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EVALUATION:

COMMUNITY BASED MATERNAL, NEONATAL AND CHILD HEALTH INNOVATION IN THE CONTEXT OF THE NATIONAL HEALTH SYSTEM DECENTRALIZATION IN FRANCISCO MORAZÁN SUR, HONDURAS

October 2013

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Ramiro Llanque Torrez.

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October 30th, 2013

C.A. #. AID –GHS-A-00-09-00011

CONTENTS

ACRONYMS

ADACAR	Implementing partner in Reitoca, Curaren and Alubaren
ADAL	Implementing partner in Lepaterique
AIN-C	Integrated Community Child ***Health Program (****Atención Integral a la Niñez en la Comunidad)*
CB	Community Based
CENET	Honduran OR partner agency (Centro Nacional de Educación para el Trabajo)
CESAMO	Health Center with physician
CESAR	Rural Health Post with Auxiliary Nurse
CHV	Community Health Volunteer (UCOS Volunteer)
CMI	Maternal and Infant Health Clinic (Centro Materno-Infantil)
CONE	National Health Strategy for Obstetric & Neonatal Essential Care
CONE Ambulatory	National out-patient, pre-natal care strategy
CONE Basic	National Basic Emergency Obstetric Care Strategy
CQI	Continuous Quality Improvement
CSHGP	Child Survival and Health Grant Program
CSP	Child Survival Project
CTE	Committee for Transportation in Emergencies
DIP	Detailed Implementation Plan
DMOH	Ministry of Health at the Departamental level
ECD	Early Childhood Development
EONC	Emergency Obstetrical and Neonatal Care
FE	Final Evaluation
GOH	Government of Honduras
GPS	Global Positioning System
HF	Health Facility
HIS	Health Information System
IFC	Individual, Family, Community (MOH Policy)
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Result
KPC	Knowledge, Practice, and Coverage Survey
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MNCHN	Maternal, Neonatal, and Child Health and Nutrition
MOH	Ministry of Health (Secretaria de Salud)
MTE	Mid-term Evaluation
NGO	Non-governmental organization
OR	Operations Research
RAMNI	Accelerated Reduction of Maternal and Infant Mortality Strategy (GOH,2008-2015)
TTBA	Trained Traditional Birth Attendant
UCOS	Community Based Health Service Delivery Site
ULAT	Technical Assistance Local Unit (USAID Mission bilateral partner agency)
USAID	United States Agency for International Development

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ChildFund Honduras through the implementation of community-based structures and strengthening the public health system has demonstrated the feasibility to provide effective, cost-efficient primary health care with quality to rural low-income people, in the context of the Honduran National Health System Decentralization, with genuine participation of the civil society. This experience has the potential to be effective in reaching the MDG's and be sustained and scaled up at the national and even to international levels. The experience can contribute to global health

COMMUNITY BASED MATERNAL, NEONATAL AND CHILD HEALTH INNOVATION IN THE CONTEXT OF THE NATIONAL HEALTH SYSTEM DECENTRALIZATION IN FRANCISCO MORAZÁN SUR, HONDURAS

Executive Summary

This project was funded by the U.S. Agency for International Development through the Child Survival and Health Grants Program.

November 2013

Evaluation, Purpose, and Evaluation Questions

The overall purpose of the FE was to provide an overview of project goals, objectives and key interventions and strategies implemented; describe key factors that contributed to what worked or did not work and to demonstrate how the project contributed to learning and evidence that is directly relevant to improving MOH policies and practices, as well as global learning about community-oriented health programming.

The Evaluation Questions are the following:

1. To what extent did the project accomplish and/or contribute to the results (goals/Development Hypothesis, Results) stated in the DIP?
2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?
3. Which elements of the project have been or are likely to be sustained or expanded (through institutionalization, policies, etc.)?
4. What are stakeholder perspectives on the results of the Operations Research (OR) Study, and how could the OR study affect capacity, practices and policy?

Project Background

Honduras is poised to improve its national health system and maternal and child outcomes by 2015. New national laws and policies are introducing improvements to government facility

FINAL EVALUATION EXECUTIVE

services, and increasing the role of civil society through a decentralized health strategy. Nevertheless, despite a clear intention by the Government of Honduras (GOH) to include communities, community based (CB) strategies remain poorly defined, and processes, norms and indicators have not been established. This project attempted to respond to these shortcomings, and build upon successful interventions being supported by the USAID Mission to increase health service equity (defined here as improved physical access to services, better population coverage, and reduced health costs among the poor), and improve service quality.

ChildFund International, based in Richmond, Virginia, was awarded a Child Survival & Health Grant (CSHGP) through the United States Agency for International Development (USAID) for a four year period (October 1, 2009 - September 30, 2013).

The goal of this Child Survival Project (CSP) was to decrease maternal, neonatal, infant and under-five child mortality in the project area to levels established by the Government of Honduras (GOH), in harmony with the Millennium Development Goals (MDGs) of 45 per 100,000 live births, and 7, 15, and 23 per 1,000 live births, respectively.

The project proposed three Community Based (CB) health innovations:

1. Define and standardize the role of communities in order to increase institutional deliveries and strengthen CB obstetric and neonatal care within a national decentralization strategy;
2. Create self-sustaining CB health units (UCOS) which integrate vertical MOH programs and various cadres of volunteers; and
3. Adapt and implement CB continuous quality improvement (CQI) systems for UCOS.

Evaluation Questions, Design, Methods, and Limitations

The evaluation methodology consisted of a mixed methods approach using both quantitative and qualitative techniques. Methods included, review of secondary data, key informant Interviews, Group Interviews, Observations and a participatory analysis workshop. In Annex 1, there is a table describing Evaluation questions and its specific methods for data collection.

a) Review of secondary data:

The FE external consultant reviewed project reports and other key USAID strategic documents at the global and national levels relevant to the content of project

b) Quantitative assessment:

The FE external consultant assessed the quality of the data gathered and the processes implemented and followed up the MTE recommendations. The project HIS system and reports, the HIS of HF as well as the community registers were also reviewed and the data collected through these sources.

c) FE Participatory Analysis Workshop.

The workshop was carried out during two days with the participation of the ChildFund staff, representatives of partners and other stakeholders (DMOH, ADAL, ADACAR, among others).

d) Qualitative assessment:

1. *Focus Groups and Groups Interviews:* These techniques were applied to work with beneficiaries of the project.

Sampling: The project implemented 28 UCOS during the life of the project in different periods and in different contexts. Out of the 28, four UCOS were selected using the following criteria:

a) UCOS with different times of initiation (Years 2010, 2011, 2012)
b) UCOS with weak or strong performance.
c) The context in which the UCOS were implemented:
   - Places with the CF support: CSP + CF sponsor program + Decentralization Model
   - Places with the CF support: CSP + Traditional public health care model
   - Places without CF support and the presence of the Traditional public health care model

The following are limitations identified during the FE activities, however they did not affect in the overall quality of the results obtained:

Due to difficult access to communities because of the rainy season, only four UCOS were visited.

- Since the project was ending, no regular CSP field activities could be observed to assess their process and quality.
- Some documentation was not timely available to the external FE consultant (e.g. FE KPC indicators or mortality data) prolonging the time for data analysis process.
- Some interviews to key stakeholders (e.g. representatives of the MOH at the national level or the ULAT) were not yet conducted, due to difficulties in finding a space in their agendas.

The CSP data available gathered through different sources, does not differentiate gender, that is why the FE team could not assess outcomes or impact considering gender

Findings and Conclusions

FINDINGS

- The CQI process was implemented in 14 HFs (CESAMOs) plus one Maternity (CMI).
- Fourteen CESAMOS and the maternity have CQI committees organized, trained and leading the implementation of quality processes. (See training Matrix)
- The DMOH has a team organized and trained in monitoring and supervision of CQI processes in the HFs of the project area.

- Staff in all the HFs were trained in institutional IMCI. Some staff also received refresher training in community IMCI. (Detailed information still pending)
- HF staff were trained in Basic EONC in the CMI of Reitoca.
- Staff of twelve HFs trained in Ambulatory EONC.
- The mortality data is being registered, in a regular basis, at the HFs and sent to the DMOH (Regional level). The data is consolidated in tables differencing the mortality occurred at the community level and the institutional level.
- At the time of the FE, 28 UCOS were established: eight of them had been functioning before the project started and 20 new ones were progressively established in the project area. These CB structures were implemented in a joint effort with the Departmental Ministry of Health Office (DMOH), municipal governments, ADAL, ADACAR and people from communities, among other local actors. The criteria used to determine the best location for the UCOS, took into account existing community resources, health service points, population density, transportation routes, market access, among other factors.
- The UCOS have a revolving fund supported initially by ChildFund. Each UCOS charges a small percentage above cost to cover transportation and provide funds for the functioning of the UCOS. Antibiotics are included in the program.
- No relevant qualitative differences of functioning were found during field visits in the UCOS implemented in the three contexts described.
- A total of 618 CHVs were identified, 479 (75%) are women and 139 men. Two hundred TTBAs. The project worked with 135 Child Health Weight Monitors with 405 individuals approximately. The desertion rate of the CHVs, during the overall project's period, is 5% (29).
- No information was available regarding Volunteer knowledge or skills assessment.
- The CB CQI process was implemented in 68% (19/28) of the UCOS established.
- The trained CHVs are monitoring the implementation of ten maternal and child health quality standards in their UCOS, on a monthly basis, with technical assistance of ChildFund:
- One of the UCOS received a recognition certificate from the DMOH for implementing health care services with quality.
- CHVs from different UCOS presented the CB CQI process and Results in the Students of Medicine Annual Congress and in the National Quality Congress organized by the MOH
- The following are the main evidence-based information generated during the project implementation: The OR which has been finalized (see section Data Quality and use); The equity study; The cost study; Exit interviews to measure client satisfaction; Comparative evaluation of CQI process at HFs; Implementation materials

CONCLUSIONS

Globally and specially in countries with weak health systems, the main challenge faced by the health community is related to successful coverage of evidence-based, with effective health interventions. ChildFund Honduras through the implementation of community-based structures and strengthening the public health system has demonstrated the feasibility to provide effective, cost-efficient primary health care with quality to rural low-income people, in the context of the Honduran National Health System Decentralization, with genuine participation of

the civil society. This experience has the potential to be effective in reaching the MDG's and be sustained and scaled up at the national and even to international levels. The experience can contribute to global health learning.

Decreasing maternal and child mortality
Based on the data available, the project decreased the maternal, the under-five years old, neonatal and the infant mortality rates in the project's geographical area during the period of 2008-2013.

Attention to equity
The UCOS is improving health equity among rural, low-income beneficiaries living in very remote communities. Ninety four percent of people participating in the assessment of the socio economic profile of beneficiaries fell into the lowest socio economic quintiles. The 28 UCOS are covering almost the fourth part (21.424) of the total population (101,755[*]) of the project area.

