

~~3704~~
PD-ABE-223
77423

**MODEL FOR COMMUNITY PARTICIPATION IN CHILD SURVIVAL
DEPARTMENTS OF SAN MARCOS AND QUETZALTENANGO, GUATEMALA**

September 1, 1988 to August 30, 1991

FINAL REPORT

Submitted to:

**Bureau for Food and Humanitarian Assistance
Office of Child Survival and Health
Private and Voluntary Cooperation
515 22nd Street, N.W., Suite 103C
Washington, D.C. 20037**

by:

**THE PEOPLE-TO-PEOPLE HEALTH FOUNDATION, INC.
(Project HOPE)
Millwood, Virginia 22646
(703) 837-2100**

November, 1991

TABLE OF CONTENTS

	PAGE
A. SUSTAINABILITY STATUS	1
B. SUSTAINABILITY PLAN	1
C. COMMUNITY PARTICIPATION AND PERCEPTION OF PROJECT EFFECTIVENESS	3
D. INSTITUTIONAL SUSTAINABILITY - STRENGTHENING LOCAL MANAGEMENT	5
E. MONITORING AND EVALUATION OF SUSTAINABILITY	8
F. CALCULATION OF RECURRENT COSTS	8
G. COST RECOVERY ATTEMPTS	9
H. INCOME GENERATION	9

APPENDICES

- A. Survey Results
- B. Financial Pipeline

ACRONYMS

CS	Child Survival
CHV	Community Health Volunteer
DIP	Detailed Implementation Plan
MOH	Ministry of Health
ORT	Oral Rehydration Tablets
ORS	Oral Rehydration Salts
TT	Tetanus Toxoid

A. SUSTAINABILITY STATUS

A.1. Project HOPE completed its Child Survival activities in the CS-IV areas on August 30, 1991.

A.2. Major project responsibilities were phased over gradually to the Ministry of Health (MOH) during the last project year. On September 1, the MOH was responsible for direct supervision of all Project HOPE trained promoters and volunteers.

B. SUSTAINABILITY PLAN

B.1. Three major strategies were used:

1. Initially, Project HOPE only trained Community Health Volunteers (CHVs) in the child survival strategies as described in the Detailed Implementation Plan (DIP). However, the MOH only uses promoters at the community level. Promoter training includes additional interventions and first-aid and lasts about twice as long as the training of the CHVs. In order to facilitate the absorption of the CHVs by the MOH, Project HOPE, jointly with the MOH, offered promoter training to all its CHVs. This increased the acceptance of the CHV and the project by the community and the MOH. It also improved the volunteers' ability to relate to the MOH and made the volunteer less dependent on the MOH for supervision.

2. Involvement of the communities in their own health care through community organization.

3. Requests that the MOH absorb Project HOPE field personnel so as to continue the intensive supervision of the volunteers.

B.2. Through the coordinated efforts of the CHVs, Project HOPE, and the MOH, over 700 of the community volunteers (more than 60% of the active volunteers) have been trained and certified as MOH Health Promoters. The volunteers received this training at their own expense. Project HOPE provided the training materials, personnel time, and a copy of the MOH Health Promoter Manual for each new promoter. The MOH provided personnel time for over half the training period.

All of the 300 communities are currently reported to have active health committees. Also, in each municipality the promoters have formed their own organized groups in order to provide mutual support and seek any external support which they might need.

The District Health Chiefs of San Marcos and Quetzaltenango formally petitioned the MOH to hire Project HOPE field staff at project end. However, the MOH is going through serious financial difficulties, and there is a government hiring freeze. There-

fore, Project HOPE field staff have not been hired by the MOH.

B.3. The Country Agreement between Project HOPE and the MOH commits the MOH to "use these individuals [i.e., local staff trained by Project HOPE] in its programs and put in practice the experience they have gained and the proven methodologies they have learned during their training" within its financial limitations.

The local MOH personnel continue to support and supervise the project activities, through the CHVs and promoters, within their financial limitations. Thus the MOH is fulfilling its commitment.

B.4. As stated above, the MOH is fulfilling its commitment to the project. The reason for this success is that the MOH is dedicated to Child Survival and has been an integral part in project planning and implementation from the beginning.

Major support for the continuation of the project comes from the MOH at the local level. MOH staff in their work with the communities have seen the value of the promoters firsthand.

They [the promoters] collaborate directly with the health post. They take care of the children with mild illnesses in their community. They send or bring the very sick to the health post. Now we see more children at the health post, more of the very sick, and very few of those that can be care for in the community. [Alicia Veliculis, District Head Nurse, Cabrican, Quetzaltenango]

MOS staff at the local level are planning to continue supervising and supporting project-trained promoters. Project HOPE tried to facilitate their work by donating the project's motorcycles to those MOH staff who would be most likely to continue to supervise the volunteers in the target area.

Project HOPE gave me a motorcycle which helps greatly in the supervision [of promoters]. We meet every month with the promoters and when Flor [Project HOPE Social Worker] is gone we will continue these meetings. [Miguel Perez, MOSHA Rural Health Technician, San Cristobal Cucho, San Marcos]

I have a motorcycle donated by Project HOPE. This helps me to do the supervision. I continue supervising the promoters. I have the desire to work with them. What I do not have is the gas. I pay all the expenses [of visiting volunteers] from my pocket. [Rural Health Technician, Rio Blanco, San Marcos]

Because there is not yet a rural health technician assigned to Cabrican, we [the nurses] will be responsible for

supporting the promoters. We have planned monthly meetings with them, and they are working with us. Because of the motorcycle donated by Project HOPE, the supervision is easier. [Besser De Leon, Auxiliary Nurse, Cabrican, Quetzaltenango]

Unfortunately, the dedicated local MOH staff can expect little financial support from the central MOS.

Although we are very interested in the project activities, the financial situation of the Ministry is very serious. The government has a hiring freeze and none of the current HOPE personnel who are supervising promoters can be contracted by the Ministry [as was formally petitioned by the District Health Chiefs]. We cannot promise to cover any project cost which Project HOPE currently covers because we do not have the resources. [Dr. Raul Chinchilla, Area Health Chief for Quetzaltenango]

C. COMMUNITY PARTICIPATION AND PERCEPTION OF PROJECT EFFECTIVENESS

C.1. At the beginning of the project, each community elected volunteers to be trained in Child Survival. These volunteers are the core of the project. They work directly in their own community delivering CS education and services. After completing their initial CS training, the volunteers reported that their communities wanted them to have more extensive training, so that they could be a community health resource in additional areas, such as basic first aid. As mentioned above, Project HOPE and the MOH provided this training.

Over 700 of the volunteers are now fully trained as MOH health promoters. The volunteers dedicated their time and received no financial compensation for their training expenses (food, transportation, housing).

Now they have much more influence in their community because they are promoters. [Besser De Leon, Auxiliary Nurse, Cabrican, Quetzaltenango].

The promoters/CHVs are now an extremely valuable resource, provided by the community for the community. They also represent, through their newly gained knowledge and willingness to serve, the potential for sustaining the activities of the CS project at the community level.

