

PDAAN 781

520-0251

ASSESSMENT OF THE TRAINING
PROGRAM OF THE PRIMARY HEALTH
CARE COMPONENT OF THE COMMUNITY-BASED
HEALTH AND NUTRITION SYSTEMS
PROJECT OF GUATEMALA

A Report Prepared By:
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During The Period:
JULY 25 - AUGUST 10, 1983

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:
Ltr. AID/DS/HEA: 10-19-83
Assgn. No. 583151

CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY: FINDINGS AND RECOMMENDATIONS	i
Project Background	
Training Project and Projections	
Overall Program Implementation	
Technical Aspects of Training	
I. INTRODUCTION AND BACKGROUND	1
Project Goals and Objectives	1
The Scope of Work	1
Itinerary and Methodologies Employed	2
Intended Audiences for the Consultant Report	3
II. OBSERVATIONS AND FINDINGS ON TRAINING PROGRESS	5
Background	5
Progress in Achieving Targeted Training Output	7
Progress and Status of the Training Component	15
III. TRAINING QUALITY AND EFFECTIVENESS	21
Methods of Assessment	21
Trainers and Training Methods	21
APPENDICES	
List of Persons Contacted	
Consultant Itinerary	
Project Inputs: Training and T.A.	
Process of Materials Development	
Vignettes: Discussions with Trained Community-Based Personnel	

EXECUTIVE SUMMARY

During the period of July 25-August 10, 1983, the consultant writer, Petra S. Reyes, participated with Environmental Engineer Dr. Henry Van in a progress evaluation of two components of the Community-Based Health and Nutrition Systems Project of Guatemala.

This report is an assessment of the training aspects of the primary health care component of the project. During a 14-day work period, the consultant devoted 6 days to field observation of ongoing training sessions, and interviews with training team members, trainees, and community-based workers already trained. At the central level of project implementation, assessment methods included review and discussion of a wide range of educational materials and training guides and individual and group discussion with Ministry of Health and project personnel and with USAID/G staff.

The major findings and recommendations summarized here have been discussed with MOH senior staff and/or with appropriate Mission personnel. Findings and recommendations address questions posed in the scope of work, pertinent implementation issues not included in the scope of work, and offer observations about the future programming and management requirements for improved project implementation.

As a point of reference, it should be noted that the individual pertinent findings reviewed here do not necessarily have a corresponding recommendation. Recommendations are made on the basis of several related findings.

Project Background

Findings

To insure continuity and integration the project designer located the program within the existing MOH structure, with the objective of strengthening the OCOH technical capacity at decentralized levels to implement the project.

The project design has a major flaw, which has affected all aspects of program implementation. An assumption was made (p. 12 of the project paper) that management development assistance to the central MOH organization, supported by the PAHO and CDC, would complement regional management development under the project and serve to strengthen central level capability to run the program. This assumption is missing from the LOGFRAME.

Unlike the USAID-funded management development projects, this program has been implemented without the assistance of resident foreign technical advisers. Accomplishments to date have been due to local expertise.

Delay in program implementation has been due to factors within the larger GOG structure and to the institutional weaknesses within the MOH's changeable organizational and administrative structure, as identified in the institutional analysis of the project paper. The MOH is currently responding very positively to the identified organizational and administrative problems that have impeded project implementation.

Recommendations

USAID should assist the MOH by providing an intermediate term (4-6 months) technical adviser with expertise in management systems analysis and practical systems development. This person should work in tandem with the new project administrator.

One objective of the technical adviser should be the development of a functional, practical implementation plan corresponding to the remaining project time frame.

Training Progress and Projections

Findings

In spite of the delay in project implementation, training output at mid-project is adequate and will exceed the 50-percent mark at the end of CY 83 for all levels of personnel to be trained. A functional training system is in place and most of the systems' components are sufficiently well developed.

Impressive accomplishments have been made in the adaptation and revision of training materials; standardized services and training norms, training guides for all trainers, and service reporting formats for the information system. All personnel have received initial training in the use of these materials.

The absence of an implemented supervision/information system is at present the most serious obstacle to assessment of service delivery under the program, evaluation of worker performance, community contact, and logistical support.

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Recommendations

The insufficiently developed components of the training system, i.e., evaluation methodologies and a training information system, should be developed as soon as possible (see recommendations under Technical Aspects of Training) Full implementation of the supervision/information system should be given top priority. To insure effective implementation of these systems, the continued training of further groups of PSR and CTs (beyond those currently scheduled still for CY82) should be delayed.

Findings

Training support continues to be inadequate and has not received sufficient attention from the MOH. These crucial problems include logistical support in the form of drugs and supplies for PSRs, transport and gasoline for trainees/supervisors, per diem payment for trainers and trainees, and educational materials and visual aids. Although decentralization of decision authority for certain aspects of the training system has been proposed as a means of solving administrative impediments to training progress, the status of this is nebulous.

It has been observed repeatedly (as was done in the project paper) that area medical chiefs are deficient in managerial and administrative capacity. It has also been reported that physicians at area and especially at district levels demonstrate lack of understanding of the program and their responsibilities and functions for its support. The communication flow among project levels is inadequate.

Area medical chiefs report an imminent shortage of trainers/supervisors to train further groups of community-level workers. By the end of CY83, the standards set for supervision ratios will have been reached. Provided that the current managerial and systems support problems are resolved and that the number of trainers/supervisors is augmented by the beginning of Cy84, the project will be able to meet the training output targeted for EOP by August 1985.

Recommendations

A training management plan must be developed concurrently with a revised and detailed program implementation plan. Training should be decentralized in accordance with the systems management plan. Area medical chiefs and district level physicians must have clear definitions of their

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responsibilities and functions. A series of program orientations and problem-solving seminars should be held for the area chiefs and district medical officers. Area medical chiefs should be responsible for the orientation to the program of all district level medical staff and should be held accountable for compliance with project requirements. Redefinition of the responsibilities of the District Medical Officers may be required.

Area Medical Chiefs and their respective training teams should develop quarterly work plans, indicating support requirements necessary to accomplish training output, supervision, and services integration. Analysis of the management information system should be routinely communicated to the decentralized levels and serve as a basis for site visits by the project director and the central level team.

Overall Program Implementation

Findings

The project has now gained momentum and the specific primary care intervention strategies will become fully implemented, i.e., the immunization, ORT, and nutrition concomitantly with implementation of the supervision/information system. Direction and surveillance of these activities at central level will be the responsibility of the same small team that is now directing the training program.

