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PROJECT PAPER

GUATEMALA

POPULATION/FAMILY PLANNING

PROJECT PAPER

GUATEMALA-POPULATION/FAMILY PLANNING

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8. ESTIMATED FY OF PROJECT COMPLETION FY <div style="border: 1px solid black; display: inline-block; padding: 2px;">80</div>		9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY <div style="border: 1px solid black; display: inline-block; padding: 2px;">77</div> B. QUARTER <div style="border: 1px solid black; display: inline-block; padding: 2px;">2</div> C. FINAL FY <div style="border: 1px solid black; display: inline-block; padding: 2px;">79</div> (Enter 1, 2, 3, or 4)	

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$1 -)						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	290		290	921		921
(GRANT) PH	(290)	()	(290)	(921)	()	(921)
(LOAN)	()	()	()	()	()	()
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY		72	72		216	216
OTHER DONOR(S)	799		799	1472		1472
TOTALS	1089	72	1161	2393	216	2609

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>77</u>		H. 2ND FY <u>78</u>		K. 3RD FY <u>79</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
1) PH	444	440		290		310.7		320.4	
2)									
3)									
4)									
TOTALS				290		310.7		320.4	

A. APPROPRIATION	N. 4TH FY		Q. 5TH FY		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED MM YY <div style="border: 1px solid black; display: inline-block; padding: 2px;">03 78</div>
	O. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
1) PH					921		
2)							
3)							
4)							
TOTALS					921		

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1

 1 = NO
 2 = YES

14. ORIGINATING OFFICE CLEARANCE				15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION					
SIGNATURE <i>Edward W. Coy</i> Edward W. Coy		TITLE Director						DATE SIGNED	
				MM	DD	YY	MM	DD	YY

B. Recommendation

USAID/Guatemala recommends the approval of a Title X grant in the amount of \$921,100 over a three-year life of project to enable APROFAM, the Guatemalan IPPF affiliate, to expand the availability of contraceptives nationwide and to make family planning information available to the entire population.

C. Description of the Project

The project's goal is to progressively reduce the crude birth rate of approximately 39 per 1000 in 1977 and 37 per 1000 by the end of the project in 1979, and to assure conditions that would continue such a decline after AID assistance is terminated.

This new Population/Family Planning Project will focus on the following activities:

1. Contraceptive Logistics Program

As of November 1976, the Ministry of Health had 591 clinics, 75% of which are Rural Health Posts. Under MOH management, it has taken seven years to introduce FP services in 126 clinics. Since APROFAM took charge of this aspect of the MOH's program in June 1976, 149 additional clinics have been stocked with contraceptives. Under the proposed Title X project, APROFAM will assure the availability of contraceptives in at least 500 MOH clinics by January 1978, and as additional MOH clinics are completed with IDB financing, the number of MOH clinics that offer FP services will be progressively increased.

2. Information, Education & Communications Program

Based on the findings of University of Chicago/APROFAM IE&C & KAP research, a new multi-media and person-to-person communications program will be developed in early 1977. The country will be divided into two areas, Indian

and non-Indian, and two substantially different approaches will be adopted. Radio, TV, and newspapers will be utilized based on the CY 76 pilot program results, but message content would be modified to increase its impact on different ethnic and social population groups. The University of Chicago proposes to complement the mass media program with an experimental two-year person-to-person activity at the community and clinic level. Initially field workers would be deployed to work in communities surrounding health centers and rural posts. They would give talks on FP to women one day per week at the health centers, continuously motivate clinic personnel, and perhaps more importantly, organize a network of community distributors of contraceptives.

3. Campechano League Community-Based Distribution Project

A pilot CBD project was started in May 1976 in one of Guatemala's 22 departamentos among 45 Campechano Leagues with approximately 4,000 members. After a series of weekend community meetings, the project was accepted by the national federation of campechano leagues and the communities. Community distributors were selected and trained and the distribution of contraceptives began in October in eight of the communities. The Federation has indicated that it wants to expand the project into all departamentos where Campechano leagues operate. With the new F/FP project the Mission will assist APROFAM in expanding the project to two additional departamentos annually during the 1977-1979 period.

4. Urban Community-Based Distribution Project

APROFAM initiated a pilot CBD project in Guatemala City in October 1975. The project has grown rapidly, increasing the number of new acceptors by 45% quarterly. In only two sectors of the City, with 40 distributors, there are approximately 5,000 women active in the project. With Mission support, APROFAM plans to expand the project to 12 sectors by 1979. It is estimated that this would produce approximately 25,000 active users.

5. Ministry of Defense Family Planning Program

With USAID assistance, APROFAM developed a FP program in the Ministry of Defense (MOD) in July 1976, which is designed to train military personnel to teach FP to soldiers and recruits, train personnel from 48 MOD clinics, and provide contraceptives to career soldiers and recruits. The Mission proposes one final year of funding in 1977 to train a second group of 25 MOD trainers, provide a refresher course for the first group, and provide the MOD with FP posters and pamphlets.

6. APROFAM Clinic Services

The Mission plans to terminate support for FP clinic services by the end of 1977. This will entail reducing support from \$112,000 in 1976 to \$30,000 in 1977. APROFAM has agreed to progressively phase down the number of clinics it supports from eight to four, which they will continue to support for training and research purposes.

D. Summary Findings

In the judgment of USAID/Guatemala, the new Population/Family Planning project is sound and will meet its objectives. Based on a recent outside management study, plus the CDC/Atlanta evaluation of the contraceptives logistics system, and the results and recommendations of the University of Chicago IPFC research, it is clear that APROFAM has the technical and administrative capability to carry out the activities enumerated above.

In consonance with the Congressional Mandate, the ultimate beneficiaries of the project will be the urban and rural poor. CBD projects will be functioning in both urban and rural areas, and contraceptives will be available in 591 health facilities, of which 444 are rural health posts.

The project meets all applicable statutory criteria.

E. Project Issues

1. The key issue continues to be the GOG's lack of a clear commitment to implement effective multi-disciplinary and multi-sectoral P/FP programs. The present government has recently indicated that it will not pursue the formulation and declaration of a population policy, at this time, although it has concurred in the expansion of FP services within the Ministry of Health.

Current Ministry policy is to have the private sector assume responsibility for the supply and distribution of contraceptives to the 591 MOH clinics and for all communications and promotional activities. Whether this joint private sector/MOH effort can be successful in the final analysis will depend upon the support and attitudes of top-level and clinic-level personnel of the MOH.

There are indications that the MOH will increase its supervisory support of this project. In addition, the local demand for FP services, physical availability of contraceptive supplies and clinic level motivation caused by APROFAM personnel's contacts are expected to generate increased enthusiasm among MOH clinic level staff to provide family planning services.

2. USAID believes that the issue of financial viability of APROFAM when the AID grant ceases in 1980 is successfully addressed in the cash flow analysis presented in this paper. This viability assumes a continued supply of donated contraceptives. Should that assumption prove unrealistic in 1979, the USAID believes that the demand for contraceptives which will have been demonstrated at that time will persuade the GOG to provide the supplies.

3. The critical issue of continued funding for APROFAM in early CY 1977 during the transition from the prior project to the new project was described to AID/W in GUATEMALA 4439 of June 11, 1976 and GUATEMALA 5226 of

September 2, 1976. If it is not administratively feasible to approve the new project before December 31, 1976, the Mission requests that AID/W authorize APROFAM to borrow from IPPF funds to carry on essential operation costs that would be part of the AID grant until a Pro-Ag is negotiated and signed. USAID also requests authority to reimburse APROFAM for such eligible project related costs which they incur between January 1, 1977 and the date the grant agreement is signed.

4. A pending issue that is carried over from the prior Population-Family Health Project is the accrued liability (in some cases going back to 1968) for APROFAM employee's severance pay which is required by Guatemalan law. As of January 1, 1977, the AID share will total \$43,450. IPPF is wrestling with the same problem, since its share will approach \$40,000 at the end of 1976. In AID's case, we will attempt to arrive at an understanding with APROFAM that proceeds from the sale of contraceptives be applied to future severance pay demands.

PART II - PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background and Strategy

The middle and upper classes in Guatemala have long been aware of and, in fact, have practiced contraception. The rural and urban poor have largely been without knowledge and access to contraceptive technology, and consequently continue to suffer the burden of excessively large families. With a 1977 population of 6.6 million, which is growing at 3.1% annually, the population will double in 23 years which will require massive increases in central government support for health care and educational services as well as greatly increased employment opportunities if the overall welfare of the target group is not to deteriorate.

Organized family planning programs have existed in Guatemala since 1965, when the local affiliate of the International Planned Parenthood Federation, APROFAM, was created. The APROFAM program was expanded in FY 1968, and a bi-lateral agreement between USAID and the Guatemalan Ministry of Public Health initiated public sector activities in FP. The explicit policy at that time was to reduce infant and maternal mortality through the spacing of births and to curb the practice of induced abortions. The policy did not include a consideration of the relationship between economic development, deficits in social services, and accelerated population growth.