C.2. There are 298 communities of varying sizes in the project area. Each community is reported to have a committee concerned with health issues.

The committee is our voice. [Edna Vin, a project trained promoter and midwife in El Palmar]

C.3. It is impossible to list the topics discussed at the meeting on 298 committees. However, cholera has been a major concern for everyone in the last few months.

Our committee is trying to respond to the cholera emergency through communicating to the people means of preventing and treating cholera. [Isaias Humberto Coq, project-trained promoter and active member of the health committee in El Palmar, Quetzaltenango]

The promoters have organized committees. They are a resource in the face of this epidemic. We have given them training to prevent cholera. [Beser De Leon, Auxiliary Nurse, Cabrican, Quetzaltenango]

C.4. With the spreading of the cholera epidemic, community leaders have become very aware of the benefits of improved sanitation and oral rehydration therapy. They are quick to point out that these are things the project has been teaching people for the past three years, as if anticipating the epidemic, and turn to project-trained volunteers and promoters as the primary resource in combatting the epidemic.

We will use the knowledge of the promoters in preventing diarrhea and using oral rehydration therapy to help us combat cholera. [Dagoberto Diaz, Sanitation Inspector of El Palmar]

The project has done much to prepare people for the cholera epidemic because now everyone knows about oral rehydration therapy. [Isaias Humberto Coq, Health Promoter, El Palmar, Quetzaltenango]

[The project] has promoted the formation of committees. Now the people are organized to help themselves and to look for the assistance they need. This can continue. [Mr. Ometo, Municipal Treasurer, San Cristobal Cucho, San Marcos]

[The project] has greatly benefitted the people, the medicine has really helped, especially those with very limited resources. Also [the project] has helped very much with the seeds, the gardens have given good results. [Horacio Cain, Mayor, Rio Blanco, San Marcos].

[The project] has helped the area and has been of much benefit to our communities. [Octavio Maldonado, former Mayor, San Cristobal Cucho, San Marcos]

According to the promoters and MOH staff, the attitude of the people in their communities has changed greatly due to the project, and community acceptance of project interventions is very high.

Now the same people ask for ORS who before would not accept it. And every child has its vaccine. [Elsa Navarro, Head Nurse, Rio Blanco, San Marcos]

Now everyone goes with the education, more prepared than before; their homes and their hygiene are improved. [Jovita DeLeon Lopez, project-trained promoter, Durazno, Rio Blanco, San Marcos]

The majority of people now know how to prepare ORS, understand the importance of vaccines, and accept home gardens. [Miguel Perez, Rural Health Technician, San Cristobal Cucho, San Marcos]

The people [in my community] were not very interested in vaccines. Many said vaccines are harmful. Now the majority of children are immunized. Now they recognize ORS, everyone can prepare it. [Francisca Yaq, project-trained promoter, Las Canaas, San Cristobal Cucho, San Marcos]

C.5. The major resource the community has provided is the willingness of the volunteers to take time to learn about CS interventions and other basic health skills and to transfer these new skills to the people in their communities.

We need to involve the community in the resolution of their own problems. This is possible through the promoters. [Alicia Veliculis, District Head Nurse, Cabrican, Quetzaltenango]

D. INSTITUTIONAL SUSTAINABILITY - STRENGTHENING LOCAL MANAGEMENT

D.1. The MOH has participated directly in the CS-IV project since its initiation. The project complements the MOH activities in CS. Project planning and implementation was coordinated with the MOH at the national, regional, departmental, and municipal levels. The MOH staff in the municipalities were the most directly involved in daily project activities. Many of them benefitted from motorcycles donated through the project or assistance with travel expenses for promoter training and supervision. No other financial exchanges took place.

D.2. Project HOPE has worked directly with the MOH staff responsible for promoter supervision. They have been using the system developed by Project HOPE for tracking promoter activities

and achievements and have reported that this system is useful for monitoring the promoters.

D.3. Child survival interventions are a major focus of the MOH. One of the four stated goals of the MOH is to reduce the infant mortality by 50% in 1991 through CS activities. The project activities are viewed as very helpful by the MOH.

There is no doubt, before the people did not accept health services. There was a barrier between the community and the MOH. But by means of the promoters, who are of the community, and who have taught the community, this barrier has been broken. This is the success of the promoters. [Dr. Arnaldo Sun, District Health Chief, Cabrican, Quetzaltenango]

It is a success that we have increased the number of promoters." [Nurse, Acting District Chief, El Palmar, Quetzaltenango]

Anyone can see that you have had success, that you have reached even the most distant communities. I would like to congratulate HOPE, the MOH, and the promoters for the work that you have done. [Angel Ramirez, Municipal Secretary, El Palmar, Quetzaltenango]

Because you are human, you made some mistakes, and I cannot give you a 100%. But I would give you [the project] a 99%. [Sanitation Inspector, El Palmar, Quetzaltenango]

By means of the promotion done by the promoters, we have increased the vaccine coverage. They teach the families about the need for vaccines, they organize their communities for the vaccine campaigns, and they bring children to the vaccine sites. [Alicia Veliculis, Head Nurse, Cabrican, Quetzaltenango]

In the second vaccination campaign (1991) Cabrican had the highest vaccine coverage [in the department]. This is a reflection of the education of the promoters. The work of the promoters has changed the attitudes [of the people]. Project HOPE has greatly influenced the health of the people of Cabrican. We will continue to reap the fruit of your efforts for many years. [Dr. Arnaldo Sun, District Health Chief, Cabrican, Quetzaltenango]

D.4. The resources necessary to continue the project activities include:

1. The desire of the promoters to help their communities and to be recognized by their communities.
2. The quality of education given to promoters by the project.

3. The continued supervision and support of the MOH.
4. Materials such as ORS, acetaminophen, seeds, and vitamins that may act as additional incentives or provide recognition to the promoters.

The most important element in the success of the program is the personal interaction between the promoters and the families they are teaching and helping.

I am not the most schooled woman in my community. There are others who have finished sixth, some even ninth grade. But I have something they do not have. I know how to prevent disease and what to do for a sick child. Before I knew nothing of this. Now I know how to help my people. I continue teaching the persons I cover, using the action guidelines to give them a better understanding and to prepare them to prevent diseases. When I told the mothers that Project HOPE would not be helping us anymore some of them cried. They said 'What will we do without the medicines?' I told them that it would be hard without the medicines, but that the project had given us something more important, something that could not be taken away or used up. That is the knowledge of how to prevent diseases and how to care for children with diarrhea. [Jovita DeLeon Lopez, project-trained promoter, Durazno, Rio Blanco, San Marcos]

An additional factor is the support and supervision of the promoters to allow them to continue their work. This has been the sole responsibility of the MOH since September 1, 1991. The local MOH office in each district believes that they have adequate staff to continue working with the promoters. In fact, the staff feel that the promoters help them to perform their duties more effectively and efficiently thus saving staff time.

