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**CHILD AND MATERNAL HEALTH IN THE DEPARTMENT OF TOTONICAPAN
DELIVERING ESSENTIAL HEALTH SERVICES
IN THE REMOTE AND CULTURALLY-ISOLATED GUATEMALA HIGHLANDS**

MID-TERM EVALUATION

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Submitted by:

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ACRONYMS

CS	Child Survival
DIGESA	Agricultural Extension Services, Ministry of Agriculture
DIP	Detailed Implementation Plan
HIS	Health Information System
INCAP	Institute for Nutrition of Central America and Panama
MOH	Ministry of Health
NGO	Non Governmental Organization
PVO	Private and Voluntary Organization
TBA	Traditional Birth Attendant

INTRODUCTION

This report contains the midterm evaluation of Project HOPE's CS-VI Vitamin A project. This project is located in the Departments of Quetzaltenango and San Marcos and targets municipalities with the greatest levels of Vitamin A deficiency based on the results of the project's baseline survey.

The evaluation covers project planning, implementation, and impact. With respect to planning, the structure of the project based on purpose, objectives, activities or interventions, and its strategies or methodologies were evaluated, as well as the consistency among the components of the structure. With respect to implementation, the degree of achievement of the objectives in quantity as well as quality was assessed. Finally, with respect to impact, the project outputs were assessed in relation to proposed objectives and indicators and the quantity and quality of activities.

The primary purpose of this evaluation is to provide feedback to Project HOPE and guidance in the adjustment and refinement of the project interventions.

The report takes into account the evaluation guidelines provided by HOPE Center and has structured the evaluation report as follows:

- I. EXECUTIVE SUMMARY
- II. ANALYSIS OF THE DEVELOPMENT OF THE DETAILED IMPLEMENTATION PLAN
- III. ACHIEVEMENTS
- IV. PROJECT IMPLEMENTATION
- V. SUSTAINABILITY
- VI. RECURRENT COSTS
- VII. RECOMMENDATIONS
- VIII. APPENDICES

I. EXECUTIVE SUMMARY

1. Evaluation Team

The evaluation team consisted of Dr. Marco Donis, external evaluator, and key staff of Project HOPE, Dr. Manglio Ruano, Interim Chief of Vitamin A, and Lic. Angela LuTena, representative for Project HOPE headquarters. In addition, Dr. Omar Dary, INCAP representative, participated in the two days of field visits to communities in San Marcos, and on alternating days each, Dr. Anabella Aragon, Epidemiologist of the San Marcos Health Area, and Dr. Manuel Gutierrez, Chief of the Health Area of San Marcos. The Health Area epidemiologist, Roberto López Ovando of the Health area of Quetzaltenango participated during the field visits to

communities in Quetzaltenango.

2. Schedule of Activities

Two days, review and discussion of documents (Detailed Implementation Plan, monthly and quarterly reports, VITAL evaluation report, and midterm evaluation guidelines). One day, development of the evaluation strategy, one day, information exchange about scientific approaches to evaluations and analysis of the goal and objectives of this evaluation with project staff. Five days, field visits. One day, discussion of the findings of the field visits, observations, and recommendations with all project staff. Six days, development of the general evaluation report and the organized analysis and representation of the collected information (information appearing in tables was provided by Project HOPE and the Ministry of Health at the request of the external evaluator who organized and displayed this information). Total number of days: fifteen days (three weeks).

3. Evaluation Design

Three basic aspects were considered: the development of the DIP, the process or implementation of the project, and its impact or outputs. The instruments of evaluation were designed based on the DIP and the evaluation guidelines.

The methodology covers the study and analysis of the project documents and reports; the compiling of statistical data to confirm indicators/outputs that make it possible to evaluate the direction and implementation of the interventions and the impact; and the observation of project activities through interviews with project staff, counterparts, promoters, community leaders, and the communities themselves through field visits.

4. Results

The achievements are related to

- o The implementation of activities as a new strategy to reduce morbidity and mortality, demonstrated and proven through acceptance of the communities in changes in dietary habits and cultivation of foods rich in Vitamin A;
- o Significant coverage levels achieved in a short time in Vitamin A supplementation of children under six and the increasing supplementation of postpartum women through TBAs;
- o The project emphasis on the participation of women and community leadership in the implementation of the project are among those lessons-learned which today assures the sustainability of the project.

- o The increase in community demand for health services stimulated by the administration of Vitamin A supplements.

5. Recommendations

The project should address the following issues:

- o Identification and numbering of small villages in the high risk municipalities; reprogramming of activities and adjustment of objectives considering the available resources and taking into account the quantity, dispersity, and accessibility of the population; utilization of risk indicators by comparing social and health indicators for each municipality, as well as the results of the study of retinol levels and the food consumption survey;
- o Strengthening the coordination, the timely management of information, supervision, monitoring, and evaluation with the MOH in an integrated way; and
- o Given that the interventions address the problem well and have been proven to provide good results, the present limitation is the low coverage of a large target population, living in communities with limited access, due to the project's limited human resources. A reprogramming has to be suggested which encompasses -- externally -- increasing coverage levels through greater involvement of the counterparts and -- internally -- an increase in the human resources of the project.

II. ANALYSIS OF THE DETAILED IMPLEMENTATION PLAN (DIP)

1. Background

The departments where the Vitamin A activities are implemented can be described with basic health and development indicators from the CS-IV baseline survey implemented by Project HOPE and with information from other credible sources in the country. The CS-IV baseline survey noted that large segments of the population are using "panela" (molasses) rather than sugar fortified with Vitamin A. Not described are similar interventions or presently existing ones which might help in influencing the planning and implementation of the project with respect to a better targeting of the activities, budget adjustments, and coordination to achieve a better coverage and utilization of the resources. However, when taking into account other studies about Vitamin A deficiency in these departments, Project HOPE's experiences during the last ten years, and the present coordination with the MOH, INCAP, and other interested agencies is an important step toward reducing infant and child morbidity and mortality.

2. Target Population

Strengths

- The population at risk was determined at the municipal level using a survey of children's consumption of foods rich in Vitamin A. This survey was planned and implemented jointly by Project HOPE and INCAP at the municipal level with a study of children's serum retinol levels which is unique in the country, and information about the overall health situation, utilizing social and departmental health indicators.

Weaknesses

- The identification of high risk populations at the municipal level through national or departmental social and health indicators means that local and, therefore, different indicators are lost.

3. Geographical Area

Strengths

- At the request of the MOH, the project was located in the departments of Quetzaltenango and San Marcos, in health districts where a large percentage of children had serum retinol levels of less than 20 mcg/dl, based on information collected by Project HOPE in the baseline survey. Demographic information about this population was obtained from projections of the National Institute of Statistics.

Weaknesses

- The location, accessibility, and dispersion of the target population was not determined in the plan. Project HOPE does not know the exact number of communities per municipality and their subdivision into small villages and hamlets, which makes coverage difficult.

