

MID-TERM EVALUATION

***CHILD SURVIVAL IX
PASS PROJECT***

CARE Guatemala

September 1995

**MID-TERM EVALUATION
CHILD SURVIVAL IX
PASS PROJECT
CARE Guatemala**

Evaluation Team:

Isabel Nieves (team leader)
Fidel Arévalo
María Dolores Díaz
Liliana González de Chávez

September 1995

TABLE OF CONTENTS

Page No.

Executive Summary

Introduction	1
Background and Project Description	1
Methodology of the Mid-term Evaluation	2
1. Accomplishments	3
2. Effectiveness of the Interventions	7
3. Relevance to Development	12
4. Design and Implementation	13
4.1.1 Project Phases	13
4.1.2 Project Design	14
4.1.3. Implementation Strategies to Ensure Sustainability: Progress to Date	16
4.2. Management and Use of Data	20
4.3 Community Education and Social Promotion	22
4.4 Human Resources for Child Survival	25
4.5 Supplies and Materials for Local Staff	27
4.6 Quality Assurance	29
4.7 Monitoring and Supervision	30
4.8 Regional and Headquarters Support	31
4.9 CARE's Use of Technical Support	32
4.10 Assessment of Counterpart Relationships	32

4.11	Referral Relationships	33
4.12	PVO/NGO Networking	34
4.13	Budget Management	35
5.	Sustainability	36
6.	Recommendations.	37
	Documents Consulted for the Evaluation	44

Annex A: Terms of Reference for the Evaluation

Annex B: Evaluation Time Line

Annex C: Data Collection Instruments

Annex D: Individual or Group Interviews Undertaken in the Field

Annex E: 16-month Global Implementation Plan

Annex F: Project Phases Design Document

Annex G: Training Sessions to Date by Type of Trainer and Trainee

Annex H: MSS Design

Annex I: Country Project Pipeline Analysis

List of Tables

	Table	Page No.
2.1	Immunizations	8
2.2	CDD and ORT	
2.3	Child Nutrition	9
2.4	Maternal Care	10
2.5	A R I / L A R I	10
2.6	HIV/AIDS	11
4.1.3	Progress in Implementation Strategies	18
4.3.1	Training of CHC's in Child Survival	22
4.3.2	IEC to Mothers, Fathers and/or Family Groups	22
4.4	Project Field Staff	25
4.5	Summary of Equipment Available by Intervention	28
4.10	Resources and Services Contributed by each Party	32
4.13	Budget Analysis by Line Item	35
5.1	Steps Undertaken to Promote Sustainability	36

List of Acronyms

AID	U.S. Agency for International Development
AIDS	Acquired immunodeficiency syndrome
AR	Annual report
AR1	Acute respiratory infections
CHC	Community health committee (<i>Comité de salud</i>)
CHW's	Community health workers
CDD	Control of Diarrheal Diseases
CMS	Multisectorial coordinating boards (<i>Coordinadora Multisectorial de Salud</i>)
CORU's	Community oral rehydration units
DIP	Project detailed implementation plan
EPI	Expanded program on immunizations
GOG	Government of Guatemala
GO's	Governmental organizations
HIV	Human immunodeficiency virus
IEC	Information, education and communication activities
KPC	Knowledge, practices and coverage
LARI	Lower acute respiratory infections
LHIS	Local health information system
MOH	Ministry of Health
MSS	Monitoring and supervision system
NGO's	Non-governmental organizations
ORT	Oral rehydration therapy
PASS	Child Survival IX Project: Health Services Support Project <i>(Proyecto de Apoyo a Los Servicios de Salud)</i>
PHC	Primary health care
RTA	Regional technical advisor
TBA's	Traditional birth attendants
TSR	Rural health technician (<i>Técnico en salud rural</i>)

Executive Summary

This evaluation determines progress in project implementation and effectiveness to date for CARE's Guatemala CS-IX project. It was conducted by four individuals with joint expertise in public health, health behavior, child survival, health planning and administration for (three external, one internal) sustainability and evaluation research, in 23 days. Data gathered were mostly qualitative; when possible quantitative data on inputs and outputs are presented. Five days were spent in the field; seven communities in four project districts were visited. Total evaluation costs were **US\$10,750**.

The project has been operating for 24 months in 103 Mayan communities with a population of 52,100, in four provinces. It has been very successful in community outreach, starting the mobilization process for health activities and taking immunization services to populations never reached before in their own communities. It has also been very successful in funding, supporting and implementing health-related activities that complement those of the MOH and NGO's.

Measurable outcomes are not available. Preliminary MOH district-level data indicate that immunization coverage rates have improved over the last year. Project efforts may have contributed to this increment since it has conducted six campaigns in 103 communities in two years. Most other accomplishments can be characterized as inputs preparatory for the launching of the child survival interventions and outputs related to training and IEC for four of these interventions. Some progress has been achieved in the implementation of ORT facilities and growth monitoring in the community; training is on target for the maternal care and above target for the ARI/LARI interventions. Very little progress has been achieved in the HIV/AIDS intervention. Monitoring, supervision and evaluation activities, including a LHMIS, need to be implemented immediately for all interventions.

Likewise, inputs for the sustainability implementation strategies, a central project component, refer to the formation of key institutions for community participation and inter institutional collaboration and the provision of initial training on sustainability (management and financial); outputs for sustainability include organization and initial training of district and community entities, and collaboration agreements with counterparts, public and private. These products are to serve as building blocks for the provision of child survival services at the community level and for more intensive training in sustainability knowledge and skills, due to begin immediately.

The original design was overambitious in its strategies to promote sustainability, number of interventions and population coverage given geographical conditions and ethno-linguistic diversity. The 3-year period stipulated for CS-IX projects is insufficient to achieve sustainable results based on trials of innovative but untested strategies. In the 12 months left the project staff must consolidate progress obtained and implement sustainable child survival interventions of high quality.

Recommendations are to focus on fully developing immunizations, CDD/ORT, ARI/LARI and maternal care interventions for one targeted sector in each of 4 project districts in the next 8 months, along with the immediate implementation of a LHMIS and a MSS and the intensive training of counterparts in technical and financial aspects of sustainability. In the following 4 months until project completion, CARE should closely monitor and support the sustainability of the child survival activities and benefits. Specific recommendations are included to improve the coverage, quality and sustainability of each child survival intervention. Recommendations in this report reflect feedback provided by CARE Guatemala technical staff, project management and field staff, COG, including MOH, and NGO counterparts and community health workers.

This report was primarily prepared by the evaluation team leader, with contributions from other team members, CARE staff, project staff and the RTA for primary health.

Introduction

Background and Project Description

This evaluation complies with the requirements of AID Washington for a mid-term assessment of any child survival project. The purpose of this mid-term evaluation is to determine the progress in project implementation, effectiveness to date measured against the goals, objectives and indicators outlined in the project's Detailed Implementation Plan (DIP), and provide recommendations for the last year of project implementation. The terms of reference for the evaluation appears in Annex A.

CARE Guatemala's Child Survival IX project, the PASS project for its Spanish title (*Proyecto de Apoyo a los Servicios de Salud*), seeks to strengthen community and district-level health services for child survival. Its design was based on lessons learned from Child Survival V, Community Health Outreach, also implemented by CARE (from 1989-1993).

The PASS project has been in operation for 24 months. It covers a total of 103 rural Mayan communities and a population of 52,100 in four health districts in four different departments (provinces). According to the project's DIP these districts were selected in conjunction with the Guatemalan MOH because they lacked access to health care and exhibited low service coverage. The project is characterized by two features:

1) it identified and implemented three strategies meant to ensure project and benefit sustainability:

- a) community participation
- b) inter institutional collaboration
- c) training of local human resources for sustainability and child survival;

2) it is implementing six child survival interventions:

- a) immunizations
- b) diarrheal disease control and oral rehydration therapy
- c) acute respiratory infections and pneumonia treatment
- d) child nutrition
- e) maternal care
- f) HIV/AIDS

In addition to a project manager, project staff includes field assistants and field extensionists. Community level health workers include promoters, collaborators (also known as volunteer workers) who assist promoters in outreach activities and traditional birth attendants.

Methodology of the Mid-term Evaluation

The evaluation was conducted by a team of four individuals (three external, one internal) with joint expertise in the areas of public health, health behavior, child survival, health planning and administration, health sustainability and evaluation research, in a 23-day period. A time-line for the evaluation appears in Annex B. The team developed data collection instruments and interview guides following AID's "Mid-term Evaluation Guidelines for Child Survival-IX Projects". These instruments are presented in Annex C. Techniques for data collection included presentations by CARE Guatemala staff and CARE's RTA in primary health care, review of project documents and files, project-generated data, field visits to the four districts where the project is being implemented to conduct observations, individual and group interviews with project staff and beneficiaries. Data gathered were mostly qualitative; where possible and when time allowed, quantitative data on inputs and outputs were gathered for each district and then consolidated. Data collected from project beneficiaries was conducted in Spanish and in the native language with the aid of an interpreter.

The evaluation team was divided into two groups of two persons each for the field visits. Each group covered two districts and was accompanied by project field staff. Five days were spent in the field, including travel time. In each district the team chose two communities to visit, in consultation with project staff: a community where most of the activities previously identified as important benchmarks of project progress were being implemented and another where fewer were in place, roughly corresponding to a "successful" setting and a less successful one. Every effort was made to visit two communities per district, although in San Miguel Acatán only one visit was possible because of time and accessibility constraints. In total, data were obtained from visits to seven project communities. In addition some promoters from other communities not visited were interviewed. MOH district personnel, NGO's and members of the district's Multisectorial coordinating Boards (CMS) were also interviewed during the field trips.

Seven communities were visited and seven group interviews with mothers carried out, one per community. Ten promoters, two TBA's were interviewed individually. Nurse auxiliaries from three districts were interviewed and four group interviews were conducted with MOH district staff. Five Community Health Committees (CHC) and three CMS's were interviewed in group fashion, while representatives from two NGO's were approached individually. PASS project staff interviewed included five field assistants and five extensionists. The table presented in Annex D presents the numbers of individual and group interviews conducted by district and type of informant.

For data analysis the information was organized by sections, following the AID guidelines. Each team member analyzed data for a number of sections individually; then the team met to discuss the results, contribute additional information and insight from analysis of other sections, identify data gaps and inconsistencies, and offer joint interpretation. After additional data were gathered from project staff and files, the team met again to jointly interpret the results and provide conclusions and preliminary recommendations. During this process data

from different sources were compared for consistency and to improve reliability. Whenever possible these inconsistencies were resolved. It should be noted that much project information has not been systematized and some activities, decisions and processes have not been documented. For these reasons data obtained are of variable reliability.

Preliminary recommendations were presented at a one-day workshop attended by CARE Guatemala, project management and field staff, MOH district level staff for each of the four districts, one NGO counterpart, and community health promoters. Modifications to the recommendations were made with their input.

1. Accomplishments

The project has been operating for 24 months. It has been very successful in community outreach, starting the mobilization process for health activities and taking immunization services to populations never reached before in their communities of residence. It has also been very successful in funding, supporting and implementing health-related activities that complement those of the Ministry of Health in the districts served and collaborating/coordinating with NGO's in one district where these are active in health issues .

