THE HONDURAS CHILD SURVIVAL FOR VITAMIN A PROJECT TEGUCIGALPA: THE PERI-URBAN COMMUNITIES USAID CHILD SURVIVAL TX

MID-TERM EVALUATION
COOPERATIVE AGREEMENT # FAO-0500-A-00-3020-00

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Tegucigalpa, Honduras

REPORT OF THE

CHILD SURVIVAL FOR VITAMIN A PROJECT

MID-TERM EVALUATION

Presented by:
Lynn Johnson, M.P.H.

Ott ober 1995

IEF/Honduras
Debriefing

Presentation
and Discussion
of Findings

Focus Group
with Mothers

INTERNATIONAL EYE FOUNDATION - TEGUCIGALPA, HONDURAS
Child Survival IX Mid-Tom Evaluation - August 1995

Home of Community Health Volunteer

Interview with Mothers

Interview with CHVs

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The effectiveness of the evaluation process could not have been possible without the complete cooperation and interest of the community health volunteers and mothers we interviewed. I sincerely hope that the results of this evaluation serve them and their children to the fullest.

Lynn Johnson

ABBREVIATIONS AND ACRONYMS

ADRA	Adventist Relief and Development Agency
A.I.D.	U.S. Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AR1	Acute Respiratory Infection
ALRI	Acute Lower Respiratory Infection
BCG	Bacille Calmette-Guerin (tuberculosis vaccine)
CESAMO	Ministry of Health Center with a Physician
CHV	Community Health Volunteer
CDD	Control of Diarrhea1 Diseases
DIP	Detailed Implementation Plan
DPT	Diphtheria-tetanus-pertussis Vaccine
EPI	Expanded Program on Immunization
IEF	International Eye Foundation
IVACG	International Vitamin A Consultative Group
KPC	Knowledge, Practice and Coverage
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non-governmental Organization
OPV	Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
TT	Tetanus Toxoid
l-l-V	Tetanus Toxoid Vaccine
UNICEF	United Nations Children's Fund
USAID	AID Mission to Honduras
WHO	World Health Organization

INTERNATIONAL EYE FOUNDATION
HONDURAS

CHILD SURVIVAL IX PROJECT MID-TERM EVALUATION

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1
EXECUTIVE SUMMARY

The primary purpose of this Mid-Term Evaluation is to assess progress achieved to date and to identify necessary corrective actions in order to enhance the effectiveness of the implementation strategy and the potential sustainability of project benefits. The evaluation comes at a critical time when IEF is entering the final year of two consecutive three-year child survival grants. Responsibilities for child survival activities need to be fully transferred to collaborating institutions, and new strategic directions developed for IEF's future programming in Honduras. Thus, the results of this evaluation have significant implications for both down-scaling and transfer of current activities, plus reinforcement of key interventions areas which will be the focus of IEF's future programming.

Members of the evaluation team included: Lynn Johnson, external evaluator; Jeffrey Brown, IEF/HQ Child Survival Coordinator; Raul Gbmez, IEF's Country Director; Victoria Vivas, Child Survival Coordinator; Marylena Arita, Medical Advisor; Laura Molina, field supervisor, Teresa Bonilla, CESAMO social worker, and Martha Piedrasanta, IEF/Guatemala CS project manager. MOH Drs. Dagoberto Torres (CESAMO San Francisco) and Carlos Villalobos (National Chief of the MCH Division) also participated in the planning of the evaluation and the analysis of the results. The evaluation report was prepared by Lynn Johnson, with revisions of the draft done by the evaluation team prior to the departure of the consultant.

The evaluation took place in the city of Tegucigalpa, Honduras, from July 31 to August 9, 1995. IEF spent a total of $10,300 on the evaluation, including headquarters costs, field expenses, travel, per diem and consultant fees. Visits were made to **6** project communities where CHVs, mothers, breastfeeding counselors and community leaders were interviewed. In addition the team visited three MOH CESAMOs, three collaborating NGOs (ADRA, Project Hope and La Leche League), the head of the Foreign Relations Office of the MOH and the USAID Mission in Tegucigalpa.

The evaluation methodology included a KPC survey, which provided quantitative data on mothers' knowledge and practice and coverage information, in addition to qualitative data collected during the site visits. Results of the findings were analyzed by the evaluation team with input from MOH representatives and IEF staff.

IEF has developed a network of CHVs which provide education and some basic health services to mothers. The CHVs receive close supervision from IEF auxiliary nurses and backstopping from 3 field supervisors, a medical advisor and a CS coordinator. The results of the efforts of all categories of workers are impressive. Specific accomplishments include: vaccination coverage of children 12-23 months is close to 90% ; 77% of diarrhea cases in children age O-23 months are treated with ORT; 79% of children age O-23 months receive equal or more food during diarrhea episodes; 90% of children age 6-59 months receive one dose of vitamin A every 6 months; 88% of mothers can cite the danger signs for pneumonia; and 74% of mothers know that condoms can be used to prevent AIDS. In addition, breastfeeding support groups have been established in 18 communities, 16 community banks have been formed, and 6 fruit tree nurseries are being organized.

Project interventions have been applicable to the needs of the community and well coordinated with collaborating institutions. The quality of the one-on-one education provided by the CHV to the mother, by the IEF nurse to the CHVs, and by IEF staff to the CESAMOs has been excellent, as evidenced by the results of the KPC survey. Areas which need further strengthening include: supervision procedures; relationships between the CHVs and the CESAMO staff; the referral system; development of leadership skills at all levels; involvement of *patronatos* in child survival activities; and use of health data for informed decision making by ***parronaros*** and CESAMO staff.

As coverage rates for the majority of project objectives have already been reached, project staff should reduce the amount of time dedicated to mature interventions and concentrate efforts on areas not fully implemented to date. The evaluation team recommends the following: 1) EPI activities need to be strengthened in education regarding TT vaccination for women of child bearing age; 2) concentrate efforts to reduce the use of antibiotics for treatment of diarrhea cases, increase the distribution of ORS packets to stores, and emphasize education to mothers regarding correct home management during diarrhea episodes; 3) improve referral of pneumonia cases by CHVs, as opposed to upper respiratory tract infections; 4) implement activities with men and teenagers in the use of condoms and the provision of more condoms to CHVs for distribution; and 5) establish community banks and breastfeeding groups in each project community, and assist nursery owners to improve marketing of fruit trees, to assure future support from collaborating NGOs and as on-going incentives for CHVs.

Lesson learned which may be relevant to other child survival projects are: 1) the development of a close working relationship with the MOH is essential for sustainability of project activities; 2) quality, not quantity, should be the basis for selection of participants for income generation activities such as community banks and fruit tree nurseries; 3) more effective results can be obtained by dedicating effort to a few well implemented interventions, as opposed to many interventions which may have limited impact due an insufficient allocation of human and financial resources to guarantee their success; and 4) work with community leaders requires additional effort and time, however, their involvement in health decision making fosters sustainability of project benefits and serves as a source of continued support for local CHVs.

The evaluation results were shared with representatives of the MOH and IEF staff during the

final debriefing meetings. A copy of the evaluation report will be given to counterpart agencies and a summary of results will be given to community leaders and CHVs. Meetings to discuss the findings and to consolidate the sustainability plan will be held with all parties.

2
INTRODUCTION

2.1 Background

The International Eye Foundation (IEF) has been active in Honduras since 1981. The initial focus of the organization was curative and preventive eye care. In 1990 IEF was awarded a grant by USAID (CS-VI) to implement a Vitamin A for Child Survival Project, focusing on Vitamin A supplementation, nutrition education, promotion of vegetable gardens, primary eye care, control of diarrhea1 diseases (CDD) and immunizations (EPI). The project covered 25 peri-urban communities surrounding three MOH Health Centers (CESAMOs) in Tegucigalpa. The Metropolitan Health Region identified these centers and the neighboring communities as priority areas for IEF's Child Survival for Vitamin A project.

Beginning in October 1993, IEF was awarded a second three-year Child Survival grant (CS-IX) with a total estimated budget of $706,471. Project interventions were expanded to include management of acute respiratory infections (ART), income generation, and AIDS prevention along with the six original project components.

A baseline survey was carried out in August 1993, however the results have changed since they were presented in the DIP, due to errors in the first analysis, which were detected after the data was processed on EPI-INFO. Therefore the baseline data presented in this document differs from that found in the DIP. (See ANNEX G for a list of indicators with the revised data.)

The present Mid-Term Evaluation (MTE) takes place during the 23rd month of project implementation. The purpose of the evaluation is to review current progress and constraints of the implementation strategy and to identify possible modifications in project design in order to enhance the effectiveness and potential sustainability of the project interventions.

IEF selected an evaluation team which had extensive experience in USAID funded child survival projects in Central and South America. The team leader was Lynn Johnson, a public health consultant currently residing in Bolivia. Other members of the evaluation team included the IEF Child Survival Coordinator at headquarters, IEF's Country Director, the project's Child Survival Coordinator, Medical Advisor, one field supervisor, one MOH representative, and the manager of IEF's child survival project in Guatemala. (See ANNEX A for a list of team members.)

2.2 Project Description

The project impact area comprises 25 marginal urban communities in the jurisdiction of the CESAMOS of Las Crucitas, 3 de Mayo and San Francisco. Apart from the three CESAMOS

no other health services exist in the project area. These growing per-i-urban communities lack adequate infrastructure: local food markets are non-existent, there are no sewage systems, and only 16% of the communities have access to potable water systems. Government services in health, education, communication and transportation are severely limited. The majority of the population live at the poverty level, etching out a meager living as unskilled laborers in factories, businesses and construction sites. Only 20% of the women work in any paid activity and the majority have less than a 5th grade education. (IEF Baseline, 1993)

The project area was chosen due to the great need for primary health care services to complement the limited coverage of the MOH facilities. Primary causes of death are acute respiratory infections and diarrhea1 disease (46% of all child deaths) compounded by chronic malnutrition. UNICEF data indicate an infant mortality rate of 50 per 1,000 and a child mortality rate of 65 per 1,000 (MOH Family Health Survey, 1992).

Potential constraints to child survival activities unique to the project location include: low per capita income, unemployment, high levels of migration (12% annually), limited access to water and land, and insufficient government resources for health and basic services.

IEF has identified a target population consisting of 21,485 direct beneficiaries: children O-l 1 months = 1,236; 12-23 months = 1,398; 24-59 months = 4,773; and women 15-44 years = 10,605, new births = 3,473 (project census 1994).

The project design includes four complementary strategies to achieve the child survival objectives: 1) activities managed by the IEF health staff; 2) strengthening of local MOH facilities and service delivery; 3) collaborative efforts with other non-governmental organizations (NGOs); and 4) activities undertaken by community members. The project seeks to promote long term sustainability and continuity by enabling the community to actively and effectively participate in the different activities that will safeguard their health, through the training of mothers, community health volunteers (CHVs), and MOH personnel.

2.3 Evaluation Methodology

A detailed Scope of Work for the evaluation was initially prepared by the IEF Child Survival Coordinator (ANNEX B), which outlined the objectives and schedule of the MTE. The evaluation also responds to the USAID" 1995 Mid-Term Evaluation Guidelines" (ANNEX C). Based on these requirements, the evaluation team prepared an evaluation schedule and data collection forms (ANNEX D).

A number of instruments were developed for the collection and analysis of data (also included in ANNEX D). The majority of these were used during the visits to project communities and referral health facilities. Field visits and observations were made to six communities, representing the three MOH areas where the project is implemented. The communities were selected at random by the evaluator. If the community chosen did not have all nine project components, the next community on the list with these components was chosen.

Two teams were formed to conduct the community visits. Structured interviews were held with community leaders from 3 "*patronatos*" (FORM 1). Each team interviewed community health volunteers (FORM 2), mothers in charge of breastfeeding support groups (*madres consejeras*) (FORM 10), mothers (focus groups and random home visits) (FORM 9), and individuals involved in fruit tree nurseries (FORM 8). In addition representatives of 3 community health banks were interviewed. At the institutional level, interviews were held with representatives of the 3 CESAMOS (FORM 3), and collaborating PVOs (FORM 12). The teams interviewed a total of 34 CHVs, 82 mothers in focus groups, 10 mothers through random home visits, 5 *madres consejeras*, 9 community leaders, 3 community bank members, 4 individuals working with nurseries, and 8 CESAMO staff. (See ANNEX E for the list of contacts.)

The evaluation team held structured meetings to study implementation, management and sustainability issues (FORMS 4-6). Finally a meeting was held to summarize the results and conclusions and to document key recommendations (FORM 7). Debriefings were held with the USAID Mission and representatives of the Ministry of Public Health. A list of documents reviewed is provided in ANNEX F.

3
PROJECT INTERVENTIONS

3.1 IMMUNIZATIONS (EPI)

Problem Statement

According to the National Health and Epidemiology Survey of 1991/92 (ENESF), the proportion of childhood deaths due to vaccine-preventable diseases appears relatively low, especially when compared with deaths associated with maternal health, acute respiratory infections and diarrhea1 disease. However, tuberculosis, diphtheria, whooping cough and polio may also be included in the category of respiratory illnesses.

IEF's baseline survey (1993) reported 84.6% of children age 12-23 months to be fully immunized. The dropout rate for DPTI-DPT3 was 2.4%. Almost all mothers (91.3%) could demonstrate their child's vaccination card, although 42% did not know at what age the measles vaccine should be correctly applied. Approximately 60% of births were protected by tetanus toxoid (TT) immunization. Only 37% of mothers knew that TT was to protect the child and mother against tetanus.

Proposed Obiectives and Strategy

The Detailed Implementation Plan established objectives in terms of coverage targets for children O-12 months with the completed series of vaccinations, (i.e. BCG, DPT3, OPV3 and measles). In addition, coverage of women age 15-49 years was projected based on at least 2 doses of tetanus toxoid. The project's immunization objectives are as follows:

1. 80% of children O-12 months of age will be completely immunized in the impact areas during 1993- 1996.

2. 70% of women of child-bearing age (15-49) will receive two or more doses of tetanus toxoid in the impact areas during 1993- 1996.

The project will support the MOH expanded program of immunizations through community education and tracking of women and children. The MOH provides year-round vaccination services at fixed sites (CESAMOS) and through mobile teams during trimester campaigns. High risk is defined as those children under two who have not received all their vaccines, women without 2 doses of tetanus toxoid, no-shows and drop-outs.

The USAID Technical Review of the DIP expressed concern that the target groups should include single parent families, families with a history of infant/child death, mothers of low socioeconomic status, mothers of low literacy, and mothers with children without health cards. The project will target all women of child bearing age and thus covers those women with special problems.

Findings

Data collected during the knowledge/practices/coverage (KPC) study undertaken for the MTE in July 1995, show a slight increase in population coverage for all antigens. The following chart shows comparisons from the baseline (1993) and the recent KPC study for children age 12-23 months and women age 15-49 years. (See ANNEX G for a summary of the KPC survey results.)

Children Age 12-23 Months

INDICATOR	BASELINE 1993	KPC JULY 1995
DPT1	89.0	92.0
DPT3	86.8	88.0
OPV1	89.0	92.0
OPV3	87.6	88.0
MEASLES	86.0	92.0
BCG	88.0	90.4
DPT3-DPT1	2.4	4.3
COMPLETE	84.6	88.0

Women Age 15-49 Years

INDICATOR	BASELINE 1993	KPC JULY 1995
TTV2	60.0	36.0

The number of mothers who can show vaccination cards for their children has increased from 91.3% to 93.6%, and those who have prenatal cards has increased form 63.0% to 71.7%. Interviews with community health volunteers showed accurate knowledge regarding the key EPI messages, and 85% could correctly repeat the vaccination schedule. Mothers interviewed during the community visits indicated that many women do not want to be vaccinated against tetanus due to fear of the vaccine or because it is painful.

Discussion and Conclusions

Effectiveness

The efforts to improve and maintain vaccination coverage have been very effective, especially regarding childhood immunizations. The Ministry of Health is delivering adequate vaccination services on a regular basis. Although very few cases of neo-natal tetanus have been reported in the project areas, vaccination coverage rates for women of childbearing age need to be increased to provide adequate protection.

