

**PVO – NGO Experiences
With AIN-C in Honduras
Participatory Study**

**THE CORE GROUP
IMCI and NUTRITION WORKING GROUPS**

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The CORE Group

The Child Survival Collaborations and Resources Group (The CORE Group) is a membership association of more than 35 U.S. Private Voluntary Organizations that work together to promote and improve primary health care programs for women and children and the communities in which they live. The CORE Group's mission is to strengthen local capacity on a global scale to measurably improve the health and well being of children and women in developing countries through collaborative NGO action and learning. Collectively, its member organizations work in over 140 countries, supporting health and development programs.



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EXECUTIVE SUMMARY

AIN-C (*Atención Integral de la Niñez en la Comunidad*) is a preventive health program created in Honduras to prevent mild and moderate malnutrition through a focus on growth promotion.

The CORE Group commissioned a study to examine the positive aspects and implementation challenges faced by NGOs implementing the AIN-C strategy in Honduras. The study consisted of a literature review, key informant interviews, site visits to AIN-C communities, and workshop discussion. It was an attempt to grasp retrospectively – and through the perspectives of NGOs at different stages of implementation – programmatic aspects related to training, program integration, service delivery, supervision, sustainability and scaling up. The intention of the study was to present recommendations based upon concrete implementation experiences of integrated community-based child health care in Honduras. It included analysis of NGOs past participation in AIN-C policy stages and considered the desirability of active NGO engagement in policy formation and program design in the future. All NGOs interviewed have extensive experience implementing child survival activities in Honduras within a broad health and development context. Programs are aimed at reaching marginalized and under-served populations.

The overall impression of NGOs involved in AIN-C is very positive. Collaborating NGOs find the AIN-C strategy to be a health and nutrition promotion strategy that actively involves families and communities in the achievement and maintenance of adequate growth for children under age two and in the care of sick children between zero to five years of age. Most NGOs feel the AIN-C strategy is improving community access to and use of health facility services, especially through referral processes established at community level, but also suggest that there is room for further improvements. The weakest variable was seen as the lack of feedback of information from the health center to the community. NGOs are concerned about ongoing sustainability, especially related to follow-up and supervision of local Monitors.

Based on the Honduran experience, AIN-C can be implemented in countries with or without health sector experience within the Integrated Management of Childhood Illness (IMCI) framework. However, countries seeking to incorporate the AIN strategy into their health care system should clearly address the relationship between the AIN and IMCI strategies to avoid potential confusion among implementers. Five of the six NGOs are implementing a systematized growth promotion strategy using MOH/BASICS tools and following key AIN-C concepts. The majority of these NGOs have successfully combined Module One (growth promotion) after having previously initiated a disease treatment module for diarrhea and pneumonia prior to adoption by the MOH in Honduras of the complete AIN-C framework. NGOs merged these two modules by stressing the focus on growth promotion as the key entry point for MOH outreach activities to communities.

NGOs are contributing to AIN-C implementation, follow-up and scale by providing human resources for implementation and supervision, technical assistance to local health units for supporting and supervising local Monitors and significant financial support for materials and activities. NGOs are an important resource that can assist in the implementation and/or scaling up of the AIN-C strategy, especially among target populations that are not easily linked to health facility services due to distance or marginalization.

NGOs identified the government's capacity to provide sufficient funds for training of community Monitors, along with supervisory follow-up of implementation, as the major issues related to future sustainability and as the limiting factors for further expansion. All NGOs brought in external funds to support AIN-C efforts and estimated that initial training, material and equipment costs ranged from US \$400 - \$600 per Monitor.

Governments have not taken full advantage of NGO know-how to promote intersectoral approaches. NGOs not only undertake child survival programs, but also have experience with other type of programs. Utilizing NGO experience to position community child health care in the agenda of different sectors can be an effective advocacy for economic resources in support of an integrated community child health strategy.

The involvement of NGOs in policy design for child health strategies at the community level is a resource that has not been fully utilized in most countries. None of the participating NGOs had been involved with AIN policy formation and only one NGO with program development. All interviewed NGOs stressed that closer coordination during these two phases would provide for more long-term follow-up and sustainability. It could also have more quickly increased the scale of the program. Examples of implementation issues that could be addressed by ongoing dialog with the MOH are suggested.

A cost-benefit or cost-effectiveness study may be desirable to validate assumptions that a reallocation of government resources for purposes of supervising the AIN-C monitors would represent an overall economic savings. An integrated community child health strategy can diminish health centers' workload (and costs) since a child that grows well is a healthy child.

I. Introduction

A. Purpose and Objectives

The CORE Group, a collaboration of more than 35 U.S.-based NGOs involved in maternal and child health programs worldwide, commissioned a participatory study of NGO experiences with the AIN-C (Atención Integral de la Niñez en la Comunidad) strategy in Honduras.

The objectives of this study were to:

1. Identify strengths, weaknesses and lessons learned by NGOs supporting the implementation of the AIN-C strategy by the MOH¹ of Honduras
2. Consider the implications for NGOs wanting to expand or scale-up the AIN-C strategy and/or considering implementing growth monitoring as part of IMCI strategies in other country contexts
3. Provide recommendations on how the NGO community in Honduras can complement efforts of the MOH in Honduras

The study examined the positive aspects and implementation challenges faced by NGOs through facilitating informed discussions among Honduran-based PVOs/NGOs implementing the AIN-C strategy. It was an attempt to grasp retrospectively – and through the perspectives of NGOs at different stages of implementation – programmatic aspects related to training, program integration, service delivery, supervision, sustainability and scaling up. The intention of the study was to present recommendations based upon concrete implementation experiences of integrated community-based child health care in Honduras. It included analysis of NGO's past participation in AIN-C policy stages and considered the desirability of active NGO engagement in policy formation and program design in the future.

B. Methodology

The study consisted of a literature review, key informant interviews, site visits to AIN-C communities, and workshop discussion. The study direction and methodology was developed through an iterative process with a steering committee composed of Honduran and US-based public health professionals. One-on-one semi-structured interviews with CORE members and telephone and e-mail exchanges with BASICS staff in Honduras and in the USA, CARE Honduras and USA, CRS Honduras and USA, Emory University, John Snow Inc., Mercy Corps/PAG Honduras/USA, The Manoff Group, and The World Bank helped inform the study direction.

¹ In Honduras, the national level of the health sector is the Secretariat of Health; however, in this document, it will be referred to as the more commonly known Ministry of Health (MOH).

NGOs involved in the study included the American-Honduran Red Cross, Canadian-Honduran Red Cross, Catholic Relief Services, CARE USA, Global Village Program/Mercy Corps International and World Vision. The NGOs were selected based on their level of experience with the AIN-C strategy. Five of the NGOs have been directly involved with AIN-C implementation and one was scheduled to begin implementation in July 2002.

Literature Review. The lead consultant reviewed both published and unpublished literature covering aspects of the development of AIN-C in Honduras. Materials were provided by members of the CORE Steering Committee and identified through literature databases on the Internet. A list of references can be found in Appendix B.

Key Informant Interviews were conducted with high-level program staff (NGO directors or program managers) with extensive experience in their organization's AIN-C implementation. Open-ended questions covered perceptions of the AIN-C strategy, political will and commitment, experiences with implementation and recommendations for improvements. Interviewees were informed that all responses would be anonymous and were encouraged to express their unguarded opinions of the AIN-C approach. The results of the key informant interviews were compiled and reviewed by the study team and fed into the workshop discussion. The lead consultant and a Honduran consultant conducted in-person key informant interviews together between June 10 and June 15, 2002 with four of the NGOs. One NGO postponed the interview but completed the questionnaire and discussed responses via e-mail. The final interview was conducted via phone by the lead consultant. The guide for key informant interviews is included in Appendix D.

Site visits. Each participating NGO was asked to select two communities with on-going implementation in an AIN-C program for field visits. A total of eight field visits to communities (six rural and one urban) were conducted. Non-participant observations were made during community-based growth monitoring and follow-up counseling sessions conducted by community Monitors. All communities but one were a significant distance from urban centers with poor road access. The one urban area project visited was in a marginalized area. In a few instances, due to time constraints, a simulation of community growth monitoring activities was organized by Monitors to facilitate this study. Originally, the consultants planned to conduct home visits and interview mothers during the same community visits; however, due to time constraints and the distance involved in visiting the sites, home visits were conducted in only two communities within one NGO project area. Two visits with MOH staff at centralized health facilities (one rural municipal and one urban health center) were also included in field visits.

Workshop. Finally, a one-day workshop was organized and conducted with the participation of all six NGOs and representation by the MOH. Workshop activities involved two steps:

Step 1: Categorization of NGO experiences in order to understand the national development context and gather general data on project implementation.

The starting point for consideration of NGO participation in a national development context was adapted from the Pyle-Wallerstein model. Participation within the national development context ranges from policy formulation and definition of health strategies, to implementation of the AIN-C strategy, to expansion and replication of the AIN-C strategy, and to long-term sustainability.

In order to categorize the NGO's level of national development participation, five modifiable conceptual diagrams were created and provided to each NGO. The diagrams represented a variety of possible scenarios of implementation. In individual groups during the workshop, each NGO selected and/or adapted these diagrams to describe their own situation. The descriptions for each original diagram (or "mode" of implementation), in relation to the AIN-C strategy in Honduras, were as follows:

AIN-C MODES ONE THROUGH FIVE

Diagram 1: Coverage of an MOH Health Area that has the AIN-C strategy functioning in at least half of communities and now must maintain these communities while expanding coverage to the remaining half;

Diagram 2: Coverage in an MOH Health Area that is just initiating the AIN-C strategy.

Diagram 3: Coverage in an MOH Health Area that has initiated the AIN-C strategy and wishes to expand, but does not have access to technical or financial assistance.

Diagram 4: NGOs implementing AIN-C with varying amounts of coordination with the MOH, and with some adaptation of AIN to their own program requirements.

Diagram 5: Communities implementing the AIN-C strategy at present, but having initiated with a disease treatment module.

Each NGO was asked to select the diagram most representative of their stage, and to modify it as necessary in order to conceptually portray their stage of AIN-C implementation (Appendix C).

Step Two: Rating NGO involvement in each of three stages.

After group discussion of key issues related to three national policy development stages, each NGO used a scale to rate its level of participation within the three stages.

The stages of national policy development were divided into the following categories:

- a) Policy Formulation: Three performance factors related to policy formulation were considered, including participating in the origin of policy, in defining policy objectives, and in providing policy support.
- b) Program Development: Three performance factors reflecting program development were considered, including program linkages to policy, level of agency action, and awareness of management issues.
- c) Policy Implementation: Performance factors reflecting project implementation were considered, including targeting, infrastructure and supplies, and sustainability.

The workshop ended with an open forum during which NGOs provided recommendations for the AIN-C strategy and the role of NGOs within each one of the national policy development stages.

II. Background and Development of AIN-C in Honduras

A. Poverty and health in Honduras

Honduras, with a total surface area of 12,090 km² and population density of 58 per km², is a beautiful country of mountains and valleys located in the heart of Central America. With a gross national income per capita of \$850 in 1998, the World Bank classifies Honduras as a lower-middle-income economy and as a heavily indebted poor country². According to The United Nations Economic Commission for Latin America and the Caribbean (*CEPAL*), Honduras is a country with low levels of social development and elevated poverty levels greater than 50% of population, similar to that found for Guatemala and Nicaragua³.

