PD-ABP-971
95957

World Relief Corporation/World Relief Honduras

DETAILED IMPLEMENTATION PLAN

El Paraíso Child Survival XI Project

Departments of Francisco Morazán and El Paraíso
Honduras

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COOPERATIVE AGREEMENT NO: FAO-0500-A-00-5023-00
PROJECT DATES: September 30, 1995 - September 29, 1999
SUBMISSION: April 15, 1996

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Section C. PROJECT LOCATION

C.1 Location Maps

See map of the project area in Appendix A.

C.2 Location Description

The project has two impact areas. Area One is located in the Department of Francisco Morazán, in the marginal urban zone called the Falda del Cerro el Picacho of Tegucigalpa, and the municipalities of Valle de Angeles, Tatumblá and Santa Lucía. Area Two spans the Department of Francisco Morazán and the Department of El Paraíso, in the municipalities of Morocelí, Yuscarán, Guaimaca, Talanga, San Juan de Flores, La Villa de San Francisco. (Refer to the map in Appendix A.) The total number of municipalities is 10. These municipalities, however, are medium sized towns and contain numerous subdivisions called *caserios, barrios,* and *aldeas.* For the purpose of this proposal, these subdivisions are referred to as "communities." The number of communities targeted in this proposal is 66.

Eighty percent of the Project area is Roman Catholic in religion, and the remaining 20% are Protestant. The project areas are characterized by two types of populations. One type is formed by inhabitants with minimal financial resources who have immigrated from the interior of the country and have invaded the urban slum areas of Tegucigalpa. These are the inhabitants of the Falda del Cerro el Picacho. Their primary occupation is sidewalk shops for selling food and daily work in construction or domestic service.

The second type of population is people who live in the municipalities surrounding Tegucigalpa. The basis of their livelihood is subsistence agriculture. They have to supplement their income by selling food on the street, performing day-labor, etc. This is a more stable population as most of the residents have grown up in the area where they currently live. The municipality that is furthest from Tegucigalpa is Guaimaca, which is 87 kilometers away. On public transport, it takes people over 2 hours to reach the outskirts of Tegucigalpa. For people who live in the neighborhoods and outlying villages around Guaimaca, it can take an hour or more to reach the bus station in Guaimaca.

The status of women in these areas is subservient to men. They do most of the work around the house while also having to work to supplement the family income, and they are paid less than men for equivalent work. In a survey of members of WRH's community banks, 32% of the members were single mothers. In the same survey, 88% of the women had dependent children. This population is comparable to the population in the project area. In general, people are under constant financial pressure because of their subsistence economic level. The baseline survey found that 77% of women were literate. Women are often victims of domestic violence and

sexual abuse because of their low status. This in turn influences low self-esteem and a low value on caring for their own health.

Some of the social and cultural constraints that will affect the project are:

- a lack of time to take part in non-economic activities because of the economic pressures that people live under;
- the precedent of paternalistic patterns of behavior on the part of health center team members that have created an attitude of passivity in people about responsibility for their own health care;
- parallel with the above factor is the disrespectful treatment that people receive at health center, which has created an attitude of distrust and resentment toward the health centers;
- the lack of a cultural precedent for women to learn and work in groups that are not part of their immediate family;
- the potential for manipulating the community groups that are formed as part of the project for political ends by local political leaders.

Mothers and infants continue to suffer the most with the highest morbidity and mortality rates in Honduras. The maternal mortality rate in Region 1 is 255/100,000 live births.[1] This is higher than the national maternal mortality rate of 220/100,000 live births.[2] The neonatal mortality rate in Region 1, although not available, is also estimated to be higher than the national neonatal mortality rate of 19/1,000.[3] The infant mortality rate for Region 1 was not available, but health personnel estimate that it is considerably higher than the national rate of 50/1,000 due to the high poverty levels in the region.[4] During 1993, 38% of all children seen at health centers were malnourished.[5] The causes of infant mortality in Region 1 in order of frequency are: pneumonia, neonatal factors (such as premature birth and sepsis), diarrheal disease, and malnutrition.

The MOH has 15 health centers in the project areas. There are two types of centers. One is called *CESAMO*, which has physicians, nurses, nurse auxiliaries, vector control promoters, sanitarians, and health educators. Some *CESAMO*s have social workers and psychologists. Nine of the 15 health centers are *CESAMO*s. Medical care is provided free of charge. These centers provide maternal and child care (prenatal and postpartum care, growth monitoring, immunizations, nutrition and breastfeeding counseling, vitamin and iron supplements), family planning, respiratory infection control, diarrhea control, HIV and STD control, rabies control and tuberculosis control.

The second type of health center is called *CESAR* and is staffed by a auxiliary nurse, an assistant and one or two field workers. The range of services are the same as in the *CESAMO*s, however, at a level appropriate to the team member's training.

Section D. PROJECT DESIGN

D.1 Summary Of Overall Project Design

The child survival (CS) interventions that will be implemented in this project are pneumonia detection and control, diarrheal disease control, maternal health, nutrition, immunizations, Vitamin A, and family planning. There are three aspects to the design for implementing these interventions. World Relief's Child Survival philosophy is guided by the principle that "no child is left out" and the project staff will be using a three-pronged approach in making every effort to include all the children in each area in child survival activities.

First, health volunteers will be organized using a block approach. In this model, one representative for each urban block, or neighborhood, in each municipality, is elected by the residents of that block to be trained and supervised by the WRH health promoter. The actual area that comprises a block will have an average of 20 families. Each promoter will supervise an average of 24 volunteers. WRH has found from experience in their previous CS project that the block approach is an effective way to increase community participation and to educate and motivate mothers in CS initiatives. (Refer to Section E.3 in this document for more description of the ratios of volunteers to families and promoters to volunteers.)

Secondly, the project team members will use growth monitoring as the intervention for gaining entry and credibility in the community. Monthly growth monitoring sessions will be the focal point in the community for organizing and teaching mothers and introducing the rest of the planned interventions. The reason for this is that growth monitoring provides a concrete reason for the mothers to attend group meetings, it gives prestige and credibility to the volunteers, it focuses on a positive aspect of health, and it provides a context for introducing other interventions related to child and mother's health. See page 12 for more details on the growth monitoring strategy.

The third component of the project design is collaboration with the local health centers. In planning meetings with the MOH at the regional level, the administrators have stated that they want to do all they can to support full collaboration between the local health centers and WRH. The directors and staff at the local health centers have reiterated the same desire. As a result, WRH's plan will incorporate an average of 2 auxiliary nurses, or equivalent team members, from each of the health centers as part of the team of health promoters who will recruit, train and supervise health volunteers. They will be incorporated from the beginning of the project and will participate in all of the health promoter training workshops, monthly, quarterly and annual reporting and planning meetings. Additionally, WRH will involve the health center directors in all planning and reporting meetings. By the end of the second year the auxiliary nurses will have the primary responsibility for supervising the volunteers trained by this time. The auxiliary nurses will be the linkage between the health centers and the community and will be the key for sustaining CS interventions after this project is finished.

The strategy for covering all of the communities in the project areas will have two phases. In Phase I, project and health center team members have identified the communities where there are

the greatest number of people with health problems. The data from the health centers were used to help identify these communities. Another criterion that was used was to begin working in the communities where there are no major disputes and divisions, so as to begin where there is the greatest likelihood of early success. The number of communities targeted in Phase I is 27. In Phase II, the remaining communities will be incorporated during the second year.

The following list contains the population groups targeted in this project.

1. Children under six months: exclusive breastfeeding
2. Children under 12 months: immunizations
3. Children under 24 months: growth monitoring, diarrhea control, prevention of death from pneumonia
4. Children under 5 years: Vitamin A supplements
5. Women 4 weeks post partum: postpartum care, TT vaccination, family planning, Vitamin A supplement
6. Women of childbearing age (12-49 years old): TT vaccination, family planning
7. Pregnant women: TT vaccination, prenatal care, breastfeeding

The high-risk populations for each intervention are as follows.

1. Immunizations: newborns and children under 12 months with incomplete vaccinations
2. Diarrhea: malnourished children, infants under 6 months who are not being exclusively breastfed, children 9 months and older without measles vaccination, children without Vitamin A supplements, children with signs of dehydration or any other complication of diarrhea, children who have persistent diarrhea
3. Pneumonia: infants under 2 months, malnourished children, children with incomplete vaccinations, children without Vitamin A supplements
4. Nutrition/growth monitoring: underweight newborns, children who falter in growth, children with persistent and/or severe diarrhea, children with infections such as pneumonia, malnourished children and their siblings
5. Vitamin A: children under 5 years, children with infections--especially with diarrhea and pneumonia
6. Maternal Health: women less than 18 and greater than 35 years old, women with more than 4 children, mothers who have children spaced less than two years apart
7. Family Planning: mothers who have children spaced less than two years apart, women less than 18 and greater than 35 years old, women with more than 4 children

D.2 Collaboration and Formal Agreements

WRH has signed an agreement with the MOH in September 1995 regarding this CS project. The MOH has agreed to provide technical assistance, facilitate coordination with local health centers and facilitate duty-free import of equipment needed for the project. This document is now in the process of being signed by the president of the Republic, it has not been returned to WRH. MOH staff participated in planning the project.

Additionally, Project Hope staff participated in the initial planning sessions. WRH met with community leaders and staff from local health centers to plan the project. Community leaders, however, did not participate in the writing process.

WRH is part of a network of PVOs that are involved in child survival and other related projects. The network meets once a quarter. PVO team members regularly exchange information, experiences and assist each other informally with activities such as field visits and technical assistance.

World Relief Honduras is a subcontractor to World Relief Corporation, please find a copy of the signed counterpart agreement in Appendix B.

D.3 Technical Assistance

World Relief Honduras (WRH) is an experienced team with years of Child Survival experience. Dr. Orestes Zúniga, the CS Director, and his staff are already competent in conducting 30 cluster KPC surveys, focus groups, and in developing and testing CS curriculum. In these areas technical assistance will not be needed from HQ. In fact, Dr. Zúniga has provided assistance in these areas to WRC supported CS projects in El Salvador and Nicaragua.

However, WRC will provide additional technical assistance to the project in the form of professional literature and linkages with experts in the field. In January 15-19, 1996, Dr. Richard Crespo conducted a workshop on principles of popular education for the staff of WRH and WV. The one area where technical assistance could be needed is the HIS development, and the Project has since hired an HIS Administrator. Due to HQ staff shortages, Dr. Crespo retunred to Honduras on March 14-21, 1996, to assist with the final draft of the DIP. Project staff had already completed a full draft of the DIP, so Dr. Crespo and WRC HQ staff acted as advisors and made suggestions to improve the document.

WRC CS HQ staff will maintain telephone and fax communication with the field on a bi-weekly basis. WRC's Latin America/Carribean Director will also monitor progress of the project during routine visits. Project team members will use technical resources from the members of the network of PVOs in Honduras.

D.4 Detailed Plans By Intervention

D.4.a Immunizations

4a.1 Incidence and Outbreaks

The data from the MOH for Region 1 indicates the following regarding surveillance of vaccine preventable diseases (VPDs) : measles, 0 cases; whooping cough, 0 cases; neonatal tetanus, 1 case; non-neonatal tetanus, 1 case; and meningitis, 0 cases. There have been no outbreaks of vaccine preventable diseases in the last two years. Data from the MOH show that there have been no outbreaks of VPDs in any of the eight Health Regions in 1995.[6]

4a.2 Baseline Coverage Estimates

The baseline coverage estimates in children 12-23 months for DPT, OPV, measles and complete coverage are listed below. Also included is the current dropout rate for DPT immunizations.

IMMUNIZATION	BASELINE %
DPT_1	75.0
DPT_3	72.8
DPT Dropout rate	2.9
OPV_3	72.8
Measles	72.1
Complete immunization	68.4

Data are not available regarding the percentage of births protected by tetanus toxoid immunization. The baseline survey, however, shows that 47% of mothers with children under 2 had received two dosages of TT.

The comparison of the project area with MOH statistics for Region 1 is presented in the following table. Please note that the data available from the MOH are based on children ages 1 through 4, while the baseline data are based on children 12-24 months.[7]

IMMUNIZATION	REGION 1 DATA	PROJECT BASELINE
DPT_1	NA	75.0
DPT_3	96.0	72.8
DPT Dropout rate	NA	2.9
OPV_3	93.0	72.8
Measles	99.0	72.1
Complete immunization	NA	68.4

4a.3 MOH Policies

No differences exist between MOH and WHO immunization policies. The MOH immunization schedule for Honduras is attached in Appendix C.

4a.4 Knowledge and Practice

Data from the baseline survey indicate that mothers have limited knowledge about immunization schedules. Only 44% of the mothers knew the age at which the first measles vaccination should be given, and only 14.5% knew that TT protected both mother and infant. On the other hand, the practice of mothers regarding immunizations is much better than their knowledge base. This indicates that immunization services are being utilized by mothers to some extent. The problem in the project areas is that immunization coverage is still not up to acceptable levels. One of the

reasons is limited access to health centers. In the baseline survey only 75% of mothers had access to immunization services. See below for barriers to immunization.

4a.5 Immunization Objectives

OBJECTIVES	Yr. 1	Yr. 2	Yr. 3	Yr. 4
Children completely immunized by 12 mo.	68	80	90	90
Women 12-49 yrs. receiving at least two doses of tetanus toxoid	47	55	66	80

4a.6 Approach

The barriers that exist to immunizations are:

1. limited knowledge about immunizations and times of administration;
2. little community participation;
3. ineffective system for opportune identification and follow-up of newborns;
4. mothers' fear of taking their children for immunization when they have even the slightest sign of not feeling well;
5. mothers' fear of the secondary effect of immunizations;
6. poverty, which makes it difficult for parents to take time from work to take their children to the health center.
7. disrespectful treatment of the poor at health centers.

In reference to the quality of services, the quality of immunizations is good, the cold chain is maintained well, and most of the MOH staff are adequately trained. The barriers listed above, however, limit coverage.

The approach to be used in the project is centered around the health volunteers. They are key to increasing immunization coverage because they can interact with mothers on a peer level. They will be able to talk from personal experience in regards to mothers' fears of vaccines making their children sicker and of secondary effects of immunizations. The organization of volunteers into health committees will help to strengthen the lack of community organization and in turn will be a community-based organization that will promote and help organize immunization campaigns.

The two fundamental techniques for reaching mothers are home visits and health education. Volunteers will visit the mother within one week of a child's birth. At this time the volunteer will explain vaccination schedules and answer questions. Mothers will be followed up by monthly checks of the children's vaccination cards. Health education sessions will be held at the growth monitoring meetings, community meetings, and community bank meetings. The volunteers will be trained in the basic immunization messages, how to read the vaccination cards and how to administer oral polio vaccine. This action has been approved by the MOH in order to extend services into the community. The volunteers will be trained in popular education methods for teaching about immunizations. Each volunteer will keep a register of children under two and

pregnant mothers (*Listado Infantiles de Vigilancia Integral*--List of Visits to Children under one year of age) in order to monitor immunization schedules and follow up high-risk children.

The basic tools that the volunteers will have are educational materials, a registry of children under two and women of childbearing age, and a weekly activity schedule. They will be supervised initially by the project's health promoters, then after the first year, completely by the auxiliary nurses from the local health center. The health promoters, auxiliary nurses and volunteers will meet as a group once a month to review past activities and write a plan of action for the coming month. Additionally, volunteers will be supervised individually by the health promoters as they do on-the-job training.

The role of the local MOH health center staff will be to provide immunizations, work alongside WRH in training and supervising health volunteers. The local MOH health centers will be responsible for monitoring the immunization program in their respective catchment areas. WRH will assist in monitoring immunizations through the risk maps that will be managed by the health promoters. WRH coordinators and health promoters will meet once every 3 months with the health center staff to review CS services, including immunizations.

Immunizations are available year-round at the local health centers. The MOH also organizes annual immunization campaigns out of the local health centers. Health center staff are adequately trained in administering vaccines and sufficient supplies are available year around, even with the increased demand created by the project.

Immunization activities will begin in the communities that the MOH has determined are the least served. In Project Area 1 WRH will begin in 17 of the 32 targeted communities. In Project Area 2, WRH will begin in 9 of the 34 targeted communities. By the end of Year 2, WRH will have begun project activities in all of the remaining communities in each project area. When the MOH organizes immunization campaigns, the volunteers will assist in promoting the campaign and organizing the community. They will also participate in the campaign as assistants to the MOH staff.

4a.7 Individual documentation

The project will use the MOH/EPI immunization card (*Tarjeta de Niño*--child's card) See Appendix D for a copy of this card. The cards are provided by the MOH. If a mother loses her card, the data will not be lost since the volunteers will have the data recorded in their registry. During immunization campaigns mothers will be asked to bring their children's cards. The health volunteers will assist in revising immunization cards during vaccination campaigns. The MOH provides immunization cards, and these are available in sufficient quantities so that they are easily replaced when lost.

Women's TT immunizations will be recorded in their perinatal charts, which are kept at the health center, when they receive prenatal care. Women also have their own immunization card that they keep.

4a.8 Dropouts--Children

Data from the baseline survey indicate that there is a low dropout rate (2.9%) for childhood immunizations. The main cause of these dropouts is an inadequate monitoring system in the local health centers.

The identification of defaulters in this project will be based on the registry that the volunteers will keep of all children and pregnant mothers in their blocks. The volunteers will visit mothers whose children fall one month behind schedule to find out the reasons for the delay and encourage them to get the children back on schedule. The volunteers will monitor vaccination schedules through the registry. Volunteers will mark names of the children that are behind schedule as a means for easily identifying high-risk children.

4a.9 Dropouts--Mothers

The reasons for dropouts among mothers are 1) mothers do not value themselves and consequently do not value the vaccination; 2) mothers find it difficult to find time to go to the health center because of their subsistence economic level; 3) mothers lose their card and do not replace it; 4) women do not receive timely attention at the health center; 5) health centers do not have an adequate system for monitoring dropouts.

The project will focus on two strategies for addressing these problems. First, in coordination with the Committee for Human Rights (CODEH) and the Center for Women's Studies (CEM), volunteers will be trained in methods and techniques for self-esteem building with women. Volunteers will incorporate this training in their home visits and health education sessions.

Secondly, the WRH supervisors and health promoters will work with the local health centers to design a system for monitoring dropouts. It is crucial that the system be developed with the full participation of the health center staff so that they will have ownership of the system. The WRH staff will also incorporate relevant portions of the training received from the Committee for Human Rights and the Center for Women's Studies to raise the consciousness of the staff about respect for women and the poor.

4a.10 Population

Children under 1 yr	4390
Estimate of children born in next 4 years	12289
No. of visits needed for full coverage at 12 mo.	5
Women of childbearing age (12-49 yr. old)	27565

The project will target all women of childbearing age for TT vaccinations. The project objective is that 80% of women will receive TT vaccinations, or a total of 21,600 women.

4a.11 Cold Chain Support
The MOH has a good cold chain system. The project will not need to provide assistance in this area.

4a.12 Surveillance
The project does not plan to have EPI surveillance activities. The MOH has a nationwide surveillance system in place.

D4.b Nutritional Improvement
4b.1 Nutritional improvement for infants and children
4b.1a Baseline
Data on malnutrition from the National Epidemiological Survey of 1991 indicates that 13.1% of children in Honduras suffer from acute malnutrition. Chronic malnutrition is at 39.4%. Nutritional status was calculated based on weight-for-height.

The major problems that lead to malnutrition in the project areas are: subsistence living standards, the high cost of food, the high percentage of single parent homes, the habit of eating the same foods and lack of variety in the daily diet, and the practice of reducing food intake when children are sick.

4b.1b Current Knowledge and Practices
The following chart presents data regarding breastfeeding and complementary feeding practices.

PRACTICE	PERCENT
Exclusive breastfeeding up to 6 months	19
Complementary feeding of children between 6 and 9 months	90
Continued breastfeeding between 20 and 24 months	35
Breastfeeding initiated within first 8 hours	75

Colostrum use is good, considering such a high percentage of mothers breastffed within the first 8 hours (75%). In regards to feeding practices, children under 1 year are given food upon demand. After the first year children begin eating with adults three times a day. When children ask for food between meals the custom is to scold them and treat eating between meals as if it were a bad habit. Prior to one year of age children are assisted with eating; after that they are taught to feed themselves. In homes where there is a father present, the custom is for him to get the best food. Where no father is present, the best foods are given to the smallest children.

