasis on cost-effective preventive interventions; b) concentrating resources on environmental sanitation and safe potable water, controlling major communicable diseases, and reducing malnutrition and fertility; c) installing a more cost-effective delivery system for preventive and curative health care; and d) installing revenue-generating mechanisms for maintaining the health care system.

## 3. Host Country

The government of Honduras and the Ministry of Health have expressed support and appreciation for AID and PVO activity in furthering their goals of improved health for their people. Cooperation has been good with problems related more to logistics and resources rather than disagreements or philosophical differences.

## III. THE ADRA/HONDURAS MATCHING GRANT

The project in Honduras, which is the focus of this report, began in 1982 in Valle de Angeles, near the capital city of Tegucigalpa. Because of a number of factors, the project was relocated to Lepaera, Lempira, at the end of 1985. In one sense, the current project is a continuation of the original project, but since it was necessary to recruit and train new staff members (only the project administrator continued from the original project), relocate the project headquarters, select new target communities, conduct new baseline studies,

and develop new contacts, this is in reality a project which began in 1986. Because of the start-up time involved in initiating a new project, the direct involvement in the communities began in June, 1986. For purposes of this evaluation, the logistical framework time line begins on 15 February, 1986.

#### IV. ACTIVITIES TO DATE IN THE PROJECT

##### A. Project Phases

##### 1. The Project Development Phase

This project is part of a Matching Grant Proposal submitted by ADRA to AID in March, 1981. The Matching Grant (MG) was signed in October of 1981. ADRA/Honduras developed a proposal within the master MG and began operation in 1982 on the grounds of the Valle de Angeles Hospital, outside of the capital city of Tegucigalpa, Honduras. Because of problems described elsewhere by ADRA, the project was terminated at Valle de Angeles in 1985. That project was formally reviewed and audited in June 1985. The decision was made to transfer the project for the remainder of the grant to another location and begin again with basically the same goals and plans. Modifications were made based on experience gained at Valle de Angeles and the needs of the new communities, but the present project is in agreement with the original country proposal and the master MG. Not all components of the MG are included in this project, but this is in line with the original MG proposal: "...It is not intended that services and programs offered in this Matching Grant Proposal be implemented in each of the sixteen countries listed, nor in every community in the environs of the institutions operated by SAWS in these countries." From the inception of the MG it was clear that each project would need specific components and plans of action to accomplish the overall goal of improving the health and economic status of the target communities.

The revised project was accepted in June, 1985, and money was obligated. Between June and November, implementation plans were submitted to and approved by ADRA/I.

##### 2. Project implementation Phase

##### a) Personnel selection

The first disbursement was made in November, 1985, and hiring and purchasing began.

On 15 Feb. 1986, the project director moved to the town of Lepaera, in the state of Lempira.

During February the remaining members of the project team, the local employees, were hired. The team now consisted of the director, an agriculture coordinator, a health coordinator, and four promoters. Some administrative and accounting services are performed by people at the SDA headquarters office in Valle de Angeles.

b) Site selection

During the last week of February the team began selecting the target communities. Of the 40 communities in the township of Lepaera, 24 were initially selected based on probable need. All 24 communities were visited by the team and an attempt was made to register and weigh all children under five. This effort met with some resistance for reasons not directly associated with the project. Stories were circulating, before the initiation of the project, that babies were often stolen and sold. Some stories had the children shipped to Cuba and the Soviet Union, other stories had the children shipped to the United States. Many parents feared this was the goal of the inventorying of children for the project. The stories had some validity because newspaper articles had reported on adoption agencies who placed orphans in homes outside the country and received a fee from the new parents. This was interpreted as selling the children.

