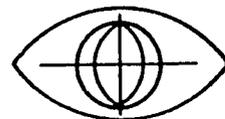


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**INTERNATIONAL EYE FOUNDATION
COBAN, GUATEMALA
VITAMIN A FOR CHILD SURVIVAL
MID-TERM EVALUATION
USAID CHILD SURVIVAL IX
COOPERATIVE AGREEMENT NO:
FAO-0500-A-00-3020-00**

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November 1995

the
**International
Eye Foundation**

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Note: The following report is a translation from Spanish to English

JULY 10 - 19, 1995

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMPROS	"Ayuda Mutua Pro Salud" or Mutual Help for Health,
ARI	Acute Respiratory Infections
BF	Breastfeeding
CESSIAM	Center for the Study of Sensory Impairment, Aging and Metabolism
CDD	Control of Diarrheal Diseases
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FIS	Guatemalan Social Investment Fund
HIS	Health Information System
IEC	Information, Education, and Communication
IEF	International Eye Foundation
IG	Income Generation
INCAP	Nutrition Institute of Central America and Panama
KPC	Knowledge, Practices, and Coverage
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PCV	Peace Corps Volunteer
PVO	Private Voluntary Organization (see also NGO)
TA	Technical Assistance
TBA	Traditional Birth Attendant
WHO	World Health Organization
UPVA	IEF Vitamin A Training Unit, Guatemala
USAID	United States Agency for International Development

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1. EXECUTIVE SUMMARY

The Mid-term Evaluation of the IEF Vitamin A for Child Survival, Mutual Help for Health (AMPROS) took place from the 10th to the 19th of July 1995. The evaluation team consisting of the following persons: Jeffery Brown, Program Coordinator/IEF Headquarters; Dr. Edmundo Alvarez, IEF National Director; Dr. Raúl Gómez, IEF Honduras National Director; Martha Burdick de Piedrasanta, IEF Project Manager; Mauro Pineda, Ministry of Health (MOH)/Area Office Health Technician; Bonnie Martin, Peace Corps Volunteer; IEF Project Supervisors, Luis Sierra, Esperanza Caal, Julio Gálvez, and Enrique Fernández; and Dr. Julio Caldéron, External Evaluator.

The evaluation used a combination of methodologies including "Evaluation by Objectives" and "Judgement of Experts". The evaluation team visited a total of six randomly selected communities in order to observe educational activities, review the village registration system and conduct focus groups of mothers, leaders and volunteers. Interviews with project supervisors and extensionists, MOH Area Office and District Health Center physicians and nurses in San Pedro Carchá, San Juan Chamelco and Cobán were also conducted.

The evaluation showed that more than 50% of the objectives of the DIP have been reached in the following components:

EPI (children from 12 to 24 months, with a complete scheme, excluding DPT), nutrition (children older than 5 months that receive vitamin A-rich foods), vitamin A (children from 6 to 71 months that receive vitamin A supplements every six months and postpartum mothers that receive vitamin A within 30 days), acute lower respiratory infections (ALRI) (mothers that can identify the warning signs and make an appropriate reference), eye care (eye campaigns held) and income generation (number of income generating activities established.)

Nevertheless, the following components need to be strengthened or re-examined:

EPI (TTV for women of child-bearing age), control of diarrheal diseases (CDD) (use of ORS, ORT, and antibiotics), nutrition (food during episodes of diarrhea), gardens (planting of family gardens).

From focus groups it was apparent that mothers, volunteers and leaders are aware of and support AMPROS' activities. Both mothers and volunteers recommend that volunteers be trained as health promoters in order for volunteers/promoters to continue the educational activities until the end of the project. They feel that the activities are important to help them improve their children's health as well as their own.

Results of the interviews with the field supervisors and extensionists show the need to improve the quality of educational activities by reducing the number of educational messages and ensuring that all educational messages coincide for each component.

MOH Area and District staff (physicians and nurses) indicated that the project is well-known and respected for its educational activities in communities. They also indicated a willingness to train the volunteers as health promoters over time (recommendation from the communities) rather than insist that they attend one initial, long, four week course.

PROJECT STRENGTHS

The following aspects are considered strengths of the project:

1. Widespread, positive recognition as an effective educational project,
2. Acceptance by both mothers and leaders of the community,
3. Development of local personnel through the training of personnel from other organizations as well as its own,
4. The strengthening of a network of NGOs through close communication and cooperation through activities,
5. The development of a community distribution network of volunteers for ORS and vegetable seeds,
6. The provision of health education using a variety of media including cooking demonstrations and radio spots,
7. Sound administrative management of its budget by project staff,
8. Completely bilingual field staff (Q'eqchi and Spanish).

PROJECT WEAKNESSES

Project weaknesses are noted as follows:

1. The project includes too many interventions. Many interventions require the transmission of a large amount of information and high number of messages. As a result, quality of the information transmitted can be compromised.
2. The management of the information system is very centralized with only one person in charge (Project Manager). As a result this person is currently indispensable and the system is not sustainable without her.
3. The Project Manager and the National Director dedicate little time to the supervision of the community activities.
4. There is little educational material for use by community members and, what exists, is not very usable for activities employing a participatory educational methodology.
5. Formative research has not been completed in all intervention areas, only in regards to nutrition and ALRI.
6. There is little supervision for the testing of the education messages.
7. The project has not greatly improved its level of communication with some levels of the MOH.
8. The project has not fully planned the steps of how to transfer some responsibilities, materials or educational methodologies to the MOH and the communities.
9. The number of documented family gardens does not correspond well with the number of vegetable seeds sold.

While the project's approach to sustainability is well-supported by the MOH and communities, written formal agreements should be drafted with the help of the local community committees.

Institutional sustainability should be strengthened through more frequent and better quality meetings with the MOH, local churches including the Catholic Church and other NGO's.

Financial sustainability should be strengthened through the diversification of income sources for the project (both public and private funding within country and on a larger, international basis.) Funding should be sought to further establish IEF's role as an expert in community education and investigation.

2. ACHIEVEMENTS

The project has been operating for 22 months (October 1993 - July 1995) in 49 rural communities within the municipalities of San Pedro Carchá, San Juan Chamelco and Cobán. Each component consists of training activities targeted to staff of other institutions, project staff, village volunteers and mothers. The project has supported vaccination efforts of the MOH, conducted vitamin A capsule distribution (children < six years of age and postpartum mothers), de-worming campaigns and educational sessions (educational talks and cooking demonstrations) with mothers. Listed below are the accomplishments to-date:

EPI	25 people from the project trained 5 trimestral vaccination campaigns supported 91 educational talks given
Ocular Health	25 people from the project trained 1 annual campaign held in each community
Vitamin A	25 people from the community trained 165 volunteers trained 168 people from the MOH trained (doctors, nurses, promoters and nursing students) 2 semi-annual campaigns held 338 postpartum mothers supplemented with vitamin A 29,125 capsules distributed to other organizations 60 teachers trained 1 Health Fair held
CDD	25 people from the project trained 165 volunteers trained 55 ORS distributors trained and deployed 204 educational talks about ORT given 2,667 packets of ORS distributed 250 latrines installed 1 radio spot produced and transmitted

- ALRI** 26 people from the project trained
 32 people from the MOH trained (by Clapp & Mayne)
 67 educational talks
 1 radio spot transmitted
- NUTRITION** 25 people from the project trained
 366 talks given
 450 cooking demonstrations conducted
- INCOME GENERATION** 25 people from the project trained
 4 micro enterprises established
- GARDENS** 25 people from the project trained
 165 volunteers trained
 49 functioning revolving funds established
- OTHER** 1 de-worming campaign held
 73% of children between the ages of 2 to 6 years received treatment
 The monthly average of women who attended educational talks was 750

IEF staff consist of 15 extensionists that cover the 11 communities of Cobán, 30 communities of San Pedro Carchá, and 8 communities of San Juan Chamelco. The four field supervisors are Luis Sierra, Enrique Fernández, Esperanza Caal (seconded from DIGESA) and Julio Gálvez (seconded from the MOH). The field supervisors are led by the Project Manager, Martha Burdick de Piedrasanta who in turn reports to the Country Director, Dr. Edmundo Alvarez. Bonnie Martin, a microenterprise Peace Corps Volunteer assists the project with the development of small business activities. Jefferyrey Brown, the IEF/HQ Child Survival Coordinator provides oversight and technical assistance to the project.