[The promoters] help us greatly with home visits and with translation. [Angelina Ramos, Auxiliary Nurse, Cabrican, Quetzaltenango]

[The promoters] collaborate directly with the health post. They bring sick children directly to the post. [Beser De Leon, Auxiliary Nurse, Cabrican, Quetzaltenango]

However, the MOH staff can expect little financial or material support from the central MOH. (See B.4., comments made by Dr. Chinchilla)

Personnel is the only resource that we have. [Dr. Arnaldo Sun, District Health Chief, Cabrican, Quetzaltenango]

We have the desire and the human resources to supervise the promoters, but we do not have the gas. [Sanitation Inspector, El Palmar, Quetzaltenango]

D.5. As mentioned above, lack of logistic and material support may limit the ability of local MOH personnel to support and supervise the promoters. However, it should be noted that this problem is not unique to the project activities. The local MOH staff do not have logistic or material support for many of their assigned duties. Still, they somehow manage to get things done, though not at the level at which they could perform with more support. To fill those gaps in the MOH system, the project attempted to assure a continuous supply of ORS packets to the promoters, as well as acetaminophen and vegetable seeds when they were available. These simple materials are quite important to the promoters, although they were never a major focus of the project. These materials are not likely to be supplied as regularly by the MOH.

It will be difficult without the material support which HOPE has provided. What will we give a child who needs acetaminophen when we have none? But we will continue our work. [Edna Vin, a project-trained promoter and midwife in El Palmar.]

The contact will be less. Promoters will have to come to the health post or center for supervision. [Sanitation Inspector, El Palmar, Quetzaltenango]

Now, with the education we have, we continue, even though we have no medicines. [Jovita DeLeon Lopez, project-trained promoter, Durazno, Rio Blanco, San Marcos]

E. MONITORING AND EVALUATION OF SUSTAINABILITY

E.1. The indicators used by the project to track sustainability were the number of volunteers who were certified as MOH health promoters and the ability of the MOH to hire Project HOPE field staff.

E.2. The certification of over 700 volunteers as MOH health promoters dramatically improves their ability to continue the CS interventions under MOH supervision and provide services to their communities.

E.3. Both the midterm and final evaluation were conducted in coordination with the MOH at the local and departmental levels.

F. CALCULATION OF RECURRENT COSTS

F.1. The Financial Pipeline includes a chart comparing the projected DIP budget to the final expenditures. As can be seen, the line items of the A.I.D. portion of the project budget are close to the expected expenditures. Additional project expenditures were assumed by Project HOPE, and the budget

variance is much more significant in the Foundation's budget. Additional expenditures in the category of Procurement and Other Program Costs are mainly due to the fact that the project trained and supervised almost twice as many volunteers as originally anticipated. The changes in the Indirect Cost category are related to changes in Foundation practice of charging overhead.

F.2. The recurrent costs of the promoters teaching families in their communities are very difficult to calculate. These costs are not expected to change significantly. However, the promoters will have less material support.

Project HOPE's recurrent costs for the support and supervision of the promoters are:

Field and Staff Salaries	Q 8,455	or \$1,691 per month
Travel Expenses	Q 5,000	or \$1,000 per month
Gasoline	Q 4,000	or \$ 800 per month
Vehicle Parts and Maintenance	Q 2,500	or \$ 500 per month
TOTAL	Q19,955	or \$2,991 per month

F.3. Recurrent costs were calculated based on the average recurring project expenditures for the last three months of the project. These costs do not include the costs of replacing promoters lost through attrition.

F.4. The amount of money necessary to sustain project activities is listed above. Considering the estimated population in the project area is 30,000 families, the average cost per family benefitted is only about Q8 per year, or \$1.60 per year.

F.5. As mentioned above, the costs born by the volunteers will not change substantially, and it is expected that most volunteers will continue to work given these costs. The MOH has stated unequivocally that it cannot assume responsibility for any other costs.

Therefore, none of the above costs will be covered.

G. COST RECOVERY ATTEMPTS

G.1. In the final year of the project, when a field staff terminated employment, no new staff member was hired. Rather the MOH counterpart, working in the same municipality, was given the logistic support necessary to perform the supervision duties of the individual leaving. This saved staff salaries and prepared the MOH counterparts to assume those duties which they would have to assume at the end of the project funding.

G.2.-6. No other cost-recovery mechanisms were implemented.

H. INCOME GENERATION

H.1.-4. The project did not implement any income generating activities.

**APPENDIX A
FINAL SURVEY**

FINAL EVALUATION SURVEY
PROJECT HOPE CHILD SURVIVAL PROGRAM
DEPARTMENTS OF SAN MARCOS AND QUETZALTENANGO, GUATEMALA

Purpose of the Survey:

This survey was performed in order to evaluate the impact of Project HOPE's CSIV program on the knowledge, attitudes and practices of mothers in the project area. Specific attention was given to measuring achievement of project objectives.

Survey Dates:

The survey was conducted between May 1, 1991 to June 4, 1991.

Sampling Methodology:

A two-staged sampling procedure was used in the ten municipalities in which Project Hope has been working for the past three years. First a list of every community in the municipality was created including the number of households in that community and the cumulative number of households. This information was taken from the project information system and cross-checked with the projections of the National Institute of Statistics for 1991. Twenty communities were selected using the "Probability Proportionate to Size" sampling methodology. In this methodology the sum of all households in a municipality is divided by the number of clusters desired (M) to obtain a sampling interval K. A random number (R) less than K is selected by the computer and the location numbers are calculated as {R, R+K, R+2K, R+3K,R+M-1}. A cluster is assigned to each community in which the location number is included in the cumulative number of households (i.e. the number is greater than the cumulative number of households for the previous community on the list but less than or equal to the cumulative total for this community). More than one cluster can be assigned to a community and many communities are not assigned any cluster. Because the cluster size is 1 household, there is no design effect to this methodology. Each household in any given municipality has the same probability of being selected as any other household in that municipality.

This equal probability methodology is carried through to the second sampling stage, carried out at the community level. The number of households listed for a community is entered into a hand-held calculator which has a sampling program. The number of households to be sampled in that community is also entered.

The surveyor then passes each house entering the sequential number of the house (at the first house he enters 1, at the second house 2, etc). When the surveyor enters a number which the computer program has selected randomly, the computer advises the

surveyor that this house is to be sampled. This program was developed by Jorge Matute, a statistician at INCAP, who trained Project HOPE staff in its use.

The sampling methodology was designed to be flexible. The initial intended use was to assess progress toward objectives in each municipality. The analysis presented here is a summary of the information from all surveyed municipalities.

Surveyors:

The survey was completed by two Guatemalan physicians and one social worker who were contracted and trained specifically for this purpose in order to avoid the possible bias of having Project HOPE personnel evaluate the impact of their own efforts.

Survey Instrument:

The survey form was designed field-tested, and revised by Project HOPE Guatemala in accordance with the project objectives. The instrument was then field-tested and revised by the surveyors who had been trained in its use. The survey form is attached. The format of the survey was to ask open ended question and during the implementation code the answer according to pre-specified categories. The answers of the survey did not prompt the respondents to give specific answers.