Relevance

The current prevalence of vaccine-preventable diseases is not nearly as severe as ARIs, diarrhea1 disease and dehydration, complications of pregnancy and childbirth, or malnutrition. The regular EPI activities of the MOH and the educational and tracking activities of community health volunteers indicate that these disease rates will likely remain under control with minimum direct support from IEF.

The evaluation results show that vaccinations are not only acceptable but are valued and in demand by families in the project area. Community members and health workers actively promote and monitor vaccination coverage, and will likely maintain high demand on the MOH to provide continuous service.

Specific Recommendations

* The evaluation supports without reservation the current IEF strategy to support the MOH through education, promotion and tracking activities. Due to the low level of TT coverage, educational efforts should be strengthened, including the importance of TT for protection from cuts and wounds and the fact that the antigen protects children as well as women. Educational messages given by the mobile loudspeaker and the radio program, "El Medico y Su Salud", should emphasize the importance of TT immunizations.

* Women with special problems such as low literacy, history of infant/child death, etc. can be identified by the CHV in the family register, to be sure that they receive adequate vaccination coverage.

* Since this is a mature intervention which is well implemented by the MOH, it is recommended that the project concentrate a minimum amount of effort during the last year of implementation. IEF should maintain a supportive role and concentrate on assisting the MOH to improve TT coverage. Opportunities should not be missed to vaccinate mothers when they bring their children to the CESAMO or during community based-campaigns.

3.2 CONTROL OF DIARRHEAL DISEASES (CDD)

Problem Statement

The 1991/92 ENESF Survey reports the prevalence of diarrhea for children age O-59 months at 22%, in the per-i-urban areas surrounding Tegucigalpa. Of these cases, 67% lasted less than four days, while 21% lasted as long as six days. The 1987 National Nutrition Survey indicates that each child suffered approximately 7.3 episodes of diarrhea per year.

The 1993 Baseline Survey indicated that close to half (48.3%) of children age O-23 months were treated with ORT during episodes of diarrhea. However, as many as 57.3% of mothers gave children antibiotics or other inappropriate medicines during the diarrhea episode.

Prooosed Obiectives and Strategy

The project's objectives for diarrhea1 disease control are as follows:

1. 65% of children less than 24 months of age will receive appropriate ORT fluids (ORS & home fluids) during episodes of diarrhea during 1993-1996.

2. Decrease from 60% to 40% the number of children less than 24 months of age who receive antibiotics and other medicines during episodes of diarrhea.

The DIP called for the establishment of community ORT Units. This strategy has been changed based on the findings of an investigation of the effectiveness of community oral rehydration units in Honduras by BASICS/USAID (1994). The recommendations of this study include: 1) replace the concept of the ORT Unit with the idea of a CHV trained in the management of diarrhea; 2) improve IEC strategies; 3) clarify the role of the MOH vis-a-vis the volunteer, and 4) create a system of incentives for the CHV.

In accordance with the above mentioned recommendations, the project, in coordination with the CESAMOs, will train and supervise volunteers to provide education to mothers, distribute ORS packets and refer children who are in danger of dehydration to MOH facilities. Education will be given through home visits and group demonstrations of correct ORS preparation. Mobile loudspeaker messages and radio programs will reinforce the educational messages given by the volunteer. In addition, pharmacy and store owners that sell anti-diarrhea1 medicines and antibiotics will be educated regarding correct treatment of diarrhea with ORS.

Findings

The 1995 KPC Survey indicates that more children age O-23 months are receiving ORT during cases of diarrhea, and fewer are being treated with antibiotics. The following chart shows comparison data for the CDD indicators:

Children Age O-23 Months

INDICATOR	BASELINE 1993	KPC JULY 1995
% of children who received ORT during the last episode of diarrhea	48.3	77.1
% of children who received antibiotics during the last episode of diarrhea	57.3	40.6
% of children who received ORS during the last episode of diarrhea	37.1	58.3
% of children who received the same or increased amounts of liquid during the last episode of diarrhea	74.6	89.3
% of children who received the same or increased amounts of food during the last episode of diarrhea	51.9	79.4
% of children who received equal or increased amounts of breast milk during the last episode of diarrhea	62.9	65.6

All the CHVs interviewed could explain how to prepare and administer ORS, recite the danger signs for dehydration, and repeat the key educational messages for mothers. All the CHVs correctly indicated correct referral procedures. Volunteers stated that they receive the following benefits for their work: training and education, an opportunity to serve the community, free medical attention at the CESAMO, and the appreciation of the community.

The CHVs indicated that most of the supervision is provided by IEF auxiliary nurses who visit the volunteer about once a week. Only 6 volunteers stated receiving supervision from the CESAMO. CHVs indicated that the supervision visits included education, review of home registers, and joint visits to mothers. Resupply of ORS packets takes place at monthly meetings at the CESAMO, however IEF staff are responsible for the distribution of these supplies to the CHV.

All of the mothers (92) who were interviewed, including the random home visits, stated that a volunteer lived in their community and only 6 had not been visited by the volunteer. It is important to note that the mothers who had not been visited were from the group of randomly selected houses.

Discussion and Conclusions

Effectiveness

Data from the KPC Survey indicate that targeted high risk groups are being reached effectively, as the use of ORS has increased since baseline data was gathered in 1993. In addition, the process of supervision, training and supply of CHVs with ORS packets has proven effective in maintaining successful functioning of the community health volunteers.

So far, the strategies implemented by the project have proven effective regarding the first objective for this intervention which calls for 65% of the cases of acute diarrhea occurring

during the last 2 weeks in children aged O-23 months to be treated with ORT. Results of the KPC Survey indicate that 77.1% of diarrhea cases which occurred within the last two weeks received ORT. In addition, the percentage of mothers who administered antibiotics for diarrhea episodes decreased from 57.3 % to 40.6%) nearing the project objective of less than 40%.

The KPC Survey results indicate that educational strategies have been effective, as a majority of children age O-23 months now receive the same or increased liquids during diarrhea episodes. In addition, there as been a 20% increase in the number of children age O-23 months who receive ORS. However, the number of children who receive the same or additional breastfeeding has not increased significantly. (See above chart for comparison data.)

Relevance

The major causes of illness and death due to dehydration in the project service area include: lack of potable water, poor or non-existent sewage systems, lack of hygiene in and around the home, and inadequate management of diarrhea cases by mothers. CDD activities emphasize education of mothers regarding proper home management of diarrhea and training of CHVs to provide adequate diagnosis, treatment and referral procedures, both of which have proven effective in diarrhea1 disease control at the community level.

Specific Recommendations

* As coverage rates for the project objectives have already been reached, project staff should reduce the amount of time dedicated to CDD and continue only with maintenance activities to keep the CHVs active. Staff time should be directed to developing other interventions not fully implemented to date.

* Where possible the CESAMO staff could take over this intervention and coordinate directly with the CHVs regarding training, supervision, supply, reporting procedures and incentives.

* Further training of CESAMO personnel for supervision skills should be a priority during this last year.

* Although the project has reached its objective in reducing the use of antibiotics for the treatment of diarrhea cases, inappropriate use of medications continues to be a problem. It is recommended that correct treatment of diarrhea be prioritized in educational activities and messages.

3.3 NUTRITIONAL IMPROVEMENT

Problem Statement

General Nutrition

Although malnutrition does not appear as a direct cause of childhood death in the National Family Health and Epidemiology Survey (1991/92), it is a common denominator in the downward cycle of infection, illness and death brought on by other diseases. Metropolitan Health Region data for marginal urban communities (ENESF 1991/92) indicate that 36% of children under five are chronically malnourished (> 2 S.D., height for age) and 17.5% acutely malnourished (> 1 S.D., weight for height).

The IEF's 1993 Baseline Survey did not establish prevalence rates, but concentrated on knowledge and practices of mothers with children under five years. A majority of women with children under two (68%) continued to breastfeed their children, and 77% began to breastfeed within the first eight hours after birth. Only 23.5% of mothers with children less than four months of age reported exclusive breastfeeding. By the time the child reaches four months only 11% of mothers will be exclusively breastfeeding. The ENESF Survey indicates that 8% of women exclusively breastfeed their children through the first four months of life.

Regarding complementary feeding, the IEF Baseline (1993) indicates 98% of 5-8 month olds receive semi-solid or solid foods. During diarrhea episodes 62.9% of mothers continue as normal or increase breastfeeding and over half (51.9%) feed children the same amount or increase solid foods. Typical weaning foods include cereals, yellow vegetables, eggs and cheese. Salt, sugar/honey and oil is frequently added to other foods during the weaning period.

Vitamin A Deficiency

Increased risk of mortality and morbidity among children is reported to be associated with clinical vitamin A deficiency (IVACG 1989). Prolonged deficiency leads eventually to partial or total blindness. Young children and women who experience repeated pregnancies and lactations are likely to be at greatest risk of being marginally or clinically deficient. Studies reported by VITAL show that vitamin A supplements can reduce infant mortality by as much as 30% in populations with a high prevalence of mild to moderate vitamin A deficiency.

A national survey conducted by the MOH in 1987 (N= 111, Health Region #l) that 14.4% of children age 6 months to 7 years of age showed circulating retinol levels less than 20 ug/dl. Measurements under 20 ug/dl are considered to be low (lo-19 ug/dl) or deficient (O-9 ug/dl). The IEF 1991 Baseline Survey (N=205) among children age 2-6 years reports that 14% had low levels of immunologically active retinol-binding protein (2-3 mg/dl), 48% were considered marginal (1-2 mg/dl) and 9% were severely deficient (0- 1 mg/dl).

Regarding mothers' knowledge and practice, IEF's Baseline Survey indicates that approximately one third of mothers know that vitamin A helps prevent blindness (28%), yellow fruits and/or

vegetables contain vitamin A (37.3%). However only 21.4% could identify 2 or more food sources of vitamin A. The majority of mothers give their children eggs and/or cheese (87.1%) and 62% feed children age 5-9 months yellow vegetables. Only 7.1% feed their children green or leafy vegetables.

Food Production

IEF baseline data indicate that yellow fruits are well-accepted and generally consumed by both adults and children. Only 12% of families had a garden, but the majority would be willing to purchase fruit trees if made available in the community.

Income Generation

Project communities are poor with limited access to work opportunities, especially for women, the majority of whom have less than a 5th grade education and do not engage in any income generating activity (74 %). As income increases so does the quality and quantity of food consumed by the family.

Proposed Obiectives and Strategy

In the Detailed Implementation IEF has documented several interventions which contribute to nutritional improvement, including: 1) breastfeeding and correct feeding practices during illness (ARI, diarrhea1 disease); 2) prevention of vitamin A deficiency; 3) screening for signs of xerophthalmia; 4) increased consumption of vitamin A rich foods through establishment of fruit tree nurseries; and 5) income generation activities to increase family purchasing power and thus increase nutritious food consumption through the organization of community banks. Community banks also offer an incentive to CHVs and provide a health education component in all the other project interventions.

Objectives for the above mentioned components are as follows:

1. 35 % of lactating women with children under four months of age will exclusively breastfeed their infants.

2. 40% of children are fed the same or more often during episodes of diarrhea.

3. 80% of children 6-59 months of age will receive vitamin A supplementation (one dose) every six months in the impact areas during 1993-1996.

4. 60% of women will receive vitamin A supplementation within one month after delivery.

5. 75% of children under five years of age are provided with annual eye examinations and treatment/referral.

6. Increase availability of food sources of vitamin A by establishing six fruit tree nurseries.

7. Over 200 families plant and maintain fruit trees.

8. Increase family income by assisting with the establishment of 15 community banks to assist women with small business development in project communities.

To improve feeding practices, the project will establish breastfeeding support groups in each community, with assistance form La Leche League. The groups will provide emotional support and practical assistance to help women exclusively breastfeed their children for the first four months of life. CHVs will be trained to provide education to mothers regarding basic nutrition and the importance of breastfeeding.

To prevent vitamin A deficiency, the project will distribute vitamin A capsules directly through its volunteer network and assist the MOH in capsule distribution at the CESAMOs. Eye screening activities will take place during joint MOH/IEF vaccination and vitamin A campaigns. IEF auxiliary nurses and MOH personnel will be trained to provide these services. Children in need of further diagnosis/treatment will be referred of the Las Crucitas Eye Clinic. The consumption of yellow fruits will be promoted by establishing fruit tree nurseries in six communities. Seedlings will be sold at a slight profit to promote the sustainability of these nurseries as income-generating businesses. IEF will train and supervise CHVs to distribute and track vitamin A supplementation and interested individuals will be trained and supplied to establish the nurseries.

Community banks will be established in collaboration with Project HOPE. CHVs and women with children under five will be given priority to participate in the bank program. Project staff will be trained by HOPE to provide education and training to the bank members.

Findings

Following is a summary of the results of the 1995 KPC Survey indicators for nutrition and vitamin A.

INDICATOR	Baseline 1993	KPC 1995
% of children age O-3 months exclusively breastfed	23.5	31.8
% of children age 12-23 months who received one dose of vitamin A supplementation every 6 months	59.9	89.6
% of postpartum women given vitamin A within 30 days of delivery	----	65.7
% of children over 5 months of age who rcccivc vitamin A rich foods twice weekly	60.4	71.7
% of women who can state two food sources of vitamin A	21.4	84.0

The project has established 18 breastfeeding support groups to date, in coordination with La Leche League. The *five madres consejeras* interviewed indicated that they meet once a month with their group and provide education and support to the group members. The *madre consejera*

received supervision and support from IEF auxiliary nurses on a weekly basis, and visits from La Leche League approximately once a month.

Interviews with CHVs indicated an excellent knowledge of vitamin A supplementation protocol and correct educational messages. Regarding breastfeeding messages 70% cited giving the message that children should be exclusively breastfeed during the first 6 months of life. The remainder were not clear regarding the message. Eye screening activities have reached 53.7% of the children in the target area.

In collaboration with Project LUPE, 6 fruit tree nurseries are in the process of being established. Participants have received training and an allotment of 100 seedlings. So far more than 200 seedlings have been sold. Interviews with the participants indicated a need for assistance in accounting procedures and marketing the trees. As this component is not fully developmented, these activities are anticipated in the coming months.

A total of 16 community banks have been established to date, and interviews with bank members indicate that these are functioning well. Activities of the members include food production, commercial activities, and sewing.

Discussion and Conclusions

Effectiveness

The results of the KPC Survey indicate excellent coverage of vitamin A supplementation and a high rate of knowledge and consumption of vitamin A rich foods, showing that the project strategy has been effective in these two areas. Exclusive breastfeeding has improved indicating that educational activities and the work of the *madres consejeras* is making a difference. Both the fruit tree nurseries and community banks have the potential to improve nutrition indirectly, however it is too early to assess the effectiveness of these initiatives.

Relevance

The focus of the project's vitamin A strategy contributes to long-term solutions to the problem of an inadequate vitamin A status through improving dietary intake of vitamin A (e.g. education, vegetable/fruit gardens). The emphasis on exclusive and continued breastfeeding will not only protect children from other diseases but is also a good source of preformed vitamin A and fat that are easily absorbed by the nursing infant. Seldom does clinical vitamin A deficiency occur while breastfeeding continues. Since the MOH has recently included vitamin A supplementation as part of its basic program for child health, this intervention will be sustainable after the project ends. Both the community banks and the fruit tree nurseries are relevant in that they provide income generation opportunities and educational activities that contribute to improved nutrition.

Specific Recommendations

* IEF is training elementary school teachers to screen children and refer cases to MOH facilities for treatment, through its Childsight program. It is recommended that this project establish a referral system for cases detected by the teachers. This project will function in the same communities as the child survival project and can provide continuity for the eye screening activities which are currently implemented in conjunction with the CESAMO Las Crucitas.

* A "madre consejera" should be selected and trained in the remaining eight communities without breastfeeding support groups to assure continued supervision from La Leche League and incentives. La Leche League is negotiating with the MOH to provide medical social security benefits to all *madres consejeras* and their children under 5 years of age.

* The CESAMO should participate in the coordination between IEF and the La Leche League to assure continuation of support to the "madre consejera" after the project ends. The CESAMO could assign this responsibility to specific staff member, preferably a nurse.

