Improving the Health of Guatemala's Most Vulnerable Population: Migrant Women and Their Children in the Boca Costa of Guatemala

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MID-TERM EVALUATION

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Submitted by:
The People-to-People Health Foundation, Inc.
(Project HOPE)
Millwood, Virginia 22646
Tel: (540) 837-2100
Fax: (540) 837-1813

Prepared by:
Barton R. Burkhalter, PhD
External Evaluator

Contact person:
Bettina Schwethelm, PhD, MPH
Director, Maternal & Child Health Programs

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Mid-Term Evaluation

for Project HOPE child survival project in Guatemala entitled:

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Report prepared by:
FANTA Project
Academy for Educational Development
Washington, DC 20009

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Mid-term Evaluation Team:

Barton R. Burkhalter, PhD (team leader)
Elisa Barrios, MD
Luis Benavente, MD
Victor Calderon, MD
Edmundo Dominguez, MD
Lic. Alicia Ruano
Renato Umaña, MD
Vilma Villatoro, MD
Diana Klein
EP Karina Galvez
EP Ericka Sandoval
EP Juana Xuruc
EP Brenda Yes
TSR Pedro Alvarado
TSR Anibal Bin
TSR Benedicto Huinac
TSR Hector Xiloj

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Project HOPE, Millwood, VA 22646

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Acronyms

ARI	acute respiratory infection
BHR	Bureau of Humanitarian Response
CHV	community health volunteer
CMCI	case management of childhood illness
DIP	detailed implementation plan
DPT	diphtheria-pertussis-tetanus
EOP	end of project
FIC	fully immunized child
HIS	health information system
IEC	information, education, communication
IGSS	Guatemala Social Security Institute
KPC	knowledge-practice-coverage
MOH	Ministry of Health
mte	mid-term evaluation
NGO	non-governmental organization
PVC	Office of Private and Voluntary Cooperation
PVO	private voluntary organization
TA	technical assistance
TBA	traditional birth attendant (*comadrone*)
TT	tetanus toxoid
USAID	United States Agency for International Development

Preface

The People-to-People Health Foundation, Inc. (Project HOPE) received a four year child survival grant from the United States Agency for International Development (USAID Grant No. FAO-A-00-97-00030-00) for the period 1997-2001 (CS-XIII) for a project entitled *Improving the Health of Guatemala's Most Vulnerable Population - Migrant Women and Their Children in the Boca Costa of Guatemala.* The project entails working with coffee estates, the Ministry of Health, the Guatemalan Social Security Institute and several NGOs in parts of five departments to improve the health and survival of the families of resident and migrant workers on the estates.

This mid-term evaluation (mte) report is based on a two week investigation of the project by the mte team and is supported by preliminary results of a migrant survey conducted during October-December, 1999. The field investigation occurred November 8-19, 1999. The evaluation team and the evaluation process was organized by Project HOPE according to the written guidance for mid-term evaluations provided by USAID/BHR/PVC (*Guidelines for Mid-Term Evaluation*, USAID/BHR/PVC, PVO Child Survival Grants Program, CS-XIII, 1997-2001, June 10, 1999. That is, it was a participatory evaluation process that included representatives from the key stakeholders in the project, with an external team leader. The team was centered in Quetzaltenango, Guatemala, where the project office is located, and made day trips and some overnight trips to many sites where the project is being implemented, including coffee estates, Ministry of Health offices and health facilities, Social Security hospitals, and radio stations. Due to the size of the team and the number of sites to visit, two sub-teams were formed that visited separate sites. The final two days were spent together developing findings and recommendations. The entire process was extremely well organized, and the evaluation team was received with wonderful enthusiasm and hospitality everywhere. The project staff worked well beyond the call of duty to make the time of the evaluation team productive.

The team members included: Elsa Barrios, MD (Ministry of Health, San Marcos), Luis Benavente, MD (Project HOPE, headquarters), Bart Burkhalter, Ph.D (team leader through FANTA project, Academy for Educational Development), Victor Calderon, MD (project director and country director, Project HOPE, Guatemala), Edmundo Dominguez, MD (director of training, Project HOPE Guatemala), Alicia Ruano (Maternal Neonatal Health Project), Renato Umaña, MD (Guatemala Social Security Institute, Suchitepequez), Vilma Villatoro, MD (Ministry of Health, Quetzaltenango), Juana Xuruc (Guatemala Social Security Institute, Suchitepequez). This report was prepared by the mte leader (B. Burkhalter) relying heavily on the summary of findings and recommendations prepared by the evaluation team members (Table 7), on the preliminary results of the migrant survey, and on comments made by Project HOPE and FANTA Project staff in response to an earlier draft.

A special survey of resident and migrant mothers was undertaken by Project HOPE during October-December, 1999. Some of the results from the migrant mother portion of the survey had been complied and were available in preliminary form at the time of the two-week investigation.

This report is organized according to the outline recommended by USAID/BHR/PVC in *Guidelines for Mid-Term Evaluation.* That outline explicitly favors thoroughness at the price of redundancy, and as a result the reader will note that several items appear in more than one place and are cross-referenced.

Bart Burkhalter
February 18, 2000

1. Summary

The purpose of this project is to improve the health of families (especially mothers and children) of workers on coffee estates located in five different departments of Guatemala. While all the estates have resident workers, many of the workers are migrant families who come down from their homes in the highlands for a month or so during harvest. The migrants are from various indigenous tribes, most of whom do not speak Spanish, and who receive little or no health care services in their home communities. They are very poor and suffer extremely bad health status. For example, partial results from a survey of 1126 migrant children on the estates found that 30% had ARI and 23% had diarrhea at the time of the survey (Table 4).

The project strategy is to build the capacity of and promote collaboration among the coffee estates, the Ministry of Health offices in the departments and municipalities, the Social Security hospitals and health services, and health centers operated by Anacafe, the association of coffee growers, so that they find sustainable solutions to the formidable health problems faced by the target population, rather than the project attacking these problems directly. The project facilitates by providing training activities for the health staff of the various partner organizations and other community health workers, and by providing technical assistance of various types to identify and resolve problems. To join the program, coffee estates are required to provide space for a health unit on the estate staffed by a trained volunteer health worker.

This is a very ambitious project. The target population and the strategy itself are risky ventures, and include at least three cutting-edge issues any one of which would be a significant challenge. The three issues are: working with migrants who provide a very small window of opportunity, working with many different indigenous cultures, and working with the commercial enterprises that employ these people. Another challenging aspect of the project is the shear number of partner organizations the project is attempting to coordinate, including 150-200 different coffee estates, three separate departmental Ministry of Health offices each with an array of district offices and health centers, in addition to the Social Security and NGOs. In short, this is a high-risk but potentially high payoff project.

The project has met or exceeded most of its scheduled implementation targets to date. It has trained 197 staff from the partner health organizations, 473 volunteer health promoters, and 667 traditional midwives in case management and/or IEC, reflecting 83%, 124% and 102% respectively of the targets (Table 1). It has convinced 130 coffee estates to commit resources and join the program. It has created a series of audio tapes on various common illnesses in Spanish and two Indian languages which have been broadcast on radio stations and from the health posts at numerous coffee estates. It has gained the full support of the top management of the departmental Ministry of Health offices and Social Security offices. It has already begun to see significant improvements in health services, as evidenced by increases in vaccination coverage and prenatal visits (Tables 2 and 3).

One reason for the success of the project to date appears to be that Project HOPE itself is performing very competently, including the various administrative responsibilities. For example, the project staff works hard and are very happy with their relationship to the project and co-workers. Another example is the information systems used by Project HOPE in the project: (1) a well-functioning financial information system operating by email between HOPE central in Millwood, Virginia and the Project HOPE office in Quetzaltenango that provides current and useable information of expenditures against budget, (2) a project achievement monitoring system that is operated by the Ministry of Health, with technical assistance from Project HOPE, that has suffered fits and starts but which is gradually

developing into a valuable component of management for the local Ministry offices and the project, (3) a personalized but systematic effort of contact and communication with the many partner organizations that identifies and resolves issues and opportunities, and (4) mini-studies of particular issues that is in its early stages but which will likely prove increasingly important as an information source in the second half of the project.

Another important reason for the success of the project to date is the excellent relationships that Project HOPE has established with the partner organizations. Key persons from the Ministry, Social Security and the estates all expressed high regard for the professional capacity of Project HOPE. This view had two dimensions - - high regard for Project HOPE's technical know-how in health, and high regard for Project HOPE's professional manner in handling the process of planning and implementation with them in particular and with the diverse set of stakeholders in this project. The capacity, personality and long term relationships of the Project Director is an important element in the credibility of Project HOPE.

Why did the coffee estates decide to commit their resources to this program? This is an important question for the sustainability of the program. Estate owners and managers generally responded to this question in two ways. First they thought it was the right thing to do. Second, they thought that it would increase the long-term stability of their work force and productivity of the enterprise. None seemed to think it would increase short-term profits. Other important factors included the credibility of Project HOPE in health care, and the fact that the cost to the estates was not very high.

Supply of medications is a major problem facing the project. Many problems remain to be solved in order to insure an adequate and sustainable flow of medicines. For example, in some estates adult workers are complaining that medicines are available for children but not for adults, and the relative financial contributions by patients, estates and the Ministry that pay the costs of medicines differ widely from place to place. Project HOPE has taken an important first step towards a solution by establishing a local NGO which, as its first activity, has obtained a small contract from the Ministry of Health to acquire and distribute the needed medicines in a rational fashion.

Other challenges remain, including investigations to determine whether the quality of care being provided by the health workers is adequate and addressing the inevitable change in Ministry personnel following the change in government that is likely to occur in the near future. The evaluation team expressed concern that there was little or no attention given to child spacing or family planning in the work plan or the program implementation. Stipends may be required for the health volunteers staffing the health units on the estates. Estate health units should consider providing first aid to adults. Tapes should be developed and broadcasted in additional native languages and on additional health topics. The MOH monitoring system is still not fully functional.

This project is designed to be sustainable. It focuses on coordinating and building capacity in local organizations, including the estates and the Ministry. It has identified local funding sources right from the start, created capacity in existing organizations, and created a new local NGO for which it has obtained local funding. But continued focus needs to be given to arranging sustaining funding for the program.

In conclusion, this project appears on the road to a resounding success. It may well become a model for Guatemala and internationally as well. Steps should be taken now to make this possible if warranted. For example, USAID may want to focus more attention on the final evaluation of the project than is usually done with PVO child survival grant projects, so that the results are both insightful and credible at

the national and international level. Project HOPE may want analyze the cost implications of the program on the budgets of coffee estates of different types, so that it is clear just how much it is costing them in relation to their total budget.

2. Assessment of Progress towards Achievement of Program Objectives

2.1. Technical Approach

2.1.1. Overview of Project

This 4-year project aims to improve health services to and the health status of families working on Guatemalan coffee estates. Many of the families are temporary migrant workers of Mayan ethnicity characterized by poverty, low education and illiteracy especially in women, high fertility, little or no Spanish, coming from different areas and linguistic groups with different disease profiles, making them the population at highest risk for morbidity and mortality in all of Guatemala.