Recommendations

The current status of the services system should be reviewed for each area, and a phased implementation plan should be developed to coordinate the training and support systems. Central level staff functions should be reviewed; to identify new functions to be filled, decision authority to be delegated, and coordination mechanisms to be established. At least one additional technical person should be added to the central level team. There should be reallocation of functions among team members to meet requirements for expansion of program activities in primary care. Experienced senior personnel should be given greater responsibility to insure job satisfaction and motivation.

With the training system fully developed, direct responsibility for day-to-day management of the training program should be delegated. Because of the importance of integrating training with the expanding primary care intervention strategies and the information/supervision systems, the current

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coordinator of training should assume broader responsibilities in these additional areas, while supervising the training program. A full-time project director should have overall responsibility for the primary care activities, but should devote at least one-half time to coordinate project support within the MOH, to obtain GOG interagency coordination, and to work with external agencies. Short-term technical assistance in programming could be helpful.

Technical Aspects of Training

General Findings

On the whole, the technical aspects of training are satisfactory, given the design for a locally developed project. Training is by objectives and is task-oriented. The technical capabilities of central and area level trainers are of good caliber. Most are sufficiently experienced and knowledgeable about adult education processes. Inadequacies in the training system are not due to lack of competence, but rather to inadequate staffing, competing task assignments, and the severely curtailed implementation time frame with lack of training support.

Recommendations

The project should augment the training team at central level with an additional trainer/education specialist to assist in addressing specific deficiencies and to help area teams in the decentralization process. Technical assistance could be used in the meantime to fully develop the training system as quickly as possible.

Specific Findings

Evaluation methodologies of training are weak, and a training information system is not yet in place.

Recommendations

Evaluation methodologies should be given priority. Particularly important are methods for pretesting, interview progress testing and posttesting the mastery of key learning points for community-level personnel. A training information system must be established. This should include a good registry of courses, trainees and their performance levels and the effectiveness of the trainers themselves.

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The training information system should be linked with the supervision/information system, so as to facilitate on-the-job performance monitoring and training followup.

Specific Findings

The TSR/PSR training appears to be solid. The trainers are practical in appropriate training techniques, the materials are functional and appropriate for the training objectives, and trainee response appears to be very good.

Recommendations

Irrespective of possible pressures from other agencies to revise this training program and/or the materials, the existing program should be left intact at this time. Once the supervision system is fully implemented and performance evaluation are standardized, training for this group can be modified in accordance with specific documented training/performance deficiencies.

The training of comadrones by auxiliary nurses is comparatively weak. The trainers lack sufficient experience in training older, illiterate adults, the majority of whom are somewhat limited in Spanish language facility. Specifically, training guides for the trainers are inappropriate, training manuals for the Comadrones are functional and adequate, and evaluation methods are very weak.

Recommendations

A simplified training guide should be developed for the auxiliaries. It should focus on essential teaching points and skills to be practiced by the trainee and should provide the trainee with specific learning experiences designed to teach the point or skill. Concomitantly, effective measurement techniques for assessing comadrone learning must be developed. Based on training evaluation and supervisory followup, the curriculum for comadrones should be reviewed, possibly narrowed, and made more specific to essential skills.

Training of the auxiliaries as trainers should also be reviewed and modified based on evaluation of their training effectiveness, and curriculum modifications. Upgrading the skill levels of auxiliaries as trainers through followup training sessions in training methods should have priority over increasing the training output of comadrones. Training/teaching methods used by the auxiliaries should become less didactic, and more experience-centered and participatory. The use of already trained comadrones as training assistants might facilitate experience-centered learning and participation in

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the project. To increase auxiliaries' experience in adult education/training process, the project could experiment with ways of team-teaching together with the well prepared TSRs. The program should develop a continuing education/training plan so that trainers also have the experience of methodological refresher workshops for reinforcement and maintaining motivations.

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INTRODUCTION AND BACKGROUND

As stipulated under Assignment No. 583150, the purpose of the consultancy contracted through the American Public Health Association (APHA) was to participate in a progress evaluation of AID project number 520-0251/Loan 520-U-033, the Community-Based Health and Nutrition Systems Project of Guatemala.

Project Goals and Objectives

The purpose of the project is to develop the institutional capacity of the Ministry of Health (MOH) to increase coverage and effectiveness of the existing structure of fixed services facilities by implementing a fully integrated rural health services system. To achieve this purpose, the 5-year project is financing the implementation of a regional environmental sanitation program and an integrated primary health care system utilizing volunteer community-based personnel and traditional midwives, and the establishment of support systems capacity necessary to carry out an integrated project.

The Scope of Work

Cable No. R 1217072 dated May 1983 from USAID/Guatemala spelled out a scope of work for one primary health care evaluator to address a series of questions concerning the progress, status and effectiveness of the training component, and the status of the oral rehydration therapy and expanded immunization program aspects of the project.

Subsequently, the scope of work was divided into two equal time allocations for two evaluators. A second primary care evaluator could not be contracted in time, so that the writer was the only evaluator working on the primary care component, as co-team member with the environmental sanitation engineering evaluator, Dr. Henry Van.

Following a mission briefing on the project, the writer worked out a redefinition of the task assignment with Chief of the Public Health Office, USAID/G, Paul Cohn. The scope of work for the writer was to focus solely on the training aspect of the primary care component, with observations concerning the broader program component and recommendations where appropriate. Time allocation was set at 11 working days; after an initial 3-day visit to the field, a 3-day extension was approved.

It is pertinent to note that the assessment presented here is not intended to represent in any way an evaluation of the primary care component, although the training system touches all aspects of the primary care. The assignment was facilitated by the fact that a local consultant had just completed an assessment of the organizational/administrative and management problems afflicting the Project and the MOH. On the other hand, the assignment was made very difficult by the fact that a major aspect of the project was not being evaluated simultaneously: the information and logistical support system that are key elements in the progress and status of the project. In assessing the training aspects, the writer continually came up against support system problems that affected training but were too complex to analyze in conjunction with the training.

Another gap in the evaluation is an assessment of the fixed-facility services delivery with which the training is linked. These information gaps should be included in a subsequent scope of work for the second primary care evaluator. As it stands, this training component assessment will be more useful when integrated with the later evaluation reports.

Itinerary and Methodologies Employed

The writer arrived in Guatemala City on July 24 and spent two days in briefings with the USAID Mission, initial meetings with members of the MOH project, perusing documents, files, reports, etc. and planning an itinerary of travel with the MOH personnel.

July 26 through 29 were spent in travel to the three departments in order to interview training teams to observe training groups and to talk with as many trainees as possible (see Appendix A, B).

July 30 and 31 and August 1 were spent in Guatemala City reviewing program training materials, curricula, and reports, writing field notes and scheduling as many meetings as possible to obtain an overview of this very complex project. It became clear that a second visit to the field was warranted to visit communities with already trained community personnel, where the environmental components were underway. A second 3-day visit to the field again touched each of the three areas--Solola, Totonicapan, and San Marcos--accompanied solely by MOH project personnel. The interviews and observations were not only fruitful but essential to meeting the assessment objectives. Travel also gave the writer first hand experience in problems of accessibility and logistical and transport problems of the program.