4. Objectives, Indicators, Activities, Strategies, and Methodologies

Strengths

- Overall, the methodology of implementing this project has been well described in each of the proposed activities. It is based on a prior study of health conditions with an emphasis on high risk groups and includes strategies which make its implementation easier.
- The objectives are derived from the baseline survey and

general complementary information about the nutritional status which results in a good implementation of this plan's goal of reducing the mortality and morbidity in children under six.

In the following sections, each of the project's objectives will be discussed.

A. Objective I. Health districts with high prevalence of Vitamin A deficiency in the Departments of San Marcos and Quetzaltenango are identified by April 1991.

Strengths

- To achieve this objective the project implemented a survey of consumption of foods rich in Vitamin A and measured serum retinol levels in children under six years of age, as part of the first phase of the project called "Needs Assessment."
- In order to coordinate activities with the MOH, the survey was implemented with the assistance of the MOH district staff.
- The procedures and strategies to achieve this objective are well described, emphasizing the involvement of local authorities and recognized traditional community leaders.
- The objective and proposed activities are clearly congruent.
- The communities at high risk were selected exclusively based on the results of the data collected, which took as an indicator a prevalence of more than 5% of children with Vitamin A deficiency (< 20 mcg/dl).

Weaknesses

- The results of the survey were not related to the socio-economic and health indicators of the population.

B. Objective II: At least five Vitamin A supplementation campaigns will be completed in the high-risk districts (one in Year 1 and two each in Years 2 and 3) reaching at least 75% of children age six months to six years.

Strengths

- To achieve this objective, the following main activity is proposed: Vitamin A supplementation campaigns with the necessary promotional activities, distribution of Vitamin A, and training of MOH staff in promotion, administration, and recording. This activity is part of the second phase called "Short-term Interventions," all of which are delineated in

the Detailed Implementation Plan.

- Strategies and procedures are developed, responsibilities assigned, and mechanisms of coordination established among Project HOPE, the MOH, and INCAP, based on mutual respect, an interest in maximizing available resources, and a desire of avoiding a duplication of efforts.
- The objective and proposed activities are clearly congruent.

Weaknesses

- The achievement of the coverage level of this objective is limited by the fact that the actual administration of the Vitamin A supplement is the responsibility of the MOH which overall has service delivery coverage levels of about 40%, with coverage levels during immunization campaigns vacillating between 30-40%. In addition, the geographical and cultural accessibility of these populations limit the effectiveness of promotional activities and social mobilization.
- With respect to evaluating this activity, the project proposed to conduct further studies of serum retinol levels to determine the appropriate intervals for supplementing the target population with Vitamin A. This strategy would increase the population's mistrust and non-acceptability of this intervention and is not essential because of available technical information.
- No evaluation of the process is planned to improve coverage levels during the supplementation campaigns.

C. Objective III: 80% of children with measles who are identified by the MOH will be treated with Vitamin A during the project.

Strengths

- The activities under this objective focus on the training of MOH staff in treatment, registration, and data collection related to the treatment of children with measles by MOH staff and the provision of Vitamin A to the health facilities in the high-risk municipalities. These activities are part of Phase II "Short-term Interventions."
- Training strategies were developed by Project HOPE and the MOH, including the development of a curriculum and guidelines for case management. Project HOPE was responsible for the training of MOH staff and the provision of Vitamin A.

- The objective and the proposed activities are clearly congruent.
- The evaluation of this activity is directed at the outputs using recording sheets and reports and at the process through a quarterly analysis of this information for decision-making.

Weaknesses

- The coverage level depends on the spontaneous demand of the population for health services. As a result the benchmark for this objective should be the meeting of 100% of the demand.

D. Objective IV: 30% of women who give birth in Year 2 and 60% of those who give birth in Year 3 will receive Vitamin A supplementation within one week of delivery.

Strengths

- The activities to achieve this objective target women during the immediate post-partum period. This activity is part of Phase II activities, "Short-term Interventions."
- Strategies and procedures include the development of a training curriculum for TBAs; the development of an HIS that utilizes a simple graphics reporting form to be completed by the TBAs; the provision of Vitamin A capsules to the MOH who in turn distributes the capsules to the TBAs through a monitoring system of minimal and maximal supplies to be managed by the TBAs; and supplementation of mothers immediately during the post-partum period by the TBAs, whose reports are compared to the entries in the civil registry to obtain an estimate of coverage.
- The evaluation of these activities is directed at the outputs (i.e., coverage levels) and at the process (i.e., implementation), allowing for adequate monitoring of these activities.

E. Objective V: Vitamin A education will be provided to 30% of the families by February 1992 and to 70% by August 1993.

- The specific activities of this objective are: development and validation of training modules for health facility staff and promoters, development of educational materials, and development of educational methodologies for teaching families. These activities are part of Phase III, "Long-term Interventions" and have important repercussions on sustainability.

- Strategies and procedures include the implementation of educational activities through health facility staff, promoters, and community leaders through the creation of community groups for education. The former receive training in content and even more importantly in effective adult teaching methodologies. These activities are coordinated among Project HOPE, the MOH, and INCAP, with a clear division or sharing of responsibilities.
- The activities address the requirements of the objective which is directed at changing the dietary practices of the population through nutrition education in food consumption, natural resources, and preparation of foods rich in Vitamin A. Education can be considered the crucial aspect of this project, integrating all activities and being the means for implementing this project and resolving the problem at hand (i.e., Vitamin A deficiency).
- Evaluation activities are directed at the process and the product and will use the results of a food consumption survey in Year 3. They are of vital importance to assess the overall success and sustainability potential of the project at the community level.

Weaknesses

- The benchmarks are set too high given the number of target families, the project duration, and the financial and human resources.

F. Objective VI: By February 1992, 30% of families in high-risk districts will have vegetable gardens (60% by August 1993).

Strengths

- To meet this objective, the following activities are proposed: development of practical training modules for agricultural extensionists of DIGESA and promoters of the MOH, practical training for families of the communities, and provision of vegetable seeds for family home gardens. These activities are part of the Phase III, "Long-term Interventions," and are of the greatest importance given that their implementation shows community ownership in resolving the problem of Vitamin A deficiency.
- These strategies are of vital importance because they demonstrate a great degree of coordination involving other disciplines (agronomy), sectors (agriculture) in resolving health problems through an interdisciplinary and intersectoral approach. They emphasize organized community participation through the development of model gardens and the formation of community education groups, with the

assistance of promoters and community leaders.

The sustainability of the objectives, activities, and achievements has been considered of vital importance as the key element of a project that will foster community ownership and promote the assumption of responsibilities by the MOH, so that at project end the external assistance has made a lasting contribution.

