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DEVELOPMENT PROJECTS FOR EXECUTIVE BOARD APPROVAL

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PROJECT HONDURAS 5691

Health and community development

Duration of project	Five years
Total food cost	4 829 580 dollars
Total cost to WFP	8 890 434 dollars
Total cost to Government	2 750 000 dollars
Number of beneficiaries	106 050 (96 000 family members, 2 500 children, 3 050 expectant mothers and 4 500 trainees)

All monetary values are expressed in United States dollars, unless otherwise stated. One United States dollar equalled 13.1 lempiras in July 1997.

ABSTRACT

The project is expected to improve the health conditions and nutritional status of 19,200 families belonging to vulnerable groups in 465 towns and 38 municipalities, and strengthen community-based organizations in formulating their local development plans. Activities will support the Government's poverty alleviation policy, the ACCESS programme through which the Government aims to improve the coverage of health services, and the decentralization policy which enhances the management of local development plans. Food aid is provided as: i) a nutritional complement to poor rural families with expectant and nursing mothers, women heads of household and children under five years old who are at risk of malnutrition; ii) an incentive for participation in prenatal care and growth monitoring of children; and iii) a support for infrastructure building and community development. The project will be implemented in a coordinated manner by the Ministry of Health, the Community Councils and Non-Governmental Organizations (NGOs) already operating in the project area. A Project Management Unit (PMU) will coordinate activities and manage the project with the support of three Project Field Units (PFUs). The Pan American Health Organization (PAHO) will provide one permanent technical advisor for each PFU. The United Nations Fund for Population Activities (UNFPA) will support training courses for trainers. UNICEF will contribute to the reproduction of training materials and offer technical advice. Canadian International Development Agency (CIDA), through the Micronutrient Women's Health Facility Programme, will provide the micronutrients, food items and other resources required for monitoring and training activities.

NOTE TO THE EXECUTIVE BOARD

This document contains recommendations for review and approval by the Executive Board.

Pursuant to the decisions taken on the methods of work by the Executive Board at its First Regular Session of 1996, the documentation prepared by the Secretariat for the Board has been kept brief and decision-oriented. The meetings of the Executive Board are to be conducted in a business-like manner, with increased dialogue and exchanges between delegations and the Secretariat. Efforts to promote these guiding principles will continue to be pursued by the Secretariat.

The Secretariat therefore invites members of the Board who may have questions of a technical nature with regard to this document, to contact the WFP staff member(s) listed below, preferably well in advance of the Board's meeting. This procedure is designed to facilitate the Board's consideration of the document in the plenary.

The WFP focal points for this document are:

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Should you have any questions regarding matters of dispatch of documentation for the Executive Board, please contact the Documentation and Meetings Clerk (tel.: 6513-2641).

PROBLEM ANALYSIS

1. Honduras is the fourth poorest country in Latin America and the Caribbean. Its economy showed an annual per capita Gross Domestic Product (GDP) of 589 dollars in 1995, declining food production rates and a dependence on sustained levels of cereal imports over the last decade. The country still has a high prevalence of chronic malnutrition. During the period 1985-95, the food price index increased by 400 percent; despite the recent increase in the legal minimum daily wages to 2.40 dollars. Real daily wages for agricultural work remain low (1.55 dollars), and most rural workers cannot afford the estimated cost of a family's daily food basket. In 1993, approximately 77 percent of the rural population lived below the poverty level, and 56 percent under the level of indigence, defined as the inability to purchase a basic daily food basket.

2. The basic Honduran diet is largely based on two staples - maize and beans - and is therefore highly vulnerable to periods of scarcity. Domestic food production has not kept pace with demand. Since 60 percent of agricultural land is comprised of small plots (under three hectares) for subsistence agriculture, crop failure directly affects household food security, as approximately 45 to 66 percent of the corn and 48 to 71 percent of the beans are dedicated to family consumption. In the area selected for the project, water shortage, lack of irrigation systems, soil erosion and erratic rainfall pose constant threats to community and household food security. By 1994 the daily caloric intake was only 66 percent of the recommended minimum in the rural western region and 76 percent in the rural south, where the project's target population is located.

3. Household coping strategies, i.e., giving the largest rations to working members in order to ensure that they are strong enough to continue working, may expose the more vulnerable household members such as expectant or nursing mothers and small children to the risk of malnutrition. Children in families living in conditions of food shortage will suffer the greatest gaps in food consumption in relation to requirements. Honduran children 18 to 59 months of age consistently take in 25 percent less food energy than the minimum requirement. Pre-school children in Honduras have the second largest incidence of global undernutrition in Central America: 19.3 percent of children under five years of age were found to have low weight-for-age values in 1996. Growth retardation among children aged 12 to 59 months in rural areas varied between 38.7 and 62 percent. Complementary food is necessary to fill the gap in intake and prevent irreversible damage during foetal life and infancy, while the longer-term, production aspects of food security are also addressed.

4. The physical impact of chronic malnutrition in Honduras was assessed in 1995 through a height census of schoolchildren. This National Height Census of primary schoolchildren (aged six to nine) pointed to the project area as one of the most severely affected. Contrasting with the national figure of 38.5 percent, 62 percent of children in rural Copán and 47 percent in rural Ocotepeque are chronically undernourished. The combined prevalence of height-for-age retardation in the departments of El Paraíso and Choluteca is 53.2 percent. There are no significant gender differences in growth retardation in Honduran children.

5. Growth retardation is often accompanied by nutritional deficiencies, such as iron, iodine and vitamin A. Vitamin A and iodine deficiencies have been addressed effectively through food fortification strategies. Iodine deficiency is currently under control because of universal salt fortification. Fortification of sugar with vitamin A is contributing

significantly to the reduction of vitamin A deficiency. Since children under five do not obtain sufficient vitamin A from fortified sugar, the Ministry of Health distributes megadoses of Vitamin A, to these children every six months. The only micronutrient deficiency left relatively unattended is iron deficiency. Thus, anaemia affects 30.5 percent of expectant mothers, 22 percent of women and 28 percent of children 12 to 59 months of age.

6. Vitamin/mineral supplements are well accepted by fertile-age women. However, prenatal care coverage and the Ministry of Health's capacity to supply the demand for supplements are limited to about 50 percent of needs. Thus, the current iron enrichment of wheat flour and the programme providing iron supplements to expectant mothers and pre-school children have not sufficed to control and prevent this deficiency adequately. Given the negative effects of iron-deficiency anaemia on school performance, resistance to infection, physical endurance, work capacity, maternal mortality rates and growth, more intensive measures have to be launched to address nutritional anaemia. Locally available and traditionally consumed food sources of iron are inadequate in both quantity and quality. The availability of iron from plant food sources is low, and even with high intakes of food from animal sources - which are not available to the poorest - the requirements during pregnancy could not be met without medicinal iron supplements. For these reasons, extending the coverage of prenatal care and iron supplementation is essential to correct this deficiency.

