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Office of Food for Peace**

Fiscal Year 2013 Annual Results Report

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LIST OF ACRONYMS

AOR	Agreement Officer's Representative
ARD	Acute Respiratory Diseases
ARR	Annual Results Report
AV	Alta Verapaz
BCC	Behavior Change Communication
BL	Baseline
CC	Convergence Center
CHC	Community Health Commission
CHF	Community Health Fund
CHV	Community Health Volunteers
COCODE	Community Development Council
CSB	Corn-soy blend
CTS	Commodity Tracking System
DIP	Detailed Implementation Plan
EBS	Basic Health Teams (field teams from PSS)
FANTA-3	Food and Nutrition Technical Assistance Project (Phase 3)
FFP	Office of Food for Peace
FFP/M/R	Office of Food for Peace/Mission and/or Regional Office, as appropriate
FFP/W	Office of Food for Peace/Washington
FY	Fiscal Year (October 1 st - September 30 th)
GIS	Geographical Information System
GOG	Government of Guatemala
HHAP	Household Action Plan
HP	Health Post
ICO	Social Cooperation Institute
IFPRI	International Food Policy Research Institute
INE	National Statistics Bureau
IPTT	Indicator Performance Tracking Table
IR	Intermediate Result
IS	Institutional Strengthening
IY	Implementation Year (July 1 st – June 30 th)
LNS	Lipid-Based Nutrient Supplement
LOA	Life of Award
MC	Mercy Corps
MCG	Mercy Corps Guatemala
MIS	Management Information System
MNP	Micro-nutrient Powder
MOH	Ministry of Health
MOU	Memorandum of Understanding
M&E	Monitoring and Evaluation
MT	Metric Ton
MTE	Mid-term Evaluation
MYAP	Multi-Year Assistance Program
NGO	Non-Governmental Organization

PEC	Coverage Extension Program, MOH
PM2A	Preventing Malnutrition in Children Under Two Approach
PSS	Decentralized Health Service Providers
PREP	Pipeline and Resource Estimate Proposal
PROCOMIDA	Programa Comunitario Materno Infantil de Diversificación Alimentaria (Mercy Corps' Title II PM2A MYAP in Guatemala)
SAM	Severe Acute Malnutrition
SAPQ	Standardized Annual Performance Questionnaire
SESAN	Secretariat of Food Security and Nutrition
SIAS	Integrated Health Attention Service
TDP	Training and Distribution Points
TSU	Technical Support Unit
USAID	United States Agency for International Development

A. Introduction: Annual Food Aid Program Results

This Annual Results Report (ARR) summarizes all activities PROCOMIDA implemented during Implementation Year (IY) 4 (July 2012 to June 2013). In this year the program continued implementation with changes geographical area, as also mentioned in the PREP IY 5.

As mentioned in page one of FY14 PREP, the program expanded in August 2012 to the north-eastern part of Alta Verapaz (municipalities of Chahal, Fray Bartolomé de las Casas and Chisec) to an additional 65 Training and Distribution Points (TDP¹), summing to a total of 347 TDP. In addition, as requested by MOH in order to cover jurisdictions within the program area at 100%, the program closed 25 non-research TDP in May 2013 to accommodate 36 new TDP. This enabled the program to accommodate the MOH's request that the program cover all convergence centers in each jurisdiction.

Table 1. Geographic Coverage (program data)

Municipality	IY 2	IY 3			IY 4		
	CCs in Program	CCs in Program	Health Posts in Program	Total TDP	TDP	Health Posts in Program	Total TDP
1 Cahabón	31	31	1	32	37	0	37
2 Cobán	64	70	6	76	70	0	70
3 Lanquín	15	15	0	15	15	0	15
4 San Pedro Carcha	111	115	5	120	126	0	126
5 Senahú	0	39	3	42	46	0	46
6 Chahal	0	0	0	0	11	0	11
7 Fray Bartolome de las Casas	0	0	0	0	37	0	37
8 Chisec	0	0	0	0	15	0	15
9 Raxruha	0	0	0	0	1	0	1
TOTAL	221	270	15	285	358	0	358

Source: PROCOMIDA MIS system

A.1. Beneficiary interventions

A total of 24,935 mother/child units² (MCU) were active at the end of IY3, representing a total of 24,317 families. Mother/child units participate for a minimum of six months and a maximum of 30 months (the first 1,000 days approach). To date, an accumulated total of 42,148 families

¹ Initially the program was only working with Convergence Centers, but included Health Post last year, as reported in the FY 12 ARR.