Two problems were noted with the survey in its final form. First, it is very difficult for the mothers to give multiple responses to a single question. For example, if asked "What can you do to prevent your child from getting diarrhea?" a mother might respond "Wash your hands." It often took a good amount of probing to get the mother to give additional responses. "Is there anything else...?" or "What else could you do?" were used frequently. Second, most mothers had problems with the term dehydration, although they appeared to understand the concept. It was often necessary to explain the term after the mother had been recorded as failing to define it in order to complete the questions about dehydration that followed. Many times mothers knew how to prevent dehydration even though they were not familiar with the term itself.

Analysis of the Data:

The data was entered into computer, cleaned and verified thoroughly and analyzed using Epi Info, version 5.01. The analysis performed consisted of calculating frequencies of specific responses and the percent of respondents who gave a particular answer.

One of the objectives of the survey was to establish the coverage reached by the project i.e., what percent of the families in the

project area had been reached by a project-trained promoter? Of the 200 mothers interviewed 112 (56%) had been visited by a promoter. 96% of these mothers could give the promoter's name. Because the coverage was around 50% the data was well suited for comparing families who had been visited by a promoter to those who had not, although the small number of the sample only allowed detection of large differences.

Most of the tables which follow have data listed in several columns. The first column of each table lists the name of the variable in question; the second column lists the number and percent of all respondents who gave the specific desired answer; the third column lists the number and percent of respondents who have been visited by a promoter and gave the specific desired answer; the fourth column lists the number and percent of respondents who have not been visited by a promoter and gave the specific desired answer.

The fifth column compares the respondents visited by a promoter to those not visited. When there is a statistically significant difference, it is expressed as a relative ratio (RR), i.e. it compares the percent of respondents visited by a promoter and giving the desired answer to the percent of those not visited and giving the desired answer. As such, it represents an estimate of probability. For example, if the RR is 1.2, a promoter-visited mother was 20% more likely to give a particular response than a mother who was not visited. If the RR is 2.0, a promoter-visited mother was twice as likely (100% more likely) to give a particular response than a mother who was not visited. A RR of 1.0 indicates that promoter visited and not visited mothers were equally likely to give the indicated response. A RR of less than 1.0 would indicate that mothers who had not been visited were more likely to give that response. If no statistically significant difference was found, "NSSD" is listed to indicate "No Statistically Significant Differences."

In addition to the RR a p value was calculated. The p value gives the probability that the difference which is seen between the two groups occurred by chance. For example, if $p=.05$, a difference as great or greater than that listed might occur 5 times in 100 solely by chance. P values of .05 or less are considered scientifically significant. Any RR which has a P value of < 0.10 is listed in the charts. Also listed are the 95% confidence intervals for the RR.

For some variables such as vaccines there were not sufficient respondents in the particular age groups to allow such comparisons to be made so none are listed in the tables.

Key Findings

TABLE I DEMOGRAPHIC VARIABLES

The educational level of the mothers interviewed is quite low, with 47% reporting no formal education.

Most (71%) mothers consider Spanish their first language, and all but 6% report that they speak Spanish.

There were 328 children under five in the 200 households surveyed, giving an average of 1.64 children under five per household. This is comparable to previous studies in the area.

It is important to note that none of these variables show a significant difference between the visited and not visited groups. This means that differences between these two groups on the impact variables are not a result of different levels of education or language differences.

TABLE II. CHILDREN UNDER 5 YEARS OLD WITH REPORTED DIARRHEA DURING THE TWO WEEKS PRIOR TO SURVEY

Of the 328 children in the households surveyed 85 (43%) were reported to have had diarrhea during the two weeks prior to the survey. There was no difference in the occurrence of diarrhea between the visited and not visited groups.

Of the mothers of children who had diarrhea, 37 (50%) reported using ORS from a packet to treat it. This meets the specific project objective for Oral Rehydration Therapy. The mothers in the visited group were three times more likely to have used ORS packets than those in the group not visited. This suggests that much of the difference between the 15% ORS usage rate reported in the baseline survey and the 50% reported here is as a result of project interventions. The group of mothers not visited has an ORS usage rate of only 23%. This is not substantially different from the baseline rate. However, the visited group has a usage rate of 70%.

TABLE III: PREPARATION AND USE OF ORS BY MOTHERS WHO TREATED THEIR CHILDREN WITH ORT

When mothers who had used ORS were questioned about how they had prepared it 32 (86%) listed all three required steps. The visited group appeared somewhat more likely to list all three steps, but the small number of women in these groups makes confident comparison difficult.

When questioned about the use of ORT almost all mothers listed the necessity to give it frequently but very few listed the need

to dispose of the ORS after 24 Hours.

TABLE IV. REASONS FOR NOT USING ORS AMONG MOTHERS WHO DID NOT TREAT THEIR CHILD WITH ORT

Mothers who had not used ORS, gave three principal reasons. Only one of the promoter-visited mothers repeated she did not know how to prepare ORT.

TABLE V. GENERAL KNOWLEDGE OF ORAL REHYDRATION THERAPY OF ALL MOTHERS SURVEYED

All mothers were tested on their general knowledge of ORS. Although the visited group was more likely to give the correct response that ORT is intended to replace fluids, they also appeared somewhat more likely to incorrectly answer that ORT cures diarrhea.

Mothers in the visited group were six times more likely to report that ORS had been recommended to them by the promoter.

Although there are other opportunities for contact with the promoter (going to the promoter's house for help or attending a promoters meeting), the home visit is obviously the key intervention of the promoter.

Mothers in the visited group were more than 15 times less likely to report that ORS had never been recommended to them. Although the confidence interval is quite wide, most conservatively, the visited mothers were at least two times less likely to give this answer.

Mothers in the visited group were eight times more likely to report that the promoter had taught them to prepare ORS.

60% more mothers in the visited group knew how to prepare ORS.

TABLE VI. PRACTICAL TEST OF ORS PREPARATION OF ORS FOR MOTHERS WHO SAID THEY CAN PREPARE ORS

A practical test of ORS preparation was performed with the 162 mothers who said they knew how to prepare it. The preparation of ORS was observed by the surveyor and the volume of water used was measured using a graduated plastic container. Although 84% of mothers prepared the ORS correctly, 13% used inadequate volume. Over 70% of the inadequate volumes came from mothers who used a glass, or an unknown or miscellaneous container to measure the water.

The most precise container used was the Project HOPE distributed plastic liter bottle. All ORS prepared with this container had the correct volume. Of the mothers surveyed, 27 (14%) had a Project HOPE container in their house. It is interesting to note that eight of these mothers were among the group who reported not having been visited by the promoter. (Some liter bottles were distributed through health posts.)

Soda bottles, beer or liquor bottles, and other bottles with a liter marking also were accurate measuring devices for preparing ORS. Pitchers and jars were intermediate in accuracy.