* Project HOPE plans to continue in the project communities with their community bank program. It is recommended that the project coordinate with HOPE to establish a bank in each of the 25 communities. Since the banks focus on health education and income generation this would provide continuity of educational messages and incentives for the CHVs who participate in the banks.

* As coverage rates for the project objectives for vitamin A supplementation and knowledge of foods rich in vitamin A have been achieved, project staff should reduce the amount of time dedicated to these activities and concentrate on the strengthening of fruit tree nurseries and community banks. Responsibility for vitamin A supplementation and support of the breastfeeding groups should be transferred to the CESAMOs.

* It is recommended that IEF investigate the feasibility of including target communities in a new MOH national infant and child health program (SAIN), as a mechanism for involving CHVs in a permanent MOH structure which will organize and supervise community based growth monitoring using volunteers.

3.4 MANAGEMENT OF ACUTE LOWER RESPIRATORY INFECTIONS (ALRI)

Problem Statement

Acute lower respiratory infections account for over 22% of all deaths of children under five in Honduras (ENESF, 1991/92). The Honduras Center for Health Information (1991) estimates the under five ALRI mortality at 89 per 1,000 live births, and ALRI specific mortality at 20 per 1,000. MOH Metropolitan Area officials estimate that less than 10% of ALRI episodes are treated in health care institutions.

Regarding mothers' knowledge and practice, IEF's 1993 Baseline reports that 62% recognize rapid or difficult breathing as a sign of probable pneumonia, and 77.9% reported seeking assistance from a health center, clinic or CHV for their child's respiratory illness. Only 6%, however, indicated chest in-drawing as an important danger sign.

Proposed Obiectives and Strategy

The project's ALRI objectives follow:

1. 80% of MOH CESAMO staff, project staff and volunteers can correctly cite the MOH ALRI case management protocol by the end of the project.

2. 70% of mothers with children O-24 months of age can correctly identify danger signs of pneumonia and explain when to refer their children to the nearest CESAMO in the impact areas.

The project will increase the level of training of both CHVs and CESAMO staff in the referral and treatment of ALRI cases in accordance with the WHO/MOH protocol. CHVs will educate mothers to recognize the danger signs of ALRI and to seek timely professional help. IEF auxiliary nurses and supervisors will train the CHVs and then supervise the training of mothers in the field. IEF's Medical Advisor will provide training directly to staff at the three CESAMOs.

The USAID Technical Reviewers recommended that the project carry out an ALRI baseline and ethnographic survey to obtain information on parents knowledge regarding treatment procedures. A similar study was undertaken in Honduras by HEALTHCOM, titled "Nothing to Sneeze At" (1991). The project is using the information from this study to develop appropriate ALRI messages.

Findings

Results of the 1995 KPC Survey indicate that 87.7% of mothers can state the danger signs for probable pneumonia (rapid breathing and chest in-drawing), and ***83%*** seek attention from a health volunteer, health center or clinic.

All of the CHVs interviewed could state some of the danger signs of pneumonia and were able to repeat the key messages mothers should receive. Of the 34 CHVs interviewed, only 2 did not know the procedures for making referrals to the CESAMO.

Discussion and Conclusions

Effectiveness

Data from the KPC Survey indicate that the majority of mothers are aware of the danger signs for probable pneumonia, indicating that the one-on-one education provided by the CHV has been effective. However, the high number of cases referred to the CESAMOs for AR1 indicates that all children with any type of respiratory illness were classified as cases of ALRI. This shows that education of mothers and CHVs regarding early diagnosis and treatment needs to be improved so that only cases with rapid breathing and/or chest in-drawing are referred to the CESAMOs.

Relevance

Although education activities have been effective in raising levels of knowledge regarding the danger signs for pneumonia, knowledge alone is not sufficient to change mothers' behavior. Even though many mothers flock to the CESAMO for treatment for common colds and other upper respiratory tract ailments, there are cases which arrive at health facilities too late to save the child's life.

Most parents cannot recognize the difference between common colds and ALRIs, nor do they seek timely, adequate treatment. If a child becomes sick at night or on weekends the only option is the central hospital. Transport is difficult at night, limiting access to treatment centers. No community based treatment programs are operative, as only trained health personnel can administer antibiotics.

Specific Recommendations

* The project should continue its strategy to educate mothers regarding early diagnosis and referral of potential pneumonia cases. Two important factors in case fatality are the patients age (more dangerous in infants) and the severity of the pneumonia at the beginning of the treatment (more lethal if severe).

* The knowledge and skills of CHVs needs to be improved in the proper referral of children with probable pneumonia, to decrease the number of cases referred to the CESAMO for upper respiratory tract infections.

* Additional educational methods should be explored by the project for use with both the mothers and CHVs including radio, mobile loudspeaker messages and participatory learning techniques and demonstrations (for example: demonstrations of lung functioning using a balloon).

* The referral network needs to be strengthened, especially in terms of reception of referrals at the CESAMOs and counter-referrals. Some CHVs reported cases being returned to the community because they were not received by the CESAMO staff.

3.5 HIV/AIDS PREVENTION

Problem Statement

Over one half (55%) of all AIDS cases in Central America are found in Honduras, where 60,000 people are infected with HIV (MOH 1993). Over 78 % of all cases are attributed to heterosexual sexual relations, while homosexual relations account for slightly less than 14% of all cases. Relations with prostitutes are a common high risk behavior. Men accounted for 70% of all diagnosed AIDS cases in 1992.

Proposed Objectives and Strategy

The objective for this component, as revised in the Annual Report (1994), is as follows:

> 90% of parents (both men and women) identify condom use as a principal means of preventing AIDS.

MOH personnel, IEF staff, and community volunteers will be trained in AIDS control. Volunteers will provide education to families and distribute condoms during home visits. Community leaders will be enlisted to support the community based distribution activities. Men will be specially targeted for education efforts and condom distribution during home visits.

The AID Technical Review suggested that more information be gathered regarding AIDS. IEF will use focus groups to ascertain data such as: do men regularly use condoms with prostitutes, do they have their wives consent, are such topics discussed openly between men and women, what are men's and women's attitudes towards use of condoms, etc.

Findings

The 1995 KPC Survey reports that 74.3% of mothers know that condoms can be used to prevent AIDS. During visits to mothers the evaluation team found that men don't like to use condoms, and when the topic is discussed, they affirm their fidelity. It was also observed that the CHVs distribute few condoms (they are only supplied with 20 at a time), and there are often stock-outs at the CESAMOs.

Discussion and Conclusions

Effectiveness

The educational strategy has been effective in raising mothers' knowledge, however it has not been effective in reaching high risk groups, namely men and adolescents.

Relevance

The educational component fostered by the project is a first step to increasing mothers' awareness of the use of condoms to prevent AIDS. However, the real problem here is not with women but with men. Since the KPC survey did not collect data regarding men's knowledge, the project does not know the status of achievement towards this objective. The question the project needs to ask is "is knowledge of prevention methods enough?"

Specific Recommendations

* Re-design the educational program to include both men and teenagers. Include demonstrations on how condoms should be used.

* Increase the amount of condoms distributed by CHVs.

* The MOH is currently implementing a national AIDS program. It is recommended that the project coordinate activities at the CESAMO level in an effort to strengthen this intervention.

4
IMPLEMENTATION ISSUES

4.1 Community Education and Social Promotion

The primary focus of IEF's child survival activities is health education and promotion, occupying approximately 70% of effort, as opposed to 30% spent on service delivery. Educational activities carried out by the project include: broadcasting of messages in communities through a loudspeaker attached to a vehicle; radio spots on the program ***El Médico y Su Salud***; educational talks and presentations for CHVs by auxiliary nurses; meetings of CHVs with groups of mothers; home visits; and use of informational posters which are given to each family and put up in the home.

The project has used many educational materials and messages developed by the MOH which have already been tested. In cases where IEF developed the content themselves, the messages were tested and refined using focus groups. The project has developed procedures for validation of messages for vitamin A, CDD, ARI and EPI interventions. The project assures that messages are consistent by working with the same protocol recommended by the MOH for each intervention. A list of basic messages is given to each CHV and all educational materials and presentations emphasize the same messages.

The project distributes posters for CDD, EPI and ARI; vitamin A information sheets; posters about vitamin A rich foods; cookbooks; guides for breastfeeding and weaning; and flip-charts developed by the MOH. All the materials were pre-tested and are appropriate for the educational level of the audience. The project has implemented an individualized approach to education through one-on-one education between the CHV and family. Participative methodologies are used in group training activities for MOH and IEF staff and for training CHVs. The project measures the level of learning through written pre and post tests, KPC surveys and through focus group discussions.

4.2 Human Resources

Sixteen professional staff are working with the project including: IEF Country Director, CS Coordinator, Medical Advisor, field supervisors (3), auxiliary nurses (11) and an ophthalmologist. In addition 292 CHVs dedicate one to two days a week to project activities. The number and mix of individuals is adequate to meet the managerial, technical and operational needs of the project. The IEF project staff have distributed responsibilities efficiently and coordinated closely with MOH personnel, therefore there is little duplication of effort.

The CHVs are responsible for visiting each family in their neighborhood once a month. Each CHV is responsible for approximately 30 families. Duties of the CHV include: manage a family register system; monitor vaccination coverage, distribute vitamin A capsules, ORS and condoms; provide education to the mother and her family; and refer cases of diarrhea with dehydration and pneumonia to the CESAMO. The main responsibility of the CHV is performing the home visits and education. The workload is not too heavy if the CHV does not work outside the home. Drop out rates are high (12 %) due to high migration rates (both influx and out-flow of families), and the need for many women to take full time jobs in the center of town.

IEF staff have received extensive training in each of the project interventions. Additional topics include: management information systems, community census procedures, participative education methodologies, KPC surveys, and focus groups. MOH staff have been trained in the project interventions and have received some training in participative learning, motivation and organization, and quality control. CHV training has concentrated on basic messages for each of the interventions. (See training chart in ANNEX H.) The training methodology and duration has been appropriate for each type of worker, however there is a marked dependence of the CHV and the MOH auxiliary nurse on IEF field staff. During this last year of project implementation, more emphasis should be given to management skills to prepare both MOH staff and CHVs to undertake child survival activities independently. Regarding evaluation of training, pre and post testing has not been done for CHVs since March 1995, although IEF staff report that focus group discussions and site observations indicate adequate levels of knowledge and skills. Pre and Post test results with MOH personnel indicate an increase from an average grade of 50% to 90% respectively. (See ANNEX H.)

4.3 Supplies and Material Resources

Supplies for the interventions implemented by CHVs include ORS packets, condoms, vitamin A capsules, training materials and forms for the information system. IEF has assured that the MOH provides adequate supplies of ORS packets and vitamin A, however the quantity of condoms distributed to CHVs is insufficient. All forms are provided to the CHV by IEF staff. Conversations with MOH personnel indicate some problems at the CESAMO level with supply of some drugs and condoms. The problem with condoms is one of distribution from the central level to the CESAMOs, and CESAMO directors are addressing this problem. All of the CHVs visited had adequate stocks of ORS packets and vitamin A. The ORS packets are given to mothers who seek assistance from the CHV for diarrhea cases, and vitamin A capsules are distributed to mothers through home visits. The supplies provided to CHVs are appropriate for their assigned duties.

4.4 Quality Assurance

The project has identified the specific knowledge and skills essential for mothers, CHVs and MOH staff for each intervention, and training events have been programmed accordingly. The project began with pre and post testing for both CHVs and MOH personnel, but has only continued the testing with the MOH. Results of the testing indicate a significant improvement in participants' knowledge levels. The results are also used by trainers to improve the

educational program. (See ANNEX H for results.) Evaluation of knowledge and skills of mothers was measured in the recent KPC Survey, showing a marked improvement since baseline data was collected in 1993. (See ANNEX G for results.) Interviews and focus group discussions with mothers, CHVs and auxiliary nurses indicated adequate knowledge regarding key health messages. The communication skills and counseling skills of the IEF Coordinator, supervisors and auxiliary nurses are excellent. IEF consider that the skills of CHVs range from fair to good, as evidenced by the impressive results of the recent KPC Survey.

IEF has been implementing a quality assurance project with all three CESAMOs and the Maternal-Infant Hospital since January 1995. This project has inspired CESAMO directors to undertake quality control investigations with their staff. IEF plans to follow-up this effort with one day workshops emphasizing supervision and referral procedures.

4.5 Supervision and Monitoring

Supervision of project workers is carried out in the following manner. Each auxiliary nurse supervises 25-30 CHVs during community visits, and the 11 auxiliary nurses are supervised by two field supervisors in the community. The field supervisors are supervised by the CS Coordinator, who also supervises the Community Banks and Fruit Tree Nursery Supervisor. The IEF Country Director supervises both the CS Coordinator and the Medical Advisor. IEF headquarters personnel supervise the Country Director through reports, phone and fax communication, and quarterly visits to the project. The ratios of supervisors to those being supervised is appropriate. The following chart shows the amount of time dedicated to different aspects of the supervision visit:

Time Dedicated to Different Supervision Task

Supervisor	Person Supervised	Contacts per month	Performance Evaluation	On-the-job Education	Administration	Counseling support
Auxiliary Nurse	CHV	3	0%	45%	5%	50%
Field Supervisor	Auxiliary Nurse	3	5%	45%	5%	45%
CS Coordinator	Field Supervisor	8	5%	45%	20%	30%
Country Director	CS Coordinator	4	5%	30%	50%	15%
Country Director	Medical Advisor	5	5%	30%	50%	15%
IEF/HQ Program Director	Country Director	4	5%	25%	40%	30%

Supervision is used to assess and improve the quality of services provided by those who are supervised through immediate feedback during the supervision visit, review of monthly community reports to detect problem areas, and through training events which are planned, based on the results of the supervision process. Although the system works relatively well, results of the supervision of CHVs are not tabulated (a form has been developed, but is not always used), and staff consider the supervision at this level to be inconsistent.

Although IEF supervision has been adequate for assuring quality of service for each intervention, CESAMO staff have had minimal involvement in the supervision of CHVs. If project benefits are to be sustained, the joint development of workable supervision strategies is imperative. Efforts should be re-directed to plan and implement a supervision plan with CESAMO personnel.

4.6 Referral Relationships

Referral sites include the three CESAMOs for primary care and the *Hospital Escuefa* and the Maternal-Infant Hospital for higher levels of attention. The Las Crucitas CESAMO provides eye screening and cases are referred to the *Hospital* San *Felipe*. The quality of services is good at all the referral centers, although medications are not always available. Medications can be purchased by the patient or a family member at a pharmacy. All of the referral centers are within one hour's distance by bus. Referral sites are often used for health problems that could be treated at home, such as common colds and diarrhea without signs of dehydration, resulting in a heavy burden of patients at the CESAMOs.

Relationships between the CESAMOs and the communities need to be improved, especially at the CESAMO Las Crucitas. When a member of the CESAMO staff is not chosen to work directly with CHVs, or the designated person does not have a positive attitude, CHVs mentioned that they have not always been treated with courtesy and respect. This is a key factor in volunteer continuity, since appreciation for his/her work is an important incentive. The social workers at the CESAMOs 3 de Mayo and San Francisco have made an effort to assist the CHVs, thus improving communication between community and each CESAMO. Information is not fed back to the community by the CESAMO, and counter referrals are often not given. The project is planning to improve referral relationships during the coming year as part of the sustainability plan developed during the MTE. (See Chapter 6.)

5
MANAGEMENT ISSUES

5.1 Project Design

All of the project interventions are relevant to the needs of the project area and are being implemented in accordance with MOH norms. EPI, CDD, AR1 and vitamin A have been effective and attained a high coverage in target communities. IEF should concentrate its efforts over the next year on (1) consolidating the transfer of EPI, CDD, AR1 and vitamin A activities to the CESAMOs and (2) on strengthening, jointly with the MOH and collaborating NGOs, the AIDS and nutritional improvement strategies (e.g. breastfeeding support groups, fruit tree nurseries and community banks).

The project has not changed its target area, however the number of beneficiaries was adjusted after the completion of a community census in 1994. (See Chapter 2 for population data.) The CDD strategy was changed in accordance with the results of a BASICS/USAID investigation on the effectiveness of ORT Units. The project management was willing to make the appropriate changes which were justified based on the results of the BASICS investigation.