August 6-10 were spent almost entirely in individual and group meetings and debriefings with AID/G and MOH personnel. The coup d'etat on Wednesday, August 10, disrupted the work schedule, so that official debriefing with the MOH had to be postponed. Writing of the report had to be squeezed into this schedule in a desultory fashion. For example, enumerative statistics on training output that had been requested early in the assignment were not available until the last day of contracted work.

Hence, the report presented here is necessarily a first draft. Although most of the observations were discussed with both mission staff and MOH personnel, the draft could not be reviewed by them.

Intended Audiences for the Consultant Report

Various readers of this report may find it excessively descriptive and insufficiently analytical. The readers are asked to forbear and keep in mind that the report is written for several different audiences with varying degrees of knowledge about the project: USAID/G, the MOH, AID/W, APHA/Washington, and for the benefit of the third project evaluator to be contracted at a later date.

Inclusion and analysis of information presented here is largely a function of accessibility to information within the very limited time frame of the assessment.

II. OBERVATIONS AND FINDINGS ON TRAINING PROGRESS

OBSERVATIONS AND FINDINGS ON TRAINING PROGRESS

Background

To expand the coverage of preventive and curative services to the dispersed rural population of three Altiplano Departments, the project is augmenting the fixed-facilities base of the Ministry of Health (MOH) services with community-based volunteer health practitioners. The rural health promoters (PSRs) are selected by their communities and trained and supervised by the Rural Health Technicians (TSRs), and both functionaries have been incorporated into the MOH structure.

Following many years of Guatemalan experience with training the local traditional midwives--comadrones (CTs)--the project design incorporates them into the services system. Training and supervision of the CTs, however, has now been delegated to the auxiliary nurses, under the supervision of graduate nurses (EPs). Many of the existing CTs have in the past already received some training.

Since the project design provides for an integration of this primary health care system with a strong environmental sanitation component to amplify the preventive services thrust, complex mechanisms of coordination and collaboration at all levels have been designed. The PSR and TSR functions provide the principal linkages at the community level.

To insure continuity and integration of the project within the MOH structure, utilizing the experience of previous programs, the project design has located the program within the MOH structure rather than as an externally directed project component. In anticipation of the structural and administrative problems attendant to this implementation strategy, the project purpose is the strengthening of the MOH capacity to execute such an integrated services approach.

Project Timeframe

The project was authorized in August 1980, but the initial disbursement against obligated funds was not made until August 1982, with training activities starting the following month. A host of political and bureaucratic factors internal to the MOH as well as within the GOG itself were responsible for the delay in startup. These have included a change in government attended by redefinition of political priorities, ambivalent policy formation, and changes in the MOH. It is reported that there has been a turnover of about 20 percent

among senior staff in the ministry, with replacements drawn partly from a pool of young and relatively inexperienced personnel. Some divisions within the organization are said to be virtually dormant. Of import to this evaluation is the fact that project activities started about 2 years behind schedule, and that MOH policies and commitments to the integrated program have not been sufficiently formalized.

Further operational vagaries in current project implementation involve a PAHO-directed program to restructure and decentralize the MOH. The plan, however, has apparently not received approval by the GOG, and policies concerning health priorities and the MOH of the new government, changed again by a coup d'etat during the writing of this report, have not yet been articulated.

Project Inputs

Insofar as training and supervision are key mechanisms for realizing the strengthening of the MOH capacity to implement this services program, AID loan resources support the training of trainers and the training of community-level personnel, with retraining and continuing education according to service requirements and personnel capabilities.

Additionally, funds support a wide array of training courses and inservice training seminars in technical and administrative and evaluation techniques. Training and educational materials development are also supported by 18 months of technical assistance (see Appendix C).

Project Outputs

It is expected that at the end of the project (EOP) the program will have established an ongoing training program for community-based personnel and for their trainers and supervisors, and that supervision, information and evaluation systems will be in place. Output targets for personnel trained have been calculated on the basis of a 30-percent increase in existing primary care service coverage and stipulated criteria for supervision.

Evaluation Plan

The project implementation budget provides for a total of 13 workshop evaluations of the primary health care component for the development of evaluation methodologies and to evaluate implementation progress as well as process. The project paper

evaluation plan is focused on the impact of project interventions on the stipulated coverage and health status of the population. There are no specifications for intermediate process evaluations of steps to be taken in strengthening the capacity of the MOH to implement this program.

Progress in Achieving Targeted Training Outputs

Accomplishments

While the current evaluation addresses mid-project progress in accordance with the loan agreement authorization, activities in the training component have in fact been operational for about a year but are measured against EOP output targets.

Training activities started slowly and have gained momentum during the past 6 months. One of the reasons, as will be described fully in a subsequent section, is that a wide range of steps and developments must be undertaken in the training component to produce the targeted output.

As a first step, all of the institutional personnel in the program and at all levels of participating health facilities were oriented to the program and trained. In December 1982, the first groups of community-based personnel entered training and assumed responsibilities in March/April of 1983. A second cycle of training is currently being completed, with a third cycle scheduled for later this year.

Categories and Numbers of Personnel Trained. Table 1 documents that very substantial progress has been made in a shortened period of project implementation. Nearly two thirds of the projected required institutional personnel has received the initial training for their functions and responsibilities in the project. The output of auxiliary nurses and TSRs includes all of the personnel currently operating within the project. More than 60 percent of the targeted CTs have been trained, and it should be noted that the current target for CTs has been increased from the 950 stipulated in the project paper to 975 by the program direction. The percentage of PSRs trained to date is considerably smaller than that of the CTs and, as can be seen, there is also considerable variation in output by area.

Many factors account for the differences in output by area, but these are of less importance per se than are their implications for reviewing and redefining program directions. Irrespective of program delay, the numerical output of personnel trained is adequate and acceptable as a mid-project accomplishment.

Projections for Achieving Output Targets by EOP. Once established, a pattern of training activities can easily be turned into a mechanical process akin to assembly line manufacture. From a purely numerical output perspective, there is no doubt that the program can accomplish the remaining output by EOP, provided that the project can procure the additional institutional personnel required in the plan. Table 1 indicates a shortfall of about 37 percent in TSRs and auxiliary nurses to be trained. Existing institutional personnel could conceivably train almost most of the remaining targeted community-based personnel, but that would quickly bring about a collapse in the program. The key element in the design are the dual functions of institutional personnel in training and SUPERVISION.

