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**INTERNATIONAL EYE FOUNDATION
ALTA VERAPAZ, GUATEMALA
VITAMIN "A" FOR CHILD SURVIVAL
FINAL EVALUATION
USAID CHILD SURVIVAL IX
COOPERATIVE AGREEMENT No:
FAO-0500-A-00-3020-00**

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The effectiveness of the evaluation process could not have been possible without the complete cooperation and interest of the community health volunteers, health promoters and mothers we interviewed.

I sincerely hope that these results will serve USAID and the technical staff from other Child Survival Projects of Private Volunteer Organizations working in developing countries

Oscar Cordon, MD, MPH
Guatemala, April 1997

ACRONYMS

| | |
|----------------|--|
| AMPROS | "Ayuda Mutua Pro Salud" or Mutual Help for Health |
| ARI | Acute Respiratory Infections |
| BF | Breastfeeding |
| BCG | Bacille Calmette-Guerin (tuberculosis vaccine) |
| CESSIAM | Center for the Study of Sensory Impairment, Aging and Metabolism |
| CHV | Community Health Volunteer |
| CDD | Control of Diarrheal Diseases |
| CS | Child Survival |
| DHS | Demographic and Health Surveys |
| DIP | Detailed Implementation Plan |
| DPT | Diphtheria-tetanus-pertussis Vaccine |
| EPI | Expanded Program of Immunization |
| IEF | International Eye Foundation |
| INCAP | Nutrition Institute of Central America and Panama |
| JHU | Johns Hopkins University |
| KPC | Knowledge, Practices, and Coverage |
| MOH | Ministry of Health |
| NGO | Non Governmental Organization (see also PVO) |
| OPV | Oral Polio Vaccine |
| ORS | Oral Rehydration Solution |
| ORT | Oral Rehydration Therapy |
| PHC | Primary Health Care |
| PVO | Private Voluntary Organization |
| TBA | Traditional Birth Attendant |
| WHO | World Health Organization |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |

EXECUTIVE SUMMARY

The overall goal of the final evaluation of the Child Survival IX is to assess the impact, effectiveness and the sustainability of the project. The evaluation comes at a critical time when IEF is finishing a six-month-no-cost extension of a three year child survival grant. Responsibilities for child survival activities need to be fully transferred to collaborating institutions. The results of this evaluation have significant implications for the transfer of current activities, and provide reinforcements for the counterparts that will include the recommendations in their program activities.

Members of the Evaluation team included: Oscar Cordon, MD, MPH External Evaluator; Martha B. de Piedrasanta, MPH, RD, Country Director and Child Survival Project Manager; Mauro Pineda, Health Technician from the Health Area of province of Alta Verapaz; Agripina Tot, extensionist from CARE's Reproductive Health Project in Alta Verapaz; Julio Galvez, Alvaro Sierra, Luis Sierra, and Enrique Fernandez, Child Survival Project Supervisors. The evaluation report was prepared by Oscar Cordon, with review of the draft done by the Country Director and the field team.

The evaluation took place in the Health Districts of Coban, San Pedro Carcha and San Juan Chamelco in the province of Alta Verapaz in the northern region of Guatemala, from April 16 to May 2, 1997. Visits were made to four project communities randomly selected, in order to observe educational activities, cooking demonstrations, observe home gardens and conduct focus groups and interviews with CHV's, mothers, religious leaders and community leaders. In addition the team visited four collaborating NGO's.

A technical meeting was conducted on April 24, 1997 with the staff of the three health districts where the project was enforced. The Health District Chief, the Professional Nurse and the Rural Health Technician of each health district participated together with the Province Health Chief and the IEF/Technical Staff in the discussion of the KPC survey results and the Qualitative Final Evaluation Research.

The evaluation methodology included a KPC survey completed from March 31 to April 16, 1997, which provided quantitative data on mothers knowledge and practices as well as coverage information, in addition to qualitative data collected during the site visits. Results of the findings were analyzed by the evaluation team with input from MOH representatives and IEF staff.

IEF has developed a network of CHVs which provide education and some basic health services to mothers. The CHVs received close supervision from 14 IEF extensionists and backstopping from four field supervisors and the Country Director/CS Project Manager. The results of the efforts of almost all categories of workers are impressive. Specific accomplishments include: vaccination coverage of children 12-23 months of 43% excluding BCG; 44% of diarrhea cases in children age 0-23 months were treated with ORT; 67% of children age 0-23 months received equal or more fluids besides breastmilk during diarrhea episodes; 84% of children 12-23 months received a dose of vitamin A every 6 months; 62%

of mothers whose child breathed rapidly and with difficulty sought treatment for their child's respiratory problem; and in addition 560 home gardens are functioning, 129 compost piles have been installed and 11,020 small baggies of six varieties of seeds have been given to 38 volunteers trained as part of the sustainability plan. During the last vitamin A campaign in October 1996, 7,705 children received vitamin A in 50 communities for a total coverage of 87%.

The Project has also implemented Quality Assurance methods that can be adapted by basic health workers to monitor and evaluate communication plans. Project interventions have been applicable to the needs of the community and well coordinated with collaborating institutions. Most of the coverage rates for project objectives reached 70% of the set goal. Future efforts in the area should be directed to the following activities:

1. Reinforce educational activities with mothers regarding the importance of the maternal card as well the immunization with Tetanus vaccine. Qualitative research should be done to design more comprehensive educational material regarding the misconceptions about the benefits and the risks of TT vaccine.
2. The same problem occurs with ARI messages. Mothers do not understand the question about the signs or symptoms of risk that must make the mother seek advice or treatment.
3. Coordinate with MOH the information for the health committees and CHVs in order to include them in the future action plan for the Health Sector Reform and the new **Health Attention Model** called S.I.A.S. (Sistema Integrado de Atención en Salud).
4. More qualitative research can be done to obtain new ideas how to explain to mothers the correct way to prepare homemade insecticides for their home gardens.

The evaluation results were shared with representatives of the MOH and NGOs and IEF staff during technical and debriefing meetings. A copy of the major findings in the KPC survey and the qualitative study were given to the MOH health districts of Cobán, San Pedro Carchá and San Juan Chamelco as well as to the Health Province Area. This material was also shared with CARE, the School of Nursing, the Maternal Department of the National Hospital, a local NGO **Talita Kumi** and the Health Program of the Catholic Church (Pastoral de Salud) these institutions are crucial in consolidating the sustainability phase over-all plan of some IEF's **project** activities.

INTRODUCTION

Background

The International Eye Foundation (IEF) has been active in Guatemala since 1983. In 1990 the Child Survival Activities began in Coban in the region of Alta Verapaz (cooperative agreement no. FAO-0500-A-00-3020-00).

Beginning in October 1993, IEF was awarded a second three year Child Survival grant extension (CS IX) by USAID with a total estimated budget of \$813,429 to implement a Vitamin A for Child Survival Project. The goal of the project extension was to decrease infant and child mortality and morbidity through vitamin A supplementation, improved nutrition and infection control during the period 1993-96. Principal interventions and their associated beneficiary populations were as follows: 1) vitamin A supplementation of children under 6 years of age and postpartum women, 2) diarrheal disease management of children under 24 months of age, 3) the promotion of family gardens to increase the availability and consumption of vitamin A rich foods, 4) nutrition education for mothers emphasizing energy dense and vitamin A- rich weaning foods for children under 2 years of age, 5) support of Ministry of Health (MOH) immunization activities focusing on children under 12 months of age and women of child-bearing age, 6) training of MOH personnel, including village promoters, health technicians, nurses and physicians in the treatment of pneumonia, vitamin A deficiency and diarrheal disease control.

A mid-term evaluation was carried out in 1995. The purpose of that evaluation was to assess the impact, effectiveness and the sustainability of the project. IEF selected an evaluation team to review the accomplishments obtained at the end of the project and constraints and lessons learned with the implementation strategies. See section III.

Project Description

The Vitamin A for Child Survival Project was implemented originally in 50 communities and as of January 1, 1997 in 42 of the 45 rural villages originally proposed and located in the municipalities of Cobán, San Juan Chamelco and San Pedro Carchá. This project was also an extension of a previous project that worked in 23 of the proposed communities. The total population served ranged from 43,000 to 37,000 people living in approximately 7,400 to 7,300 households respectively.

This area is located in the south-central region of the province of Alta Verapaz, one of Guatemala's northern departments. Alta Verapaz is located in a mountainous forested region of the Sierra Madre mountain range. In the project area, over 95% of the total population is indigenous, the highest percentage of indigenous people of all of Guatemala's municipal areas. The population is predominantly Catholic (75%), with approximately 20% of villagers identifying themselves as Protestants.

Project communities are marked by high levels of rural poverty. Over 80% of the villages have no electricity. Less than 30% of homes have potable water services or latrines. Access to health services is very limited, with the MOH only providing limited outreach to villages with trimester vaccination campaigns. Only three health centers exist to serve these communities, one in each of the municipal centers. Four additional health posts staffed by auxiliary nurses serve the project catchment areas, but with severe limitations. They are often closed, due to staffing problems and when open, regularly do not have sufficient stocks of medicines to treat even the simplest illnesses. Use of these facilities by villagers is limited.

Most families practice subsistence farming. Approximately 27% of women in the project communities are semi-literate. Forty nine percent (49%) of these semiliterate women can read only in their indigenous language. These statistics are very similar to the indicators determined by the 1995 DHS/MCH survey for this province, 61.2% non literate and only 32.1% with primary school.

Guatemala has one of the highest children mortality rates in Latin America. A DHS Maternal and Child Survey (1995) indicated an infant mortality rate (IMR) for the country of 57 x 1,000 of live births and a child mortality rate of 80 x 1000 live births. The same study showed an IMR for Alta Verapaz of 66 x 1,000 live births and a Child mortality rate of 102 x 1000 live births, both of which are higher than the country average. The two causes of infant deaths are respiratory infections and diarrheal diseases. These two conditions account for the majority of deaths among infants as well as among the general population.

Evaluation Methodology

A detailed Scope of Work for the evaluation was initially prepared by the IEF Child Survival Coordinator, which outlined the objectives and schedule of the Final Evaluation Team. The evaluation also responds to the USAID BHR/PVC GUIDELINES FOR FINAL EVALUATION OF CHILD SURVIVAL PROJECTS ENDING IN 1996 (CS-IX). (See APPENDIX A). Based on these requirements, the evaluation team prepared an evaluation schedule and data collection forms (APPENDIX B).

A number of instruments were developed for the collection and analysis of data (included in APPENDIX C). The majority of these were used during visits to project communities. Field visits and observations were made to four communities, representing the three MOH Health Districts where the project has been implemented. The communities were selected at random by the evaluator.

Focus groups were conducted with mothers (FORM 1), religious leaders and community leaders (FORM 2). Community Health Volunteers were interviewed regarding sustainability actions of educational activities with mothers, the transfer distribution of ORS to MOH, the revolving seeds funds, functioning of vaccinations for chickens and numbers of families with chicken projects (FORM 7).

Representatives from the three health districts were interviewed (FORM 4) and invited to a technical presentation of the final results of the KPC survey and the Qualitative Research. The Health Area Chief was also interviewed and invited to the technical meeting.

At the institutional level, representatives of four collaborating PVO's were interviewed regarding the plan of transferring some educational activities, the reference to the MOH of high risk emergencies cases of ARI and diarrheal diseases, and the distribution of the ORS in coordination with the MOH health promoters (FORM 9).

The evaluation team also had the opportunity to observe three educational activities directed by the CHVs and one cooking demonstration (FORM 3). Two mothers who had not participated with the project were interviewed (FORM 5) also two mothers that participated temporarily were interviewed (FORM 6). During this week the full team of 14 extensionist was interviewed (FORM 8) and debriefings were held with the supervisors individually and in group. Various debriefings and a long interview was held with the Country Director/Project Manager and some questions were sent to headquarters in Bethesda, MD to have a broad perspective of all the sectors involved in project execution.

The evaluation team held structured meetings to review the sustainability plan (See Section II). Finally a meeting was held to summarize the results and conclusions and to document key recommendations. A list of documents reviewed is provided in APPENDIX D.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A.1 Immunizations (EPI)

Problem Statement

According to the DHS/Maternal and Child Health Survey of 1995, the full immunization coverage is 28.9% see table No. 1. The project supported the MOH staff in the three health districts to expand the coverage obtained during the baseline survey that was 3.9% including BCG and 11.1% excluding BCG through community education and tracking of women and children. The reason to exclude the BCG vaccine was that during the time the project started the second phase, the MOH was not offering the vaccine; in 1996 the MOH started offering the BCG vaccine, to children under 12 months of age and to school-age children from first to sixth grades.

The Detailed Implementation Plan established the EPI objectives in terms of coverage targets - 60% of children 12-24 months of age will be completely immunized (excluding BCG) in the impact areas. The final result was 28% (see Table No.1), almost identical to the result obtained for that province in the 1995 DHS/Maternal and Child Health Survey. The coverage excluding BCG was 43%. Regarding this indicator, it is very important to mention that the KPC survey methodology does not accept the answers of mothers who cannot demonstrate the child's vaccination card, that was common in the population surveyed and also the problem that in many cards the MOH staff simply wrote "vaccinated", and did not clarify what vaccine and what dose was applied to the child. In those cases, the surveyor marked "child not vaccinated".

In discussions during the technical meeting with the MOH staff from the three health districts, this issue was exposed and they answered that they did not have enough time to fill all the information of the vaccination card. It was explained to them that our indicator for immunization coverage was considerably lower in comparison with their own statistics. It is very interesting to recognize that the number of mothers that lost their child's vaccination cards decreased from 24.0% in the baseline survey to 8.0% in the final KPC survey (See Table No.1). At this point it is important to state that the MOH staff does not accept that it could be easy for their personnel during immunization campaigns to ask the CHV to help them fill in the cards. If it is a problem to fill in the date and the dose for every vaccine, at least ask them to fill in the dose for the two more common vaccines (OPV and DPT).

The number of mothers who can show prenatal cards has remained low at 11.3%. Interviews with CHVs and mothers provided information regarding the reason why mothers lost their health cards. Some mothers answered that for them their cards are not important because they feel old and that it is more important to keep the child's card, that is one of the reasons they lose their cards. Others answered that they did not see the importance of that card.