IEF is in a period of transition from a fully implemented CS project with nine interventions to the transfer of responsibility for project activities to the MOH and collaborating NGOs. During the coming year direct delivery, supervision and logistic support of services at the community level will be gradually replaced by developing unified support systems (supervision, information, logistics, referral) and providing training and technical assistance to MOH personnel so that they have the capacity to fulfill these functions. This shift in approach will require a substantial investment in the strengthening of these support systems and the training and follow-up activities which are needed to foster the sustainability of project benefits.

Relatively little effort has been placed thus far on developing the capacity of community leadership to comprehend its role in the support of CHVs or other community based initiatives and the resources necessary for their continuation, and in preparing the leadership to effectively carry out this role. Additional work will be needed to identify mechanisms to strengthen both *parronaros* and community volunteer committees, including providing adequate incentives to assure the continued functioning of the CHVs.

5.2 Management and Use of Data

Each CHV collects data on individual family register forms. The data is consolidated by the IEF auxiliary nurse and presented to the CESAMO social worker. The social worker is responsible for consolidating this data and presenting a report to the CESAMO director. IEF also

consolidates the data on EPI-INFO and prepares a monthly report. Quantitative data is collected to monitor the number of persons trained, visits and educational meetings, active volunteers, amount of supplies distributed, cases of diarrhea and ARI, referrals and counter referrals. Qualitative data is collected through focus group discussions with mothers and CHVs. KPC surveys were conducted to obtain baseline data and information for the MTE. The results of the KPC surveys are shared with data collectors, project staff, counterparts and community members, and are being used to make programming decisions to insure the fulfillment of objectives by the end of the project.

The routine health information system is managed by the MOH, and data from CHVs has not been well integrated into the system. CESAMOs do not make full use of the data for decision making. The main lesson learned here is that although the project uses the same forms as the MOH, the information generated by the community needs to be integrated into the MOH system and actually used by the CESAMO staff. Key indicators need to be agreed upon by both parties to avoid the collection of data which is not used to make decisions and take corrective actions. Lessons learned are documented by IEF, mostly in conjunction with project evaluations, and shared with other PVOs and the MOH.

Interviews with *patronaros* and health workers revealed that very little information is currently being used for analysis and decisions at the community level. The evaluation team found no systematic reporting and analysis of priority health problems by community leaders.

5.3 Budget Management

The rate of expenditures is appropriate given the project budget: 47% of central funding has been utilized during approximately 43% of the life of the project. The project should be able to achieve its objectives with the remaining funding, and the budget needs to be spent carefully to insure the successful completion of all of project activities. (See ANNEX I for the Country Project Pipeline Analysis.)

Historically, IEF has managed the budget very tightly at headquarters, leaving little room for financial analysis and decision making at the field level. The Country Director and the project administration received some training from IEF's Finance and Administrative Director, Ed Henderson, however the field staff do not feel competent in this area. The responsibilities of both IEF's central office and the field office need to be clarified, and the local staff need more experience in financial analysis and decision making.

5.4 Use of Technical Support

The project has required and received technical assistance in the following areas: rapid survey techniques, use of EPI-INFO, information systems, strategic and operational planning, administration, quality assurance assessments and computerized accounting systems. Technical support needs during the next six months include: supervision and monitoring, implementation of sustainability strategies, and financial management. The required technical support will be

provided by IEF's Child Survival Coordinator and through use of local consultants and/or trainers.

5.5 Regional and Headquarters Support

Administrative monitoring and technical support have been appropriate in terms of timing, frequency and needs of field staff. IEF's Program Director, John Barrows, visits the project once a year and provides administrative backstopping. The CS Coordinator, Jeffrey Brown, visits the project three times a year and provides technical assistance. In addition, IEF headquarters staff are in communication with the field office on a weekly basis via fax and telephone.

5.6 PVO/NGO Networking

An inter-agency committee was established in Honduras in May of this year to promote effective networking among all institutions working in health. Representatives from USAID, WHO, UNICEF, the European Community, and other international donor agencies, plus PVOs and NGOs meet with the Minister of Health on a monthly basis to share information and coordinate activities.

Interviews with Project HOPE, the Adventist Development and Relief Agency (ADRA), Project LUPE and La Leche League show excellent collaboration among these agencies and IEF. HOPE has collaborated with the project in the development of community banks and La Leche League is assisting with breastfeeding support groups. Training events have been planned in coordination with ADRA and educational materials are shared and exchanged. Project LUPE has provided technical assistance and training in the development of fruit tree nurseries. PVOs consult with each CESAMO and are assigned to different communities so as not to duplicate efforts.

6
SUSTAINABILITY

6.1 Sustainability Status

IEF has developed effective interventions which show positive potential for sustainability. With wise inversion of both material and human resources IEF can transfer key project benefits to the MOH and collaborating NGOs during the last year of the project. IEF should continue to foster close coordination and shared implementation of training, supervision and information systems with communities and health service providers to enhance both effectiveness and sustainability.

Lessons learned during several years of USAID funded child survival projects in Africa and Central America (Bossert 1990) indicate the following as important elements of a sustainable program: 1) effectiveness in reaching clearly defined goals; 2) coordination with local counterparts and beneficiaries and fostering their participation in the decision making process; 3) training of community leaders, volunteers and local health staff; and 4) the integration of Child Survival activities into MOH systems.

The results of the MTE show that the project has well defined goals and has been effective in reaching these. Coordination with local counterparts has been excellent, however both community leaders and MOH staff need to become more involved in the decision making process (e.g. analysis of health data generated by the information system and planning based on the results). Child survival activities have been effective when implemented by IEF staff, however the CHV network has not been fully integrated into the MOH system. Income generation activities such as fruit tree nurseries and community banks provide incentives and have the potential to become self-sustaining, especially with continuing support from collaborating NGOs.

To assure transfer of key project activities to the MOH and collaborating NGOs, IEF staff prepared a sustainability strategy for the coming year, which details the specific activities, person(s) responsible and dates to fulfill the objectives. Activities include: meeting with the MOH at the regional and area levels to discuss transfer issues; sponsorship of a sustainability workshop with local counterparts; investigation of the new MOH strategy to establish a community based integrated child health program (SAIN), and if advisable, a pilot involvement of CHVs in the program; transfer of responsibility for support of community banks and nurseries to Project HOPE and LUPE respectively; strengthening community CHV committees; establishment of breastfeeding support groups and health banks in each project community; and training activities designed to improve management skills of both MOH staff and CHVs. (See ANNEX J for the plan, and the following section for sustainability objectives and outcomes.)

6.2 Sustainability Objectives and Outcomes

GOAL	END OF PROJECT OBJECTIVES	STEPS TAKEN TO DATE	MID-TERM MEASURE	STEPS NEEDED
The MOH will promote key CS project activities	I) Staff at 3 MOH CESAMOs will supet-vise. train and support CHVs 2) MOH will provide ocular health services at the Las Crucitas Eye Clinic	1) 80% of CESAMO staff trained in Vitamin A, ALRI. AIDS, and CDD supervision skills 2) IEF contracted ophthalmologist currently treats patients	1) 4 annual supervisory visits held by CESAMO staff 2) IEF ophthalmologist continues until August 1995	1) Assist CESAMO staff to undertake monthly supervisory visits 2) Two CESAMO nurses will be trained to replace the ophthalmologist
Community groups will support CS activities	I) Community health volunteers will educate mothers in vitamin A, ALRI, CDD. EPI and basic nutrition 2) *Patronatos* will support CS activities	1) 292 volunteers trained in vitamin A, ALRI, CDD, basic nutrition, EPI 2) *Patronatos* have hecn contacted by IEF staff	1) Educational activities implemented by CHVs include: home visits to mothers; and breast-feeding support groups (18 groups have been established). 2) *Patronatos* are becoming involved in CS activities in some communities.	1) CHVs will participate in TOT workshops and give educational talks. Breastfeeding support groups will be established in the remaining project communities. 2) Hold workshop for *patronato* members and include more *patronatos* in CS activities.
Communities will produce vitamin A rich food	Establish 6 fruit tree nurseries	12 persons trained in fruit tree production	6 fruit tree nurseries established	Continue training and support of the nurseries. Select additional participants who are interested in growing and marketing fruit trees.
Communities will participate in income generation activities	Establish 15 community banks	Financial/credit support mechanisms established for community banks 3 individuals trained in management of community banks	15 functioning community banks	Establish banks in the remaining project communities.

7
RECOMMENDATIONS

The following recommendations are based on an analysis of the findings of the MTE undertaken by the evaluation team, IEF staff and MOH representatives during the final debriefing sessions. The evolving institutional focus of IEF/Honduras, as well as the particular requirements of the child survival interventions served as a frame of reference for the formulation of the recommendations.

IEF/Honduras is striving to achieve a series of benefits at the family and community level through a combination of direct health services and educational activities. The development and sustainability of these activities require, in turn, the provision of a great deal of training and technical assistance, on-going supervision and supplies, and coordination among participating organizations. As IEF enters the last year of the child survival project, programmatic efforts will be shifting from providing direct services and education in the communities to becoming increasingly involved in training community leaders, CHVs, and MOH workers to provide and supervise these services. The function of IEF staff at the community level will shift from providing services to advising and monitoring what is done by others.

Health activities involve the development of human resources and systems. The focus during this final year will be on the empowerment of CHVs to plan and organize their own activities, and on the development of managerial skills of MOH staff to strengthen supervision, information, training, referral, and logistics systems to better support the network of community health volunteers which IEF will leave in place.

7.1 Project Interventions

* As coverage rates for the majority of project objectives have already been reached, project staff should reduce the amount of time dedicated to mature interventions and concentrate efforts on areas not fully implemented to date, as follows:

Recommended Level of Effort

EPI (10%) — EPI activities need to be strengthened in education regarding TT vaccination for women of child bearing age.

CDD (10%) — Concentrate efforts to reduce the use of antibiotics for treatment of diarrhea cases, increase the distribution of ORS packets to stores, and

	strengthen education to mothers regarding correct home management during diarrhea episodes.
AR1 (20%)	Improve referral of pneumonia cases by CHVs, as opposed to upper respiratory tract infections.
AIDS (20%)	Strengthen activities with men and teenagers in the use of condoms and the provision of more condoms to CHVs for distribution.
Nutritional Improvement (40%)	Strengthen the breastfeeding support groups, community banks and fruit tree nurseries. In addition banks and breastfeeding groups should be established and consolidated in each project community before grant funding ends.

7.2 Supervision

* IEF should increase its efforts to gradually transfer the responsibility of on-going supervision of community-based services to MOH and NGO personnel. The current procedure of joint supervision should be utilized to assure continuity and standardization of methods, followed by gradual but planned disengagement by IEF.

* IEF should initiate a joint effort with the three CESAMOs to develop a unified system of supervision, with standard instruments and protocols. IEF staff could be instrumental in training MOH personnel in the new system and monitoring its implementation. The supervision system should emphasize positive reinforcement and learning for both parties. Consolidated results should be used for identifying continuing education needs and specific problem areas in need of resolution.

* Supervision by MOH CESAMO staff face barriers, including insufficiently trained supervisory staff, low levels of compensation and a general lack of recognition of the importance of supervision. IEF should work with the MOH to provide specific motivation incentives which could include the election of an "Employee of the Month" and/or letters of commendation to those with outstanding service.

* To improve supervision, IEF can assist the MOH to address the following: (1) Utilize the monthly meeting of CHVs at the CESAMO to assess results, identify problems and plan visits to CHVs in need of assistance rather than attempting to visit each and every CHV on a monthly basis. (2) Rotation of CESAMO field personnel could be each year rather than every quarter or semester, to assure continuity in the relationship between the MOH nurse and the CHVs and mothers. (3) Include field supervision as part of the job description of the CESAMO auxiliary nurse. Plan specific training activities for the auxiliary nurse who will do the supervision with an emphasis on leadership and motivation. Consider some non-financial incentives as a means to motivate MOH field staff. (4) Develop simple supervision forms which are easy to use and tabulate.

7.3 Training

* Training is a major key to meeting project goals, particularly with the shift in focus requiring the transfer of responsibilities from IEF to the CESAMOs for implementation of field activities. Training should not be limited to technical interventions but include managerial topics such as supervision, referral, information systems, use of data for decision making, and human relations. Leadership training, with a focus on individual and social transformation, should be given to all levels of workers, to achieve community self-initiative and MOH management of interventions. (See community leadership course materials published by Nur University, Santa Cruz, Bolivia.)

* Provide all staff (IEF, MOH and CHVs) with training and technical assistance in methods and techniques of adult, non-formal education, i.e. training of trainers (TOT) for community learning.

* Continue with the participative educational methodologies and use pre and post tests to evaluate all training events. Improve the training in terms of content and methods, based on the results of the testing.

7.4 Information Systems

* In conjunction with community leadership training activities, promote the regular reporting of health related activities and data by the CHVs and MOH field personnel to the local *patronato,* and the use of this data for analysis and informed decision-making.

* Data collected by CHVs is incorporated into IEF's information system and used for monthly reporting purposes. However, the same data, which is consolidated by the social worker at each CESAMO is not used for analysis and decision making at the CESAMO. It is recommended that IEF and the CESAMO jointly assess the value of the information being collected, agree on a few important indicators, and streamline the system. A procedure for incorporating the information into the decision making process at the CESAMO should also be developed.

7.5 Sustainability

* The goal of sustainability --that is, who will be responsible for assuming the recurrent operational expenses and functions of project interventions-- should be addressed during the next few months in negotiations with collaborating agencies. Realistic understandings should be reached regarding short-term commitments as well as long-term goals in order to identify appropriate strategies and to avoid future problems of transfer. The sustainability plan developed by IEF staff during the MTE should be incorporated into monthly planning and strictly adhered to. (See ANNEX J)

* The MOH has begun a new national program titled *Servicio de Arencih Integral al Niño* (SAIN), which will use community volunteers to implement monthly growth monitoring

sessions combined with revision of vaccination cards, distribution of vitamin A capsules and education to mothers. The MOH will train CHVs in the needed skills and supervise their work on a periodic basis. It is recommended that IEF visit a pilot SAIN to determine the feasibility of including the project's CHVs in this program. The MOH will implement the SAIN's in the Metropolitan Health Region in 1996, however IEF could coordinate with the CESAMOs to organize the SAIN's in some of the project communities, paving the way for the inclusion of the CHVs in the national program.

The local *patronatos* are the only community organization which has power to negotiate with public and private agencies on behalf of the community. The *patronato* could provide support of the CHVs by serving as an official link between the community and the CESAMO. IEF should provide orientation and training of *patronuto* members in health matters, thereby strengthening the relationship between CHVs and *theputronato,* in addition to the connection between the *purronuto* and the CESAMO. Since the *purronutos* are highly politicized, care needs to be taken so that CHVs do not become identified with any one political party.

* Interviews with Project HOPE and La Leche League indicate that these two organizations will continue to support community banks and breastfeeding groups, respectively. IEF should form community banks and breastfeeding support groups in each community, and consult with these agencies and arrive at agreements regarding sustainability. Project LUPE should also be consulted to negotiate continued technical support for the fruit tree nurseries.

* IEF auxiliary nurses should receive orientation regarding the entire transfer process, and begin to train CHVs to carry out the activities that the auxiliary currently undertakes (e.g. educational talks, consolidation of reports, obtaining supplies from the CESAMO, etc.)

* IEF should negotiate with the CESAMOs regarding the assignation of a nurse to work directly with the *mudres consejerus.* She could organize regular meetings with all the *mudres consejerus* at the CESAMO for continued education and supervision.

* IEF should continue to work with committees of CHVs in each community and provide further training to assist them to plan and implement health activities and coordinate these activities with each community's respective *putronuro.*

* An important incentive for the CHV is the treatment he/she receives at the CESAMO, and the smooth functioning of the referral system. Problems have arisen regarding poor treatment of CHVs and with the provision of counter-referrals. It is recommended that IEF address these issues jointly with the CESAMOs, to make the relationship between the CESAMO and the CHV a positive one.

* Sustainability of the ocular health activities can be promoted through IEF's Childsight program, where school teachers screen elementary school children for eye problems. It is

recommended that IEF explore the possibility of institutionalizing eye screening procedures with the Ministry of Education.