Data sources for assessment of inputs, outputs and outcomes are project documents and data in CARE Guatemala and field offices, project files, the first annual report, the internal review conducted in June 1995, and interviews with project staff. These sources present inconsistent data sometimes. Much quantitative data are approximate. Although census data are available for 75 of the 103 project communities (1994 data for Cahabon and 1995 data for the other three districts) no aggregate population data are available in order to assess percentages of target groups reached or coverage rates. Below, accomplishments are summarized for inputs for child survival interventions and sustainability implementation strategies; then outputs are presented for interventions and strategies. These summaries are based on Tables 2.1 to 2.6, 4.1.3, 4.3.1 and 4.3.2., appearing further on in this report, and Tables 1 to 12 in Annex G on training accomplishments.

Measurable **inputs for child survival** interventions include:

- immunization campaigns conducted in a total of 102 communities in collaboration with counterparts: 6 per community in Zacualpa, 7 per community in San Miguel Acatán and Cahabon and 12 per community in Purulhá
- transportation and equipment for maintenance of the immunization cold chain in 4 districts
- equipment for 100 CORU's available and 30 sets of equipment delivered to communities
- 40 Salter-type scales available for growth monitoring
- at least one training session in each of 3 districts to MOH personnel on case management of diarrheal disease and ARI/LARIs, including referral by community personnel: San Miguel Acatán: 5 days (one NGO participated in the session); Cahabon: 2 days; Purulha: 5 days;

- one training session on reproductive health to MOH personnel, including reproductive risk, case management and referral by community personnel in Zacualpa: 3 days
- 1 3-day training session on immunizations (including training for LHM for this intervention) for promoters in Cahabon and Purulha; 1 1-day training session on immunizations for collaborators and TBA's in Cahabon; 1 2-day training session and 1 2-day follow-up training for promoters in San Miguel Acatán and Zacualpa
- 1 2-day training session on CDD/ORT for promoters in Cahabon and Zacualpa (including training for LHM in this intervention); 1 2-day training session and 1 1-day follow-up session on same topics for promoters in San Miguel Acatán and Purulha
- 1 2-day training session and 1 1-day follow-up session on child nutrition for promoters in San Miguel Acatin, Zacualpa and Purulha
- 1 2-day training session on ARI/LARI for promoters and 1 1-day session on same topic for TBA's in Purulha
- 1 3-day training session on maternal care for promoters and 4 2-day training sessions for TBA's in Purulhá; 6 2-day training sessions on maternal care for promoters and 4 1-day training sessions for TBA's in San Miguel Acatin; 1 2-day training session on same topic for TBA's in Cahabon (an activity financed by the MOH with training by PASS Project); 1 2-day training session on same topic to TBA's in Zacualpa
- six training sessions for CHC's in immunizations: San Miguel: 1; Zacualpa: 1; Cahabon: 4
- six training sessions for CHC's in CDD/ORT: San Miguel: 1; Zacualpa: 1; Cahabon: 4
- two training sessions for CHC's in child nutrition: San Miguel: 1; Zacualpa: 1
- contributions in kind or cash for counterparts, including MOH and NGO's, for medicines and salaries of field personnel
- one field study on KAPs related to HIV/AIDS conducted in 6 communities and data analysis proceeding
- 242 IEC sessions on immunizations conducted with mothers and/or fathers in 94 communities (all districts)
- 218 IEC sessions on CDD/ORT conducted with mothers and/or fathers in 72 communities (all districts)
- 8 IEC sessions on child nutrition with mothers and/or fathers in at least seven communities in San Miguel Acatán and Purulhá
- 5 IEC sessions on ARI/LARI with mothers and/or fathers in at least 5 communities in Purulha
- 54 IEC sessions on maternal care to mothers and/or fathers in 29 communities in Cahabon and Purulha; additionally 2 sessions on the same topic conducted by health workers of NGO's in one community in San Miguel with participation of people from several of 18 communities invited.

Inputs for implementation strategies aimed at ensuring project sustainability include:

- CMS's in 3 districts (with the exception of San Miguel Acatin) attended workshops to develop operational plans in which the strategic planning methodology was implemented: Cahabon: 6 days; Purulha: 7 days; Zacualpa: 2 days

- CMS's in 4 districts participated in 1 2-day workshop per district on the IEC methodological guides, received exposure to and provided feedback on the educational techniques and key messages in these guides
- One Municipal Technical Board (UTM) in each of two districts receiving training on health and development
- At least one training session per district for CHC's on issues related to sustainability: San Miguel Acatán: 2 days; Zacualpa: 3 days; Cahabon: 4 days; Purulha: 1 day
- At least one training session per district for promoters on issues related to sustainability: 2 days in San Miguel Acatán; 3 days in Zacualpa; 4 days in Cahabon; 1 day in Purulha

Project outputs to date for child survival interventions are:

- children under one year immunized in 103 communities (coverage rates not available)
- 20 Community Oral Rehydration Units (CORU's) set up: 10 in Cahabon and 10 in Purulha
- growth monitoring currently being conducted in 10 communities in the district of Purulha
- 75 community censuses completed with community participation and 14 more in the process of data collection or analysis : 30 conducted in Cahabon in August 1994, not updated in 1995; 25 in Purulha in June 1995; 18 in San Miguel Acatán in June 1995; 2 in Zacualpa in July 1995
- 240 health promoters with at least 24 hours of training (including follow-up training) in immunizations, including training in LHMIS for this intervention in 4 districts; 35 collaborators and 48 TBA's with eight hours of training in immunizations in Purulha; additionally 31 immunization workers from communities not participating in the project received training in Cahabon;
- 247 health promoters with at least 16 hours of training in CDD/ORT, including LHMIS for this intervention in 4 districts; additionally 133 promoters with 8 hours of follow-up training in San Miguel and Purulha
- 119 health promoters with at least 16 hours of training in child nutrition in 3 districts (not in Cahabon) ; additionally, 93 promoters with 8 hours of follow-up training in San Miguel and Purulha
- 46 health promoters with 16 hours of training in ARI/LARI in Purulha; additionally 26 TBA's with 8 hours of training on same topic in same district
- Between 236 and 259 TBA's with at least 16 hours of training in maternal care in 4 districts: San Miguel Acatán: 130 or 135 for at least 16 hours of training (some of them may have received as many as 96 hours); Cahabon: 25 for 16 hours; Purulha: between 41 and 45 for at least 16 hours each (some may have received as many as 64 hours) Zacualpa: 40 or 54 for 24 hours
- 79 promoters with at least 24 hours of training in maternal care: Purulha: 65 for 24 hours; San Miguel Acatán: 14 for at least 16 hours (some of them may have received as many as 96 hours)
- 20 CHC's with at least one IEC session on immunizations: San Miguel: 10; Zacualpa: 8; Cahabon: 6

- 20 CHC's with at least one IEC session on CDD/ORT: San Miguel: 10; Zacualpa: 8; Cahabon: 6
- 16 CHC's with at least one IEC session on child nutrition: San Miguel: 10; Zacualpa: 6
- 3110 individuals (mothers and fathers) attended at least one IEC session on immunization in the four districts: San Miguel: 1145; Zacualpa: 150; Purulha: 488; Cahabon: 1327
- 1670 individual attended at least one session on CDD/ORT in four districts: San Miguel: 150; Zacualpa: 100; Purulha: 395; Cahabon: 1025
- 265 individuals attended at least one IEC session on child nutrition: San Miguel: 120; Purulha: 145
- 175 individuals attended at least on IEC session on ARI/LARI in Purulha
- 555 individuals attended at least one IEC session on maternal care: San Miguel: 260; Purulha: 145; Cahabon: 150
- 10 focus groups on KAP's in HIV/AIDS

Outputs for implementation strategies for project sustainability are:

- 73 or 75 CHC's or community development committees formed and active in 4 districts: San Miguel: 10; Zacualpa: 10; Cahabon: 28 or 30; Purulha: 25; in addition, 14 in the process of formation in San Miguel
- 25 community development committees receiving training in the incorporation of health concerns to their work: Zacualpa: 10; Purulha: 25
- Community participation in selection of health collaborators in approximately 50 communities in three districts: San Miguel: 21; Cahabon: approximately 10; Purulha: 20
- Training for participatory needs assessment begun with CHC's in 30 communities in Cahabon
- 103 family groups or mothers' groups organized in a total of 46 communities: Cahabon: 65 family groups in 30 communities; Purulha: 38 family groups in 16 communities
- One CMS fully functioning (Cahabon: formed as a CMS as conceived in DIP and implementing action plan developed by them) and one partially functioning (San Miguel Acatán: formed as a CMS as conceived in DIP, not implementing an action plan developed by them and with weak inter-institutional links and coordinating capacity)
- Two UTM's in training on incorporation/coordination of health activities into their work
- formal agreements with MOH district establishments in four districts and with two NGO's in one district
- Representatives of 75 (or 89) CHC's in 4 districts attended at least one training sessions on committee structure and organization, functions and responsibilities, group formation, leadership, problem tree approach to problem identification and prioritization (last two only in Cahabon): San Miguel Acatán: 10 (or 24) CHC's for 2 days; Zacualpa: 10 CHC's for 3 days; Cahabon: 30 CHC's for 4 days; Purulha: 25 CHC's for 1 day
- 149 promoters in 4 districts attended at least one training session on same topics described in previous point, plus initial training on financial sustainability of immunization services and CORU's : 24 for 2 days in San Miguel Acatán; 28 for 3 days

- in Zacualpa; 72 for 4 days in Cahabón; 25 for 1 day in Purulhá; in addition 19 TBA's received 1 day of training on same topics in Purulhá
- participation of community members (leaders and promoters) in community censuses in 75 communities.

Measurable outcomes are not available. Preliminary district-level data provided by the MOH and project staff indicate that immunization coverage rates have improved over the last year in the four districts, including communities not participating in the project. Qualitative data suggest that mothers have improved knowledge of and attitudes towards immunizations, and know how to prepare OR solutions, both home-based and from pre-packaged salts. Project and district level MOH staff consistently report that mothers provide ORT to children during diarrhea while mothers interviewed reported this behavior less consistently. MOH district level personnel report increases in demands for immunizations and prenatal health care. Mothers' reporting of prenatal care use is less.

Most accomplishments to date can be characterized as inputs preparatory for the launching of the child survival interventions and outputs relating to training and IEC for four of these interventions. The exception is immunizations, which has been implemented in all project communities. It was not possible to assess the quality of the outputs identified. Likewise, inputs for the implementation strategies refer to the formation of key institutions for community participation and inter institutional collaboration and the provision of initial training on sustainability (management and financial); outputs for sustainability include coordinating boards and community entities formed and receiving training, and agreements reached to formalize relations with counterparts, public and private. Again, these products are to serve as building blocks for the provision of child survival services at the community level and for more intense training in sustainability knowledge and skills, due to begin immediately.

2. Effectiveness of the Interventions

An informal internal review of the project was conducted in June 1995. As a result, a 16-month operational plan was developed and changes proposed for the remainder of the project. According to this plan, the mid-term evaluation would focus on the progress achieved and the pertinence of the changes proposed, in addition to assessing the issues included in the AID guidelines. The following evaluation of effectiveness to date takes the 16-month plan as its point of reference, as neither the DIP nor the first AR contain detailed action plans. The 16-month global implementation plan is presented in Annex E. The following tables respond to the question: how do the accomplishments achieved so far compare with the accomplishments anticipated in the DIP (in this case the mentioned 16-month plan)? Accomplishments are measured for each of the child survival interventions. Most accomplishments are anticipated at the end of the 16-month period, not to date, unless otherwise noted.