5. Coordination

Strengths

- This aspect is well described in the development and implementation of the project plan, with detailed activities and strategies and a inter-institutional distribution of responsibilities. It is based on Project HOPE's traditional good relations with country agencies and affirmed in agreements that demonstrate national recognition. The plan for coordination is directed mainly at the MOH, INCAP, and DIGESA.

Weaknesses

- The mechanism of coordination in planning, implementation, monitoring, and evaluation is not described, despite the fact that a major part of the responsibility to achieve coverage is based on it.

6. Administration

Strengths

- The project has an organizational chart that described the functions and responsibilities of the staff. It also has a workplan of activities; an estimated yearly budget; the requirement of monthly, quarterly, and annual reports; and a well defined HIS for decision-making purposes.

Weaknesses

- The project does not have a clear administrative structure concretely defining program management at the operational and supervisory level, with clear supervisory and monitoring procedures, and to a lesser degree, evaluation procedures.

7. Resources

Strengths

- The human, financial, and material resources for implementing the project have been considered.

Weaknesses

- Resources are not described in relationship to the activities that are being implemented. This makes it difficult to maximize the utilization of these resources, a requirement for cost-benefit analyses.

8. Evaluation, Follow-up, and Health Information System

Strengths

- Evaluation activities are described for each of the objectives and activities. They are taken into account in the implementation of the plan (process) and in the achievements (products). Two evaluations, at midterm and at project end, with different methodologies (external and internal) are planned and well defined.
- The evaluations are part of the implementation plan and are taken into account in the monitoring of objectives through coverage levels. For this purpose, the project has developed an HIS.
- The HIS was designed to monitor and evaluate the project and has been thought through from its development to its utilization, making it possible to use it for monitoring and evaluation and for timely decision-making.
- It has important training components in the administrative management of the information and its analysis, which assures its appropriate utilization.

Weaknesses

- There are few indicators for monitoring the implementation of the project, for example, in training and nutrition education, the number of individuals participating should be compared to the target population; the same for the number of family gardens established.
- Follow-up and monitoring of the implementation of the project is not clearly defined, making it difficult to make timely adjustments in the program. Staff are not assigned to a permanent team with the purpose of monitoring and evaluation.
- The plan does not contain considerations to make the systems and programs compatible with those of the MOH which may cause difficulties in recording, reporting, and data management.
- Indicators do not cover all interventions and activities to

assess the process and product of the project activities.

General Impressions about the Project Interventions:

The Detailed Implementation Plan is well designed. Interventions are well defined as short, medium, and long-term.

III. ACHIEVEMENTS

1. Duration of Project

The project was initiated in November 1990 and at this time has operated for 22 months.

2. Vitamin A Interventions

The project interventions can be summarized as follows:

- o Nutrition education of families by Project HOPE and MOH staff.
- o Training of health facility staff and others.
- o Training of TBAs in the supplementation of mothers during the immediate post-partum period with Vitamin A (within 24 hours of delivery).
- o Training of promoters to participate in the implementation of the project interventions.
- o Training and nutrition education of families to help them develop home gardens and cultivate them.
- o Supplementation of children ages six months to six years and supplementation of children with measles.
- o Supplementation of mothers during the immediate post-partum period.

3. Training

A total number of 83,619 families are living in the 24 high risk municipalities of Quetzaltenango and San Marcos (12 municipalities per department; data from the National Institute of Statistics). At this time, 9.25% of the families (7,735 families) have been educated in the importance of Vitamin A rich foods and have established a family garden. By department, this is as follows (also see Table 2):

Department	<u>Total Number of families</u>	<u>Number Trained</u>	<u>Percent Trained</u>
Quetzaltenango	49,562	3,230	6.56%
San Marcos	34,057	4,505	13.22%

Seventy one MOH health staff work in the high-risk municipalities; 59% of them were trained in Vitamin A (11 physicians, 11 nurses, and 23 auxiliary nurses and rural health technicians).

Ninety one technicians of DIGESA were trained in San Marcos and Quetzaltenango. In addition, 300 soldiers were trained in the Department of San Marcos to develop vegetable gardens for military consumption. Since these soldiers are drafted for short-term military service and are mostly peasants, they will take their new knowledge back to their communities.

According to the MOH, there are 601 TBAs in the 24 high-risk districts. To date, the project has trained 193 (32.11% of these in the administration of Vitamin A to women during the immediate post-partum period (Quetzaltenango: 3.5% of 253 active TBAs have been trained; San Marcos: 52.8% of 348 active TBAs; see Table 2).

24% or 204 promoters and volunteers were trained in the high-risk municipalities in Vitamin A supplementation and home gardening.

Strengths

- Community participation and training of promoters are important elements. In the communities visited by the evaluator, good community participation was evident.

Weaknesses

- There is no separate program for promotion, but it is a component of all other activities. No flyers or posters were found in the communities, and radio spots have not yet been produced.
- There are no records and reports about the nutrition education activities of promoters and MOH staff.

4. Supplementation of Children Six Months to Six Years with Vitamin A

There are a total number of 96,075 children under six years in the high risk municipalities (National Institute of Statistics). The Vitamin A supplementation coverage levels are 44.5% for the target area overall (45.24% for Quetzaltenango and 43.5% for San Marcos; see Table 4).

5. Treatment of Children with Measles with Vitamin A

Since project initiation, health facilities have not reported any measles cases, and according to the health area epidemiologists, no measles cases have occurred in the two departments during this time period.

6. Supplementation of Women Immediately Post-partum

A total of 21,146 births should have occurred in the 24 high-risk municipalities (see Table 1).

Strengths

- The design of the reporting system which was developed for TBAs merits special attention. It is a simple and highly useful system which promotes great community participation and is easy to manage for TBAs.
- The project began to collect this information only recently, and, therefore, this activity has not yet been evaluated.

7. General Observations about the Interventions

Strengths

- The combined interventions address the problem identified by the baseline survey; the use of financial and material resources provided by the project are appropriate; and Project HOPE is characterized by the counterparts and the communities as an agency which provides the necessary supplies and meets its commitments.
- High risk indicators have been used as the primary method to guide the project activities directed at resolving the problem situation.
- According to statements by MOH and INCAP representatives during the field visits, INCAP believes that the project is well accepted by the communities and that it has managed to demonstrate that the strategies and methodologies are appropriate, thus assuring its success. The MOH representatives stated that the project provides substantial assistance to the MOH and complements its programs.

Weaknesses

- The evaluator did not see the implemented budget.
- The human resources of the project are insufficient to achieve the proposed objectives, particularly when there are problems of coordination and when Project HOPE assumes

responsibility for tasks which should be the responsibility of its counterparts.

- In prioritizing the high risk groups for project interventions, the project did not prioritize the communities according to size of the population, seriousness of health problems, and the level of community organization.
- Focus groups have not been used for educational purposes.

