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December 30, 1996

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TO: Cathy J. Bowes
Project Officer
USAID/BHR/PVC/CSH

FROM: David Newberry
Senior Public Health Advisor
Health & Population Unit

FIFTY CARE YEARS

SUBJECT: CARE Guatemala Child Survival IX Final Evaluation Report

Dear Cathy:

We are sending you Final Evaluation report of CS IX (PASS) project in Guatemala. The 30 Cluster KPC Survey Report is submitted under a separate cover called "Annex H". As you recall this CS IX project experienced start-up difficulties and a turn-over involving multiple project managers. It wasn't until the Mid-Term Evaluation that the major problems surfaced. As generally noted for three year CS projects achievement difficulties are documented very late in the cycle which required DIP revision and scaled down targets. Kathy Tilford participated in a field level assessment of the situation and CARE Guatemala submitted a revised Plan of Action based on the MTE findings and recommendations. The achievements documented during the Final Evaluation of the Guatemala CS IX project showed modest gains in interventions. Problems were honestly reported and recommendations carefully followed. CARE Guatemala was concerned with the time needed to assure sustainability. The evaluation report also noted that the MOH coordination was limited too the interest of individual commitment rather than empowerment and development. Recommendations were focused by time on a short and long term basis.

Major portions of this final evaluation report is in Spanish and would require someone with Spanish fluency to read and understand. The KPC Survey report contains a comprehensive English section which covers all the major findings but the Survey Questionnaire and training details are all in Spanish. The sampling frame and the number of survey clusters was adjusted from 45 to 30. Statistically the assessment of nearly any size population-based study can be done with the 30 cluster method. Very often projects want to add strange combinations of clusters to cover various and unique needs of their project without realizing that the 30 cluster methodology works in nearly all instances.

One profound observation will require additional effort on CARE's part and that is the concept of training a skilled cadre of 30 Cluster Survey KPC Survey proficient workers.

CARE Guatemala was able to identify another donor who will support the CS IX project with improvements. An extension type project will continue to serve the needy population in the former USAID funded Child Survival impact area.

Thanks for your support.

Sincerely,

David Newberry
Senior Advisor
Health & Population Unit

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CARE
GUATEMALA

FINAL EVALUATION
CHILD SURVIVAL IX
-PASS-

November, 1996

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infections
CDD	Control of Diarrheal Disease
CHO	Child Health Outreach
CLS	Comites Locales de Salud/Community Health Committees
CMS	Coordinadora Multi Sectorial/Multi-Sectorial Coordination Board
CONALFA	Comisión Nacional de Alfabetización
CPRS	Coordinador de promotores rurales de salud/Rural Health Promoters Coordinator
DIGESA	Dirección General de Servicios Agrícolas
DIP	Detailed Implementation Plan
EPI	Expanded Immunization Program
GO	Government Organization/Institution
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
INACOP	Institution Nacional de Cooperativas/National Cooperatives Institute
JCM	Junta Central de Medicamentos/Medicaments Central Board
JdeA	Jefe de Area/ MD Chief of a Health Area (Departmental)
JdeD	Jefe de Distrito/ MD Chief of a Health District (municipal)
JDP	Junta directiva de Promotores/ Health Promoters Directive Board
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Government Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PASS	Proyecto de Apoyo a los Servicios de Salud/Health Services Support Project
PRS	Promotores Rurales de Salud/Rural Health Promoters
RCS	Redes de cooperación Social/Social Cooperation Networks
RTA	Regional Technical Advisor
TBA	Traditional Birth Attendant
TPM	Team Planning Meeting
TSR	Técnicos en Salud Rural/Rural Health Technicians
TT	Toxoide Tetánico
UDRI	Unidad de Desarrollo Rural Integral/Integrated Rural Development Unit
USAID	United States Agency for International Development
UROC	Unidad de Rehidratación Oral Comunitaria/community Oral Rehydration Unit
UTM	Unidades Técnicas Municipales/Municipal Technical Unit

1. INTRODUCTION

This report complies with the requirements of USAID Washington for a final evaluation of CARE Guatemala's Child Survival IX Project, the PASS project (Health Services Support Project or, in Spanish, Proyecto de Apoyo a los Servicios de Salud). The overall goal of the final evaluation was to assess the impact, effectiveness and sustainability of the project. Terms of reference and USAID guidelines for this evaluation appear in **Annex A**.

Background and Project Description

The PASS project, as its name in Spanish indicates, was carried out to strengthen the health services responsible for delivering child survival interventions in selected departments, districts and communities in Guatemala. Specifically, the project was designed to decrease morbidity and mortality among children under 3 years of age and women 15 to 45 years old.

The design of the project was based on lessons learned from the Maternal and Child Health (MCH) project and the preceding Child Survival Outreach (CHO) project implemented by CARE Guatemala. Successful elements in these projects were to be adapted to PASS, and the need to create stronger ties with the Ministry of Health (MOH) at regional and local levels was to be addressed.

The project has been in operation for 36 months in four departments in Guatemala: Alta Verapaz, Baja Verapaz, Quiché and Huehuetenango. Within each department one health district was selected by CARE in conjunction with the MOH: Cahabón, Purulhá, Zacualpa, and San Sebastián Coatán, respectively. Selected districts lacked access to health care and exhibited low service coverage rates. At final evaluation the project covers 86 communities (103 were reported in the mid-term evaluation and 100 established in the DIP)[1] with a total population of around 34,500 (see **Table 1**).

Table 1
POPULATION COVERED BY THE PASS/CARE PROJECT
BY DISTRICT

DISTRICT	COMMUNITIES	POPULATION	FAMILIES
Cahabón	30	12,674	2,304
Purulhá	30	8,561	1,556
Coatán	18	4,519	822
Zacualpa	8	8,707	1,583
TOTAL	86	34,461	6,265

[1] Transfer of project site from San Miguel Acatán to San Sebastián Coatán (area of influence of San Jose Pueblo Nuevo Health Post) accounts for the drop in the number of communities.

The project identified and implemented three main strategies to ensure sustainability (Document April 1995):

a) inter-institutional collaboration operationalized through Multi-Sectorial Coordination Boards (CMS) to agglutinate MOH and other government organizations (GOs), non-government organizations (NGOs) including CARE, and international agencies' representatives;

b) community participation, operationalized as Social Communication Networks (RCS) including Rural Health Technicians (TSR), Rural Health Promoters (PRS), traditional birth attendants (TBAs), collaborators and family groups; and

c) local programming units, operationalized as sectors at the community level.

In addition, training of local human resources for sustainability and child survival were deemed important at all levels.

Initially, implementation of six complementary child survival interventions was planned:

a) immunizations (EPI)
b) control of diarrheal diseases (CDD), and oral rehydration therapy (ORT)
c) acute respiratory infections (ARI), and pneumonia treatment
d) infant and child nutrition
e) maternal care
f) HIV/ AIDS prevention

However, given difficulties encountered, as of June 1995 the family planning activities were excluded from the Maternal Care intervention. Also, activities for ARI and pneumonia control were diminished or excluded in all districts and HIV/ AIDS prevention activities were excluded in all project sites.

Project staff are based at the district MOH offices. It includes 7 CARE field extensionists (down from 16 reported before), 3 field assistants, and one project manager.

EVALUATION OBJECTIVES

The overall goal of the final evaluation of a Child Survival project is to assess the impact, effectiveness and the sustainability of the project. Specifically, the evaluation team of the PASS project was asked to address the following points: I) project accomplishments and lessons learned, and II) project sustainability. Also, as requested by CARE, recommendations for follow-up and future projects were to be provided.

2. METHODOLOGY

The project operated for 36 months from October 1, 1993 to September 30, 1996. A baseline survey was conducted in February 1994 in four districts (Cahabón, Rabinal, San Miguel Acatán and Zacualpa) and in October 1994 in Purulhá. The baseline sample of 939 respondents was obtained selecting for interview 7-8 mothers with a child under two years of age from each of 30 clusters in each District (San Miguel Acatán and Zacualpa had 16 and 14 conglomerates, respectively). In July 1996, the final survey was conducted. The sample for the final survey was drawn from a total of 45 clusters in the project areas from which a total of 311 respondents was selected taking into account the proportion of the population in each district. Cost and time constraints did not allow for similar sampling procedures and sizes for the baseline and final evaluation. A comparison between figures for key child survival indicators at baseline and at final survey and project objectives was provided to consultants by CARE Regional Technical Advisor (RTA) James Becht and will be discussed below.

The qualitative evaluation was conducted by a team of two, a physician and a social scientist, both with training and experience in public health, from August 19 to September 13, 1996. A Team Planning Meeting (TPM) was conducted in the first two days of the assignment. All available documents were subsequently reviewed and the specific methodology to use for the evaluation developed.

The evaluation included 10 days of field work. During field work visits to each of the four districts and one community in each district were made. All the actors/ sources of information in the project were identified and several were selected for interview in each district. Actors included CARE personnel, MOH personnel and community participants in each district. Data collection instruments consisted of open-ended interview guides. Also, selected questions from monitoring and supervision forms were used in interviews to PRSs and mothers.

Time and accessibility constraints prevented the selection of more than one community in each district and the only community visited had to be selected purposely (as opposed to randomly). Although, there may have been a bias toward selecting the more successful of project communities, according to project staff, this was precluded because the more distant communities were the more successful ones. Few people were interviewed in each community visited and extensive interviewing of them was not possible in most cases.

In all more than 100 people were interviewed individually or in group including: 4 Chiefs of District (JdeD), 3 TSRs, 1 Sanitation Inspector, 2 Auxiliary Nurses, members of 12 different CLS, 12 PRSs, 2 collaborators, 2 PRSs Coordinators, 2 TBAs, a group of 17 mothers in Purulhá (Eben Ezer), 10 individual mothers, 1 member of the CMS and another of the UTM, 10 project extensionists (3 now working for another CARE project), 3 project field assistants, one project manager, and 1 NGO staff member.

Information obtained directly in field work and that from written reports were included as data subject of analysis and interpretation. Information was organized trying to respond to the different questions of interest in USAID guidelines and additional questions posed by CARE regarding the quality of services.

On September 10, 1996 a workshop for the presentation of preliminary findings of the final evaluation results and the discussion of recommendations was carried out. The workshop was attended by CARE's project staff and a few MOH personnel.

Annex B contains all materials pertaining to the TPM. **Annex C** contains details of the methodology, data collection instruments, lists of people interviewed in each project site and the detailed calendar followed. In **Annex D** materials prepared for the final workshop are presented.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. PROJECT ACCOMPLISHMENTS

1. *COMPARISON OF PROJECT ACCOMPLISHMENTS AND OBJECTIVES*

In this section a comparison of project accomplishments with objectives outlined in the Detailed Implementation Plan (DIP) is made and explanations for differences are offered. Also, circumstances which may have aided or hindered the project in meeting these objectives are described.

The primary results of the baseline survey were summarized in terms of a set of standardized indicators in the DIP (March 1994). It should be noted that DIP objectives were set without considering the Purulhá data because in the project's original design Rabinal, not Purulhá, was selected as a target district for Baja Verapaz. The survey results showed the Rabinal data were not among the lowest in the department and Rabinal was starting to receive support from other international NGOs. Therefore, the district of Purulhá was chosen as a replacement based on its poor health indicators and its need for health services. This change affected global percentages of the baseline; however, objectives were not changed accordingly. Thus, for most indicators, objectives might have been set higher than it was realistic.

Table 2 presents a comparison between key indicators from the baseline survey, the project objectives outlined in the DIP, and the final survey. Indicators are grouped according to the child survival interventions undertaken.

As shown in the table, all child Immunization objectives were reached and even surpassed. Both access and coverage were increased above the percentages set as objectives and the drop out rate was decreased to 5.6%. These figures, which were previously considered unsafe, are now in safe levels. All differences between baseline and final survey percentages are statistically significant.

For the CDD component, indicators of practices about fluid replacement and dietary management of diarrhea in infants and children ill with diarrhea in the past two weeks did not improve and in some cases deteriorated. The difference was statistically significant in the percentage of children who were not breastfeeding and were given the same or greater quantities of foods during the episode of diarrhea which went down from 48.8% to 28.3%.

Regarding the Infant and Child Nutrition intervention, the objective of increasing to 70% the number of infants being breastfed within the first eight hours after birth was reached (71.3%) and the difference with the baseline percentage was significant. The table does not show significant improvements in the rest of the indicators. The percentage of infants between 6 and 10 months who were being fed solids or semisolid foods besides breastmilk increased slightly. The percentage of children 20-24 months who were still breastfeeding dropped and the percentage of children less than 4 months who were being exclusively breastfed remained the same (45.5%).

The evaluation of the Maternal Care component showed that all indicators remained as low as the corresponding baseline figures. Low percentages of women could show a health card, had received two doses of the tetanus toxoid vaccine (TT) according to the card or had had at least one prenatal visit to the health center or post (CdeS) during their last pregnancy. Of 286 women who were not pregnant at the time of interview (91.7%), 63% did not want or were not sure they wanted another child in the next two years. Interestingly, only 10% of them were doing something to prevent getting pregnant suggesting a potential unmet demand for contraceptives. The percentage of women doing something to prevent getting pregnant was not measured at baseline, but was found to be very low in the final evaluation survey.

The only indicator considered for ARI indicates a lower percentage of mothers seeking medical treatment for children with cough and rapid and difficult breathing in the past two weeks in the final survey than in the baseline survey. The difference was statistically significant.

In summary, the comparison presented in **Table 2** indicates that project objectives were reached only for the immunization intervention. The main explanation offered by project staff for this finding is that immunization has been a priority in the past and present government. Given that the PASS/CARE project was not implementing the interventions directly, but working mainly through the MOH, the MOH priorities were reflected in implementation. Also, it is possible that immunization is an easier intervention to implement than the others because it requires behavior changes of less complexity, duration and persistence than other interventions. Furthermore, it has a concrete product (the vaccine) to offer and a skill to teach PRSs. Finally, the First Annual Progress Report of the project (November 1994) indicates that only the immunization intervention was carried out in all the districts during the first year of the project. In the interviews conducted it was confirmed that immunization was the first intervention to start in all but one district as shown in **Table 3**.

The final evaluation survey report is included as an annex to this document, and presents an analysis of the findings.

TABLE 2
CHILD SURVIVAL KEY INDICATORS: BASELINE LEVELS, OBJECTIVES, AND FINAL RESULTS

Child Survival Key Indicators	Baseline Survey	Project Objectives	Final Survey	P Value
Appropriate Infant Feeding Practices				
Percent of infants/children, less than 24 months(0-23 months), who were breastfed within the first eight hours after birth.	61.2%	70.0%	71.3%	<0.01
Percent of infants less than four months(0-3 months) who are being given only breastmilk	46.3%	n/a	45.5%	
Percent of infants between six and ten months(6-9 months) who are being given solid or semi-solid foods	70.1%	80.0%	75.7%	
Percent of children between 20 and 24 months(20-23 months) who are still breastfeeding.	69.5%	70.0%	58.8%	
Management of Diarrheal Diseases				
Percent of infants/children, less that 24 months(0-23 months), with diarrhea in the past two weeks who were given the same amount or more breastmilk.	69.1%	80.0%	61.2%	
Percent of infants/children, less than 24 months(0-23 months), with diarrhea in the past two weeks who were given the same amount or more fluids other than breastmilk.	69.3%	80.0%	60.7%	
Percent of infants/children, less than 24 months(0-23 months), with diarrhea in the past two weeks who were given the same amount or more food.	48.8%	70.0%	28.3%	<0.01
Percent of infants/children, less than 24 months(0-23 months), with diarrhea in the past two weeks who were treated with ORT.	36.8%	55.0%	44.8%	

P Values: <0.01 is very significant; <0.05 is significant; >0.05 is not significant.

Pneumonia Control				
Percent of mothers who sought medical treatment for their infant/child,less than 24 months, with cough and rapid, difficult breathing in the past two weeks	19.4%	40.0%	7.4%	<0.01
Vaccination Coverage				
Access: Percent of children 12-23 months who received DPT1 vaccine.	65.6%	70.0%	85.6%	<0.01
Coverage: Percent of children 12-23 months who received OPV3 vaccine.	47.0%	70.0%	78.8%	<0.01
Coverage: Percent of children 12-23 months who received measles vaccine.	48.0%	70.0%	77.4%	<0.01
Drop Out Rate: Percent change between DPT1 and DPT3 doses [(DPT1-DPT3)/DPT1] x 100 for children12-23 months.	25.7%	25.0%	5.6%	<0.01
Maternal Care				
Percent of mothers with a maternal card for the birth of her youngest child less than 24 months.	13.5%	n/a	17.6%	
Percent of mothers who received at least two doses of tetanus toxoid vaccine (card) before the birth of her youngest child less than 24 months of age	9.6%	50.0%	13.1%	
Percent of mothers who had at least one ante-natal visit (card) prior to the birth of her youngest child less than 24 months of age.	5.5%	25.0%	4.5%	
Percent of mothers of children less than 24 months of age who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.	n/a	n/a	3.9%	n/a

Dates of baseline survey: February 1994 for Cahabón, San Sebastián Coatán, and Zacualpa; October 1994 for Purulhá; N = 830.
Date at which project objectives were established: March 1994 (Detailed Implementation Plan)
Date of final survey: July 1996; N = 313.

JNB: 10-SEP-96

Table 3
MONTH AND YEAR EACH INTERVENTION STARTED
(NUMBER OF MONTHS OF IMPLEMENTATION)
IN EACH HEALTH DISTRICT

DISTRICT	EPI	CDD/ ORT	INFANT NUTRITION	MATERNAL CARE
Cahabón	Oct.1994 (24 mos)	June 1995 (16 mos)		
Purulhá	April 1995 (18 mos)	May 1995 (17 mos)	June 1995 (16 mos)	March 1995 (19 mos)
Coatán	Feb. 1995 (20 mos)	June 1995 (16 mos)		
Zacualpa	July 1995 (17 mos)	Nov. 1995 (10 mos)	Nov. 1995 (10 mos)	Nov 1995 (10 mos)

The general explanation provided by people interviewed for not reaching the rest of the objectives had to do with the delay in the implementation of the child survival interventions. No interventions were carried out during the first year of the project (except possibly immunization) as this was spent mostly in the development of the inter-institutional coordination strategy. Initial efforts gave rise to the formation of the Multi-Sectorial Coordination Boards in all districts which have since dissolved or been integrated into the Municipal Technical Units (UTMs).

Even the second year of the project cannot be characterized as one of full implementation of interventions since it was mostly devoted to training of the Social Cooperation Networks, including PRSs, community health volunteers or collaborators, traditional birth attendants TBAs, and, more recently, the rural health promoter coordinators (CPRSs), the Directive Boards of promoters (JDP), and the community health committees (CLS). The mid-term evaluation conducted in September 1995 considered that up to that point, accomplishments were inputs preparatory for the launching of the child survival interventions and outputs relating to training and information, education and communication (IEC) for some of the interventions. Also, during the second year, the provision of basic inputs such as the oral rehydration salts (ORS) packets was still irregular, and continues to be insufficient in all districts.

Therefore, it is only in the third year of the project that interventions were fully implemented. Furthermore, based on the results of the mid-term evaluation priority was given to only four of the original six interventions, and not in all of the four districts. For example, in Cahabón and Coatán only two of the interventions, EPI and CDD, were implemented. Maternal health was implemented with traditional midwives in Purulhá, and minimally in a few communities in Zacualpa. Also, the infant and child nutrition intervention was implemented in only 19 communities in Purulhá and 5 communities in Zacualpa. Unfortunately, the final survey sample was not designed to be representative at the district level and data could not be desegregated to explore differences in results by district.

A summary of factors facilitating and impeding the project following the timetable and meeting all of its objectives are presented in **Tables 4.1-4.4** for each project site. As shown in those tables geographical accessibility factors were a limitation in three of the four districts. Community factors, institutional experience and other institutional factors, and some factors having to do with characteristics of personnel were also implicated. There was considerable turnover among CARE staff in two districts and the current number of staff is insufficient, with only one field assistant covering the two districts. The project has had three managers and periods of time with no manager. While more facilitating factors could be identified for the Northern Departments (Alta and Baja Verapaz), constraining factors were more numerous in the Northwestern area (Huehuetenango and Quiché). This corresponds directly to the progress made to date by the project in the two areas.

Table 4.1
Factors Affecting Project Accomplishments in Cahabón, Alta Verapaz

FACILITATING FACTORS	IMPEDING FACTORS
• Initial participation of CMS • Community participation and organization; some Cholera Committees became CLS; less accessible communities participated more • Previous experience with UDRIs • Previous experience with medicine chests in the UDRIs • Moderate acceptance and support from MOH	• Difficult access to communities (extensionists' perspective) • Initially hostile MOH environment; no participation from TSR, created division between "old" and PASS/CARE PRSs

Table 4.2
Factors Affecting Project Accomplishments in
Purulhá, Baja Verapaz

FACILITATING FACTORS	IMPEDING FACTORS
• Community organization and participation • High degree of acceptance and support from MOH; sense of ownership of the project by JdeD and MOH personnel • Former project (CHO) personnel was transferred to the PASS project (including experience in growth monitoring and understanding of need to coordinate with MOH) • Closer supervision from management level • Field assistant characteristics: speaks local language; very proactive in asking for feedback	• Few NGOs working in the area with no experience of coordinating (field assistant's perspective)

Table 4.3
Factors Affecting Project Accomplishments in
San Sebastián Coatán, Huehuetenango

FACILITATING FACTORS	IMPEDING FACTORS
* Incipient community organization and participation	* Inaccessibility (long distances, and bad conditions of roads, especially during rainy season) * Past violence (people are distrustful) * Divisions in communities due to religious and other motives * Out-migration especially to the US * Lack of acceptance and support from MOH * Initial misunderstanding, creation of false expectations in different actors * Lack of knowledge and experience in this geographic, social and cultural area * Insufficient PASS personnel
* Acceptance and support in one health post (San José) by local Auxiliary Nurse who speaks local language; support by TSR	* Changes in PASS personnel; constant reorganization * Less supervision from management level of the project (down to visiting communities) * Characteristics of personnel: none speaks local language; sense of having been left on their own and considered less important than personnel in other areas; comparisons with other areas lowered morale

Table 4.4
Factors Affecting Project Accomplishments in
Zacualpa, Quiché

FACILITATING FACTORS	IMPEDING FACTORS
• Community participation beginning in some communities • Present JdeD supportive of the project • Characteristics of personnel: present extensionists speak local language	• Internal migration to the South Coast. Out-migration to the US • Effects of past violence (people don't want anything to do with organizations; have experienced poor quality of care in CdeS) • Changes in medical personnel in the CdeS (3 during project) • Low acceptance and support from health services • Changes in PASS/CARE personnel

Tables 5.1-5.4 present a comparison of accomplishments reported in the mid-term evaluation and those to date. The mid-term evaluation took a 16-month plan as its point of reference and this evaluation takes the mid-term evaluation as reference. The percentages of the target groups reached by the different interventions were in most cases calculated according to perceptions of PASS/CARE staff. It was difficult to determine objective coverage rates because the health information system (HIS) is not fully updated. Explanations provided and observations made regarding the quality of each intervention can further account for progress or lack of progress in the indicators.

The quality of the immunization intervention was rated very good by most informants. The cold chain has been maintained in all districts by means of the provision of thermoses at the community level. The active involvement of the CLS that appoints someone to get the vaccines from the health service and convenes women to the vaccination post, and the active involvement of PRSs who have conducted censuses of the community identifying all eligible infants, children, and pregnant women and who have even started themselves to vaccinate in the communities can also be noted. Furthermore, greater acceptance by the community than previously and no major problems were reported (only 3 abscesses in Huehuetenango) when PRSs conduct immunization. Finally, the supervision of MOH personnel and the project's extensionists who sometimes also participated directly in immunization have contributed positively.

In relation to CDD, even if limited, ORS are accessible in Oral Rehydration Units (UROCs) in 66 of 86 communities (40 were anticipated by the end of the project). PRSs give ORS to mothers with children with diarrhea and teach them how to prepare and administer the solution; PRSs also register cases attended and followed-up and packets provided. Women interviewed knew about ORS, although they don't necessarily use them and continue to mention popular store-bought medicines for diarrhea as first options in treatment. The home-based sugar and salt solution is known in some communities, but women interviewed could not tell the exact quantities of ingredients used.

As mentioned, in 24 of 86 communities are women attending growth monitoring/ weighing sessions (62 communities were to have infant nutrition activities by the end of the project). In Purulhá a group of 17 women were interviewed regarding the activity and their understanding of the weight-for-age graph. Women could correctly explain the meaning of their children's weight going up or down, but were unable to identify their children's place on the communal graph (marked with a thread they had brought) or "read" the graph. Promoters explained that women still need more practice with the graph. It was mentioned by project staff that child feeding and other nutritional messages confront poverty and extreme poverty in many families, especially in Quiché.

The two TBAs interviewed, one in Purulhá and one in Zacualpa, said they had learned about danger signs during delivery. Also, they had received materials and liked them. It will be difficult to assess if practices have changed as a result of training and materials provided. Midwives reported that they refer women to health services for prenatal care, but admit that few women comply due to long

distances to the health services and fear and shame of exams performed. In Cahabón, there was no Maternal Health intervention because husbands, not midwives, attend most births. Informal conversations with men indicated that fathers start teaching their sons about delivery around 15 years of age. The project could have adapted the training for midwives to train husbands and young unmarried men.

Regarding the low percentage of women receiving the TT vaccine in their last pregnancy, according to extensionists, censuses kept by PRSs indicate higher figures than the final survey. Pregnant women were being referred by trained TBAs for immunization in the community, not necessarily to health centers. Some of these women might not have received an immunization card and, therefore, could not show one when asked. Another explanation regarding this point had to do with the training TBAs received which emphasized prenatal care at the community level and referral to health services only for danger signs. In general, messages on maternal care confront deep-rooted knowledge and practices of women and midwives who distrust health services for prenatal care.

For the ARI intervention, only the MOH personnel (and not in all districts) was trained in conjunction with the USAID-funded Clapp and Maine project. Everybody agrees that this intervention should be tied to the communal medicine chest intervention to provide antibiotics for pneumonia cases. However, at final evaluation, medicine chests had been provided (the community supplying 50% of the cost) to only 13 communities in Cahabón. Questions posed to three PRSs in charge of medicine chests indicated that they knew what medicines to give based on symptoms reported.

Regarding the development and diffusion of educational messages the mid-term evaluation stated that the communication strategy was not developed based on formative research, on the feasibility of adoption given cultural and material constraints, and opportunities of behavior modification (Mid-term Evaluation 1995, p.23). The lack of precise behavior analysis for each intervention can be a reason for the low level of knowledge and practice of key messages by women interviewed in the final survey and the few women interviewed in the qualitative evaluation. The conventional idea that knowledge is necessary and always precedes behavior is still prevalent among project staff; therefore, they consider changes in knowledge (which the survey showed in a few cases) as important as changes in behavior. There was no distribution of communication materials for promotion or to aid recall.

PRSs training as facilitators was limited. It included information contained in a methodology guide (Guías Metodológicas) with 6 specific steps to follow from establishing local knowledge in a participatory manner to participatory evaluation. However, the process expected to be implemented by them is complex and requires intensive training and practice of communication skills. PRSs interviewed did not have the methodology guides at hand and it was not clear they were using them in their communication efforts.

After the mid-term evaluation, project staff developed and tested the instruments for monitoring and supervision of the quality of training and services provided for immunizations, CDD/ ORT, ARI, nutrition and maternal care. These forms were applied regularly (three times up to the present evaluation) and completely to PRSs, PRS coordinators and family groups only in Purulhá, with decisions regarding technical assistance to promoters taken as a result of their analysis. In addition, extensionists in all districts filled in a table of monthly information by community as part of the HIS, including activities for immunization, nutrition, CDD/ORT, ARI, maternal care, training and other information (e.g. census updated); a copy of the form is included in **Annex E**. These tables have been turned in by all districts, but have been entered in the computer only for Purulhá.

In the PASS Project, the final balance of accomplishments in implementation and sustainability strategies (social mobilization and community participation), on the one hand, and child survival interventions (except immunization), on the other, favors the former. Accomplishments in sustainability will be discussed below.

Table 5.1
Immunizations

ACCOMPLISHMENTS ACHIEVED MID-TERM EVALUATION	ACCOMPLISHMENTS ACHIEVED FINAL EVALUATION
6 or 7 immunization campaigns have been supported in each district, covering 103 communities	From January to August 1996 immunization campaigns have been supported in each district, covering 86 communities[2]. Number of campaigns by district: Cahabón - 6 Purulhá - 3 Coatán - 4 Zacualpa - 7
3110 mothers with at least one IEC session (141% accomplished) Cahabón - 1327 Purulhá - 488 San Miguel - 1146 Zacualpa - 150	At least 80% of mothers with children <60 months have participated in one or more IEC sessions in all districts Cahabón - 1474 Purulhá - 996 Coatán - 526 Zacualpa -1013
Cold chain maintenance has been carried our in the 4 districts during each campaign	Cold chain maintenance has been carried our in the 4 districts during each campaign
Local programming of immunization activities has been accomplished in 68 communities (67% accomplished)	Local programming of immunization activities has been accomplished in 86 communities (86% accomplished); PRSs have conducted immunization at the community level in Cahabón and Coatán
75 community census completed (73% accomplished): Cahabón: 30 in August 1994 Purulhá: 25 in June 1995 San Miguel: 18 in June 1995 Zacualpa: 2 in July 1995	Community census completed in 86 communities. Cahabón: 30 Purulhá: 30 Coatán: 18 Zacualpa: 8 (not updated)
240 promoters with at least 24 hours training Cahabón - 72 Purulhá - 60 San Miguel - 80 Zacualpa - 28	192 promoters trained in immunizations Cahabón - 72 Purulhá - 57 (3 PRSs inactive) Coatán - 35[3] Zacualpa - 28
Immunizations coverage has increased in the 4 districts according to MOH data	Immunization coverage has increased in the 4 districts according to PRSs, MOH and final survey data

[2]Transfer of project site from San Miguel Acatán to San Sebastián Coatán (area of influence of San José Pueblo Nuevo Jurup Health Post) accounts for the drop in the number of communities.

[3]Transfer of project site from San Miguel Acatán to San Sebastián Coatán (area of influence of San José Pueblo Nuevo Jurup Health Post) accounts for differences in the number of promoters.

Table 5.2
CDD and ORT

ACCOMPLISHMENTS ACHIEVED MID-TERM EVALUATION	ACCOMPLISHMENTS ACHIEVED FINAL EVALUATION
247 promoters with at least 16 hours training (90% accomplished) Cahabón - 72 Purulhá - 67 San Miguel - 80 Zacualpa - 28	192 promoters trained in CDD and ORT Cahabón - 72 Purulhá - 57 (3 PRSs inactive) Coatán - 35[4] Zacualpa - 28
20 UROCs implemented (50% accomplished) Cahabón - 10 Purulhá - 10 San Miguel - none Zacualpa - none	66 UROCs implemented (165% accomplished) Cahabón - 21 Purulhá - 20 Coatán - 15 Zacualpa - 10
1670 individuals with at least one IEC session (73% accomplished) Cahabón - 1025 Purulhá - 395 San Miguel - 150 Zacualpa - 100	70% of mothers with children <60 months have participated in one IEC session Cahabón - 1290 Purulhá - 871 Coatán - 460 Zacualpa - 886
Monitoring and evaluation Cahabón: household visits Purulhá: PRSs provide SRO, follow-up diarrhea cases in the community, with support of CLS manage UROCs San Miguel : No activity Zacualpa: No activity	Monitoring and evaluation Cahabón: communal visits every month or 2 months Purulhá: achievements maintained Coatán: In 15 communities PRS provide SRO, follow-up cases Zacualpa: In 10 communities PRSs provide SRO, follow-up cases

4 Transfer of project site from San Miguel Acatán to San Sebastián Coatán (area of influence of San José Pueblo Nuevo Jurup) accounts for the difference in the number of promoters.