TABLE VII. KNOWLEDGE OF DIARRHEA PREVENTION METHODS OF ALL MOTHERS SURVEYED

Mothers in the visited group were ten times more likely to report that the promoter had taught them about diarrhea prevention.

Most mothers could list at least three means of preventing diarrhea. Very few mothers listed breast feeding as a method to prevent diarrhea, although this was a message which the project attempted to deliver.

Also, very few mothers could list indications for taking a child with diarrhea to the health post although this was a message which the project attempted to deliver.

TABLE VIII. GENERAL KNOWLEDGE OF DEHYDRATION CONCEPTS ALL MOTHERS SURVEYED

Mothers in the visited group were more than five times more likely to report that the promoter had taught them about dehydration.

Few mothers could adequately define dehydration.

Almost all mothers knew that diarrhea was a cause of dehydration. More mothers in the visited group also listed vomiting than those in the not visited group.

Most mothers could list at least three symptoms of dehydration. Mothers in the visited group were more likely than those not visited to list 4 or more symptoms or 5 or more symptoms.

TABLE IX. KNOWLEDGE OF DEHYDRATION PREVENTION AND TREATMENT METHODS OF ALL MOTHERS SURVEYED

71% of all mothers knew that ORS should be used to prevent dehydration. Visited mothers were 50% more likely than not visited mother to give this response.

Very few mothers could list indications for taking a child with dehydration to the Health Post although this was a message which the project attempted to deliver.

TABLE X. GENERAL VACCINE KNOWLEDGE OF ALL MOTHERS SURVEYED

Mothers in the visited group were almost seven times more likely to report that the promoter had taught them about the importance of vaccination.

Almost all mothers correctly responded that vaccines prevent disease.

78% of mothers could list three or more diseases preventable by vaccines.

Mothers in the visited group were more likely to know that only one dose of measles is required. Most mothers did not score very well on the number of doses necessary for the various vaccines.

Only 37% of mothers responded that a child should have all his shots by one year of age.

TABLE XI. VACCINE COVERAGE IN CHILDREN 12 TO 23 MONTHS OLD

The estimates of the vaccine coverage rate estimates for children 12 to 23 months exceed the project objective. The exception is Polio3, for which coverage rates to be obtained had been increased to 90% at the request of the Ministry of Health during the course of the project. An estimated 89% coverage was achieved for Polio3.

Most of the coverage rates for each disease listed was confirmed by the child's immunization pass.

With the exception of BCG, the confidence intervals are fairly small. Several of the vaccines exceed target coverage even at the lower limit of the confidence interval.

TABLE XII. VACCINE COVERAGE OF THE MOTHERS SURVEYED

Two dose coverage with tetanus toxoid is estimated at 59%. The lower limit of the 95% confidence interval is 52% which is above the 50% objective set by the project. Documentation of two dose vaccination was provided by 32% of mothers surveyed. There may be a slight selection bias in this estimate. Only mothers were surveyed, therefore this estimate may not accurately represent all women of fertile age between the ages of 15 and 49 years old.

TABLE XIV. GENERAL KNOWLEDGE OF HYGIENE OF ALL MOTHERS SURVEYED

Mothers in the visited group were five and a half times more likely to report that the promoter had taught them about basic hygiene. They were no more likely to list any specific hygiene measure.

TABLE XV. GENERAL NUTRITION KNOWLEDGE OF ALL MOTHERS SURVEYED

Mothers in the visited group were five and a half times more likely to report that the promoter had taught them about basic nutrition. They were no more likely to list any specific keys to good nutrition.

TABLE I
DEMOGRAPHIC VARIABLES

DEMOGRAPHIC VARIABLES	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO
	NO.	%	NO	%	NO	%	
EDUCATION (YEARS)							
NONE	94	47%	49	44%	45	51%	NSSD
1 TO 3	58	29%	37	33%	21	24%	NSSD
4 TO 6	39	20%	23	21%	16	18%	NSSD
7 TO 9	4	2%	1	1%	3	3%	NSSD
10 OR >	5	3%	2	2%	3	3%	NSSD
TOTAL	200	100%	112	100%	88	100%	
LANGUAGE							
SPANISH ONLY	141	71%	78	70%	63	72%	NSSD
SPANISH + MAM	41	21%	22	20%	19	22%	NSSD
SPANISH +QUICHE	7	4%	3	3%	4	5%	NSSD
MAM ONLY	11	6%	9	8%	2	2%	NSSD
TOTAL	200	100%	112	100%	88	100%	
CHILDREN < 5Y	328		191		137		
CHILDREN < 5Y PER HOUSEHOLD		1.64		1.71		1.56	NSSD

20

TABLE II
CHILDREN UNDER 5 YEARS OLD WITH
REPORTED DIARRHEA DURING THE
TWO WEEKS PRIOR TO SURVEY

CHILDREN <5Y WITH DIARRHEA IN THE PREVIOUS 2 WEEKS*	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
# OF CHILDREN	85	43%	52	46%	33	38%	NSSD
TREATMENTS**							
HOME ORS	7	9%	3	7%	4	13%	NSSD
INCREASED FLUID	48	65%	29	67%	19	61%	NSSD
PACKET ORS	37	50%	30	70%	7	23%	3.09 P=.00006 1.6<RR<6.1

TABLE III
PREPARATION AND USE OF ORT BY
MOTHERS WHO TREATED THEIR CHILDREN WITH ORS

MOTHERS OF CHILD WITH DIARRHEA WHO USED ORS PACKETS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
ORS PREPARATION							
BOILED WATER	37	100%	30	100%	7	100%	NSSD
USED 1 LITER	32	86%	27	90%	5	71%	1.3 P=0.10 0.8<RR<2.1
ENTIRE PACKET	37	100%	30	100%	7	100%	NSSD
DID ALL THREE	32	86%	27	90%	5	71%	1.3 P=0.10 0.8<RR<2.1
USE OF ORS							
GAVE FREQUENTLY	34	92%	27	90%	7	100%	NSSD
USED ONLY 24HRS	4	11%	3	10%	1	14%	NSSD

TABLE IV
REASONS FOR NOT USING ORS AMONG MOTHERS
WHO DID NOT TREAT THEIR CHILD WITH ORT

REASONS FOR NOT USING ORS THOSE WHO DID NOT	TOTAL WHO DID NOT USE ORS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
NEVER HEARD OF IT	6	16%	1	8%	5	21%	NSSD
DID NOT HAVE ANY	23	62%	7	58%	16	67%	NSSD
DO NOT KNOW HOW	10	27%	1	8%	9	38%	1.5 P=0.07 1.03<RR<2.1