Extensionists are in charge of training mothers and supporting volunteers. Each extensionist works with approximately 15 volunteers. Volunteers are assigned 30 - 35 families in each community and are given the responsibilities of promoting project activities, record family data, and distribute seeds and oral rehydration salts.

3. EFFECTIVENESS

Component	Planned Objectives of the DIP	Baseline	Accomplishments
EPI	60% of children 12 to 24 months will be completely immunized (excluding BCG), in the project target areas from 1993-96.	11.1%	33.9%
Sufficient progress is shown to reach the objectives of the DIP.			
	35% of the women of child-bearing age (15 to 49 years of age) will receive two or more doses of TT in the target areas.	15.3%	5.3%
There is not sufficient progress to reach the objectives of the DIP for the following reasons: The MOH does not give priority to vaccinating women of childbearing age, rather pregnant women are given priority for vaccination; some mothers were not in possession of their vaccination cards; some mothers were afraid or excessively modest and were embarrassed to attend or to request prenatal health services; some MOH personnel do not know the project communities; lack of TTV by the MOH; lack of understanding of the benefits of immunization by the mothers; poorly coordinated vaccination campaigns which do not provide mothers with enough notice.			
CDD	65% of children under the age of 24 months will receive ORS (prepared in individual households).	20.7%	22.4%
There has not been sufficient progress to reach the objectives named in the DIP, although there has been an increase in the number of mothers giving ORS over the baseline values.			
	Children under 24 months will receive ORS during diarrheal episodes.	9.6%	15.8%
Although it was not formally part of the DIP, it should be noted that more mothers are now using ORS that did at baseline.			
	Less than 35% of children under 24 months of age will receive antibiotics and other medicines as treatment for diarrheal episodes.	39.4%	54.6%
There is insufficient progress in these data to reach the objectives of the DIP. This may be a result of the following factors: a strong system of marketing and distributing popular medicines, lack of prescription of ORS as a diarrheal cure affording it a lower status than other medical treatments.			
Nutrition	40% of children will receive breastmilk and will be fed with the same or increased frequency during diarrheal episodes.	10.7%	9.2%
There is insufficient progress to reach the objectives set by the DIP. This is potentially due to the belief held by the mothers that increasing food consumption of the sick child will lead to greater diarrhea.			
	90% of children 5 months and older will regularly receive foods rich in vitamin A.	84.3%	83.1%
Although progress towards the DIP objective can not be reported, the level of intake of vitamin A rich foods			

Component	Planned Objectives of the DIP	Baseline	Accomplishments
Vitamin A	80% of children 6 to 71 months in age will receive vitamin A supplements every 6 months.	27.4%	68.5%
	There is sufficient progress to reach the objectives stated in the DIP.		
	50% of women will receive a vitamin A supplement within 30 days postpartum.	0%	22.3%
	There is good progress being made from baseline values, even though the number of postpartum women identified remains low. Men often accompany women to the birth and they are not knowledgeable about the importance of vitamin A at this time period because they have not participated in the health talks.		
ARI	80% of MOH health center personnel will be capable of correctly reciting the protocol for the management of ARI, by the end of the project.		
	Clapp and Mayne have organized ARI training on a national basis and trained local MOH staff. However, no results exist to measure how successful this training was.		
	100% of project personnel will be able to correctly cite the protocol for ARI management by the end of the project.		
	Staff knowledge was tested after completion of the workshop. They increased their knowledge level by approximately 25% with average post-test score of 75%.		
	75% of the health promoters and volunteers will be capable of properly reciting the ARI management protocol at the end of the project.		
	This activity is scheduled to take place in year three of the project.		
	50% of mother with children 0 to 24 years of age will be able to identify the signs of pneumonia and be able to explain when they should refer their child to the CS nearest their area.	43.0%	27.3%
	Although the data do not show progress in relation to baseline levels, it should still be possible to reach DIP objectives by the end of the project. The broad range of messages may be creating confusion amongst the population. Additionally, there is some doubt that the question which yielded this information on the mid-term evaluation was properly translated from Spanish to Q'eqchi.		

Component	Planned Objectives of the DIP	Baseline	Accomplishments
Gardens	50% of families will plant and maintain vegetable gardens.	38.0%	19.3%
<p>There is insufficient progress in this data to reach the DIP objectives. This could be due to: prolonged summer; families having insufficient land for cultivating vegetables on their property and the population being completely mono or bi-cultural.</p> <p>Nevertheless, seed distribution is progressing well. Staff have been trained by CARE and they are now capable of conducting their own germination tests. As a result staff should demand more participation in this area.</p>			
Eye Care	A yearly treatment regimen will be provided for ocular conjunctivitis in every village.	0%	100%
<p>There is sufficient progress to reach DIP objectives.</p>			
Income Generation	Increase familial incomes through assistance and establishment of four cooperatives or microenterprises.	0%	100%
<p>The is sufficient progress to reach DIP objectives. Initially, the project worked with a group of jewelers who continue to operate independently. Current microenterprise efforts support a women's embroidery group as well as two different poultry projects. There also exists three to four applications from groups to support their budding activities.</p>			
Maternal Health	80% of the hospitals and health centers of the MOH will have medical staff who can identify three principal benefits of family planning.		
<p>The DIP objectives have not been met because these activities are scheduled to begin in year three of the project.</p> <p>80% of the hospitals and health centers of the MOH will have medical staff who can identify the most commonly used methods of family planning, their benefits and limitations.</p> <p>Given that activities are not scheduled until next year, there has been no progress in respect to this objective.</p> <p>70% of the traditional birth attendants will be capable of identifying a high risk pregnancy and will be able refer these women to a medical professional.</p> <p>Again, there has been no progress towards this objective as this activity is scheduled for the final year of the project.</p>			

4. RELEVANT DEVELOPMENT

The project has improved family participation in project activities by employing the following strategies: home visits; organization of groups independent of religious affiliation; extensive contact with leaders to inform them of project activities and enlist their support; use of different methods of communication, including social marketing via radio spots to increase the demand for services and to motivate learning.

5. DESIGN AND IMPLEMENTATION

5.1 DESIGN

Even though the project has not changed its size or impact area, it is important to mention aspects that have affected both project design and implementation as follows:

Positive Design Aspects: The design utilizes volunteers, who are supervised by extensionists. This type of infrastructure strengthens the health sector without creating extra work or need for additional resources. Project activities were derived from needs identified by the baseline survey and the experience of the previous project, including what worked well in communities and what did not.

Negative Design Aspects: The design contains an exceptionally large number of interventions. As a result, the project attempts to transmit a large number of different messages. Additionally, there have been problems working with some communities. The two peri-urban communities originally targeted by the project have been difficult to work with due to a variety of factors, including a general lack of interest in participating with the project. These communities have much greater access to health services and are culturally different (less indigenous). As such, these community members have different perspectives of their health needs and practices.

Some of the communities that were served by the previous project have begun to lose interest in project activities and have also become difficult to work with.

Positive Aspects of Implementation: The most positive implementation component has been health education, which has included the participation of religious leaders and entire villages (both men and women). Having project extensionists stay overnight in the communities has also been beneficial and has also allowed the extensionists to spend more time with volunteers and mothers. Finally, the project has coordinated its activities well with other organizations such as: DIGESA, Share, CARE, Proyecto Q'eqchi, Peace Corps, Clapp & Maine Inc., Proyecto HOPE, UNICEF, INCAP and the National Committee for the Blind and the Deaf.

Each position has a specific job description which allows for the efficient evaluation of project personnel. Two of the field supervisors are seconded from the Government, one from the Ministry of Health and another from DIGESA, the Agriculture Ministry. Both of these individuals train other project staff in their areas of expertise and facilitate the coordination of activities.

Negative Aspects of Implementation: The changes in management staff have been beneficial but have also slowed some activities or interrupted the start of others. Some extensionists trained by the project left soon thereafter in search of a better salary. This forced the project to continue to recruit and train new personnel. Finally, a cholera epidemic forced project extensionists to temporarily drop scheduled activities to support the MOH with its response to the problem.

The project has not changed its area of influence, but it has dropped two suburban communities due to lack of participation. Also, due to the low education level of volunteers, extensionists were forced to assume the role of coordinator and provider of health education in villages. Volunteers were reoriented to focus their efforts on promotion of project activities.

