

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS) ISN 67786

A. REPORTING A.I.D. UNIT: <u>Guatemala</u> (Mission or AID/W Office)		B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN? yes <input checked="" type="checkbox"/> slipped <input type="checkbox"/> ad hoc <input type="checkbox"/> Eval. Plan Submission Date: FY <u>88</u> Q <u>2</u>		C. EVALUATION TIMING Interim <input checked="" type="checkbox"/> final <input type="checkbox"/> ex post <input type="checkbox"/> other <input type="checkbox"/>	
(ES# <u>88-15</u>)		D. ACTIVITY OR ACTIVITIES EVALUATED (List the following information for project(s) or program(s) evaluated; If not applicable, list title and date of the evaluation report)			
Project #	Project/Program Title (or title & date of evaluation report)	First PROAG or equivalent (FY)	Most recent PACD (mo/yr)	Planned LOP Cost ('000)	Amount Obligated to Date ('000)
520-0288	EXPANSION OF FAMILY PLANNING SERVICES	8/31/82	12/91	31,331	31,331

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR		Name of officer responsible for Action	Date Action to be Completed
Action(s) Required			
1.	Start Integration of selected maternal/child health activities with family planning services.	J. Massey	No date given
2.	Provide TA to the MOH to improve their management systems: logistics, supervision and service data.	J. Massey	No date given
3.	Explore the possible use of volunteer promoters and other auxiliary personnel to provide FP services and information.	J. Massey	No date given
4.	Begin phased support to MOH's clinical contraceptive program including post-partum surgical contraception and IUD insertion.	J. Massey	No date given
5.	Expand present CBD program and clinical program.	J. Massey	No date given
6.	Support IPROFASA's product diversification.	J. Massey	No date given
7.	Explore use of Iprofasa to market "concepts" and not just products.	J. Massey	No date given
8.	Consider the creation of an "umbrella" organization.	J. Massey	No date given

F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION: mo 4 day 23 yr 90

G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:

Signature	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
<i>[Signature]</i>	Lynn Gorton	N/A	<i>[Signature]</i> Theilerman, A	<i>[Signature]</i> AJC Interucci
Typed Name				
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE
DIRECTOR

Actions Required	Name of officer responsible for action	Date Action to be Completed
9. Provide financial support to Aprofam's Pipom activities.	J. Massey	No date given
10. Continue financial support to AGES.	J. Massey	No date given
11. Provide IE&C TA to all components.	J. Massey	No date given
12. Continue current TA to Iprofasa.	J. Massey	No date given

-b-

H. EVALUATION ABSTRACT (do not exceed the space provided)

Kraus International Inc. carried out an interim evaluation of Project No. 520-0288, Expansion of Family Planning Services in March 1988 under contract No. 520-0288-C-00-8137-00.

The purpose of the evaluation was to determine if project goals were being achieved, to conduct an assessment status of each component and to recommend a course of action to the Mission for the project for 1989-1991. The methodologies used in the study were: interviews, review of project documentation and field visits.

The general conclusion of the evaluation is that the four institutional components responsible for implementation have successfully carried out the program activities contained in the original project design. The project surpassed almost all of the outputs established in 1982. The project also contributed to a decidedly improved climate for family planning, creating a viable and solid basis for expansion in the future.

Two of the institutions --APROFAM and IPROFASA-- have achieved a large degree of operational and managerial efficiency: the other two agencies have minor problems which can be easily remedied. Service delivery programs are functioning smoothly although adjustments and improvements are needed in two of the agencies. The quality of Information, Education and Communication (IEC) programs has progressed remarkably since 1982, but remains an area that can become even more effective with additional support.

The methodology included: review of project documentation, interviews with key staff and field visits.

The evaluators noted the following "lessons" learned:

- Satisfied users make the best Community Based Distribution (CBD) promoters.
- If Contraceptive Social Marketing (CSM) programs must reach "self-sufficiency" quickly, hard to reach rural populations may not be served.
- Appropriate Information, Education and Communication (IEC) material is crucial for improving project impact.

ABSTRACT

I. EVALUATION COSTS

1. Evaluation Team		Contract Number <u>OR</u> TDY Person Days	Contract Cost <u>OR</u> TDY Cost (US\$)	Source of Funds
Name	Affiliation			
Clifford Belcher	KRAUS INT'L	520-0288-C-00-8137-00	\$54,349	Project
Ramón Portes Carrasco	KRAUS INT'L			
Danielle Rodríguez Schneider	FRAUS INT'L			

2. Mission/Office Professional
Staff Person-Days (estimate) 3

3. Borrower/Grantee Professional
Staff Person-Days (estimate) 8

COSTS

C

A.I.D. EVALUATION SUMMARY PART II

J. SUMMARY OF EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS (Try not to exceed the 3 pages provided) Address the following items:

- Purpose of activity(ies) evaluated
- Principal recommendations
- Purpose of evaluation and Methodology used
- Lessons learned
- Findings and conclusions (relate to questions)

Mission or Office: USAID/GUATEMALA OHRD

Date this summary prepared: APRIL 24, 1990

Title and Date of Full Evaluation Report: March 1988 "Evaluation of USAID Project No. 520-0288
Expansion of Family Planning Services"

1. Purpose of activities evaluated

The purposes of the project No. 520-0288, Expansion of Family Planning Services, are the following:

- a. Improve socio/economic welfare of the poor by increasing access to family planning services and information.
- b. Expand availability.

2. Purpose of Evaluation and Methodology Used

The purposes of the evaluation were to:

- a. Determine if project goals/purposes had been reached and the degree of contribution to that achievement by the project components.
- b. Conduct an assessment of the current status of each project component in three comprehensive areas of activity: management, service delivery and information-education-communication (IE&C).
- c. Recommend to the USAID/Guatemala Mission a course of action for the project for the period 1989-1991.

Methodologies used for the evaluation were:

- a. Examination of Project Paper;
- b. interviews with key cooperating agency officials;
- c. interviews with AID Mission staff;
- d. review of project documentation, and
- e. field visits.

3. Major Findings and Conclusions

The goals set for the project in 1982 were valid and attainable and were, in almost every instance, surpassed by 1987. A summary of results is given below:

- a. The quantitative goal of 400,000 couple-years-of protection (CYP) was surpassed (see annex D of attached evaluation). A total of CYP from all contraceptive methods, permanent and reversible, reached 1,235,060, or slightly more than three times the level projected by the designers of the project.
- b. Preliminary data indicate that the goal of reducing the Crude Birth Rate (CBR) from 41/1000 to 36/100 was achieved. A decline in the Crude Birth Rate (CBR) could mean a slowing of Guatemala's population growth rate.
- c. The 716 MOH health facilities providing family planning services surpasses the design goal of 650 by 66. The number of Community Based Distribution (CBD) promoters by the end of 1987 had surpassed this set goal of 500 by 1300 to a total of 1800.
- d. The overall management capacity of the institutional components has improved considerably.

- e. An improved climate for family planning exists and may be attributable to effects of the project.

Overview of the Current Status of the Institutional Components

Two of the institutions -- APROFAM and IPROFASA -- have achieved a large degree of operational and managerial efficiency: the other two agencies have minor problems which can be easily remedied. Service delivery programs are functioning smoothly, although adjustment and improvements are needed in two of the agencies. The quality of IEC programs has progressed remarkably since 1982, but remains an area that can become even more effective with additional support.

Conclusions:

- a. The management and administrative functions in APROFAM and IPROFASA are efficient and effective. No changes are recommended at this time.
- b. AGES is undergoing normal administrative problems which arise in conditions of rapid expansion. AGES is presently dealing rapidly and effectively with these problems.
- c. The MOH/FPU is headed up by highly motivated person. However, the addition of selected administrative staff would strengthen the Unit's management capacity. This is particularly important in view of the added administrative responsibilities in relation to the 13 Health Areas presently being turned over by APROFAM to the MOH technical assistance is suggested to assist with the medium and long term implication of this transition.
- d. The three agencies with service delivery activities are operating well. The logistics systems of each -- ranging from off shore procurement to warehousing to stocking and restocking of outlets -- is functional.
- e. All the institutions with exception of the MOH/FPU are producing and pretesting IEC materials. Baseline data on IEC recipients is partial and the effect/impact of the effort are not measureable at this time.

4. Principal Recommendations for the Future -- 1989 through 1991

This evaluation has intended to assist USAID/Guatemala in focusing programmatic activities for the extension of this project through 1991. Presented below are capsule summaries of team recommendation for future directions.

- a. An increasingly closer relationship between Family Planning and Child Survival, within the context of traditional Maternal/Child Health programs, should be the theme and focus of the extended project.
- b. The USAID should continue and increase its assistance to each of the institutional components presently included in the project.

In addition, the original concept of supporting small Private Organization (PVO's) who express interest in adding FP services to their regular activities should be reexamined. In view of the current climate for family planning, this option to effect expansion of service availability may be more feasible. This must be weighed against the management burden that accompanies increasing the number of implementing agencies.

- c. Present efforts to move IPROFASA away from an emphasis on financial self-sufficiency should be continued.

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Adjustment to the grant agreement language which will be signed later this year might include reaffirmations by the Mission of the principle of reaching eventual self-sufficiency but within a reasonable time frames.

- d. The project, building on the present IEC structure should attempt to reshape family planning (FP) messages to include marketing and strategic planning considerations and give greater emphasis to the educational content of messages. Continue strengthening the processes now being followed for the development of materials that reflect the ethnicity of recipients.
- e. Long-term technical assistance consisting of an IEC specialist a Contraceptive Social Marketing advisor and a Management/Logistics expert, is recommended.

5. Lessons Learned

- a. The contribution to the project goal projected for the CSM program was overestimated. It should be noted that little was known about performance of CSM projects following the very considerable pressures to emphasize privatization of such programs at the time of PP preparation.
- b. The pressure exerted by the Mission on IPROFASA to implement an "experimental program" and the need for "self-sufficiency" within a specified, limited time frame was counterproductive. To achieve self-sufficiency, IPROFASA took the line of least resistance which was to generate sales income as quickly as possible, within the parameters of a social marketing enterprise. This meant covering the urban and Ladino markets, i.e.: those with easy access and at lowest cost. These were precisely the markets already being reached by other contraceptive marketing efforts and so were not composed of persons in greatest need. Rural and Mayan markets, where the greatest emphasis on providing services should have been placed were given lowest priority due to the expense reaching them. The Contraceptive "Social" Marketing Program, in effect, became a Contraceptive "Marketing" Program, using low priced products as a selling point.
- c. Although the 1987 Demographic and Health Survey (DHS) findings are not yet available, there appears to have been little success in raising contraceptive prevalence among mayan groups in the country. Careful, intensive analysis of the DHS data in the area of knowledge of contraception and targeting of ethnic groups and geographic areas may shed light on how to strengthen the IEC effort during the extension.
- d. The final overall CYP achieved was more than three times that which was originally planned. The highly positive correlation between the numbers of CBD promoters and acceptors indicates that the person-to-person approach where the promotor provides the potential user with information and may indeed be a "satisfied user" him or herself, seems to be the most effective. It also shows that potential demand was far greater than the planners had expected. The prospect of the MOH/FPU introducing "CBD-type" promoters of its own who could operate out of Posts and Centers in the "interior" ought to be considered, such as midwives and Rural Health Technicians.
- e. Technical assistance in the area of IEC was provided on a short-term, periodic basis to solve immediate problems, rather than implement a medium or long-term communication strategy. The evaluation indicates that this is a problem area where long-term technical assistance would be more appropriate.

(List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier)

ATTACHMENTS

Full Copy of Evaluation Report

L COMMENTS BY MISSION, AID/W OFFICE AND BORROWER/GRANTEE

Overall the Mission found the quality of the evaluation acceptable. The Mission was pleased to see that the project has had an effect in creating a more positive climate for family planning as well as surpassed almost all the established outputs.

The recommendations of integrating selected MCH services, continued support and the needed Technical Assistance were taken into account for the 3 year extension of the project.

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MISSION COMMENTS ON FULL REPORT

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Evaluation of USAID Project No. 520-0288
Expansion of Family Planning Services

March, 1988

Contract No. 520-0288-C-00-8137-00

Team Members:

Clifford Belcher. Chief of Party and Management Specialist
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I. EXECUTIVE SUMMARY

Between January 5 and February 2, 1988 a three-person team evaluated Project 520-0288, Expansion of Family Planning Services. The team consisted of: an Administration and Management Consultant; a Family Planning Service Delivery Consultant, and an Information, Education and Communications (IEC) Consultant.