TABLE 5.3

Infant and Child Feeding and Nutrition

ACCOMPLISHMENTS ACHIEVED MID-TERM EVALUATION	ACCOMPLISHMENTS ACHIEVED FINAL EVALUATION
119 promoters with at least 16 hours of training (43% accomplished) Cahabón - none Purulhá - 53 San Miguel - 40 Zacualpa - 26	118 promoters have been trained in infant and child feeding and nutrition Cahabón - none Purulhá - 57 Coatán - 35 Zacualpa - 26
10 communities in Purulhá have started monthly growth monitoring mensual	26 communities in 2 districts are conducting monthly growth monitoring (42% accomplished) Purulhá - 19 Zacualpa - 7
265 individuals with at least one IEC session (12% accomplished) Purulhá - 145 San Miguel - 120	30% of mothers with a child <24 months have participated in IEC session(s) Cahabón - none Purulhá - 285 Coatán - none Zacualpa -105
Extensionists have initiated monitoring and evaluation activities in Purulhá	Purulhá and Zacualpa- extensionists are conducting monitoring and evaluation of growth monitoring activities at the community level

Table 5.4
Maternal Health

ACCOMPLISHMENTS ACHIEVED MID-TERM EVALUATION	ACCOMPLISHMENTS ACHIEVED FINAL EVALUATION
236-259 TBAs with at least 16 hours training (163-179% accomplished) Cahabón - 25 Purulhá - 41 or 45 (depending on the activity attended) San Miguel - 130 or 135 (exact figure not known) Zacualpa - 40 or 45 (exact figure not known)	163 TBAs have been trained in maternal care Cahabón - 25 (1 training course in 1996) Purulhá - 40 Coatán - 30[5] Zacualpa - 68 (1 training course after the mid-term evaluation in 1995)
555 individuals with ate least one IEC session (222% accomplished) Cahabón - 150 Purulhá - 145 San Miguel - 260 Zacualpa - No activity	Figures not known because TBAs provide information individually to pregnant women Cahabón - none Purulhá - (>50% pregnant women) Coatán - 260 women Zacualpa - ?
	TT vaccine administered at the community level in: Cahabón Purulhá Zacualpa (in 4 communities PRSs apply vaccine)
Monitoring and evaluation only in Purulhá where a health information system has been implemented: TBA records number of pregnancies and deliveries	Cahabón - few CLSs are in charge of transportation of obstetrical emergencies Purulhá - accomplishments maintained; TBA records pregnancies, prenatal visits, referrals to health services and deliveries Coatán - referral to health services by TBA occurs but is not recorded (no prenatal care card)

5 Transfer of project site from San Miguel Acatán to San Sebastián Coatán (area of influence of San José Pueblo Nuevo Jurup Heath Post) accounts for the difference in the number of TBAs.

2. *Unintended Positive and Negative effects*

In addition to the intended effects discussed above, unintended positive and negative effects of the PASS project were identified. Again, most effects judged positive have to do with the sustainability strategies, rather than with the specific child survival interventions.

The following were mentioned as positive unintended effects:

- Training was decentralized. In each district there were several centers making it more accessible to more community volunteers to attend training. Also, several training courses could be simultaneously conducted.

- The costs of training were shared by different institutions, especially the MOH and other government organizations. Cost sharing included human and material resources and it allowed for cost reduction in the PASS Project. Also, the involvement of the MOH allows PRSs to have more credibility with the health services personnel and PRSs trained become acquainted with the MOH personnel who should continue supervising them.

- The function of the PRS collaborator was not initially planned for. This person helps the PRS in the community, but also has the possibility (as in Purulhá) to attend training along with the PRS, thus having the potential of becoming an additional PRS. Collaborators in Purulhá are almost the only women in the project, and were chosen for their ability to communicate with other women.

- The PRSs coordinator was not planned for, but implemented successfully in at least two project sites. The idea was for the CPRS to be strategically located in a sector. Each CPRS provides technical support to several promoters, and transmits information to and from the rest of PRSs, thus acting as an effective liaison between MOH services, other PRSs and the community.

- The organization of PRSs in Committees or in a Medicaments Central Board (JCM) as in Cahabón was not foreseen. These organizations are now deemed critical for sustainability, especially of the communal medicine chests.

- Local epidemiological surveillance was strengthened with PRSs collecting information at the community level and sending it to the District Health Center.

- Immunization services are provided directly by PRSs in some communities which makes those services more accessible and acceptable to mothers.

- Cost recuperation at the community level is taking place in a few communities where mothers are paying for services such as immunizations, growth monitoring, and ORS.

- Local Health Committees were trained in sanitation (latrinization) and other environmental issues which were of more interest to them than the specific child survival interventions.

- In Purulhá, Baja Verapaz the owner of a plantation became interested in the PASS health delivery model and asked to have it implemented in his plantation. The owner is highly motivated and encourages workers to participate. Although isolated, this effect is judged positive because populations living in plantations have been among the more under-served by health and other services in Guatemala.

The following were observed to be negative unintended effects:

- Conflicts of varying degrees between "old" (MOH-trained) and "new" (PASS/CARE motivated) promoters were reported in all districts, except Purulhá. Old promoters are those who had been previously (even 20 years earlier) identified and trained by the MOH; some were not active at the time the project began, but others were under the influence or supervision of a TSR. The PASS project asked for the selection of PRSs and, either communities themselves or the project personnel, did not always take into account the old promoters. This gave rise to resentment on the part of some of them and on the part of the TSR, which led them to obstruct project activities.

- Leadership struggles with a few NGOs present (for example, with Seguro Médico Campesino in San Miguel Acatán where the project intended to work) took place. These struggles arose from incompatibility between the objectives and activities of the NGO already present in the area and the plans and objectives of the PASS Project. These conflicts caused a delay in project activities.

- Initial communications in some areas (Huehuetenango and Quiché) led to the creation of false expectations among MOH personnel and community members. The negative consequence for CARE was the loss of credibility in the organization and in the project.

- Although the involvement of women was listed as and achievement in the CHO final evaluation report (CHO October, 1993) and was anticipated for the PASS project, mostly men were involved in the PASS Project. In Alta Verapaz, for instance, aside from two extensionists there were no other women in the project. Staff said women in the area are not used to participating, but no specific strategies were considered in the project to stimulate the participation of women. Also, it is possible that the term "promotores" used in all written and verbal communications was associated, as it was in the past, by the different actors only with male PRSs. Finally, it is worth noting that in Purulhá, where the field assistant was a woman, there were a few females PRSs, mostly female collaborators and the only female PRSs coordinator in the project.

3. *Final Evaluation Survey*

A copy of the Final Evaluation Survey instrument and survey results can be found in **Annex H (Separate bound report)**

B. PROJECT EXPENDITURES

1. *PIPELINE ANALYSIS*

Table 6 presents the pipeline analysis of project expenditures to date. (Also presented in **Annex G**)

2. *COMPARISON OF BUDGET AND ACTUAL EXPENDITURES*

On the basis of the pipeline analysis the proportion of the budget destined to each item and percentages spent and available to August 1996 were examined. A larger proportion of funds were allotted to personnel, followed by procurement of office equipment, supplies, consultants (excluded evaluations costs) and services (excluded evaluation costs). Expenses have been slightly higher than allotted funds for consultancies and other direct costs; however, these have been covered with funds from CARE (i.e. from the government of Guatemala). Funds are still available in the travel and per diem, the personnel, and the procurement budget line items.

A global comparison between the budget contained in the DIP and actual expenditures of the project shows that to date the project has spent 95.8% of the funds. The remaining funds should allow the project to complete activities pending until December 1996 (instead of the official termination date). However, the USAID/ Washington funds will be spent by September 1996. The Project will continue to function with funds from other CARE sources after this date.

any participation funds from USAID's CS projects

C. LESSONS LEARNED

1. *SPECIFIC INTERVENTIONS*

a) Immunization is a more discrete intervention than the others. In addition, when health promoters are involved, mothers are more willing to bring their children in and promoters learn and practice a skill that is highly desirable to all of them. Thus, it proved to be a good entry point to the communities.

b) Other activities, such as growth monitoring, and personal and domestic hygiene promotion are better understood and accepted using social mobilization and community participation.

c) The utilization of communal weight-for-age graphs orients mothers in a concrete way about the health status of their children and is a good means to convene women and communicate with them on other issues affecting their children's and their own health.

d) Basic services provided at the community level, especially in remote communities, save women time, effort, and money.

e) When there are modifications in project design (such as changes in participating communities and changes in baseline indicators), child survival indicators set as objectives should be revised accordingly.

f) Behavior change required in each child survival intervention is a long-term process, and can differ for different sites and for different interventions. Too many interventions were included in the project. A package of three or four interventions (EPI, CDD and ARI), addressing the major causes of infant and child morbidity and mortality in the communities would have been a more manageable option.

2. ***SUSTAINABILITY***

a) Community participation is essential for project implementation and sustainability. The conceptualization and operationalization of social cooperation networks proved to be a good strategy to achieve social mobilization and community participation.

b) Coordination with the MOH is also a critical element for the success of a project, specially of one designed to support health services. However, it is not an easy tension-free relation and it can depend upon the willingness of individuals to coordinate. Knowing the sources of tension, discussed below, can help improve the relation with the MOH.

c) Coordination among all organizations working for and with the communities is desirable, especially from a philosophical perspective. However, it is very hard to implement "multi-sectorial" coordination when a project is perceived as highly "sectorial" (sector-specific). Organizations not working in health have difficulties understanding their role and coordinating with a project that emphasizes immunizations, oral rehydration units (UROCs) and other very specific child survival interventions. Rather, instances of coordination of the project with GOs and a few NGOs occurred at the community level when organizations realized they were working in the same community, with the same population and decided to coordinate and support each other.

d) Coordination with other CARE projects can be attempted, but cannot be counted on or offered to communities as a motivation to participate, because other projects have their own inclusion criteria and requirements.

e) Changes in local authorities, in personnel both in the MOH and in the project affect the timing and progress of projects.

f) Activities conducted to guarantee sustainability are time-consuming. Three years is a very short period of time to completely accomplish these activities, in addition to completing high quality child survival intervention activities, especially when CARE is working through the MOH and not implementing them directly.

g) Knowledge of the historic, socio-cultural, ethnic and institutional context in which a project will work is a necessary preliminary step to set objectives more realistically and to be more effective in implementation. Having projects in diverse settings, with inaccessible and disperse communities requires more personnel and more funds. Costs of evaluation are also increased. Such projects need an understanding of the particular differences and much flexibility: in objectives, activities, and time-tables. Also, the human resources planning aspects have to follow different criteria, since the number of personnel needed, personnel profiles and incentives can differ for different areas.

h) Shared cultural background and knowledge of the local language is necessary for all project field personnel. Translation creates problems in communication.

I) Time actually spent in the community by project personnel is crucial for project credibility and for successfully establishing social cooperation networks. There should be enough personnel budgeted to spend enough time at the community level, especially at the beginning of a project.

j) According to all those interviewed (although not confirmed by other means) projects working to provide access to health services at the community level are more successful in remote communities than in communities closer to urban centers. Therefore, the degree of accessibility of the community appears to be an important criteria for selection of communities for the project's community-managed health care delivery model.

3. *EXPENDITURES*

a) The budget was adequate to conduct a project relying mostly on CARE providing technical assistance and material/ monetary resources to the MOH and not in CARE's direct execution of intervention activities (although a little of the latter occurred in the case of immunization).

II. PROJECT SUSTAINABILITY

The following section provides additional information from field work and document revision and focuses on sustainability of project accomplishments.

A. COMMUNITY PARTICIPATION

As mentioned, the project adopted community participation as an implementation strategy operationalized through community cooperation networks. The PASS Project started developing the organization sustainability from the beginning through establishment of community health committees (presently active in 81 of 86 communities) and the identification of community leaders. Through their committees, communities participated in all aspects of the process, from design to implementation and evaluation. Major resources contributed by communities included time and effort, and sometimes land, materials, and labor for communal constructions of buildings to house all project activities, not just UROCs. This was one of the major accomplishments of the project.

Project extensionists recently conducted self-evaluation and developed a comparison between initial and final community scenarios which show that, at the community level, the project was successful in strengthening local organization, providing basic health services, training community volunteers, and linking the different actors in the social cooperation networks including the creation of the roles of PRS coordinator and collaborator (Ruta Crítica documents, August 1996).

High level of community organization and participation was evidenced in the few communities visited. The same was expressed by PRSs interviewed. Nevertheless, those communities and individuals that participated were self-selected into the project and in each District examples were provided of communities/ individuals that did not participate or whose level of participation was lower. Among the reasons some communities had for not participating were:

- proximity to health services making it unnecessary to consult PRS
- distrust of health services due to past bad experiences with them, especially poor quality of care
- people saying they know all they need to know regarding health; lack of interest in preventive services

Community problems specific to Huehuetenango and Quiché are the effects of political violence and conflict in the past decades which make people distrust both government and non government institutions and migration, both seasonal labor and out-migration to the US, that prevent people from participating in a continued manner.

1. *Community Health Committees*

CLS are in some cases committees that have been reactivated, such as the Cholera Committees or other already existing "Pro-Mejoramiento" committees strengthened by the project. Those interviewed were probably among the most active ones participating in the entire process from diagnosis and planning to evaluation and co-financing. In addition, they have been active in promotional activities of PRSs services; most offer important and needed support to the PRS summoning people to meetings and to the vaccination post. Sustainability of services is doubtful in the few communities where there is no CLS.

In communities visited in Cahabón and Purulhá, consultants signed a record kept by the committee's secretary with a summary of the meetings held and interviews conducted, which reflected their training in organization, functions and responsibilities of community groups. The committees have also received mini-training in child survival interventions, but those interviewed tended to mention more involvement in the promotion of domestic hygiene and sanitation activities. All committees expressed plans to continue working after the project leaves, especially because they are not exclusively health committees, but deal with other community needs for development (such as roads, electricity, piped water, etc.).

2. *Rural Health Promoters*

Most PRSs were elected by their communities in meetings of groups of families or by the entire community (for example, community assemblies in Coatán and Zacualpa). However, two other ways of becoming a PRS were also documented: self-appointed (interest in becoming a health promoter) and had been a promoter before (trained by MOH or an NGO). Although community selection is favored, other means of becoming a PRS are not necessarily negative provided individuals are needed, accepted and show strong motivation in participating.

PRSs interviewed were probably among those more active and they were always members of the CLS. In general, they were very satisfied with the project and expressed their gratitude for training and for support with meals and materials while attending training courses. They mentioned as the most important accomplishment of the project the provision of services at the community level, especially immunizations, noting the importance of explaining to families the need for them and their schedule.

A problem for PRSs is that time devoted to the project represents "time lost" for work. Several mentioned that they need an economic compensation for their services. Only a few have experienced charging for services, through the CLS. In the community visited in Huehuetenango, the PRS had started charging 50 cents for immunization services, but had stopped due to criticism on the part of men. While he thought women understood better than their husbands why promoters need to charge, men are the ones that control economic resources.

All PRSs interviewed expressed their desire to continue working as such once the project leaves. Several of them commented that "the project leaves, but the knowledge stays". According to them, the ingredients necessary for sustainability include: more training (PRSs in Huehuetenango and Quiché want to improve their knowledge in order to get a PRS identification card, all want training in other topics), that meals are provided when attending meetings, and supervisory and training visits from a project or MOH personnel. Sustainability is doubtful where PRSs have not developed sufficient self-confidence in their abilities and/or there is no incentive for them to carry on project activities.

The PRSs coordinators active in two Districts (Purulhá and Zacualpa) offer support to PRSs through visits, and they think they can contribute to sustainability provided they also receive more training and support. Collaborators are active in communities in two districts; incentives such as increased community status and being able to attend training (as in Purulhá) could motivate them to continue collaborating. In most places, however, is the CLS who acts as the PRS collaborator.

The communal medicine chests are seen by CLS and PRSs as critical for sustainability. Precise mechanisms to insure resupply and monitor management still need to be worked out. Plans for sustainability at the community level also include giving more attention to the strategic location of PRSs collaborators and coordinators, carrying out fund-raising activities in support of the CLS, legalization of the CLS or other community-based organization, local planning and presentation of specific projects to funding agencies, and the community providing food and fuel to MOH personnel in exchange for training and supervision of local PRSs.

In Purulhá the extensionists have started developing together with the CLS and PRSs specific plans for sustainability which present concrete examples of the above plans. For instance, in one place a community member donated a piglet to be raised and sold by the CLS.

3. *FAMILY GROUPS*

The concept of family groups is one that has been implemented in only a few communities. What can be observed or was reported at the community level is groups of women attending immunization, educational sessions and/or growth monitoring. Individual women visit medicine chests (or send a child) to consult the PRS and buy the medicine. No sense of pertaining to a "family group" was found.

Mothers interviewed in Purulhá (17 mothers in a growth monitoring activity) expressed that they were willing to pay for services provided by PRSs because if they go to the Health Center in town (more than one hour walk one way) they end up spending more than the 50 cents charged for services. All mothers interviewed reported that their children were vaccinated, and most of them had attended educational sessions provided by the PRS. Although they could mention general themes discussed, key messages were generally not recalled or mentioned correctly. Interestingly, where women groups were not attending sessions anymore, PRSs explained that they had gotten bored of listening to the same messages.

B. NGO's

Although the participation of NGOs as counterparts to the project was anticipated, it was not achieved for several reasons. In the first place, there were few NGOs working in the project areas. Of the few identified, most were religious NGO's who did not want to coordinate with the MOH due to negative experiences in the past and/or refused to support family planning activities. Finally, two NGOs with whom formal agreements were reached ceased to participate due to conflicts with project staff. One member of an institution active in Baja Verapaz (CIF) who was briefly interviewed explained that they have their own methodology and do not want to coordinate. CIF also conducts training in this community (at the time of visit they were conducting training of the CLS) and has supported a medicine chest in the community, but there has not been any desire on their part to coordinate with PASS.

Regarding plans for sustainability involving NGOs, the only one documented was the relation recently established in Cahabón with "Medicos del Mundo" who will provide technical assistance to PRSs for the remaining months of the year.

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

1. *Ministry of Health*

The other relevant counterpart institution was the MOH through its district health center and posts. As mentioned, the coordination with the Ministry of Health is crucial to the success of a project dealing with health interventions. However, in several of the project sites lack of coordination impeded or greatly delayed project implementation.

With some exceptions, when an NGO attempts to work with the MOH it is seen more as a threat, than as an opportunity, by MOH personnel. Project members are viewed as unwanted observers of MOH work schedules and loads, quality of care and unconventional activities (for example, selling of medicines or charging for services) of some individuals. The notion that the project has the financial resources (including better-paid personnel), but the MOH has the power to allow them to work or not in "their" area is always at the root of the conflicts and negotiation.

Justified or not, the main complaints of the MOH personnel, interviewed, especially those who did not get fully involved in project activities, included the following:

- Project created conflicts with existing programming (mentioned in Alta Verapaz, Baja Verapaz, Huehuetenango, Quiché). MOH programming responds to its priorities and cannot be easily modified to suit project demands.

- Project created conflicts between old promoters and new promoters (mentioned in Alta Verapaz and Huehetenango).

- Project talked about participation, but already had its plans and objectives defined (Alta Verapaz and Huehetenango). Project personnel were imposing their plans on MOH and the other organizations (Huehuetenango).

- Project was to support health services, but did not ask what did they need support with; ironically, they expected support from the MOH (Huehuetenango).

- Agreements are reached with the Chief of Area (JdeA) but are not discussed at the district level where projects will ultimately work (Huehuetenango).

Unfortunately, willingness of the MOH to coordinate with a project often depends on individuals. A comment by an auxiliary nurse interviewed is telling: "CARE was looking for a job, we heard they had had problems with the MOH in other parts, so we are needy and decided to accept them here". This is the present project site in Huehuetenango, where the project was forced to move out twice before.

In the most successful district (Purulhá), the JdeD interviewed appeared so completely involved in the project that he talked about "our" project and not the PASS/ CARE Project as the rest did. He has made presentations of the project at higher MOH and regional levels and has plans to extend the project's health delivery model to another 30 communities in the District. In Zacualpa the new JdeD, in contrast to former ones, is also very supportive of the project and for that reason recently the project has started to fully implement several activities. PASS personnel commented "we feel as if it were all starting" for them and the project.

However, in all areas some coordination with the MOH was reached at different points in time and different levels, with the MOH contributing the following:

- Physical space for project personnel (including sleeping quarters in Cahabón)
- Personnel to facilitate and translate during training
- Vaccines and ORS packets

Direct participation: time and effort of at least one member of MOH health center personnel (usually a TSR) to support project staff.

As mentioned, ability and willingness of the MOH to sustain activities is frequently based on individuals. Additional information from interviews of MOH personnel, the consultants observations and plans mentioned by project staff is presented organized in factors and plans that point towards sustainability and factors that detract from sustainability. Among the former, the following were identified:

a) There are several components of the new MOH policy (Reforma Sectorial de Salud) that are addressed by the PASS/ CARE model such as community participation, coordinating resources with private sector, CMS and UTMs (or Municipalización), and improving management capacity of MOH personnel.

b) While at the beginning of the project there were no mechanisms in the MOH for the management of funds at the area or district level, at present the process of decentralization is making possible the local management of different accounts and revolving funds. Extra funds obtained and managed this way can help support continued training of community volunteers and production of communication and training materials in a district or area.

c) The concept of "social inspection" (Fiscalización Social) can have its operationalization in entities such as the PRS Boards/ Committees or Medicament Boards that could get involved monitoring resources and the delivery of services by the MOH.

d) All the PASS/ CARE child survival interventions are included in the programmatic priorities (ejes programáticos) of present MOH plans. Only malaria, dengue fever, and rabies interventions would need to be added to the package of interventions already included in the PASS Project.

Plans for sustainability include the following:

- MOH will continue provision of vaccines and ORS.
- MOH will continue providing technical assistance to community personnel trained by the project, as well as maintain the linkage with the newly elected PRSs coordinators. In the Purulhá Health Center a TSR has already been appointed responsible for coordinating and providing follow-up to project activities.
- The extension of the PASS strategies and methodology to the rest of the District (mentioned in Purulhá)

Factors identified that can detract from sustainability include:

a) Lack of sufficient financial, human and material resources for MOH to continue with outreach activities. For example, ORS are insufficient; lack of transportation or fuel makes supervision difficult and time-consuming.

b) Attitudes and practices of some MOH personnel who do not favor outreach activities. In places where MOH personnel became used to having an extensionist doing the outreach, it is not certain that they will provide follow-up once the extensionists leave. For example, recently, in a community previously covered by a project extensionist in Cahabón, children did not receive immunizations because the TSR argued that it was not his responsibility.

c) The organization of service delivery in some health centers does not favor outreach. For example, there are services where physicians are completely clinic-based never visiting communities. (On the contrary, in the Purulhá district each staff member, head physician and maintenance person included, is in charge of providing follow-up to several communities.)

2. *OTHER GOS*

As with NGOs, it was anticipated that other GOs (besides the MOH) would act as counterparts to the project. However, there were only a few examples of coordination at the community level with DIGESA (Dirección General de Servicios Agrícolas) and CONALFA (Comisión Nacional de Alfabetización) reported. Mostly, these included sharing of resources such as transportation and materials. Regarding GOs, the only plan found for sustainability was that the National Cooperatives Institute (INACOP) will provide training and technical assistance to community medicine chests and strengthen the JCM in Cahabón and the PRSs Directive Board in Zacualpa.

D. SUSTAINABILITY PLAN, OBJECTIVES, STEPS TAKEN, AND OUTCOMES

Table 6 developed for the mid-term evaluation has been revised and updated using findings presented above.

TABLE 6
SUSTAINABILITY OBJECTIVES, INDICATORS, OUTPUTS AND PLANS

END OF PROJECT OBJECTIVES	INDICATOR	OUTPUTS	PLANS
Each community participating in the project will have and organization capable of supporting child survival interventions and other development project	Creation of Community Health Committees (CLS) and/or names of health promoters (PRSs), voluntary health workers, TBAs. FPCs. and AIDS volunteers in each community	Community health Committees were formed in 81 communities. Most CLSs are capable of supporting child survival interventions and other development projects; planning, implementing, managing, monitoring, evaluating and cofinancing. PRSs in Cahabón and Purulhá have MOH promoters identification cards.	• Legalize community Health Committees or other committees (Promejoramiento) in which PRS participants. • Provide MOH identification cards to promoters in Coatán and Zacualpa. (For other sustainability plans see Section II of report)
Each active health promoter will operate a community revolving fund medicine chest to generate income to support his work.	Establishment of a community medicine chest and % that are able to resupply products.	A network of 13 communal medicine chests has been established in Cahabón which will cofinance shild survival interventions. Other financing options have been identified: direct payment for services to the CLS, montly fee and medicine chests. Resupply mechanisms are being discussed.	• Implement communal medicine chests in 3 remaining districts. • Training on essential drugs and medicine chests of MOH and PRSs in 2 remaining districts. • identify and implement specific medicine resupply mechanisms to medicine chests.
4 district MOH staff will have improved capabilities for the administration and supervision of a system of health promoters in the project area.	MOH implements a plan for support and supervision of Health Promoters and retains 80% or more.	MOH personnel was trained in child survival interventions. In each district a Rural Health Technician (TSR) has improved capabilities for the administration and supervision of health promoters. An MOH plan for support and supervision of PRSs has been developed in Purulhá.	• MOH plans for support and supervision of PRSs will be developed in 3 remaining districts.
10 local NGOs will have improved insittutional capabilities for planning implementation, monitoring and evaluation of child health interventions.	Number of NGOs which have participated in institutional develpment training and number that improve performance.	No NGOs participated effectively in the project.	• INACOP (a government organization) will provide training for communal medicine chests in 3 remaining districts.

III. RECOMMENDATIONS

The recommendations have been organized in short-term and long-term. Short-term recommendations are offered for the period of phase-over of project activities and accomplishments to the MOH, between September and December, 1996. Long-term recommendations are provided for the communities, the MOH and CARE. Recommendations were revised by participants in the workshop held September 10, 1996 for the presentation of preliminary results of the final evaluation.

A. SHORT-TERM RECOMMENDATIONS

These recommendations are oriented towards encouraging the completion of short-term sustainability plans. They involve both PASS/ CARE staff and the MOH.

1. Provide minimal equipment to PRSs in communities in Quiché and Huehuetenango.

2. Provide equipment to midwives who have not yet received it.

3. Promote the official recognition by the MOH of all voluntary health workers trained (PRSs and TBAs). PRSs in Purulhá have a local identification card (provided by the health center not by the central MOH offices), and PRSs in Zacualpa and Coatán still do not have an identification card.

4. Promote and help the CLS or the community organization most convenient for sustainability achieve legal status. The PRS should be part of the local organization.

5.

6. Invite PRSs coordinators to relevant (sustainability) meetings in the health centers.

7. Evaluate the knowledge and practices of PRSs coordinators to identify strengths and weaknesses for future training.

8. Simplify instruments in the HIS; compare to those of the national system, and adapt them.

9. Complete sustainability plans with communities according to their level of organization.

10. Implement communal medicine chests in all interested communities that have completed requirements (for example, 50% of its cost).

11. Provide training in essential medicines and the communal chest management to MOH personnel and to PRSs in Quiché and Huehuetenango. Also, provide refresher training on child survival interventions to PRSs in the same areas.

12. Identify precise mechanisms for resupply (acquisition, storage and distribution) of medicines to the medicine chests.

13. Establish monitoring and supervisory mechanisms to assess the quality of services being provided at the community level. PASS instruments need to be simplified. Also, make arrangements for monitoring and supervision of the medicine chests.

14. Conduct the formal transference of project activities and materials to the MOH in every health district.

15. In each district, develop detailed specific sustainability plans for negotiation. The methodology should be adapted in each place according to needs.

B. LONG-TERM RECOMMENDATIONS

These recommendations were developed taking into account the health sector reform and that are the needs and responses of the community, the MOH and CARE's future projects. Some recommendations are repeated for the three actors.

Community

1. Learn about the health sector reform in order to participate.

2. Apply participatory local planning.

3. Participate in defining community selection criteria for different projects.

4. Strengthen the IEC strategy.

5. Identify and implement strategies to promote the participation of women in projects.

6. Contribute to monitoring the quality of health care at the community level.

7. Reach agreements with the MOH to sustain interventions of mutual interest. Each community should have the opportunity for deciding the type and number of interventions that wishes to finance and support.

8. Discuss the different options for financing and managing the interventions: fee for service, fixed fee per family per month, revolving fund, etc.

MOH

1. MOH personnel should be better informed about the health sector reform.

2. Obtain critical inputs to sustain the interventions in each district.

3. Promote strategical participatory planning at all levels.

4. Define criteria for community selection for the different interventions.

5. Coordinate with other institutions, specially those sector-specific.

6. Monitor and evaluate the quality of health care provided in services and by voluntary workers at the community level.

7. Reach agreements with communities to sustain interventions of mutual interest. Each community should have the opportunity for deciding the type and number of interventions that it wishes to finance and support.

8. Discuss with communities the different options for financing and managing the interventions: fee for service, fixed fee per family per month, revolving fund, etc.

9. Based on agreements continue provision of basic health services at the community level, especially in more remote communities.

10. Continue to provide training and technical assistance to PRSs and TBAs, collaborators and coordinators.

CARE

1. Involve MOH personnel from the beginning in all the process of project design and implementation, from planning to evaluation.

2. Take into consideration the programmatic priorities of the MOH.

3. Take into consideration criteria such as population concentration and accessibility for community selection.

4. Conduct joint strategic planning with the MOH.

5. Try to coordinate with other institutions, without spending an undue amount of time in it.

6. Continue using the methodology developed in the PASS Project for "community management" of interventions.

7. Take into account the two critical elements for successful health projects implementation: community acceptance and participation and coordination with the MOH. In places where these two elements are not present, projects should not be initiated.

8. Exercise more sensitivity in relations with the MOH and the communities (be careful about creating false expectations, making false promises; be careful when awarding recognition or documenting the process with photographs and films as the latter sometime create suspicions).

9. Have new projects work in the PASS/ CARE communities to provide follow-up (to be able to complete planned activities in communities in Huehuetenango and Quiché).

10. Develop the communication strategy on its own and in support of other strategies in the project to produce desired behavior change. This requires the process of formative research, behavior analysis, behavior trials, strategic planning, development of training and communication materials, and a plan for monitoring progress. Change agents should be trained as facilitators.

11. Include specific strategies to stimulate participation of women in projects. Alternative terms that can be used to include women are "promotoras", voluntary mothers, women leaders, "monitoras" as in the previous CHO project, etc.

12. Strengthen the process of orientation of all new personnel in the project.

13. The theme of reproductive health can start to be integrated into the different child survival interventions. For example, exclusive lactation as a contraceptive method in the first 6 months postpartum and the concept of child spacing can be part of infant nutrition.