7. The main cause of malnutrition in Honduras is the vicious circle of inadequate food intake and recurrent infections, particularly acute diarrhoea and respiratory infections that begin during weaning. The unsanitary conditions of the physical environment surrounding the majority of the population contribute significantly to morbidity and mortality among vulnerable groups. Anaemia underlies approximately 20 percent of maternal deaths. Honduras has one of the highest maternal mortality rates in Latin America, with over 15 deaths per 10,000 live births. Infant populations living under conditions of chronic malnutrition and in unhygienic environments have high mortality rates. Current estimations of the infant mortality rate (IMR) are either projections of actuarial data from 1987 or indirect estimations from population surveys. Projected figures for 1995 show mortality rates by province, with Copán having an IMR of 64 per 1,000 live births, Ocotepeque 63, El Paraíso 59 and Choluteca 56 . Since in Honduras the IMR is at least 12 percent higher in rural than in urban areas (and over 30 percent higher than in other Latin American countries), the actual IMR for the project area exceeds 60 per 1,000 live births.

8. In the rural areas where the project will be implemented, the existence of a chronic food deficit is compounded by the lack of basic water and sanitation infrastructure. Approximately 75 percent of the families in these areas have no access to safe drinking-water, and 45 percent lack basic sanitation services. Housing shows major deficiencies in the condition of walls, floors and roofs. This contributes to a further vulnerability of the target population. In terms of household food security, it was determined that major factors contributing to food insecurity were not only decline in food production, but also a lack of access roads that would enable farmers to take products to potential markets. This constraint also decreases the access to health services. The Community Councils have identified the lack of sanitation, water and basic infrastructure as the major problems they must face.

9. Three Government policies are crucial in Honduras: a) the Food Security Plan, through which the Government supports programmes to alleviate poverty in the country; b) the ACCESS programme which aims to improve the coverage of health services; and c) the

political decentralization policy which supports the implementation of community development plans .

10. The ACCESS Programme acknowledges the lack of access to health services by the majority of the population, especially in rural areas. The Ministry of Health, with the support of multilateral and bilateral agencies (PAHO, UNICEF, USAID and the Government of Sweden) implements the programme, through which communities are encouraged to identify their health priorities and promote action plans. In June 1996, the process began in 72 percent of the municipalities and reached 66.4 percent of the total population. However, in many of the proposed project areas, the municipalities lack resources and expertise to implement local plans, including nutritional, educational and vulnerable group feeding activities.

11. After years of health services managed with a central approach and top-down decision-making, organizations at the grass-roots level need to be strengthened in order to review and actively participate in the implementation of local plans in coordination with government organizations and other representatives of civil society. Community Councils vary in level - some have experience and wide participation of community members in identifying local priorities and drafting plans, while others need to be strengthened. Special efforts are necessary to support the participation of women in the decision-making positions within the councils.

PREVIOUS WFP ASSISTANCE

12. In the past, assistance to vulnerable groups (expectant and nursing mothers and children under five) was provided through project Honduras 2523.01. From 1991 to 1996, 17,000 tons of food items was directly distributed and 5,000 tons of wheat was monetized to support community and household development as well as productive activities (training and credit) with a specific emphasis on women.

13. The main objective of the project was to increase the frequency of visits of vulnerable groups to primary health and nutrition centres in the poorest communities. This was to be achieved through the distribution of family rations as an incentive for attendance. The project also had resources for nutrition and health training and for encouraging the attendance of pre-school children at day-care centres. Project implementation during the first two years was significantly affected by problems in the execution and coordination capacity of the Ministry of Health, which were later mostly solved. The achievements of the training and credit component were modest; they were made possible through the active involvement of NGOs and local government institutions.

14. Lessons learned from the previous project were incorporated into the present one so that, for example, local authorities and beneficiaries have been directly involved in project design. Specific operational agreements have been reached between the Ministry of Health and WFP which will facilitate project implementation. Initial agreements were also undertaken with NGOs as co-executors.

PROJECT OBJECTIVES AND OUTPUTS

15. The project's **long-term objective** is to contribute to the improvement of the health and nutritional status of poor families in rural areas by enhancing their access to food, health

services, and strengthening community organizations in line with Government policies on food security, access to health services and political decentralization.

16. The **immediate objectives** are to:

a) improve the health conditions and nutritional status of vulnerable groups (children under five, expectant and nursing mothers, and women heads of household) in the project area.

The key indicators for the achievement of objective a) are:

i) a change in the prevalence (percentage) of chronic malnutrition in beneficiary children aged six to 23 months; and

ii) a change in the prevalence (percentage) of anaemia among beneficiary expectant mothers (adjusting for stage of pregnancy).

b) Increase access to sanitation and infrastructure services in selected communities of the project area.

The key indicators for the achievement of objective b) are:

i) number of houses improved (floors, roofs, walls, stoves with chimneys, latrines);

ii) number of community infrastructure and community buildings constructed or improved; and

iii) number of women who have finished training courses on general health practices and waste disposal techniques.

c) Strengthen community organizations to enable them to implement their own development plans.

The key indicators for the achievement of objective c) are:

i) number of community organizations that have prepared and implemented development plans;

ii) percentage of women involved in community organizations and in decision-making positions; and

iii) percentage of health volunteers and social workers participating in Community Councils.

OUTPUTS

17. The project's outputs for objective a) are as follows:

i) universal deworming of children under five within the project area to improve biological utilization of nutrients;

ii) provision of a supplement of ferrous sulphate in syrup form to all children under five to reduce the prevalence of iron deficiency;

iii) reduction by 30 percent in the prevalence of anaemia among expectant mothers and children under two in the project area after three years of universal iron/folic acid supplementation;

iv) reduction by at least 20 percent in the prevalence of weight-for-age deficit among children six to 23 months after three years of project food aid and training in infant feeding;

v) increase by at least 10 percent of mean caloric intake for all beneficiary children at the end of the food aid period (12 months);

vi) training in child growth monitoring and provision of spring scales for at least 450 local health care staff and community volunteers (weight monitors and traditional birth attendants); and

vii) establishment of an operational simplified child growth and anaemia monitoring system.

18. The outputs for objective b) [1] (See Annex III a)) are:

i) approximately 900 stoves improved in 38 municipalities;

ii) approximately 1,300 latrines built and operational in 38 municipalities;

iii) floors, walls and roofs of approximately 600 houses improved in 38 municipalities;

iv) approximately 30 water systems installed or improved in 30 municipalities;

v) approximately 30 community centres (schools, and health, child-care and other centres) built or improved;

vi) approximately 900 kilometres of community roads built and/or rehabilitated; and

vii) 100 percent of the families trained in waste disposal techniques and adequate food preparation.