² The program measures its beneficiaries as mother/child units.

have participated in the program. The majority of the beneficiaries are children 6-24 months (65%), as was expected. The percentage of pregnant mothers for 2011 (13.3%), 2012 (13.1%) and 2013 (15.2%) suggests that the program has not had a significant impact on the pregnancy rate (program data).

A total of 188,017 individual rations and 181,400 family rations (rice, pinto beans and vegetable oil) were distributed during IY3. The difference is due to arm C only receiving individual rations and to families that have more than one MCU³ and receive thus various individual rations.

Table 2: Active Beneficiaries by Type (as of June 30, 2013)

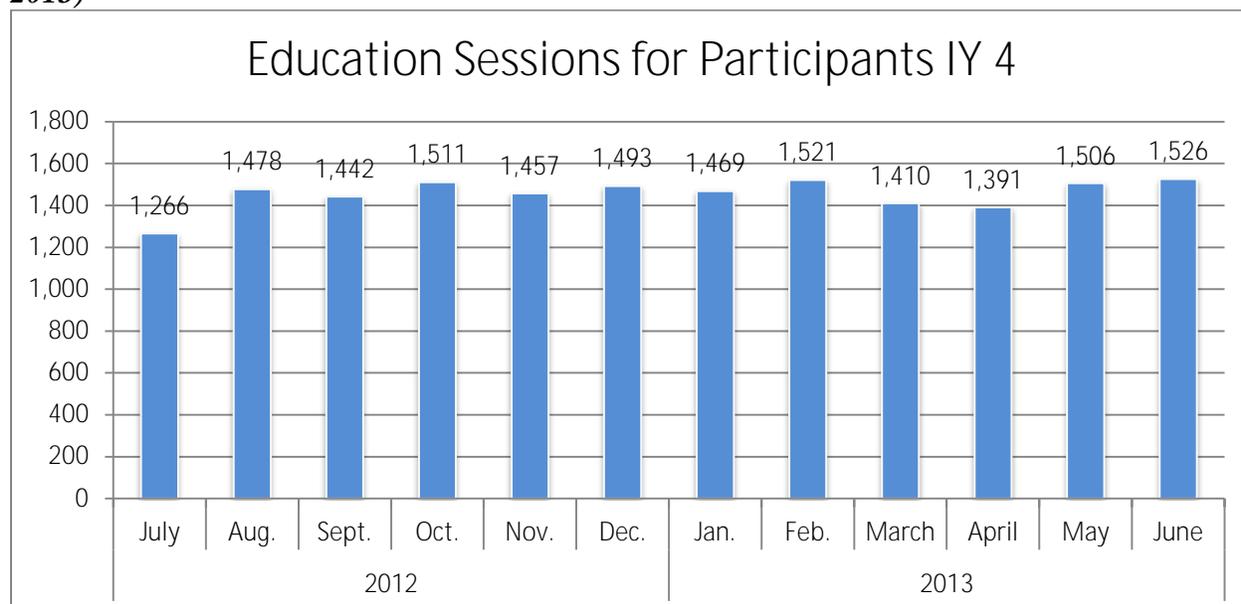
Beneficiary Type	IY 4
Pregnant women	3,795
Lactating mothers	4,971
Children 6 to 24 months	16,169
Total active MCU	24,935
Total Families	24,317
Graduated families	21,504
Accumulative families	42,148

Source: PROCOMIDA MIS system

Beneficiaries received monthly training from program field staff through education sessions, divided in different interest groups (pregnant women, lactating women with children from 0 to 6 months of age and women with children from 6 to 24 months). Specific sessions for sick and/or malnourished children are provided as needed. Field staff trained an accumulated total of 42,148 families since the inception of the program, as well as the health commissions in all 358 TDP. Monthly sessions are held in each CC with the different groups. During IY 4, a total of 17,470 educational sessions were held (see Graph 1).