The project does not have an explicit written gender strategy, but it does focus mainly on women as the primary care taker of herself during pregnancy and childbirth, and of young children (including ECD, health and nutrition). Recognizing that women do not make decisions without other influences, a number of strategies are used for involving the family. For example, the birth plan is designed to be filled out by the whole family; home visits by TTBAs, CHVs and Monitors are one of the principal methodologies for education and involve the family. Many of the volunteers are women, providing them with an opportunity to receive training and assume a leadership role in their communities.

Improving access and utilization of health care services
The UCOS are increasing utilization of local health care among people in general and women in particular in the target population. The overall number of patients attended by the UCOS increased in 218% between 2012 (1,249) to September 2013 (2,726). Based on the KPC results women, interviewed in the project area, improved their knowledge and practices regarding key common maternal and child health behaviors that save lives. Compared to the BL many more women could correctly identify two or more danger signs in the new born (BL= 7, 4% - FE= 43%). Many more women were assisted by a qualified health worker (doctor, nurse or auxiliary nurse) in their delivery (BL=71% - FE=80%). Many more women were seeking support of health workers when their children had diarrhea (BL=70% - FE=83%). Based on reports from the Reitoca HF (CMI) there are more pregnant women who gave birth in the maternity. During the year 2012, the "Lodo Negro" HF increased the percentage of births attended in the Reitoca Maternity from 71% in 2011 to 79% in 2012[†].

The UCOS demonstrated to be a cost-efficient strategy. The UCOS cost study concludes that when a family found a solution to a child health problem at the community level, they save

[†] HIS Reiotoca

from USD $6.03 if they do not attend a CESAR to USD 70.24 if they do not attend a hospital. The Government earns similar amounts of money, having improved health care services at the community level, from USD 6.07 at not having attended a CESAR to USD 33.13 at not having attended a hospital.

Civil society participation
The project has increased the participation of the civil society in mortality surveillance. There are cadres of CHVs working with UCOS detecting, registering and informing to the upper levels of the system (Regional Health System) deaths among women and children under-five years old.

Contribution to global learning
The CSP also supports learning in accordance with the core principles of the Global Health Initiative: specifically in promoting a woman-centered approach; increasing impact through strategic coordination with the MOH and partners and the integration of multiple MOH technical strategies within one community structure; building sustainability through health systems strengthening; addressing equity issues in order to reach the most vulnerable populations; innovative approaches to maximize the efficiency and performance of CHWs; and promoting research and innovation.

Expansion or scaling up
The MOH is currently promoting the implementation of Primary Health Care as the National Strategy to address Social Determinants of Health, improve coverage and equity. The current political context represents the momentum for the CSP. The MOH has not yet decided to apply this model for its National Plan; however, they are participating actively in its implementation.

Other NGOs such as World Vision or JICA are implementing and even complementing the innovation with other services. World Vision has incorporated to the model development and child stimulation issues. There are four levels of replication addressed through the design of this CSP:

1) Through USAID and ULAT as part of the process of health reform and decentralization by providing a model for community based services;
2) Through the MOH where the CSP plays a catalytic role by presenting an evidence based, cost effective, documented model , with guides and tools for implementation for expansion to other departments;
3) Through other NGOs as the CSP seeks to share the experience, engaging in policy dialogue and advocacy activities, and building a coalition with other decentralized implementing agencies; and
4) ChildFund International level is committed to developing this model for use in other countries throughout the world.

Neonatal and Child Health Innovation in the Context of the National Health System Decentralization" is managed by ChildFund under Cooperative Agreement No. C.A. #. AID –GHS-A-00-09-00011. The views expressed in this material do not necessarily reflect the views of USAID or the United States Government.

For more information about the project, visit: http://www.childfund.org/honduras/

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The Final Evaluation (FE) is proposed to be a performance evaluation. The following are its main purposes:

- To provide an overview of project goals, objectives, and key intervention strategies implemented
- To determine the extent to which the project accomplished the results outlined in the Detailed Implementation Plan (DIP) and to present evidence of these accomplishments
- To describe key factors that contributed to what worked or did not work regarding some or all aspects of the program
- To demonstrate how the project contributed to learning and evidence that is directly relevant to improving Ministry of Health (MOH) policies and practices, as well as global learning about community-oriented health programming
- To provide a record of the results obtained by the project and the process by which they were achieved, so USAID can share these results with others outside of the CSHGP—including the U.S. Congress and in-country partners—and help others understand what should be done if they want to reproduce these results

EVALUATION QUESTIONS

5. To what extent did the project accomplish and/or contribute to the results (goals/Development Hypothesis, Results) stated in the DIP?

    5.1. What is the quality of evidence for project results?
    5.2. How were results achieved? If the project improved coverage of high impact interventions simultaneously, what types of integration enabled this? Specifically refer to project strategies and approaches and construct a logic model describing inputs, process/activities, outputs and outcomes. Describe the extent to which the project was implemented as planned, any changes to the planned implementation and why those changes were made.
    5.3. What is the quality of project MNCHN services provided and what indicators were used to document this?
    5.4. What are the significant lessons learned of this project?

6. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

6.1. What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, etc. that affected implementation and outcomes?
6.2. What capacities were built, and how?
6.3. Were gender considerations incorporated into the project at the design phase or midway through the project? If so, how? Are there any specific gender-related outcomes? Are there any unintended consequences (positive and negative) related to gender?

7. Which elements of the project have been or are likely to be sustained or expanded (through institutionalization, policies, etc.)?

    7.1. Analyze the elements of scaling up and types of scaling up that have occurred or could likely occur (dissemination and advocacy, organizational process, costs and/resource mobilization, monitoring and evaluation.)
    7.2. Analyze the costs and resources associated with implementation relevant for replication or expansion as well as estimated cost per beneficiary.

8. What are stakeholder perspectives on the results of the Operations Research (OR) Study, and how could the OR study affect capacity, practices and policy?
    8.1. What are the activities and plans of ChildFund Honduras, the MOH and other stakeholders to scale up and expand the successes of the project in Honduras?

PROJECT BACKGROUND

Honduras is poised to improve its national health system and maternal and child outcomes by 2015. New national laws and policies are introducing improvements to government facility services, and increasing the role of civil society through a decentralized health strategy. Nevertheless, despite a clear intention by the Government of Honduras (GOH) to include communities, community based (CB) strategies remain poorly defined, and processes, norms and indicators have not been established. This project attempted to respond to these shortcomings, and build upon successful interventions being supported by the USAID Mission to increase health service equity (defined here as improved physical access to services, better population coverage, and reduced health costs among the poor), and improve service quality.

ChildFund International, based in Richmond, Virginia, was awarded a Child Survival & Health Grant (CSHGP) through the United States Agency for International Development (USAID) for a four year period (October 1, 2009 - September 30, 2013).

The project's goal, development hypothesis, objectives and results were as follows:

The goal of this Child Survival Project (CSP) was to decrease maternal, neonatal, infant and under-five child mortality in the project area to levels established by the Government of Honduras (GOH), in harmony with the Millennium Development Goals (MDGs) of 45 per 100,000 live births, and 7, 15, and 23 per 1,000 live births, respectively.

Development Hypothesis: A community-based model of integrated basic MNCHN services (community volunteers working from a local physical structure applying quality improvement practices) linked to the Honduras national health system's decentralization strategy will improve health equity among rural, low income beneficiaries by lowering barriers to access, cost and use.

Project design:
The project proposed three Community Based (CB) *health innovations:*

- Define and standardize the role of communities in order to increase institutional deliveries and strengthen CB obstetric and neonatal care within a national decentralization strategy;
- Create self-sustaining CB health units (UCOS) which integrate vertical MOH programs and various cadres of volunteers; and
- Adapt and implement CB continuous quality improvement (CQI) systems for UCOS.

What is a UCOS?

UCOS are small freestanding structures located in selected communities, equipped with essential drugs, basic equipment and health education materials. Community volunteers offer care, attention, and education to persons in need, with an emphasis on women, infants and children. They are self-sustaining financially, managed by the community, supervised by the MOH, and given technical and logistical support by ChildFund Honduras. UCOS sustainability depends upon a functioning revolving drug fund

The CSP had three objectives:

- Strengthen facility-based maternal and child health services, improving quality and demand;
- Systemize a CB model of maternal, neonatal, and child health and nutrition (MNCHN) services, improving equity and quality; and
- Document, disseminate, and promote improved CB MNCHN services, standards and norms within the national decentralization strategy, improving sustainability.

Key strategies to support these objectives were:

1. Facility-based system strengthening, trained staff, and the introduction and support of CQI teams by the regional MOH and University Research Corporation (URC);
2. CB interventions to address morbidity and mortality of women of reproductive age, neonates and children under 5 years of age, based on successful ChildFund Honduras pilot projects
3. A national discussion on the inclusion of measurable, reimbursable CB health interventions within the national health decentralization strategy.

The vision of the project evolved during the past four years of implementation due to contextual factors both internal and external to the project, which is analyzed in the section Findings and Conclusions. As a result, activities were modified to respond to the changing project environment. For

example, the project evolved from documenting the implementation of UCOS within the decentralization process, to now considering how UCOS sustainability will be influenced by the type of support it will receive during post-project period 1) ChildFund supported service areas with decentralization. 2) ChildFund supported service areas with centralized health service access; and 3) service areas without ChildFund support with only centralized health service access. Each situation may define differing circumstances for long-term UCOS sustainability.