The project area, known as *Boca Costa*, which is literally translated as "mouth of the coast," is the principle coffee producing region of the country, stretching over a 20 by 80 mile area of slopes and valleys reaching from the mountains to the Pacific coast in parts of five government departments. The area contains about 500,000 residents plus another 90,000 migrants, including 107,000 women of reproductive age and 102,000 children under five years. The economy of the area is dominated by about 600 coffee estates. The coffee must be hand picked, creating a seasonal demand for labor that is largely filled by migrants. Those who come are the poorest families of the highlands, with inadequate land or skills to survive solely on subsistence farming. Migration for perhaps 30 days to pick coffee provides sufficient cash to survive the rest of the year. Men, women and children all pick coffee, working up to 12-hour days, and are paid at the end of each day by the volume picked that day.

The coffee estates in Boca Costa are largely owned by absentee families and corporations, and run day-to-day by resident professional managers. The size, capitalization and technical sophistication of the estates varies considerably. There are several sources of health services in the area in, including 45 Ministry of Health (MOH) hospitals and health centers, 5 Social Security (IGSS) facilities, 8 Anacafe (Guatemala Coffee Growers Association) health centers, 14 other NGO (mostly church affiliated) facilities. Many of the coffee estates provide limited health services to its workers. The area has recently emerged from a long period of guerilla warfare with its associated instability and tension.

In order to improve disease prevention and care-seeking behaviors in the target population and improve health service delivery, Project HOPE has formed an alliance with MOH, IGSS, Anacafe, several NGOs and many coffee estates. Rather than delivering health services directly, Project HOPE is facilitating, training and providing technical assistance to its partners in the alliance so that they can deliver more effective and sustainable services by the end of the project.

The project is focusing on diarrhea, pneumonia, maternal care, immunizations, and nutrition. Major activities of the project include:

Recruiting coffee estates to join the program, with the stipulation that they support a health unit on the estate to provide maternal and child health services that is staffed by a trained health volunteer.

Forming high-level planning/management teams in each department with representatives from the partner organizations to plan and oversee all aspects of the program.

Training in case management and communication skills (IEC) for health facility staff, for paid and volunteer community health workers, and for traditional midwives.

Enhancing supervisory practices and logistic systems related to health services, including medicines, vaccines, and field equipment (e.g., weighing scales, respiratory timers).

Improving the MOH information system with regard to migrant data, and its analysis and use for decision-making.

Developing and broadcasting health messages in native languages on radio stations and over loudspeakers at coffee estates.

2.1.2. Progress Report by Intervention Area

Intervention areas. The objectives of the project are organized, for the most part, by the traditional child survival and maternal interventions. Specifically there are seven intervention areas: (1) access to care, (2) immunizations, (3) nutrition, (4) diarrhea control, (5) pneumonia, (6) maternal care, and (7) capacity building. Table 1 lists indicators for the seven intervention areas, along with their baseline values and EOP targets.

Activities. The project has organized its activities into seven broad categories: (1) training, (2) health units on coffee estates, (3) structures for coordination, planning and implementation, (4) logistic support, (5) information activities, (6) health message broadcasting, and (7) technical assistance. The activities apply across most or all of the intervention areas. For example, training sessions on case management of childhood illness (CMCI)[1] cover access, immunization, nutrition, diarrhea, and pneumonia. The activities are being implemented at several levels (including department, district, municipal, community and estate), and for different types of providers.

The theory is that accomplishing the activities will cause the attainment of the objectives and targets identified in Table 1. The main activities are broken down into sub-activities as listed in Table 2. Note however that this is a complex project with a large number of activities that are not all listed here, but which can be found in the DIP and Annual and Quarterly Reports.

Progress towards benchmarks. Benchmarks are attached to particular activities. They define stages of achievement in implementing the project work plan. From Tables 2 and 3 it is clear that the project is doing a good job of meeting most of its benchmarks. Although the project has fallen short of some benchmarks, and not measured progress against others, it has met or exceeded many of its targets. In other words, the plan has been well implemented to date.

Project effectiveness to date. Project effectiveness finally is determined by the impact of the project on the health and survival of children and their mothers. In general terms, this depends on:

[1] The Guatemalan government has adopted a modified version of integrated management of childhood illness (IMCI) which we refer to as case management of childhood illness (CMCI).

(1) whether the activities are well implemented;

(2) whether the well implemented activities lead to improvements in the indicators of access, immunizations, nutrition, maternal care, and diarrhea and pneumonia control; and

(3) whether improvements in these indicators lead to improved health and survival.

At this stage of the project we have evidence that the project is being well implemented, that the baseline values of many indicators are not good, and that the health status of migrants is very poor. There is some evidence that vaccination coverage of migrant children is increasing as a result of the project (Table 4). However, with the exception just noted, we do not yet have any evidence about whether the project improves the indicators or the health and survival of women and children. This lack of information about impact on health practices and status is expected such a short time following the start-up of the project, which is why mid-term evaluations such as this one are charged to assess process rather than outcome.

Changes in plan subsequent to DIP. There have been amazingly few changes to the plan as presented in the DIP. The target for the number of coffee estates to include in the program has been reduced from 200 to 150, following recommendations in the DIP to concentrate in order to achieve higher quality. Potential problems with the cost and supply of medicines has led the project to form a new local NGO which has taken leadership to stabilize and rationalize the supply of medicines to the estates.

Next steps. Given the success so far, the most important next step is to continue to implement the work plan as it has been to date. In other words, keep up the good work.

Beyond that, several key issues were identified by the evaluation team and the project staff that deserve special attention by the project. First, the project will need to address whatever changes occur as a result of the recent national elections and incoming new government, such as changes in policies and departmental health personnel. This is an immediate priority. Second, the start that the project has made in addressing the rational supply of medicines through the new NGO needs to be continued and expanded. Third, the project should explore ways of connecting with the home areas of the migrants. Although the project is making early inroads in reaching migrant mothers, there is a long way to go that can only be partly achieved in the short time the migrants are on the estates. But the involvement of the MOH in the project creates a way of extending the contact to the home communities. Fourth, the new initiative to carry out mini-studies as part of the information system should be pursued with vigor and in coordination with the counterparts so that this approach is institutionalized and made sustainable.

We call attention to Table 7, which contains a summary of the findings and recommendations of the evaluation team, and which includes several follow-on recommendations for improving the quality of the program.

In light of the success of the project so far, and its potential to be a model for dealing with the families of migrant and resident workers in Guatemala and elsewhere, we believe that Project HOPE and USAID should pay special attention to the final evaluation of the project, beyond what is normally the case. Planning should start now for the final evaluation so that a credible assessment is made of the project results that can form the basis on which Guatemala and other countries can make an informed decision

about whether to invest in a similar program.

2.1.3. New Tools and Approaches

Migrant survey. The data collection form and procedures for a knowledge-practices survey of migrant mothers has been prepared and translated into the native languages. As a result of its application, various modifications have been made.

Health message audio tapes. Audio tapes containing basic health messages have been written and produced in several native languages.

Collection of training materials. The project has pulled together a rather nice collection of training materials in case management of childhood illness, IEC for childhood illness, and maternal care that others may find useful as a collection.

Local NGO strengthening supply of medicines and its arrangement with MOH. Although organizations that operate revolving drug funds are not new in the wake of the Bamako Initiative, the NGO established by the project has some interesting twists that make it notable. Of particular note is its contract with the MOH that is providing it with funds and authorization.

The private-public collaboration. The most important development of this project may well be the public-private collaboration among government agencies (MOH and IGSS), non-profit NGOs , the commercial sector (the coffee estates and their association, Anacafe), with the leadership of a PVO (Project HOPE).

2.2. Cross Cutting Approaches

2.2.1. Cross-Cutting Activities Used by the Project

The "cross-cutting approaches" refer to the activities of the project that further the achievement of many or all of the objectives in the individual intervention areas, such as training, planning, supervision, and information management. These activities were discussed above in section 2.1.2 under the paragraphs on "activities" and "progress towards benchmarks," and below in section 3, especially section 3.7 on information management.

2.2.2. Capacity Building Approach

Strengthening Project HOPE. This project is serving to strengthen Project HOPE in Guatemala in several ways. First is the creation of a highly competent and well functioning staff in Project HOPE's Quetzaltenango office. The office is supported by useful systems and procedures as described in section 3 - Program Management. Second, and perhaps most important for the long-term future of Project HOPE, is the know-how and experience the organization is acquiring on how to work with large agricultural employers such as the coffee estates and with indigenous migrant workers. These cutting edge challenges could play an important part in the future of Project HOPE and the PVO effort in developing countries in general.

Strengthening the partner organizations. This topic lies at the heart of the project strategy. Not only is the central approach of the project strategy aimed at strengthening the local partner organizations

(namely the MOH, IGSS, NGOs and coffee estates) with respect to family health, but to strengthen them in an integrated manner so that they work together. The entire work plan explicitly is built with this approach in mind. There are many manifestations of this concern, such as: baseline measurements of the counterpart capacities and training needs, formation of joint planning and management groups at the departmental levels, having the coffee estates form health units on the estates and have the MOH provide technical support to them, strengthening the MOH information monitoring system and getting the other partner organizations to use it (rather than developing an independent system for the project). A particularly interesting development is the creation of a new local NGO to bolster to the long-term sustainability of the program and which is already contributing to the solution to the medicine supply problem discussed in paragraphs 2.1.2 and 2.1.3 above. These and other manifestations are discussed throughout this report.

Health facilities strengthening. So far the project has focused more on strengthening the outreach capacity of the health facilities operated by MOH, IGSS and the NGOs than strengthening the functions performed at the facilities themselves. This is appropriate and according to the project plan. Nevertheless, the evaluation team noted that additional effort should be devoted to quality assessment and assurance, both in the facilities and without.

Strengthening health worker performance. The project is aiming to strengthen health worker performance by adopting protocols, training in the use of the protocols, and encouraging the use of weekly plans by providers and especially supervisors. The monitoring system anticipates measuring practices (such as immunizations and prenatal care) at the estate and municipal level in order to ascertain how well the project is working, including the strengthening of health worker performance. However, it is still too early to tell how well the strategy is working with regard to health worker performance.

Training. The project is devoting a large portion of its resources to the training of health staff, community health workers and TBAs in case management and IEC for child and maternal health. The evaluation observed many of the trainings and noted that the teaching methodology was well done, with a strong emphasis on participation and teaching aids rather than lectures. Trainees are universally positive about the experience. The training activities are discussed elsewhere in the report and number of persons trained against plan are reported in Table 3.

2.2.3. Sustainability Strategy

The DIP strategy for sustainability is organized at three levels: department, municipality and community. At the department level, the strategy calls for strengthening department health councils, permanent education committees, and then the replication of project activities by NGO counterparts. At the municipal level, the strategy calls for the training of master trainers who then take over the implementation and oversight of all training, including the training of counterpart staff, the formation committees of estate owners and managers, plans for monitoring and supervising, and development and use of a unified HIS. At the community level, the sustainability strategy involves training CHVs, promoting mothers groups and estate health units, and delivering preventive health services and health education through the estate health units and mothers groups.

Table 2 indicates that good progress has been made in implementing the sustainability strategy, as indicated by the benchmarks established in the DIP.

Probably the most impressive achievement with regard to achieving sustainability is the fact that 130

coffee estates have joined the program and committed themselves to supporting a health unit on the estate. The reasons motivating the coffee estates are discussed in section 4.1. Other important achievements include the strong collaborative relationships developed among the partner organizations, the departmental committees that have taken over much of the management of the program, and the extensive staff training. The newly created NGO is a further contribution to sustainability.