Table 2.1: Immunizations

ACCOMPLISHMENTS ANTICIPATED by END of 1 B-MONTH PLAN	ACCOMPLISHMENTS ACHIEVED
Immunization campaigns supported in 102 communities every two months throughout the period	6 or 7 immunization campaigns have been supported in each district. covering 103 communities
Key messages to 2,200 families	3110 mothers with at least one IEC session (141% accomplished): Cahabon: 1327 San Miguel: 1145 Zacualpa: 150 Purulhá: 488
Cold chain maintenance	It has been carried out in the 4 districts during each camoaión
Local programming of immunization activities in 102 communities	It has been accomplished in 68 communities (67% accomplished): Cahabon: 30 San Miguel: 18 Zacualpa: 10 Purulhá: 10
Community census in 103 communities by 30 September 1995	75 census completed (73% accomplished): Cahabon: 30 in August 1994, not updated in 1995 San Miguel: 16 in June 1995 Zacualpa: 2 in July 1995 Purulhá: 25 in June 1995
Promoters health training on promotion of immunization campaigns and vaccination (at least one in each community). No numbers specified	240 promoters with at least 24 hours training Cahabon: 72 San Miguel: 80 Zacualpa: 28 Purulhá: 60
Immunization coverage increment in 4 health districts.	The coverage has increased in the 4 districts according to MOH data

Table 2.2: CDD and ORT

ACCOMPLISHMENTS ANTICIPATED by END of 1 & MONTH PLAN	ACCOMPLISHMENTS ACHIEVED
<p>Training to 275 promoters due to occur in July 1995:</p> <ul style="list-style-type: none"> -Standardized management of diarrhea cases -OR T management -LHIS 	<p>247 promoters with at least 16 hours training (90% accomplished):</p> <p>Cahabdn: 72 San Miguel: 80 Zacualpa: 28 Purulhl: 67</p>
<p>Implementation of 40 CORU's due to occur between July and September, 1995</p>	<p>20 CORU's implemented (50% accomplished):</p> <p>Cahabón: 10 Purulhá: 10. San Miguel: none but equipment for 10 distributed Zacualpa: none</p>
<p>Key messages delivered to 2,300 families due to occur between July and October 1995</p> <ul style="list-style-type: none"> -Diarrhea prevention -Risk signs -Proper management of diarrhea at home 	<p>1670 individuals with at least one IEC session (73% accomplished):</p> <p>Cahabdn: 1,025 San Miguel: 150 Zacualpa: 100 Purulhd: 395</p>
<p>Monitoring and evaluation</p> <ul style="list-style-type: none"> -OR cases proper management -OR cases referral system -key message adoption 	<p>Purulhl: The health promoters provide oral rehydration solutions as well as education on demand to women/families that request it</p> <p>The health promoters follow-up diarrhea cases in the community.</p> <p>The health promoters with support from the CHC's manage the CORU's already set up.</p> <p>Cahabdn: household visits carried out in order to evaluate mothers' attitudinal and behavioral changes after receiving the health promoters messages.</p> <p>No activities implemented in two districts.</p>

Table 2.3: Child Nutrition

ACCOMPLISHMENTS ANTICIPATED by END of 16-MONTH PLAN	ACCOMPLISHMENTS ACHIEVED
<p>Training to 275 health promoters due to occur in August 1995:</p> <ul style="list-style-type: none"> -Nutrition education -Growth monitoring -Follow-up on children with faltering growth -Feeding during the weaning period 	<p>119 promoters with at least 16 hours training (43% accomplished):</p> <p>San Miguel: 40 Zacualpa: 26 Purulhá: 53 Cahabón: none</p>
<p>Implementation of monthly growth monitoring for children under 3 in 62 communities in 4 districts</p>	<p>10 communities in Purulhá have started monthly growth monitoring (16% accomplished)</p>
<p>Key messages to 2,200 families</p> <ul style="list-style-type: none"> -Demonstration of food preparation -Weaning -Nutritional care at home for children with faltering growth 	<p>265 individuals with at least one IEC session (12% accomplished):</p> <p>Purulhá: 145 San Miguel: 120</p>
<p>Monitoring and evaluation</p> <ul style="list-style-type: none"> -Proper implementation of growth monitoring -Follow-up on mothers of children with faltering growth -Weaning practices -Use of local food resources at home 	<p>Extensionists have initiated these activities in Purulhd</p>

Table 2.4: Maternal care

ACCOMPLISHMENTS ANTICIPATED by END of 1 B-MONTH PLAN	ACCOMPLISHMENTS ACHIEVED
<p>Training to 145 TBA's:</p> <ul style="list-style-type: none"> -Pre-natal care -Delivery care (peri-natal care) -Post-natal care -High risk pregnancy -family planning 	<p>236 or 259 TBA's with at least 16 hours training (163% or 179% accomplished):</p> <p>San Miguel: 130 or 135 (exact figure not known)</p> <p>Cahabón: 25</p> <p>Purulhá: 41 or 45 (depending on the activity attended)</p> <p>Zacualpa: 40 or 54 (exact figure not known)</p> <p>Zacualpa: 1 training activity in 1994 (there is no information regarding content or the number of participants)</p> <p>Family planning was dropped from intervention</p>
<p>Key messages to 125 pregnant women and mothers with children under 12 months:</p> <ul style="list-style-type: none"> -Importance of prenatal care -Breast feeding in the first 8 hours after birth -Exclusive Breast feeding during first 6 months -Benefits of limiting and spacing births 	<p>555 individuals with at least one IEC session (222% accomplished):</p> <p>San Miguel: 260</p> <p>Purulhá: 145</p> <p>Cahabón: 150</p> <p>No family planning IEC.</p>
<p>Monitoring and Evaluation</p> <ul style="list-style-type: none"> -Referral system for high risk pregnancies, delivery complications -Prenatal care compliance -Delivery and post-natal visit compliance 	<p>Only in Purulhá, where a health information system is in implementation: the TBA records number of pregnancies and deliveries.</p>

Table 2.5: ARI/LARI (Pneumonia Control)

ACCOMPLISHMENTS ANTICIPATED by END of 16-MONTH PLAN	ACCOMPLISHMENTS ACHIEVED
<p>Training to 25 health promoters to occur in September 1995:</p> <ul style="list-style-type: none"> -Standardized case management -Implementation and management of community center for pneumonia 	<p>46 with at least 16 hours training in Purulhá (184% accomplished)</p>
<p>Key messages to mothers (no numbers provided) to occur between September and November 1995:</p> <ul style="list-style-type: none"> -Prevention of pneumonia -Recognition of pneumonia signs 	<p>175 individuals with at least one IEC session in Purulhá</p>
<p>Monitoring and evaluation:</p> <ul style="list-style-type: none"> -Referral system -Proper management of pneumonia cases at the community center -Early recognition of pneumonia signs at home 	<p>Not yet implemented.</p>

Table 2.6: HIV/AIDS

ACCOMPLISHMENTS ANTICIPATED by END of 16-MONTH PLAN	ACCOMPLISHMENTS ACHIEVED
<p>KAP survey: -Questionnaire design -Data collection -Data analysis and report to be completed by July 1995</p>	<p>10 focus group discussions on KAP's were conducted in 6 communities in Zacualpa. At this moment the draft report on the KAP study is being revised.</p>
<p>Training to health promoters, collaborators and teachers due to happen in July and August 1995</p> <p>IEC sessions to migrant workers due to happen in August and September 1995, and again in 1996</p> <p>-risk behavior -safe practices</p>	<p>It has not been implemented yet</p> <p>Not yet implemented</p>
<p>Monitoring and evaluation due to happen in August and September of 1995 and again in 1996</p> <p>-adoption and knowledge of safe practices</p>	<p>Not yet implemented</p>

Much progress is evident in the immunization intervention. Promotion of immunization campaigns has improved, especially those campaigns initiated by the MOH. District-level preliminary data from the MOH, although presenting some quality problems, appear to indicate that immunization coverages have improved in the four districts. Project efforts may have contributed to this increment.

Promoter training, implementation of CORU's and IEC to mothers in CDD/ORT are behind schedule according to the 16-month global plan (see Annex E). In the child nutrition intervention, training of health promoters is behind schedule but some progress is being made in reaching the objective of growth monitoring in 62 communities by the end of the project. IEC messages to families are just beginning, as planned. Monitoring, supervision and evaluation activities need to be implemented soon. In maternal care, project progress is on target or above target, except for the monitoring, supervision and evaluation component. Training of promoters in ARI/LARI has surpassed the target, IEC activities have just begun, as planned, but monitoring, supervision evaluation activities require implementation. Very little progress has been achieved in the HIV/AIDS intervention, which is now scheduled to be implemented in only 10 communities of one district.

The high risk groups identified by the project are preschool children and mothers (pregnant and lactating women). Target groups vary by intervention: children under one year for immunizations (sometimes children under 3, depending on MOH targets); children under 3 for CDD/ORT and child nutrition activities, children under 5 for IRA/LIRA, pregnant and lactating mothers and newborns for maternal care, and women and men of reproductive age (15-45) for HIV/AIDS. It is not possible at this stage of the project to determine whether and how

the interventions are reaching these target groups because most child survival interventions are just beginning. Immunizations is reaching between 50 and 90% of the target groups according to district-level coverage rates and to perceptions of MOH staff. It is difficult to determine objective coverage rates for the communities participating in the project because the health information system is not fully in place.

The major constraints to meeting objectives and reaching high risk groups are:

- although MOH staff have participated in promoter training activities, they need to participate actively in strategic planning, programming and development of supervision activities for community health workers;
- the CMS's are institutions in the making, too weak at this point to plan or implement child survival interventions and developing capacity to perform as coordinating agents;
- MOH district offices do not have consolidated information on immunization to allow objective verification of expanded immunization coverage, with the exception of Zacualpa;
- some MOH districts do not have enough supplies to cover the needs of the populations they serve (rehydration solutions in San Miguel Acatán, vaccines in others);
- there has been delays in the delivery of scales and charts for growth monitoring;
- in some communities the presence of the MCH project and its food distribution component acts as disincentive to participation in PASS project's educational activities in nutrition;
- project field staff is insufficient to effectively cover the number of target communities selected;
- the majority of communities are inaccessible and disperse.

3. Relevance to Development

During project implementation in most communities families reluctant to participate in Child Survival activities have been identified. The PASS project has taken the following measures to increase the ability of families to participate in and take advantage of these activities and their benefits. From the beginning the project adopted community participation as an implementation strategy, operationalized through community cooperation networks among others.

Community mobilization in the form of social cooperation networks, has been more successful in Cahabon and Purulha than in the other two districts. These networks are activated in some instances to persuade families to participate: CHC members, community leaders and promoters visit reticent families in Purulha, Cahabon and Zacualpa. Where collaborators (another type of CHW aiding promoters) are already active, as in Purulha, they participate in these networks, as do some MOH personnel. PASS project field staff also perform motivational household visits. In the districts of Cahabon and Purulha social cooperation networks are activated to a greater degree than in the other two districts. Some communities are also holding town meeting for consciousness raising and to analyze constraints to project implementation and

seek solutions. This has not been promoted yet in San Miguel and is getting underway in Zacualpa. The project has been much more successful in building on traditional cooperation networks and activating them for health purposes in the two northern districts because these are relatively free of political violence and conflict, seasonal and external migration, NGO's and GO's that create expectations and attitudes of dependence in the population, and MOH representatives that are unwilling to coordinate with NGO's.