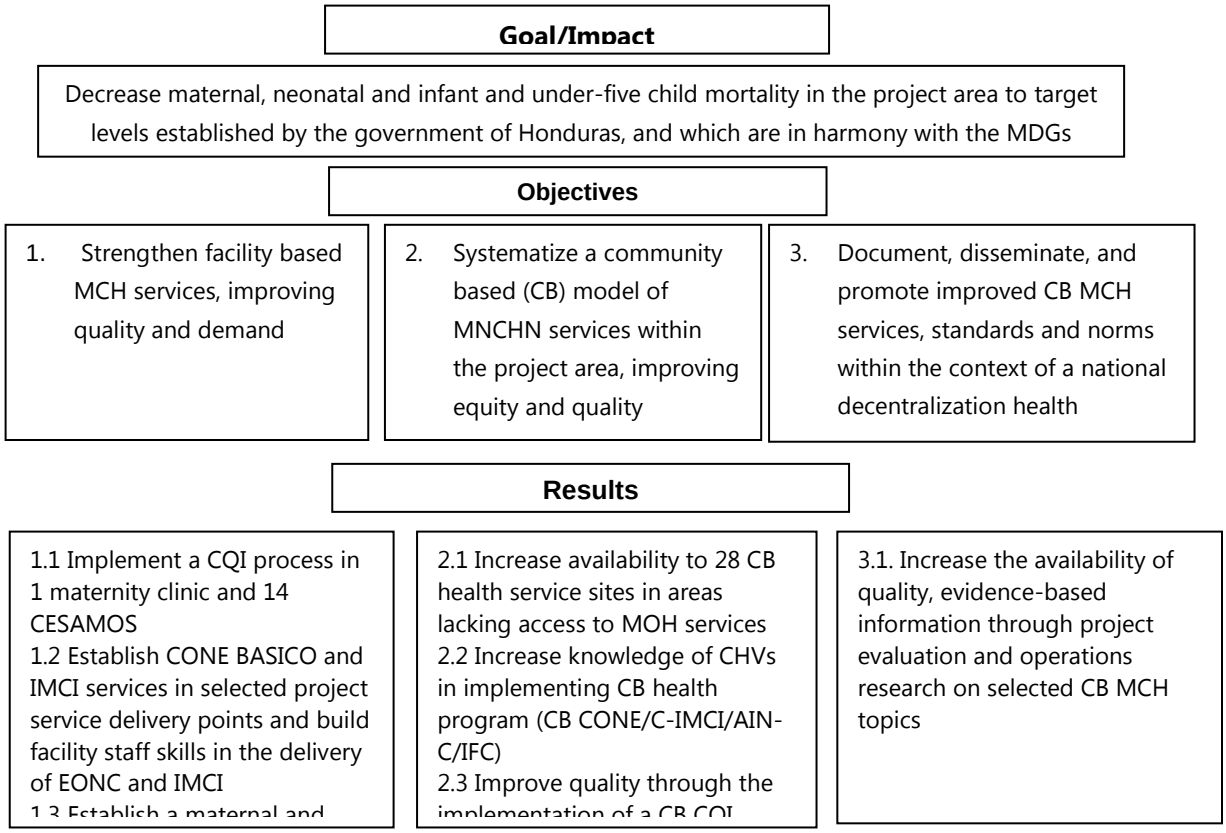
The project's key current objectives and Intermediate Results (IR) assessed included the following:

1. Strengthen facility-based MCH services, improving quality and demand
    - 1.1 Implement a CQI process in one maternity clinic and 14 CESAMOS
        - CQI monitoring system implemented, learning sessions conducted with health facility staff, database of CQI teams implemented, client satisfaction surveys conducted, supportive supervisory visits conducted
    - 1.2 Establish Essential Obstetric and Neonatal Care (CONE BASICO) and IMCI services[3] in selected project service delivery sites and build facility staff skills in the delivery of EONC and IMCI
        - Baseline conducted on EONC and IMCI performance, plan for EONC and IMCI strengthening developed at facility level, training process in EONC and IMCI supported
    - 1.3 Establish a maternal and child mortality reporting system
        - Facilitate integration of MOH's maternal and early child surveillance system at health facilities and CB-MCH sites, integrate mortality surveillance guidelines
2. Systemize a CB model of MCH services improving equity, access and quality.
    - 2.1 Increase availability to 28 health service sites (UCOS) in areas lacking access to MOH services
        - Select 20 new sites, hold local community assemblies, equip and stock CB health services, design and implement CB-CQI, train TBAs, child weight monitors, and emergency evacuation committees, document the pilot experience
    - 2.2 Increased knowledge of community health volunteers (CHVs) in implementing CB health programs (CB CONE/AIN-C/IFC)
        - Review and adapt materials for CHVs and TOT, inventory existing CHVs, select, train and develop skills of CHVs, assess responsibilities and skills to be consistent with MOH, implement formal and in-service trainings, support simple community reporting system, monthly monitoring
    - 2.3 Improve quality through the implementation of a CB-CQI process in 28 sites
        - Design CB-CQI, negotiate indicators with MOH, pilot CB-CQI, implement database, hold community meetings to exchange experiences and set benchmarks, supervise CB-CQI teams
3. Document, disseminate, and promote improved community based MCH services, within the context of a national decentralization health strategy, improving sustainability.

[3] According to Honduras MOH guidelines for CONE BASICO and IMCI.

1.1 Increased availability of quality, evidence-based information through project evaluation and operations research on selected CB MCH topics
- Develop OR plan, establish work alliance with CENET for OR, disseminate research findings and lessons learned through RAMNI, and USAID bilateral partners

Result framework:



The UCOS model integrates the work of trained Traditional Birth Attendants (TTBAs), Growth Promotion Monitors (AIN-C monitors), Community UCOS Health Volunteers (CHVs), and UCOS Management Committee and Committee for Transport in Emergencies (CTE). The UCOS model integrates multiple vertical MOH programs of Integrated Community Child Health Program **(**AIN-C), Integrated Management of Childhood Illnesses (IMCI), Accelerated Reduction of Maternal and Infant Mortality Strategy (RAMNI), Individual, Family, Community (IFC), and Essential/Emergency Obstetric-Neonatal Care (EONC or CONE).

The project was located in 12 southern municipalities of the Department of Francisco Morazán, which includes 293 communities. The municipalities are Ojojona, Santa Ana, Nueva Armenia, San Buena Ventura, Sabanagrande, San Miguelito, La Libertad, Alubaren, Reitoca, Curaren, La Venta del Sur and Lepaterique.

Table 1: Beneficiary Population Summary	
Infants: 0-11 months	2,569
Children: 12-23 months	4,071
Children: 25-59 months	7,933
Total Children: 0-59 months	14,573
Women: 15-49 years	26,454
Total Target Population	41,027

Source: Honduras' National Institute of Statistics (INE). 2008. (Extracted from the DIP)

The CSP worked within a national process of decentralization, which increases the responsibility of municipalities and the MOH to implement and sustain local health services, and separates MOH responsibilities (technical and quality leadership, training and oversight) from municipal responsibilities (direct service delivery through a third party mechanism). ChildFund Honduras has a contract with the GOH to provide direct maternal health services in three municipalities under the national plan for decentralization.

Partnership/Collaboration. The following are the key active partners of the CSP: The MOH (Secretaria de Salud) that provided direct health services, supervision and monitoring; ADAL and ADACAR (Respectively, Development Associations in Lepaterique, and in Curaren Alubaren, and Reitoca), two development associations formed and supported by ChildFund. They receive support and capacity building in a variety of areas. Centro Nacional de Educación para el Trabajo (CENET) that contributed in the evaluation of the project innovations and Operations Research (OR); and URC for the initial implementation of the CQI process at Health Facilities (HF) and UCOS. Partnerships and collaboration with the USAID Mission in Honduras and other partners and ULAT (Technical Assistance Local Unit-USAID Mission bilateral project) a USAID bilateral program working with the MOH to improve equitable social sector investments and to increase the use of quality maternal, child, and family planning/reproductive health services within the framework of national decentralization. Spanish Red Cross and World Vision. Joint implementation for select AIN-C groups and UCOS; training of World Vision staff on CB-CQI; Red Cross provides technical support for AIN-C training.

A detailed workplan of project activities from the Detailed Implementation Plan (DIP) is included in Annex IV outlining what was achieved, modifications in some activities based on Mid Term Evaluation (MTE) recommendations.

EVALUATION METHODS AND LIMITATIONS

The FE field work was conducted in September 2013. The overall purpose of the FE was to provide an overview of project goals, objectives and key interventions and strategies implemented; describe key factors that contributed to what worked or did not work and to demonstrate how the project contributed to learning and evidence that is directly relevant to improving MOH policies and practices, as well as global learning about community-oriented health programming.

The methodology for the FE responded to the requirements of the *CSHGP Guidelines for Final Evaluations*, which recommend participatory approach resulting in an effective learning experience for the NGO and local partners. The evaluation methodology consisted of a mixed methods approach using both quantitative and qualitative techniques. Methods included, review of secondary data, key informant Interviews, Group Interviews, Observations and a participatory analysis workshop.

In Annex 1, there is a table describing Evaluation questions and its specific methods for data collection.

e) Review of secondary data:
The FE external consultant reviewed project reports and different kind of materials produced. The review process of these documents aimed to assess the quality of quantitative and qualitative data available.

Other key USAID strategic documents at the global and national levels relevant to the content of project were reviewed as well as relevant MOH policy and strategy documents at the national level, such as: Modelo Nacional de Salud 2010-2014; Marco Político y Estratégico de la Reforma del Sector Salud (Política de Descentralización); Honduras Demographic and Health Survey 2011-2012; Perfil de los sistemas de salud de Honduras; Monitoreo y análisis de los procesos de cambio y reforma /Organización Panamericana de la Salud/ Organización Mundial de la Salud.

f) Quantitative assessment:
The Project team had completed the FE KPC survey before the FE activities started. The external consultant assessed the quality of the data gathered and the processes implemented and followed up the MTE recommendations. The project HIS system and reports, the HIS of HF as well as the community registers were also reviewed and the data collected through these sources.

g) FE Participatory Analysis Workshop.
The workshop was carried out during two days with the participation of the ChildFund staff, representatives of partners and other stakeholders (DMOH, ADAL, ADACAR, among others). To provoke discussion, the CSP staff presented the results of the CQI process at HFs, specifically the results of the comparative evaluation conducted in 2013, and the OR results. The workshop

provided an opportunity for partners and CSP staff to identify the project's strengths and weaknesses discuss the lessons learned and their perspectives about sustainability and a strategy for scaling up.

h) Qualitative assessment:
The FE team conducted the following qualitative techniques aiming to complement existing data and to understand the findings analyzed on the participatory workshop and the project accomplishments overall.

2. *Key Informant Interviews:* In Annex 2 there is a list of people interviewed
3. *Focus Groups and Groups Interviews:* These techniques were applied to work with beneficiaries of the project.

Sampling: The project implemented 28 UCOS during the life of the project in different periods and in different contexts. Out of the 28, four UCOS were selected using the following criteria:

d) UCOS with different times of initiation (Years 2010, 2011, 2012)
e) UCOS with weak or strong performance.
f) The context in which the UCOS were implemented:
   - Places with the CF support: CSP + CF sponsor program + Decentralization Model
   - Places with the CF support: CSP + Traditional public health care model
   - Places without CF support and the presence of the Traditional public health care model

Based on these variables the following municipalities were visited:

	Year 2010	*Year 2011*	*Year 2012*
UCOS/Municipality	*1. UCOS of Lepaterique*	*2. UCOS of Reitoca*	*3. La Venta del Sur* *4. Sabana Grande*
Characteristics	• *Area of ADAL* • *Implemented even before the life of the project* • *Pilot of CQI with URC* • *Weak progress (perception)* • *CQI re implemented in 2012*	• *Area of ADACAR* • *Are a of Decentralization model* • *CQI implemented in 2012* • *Good performance*	• *Place with the CF support: CSP + Traditional public health care model* • *CQI implemented in 2012*

The FE team applied semi-structured questionnaires as guidelines for the interviews and focus groups discussions. Annex 3. List of questions for interviews and focus groups discussions.