The details of long-term financial support of the program remain to be worked out, although the broad elements are clear. The estates will provide on-site health units and a health worker, the MOH is providing the primary system of training, supervision, technical support and referral, and the IGSS, which receives tax revenues from the estates in the name of the workers, provides clinical care. The different roles and financial contributions of the estates, the estate workers, the NGOs and the government through the MOH and IGSS is not yet settled and remains a major challenge for the project. The solution may look different in the different departments, but large disparities between departments may not be stable.

2.2.4. Training Health Providers

The project has devoted more resources to training than any other activity. It is identified here in a special section in recognition of its importance in the project. Training has been carried out at all levels of the project, including departmental, municipal and community/estate. (This is similar to the sustainability strategy described in section 2.2.3 above and in fact training is a main component of that strategy.) Departmental committees of counterpart representatives have been established to plan and oversee the implementation of the training programs, an approach which appears to be working.

Initially, technical assistance was received from outside expert organizations (BASICS, Mothercare, Universidad del Valle) in the design of curricula, and in the training of master trainers from the MOH and other counterpart organizations. Now all training is done by trainers from the counterpart organizations. The evaluation team observed that the training methodology being used for CHVs and TBAs was excellent, and the achievement of benchmarks for number trained is high (Tables 2 and 3). Aspects of the training activity are discussed further in other sections of this report (2.1.3 and 2.2.2).

2.2.5. Information Systems

All too often, discussion of information systems is limited to computer-based quantitative monitoring systems. The systems used by this project go well beyond that, and for that reason are important to highlight. They include: the financial management system; the MOH population based monitoring system; various one-time surveys such as the training needs assessment, the baseline survey of resident worker families, an informal but systematic person-to-person communication network, and various "mini-studies." These developments are discussed in section 3.7.

3. Program Management

3.1. Planning

All planning was accomplished cooperatively among the major organizational partners, including the central and national (project) offices of Project HOPE, Anacafe (representing the coffee estates), the

Ministry of Health, and Social Security.

The implementation schedule submitted in the DIP is on schedule in almost all respects.

The program objectives and work plan are well understood by project staff and by the key staff in the organizational partners. This is due in part to the fact that all parties have been given a copy of key project documents, but probably more important is the emphasis given to effective and frequent communication by the project staff.
The program monitoring system is being implemented as part of the Ministry of Health information system, with technical assistance from Project HOPE staff. Initially the system is to provide data on morbidity and vaccination coverage. The point of working through the Ministry system rather than developing an independent system for the project is to create a sustainable monitoring system that will survive after the project grant period has ended. The Ministry information system has been revised twice during the first half of the project, and the project monitoring system has followed along with these revisions. This has resulted in a potentially more useful and sustainable system but it has delayed the full functioning of the system for the project.

3.2. Staff Training

So far staff training has been the main activity of the project, since the implementers of the project really include all the health workers at the Ministry, Social Security and Anacafe, plus the promotores and traditional midwives (See Table 1). In addition, Project HOPE staff on the project have received training in case management and obstetric care from the BASICS and Mothercare projects of USAID.

The evaluation team observed the Ministry staff giving training sessions to promotores and traditional midwives. Their teaching methodology was excellent, making frequent uses of props and colorful pictures to illustrate their points, engaging the students in hands-on practice, and maintaining an ongoing flow of one-on-one questioning and answering that involved even the most reticent of the students. The trainers were working from a written curriculum in order to insure that all information was correct and all points were covered.

In order to monitor the effectiveness of the training activities, the project completed pre and post training tests of knowledge during the first two years of the project. It is just beginning a process of selected on-the-job observations of trainees following training sessions to monitor practice.

3.3. Supervision of Program Staff

The direction and support given to Project HOPE staff is particularly well done. They know what they are to do; feel challenged by it; and are very enthusiastic about their work and the project. Project HOPE staff in supervisory positions appear to have found the difficult balance that keeps them much involved in the day-to-day activities of their staff so they can provide support, yet not guilty of micro-management. Furthermore, the Project HOPE technical staff seem to spend a lot of time in the field visiting and working with the large number of sites that the program touches.

The project has attempted to systematize the supervisory function throughout the project. A manual has been produced on work planning and supervision (*Procedimientos Operativos de Funcionamento*) that deals with such items as work flows, maintenance of vehicles, and supply control. All supervisors have a copy. Every week, each field worker prepares a work plan for the coming week. Although the manual

procedures and weekly work plan system are not always followed, it provides a structure that seems to work well.

In addition to the formalities of supervision, the project leaders appear to be very concerned about the interpersonal skills of its supervisors. Good interpersonal skills and relationships are encouraged. In the past, supervisors with insufficient interpersonal skills have been reassigned to different positions.

The supervisory styles and adequacy in the other participating organizations appears to vary widely among the estates and among the different departments and offices of the Ministry, Social Security and Anacafe. In recognizing this variability, the evaluation team was not able to draw systematic conclusions about the supervisory practices in the partner organizations. However, in light of the apparent success of the project to date, this probably should not be a major concern of the project, except insofar as wholesale changes in Ministry personnel following a change in government may require special attention from the project leaders.

3.4. Human Resources and Staff Management

As noted above, the cohesion and morale of the project staff at Project HOPE are very high. It is one of the most outstanding characteristics of the program. It shows in the low turnover of staff, which is virtually nil.

Turnover in the partner organizations has also been relatively low. Exceptions include the recent turnover in management of Anacafe in the region, turnover in the core facilitator groups, and the potential of turnover in top district positions following the election.

The project has written job descriptions for all positions. At Project HOPE these are in the form of detailed flow charts. Every sub-agreement from Project HOPE to the partner organizations contains written job descriptions for all positions funded under the sub-agreement.

The attitude of Project HOPE project staff towards job prospects following termination of the grant period is to find additional funding sources and continue useful work related to health and development in the area as the country Project HOPE office. Thus they clearly distinguish between the sustaining of the program and the sustaining of the Project HOPE office.

3.5. Financial Management

The financial management system is adequate. A report of expenses against budget is produce on the 20th of each month by the central office of Project HOPE for the immediately preceding month and emailed to the HOPE office in Quetzaltenango. Control measures are in place. Three bids are obtained on all purchases. Financial records are reviewed by HOPE's Latin America Regional Director on all visits to the office.

3.6. Logistics

Project HOPE vehicles have been very well maintained. In fact, one Ministry of Health Department Director held up the longevity of HOPE vehicles as an example of the good management that has helped to create the high credibility that Project HOPE enjoys. His point was that when something is well done technically, people are more highly motivated to sustain it.

Supplies of medicine and of certain equipment (weighing scales, respiratory timers) are important to the success of the project. Both have experienced problems. Although the coffee estates are supposed to purchase a scale and a timer as part of their agreement with the project, many have not. This is an important issue that needs to be solved. Project HOPE is well aware of the problem and has been trying various approaches to its solution. The problem of medicines is discussed above in section 2.2.3.

3.7. Information Management

The information system for the project has several components: a monitoring system operated by the Ministry of Health, a personalized but systematic activity of contacts with key individuals in the participating organizations, and a new effort of mini-studies.

Currently the monitoring system operated by the Ministry functions primarily for residents of the municipalities where the estates are located, but not so well for the migrants. Project HOPE has been working with the Ministry to build information on migrants who work on the estates into the system, initially with vaccination and prenatal coverage. Previously, Project HOPE had set up a parallel system on monitoring, but for this project they made the decision to work through and strengthen the Ministry system instead. Development of the Ministry system into one that is useful to the project has been delayed by two major re-definitions by the national office of the variables to be collected. This now appears to be stabilized, and progress is being made. Project HOPE's strategy has been to focus on specific analyses that can be done with the coverage data and actions taken as a result of the analyses. For example, the early result from the ongoing survey of migrants that only 10% of the migrant children were immunized convinced Ministry personnel to devote more attention to this activity. Thus the modifications and additions to the system are being driven by specific practical improvements to the care being given.

The personalized contact the project staff has designed into its individual work plans and implemented with skill appears to be a key reason for the success of the project to date. The project director and other key staff members of the project have maintained frequent and effective communication with key personnel in the participating organizations, including estate managers and owners, directors and sub-directors of the Social Security and Ministry of Health departmental offices, and also the municipal offices and health centers. This is an absolutely vital component of a good monitoring system that is sometimes neglected in the drive to automated and quantitative systems. The achievement of the project in this regard is considerable in light of the sheer number and diversity of participating organizations, including 130 coffee estates, three departments each with a Ministry and Social Security office and approximately 20 relevant municipal health centers. To put this in perspective, a quarterly contact with each organization means that project staff must make about two such contacts per working day.

The project is initiating a new effort on mini-studies in which particular issues will be investigated. This holds the promise of identifying and shedding light on a multitude of problems, while at the same time transferring an analytic approach to health problem solving to the participating organizations. We found the managers of the estates that we visited were very interested in this approach and were already identifying issues to be studied. Examples include: Why won't the migrants use the latrines we have provided them? and Do the migrants remember any of the health messages we have been broadcasting over the loudspeaker in front of the estate health office?

3.8. Technical and Administrative Support

The project has received technical assistance from a number of outside organizations that have been very useful, including the BASICS, Mothercare, and Maternal-Neonatal Health projects, Population Council, and Universidad del Valle. These groups have provided training to project staff on a number of technical topics, as well as training materials and protocols for care. The project anticipates that it will need additional assistance in maternal and neonatal health care in the last two years of the project.

The project has received several supervisory and technical support visits per year from persons stationed at Project HOPE's headquarters, including primarily the Regional Director for Latin America and the Associate Director for Maternal and Child Health.

4. Other Significant Issues

4.1. Why Coffee Estates Participate in the Program

One of the most unique, and potentially important, aspects of this project is its partnership with the coffee estates. Large employers of agricultural workers, especially seasonal workers, hold an important key to the health of the families of these workers. Not many countries have been able to tap this resource. It appears that Project HOPE is making a success of it in Guatemala.

The question is how? Why have the coffee estates in Guatemala decided to join this project and commit resources to improving the health of families when most have not done so in the past? In fact, the Project Director noted that several years ago he had discussions with the MOH and several estates about such an effort that came to naught; no one was interested. What is it about the present project and the present time that appear to have changed this?

The evaluation team probed this issue with estate managers and owners. The answers given were amazingly consistent. First, most said, in one way or another, that it was the right thing to do. Especially since it did not cost too much. Second, most thought that it would increase the long-run stability and productivity of the estate. This view was articulated in various ways of course. Some paraphrased quotations follow:

> "Healthy people, like healthy coffee trees, produce more."
>
> "More likely to come back next year."
>
> "Times are changing; we need more stable relationships."

None of the estates thought that the program would increase short-term profits, but this was not viewed as an important limitation.

A key reason that the estates decided to go forward with the program was their confidence in Project HOPE. They believe that Project HOPE is technically competent in health, and knows how to design and implement public health programs such as this one in a professional manner. They are viewed as an organization that can manage the project in a professional manner, keep stakeholders involved and get

results. In essence, the estates took the position that they are professional coffee estate managers but do not know much about health care, while Project HOPE is expert at health and not coffee.

What are the underlying forces that have changed the attitudes of the estates? We did not obtain this information, but some conjectures include:

* The Peace Accord in Guatemala that has ended the internal warfare;
* More income opportunities in the highlands for the migrants (in part due to government programs resulting from the Peace Accord) have resulted in increased competition for seasonal workers;
* International pressure about human rights for workers; and
* Changing technology is bringing in more young, university trained engineers as estate managers.