The kind of foods that are given to children between 6 and 9 months old are as follows: bland food or soups (87%); fruits (83%); yellow vegetables (72%); green leafy vegetables (13%); meat (68%); eggs and dairy products (81%); honey or sugar products (68%); and food prepared with

lard or oil (76%). In the case of children with diarrhea, 26% of the women reduced the amount of food given and 7% completely stopped giving food.

4b.1c Nutrition Objectives

OBJECTIVE	YEAR 1	YEAR 2	YEAR 3	YEAR 4
Children 0-23 mo. weighed monthly	13%	30%	50%	70%
Children 0-23 mo. who do not gain weight regularly receiving nutritional counseling	10%	30%	45%	60%
Children 0-5 mo. exclusively breastfed	19%	25%	30%	40%

* Rehabilitative home visits with food preparation demonstrations

4b.1d Approach

The two foundational tactics for teaching about nutrition will be through home visits by the health volunteers and teaching during monthly growth monitoring sessions. The volunteers will keep track of newborns on their registry and will visit mothers as soon as possible after the birth of the child to support the mother and encourage exclusive breastfeeding. The volunteers will emphasize that breastfeeding should begin within eight hours after birth, especially within the first hour of birth. At this time they will assist mothers who are having difficulty getting started with breastfeeding. Health volunteers will visit mothers with children under six months on a monthly basis to encourage them in breastfeeding and infant care. The basic messages that they will communicate are:

- Exclusive breastfeeding up to six months is best for the child.
- Children under three years old should be given food six times a day.
- Children should be given a mixture of local cereals and vegetables.
- Mothers should prepare foods rich in Vitamin A.
- Increasing caloric intake by adding oil to foods will help to make children stronger.
- Breastfeeding should continue up to 24 months.

Additionally, volunteers will encourage mothers to continue feeding their children when they are sick and to add an extra meal during the time of recuperation.

During the monthly growth monitoring sessions infants will be weighed, and the health volunteers and health promoters will facilitate educational sessions about nutrition and child care. Additionally, during these monthly sessions mothers will be encouraged to form breastfeeding support groups. The health volunteers will use popular education methods in order to maximize reflection and discussion among the mothers. It is important that mothers openly discuss their questions and reservations about the recommended practices and have the recommended behavior changes clearly explained to them.

For the mothers of children who are not gaining weight, volunteers will sponsor monthly food preparation demonstrations. They will invite mothers who have successfully been able to nutritionally rehabilitate their child to share their experience and demonstrate the foods that they have prepared to restore their children to a healthy weight. These sessions will begin during the second year of the project.

TBAs will also be members of the perinatal team. They will be trained in how to teach mothers about breastfeeding and will assist mothers in putting the baby to the breast as soon as possible.

Another project component that will support nutritional interventions are the community banks. Health talks will be included in the regular membership meetings, using the same participatory methods as in the growth monitoring session. The community banks will have the added benefit of contributing to improving the economic level of women, which is one of the principal barriers to good nutrition.

Nutrition interventions will be introduced according to the training plan found in Section E.3. The quality of the interventions will be monitored in the following ways:

1. Project supervisors will review data regarding nutritional objectives each quarter to assess whether infants in their area are developing according to schedule.
2. Health promoters will conduct semiannual focus groups to evaluate nutritional messages and assist in making revisions if needed.
3. Health promoters will visit mothers whose children do not gain weight to inquire into the reasons for the problem. If some of the problems are related to the quality of interventions, the project staff will design appropriate changes.

4b.1e Low Birth Weight Babies

Mothers at risk for low birth weight babies will be encouraged to deliver in the hospital. In cases where mothers deliver low birth weight babies at home, the TBAs will be trained in referring high-risk cases to a physician. Refer to Section E.3 in this document for more information on TBA training.

In cases where home care is indicated, the protocol for medical supervision is as follows: For the first week, either from birth or release from the hospital, the mother should take the baby to the doctor every day. Subsequently the mother should take the baby to the doctor every two weeks until the doctor has determined that the infant has reached a satisfactory weight.

Mothers will be taught the kangaroo method of home care for low birth weight babies. The method calls for mothers and adult members of the family to carry the infant next to their chest at all times in order to transmit body warmth at all times. This should be done until the doctor determines that the infant is no longer at risk. The health volunteers and auxiliary nurses will teach and encourage mothers in this method. They will also help to make sure that mothers are taking their infants for the prescribed medical checkups.

4b.2 Growth Monitoring

4b.2a Baseline

According to the baseline survey only 13.2% of the children under two were weighed in the last four months. The norm for the MOH is that children under two should be weighed once a month for the first 12 months. Currently the local health centers in the two project areas do not have an effective system for monitoring high-risk children.

4b.2b Knowledge and Practices

Current growth monitoring practices at the health centers in the target areas are characterized by what is not being done. Health care staff do not take the time enter data on the infants growth chart, growth monitoring services are poorly organized, referral systems are weak and no time is taken to explain to mothers the significance of growth monitoring. The MOH has a protocol for growth monitoring at health centers, but it is not put in practice. Additionally, there are no existing volunteers who know about and practice growth monitoring at the community level. As a result, parents have no appreciation of the value of growth monitoring. In some communities there have been programs that provided growth monitoring services and have given away food as an incentive. Mothers state that the primary reason for attending these sessions is to receive food. For these reasons mothers have little appreciation for growth monitoring and little understanding of the relationship of growth monitoring to feeding practices and illness.

4b.2c Growth Monitoring Objectives

OBJECTIVE	Year 1	Year 2	Year 3	Year 4
Children 0-23 mo. weighed monthly	13%	30%	50%	70%

4b.2d MOH Protocol and Strategies

The policy of the MOH is that children are weighed once a month for the first year, and every 2 months in the second year. In practice this is not done consistently. The staff have the necessary skills and experience to manage growth monitoring, but their communication and counseling skills are deficient. The type of scale used is a balance scale. In the past, children who are underweight received donated food, but this program has been discontinued. The children with severe malnutrition are referred to the San Felipe Hospital or the Teaching Hospital in Tegucigalpa.

4b.2e Individual Documentation

The MOH growth card (*Tarjeta de Niño*) will be used in the project (see Appendix D). If a child's card is lost, the card is easily replaced at the health center. The growth data are recorded in the registry kept by the health volunteers, who will help mothers fill out a new card. The growth cards have a space for recording Vitamin A supplements. The MOH supplies the cards at no cost to mothers, and supplies are not limited.

Mothers will gain appreciation for the cards as they learn about the value of growth monitoring. Additionally, the status of having the card available during the monthly growth monitoring sessions will create an incentive to not lose them.

4b.2f Approach

The approach for growth monitoring will be to organize monthly growth monitoring sessions in the community. The sessions will be led by the volunteers, with supervision by the health promoters and the health center's auxiliary nurses. Volunteers will weigh infants and work with mothers to teach them how to enter the information on the growth charts. Volunteers will verify entries made by the mothers. Previous experience has shown this to be a workable, sustainable method.

Mothers will be encouraged to bring their infants for growth monitoring sessions as soon after birth as possible. At the first session for a newborn volunteers will take extra time with the mother to talk through the importance of GMC and encourage appropriate practices for the infant's growth.

Growth monitoring will be the first CS intervention implemented in the community. It is a concrete activity, provides a context for health education and community organization, and it is an activity that gives prestige to the volunteers. The phase-in of growth monitoring in all targeted communities will occur as in the overall plan for expansion into all communities. (Refer to section D.1.)

The project will identify high-risk groups through the registry that the volunteers will keep of all the children on their block. They will visit the mothers on their block who do not participate to encourage them to take part in the project. For children on the registry who falter, the volunteers will note this on their registry and will follow up with a home visit. For children with diarrhea, the volunteers will visit the home to assess if a referral is indicated and to counsel the mother in strategies for rehabilitation.

The constraints to growth monitoring are:

- mothers do not understand the importance of growth monitoring because of the relatively low importance given at the health center
- the subsistence standard of living that makes it difficult for parents to take time from work to take their children to the health center
- the disrespectful treatment that parents receive at the health center.
- In some communities growth monitoring has been associated with donations of food, which has created a false impression of the value of growth monitoring.

These barriers will be addressed by improving access through moving the growth monitoring to the community, giving leadership to the volunteers who are community members and involving the health centers' auxiliary nurses in the training given to the health promoters. In these training sessions the auxiliary nurses will be taught skills in effective communication and counseling.

The quality of growth monitoring interventions will be monitored in conjunction with the nutritional improvement interventions.

4b.2g Follow-up on Children

The volunteer will track infants' growth in their registry. If a child begins to falter the volunteer will mark this on the registry. For children who falter the volunteer will visit mothers at home and give demonstrations of how to prepare nutritious foods. Infants who continue to falter will be referred by the volunteer to the health center physician. The volunteer will also report the referral to the health center.

4b.2h Population

The population eligible for growth monitoring is 4,390 children under 12 months and 4,288 between 12 and 23 months. Additionally, an estimated 12,289 children will be born during the life of the project. The plan is that children 0-23 months will be weighed once a month. The strategy for enrolling children for growth monitoring will be for the health volunteers to sponsor monthly growth monitoring sessions in the community. Additionally, volunteers will visit mothers with newborns within the first week of birth and will encourage mothers to begin growth monitoring at the next monthly session.

4b.3 Nutrition Improvement for Pregnant & Lactating Women

4b.3a Baseline

The major causes of nutritional problems within the project area are:

- bad lactating practices
- lack of knowledge about weaning
- the high cost of food which results in little variety and quantity in the diet and not using many vegetables
- diarrhea
- respiratory infections
- poor use of available foods.

The proportion of children that are Low Birth Weight (under 2,500 grams) in the area are 9%, according to to 1995 statistic from the Hospital Escuela.

4b.3b Knowledge and Practices

The baseline KPC did not ask a specific question on pregnant women's eating practices and beliefs about weight gain during pregnancy. However, some of the cultural beliefs and practices that affect pregnant and lactating women are:

- Mothers should not breastfeed while they are eating because the food will pass directly to the child and choke him.
- Lactating mothers should not eat green leafy vegetables because it will give the baby green-colored diarrhea.

- In the first six weeks after giving birth mothers should eat only toasted tortillas with cheese because everything else will produce a bad odor in the mother's vaginal secretions.
- Mothers should not breastfeed when they are tired because it will cause the infant to grunt and be restless.
- Pregnant women who do not satisfy their desire for odd foods will cause the death of the fetus.
- Pregnant women should not eat too much so the fetus will not be too large and cause problems during delivery.

Mothers generally associate their good health with successful breastfeeding. Women also are expected to not do heavy work in the last trimester of pregnancy. In more rural areas women tend to consult TBAs for advice and in urban areas mothers consult relatives and friends. Pregnant women are given multiple vitamin capsules with iron. Women are also given Vitamin A capsules in the first month after delivery.

4b.3c Nutritional Objectives

The project does not have objectives in this area. Please see section D4.c for Vitamin A objectives.

4b.3d Approach

The project staff will monitor pregnant women through the registry of women on their block (*Listados de Embarazadas*--list of pregnant women), kept by the volunteers with assistance from the promoters. Women will be counseled about diet and prenatal care in the first trimester of pregnancy. At this time they will also be told about breastfeeding support groups and encouraged to join one. The volunteer will at the same time inform the support group and help them contact the pregnant women.

The constraints listed above in 4b.3a having to do with lack of knowledge will be addressed through the home visits by volunteers. The experience of the project staff is that the process of clarifying misunderstandings, answering questions and sharing new information is done more effectively by peers on a one-on-one basis. Additionally, the volunteers will do food preparation demonstrations with the women in their own kitchens. The personal attention that newly pregnant women receive during these visits is very gratifying and creates a positive environment for behavior change. In regard to economic constraints, the volunteers will encourage women to join a local community bank.

4b.4 Supplementary Foods

The project will not supply supplementary foods.

4b.5 Health Messages

The project staff will communicate to mothers the following nutritional messages:

- They should have a varied diet with local foods

- an extra meal and special times for rest during the day, especially in the third trimester of pregnancy.
- abstain from use of tobacco and alcohol
- do not take any drugs unless prescribed by a physician.

The project staff intend to assess the quality of their nutritional messages through the participatory educational strategy used throughout the project. During the course of reflection and dialogue about nutritional messages women will evaluate the messages being used and participate in making modifications when needed. Women will also participate in developing simple educational materials for local use such as coded diagrams, posters, role plays, etc.

The health volunteers will be trained to educate pregnant women and mothers in their blocks. (Refer to the training plan in Section E.3.)

D4.c Control of Vitamin A and Other Micronutrient Deficiencies

4c.1 Baseline

The project staff only plan interventions for Vitamin A. No data exist regarding the rate of night blindness. The data in Vitamin A deficiency from a study conducted in a 1987 study by the MOH showed 67% of the children under 5 ingested less than 250 micrograms of Vitamin A per day, which is not sufficient.[8] In the same study, 53% of the children consumed less than half of the recommended amount of Vitamin A.

4c.2 Knowledge and Practices

According to the baseline survey, 32% of children 12-23 months have received at least one dose of Vitamin A in the last six months. In regard to mothers' knowledge base, 56% of the mothers surveyed could not identify foods rich in Vitamin A. However, 62% of the women identified Vitamin A-rich foods in the list of foods given infants during weaning.

The project areas have plentiful production of fruits and green leafy vegetables. The reasons for the low consumption of these foods is that culturally, people do not usually eat green leafy vegetables, and fruits are available only when in season. The majority of the population do not have regular access to meat of any kind.

4c.3 Objectives

OBJECTIVES	Year 1	Year 2	Year 3	Year 4
Children 6-59 mo. receiving Vitamin A supplements every 6 mo.	32%	50%	65%	80%
Mothers receiving one dose of Vitamin A during the first month postpartum	20%	40%	60%	80%

4c.4 MOH Protocol and Practices

The MOH protocol is that children 6 through 11 months should receive one dose of 100,000 units of Vitamin A, children 12 months and older should receive doses of 200,000 units every 6 months. Women should receive a dose of 200,000 units sometime during the first 30 days postpartum. The project will follow the MOH protocol.

4c.5 Individual Documentation

The project will use the MOH registry for children (*Tarjeta del Niño*--child's card) and the registry for pregnant women (*Listado de Embarazadas*--list of pregnant women). Copies are attached in Appendices D and F. The volunteers' registries include space for recording Vitamin A administration. If a mother loses her card or her child's card, the volunteers will have the data.

The MOH is providing Vitamin A supplements during mass immunization campaigns. The volunteers will participate in these campaign by distributing Vitamin A and will assist mothers in recording Vitamin A administration as they assist in recording vaccinations. Additionally, the volunteers will sponsor quarterly mini-campaign for distributing Vitamin A.

4c.6 Approach

The project will provide Vitamin A supplements. The volunteers will distribute the supplements and will record the data in the appropriate registry as described above. The populations targeted for this intervention are children 6 through 59 months of age and women in the first thirty days postpartum. The protocol for administration of Vitamin A is the same as used by the MOH, described in Section 4c.4 above.

The project staff will collaborate with the MOH in their mass vaccination campaigns, where Vitamin A supplements will also be distributed. No other organizations are working with Vitamin A supplements in the project areas.

Mothers will be taught about the value of green leafy vegetables and fruits and how to prepare them as part of the nutritional improvement interventions, described in Section D4.b.1d.

Additional resources in the project areas are the four other PVOs that are working in food production projects. Project staff will encourage people to participate in these projects.

4c.7 Population

The beneficiaries of the Vitamin A interventions are 33,728 children under 5 years of age and 2,289 mothers with newborns. The protocol to be used is described in Section 4c.4 above. The methods for reaching the target population are:

- monthly growth monitoring sessions
- annual immunization campaigns
- quarterly minicampaigns for Vitamin A distribution
- Volunteers will follow up individually with mothers during their schedule of home visits.

The number of visits needed per child is 2 per year and 1 for reaching mothers who have recently given birth.

D4.d Diarrhea Case Management

4d.1 Baseline

Project staff estimate than on a national level the average child has three episodes of diarrhea per child per year (*Manual de Normas y Procedimientos de Programación Local.* MSP, 1990. *Manual of Norms and Procedues for Programming at a local level*, MOH, 1990.) The 1991 National Survey of Epidemiology and Family Health found that 3.5% of the disrrheal cases at the time of the study had lasted longer than 14 days, and 5.7% were dysenteric. These data will not be monitored regulary throught the Health Information System. In the project area no data exists on antibiotic-resistant strains of dysentery, because it has not been studied in the project area. The MOH calculates the demand for ORS packets by the formula of three episodes of diarrhea per child per year.

4d.2 Knowledge and Practices

The current knowledge and practices of mothers in the project area as described by the baseline survey showed the following:

- 42% of the children with diarrhea in the survey received ORT
- 61% of children continued receiving solid or semi-solid food during diarrhea episodes
- 69% of children receive the same or more liquids during diarrhea episodes
- 51% of the children with diarrhea received antidiarrhea medications or antibiotics
- an estimated 81% of mothers continued to breastfeed while their child had diarrhea

4d.3 Case Management of Diarrheal Disease Objectives

OBJECTIVE	Year 1	Year 2	Year 3	Year 4
Children 0-23 mo. with diarrhea in the last 2 weeks who have received ORT	42%	45%	50%	60%

4d.4 MOH Protocols and Practices

The MOH protocol is as follows:

1. All children should receive ORS after every incident of diarrhea or vomiting.
2. Mothers should continue to breastfeed during a child's diarrhea or vomiting episodes.
3. Children should receive an extra meal per day for 2 weeks following the diarrhea episode.
4. If the child has at least two of the following signs of dehydration then the child should be referred to the health center:
   - blood in the stool
   - uncontrolled vomiting

- diarrhea that persists for more than 15 days
- a distended abdomen

5. Avoid the use of laxatives

The MOH promotes the use of traditional teas, cereal-based water, and natural juices for children with diarrhea. They recommend avoiding the use of bottled drinks and artificial juices.

4d.5 Approach

The strategy for addressing this intervention is the use of monthly growth monitoring sessions to teach mothers about preventing and treating diarrhea. Additionally, volunteers will teach about prevention and treatment during their regularly scheduled home visits.

High-risk children will be reached through home visits. Children are considered to be at high risk if they are

- malnourished
- not breastfed exclusively
- are under 6 months
- do not have measles vaccination after nine months of age
- have not received Vitamin A supplements
- have signs of dehydration or have diarrhea for more than two weeks.

The protocols (in Spanish with an English translation) for home management of diarrhea and for management of more severe cases are found in Appendix E.

Interventions for diarrhea case management will begin in the first year, in the communities in Phase I. In Phase II communities, these interventions will also begin within the first year that the project expands into these communities.

The project staff will work alongside the health centers in case management, but will not supervise their work. Health center staff are skilled in case management, thus no plans have been made to provide additional training.

4d.6 ORS

ORS packets are distributed by the health centers and are available free and in sufficient quantities to meet the needs of the project. The health promoters will train the volunteers in how to administer the packets. The volunteers in turn will train mothers in demonstrations during growth monitoring sessions and during home visits. Each mother will be observed as they prepare the solution. The volunteers will repeat the hands-on demonstration in mothers' homes when a child is sick and assist the mother in administering the solution to the sick child. The volunteers will visit mothers with sick children the next day to verify that the solution is being given correctly. Additionally, diarrhea incidence will be monitored in the sentinel system which will provide data on the effectiveness of this intervention.

4d.7 Home Available Fluids

The project staff will promote the use of traditional teas, cereal-based water, corn meal and natural juices for children with diarrhea. They will recommend avoiding the use of bottled drinks and artificial juices and avoid homemade sugar-salt solutions.

4d.8 Health Education

The health education messages will be the following:

- excessive loss of fluids from diarrhea can cause death in infants and young children
- ORS will rehydrate a dehydrated child
- infants with diarrhea should continue to be breastfed and if weaned continue to be given food
- do not use antidiarrhea medicines.

Refer to Section 4d.9 for prevention messages.