8. Effectiveness

<u>Objective</u>	<u>Actual Coverage</u>	<u>Benchmark</u>
Identification of high-risk communities (baseline survey)	100%	100%
Supplementation of 75% of children 6 months to 6 years with Vit. A	44%	75%
One campaign in Year 1	0	1
Two campaigns in Year 2	2	2
Supplement 80% of children with measles with Vitamin A	no cases reported	
Supplement 30% of women in post-partum period with Vit. A in Year 2	data not yet available	
Train 100% of TBAs in high-risk districts	32%	100%
Educate 30% of families by 2/1992	data not yet available	
Train and develop home gardens with 30% of families by 2/92	9%	30%
Train 100% of promoters in high-risk districts	24%	100%

Strengths

- The high risk groups are being reached, and the interventions are well targeted to them.

Weaknesses

- Taking into account what was planned, coverage levels are not achieved in the time estimated and interventions do not reach the beneficiaries in a coordinated way due to the lack

of participation of the counterparts and Project HOPE's limited human resources.

- The most important limitations are addressed in the form of recommendations at the end of the report and are as follows:
 - o The large number of communities in the target area with a significant degree of inaccessibility, lack of information about their exact number, location, and dispersity;
 - o The lack of joint permanent and decentralized programming of activities with a workplan at the operational and administrative level, developed and shared jointly by Project HOPE, counterparts, and the organized communities (promoters, community leaders, TBAs, committees, and focus groups) for follow-up and evaluation.

Limited coordination at the administrative and operational level which would facilitate the sharing and analysis of information, distribution and fulfillment of responsibilities by each of the counterparts, committees, promoters, TBAs, and leaders of organized communities.

- o Deficiencies in the social marketing, information, and education of the communities through mass media, and educational materials acceptable and used by the population which emphasize major participation of the population.
- o Underutilized available information for making timely decisions at the operational and administrative level.
- o Lack of social workers, educators, and nutritionists specialized in community work which would make Project HOPE's team more multidisciplinary.

IV. IMPLEMENTATION OF THE PLAN (PROCESS)

1. Project Design and Location

Strengths

- The project is targeting its activities to the population determined to be at high risk by the food consumption survey and the study of serum retinol levels.
- The project targets twelve municipalities in each department, encompassing about 50% of the population of

children under six years of age. Vitamin A deficiency ranges from 14% to 60% in the municipalities (see Table 1).

- In Table 1, it can also be seen that in Quetzaltenango about 50% of the municipalities with high rates of infant and maternal mortality also have high rates of Vitamin A deficiency, in San Marcos this is true for 66%. The lower correlation for Quetzaltenango may be due to greater underreporting in that department.

Weaknesses

- It should be noted that more than 50% of the population in high risk districts in Quetzaltenango is located in five municipalities with the highest level of Vitamin A deficiency and the highest rates of infant mortality. This is not true for San Marcos and should be taken into account in programming.

2. Design, Objectives, and Indicators

Strengths

- The objectives are further detailed with activities and indicators which make it possible to assess progress during evaluations.
- Since there have been no measles cases after the recent epidemic and during the project duration, no children have been supplemented.

Weaknesses

- Because of a lack of ongoing monitoring of activities, there are no graphics or organized data that make it possible to assess monthly outputs and make any necessary changes in programming.
- For supplementing children under six years with Vitamin A, coverage levels by district are used (in most cases, there are two municipalities per district; see Table 4) which makes it difficult to estimate the actual coverage by municipality.

3. Information System

Strengths

- The data collected are simple and useful and the quality and quantity is limited to the information needed to measure the proposed indicators.

- The indicators are directed at outputs of the interventions that address Vitamin A deficiency problems identified in the baseline survey. This assures a great deal of reliability and sensitivity.
- The staff are aware of the importance of health information for monitoring and evaluation purposes and are ready to give it priority in the implementation of their activities, recognizing that this has been a weak point of the project until now.
- The staff have been trained in the management of information and have taken some important decisions. For example, they now limit their activities to the high risk municipalities based on the low Vitamin A supplementation coverage levels achieved during the first supplementation campaigns when--based on the request of the MOH -- it was attempted to completely cover both departments.

Weaknesses

- The project HIS has only been implemented recently.

4. Social Marketing and Community Education

Strengths

- The project has provided more than 90% of the planned materials and supplies which made it possible to achieve a positive community response proportionate to the educational efforts, particularly in the area of home gardens (see Table 2).
- The project implements education and social promotion activities directly with significant participation of DIGESA staff.
- Education activities were planned based on the results of the food consumption survey. There are well designed training modules which take into account the cultural background of the community and use a teaching methodology that facilitates communication.
- It was observed during field visits, that about 70% of the target population participates in practical teaching activities because the project has involved promoters and community leaders; these are optimal results.
- Training materials are limited, however those that are available are well accepted and understood by the community members and the project staff.

- During the field visits, when a meeting of TBAs was observed, it was noted that these women give great importance to Vitamin A, as well as to the reporting their activities and to maintaining adequate stocks of Vitamin A capsules. They stated that demand for their services has increased because of the Vitamin A supplement (see Table 3).
- Even in very distant and inaccessible communities, such as Santa Rita, San Marcos, it was observed that families have home gardens and are changing their dietary patterns. This was demonstrated in the lunch which contained vegetables grown by the community.

Weaknesses

- The response of the communities to the Vitamin A supplementation campaigns is low and is related to the promotion and education provided by MOH health facility staff (see Table 4). MOH staff have to become more actively involved to raise coverage levels.
- Project staff need to increase training in those educational methodologies that are most successful in maximizing community participation.
- The project has taken into account the level of education of the community but has not documented it.

5. Human Resources

Strengths

- The project's field staff consists of two physicians and two agronomists which gives it an interdisciplinary character.
- The promoters participate significantly in the project and are involved in simple but very important activities of social mobilization. It has to be concluded that their participation has been a determining factor of project success.
- The extensionists of DIGESA are so actively involved that they divide up communities with project staff to achieve greater coverage levels.
- As a result of initial training, project staff implement the tasks assigned to them well. The knowledge they have gained through their work is obvious. They are well accepted by the communities and work professionally. They guide the TBAs and mothers well in finding solutions to the problem situation.

- With respect to logistics, the field staff stated that they have what is needed, including a motorcycle.

Weaknesses

- The project team does not include a nutritionist even though this is of vital importance.
- The role of the MOH counterparts is not clearly defined, i.e., the involvement of nursing staff and rural health technicians. Even though they are involved in project implementation, their participation with respect to quality and quantity is questionable (see coverage tables 2, 3, and 4).
- Newly hired staff need more help and training to provide high quality work and improve their communication skills.
- More attention has to be given to in-service education, and a specific time has to be set aside for it.
- The amount of work necessary to achieve the objectives was not well estimated, taking into account the available human resources. If Project HOPE wanted to complete all tasks rather than coordinate efforts, ten work teams, each consisting of a physician and agronomist, would be needed. This suggests the need for reprogramming.
- Salaries are low compared with those in public health and in the Social Security Office which had increases of about 100%.
- Half of the staff (two of four) that started with the project no longer works with Project HOPE, and the hiring of new staff has required major time involvement at the cost of service delivery and attention to the communities.
- The staff stated that they had administrative difficulties to get gas and other supplies, such as sleeping bags, that would allow them to stay in the communities. They have requested these, but have not received a positive response.
- The promoters and community volunteers have no educational materials to implement their promotional activities.