5.2 MANAGEMENT AND DATA USAGE

The project collects and manages the following data:

- Volunteer:** Family Register, immunization and vitamin A data on mother and child
Register of the distribution of ORS
Register of the distribution of seeds for gardens
- Extensionist:** Educational Activity Register
Gardens Register
Daily Activities Register
Time Sheet Register
Weekly Planner
Report of postpartum mothers who receive vitamin A
Report of distribution of Tetracycline
Report of seed distribution
Report of ORS distribution
Report of control of mileage (Cars and Motorcycles, only 3 extensionists use motorcycles)
- Supervisor:** Activities Planning Sheet
Time Sheet
Calendar of completed activities
Report of mileage control for vehicles
Narrative report by intervention
Consolidated ORS distribution by community
Consolidated seed distribution by community
Consolidated vitamin A administration to postpartum mothers by community
Supervision check list
Consolidated list of tetracycline distribution by community
Consolidated educational sessions by community

The Project Manager inputs this data monthly into an EPI-INFO program for analysis. This information is used for preparing the monthly technical report.

The Project Manager, the Country Director and the accountants from Coban and Guatemala prepare the financial report. These reports, together with timesheets, are then sent to the Director of Administration and Finance at headquarters in Bethesda. Annual reports are sent to both USAID Washington and the Hoffmann-LaRoche's "Sight and Life" Program. Initially, the project sent a report to the MOH every four months but stopped this due to the lack of interest in this report by the MOH.

The Program Coordinator at headquarters and the Country Director use the monthly reports to better understand project progress and problems and provide feedback to the Project Manager, supervisors and extensionists. They also share project information with other organizations such as INCAP, UNICEF, Project HOPE, and the National Committee for the Blind and the Deaf. Monthly reports are also used to provide information for the IEF newsletter, to other IEF programs such as Honduras and Malawi, and to other NGOs.

Management in Cobán use monthly information to:

1. Determine the ratio between time and effort that is invested in each intervention,
2. Guide the work of the extensionists,
3. Provide feedback to the supervisors so they in turn can provide feedback to their extensionists,
4. Support the efforts to develop educational talks and cooking demonstrations,
5. Provide a data base for verbal presentations with local authorities (MOH and the nursing school),
6. Provide documentation to UNICEF to continue their donation of ORS,
7. Order supplies and materials,
8. Coordinate plans with MOH,
9. Explore strategies that support the priority components of the MOH.

At the supervisor level, data is used to:

1. Monitor the work of each extensionist,
2. Select future activities in each community,
3. Manage program logistics,
4. Maintain inventories of vitamin A, seeds, ORS and Tetracycline Eye Ointment.

The HIS functions well as the supervisors dedicate only 15% of their time collecting data and providing feedback to their extensionists. The Project Manager dedicates almost 30% of her time condensing and analyzing information in order to produce the reports and provide feedback to the supervisors and extensionists.

All project personnel are involved with data collection and are familiar with the HIS even though only one person, the Project Manager, analyzes and synthesizes the data using EPI-INFO.

The project has implemented changes due to many lessons learned. For example, increased sharing of information at the community level permits the transfer of responsibility to the community for

self care of many health care problems. At the same time, information empowers community members to become more actively involved in solving their own problems. Finally, the result of more active involvement is the creation of demand for MOH services.

Project data serves to convince decision makers of the benefits of project activities, to monitor the usage and inventories of project resources, evaluate the effectiveness of new approaches directed toward sustainability, assist with the motivation of personnel and finally to stimulate the creativity of the project participants to create innovative strategies to improve program implementation in order to achieve the objectives stated in the DIP.

5.3 COMMUNITY EDUCATION AND SOCIAL PROMOTION

The balance between health promotion/social mobilization and service provision is approximately 30% to 70% respectively (when all project activities are combined with support to vaccination campaigns). The project utilizes educational talks, cooking demonstrations, radio spots, home visits, posters, educational videos, flip charts, and other field demonstrations (e.g. demonstration gardens, compost piles, etc.).

Project radio spots and posters have been tested for both content (educational messages) and presentation. In the case of nutrition, messages developed and tested by the IEF Vitamin A Training Unit in Guatemala are used. Project messages on vitamin A and CDD have been tested by KAP surveys. ALRI messages have been tested by Clapp & Mayne. Vaccination messages have been developed and tested by CARE and the MOH. Gardening messages have been approved by Panufam/CARE and DIGESA. Finally, ocular health messages were adopted from approved curriculums of the National Committee for the Blind and Deaf. In summary, the project has only itself tested messages for nutrition and CDD materials although it has utilized other materials already tested by other organizations. Only qualitative information exists for the ARI and nutrition components.

In the area of income generation, the project used materials developed and approved by the Peace Corps. No messages/materials have yet to be developed for the project's maternal health activities which are planned for the third year of the project.

All educational messages are contained in a "Training Guide". While all project personnel are familiar with this guide, it lacks a detailed guide describing methodology and educational objectives. It is recommended that the project better develop its method of participatory education for adults.

The Project does not generally distribute printed promotional or educational materials to project communities. Printed material is distributed to project extensionists for use in communities. These extensionists also have access to an inventory of audio visual materials. Messages are primarily transmitted by way of educational talks and demonstrations. The project does not use nonformal education methodologies. It could also use technical assistance to better evaluate the effectiveness of its current health education activities.

5.4 HUMAN RESOURCES FOR CHILD SURVIVAL

The number and mix of personnel corresponds well to the technical, administrative and operational needs of the project. This mix is estimated to be 70% effective, with the major limitations focused on staff changes during start-up and the limited education levels and experience of field staff. Nevertheless, there is no duplication of work as staff responsibilities are detailed in official position descriptions and all personnel are familiar with their individual assignments.

Volunteers are responsible for the following tasks: promotion of vaccination campaigns, registration of children, registration of mothers, registration of vitamin A administration, distribution of ORS and seeds, registration of gardens, and technical assistance to families regarding the planting of the gardens. Currently, there are approximately 200 volunteers in 49 communities. Volunteers dedicate between 1/2 and 1 day per week to their activities with the project.

Project extensionists dedicate one day per week to each community. They are in charge of giving educational talks according to an established schedule specifying a theme of the month (e.g. CDD, vitamin A, immunizations, etc.) coordinating cooking demonstrations, providing technical assistance on the planting and care of home gardens and on the maintenance of family registers and data collection.

Field supervisors dedicate: 70% of their time each month to visiting communities and supervising extensionists; 15% to preparing reports; 10% to coordinating specific activities; and 5% to participating in training. The Project Manager spends 30% of her time preparing reports, 20% coordinating activities with other organizations, 25% performing general administration, 15% coordinating training activities and 10% visiting project activities in the field.

Most project training activities have utilized traditional methodologies. There have been refresher courses and evaluations to test the level of comprehension for volunteers, extensionists, and supervisors to assure the consistency of understanding.

Post training tests given to project supervisors and extensionists have shown an average increase in knowledge levels of approximately 25% from the pretest. A norm of 75% comprehension is considered adequate for each theme (see Annex A.2).

The maternal health activities (TBA training and workshop for MOH personnel on reproductive health) noted in the DIP are scheduled for later this calendar year. It is recommended that the project consider the inclusion of information regarding sexuality (e.g. male and female fertility, menstruation, etc.) in all training to begin the long process of educating villagers to attempt to remove many of the incorrect cultural beliefs around reproductive health.

5.5 MATERIALS AND SUPPLIES FOR LOCAL PERSONNEL

Essential materials and supplies for each intervention are noted below:

<u>Component</u>	<u>Essential Materials/Supplies</u>
CDD	ORS, data collection forms, educational posters, signs indicating where ORS is distributed, educational materials (e.g. videos, flip charts, radio spots, learning games)
ALRI	Educational materials (e.g. message guide and radio spots)
Vitamin A	Vitamin A capsules and educational materials (e.g. message guide, flip chart, posters and filmstrips).
Nutrition	Educational materials (e.g. message guide, flip charts, posters, banners, recipes, flannel graph and radio spots)
EPI	Immunization cards, registration forms and educational materials (e.g., videos, radio spots and posters)
Ocular Health	Tetracycline eye ointment and education materials (e.g. message guide, eye charts, radio spots, posters, etc.)
Maternal Health	No materials yet needed or developed
Gardening	Seeds, signs indicated where seeds are sold and educational materials (e.g. message guide, radio spots, flip charts, recipe books, and guides to making natural fertilizers and insecticides)

There are not enough materials for all project personnel or for key reference sites such as district health centers. Supervisors and extensionists have 93% of the educational message guides needed but these guides are not organized according to each month's theme. Project staff have access to sets of materials for each intervention. Volunteers and reference sites, however, have insufficient educational materials and message guides. (Source: inventory of educational material and group consensus among field supervisors and the Project Manager.)