Consistency with Malawi tea estate study. The factors motivating the participation of coffee estates in Guatemala are very consistent with the factors that motivated tea estates in Malawi to provide health care to the families of tea estate workers. A study of the Project HOPE program in Malawi[2] concluded that the tea estate owners and managers decided to join and then to maintain the program on the tea estates because "it was the right thing to do" and worth continuing as long as it contributed to the health of worker families and did not cost the tea estates very much. They relied on information from physicians they knew and on increased cleanliness in the resident communities to decide if the program was successful. Similar to the Guatemala coffee estates, the Malawi tea estates did not join or maintain the program because they thought it would increase short-term profits.

The Malawi study also noted that tea estates relied heavily on the professional competence of Project HOPE to make the program successful, and to manage it in a way that avoided unwanted disruptions. Most said they would not have even considered joining the program in the first place if they did not think that Project HOPE was technically competent in the field of health.

4.2. Strategic Opportunity for Project HOPE

The success of the Malawi tea estate program and the potential success of the Guatemala coffee estate program suggests that Project HOPE has opened an important road to public-private partnerships that improve the health of poor working families in developing countries. Its leadership in defining how such partnerships can work in the agricultural sector could form the core of a major worldwide activity for Project HOPE. Project HOPE should seriously consider seizing this opportunity by taking aggressive leadership to define the magnitude and nature of the opportunity, identifying other NGOs that could join with it in a worldwide campaign, and seeking major country and donor support.

A key factor in the success of the Malawi and Guatemala programs has been the credibility of Project HOPE's technical competence in health and as managers of field health programs. This suggests that Project HOPE may want to strengthen its (already impressive) commitment and policies in support of its competency in these areas. What must it do to achieve and maintain top billing as designer and manager/facilitator of field health programs, especially public-private partnership programs, in developing areas? How can it attract and keep the top people in this field, both at its headquarters and in

[2] C Franco, JC Quinley, B Schwethelm, TE Kachule, BR Burkhalter. *Employer-based programs in maternal and child health: Project HOPE's strategy for attaining long-term sustainability of health promotion in Malawi.* Published by the BASICS project, Arlington, Va., for Project HOPE and USAID. 1997.

its field offices? What liaisons it needs to develop with universities and other technical and scientific organizations to stay at the cutting edge of new approaches and knowledge? Project HOPE's focus on public health (as opposed to development in general), its extensive experience with field health programs in many countries, its credibility as a competent technical and development agency in field health programs, and its connections to the private sector all indicate that this may be a wonderful opportunity (its natural market niche).

5. Findings and Recommendations

This section summarizes findings and recommendations, most of which are described elsewhere in the report. Much of the information reported here comes from Table 7.

Finding 1: Challenging project. This is a very challenging project, but one that holds great potential for solving important social problems. In other words, it is a high risk, potentially high payoff project.

It is high risk because it addresses a difficult beneficiary population, namely migrant worker families who are poor, in very poor health and indigenous, and because it has selected a strategy that has not been used very often, namely, creating and then working through an alliance of governmental health providers and commercial coffee estates. This strategy is all the more challenging because it involves many independent coffee estates (approximately 200) and many different governmental and private non-profit offices and health facilities. It is easy to imagine many ways in which the project can fail.

But, if successful, it will have made a very important contribution. The indigenous people in Guatemala have poor health practices, receive poor health services, and are in very poor health. The indigenous migrant worker families may be the worst off. Sustainable solutions to these problems have not been found. This project could provide such a solution. Furthermore, if the project is successful in building a model for involving commercial employers such as the coffee estates in such a solution, it could be used with other commercial ventures for other social problems in other areas.

Finding 2: Well implemented to date. The project has been largely successful in implementing its ambitious work plan, and has achieved most of the 2-year targets (benchmarks) established in the DIP. This achievement is documented in Table 2. Some of the important achievements include: signing up approximately 130 coffee estates for the program; agreements reached with all (10) partner organizations planned; four staff and four volunteer facilitator teams organized and trained, one in each MOH department and IGSS (100% of target); exceeding targets for number of CHVs, TBAs and institutional staff trained in case management and IEC; departmental health councils, facilitator groups, estate manager groups and permanent education committees formed and operating in all three departments.

Individual activities that have not been implemented according to plan are listed below as separate findings and recommendations.

This is an especially strong positive finding in light of the difficulties that this project poses, as described in finding 1.

[3] *Recommendation 2*: In view of the success to date, continue to implement the program

[3] Recommendations are attached to findings, and identified by the same number as the finding to which they are attached. Thus, although findings are numbered consecutively, the recommendations are not.

according to the style and principles used to date. In other words, keep up the good work.

Finding 3: Sustainability. The project appears to be on the right track for achieving long-term sustainability. By working cooperatively with local organizations to build inter-agency committees at the departmental level and to train health workers at different levels, it has built the local capacity in leadership, structures and individual skills necessary to maintain the program. Sustaining funding is an important element that is not yet solved, but is being explicitly addressed by the partner organizations.

Recommendation 3: Continue to focus on arrangements for sustaining funding.

Finding 4: Model project. If successful, this project can serve as a model for improving the health of families of migrant and indigenous workers on agricultural estates, and as a model of public-private cooperation in public health, both in Guatemala and in other countries. In light of the success to date, the strong management of the project, and the excellent working relationships among the partner organizations, the project is likely to be successful.

Recommendation 4: Project HOPE and USAID should beginning planning now for the final evaluation of the project, with the idea of ascertaining whether or not, and how, the project should be expanded and disseminated widely in Guatemala and in other countries.

Finding 5: Multi-level coordination. Coordination among the partner organizations at the different levels (i.e., department, district, municipal, community/estate) has been crucial to the success of the project to date and will continue to be crucial to the long-term success and sustainability of the program.

Recommendation 5: Seek additional opportunities for local involvement and coordination in health care.

Finding 6: MOH leadership. The leadership that the MOH has provided at the district and department level has been very important for the success of the project to date, and is key to the long-term sustainability of the program.

Recommendation 6: Continue to strengthen MOH leadership.

Finding 7: Core facilitator groups. The existence of the core facilitator groups appears to be key to the sustainability of the program, but high staff turnover threatens the sustainability of some groups.

Recommendation 7: Systematize and institutionalize the periodic selection, training and incorporation of new individuals into the core facilitator groups.

Finding 8: Multi-level communication. Although the partners are coordinating well within levels, communication between levels in the same partner organization is less than adequate in some situations.

Recommendation 8: Strengthen individual partner organization skills in monitoring, supervision, evaluation and team work.

Finding 9: Training methodology. The training methodology used to train CHVs and TBAs is good. There is a high degree of student participation, concrete examples, and frequent use of visual and hands-on teaching materials.

Finding 10: Training in case management. There are health facility staff not trained in CMCI and not following case management protocols. The number of staff trained is slightly behind the benchmark (197 trained against a benchmark of 231, or 85%) due to the delay by the MOH in adopting an integrated program of care for women and children..

> *Recommendation 10*: Strengthen MOH planning and implementation in training of case management.

Finding 11: Project management. The project is well managed, as manifested by good financial control, strong staff commitment, proper planning and adequate procedures and administrative systems. (See section 3.)

Finding 12: MOH/project monitoring system. The MOH operated health information monitoring system for the project is not yet fully functional, although there are some encouraging developments, including the willingness of CHVs to report to health facilities.

> *Recommendation 12*: Continue providing support to the MOH to help it to implement and supervise its community reporting system.

Finding 13: Information strategy and mini-studies. The broad information strategy being pursued by the project that includes systematic personal contact and mini-studies in addition to computerized quantitative information provides greater flexibility and interpretative power than most. (See section 3.7.)

> *Recommendation 13A*: Continue to pursue and to systematize the personal system of contacts with key people in the partner organizations.
>
> *Recommendation 13B*: Aggressively pursue the undertaking of mini-studies as planned, keeping them as focused and low-cost as possible. For example, focus them on issues presented at individual estates or health facilities, and involve key personnel at these locations to the full extent in order to be able to implement the findings and transfer the mini-study approach. Bring in outside expertise to help with the mini-studies when appropriate and not too costly in terms of time and money. Examples of mini-studies that might be pursued noted elsewhere in this report include:
>
> * reasons why migrant families do not use sanitary facilities;
> * criteria migrants use to decide whether or not to return to same estate;
> * costs to estates of providing health units, in relation to total budget;
> * quality of case management services provided by CHVs.

Finding 14: Credibility of Project HOPE. The credibility of Project HOPE is very high with the partner organizations, both as an organization that is knowledgeable about public health and that knows how to implement at the local level. This credibility is crucial to the support given to the program by the partners, and should be maintained.

> *Recommendation 14A*: The project should develop and disseminate a periodic progress report (perhaps quarterly) that is shared with all stakeholders in the project, including all owners and managers of partner estates. Its continuation should be subject to how well it is received.

Recommendation 14B: This finding has implications for Project HOPE throughout the organization with regard to its competitive strategy and policies. (See section 4.2.)

Finding 15: Credibility and technical assistance. The provision of high quality technical assistance is an essential ingredient of the credibility that the partner organizations have for the project and for Project HOPE.

Recommendation 15: Staff of Project HOPE must constantly upgrade their technical skills, and continue to involve expert outsiders, including other USAID supported projects, for the provision of technical assistance.

Finding 16: Availability of medicines, supplies and equipment. A consistent supply of affordable medicine is essential for the provision of adequate health care and also to maintain demand for health care services on the estates, yet there are significant concerns and some evidence that medicines are not always available. The new NGO that is addressing the issue of local availability of essential medicine in estates and worker communities is an important step. Certain equipment that was supposed to be available for estate based CHVs (notably, weighing scales and respiratory timers) is missing.

Recommendation 16A: The project should negotiate with the estates, the MOH and other partners to ensure a consistent supply of essential medicines, supplies and equipment.

Recommendation 16B: MOH should provide funding for essential medicines in its future budgets.

Recommendation 16C: Continue to give priority to helping the new NGO find and implement solutions to the medicine supply problem. The project should work with the new NGO to explore sustaining funding from estates and local organizations as well as the government for the provision of medicines.

Finding 17: Medicines for adults. Currently most estate health units provide only medicine for children. Many workers and their families have expressed a desire for access to adult medicines as well. This would increase the credibility, and probably usage, of the health units in the eyes of the workers and their families.

Recommendation 17: The project should encourage estates to seek ways whereby the health units can provide essential medicines and supplies (such as pain relievers, multi-vitamins, first aid supplies) for adults.

Finding 18: First aid. Workers on the estates want the estate health units to provide health services to adults as well as children. First aid would be especially welcome. It would probably increase the acceptance and prestige of the CHVs. (This finding and its associated recommendation are related to finding 17 above.)

Recommendation 18: The project should coordinate with the MOH, IGSS and the estates to provide first aid training for the estate based CHVs, and to create a consistent supply of first aid supplies for the estate health units, which can be used to provide health service to adults.

Finding 19: Estate health units and demand on health facilities. The estate health units appear to be doing a good job of screening, diagnosing and referring patients to health centers, but the additional volume this has created does not appear to have overburdened the health centers. There are additional unmet health care needs among the estate families that could be identified and referred without exceeding current health facility capacity.

> *Recommendation 19*: Health staff at the partner organizations should continue to provide supportive supervision and follow-up to the CHVs working on the estates.