³ e.g.: twins under two year or a child under two years and a pregnant mother.

Graph 1: Number of Educational Sessions Implemented to Participants (July 2012 – June 2013)



Source: PROCOMIDA monitoring system

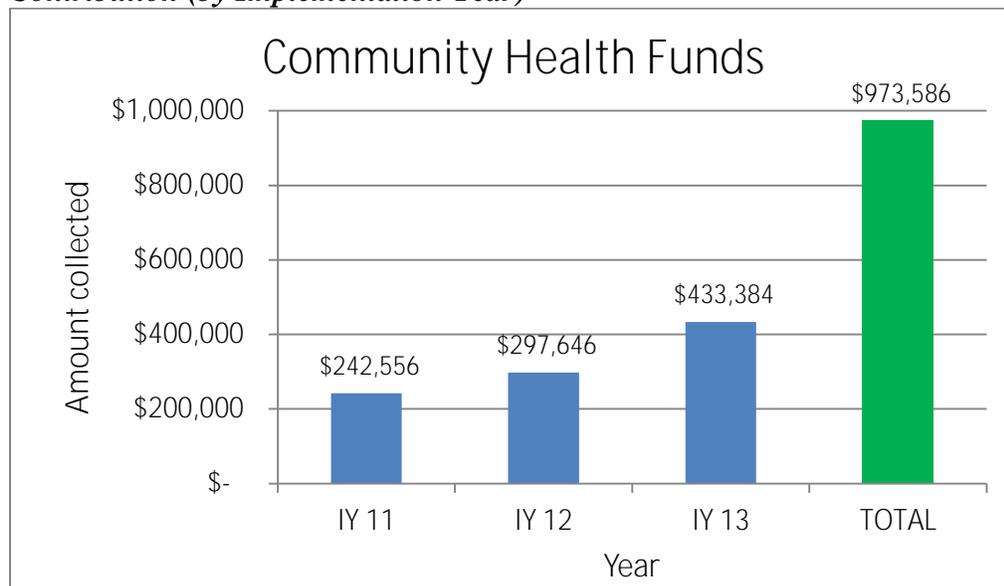
In addition to the education sessions, cooking demonstrations are held with Mother Leaders, who in return replicate them with beneficiaries in their community. A total of 6,455 demonstrations to Mother Leaders were given in this IY, who in their turn held a total of 18,285 demonstrations with participant mothers. The demonstrations use recipes developed by the program, which include both donated and local nutritious food to promote diet diversity. On average 70% of the participant mothers attend the demonstrations, proving the cascade process works.

This year, PROCOMIDA shifted the responsibility of household visits to the local NGO PSS. The PSS staff, in charge of these visits, assists in the monthly training sessions for PROCOMIDA staff and receives supervision from both PROCOMIDA and PSS. Program field staff still makes visits to families that are at risk, either the mother or the child. During the year, the field staff made 7,048 household visits. The PSS staff made an additional 11,927 household visits for a total of 18,975 house visits overall. During the visits emphasis is given to the importance of attending trainings, strengthening key messages, monitoring donated food use, following up malnourished children and giving nutrition counseling.

Emergency funds have been employed from the beginning of program interventions. To date, a total of nearly US\$ one million has been collected and managed by the Community Health Commissions, as reflected in Graph 2. Overall, management of the funds has been transparent, where the CHC reports twice a year to the community. In 17 TDP (4.7%) there have been some problems with cash management in this IY. In these cases the program intervenes through a series of visits from its Institutional Strengthening Component, which guides the community to take actions to recover lost funds, strengthening management capacities of the CHC and social

audit capacity of the whole community. In only seven of these cases the program had to put in effect more severe measures such as suspending program interventions for one or two months.