The educational sessions on DDC will be based on demonstrations and direct observation of mothers preparing and administering ORS. One of the primary settings for this method of teaching will be the monthly growth monitoring sessions. The other main setting will be during home visits. Other methods that the project staff will use are diagrams to facilitate problem-posing sessions and role plays.

The quality of the interventions will be monitored by direct observation by the volunteers during home visits, semiannual focus groups involving mothers, data from the HIS and the midterm KPC survey.

4d.9 Prevention

Project staff and volunteers will teach mothers about prevention through messages on:

- breastfeeding
- proper weaning
- use of the cleanest water available
- washing hands with water and soap
- use of latrines
- administration of Vitamin A
- hygienic cleaning of diapers
- measles vaccination

Prevention messages will be incorporated into the teaching about ORS and will be evaluated along with ORS interventions.

The project will not directly support latrine and water system construction, but the staff will help families and communities take advantage of related programs provided by the MOH and other PVOs.

4d.10 Population
The population that will benefit from DDC interventions are 8,678 children under 2 years of age. The project staff calculate that it takes an average of three contacts with a mother to assure that ORS is being administered correctly.

D4.e Pneumonia Case Management

4e.1 Providers Effectively Trained, Supervised and Supplied

4e.1a MOH Policies
The MOH permits physicians and nurses who have been trained by the Program for Control of Acute Respiratory Infections to administer antibiotics. The MOH physicians use the protocol found in the Manual of Norms and Procedures. This protocol is consistent with the WHO protocol.

4e.1b Current Situation
All Health Centers provide standard treatment of pneumonia, and antibiotics are available in sufficient quantities. All physicians and nurses in health centers are trained and authorized to perform case management. Their protocols follow MOH/WHO guidelines. Their management of pneumonia appears to be correct. The types of antibiotics commonly used are penicillin and ampicillin. They also use acetomenophen in case management. The policy of the MOH is to supervise once a quarter the health centers that have the highest incidence of pneumonia and other respiratory infections.

The MOH health centers and hospitals will be responsible for estimating the amount of antibiotics needed based on monitoring the number of pneumonia cases/year to ensure that there is an adequate supply of antibiotics, and to look for alternative sources if needed. The Project will not participate in this, as it is already being done well by the MOH.

The preferred courses for antibiotics are:
- Infants under 2 months with severe pneumonia or sepsis -- crystalline penicillin 200,000 units/kg/da for ten days; and entamicina 7mg/kg/da for ten days.
- Infants 2 months and older with severe pneumonia: penicillin crystalline 200,000 units/kg/da for ten days.
- Infants 2 months and older with pneumonia: penicillin procainica 100,000 units/kg/da for 5-7 days.

4e.1c Plans for Current Providers
The project will not monitor MOH providers.

4e.1d Involvement of Workers Not Currently Treating Pneumonia
The staff will emphasize with volunteers and mothers that early detection and referral are key to a good outcome. The project staff will train the health volunteers to identify cases of pneumonia

and make appropriate referrals. They will also be trained in how to teach mothers about pneumonia.

The role of Promoters and health volunteers in pneumonia control is to educate the community to identify rapid respiration as an early sign that a mother should take her child to the nearest health center as soon as possible. Mothers will not expect volunteers to be able to treat their children when they have pneumonia. The credibility of the project health worker will not be based on solely on this intervention, but on their work in all of the interventions as a whole. For example, their work with contraceptives, Vitamin A distribution, Polio vaccine administration, their ability to organize their block, etc.

Mothers will be taught how to recognize the presence of an increased respiratory rate, which indicates that immediate treatment must be sought at the health center. Mothers will also learn to prevent pneumonia by immunizing their children, continuing breastfeeding, providing Vitamin A rich foods for their children and continuing foods and increasing liquids during the ARI episode. Additionally, mothers will be taught that children should be given an extra meal a day for the two weeks following an illness. The volunteers will not manage cases or administer antibiotics.

The quality of these interventions will be assessed through the use of semiannual focus groups, through data from the HIS, and from feedback from the volunteers during monthly meetings. The health promoters will provide regular in-service training for the volunteers by doing home visits with them.

4e.1e Training Program

Health promoters and health volunteers will be trained in early detection and referrals of pneumonia. They will not be involved in treating Pneumonia cases.
The topics to be included in training the health volunteer are:

1. the extent of the problem in Honduras,
2. how to recognize pneumonia in children less than two months old and two months and older,
3. the importance of prompt referrals and how to do so within the MOH system,
4. the home management of ARI without pneumonia, and measures for preventing pneumonia*.

*The home management of ARI without pneumonia will include: keeping the child warm and covered to help avoid catching a chill, frequent breastfeeding, continue regular feedings, give the sick child an additional meal while s/he is recuperating.

Project supervisors, health promoters and health center auxiliary nurses will train the health volunteers. They will be trained in groups of 15-20 at a time in a four-day workshop and will be supervised for the three weeks following the workshop. Half of the workshop time will be dedicated to early detection, referral and follow-up of pneumonia cases. The educational methodology will concentrate on the use of demonstrations, role plays and group discussion.

Annual continuing education seminars will be given to health center staff, health promoters and volunteers.

A total of 32 hours of instruction and practice time will be provided in the workshop. Staff from the MOH Department of Respiratory Infection Control will assist the project's supervisors in conducting the training. The project will ensure that the volunteers have gained adequate knowledge and skills by constant supervision on the part of the Promoters Area Coordinators and Auxiliary Nurses.

Health volunteers will also be trained in follow-up of pneumonia cases. They will be taught that if a child does not improve by 48 hours after treatment, they should return to the health center, children should be kept warm, lactating mothers should continue breastfeeding, and children should eat as much as they can. Additionally, children should be given a extra meal each day during the recuperation period.

4e.1f Assessment

The project will train health promoters and volunteers in early detection and referrals. Both groups will be trained in the same content. The criterion for referral by age group is as follows:

- infants under 2 months old with breathing rates greater than 60 per minute
- infants 2-11 months old with breathing rates greater than 50 per minute
- children 12 months or older with breathing rates greater than 40 per minute

In reference to methods for time measurement, the reality in the field is that there is no mechanism that is financially viable for accurately measuring respiratory rates. Prior experience has shown that mothers are able to recognize when a child is breathing fast. Project staff will teach mothers that rapid breathing is the sign of danger and the child should be taken to the health center.

During their training, volunteers will be taken to the Health Center, where they will onserve children with pneumonia. Also, they will watch a video distributed by the World Health Organization on Control of Acute Repiratory Infections, and this will enable them to recognize chest indrawing.

4e.1g Malaria

Malaria is not present in the project areas.

4e.1h Antibiotic Treatment

The project staff will not train health care providers in antibiotic treatment. The plan is to depend on the MOH to train and supervise their own staff. Additionally the project will not provide antibiotics. Data are not available from the MOH at this time regarding the rate of pneumonia treatment for each of the three age groups.

The trained Health Volunteers will monitor the success/failure of each treatment by providing follow up on children who have been treated for pneumonia at the Health Center. Volunteers will record children who have not improved, worsened, or whose treatment has failed 48 hours after treatment. Failure is defined as a child who has difficulty swallowing, subcostal retractions, and other signs. Then the mother will be counseled to take her child back to the Health Center or the hospital.

The Project HIS will not monitor the percentage of referred cases which promptly reach the referral sites. From a practical point of view, if the volunteer made the referral, she will make the home visit to verify that the mother did take her child to the Health Center, and to learn what treatment was recommended at the Health Center.

4e.2 Sufficient Access of the Target Population to SCM

4e.2a Current Access

All the Health Centers and Hospitals (already maked on map in Appendix A) have personnel who are trained in standard management of pneumonia.

The time that it takes for most people in the project areas to reach the local health center ranges from 1 to 2 hours and they have a wait of about the same amount of time to be seen by a provider for SCM. Health care and antibiotics are free from the health center, when they are available. If parents have to purchase them at a pharmacy, it will cost them from $5.00 to $15.00 US. The first three days of the week are the busiest. During the rainy season the time it takes to get to the health center can increase an hour. Health Centers are open from 7:00 AM to 4:00 PM Mondays through Fridays. The Hospital Escuela is open 24 hours a day, 365 days a year.

4e.2b Sufficient Access

No data exist at this time regarding the time and money that families spend seeking pneumonia treatment, and the percentage of the population which currently has sufficient level of access to treatment. Prior experience in CS programs by WRH indicates that parents who desired to take a sick child to the health center found a way to do so. Sufficiency of access was not an obstacle to seeking care.

4e.2c Increasing Access

The project does not plan to increase the number of providers. Project staff, however, will give feedback to MOH Regional Directors about the access levels and encourage them to increase the number of providers in the most deficient areas. Project staff estimate that at least 50% of the population will have sufficient access to treatment following the training of the Health Volunteers.

4e.3 Prompt Recognition, Seeking and Compliance with SCM

4e.3a Methods

Methods used to gather information about local beliefs include direct observation, interviews, focus groups and KPC surveys throughout the past 6 years that WRH has been working in Child Survival in Honduras.

Some of the local practices are to avoid giving a child "cold" foods such as fruits and uncooked vegetables, to not bathe them, not expose them to breezes or cold air, and give them broth made of animal fat or fish oil. The common words used to refer to rapid breathing are: *ansias* (anguish), *ansia de el pecho* (chest anguish), *no le alcanza el juelog, le brinca el pecho* (his chest leaps), *hervor en el pecho* (boiling in chest), *jir jir en el pecho, infección en el pecho* (chest infection), *tiene amonia* (has pneumonia). Prior experience has shown that when mothers understand that a child with rapid breathing is in danger and should be taken to the health center, they readily do so. Convincing mothers of the value of taking a child to the health center has not been a problem.

4e.3b Findings

Data from the baseline survey are as follows:

FINDINGS	PERCENT
Prevalence of ARI	45%
Prevalence of ALRI	25%
Percent of mothers who sought treatment when they suspected pneumonia	87%
Percent of cases managed by trained health professionals	77%
Percent of mothers who recognize rapid breathing as a reason for taking their child to the health center	62%

It is interesting to note that in comparison to the earlier CS project managed by WRH, a 1991 basline KPC survey found that 28% of mothers recognized rapid breathing as a reason for taking the child to the health center. The baseline percentage for this indicator in the current project is 34% higher than the baseline for the previous project. There appears to be a relatively high awareness of respiratory infections in the target population.

These symptoms are considered serious and mothers, in consultation with fathers, will make the decision to take the child to the health center. It is not known if the parents are satisfied with the quality of care at the health centers. The project staff will gather data on this factor during the regularly scheduled health education sessions held during growth monitoring sessions.

Some of the most common barriers to prompt recognition, care seeking and compliance with treatment are:

- lack of knowledge on the part of a significant percentage of the population about the signs of respiratory infections and their importance
- subsistance living standards which make it difficult for parents to take time off work to take a child to the health center--parents will tend to delay seeking treatment because of time pressures if they are not aware of the severity of the illness
- disrespectful treatment in general received at the health centers

- the high demand among the population for antibiotics as a "cure-all" for the slightest illness and the tendency of health center staff to give in to this demand depletes supplies
- the difficulty some people experience in getting to the health center during the rainy season

4e.3c Communication Strategy

The objective of the pneumonia-related communication strategy will be to teach mothers early detection through recognition of rapid breathing as a sign of danger and to teach immediate referral to the health center when this sign is present. All mothers will be taught about pneumonia during the monthly growth monitoring sessions and during home visits.

They will also be taught that the following behaviors will help to prevent respiratory infections:
- breastfeeding
- appropriate feeding during and following an illness
- immunization of children
- eating Vitamin A-rich foods
- timely prenatal care to facilitate good birth weight and a healthy mother

The two key health messages for this program area are:
- A child with cough could catch pneumonia and die.
- If a child with cough is breathing fast while at rest, take him immediately to the health center. He could have pneumonia and die.

These two key messages were used in the previous CS project, and will be validated in the new project areas during Year 1.

The volunteers will follow up mothers at home after their children have received treatment at the health center. The health center's auxiliary nurses who supervise the volunteers will relay counter-referral information to the volunteers. The volunteers will monitor compliance with treatment.

Information will be communicated by the health volunteers during the health education session at the monthly growth monitoring sessions. Volunteers will also communicate it one-to-one during home visits. Additionally the volunteers and mothers, with assistance from the health promoters, will make a series of posters about recognition of respiratory infections and timely referrals. These posters will be placed in schools, local businesses and churches. The project staff will use these posters as models and will sponsor a poster contest among community member. Winners will be given a token prize and their posters will be displayed in prominent places throughout the community.

The quality of these interventions will be assessed through the use of quarterly focus groups, through data from the HIS, and from feedback from the volunteers during monthly meetings. The health promoters will provide regular in-service training for the volunteers by doing home visits with them.

D4.f Malaria Control

No malaria is found in the project areas.

D4.g Maternal and Newborn Care

4g.1 Baseline Information

According to statistic from MOH from 1995, the maternal mortality ratio in Region 1 is 255/100,000. The causes of maternal mortality are as follows:

1. Hemorrhages -- 40%
2. Indirect causes* -- 20%
3. Infections -- 10%
4. Preeclampsia -- 10%

*Indirect causes refers to all deaths that are caused by an illness that existed before the pregnancy, birth or puerpium.

The following table presents baseline data regarding maternal care behaviors.

PREVENTIVE BEHAVIORS	PERCENT
Mothers who have TT vaccination card	52
Women who have received 2 or more doses of TT	47
Women who know that prenatal care should begin before the last trimester of pregnancy	93
Women who received prenatal care	88
Women attended by a physician during delivery	83
Women attended by a TBA during delivery	15

In the project areas outside of Tegucigalpa transportation for obstetrical emergencies is a major problem. If an emergency occurs at night it is difficult to find transport and it will cost from $30 to $40 US. It can take up to five hours to drive to a hospital that can take care of the emergency. Within Tegucigalpa it can be dangerous to go out at night because of the high crime levels.

4g.2 Maternal Care Objectives

OBJECTIVES	Year 1	Year 2	Year 3	Year 4
Women 12-49 yrs. old receiving at least 2 doses of tetanus toxoid	47%	60%	75%	90%
Women with a partner using modern methods of birth spacing	49%	50%	55%	60%
Pregnant women receiving prenatal care	88%	88%	90%	90%

4g.3 Prenatal Care

Within the project areas there are two public hospitals, one social security hospital, 15 health centers and numerous private clinics and hospitals. The prenatal care services that are offered at the MOH facilities are:

- provision of iron supplements
- provision of folic acid
- provision of multivitamins
- TT vaccinations
- weight monitoring
- blood pressure monitoring
- lab tests of hemoglobin and hematocrit, blood type and Rh factor, VDL, urine, and glycemia
- Detection and treatment of urinary tract infections, STDs (including HIV)
- screening for danger signs during pregnancy and treatment of obstetrical emergencies

4g.4 Delivery/Emergency Care

The facilities that are available for delivery and emergency care are the Public Hospital (*Hospital Escula*), the Social Security Hospital and the homes of the TBAs. Additionally there are various private hospitals that provide delivery services. By far the most often used facility is the *Hospital Escula*. For those women who are insured by Social Security prefer to use their hospital. Both of these hospitals are equipped to care for almost all obstetrical emergencies.

The areas outside of the capital are not equipped with emergency transport. When an emergency occurs people have to hire transport. Even in the capital, emergency transport is not available to most people because they do not have access to telephones. The time that it takes to reach a hospital from outside of Tegucigalpa can be up to 5 hours. From inside the city, at times it can take up to 2 hours.

4g.5 Postpartum Care

The local health centers have services for treating postpartum infections, providing assistance for mothers with difficulty breastfeeding and family planning. However, the counseling skills of the staff for breastfeeding and family planning are often weak. The services are provided by physicians and nurses.

4g.6 Constraints

Practically no constraints exist for prenatal care because 88% of the mothers in the baseline survey received prenatal care. Mortality tends to occur during delivery and postpartum. Constraints in these areas are:

- difficulty in finding and paying for transport
- lack of understanding about the importance of postpartum care, and the belief that newborns should not be taken out of the house for the first 40 days after birth.

4g.7 Population

The potential beneficiaries are mothers of the estimated 12,289 births during the life of the project.

4g.8 Approach

4g.8a Maternal Care Providers and Birth Attendants

Baseline data indicate that 83% of the most recent births were attended by physicians or nurses, 15% by untrained TBAs (presently being trained by the project), and 1% by a family member.

The project staff will train the existing TBAs in prenatal care, hygienic delivery procedures, postpartum care, breastfeeding, family planning and recognition of reproductive risk. Health volunteers will be trained in the importance of prenatal care, how to make referrals for prenatal care, and in postpartum care. Women will be taught about prenatal and post partum care, and danger signs during pregnancy.

The curriculum that will be used for training in maternal care is the MOH curriculum. Additionally, project staff have used the Gold Standards of Maternal Care to enrich the existing curriculum. Project staff will supervise TBAs by means of quarterly visits to each TBA, with priority given to those who need the most help. During these visits the supervisors will accompany the TBA during prenatal care visits and when possible attend deliveries with her. During the visits the supervisor will also emphasize the reduction of reproductive risks and recognition of danger signs during a pregnancy.

The TBA supervisor and auxiliary nurse will also hold monthly meetings with the TBAs to provide instruction, analyze data regarding maternal care and discuss issues related to their services.

4g.8b Prenatal Care

The project will be involved in promoting prenatal care via Health Promoters and volunteers and in training TBAs. TBAs will be strengthened in prenatal care, hygienic delivery and detection of obstetrical problems/danger signs. The training manual used for TBAs is one developed by the MOH. The project can provide an summary of the curriculum that is developed and sent in the First Annual Report.

TBAs will provide prenatal care in their homes and in the homes of pregnant women. Prenatal care will begin in the first trimester and subsequently in the fifth, seventh, eighth and ninth months (a total of five visits). These five contacts will be provided by the TBAs and the Health Center. All women will be referred to the health center for at least one prenatal visit to a physician. Only the Health Center staff will be able to weigh pregnant women, and provide Iron and Folate supplements free of cost.

Prenatal care will involve the following procedures:

1. Confirmation of the pregnancy

2. Counseling about TT immunizations
3. Identification of high-risk pregnancies*: women less than 18 and greater than 35 years old, women with more than 4 pregnancies, with pregnancies that are less than 2 years apart, and women with preexisting complications.
4. Detection of danger signs during pregnancy: vaginal bleeding, severe headaches/blurred vision/convulsions, edema, fever or chills, excessive tiredness or pallor.
5. Referral to the health center of women who are high risk or exhibit danger signs.

**High risk pregnancies will be identified as a guide to the health worker and referred to the Health Center/Hospital. This project will not be addressing these specific risk conditions due to the low sensitivity and specificity of screening criteria as pointed out in the DIP guidelines. However, it is a useful educational and counseling tool for health workers to identify a potential pregnancy. Therefore the project will address high risk conditions by referral to a local Health Center/Hospital.*

If any conditions exist referred to in 3 and 4 above, the TBAs will refer the woman to the health center for supervision. This will be a critical service for preventing maternal morbidity and mortality. The value of involving the TBAs in prenatal care is that care will be based in the community where access and trust is greater.

Vaccinations for TT will be given at the health center. (Refer to Section D4a.3, for the protocol for TT vaccinations.) The TBAs will determine gestational age by measuring the fundal height. They will also refer to the date calculated at the health center if it is available. Gestational age will be used to assess fetal development and to make a referral if a woman passes her delivery date. TBAs will use the MOH charts for documenting prenatal care. (Refer to Appendix F.)

The TBAs will be trained to assess the status and presentation of the fetus and to make a referral if there is a pelvic restriction or if the fetus is breech or transverse. In these cases the TBA will refer the mother to the health center.

The prenatal care services are listed above in Section 4g.3.