4. Design and Implementation

4.1.1 Project Phases:

Between the preparation of the DIP and the first annual report , five implementation phases were defined for the project (see Annex F). These phases are not reflected in either document, but have since served as the guide for project implementation by project staff. These phases as described in the annexed document do not have time periods or dates identified. Project staff provided this additional information during interviews and are reported here:

Phase	Time Period	Completion Date
I: Preparatory	12-14 months	Sept.- Nov., 1994
II: Social mobilization	12 months	Sept., 1995
III: Health system strengthening	12 months	Sept., 1996
IV: Self financing health system	6-8 months	March-May, 1997
V: Local community development	12 months	March-May, 1998

Although they probably were conceived and formalized as project implementation progressed during the first year, the internal review carried out by CARE Atlanta in June 1995 considered this design by phases and proposes a 16-month plan to complete phase III, strengthening the local health system, although the plan itself does not make reference to which activities fall in phase II and which in phase III.

The first three phases are to be completed in the three years of project funding. A fourth phase in which the project's sustainability would be monitored, falls outside the scope of the period funded in this design. At the moment of the evaluation (late September) phase II is being completed; phase III is due to begin 1 October, 1995.

In contrast, the project's DIP considers a phase in which project responsibilities would be phased over to the counterparts--the MOH, NGO's and community organizations--in the second half of the third year, set to begin in March 1996, in order to monitor the success of project sustainability for a 6 month period. As currently planned, this will no longer be possible.

4.1.2 Project Design:

Design Issues

The original design as reflected in the DIP does not clarify the criteria for establishing the number (100-103) of communities served by the project nor those for community selection beyond the MOH recommendation that they be communities in health districts with little access to health services and low coverage rates. Selection criteria did not appear to include epidemiological, distance and physical accessibility factors which have been important limitations for project implementation in three of the four districts, especially given the numbers of project field staff assigned per district. The human resources planning aspects of the DIP lack rationality criteria: two promoters per community were proposed, independent of the size or dispersion of the community; four extensionists were planned for each district, again with no consideration of numbers and accessibility of communities per district. The DIP does not make clear whether all child survival interventions were to be implemented in all communities or if immunizations, CDD/ORT and child nutrition were to be implemented in all and the others in some. Project staff favor the second interpretation.

Design Changes Recommended in June 1995

There is a standing recommendation by CARE, emanating from the internal review of June 1995, review the project's area of implementation and change the relative levels of effort for each technical intervention as follows:

1. The majority of project efforts should be focussed on a minimum package of three child survival interventions: immunizations, CDD and nutrition, including growth monitoring.
2. Percent of total effort per intervention would be revised as follows: for immunization and CDD it would double; for ARI/LARI, maternal care and HIV/AIDS it would be reduced by half or more.

intervention	current	proposed
immunization	15%	30%
CDD	15%	30%
Nutrition	20%	20%
ARI/LARI	15%	5%
Maternal care	20%	10%
HIV/AIDS	15%	5%
TOTAL	100%	100%

3. Budgetary allotment to each intervention would reflect these changes. Also, CDD interventions would include 40 CORU's in as many communities and growth monitoring activities in 62 communities. These suggested changes are included in the 16-month plan developed as part of the recommendation. Effectively, the plan is reducing the number of communities for CDD/ORT and child nutrition interventions.
4. The three remaining interventions--maternal care, ARI/LARI and HIV/AIDS each will be piloted in a reduced number of communities: maternal care in a total of 30 communities in three districts, excluding Cahabon; ARI/LARI in a total of 30 communities with 25 trained promoters in Cahabon only; HIV/AIDS will be implemented in 10 communities in Zacualpa only. Family planning activities have been completely dropped from the maternal care component because implementation was very difficult and the CARE reproductive health project would provide services and IEC activities to cases referred by the PASS project.

Project management is supporting these recommendations and willing to implement them when authorization is received. Reasonable explanations and justifications for these modifications were developed by CARE in a document dated June 1995: delays in project implementation in the first 18 months and the need to maximize the probability of success in sustainable child survival interventions and benefits by the end of year 3.

The referred document (p. 6) states that the majority of efforts will be given to immunizations, CDD and child nutrition given: 1) the health needs of the 103 communities included in the DIP and MOH priorities; 2) the difficulty in implementing an ARI/LARI intervention; and 3) that the three interventions mentioned will have the most impact in the communities. With regard to the first, ARI's are a considerable contributor to child morbidity in Guatemala and mothers interviewed say their children get sick from ARI's mostly. No written documentation of MOH priorities at the district or national levels is available. With regard to the second, the degree of implementation difficulty appears to be a criterion not consistent with the need criterion established in the DIP. Third, it is arguable whether an ARI/LARI intervention will not have impact of the same magnitude as the other three. The proposed level of effort for the ARI/LARI component is not commensurate with the magnitude of the problem.

The criteria for selecting the districts for the implementation of the pilot interventions were not made clear in the recommendations. The ARI intervention will be piloted in one district in the northern region only; yet, according to the DIP (p.27) infant mortality from LARI's is higher in the northwest region where two additional districts are located. In terms of HIV/AIDS, the district selected for the pilot intervention (Zacualpa) is one of two high risk districts where seasonal migration to the coastal zones and international migration to Mexico and the U.S. greatly increase the risks of infection. In fact some AIDS cases and at least one death have been reported among international migrants in the San Miguel Acatán district of Huehuetenango.

The maternal care component will be piloted in three districts according to the June 1995 recommendation, with the exception of Cahabon where there are few TBA's. The criterion for this choice appears to be health care availability as opposed to lack of care which was the criterion originally adopted.

4.1.3 Implementation Strategies to Ensure Sustainability: Progress to Date

The project proposes three implementation strategies to ensure sustainability of interventions and benefits after a three-year period: community participation, inter institutional collaboration with MOH, other GO's, NGO's, and community-based groups, and training/strengthening of local human resources in sustainability-related skills. To determine progress to date benchmarks were identified from the DIP and the five-phase project design document described in section 4.1.1 above and shown in Annex F. Phase II of the project, due to end 30 September 1995, is to have activities for each strategy in the process of implementation. By the middle of project year 3, March 1996, responsibility for the project is to be completely phased over to the MOH, NGO's and community organizations, according to the DIP.

It is difficult to determine the degree of fit between the implementation of these strategies as they are planned in the DIP and further explained verbally by project staff, the five-phase project design document, (which includes activities for child survival and implementation strategies), and the 16-month plan developed in June 1995. This is particularly the case, since the latter makes no reference to phases when identifying activities and months of implementation, and begins in July 1995 whereas the third phase, according to the document presented in Annex F, begins 1 October. The timing of some activities and products, such as training of MOH staff, are not clearly defined in the global 16-month plan nor in any of the other two documents, so it is not possible to determine exact progress to date in all of them.

Table 4.1.3 summarizes quantitative progress to date in achieving the benchmarks set for each strategy at both district and community levels. The table organizes benchmarks by type of strategy: first community participation, then inter institutional collaboration and human resource training. Since there are different units of measure, these are identified for each benchmark.

The table shows that progress has been achieved in benchmarks for community participation in all districts, most notably in Cahabon and Purulha where censuses have been completed but not yet updated where they need to be, and family groups are being formed and are beginning to meet. In these districts CHC's have been formed and are active. Phase II activities for community participation most likely will not be all in place by 30 September 1995. The benchmark on organization of family groups, also due to be achieved by the end of the month, will be difficult to achieve.

Community census activities were participatory to the degree that community members assisted in data collection and in some communities suggested questions to be included in the data collection forms. Community networking for health has not yet become effective with the

exception of the two northwest districts where some evidence of networking is evident at the community level. Most of the entities that are to participate in networking have been formed or recruited, or are in the process of becoming integrated into the project. The PASS project has had a fairly consistent presence at the community level, despite these weaknesses, an accomplishment readily recognized by the MOH in all districts and one NGO.

Inter institutional collaboration has been successful in terms of negotiating and reaching formal agreements with the MOH and NGO's, especially in overcoming traditional reticence to coordinate with these counterparts. Additionally, the project has been very successful in supporting and complementing the health activities of government agencies and NGO's: transport, materials and staff for immunization campaigns, materials and drugs for health establishments, training in child survival activities and monetary contributions to partially cover health extensionists' salaries. Perhaps the most difficult activity has been to form, develop and institutionalize the work of the CMS's. This is an experimental model of inter-institutional coordination which has proven hard to put into practice and sustain, for any development or health project.

**Table 4.1.3.
Progress in Implementation Strategies by Phase, Strategy, District and Number of Communities**

Phase when benchmark must be reached according to 5-phase design document and project staff	Benchmark	Unit of measure	San Miguel Acatán (n = 30 comm's)	Zacualpa (n = 13)	Cahabón (n = 30)	Purulhá (n = 30)
For Community Participation						
Phase II	CHC's formed & active	communities	10 (33 %)	10¹ (77%)	28 or 30 (93 or 100%)	25' (75%)
Phase I	Prom's & TBA's select'd, legitim'd by community	communities	30 (100%)	13 (100%)	30 (promoters) (100%) 25 (TBA's) (75%)	29 (promoters) (93 %) 19 (TBA's) (63%)
Phase II	VHW's selection underway	communities	21 (70%)	none (0%)	approx. 10 (approx. 33 %)	20 (67 %)
Phase II	Participatory census completed and year	communities	1995: 18 (60%)	1995: 2 (25%)	1994: 30 (100%)	1995: 2.5 (75%)
Phase III	Participatory needs assessment done	communities	none (0%)	none (0%)	30 (100%) (training started)	none (0%)
Phase II	family groups organized	communities fam. groups	none (0%)	none (0%)	30 (100%) 65. fam groups	16 (53%) 38 fam. groups

¹Community development committees with health components

For Inter Institutional Collaboration						
Phase I	CMS formed & implementing action plan: 1 per district	CMS	formed: 1 impl act pln: no	formed: 1 impl act pln: no ²	formed: 1 impl act pln: yes	formed: 1 impl act pln: no ²
Phase I	Agreements with NOG's, MOH	number of agreements	3 (1 MOH and 2 NGO's)	1 (MOH)	1 (MOH)	1 (MOH)
Phase II	Support for GO's and NGO's	support provided	yes	yes	yes	yes
For Training of Local Human Resources in Sustainability						
Phase III	CMS's, MOH and NGO's in training for sustainability: community participation, training of trainers, educational methods, some aspects of strategic planning	training begun sessions	yes at least 4	yes at least 4	yes at least 4	yes at least 4
Phase III	CHC's in training for sustainability	CHC's sessions	10 or 24 (33 or 80%) 1 each	10 (77%) 1 each	30 (100%) 1 each	25 (75 %) 1 each
Phase IV	Promoters, TBA's in training for sustainability	communities promoters TBA's	24 (80%) 84 none	13 (100%) 28 none	30 (100%) 72 none	29 (97%) 60 45 (19 comm's .)

² Municipal Technical Units being mined to function as CMS's

In two districts a new modality is being tried out: attempting to incorporate health coordinating tasks into the scopes of work of municipal multisectorial boards. Success cannot be determined yet. Progress to date in inter institutional collaboration has been comparable across districts: in some districts it has been possible to work with NGO's and in others to maintain the CMS's active.

Training of CMS's, MOH personnel, NGO's and community groups in skills necessary to ensure project sustainability is due to begin with Phase III on 1 October, 1995, according to the design by phases and the 16-month plan. These skills, as described in the project DIP, include strategic planning, coordination, and project development for the CMS's, problem identification, planning, implementation, monitoring and evaluation of child survival interventions and coordination with the MOH for NGO's, case management and administration and supervision of community health workers for the MOH, and needs assessment, prioritization and problem solving, planning and implementation, coordination with MOH and NGO's and monitoring of health indicators for the community health committees.