Rural poverty continues to be a problem of great magnitude with rural poverty rates of 80% and urban poverty rates of 67%⁴. Fifty six percent of Hondurans live in rural areas and three-quarters of the rural population depends on the public health system for health services. The rural population is distributed in 3,730 towns and 27,764 hamlets in mountainous areas. The dispersion of the Honduran rural population makes access with universal social programs difficult and expensive. The urban population is concentrated in two cities: Tegucigalpa and San Pedro Sula.

It is estimated that in 2002 there were 188,179 children under the age of one year in Honduras and 712,863 children between ages one to four.⁵ In ideal settings, a country

² World Bank July 2002; <http://www.worldbank.org/data/countryclass/classgroups.htm> (August 2002).

³ Basic Social Indicators of Countries in the Northern Subregion of Latin America and the Caribbean, 2000-2001; United Nations, Economic Commission for Latin America and the Caribbean (*CEPAL*); April 6, 2001.

⁴ Poverty is defined as the percentage of households with income that is less than two times the cost of the basic food basket; *CEPAL*, 1997.

⁵ Health Situation in Honduras in 2002, Basic Indicators; Statistics Dept, SOH, Honduras.

should be able to prevent malnutrition and disease among children in all age groups. Dealing with economic constraints, policy makers are forced to set priorities. Poverty has exacerbated crime, which is linked to the traffic of illegal drugs and to an increase in urban youth gangs. To address poverty, Honduras must confront multiple problems, many of them related to water, sanitation and housing⁶, making it essential to propose interventions within and outside the health sector. High indices of Unsatisfied Basic Needs are complicated by frequent natural disasters. In 1998, Hurricane Mitch destroyed 70% of the country's crops and had a deleterious effect on exports that dropped to negative values (-9.4%). Decreases in production of bananas; plantains, rice, beans and coffee further contributed to an increase in poverty.

The Secretariat of Health in Honduras, referred herein as the Ministry of Health (MOH), is geographically divided into nine Health Regions, which are then divided into 42 divisions known as Areas. Health Areas do not directly correspond to the political-administrative divisions known as Departments. The Honduran health sector depends substantially on foreign funds. For example, from 1990-1995, foreign funding represented 22% of the total resources available for the health sector. Bilateral cooperation accounted for 53.3% of international cooperation for health with the United States of America the largest donor (45.2%). Cooperation from agencies of the United Nations system and financial institutions such as the Inter-American Development Bank and the World Bank was also available.

B. Reasons for targeting malnutrition

Honduras has searched for answers to improve the health conditions of its children. In the late 1980s and early 1990s, despite declines in the infant mortality rate (from 54 per 1000 live births in 1985 to 52.7 in 1990⁷), malnutrition continued to represent a public health problem. From 1987 to 1994, rates of underweight children, defined as low weight-for-age, remained almost constant at 20.6% in 1987 and 21% in 1991. Stunted growth in children under age five, a sign of chronic malnutrition, hovers near 40% (39.1% in 1987; 39.7% in 1994).

The relationship between child anthropometric status and mortality has been well established. About half of all deaths among children under five years of age is attributable to underlying malnutrition (Figure No.1).⁸ The classic epidemiologic analysis published in 1995 by Pelletier et. al., conclusively demonstrated that children moderately and mildly underweight have a 4.6 and 2.5 times higher risk of dying than children that are well-nourished.

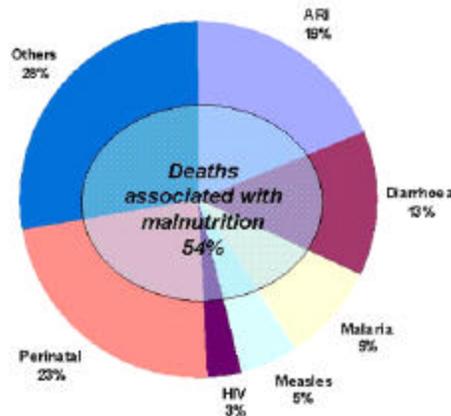
⁶ The Basic Needs Index measures 5 parameters, ranging from access to basic services to the economic dependency ratio; any household that does not satisfy at least 3 of the 5 criteria is considered "poor".

⁷ This declining trend has continued, with the IMR in 1998 estimated at 42 per 1000 live births.

⁸ Nutrition Essentials a Guide for Health Managers. WHO/UNICEF/BASICS 1999.

Figure No.1

Major causes of death among children under five, worldwide, 2000



Sources:

For cause-specific mortality: EID/WHO

For malnutrition: Pelletier DL, et al. *AMJ Public Health* 1998; 88:1130-3.

It is a well-known clinical fact that cases of measles, pneumonia and diarrhea are complicated among undernourished children. The association between malnutrition and cognitive development, leading to poor school performance, are also established. Malnutrition, a modifiable risk factor, increases a child's risk of dying from infectious diseases. As in other countries in the region, acute respiratory infections and diarrheal diseases are the major causes of mortality in the under five year old pediatric population in Honduras. In 1996, acute respiratory infections accounted for 23% and diarrheal diseases accounted for 21% of childhood deaths.

In the late 1980's, public health programs in Honduras determined that⁹ :

- Almost all permanent nutritional damage is suffered by children in the first two years of life;
- Nutritional status is the most comprehensive indicator of overall child emotional physical, and psychological well-being; and
- The principal causes of chronic infant malnutrition in Honduras are not a lack of food but illness and inappropriate feeding practices.

There was already a strong movement afoot in Latin America to look at the child in a more integrated or holistic manner, and the Hondurans saw growth monitoring as an entry point that addressed their specific concerns about nutrition within an integrated approach.

⁹ Corrales, G. "AIN-C. A New Paradigm Oriented to Promote the Healthy Growth of Children at the Community Level"; (workshop presentation); February 2002.

C. Development of the AIN strategy

The AIN strategy refers to the Integrated Child Health Strategy or *Atención Integral a la Niñez* (in Spanish). The goal of the AIN strategy is to prevent mild and moderate malnutrition, thereby decreasing morbidity and mortality.



AIN was originally introduced in 1990 as a facility-based preventive health program to address childhood malnutrition. Rooted in the utilization of infant growth for diagnostic purposes, its activities – converging around monthly growth sessions in the health center - included education for the improvement of nutritional practices, along with diarrheal disease and pneumonia case management.

To provide appropriate health services (such as immunizations, control of diarrhea or respiratory illness, etc), health center staff first established whether growth faltering was present and then determined the cause. By focusing on infant growth, AIN allowed for tailor-made management plans for children, including specific counseling in appropriate feeding practices for the caregivers.

Monthly growth monitoring proved to be a diagnostic tool easily accepted by health center staff for early identification of growth faltering and health services integration in the four pilot health centers. Every child that moved out of his or her individual growth curve was subject to a Protocol for the Investigation of Children Not Growing Adequately. This protocol systematically looked for the causes of inadequate growth due to illness, feeding practices, caretaker characteristics and food availability. Based on the results of the investigation, the health worker developed solutions. Focusing on the early identification of growth faltering gave excellent results and a 25% reduction in malnutrition was accomplished in the four pilot health centers over a three-year period¹⁰.

An essential component of the AIN strategy was changing the concept of malnutrition from a state-of-being to a dynamic process. The approach focused on the belief that a malnourished child is any child that begins to falter, no matter what his or her weight, rather than a categorization of a certain standard of weight for age.

¹⁰ Villalobos, C., et al; “AIN-C Integrated Child Health Care Improving Health and Nutrition at the Community Level”, World Bank Report; 2000.

The bulk of the early work was done in Health Region II, Comayagua. Region II had the advantage of being relatively close to the capital, Tegucigalpa. It had a history of strong public health leadership, and had often offered itself as a site for experimentation and innovation. Early efforts were guided by a working group of MOH personnel, with the technical assistance of the Latin America Center for Perinatology (CLAP) and Management Sciences for Health (MSH).

Encouraging results, along with the desire to expand coverage and reach the population not accessing available health services, motivated the Honduran health authorities to expand the strategy beyond the institutional level. In 1994, Honduras added a community-based component, referred to as the Integrated Community Child Health Program (*Atención Integral de la Niñez en la Comunidad*, or “AIN-C”). Experimentation with AIN as a community, rather than a facility-based, strategy also began in Region II. Two communities from each of four rural health posts were initially selected for implementation. It is worth noting that one of the criteria for selection of the health posts was that they were staffed with two auxiliary nurses. This was seen as assuring coverage for services at the clinic with one auxiliary nurse while providing a significant level of accompaniment of AIN implementation at the community level by the second auxiliary nurse.

In 1996, BASICS conducted an evaluation of the early implementation of AIN and Manoff, on behalf of the World Bank, conducted a larger evaluation of nutrition programs worldwide. The two sets of evaluation results were combined to provide a series of recommendations for how the AIN strategy could be strengthened.

The BASICS’ evaluation identified the following key problems, which were addressed in a redesigned AIN-C:

- a lack of a clear conceptual basis;
- a lack of a precise method to define adequate and inadequate growth;
- a lack of clear methods to assess the origins of problems and to provide adequate counseling messages to mothers;
- a lack of an information, monitoring and evaluation system.

Client-based research was conducted, a standardized training program was developed, clear standards for weight gain were established (based on new Latin American scientific norms for weight gain for infants), and other tools from different parts of the world were adapted. Villalobos describes the strategy as a new demand-generating AIN–C. This refined AIN–C included adapted experiences from different parts of the globe: a job description for community Monitors and an accompanying manual, from India; counseling card concepts from the Dominican Republic; a simple information system from Indonesia. The concept of using child growth as a community mobilization tool came from Tanzania, and nutrition education messages were developed in collaboration with projected program beneficiaries, as had been done in Indonesia. The “New AIN-C” was inaugurated in late 1997 and extended to other communities, ultimately covering about one-third of the population.

D. Introduction of IMCI

In 1992, WHO and UNICEF created the Integrated Management of Childhood Illness (IMCI) strategy to address the five principal causes of childhood morbidity and mortality (diarrhea, malaria, measles, pneumonia, and malnutrition). The initial focus was on an 11-day training course for health care providers to enable them to apply an integrated algorithm to classify and treat sick children. While the MOH was refining AIN-C, PAHO and BASICS were involved in the hemisphere-wide introduction of IMCI. Many countries in Latin America had anticipated the integration of previously vertical health programs in their national strategies. When, in 1996, the IMCI standard training course was introduced to Honduras, the MOH saw it as an opportunity to strengthen the clinical care provided by its facility based staff and it was adapted and adopted into facility-based AIN.

In 1997-98, global partners recognized the importance of creating a community component for IMCI. In the Americas, PAHO developed a generic set of training materials for community health workers to complement facility-based IMCI. These materials were designed to be adapted by each country for incorporation into national strategies. Honduran MOH staff involved in AIN-C implementation saw the proposed C-IMCI model as an external imposition, which did not reflect their national priorities and experience. They saw the community volunteer's role under C-IMCI reduced to the identification and referral of sick children as opposed to the more preventive role currently played by a variety of community health workers, including the AIN-C monitoras.

Continuing stress and confusion resulted in a meeting in San Pedro Sula in September 1999 chaired by Dr. Jorge Melendez, then head of Maternal and Child Health. As a result of this meeting, it was agreed that the Division of Maternal and Child Health would develop a "blended" model that assured that the primary elements of each approach would be incorporated into one integrated, MOH sanctioned approach.