Limitations of the FE process:

The following are limitations identified during the FE activities, however they did not affect in the overall quality of the results obtained:

- Due to difficult access to communities because of the rainy season, only four UCOS were visited.
- Since the project was ending, no regular CSP field activities could be observed to assess their process and quality.
- Some documentation was not timely available to the external FE consultant (e.g. FE KPC indicators or mortality data) prolonging the time for data analysis process.
- Some interviews to key stakeholders (e.g. representatives of the MOH at the national level or the ULAT) were not yet conducted, due to difficulties in finding a space in their agendas.
- The CSP data available gathered through different sources, does not differentiate gender, that is why the FE team could not assess outcomes or impact considering gender.

Data Quality and Use

Following is an explanation of the key sources of data used for the FE process:

KPC Survey

The CSP carried out Knowledge, Practices, and Coverage (KPC) surveys in the first, as Base Line (BL), third and the last year of the project. The Lot Quality Assurance Sampling (LQAS) methodology was applied in the three surveys.

The MTE evaluation report describes specific recommendations about the baseline indicators and the survey questionnaires.

The FE KPC survey was overall of good quality however, there were some specific weak aspects identified, that the FE team had to adjust: The list of FE indicators, calculated initially by the project team, did not include all of the recommendations made by the MTE such as eliminating, replacing or modifying some of the indicators. The definitions, including the formulas for calculation, was not early available, and the database was tabulated manually. These aspects resulted in delays in indicators calculation and analysis. Based on this, the FE team: a) revised the original project's list of indicators, resulting in a modified list of 31. Twenty-three of them are KPC, including rapid catch indicators with the surveys as their data source; whereas the remaining eight indicators are extracted from the project's HIS. b) Revised the definitions for each indicator, based on the MTE recommendations, and re calculated the BL and the FE indicators. Annex V. KPC compared indicators.

Equity study

At initiative of ChildFund Honduras, a study to assess the socio-economic status of beneficiaries of the community-based intervention was conducted using a proven quantitative method[4], in

[4] This method was first proposed by Gwatkin et al. See for example: Gwatkin DR, Rutstein S, Johnson K, Suliman E, Wagstaff A & Amouzou A (2007). *Socio-economic differences in health, nutrition, and*

order to determine the proportion of beneficiaries belonging to each socioeconomic group. The assessment included the following key steps: 1) Generate an asset index based on the questions and pre-defined responses of the DHS. This step helped in defining the cut-off points for the asset quintiles, meaning the values of the asset index that delimit the quintiles. As a result of this step a questionnaire was designed. 2) Exit interviews with beneficiaries of the Community Interventions; 3) Calculate the value of the asset index: The DHS weighs obtained under step 1 were applied to the beneficiary's responses to the asset questionnaire; 4) Interviewed beneficiaries were then placed in the appropriate socio economic quintile using the DHS cut-off points. The final report of the study is still in process.

Operations Research (OR)

The OR implemented had the main purpose of assessing the utilization of a community based health unit (UCOS) to provide integrated MNCHN services in hard-to-reach areas while closely linked to the formal national health system. The OR had two phases: the first oriented to design, protocols and the indicators. To assess the changes, the CSP designed indicators related to provision of service, coverage of service, and health impact within geographical areas served by UCOS. The second phase measured two sets of outcomes: 1) Service access, coverage, and health impact applying a quasi-experimental, using a one group pretest-posttest approach. The overall methodology of this was good of quality; however, a quasi-longitudinal case control study would have helped identified causality. 2) A cost study that aimed to determine the costs associated with the implementation of the services of the new comprehensive health model (UCOS). The specific objectives of the study were: 1) Determine and compare the costs associated with giving birth at the Maternity of Reitoca and births attended by TTBAs at the community level. 2) Determine and compare the costs associated with attending a child younger than 5 years old in a hospital, a HF with doctor (CESAMO), a Rural Health Center (CESAR), and at a UCOS. III) Determine and compare the out of pocket expenses of families giving birth in a HF or at the community level; and attending children younger than 5 years old, in the levels of hospital, maternity, CESAMO, CESAR, and UCOS.

Mortality Registration

The CSP designed and implemented a mortality surveillance system for women and children at the community level for reporting to HF. The system includes a standard format to notify the deaths occurred in women and under-five children in a monthly basis. The project trained Community Health Volunteers (CHVs) and community committees (see training matrix) on proper data collection and timely notification to the HF. A process in the HF to verify the death, to classify it and to conduct a verbal autopsy, follows the notification. The HF consolidates the community and institutional information.

Health Information System (HIS)

The project HIS is based mainly on a monthly report for each UCOS. Information for the monthly report comes from a series of community registers for daily activities, infant and young child

population: Nepal. *Washington, DC: World Bank*

growth monitoring, and tracking of pregnant women. All volunteers in the UCOS network work together to fill out a consolidated report with three copies (original to HF, copies to the UCOS & CSP). The current system has been operational for a few months, is computerized in ACCESS, and can generate monthly, quarterly, and annual reports.

Continuous Quality Improvement (CQI) process

A comparative evaluation of the implementation of the CQI process was developed in a sample of HFs (8/14 CESAMOS) and the maternity (CMI) in the year 2010 (first study) and 2013 (second study), using nine prioritized quality standards. The methodology was the same in both moments.

Use of Information

During the FE field visits the FE external consultant found out there are two levels regarding information utilization. The first level occurs at the grassroots where the CSP field staff collect the information from the sources of data and send them to next level. They participate periodically with community health authorities and other local stakeholders, in meetings to whom they inform about their activities developed. However, this process is not formal, meaning there is no a standard methodology or analyzing tools being used. Individuals interviewed at this level mentioned they do not receive information about project's indicators and they could not name the key indicators of the project suggesting they do not revise them frequently. The second level occurs with the CSP managers and ChildFund National staff where it was found the analysis and participatory decision-making is regular praxis. They participate in different meetings with different actors and authorities where they present the project's evolution.

The indicators gathered from the KPC survey and OR are overall different, the KPC shows information from the whole project area meanwhile the OR from the specific UCOS areas. This aspect was one of the reason why the CSP managers preferred to use the OR information instead of the KPC indicators.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

FINDINGS

EQ 1: To what extent did the project accomplish and/or contribute to the results (Goal/Development Hypothesis, Results) stated in the DIP?

a) Findings regarding project's Strategic Objectives and Intermediate Results:

Logic model describing a summary of main CSP accomplishments.

Table 2: Summary of Major Project Accomplishments

Project Inputs	Activities	Outputs	Outcomes
SO 1. Strengthen facility based MCH services, improving quality and demand			
Training Materials and curricula Trainers CQI Process MOH staff in 1 maternity clinic and 14 CESAMOs, project staff MOH protocols and quality standards tools Partners: URC, MOH	Training for HF staff Monitoring of quality standards and supervision Mortality reporting by communities to HF	Health professionals trained Increased maternal child health knowledge and practices CQI process implemented at HFs Improved quality of Maternal-neonatal care	CQI processes implemented in 1 maternity clinic and 14 CESAMOS CONE BASIC and IMCI services implemented in selected HFs and staff skills built in the delivery of EONC and IMCI Maternal and child mortality reporting system established
SO 2. Systematize a community based (CB) model of MNCHN services within the project area, improving equity and quality			
Training Materials and curricula Trainers Infrastructure and equipment for UCOS CQI Process MIS system and formats Community volunteers, MOH and project staff Partners: URC, ADAL, ADACAR, and MOH	Monthly weighing and counseling for under 2 children Home visits to educate mothers Training of volunteers CQI process implementation in UCOS Monitoring and supervision Monthly reporting by Community Health Workers (CHWs) Monthly meetings for CHWs at HFs	Volunteers trained and supported Increased maternal health knowledge and practices Establishment of UCOS CQI process implemented at UCOS Communities with functioning Committee for Transport in Emergencies (CTE)	Increase access to health services through 28 UCOS AINc groups currently operational CHWs trained in implementing CB health program (CONE/C-IMCI/AIN-C/IFC) Improved quality through the implementation of a CB CQI process in 28 sites 28 UCOS are operational CTE are currently operational
SO 3. Document, disseminate, and promote improved CB MCH services, standards and norms within the context of a national decentralization health strategy, improving sustainability			
Past ChildFund experience in CB	Contracting of CENET to measure innovation for	Operational Research Cost study	Increase availability of quality, evidence-based information through project evaluation and

model Partners: CENETand ULAT.	development of CB Model Implementation of innovations Development of guides and systems for model	Documentation of CB model	operations research Implementation of a CB pilot project to be presented to the MOH, for consideration as a national model for MNCH service delivery at the community level

Following there is a description of the main findings in each Strategic Objective (SO) and Intermediate Result (IR):

SO 1: Strengthen facility-based MCH services, improving quality and demand
IR.1.1 Implement a CQI process in 1 maternity clinic and 14 CESAMOS

- The CQI process was implemented in 14 HFs (CESAMOs) plus one Maternity (CMI).
- A facility baseline assessment was conducted in all HFs that helped identify limitations in the quality of health care services. The key findings included 10% (1/10) of health services provided prenatal care according to national norms; no facilities correctly utilized the partogram. Moreover, early post-partum visits occurred (within 10 days after delivery) in less than 50% of cases.
- Fourteen CESAMOS and the maternity have CQI committees organized, trained and leading the implementation of quality processes. (See training Matrix)
- The DMOH has a team organized and trained in monitoring and supervision of CQI processes in the HFs of the project area.
- ChildFund and the DMOH have developed a set of quality standards with tools for periodic measurement at the HFs, based on the maternal and children health national programs and norms (RAMNI, CONE, and IMCI).
- A comparative evaluation of the implementation of the CQI process was developed in a sample of HFs (8/14 CESAMOS) and the maternity (CMI) in the year 2010 (first study) and 2013 (second study), using nine prioritized quality standards:

Table 3: Maternal and Child Quality Health Standards for CESAMOS	
Maternal quality standards	Child quality standards
1. Monitoring and use of the pregnant list 2. Prenatal checkups according to national norms 3. Attention to women in Post-partum period according to national norms	4. Utilization of the children's medical record. 5. Correct application of the IMCI assessment form 6. Pneumonia case management according to IMCI and national norms 7. Diarrhea case management according to IMCI and national norms
General Quality standards	
8. Essential prioritized medicines and supplies, for maternal and child health, in stock at the HFs 9. Biosafety quality standards	
Maternal and Children Quality Health standards for the maternity (CMI)	
1. Essential prioritized medicines and supplies, for maternal and child health, in stock at the HF	

2. Use of partogram according to national norms
3. Newborn health care services
4. Family planning services
5. Specialist attention
6. Obstetric complications management
7. Third period active attention
8. Attention to women in Post-partum period according to national norms