The following table outlines the danger signs that will taught to mothers, volunteers, family members, and others. Women exhibiting the following danger signs will be referred to the Health Centers/Hospitals:

Danger signs	**Conditions**
Severe headaches/ blurred vision/ convulsions and edema	Complications of toxemia and other hypertensive problems during pregnancy.
Fever and chills	Complications from infections

Vaginal bleeding	Spontaneous abortions, identify ectopic pregnancies, premature delivery, premature delivery of the placenta, depending on the stage of pregnancy in which the bleeding is present
Excessively tired or pale	Identify cases of anemia

The focus of the activities in the project will be in promoting prenatal care, teaching mothers and family members, and training the health volunteers. Women will be reached through home visits and health education sessions during growth monitoring sessions. Methods used will be role plays, problem posing diagrams during group learning sessions, and posters placed where women congregate.

The messages that will be used include:

- Prenatal care will protect the health of the mother and her child
- Mothers should gain weight during pregnancy and eat foods rich in Vitamin A and iron
- Mothers should take supplements or iron, folic acid and fluoride
- Mothers should receive TT vaccinations to protect their health and that of their children
- Mothers and their families should be prepared to go to the hospital immediately if there are signs of danger or complications
- The risk factors that could present complications for pregnant women are: women under 18 and over 35 years old, more than 4 children, preexisting illnesses, spacing between pregnancies of less than 2 years. Women with any of these risk factors should be cared for at the health center.
- Signs of danger during pregnancy are: vaginal bleeding, severe headaches/ blurred vision/convulsions, edema, fever or chills, excessive tiredness or pallor. Women with any of these signs should be taken to the hospital immediately.

The health volunteers will keep a registry of pregnant women on their blocks. The registries will include records of risk factors, and the volunteers will encourage mothers to receive prenatal care at the health center.

4g.8c Delivery/Emergency/Newborn Care

The project will train TBAs to perform only low-risk deliveries. The care for newborns will include:

1. establishing a clear airway
2. keeping the infant dry and warm
3. cutting the cord with a sterile instrument
4. eye drops for the infant
5. placing the infant in the mother's arms as soon as possible and encouraging the mother to place the baby on the breast

6. examination of the newborn for congenital birth defects, and if any are found, to make a referral to the health center
7. refer the newborn to the health center for height and weight measurement and BCG vaccination

TBAs will be taught to monitor the mother immediately after delivery for signs of excessive bleeding. In cases of excessive bleeding, the TBAs will be trained to perform first aid while the mother is being transported to the hospital. First aid procedures will include:

- stimulating the nipple
- external massage of the base of the uterus
- manual compression of the uterus.

There is no system of communication or emergency transport available for obstetrical emergencies. Transport for obstetrical emergencies is only available from private vehicles. The project staff will encourage municipalities to create a community fund for assistance of these emergencies. In Tegucigalpa Red Cross vehicles and Fire Engines are available, but only for that small portion of the population that has a telephone to be able to call them. Even in Tegucigalpa which has access to vehicles 24 hours a day, after 6:00 PM people are more afraid to leave their homes due to the high crime rate.

Project staff will educate family members about delivery and obstetrical emergencies. They will receive the messages about maternal care from posters and health education sessions. TBAs will talk with family members during prenatal care visits about having a contingency plan for emergency care.

4g.8d Postpartum Care

The health volunteers will teach mothers about postpartum care. They will make a home visit within the first eight days after delivery. During this visit they will:

- assess the general health of the mother and infant
- look for signs of extreme paleness of the skin and mucus membranes
- examine the mother's nipples for hardness, plethora, and mastitis
- verify the contraction of the uterus
- ask about vaginal bleeding
- verify fetid vaginal secretions, and fever or chills
- discuss family planning.

In the infant, the volunteer will verify that the infant can suck and cry heartily; urinate and defecate; examine the base of the umbilical cord for signs of infection; examine the color of the infant's skin; and verify that there are no congenital abnormalities.

4g.9 Documentation

Appendix F contains a copy of the perinatal card. If a mother loses her Perinatal Card the data can be recovered from her record kept at the Health Center she had been visiting.

D4.h Family Planning

4h.1 Baseline Information

Data from the baseline survey indicate that 87% of the women who are not currently pregnant do not want to have a child in the next 2 years; only 49% are currently using some form of modern contraceptive. Data on the national level indicate that the prevalence of contraceptive use is 47%. The potential demand for contraceptive use among married women is 13%, according the MOH. No data exist regarding dropout rates. (*Enquesta Nacional de Epidemiologia y Salud Familiar*-- National Survey of Epidemiology and Family Health. MOH, 1991.)

4h.2 Family Planning Objective

OBJECTIVE	Year 1	Year 2	Year 3	Year 4
Women with a partner using modern methods of birth spacing	49%	50%	55%	60%

4h.3 Current Family Planning Services and Constraints

Methods of contraceptives that are easily available in the project areas are oral contraceptives, condoms, and IUDs. Sterilization is more difficult to access, as it is only available at the hospitals in the capital and from the Honduran Association of Family Planning (ASHONPLAFA). Contraceptives are available at the health centers or from ASHONPLAFA, which charges between $0.50 to $3.00US. The MOH at this time states that there are no barriers to maintaining the availability of contraceptives.

Data from a national survey conducted by the MOH indicate that the most common barriers are:

- lack of knowledge about the benefits of family planning
- fear of complications from using oral contraceptives and IUDs
- one spouse is opposed
- medical conditions which prevent their use

4h.4 Population

The number of people who will benefit from this intervention is 27,565 women of childbearing age.

4h.5 Approach

The health volunteers will teach men and women about family planning using a discussion format and making the contraceptive devices available for them to look at and handle. They will also make themselves available to talk about family planning with couples in their homes. As much as

possible the volunteers will seek to talk with both the man and woman. The Health Volunteers will share family planning messages with men during home visits, meetings at community and sport clubs, etc. The health volunteers will know the families in their spheres of influence very well. They know their work schedules and habits, and when men are home. They can take advantage of this specialized knowledge to plan thier visits to be able to speak to couples about family planning together. TBAs will discuss family planning with parents during prenatal visits. They will also encourage parents after delivery to wait two years before having another child.

The volunteers and TBAs will be trained and supervised by the health promoters and auxiliary nurses to teach about contraceptives, but with the exception of condoms, will not prescribe them. They will, however, dispense oral contraceptives when a couple has approval from a physician. Volunteers can refer women who want IUDs to the Health Center.

Contraceptives are available from the health center the project will not provide them. When supplies are depleted at the health center, project staff will contact ASHONPLAFA to inquire if they can meet the demand. Volunteers will be given supplies of condoms by the health center and will freely dispense them. This approach is in line with MOH policies for PVO collaboration with family planning.

The health promoters and auxiliary nurses will be trained in a three-day workshop, followed by 3 weeks of supervision in the field. Staff from ASHONPLAFA will assist in the training.

4h.6 Health Education Messages

The content for training in family planning is still being developed in full. This intervention will not be phased in until the end of year 1. Family Planning Curriculum/training for each level of health worker can be provided in the First Annual Report.

Some main concepts that will be taught include:

- contraceptive methods for spacing births are a way to promote the health of mothers and babies and to reduce the threat of non-obstetrical reproductive risks;
- the use of condoms and the distribution of oral contraceptives (when authorized by a physician);
- referrals to health centers and private organizations such as ASHONPLAFA for IUDs and sterilization.

Health messages used in the project will include information about the conditions that increase the risk of reproductive problems, the benefits of parents being able to decide how many children they want and of spacing them, and the ability of parents to stop having children when they decide to do so.

4h.7 Documentation

Volunteers will keep records of family planning in their registries of women of childbearing age. The forms have a space for indicating the type of family planning being used, and for indicating

those women who have reproductive risk factors and are not using family planning. Women in this condition will be marked in red on the registries and will be visited by the volunteers to discuss family planning.

D.5 Table C: Schedule of Field Project Activities

Please refer to the list of tables.

Section E. HUMAN RESOURCES

E.1 Organizational Chart

Please refer to Appendix G.

E.2 Table D: Training and Supervision Summary

Please refer to the list of tables.

E.3 Training and Supervision Plan

The training program for the health volunteers is designed on the basis of workshops that are 2 to 4 days long for each intervention, followed by 2 to 3 weeks of practice in their communities. This cycle will be repeated for each intervention. The order in which the CS interventions will be addressed is the same as described in the project design. (Refer to Section D.1.) With this sequencing of content--practice, content--practice, the volunteers will not be overwhelmed with new information. The opportunity to immediately practice what they have learned will improve their retention. And finally, project team members will be able to begin interventions in the community early in the first year, without having to wait for health volunteers to complete the whole training package. The total time that it will take to train the health volunteers is approximately 21 weeks.

The training objectives for the health volunteers are:

1. Education, prevention, care and referral of cases of acute diarrhea
2. Education, prevention, care and referral of cases of acute respiratory infection
3. Education, detection and referral of pregnant women
4. Education and care of the mother and the newborn
5. Education and promotion of good nutrition for infants, young children and pregnant and lactating mothers
6. Promotion and assistance with family planning
7. Promotion and implementation of growth monitoring
8. Promotion of immunizations and delivery of oral polio vaccine
9. Facilitating learning using popular education methods and materials

The evaluation of the health volunteers' learning will be done at two levels. First, at the end of each workshop the volunteers will communicate the appropriate information and perform the indicated skills in a simulated situation and will be evaluated based on a knowledge and skills checklist. Second, they will be evaluated during the 2-3 week practicum by the health promoters. The promoters will assess the volunteers performance based on the performance checklist and

give them personal feedback on site. It is not expected that the volunteers will immediately acquire the necessary knowledge and skills, thus the promoters will use positive reinforcement techniques and expect progressive development in the volunteers' knowledge and skills.

After the training package is completed, the promoters will visit, on-site, each of the volunteers at least once a month. They will use the knowledge and performance checklist as a tool for continuing education. The health educator will also make rounds once a quarter to clusters of communities to conduct continuing education workshops and do on-the-job training.

The project team members intend to train 800 volunteers. This will create a ratio of 20 families per volunteer. The team that will supervise the volunteers is comprised of 12 health promoters employed by WRH and 2 auxiliary nurses from 11 health centers. Thus the total number of supervisors of volunteers is 34. The ratio, then, of promoter/supervisors to volunteers is 1 to 24. The 12 WRH health promoters will be supervised by a team of 4 supervisors (2 Area Coordinators, 1 Health Educator and 1 HIS Manager). The MOH auxiliary nurses will be supervised by the health center directors. The ratio of supervisors to promoters is 1/3.

E.4 Community Health Workers

The estimate for the total number of volunteer health workers needed is 800. This number was calculated based on the assumption of 6 members per family and that at least 20% of the families in the project's location will not have members who are beneficiaries. Of the number needed, there are currently 50 volunteers actively working with the local health centers. The remaining volunteers will be recruited by the project team members. The estimated ratio of families per volunteer is 20.

The volunteers will be supervised by monthly visits from the health promoters and auxiliary nurses. The promoters will use the knowledge and skills checklist to give feedback during the supervision visits. The area supervisors, promoters and volunteers will also have monthly planning meetings to review HIS data, discuss activities and write the action plan for the coming 4 weeks.

The estimated replacement rate per year is 20%. Based on prior experience, the reasons for volunteers leaving their service are:

- moving to live in another area;
- interpersonal conflicts with women in their blocks;
- disrespectful treatment by the health center team members;
- personal health or financial problems.

In order to minimize the replacement rate, the project team members will adopt a number of measures to build confidence and solidarity among the volunteers. They will include fun and personal sharing activities during the monthly meetings, sponsor an annual outing for all the volunteers, give special recognition to the volunteers on Mother's Day and the Day of the Children, sponsor contests and give special recognition to those who do things beyond the call of

duty. They will also encourage the volunteers to become members of community banks. The auxiliary nurses from the local health centers will be part of this whole process and will help to build bridges with the rest of the health center team members.

E.5 Community Committees and Groups

The project team members will facilitate the formation of health committees. For each cluster of 6-10 volunteers, one volunteer will be asked to serve as a member of the health committee. The committees will be made up of 4-6 health volunteers. An estimated total of 20 health committees will be formed. The committees will meet once a month, accompanied by the auxiliary nurse. The responsibilities of the committees are to analyze pertinent data from the HIS and promote and organize activities on a community-wide basis that support project activities. The committees will also serve as a link between the rest of the volunteers and the health center team members. For example, health committees will help local health centers promote and organize mass vaccination campaigns.

Another community-based group that will participate in the project is the community banks. WRH is involved in organizing community banks in a variety of regions in Honduras. The banks are formed by groups of 20-60 women from the same community. Many of the these women are natural leaders. In communities where community banks already exist, the health promoters will use the group as a point of contact with the community. Where banks do not already exist, the promoters will work with the Income Generating Facilitators to encourage forming a bank. The weekly meetings of the bank members will provide an opportunity for education about CS interventions. A total of 10 banks will be established with funds from the project. WRH will establish additional bank with funds that it has from other sources.

E.6 Role of Country Nationals

WRH is completely run by Hondurans, no expatriates are involved in the implementation of the project. The WRH team members will be responsible for the administration and financial management of the project. The Project Director, Area Coordinators, office team members and 3 of the 12 health promoters were involved in WRH's previous CS project. Thus the investment in team members' development will be in the area of continuing education. The Project Director, Area Coordinators and Health Educator will attend at least two continuing education conferences a year in Honduras. The HIS manager will also attend at least two conferences related to HIS management.

E.7 Role of Headquarters Staff

The Child Survival Director or Program Specialist, both to be recruited in the next month, will provide administrative backstopping for the project from World Relief headquarters in Wheaton, IL. Headquarters team members will make 2 visits per year of seven days each. The team members will provide technical assistance as determined jointly by the project director, Dr. Zúniga, and the HQ Child Survival director.

Section F. PROJECT MONITORING/HEALTH INFORMATION SYSTEMS

F.1 HIS Plan

The HIS system will be supervised by Dr. Zúniga, who has five years of experience as director of WRH's CS projects. The system will be managed by Claudia Gómez who has 4 years of experience managing the health information system.

The project's HIS is integrated with the MOH HIS, and will use the MOH forms. The data collected will track children under 2, pregnant women, and women of childbearing age (12-49 years old). The forms that will be used are included in Appendices D and F. The project will also set up a sentinel system for tracking project objectives on a quarterly basis. KPC surveys will be conducted at the midterm and end of the project. Project activities and services will be tracked using the monthly reporting system that will be used by the area coordinators and health promoters. Additionally, once a quarter all of the employed team members and local health center team members will meet to review progress and develop an action plan for the next quarter.

F.2 Data Variables

The variables that will be monitored are:

1. Childhood immunizations
2. Utilization of ORT
3. Recognition of the signs of pneumonia
4. Seeking treatment for pneumonia
5. Weight of children up to 24 months
6. Appropriate feeding practices of infants and children up to 24 months
7. Exclusive breastfeeding
8. Dosages of Vitamin A
9. TT immunizations
10. Use of family planning
11. Prenatal care services
12. Activities of the health committees
13. Health activities of the community banks

The sentinel system will collect data on exclusive breastfeeding, utilization of ORT, feeding practices, and recognition of the signs of pneumonia. The data collection for the sentinel system will be done by the health promoters, auxiliary nurses and community leaders.

The registries for tracking children, pregnant women and women of childbearing age will be used to gather data on immunizations, weight, Vitamin A, family planning and prenatal care. These will be filled out by the volunteers with assistance from the promoters and auxiliary nurses. The activities of the health committees and community banks will be reported on a Sustainability Report form.

Data on the quality of interventions will be collected by the health education component through the problem-posing process which asks for regular feedback from mothers. The volunteers and promoters will report this information during the monthly planning meetings.

F.3 Data Analysis and Use

Data from the registries kept by the volunteers will be analyzed during the monthly meeting with promoters, auxiliary nurses and volunteers. The findings from this analysis will be communicated to the community by the volunteers at the monthly growth monitoring sessions; to the local health centers by the auxiliary nurses; to the WRH office in a separate monthly meeting between promoters, auxiliaries and area coordinators. These data will be used to guide monthly planning priorities and to make adjustments in intervention strategies.

Another tool for using data will be to create graphs of key indicators and have them posted during the monthly growth monitoring sessions. Project team members will begin with graphs of the percentage of children who are being weighed on schedule. This will give visual feedback to mothers on the progress of their group. It will create a sense of group movement toward a common goal. Staff will add graphs of progress on other indicators on an incremental basis.

F.4 Other HIS Issues

The confidentiality of the participants will be preserved by educating the health promoters and volunteers, by a policy of not using individuals' names during monthly planning meetings where data are analyzed and by the policy of volunteers keeping the data recording forms private.

The equipment needed for managing the HIS are two computers and the data collection forms. WRH will provide the forms for the volunteers. The HIS manager will need technical assistance for computerizing the HIS. This assistance is available from the network of PVOs working in CS: USAID, PAHO, UN and UNICEF. The HIS is ready to be operationalized manually as soon as the volunteers are trained; however, WRH intends to computerize the system.

Section G. BUDGET

G.1 Budget Information

Refer to Appendix H for a detailed line item budget differentiating between USAID and PVO contributions, as well as between the field and HQ portions of the buget.

G1.a/b Salaries and Fringes

a. Headquarters - Include all paid HQ backstopping personnel. Includes a portion of the Child Survival Director's salary, a portion of the Child Survival Program Specialist's salary, a portion of the Child Survival Grants Manager's salary, and a portion of the Child Survival secretary's salary. All HQ staff will give the remainder of their time to other CS Projects in Mozambique, Bangladesh and El Salvador.

Field Technical Includes 1 Project Director, 48 PMs $19,617/yr.; 2 Field Supervisor, 96 PMs, $7,940 ea./yr.; 1 Educational Specialist, 48 PMs, $7,940/yr.; HIS Manager, 48 PMs $7,473/yr.; TBA Training Facilitator, 48 PMs, $7,473/yr.; 12 Health Promoters, 48 PMs $2,802 ea./yr.
Field, Other Personnel - Includes National Director 24 PMs, $20,750/yr.; 1 Administrative Assistant, 48 PMs, $8,407/yr.; 1 Financial Assistant, 48 PMs $8,407/yr.; 1 Bilingual Secretary, 48 PMs, $6,539/yr.; 2 Accountant Secretaries, 96 PMs, $2,335 ea.yr. Since this project is focused primarily on effecting behavior change in mothers and not on delivery of services it requires a heavy commitment (62% of direct field costs) to personnel who will do the training and be "trainer of trainers."
Fringe Benefits are 9.3% of the total salaries/benefits listed above.

G1.c Travel/Per Diem

Includes all travel, per diem and other related costs for all personnel except consultants.
a. Headquarters - Domestic (USA): All US travel and per diem costs for headquarters personnel for listing of all U.S. travel, covered by PVO contribution. This includes travel, meals, and lodging for the CS Specialist and one other CS HQ staff member to attend the PVO workshop, a professional conference such as the NCIH conference or the APHA conference and one visit to USAID/Washington each year.
b. Headquarters - International: Includes international travel between the U.S. and overseas location per diem and other applicable costs incurred in the country visited. Includes monitoring visits and Midterm Evaluation and Final Evaluation visits. Field In Country: Includes project staff travel for training, supervision, coordination and other implementation activities.

G1.d/eEquipment and Supplies/Procurement

a. Headquarters Supplies: Includes software, stationery, and other office-related products.
Field - Pharmaceutical: Includes Vitamin A capsules, covered by PVO match funds.
Field - Other: Includes office supplies and training materials.
b. Headquarters Equipment: Includes microcomputers. Field Equipment: Includes 1 vehicle for central office, 2 motorcycles for area offices, 12 bicycles for the health promoters, 1 phone/fax machine and 1 computer. 100 baby scales, loud speaker system, 2 typewriters for the area offices, and the office furniture for the area offices.
c. Headquarters Training: Conference registration fees. Field Training: Includes cost for training workshops for promoters, volunteers, TBAs, MOH personnel and community leaders. The numbers of training days conducted each year are as follows: Yr 1 (7,756 days), Yr 2 (7,364 days), Yr 3 (11,226 days), Yr 4 (1,418 days).