6. Supervision and Monitoring

Strengths

- The planning of the Midterm Evaluation as part of the Detailed Implementation Plan is an important monitoring instrument for project implementation.

- Recently, the project has implemented a field-based supervision and monitoring system that is being strengthened by the Midterm Evaluation.

Weaknesses

- This is probably the weakest part of the project, according to the reports sent to headquarters.
- The monthly report does not allow for measuring project progress and uses up time at the expense of other activities. Staff use a narrative format without statistical information, do not provide information about the quality of work, and their presentation is disorganized. Until May, the quarterly reports have had a better structure and were more complete.
- The Annual Report is quite complete but does not report achievements in terms of coverage levels.
- The project field staff does not know the content of the report sent to headquarters.
- The field staff feel that the limited supervision they have received was more related to financial matters and does not assure the quality of their services.
- Monitoring and supervision procedures for MOH staff are not clearly described, MOH staff are merely assigned tasks to be completed.
- Monitoring and supervision procedures are not clearly defined in terms of providing assistance, guidance, and continuing education for tasks, administration, and evaluation.

7. Use of Central Funds

Strengths

- According to staff, the administrative and technical monitoring of the Central Office has been appropriate and frequent.
- Financial funds arrive on a timely basis and are sufficient.

Weaknesses

- The use of headquarters funds is not known by the administration of the project, according to the administrative assistant.

- Headquarters was not aware of the lack of monitoring and supervision of field staff on the part of the Chief of Vitamin A.
- The level of technical and administrative monitoring on the part of the Chief of Vitamin A has not made it possible to achieve better coordination with counterparts at the management level to achieve a higher level of coverage of activities, and staffing needs do not correspond with existing work load.

8. External technical assistance

Strengths

- Technical assistance in program implementation provided by headquarters has been appropriate.
- Technical assistance has been timely and efficient.

Weaknesses

- Technical assistance is needed to develop educational materials. Professional educators should be hired or consultancies obtained to improve the communication with the community and improve adult teaching methodologies to increase community participation.
- Project staff do not know other similar or more developed projects which would allow them to learn innovative strategies to be included in their work.

9. Counterparts

Strengths

- The counterparts are satisfied with the project which for them is a way of reducing malnutrition and infant mortality. The project contributes to improve coverage rates and their relationship with the communities. This was expressed in the interviews with MOH and other institutional staff (MOH: two epidemiologists, the health area chief of San Marcos, three graduate nurses, six auxiliary nurses; DIGESA: three extensionists; INCAP: Dr. Omar Dary).
- The existing open communication channels should be used to establish concrete mechanisms of coordination with the management level of these agencies which will strengthen the operational level.
- During the field visits, it was obvious that communication at the operational level was much better than at the

management level.

- Health staff were trained in all high-risk municipalities, including at health posts and health centers.

Weaknesses

- Many of the trained MOH staff have been transferred making it necessary to train the new staff and have Project HOPE and the MOH together provide coordinated monitoring and evaluation.
- The interinstitutional committee created for coordination purposes does not function any more.

10. Quality and Accessibility of MOH Services Considered as Referral Sites

Strengths

- About half of the health services in locations where the project is being implemented are difficult to access by the population, (almost 60% in San Marcos). During the evaluation, the team visited a community (hamlet Sta. Rita, San Marcos) that was located more than 150 km from Project HOPE's office, where the team had to walk for more than two and a half hours (7 km) uphill crossing over to Mexico, since access from Guatemala is even more difficult.
- The quality of services provided by the MOH referral sites is adequate if, when evaluating them, it is taken into account that service delivery is in line with the epidemiological profile of the country.
- During the field visits, the team observed strong coordination at the operational level.
- It is worthwhile to mention that DIGESA has demonstrated that community organization facilitates the implementation of activities. Project HOPE is utilizing the lessons-learned and maintains very good relations and coordination with DIGESA at the operational level.
- Presently, the MOH is administering the Vitamin A capsules provided by Project HOPE to children six months to six years (see Table 4), maintains recording forms, and provides reports to Project HOPE. DIGESA distributes the vegetable seeds provided by Project HOPE and trains families in coordination with Project HOPE staff.
- The plan does not consider strengthening the health services. However, the addition of Vitamin A has increased community participation in EPI activities according to

health facility staff of the MOH in the places visited.

- CARE has produced educational materials and has made it available to Project HOPE. These materials are used for training purposes at the community level.

Weaknesses

- The MOH is experiencing a crisis because of lack of staff and staff absences.
- At the Chief of Vitamin A level, the coordination with the health areas was not strengthened, despite open communication channels.
- During the field visits it was noted that the completion of responsibilities is left to the discretion of the MOH staff, who frequently do not fulfill their responsibilities.
- Project HOPE staff are attempting to do all the work themselves, especially in those places where coordination and communication has deteriorated, i.e., mainly in Quetzaltenango.

11. Management of Budget

Weaknesses

- The project does not calculate costs per intervention.
- The budget is not made based on prior expenditures.
- At the local level, expenditures should be permanently monitored.

VI. SUSTAINABILITY

Strengths

- The communities that have received services up to now are very well motivated, assuring the continuity of the activities.
- The project is being fully implemented in the majority of communities of San Marcos.
- Community participation of promoters, leaders, and family groups, in the planning and implementation of the project has been a determining factor in the development and sustainability of the activities.

- In the majority of the communities, vegetable gardens are first initiated communally and then on an individual/family basis.
- Mothers take their children to receive Vitamin A and many times participate in the organization of campaigns which are implemented jointly with EPI campaigns, thus increasing the number of children participating, according to MOH health facility staff.
- The women organize community presentations and are more likely to request service delivery from TBAs, as reported by the latter group. This has increased the number of referrals of women for prenatal care to health facilities.
- The communities have assumed ownership of the activities through their involvement in planning and implementation.
- Project and counterpart staff are very motivated; the project is well accepted in the communities, particularly in those where all project components are being implemented, which generally coincides with a high level of coordination with the counterparts, MOH and DIGESA.
- The volunteers are role models for their communities. Many of them have already experimented with self-financing by selling excess produce to buy seeds and other items, as noted in the communities Pia Monte in San Marcos and San Carlos Sija and Salcaja Aldea Chuitarazena in Quetzaltenango. This role modeling of the promoters has stimulated many family home gardens.
- The community organization promoted through this project can benefit other development activities.
- The Ministries of Health and Agriculture have demonstrated that they can develop such projects -- as community ownership grows with the Project HOPE experience -- and because they begin to understand and experience that their programs are strengthened through community participation (e.g., the significant increase in number of children immunized during joint Vitamin A and EPI campaigns) reported by the MOH.