Another problem was the perception of an orphan being available for adoption. In the urban areas, many children have been put out for adoption when orphaned or when the parents were unable to care for the children. In the rural areas, an orphaned child is absorbed into another family and taking a child from the community is seen very differently than in the cities. The children would appear to have been "stolen". When the team tried to reassure the parents that they only wanted to involve the children in a program to improve their health by helping the children gain weight, some parents saw that as a plan to fatten the children until they were desirable to be stolen and sold. Because of the reluctance of some parents to participate, the baseline data on the number of children and percentage of malnourished children is suspect. Some parents allowed their children to participate in the feeding programs after the data was gathered, even though they had not admitted they had children during the initial survey. Other parents refused to bring their children to the lunch program on weighing day, to avoid losing their children when they became fat enough. It appears that the fear and resistance have been overcome but the project suffered in the beginning.

A second problem was encountered when some people accused the project of being "communist". In Honduras this is a very serious charge. The charge of communism stemmed from the attempts to inventory family land holdings, animals, etc., and from attempts to organize the community. Some people feared their goats, land, and other belongings were being inventoried so they could be confiscated and collectivized. Efforts to organize the community into project groups, e.g. community committees, were viewed with suspicion by some. In most cases, the people in the community, or many of them, were persuaded to give the program a trial period, but in two communities the people were so opposed, the project withdrew and selected other communities to work with.

After weighing all the available children in the 24 communities, the 12 communities with the highest percentage of underweight children were selected for the target communities. The premise used in selecting the twelve "worst" communities was that they would show the greatest results from the intervention and thus would encourage other communities to initiate the program. This final selection process was completed by the end of April.

This project deviates from the MG plan of using an existing SDA institution as the base for all projects. When operations began in Honduras, in Valle de Angeles, the hospital was the institutional base. When it was transferred to Lepaera, there was no institution to work with.

The location of the project and the 12 communities selected has presented some logistical problems. Originally, Lepaera was chosen because of its remoteness from government and institutional services. Due to this remoteness, there was very little infrastructure developed to assist the project. Information concerning the community was essentially non-existent. The communities were also physically remote, even from the municipal center. Travel time to the villages from the project headquarters ranges from thirty minutes to two hours. This travel time is significant because the promoters spend one to four hours each day just traveling to and from the villages. Three of the promoters have motorcycles provided by the project. The fourth promoter, an older man, who had never ridden a motorcycle before, had an accident while learning to ride, which, while not serious, convinced him he wouldn't risk his neck on the motorcycle. He uses a horse to travel to the villages. The travel time to villages is greater for him, but he

does not return to town each night. He rides out Monday morning, sleeps in the community he works in, and rides on to the next community the next day. His total travel time is greater than the other promoters, but his horse gives him some advantage in the often difficult terrain between homes in a community.

The remoteness of the communities and the difficulty of transportation and communication has caused some inconveniences and has been a factor in some phases of the project. Distribution of supplies and accessibility for the project director and coordinators have been affected by the remoteness. All villages were visited during this evaluation. Future project planning should consider whether effectiveness is significantly reduced by physical remoteness of the target communities.

c) Financial Systems

This report does not include a financial picture of the project. The financial auditing and evaluation will be done at a separate time. A couple of comments concerning the financial system are important in the evaluation. The budget for the project was reduced by 25% from the proposal, but the original goals were maintained and the size of the project was not reduced. The staff decided to try to cut costs and operate a large project on a reduced budget rather than reduce the number of potential beneficiaries. This is an admirable objective but it must be questioned whether the effectiveness of each part of the project has been compromised by the budget constraints.

The budget cut is manifested in three sectors. All staff salaries were reduced, but workload was not reduced. The salary allocated for a trained nurse was eliminated and the health coordinator had to be a person who was willing to work for a lower salary; consequently, the health promoter is not as well trained as planned. Third, the money allocated for development credit was reduced by 50%. In this region, as in most of the country, there are very few sources of credit and none are available to the average family. Money lenders may provide emergency loans, but at very high interest. As a result of the reduction in development credit money available, fewer families can be involved in some of the food production and income enhancement programs.