19. The outputs for objective c) are:

i) 100 percent of Community Councils prepare an analysis of local needs, and work plans;

ii) each Community Council carries out a local development plan; and

iii) more women participate in Community Council Boards.

ROLE AND MODALITIES OF FOOD AID

20. The project will improve the health conditions and nutritional status of vulnerable groups and strengthen community-based organizations to develop their local plans.

Functions

21. Food aid is provided in this project as a nutritional complement to poor rural families with expectant and nursing mothers, women heads of household, and children under five at risk of malnutrition or children who are already underweight. The rations will include micronutrients, both from fortified commodities (corn-soya blend (CSB) and vegetable oil) and iron supplements, and, in the case of women, folic acid.

[1] The outputs for objective b) are only indicative. The Community Councils will finalize them through a consultation process.

22. Food aid will be used as an incentive for mothers to regularly attend rural health centres for pre- and post-natal care, and to have their children's growth and development monitored by trained health care personnel, particularly during the pre-harvest season when food shortages occur. To encourage attendance beyond the direct beneficiaries of the project, iron supplements and anthelminthic treatments will be provided to the totality of the at-risk population, even when not included in the food assistance package.

23. Food aid will be an incentive for infrastructure building and community development, giving families access to increased food intake through participation in community works. Food aid for labour-intensive public works will provide a boost to strengthen grass-roots organizations. Food aid will also be used as an incentive for key health care volunteer participation. Training of volunteers for growth monitoring will be supported with food aid as a means of compensating weight monitors and traditional birth attendants for the time invested.

Food inputs and commodity justification

24. The daily food ration for a vulnerable group beneficiary family of five will be as follows: 500 grams of corn, 375 of beans, 75 of canned fish, 500 of iron-fortified CSB, and 50 of vitamin-A-fortified vegetable oil. This ration, which will meet approximately 50 percent (1,114 kilocalories) of the daily energy requirement for an adult, will be provided for 12 months only.

25. The value of the daily family food ration for participants in food-for-work activities is approximately 80 percent of the national minimum daily wage. Each ration contains 3.25 kilograms of corn, 330 grams of beans, 75 grams of vitamin-A-fortified vegetable oil and 150 grams of canned fish. The ration will be given to an individual family for no longer than five months, during the periods of greatest scarcity.

26. The wet food ration for children attending the day-care centres will support ongoing feeding activities of the "Junta Nacional de Bienestar Social" (National Board for Social Welfare - JNBS) in the four departments where the project will be implemented. Each daily wet ration will provide approximately 98 percent (1,100 kilocalories) of the average daily energy requirements for children one to five years of age and will be composed of 20 grams of canned fish, 15 of vegetable oil, 150 of CSB and 100 of beans. Children will receive this ration 250 days a year. Individual daily wet rations for at-risk expectant mothers confined to maternity homes in Copán and Ocotepeque will contain 250 grams of maize, 15 of fish, 30 of oil, 200 of CSB and 100 of beans, amounting to 2,306 kilocalories (100 percent of energy requirement for an expectant mother with a low level of physical activity).

Food aid modalities

27. **Food distribution to vulnerable groups**. The Ministry of Health will play a key role in this component of the project. Its network will be used at all organizational levels for implementing the project.

28. The identification of beneficiaries, distribution of family rations and monitoring of the nutritional progress of project beneficiaries will be carried out by the Community Council with the participation of a committee formed by women beneficiaries and staff from the rural health centres. If the beneficiaries do not show at least 50 percent of the targeted expected outputs (compliance with supplement schedule and a rising trend in the weight-for-age after one year), the project will be phased out in the respective community. This

mechanism is expected to create a sense of communal responsibility about nutritional problems.

29. Food-for-work activities will give an alternative to free food distribution. The Community Council, in consultation with NGOs and community associations, will decide which works to undertake and on the selection of the poorest beneficiaries. Special attention will be given to identifying projects that benefit women. NGOs will work closely with Community Councils in monitoring the project's progress.

30. The following table shows the indicative breakdown of beneficiaries and rations.

BENEFICIARY BREAKDOWN

Type of beneficiaries	Number of beneficiaries	Number of days a year	Number of rations	Quantity (tons)	Total value (dollars)
Vulnerable group	72 500	360	5 220	7 83	3 37
Food for work	23 500	150	705 000	2 68	829 96
Children (day-care centres)	2 500	250	625 000	178	96 56
Expectant mothers (maternal homes)	3 050	30	91 500	54	19 36
Training	4 500		67 500	257	79 46
Monetization for micronutrient component				2 15	430 80
Total				**13 15**	**4 82**

PROJECT STRATEGY

31. The project's strategy is based on four principles: targeting the most vulnerable groups, a participatory approach and gender perspective, project implementation which strengthens locally-based organizations, and inter-agency cooperation.

32. The Ministry of Health will be the leading executing agency for the vulnerable group feeding component and will liaise with Community Councils and NGOs for the execution of other activities. A Project Management Unit (PMU) will be constituted, under the responsibility of the Ministry of Health, to manage project activities and monitor results. The PMU will be supported by three Project Field Units (PFU) (Copán, El Paraíso and Choluteca). The PFUs will implement project activities in close coordination with NGOs and Community Councils. The PFUs will have technical and logistic expertise and will comprise staff from WHO (ACCESS project) to implement the project in coordination with the existing network of the Ministry of Health, and at the community level with midwives, health volunteers and weight monitors.

33. The Strategic Management Committee - which will start up project implementation - will comprise the Under-Secretary of Populations at Risk of the Ministry of Health and a WFP representative. It will form a Board of Directors, who will invite representatives of stakeholders involved in the project as needed, including the lead government agency on gender issues. In line with Government policies, this Committee will provide advice to the PMU regarding the project's results. It will meet twice a year to review project progress and annual plans.

34. The **Project Management Unit (PMU)** will be composed of a director, a programming officer, a logistics officer, a trainer, two secretaries and one driver.[1] Personnel will receive training on project objectives and approaches (gender perspective and participatory techniques). Community Councils and NGOs will participate in the Strategic Management Committee as appropriate. The PMU will receive advice from WFP and other United Nations agencies such as PAHO, UNFPA and UNICEF.

35. Each Project Field Unit (PFU) will have the following staff: a coordinator, a nurse, a programme logistics officer, a social worker, a secretary and a driver. PAHO staff will follow up project results and monitor nutritional progress. The PFU will catalyze project activities at the field level, coordinating all activities and monitoring results with The Ministry of Health, NGOs and Community Councils.

PROJECT IMPLEMENTATION

36. The project will be implemented in a coordinated manner by the Ministry of Health, the Community Councils and NGOs.

37. The network of the Ministry of Health, which includes regional, local and community personnel in the project area, will provide preventive health care to project beneficiaries, monitor the nutritional impact of the project and coordinate with the PFUs regarding efforts, initiatives and results. Each community will have a weight and nutritional monitor. The volunteers will be trained in health and nutrition issues (including gender), and community development issues. The network of the Ministry of Health at the community level will provide information regarding the beneficiaries' progress to the Community Council (CODEMs), which will be in charge of food distribution.