Progress in meeting these policy objectives has not been satisfactory. The Ministry of Health program reached significantly fewer acceptors than planned with the result that the rate of population growth has continued to increase. According to MOH and APROFAM figures, by January 1, 1976 there were only 33,869 women actively participating in their FP programs or 2.5% of WIFA. This somewhat understates the actual impact of the two programs, however, due to a number

of factors:

- the figures do not count women contracepting outside these programs who may have begun as the result of public information and education programs or those who transferred to private programs after beginning with public programs; and

- the totals are affected by under-registration of users at MOH clinics which according to recent estimates (see Annex D) could amount to 40% of total program users, with the result that public programs may be reaching 3.5% of WIFA.

To complete the FP picture it is necessary to examine also private (i.e. non MOH and APROFAM) participants. According to an October 1975 APROFAM study, private sector sales of orals and injectables increased by 85% over 1971, with an estimated 43,700 women participating by the end of 1974. Adding this figure to the one for the public sector, the percent of women contracepting in Guatemala rises to 6.7% (see Annex E for study details). Taking another approach, using the methodology developed by Barelson which appeared in "World Population Status Report", the WIFA percentage in Guatemala would be 8.4% using a crude birth rate of 41.2 per thousand.

Either way the percentage is calculated, the results do not meet past program targets. A number of factors can be cited as bearing on these results. MOH FP activities were an adjunct to its MCH program, and with MOH budgets chronically tight in comparison to the needs, there was always the temptation on the part of the implementing agency to direct funds to MCH activities. This coupled with lack of top-level push to maintain a vigorous program meant that FP priorities were always secondary. Top level interest was not forthcoming due to a number of inter-related factors which are not uncommon to Latin American

countries. Guatemala's social structure is highly traditional with the formal manifestation of the Church through its hierarchy still exerting strong influences. There is a division of opinion also among political parties as to the need for population control in that Guatemala still has extensive areas of sparsely settled land which "only a growing population can adequately develop". Of course this attitude ignores the reality of overcrowded settled areas and the lack of effective resettlement programs with the result that the country is, in effect, already overpopulated. These conflicting points of view, however, exert a strong influence on policy makers who are greatly concerned about possible negative fallout from an apparently controversial area of public policy. At the same time, this concern has not stopped successive Ministers of Health from wanting to pursue FP programs based on administrative directives. Unfortunately this approach never resulted in the assigning of a high priority to FP activities in the minds of MOH staff who had to implement these directives, possibly because health needs, especially in rural areas, are so pressing, and resources so limited, that it is difficult to accept an admittedly long-range program as being of highest priority. No matter the reason, program impact began to stabilize in 1971, with new acceptors leveling off at about 20,000 per year. According to official figures women active in the program rose only from 25,000 in 1971 to 34,000 in 1975.

With these factors in mind, and with the concurrence of top-level MOH policy makers who tacitly recognized the reality of the situation, the USAID withdrew financing for the MOH FP program at the end of CY 1975 thereby closing out seven years of AID support for public FP programs in Guatemala. With one more year to run under the existing PROP (which terminates on December 31, 1976), the USAID concentrated during 1976 on developing alternative approaches to bringing effective FP services to the target population as outlined in the PRP submitted by the Mission (and approved by AID/W) in December, 1975.

The program described herein is based on the premise that no FP program can be truly effective in rural areas over the long run which does not build upon the extensive MOH infrastructure outside of Guatemala City which currently encompasses some 39 departmental hospitals and 552 health posts and health centers. This outreach capability will be greatly expanded over the next four years through new construction of 228 new facilities under a recently-signed \$28 million IDB loan. Accordingly, during CY 1976 APROFAM, with the concurrence of the MOH, initiated a program under which APROFAM took responsibility for activities which heretofore had been carried out by the MCH division of the Ministry. APROFAM is now responsible for distributing contraceptives to all health posts and centers, for maintaining inventory levels, and for collecting and analyzing data on users. Since initiating activities in late June of this year, APROFAM has expanded the number of health centers and rural health posts stocking contraceptives to 275, up from the 126 the MOH had reached after 7 years of effort. Coverage of 500 facilities is expected by the end of CY 1977.

Another key APROFAM activity, also with MOH concurrence, has been initiation of a widespread IE&C program in August, 1976. Five national and twenty-five Departmental (State) radio stations as well as three TV networks are being utilized as are sixteen newspapers. One immediate result has been increased levels of new acceptors in APROFAM's own clinics in Guatemala City, an increase of 60.4% in the third quarter of 1976. (The historical rate of increase per quarter in new acceptors has been 15%).

New programs have also been initiated with the Ministry of Defense (provision of FP information and contraceptives to military personnel) and with rural campesino groups which are members of a national campesino federation.

While greatly improved logistics for contraceptive supply and well-designed IE&C campaigns will go a long way

toward correcting past program defects, creation of an effective, self-sustaining FP program in Guatemala's rural areas must count on active MOH support. A potential framework for policy development already exists in the form of a special commission created on December 31, 1975 by Presidential Decree for the purpose of "analyzing the different aspects concerning population growth and distribution in Guatemala". Unfortunately, the work of this commission, composed of key ministers has not gotten underway due to the earthquake and probably will not because of the approaching presidential elections. Nevertheless interest in this initiative remains and with proper orchestration, work could be initiated in the near future. At the MOH level, the new Minister (appointed in August, 1976) has fully supported APROFAM's activities with the health clinics and has indicated his desire to see the program expanded. He intends to communicate his position to Area Health Chiefs so that there will be no question as to what the Ministry's policy is with respect to working with APROFAM. Still, the key step will be in obtaining the widespread active participation of MOH personnel in promoting FP. The Mission believes that this will be facilitated over time through program activity - periodic visits of APROFAM personnel, the IESC program and use of promoters who will generate local interest - which will create momentum that cannot be ignored. Renegotiation of the scope and content of the proposed UNFPA grant to Guatemala, which has been requested by the MOH, should, if successful, result in a higher priority for FP within the Ministry in that a separate FP office is being contemplated for administering the program. Obviously, there remains a great deal of uncertainty with respect to official attitudes toward FP, but a successful program carried out through APROFAM will demonstrate feasibility and acceptability which should go a long way toward overcoming objections. At the same time, an effective APROFAM program could well demonstrate to top-level policy makers that FP activities are not as controversial as many feel and that the "price" which would have to be paid for adopting an official policy would not be so

great after all. Of course, program success will largely hinge on acceptability to potential clients, and if obstacles here cannot be overcome, then there would be little justification for further investment of AID funds. This factor should be amply demonstrated over the relatively short life proposed for this project.

B. Detailed Description of New Project

APROFAM with USAID assistance, will focus on the following activities:

- 1) Contraceptives Logistics Program
- 2) Information, Education and Communications Program
- 3) Campesino League Rural Community-Based Distribution Project
- 4) Urban Community-Based Distribution Project
- 5) Ministry of Defense FP Program
- 6) FP Clinical Services

These activities are complementary to the anticipated other donor input which is described at the end of this section.

1. Contraceptives Logistics Program

The objective of this activity is to assure the constant availability of contraceptives in MOH clinics. As of November 1976, the Ministry of Health had 39 hospitals, 108 health centers, and 444 rural health posts operating for a total of 591 facilities of which approximately 550 will be utilized for FP. Seventy-five percent of these are located in rural areas which serve the poor majority (see Map in Annex R). Additionally, the majority of health

centers could also be classified rural if the U.N. definition of urban and rural areas is applied. This infrastructure of 591 facilities will grow to 44 hospitals, 161 health centers, and 614 rural health posts by 1980 with the aid of a \$28 million loan from the IDB. As of June 1976, FP was available in only 126 clinics.

In June 1976, APROFAM and the MOH reached an agreement under which APROFAM will stock all MOH clinics with contraceptives and assume responsibility for the monitoring of use and restocking of the contraceptive supplies. APROFAM began pilot activities to implement this agreement during 1976. AID will assist them to expand and continue their coverage of MOH facilities under this project.

The current policy is to work intensively with those health areas (there are 22 in total) which are more receptive to the program and gradually to expand the program to 500 of the 591 MOH clinics which will be incorporated by January 1978. As of November 15 APROFAM has stocked 149 additional facilities..

To accomplish the expansion APROFAM plans to recruit an additional drug salesman in order to assure that each clinic receives one visit every month and a half. Simultaneously with re-stocking the clinics, collecting the proceeds from contraceptive sales, and personal motivation of clinic personnel, the distributors will re-stock the clinics with IE&C materials. In 1978 and 79 APROFAM will continue to expand the program to include approximately 150 municipal pharmacies, and additional MOH facilities as they are constructed. A description and an evaluation of the contraceptive distribution system by CDC/Atlanta appears in Annex H.