E. Current AIN Strategy

The AIN strategy currently has two components: IMCI, a strictly institutional component, and AIN-C, a community-based component that has a growth monitoring module (Module One) and a disease treatment module (Module Two).

The guiding principles for the AIN-C strategy are listed in Table No.2:

Table No.2

1. Program activities are conducted within the community, by community members.
2. The focus is on the youngest children (0 - 2 years), the most vulnerable, with emphasis on prevention.
3. The focus is upon adequacy of growth as the indicator of health and development status. The priority is to address initial growth faltering to prevent malnutrition.
4. Data collection is used for decision making at every level, beginning with the family.
5. The program's vision is defined from the community to the central level.
6. The search for solutions begins with the family and in the community and can involve integrated programming.
7. The key solution to faltering growth is to achieve improvements in behaviors to address inadequate feeding practices.
8. Training serves to build new skills.
9. Family education is participatory and based upon negotiation.

"Promoting the Growth of Children: What Works"; Marcia Griffiths, Kate Dickin and Michael Favin; Human Development Department, World Bank; May 1996.

AIN uses a **problem solving approach methodology**, incorporating the steps described in the following growth promotion package¹¹:

- Regular assessment of child growth.
- Decision-making and action needed for the child.
- Decision-making and action at the community and program level to integrate and target services and resources to motivate and enhance actions in the household.
- Follow-up/feedback on the effects of actions taken.

¹¹ Marcia Griffiths, K.Dickin and M.Favin, "Promoting the Growth of Children: What Works"; Human Development Department, World Bank; May 1996.

Early growth faltering detection. Designed with a preventive emphasis, AIN has a focus on the growth of children from zero to two years, especially during their first six months of life to “detect the problem when it first begins.” The manual for community health volunteers (known as "Monitors") refers to AIN–C as a “new way to take care of children in the community” by which, instead of waiting for mothers to arrive at the Health Center with a sick child, disease (and death) are prevented by taking better care of children in the community.¹²

Training and supervision. Monitors are trained using a standardized training program and tools. Training in Module One lasts for five days. The MOH considers that three to four months of practice in the community provides sufficient preparation for Monitors to pass an evaluation of their capacity to implement Module One. To determine if a Monitor has mastered Module One, direct field observation of her/his work takes place, using a standardized checklist. Upon passing Module One at a 95% proficiency level, Monitors can proceed to receive training in the second module. Module Two has a focus on community-based treatment and management of common childhood illnesses through the use of simplified algorithm questions (flowchart) derived from the IMCI approach. The algorithms



AIN–C Community weighing session. Source: K. Van Roekel.

center around danger sign recognition, disease classification, treatment of dehydration and referral. In some instances, community volunteer Monitors have also been trained to provide the first dose of antibiotic, with referral, for cases of child pneumonia.

Beginning activities in the community. To begin activities at the community level, Monitors are selected by the community. Local MOH staff and community Monitors participate in a joint exercise to map the community and develop a list of children under age two. A baseline study of these children's age, weight and height is conducted. Community leaders also have a role in AIN-C. Monitors are encouraged to include them in community health activities, as they are people with decision-making power and leverage within the community.

Monthly meetings. Monthly meetings are health promotion activities held by the community Monitor with parents and caretakers to promote appropriate growth and take action to maintain health. Meeting dates and times are previously agreed upon with

¹² *Atención Integral a los Niños y Niñas en la Comunidad. Manual del Monitor y Monitora de AIN-C.* SOH, BASICS II, USAID. Tegucigalpa, Febrero 2000.

mothers. Teams of three Monitors per community hold monthly meetings at the house of one of the Monitors, in schools or in other communal sites. Ideally, each session enrolls 15 to 25 children.

Prior to the meeting, children with danger signs are identified, to receive immediate attention or to be referred as needed. Monitors follow six steps during these monthly meetings:

- ✓ Weigh each child under two years of age.
- ✓ Determine if growth is adequate: a) compare actual weight gain to expected weight gain, as calculated the month before by using a minimum expected weight gain chart; b) trace the growth curve on the child's health card.
- ✓ Appraise immunization status, practice of exclusive breastfeeding, status of iron and/or Vitamin A supplementation.
- ✓ Using the AIN-C Guide for Action (which takes into account a child's age, quality of growth, disease status, and other factors), assess the child's status to determine the emphasis for health and nutrition counseling.
- ✓ Using the AIN-C Counseling Cards, negotiate with the mother or caretaker a plan of action to maintain or improve the health and growth of children.
- ✓ Refer to the nearest health unit any cases that can't be resolved in the community.

The AIN-C Guide for Action is a set of simplified decision-making trees to help Monitors evaluate children and select the appropriate AIN-C Counseling Cards. Counseling information is divided by child age group in months: 0 to 2; 3 to 5; 6 to 8; 9 to 11; 12 to 17; 18 to 23; and 24 to 60 months. The guidance for children over 6 months also includes an evaluation of appetite. The guidance for ages 24 to 60 is exclusively focused on counseling for the sick child.

Home visits. The Monitors visit the homes of newborn children, children that fail to gain adequate weight from the previous month, children that are anorexic or sick, children under six months that are not breastfed, and mothers with breastfeeding problems. Every four months, the community Monitors hold community meetings. Guidance on how to prepare and lead meetings is provided in the Monitors' manual. At these meetings, they jointly analyze the growth and health of children in the community and organize community actions to solve the problems. Health center staff attend the initial meetings, to provide support.

Coordination with Health Center. AIN-C emphasizes good relations with all health center staff. The points of contact between Monitors and health center staff are multiple. Health center staff participate closely in the initial launching of AIN-C activities

in communities. The role of the Auxiliary Nurse at the local health center, and of other health center staff, is that of a trainer, supporter and counselor for the community Monitors. Meetings are used for continuing education of community Monitors, with a topic of interest selected each month, as well as for data sharing.

At present, the MOH of Honduras expects that by the end of FY2002, health care workers will be trained as AIN facilitators in 17 to 18 geographic Departments and 17 Departments will have at least two communities functioning with the AIN-C approach. (Note that most of these Department and communities are expected to implement the "complete" AIN-C package, i.e., Module One for growth monitoring and nutrition counseling, along with Module Two, for community-based treatment of child illness). It is expected that coverage will increase by one or two communities per year. It is recognized that NGO partners can help extend this coverage further. By the end of 2004, half of Honduras's communities should be covered, reaching all children under age two children with the full set of growth promotion and illness treatment activities and all under fives with illness treatment activities.

III. Results and Discussion

These results represent a combination of responses from the key informant interviews, site visits, and small group work and large group discussions at the workshop.

A. Role of NGOs

The six NGOs participating in this study have extensive experience in implementing child survival activities in Honduras. These activities generally focus on proven strategies to reduce child and maternal mortality and morbidity, such as the promotion of immunizations, along with innovative techniques to reach the most marginalized and under-served populations.

NGO activities to complement the MOH AIN-C in Honduras focused on several key areas:

- a) Promoting community-based democratic processes for increasing civil society involvement through the selection of community Monitors, the formation of community health committees or sub-committees and strengthening the linkage between the community forum and local government/national institutions.
- b) Promoting the use of community-based health information systems to enhance the role of Monitors within their communities and to contribute to an efficient targeting of MOH resources and local government decision-making and planning.
- c) Assisting in the design of processes and/or materials for the training of Monitors and for supervision and follow-up.
- d) Supporting Monitors in developing behavioral change communication plans and activities (e.g. the formation of mothers groups or community health events).
- e) Assisting communities to develop adjunct sustainable activities, such as cooking demonstrations, rotating community medicine chest funds, income generation activities, improvements to water and sanitation, etc.
- f) Supporting training activities for monitors. These activities either consisted on financial support to the MOH or direct implementation of the training.
- g) Supporting supervision for community volunteers. The main mode of support was by providing either logistical and/or financial (stipends) support to MOH personnel.
- h) Promoting and supporting scaling up of AIN-C activities. Given policy constraints from the MOH, such as limiting AIN-C activities to two villages per health center, many PVOs advocated at regional and local levels to expand AIN-C activities in all the villages influenced by PVO's health activities.

As NGO programs in Honduras have a strong focus on community-based approaches, their position within communities enabled them to mobilize resources for AIN-C implementation within communities quickly and efficiently. Many NGOs, such as those supporting the AIN-C strategy in Honduras, provide additional support to national governments in the areas of the country with the greatest need. This often implies project implementation in remote areas of the country where there may be limited MOH coverage or difficult access to services. Often NGO projects include a specific focus on "reaching the hardest to reach", be it defined by geographic terms or by elements of marginalization from civic society in rural, semi-urban or urban settings. The primary focus of NGO programs is at the community level, increasing demand, access to and use of available health services, and improving practice of important healthy behaviors.

A recent publication by The CORE Group¹³ notes the following strengths of NGO participation in child survival activities:

- Much of their (NGO) work exemplifies a community-based approach that is participatory and responsive to local customs, needs, and concerns. This approach contributes to long-term sustainability of the gains achieved over the course of a project's lifetime.
- NGO work expands funding and constituency for primary health care programs by raising public awareness of and building support for international development in general, and health sector issues of special import to women and children in particular.
- NGOs work in partnership with many different actors at the district level and with national task forces and the work of NGOs reflects the highest technical standards, working systematically to build capacity in local institutions and communities.

B. Extent of NGO AIN-C implementation

As described in the methodology section, information on NGO "mode" of implementation, length of implementation, target groups and plans for expansion was gathered through small group work at the workshop. Conceptual graphic representation of five modes of implementation were provided and each NGO adapted these to represent their situation (diagrams and results in Annex C).

The length of implementation of the AIN-C approach (i.e. the number of months of implementation of a systematized strategy using MOH/BASICS tools and following key AIN concepts) ranged from 1 to 36 months. Five of the six NGOs were specifically

¹³ Levinger, B. and J. McLeod, "A Wealth of Opportunities: Partnering with CORE and CORE Group Members" Washington, DC; Child Survival Collaborations and Resources (CORE) Group; June 2002.

implementing the AIN-C strategy. One NGO was scheduled to start implementation of a PAHO-linked pilot embracing some of the AIN-C components.

Table No.3
Length of Implementation of AIN-C Strategy

Stage of Implementation	Interval in Months	NGO Identification	AIN "Mode" ¹⁴
Early stage	1 to 11 months	NGO 2 NGO 5	Five Five
Intermediate stage	12 to 24 months	NGO 1 NGO 3	Four (undefined)
Extended experience	> 24 months	NGO 4 NGO 1	Five Five

As seen in Table No.3, participating NGOs could be categorized into three groups based on the length of their experience with the AIN-C strategy, ranging from "early stages" to "extended experience". Of the NGOs selected for the study, one was about to begin field implementation; two were in the early stages of implementation (2 months and 11 months), two in the intermediate stage (12 and 13 months), and two had at least 24 months of implementation (24 and 36 months). Note that one NGO had two separate target areas with different lengths of implementation.

As can also be seen in Table No.3, most of the NGOs defined a conceptual categorization of their program's phase of implementation as Mode Five, which was defined as "communities are implementing the AIN-C strategy at present, but initiated with a disease treatment module." One NGO considered its "mode" to be a Four and Five, with Mode Four defined as "NGO is implementing AIN-C with varying amounts of coordination with the MOH and with some adaptation of AIN to their own program requirements."