Graph 2: Amount (US\$) Collected for Community Health Funds through Voluntary Contribution (by Implementation Year)



Source: PROCOMIDA monitoring system

Institutional Strengthening (MOH, PSS, Community)

During the year, the program intensified its institutional strengthening (IS) component. First, we have achieved better coordination with departmental MOH, as a result of the coverage negotiations mentioned earlier. In addition to PSS staff from the program area, this year the program has included training sessions for PSS staff from non-program jurisdictions in Alta Verapaz. This helped support and strengthen the GOG Zero Hunger Pact (*Pacto Hambre Cero*) and standardizing food security and nutrition interventions. Special training sessions have been held to improve growth monitoring expertise within the PSS. Anthropometric standardization workshops were repeated, but this time it started with program staff, then MOH and PSS staff. The latter will replicate the standardization at community level, supported by the program. Emphasis has been given to length/height measurements since MOH is requiring monthly measurements, as part of the Zero Hunger Pact.

At community level, the program has prioritized implementation of household action plans (HHAP). The plan includes components regarding health, hygiene and nutrition. Implementation includes startup of small home gardens to improve diet diversity and access to nutritious local food. To date, a total of 4,181 HHAP have been implemented.. Inputs for this plan have been provided through the community health fund and individual funds from each family.

A.2. Warehouse

During the fourth implementation year the program distributed 3,671.3 MT of commodities to 358 TDP in eight municipalities of Alta Verapaz.

Table 4: Distribution Summary by Research Arm (in MT, from July 2012 to June 2013)

Research Arm	CSB	Rice	Beans	Veg oil	Totals
Non – Research*	758.8	1,094.5	729.5	325.9	2,908.7
A	59.2	86.4	57.6	25.8	229.0
B	57.5	41.7	41.7	13.8	154.8
C	29.7	-	-	-	29.7
D	-	90.7	60.5	27.0	178.2
E	-	86.9	58.0	26.1	170.9
Totals	905.1	1,400.2	947.3	418.7	3,671.3

*Includes non research TDP which receive CSB + Vegetable Oil

Source: PROCOMIDA Commodity Status Reports and Food Logistics Unit

The program made four direct distribution call forwards for FY 13 to ensure the continual availability of commodities in warehouse for repackaging. Mercy Corps duty-free status was used for the imports. Three out of the four Call Forwards have been received in four shipments and as of this submission; there is one Call Forward in transit. From a total tonnage of 4,220 MT call forwarded during FY 13, the program has received 3,482.80 MT.

Table 5: Commodity shipments for IY 3 in MT (direct distribution, dates are arrival at port).

Commodity	FY 2013					Total
	CF 1	CF2	CF3		CF4 *	
	Shipment 1	Shipment 1	Shipment 1	Shipment 2	Shipment 1	
	April 2013	May 2013	Aug 2013	Sep 2013	Nov 2013	
CSB	467.58	317.28	228.58		220.00	1,233.43
Rice	468.05	439.60	289.45		300.00	1,497.10
Beans	319.40	299.85	79.70	118.30	200.00	1,017.25
VegOil	148.34	148.34	158.35			455.03
TOTAL	1,403.37	1,205.07	756.07	118.30	720.00	4,202.80

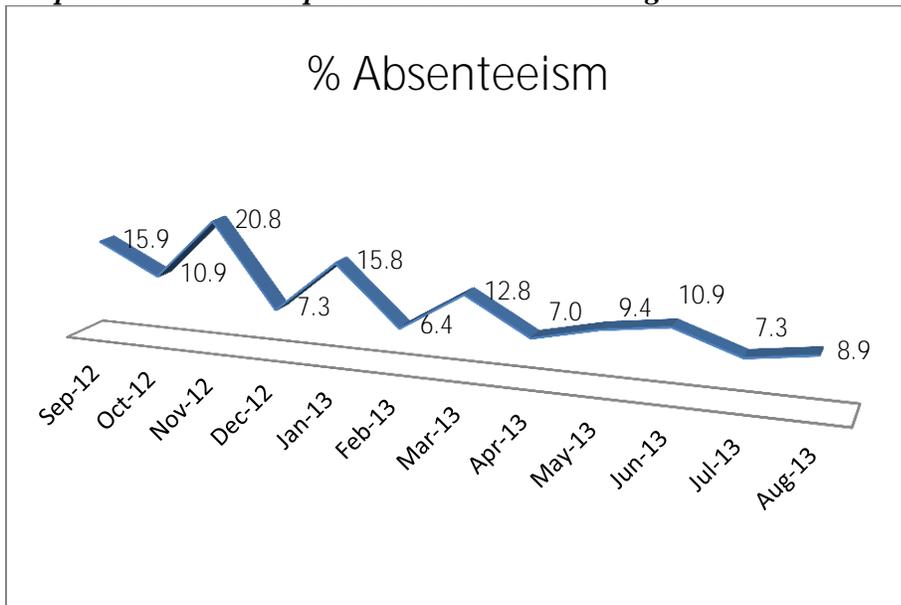
*Shipment pending arrival at Guatemala port