AID will support this distribution system with \$156,448 of project funds. APROFAM will use this grant to finance 22.5 person months of the required logistics management staff including the project director, 3 distributors, a

secretary, warehouseman and an accountant; transport costs of distribution and supervision; record keeping materials; warehouse rent; and annual evaluation of the distribution system. See Annex T for detailed budget calculations.

The distribution project will depend on continued donations of contraceptive supplies from FPIA and IPPF to complement the AID resources supporting APROFAM's activities. It is estimated that the value of contraceptives from these sources will be over \$700,000 during the three year project life.

2. Information, Education, and Communications Program

The objective of the IE&C Program is to make FP information available to the total population by the end of CY 1977 and to sustain the program during 1978 and 1979.

The University of Chicago has made recommendations (Annex I) for the P/FP communications program based on the results of their IE&C and KAP Research Project which was completed with APROFAM in November 1976. They recommend that two distinct multi-media/person-to-person programs operate simultaneously: one for the Spanish-speaking regions and one for the Indigenous region. Refer to Annex J for a summary of the principal findings from the University of Chicago research.

There is cause to be optimistic about the potential for FP adoption among the rural Ladino (Spanish-speaking) population. Despite the limited communication activities and lack of FP services in these rural communities, 10% are already using family planning. Moreover, a strong majority favor small families, are aware of family planning, know one or more of the reliable methods, approve of family planning, and want more information about it. The Ladino population is indeed at a "take-off" point, where a strong IE&C program is needed to convert favorable attitudes into actual adoption. Such a program should reach out to both

*Probably available
strong evidence
FP prog. more important*

sexes; although women tend to have better information about the specific methods, men are equally favorable and interested in learning more on FP.

In contrast, the Indigenous groups lag behind in knowledge, favorable attitude, and use of family planning. Cultural patterns, religious beliefs, lack of education, and a low standard of living all represent obstacles to family planning adoption. However, it is notable that even 2% of the population are using family planning in a setting where it is not generally accepted and services are not readily available. This would suggest that with greater awareness that effective family planning methods exist and greater consciousness of the benefits for Indigenous families, the number of those who would seek FP services would increase. However, the Indigenous population differs markedly from the Ladino and have informational needs which would not be met by a "Blanket campaign" for all Guatemala.

In addition to the ethnic differences, the program must address rumors which circulate about various contraceptive methods. Few people are likely to adopt a method which they believe causes cancer, produces stomach problems, damages health in general, etc. These rumors must be confronted, not overlooked, if greater acceptance is to come about. In addition, the IE&C programs must be tailored to provide relevant information to the vast majority of those who have heard of various family planning methods but who lack specific knowledge of how they are used.

The proposed communications program will utilize 5 national-coverage radio stations, up to 22 Department-level stations, and approximately 150 local stations. Four 20-second spots will be broadcast daily. All three Guatemala City TV stations (two of which reach about half of the 22 departments) will run one 20-second spot nightly during prime time. Approximately 15 newspapers will be utilized for advertisements and articles. A series of pamphlets and

posters will be designed and tested during January-February 1977.

The University of Chicago has recommended that APROFAM utilize field workers as community and clinic level motivators during 1977-1978 on an experimental basis in order to complement the mass media communications. These community motivators will establish networks of village-level contraceptive distributors. For a detailed description of this aspect of the IE&C Program refer to Annex I.

Finally, in order to measure the impact of the IE&C Program, in terms of increased knowledge about family planning, increased use of contraceptives, and of continuing constraints to the adoption of birth control, a follow-up research project will be carried out during January-June 1978, 19 months after the base line study. Once again the sample size will be about 600 interviews.

AID will grant to APROFAM a total of \$430,674 over the life of this project to finance the costs of the IE&C activity. APROFAM will use the grant to defray costs of 4 IE&C specialists, pay for radio, newspaper and TV time, develop and distribute posters and pamphlets, support the community level promotion pilot program and assist the University of Chicago to evaluate the impact of the program. We estimate that evaluation of program results will require an input of approximately \$21,000 from the centrally funded University of Chicago family planning project. See Annex T for annual budget details.

3. Campesino League Community-Based Distribution Project

A pilot project was begun in May 1976, in coordination with the National Campesino League Federation, in the Department of Jutiapa among 45 campesino leagues which contain approximately 4,000 members. After a lengthy series of community meetings carried out by APROFAM staff, the project

was accepted by the Federation and the local leagues. Eight persons selected from the communities were trained in FP and began distribution of orals and condoms in October 1976. It is still too early to evaluate the impact that the pilot project will have on contraceptive use, but the policy and organizational structures have been created, and both APROFAM and the Federation want to expand the project to include all of its 60,000 members located in seven departments. During CY 1977, the project will operate in the Department of Escuintla and Mazatenango. In 1978, the Departments of Retalhuleu and San Marcos will be incorporated and in the final year, the Departments of Quezaltenango and Huehuetenango. The Federation and APROFAM have agreed to assume full responsibility for the project upon termination of bi-lateral AID support, with proceeds derived from the sale of contraceptives.

From the AID grant, APROFAM will finance \$118,445 of the cost of the expansion of the campesino league distribution program over three years. These grant funds will pay for the distributors, organizational and training meetings, transportation and informational materials required to expand program.

See Annex T for annual budget details.

4. Urban Community-Based Distribution Project

An experimental CBD was started in Guatemala City in October 1975. There has been sporadic opposition to the project by parish priests, however, during the trial period working in only two sectors of the city with 40 distributors there are approximately 5,000 active users, and the new acceptor rate is increasing by 33% quarterly. APROFAM plans to expand the project to four new sectors in 1977, three in 1978, and three in 1979 for a total of 12 sectors. When we have complete coverage in these sectors we estimate that there will be about 25,000 active users.

The major expense of operating the urban distribution activity is the cost of social workers and community agents who organize and train the neighborhood distributors. Although the distributors pay their expenses from a percentage of the sales, such proceeds will be inadequate to support the organizational infrastructure while the program expands. APROFAM, therefore, will finance these start up costs with \$118,446 from the AID grant over its 3 year project life.

5. Ministry of Defense Family Planning Program

APROFAM developed a family planning program in the Ministry of Defense which began in July 1976. The objectives of the project are to: a) train MOD personnel so that they can teach P/FP to soldiers; b) train medical and paramedical personnel that work in 48 MOD clinics; c) provide contraceptives to career soldiers and recruits; and d) to design and provide FP posters and pamphlets for the MOD's Program.

The Plan is to provide each career soldier with 8 condoms monthly, 4 condoms to each recruit, and oral contraceptives to all soldiers' wives who request them. APROFAM will charge \$0.15 per cycle and \$0.025 per condom. Only small quantities of contraceptives have been provided to the MOD to date, since the MOD had not provided funds in its FY 1976 budget (prepared in late 1975) for the cost of the contraceptives.

APROFAM will use \$24,197 of the AID grant to successfully conclude this program in 1977. This amount will pay the training and information materials costs of the program as well as one project manager.

6. APROFAM Clinic Services

The Mission will reduce its level of funding from \$112,000 in CY 76 for clinical services to \$30,000 in CY 77,

the last year USAID will support this activity. APROFAM's Executive Director has agreed to a gradual phase-down of clinic operations.

Of APROFAM's eight clinics, one was closed in October 1976, another will close in January 1977, and another two by June 1977. APROFAM's Central Clinic (the largest in Guatemala), Roosevelt Hospital, La Palmita, and La Parroquia clinics will remain in operation with IPPF funding for training and research purposes. However, in some instances, staffs will be reduced. It should be noted that it was USAID/Guatemala who urged APROFAM to undertake, with bilateral assistance, the original expansion to eight clinics.

The final \$30,000 grant from AID to APROFAM for clinic services will finance staff salaries pending assumption of these costs by IPPF.

C. Anticipated Other Donor Activities

1. International Planned Parenthood Federation

The confirmed CY 1977 budget from IPPF is \$265,000 of which \$65,000 is for contraceptives and equipment. With the remaining \$200,000 APROFAM plans to support clinical services, the evaluation unit, the urban adult and adolescents sex education program, and central administration. IPPF/WHR has not provided budgets for 1978 and 1979.

2. Association for Voluntary Sterilization

APROFAM, with AVS support, will embark on an ambitious two-year project starting in January 1977 which has as its objective the expansion of male and female sterilization services to each of Guatemala's 22 Departments. In 1977, 10 Departments will be incorporated into the program, and the balance in 1978.

3. United Nations Fund for Population Activities

The Guatemalan proposal to the UNFPA has delayed 2½ years is still pending approval in New York. According to USAID analysis, the proposal is 94% MCH and 6% family planning. The detailed budget appears in Annex L.