Coverage of project communities with the AIN-C strategy by the NGOs varied from partial coverage of approximately 50% to complete coverage within their defined project area. Community coverage ranged from 12 to 128 communities. Each individual NGO AIN-C target population ranged from 350 to 8,700 children under age two. In most of the six NGO target areas, NGOs are supporting the implementation of the AIN-C strategy in roughly two-thirds of communities in each MOH unit coverage area, while the MOH implements the strategy alone, or without additional support, in approximately one-third of communities.

Of the five NGOs implementing AIN-C, four had implementation experiences with both the first and second modules. NGO 2 had recently started implementation of the first AIN module but had prior experience with disease management of diarrhea and/or pneumonia through different programs. NGO 1 was implementing both modules in 80 communities in one department and the first module in 48 communities in a different

¹⁴ All five "modes" are defined in section I.C. Methodology.

department. NGO 1 had had prior experience in community-based management of diarrhea and pneumonia in the area where both modules are being implementing. Table No.4 summarizes these characteristics.

**Table No.4
NGO Participation with First and/or Second AIN-C Module**

NGO	First Module	Second Module
NGO 1	+	+
NGO 2	+	-
NGO 3	+	+
NGO 4	+	+
NGO 5	+	+
NGO 6	-	-

Due to the timing of NGO project proposal submissions, some of the NGOs had designed their activities to start with a focus on community-based treatment of disease, prior to adoption by the MOH in Honduras of the complete AIN-C framework. When these NGOs incorporated the AIN-C focus on growth monitoring, or Module One, they were able to essentially merge Module Two and Module One activities. NGOs stated that a key element at this stage was to stress the focus on growth promotion as the entry point for MOH outreach activities with communities.

The discrete program interventions by NGOs ranged from an almost exclusive focus on AIN-C strategies to a combination of AIN-C strategies along with other health interventions, such as HIV/AIDS prevention, to a combination of health interventions along with other sectoral interventions, such as environmental protection and/or water and sanitation activities.

The level of human resources involved in NGO AIN-C activities varied from 4 to 35 NGO staff members. The number of MOH staff directly collaborating with these NGO projects ranged from 7 to 56 and consists primarily of auxiliary nurses, but also included MOH sector Supervisors and Area Directors. The total number of community Monitors, directly participating in the six NGO projects ranged from to 52 to 380, both male and female. (Note that information on gender ratios was not requested.)

C. NGO perceptions of the AIN-C strategy

The overall impression for NGOs involved in implementation of the AIN-C strategy is very positive. Study data shows extended NGO familiarity with the key concepts of this national strategy (Table No.6).

**Table No.6
NGO Perceptions of the AIN-C Strategy**

NGO	VARIABLE													
	1	2	3	4	5	6	7	8	9	10	11	12		
NGO 6	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N	N/A	
NGO 5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N/A	
NGO 4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	
NGO 3	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
NGO 2	Y	Y	Y	N	Y	N	Y	Y	Y	Y	Y	N/A	N/A	
NGO 1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
KEY TO VARIABLES														
1.	Officially-sanctioned strategy.					8.	Systematic growth monitoring can be used for early identification of health problems.							
2.	Responds to individual problems.													
3.	Responds to local problems.													
4.	Has been used as an entry point for other child survival interventions.					9.	Systematic growth monitoring can be used to identify need for additional health care in children under two years of age.							
5.	Targets children between 0-2 yrs.													
6.	Targets sick children under 5 years of age.					10.	Data flows from community towards health center.							
7.	Appropriate growth is an indicator of health status for children under 2 years of age					11.	Data flows from health center to other levels.							
						12	Data currently used for decision-making.							
KEY TO RESPONSES: Y = Yes; N= No; N/A = Not answered.														

All six NGOs interviewed recognize AIN as an officially sanctioned strategy, all six describe it as a strategy responding to individual problems and targeting children between zero and two years of age. Five of six consider the strategy to respond to local problems and/or have used the strategy as an entry point for other child survival interventions. All six NGOs believe that: a) appropriate growth is an adequate indicator of health status for children under two years of age; b) systematic growth monitoring can be used for the early identification of health problems; and c) systematic growth monitoring can be used to identify additional health care needs for children under two years of age. Only one NGO does not feel that the strategy sufficiently targets sick children less than five years of age.

The weakest variable investigated appears to be the use of data from the health information system. An area of concern expressed by NGOs was the lack of feedback of information from the health center to the community.

D. NGO participation in policy stages

A model for defining and measuring "political will" was adapted from the Pyle-Wallerstein framework¹⁵ to capture NGO participation in the formulation and development of the national health strategy in Honduras. For Pyle-Wallerstein, political will is defined as "the capacity and inclination of decision-makers to follow through on rhetorical statements of support to maintain program resources in the face of competing demands, and to defend a program from its critics." Indicators of political will are considered to proceed from a first stage of policy formulation to a second stage of program development to a third stage of sustained policy implementation. During the workshop, NGOs were asked to define their degree of participation in these stages.

Table No.7
NGO Experience with AIN Policy Formation and/or Program Development

NGO	Participation in Policy Formulation	Participation in Program Development
NGO 1	-	-
NGO 2	-	-
NGO 3	-	+
NGO 4	-	-
NGO 5	-	-
NGO 6	-	-

As seen in Table No.7, none of the participating NGOs had been involved with AIN policy formation and only one had been involved with program development. In discussions during the workshop, NGO participants expressed the opinion that government, NGOs and community representatives should all participate in policy formulation. It was felt that the MOH has the primary responsibility for strategy implementation and evaluation and that broad participation of community members would result in community ownership that would facilitate sustainability. NGOs also see the capacity-building of grassroots community organizations as crucial for sustainability.

During workshop discussion, NGO participants described their role as that of "enhancing the dissemination of policy, reaching all interested parties." NGOs suggest that when formulating policy, periodic review should be included in which the ability of policy to reflect and meet community needs would be addressed, as community needs change over time. NGOs suggest that indicators of policy implementation be included in the health information system.

¹⁵ Pyle-Wallerstein citation

Workshop discussions about NGO involvement in program development revolved around leadership roles. The leadership role clearly belongs to the MOH in NGO's opinion. NGO's are eager to be involved with the MOH in this process and have multiple programmatic experiences that can be shared to enriching program development. NGO's are especially aware of the local needs of their areas of influence. For example, NGOs have a wealth of experience in working in areas with low literacy levels and could contribute to the adaptation of counseling tools for such target areas. The consultants for this study note that there are multiple opportunities for NGOs and government to jointly define programs, but probably neither government nor NGOs are aware of them. One NGO did mention that participation in the *COMSAIN* group, which developed IEC strategies for the AIN-C approach, had built momentum for consensus.

NGOs expressed concerns that the MOH "take ownership" of communities through active supervision where implementation of the AIN-C strategy is supported by NGOs. Mention was also made of the value that could be added if central-level policies were less rigid and more open to suggestions from NGOs. For example, several NGOs implement strategies that are successful in increasing the MOH registration of children within the first few days of life. A lack of sufficient MOH follow-up at the community level was expressed and NGOs consider that this could be addressed by: a) defining follow up needs at the regional level, and/or b) having a person specifically hired by MOH to provide AIN-C follow up at the local level.

All six NGOs are (or shortly will be) involved in program implementation; however, they did not feel they could define the likelihood of the long-term sustainability of policy implementation. In fact, this is a concern of NGOs, which is discussed in more detail in section V. Recommendations and Implications for Other Countries. When asked to rate several variables related to policy support, the NGOs were generally evenly divided as to whether MOH funding and resources were adequate and as to whether or not sufficient resources had been defined for program expansion.

E. Training of community health volunteers (Monitors)

Key informant interviews and large group discussion during the workshop also focused on issues related to the organization, logistics, materials, level of and quality of the training provided to community health volunteers (known as "Monitors"). All NGOs had used training materials developed by the MOH in collaboration with BASICS and had followed a standardized training module. They felt that all the needed tools and materials are available and there is uniformity in training design and logistics.

Table No.5 summarizes NGO opinion on some of the training issues.

Table No.5
Summary of NGO Perceptions on Volunteer Training

Variable	Yes	No	No answer
Volunteers trained to evaluate growth faltering	4	0	2
Volunteers trained to evaluate additional danger signs	3	1	2
Volunteers have received other types of training (non-AIN)	4	0	2
Volunteer training costs (partial) covered by MOH	2	3	1
Other source for volunteer training costs	5	0	1
Volunteer training costs affect AIN-C sustainability	3	2	1
Volunteer training costs affect AIN-C expansion	4	2	0

As seen in Table No.5, the majority of NGOs had participant volunteers that were trained in the evaluation of growth faltering and trained to evaluate additional danger signs. The majority of NGOs had also provided other non-AIN training to volunteers. Information on the type of other training provided was not investigated, but anecdotal information mentioned training in first aid, HIV/AIDS prevention messages and community organization. As pointed out by several NGOs and community volunteers, the assimilation of concepts is easier for volunteers that have been previously exposed to training and have field experience.

All NGOs brought in their own funds to support volunteer training (Note that one NGO had not yet implemented the training of volunteers thereby accounting for the "no answer" response.) Two NGOs shared costs with the local MOH partner. The majority of NGOs felt that the cost of training would be a key factor affecting the sustainability and/or expansion of the AIN-C strategy.

NGOs interviewed for this study had not done a cost analysis of implementation of the AIN-C strategy; however, they provided information on the cost of providing the initial training, materials and equipment to Monitors -- a process that takes approximately one year. Costs ranged from US\$400 to \$600 per Monitor trained. These costs do not include the on-going costs of supervision of implementation, such as salaries and operational costs for travel, etc.

Site visits to observe growth monitoring and nutrition counseling by Monitors, and interview these volunteers, was conducted by the study team. The Monitors ranged in age from 14 to 60 years. Most had some formal education (elementary school), while two had studied at the secondary, or high school level (one for two years, while another

finished secondary education and studied commerce.) Only one Monitor was trained and had supplies for dispensing the first does of antibiotic, with referral, of cases of pneumonia. All preferred working in the recommended group of three volunteers, but one mentioned that “two can be enough to do the work” while another was working only with the support of a mother that had not been trained as a volunteer. Both male and female Monitors were visited.

All Monitors had positive comments about AIN and were very proud of their job as volunteers. One Monitor mentioned that the "*AIN-C process helps a community to advance by building family and community interest in and attention to the health of children in the community.*" Specific NGO activities for the generation of additional income were not common and the relation between volunteerism and turn-over of volunteers was not investigated. Monitors stated they feel competent and comfortable conducting the steps involved in growth monitoring for expected weight gain, and the study consultants' observations concur.

Community Monitors were interviewed in regards to the linkage between the AIN-C activities in their community and the local health unit. All agreed that the AIN-C strategy has contributed to:

- improved household health and nutrition practices
- prevention of mild and moderate child malnutrition
- enhanced identification at the community level of children with signs of disease
- enhanced referral of children with danger signs to the health center

Comments from mothers at community growth monitoring sessions:

"I appreciate being able to have the growth of my child measured in my community. When I had to travel to and wait at the health center, it would use up the entire morning so I didn't have my child's growth checked as often as I do now."

"The community monitors know my child and treat him with affection."

"I am following the advice given by the monitor and exclusively breastfeeding my child. I am happy -- she is growing well."

Some Monitors mentioned a need for further reinforcement training in counseling skills, while others stated that while their counseling skills are weak they expect they will improve with practice. Management at three of the five NGOs felt that volunteers need more training to further develop counseling skills.