IV. EVALUATION TEAM

External Consultants

- Elena Hurtado
- Américo López

(The external evaluators' curricula is found in **Annex G**)

CARE Personnel

- Jim Becht, Regional Technical Advisor
- Sumana Brahman, Health Sector Coordinator

PASS Project Personnel

- Walter Flores, Project Manager
- Karla Droege, Field Assistant (Purulhá, Baja Verapaz)
- Jorge Medrano, Field Assistant (Cahabón, Alta Verapaz)
- Cristóbal Ventura, Field Assistant (Zacualpa, Quiché y San Sebastián Coatán, Huehuetenango)

Documents Consulted for the Evaluation

- Report of Baseline Survey (in Spanish), February 1994
- Detailed Implementation Plan, March 1994
- First Annual Report, October 1994
- Informe del Estudio de Rentabilidad de los Botiquines Comunitarios, November 1994
- Frequency Distributions of the Baseline and Final Survey Data (1994 and 1996)
- Trip Report, Kathy Tilford, PHC Director CARE, May-June 1995
- Mid-Term Evaluation Report, September 1995
- Second Annual Report, November 1995
- Documento sobre estrategias del Proyecto, April 1996
- Soporte Técnico al Proceso de Sostenibilidad Técnica y Financiera de Intervenciones de Salud, May 1996
- Autoevaluaciones de los Asistentes de Campo, Ruta Crítica, August 1996
- Plans for training
- PRS census
- Agreements with institutions
- Sustainability plans with CLS

ANNEX A
TERMS OF REFERENCE FOR THE FINAL EVALUATION

TERMINOS DE REFERENCIA
EVALUACION FINAL

I. DATOS DEL PROYECTO

NOMBRE: PROYECTO DE APOYO A LOS SERVICIOS DE SALUD (PASS)

FECHA DE INICIO: OCTUBRE 1993

FECHA DE FINALIZACION: SEPTIEMBRE 1996

II. ANTECEDENTES

PASS es un proyecto de Supervivencia Infantil que parte principalmente de las lecciones aprendidas de anteriores proyectos, tanto de salud como de Desarrollo. El principal reto que se ha planteado el proyecto es el aumento de cobertura de las intervenciones de supervivencia infantil en una forma sostenible, además de promover la calidad en la prestación de los servicios de salud a la población. La principal estrategia del proyecto en ésta tarea, ha sido la de moverse de intervenciones puramente salubristas a una inserción dentro del esfuerzo multisectorial local de desarrollo comunitario. Además de lo anterior, el proyecto busca validar un proceso metódologico que permita la descentralización de servicios y la movilización social para el aumento de coberturas.

El proyecto ha estado en operación durante 26 meses en 4 distritos de salud: Cahabón en Alta Verapaz, Purulhá en Baja Verapaz, Zacualpa en Quiché y San Miguel Acatán en Huehuetenango. Se está sirviendo un total de 87 comunidades. El proyecto PASS ha sido diseñado para promover una participación amplia del personal local del Ministerio de Salud Pública (MSP), Organizaciones no Gubernamentales en el área (ONG's) Organizaciones Gubernamentales (OG's) y Grupos Comunitarios. El proyecto PASS realizó una evaluación externa de medio término durante Septiembre de 1995. De esta evaluación surgieron las principales actividades y procesos que se están llevando a cabo en los 4 distritos de salud.

Actualmente, PASS se encuentra en la tercera fase de su diseño, la cual es de mejoramiento de la calidad de las intervenciones y el inicio del proceso para la busqueda de la sostenibilidad técnica y financiera de las intervenciones de supervivencia infantil.

III. OBJETIVOS DE LA EVALUACION FINAL

1. PROPOSITO GENERAL DE LA EVALUACION FINAL
El propósito general de la evaluacion final es documentar los logros, lecciones aprendidas y la sostenibilidad de las intervenciones.

2. OBJETIVOS ESPECIFICOS DE LA EVALUACION FINAL

- Comparar los logros del proyecto con los objetivos definidos en el plan detallado de implementacion.
- Identificar las principales lecciones aprendidas durante la implementación del proyecto, así como las que son relevantes y/o aplicables a otras instituciones que implementan proyectos de supervivencia infantil. .
- Evaluar las probabilidades de que las intervenciones generadas por el proyecto sean sostenibles, incluyendo la habilidad y disponiblidad de la contraparte (MSP, ONG's) y Comunidades para sostener dichas intervenciones.

IV. METODOLOGIA DE LA EVALUACION

1. EQUIPO DE EVALUADORES:

El proceso utilizado en la evaluación será participativo hasta donde sea posible, en el cual los beneficiarios, contrapartes y personal del proyecto serán invitados a participar en el proceso de evaluación. Un equipo externo de dos consultores será contratado para coordinar el proceso, consolidar y revisar la información, y desarrollar un reporte final con las recomendaciones necesarias para el proyecto.

2. METODOLOGIA
Para poder desarrollar la evaluación en la forma requerida es necesario obtener información por parte de los beneficiarios, contrapartes del proyecto PASS (gobierno y ONG's) y personal de campo. Los consultores trabajarán en lo siguiente:

⇒ Revisar todos los reportes técnicos y otros documentos del proyecto que sean relevantes, el plan detallado de implementación, reporte anual, documento de revisión interna del proyecto, evaluación de medio término, los instrumentos para monitoreo y recolección de datos.

⇒ Revisar los resultados de la encuesta de linea final y documentar cada uno de los indicadores que sean relevantes.

⇒ Participar en la reunión de planificación de equipo, con el objetivo de llegar a una comprensión común de los alcances de la tarea a realizar.

⇒ Diseñar los métodos y herramientas necesarias para recolectar información adicional, incluyendo cuestionarios para entrevistas semi-estructuradas, discusiones de grupo, entrevistas a profundidad, etc.;

⇒ Conducir entrevistas a profundidad con informantes claves. Esto incluye la planificacion de una serie de entrevistas y reuniones con los participantes del proyecto a diferentes niveles: personal de campo, personal gerencial; entrevistas a profunidad con las contrapartes gubernamentales y ONG's;

⇒ Hacer un análisis de los gastos del proyecto, y hacer una comparación de los gastos reales con el presupuesto definido en el DIP.

⇒ Planificar y ejecutar visitas al campo para observar las actividades del proyecto PASS, así como reuniones para entrevistas individuales o en grupos pequeños dirigida al personal de campo y/o comunitarios (e.j. beneficiarios del proyecto).

⇒ Facilitar una reunión/taller de analisis de los hallazgos preliminares de la evaluación con el personal y socios claves del proyecto. El objetivo de ésta reunión es el de revisar y finalizar los resultados y recomendaciones que irán en el reporte.

V. PREGUNTAS CLAVES

Es de suma importancia revisar cuidadosamente las guias de evaluación de USAID/W. Las preguntas que se encuentran en las guias son muy importantes y deben ser abordadas en su totalidad. Además de lo anterior, existen una serie de preguntas básicas que están relacionadas directamente a las estrategias especificas del proyecto PASS, las cuales son:

Que se ha hecho con respecto a las diferentes estrategias dentro del proyecto? Como corresponden éstas estrategias al diseño del proyecto?

Cual es la calidad de las actividades que se están llevando a cabo

Cuales son las situaciones claves relacionadas con la sostenibilidad institucional de los componentes específicos del proyecto (e.j. redes de cooperacion social, el asocio con el gobierno y ONG's) ? Que apoyo adicional e insumos serán necesarios para asegurarse que los beneficios y relaciones continuan una vez que PASS salga del área?

Fue apropiada la estrategia del proyecto, tomando en cuenta las lecciones aprendiadas de anteriores proyectos y los esfuerzos de descentralizacion del sector salud?

Como son monitoreados y evaluados los componentes del proyecto? cual es la calidad del monitoreo de las actividades?

Como podrian ser mejorados los diferentes componentes del proyecto en el futuro, a la luz de que el MSP será el principal encargado del seguimiento?

VI. ACTIVIDADES PRINCIPALES

a. Participar en una reunión de planificación por dos dias, en conjunto con el coordinador del sector salud y personal clave del proyecto PASS. El propósito de ésta reunion es llegar a una comprensión común sobre los términos de referencia, roles individuales y las diferentes responsabilidades de los miembros del equipo, así como los productos esperados de la evaluación.

b. Revisar todos los documentos relevantes del proyecto, incluyendo el plan detallado de implementacion, reporte anual, la revisión interna del proyecto, herramientas de monitoreo, evaluacion de medio término, reporte de encuesta de linea final y cualquier otro documento relevante a la implementación del proyecto.

c. En particular, analizar la evaluación intermendia del proyecto y el reporte de encuesta de linea final.

d. Determinar las actividades que son necesarias para recolectar la información a nivel de campo, así como la forma en que deben ser ejecutadas. Diseñar las diferentes metodologías y herramientas necesarias. Realizar visitas de campo para observar las actividades del proyecto y recolectar información sobre las mismas. Visitar y entrevistar a los comunitarios participantes en el proyecto.

e. Reunirse y consultar con los diferentes niveles de personal del proyecto PASS, contrapartes gubernamentales y ONG's, revisar sus roles y las herramientas gereciales y de supervisión que se utilizan para monitorear las actividades de campo.

f. Reunirse y discutir los diferentes aspectos del proyecto con comunitarios claves, de acuerdo a la metodología aprobada para la evaluación comunitaria.

g. Preparar un reporte de la evaluación en inglés, basado en los hallazgos y recomendaciones de los evaluadores y siguiendo las guias de USAID. El reporte debe contener recomendaciones específicas que fortalezcan las actividades actuales del proyecto PASS.

h. El coordinador del equipo tendrá al final una reunión con el coordinador del sector salud y personal clave del proyecto PASS para presentar, discutir y revisar las recomendaciones que sean necesarias. Durante ésta reunión, el reporte de evaluación debe ser entregado para comentarios.

i. Facilitar un taller de hallazgos de la evaluación final, en el cual participarán personal clave de las contrapartes y CARE. El objetivo de dicho taller es recibir la retroalimentación necesaria para la elaboración del informe final.

j. Revisar y finalizar el reporte basado en los comentarios recibidos. Entregar el reporte final a CARE con todos los datos y documentos que apoyen el mismo. Además una copia del reporte completo con anexos en diskette.

VII. PRODUCTOS ESPERADOS

a. Una reunión de retroalimentación en las oficinas centrales de CARE para compartir los hallazgos y recomendaciones principales de la evaluación. Esta

reunión debe servir para aportar las observaciones y comentarios de los participantes sobre los hallazgos y conclusiones preliminares.

b. Reporte de la evaluación final del proyecto (en inglés) el cual detallará los logros y efectividad del proyecto, así como las lecciones aprendidas. El reporte debe ser congruente con la guía de evaluación de medio termino, elaborada por USAID/W para éste propósito.

VIII. DURACION DE LA EVALUACION

La evaluación dará inicio el 9 de agosto y se extenderá hasta el 13 de septiembre.

IX. CALIFICACIONES DEL EQUIPO EVALUADOR

El equipo de consultores incluirá un coordinador de equipo con demostrada experiencia en la evaluación de proyectos de salud pública en Guatemala. Los otros miembros de equipo (los cuales también tendrán una amplia preparación y experiencia en salud pública) incluye un representante del Ministerio de Salud Pública y un Representante de CARE. Todos los miembros del equipo deberán estar muy bien familiarizados con la estructura y programas del Ministerio de Salud Pública, así como una buena comprensión del trabajo y rol de ONG's y de los servicios de salud basados en la comunidad.

X. APOYO LOGISTICO PARA EL TRABAJO DE EVALUACION

CARE brindará todo el apoyo logístico para apoyar la evaluación, tales como:

- transportación para las visitas de campo
- alimentación y hospedaje.

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U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

MAY 3 1996

Re: 1996 Final Evaluation Guidelines for CS-IX Projects

Dear Colleague,

The overall goal of the final evaluation of a Child Survival project is to assess the impact, effectiveness and the sustainability of the project. With this in mind, BHR/PVC requires all PVOs with projects ending in 1996 to submit the following documents (in English):

a) a narrative report, addressing the topics and questions contained in the enclosed Guidelines;

b) a final evaluation survey; and

c) a final pipeline analysis.

The evaluation team leader should be someone who is not employed by, or otherwise professionally associated with, your organization and must be approved by BHR/PVC. This person must be knowledgeable of child survival interventions. At least one member each from the field and headquarters staffs should be on the evaluation team. Please discuss with your project officer the proposed composition of the team and the evaluation schedule.

A one-sided unbound original and one bound, double-sided copy of all reports are due 90 days after the project termination date. An additional copy of the report should also be sent to JHU-CSSP. Please direct inquiries to your project officer.

Sincerely,

Katherine Jones-Patron

Katherine Jones-Patron
Chief, Child Survival and Health
Office of Private and Voluntary Cooperation
Bureau for Humanitarian Response

Enclosures

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

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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.

43.

PVO/COUNTRY: _____

COOPERATIVE AGREEMENT NO.: _____

DATE BUDGET PREPARED: _____

DATE SUBMITTED TO USAID: _____

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 (/ /)	
I. DIRECT COSTS		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
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)									

A:\96PIPELN.wk4 (Pipeline A)

BEST AVAILABLE COPY

PVO/COUNTRY: _____

COOPERATIVE AGREEMENT NO.: _____

DATE BUDGET PREPARED: _____

DATE SUBMITTED TO USAID: _____

1996 PIPELINE ANALYSIS: PART B - COUNTRY 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 (/ /)	
I. DIRECT COSTS		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
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)									

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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_____

		Total Agreement Budget (/ /)to(/ /)		Actual Expenditures to Date (/ /)to(/ /)		Project Expenditures Against Remaining Obligated Funds (/ /)to(/ /)		Projected Unobligated Funds at End of Project (/ /)to(/ /)	
I. DIRECT COSTS		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO
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)									

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ANNEX B
TEAM PLANNING MEETING
19 - 20 AUGUST 1996

EQUIPO DE EVALUACIÓN FINAL
PROYECTO PASS/ CARE

Consultores externos

* Elena Hurtado
* Américo López

Personal CARE

* Jim Becht, RTA
* Sumana Brahman, Coordinadora del Sector

* Walter Flores, Gerente del Proyecto PASS/ CARE
* Karla Droege, Asistente de Campo PASS/ CARE (Purulhá, Baja Verapaz)
* Jorge Medrano, Asistente de Campo PASS/ CARE (Cahabón, Alta Verapaz)
* Cristóbal Ventura, Asistente de Campo PASS/ CARE (Zacualpa, Quiché y San Sebastián Coatán, Huehuetenango)

* Mónica Ochoa, encargada administración y logística

EVALUACIóN FINAL PROYECTO PASS/ CARE
PREGUNTAS PARA EL TPM

* Cuáles son las preguntas críticas para responder en la evaluación

* Qué se puede hacer en vista del tiempo (planificar trabajo de campo)

* Qué apoyo logístico se tendrá de CARE

* Quiénes conforman el equipo de evaluación
    - cómo coordinar
    - cómo comunicar

* Quiénes aportan otras secciones del informe
    - Encuesta de base y final
    - Pipeline

* Qué documentación existe

EVALUACIÓN FINAL PROYECTO PASS/ CARE
INVOLUCRAMIENTO DE CLIENTES
TPM

PROCESO	FORMA DE INVOLUCRAR AL CLIENTE
Planificación	USAID/W, CARE, MSPAS
Trabajo de Campo	CARE, MSPAS, UTM, CMS
Taller de Análisis de Resultados	USAID/G, CARE, MSPAS, UTM, Comité de Salud (?)
Informe de Evaluación (Resumen, traducción)	USAID/W, USAID/G, CARE, MSPAS, UTM
Retroalimentación sistemática	Recomendar a CARE que lo haga a los demás niveles: * Comunidad/ Comités * Consejo Técnico de Area/ MSPAS * Consejo Departamental de Desarrollo

EVALUACIÓN FINAL PROYECTO PASS/ CARE
CLIENTES DE LA EVALUACIÓN E INTERESES
TPM

CLIENTES	INTERESES
USAID/ W Agencia de financiamiento	* Uso debido de recursos * Logros * Sostenibilidad
CARE/ G	* Impacto a nivel de hogares * Coord. OGs, ONGs, OCBs * Estrategias * Coordinación interna CARE
MSPAS	* Coord. interinstitucional * Sostenibilidad * Replicabilidad * Reforma Sectorial (extensión de coberturas, financiamiento local y fortalecimiento institucional)
UTM	* Continuidad * Efectividad del modelo * Financiamiento local
Comités de Salud	* Servicios * Continuidad * Apoyo institucional

EVALUACIÓN FINAL PROYECTO PASS/ CARE
DOCUMENTOS DISPONIBLES

- Propuesta original del proyecto de finales de 1992 (en Mayo 1993 se logra el financiamiento y el proyecto inicia el 1 de Octubre de 1993)

- Plan detallado de implementación (DIP)

- Informe del Taller Regional sobre VIH/SIDA en Junio 1994

- Primer Informe Anual de Octubre 1994

- Informe de Viaje de Kathy Tilford, PHC director CARE Mayo-Junio 1995

- Revisión del Diseño del Proyecto Junio 1995

- Segundo Informe Anual de Noviembre 1995

- Evaluación de Medio Término de Septiembre 1995

- Datos de Encuestas Basal y Final (1994 y 1996)

- Consultoría sobre Sostenibilidad, Mayo 1996

- Autoevaluaciones de los Asistentes de Campo 1996

- Censos de los promotores

- Acuerdos con instituciones

- Planes de sostenibilidad de los Comités

- Planificación de capacitaciones

- Documentación sobre botiquines, capacitación

EVALUACIÓN FINAL PASS/CARE
CALENDARIO DE ACTIVIDADES

DIA / FECHA	ACTIVIDADES
Lunes, 19 agosto	CARE Guatemala: Taller de planificación
Martes, 20 agosto	CARE Guatemala: Taller de planificación
Miércoles, 21 agosto	Revisión Documentación Trabajo con Asistentes de Campo, gerente
Jueves, 22 agosto	Desarrollo de guías de entrevista/discusión
Viernes, 23 agosto	Revisión del Plan de trabajo Presentar a Asistentes de Campo, Gerente
Sábado, 24 agosto	
Domingo, 25 agosto	Salida Dormir en Cobán
Lunes, 26 agosto	10:00 a.m. Cahabón 6 entrevistas Dormir en El Recreo
Martes, 27 agosto	10:00 a.m. Purulhá Dormir en Tactic
Miércoles, 28 agosto	Visita Eben Ezer Regreso a Guatemala
Jueves, 29 agosto	Viaje a Nentón (salida 9:00 am)
Viernes, 30 agosto	8:00 a.m. Coatán Dormir en Jucup a Nentón
Sábado, 31 agosto	Visita a Hoom Dormir en Nentón
Domingo, 01 sept.	Dormir en Quetzaltenango
Lunes, 02 sept.	Viaje a Zacualpa Visita Tunajá Dormir en Santa Cruz

DIA / FECHA	ACTIVIDADES
Martes, 03 sept..	Visita Regreso a Guatemala
Miércoles, 04 sept.	Elaborar informe
Jueves, 05 sept.	Elaborar informe
Viernes, 06 sept.	Elaborar informe, entrega 1er. borrador
Sábado, 07 sept.	
Domingo, 08 sept.	
Lunes, 09 sept.	Discutir informe con Walter, Sumana, Jim
Martes, 10 sept..	CARE Guatemala: Taller de presentación de los resultados.
Miércoles, 11 sept.	Revisar informe
Jueves, 12 sept.	Revisar informe
Viernes, 13 sept.	Entrega del Informe Final de la Evaluación

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EFECTIVIDAD Y SOSTENIBILIDAD DE ESTRATEGIAS				LOGROS/IMPACTOS (Hacia el)	
ACTORES	PLANIFICACION PARTICIPATIVA	COOPERACION SOCIAL	PROGRAMACIÓN GEOGRÁFICA	PRINCIPALES LOGROS (PERSPECTIVA)	EXPLICAR LOGROS/FALTA DE LOGROS ENC.
• Colaborador					
• Promotor					
• Comadrona					
• Coordinador de promotor					
• Comité local de salud					
• Junta Central de Medic.					
• TSR					
• Auxiliar de enfermería					
• Personal área [illegible]					
• UTM					
• Extensionista					
• Asistente de campo					
• Gerente					
• Encargada monitoreo & Evaluac.					
• Coordinadora					

ANNEX C
METHODOLOGY FOR THE FINAL EVALUATION

Evaluación Final Proyecto PASS/ CARE
Trabajo de Campo
Personas a Entrevistar

1 Gerente de Proyecto

Cahabón

1 Comité local de salud

1 Junta Central de Medicamentos

1 Inspector de Saneamiento Ambiental

1 Jefe de Distrito (Médico)

1 Unidad Técnica Municipal (Técnico de INACOP)

1 Extensionista de CARE

1 Asistente de Campo (Jorge Medrano)

1 Visita a Comunidad

3-5 Hogares

Purulhá

2 Coordinadores de Promotores

1 Comité Local de Salud (en comunidad visitada)

2 Técnicos de Salud Rural

1 Jefe de Distrito (Médico) - Miembro de UTM

2 Extensionistas de CARE

1 Asistente de Campo (Karla Droege)

1 Visita a Comunidad (Eben Ezer)

3-5 Hogares

Huehuetenango

1 Junta Directiva de Promotores y Comadronas

1 Comité Local de Salud (en comunidad visitada Hoom)

1 Técnico en Salud Rural

1 Auxiliar de Enfermería

1 Jefe de Distrito (Médica) - en Huehuetenango

2 Extensionistas de CARE

1 Asistente de Campo

1 Visita a Comunidad (Hoom)

3-5 Hogares

Zacualpa

1 Promotor de Salud

1 Comité Local de Salud (en comunidad visitada Tunajá)

1 Técnico en Salud Rural

1 Jefe de Distrito (Médico)/ Miembro de UTM

2 Extensionistas

1 Asistente de Campo

1 Visita a Comunidad (Tunajá)

3-5 Hogares

Persons interviewed
Final Evaluation PASS Project

Project Manager Lic. Walter Flores

CAHABÓN, ALTA VERAPAZ

Individual interviews

CARE (1)

Field Assistant, Jorge Medrano

MOH (3)

JdeD Dr. Carrera
TSR Jairo Noé López
ISA Jorge Ramos

Community (2)

1 PRS Chaslau

1 PRS's wife Cristóbal Che Tziu (Julijix)

Women (4)
- Angelina
- Matilde
- Concepción
- No name

GOs (2)

Multi-Sectorial Coordination Board representatives interviewed individually by Dr. Américo López

Group interviews

CARE (3)

Ext Anselmo Asij
Ext Herminia Coj
Ext Orlenda Reyes

PRS (5)

Eduardo Choj Tiul - Secampana
Juan José Chub Xal - Secampana
Carlos Pop Pop - Chilajap
Eduardo Quib Sub - San Martín Chichaj
Antonio Cucul Ical -·Chivite Santa Rosa

Community Health Committees (9)

Juan José Chub Xal - Secampana (PRS and Committee)
Arnulfo Pop - Chilajap
Marcelino Cho Cac - Julijix
Miguel García - Julijix
Mateo Choc Chub - Chivite Santa Rosa
Abelardo Caal Pop - Sactá
Joaquín Pop Choc - Secacao
Leonzo Asig - Chitzac
Lorenzo Cho Chen - Chitzac

Medicaments Central Board (5)

Vicente Sacul Chun - President (Chaslau)
Pedro Carmelo Torres - Vice-Presidente (Nuevo Progreso Tuilá)
Norberto ? - Secretary
Antonio Cucul Ical - Treasurer (Chivite Santa Rosa)
Agustín Tzir Caal - Vocal 1 (Chipoc)

PURULHÁ, BAJA VERAPAZ

Individual interviews

CARE (1)

Field Assistant Karla Droege

MOH (3)

JdeD Dr Guillermo Enríquez
TSR Neftalí
TSR Santos Ajualip Rosales

Community (5)

1 PRS Sebastián Choc, Eben Ezer
1 CPRS Antonio Cuz, El Repollal
1 PRS Collaborator Luisa PopEben Ezer
1 TBA, mother of 2 health promoters

1 PRS Coordinator (the only woman CPRS, interviewed by Dr. Américo López)

Group interviews

CARE (3)

Ext Agripina Tot Maas
Ext Amelia Rosa Chon de Palomina
Ext Rosalía Tot de Morales

Community - Eben Ezer

Mothers (17) attending growth monitoring activity

San José, San Sebastián Coatán, Huehuetenango

Individual interviews

CARE (1)

Field Assistant Cristóbal Ventura

MOH (3)

AdeE Baltazar Juan Baltazar
Dr William Balcárcel (interviewed in Huehuetenango)
TSR Miguel Hurtado

Community (1)

1 PRS Pedro Mateo, Hoom

Women (3)

Rebeca Pascual
Eulalia Mateo
No name

Group interviews

CARE (2)

Ext Juan Domingo Cárdenas
Ext Maria Eugenia

Community (5)

Local Health Committee, Hoom

PRSs San José Health Post (5)

ZACUALPA, QUICHÉ

Individual interviews

CARE (1)

Field Assistant Cristóbal Ventura

MOH (2)

JdeA Dr. Ezequiel Urízar
AdeE

Community (4)

1 PRS Cruz García - Xejox, President of PRSs Central Board
1 PRS Toribio Chingo - Tunajá 1
1 PRS Diego Ventura - Tunajá 1
1 TBA - Tunajá 1

Women (4)

Group interviews

CARE (2)

Ext Aura Marina Gómez Hernández
Ext Juan Us Vicente

Community (5)

Local Health Committee members - Tunajá I

Guía de Entrevista a Comité de Salud

Historia del Comité de Salud
- cuándo se formó
- que los motivó a formarse

Quiénes están en el Comité de Salud

Cada cuánto se reunen/ cuándo fue la última vez

Qué hacen, cómo funciona el Comité

Qué relación tienen con promotores/ comadrona/ coordinadores de promotores/ Centro o Puesto de Salud/ UTM

Cuáles consideran sus logros (y en salud)

Qué dificultades o problemas han tenido, cómo responde la comunidad

Cómo han resuelto problemas (problemas de salud)

Qué planes tienen para el futuro, cómo se van a sostener las acciones que se hacen (sostenibilidad de servicios y otros)

Cómo ha apoyado el Proyecto PASS/ CARE a su comunidad, cómo ha sido el trabajo del Proyecto con el Comité

Guía de Entrevista
Junta Central de Medicamentos

Historia de la Junta
- qué es
- cuándo se formó
- por qué se formó

Quiénes están en la Junta/ de qué comunidades

Qué ha hecho hasta el momento la Junta

Qué dificultades han tenido, cómo las han enfrentado

Qué planes tiene para el futuro (sostenibilidad)
- abastecimiento
- manejo de fondo revolvente
- ganacia contemplada en manejo de medicamentos
- cómo se va a renovar la Junta

Cómo ven los promotores/ comité de salud a la Junta

Cómo los ha apoyado el Proyecto PASS/ CARE

Guía de Entrevista
Técnico en Salud Rural/
Inspector de Saneamiento Ambiental/
Auxiliar de Enfermería

Cómo ha sido la experiencia con el Proyecto PASS/ CARE

Cuál ha sido su involucramiento

Cómo ha sido la coordinación y respuesta con Jefatura de Distrito, otras dependencias del Gobierno, ONGs, UTM y las comunidades

Qué dificultades han enfrentado, cómo las han resuelto

Capacitaciones a promotores/ comadronas/ comités

Tipo y apreciación de la calidad de las capacitaciones

Calidad de los servicios que están prestando a nivel comunitario

Cuáles son los principales logros del proyecto

Según la encuesta de evaluación final, el componente de inmunizaciones del Proyecto ha sido el más exitoso, por qué cree que esto fue así; qué pasó con los otros componentes (ej. control de diarreas)

Qué ha pensado sobre el proceso de sostenibilidad de las acciones del Proyecto

Guía de Entrevista
Jefe de Distrito (Médico)

Podría explicar qué es el Proyecto PASS/ CARE
- propósitos y objetivos
- metodología de trabajo
- organización

Por qué está el Proyecto PASS/ CARE en su Distrito

Cómo ha sido la coordinación del Proyecto en el Distrito, a diferentes niveles: comunidad, OGs, ONGs, UTM, Municipalidad, internamente

Cuáles son los principales logros del Proyecto

Cuáles han sido las dificultades con el Proyecto

Según la encuesta de evaluación final del Proyecto, el componente de inmunizaciones del Proyecto ha sido el más exitoso, por qué cree que esto fue así; qué pasó con los otros componentes (ej. control de diarreas)

Qué ha pensado sobre el proceso de sostenibilidad de las acciones del Proyecto

Qué sugerencias da para el Proyecto, en qué aspectos debe fortalecerse

Guía de Entrevista
Unidad Técnica Municipal

Qué conoce del Proyecto PASS/ CARE
- dónde se está desarrollando
- qué está desarrollando
- metodología de trabajo

Cómo se involucraron en el Proyecto, qué logros han tenido en conjunto con el Proyecto

Hubo una Coordinadora Multisectorial

Cómo la conformaron

Qué relación tiene/ tuvo con la UTM (se convirtió en UTM, se integró)

Qué dificultades ha tenido la UTM; qué respuesta tiene la UTM del Alcalde, por qué hay esa respuesta (buena o mala)

En el futuro, cómo va la UTM a apoyar los programas y actividades que se están desarrollando a nivel de comunidades

Que sugerencias dan para el Proyecto, en qué aspectos debe fortalecerse

Guía de Entrevista
Extensionista de CARE

Cuándo comenzó a trabajar en el Proyecto PASS/ CARE, hubo un proceso de orientación inicial, de cuánto tiempo

Cuál es la misión, objetivos y propósitos de PASS/ CARE

Cuál ha sido su función dentro del proyecto

- actividades
- planificación
- capacitación
- organización
- coordinación

Qué dificultades ha enfrentado; qué respuesta se ha obtenido a diferentes niveles: comunidades, Municipal, Ministerio de Salud, OGs, ONGs

- grado de satisfacción
- dificultades/ problemas enfrentados
- qué ha hecho para resolverlas
- logros

Cuáles han sido los programas más exitosos, por qué

En el futuro, cómo piensa que van a ser sostenibles las actividades del Proyecto, qué planes ha hecho

Qué sugerencias tiene para la sostenibilidad del Proyecto, en qué aspectos debe fortalecerse

Coordinador de Promotores
Junta Directiva de Promotores y Comadronas

Qué conoce del Proyecto PASS/ CARE

Cómo fue elegido Coordinador de Promotores; cómo fueron elegidos los promotores

Cuáles son sus funciones; cuál ha sido el funcionamiento de la Junta

Qué dificultades o problemas han enfrentado promotores/ Junta

Cuántos promotores tiene a su cargo, cómo se relaciona con ellos, dificultades y qué ha hecho para superarlas

Cómo capacita a los promotores

Cómo hace para saber que los promotores están trabajando bien, si la gente está contenta o no con el servicio que prestan

Cómo es la relación con el Comité de Salud/ Centro y Puesto de Salud

Se siente bien en su papel de coordinador de promotores, qué le hace falta para poder trabajar mejor

Cómo lo ha apoyado el Proyecto PASS/ CARE

Qué está haciendo para que las actividades de ustedes/ promotores/ comadronas se mantengan prestando servicio en la comunidad; piensan que puede mantenerse y extenderse a otros lugares

Que sugerencias puede dar para que esto ocurra

Guía de Observación y Preguntas en Visita a Comunidad

UROC, Casa de Salud o espacio físico de actividades comunitarias PASS/ CARE

OBSERVAR:

Construcción

Insumos (equipo, medicamentos, balanzas, muebles, tabla de crecimiento, manual, material didáctico)

Condiciones de orden y limpieza

PREGUNTAR:

Servicios que prestan; apreciación sobre calidad de los servicios

Quién los presta

Horario de atención

Se ha logrado unificación de promotores y comadronas, por qué, dificultades, factores facilitadores

Tienen colaboradores; cómo estimulan la participación de colaboradores

Cómo están organizados en la comunidad (programación geográfica)

AL PROMOTOR PREGUNTAR:

Cómo fue elegido promotor

Mensajes claves para cada intervención, metodología de enseñanza-aprendizaje (USAR FORMULARIOS DE SUPERVISIóN)

Conoce guías metodológicas, tiene una copia a mano

Cómo le apoya el comité/ los voluntarios para realizar sus actividades; cómo ha sido el apoyo de los servicios de salud, del Proyecto PASS/ CARE

Dificultades enfrentadas y mayores satisfacciones o logros

Guía de Entrevista a nivel del Hogar

Cónoce al promotor de esta comunidad/ de su grupo

Ha asistido a alguna plática de ese promotor

(SI) Cuándo fue la última vez

(SI) Sobre qué fue la plática

Alguna vez ha ido a la Casa de Salud

(SI) A qué fue la última vez

(SI) Pagó usted por el servicio, cuánto pagó

(SI) Cómo le parece el servicio, qué le hace falta para ser mejor

Qué puede hacer una madre cuando su hijo(a) tiene diarrea

Conoce cómo preparar suero/ el sobre de SRO

Qué puede hacer una madre para que su hijo no se enferme de diarrea

INMUNIZACION

INSTRUMENTO DE SESIONES EDUCATIVAS

NIVEL: PROMOTORES

Nombre de quien llena el instrumento:_____

Nombre del supervisado:_____

Comunidad: _____ **Sector:** _____ **Fecha entrevista**_____

Indicaciones: El entrevistador debe chequear las opciones que responda el entrevistado.