Finding 20: Unfilled migrant need. Migrant mothers are generally aware of the existence and function of the estate health units, but many do not use them yet. There are many potential reasons for this lack of use, including language problems, short stays and long work hours at the estates, limited health unit hours, and lack of specific knowledge. Early evidence indicates that usage of the estate-based health units by migrants is growing and has already had positive effects; the plan to increase usage is sound and this important issue should continue to be a high priority of the project.

> *Recommendation 20A*: Undertake mini-studies on the reasons the migrant mothers do not use the health units and develop strategies to overcome those barriers.

> *Recommendation 20B*: The project should explore how to extend its contact with migrants working on the estates to the home communities of the migrants. Many of these communities are in the same departments where the project is now working, which provides opportunities for collaborative effort by the current partner organizations, including especially the MOH. Careful planning is needed to make such an extension.

> *Recommendation 20C*: Increase availability of medicines and supplies (see findings 16 and 17).

> *Recommendation 20D*: Move to regular hours and explore payments to health unit staff with the estates (see findings 22, 23, 24).

Finding 21: Difficulty of one-on-one counseling of migrants. It is difficult to provide effective individual counseling on maternal and child care to migrant mothers on the estates, due to language, cultural and time availability issues.

> *Recommendation 21A*: Strengthen radio broadcasting and estate loudspeaker broadcasting of health messages in native languages, but analyze the effectiveness of this action before moving too fast and far to expand it.

> *Recommendation 21B*: (See recommendation 20B.)

Finding 22: Lack of regular health unit hours. Many estate health units do not have regularly scheduled hours during harvest season when demand is highest and regular hours most needed because the CHVs are themselves very busy with harvest work. This contributes to the unfilled migrant need (finding 19). One reason for this situation is the lack of financial remuneration to the estate CHVs (see finding 21).

> *Recommendation 22*: (See recommendation 23.)

Finding 23: Estate funding for health unit managers. Estates may be willing to fund better health

services for their workers and their families.

> *Recommendation 23*: Conduct estate-specific cost and effectiveness studies on having a paid manager of the health units, such as a part-time or full-time auxiliary nurse or a stipend for a competent CHV.

Finding 24. Stipends for estate-based CHVs and Auxiliary Nurses. The CHVs who run the estate health units are volunteers and are faced with difficult trade-offs during the harvest season between work for pay as a coffee harvester or volunteer CHV work in the health unit. Many say they prefer to receive a stipend for their work in the health unit. Although experience in other programs indicates that stipends for volunteers can lead to sustainability problems, this may not apply here to the situation on the estates, where an increasingly professionalized presence in the health units is needed and the success of the program may make some additional financial support possible (finding 23). Some of the larger estates may want to upgrade to auxiliary nurses.

> *Recommendation 24*: The project should explore with the partner organizations a stable arrangement of paid auxiliary nurses or stipends for estate-based CHVs who manage the health units.

Finding 25: Migrant health practices and living conditions. Migrant living conditions on the estates are very inadequate, in spite of significant efforts by some estates to improve them. The problem is deeper than simply providing better physical facilities. For example, hygiene and nutrition practices do not appear to have improved much even when estates have improved the cooking and sanitary facilities.

> *Recommendation 25A*: Promote meetings with estate owners/managers about migrant living conditions that share lessons about improving those conditions and, when appropriate, which seek innovative strategies to improve migrant living conditions on the estates that improve health.

> *Recommendation 25B*: Undertake mini-studies to determine how to design more effective facilities, and how to improve the health practices of the migrants and help them take advantage of existing facilities. The project should consider involving organizations with expertise in formative research and behavior change in this effort.

Finding 26: Mothers value broadcasted messages. Mothers on the estates value the broadcasted messages when in their own language.

> *Recommendation 26*: Seek funding to: (A) develop health messages in additional native languages and in local variations of Mam and Quiche, (B) develop and record new health messages, and (C) expand broadcasting to additional estates and radio stations.

Finding 27: Messages in native languages. Currently tapes of health messages exist in Spanish, Mam and Quiche. Radio stations have requested translations of the tapes to other native languages. Migrant mothers would also appreciate hearing these messages in their own language (finding 26).

> *Recommendation 27*: (See recommendation 26A.)

Finding 28: Additional health topics. Some radio stations would like to broadcast on additional health

topics. Mothers appreciate the current broadcasts (finding 26).

Recommendation 27: (See recommendation 26B.)

Finding 29: Commercial stations not yet broadcasting. While non-profit radio stations are broadcasting the health messages at no cost to the project, commercial stations with much larger listening audiences are not yet broadcasting and are not likely to do so for free.

Recommendation 29: The project should work with local companies to obtain funds to pay for broadcasting on commercial stations.

Finding 30: Live participation in radio shows. The non-profit stations desire audience participation shows that include live participation from local health care staff. This could provide an interesting opportunity for staff training.

Recommendation 30: The project should promote this.

Finding 31: Sound quality. Although the technical content and style of the current broadcasted messages is very good, the sound quality of the tapes is monotonous and poor.

Recommendation 31: Seek funding to upgrade the sound quality of the tapes by using higher quality recording equipment and the use of a professional recording studio to improve sound effects, background music, etc.

Table 1. *Indicators of and Progress towards Program Objectives*

Topic	Indicator [DIP] (1)	EOP Target [DIP] (1)	Baseline Value (3)			After 2 years (migrants)
			Residents	Migrants	All (13)	
Access	1.1. Utilization of MCH services by migrants	Up by 10%	--	NR (5)	--	
Immun-ization (children)	2.1(a). Fully immunized children, 12-23 mths 2.1(b). Measles immunization, 12-23 mths	80%	35.1% (4) 40.4% (10)	NR (5) 16.2% (10)	NR (5) 38% (10)	NR (5) 27.0% (10)
	2.2. Mothers know to get measles vaccine at 9 mths	50%	39.7%	2.4% 4/165	36%	
	2.3. Families with child health cards	60%	48.1%	9.1% 15/165	44%	
Nutrition	3.1. Exclusive breast-feeding, 0-3.9 mths	60%	47.8% (22/46)	25% (11) 2/8	46%	
	3.2. Complementary feeding, 5-8.9 mths	Up by 20%	85.1% (63/74)	93% (12)	86%	
	3.3. Three or more meals previous day	90%	NR (5)	NR (5)	NR (5)	
Diarrhea	4.1. Diarrhea cases (0-5 yr) seeking care	60%	51.8% (6)	33.9% 56/165	50%	
	4.2. Dehydration cases (0-5 yr) using ORS or home fluid (not excl BF)	30%	NR (5)	"Low"	NR (5)	
	4.3. Mothers maintain or increase breastmilk- fluid-food during/after diarrhea	60%	about 60%	about 50%	about 59%	
	4.4. Diarrhea cases (0-5y) treated by WHO protocol	90%	NR (5)	NR (5)	NR (5)	
Pneumonia	5.1. Cases (0-5 yr) treated by WHO protocol	90%	NR (5)	NR (5)	NR (5)	
	5.2. Mothers who recognize signs of pneumonia	40%	NR (5, 7)	NR (5, 7)	NR (5, 7, 13)	
	5.3. Care seeking for cough or difficult breathing (0-5 yr)	60%	69.9% (100/143)	42.5%	67% (13)	
Maternal Care	6.1. Mothers seeking prenatal care (2)	70%	3.9% - 58.8% (8, 9)	20% (9)	55% (13)	
	6.2. Mothers with TT2	70%	4.1% (8)	15.0%	5%	
	6.3. Births attended by trained provider	40%	NR (5)	9.1%	NR (5)	
Health Cards	7.1. Use of family health cards by families	60%				
Capacity Building	8.1. Co-development of systems for information, monitoring, supervision					

Notes. **(1)** Copied from the table on pages 8-11 in DIP. **(2)** As measured by one or more prenatal visits to a trained provider. **(3)** Two baseline surveys were done, one of families working on estates and residing in the estates or nearby communities completed in December 1997, and another of migrant worker families completed in October, 1998. The resident survey sample includes 803 mothers with 31 (3.9%) of them migrants, and is found as Annex C (see text and App C to Annex C) in the DIP. The migrant survey includes 165 mothers, and is found as Appendix A in the First Annual Report of the project **(4)** 48.1% of children 12-23 mths had health cards, and of those 73% were fully vaccinated. Thus only 35.1% (48.1%x73%) of all children were documented as fully immunized. **(5)** Not reported **(6)** Those reporting seeking care from a trained provider for diarrhea cases in past two weeks. **(7)** 78.8% of resident mothers, about 17% of migrant mothers, and thus about 71% of all mothers recognized at least one sign of pneumonia, but precise definition of this indicator not given. **(8)** Only 6.6% of resident mothers had health cards, and of those 58.5% had one or more prenatal visits (but only 60% had a "prenatal space" in the card) and 62% had TT2. Thus 3.9% (6.6%x58.5%) had documented prenatal visit, and 4.1% (6.6%x625) had documented TT2. **(9)** 58.8% of all resident mothers and 20% of migrant mothers self-reported they had received prenatal care **(10)** Measles coverage not defined as indicator in DIP, but reported here for migrants in lieu of FIC because FIC not calculated from survey data. **(11)** 0-5 9 months, not 0-3.9 months. **(12)** Children receiving gruel at 6-8.9 months. **(13)** Baseline KPC estimates that 22,017 (9.5%) of the 232,565 beneficiary population are migrants The total baseline estimates are made by weighting the resident and migrant figures by their population proportions.

Table 2. *Program Activities and Progress in Achieving Benchmarks*

Components/Activities (1, 2)	EOP target (1)	Year 1 (5)		Year 2 (6)	
		Benchmark	Achieved (%)	Benchmark	Achieved (%)
1. Training					
1.1. Select and train master trainers	14	14	14 (100%)	NR	NR
1.2. Staff facilitator teams trained in CMCI and maternal care	4 teams	4 teams	4 tms (100%)	4	4 (100%)
1 3. Vol. facilitator teams trained in CMCI and maternal care	4 teams	4 teams	4 tms (100%)	4	4 (100%)
1.4. Institutional health staff trained in: CMCI IEC	250 160	228 NR	136 (60%) NR	231 NR	197 (85%) NR
1.5. Promotoras (CHVs) trained in: child health CMCI IEC	500 250 250	NR NR 234	NR NR 204 (87%)	NR 121 381	NR 150 (124%) 473 (124%)
1.6. TBAs trained in maternal care and breastfeeding	250	254	74 (29%)	654	667 (102%)
1.7. Mothers groups trained in child health	200 groups	50	47 (94%)	NR	NR
2. Health Units on Coffee Estates					
2.1. Coordination agreements with estates	200-150 estates(1)	100	100 (100%)	NR	130
2.2. Health units established	200-150 units (3)	30	15 (50%)	75	70 (93%)
3. Structures for Coordination, Planning and Implementation					
3.1. Agreements with all provider counterparts	10 (4)		8	10	10 (100%)
3.2. Departmental health councils formed & operating	3	3	3 (100%)	3	3 (100%)
3.3. Departmental facilitator groups formed & operating	3			3	4 (133%)
3.4. Departmental committees of estate owners/managers	3			3	2 (67%)
3 5. Departmental permanent education commissions	3	2	1 (50%)	NR	NR
3.6. Municipal level monitoring and supervision plans	20 plans		Agreement on key issues	NR	NR
3.7. Coordinated immunization plans developed	3 plans	1	1 (100%)	NR	4 (100%) (7)
3 8. Mothers groups formed and meeting monthly	200 groups	NR	NR	NR	NR
4. Logistic Support					
4.1. Vaccines available at MOH: child vaccines TTV	NR NR	50 facility 30 facility	45 (90%) 15 (50%)	NR NR	NR NR
4.2. ORS & antibiotics available: MOH facilities estate health units	NR NR	50 facility 30 units	45 (90%) 15 (50%)	50 facility NR	50 (100%) NR
4 3. Supplies available (scales, timers, health cards)	NR	NR	NR	NR	NR