7.6 Staffing

* It is recommended that IEF not make any changes in personnel during this last year. The current child survival staff have developed excellent relationships with collaborating institutions, communities and CHVs, and their continuity will enhance the success of the transfer of program responsibilities. If any of the managerial staff resign, IEF should seriously consider re-distributing their duties among existing staff, since the process of selection, training and adaptation of new staff will take at least six months, and may not be the best use of IEF human resources at this stage.

* There is a possibility that the auxiliary nurses on staff now will begin to resign, since they know this is the last year of the project, especially if they are offered long-term employment by the MOH or other NGOs. It is recommended that IEF provide motivation and non-financial incentives to keep the nurses on board until the project ends in September 1996.

* If any IEF auxiliary nurses do resign, consider the possibility of offering non-financial incentives to an auxiliary nurse at one of the CESAMOs to undertake some of the community work previously done by the IEF person. Incentives could include training and occasional days off to compensate for the longer hours which field work entails. The CESAMO nurse chosen should be someone who likes community work. The experience would strengthen the habit of community visits and supervision activities on behalf of the CESAMOs.

7.7 Financial Management

* IEF administrative staff indicated that decisions are not made based on financial information because the field office does not receive complete information from IEF headquarters regarding total budget allotments for each line item, nor do they have the skills required for financial decision making. It is recommended that IEF headquarters provide more information to the Country Director and prepare a manual with key guidelines for the administrative staff to follow, including use of the accounting software.

* It is recommended that IEF administrative staff receive basic training in financial management including: analysis of financial reports, cash flow, cost structures (recurrent and fixed), budget management (preparation, control and projections) and financial decision making. A local expert could provide this training based on the needs identified by IEF headquarters and field staff.

8
LESSONS LEARNED

* Although coordination with the MOH is often difficult, the development of a close working relationship is essential for sustainability of project activities.

* Quality, not quantity, should be the basis for selection of participants for income generation activities such as community banks and fruit tree nurseries.

* More effective results can be obtained when a project dedicates effort to a few well implemented interventions, as opposed to many interventions which may have limited impact due an insufficient allocation of human and financial resources to guarantee their success.

* Work with community leaders requires additional effort and time, however, their involvement in health decision making fosters sustainability of project benefits and serves as a source of continued support for local CHVs.

* In recruiting CHVs, individuals should be chosen who do not have full-time jobs outside the home. Volunteers who do work have very little time and energy to dedicate to community health activities.

ANNEX A

EVALUATION TEAM MEMBERS

MEMBERS OF THE EVALUATION TEAM

Evaluation Team Members:

Lynn Johnson	External Evaluator
Jeffrey Brown	CS Coordinator, IEF/Washington
Raúl Gómez	Country Director, IEF/Honduras
Victoria Vivas de Alvarado	CS Coordinator, IEF/Honduras
Marylena Arita	Technical Advisor, IEF/Honduras
Laura Molina	Supervisor, IEF/Honduras
Teresa Bonilla	Social Worker, CESAMO Tres de Mayo
Martha de Piedrasanta	CS Coordinator, IEF/Guatemala

Participants in some field and debriefing activities:

Carlos Villalobos	MOH National Program Director: "Atención lntegral de1 Niño"
Dagoberto Torres	MOH Director, CESAMO San Francisco

ANNEX B

SCOPE OF WORK

SCOPE OF WORK
HONDURAS MIDTERM ***EVALUATION***
CHILD SURVIVAL FOR VITAMIN A PROJECT
TEGUCIGALPA JULY 31th - August 8th, 1995

1. INTRODUCTION

The purpose of the Midterm Evaluation (MTE) is to review the progress of the IEF-Honduras Child Survival for Vitamin A Project in the per-i-urban areas surrounding Tegucigalpa. The MTE is a requirement of the United States Agency for International Development, Bureau for Humanitarian Response/Private and Voluntary Cooperation/Survival and Health funded Cooperative Agreement No. FAO-0500-A-00-3020-00. The life of the project extends from September 30, 1993 through September 29, 1996.

The MTE evaluation is estimated to require 16 days from an external evaluator. The dates for the field visit are tentatively scheduled from July 31st - August 8th.

2. OBJECTIVES

The requirements of BHR/PVC for the final evaluation are:

a. A narrative report (English), addressing project progress towards achieving its goals and objectives as stated in the cooperative agreement (AID guidelines provided);

b. A final financial pipeline analysis (completed with assistance from Bethesda headquarters in advance).

Additional requirements of IEF for the final evaluation are:

c. Assess the implementation process and identify common constraints that have impeded effective implementation;

d. Assess technical appropriateness of interventions;

e. Develop recommendations for developing other programming in the project area, including other health activities and income-generating activities.

Specific guidelines are provided from USAID BHR/PVC/CSH for this purpose. Additional questions for consideration will also be provided by IEF. The final evaluation will be made available to IEF (headquarters and country staff) and U.S.A.I.D. (Washington and Mission).

3. ACTIVITIES

The evaluator will lead a team consisting of the IEF-Honduras staff (Country Director, Project Coordinator, Medical Advisor, Field Supervisors, and Auxiliary Nurses); the IEF-Headquarters Child Survival Coordinator; an official from the Ministry of Health (to be designated); and a representative from a sister PVO (to be identified). Major tasks are:

a. Review documentation (1 day)

Review all project related documentation (proposal, detailed implementation plan, annual report and evaluation guidelines). This information should be reviewed in advance of the evaluation.

b. Travel from the United States (2 days)

Travel from the United States to Tegucigalpa will require approximately one day each way.

c. Preparation of interview forms (1 day)

Qualitative data will be collected through a combination of key informant interviews and focus groups. To prepare for this "BHIUPVC Child Survival Mid-Term Evaluation Guidelines" will be used to develop a specific set of interview questions to interview 1) community members, 2) local leaders, 3) project volunteers, 4) project staff, and 5) Ministry staff.

d. Data Gathering (3 days)

Team members will be divided into groups each consisting of IEF staff paired with PVO/MOH representatives and/or the Team Leader. In a sample of project communities (4-6), teams will complete structured interviews and focus groups with 1) community members, 2) local leaders, 3) project volunteers, 4) project staff and 5) Ministry staff. Project staff interviews and focus groups will be limited to 1, 2 and 3 only; the Team Leader will conduct interviews of all of the above levels. The total number of interviews and focus groups will be determined in-country.

At the end of each day, findings will be summarized and presented to the entire team for discussion. This will identify whether any changes in the questions or the interview methods, or new questions are required for the next day, and to identify response patterns.

e. Data Analysis (1 day)

One day is required to process major findings from all interviews and focus groups following the AID guideline headings.

f. Findings/Recommendations & Lessons Learned (1 1/2 days)

One day is required to review the fmdings and process major recommendations and lessons learned from all interviews and focus groups by the evaluation team following the AID guideline headings.

g. Debriefing (1 1/2 days)

Presentations to the MOH and USAID will be conducted (and if time allows other institutions may also be included). The debriefing will consist of a review of the evaluation process, and the draft findings and recommendations.

h. Report Writing (5 days)

i. The Team Leader will write a ***first draft report in Spanish*** (conclusions and recommendations) for debriefing and for presentation to IEF for comments and suggestions prior to departure. Preparation of the report will be a continuous daily process of typing interview forms, interviewee lists, findings and recommendations lists.

ii. ***The second draft in English*** will incorporate staff comments from the first draft and will be submitted to IEF/HQ by August 18th. Write-up of this and final drafts may be completed outside of Honduras. A diskette of the word processing file (Wordperfect 5.1) will be delivered to IEF along with a hard copy of the draft. IEF staff will have the opportunity to make final comments on the second draft before the final report in English is completed.

iii. ***The final draft in English*** will incorporate comments from the second draft. It will be forwarded to IEF/HQ (hard copy plus WordPerfect 5.1 file) by September 1st. This report will be submitted to BHR/PVC/CSH by IEF/HQ once all modifications have been finalized.

4. SCHEDULE

See attached.

5. REQUIREMENTS

IEF is seeking an evaluator with proven skills in program evaluation, bilingual (Spanish-English) abilities, familiarity with USAID Child Survival program and private voluntary organizations, and preferably the country of Honduras.

6. ATTACHMENTS

AID Guidelines
IEF Questions
Schedule
Report Outline

i:\docs\cs\adm\sow\H_mte

ADDITIONAL **QUESTIONS**

To be determined

REPORT OUTLINE (Preliminary)

COVER PAGE
i Acknowledgements
ii Acronyms
iii Table of contents

I. Executive summary
II. Background
III. Evaluation methodology
IV. Findings and conclusions
- A. Accomplishments
- B. Effectiveness
- C. Relevance to Development
- D. Design and Implementation
  1. Design
  2. Management and Use of Data
  3. Community Education and Social Promotion
  4. Human Resources for Child Survival
  5. Supplies and Materials for Local Staff
  6. Quality
  7. Supervision and Monitoring
  8. Regional and Headquarters Support
  9. PVO's Use of Technical Support
  10. Assessment of Counterpart Relationships
  11. Referral Relationships
  12. PVO/NGO Networking
  13. Budget management
- E. Sustainability
- F. Recommendations

V. Appendices
- A. Evaluation team
- B. Scope of work
- C. Evaluation schedule
- D. Sources of information (lists of interviewees)
- E. Interview guides (interviews, focus groups)
- F. List of documents used
- G. List of individuals/institutions consulted
- H. Financial pipeline analysis

Schedule - Honduras MTE

Sun	Mon	Tues	Wed	Thur	Fri	Sat
July 30 Travel to Hond.	31 Orientation Forms develop.	August 1 Data collection	2 Data collection	3 Data collection	4 Analysis	5 Findings
6	7 Recommend. Debriefing	8 Debriefing				

ANNEX C

USAID MID-TERM EVALUATION GUIDELINES

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

MAR 24 1995

Re: Mid-term Evaluation Guidelines for CS-IX Projects

Dear Colleague:

Enclosed are the guidelines which are to be used to conduct **the mid-term evaluation of three-year child survival** projects which the Office of Private and Voluntary Cooperation funded under the CS-IX Child Survival Grants Program. An original and two copies of the evaluation report should reach **BHR/PVC** by October 31, **1995.**

The main purpose of the mid-term evaluation is to review progress toward achieving the goals and objectives of **the** cooperative agreement. It can be used to identify what is working well with a project, suggest areas which need further attention, and recommend useful actions to guide the staff through the last half of the project.

The mid-term evaluation team must include at least one external evaluator, i.e., someone who is not employed by, or otherwise professionally associated with, your organization. We also suggest **that** at least one member of the project field staff and one headquarters representative be included on the mid-term evaluation team. Please discuss with your project officer the proposed composition of the team and the evaluation schedule.

If you need further clarification of these guidelines or if you need other related information, please do not hesitate to call (703-351-0226).

Sincerely,

Cathy Jane Bowes

Cathy Jane Bowes, Acting Chief
Child Survival and Health
Office of Private & Voluntary Cooperation
Bureau for Humanitarian Response

Enclosures

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

1995 BHR/PVC CHILD SURVIVAL MID-TERM EVALUATION GUIDELINES
(For CS-IX Three-Year Projects)

1. Accomplishments

How many months has the project been operating? What are the measurable inputs (e.g. training sessions held, supplies provided), outputs (e.g. persons trained, mothers educated, treatments provided), and outcomes (e.g.immunization coverage, change in mothers' use of ORT)? If available, provide information for important outputs and outcomes (using rates or percentages in addition to counts, where applicable) by intervention, by time period, by age and/or risk group, and by category of health worker or provider. Cite data sources, and comment on the level of specific outputs and/or outcomes compared to objectives and/or expectation.

2. Effectiveness

How do the accomplishments achieved so far compare with the accomplishments anticipated in the DIP? Has there been sufficient progress in meeting stated objectives and yearly targets? Are targeted high-risk groups being reached effectively? If not, what are the constraints to meeting objectives and to reaching high-risk groups?

3. Relevance to Development

What has the PVO project done to date to increase the ability of families to participate in and benefit from child survival activities and services?

4. Design and Implementation

Are there any particular aspects of project design or implementation which may be having a positive or negative effect on meeting project objectives? Please take into account the following:

4.1 Design

Has the project changed its project area or size of impact population? If the project has had to change it's strategies, has the project management been willing to make changes when appropriate, and can the PVO justify or give a reasonable explanation for the changes undertaken?

4.2 Management and Use of Data

What type of data is being collected by the project, both qualitative and quantitative? Is the project using surveys for monitoring and evaluation? By whom, and how, is data being used for decision making? (Please give examples).

Is the project's routine health information system fully functional? Who is managing and maintaining the health information system? Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members? What lessons have been learned as a result of the data collection? Is the PVO, headquarters and/or field, institutionalizing lessons learned by documenting, incorporating and sharing?

4.3 Community Education and Social Promotion

What is the balance between health promotion/social mobilization and service provision in this project? What community information, education, or communication activities has the project carried out? Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc. in developing the messages? Were the messages tested and refined? How does the PVO ensure that messages to community members are consistent?

Does the project distribute any printed materials? Were the materials pre-tested? Do members of the community regard these materials as simple, useful, and of value? What is the project's approach to community education? Have any non-traditional or participatory education activities been used? How has the project assessed the level of learning that has occurred with these methods?

4.4 Human Resources for Child Survival

How many persons (by category) are involved with this child survival project? Comment on the numbers and mix of persons to meet the technical, managerial and operational needs of the project. How efficient is this mix, and how much unnecessary duplication of effort is there on the part of different categories of workers (including those not involved in the project)?

Describe the roles of community volunteers in this project. How many are in place, and which interventions are they responsible for? Comment on their workload and drop-out rates.

Comment on the appropriateness of the duration and methodology of training for each type of worker and for each intervention or job. Describe

the results of pre- and post-training assessments, any modifications of training program content or methodology, and the reasons for the changes. Please complete a table (example below) with the requested information.

Child Survival Training Program Summary

Type/# Dates	Training Topics	Topic Hours	Training Methods for Topic
CHW (8) 3/15-23	ALRI intro., symptoms, local terms and practices	2	listing by CHWs, discussion
CHW (9) 4/3-11	ALRI assess./classif.	10	lecture, slides, video discussion, role plays, practice at chic visit
CHW (7) 4/17-25			

If your project has a maternal care/family plating component, please include your curriculum for training health workers in maternal care/family planning and the health messages used to teach mothers about maternal care/family planning, regardless of whether you sent a set last year. (Please provide one unbound, single-sided original and two bound copies of each document in English).

4.5 Supplies and Materials for Local Staff

Which materials and supplies are essential or important for each type of worker and for each referral site, for each intervention? Have all workers and referral sites had adequate quantities of all of these supplies for each intervention since initial training or the start of intervention activities (cite sources of information)? What percentage of each type of worker and referral site visited by the evaluators had adequate stocks, and which materials were in short supply? How are these supplies being used? How appropriate are they to the health worker's job?

4.6 Quality

Discuss how well the project has identified and documented the specific knowledge and skills essential for mothers, health workers, and clinic staff to implement each intervention and meet project objectives. Discuss how the project has been evaluating the levels of specific essential knowledge and skills, and summarize the results of these evaluations. Discuss the results of any evaluation of essential knowledge and skills of mothers, health workers and/or clinic staff conducted by the evaluators as part of the mid-term evaluation. Comment on the communication and counselling skills of health workers.

4.7 Supervision and Monitoring

What is the nature of supervision and monitoring carried out in this project? Describe the sites, frequency, and duration of supervisory contacts with all categories of project related staff and volunteers. What are the ratios of supervisors to those being supervised, at all levels, and are these ratios appropriate? From the viewpoint of the health worker, how much of the supervision is counseling/support, performance evaluation, on-the-job education, or administration? How, and how well, do supervisors assess and improve the quality of services provided by those they are supervising? To what extent have checklists been used for supervision? Discuss whether the supervision of each level of health worker has been adequate for assuring quality of service for each intervention. What are the monitoring and supervision requirements for the remainder of the project?

4.8 Regional and Headquarters Support

Have administrative monitoring and technical support from the PVO regional or central offices been appropriate in terms of timing, frequency and needs of the field staff? If not, what constraints does the project face in obtaining adequate monitoring and technical support from PVO regional or central offices?