Even if the UNFPA were to approve the project, little positive benefit would be derived for the MOH's family planning program. However, the current Minister of Health has requested that the UNFPA send a team of experts to Guatemala to reformulate the proposal in line with the Minister's plans for the FP Program. As a result of this review, the UNFPA may be interested in supporting such complementary activities as training and CBD for empirical midwives, CBD through malaria workers and volunteers, provision of complementary contraceptives which IPPF and FPIA cannot provide, and support to a future evaluation unit within the proposed MOH Office of Population and Family Planning.

4. Pathfinder Fund

Pathfinder will begin a two-year project in January 1977 with APROFAM which envisions working with factory workers in seven of Guatemala's largest cities. Primary emphasis will be given to vasectomy, and secondarily to factory level and community-based distribution projects.

5. Family Planning International Assistance

In February 1976, FPIA provided APROFAM with one million cycles of orals and 7.5 million condoms. As demand is determined by experience, we anticipate that FPIA will continue to be the major supplier of these two contraceptives.

6. Development Associates

Development Associates has constituted an excellent mechanism for short-term training outside of Guatemala.

Through close coordination with APROFAM and the Mission, only carefully selected Guatemalans have been provided fellowships. It is hoped that D. A. will be able to continue its assistance throughout the life of the new Population/Family Planning Project.

Starting in January 1977, D. A. will assist APROFAM in carrying out 6 in-country leadership seminars annually.

7. International Fertility Research Program

IFRP has indicated that it plans to expand its activities in Guatemala, but neither APROFAM nor the Mission is aware of the nature of the proposed studies.

8. University of Chicago

It is expected that the University of Chicago will provide technical assistance to APROFAM during the life of project in the areas of message design, pre-testing, and evaluation of the IE&C Program. Technical assistance is also required for the January 1978 six-month follow-up IE&C C/KAP research project.

9. CDC/Atlanta

APROFAM, and very likely the possible MOH Office of Population and Family Planning, will require technical assistance in the contraceptives logistics program and the evaluation of the MOH's Program.

PART III - PROJECT ANALYSES

A. Technical Analysis

1. Acceptability of Family Planning in Guatemala

Much of the rationale for the acceptability of FP in Guatemala is presented in Social Analysis section below and in several annexes. Grass roots support is evident from the principal results of the recent University of Chicago/APROFAM research project, in which 58% of the population was in favor of FP, 69% wanted to learn more about FP, 83% said they would like to attend public meetings on FP, 80% said they would like to receive written materials on FP, and 95% said they would like to receive FP information on radio and television. Finally, 48% said that they did not want any more children.

2. Institutional Capacity of APROFAM

During CY 1976 two important studies of APROFAM were carried out. The first, a study of overall management capabilities, was conducted by INCAE (the Central American School of Business Administration) in June. The study looked at personnel policies, staffing patterns, decision-making process, financial and administrative controls, internal communications, etc. It concluded that APROFAM has the strongest general management capabilities of any of the six IPPF affiliates in Central America. A number of observations were made - too many administrative controls due to differing demands made by the various donors, understaffing in the evaluation unit, and the time-consuming nature of the client registration forms designed by CDC/Atlanta.

The other study consisted of a detailed evaluation of APROFAM's contraceptive distribution system by a two-man team from CDC/Atlanta. The team made 17 recommendations of which all but three were accepted by APROFAM and put

into practice. The Mission believes that the three which were not accepted are not material to the success of this activity. APROFAM has requested that CDC return in February 1977 to reevaluate the system at all levels.

From the above and on the basis of our continuing relationship with APROFAM over the years, the Mission concludes that APROFAM has the capability to carry out the proposed project.

3. MOH Infrastructure

In October, 1976 the Mission and APROFAM conducted a baseline study of 50 MOH clinics in 17 of 22 Health Areas to assess the condition of the MOH infrastructure on which the APROFAM distribution system will depend. Following is a summary of the findings (see Annex G for more details):

- 97% of health centers and 92% of rural health posts had personnel trained in FP.
- Only 35% of health centers and 66% of rural posts offered FP at all hours every day.
- 76% of health centers and 50% of the rural posts were offering at least three contraceptive methods.
- 39% of health centers and 44% rural posts provided only one cycle of orals on the first visit to the clinic.
- At least half of the health centers and rural posts did not have clinic forms.
- Three out of four clinics did not have FP posters.
- Six out of ten health centers and nine out of ten rural posts did not have FP pamphlets.

- 90% of health centers were equipped for IUD insertions.
- 74% of the health centers and 92% of the rural posts had never received a supervisory visit on FP from the Ministry of Health. Since APROFAM took charge in June 1976, it had supervised 90% of the health centers and 50% of the rural posts.
- Since APROFAM launched its new IE&C program in July 1976, personnel in 82% of the health centers and 80% of the rural posts had heard FP spots on the radio.

Although facilities were included in the survey which had been incorporated a month or two earlier into APROFAM's new distribution system, no conclusions could be reached as to increased usage of contraceptives due to the short period the system has been operating. Also APROFAM's initial activities had been concentrated primarily on organizing the logistic system.

B. Financial Analysis and Plan

1. Financial Analysis

The project proposed herein will total \$2.7 million of which \$921,100 will be in the form of an AID grant, with the remaining \$1.73 million coming from various donors (see Table I, Summary Cost Estimate and Financial Plan). AID funding will cover a three-year period totaling \$290,000, \$310,700 and \$320,400 in 1977, 1978 and 1979 respectively (Table 2).

Discussion of APROFAM's institutional capacity and organization are found in Section III A. and Section IV. With regard to its financial management, Price Waterhouse has been APROFAM's external auditor for several years. In

April 1974, due to a disclaimer on APROFAM's 1973 financial statements, APROFAM undertook the installation of a PW designed accounting system and contracted with PW to supervise its installation. The new system was installed during 1974/75 and unqualified opinions were issued for those two years.

Attached as Tables 3, 4, and 5 are the comparative financial statements of APROFAM for Fiscal Years 1973, 1974 and 1975. Table 3, Comparative Consolidated Balance Sheets, reflects a two-year Balance Sheet increase of \$178,594 or an average of 57% per year. Asset increases associated with this Balance Sheet increase are as follows:

	<u>Increase</u>	<u>% of Total</u>
Cash	\$ 18,206	10
Accounts Receivable	56,804	32
Inventories	63,806	36
Plant & Equipment	<u>39,778</u>	<u>22</u>
	\$178,594	100%

The Liability and Equity side of the Balance Sheet included a \$47,746 increase in liabilities and a \$130,848 increase in the Equity section. A significant portion of the Balance Sheet increase (36%) is due to APROFAM's method of inventory valuation as it relates to donated medical supplies and contraceptives. The Association follows the practice of valuing donated items at their anticipated sales price when they are received at APROFAM. It also immediately recognizes the donated supplies as income at their anticipated sales price. When the items are

eventually sold, the sales price is recorded and offset by a charge to the "Cost of Goods Sold" account at the selling price. Thus the sale is in actuality a "wash" transaction and there is no recognition of income at the time of sale. The historical effect of this procedure has been to increase the Equity of the organization by increasing donated inventories. Although this procedure isn't improper it doesn't lend itself to cash flow planning within APROFAM.

Below are shown certain financial indicators which are based on information contained in APROFAM's Balance Sheets.

<u>Indicator</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>Oct. 1976*</u>
Current Ratio	10.2:1.0	9.1:1.00	15.1:1.0	24.5:1
Acid-Test Ratio	4.5:1.0	5.2:1.0	7.5:1.0	8.7:1
Working Capital	\$102,641	\$121,408	\$235,916	\$630,003
Working Capital/ Total Assets	65.4%	62.1%	70.3%	84.7%

As indicated by the relationships shown above, APROFAM has been able to maintain a very strong current position. The most revealing of these indicators is the Acid-Test ratio which increased from 7.5:1.5 in 1975 to its present level of 8.7:1.0. This ratio is indicative of an entity's ability to meet current obligations and therefore excludes inventories

* Note: For purposes of these calculations, an estimated \$20,500 of the reserve for Social Benefits has been included as Current Liabilities since severance payments are anticipated at that level in 1977.

in its calculation. It is most applicable in APROFAM's case since inventories maintained by APROFAM are not quickly convertible to cash and thus, in theory, cannot be used to pay current obligations. The present Acid-Test ratio is very good, (a ratio of 1:1 would be acceptable). Since inventory comprises so much of APROFAM's current assets, this ratio is a much better tool for judging liquidity than the other three indicators.