Some advances have been achieved in this regard. CMS's and MOH district staff have received at least one training session in each of the following: community participation, training of trainers, educational methods, some aspects of child survival and case management, and some aspects of strategic planning although they are still to receive formal training in the strategic planning methodology. Community groups have started training in formation, structure and organization, functions and responsibilities of community groups.

The goal to phase over project responsibility completely to the entities mentioned above, set for March 1996 in the DIP, probably will not be reached given the delays in the first year of project implementation, and the rescheduling of training for sustainability to begin 1 October 1995.

4.2 Management and Use of Data

A knowledge, practices and coverage (KPC) survey was implemented at project start following the technical guides provided by AID. Four surveys were undertaken, one per district. The baseline data served to produce the DIP and was available for district-level programming. Data were combined to produce overall baseline values for key indicators. One district was later substituted. Where available these baseline figures were presented to potential counterparts during the CMS's formative stages and were offered as input during the workshops to produce the district's operational plans.

According to the DIP, the project should have implemented a health information system as of July 1994. A proposal for a project health information system was developed by CARE staff. It contains 17 instruments and their respective manuals, three of them to be administered by project staff (assistants and extensionists) and the rest--census forms and activity monitoring sheets among others--to be used by CHW's. This proposal received inputs from an outside consultant. The instruments were pretested by project staff and recommendations for improvement were partially incorporated. Community health workers did not participate in these pretests. At some point during the last year project staff made the decision not to implement the proposed system in full, but to select those instruments they considered essential for project needs and adopt them as part of a monitoring and supervision system which was subsequently designed in more detail (see section 4.7). Currently there are no monitoring and supervision instruments or surveys in place, except for those used to monitor immunization interventions. The data collected require systematization and consolidation.

As mentioned previously, community censuses have been completed in 75 communities. Census data includes: number of homesteads, numbers with latrines and tubed water, number of households, number and ages of children, their immunization status by type of vaccine and dosage, and mothers participating in IEC activities. The health promotor registers this information in a notebook, not the previously designed form, and the project extensionist prepares the report. Districts are using community-level census figures where available to estimate the level of supplies needed for immunization campaigns at the community level. In Zacualpa this has not been possible since only two communities out of 13 have conducted censuses.

So far only promoters in Cahabón and Purulhá have used these data to inform their communities about their health status, with the help of their collaborators. There is no evidence that these data sources are being used by the community or the CMS's for decision making. For the most part, results have not yet been shared with those who collected the data, counterparts or community members.

The LHIS design was presented to project staff for pretesting and feedback. Had the project staff who were to implement the system been involved in the actual design and preparation of the system and its instruments, the institutionalization of the system might have been easier. Project staff has expressed a conviction that any LHIS developed must build on traditional, oral information transmittal mechanisms, but the idea has not been systematically piloted yet. No opportunities have arisen for the institutionalization of lessons learned from data collected through a LHIS. Further, little formal documentation, narrative or otherwise, has occurred of community participation processes described elsewhere in this report.

In conclusion, there is no health information system in place. At the local level systematic data collection to monitor and supervise project activities has not begun. However, a system has been designed by CARE and could be functioning by November, 1995 if implemented immediately.

4.3 Community Education and Social Promotion

The current balance between health promotion/social mobilization and service provision in the PASS Project definitely favors the former, with much more emphasis given to social promotion for community mobilization and participation than to health promotion. According to the project phases design document (dated April 1995), the current attention to social promotion over community education and service provision is intentional. The first two phases are conceived as promotional of those strategies meant to contribute to sustainability (see section 4.1). Concretely, the project has delivered at least one IEC session to CHC's as follows:

Table 4.3.1
Training of CHC's in Child Survival by District and Type of Training

Type of training	Sn Miguel (n=30)	Zacualpa (n= 13)	Cahabón (n= 30)	Purulhá (n= 30)
immunizations	10 CHC's (33 %): 1 session each	8 CHC's (62 %): 1 session each	6 CHC's: (20 %) 4 sessions each	none (0%)
CDD/ORT	same as above (33 %)	same as above (62 %)	same as above (20%)	none (0%)
child nutrition	same as above (33 %)	6 CHC's (46 %): 1 session each	none (0%)	none (0%)

The PASS project has also started providing at least one IEC session in child survival topics to mothers, fathers or organized family groups, as described in section 1 on accomplishments and in Tables 2.1 to 2.6 on effectiveness. The following table summarizes those findings in terms of communities per district where mothers/fathers are already receiving IEC messages, but type of child survival intervention.

Table 4.3.2
IEC to Mothers, Fathers and/or Family Groups by District, Number of Communities per District and Child Survival Topics

Topics	San Miguel Acatán	Zacualpa	Cahabon	Purulhá
immunizations	30 (100%)	8 (62%)	30 (100%)	26 (87%)
CDD	10 (33%)	6 (46%)	30 (100%)	26 (37%)
maternal care	1 (3%)	none (0%)	3 (10%)	26 (87%)
nutrition	1 (3%)	none (0%)	none (0%)	20 (67%)

Key messages were outlined in the DIP based on knowledge and behavioral indicators collected in the baseline and on input provided by AID's technical assistance partners in Child Survival. Project staff critically reviewed several sets of educational materials and selected community education and promoter training materials produced by CARE's MCH program as the basis for fine tuning key messages. They then included these in methodological guides produced for immunizations, CDD, feeding and nutrition, and pre, peri and post natal care. A focus group study of HIV/AIDS was conducted in six communities in one district to provide data to use in community education. No other focus groups, interviews or other recommended techniques (concept testing, household trials) were implemented to gather data on which to base development, selection, testing or refinement of key messages. Key messages have not been identified for ARI/LARI and HIV/AIDS. Other messages were discussed and refined in meetings with members of CMS's, some MOH district personnel in some districts only, and extensionists who are or the same cultural background as target populations, but not with main target groups of IEC activities. Key messages were not selected based on community-based formative research on the feasibility of adoption given cultural and material constraints and opportunities for behavioral modification with the target groups themselves.

At the moment there is no system for ensuring that the messages to community members are consistent. Some extensionists and promoters in all districts, and CHC members in the district of Cahabon, visit homes periodically but not systematically to ask and observe how mothers prepare sugar-salt OR solutions, perform child feeding and review immunization cards,

The DIP proposes in several places that educational materials in child survival interventions would be developed or adapted based on limited community KAP assessments. In 1994 Project staff analyzed a variety of educational materials and concluded they were inappropriate for PASS for at least one of the following reasons: they did not reflect the linguistic and ethnic variety of the population served by the project; were not developed based on the community's current degree of understanding of child survival issues; reproduction was

expensive and unsustainable; they were not easily used as a tool or means towards an educational objective. Then, in late 1994, PASS rejected a proposal from a local firm for the development of educational materials as unfeasible from a budgetary perspective. In March, 1995 CARE Guatemala reiterated its intention to CARE Atlanta of developing educational materials for the nutrition and HIV/AIDS interventions. Project management decided sometime in the first semester of 1995 that there would be no educational material produced, adapted or distributed at the community level. No materials produced by other CARE projects or by the MOH were pretested with PASS target populations at the community level to determine how they could be modified; instead they were reviewed by project extensionists and MOH personnel familiar with local cultures.

Instead, the project adopted an educational approach based on the “popular education” concept, which builds on local knowledge, use local resources and participatory techniques to conduct IEC activities. At this point the methodological guides were developed. Promoters and other community health workers are being trained with these guides. They are not given copies of the guides or any materials to aid their own IEC sessions with families. They write notes in their notebooks and rely on these for planning and implementing IEC activities, most of which are delivered as informal talks and discussions. In two districts (Cahabón and Zacualpa) they either produce educational plans that are reviewed and approved by MOH staff or jointly produce a monthly plan that incorporates educational planning. There is no evidence that the content of educational messages is consistently and appropriately transmitted in these activities because no MSS has been implemented yet. Household visits to assess if the actions promoted through educational messages have been adopted tentatively suggest that there is some consistency in message content.

There are no systematic attempts to assess the level of learning and behavioral change achieved through these activities. Project and MOH staff believe that more mothers immunize their children, practice OR therapy during diarrhea and attend prenatal care than before the IEC activities. Mothers interviewed showed uneven knowledge of recommended behaviors, varied greatly in their reports of adopted behaviors and consistently said they do not remember the messages received. They also want printed educational material like posters and drawings.

Effective education and promotion activities are essential for sustainability of project benefits. Current efforts have focussed mainly on promotion of social mobilization and community participation. The health IEC component of the child survival interventions needs to be strengthened to improve its effectiveness in achieving behavioral change as follows: training, supervision and follow-up of community health workers in IEC, development of educational objectives for each audience, careful selection and formulation of key messages based on an analysis of opportunities and obstacles to adoption of behavioral recommendations, and distribution of educational materials.

4.4 Human Resources for Child Survival

According to the project's implementation plans, PASS staff would work jointly with MOH health establishments in the four districts and with up to 10 NGO's in order to assist 100 communities and reach approximately 52,100 beneficiaries. To accomplish this would require 16 extensionists, four per district, each responsible for five to six communities in addition to a project manager. As was described in section 4.1.2., these human resource needs were not established rationally, as districts of different size, populations and geographical access all have teams of the same size and composition.

The first two project managers were public health physicians, one of them with considerable experience implementing primary health care projects. Currently, the PASS project has an assistant manager with background in community participation and mobilization, acting as manager, 5 field assistants--a post created after the DIP was developed-- and 9 extensionists. This staff is distributed as follows:

Table 4.4
Project Field Staff by Type and District

Field staff	Sn Miguel Acatán	Zacualpa	Cahabón	Purulhá	TOTAL
Communities	30	13	30	30	103
Field Assistants	2	1	1	1	5
Extensionists	2	0	4	3	9
TOTAL	4	1	5	4	14

Although the project is covering 103 communities in the four districts, the number of extensionists falls short by 44% from the plans. In Zacualpa one field assistant must currently cover 13 communities. Two extensionists were dismissed and not replaced. In San Miguel Acatán, one of two districts with the most inaccessible communities (two to eight hours by foot) each extensionist must cover 15 communities. They can only visit each community once every 6 weeks. Project staff report difficulty identifying trained and capable personnel who speak the local languages for Huehuetenango and personnel willing to live and work in Quiche where political violence has stopped only recently.

The MOH has made formal and concrete personnel assignments to support project activities: at least 5 individuals per district although none of them full time. The teams of MOH district offices contribute in different measures to activities initiated or promoted by the project. Size of MOH teams range from nine to 15, including the physician in charge of the district, one or two nurses, several auxiliary nurses, and some rural health technicians (TSR's). As part of their regular activities, MOH personnel provide services in EPI, CDD, ARI, maternal

care, and nutrition. They have no HIV/AIDS activities and do not provide systematic health IEC services. MOH personnel consistently reported that the PASS project has developed and supported health activities that dovetail with their own and complement their own capabilities and resources, especially training of CHW's in EPI, CDD and ORT, and community outreach.

The project's DIP indicates that each community should have the following CHW's: one or two health promoters, three or four health volunteer workers (collaborators), one trained TBA, one family planning counsellor, and one AIDS volunteer worker. No criterion was defined to determine the number of households that each CHW would cover. During project implementation it was agreed that one promoter should have responsibility for no more than 20 households. Actual numbers of promoters per community were then determined based on community size and level of dispersion. All communities currently have at least one promoter and some have as many as four. Volunteer collaborators are active in Purulhá, Zacualpa and San Miguel Acatin.