The objectives of the evaluation were to:

1. Determine if project goals/purposes had been reached and the degree of contribution to that achievement by the project components.
2. Conduct an assessment of the current status of each project component in three comprehensive areas of activity: Management, Service Delivery and Information -Education-Communication (IEC).
3. Recommend to the USAID/Guatemala Mission a course of action for the project for the period 1989-1991.

The four major institutional components of this project are: APROFAM, the Association for Family Planning; IPROFASA, the company conducting the Contraceptive Social Marketing activity; MOH/FPU, the Ministry of Health's Family Planning Unit; and AGES, the Guatemalan Association for Sex Education.

Major findings related to the objectives stated above are reviewed below. Charts and Tables presenting a graphical picture of points in the text are grouped in Annex D.

A. General Conclusions

The general conclusion of the evaluation is that the four institutional components responsible for implementation of the program have successfully carried out the program activities contained in the original project design. Indicative is that the project surpassed almost all of the outputs established in 1982, when the project was originally designed. But perhaps as important is the fact that a number of other highly favorable, non-quantitative outcomes have resulted directly and indirectly from project activities. Most important among these outcomes, it is believed, is a decidedly improved climate for family planning, which has permitted a steady institutional growth and development which in turn, has led to program expansion. This augurs well for the project in the future, both in terms of continued expansion and an increased application of selected technical assistance in key areas, notably education and communication. In summary, a viable and solid basis for expansion and/or redirection of project activities in family planning is in place.

Highlights of the Evaluation

1. Major Findings

The goals set for the project in 1982 were valid and attainable and were, in almost every instance, surpassed by 1987. A summary of results is given below:

- a. The quantitative goal of 400,000 Couple-Years-of Protection (CYP) was surpassed (See Annex D). A total of CYP from all contraceptive methods, permanent and reversible, reached 1,235,060, or slightly more than three times the level projected by the designers of the project.
- b. Preliminary data indicate that the goal of reducing the Crude Birth Rate (CBR) from 41/1000 to 36/1000 was achieved. A decline in the CBR could mean a slowing of Guatemala's population growth rate.
- c. The 716 MOH health facilities providing family planning services surpasses the design goal of 650 by 66. The

number of CBD Promoters by the end of 1987 had surpassed this set goal of 500 by 1300 to a total of 1800.

- d. The overall management capacity of the institutional components has improved considerably.
- e. An improved climate for family planning exists and may be attributable to effects of the project.

2. Overview of the Current Status of the Institutional Components

Two of the institutions -- APROFAM and IPROFASA -- have achieved a large degree of operational and managerial efficiency; the other two agencies have minor problems which can be easily remedied. Service delivery programs are functioning smoothly, although adjustments and improvements are needed in two of the agencies. The quality of IEC programs has progressed remarkably since 1982, but remains an area that can become even more effective with additional support.

Conclusions:

- a. The management and administrative functions in APROFAM and IPROFASA are efficient and effective. No changes are recommended at this time.
- b. AGES is undergoing normal administrative problems which arise in conditions of rapid expansion. AGES is presently dealing rapidly and effectively with these problems.
- c. The MOH/FPU is headed up by highly motivated persons. However, the addition of selected administrative staff would strengthen the Unit's management capacity. This is particularly important in view of the added administrative responsibilities in relation to the 13 Health Areas presently being turned over by APROFAM to the MOH. Technical assistance is suggested to assist with the medium and long term implications of this transition.
- d. The three agencies with service delivery activities are operating well. The logistics systems of each -- ranging

from offshore procurement to warehousing to stocking and restocking of outlets -- is functional.

- e. All the institutions with exception of the MOH/FPU are producing and pretesting IEC materials. Baseline data on IEC recipients is partial and the effects/impact of the effort are not measurable at this time.

Recommendations for the Future -- 1989 through 1991

As described above, this evaluation is intended to assist USAID/Guatemala in focusing programmatic activities of the extension of this project through 1991. Presented below are capsule summaries of team recommendations for future directions.

- a. An increasingly closer relationship between Family Planning and Child Survival, within the context of traditional Maternal/Child Health programs, should be the theme and focus of the extended project.

The now well established relationship between birth interval (birth spacing), reproductive risks related to age and parity of the mother and mortality of both the infant and his mother should ease introduction of these concepts into the Ministry of Health. This will permit more precise definition of goals and objectives as well as the measurement of achievements.

- b. The USAID should continue and increase its assistance to each of the institutional components presently included in the project.

In addition, the original concept of supporting small Private Organizations (PO's) who express interest in adding FP services to their regular activities should be reexamined. In view of the current climate for family planning, this option to effect expansion of service availability may be more feasible. This must be weighed against the management burden that accompanies increasing the number of implementing agencies.

- c. Present efforts to move IPROFASA away from an emphasis on financial self-sufficiency should be continued.

Adjustments to the grant agreement language which will be signed later this year might include reaffirmation by the Mission of the principle of reaching eventual self-sufficiency, but within a reasonable timeframe.

- d. The project, building on the present IEC structure, should attempt to reshape family planning (FP) messages to include marketing and strategic planning considerations and give greater emphasis to the educational content of messages. Continue strengthening the processes now being followed for the development of materials that reflect the ethnicity of recipients.

- e. Long-term technical assistance, consisting of an IEC specialist, a Contraceptive Social Marketing advisor and a Management/Logistics expert, is recommended.

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tives. Of the remaining funds, \$400,00 was earmarked for the Ministry of Health (MOH); \$631,000 for the development and support of small organizations in the private sector (PO's) who had indicated interest in including family planning (FP) in their activities; and lastly, \$115,000 was set aside for evaluations and audits.

Apart from the normal shifting of funds among project components, the only element of the project in the original design that experienced significant change was the Private Organization (PO) component. At the time of project preparation, the Guatemalan Association for Sex Education (AGES), the Movimiento de Campesinos Independientes (MCI), the National Organization for Women (ONAM) and a number of other small groups were either operating FP service programs or had expressed an interest in doing so. It was expected that other PO's -- 30 were projected -- would be added to the above during the project. As it turned out, ONAM dissolved and the 30 projected PO's never materialized. MCI continued as a part of APROFAM's Community Based Distribution (CBD) program, and the remaining funds were eventually reprogrammed to support an expanded AGES project.

Between 1982 and the present, the CSM project (now called IPROFASA), APROFAM, AGES and the MOH emerged as the principal operational components of 520-0288. In CY 1987 the Guatemala AID Mission extended project 520-0288 to a Project Activity Completion Date (PACD) of December 31, 1988 with no substantive changes in project goals or implementation modes. Grant funds in the amount of \$3.4 million were also added at this time, bringing the LOP funding of the project to \$12.116 million.

A. Background

The "0288" project was planned and prepared in an ambience of violence and uncertainty. Programming for a total 500 CBD promoters was probably unrealistic in 1981-82, when promoters were being murdered in rural areas or "disappearing". On the U. S. Government side, there was strong opposition to 0288 within the Mission itself and many influential voices in the U.S. questioned the wisdom of providing aid in any form to Guatemala, citing the questionable human rights record of that time.

Once approved in the Mission and AID/Washington, the problems surrounding implementation of the project began. The contraceptive social marketing project, IPROFASA, was particularly hard hit. Total project funding was not available at the outset for IPROFASA and the Mission was only able to obligate sufficient funds to cover contract services plus \$400,000 for local operations. A number of procedural and documentation problems also served to slow implementation.

In the meantime, the murder of Guatemalan employees of an AID education project and reluctance of the GCG to take action on the issue, resulted in a suspension of all U.S. assistance to Guatemala, except to PVO's. The Mission registered APROFAM as a PVO and was able to continue operations. But IPROFASA, a "for-profit" venture, did not meet the requirements as a PVO and could not receive new obligations. IPROFASA carried out all the activities requiring little or no funding, but many important implementation steps were delayed. Funds finally became available in late CY 1984 and progress from there on was remarkable, with product launch taking place eight months later.

The MOH was not affected by the suspension of U.S. aid to Guatemala, since their activities could be financed by prior year money which was not affected by the cut-off. These funds supported the project activities until 1985. Although the MOH's attitude towards Family Planning (FP) programs in 1982-3 was largely one of indifference, USAID obtained agreement from the MOH to undertake a full review of their FP program. The principal outcome of this review was the establishment of the MOH Family Planning Unit (FPU) which was intended to implement a modified plan of action. The FPU's progress was affected by several changes in MOH personnel, who brought varying degrees of expertise, enthusiasm and energy to the project. The relatively steady progress of the FPU was interrupted in early 1986 when the new Government took office and services were suspended while decisions could be taken regarding the nature and extent of family planning activities.

Only APROFAM seemed to be unaffected by the events of the early 1980s, although its abrupt withdrawal from the social marketing program in 1984 caused an important restructuring of this activity and a time consuming change in planning resulted.

By the end of 1985, the environment seemed to begin to stabilize with the enactment of Article 47 of the Constitution, which guarantees the right of Guatemalans to space their children and limit family size. However, with the incoming democratic government in 1986 the Church raised allegations of "forced sterilization" on a large scale, specially among the Mayan population. A White House commission in early 1986, however, found no foundation to the charges and concluded that this program was being carried out in strict conformity with AID policy and Guatemalan law.

B. Scope of Work

1. Team Composition

The evaluation team consisted of an administration and management consultant who also acted as Chief of Party (COP); a family planning services delivery consultant; and an information, education and communications (IEC) consultant. It is believed that all important areas of functional activity being carried out by the implementing institutions are covered adequately by these three areas of expertise on the the team.

2. Objectives of the Evaluation

The objectives of this report are three-fold. First, each of the major program elements was examined to determine whether or not and to what degree each has contributed to achievement of the project goals, purposes and objectives as established in the original Project Paper (PP). Secondly, each agency or institution was analyzed as to its management and operational efficiency and its state of development in the areas of education, communications and information. These analyses were intended to serve both to identify areas for possible improvements to current performance and to the provide the Mission with guidance on the role each implementing agency ought to and is capable of playing in an expanded and possibly redesigned project covering the period 1989 to 1991.

C. Methodology

As a preliminary step to the entire evaluation process, the team examined the original goals and purposes of the project, as they were stated in the Logical Framework (Logframe) of the Project Paper. The original Logframe is included in Annex C of this report and is the most concise representation of the original intent of the designers of the project. For the institutional analyses, the team relied principally on interviews and examination of project documentation, both in the AID Mission and the implementing agencies. Specifically, interviews were held with key persons in each of implementing agencies, with officials of the AID Mission and with other multinational organizations.

Documents reviewed included manuals and other materials pertinent to the management and administrative functions of the implementing agencies, including audit findings, surveys, previous evaluations, work plans, financial records, implementation documents (PIs, project agreements, etc.), all as appropriate, necessary and available. Additionally, there were reviews of media plans, advertising campaigns, and media materials produced or planned.

Field visits were taken to a number of areas of the country to familiarize team members with Guatemala and to observe firsthand implementation of project activities.

III. EXAMINATION OF GOALS AND PURPOSES

A. Analysis of the Logical Framework

Two versions of the Logframe for this project were found in the official records of the AID Mission, one dated November 1981 and another, May 28, 1982. The later version, almost identical to the first, was apparently prepared only three weeks before the final PP was sent to AID/Washington for the required approvals. The extent to which the Logframe process was used as recommended by AID in the actual design of the project is unknown.

Project Implementation Letters (PIL's), obligating documents and Quarterly Reports were also reviewed in order to substantiate the original Project goals, purposes, outputs and inputs. The team found, however, that it was not until 1985 that the Mission required each of the grantees to submit project work plans with quantified and time-based progress indicators.

B. Validity of Project Goal, Purpose, Inputs and Outputs

In this section, the reader should refer to the Logframe in Annex C of this report, as the analysis presented below proceeds.

1. Sector Goal: Improve socio/economic welfare of the poor by increasing access to FP services and information.

Commentary: The sector goal is regarded as being totally unrealistic, without some qualifying assumptions. For example, even had the Guatemalan economy performed reasonably well during the period, which it did not, increased access to FP services and information, by and of itself, would not have improved the welfare of the poor. Moreover, a decrease in the Crude Birth Rate (CBR) as an indicator of improved socio/economic welfare does not have a direct causal relationship. We believe that the quantitative reduction in CBR is indeed valid.

but as a measure of the Project Purpose rather than the Sector Goal. See section below.