The Income Statements attached as Table 4, show a 24.3% increase in income from 1973 to 1975. This growth is the result of a revenue increase of \$140,838 combined with an expense increase of only \$73,895. Cash donations increased 24.7% while donations of supplies went up 116.4%. Thus, although income increased rapidly during the period, much of that increase was due to increased donations of supplies and not to actual APROFAM operations. Further, to the extent that these donated supplies are not sold during the year donated, they do not contribute to the Institution's cash requirements. Cash requirements are being satisfied primarily from donations by various International Organizations. These Organizations and their donations during the past three years have been as follows:

Handwritten notes:
 This is a summary of the cash requirements of the Institution. The cash requirements are met primarily from donations by various International Organizations. These Organizations and their donations during the past three years have been as follows:

<u>Organization</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>
AID	\$171,492	\$189,541	\$207,373
IPPF	118,402	149,212	184,500
The Pathfinder Fund	58,456	63,384	36,713
World Neighbors	13,870	19,592	17,813
Ass'n. for Voluntary Sterilization	7,000	18,586	13,684
Development Associates, Inc.	4,000	10,100	---
Union of Evangelical Churches	---	22,555	5,415
Bread for the World	---	12,305	---
UNESCO	---	4,000	---
	<u>\$373,220</u>	<u>\$489,275</u>	<u>\$465,498</u>

Table 5 Comparative Statement of Changes in Financial Position, reflects a constantly increasing working capital base. In this Statement all donated inventories are included in the computation of the net income figure used in Table 5. While inventories are normally treated as working capital, the reader should be aware that during the three-year period being discussed there, APROFAM has systematically increased their inventory. Therefore, the argument can be made that all of APROFAM's inventory is not working capital, since, by definition, working capital is normally composed of assets repeatedly used in operations throughout the year.

The two other significant items accounting for the increase in Working Capital are Accounts Receivable and the Social Benefits Reserve. These two increases are directly related because during FY 1975, APROFAM increased their Reserve for Social Benefits account (a liability) by charging \$43,790 to the Account Receivable account (an asset account). Much of this receivable is due from AID upon the involuntary separation of AID-funded APROFAM employees. AID will therefore have to disburse approximately \$20,500 during FY 1977 as the staff of APROFAM's Clinic Services project is reduced. There are currently no plans for staff reductions other than those mentioned above.

*was classified
8/1/81
shown as
liability*

2. Financial Plan

The Seven-Year Cash Flow Statement (Table C) indicates that APROFAM, through certain cost reduction measures, increased contraceptive sales and the establishment of overhead rates, should reach a cash flow level in 1981 sufficient to enable it to continue an expanded program without continued AID support. Cost reductions will primarily arise from completion of MOD Family Planning Assistance Program in 1977 and reduction of the Clinic Services project to about two-thirds of its current level

beginning in 1977. A dramatic increase in contraceptive sales is anticipated as a result of an increase in public media advertising and greater availability in rural areas.

The USAID is assisting APROFAM in the development of an overhead rate to be applied to all direct project costs. It is anticipated that the use of such a rate will enable APROFAM to fund its central administration costs by having each donor pay an appropriate share of APROFAM's overhead. The AID funding being proposed by this paper contains a provision for overhead to be applied against all project elements except commodities (see Table 7).

The financial plan contained in Table 1 as well as the projected cash flow statements contain a great number of variables and are therefore subject to considerable revision. If anticipated donations are forthcoming and APROFAM is able to execute the various projects without significantly expanding its staff, the financial plan will probably be fairly accurate over the life of the project.

TABLE 1
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
 (US\$ '000)

<u>SOURCE</u>	<u>AID FX</u>	<u>HOST COUNTRY LC</u>	<u>IPPF FX</u>	<u>OTHER DONORS FX</u>	<u>TOTAL</u>
<u>Project Specific Inputs</u>					
Operational Assistance	\$896.6	\$135.0	\$265.0	\$1,335.5	\$2,674.3
Vehicles and Equipment	\$ 24.5	\$ -	\$ -	\$ -	\$ 24.5
TOTAL	<u>\$921.1</u>	<u>\$135.0</u>	<u>\$265.0*</u>	<u>\$1,335.5</u>	<u>\$2,656.5</u>

* Includes only 1977 inputs.

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TABLE 2

PROJECT INPUTS BY FISCAL YEAR
(US\$ '000's)

Project No. _____	Title: _____			
<u>PROJECT SPECIFIC INPUTS</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>TOTAL</u>
<u>AID Appropriated</u>				
Operational Assistance	\$265.5	\$310.7	\$320.4	\$ 896.6
Vehicles and Equipment	24.5	-	-	24.5
Total	<u>\$290.0</u>	<u>\$310.7</u>	<u>\$320.4</u>	<u>\$ 921.1</u>
<u>Host Country</u>				
Operational Assistance	\$ 45.0	\$ 45.0	\$ 45.0	\$ 135.0
<u>IPPF</u>				
Operational Assistance	\$265.0	*	*	\$ 265.0
<u>Other Donors</u>				
Operational Assistance	\$234.2	\$526.0	\$575.3	\$1,335.5
TOTALS	<u>\$834.2</u>	<u>\$881.7</u>	<u>\$940.7</u>	<u>\$2,656.6</u>

* Figures not available at this time. However, neither the Mission nor APROFAM have any indication that funding for these years will not be forthcoming.

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ASOCIACION PRO BIENESTAR DE LA FAMILIA DE GUATEMALA
(APROFAM)
COMPARATIVE CONSOLIDATED BALANCE SHEETS (AUDITED)

As of December 31, 1973, 1974 and 1975

	<u>1973</u>	<u>1974</u>	<u>1975</u>
ASSETS:			
Current Assets:			
Cash	\$ 43,097	\$ 76,317	\$ 61,302
Accounts Receivable	7,273	1,930	64,077
Inventories	<u>63,445</u>	<u>18,120</u>	<u>127,251</u>
Total Current Assets	<u>\$113,815</u>	<u>\$116,367</u>	<u>\$252,631</u>
Plant and Equipment	\$ 91,513	\$117,594	\$155,442
Less Accumulated Depreciation	<u>(48,354)</u>	<u>(58,422)</u>	<u>(72,505)</u>
Net Plant and Equipment	<u>\$ 43,159</u>	<u>\$ 59,171</u>	<u>\$ 82,937</u>
TOTAL ASSETS	<u>\$156,974</u>	<u>\$195,538</u>	<u>\$335,568</u>
LIABILITIES AND SOCIAL FUND (EQUITY)			
Accounts Payable	\$ 11,174	\$ 14,959	\$ 16,715
Reserve for Social Benefits	58,358	56,773	100,563
Social Fund	<u>87,442</u>	<u>123,806</u>	<u>218,290</u>
TOTAL LIABILITIES AND SOCIAL FUND	<u>\$156,974</u>	<u>\$195,538</u>	<u>\$335,568</u>

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ASOCIACION PRO BIENESTAR DE LA FAMILIA DE GUATEMALA
(APROFAM)
COMPARATIVE INCOME STATEMENTS (AUDITED)
FOR FISCAL YEARS ENDING 12/31/73, 12/31/74 AND 12/31/75

	FYE <u>12/31/73</u>	FYE <u>12/31/74</u>	FYE <u>12/31/75</u>
INCOME:			
Donations - Cash	\$ 373,220	\$ 489,275	\$ 465,493
Donations - Medical Supplies	62,401	70,345	135,015
Miscellaneous	<u>42,698</u>	<u>53,011</u>	<u>18,644</u>
Total Income	\$ <u>478,319</u>	\$ <u>612,631</u>	\$ <u>619,157</u>
EXPENSES:			
Administrative Expenses	\$ 89,011	\$ 81,960	\$ 99,518
Project Expenses	352,403	479,201	411,073
Depreciation	<u>9,364</u>	<u>12,106</u>	<u>14,038</u>
	\$ <u>450,778</u>	\$ <u>573,267</u>	\$ <u>524,629</u>
Net Income	\$ <u>27,541</u>	\$ <u>39,364</u>	\$ <u>94,528</u>

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ASOCIACION PRO BIENESTAR DE LA FAMILIA DE GUATEMALA
(APROFAM)
COMPARATIVE STATEMENT OF CHANGES IN FINANCIAL POSITION
FOR FISCAL YEARS ENDING 12/31/73, 12/31/74 AND 12/31/75

	FYE <u>12/31/73</u>	FYE <u>12/31/74</u>	FYE <u>12/31/75</u>
FUNDS PROVIDED BY:			
Net Income	\$ 27,541	\$ 36,364	\$ 94,484
Non-Cash Items:			
Depreciation	9,364	12,106	14,032
Fixed Asset Retirement	<u>112</u>	<u>703</u>	<u>-</u>
Working Capital Provided by Operations	\$ <u>37,017</u>	\$ <u>49,173</u>	\$ <u>103,566</u>
FUNDS USED FOR:			
Acquisition of Fixed Assets	\$ <u>20,259</u>	\$ <u>28,821</u>	\$ <u>37,848</u>
INCREASE IN WORKING CAPITAL	\$ <u>16,758</u>	\$ <u>20,352</u>	\$ <u>70,718</u>