Training of promoters is conducted by PASS project and MOH personnel. NGO's and CMS's participation in training is minimal. Training activities follow the popular education approach described in section 4.3 for IEC activities and revolve around the key messages identified in methodological guides. Promoters are not given printed training materials according to their own reports. No evidence was found that pre and post-training evaluations are conducted systematically. Assistants and extensionists mention they use questions and answers to evaluate training results. Tables 1 to 12 in Annex G detail the types of training received, topics, personnel trained and number of training hours in the four districts.

The promoter conducts the community census. Promoters interviewed reported they are to update census data yearly, but have not yet done so in Cahabón where they were first done in August 1994. Promoters also provides health education on immunizations and CDD to mothers and to other health volunteer workers. Eventually, the promotor will vaccinate, do case management of diarrheal disease, ARI's and malnutrition and refer cases to MOH facilities.

In Cahabón and Purulhá collaborators are receiving leadership training from promoters, and in the latter, training in ARI/LARI, child nutrition and maternal care. Those already active perform household visits and conduct some IEC activities with mothers, reinforcing the key messages delivered by promoters. The remaining districts do not have active health collaborators yet. TBA's conduct maternal care IEC activities with mothers in Purulhá, but this is not a very active intervention yet.

Drop out rates for volunteer personnel have not exceeded 10%. The highest drop out rates are found in San Miguel Acatin and Zacualpa, both regions of considerable internal, seasonal as well as international migration. Drop out and turnover rates have been much higher for project management levels than for CHW's levels: the project has had three managers and periods of time with no manager. Field assistants have been replaced in one district and extensionists who have left the project have not been replaced in one district.

Project progress has been hindered by a high degree of turnover in staff at the management level. Current management staff has strong skills in community participation and grass-roots development approaches but no formal training in public health and child survival. Decisions documented in the DIP regarding numbers of field personnel and distribution by district, including community-based health promoters, in retrospect, seem to have lacked rationality. Size and distribution of current field level personnel are inadequate to cover the 103 communities included in the project, especially in San Miguel Acatán and Zacualpa.

4.5 Supplies and Materials for Local Staff

The DIP's intervention plans describe the minimum supplies and materials that are to be provided or facilitated by the project to community health workers, but does not address material needs of the MOH, NGO's acting as counterparts, and project field staff in order to support their participation in the development of child survival interventions, including IEC activities.

- A) Immunization workers were to be provided with a cooler or thermos for the transportation of vaccines from the nearest health facility to his or her community. In addition, they were to have maternal and infant vaccination cards and bracelet beads for the monitoring of vaccinations. Currently, these volunteers transport vaccines in MOH thermoses, but there are not enough to distribute one to each community as described in the DIP. The 46 available thermoses are not sufficient to cover the 103 communities included in the project, and are not consistently available to the volunteers. Nonetheless, those who have them make optimal use of them. They also have not been allocated the necessary immunization cards or beads and have had to rely on immunization cards distributed by the MOH during immunization campaigns.
- B) CHW's participating in the CDD/ORT intervention were to be provided with at least the equipment needed to set up CORU's: a pitcher measuring one liter, a cup, a spoon, and packets of rehydration salts. Currently, 10 CORU's are operational in Purulha and 4 in Cahabbn. The project however has enough supplies for 100 Rehydration Centers. Delays in distribution were explained in terms of lack of appropriate installations at the community level. It is also likely that project staff has had no time to distribute these materials, oversee their installation and train CHW's in their use. The materials and supplies observed in the CORU's during field visits are considered sufficient and are being used appropriately.
- C) Volunteers participating in the ARI/LARI intervention were to be given a medical kit with revolving funds for the treatment of pneumonia cases. This intervention has not yet initiated.

- D) Volunteers participating in growth monitoring were to be provided with a Salter-type scale and a community monitoring chart. The project currently has 8 scales for 30 communities in the San Miguel Acatán District, 8 for 13 communities in Zacualpa, 12 for 30 communities in Purulha and 12 for 30 communities in Cahabón. The number of scales available (one for every 3 communities) is insufficient, and is considered so by project staff and volunteers, due to the inaccessibility of the communities in at least three of the districts.
- E) TBA's were to be provided with Salter-type scales to register the weight of infants at birth, platform scales to weigh mothers during prenatal control, scissors, sterilization equipment and monitoring cards. To date, the birth attendants have not received any equipment.

Table 4.5
Summary of Equipment Available by Intervention

Intervention	Equipment available	Equipment not available	Equipment partially available
Immunizations		Immunization cards Beads for monitoring	Thermoses
CDD/ORT	Materials for 100 CORU's: liter pitchers, spoons, cups, pots to boil water and salts		Installations to set up CORU's in the communities
ARI/LARI	Community medicine chests with drugs managed with revolving funds		
Maternal care	Salter-type scales; scissors; sterilization equipment		
Growth monitoring	Community monitoring charts		Salter-type scales (one for every 3 communities)

In conclusion, supplies and materials for child survival are available only for the CDD intervention. Sufficient materials are available to equip 100 CORU's but have not been distributed yet. Supplies and materials for the other interventions are not yet fully available. Scales have been purchased but not distributed for the child nutrition intervention. The number of scales is inadequate to conduct growth monitoring on an ongoing basis at the community level.

4.6 Quality Assurance

Currently the project has identified and documented specific knowledge and essential skills that mothers and health workers require to implement each intervention and to achieve the project objectives as key messages included in methodological guides for four interventions. For clinical staff it has adopted MOH norms on essential knowledge and skills in CDD, nutrition and immunization since the clinical staff the project is training are MOH employees. It has also developed norms for cold chain management and incorporated them into current MOH procedures. In general, the project has not implemented yet a systematized process for the monitoring and supervision of the quality of the interventions (see section 4.7).

The methodology currently used by the project to evaluate knowledge and behavioral in CDD, including preparation of OR solutions. This method is most frequently used in Purulha and Cahabón. However, it lacks systematization and institutionalization. It also lacks the development and implementation of instruments for monitoring and supervision of CHW's and monitoring at the household level.

The methods currently used to ensure quality of CHW's training were discussed in section 4.4. above. Quality assurance during training for CHW's needs to be strengthened. Health promoters know how to prepare OR solutions and understand the importance of ORT in CDD. Mothers' knowledge and reported use of ORT was variable, although their reports of demands for immunizations for their children are consistent, as reported in section 4.3.

The evaluators could not obtain information regarding communication and counselling skills of CHW's because no IEC activities were observed in the field. An important fact that will strengthen these skills is the ability of all CHW's to speak the Mayan language of their communities.

Mothers expressed some satisfaction with the performance of health promoters and the services they provide. They also perceive that promoters lack adequate training and materials to be able to solve their families' health problems at the local level and reported that they must go to the nearest health establishment or private provider to receive treatment, usually in the form of medicines.

To date the project has not developed a system for monitoring the knowledge and skills of community health workers and family groups/mothers. Monitoring activities are undertaken by project staff during their visits to communities and by community health workers on an ad-hoc basis. These provide a good starting point for further systematization. Likewise, the project has not yet implemented a systematic way of monitoring the quality of child survival services at the community and health establishment levels.

4.7 Monitoring and Supervision

According to the DIP the project would develop a health MSS, based on an LHS which was to be designed first. The main objective of the MSS system would be to effectively monitor and provide feedback to the child survival interventions. As part of the LHS/MSS system designed, 12 data collection forms for M&S have been designed. Section 4.2 describes progress to date and decisions made regarding the LHS component. Currently, the MSS component has been designed taking into account decisions made by PASS project management on which and how many of the instruments originally designed for LHS to incorporate into a local MSS system. This revised MSS system is presented in Annex H. It has not been implemented to date.

Technical (as opposed to administrative) monitoring and supervision activities are carried out in unsystematic fashion at this point, mostly by field assistants and extensionists of the work of CHW's. In Cahabón the field assistant visits each of the communities every quarter and in Zacualpa promoters have a monthly meeting with field assistant and TSR to plan activities, receive support in doing so, and review achievements for the previous month. Project field staff lack time and resources to systematize and institutionalize these activities and they require technical support. Promoters have a felt need for more monitoring and support visits.

The monitoring and supervision links that exist are established directly between the extensionist and the CHW being supervised: promoter, collaborator or TBA, as the case may be. CHW's interviewed report that these visits are valuable to them to improve their work and provide solutions to problems they encounter, especially doubts they have about case management. They identify knowledge gaps in their own training and want more monitoring and supervisory visits.

There is no evidence of a system to monitor the quality of the services provided by extensionists to CHW's and by CHW's to community members. No verification lists or other forms of supervision have been implemented. Community level supervision guides and forms need to be developed, as they are not part of the MSS already designed.

The MOH does not have a monitoring and supervision system, in order to follow up all interventions. Ministry staff has not received any management and supervision training, nor have CMS members. MOH personnel have not participated consistently in the supervision activities performed by project staff described in earlier paragraphs. These offer good training opportunities for MOH staff and would contribute to the development of a sustainable system.

Supervision and monitoring of project staff for child survival interventions are conducted on an ad-hoc basis at this point in the project, although the administrative supervision and monitoring system is in place. Building on current activities, a system to monitor and supervise project staff and child survival activities needs to be put in place at the same time the child survival interventions are implemented. A proposal exists, based on the health information

system already designed. Community health workers interviewed expressed a need for additional training, technical support and supervision in child survival.

4.8 Regional and Headquarters Support

Technical support on the part of CARE Atlanta by means of the Regional Technical Advisor (RTA), and the Director of the Primary Health Care Sector has been carried out as described in the DIP: revision of project goals and indicators, technical support and assistance in the development of the regional AIDS workshop, and conducting an internal project review in June of 1995. In addition the RTA provided support in baseline data analysis, definition of indicators for the HIS, design of the HIS and formulation of recommendations presented in June 1995. CARE Atlanta provided additional assistance for the revision of monitoring systems for child survival projects that are funded by AID and implemented in Guatemala. A final report of this consultancy was never received by CARE Guatemala. It is not clear whether and how recommendations made were used by the project.

The technical support provided by CARE Guatemala's central office to project field staff has both strengths and weaknesses, but is considered satisfactory overall for a majority of the activities. Project operational staff are of the opinion that greater technical support is needed in terms of project sustainability and some child survival interventions, including ARI/LARI, maternal care and HIV/AIDS.

The evaluation found that the size of the field team is inadequate to provide administrative, managerial and technical support at the community level, most notably in San Miguel Acatán and Zacualpa. Finally, the project would benefit from an internal needs assessment exercise to identify where and when they require support from CARE Guatemala, the RTA, and external consultant, taking the recommendations of this evaluation as a point of departure. This activity would help determine the expectations of direct and indirect technical assistance from CARE Atlanta and from the RTA.

In summary, CARE Atlanta has responded to the technical support requests as planned in the original DIP and has provided additional support via the RTA and an international consultant. The level of support planned was insufficient to cover the project's technical needs, especially given the turnover in project management staff. Recent measures (June 1995) taken by CARE Atlanta and CARE Guatemala to ensure future technical support from headquarters and the RTA in primary health care provide reasonable assurance that the project will receive technical support in child survival during the last year of activities. Project staff will need to conduct a needs assessment of technical support based on recommendations made in this report.