When they were asked about what can be done, they answered that they could receive more "education" about the prenatal card. Another question asked what can future projects do with this problem, and the mothers answered that maybe these projects could replace the cards lost and teach them how to keep it with the child card.

Regarding the Tetanus vaccine some mothers answered that the vaccine produces heat in their arms, that is one reason why they do not like it. Other mothers indicated that many women do not want to be vaccinated against tetanus due to fear of the vaccine or because it is painful.

Table No. 1
PROJECT GOALS AND INDICATORS

| INDICATOR | GOAL | KPC 4-94 BASE LINE | KPC 6-95 MID TERM | KPC 4-97 FINAL | DHS 95 |
|------------------------------------|------|--------------------------|-------------------------|-------------------|-----------|
| EPI | | | | | |
| % ch. 12-23 full coverage w/o BCG | 60.0 | 11.1 | 33.9 | 43.0 | |
| % mothers w/ 2 TTV | 35.0 | 15.3 | --- | 14.1 | |
| EPI | | | | | |
| DPT1 12-23 | | 39.9 | 63.0 | 70.8 | 82.6 |
| DPT3 12-23 | | 20.9 | 37.8 | 50.9 | 51.2 |
| OPV1 12-23 | | 47.7 | 65.8 | 74.1 | 87.6 |
| OPV3 12-23 | | 21.6 | 37.8 | 51.4 | 56.2 |
| DPT1-DPT3/DPT1 | | 47.6 | 40.0 | 28.1 | 38.0 |
| OPV1-OPV3/OPV1 | | 54.7 | 42.2 | 31.0 | 42.0 |
| OPV1-OPV2/OPV1 | | 31.4 | 42.2 | 30.6 | 10.8 |
| measles | | 26.9 | 53.5 | 53.7 | 71.1 |
| BCG | | 19.4 | 15.7 | 42.6 | 49.8 |
| full coverage w/ BCG | | 5.2 | 11.0 | 28.0 | 28.9 |
| full coverage w/o BCG | | 11.1 | 33.9 | 43.0 | |
| TTV1 | | 23.0 | 7.3 | 7.0 | 14.4 |
| TTV2 | | 55.3 | --- | 14.1 | 34.7 |
| % children 0-23 months with CARD | | 38.0 | 62.0 | 71.0 | 55.7 |
| % child 0-23 w/ cards lost | | 24.0 | --- | 8.0 | |
| % mother reported child vaccinated | | 62.0 | 84.3 | 82.0 | |
| % mothers w/ antenatal card | | 31.0 | 11.3 | 11.3 | |

Discussion and Conclusions

The evaluation results show that vaccination coverage is increasing every year and vaccines are more valued and demanded by families in the project area. The MOH maintains five cycles of vaccination during the year, besides the Immunization National Campaigns that regularly are provided twice a year.

The problem is the registration of the information due to misfiling cards. The second problem was mentioned by some mothers that point out the MOH confused them because they are vaccinating five times during the year so they think the child needs to receive five vaccine doses during the year. That is one of the reasons why mothers did not answer correctly the child's age when measles vaccine must be received.

Specific Recommendations

- Future projects interested in working with Immunizations Programs must first interview MOH authorities to point out how information must be filled in the immunization cards to avoid excluding some cards during an investigation or technical activity.
- Since this is a mature intervention which is implemented by the MOH and other local NGO's, it is recommended that **future projects concentrate a minimum amount of effort in this activity.**
- Future projects must focus their attention in sending the MOH information of women and children that have not completed their respective vaccination schedules through the CHV .

A. 2 Control of diarrheal diseases (CDD)

Problem Statement

Overall the national prevalence of diarrheal diseases is estimated at 24% for children under five years of age (1995 DHS/Maternal and Child Health Survey). The 1994 Baseline Survey indicated that 21% of children age 0-23 months was treated with ORT during episodes of diarrhea. However, as many as 35.0% mothers gave children antibiotics or other inappropriate medicines during the diarrhea episode.

Proposed Objectives and Strategy

The proposed CDD objectives were as follows:

1. Sixty five percent of children less than 24 months of age will receive ORT such as home available fluids and ORS during episodes of diarrhea.
2. Less than 35% of children less than 24 months of age will receive antibiotics and other medicines during episodes of diarrhea.

The DIP called for trained and support health promoters and selected volunteers to establish community ORT units, in addition to supporting health promoters who currently distribute ORS. These units will serve as community-based sources of information, training, ORS

packets distributors and referrals. In addition, the project will assist the MOH with its latrine construction project in villages to improve basic sanitation. The DIP called to stress importance of all of the following:

1. Inappropriate use of antibiotics and other medicines for treatment
2. Early initiation of fluids
3. Increased frequency of fluids
4. Proper preparation of ORS
5. More frequent, smaller feedings during diarrhea episodes
6. More feeding after diarrheal episodes so children can regain lost weight.

Pharmacy and store owners who sell anti-diarrheal medicines and antibiotics will be targeted for individual discussions and education regarding correct treatment of diarrheal diseases. They will be urged to sell instead ORS for treatment of children's cases of diarrhea.

Findings

The 1997 KPC Survey indicates that more children age 0-23 months are receiving ORT during cases of diarrhea, but more are being treated with antibiotics. The Table No. 2 shows comparison data for the CDD indicators:

The project trained volunteers as ORS distributors in every community of the 42 project village. A total of 87 individuals currently provide education and ORS packets to mothers with children who suffer from diarrhea.

Last year, 1,623 children were treated with ORS.

Over the course of the Project 600 latrines have been constructed in a joint effort between the MOH, communities and IEF personnel.

The project carried out two mass distribution campaigns with albendazole to children 2 through 12 years of age in 1995 and 1996. Coverage of children 24 to 71 months of age was 75 and 72%, respectively.

Table No. 2
PROJECT GOALS AND INDICATORS

| INDICATOR | GOAL | KPC 4-94 BASE LINE | KPC 6-95 MID-TERM | KPC4-97 FINAL |
|--|--------|-----------------------|----------------------|------------------|
| CDD | | | | |
| % ch. <24m receiving TRO in diarrhea episode | 65.0 | 20.7 | 22.4 | 44.0 |
| % ch. <24m receiving antibiotics or medication during diarrhea episode | < 35.0 | 35.0 | 54.6 | 49.0 |
| % ch receiving same or more amount of fluids in diarrhea episode | | 45.9 | 45.7 | 67.0 |
| % ch receiving same amount or more breastmilk in diarrhea episode | | 49.7 | 41.6 | 54.0 |
| % ch rec SRO during diarrhea episode | | 9.6 | 15.8 | 32.8 |

Regarding these issues, it is important to point out that in the KPC Questionnaire the questions relative to high risk for diarrheal diseases and acute respiratory infections were not understood by the mothers.

These issues were confirmed during the focus groups and interviews with mothers. After some introduction, the mothers could explain the risk signs or symptoms for diarrheal diseases and the importance of early fluids initiating and increase in their frequency, also the importance of initiating more frequent and smaller feedings during diarrhea episodes.

During interviews, CHVs indicated that it is very important to point out that commercial companies that sell the "anti-diarrheic medicines" have strong commercial campaigns, specially through radio spots that are transmitted at premium time, where mothers can listen them and can be convinced of the necessity to start the child on this medicine to stop the diarrhea episode.

It is also interesting that even though the messages were directed to point out that the cost of these medicines is higher than the ORS packet, the mothers indicated the importance for them to stop the diarrhea episode immediately and the idea that "medicine" or antibiotic can do it is very common.

Discussion and Conclusions

Although there has been a consistent increase in the number of mothers giving ORS, over the baseline values (See Table No. 2), there has not been sufficient progress to reach the objectives stated in the DIP. Although this is true the process of supervision, training and supply of CHVs with ORS packets has proven effective in maintaining successful functioning of community health volunteers. The accomplishment of the goal of children receiving ORT for the diarrheal episodes was 67% but more emphasis must be directed for future projects in educational messages about the risk of the use of medicines and antibiotics during the diarrheal episodes.

Though the goal was to reduce to <35% of children <24 months receiving medicines during the diarrheal episode, the indicator increased from 35.0% in the baseline survey to 49.0% in the final KPC. However it is very important to point out here that the indicator decreased from the mid term evaluation where 54.6% of the mothers answered positively regarding the use of medicines for their child with diarrhea.

Specific Recommendations

- Although the project has reduced the use of antibiotics for the treatment of diarrhea cases, inappropriate use of medications continues to be a problem. It is recommended for future projects **that correct treatment of diarrhea be prioritized in educational activities and messages.**
- It is very important to recognize that these educational activities are developed against a strong marketing campaign that promotes the use of medicine or antibiotics for diarrhea, and also the misconception that these medicines are not dangerous. This effort must be directed to the target population using mass media with premium time schedule, where mothers are home preparing meals, early in the morning, at noon and in the afternoons when the family members are together sharing mealtime.

A.3 Nutritional improvement

Problem Statement

Chronic malnutrition continues to be a significant problem in Guatemala. Among the children under five years of age, over 80% are two standard deviations less than the WHO height for age average. The project did not intend to collect any anthropometric data.

Nutrition Objectives

The DIP Nutrition Objectives include:

1. Forty percent (increase from 15%) of children are fed the same or more often during episodes of diarrhea.
2. Ninety percent of children five months and older are regularly fed foods rich in vitamin A.

Current Practices

Breastfeeding is an accepted practice in the project area. Both baseline and final evaluation survey data show that 90% of women with children under two years of age were still breastfeeding their children. Similarly, 20% of women reported breastfeeding their child within the first eight hours after birth, with the majority of the rest (27%) breastfeeding their child within 24 hours after birth. Seventy two percent of the mothers with children 0-3 months of age reported exclusively breastfeeding.

Regarding complementary feedings, the IEF baseline (1994) indicates 53.0% of 5-8 months old receive semi-solid or solid foods. That indicator increased to 74.4% in the Final KPC survey of 1997. Typical weaning foods include cereals, yellow vegetables, eggs and cheese. Salt, sugar/honey and oil is frequently added to other foods during the weaning period. (See table No. 3)

The DIP proposed a pilot project that will work in two primary schools to provide health and nutrition education using a Child to Child curriculum. The project reviewed background information available on related radio education projects in Guatemala and the subsequent design of two lesson plans entitled: "The Prevention and Identification of Diarrheal Diseases and Oral Rehydration Therapy" and "The importance of Breastfeeding and Vitamin A-rich foods in the Feeding of Children During their First Year of Life". Each interactive lesson was recorded on a cassette (in Q'eqchí) and was accompanied by appropriate visual materials as well as a list of suggestions for related activities for the students. Since the message were pre-recorded on a cassette, the same message was played to all students, countering the common problem of interjecting personal opinions about a subject during a lesson plan. Approximately 105 students participated in pre- and post test measures as well the implementation of the project of both themes. A sub-sample of mothers was randomly selected among the sample of students selected to participate in the study. Preference was given, to the mothers of students who were known by teachers to have fairly consistent attendance at school and who had younger brothers and sisters in school or at home. Approximately 45 mothers participated in "pre- and post-test" interviews for both of the themes.

The final results from pre- and post tests showed interesting findings:

- Some of the lessons learned from the project were related to language and testing abilities of the students. Even though the students were ≥ 10 years old and were literate, many could not complete the written pre- and post- test due to a lack of understanding of the process.
- Many students could not respond to fill-in the blank or true-false questions, so the exam had to be changed to include only multiple choice questions. Even with the multiple choice questions, a number of students participating in the study had difficulty in selecting one response and underlined them all.
- With the post-test a difficulty was discovered; they were done in Spanish, but the children were having difficulties answering questions in Spanish, while they had been taught the theme in Q'eqhí.
- The difference in the scores (pre and post test) of mothers who did not participate in the project were higher than those of mothers who attended project meetings regularly.
- No noticeable difference existed in the scores among children that participated in all the education activities than those that participated only in two or three. For further information and analysis please refer to APPENDIX E.

**Table No.3
NUTRITION PROJECT GOALS AND INDICATORS**

| INDICATOR | GOAL | KPC 4-94 BASE LINE | KPC 6-95 MID-TERM | KPC 4-97 FINAL |
|---|------|-----------------------|----------------------|-------------------|
| NUTRITION | | | | |
| % ch. receiving same amount or food or more during diarrhea episode | 40.0 | 14.0 | 9.2 | 25.0 |
| % ch. 5 > months. receiving 2-3/week foods rich in Vit. A | 90.0 | 81.0 | 83.1 | 92.0 |
| % ch 0-3m receiving breast milk exclusively | | 61.0 | 74.5 | 78.0 |
| % ch 5-8 m receiving food | | 53.0 | 63.5 | 74.4 |
| % mothers knows +2+ Vit. A foods | | 63.0 | 84.0 | 89.0 |

A.4 Prevention of vitamin a deficiency

Vitamin A deficiency is a significant public health problem in Guatemala. The 1991 baseline survey of the previous project revealed that over 21% of children under age six in project villages are deficient, with circulating retinol concentrations of less than 20 μ /dl.

Furthermore seven-day recall data showed that 66% of these children consumed less than the WHO recommended daily amounts of vitamin A (IEF/CeSSIAM, 1991). While vitamin A fortification of sugar is mandatory by law, sugar is not consistently fortified.

A national survey conducted by the MOH in 1995 showed for the North Region where the province of Alta Verapaz is located, that 16.2% of children under six in Alta Verapaz are deficient, with circulating retinol concentrations of less than 20 μ /dl. As part of the mid-term evaluation, 66 samples of sugar on the household level were taken and were analyzed at INCAP. The results revealed that 60% of the household samples fell within the acceptable level of fortification with retinol palmitate on the household level (5-20 μ /dl), 29% were <5 μ /dl and 11% were > 20 μ /dl.

The MOH does not have an official protocol for vitamin A supplementation. The last time vitamin A was distributed was in 1988; the same year a strong effort was placed behind sugar fortification. The MOH assumed that with sugar fortification no further supplementation would be necessary.

The project promotes the standard International Vitamin A Consultative Groups (IVACG) protocol, with children from one to five years of age to be given 200,000 International Units (I.U.) every six months. Post partum will be given 200,000 I.U. within 30 days of delivery.