The budget process appears to be acceptable within the project. The director works with the SDA financial officers in Valle de Angeles. Monies are authorized according to the budget and quarterly reports. There are occasional conflicts caused primarily by the lack of direct involvement on behalf of the financial

officers. At the time of this evaluation, seventeen months after initiation of the project, the people involved in the MG who are stationed at the SDA headquarters in Valle de Angeles had not yet made a visit to the project site. There is no evidence of problems encountered by the financial accounting and disbursement system, except for delays in getting authorized funds, but it would make sense for the financial officers to take a more direct interest in the project so they operated from a better knowledge base.

d) Training

ADRA/I contracted with the Loma Linda University School of Health, Loma Linda, California, to develop a training curriculum for people involved in the MG program. The faculty in the Department of International Health in the School of Health subscribe to the concept of integration of all factors of health and development and are rich in health and development experience. A model curriculum was included in the MG proposal and was adapted for the needs in Honduras. The director is educated and experienced in extension education, having worked for the government Agriculture Extension service. He directed the training of health and agriculture promoters in the first phase of the project in Valle de Angeles.

The curriculum developed at Loma Linda University emphasized the educational process of learning as well as the content. Stories and parables are designed to be easily remembered. Each story contrasted the positive, negative, and neutral sides of an issue and included simple audiovisual materials. The first phase of the two-phase training included: basic nutrition, food groups, balanced diet, food supplementation, food preparation, diet analysis, breast-feeding and weaning methods, weighing and charting, control of infectious disease, anemia and xerophthalmia, crop production, animal husbandry, home crafts, and money management. The second phase included: advanced training in the above topics, simple health treatments, sanitation, prenatal care, immunization, family planning, potable water development, soil and water conservation, marketing skills, and project planning, implementation and evaluation. Other topics were added as the need developed in the project.

The training period for the promoters was mornings from March through May. Afternoons were spent conducting the baseline surveys. Each Friday since the completion of the training program, the promoters have met with the director and coordinators to discuss problems, share experiences and solutions, and receive advanced

instruction. The director and coordinators also work in the field with the promoters to continue the training process.

In June, 1986, the promoters were sent into the communities to begin implementation of the project. They established regular training programs for the participants. Courses are tailored to the needs of the target group. Training includes both formal and non-formal education. It is conducted in scheduled group sessions and on an individual basis. Like the promoter training, it includes basic instruction and advanced instruction.

Each promoter visits each community in his district once a week. Training is conducted during these visits. Specific courses have been developed with fixed schedules and a certificate of completion is issued. During the evaluation visit, one group of women received their certificates in a ceremony which attracted the entire community. The mayor of Lepaera, the district priest, the district health director, and the police representative all participated in the ceremonies. The certificates are generally hung in the homes and during the evaluation visits, several people showed the evaluation team their certificates, with obvious pride.

#### e) Program Changes During Implementation

The proposal for this project has been generally followed during the implementation process. This is a result of careful development of the proposal and the experience of the project director. Two components of the proposal have not been implemented as yet. No programs have been started for literacy training or fish pond development. This is a result of lack of time for the promoters. Their workload is already very heavy, and it is understandable why they have not added these components. As the people get involved in their current activities and become more competent, less time will be needed by the promoters on current activities and the literacy program and fish pond development can proceed. These changes are simply a modification of the log frame rather than a change of program. In retrospect, some other components should probably have been scheduled to begin later, but the staff has been anxious to see "maximum impact" in their communities.

### 3. Community participation

Community participation is central to all ADRA activities. The MG was written by "outside professionals", i.e. those who don't live in the affected communities. The proposal was based on professional observation of the problem of poor

health and economic status. The proposal was a general statement of the need and an "umbrella" plan to deal with the problem. The proposal was not seen as a specific plan to be implemented in any or all communities. ADRA believes that only the people involved in the problem can best define their needs and desires and the solutions can only come after the specific needs have been expressed and identified. Outside expertise is useful in shaping programs and ideas, but outsiders cannot do the work alone. Each project within the MG is developed on two levels of involvement. First, people with experience and expertise at the local level are involved to write a general plan. Then the projected beneficiaries are involved in stating specific needs, suggesting desired outcomes, and assisting in developing strategies to achieve the outcomes. ADRA has the same goal as AID in the matching grant: to improve the health and economic status of the poorest of the population. The individual recipients must determine what they need to achieve the larger goal.