1. Cómo realiza sus sesiones educativas?

Partiendo del conocimiento de los participantes	☐
Haciendo preguntas	☐
Tomando ejemplos locales	☐
Utilizando recursos locales	☐

2. Cada cuánto tiempo da sesiones educativas y cuánto duran?

Cada semana	☐	12 min.	☐
Cada dos semanas	☐	30 min.	☐
Cada tres semanas	☐	1 hora	☐
Cada cuatro semanas	☐	2 horas	☐

3. Cómo logra reunir a las madres participantes para que participen?

Aviso del comité	☐	Por sector	☐
Asambleas	☐	No sabe	☐
Ya saben	☐		

4. Cuántas madres están participando en las sesiones educativas?

10 a 15	☐
16 a 20	☐
21 a 30	☐

5. Tiene una lista de participación en las sesiones educativas?

Por sector	☐
Una sola lista	☐
No tiene	☐

6. Está manejando las guías metodológicas?

Si ☐ No ☐

7. Mencione los pasos clàves de la guía metodológica.

Partiendo de los conocimiento s y prácticas ☐
Hace preguntas de reflexión ☐
Se evidencian las actitudes y prácticas de los participantes ☐

8. Cómo planifica su sesión educativa y con quién?

Coordinador de promotores ☐
Técnico salud ☐
Personal de PASS ☐

9. Dónde realizan las sesiones educativas?

Escuela ☐
Casa promotor ☐
La Hermita ☐
Otro ☐

10. Cuentan con material de apoyo?

Rotafolios ☐
Dibujos ☐
Nada ☐

11. Observe una sesión educativa y verifique lo siguiente

Utilizar recursos locales ☐
Parte del conocimiento de los participantes ☐
Promueve la participación de todos ☐
Transmite mensajes claves ☐

INMUNIZACION

NIVEL: GRUPO FAMILIAR

Nombre de quien llena el instrumento:_____

Nombre del supervisado:_____

Comunidad: _____ **Sector:** _____ **Fecha entrevista**_____

Indicaciones: observe lo siguiente y llene cada una de las casillas únicamente si el promotor responde correctamente a la pregunta o realiza la actividad requerida.

PREGUNTAS DE CONOCIMIENTO

Pregunte al entrevistado:

1. Sabe usted que vacunas debe ponerse a un niño?

DPT	☐	ANTIPOLIO	☐
BCG	☐	ANTISARAMPIONOSA	☐

2. Sabe usted que enfermedades se evitan con las vacunas?

Tosferina-Difteria-Tétanos	☐	Poliomelitis	☐
Tuberculosis	☐	Sarampión	☐

3. Sabe usted a que edad debe un niño tener completo su esquema de vacunación?

antes de los 2 años ☐

4. Participa usted en las sesiones educativas que da el promotor?

Si ☐ No ☐ porque _____

5. Sabe usted a que edad debe empezar a recibir sus vacunas un niño?

DPT dos meses	☐
BCG	☐
Antipolio recién nacido 2 meses	☐
Antisarampionosa 9 meses	☐

DIARREA/TRO

NIVEL: **GRUPO FAMILIAR**

Nombre de quien llena el instrumento:_____

Nombre del supervisado:_____

Distrito de salud:_____ **Fecha entrevista**_____

Indicaciones: El entrevistador debe chequear las opciones que responda el entrevistado.

PREGUNTAS DE CONOCIMIENTO

Pregunte al supervisado lo siguiente:

1. A dónde lleva a su niño cuando tiene diarrea

Curandero	☐	Promotores	☐
Comadrona	☐	Comité local de salud	☐
UROC	☐	Centro de salud	☐

2. Qué le ve a su niño cuando está grave de diarrea

No reacciona fácilmente	☐
Ojos hundidos y secos	☐
No salen lágrimas	☐
Boca y lengua muy seca	☐
Tiene sed pero no toma ningún líquido débil y desganado	☐

3. Se ha enfermado alguno de sus niños menores de 5 años durante las 2 últimas semanas?

Si ☐ No ☐

Si la respuesta es **NO**, pase a la pregunta 5

4. Que le dió a su niño para curar la enfermedad?

Más líquidos	☐	Sobres de rehidratación oral	☐
Remedios caseros	☐	Otros	☐

5. Qué hace usted para que no le de diarrea a su niño?

Hervir el agua	☐	Tapar los alimentos	☐
Lavarse las manos	☐	Higiene en la vivienda	☐

6. Qué se debe hacer cuando un niño tiene diarrea?

Dar bastante líquido	☐	☐	Llevarlo al Centro o Puesto de salud	☐
Llevarlo a la UROC	☐	☐	No sabe	☐

DIARREA/TRO
INSTRUMENTOS DE SESIONES EDUCATIVAS

NIVEL: PROMOTOR

Nombre de quien llena el instrumento y nivel _____

Preguntas sobre realización de sesiones educativas_____

Distrito de salud:_____ **Fecha entrevista**_____

Indicaciones: El entrevistador debe chequear las opciones que responda el entrevistado.

1. Cada cuánto tiempo imparte sesiones educativas?

   Cada semana ☐
   Cada mes ☐
   Cada 15 o 20 días ☐

2. Cómo logra reunir a las madres participantes?

   A través de mensajes con alcaldes auxiliares ☐
   Por avisos del comité local de salud ☐
   Por sectores ☐
   Por medio de asambleas generales ☐

3. Cuántas madres están participando en las sesiones educativas?

   10 - 20 ☐ 36 - 40 ☐
   21 - 35 ☐ 41 y más ☐

4. Tiene listado de participantes en las sesiones educativas?

   Una sola lista ☐ No lleva ☐
   Por sectores ☐

5. Está manejando las guías metodológicas?

   Si ☐ No ☐

6. Mencione los pasos claves de las guías metodológicas:

   Partiendo de los conocimientos y prácticas ☐
   Haciendo preguntas de reflexión ☐
   Evidenciar las actitudes y prácticas de las participantes ☐

7. Con quien planifica su sesión educativa?

Con el técnico en salud ☐
Con coordinador de promotores ☐
Con los extensionistas del Proyecto PASS ☐
Comité local de salud ☐

8. Dónde realiza las sesiones educativas?

En la casa del promotor ☐
En un aula de la escuela ☐
En el salón comunal ☐
En la casa de salud ☐
Otros ☐

9. Con que tipo de material de apoyo cuenta?

Rotafolios ☐
Dibujos ☐
Fotocopias de documentos ☐
Recursos educativos hechos por el mismo promotor ☐
Nada ☐

IRA

NIVEL: GRUPO FAMILIAR

Nombre de quien llena el instrumento y nivel:_____

Nombre del supervisado:_____

Comunidad: _____ **Sector:** _____ **Fecha entrevista**_____

Indicaciones: El entrevistador debe chequear las opciones que responda el entrevistado.

PREGUNTAS DE CONOCIMIENTO

1. A quién acude cuando su niño tiene tos o catarro, o problemas para respirar?

Curandero	☐	Comadrona	☐
Promotor	☐	CLS	☐
Centro o Puesto de salud	☐	Otros	☐

2. Cuando está grave un niño que se ha enfermado de tos y catarro?

Dificultad para respirar	☐	Dificultad para beber	☐
Fiebre	☐	Dificultad para comer	☐
Tos	☐	No sabe	☐

3. Se ha enfermado alguno de sus niños menores de 5 años durante las últimas dos semanas?

Si ☐ No ☐

Si la respuesta es **NO** pase a la pregunta 5

4. Qué le dio para tratar la enfermedad?

Remedios caseros	☐	Doy de comer	☐
Mas líquidos	☐	Bajó la calentura	☐

5. Sabe usted qué es una respiración rápida?

Cuando el niño respira como cansado	☐
Cuando el niño respira como perrito	☐

6. Qué es un tiraje al respirar?

Cuando al niño no le alcanza el aire	☐
Cuando se le ven las costillas al respirar	☐

7. Qué le explicó el promotor sobre lo que tiene que hacer en la casa cuando un niño tiene problemas de tos y catarro?

Alimentación: mantener alimentación	☐	Tos: remedios caseros	☐
Líquidos: aumento de líquidos	☐	Nariz: limpiarla si se requiere	☐
		No sabe	☐

INSTRUMENTOS DE SESIONES EDUCATIVAS

NIVEL: PROMOTOR

Nombre del entrevistador y nivel:_____

Nombre del supervisado:_____

Comunidad: _____ **Sector:** _____ **Fecha entrevista**_____

Indicaciones: El entrevistador debe chequear las opciones que responda el entrevistado.

PREGUNTAS SOBRE REALIZACION DE SESIONES EDUCATIVAS

1. Cada cuánto imparte sesiones educativas?

Cada semana ☐
Cada mes ☐
Cada 15 días ☐

2. Como logra reunir a las madres participantes para que participen

Aviso del comité ☐
Asambleas ☐
Ya saben ☐
Por sector ☐
No sabe ☐

3. Cuantas madres están participando en las sesiones educativas

10 a 15 ☐
16 a 20 ☐
21 a 30 ☐

4. Tiene una lista de participación en las sesiones educativas

Por sector ☐
Una sola lista ☐
No tiene ☐

5. Esta manejando las guías metodológicas

si ☐ no ☐

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6. Mencione los pasos claves de la guía metodológica.

Partiendo de los conocimiento s y prácticas ☐
Hace preguntas de reflexión ☐
Se evidencian las actitudes y prácticas de los participantes ☐

7. Como planifica su sesión educativa y con quien:

Coordinador de promotores ☐
Técnico salud ☐
Personal de PASS ☐

8. Donde realizan las sesiones educativas

Escuela ☐
Casa promotor ☐
La Hermita ☐
Otro ☐

9. Cuentan con material de apoyo

Rotafolios ☐
Dibujos ☐
Nada ☐
Recursos educativos hechos por el mismo promotor ☐

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CUIDADO MATERNO

NIVEL: PROMOTOR RURAL DE SALUD

Nombre de quien llena el instrumento: _____

Nombre del supervisado: _____

Comunidad: _____

Sector: _____

Fecha en que se llenó el instrumento: _____

INDICACIONES: El entrevistado debe responder las opciones de las preguntas para poder chequear la casilla del "si", si responde incorrectamente o no contesta marque la casilla "no".

* Preguntas:

1. Cuales son los signos de un embarazo de alto riesgo?

	si	no
a) Es menor de 15 años de edad	____	____
b) Es mayor de 35 años	____	____
c) Estado nutricional (desnutrida)	____	____
d) Es multipara (mas de 4 hijos)	____	____
e) Problemas obstétricos anteriores	____	____
f) Hinchazón en las piernas	____	____
g) Hemorragias	____	____
h) Desmayos o fatiga	____	____
i) Dolor de cabeza	____	____
j) No aumenta el peso	____	____

2. Cual es la vacuna que se aplica a las embarazadas?

Toxoide tetánico	____	____

3. Porque deben asistir las comadronas al control prenatal?
   a) Para cuidar el desarrollo del embarazo ____ ____

   b) Identificar problemas en el embarazo y emergencias ____ ____

4. Cuantas visitas de control prenatal debe tener una embarazada?

   a) Por lo menos una ____ ____

NUTRICION

NIVEL: PROMOTOR RURAL DE SALUD

Nombre de quien llena el instrumento y nivel:_____

Nombre del supervisado: _____

Distrito de Salud _____Fecha de entrevista: _____

Indicaciones: El entrevistado debe de responder a las opciones de cada pregunta correctamente para poder marcar la casilla de "si", si responde incorrectamente o no contesta, marque la casilla de "no".

Pregunta dirigidos al coordinador de promotores, promotores de salud, comadronas.

PREGUNTAS SOBRE CARACTERISTICAS GENERALES DE LA MUJER EMBARAZADA, LA MADRE LACTANTE Y EL NIñO MENOR DE UN AñO.

1. Cuales son las características generales de la mujer embarazada:

a) Cambios en su cuerpo ____

b) cambios en el apetito ____

c) empieza a pesar mas ____

A. De la mujer que da de mamar

a) produce leche para su niño ____

b) toma muchos líquidos ____

B. Cuales son los factores de riesgo Nutricional:

a) Que durante la lactancia la madre no se alimente bien ____

b) Durante el primer año de vida del niño tenga bajo peso o que sea prematuro ____

CONOCIMIENTOS SOBRE LACTANCIA MATERNA

1. A las cuantas horas de nacido se le debe dar pecho a un niño — SI NO

   a) las primeras 8 horas — ___ ___

2. A los cuantos meses de edad se le debe manter a un niño **solo** con leche de la madre, sin darle otro tipo de comida:

   a) hasta los 6 meses — ___ ___

3. A los cuantos meses de edad se le puede empezar a dar otros alimentos al niño.
   A partir de los 6 meses — ___ ___

4. Cuales son los alimentos que se le pueden empezar a dar
   a) papillas — ___ ___
   b) Jugos de fruta — ___ ___
   c) Sopas — ___ ___
   d) frijoles molidos — ___ ___

5. Cuando al niño le empiezan a dar otros alimentos, le siguen dando leche de la madre:

   SI___ NO___

NUTRICION
MONITOREO DE CRECIMIENTO

NIVEL: PROMOTOR RURAL DE SALUD

Nombre de quien llena el instrumento y nivel:_____

Nombre del supervisado: _____

Distrito de Salud _____Fecha de entrevista: _____

Indicaciones: El entrevistado debe de responder a las opciones de cada pregunta correctamente para poder marcar la casilla de "si", si responde incorrectamente o no contesta, marque la casilla de "no".

1. Como hace usted para saber el desarrollo normal de un niño

   A través del monitoreo de crecimiento _____

   NO SABE _____

2. Diga como hace para pesar y medir correctamente a un niño:

   a) le quita los zapatos y la mayor parte de ropa antes de pesarlo. _____

   b) revisa si la pesa esta calibrada _____

   c) coloca al niño en forma recta para medirlo _____

   NO SABE _____

3. Que hace usted cuando un niño que se mantiene en el mismo peso o baja de peso:

   a) Recomendar a la madre dar solo lactancia materna si es menor de 6 meses _____

   b) Identifica si tuvo un cuadro de diarrea, infección respiratoria u otro. _____

   c) lo visita seguido para dar consejería _____

   d) aumentar el número de veces la lactancia si es menor de seis meses _____

   NO SABE _____

FECHA DE INICIO DE CADA INTERVENCIÓN
EN CADA DISTRITO

DISTRITO	PAI	CED	NUTR.INF	SALUD MAT.
Cahabón				
Purulhá				
Coatán				
Zacualpa				

ANNEX D
MATERIALS PREPARED FOR WORKSHOP
SEPTEMBER 10, 1996

Proyecto PASS/CARE

TALLER DE RESULTADOS - EVALUACION FINAL

Martes, 10 de septiembre de 1.996

09:00	Bienvenida y Presentaciones
09:15	Propósitos y Metodología de la Evaluación
09:45	Resultados de la Encuesta Final - Indicadores Claves
10:30	*Receso*
10:45	Hallazgos y Conclusiones Preliminares
12:15	*Almuerzo*
13:30	Elaboración de Recomendaciones:
	Grupo A - Para los Distritos del Proyecto
	Grupo B - Para nuevos proyectos del MSP y CARE
14:30	*Receso*
14:45	Informes y Discusión
16:00	Palabras Finales

INSTRUCTIVOS PARA LOS GRUPOS DE TRABAJO

- *Seleccionar a un(a) facilitador(a) y un(a) relator(a) para cada grupo de trabajo.*

- *Responder a las preguntas respectivas, tomando en cuenta las recomendaciones tentativas del equipo evaluador.*

- *Anotar sus recomendaciones en papelógrafo o en acetatos.*

Grupo A - Recomendaciones para los Distritos del Proyecto PASS

1. Cuales pasos y decisiones deberá tomar la Dirección Distrital de Salud para corregir las deficiencias del proyecto y para consolidar los logros?

2. En el tiempo que le queda (hasta diciembre próximo), que acciones debe tomar CARE para apoyar a la Dirección Distrital de Salud, a las coordinadoras a nivel distrital, y a las comunidades participantes?

Grupo B - Recomendaciones para Nuevos Proyectos del MSP y CARE

1. Dentro del marco actual de la reforma del sector salud, cuales son las necesidades principales del Distrito de Salud para ejercer eficazmente sus funciones?

2. Dentro del mismo marco de reforma, cuales son las necesidades principales de la organización comunitaria para velar por la salud familiar y comunal?

3. En cuanto a nuevos proyectos de asistencia al sector salud, cual sería el papel o rol mas apropiado de una ONG internacional como CARE en su relación al Area y Distrito de Salud y la organización comunitaria?

PROYECTO DE APOYO A LOS SERVICIOS DE SALUD
PASS/CARE

MORBILIDAD Y MORTALIDAD DE NIñOS <3AñOS, DE MADRES 15-45 AñOS

FORTALECER SERVICIOS DE SUPERVIVENCIA INFANTIL

LECCIONES APRENDIDAS DE MCH Y CHO

4 AREAS/ DEPARTAMENTOS
4 DISTRITOS/ MUNICIPIO

ESTRATEGIAS DE SOSTENIBILIDAD
* COORDINACIóN INTERINSTITUCIONAL
* PARTICIPACIóN COMUNITARIA
* PROGRAMACIóN LOCAL

INTERVENCIONES
* INMUNIZACIONES
* CED Y TRO/ SRO
* NUTRICION INFANTIL
* SALUD MATERNA
* IRA
* PREVENCION HIV/ SIDA

36 MESES DE DURACIóN

POBLACIóN CUBIERTA POR PASS/CARE
POR DISTRITO

Distrito	Comunidades	Población	Familias
Cahabón	30	12,674	2,304
Purulhá	30	8,561	1,556
Coatán	18	4,519	822
Zacualpa	8	8,707	1,583
TOTAL	86	34,461	6,265

METODOLOGIA EVALUACIóN

ENCUESTA BASAL
OBJETIVOS
ENCUESTA FINAL
    Indicadores de cada intervención

REVISIóN DOCUMENTAL

TRABAJO DE CAMPO (10 DíAS)
    Entrevistas semi-estructuradas
    Visita a una comunidad por distrito

OBJETIVOS DE LA EVALUACIóN FINAL
PROYECTO PASS/ CARE

Evaluar el impacto, efectividad y sostenibilidad del proyecto

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Cuadro 2.1: Inmunizaciones

LOGROS ANTICIPADOS PARA EL FINAL DEL PLAN DE 16 MESES	LOGROS REALIZADOS
Campañas de inmunización en 102 comunidades reciben apoyo cada dos meses durante todo el período.	6 ó 7 campañas de inmunizaciones han recibido apoyo en cada distrito, cubriendo 103 comunidades.
Mensajes claves a 2,200 familias	3110 madres con por lo menos una sesión de IEC (141% logrado): Cahabón: 1327 San Miguel: 1145 Zacualpa: 150 Purulhá: 488
Mantenimiento de la cadena de frío	Se ha llevado a cabo en los 4 distritos durante cada campaña.
Programación local de las actividades de inmunización en 102 comunidades	Se ha logrado en 68 comunidades (67% logrado): Cahabón: 30 San Miguel: 18 Zacualpa: 10 Purulhá: 10
Censo comunitario en 103 comunidades para el 30 septiembre de 1995	75 censos completados (73% logrado): Cahabón: 30 en agosto 1994, no actualizados en 1995 San Miguel: 18 en junio de 1995 Zacualpa: 2 en julio de 1995 Purulhá: 25 en junio de 1995
Capacitación de promotores sobre la promoción de campañas de inmunización y aplicación de vacunas (por lo menos una en cada comunidad). No hay números especificados	240 promotores con por lo menos 24 horas de capacitación Cahabón: 72 San Miguel: 80 Zacualpa: 28 Purulhá: 60
Incrementos en la cobertura de inmunizaciones en 4 distritos de salud.	La cobertura ha aumentado en los 4 distritos según los datos del MSP

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Cuadro 2.3: Nutrición Infantil

LOGROS ANTICIPADOS PARA EL FINAL DEL PLAN DE 16 MESES	LOGROS REALIZADOS
Capacitación de 275 promotores de salud programada para hacerse en agosto de 1995: -Educación nutricional -Monitoreo del crecimiento -Seguimiento de niños con crecimiento inadecuado -Alimentación durante ablactancia	119 promotores con por lo menos 16 horas de capacitación (43% logrado): San Miguel: 40 Zacualpa: 26 Purulhá: 53 Cahabón: ninguno
Implementación de monitoreo mensual del crecimiento de niños menores de 3 años en 62 comunidades en 4 distritos	10 comunidades en Purulhá han comenzado control del crecimiento mensual (16% logrado)
Mensajes claves para 2,200 familias -Demostración de preparación de alimentos -Ablactancia -Cuidados nutricionales a nivel del hogar para niños con crecimiento inadecuado	265 personas con por lo menos una sesión de IEC (12% logrado): Purulhá: 145 San Miguel: 120
Monitoreo y evaluación -Implementación apropiada del monitoreo del crecimiento -Seguimiento a madres de niños con crecimiento inadecuado -Prácticas de ablactancia -Uso de alimentos locales a nivel del hogar	Extensionistas han iniciado estas actividades en Purulhá

Cuadro 2.5: IRA/IRAI (Control de la Neumonía)

LOGROS ANTICIPADOS POR EL FINAL DEL PLAN DE 16 MESES	LOGROS REALIZADOS
Capacitación de 25 promotores de salud programada para septiembre de 1995: -Manejo estandarizado de casos -Implementación y manejo de centros comunitarios para tratamiento de neumonías	46 promotores con por lo menos 16 horas de capacitación en Purulhá (184% logrado)
Mensajes claves a madres (no se dieron cifras) programado para septiembre a noviembre de 1995: -Prevención de neumonía -Reconocimiento de signos de neumonía	175 personas con por lo menos una sesión de IEC en Purulhá
Monitoreo y evaluación: -Sistema de referencia -Manejo apropiado de casos de neumonía en el centro comunitario -Reconocimiento precoz de signos de neumonía en casa	Todavía no se ha implementado.

Cuadro 2.6: VIH/SIDA

LOGROS ANTICIPADOS PARA EL FINAL DEL PLAN DE 16 MESES	LOGROS REALIZADOS
Encuesta CAP: -Diseño del cuestionario -Recolección de datos -Análisis de datos e informe programados para terminarse en julio de 1995	Se realizaron discusiones de grupos focales sobre CAPs en 6 comunidades en Zacualpa. En este momento el borrador del informe sobre el Estudio de CAPs está en revisión.
Capacitación para promotores de salud, colaboradores y maestros programada para julio y agosto de 1995	No se ha implementado todavía
Sesiones de IEC para obreros migrantes programadas para agosto y septiembre de 1995, y otra vez en 1996 -comportamientos de riesgo -prácticas seguras	No se ha implementado todavía
Monitoreo y evaluación programado para agosto y septiembre de 1995 y otra vez en 1996 -adopción y conocimiento de prácticas seguras	No se ha implementado todavía

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Cuadro 3.1
Inmunizaciones

LOGROS ALCANZADOS EVALUACIÓN DE MEDIO TIEMPO	LOGROS ALCANZADOS EVALUACION FINAL
6 ó 7 campañas de inmunizaciones han recibido apoyo en cada distrito cubriendo 103 comunidades	De enero a agosto de 1996 han habido jornadas de inmunización en todos los distritos así: Cahabón - 6 Purulhá - 3 Coatán - 4 Zacualpa - 2
3110 madres con por lo menos una sesión de IEC (141% logrado) Cahabón - 1327 Purulhá - 488 San Miguel - 1146 Zacualpa - 150	80% madres capacitadas Cahabón - 1843 Purulhá - 1245 Coatán - 658 Zacualpa -1266
Mantenimiento de la cadena de frío	Se ha llevado a cabo en los 4 distritos durante cada jornada
Programación local se ha logrado en 68 comunidades	Programación local se ha logrado en 86 comunidades; PRSs han comenzado a vacunar
75 (73%) censos completados	Censos completados en 86 comunidades (no actualizado en las de Zacualpa)
240 promotores con por lo menos 24 horas de capacitación Cahabón - 72 Purulhá - 60 San Miguel - 80 Zacualpa - 28	192 promotores capacitados Cahabón - 72 Purulhá - 57 Coatán - 35 Zacualpa - 28
Incrementos en la cobertura de inmunizaciones en 4 distritos de salud	La cobertura ha aumentado en los 4 distritos según datos de PRSs, servicios de salud y encuesta final

Cuadro 3.2
CED y TRO

LOGROS ALCANZADOS EVALUACION DE MEDIO TIEMPO	LOGROS ALCANZADOS EVALUACION FINAL
247 promotores con por lo menos 16 horas de capacitación Cahabón - 72 Purulhá - 67 San Miguel - 80 Zacualpa - 28	192 promotores capacitados Cahabón - 72 Purulhá - 57 Coatán - 35 Zacualpa - 28
20 UCROs implementadas Cahabón - 10 Purulhá - 10 San Miguel - ninguna Zacualpa - ninguna	65 UROCs implementadas Cahabón - 21 Purulhá - 19 Coatán - 15 Zacualpa - 10
1670 personas con por lo menos una sesión de IEC Cahabón - 1025 Purulhá - 395 San Miguel - 150 Zacualpa - 100	70% madres capacitadas Cahabón - 1613 Purulhá - 1089 Coatán - 575 Zacualpa - 1108
Cahabón: visitas domiciliaria evaluar cambio en CAP madres Purulhá: PRSs dan SRO, seguimiento casos, manejan UROCs San Miguel : Ninguna actividad Zacualpa: Ninguna actividad	Cahabón: recorridos comunales cada mes o 2 meses Purulhá: logros se mantienen Coatán: En 15 comunidades PRS dan SRO y registran casos Zacualpa: En 10 comunidades PRSs dan SRO y registran casos

Cuadro 3.3
Nutrición Infantil

LOGROS ALCANZADOS EVALUACION DE MEDIO TIEMPO	LOGROS ALCANZADOS EVALUACIÓN FINAL
119 promotores con por lo menos 16 horas de capacitación (43% logrado) Cahabón - ninguno Purulhá - 53 San Miguel - 40 Zacualpa - 26	118 promotores capacitados Cahabón - ninguno Purulhá - 57 Coatán - 35 Zacualpa - 26
10 comunidades en Purulhá han comenzado control del crecimiento mensual	25 comunidades con control de crecimiento mensual Purulhá - 18 Zacualpa - 7
265 personas con por lo menos una sesión de IEC (12% logrado) Purulhá - 145 San Miguel - 120	30% madres capacitadas Cahabón - 691 Purulhá - 467 Coatán - 247 Zacualpa - 475
Extensionistas han iniciado actividades de monitoreo y evaluación en Purulhá	Purulhá - se han implementado actividades de monitoreo en 18 comunidades

Cuadro 3.4
Salud Materna

LOGROS ALCANZADOS EVALUACIÓN MEDIO TIEMPO	LOGROS ALCANZADOS EVALUACIÓN FINAL
236-259 comadronas con por lo menos 16 horas de capacitación (163-179% logrado) Cahabón - 25 Purulhá - 41 ó 45 (dependiendo de la actividad) San Miguel - 130 ó 135 (no se sabe cifra exacta) Zacualpa - 40 ó 45 no se sabe cifra exacta	163 comadronas capacitadas Cahabón - 25 (1 capacitación en 1996) Purulhá - 40 Coatán - 30 Zacualpa - 68 una capacitación después de evaluación medio tiempo
555 personas con por lo menos una sesión de IEC (222% logrado) Cahabón - 150 Purulhá - 145 San Miguel - 260 Zacualpa - Ninguna actividad	? madres capacitadas Cahabón - Purulhá - (>50% embarazadas) Coatán - Zacualpa - (Difícil saber porque comadronas dan información individualmente a embarazadas)
	Aplicación del TT a nivel comunidad en: Cahabón Purulhá Zacualpa (en 4 comunidades los PRSs la aplican)
El monitoreo y evaluación sólo está implementado en Purulhá donde hay sistema de información local: comadrona registra número de embarazos y partos	Purulhá - logros se mantienen

RAZONES POR FALTA DE EXITO EN INDICADORES

1. Ninguna intervención (excepto inmunizaciones) en el primer año del proyecto. Prioridad a CMSs.

2. Segundo año dedicado a formación y capacitación de RCS.

3. Tercer año implementación de intervenciones en forma secuencial. Algunas intervenciones reducidas o eliminadas.

4. Otras explicaciones específicas a algunos indicadores.

Cuadro 4.1
Factores que Afectaron el Avance y Logros del Proyecto
en Cahabón, Alta Verapaz

FACILITADORES	LIMITANTES
* Participación inicial de CMS	
* Participación y organización comunitaria: algunos Comités de Cólera se transformaron en CLS; comunidades menos accesibles participaron más	* Difícil acceso a las comunidades (extensionistas)
* Experiencia previa con las UDRIs	
* Experiencia previa con botiquines de medicinas en las UDRIs	
* Aceptación y apoyo moderado del MSP	* Inicialmente ambiente hostil en los servicios de salud; el TSR no participó, obstaculizó creando divisiones entre PRSs "antiguos" y PRSs de PASS/CARE

Cuadro 4.2
Factores que Afectaron el Avance y Logros del Proyecto
en Purulhá, Baja Verapaz

FACILITADORES	LIMITANTES
* Participación y organización comunitaria	
* Alto grado de aceptación y apoyo del MSP; apropiación de la metodología del proyecto y logros por el JdeD y personal	* Pocas ONGs sin experiencia en coordinar; sólo coordinaron con MSP
* Extensionistas habían trabajado antes en CHO con experiencia en monitoreo de crecimiento y comprensión de necesidad de coordinar con MSP	
* Buena supervisión y apoyo del nivel gerencial	
* Características de la asistente de campo: habla idioma local; proactiva en buscar retroalimentación	

Cuadro 4.3
Factores que Afectaron el Avance y Logros del Proyecto
en San Sebastián Coatán, Huehuetenango

FACILITADORES	LIMITANTES
* Organización y participación comunitaria incipiente	* Inaccesibilidad (distancias grandes y caminos muy malos especialmente durante estación lluviosa) * Violencia y conflicto en el pasado reciente (las personas son desconfiadas) * Divisionismo en las comunidades por motivos religiosos y otros * Emigración principalmente a los EE.UU.
* Aceptación y apoyo por el Auxiliar de Enf. de la localidad en un Puesto de Salud (San José); apoyo de un TSR	* Falta de aceptación y apoyo del MSP; cambio de sitio de trabajo (de San Miguel Acatán a San Sebastián Coatán y luego a San José/ PN/ J) * Mala comunicación inicial creando falsas expectativas en diferentes actores * Falta de conocimiientos y experiencia en esta área geográfica y socio-cultural * Insuficiente personal PASS * Cambios en el personal PASS y reorganización constante * Falta de supervisión del nivel gerencial hasta las comunidades mismas * Características del personal: ninguno habla idioma local; sentimiento de estar solos y ser considerados menos importantes que el personal de otras áreas; comparaciones con otras áreas

Cuadro 4.4
Factores que Afectaron el Avance y Logros del Proyecto
en Zacualpa, Quiché

FACILITADORES	LIMITANTES
* Participación comunitaria se ha iniciado en algunas comunidades	* Migración interna estacional a la Costa Sur; emigración a los EE.UU. * Efectos de la violencia y conflicto del pasado reciente (las personas no quieren trabajar con instituciones; mala experiencia con calidad de atención en el CdeS)
* El actual JdeD da apoyo al proyecto	* Cambio de médicos JdeD (3 durante la duración del proyecto) * Baja aceptación y apoyo de los servicios de salud
* Los extensionistas actuales hablan el idioma local	* Cambios en el personal de PASS

CALIDAD DE LA ATENCIóN

NOTA DE PRECAUCIóN: muchos elementos, difícil de evaluar en una visita

INMUNIZACIONES - Buena calidad: cadena de frío, termos en la comunidad, CLS involucrado, no se han reportado problemas.