Source: PROCOMIDA CTS and Food Logistics Unit

The clearance process, inland transportation, unloading and return of the empty containers to the port for each shipment was completed within the 45 free-day period, as established in the ocean freight contract. The whole process took on average 35 days, with a minimum of 25 days and a maximum of 45 days. In this calculation, the days taken to fumigate the commodities in port are not counted as part of the free-days, since that period is responsibility of the carrier as per the freight tender. The customs process and port exemption process were completed normally in coordination with USAID, GOG and Port Authorities.

During the implementation year, the program imported vegetable oil in 208 liter drums and bottled it into 2-liter containers, which allowed the program to distribute oil monthly to its beneficiaries instead of every other month. This process has resulted in reducing absentee rates as participant absenteeism was high in months when vegetable oil was not distributed (see Graph 3).

Graph 2: Absenteeism per month in TDP with vegetable oil



Source: PROCOMIDA MIS

A.3. Monitoring and Evaluation

In the FY14 PREP the program requested approval of some changes to the IPTT⁴. For some indicators, out-year targets were adjusted according to MTE findings. In this report, the revised out-year targets are included for reference, although the program is aware they have not yet officially been approved by FFP.

A.3.1. Annual Monitoring Results

The annual monitoring followed the same sampling method as annual monitoring in FY11 (30 x 30 design) and has used the same surveys as baseline and mid-term. The data collection application for tablets used in the mid-term evaluation (MTE) was revised and improved to reduce the need for data cleaning and to improve on-site data control. This tool will continue to be improved over the next year.

⁴ FY 14 PREP, pages 12 – 18.

The results of annual monitoring confirmed findings of last year's MTE with respect to mothers not being able to convert knowledge into practice. However, this year's measurements also identified a decrease in new knowledge. The program is implementing changes, as discussed in A.4. below, to assure both improved knowledge and practices. It will also implement spot tests during the year to closely monitor increase in knowledge and knowledge into practice.

It also confirmed the MTE recommendation to negotiate indicators that are influenced by factors beyond the program's control.

Indicators⁵ that met or exceeded target:

S.O. 1, Monitoring Indicators

I.R. 1.1

- Indicator 4 (#pregnant and lactating women receiving food rations, accumulative; 16,304) exceeded its target of 14,000 by 166%
- Indicator 6 (# children aged 6 – 24 months receiving food rations, accumulative; 30,135) exceeded its target 23,000 by 131%.

This is consistent with former years and responds to expansions and program growth. As mentioned above, target adjustments of both indicators have been proposed for out-years.

I.R. 1.2

- Indicator 7 (% caregivers demonstrating increased nutritional knowledge; 66.6%) far exceeded its target of 15%. Out-year targets have been adjusted.
- Indicator 16 (% mothers receiving minimum recommended post natal care; 58.9%) also exceeded its targets of 36% as in former years. Out-year targets have been adjusted.
- Indicator 8 (% of newborns who receive essential newborn care; 76.6%) almost met target of 82%, reaching 94% of its target. This is an improvement over last year's result.
- Indicator 9 (% of children between 0 and 6 months that are exclusively breastfed; 81.3%) met target of 80%, increasing considerably compared to last year.
- Although indicator 11 (% mothers with proper identification of childhood illness warning signs; 32.2%) met its target of 30%, it is much lower than last year's MTE result, but consistent with earlier measurements (BL and FY11). Changes in BCC activities are addressing this issue.

I.R. 1.3

- Indicator 19 (% of households with household action plans; 5.3%) exceeded target of 3.5% as former years. The program is increasing coverage of this strategy and thus out-year targets have been adjusted.