Regarding horticulture, the project has acquired sets of educational materials which are used appropriately by extensionists in their assigned communities.

5.6 QUALITY

The project has only gathered data using qualitative methods for its ALRI and nutrition components. Apart from other information gathered by the KAP surveys (re. CDD and maternal health) very

little other qualitative data exists. Additional qualitative data, especially information describing knowledge, skills and practices of the mothers in relation to the other project components would be helpful to assist with implementation of other field activities.

The results of the information gathered as part of this evaluation (mothers, volunteers, leaders, and counterpart personnel) are found in the Appendix. Overall, there is interest to support sustainability of the project at the community level. People in the communities (mothers, volunteers and leaders) are familiar with the project, its activities and its personnel. They know where to obtain ORS and where to buy seeds. Many suggested that volunteers/other villagers be trained to continue the work of the project once it finishes in September 1996. The majority of those interviewed believe that the participation of the men of the community is indispensable.

MOH staff are also familiar with the project and its activities. While they believe that project activities benefit project communities, and project personnel are very responsible and hard working, they would like to improve the relationship between the MOH and the project, and increase the exchange of information to improve future coordination and activity planning. They noted that the delivery of health education messages by the project and the MOH has not been very well coordinated. They also remarked that they would like to learn more about non-formal educational methods.

While in the beginning of the project, communication between staff was affected by some personality differences, this problem has since been successfully resolved. Currently, men seem to excel at the position of extensionists working well with both men and women, even though it was more difficult for them to initiate activities with mothers in the beginning. Female extensionists have found it easier to start their work in the communities, but they seem to work exclusively with women. Female extensionists believe that they can improve their work if they receive training in different educational methodologies (e.g. participatory methodologies) that remove them from the center of attention yet allow them to promote learning in a group setting.

5.7 SUPERVISION AND MONITORING

Field supervisors accompany their extensionists to the field four or five days per week. They use a check list to evaluate the work of extensionists regarding educational activities, cooking demonstrations, home gardens, seed sales, and ORS distribution. Supervision takes place weekly and usually last the entire day. Supervision of the field supervisors by the Project Manager takes place weekly. Annually, a formal performance evaluation of field supervisors and extensionists is completed, using a format which first allows for a self-evaluation and then is completed by each class of worker's supervisor. The ability of the Project Manager to make field visits has been limited by her administrative workload and the number of inter-agency meetings that she must attend.

Field supervisors and extensionists would like to be visited in the field by the Project Manager and Country Director more often. They stated that supervisory field visits motivate them to be better prepared for their work. The Country Director currently spends 20% of his time on general

administrative matters, 15% of his time attending meetings, and 65% of his time on supervision and technical matters. He was ultimately responsible for four projects in 1994 and is currently responsible for three projects.

The Country Director has provided only limited support to the Project Manager. His visits to Coban were sporadic in the past few months and when they did occur, they were not planned in advance with any outlined objectives. Nevertheless, he stays in constant telephone contact with the Project Manager.

The Program Coordinator from Bethesda Headquarters visits Guatemala every four months and is the principal source of technical assistance to the Project Manager. The Project Manager mainly consults the Country Director regarding administrative matters.

The duration and frequency of supervision is appropriate at the level of volunteer, extensionist and field supervisor. It is necessary to augment the amount of field supervision on the part of the Project Manager and the Country Director to reinforce technical aspects of program implementation and insure a good level of coordination with the counterpart organizations.

Extensionists and field supervisors feel they need a refresher course in the technical aspects of Child Survival and in educational methodology to improve their skills.

Supervisors use a one page checklist to evaluate the extensionists in their activities, (register of cases of diarrhea and the use of ORS, seed sales register, school gardens register, family gardens register, educational talks methods, cooking demonstration, and feedback to the leaders). The activities are evaluated according to whether they have been presented correctly or not. No detailed provision is made for grading degrees of quality nor is there any provision to noting what improvements are warranted.

The checklist needs to be improved to better evaluate the quality of the services performed. The Project Manager needs to constantly evaluate the knowledge and quality of services provided by the extensionists and the supervisors through continuous spot checks.

5.8 SUPPORT FROM THE REGIONAL AND CENTRAL OFFICES

The support from Bethesda Headquarters is appropriate on the part of the Program Coordinator in terms of frequency and duration. However, the Executive Director has not visited the project in the last few years. The Director of Administration and Finance and the Director of Programs should visit the project at least biannually.

Prior to each visit to Guatemala or Coban, Headquarters staff should inform the Country Director of his or her objectives so that he can prepare an agenda and schedule the activities appropriately. While this has happened informally in the past, a more formal process would aid the Country Director in his planning and support of such visits.

5.9 USE OF TECHNICAL SUPPORT

The Project has received technical support from the following local organizations: CARE, Gardens; Clapp & Mayne, ALRI; MOH, CDD; and the National Committee for the Blind and the Deaf, ocular health.

Technical assistance needs to be provided in quality assurance of field supervision, non-formal education techniques and qualitative investigation to refine the basic messages of each project component.

Obstacles have been encountered in obtaining technical support. Often, consultants provide assistance that is not precisely targeted towards the needs of the project beneficiaries. For example, support that was to be obtained from Genesis in small business development was not provided. While it appeared to be appropriate at the time of the development of the DIP, villagers concluded that they did not want to work with this agency due to the high rates of interest that it charged its customers for short-term business loans. Short-term consultancies with very defined objectives and work tasks may be a good strategy to obtain the assistance that the project needs in its last year of implementation.

5.10 COUNTERPART RELATIONS EVALUATION

The project's main counterpart is the MOH. The project has coordinated with the MOH during vaccination and vitamin A campaigns, training sessions and information exchanges. There has not been any exchange of money between the project and the MOH although the project has donated some educational materials to the health centers. Regarding human resources, the MOH and DIGESA have seconded a health technician and a home educator, respectively to work as project field supervisors. Both employees have received their principle salaries from the Government for the past twenty months.

The MOH personnel do not currently possess the administrative or technical capacity to continue the operation of project activities in project communities. Before they can assume this responsibility they will have to be further trained in health education and project administration and be given additional educational materials.

The project maintains an open dialogue with the MOH, but local MOH representatives feel that improvement can be made to strengthen communication. The MOH's relationship with the community is weak in some cases.

5.11 REFERENCE RELATIONSHIPS

Referrals and counter-referrals from volunteers to MOH reference sites is good. However, these same volunteers and other community residents think that they are not being attended to well. Reasons cited for this perceived treatment and the failure of villagers to utilize referral facilities include:

1. The MOH does not recognize the importance of health volunteers,

2. Health centers are not very accessible in terms of distance from villages or hours open,
3. Villagers fear hospitals believing that only terminally ill cases are referred to the hospital.

Currently, with the National Committee for the Blind and the Deaf's Hospital in San Pedro Carchá, referrals and counter-referrals work well. Daily referrals are made to this facility by project extensionists. This reflects the impact of the educational activities and eye campaigns in project villages which have increased the demand for ocular health services.

Some small problems regarding specific negative attitudes and misinformation need to be resolved in order to improve the referral relationship between MOH facilities and project personnel. While the overall relationship between the project and the MOH is adequate, it could be improved by dedicating more time to communication and joint planning.

There have been few formal efforts to improve the access to the services (qualitative investigation of barriers: work schedule, geographic access, acceptability, language, attitudes, credibility, satisfaction with the services, etc.) or to strengthen these services at referral sites.

5.12 COOPERATIVE NETWORK WITH OTHER ORGANIZATIONS:

The MOH has improved its vaccination coverage by integrating vitamin A supplementation activities with EPI campaigns. Impact can also be seen through the increased sales of vegetable seeds, increased numbers of family gardens, improved nutritional habits, and increased knowledge of the benefits associated with increased consumption of vitamin A-rich foods combining the support of DIGESA and the transportation and resources of the project. Upon combining CARE's planting methods with the project's educational materials, technical assistance and seeds, there has been an improvement in the project personnel and community members knowledge of home gardening.

The income generation component has achieved its modest goals thanks to the collaboration of a microenterprise Peace Corps volunteer. The project supports this component with a revolving fund, transportation and supervision.

The project has also collaborated with both INCAP and CeSSIAM to monitor the levels of fortification of both sugar and salt with vitamin A and iodine respectively.