CED/ SRO/ UROCs - Aunque limitadas, las SRO están accesibles, más de la mitad de comunidades con UROCs, las madres conocen SRO aunque no necesariamente las usan, conocen ingredientes del suero casero, pero no la receta exacta.

NUTRICIóN - en Purulhá y Zacualpa madres llevan a los niños a pesar, interés en conocer estado de niño, comprenden y explican razones cuando peso sube o baja, pero no pueden "leer" la gráfica

SALUD MATERNA - las pocas comadronas entrevistadas mencionaron señales de peligro durante parto (posición transversa y parto prolongado), recibieron y les gustaron materiales; difícil saber si prácticas han cambiado. Situación especial en Alta Verapaz, donde hace falta identificar oportunidades.

IRA - sólo el personal del MSP fue capacitado, no a nivel de comunidades, intervención ligada a botiquines. Preguntas hechas sobre medicinas en los botiquines visitados en Alta Verapaz fueron respondidas correctamente.

COMUNICACION DE MENSAJES CLAVES - falta mejorar, PRSs no tienen a mano Guía Metodológicas ni es claro que siempre usen esa metodología participativa sino comunicación en una vía y en una misma sesión educativa mezcla de numerosos mensajes.

FUENTES DE TENSIóN CON MSP

* Observadores (bien pagados) no llamados ni deseados

* Programación responde a prioridades no es fácil modificarla

* Conflictos entre promotores antiguos y nuevos

* Proyecto participativo que ya tiene objetivos y planes definidos; de apoyo pero que pide apoyo

* Acuerdos con JdeA, pero no discutidos con distritos, nivel donde se ejecutan

APOYO DEL MSP

* Espacio físico en los servicios de salud
* Facilitadores y traductores para las capacitaciones
* Vacunas y sobres de SRO
* Participación directa de su personal

APOYO DE PASS/ CARE

* Financiero
* Recursos humanos
* Capacitaciones
* Materiales

LECCIONES APRENDIDAS 1

1. Intervenciones específicas

* Inmunizaciones quizás más fácil; aceptada con personal comunitario

* Demás intervenciones mejor aceptadas con personal comunitario

* Provisión de servicios básicos a nivel comunitaria mejor aceptada en comunidades alejadas; ahorran tiempo, esfuerzo y dinero

LECCIONES APRENDIDAS 2

2. Sostenibilidad

* Participación comunitaria es crítica - concepto y operacionalizacion de RCS buena estrategia

* CMS es difícil por muchas razones; percepción de proyecto "sectorial"; quizás demasiado tiempo gastado en lograrlas

* Coordinación con el MSP es crítica, pero difícil por muchas razones

* Cambios de autoridades, personal del proyecto y personal del MSP afectan tiempos y progreso de un proyecto

* Proyecto en áreas diversas (geográfica y socio-culturalmente) requieren flexibilidad en muchos aspectos.

LECCIONES APRENDIDAS 3

3. Presupuesto

* Adecuado para proyecto de asistencia técnica y no de ejecución directa por CARE

* Hubo reducción de costos al compartir capacitación

EFECTOS POSITIVOS NO ANTICIPADOS

* Capacitación descentralizada

* Costos de capacitaciones compartidos (recursos humanos y materiales)

* Colaboradoras de PRSs

* Coordinador(a) de PRSs

* Organización de promotores: Juntas directivas de PRSs, Junta Central de Medicamentos

* Información recolectada a nivel local

* Vacunación a nivel local

* Recuperación de costos a nivel local

* Capacitación a CLS en letrinizacion y otros aspectos de saneamiento

* Interés en el modelo de atención por un finquero

EFECTOS NEGATIVOS NO ANTICIPADOS

* Conflictos entre promotores antiguos y promotores PASS

* Demandas de diferentes agencias/ organizaciones internacionales

* Conflictos con ONGs

* Muy pocas mujeres en el proyecto (algunas en Purulhá)

Sostenibilidad del Proyecto
(documentos, entrevistas)

1. Comunidad

- Fortalecimiento de lás redes de cooperación comunitaria en apoyo a intervenciones locales de interés

- Ubicación estratégica de corrdinador de PRSs en zona geográfica en apoyo y seguimiento a las actividades de PRS

- Manejo adecuado del fondo revolvente y abastecimiento del botiquín comunitario

- Pago simbólico a PRS por vacunación, control de crecimiento y atención de morbilidad a través de usuarios de servicios

- Actividades comunitarias internas para captación de fondos de apoyo al CLS

- Legalización y reconocimiento de las instancias locales para el desarrollo de sus actividades

- Definición de plan de trabajo comunitario elaborado a nivel local

- Existencia de recurso humano voluntario capacitado y participando; deseo de continuar

- CLS gestionará y/o gerenciará recursos de apoyo al proceso

- Comunidad apoyando al recurso humano del MSP dándole alimentación y combustible para su mobilización

2. ONGs

- Médicos del Mundo darán asistencia técnica a PRSs en Cahabón (1997)

3. MSP y OGs

- MSP apoyará con vacunas y SRO

- MSP dará seguimiento con base en información mensual comunitaria

- Acuerdos entre MSP y comunidad para sostener intervenciones locales de mutuo interés

- MSP dará asistencia técnica a PRSs y CATs y mantener enlace con los coordinadores

- MSP designará miembro de personal por sector, responsable de seguimiento (Purulhá)

- INACOP dará seguimiento a Junta Central de Medicamentos y

botiquines (Cahabón)

Cuadro 5.1

Medidas Tomadas para Promover Sostenibilidad de las Actividades de Sobrevivencia Infantil

Después de que Termine el Financiamiento

OBJETIVOS*	OBJETIVOS PARA FINAL DEL PROYECTO*	PASOS SEGUIDAS HASTA LA FECHA	MEDIDAS DE MEDIO TIEMPO	PASOS PENDIENTES
1)Implementar y dejar funcionando una comunidad mejor preparada para monitorear indicadores claves para salud infantil, identificar necesidades de salud e iniciar proyectos para atender esas necesidades. 2)La comunidad también tendrá experiencia en trabajar colaborativamente con el MSP y ONGs locales para asegurar que se están atendiendo las necesidades de salud y que los problemas y obstáculos se resuelven adecuadamente. 3)A nivel distrital del MSP el personal de salud tendrá mayor capacitación para habilidades relacionadas al manejo de casos de diarrea y IRAI y la capacidad de monitorear los indicadores claves de salud infantil para identificar las necesidades y obstáculos para la programación de actividades de salud. Un sistema estará funcionando para manejar y apoyar a los promotores de salud y otros trabajadores voluntarios que funcionan a nivel de la comunidad. 4)A nivel local, el personal de ONGs habrá mejorado sus capacidades institucionales, sus habilidades para planificación en salud y su relación colaborativa con el MSP y las comunidades para que las necesidades prioritarias de salud estén atendidas.	Cada comunidad participando en el proyecto tendrá una organización capaz de apoyar intervenciones de sobrevivencia infantil y otros proyectos de desarrollo. Cada promotor de salud activo tendrá un botiquín comunitario con un fondo rotativo bajo su responsabilidad para generar fondos para apoyar su trabajo. 4 personas del equipo distrital del MSP tendrán mayores habilidades para la administración y supervisión de un sistema de promotores de salud en el área del proyecto. 10 ONGs locales tendrán mayores en su capacidad institucional para planificación, implementación, monitoreo y evaluación de las intervenciones de sobrevivencia infantil.	Se agregó un grupo adicional para acciones de sostenibilidad: Los CMS. Los CMS fueron expuestos a la metodología de la planificación estratégica durante talleres realizados para desarrollar sus planes operacionales de distrito. Los CMS recibieron capacitación en el desarrollo de guías metodológicas. Los 4 distritos de salud del MSP recibieron orientación en el uso de planificación estratégica durante el desarrollo de planes operacionales. Algunos CSs están proporcionando apoyo al promotor para planificación, especialmente para inmunización y están aprendiendo a la vez. El sistema de información aún no se ha implementado. Todos los representantes de los comités de salud de los 4 distritos han participado en las actividades de capacitación con respecto a funciones y estructura del comité. Se han iniciado negociaciones en Colombia para implementar un botiquín comunitario En las comunidades donde se han implementado UCROs, su población proporcionó ayuda financiera voluntaria para apoyarlo. Redes de cooperación social están formadas y activas en algunas comunidades.	Ver comentarios en la siguiente página.	1) El desarrollo de herramientas para monitorear la implementación de los planes operacionales. Esto debe permitir la identificación de necesidades para asistencia técnica. 2) Fortalecimiento de los siguientes aspectos: manejo del proyecto, programación de las actividades de las intervenciones, monitoreo y supervisión de actividades y personal, evaluación del proyecto. 3) Capacitación en desarrollo, manejo y utilización del SLIS. 4) Implementar un SLIS. 5) Diseñar e implementar estudios de factibilidad para implementar mecanismos de recuperación de costos. 6) Capacitación en análisis de costos, manejo de intervenciones, preparación de presupuestos, y manejo financiero y administrativo de proyectos para todas las contrapartes. 7) Incluir los CMSs en la planificación de capacitación de trabajadores comunitarios de salud y CS y en la capacitación misma. 8) Capacitación de todas las contrapartes en monitoreo, supervisión y seguimiento de las actividades de las intervenciones y manejo de personal. Desarrollar un sistema de SMS para el nivel comunitario. 9) Capacitación en control de calidad para las intervenciones de sobrevivencia infantil para todas las contrapartes. 10) Capacitación en administración de recursos humanos y planificación para todas las contrapartes.

*PDI, Sección D (Estrategia de sostenibilidad)

BEST AVAILABLE COPY

OBJETIVOS DEL PROYECTO PARA PROMOVER SOSTENIBILIDAD

OBJETIVOS AL FINAL DEL PROYECTO (EVALUACIÓN MEDIO TIEMPO)	PASOS DADOS HASTA LA FECHA	PASOS PENDIENTES DEL PROYECTO
1. Cada comunidad participando en el proyecto tendrá una organización capaz de apoyar intervenciones de sobrevivencia infantil y otros proyectos de desarrollo.	1. Elaboración de diagnósticos participativos comunitarios. Capacitación de voluntarios voluntarios CAT y PRS. Formación y capacitación de comités locales de salud. Aprovechamiento de organización interna y experiencias previas comunitarias (comités, UDRIs, PRS). Apertura del canal de comunicación, comunidad y servicios de salud del MSP. Crear conciencia de sostenibilidad a nivel comunitario, con inicio de la misma. Inicio de elaboración de planes comunitarios enfocados a sostenibilidad local. Identificación de líneas de intervención prioritarias de atención desde el nivel comunitario para la sostenibilidad.	1. Identificación de mecanismos alternativos de sostenibilidad a ser propuestos a nivel comunitario. Aprovechamiento de la consultoría sobre sostenibilidad hecha para PASS, con el mismo propósito.
2. Cada promotor de Salud, activo tendrá un botiquín comunitario con un fondo rotativo bajo su responsabilidad, para generar fondos para apoyar su trabajo.	2. PRS han iniciado vacunación a nivel de su comunidad. Implementaron de UROC/casas mínimas de salud (65) y botiquines comunitarios (13). Conformación de comité central/junta central de medicamentos como punto de apoyo a la estructura de sostenibilidad. Creación de las figuras de coordinador de PRS y colaboradores de PRS. Control de crecimiento (con gráficas) por personal voluntario a nivel comunidad. Participación de madres a realizar actividades específicas como charlas, vacunación, control de crecimiento y desarrollo	2. Fortalecer conocimientos de PRS y coordinador de PRS, con mayor énfasis a las líneas de intervención priorizadas por la comunidad; proveer material recordatorio. Proveer de botiquines a las comunidades PASS, prinicpalmente a aquellos que ya cuentan con el aporte local. Proveer texto de consulta para coordinador de PRS sobre medicamentos. Capacitar a coordinador y PRS sobre uso de recursos con que cuenta el botiquín comunitario. Capacitar al comité y PRS sobre aspectos administrativos y financieros para manejo del botiquín y el fondo revolvente. Definir y montar la estructura gerencial para el control y abastecimiento de medicamentos de los botiquines comunitarios. Completar equipo a PRS y CAT que aún no cuentan con él.
3. Cuatro personas del equipo distrital del MSP tendrán mejores habilidades para la administración y supervisión de un sistema de promotores de salud en el área del proyecto.	3. Capacitación de recursos humanos del MSP Y OGs. Contar con apoyo parcial del MSP para el proyecto.	3. Establecer mecanismos claros, consensuados, precisos y factibles para efectuar la transferencia del proyecto hacia la responsabilidad del MSP. Sistematizar el SIC, de forma simplificada para hacerlo sostenible
4. Diez ONGs locales tendrán mejoras en su capacidad institucional para planificación, Implementación, monitoreo y evaluación de las intervenciones de sobrevivencia infantil.	4. Conformación de CMS/UTM. Limitados intentos de coordinación con ONG, no satisfactorios.	4. Acuerdo con una ONG (Cahabón)

RECOMENDACIONES

A corto plazo (hasta diciembre de 1996)

CARE

* Capacitación a los PRSs que faltan; materiales, botiquines, carnet

* Capacitación y materiales a comadronas que faltan

* Enviar un listado de todo el personal voluntario capacitado a nivel superior del MSP para su reconocimiento oficial y para su seguimiento por personal apropiado

* Completar planes de sostenibilidad con comunidades de 4 distritos

* Terminar de definir estructura de abastecimiento y distribución de medicamentos para botiquines

* Transferencia de actividades y materiales del proyecto al MSP

MSP

* Identificar persona para dar seguimiento a actividades del proyecto

RECOMENDACIONES

A largo plazo

CARE

* Proyectos con dos elementos críticos: participación comunitaria y coordinación con el MSP

* Definir precisamente criterios de selección de comunidades

* Sensibilidad en relaciones con el MSP

* Buscar coordinación con otras instituciones, pero no gastar tanto tiempo en ella; coordinar dentro de sector específico

* Fortalecer estrategia de IEC

* Identificar e implementar estrategias para participación de mujeres

* Que nuevos proyectos trabajen en comunidades de PASS/CARE para dar seguimiento

* Fortalecer proceso de inducción de todo nuevo personal

* Monitoreo y evaluación de la calidad de la atención

MSP

* Acuerdos entre MSP y comunidades para sostener intervenciones de mutuo interés

* Discutir con comunidades distintas opciones para financiar y manejar intervenciones

* Mantener seguimiento capacitante a comadronas y PRSs y comités

* Monitoreo y evaluación de la calidad de la atención

ANNEX E
HEALTH INFORMATION SYSTEM

Cuadro de Información mensual por comunidad del Area de Rivacó

Extensionista _____ Período del _____ al _____

ACTIVIDAD	ALIRA	RIVACO	OLIMPIA	[illegible]	SACSAMAN	PALAUTE	[illegible]	PANCALA	PANCIT	[illegible]	[illegible]	[illegible]
INMUNIZACION												
# vacunadores activos												
# madres que particip. en sesiones educ. de PAI												
# niños participantes en el PAI:												
DPT 1ra.												
2da.												
3ra.												
Polio 1ra.												
2da.												
3ra.												
BCG (única)												
Sarampión (única)												
Embarazadas con TT												
1ra.												
2da.												
NUTRICION												
# niños en monitoreo de crecimiento												
# niños que aumentaron peso												
# madres que particip. en sesiones educ. s/nutrición												
# madres que recibieron consejería individualizada												
DIARREA/TRO												
# UROC funcionando												
# madres participando en sesiones educ. s/diarrea												
# Casos atendidos en la UROC												
# casos referidos												
IRA												
# Centros de IRA funcionando												
# Casos atendidos												
# Casos referidos												
# madres que han asistido a sesiones educ. s/IRA												
CUIDADO MATERNO												
# comadronas activas												
# madres que asistieron a ctrl. prenatal												
# partos atendidos por comadronas capacitadas												

ANNEX F
EVALUATORS' CURRICULA

CURRICULUM VITAE : ELENA HURTADO

PROFESSIONAL EXPERIENCE

From 1979 to the present, working in medical and nutritional anthropology research; qualitative research applied to mother-child and women's health and nutrition service delivery; and health and nutrition education and social communication. In the past 4 years, consultant experience in international public health with numerous short term assignments in Latin America, working with government, non government, and donors organizations in monitoring and supervision design, applied qualitative research, social communication programs, and evaluations

CAPABILITIES AND SKILLS

Qualitative Research: qualitative designs, qualitative methods of data collection, rapid assessment of procedures (RAP, RRA, PRA), qualitative analysis, interpretation and reporting.

Project Design, Monitoring and Evaluation: project design, proposal development, data needs, protocol design, process and impact assessment, qualitative evaluation.

Social Communication/ Social Marketing: formative research, qualitative and behavior analysis, behavior trials, product and materials protesting, social communication planning and design, monitoring and evaluation.

Language and Computer Skills: Spanish native, English fluency, some French and Tzutuhil (Mayan language), WordPerfect, The Ethnograph, Anthropac, Gofer, Epi Info, Harvard Graphics.

FORMAL EDUCATION

Master of Public Health (1978): Community and International Health, University of California Los Angeles, School of Public Health.

Bachelor of Science (1974): Psychology and Anthropology, Tulane University, New Orleans, Louisiana.

AFFILIATIONS

Delta Omega Membership, Honorary Public Health Society,
University of California, Los Angeles, June 1987
American Anthropoligical Association, member 1990 to present

Guatemalan Scholars Network, member 1990 to present

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EMPLOYMENT SUMMARY

Jul 92 - Present	Independent Consultant
Jan 86 - Jun 92	Researcher, Coordinator of Applied Anthropology Component, Instate of Nutrition of Central America and Panama (INCAP)
Jul 84 - Dec 85	Researcher, Division of Food and Nutrition Planning, Institute of Nutrition of Central America and Panama (INCAP)
Jul 82 - Jun 84	Independent Consultant
Jan 81 - Jun 82	Division of Human Resources, Ministry of Public Health Guatemala
Apr 79 - Dec 80	Research Associate, Division of Human Development, Institute of Nutrition of Central America and Panama (INCAP)
Jul 78 - Mar 79	Independent Consultant
Sep 76 - Jun 78	Research Assistant, Institute for Social Science Research, UCLA
Sep 74 - May 76	Research Assistant, Division of Human Development, Institute of Nutrition of Central America and Panama (INCAP)

SHORT TERM ASSIGNMENTS

Clients: Two Ministries of Health; non- government organizations in Guatemala: AGROSALUD, APROFAM, CARE, HOPE, International Eye Foundation, Project Concern/Rxxin Tnamet USAID contracting agencies: John Snow, Inc. (for MotherCare and OMNI Projects) and Partnership for Child Health Care, Inc. (for BASICS Project); Population Council: Manoff Group, Inc; Academic Institutions: Johns Hopkins University, London School of Hygiene and Tropical Medicine, McGill University, Cal Poly State University, RAND Corporation; World Health Organization; Pan American Health Organization; USAID; the World Bank, the Interamerican Development Bank.

Countries: Belize, Chile, Colombia, Cuba, Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, Nicaragua, Costa Rica, Peru, Venezuela.

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CURRICULUM VITAE

DATOS GENERALES:

NOMBRE: Carlos Américo López Gutiérrez

FECHA DE NACIMIENTO: 12 de diciembre de 1953

LUGAR DE NACIMIENTO: Antigua Guatemala, Sacatepéquez

EDAD: 37 años

ESTADO CIVIL: Soltero

CEDULA DE VECINDAD: Reg. B-2 ORDEN 19456

ESTUDIOS REALIZADOS:

- Maestro de Educación Primaria Urbana
  Instituto Normal para Varones "Antonio Larrazábal"
  Antigua Guatemala, Sacatepéquez
- Médico y Cirujano. Colegiado Activo No.4873
  Facultad de Ciencias Médicas, Universidad de San Carlos de Guatemala, 1982.
- Curso de Salud Pública Básica con énfasis en Administración M.S.P. y A.S. Instituto Nacional de Adiestramiento de Personal en Salud. INDAPS.
  Quiriguá, Los Amates, Izabal. Mayo 1985
- Seminario Taller de Supervisión
  Unidad de Supervisión y Coordinación de Areas de Salud.
  Unidad Panamericana de la Salud PASCAP.
  Quiriguá, Los Amates Izabal, septiembre 1985.
- Taller; "Metodología para la investigación Epidemiológica Operacional y Clínica, con ejemplos en el area Perinatal Y Materno Infantil.
  Centro Latinoamericano de Perinatología y Desarrollo Humano O.P.S., O.M.S..-
  Montevideo, Uruguay, noviembre de 1987.
- Seminario Taller sobre la Aplicación del Modelo de Investigación.
  Ministerio de Salud Pública y Asistencia Social, DGSS, División de Recursos Humanos, O.P.S., PASCAP.
- Seminario Nacional sobre la Convención Internacional de Los Derechos del Niño.
  UNICEF, CONANI.
  Panajachel, noviembre de 1989.
- I Seminario ICOMOS- Guatemala, "Problemática del Patrimonio Cultural y el Desarrollo del Turismo.
  ICOMOS Guatemala, Antigua Guatemala, marzo 1991.
- Posgrado en Gestión de Salud MSP y AS, OPS, INAP, Guatemala junio de 1995.

CARGOS DESEMPEÑADOS

- Médico de Salud Pública
  Centro de Salud de Cahabón, A.V.
  24 de enero al 30 de junio de 1984
- Monitor de Area de Salud de A.V. y Coordinador del proyecto de Unidades de Desarrollo Rural Integral, UDRI.
  julio 1984 a enero de 1986
- Jefe de Area de Salud de Alta Verapaz
  febrero 1986 a marzo de 1988
- Monitor de Area de Salud de Alta Verapaz
  abril a agosto de 1988
- Jefe Departamental del Ministerio de Desarrollo Urbano y Rural.
  septiembre de 1988 a marzo 1989
- Director del Centro de Salud de Senahú, A.V.
  abril 1989 a agosto 1989
- Asistente de la Presidencia del Consejo de Desarrollo Urbano y Rural, Región Norte. Coordinador del Programa Regional de Turismo, de septiembre 1989 a junio 1991
- Jefe de Area de Salud de Alta Verapaz, interino de julio 1991 a enero de 1992
- Director del Programa Médico de la Fundación Guatemalteca para el Desarrollo "Carroll Behrhorst" Chimaltenango de febrero a mayo de 1992
- Jefe de Area de Salud de Baja Verapaz junio 1992 hasta la fecha.

OTRAS ACTIVIDADES IMPORTANTES

- Representante-Guatemala en el Taller de Integración de Malaria a servicios de salud de Centro América y México (OPS), Nicaragua julio de 1991
- Representante-Guatemala en el Taller sobre Educación Sanitaria y Ambiental, UNICEF, Panamá abril de 1994
- Representante-Guatemala en el Seminario de OPS sobre La Iniciativa ONG-Gobierno, Washington, marzo de 1996
- Servicio de Consultoría CARE/Guatemala referente al Proyecto de Supervivencia Infantil septiembre/octubre/1993.
- Servicio de Consultoría CARE/Guatemala para el proyecto de Producción Agropecuaria y Nutrición Familiar octubre/noviembre 1994.

Dr. Carlos Américo López Gutiérrez

ANNEX G
COUNTRY PROJECT PIPELINE ANALYSIS

SECTION V

PVO/COUNTRY. GUATEMALA
Cooperative Agreement No.: #FAO-0500-A-00-3023-00
DATE SUBMITTED TO USAID. NOVEMBER 7, 1994

1996 COUNTRY PROJECT PIPELINE ANALYSIS: PART B – COUNTRY BUDGET

(PAGE 1 OF 1)

		Actual Expenditures to Date (01/10/93 to 30/09/96)			Projected Expenditures Against Remaining Obligated funds (01/08/96 to 30/09/96)			Total Agreement Budget (Columns 1 & 2) (01/10/93 to 30/09/96)		
DIRECT COSTS		AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters–salaries/wages	92,661	11,585	104,246	(39,923)	0	(39,923)	52,738	67,262	120,000
	2. Field, Technical Personnel–salaries/wages	264,366	105,353	369,719	(7,387)	0	(7,387)	256,979	18,421	275,400
	3. Field, other personnel–salaries/wages				0 0					
	4. Fringes – Headquarters + Fiel	76,805	44,400	121,205	12,404	0	12,404	89,209	29,934	119,143
	SUBTOTAL – PERSONNEL	433,832	161,338	595,170	(34,906)	0	(34,906)	398,926	115,617	514,543
B. TRAVEL/PER DIEM	1. Headquarters–Domestic (USA)				0		0			
	2. Headquarters – International				4,000		4,000	4,000	0	4,000
	3. Field in country	50,714	19,105	69,819	(13,288)	0	(13,288)	37,426	27,024	64,450
	4. Field – International				0		0			
	SUBTOTAL–TRAVEL/PER DIE	50,714	19,105	69,819	(9,288)	0	(9,288)	41,426	27,024	68,450
C. CONSULTANCIES	1. Evaluation Consultants–Fees		16,004	16,004	15,664	0	15,664	15,664	10,556	26,220
	2. Other Consultants–Fees	12,441	21,179	33,620	892	0	892	13,333	1,667	15,000
	3. Consultants travel/per diem				0		0	0	0	0
	SUBTOTAL – CONSULTANCI	12,441	37,183	49,624	16,556	0	16,556	28,997	12,223	41,220
D. PROCUREMENT (provide justification/ explanation in narrative)	1. Supplies				0					
	a. Headquarters				0					
	b. Field–Pharmaceutics's (ORS, VIT A, drugs etc.				0 0					
	c. Field – Other	9,665	5,908	15,573	16,167	0	16,167	25,832	27,222	53,054
	2. Equipment				0					
	a. Headquarters				0					
	b. Field	45,406	57,028	102,434	(9,406)	0	(9,406)	36,000	909	36,909
	3. Training				0					
	a. Headquarters			0	0					
	b. Field	7,281	8,515	15,796	12,792	0	12,792	20,073	0	20,073
	SUBTOTAL – PROCUREMEN	62,352	71,451	133,803	19,553	0	19,553	81,905	28,131	110,036
E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1. Communications				0					
	a. Headquarters				0					
	b. Field	4,721	1,312	6,033	(3,068)	0	(3,068)	1,653	1,147	2,800
	2. Facilities				0					
	a. Headquarters				0					
	b. Field				0		0	0	0	0
	3. Other				0					
	a. Headquarters				0					
	b. Field	53,484	54,089	107,573	(10,134)	0	(10,134)	43,350	35,836	79,186
	SUBTOTAL – OTHER DIRECT	58,205	55,401	113,606	(13,202)	0	(13,202)	45,003	36,983	81,986
TOTAL – DIRECT COSTS		617,544	344,478	962,022	(21,307)	0	(21,307)	596,237	219,978	816,215
II. INDIRECT COSTS										
A. INDIRECT COSTS	a. Headquarters	52,479		52,479	(1,963)	0	(1,963)	50,516	16,719	67,235
	b. Field (if applicable)				0					
TOTAL – INDIRECT COSTS		52,479	0	52,479	(1,963)	0	(1,963)	50,516	0	50,516
B. AIDS Latin American Workshop		39,976		39,976	23,272		23,272	63,248	219,978	283,226
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		710,000	344,478	1,054,478	1	0	1	710,001	236,697	946,698

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Prepared By: Esthela M. Sosa, Financial Assistant

Approved By: Sumana Brahman, Sector Coordinator

Revised By: Patty de la Cruz, Chief Accounting

TOTAL PROJECT

BEST AVAILABLE COPY

ANNEX H
FINAL EVALUATION SURVEY
(SEPARATE)

CARE
GUATEMALA

ANNEX H
FINAL EVALUATION SURVEY

CARE GUATEMALA

HEALTH SERVICES SUPPORT PROJECT
(Child Survival IX)

Proyecto de Apoyo
a Los Servicios de Salud (PASS)

Final Study of Knowledge, Practices and Coverage (KPC) in Four Health Districts

Guatemala, July 1996

James N Becht, MPH
Regional Technical Advisor
CARE Latin America

Guatemala, October 1996

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARI	acute respiratory infections
ALRI	acute lower respiratory infections
BCG	anti tuberculosis vaccine
CDC	U.S. Centers for Disease Control and Prevention
CDD	control of diarrheal diseases
CS	child survival
CSSP	PVO Child Survival Support Program
DIP	detailed implementation plan
DPT	diphtheria, pertussis, tetanus (vaccine)
EBF	exclusive breastfeeding
EPI	Expanded Programme on Immunization, WHO
GM/P	growth monitoring and promotion
HIS	health information system
HIV	human immunodeficiency virus
IEC	information, education and communication
JHU	Johns Hopkins University, The
KPC	knowledge, practices and coverage
MCH	maternal child health
MH	maternal health
MIS	management information system
MOH	Ministry of Health
NGO	non-governmental organization
ORS	oral rehydration solution (or salts)
ORT	oral rehydration therapy
PAHO	Pan American Health Organization
PASS	Proyecto de Apoyo a los Servicios de Salud (Health Services Support Project)
PHC	primary health care
PVO	private voluntary organization
QA	quality assurance
STD	sexually transmitted disease
TT	tetanus toxoid (vaccine)
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

CARE Guatemala initiated its second USAID-funded Child Survival project (CS-IX) in October 1993. The project, known by its Spanish acronym PASS, is located in the departments of Alta Verapaz, Baja Verapaz, El Quiché and Huehuetenango which together comprise the North and Northwest Health Regions of the country. CARE, in conjunction with the Ministry of Health, selected one Health District within each department in which to implement PASS activities. The original districts were Cahabón, Rabinal, Zacualpa and San Miguel Acatán, respectively. Subsequent to the preparation of the detailed implementation plan (DIP), Rabinal was replaced by the Purulhá health district and in San Miguel Acatán the project concentrated activities in the municipality of San Sebastián Coatán. The project eventually reached a direct population of 34,000 people residing in 84 rural communities.