- Overall, on average, the nine (100%) quality standards improved in the second measurement (2013) in the eight CESAMOS evaluated. The diarrhea and pneumonia case management are the weakest standards especially in 2/8 HFs where the standards did not reach 50% in the second measurement.
- Overall, the eighth standards (100%) quality standards in the maternity improved in the second measure (2013)
- ChildFund developed an exit interview of clients in order to track changes in client satisfaction. The variables considered included: Waiting time, Physical Infrastructure (cleanliness, air circulation, etc.), perception of the health service payment, availability of medicines at the HF, interpersonal relationships (treatment). The first measurement was carried out in January 2013, considered as BL and the second in August 2013. Fifteen HFs were included in the first study and five in the second[5]. These are the key findings:
    - Twenty four percent of people interviewed mentioned the waiting time was acceptable, compared with 37% in the BL.
    - Regarding perception about the payment for attention, 69% of people interviewed considered it acceptable compared with 56% in the BL.
    - Ninety six percent of people interviewed mentioned their health problem had been solved, indicator that is 10 points above the first measurement

IR.1.2 Establish Essential Obstetric and Neonatal Care (CONE BASICO) and IMCI services[6] in selected project service delivery sites and build facility staff skills in the delivery of EONC and IMCI

- Staff in all the HFs were trained in institutional IMCI. Some staff also received refresher training in community IMCI. (Detailed information still pending)
- HF staff were trained in Basic EONC in the CMI of Reitoca.
- Staff of twelve HFs trained in Ambulatory EONC.
- The CMI has been strengthen by ChildFund with funds in addition to the CSP financing (Funds received by Government due to a contract signed between ChildFund and the government, that allows ChildFund manage the Health System Network-Decentralization policy).
- There is a maternity house in the CMI of Reitoca, where women can stay (with their families) both before and after giving birth. ChildFund added a kitchen to the Maternity house to

[5] Ten of the HFs included in the first measure, did not started the implementation of their improvement plan elaborated based on the findings of the first measure

[6] According to Honduras MOH guidelines for CONE BASICO and IMCI.

allow families to prepare their own food, through additional funds from the municipal government. ChildFund also pay incentives to TTBAs (200 Lempiras=USD 11) for bringing pregnant women to the clinic to give birth, and women receive 200 to 350 Lempiras (USD 11-19), depending on the distance they travel, when they give birth at the CMI.

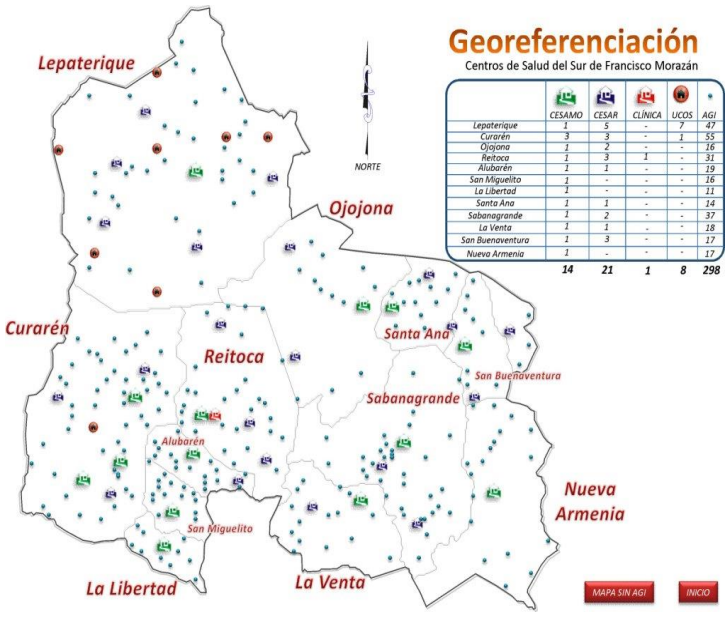
IR.1.3 Establish a maternal and child mortality reporting system

- The Honduran MOH has been prioritizing the collection of mortality among the under-five and maternal populations as part of its national MNCHN policies (RAMNI, CONE, IMCI, and AINC-C). Nevertheless, there was a lack of mortality data available before the project started (2008), especially for neonatal mortality.
- Activities with public health workers, conducted by the project team, at the Health Facilities (HF) were oriented to enhance the Health Information System (HIS) specifically the registration, documentation of the maternal, and under-five mortality data. In two of the HF visited, they were using tools designed by the MOH, such as verbal autopsies or registration instruments to classify the deaths.
- The mortality data is being registered, in a regular basis, at the HFs and sent to the DMOH (Regional level). The data is consolidated in tables differencing the mortality occurred at the community level and the institutional level.

SO.2. Systemize a CB model of MCH services improving equity, access and quality.
I.R. 2.1. Increase availability to 28 health service sites (UCOS) in areas lacking access to MOH services

- The project's Community Based (CB) interventions were supported through two management strategies: The UCOS were established for the provision of basic MNCHN services to remote geographic areas. In other communities that are not as remote, community AIN-C health groups were supported. The AIN-C are part of the MOH national nutrition program.
- At the time of the FE, 28 UCOS were established: eight of them had been functioning before the project started and 20 new ones were progressively established in the project area. These CB structures were implemented in a joint effort with the Departmental Ministry of Health Office (DMOH), municipal governments, ADAL, ADACAR and people from communities, among other local actors. The criteria used to determine the best location for the UCOS, took into account existing community resources, health service points, population density, transportation routes, market access, among other factors.

- ChildFund Honduras carried out a global positioning (GPS) community mapping exercise with input from key stakeholders and partners such as the MOH, representatives of local government, civil society organizations and local beneficiaries. This resulted in electronic



maps to locate the 12 municipalities within Honduras, the locations of the UCOS, all public HFs, communities, populations, distances and travel conditions between communities and nearest HFs:

- Overall, the UCOS were established in three different contexts:

Table4: Contexts where UCOS where established

Contexts	*Characteristics*	*UCOS of:*
a) ChildFund supported service areas with centralized heath service access	In these areas, the presence of ChildFund was through the project itself, and two nonprofit community development associations (ADAL and ADACAR) supported by ChildFund. These associations support activities in education, health (primary health care), food security and youth programs. They also carry out the sponsorship ChildFund program at the community level. They work in close coordination with the HF staff to develop vertical MOH health programs. During the project, ADAL and ADACAR supported financially community health activities such as training or provided in-kind match funding for the project.	Lepaterique La Venta del Sur
b) ChildFund supported service areas with decentralization	In these areas, ChildFund signed a contract with the MOH to manage the health system. This contract aims to increase service access and promote demand to existing health services through a decentralized health-financing scheme. ChildFund receives funds from MOH to cover different needs of the health system such as purchasing medicines for the HFs or even implementing incentives (e.g. transport for pregnant women or a payment given to TTBAs that refers pregnant women to a HF for delivery). For community activities, ChildFund hired "promoters" that link community activities to HF services. The MOH has established specific quarterly indicators, which ChildFund has to accomplish before receiving the funds.	Reitoca Curaren Alubaren
c) Service areas without ChildFund support with only centralized health service	In these areas, there is no presence of ChildFund besides the current project. The HF staff is the main responsible for the implementation of vertical MOH health programs	La Venta del Sur Sabanagrande Santa Ana San Miguelito La Libertad Nueva Armenia

access		Ojojona San Buenaventura

Source: Elaborated by author

- The UCOS have a revolving fund supported initially by ChildFund. Each UCOS charges a small percentage above cost to cover transportation and provide funds for the functioning of the UCOS. Antibiotics are included in the program.
- In both the AIN-C program and the UCOS there are drugs available for distribution by volunteers. In the case of AIN-C, the medicines are received directly from the HFs and provided at no cost.
- No relevant qualitative differences of functioning were found during field visits in the UCOS implemented in the three contexts described.

I.R. 2.2. Increased knowledge of community health volunteers (CHVs) in implementing CB health programs (CB CONE/AIN-C/IFC)

- The UCOS integrate the work of cadres of Community Volunteers: Trained Traditional Birth Attendants (TTBA), Growth Promotion Monitors (AIN-C monitors), Community Health Volunteers (CHVs), and health Management Committee and a Committee for Transportation in case of Emergencies (CTE).
- A total of 618 CHVs were identified, 479 (75%) are women and 139 men. Two hundred TTBAs. The project worked with 135 Child Health Weight Monitors with 405 individuals approximately. The desertion rate of the CHVs, during the overall project's period, is 5% (29).
- They received training in basic children as well as maternal health care services and administrative issues. However, CHVs focus on IMCI services, TTBAs on maternal and newborn health care, and AIN-C Monitors on growth promotion. One hundred and ninety six (196) were trained in a modified version of C-IMCI; Two hundred (200) TTBAs in EONC; 80 members of the UCOS management committee in drug funding and 388 AIN-C Monitors in growth monitoring and health nutrition promotion. ChildFund and the health staff were mainly responsible for the training process. (Annex VII_Community Health Worker Training Matrix)

- The following is a list of the main CB health care services provided through UCOS:

Table 5: Community health care services portfolio

Maternal Health	Child health
▪ Pregnant women early detection ▪ Promotion of facility based pre-natal visits ▪ Information of maternal key messages, including recognition of danger signs ▪ Post-natal and neonatal home visits within the first three days of life ▪ Facilitated transportation for emergency obstetric care ▪ Referral for HF based delivery by TTBA	▪ Counseling on breastfeeding and infant care ▪ Growth promotion and monitoring activities for under 2 children and support through monthly AIN-C meetings ▪ Community management of diarrhea, pneumonia and malnutrition. ▪ Follow up: CHVs for sick children, and AIN-C Monitors for malnourished under 2

(Provision of clean and safe home deliveries, if necessary) ▪ Home visits by TTBAs for maternal newborn care	children ▪ Recognition of danger signs in diarrhea and pneumonia (Referral and when indicated, first line treatment) ▪ Hygiene and sanitation education

Source: Project's documents

- During field visits in the FE process, CHVs in two of the four UCOS visited mentioned they received training in other basic health care concerns such as blood pressure measurement or first aid, which are other essential services demanded by adult people at the communities. Another UCOS visited was offering child development services, supported financially and technically by World Vision.
- No information was available regarding Volunteer knowledge or skills assessment. During the field visits, CHVs mentioned they receive visits in a monthly basis, from the CSP staff to monitor their activities, to assess their knowledge and strengthen their skills; however, it is not a formal procedure with a defined methodology.