Some local situations have negatively affected implementation of the project, such as: religious beliefs contrary to reproductive health activities; rumors of project activities leading to/supporting sterilization; poor access to health centers (isolated centers, lack of transportation, absence of personnel and/or overworked personnel); cholera epidemics which forced the project to delay programmed activities, lack of confidence by villagers in the services that the health centers provide; paternalism created by other institutions; cultural differences between indigenous villagers and usually mestizo health providers; male dominance of local culture limiting the decision-making ability of women.

Positive aspects that facilitate project implementation include: good inter-institutional coordination; strong, existing community organizations (leaders, midwives, and promoters); demand in

communities for training of local people as health promoters; no other competing health organization most communities; positive projection of the project in communities; isolated areas with great need and demand for health education; favorable climate and soils for the planting of family gardens; and the convenient location of the eye hospital of the National Committee for the Blind and the Deaf.

At the national level a number of negative aspects have influenced implementation of the project. The overall economy is in a state of deterioration and poverty abounds. Rumors continue to spread regarding abductions of children. Finally, there exists a tremendous apathy regarding the government's inability to provide services which, in turn, leads to a reduction in the demand for these services which are the Government's responsibility.

Positive situations on the national level that aid project implementation include: the move towards decentralization of the MOH, the willingness of the government to cooperate with NGOs and the positive attitudes and demonstrated leadership of MOH management in relation to collaborative activities.

Project activities are not being duplicated by any other organization. The project is recognized as an educational entity in the health care field, and its effectiveness has increased as a result of the support provided by other organizations. The project should continue to assume a leadership role, organizing and convening meetings among other NGOs in relation to pressing health and development issues.

5.13 BUDGET MANAGEMENT

An analysis of the budget analysis shows that 43% of the budget has been spent. No major changes have yet to be made to the budget. The project has sufficient funds to continue its effort to reach the goals proposed in the DIP. It is likely that all of the budget will be spent. The budget is being managed well. To be able to solicit funds from the local USAID mission, the project should investigate what certification of its financial system would be necessary, and it should pursue this (please refer to Annex B).

6. SUSTAINABILITY

Please refer to Annex C.

7. RECOMMENDATIONS

SPECIFIC RECOMMENDATIONS

It is recommended that the project pursue the following recommendations:

1. Participate in scheduling collaborative activities with the MOH and continue to promote MOH services. Improved communication should be encouraged on all levels, especially given the movement towards health care reform in Alta Verapaz.

2. Initiate the transfer of materials and educational methodology to the MOH as soon as possible in the key project interventions.
3. Solicit financial certification from USAID/Guatemala so that the project will be sanctioned to manage local USAID funds.
4. To strengthen local personnel as a move toward sustainability, provide more budget information to project personnel so that they can better budget purchases of tools and materials.
5. Strengthen the supervision and monitoring objectives for each intervention at each job level to improve the quality of services provided. Perform random "spot check" evaluations of staff knowledge of key interventions to ensure that staff maintain an adequate level of knowledge and a consistent level of performance transmitting health messages.
6. Revise the message guide, selecting the minimum number of key messages for each component. Messages should be tested. Finally, messages should be delivered using a participatory methodology with well defined educational objectives. This will help extensionists evaluate the results of their educational activities.
7. Initiate maternal health activities with an investigation of the knowledge and beliefs regarding sexuality (menstrual cycles -- fertile and infertile stages, duration, etc., masculine and feminine fertility) as a first step toward a larger informative program based on UNICEF's book, Facts for Life. This could serve as the basis of a research proposal.
8. Prioritize project components based on the probability of success and emphasize these priorities when training personnel to better utilize project resources. Currently, staff are overwhelmed with the great number of interventions and project messages.
9. To promote sustainability, the project should begin training community health promoters and TBAs using a phased training schedule (e.g. training sessions of 2 to 3 days per week).
10. To address the outstanding training needs of the project over the next six months, consultants should be employed to complete identified decreet tasks. They could also be utilized to work on projects to strengthen specific program components.

GENERAL RECOMMENDATIONS

1. Strengthen the educational methodologies and qualitative research of the project to provide information to better guide project implementation and provide the project with additional skills to allow it to be more flexible to modify the program focus and even offer services to other institutions.
2. Continue collaborative activities and to share information with the local, public, private, national and international, health and development organizations.

3. Investigate the possibility of diversifying funding sources taking advantage of the solid financial management capability experience developed by the current project.
4. Strengthen the qualitative data bank to improve health education messages and actions at the community level.
5. Improve relationships with local religious leaders, including the Catholic Bishop and other leaders of the Catholic Church in Guatemala City, and government representatives.
6. Familiarize staff with the Guatemala's Catholic churches stand on family planning.
7. Continue the referral system established with the National Committee for the Blind and the Deaf and pursue a joint investigation with the MOH of the barriers affecting its referral/counter-referral system.
8. Delegate data consolidation responsibilities to administrative staff to allow for more time to ensure the quality of services provided by field staff.
9. Have the Country Director and the Project Manager jointly plan visits to local organizations and coordinate the procurement of technical support from IEF Headquarters, as well as from other available local resources.
10. Have the Program Coordinator at Headquarters investigate the possibilities of modifying the focus of the project without losing its principal organizational characteristics (health education program focused on the transfer of information and knowledge based on qualitative investigation).
11. Take advantage of the project's prestige to continue investigating themes that might interest different sectors such as: education for young girls with AED and FONAPAZ; reproductive health/sexuality with USAID/Guatemala, PATH, Mother Care, and Population Council; HIV/AIDS with USAID/Guatemala, the Catholic Church, AIDSCAP; street children with PAMI, UNICEF and Child Hope; training for traditional birth attendants with INCAP and Mother Care; Women's issues with UNICEF; income generation activities with USAID/Guatemala and the German Chamber of Commerce; educational activities in maternal and infant health with Project HOPE; and natural family planning and breastfeeding with Georgetown University.
12. Explore local foundations as possible funding sources including Castillo Love and Castillo Brothers. The project should also investigate if any the owners of any large farms would be willing to pay to support project educational activities.
13. Implement a participatory education methodology that would investigate the main health problems in each community and how to solve them locally with the help of a recognized, organized committee (Pro Health Committee). A proposal with a detailed implementation plan including a budget detailing the communities' contribution in terms of time, labor, materials, land, etc. could be developed and used to solicit funds from other institutions.

8. ANNEXES

ANNEX A

Table 1: Project Inputs and Outputs

Table 2: Training Workshop/Courses

Table 3: In-service Training

ANNEX B: BUDGETARY ANALYSIS

Pipeline analysis

ANNEX C: SUSTAINABILITY GOALS, MID-TERM MEASURES AND STEPS TAKEN/NEEDED

ANNEX D: SOURCES OF INFORMATION

ANNEX E: INSTRUMENTS USED TO COLLECT INFORMATION

ANNEX F: RESULTS OF INTERVIEWS AND FOCUS GROUPS

ANNEX A

**Table 1
Project Inputs and Outputs**

Intervention	Results
1. EPI a. IEF staff trained b. Quarterly campaigns c. Education talks	 25 5 91
2. Primary Eye Care a. IEF staff trained b. Community campaigns	 25 1
3. Vitamin A a. IEF staff trained b. Volunteers trained c. MOH staff trained d. Semiannual campaigns e. Women postpartum receiving vitamin A f. Capsules distributed to MOH/other institutions g. Health fairs h. Teachers trained	 25 165 168* 2 338 29125 1 60

* Doctors, nurses, health promoters and nursing students

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Intervention	Results
<p>4. Control of Diarrhea</p> <ul style="list-style-type: none"> a. IEF staff trained b. Volunteers/promoters trained c. ORS distributors selected & trained d. ORT education talks e. ORS distributed f. Latrines i. Radio spots produced 	<p>25</p> <p>165</p> <p>55</p> <p>204</p> <p>2667</p> <p>250</p> <p>1</p>
<p>5. ARI</p> <ul style="list-style-type: none"> a. IEF staff trained b. MOH staff trained c. Health education talks d. Radio spots produced 	<p>26</p> <p>32*</p> <p>67</p> <p>1</p>
<p>6. Nutrition/Health Ed.</p> <ul style="list-style-type: none"> a. IEF staff trained b. Education talks c. Cooking demonstrations 	<p>25</p> <p>366</p> <p>450</p>

* Provided by Clapp and Mayne

Intervention	Results
7. Income Generation a. IEF staff trained b. Formation of IG groups	25 4
8. Home Gardens a. IEF staff trained b. Volunteers trained c. Functioning revolving funds	25 165 49
9. Intestinal Parasites a. Campaigns b. % children 2 - 6 years receiving treatment	1 73