The final survey was undertaken in July 1996, approximately two and one half years after the baseline survey was conducted. A total of 313 women, with children under two years of age, were interviewed to determine end-of-project levels of knowledge, practices and coverage (KPC) related to health care and services. The primary purpose of the final survey was to compare end-of-project levels of KPC with those found during the baseline and to use these results as part of the final evaluation process.

A standardized questionnaire and survey methodology was based on a generic format developed specifically for USAID-funded child survival projects by The Johns Hopkins University, School of Hygiene and Public Health, PVO Child Survival Support Program. A major difference between the final and baseline survey methodologies in the present project was that for the baseline a 30-cluster sample design was used in each of the four districts, with a total of 830 interviews. Due to a scarcity of resources and the dispersed nature of the project districts, the final survey was limited to a sampling design based on 45 clusters for the project area as a whole. While these sampling frames are adequate for making project-wide comparisons, the design of the final survey does not allow for district-level analysis as was originally intended.

NOT NECESSARY

The analysis of survey results included a pre and post comparison of 16 key indicators that were developed and standardized for USAID funded child survival projects. Chi-square and p-value tests were done to determine the significance of differences between the baseline and final levels of KPC. Changes in seven of the 16 indicators were found to be statistically significant, all with a p-value of <0.01. All four indicators relating to child immunizations improved considerably

1 INTRODUCTION

1.1 Background.

Child survival initiatives are based on the availability of low cost technologies which have proven to be highly effective in reducing infant and child mortality in Third World settings and elsewhere. Many governments have established national policies and successfully implemented child survival programs, with support from international agencies. However, one of the persistent problems confronting these initiatives is the inadequacy of relevant and reliable information with which results can be measured and evaluated. Similarly, many government agencies and non-governmental organizations (NGOs), particularly at decentralized levels, do not have personnel adequately trained to obtain, analyze and utilize epidemiological data for making management decisions, monitoring and adjusting program interventions, documenting progress, designing projects and justifying financial investments.

Fortunately, new and relatively simple methodologies have been developed by the World Health Organization (WHO), academic institutions such as The Johns Hopkins University, School of Hygiene and Public Health, and the U.S. Centers for Disease Control and Prevention (CDC). One of these methodologies is a rapid epidemiological survey developed to obtain data on health knowledge, practices and coverage (KPC) by interviewing women with young children in their homes. The generic survey employs a 30-cluster sampling method and the data is processed on a microcomputer using Epi Info statistical software. The technology is low cost and easily replicated with minimum limitations.

CARE Guatemala initiated its second USAID-funded Child Survival project (CS-IX) in October 1993. The project, known by its Spanish acronym PASS, is located in the departments of Alta Verapaz, Baja Verapaz, El Quiché and Huehuetenango which together comprise the North and Northwest Health Regions of the country. These four departments were chosen for a number of reasons. They are among the areas of greatest need in the country and are considered a high priority by the Ministry of Health (MOH). The criteria of need included: highly rural and indigenous populations; conditions of severe poverty; low rates of literacy (especially among women); high infant and maternal mortality rates; and difficult geographic and cultural barriers that limit accessibility to health services, including low coverage of maternal and child health services. There was also expressed interest by district government officials and MOH personnel in working collaboratively with CARE, community interest in participating in preventive health care activities, and the presence of several local organizations with which the project expected to collaborate.

February. The formal report of baseline findings, as well as the formulation of the DIP, reflected the results obtained in these original districts. In October-November of 1994, due to the change in target health districts, another 30-cluster sample survey was undertaken in the Purulhá municipality. A new set of baseline data was subsequently processed and reported in July 1995. The records from Rabinal and San Miguel Acatán municipalities were deleted from the original data base and the new data from Purulhá was added to that of Cahabón, Zacualpa and San Sebastián.

In the present report, the results of the final KPC survey are compared to this revised baseline data set. Unfortunately, project staff did not review and adjust project objectives based on the revised baseline indicators. Therefore, most comparisons of accomplishments to planned objectives (presented in the DIP) are irrelevant for the final evaluation. In addition, the achievement of planned objectives by district cannot be determined because the final survey design did not provide adequate samples at the district level, only for the project area (four districts) as a whole.

The activities related to the final KPC survey were carried out during the third quarter of 1996.

<u>July</u> :

- 04-13 Planning and design-
  - Review of the survey instrument;
  - Compilation of population data;
  - Design of sampling methodology;
  - Development of the training plan.
- 15-16 Training of supervisors and interviewers (in Guatemala)
- 17 Materials and logistics preparation
- 18 Field practice and language adaptation (in each district)
- 19-25 Data collection in four districts.
- 26-> Data entry and processing.

<u>August</u> :

- <-05 Data processing (continued)-
  - Production of frequencies and indicators.
- 06-09 Analysis of results -
  - Preparation of tables and graphics.
- 17-20 Results workshop, preparation and realization.

<u>September</u> : Preparation of study report.

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According to the standardized guidelines prepared by the Child Survival Support Program, an adequate sample size was calculated the following formula: $\mathbf{n = z^2(pq)/d^2}$, where **n** = sample size, **z** = degree of confidence (or statistical certainty) chosen, **p** = estimated prevalence or coverage rate, **q** = 1 - p, and **d** = precision (acceptable error) desired.

The value of **p** was determined by the coverage rate that requires the largest sample size (**p** = 50% or 0.5). The value **d** depends on the precision, or margin of error, desired (in this case, **d** = 10% or 0.1). The statistical certainty was chosen to be 95% (**z** = 1.96). Given the above values, the necessary sample size (**n**), for a straight random selection, was determined as follows:

$$\mathbf{n = (1.96 \times 1.96)(.5 \times .5)/(.1 \times .1)}$$
$$\mathbf{n = (3.84)(.25)/(.01)}$$
$$\mathbf{n = 96}$$

It would take an unreasonable amount of time to identify and randomly select each individual from within the survey population, repeatedly performing this selection 96 times to obtain a sample of **n = 96** in the four-district project area. Time can be saved by conducting a **30-cluster** sample survey by which various individuals within each cluster are selected until the required sample size is reached. However, in order to compensate for the bias which enters the survey from interviewing persons in clusters, rather than randomly selecting each individual, experience has shown that a minimum sample of 210 (7 per cluster) should be used given the values of **p**, **d** and **z** noted above.[2] In general, when using a 30-cluster sample methodology, the size of the sample used should be approximately double the value **n**, when the value of $\mathbf{n = (z \times z)(pq)/(d \times d)}$.

For the baseline survey, a sample size of 240 (8 per cluster) was selected for each district so as to ensure that the sub-samples would be of sufficient size (a minimum of 210 interviews) to obtain useful information. For the final survey, the decision was made to expand the number of clusters to 45 to compensate for the high degree of dispersion and internal variances presented by the target populations. Thus, the selected sample size was 315 (7 households per cluster).

The estimates of confidence limits for the results of the survey were calculated using the following formula: **95% confidence limit** $\mathbf{= p \pm z \sqrt{(pq/n)}}$, where **p** = proportion found in the population from survey; **z** = statistical certainty chosen (if 95% certainty was chosen, then **z** = 1.96); **q** = 1 - p; and **n** = sample size.

Example: The proportion of children under two years who were breastfed within the first eight hours after birth was reported **in the final survey** to be **71.3%**, with **n** = 308. Therefore:
95% confidence limit $\mathbf{= .71 \pm 1.96 \sqrt{\{(.71 \times .29)/308\}} = .71 \pm .05}$ **(or 66% <> 76%).**

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[2] Henderson, RH and Sundaresan, T. Cluster Sampling to Assess Immunization Coverage: A Review of Experience with a Simplified Sampling Method. Bulletin of the World Health Organization 1982; 60:253-260.

of formal education while supervisors had a minimum of nine years. The final selection was based on individual interviews of the candidates by project and MOH district personnel.

All participants --interviewers, supervisors and district coordinators-- attended two days of training in Guatemala in preparation for the actual data collection. This training was conducted by the study coordinator and CARE's Regional Technical Advisor for Latin America, and was based on a training format suggested by the JHU Child Survival Support Program.[3] The training plan included a review of the purpose and substance of the survey instrument, sampling methodology, interview techniques, individual responsibilities, and logistics. Interviewers, supervisors and coordinators then traveled to the four project districts and undertook practice interviews and had ample discussions to reach agreement on the translation of each question into the local dialects (most of which are not written languages). The supervisors and field coordinators had one additional day of training which emphasized supervisory functions, sample selection method, and administrative matters.

2.5 Field Implementation.

The survey was conducted over a period of six consecutive days, July 19-24, simultaneously in the four health districts. An additional day was taken to review questionnaires for completeness and consistency in the field prior to returning to Guatemala City for processing. CARE staff worked closely with the MOH and the designated communities to organize the planned activities. The district health personnel played a crucial role in informing the communities about the survey and its purpose. Community leaders also assisted by informing the residents and requesting that they cooperate fully and provide accurate information.

The supervisors were responsible for determining the direction and starting point for each cluster, identifying and introducing the interviewers to the selected household, monitoring the interviews and resolving questions of interpretation, and reviewing each questionnaire at the end of each day. On average, each team of two interviewers and one supervisor were responsible for six clusters and 48 interviews. The interviewers worked separately and each interview took approximately 45 minutes to complete.

The supervisors checked each questionnaire for completeness before the survey team left the community so that, in the case of missing or contradictory information, the mother could be visited again the same day. The CARE field coordinators provided logistics support to the survey teams, resolved problems which were beyond the capacity of the supervisors and maintained a link with the CARE study coordinator. The coordinators also monitored the sampling process, did spot checks of 10% the interviews and completed questionnaires as a means of quality assurance during the survey.

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[3] Survey Trainer's Guide for PVO Child Survival Project Rapid KPC Surveys. JHU School of Hygiene and Public Health, PVO Child Survival Support Program, 1995.

3 FINDINGS

3.1 Characteristics of Respondents.

Characteristics of the responding women varied little from the baseline survey. The average age was 25 years, compared with 27 in the BLS, and illiteracy remains very high at 79.8% (BLS, 76.9%). More than half of the women (51.4%) reported participating in no income generating activities (BLS, 57.0%). More than one-third of the women (35.1%) indicated that they worked away from their home (BLS, 27.6%). When the mother leaves home, she most likely takes her child with her (54.5% final survey, 62.8% BLS). Older siblings (20.6%) and relatives (21.3%) also have significant caregiving responsibilities.

The average age of the children was also slightly lower in the final survey (11.20 months) than in the baseline survey (11.99). The women reported having given birth to an average of 4.75 children (BLS, 4.41), of which 4.23 or 89.1% were still living (BLS, 86.8%). It should be noted, however, that most of these women have not completed their child-bearing years.

3.2 Breastfeeding and Nutrition.

The percent of infants who were breastfed within the first eight hours after birth increased significantly from 61.2% to 71.3% ($p < 0.01$) during the life of the project (LOP). Infants breastfed during the first hour after birth also increased from 40.2% to 47.6%. The percent of children under two years of age currently breastfeeding at the time of the survey was 91.0% (BLS, 87.9%).

Only 12.9% of the women said that supplementary foods should be added to breastfeeding before six months of age or didn't know, compared with 17.1% in the baseline survey. However, in practice the percent of infants less than four (0-3) months who were being exclusively breastfed remained the same at 45.5% (BLS, 46.3%). Mothers reported limited knowledge regarding practices to increase the production of breast milk during the infant's first six months: many did not have a response, 39.4% (BLS, 26.4%); others reported frequent sucking, 17.6% (BLS, 27.1%) and breastfeeding immediately after birth, 15.1% (BLS, 21.8%).

The percent of infants between six and ten months (6-9) who were being given solid or semi-solid foods increased slightly, but not significantly, from 70.1% to 75.7%. Mothers' knowledge of appropriate kinds of weaning foods also remained about the same: foods rich in vitamin A, 58.3%

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infusions and other fluids, 19.2% (BLS, 15.9%); thin grain gruels, 7.2% (BLS, 6.8%); and sugar/salt solution, 4.0% (BLS, 6.5%).

The percent of children treated with medicines and antibiotics for diarrhea remained high at 56.8% (BLS, 54.8%). More than half of the mothers, 54.4% (BLS, 58.1%) sought help for the diarrheal episode. Of those who sought help, 22.4% (BLS, 32.7%) went to a hospital, health center or private doctor; 44.8% (BLS, 22.4%) went to a community health promoter, and 16.4% (BLS, 22.0%) went to a pharmacy.

When all of the mothers were asked what conditions associated with diarrhea would cause them to seek help, they gave the following responses: general weakness, 34.3% (BLS, 18.4%); dehydration, 33.7% (BLS, 25.7%); loss of appetite, 25.3% (BLS, 20.7%); prolonged diarrhea, 15.1% (BLS, 18.3%); fever, 10.9% (BLS, 26.8%); vomiting, 9.6% (BLS, 36.1%); and, blood in the feces, 1.9% (BLS, 2.2%). One-fourth of the women, 25.6% (BLS, 19.8%) had no response to the question.

When all mothers were asked what actions they would take if their child had diarrhea, one-fifth, 20.8% (BLS, 20.1%) had no response. Specific actions included: giving liquids immediately, 29.4% (BLS, 30.5%); giving oral rehydration solutions, 27.8% (BLS, 18.3%); taking the child to a hospital or health center, 22.0% (BLS, 22.4%); giving foods, less quantity but more frequently, 10.9% (BLS, 9.2%); and, giving more liquids than usual, 6.4% (BLS, 9.3%).

3.5 Acute Respiratory Infections.

The reported incidence of children under two with cough and rapid or difficult breathing during the two weeks prior to the survey was 30.4% (BLS, 40.5%). Mothers sought medical attention for only 7.4% (BLS, 19.4%) of these cases. This decrease is statistically significant ($p < 0.01$). However, mothers who sought primary assistance from a village health worker increased from 14.5% to 41.0%.

When all of the mothers were asked what conditions associated with respiratory infections would cause them to seek help, their responses varied little from the baseline survey: fever, 42.9% (BLS, 45.6%); cough, 37.5% (BLS, 39.5%); loss of appetite, 19.6% (BLS, 18.8%); rapid or difficult breathing, 15.7% (BLS, 34.4%); and, chest indrawing, 7.4% (BLS, 6.6%).

3.6 Immunizations.

Mothers reported that 92.7% of all children under two years have received at least some vaccines, as compared with 77.6% at the time of the baseline survey. The percent of women who could produce a vaccination card for their child also increased from 59.8% to 84.0% during the LOP. Data recorded on these cards show dramatic and statistically significant ($p < 0.01$) improvements in all key immunization indicators in the project area. BCG coverage also increased to 81.5% in the final survey.

For the birth of her last child, 57.5% (BLS, 62.1%) of the mothers reported that the umbilical cord was tied and cut by traditional birth attendant or midwife. Family members attended in 31.9% of the births (BLS, 26.7%). Trained health personnel attended only 2.6% of the births (BLS, 4.5%).

Of the women who were not currently pregnant, 62.6% in final survey indicated that either they do not want another child within the next two years or they are not sure. However, only 3.9% of these women are currently using a modern method of contraception. Contraceptive use rate for the baseline survey was not calculated.

3.8 AIDS Awareness.

Only 27.3% of all respondents (BLS, 29.6%) reported ever having heard of AIDS. Extremely few women, 96.2% (BLS, 90.4%) had any idea of how AIDS was transmitted, or how to prevent infection, 97.4% (BLS, 91.9%).

Similarly, 94.9% of the women reported that, to the best of their knowledge, no member of their household had ever participated in educational presentations or discussions about AIDS (BLS, 92.9%).

DID 82 DO NOT!

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4.3 Maternal Health Care.

While most women reported seeking ante-natal services during their last pregnancy, very few were able to produce ante-natal or vaccination cards. There has apparently been a slight increase in knowledge about appropriate foods to eat and amount of weight to gain during pregnancy, but these levels continue to be quite low. The vast majority of births in the project areas are attended by traditional birth attendants and family members. The current use rate of modern contraceptives in the project districts remains extremely low, and the surveys suggest a high unmet demand for family planning services.

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ACKNOWLEDGMENTS

Overall direction, coordination and oversight of the final survey was handled by Mr. Walter Flores, Project Manager of the PASS Child Survival IX Project. Ms. Sumana Brahman, the Health Sector Coordinator for CARE Guatemala, provides technical and management oversight of the child survival project.

The generic survey questionnaire and methodology was developed by the JHU/CSSP. This instrument was adapted to the conditions of the project area and the requirements of the PASS project by Mr. Flores and Dr. Liliana Gonzalez, Health Sector Monitoring and Evaluation Coordinator, for the baseline survey in 1994. The same instrument was used for the final survey.

Mr. Flores served as field coordinator for both the baseline and final surveys. For the final survey, he was assisted in the field implementation by Ms. Karla Droege, Mr. Jorge Medrano and Mr. Cristobal Ventura all of whom are Field Assistants in the PASS project and acted as field supervisors of the interviewers.

Electronic data processing including the output of frequencies and the calculation of key indicators, was done by Mr. Leo Masa of the Francisco Marroquín University in Guatemala City.

The author provided technical assistance in the selection of clusters, the training of survey supervisors, and the analysis and presentation of results.

Annex A

SURVEY QUESTIONNAIRE

PVO/PAÍS _____ IDNUM: _____

LINEA FINAL PROYECTO PASS, JULIO 1996
CUESTIONARIO SOBRE CONOCIMIENTOS Y PRACTICAS EN SUPERVIVENCIA INFANTIL, GENÉRICO

Las siguientes preguntas son para las madres de niños menores 24 meses.

Fecha de entrevista_____ **re-entrevista**_____

Nombre del entrevistador_____

Supervisor_____

Comunidad_____

Idioma durante la entrevista _____

Fecha entrevista __/__/96 (dd/mm) **Re-entrevista** __/__/96 (dd/mm)

Nombre entrevistador_____

Supervisor_____

---

1. Nombre y edad de la madre

   Nombre _____ Edad (años) _____

2. Nombre y edad del niño menor de 24 meses

   Nombre _____

   Fecha de nacimiento __/__/__ (dd/mm/aa)

   Comunidad _____

2.1 Número total de hijos _____vivos _____muertos _____

Educación

3. ¿Cual fue el grado de educación mas alto que alcanzó?
   1. ninguno [ ]
   2. alfabetizado [ ]
   3. primaria y no lee [ ]
   4. primaria y si lee [ ]
   5. secundaria o mas [ ]

b. ¿Le está dando leche/atoles en la pacha a (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ ]

c. ¿Le está dando verduras y frutas a (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ ]

d. ¿Le está dando vegetales verdes como la espinaca, macuy, chipilín, berro o la hoja de yuca a (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ ]

e. ¿Le está dando carne, pollo o pescado a (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ ]

f. ¿Le está dando frijoles, huevos, crema y queso a (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ ]

g. ¿Le esta añadiendo azúcar, miel o panela a los alimentos de (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ ]

h. ¿Le esta añadiendo aceite o manteca a los alimentos de (nombre del niño)?

1. si [ ]
2. no [ ]

Enfermedades diarréicas

16. ¿Ha tenido (nombre del niño) diarrea en las dos últimas semanas?
    1. si [ ]
    2. no [ ]——> PASE A LA 23
    3. no sabe [ ]——> PASE A LA 23

17. Durante la diarrea de (nombre del niño), le dio de mamar (lea las opciones a la madre).....
    1. más de lo acostumbrado? [ ]
    2. igual a lo acostumbrado? [ ]
    3. menos de lo acostumbrado? [ ]
    4. dejó de darle completamente? [ ]
    5. el niño no está siendo amamantado [ ]

18. Durante la diarrea, usted le dió a (nombre del niño) otros líquidos (aparte de la leche de pecho, si el niño esta mamando)
    (lea las opciones a la madre)
    1. le dió mas de lo acostumbrado? [ ]
    2. le dió igual a lo acostumbrado? [ ]
    3. le dió menos de lo acostumbrado? [ ]
    4. le dejó de dar completamente? [ ]
    5. le dió unicamente de mamar? [ ]

19. Durante la diarrea de (nombre del niño) continuo usted dándole comida sólida o semisólida.....
    (lea las opciones a la madre)
    1. más de lo acostumbrado? [ ]
    2. igual a lo acostumbrado? [ ]
    3. menos de lo acostumbrado? [ ]
    4. dejó de darle completamente? [ ]
    5. únicamente de mamar? [ ]

20. Cuando (nombre del niño) tuvo diarrea, ¿que tratamientos le dio?
    (puede marcar más de una respuesta)
    a. nada [ ]
    b. sobre de rehidratación oral [ ]
    c. solución de agua y sal (suero casero) [ ]
    d. atoles [ ]
    e. líquidos, aguitas, café o tés [ ]
    f. medicinas [ ]
    g. otro (especifique) _____ [ ]

21. Cuando (nombre del niño) tuvo diarrea, buscó usted ayuda o tratamiento para la diarrea?
    1. si [ ]
    2. no [ ]---- pase a la 23

Infecciones Respiratorias Agudas

26. ¿Ha estado (nombre del niño) enfermo con tos o dificultad para respirar en las dos últimas semanas?
    1. si [ ]
    2. no [ ] **PASE A LA 30**

27. Tuvo (nombre del niño) dificultad para respirar (como cansado), o estuvo respirando muy rápidamente al enfermarse?

    1. si [ ]——> **MUY RAPIDAMENTE**
    2. no [ ]——> **PASE A LA 30**
    3. no sabe [ ]——> **PASE A LA 30**

28. ¿Pidió Ud. consejo o ayuda para (nombre del niño) cuando estuvo enfermó con dificultad para respirar o respiración rápida?

    1. si [ ]
    2. no [ ]——> **PASE A LA 30**

29. ¿De quien recibió consejo o ayuda para la respiración rápida y dificultad respiratoria de (nombre del niño)?
    (puede marcar más de una respuesta)

    a. hospital general [ ]
    b. centro de salud/puesto de salud [ ]
    c. médico/clínica particular [ ]
    d. farmacia [ ]
    e. monitora/promotora de salud [ ]
    f. curandero [ ]
    g. comadrona [ ]
    h. parientes y amigos [ ]
    i. otro (especifique) _____ [ ].

30. ¿Cuales son las señales que harían que busque ayuda para las enfermedades como catarro, gripe o pulmonía de (nombre del niño)?
    (puede marcar más de una respuesta)
    a. no sabe [ ]
    b. respiración rápida y agitada [ ]
    c. hundimiento del pecho [ ]
    d. pérdida de apetito [ ]
    e. fiebre [ ]
    f. tos [ ]
    g. otro (especifique)_____ [ ]

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Salud materna

37. Tiene usted algún carnet de vacunación o control prenatal?
    1. si [ ] (debe mostrarle el carnet)
    2. lo perdió [ ] PASE A LA 41
    3. no [ ] PASE A LA 41

38. Mire el carnet de vacunación materna y registre el número de vacunas TT (toxoide tetánico) en el espacio correspondiente:
    1. una [ ]
    2. dos o mas [ ]
    3. ninguna [ ]

39. Tiene el carnet espacio para marcar las consultas prenatales?
    1. si [ ]
    2. no [ ] PASE A LA 41

40. Si lo tiene marque si la madre alguna vez ha tenido una consulta prenatal?
    1. una [ ]
    2. dos o más [ ]
    3. ninguna [ ]

41. Está usted embarazada en este momento?
    1. si [ ]PASE A LA 45
    2. no [ ]

42. Desea usted tener otro hijo en los próximos dos años?
    1. si [ ]PASE A LA 45
    2. no [ ]
    3. no sabe [ ]

43. ¿Está Ud. haciendo algo para evitar el embarazo?
    1. si [ ]
    2. no [ ] PASE A LA 45

44. Cual es el principal método que usted o su esposo estan usando actualmente para evitar el embarazo?
    1. ligazón de las trompas [ ]
    2. vasectomía [ ]
    3. inyecciones [ ]
    4. píldoras [ ]
    5. T de cobre [ ]
    6. Diafragma [ ]
    7. condones [ ]
    8. espumas [ ]
    9. método de amenorrea por lactancia exclusiva [ ]
    10. rítmo [ ]
    11. abstinencia [ ]
    12. coito interrumpido [ ]
    13. otro [ ]

52. Sabe usted cómo se puede transmitir el SIDA?
(Puede marcar más de una respuesta)

1. No sabe [ ]
2. Por contacto sexual [ ]
3. Por transfusión de sangre contaminada [ ]
4. Por usar agujas contaminadas [ ]
5. Por embarazo [ ]

53. Sabe usted cómo se puede evitar prevenir el SIDA?
(Puede marcar más de una respuesta)

1. No [ ]
2. Fidelidad a la pareja [ ]
3. Usando condón [ ]
4. Usando agujas limpias [ ]

54. Ha participado usted o alguien de su familia en pláticas sobre el SIDA?
(marque todas las respuestas recibidas)

1. Ninguno [ ]
2. La madre [ ]
3. El esposo [ ]
4. Otras personas mayores de 12 años [ ]

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PLAN DE CAPACITACION PARA DESARROLLO DE ENCUESTA PROYECTO PASS

INTRODUCCION:

El Proyecto de Apoyo a los Servicios de Salud durante el mes de julio estará desarrollando la encuesta final para el análisis comparativo de los resultados, despues de tres años de intervención del Proyecto en 84 comunidades de tres Distritos de Salud del Ministerio de Salud Pública, con los que corresponden a los datos recolectados en la linea de base respecto al cambio de conocimientos y practicas en Inmunizaciones, Diarrea y terapia de rehidratación oral, infecciones respiratorias y salud de la mujer.

OBJETIVO:

Qu el personal que participe en la capacitación adquiera la habilidad para utilizar el instrumento correctamente en la recolección d ela información que permitirá medir el efecto de las intervenciones que realizó durante 2 años el proyecto PASS en la población meta.

<u>Temas:</u>

1. Rol del coordinador de campo

Objetivo: Revisar y dar a conocer el rol que desempeñara el coorinador de campo en la ejecución de la encuesta.

2. Rol de los coordinadores de distrito:

Objetivo: Revisar y dar a conocer el rol que desempeñara los coordinadores de distrito en la ejecución de la encuesta.

3. Rol de los supervisores:

Objetivo: Revisar y dar a conocer el rol que desempeñara los supervisores de distrito en la ejecución de la encuesta.

4. Metodología de la encuesta:

Objetivo: Que los participantes conozca la forma en que se selecciono la muestra y como se seleccionaran los hogares a encuestar.

5. Revisión del cuestionario:

Objetivo: Que los participantes adquieran la habilidad tecnica para el manejo correcto del instrumento para la recolección de los datos.

6. Practica:

Objetivo: Que los participacte ademas de adquirir la habilidad tecnica para el manejo del instrumento, adquieran la habilidad de forma práctica.

CARE Guatemala - Proyecto PASS (PN40) - Supervivencia Infantil IX

ENCUESTA CPC FINAL

FUNCIONES DEL COODINADOR

PLANIFICACION DE LA ENCUESTA

01. _____ Determinar cuales secciones de la encuesta a incluir.

02. _____ Determinar las fechas de la encuesta.

03. _____ Determinar el tamaño y la distribución de los conglomerados.

04. _____ Preparar el presupuesto.

05. _____ Identificar todas las personas que deberán estar involucrado.

06. _____ Obtener autorizaciones oficiales y compromisos individuales.

07. _____ Elaborar la cronología de actividades.

PREPARACION PARA IMPLEMENTAR LA ENCUESTA

08. _____ Revisar y ajustar la encuesta de línea de base.

09. _____ Adquirir materiales y equipo; reproducir los formularios.

10. _____ Determinar el número de niños/madres requerido.

11. _____ Determinar el número de encuestadores y supervisores requeridos.

12. _____ Seleccionar los encuestadores y supervisores.

13. _____ Obtener los datos de población y mapas de la comunidades activas.

14. _____ Elaborar la lista de comunidades con sus respectivas poblaciones.

15. _____ Seleccionar las comunidades donde se ubican los conglomerados.

16. _____ Hacer contacto con los líderes de las comunidades seleccionadas.

17. _____ Adaptar el contenido de la capacitación para encuestadores y supervisores.

FUNCIONES DE LOS ASISTENTES DE CAMPO

01. _____ Programar en detalle el trabajo de campo: itinerarios, procedimientos, etc.

02. _____ Completar arreglos administrativos y logísticos:
- ◊ transporte
- ◊ alojamiento
- ◊ viáticos
- ◊ materiales
- ◊ formularios
- ◊ mapas de comunidades
- ◊ hojas de resumen de las conglomeraciones

03. _____ Hacer contacto con los líderes de las comunidades seleccionadas.

04. _____ Definir correctamente la locación de cada conglomerado.

05. _____ Encontrarse con los supervisores durante la encuesta para monitorear el progreso y ayudar la resolver problemas.

06. _____ Evaluar la calidad de la encuesta utilizando la lista de supervisión.

07. _____ Realizar una auditoría de todos los formularios completados antes que los encuestadores y supervisores salgan del sector.

08. _____ Compilar los resultados de los conglomerados en la Hoja de Resumen.

09. _____ Entregar las encuestas completadas y revisadas al coordinador.

10. _____ Colaborar, durante las sessiones de capacitación y en el campo, a motivar y mejorar el desempeño de los encuestadores.

11. _____ Saber, en todo momento, donde están los encuestadores, supervisores y el coordinador en caso que necesitan ayuda.

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FUNCIONES DE LOS ENCUESTADORES

01. _____ Juntamente con su supervisor, aplicar la metodología correcta para seleccionar el conglomerado dentro de la comunidad e identificar las casas para ser entrevistadas.

02. _____ Siempre usa correctamente el procedimiento para iniciar el contacto con la familia y para empezar la entrevista.

03. _____ Seleccionar correctamente al azar el niño pertinente cuando se encuentran dos o mas niños menores de dos años en la familia.

04. _____ Hacerle recuerdo a las familias seleccionadas que su participación es voluntaria, pero valiosa y que sus respuestas se mantendrán confidencial.

05. _____ El encuestador siempre se vista apropriado para el trabajo, trata de establecer una relación positiva con la familia, y no demuestra emociones en cuanto a si las respuestas fueron "correctas" o "equivocadas."

06. _____ Traducir y administrar las preguntas de la encuesta en el idioma principal del lugar, o séa el que séa mas cómodo para la familia.

07. _____ El encuestador hace las preguntas con paciencia y sin dirigir o señalar a la madre su respuesta.

08. _____ Se hace las preguntas en una manera de conversación y no de interrogación. El encuestador puede indagar para encontrar "prácticas" pero nunca para "conocimientos."

09. _____ Registrar las respuestas en forma completa y legible.

10. _____ Siempre agradecer a la familia por su colaboración a finalizar la entrevista.

11. _____ Completar los formularios completamente y con exactitud. Hay que corregir las omisiones y errores antes de salir de la comunidad.

12. _____ Saber, en todo momento, donde está su supervisor en caso que necesita su ayuda.