ANALYSIS OF CHANGES IN WORKING CAPITAL

INCREASE IN WORKING CAPITAL ACCOUNTED
FOR AS FOLLOWS:

INCREASE (DECREASE) IN CURRENT ASSETS:

Cash	\$ 21,396	\$ 33,220	\$ (15,014)
Accounts Receivable	(12,320)	(5,343)	62,147
Inventories	<u>5,297</u>	<u>(5,325)</u>	<u>69,131</u>
	\$ <u>14,373</u>	\$ <u>22,552</u>	\$ <u>116,264</u>

(INCREASE) DECREASE IN CURRENT LIABILITIES

Accounts Payable	12,517	(3,785)	(1,756)
Reserve for Social Benefits	<u>(10,132)</u>	<u>1,585</u>	<u>(43,790)</u>
	\$ <u>2,385</u>	\$ <u>(2,200)</u>	\$ <u>(45,546)</u>
INCREASE IN WORKING CAPITAL	\$ <u>16,758</u>	\$ <u>20,352</u>	\$ <u>70,718</u>

TABLE 6

APPOFAM
CASH FLOW STATEMENT AND PROJECTIONS
FISCAL YEARS 1975-1981

	Budgeted		Projected				
	FY 75 1/	FY 76	FY 77	FY 78	FY 79	FY 80	FY 81
AID	\$175.6	\$246.0	\$283.5 2/	\$ 310.7	\$ 320.4	\$ -	\$ -
IPPF	180.5	333.1	200.0	265.0	265.0	265.0	265.0
AVS	13.7	36.1	156.4	172.0	150.0	150.0	150.0
Pathfinder Fund	39.9	6.3	20.0	22.2	20.0	20.0	20.0
Development Associates, Inc.	-	-	33.8	35.0	35.0	-	-
Int'l Fertility Research Program	-	-	5.0	-	-	-	-
Center for Disease Control-Atlanta	-	-	12.0	12.0	12.0	-	-
University of Chicago	-	13.0	7.0	7.0	7.0	-	-
World Neighbors	17.8	32.1	-	-	-	-	-
Union of Evangelical Churches	5.0	17.8	-	-	-	-	-
Consultation Fees and Interest	25.0	25.0	25.0	35.0	-	-	-
Contraceptive Sales (Net) 3/	(6.7)	25.0	102.6	145.0	55.0	75.0	75.0
Other	4.4	-	-	-	202.3	222.5	244.7
Use of Funds	\$455.2	\$734.4	\$845.2	\$1,003.9	\$1,066.7	\$732.5	\$754.7
Regular Programs							
Administration/Overhead	\$ 86.5	\$102.8	\$145.0	\$ 142.8	\$ 143.0	\$135.8	\$136.4
Clinic Services	174.6	206.1	130.0	103.0	103.0	100.0	100.0
Information, Education & Communicat.	87.1	98.7	189.4	200.0	200.0	171.6	171.6
Direct Distribution	2.5	25.0	71.6	59.8	63.4	60.0	65.0
Urban & Rural Community Based Dist.	-	31.5	100.1	104.8	98.3	98.3	98.3
Evaluation Unit	7.1	31.1	15.3	15.3	15.3	15.3	15.3
Special Programs	124.2	266.9 4/	161.4	190.4	195.0	170.0	170.0
Severance Payments 5/	-	-	24.5	-	-	-	-
	\$482.0	\$762.1	\$837.3	\$ 816.1	\$ 818.0	\$751.0	\$756.0
Cash Excess (Deficit)	(\$ 26.8)	(\$ 27.7)	\$ 7.9	\$ 187.8	\$ 248.7	(\$ 18.5)	(\$ 1.9)

See Notes on Following Page.

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TABLE 7
 PROPOSED BUDGET OF AID RESOURCES
 BY PROJECTS AND PROJECT SPECIFIC INPUTS
 FY 1977 - FY 1979

PSI No.	Description	FY 1977	FY 1978	FY 1979	TOTAL
1	Contraceptives Logistic Progr.	\$ 40,329	\$ 48,056	\$ 51,302	\$139,687
	12% Overhead	4,839	5,766	6,156	16,761
	Total	<u>\$ 45,168</u>	<u>\$ 53,822</u>	<u>\$ 57,458</u>	<u>\$156,448</u>
1	Information, Education & Communications Program	\$ 98,435	\$139,100	\$146,960	\$384,495
	12% Overhead	11,812	16,632	17,635	46,139
	Total	<u>\$110,247</u>	<u>\$155,732</u>	<u>\$164,595</u>	<u>\$430,634</u>
1	University of Chicago Follow-Up	\$ -	\$ 16,465	\$ -	\$ 16,465
	12% Overhead	-	1,975	-	1,975
	Total	<u>\$ -</u>	<u>\$ 18,440</u>	<u>\$ -</u>	<u>\$ 18,440</u>
1	Campesino League Rural Community-Based Distribution Project	\$ 25,960	\$ 38,503	\$ 41,292	\$105,755
	12% Overhead	3,115	4,620	4,955	12,690
	Total	<u>\$ 29,075</u>	<u>\$ 43,123</u>	<u>\$ 46,247</u>	<u>\$118,445</u>
1	Urban Community-Based Distribution Project	\$ 23,985	\$ 35,274	\$ 46,498	\$105,757
	12% Overhead	2,878	4,232	5,579	12,689
	Total	<u>\$ 26,863</u>	<u>\$ 39,506</u>	<u>\$ 52,077</u>	<u>\$118,446</u>
1	Clinical Services Program	\$ 26,785	\$ -	\$ -	\$ 26,785
	12% Overhead	3,215	-	-	3,215
	Total	<u>\$ 30,000</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 30,000</u>
1	Ministry of Defense Program	\$ 21,605	\$ -	\$ -	\$ 21,605
	12% Overhead	2,592	-	-	2,592
	Total	<u>\$ 24,197</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 24,197</u>
2	Vehicles and Equipment	\$ 24,450	\$ -	\$ -	\$ 24,450
	Vehicles \$20,400				
	Training Aids 4,050				
	Total - Direct Project Costs	\$261,549	\$277,398	\$286,052	\$824,999
	Total - Overhead	28,451	33,285	34,325	96,061
	Total AID Funding	<u>\$290,000</u>	<u>\$310,683</u>	<u>\$320,377</u>	<u>\$921,060</u>
By Project Specific Inputs:					
PSI 1 - Operational Assistance		\$265,550	\$310,683	\$320,377	\$896,610
PSI 2 - Vehicles & Equipment		24,450	-	-	24,450
TOTAL		<u>\$290,000</u>	<u>\$310,683</u>	<u>\$320,377</u>	<u>\$921,060</u>

Notes to Cash Flow Statements

- 1/ Per APROFAM Internal Financial Statements. Amounts shown differ from FY 75 Audited Statements; however, such statements do not provide sufficient detail for cash flow preparation.
- 2/ Includes \$18,000 prior year AID funding for purposes discussed in note 5/ below.
- 3/ Heretofore APROFAM followed the practice of recognizing as income the total estimated sales price of donated medicines and contraceptives when received and recording no profit when these items were sold. For projected cash flow purposes we recognize only the sale of such items since in-kind donations are non-cash transactions.
- 4/ Includes \$105,000 for emergency assistance to earthquake victims.
- 5/ FY 77 provision for severance payments represents the cost of reducing clinic services staff by approximately one-third during 1977.

C. Social Analysis

The intended initial and ultimate beneficiaries of the proposed program are poor urban and rural families in Guatemala. Many adult members of such families are illiterate and unaware of how to plan their families and of the availability of FP services. Given the pattern of Indian dialects and cultural dissimilarities existing in Guatemala, combined with the distrust with which substantial numbers of the target group view the formal medical system, general awareness of FP and FF services is difficult to communicate. Research that has been carried out concerning these problems is summarized below.

1968: In a study carried out by the Central American Population and Family Institute among a sample of 1,160 urban men and women, 463 rural Ladino men and women, and 122 rural Indian men and women it was found that:

- 38% of urban women, 11% of rural and zero % of Indian women had used contraceptives.
- 76% of urban, 72% of rural, and 47% of Indians wanted to receive information on how to plan their families.
- 21% of urban, 45% of rural, and 85% of Indians interviewed had never heard of contraceptives.
- 24% of urban, 33% of rural, and 51% of Indians interviewed said that although they didn't want any more children, they didn't use contraceptives because no information was available, there was no one to tell them about them, and there was no place to go for this advice.
- In this sample, the average number of children desired was:
 - 3.3 for urban residents;
 - 4.1 for rural Ladino residents; and
 - 6.0 for Indians in rural communities

1969: In a survey of 2,100 women in Guatemala City, 836 admitted having had an abortion, 44 induced and 792 spontaneous. Eighty-one percent of the 1,348

married women in the sample said they had used some type of contraceptive, and 40.8% said they were currently contracepting, of which 10% were using the rhythm method or coitus interruptus.