G1.f Contractural

These line items refer to the fees, travel, and per diem costs of consultants (evaluation and other) only. Evaluation Consultant--Fees: Includes fees for 1 external midterm evaluator in Year 2 ($5,000) and 1 external final evaluator in Year 4 ($5,000). Other Fees: Includes 2 local consultants to assist in implementing the nutrition and ARI interventions in Year 1 ($250 ea.) and Year 3 ($250 ea.); a local HIS consultant to revise and update the HIS in Year 2 ($3,000), a local consultant to analyze operational costs and design a proposal for the MOH to sustain community

health activities ($500). Consultant Travel/Per Diem: Includes travel/per diem cost for the external midterm evaluator and entire evaluation team ($8,350), the external final evaluator ($8,350) and for annual internal evaluations: $1,000 in Year 1; $900 in Year 2; $800 in Year 3 and $700 in Year 4. A Scope of Work for each of these consultancies will be written with specific needs of the project in mind. Therefore, specific Scope of Work and Contracts for this project have not been written yet.

Other Direct Costs
a. Headquarters Communications: Includes printing/reproduction and postage costs. Field Communications: Includes postage/delivery system ($4,560) and telephone/fax costs ($5,350).
b. Headquarters Facilities : none Field Facilities: Includes office rent for the area offices ($10,520).
c. Other - Headquarters: Miscellaneous costs not already listed_
Field Other: Includes vehicle maintenance and operation costs fuel, spare parts, insurance, etc ($38,675); Building/equipment insurance, repairs and maintenance ($5,900); Volunteers Enablement Fund ($2,000) for volunteer incentive and recognition; Women's Income Generation Loan Fund ($24,000)/yr. for Years 1-3; and KPC survey costs in Years 1,2 and 4.

Section H. SUSTAINABILITY STRATEGY

H.1 Table E: Sustainability Goals, Objectives and Activities

Please refer to the list of tables.

H.2 Sustainability Plan

At the end of the project, teams of health volunteers and health committees will exist who will serve as community-based counterparts to the local health centers. The volunteers will have the ability to identify problems, pose solutions and implement plans to address the problem. They will be trained in the CS interventions. They will have participated in recruiting new volunteers and will have the resource of the auxiliary nurses for training new volunteers.

A critical source of support for the volunteers will be the auxiliary nurses who will link the volunteers with the local health centers. Recognizing this critical linkage, the project team members will involve the auxiliary nurses from the beginning as part of the team. They will participate in all the training given the promoters, the monthly planning meetings, all field-level team members meetings, and will have responsibility for supervising the volunteers side-by-side with the promoters during the first year. During Year 2, they will supervise the volunteers in all of the established communities.

Another source of support for sustainability is the community banks. Project team members will promote the creation of banks throughout the target communities. The banks will continue independent of external financing and will provide its members with improved financial standing for their families. The weekly meetings of bank members will continue and will serve as a forum for continued health education.

Project team members will work with the health committees and volunteers to help them with projects that generate a small amount of income. Some of the PVOs in Honduras have had good success with pharmacies and community stores. The team members will help the committees and volunteers think through their options and provide technical assistance.

H.3 Community Involvement

Community involvement will center on the health volunteers. The volunteers who have been in the first cycle of training will assist in recruiting, selecting, training and supervising new groups of volunteers. In this way they will learn how to continue the process of replacing volunteers after the project has ended its activities. The opportunity for expanded responsibilities has proven to be an excellent avenue for natural leaders from among the women to emerge and exercise their skills. The volunteers will also learn how to clean and maintain their scales, so as to be able to continue on their own.

Another aspect of community involvement are the health committees. They will have gained experience in assessing needs, planning and implementing projects and thus will be able to continue on their own. The opportunity to work with some of these committees for almost four years will help to establish a nucleus of solid, experienced health committees. Additionally, project team members will facilitate the creation of a network of health committees in geographically contiguous areas so that the committees can support and encourage each other.

The priority concerns that community members have expressed to project team members are their subsistence living standard and the health of their children. Thus community members are very interested in the CS project. An observation that supports this priority is that in the health centers, the majority of patients are children. While parents may find it difficult to seek care for themselves they will make an extra effort to seek care for their children. Additionally, it has been the experience of WRH that community members attend vaccination campaigns in mass--there is no problem convincing parents to have their children cared for in this way.

Project team members will keep community members regularly informed about the progress of the project and will discuss questions and concerns with them. This will be done in the context of community meetings that are regularly held independent of the project. This will help to create a high level of awareness about CS activities in their area.

H.4 Phase-Over Plan

The project team members intend to turn over most of the responsibilities for training and supervision of health volunteers early in the life of the project. By the second year, the auxiliary nurses will be in charge of continuing education and supervision of volunteers in Phase I communities.

From the beginning project team members have involved MOH team members in planning the project so that they share ownership of the project. All planning, implementation and evaluation activities will be done with MOH team members. They will be intimately familiar with the

objectives and developmental processes used in the project. When time comes for WRH to phase out, MOH team members will already have the ability to carry on. No transition period will be needed at the end for them to learn how to sustain interventions and activities.

H.5 Cost Recovery

No cost recovery activities are included in the project.

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2. Manual para la Capacitación de Parteras Tradicionales en Honduras. Ministerio de Salud Pública, Honduras. 1994.
3. Manual de Normas y Procedimientos de Atención Integral a la Mujer. Ministerio de Salud Pública, Honduras. Abril, 1995.
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Appendices

Appendix A Maps of Project Area

Appendix B Scope of Work of Sub-contractor

Appendix C MOH Immunization Schedule

Appendix D Child's Grwoth Card

Appendix E Protocols for Management of Diarrhea Spanish/English

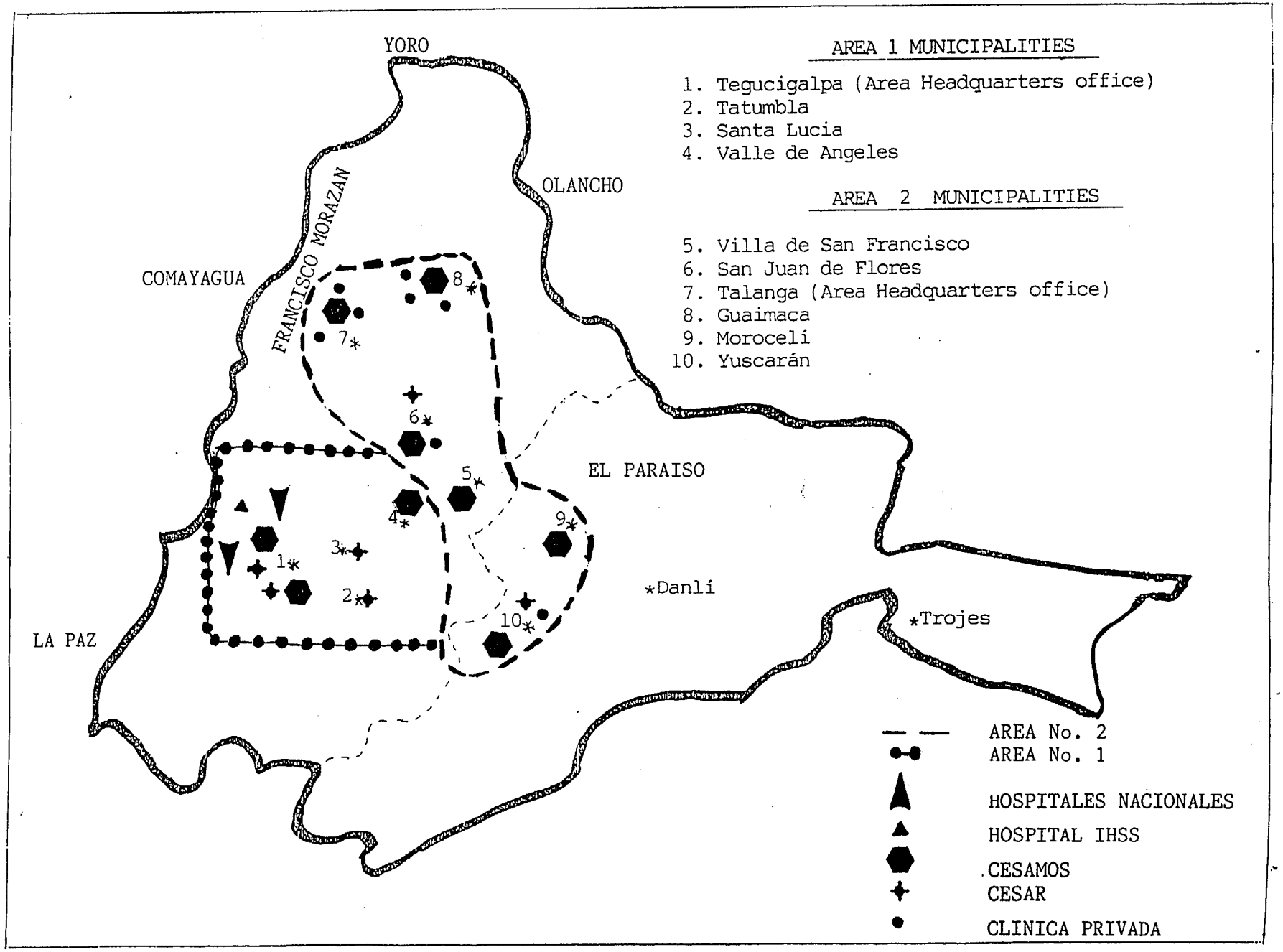
Appendix F MOH Maternal Prenatal Care Card

Appendix G WRH Organizational Chart

Appendix H Budget

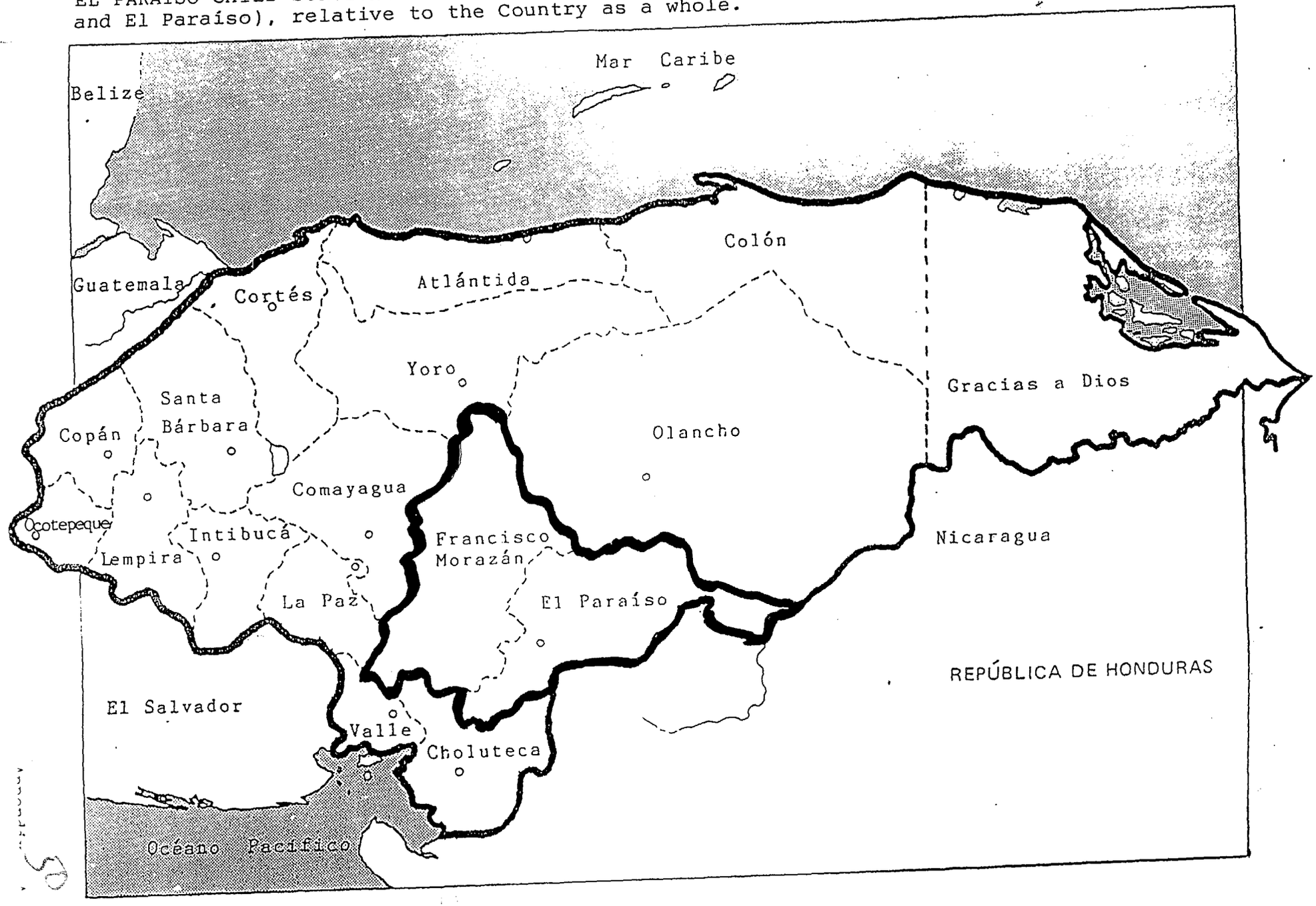
Appendix I Response to proposal review comments

EL PARAISO CHILD SURVIVAL PROJECT: MAP OF THE PROJECT IMPACT AREA



Appendix A

EL PARAISO CHILD SURVIVAL PROJECT: MAP OF THE IMPACT AREA (Departments of Francisco Morazán and El Paraíso), relative to the Country as a whole.



MG
CCS CS files

AGREEMENT BETWEEN

WORLD RELIEF CORPORATION, hereinafter referred to as WRC,

and

WORLD RELIEF HONDURAS (WRH)

PURPOSE, PERIOD, FUNDS AVAILABLE, EVALUATIVE REPORTING REQUIREMENTS

1. **PURPOSE:** The purpose of this agreement is to formalize the partnership between WRC and WRH to provide resources and facilitate the development of local expertise in child survival for the CSXI project.

2. **EFFECTIVE DATES:** This agreement is effective for the period from October 1, 1995 to September 30, 1999. This agreement may be terminated by WRC or WRH after 90 days written notice.

3. **FUNDS AVAILABLE:** Total estimated funds available from WRC for the above period are $269,868 from private sources (25%) and $601,782 from USAID (75%).

4. **EVALUATION AND REPORTING REQUIREMENTS:**

   a. WRH shall work on cooperation with WRC representatives to prepare reports required by the United States Agency for International Development (USAID). Such reports include a detailed implementation plan and annual reports. All reports will be written in accordance with USAID guidelines. WRH shall also collaborate with WRC in both a mid-term and final evaluation. These also shall be carried out in accordance with USAID guidelines.

   b. WRH will complete quarterly reports within the format prescribed by the WRC representative which outlines activities completed during the quarter and progress made towards achieving the project's objectives. Quarterly reports will be due 15 days after the close of each quarter for the quarters ending March 31, June 30, September 30 and December 31. The quarterly reports must be received by WRC before additional funds are advanced to WRH.

c. Other Reports:

1) When something occurs that could negatively impact the project, the achievement of objectives, or other activities; WRH will immediately make a special report and send it to the WRC Representative.

2) WRH will request in writing the authorization to make changes in communities, the population, the interventions, details of the DIP or annual plan, and the principle strategies and methodologies of the project, and any changes needed in budget line items. In addition, WRH will request in writing the authorization to contract consultants and auditing firms.

FINANCES

5. **DOLLAR CONVERSION:** The procedure followed for conversion of United States dollars to local currency shall be based on a written decision WRH shall obtain (if possible) from the USAID Mission Director within Honduras. Any net gains on currency exchanges received from funds under this agreement must be applied to the approved program related to this agreement.

6. **INTEREST BEARING ACCOUNTS:** If USAID funds are advanced:

a. WRH shall maintain WRC provided USAID funds in interest bearing accounts. Interest in excess of U.S. $250 on USAID funds for January through December shall be reported quarterly.

b. A procedure is to be followed to minimize the time before expenditure of USAID funds.

7. **MATCHING FUNDS:** For the four years covered by this agreement, WRH agrees to expend from World Relief funds an amount equal to the agreed upon percentage set in the matching grant.

SV

8. **FINANCIAL REPORTING REQUIREMENTS:** The following standards apply:

a. Accurate, current, complete and consistent.

b. Separate 1) WRC from 2) WRC provided USAID funds.

c. Annual reports are to be on an accrual basis (in contrast to accounting on the cash basis). Since WRH's accounting is on a cash basis, WRH needs to analyze documents on hand at year end and adjust annual reports to an accrual basis. Include copies of the analysis with the annual report.

d. Annual reports should include a list of any property, buildings or equipment on hand purchases with funds received under this agreement.

e. Monthly reports are to include copies of exchange rate documentation. These reports are due to WRC 15 days after the close of each month. Monthly reports must be received before WRC will advance further funds.

f. WRC uses WRH's yearly projections to calculate each month's disbursement. If there will be a significant difference between the projected budget for the month and what WRH plans to actaully spend the following month, WRH is to notify WRC at the time of the monthly report.

9. **UNDERLYING FINANCIAL RECORDS:** Records supporting financial reports shall:

a. Include assets, liabilities, income and disbursements.

b. Separate 1) WRC from 2) WRC provided USAID funds.

c. Include original source documents, books, records and other evidence in accordance with WRH's usual accounting procedure.

d. Document exchange rates monthly from official sources such as bank receipts, written bank quotes, or newspapers.

e. Be made available along with non-financial records to WRC for review and audit, as well as, the US Comptroller General, or any of his/her duly authorized representatives.

f. Include a property management system for property purchased with USAID funds with a life over one year and cost of U.S.$300 or more. See

A110, attachment N, paragraph 6 d. for specific details to include.

g. Be retained for at least three years after submission of the final report or longer if an audit is in progress or if audit issues are unresolved.

10. **INTERNAL CONTROLS:** Internal control procedures shall assure:

a. For all funds, property and other assets: effective control, accountability, adequate safeguards and assurance of use only for authorized purposes.

b. For audit findings and recommendations, a procedure to assure timely and appropriate resolution.

11. **AUDITS:** WRH will retain independent auditors to conduct annual A-133 audits at the end of the WRH fiscal year. The selection of the auditors is to be in accordance with "Guidelines For Financial Audits Contracted by Foreign Recipients" March 1991 by the AID Inspector General (I/G), a copy of which is attached. The key provision is that the auditor must be on the list approved by the USAID Regional I/G or you must obtain this approval. The second key provision is that the audit must be conducted by U.S. Government Auditing Standards. WRH shall provide a copy of these guidelines to the independent auditors as they also provide guidelines for conducting the audit and the reports required. Costs related to the A-133 audits are reimbursed under the sub-agreement as long as WRC approves these costs in advance.

PROCUREMENT OF GOODS AND SERVICES

12. **AIR TRAVEL:** Purchase of commercial air travel charged to WRC provided USAID funds must be made on U.S. flag carriers to the extent service by such carriers is available. Foreign air carrier service when U.S. carriers are available may be used if paid for out of WRC provided non-USAID funds.

13. **PURCHASE RESTRICTIONS:** Specific items cannot be purchased with USAID funds such as for political activity of any kind, abortion equipment or services, luxury goods or gambling equipment. Restricted items such as agricultural commodities, vehicles, pharmaceutical, used equipment, fertilizer or pesticides can be purchased only under specific authorization from USAID. Restricted items may be purchased if paid for out of WRC provided non-USAID funds. See the USAID Standard Provision for Procurement for more details.

14. **RULES FOR PURCHASING:** Certain rules must be followed in addition to those above to insure no conflict of interest, use free and competitive markets, price comparison analysis for all purchases and supplying bidding information that does not unduly restrict competition. See A110 Attachment O for more details. Sub-awards to parties debarred or suspended by either USAID in Washington, D.C. or by the mission director of the in-country USAID office are prohibited.

INCOME USE RESTRICTIONS, DRUG FREE, ATTACHMENTS, LIAISONS

15. **RESTRICTIONS ON USE OF PROGRAM INCOME:** All income from activities funded by this agreement shall be:

    a. Added to funds provided from WRC and USAID and used to further program objectives or

    b. When approved by USAID, used to finance the non-USAID share of project, or

    c. Deducted from the total project costs in determining the net costs on which the USAID share of costs will be based.

    d. Exceptions:
        (1) Interest on USAID advances, see item 6.a. above.

        (2) Income from sale of property or equipment are subject to A110, Attachment N.