4.9 CARE's Use of Technical Support

At the onset of the project technical assistance was needed to facilitate a workshop for the revision and analysis of lessons learned from the Child Survival Project that terminated in October of 1993. The findings and conclusions of this workshop were used to develop the DIP.

External technical assistance was procured for the collection, entry and analysis of the data obtained from the Baseline Survey conducted in all four project districts; the development of an Information System; and the development of a training curriculum for the AIDS intervention. The information system designed by CARE Guatemala for the PASS project incorporated the recommendations of the external consultant.

The project did not receive CDC support for the development of the AR1 intervention, as was suggested in the AID review of the AR. The project did not solicit this support as volunteer personnel had not yet been provided with necessary medicines.

In the next 12 months, the project will require external technical assistance to strengthen the health IEC and the sustainability components of the project, including cost analysis, planning, monitoring and supervision.

In summary, the project has received external technical support in the areas of health information systems and monitoring of child survival interventions. It requires additional support in sustainability, including cost analysis, planning, monitoring and supervision, and in health information, education and communication.

4.10 Assessment of Counterpart Relationships

The main counterparts of the PASS project are the Ministry of Health and other Government Agencies active in the CMS's or the UTM's. In San Miguel Acatán the project has two formal NGO counterparts. No other NGO's are active in other project districts .

As mentioned above, the CMS coordination model has proved difficult to implement. One CMS has stopped functioning (Zacualpa) and another does not recognize the operational plan as theirs (San Miguel). It also exhibits internal religious and political strife. This has slowed its progress in becoming an effective coordinating entity. The CMS in Cahabon is active and functioning. This entity has provided funds for vehicle maintenance and fuel, staff transportation and materials procurement in order to implement the CORU's activities. CMS's have provided effective channels for communication and dialogue between the PASS project and its counterparts and among counterparts.

Relations between the PASS project and its counterparts in the four districts have led to collaboration, coordination, and resource exchange in the following types of activities:

- organization of CHC's
- training of CHW's and CHC's in child survival
- transport, materials and staff for immunization promotion and campaigns
- community censuses
- implementation of CORU's, mainly in Purulhá and Cahabón
- materials and drugs for health establishments: child nutrition and CDD
- monetary contributions to partially cover NGO's health extensionists' salaries.

**Table 4.10
Resources and Services Contributed by Each Party**

Resources/Services	MOH	Other GO's	NGO's	PASS Project
Monetary				X
Human	X		X	X
Materials (including vaccines)	X	X	X	X
Training	X	X	X	X

As for the technical and managerial skills required of counterparts to eventually take over the project, the PASS project is currently training them in technical aspects of child survival and sustainability. The felt needs of counterparts interviewed match well the types of training that the DIP and the 1&month implementation plan have envisioned.

Although MOH relations with communities have traditionally been weak because of little outreach capacity, the project has promoted more direct relations through training and community participation activities. Promoters trained by the project now request MOH certification. Promoters visit the health establishment as part of their work. Likewise, the MOH has legitimized the activities of the project vis-a-vis the communities, especially early on in the process of community outreach. Community health committees are being developed to become counterparts but do not function in that capacity yet.

The MOH is the most important counterpart in this project. Only one local NGO is a collaborating partner at this point in the project. Community organizations are in the formative process and cannot function as full counterparts yet. Relations between the project and its counterparts have been effective and complementary.

4.11 Referral Relationships

Referral sites in all districts are the MOH services. Distance from the community to the referral services ranges between 1 and 12 hours on foot. By reaching communities more frequently and having good counterpart relations with the MOH the project has paved the way

for improving the continuity of contact between MOH establishments and communities. The MOH's establishments in the district are currently receiving training in case management which should strengthen their capacity to respond to referrals in terms of treatment provided and to the increased demand for health services product of a future referral system.

Training in terms of provider-client relations for referral services will be desirable to complete the training in quality of care. Quality of care has been a persistent problem of MOH services throughout the country and referral activities carried out by the project are faced with this obstacle. Community members are used to seeking health care only in emergency situations. People interviewed expressed that they have to wait long periods before being assisted in a health establishments, that they are not given any medicines, and that MOH staff do not speak their language.

To date the project has not systematized a referral system, basically because the child survival interventions are not yet at the point of performing case management at the community level and using established criteria for case referral. Training is underway in this regard. Case management and referral procedures need to be implemented alongside training. Referrals are currently occurring from project promoters who complain that the response of the MOH facility is not consistently positive and that they have to personally negotiate most referrals. No evidence was obtained that TBA's trained by the project are referring cases to health establishments.

In summary, a referral system has not yet been implemented. Non-systematic referral activities are underway, conducted by health promoters. Since protocols in case management have not been distributed to community health personnel, referral norms are not available. Physical access to reference services will continue to be a problem in most project communities, one that cannot be resolved by the PASS project.

4.12 PVO/NGO Networking

According to the DIP local NGOs were to be important counterparts to the project, on the same level as the MOH. Unfortunately, no local counterparts are working in the districts where the project operates, with the exception of the two NGO's in San Miguel Acatán mentioned before. Networking with these NGO's has demanded considerable time and project resources, and success has been partial. Although two formal agreements have been reached, after much persuasion, relations with one NGO are strained. As best could be determined, the reasons may be financial: the PASS project delivered a sizeable contribution for medicines to this NGO with certain conditions that have not been fulfilled to date. Relations with the other NGO are satisfactory to both parties. This NGO is contributing to project activities with training and human resources and making concrete proposals for joint activities or projects. The relationship in this instance has led to sharing and exchange of resources. There is no evidence of any duplication of efforts or services.

The PASS project does not have formal or continuing networking relations with other international PVO's working in the districts.

In conclusion, networking activities with local NGO's have produced few tangible results because these are few, organizationally weak and highly sectarian. NGO's do not constitute a viable project counterpart in the last year of the project.

4.13 Budget Management

The country project pipeline analysis appears in Annex I. The proportion of project funds spent to date is 83.48 % of the total amount budgeted for years 1 and 2. For FY 94, the first project year, 58% of budget funds allotted to that year were spent. The remaining 42% were carried over to FY 95. For FY 95, the second project year, 100% of funds available for that year were spent in addition to 17% of FY 94 funds carried over. For FY 96 funds available include 100% of those assigned for this year plus the remaining 25% of FY 94 funds carried over. No shifts have been made among budget categories. With the remaining funds the project could focus all its efforts in one sector per district and implement four child survival interventions during the next eight months, as suggested in the recommendations, and monitor project sustainability for a four-month period, as recommended in the same section. It is also possible to expect that the project will be able to cover the full costs of the external support needs identified in the mid-term evaluation (see section 6).

Expenditures to 31 August 1995 and available funds per budget line item as percentages of total funds budget appear in the following table.

Table 4.13
Budget Analysis by Line Item: Percentages Spent and Available to 31 August, 1995

Budge Line Item	Spent	Avaiailable
Personnel	69%	31%
Travel and Per Diem	66%	34%
Consultancies	44%	56%
Procurement	46%	54%
Other Direct Costs	64%	36%

This analysis was performed on the basis of the pipeline analysis presented in Annex I. To date the project has spent proportionately more on salaries for headquarters and project staff than on any other budget category. More funds are available for consultancies and procurement, including supplies and equipment for the field, than for any other category, again proportionately speaking.

5. Sustainability

Table 5.1
Steps Undertaken to Promote Sustainability of Child Survival Activities once Project Funds End

CON.5	END OF PROJECT OBJECTIVES*	STEPS TAKEN TO DATE	MID-TERM MEASURE	STEPS NEEDED
<p>1) Implement and leave in place a community that is better prepared to monitor key indicators of child health, identify health needs and to initiate projects that will address those need&</p> <p>2) The community will also have experience in working collaboratively with the MOH and local NGOs to ensure that its child health needs are being met and that problems or obstacles are adequately resolved.</p> <p>3) At the MOH district level, health staff will have greater skills training ill areas in diarrhea and LARI case management and the ability to monitor key child health indicators to identify health needs and barriers in programming health activities. A system will be in place for managing and supporting health promoters and other community workers who function al the community level.</p> <p>4) At the local level, NGO staff till have improved institutional capabilities, health planning skills, and a collaborative working relationship with the MOH and the communities so that priority health needs are addressed.</p>	<p>Each community participating in the project will have an organization capable of supporting child survival interventions and other development projects.</p> <p>Each active health promoter will operate a community revolving fond medicine chest to generate income to support hi8 work.</p> <p>4 district MOH staff will have improved capabilities for the administration and supervision of a system of health promoters in the project area.</p> <p>10 local NGOs will have improved institutional capabilities for planning, implementation, monitoring, and evaluation of chid health interventions</p>	<p>An additional target group was included for sustainability actions: CMS's.</p> <p>CMS's were exposed to the strategic planning methodology during lbe workshops conducted to develop their district operational plans.</p> <p>The CMS's were trained in development of methodological guides.</p> <p>The 4 MOH health districts received orientation in the use of strategic planning during the development of operational plans.</p> <p>Some CHC's are providii support to the promoter for planning, especially for immunization, and learning in the process.</p> <p>The information system has not been implemented.</p> <p>All representative persons from the health committees of the 4 districts. have participated in training activities regarding functions and committee structure.</p> <p>In Cahabon there has been initiated the negotiations. in order to implement a community medical kit.</p> <p>In the communities where CORU's have been implemented, their population have provided volunteer financial aid for its functioning.</p> <p>Social cooperation networks have been formed and are active in some communities.</p>	<p>See comments on next page.</p>	<p>1) Development of tools to monitor implementation of operational plans. Thii should allow the identification of needs for technical assistance.</p> <p>2) Strengthening the following aspects: project management, programming of intervention activities, monitoring and supervision of activities and personnel, and projects evaluation.</p> <p>3) Training in development, management and utilization of LHIS.</p> <p>4) Implement a LHIS.</p> <p>5) Design and implement feasibility studies in order to implement cost recovery mechanisms.</p> <p>6) Training in cat analysis and management of interventions, budget preparation, and project financial and administrative management for all counterparts.</p> <p>7) Include the CMS's in planning the training of community health workers and CHC's and in the training itself.</p> <p>8) Training all counterparts in monitoring, supervision and follow-up of intervention activities and personnel performance management. Develop a MSS system for the community level.</p> <p>9) Training in quality control for child survival interventions for all counterparts.</p> <p>10) Human resources administration and planning training for all counterparts.</p> <p>11) Thorough training regarding management, planning and programming aspects of public health interventions, including programming, monitoring, evaluation and quality control.</p>

*DIP, Section D (Sustainability strategy).

The project has defined three main actors in each district for the implementation of activities related to sustainability: CMS's, the MOH's district staff and NGO's, and community organizations. Table 5.1 shows that the following activities have been accomplished:

CMS and MOH district staff:	One workshop on operational plans with input on strategic planning methodology
MOH district staff:	Training in technical aspects of child survival interventions
Community organizations:	Selected members received training on functions and responsibilities of health committees.

In summary, following the 16-month plan, sustainability activities are just beginning. In the last column of the previous table a number of concrete steps are identified which need to be implemented as soon as possible in order to achieve project sustainability. This evaluation found that the scheduling of sustainability training and development for the last year of the project is inadvisable. The design of the project by phases and the 16-month plan as well as the DIP should have considered concrete and detailed plans for sustainability measures to be implemented starting early in the second year of project activities.