ADRA/H used government data to develop the hypothesis that malnutrition was a problem in the target region. ADRA/H then employed local residents to survey the communities and determine the extent of the actual problem. When the problem was verified, intervention began.

The first step was to organize community planning committees. Each community was asked to select members. These committees generally consisted of the village "mayor", the local health worker (if available), and members selected at-large by the community. This committee serves as the "board of directors" for all activity in the community. Sub-committees are often formed for specific components such as well drilling, chicken raising, feeding programs, etc. These committees are presented with ideas for intervention and asked to formulate specific plans for their community. Not all members agree on the specifics, but nothing is done that does not have committee approval.

The local committees remain involved from planning, through implementation, to evaluation and adjustment. Occasionally committee members change as plans evolve or community members sense a committee member is not serving their interests. When sub-committees are formed, the leader of the sub-committee usually sits on the general committee.

Some problems have arisen as a result of the establishment of these committees. The fear of "community organization" has been raised by some. It is new and therefore suspect. It sounds like political activity to others. Traditional power bases are not always evident in the committees. Some traditionally powerful figures, money lenders for example, are not always included, since they don't participate in the project. Some of these traditional power sources resent the dilution of their authority. In spite of the problems, the

project staff is convinced that the committees are both necessary and effective.

All participation in the project is voluntary. Participants may be eligible for certain benefits, such as credit, but no one is required to participate. Many people who were reluctant or even opposed at first are now active participants since they have seen the benefits of the program. New ideas, both for activities and for ways to improve the impact, are being offered by the people. This must be encouraged and strengthened if the projects are to survive beyond the external funding period.

In addition to the planning, implementation, and evaluation process, participation is most easily quantified as involvement in the activities. If the project includes a feeding program for under-weight children, it is important to determine how many of the parents/children are participating. This evaluation was conducted when the community activities were just one year old, at best, and many components were much newer. The number of participants is not yet an accurate tool for project assessment, but increase in numbers is encouraging and perhaps can serve as a measure of project acceptance and effectiveness.

One issue often wrestled with in this type of project is participant contribution to the project. If everything is given to the participants, they may not be psychologically prepared to continue the activities after the external funding expires. On the other hand, if there is a cost to participate, the neediest may not be able to participate. This project has started with the premise that no money will be required to participate but each person must contribute in-kind support. Children in the feeding program were not charged for the food they received but mothers took turns preparing the food, serving, and cleaning up. Occasionally a mother refuses to participate and the group generally agrees to continue feeding the child hoping to persuade the mother while not penalizing the child. This tactic, determined by the feeding committee, has generally been successful.

In addition to allowing all to participate in the project, the project is designed to allow members to improve their economic status so they can be relieved of any concern over ability to pay. Each community is involved in income-generating projects, such as raising chickens, goats, bees, and crops for market. In these projects the materials needed, such as baby chicks, are sold to the participants with the project providing monetary credit. This is a crucial component, since there is usually no other source of credit and thus, no opportunity for the participants outside of the project. Eventually, a system should develop within the community which provides inputs and credit. The project is

designed to support this long-range goal as well as the more immediate activities.

One sidelight to the issue of participation was raised when it was reported by staff that in two communities, during the initial baseline surveys, the problem of "intruding religion" was raised. The people are predominately Roman Catholic and the project was identified with Seventh-day Adventists. Fears were voiced that the program was to be limited to Adventists and thus was to be an evangelistic tool rather than a community service. In both communities the team elected to select other villages rather than fight the prejudice. During the evaluation, people were asked if there was any sign of preference given to Adventists or efforts made to proselytize. No affirmative answers were given. In most cases there are few if any Adventists in the community. The presence of the regional priest at the nutrition course graduation services suggests that religious prejudice is not a serious problem.