TABLE V
GENERAL KNOWLEDGE OF ORAL REHYDRATION
THERAPY OF ALL MOTHERS SURVEYED

GENERAL KNOWLEDGE OF ORT ALL MOTHERS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
PURPOSE OF ORT							
CURE DIARRHEA	86	43%	54	48%	32	36%	1.37 P=.06 .98<RR<1.91
REPLACE FLUIDS	100	50%	65	58%	35	40%	1.58 P=.001 1.1<RR<2.1
NUTRITIONAL	27	14%	15	13%	12	14%	NSSD
ORT RECOMMENDED BY							
PROMOTER	108	54%	96	86%	12	14%	6.3 P<0.000 3.7<RR<10.7
HEALTH POST	95	48%	53	47%	42	48%	NSSD
DOCTOR OR NURSE	27	14%	11	10%	16	18%	NSSD
NEVER RECOMMENDED	15	8%	1	1%	14	16%	15.8 P<.000 2<RR<117
PROMOTER TAUGHT ORT PREPARATION	105	53%	96	86%	9	10%	8.4 P<0.000 4.5<RR<15
KNOW HOW TO PREPARE ORS	162	81%	108	96%	54	61%	1.6 P<0.000 1.3<RR<1.86

TABLE VI
PRACTICAL TEST OF ORS PREPARATION OF ORS
FOR MOTHERS WHO SAID THEY CAN PREPARE ORS

PRACTICAL TEST OF ORS PREPARATION THOSE WHO KNOW HOW TO PREPARE	PREPARED ORS RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
DISSOLVED WELL	158	99%	106	100%	52	96%	NSSD
ENTIRE PACKET	159	99%	105	99%	54	100%	NSSD
VOLUME							
< 850 CC	21	13%	12	11%	9	17%	NSSD
850 TO 1150 CC	137	86%	92	87%	45	83%	NSSD
> 1150 C	4	3%	4	4%	0	0%	NSSD
ALL CORRECT	135	84%	92	87%	43	80%	NSSD

- 23

TABLE VII
KNOWLEDGE OF DIARRHEA PREVENTION METHODS
OF ALL MOTHERS SURVEYED

DIARRHEA PREVENTION ALL RESPONDENTS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
PROMOTER TAUGHT	99	50%	92	82%	7	8%	10.3 P<.000 5.1<RR<21.1
DEFINE DIARRHEA	181	91%	98	88%	83	94%	NSSD
PREVENTION MEASURES							
WASH HANDS	182	91%	103	92%	79	90%	NSSD
WASH FRUIT	164	82%	94	84%	70	80%	NSSD
USE LATRINE	56	28%	39	35%	17	19%	2.0 P=.002 1.3<RR<3.3
BOIL WATER	153	77%	83	74%	70	80%	NSSD
COVER FOOD	91	46%	56	50%	35	40%	1.4 P=.038 1.01<RR<1.4
COOK FOOD WELL	101	51%	57	51%	44	50%	NSSD
BREAST FEED 2 YEARS	1	1%	1	1%	0	0%	NSSD
ONLY BREAST MILK FIRST 6 MONTHS	3	2%	2	2%	1	1%	NSSD
LISTS 3 OR >	172	86%	99	88%	73	83%	NSSD
LISTS 4 OR >	137	69%	82	73%	55	63%	NSSD
LISTS 5 OR >	54	27%	36	32%	18	20%	1.6 P=.07 .96<RR<2.57
WHEN TO TAKE A CHILD WITH DIARRHEA TO THE HEALTH POST							
BLOOD IN STOOL	5	3%	3	3%	3	3%	NSSD
HIGH FEVER	52	26%	32	29%	20	23%	NSSD
ABDOMINAL PAIN	9	5%	6	5%	3	3%	NSSD
WORMS	9	5%	7	6%	2	2%	NSSD

24

TABLE VIII
GENERAL KNOWLEDGE OF DEHYDRATION CONCEPTS
OF ALL MOTHERS SURVEYED

DEHYDRATION KNOWLEDGE ALL RESPONDENTS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
PROMOTER TAUGHT	59	30%	52	46%	7	8%	5.8 P<.0000 2.8<RR<12.1
DEFINE DEHYDRATED	74	37%	46	41%	28	32%	NSSD
CAUSES OF DEHYDRATION							
DIARRHEA	180	90%	103	92%	77	88%	NSSD
VOMITING	100	50%	63	56%	37	42%	1.5 P=.009 1.1<RR<1.9
FEVER	52	26%	32	29%	20	23%	NSSD
SYMPTOMS OF DEHYDRATION							
NO TEARS	18	9%	13	12%	5	6%	2.36 P=.08 .9<RR<6.4
SUNKEN FONTANEL	38	19%	25	22%	13	15%	1.7 P=.08 .9<RR<3.1
DRY MOUTH	163	82%	89	79%	74	84%	NSSD
SUNKEN EYES	135	68%	72	64%	63	72%	NSSD
DRY SKIN	73	37%	44	39%	29	33%	NSSD
LITTLE URINE	4	2%	4	4%	0	0%	UNABLE TO CALCULATE
WEAKNESS	124	62%	80	71%	44	50%	1.5 P=.0002 1.2<RR<1.9
LISTS 3 OR >	127	64%	72	64%	55	63%	NSSD
LISTS 4 OR >	57	29%	39	35%	18	20%	1.7 P=.03 1.1<RR<2.8
LISTS 5 OR >	21	11%	18	16%	3	3%	4.7 P=.004 1.4<RR<15.5

TABLE IX
 KNOWLEDGE OF DEHYDRATION PREVENTION AND TREATMENT
 METHODS OF ALL MOTHERS SURVEYED

DEHYDRATION PREVENTION ALL RESPONDENTS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
HOW TO PREVENT OR TREAT DEHYDRATION							
GIVE FLUIDS	37	19%	25	22%	12	14%	1.8 P=.06 .96<RR<3.4
ORS FROM PACKET	141	71%	92	82%	49	56%	1.5 P<.0000 1.3<RR<9.6
HOMEMADE ORS	21	11%	13	12%	7	8%	NSSD
WHEN TO TAKE A CHILD WITH DEHYDRATION TO THE HEALTH POST							
MUCH VOMITING	30	15%	20	18%	10	11%	NSSD
VERY DEHYDRATED	56	28%	30	27%	26	30%	NSSD
UNCONSCIOUS	2	1%	2	2%	0	0%	UNABLE TO CALCULATE
NOT IMPROVED IN 2 DAYS	74	37%	43	38%	31	35%	NSSD

26

TABLE X
GENERAL VACCINE KNOWLEDGE OF ALL MOTHERS SURVEYED

VACCINE KNOWLEDGE ALL RESPONDENTS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
PROMOTER TAUGHT	106	53%	95	85%	11	13%	6.9 P<.0000 4.0<RR<12.0 NSSD
PURPOSE OF VACCINES	191	96%	109	97%	82	93%	
WHICH DISEASES CAN BE PREVENTED							
MEASLES	189	95%	109	97%	80	91%	1.07 P=.05 1.0<RR<1.15 NSSD
POLIO	148	74%	85	76%	63	72%	NSSD
DIPHTHERIA	14	7%	10	9%	4	5%	NSSD
TETANUS	97	49%	57	51%	40	45%	NSSD
PERTUSSIS	157	79%	88	79%	69	78%	NSSD
TUBERCULOSIS	77	39%	48	43%	29	33%	1.4 P=.06 .98<RR<2.0
LISTS 3 OR >	155	78%	92	82%	63	72%	1.2 P=.08 .98<RR<1.3
LISTS 4 OR >	100	50%	61	54%	39	44%	NSSD
LISTS 5 OR >	33	17%	20	18%	13	15%	NSSD
VACCINE FOR WOMEN							
TETANUS TOXOID	131	66%					
HOW MANY DOSES							
MEASLES (=1)	118	59%	76	68%	42	48%	1.4 P=.004 1.1<RR<1.8
DPT (=3)	76	38%	48	43%	28	32%	NSSD
POLIO (=3)	59	30%	37	33%	22	25%	NSSD
BCG (=1)	141	71%	83	74%	58	66%	NSSD
TT (=2 OR 3)	128	64%					
BY WHAT AGE (1YR)	74	37%	49	44%	25	28%	1.5 P=.03 1.04<RR<2.3