Average attendance of mothers at monthly educational talks is 750

Table 2
Training Workshops/Courses

Ext = Extensionist
 Field Supervisor = FS
 PM = Program Manager
 MOH = MOH staff

Type/# Dates	Topics	Hours	Training Methods
5 FS 14 Ext 2/8-9/94	Rapid Surveys	16	Lecture, role play, field practice
5 FS 14 Ext 2/22-23	Community Diagnosis	16	Lecture, small discussion
1 PM 5 FS 4 Ext 2/24/94	Program Planning	8	Lecture, discussion
4 FS 14 Ext 4/20-22/94	Leadership	24	Lecture, role plays, discussion
4 FS 12 Ext 4/4/94	Vitamin A	5	Lecture, discussion
4 FS 12 Ext 4/7/94	Nutrition	8	Lecture, discussion
4 FS, 12 Ext 4/5/94	EPI	8	Lecture, discussion
4 FS 12 Ext 4/29/94	Gardening	8	Lecture, field practice

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Type/# Dates	Topics	Hours	Methods
4 FS 12 Ext 4/6/94	CDD	8	Lecture, discussion
5 FS 12 Ext 4/27/94	ARI	8	Lecture, discussion
5 FS 12 Ext 4/1/94	Needs analysis - IGAs	8	Lecture, discussion
1 PM 5 FS 14 Ext 7/21-22/94	Primary eye care	12	Lecture, field practice
165 Vols. 8/29-9/1/94	CS - CDD, Vitamin A, Gardens, MIS and Responsibility	64	Lecture, role plays, discussion
1 PM, 4 FS 11/17/94	ALRI	6	Lecture, video
4 FS 12 Ext 1/2-6/95	EPI, ARI, CDD, Nutrition, PEC, Gardening	40	Lecture, role play, videos, discussion Pre: 64/100 Post 85/100

2 FS 7 Ext 4/6-7/95	EPI, ARI, CDD, Nutrition, Gardening, PEC	24	Lecture, role play, videos, discussion Pre:77/100 Post:85/100
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Type/# Dates	Topics	Hours	Methods
1 PM 5 FS 15 Ext 4 MOH 2 IEF/Hond 6/1-6/95	Rapid surveys	48	Lecture, small group discussion field activity

Table 3 - In-Service Training

Type/# Dates	Topic	Hours	Methods
3 FS 12 Ext 3/11/94	Audio-visual aids - general	1	Lecture, role play
4 FS 12 Ext 9/30/94	Audio-visual aids - posters/flannelgraphs	0.5	Lecture, role play
12 Ext 6/24/94	Audio-visual aids - flipcharts	1.5	Lecture, discussion
3 FS 12 Ext 9/23/94	Organization management	2	Lecture, discussion
5 FS 11 Ext 9/30/94	Group education	2	Lecture, discussion
4 FS, 12 Ext 5/24/94	Vitamin A	1	Lecture, discussion
4 FS 12 Ext 5/13/94	Intestinal parasites	1	Lecture, discussion
4 FS, 12 Ext 9/30/94	Nutrition of pregnant women	1.5	Lecture, discussion
4 FS, 12 Ext 7/29/94	EPI	2	Lecture, discussion
5 FS, 12 Ext 5/20/94	Cholera	2	Lecture, discussion
5 FS, 12 Ext 9/2/94	ARI	2	Lecture, discussion

Type/# & Dates	Topic	Hours	Methods
5 FS, 12 Ext 6/1/94	Management of revolving funds	2	Lecture, discussion
5 FS, 12 Ext 9/1/94	Family budgeting	2	Lecture, discussion
3 FS 8/1/94	Computers - WordPerfect	3	Lecture, practice
41 MOH 10/4/94	Vitamin A	2	Lecture
4 FS, 12 Ext 10/14/94	Infant nutrition	1.5	Storybooks
4 FS, 12 Ext 10/14/94	CDD	2	Lecture, demonstration
4 FS, 11 Ext 11/11/94	Small business feasibility studies	2.5	Storybooks Pre: 3.5/5 Post:4.6/5
4 FS, 12 Ext 11/25/94	PEC	2	Lecture, discussion Pre:2.9/5 Post:4.0/5
4 FS, 16 Ext 2/24/95	Small business administration	1.5	Lecture, small group discussion Pre:3.3/6.0 Post:5.7/6.0
4 FS, 16, Ext 5/12/95	Operational costs	1.5	Small group discussion Pre:3.9/6.0 Post:5.3/6.0
60 Teachers 5/25/95	Vitamin A	2	Lecture with slides

ANNEX B

BUDGETARY ANALYSIS

1. During the 57% of the completed project period, the project has spent 42% of its original budget.
2. Fifty-one percent of the salary line item has been spent, although this does not take into account severance pay which will be paid at the end of the project.
3. Regarding transportation and per diem, 73% of allotted funds have not been spent, although the funds for international travel have been over spent and the funds for in country travel have been under spent.
4. Eighty-five percent of funds for consultants are still available.
5. There still remains 83% of the originally budgeted funds for supplies, equipment, and training.
6. Regarding the communications, facilities and other direct cost line item, 65% of budgeted funds still remain.
7. Eighty-four percent of the funds budgeted for indirect costs still remain.

For more information, please refer to the attached budget. The project has shown significant savings and plans to use these funds to strengthen the information system, assist with the transfer of technology and educational methodology to the MOH and to purchase educational materials and gardening tools for use at the community level. The project should review the projected expenditures associated with training, maintenance costs of vehicles, computers and office equipment and development of educational materials to be used in communities. The project should also review the recurrent costs associated with its long-term sustainability in Guatemala.

1994 COUNTRY PROJECT PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

		Actual Expenditures to Date 09/30/93 to 09/30/95			Projected Expenditures Against Remaining Obligated Funds 10/01/95 to 09/29/96			Total Agreement Budget (Columns 1 & 2) 09/30/93 to 09/29/96		
I. DIRECT COSTS										
A. PERSONNEL (salaries, wages, fringes)										
1. Headquarters-wages/salaries		5,754	6,195	11,949	4,450	17,218	21,676	10,213	23,413	33,625
2. Field, Technical Personnel-wages/salaries		154,182	12,860	167,022	64,518	14,070	98,588	238,680	26,930	265,610
3. Field, Other Personnel-wages/salaries		17,248	17,712	34,958	22,727	4,066	26,793	39,873	21,778	61,751
4. Fringes - Headquarters + Field		29,341	20,968	50,009	6,768	6,906	13,374	36,109	27,274	63,383
SUBTOTAL - PERSONNEL		206,503	57,435	263,938	118,472	41,960	160,431	324,975	99,395	424,399
B. TRAVEL/PER DIEM										
1. Headquarters - Domestic (USA)		590	66	656	1,810	(66)	1,744	2,400	0	2,400
2. Headquarters - International		2,328	3,418	5,746	(516)	2,532	2,016	1,812	5,950	7,762
3. Field - in country		7,479	0	7,479	15,421	0	15,421	22,900	0	22,900
4. Field - International		2,055	0	2,055	3,195	3,450	6,645	5,250	3,450	8,700
SUBTOTAL - TRAVEL/PER DIEM		12,452	3,484	15,936	19,910	5,918	25,828	32,362	9,400	41,762
C. CONSULTANCIES										
1. Evaluation Consultants - Fees		0	0	0	12,000	0	12,000	12,000	0	12,000
2. Other Consultants - Fees		4,153	400	4,553	3,405	(400)	3,005	7,558	0	7,558
3. Consultant travel/per diem		2,444	575	3,019	6,066	3,225	9,291	8,500	3,800	12,300
SUBTOTAL - CONSULTANCIES		6,597	975	7,572	21,461	2,825	24,286	28,058	3,800	31,858
D. PROCUREMENT (provide justification/explanation narrative)										
1. Supplies										
a. Headquarters		0	310	310	700	(160)	540	700	150	850
b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)		543	3,678	4,421	10,227	18,622	28,849	10,770	22,500	33,270
c. Field - Other		15,482	1,421	16,903	(4,432)	(1,421)	(5,853)	11,060	0	11,060
2. Equipment										
a. Headquarters		0	670	670	0	80	80	0	750	750
b. Field		0	17,046	17,046	0	13,964	13,964	0	31,000	31,000
3. Training										
a. Headquarters		0	57	57	250	(57)	193	250	0	250
b. Field		8,390	12	8,402	21,185	(12)	21,173	29,575	0	29,575
SUBTOTAL - PROCUREMENT		24,415	23,364	47,809	27,930	31,006	58,938	52,345	54,400	106,745
E. OTHER DIRECT COSTS (provide justification/explanation narrative)										
1. Communications										
a. Headquarters		0	2,855	2,855	0	2,020	2,020	0	4,875	4,875
b. Field		7,875	484	8,359	3,525	(484)	3,041	11,400	0	11,400
2. Facilities										
a. Headquarters		0	0	0	0	0	0	0	0	0
b. Field		18,245	2,500	20,745	5,830	2,700	8,330	23,875	5,200	29,075
3. Other										
a. Headquarters		250	1,334	1,584	(250)	(1,334)	(1,584)	0	0	0
b. Field		24,682	20	24,702	15,518	(20)	15,498	40,200	0	40,200
SUBTOTAL - OTHER DIRECT		51,052	7,169	58,245	24,423	2,882	27,305	75,475	10,075	85,550
TOTAL - DIRECT COSTS		301,019	92,481	393,500	212,196	84,599	298,784	513,215	177,070	690,284
II. INDIRECT COSTS										
18.7%										
A. INDIRECT COSTS										
1. Headquarters		50,999	11,830	62,729	45,073	15,345	60,418	95,972	27,175	123,147
2. Field (if applicable)		16.7%			21.2%					
		50,999	11,830	62,729	45,073	15,345	60,418	95,972	27,175	123,147
TOTAL - INDIRECT COSTS		351,918	104,311	456,229	257,269	99,934	357,202	609,187	204,245	813,431