⁵ Indicator numbers refer to Column A of IPTT.

- Indicator 20 (# Training and Distribution Point with emergency funds; 358) exceeded their target of 347 due to the expansion to new TDPs. Out-year targets have been adjusted to this expansion.

S.O. 2, Monitoring Indicators

I.R. 2.1

- Indicator 23 (# health commissions with regular meetings; 358) exceeded its target of 347 due to the expansion, since in all TDP CHC are required to hold monthly meetings. Targets have been adjusted accordingly
- Indicator 24 (#health commissions demonstrating progress on action plans; 358) also exceeded its target of 347 due to the expansion. As expected, CHC of all TDP have demonstrated progress on their annual plans. Targets have also been adjusted accordingly.
- Indicator 25 (# of midwives and/or pregnant women in health facility orientation visits; 1,053) exceeded its original target of 540, As mentioned in ARR FY12 and FY14 PREP, the program has shifted its focus to include midwives in the visits, since they are key influencers in deciding where to have deliveries. Out-year targets have been adjusted.
- Indicator 26 (% deliveries at health facilities; 36.3%) almost met target of 40%, improving with regards to MTE results.

I.R. 2.2

- Indicator 29 (% of detected SAM cases referred per MOH protocols; 97%) exceeded the target of 95%, which is consistent with former years.

Indicators that did not meet target:

S.O. 1, Monitoring Indicators

I.R. 1.1

- Indicator 5 (% children 6 – 24 months with minimal acceptable dietary diversity; 55.3%) did not meet target 75% by far. Although lower than MTE it is consistent with FY11 findings. The program’s Action Plan⁶ was not fully implemented when data collection took place; hence it is expected to increase in the following year (IY 5).

I.R. 2.1

- Indicator 10 (% mothers that know the danger signs of pregnancy; 9.5%) by far did not reach 30% target. When comparing with former years, especially with MTE, this

⁶ See FY14 ARR, page 6 – 8.

indicator has significantly decreased. After program-wide discussion and analysis, it is considered that current training techniques should be changed to make sure all mothers receive key messages within the short timeframe during pregnancy. As mentioned earlier, field activities should integrate key messages into fewer sessions and should be related to real life conditions. The program will implement spot tests during the year to monitor closely increase in knowledge.

- Indicator 12 (% children aged 6 – 23 months with diarrhea that received adequate treatment; 15.1%) continues to be far below target (65%). When analyzing more closely, most mother seek attention in case of diarrhea, while only half of them give ORS. The program also interviewed all 30 CC CHV in the sample and remarkably in 93% of the CCs there is ORS available, but apparently it is not distributed. The program will meet with PSS to assure improved access to ORS for the population
- Indicator 13 (% children aged 6 – 23 months with respiratory diseases that received adequate treatment; 6.7%) also continues to be far below target (65%). Apparently mothers do not seek health services often enough. This will be addressed through the training sessions (see A.4.).
- Indicator 14 (% of mother that received minimum antenatal care; 41%) is far below target of 88%. The main reason for this drop compared with former years is the lack of distribution of antenatal supplements in the CCs. 80% of the mothers interviewed had attended at least four prenatal controls. According to the interviews at CC level, all CCs had Iron and almost all (97%) had Folic Acid. Zinc was also available in 80% of the cases. However, of the 80% of the mothers, only 49% received supplements. This issue will also be addressed with PSS.
- Indicator 17 (% children receiving full vaccinations; 74.2%), as in former years, did not meet target of 92%. It did increase considerably compared to FY11 and MTE but is still below MOH requirement of 95%. This indicator depends mainly on MOH vaccine provision and PSS admission.
- Indicator 18 (% children receiving routine health services; 45.2%) also did not meet targets. It is higher than MTE, but equal to FY11. The strategies mentioned below (A.4.) regarding growth monitoring will ensure the program reaches its final targets for this indicator.

I.R. 2.2

- Indicator 28 (availability of a minimal level of infrastructure, supplies and medications at health facilities) continues to be stagnant at 0% since baseline. Since this indicator relies mainly on MOH budget availability, which cannot be influenced by the program, it has been proposed for elimination in FY14 PREP (page 12).