#### V. RESULTS TO DATE IN THE PROGRAM

At this point in the project history, it is extremely difficult to use any measurable data to evaluate the project. Many of the interventions have been active for a short time, activities are evolving within each component and within each community, and baseline data is generally suspect for reasons discussed earlier. This data will be supplemented by a narrative description and subjective assessment of the project activities.

Several activities are occurring in each community. Not all components are active in each community and the method of operation is not rigidly structured. This is a result of ADRA's commitment to community participation.

#### A. Lactarios/Feeding Centers

The focal point of each community project is the lactario where children under five years of age who are malnourished according to the Gomez scale, receive a daily food supplement. All children in the community who have willing parents are included in the initial survey and can be included subsequently if a later weighing shows their eligibility. Once a child is in the program, it remains eligible until it reaches 5 years of age or achieves normal weight for age. One of the problems with trying to use results from this activity as an indicator of success is the fact that there are two ways a child leaves the program. The project goals state that malnutrition will be reduced from 75% to 40%. At present the project is using the number eligible at the baseline survey to determine the starting point and the number currently in the program as an

indicator. Since a child leaves the program at age five, even if still underweight, it appears that more children are being remediated than is actually the case. A much more sophisticated and comprehensive system of record keeping would be necessary to track each participant and keep the results consistent. In spite of this problem, many children are showing progress and the idea seems to be working.

The lactario feeds each child a standard portion of a meal determined by available food commodities. Often children get more than their allotted share if the number of portions prepared exceeds the number of children present. The commodities are distributed to ADRA/H from CARE facilities and are PL 480 commodities. ADRA/H distributes the commodities to each lactario through the promoters, who require an accounting from the lactario director, who is a volunteer. The lunch meal is prepared five days a week in the center, which is usually connected to the home of a community volunteer. The meal can either be eaten on site or taken home. Most meals are consumed on site. The meals are prepared by the participating mothers on a rotating basis. This is the families' only contribution to the program. Attendance records are kept and the health committee and the promoter visits homes if the children don't attend regularly. At present, the children are weighed every three months. When asked why the weighings were so infrequent the promoters responded that initially they were scheduled every 2-4 weeks but some parents kept their kids away during weigh-day for fear of the children being fattened and stolen. Another factor was that the high level of absence of many children amounted to a quarterly weighing and that was the adopted plan. When the children reach normal weight, they are graduated (dropped) from the program. Many parents continue to bring these children in for weighing and re-enter them in the program if they fall below the normal weight. At the time of the evaluation, 173 children were receiving feeding supplements. About one ton of commodities per month were being consumed. It appears that there is an adequate accounting system for the commodities. It also appears that there is good support for the lactario.

#### B. Health Education

Mothers who bring their children to the lactarios are the prime targets for health education courses. They are often the most needy and they are often interested because they see changes in their children. The time the children are eating is a good time for organized classes.

Two formal courses with specific curricula are used. The first cycle of lectures is eight hours. It covers personal and home hygiene, water purification (boiling), waste disposal, the importance of using latrines, keeping animals out of the house, and waste water drainage. The second cycle

of lectures is also eight hours and includes: definition of malnutrition, symptoms, causes; food groups; general family nutrition; care of pregnant and lactating mothers; infant feeding; and the importance of immunization. Mothers are referred to the government health center for immunizations.

In addition to the lectures, field trips are made to homes which have instituted improved health practices. Promoters visit each home to assist the mother in adopting these practices in her home. These are followed by periodic visits from the promoters to encourage and assist the incorporation of the practices.

### C. Agriculture/Food Production

Agriculture practices have two main objectives and encompass four components. The objectives are to increase food available to reduce malnutrition and to increase surplus for market. The components are crop production, animal production, resource conservation (soil water, and nutrients), and marketing. Generally, the men are responsible for the majority of the agriculture, but women are often involved with some of the family agriculture as well as maintaining a kitchen garden and perhaps the animals. Courses are offered in crop production including: improved variety selection, plant and soil nutrition, pest management, soil conservation, water management, etc.