38. CODEMs will select the target population, in coordination with health personnel, and monitor project results. They will manage food distribution and collect money to pay for transport to the villages. An ad hoc committee composed mainly of women will distribute the food.

39. The food-for-development activities will be managed by CODEMs in coordination with NGOs. CODEMs will receive all the local development plans and decide which initiatives should be funded by the project. Special consideration will be given to activities identified by women or which benefit them.

40. The NGOs identified will play a key role in the food- or-development scheme. In coordination with CODEMs they will: a) select food-for-work beneficiaries; b) follow up the preparation of community plans; c) identify community works to be undertaken; d) monitor food distribution and project progress according to plans; e) support training activities; f) prepare progress reports; g) participate in the Board of Directors; and h) coordinate with other implementing agencies. Save the Children, World Vision, Christian Commission for Development (CCD) and the Development Association of Ocotepeque have been identified as project co-executors.

41. The criteria for the selection of NGOs are as follows:

[1] The Ministry of Health will provide the resources to pay salaries to PMU and PFU staff, with the exception of the programme officers, who will be United Nations Volunteers, and three PAHO staff.

a) work in project area;

b) possess technical assessment capacity as well as targeting methods to reach the poorest;

c) have obtained non-food contributions required for activities from other donors to cover their overhead costs;

d) have food management capacity, and understanding and acceptance of WFP's aid modality;

e) are familiar with gender perspective and participatory approaches;

f) possess technical and social monitoring and on-site supervision capacity; and

g) have outlined objectives and plans that are in line with the project's objectives.

42. The food-for-development activities will be planned in each PFU with the participation of NGOs and Community Councils. Food commodities will be managed by women's groups. The project will mobilize local resources and the Councils will identify new opportunities for development; a portion of the funds can be re-allocated for emergency rehabilitation. Adherence to WFP's commitments to women will be part of Letters of Understanding/contracts with NGOs and with implementing government agencies.

Food logistics

43. WFP commodities will be received in Puerto Cortes, located on the Atlantic Coast, and stored in the Central Warehouse JNBS in San Pedro Sula. At regular intervals, JNBS or private entrepreneurs will transport the commodities by truck from the central warehouse to the intermediate warehouses in Santa Rosa de Copán, Choluteca and Zamorano, and from there onwards to the municipalities. These expenses will be borne by the Ministry of Public Health. Community Councils will be responsible for organizing and, if necessary, financing the transport of food from the municipalities to the final distribution points in their villages.

Generated funds

44. The micronutrient component of this project will be funded by the Canadian Women's Health and Micronutrient Facility. Under this scheme, it is foreseen to monetize 2,154 tons of wheat to cover costs related to the provision of micronutrients, including monitoring and evaluation and training (see Annex III b)). Wheat will be provided by Canada and sold at c.i.f. price or above, under the supervision of the Ministry of Finance and Public Credit, to the highest bidder for delivery at the port of arrival. Past monetization experience has shown that the rate of return is over 100 percent in Honduras. The modalities for the establishment and management of the funds thus generated will be detailed in the plan of operations.

Phasing out

45. During the first year the PMU will conduct preparatory activities using a participatory planning process. The local Committees will be formed, the personnel trained and agreements with the implementing partners stipulated. Since the setting up of the project is critical to its success, technical support will be needed during this phase. The project will come into full implementation in its second, third, fourth and fifth years. Closer cooperation between the health sector, NGOs and Community Councils is expected to be achieved by the end of the project. Moreover, the infrastructure, organizational capacity

and human capital generated with support from food assistance will constitute the project's social sustainability and will contribute to the improvement of the communities' potential for food security. At the end of the project's duration, it is expected that the Community Councils will be able to continue to implement their development plans with their own resources and with support from the Government without need for WFP aid.

BENEFICIARIES AND BENEFITS

46. During the five years of its duration, the project will directly benefit a total of 19,200 families (14,500 vulnerable groups and 4,700 food for work), 2,500 children attending JNBS day-care centres and 3,050 at-risk expectant mothers confined to maternity homes living within the project area, which comprises 465 rural villages and 38 municipalities.[1] A complete breakdown is given in Annex II.

47. Through training activities in food and nutrition, food management, and other relevant topics, the project will improve the technical capacity of the Ministry of Health and municipal corporation members/personnel directly involved with project activities (4,500 persons).

48. The criteria for the selection of vulnerable group beneficiaries will be as follows:

a) residents of the villages within the project's area of influence;

b) previous or concurrent enrolment in an integrated child care programme or pre-natal/post-natal care programme at the nearest Ministry of Health clinic (continued participation in these programmes is a requisite for maintaining the status of beneficiary);

c) justified, written approval from the candidate's village beneficiary selection and monitoring committee (i.e., on the grounds of extreme poverty);

d) women who are pregnant or currently breast-feeding a child (under 18 months of age);

e) children six to 12 months of age, regardless of their nutritional status (prevention of damage); and

f) underweight children 13 to 59 months of age (weight-for-age <-2 standard deviations - NCHS/WHO reference).

49. The criteria for the selection of food-for-work beneficiaries will be as follows:

a) residents of villages within the project's area of influence; and

b) the most vulnerable household members recommended by the Community Councils (including members of households headed by poor women).

[1] The criteria for the selection of municipalities are in line with the Country Strategy Outline for Honduras, presented to the Executive Board at its Annual Session of 1997.

ANTICIPATED EFFECTS OF THE PROJECT ON WOMEN

50. The gender perspective is present not only in the criteria for selecting beneficiaries, but also in monitoring how women will benefit from project results. Gender analyses will permit to verify whether women's access to and control over the resources has improved, and whether they have obtained decision-making positions in community organizations.

51. The main effects of the project on women will be:

a) the nutritional status of women and girls (approximately 70 percent of the vulnerable group beneficiaries) will be improved;

b) food-for-development activities will give priority to projects that benefit women;

c) more women will participate in community organizations;

d) more women will hold decision-making positions in Community Councils;

e) the nutritional problems of children will be perceived more as a community issue and not as an isolated one to be addressed by mothers;

f) women at the household level will have increased control over the food resources;

g) women will coordinate with NGOs, the Ministry of Health's network and Community Councils; and

h) household members will be more sensitive to gender gaps in food management and distribution within households.