4.9 PVO's Use of Technical Support

What are the types of external technical assistance the project has needed to date, and what technical assistance has the project obtained? What are the technical support needs of the project in the next six months? Are there any constraints to obtaining the support?

4.10 Assessment of Counterpart Relationships

What are the chief counterpart organizations to this project? What collaborative activities have taken place to date? Are there any exchanges of money, materials, or human resources between the project and its counterparts? Do the counterpart staffs have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities? Is there an open dialogue between the PVO project and counterparts? What'are the counterpart(s) relationships with the community?

4.11 Referral Relationships

Identify the referral care sites and comment on access and service quality. Has the project made appropriate use of these deferral sites? What is the continuity of relationships between the referral site and the community project? Is the dialogue between project and referral site adequate? Is the

project taking any steps to strengthen the services of the referral site or increase community access to the referral site?

4.12 PVO/NGO Networking

What evidence is there of effective networking with other PVOs and NGOs working in health and child survival? Are there any situations in country or in the community which have had a positive or negative effect on networking? Discuss any duplication of effort/services in the project area or any resource sharing with other NGOs/PVOs which increase efficiency.

4.13 Budget Management

How does the rate of expenditures to date compare with the project budget? How does the PVO justify any budget shifts that may have occurred? Can the project achieve its objectives with the remaining funding? Is there a possibility that the budget will be underspent at the end of the project? If so, why?

Include an original and two copies of the Country Project Pipeline Analysis, using the categories indicated on the enclosed pipeline format.

5. Sustainability

What are the steps the project has undertaken to promote sustainability of child survival activities once project funds end? Please fill in a table (example below) with sustainability objectives and outcomes.

Sustainability Goals, Objectives, Mid-term Measures, and Steps Taken/Needed

Goal	End of project objectives	Steps taken to date	Mid-term measure	Steps needed
A) MOH will take on health promotive activities of CS project	1) MOH will supervise and provide refresher training for 50 CHVs	1) 2 MOH nurses trained in CHV supervisory methods	1) 10 CHVs being supervised by MOH nurses (20% of objective)	1) Train 8 more MOH nurses
	2) Health officer will meet monthly with community health committees	2) Health officer attended 3 health committee meetings	2) Health officer attended 3/10 meetings (30%)	2) Introduce health officer to more community leaders
B)				

6. Recommendations

What steps should be taken by PVO field staff and headquarters for the project to achieve its output and outcome objectives by the end of the project? Are there any steps the project and PVO headquarters can take to make the project activities more sustainable ? Are there any steps the project and PVO headquarters should take to make the project activities more applicable, the staff more competent, or the services of higher quality? Are there any steps the project and PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development projects sponsored by USAID, or by the PVO? Finally, are there any issues or actions that USAID should consider as a result of this evaluation?

7. Summary

Write a brief summary, no more than one page, of the highlights of the midterm evaluation covering: composition of the evaluation team; time spent; total costs; field visits; quantitative/qualitative methods; main project accomplishments and measurable outcomes; assessment of applicability and quality of child survival programming; relevance of lessons learned to other child survival and community development programs; key recommendations; planned or actual feedback of evaluation results; and author(s) of the midterm evaluation report.

ANNEX D

METHODOLOGY OUTLINE AND DATA COLLECTION INSTRUMENTS

EVALUATION METHODOLOGY

Participants	July 31 Monday	August 1 Tuesday	August 2 Wednesday	August 3 Thursday
Group 1*		FATIMA Interviews: CHVs mothers viveros madres consejeras	1 DICIEMBRE Interviews: CHVs mothers viveros madres consejeras community bank leaders	NUEVA DANLI Interviews: CHVs mothers madres consejeras
Group 2**		SAN BUENA VENTURA Interviews: CHVs mothers madres consejeras	CAMPO CIELO Interviews: CHVs mothers viveros madres consejeras community bank	ALTOS DEL PARAISO Interviews: CHVs mothers madres consejeras
Groups 1 & 2	Design evaluation methodology Prepare interview forms	Meeting with IEF staff: Discussion of implementation issues	Meeting with IEF staff: Discussion of implementation issues	Summary of findings, conclusions and formulation of recommendations by intervention
Some members from each group		(1) CESAMO: San Francisco (2) FATIMA Interviews: community leaders community bank	(1) CESAMO: 3 de Mayo (2) CAMPO CIELO Interviews: leaders	(1) CESAMO: Las Crucitas
Some members from each group		Interview with ADRA	Interview with La Leche League	Interview with USAID Mission

* Group 1: Raúl Gomez, Jeffrey Brown, Laura Molina, Martha Piedrasanta

** Group 2: Lynn Johnson, Victoria Vivas, Marylena Arita, Teresa Bonilla

Participants	August 4 Friday	August 5 Saturday	August 7 Monday	August 8 Tuesday
Groups 1 & 2	Summary of findings, conclusions and recommendations by intervention Debriefing meeting with MOH representatives Meeting with IEF staff: Discussion of management issues	Meeting with IEF staff: overall conclusions and recommendations for implementation and management issues	Meeting with IEF staff: sustainability plan	Meeting with IEF staff to review draft of report
Some members from each group	Interview with Project HOPE	Report preparation (L.Johnson)	Interview with MOH Director of Integrated Child Health Program	Report preparation (L.Johnson)

FORMULARIO #1
ENTREVISTA A AUTORIDADES COMUNALES

Comunidad: _____

Lideres Entrevistados:

1. Cuándo se inició esta Junta Directiva?

2. Cuáles son 10s problemas de salud más prioritarios en su comunidad?

3. Cómo está la comunidad resolviendo estos problemas de salud?

4. Quién les ayuda a resolver estos problemas'! Cdmo?

5. Conoce 10s Voluntarios de Salud? Qué hacen?

6. Qué necesitan ellos para hater una labor efectiva?

7. Qué podrían hater ustedes para apoyar al Voluntario de Salud?

8. Cómo se dan cuenta ustedes de 10s logros de las actividades de 10s Voluntarios de Salud dentro de su comunidad?

9. La FIO ha compartido información de sus actividades con ustedes? Cada cuinto?

FORMULARIO #2
ENTREVISTA A VOLUNTARIOS DE SALUD

Comunidad: _____ Fecha: _____

Nombre de los Participantes — Tiempo de ser Vol. de Salud

a. _____ _____ años/meses

b. _____ _____ años/meses

c. _____ _____ años/meses

d. _____ _____ años/meses

e. _____ _____ años/meses

1. Cuáles son sus funciones y responsabilidades principales?

2. CED
   a. Cómo prepara el suero oral y cdmo se administra?
   b. Cuales son las señales de peligro para la deshidratacidn?
   c. Qué consejos da usted a las madres cuando sus niños tienen diarrea?
   d. Cómo sabe usted cuando hater la referencia y a qué lugar referirlo?

3. IRA
   a. Cuales son las señales de peligro de neumonfa?
   b. Qué consejos da usted a las madres sobre el cuidado de1 niño con IRA?
   c. Cdmo sabe usted cuando hater a referencia y a qué lugar referirlo‘?

4. PAI
   a. Qué mensajes da usted a las madres sobre las inmunizaciones?
   b. Qué vacunas deben recibir 10s niños y a qué edad deben recibir cada una?
   c. s puede mostrar su registro familiar e indicar cómo hace el seguimiento a 10s niños no vacunados?
   d. Hate usted seguimiento a las madres que necesitan el toxoide tetánico? Cómo?

5. Vitamina A y Nutricidn
   a. Qué mensajes da usted a las madres sobre la Vitamina A y sobre la nutrición en general?

b. A quienes da usted Vitamina A?

c. A partir de qué edad da usted Vitamina A a 10s niños? Cada cuánto? Y qué dosis?

d. Cuándo da usted Vitamina A a las mujeres puérperas? Qué dosis le da?

e. Cuáles son 10s mensajes claves sobre lactancia matema?

6. SIDA
   a. Qué mensajes da usted sobre SIDA y a qué personas?

   b. Distribuye usted condones? Cómo?

7. Recibe usted algún beneficio por su trabajo? (De FIO, comunidad o CESAMOS)

8. Cree usted que la comunidad valora y aprecia lo que usted hate?

9. SUPERVISION TECNICA Y ADMINISTRATIVA
   Quién le super-visa?
   Con qué frecuencia?
   Qué apoyo recibió durante las supervisiones?
   Piensa que esta supervision es apropiada'?

IQ. Cuántas veces participó usted en actividades de capacitacidn durante el último año? En qué temas recibid capacitacibn?

II. Entrega usted informes a FIO/CESAMO sobre sus actividades?

12. Cuáles son las mayores limitaciones o problemas que encuentra en realizar su trabajo?

13. Qué sugiere usted para mejorar su trabajo'? Habrán algunas cosas que necesitan ser modificadas para que funcionen mejor sus actividades? Cuáles?

FORMULARIO #3
ENTREVISTA CON PROVEEDORES DE SALUD

Nombre de la Institución:

Persona(s) Entrevistadas:

1. Por favor desctiba las actividades que realiza conjuntamente con IEF en las siguientes keas:
a) Planificación de actividades:

b) Capacitación a Voluntarios de Salud:

c) Capacitacidn al personal de su institucih:

d) Supervisión a 10s Voluntarios:

e) Educación para la salud:

f) Ejecucidn de otras actividades de campo:

g) Monitoreo y evaluacih de actividades (sistema de informacibn):

2. Que ventajas ve Ud. en esta colaboracidn?

3. Que recomendaciones daría Ud. a su propia institucih y a IEF para que esta cooperación mejore?

4. ¿Qué sugerencias tiene para sostener las actividades de IEF, una vez que su financiamiento termine'?

FORMULARIO #4
ENTREVISTA AL PERSONAL DE IEF

IMPLEMENTACION DEL PROYECTO

Educacidn Comunitaria:

1. ¿Cuanto esfuerzo está dedicado a educación y promocidn comunitaria en relación al esfuerzo dedicado a la prestación de servicios?

2. ¿Qué activadas de IEC se han realizado?

3. ¿Han utilizado informacidn de 10s estudios CAP o de grupos focales o entrevistas para desarrollar 10s mensajes educativos?

4. ¿Los mensajes fueron probados y refinados?

5. ¿Cómo saben que 10s mensajes son uniformes en cada actividad educative?

6. ¿Distribuyen material impreso?

7. ¿Fueron probados antes de imprimirlos?

8. ¿Son sencillos y útiles segdn el punto de vista de 10s comunarios?

9. ¿Cuál es el enfoque de1 Proyecto hacia la educacidn comunitaria'?

10. ¿Han utilizado metodos no-tradicionales o actividades participativas?

11. ¿Cómo han medido el nivel de aprendizaje utilizando estos metodos'?

Recursos Humanos

PERSONAL

1. ¿Cuántas personas están trabajando con el Proyecto, y en que categoría?

2. ¿Está adecuado el numero y mezcla de personas para las necesidades de1 proyecto (técnicas, gerenciales, y operacionales)

3. ¿Es eficiente este conjunto de personal? ¿Hay duplicación de esfuerzo de parte de las diferentes categorías de trabajadores (incluyendo 10s que no están involucrados en el proyecto)?

VOLUNTARIOS DE SALUD

4. ¿Cuál es el rol de voluntarios comunitarios en el Proyecto?

5. ¿Cuantos están trabajando actualmente, y en que intervenciones están trabajando‘?

6. ¿Cuantas horas por semana dedican al trabajo 10s VS y cuál es la tasa de desercidn?

CAPACITACION

7. ¿La capacitación y la metodologia son adecuados para cada intervención y cada nivel de trabajador?

8. ¿Hay resultados de pre y post tests‘? ¿Han hecho modificaciones segdn estos resultados?

9. Llenar la tabla sobre capacitación. Ver Formulario #5-B.

Suministros v Materiales para el Personal Local

1. ¿Qué materiales y suministros son esenciales o importante para cada tipo de trabajador, para cada centro de referencia y para cada intervencibn?

2. ¿Todos (trabajadores y centros de referencia) han tenido cantidades adecuadas de estos suministros pat-a cada intervención (indicar fuente de información)?

3. ¿Qué porcentaje de cada tipo de trabajador visitado por el evaluador tuvo suministros adecuados y cuales estaban desabastecidos?

4. ¿Cómo es están utilizando estos suministros'? ¿Son apropiados para el trabajado de cada tipo de trabajador?

Calidad

1. ¿El proyecto ha identificado y documentado 10s conocimientos y destrezas especificas, necesarias para madres, trabajadores y personal de salud para implementar cada intervención y lograr 10s objetivos?

2. ¿El proyecto ha evaluado 10s niveles de conocimientos y destrezas necesarias? Resuma 10s resultados.

3. ¿Qué tal son las destrezas de comunicación y consejeria de los trabajadores de salud?

Supervisión v Monitoreo:

I. ¿Qué tipo de supervisión y monitoreo se realiza en el proyecto?

2. Describa 10s sitios, frecuencia y duración de 10s contactos de supervisión con todos 10s tipos de personal y voluntarios:

3. ¿Cuál es la relacidn entre supervisores y supervisados en cada nivel? ¿Son apropiados?

4. ¿Qué porcentaje de la supervisión es consejeria/apoyo, evaluación de desempefio, capacitacih en el puesto, y administración?

5. ¿Cómo evaldan y mejoran 10s supervisores la calidad de servicios? ¿Es adecuada la supervisión?

6. ¿Cuáles son 10s requerimientos de supervisión y monitoreo para la duracih de1 proyecto?

Relaciones de Referencia

1. lndentifique 10s servicios de referencia y comente sobre acceso y calidad de servicios:

2. ¿Han utilizado 10s servicios de referencia en forma apropiadas?

3. ¿Cuál es la continuidad de relaciones entre 10s servicios de referencia y la comunidad?

4. ¿Es el dialogo entre comunidad y servicio de referencia adecuada?

5. ¿Están tomando alguna accidn para mejorar/fortalecer 10s servicios de referencia o incrementar el acceso a 10s servicios?

FORMULARIO #5
ENTREVISTA AL PERSONAL DE IEF

ADMINISTRACION DEL PROYECTO

Diseño del Proyecto

1. ¿Ha cambiado la zona objeto y tamaño de la poblacidn beneficiaria?

2. ¿Si el proyecto tuvo que cambiar sus estrategias, estuvo dispuesto la administración en hater 10s cambios necesarios/apropiados ? ¿Puede justificar 10s cambios?

Maneio y Utilización de Información

1. ¿Qué tipo de información está recolectada por el proyecto, tanto cualitativa coma cuantitativa'?

2. ¿Está funcionando el sistema de informacidn?

3. ¿Quien esta manejando el sistema de informacibn'?

4. ¿Han compartido 10s resultados con 10s que han colectado 10s datos, con el personal de1 proyecto, contrapartes y comunarios?

5. ¿Qué lecciones han aprendido coma resultado de la recolección de datos?

6. ¿Están institucionalizando las lecciones aprendidas al documentar, incorporar o compartir?

Maneio de1 Presunuesto

1. ¿Cómo se compara el ritmo de gastos con el presupuesto?

2. ¿Cómo justifica cambios presupuestarios que hayan ocurrido?

3. ¿Puede el proyecto lograr sus objetivos con el financiamiento restante?

4. ¿Es posible que no gastarán el presupuesto al terminar el proyecto? ¿Por qué?

Utilizacidn de Apoyo Técnico

1. ¿Qué son 10s tipos de asistencia técnica que el proyecto ha necesitado hasta la fecha, y que asistencia han obtenido?

2. ¿Cuáles son las necesidades técnicas de1 proyecto durante 10s proximos 6 meses? ¿Hay alguna barrera en lograr este apoyo?

Relaciones con otras ONGs

1. ¿Qué evidencia hay de relaciones efectivas (redes) con otras PVOs y ONGs trabajando en salud y supervivencia infantil?

2. ¿Hay algunas situaciones en el país o en la comunidad que han afectado estas relaciones en forma positiva 0 negativa?

3. ¿Existe duplicación de esfuerzo/servicios o comparten recursos para mejorar la eficiencia?