2. Project Purpose: Expand availability of family planning services through public, private and commercial activities.

Commentary:

Since all the project components were aimed at accomplishing this purpose, the statement as a project purpose is valid. Furthermore, the indicators used are also valid. The quantitative measure of 400,000 acceptors, considering the magnitude of the inputs from all of the participants, is entirely within reach.

3. Outputs:

The three outputs that are listed are valid and are supported by the project narrative. The team felt, however, that a larger number of outputs with corresponding indicators would have been useful and appropriate. The indicators for the Magnitude of the Outputs seem appropriate with the exception of #2, which refers to the number of pharmacies and retail sales outlets the contraceptive social marketing (CSM) component would reach. An examination of the CSM narrative in the PP reveals the planners were probably over optimistic on this component of the project.

4. Inputs:

Essentially, the inputs are listed as totals some part of which each of the donors is expected to contribute to the project. This should have been expanded and presented in more detail since the contribution of all of the listed donors go to make up the 400,000 user goal, not just the activities funded directly by this project.

Commentary:

The evaluation found actual financial contributions by the donors to have exceeded the inputs as listed in Logframe (see Annex C). Interestingly enough, the only functional field to be broken out of the AID contribution is IEC.

as opposed to commodities, technical assistance, participants or other costs. The planners appear to have placed great importance on IEC as the FP narrative does contain extensive, detailed descriptions of IEC activities.

To sum up, the planners used the logical framework as a planning and project preparation tool. The important parts of the Logframe -- Project Purpose and Outputs -- were used properly and are valid as a basis for judging whether the objectives were reached.

C. Goal Achievement

The basis for this analysis is found in the Objectively Verifiable Indicators column of the Logical Framework Matrix. The evaluators felt that the crude birth rate per thousand (CBR) was more properly an indicator of the project purpose rather than the goal. Hence, the CBR and the total number of users of FP services are the two major indicators which indicate whether the planned conditions have been achieved at the end of the project.

One of the objectives of this evaluation is to provide a basis for any redesign or simple reprogramming of the project that may be necessary for the period 1989-91. This mandates an analysis of the causal relationships which do, or do not, exist between achievement of the project purpose and the various activities carried out or attempted during the project. This analysis requires such questions as whether the project really made any difference. Would the conditions at the end of the project have been the same if nothing had been done? Further, which among 0288's outputs and other desired conditions were significant towards reaching a satisfactory end-of-project -status (EOPS)?

The EOPS called for acceptance of FP in rural areas to have increased in proportion with urban areas. Since the statistics on acceptors kept by the service agencies do not attempt to distinguish between Ladino and Indian, we assume the original logframe did not either. However, APROFAM statistics show that 70% of the user increase came from women living in the "interior". Unquestionably the dramatic increases in CBD promoters in the rural areas was responsible.

The MOH/FPU does not break out rural vs. urban users, but since 75% of the health centers and posts are in rural areas, it is reasonable to assume that more of the increase the MOH/FPU experienced during LOP came from rural acceptors. These results are gratifying since the 1983 CPS showed 49% of users as "Urban" and 33.4% as rural. The Demographic and Health Survey of 1987 ought to show increases in the latter.

As shown in Annex D, the growth in the number of CBD promoters correlates directly with the increase in users. We feel it is safe to assume that improvement in the MOH/FPU's service delivery system to its rural clinics would show the same correlation, had the MOH/FPU maintained such information.

Moving to the "Magnitude of Outputs" section of the logframe, paragraph # 1 reads: "650 MOH facilities, 8 APROFAM clinics, 500 community based distributors and 30 identified PO's providing FP services." With one exception, these numerical targets for service points were surpassed. It is believed, therefore, that there is a direct causal relationship between the increase and improvement in service delivery and increased numbers of users. This positive relationship confirms the likelihood of the existence of a large felt need for FP services in rural areas, since the mere establishment of additional service delivery points does not automatically mean a corresponding increase in acceptors.

Paragraph # 2 reads: "Contraceptives available at reduced prices in 1200 commercial pharmacies and 5000 retail sales outlets." This indicator fell short of planned achievement, with only about 55% of commercial pharmacies having been stocked and virtually no other sales outlets involved. Even had the CSM project not suffered the start-up problems and delays mentioned above, these numbers could probably only have been reached under extraordinarily ideal circumstances, if at all. In short, the team concludes that objectives set for the CSM component were probably impossible to reach in this time period. This does not invalidate the output indicators per se, at the time these were selected. Rather, it is felt that these arose out of a high degree of optimism over what the CSM project could in fact accomplish. The Population Services International (PSI) evaluation of IPROFASA conducted in April, 1987 points out that the cost per acceptor is, after less than two years, better than that of El Salvador, where a CSM program has been in operation for several years longer. As in the case of the increase

of CED promoters, we believe there is a causal relationship between increased acceptors and the CSM program's distribution activities, even though these may have fallen short of the numerical targets set in 1982.

The final Output Indicator reads: "95% of Ladino and 85% of Indian populations aware of FP services available in their area." Unfortunately, verification of these data from the Demographic and Health Survey (DHS) were not yet available at the time this evaluation was conducted. Additionally, the AGES project, where educational activities could have influenced this indicator, is still in the process of getting underway. Nonetheless, knowing about services at nearby facilities does not necessarily nor automatically translate into increased acceptance of FP services. Hence, we must conclude until the DHS data are available, that the causal relationships are present, but at this point can only be characterized as logically related.

D. Contribution of Grantees to Goal Achievement

1. Numerical Indicators

According to the Centers for Disease Control (CDC), the figure of 400,000 "users" used as a project goal is equivalent to 400,000 Couple-Years-of-Protection, or CYP. All grantee contraceptive user figures were converted to CYP, in accordance with the formula also recommended by the CDC. This method divides the total number of condoms and oral contraceptive cycles distributed (assumed to be used by recipients) by 100 and 13, respectively. In the case of surgical contraception, the total number of procedures is multiplied by 12.5 to estimate the number of years of "protection" the method provides. In all cases, these arithmetic manipulations are designed to convert usage data -- numbers of acceptors -- to year-equivalents that couples are protected from unwanted pregnancies.

Calculated on this basis, the cumulative CYP over the period of the project which was contributed by each service delivery agency, as of 12/31/87, is as follows: (See Annex D.)

<u>Service Agency</u>	<u>CYP Contribution</u>	<u>Percent of Total</u>
APROFAM	1,149,777 *	93.1
MOH/FFU	50,882 **	4.0
IPOFASA	34,426	2.9
TOTAL	1,235,060	100

While some of the statistical data on users/methods are somewhat uncertain, there is no question that the quantitative goal of 400,000 CYP by the end of the project, or December 31, 1987, had been surpassed. Clearly, APROFAM was the greatest contributor to this achievement with 93.1% of the CYP, with the MOH second and IPOFASA, third.

With respect to the goal of lowering the Crude Birth Rate, preliminary data from the Ministry of Health indicate that this goal may have been attained, as well.

2. Unplanned Results

But having satisfactorily reached these goals, what has really been accomplished? There is apparently no measurable improvement in the socio/economic status of the poorer segments of the Guatemalan population. This may be accounted for by consistently poor performance of the economy and population growth rates which regularly exceeded whatever gains the economy was able to make. Contraceptive prevalence seems not to have markedly increased since 1983, and acceptance remains low among Guatemalan Indian groups although a large percentage of new users appear to be from rural areas.

* The figures for APROFAM include sterilizations performed from 1983-87 and Direct Distribution activities, through January 1988.

** Does not include CYP generated from the Direct Distribution Program conducted until January 1988 by APROFAM.

A number of other things did happen, however, that were not explicitly noted by the planners and in this sense they may be called "Unplanned Results". First, and most important, there is an ambience which favors family planning that did not exist before and which is now seemingly well established. It is extremely doubtful that an arbitrary suspension of the program by the MOH could be carried out today without very severe political backlash. When this was tried in 1986 by the new Minister of Health, there were public demonstrations of protest and many women who felt their rights as human beings were being violated signed petitions to restore the program. Attacks on APROFAM drew similar expressions of outrage.

The PIPOM (Population Information for Policy Makers) project undoubtedly had a major role in shaping this positive environment. This activity, under guidelines from IPPF and with project funding, kept information flowing to influential groups -- professors, politicians, industrialists, chambers of commerce -- such that a majority of Cabinet Ministers in session voted to overrule the Minister of Health in his decision to suspend family planning activities. It is also believed that staff engaged in implementation of the PIPOM activities can take direct credit for inclusion of Article 47 in the Constitution which guarantees Guatemalans the right to plan the number and spacing of their children. Only twelve constitutions in the world, four of them in Latin America, can claim a legal basis for family planning programs.

Three major service delivery channels have been established and are operating, with varying degrees of efficiency and outreach. In whatever context the GOG and the donor agencies decide to place family planning and for whatever reasons people decide to plan/space their families, a service delivery system has to exist. Few improvements could be suggested for APROFAM's service delivery program. IPROFASA, with a few adjustments in direction and emphasis of its current program, could sharply increase its contribution to CYP. And the MOH/FPU, with continued constructive support from the GOG, can gradually increase their CYP through the large standing network of facilities throughout the country.

3. Lessons Learned

In this section, we review some of the issues which may serve to assist in improving the design and subsequent implementation of the extension of this project.

- b. The pressure exerted by the Mission on IPROFASA to implement an "experimental program" and the need for "self-sufficiency" within a specified, limited time frame was counterproductive. To achieve self-sufficiency, IPROFASA took the line of least resistance which was to generate sales income as quickly as possible, within the parameters of a social marketing enterprise. This meant covering the urban and Ladino markets, i.e.: those with easy access and at lowest cost. These were precisely the markets already being reached by other contraceptive marketing efforts and so were not composed of persons in greatest need. Rural and Mayan markets, where the greatest emphasis on providing services should have been placed, were given lowest priority due to the expense reaching them. The Contraceptive "Social" Marketing Program, in effect, became a Contraceptive "Marketing" Program, using low priced products as a selling point.
- c. Although the 1987 DHS findings are not yet available, there appears to have been little success in raising contraceptive prevalence among Mayan groups in the country. Careful, intensive analysis of the DHS data in the area of knowledge of contraception and targeting of ethnic groups and geographic areas may shed light on how to strengthen the IEC effort during the extension.
- d. The final overall CYP achieved was more than three times that which was originally planned. The highly positive correlation between the numbers of CBD promoters and acceptors indicates that the person-to-person approach where the promotor provides the potential user with information and may indeed be a "satisfied user" him or herself, seems to be the most effective. It also shows that potential demand was far greater than the planners had expected. The prospect of the MOH/FPU introducing

"CBD-type" promoters of its own who could operate out of Posts and Centers in the "interior" ought to be considered, such as midwives and Rural Health Technicians.

- e. Technical assistance in the area of IEC was provided on a short-term, periodic basis to solve immediate problems, rather than implement a medium or long-term communication strategy. The evaluation indicates that this is a problem area where long-term technical assistance would be more appropriate.

IV. INSTITUTIONAL ANALYSIS BY FUNCTIONAL AREA

A. Administration, Management, Organization

1. APROFAM

The Project Paper, under the "Institutional Analysis" section, notes that INCAE (Central American School of Business Administration) concluded in 1976 that APROFAM had the strongest general management capabilities of any of the six IPPF affiliates in Central America. Another evaluation of APROFAM conducted in 1979 by APHA not only reaffirmed this earlier finding, but also noted that APROFAM's administrative capacity had handled a rapid expansion of the program in a superb manner and indeed, had probably even improved as a result of the process. Yet a third evaluation by Development Associates Inc. (DAI), an in-depth examination of APROFAM's organization, again gave high marks to APROFAM's administrative capacity. This latter evaluation noted that due to a January 1984 reorganization, traditional hierarchical, top-management decision making was giving way to permitting greater flexibility to division chiefs. Other notable recommendations for improvement were: creation of a finance unit; provision of a deputy to the chief of the CBD program (APROFAM's largest operational unit); greater coordination of clinical and CBD services in the field; a separate training unit; systematic personnel evaluation. APROFAM has implemented all of these recommendations since that evaluation.