52. The project's mechanisms to ensure benefits to women will be: a) women will participate, through committees at the community and municipal level, in the distribution of food, monitoring of project results and assessment of projects that will be carried out under a food-for-development-scheme. The committees will be represented on the Community Councils; it is expected that by the end of the project there will be 50 percent participation of women in the councils. b) A simple monitoring tool will be distributed to the PFUs to monitor food distribution among household members, access to food and control over resources. c) The training packages (on health and nutrition, project implementation and community building) delivered by UNFPA, UNICEF, PAHO and WFP will include gender as a cross-cutting issue. d) The PMU will receive advice from the main Women's Office on how to meet the Commitments to Women outlined at the Beijing Conference in 1995. e) The terms of reference of project personnel will include gender sensitivity, especially for PMU staff. f) The project will organize a gender workshop every year, with the participation of NGOs, Municipal Councils and the health sector to assess how gender issues are being included in project implementation. g) Data collection and indicators will be disaggregated by gender. The indicators to measure women's control over food resources will include the assessment of food controlled by women (for sale, household consumption, exchange and food donation) and the products consumed daily by family members.

PROJECT SUPPORT

53. Technical cooperation from PAHO/Instituto de Nutrición de Centro América y Panamá (INCAP) for the design and implementation of baseline surveys and monitoring systems will be provided in the form of consultants. PAHO/Honduras will finance one permanent

technical advisor per PFU. UNFPA will support the project's training activities with experienced personnel to conduct training of trainers. UNICEF/Honduras will support the reproduction of training materials.

54. Iron and iron-folate supplements as well as equipment for monitoring anaemia and weight will be supplied by CIDA. The communities themselves will contribute to the project by covering the costs of moving the food commodities and supplements from municipal warehouses to their final destination.

55. NGOs (Save the Children, CCD, World Vision , PRAF and ADEVAS) will implement the food-for-development scheme. They will provide their expertise, which includes: a) identification of local projects; b) decision-making process; c) follow-up of food distribution for project implementation; d) reporting; and e) coordination. PRAF and ADEVAS will cover implementation costs which include personnel and overhead.

Training

56. The training portfolio is considered a key to the project's success because of the need to foster awareness in community leaders, and in health and project personnel on issues related to project implementation, such as objectives, responsibilities in monitoring, etc. The training modules cover a range of 15 themes on health and nutrition, from monitoring children's weight to reproductive health. Another eight training modules will cover aspects related to community development and community infrastructure.

57. The project will train health volunteers and community leaders, project staff and selected beneficiaries. Training packages will be delivered by UNFPA, PAHO INCAP and UNICEF in coordination with NGOs and project staff. Approximately 4,500 people will be trained during the five years of the project. A family food ration will be distributed to health volunteers assisting in training activities.

Non-food items

58. The lack of non-food items can become an obstacle for the effective delivery of WFP assistance, especially as regards the food-for-development scheme. Therefore, to maximize the effect of WFP assistance, a certain amount of non-food support must accompany WFP food aid. Since, except for the micronutrient component to be financed by Canada, monetization is not being applied in this project, additional resources are needed to implement it. WFP will request donors to procure the items needed for project implementation. Resources from an earlier project will be used to cover some of these costs.

Monitoring and evaluation (M&E)

59. A baseline survey to assess the proportion of underweight children, the prevalence of anaemia among expectant mothers, and dietary patterns of households, focusing on feeding practices of pre-school children, will be carried out with technical assistance from PAHO/INCAP. The basic study design will be used for follow-up evaluations at the end of the second and fifth years of the project.

60. Monitoring of weight trends, food consumption, and iron supplement consumption by children and beneficiary women will be performed by community weight monitors (volunteer adult female villagers trained and supervised by the public health clinic auxiliary nurse and health promoters) using simplified (pictorial) formats.

61. The project will have a M&E system for the management of food and iron supplement inputs. The indicators proposed for this project (prevalence of anaemia, food energy intake by families and pre-school children, prevalence of low weight-for-age among children under two) are comparable with those used by USAID/CARE and in line with the Government's nutritional goals.

62. The M&E reporting system will be based on the existing but strengthened network of health care facilities and community volunteer health staff. Child weight and supplement consumption monitors (CWMs) will liaise with the community food and nutrition committees and the local health centre personnel, providing monthly reports on the weight and health conditions of all children in their respective communities. CWMs pass on notification of new beneficiaries and benefit suspensions from the village committee to the health personnel (and through the latter to the municipal committee).

63. NGOs will monitor food-for-work schemes according to food norms already established by Community Councils and the Project Management Unit. A number of rations will be established for each communal work, according to local parameters.

PROJECT FEASIBILITY AND SUSTAINABILITY

Technical viability

64. The proposed food assistance scheme is highly viable, as it relies on health care and local community networks. The implementation of the project's health and nutrition activities is part of duties already performed by the local health staff, such as deworming, prescription of iron supplements, and health and nutrition education. It is envisaged that at the end of the project the Ministry of Health personnel, especially at the community level, will monitor the population's nutritional progress and will identify nutritional risks, especially among children under five and expectant mothers. The Ministry will entrust its regional offices with maintaining equipment during the project's lifetime.

65. Food supplementation for children and adults living in food-deficit environments should produce positive social effects which should in turn enhance the communities' potential for livelihood security. Feeding people during critical times of their lives contributes to better health and nutrition. The social benefits derived from food assistance and micronutrient supplementation are trans-generational and the positive economic consequences of training human capital place the family in a better position to deal with the food insecurity problem in the project area.

66. Food-for-work activities will support the development of community infrastructure and strengthen Community Councils. The outputs will be set according to community priorities and efforts will be made to be cost-effective. The project will provide some of the inputs required and the Community Councils will supply local resources. At the end of the project the Councils will guarantee the maintenance of the community works and seek to mobilize resources to fund new initiatives.

Social and political viability

67. The social viability of the project is supported by a national process of political decentralization which is based on strengthening local organizations. Although the results of local management have been variable to date, the process has started, and involves

stakeholders of civil society responding to their basic needs more appropriately. This process will continue and is supported by bilateral and multilateral agencies involved in local community development. In addition, this project will support the ACCESS programme of the Ministry of Health through which the communities will manage their own health plans.

68. Even though a new government will be elected in early 1998, all parties have expressed a common objective of supporting activities and plans which will reduce food insecurity, improve the access of health services, especially in rural areas, and strengthen political decentralization.

RISKS

69. The project needs full-time staff and all the agreed resources to implement activities. Since programming and coordination are vital for project management, WFP will fund a coordinator for nine months to ensure that the project's strategy is implemented on sound technical grounds. If all the agreed resources are not secured, the project will start operations in a reduced target area.

70. NGOs have expressed some concern about the creation of dependency in the food-for-work scheme, since rural families who have received "compensation" for their work through food aid may not be so willing to voluntarily participate in extensive community works without this incentive. It is suggested that the best way of carrying out this scheme be studied in depth so as to avoid the possible side effects of food-for-work activities.

DISINCENTIVES, DISPLACEMENT AND DEPENDENCY

71. Distortions of national production and policies resulting from the distribution of food aid are not expected: in 1996 national production amounted to approximately 530,000 tons of maize and 54,000 of beans. WFP will provide an average of 1,028 tons of maize a year (0.19 percent of national production) and 456 of beans (0.84 percent of national production). Honduras does not produce wheat.