27

TABLE XI
VACCINE COVERAGE IN
CHILDREN 12 TO 23 MONTHS OLD

VACCINE COVERAGE N=61 CHILDREN 12 TO 23 MONTHS	TOTAL COVERAGE		CONFIRMED BY CARD		REPORTED BY MOTHER		95 % CONF INTERVAL FOR TOTAL
	NO.	%	NO	%	NO	%	
BCG	43	70%	21	34%	22	36%	58% TO 82%
DPT1	57	93%	35	57%	22	36%	87% TO 99%
DPT3	52	85%	28	46%	24	39%	76% TO 94%
POLIO1	58	95%	36	59%	22	36%	89% TO 100%
POLIO3	54	89%	30	49%	24	39%	81% TO 97%
MEASLES	54	89%	31	51%	23	38%	81% TO 97%

TABLE XII
VACCINE COVERAGE
OF THE MOTHERS SURVEYED

VACCINE COVERAGE N=201 WOMEN 15 TO 49 YEARS	TOTAL COVERAGE		CONFIRMED BY CARD		REPORTED BY MOTHER		95 % CONF INTERVAL FOR TOTAL
	NO.	%	NO	%	NO	%	
TT1	137	68%	72	36%	65	32%	62% TO 74%
TT2	118	59%	65	32%	53	26%	52% TO 66%
TT3	84	42%	47	23%	37	18%	35% TO 49%

23

TABLE XIV
GENERAL KNOWLEDGE OF HYGIENE
ALL MOTHERS SURVEYED

HYGIENE KNOWLEDGE ALL RESPONDENTS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
PROMOTER TAUGHT	99	52%	87	80%	12	15%	5.5 P<.0000 3.2<RR<9.3
HAVE A LATRINE	151	79%	84	77%	67	82%	NSSD
USE A LATRINE	164	86%	93	85%	71	87%	NSSD
ANIMALS OUTSIDE	121	63%	70	64%	51	62%	NSSD
WASTE DISPOSAL	158	83%	97	89%	61	74%	1.2 P= .01 1.04<RR<1.3
COVER FOOD	144	75%	83	76%	61	74%	NSSD
AVOID FLIES	102	53%	53	49%	49	60%	NSSD

TABLE XV
GENERAL NUTRITION KNOWLEDGE
ALL MOTHERS SURVEYED

NUTRITION KNOWLEDGE ALL RESPONDENTS	TOTAL RESPONDENTS		VISITED BY PROMOTER		NOT VISITED BY PROMOTER		RELATIVE RATIO AND 95% CI
	NO.	%	NO	%	NO	%	
PROMOTER TAUGHT	70	35%	59	53%	11	13%	5.5 P<.0000 3.2<RR<9.3
BREAST FEEDING							
FROM BIRTH	140	70%	79	71%	61	69%	NSSD
AT LEAST 2 YRS	80	40%	40	36%	40	45%	NSSD
BEGIN SOLID FOODS AT 4 TO 6 MONTHS	112	56%	66	59%	46	52%	NSSD
HAVE A GARDEN	35	18%	16	15%	19	23%	NSSD

29

**APPENDIX B
FINANCIAL PIPELINE**

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
PVO/COUNTRY PROJECT: GUATEMALA CHILD SURVIVAL

Page 1 of 3

HEADQUARTERS COST ELEMENTS	Actual Expenditures To Date (09/01/88 to 08/31/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (09/01/88 to 08/31/91)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies/Equipment	0	0	0	0	0	0	0	0	0
B. Consultants									
Local & Expatriate	0	0	0	0	0	0	0	0	0
SUB-TOTAL I	0	0	0	0	0	0	0	0	0
II. EVALUATION/SUB-TOTAL II	3,000	2,632	5,632	0	2,000	2,000	3,000	4,632	7,632
III. INDIRECT COSTS									
Overhead on HQ/HO & Overhead/PM-Field	83,252	95,622	178,874	0	1,100	1,100	83,252	96,722	179,974
SUB-TOTAL III	83,252	95,622	178,874	0	1,100	1,100	83,252	96,722	179,974
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
Technical, Admin. & Support	130,868	75,027	205,895	0	2,000	2,000	130,868	77,027	207,895
B. Travel/Per Diems									
In-country & International	7,940	369	8,309	0	0	0	7,940	369	8,309
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	21,252	868	22,120	0	300	300	21,252	1,168	22,420
SUB-TOTAL IV	160,060	76,264	236,324	0	2,300	2,300	160,060	78,564	238,624
TOTAL HEADQUARTERS	246,312	174,518	420,830	0	5,400	5,400	246,312	179,918	426,230

11/27/91
8:18

31

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
PVO/COUNTRY PROJECT: GUATEMALA CHILD SURVIVAL

Page 2 of 3

FIELD	Actual Expenditures To Date (09/01/88 to 08/31/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (09/01/88 to 08/31/91)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
COST ELEMENTS	---	---	---	---	---	---	---	---	---
I. PROCUREMENT									
A. Supplies/Equipment	0	92,910	92,910	0	0	0	0	92,910	92,910
B. Consultants									
Local & Expatriate	4,620	6,051	10,671	0	0	0	4,620	6,051	10,671
	-----	-----	-----	-----	-----	-----	-----	-----	-----
SUB-TOTAL I	4,620	98,961	103,581	0	0	0	4,620	98,961	103,581
	-----	-----	-----	-----	-----	-----	-----	-----	-----
II. EVALUATION/SUB-TOTAL II	0	0	0	0	0	0	0	0	0
	-----	-----	-----	-----	-----	-----	-----	-----	-----
III. INDIRECT COSTS									
Overhead/G&A-Field	44,663	2,157	46,820	0	0	0	44,663	2,157	46,820
	-----	-----	-----	-----	-----	-----	-----	-----	-----
SUB-TOTAL III	44,663	2,157	46,820	0	0	0	44,663	2,157	46,820
	-----	-----	-----	-----	-----	-----	-----	-----	-----
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
Technical, Admin. & Support	166,591	6,497	173,088	0	0	0	166,591	6,497	173,088
B. Travel/Per Diems									
In-country & International	30,218	67,469	97,687	0	0	0	30,218	67,469	97,687
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	107,596	16,970	124,566	0	0	0	107,596	16,970	124,566
	-----	-----	-----	-----	-----	-----	-----	-----	-----
SUB-TOTAL IV	304,405	90,936	395,341	0	0	0	304,405	90,936	395,341
	-----	-----	-----	-----	-----	-----	-----	-----	-----
TOTAL FIELD	353,688	192,054	545,742	0	0	0	353,688	192,054	545,742
	=====	=====	=====	=====	=====	=====	=====	=====	=====