I.R. 2.3. Improve quality through the implementation of a CB-CQI process in 28 sites

- The CSP developed the conceptual design, based on the CQI experience carried out at the HFs.
- The CB CQI process was implemented in 68% (19/28) of the UCOS established.
- Materials for CB CQI were developed in three Modules, which include tools for measuring, flipcharts on service standards and a facilitator guide.
- Each UCOS have a CQI committee organized and functioning. CHVs received training in the three Modules: Module #1=172 CHVs, Module #2=119 CHVs and Module #3=95 CHVs.
- The trained CHVs are monitoring the implementation of ten maternal and child health quality standards in their UCOS, on a monthly basis, with technical assistance of ChildFund:

Table 6: Maternal and Child Quality Health Standards for UCOS	
Maternal quality standards	*Child quality standards*
1. Early detection (3 months) and Reference of pregnant women to HFs 2. Support to pregnant women in Birth Planning 3. Follow up visit to women and the neonate in the Post-partum period 4. Family Planning supplies available at UCOS	5. Pneumonia case management according to IMCI and national norms 6. Diarrhea case management according to IMCI and national norms 7. Follow up visits to children with diarrhea or pneumonia within 2 days after detection 8. Monthly child weighing
General Quality standards	
9. Essential prioritized medicines and supplies, for maternal and child health, in stock at the UCOS 10. Reference to HFs of all emergency cases detected 11. Follow up of patients received from HFs	

Source: Project's documents

- One of the UCOS received a recognition certificate from the DMOH for implementing health care services with quality.
- CHVs from different UCOS presented the CB CQI process and Results in the Students of Medicine Annual Congress and in the National Quality Congress organized by the MOH

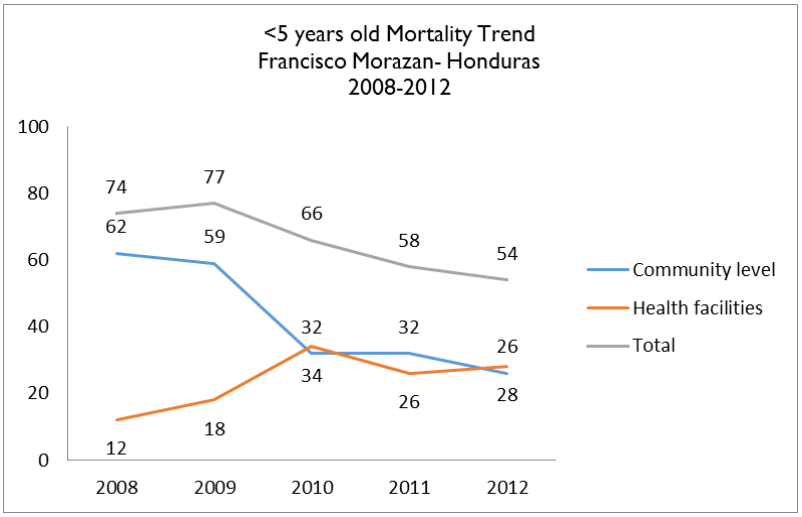
SO.3. Document, disseminate, and promote improved community based MCH services, within the context of a national decentralization health strategy, improving sustainability
I.R. 31. Increased availability of quality, evidence-based information through project evaluation and operations research on selected CB MCH topics

- The following are the main evidence-based information generated during the project implementation:
    - The OR which has been finalized (see section Data Quality and use)
    - The equity study
    - The cost study
    - Exit interviews to measure client satisfaction
    - Comparative evaluation of CQI process at HFs
    - Implementation materials

- The results of the CSP has been presented in different events at the national as well as international level. (Annex 4: Events_CSP presentations)

b) Findings regarding goal of the project:

- The overall mortality among children under-five years of age shows a decreasing trend in the last 5 years (2008-2012):



- *Neonatal mortality:* The overall neonatal mortality decreased from 36 neonatal deaths in 2009 to 27 in 2012 thanks to the neonatal mortality at the community level which shows a

sharp decline from 22 in 2009 to 8 in 2011 whereas the neonatal mortality in hospitals maintained a flat trend with 14 deaths in 2009 and 19 in 2012.

- In the period of 2008-2013, the neonatal mortality represents the 46% (131/286) of the infant mortality and the 38% (131/349) of the deaths among children under five years old, in the project area.
- *Infant mortality*: The overall infant mortality decreased from 53 deaths in 2008 to 47 in 2012 thanks to the decreasing trend of the mortality at the community level which shows reduction from 41 deaths in 2008 to 19 in 2012 whereas, deaths occurred at the hospital level, shows even an increasing trend from 12 in 2008 to 28 in 2012.
- *Regarding Maternal Mortality,* the data available shows a stationary trend with one death per year in the period of 2008-2012 with a peak of cases (4) in 2010.

c) Findings regarding the project´s hypothesis:

- An assessment of the *socio economic profile of the beneficiaries* of the Community Based Intervention was carried out, which included the following key steps: 1) Generate an asset index based on the questions and pre-defined responses of the DHS. This step helped in defining the cut-off points for the asset quintiles, meaning the values of the asset index that delimit the quintiles. As a result of this step a questionnaire was designed. 2) Exit interviews with beneficiaries of the Community Interventions (477 in total): a) A sample of beneficiaries (20% of the total patients seen in one month) who attended to five HF closest to UCOS (143 interviews randomly selected); b) the total patients seen in 11 UCOS in one month (334 interviews); 3) Calculate the value of the asset index: The DHS weighs obtained under step 1 were applied to the beneficiary's responses to the asset questionnaire; 4) Interviewed beneficiaries were then placed in the appropriate socio economic quintile using the DHS cut-off points and the results are as follows:

Table 7: Assessment of the socio economic profile of UCOS beneficiaries

Quintiles	Number	Proportion
Poorest quintile	185	40%
2nd quintile	163	35%
Middle quintile	89	19%
4th quintile	25	5%
Best-off quintile	2	0%
	464*	100%

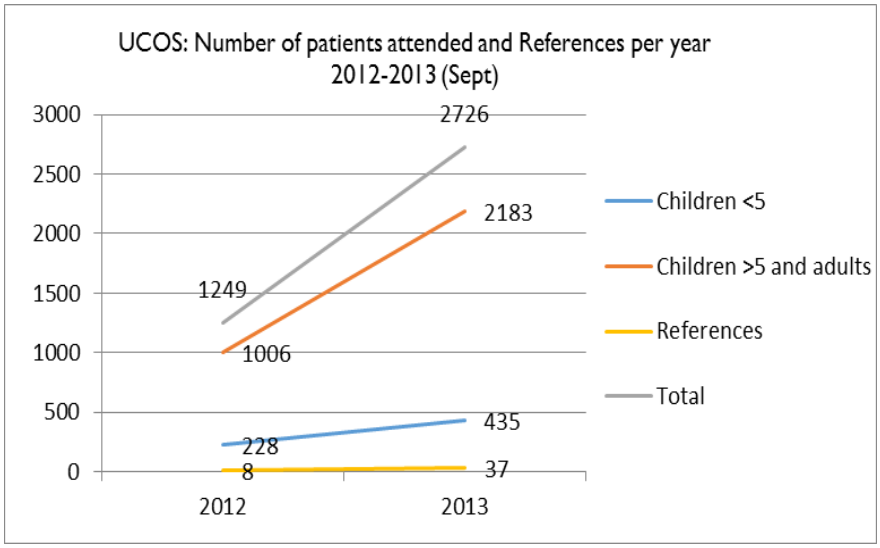
Source: Results of the analysis of the assessment, extracted from the partial report of the study.
**13 interviews were cleaned from the database for different reasons*

- *A cost study* was carried out that aimed to determine the costs associated with the implementation of the services of the new comprehensive health model (UCOS). The specific objectives were: 1) Determine and compare the costs associated with giving birth at the Maternity of Reitoca and births attended by TTBAs at the community level. 2) Determine and compare the costs associated with attending a child younger than 5 years old in a hospital, a

HF with doctor (CESAMO), a Rural Health Center (CESAR), and at a UCOS. III) Determine and compare the out of pocket expenses of families giving birth in a HF or at the community level; and attending children younger than 5 years old, in the levels of hospital, maternity, CESAMO, CESAR, and UCOS. These are the most important results:

- *T*he average implementation cost of the Comprehensive Community Health Model is USD 5,864.
- The total average cost for each attention (regardless of the type of services) is USD 8.18.
- The cost for each community is USD 1,955, including around 230 beneficiaries (each UCOS serves about three communities on average).
- Giving birth in a Maternity clinic is 60 percent cheaper than in a governmental hospital.
- The cost associated with health attention at a UCOS for a child younger than 5 years old is USD 3.50.
- The services offered at this level (UCOS) avoid families to spend huge amount of money (400%, 600%, and 2,300% more) if the health service would have been received from a CESAR, CESAMO or Hospital respectively.

- An assessment made by the FE external consultant regarding the patients and references made per year by the UCOS, shows:



- The number of patients attended by all the CHVs at the 28 UCOS or during home visits shows and increasing trend from 1,249 in 2012 to 2,726 until September 2013. The data available shows that 80% (2,183) are children older than 5 or adults, including WRA, and the references represents 1, 3%, suggesting most of the health problems seen are solved locally. There were no detailed information available regarding types of services provided.
- The results of the KPC surveys show: 65% (15/23) of the KPC indicators improved in the FE survey compared with the BL, however 82% (14 out of the 17 indicators that has a target) did not reach the target established in the DIP. (See Annex V_KPC indicators)

d) Significant CSP lessons learned:

- When construction is included, it is important to take into consideration the different contingencies that would influence the progress of the project. It was supposed that the financial contribution of the municipal governments would be higher for UCOS building.
- It is important to define the indicators that would measure the main aspects of the project (in this case for the innovation), since its beginning. The CSP currently has specific indicators for the KPC study, others for the OR and others for the CQI process, which resulted in confusion for project staff.
- Activities of the project are more likely to be sustained as long as they are flexible and can be adapted to local health needs. Some UCOS started to offer other health services for other community health issues e.g. blood pressure measurement.
- It is important to consider and design, since the beginning of the project, a project exit strategy with participation of stakeholders and other community actors, which would allow establish strategies and mechanisms to sustain project's activities.
- The combination of adults CHVs with younger ones has resulted in an effective inter-generational experience, where both groups share their experiences; increase their knowledge by learning from each other.
- The UCOS infrastructure had been designed to offer certain health care services; however, especially for women participating, it also meant a social, helping improve social the cohesion between them and their self - esteem.

E.Q.2. What were the key strategies and factors, including management issues, that contributed to what worked or did not work?

The following are the main contextual factors, both internal and external that influenced project's implementation and outcomes:

External factors:

a) The GOH has been facing several health system challenges, with more emphasis in the last two decades: The services are insufficient in terms of coverage, are inequitably distributed, and suffer from poor quality. Health centers exist only in the more densely populated areas of each municipality and the number of health posts is insufficient.[7] The health centers in poorer socio-economic regions generally suffer from dissatisfaction among users due to the attitude of service providers. In CPS project area a study of women who chose not to use MOH services, almost half expressed having problems accessing health services. The most important cause was thinking they would not receive medicine, followed by assuming they would not find anyone at the center, and thirdly, not having any money to pay for treatment.

[7] There are a total of ten physicians, four professional nurses, and fifty-two auxiliary nurses who serve a population of nearly 102,000; giving the project area a rate of 0.98 physicians per 10,000 people, considerably worse than the national average of 8 per 10,000 inhabitants.