16. **DRUG FREE WORK PLACE:** WRH employees engaged in the performance of this agreement shall be given written notice of the prohibition in any WRH office or workplace of the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance. See the Compliance Supplement for Single Audits of State and Local Governments for further specific Drug Free Workplace Act requirements.

17. **KEY ATTACHMENTS:** As required by USAID, the following documents are incorporated as a binding part of this agreement by attachment. Key provisions have been restated above for emphasis:

    a. OMB Circular A-110 defining uniform administrative requirements.

b. OMB Circular A-133 which further defined the audit section of A-110.

c. The mandatory standard provisions of the specific AID grant involved.

d. Guidelines for Financial Audits Contracted by Foreign Recipients 3/91.

e. Guidelines for Audits of Federal Awards to Non-Profits 4/89.

18. **LIAISONS:** One representative from WRC and one from WRH shall serve as liaisons by whom every contact shall be initiated by and/or copied to . This includes memos from conversations containing key information or decisions. The WRH liaison will be Mr. Roberto Ruiz and the WRC liaison will be KenGraber.

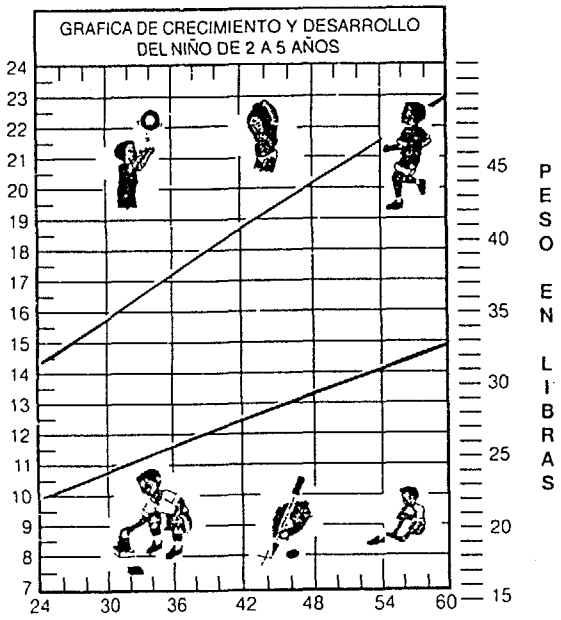
THIRD PARTY CLAIMS, SIGNERS

19. **THIRD PARTY CLAIMS:** WRC does not assume liability for any third party claims for damages arising out of this agreement.

20. **SIGNERS:** The signers below represent that they are authorized to bind their organizations to this agreement and signify their acceptance of the terms signing below:

By:	Kenneth L Graber	By:	
Of:	World Relief Corporation	Of:	World Relief Honduras
Title:	Latin America Regional Director	Title:	Executive Director
Date:	Nov. 17, 1995	Date:	Nov. 21, 1995

1995 MOH IMMUNIZATION SCHEDULE			
Vaccine	Age	No. of Dosage	Interval between Dosages
BCG	at birth 7 yrs.	1st 2nd	Seven years
Polio	at birth* 2 months 4 months 6 months	 1st 2nd 3rd	Six to eight weeks
DPT	2 months 4 months 6 months	1st 2nd 3rd	Six to eight weeks
Measles	9 months 1 to 14 yrs.	1st 2nd	
Tetanus Toxoid	Women 12-49 yrs.	1st 2nd 3rd 4th 5th	First contact with MOH 6-8 weeks later 6 mo. after 2nd 1yr. after 3rd 1yr. after 4th
Hepatitis B	High-risk groups	1st 2nd 3rd	First contact with MOH 30 days after 1st 6 mo. after 2nd



OBSERVACIONES:

ANTECEDENTES PERINATALES	LUGAR DE NACIMIENTO	TIPO DE NACIMIENTO
	Institul. ☐ Domic. ☐ Otro ☐	Unico ☐ Multiple ☐

ATENDIDO POR: Médico ☐ Enfermera ☐ Partera ☐ Otro ☐

PATOLOGIA EMBARAZO PARTO Y PUERPERIO	EDAD GEST. AL NACER	PESO AL NACER	TALLA
no ☐ Si ☐	☐☐ Sem Menor 37 ☐ Mayor 41 ☐	☐☐☐☐ Menor de 2.500 g. ☐	☐☐☐cm Per. Cef. ☐☐☐cm

VACUNAS	FECHA DE APLICACION			
	RECIEN NACIDO	1ª Dosis	2ª Dosis	3ª Dosis
ANTIPOLIOMIELITIS	/ /	/ /	/ /	/ /
D.P.T.		/ /	/ /	/ /
ANTISARAMPION		/ /		
ANTITUBERCULOSIS (BCG)	/ /	/ /		

BAÑOS ANTIPOLIO

FECHAS DE ADMINISTRACION DE VITAMINA "A"		
FECHA	EDAD	DOSIS
		100,000 U
		200,000 U
		200,000 U
		200,000 U
		200,000 U
		200,000 U
		200,000 U
		200,000 U
		200,000 U
		200,000 U

FECHA DE PROXIMA CITA

TARJETA DEL NIÑO

NOMBRE _____

Nº DE IDENTIDAD ☐☐☐☐-☐☐-☐☐☐☐☐

PADRE _____

MADRE _____

FECHA DE NACIMIENTO: DIA ☐☐ MES ☐☐ AÑO ☐☐

Nº EN EL LISTADO _____ SEXO F ☐ M ☐

Nº HISTORIA CLINICA _____

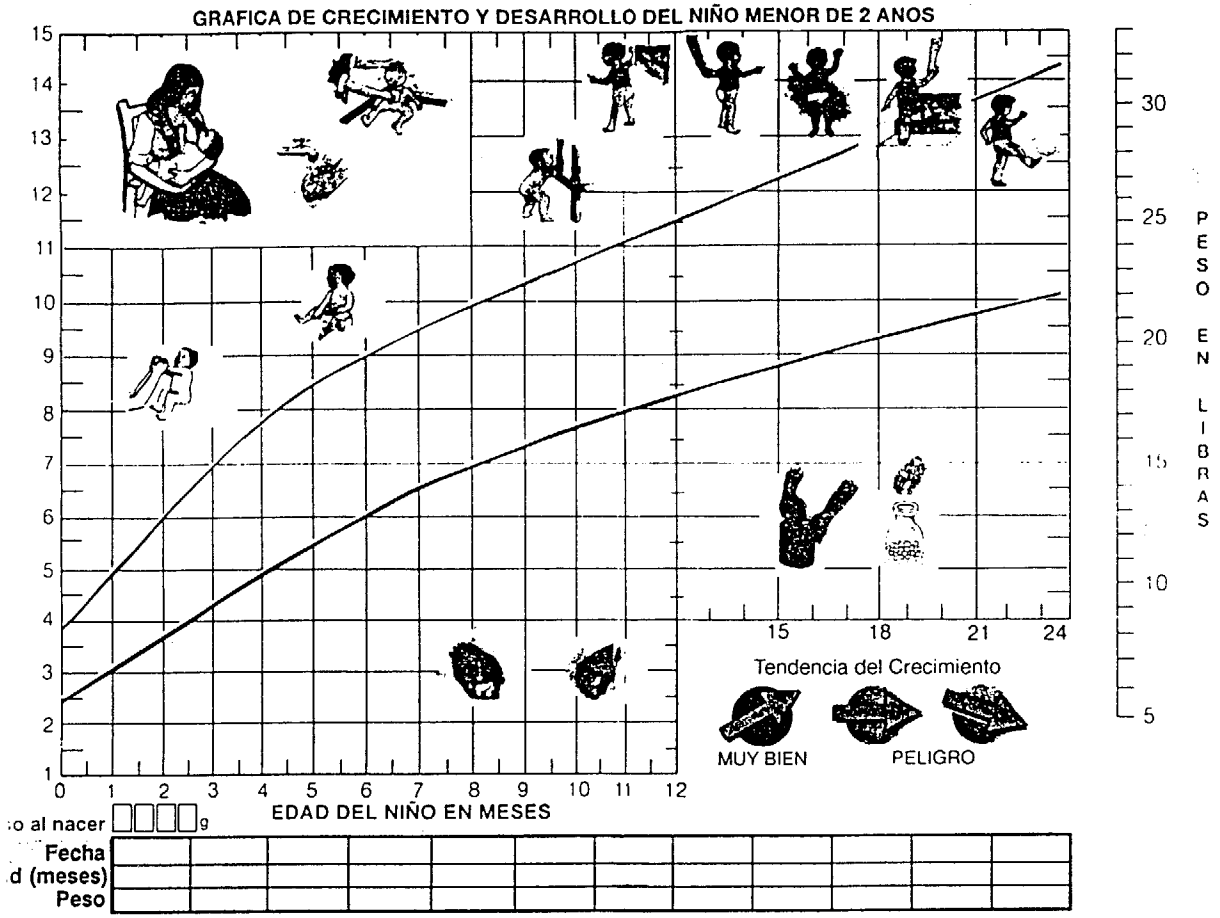
DOMICILIO _____

ESTABLECIMIENTO _____

Ministerio de Salud Pública

WORLD RELIEF (Auxilio Mundial)
DE HONDURAS
PROYECTO DE SALUD MATERNO INFANTIL

GRAFICA DE CRECIMIENTO Y DESARROLLO DEL NIÑO MENOR DE 2 ANOS

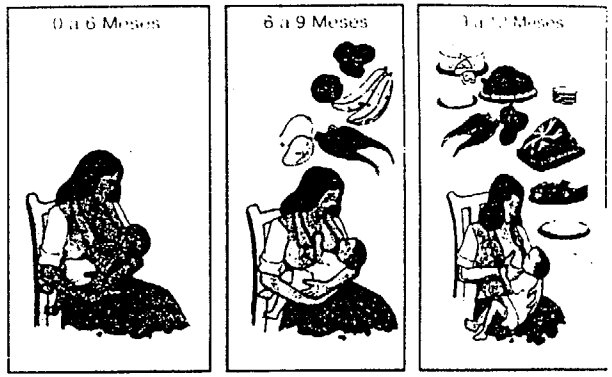


:o al nacer □□□□g

Fecha												
d (meses)												
Peso												

ALIMENTOS	EDAD EN MESES CUMPLIDOS											
	0	1	2	3	4	5	6	7	8	9	10	11
Leche materna												
Vegetales												
Frutas												
Maíz												
Arroz												
Otros Cereales												
Frijoles												
Carne												
Huevo												
Derivados de la Leche												

El niño que amamanta no necesita tomar agua,
porque la leche materna contiene suficiente agua.



Al año de vida, el niño debe comer de todo.

Para cuidar mejor a su hijo espere por lo menos,
2 años antes de un nuevo embarazo.

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

LISTADO DE VIGILANCIA INTEGRAL PARA EL MENOR DE UN AÑO

Nombre del Voluntario _____ Comunidad _____ Año _____

MES DE CAPTACION	DATOS DEL NIÑO			DATOS DE LA MADRE				VIT "A" ADMINISTRADA		ESTADO DE VACUNACION								LACTANCIA MATERNA EXCLUSIVA				
	NOMBRE COMPLETO	FECHA DE NACIMIENTO	EDAD ACTUAL	NOMBRE COMPLETO	EDAD	No DE EMBARAZOS	MES/AÑO ULTIMO PARTO	1	2	POLIOMIELITIS 1	POLIOMIELITIS 2	POLIOMIELITIS 3	D P T 1	D P T 2	D P T 3	SARAMPION	BCG	1	2	3	4	5

nvaciones

CF-PSI-G 001

MINISTERIO DE SALUD PUBLICA / AUXILIO MUNDIAL DE HONDURAS
PROYECTO DE SUPERVIVENCIA INFANTIL – GUAYAPE

LISTADO DE VIGILANCIA INTEGRAL PARA EL MENOR DE UN AÑO

Nombre del Voluntario _____ Comunidad _____ Año _____

CONTROLES Y VISITAS SEGUN MES DE EDAD ACTUAL																						CAUSAS DE NO CRECIMIENTO	NIÑOS RETIRADOS DE CONTROL (CAUSAS)
0		1		3		4		5		6		7		8		9		10		11			
TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita	TN	Visita		

Observaciones:

IV.D. 2 MANEJO DE CASOS A NIVEL COMUNITARIO

7. Los agentes comunitarios identificarán la presencia de deshidratación en el niño con diarrea, en base al reconocimiento de las siguientes señales:

   - mollera hundida
   - ojos hundidos
   - falta de lágrimas
   - boca seca
   - mucha sed
   - pliegue de la piel
   - orina poco
   - desganado
   - decaído

7. 1 Determinar que el niño tiene diarrea con deshidratación si presenta dos o más de las señales mencionadas.

7. 2 Determinar que el niño tiene diarrea sin deshidratación si no presenta ninguna o si presenta solamente una de las señales mencionadas.

8. Los agentes comunitarios indicarán las medidas orientadas a prevenir la deshidratación y la alteración del estado nutricional del niño con diarrea.

8. 1 Promover el uso de líquidos tradicionales (té, de manzanilla, atole de arroz, té de canela, jugos etc.) y evitar el uso de refrescos embotellados y jugos artificiales.

8. 2 Entregar 3 sobres de Litrosol.

8. 3 Indicar a los padres la forma correcta de preparación de Litrosol.

8. 4 Orientar a los padres para que den los líquidos tradicionales y el Litrosol frecuentemente, en cantidades pequeñas y en particular después de cada evacuación y/o vómito, utilizando preferiblemente una taza y cuchara.

Nota: Administrar el Litrosol en biberón aumenta los vómitos.

8. 5 Indicar la continuación de la lactancia materna y de la alimentación habitual durante el episodio diarréico.

8.6 Indicar la importancia de dar por lo menos una comida adicional durante dos semanas después del episodio diarréico.

8.7 Orientar a los padres sobre el reconocimiento de las señales de peligro y la importancia de acudir al centro de salud cuando se presenta.

8.8 Orientar a los padres sobre las medidas de prevención para evitar la recurrencia de la diarrea:
- Lavado de manos
- Hervido del agua
- Uso abundante del agua
- Disposición de excretas y basuras
- Higiene personal
- Preparación y conservación de alimentos
- Lactancia materna
- Vacunación

8.9 Orientar a los padres para que no den purgantes o aceites al niño con diarrea.

9. Los Agentes Comunitarios tomarán medidas inmediatas encaminadas a evitar la muerte por las complicaciones de la diarrea que pongan en peligro la vida del niño:
   - Deshidratación
   - Diarrea con sangre
   - Diarrea con vómitos incontrolables
   - Diarrea persistente más de 15 días.

9.1 Iniciar de inmediato la rehidratación utilizando sobres de Litrosol.

9.2 Referir al niño de inmediato al Centro de Salud más cercano, orientando a los padres sobre la importancia de continuar administrándole líquidos mientras dure el traslado.

9.3 Referir a todo niño que presente
- Diarrea con 2 o más signos de deshidratación.
- Diarrea con sangre
- Diarrea con vómitos incontrolables
- Diarrea persistente (más de 14 días)
- Diarrea con distensión abdominal

9.4 Comprobar la recuperación del niño que ha sido atendido en el Centro de Salud y darle apoyo para que continúe el tratamiento prescrito, incluyendo el manejo alimentario-nutricional.

9.5 Orientar a los padres sobre las medidas de prevención de la diarrea cuando el niño se está mejorando.

English Translation

Community-Level Home Management (of Diarrhea)

7. The Community's agents will identify the presence of dehydration in the child with diarrhea, on the basis of the following signals:
   - sunken crown
   - sunken eyes
   - lack of tears
   - dry mouth
   - extremely thirsty
   - fold in skin
   - urinates little
   - lack of appetite
   - weakness

7. If the child shows two or more signs listed above, the child has diarrhea with dehydration.

7.2 If the child exhibits one or none of the signs listed above, the child has diarrhea without dehydration.

8. Community agents will use the following rules to prevent dehydration and a worsened nutritional condition among children with diarrhea.

8.1 Promote the use of traditional liquids (camomile tea, rice atole, cannel tea, juices, etc.) And avoid the use of bottled drinks and artificial juices.

8.2 Give the parents 3 envelopes of Litrosol (trade name of ORS in Honduras/LatinAmerica)

8.3 Show parents the proper way to prepare the Litrosol

8.4 Encourage parents to give traditional liquids and Litrosol frequently in little quantities, preferably with a cup and spoon and after each bowel movement or vomiting spell.
*Note: Giving Litrosol in a bottle will increase the chances of vomiting

8.5 Encourage breastfeeding and normal meals throughout the diarrheal episode

8.6 Teach the importance of giving at least one additional meal during the two weeks after a diarrheal episode.

8.7 Teach parents danger signs of dehydration and to go to the nearest Health Center when they appear.

8.8 Teach parents how to prevent diarrhea by following these rules:

- Hand Washing
- Boil water
- Use plenty of water
- Proper disposal of excreta and rubbish
- Personal hygiene
- Preparation and preservation of foods
- breastfeeding
- vaccinations

8.9 Teach parents not to give child with diarrhea oil or laxatives.

9.0 The Community Agents will take immediate measures to avoid the death due to complications of diarrhea that will endanger the life of the child.

- Dehydration
- Diarrhea with blood
- diarrhea with uncontrollable vomiting
- Diarrhea that persists more than 14 days

9.1 Begin rehydration immediately using Litrosol.

9.2 Take child to nearest Health Center immediately, and teach parents to continue to give liquids to the child as they transport him/her.

9.3 Refer all children who have the following signs:

- Dehydration
- Diarrhea with blood
- diarrhea with uncontrollable vomiting
- Diarrhea that persists more than 14 days

9.4 Check on the recovery of a child who has gone to a Health Center and offer support to the parent who is giving care to their child, including nutritional management.

9.5 Teach parents about prevention of diarrhea when the child is recovering.

LISTADO DE MUJERES EN EDAD FÉRTIL

REGIÓN: ____________ ÁREA: __________ SECTOR: ________ UPS: ________ COMUNIDAD: __________ MEF: __________ AÑO: __________

No ORDEN	No HIST CLIN	NOMBRE DE LA MUJER	EDAD ACTUAL	No DE HIJOS	FECHA ÚLTIMO PARTO	LACTANCIA MATERNA	ENFERMEDAD CRÓNICA	ESTADO CIVIL	ANTECED PATOLÓGICOS OBSTÉTRICOS	TOXOIDE TETÁNICO					FECHA ÚLTIMA CITOLOGÍA	MÉTODO ANTICONCEPTIVO						OBSERVACIONES
										1	2	3	4	5		ORAL	DIU	IQ	CONDÓN	NATURAL	NINGUNO	

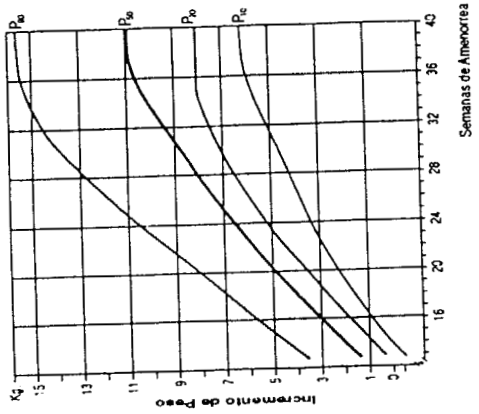
BEST AVAILABLE COPY

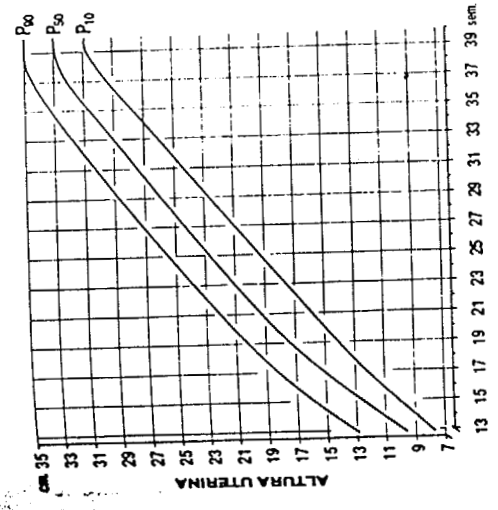
Listado de Embarazadas (LISEM)

No EMBARAZADAS ESPERADAS EN EL AÑO

UPS ______________ COMUNIDAD ______________ REGION ______________ AÑO ______________ No EMBARAZADAS ESPERADAS CADA MES

No de Orden	No Vivienda	No Historia Clinica	NOMBRE DE EMBARAZADAS	Riesgo Reproductivo		FUM o AU	FPP/ Fecha de Parto	Toxoide Tetanico			VDRL	CONTROLES PRENATALES										Referencia Sitio de Parto	Resultado Embarazo	Duración Embarazo	No de Niño en Linvac	Control Puerperal		Mujer V o M	Lactancia materna exclusiva		PLANIFICACION FAMILIAR	Vitamina "A"	OBSERVACIONES
												< 20 Sem		21 (22-24) 25		26 (27-29) 30		31 (33-35) 36		37 (38-40) +													
				Edad	otros			#Dosis	Fecha	Da próxima Dosis		Fecha	Situación	Fecha	Situación	Fecha	Situación	Fecha	Situación	Fecha	Situación					Fecha	Situación		Si	No			





EXAMENES COMPLEMENTARIOS

HOSPITALIZACIONES

ESTABLECIMIENTO	INGRESO		EGRESO	
	Dia	Mes	Dia	Mes

OBSERVACIONES

MINISTERIO DE SALUD PÚBLICA

CARNET PERINATAL

NOMBRE: _____

Dirección: _____

Nº Identidad: _____

Nº Historia Clínica o Carpeta Familiar: _____

Nº de Listado: _____

FECHA PRÓXIMA CITA

DÍA	MES	DÍA	MES	DÍA	MES

El embarazo bien ciudado ayuda a tener un parto con un final feliz.