Apoyo de la Oficina Central

1. ¿El apoyo administrativo de la sede son apropiados en cuanto a tiempo, tiecuencia y las necesidades del personal de campo?

2. ¿Cuáles son las barreras para obtener monitoreo adecuado y apoyo técnico de la sede?

Relaciones con Contrapartes

1. ¿Cuales son las contrapartes principales'?

2. ¿Qué actividades colaborativas se han realizado?

3. ¿Han habido intercambios de dinero, materiales o recursos humanos?

4. ¿El personal contraparte tienen la capacidad tecnica y administrativa para asumir las responsabilidades para las actividades de CS?

5. ¿Hay un dialogo abierto entre IEF y las contrapartes?

6. ¿Cuál es la relacidn de contraparte con la comunidad?

FORMULARIO #6
ENTREVISTA AL PERSONAL DE IEF
SOSTENIBILIDAD

1. ¿Qué pasos han tornado para promover las sostenibilidad?

2 Usar la tabla para hater un plan de sostenibilidad:

Meta	Objetivos	Actividad	Persona Responsable	Fecha

FORMULARIO #7
ENTREVJSTA AL PERSONAL DE IEF
RECOMENDACIONES

1. ¿Qué pasos deben tomar el personal de IEF (campo y sede) para que el proyecto logre sus objetivos hasta el fin de1 proyecto?

2. ¿Qué pasos deben tomar para promover las sostenibilidad?

3. ¿Qué pasos deben tomar para lo siguiente:
   a) Actividades más aplicables
   b) Personal más competente
   c) Servicios de más calidad

4. ¿Qué pasos deben tomar para difimdir las lecciones aprendidas a otros proyectos auspiciados por AID?

5. ¿Qué acciones o asuntos debe considerar AID coma resultado de esta evaluación?

FORMULARIO #8
ENTREVISTA A VIVERISTAS

Viveros

1. Qué tipo de arbolitos tiene en su vivero?

2. Cuántos arbolitos ha vendido?

   a. A qué precio?

   b. A quién?

3. Cdmo está manejando la contabilidad'?

4. Es rentable? ( ) SI ( ) NO

   Por qué?

5. Qué hate con el dinero de la venta'?

6. Cómo va a mantener el negocio?

7. Qué problemas ha tenido en el manejo de su vivero?

8. Qué sugerencias tiene usted para mejorar su vivero?

FORMULARIO #9
ENTREVISTA A MADRES

Madres

I. Existen Voluntarios de Salud en su comunidad?

( ) SI ( ) NO

2. La visitan'? ( ) SI ( ) NO

3. Si su respuesta a la pregunta No. 2 es Sl, con qué frecuencia la visitan? Qué hate la Voluntaria?

4. Escucha usted 10s mensajes de1 altoparlante?

( ) SI ( ) No

5. Qué dicen 10s mensajes?

6. Ha utilizado usted Litrosol? ( ) SI ( ) NO

7. Si su respuesta a la pregunta No. 6 es Sl, dónde lo ha obtenido?

8. Por qué piensa usted que algunas madres no se vacunan con TT?

9. Qué piensa su marido o compañero sobre el uso de1 condón?

IO. Cuál sería la mejor forma para convencer a su marido a usar el condón?

FORMULARIO #lO
ENTREVISTA A MADRES CONSEJERAS

1. ¿Qué hate usted coma madre consejera?

2. ¿Cada cuánto se redne corn0 grupo?

3. ¿De quienes recibe apoyo'?
¿Qué tipo de apoyo?
¿Cada cuánto?

4. ¿En case de un problema, a dónde refiere la persona?

5. Al final de1 año próximo, cuando termine el proyecto de FIO, ¿cómo podría usted continuar con las actividades?

FORMULARIO #11
ENTREVISTA A AUXILIARES DE ENFERMERIADE IEF

Fecha: _____

Nombre de la Enfermera Auxiliar: _____

1. Desde cuándo trabaja para la FJO? _____ años/meses

2. Cuáles son sus funciones y responsabilidades principales?

3. CED
   a. Cdmo prepara el suero oral y cómo se administra'?
   b. Cuáles son las sefiales de peligro para la deshidratación?
   c. Qué consejos da usted a las madres cuando sus niiios tienen diarrea?
   d. Cdmo sabe usted cuando hater la referencia y a qué lugar referirlo?

4. IRA
   a. Cuáles son las sefiales de peligro de neumoma?
   b. Qué consejos da usted a las madres sobre el cuidado de1 niiio con IRA?
   c. Cómo sabe usted cuando hater a referencia y a que lugar referirlo'?

5. PA1
   a. Qué mensajes da usted a las madres sobre las inmunizaciones?
   b. Qué vacunas deben recibir 10s niños y a qué edad deben recibir cada una?
   c. Hate usted seguimiento a las madres que necesitan el toxoide tednico? Cómo?

6. Vitamina A y Nutrición
   a. Qué mensajes da usted a las madres sobre la Vitamina A y sobre la nutrición en general?
   b. A quiénes da usted Vitamina A?
   c. A partir de qué edad da usted Vitamina A a 10s niños? Cada cuánto? Y qué dosis'?
   d. Cuándo da usted Vitamina A a las mujeres puérperas? Qué dosis le da?
   e. Cuáles son 10s mensajes claves sobre lactancia matema?

7. SIDA
   a. Qué mensajes da usted sobre SIDA y a qué personas?
   b. Disbibuye usted condones? Cómo?

8. Cree usted que la comunidad valora y aprecia lo que usted hace?

9. SUPERVISION TECNICA Y ADMINISTRATIVA
   Quién le supervisa?
   Con qué frecuencia?
   Qué apoyo recibid durante las supervisiones?
   Piensa que esta supervisión es apropiada?

IO. Cuántas veces participó usted en actividades de capacitación durante el último año? En qué temas recibió capacitacibn?

Il. Entrega usted informes a FIO/CESAMO sobre sus actividades?

12. Cuáles son las mayores limitaciones o problemas que encuentra en realizar su trabajo?

13. Qué sugiere usted para mejorar su trabajo'? Habrán algunas cosas que necesitan ser modificadas para que funcionen mejor sus actividades? Cuáles?

FORMULARIO #12
ENTREVISTA CON INSTITUCIONES Y ONGs

Nombre de la Institución:

Persona(s) Entrevistadas:

1. Por favor describa las actividades que realiza conjuntamente con IEF en las siguientes áreas:
a) Planificación de actividades:

h) Capacitacidn a Voluntarios de Salud:

c) Capacitación al personal de su institucidn:

d) Supervisión a 10s Voluntaries:

e) Educación para la salud:

f) Ejecución de otras actividades de campo:

g) Monitoreo y evaluación de actividades (sistema de informacidn):

2. Que ventajas ve Ud. en esta colaboración?

3. Que recomendaciones daría Ud. a su propia institución y a IEF para que esta cooperacidn mejore?

4. ¿Qué sugerencias tiene para sostener las actividades de IEF, una vez que su financiamiento termine?

ANNEX E

LIST OF CONTACTS

MEETING WITH MOH REPRESENTATIVES

ND.	Name	Position	Institution
1	Lynn Johnson	Evaluator	
2	Martha L. Burdick de Piedrasanta	Manager	C.S. Project, IEF-Guatemala
3	Marylena Arita	Medical Advisor	IEF-Honduras
4	Fiosa Marlen Flores	Professional Nurse	CESAMO 3 de Mayo
5	Jaime D. Irias	Social Worker	CESAMO San Francisco
6	Teresa Bonilla	Social Worker	CESAMO 3 de Mayo
7	Laura Molina	Supervisor	IEF-Honduras
6	Jeffrey Brown	C.S. Coordinatcu	IEF-Washington
9	Victoria de Alvarado	Coordinator	IEF- Honduras
10	Dagoberto Torres	Director	CESAMO San Fiancisco
11	Danilo Velasquez	Head	International Relations, MOH
12	Raul F. Gomez	Director	IEF-Honduras

MEETING WITH THE USAID MISSION

1	Dr. Stanley Terrell	Child Survival Officer	USAID-
2	Ms Laurie Ann Lous	Population Officer	USAID-
3	Dr. Jeffrey Brown	C.S. Coordinator	IEF Washington
4	Dr. Raul Gomez	Director	IEF Honduras
5	Lit. Victoria de Alvarado	Project Coordinator	IEF Honduras

MEETINGS WITH NGOS

ADRA: ADVENTIST DEVELOPMENT AND RELIEF AGENCY

I	Nelson Tavares	Director
2	Jeffrey Brown	IEF Washington
3	Lynn Johnson	Evaluator

LA LECHE LEAGUE

1	Esperanza Meza	Program Coordinator
2	Gilma Bustillo	Director
3	Victoria de Alvarado	IEF Coordinator
4	Marylena Atvaredo	Technical Advisor, IEF
5	Lynn-Johnson	Evaluator

PROJECT HOPE

1	Marten Espinal	Sub Coordinator Microenterprise
2	Victoria de Alvarado	IEF Coordinator
3	Teresa Bonilla	Social Worker
4	Lynn Johnson	Evaluator
5	Jeffrey Brown	IEF Washington

CESAMO PERSONNEL

CESAMO	**San Francisco**
Nohemy Padilla	**Auxiliar de Enfermeria**
Dagoberto Torres	**Director CESAMO**
CESAMO	**Tres de Mayo**
Rosamalen Flores	**E P**
Celina Carrasco	**E P**
Rosa Molina Flores	**Enfermera Auxiliar**
CESAMO	**Las Crucitas**
Felicito Montalvan	**Director**
Lizzete Arguijo	**Auxiliar de enfermeria**
Maribel Navarro	**E P**

COMMUNITY HEALTH VOLUNTEERS

SAN BUENA VENTURA
Mirian Hernández
Genoveva Flores
Marlen Ordofiez Oliva
Blanca Lidia Vargas
Ana Lizeth Ramirez
Marlen Umanzor Reyes
Karla Yesenia Banegas
Rosalina Calix

CAMPO CIELO
Eva Matute
Teresa Moreno
Alejandra Baquedano
Francisca Juarez
Sergia Sierra
MMaría Saraí Munguia

1ERO DE DICIEMBRE Y CALLEJAS
Maritza Hernández
Maria Fidelina Galindo
Claudia Zambrano
Maria Trinidad Vasquez Torres
Maria Estela Coello
Susie Yamilet Corrales
Maria Isabel Bahia
Patricia Medina
Daisy Rivera

FATIMA
Felipe Nuñez
Betulia Hernández
Gemercinda Servelldn
Suyapa Sanchez
Amparo Godrey

NUEVA DANLI
Ondina Diaz
Anan Jesus Valladares Varela
Maria Carmen Goméz

ALTOS DEL PARAISO
Mirian Flores
Juana Ayala
Olga Marina Cerrato
Berta Erazo Elvir
Ana Julia Molina Agurcia

MOTHERS

SAN BUENA VENTURA

Angela Liliana Banegas
Marta Maritza Barrientos
Lilian Flores
Maritza Velasquez
Rosa Aurora Flores
Claudia Suyapa Amaya
Esmeralda Ramos
Ilsy Esperanza Cruz

CAMPO CIELO

Porfiria Garcia Ruiz
Norma Alicia Castillo
Ana Daisy Vasquez
Maria Reyes Avila
Iris Yolanda Gómez
Patricia Zúniga

1 DE DICIEMBRE Y CALLEJAS

:odia Suyapa Mejia
Maria de1 Carmen Gonsalez
Martha Isabel Figueroa
Yesenia Trinidad Puerto
Mirian Velasquez
Trinidad Rivera
Jesus Tome
Maria Cristina Diaz
Rosa Albertina Estrada
Sonia Ondina Aguilera
Elsy Ondina Berrios
Ofelia Baizá
Ivan Diaz Chavez
Maru de1 Rosario Meza
Elin Rosario Mendoza
Martha Beatriz Salgado
Maria Elsa Paredes
Brijida Alvarez Paredes
Lilian Yolanda Ulloa
Maria de1 Carmen Avila

NUEVA DANLI

Norma Castillo
Maribel Urbina
Leyla Nolasco
Rosa Gomez
Marili Lopéz
Elida Rodriguez
Augustina Vaquedano
Antonia Torres
Rosalinda Osorto
Margarita Palma

Luz Alvarado
Rafaela Vasquez

ALTOS DEL PARAISO
Daisy Marina Santos
Leonarda Villalta Reyes
blanca Nieves Funez
Maria Ercilia Murillo
Sonia Marina Sanchez
Argentina Rivera
Maria Edith Rubio
Sonia Ksperanza Nuñez
Beneranda Carranza
Alicia Flores
Maria Nicolasa Guevara
Rosalinda Zambrano
Carmen Ochoa
Vilma Araceli Acosta
Nuvia Ondina Acosta
Ana Georgina Rodriguez
Ana Julia Corrales
Lizeth Andino
Gumercinda Calix
Lidia Lazo
Gloria Antonia Dominguez
Estela Marquina

HOME VISITS

1ERO DE DICIEMBRE
Daisy Suyapa Osorio
Adilia Rodas

FATIMA
Obdulia Cálix

NUEVA DANLI
Maribel Urbina

ALTOS DEL PARAISO
Mar ía Suyapa
Eva Cristina Amador

COMMUNITY LEADERS

FATIMA
Jose Maldonado
Victor Astor Banegas
Aixea Vargas

CAMP0 CIELO
Rigoberto Beltran
Epifanio Nuñez
Angela Bienvenida
Rigoberto Quiroz
Teresa Moreno

1 DE DICIEMBRE
Cristobal Guzman

BREASTFEEDING SUPPORT GROUPS

SAN BUENA VENTURA
Karla Yesenia Banegas

DUARTE
Reyna Isabel Montecinos
Nora Amelia Lopez
Mercia Mejia
Blanca Ondina Diaz

1ERO DE DICIEMBRE
Daisy Rivera

FATIMA
Gloria Amparo Godoy

NUEVA DANLI
Blanca Ondina Diaz

ALTOS DEL PARAISO
Mirian Flores

FRUIT TREE NURSERY OWNERS

CAMP0 CIELO
Alejandra Ramos

1ERO DR DICIEMBRE
Isabel Bahia

FFATIMA
Romulo Sanchez
Felipe Nuñez

COMMUNITY BANKS

FATIMA
Aixea Vargas

CAMPO CIELO
Sergia Sierra

1ERO DE DICIEMBRE
Maria Isabel Bahia

ANNEX F

LIST OF DOCUMENTS REVIEWED

DOCUMENTS REVIEWED

1. Annual Report of the Child Survival for Vitamin A Project, International Eye Foundation, Tegucigalpa, Honduras, November 1994.

2. Bossert, Thomas J., Sustainability and Child Survival: Are They Compatible, APHA Presentation, September 1990.

3. Bossert, Thomas J., Can They Get Along Without Us? Sustainability of Donor Supported Health Projects in Central America and Africa, Social Science Medicine, Vol.30, No. 9, Great Britain, 1990.

4. Brown, Jeffrey, Scope of Work, Honduras Midterm Evaluation, International Eye Foundation, Bethesda, Maryland, July 1995.

5. Child Survival for Vitamin A Project, International Eye Foundation, Tegucigalpa, Honduras, proposal submitted to US Agency for International Development, Washington, D.C., Decemmber 1992.

6. Detailed Imnlementation Plan, Child Survival Project, International Eye Foundation, Tegucigalpa, Honduras, submitted to US Agency for International Development, Washington, D.C., April 1994.

7. International Vitamin A Consultative Group, Guidelines for the Development of a Simplified Dietary Assessment to Identify Grouts At Risk for Inadequate Intake of Vitamin A, Washington, D.C., July 1989.

8. International Vitamin A Consultative Group, Guidelines for the Eradication of Vitamin A Deficiency and Xerouhthalmia, Washington, D.C., 1989.

9. Lara, Victor, Report of the Vitamin A for Child Survival VI Project, Mid-Term Evaluation, International Eye Foundation, Honduras, November 1992.

10. Mid-term Evaluation Guidelines, US Agency for International Development, Washington, D.C., 1995.

11. Technical Review of the DIP: IEF/Honduras, US Agency for International Development, Washington, D.C., July 1994.

12. Wind, Alonso, Final Evaluation and Sustainability Assessment, Child Survival for Vitamin A VI Project, Tegucigalpa, Honduras, December 1993.