72. Food aid donations will be used as an incentive for people's participation in food-for-development activities. These will be carried out during periods of food scarcity, which usually extend from January to August, with a peak from May to August. A beneficiary may receive only a maximum of 150 rations a year, in order to avoid dependency on food aid and competition with farm and off-farm work.

73. Food aid will be utilized to supplement for 360 days a year the diet of expectant and nursing mothers and their children under five who are at risk of malnutrition. Influences on the local market economy are not expected; the fact that the target group is undernourished suggests that the alternative to receiving food aid is not the purchase of commodities in the local market but inadequate access to food due to a lack of resources.

PROJECT COSTS

74. The cost breakdown for the project is as follows:

PROJECT COST BREAKDOWN

	Quantity *(tons)*	Average cost per ton	Value *(dollars)*
WFP COSTS			
A. Direct operational costs			
Commodity[1]			
– Maize	5 144	185	951 640
– Vegetable oil	331	900	297 900
– Pulses	2 284	450	1 027 800
– CSB	2 722	320	871 040
– Canned fish	521	2 400	1 250 400
– Wheat (See Annex III b))	2 154	200	430 800
Total commodities	**13 156**		**4 829 580**
External transport			
Ocean	13 156	133	1 749 748
Superintendence	13 156	2.50	32 890
LTSH			
a) Landside transport	-		-
a) ITSH	-		-
Subtotal direct operational costs			**6 612 218**
B. Direc support costs (See Annex I)			**1 193 255**
Total direct costs			**7 805 473**
C. Indirect support costs (13.9 percent of total direct costs)			**1 084 961**
TOTAL WFP COSTS			**8 890 434**
GOVERNMENT COSTS			
- Handling, storage and transport of commodities			730
- Staff costs			364 000
- Project			560 000
- Ministry of Health			
- Vehicle costs			59 000
- Maintenance			59 000
- Fuel			59 000
- Monitoring			
- Travel and DSA for project staff			338 000
- Travel and DSA for Ministry staff			435 000
- Office expenses			155 000
- Miscellaneous			50 000
TOTAL GOVERNMENT COSTS			**2 750 000**
TOTAL PROJECT COSTS (WFP and others)			**11 640 434**

PROJECT COST BREAKDOWN

	Quantity *(tons)*	Average cost per ton	Value *(dollars)*
WFP costs as a percentage of total project costs: 79.1 percent			

[1] This is a notional food basket used for budgeting and approval purposes. The precise mix and actual quantities of commodities to be supplied to the project, as in all WFP-assisted projects, may vary over time depending on the availability of commodities to WFP and domestically within the recipient country.

COORDINATION AND CONSULTATION

75. The project was prepared in close coordination with PAHO, UNFPA, UNICEF and FAO. Staff from the Ministry of Health at the central and local level were directly involved in the appraisal phases and developed the operational agreements which the Ministry has undertaken with WFP for the project's implementation. NGOs in the project area were also consulted and their mode of participation was agreed during the appraisal mission. Local governments and community-based organizations were consulted for their views and priorities, and also to define their implementation roles. Comments from the relevant United Nations technical agencies have been sought. CSD clearance will be requested.

RECOMMENDATION OF THE EXECUTIVE DIRECTOR

76. The project is recommended for approval by the Executive Board.

ANNEX I

DIRECT SUPPORT REQUIREMENTS (dollars)

Staff costs	
International	72 000
UN Volunteers (3)	360 000
DSA/UNVs	43 200
Subtotal	**475 200**
Technical support services	
Project preparation	29 650
Project appraisal (project monitoring) - baseline study	100 000
Project evaluation (Consultancy)	20 000
Subtotal	**149 650**
Equipment	
Communication	
Vehicles	75 000
Motorcycles	6 000
Computer equipment	19 000
Other equipment (medical and monitoring)	93 877
Subtotal	**193 877**
Non-food items	
Storage facilities	22 466
Other (tools or construction materials)	252 062
Subtotal	**274 528**
Other:	
Training	100 000
TOTAL	**1 193 255**

ANNEX II

DEPARTMENTS, MUNICIPALITIES AND TARGET POPULATION

	Departments and Municipalities	Total population 1977	Population 1997 0 to 4 years	Women 15-45 years	Children 0-4 yrs + women 15-45 years	Percentage of poverty	Target Families(*)	Target Population
	Choluteca	**208 2**	**32 82**	**35 5**	**68 399**		**9 2**	**46 2**
1	Apacilagua	10 9	1 72	1 8	3 587	55.54	484	2 4
2	Concepción de María	29 3	4 63	5 0	9 650	61.25	1 3	6 9
3	Duyure	3 3	521	565	1 086	48.90	135	675
4	El Corpus	26 1	4 12	4 4	8 600	54.80	1 1	5 7
5	El Triunfo	35 0	5 52	5 9	11 519	65.28	1 7	8 6
6	Marcovia	36 5	5 75	6 2	12 000	60.88	1 7	8 6
7	Morolica	5 3	845	916	1 761	53.02	230	1 1
8	Orocuina	18 7	2 95	3 2	6 162	45.15	728	3 6
9	Pespire	27 8	4 38	4 7	9 141	40.52	1 0	5 0
10	San Antonio de Flores	6 2	978	1 0	2 038	59.20	287	1 4
11	San Isidro	4 3	686	743	1 429	54.36	190	950
12	San José	4 3	684	741	1 425	57.74	197	985
	Copán	**107 2**	**17 17**	**17 8**	**35 064**		**4 5**	**22 6**
1	Cabañas	9 5	1 53	1 6	3 137	51.83	405	2 0
2	Concepción	5 1	826	860	1 686	60.39	241	1 2
3	Copan Ruinas	29 3	4 70	4 8	9 596	53.85	1 2	6 3
4	San Agustín	4 2	684	712	1 396	51.24	179	895
5	San Antonio	11 3	1 81	1 8	3 713	48.61	460	2 3
6	San Jerónimo	5 2	836	871	1 707	43.99	199	995
7	San Juan de Opoa	8 7	1 40	1 4	2 870	52.89	376	1 8
8	San Nicolas	6 7	1 07	1 1	2 198	47.30	268	1 3
9	Santa Rita	23 9	3 84	3 9	7 838	52.16	1 0	5 0
10	Veracruz	2 8	452	471	923	48.91	115	575
	El Paraiso	**89 6**	**14 27**	**15 5**	**29 811**		**4 1**	**20 6**
1	Alauca	8 0	1 27	1 3	2 664	58.90	372	1 8
2	Liure	11 2	1 78	1 9	3 734	62.32	542	2 7
3	Oropoli	6 0	960	1 0	2 005	44.02	232	1 1
4	San Antonio Flores	6 0	956	1 0	1 996	49.47	249	1 2
5	San Lucas	8 2	1 32	1 4	2 757	47.51	335	1 6
6	Soledad	11 6	1 86	2 0	3 887	54.84	678	3 3
7	Teupasenti	24 7	3 93	4 2	8 227	52.16	1 0	5 3
8	Texiguat	9 7	1 55	1 6	3 244	60.28	461	2 3
9	Vado Ancho	3 9	621	676	1 297	68.79	202	1 0
	Ocotepeque	**32 9**	**5 40**	**5 5**	**10 959**		**1 2**	**6 4**
1	Belen Gualcho	11 0	1 81	1 8	3 669	44.86	429	2 1
2	Concepción	3 6	601	618	1 219	38.38	130	650
3	Dolores Merendón	2 0	344	353	697	56.59	96	480
4	Fraternidad	1 8	298	306	604	49.55	76	380
5	Mercedes	5 7	948	974	1 922	42.19	217	1 0
6	San Jorge	3 4	567	582	1 149	48.74	142	710
7	Sinuapa	5 1	838	861	1 699	41.99	191	955
38	**Total**	**438 0**	**69 68**	**74 5**	**144 233**		**19 2**	**96 0**