Madres y recién nacidos sanos

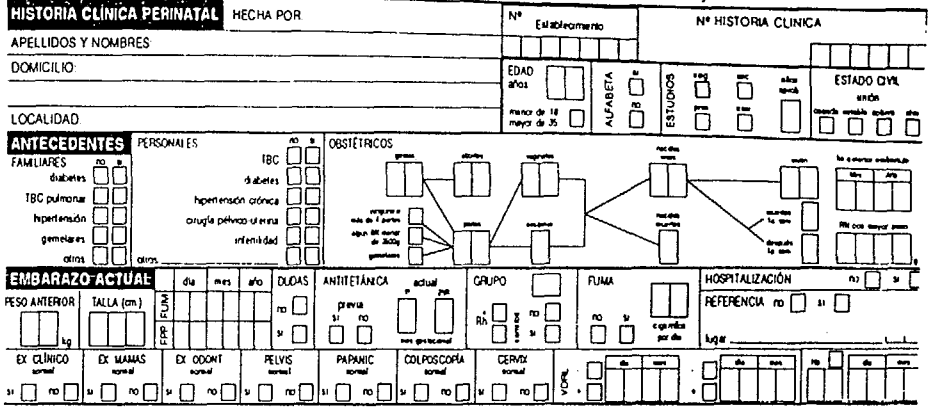
Cumpla con las citas y las recomendaciones que le den en el Centro de Salud.

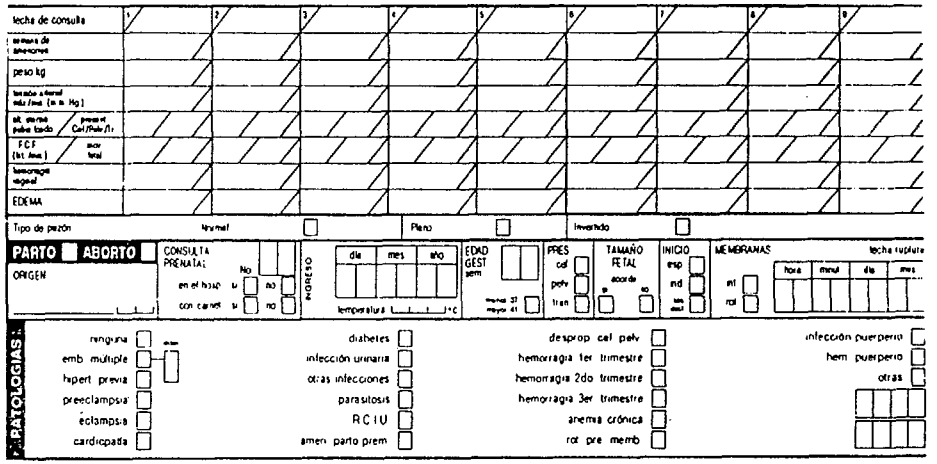
Este carnet contiene información indispensable para su salud y la de su hijo. Llévelo con usted siempre que acuda al servicio de salud y requiera una atención, ya sea para el embarazo, parto, puerperio o control de crecimiento y desarrollo de su hijo.

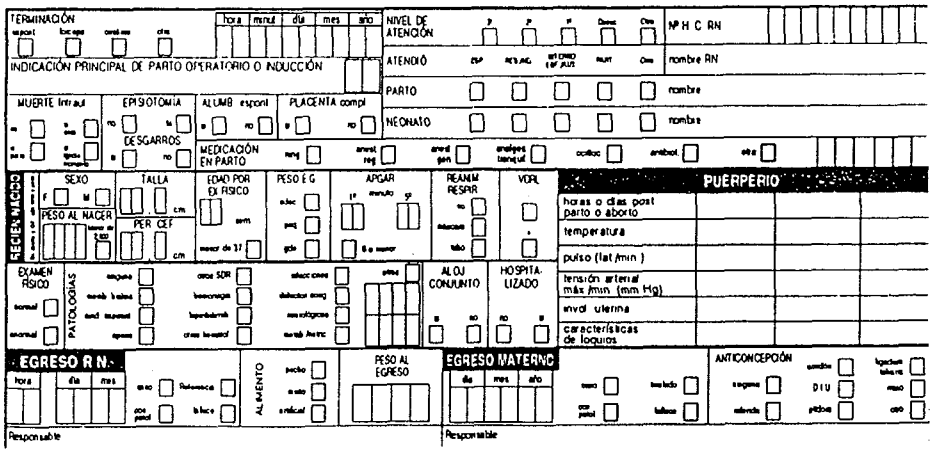
EXIJA SU DEVOLUCIÓN

HONDURAS, C. A.

MINISTERIO DE SALUD PÚBLICA, HONDURAS, C. A.





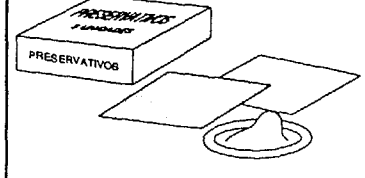


MINISTERIO DE SALUD PÚBLICA
DEPARTAMENTO DE ATENCIÓN A LA MUJER
DEPARTAMENTO DE ESTADÍSTICAS

FORMULARIO MENSUAL DE ATENCIONES POR PARTERA TRADICIONAL CAPACITADA

REGIÓN DE SALUD No._____ , ÁREA No._____ , UPS _____

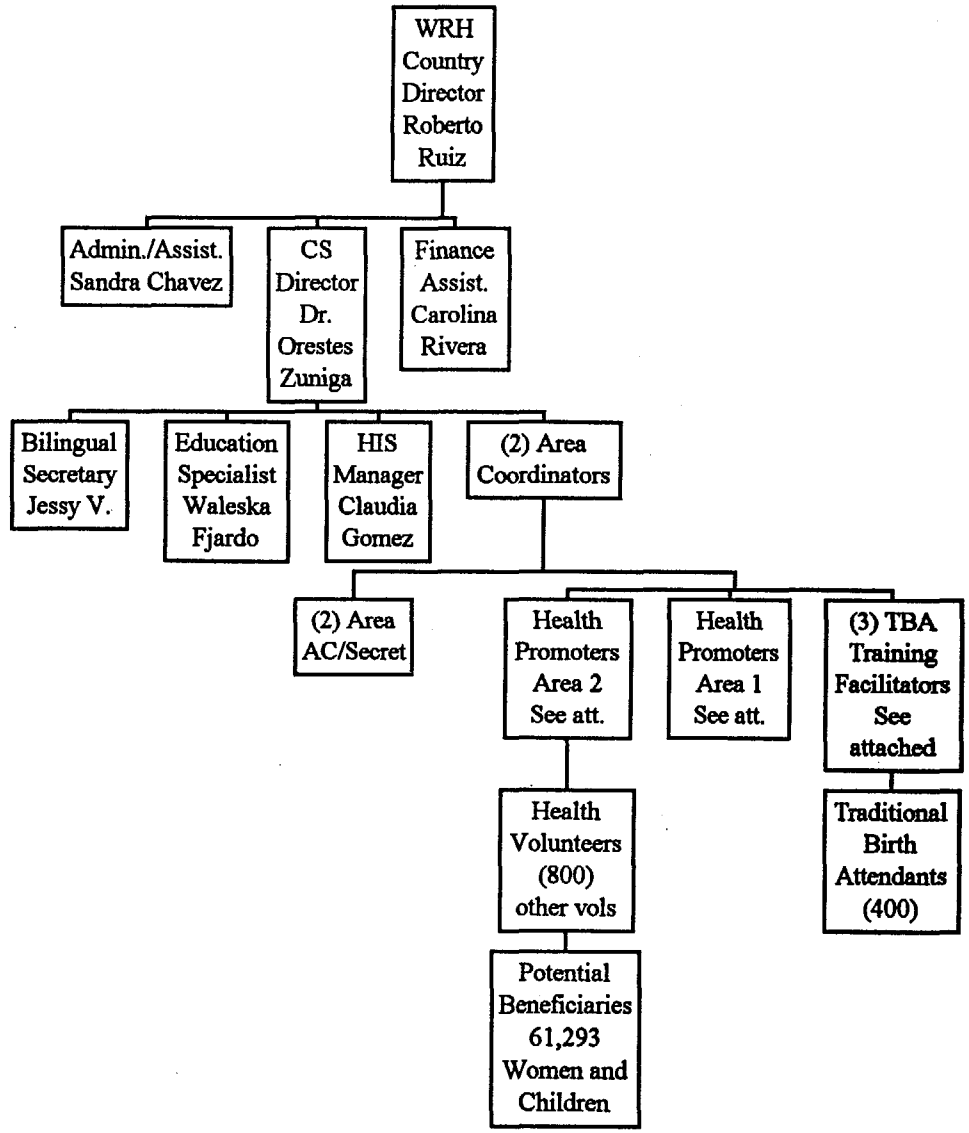
PARTERA: _____ ,MES Y AÑO _____

ACTIVIDAD	CANTIDAD	TOTAL	REFERENCIA
			
			
			
			

COMP-4

☐ ATENCIÓN NUEVA (Referencia de Riesgo)

World Relief Honduras El Paraíso Child Survival Project Organizational Chart (Page 1 of 2)



Notes on Organizational Chart:

Roberto Ruiz:	Financial Management and Leadership
Dr. Orestes Zuniga:	Overall Planning, Administration and Monitoring
Waleska Fajardo:	Training of Promoters, Follow up and Supervision
Claudia Gomez:	Data Gathering, Analysis and Application of Data at all levels
TBA Facilitators:	paid with funds from UNPFA for one year
Other Volunteers:	include members of the community health committees, church leaders and school teachers.

Area One Coordinator:	Joel Duron
Area Two Coordinator:	Guadalupe Solis
Area One Health Promoters:	Carmen Molina
	Yolani Lopez
	Nubia Lainez
	Etna Elvir
	Blanca Pino
	C. Raudales
	M. Aceituno
Area Two Health Promoters:	Martha Godoy
	Alba Cruz
	Veneranda Caceres
	Gloria Canadas
	Patricia Diaz
TBA Training Facilitators:	Rosbinda Zuniga
	Carmen Sevilla
	Leyla Flores
Area AC/secret:	Gloria Salgado
	Edna Lanza

All staff are National Hondurans.
Volunteers including Health Volunteers and TBAs are unpaid nationals
All others are Full-time salaried Honduran staff

TABLE E: HEADQUARTERS BUDGET

PVO/COUNTRY World Relief Honduras/Honduras COOPERATIVE AGREEMENT BUDGET
DATE BUDGET PREPARED 6/6/95
DATE SUBMITTED TO USAID 6/12/95

Check one: ORIGINAL BUDGET_____ REVISED BUDGET_____

I. DIRECT COSTS		YEAR 1		YEAR 2		YEAR 3		YEAR 4		SUBTOTAL - YEARS 1-4		TOTAL YEARS 1-4
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters - salaries/wages	37,976	6,993	32,465	9,186	32,002	9,504	21,344	6,002	123,787	31,685	155,472
	2. Field, Technical Personnel-salaries/wages											
	3. Field, Other Personnel-salaries/wages											
	4. Fringes- Headquarters + Field	8,908	1,640	7,615	2,155	10,672	2,839	4,477	1,362	31,672	7,996	39,668
	SUBTOTAL- PERSONNEL	46,884	8,633	40,080	11,341	42,674	12,343	25,821	7,364	155,459	39,681	195,140
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)		2,295		3,652		3,473		3,623	0	13,043	13,043
	2. Headquarters-International		7,015		2,226		2,338			0	11,579	11,579
	3. Field- in country											
	4. Field- International											
	SUBTOTAL- TRAVEL / PER DIEM	0	9,310	0	5,878	0	5,811	0	3,623	0	24,622	24,622
C. CONSULTANCIES	1. Evaluation Consultants- Fees									0	0	0
	2. Other Consultants- Fees									0	0	0
	3. Consultant travel / per diem									0	0	0
	SUBTOTAL- CONSULTANCIES	0	0	0	0	0	0	0	0	0	0	0
D. PROCUREMENT (provide justification/ explanation in narrative)	1. Supplies											
	a. Headquarters		500		750		500		500	0	2,250	2,250
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)											
	c. Field - Other											
	2. Equipment											
	a. Headquarters		2,400							0	2,400	2,400
	b. Field											
	3. Training											
	a. Headquarters									0	0	0
	b. Field											
	SUBTOTAL- PROCUREMENT	0	2,900	0	750	0	500	0	500	0	4,650	4,650
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1. Communications											
	a. Headquarters									0	0	0
	b. Field											
	2. Facilities											
	a. Headquarters									0	0	0
	b. Field											
	3. Other											
	a. Headquarters		250		250		741		250	0	1,491	1,491
	b. Field											
	SUBTOTAL- OTHER DIRECT	0	250	0	250	0	741	0	250	0	1,491	1,491
TOTAL - DIRECT COSTS		46,884	21,093	40,080	18,219	42,674	19,395	25,821	11,737	155,459	70,444	225,903
II. INDIRECT COSTS												
A. INDIRECT COSTS	1. Headquarters	16,394		14,575		15,518		9,389		55,876	0	55,876
	2. Field (if applicable)											
TOTAL - INDIRECT COSTS		16,394	0	14,575	0	15,518	0	9,389	0	55,876	0	55,876
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		63,278	21,093	54,655	18,219	58,192	19,395	35,210	11,737	211,335	70,444	281,779

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TOTAL PROJECT

PVO/COUNTRY: World Relief Honduras/ Honduras COOPERATIVE AGREEMENT
DATE BUDGET REVISED 06/22/95

TABLE F: FIELD BUDGET

Check one: ORIGINAL BUDGET_____ REVISED BUDGET_____

I. DIRECT COSTS		YEAR 1		YEAR 2		YEAR 3		YEAR 4		SUBTOTAL - YEARS 1-4		TOTAL YEARS 1-4
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters - salaries/wages											
	2. Field, Technical Personnel-salaries/wages	72,773		80,161		88,288	0	97,225	0	338,447	0	338,447
	3. Field, Other Personnel-salaries/wages	15,150	28,100	16,050	29,450	19,451	28,526	18,129	32,568	68,780	118,644	187,424
	4. Fringes- Headquarters + Field	3,613	3,925	3,703	4,294	2,377	6,092	3,319	5,573	13,012	19,884	32,896
	SUBTOTAL- PERSONNEL	91,536	32,025	99,914	33,744	110,116	34,618	118,673	38,141	420,239	138,528	558,767
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)											
	2. Headquarters-International											
	3. Field- in country		2,850		3,135		3,449		3,799	0	13,233	13,233
	4. Field- international									0	0	0
	SUBTOTAL- TRAVEL / PER DIEM	0	2,850	0	3,135	0	3,449	0	3,799	0	13,233	13,233
C. CONSULTANCIES	1. Evaluation Consultants- Fees			5,000				5,000		10,000	0	10,000
	2. Other Consultants- Fees	500		3,500		500				4,500	0	4,500
	3. Consultant travel / per diem	1,000		900	8,350	800		700	8,350	3,400	16,700	20,100
	SUBTOTAL- CONSULTANCIES	1,500	0	9,400	8,350	1,300	0	5,700	8,350	17,900	16,700	34,600
D. PROCUREMENT (provide justification/ explanation in narrative)	1. Supplies											
	a. Headquarters											
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	0	2,000	0	2,000	0	2,000	0	2,000	0	8,000	8,000
	c. Field - Other	3,000		3,200		2,210		2,331		10,741	0	10,741
	2. Equipment											
	a. Headquarters											
	b. Field		13,870		26,500					0	40,370	40,370
	3. Training											
	a. Headquarters											
	b. Field	30,107	436	32,822	1,594	29,977	2,363	12,434		105,340	4,393	109,733
	SUBTOTAL- PROCUREMENT	33,107	16,306	36,022	30,094	32,187	4,363	14,765	2,000	116,081	52,763	168,844
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1. Communications											
	a. Headquarters											
	b. Field		2,200		2,400		2,510	1,500	1,300	1,500	8,410	9,910
	2. Facilities											
	a. Headquarters											
	b. Field		2,267		2,493		2,743		3,017	0	10,520	10,520
	3. Other											
	a. Headquarters											
	b. Field	12,567	6,067	11,833	6,673	12,520	8,324	9,142	8,650	46,062	29,714	75,776
	SUBTOTAL- OTHER DIRECT	12,567	10,534	11,833	11,566	12,520	13,577	10,642	12,967	47,562	48,644	96,206
TOTAL - DIRECT COSTS		138,710	61,715	157,169	86,889	156,123	56,007	149,780	65,257	601,782	269,868	871,650
II. INDIRECT COSTS												
A. INDIRECT COSTS	1. Headquarters											
	2. Field (if applicable)	46,639		54,389		53,033		53,759		207,820	0	207,820
TOTAL - INDIRECT COSTS		46,639	0	54,389	0	53,033	0	53,759	0	207,820	0	207,820
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		185,349	61,715	211,558	86,889	209,156	56,007	203,539	65,257	809,602	269,868	1,079,470

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TOTAL PROJECT

TABLE . COMBINED HEADQUARTERS/FIELD BUDGET

PVO/COUNTRY : World Relief Honduras/ Honduras COOPERATIVE AGREEMENT
DATE BUDGET PREPARED : 06/07/95
DATE BUDGET SUBMITTED TO USAID :06/12/95 DATE REVISED 06/19/95