The present examination, while not as penetrating as that conducted by DAI, finds APROFAM's administrative structure has remained strong. Computerization has increased its effectiveness in managing large, complex budgets. Information requested by the current evaluation team was rapidly and accurately produced. The organization functions smoothly and effectively, aided by a high degree of personal commitment and motivation from its key officers, many of whom are women.

APROFAM has grown in size and complexity in recent years. With this growth came a recognition that decision making authority needed to be decentralized to staff in the clinics in the interior. In addition, roles and responsibilities needed to be more clearly defined. This process began in late 1986 on a pilot basis in a number of locations and includes the following objectives (paraphrased from an internal APROFAM document): (1) Establish clearly the functions and responsibilities of each different level, by which current ambiguity can be eliminated; (2) Establish common program targets for the Clinics and the Community Based Distribution (CBD) Program, thereby eliminating inter-program competition; (3) Unify information received by the client population so that they may decide in an informed fashion among available family planning methods; (4) Decentralize authority for certain operational decisions to the Clinic Medical Director and Area CBD Chief, such as personnel hiring and planning/programming of annual program targets; and (5) Establish the clinic as a support facility for the community-based programs. In effect, with this decentralization program APROFAM has begun the process of creating "mini APROFAMs." These administrative changes have resulted in clearer lines of authority, more rapid decision-making and, it is believed, more efficient management.

An important organizational change, which grew out of recommendations made by evaluations performed by both USAID and IPPF during 1983-4, was the establishment of the Program Coordinator position reporting directly to the Executive Director of APROFAM. This top-management position is filled by a competent young administrator who has been able to relieve the Executive Director of many routine operational decisions and has introduced a number modern management techniques into APROFAM's operations.

A significant problem facing APROFAM is holding competent, motivated personnel below the management level because of inadequate salary levels. A number of key personnel have moved onward to other employment, some for improved salary levels but also for greater responsibilities. This situation is somewhat offset by considerable enthusiasm among the staff. A conclusion of this evaluation is that APROFAM may have to break through the 12.8% ceiling on administrative costs it has maintained for a number of years, in order to effect a general increase in salaries, particularly those salaries not funded by the USAID project.

The only other major problem seems to be control over distribution and sales of contraceptives in the field to prevent

illegal sales to pharmacies, while at the same time not dampening initiatives of the community distributors. Highly costly supervision seems to be the only solution at present and one which APROFAM wants to avoid. Both this problem and that of salaries are under study.

2. I PROFASA

A full evaluation of I PROFASA's operations was conducted by PSI in the Spring of 1987. Therefore, the current examination was confined to reviewing the recommendations made in the PSI report which pertain to management and to comment on action taken and progress made. These recommendations are as follows:

Recommendation (Page 19): In paraphrased form. I PROFASA should: (1) develop a formal policy regarding accrued employee benefits and (2) develop a document which spells out these benefits in detail, including leave, performance evaluation, bonus/commission plans, etc.

Commentary: I PROFASA's lawyer has developed a policy determination conforming with the content of the recommendation. As the law requires, this has been sent to the Ministry of Labor for approval and I PROFASA is awaiting this approval at the present time. Action on this recommendation has been taken, but is not yet completed.

Recommendation (Page 22): "I PROFASA should dedicate time to on-the-job training on the computer and data system to all levels of relevant staff".

Commentary: This recommendation has been completed. All sales, accounting and credit department personnel, secretaries and general management have received Lotus and Wordstar courses. Additionally, department chiefs have been taught individual programs for their areas.

Recommendation (Page 23): "1. I PROFASA should complete an inventory cerecloths study that includes personnel time, obsolescence, rent, office materials, and so forth. Such a study would also facilitate additional calculations, such as economic order points, should these become practicable."

"2. IPROFASA should conduct a warehouse space sizing study based on current needs and projections of inventories over the next five-year period. A formal calculation of this nature, covering space and conditions necessary for bulk storage of product and materials, packaging, and active inventory would provide management with a quantified basis for planning and decision making.

Commentary: Action on recommendation No. 1 above has been completed. The system has been computerized. Tracking systems of the points noted in the recommendation have been devised and implemented. Recommendation No. 2: A warehousing expert from El Salvador was contracted to study the problem and his recommendations carried out.

Recommendation (Page 40): In paraphrased form, IPROFASA, the Resident Advisor, and USAID Project Officer should participate in the development of a marketing plan with a specified deadline, including such activities as market research, financial requirements, and revenue projections. The plan needs to be based on the primary goals of the organization and must reflect IPROFASA's complete experience via a diagnosis of both internal and external environments.

Commentary: Action has been completed. The plan has been written. Our only recommendation is provide for a mid-progress review of implementation of this plan.

PSI found the management/administration of IPROFASA functioning well. Basic such as accounting, sales, inventory, credit collections and management information systems are fully functional. Supervision of current operations is adequate.

As for further activities, we concur with the following quote from the PSI evaluation: "Given the present stage of the project and level of activity, and due largely to the smallness of the organization and the dedication and dynamism of the people involved, IPROFASA functions very well. IPROFASA is aware that project expansion would require revision to its organization."

organizational options, job descriptions, personnel selection and evaluation.

AGES also had problems with accounting and financial records. The accountant (who is also the only trained computer operator) resigned recently and his replacement is learning the job. AGES plans to take immediate steps to hire computer software expertise in order to develop an accounting and records system that is capable of expanding as AGES grows.

AGES has made remarkable progress on the program development side. In addition to a facility in the capital city, five centers have been opened -- Huehuetenango, San Marcos, Quetzaltenango, Alta Verapaz, and Chimaltenango. As planned and programmed, staff in all of these centers have been trained in formal sessions lasting 2 to 3 weeks in such subjects such as administration, teaching and materials development. The number of persons being affected by the program is more than double that programmed. Activities are going forward in both urban and rural areas. AGES staff feel that their success in working in Mayan areas is due to both the cultural sensitivity of their approach and simply fulfilling on their promises to these communities. Apparently, there is a pervasive and profound mistrust in rural Guatemalan communities for the motives of external "change agents."

With the steps being taken to correct current problems, and AGES's past record of common sense approaches to management difficulties, it can be safely assumed that this capable organization will be able to shoulder its responsibilities under a redesigned and expanded FP project.

4. MOH/FPU

In early 1983, the USAID informed the MOH that it wished to terminate Project 520-0263 Integrated Family Planning -- the predecessor project to 520-0288. At the time, the Project had a fairly large pipeline of unspent funds. The MOH requested, and the USAID agreed, that the termination be held in abeyance until an evaluation could be carried out. The evaluation, carried out in May-June 1983, recommended that the project be continued on a restructured basis. By the fall of 1983 an agreement was reached on the nature of the new structure.

The restructured project consisted of the formation of the Family Planning Unit to carry out the following components: improved field supervision of FP services offered in Health Posts and Centers; training of nursing personnel in Health Centers, Posts and Guatemala City facilities in FP technical material and acceptor counselling; improved logistics system for offshore procurement of commodities, in-country warehousing, inventories, field supply and re-supply; an information system to provide accurate information on new and continuing users. The newly restructured unit began to make steady progress and services began to become available once again in Centers and Posts through out the country.

The FPU is understaffed in management and administration. The Chief of the Unit and the administrator are essentially handling all the technical and management functions, including planning, programming, financial management, contraceptive logistics, as well as daily supervision of field medical and nursing personnel currently supervising FP activities in 11 Health Areas. Recently, final selection took place for the contracting of an additional four medical supervisors who, in time, will absorb the increased supervisory work load created by the transfer of the remaining 13 Health Areas from APROFAM back to the MOH.

We understand that the Mission is carrying out a continuing dialogue with the MOH with a view to identifying and describing the nature of the management problems which will come with the additional Health Areas. During the negotiations for the amendment obligated in 1987, the MOH expressed agreement to the concept of accepting medium term technical assistance in the areas of logistics and training. The Director of the FPU was less enthusiastic, however, about other types of technical assistance -- FP program management, supervision, evaluation, and so on.

With regard to the position of the FPU within the MOH organization, we learned during the evaluation that changes are taking place. We were shown two organizational charts: one with the FPU reporting to the Director General of Health Services (DGSS); and a second showing the FPU reporting to MCH Department, which is under the Applied Programs Unit. The former arrangement is the legally recognized, "approved" organizational location for the FPU, which has been operative since the establishment of the FPU in 1983. This arrangement, in recent times has functioned well, as the approvals needed to carry out the program were few. And so long as the Director General was favorable toward family planning, the FPU viewed this to be the ideal arrangement.

The second organization, with the FPU reporting to the MCH Department, is the preferred relationship as it is consistent with the integrated approach to MCH and family planning. The disadvantages with this latter arrangement are largely bureaucratic -- loss of independence of action, more layers of administrative approvals needed, and the greater risk, loss of identity. We also learned that under this plan for reorganization, the head of the FPU was to be named responsible for "maternal services", within the context of the traditional Maternal-Child Health Department structure.

With all these changes in the making, a full discussion of current lines of authority, administrative and technical relationships between field and headquarters, job descriptions/ qualifications and other aspects of administration and organization is problematic. These changes, should they materialize, present both risks and opportunities for the USAID Mission which are consistent with the direction of current decisions to integrate family planning (birth spacing) into its general health strategy and the child survival strategy, in particular. Great skill will be needed to navigate the "integration" course so as to minimize the risk of completely losing the identity of family planning, within the broader health context.

5. Summary

APROFAM and IPROFASA have strong, well-functioning management systems which are capable of expansion and increased activities. AGES has temporary administrative problems which it is taking appropriate steps to correct. The MOH/FPU will need additional administrative personnel if the unit is to function properly under the additional responsibilities created by supplying services to all

24 Health Areas, beginning in February 1988. The problems at AGES and the MOH/FPU are those which can be remedied relatively easily.

B. Delivery of Family Planning Services

1. APROFAM

APROFAM has built a dynamic infrastructure which guarantees the delivery of modern contraceptive methods to a large segment of the population who do not have access to other kinds or types of services, either from the public or the private sector. APROFAM's network of clinics throughout the country and the Community Based Distribution (CBD) unit guarantees the continuing supply of services. We could see no obstacles to expansion of APROFAM's service delivery operations.

The CBD unit's organization is linear and reports directly to the Office of the Executive Director. See Annex D. The Chief of the unit is a highly-motivated, experienced and dynamic person. Two assistants each cover 12-14 areas, corresponding to the country's 24 political divisions. Additionally, there are 12 supervisors, or Area Chiefs, some of whom supervise more than one area.

Reporting to the 12 Area Chiefs are 98 Health Educators who in turn supervise distributors at the community level. Educators are persons with training in the field of human resource development and include high school graduates, teachers, accountants, and others. Each Educator supervises 20 distributors, who are people from the community chosen by the leaders of their own villages. The total number of distributors is 1800, of which 1500 report their activities every month. The remaining three hundred report irregularly and are considered as "non-active". Their remuneration consists of a 40% commission on the sale of contraceptive pills (Noriday, Norminest, Lo-Femenal), condoms, vaginal tablets (Neo-Sampoon, Conceptrol) or foam.

Besides the distribution of contraceptives, the distributors provide simple health education messages such as advice on environmental sanitation, personal hygiene, distribution of oral rehydration salts and anti-helminths. The training of distributors

is a continuous process, both for new distributors as well refresher training for existing distributors. In addition, there are on-going refresher courses for the Educators.

The CBD system described above provides a steady, adequate and timely supply of contraceptives from APROFAM's warehouse in Guatemala City. Storage conditions at the APROFAM Central Warehouse are secure and stable. There are adequate administrative mechanisms for managing, planning and updating of inventories. Deliveries to community distributors are made at least once a month. Inventories and restocking requirements flow back through the system by use of monthly report forms covering the activities of the distributors. This information is also provided to the Evaluation Unit for compiling statistical information which is submitted to APROFAM's main office.

Of the 1800 CBD distributors providing services as of December 31, 1987, some 540 are in clearly urban areas (30%), while 1260 cover the high priority rural area. An analysis of the Western and Northern departments with predominantly Indian populations shows a higher average number of contacts per distributor are being made by program personnel in the Mayan population. Of 531 distributors in the Departments of Solola, Totonicapan, Quetzaltenango, Huehuetenango, Chimaltenango, Alta Verapaz, and Progreso, 256 are bilingual. Distributors include both men and women, the latter being about twice the number of the former.