Table 2 continued

Components/Activities (1, 2)	EOP target (1)	Year 1 (5)		Year 2 (6)	
		Benchmark	Achieved (%)	Benchmark	Achieved (%)
5. Information Activities					
5.1. Design and implement migrant data collection tool	Complete	Develop	Developed	Complete	Data collection in process
5.2. Integrated HIS thru MOH at municipal level	20 municip	NR		NR	Still in process
5.3. Baseline survey (residents, migrants, health providers)	Survey completed	Complete	Completed		
5 4. Training needs identification survey	Complete	Complete	Completed		Completed (yr 1)
5.5. Family health cards, promoted by: MOH estates				50 municip 60estates	50 (100%) 60 (100%)
6. [illegible]					
6.1. Develop health messages in Spanish and native languages	NR			NR	Developed in 3 languages
6.2. Radio stations broadcast in Spanish and native languages	10 stations	10 willing	5 (50%)		
6.3. Estate health units broadcast in Spanish and native lang.	NR	NR	NR	NR	18
7. Technical Assistance					
7.1. CMCI and maternal care support	NR	NR	Agreements: Mothercare, Univ del Valle	NR	TA provided: BASICS Mothercare Univ del Valle
7 2. Information systems support					TA provided: Project HOPE

Notes. **(1)** DIP is source of components and EOP (End-of-Project) targets. **(2)** CMCI = dase management of childhood illness, a modified version of integrated management of childhood illness (IMCI), and IEC = information-education-communication. **(3)** Original target was 200, but dropped to 150in First Annual Report in response to DIP reviewer comments. **(4)** Provider counterparts include: 5 MOH departments, IGSS, Anacafe, 3 NGOs. **(5)** First Annual Report is source of Year-1 targets and achievements. **(6)** Trimester Report Jul-Sep 1999 and presentation slides by V. Calderon are sources of Year-2 targets and achievements. **(7)** Initially target was 3 departmental plans, but IGSS added as separate plan. **(8)** "NR" = not reported or not available at time of report preparation.

Table 3. *Training Activities Completed by November 1, 1999*

A. Facilitator Teams - *Number of facilitator teams trained in case management of childhood illness and in obstetric and prenatal care.*

Institution	Institutional Staff			Voluntary Staff		
	Objective	Achieved	%	Objective	Achieved	%
MOH San Marcos	1	1	100%	1	1	100%
MOH Quetzaltenango	1	1	100%	1	1	100%
MOH Suchitepequez	1	1	100%	1	1	100%
Social Security (IGSS)	1	1	100%	1	1	100%
Total	4	4	100%	4	4	100%

B. Institutional Health Staff - *Number of staff members trained in case management of childhood illness.*

Institution	Objective	Achieved	%
MOH	92	33	46%
IGSS	123	123	100%
Anacafe	6	4	67%
NGOs	37	37	100%
Total	238	197	83%

C. Promotoras - *Number of promotoras trained in case management of childhood illness and IEC.*

Area	Case mgt of childhood illness			IEC		
	Objective	Achieved	%	Objective	Achieved	%
San Marcos	40	65	163%	120	130	108%
Quetzaltenango	35	42	120%	131	168	128%
Suchitepequez	46	43	93%	130	175	135%
Total	121	150	124%	381	473	124%

D. Traditional Midwives - *Number of traditional midwives trained in obstetrical and prenatal care.*

Area	Objective	Achieved	%
San Marcos	368	377	102%
Quetzaltenango	148	144	97%
Suchitepequez	138	146	106%
Total	654	667	102%

Note. This data reflects preliminary results from the mother survey carried out during October-December, 1999, as reported by Victor Calderon to the mte team.

Table 4. *Vaccination Coverage: Preliminary results of survey of migrant children under 5*

Vaccine	Age Range	Sample (1)	Vaccinated before arrival		Vaccinated during and by end of program		
			Number (2)	% of Total	Number vaccinated during program	Total vaccinated by Nov 1, 1999	Percent vaccinated by Nov 1, 1999
DPT3/ Polio3	0 - 0.9 yrs	323	19	5.9%	27	46	14.2%
	1 - 1.9 yrs	222	41	18.5%	23	64	28.8%
	2 - 4.9 yrs	581	92	15.8%	60	152	26.2%
	0 - 4.9 yrs	1126	152	13.5%	110	262	23.3%
BCG	0 - 0.9 yrs	323	68	21.0%	20	88	27.2%
	1 - 1.9 yrs	222	33	14.9%	5	38	17.1%
	2 - 4.9 yrs	581	124	21.3%	28	152	28.2%
	0 - 4.9 yrs	1126	225	20.0%	53	278	24.7%
Measles	0 - 0.9 yrs	323	19	5.9%	20	39	12.1%
	(3)	222	36	16.2%	24	60	27.0%
	1 - 1.9 yrs	581	65	11.2%	67	132	22.7%
	2 - 4.9 yrs						
	0 - 4.9 yrs	1126	120	10.7%	111	231	20.5%

Note. **(1)** Children in 15 coffee estates surveyed, October 1999. **(2)** Only children with cards showing they have been vaccinated are counted. Analysis of a sub-sample of 645 children under 5 found that 10% had cards, and of these 88% had Polio1, 39% had Polio3, 89% had DPT1, 38% had DPT3, 83% had BCG, and 52% had measles. **(3)** The target population for measles vaccine only includes children over 9 months of age, which could be estimated to equal 25% of the under 1 population, or 323/4 = 80 in this case. Under this assumption the coverage for the 1-2 age range is the more appropriate figure for monitoring of performance.

Table 5. *Prenatal Coverage: Preliminary results of survey of pregnant migrant women*

Service	Sample (1)		1 contact or dose	2 contacts or doses	3 contacts or doses	1 or more contacts or doses	2 or more contacts or doses
Women contacted	147	Number	9	27	0	36	27
		Percent of Total	6.1%	18.4%	0%	24.5%	18.4%
TT doses given	147	Number	30	17	5	52	22
		Percent of Total	20.4%	11.6%	3.4%	35.4%	15.0%

Note. **(1)** Women in 15 coffee estates surveyed, October 1999.

Table 6. *Diarrhea and ARI Morbidity: Preliminary results of survey of migrant children under 5*

Morbidity	Type	Number of cases (2)	Cases as % of total sample (n=1126) (3)	Cases as % of all cases
Diarrhea	Persistent	9	0.8%	3.5%
	Liquid	158	14.0%	61.0%
	Dysentery	92	8.2%	35.5%
	All Types	**259**	**23.0%**	**100%**
ARI	Cough, cold	119	10.6%	35.6%
	Pneumonia	166	14.7%	49.7%
	Severe pneumonia	1	0.1%	20.3%
	Ear infection	25	2.2.%	7.5%
	Strep throat	19	1.7%	5.7%
	Viral pharangitis	4	0.4%	1.2%
	All Types	**334**	**29.7%**	**100%**

Note. (1) Data based on preliminary results of survey during Oct-Dec, 1999 as reported by Victor Calderon to mte team. **(2)** Number of children with morbidity at time of interview. **(3)** Total sample of migrant children equals 1,126.

Table 7. *Summary of Findings and Recommendations Developed by the Evaluation Team*

ISSUE	FINDINGS	CHALLENGES	CONCLUSIONS	RECOMMENDATIONS	LESSONS-LEARNED
Partner Organizations					
Coordination	- Coordination among the partner organizations has improved through the project; - HOPE has supported and respected the leadership role of the MOH; - HOPE has promoted the coordination amongst its partners and between its partners and other organizations.	Need to continue to promote and strengthen the leadership of the MOH in the target area.	There continues to be a need to further strengthen coordination at different levels (department, districts, estates).	- Continue to provide further assistance through this project; - Continue to strengthen the leadership role of the MOH; - Seek opportunities to further open up new opportunities for local coordination with health-related activities.	- HOPE needs to develop more skills to negotiate with all its partner agencies; - Respecting and working in accordance with MOH policies strengthens coordination and team work.
Technical Assistance	Technical assistance to the project was of high quality, technically and administratively.	Strengthen the technical capacity of the MOH/IGSS training teams at the department and district levels.	The quality of TA increased credibility with the partner agencies.	HOPE staff need to continuously upgrade their technical and management skills	The quality of technical assistance is strongly related to HOPE's credibility with its partner agencies.
Core facilitators (master trainers)	The existence of a core group of facilitators is key to sustainability.	If the core group of facilitators can be maintained, then the project can overcome the political instability associated with national elections.	The fact that there is a core group of facilitators in each department increases the likelihood of sustaining the in-service training and education process.	Staff turnover creates a continuing need to train partner agency staff that could become part of the core group of facilitators.	The core group of facilitators have the technical skills to conduct training/education activities.
Budget constraints	The MOH' s financial constraints to purchase essential drugs and supplies are a barrier to supplying all the necessary drugs to the estate health units.	The estate health units needs a basic stock of essential drugs and supplies in order to provide services.	Patient demand is driven in great part by the availability of drugs and essential supplies.	The MOH needs to make some adjustments/transfers in its Year 2000 budget to purchase the basic drugs to meet local health needs. In the Annual Operational Plan for 2001, a budget to cover medications for migrants needs to be included.	
Project					
Coordination	Communication between the different levels of the partner organizations is not very good, making it necessary for the project to organize many coordination meetings.	Communication lines between the various levels and geographical locations of the partner agencies need to be improved.		- Strengthen the capacity of partner agencies for supervision, monitoring, and evaluation; - Strengthen team work.	

Table 7 continued on next page ...

Table 7 continued

ISSUE	FINDINGS	CHALLENGES	CONCLUSIONS	RECOMMENDATIONS	LESSONS-LEARNED
Technical skills	Not all health facility staff are trained in standard case management protocols.	MOH maintain and implement a plan for training and updating staff.		Assure that all MOH staff are up-to-date in using MOH case management protocols.	
Community outreach and increased access	Health centers are not being overloaded with cases referred from the estate health units.	Maintain volunteer commitment and quality of work in diagnosing, treating, and referring patients.	- Access is being increased at the community level through the estate health units; - Cases are classified correctly and referred in a timely manner.	Partner organization staff should continue follow-up and supportive supervision through refresher trainings, and supervision of promoters and volunteers.	
Information System	The community-based information system is not yet fully functional	Assure the availability and use of the community-based information system.	- Strengthen the community-based information system with the health facility staff; - Take advantage of the willingness of promoters at the community level to report to the health facilities.	Continue to provide support to strengthen the community-based HIS.	
Drugs, supplies and stipends	TBAs and promoters need and want supplies, drugs, equipment and stipends.	Maintain costs of the community-level services as low as possible.	.	Negotiate with NGOs, owners and managers of the estates, MOH and other partners to obtain drugs, equipment and stipends	
Promoters Managing Estate Health Units					
Reaching migrants with education and counseling	It is difficult to provide individual counseling to migrants on maternal and child health issues on the estates.	- Increase the use of the mass media; - Reach migrants in their communities of origin; - Involve health areas covering the communities of origin to seek joint strategies of better serving the migrants.	Additional innovative strategies have to be developed to better serve the migrant population.	Strengthen the emphasis on health education message broadcast by radio in the various native languages.	
Technical skills of promoters	Promoters who manage estate health units follow established case management protocols.	Maintain the current level of quality in health services delivery.	Assist promoters to continue to improve their skills in the classification and timely referral of cases.	- Assure that partner organizations provide follow-up and supervision; - Assist the health units in managing a revolving drug fund in cooperation with local counterpart drug committees.	The promoter on the estate is the key to increasing access and coverage. A well-trained promoter can address and solve basic health problems.