Note: UBN: unsatisfied basic needs.

(*) Data provided by MOH.

ANNEX III a)

FOOD FOR WORK COMPONENT WORK NORMS

Activity	Unit	Norm (Work days)	Target	Nº of Rations
Construction of stoves	No.	5	900	4 500
Construction of latrines	No.	15	1 300	19 500
Improvement rural houses	No.	100	600	60 000
Establishment of water distribution system	No.	900	20	18 000
Improvement of water distribution system	No.	300	10	3 000
Construction of community centres	No.	900	10	9 000
Improvement of community centres	No.	300	20	6 000
Opening and improvement of secondary roads	Km.	650	900	585 000
Total				**705 000**

ANNEX III b)

Cost to be covered by the Women's Health and Micronutrient Facility with the Monetization of Wheat (*)

	Quantity	Unit cost	Cost
		(dollars)	
Ferro sulphate syrup 8oz/bt	67 3	2	134 781
2. Abendazole 400 mg. tab	718 8	0.05	35 942
3. Ferro sulphate tablets	34 6	0.00015	5 194
4. Hemocue haemoglobin meter	120	500	60 000
5. Hemocue disposable cubets	62 0	2	124 000
6. Water quality test kit	4	1 325	5 300
7. First aid kit	20	24.35	487
8. Salter scale	600	33	19 800
9. Midwives' kit	600	42.68	25 608
10. Spare equipment to replace broken/worn-out items	2 4	20	48 000
11. Baseline study			30 000
12. M&E and follow-up			50 000
5. Training			20 000
Sutotal: cost to be covered by monetization			**559 112**

(*) Wheat to be provided by Canada.

ANNEX IV

LOGICAL MATRIX

Specific goals	Problems	Outputs	Indicators	Activities	Means of verification	Assumptions
• Improve nutritional status of children under 5, expectant and nursing mothers, and women heads of household in project areas	• Inadequate biological use of nutrients resulting from a high incidence of infectious diseases in vulnerable groups	• Vulnerable groups treated against intestinal parasites and with periodical supplements of micronutrients to improve the biological use of ingested foods	• 90% of expectant and nursing mothers and adolescent women receive iron/folic acid supplements (according to the Ministry of Public Health norms) • As of 1999 (2nd year of the project), 80% of pre-school children will take antiparasite medicines at quarterly intervals and periodically receive iron supplement	• Procure Albendazol and iron and folic acid supplements according to need. Prepare a logistics plan for distributing supplements and antiparasites. • Provide supplements to the vulnerable population during delivery of the basic package combined with an education plan • Provide antiparasites, according to norms, to 1-4 year-old children • To ensure that the vulnerable population take the supplements according to the norms	• Integrated child care monthly report of health clinic activities • Inventory of medicines of health clinics • PFU supervisory reports • Survey data for intermediate and final evaluations • Midwives' Information/Sheets	
	• Inadequate qualitative and quantitative food consumption: mainly in vulnerable groups.	• Families to have healthy food consumption habits	• The project's target families diversify their intake pattern, especially during the period of weaning	• Identify consumption patterns in the project's intervention area • Prepare a nutrition and food education plan adequate for each project region with an emphasis on maternal and child feeding • Establish a progressive food-and nutrition education plan for the operations of the Ministry of Public Health • Verify modifications to feeding habits of vulnerable groups	• Qualitative survey data by ethnic and agro-ecological regions • Food and nutrition education plan document • Food guide for operation level staff • Technical consultant reports on design and validity of education plan and food guidelines • Six-monthly progress reports on the PMU • Project plan and programme activities • Survey data for intermediate and final evaluations (24-hour recall)	
	• High prevalence of chronic malnutrition among women of fertile age and children under 5. Prevalence of anaemia in women of fertile age	• Decrease in prevalence in chronic malnutrition in children under 5 years of age • Decrease in anaemia prevalence in women of fertile age	• Prevalence of undernourishment in children 6-23 months old has diminished by 20% in the project area • The anaemia prevalence in women of fertile age and children under 2 has decreased by 30% during the project period • The caloric intake of children under 2 to increase by at least 10% through project food aid	• Carry out baseline, intermediate and final surveys to estimate the prevalence of anaemia and protein-energy malnutrition • Prepare and execute the food logistics plan • Control the delivery of food aid and its use 1.CODEM (UNICAMs), unions/Community Councils 2.Beneficiaries (health)	• Survey data for intermediate and final evaluations (children under 2 and expectant mothers, 24-hour recall in sub-samples) • Beneficiaries´ haemoglobin monitoring reports (and control) generated by 11 Public Health Units (PHUs) • Turnover reports on supplements for children and beneficiary mothers	• Household's usual food contribution is guaranteed • Prevention of infections by immunization is effective