6. Recommendations

The child survival goals and objectives of the project cannot be met in the next 12 months with the current number of interventions and participating communities. Likewise, the sustainability goals cannot be met unless some reallocations of project inputs and time are made. The following recommendations reflect the view of the evaluation team that effectiveness of child survival and sustainability can be achieved by reducing the number of interventions and the geographical scope of the project and by selecting those interventions that will have the greatest impact on child survival indicators: immunizations, CDD/ORT, ARI/LARI and maternal care. HIV/AIDS is not as high a public health priority for the majority of the beneficiary population. Child nutrition, although as much of a priority as ARI/LARI would require a considerable time investment from project staff and community health workers.

Recommendations are presented for restructuring the PASS project (numbers 1 to 12) ; these should be interpreted as key elements of a general recommendation. Then recommendations for each child survival intervention are presented.

1. In the year remaining, concentrate on implementation and monitoring of four child survival interventions: immunizations, CDD, ARI/LARI and maternal care. These interventions are underway, with the exception of ARI/LARI. For the last one, the MOH and its consulting agency are testing and implementing norms, case management guides and staff training.
2. Concentrate on monitoring and supervising the immunization interventions, which has shown the greatest progress and the maternal care intervention in those districts where progress has been made. Concentrate, at the same time, on developing and implementing the CDD,

ARI/LARI and maternal health interventions in all districts. Continue training on these to project personnel and counterparts in the sector, and include staff from other sectors in training activities.

3. Design, test, refine and implement the monitoring and supervision instruments required for the immunization and maternal care interventions. Train staff in their use. As CDD and ARI/LARI interventions are developed and implemented, incorporate their monitoring and supervision tasks and add instruments as needed. Train staff in their use.

4. Implement a LHMIS system immediately.

5. Allow a period of eight months to perform the activities described in points 1-4 above: 1 October 1995 to 30 May 1996.

6. Choose one sector in each of four districts to focus the activities recommended above. Choose the sectors using epidemiological criteria (child and maternal mortality using MOH statistics for the district, making allowances for under reporting), numbers and types of human resources the project and the MOH have available per district, and effective time available to implement activities at the community level once travel time to and from communities is considered. Districts which have only two sectors, communities only accessible by foot and very dispersed populations should redefine their sectors rationally. By concentrating in one sector per district, the project will be effectively reducing the number of communities it will concentrate services during the coming year. Eventually, once project sustainability has been piloted and adjustments made, the number of communities could be expanded once more to include all the original communities and more, if feasible. This should happen in phase V of the project.

7. In the same 8-month period, implement measures to ensure sustainability of the interventions and of the project. See Table 5.1 for the list of measures recommended.

8. Define scopes of work with functions and responsibilities for each type of project staff involved in implementing the activities proposed above. Consider creating a coordinator of promoters in the sector to support, monitoring and supervise promoters and collaborators.

9. During this eight-month period, distribute time and levels of effort according to the following scheme:

Component	% of Effort:
Sustainability:	70%
CHC's and other community groups	60 % (of above)
MOH	25 % (of above)
CMS's	15 % (of above)
Monitoring and supervision of immunizations and maternal care	20%
Development and implementation of CDD and ARI/LARI	10%

10. Allow a four-month period, following the eight-month implementation period described above, to monitor project sustainability: 1 June to 30 September 1996.
11. Phase over project responsibilities to counterparts during October 1996.
12. Obtain expert technical assistance in sustainability, including planning, cost-analysis, monitoring and evaluation, and in health information, education and communication.

Recommendations for expanding coverage, improving quality and enhancing sustainability of activities and benefits for each child survival intervention are provided in the following tables.

Intervention	Expanding coverage	Improving quality	Sustainability of activities	Sustainability of benefits	Comments
immunization	<ol style="list-style-type: none"> 1. Community census includes information on target populations: children under 1, under 3 and pregnant and lactating women. 2. Census is updated periodically. 3. Census data are used to plan human and material resources for community, including IEC activities and to create awareness at community level. 4. Strengthen the organization and meetings of family groups. Promote monthly meetings. 	<ol style="list-style-type: none"> 1. Census data are jointly analyzed with CHW's and CHC's. 2. Ice chests for cold chain for CHW's 3. LHIS in place: adapt Sn Miguel LHIS *promoters use standardized instruments adequately and fill immunization cards. *consolidated data are fed into MOH HIS. 4. Develop and implement supervision guides and plans for all levels, especially for promoters. 5. Improve CHW's and CHC's training in promotion and IEC to community. 6. Monitor consistency of message contents delivered to community. 	<ol style="list-style-type: none"> 1. Conduct a cost-analysis exercise with MOH district and regional staff and CMS's, including monitoring and supervision of CHW's and community IEC for intervention. 2. Conduct strategic planning in conjunction with MOH. 3. Develop supervision activities in conjunction with MOH and CMS's. 4. Train project staff and counterparts in technical aspects of sustainability (see Table 5.1, last column). 	<ol style="list-style-type: none"> 1. Strengthen IEC to community, including development of communication strategy, identification of primary and secondary audiences, and distribution of educational materials. 2. Strengthen organization and meeting of family groups. 	<ol style="list-style-type: none"> 1. MOH has no IEC activities at the community level. Training of CHW's is critical for sustainability of IEC. 2. Sustainability of volunteer workers is an issue. Sustainability and community participation experts should work together on this issue. 3. MOH needs to develop capacity to provide ongoing IEC training to CHW's, and to monitor, supervise and administer their work.

Inlet-vent.	Expanding coverage	Improving quality	Sustainability of activities	Sustainability of benefits	Comments
Maternal care	<ol style="list-style-type: none"> 1. Recruit active TBA's and apprentices 2. Provide training to promoters as well as TBA's especially in communities with few TBA's. 3. Effectively train CHW's in active early detection of pregnancies. 4. Effectively train CHW's to begin pre-natal care as soon as pregnancy is detected. 5. Effectively train CHW's in case management of high risk pregnancies following clearly defined protocols. 6. Strengthen the organization and meetings of family groups. 7. Tram and negotiate with MOH counterparts to provide attention and treatment to referrals made by CHW's. 8. Provide minimum equipment to TBA's for adequate prenatal and delivery care. 	<ol style="list-style-type: none"> 1. Institute an effective periodic monitoring and supervision and support system for CHW's, especially for early detection of pregnancy, application of high risk criteria and referral to MOH by TBA's. 2. Improve quality of training to CHW's, especially TBA's Training should be on-going for TBA's. Training materials should be appropriate to their educational levels. 3. Focus on training of detection and referral of high risk pregnancies. 4. Recruit CHC's to perform promotion activities for compliance with prenatal care and referrals. 5. Include MOH in training of CHW's to improve the latter's credibility with community and MOH. 	<ol style="list-style-type: none"> 1. Conduct a cost-analysis exercise with MOH district and regional staff and CMS's, including monitoring and supervision of CHW's and community IEC for intervention. 2. Conduct strategic planning in conjunction with MOH. 3. Develop supervision activities in conjunction with MOH and CMS's. 4. Train project staff and counterparts in technical aspects of sustainability (see Table 5.1, last column). 	<ol style="list-style-type: none"> 1. Strengthen IEC to community, including development of communication strategy, identification of primary and secondary audiences, and distribution of educational materials 2. Strengthen organization and meetings of family groups. 	<ol style="list-style-type: none"> 1. MOH has no IEC activities at the community level. Training of CHW's is critical for sustainability of IEC. 2. Sustainability of volunteer workers is an issue. Sustainability and community participation experts should work together on this issue. 3. MOH needs to develop capacity to provide ongoing IEC training to CHW's, and to monitor, supervise and administer their work.

Intervention	Expanding coverage	Improving quality	Sustainability of activities	Sustainability of benefits	Comments
ARI/LARI	<ol style="list-style-type: none"> 1. Effectively train CHW's to perform periodic household visits to actively seek cases of mild cases and begin treatment according to established case management protocols. 2. Support and monitor CHW's visits to all households with children under 5 years. 3. Institute monthly meetings with mothers to monitor children's health and detect cases between household visits. These could be IEC sessions. 4. Strengthen the organization of family groups. 	<ol style="list-style-type: none"> 1. Adopt norms and protocols for prevention, treatment and case management proposed by Clapp & Maine to MOH. Develop norms for household visits and follow-ups. 2. Effectively train CHW's following 1. 3. Implement an effective referral system to MOH facilities for immediate attention and treatment of referred cases. Use red referral cards, for instance. 	<ol style="list-style-type: none"> 1. Conduct a cost-analysis exercise with MOH district and regional staff and CMS's, including monitoring and supervision of CHW's and community IEC for intervention. 2. Conduct strategic planning in conjunction with MOH. 3. Develop supervision activities in conjunction with MOH and CMS's. 4. Train project staff and counterparts in technical aspects of sustainability (see Table 5.1, last column). 	<ol style="list-style-type: none"> 1. Strengthen IEC to community, including development of communication strategy, identification of primary and secondary audiences, and distribution of educational materials. 2. Strengthen organization and meetings of family groups. 	<ol style="list-style-type: none"> 1. MOH has no IEC activities at the community level, Training of CHW's is critical for sustainability of IEC. 2. Sustainability of volunteer workers is an issue. Sustainability and community participation experts should work together on this issue. 3. MOH needs to develop capacity to provide ongoing IEC training to CHW's, and to monitor, supervise and administer their work. 4. With no cost analysis sustainability of medicine chest proposal is difficult.

Intervention	Expanding coverage	Improving quality	Sustainability of activities	Sustainability of benefits	Comments
CDD/ORT	<ol style="list-style-type: none"> 1. Effectively train CHW's to perform periodic household visits to actively seek cases of mild cases and begin treatment according to established case management protocols. 2. Support and monitor CHW's visits to all households with children under 5 years. 3. Institute monthly meetings with mothers to monitor children's health and detect cases between household visits. These could be IEC sessions. 4. Strengthen the organization of family groups. 	<ol style="list-style-type: none"> 1. Adopt recommended norms and protocols for prevention, treatment and case management. Develop norms for household visits and follow-ups if not available. 2. Effectively train CHW's following 1. 3. Implement an effective referral system to MOH facilities for immediate attention and treatment of referred cases. Use red referral cards, for instance. 	<ol style="list-style-type: none"> 1. Conduct a cost-analysis exercise with MOH district and regional staff and CMS's, including monitoring and supervision of CHW's and community IEC for intervention. 2. Conduct strategic planning in conjunction with MOH. 3. Develop supervision activities in conjunction with MOH and CMS's. 4. Train project staff and counterparts in technical aspects of sustainability (see Table 5.1, last column). 	<ol style="list-style-type: none"> 1. Strengthen IEC to community, including development of communication strategy, identification of primary and secondary audiences, and distribution of educational materials. 2. Strengthen organization and meetings of family groups. 	<ol style="list-style-type: none"> 1. MOH has no IEC activities at the community level. Training of CHW's is critical for sustainability of IEC. 2. Sustainability of volunteer workers is an issue. Sustainability and community participation experts should work together on this issue. 3. MOH needs to develop capacity to provide ongoing IEC training to CHW's, and to monitor, supervise and administer their work.

Documents Consulted for the Evaluation

1. AID Mid-term evaluation guidelines for CS-IX projects
2. Health Services Support Project (PASS) CS IX: Detailed Implementation Plan (DIP)
3. Annual Progress Report Child Survival IX
4. Fases del Proyecto PASS: project phases design document
5. CARE internal project review document: June 1995
6. Project implementation reports: October-December, 1993 to April-June, 1995
7. Coordinadoras Locales de Salud (work guides for project staff on local health coordinating agencies)
8. LHM design proposal for PASS project
9. MSS design proposal for PASS project