Table 7 continued on next page ...

Table 7 continued

ISSUE	FINDINGS	CHALLENGES	CONCLUSIONS	RECOMMENDATIONS	LESSONS-LEARNED
First Aid	Promoters are not trained in first aid, which may negatively affect their acceptance by the target population.	Partner organizations should consider training promoters in first aid.	This recommendation is also supported by owners and administrators and may increase their acceptance of supporting the promoters.	HOPE should coordinate with the MOH and IGSS in the training of promoters in first aid and giving them a supply of basic first aid materials.	The ability of the promoter to treat small wounds, cuts, and burns in all individuals may increase their acceptance as health providers by the residents and migrants.
Clinic hours	The majority of promoters don't have scheduled clinic hours.	Willingness of estates to authorize the promoter to keep clinic hours during the coffee harvest and free him from harvesting duties.	During the coffee harvest, promoters don't have sufficient time for their health activities.	The project needs to further negotiate with individual owners/administrators so that promoters have the time to provide services to residents and migrants.	
[illegible]					
Involvement	Owners and administrators know about the health activities conducted in the estate health units.		It is important to maintain the credibility of the partner organizations in the eyes of owners and administrators.	- Develop a quarterly project progress report that can be shared with owners and administrators; - Further streamline the activities of the promoters.	- Living conditions have to be improved to increase impact on health status
Living conditions of the migrants	- The living conditions of the migrants in the estates are very inadequate. - There is international pressure to improve these conditions.	Sensitize owners and administrators to improve the living conditions for migrants.		- Coordination meetings with owners and administrators about the living conditions of the migrants; - Seek innovative strategies with the private sector to improve the living conditions of migrants.	
Cost-sharing	Owners/administrators are willing to contribute towards the cost of the health activities.	Increase the financial contributions of the estates.		Conduct cost-effectiveness studies to explore whether health units could be effectively staffed by permanent auxiliary nurses.	
[illegible]					
Service availability	Migrant mothers know that there is a health unit on the estate.	That health units on the estates provide services when needed.	Access to services and essential drugs has increased.	- Formal health services need to provide follow-up and supervision to the promoters managing health units; - Need to maintain a regular drug supply.	
Education	Migrant mothers value the education messages.	Education messages should reach the majority of mothers.		Messages should be disseminated in strategic location on the estates in all languages used by the migrants.	

Table 7 continued on next page ...

Table 7 continued

ISSUE	FINDINGS	CHALLENGES	CONCLUSIONS	RECOMMENDATIONS	LESSONS-LEARNED
Drugs and Supplies	There are only drugs for children and pregnant women.	Health units should have basic drugs for adults.	Migrant and residents want to meet their basic health needs.	HOPE needs to negotiate with partner agencies to also supply basic drugs for adults, e.g., pain relievers, multi-vitamins.	
Practices	Hygiene and nutrition practices have not improved noticeably in most situations.	A better understanding of the cultural background and socio-cultural factors is needed.	With a better understanding of cultural factors, it will be easier to promote a change in practices.	HOPE should look for other organizations (e.g., universities, USAID contractors) to conduct studies about cultural barriers and strengthen the understanding of these in the staff of its partner organizations.	
Directors of Radio Stations					
Broadcasting of messages	- Non-profit radio stations are broadcasting the basic health messages at no cost to the program; commercial radio stations, with larger audiences, have not been willing to do so.			- The project should work with local companies to obtain funding for broadcasting the basic health messages on commercial radio stations.	
	- Non-profit radio stations would like to have health staff available for live transmission of health programs.		Radio stations like live programs with audience participation.	- Promote the participation of HOPE and partner organization staff in radio programs.	
Technical quality	- Technical content of messages is good; - Messages are very concrete; - Sound quality of tapes is poor and monotonous.		Sound quality of tapes needs to be improved.	Seek funding from other agencies or the private sector to improve the sound quality of the tapes in a professional studio (e.g., different sound effects, etc)	
Languages used	Messages are only in Spanish, Mam, and Quiché.	Radio stations have also requested the messages in other local dialects.		Seek funding to duplicate tapes in other Mayan dialects used by the migrants and local variations of Mam and Quiché.	
Coordination	All interviewed directors of radio stations mentioned good coordination with the health areas.		The coordination between the radio stations and the health areas is good.		
Additional needs	Radio stations would like additional health topics and materials	Radio stations appear to be willing to increase their involvement in disseminating health information.		Identify/develop additional health messages/programs.	

INDIVIDUALS INTERVIEWED

Nombres de Personas Entrevistadas	
Jefatura de Area de Salud San Marcos	Dra. Elisa Barrios Enfermera Profesional Vilma Vásquez E.P. Adriana de Castillo T.S.R. Luis Quemé Dr. Osmin Reyna E.P. Carlos Sandoval
Radio Recuerdo Estéreo	Señor Francisco Ricardo Mérida Orozco
Radio La Buena Nueva	Monseñor Alvaro Leonel Ramazzini
Radio Tacaná	Señora Juana Alicia Vásquez
Centro de Salud San José El Rodeo	E.P. Reyna de Ovalle Inspector en Saneamiento Ambiental Marilú Cax Auxiliar de Enfermería Violeta Reyna
Finca Liberia	PRS Ada Virginia Castro Administrador Eduardo Gómez
Jefatura de Area de Salud San Marcos Núcleo Básico de Facilitadores	Dra. Elisa Barrios Dra. Yolanda Velásquez Dra. Alma Zoemia Chew EP Vilma Velásquez EP Adriana de Castillo EP Hilda de Chilel Dr. Gustavo Sandoval
Centro de Salud San Pablo	Dr. Edgar Ordoñez TSR Waldemar Angel EP Gislena Solórzano
Finca Buena Vista	Administrador Miguel Santizo PRS Consuelo de Santizo
Centro de Salud Malacatán	Dr. Telma de Aldana TSR Lisandro Barrios EP Maritza Gómez
AASDIMA	Señor Jose Barrios Señor Jesús Roblero Doctora María de los Angeles Makepcace Dr. Byron Orozco AE María Reyes
Centro de Salud San Pablo Facilitadores de Comadronas	Dra. Mirna López EP Gisela Solórsano
Finca Platanillo	PRS Eluvia Sandoval Administrador Mynor González
Centro de Salud El Quetzal	Dr. Ramón Ovalle EP Mayra Escobar AE Migdalia Orozco TSR Héctor López

Finca ONA	Administrador Marciano León PRS César Agustín Ventura
Finca Nahuatancillo	PRS Carlos Marínez
Finca Medio Día	PRS Carlos Barrios
Finca La Soledad	Administrador Cristian Chaps
Finca Buena Vista	Administrador Miguel Santizo
Finca El Edén	Administrador Rogelio De León
Finca Neblinas	Administrador German López
Finca Clermont	Administrador Marco Antonio Moscoso
Centro de Salud El Palmar	Dr. Oscar Nimatuj EP Idalia Ramírez AE Iliana López AE Dina Mayra Escobar AE Miguelina de Chay TSR Misael Cifuentes
Finca La Ceiba	Nicolás Pineda Bril
IGSS Suchitepéquez	Dr. Benjamin Ruiz Carlos, Director Regional Dr. Renato Umaña, Epidemiólogo Lic. Juan José Campo, Jefe Nivel I Dr. Obdulio Laparra, Jefe Sector I Dr. José Antonio Zasdi, Jefe Sector II EP Sonia Ixcoy EP Julia Mendoza
Núcleo Básico de Facilitadores IGSS	EP Sonia Ixcoy EP Juana Xuruc EP Julia Mendoza Dr. Mynor Ventura Dr. Edwin Lima EP Roxana De León
Radio Ke Buena	Señor Salvador García
Radio Campesina	Señor Manuel Rodas
Jefatura de Area de Salud Suchitepéquez	Dra. Silvia Rodríguez, Jefe de Area TSR Isaí Cariás, Coordinador de Técnicos EP Jovita de López
Finca Margaritas	Administrador Esteban Mateo Francisco PRS Lidia Leticia Pérez Propietario Familia Bonifasi
Educación Extraescolar	Director Nasario Canastuj Sub Coordinador Rolando Ixcot
Radio Fraternidad	Señorita Patricia Vásquez
Radio Nacional	Señora Marielena Marroquín
Radio Tulán	Ricardo Valentín Tay
Centro de Salud Colomba	Dr. Roberto Sandoval TSR Federico Mota
Finca Nueva Austria	Aparicio López
Fina La Violeta	Héctor Pérez

Finca Vizcayá	Cristobal Domingo
Finca La Unidad	David Castillo
Finca San Carlos Miramar	Miguel Serrano
Finca Providencia Fernández	Feliciano Reynosa
Centro de Salud Flores Costa Cuca Núcleo Básico de Facilitadores de Comadronas	Dra. Alba Diaz AE Hilario Chay
Fina San Carlos Miramar	Administrador Miguel Serrano PRS Gumercinda López
Finca Patio de Bolas	Propietaria Lorena de Procharsqui Administrador Ricardo González PRS Francisco Ismael Matías

SCHEDULE OF ACTIVITIES

CALENDARIZACION DE ACTIVIDADES DE EVALUACION DE MEDIO TERMINO
PROGRAMA DE SUPERVIVENCIA INFANTIL VIII BOCACOSTA DEL 8 AL 19 DE NOVIEMBRE DE 1999
HOPE GUATEMALA

LUGAR DE SALIDA			LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
SEDE	FECHA	HORA								
Hope	8-11-99	8:00 A.M.	Oficina de Hope	8:00 18:00	Preparación del Centro de Documentación			Educador Hope		Apoyo Staff
Hope	8-11-99		Oficina de Hope	17:00	Bienvenida a Evaluadores			Dr. Calderón		Apoyo Staff
				8.00 10:00	Presentación del resumen del Program de SI		Dr. Calderón	Dr. Calderón		Apoyo Staff y Secretaria
Hope	9-11-99		Oficina Hope	10:00 18:00	Elaboración de los Instrumentos de Evaluación		Evaluador Staff	Evaluador		
Hope	10-11-99		Oficina de Hope	8:00 12:00	Elaboración de Instrumentos de Evaluación		Evaluador Staff	Evaluador		Apoyo Staff y Secretaria
				15:00 16.00	Discusión de Instrumentos de Evaluación		Evaluador Staff	Evaluador		Apoyo Staff y Secretaria
				16:00 16:30	Conformación de Equipos de Evaluación		Evaluador Staff			
				16.30 18:00	Revisión de Material Educativo		Evaluador Staff			