Check one: ORIGINAL BUDGET_____ REVISED BUDGET_____

I. DIRECT COSTS		YEAR 1		YEAR 2		YEAR 3		YEAR 4		SUBTOTAL - YEARS 1-4		TOTAL YEARS 1-4
		HEAD	FIELD	HEAD	FIELD	HEAD	FIELD	HEAD	FIELD	HEAD	FIELD	
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters - salaries/wages	37,976	6,993	32,465	9,186	32,002	9,504	21,344	6,002	123,787	31,685	155,472
	2. Field, Technical Personnel-salaries/wages	72,773		80,161		88,288		97,225		338,447	0	338,447
	3. Field, Other Personnel-salaries/wages	15,150	28,100	16,050	29,450	19,451	28,526	18,129	32,568	68,780	118,644	187,424
	4. Fringes- Headquarters + Field	12,521	5,565	11,318	6,449	13,049	8,931	7,796	6,935	44,684	27,880	72,564
	SUBTOTAL- PERSONNEL	138,420	40,658	139,994	45,085	152,790	46,961	144,494	45,505	575,698	178,209	753,907
B. TRAVEL/PER DIEM	1. Headquarters-Domestic (USA)		2,295		3,652		3,473		3,623	0	13,043	13,043
	2. Headquarters-International		3,507		2,226		2,338		3,507	0	11,578	11,578
	3. Field- In country		2,850		3,135		3,449		3,799	0	13,233	13,233
	4. Field- International									0	0	0
	SUBTOTAL- TRAVEL / PER DIEM	0	8,652	0	9,013	0	9,260	0	10,929	0	37,854	37,854
C. CONSULTANCIES	1. Evaluation Consultants- Fees			5,000				5,000		10,000	0	10,000
	2. Other Consultants- Fees	500		3,500		500				4,500	0	4,500
	3. Consultant travel / per diem	1,000		900	8,350	800		700	8,350	3,400	16,700	20,100
	SUBTOTAL- CONSULTANCIES	1,500	0	9,400	8,350	1,300	0	5,700	8,350	17,900	16,700	34,600
D. PROCUREMENT (provide justification/ explanation in narrative)	1. Supplies											
	a. Headquarters		500		750		500		500	0	2,250	2,250
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)		2,000		2,000		2,000		2,000	0	8,000	8,000
	c. Field - Other	3,000		3,200		2,210		2,331		10,741	0	10,741
	2. Equipment											
	a. Headquarters		2,400							0	2,400	2,400
	b. Field		13,870		26,500					0	40,370	40,370
	3. Training											
	a. Headquarters									0	0	0
	b. Field	30,107	436	32,822	1,594	29,977	2,363	12,434		105,340	4,393	109,733
	SUBTOTAL- PROCUREMENT	33,107	19,206	36,022	30,844	32,187	4,863	14,765	2,500	116,081	57,413	173,494
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1. Communications											
	a. Headquarters									0	0	0
	b. Field		2,200		2,400		2,510	1,500	1,300	1,500	8,410	9,910
	2. Facilities											
	a. Headquarters									0	0	0
	b. Field		2,267		2,493		2,743		3,017	0	10,520	10,520
	3. Other											
	a. Headquarters		250		250		741		250	0	1,491	1,491
	b. Field	12,567	6,067	11,833	6,673	12,520	8,324	9,142	8,650	46,062	29,714	75,776
	SUBTOTAL- OTHER DIRECT	12,567	10,784	11,833	11,816	12,520	14,318	10,642	13,217	47,562	50,135	97,697
TOTAL - DIRECT COSTS		185,594	79,300	197,249	105,108	198,797	75,402	175,601	80,501	757,241	340,311	1,097,552
II. INDIRECT COSTS												
A. INDIRECT COSTS	1. Headquarters	16,394		14,575		15,518		9,389		55,876	0	55,876
	2. Field (if applicable)	46,639		54,389		53,033		53,759		207,820	0	207,820
TOTAL - INDIRECT COSTS		63,033	0	68,964	0	68,551	0	63,148	0	263,696	0	263,696
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		248,627	79,300	266,213	105,108	267,348	75,402	238,749	80,501	1,020,937	340,311	1,361,248
												TOTAL PROJECT

PVCCS5\95TBL-0.WK1

Response to Technical Review

1. Reviewers stated that the proposal did not adequately provide feasible responses to identified health problems. In regards to problems related to birth control, pneumonia and breastfeeding, specific responses to these problems are referred to in the detailed plans for these interventions. In regards to concern about problems of access and helping the MOH offer better service, refer to the Summary of the Overall Project Design, on page 6 for a description of the collaborative relationship that WRH will have with local health centers.

   Additionally, refer to Section E.3 for a description of how WRH will include MOH personnel in their training plan. Concerns about untrained TBA are addressed in Section D4g.8 that explains the plan for training TBA. The problem of the lack of community participation is addressed in the Summary of the Overall Project Design, Section D.1. It explains the strategy of using growth monitoring sessions as the point of entry into the community. These sessions will provide a context for health education, for facilitating community organization, and for introducing the rest of the CS interventions. Additionally, refer to the description of the role of community banks in facilitating participation in CS interventions, found in Section E.5.

2. Reviewers were concerned that the proposal did not present consistent numbers of ratios of families to volunteers and volunteers to promoters. Refer to Section E.3 for a discussion of the number and for a summary statement of the ratios.

3. Reviewers stated that the proposal did not clearly address the problem of the lack of access to MOH health care facilities. Refer to the sustainability plan for a description of the collaboration with the MOH.

4. Reviewers would like to see information on the availability, training, retention and acceptability of MOH facility-based health workers. Refer to the Summary of the Overall Project Design, on page 6 for a description of how WRH will incorporate MOH staff in the project, and Section E.3 for a description of how WRH will include MOH personnel in their training plan.

5. Reviews felt that targets for growth monitoring seemed low. The targets have been raised. Refer to Section 4b.2c for further discussion.

6. Reviewers recommend that additional objectives be added for pneumonia control. The following indicator has been added to the project.

OBJECTIVE	Year 1	Year 2	Year 3	Year 4
Children with signs of pneumonia who receive treatment by trained professionals	77%	80%	85%	90%

7. Reviewers stated that it is important that WRH be familiar with national ARI control activities and to work with the MOH in this area. Refer to Section 4e.1a for a discussion of national ARI control activities and to Section 4e.1d for a description of how WRH will train promoters and volunteers to participate, at their level, in the national program.

8. Reviewers were concerned that the proposal did not put enough emphasis on recognition and follow-up of at-risk pregnant women and transport for obstetrical emergencies. Additionally, reviewers wanted to see more information of the role of TBAs. Refer to Section 4g.8a and 4g.8b for explanations of WRH plans for this intervention.

9. Reviewers wanted a clearer explanation of the ratio of block representatives to supervisors and of their selection. Refer to Section E.3 for a description.

10. Reviewers wanted greater details of the training plan. Please refer to Section E.3 for the details, including a description of the participation of MOH staff.

11. Reviewers recommended that the project have a good system of supervision for identifying and solving problem areas. Refer to Section E.3 and E.4 for a description.

12. Reviewers were concerned that the data analysis done by health committees be appropriate to their skill level. Refer to Section H.2 and H.3 for a description of the overall plan for data analysis and the health committee's role in it.

13. Reviewers commented that no funds were included for HQ travel for the Final Evaluation in Year 4. Money from Year 1 Headquarters Internation travel has been allocated to be divided between Year 1 and Year 4. Please see revised budget in Appendix H.

14. Reviewers felt that $2,000 was inadequate for purchasing Vitamin A capsules. WRH is able to obtain Vitamin A capsules from Sight and Life, a Swiss PVO that donates Vitamin A capsules to WRH. Sight and Life pays for all costs, including transport, handling fees, etc. WRH put $2,000 in the budget as a contingency in case shipments are delayed. In this case WRH would purchase capsules to cover the period of the delay.

Tables

DIP TABLE A: FIELD PROJECT SUMMARY

PVO/Country: World Relief Honduras

Cooperative Agreement No.: FAO-0500-A-00-5023-00

Project Duration (mm/dd/yy):
Start Date 9/30/95

Estimated Completion Date 9/29/99

1. PERCENT OF TOTAL USAID CONTRIBUTION BY INTERVENTION

Percentages must add to 100%.

INTERVENTION	Percent of Total Project Effort (%)	Percent of Total USAID Funds in US $
Immunization	5	$ 51,046
Diarrhea Case Management	20	$204,188
Nutrition	15	$153,140
Micronutrients	5	$ 51,046
Pneumonia Case Management	25	$255,235
Maternal Care	10	$102,094
Family Planning	10	$102,094
Malaria Prevention & Management		
HIV/AIDS Prevention		
Other (specify) Income Generation	10	$102,094
Other (specify)		
TOTAL	100 **0%**	$ 1,020,937 **$0**

2. SIZE OF THE POTENTIAL BENEFICIARY POPULATION

Note: Potential beneficiaries are the individuals eligible to receive services under Child Survival funding to whome you will provide services. Females (ages 15 - 49) should only be included as direct beneficiaries of services (for example, TT immunizations or family planning services), and not for educational interventions (for example, education on proper use of ORT).

Current Population Within Each Age Group	Number of Potential Beneficiaries
Infants, 0 - 11 months	4,390
Children, 12 - 23 months	4,288
Children, 24 - 59 months	12,761
Additional Births Year 2,3, & 4	12,289
Females, 15 - 49 years	27,565
Total Potential Beneficiaries Per Year	61,293 **0**

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DIP TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:
1. Reduce mortality and morbidity of children under 5 years of age and women 12-49 years.
2. Strengthen the capacity of the MOH to implement Child Survival Interventions.
3. Empower community leaders and families to act in ways that protect the health of 11 municipalities in El Paraíso and Francisco Departments of Honduras.

Project Objectives	Measurement Method for Objectives	Major Planned Inputs	Outputs	Measurement Method for Outputs
Children completely immunized by 12 mo. from 68% to 90%	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Training TBAs 4. MOH nurse auxiliaries	1. Increase of children immunized 2. Trained volunteers and promoters 3. Mass campaigns implemented	1. HIS monthly reporting system 2. Focus groups to evaluate promoters and volunteers
Children 0-23 months with diarrhea in the last 2 weeks who have received ORT increased from 42% to 60%.	1. KPC survey baseline, mid-term and end. 2. HIS 3. Sentinel evaluation system.	1. Training courses for health volunteers 2. Training courses for health promoters 3. Development of health education program.	1. Increase in the number of mothers giving ORT. 2. Trained volunteers and promoters	1. Focus groups to evaluate health messages. 2. Sentinel evaluation system. 3. Knowledge and skills checklist.
Mothers of children 0-23 months recognizing at least one sign of pneumonia for purposes of referral increased from 62 to 80%.	1. KPC survey baseline, mid-term and end. 2. HIS 1. KPC survey baseline, mid-term and end. 2. HIS 3. Sentinel evaluation system.	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program.	1. Increase in the number of mothers who know one sign of pneumonia. 2. Trained volunteers and promoters	1. Focus groups to evaluate health messages. 2. Sentinel evaluation system. 3. Knowledge and skills checklist.

Children with signs of pneumonia who receive treatment by trained professionals increased from 77 to 90%.	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program	1. Increase in the number of children referred for treatment. 2. Trained volunteers and promoters	1. Focus groups to evaluate health messages 2. Knowledge and skills check list.
Children 0-23 months weighed monthly increased from 13% to 60%.	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program 4. Scales for volunteers	1. Increase in the number of children who are weighted monthly. 2. 2. Trained volunteers and promoters	1. Focus groups to evaluate health messages 2. Knowledge and skills check list.
Children 0-23 months who do not gain weight regularly receiving nutritional counseling increased from 10% to 60%.	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program	1. Increase in the number of children receiving nutritional counseling. 2. Trained volunteers and promoters	1. Focus groups to evaluate health messages 2. Knowledge and skills check list.
Children 0-5 months exclusively breastfed increased from 19% to 40%.	1. KPC survey baseline, mid-term and end. 2. HIS 3. Sentinel evaluation system.	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program	1. Increase in the number of children being breastfed. 2. Trained volunteers and promoters	1. Focus groups to evaluate health messages 2. Knowledge and skills check list. 3. Sentinel evaluation system.

Children 6-59 months receiving Vitamin A supplements every 6 months increased from 32%-80%.	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of system for administration and distribution of Vitamin A capsules.	1. Increase in the number of children receiving Vitamin A capsules. 2. Trained volunteers and promoters 3. System in place for distribution of Vit. A.	1. HIS monthly report form 2. Knowledge and skills check list.
Mothers receiving 1 dose of Vitamin A during the first month post partum increased from 20% to 80%.	1. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of system for administration and distribution of Vitamin A capsules.	1. Increase in the number of women who receive Vitamin A during the first month post partum. 2. Trained volunteers and promoters 3. System in place for distribution of Vit. A.	1. HIS monthly report form. 2. Knowledge and skills check list.
Women 12-49 years old receiving at least 2 doses of TT increased from 47% to 90%.	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program 4. Development of immunization strategy.	1. Increase in the number of women who receive TT vaccinations. 2. Trained volunteers and promoters (in education)	1. HIS monthly report form. 2. Knowledge and skills check list.

Women with a partner using modern methods of birth spacing increased from 49% to 60%.	1. KPC survey baseline, mid-term and end. 2. HIS 3. Sentinel evaluation system	1. Training courses for Health volunteers 2. Training courses for health promoters 3. Development of health education program. Contraceptives.	1. Increase in the number of women and their partners using birth control. 2. Trained volunteers and promoters (in education)	1. HIS monthly report form. 2. Knowledge and skills check list.
Pregnant women receiving prenatal care increased from 88% to 90%.	1. KPC survey baseline, mid-term and end. 2. HIS	1. Training courses for Health volunteers and TBAs. 2. Training courses for health promoters 3. Development of health education program.	1. Increase in the number of women receiving prenatal care. 2. Trained volunteers and promoters (in education) 3. Trained TBAs.	1. HIS monthly report form. 2. Knowledge and skills check list.
MOH implementing CS interventions in Health Centers by the end of Year 2.	1. HIS.	1. Training courses for nurse auxiliaries in con-junction with health promoters training. 2. Monthly review and planning meetings. 3. Development of a coordination system.	1. Health center team members trained. 2. Volunteers supervised by nurse auxiliaries.	1. HIS monthly report form. 2. Knowledge and skills check list.
Local health committees functioning for at least two years.	1. HIS.	1. training and technical assistance to committees.	1. Functioning health committees.	1. HIS monthly report form.

Community banks participating in CS programs for at least 2 years.	1. HIS.	1. Organizing community banks. 2. Credit for banks. 3. Development of health education plan.	1. Organized and functioning banks. 2. Increase in number of bank members who are participating in CS programs.	1. HIS monthly report form.
Two hundred health volunteers functioning for at least 2 years.	1. HIS.	1. Training courses for Health volunteers. 2. Incentive system for volunteers.	1. Volunteers functioning.	1. HIS monthly report form

Summary of World Relief/World Relief Honduras Child Survival Project Objectives

	OBJECTIVES	YEAR 1	YEAR 2	YEAR 3	YEAR 4
	Immunization	68%	80%	90%	90%
1	Children completely immunized by 12 months				
	Nutritional Improvement	10%	30%	45%	60%
2.	Children 0-23 months who do not gain weight regularly receiving nutritional counseling*				
3.	Children 0-5 months exclusively breastfed	19%	25%	30%	40%
	Growth Monitoring	13%	30%	50%	70%
4.	Children 0-23 months weighed monthly				
	Vitamin A	32%	50%	65%	80%
5.	Children 6-59 months receiving Vitamin A supplements every 6 months				
6.	Mothers receiving one dose of Vitamin A during the first month postpartum	20%	40%	60%	80%
	Diarrhea Case Management	42%	45%	50%	60%
7.	Children 0-23 months with diarrhea in the last 2 weeks who have received ORT				
	Pneumonia Case Management	62%	65%	70%	80%
8.	Mothers of children 0-23 months recognizing at least 1 sign of pneumonia for purposes of referral				
9.	Children with signs of pneumonia who receive treatment by trained professionals	77%	80%	85%	90%
	Maternal and Newborn Care	47%	60%	75%	90%
10.	Women 12-49 years old receiving at least 2 doses of tetanus toxoid				
11.	Women with a partner using modern methods of birth spacing	49%	50%	55%	60%
12.	Pregnant women receiving prenatal care	88%	88%	90%	90%
	Family Planning	49%	50%	55%	60%
13.	Women with a partner using modern methods of birth spacing				

* Rehabilitative home visits with food preparation demonstrations

TABLE C: FIELD SCHEDULE OF ACTIVITIES
(Check box to specify Quarter and Year)

PVO: World Relief Corporation
COUNTRY: Honduras

	Year 1				Year 2				Year 3				Year 4			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position																
a. Project Manager	X															
b. Technical Coordinator	X															
c. Health Information System Manager	X															
d. Community/Village Health Workers	X															
e. Other Support	X															
2. Baseline Survey																
a. Design/Preparation	X							X							X	
b. Data Collection and Analysis	X							X							X	
c. Feedback to Community		X							X							X
3. Health Information System																
a. Consultants/Contracts to Design HIS					X											
b. Develop and Test HIS					X											
c. Implementation		X				X										
d. Feedback to Community			X			X										
4. Training																
a. Design	X															
b. Training of Trainers		X			X		X		X		X		X			
c. Training Sessions		X	X	X	X	X	X	X	X	X	X	X				
d. Evaluation of Knowledge of Skills								X								X
5. Procurement																
a. Supplies																
- Pharmaceutical	X				X				X				X			
- Other	X				X				X				X			
b. Equipment	X				X											
6. Service Delivery to be Initialed																
a. Area 1																
growth monitoring		X			X				X							
Nutrition			X			X				X						
Vitamin A			X			X				X						
Diarrhea Case Management			X			X										
Pneumonia Case Management				X			X				X		X			
Maternal Health				X			X				X		X			
Immunization				X			X						X			
TBA Training		X		X		X		X		X			X			
TBA Follow Up			X		X		X		X	X	X	X	X	X	X	X
b. Area 2																
growth monitoring		X			X				X				X			
Nutrition			X			X				X			X			
Vitamin A			X			X				X			X			
Diarrhea Case Management			X			X				X			X			
Pneumonia Case Management				X		X				X			X			
Maternal Health				X			X				X		X			
Immunization				X			X				X		X			
TBA Training		X			X				X				X			
Community Bank Training/Organization		X			X				X				X			
7. Technical Assistance																
a. Headquarters								X								X

b. Consultants		X						X								X
. Progress Reports																
a. Annual Reports				X								X				
b. Mid-Term Evaluation								X								
c. Final Evaluation																X

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DIP TABLE D: TRAINING AND SUPERVISION SUMMARY

PVO/ Country: World Relief Honduras **Project Duration: Start Date:** Sept. 30, 1995 **Completion date:** Sept. 29, 1999.

TRAINEE JOB TITLE	COURSE TITLE	NO. OF HOURS INITIAL SERVICE		SUPERVISOR	CONTACTS PER MONTH	INTERVENTIONS
Coordinators Health Promoters	Planning, organizing and community development	80	8	Guadalupe Solís	Daily	Introduction and training
Health Promoters	Growth monitoring	24	8	Guadalupe Solís	Daily	Growth monitoring
Coordinators Health Promoters	Maternal Health	40	8	Guadalupe Solís Joel Durón	Daily	Prenatal care and family planning
Coordinators Health Promoters	Popular Education	40	8	Orestes Zúniga	Daily	adult education
Coordinators Health Promoters	Nutrition	72	8	Guadalupe Solís Joel Durón	Daily	Breastfeeding, infant/child nutrition
Coordinators Health Promoters	ORT	24	8	Guadalupe Solís Joel Durón	Daily	ORT
Coordinators Health Promoters	Pneumonia	32	8	Guadalupe Solís Joel Durón	Daily	Signs, referrals
Coordinators Health Promoters	Immunizations	32	8	Guadalupe Solís Joel Durón	Daily	Protocols, referrals
Coordinators Health Promoters	HIS	56	8	Guadalupe Solís Joel Durón	Daily	management and reporting system
TOTALS		384	72		20	

DIP TABLE E: SUSTAINABILITY GOALS, OBJECTIVES, AND ACTIVITIES

Sustainability Goals	Objectives	Activities Required
MOH implementing CS interventions in Health Centers by the end of Year 2	80% of the Health Centers implementing CS interventions by the end of Year 2	1. MOH auxiliaries trained in CS interventions. 2. Health centers providing supplements, ORS, and FP methods. 3. MOH auxiliaries training and supervising volunteers. 4. Auxiliaries participating in planning and evaluation activities.
Health Committees functioning for at least 2 years	From the third year onward, 80% of the HC will have been functioning for 2 consecutive years.	5. Organization and training of HC 6. HC planning health activities jointly with health center staff.
Community banks participating in CS programs for at least 2 consecutive years.	100% of the community banks organized by the project, participating in CS activities for 2 consecutive years.	7. Organizing community banks. 8. Health education sessions held in weekly bank meetings.
Health Volunteers functioning for at least 2 years.	From the third year onward, 80% of the health volunteers trained by the project will have been functioning for 2 consecutive years.	9. Training and supervision of health volunteers. 10. Implementation of the incentive system for the volunteers. 11. Participation of the health volunteers in monthly planning and evaluation meetings.