Other barriers were distance, lack of transport, lack of female providers and almost 20 percent said they would have to get permission from their partners first.[8]

- Since the early 1990s, the country promoted a health sector reform process based on: strengthening the steering role of the MOH; comprehensive health services network; decentralization; and equity, efficiency, effectiveness, and social participation as essential requirements for the health care model. The Country vision as well as other National policies, including the National Health Plan 2010-2014 has as a general objective to improve basic health conditions and health services delivery. The plans emphasize sectoral reform and increase coverage for delivery of health services. The main initiative of the plans is to transfer responsibilities to the health regions, including budget planning and implementation on the frame of a decentralization policy[9].

  This context has provided enormous political support to the project. Moreover, recently a Law regarding working with CHVs has also been launched in which it is defined their roles, rights and duties[10].

b) The SO 3 had to be modified in the MTE since Hondusalud lost its principle source of funding from the USAID Mission, and was unable to function actively in the project. The CSP managers mentioned in the interviews that their advocacy efforts were re oriented to other implementing partners or donors and to the MOH directly. These aspects resulted in delays especially in activities related to SO3.
c) Currently the GOH is preparing the president election. In June 2009, the Honduran President was forced to leave office, which temporarily stopped almost all international donor support, and diminished political support and momentum for decentralization process. The current MOH authorities are functioning as transition administration.
d) Another major limitation to project implementation was the lack of approval for official tax exempt status. As a result, delays in construction and stocking the new UCOS occurred.
e) The presence of other partners such as JICA or World Vision supported the efforts on the project implementation. World Vision is right now supporting UCOS.

Internal factors:

a) Project's staff changes: The national and the field project's staff interviewed mentioned there were many problems (technical as well as attitudinal problems) with the project manager hired at the beginning of the project, resulting in delays in implementation of some activities, in particular, UCOS implementation and follow up to training in the project implementation. The CSP Manager and the Training Specialist both left the project in June 2011. A new CSP manager and The Training Manager were contracted and began work in early July. The field project's staff, the CHVs, the stakeholders and other project's partners recognize the

[8] GOH 2008. RAMNI
[9] Secretaría de Salud (2006): Plan Nacional de Salud 2021. Tegucigalpa, M.D.C
[10] Ley del Voluntariado. Republica de Honduras, Tegucigalpa. Diciembre 2011

leadership of the new project's managers. These changes were considered by them as one of the key aspects that helped achieve the objectives of the project.

b) ChildFund has a holistic model for children. Health and education play a key role in all ChildFund programming, and communities where affiliated children live receive education in: immunizations, environmental sanitation, safe water, management of respiratory infections and diarrhea, nutrition, and for adolescents, prevention of HIV/AIDS. They also have programs for early childhood development (ECD) and preschool activities, as well as programs to improve the quality of education and literacy. Other programs include construction of latrines and the provision of community managed drug funds in isolated communities. These many activities provided a supportive environment for CSP implementation.

E.Q.3. Which elements of the project have been or are alike to be sustained or expanded?

The following table describes the CSP elements related to sustainability and scaling up based on the ExpandNet guide:

Table 8: elements related to the CSP sustainability and scaling up

The elements	*CSP* Current status
The Innovation	
Community based health care interventions through Community Health Units (UCOS)	The project innovation is the provision of an integrated community based package, of various vertical MOH programs[11], which should result in more effective coverage and access, and improve equity in the project area. These programs include RAMNI, CONE, C-IMCI, and AIN-C. Each UCOS provides these basic maternal, neonatal, and child health and nutrition (MNCHN)
User organization (s)	
The project staff interviewed consider the innovation's users the following actors:	1. The MOH 2. The communities 3. The NGO's and donor agencies 4. Implementing organizations of the decentralization policy (municipal governments, NGO's)
Environment	
The environment or context in which the project was implemented was discussed in previous section: internal and external factors and summarized here:	– Despite efforts made by countries in the region, and as reaffirmed in the previous declarations, providing more equitable, comprehensive, integrated, and continuous health services remain an imperative for the majority of countries in the Americas[12]. – The Honduran public health services are insufficient in terms of coverage; are inequitably distributed, and suffer from poor quality.

[11] These MOH programs are currently being provided by the most peripheral health service level (health posts, or CESARs) as vertical packages though: AIN-C, breastfeeding promotion activities, health education through a national communication strategy, and the promotion of institutional delivery.

[12] Renewing Primary Health Care in the Americas. PAHO 2011

	– In the country, a reform of the health sector is going on, based on: strengthening the steering role of the MOH; comprehensive health services network; decentralization; and equity, efficiency, effectiveness, and social participation. – Recently a CHVs law was launched which will support the activities being developed through the UCOS. – A president election is going to take place very soon. The transition administration is very interested in identifying effective methodologies for implementing PHC.
Resource team	
The project team has developed materials, tools and implementation guides for the UCOS	• The CSP developed the conceptual design of the improved UCOS based on previous experience. • Protocols, materials and implementation guides are already designed and validated. • CHVs as well as key partners (ADAL, ADACAR, the DMOH are trained in the protocols, materials and the UCOS implementation guides • Studies that support the effectiveness of the innovation were conducted: o OR indicators that shows effectiveness (pre- post studies). o Equity study that confirms the health care services offered by the UCOS benefit to rural low income people. o A cost study that confirms that the UCOS model is a cost efficient intervention. This study includes information about the implementation cost of the model.
Scaling up strategy	
There are no written documents regarding project sustainability or scaling up strategies, however: a) It is important to highlight that the project design itself implemented interventions oriented to sustain the activities of the project. b) During the interviews and the FE analysis workshop the DMOH and the project's manager staff expressed the ideas and interventions they planned about sustainability and scaling up.	a) Aspects of sustainability in the design of the project: – The UCOS work with cadres of CHVs. During field visits, the CHVs mentioned that working through cadres of individuals helped disburse the workload among them; created a sense of mutual responsibility and teamwork and provided a peer support network. As mentioned before that is why the desertion rate in the CSP area is very low (5%) in the last year. – The UCOS are designed to attend permanently to people from adjacent communities and other ones from other geographic areas. The 4 UCOS visited were open half day (the seven days of the week) and attended by the CHVs through a part-time schedule, established by them. However, the health services are offered permanently to the community especially emergency services. – The UCOS are self-sustaining financially, managed by the community. The four UCOS visited had administrative committee functioning, responsible for the management of the UCOS wages, including the drug revolving funds. All of them keep their administrative and financial records updated supervised by the president of the committee and a kind of prosecutor that controls the president, however all of the CHVs mentioned also they are permanently controlling and asking for periodic financial reports. – The UCOS incomes are basically intended for purchasing drugs however three of the four UCOS visited mentioned their incomes are sufficient enough to cover other basic needs for the UCOS (office supplies, trash baskets, sphygmomanometer, etc.) or to contribute to funds for the

	maintenance of the infrastructure. – The project built capacity in HF staff. Several training sessions were developed in different topics, and many processes were enhanced such as the CQI process, maternal and child mortality surveillance systems among others. b) Information regarding sustainability and scaling up interventions gathered from interviews and FE analysis workshop: – *DMOH authorities*, mentioned the model is not yet ready to be scaled up and suggested three key steps that will reinforce the model and will contribute in increasing the participation of the DMOH in the UCOS implementation, monitoring and evaluation[13]: 1) Detailed participative comprehensive assessment of the model 2) Reinforce/complement the model with other CB experiences developed in Honduras and other experiences in other contexts of Latin America. 3) Design methodology and tools for the DMOH to monitor and evaluate the model. – On the other hand, the project's manager staff analyzed the three different contexts in which the UCOS is currently functioning and the projections of sustainability in these specific contexts: 1) ChildFund supported service areas with centralized heath service access. In these sites ChildFund will assign child sponsorship funds to implement new UCOS. 2) ChildFund supported service areas with decentralization. In these sites, ChildFund will organize meetings with implementing organizations that work whit the decentralization process to offer help in implementing the UCOS model. Currently there are 30 organizations working in 70 municipalities 3) Service areas without ChildFund support with only centralized health service access. ChildFund will not have presence in these municipalities however the UCOS located in these sites will receive a minimum number of visits a year just to monitor the progress of the UCOS. – ChildFund expects to have 60 UCOS with CQI process by the end of 2014.

E.Q.4. What are stakeholders perspectives on the results of the OR study and how the OR study affect capacity?

During interviews and the analysis workshop, stakeholders and other local actors expressed their perspectives about the CSP and their suggestions regarding sustainability and scaling up efforts:

[13] FE analysis workshop. Tegucigalpa. Honduras 2013

- The communities are the main users of the innovation. Mothers and CHVs of the communities visited, participating in the focus groups discussions, mentioned:
  - *"The CHVs at the UCOS are always worried about us"*
  - *"We do not have to walk very far to get a medicine"*
  - *"We want to participate and support the CHVs because they work without payment"*
  - *"I am happy because (UCOS) I always find help here (UCOS)"*.
- The mayor of one of the municipalities visited mentioned: *"It is a relief for me, in the past we used to struggle with many demands coming from communities asking us for help to transport an emergency. Now with the UCOS there are Committees for Transportation. It is a kind of self-support what is happening in the communities"*
- The director of the DMOH (regional revel) and other health authorities, representatives of the MOH that participated in the analysis workshop in Tegucigalpa mentioned the UCOS model is an opportunity considering the MOH has a huge interest in implementing Primary Health Care (PHC). The director of the DMOH mentioned, *"The UCOS is like the ring for the finger"*. However the DMOH authoritie mentioned that the UCOS model is not ready yet for sacaling up and suggested
- *The NGO's and other donor agencies* (JICA, Interamerican Development Bank, among other), are looking for ways how to improve their support to the MOH and the GOH in implementing their health plans and policies. Due to time constraints, interviews with those organizations could not be arranged yet.
- *Implementing organizations of the National Health Decentralization program*. The CSP staff has defined as prioritized advocacy method to arrange meetings with the organizations hired by the MOH to administer health system networks. During the FE field activities the project staff organized meetings and workshops as well as breakfast meetings, with these organizations or municipal governments aiming to attract their attention presenting them the main achievements of the project, especially the OR results.

CONCLUSIONS

Globally and specially in countries with weak health systems, the main challenge faced by the health community is related to successful coverage of evidence-based, with effective health interventions. ChildFund Honduras through the implementation of community-based structures and strengthening the public health system has demonstrated the feasibility to provide effective, cost-efficient primary health care with quality to rural low-income people, in the context of the Honduran National Health System Decentralization, with genuine participation of the civil society. This experience has the potential to be effective in reaching the MDG's and be sustained and scaled up at the national and even to international levels. The experience can contribute to global health learning.

Decreasing maternal and child mortality

Based on the data available, the project decreased the maternal, the under-five years old, neonatal and the infant mortality rates in the project's geographical area during the period of 2008-2013.