In discussions with Monitors, it was also noted that the majority of Monitors exemplify a spirit of volunteerism. Many had been trained through earlier health center volunteer programs and/or midwife trainings; several were receiving on-going training in other NGO health interventions, such as

HIV/AIDS prevention. The majority were also active in both church and community development organizations. NGOs note that community Monitors with previous training

and community experience in health issues are able to quickly grasp the issues involved in the AIN-C strategy.

F. Links between Module One and Module Two

The MOH/BASICS protocol for transition from Module One to Module Two consists of two to four months of field practice of Module One by community Monitors, followed by assessment through direct field observation in the community of her/his abilities. Despite the statement of this protocol, several partners report a difficulty in accessing the criteria for evaluation.

At present, the great majority of sanitary regions are implementing Module One of the AIN-C strategy; very few (and perhaps only those sanitary regions with PVO presence) are implementing Module Two. The Secretary of Health in Honduras, and specially the regional levels, are, in many cases, resistant to implementing Module Two arguing that the Module One has not been adequately consolidated, albeit that in certain places the strategy has been implemented for more than two years.

There was discussion during the workshop around training issues for Modules One and Two. Some representatives are concerned that training in both modules could overwhelm Monitors while others felt that it empowers them to be effective community volunteers with the knowledge needed to manage their children when “health access for all” is not easily available through the formal system.

Since the Monitors are supposed to be evaluated on their proficiency with Module One before progressing to Module two, some NGOs raised a concern about evaluating volunteers. They were concerned about maintaining a community volunteer’s self-confidence, pride, and motivation to continue. The NGOs involved collectively suggest that there are several approaches to prevent this from happening. One approach is for the field supervisors to provide additional one-on-one training in the form of coaching through more frequent community visits to reinforce specific skills. A second suggestion by some NGOs is that Monitors not be informed when they are being evaluated in order to diminish apprehension.

G. Supervision, expansion and sustainability

The MOH has limited the expansion of the AIN-C strategy through a consideration of available resources for supervision and follow-up, and recommends that the strategy be initially launched in only two communities at a time, per health center. NGOs have raised concerns about equitability and the need to expand the strategy to more communities.

NGOs feel that implementation of the AIN-C strategy requires frequent supervision in order to be successful. In general, the PVO community felt that there is limited capacity at both regional and local level to take responsibility for supervision and most of the six

NGOs support implementation and follow-up of the AIN-C strategy in roughly two-thirds of the communities in the health centers' area of coverage. As stated by one PVO: "originally volunteer health workers were to receive technical supervision from Rural Auxiliary Nurses. However, the nurses rarely visit the communities and do not generally supervise the voluntary health workers due to logistic and time constraints".

NGOs perceive that the formal health system is not always able to cover the costs of community supervision by Auxiliary Nurses. They sympathize with the multiple roles and responsibilities expected of health center staff and recognize that attitudes about per diem compensation and the difficult level of access to communities in some regions also influences the frequency of supervision.

One solution brought up by NGOs was contracting out the follow-up supervision of the AIN-C strategy at the community level to an NGO with experience in maternal and child health. A second suggestion from the NGOs was to assign a technically trained staff member, such as a registered nurse trained in maternal and child health, to function solely as the AIN-C link between communities and the MOH units. A third option mentioned by NGOs is to conduct a cost-benefit study that would demonstrate to the government that reallocating personnel to purely focus on the supervision of AIN-C would represent important savings over time.

Several NGOs consider it a challenge to find additional resources for expansion of the AIN-C strategy. As in any public health project in less developed countries, sustainability is of concern. For the sake of discussion, the following statement is borrowed and adapted by substituting "Latin American" for "African" and "public health" for "education":

*"Successful transition from project to program is associated with a learning process. That requires organizations that (A) embrace error, (B) plan with the local community, and (C) link knowledge building with action. Scaling up risks distracting key leadership and spreading managerial and other capacities so widely that they can no longer cope. While everyone agrees on the importance of self-reliance and sustainability, both in tension with continued dependence on external funding, it would be naive to assume that in the near future (African) Latin American countries will forego foreign support to (education) Public Health."*¹⁶

All the NGOs interviewed have experience in addressing the first two points mentioned in this statement, which refers to the learning process and managing scale-up. During the workshop, one NGO suggested that building the capacity of community organizations at the grass-roots level, including training human resource volunteers, is the answer to the final point of the statement cited above. What is needed at the

¹⁶ Samoff J., Molapi E., and M. Dembélé; "Reaching Out, Reaching All – Sustaining Effective Policy and Practice for Education in Africa, From Pilot to Scale: Issues and Experience, Scaling up by focusing down: Creating space to expand education reform"; ADEA Biennial Meeting Tanzania, Oct. 2001.

present time is to strengthen the linkage between community organizations and the formal health care system. NGOs suggest that better use of monthly meetings between Monitors and health center staff can provide significant support to establishing the AIN-C process. This includes better feedback to the community level of health information system data. PVOs agree that, although the process for program implementation is slower, working within the Ministry of Health structure makes the process sustainable.

Linkage with universities and/or nursing schools was also mentioned as a possible resource for long-term sustainability of the AIN-C strategy. Teaching institutions could undertake some of the responsibilities for training and support, with clear standardization and institutionalization of the training process and curricula. NGOs could possibly provide the training grounds for student practicum. Training was seen as a potential bottleneck in expansion efforts since expansion required and increase the number of AIN-C trainers.

One preliminary example of long-term sustainability after NGO support was withdrawn was found at an urban health center in the capital. (It should be noted that the initial NGO support came in the early stages of national development of the AIN-C strategy vs. the more developed model in existence today). Despite the absence of direct NGO support, a less intense AIN-C is functioning two years after NGO support ended. Health center staff describe the AIN-C strategy as "bringing in mothers" and meeting health needs while also diminishing congestion and waiting times at health units." However, they did note that follow-up supervision and support for community volunteers is difficult without NGO support. Nevertheless, of the sixty Monitors initially trained almost six years ago, thirty remain active.

IV. Conclusions

The AIN-C approach in Honduras has successfully systematized an integrated community-based child survival strategy with uniform dissemination of concepts and provision of good training tools. Based on the Honduran experience, AIN-C can be implemented in countries with or without health sector experience within the Integrated Management of Childhood Illness (IMCI) framework. However, countries seeking to incorporate the AIN strategy into their health care system should clearly address the relationship between the AIN and IMCI strategies to avoid potential confusion among implementers. The integration of Modules One and Two provided an opportunity to emphasize the importance of growth monitoring as the entry point for an integrated child health strategy.

NGOs identified the government's capacity to provide sufficient funds for training of community Monitors, along with supervisory follow-up of implementation, as the major issues related to future sustainability and as the limiting factors for further expansion. All NGOs brought in external funds to support AIN-C efforts and estimated that initial training, material and equipment costs ranged from US \$400 - \$600 per Monitor.

It is important to recognize the multiple contributions NGOs have made in supporting the implementation and supervision of the AIN-C strategy at the community level. This has included human resources for implementation and supervision, technical assistance to local health units and/or community Monitors and significant financial support for materials and activities. NGOs are an important resource that can assist in the implementation and/or scaling up of the AIN-C strategy, especially among target populations that are not easily linked to health facility services due to distance or marginalization.

AIN-C is a mature child health strategy in Honduras that offers an excellent opportunity to integrate NGO-promoted activities for strengthening the linkage of local individuals and entities with local government and national institutions. The long-term involvement of NGOs within communities and opportunities for participation in other sectoral projects may provide additional and unrecognized incentives for the participation of community volunteers in the AIN-C strategy. This may have important implications for approaches to scaling-up this strategy at the national level, where such incentives will not exist.

Governments have not taken full advantage of NGO know-how to promote intersectoral approaches. NGOs not only undertake child survival programs, but also have experience with other type of programs. Utilizing NGO experience to position community child health care in the agenda of different sectors can be effective advocacy for economic resources in support of an integrated community child health strategy.

The involvement of NGOs in policy design for child health strategies at the community level is a resource that has not been fully utilized in most countries. It is desirable to involve NGOs early in the policy development process, as they have a wealth of community-level experience in health programming. The MOH's role, as the rectors of health care at the national level, would profit by including additional perspectives to decision-making processes. This message requires active NGO lobbying at the national and international levels.

The participating NGOs in Honduras also recommend that NGOs in any country closely collaborate with national and local government entities. It is recognized that coordination between multiple actors can initially decelerate the process of Implementation; however, all six NGOs stress the greater benefit that close coordination provides for long-term follow-up and sustainability.

A cost-benefit or cost-effectiveness study may be desirable to validate assumptions that a reallocation of government resources for purposes of follow up of the AIN-C strategy would represent an overall economic savings. An integrated community child health strategy can diminish health centers' workload (and costs) since a child that grows well is a healthy child.

Appendix A: Acronyms

AIN: Integrated Child Health Program (*Atención Integral de la Niñez*)

AIN-C: Integrated Community Child Health Program (*Atención Integral de la Niñez en la Comunidad*)

ARI: Acute Respiratory Infections

BASICS: Basic Support for the Institutionalizing of Child Survival

C-IMCI: Community IMCI

CORE: Child Survival Collaborations and Resources Group

CRS: Catholic Relief Services

IEC: Information, Education, Communication

IMCI: Integrated Management of Childhood Illness

MOH: Ministry of Health

NGO: Non Governmental Organization

PAG: Proyecto Aldea Global

PAHO: Pan American Health Organization

PVO: Private Voluntary Organization

SOH: Secretariat of Health (*Secretaría de Salud*) (Honduran MOH equivalent)

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

WHO: World Health Organization

Appendix B: Documents, tools, and materials reviewed

1. BASICS II narrative (Honduras country program).
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3. Encuesta de la Evaluación de Medio Termino del Modelo AIN. S de S/BASICS II-USAID. Sep. , 2000.
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AIN-C TOOLS

Tool	Purpose/User
Chart of minimum expected weight Counseling Cards	Early Identification of growth faltering At monthly weighing session determines and note adequacy of weight gain. Honduran-specific counseling cards with age and situation-specific guidance. For use by volunteers counseling caregivers on feeding practices, health maintenance, illness prevention, and household management of illness.
Community Health Volunteer Manual and Curricula	Assist volunteers in all AIN-C activities. Volunteers use manual to learn how to map community, determine baseline, develop list of beneficiaries, plan monthly meetings and weighing sessions, provide counseling, implement educational sessions, learn about care of the sick children, conduct home visits, and organize meetings to inform the community and solve problems.
Implementation form/ guidelines (check list)	Facilitate supervision/ follow up of institutional and community based staff. SOH (Region, Health Area, Sector and Auxiliary Nurse).
Notebook for children enrolled	"Listado de Niños/Niñas en la Comunidad" includes data on children's names, # of children/session, ages, expected weight, current weight, tendency of weight, immunization status, breastfeeding status, complementary feedings, and Iron and Vitamin A supplementation
Child's Card	Includes: Name; ID #; father/mother's name; DOB;Sex; # in AIN List; Medical Record #;Home address; institution; growth chart; feeding 1 st yr of life; feeding recommendations (0-6 m) (9-9 m) (9-10 m). Perinatal antecedents. Place of birth. Newborn's condition. Delivered by. Pathology of pregnancy, birth and puerperium.; Gestational age at birth; BW. Vaccines (dates of

<p>HC Daily Activity Register AT1 – 2001</p>	<p>application + name of vaccine). Micronutrients (includes vitamin A for post-partum mothers). Date of next appointment.</p>
<p>Monthly Summary Community Care (AC- 2001)</p>	<p>RN/MD at HC (Medical Record #, Pt. Name, ID, Sex, DOB, Place of origin, Care provided at X service, Dx./Activity, Reference).</p> <p>Auxiliary Nurse. (By health region, health area, health delivery unit UPS, month, year, community). Variables 1 -24 (pediatric AIN –C Data, pediatric morbidity and mortality; pediatric referrals; OB-GYN/ malaria, family planning, TRO.</p>
<p>Monthly Consolidate of Indicators</p>	<p>CHV and Auxil.Nurse. Variables: (1 – 5 for # <2) (by health region, health area, health delivery unit UPS, month, year, community) 1.enrolled that month (listed) 2 # assisting to session that month 3 # w appropriate weight gain 4 # w inappropriate weight gain. 5 # w inappropriate weight gain in this session and in previous session 6 # of new children 7# of discontinued children (Manual and simple bar graphs system).</p>

Appendix C: Guide for Key Informant Interview and Workshop Group Discussions

KEY INFORMANT INTERVIEW GUIDE

DATE

CODE

Interviewer (s)

I Introduction.