Project standards for supervision have been set at 15 CTs per auxiliary nurse and 20 PSRs per TSR. Table 2 shows that present supervisory ratios are within the standards, but that for example in Solola, with 62 percent of the CTs trained, the supervisory ratio per auxiliary is already approaching the standard. Totonacapan still has the greatest absorptive capacity for more community personnel.

At the end of 1983 with the completion of the training of the third group of PSRs, both San Marcos and Solola will have reached their capacity with given institutional personnel. In fact, the standards for supervision may have to be modified according to locality, taking into consideration the dispersion of population, difficulty in access posed by terrain and the logistical support system. A practical analysis of supervisory output, however, can be made only after the supervision/information systems have been fully implemented.

Table 1
 Progress Toward Training Targets
 Community-Based Health and Nutrition Systems
 Project of Guatamala, 1983

<u>Personnel</u>	<u>Life-of-project Total</u>			<u>Percent of Area Target by Area/Department</u>		
	<u>Target number</u>	<u>Output to date number*</u>	<u>Percent of target</u>	<u>Solola</u>	<u>Totonicapan</u>	<u>San Marcos</u>
(160)#						
Aux. nurses	95	60	63.2	(9/N.A.)#	(26/N.A.)#	(25/N.A.)#
TSRs	75	48	64.0	58.8	77.8	76.9
PSRs	1,500	577	38.5	47.6	42.9	32.6
CTs	975	610	62.1	59.5	48.0	63.0
Projected PSR output by 12/83	1,500	(817)	(54.46)	(61.0)	(57.4)	(50.4)

* Includes Group 2 currently completing training

Percentages could not be calculated because original targeted denominators have been increased by program.

TABLE 2--Training/Supervision Status by Department
Community-based Health and Nutrition Systems
Project of Guatemala, 1983

Item	Department/area			
	Solola	Totonicapan	San Marcos	Total
Number trained:				
Trainees				
Aux. enf.....	9	26	25	60
TSRs.....	10	18	20	48
Groups I & 2*.....				
CTs.....	125	173	255	610
PSRs.....	183	241	393	817
Supervision ratios:				
Groups 1 & 2				
CTs/aux. enf.....	13.9	6.7	10.2	10.1
PSR/TSRs.....	14.3	10.0	12.7	12.3
Groups 1, 2, & 3#				
PSR/TSRs.....	18.3	13.4	19.7	17.0

* Includes Group 2 currently in training

Projections for third group of Comadrones not included

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There are other questions that could be raised on basis of the information presented in tables 1 and 2. One of these has implications for general program policy and the priority assigned by the MOH to this program: The tables indicate that San Marcos has trained a considerably larger proportion of CTs than of PSRs; yet, at the same time it is reported that this area is weakest in graduate nurses to supervise the training and supervisory work of the auxiliary nurses. (It is said that all but one nurse have been reassigned by the MOH from the program to hospital duty, so that supervision falls directly to the physicians in the districts.)

The two area department medical chiefs interviewed concurred with opinions voiced by the training teams of the three areas: That they are most concerned about the supervision of already-trained personnel. Effectiveness of training can only be gauged through an effective supervision system. Of particular concern to all interviewed was the quality of services rendered by the PSRs and the ability and willingness of the CTs to screen and refer cases properly and in a timely fashion.

With each additional community-level worker trained, the supervisory load increases. To reach the current 50-percent accomplishment of the targets, institutional personnel have already been shifted from other areas in the program. The program director recognizes the problem and is assured that the program will add five auxiliary nurses and 33 TSRs to the program; funds are available and presumably the personnel are as well.

The point is that the area teams feel that they can cover the third cycle of training PSRs, but that thereafter additional trainers will be required for further training output. This situation seems quite clear, but does not take into account the time required to effectively put an information system into place.

Hence, the real question is not whether the targets can be achieved within the time frame of the project--they clearly can. The appropriate question to be addressed is: Given the situation as reported, what priority should be given to further training at this time? And from a broader program management perspective, what activities should receive emphasis at this time to maximize not only the integration of the environmental and primary care components, but to insure quality of services delivery and community satisfaction?

Problems and Constraints

Without belaboring the point, this project is complex and difficult to implement, even by the most experienced managers in an ideal organizational environment.

The training output to date and the further accomplishments analyzed in the next section are in fact astonishing, given the plethora of administrative impediments within the larger system. As these have been fully explored in Sr. Juan Valle Garido's consultant report, they will not be discussed here, except insofar as they affect the training activities directly. Organizational and administrative issues are currently being addressed through an administrative reorganization of the program. Problems can be summarized as follows:

General administrative problems of the MOH

- Centralization of decision authority.
- Inadequate and ineffective communication flow.
- Inadequate logistical support.
- Excessive bureaucratic accountability procedures.
- Lack of material support for training.
- Interference from policy levels in the technical areas related to educational manuals and methods.
- Lack of general support and low priority status of program, e.g., movement of staff out of project.

Selected problems specific to project

- The technical team on the central level has and still is understaffed, working in adequate conditions.
- Area and district level physicians have a poor orientation to the program objectives and their own responsibilities.
- Project staff on lower levels have been used for other activities and are not receiving necessary logistical support.
- Reported absence of decision authority in project direction.

- Bottlenecks in the information flow of problems in project to decision levels in the MOH.
- Untimely payment to trainers and trainees of travel and per diem allowances.
- Increasing lack of communication and coordination of work plans, scheduling of community activities between the primary care and environmental components
- Lack of training support materials, particularly visual aids, equipment, and drugs for PSRs.
- Insufficient logistical support, transportation.
- Interference from local military, harrassment of PSRs
- Problems/misunderstandings concerning functions of the TSRs: Since the TSR is the key functionary on the community level, this alleged problem is presented here more fully. One department medical chief felt that there had not been sufficient community education and preparation for the integrated program. Others feel that the intensive PSR training program has shifted TSR functions away from community organization and coordination of environmental sanitation activities, i.e., that the TSR has been pulled too far into the primary care component to the detriment of the environmental component. This supposedly has caused an imbalance in the integration of the two components.
- The most serious problems confronting the program to the present are the lack of an information system and the lack of support for the PSRs in the field. Many are functioning without drugs and supplies and are afraid of losing credibility in the community.

These problems are being addressed by the MOH and the supervision/information system will be initiated this month. On the very positive side, the morale of project staff is still good, so that their combined enthusiasm helped them to carry on in spite of the frustrating unresponsiveness and intransigence of the current administrative system.

Progress and Status of the Training Component

One of the project objectives is to establish an ongoing training program for the community level practitioners and the supervisory personnel. Training is not only an essential mechanism for strengthening technical and managerial capacity of the MOH, but also the key element in implementing an effective primary health care program. To produce both the ongoing training program and to achieve targeted training output, a wide range of laborious and time-consuming activities must be undertaken. While these are subsumed and generally less visible, they also constitute a major form of output that must be reviewed in assessing both progress and quality of the training component.