Vitamin A Objectives

Vitamin A objectives include the following:

1. Eighty percent of children 6-59 months of age will receive vitamin A supplementation every six months.
2. Fifty percent of women will receive vitamin A supplementation within one month of delivery.

Approach

The project will directly distribute vitamin A at joint EPI/Vitamin A campaigns and through its health promoter/volunteer network. Capsules will also be provided to health centers and the regional hospital for treatment of serious cases of diarrheal diseases, measles and malnutrition. A donation of vitamin A was obtained from the Hoffman-La Roche "Sight for Life" Program.

A host of vitamin A-rich vegetables grow in the Coban area. The past project was very successful in the promotion of green leafy vegetables such as swiss chard, radish leaves and *macuy*. The most common yellow vegetables included squash and carrots. Fruits are well-liked by the majority of villagers. Children are fed all of the above foods, including leafy green vegetables.

The project promoted the increased consumption of these fruits and vegetables and also promoted sweet potato, and indigenous vegetable with high levels of beta carotene. The project continued promoting cooking demonstrations among women groups. This intervention was one of the most popular in the previous project. Demonstrations utilized fruits and vegetables produced in local gardens. Weaning foods were focused in these demonstrations.

The promotion of family gardens was accomplished through a horticulture education program and the establishment and management of revolving seed funds for the sale of vitamin A-rich, vegetable seeds. A single individual, was selected by the community and was trained and entrusted with the management of the rotating fund. Seeds were sold at a slight profit to sustain these seed funds. Technical assistance was provided by extensionists of the Ministry of Agriculture. Inputs for vitamin A supplementation consisted of training, supervision and vitamin A. The expected outcome was reduced levels of vitamin A deficiency and child mortality.

- Supplementation of post-partum women continued in all 42 communities (approximately 50 women monthly, for a total of 575),
- On a monthly basis, an average of 220 mothers are receiving vitamin A, within 30 days of delivery at the Regional Hospital.
- The project also supplied vitamin A to the National Hospital of Coban for treatment of cases of Xerophthalmia, measles, and severe cases of malnutrition, diarrhea and acute respiratory infections (approximately 5,500 capsules donated).
- IEF trained a total of 21 staff and 198 volunteers in vitamin A.
- Vitamin A supplementation has been introduced as part of the EPI system. During the focus groups and interviews some mothers indicated that they accept vaccination of their children when the MOH gives them vitamin A because that is important for the child.

It is important to stress that education messages directed to the importance of vitamins in general and specifically for vitamin A for children's health have been successful. In other words the cost benefit investing in this kind of activities has been very worth while.

Findings: The following is a summary of the results of the KPC survey indicators for Vitamin A

Table No. 4

| INDICATOR | GOAL | VITAMIN A PROJECT GOALS AND INDICATORS | | |
|---|------|--|----------------------|-------------------|
| | | KPC 4-94 BASE LINE | KPC 6-95 MID-TERM | KPC 4-97 FINAL |
| VITAMIN "A" | | | | |
| % ch. 6-23m receiving Vit A every 6 months | 80.0 | | | |
| Reported | | --- | 68.5 | 86.0 |
| Regist in Card | | --- | 58.3 | 84.0 |
| % mothers post-delivery receiving Vit. A within 30 d after delivery | 50.0 | | | |
| Reported | | ---- | 22.3 | 45.0 |
| Registered in Card | | ---- | 11.5 | 19.0 |

--- Data not available

Interviews with CHVs and mothers indicated an excellent knowledge of the vitamin A supplementation protocol and correct educational messages. Regarding the knowledge of foods rich in vitamin A, the indicator increased from 63.0% in 1994 to 89% of mothers that know more than two foods rich in vitamin A for the 1997/ KPC. The Project implemented a Quality Assurance Method for Evaluating a Vitamin A Communication Strategy in Guatemala (funded by Omni Research). This Project sought to evaluate quality assurance (QA) methods that can be adapted for use by basic health workers to monitor and evaluate a communications plan. The following results are the main goals obtained:

- the project increased the amount of mothers (15-49 years) receiving education from 15.62% in August to 29.21% in November.
- The number of extensionist that use educational techniques in all their activities increased from 25% in September to 93% in November.
- The average knowledge level of Vitamin A in average changed from 58.3% in the 22 team members (4 Supervisors, 2 technical assistants and 16 extensionists) to 83.9% during the monitoring and 99.5% at the final evaluation (18 members).
- The knowledge level of mothers of Vitamin A changed in average from 54% in mothers (n=310) to 84.3% (n=285) for the final evaluation.

A second Project entitled "Understanding and Strengthening the Capacity of Intermediate Organizations (PVO's and NGO's) to provide Integrated Community-Based Vitamin A Programs in Guatemala" was also implemented in the project area (funded by USAID). Main results from the KPC and Dietary Surveys are:

- the percentage of families with home gardens increased from 6.7% to 39.1%,
- the number of families that have planted at least one green leafy vegetable in home gardens increased from 5.3% to 43.7%.
- The percentage of 1 to 6 year olds that consume the RDA for vitamin A (includes sugar but no breast milk) increased from 34.2% to 77.8%.
- The number of families that have planted at least one vitamin A containing food increased from 8.0% to 99.4%.

Discussion and Conclusions

Effectiveness

The results of the 1997 KPC Survey indicate excellent coverage of vitamin A supplementation and a high rate of knowledge and consumption of vitamin A rich foods, showing that the project strategy has been effective in these two areas.

Relevance

The focus of the project's vitamin A strategy contributes to long-term solutions to the problem of an inadequate vitamin A status through improving dietary intake of vitamin A (e.g. education, vegetable/fruit gardens). The emphasis on exclusive and continued breastfeeding will not only protect children from other diseases but is also a good source of performed vitamin A and fat that are easily absorbed by the nursing infant.

Specific Recommendations

- As coverage rates for the project objectives for vitamin A supplementation and knowledge of foods rich in vitamin A have been achieved, future projects should reduce the amount of time dedicated to these activities and concentrate on the strengthening of revolving seed funds, and chickens.
- It is very important to mention that during the focus groups and interviews the mothers asked for different recipes. The project has been successful in informing these mothers of different foods rich in vitamin A. Now future projects will focus on different menus that could be interesting for their families and children. Also in many cases the mothers sell the food that they did not eat.

A.5 Food production

Baseline survey data showed that green leafy vegetables and yellow fruits and vegetables are well accepted and generally consumed by both children and adults.

Food Production Objectives

1. Fifty percent of families plant and maintain a vegetable garden.

Findings

On Table No. 5, we can see the project nearly accomplished 100% of the goal of 50% mothers with home gardens functioning and able to identify more than two foods rich in vitamin A.

Table No. 5

**FOOD PRODUCTION
PROJECT GOALS AND INDICATORS**

| INDICATOR | GOAL | KPC 4-94 BASE LINE | KPC 6-95 MID-TERM | KPC 4-97 FINAL |
|---|------|-----------------------|----------------------|-------------------|
| FOOD PRODUCTION % mothers (fam)w/home gardens | 50.0 | 38.0 | 19.3 | 41.0 |
| FOOD PRODUCTION % mothers w/home garden and more than 2 foods rich in Vit. A. | | 12.0 | 19.3 | 41.0 |

Relevance

The focus of the project vitamin A strategy will contribute to long-term solutions to the problem of an inadequate vitamin A status through improving dietary intake of vitamin A (e.g. education, vegetable/fruit garden). The Vitamin A sources are sustainable according the answers that mothers gave during the focus groups and interviews, where they pointed out that their home gardens are their best source of vitamin A.

The project successfully developed seed distribution systems (seed revolving funds) in all 42 project villages, with volunteers serving as garden promoters as well as seed vendors. Approximately 84% of the Seed/Garden volunteers have their own family garden. The number of home gardens, until March 1997, are 786 in 42 communities served by the project. There are also two community gardens and two school gardens functioning. Two hundred forty new gardens were established during the last month of the project. A total of 130 compost piles were created in the last two months of the no cost extension (Feb-Mar/1997).

Specific Recommendations

- Future projects will assure the provision of enough seed from the beginning of the project. It continues to be necessary to ensure mothers of the location of different providers where seeds can be found at good prices.

A.6 Management of acute lower respiratory infections (ALRI)

Problem Statement

ALRI is the main cause of death of children under the age of five. Regarding mothers' knowledge and practice, IEF's Baseline reports that 39% recognize rapid or difficult breathing as a sign of probable pneumonia, and 55.7% reported seeking assistance from a health center, clinic or CHV for their child's respiratory illness. For the final KPC survey only 2%, however, indicated chest in-drawing as an important danger sign.

Proposed Objectives and Strategy

The project's ALRI objectives were as follows:

1. Eighty percent of MOH health center staff, 100% of project staff and 75% of health promoters/volunteers can correctly cite the MOH/ALRI case management protocol by the end of the project.
2. Fifty percent of mothers with children 0-24 months of age can correctly identify danger signs of pneumonia and explain when to refer their children to the nearest health center in the impact areas.

Findings

The Project canceled its plans to provide training to MOH personnel as this was provided by officials from Clapp & Mayne, one of the principal contractors with the local USAID Mission.

Results of the 1997 KPC Survey indicate that 35% of mothers can state the danger signs for probable pneumonia (rapid breathing and chest in-drawing), and 79% seek a health volunteer, health center or private clinic/doctor. All CHV interviewed could state some of the danger signs of pneumonia and were able to repeat the key messages mothers should receive. See Table No.6

Table No. 6

**ACUTE RESPIRATORY INFECTION
PROJECT GOALS AND INDICATORS**

| INDICATOR | GOAL | KPC 4-94 BASE LINE | KPC 6-95 MID-TERM | KPC 4-97 FINAL |
|---|-------------|-------------------------------|------------------------------|---------------------------|
| ARI % mothers who recognize pneumonia signs | 50.0 | 65.0 | 27.3 | 35.0 |
| ARI mothers seek advice center or health promoter | 55.7 | 38.4 | 79.0 | |

Discussions and Conclusions

Data from the KPC Survey indicates that half of mothers are aware of the danger signs for probable pneumonia. However the high number of cases referred to the health center for ARI indicates that all children with any type of respiratory illness were classified as cases of ALRI. This shows that education of mothers and CHVs regarding early diagnosis and treatment needs to be improved so that only cases with rapid breathing and/or chest in-drawing are referred to the health center.

Although education activities have been effective in raising levels of knowledge regarding the danger signs for pneumonia, knowledge alone is not sufficient to change mother's behavior. Most mothers cannot recognize the difference between common colds and ALRIs, nor do they seek timely, adequate treatment.

Specific Recommendations

- Future projects should continue their strategy to educate mothers regarding early diagnosis and referral of potential pneumonia cases. They must be informed as to what to do, specially during the night or weekends.

- Additional educational methods should be explored by future projects for use with both the mothers and CHV including radio and participatory learning techniques and specially ethnographic research to explore better ways of asking questions regarding the signs and symptoms of pneumonia that could make mothers seek advice or treatment.
- Health promoters and CHV must be trained constantly due to the high number of patients that are seeking advice or treatment with them especially during weekends or late at night.

A7. Maternal health

The Maternal mortality rate is estimated at 240/100,000 for Alta Verapaz (MOH 1995). The specific causes are complications of labor (56%), complications of pregnancy (14%), puerperal sepsis (13%) and abortion (11%) (PAHO 1990).

Proposed Maternal Health Objectives

1. Eighty percent of MOH hospital and health center medical personnel can identify three major benefits of family planning/child spacing programs.
2. Eighty percent of MOH hospital and health center medical personnel can identify the most commonly used contraceptive methods and their benefits and limitations.
3. Seventy percent of trained midwives can identify what constitutes a high risk pregnancy and when to make a referral to a trained health professional.

Approach

While maternal health expenditures are a small portion of the project budget, two very important maternal health activities of the project were the training of traditional birth attendants (TBAs) selected from project communities and training of MOH personnel in reproductive health.

Findings

Table No. 7 shows that maternal health indicators were low. The project focuses its activities in providing support to MOH promotion and distribution of prenatal cards. In the baseline survey (1994), the number of mothers that have at least one antenatal visit during the pregnancy was of 91% while in the 1997 KPC the indicator still remains almost the same (100%). It is very important that both indicators are misleadingly high due to the fact that

they represent the percentage of mothers with antenatal cards who have had at least one visit. If one were to include all mothers in the denominator the percentage drops drastically; for the Baseline KPC (1994) to 14% (43 mothers of 300) and for the final KPC (1997) to 11% (36/319).

Table No. 7
MATERNAL HEALTH
PROJECT GOALS AND INDICATORS

| INDICATOR | GOAL | KPC 4-94 BASE LINE | KPC 6-95 MID-TERM | KPC 4-97 FINAL |
|--|------|-----------------------|----------------------|-------------------|
| MATERNAL HEALTH | | | | |
| % mothers w/one antenatal visit registered in card | 26.0 | --- | 28.0 | |
| % mothers w/two antenatal visits registered in card. | 66.0 | --- | 72.0 | |

--- Data not available

Discussion and Conclusions

The project provided the support of 46 women from selected project communities to be trained as TBAs by MOH. UNICEF's recently developed curriculum which includes child spacing messages and a participatory methodology was used during the three weeks of training.

The objectives for this intervention have been hardly accomplished because just recently an initial plan for "Sexual Education" with an integrated focus on reproductive health in general has been developed between the MOH medical personnel, representatives from the Ministry of Education and representatives from the Catholic church. The focus of the Sexual Education Plan is on "Responsible Parenting" including birth-spacing in the manner accepted by each couple. Rural Health Promoters from the MOH, as well as church lay people, will be involved in community education and the school teachers will be involved in incorporating the themes into the school curriculum.

It is necessary to note that reproductive health is an extremely sensitive issue in this province of the country, more than anywhere else. The reason may be historical because this region was conquered by the catholic church rather than the conquistadors. The presence of the church, specially in rural areas where the Catholic church lay people ("catequistas") have a very important role, is very strongly set against any activity directed to mothers that can address some issue of reproductive health. This is the reason why many projects must have left some communities in recent time, accused by the people of introducing family planning campaigns covered with different names like vaccines, vitamins, etc.