1970: Two studies carried out in a totally Indian community revealed the following:

- The crude birth rate was 52 per 1,000 (as opposed to the national average of 41 per 1,000).
- Of the 370 families studied, women 45 years old or older had averaged 9.2 live births.
- 70% of the Indian women said they wanted as many children as God would send, 88% had never heard of contraceptives, and 74% said they would use contraceptives if made available.

1972: In a study carried out by the Central American Nutrition Institute in four rural Ladino communities the following was found:

- Of 80 men and women interviewed, 71% were functionally illiterate.
- Only 16.4% knew anything of the possibility of planning their families.
- 6.9% of those interviewed said they were currently contracepting.
- 68% wanted information on FP.
- The ideal number of children was 4.6.
- 48% declared that they did not want to have any more children.

1974: Characteristics of new acceptors to the Ministry of Health and APROFAM's family planning programs are presented below.

- 25.7% of the new acceptors had two living children when they sought FP services. 21.6% had only one child, and 2.2% had none.

- 97.6% were legally married or living in consensual union.
- 40% of the new acceptors were referred to the clinics by other women that were receiving FP services in the program. 22.2% were referred by an auxiliary nurse, and 11.7% by community health promoters.
- Almost half of the new acceptors were 24 years old or less, 12.3% were 15 to 19 years old, and 36.2% were 20 to 24 years old.
- The educational level of the new acceptors in 1974 is presented in the following table:

<u>E D U C A T I O N</u>	<u>MOH Clientele</u>	<u>APROFAM Clientele</u>	<u>Combined Total</u>
Never attended school	42.7%	16.8%	30.1%
1st to 3rd grade primary	33.3%	24.7%	29.2%
4th to 6th grade primary	19.7%	40.8%	29.9%
Uncompleted secondary school	1.9%	6.5%	4.1%
Completed secondary school	2.3%	10.7%	6.3%
Some University studies	<u>0.1%</u>	<u>0.5%</u>	<u>0.3%</u>
	100.0%	100.0%	100.0%

- It is clear that there is a marked difference in the level of education between Ministry of Health and APROFAM clientele. This can be explained by the fact that APROFAM clinics operate only in the capital city,

while MOH clinics are predominately rural clinics. Almost half of MOH acceptors had never attended school.

- In 1971, 31.1% of all MOH/APROFAM new acceptors were illiterate. By 1974, there was a slight decrease in the percentage of illiteracy which reached 29.9%. In any case, approximately one out of three new acceptors is classified as illiterate. Once again, the differential between MOH and APROFAM clientele is sharply contrasted. 42.7% of the MOH acceptors are illiterate while only 17.3% of APROFAM acceptors are illiterate.
- The following table demonstrates that the new acceptors to the program are stimulated by the desire to space their children.

Percentage of Women Who Have Adopted Family Planning
in order to Space Children.

<u>Year</u>	<u>Indian</u>	<u>Ladino</u>	<u>Total</u>
1971	22.1%	41.0%	38.5%
1972	29.1%	47.2%	45.3%
1973	36.7%	54.1%	52.0%
1974	41.0%	59.5%	57.3%

- By the end of 1974, 11.7% of the new acceptors were Indian and 88.3% Ladinos. The differential between MOH and APROFAM clientele is not so significant as in the case of literacy and educational achievement.

<u>Year</u>	<u>% Indian MOH Clientele</u>	<u>% Indian APROFAM Clientele</u>	<u>% Indian Total Program</u>
1971	20.9%	4.3%	13.0%
1972	19.0%	4.1%	11.5%
1973	18.0%	3.8%	11.5%
1974	19.0%	3.9%	11.7%

- Approximately two out of ten MOH acceptors were Indian, while only 4 out of 100 APROFAM acceptors were Indian. As in the preceding differentials, this is clearly a function of clinic location.

As of June 30, 1975, 70% of the active users were using oral contraceptives, 23% the IUD, 4.5% injectables, and 2.5% other methods.

Historical data from 1971, indicate that 58.9% of the new acceptors in that year entered the program because they didn't want to have any more children. Another 37.3% said that they wanted to space their children. 45.3% admitted having a previous abortion or miscarriage.

1975: A study of hospitalized abortion in Guatemala City showed that 50% of maternal deaths are due to abortion complications and that 20% of all patients in maternity wards are there because of abortions. Of the 678 women who were treated for abortions from May 1974 to May 1975, 95% were married, 76% were Ladinos, and 84% had less than 6 years of primary school education.

In a study of 82 Ladino and 82 Indian women in the small towns, Dr. J. Guttenberg reported the following:

- A crude birth rate of 48.5 per 1,000 among the Ladino population, and 49.0 per 1,000 in the Indian population.

- On average, the Ladino women had had 5.1 pregnancies, and the Indian women 5.0 pregnancies.
- On average Indian women had become sexually active at age 18.2 years and the Ladino women at 19. The mean coital frequency per month was 3.8 for Indian women and 4.2 for Ladino women.
- 38.6% of the Ladino women knew about family planning, 78.9% was in favor of FP, and 15.8% said they were currently contracepting.
- 5.4% of the Indian women knew about FP, 80.4% were in favor of FP, and 3.6% said they were currently contracepting.

The following characteristics were obtained in a study of 986 men who had been vasectomized in the APROFAM Surgical Center between 1973 and 1975;

<u>AGE</u>	<u>PERCENT</u>
25 or less	3.6
25 to 34	49.7
35 to 44	37.5
45 or more	9.3
<u>EDUCATION</u>	
None	6.0
1st to 3rd grade primary	18.9
4th to 6th grade primary	39.9
7 to 9 years schooling	15.8
10 or more years schooling	19.5
<u>NUMBER OF CHILDREN</u>	
1 or 2	13.6
3 or 4	52.1
5 or 6	23.5
7 or more	10.7

- 42.7% of the men were skilled workers; 33.3% unskilled workers; 9.3% professionals; 6.5% craftsmen; and 8.2% miscellaneous classification.
- 47.9% said they had sought vasectomy because they were dissatisfied with other contraceptive methods. 86.6% were using contraceptives before sterilization.
- 49.4% of the men had been sent to the Surgical Center by FP program personnel; 8.3% by another previous vasectomized man; and 6.9% by a private physician.
- 88% was Catholic; 6.6% Protestant; and 5.4% said they did not have a religion.

1976: In a study of women undergoing laparoscopic sterilization in APROFAM's Surgical Center, the following characteristics were observed:

<u>AGE</u>	<u>PERCENT</u>
20 to 24	11.1
25 to 29	32.5
30 to 34	36.5
35 to 39	17.4
40 to 44	2.3

- 59.5% was married; 38.9% was living in consensual union; and 1.6% was single.
- 87.4% was Catholic and 11.1% was Protestant.
- 19% had not attended school; 21.4% some primary, and 11.1% some secondary.

In a study of 4,356 new acceptors at APROFAM clinics during January to June 1976, the following was observed:

<u>AGE</u>	<u>PERCENT</u>
15 to 19	19.7%
20 to 24	40.9%
25 to 29	23.4%
30 to 34	9.8%
35 to 39	4.3%
40 or more	1.6%

- 60.6% was 24 years old or less; 99.2% was classified as urban; 39.9% was married; 60.1% was living in consensual union.

Between May and October 1976, the University of Chicago assisted APROFAM in carrying out a national IE&C and KAP research project. This constitutes the most extensive and current P/FP information available in Guatemala, and its findings are being used to formulate the IE&C program which is presented in the PP.

Following are the principal findings (refer to Annex J for additional information):

The study population, 284 men and 282 women, is classified as totally rural.

34.9% of the persons interviewed were Indian, and 64.6% Ladino (mestizo).

65% spoke Spanish, 16.6% Quiché, and 16.2% Kekchi.

62.1% of the study population was illiterate.

F I N D I N G S :

- 94.2% of the non-Indian population had heard of Family Planning; 69.4% was in favor of FP, and 9.9% of the non-Indians was currently contracepting.

- 35.6% of the Indian population had heard of FP; only 22.8% were in favor; and only 2.6% was currently contracepting.
- Contraception is more prevalent on the South Coast where 11.1% declared that they were currently contracepting. The East followed with a rate of 8.8%, and the Highlands, (predominately Indian) with 2.2%.
- 47.9% of the men and women interviewed said that they did not want to have any more children.
- 30.4% believe that the population is growing too fast. Of these, 67.6% say that it is a very serious problem; 87.4% say that something should be done about it; and 80.2% believe that Family Planning is the appropriate solution.
- 28.4% of the women interviewed were concerned about getting pregnant again.
- 36.2% of the study population had never heard of family planning.
- 61.9% did not believe it is good to have 5 or more children, but almost 40% did. Of those who believe it is good to have five or more children, two out of three said to assist parents in old age, or to increase the family's income.
- 42.2% of the study population was not in favor of family planning.