Establishment of a Training System

From a management perspective, the first criterion for assessing training activities is the extent to which the basic elements of area training systems have been developed and standardized.

Virtually all of the essential components of a system have been instituted and are functional:

- Adequate training staff
- Job descriptions
- Task analyses
- Trainee selection criteria
- Instructional objectives
- Curriculum and course planning.
- (Teaching plans/learning activities)
- Instructional materials
- (Evaluation methodologies)
- Course scheduling
- Adequate training settings
- (Training information system)
- Training feedback/trainee followup

From cursory review and observations, it appears that at present the bracketed elements still require continued development for specificity and control. Given the brevity of the actual project implementation period, the small group of technical staff, and the demands for training output, the system is indeed well developed.

Formation of Training Teams

Field visits with lengthy discussions testify to highly motivated collaborative teams at headquarters, department and district Levels. Orientation seminars, workshops, and good interpersonal relations among team members of the various levels seem to have outweighed the common frustrations resulting from inadequate logistical and administrative support. A strong positive factor appears to be the decentralized, inclusive approach to materials development, whereby revisions are made equally on the department levels rather than on the central level (see Appendix D for schematic diagram).

Production of Training Materials

One of the most difficult tasks in human resource development is the production of training materials.

Training Manuals. During a relatively short period of time, the project has adapted materials previously produced in the aforementioned research/demonstration projects. Repeated revision, testing, and simplification have produced one set of four well illustrated and written manuals for the PSR, and another set for the Cs with an accompanying set of instructional guides for the auxiliary nurse as trainer.

Systems guides have been developed for the training of comadrones, baseline survey interviewers and their supervisors, data collection and the information and supervision systems, and the Implementation of the integrated project program.

Protocols/standing orders for the training and use of ORT have been completed and those for immunization and cold chain management are underway.

Standards and norms for the selection and training of community-based personnel.

Research protocols for the identification and selection of project communities.

Guide for radio programming for the PRS.

Implementation of a Baseline Community Study

The baseline community study is a major accomplishment and has produced not only a tested, standardized format but the accompanying guidelines and manuals for training, supervision, and analysis.

Forms and Records for the Services Components

Referral coupons for the PSRs, family health service records, birth registration forms with tearoff strips for measuring newborns arm circumference, etc., have been carefully designed and repeatedly tested until a functional tool has been produced. These items are highlighted here because they are of particular importance in service delivery and form the base for task-specific training and supervision.

Numerous other forms, including those for control of drug supply and flow, are being developed, with an emphasis on simplicity and function.

Community Orientation, Organization and Training

Less visible but of equal import has been preparation of communities by members of the training teams from the area and district levels for selection of community candidates for training.

TSRs and social workers have worked with trained community committees in a variety of activities related to both the primary care and environmental sanitation component. While this training may have focused on management of load funds, etc., it has served to develop support for the PSRs and CTs functions in the community.

Orientation meetings have been held with the local military authorities, who not infrequently are inclined to overrule civil authority. Sessions have also been held with the civil registrars, to whom the CTs must report births and vital events.

Interagency Communication for Training Support

The central level training team has established coordination and technical assistance mechanisms from CARE, INCAP, APROFAM, the Secretariats of Bienestar Social, and Educacion Extraescolar.

MOH Interdivisional Coordination and Collaboration

While it is not possible to assess progress in this area, it is clear that communication and collaboration efforts have increased, particularly with Drogueria Nacional, the Human Resources Planning, etc., as well as with the Health Education and Training Divisions. Coordination on decentralized levels could not be explored.

Workshops, Seminars, Working Groups

Easily overlooked work output that forms the basis of any developmental activity are the various forms of working sessions that build teams, provide in-service education, and prepare the program personnel for their functions. Though they are quantifiable in one sense, the amount of preparation required to conduct them remains largely hidden. Nor is their effect quantifiable. These group working sessions continue to be the major cementing force of the program, bringing together methods, materials, technical content, orientation, motivation and supervision. To date the project has conducted the following activities:

Program Implementation Workshops/Seminars

Number of sessions:

- (3) Implementation of the integrated program
- (3) Evaluation/methods of the integrated program
- (3) Implementation of community rotating funds
- (6) Workshops for graduate nurses on use of training manuals
- (16) Workshops for auxiliary nurses on use of training manuals
- (19) Workshops on the training manuals for the comadrones
- (55) Working groups on use of training Manuals for the PSRs
- (21) Workshops on use of arm circumference measures
- (3) Workshops on the implementation of the expanded immunization program
- (25) Meetings with the community committees
- (6) Workshops on conducting the baseline study
- (3) Courses on MCH for TSRs and auxiliary nurses
- (4) Hospital-based seminars on ORT

Training Supervision Visits. A total of 251 visits were made by the central level and area/department level training teams to supervise the ongoing training activities. These figures do not include all the additional supervision visits made to training sites by District level health personnel.

Programming of Training Activities

Review of training plans and documents and discussion with the training teams at all the levels indicated that there has been notable learning by doing. Department level personnel in particular appear to feel comfortable and secure in their own elaborations of the centralized programming. This progress has been due to the training development process itself and to the supportive relationship with the coordinator of the central level.

The writer was particularly pleased to find fairly well internalized systems-thinking on part of the senior trainers on the department/area and central levels. It suggests that the process of repeated in-service workshops and seminars, as described in the previous section, have served to develop a well prepared training staff.

These examples of largely nonquantifiable progress testify to a commendable accomplishment on the part of relatively small teams. It should also not be overlooked that, in contrast to similar projects being implemented elsewhere, this program has been developed entirely with local talent and without the benefit of resident external technical advisers. A striking observation made at all levels is that personnel involved in training all see this as their own program.

To date, short-term TA budgeted for training and continuation support has not been utilized. While there are two sides to this issue, suffice it to say that the program has made excellent progress in the training component in spite of long-standing and continuing management problems in the project.

III. TRAINING QUALITY AND EFFECTIVENESS

TRAINING QUALITY AND EFFECTIVENESS

Methods of Assessment

In the absence of a functioning supervision/information system, it is not possible to objectively judge either the performance of trained personnel at the community level or their direct impact on services utilization and coverage. Field observations of training, interviews with trainers and trainees, together with review of the training content, methods and plans permit subjective but nonetheless valid impressions of quality. Field visits to the homes of community personnel already trained reinforced these impressions.

During 6 days of travel in the three departments, the writer observed and held lengthy discussions with the members of 10 training groups: six groups of PSRs and four groups of comadrones, each with between 14 and 20 trainees. Subsequently, the writer visited the homes of seven PSRs and talked with two trained comadrones.