It was pointed out in the DIP that the misconceptions of "population control" programs are the same as maternal health activities, in the minds of physicians and some MOH personnel and of course for the "catequistas" at the rural communities.

Specific Recommendations

- For future projects that desire to work with reproductive health, family planning or family health issues in this province it will be necessary, almost vital, to present the entire project design to both the Catholic and Protestant churches to obtaine minimal support.
- The educational messages must be addressed to the reproductive risk and obstetric risk. The only way that most of the institutions accept preventive programs is where the woman that does not receive counseling or treatment will die.

A.8 Income generating activities

Project communities are some of the poorest in Guatemala. Most families practice subsistence farming. In project communities only 28% of women are semi-literate. Half of these semiliterate women can only read their indigenous language. Thirty six percent of women attempt to improve their families incomes by selling a host of agricultural products, prepared foods or handicrafts.

Income Generating Objectives

1. Increase family income by assisting with the establishment of four cooperatives/small businesses.

Findings

- The number of "chicken bags" given until March 1997 were 331, with a total of 384 beneficiary families in 13 communities. Each bag consisted of a dozen chicken, 10 females and 2 males.
- Five community first aid kits for chickens are active

Discussions and Conclusions

The project encountered two major constraints related to IGAs. The Peace Corps Volunteer who was in charge of IGAs, was including women for loans for small business activities who were not participating in other project activities. This caused an uncomfortable situation amongst the participating mothers who were not included in the loan program.

Due to the fact that the majority of women do not speak Spanish, they were unable/unwilling to travel in order to sell their products in markets or shops that were a distance from their village, even though they could potentially receive a higher price for their goods.

The project changed the focus of the Income Generation Activities (IGA) during the third year to focus exclusively on small animal projects, starting with chickens for eggs and meat production. This change was made in response to the women's complaints that selling the products from the weaving IGA required them to travel long distances.

Eggs and meat, on the other hand, could be sold in their own villages. Additionally, the project made the decision of concentrating on these IGAs because the immediate nutritional benefits provided by increasing egg and meat production in villages.

During the focus groups and especially in the interviews and observation activities it was interesting to learn by talking with mothers and CHVs about their having been successful with the chicken bags. Some mothers are also selling the food they prepare after the cooking demonstrations.

All these people manifested that they are interested to continue exploring activities that can generate an income, even though the project will leave the community, but they would appreciate it if future projects could provide them more advice and counseling to increase their businesses.

Specific Recommendations

- For future projects regarding this kind of interventions it is very important to provide the future small enterprise owner fuller training in marketing and sales strategy.
- It is very important to present them with different options of future providers once the project ends.
- The project must follow interested people at least two complete cycles to assure they have no doubts or serious problems to continue increasing their enterprises.

As part of the IGA interventions through the failed experiences of a Peace Corps Volunteer, a lesson learned could be that before starting any activity for small businesses, it is necessary to make sure that the ideas suggested must be explored in depth with the interested group. This would ensure that it will be supported by the majority. Consequently it will have better chances of success.

A.9 Eye Care Activities

The prevalence of blindness in Guatemala is estimated at 0.4% of the total population (WHO, 1987). Many experts believe this is an extremely low estimate.

Regarding vitamin A deficiency and its links to childhood blindness, serum retinol data is the most common measurement. The National Committee for the Blind and the Deaf (NCBD) has a satellite eye hospital in San Pedro Carcha. It is not well utilized due to lack of effective outreach.

Objectives

1. The project proposes to hold annual eye screening and conjunctivitis treatment campaigns in each project village.

Findings

- Primary eye care campaigns were carried out in all project villages. It was judged that approximately 750 of the over 2000 people examined during the last campaign required referral to an Ophthalmologist or hospital.
- In response to referral needs, the project planned and coordinated two Ophthalmologic Eye Campaigns in coordination with personnel from the National Committee for the Blind and Deaf (NCDB) and with IEF's Child Sight program.
- A total of 129 people were seen by the NCDB Ophthalmologist in the October campaign at least 10 purchased glasses, and various others made the initial contacts for their future surgery, while a total of 118 people were seen by IEF's Ophthalmologists during the 1996 Campaign.

Discussion and Conclusions

Regarding the eye care activities intervention, it is very important to mention that the initial objective was to increase the credibility of the NCDB in San Pedro Carcha, specifically regarding the hospital services. The results at the end are very poor. The demand increased

as a result of the different campaigns that IEF developed, but the services that the hospital offers still remain very low. In some ways now it is worse than before, due the fact that the credibility of both the Hospital and AMPROS has been seriously damaged. People's expectations were heightened while the hospital was unable to meet their basic needs.

Specific Recommendation

- A copy of this report should be presented to the National Committee of Blind and the Deaf and also to MOH to let them know that there is an increasing demand for ophthalmologic services that is not covered adequately by the hospital in San Pedro Carcha.

B. Project Expenditures

B.1 Pipeline Analysis

1. An analysis of the budget shows that during the life of the project 93% of the total project funds has been spent.
2. The funds originally budgeted for the personnel line item (salaries, fringes - headquarters and field) were over spent by 5%.
3. In item Travel/Perdiem, the funds for international and in country travel have been over spent, although there is 16% of funds still available for the line item.
4. For consultancies item, 42% of allotted funds have not been spent.
5. There still remains 36% of the originally budgeted funds for supplies, equipment, and training.
6. Regarding communications, facilities and other direct cost item, of the funds originally budgeted 11% were over spent.
7. Twenty two percent of the funds budgeted for indirect costs were over spent. (Editing note: This statement is incorrect. Actual figures show indirect costs underspent by 17.7%.)

For more information, please refer to the attached budget. In general the project has expended its funds appropriately. According to the recommendations of the mid-term evaluation, the project reviewed the projected expenditures associated with training, maintenance costs of vehicles and computers and the resources were allocated.

Even though the funds originally allotted for the procurement item were not spent 100%; the management of priority lines were appropriately expended.

It was observed that the budget is tightly managed at headquarters leaving little room for financial analysis and decision making at the field level.

C. Lessons Learned-Logistics/Project Implementation

- It has been a very strong obstacle for the technical staff of this project to work within the urban or peri-urban communities due to lack of interest and time of mothers to participate in the project's activities.
- It is a big disadvantage to work in communities where another institution is already working, and worse if this institution is giving some kind of products like food (i.e. SHARE), because the people lose interest in participating only for the benefits of increasing their knowledge.
- It is a very serious obstacle to implement a project when there is not enough knowledge about cultural beliefs. It is necessary to develop more ethnographic research for future projects in this specific area.
- The kind of work that must be developed in these projects needs personnel that can stay overnight in the community in order to have enough time to work with mothers and volunteers.
- There are many mothers who have more than three children. These mothers said during interviews that they do not have free time to attend the meetings but they will participate if the extensionist visits them at their homes or if they perform activities during weekends, especially Saturday mornings.
- The IEF's technical staff recommended, according to their experience of working for many years with communities, that frequently the communities that are interested in participating within a development project are located 20 to 30 kilometers and/or 1 hour distance.
- It is very important to identify all the institutions working in the area to avoid duplication of activities. For example, a local NGO (Talita Kumi) has started training CHV in home gardens in some communities where IEF has already trained CHV.
- According to the experience of this project, before starting the activities it is necessary to present the design to all governmental institutions and specially to religious authorities.

- The working relationships between the supervisor and extensionists (field workers) sometimes influence negatively the work between the extensionists and the volunteers and/or promoters.
- There are many difficulties with some extensionists. It is hard for them to let the mothers and volunteers manage and direct the educational activities. They felt that were losing control or authority if they accepted that mothers can manage the activity and the group.

Sustainability

- For sustainable IGA activities it is very important that the initial funds are enough to permit the majority of interested participants to complete at least two cycles of buying and selling the product.
- With these IGA activities for sustainability, it is vital to select the persons and after that to give them training to assure successful small enterprises.

Community Health Volunteers

- In order to obtain real commitment from CHVs, and according to experience of IEF's technical staff, it is necessary to offer them training oriented towards obtaining a future job, as compensation for their free time used in health activities.
- It is crucial to select carefully the CHVs. First ask people's opinions within the community. Second, check the time availability of the candidate and determine his/her interest in receiving formal training.

Educational Activities

- For educational activities and the use of educational material it is very important to check all the problems observed during the implementation process even after the validation.
- It is very important to keep in mind that when a project involves illiterate mothers, the messages must be presented using visual aids or examples because the recall for messages or instructions is very low.

Home gardens

- With the implementation of home gardens it is very important to explain to mothers the most common plagues and the way that they can be treated with homemade insecticides.

- There exists in many mothers confusion about the difference of space for every vegetable planted in the home garden. Therefore, more qualitative data is necessary to explore different ways to teach them.

Management/Coordination

- One of the major obstacles for a good performance in this project was the frequent times when there was no coordination or managerial direction for their activities, specifically when they did not have a Project Manager. They changed manager three times in two and a half years and once they had to wait 6 months for a replacement.
- The most common reasons given by the people interviewed in the communities for their not participating, or having stopped their participation with the project is:
 - that time schedules were not covered
 - the personnel did not follow the time charts planned for the activities
 - or that the activities started late.
- Another cause of problems during the development of the project was the rotation of field staff. That is a serious disadvantage because the communities lost communication with the direction of the project and the standardization of educational messages changed.

Nutrition barriers

- A big barrier in this region was that vegetables have not been part of their food habits for centuries. The introduction of change of habits, especially in food is very slow. For this reason it is very important to give mothers many receipts to let the interest in their families encourage them, to constantly try different menus.

LESSONS LEARNED FROM IEF's HEADQUARTERS PERSPECTIVE

Describe the lessons learned from the Child Survival Project IX in Guatemala which could help other Child Survival Projects.

Sustainability Plan

- Sustainability should be built into CS programs from the start. The sustainability plan for the program started off weakly and, in hind sight, we can see that it took the wrong direction when it was decided to concentrate on handing over the interventions to the MOH. This was because much of USAID's focus on sustainability centered on this approach and because the MOH was a willing and logical partner.
- Capacity building of the MOH therefore took a leading role in activities of the program. Unfortunately, the weaknesses of the MOH did not allow for effective transfer of skills/knowledge (due to weak baseline knowledge of MOH, lack of commitment to Coban, turnover, political nature of MOH personnel).
- The lack of a clearly defined sustainability agenda with corresponding "tools" to develop a locally appropriate sustainability plan is also a major hindrance. In hindsight, it would have been more successful to develop a stronger community based sustainability strategy.

Culture

- Due to years of civil war and centuries old subjugation of native people in Guatemala, communities have developed an understandably fearful and mistrustful nature. Although this is not a reason to avoid working in the area, it does make work more difficult. Measures should be taken, such as in strategy planning to take this basic fact into consideration. For example this should have been reflected in a lower standard indicator change on the part of IEF and USAID.

Leadership and Turnover

- Strong leadership in the field was difficult to find and to maintain. On a few occasions there was leadership but it was unfortunate that a Guatemalan national who had these skills and was willing to live in the relatively remote area of Coban was never found. Turnover, due to the demand for good people and the general lack of interest of management level staff in Coban contributed to difficulties.

- At the end, the promotion of staff from local communities was successful and illustrates what can be accomplished with a long term view to building qualifications and skills and abilities in community participants.

Baseline Data

- Anthropological data and a rapid assessment should have been completed at baseline to enrich IEF's knowledge of the area and to establish community linkages. This should be a recommended first step for all CS programs.

Quality Assurance

The QA component of the program has been a great success in the last year of the project. QA should have been incorporated into programming from the start.

Technical Resources and Local Partners

Local resources in Guatemala have not always been the best. It is important to balance local assistance with expert technical help. An assessment of local partners and local TA would be a useful first step for any project.

Too many Interventions

At the start of the CS IX project, USAID was recommending program increase in population size and in the number of interventions. This type of across the board push for CS programs is not advised. Programs should carefully assess the local needs and adapt changes accordingly. It should be noted that although many programs did increase population and interventions, current recommendations reflect the fact that this approach was generally unsuccessful and now the call is to limit interventions and focus on quality rather than quantity.

What are your recommendations, related to the components of the Project interventions, that you would suggest to USAID in order to improve their assistance to other NGOs with CS projects?

USAID ASSISTANCE

Heavy Reliance on Volunteers

This is a problem in almost all CS programs on all continents and should be carefully examined in a coordinated fashion. The problem of turnover and payment of volunteers is specially problematic. The true costs of "free" labor should also be detailed.

Sustainability

USAID should view CS from a two cycle perspective, using the first cycle to establish the PVO presence and to produce quality interventions and concentrate on sustainability in the second cycle. The phase out of the PVO is the second cycle and should be gradual and be planned over a four year period.

In general, how do you view the performance of the Technical Team of the CS project in Guatemala?

TECHNICAL TEAM

Skills

It took a year to develop the qualifications in the current technical team. They have exhibited their abilities by taking over leading management in the field and taking on the responsibilities of QA with little support after initial training. Now their skills may be lost. Although they are marketable to other PVO/NGO's there is less activity of such entities in Alta Verapaz than in other parts of Guatemala because of the difficulties of working in this area.

II.PROJECT SUSTAINABILITY

A. Community Participation

The total amount of home gardens will give opportunity to mothers to continue giving foods rich in vitamin A to their children and all the family, also there is a chance for some mothers to sell prepared food, as a rich source of vitamin A .

The seeds and chicken bags encouraged other community members and mothers to explore the possibility of small businesses.

B. NGO's

In the project area there are many institutions that collaborated with IEF's project. CARE will start working with some CHVs trained by IEF for the MOH. They will start a plan to phase over some educational activities with CHV and TBAs. They are also interested in IEF training them in vitamin A benefit for health of mothers and children.

Regarding the income generation activities there is another institution (Talita Kumi) that has promoters in many communities where IEF worked. They have showed interest to include the educational material and educational methodology in those areas.

The school of nursing manifested their interest to continue teaching their students in concepts related the benefits of vitamin A. They have practical training for 6 to 8 months in different rural communities where they can use the education material with mothers and children.

The Catholic Office for Health (Pastoral de Salud) manifested their interest to incorporate IEF's educational material into their Rural Promoters Training.