The CBD unit has an average of 42,000 new users per year, or a monthly average per distribution post of 2.5 users. Continuing acceptors average 66,000 per year resulting in a contribution by the CED program of somewhat more than 100,000 CYP. Mechanisms have been created with respect to referrals of beneficiaries to the APROFAM clinics for family planning services, and for follow-up of CBD users. See Annex D.

For many years, APROFAM's clinical services was concentrated in the capital and consisted of one central clinic with three other smaller clinics in various parts of the city. With support provided under this project, this system has been expanded to ten clinics located in Escuintla, Solola, Zacapa, Puerto Barrios, Quetzaltenango, Quiche, Jutiapa, Huehuetenango, Coban and Coatepeque.

The 13 clinics are "full service" in that they provide not only FP services, but also gynecological exams, Pap smears, infertility,

pre- and post-partum services and receive referrals from the CBD promoters. These clinics will also implement selected Child Survival services (well child services, oral rehydration, immunization, etc.) during 1988. This package of services should serve various purposes: (1) help increase utilization of clinic services in general and family planning, in particular; (2) related to (1) above, reduce the unit costs of the specific services and the overall clinic contact with the client; (3) promote the image of APROFAM as a provider of valuable health services to the community; and (4) provide another source of revenue for APROFAM.

APROFAM is also providing, on an ad hoc basis, surgical contraception supplies (Yoon rings, etc.) to the Guatemalan Social Security Institute (IGSS).

2. MOH/FPU

The FP Unit has a warehouse with adequate capacity located in Guatemala City which was specially built to store contraceptives. It meets all requirements to ensure the preservation and stability of the physical condition of the commodities. Stocks are stored correctly to prevent damage caused by moisture, heat and other factors, and are placed on 10 cm. high wooden stands at a distance of one meter from the walls. There are sufficient shelves to handle increased stocks as well as other materials and office supplies. Adequate forms exist for controlling the in/out movement of contraceptives and other materials. Request and dispatch procedures are secure. All requests are made by FPU supervisors as a result of inventories taken during each supervisory visit. Requests are evaluated by Administration, which then authorizes the person in charge of the warehouse to dispatch the order. The procedure is fast and adequate.

Contraceptives are issued to the FPU supervisors against the requested and approved amounts. The supervisors in turn deliver the contraceptives to the MOH outlets. Another delivery mode is to ship a determined amount of contraceptives to Health Area redistribution points. Each Area Health Office has an assigned person who controls and assures delivery from the redistribution points to the centers and posts.

The Unit has adequate procedures to assure an effective supervisory job of delivery and accounting for contraceptives. A

complete set of forms used for these controls includes: appointment book, appointment control card, monthly report, daily individual card, supervisory guide, shelf card and a Return-to-Warehouse form. A review of these forms indicates that far too much information tends to be collected and most staff are unsure of what the information is for and who uses it.

While this statistical system works quite well for re-supply, the figures maintained on contraceptive users are confusing and contradictory at times. In general, however, there is an upward trend in the number of users in MOH establishments supplied by the FPU. There is an accompanying increase in user coverage of the target population in these areas, which historically have had the lowest incidence of contraceptive use. Hence, an improved delivery system, such as that described must be maintained in order to adequately reach, on a continuing basis, these priority potential FP acceptors. A full review of the information system, in the context of the latest thinking in FP program management and logistics, is considered necessary.

Between January 15-30, 1988, the transfer by APROFAM back to the MOH of 13 health areas took place. Approximately 395 health facilities are involved. Since the 1976 earthquake, APROFAM had carried out the responsibility for delivery of contraceptives in these 13 health areas. APROFAM left a four-month supply of contraceptives at each health facility, which is expected to assure adequate stocks while the FPU takes over.

Up to the time of this transfer, the FPU had been serving 716 facilities in the Western and Northern regions of the country. Starting February 1, 1988, this will increase to 944. This represents 91% of all service facilities, which at the beginning of 1988 totaled 1034.

The FPU's Operational Plan for 1988 (January - December) includes a supervisory calendar for the 24 areas, guaranteeing at least 3 visits per year to all MOH Health Posts and Centers. The supervisors on these visits leave at least four months supply of all contraceptives used. The FPU's service delivery capability has been reinforced with 4 new vehicles and 4 new supervisors, assuring supervision and support to all 24 health areas. Additionally, the Supervisors' manual has been completed and covers, besides Family Planning, other MCH program components such as immunization, and oral rehydration therapy.

The evaluation team believes that if the FPU continues to concentrate on improving the operation of its service delivery system, this problem area will give way to significant progress towards an efficient nationwide service delivery program.

3. I PROFASA

Since launching its products on the Guatemalan market in June 1985, I PROFASA has essentially followed the service delivery strategy of filling the pipeline to traditional outlets. These outlets include pharmacies throughout the country, but primarily in urban, peri-urban areas and the larger towns in the "interior". I PROFASA now serves 757 of the 1364 pharmacies listed in the Pharmacy Register, or 55% of the total pharmacies in Guatemala.

The delivery system is rather simple and best described by quoting from the PSI Evaluation which provides a succinct analysis of this area:

"The sales and distribution activities of I PROFASA are conducted according to classical business approaches. The organization has established procedures and an infrastructure that function effectively....."

"I PROFASA presently has a sales staff consisting of a sales manager, and three salesmen. A medical representative is on staff (they are contemplating adding another) to promote Perla to physicians. The country is divided into 3 sales zones, each of which is arranged geographically to include a part of the capital city. Tour schedules are carefully planned on a 5-week cycle, 3 weeks of which are spent outside Guatemala City. The Sales Manager (who has only recently joined the company) travels 7-10 days per month checking on the accuracy of call reports and generally making sure the sales force is doing its job, which includes, in addition to checking stocks and taking orders, collection of money and payment of bonuses to retail clerks.

"Each salesman is expected to average about 12 calls per day. With three salesmen, therefore, the country's 650 outlets are easily covered at least once during each 5 week schedule; more important outlets are visited more frequently.

"Additionally, shopkeepers can and do telephone orders into the head office, which arranges delivery of the products. According to shopkeepers interviewed both in and out of Guatemala City, IPROFASA provides excellent service and stock-outs seldom occur. The response time and frequency of visits is obviously very good."

Within the product line, the sale of condoms has enjoyed sustained growth which was reinforced in 1987 by the introduction of the Pantera condom, selling at a price lower than Scudo. There was a small decrease from 1986 to 1987 in the sales of Lirio and Perla. IPROFASA conjectures that this could be due to several factors, such as saturation of the current coverage and possibly increased black market sales.

The coverage obtained by IPROFASA for the period is 34,486 CYP. (See Annex D) Through this service delivery system, the average monthly sales are in excess of Q 30,000, with a yearly total of Q 400,000 and accumulated sales of Q 854,656.20 for the 30 months in operation.

The IPROFASA Work Plan for 1988 calls for increased sales to the greatest number possible of the low-middle-class population. IPROFASA also seeks to introduce its products to the rural areas through appropriate outlets in these communities and by incorporating pharmacies with a low purchasing capacity. IPROFASA is also exploring alternative mechanisms to penetrating the Indian market. Under study are which might be the most adequate strategies to use because of the cultural and linguistic differences found in Guatemala's ethnic groups.

4. Summary

Of the institutions evaluated, APROFAM enjoyed the highest rate of success and contributed more than 90% to the quantitative CYP goals. Additionally, APROFAM has experienced a large degree of institutional development and maintained the excellence of its highly motivated professional staff. Their various modes of FP service delivery are of very high quality and operate through an infrastructure easily capable of expansion, especially for the CED component.

The MOH FPU provided limited contribution to the project objectives, in large part because of the adverse political

circumstances which affected this component between 1983 and 1986. There are signs, however, that the MOH is slowly beginning to include family planning as a regular service in their facilities. According to data reviewed during this evaluation, 716 health facilities (of a total of more than 1,000) have been providing at least minimum family planning services on a continuing basis since March 1987. With the transfer by APROFAM of the 13 Health Areas back to the MOH in January 1988, the number of facilities being served by the FPU will grow to slightly more than 900.

The evaluation team sensed an enthusiasm and purpose in the central MOH staff and their field supervisors which may serve to bring about positive change in public sector family planning service delivery. No doubt, the current environment which has allowed the FPU to carry out vigorous training programs (see the following section) for medical and nursing staff and greatly increased supervision and contraceptive re-supply, has contributed to this positive outlook. It is also true, however, that the political winds can change just as rapidly against the program, with a virtual shutdown such as in early 1986 a real possibility. The team feels, however, that this likelihood is much less today than even one year ago.

The MOH/FPU will require strengthening and reinforcement in the form of additional personnel and management training if it is to carry out its rapidly expanding responsibilities.

I PROFASA provided 34,486 CYP to the quantitative objectives of the project, which is a respectable contribution for an organization that has been in operation for such a short time. Through commercial channels I PROFASA reached many FP acceptors that were not covered by other service delivery agencies. The expansion of market penetration to the Mayan areas should be encouraged and monitored closely, as this group represents the largest proportion of need for family planning services.

C. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

In this section, we will examine the IEC activities being carried out by the implementing agencies. The acronym, IEC, is shorthand for: Information - Design/Production of Informational Materials; Education - Training, both in-service and continuing; and, Communication - Social Communication or Use of Mass Media for Social Purposes.

Although very different activities, each with unique characteristics and skills required, IEC activities are joined by their ultimate purpose: the change in behavior in desired direction(s). The following objectives for an IEC program illustrate more clearly whose behavior is to be changed and how:

- (1) promoting behaviors in the target population, through information and mass communication, which facilitate informed, voluntary decision making regarding the utilization of services which help regulate their fertility; and,
- (2) helping health workers, through training programs, deliver technically and culturally appropriate family planning services to the client population.

Thus, in this section we will examine the efforts of the implementing agencies to design and produce informational materials, their success in using mass media as an effective means of educating and changing the behavior of the target population and training programs as a support system to the service delivery programs.

Before reviewing these areas of activity in each agency, a brief discussion of the background is considered useful. The 1982 Project Paper identified lack of knowledge of family planning services as a major constraint to the success of family planning in Guatemala. In the 1978 CPS, Morris et al. concluded that 27% of all Guatemalan women of child bearing age expressed a desire to prevent pregnancy, but were not using a family planning method. The Mission regarded the IEC component as an important element of the current project, with considerable attention given to this area in the Project Paper.

The Project Paper also identified advertising and promotion as an important tool for marketing contraceptive methods in the Contraceptive Social Marketing program. APROFAM, on the other hand, viewed information, education and communications activities as the principal tool for reaching their target audience.

The MOH's function, according to the Project Paper, was to continue providing FP services through its hospitals, health centers and health posts, while APROFAM was tasked with responsibility of promoting the utilization of these services.

Another key constraint identified in early project documents was the acceptance of FP services by the Mayan community. Just under half of the population has Mayan Indian roots. In Guatemala, this is virtually synonymous with poverty, low literacy rates, high maternal, child, and infant fatality rates, and high morbidity rates -- all the down side social correlates of a poor, marginal population. At present Mayan women marry younger and bear more children at more frequent intervals than their Ladino counterparts.

In order for family planning to be effective and meaningful, much less to have a significant demographic impact, it must reach the 43% of the population which does not speak Spanish and which is culturally distinct from the dominant Ladinos in a variety of ways relevant to family planning and health care delivery. The very low rates of contraceptive acceptance among the Mayan population indicates that this has not yet happened. This population group, then, presents the greatest challenge to IEC activities of project implementing agencies.

1. AGES

The Asociacion Guatemalteca de Educacion Sexual (AGES) was not identified by name in the 1982 project paper. AGES was incorporated financially into APROFAM's budget in 1983 and signed an Operational Program Grant (OPG) directly with USAID under project 520-0288 on December 2, 1985.

AGES provides educational programs and activities for young adults, parents, teachers, schools and other community groups in Guatemala's marginal peri-urban slums. As an extension to this program, AGES has expanded their operation to six departmental centers, with a seventh to be established by the end of 1988. By 1990, AGES aims to have eleven (11) centers, in addition to its program in Guatemala city. The Guatemala city and departmental centers base their educational programs on a network of young adult promoters who are trained in group work skills and the content of family life education. More recently, AGES has begun developing promoters among parent groups with some success. Curriculum development for these educational programs is carried out through a process involving identification of family life education themes, content research and pre-testing of the curricula on the target audience using the focus group technique.