Trainers and Training Methods

Training and Quality of Trainers

From observation it was clear that at least two of the three graduate nurses responsible for training and supervising the auxiliary nurses have many years of experience as trainers of other personnel. Their methods of supervising the ongoing training sessions for CTs indicated that they are both knowledgeable and skilled in the training of illiterate adults. Their training of auxiliary nurses, however, could not be observed.

The training technicians (tecnicos de adiestramiento II) of the three departments were most impressive in terms of their background in practical and theoretical experience in adult education and community development methods. They in turn orient and supervise the rural health technicians (TSRs) who train the PSRs.

Training methods employed by the TSRs in the training sessions observed were excellent, with appropriate balance between didactic and group approaches, role play, and a variety of supportive adult education methods. Group responses were accordingly very positive and group tasks were being carried out with enthusiasm.

Auxiliary nurses not only have a more difficult job in teaching/training illiterate older women, but appeared to be considerably less skilled in their approaches. Although the groups of CTs trainees are so structured as to provide peer leadership and reinforcement, the instructional methods tended to be primarily didactic, employing mostly role learning and repetition of responses. Many of the CTs have little language facility in Spanish; hence, in cases where the trainer is not bilingual, trainee participation is limited. It was evident that the auxiliary nurses had undergone training in methodological approaches to prepare them for their job, but that these approaches and methods had not been fully internalized or practiced sufficiently.

It should be noted that another major accomplishment of the program has been a complete reorientation of the training methods from theoretically oriented didactic classroom methods to a functional task-oriented approach. The change is recent and with further on-the-job and inservice training, the auxiliary nurse trainers should soon be better able to master the more appropriate training methods.

In the final analysis, as the experiences of many programs around the world have shown, less-than-perfect training methods are not nearly as detrimental to good performance as is the absence of good trainee followup and supervision with on-the-job correction and continuous reinforcement. Training protocols call for regular group meetings with the CTs, but until the information system is operational, adherence to the monthly followup schedule cannot be verified.

Trainee Performance and Satisfaction

All of the training groups visited were in the first of their five training units, and trainee satisfaction and enthusiasm were overwhelming. Since several supervisory functionaries were present during visits to the homes of trained personnel, reflections on aspects of the training could not be elicited.

Effectiveness of the training can be deduced from certain observations; but, again, there are other intervening factors that make it impossible to separate the effect of training from circumstantial factors.

All of the PSRs had clear, detailed maps of their areas of responsibility and were able to point out where the CTs live, the houses visited, and the types of problems encountered. Their records, currently kept in the form of notebooks, indicated treatments given and the referral books were well

kept. It may be assumed that only the best of the accessible PSRs had been selected for the consultant visits. Their grasp of their work, their own and community objectives, and their attempts to balance this volunteer work with earning a livelihood suggest that the training has been very effective in channeling a high level of commitment to the community cause. The frustrations expressed, when expressed, had to do with the support system; the drug supply system is not working. Although the implementation of the municipal pharmacy may alleviate some of the drug problems, it is at present only a stopgap measure for the PSR. One PSR has had difficulty getting his referral cases managed at the fixed facilities (for more details see Appendix E).

PSRs are making community contact, but the time available for this is limited by their work. It appears that they are visiting on the average of two to five houses per week, and that the major form of contact may actually be weekly group meetings with people in their area. The variations in modus operandi need to be surveyed. In some cases, there are husband-wife teams of PSRs and PSRs-CTs with division of labor between group meetings and home visits. One important fact emerged from the interviews: The PSRs are being sought out by the communities, often at night. They are making referrals.

Senior project staff report that there has been an increase in service demands and output in those areas where the community-based workers are operating. Comparison of immunization rates over a period of 5 years in areas with and without community personnel definitely indicates the positive influence of the program. Data, however, are not sufficiently compiled for review at this time.

Selected Training Content

Another method of evaluating the quality of the training program is to assess the appropriateness and inclusivity of content in relation to the planned health intervention strategies and to the health problems to be solved. Training manuals and guides were reviewed for selected content areas:

- Nutrition, breastfeeding, and ORT are strongly emphasized and treated appropriately at the community level.
- Utilization/benefits of formal health services: Introduction to the types of facilities and personnel is heavily emphasized for both PSRs and CTs.

- Immunization for MCH also has appropriate attention.
- Referral and limitations of skills are standardized, clear, and receive sufficient emphasis with continuous repetition.
- Purposes and methods of reporting: The information system is built into the job training and appears satisfactory. Implementation of the information system will determine further required training content and skills.
- Methods of Supervision: This area could not be judged. The reporting forms are accompanied by instructional guides. The philosophy of supervision, methods of evaluation, interpersonal relations and on-the-job correction, and inservice training appear to form part of the training content, but could not be reviewed.
- Health education is strongly emphasized at all levels of the training. From group observations and interviews with PSRs, it is evident that they have received some training content in interpersonal methods, group process, and use of visual materials. This area could not be explored further; more likely, however, as in most programs, this content area could be strengthened over time.

A major problem in trying to assess effectiveness and quality is that information is currently based on self-reports. Until the supervision-information system is sufficiently in place, neither TSRs nor auxiliary nurses have a firm base to verify activities on the family level.

In summation, it may safely be said that the training system is working sufficiently well to serve the program objectives, and that though somewhat uneven, it appears to be of good quality.

APPENDIX A

LIST OF PERSONS CONTACTED
(Program Discussions Held)

USAID/GUATEMALA

Charles E. Costello, Director

Gary Vaughan, Program Development and Support Officer

Clara Carr, Deputy Program Officer

Paul Cohn, Chief, Office of Public Health

Dr. Leonel Barrios, Medical Assistant

Lic. Carlos Andrino, Program Specialist

Dr. Henry Van, Washington Engineering Consultant Team
Co-Member, Evaluation

PROGRAMA SISTEMAS COMUNITARIOS INTEGRADOS DE SALUD Y NUTRICION
(SCISYN)

Dr. Francisco Zambroni, Director General de Servicios de Salud,
DGSS

Dr. Danilo Aldana, Subdirector General de Servicios de Salud,
DGSS

Dr. Edgar Lara C., Coordinator Medico del Programa SCISYN,
GDSS

Sr. Gustavo Linares, Administrador del Programa SCISYN, DGSS

Dr. Baudilio Lopez, Encargado de Formacion de Recursos Humanos
del Programa, SCISYN, DGSS

Sra. Mercedes Castillo, Enfermera Professional, Encargada de
Docencia del Programa SCISYN, DGSS