The Maternal Department of the National Hospital indicated their interest to continue giving the vitamin A to post-partum mothers and agreed to coordinate the administration of vitamin A with the Health Center and the Health Districts .

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

The most concrete possibility to obtain some sustainability in educational activities is CARE's offer to include some educational materials in their training for technicians and for mothers receiving food at the health centers.

- CARE also offered the coordination with the IEF/CHVs and health promoters for including them into their own network of volunteers that will work with community committees of food security .

- CARE is also interested to include some experiences obtained with the IEF/CHVs into the community pharmacies that are planned for implementation in many communities of Alta Verapaz.

- MOH is interested to accept some CHVs and provide them the training for MOH/Health Promoters.

- MOH is interested to establish a communication channel between the Community Health Committees and Rural Health Promoters and accepted the collaboration of the IEFs CHVs.

D. Sustainability Plan, Objectives, Steps Taken to date and Outcomes

| GOALS | OBJECTIVES UPON TERMINATION OF PROJECT | OUTCOMES |
|--|---|--|
| Gradually transfer project's educational activities to AMPROS Volunteers | Transfer key health messages to project communities | <p>The transferring activities to the CHVs has been slow, but they indicated, through the focus groups and interviews, that they have started with some activities i.e. educational activities since January 1996. They just asked for support from MOH regarding technical training to convert them into MOH/Health Promoters.</p> <p>The role of other NGO's working in the area will be very important. CARE's Project of Food security and Reproductive Health offered to incorporate these CHV and the Educational Materials into their own activities.</p> |

GOAL

Give educational material designed by project, to most active volunteers (at least one per community)

**OBJECTIVES UPON
TERMINATION OF
PROJECT**

Assure appropriate and productive use of educational material left by AMPROS

OUTCOMES

The project has been very successful in this area. During the Educational activities the evaluation team had the opportunity to observe the right way that CHVs performed, their education talks ("charlas") and how they obtained the participation from mothers. Future projects need to focus in the transfer of educational material to other NGO's and the MOH staff in the impact area.

The project also trained staff from MOH, School of Nursing and Private NGOs regarding the production of Radio Spots with Health Messages.

During the interviews with mothers many of them answered that they have listened to the messages during mornings and at noon when they were preparing the meals. More financial support must be located by future projects to maintain this kind of activities that have shown that are very effective with this kind of population.

| GOAL | OBJECTIVES UPON TERMINATION OF PROJECT | OUTCOMES |
|--|---|--|
| Transfer distribution of ORS to MOH | Expand MOH's coverage in distribution of ORS, including AMPROS ORS Vols. as part of the MOH system. | It is very important to point out the number of mothers that use ORS during diarrhea episodes increased, but also that it is necessary to assure that CHVs will receive enough ORS packets for mothers demand. For future projects or NGO's working in the impact area it is necessary to do more qualitative research to know if it is feasible to obtain and to sell ORS with slight profit to start revolving funds at community level. |
| Train AMPROS staff, Health Center staff and staff from the Nursing School on WHO rules for VA supplementation. | Guarantee the correct supplementation (dose) of VA-in preventive as well as curative situations. | The results were very impressive for this goal. The project has guaranteed the correct supplementation (dose) of Vitamin A in preventive as well as curative situations. The interviews with the School of Nursing as well with the Maternity of National Hospital showed the impact of these activities for the target population. |

| GOALS | OBJECTIVES UPON TERMINATION OF PROJECT | OUTCOMES |
|--|---|---|
| <p>Coordinate with the MOH, the organization of "Health Communities where they don't exist.</p> | <p>Fortify the social organization of Communities in order to improve their health, as an instrumental activity in support of the "Health Sector Reform" in Alta Verapaz.</p> | <p>The project has managed to organize Health Committees and has improved the information and communication between these Health Committees and the Health Area Chief. They were involved in training the CHV according MOH/Manuals for Community Health Committees and Rural Health Promoters.</p> |
| <p>Discuss/propose new mechanism of reference with the Eye Hospital in San Pedro Carcha, to help improve coverage.</p> | <p>Improve the eye care of the members of project villages, as well as the general public.</p> | <p>Performance regarding this goal has been very low despite IEF's efforts to improve reference and coverage of Eye Hospital in San Pedro Carchá. The main problem is the scarcity of human and material resources at this Hospital. These observations should be presented to the National Committee of Blind and the MOH.</p> |

| GOAL | OBJECTIVES UPON TERMINATION OF PROJECT | OUTCOMES |
|---|---|--|
| Support/promote a harmonious relationship with village religious leaders in order to create a more positive atmosphere for those working in health. | Raise consciousness related to the importance of/need to coordinate with health workers, especially those from MOH and other NGOs such as AMPROS. | During the focus groups and interviews it was clear that to include religious leaders is vital for a project that will work at community level. The Catholic and Protestant churches both already have health related activities. Future projects must present to them first their proposed activities to get support and harmonious relationships. |
| Motivate and train staff from the Health Center and the Nursing School in the development of educational radio spots on health. | Reach an important sector of the population, offering education in health through a very valuable resource - the radio. | The project fulfilled this goal. They trained staff from three health districts and Nursing School, but the activity has not continued due to the scarcity of economical support. Radio stations require a pre-payment to transmit the spots. Future projects could explore different options with the churches or private sectors. They could explore also with recent governmental Plan of Publicity Sector "Guatemala está en tus Manos" whose interest can be raised to absorb educational messages. |

| GOALS | OBJECTIVES UPON TERMINATION OF PROJECT | OUTCOMES |
|--|---|---|
| Present medical personnel from Health Centers and National Hospital with an integral focus, prioritizing human and cultural aspects of Family Planning in order to promote a more positive acceptance in the villages. | Assure a friendlier environment for regional family planning efforts and that MOH and National Hospital medical personnel become able to identify the major benefits of family planning/child spacing programs. | Regarding this goal, the project can not encompass major activities due to the uncertainty of MOH with a Family Planning Policy. |
| Increase resources at the village level in order to sustain family gardens | Establish 25 revolving seed funds (50% of project villages-established in mid-term evaluation) | This is the most important goal accomplished by the project. Even though the number of seeds revolving funds is not what was planned, the experience with those still working has a high potential for future projects that will want to take advantage of this works accomplishment |
| | | With the family gardens the mothers are convinced even though the project will be finished in the next two months. They will continue obtaining Vitamin A from the gardens, and when they were asked how they will obtain the seeds they answered that will request them from the seeds volunteers or buy them directly in Coban. |

| GOALS | OBJECTIVES UPON TERMINATION OF PROJECT | OUTCOMES |
|--|---|--|
| Increase the availability of VA-rich foods (animal sources-retinol) their possibility of generating income | Improve nutritional status of family members through the availability consumption of foods rich in protein and VA and increased availability. | The results with this goal are almost the same as with the last one. The number of children receiving food rich in Vitamin A twice a week increased to 72% . Mothers who experimented with results are very interested to continue buying more. In relation to First Aid Kits for chickens was pointed out by some mothers interviewed that they just accepted those mothers who attend the Educational activities. Future projects should explore different mechanism to allow more participation of mothers interested although they do not participate in project activities. |

GOALS

OBJECTIVES UPON TERMINATION OF PROJECT

OUTCOMES

Consider the elimination of the few villages where there has been little cooperation or lack of support for project activities.

Concentrate time and funds on villages where there has been a more positive response both on the village as well as Volunteer level.

In relation to this goal it is necessary for future projects to identify since the beginning to communities that really will be interested in participate in projects activities.

The technical staff of IEF's Child Survival Project recommended to work just with communities out the urban sector located from 20 to 30 Kms. and or more than one hour traveling by car or motorcycle

III.EVALUATION TEAM

LIST OF TEAM MEMBERS

| | |
|--------------------------|--|
| Oscar Cordon | External Evaluator |
| Martha B. de Piedrasanta | IEF/Country Director/Project Manager |
| Enrique Fernandez | IEF/Supervisor |
| Julio Galvez | IEF/Supervisor |
| Luis Sierra | IEF/Supervisor |
| Alvaro Sierra | IEF/Supervisor |
| Maria Cristina Ayala | IEF/Extensionist |
| Ricardo Bin Jor | IEF/Extensionist |
| Carlos Heriberto Caal | IEF/Extensionist |
| Francisco Caal Mucu | IEF/Extensionist |
| Maria Elena Ac | IEF/Extensionist |
| Sonia Antonieta Cocical | IEF/Extensionist |
| Jose Alfonso Cucul | IEF/Extensionist |
| Aura Esmeralda Chen | IEF/Extensionist |
| Carlos Chub | IEF/Extensionist |
| Leticia Mendoza | IEF/Extensionist |
| Gilberto Leonel Soria | EF/Extensionist |
| Fidelina Tux | IEF/Extensionist |
| Juan Tzimaaj | IEF/Extensionist |
| Mauro Pineda | MOH/Rural Health Technician - Coordinator |
| Agripina Tot | CARE/Health Reproductive Project |

APPENDICES

APPENDIX A

**BHR/PVC GUIDELINES FOR FINAL EVALUATION OF CHILD SURVIVAL
PROJECTS ENDING IN 1996 (CS-IX)**

**BHR/PVC GUIDELINES FOR FINAL EVALUATION
OF CHILD SURVIVAL PROJECTS ENDING IN 1996 (CS-IX)**

The final evaluation team should address each of the following points. As far as possible, respond to each point in sequence.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

1. Compare project accomplishments with the objectives outlined in the DIP and explain the differences. Describe any circumstances which may have aided or hindered the project in meeting these objectives.
2. Describe unintended positive and negative effects of project activities.
3. Attach a copy of the project's Final Evaluation Survey with the survey results

B. Project Expenditures

1. Attach a pipeline analysis of project expenditures.
2. Compare the budget contained in the DIP with the actual expenditures of the project. Were some categories of expenditures much higher or lower than originally planned? Please explain.

C. Lessons Learned

Outline the main lessons learned regarding the entire project which are applicable to other PVO CS projects, and/or relevant to USAID's support of these projects. Be sure to address specific interventions, sustainability and expenditures.

II. PROJECT SUSTAINABILITY

A. Community Participation

What resources has the community contributed and will continue to contribute that will encourage continuation of project activities after donor funding ends?

4/6A

B. NGO's

What is the current ability of the NGO partners to provide the necessary financial, human and natural resources to sustain effective project activities once Child Survival funding ends?

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

C. Sustainability Plan, Objectives, Steps Taken, and Outcomes

What are the steps the project has undertaken to promote sustainability of child survival activities once project funds end? Please fill in a table (example below) with sustainability objectives and outcomes.

| Goal | End-of-project objectives | Steps taken to date | Outcomes |
|---|--|--|--|
| 1) MOH will take on health promotive activities of CS project | 1) MOH will supervise and provide refresher training for 50 CHVs 2) Health officer will meet monthly with community health committees | 1) 2 MOH nurses trained in CHV supervisory methods 2) Health officer attended 3 health committee meetings | 1) 10 CHVs being supervised by MOH nurses (20% of objective) 2) Health officer attended 3/10 meetings (30%) |
| B) | | | |

III. EVALUATION TEAM

A. Identify by names, titles and institutional affiliations all members of the final evaluation team.

PYOCOUNTRY: _____
 COOPERATIVE AGREEMENT NO.: _____

DATE BUDGET PREPARED: _____
 DATE SUBMITTED TO USAID: _____

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1996 PIPELINE ANALYSIS: PART A - HEADQUARTERS BUDGET

Check one: ORIGINAL BUDGET _____ REVISED BUDGET _____

| | | Total Agreement Budget (/ /) to (/ /) | | Actual Expenditures to Date (/ /) to (/ /) | | Projected Expenditures Against Remaining Obligated Funds (/ /) to (/ /) | | Projected Unobligated Funds at End of Project (/ /) to (/ /) | |
|--|--|--|-----|---|-----|---|-----|--|-----|
| | | USAID | PVO | USAID | PVO | USAID | PVO | USAID | PVO |
| I. DIRECT COSTS | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | 1. Headquarters - salaries/wages | | | | | | | | |
| | 2. Field, Technical Personnel - salaries/wages | | | | | | | | |
| | 3. Field, Other Personnel - salaries/wages | | | | | | | | |
| | 4. Fringes- Headquarters + Field | | | | | | | | |
| | SUBTOTAL- PERSONNEL | | | | | | | | |
| B. TRAVEL/PER DIEM | 1. Headquarters-Domestic (USA) | | | | | | | | |
| | 2. Headquarters-International | | | | | | | | |
| | 3. Field- in country | | | | | | | | |
| | 4. Field- International | | | | | | | | |
| | SUBTOTAL- TRAVEL / PER DIEM | | | | | | | | |
| C. CONSULTANCIES | 1. Evaluation Consultants- Fees | | | | | | | | |
| | 2. Other Consultants- Fees | | | | | | | | |
| | 3. Consultant travel / per diem | | | | | | | | |
| | SUBTOTAL- CONSULTANCIES | | | | | | | | |
| D. PROCUREMENT (provide justification/ explanation in narrative) | 1. Supplies | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | | | | | | | | |
| | c. Field - Other | | | | | | | | |
| | 2. Equipment | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 3. Training | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| SUBTOTAL- PROCUREMENT | | | | | | | | | |
| E. OTHER DIRECT COSTS (provide justification/ explanation in narrative) | 1. Communications | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 2. Facilities | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 3. Other | | | | | | | | |
| a. Headquarters | | | | | | | | | |
| b. Field | | | | | | | | | |
| SUBTOTAL- OTHER DIRECT | | | | | | | | | |
| TOTAL - DIRECT COSTS | | | | | | | | | |
| II. INDIRECT COSTS | | | | | | | | | |
| A. INDIRECT COSTS | 1. Headquarters | | | | | | | | |
| | 2. Field (if applicable) | | | | | | | | |
| TOTAL - INDIRECT COSTS | | | | | | | | | |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | | | | | | | | |

BEST AVAILABLE COPY

PVO/COUNTRY: _____
 COOPERATIVE AGREEMENT NO.: _____

DATE BUDGET PREPARED: _____
 DATE SUBMITTED TO USAID: _____

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1996 PIPELINE ANALYSIS: PART B - COUNTRY BUDGET