CARE Guatemala - Supervivencia Infantil IX - PASS PN40

ENCUESTA CPC FINAL - SELECCION DE LA MUESTRA

Número		Comunidad	Población		Muestra de
Corr	Dist.		Comunidad	Cumulativa	Comunidades
		MUNICIPIO DE SAN SEBASTIAN COATAN, HUEHUETENANGO			
1	1	Yalancamposanto	178	178	
2	2	Yalanculuz Jajhuitz	251	429	1
3	3	Bolontaj	178	607	
4	4	Ticolal	364	971	
5	5	Jolombojop	157	1,128	2
6	6	Ucachoj	208	1,336	
7	7	Jolomtenan	100	1,436	
8	8	Calhuitz	834	2,270	3
9	9	Taaj	111	2,381	
10	10	Xeen	308	2,689	
11	11	Ulan	330	3,019	4
12	12	Lolbatzam	297	3,316	
13	13	Yocxacla	545	3,861	5
14	14	Ixtenam Ixquin	60	3,921	
15	15	Julutz	132	4,053	
16	16	Joom	103	4,156	6
17	17	Yalanculuz 1	196	4,352	
18	18	Yichicun	167	4,519	
		MUNICIPIO DE PURULHA, BAJA VERAPAZ			
19	1	Duranzno	422	4,941	7
20	2	Repollal I	340	5,281	
21	3	Cuchilla del Nogal	210	5,491	
22	4	Jute	98	5,589	
23	5	Mocohan	1,350	6,939	8,9
24	6	Repollal II	195	7,134	
25	7	Eben-Ezer	240	7,374	10
26	8	Comunal	371	7,745	
27	9	Tres Cruces	238	7,983	
28	10	Pampa	629	8,612	11
29	11	Sinanja Chacalte	213	8,825	12
30	12	La Colina	505	9,330	
31	13	San Luis	106	9,436	
32	14	Monjon	122	9,558	13
33	15	Maxaxa	216	9,774	
34	16	Cumbre de Chacalte	92	9,866	
35	17	Panima	135	10,001	
36	18	Sachoxa	117	10,118	
37	19	Panchisivic	527	10,645	14
38	20	Pancala	318	10,963	
39	21	Rivaco	216	11,179	15
40	22	Balamche	96	11,275	
41	23	Calija	67	11,342	
42	24	Moxante	72	11,414	
43	25	Olimpia	116	11,530	
44	26	Las Flores	83	11,613	
45	27	Panalbarda	100	11,713	
46	28	Sacsamani	464	12,177	16
47	29	Jalaute	697	12,874	17
48	30	Guaxabaja	206	13,080	

Número de conglomerados:	45
Intervalo del muestreo (pob/45):	763
Número de inicio (al azar):	357

Selección de los Conglomerados	
Núm.	Población
1	357
2	1,120
3	1,883
4	2,646
5	3,409
6	4,172
7	4,935
8	5,698
9	6,461
10	7,224
11	7,987
12	8,750
13	9,513
14	10,276
15	11,039
16	11,802
17	12,565
18	13,328
19	14,091
20	14,854
21	15,617
22	16,380
23	17,143
24	17,906
25	18,669
26	19,432
27	20,195
28	20,958
29	21,721
30	22,484
31	23,247
32	24,010
33	24,773
34	25,536
35	26,299
36	27,062
37	27,825
38	28,588
39	29,351
40	30,114
41	30,877
42	31,640
43	32,403
44	33,166
45	33,929

CARE Guatemala
Proyecto de Apoyo a Los Servicios de Salud (PASS - PN40)

RESUMEN DE RESULTADOS: ENCUESTA FINAL DE CONOCIMIENTOS, PRACTICAS Y COBERTURAS (CPC)[1]

A. Datos Generales

1. EDAD DE LA MADRE?

Total entrevistas	311 madres
Sin respuestas	2 madres
Edad promedio	26.75 años
Desviación estandar	7.11
Edad mediano	25.0 años
Edades mín - max	? - 45 años

2. EDAD DEL NIÑO?

Total muestra	311 niños
Sin respuestas	2 niños
Edad promedio	11.20 meses
Desviación estandar	6.07
Edad mediano	11.0 meses
Edades mín - max	0 - 23 meses

2.1 NUMERO TOTAL DE HIJOS?

Total respuestas	312 madres
Sin respuestas	1 madre
Número promedio	4.75 hijos
Desviación estandar	3.06
Número mediano	4.0 hijos
Número mín - max	1 - 15 hijos

[1] La encuesta fue realizado del 19 al 24 de julio de 1.996 con una muesta de 45 conglomeraciones. Un total de 313 entrevistas fueron completadas y tabuladas según la siguiente distribución: Municipio San Sebastián Coatán, 42; Municipio Cahabón, 119; Municipio Purulhá, 77; y Municipio Zacualpa, 75.

2.2 NUMERO DE HIJOS VIVOS?

Total respuestas	312 madres
Sin respuestas	1 madre
Número promedio	4.23 hijos
Desviación estandar	2.65
Número mediano	4.0 hijos
Número mín - max	1 - 11 hijos

2.3 NUMERO DE HIJOS MUERTOS?

Total respuestas	313 madres
Número promedio	0.51 hijos
Desviación estandar	n/a
Número mediano	0.0 hijos
Número mín - max	0 - 5 hijos

3. GRADO DE EDUCACION MAS ALTO DE LA MADRE?

	Frec.	Porcent	Cum.
Ningúno	222	70.9%	70.9%
Alfabetizada	13	4.2%	75.1%
Primaria y no lee	28	8.9%	84.0%
Primaria y si lee	49	15.7%	99.7%
Secundaria o más	1	0.3%	100.0%
Total	313	100.0%	

4. TRABAJA LA MADRE FUERA DE SU CASA?

	Frec.	Porcent	Cum.
Si	110	35.1%	35.1%
No	203	64.9%	100.0%
Total	313	100.0%	

5. REALIZA LA MADRE ALGUN TRABAJO ECONOMICO?

	Frec.	Porcent
Ningún	161	51.4%
Manualidades, etc.	82	26.2%
Recogiendo cosecha	45	14.4%
Venta de productos agric.	24	7.7%
Venta de comida	1	0.3%
Sirvienta/muchacha casa	1	0.3%
Atiende tienda, vende en calle	2	0.6%
Otro	13	4.2%
Total	313	100.0%

6. QUIEN CUIDA AL NIÑO CUANDO LA MADRE ESTA FUERA?

	Frec.	Porcent	Cum.
La madre lo lleva	164	54.5%	54.5%
Esposo/compañero	9	3.0%	57.5%
Niños(as) mayores	64	20.6%	78.1%
Familiares, parientes	68	21.3%	99.3%
Vecinas/amigas	4	0.7%	100.0%
Total	301	100.0%	
Sin respuestas	12	madres (no trabajan fuera de la casa)	

B. Lactancia Materna y Nutrición

7. LA MADRE ESTA DANDO DE MAMAR AL NIÑO?

	Frec.	Porcent	Cum.	
Si	284	91.0%	91.0%	Pase a #9
No	28	9.0%	100.0%	
Total	312	100.0%		
Sin respuesta	1	madre		

8. HA DADO DE MAMAR ALGUNA VEZ AL NIÑO?

	Frec.	Porcent	Cum.	
Si	27	100.0%	100.0%	
No	0			Pase a #10
Total	27	100.0%		
Sin respuesta	1 madre			

8.1 HASTA QUE EDAD?

Total respuestas	27 niños
Promedio duración	14.93 meses
Desviación estandar	3.79
Duración mediano	15.0 meses
Duración mín - max	8 - 22 meses

9. DESPUES DEL PARTO, CUANDO LE DIO DE MAMAR AL NIÑO?

	Frec.	Porcent	Cum.
Durante la primera hora	149	48.4%	48.4%
Durante las primeras 8 horas	74	24.0%	72.4%
Más de 8 horas después	82	26.6%	99.0%
No se acuerda	3	1.0%	100.0%
Total	308	100.0%	
Sin respuesta	3 madres		

10.a. LE ESTA DANDO AGUITAS, CAFE, CEBADA, TES AL NIÑO?

	Frec.	Porcent	Cum.
Si	257	82.1%	82.1%
No	56	17.9%	100.0%
Total	313	100.0%	

10.b. LE ESTA DANDO LECHE/ATOLES EN PACHA AL NIÑO?

	Frec.	Porcent	Cum.
Si	192	61.5%	61.5%
No	119	38.1%	99.7%
No sabe	1	0.3%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

10.c. LE ESTA DANDO VERDURAS Y FRUTAS AL NIÑO?

	Frec.	Porcent	Cum.
Si	216	69.7%	69.7%
No	93	30.0%	99.7%
No sabe	1	0.3%	100.0%
Total	310	100.0%	
Sin respuesta	3 madres		

10.d. LE ESTA DANDO VEGETALES VERDES AL NIÑO?

	Frec.	Porcent	Cum.
Si	205	65.7%	65.7%
No	106	34.0%	99.7%
No sabe	1	0.3%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

10.e. LE ESTA DANDO CARNE, POLLO O PESCADO AL NIÑO?

	Frec.	Porcent	Cum.
Si	195	62.5%	62.5%
No	117	37.5%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

10.f. LE ESTA DANDO FRIJOLES, HUEVOS, CREMA O QUESO AL NIÑO?

	Frec.	Porcent	Cum.
Si	219	70.2%	70.2%
No	93	29.8%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

10.g. LE ESTA AÑADIENDO AZUCAR, MIEL O PANELA A LOS ALIMENTOS?

	Frec.	Porcent	Cum.
Si	249	79.8%	79.8%
No	63	20.2%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

10.h. LE ESTA AÑADIENDO ACEITE O MANTECA A LOS ALIMENTOS?

	Frec.	Porcent	Cum.
Si	204	65.4%	65.4%
No	108	34.6%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

11. QUE HACE LA MADRE PARA TENER SUFICIENTE LECHE?

	Frec.	Porcent.
No sabe	123	39.4%
Dar de mamar inmediat.	47	15.1%
Evitar la pacha	4	1.3%
Dar de mamar seguido	55	17.6%
Cuidado de los pechos	5	1.6%
Otros	88	28.2%
Total	312	100.0%
Sin respuestas	1 madre	

12. A QUE EDAD SE DEBE EMPEZAR A DAR OTRA COMIDA?

	Frec.	Porcent.	Cum.
A los 6 meses de edad	176	56.6%	56.6%
Antes de los 6 meses	18	5.8%	62.4%
A los 7 meses o más	95	30.5%	92.9%
No sabe	22	7.1%	100.0%
Total	311	100.0%	
Sin respuesta	2	madres	

13. CUAL DEBERIA DE SER LA COMIDA COMPLEMENTARIA?

	Frec.	Porcent.
No sabe	68	21.8%
Agregar aceite a la comida	50	16.0%
Comida rica en vitamina A	182	58.3%
Comida rica en hierro	142	45.5%
Otra	2	0.6%
Total	312	100.0%
Sin respuestas	1	madre

C. Monitoreo de Crecimiento

14. TIENE EL NIÑO EL CARNET DE CONTROL DE PESO?

	Frec.	Porcent	Cum.	
Si	63	20.1%	20.1%	
Lo perdió	11	3.5%	23.6%	Pase a #15.1
No	239	76.4%	100.0%	Pase a #15.1
Total	313	100.0%		

15. HA SIDO PESADO EL NIÑO EN LOS ULTIMOS 4 MESES?

	Frec.	Porcent	Cum.
Si	50	82.0%	82.0%
No	11	18.0%	100.0%
Total	61	100.0%	
Sin respuesta	2 niños		

15.1. HA LLEVADO AL NIÑO A CONTROL DE PESO EN ULTIMOS 4 MESES?

	Frec.	Porcent	Cum.
Si	92	31.4%	31.4%
No	201	68.6%	100.0%
Total	293	100.0%	
Sin respuesta	20 niños		

D. Control de Enfermedades Diarréicas (CED)

16. HA TENIDO EL NIÑO DIARREA EN LAS DOS ULTIMAS SEMANAS?

	Frec.	Porcent	Cum.	
Si	125	39.9%	39.9%	
No	182	58.1%	98.1%	Pase a #23
No sabe	6	1.9%	100.0%	Pase a #23
Total	313	100.0%		

17. DURANTE LA DIARREA, LE DIO DE MAMAR AL NIÑO?

	Frec.	Porcent	Cum.
Más de lo acostumbrado	26	22.4%	22.4%
Igual a lo acostumbrado	45	38.8%	61.2%
Menos de lo acostumbrado	43	37.1%	98.3%
Dejó de darle completamente	2	1.7%	100.0%
Total	116	100.0%	
El niño no está amamantando	9 niños		

18. DURANTE LA DIARREA, LE DIO AL NIÑO OTROS LIQUIDOS?

	Frec.	Porcent	Cum.
Más de lo acostumbrado	28	26.2%	26.2%
Igual a lo acostumbrado	37	34.6%	60.7%
Menos de lo acostumbrado	39	36.4%	97.2%
Dejó de darle completamente	3	2.8%	100.0%
Total	107	100.0%	
El niño solo toma pecho	18 niños		

19. DURANTE LA DIARREA, LE DIO AL NIÑO COMIDA SOLIDA O SEMISOLIDA?

	Frec.	Porcent	Cum.
Más de lo acostumbrado	9	7.6%	7.6%
Igual a lo acostumbrado	17	18.5%	28.3%
Menos de lo acostumbrado	54	58.7%	87.0%
Dejó de darle completamente	12	13.0%	100.0%
Total	92	100.0%	
El niño unicamente mama	33 niños (incluyendo los que toman solo líquidos)		

20. DURANTE LA DIARREA, QUE OTROS TRATAMIENTOS LE DIO?

	Frec.	Porcent
Nada	23	18.4%
Sobre de rehydratación oral	29	23.2%
Solución agua, azucar,sal	5	4.0%
Atoles	9	7.2%
Aguitas, café, tés	24	19.2%
Medicinas	71	56.8%
Otros	2	1.6%
Total	125	100.0%

21. CUANDO EL NIÑO TUVO DIARREA, BUSCO AYUDA O TRATAMIENTO?

	Frec.	Porcent	Cum.	
Si	68	54.4%	54.4%	
No	57	45.6%	100.0%	Pase a #23
Total	125	100.0%		

22. A QUIEN ACUDIO USTED EN BUSCA DE AYUDA O TRATAMIENTO?

	Frec.	Porcent
Hospital	14	20.9%
Centro/puesto de salud	1	1.5%
Farmácia	11	16.4%
Promotor de salud	30	44.8%
Curandero	5	6.0%
Comadrona	3	3.0%
Familiares, amigos	5	4.5%
Otros	2	3.0%
Total	67	100.0%
Sin respuestas	1 niño	

23. CUANDO EL NIÑO TIENE DIARREA, QUE SEÑALES HARIAN QUE USTED BUSCARA AYUDA PARA CURARLO?

	Frec.	Porcent
No sabe	80	25.6%
Vómitos	30	9.6%
Fiebre	34	10.9%
Boca seca, ojos hundidos, etc.	105	33.7%
Diarréa prolongada	47	15.1%
Sangre en la heces	6	1.9%
Pérdida del apetito	79	25.3%
Débil o desganado	107	34.3%
Otros	10	3.2%
Total	312	100.0%
Sin respuesta	1 madre	

24. CUALES SON LAS COSAS MAS IMPORTANTES QUE HARIA USTED SI EL NIÑO TIENE DIARREA?

	Frec.	Porcent
No sabe	65	20.8%
Darle líquidos inmediat.	92	29.4%
Darle más líquidos	20	6.4%
Dar alimentos frecuente	34	10.9%
Darle sueros rehydrat. oral	87	27.8%
Llevarlo al centro/puesto	69	22.0%
Alimentarlo después	17	5.4%
No darle líquido	2	0.6%
No darle comida	4	1.3%
Otro	42	13.4%
Total	313	100.0%

25. QUE COSAS IMPORTANTES DEBE USTED HACER CUANDO EL NIÑO LE ESTA PASANDO LA DIARREA?

	Frec.	Porcent
No sabe	88	28.1%
Dar alimentos frecuente	129	41.2%
Más alimentos de lo usual	75	24.0%
Comidas con alto calorías	42	13.4%
Otros	23	7.3%
Total	313	100.0%

E. Infecciones Respiratorias Agudas (IRA)

26. HA ESTADO EL NIÑO ENFERMO CON TOS O DIFICULTAD PARA RESPIRAR EN LAS DOS ULTIMAS SEMANAS?

	Frec.	Porcent	Cum.	
Si	129	41.3%	41.3%	
No	183	58.7%	100.0%	Pase a #30
Total	312	100.0%		
Sin respuesta	1 madre			

27. TUVO EL NIÑO DIFICULTAD PARA RESPIRAR (CANSADO) O ESTUVO RESPIRANDO MUY RAPIDAMENTE AL ENFERMARSE?

	Frec.	Porcent	Cum.	
Si	95	73.6%	73.6%	
No	29	22.5%	96.1%	Pase a #30
No sabe	5	3.9%	100.0%	Pase a #30
Total	129	100.0%		

28. PIDIO UD. CONSEJO O AYUDA PARA EL NIÑO CUANDO ESTUVO ENFERMO CON DIFICULTAD PARA RESPIRAR O RESPIRACION RAPIDA?

	Frec.	Porcent	Cum.	
Si	39	41.1%	41.1%	
No	56	58.9%	100.0%	Pase a #30
Total	95	100.0%		

29. DE QUIEN RECIBIO CONSEJO O AYUDA PARA LA RESPIRACION RAPIDA Y DIFICULTAD RESPIRATORIA DEL NIÑO?

	Frec.	Porcent
Centro/puesto de salud	4	10.3%
Médico/clinica particular	3	7.7%
Farmácia	8	20.5%
Promotora de salud	16	41.0%
Curandero	4	10.3%
Parientes, amigos	1	2.6%
Otros	4	10.3%
Total	39	100.0%

30. CUALES SON LAS SEÑALES QUE HARIAN QUE BUSCARA AYUDA PARA LAS ENFERMEDADES COMO CATARRO, GRIPE O PULMONIA?

	Frec.	Porcent
No sabe	98	31.4%
Respiración rápida, agitada	49	15.7%
Hundimiento del pecho	23	7.4%
Pérdida de apetito	61	19.6%
Fiebre	134	42.9%
Tós	117	37.5%
Otros	12	3.8%
Total	312	100.0%
Sin respuestas	1 madre	

F. Cobertura de Inmunizaciones (PAI)

31. LE HAN PUESTO AL NIÑO ALGUNA VACUNA?

	Frec.	Porcent	Cum.
Si	290	92.7%	92.7%
No	23	7.3%	100.0%
Total	313	100.0%	

32. A QUE EDAD EL NIÑO DEBE RECIBIR LA VACUNA CONTRA EL SARAMPION?

	Frec.	Porcent	Cum.
A los 9 meses	105	33.5%	33.5%
No sabe	208	66.5%	100.0%
Total	313	100.0%	

33. CUAL ES LA RAZON PRINCIPAL PORQUE UNA MUJER EMBARAZADA DEBE SER VACUNADA CONTRA EL TETANOS?

	Frec.	Porcent	Cum.
Proteger madre y niño	112	36.6%	36.6%
Proteger solo a la mujer	7	2.3%	38.9%
Proteger solo al niño	39	12.7%	51.6%
Otro o no sabe	148	48.4%	100.0%
Total	306	100.0%	
Sin respuesta	7 madres		

34. CUANTAS VACUNAS NECESITA UNA MUJER EMBARAZADA PARA PROTEGER DE TETANOS AL RECIEN NACIDO?

	Frec.	Porcent	Cum.
Una	10	3.2%	3.2%
Dos	20	6.4%	9.6%
Más de dos	143	45.8%	55.4%
Ninguna	7	2.2%	57.7%
No sabe	132	42.3%	100.0%
Total	312	100.0%	
Sin respuesta	1 madre		

35. TIENE USTED EL CARNET DE VACUNACION DEL NIÑO?

	Frec.	Porcent	Cum.	
Si	263	84.0%	84.0%	
Lo perdió	17	5.4%	89.5%	Pase a #37
No	33	10.5%	100.0%	Pase a #37
Total	313	100.0		

36. VACUNAS NOTADAS EN EL CARNET DE NIÑOS 12-23 MESES DE EDAD

	Frec.	Porcent.
BCG	119	81.5%
DPT-1	125	85.6%
DPT-3	116	79.5%
Polio-3 (OPV)	115	78.8%
Sarampión-1	113	77.4%
Total niños, 12-23 meses	146	100.0%

EDAD DEL NIÑO CUANDO RECIBIO LA VACUNA CONTRA SARAMPION

	Frec.	Porcent.	Cum.
Antes de los 9 meses	20	19.2%	19.2%
A los 9 meses o más	84	80.8%	100.0%
Total	104	100.0%	
Sin respuesta	9	niños	

G. Salud Materna

37. TIENE USTED CARNET DE VACUNACION O CONTROL PRENATAL?

	Frec.	Porcent	Cum.	
Si	55	17.7%	17.7%	
Lo perdió	50	16.1%	33.8%	Pase a #41
No	206	66.2%	100.0%	Pase a #41
Total	311	100.0%		
Sin respuesta	2	madres		

38. NUMERO DE VACUNAS TOXOIDE TETANICO (TT) SEGUN CARNET

	Frec.	Porcent	Cum.
Una	13	22.8%	22.8%
Dos o más	41	71.9%	94.7%
Ninguna	3	5.3%	100.0%
Total	57	100.0%	

39. TIENE EL CARNET ESPACIO PARA MARCAR LAS CONSULTAS PRENATALES?

	Frec.	Porcent	Cum.	
Si	16	28.6%	28.6%	
No	40	71.4%	100.0%	Pase a #41
Total	56	100.0%		
Sin respuesta	1 madre			

40. LA MADRE ALGUNA VEZ HA TENIDO UNA CONSULTA PRENATAL?

	Frec.	Porcent	Cum.
Una	6	37.5%	37.5%
Dos o más	8	50.0%	87.5%
Ninguna	2	12.5%	100.0%
Total	16	100.0%	

41. ESTA USTED EMBARAZADA EN ESTE MOMENTO?

	Frec.	Porcent	Cum.	
Si	26	8.3%	8.3%	Pase a #45
No	286	91.7%	100.0%	
Total	312	100.0%		
Sin respuesta	1 madre			

42. DESEA USTED TENER OTRO HIJO EN LOS PROXIMOS DOS AÑOS?

	Frec.	Porcent	Cum.	
Si	106	37.3%	37.3%	Pase a #45
No	87	30.6%	68.0%	
No sabe	91	32.0%	100.0%	
Total	284	100.0%		
Sin respuesta	2 madres			

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43. ESTA USTED HACIENDO ALGO PARA EVITAR EL EMBARAZO?

	Frec.	Porcent	Cum.
Si	18	9.9%	9.9%
No	163	90.1%	100.0%
Total	181	100.0%	

44. CUAL ES EL PRINCIPAL METODO QUE USTED O SU ESPOSO ESTAN USANDO ACTUALMENTE PARA EVITAR EL EMBARAZO?

	Frec.	Porcent
Ligazón de trompas	1	5.6%
Inyecciones	5	27.8%
Amenorréa lactancia excl.	1	5.6%
Rítmo	7	38.9%
Abstinencia	3	16.7%
Otro	1	5.6%
Total	18	100.0%

45. CUANDO UNA MUJER ESTA EMBARAZADA, A LOS CUANTOS MESES DEBE SER CONTROLADA EN EL CENTRO DE SALUD O COMADRONA?

	Frec.	Porcent	Cum.
1-3 meses	106	33.9%	33.9%
4-6 meses	139	44.4%	78.3%
7-9 meses	25	8.0%	86.3%
No necesita ir	5	1.6%	87.9%
No sabe	38	12.1%	100.0%
Total	313	100.0%	

46. QUE ALIMENTOS DEBERIA COMER UNA MUJER PARA EVITAR LA ANEMIA DURANTE EL EMBARAZO?

	Frec.	Porcent
No sabe	58	18.5%
Hiervas, verduras, frutas	225	71.9%
Pescado, carne, huevo, etc.	158	50.5%
Otros	6	1.9%
Total	313	100.0%

47. CUANTO PESO DEBE AUMENTAR UNA MUJER DURANTE EL EMBARAZO?

	Frec.	Porcent	Cum.
De 22-27 libras	12	3.8%	3.8%
El peso del bebé	32	10.2%	14.1%
No sabe	264	84.3%	98.4%
Otro	5	1.6%	100.0%
Total	313	100.0%	

48. CUANDO USTED ESTABA EMBARAZADA DEL NIÑO, VISITO ALGUN CENTRO DE SALUD, COMADRONA PARA CONTROL DEL EMBARAZO?

	Frec.	Porcent	Cum.
Si	234	75.5%	75.5%
No	76	24.5%	100.0%
Total	310	100.0%	
Sin respuesta	3 madres		

49. DURANTE EL EMBARAZO DEL NIÑO, LA CANTIDAD DE ALIMENTOS QUE USTED COMIO FUERA

	Frec.	Porcent	Cum.
Más de lo acostumbrado	55	17.6%	17.6%
Igual a lo acostumbrado	105	33.5%	51.1%
Menos de lo acostumbrado	148	47.3%	98.4%
No sabe	5	1.6%	100.0%
Total	313	100.0%	

50. CUANDO NACIO EL NIÑO, QUIEN AMARRO Y CORTO EL CORDON UMBILICAL?

	Frec.	Porcent	Cum.
Ella misma	8	2.6%	2.6%
Miembro de la familia	100	31.9%	34.5%
Partera, comadrona	180	57.5%	92.0%
Médico, enfermera	8	2.6%	94.6%
Otro	13	4.2%	98.7%
No sabe	4	1.3%	100.0%
Total	313	100.0%	

51. HA OIDO USTED HABLAR DEL SIDA?

	Frec.	Porcent	Cum.
Si	85	27.3%	27.3%
No	226	72.7%	100.0%
Total	311	100.0%	
Sin respuesta	2 madres		

52. SABE USTED COMO SE PUEDE TRANSMITIR EL SIDA?

	Frec.	Porcent	Cum.
No sabe	301	96.2%	96.2%
Por contacto sexual	9	2.9%	99.0%
Por usar agujas contaminadas	3	1.0%	100.0%
Total	313	100.0%	

53. SABE USTED COMO SE PUEDE EVITAR O PREVENIR EL SIDA?

	Frec.	Porcent
No	304	97.4%
Fidelidad a la pareja	5	1.6%
Usando condón	1	0.3%
Usando agujas limpias	2	0.6%
Total	312	100.0%
Sin respuestas	1 madre	

54. HA PARTICIPADO USTED O ALGUIEN DE SU FAMILIA EN PLATICAS SOBRE EL SIDA?

	Frec.	Porcent
Ninguno	297	94.9%
La madre	7	2.2%
El esposo	11	3.5%
Total	313	100.0%

CARE Guatemala - Proyecto PASS (PN40)

CUADRO COMPARATIVO DE INDICADORES CLAVES: LINEA BASE, OBJETIVOS, Y RESULTADOS FINALES

Indicador Clave	Encuesta Línea Base	Objetivo Proyecto	Encuesta Final	Valor P
Prácticas Apropiadas de Alimentacion Infantil				
Porcentaje de niños (menores de 24 meses) que fueron amamantados dentro de las primeras ocho horas después del nacimiento.	61.2%	70.0%	71.3%	**<0.01**
Porcentaje de niños menores de cuatro meses (0-3 meses) que están siendo alimentados únicamente con leche de pecho.	46.3%	n/a	45.5%	>0.90
Porcentaje de niños entre seis y diez meses (6-9 meses) que están siendo dados comidas sólida y semisólida además de la leche materna.	70.1%	80.0%	75.7%	>0.45
Porcentaje de niños entre 20 y 24 meses (20-23 meses) que aún están lactando.	69.5%	70.0%	58.8%	>0.20
Control de Enfermedades Diarréicas (CED)				
Porcentaje de niños (menores de 24 meses), que están lactando y que tuvieron diarréa durante las pasadas dos semanas, que les fue proporcionada la misma cantidad o más de leche de pecho durante el episodio de diarréa.	69.1%	80.0%	61.2%	>0.10
Porcentaje de niños (menores de 24 meses), que no reciben unicamente leche de pecho y que tuvieron diarréa durante las pasadas dos semanas, a quienes les fue proporcionada la misma cantidad o más de líquidos durante el episodio de diarréa.	69.3%	80.0%	60.7%	>0.10
Porcentaje de niños (menores de 24 meses), que no reciben unicamente leche de pecho y que tuvieron diarréa durante las pasadas dos semanas, a quienes les fue proporcionada la misma cantidad o más de comida durante el episodio de diarréa.	48.8%	70.0%	28.3%	**<0.01**
Porcentaje de niños (menores de 24 meses), que tuvieron diarréa durante las pasadas dos semanas, que les fue tratado con TRO.	36.8%	55.0%	44.8%	>0.10

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Indicador Clave	Encuesta Línea Base	Objetivo Proyecto	Encuesta Final	Valor P
Tratamiento Médico para Neumonía (IRA)				
Porcentaje de madres que buscaron tratamiento médico para sus niños (menores de 24 meses) con tós y respiración rápida y dificultosa en las pasadas dos semanas.	19.4%	40.0%	7.4%	**<0.01**
Cobertura de Inmunización (PAI)				
Acceso: Porcentaje de niños de 12 a 23 meses que recibió la primera dosis de triple (DPT1).	65.6%	70.0%	85.6%	**<0.01**
Cobertura: Porcentaje de niños de 12 a 23 meses que recibió la tercera dosis de polio (OPV3).	47.0%	70.0%	78.8%	**<0.01**
Cobertura: Porcentaje de niños de 12 a 23 meses que recibió la vacuna para la sarampión.	48.0%	70.0%	77.4%	**<0.01**
Abandono: Diferencia de porcentaje entre niveles de cobertura de DPT1 y DPT3 para niños 12-23 meses.	25.7%	25.0%	5.6%	**<0.01**
Atención de Salud Materna				
Porcentaje de madres con carnet materno para el nacimiento de su niño más pequeño menor de 24 meses.	13.5%	n/a	17.6%	>0.05
Porcentaje de madres que según carnet recibió dos ó más dosis de toxoide tetánico antes del nacimiento del niño más pequeño menor de 24 meses.	9.6%	50.0%	13.1%	>0.05
Porcentaje de madres que según carnet ha tenido por lo menos una consulta prenatal previo al nacimiento del niño más pequeño menor de 24 meses.	5.5%	25.0%	4.5%	>0.45
Porcentaje de madres que no está embarazada y no desea más niños en los próximos dos años, o no está segura, y que está usando un método moderno de anticonceptivo.	n/a	n/a	3.9%	n/a

Valores P: <0.01 es muy significativo; <0.05 es significativo; >0.05 no es significativo.
Fechas de la línea base: Febrero 1994 para Cahabón, San Sebastián Coatán, y Zacualpa; Octubre 1994 para Purulhá; N = 830.
Fecha de estabecer los objectivos: Marzo 1994 (Plan de Implementación Detallado - DIP).
Fecha de la encuesta final: Julio 1996; N = 313.