Weaknesses

- In communities visited in Quetzaltenango, it was observed that some communities have not had follow-up and that the development of gardens appropriate for this area has not progressed much; Vitamin A has not been distributed, and the TBAs have not yet distributed Vitamin A to women immediately after delivery (a recently initiated project activity).

- Due to the volume of work, some communities are not served, in particular in terms of follow-up. Therefore, community participation in planning and implementation is limited, which might endanger sustainability in those locations.
- Other NGOs are developing similar project at a much smaller scale, but do not coordinate with Project HOPE; others have not included such activities, possibly due to lack of knowledge.
- Project HOPE has much valuable information which has not been published, and other information that has not yet been organized.

VII. RECURRENT COSTS

Strengths

- The sale of excess produce favors cost-recovery in some communities.

Weaknesses

- Cost-benefit information, costs of activities, and costs by project component are not available.
- In the communities visited, the population has expressed that they do not have the resources to pay for preventive services and promotion. This has to be expected since more than 80% of the population is under the poverty level, and severe poverty is more than 65% in the two departments.

VIII. RECOMMENDATIONS

- o Identify and number the communities of the high risk municipalities into villages and hamlets. Adjust activities and indicators taking into account the available resources with respect to quantity, dispersity, and accessibility of populations; utilize the high risk approach in comparing social and health indicators for each municipality to the results of the baseline survey and serum retinol levels.
- o Develop a plan of coordination that defines adequate mechanisms for planning, implementation, monitoring, and evaluation and assigns responsibilities to the counterparts at the operational and management level to improve coverage. Emphasize that Project HOPE should not assume responsibility for implementing the major part of the activities.

- o Program activities jointly with the counterparts on a permanent basis and in a decentralized fashion, with a workplan at the operational and management level, involving Project HOPE, counterparts, and the organized communities (promoters, community leaders, TBAs, committees, focus groups).
- o Jointly with the MOH increase social promotional activities in information and education through the mass media, particularly radio and educational materials accepted and understood by the population, and emphasize active community participation.
- o Develop an administrative plan that facilitates good project management at the operational and management level by establishing clear procedures for management, supervision, monitoring, and evaluation. Reports should be shared with project staff and should contain statistical information that compares planned and actually achieved outputs.
- o Reinforce the utilization of this information to make timely decisions in shared project management with project staff, data collectors, counterparts, and especially with the communities.
- o Revise indicators of each intervention for better feedback and refinement to staff at the operational and management level so that they can measure process and not only outputs, e.g.:

# of communities with gardens	vs.	# of communities participating
# of training session in gardening	vs.	# of gardens developed
# of family gardens	vs.	# of target families
# of educational meetings	vs.	# of target families
# of TBAs trained	vs.	# of TBAs to be trained
# of TBAs trained	vs.	# of women supplemented after delivery
# of women supplemented	vs.	# of expected births
IMR by year	vs.	# of children supplemented with Vitamin A
Child mortality per year	vs.	# of children supplemented with Vitamin A

Morbidity due to diarrheas, vs. # of children supplemented with Vitamin A
immunizable disease, or ARI

- o Train MOH staff in better recording of data to improve the quality of the information and indicators.
- o Establish a permanent system of supervision, monitoring, and evaluation through a team of Project HOPE and counterpart staff which emphasizes timely information about project progress, assists and guides the implementation of activities, and assesses the work to be accomplished.
- o Add social workers, educators, and nutritionists specialized in community work to the work team and making it more multidisciplinary.
- o In coordination with the MOH and DIGESA and to increase coverage, strengthen the training of promoters, volunteers, and community leaders through the formation of educational focus groups.
- o Develop a sustainability plan based on aspects of community participation where the involvement of the counterparts is assured, now that they have experience and knowledge about the special benefits.
- o Training of the new MOH staff and monitoring of permanent staff is key for project implementation. The participation of other NGOs is of vital importance, and the project should look for opportunities to coordinate activities with them.
- o Develop a project budget that makes it possible to calculate the cost-benefit ratio of the project components and to speed up project implementation if the necessary funds become available.
- o Train the project staff in didactic educational methods for the communities and document the degree of learning that takes place in the community. In this manner, a permanent educational system is being developed and adequate time is set aside to develop it. External technical assistance is needed to develop and reach the utilization of these methodologies. Also needed are exchanges or visits with staff from similar projects in the subregion.
- o Reactivate the inter-institutional committee.

MUNICIPIOS DE ALTO RIESGO

INDICADORES DEMOGRAFICOS Y DE SALUD
(High Risk Municipalities)PROYECTO HOPE INTERVENCIONES DE VITAMINA A
(Demographic and Health Indicators)

CUADRO No. 1 (Table 1)

DEPARTAMENTO DE QUETZALTENANGO						
MUNICIPIO	% S. RETINOL 1	No. FAMILIAS 2	PARTOS ESP. 3	POB. 6m < 6a 4	M. INFANT. 5	M. MATER. 6
SALCAJA	60.00%	2793	870	3023	41.09	0
COATEPEQUE	46.05%	11881	2851	12862	133.65	9.6
EL PALMAR	00.00%	9077	945	4262	88.08	0
CANTEL	33.33%	4259	1022	4611	81.68	0
GENOVA	31.25%	5578	1338	6039	243.11	0
OLINTEPEQUE	25.00%	2941	700	3104	05.05	0
SAN FRAN. LA UNION	25.00%	1485	352	1587	108.89	0
CAJOLA	25.00%	1601	384	1733	85.08	18.9
SAN MIGUEL SIGULA	25.00%	799	176	7092	52.35	0
PALESTINA DE LOS ALT	19.70%	205	481	2171	116.19	0
SAB CARLOS SJA	17.86%	4739	1137	5150	39.8	0
COLOMBA	14.00%	7584	1816	8188	67.7	19.7
totales	29.67%	49582	11877	53602	90.89	4.01
DEPARTAMENTO DE SAN MARCOS						
ESQUIPULAS PAL. GORDO	45.45%	911	219	1002	68	72
SAN RAFAEL P. C.	43.75%	2449	588	2693	49	0
SAN JOSE OJETENAM	29.75%	2721	653	2993	34	57
SIPACAPA	26.19%	1940	468	2133	95	24
TACANA	25.00%	6342	2002	9178	5	0
SAN CRIST. DECHIGUAN	24.13%	2873	689	3160	32	38
TAJUMULCO	22.58%	5578	1339	6134	3	49
SIBINAL	22.22%	2010	482	2211	6	0
LA REFORMA	16.27%	3119	749	3431	13	0
SAN MARCOS	12.79%	5147	1235	5661	49	40
SAN LORENZO	12.34%	1417	340	1557	82	55
SAN CRISTOBAL CUCUD	10.34%	2111	507	3222	71	0
totales	24.23%	34057	9269	42473	42.25	27.92
TOTALES GENERALES	27.96%	83619	21146	96076	66.57	15.9

MARCO V. DONIS. PROYECTO HOPE VITAMINA A EVAL. MID-TERM. QUETZALTENANGO Septiembre 1992.