AGES also has a pilot program aimed at selected communities in 5 departments which have significant Mayan populations to disseminate family life education through the national bilingual education program. Through this pilot program, parent-teacher committees are working with AGES to develop culturally appropriate materials. In addition to providing family life education to community leaders, parents, teachers and students, five hundred and forty (540) Indian girls between the ages of 8 and 15 will be granted scholarships equivalent to Q 15 a month. This scholarship is meant to facilitate the continuation by the girls of their education by postponing school dropouts and early marriage. This program grew out of the need identified in the 1985 Education Sector Assessment carried out by AID which demonstrated the need to reach Indian girls with educational services.

AGES has submitted an operations research proposal to the Population Council to examine the effectiveness of alternative approaches for reaching the Mayan population with family life education, including family planning education. The study will begin in March 1988, with technical assistance in research techniques and data analysis to be financed from the grant. It is hoped that the results of this study will be helpful in systematizing the strategies employed by AGES in developing and implementing educational programs for Mayan youth in the eleven North and Western highland departments targeted by this agency. AGES produces a number of informational pieces, including a promotional newsletter that is distributed to all its centers. The newsletter includes descriptions of the activities of other centers and encourages AGES clients to share positive experiences. Another educational tool used by the Association is a series of informational cards which are distributed personally by AGES volunteers in the community. These cards provide information on topics relevant to youth, including such topics as venereal diseases and AIDS. AGES also produces small booklets on a variety of topics such as growth, reproduction and sex education/information, which are sold as part of their income generation program.

Project records indicate that AGES has consistently equalled or surpassed the output targets which were specified in the original agreement documents: new departmental sites established, clients receiving educational services, training of trainer/supervisors, scholarship recipients and so on.

IEC Findings: AGES

a. Information and Communications Activities:

As mentioned, AGES is designing and producing a small number of informational materials for use in various ways in their educational programs. The printing press operation permits production of high quality and in the desired numbers. The quality of these materials -- message focus, layout and colors, choice of human subjects, use of caricatures, and so on -- is fundamentally good but could be improved by following a number of principles. The most fundamental of these is to implement consistently pretest procedures and take the results of these pretests seriously, modifying the informational piece as indicated by the pretest.

The information materials produced by AGES include a promotional newsletter, booklets and cards which are handed out by promoters. The content of the handout cards on AIDS seems to be technically accurate, but it is uncertain whether the target audience is able to read and understand the messages. Also, a red handout card appeared to be somewhat suggestive, giving the impression of a joke card or least the reader was distracted from the fact that the informational piece had a fundamentally serious purpose. AGES needs to be consistent in reproducing their identifying logo, so as not to confuse their audience. Also, to promote a positive image, AGES needs to constantly check the temptation to use the "cute", appealing approach as it can lead to destructive criticism.

It was clear during this evaluation that AGES is genuinely committed to finding systematic ways to reach the Mayan population with educational messages. Additional funds are needed to carry out research in the areas of family life and customs among Indian populations in Guatemala, and these results integrated into a systematic communications plan which includes materials development. The seminars held jointly by the family planning agencies during 1987 drew attention to the needs in the area of materials development for the Mayan segment of the population. A means to encourage and expand the ideas resulting from those seminars needs to be developed.

AGES could greatly strengthen its educational impact with the design of a comprehensive communication plan which could include: 1) guidance for judicious use of promotional advertising and mass media use to further concepts in family life improvement among Spanish speakers; 2) a public relations plan which both educates the public on matters of importance to family life and may serve to protect and enhance the image of AGES against its potential detractors; (3) a systematic plan to market its saleable items and services and (4) provide guidance for systematic research into message selection and strategies to reach the Mayan population segments. Undoubtedly, foremost among the communication strategies for AGES to reach this population group will be the person-to-person approach.

AGES could also explore the possibility of the popular, potentially highly effective medium of the "fotonovela." The issues of family life are very adaptable to this format, and skillfully executed could have good impact with a high educational content as well as entertainment value. If financing were available, AGES could serve as technical consultant to a firm under contract to design and produce series of short novelas around important themes relevant to growing up, drugs and alcohol, parenting and other relevant topics.

b. Training Activities

As mentioned earlier, AGES has engaged in very intensive training programs to develop its core staff of promoters in the central and departmental centers. In addition, these core staff must multiply their knowledge and group work skills by training district promoters. More recently, AGES has begun to integrate concepts of "competency -based" (CB) curriculum design into the various basic and in-service training programs. The CB techniques are gradually replacing more conventional curriculum design techniques, and have included the incorporation of focus group techniques to verify the relevance and understanding of family life themes in the communities being served. These focus group encounters have also generated new themes and provided a basis for modifying existing themes.

A word of caution is order in carrying out the integration of CB techniques in the training programs. AGES should make the effort to use CB techniques, but also recognize the limitations of this curriculum design approach. CB techniques are most useful in developing curricula for training in areas of human performance which are repetitive and adaptable to algorithmic definition. For instance, an instructional unit to teach a laboratory procedure or how to fill out a set of supervisory forms are highly suited to CB, because the steps involved can be clearly described and sequenced. Not so easy, however, is CB curriculum design to teach effective skill areas such as "how to teach a class" or "how to run a group meeting", both of which are highly relevant to the kinds of activities AGES carries out.

Conclusions and Recommendations - AGES:

AGES gets very high marks for its efforts thus far in the area of IEC. Institutionally, AGES takes its educational role very seriously and is trying to incorporate modern techniques to increase the relevance, effectiveness and efficiency of its various programs, e.g. focus groups and compassionateness curriculum design. Improvements could be effected, however, by designing a comprehensive communications plan which is tailored to the realities of Guatemala and AGES's perceived role as an institution. The elements of this plan are briefly described in a previous section, Communications Activities.

Within the context of the comprehensive plan mentioned above is the planning, design and execution of formative research which can provide clear guidelines for design and production of culturally acceptable informational materials for the Mayan segment of the population. There seems to be interest and enthusiasm among the family planning agencies to pursue the strengthening of this area. The Mission should capitalize on this interest as well as the growing skills and understanding of the problems involved which is already present in AGES.

As an educational activity, the Scholarship Program is considered to be a highly useful program, both in terms of the impact it is having on the lives of a few girls at present but also as a means for AGES to gain access to previously closed Mayan communities with a service which is highly regarded and appreciated by these communities. A spin-off benefit is that AGES is learning (by doing) how to approach and work with the Mayan communities. The evaluation

team considers that this program should be expanded, with appropriate attention given to the administrative capacity to operate this larger program which may be needed in the AGES central and departmental offices.

Technical assistance is viewed as potentially useful in developing the comprehensive communications strategy and planning documents, assisting with the more effective use of formative research techniques including pretesting, completing the integration of compassionateness curriculum design techniques into the training program, where appropriate, materials development including such potentially attractive ideas as the fotonovela and assisting AGES with the diffusion of new IEC ideas to other agencies engaged in related activities.

2. APROFAM

In 1982, the designers of the 0288 project viewed IEC as a vital element in the expansion of family planning services by APROFAM. The project paper lists the strategies for reaching potential acceptors of services to be followed by the IEC department to be as follows:

- Community Campaigns
- Mayan Projects
- Family Life Education
- Youth Projects
- Pharmacy Employee Training
- Information Aimed at Men as Heads of Households

These functions were expanded to include communications campaigns utilizing mass media. The purpose of the publicity campaigns was to promote the utilization of APROFAM and MOH family planning services. At the time it was thought that such campaigns would also stimulate sales of contraceptives distributed through the CSM project. The IEC functions were to be further expanded to include the use of the Resources Awareness of Population Impacts on Development (RAPID) and a project called PIPOM (Population Information for Policy and Opinion Makers). RAPID provided APROFAM with the capability of effectively communicating to a variety of audiences computer analyses of the socioeconomic costs of rapid population growth. PIPOM, as the full name indicates, is a series of educational activities complemented very well by RAPID, directed at increasing the awareness of key

persons in the government and the private sector in Guatemala on the implications of population growth on development and their potential role in this area.

1. Communications and Information Activities:

Communications: By all accounts, APROFAM implemented RAPID and PIPOM very successfully. There seems little doubt that the ratification by the Constitutional Assembly of Article Number 47 in the Constitution, which guarantees all Guatemalans the right to space births and limit family size, is directly attributable to the skillful public relations and educational campaign mounted by APROFAM through the PIPOM framework.

The 1983 Contraceptive Prevalence Survey (CPS) reported that the level of awareness of contraceptive methods was 81.6% among Guatemalans. The prevalence of use of contraception was cited at 25%. These results suggest that Guatemalans in significant numbers know about contraceptive methods, but at the same time were unfamiliar with the whereabouts of service providers, did not know how to use the methods if they were provided or the methods were simply not available to them. The 1983 CPS reported that these same groups expressed a desire for more information and services. These results indicate that a significant part of the utilization problem is lack of information or knowledge about family planning, the methods, their use, effectiveness and normal secondary effects in their use. Where services are available seems also to be a problem. The Communications Unit of APROFAM identified some important barriers to the use of methods and services which included combinations of (1) limited dialogue between and among couples; (2) negative rumors about family planning methods and services; and (3) cultural and religious taboos.

The communications strategies used by APROFAM to overcome these barriers included radio, press, the development of printed materials such as brochures, posters and flyers and person-to-person communications through their extensive network of community-based distributors. The latter are viewed as a variant of communicating through "satisfied users", by virtue of the fact that a significant proportion of these distributors are women who have planned their families.

Organizationally, the Communications Department forms part of the Information and Education Division of APROFAM. This Department

coordinates all the mass media campaigns of the Association; is responsible for the design of communications strategies for APROFAM, including public relations; coordinates the technical relationship with and interfaces with the advertising agency; and carries out the creative work for newspaper releases and radio scripts as well as editing and review of materials written by members of the association.

In 1986 and 1987, APROFAM began implementing a carefully designed communications strategy consisting of four major parts: (1) a campaign to locate the clinic services in the minds of the target audience; (2) a campaign to modify attitudes toward family planning; (3) for those already using a family planning method, messages to reinforce continuation of use of the method; and (4) a public relations campaign that has the purpose of enhancing its image as a provider of health services to the Guatemalan family. In sequence, this image-building campaign is a continuation of a highly successful "emergency" effort undertaken by APROFAM in the second half of 1985 and early 1986, when APROFAM came under heavy attack from organized groups which rallied around public statements of the Bishop and Minister of Health regarding forced, mass sterilization programs allegedly being carried out by APROFAM (for more information, see earlier sections).

With the help of an advertising agency (McCann Erickson) under contract, phase one of this campaign is underway. This phase is intended to help identify in the minds of clients APROFAM's network of clinics. The clinics facades have been redecorated with a distinctive logo of a father, mother and child, with blue as the dominant color. Two television spots are in the process of production with the messages intended for a middle class urban audience and a rural Ladino audience.

In addition, during 1987 twenty eight (28) newspaper ads on methods, institutional promotion, and the importance of medical checkups were produced. Three (3) radio spots were aired Monday through Saturday nationwide in Spanish, Mam, Cakchiquel, Zutuul, Quiche and Kekchi. As yet, the impact of the ads and spots has not been measured.

At present, the Communications Department cooperates with the I and E Division in the design and development of print material in support of APROFAM programs including: Youth and Family Education,

the Adolescent Center, "El Camino", the APROFAM library and document center, promotion of natural family planning methods, the numerous training activities (see below), general topics such as Population and Development Family Planning Orientation, and clinical areas such as male and female surgical contraception and treatment of diarrhea. Materials are designed by the communications department and tested by the Research/Evaluation Unit. Indicative of the volume of activities and the relative emphasis given by the Communications Department to the various media, of a total of approximately 1.13 million Quetzales spent in 1987, 62% was for services of the advertising agency, 27% for radio time, 6% of press advertising and 4% on other print material.

A new communications facility called the Centro Regional Educativo Americano (CREA) has been recently established at APROFAM. This unit is a television production center supported technically by the Johns Hopkins University Population Communication Services (PCS) and with AID/W funds. The center will produce television spots, documentaries and training pieces for private non-profit and commercial entities throughout the region.

Productions for APROFAM's use by CREA will be calculated at cost. Productions for government and non-profit institutions will use a rate based on their financial capabilities. For-profit rates will be competitive with other in-country production houses.

AID funded projects in the Central American region will use the center to develop videotape materials for their programs. It is too early to evaluate CREA's design and production operations as the equipment is not entirely installed. Materials produced by the staff of this Center for the image campaign in 1985 and 1986 are first rate, however, and some pieces have won international awards.