JNB: 10-SEP-96

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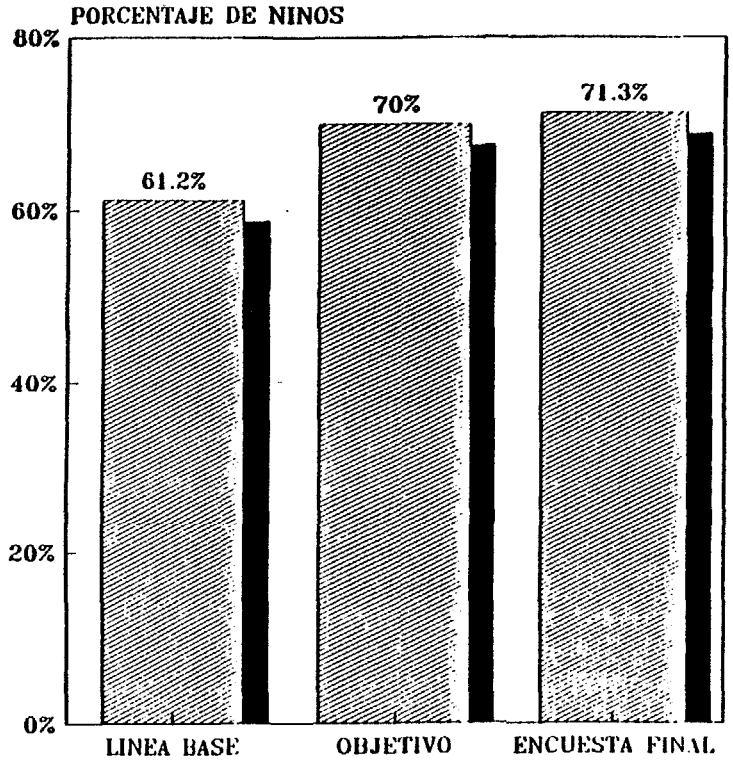
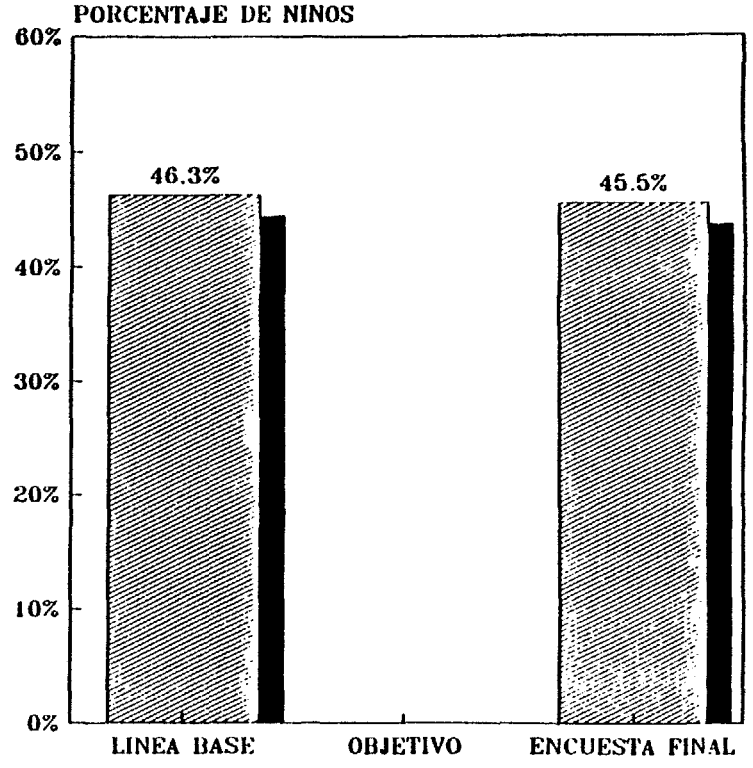
INICIO DE LA LACTANCIA
DENTRO DE LAS PRIMERAS OCHO HORAS



Chi-Sq = 9.94 P = 0.00162

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

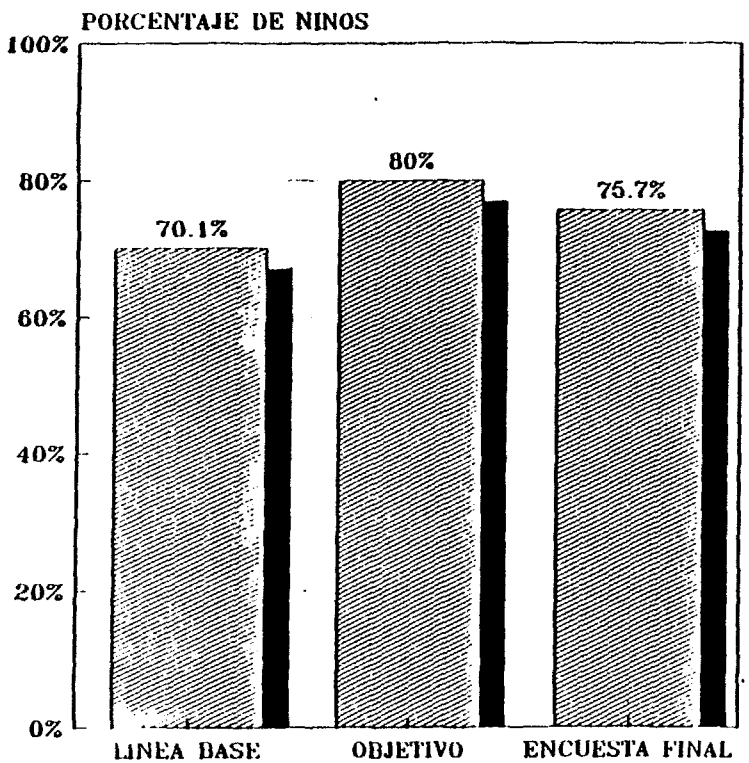
LACTANCIA EXCLUSIVA
MENORES DE CUATRO (4) MESES



Chi-Sq = 0.01 P = 0.93121

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

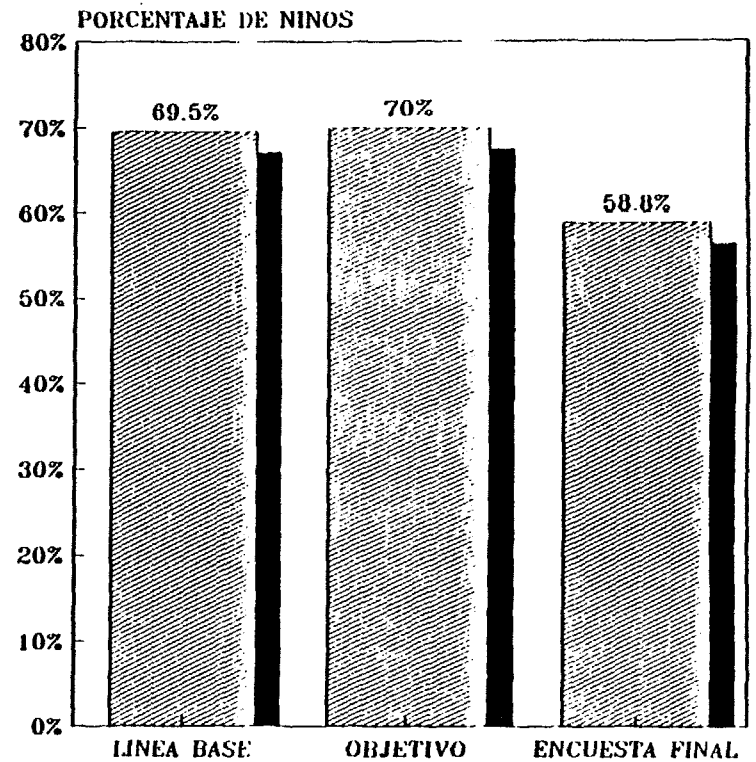
INTRODUCCION DE COMIDA
ENTRE SEIS (6) Y DIEZ (10) MESES



Chi-Sq = 0.54 P = 0.46332

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

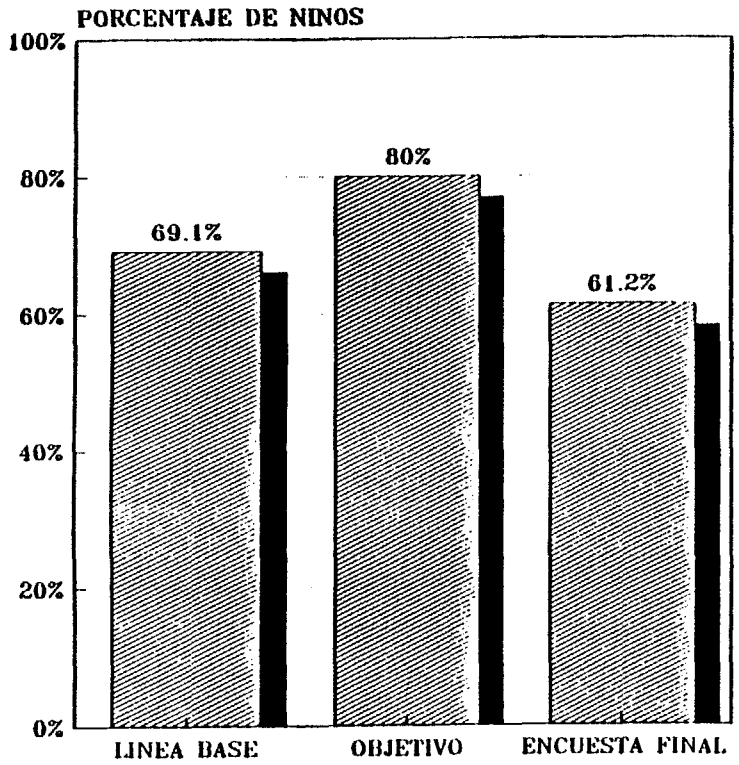
PERSISTENCIA DE LA LACTANCIA
ENTRE 20 Y 24 MESES



Chi-Sq = 1.44 P = 0.22964

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

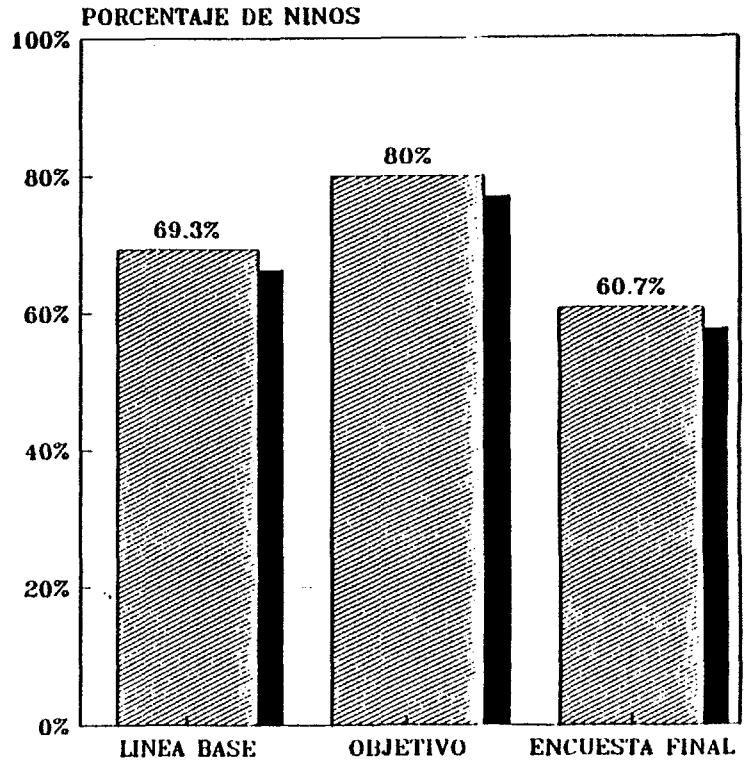
IGUAL O MAS LECHE DE PECHO
MANEJO DE DIARREA EN <24 MESES



Chi-Sq = 2.32 P = 0.12751

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

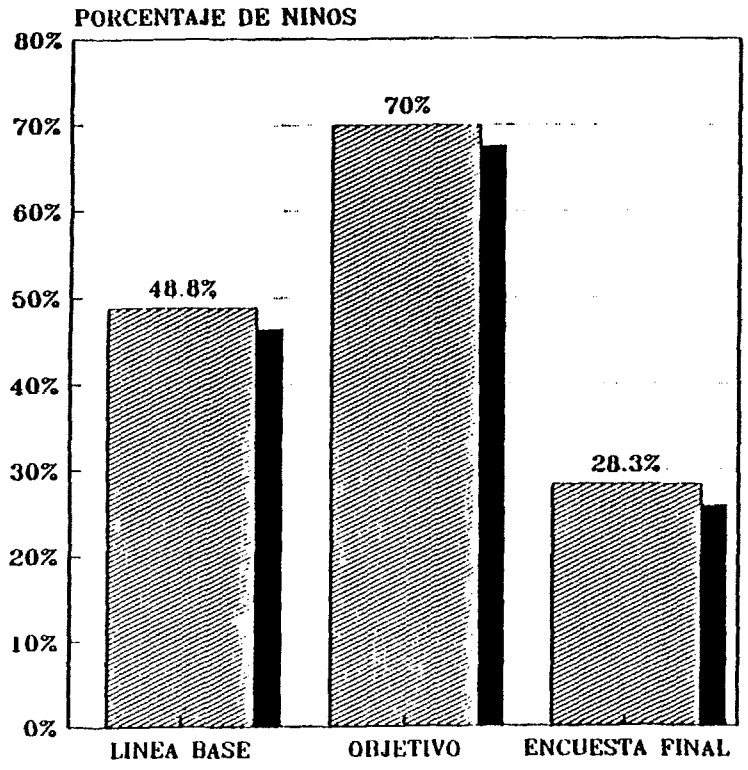
IGUAL O MAS LIQUIDOS
MANEJO DE DIARREA EN <24 MESES



Chi-Sq = 2.35 P = 0.12488

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

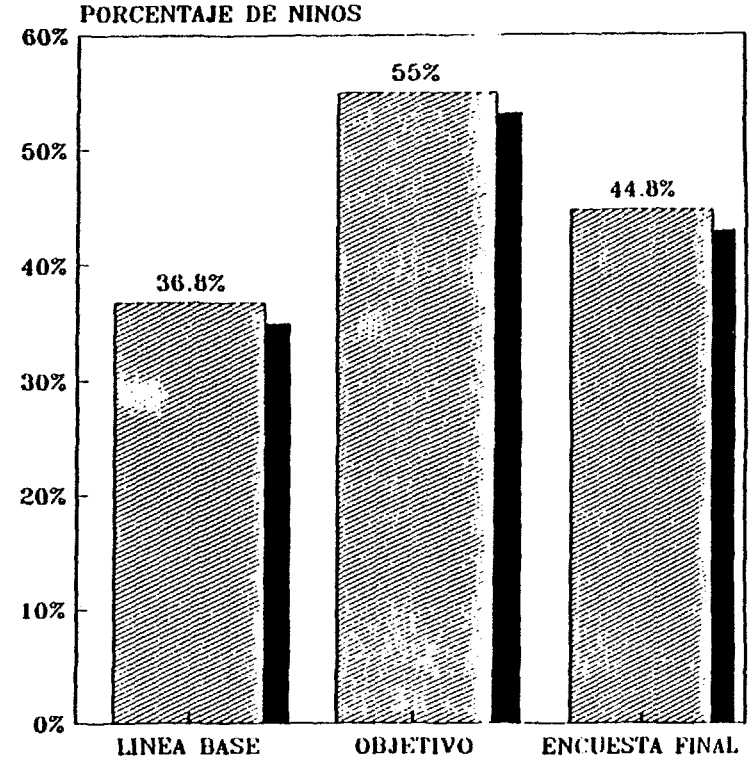
IGUAL O MAS COMIDA
MANEJO DE DIARREA EN <24 MESES



Chi-Sq = 10.95 P = 0.00094

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1998

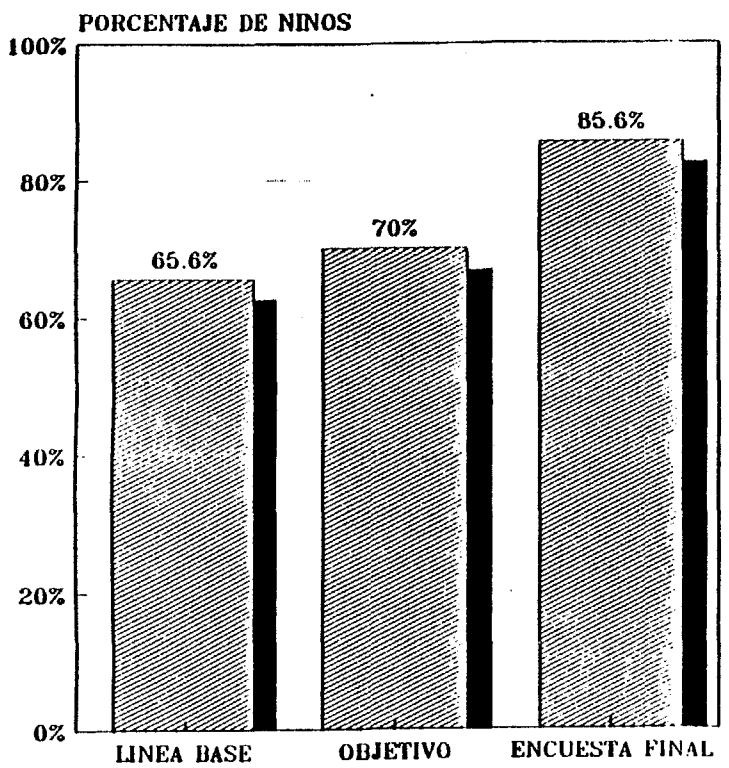
USO DE TRO
MANEJO DE DIARREA EN <24 MESES



Chi-Sq = 2.38 P = 0.12271

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1998

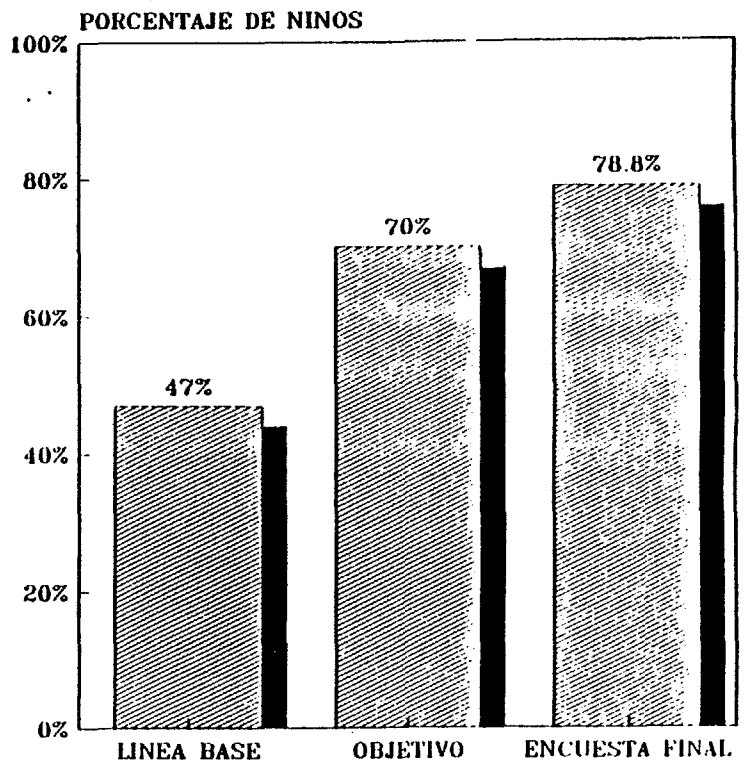
ACCESO A PAI: DPT-1
NINOS DE 12 A 23 MESES



Chi-Sq = 21.06 P = 0.000004

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

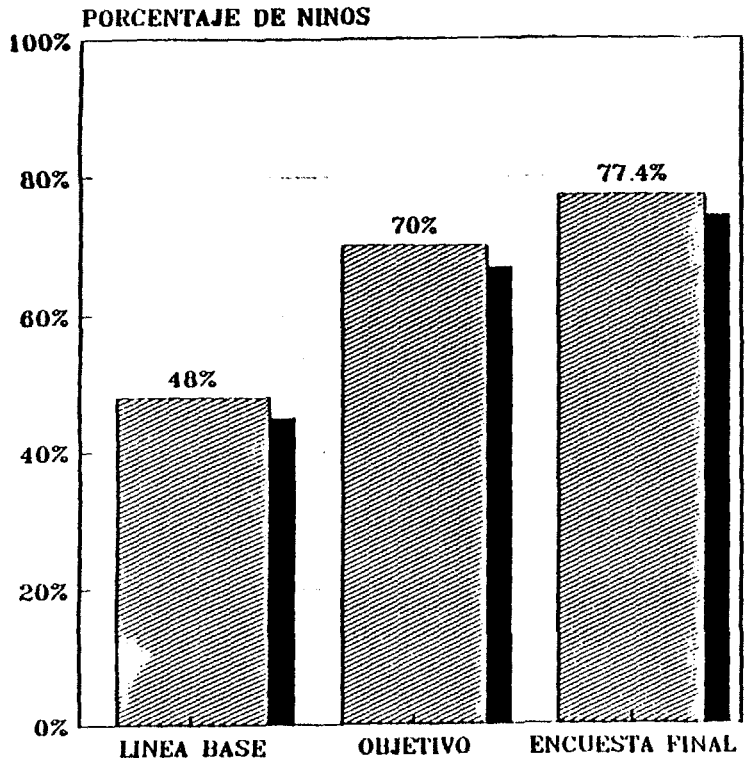
COBERTURA PAI: POLIO-3
NINOS DE 12 A 23 MESES



Chi-Sq = 44.15 P = 0.00000+

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

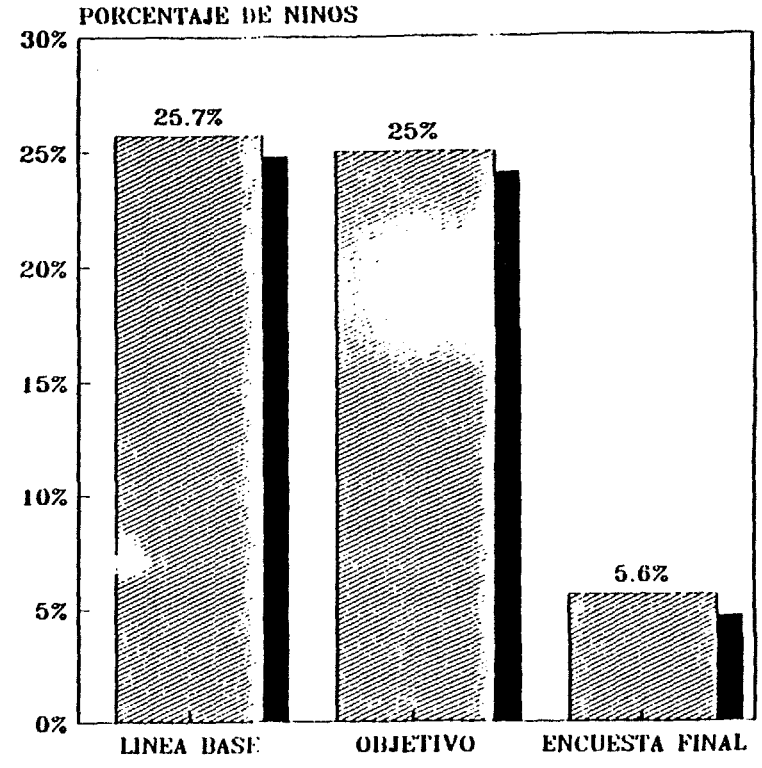
COBERTURA PAI: SARAMPION
NINOS DE 12 A 23 MESES



Chi-Sq = 37.99 P = 0.00000+

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

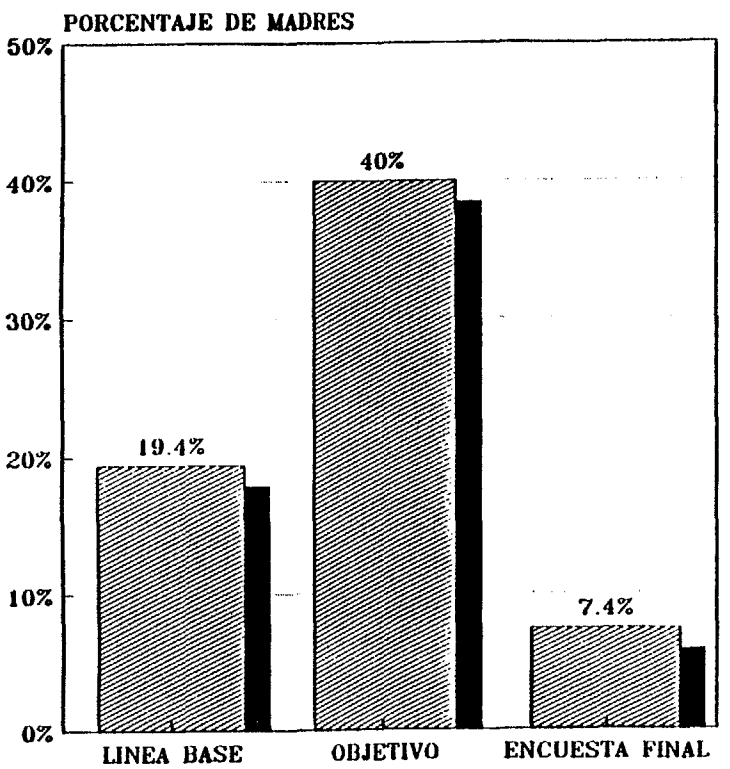
TASA ABANDONO: DPT1-DPT3
NINOS DE 12 A 23 MESES



Chi-Sq = 22.24 P = 0.000002

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

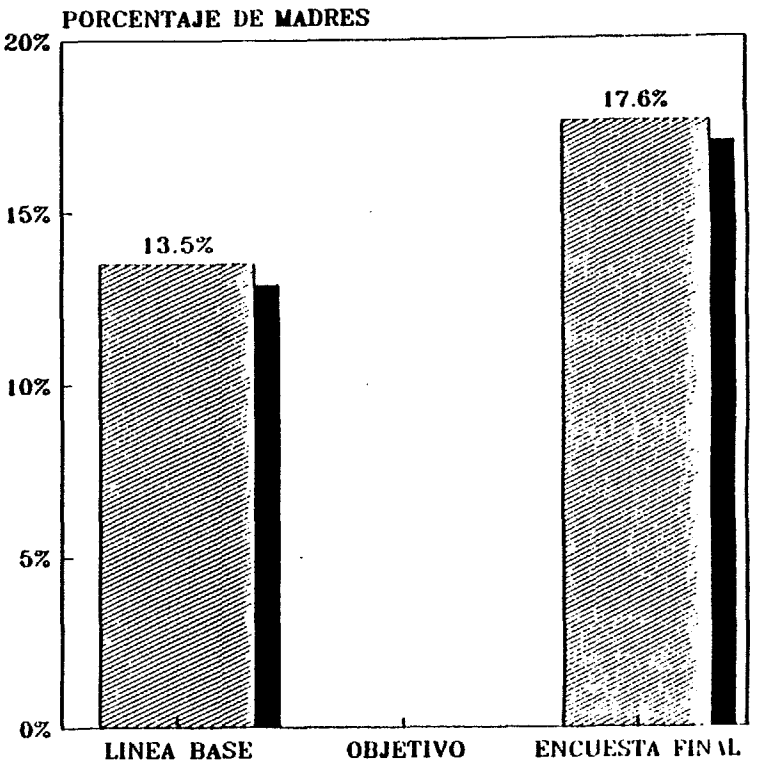
TRATAMIENTO MEDICO
MANEJO DE NEUMONIA EN <24 MESES



Chi-Sq = 7.59 P = 0.00586

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

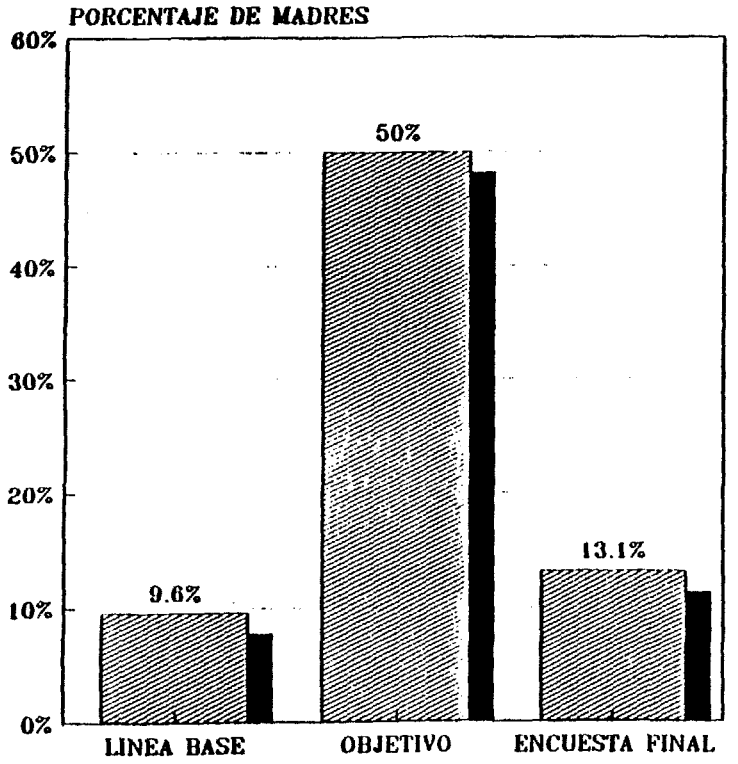
MADRES CON CARNET MATERNO
ATENCION DE SALUD MATERNA



Chi-Sq = 3.03 P = 0.08176

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

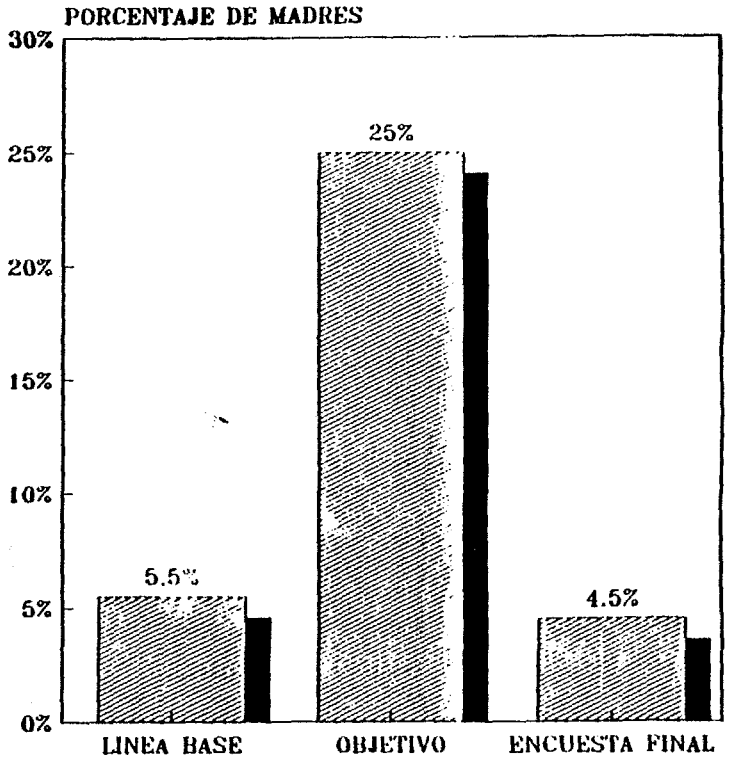
MADRES CON DOS O MAS TT
ATENCION DE SALUD MATERNA



Chi-Sq = 2.88 P = 0.08994

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996

CONSULTA PRENATAL
ATENCION DE SALUD MATERNA



Chi-Sq = 0.52 P = 0.46977

EVALUACION PROYECTO PASS/CARE
Linea base = febrero y octubre 1994
Encuesta final = julio 1996