Of these, 61.3% were opposed because it is a sin or it is against God's will. 12.3% think FP is bad for a woman's health, and 6.8% said that a woman must have all the children that God sends.

- 59.4% of the study population had heard of oral contraceptives (it should be remembered that the population is totally rural); of these 17.6% said they know how to use the pill; 28.6% believe the pill to be very effective; and 8.4% of those who had heard of the pill said they had used the pill. Among the entire study population, 4.9% had used the pill.
- 21.5% of the study population had heard of the IUD; of these 20.8% said they know how to use the IUD; 26.9% believe it to be very effective; and 6.7% have used the IUD. Among the entire study population 1.4% had used the IUD.
- 46.1% had heard of female sterilization; of these 70.6% believe it to be very effective; and 4.3% of these had been sterilized. Among the entire population 1.9% of the women had been sterilized.
- 47% had heard of injections; of these 40.7% believe them to be very effective; and 6.5% had used injections. Among the entire study population 4% had used injections.
- 24.3% had heard of the condom; of these, 17.1% believe it to be very effective; 5.9% had used the condoms. Among the entire study population 1.4% had used the condom.
- Folkloric contraceptives which were mentioned include: quinine tablets; parsley water; coconut milk with beer; aspirin with lemon juice; oregano with white honey; vaginal douche with coconut milk; flower petals with lemon juice, etc.
- Of those that had heard of contraceptives, 52.6% said that injections are the most effective method. 28.9% said pills, and 9.2% said the IUD.

- 40 out of 550 persons (7.3%) said that they were currently contracepting. 30% were using the pill; 12.% the IUD; 22.5% female sterilization; 17.5% injections; 2.5% suppositiores; 12.5% the rhythm method; and 2.5% coitus interruptus.
- Of those that had heard of oral contraceptives, 12.4% believes they cause cancer or tumors. 20.1% say that pills make women sick. 37.6% think that pills cause permanent damage, and another 30.8% think it possible they cause permanent damage.
- 98.4% would not be in favor of abortion if the mother did not want the child; 97.5% against even if it would be difficult to feed and clothe; 86.4% against even if child were to be born defective; 95.8% against even if the father of the child refused to marry the pregnant woman; 88% against even if the woman had been raped; 70.1% against even if mother's life were in danger. 97.7% said that they would not let a doctor abort themselves or their spouses even if abortion were legalized.
- 98.1 of the entire study population had never received a home visit concerning Family Planning; 96.6% had never attended a small group meeting on FP. 90.4% had never seen a pamphlet on Family Planning. 88.2% had never seen a poster on FP.

5-POINT SCALE OF ATTITUDES TOWARD FAMILY PLANNING:

Very much in favor	54.2%
Somewhat in favor	10.4%
Neutral	5.4%
Somewhat against	8.2%
Very much against	21.8%

- 5-POINT SCALE OF MOTIVATION TOWARD FERTILITY

Strongly in favor of high fertility	17.1%
Slightly in favor of high fertility	9.1%
Neutral	19.7%
Slightly in favor of low fertility	4.9%
Strongly in favor of low fertility	49.3%

- 68.9% of the study population said it wanted to learn more about Family Planning; 31.1% said no. Of those who said no, 65.6% said it is a sin, and 9.8% said they were not interested.
- 82.6% said that they would like to attend a public meeting concerning Family Planning; and 95.6% said they would like to receive a home visit on FP.
- 80.2% said they would like to receive written material on FP.
- 94.8% said they would like to receive information concerning Family Planning on radio and television.

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The foregoing summary of Population/Family Planning research and FP Program evaluations, carried out between 1968 and 1976, indicates that there is sufficient information available to guide the new project's policies and strategies. These findings will be applied principally in the IE&C Program which will try to markedly increase the number of new acceptors to the FP program and to retain greater numbers of active users. The results of these surveys will also be useful in instructing the rural promoters in techniques for relating to their target audiences.

D: Role of Women in This Project

Community-based contraceptive distribution systems and IE&C programs tailored to the cultural attitudes of the

heterogeneous target group will impact directly and favorably on the social and economic status of women. The effect on improved health and nutrition status of reduced fertility and child-spacing resulting from contraceptive usage are well known. For example, contraceptive usage by young adolescent girls in a developing society delays the age of the first birth, and thereby improves health status. The use of contraceptives, in addition to reducing maternal mortality due to aseptic abortions, will also make possible increased economic activity on the part of females. Freedom from excessive child-bearing allows time for work outside the home; in the fields, increasing food production; in the market place, increasing income as a full-time member of the labor force, etc. Smaller family size also allows women to participate in formal and non-formal educational activities. Women will have the time to learn to read and write and improve their marketable skills. Provided with educational and employment opportunities and a means to control her fertility, a woman's self-interest is expanded and lower family size results. With economic power comes increased equality, improved status and lower fertility.

Not only are women the direct beneficiaries of this project, but they are also active participants in the management and delivery of family planning services. At the health post level where contraceptives will be available, most auxiliary health care personnel are female. In the village, many informal medical services are performed by women who, under this project also will be responsible for the sale of contraceptives. The person to person information program will almost always be conducted female to female. Women will deliver family planning information and services to other females.

In summary, contraception, made possible by this project, gives women the chance to realize their full potential in participating in the economic and social development of their country.

E. Economic Analysis

An extended analysis of the impact of accelerated population growth on Guatemala's development is presented in TOAID A-15 of 5/10/76.

F. Environmental Assessment

The environmental assessment is presented in Annex X.

PART IV - IMPLEMENTATION PLANNING

A. Administrative Arrangements

The Guatemalan institution that will implement the project is the Asociación Pro-Bienestar de la Familia (APROFAM), the local affiliate of the International Planned Parenthood Federation. APROFAM was legally created in 1964 as a private non-profit social service entity. It is an organization that is almost totally subsidized by external donors, and the balance of its income is from the sale of contraceptives. As of Nov. 15, 1976, APROFAM had a total of 130 employees, consisting of 23 doctors, 28 nurses and technicians, 33 social workers and promoters, 39 administrative and clerical workers and 7 other employees. Some of the professional-type employees; doctors, nurses, etc. are part-time employees. In addition to regular and part-time employees, APROFAM also uses the services of various technicians and consultants, including lawyers, auditors and family planning experts. Fifty-one employees work in FP clinics located in Guatemala City. (See Annex M for APROFAM organizational chart.) The present organization has a General Assembly that meets annually, a seven-person Board of Directors that meets monthly (but in practice, more frequently), an Executive Director, and the following six Divisions: Education & Information; Evaluation; Medical Services; Contraceptives Logistics; Community-Based Distribution; and Administration. APROFAM has unusually strong leadership in its Executive Director; also its Division Chiefs are effective and fully committed to the guiding philosophy of the institution, i.e., Population/Family Planning.

Currently, APROFAM is efficiently managing grants from ten external donors which total approximately \$735,000 annually. For a discussion of APROFAM's strengths and weaknesses see Annex L.

B. Implementation Plan

The program implementation plan appearing in Annex W summarizes major project activities to be carried out by APROFAM. The program envisions a three year disbursement period ending in December 1979. While the PPTS network is of a summary nature, the time phasing of activities and their durations are sufficient to give an understanding of the scope and programming logic of major elements of the project. Early in CY 1977, the Mission will collaborate with APROFAM to develop a more detailed work plan for the year with critical progress indicators showing important control points for evaluation purposes. This plan will not only serve as a guide for on-going project management, but will also provide APROFAM and the Family Planning Development Officer with a tool for measuring progress and identifying problem areas. Joint annual evaluations of the program will be held.

C. Evaluation Plan

AID and APROFAM will undertake annual evaluations of the program according to the schedule set forth in the PPTS network. APROFAM's evaluation unit will be strengthened through the addition of a social scientist, and the unit will perform the in-house evaluation function. Their reports on the various activities will be available to AID. The first complete evaluation is scheduled for March 1978, and will be based on one full year of operation. Specific program elements will be studied independently using in some instances outside consultants. This process will be continued annually throughout the life of the project.

D. Project Monitoring

The Mission Family Planning Development Officer, with assistance from the Program Officer, will be responsible for monitoring this project.

E. Status of Negotiations

Assuming AID/W approval of the PP by December 31, 1976, the Mission would negotiate and sign a Project Agreement with APROFAM during January 1977. The Secretary General of the GOG's National Economic Planning Council would be a signator as well. All major project issues have been negotiated with APROFAM.