Information: As was indicated above, the portion of the 1987 budget dedicated to production of printed informational material (including press) was only 10%. This low emphasis on print material, coupled with fully one-third of budget dedicated to radio, may be consistent with general low literacy levels of the target population. (See Annex F for comments on advertising material).

It was found that print materials developed and produced prior to 1985 were generally fashioned after designs used in other countries.

Further, the materials appeared to have been designed strictly as information pieces with little attention paid to levels of literacy in the target audience, language use and the ability to understand and perform the actions suggested in the printed material. In the past two years, however, there has been a significant increase in the attention given to "educational process" methods, such as pretesting materials on the target audience, which aid greatly in addressing the above issues.

In 1987, APROFAM conducted a pretest of a brochure aimed at illiterate male audiences on the subject of vasectomy. The material was designed and developed by the Communications Department, with input from the Education Unit. The results of the pretest of this brochure indicated that there was serious confusion among the audience of the ideas which the designers hoped to communicate. For instance, many of the participants thought the pictures were to teach how to avoid or prevent sexual relations. A couple was identified as going to APROFAM to talk to a doctor who was thought to be explaining how a penis was in need of an operation. Finally, through much probing the group understood somewhat the concept of vasectomy as a family planning method.

The above example illustrates a number of important points. First, it reveals how a scientifically accurate brochure on a surgical procedure, if left the way the designers had conceived it, would have probably missed the mark completely with a majority of the audience and indeed, probably misled a great many. It reminds us again that the target audience has the ability to provide constructive comments on the messages, layout, colors and other aspects of printed material.

These pretest results also illustrate the point that some printed materials cannot stand alone if the messages are to be communicated to illiterate target audiences, that they must be accompanied by a personal one-on-one or one-on-a-group presentation by trained educators or promoters. This applies particularly to emotionally loaded, somewhat technical subjects such as vasectomy and female sterilization. Viewed from a marketing perspective, this example underscores the importance of truly understanding the nature of the product (vasectomy) in order to design the marketing program.

Print material produced in 1987 was reviewed during the evaluation. Below is a summary of observations on the material.

which may be useful in making improvements in the future. Copies of these materials are included in Annex E.

Many of the observations revolve around the issue of Ladino vs. Mayan target audience. A poster shows a clearly urban, Ladino, happy family; this piece will have an audience which is limited to the characteristics listed. A companion poster, with the happy family message, for Mayan audiences may be helpful. Another poster shows a healthy, Ladino woman; again, a companion poster with a healthy Mayan woman is needed. Several brochures/booklets on voluntary sterilization topics could be adapted to an accompanying videotape, which could be run in the waiting rooms of the clinics. This would reduce the pressure on the required literacy and increase retention of the messages. Some of the materials have drawings which are very difficult to understand, e.g. the menstrual cycle and some drawings of natural methods.

b. Training Activities

APROFAM carries out training activities through two organizational units: (1) the Training Department, which conducts non-clinical training; and the Clinical Services Unit which carries out both clinical and non-clinical training activities for physicians and medical students.

The Training Department has provided family planning training for institutions both in Guatemala and abroad. Since 1982, the Department has averaged approximately 40 training events each year, with a total of one thousand participants. In addition, the Department organized and carried out a number of international training activities and its staff have provided training consultation on a number of occasions to IPPF affiliates in Latin America. Indeed, approximately one-third of the Training Department time is presently engaged in providing technical assistance to other family planning associations.

The goals of the Department include the provision of family planning training to other institutions that are interested in providing family planning services in their programs and training support to other APROFAM programs and units with training needs. Notable among the latter clients of the Department are the large number of distributors in the CBD Program (see previous sections and a more complete description below).

Training activities are financed by funding from IPPF, AID, and to a lesser extent, Development Associates. The availability of funding determines, to a large extent, the number and types of training programs that will be implemented during the year.

Education for family life (parenting) is delivered at schools for teachers and students in Guatemala City and the interior of the country. These courses include themes such as responsible parenthood, care of children, sex education and family planning. During 1985, these courses reached a total of 65,351 persons. Courses planned and delivered totalled 786 in 421 educational institutions throughout the country. One hundred and twenty seminars reached over 3,300 high school seniors who developed activities around the topic of "socioeconomic economic development in Guatemala." This latter program gave unexpectedly good results during 1987, with a spontaneous series of activities organized by the seniors themselves. In addition, a recent survey conducted by AGES/CDC to study knowledge, attitudes and practices among Guatemalan adolescents in the capital city area indicated that APROFAM was an important source of information on sex education.

An important activity of the Training Department, because of its sheer magnitude, is the basic and continuing education program for the Community Based Distribution Program. As described earlier in the Service Delivery section, the program has approximately 1,800 distributors scattered throughout the country. These distributors are supervised by 98 Educators, who in turn, receive supervision from a dozen or so Area Chiefs. All these staff receive initial, basic training upon entering service. Since there is a constant turnover, the basic courses are scheduled periodically throughout the year. Specialized courses for supervisors and educators are also implemented periodically. The system allows for upward mobility with motivated educators able to advance to supervisors and trainers.

The curriculum for the basic course for distributors provides simple information on both permanent and temporary methods of contraception. Natural methods are not taught in detail to distributors. Illustrative of the information provided on the methods: How it (the method) works, effectiveness, advantages/disadvantages, normal signs and symptoms after starting the use of a method, how and when it should be recommended and the danger signs of who should not use a given method. The courses last five (5) days.

The material used for training varies and the content is designed through modules directed at job level and function. Thus, there are modules for each level of trainee: distributors, educators, area chiefs and so on. The training is evaluated at each level by the ability of the participant to give information to a lower level. Specially designed charts, audio-visuals and booklets are used for each level of course.

Because of the numbers of distributors involved and the volunteer nature of the work, turnover is great. This places a significant program and financial burden on APROFAM's Training Department. To try to determine the efficacy (retention of material, satisfaction of users served by the distributors, numbers of new users, etc.) and cost implications of different training "treatments" for distributors -- the same didactic material with different lengths of training and frequency -- APROFAM has initiated an operational research project with technical assistance and financing from Population Council. This project is expected to begin in March 1988.

Conclusions and Recommendations - APROFAM

APROFAM is carrying out a complex, wide-ranging, and very professional job in the area of IEC. They have been quick to adopt "educational process" methods such as pretest to increase the probabilities that messages communicated through various media in fact, achieve the desired behavior change or at least are comprehensible to the client. There is reasonably good internal coordination between the various departments within APROFAM to ensure consistency of message content between mass media and training programs, for instance. APROFAM has sought help from a reputable advertising agency to design their mass media campaigns, both educational and those for public relations purposes.

It is recommended that APROFAM look to the successes of its PIPOM effort in 1985-6 and realize that these probably occurred because, perhaps for the first time, serious and sustained attention was paid to using the mass media as an educational tool and not just a means of imparting information.

APROFAM should carefully review its print, radio and TV material to see that a balance be achieved between the population segments it seeks to reach: rural, Ladino and Mayan; urban, Ladino, lower to middle class. Good progress has been made in this area in recent years.

Likewise, APROFAM should try to achieve a balance between its literate, barely literate and illiterate population segments in the design/production of materials. Materials produced recently, such as the diarrhea and the voluntary surgical sterilization booklets, are good examples of what is needed. APROFAM should explore the possibility of installing a Video Cassete Recorder and monitor in each of the clinic waiting rooms to run a continuous program of educational material, comics for the children, etc. This might make better use of long waiting periods and serve to support the print material by reinforcing ideas using an audio-visual medium.

Pretesting of materials is like doing market research for a product, which in this case is the pamphlet or the brochure. In the pretest we try to see how the potential client views our "product", does he/she understand what it does and why to "buy" it. Likewise, in market research we would take very seriously what the client says, and so should we in pretesting of materials. The results should always be incorporated into the finished educational pieces.

In closing, it is clear that APROFAM understands the urgency of full exploitation of the educational potential of its organization in promoting family planning in Guatemala. The organizational units in APROFAM which are involved in IEC activities are proceeding with enthusiasm, along fairly well defined tracks. Overall quality of IEC is excellent and APROFAM is to be congratulated.

3. Ministry of Health/Family Planning Unit (MOH/FPU)

The 1982 project paper (PP) identifies the design and development of promotional materials as an important element for disseminating information to family planning users. For this effort, the MOH/FPU was assigned \$27,000 in the budget to produce 30,000 pamphlets that could be used by workers in health facilities to help explain contraceptive methods. The PP also indicates that the MOH had expressed a desire to produce their own material, rather than use material produced by APROFAM which, the PP observes, tended "to promote APROFAM as an organization."

The designers in 1982 also envisioned that an extensive network of 650 auxiliary nurses and two thousand voluntary health promoters and trained midwives would deliver person-to-person educational activities regarding contraceptive methods and availability of services. The 1982 PP, except for physician training for IUD

insertion, vasectomy and minilaparotomy, does not place any emphasis on the need for training of MOH staff. The budget for physician training is also included as part of APROFAM's funding, and not MOH's.

a. Information and Communication Activities - MOH/FPU

Using project funds the MOH/FPU in 1984 produced, in coordination with APROFAM, 3,000 posters, 2,500 flipcharts and 2,500 manuals for auxiliary nurses. The flipcharts and manuals have been used extensively throughout the health system; the posters are still in stock at the FPU offices. During this period, approximately 80,000 copies of 8 different pamphlets on different family planning methods designed and produced at the Social Development Center, Chicago, were donated to the FPU and distributed to health facilities in the system.

The FPU does not have a mass media campaign of any description to inform clients of the health system regarding the availability of FP services in the health facilities. APROFAM does have a radio spots which suggest that the client visit their own clinic or "your nearby Ministry of Health clinic." Funding, however, has not been provided by the Mission to the MOH in either the original project or the amendment in 1985 to finance such media activities. Funds are available to recruit and hire a local "social communicator" to assist the FPU with IEC activities. The salary provisions in the approved budget, however, are extremely low making the recruitment of qualified persons very unlikely.

A 1985 consultant report concludes that very little had been accomplished to date by the FPU in the area of IEC. The design and production of the 30,000 pamphlets never materialized. The plan to install a network of person-to-person communication by means of the nurse auxiliaries, health promoters and midwives did not become a reality. This report includes a detailed description of the functions and job descriptions of the person(s) needed to carry out the work of an IEC unit within the FPU. The only recommendation missing from this report is to suggest the implementation of a base line study in order to be able to measure behavioral changes and program impact.

2. Training Activities

As noted in the introduction to this section, very little was expected of the FPU in the area of training in the original plan for the project. In 1985, however, funds were included in the new agreement to finance training activities. Training in earnest, however, really did not begin until the Fall of 1986 and showed a remarkable increase during 1987. Indeed, more staff were trained during 1987 than had been during the previous five years. Large numbers of auxiliary nurses (855), graduate nurses (154), health technicians (152) and doctors (61) received week-long seminars which provided an overview of family planning, relevant maternal-child health material, basic contraceptive technology and so on.

Although the number of events and participants trained shows a remarkable increase, the materials used for training are quite limited. The curriculum is delivered through a series of modules which try to adjust to the needs and levels of the different categories of health workers. There is a general lack of manuals, charts, posters, motivational pieces and user handouts.

In general, the quality of the curricula was surprisingly good. A review of these modules indicates that a fair balance is maintained between strictly didactic lectures and more participatory methods such as group discussion. The educational objectives seemed clear and stated in behavioral terms. Evaluations, although necessarily not too rigorous, seemed to be valid for the objectives, as stated. FPU staff indicated that they had received some training from Development Associates in the area of curriculum design, which clearly was showing through in the materials reviewed.

Conclusions and Recommendations - MOH/FPU

The FPU has made good progress in the field of training. As noted earlier, curriculum design activities are incorporating modern pedagogical techniques and there is considerable effort to break from the traditional lecture method to using more participatory, active learning techniques. Improvements could be made in the training program by developing educational materials to accompany the modules. Technical assistance during the extension period should address this area, particularly if the decision is made to implement a "CBD-type" program using community level personnel such as health technicians and midwives to deliver family planning messages.