Dr. Osmin Reina, Encargado de Programacion e Informacion,
SCISYN

Lic. Orlando Marroquin, Asesor Tecnico del Programa SCISYN, DGSS

25

AREA DE SALUD DE SOLOLA

Sr. Geronimo Juarez, Tecnico de Adiestramiento II, SCISYN

Sra. Yolanda Aragon, Trabajadora Social, SCISYN

Dr. , Jefe de Area Interino

Sra. Astrid Reyes, Enfermera II, Enfermera Encargada de Adiestramiento de Auxiliares de Enfermeria y Comadrones, SCISYN

Sr. Manuel Tambriz, TSR, SCISYN

Sr. Vincente Macario Tumay, TSR, SCISYN

Sr. Eduardo Mogollon, TSR, SCISYN

AREA DE SALUD DE SAN MARCOS

Dr. Rudy A. de Leon, Jefe del Area de Salud, Hospital Antiguo

Sr. Guillermo Lopez, Technico de AdiestramientoII, SCISYN

Sra. Ruby Reyes, EnfermeraII, Encargada de Adiestramiento de Auxiliares de Enfermeria y Comadrones

Sr. Pedr Alvaro, TSR, SCISYN

Sr. Sofia Quijiuix, TSR, SCISYN

Sr. Edgar Lopez Aschembremer, TSR, SCISYN

Sr. Jorge Augusto Tames, Auxiliar de Enfermeria, SCISYN

AREA DE SALUD TOTONICAPAN

Dr. Jose Yax, Jefe del Area de Salud, Centro de Salud

Sr. Miguel Angel Cajas, Tecnico de Adiestramiento II, SCISYN

Srs. Alba Escobar de Galvez, EnfermeraII, Encargada de Adiestramiento de Auxiliares de Enfermeria y Comadrones, SCISYN

A-3

Sr. Roderigo Cifuentes, TSR, SCISYN

Sra. Violeta Samayoa, Enfermera Profesional, SCISYN

Srs. Esteli de Robles, Auxiliar de Enfermeria, SCISYN

Additionally numerous interviews and discussions were held with Promotores and Comadrones in training, as well as visits to the homes of already trained community-level personnel.

APPENDIX B

APPENDIX B

CONSULTANT ITINERARY
(PRIMARY HEALTH CARE TRAINING)

24 July	25	26	27	28	29	30
Arrival Guatemala	USAID: Briefings Discussions MOH: Introductions	USAID: Team Formation Meetings MOH: Educ. Materials Personnel	Travel Solola Dept. Training Obs. Discussion	Travel Tonicapan Department Training Obs. Discussions	Travel San Marcos Department Training Obs. Discussions	Field Notes Reading of Documents Team Meetings
31 August	1	2	3	4	5	6
Study of MOH Educational Materials Formulation of Evaluation Scope	USAID: Meetings MOH: Meetings Material Req. Travel/Eval. Planning	Travel Solola Dept. Com. Visits Interviews	Travel San Marcos Department Com. Visits Interviews	Travel Tonicapan Department Com. Visits Interviews	MOH Meeting Interviews Organization of Observations Findings	Field Notes Team Meetings Report Writing
7	8	9	10	11	12	13
Team Meetings Preparation for MOH & USAID Debriefing	USAID: Meetings MOH: Interviews Debriefing (Directorate Level)	USAID: Debriefing Final Interviews Report Writing	USAID - Director Committee Report Writing	USAID Debriefing MOH: Debriefing		

29

APPENDIX C

II PRIMARY HEALTH CARE
ILLUSTRATIVE BUDGET
(IN US \$000's)

Description	Total	AID/G Funds		Counterpart		Year			
		Loan	Grant	GOG	Other	1	2	3	4
<u>PER DIEM</u>									
Field Personnel	90	-	-	90-	-	21	22	23	24
Rural Health Tech. TSR	94	-	-	94	-	22	23	24	25
Total Per Diem	184	-	-	184	-	43	45	47	49

TRAINING

6 Courses for Health Teams in Primary Health Care with Em- phasis on Mater- nal/Child Care	6	6	-	-	-	2	2	2	-
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II PRIMARY HEALTH CARE
ILLUSTRATIVE BUDGET
(IN US \$000's)

<u>Description</u>	<u>Total</u>	<u>AID/G Funds</u>		<u>Counterpart</u>		<u>Year</u>			
		<u>Loan</u>	<u>Grant</u>	<u>GOG</u>	<u>Other</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>
15 Seminars for Com. Org.	20	20	-	-	-	4	4	6	6
5 Short Term Courses on Training Sup. and Control	5	5	-	-	-	2	3	-	-
4 Workshops for Area Teams in Sup., Control & Evaluation	4	4	-	-	-	1	1	1	1
3 Workshops for Districts in Sup., Control & Evaluation	3	3	-	-	-	3	-	-	-
Stipend for TSA for Cont'd Educ. Progr.	108	108	-	-	-	9	-24	36	39

32

63	Training for Trad. Midwives	131	131	-	-	-	35	38	41	17
450	Re-training of Midwives	380	380	-	-	-	46	88	109	137
75	Training of PSR's	150	150	-	-	-	35	40	45	30
	Re-training of PSR's	183	183	-	-	-	5	34	72	72
<hr/>										
	Total Training	1,083	1,083	-	-	-	190	263	322	308

63

II PRIMARY HEALTH CARE
ILLUSTRATIVE BUDGET
(IN US \$000 's)

Description	Total	AID/G Funds		Counterpart		Year			
		Loan	Grant	GOG	Other	1	2	3	4
1 TECHNICAL ASSISTANCE									
12 p/m Methods & Techniques on Continued Educ. Specialist	60	-	60	-	-	30	15	15	-
12 p/m Admin. Financial Acct. Specialist	60	-	60	-	-	60	-	-	-
2 p/m Supplies Mgt. Specialist	10	-	10	-	-	10	-	-	-
6 p/m Training Specialist	30	-	30	-	-	30	-	-	-
6 p/m Epidemiologist Surv. Specialist	30	-	30	-	-	10	10	10	-
6 p/m Laboratory Training & Implementation Specialist	30	-	30	-	-	15	15	-	-

44 p/m ¹ Total Tech: Assis.	220	-	220	-	-	155	40	25	-
Total Component	6,379	1,971	336	4,033	39	1,525	1,866	1,507	1,481
AID Grant	336	-	336	-	-	212	99	25	-
AID Loan	1,971	1,971	-	-	-	461	820	352	338
Counterpart	4,072	-	-	4,033	39	852	947	1,130	1,143

1 Person/months computed at \$5,000

25

APPENDIX D

APPENDIX D Process of Materials Development

CAPACITACION DEL PERSONAL DE NIVEL
COMUNITARIO

EQUIPO CAP*
EQUIPO DE AREA

Presentacion y
 analisis de contenido

EQUIPO CAP*

Impresion, Encuadernacion y
distribucion

EQUIPO CAP:*

Elaboracion final del documento

D.G.S.S.