Objective: Briefly describes who is doing the research and why; engage respondent and ensure that information will be kept confidential and results of study will be shared.

The CORE Group, is a network of 35 U.S.-based non-profit organizations jointly promoting and improving maternal and child primary health care programs and advocating for NGO involvement in the global community health agenda.

AIN-C is defined as preventive health and nutrition strategy that actively engages families and the community in maintaining the adequate growth of children under 2 and caring for and treating sick children under 5. It is an integrated community child health strategy that has growth promotion as its axis and integrates illness management and referral at the community level.

An initiative of CORE's IMCI-Working Group (IMCI WG) this study represents an effort to understand how NGO's input can enhance the implementation of community based integrated child health. A better understanding of the Honduran AIN-C process can be useful to other NGO's interested in integrating growth promotion into C-IMCI. Exploring the different NGO Honduran experiences with AIN-C¹⁷. the study is an opportunity to take stock of a project's progress to date, its achievements and obstacles encountered given a broad variety of on going scenarios.

II Domains

- A. GENERAL AIN-C STRATEGY PERCEPTION
- B. POLITICAL WILL/COMMITMENT
- C. NGO/OTHER EXPERIENCES WITH AIN-C IMPLEMENTATION
- D. CLOSURE/RECOMMENDATION

- A. GENERAL AIN-C STRATEGY PERCEPTION

1. Is AIN-C an officially-sanctioned strategy?

¹⁷ Developed by the Honduran Secretary of Health since 1997.

a) Y	b) N
2. Strategy responds to individual and local problems? (example)	
c) Y	d) N
3. Has been used as entry point for other child survival interventions? (example)	
e) Y	f) N
4. Targets children between 0 and 2 years of age? (which components?)	
g) Y	h) N
5. Targets sick children under 5? (how)	
i) Y	j) N
6. Appropriate Growth as an indicator of health status for children under 2 yrs of age	
k) Y	l) N
7. Can systematic growth monitoring be used for early identification of health problems?	
m) Y	n) N
8. Can systematic growth monitoring be used to identify need for additional health care for children under 2 yrs of age?	
o) Y	p) N
9. AIN-C data flows from community towards CESA/ CESAMO?OTHER?	
q) Y	r) N
10. AIN-C data currently used for decision making? (examples?)	
s) Y	t) N

B. POLITICAL WILL/COMMITMENT

Examine interviewees perception on degree of POLITICAL WILL/COMMITMENT to strategy; probe for capacity and inclination of decision-makers to follow through on rhetorical statements of support in 3 stages¹⁸

¹⁸ As defined in Pyle's Tool and incorporating AIN-C characteristics

I. Policy Formation Stage:			
Probe for			
1. Founded	Y	N	Why?
2. Adequacy of funds allocated	Y	N	
3. Adequacy of staff allocated	Y	N	
4. Budgetary sources contemplate future expansion	Y	N	
5. Was there NGO participation in this stage?	Y	N	
NGO participation in this stage (in retrospect) is			
6. A good practice		7. Not a good practice	
II. Program Development Stage:			
Probe for specific scope and nature of program established:			
1. Is it limited to technical approaches (i.e. food fortification is an example of limited technical approach) [easy to adopt]/[easy to implement] /[requiring little or no socio-political change] vis a vis 2.			
a)Y		b)N	
2. Is it an ambitious social equity oriented programs (i.e. multisectoral health and nutrition Intervention or land reform schemes are examples of ambitious social-equity oriented programs) [demands politically difficult reallocation of priorities][demands politically difficult reallocation of priorities]			
a)Y		b)N	
Probe: was there NGO participation in this stage?			
a) Y		b) N	
c) Why?			
III. Program Implementation Stage:			
Probe for extent to which program is maintained over time[note that this is a particular acute problem theoretically and as pointed in reviewed literature]			
Some possible issues affecting over time program maintenance			
1. Delay to obtain positive impact data	a)Y	b)N	
2. Similar programs competing within same resource pool	a)Y	b)N	
3. Other perceptions/reasons brought up by interviewees that could have or had implications on political will/commitment for AIN -C ore a similar strategy during implementation stage			

C. NGO/OTHER EXPERIENCES WITH AIN-C IMPLEMENTATION	
a) Training of Monitoras	
a) Trained to evaluate growth faltering	b) Trained to: evaluate additional danger signs
c) Have received other type of training?	
2. Training costs are covered by:	
a) Secretariat of Health	b) Other source? (explain)
3. Do you consider that monitoras training costs affect AIN-C sustainability?	
c) Y	d) N
4. Do you consider that training costs affect AIN- C expansion? (explain)	
e) Y	f) N
b) Program integration at the level of service delivery	
1. How would you describe interaction between Monitoras and Secretariat of Health delivery of services?	
a) Y	b) N
2. AIN-C improved health and nutrition household practices	
c) Y	d) N
3. AIN-C contributed to the prevention of mild and moderate childhood malnutrition	
e) Y	f) N

4. AIN-C identified children that were not achieving appropriate weight gain	
g) Y	h) N
5. AIN-C triggered special follow up for children not achieving appropriate weight gain	
i) Y	j) N
6. AIN-C enhanced identification at the community level of children with disease danger signs ⁴	
k) Y	l) N
7. AIN-C enhanced referral of children with disease danger signs to the health center	
m) Y	n) N
8. AIN-C has developed an adequate referral process	
o) Y	p) N
9. AIN-C needs adjustments in referral process (expand)	
q) Y	r) N
10. AIN-C alleviated the congestion of previously over crowded health centers	
s) Y	t) N
c) Supervision	
Monitoras are supervised by	
1. Secretary of Health?	2. Other?
3. How often?	

4. Constrains encountered to provide supervision
5. Proposed solutions for overcoming supervision related constrains
d) Sustainability/scaling up
1. In your opinion which are the most important sustainability issues that AIN-C needs to address?
2. In your opinion which are the most important issues that AIN-C needs to address for scaling-up purposes?

D. CLOSURE/RECOMMENDATIONS

1. Briefly describe existing link between AIN-C and AIEPI Institucional
2. If you were making recommendations to NGO's interested in integrating growth promotion into C-IMCI, would you recommend an AIN-C type strategy as an entry point? (expand)

Appendix D: Checklist for assessment of monitor capacities in Module One

1. Updating the community map:

1. New houses are registered with the correct corresponding numbers.
2. Houses with children under age two years are marked with a circle.
3. Houses where children have now grown beyond 2 years of age are no longer marked with a circle.
4. Houses where a child under age two is deceased are identified.
5. Houses with recent births are identified.
6. Houses with children under age two with inadequate growth are identified.
7. Location of the houses of community Monitors are identified.

2. Organization and management of AIN-C meetings:

1. The appropriate amount of equipment is available (recommended 3 Monitors, based on the number of children under age two)
2. Adequate location and space for the meeting.
3. Tables and chairs available.
4. Red and blue pens available.
5. Pencil available.
6. Transparent ruler available.
7. Blank child health cards available.
8. List of community children under age two available.
9. Manual(s) for the AIN Monitor available.
10. Action Guides available.
11. Counseling cards (laminated) available.
12. Table for the conversion of kilograms to pounds available.
13. Oral rehydration salts available.
14. One liter container filled with chlorinated water available.
15. Referral sheet available.
16. Home visits sheet available.

3. Measurement of weight with the Salter scale:

1. The scale is located in an appropriate and safe place.
2. The scale is hanging at the level of the eyes of the person doing the weighing.
3. The scale is calibrated before weighing each child.
4. The child is weighed without clothing and the mother is informed of the child's weight.
6. The needle on the dial of the scale is stationary when the weight is recorded.
7. The scale is stored in a secure place.

4. Graphing the child's growth:

1. The growth curve of the child's health card is used.
2. The growth of the child is determined compared to the minimum expected growth previously noted.
3. The growth curve is drawn using blue or red pen, depending on growth status, as compared to expected weight gain.
4. The child's growth situation is explained to the mother.

5. Use of the child registration list:

1. All children under age two are listed.
2. All children over age two and/or that have left the community are excluded.
3. Each child's weight at birth is recorded.
4. Each child's age is correctly noted (months and days).
5. Each child's expected weight is correctly noted.
6. Each child's weight is correctly noted.
7. The growth trend is correctly noted.
8. Each child's immunization status is reviewed.
9. Each child's health card is reviewed for micronutrient supplementation.

6. Agreements and negotiation:

1. The Action Guides are correctly used to select the correct action.
2. The correct (laminated) counseling card is selected.
3. The steps outlined in the counseling card are followed.
4. One or two agreements are negotiated with the mother.
5. Mothers are instructed about immunizations, family planning, and micronutrient supplementation with iron or Vitamin A.

7. Problem detection:

1. Sick children are identified.
2. Children with respiratory infections are identified.
3. Children with diarrhea are identified.
4. Referrals to local health unit are made.

8. Complementary activities:

1. A plan for home visits is developed.
2. The minimum expected weight gain for the next meeting is calculated.
3. The monthly report is completed.
4. Indicators are developed in graph form.
5. The situation of child growth in the community is analyzed.

Appendix E: Results from the workshop

AIN MODES ONE – FIVE

One: AIN-C functioning in at least half of their communities and now need to maintain those while expanding to additional (less needy) communities.

Two: SOH health areas just beginning AIN.

Three: SOH health areas that have initiated AIN and want to expand, but do not have access to technical or financial assistance.

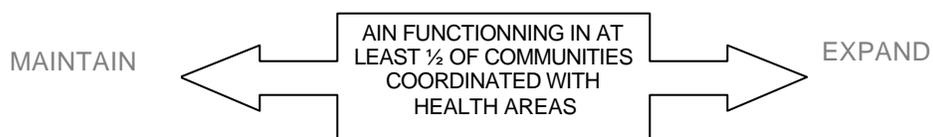
Four: NGOs implementing AIN with varying amounts of coordination with the SOH and all with some adaptation to their own program requirements.