Check one: ORIGINAL BUDGET _____ REVISED BUDGET _____

BEST AVAILABLE COPY

| | | Total Agreement Budget (/ /) to (/ /) | | Actual Expenditures to Date (/ /) to (/ /) | | Projected Expenditures Against Remaining Obligated Funds (/ /) to (/ /) | | Projected Unobligated Funds at End of Project (/ /) to (/ /) | |
|--|--|--|-----|---|-----|---|-----|--|-----|
| | | USAID | PVO | USAID | PVO | USAID | PVO | USAID | PVO |
| I. DIRECT COSTS | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | 1. Headquarters-salaries/wages | | | | | | | | |
| | 2. Field, Technical Personnel-salaries/wages | | | | | | | | |
| | 3. Field, Other Personnel-salaries/wages | | | | | | | | |
| | 4. Fringes- Headquarters + Field | | | | | | | | |
| | SUBTOTAL- PERSONNEL | | | | | | | | |
| B. TRAVEL/PER DIEM | 1. Headquarters-Domestic (USA) | | | | | | | | |
| | 2. Headquarters-International | | | | | | | | |
| | 3. Field- In country | | | | | | | | |
| | 4. Field- International | | | | | | | | |
| | SUBTOTAL- TRAVEL / PER DIEM | | | | | | | | |
| C. CONSULTANCIES | 1. Evaluation Consultants- Fees | | | | | | | | |
| | 2. Other Consultants- Fees | | | | | | | | |
| | 3. Consultant travel / per diem | | | | | | | | |
| | SUBTOTAL- CONSULTANCIES | | | | | | | | |
| D. PROCUREMENT (provide justification/ explanation in narrative) | 1. Supplies | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field - Pharmaceuticals (ORS, VR A, drugs, etc.) | | | | | | | | |
| | c. Field- Other | | | | | | | | |
| | 2. Equipment | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 3. Training | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| SUBTOTAL- PROCUREMENT | | | | | | | | | |
| E. OTHER DIRECT COSTS (provide justification/ explanation in narrative) | 1. Communications | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 2. Facilities | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| 3. Other | | | | | | | | | |
| a. Headquarters | | | | | | | | | |
| b. Field | | | | | | | | | |
| SUBTOTAL- OTHER DIRECT | | | | | | | | | |
| TOTAL - DIRECT COSTS | | | | | | | | | |
| II. INDIRECT COSTS | | | | | | | | | |
| A. INDIRECT COSTS | 1. Headquarters | | | | | | | | |
| | 2. Field (if applicable) | | | | | | | | |
| TOTAL - INDIRECT COSTS | | | | | | | | | |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | | | | | | | | |

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PVO/COUNTRY: _____
 COOPERATIVE AGREEMENT NO.: _____

DATE BUDGET PREPARED: _____
 DATE SUBMITTED TO USAID: _____

1996 PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD BUDGET

Check one: ORIGINAL BUDGET _____ REVISED BUDGET _____

BEST AVAILABLE COPY

| | | Total Agreement Budget (/ /) to (/ /) | | Actual Expenditures to Date (/ /) to (/ /) | | Project Expenditures Against Remaining Obligated Funds (/ /) to (/ /) | | Projected Unobligated Funds at End of Project (/ /) to (/ /) | |
|--|--|--|-----|---|-----|---|-----|--|-----|
| | | USAID | PVO | USAID | PVO | USAID | PVO | USAID | PVO |
| I. DIRECT COSTS | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | | | | | | | | | |
| | 1. Headquarters-salaries/wages | | | | | | | | |
| | 2. Field, Technical Personnel-salaries/wages | | | | | | | | |
| | 3. Field, Other Personnel-salaries/wages | | | | | | | | |
| | 4. Fringes-Headquarters + Field | | | | | | | | |
| | SUBTOTAL- PERSONNEL | | | | | | | | |
| B. TRAVEL/PER DIEM | | | | | | | | | |
| | 1. Headquarters-Domestic (USA) | | | | | | | | |
| | 2. Headquarters-International | | | | | | | | |
| | 3. Field- In country | | | | | | | | |
| | 4. Field- International | | | | | | | | |
| | SUBTOTAL- TRAVEL / PER DIEM | | | | | | | | |
| C. CONSULTANCIES | | | | | | | | | |
| | 1. Evaluation Consultants- Fees | | | | | | | | |
| | 2. Other Consultants- Fees | | | | | | | | |
| | 3. Consultant travel / per diem | | | | | | | | |
| | SUBTOTAL- CONSULTANCIES | | | | | | | | |
| D. PROCUREMENT (provide justification/ explanation in narrative) | | | | | | | | | |
| | 1. Supplies | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | | | | | | | | |
| | c. Field- Other | | | | | | | | |
| | 2. Equipment | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 3. Training | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | SUBTOTAL- PROCUREMENT | | | | | | | | |
| E. OTHER DIRECT COSTS (provide justification/ explanation in narrative) | | | | | | | | | |
| | 1. Communications | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 2. Facilities | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | 3. Other | | | | | | | | |
| | a. Headquarters | | | | | | | | |
| | b. Field | | | | | | | | |
| | SUBTOTAL- OTHER DIRECT | | | | | | | | |
| TOTAL - DIRECT COSTS | | | | | | | | | |
| II. INDIRECT COSTS | | | | | | | | | |
| A. INDIRECT COSTS | | | | | | | | | |
| | 1. Headquarters | | | | | | | | |
| | 2. Field (if applicable) | | | | | | | | |
| TOTAL - INDIRECT COSTS | | | | | | | | | |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | | | | | | | | |

APPENDIX B
EVALUATION SCHEDULE

APPENDIX B

CHRONOGRAM EVALUATION ACTIVITIES

| DATE | COMMUNITY | ACTIVITY | PARTICIPANTS No. |
|-------------|-----------|---|---------------------|
| 16 Apr 1997 | GUATEMALA | Bibliography and documents revision | |
| 17 Apr 1997 | | Bibliography and documents revision | |
| 18 Apr 1997 | | Final evaluation instruments design | |
| 19 Apr 1997 | | Final evaluation instruments design | |
| 20 Apr 1997 | COBAN | Final evaluation instrument revision with technical staff | |
| 21 Apr 1997 | | | |
| 22 Apr 1997 | SAMAC | Focus groups with mothers | 15 |
| | | Cooking demonstrations with volunteers | 15 |
| | | Focus groups with leaders | 14 |
| | | Volunteer interviews | 1 |
| 22 Apr 1997 | CAMPAT | Visits to home gardens and CHV interviews | 3 |
| | | | 2 |
| | | Focus groups with mothers | 16 |
| | | Focus groups with leaders | 15 |
| | | Educational activity | 21 |
| | | | 21 |
| 23 Apr 1997 | POCOLA | Focal group with leaders | 7 |
| | | Educational activity/CDD | 26 |
| | | Focus groups with mothers | 12 |
| | | Visit to home gardens | 2 |
| | | Interviews with seeds volunteers | |
| | | Sustainability (revolving funds) | 2 |
| | | | |
| | | | |
| 24 Apr 1997 | COBAN | Technical Meeting with MOH and NGOs | 10 |
| 25 Apr 1997 | CHIYO | Focus groups with leaders | 17 |
| | | Educational activity of A.R.I. | 15 |
| | | Volunteer-seeds and S.R.O.interviews | 3 |
| | | Focus group with mothers | 15 |
| | | EntervIEWS with religious leaders | 3 |
| | | | |
| | | TOTAL OF PARTICIPANTS | 199 |
| 26 Apr 1997 | COBAN | Transcription of Guides | |
| 28 Apr 1997 | GUATEMALA | Transcription of Guides | |
| 29 Apr 1997 | | Final Evaluation Report Preparation | |
| 30 Apr 1997 | | Final Evaluation Report Preparation | |
| 1 May 1997 | | Final Evaluation Report Preparation | |
| 2 May 1997 | | Final Evaluation Report presented | |

APPENDIX C
INSTRUMENTS FOR FOCUS GROUPS AND INTERVIEWS

FORM 1

Guia de preguntas para grupos focales con madres

1. Ustedes participan en las actividades del Proyecto de Vitamina A?
2. Qué es lo que más les ha gustado del proyecto?
3. Ha venido un proyecto que ha hecho cosas que no les ha gustado? cuál fue? qué fue lo que no le gustó?.
4. Qué otras cosas les gustaría que hicieran otros proyectos que vinieran a su comunidad?
5. Supo de alguna persona que quisiera participar en el proyecto y no pudo?
6. Ha escuchado algún mensaje educativo del proyecto de vitamina A por la radio. Me puede decir a qué hora lo escuchó? en qué radio? que le pareció?

Conocimientos de Salud

7. Si su niño tuviera infección respiratoria qué señales harían que usted se preocupara por su enfermedad?
8. Qué hace cuando su niño empieza a mejorar?
9. Si su niño tuviera diarrea qué señales harían que usted se preocupara por su enfermedad?
10. Qué hace cuando su niño empieza a mejorar?

Actividades Educativas

11. Les gustaron los materiales que se utilizaron en las charlas? Sí, No,
12. Porqué creen uds. que a unas señoras de otra comunidad les aburrió el material educativo?
13. Hay algunas mamás que no les gustan las charlas, por qué creen que no les gustan?
14. Ustedes saben que el proyecto vitamina A se va a terminar?

Sostenibilidad/educativa

15. Ustedes estarían dispuestas a seguir participando en las charlas que da el voluntario? Sí, No, Porqué?
16. Cuando el proyecto se retire cómo van a seguirle dando vitamina A, a sus niños/ o familia?
17. Creen ustedes que algún grupo en su comunidad estaría interesado en participar en alguna actividad que dejará de hacer el proyecto? en cuál?

FORM 2

GUIA CON GRUPO FOCAL DE LIDERES Y LIDERES RELIGIOSOS

1. Conoce las actividades que ha realizado el proyecto de vitamina A? me puede mencionar algunas.
2. En qué actividades del proyecto de vitamina A han participado ustedes?
3. Ha escuchado algún mensaje educativo en la radio sobre salud y nutrición de parte del proyecto de vitamina A? que le pareció?
4. Han observado en su comunidad algún beneficio de las actividades que ha realizado el proyecto de vitamina A.
5. Ha escuchado algún mensaje sobre el cuidado de los ojos.
6. Sabe ud. de alguna persona que haya ido a consulta al Hospital de Ojos de Carchá? Cómo lo atendieron?
7. Saben uds. que el proyecto de vitamina A se va a terminar?
8. Han recibido alguna charla sobre como mantener las actividades del proyecto de vitamina A cuando este se vaya? Si/No? Qué les han dicho?
9. De estas actividades cuáles le gustaría que continuaran cuando termine el proyecto?
10. Estaría algún grupo en su comunidad interesado en participar en alguna actividad que dejará de realizar el proyecto de vitamina A? en cuál?
11. Creen ustedes que el grupo estaría dispuesto en responsabilizarse en ella?
12. Hay alguna actividad de salud que usted cree no puede ser mantenida por la comunidad? diga cual?

Comités de Salud

13. Existe comité de salud en esta comunidad? Sí-No? Porqué?
14. Saben ustedes cuáles son las funciones del comité?
15. Hay alguien en este grupo que sea miembro del comité de salud?
16. Del centro de salud se han comunicado con ustedes? Si/No, Qué les han dicho?
17. Qué ayuda necesitaría del Ministerio de Salud para que el comité realice sus actividades?

FORM 3

HOJA DE OBSERVACION DE DEMOSTRACION DE COCINA

Nombre del Voluntario: _____ Fecha: _____

Comunidad: _____

1. Realiza algún tipo de motivación inicial? Si _____ No _____
2. Establece buenas relaciones con participantes? Si _____ No _____
3. Se expresa en forma clara? Si _____ No _____
4. Procura ser creativo para obtener atención. Si _____ No _____
5. Busca reforzar cambios de conducta
(lavar manos, lavar verduras) Si _____ No _____
6. Usa alguna técnica participativa? Si _____ No _____
7. Promueve la participación en la
demostración Si _____ No _____
8. Conocimiento de la receta (M-R-B) Si _____ No _____
9. Repitió los ingredientes de la receta Si _____ No _____
10. Preguntó si había dudas sobre la
demostración Si _____ No _____

M=Malo

R=Regular

B=Bueno

FORM 4

GUIA DE PREGUNTAS PARA ENTREVISTAS AL PERSONAL DE LOS DISTRITOS DE SALUD

1. Cómo considera que fue la labor desarrollada por el Proyecto AMPROS en las comunidades de sus distritos?
2. Qué errores considera que cometió el personal del proyecto AMPROS?
3. Qué podrían hacer proyectos futuros para evitar los errores que ha cometido AMPROS?
4. Después de conocer los hallazgos de la encuesta de CAP's realizada por el proyecto en qué creen que les ayudan estos en su trabajo?
5. Qué factibilidad habria de darles seguimiento a las actividades realizadas por AMPROS
6. Qué acciones de AMPROS considera que son las más factibles de dar seguimiento? por qué?
7. Cuales considera que son las actividades de AMPROS más difíciles de seguir y porqué?
8. Participó con AMPROS en la organización de algún comité de salud? en dónde? cómo le parece el funcionamiento de dicho comité?
9. Qué opinión le merece las coberturas de BCG y Toxoide Tetánico obtenidas en el CAPS?

Conocimientos

10. Recibió su persona o alguien del Centro de Salud capacitación sobre Salud Ocular? Mencione qué temas recibió
11. Me puede mencionar qué dosis de vitamina A debe recibir una mujer postparto? Un niño de 6 a 11 meses? y un niño de 12 a 71 meses?
12. Me puede mencionar los tres métodos de Planificación Familiar más usados, sus riesgos y bondades.
13. Me puede mencionar los dos signos de alarma en el Manejo Estándar de casos de IRA
14. Ha participado el personal de su distrito en capacitaciones sobre la preparación de spots radiales por parte de AMPROS? qué tipo de spots eran? a qué grupo de población iba dirigido? se está transmitiendo en alguna estación de radio? Sí, No, porqué
15. Qué tipo de apoyo necesitaría para poder preparar estos spots?