1/27/91
:19

32

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
PVO/COUNTRY PROJECT: GUATEMALA CHILD SURVIVAL

TOTAL - FIELD & HEADQUARTERS

	Actual Expenditures To Date (09/01/88 to 08/31/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (09/01/88 to 08/31/91)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
TOTAL HEADQUARTERS	246,312	174,518	420,830	0	5,400	5,400	246,312	179,918	426,230
TOTAL FIELD	353,688	192,054	545,742	0	0	0	353,688	192,054	545,742
TOTAL	600,000	366,572	966,572	0	5,400	5,400	600,000	371,972	971,972

11/27/91
8:20

231

GUATEMALA-CHILD SURVIVAL (OLD COOPERATIVE AGREEMENT)
 COMPARISON OF DIP BUDGET TO PIPELINE BUDGET
 GRANT DATES: 09/01/88 to 08/31/91

BUDGET CATEGORIES	AID DIP	AID PIPELINE	VARIANCE
I. PROCUREMENT	0	4,620	4,620
II. EVALUATION	5,200	3,000	(2,200)
III. INDIRECT	139,204	127,915	(11,289)
IV. OTHER PROG COSTS	455,596	464,465	8,869
TOTAL	600,000	600,000	0

BUDGET CATEGORIES	PVO DIP	PVO PIPELINE	VARIANCE
I. PROCUREMENT	69,600	98,961	29,361
II. EVALUATION	7,290	4,632	(2,658)
III. INDIRECT	40,132	98,879	58,747
IV. OTHER PROG COSTS	82,978	169,500	86,522
TOTAL	200,000	371,972	171,972

NOTE: (UNDER) = under spent in regards to AID/PVO DIP budget

11/27/91

8:40

24

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
PVO/COUNTRY PROJECT: GUATEMALA CHILD SURVIVAL

Page 1 of 3

HEADQUARTERS COST ELEMENTS	Actual Expenditures To Date (09/01/88 to 08/31/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (09/01/88 to 08/31/91)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies/Equipment	0	0	0	0	0	0	0	0	0
B. Consultants									
Local & Expatriate	0	0	0	0	0	0	0	0	0
SUB-TOTAL I	0	0	0	0	0	0	0	0	0
II. EVALUATION/SUB-TOTAL II	3,000	2,632	5,632	0	2,000	2,000	3,000	4,632	7,632
III. INDIRECT COSTS									
Overhead on HQ/HO & Overhead/PM-Field	83,252	95,622	178,874	0	1,100	1,100	83,252	96,722	179,974
SUB-TOTAL III	83,252	95,622	178,874	0	1,100	1,100	83,252	96,722	179,974
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
Technical, Admin. & Support	130,868	75,027	205,895	0	2,000	2,000	130,868	77,027	207,895
B. Travel/Per Diems									
In-country & International	7,940	369	8,309	0	0	0	7,940	369	8,309
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	21,252	868	22,120	0	300	300	21,252	1,168	22,420
SUB-TOTAL IV	160,060	76,264	236,324	0	2,300	2,300	160,060	78,564	238,624
TOTAL HEADQUARTERS	246,312	174,518	420,830	0	5,400	5,400	246,312	179,918	426,230

11/27/91
8:18

45

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
PVO/COUNTRY PROJECT: GUATEMALA CHILD SURVIVAL

Page 2 of 3

FIELD	Actual Expenditures To Date (09/01/88 to 08/31/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (09/01/88 to 08/31/91)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
COST ELEMENTS	---	---	---	---	---	---	---	---	---
I. PROCUREMENT									
A. Supplies/Equipment	0	92,910	92,910	0	0	0	0	92,910	92,910
B. Consultants									
Local & Expatriate	4,620	6,051	10,671	0	0	0	4,620	6,051	10,671
SUB-TOTAL I	4,620	98,961	103,581	0	0	0	4,620	98,961	103,581
II. EVALUATION/SUB-TOTAL II	0	0	0	0	0	0	0	0	0
III. INDIRECT COSTS									
Overhead/G&A-Field	44,663	2,157	46,820	0	0	0	44,663	2,157	46,820
SUB-TOTAL III	44,663	2,157	46,820	0	0	0	44,663	2,157	46,820
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
Technical, Admin. & Support	166,591	6,497	173,088	0	0	0	166,591	6,497	173,088
B. Travel/Per Diems									
In-country & International	30,218	67,469	97,687	0	0	0	30,218	67,469	97,687
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	107,596	16,970	124,566	0	0	0	107,596	16,970	124,566
SUB-TOTAL IV	304,405	90,936	395,341	0	0	0	304,405	90,936	395,341
TOTAL FIELD	353,688	192,054	545,742	0	0	0	353,688	192,054	545,742

11/27/91
8:19

26'

1991 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
 PVO/COUNTRY PROJECT: GUATEMALA CHILD SURVIVAL

TOTAL - FIELD & HEADQUARTERS

	Actual Expenditures To Date (09/01/88 to 08/31/91)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (09/01/88 to 08/31/91)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
TOTAL HEADQUARTERS	246,312	174,518	420,830	0	5,400	5,400	246,312	179,918	426,230
TOTAL FIELD	353,688	192,054	545,742	0	0	0	353,688	192,054	545,742
TOTAL	600,000	366,572	966,572	0	5,400	5,400	600,000	371,972	971,972

11/27/91
8:20

31

GUATEMALA-CHILD SURVIVAL (OLD COOPERATIVE AGREEMENT)
 COMPARISON OF DIP BUDGET TO PIPELINE BUDGET
 GRANT DATES: 09/01/88 to 08/31/91

BUDGET CATAGORIES	AID DIP	AID PIPELINE	VARIANCE
I. PROCUREMENT	0	4,620	4,620
II. EVALUATION	5,200	3,000	(2,200)
III. INDIRECT	139,206	127,915	(11,289)
IV. OTHER PROG COSTS	455,596	466,465	8,869
TOTAL	600,000	600,000	0

BUDGET CATAGORIES	PVO DIP	PVO PIPELINE	VARIANCE
I. PROCUREMENT	69,600	98,961	29,361
II. EVALUATION	7,290	4,632	(2,658)
III. INDIRECT	40,132	98,879	58,747
IV. OTHER PROG COSTS	82,978	169,500	86,522
TOTAL	200,000	371,972	171,972

NOTE: (UNDER) = under spent in regards to AID/PVO DIP budget

11/27/91
 8:40

28