ANNEX G

RESULTS OF THE SURVEY OF MOTHERS

METAS Y DESEMPEÑO DE FIO-HONDURAS
JULIO 1995

No.	INDICADOR	META %	LINEA BASAL %	CAP 95 %
	PAI			
1	% de niños 12-23 meses con esquema completo	80	84.6	88.0
1	% de madres con 2+ dosis de TTV	70	60.0	39.3
	CED			
1	% de niños menores de 24 meses recibiendo TRO	65	48.3	77.1
2	% de niños menores de 24 meses recibiendo antibiótico durante la diarreas	40	57.3	40.6
	NUTRICION			
1	% de niños recibiendo lo igual o más comida durante diarrea	40	51.9	79.4
2	% madres lactantes, dando lactancia materna exclusiva hasta los 4 meses.	35	23.5	31.8
	VITAMINA A			
1	% de niños 6-59 meses recibiendo vitamina A cada seis meses*	80		
	a) Una dosis		59.9	89.6
	b) Dos dosis		20.4	50.4
2	% de mujeres puérperas recibiendo vitamina A dentro de 30 días despues del parto	60		65.7
	IRA			
1	% de madres que saben señales de neumonía	70	62.0	87.7
	SIDA			
1	% de madres que saben que se puede prevenir el SIDA por uso de condones	90	54.3	74.3

* Se midió las dosis adminitradas a los niños 12-23 meses en el último año

OTROS INDICADORES DE PROYECTO DE SUPKRVI VEXCIA INFANTIL
FIO - HONDURAS

	INDICADOR	LINEA BASAL 8/93 %	CAP'S 95 7/95 %
	PAI		
	DPT1 12-23 meses	89.0	92.0
	DPT3 12-23 meses	86.8	88.0
	OPV1 12-23 meses	89.0	92.0
	OPV3 12-23 meses	87.6	88.0
	DPT1-DPT3/DPT1 12-23 meses (deserción)	2.4	4.3
	Anti sarampión	86.0	92.0
	BCG	88.0	90.4
	Esquema completo con BCG	84.6	88.0
	TTV2+	60.0	39.3
1	% niños 0-23 meses con carnets	91.3	93.6
2	% de niños 0-23 meses que ha perdido carnet	5.3	4.3
3	% madres con niños 12-23 meses reportando que su niño ha sido vacunado una vez	99.0	100.0
4	% madres con carnet prenatal/TTV	63.0	71.7
	CED		
1	% niños recibiendo igual o más líquidos durante diarreas.	74.6	89.3
2	% niños recibiendo lo igual o más pecho durante su diarrea	62.9	65.6
3	% niños recibiendo SRO durante su diarrea	37.1	58.3
	NUTRICION		
1	% niños 5+ meses recibiendo alimentos regularmente (2+ veces a la semana con comida rica en vitamina A	60.4	71.7
2	% niños 5-8 meses recibiendo alimentos	96.1	87.2
3	% madres que conocen 2+ fuentes de vitamina A	21.4	84.0
	IRA		
1	% madres que llevan a su niño con IRA al promotor/centro de salud/clinica/vs	77.9	83.1
	SALUD **MATERNA**		
1	% madres con una visita prenatal	90.3	86.7
	PRODUCCION DE ALIMENTOS		
1	% de madres (familias) con huerto 50	7.3	35.7

ANNEX H

TRAINING SUMMARY

TRAINING IN CHILD SURVIVAL
INSTITUTIONAL STAFF

DATE	No.	TOPIC	TEST (PRE=POST)	Hrs.	METHODOLOGY
3/94	28	Fruit Nurseries		20	Demonstrative Expository
3/94	31	Educational Techniques..		8	Participatory
5/94	23	Organizational Motivation		8	Expository
2/16/95	32	AIDS	95 - 100	8	Participatory
2/29/95	29	AIDS		6	Participatory
3/94	76	EPI	60 - 80	8	Participatory
4/19/95	40	EPI		6	
2/22/94	48	EPI			
5/6/94	18	EPI			
23-24/93	17				
7/27/95	25	EDA*	92%	6	Participatory
3/15/95	32	EDA**		6	Participatory
5/23/94	43		58 - 89		
3/6/94	10				
4/20/94	28				
3/4/94	9	ARI		6	Participatory
3/9/94	19				
5/29/94	38				
3/23/95	30	Nutrition Breast feeding	52% - 88%	6	Participatory
4/6/95	36	Vitamin A		8	Participatory
5/9/95	34	Vitamin A	40 - 88	8	Participatory
7/29/94	50				
5/10/95	18	Vitamin A CESAMO Los Pinos	52 - 95	6	Presentation/ Practical Magisterial/Groups

* CCD: For CESAMOS Las Crucitas and San Francisco

**CCD: For CESAMO-3 de Mayo

TRAINING IEF STAFF
(October 1994 - July 1995)
REINFORCEMENT SESSIONS

DATE	No.	TOPIC	Hrs.	METHODOLOGY
10/25-29/93	10	Breastfeeding	40	Magisterial & Participatory
3/94	10	Educat. Mat. Preparation	8	Demostrative
2/2/94	10	MIS - How to Make Visits	16	Participatory
10/93	10	Census data collection	8	Practical & field test
10/12/94	4	EPI	4	Participatory Group technique
2/27/95 11/94	10 11	AIDS	4	Participatory Group technique
10/31/94	1 1	Cholerae	2	Participatory
10/17/94	9	Nutrition	3	Magisterial & Participatory
7/17/95	1 1	Participatory Methodology Education	8	Magisterial, Participatory & Sociodrama
5/17/94	19	Vitamin A	8	Participatory
7/20/94	42	Vitamin A	8	Participatory
3/95	9	PEC	12	Exposition Demonstrative
3/28-30/95	1 1	Fast survey	24	Exposition, Practical
3/1/95	11	Focus Groups	4	Participatory Magisterial

Note: Initial training to four new nurses was given in ORT, ARI, Breastfeeding, EPI, and Nutrition

Table 4

TRAINING TO HEALTH VOLUNTEERS

DATE	No.	TOPIC	TEST (PRE=POST)	Hrs.	METHODOLOGY
1/18/95	183	MIS		8	Practical
3-94	141	EPI-ARI		4	Participative
4/94	42	Diarrhea		8	Exposition Demonstrative
4/94	76	MIS		3	Practical
4/94	51	Home visits		3	Sociodrama
4/94	30	Vitamin A Demonstration		3	Exposition Demonstrative
5/94	48	Motivation		4	Participatory
5/94	101	Diarrhea		4	Exposition Participatory
6/27, 17/94	44	Introductory Module	86	40	Exposition Demonstrative-
6-94	157	EPI		2	Participatory
6/2, 16/94	68	Vitamin A	44 - 86	6	Participatory
8/94	14	LLL Counselors		40	Practical
8/94	19	Vitamin A		3	Participatory
10/94	203	Nutrition		6	
11/94	74	Nutrition		3	Participatory
11/94	118	Cholerae		3	
11/94	10	Elaboration of bows		6	Practical
1/95	10	Vitamin A		3	Demonstration
2/95	156	AIDS		2	Expository
3/95	16	Introductory Module		40	Participatory
3/95	90	Diarrhea		3	Participatory
4/95	14	EPI		2	Participatory
4/95	26	AIDS		1	Film
3/95	15	Nutrition		4	
3/95	87	Basic Messages		4	Participatory
3/95	38	EPI		4	Participatory
6/95	27	Nutrition		2	Demonstration
6/95	64	Basic Messages		3	Participatory
5/95	54	Diarrhea		3	Participatory
5/95	54	EPI		3	Participatory
5/95	55	MIS		3	Practical
5/95	54	Nutrition		3	Participatory
6/95	245	Basic Messages		2	Participatory
6/95	187	ORT		2	Participatory Demonstration

DATE	No.	TOPIC:	TEST (PRE-POST)	Hrs.	METHODOLOGY
5/95	39	AIDS		2	Participatory
5/95	19	Home visits		3	Participatory
5/95	20	Elaboration of flowers		3	Demonstration
5/94	71	ORT		6	Participatory

ANNEX I

FINANCIAL PIPELINE ANALYSIS

PVO/COUNTRY HONDURAS
Cooperative Agreement No FAO-0500-A-00-3020-00
DATE SUBMITTED TO USAID 07/26/95

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

		Actual Expenditures to Date 09/30/93 to 06/30/95			Protected Expenditures Against Remaining Obligated Funds 07/01/95 to 09/29/96			Total Agreement Budget (Columns 1 & 2) 09/30/93 to 09/29/96			
DIRECT COSTS		AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL	
I. PERSONNEL (salaries, wages, fringes)	1. Headquarters-wages/salaries	6,908	2,292	9,200	3,305	21,121	24,425	10,213	23,413	33,625	41.67%
	2. Field, Technical Personnel-wages/salaries	93,647	10,285	103,932	92,304	10,115	102,419	185,951	20,400	206,351	32.36%
	3. Field, Other Personnel-wages/salaries	41,753	4,016	45,769	22,451	9,909	32,360	64,204	13,925	78,129	49.64%
	4. Fringes - Headquarters + Field	34,786	4,825	39,611	9,141	12,983	22,124	43,927	17,808	61,735	34.97%
	SUBTOTAL - PERSONNEL	177,094	21,418	198.512	127.201	54.128	181,328	304,295	75,546	379,840	20.81%
TRAVEL/PER DIEM	1. Headquarters - Domestic (USA)	0	41	41	375	1,934	2,309	375	1,975	2,350	41.80%
	2. Headquarters - International	2,760	2,501	5,261	14	2,486	2,500	2,774	4,987	7,761	100.00%
	3. Field - in country	1,043	0	1,043	4,957	0	4,957	6,000	0	6,000	050%
	4. Field - International	3,601	209	3,810	4,569	11,641	16,210	8,170	11,850	20,020	82.62%
	SUBTOTAL - TRAVEL/PER DIEM	7,404	2,751	10,155	9,915	16,061	25,976	17,319	18,812	36,131	55.92%
II. CONSULTANCIES	1. Evaluation Consultants - Fees	22	0	22	11,978	0	11,978	12,000	0	12,000	57.25%
	2. Other Consultants - Fees	6,304	473	6,777	5,196	7,027	12,223	11,500	7,500	19,000	99.82%
	3. Consultant travel/per diem	806	0	806	8,194	0	8,194	9,000	0	9,000	45.18%
	SUBTOTAL - CONSULTANCIES	7,132	473	7,605	25,368	7,027	32,395	32,500	7,500	40,000	91 04%
III. PROCUREMENT (provide justification/explanation narrative)	1. Supplies										78 06%
	a. Headquarters	0	309	309	700	(159)	541	700	150	850	100 00%
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	0	0	0	0 4,700	0 7,450	12,150	4,700	7,450	12,150	100.00%
	c. Field - Other	11,664	135	11,799	(3,072)	2,765	(307)	8,592	2,900	11,492	-35.75%
	2. Equipment										
	a. Headquarters	0	670	670	0	730	730	0	1,400	1,400	
	b. Field	0	39,938	39,938	0	(3,638)	(3,638)	0	36,300	36,300	
	3. Training										
	a. Headquarters	245	262	507	(245)	(262)	(507)	0	0	0	
	b. Field	16,891	0	16,891	15,609	0	15,609	32,500	0	32,500	48.03%
	SUBTOTAL - PROCUREMENT	28,800	41,314	70,114	17,692	6,886	24,578	46,492	48,200	94,692	38.05%
IV. OTHER DIRECT COSTS (provide justification/explanation narrative)	1. Communications										
	a. Headquarters	0	1,131	1,131	0	3,744	3,744	0	4,875	4,875	
	b. Field	5.917	0	5.917	2.958	0	2.958	8,875	0	a.875	33.33%
	2. Facilities										
	a. Headquarters	0	0	0	0	0	0	0	0	0	
	b. Field	7,394	0	7.394	7,506	0	7,506	14,900	0	14,900	50.38%
	3. other										
	a. Headquarters	30	0	30	(30)	0	(30)	0	0	0	
	b. Field	16,876	1,244	la.120	4,924	(1,244)	3.680	21,800	0	21,800	22.59%
	SUBTOTAL -OTHER DIRECT	30.217	2,375	32.592	15,358	2,500	17.856	45,575	4.875	50.450	3370%
TOTAL - DIRECT COSTS		250.647	66.331	318.976	195.534	86,602	282,135	446.181	154,933	601,113	43.82%
II. INDIRECT COSTS											
A. INDIRECT COSTS	1. Headquarters	28,408	4,259	32,667	55,028	17,663	72,691	83,436	21,922	105,358	65.95%
	2. Field (if applicable)										
TOTAL INDIRECT COSTS		28,408	4,259	32,667	55,028	17,663	72,691	83,436	21,922	105,358	65.95%
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		279,055	72,590	351,645	250,562	104,265	354,826	529,617	176,855	706,471	47.31%

ANNEX J

SUSTAINABILITY PLAN

PLAN DE-SOSTENIBILIDAD

OBJETIVO	ACTIVIDAD	RESPONSABILIDAD	FECHA
/A. MSP 1. Supervisarlcapacitar Vol. de-6alud	1. Abordar el tema de sostenibilidad	Reunion MSP Resultados Evaluation	15 de agosto
	2. Plan de-Sostenibilidad	FIO, MSP, ONG, LLL	6 de noviembre
	3. Recolectar datos de SAIN 3 de Mayo	FIO/CESAMO	Agosto- Octubre
	4.-Tomar decision sobre estrategia- SAIN		31 de octubre
	5. Visita de V.S. a SAIN de La Paz	FIO	IO de octubre
	● 6 Capacitation Mensual al personal de los CESAMOS	FIO/CESAMO	Mensual
	7. Implementacion del Plan de Sostenibilidad	FIO/CESAMO	15 de enero de-1996
	8. Transferencia - Bancos-HOPE- - Viveros-LUPE - Consejeras LLL y MSP	FIO	Desde enero 1996
Grupos Comunitarios apoyaran actividades- de Supervivencia Infantil			
a:-La V.S. educara a las madres	TOT a Voluntarias de Salud	FIO/CESAMO	1 de febrero
	Las Vol. de Salud daran charlas-		Mensual a partir del 15 de octubre
b. Comite de Vol. de Salud funcionando	Oficializar y orientar los comites	Supervisoras y Auxiliares FIO	Septiembre a Diciembre
	Orientacion a la A/E sobre el traspaso	FIO	5-6 de octubre
	Eualuacion de traspaso de charlas	FIO	Diciembre
c. Los patronatos- apoyaran cl trabajo de los Vol. de Salud	Eatrega de-infornes de Patronato de los Vol. de Salud - Informe oral	Vof. de Salud	Mensual apartir de enero 1996

* Temas: 1. Supervision; 2. Referencias; 3. Manejo Informacion SIS:

4. Toma de Decisiones en Grupo; 5. Transferencias; 6. Relaciones Humanas;

7. Manejo Archive (Supervision: Calidad, Frecuencia; Relaciones Humanas);

8. TOT; 9. Cllidad; 10. Information: Toma-de Decisiones, Referencias

TOT (Capacitation de Capacitadcues: A/E; Enfermeras Profesionales

11. Liderazgo Morat

OBJETIVO	ACTIVIDAD	RESPONSABILIDAD	FECHA
alud Ocular	-Capacitar dos enfermeras	Ehrler/Vicky	Agosto/Septiembre
	-Seguimiento por parte de maestros	ChildSight	
	-Referencias Min. de Education Publica		
	Gestionar la institucionalizacion con el Min. de Education para la toma de agudeza visual y referencia de ninos	ChildSight Raul Gomez	
adres Consejeras-	Reuniones trimestrales con la. Auxiliar de Enfermeria y las Madres Consejeras	Yudhy Sanchez	Mensual
	Seguimiento a LLL para incentives a las madres consejeras	Yudhy Sanchez	Mensual
ive ros	Asegurar una fuente permanente de-- asistencia tecnica para los viveristas	Victoria de Alvarado	Agosto
ancos	Establecer bancos en las 15 comunidades que no tienen	Laura Molina Renato Well Miriam Espinal	Hasta el 30 de diciembre