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ANNEX C

Sustainability Goals, Mid-term Measures and Steps Taken/Needed

Goal	End of Project Objectives	Steps Taken to date	Mid-term measure	Steps Needed
1. Train health center staff in: Vitamin A ARI CDD Reproductive Health Supervision	25 staff trained 25 staff trained 25 staff trained 25 staff trained 25 staff trained	41 staff trained 32 staff trained* 32 staff trained* 0 staff trained 0 staff trained	41 (more than 100%) 32 (more than 100%) 32 (more than 100%) 0 (0%) 0 (0%)	None None None Activity planned year 3 Activity planned year 3
2. Train health promoters and volunteers in: Vitamin A ARI CDD Nutrition EPI	185 persons trained 185 persons trained 185 persons trained 185 persons trained 185 persons trained	165 persons trained 0 persons trained 165 persons trained 0 persons trained 0 persons trained	165 (89%) 0 (0%) 165 (89%) 0 (0%) 0 (0%)	Train 20 promoters/vols Train 185 promoters/vols Train 20 promoters/vols Train 185 promoters/vols Train 185 promoters/vols
3. Create market demand for appropriate treatment of diarrhea	Sustain ORS as a marketed good sold at cost	MOH Technical Advisory group oppose ^d this idea and it was placed on hold	-----	Goal has been dropped

* Trained by Clapp and Mayne, a major contractor and source of technical assistance from the field.

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Goal	End of project objectives	Steps taken to date	Mid-term measure	Steps needed
4. Develop financial/credit support mechanisms to provide income-generating opportunities for women with children	Establish four cooperatives/micro-enterprises	Four cooperatives established	4 (100%)	Continue to support and maintain those small businesses which have recently been established
5. Improve promotion & credibility of NCBD eye hospital by making appropriate referrals	Establish a referral mechanism with the local eye hospital's Director and Social Worker	Formal referral mechanism established between the project and the eye hospital	1 (100%)	Maintain referral mechanisms y continue sending patients to the eye hospital.
6. Increase availability of local vitamin A rich food sources	Establish 1500 family gardens	274 family gardens established	274 (18%)	Promote 1226 more family gardens
7. Increase resources at local level to sustain home gardens	Establish 25 revolving funds by the end of the project	49 revolving funds are functioning and are actively supported by the project	49 (> 100%)	Train and transfer to volunteers the responsibility to maintain these funds.

ANNEX D

SOURCES OF INFORMATION

Information was obtained through focus groups and interviews with mothers, volunteers and leaders from the following communities.

**Cooperativa Samac
Chiqueleu
Pocolá
Caquipec
Granadilla
Mestelá**

The following people were interviewed:

**Dr. Enrique Velázquez, Assistant Area Director, Cobán, MOH
Dr. José Hernandez, District and Health Center Director, San Pedro Carchá
Dr. Julio Rosales, District and Health Center Director, Cobán
Magda Moeschler, R.N., District of San Juan Chamelco
Flory Baylón, R.N., District of San Pedro Carchá
Ana del Carmen Archila, R.N., District of Cobán
Carlos Piedrasanta, Manager of Project PANUFAM, CARE
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ANNEX E

INSTRUMENTS USED TO COLLECT INFORMATION

The following guides were used for the focus groups and interviews:

QUESTIONS FOR THE FOCUS GROUPS OF MOTHERS

1. What does the project do in this community?
2. What made you participate in the project?
3. Who sells seeds in your community?
4. Who distributes ORS in your community?
5. Why are there not more family gardens?
6. When the project is over who would be ideal to continue giving educational talks?
7. Which activities that the extensionist performs benefits your family the most?
8. Why don't some mother vaccinate their children?
9. Why don't some women, including the ones that are pregnant, get vaccinated?
10. Why don't some women go to the health center during their pregnancy for checkups?
11. Have you heard the vitamin A messages on the radio?
12. How often does the extensionist come to your community?

GROUP INTERVIEW WITH VOLUNTEERS

1. How long have you been a volunteer for the project?
2. What motivated you to start volunteering with the project?
3. What do you do as a volunteer?
4. How well does the project work?
5. How would you improve your work as a volunteer?
6. When the project is over will you continue your work as a volunteer, yes/no, why?
7. What would you like covered in future training? How? Where? What themes?
8. Would you like to be a Rural Health Promotor?
9. How much time do you have available to be trained to be a Rural Health Promotor?
10. What other institutions have supported you as a volunteer?
11. Why have some volunteers resigned?
12. How much time do you dedicate to your job as a volunteer?
13. What information do you collect, what is it for and to whom do you deliver it?
14. Do the extensionists share the information with you that they collect?
15. How do the referrals work? (For example, in the case of a ORT volunteer).
16. How often do the extensionist and the field supervisor visit you?

GROUP INTERVIEW WITH LEADERS

1. Are you familiar with the vitamin "A" project?
2. Who are the people who execute the activities of the project in this community?
3. Which do you feel are the most important activities?
4. Of these activities, which ones would you like to continue when then project is over?
5. How have you supported the project?
6. What needs to be done to improve the project and the community's participation?
7. What changes have you noticed since the project began?

GUIDE FOR THE INTERVIEW WITH MOH MANAGEMENT PERSONNEL

1. Which Project activities are you familiar with?
2. How do you value the contribution of the project to your district?
3. Are the health centers in your district sufficiently supplied with antibiotics and other supplies such as ORS for treating ALRI and diarrhea?
4. At some time during the year was there a shortage of medicine?
5. When did the last vaccination campaign take place in your district and what was the coverage for Polio, Measles, Diphtheria, TT, and TB?
6. To what do you attribute the low coverage of TB and TT?
7. What is the quality of the references made by the health promoters and traditional birth attendants?
8. How frequently do you train promoters?
9. How often do you supervise them?
10. How do you suggest to improve the coordination and integration of project activities with the program in your district?
11. Which activities could be integrated into the programming of your district when the IEF project leaves in September of 1996?
12. How is the health sector reform process affecting Alta Verapaz?
13. How can the project contribute to the health sector reform?

ANNEX F

RESULTS OF THE INTERVIEWS AND FOCUS GROUPS

MOTHERS

Mothers feel that the project: "teaches and brings new ideas about how to take better care of [their] health and prevent [their] children and themselves from contracting diseases". They mentioned that they have "learned how to plant vegetables" and that the project has "taught [them] to eat better", how to properly use latrines and how to make appropriate referrals for eye problems.

Mothers participate because, "[they] are interested in learning", or "[they] feel the need to learn how to take care of [their] children to help them grow up healthy", and to "take care of themselves." They also attend because they want to learn how to plant vegetables and learn how to prepare healthier food.

In all project communities, mothers know who distributes ORS and seeds for their gardens. They think that more people do not have gardens because "they do not know their benefits", "they do not want to work", "they do not have space to plant because other crops are planted (corn and beans)" or because their husbands do not let them participate as "they have to be in the kitchen". They think that this situation could change if their husbands were invited to participate.