Five: Communities initiating or operating with the disease treatment module

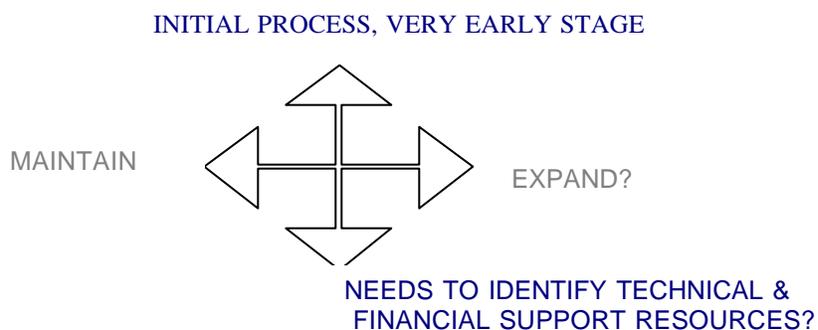
(Source: BASICS II Honduras Country Narrative)

“AIN Modes” or STAGES ONE – FIVE

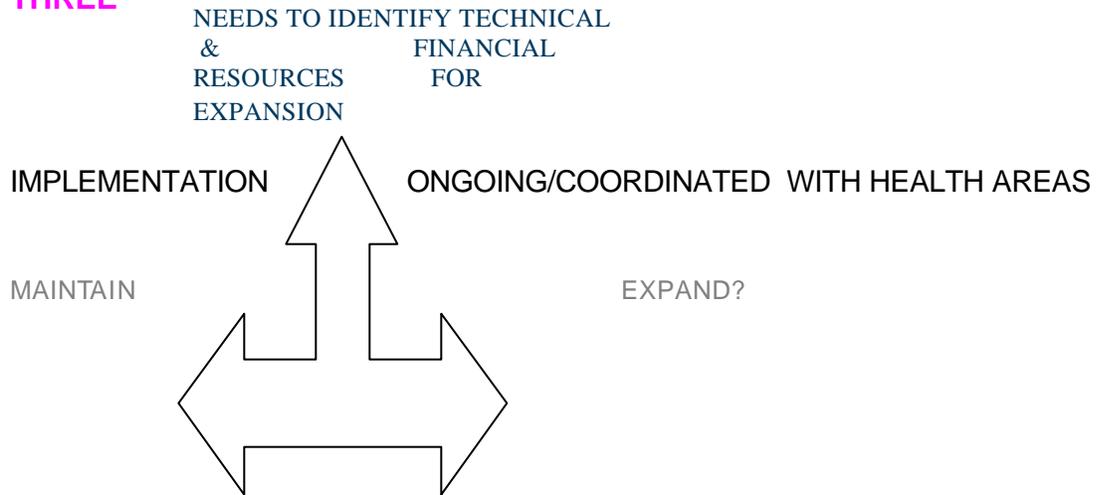
ONE



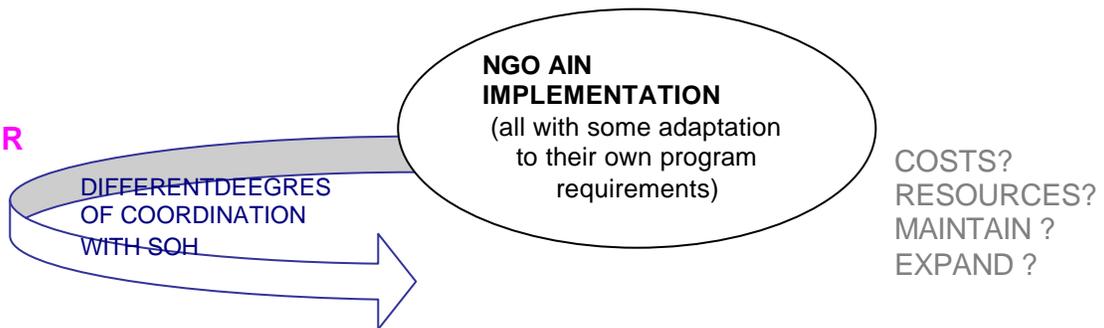
TWO



THREE



FOUR

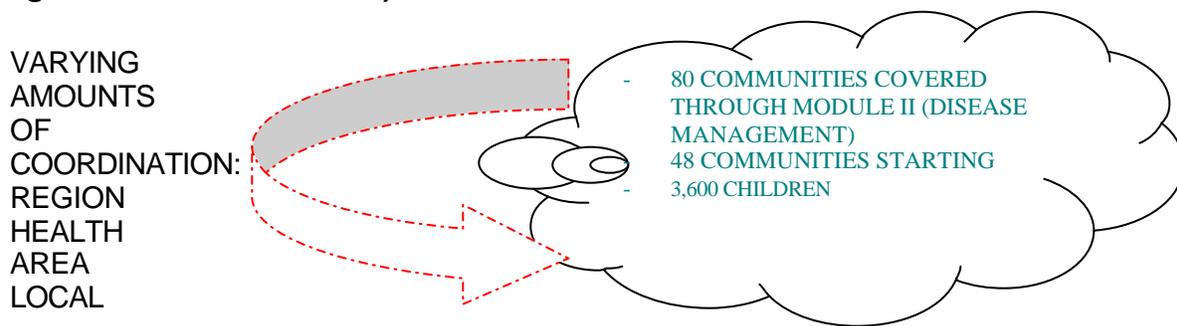


FIVE



NGO 1 Group C, intermediate implementation stage (Time of implementation in one area is 24 months and in the second one 13 months). It reaches 128 communities in two geographic areas. Of the 128 communities, 62% (80 communities) are applying AIN – C Module 2 (disease treatment module) and 48 communities are starting AIN-C. The total number of children covered with the strategy is 3,600. NGO operates as a financial advisor; counterpart carries on implementation. Coordination exists at three levels: area level, regional level and local level, working very closely with SOH. Coordination involves 31 Health Centers.

FIGURE 1 - Graphic auto-representation of NGO1. (Hybrid between “mode/stage diagrams” FOUR and FIVE).



Targetting/Coverage: Pyle-Wallerstein performance scale # 4, currently reaching 50-75 per cent of target population. NGO is working in two geographic areas one has 24 months of implementation, second one 13 months. Module 2 (disease management module) has been implemented in 80 communities; 48 communities are starting AIN-C. The process in the first area was different, initial NGO objective was to reduce EDA and ARI, volunteers were first trained in disease management. Children covered 3,600.

Infrastructure/basic supplies: existent and functional. Pyle-Wallerstein performance scale # 5, all necessary infrastructures available and operational. Staff trained following SOH norms + technical assistance from BASICS. Facilities, medications, tools and materials: adequate. Human resources: 380 monitors;35 NGO staff;56 SOH staff.(Geographic area one: 140 “monitors” ;19 NGO staff; 23 SOH staff; geographic area two: 240 “monitores”;16 NGO staff ;33 SOH staff).

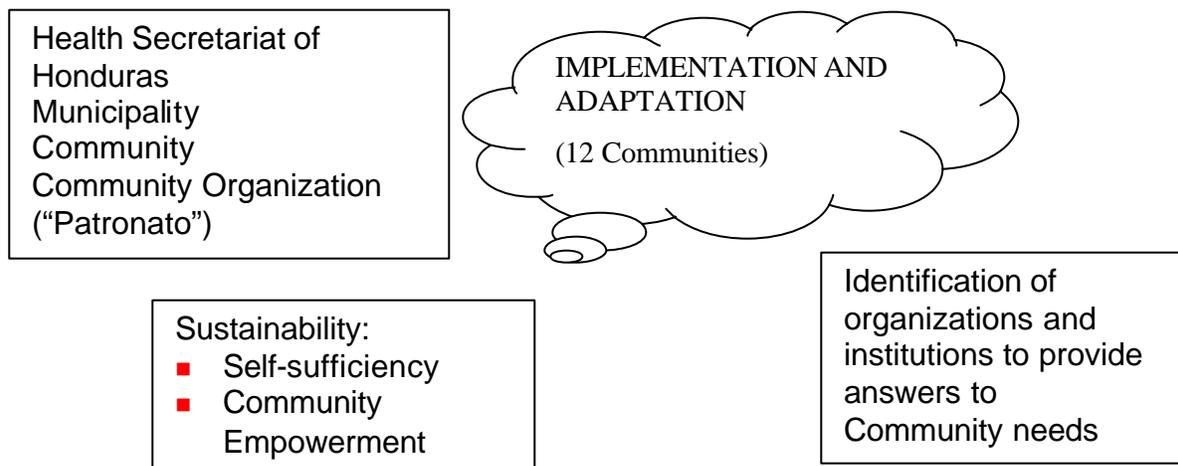
Sustainability as a function of self-reliance Pyle-Wallerstein performance scale between # 3 some self-reliance attained and # 4 significant self-reliance attained. There is broad local support to AIN-C, there is “some” self-reliance in some cases, and self-reliance is significant in other communities. NGO has promoted local organization and there is a strong link with SOH.

Expansion: plans to attain 100% of target population.

NGO 2 Group A, very early implementation stage (Time of implementation 1-2 months, first module). NGO believes they initiated AIN-C 12 months ago, considering planning stage (implementation started in May and June/02). Project has 3 platforms: AIN/ AIM/VIH/SIDA/First Aid, Community Level. It is reaching with AIN-C 12/44 communities. NGO receives support from international organizations to cover costs.

Coordinates con SOH, Municipalities and Community Organizations (“Patronatos”) and negotiates with institutions such as INFOP (National Vocational Training Institute), Pedagogic University, etc. NGO adapts projects to respond to community needs. Graphically NGO members represented themselves using **“mode/stage diagram” FIVE**.