The promoters also visit the parcels of land on which the farmers are encouraged to test the improved methods. At the time of the evaluation, eighty farmers were participating. These eighty farmers controlled a total of 150 ha with the improved practice plots totaling five ha. The farmers also get credit assistance to purchase improved seed, fertilizer, and pesticides. It is not yet possible to determine the success since the first crops grown with this technical assistance are still in the field. More assistance is going to be needed to allow the farmer to determine the economic impact of the new technology.

Animals are an important part of the Food Production plan. Families participating in the lactario program are eligible to purchase a goat for milk and meat. Through the assistance of a US\$16,000 grant from Heifer Project International, a pregnant female of an improved breed of goat is sold to the families; credit is supplied by the project. Each family must repay the project with a) the original female after the first kid is born, b) two offspring which will be used for other families (breeding is controlled by the project to insure maintenance of bloodlines), or c) cash within six months. The families must construct and maintain a shelter for the goat. This should become an important source of food for consumption and income for the family.

Chickens are being raised by families for egg and meat consumption and sale. These chickens are also part of the Heifer Project International grant. At present, the chicken raising is done as a group venture. Five families in each community were chosen to participate. Forty-five chickens are raised in a 500-square-meter fenced area built by the participants. The participants share responsibility for caring for the birds. The birds are fed a concentrate purchased on credit from the project in addition to food scraps. Fertilized eggs will be returned to the project for the next cycle of participants. After experience is gained raising the birds in the group context, participants will construct pens and raise the birds on their own.

Bees are being raised as a source of income. The project finances the construction of hives. Participants have six months to repay the project. Originally, Heifer Project International had planned to import hives and swarms, but that has not been possible. Wild swarms are collected and placed in the hives. The first participants were people who were maintaining "wild" hives and had experience with bees. The project purchased simple honey separators but it is planned to allow development of "commercial" extraction plants as part of the economic development plan.

Soil and water conservation are being included in all crop production activities. Terracing and water management is practiced by all who receive technical and credit assistance.

School gardens and gardening classes are incorporated in the school curriculum. This has been very popular with teachers, students, and parents.

The project proposal calls for development of fish ponds as a source of food and income. These fish ponds have not yet been initiated, due to lack of time.

#### D. Community Markets

One person in each community is selected by the committee to manage the community market. Each market receives a loan to purchase ten basic products commonly used in the community: salt, butter, soap, flour, yeast, rice, matches, and files for sharpening machetes. Each store is resupplied as they sell items. The profits go to increasing the inventory; ultimately, they will go to community projects. The markets sell the products for less than the stores in town. There has been some resistance to the markets for an unexpected reason. The market manager is required to write down every sale, showing the date, products, and prices received. They are encouraged to do this as they put the items in the consumer's bag. Some of the people wondered why the store kept a record of who made what purchases. Another charge of "communism". This resistance seems to be declining. Some shopkeepers in

town are encouraging community members to boycott the community markets.

#### E. Literacy Programs

The literacy programs have not been initiated with the other projects for two reasons. First was a concern that it would compete with the government program. This has proven unfounded since the government program is not functioning. Secondly, there is a lack of time for the promoters. One course is now being taught with seven students.

#### F. Integration with Other Interventions

The Government is operating two projects which integrate with the ADRA projects. Well-digging and latrine construction are being encouraged. In reality, no technical assistance is available for either project in most communities, so ADRA staff provide the expertise and the government supplies material. The collaboration of both groups benefits the communities.

### VI. ANALYSIS OF THE PROGRAM

#### A. Summary of Results

The ADRA/Honduras Matching Grant Project has demonstrated the ability to actively address the task of working in the community to improve the health and economic status of the people. The most important factor in evaluating this project is to remember the revised time frame. Chronologically, the program is seven months behind schedule. In reality, the delay set them back farther than seven months because the onset of the rainy season meant some components could not be started when the project commenced in February, 1986. The project is a very ambitious project, but most of what is called for in the proposal is at least initiated. Measurable indicators of success are not available because of the recent initiation, but there are many signs of progress. Most of the components are functioning.