Mothers said that they hope to elect one person that has sufficient knowledge to continue giving educational talks and cooking demonstrations in their community. This person, "could be the volunteer if he/she has the training of a health promotor." They mentioned that they would like a man to work with the men and a woman to work with the women.

Mothers believe that the most important activities that the extensionist performs are the educational talks about health, cooking demonstrations and the promotion of family gardens.

It seems mothers who do not vaccinate their children are afraid of the secondary effects such as fever and abscesses and are afraid that their child "could die from vaccinations." They are not aware of the benefits of vaccinations or they, "do not love their children." Some mothers speculate that in some villages, mothers are not told about vaccination campaigns because only the assistant mayor is told. Others said that perhaps some mothers believe that vaccinations "do not cure diseases."

The mothers believe that pregnant women do not get vaccinated because they are unaware of its benefits or because of rumors linking vaccinations with sterilizations. Another noted response was that, at times, there are no vaccination activities at health centers and that promoters do not seek out women to vaccinate. They feel that pregnant women do not go to their prenatal checkups because, "they are embarrassed to disrobe" and/or "to discuss pregnancy", they are "unaware of the benefits of prenatal care," "they are embarrassed for a man to see them" and because "labor does not give any warnings (what is the use in trying to prepare)."

Women are taught how to attend their own labor. Mothers-in-law also teach their sons how to attend the labor of their wife.

People are familiar with the messages that the radio spots transmit. They like the time of day they are announced (mid day) and they enjoy the dialogue between the two women or the godmothers. They know the project extensionists who visit an average of once a week.

VOLUNTEERS

People who execute the role of volunteers have been working from three months to four years. They said that they were motivated to "bring a little bit of light" to their communities, to "learn more", "to help their people", to "learn about vitamin A-rich foods", and "to guide their fellow villagers to obtain the benefits of project activities." In general, they dedicate themselves to distributing ORS and seeds, managing the registers, helping with the planting of family gardens, and promoting vaccination campaigns. Along with participating in the census, they help to maintain data regarding immunization and vitamin A coverage, deaths and births, how to instruct mothers in how to prepare the rehydration solution, how to instruct villagers in how to prepare garden plots, terraces and contours for the gardens and how to detect pregnant women.

Everyone thinks that the project is good because it "brings them new ideas", and it "provides them with insight so that women take better care of their children." They mentioned that the project "works well without any problems" and that "they have never before had the opportunity to learn how to prepare food rich in vitamin A or to plant vegetables." They believe that their performance would improve if: they had more follow-up and supervision; rumors that the registers are used for something "else" would dissipate, they had more available free time; they had different seed types and medicines to sell/distribute; they could plant gardens at their houses; they could teach at their houses; they had tools for gardens; they were given an identification card; they received more training; and they received "a monetary stipend or a first aid kit."

All of the volunteers were in favor of continuing their work after the project terminates for the following reasons: "to share what they have learned" and "because they are willing". They mentioned that they would need to "have the necessary materials and know where to get the ORS and seeds." They also mentioned that their work was important as "diseases do not just go away." They would like to receive training every two months in their communities, but they are willing to be trained elsewhere. They expressed interest in learning more about ARI, child growth and development, nutrition, agriculture, first aid and CDD. They are available for two to three days to two full weeks, but "only if per diem is provided."

They would all like to be health promoters for the following reasons: "because of the benefits to the community", "because the community is growing", "to be able to better help their neighbor." They mentioned that as promoters they would still be able to fulfill the responsibilities of a volunteer. They mentioned that institutions like DIGESA, the Catholic and Protestant Churches and the MOH have supported them. They believe that the reasons past volunteers have resigned their duties as volunteers was because the project "provided no economic incentives to them" or that the volunteers felt that they "were wasting their time", or because they have not been given the materials that were promised them. They say that they dedicate between half to two days per week to their work as a volunteer.

The volunteers collect data on: the distribution of ORS and seeds, births, deaths, vaccinations given, cases of diarrhea, cases referred, attendance at activities, number of existing gardens, vitamin A doses administered. This information is given to the extensionist weekly or monthly.

They stated that extensionists share the consolidated data with them and explain its importance monthly.

Some volunteers think that their referrals are not well received by the MOH personnel because "they do not respect them as volunteers" and "health centers are often closed." However, others believe that their referrals are well received.

Volunteers are visited weekly by each extensionists and by field supervisors approximately every two weeks.

Upon review of the forms for control inventory and distribution of seeds and ORS, it was noted that there needs to be more supervision to improve quality control.

LEADERS

Leaders are very familiar with the project and its activities such as cooking demonstrations, health campaigns, gardening promotion, and community health education.

The most productive aspects of the project according to leaders are the administration of vitamin A, training on how to plant gardens, de-worming, latrine construction, CDD, eye health and ALRI education.

They expressed the desire to have one well-trained person in their community at the termination of the project. They want to continue the following activities: planting gardens, conducting health talks (so "mothers can teach their children") and distributing ORS and seeds in their communities.

1. They mentioned that they have supported the project by participating in project activities, providing their houses or other locations for meetings, providing ingredients for the cooking demonstrations, giving their wives permission to attend project activities, repairing kitchens for cooking demonstrations, promoting the activities of the project, collaborating with the census, accompanying the extensionist on his/her home visits and promoting the administration of vitamin A to postpartum mothers.

To improve community participation leaders proposed the following: general information meetings be held to explain about the project and its benefits, elect more volunteers, continue promoting cooking demonstrations, highlight the results of family gardens, use communal gardens to promote family gardens and invite men to participate in all activities.

The changes that they have noted as a result of the project include: women practice what they learn during the cooking demonstrations, women know the importance of vaccinations, there are less cases of diarrhea and better hygiene in their communities, latrine usage has increased, consumption of vitamin A-rich foods has increased, women have organized themselves around project activities, ORS is now available in the communities and fewer children are dying in project communities.

SUMMARY OF INTERVIEWS WITH MOH MANAGEMENT PERSONNEL

District directors and registered nurses are familiar with the activities of the project. All agreed that the project is dedicated to health education, home gardens, distribution of vitamin A, de-worming, ORS distribution, community development, eye care, and institutional training. They value these activities because they focus on the community. They participate in meetings although they mentioned that there has been a lack of coordination, limiting the value of the project activities.

They noted that the health centers have enough medicine to meet current demand, but there have been periods of scarcity. They said that there was a vaccination campaigns in March, April, June and July. The coverage varies from district to district as follows:

	Polio	Diphtheria	Measles	TTV	DPT
Cobán	19.62%	19.5%	16.80%	2.20%	27.00%
San Juan Chamelco	40.00%	40.00%	40.00%	10.00%	25.00%
San Pedro Carchá	42.00%	42.00%	38.70%	80.00%	no meds

The DPT coverage is low because they do not have enough vaccine, and the cold chain does not work. That is why it is administered during campaigns.

They attribute the low coverage of TTV to fear on the part of the mothers, lack promotion as to who should be vaccinated, lack of education, changes in the norms (only pregnant women are now vaccinated in the province) and occasionally on the lack of vaccines.

They receive few referrals from promoters or traditional birth attendants because of the distance to the health center from villages, poor treatment of these workers by health center staff, lack of forms and a lack of formal referral protocols.

Regarding the training of promoters, they said that the last training course was held three or four years ago and now they can only provide refresher courses because of the lack of resources. However, refresher courses have been more frequent as of lately, supported by other organizations such as CARE, Clapp & Mayne and the project.

There is almost no field supervision of promoters because of the lack of transportation or gasoline, but monthly meetings are held with promoters at the health centers on a monthly basis.

They are willing to train volunteers to become health promoters, but will need external support for training costs. They are also willing to pilot a training schedule which provides no more than five days of training per month.

They suggested that to improve coordination and eventual integration of project activities into the MOH, meetings should continue focusing on the transfer of information, improved communication, joint planning and work in communities that the MOH does not currently serve. The MOH can sustain educational activities (as long as they are provided with the educational materials) de-worming campaigns and vitamin A supplementation activities.

Health care reform seems to involve a change in how communities are involved in the planning and provision of health services. It promotes a strategy that allows communities to analyze and attempt to resolve their own health problems. It will require villagers to consider their own health problems and assess what the community can provide to address these issues.

The project can support this reform in a number of ways, including, the sharing of project data, transferring lessons learned and educational methodologies to the MOH, providing materials, taking responsibility for providing health services in a specific geographic area, organizing the community, and/or teaching villages in problem solving techniques.