A.3.2. Trigger Indicators

Trigger indicators were measured through secondary data sources, mostly from government institutions, except for indicator 36, coping strategies. The latter was measured using the Maxwell Coping Strategy Index⁷ and was measured through the annual household survey. The index takes into consideration both the number of coping strategies used, frequency and weighs each strategy according to severity (i.e. skipping a meal is proportionally less severe than not eating in the whole day). Wasting data has been provided by MOH Department of Alta Verapaz; food prices are taken from the country's National Statistics Bureau (INE); rainfall data from the meteorological stations in the program area; and information on security is provided by the Governor of Alta Verapaz. A security index is created of data on different types of incidents, such as assaults, murders, violent attacks and others occurred in the program area.

Wasting has continued to maintain low at 0.3%, compared to 0.8% last year and 0.3% in FY 11. Likewise, there has been little change in food prices this year; prices of main food commodities (beans, rice, vegoil) have maintained stable during the year. It is important to mention that rainfall is marked yellow for three years in a row and fluctuates considerably; this year with a slight rain deficit.

Security incidents have maintained high this year (51.6). Although slightly lower than last year (67.9), it is far above threshold/baseline level (35.7) and Alta Verapaz continues to be a dangerous region.

The Maxwell Coping Strategy Index (indicator 36; 12.1) decreased considerably this year compared to last year (25.1), although it is still above threshold. This means people in the intervention area had to implement fewer strategies to cope with food insecurity than last year, but it is still above threshold level of 10..

A.4. Changes in Program Management Structure

Based on the MTE results, the program carried out a set of meetings to identify key actions and strategies for the remaining 2 years of the program. The result of this process is an Action Plan, of which a summary is attached to this report. The key actions are currently being implemented and are focused on the following areas:

- Strengthening growth monitoring, both at community and PSS level
- Improving both knowledge and practices of beneficiary mothers
- Institutional and community strengthening
- Information management

The program also made some changes in its structure. In FY 13 the MIS unit, in charge of developing and maintaining the program's data system, was moved to the Technical Support Unit (TSU). Now the TSU comprises of four components: Nutrition, BCC, M&E and MIS. This way, there is better integration between MIS and M&E, which improves data quality, analysis and reporting. As a result, an intensive restructuring of the MIS database and applications took place.

⁷ Maxwell et al, July 2003. The Coping Strategy Index, Field Methods Manual; Care and World Food Program.

Also, the program is adjusting its interventions in the field by increasing the involvement of fathers and grandmothers in program activities, which is expected to increase behavior change since both are considered influencers at household level. Simulations of real life situations with the communities will be implemented so that beneficiaries and key actors in the community learn the importance of knowledge and actions. First a community growth monitoring exercise will be held in November, followed in February/March by a simulation of a maternity emergency. These simulations allow inter-relating both key messages (danger signs, health seeking practices, hygiene, etc.) and key actors (mothers, fathers, grandparents, CHW, TBA, PSS staff and community leaders) in a life like context to which all can relate. It also helps clarify responsibilities within the community.

B. Lessons learned

- ✓ Education sessions should be more integrated and related to real life events.
- ✓ The Action Plan is designed to address the underlying causes of targets not met and will assure goals to be reached as well as sustainability.
- ✓ Coordination and consensus with MOH (departmental level) improves not only outcomes, but assures sustainability.
- ✓ GOG's Zero Hunger Pact is providing the program with the much needed inter-ministerial coordination, both at central and departmental level.
- ✓ Collection of growth monitoring data in the field has provided important information regarding growth monitoring practices in the communities and gives strong basis to strengthen PSS and CHV.
- ✓ Close coordination with PSS has allowed the program to better capture pregnant women
- ✓ Model mothers and CHV have been key in strengthening community links.
- ✓ Involving local authorities in management and planning of the Community Health Fund is important for assuring community ownership.
- ✓ More involvement of SESAN at departmental and municipal level has improved analysis and decision making between food security actors.
- ✓ Social audits of Community Health funds by the same communities assure transparency and reduces misuse of funds.