AREA DE SALUD DE SAN MARCOS

LUGAR DE SALIDA			LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
SEDE	FECHA	HORA								
Hope	11-11-99	7:00	Jefatura de San Marcos	8.30 10:30	Entrevista con Equipo Técnico del Area	Equipo "A"		Dr. Calderón	Montero verde	Cada equipo contara con 4 asesores
				10:30 11:00	Entrevista con encargados de promoción del área	Equipo "A"		Dr. Calderón	Montero verde	
			San Pedro	11:00 12:00	Radio Recuerdo Stereo	Equipo "A"		Dr. Calderón		
			Centro de Salud de San José el Rodeo	13:30 14:30	Entrevista con Personal del Distrito	Equipo "A"		Dr. Dominguez	Vitara	
			Finca Liberia	15:30 17:30	Visita a la unidad de salud de la finca. Entrevista administrador. Visita a galeras. Entrevista con migrantes grupos focales	Equipo "A"		Pedro Alvarado Dr. Dominguez	Mitsubishi	
			Hotel Pérez	19:00	Cena					
				20:00 21:00	Transcripción y análisis de la jornada de trabajo	Equipo "A" Equipo "B"	Equipo "A" Equipo "B"	Evaluador		

SAN MARCOS

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
	11-11-99	7:00	Jefatura de Area de San Marcos	8:30 10:30	Entrevista Núcleo Básico de facilitadores en MECA, personal institucional y voluntario	Equipo "B"		Dr. Domínguez	Vitara y Montero gris	
				10:30 11:30	Entrevista con directores de Radio (Estereo la Buena Nueva y Tacana)	Equipo "B"		Anibal Bin Carlos Sandoval (encargado de promoción del área)	Vitara y Montero gris	
			Centro de Salud de San Pablo	13:30	Entrevista con personal facilitador IEC-MECA Entrevista Jefe de Distrito, Enfermeras	Equipo "B"		Dr. Domínguez		
			Finca Buena Vista	16:00	Jornada de Vacunación Jornada de Alención Control Prenatal	Equipo "B"	Personal Centro de Salud de San Pablo	Hector Xiloc Brenda Yes	Vitara y Montero gris	
			Hotel Pérez	17:30 19:00	Cena					
			Hotel Pérez	20:00 21:00	Transcripción y análisis de la jornada del día					
HOPE	12-11-99	7:00	Centro de Salud de Malacatán	9:00 10:00	Entrevista con Jefe de Distrito para centro de capacitación	Equipo "A"		Dr. Dominguez Dr. Calderón	Mitsubishi	
				9.00 10:00	Seguimiento de capacitación de comadronas	Equipo "A"		Pedro Alvarado Dr. Domínguez		
					Entrevista a CATS		Enfermera Maritza			

SAN MARCOS

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
					Entrevista con el Director de ASSDIMA Entrevista a Médicos Ambulatorios					
				10:30 12:00	Reunión Mensual de facilitadores comunitarios Entrevistas a guardianes de salud	Equipo "A"		Dr. Dominguez y Pedro Alvarado		
			Finca San Luis Malacatán	14:00 15:30	Visita a Unidad de Salud de la finca. Charla a grupo de madres. Prestación de servicios. Grupo focal de madres. Visitas a galeras. Entrevista con el administrador.	Equipo "A"		Pedro Alvarado Dr. Dominguez	Mitsubishi	
			Hotel Pérez	20:00	Cena	Equipos				
HOPE	12-11-99	7:00	San Pablo Centro de Salud	9:00 11:00	Réplica de capacitación de comadronas. Entrevista a facilitadores y comadronas	Equipo "B"	Equipo de Salud de Anacafé Distrito	Brenda Yes	Vitara Montero gris y Motos	
			Centro de Salud de San Pablo	11:30 13:00	Reunión con promotores de fincas: seguimiento mensual reunión director de enfermeras	Equipo "B"	TSR Distrito Hector Xiloc Pedro Alvarado	Héctor Xiloc Pedro Alvarado	Vitara Montero gris	

SAN MARCOS

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
			San Rafael Pie de la Cuesta Finca Platanillo	15:00 17:00	Visita a unidad de salud de la finca. Entrevista con administrador. Entrevista con encargado de Centro Comunitario. Visita Galeras Prestación de Servicios a migrantes.	Equipo "B"	Equipo de Salud del Distrito	Pedro Alvarado Dr. Dominguez	Vitara Montero Gris	
			Hotel Pérez	20:00	Cena					
HOPE	13-11-99		Centro de Salud El Quetzal	9:00	Reunión de Seguimiento de comadronas Entrevista con comadronas	Equipo "A"	Personal del Distrito	Brenda Yes Dr. Calderón	Mitsubishi	
				11:00	Reunión mensual de facilitador comunitario Con promotores	Equipo "A"	TSR Distrito	Héctor Xiloc	Mitsubishi	
			Finca Oná	14:00 en adelante	Visita a Centro Comunitario. Entrevista a facilitador. Verificar sistema de información, Material educativo y Medicamentos. Entrevista con administrador.					
			Sede Hope	17:30 19:00	Transcripción y análisis de jornada de trabajo	Equipo "A" Equipo "B"	Equipo "A" Equipo "B"	Evaluador		Hospedaje Hotel Bella Luna

LUGAR DE SALIDA			LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
SEDE	FECHA	HORA								
HOPE	13.11-99	7:00	Fincas de el Tumbador		Visita a unidades de salud. Entrevista Administradores Entrevista Facilitador Comunitario.	Equipo "B"		Pedro Alvarado Héctor Xiloc Dr. Dominguez	Vitara Montero Gris	
			1. Nahuatancillo 2. Medio Dia 3. Bola de Oro	9:00-11:00 11:00-13:00 14:00-15:00	Verificación sistema de Información. Material Educativo Visitas a galeras Entrevistas a madres migrantes					
			Sede Hope	17:30 19:00	Transcripción y análisis de jornada de trabajo	Equipos "A" Equipos "B"	Equipos "A" Equipos "B"	Evaluador		Hospedaje Hotel Bella Luna

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CALENDARIZACIÓN DE ACTIVIDADES DE EVALUACION DE MEDIO TERMINO
PROGRAMA DE SUPERVIVENCIA INFANTIL VIII BOCACOSTA
DEL 10 AL 18 DE NOVIEMBRE DE 1999
AREA DE SALUD DE QUETZALTENANGO

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
HOPE	1511-99	8:00	Jefatura de Area de Quetzaltenango	8:30 10:00	Reunión con directiva del Consejo de Salud	Equipo "A"		Dr. Calderón Dr. Dominguez	Montero Verde	4-5 personas por equipo
				10:00 11:00	Reunión con encargado del seguimiento del plan de mensajes básicos de radiodifusoras	Equipo "A"		Dr. Calderón		
				11:00 12:00	Reuniones con el Núcleo Básico de Facilitadores en MECA y ARO y P.	Equipo "A"		Dr. Calderón		
			Centro de Salud de el Palmar	14:00 15:00	Reunión con equipo del distrito	Equipo "A"		Dr. Dominguez	Montero Verde Vitara	
					Réplica de comadronas	Equipo "A"	E.P. Distrito	Ericka Sandoval	Moto	
					Entrevistas individuales con comadronas. Entrevista a grupo focal de comadronas	Equipo "A"	Personal de Salud	Ericka y Benedicto	Moto	
			Finca Alianza Finca La Ceiba	15:00 18:00	Jornada de Atención Materna y Vacunación Visita a galeras	Equipo "A"	Personal de Salud	Ericka y Benedicto	Moto	

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
					Observación de la prestación de servicios del centro comunitario	Equipo 'A"		Ericka Sandoval	Moto	
					Reunión con administrador	Equipo 'A"		Ericka Benedicto	Moto	
			Hotel Bella Luna	19:00	Cena					
				20:00 21:30	Transcripción y análisis de jornada de trabajo	Equipo "A" Equipo "B"	Equipo "A" Equipo "B"	Evaluador		

AREA DE SALUD DE SUCHITEPEQUEZ

LUGAR DE SALIDA			LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
SEDE	FECHA	HORA								
HOPE	15-11-99	7:30	Jefatura departamental IGSS Suchitepéquez	9:00 10:00	Reunión director Regional Coordinar y Supervisor	Equipo "B"		Dr. Domínguez	Montero Verde	Ya se coordinó con el Lic. Campo
				10:00 12:00	Entrevista a núcleo básico de facilitadores en MECA, IEC y AROP	Equipo "B"		Dr. Domínguez	Vitara	
					Entrevista a médicos y enfermeras hospital IGSS (pediatría, y obstetricia)	Equipo "B"				
			Radiodifusora	2:00 3:00	Entrevista con director radio Campesina y Kebuena	Equipo "B"		Anibal Dr. Domínguez		
			Jefatura de Area	3:00 4:00	Reunión con personal de Jefatura de área	Equipo "B"		Dr. Calderón		
			Finca Margaritas San Francisco Zapotitlán	4:30 17:30	Visita a Unidades de salud. Reunión con el administrador Observar calidad de prestación de servicios. Revisión del sistema de información. Entrevista a migrantes	Equipo "B"		Karina y Eric	Vitara o Montero	

		Hotel Bella Luna	19:00	Cena	Equipo "A"	Equipo "A"	Evaluador			
			20:00 21:30	Transcripción y análisis de jornada de trabajo	Equipo "B"	Equipo "B"				

QUETZALTENANGO

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
HOPE	16-11-99	8:00	Oficina de Educación Extra Escolar	8:30 9:30	Reunión con coordinador de Educación Extraescolar y su equipo	Equipo "A"		Aníbal Bin		
			Radio Fraternidad Radio Nacional Radio Tulán	9:30 12:30	Reunión con el director o responsable de la radio.	Equipo "A"		Aníbal Bin Hector Larios	Montero Verde	
			Distrito San Felipe Puesto de Salud	14:00 16:00	Seguimiento de CAT Seguimiento IEC promotores Entrevista a comadronas Entrevista a los promotores	Equipo "A"	Personal de Salud	Benedicto		
			Finca Patio Bolas	16:30 18:00	Visita a unidad de salud Réplica Educativa de promotor a madre Entrevista a propietaria Visita a galera Entrevista a migrantes	Equipo "A"	Promotor de salud Comunitario	Ericka	Milsubishi	
			Hotel Bella Luna	19:00	Cena					

QUETZALTENANGO

LUGAR DE SALIDA SEDE	FECHA	HORA	LUGAR DE REUNION	HORA	ACTIVIDAD	EQUIPO EVALUACION	RESP. DE EJECUCION	RESP. DE COORDINACION	VEHICULO	OBSERVACIONES
HOPE	11 12-11-99	7:30	Centro de Salud de Colomba	9:00 10:00	Entrevista con Director de distrito E.P. y equipo	Equipo "B"	TSR Hope y MSP	Dr. Dominguez Dr. Calderón	Mitsubishi	
				10:00 12:00	Reunión seguimiento de I.E.C Reunión de administradores	Equipo "B"	Dr. Sandoval Ericka	Benedicto dr. Dominguez		
			Centro de Salud de Flores Costa Cuca	14:00 16:00	Entrevista con Equipo de distrito. Seguimiento de comadronas Entrevista a comadronas	Equipo "B"	Personal de Salud	Ercika	Moto	
			Finca San Carlos Miramar Colomba C.C.	16:00 18:00	Visita a unidad de salud Visita a galeras. Entrevista a migrantes Observar la calidad de atención del centro comunitario. Entrevista a comadronas	Equipo "B"		Benedicto Lico	Moto	