Indicators	***Baseline situation***				***MDG targets / National Goals (RAMNI)***	***FE Results***	
	Global	***LAC Region***	***Honduras***	***Project area***		***Honduras***	***Project Area***
NMR per 1,000 l.v.	*30**	*12**	*16***	*15****	*7*	*18+*	*13++*
IMR per 1,000 l.v.	*52*	*26*	*31 national 33 rural area***	*31****	*15*	*24 national 23 rural area+*	*22++*
<5MR per 1,000 l.v.	*76*	*31*	*40*	*33***	*23*	*29+*	*27++*
MMR x100,000 l.v.	*410*	*194*	*280 (CI 190-380)*****	*325****	*45*	*180+++*	*59++*

Source: Modified by author from a table presented in the Operations Research Study
**World Bank (2006). **ENDESA (DHS 2006) ***DMOH (calculated by authors of document)*
*****WHO Maternal Mortality in 2005 +ENDESA (DHS 2011-2012) ++ DMOH HIS average rate 2008-2012*
+++MOH National Health Policy

Attention to equity

The UCOS is improving health equity among rural, low-income beneficiaries living in very remote communities. Ninety four percent of people participating in the assessment of the socio economic profile of beneficiaries fell into the lowest socio economic quintiles. The 28 UCOS are covering almost the fourth part (21.424) of the total population (101,755[*]) of the project area. On

average, each UCOS serves: 3 communities with a total of 765 people, including 99 children under five years old and 167 Women at Reproductive Age (WRA). The distance to a nearest HF from the communities attended by the UCOS is 13 kilometers, which represents for people, on average 3 hours walking in very rough and dangerous roads or pathways.

Municipalities	*UCOS*	*Target population*						*No. of communities attended*	*Distance to the nearest HF (Km)*	*Time spent walking (hrs)*
		Total	*< 1*	*12-23 m*	*24m-4 years*	*< 5*	*WRA 15-49*			
12	*28*									
Total population in the 28 UCOS areas		*21.424*	*499*	*528*	*1.694*	*2.762*	*4.672*			
Average for each UCOS		*765*	*18*	*19*	*61*	*99*	*167*	*3*	*13*	*3*
Total population in the project area[†]		*101.775*	*2.569*	*4.071*	*7.963*	*14.573*	*26.454*			
% of the total population covered by the UCOS		*21%*	*19%*	*13%*	*21%*	*19%*	*18%*			

Source: Elaborated by author
**Extracted from the DIP. Honduras' National Institute of Statistics (INE) 2008*

The project does not have an explicit written gender strategy, but it does focus mainly on women as the primary care taker of herself during pregnancy and childbirth, and of young children (including ECD, health and nutrition). Recognizing that women do not make decisions without other influences, a number of strategies are used for involving the family. For example, the birth plan is designed to be filled out by the whole family; home visits by TTBAs, CHVs and Monitors are one of the principal methodologies for education and involve the family. Many of the volunteers are women, providing them with an opportunity to receive training and assume a leadership role in their communities.

Improving access and utilization of health care services

The UCOS are increasing utilization of local health care among people in general and women in particular in the target population. The overall number of patients attended by the UCOS increased in 218% between 2012 (1,249) to September 2013 (2,726). Based on the KPC results women, interviewed in the project area, improved their knowledge and practices regarding key common maternal and child health behaviors that save lives. Compared to the BL many more women could correctly identify two or more danger signs in the new born (BL= 7, 4% - FE= 43%). Many more women were assisted by a qualified health worker (doctor, nurse or auxiliary nurse) in their delivery (BL=71% - FE=80%). Many more women were seeking support of health workers when their children had diarrhea (BL=70% - FE=83%). Based on reports from the Reitoca HF (CMI) there are more pregnant women who gave birth in the maternity. During the year 2012,

[†] Detailed Implementation Plan. 2008

the "Lodo Negro" HF increased the percentage of births attended in the Reitoca Maternity from 71% in 2011 to 79% in 2012[‡].

Costs of the innovation

The UCOS demonstrated to be a cost-efficient strategy. The results of the cost study reinforce de findings obtained from other national cost studies carried out in Honduras and Central America where it was determined that for every lempira or US dollar that a family invests in its health problem, the national and local governments invest another lempira or US dollar. Based on this premise, the cost study concludes that when a family found a solution to a child health problem at the community level, they save from USD $6.03 if they do not attend a CESAR to USD 70.24 if they do not attend a hospital. The Government earns similar amounts of money, having improved health care services at the community level, from USD 6.07 at not having attended a CESAR to USD 33.13 at not having attended a hospital.

The CB CQI process implemented in the UCOS represents one of the project's key achievements. It has been oriented to improve the lack of quality of the CB health services identified initially[§]. The process helped empower CHVs in CQI process. During field visits one CHV said, *"We attend people as we would like our family to be attended at the Health Facility"*.

The model has been designed especially to address maternal and childhood health care issues, however it has been adapting to other local health needs, representing one of the main issues that will contribute to the sustainability of the CB model.

The UCOS model has demonstrated that can build trust within the community since it has been designed with a self-control organizational system making administrative processes more transparent.

Building sustainability through health systems strengthening:

The MOH Surveillance System for Maternal and Child Mortality has been strengthen in the HFs of the project's geographic area. The System links the mortality information between peripheral structures of the MOH (CESAR, CESAMOS and CMI) and community resources specially assuring that defined national instruments (IVM-6A and IVM-2A) are used effectively and in a timely fashion by health staff.

Overall, through the CQI process at the institutional level, the maternal and child health care services, provided to the population, improved in quality. For example, the percentage of accomplishment in the standard regarding post-partum attention to mothers and neonates according to national norms, are over 80% in all of the HFs evaluated. This represents one of the

[‡] HIS Reiotoca

§ UCOS baseline assessment. ChildFund. 2008

key project's contributions to decrease the maternal and neonatal mortality, since a great number of maternal and neonatal deaths occur in the perinatal period in Honduras[**]. The availability of essential medicines and supplies for maternal and child health programs have increased, on average, from 66% to 83% in 100% of the HFs[††].

The satisfaction of the population to the health care services at HFs is high (The general satisfaction index obtained through the exit interviews in 2013 shows 81% in the initial study and 86% in the second measurement)

There are local CQI teams in every HF effectively functioning, leading the implementation, monitoring and supervision of CQI activities. The teams have enhanced their capacities to advocate to local stakeholders regarding CQI needs. During field visits, the CQI team in Reitoca mentioned they got additional funds from the municipal government to improve a shelter for the maternity, built to help families of pregnant women who chose giving birth at the HF. This has resulted in a key strategy to increase births at the HF level.

Civil society participation

The project has increased the participation of the civil society in mortality surveillance. There are cadres of CHVs working with UCOS detecting, registering and informing to the upper levels of the system (Regional Health System) deaths among women and children under-five years old.

Contribution to global learning

Many Latin American countries are involved in a process of health reform, decentralization and implementation of Primary Health Care. The UCOS model of ChildFund Honduras should be considered as an input in moving that agenda forward. The project generated evidence-based information regarding costs, access and coverage that support the feasibility and effectiveness of the project. The use of CQI at the community level is another important step forward perhaps unique in Latin America.

The CSP also supports learning in accordance with the core principles of the Global Health Initiative: specifically in promoting a woman-centered approach; increasing impact through strategic coordination with the MOH and partners and the integration of multiple MOH technical strategies within one community structure; building sustainability through health systems strengthening; addressing equity issues in order to reach the most vulnerable populations; innovative approaches to maximize the efficiency and performance of CHWs; and promoting research and innovation.

** Perfil de los Sistemas de Salud. Honduras. Monitoreo y Análisis de los Procesos de Cambio y Reforma. Organización Panamericana de la Salud. 2009

†† Evaluación comparativa del Proceso de Mejora Continua de la Calidad en el Marco del Proyecto de Supervivencia Infantil. ChildFund Honduras. 2013

Expansion or scaling up

The MOH is currently promoting the implementation of Primary Health Care as the National Strategy to address Social Determinants of Health, improve coverage and equity. The current political context represents the momentum for the CSP. The MOH has not yet decided to apply this model for its National Plan; however, they are participating actively in its implementation.

Other NGOs such as World Vision or JICA are implementing and even complementing the innovation with other services. World Vision has incorporated to the model development and child stimulation issues.

There are four levels of replication addressed through the design of this CSP:

5) Through USAID and ULAT as part of the process of health reform and decentralization by providing a model for community based services;
6) Through the MOH where the CSP plays a catalytic role by presenting an evidence based, cost effective, documented model , with guides and tools for implementation for expansion to other departments;
7) Through other NGOs as the CSP seeks to share the experience, engaging in policy dialogue and advocacy activities, and building a coalition with other decentralized implementing agencies; and
8) ChildFund International level is committed to developing this model for use in other countries throughout the world.

RECOMMENDATIONS

ChildFund Honduras should assist the MOH and other project's partners in the design and initial implementation of a sustainability plan, which would include the following key activities that will contribute to the sustainability of the project's interventions:

- Reinforce the management capacities of the DMOH in implementing, monitoring and supervision of the CB UCOS model.
- Reinforce the mechanisms of the UCOS to get adapted to the permanent changing environment (political, epidemiological, and social).
- Establish a permanent local mechanism to train, reinforce and update CHVs. Although the desertion rate is low among CHVs it is important to define who is going to take the ChildFund role in training. Three alternatives can be considered:
- Formal training through HFs staff
- Peer strategy in which the CHVs who decides to stop working will identify a potential candidate and will transfer the knowledge received to the new CHV.
- Distance training. Basic implemented a program based on the cellphones sending through them key health messages that the CHVs should reinforce or maybe messages of motivation for the CHVs
- The CQI process has represented a motivation for CHVs. They learned the CQI conceptual issues and tools for the prioritized health standards. Now they are ready for a step ahead, design their own quality health standards.

The MOH and other key stakeholders should disseminate the results of the project through testimonials, videos and success histories, which will reinforce the efforts to disseminate the project's results.

ANNEXES

The evaluation report submitted to CSHGP by the evaluator must include the following as annexes, submitted as separate documents:

I. Program Learning Brief(s): Evidence Building

II. List of Publications and Presentations Related to the Project

III. Project Management Evaluation

IV. Work Plan Table

V. Rapid CATCH Table

VI. Final KPC Report

VII. CHW Training Matrix

VIII. Evaluation Scope of Work

IX. Evaluation Methods and Limitations

X. Data Collection Instruments

XI. Information Sources

XII. Disclosure of Any Conflicts of Interest

XIII. Statement of Differences

XIV. Evaluation Team Members, Roles, and Their Titles

XV. Final Operations Research Report

XVI. Operations Research Brief

XVII. Stakeholder Debrief PowerPoint Presentation

XVIII. Project Data Form

XIX. Optional Annexes