Revision del documento por el centro
Normativo correspondiente

Revision equipo de Areas

EQUIPO CAP. Elaboracion del Documento preliminar

Revisión

EQUIPO DE CAP Elaboracion del primer borrador, segun especialidad

EQUIPO DE CAP Seleccion de contenidos educativos en base a los perfiles
y necesidades establecidos y a los objetivos del SCISN

EQUIPO DE CAP Revision de perfiles educativos, antecedentes y

EQUIPO DE AREA necesidades locales.

* EQUIPO DE CAPACITACION DEL PROGRAMA SISTEMAS COMUNITARIOS INTEGRADOS DE SALUD Y NUTRICION

APPENDIX E

APPENDIX E

Discussions with Trained Promotors and Comadrones in Their Communities: Vignettes

Solola Department:

1. A young farmer, articulate in Spanish and seemingly extroverted. He speaks with conviction and self assurance. His wife is also a Promotor, but she was not interviewed, because of limited time available.

He is responsible for 53 houses, most of whom he has visited during the past four months since he began. On Saturdays he holds meetings with over 40 people and on the average he visits about 5 houses per week; although this takes a lot of his farming time, he accepts the fact because this is his way to contribute to an improved Guatemala ("pero este es mi Compromiso..." - the slogan of the governmental campaign to make people more community oriented and conscious of their individual responsibility).

People call on him and he makes house calls; he has treated mainly fever, headaches and diarrhea -- the latter with ORT solution, which people accept well. He has seen some very bad diarrhea cases. He refers to the Health Center (about 5 km distant) and has no problem with his supplies. Besides the visits with his Technico Supervisor, he has had 2 visits from the Health Center nurse.

In his area there is no water source development project and his community is 20 latrines short. People are asking him for water and latrines, but he tells them that they are "developing community personnel first" and then gradually bringing in services.

Most of his health education is focused on personal and home hygiene, and promotion of immunization. He feels he needs a health educator to assist him in his community education work. He likes to give advice - he walks into any religious gathering and requests some time to talk about health, which he is always given. People even bring sick animals to him, so he justly feels that he is well accepted. Apart from the shortage of time, he has no problems; he keeps in touch with the other Promoters and the Comadrones so that they can exchange experiences.

2. A slightly older farmer who also has been practicing for four months. His house is considerably less accessible, requiring a 3km walk from the main road about 8-9 km from the health center. His mother, living in the house, is a Comadrona, but she was not interviewed, because of limited time available.

He is responsible for 50 houses of which he now has visited only 30 because his agriculture takes so much time. Once or twice a month he holds a meeting with the people he is

responsible for; about 45/50 have confidence in him and 5 do not. He treats on the average 4-6 cases per week, mostly First Aid, diarrhea and fever, in both adults and children, some catarrhs, all of which he treats and refers according to instructions in his guide book. He sees on the average about 4 diarrhea cases per month; there have been some deaths from whooping cough, but it was not clear whether any of these were his patients or not. In four months he has referred 5 patients, but his referrals - including his wife - wife not honored at the health center, so he has not much confidence in it.

The Technico Supervisor has visited him only once, and there have been no visits from health center personnel. People ask him for drugs he does not have - currently he only has aspirin. An additional frustration is that he doesn't have the knowledge or skills to deal with real emergencies at night such as heart pain, abdominal pain, how to deal with grippe, diarrheas, etc., and would like more training. There is neither water, no latrine construction in his area, so his health education efforts are more limited to hygiene.

San Marcos Department

3. A busy, slightly middle-aged Promotor who is also a shop/pharmacy/businessman with a large house and office in the center of a small town. Though recently trained, he has 2 years previous experience in the PRINAPS program, radiates self-confidence and influence. He has responsibility for 36 houses and he visits about 2-3 per week because he is also very involved in a water project and a PROFAM program and he works with PROFAM Promotors. He gives family planning advice, talks to them about nutrition, water and sanitation. Only six houses in his area lack latrines. On the average he devotes about 4 hours/week to the Promotor responsibility. He sees mostly children with diarrhea and adults with anemia. (The interview was curtailed by him before other questions could be asked)

4. A very young Promotor, seemingly shy and introverted, but probably only intimidated by the presence of several supervisory functionaries. He also has recently been trained but also has two previous years experience with the PRINAPS Program. He receives a small remuneration from running the Municipal Pharmacy 4 hours each day, but he keeps the two responsibilities separate. Responsible for 45 houses in an exceedingly steep mountainous terrain he makes as many house

visits as he can, but up to 10 people weekly seek him out in his house. He treats mostly diarrhea and parasites and gives only individual advice about hygiene; he does not hold group meetings.

His Technico Supervisor visits monthly and more often, but he has not been visited by nursing personnel yet.

The government subsidized small pharmacy is very popular and many people know him in both capacities.

Totonicapan Department

5. Youngish Promotor four months out of training. His wife is a trained Comadrona, and they work as a team. He is more articulate in Spanish, exudes self-confidence and clearly takes a leadership role in community organization and development. One room in his house is set up as a classroom for a young teacher who gives literacy classes to children, health education with very simple visual aids is integrated.

While the Comadrona holds weekly meetings with groups of women to discuss nutrition and family planning, the Promotor does most of his health education in church services and on home visits. He has close contact with his Technico Supervisor and health center personnel, and appears to have fewer problems with supply.

The Comadrone displayed her kit and explained in detail

how she goes about using all the materials for a delivery, recounting all her training. She appears to be a model comadrone, and knows who in the area is pregnant with two deliveries due this month and three more in October and November. She routinely takes her patients to the health center which is about 4km distant.

6. A husband-wife Promotor team, also 4 months out of training, located on the slopes of a barranca settlement with difficult access to the health center. He has been visited only by his Technico Supervisor, but has had no drugs except the oral rehydration packets since he started. He appears frustrated but reluctant to speak up very much in the presence in his Supervisor.

Since he has had a lot of previous experience in working with groups through a previous similar position, he divides the health education with his wife. While he works with the churches, schools and all other institutions in the community to teach nutrition, feeding practices and health education she does home visits. It was not clear whether she also visits his houses. Their own house was dirty and unkempt, and she spat on the floor once during the interview.

People ask him for medicines, but he has none; there is a latrine construction project for his area but no latrines have

B-7

been built to date, so he is not doing any education for latrine use. One of his frustrations is a lack of resources to buy foods with which to do food preparation demonstrations for his "group" of people; they are very poor and apparently a contribution mechanism has not worked out.

4/6