FIGURE 2 - Graphic auto-representation of NGO2



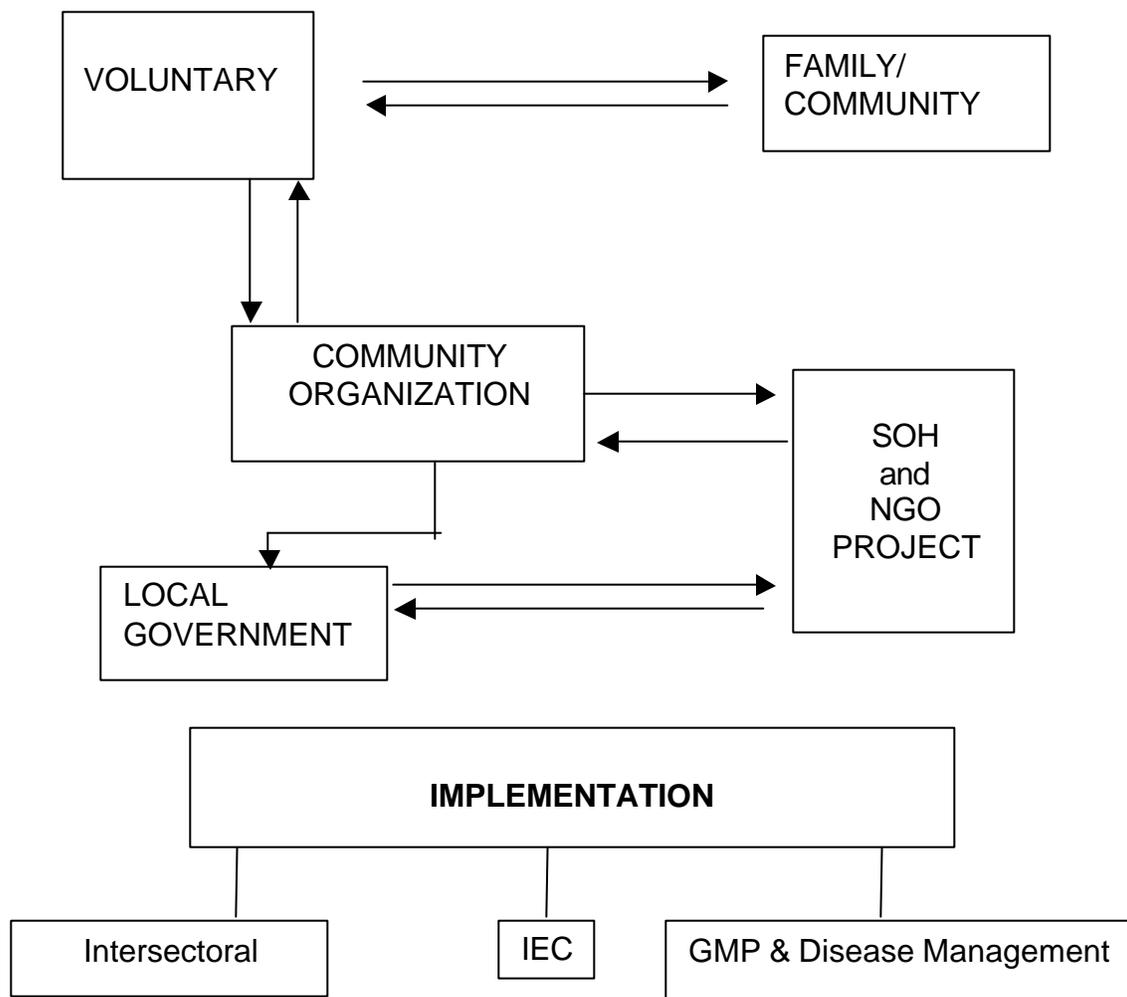
Targeting/Coverage: Pyle-Wallerstein performance scale # 4, currently reaching 50-75 per cent of target population. NGO reaches overall: 2,406 children and 34 Communities. Coverage through AIN-C 331/448 (74% of objective population). Of children enrolled in AIN-C 19,6 % (65 /331) had inappropriate weight gain.

Infrastructure/basic supplies all necessary infrastructures available and functional. Pyle-Wallerstein performance scale #5. Four ambulances, 5 vehicles, appropriate furniture. Twelve AIN –C Volunteers.Trained professionals (3 medical doctors 2 social workers, a licensed administrator, an engineer, a psychologist, 3 experts, 2 computer technicians and a Project Manager.)

Sustainability: Pyle-Wallerstein performance scale # 4: significant self-reliance attained. NGO believes in achieving sustainability through the communities, relies in its strong links (and national and international recognized trajectories) with communities and is training community leaders. Also inherent to sustainability are existence of 3 committees: Direction, Technical Assistance and Management. Organization responds to demand, works in health promotion, works through agreements, coordination and support, is integrated with local community organizations (Patronato), has trained human resources, uses intersectoral coordination, has several chapters and a central office and counts with 16 qualified technical people. These resources are seen as factors for sustainability.

Expansion: plans to attain 100% of target population and has budget for that purpose.

NGO 3 Group C, intermediate implementation stage (Time of implementation 12 months). “Implementing disease management module with support, knowledge of and approval of SOH.” Management information system with the SOH that responds to information needs of SOH and NGO. Coverage of 6950 families in 15 municipalities, 97 villages, 502 hamlets. Human Resources: 77 volunteers, 17 technicians, 3 educators, 2 coordinators, 1 sub-coordinator 1 general manager. Coordinating with SOH staff: 32 Auxiliary Nurses, 28 Health Centers, 7 Sector Supervisors, 3 Area Supervisors, 3 Area Directors (Area Chiefs) Works with gender equity and tries to have political incidence. Graphically NGO members did not represent themselves using any of the provided “*mode/stage diagrams*”, they created two diagrams of their own.



Targetting/Coverage: Pyle-Wallerstein performance scale # 5, currently reaching 100 per cent of target population. Has a monitoring and evaluation strategy, measures products and results. Has CHV trained in all areas and can provide basic health services, primary level.

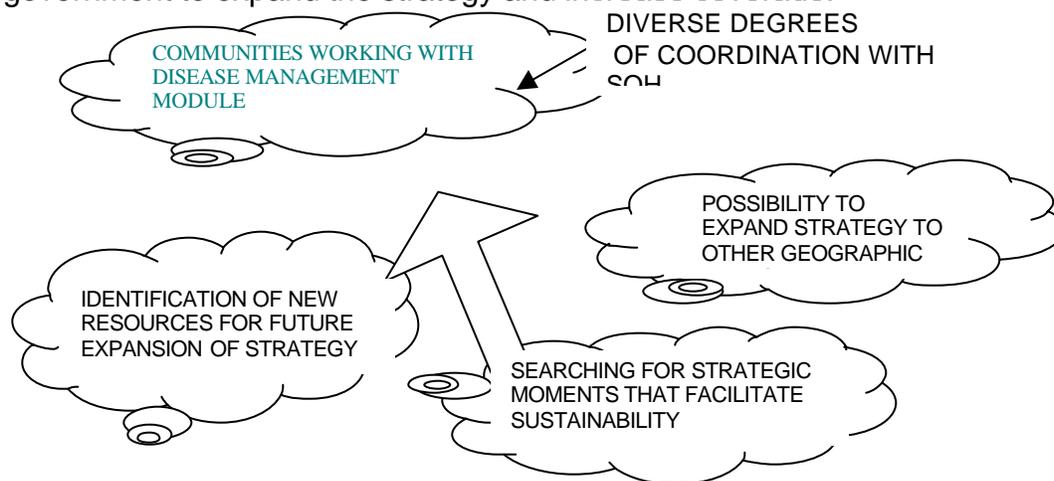
Infrastructure/basic supplies Pyle-Wallerstein performance scale # 4 infrastructure operational/Remainder under or nearing completion. Of 31 community health units

(U.C.S, *Unidades Comunitarias de Salud*) 23 have their own building and 8 function in rented or “borrowed” spaces. Buildings are used only for health care delivery (they have storage room, waiting room, delivery room, and consultorios. All U.C.S have basic equipment (68 supplies). NGO supplies first time and then community purchases supplies (communitarian funds). SOH provides medicines through U.P.S.

Sustainability: SOH approved an annual budget of Lempiras 4.000.000 (\$243.902). NGO will manage budget until 2003 and from 2004 on Health Areas will be trained to manage the budget. (See above). NGO did not provide Pyle-Wallerstein performance scale #. Given that NGO has an approved SOH budget, we classify them between 4 significant self-reliance attained and 5 - total self-reliance attained.

Expansion was not directly mentioned by NGO. They did mention high degree of illiteracy of volunteers as a barrier to their existing plans for voluntary staff training. They are facing through development of an I.E.C component.

NGO 4 Group D, extended implementation experience. Time of implementation 36 months. Coverage: 8,725 children under 2 years of age -12,174 children between 2 and 4 years of age. Total number of children under 5: 20,899. Women of reproductive age 20,066. Communities 182 (Areas 1 and 2 of SOH), eight Municipalities. Human Resources: Staff NGO 21, Monitoras 220 Health Centers 22 (4 CESAMOS, 18 CESARES), one Area Director, seven Sector Nurses. Graphically NGO members represented themselves using “*mode/stage diagram*” **FIVE** (with some modifications.) NGO 4 has been effective in the four project interventions (child survival, infrastructure, agro-ecology, water, sanitation and governance) it undertakes. Would like Honduran government to expand the strategy and increase coverage.



Targetting/Coverage: Pyle-Wallerstein performance scale # 4 - Services reaching 50-75 per cent of target group. NGO 4 has implemented AIN-C in 102 communities and is covering 75% of the target population in those 102 communities. AIN-C in 102 (“100% officially recognized by SOH”). (If counting coverage of NGO with other programs NGO has presence in 182 communities). NGO is working in the identification of additional

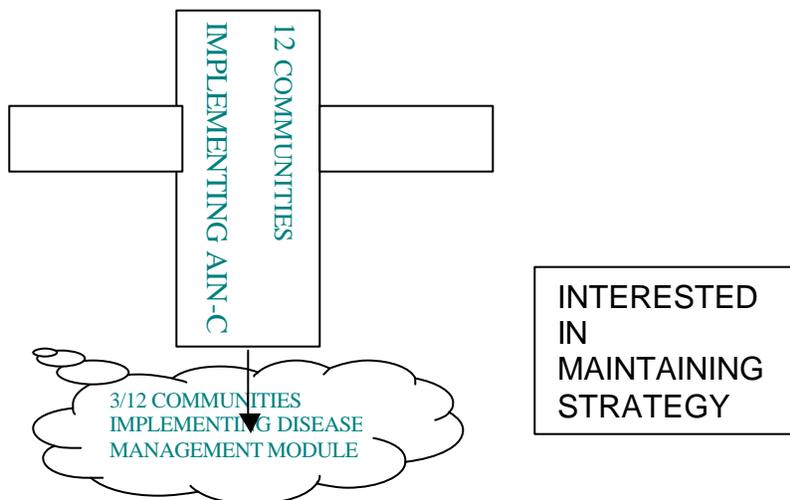
resources to expand to other communities/municipalities where NGOs are not intervening

Infrastructure/basic supplies: Pyle-Wallerstein performance scale # 5. Two strategically located regional offices, 13 motorcycles, 2 vehicles, 20 people/tech. team.

Sustainability: searching for strategic moments that make sustainability possible, “moments when SOH can provide follow up to process”. Pyle-Wallerstein performance scale between # 3 - Some self-reliance attained and # 4 - Significant self-reliance attained. For sustainability purposes, NGO 4 has actively involved the participation of municipal governments and Patronatos, created 44 community medicine chests (CMC) and increased SOH (prior MOH) through monthly meetings with Village Health Providers.

Expansion Project has 2 specific scaling up points that will conclude in Sept. 2003: consolidation and scaling up to additional municipalities.

NGO 5 Group C, intermediate implementation stage (Time of implementation [in one area]: 11 months). The NGO reaches 350 communities with different programs and has 50,000 sponsored children in Honduras (population coverage of 400,000). AIN is a relatively new line of action for this NGO. AIN – C coverage: 12 communities (specific Project to which 2 participants belong, it is not referring to the overall NGO involvement with AIN-C strategy). NGO 5 reaches 530 children under 2 years of age. They are working in 12 communities, 3 communities are working with disease management module. Human Resources: 52 monitors, 2 health facilitators, 1 medical doctor, 1 program coordinator. Graphically NGO 5 members represented themselves using “**mode/stage diagram**” FIVE (with some modifications.)



Targetting/Coverage: Population objective 1975 families (530 sponsored children). Pyle-Wallerstein performance scale # 5 - Services effectively reaching more than 75 per

cent of target group, “ because NGO has integrated to the process all the children **of more than 2 years of age**” [and because strategy includes all children, not only “sponsored” children].

Infrastructure/basic supplies Pyle-Wallerstein performance scale # 5, all necessary infrastructure available and operational.

Sustainability: Pyle-Wallerstein performance scale # 4, significant self-reliance attained. although there has been local involvement, and there are good links with SOH, would like for another NGO (or other institution) to continue supporting communities when they face out. Director at central head quarters in Tegucigalpa expressed concerns with cost of materials and constant turn-over of NGO's staff.

Expansion. NGO mentioned interest in maintaining strategy, not in expanding.