1. % of children with Vitamin A. Deficiency
2. Number of families
3. Number of births per year
4. Number of children 6 months to 6 years
5. IMR
6. Maternal Mortality Rate

MUNICIPIOS DE ALTO RIESGO
(High risk Municipalities)
COBERTURAS DE CAPACITACION Y HUERTOS
(Training Coverage and Home Gardens)
PROYECTO HOPE INTERVENCIONES DE VITAMINA A
Project HOPE Vitamin A Project

CUADRO No. 2 Table 2

DEPARTAMENTO DE QUETZALTENANGO						
MUNICIPIO	% RETINOL 1	Nº FAMILIAS 2	Nº FAM. CAP 3	COBERTURAS 4	INFANT. 4	M. MATER. 5
SALCAJA	60.00%	2793	140	5.00%	41.09	0
COATEPEQUE	46.05%	11881	120	1.00%	133.85	9.6
EL PALMAR	33.87%	3937	60	1.60%	88.08	0
CANTEL	33.33%	4259	220	5.20%	81.88	0
GENOVA	31.25%	5578	330	6.00%	243.11	0
QUINTEPPEQUE	25.00%	2941	00	0.00%	35.06	0
SAN FRANC. LA UNION	25.00%	1465	240	1.64%	108.89	0
CAJOLA	25.00%	1601	380	2.20%	85.00	10.9
SAN MIGUEL SIGUILA	25.00%	799	120	1.60%	52.35	0
PALESTINA DE LOS ALT	19.70%	206	1000	50.00%	118.19	0
SAN CARLOS SJA	17.86%	4739	400	8.40%	39.8	0
COLOMBA	14.00%	7584	180	2.10%	67.7	19.7
totales	29.67%	49582	3230	6.51%	90.89	4.01
DEPARTAMENTO DE SAN MARCOS						
ESQUIPULAS PAL. GORDO	45.45%	911	378	41.00%	68	72
SAN RAFAEL P. C.	43.75%	2449	332	13.55%	49	0
SAN JOSE QUETENAM	29.75%	2721	469	17.23%	34	57
STACAPA	28.19%	1940	379	19.53%	95	24
TACANA	25.00%	8342	331	3.96%	5	0
SAN CRIST. DEBIFUAN	24.13%	2873	428	14.78%	32	30
TAJUMULCO	22.56%	5578	310	5.55%	3	49
SIBINAL	22.22%	2010	425	21.14%	6	0
LA REPARAMA	16.27%	3119	66	2.75%	13	0
SAN MARCOS	12.79%	5147	757	14.70%	49	40
SAN LORENZO	12.34%	1417	397	28.00%	82	55
SAN CRISTOBAL CUCHO	10.34%	2111	213	10.09%	71	0
totales	24.23%	34057	4505	13.22%	42.25	27.92
TOTALES GENERALES	27.96%	83619	7735	9.86%	66.57	15.06

MARCO V. DONIS/PROYECTO HOPE VITAMINA A EVAL. MID-TERM. QUETZALTENANGO Septiembre 1992.

1. % of children with Vitamin A Deficiency
2. Number of families
3. Number of families trained
4. Coverage Rate
5. IMR
6. Maternal Morality rate

MUNICIPIOS DE ALTO RIESGO
(High-Risk Municipalities)
COBERTURAS DE CAPACITACION DE COMADRONAS
(Training Coverage of TBAs)
PROYECTO HOPE INTERVENCIONES DE VITAMINA A
(Project HOPE Vitamin A)

CUADRO No. 3 Table 3

DEPARTAMENTO DE QUETZALTENANGO						
MUNICIPIO	N.S. RETINOL 1	# COMADRONAS 2	Nº COMCAP 3	COBERTURA 4	M. INFANT. 5	M. MAT. 6
SALCAJA	60.00%	5			41.09	
COATEPEQUE	46.05%	29			133.66	
EL PALMAR	33.67%	35			88.08	
CANTEL	33.33%	21			81.68	
GENOVA	31.25%	23			243.11	
QUINTAPEQUE	25.00%	5			35.05	
SAN PABLO LA UNION	25.00%	8			118.44	
CAJOLA	25.00%	10	9	90.00%	85.08	18
SAN MIGUEL SIGUALA	25.00%	5			52.35	
PALESTINA DE LOS ALT	19.70%	28			116.19	
SAN CARLOS SIJA	17.66%	28			39.8	
COLOMBA	14.00%	60			67.7	19
totales	29.67%	253	9	3.56%	90.89	4.1
DEPARTAMENTO DE SAN MARCOS						
ESQUIPOZAS PAL GORDO	45.45%	10	9	90.00%	68	
SAN RAFAEL P. C.	43.75%	43	39	91.00%	49	
SAN JOSE QUETENAM	29.75%	27	0	0.00%	34	
SIPACAPA	26.19%	41	27	66.00%	95	
TACANA	25.00%	64	0	0.00%	5	
SAN CRIST. DEBEGUAN	24.13%	8	0	0.00%	32	
TAJUMULCO	22.58%	32	21	66.00%	3	
SIBINAL	22.22%	22	14	64.00%	6	
LA REFORMA	16.27%	23	16	69.00%	13	
SAN MARCOS	12.79%	43	29	67.00%	49	
SAN LORENZO	12.34%	22	16	73.00%	82	
SAN CRISTOBAL CUCHO	10.94%	13	13	100.00%	71	
totales	24.23%	348	184	52.80%	42.25	27
TOTALES GENERALES	27.96%	601	193	32.00%	66.57	15

MARCO V. DONIS. PROYECTO HOPE VITAMINA A EVALUACION MID-TERMO QUETZALTENANGO Septiembre 1992.