FORM 5
GUIA DE PREGUNTAS A MADRE QUE NO PARTICIPA EN EL PROYECTO

1. Ud. ha oído hablar del proyecto Vitamina A?
2. Qué le han dicho que hace el proyecto?
3. Le han invitado alguna vez a participar?
4. Por qué no le interesó participar en el proyecto?
5. Qué actividades le gustaría que hiciera el proyecto para que ud . participara.
6. Ha sabido de algo malo que haya hecho el proyecto en la comunidad?
7. Puede mencionar el problema.

FORM 6

GUIA DE PREGUNTAS A MADRES QUE PARTICIPARON EN EL PROYECTO DE VITAMINA A Y DEJARON DE PARTICIPAR

1. Participó alguna vez en las actividades del proyecto de vitamina A?
2. Hace cuánto tiempo dejó de participar?
3. Por qué dejó de participar?
4. Ha sabido de algo malo que haya hecho el proyecto en la comunidad? Si, No
5. Puede mencionar el problema
6. Qué recomendaría para evitar que en el futuro se repita el problema?.

FORM 7

GUIA DE PREGUNTAS PARA ENTREVISTAS A VOLUNTARIOS DE SOSTENIBILIDAD

SOBRE HUERTOS:

1. Conoce hortalizas que tengan Vitamina "A" ? Me puede mencionar dos ?
2. Qué tiene Sembrado ?
3. Consume algo de lo que cosecha ? Lo vende o lo da a otras personas ajenas a su familia ?
4. Usted vende las semillas que recibe del Proyecto ?A qué precio ?
- 4.1. Ha logrado vender el total de las semillas que recibió del Proyecto?
- 4.2. Ha comprado semillas por su cuenta ?
5. Ha tenido algún tipo de problema con la semilla ?Explique cuál ?
6. Por qué cree que hay unas familias que no tienen huerto ?
7. Tiene abonera orgánica en su casa ?Si respondió que no, explique porqué ?
8. Ha utilizado la abonera ?Ha visto sus beneficios ?Cuáles ?

*SOBRE AVES (bolsas pecuarias familiares)

9. En su familia tienen Bolsas Pecuarias? Si respondió que no explique porqué ?
10. Qué cantidad de aves recibió usted del Proyecto ?Cuantas tiene actualmente ?
11. Qué beneficio le han dado las aves?
12. Ha tenido algún tipo de problema con las aves ? Cuál?
13. En su comunidad se organizó algún tipo de comité Botiquín Pecuario ?Está activo ?
14. Qué beneficio ha dado el botiquín pecuario ?

SOBRE SUEROS

15. Ha recibido sobres de SRO de parte del Proyecto ?
16. La gente está utilizando los sueros ?
17. Hay personas que no usan los sueros? Si respondió que no explique porqué?
18. Cree usted que sería bueno vender el suero? porqué?
19. Si el suero se vendiera la gente lo compraría ?

*Solo para comunidades priorizadas para esta actividad (Samac y Pocola).

FORM 8

GUIA DE ENTREVISTA CON EXTENSIONISTAS

GRUPO FOCAL EXTENSIONISTAS

1. Qué piensan que ha sido lo más beneficioso del trabajo que han hecho en el proyecto ?
2. Qué piensan que ha sido lo más difícil del trabajo que han hecho en el proyecto ?
3. De los temas que ustedes daban en charlas a las comunidades hay alguno que fuera muy difícil ? cuál ? porqué ?
4. Cuando ustedes dan charlas se sienten mal si las mamás la dirigen y ustedes solo participan en el círculo.
5. Como piensan de que otros proyectos podrian mejorar la participación de las mamás ?
6. Qué podrian hacer otros proyectos para mejorar el trabajo entre supervisores y extensionistas. ?
7. Ustedes creen que su trabajo con los voluntarios se parece al del supervisor con ustedes ? si, no, porqué ?
8. Ustedes sienten presion por el cumplimiento de las metas del proyecto
9. Cómo les afecta en su trabajo ?
10. Han escuchado en las comunidades donde trabajan algun comentario negativo sobre el proyecto ? me puede hablar más sobre eso ?
11. Cómo ha sido su experiencia de trabajo en la comunidad en relación a los lideres religiosos ? y con líderes ?
12. Cómo piensan que podrian hacer otros proyectos si quisieran trabajar con líderes religiosos ?
13. Qué piensan de las actividades de sostenibilidad del proyecto?Cuál cree que es la más facil de continuar por la comunidad cuando se vaya el proyecto? porqué? cuál es la más difícil ? porqué ?
14. Qué podrian hacer otros proyectos en relación a actividades de sostenibilidad ?

FORM 9

GUIA DE ENTREVISTA DE ONG's Y/O INSTITUCIONES QUE HAN TRABAJADO CON I.E.F.

1. Ha participado en alguna actividad con el proyecto de Vitamina "A", cual? me puede hablar sobre ello ?
2. Como le han parecido las actividades donde ha participado ?
3. Sabe usted que el proyecto de Vitamina "A" esta por terminar?
4. Cree usted que existe factibilidad de parte de su institucion de poder dar seguimiento a alguna de sus actividades que desarrollaba el Proyecto de Vitamina "A" ? me puede mencionar cual o cuales podrian ser ?
5. Cual cree usted que podria ser el mecanismo de coordinación con su institución para poder hacer el traslape de actividades.

ANNEX D

LIST OF DOCUMENTS REVIEWED

1. International Ey Foundation. Detailed Implementation Plan. September 30,1993
September 29,1996
2. International Ey Foundation. Baseline Survey. USAID Child Survival IX. April 1994
3. International Ey Foundation .Mid-Term Evaluation. USAID Child Survival
IX.November 1995
4. International Eye Foundation. Annual Report - Year 3 - October 1996.
5. Fundacion Internacional del Ojo. Informe de Grupos Focales AMPROS- HOPE
6. Fundacion Internacional del Ojo. Informes Mensuales de Noviembre, Diciembre y
Enero 1996.
7. Informes sobre suministros de Vitamina A a Madres Post Parto Julio 1995 - Marzo
1997
8. Manual : Huertos de Hortalizas una Alternativa para la Salud Infantil. UPVA-Project
HOPE- The International Eye Foundation.
9. Manual: Una Comida con Vitamina A.
10. El Manual para Excelencia en la Investigacion Mediante > Grupos Focales.USAID.
Academia para el Desarrollo Educativo.
11. Guia de Habilidades para la Eficaz Realizacion de Grupos Focales. USAID
12. International Eye Foundation. Evaluacion Final y Revision de Sostenibilidad.Julio 1,
1990 - Septiembre 29, 1993
13. National Maternal and Child Health Survey. National Institute for Statistics.Ministry
of Health. USAID. UNICEF. DHS. 1995

APPENDIX E

**Final Results of Pilot Project
Child to Child**

FUNDACIÓN INTERNACIONAL DEL OJO
PROYECTO NIÑO A NIÑO
LIC. MARTHA DE PIEDRASANTA
NORA DE SALAZAR

INTERPRETACIÓN DE LOS RESULTADOS
PROYECTO PILOTO NIÑO A NIÑO

GUATEMALA ABRIL DE 1997

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IX. RESULTADOS CUALITATIVOS

En general se obtuvo muy buena respuesta de las entidades tanto del sector público como privado para el desarrollo de todas las actividades del proyecto piloto.

El grado de participación, colaboración y apoyo del personal docente en las escuelas fue satisfactorio aunque si es difícil que se logre una participación plena debido a la falta de tiempo, incentivos y motivación de los maestros.

Se logró dar un apoyo real a los maestros en la introducción de mensajes importantes de salud a sus escuelas y comunidades.

Se dio la oportunidad de autoaprendizaje y la discusión de temas de salud a personal no profesional en salud.

Se logró una estandarización en el contenido y en la divulgación de los mensajes de salud dentro de las escuelas, familiares y comunidades participantes.

Se logró motivar a los alumnos por medio del sistema de radio interactiva con lecciones radiofónicas son temas de salud para su autoaprendizaje y divulgación a nivel familiar.

Se lograron los objetivos propuestos en las fases de implementación, monitoreo y evaluación del proyecto.

INTERPRETACION DE RESULTADOS

NIÑOS:

Se encontró que el número de sesiones a las que participaron los estudiantes no fue significativo, pues los que participaron de una a tres sesiones lograron aumentar sus conocimientos al igual que los que asistieron de seis a siete sesiones.

A continuación se muestran los porcentajes obtenidos por escuela y el promedio total. (no está incluida la escuela de Muyhá, por razones de confiabilidad de los datos obtenidos.

| TEMA No. 1 | CED | (completas) | | |
|----------------|-----|----------------------|-----------------------|------------|
| ESCUELA | | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
| LAS CRUCES | | 57 | 88 | 31 |
| SAMAC | | 47 | 81 | 34 |
| <u>SEHUBUB</u> | | <u>66</u> | <u>78</u> | <u>12</u> |
| TOTALES | | 56.66 | 82.33 | 25.66 |

TEMA No. 2 NUT/LACTANCIA (completas)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 55 | 80 | 25 |
| SAMAC | 58 | 92 | 34 |
| <u>SEHUBUB</u> | <u>75</u> | <u>84</u> | <u>9</u> |
| TOTALES | 62.66 | 85.33 | 22.66 |

Lo que muestra que si hay un cambio significativo entre las respuestas de la fase inicial (pre-test) y la fase final (post-test)

MADRES:

TEMA No. 1 CED (completas)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 70 | 92 | 22 |
| SAMAC | 72 | 100 | 28 |
| <u>SEHUBUB</u> | <u>40</u> | <u>79</u> | <u>39</u> |
| TOTALES | 60.66 | 90.33 | 29.66 |

TEMA No. 1 CED (participantes del proyecto AMPROS)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 80 | 92 | 12 |
| SAMAC | 86 | 100 | 14 |
| <u>SEHUBUB</u> | <u>40</u> | <u>85</u> | <u>45</u> |
| TOTALES | 68.66 | 92.33 | 23.66 |

TEMA No. 1 CED (no participantes del proyecto AMPROS)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 64 | 92 | 28 |
| SAMAC | 44 | 100 | 56 |
| <u>SEHUBUB</u> | <u>31</u> | <u>72</u> | <u>41</u> |
| TOTALES | 46.33 | 88 | 41.66 |

TEMA No. 2 NUT/LACTANCIA (completas)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 69 | 87 | 18 |
| SAMAC | 70 | 100 | 30 |
| <u>SEHUBUB</u> | <u>44</u> | <u>74</u> | <u>30</u> |
| TOTALES | 61 | 87 | 26 |

TEMA No. 2 NUT/LACTANCIA (participantes del proyecto AMPROS)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 71 | 79 | 8 |
| SAMAC | 79 | 100 | 21 |
| <u>SEHUBUB</u> | <u>39</u> | <u>69</u> | <u>30</u> |
| TOTALES | 63 | 82.66 | 19.66 |

TEMA No. 2 NUT/LACTANCIA (no participantes del proyecto AMPROS)

| ESCUELA | PROMEDIO PRE-TEST | PROMEDIO POST-TEST | DIFERENCIA |
|----------------|----------------------|-----------------------|------------|
| LAS CRUCES | 67 | 95 | 28 |
| SAMAC | 54 | 100 | 46 |
| <u>SEHUBUB</u> | <u>46</u> | <u>77</u> | <u>31</u> |
| TOTALES | 55.66 | 90.66 | 35 |

Lo que nos muestra que si hay un cambio significativo entre las respuestas de la fase inicial (pre-test) y la fase final (post-test) tanto para los niños como para las madres o encargadas.

Los resultados demuestran que las madres no participantes del proyecto AMPROS han aumentado más sus conocimientos que el resto de las que si participan, podemos interpretar que los niños han llevado el mensaje a sus hogares.

60d

LIMITACIONES

El grado de motivación y respuesta obtenida es variable dentro de las comunidades y escuelas participantes tanto por los maestros, escolares y madres de familia o encargadas, aunque en general si presentan las mismas tendencias grupales en el cambio obtenido entre las fases iniciales y final del proyecto piloto.

El número de niños en los grados superiores no era suficiente para llevar a cabo el proyecto por lo que se tomó la decisión de incluir a los niños de grados inferiores pero que fueran mayores de 10 años, encontrando que los alumnos de los grados inferiores no tienen un completo dominio del idioma español en forma escrita, lo que afecto de alguna manera la evaluación del proyecto.

En tanto al idioma Q'eqchi' en forma verbal fue bien entendido por los escolares, pero no se maneja la forma escrita en las escuelas.

Se observaron dificultades en las evaluaciones iniciales y finales (pre y post-test) ya que los contenidos fueron presentados en q'eqchi' y las pruebas de evaluación en español, por lo que la mezcla idiomática representó una limitación en el completo dominio de los temas y por lo tanto en la evaluación de los conocimientos.

COMENTARIOS

Los comentarios generales de las experiencia son satisfactorios, ya que para los niños fue algo nuevo, creativo, alegre que los motiva a su autoaprendizaje y a la participación por medio de la radio interactiva.

Los maestros, madres de familia, encargadas y otros miembros de la comunidad nos dieron sus muestras de agradecimiento por los beneficios y conocimientos logrados a través del proyecto, tanto para las escuelas, las familias y las comunidades participantes.

Los maestros opinan que el proyecto niño a niño, mediante la metodología didáctica de radio interactiva es beneficiosa para el aprendizaje de los temas de salud, siempre y cuando se complemente con otras actividades de apoyo, se trabaje en forma bilingüe, se utilicen materiales adecuados al área, con base al conocimiento de la cultura y costumbres de la comunidad y se cuente con el apoyo del personal del proyecto AMPROS.