The most important aspect of this project is the close integration of all of the components. Each intervention is essential for all of the other interventions to succeed. The attention to integration is perhaps the strongest commendation for the program.

There has been little (no?) technical support from ADRA personnel. The project manager is competent in his technical expertise but has felt that he has no one to call if he needs help. Coordination between the project manager and the administrative support within the country has been weak. This will produce the greatest problem when someone determines a

problem or lack of specific procedure and the project manager will claim he did his best and had no guidance on alternate methods. Project monitoring by others in the ADRA chain of command has been missing. There is no evidence that the project has suffered as a result of this, but better monitoring and communication would ease some worries and may prevent future problems.

## VII. CONCLUSIONS AND RECOMMENDATIONS

### A. General Conclusions

1. The ADRA/Honduras Matching Grant project is appropriately focused in terms of the area's economic and health status. It is also harmonious with AID and USAID policies on the use of resources, including food supplements as a health improvement resource, concern for MCH projects, and economic improvement.

2. The project is too new to assess long term impact but one area which must be strengthened is the role of community volunteers who can increase the outreach now and assure the sustainability after the external funding ends. The project staff has demonstrated the ability to plan, initiate, and implement a project. Now it must move to become more active in educating those who will be the next generation of project leaders.

3. The project utilizes and coordinates with the government development and health activities in the region. No evidence of other PVO activity is evident other than CARE's provision of PL480 food to this project. The project enjoys a generally good reputation in the target communities and in the offices of the municipal and state executives and leaders.

### B. Conclusions about Project Inputs

1. Budget. The budget for the original proposal was reduced by 25% at funding, but the goals were not reduced. The project has made some adjustments, but does not seem to be suffering unacceptably. It is probable that because of the delays in implementation, the funding period will end before all of the funds have been expended. The project should request and receive an extension of time.

2. Project Management. The project manager is doing a good job of utilizing his resources and matching them to the project. More support and assistance from ADRA/I staff or consultants in education and training may be necessary.

3. Project Staffing. The project lacks a trained health expert, but has done well because the necessary health interventions to date have been simple and basic. Greater reliance may need to be placed on Government Health officers.

This greater reliance may strengthen ties. The number of target communities is high for the number of promoters because of the great time requirements for travel. As the promoters begin education of community health workers, the work load of the promoters will decrease. All of the staff appear to be competent and committed.

4. Reporting. The project staff is keeping good records. Two problems exist. The baseline data is inadequate and suspect, so it is difficult to measure progress. There is no standardized ADRA format for organizing data so that rapid analysis is possible.

5. Training. The project staff has been well trained in the areas of technical support and operations. As the recipients become more sophisticated in their demands and as the easy problems are solved, more in-depth training will be required. More emphasis needs to be given to the process of educating the village volunteers. Instruction in education methodology, informal training, educational resource preparation, etc., is needed.

6. Sustainability. This is probably the least obvious success of the project to date. Given the age of the project, it is understandable. The project has many components which should assist sustainability. With proper action, the project should be easily integrated into the community. The aspects of income generation and component integration give it great strength.

### C. General Recommendations

1. Extend the project operation time. Good progress is being made and should be encouraged. The original MG called for five years of operation. Because of the circumstances, this particular site should not be penalized for problems at the former site. Extend time and funds to allow this project to mature.

2. Increase the technical support in curriculum development toward training the volunteer community health worker/community agriculture worker. Work with the government to assist, train, or implement a system of technical support which can work with the communities when the paid ADRA staff leaves. Develop more teaching materials which can be used when the ADRA staff is gone.

3. Improve the management information system to allow better use of the data collected and better evaluation of the cost-effectiveness of the project and its components.

4. Provide better encouragement for the staff. They are working in a very isolated environment and need to know that they are doing a good job.