LOGICAL MATRIX

Specific goals	Problems	Outputs	Indicators	Activities	Means of verification	Assumptions
		• Food intake of children under 2 becomes adequate		• Check the weight-for-age of beneficiary children (once a month) • Teach mothers about the benefits of iron supplements and other food aid norms and requirements	• Midwives' information sheet (or other community staff) • UPS/CODEMs Food Distribution Control Sheets (Community Food Administration Unit)	• Community methods of environmental sanitation and hygiene effectively prevent epidemic outbreaks
	• Limited access to health services for growth control and prenatal care	• The institutional capacity and the competence of staff in the services network to monitor child growth was reinforced	• At the end of the second year, 90% of staff will carry out adequate care practices on nutrition and mother-child health • A working growth and anaemia monitoring system	• Identify requirements regarding material, equipment and training for growth monitoring at the PHCC level, and towns in the project area. • Buy and provide materials and the equipment for PHCC and volunteers at the villages, according to the needs identified • Train and reinforce PHCC staff and community weight monitors on growth assessment techniques • Train institutional and community staff in detecting, treating and referring of specific nutritional deficiencies (Vitamin A, iodine, anaemia, PEM)	• Study protocol and health care personnel diagnostic report on knowledge, attitudes and practices (KAPs) on anaemia, obstetric-perinatal risks, anthropometry, growth monitoring, treatments of diarrhea. • Inventory of equipment (scales, stadiometers, haemoglobin meters, "Hemo Cue") • Practical guidelines for reinforcing topics in PHUs and community weight control units • Technical report by consultants for designing/implementing growth monitoring programmes (and other outstanding MC and health topics) • PFU and MOH supervisory reports • KAPs intermediate and final evaluation on subjects treated in each region	
				• Reinforce and promote the application of integrated child care norms in the project area • Supervise the care provided to the users of health care services according to the norms	• Public Health at Community Centres (PHCC) diagnosis on KAPs of midwives and weight monitors on growth control, child weight measurement, filling out of inter-related forms and registries with PHCC personnel • Midwives' and monitors' monthly reports • Nutritional reports of PHCC auxiliary nurses	

LOGICAL MATRIX

Specific goals	Problems	Outputs	Indicators	Activities	Means of verification	Assumptions
					• Programme and training guidelines/consolidation of working personnel in detecting obstetrical and nutritional risks/damage • Midwives' and weight monitors' information sheet	
		• Increased number of prenatal controls of expectant mothers and child growth development check-ups	• The deficit in coverage and concentration of prenatal control and growth and development monitoring was reduced by 50%	• Upgrade the current information system between midwives and PHCCs • Midwife training for detecting obstetrical risks (malpresentation, bleeding, multiple foetuses, etc.)	• Design monitoring and evaluation systems (PAHO/INCAP consultant document) • Periodical reports from auxiliary nurses on PHCC care • Training guidelines on risk detection by midwives • Simplified and validated forms for gathering information by community staff	• PAHO extends its support to these initiatives at the project intervention area
• Improve sanitary conditions and infrastructure of the target communities influencing health conditions	• Inadequate hygiene practices regarding food preparation and housekeeping	• The families use adequate, healthy methods for preparing foods and housekeeping	• 100% of the target families have been trained and at least 50% of them have improved their techniques	• Train community health personnel on hygienic food preparation, housekeeping and waste disposal	• List of participants who have completed the training. • Rapid rural appraisals of hygienic practices	
	• Inadequate waste disposal conditions	• Adequate mechanisms for waste disposal are in place	• 100% of the target families have been trained and at least 50% have improved their waste disposal system	• Repeat training in hygienic food preparation, housekeeping and waste disposal at the community level • Monitor trainers (of NGOs, etc.)	•	
	• Harmful smoke exposure in houses, with respiratory problems and influences on the weight of newborns	• Improved stoves with chimneys are in use	• A minimum of 900 stoves have been improved	• Identify basic and infrastructure works and water systems to be improved through participatory techniques	• Lists of inputs used • Municipalities' records	• Agreements have been signed with the NGOs to rehabilitate/improve water-supply systems and infrastructure
	• Inadequate conditions for disposal of excreta	• Latrines are constructed and are being used	• The project's target families have built at least 1,300 latrines	• Design, together with grass-roots organizations and NGOs, a plan for carrying out the basic services and infrastructure works	• NGOs' periodic reports	
	• Scarce basic services and infrastructure	• The communities have more and/or better infrastructure	• At least 900 km. of community roads have been built and/or rehabilitated.	• Carry out the works according to established plans	• Field Units' reports • Field trip check lists	

LOGICAL MATRIX

Specific goals	Problems	Outputs	Indicators	Activities	Means of verification	Assumptions
			• The communities have built and/or improved at least 30 community centres (schools, health centres, child-care centres, etc.)	• Train the community in monitoring the works and food handling • Organize groups for food distribution according to the work performed		
	• Inadequate house conditions (walls, floor, ceiling), with an incidence of disease	• Walls, floors and/or roofs are being improved with local/basic resources	• Floors, roofs and/or walls of at least 600 houses have been improved	• Train the community to maintain the works	• Quarterly reports with breakdown of expenses	
	• Inadequate access to drinking-water	• The families and/or communities are supplied with water suitable for human consumption	• At least 30 water systems have been installed/improved	• Monitor NGOs' and grass-roots organizations' progress in achieving outputs	• Reports on the use of non-food items	
• Strengthen community organizations in order to manage and execute development plans	• Heterogeneity in the communities' different levels of organization	• Negotiating capacity of community organizations has been reinforced	• Number of community organizations that have prepared participatory diagnosis and work plans • Number of initiatives formulated and carried out by community organizations supported by the project	• Training for formulation, monitoring and evaluation of the project with community leaders applying participatory techniques • Training in administration of project's food aid resources • Formulate community development plans • Organize working groups • Execute community works • NGOs and the project design an M&E system	• Community development plans and work plans • Minutes of meetings of village governing bodies and unions • Quantity and quality of suggestions made by CODEMs to the project • Minutes of meeting of CODEMs	• Mayors promote the constitution and dynamics of CODEMs • NGOs promote the strengthening of community organizations
	• Limited management capacity			• Train CODEM unions and other organizations in community organization, management and gender issues		
	• Vertical and authoritarian practices in the organization	• Periodic renewal of the governing bodies in communities/local governments	• Governing bodies are renewed at 2-year intervals	• Inform communities about political commitment and democratic elections • Hold assemblies and town meetings • Hold community elections	• Electoral lists and constitution of governing bodies	
	• Insufficient coordination and communication	• Multi-community action programmes	• Plans are organized and carried out in a multi-communal way	• Formulate community development plans (CODEM) • Coordinate and interrelate works to be executed	• Documents reflecting planning process • Notes for the record/documents on completion of works	
	• Limited qualified human resources to respond to the basic needs of the community	• Number of health volunteers, social workers and community leaders has been increased	• Promoters, volunteers and leaders are working on their tasks	• Provide specialized training according to the working area (re-train community volunteers in health, nutrition and environmental sanitation) • Set up respective offices and work teams • Design a simple reporting format for each area of work in the community	• Reports from auxiliary nurses and NGOs on community participation	
	• A low participation of	• The participation of	• Percentage of women and	• Involve teachers to promote specific	• Minutes from the village	

LOGICAL MATRIX

Specific goals	Problems	Outputs	Indicators	Activities	Means of verification	Assumptions
	women and adolescents	women and adolescents in community organizations has increased to at least 50%	adolescents involved in community organizations • Percentage of women involved in governing bodies of community organizations	activities for students groups • Organize adolescents in public service groups • Train women's and adolescents' groups in organization and leadership	organizations, unions and CODEMs showing participation of women and adolescents	