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APPENDIX F
Pipeline Analysis

1996 PIPELINE ANALYSIS: PART A - HEADQUARTERS BUDGET

| | | Actual Expenditures to Date 09/30/95 to 6/30/96 | | | Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99 | | | Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99 | | |
|---|---|--|---------------|----------------|---|----------------|----------------|---|---------------|----------------|
| | | AID | PVO | TOTAL | AID | PVO | TOTAL | AID | PVO | TOTAL |
| I. DIRECT COSTS | | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | | | | | | | | | | |
| | 1. Headquarters-wages/salaries | 10,319 | 12,183 | 22,502 | (107) | 11,230 | 11,123 | 10,213 | 23,413 | 33,625 |
| | 2. Field, Technical Personnel-wages/salaries | | | 0 | 0 | 0 | 0 | | | 0 |
| | 3. Field, Other Personnel-wages/salaries | | | 0 | 0 | 0 | 0 | | | 0 |
| | 4. Fringes - Headquarters + Field | 3,096 | 3,655 | 6,751 | (32) | 3,369 | 3,337 | 3,064 | 7,024 | 10,088 |
| | SUBTOTAL - PERSONNEL | 13,415 | 15,838 | 29,253 | (138) | 14,598 | 14,460 | 13,276 | 30,436 | 43,713 |
| B. TRAVEL/PER DIEM | | | | | | | | | | |
| | 1. Headquarters - Domestic (USA) | 721 | 537 | 1,258 | 1,679 | (537) | 1,142 | 2,400 | 0 | 2,400 |
| | 2. Headquarters - International | 4,695 | 8,122 | 12,817 | (2,883) | (2,172) | (5,055) | 1,812 | 5,950 | 7,762 |
| | 3. Field - in country | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 4. Field - International | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | SUBTOTAL - TRAVEL/PER DIEM | 5,416 | 8,659 | 14,075 | (1,204) | (2,709) | (3,913) | 4,212 | 5,950 | 10,162 |
| C. CONSULTANCIES | | | | | | | | | | |
| | 1. Evaluation Consultants - Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2. Other Consultants - Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 3. Consultant travel/per diem | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | SUBTOTAL - CONSULTANCIES | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| D. PROCUREMENT (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Supplies | | | | | | | | | |
| | a. Headquarters | 0 | 673 | 673 | 700 | (523) | 177 | 700 | 150 | 850 |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | | | 0 | 0 | 0 | 0 | | | 0 |
| | c. Field - Other | | | 0 | 0 | 0 | 0 | | | 0 |
| | 2. Equipment | | | | | | | | | |
| | a. Headquarters | 0 | 670 | 670 | 0 | 80 | 80 | 0 | 750 | 750 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | 3. Training | | | | | | | | | |
| | a. Headquarters | 0 | 508 | 508 | 250 | (508) | (258) | 250 | 0 | 250 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | SUBTOTAL - PROCUREMENT | 0 | 1,851 | 1,851 | 950 | (951) | (1) | 950 | 900 | 1,850 |
| E. OTHER DIRECT COSTS (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Communications | | | | | | | | | |
| | a. Headquarters | 0 | 4,542 | 4,542 | 0 | 333 | 333 | 0 | 4,875 | 4,875 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | 2. Facilities | | | | | | | | | |
| | a. Headquarters | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | 3. Other | | | | | | | | | |
| | a. Headquarters | 250 | 1,573 | 1,823 | (250) | (1,573) | (1,823) | 0 | 0 | 0 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | SUBTOTAL - OTHER DIRECT | 250 | 6,115 | 6,365 | (250) | (1,240) | (1,490) | 0 | 4,875 | 4,875 |
| TOTAL - DIRECT COSTS | | 19,081 | 32,463 | 51,544 | (642) | 9,698 | 9,056 | 18,438 | 42,161 | 60,600 |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | | | | | | | | | | |
| | 1. Headquarters | 79,219 | 22,072 | 101,290 | 16,753 | 5,103 | 21,857 | 95,972 | 27,175 | 123,147 |
| | 2. Field (if applicable) | | | | | | | | | |
| TOTAL - INDIRECT COSTS | | 79,219 | 22,072 | 101,290 | 16,753 | 5,103 | 21,857 | 95,972 | 27,175 | 123,147 |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | 98,299 | 54,534 | 152,834 | 16,111 | 14,802 | 30,913 | 114,410 | 69,336 | 183,747 |

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1996 PIPELINE ANALYSIS: PART B - FIELD BUDGET

| | | Actual Expenditures to Date 09/30/95 to 6/30/96 | | | Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99 | | | Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99 | | |
|---|---|--|----------------|----------------|---|-----------------|-----------------|---|----------------|----------------|
| | | AID | PVO | TOTAL | AID | PVO | TOTAL | AID | PVO | TOTAL |
| I. DIRECT COSTS | | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | | | | | | | | | | |
| | 1. Headquarters-wages/salaries | | | 0 | 0 | 0 | 0 | | | 0 |
| | 2. Field, Technical Personnel-wages/salaries | 244,623 | 40,823 | 285,446 | (5,943) | (13,893) | (19,836) | 238,680 | 26,930 | 265,610 |
| | 3. Field, Other Personnel-wages/salaries | 37,894 | 18,096 | 55,990 | 2,079 | 3,682 | 5,761 | 39,973 | 21,778 | 61,751 |
| | 4. Fringes - Headquarters + Field | 49,454 | 26,364 | 75,818 | (16,409) | (6,114) | (22,523) | 33,045 | 20,250 | 53,296 |
| | SUBTOTAL - PERSONNEL | 331,971 | 85,283 | 417,254 | (20,273) | (16,325) | (36,598) | 311,698 | 68,958 | 380,657 |
| B. TRAVEL/PER DIEM | | | | | | | | | | |
| | 1. Headquarters - Domestic (USA) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2. Headquarters - International | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 3. Field - in country | 15,303 | 1,769 | 17,072 | 7,597 | (1,769) | 5,828 | 22,900 | 0 | 22,900 |
| | 4. Field - International | 2,305 | 1,441 | 3,746 | 2,945 | 2,009 | 4,954 | 5,250 | 3,450 | 8,700 |
| | SUBTOTAL - TRAVEL/PER DIEM | 17,608 | 3,210 | 20,818 | 10,542 | 240 | 10,782 | 28,150 | 3,450 | 31,600 |
| C. CONSULTANCIES | | | | | | | | | | |
| | 1. Evaluation Consultants - Fees | 0 | 0 | 0 | 12,000 | 0 | 12,000 | 12,000 | 0 | 12,000 |
| | 2. Other Consultants - Fees | 4,418 | 6,000 | 10,418 | 3,140 | (6,000) | (2,860) | 7,558 | 0 | 7,558 |
| | 3. Consultant travel/per diem | 2,444 | 575 | 3,019 | 6,056 | 3,225 | 9,281 | 8,500 | 3,800 | 12,300 |
| | SUBTOTAL - CONSULTANCIES | 6,862 | 6,575 | 13,437 | 21,196 | (2,775) | 18,421 | 28,058 | 3,800 | 31,858 |
| D. PROCUREMENT (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Supplies | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | 2,355 | 3,878 | 6,233 | 8,415 | 18,622 | 27,037 | 10,770 | 22,500 | 33,270 |
| | c. Field - Other | 22,480 | 3,784 | 26,264 | (11,430) | (3,784) | (15,214) | 11,050 | 0 | 11,050 |
| | 2. Equipment | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 0 | 17,046 | 17,046 | 0 | 13,954 | 13,954 | 0 | 31,000 | 31,000 |
| | 3. Training | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 14,884 | 312 | 15,196 | 14,691 | (312) | 14,379 | 29,575 | 0 | 29,575 |
| | SUBTOTAL - PROCUREMENT | 39,719 | 25,020 | 64,739 | 11,676 | 28,480 | 40,156 | 51,395 | 53,500 | 104,895 |
| E. OTHER DIRECT COSTS (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Communications | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 11,640 | 2,961 | 14,601 | (240) | (2,961) | (3,201) | 11,400 | 0 | 11,400 |
| | 2. Facilities | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 26,985 | 3,100 | 30,085 | (3,110) | 2,100 | (1,010) | 23,875 | 5,200 | 29,075 |
| | 3. Other | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 41,291 | 3,197 | 44,488 | (1,091) | (3,197) | (4,288) | 40,200 | 0 | 40,200 |
| | SUBTOTAL - OTHER DIRECT | 79,916 | 9,258 | 89,174 | (4,441) | (4,058) | (8,499) | 75,475 | 5,200 | 80,675 |
| TOTAL - DIRECT COSTS | | 476,076 | 129,346 | 605,422 | 18,700 | 5,562 | 24,262 | 494,776 | 134,908 | 629,685 |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | | | | | | | | | | |
| | 1. Headquarters | | | | 0 | 0 | 0 | | | 0 |
| | 2. Field (if applicable) | | | | | | | | | |
| TOTAL INDIRECT COSTS | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | 476,076 | 129,346 | 605,422 | 18,700 | 5,562 | 24,262 | 494,776 | 134,908 | 629,685 |

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1996 COUNTRY PROJECT PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

| | | Actual Expenditures to Date 09/30/93 to 03/31/97 | | | Projected Expenditures Against Remaining Obligated Funds | | | Total Agreement Budget (Columns 1 & 2) 09/30/93 to 03/31/97 | | |
|---|---|---|----------------|----------------|---|----------------|-----------------|---|----------------|----------------|
| | | AID | PVO | TOTAL | AID | PVO | TOTAL | AID | PVO | TOTAL |
| I. DIRECT COSTS | | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | 1. Headquarters-wages/salaries | 10,319 | 12,183 | 22,502 | (107) | 11,230 | 11,123 | 10,213 | 23,413 | 33,625 |
| | 2. Field, Technical Personnel-wages/salaries | 244,623 | 40,823 | 285,446 | (5,943) | (13,893) | (19,836) | 238,680 | 26,930 | 265,610 |
| | 3. Field, Other Personnel-wages/salaries | 37,894 | 18,096 | 55,990 | 2,079 | 3,682 | 5,761 | 39,973 | 21,778 | 61,751 |
| | 4. Fringes - Headquarters + Field | 52,550 | 30,019 | 82,569 | (16,441) | (2,745) | (19,186) | 36,109 | 27,274 | 63,383 |
| | SUBTOTAL - PERSONNEL | 345,386 | 101,121 | 446,507 | (20,412) | (1,727) | (22,138) | 324,975 | 99,395 | 424,369 |
| B. TRAVEL/PER DIEM | 1. Headquarters - Domestic (USA) | 721 | 537 | 1,258 | 1,679 | (537) | 1,142 | 2,400 | 0 | 2,400 |
| | 2. Headquarters - International | 4,695 | 8,122 | 12,817 | (2,883) | (2,172) | (5,055) | 1,812 | 5,950 | 7,762 |
| | 3. Field - in country | 15,303 | 1,769 | 17,072 | 7,597 | (1,769) | 5,828 | 22,900 | 0 | 22,900 |
| | 4. Field - International | 2,305 | 1,441 | 3,746 | 2,945 | 2,009 | 4,954 | 5,250 | 3,450 | 8,700 |
| | SUBTOTAL - TRAVEL/PER DIEM | 23,024 | 11,869 | 34,893 | 9,338 | (2,469) | 6,869 | 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 | 4,418 | 6,000 | 10,418 | 3,140 | (6,000) | (2,860) | 7,558 | 0 | 7,558 |
| | 3. Consultant travel/per diem | 2,444 | 575 | 3,019 | 6,056 | 3,225 | 9,281 | 8,500 | 3,800 | 12,300 |
| | SUBTOTAL - CONSULTANCIES | 6,862 | 6,575 | 13,437 | 21,196 | (2,775) | 18,421 | 28,058 | 3,800 | 31,858 |
| D. PROCUREMENT (provide justification/explanation narrative) | 1. Supplies | | | | | | | | | |
| | a. Headquarters | 0 | 673 | 673 | 700 | (523) | 177 | 700 | 150 | 850 |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | 2,355 | 3,878 | 6,233 | 8,415 | 18,622 | 27,037 | 10,770 | 22,500 | 33,270 |
| | c. Field - Other | 22,480 | 3,784 | 26,264 | (11,430) | (3,784) | (15,214) | 11,050 | 0 | 11,050 |
| | 2. Equipment | | | | | | | | | |
| | a. Headquarters | 0 | 670 | 670 | 0 | 80 | 80 | 0 | 750 | 750 |
| | b. Field | 0 | 17,046 | 17,046 | 0 | 13,954 | 13,954 | 0 | 31,000 | 31,000 |
| | 3. Training | | | | | | | | | |
| | a. Headquarters | 0 | 508 | 508 | 250 | (508) | (258) | 250 | 0 | 250 |
| | b. Field | 14,884 | 312 | 15,196 | 14,691 | (312) | 14,379 | 29,575 | 0 | 29,575 |
| SUBTOTAL - PROCUREMENT | 39,719 | 26,871 | 66,590 | 12,626 | 27,529 | 40,155 | 52,345 | 54,400 | 106,745 | |
| E. OTHER DIRECT COSTS (provide justification/explanation narrative) | 1. Communications | | | | | | | | | |
| | a. Headquarters | 0 | 4,542 | 4,542 | 0 | 333 | 333 | 0 | 4,875 | 4,875 |
| | b. Field | 11,640 | 2,961 | 14,601 | (240) | (2,961) | (3,201) | 11,400 | 0 | 11,400 |
| | 2. Facilities | | | | | | | | | |
| | a. Headquarters | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | b. Field | 26,985 | 3,100 | 30,085 | (3,110) | 2,100 | (1,010) | 23,875 | 5,200 | 29,075 |
| | 3. Other | | | | | | | | | |
| a. Headquarters | 250 | 1,573 | 1,823 | (250) | (1,573) | (1,823) | 0 | 0 | 0 | |
| b. Field | 41,291 | 3,197 | 44,488 | (1,091) | (3,197) | (4,288) | 40,200 | 0 | 40,200 | |
| SUBTOTAL - OTHER DIRECT | 80,166 | 15,373 | 95,539 | (4,691) | (5,298) | (9,989) | 75,475 | 10,075 | 85,550 | |
| TOTAL - DIRECT COSTS | 495,157 | 161,809 | 656,966 | 18,058 | 15,261 | 33,318 | 513,215 | 177,070 | 690,284 | |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | 1. Headquarters | 79,219 | 22,072 | 101,290 | 16,753 | 5,103 | 21,857 | 95,972 | 27,175 | 123,147 |
| | 2. Field (if applicable) | | | | | | | | | |
| TOTAL - INDIRECT COSTS | 79,219 | 22,072 | 101,290 | 16,753 | 5,103 | 21,857 | 95,972 | 27,175 | 123,147 | |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | 574,376 | 183,881 | 758,256 | 34,811 | 20,364 | 55,175 | 609,187 | 204,245 | 813,431 |

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