1. Percent of children with Vitamin A Deficiency
2. Number of TBA
3. Number of TBAs trained
4. Training Coverage
5. Infant Mortality
6. Maternal Mortality

MUNICIPIOS DE ALTO RIESGO
(High Risk Municipalities)
COBERTURAS DE SUPLEMENTACION DE VITAMINA A
(Supplementation Coverage)
EN NIÑOS DE 6 MESES A MENORES DE 6 AÑOS
(of children six months to 6 years)
PROYECTO HOPE INTERVENCIONES DE VITAMINA A
(Project HOPE Vitamin A)

CUADRO N.º 4 Table 4

DEPARTAMENTO DE QUETZALTENANGO						
MUNICIPIO	N.S. RETINOL 1	COBERTURAS 2	SUP. VIT. A 3	POB. 6m < 6a 4	M. INFANT. 5	M. MATER. 6
SATCAJA	80.00%	30.85%	927	3023	41.09	0
COATEPEQUE	48.05%	62.15%	7994	12062	133.85	9.6
EL PALMAR	33.87%	70.40%	3000	4262	66.08	0
CANTEL	33.33%	19.00%	876	4611	61.68	0
GENOVA	31.25%	38.75%	2340	6039	243.11	0
OLINTEPEQUE	25.00%	19.00%	605	3184	35.05	0
SAN FRANC. LA UNION	25.00%	19.00%	302	1587	106.59	0
CAJOLA	25.00%	52.25%	906	1733	75.06	18.9
SAN MIGUEL SIGULA	25.00%	54.45%	431	7092	62.35	0
PALESTINA DE LOS ALT	19.70%	55.70%	1209	2171	118.19	0
SAB CARLOS SEJA	17.86%	71.00%	3657	5150	39.8	0
COLOMBA	14.00%	24.45%	2002	8188	67.7	19.7
totales	29.87%	45.24%	24249	53602	90.89	4.01
DEPARTAMENTO DE SAN MARCOS						
ESQUIPULAS PAL GORDO	45.45%	38.00%	361	1002	68	72
SAN RAFAEL P. C.	43.75%	58.00%	1608	2893	49	0
SAN JOSE QUETENAM	22.75%	23.00%	888	2993	34	57
SIPACAPA	26.19%	44.00%	938	2133	95	24
TACANA	25.00%	41.00%	3762	9176	5	0
SAN CRIST. DE HIGUAN	24.13%	29.00%	727	3160	32	38
TAJUMULCO	22.58%	83.00%	5091	6134	3	49
SIBINAL	22.22%	74.00%	1636	2211	6	0
LA REFORMA	16.27%	25.00%	858	3431	13	0
SAN MARCOS	12.79%	23.00%	1302	5661	49	40
SAN LORENZO	12.34%	41.00%	638	1557	62	55
SAN CRISTOBAL CUCHO	10.34%	43.00%	948	3222	71	0
totales	24.23%	43.50%	16505	42473	42.25	27.92
TOTALES GENERALES	27.96%	44.50%	42756	96075	66.57	15.96

MARCO V. DONIS. PROYECTO HOPE VITAMINA A EVAL. MID-TERM. QUETZALTENANGO Septiembre 1992.

1. Percent of children with Vitamin A deficiency
2. Supplementation coverage
3. Number of children receiving Vitamin A
4. Number of children six months to six years
5. IMR
6. Maternal Mortality

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HEADQUARTERS

COST ELEMENTS	Actual Expenditures To Date (09/01/90 to 08/31/92)			Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/93)			Total Agreement Budget (Columns 1 & 2) (09/01/90 to 08/31/93)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	0	0	0	0	0	0	0	0	0
B. Equipment	0	0	0	0	0	0	0	0	0
C. Services/Consultants									
1. Local	0	0	0	0	0	0	0	0	0
2. 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	0	0	0	0	0	0	0	0	0
III. INDIRECT COSTS									
Overhead on HO/HO (55%)	5,878	1,959	7,837	1,637	546	2,183	7,515	2,505	10,020
SUB-TOTAL III	5,878	1,959	7,837	1,637	546	2,183	7,515	2,505	10,020
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
1. Technical	5,244	1,748	6,992	1,500	500	2,000	6,744	2,248	8,992
2. Administrative	1,748	583	2,331	525	175	700	2,273	758	3,031
3. Support	3,830	1,276	5,106	953	317	1,270	4,783	1,593	6,376
B. Travel/Per Diems									
1. In-country	0	0	0	0	0	0	0	0	0
2. International	1,456	486	1,942	600	200	800	2,056	686	2,742
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	532	177	709	262	88	350	794	265	1,059
SUB-TOTAL IV	12,810	4,270	17,080	3,840	1,280	5,120	16,650	5,550	22,200
TOTAL HEADQUARTERS	18,688	6,229	24,917	5,477	1,826	7,303	24,165	8,055	32,220

FIELD	Actual Expenditures To Date (09/01/90 to 08/31/92)			Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/93)			Total Agreement Budget (Columns 1 & 2) (09/01/90 to 08/31/93)		
	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	8,534	738	9,272	0	2,000	2,000	8,534	2,738	11,272
B. Equipment	0	19,709	19,709	0	1,000	1,000	0	20,709	20,709
C. Services/Consultants									
1. Local	31,042	0	31,042	0	7,109	7,109	31,042	7,109	38,151
2. Expatriate	0	0	0	0	0	0	0	0	0
SUB-TOTAL I	39,576	20,447	60,023	0	10,109	10,109	39,576	30,556	70,132
II. EVALUATION/SUB-TOTAL II	555	0	555	2,395	874	3,269	2,950	874	3,824
III. INDIRECT COSTS									
Overhead/Field (55%)	23,936	6,109	30,045	14,691	6,766	21,457	38,627	12,875	51,502
SUB-TOTAL III	23,936	6,109	30,045	14,691	6,766	21,457	38,627	12,875	51,502
IV. OTHER PROGRAM COSTS									
A. Personnel (List each position & total person months separately)									
1. Technical	24,890	6,379	31,269	17,420	2,530	19,950	42,310	8,909	51,219
2. Administrative	9,285	2,379	11,664	9,076	1,318	10,394	18,361	3,697	22,058
3. Support	9,164	2,348	11,512	7,567	1,101	8,668	16,731	3,449	20,180
B. Travel/Per Diems									
1. In-country	14,849	3,805	18,654	17,634	2,558	20,192	32,483	6,363	38,846
2. International	0	0	0	0	0	0	0	0	0
C. Other Direct Costs (Utilities, printing, rent, maintenance, etc.)	9,299	2,383	11,682	12,383	1,801	14,184	21,682	4,184	25,866
SUB-TOTAL IV	67,487	17,294	84,781	64,080	9,308	73,388	131,567	26,602	158,169
TOTAL FIELD	131,554	43,850	175,404	81,166	27,057	108,223	212,720	70,907	283,627

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TOTAL - FIELD & HEADQUARTERS

	Actual Expenditures To Date (09/01/90 to 08/31/92)			Projected Expenditures Against Remaining Obligated Funds (09/01/92 to 08/31/93)			Total Agreement Budget (Columns 1 & 2) (09/01/90 to 08/31/93)		
	AID ---	PVO ---	TOTAL -----	AID ---	PVO ---	TOTAL -----	AID ---	PVO ---	TOTAL -----
TOTAL HEADQUARTERS	18,688	6,229	24,917	5,477	1,826	7,303	24,165	8,055	32,220
TOTAL FIELD	131,554	43,850	175,404	81,166	27,057	108,223	212,720	70,907	283,627
TOTAL	150,242	50,079	200,321	86,643	28,883	115,526	236,885	78,962	315,847

9/23/92
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