In need of considerable improvement, however, is the area of Information-Communication. Progress by the FPU in the area of expansion of service delivery must be accompanied by a modest, carefully designed campaign to inform the potential client of what services are available and where, with motivational messages to use these services skillfully woven into the fabric of the campaign. With the help of external technical assistance, the considerable knowledge already available in AGES and APROFAM regarding the special Information-Communication requirements of the Mayan segment can be integrated into the FPU's service utilization campaign. Considerable progress is being made by the Ministry of Health under another USAID project (520-0339) in promoting the use of child survival services, mainly oral rehydration and immunization. Under an integrated MCH/Family Planning approach, it should be possible to add family planning (birth spacing) utilization as an objective of the communications plan.

4. I PROFASA/CSM

a. Communication and Information Activities:

As a new pharmaceutical firm with a "social marketing" mission, I PROFASA's initial communications objectives were to build an institutional and product image. Their strategy was to try to reach at an early stage distribution agents and other "gatekeepers" of use of contraceptive products. Thus, targeted early in their campaigns were pharmacists, employees of pharmacies who could affect choices of the client, and doctors. Promotional activities have included: radio spots, informational material, visits to medical personnel by detailers, bonus plans for participating pharmacies; educational programs for pharmacists and their personnel; and support for selected medical congresses.

Three contraceptive products were launched in July, 1985: Scudo, Perla and Lirio. Focus groups techniques were used in March of the same year to explore client views on price of the products, names and product packaging. Screeners were also used to explore media habits of the focus group participants. Six groups were researched in Guatemala City, four in rural areas and four in other cities. Persons for the focus groups were picked at random with no written criteria established other than their earnings be at least Q 300 per month.

Follow-up groups after the initial round of focus groups were used to investigate media habits at the national level. Not established, however, were peak viewing hours and favorite commercials and programs. The literacy level of the audience was not fully researched. Groups were only asked which newspapers they read and how often they read them. Radio was identified as the appropriate medium for this group.

The promotional campaign is multifaceted, with the use of: point of purchase publicity materials, brand specific radio-spots with a general theme of happier families, compensation schemes with retailers designed to increase repeat purchases and educational seminars with retailers. An independent survey done by ASSERTA Centro America, conducted in 1986 showed that IPROFASA, one year after product launch, had achieved a 65% market share for non-ethical contraceptives (Lirio and Scudo); the following year's ASSERTA survey showed a 72% market share for the same products (January 1987). The survey also showed that IPROFASA products were being purchased by the targeted C and D class consumers -- 95% of Lirio buyers and 75% of Scudo were lower income clients. In terms of Perla, the ASSERTA survey showed a market share of 1.6% for 1986, and a 3% share in 1987. The 1987 increase in market shares for Lirio and Scudo are impressive and indicate that both training and promotional efforts have had significant impact. It should be noted, however, that one of IPROFASA's objectives is to expand the market by reaching new clients and thus increase both market and market share. The Perla market share increase is also significant, especially when taking into account the prime target of health care providers (doctors and perhaps pharmacists or other specialized medical personnel) which must be convinced of the advantages Perla presents against other traditional brands.

The composition of the print material thus far produced by IPROFASA is consistent with its "two-tiered" communication strategy. The quality of the material compares favorably to similar material produced to support private sector initiatives in Guatemala, and in other CSM initiatives funded by USAID in Central America. The prime targets of IPROFASA, as mentioned earlier, are doctors, pharmacists and other gatekeepers to the end user. Thus, it is appropriate that some materials are aimed at an urban upper middle class population. The following is a review of print media.

1. Brochure - Nacimos para un Solo Beneficio - depicts a group of white Guatemalans, possibly students, on the cover. The

inside text never mentions family planning products. Next page shows a group of Mayan women and children.

2. Brochure - with the same title - cartoon of a family. Nine printed pages - target audience unknown. Probably too expensive for general distribution.
3. Booklet - What Every Couple Should Know. The booklet gives good information to a literate audience. All methods are discussed. It is fashioned after booklets distributed in the USA. The chart on methods is complicated and hard to read.
4. Booklet - Magazine format aimed at wholesalers and distributors. Cover shows young middle class couple; image appropriate for target audience but not for motivating the end-user of family planning methods.
5. Contraceptives - What is Social Marketing - aimed at medical profession. Describes methods and products.

The above analysis demonstrates that IPROFASA has been consistent with their objectives of trying to reach the first level of a "two-tiered consumer": ((doctors/pharmacists)(end users)). To try to reach the end user, IPROFASA has also produced radio spots with product information aimed at couples. The impression given by the spots and print material is that the couple is married and therefore a legitimate target for the use of these products. The radio spots are reinforced by print in newspapers and advertising on buses.

The 1988 Business Plan prepared by IPROFASA cites concern over their publicity campaign. They express concern over possible criticism that might arise from conservative and religious groups. Yet there is no written Public Relations plan to counteract these possible attacks.

During 1987, IPROFASA carried out a study designed to provide a better understanding possible marketing approaches that could be successful in reaching the Mayan groups in Guatemala. Overall, the study revealed that: (1) the vaginal tablet may not be an

appropriate product for marketing in this population segment, because of cultural differences regarding the genitalia; (2) educational materials must be produced in the Mayan languages; and (3) the packaging of the products must be appropriate to the Mayan context. During 1988, IPROFASA plans to develop and implement different marketing strategies in Mayan areas to test the relative efficacies of these in reaching the Mayan consumer. (See Annex G for details of marketing study of several Mayan groups).

b. Training Activities:

Since product launch, IPROFASA has carried out a number of activities in the area of training. These activities are divided into two categories: 1) training of pharmacy personnel; and 2) in-service training of IPROFASA staff.

The IPROFASA training strategy recognizes the importance of building institutional credibility among one tier of consumers (pharmacists) while at the same time providing information on family planning issues and also, on the brands the CSM project would be marketing. IPROFASA designed "Reuniones de Ablandamiento", which consist of seminars with pharmacy personnel to explore issues such as the need for family planning, methods for family planning, advantages and disadvantages of specific methods and products available for contraception. A total of 873 persons attended 41 seminars, about half of which were held in the capital and half in the interior during 1986 and 1987. During 1987, a slide presentation developed in 1986 was modified based on a critical review of its prior use. Plans for 1988 include an expansion of these seminars.

IPROFASA provided limited in-service training during 1985, focusing primarily on the upgrading of sales skills. During 1986, IPROFASA again provided sales training but also added training in computer use.

Conclusions and Recommendations - IPROFASA

As confirmed in the PSI Evaluation, IPROFASA is carrying out a generally effective marketing program. Sales have significantly increased since launch and the products presently in the line are effectively positioned in the market. IPROFASA is becoming a very

respected name in the pharmaceutical trade for quality products, good service, reasonable prices and quality advertising. Thus far, as observed earlier, IPROFASA has succeeded in penetrating the urban and rural Ladino markets.

Much more challenging will be the Mayan market. A very good start is the marketing study among the Mayan population carried out in 1987. A great deal of useful information should come from this study which should be shared more completely with other agencies in this project.

The PSI evaluation in 1987 concluded that IPROFASA's advertising intensity could be increased. The 1988 business plan expresses concern, however, that there are serious risks inherent in an overly aggressive campaign. This evaluation tends to agree with PSI's conclusion, and it may be that IPROFASA's policy may be overly conservative in this regard. There has been no adverse criticism since the launch of the first advertising campaign in August of 1986. It is also true that a good advertising firm can, because of the nature of their work, be a good barometer for the client, in this case, IPROFASA. The firm under contract, with guidance from the IPROFASA Board, should be required to develop advertising plans which systematically and gradually increase the intensity levels, both in terms of frequency and message content, keeping very much in mind the nature of the product and the potentially volatile environment in which IPROFASA operates.

The training activities for pharmacists and their staff have been remarkably successful in promoting an institutional image for IPROFASA. The quality and frequency of these training events could be increased with a minimum of effort and with maximum return.

V. OVERALL RECOMMENDATIONS FOR PROGRAM DIRECTIONS 1989-1991

"Expansion of Family Planning Services" is a successful project with regard to both planned and unplanned results. A very solid basis for program continuation and expansion has been built. As in all human endeavor, there are always improvements and adjustments possible -- some cosmetic and others substantive -- but all useful in optimizing the impact of the investments on the lives of the beneficiaries and rendering the project a more satisfactory experience for the implementing agencies and donor alike.

In this section, we provide, in summary form, team reflections on a number of issues which we consider important to the USAID Mission in planning the amendment to this project, including the very fundamental question of integrating family planning into health services. Also presented are our thoughts on the prospects for continued support and/or expansion of assistance to current grantees and the possibility of inclusion of other service delivery mechanisms. Finally, we provide a statement on the technical assistance requirements during the amendment period.

A. Integrating Family Planning into Health Services

Discussions with USAID officers and a review of the Action Plan indicate that the Mission believes it to be advantageous to move Maternal/Child Health (MCH) and family planning closer together in operational terms over the next three years. In practical, project design terms, this means including selected clinical health services in what is now a largely monovalent (single service) family planning program. This policy would, of course, primarily affect APROFAM and the MOH as they are the only agencies currently in the project with clinical service programs. The 0288 project would then serve as a "bridge" or transition into a new project starting in 1991 which provides for full integration of the two areas -- health and family planning -- into a single functional project area defined as "Family Health". The evaluation team analyzed the proposed course of action at length and concurs that it has both technical and political rationale that strongly support this decision.

Technical Rationale:

Experience and carefully controlled studies have shown that there is no longer any doubt that the effectiveness of both sets of

services -- family planning, on the one hand, and health services, on the other -- is greatly increased when they are integrated in rational, systematic ways. Program efficiency (lower costs per unit service) is also cited in the literature as improved by these actions.

Common sense also suggests that if health services are "packaged" or provided in such a way as to deal with the entire family -- at least the mother and her children -- at the same time in the same clinic setting, that efficiencies would accrue both for the mother (who has probably travelled a great distance at significant personal cost and/or discomfort) and the service providers themselves. Studies have also shown that integrated services were more effective in recruiting family planning acceptors than family planning services by themselves.

Related to the "packaging" issue is the programmatic logic of being able to organize sets of services which deal with the whole range of health problems experienced by the woman -- as a woman and as a mother -- which help her lead a healthier life before, during and after pregnancy. This set of services could be cast in terms of "reproductive risk", which operationally means: (1) helping a woman regulate her fertility so that she becomes pregnant during the safest reproductive periods of her life; (2) once pregnant, help the mother have the safest possible pregnancy, both for herself and for the unborn child; (3) minimize risks during delivery; and (4) minimize the risks during the immediate post-partum period for both mother and newborn.

On a sociobiological level, recent research and experience clearly indicates that child survival and family planning are closely interrelated. Child survival is a key variable in fertility, as the "demographic transition" so often referred to is affected not only by factors such as contraceptive use, literacy and socioeconomic status, but also by the expectations parents may have of their children reaching maturity and economic productivity. At the same time the survival of the child is related not only to immunizations, ORT and other child health services, but also to family size, the length of birth intervals, breast feeding and weaning practices.

Family planning also prevents maternal deaths. Child bearing is far safer if pregnancy and delivery are monitored and if certain conditions are met: 1) the mother is over 18 and under 35; 2) the

mother has had fewer than four births; 3) the mother's last birth has not been within two years; and 4) the mother does not have existing health problems which would be aggravated by pregnancy. To end pregnancies they did not plan to have and do not want, many women every year have abortions in Guatemala. Because abortion is illegal in Guatemala, the number of maternal deaths due to abortion can only be roughly estimated. Nonetheless, probably up to half the maternal deaths in Guatemala are due to abortion related complications, deaths which family planning can significantly reduce.

In terms of project planning, moving MCH and FP closer together makes the design process easier in a number of ways. First, it provides a comfortable focal point -- mothers and children -- for both public and private institutions which allows definition of politically defensible goals and purposes for project activities. Second, the MOH routinely collects data on all the required indicators including infant and maternal mortality, fertility related childhood diseases as well as other statistical data which will facilitate measurement of project progress. These data may be of uncertain reliability, but it may be easier to improve this dimension than to try to develop new data gathering mechanisms.

Thirdly, the IEC messages become easier to research, design and deliver. We do not believe the messages now being delivered to potential users should be abandoned. While it is probably desirable to make adjustments in their content, they have, after all, succeeded in gaining a large number of acceptors. Nevertheless, there may be many couples who have not yet accepted family planning but who might decide to do so if convinced that child-spacing will improve the health of all members of the family unit.

One area which the Mission may wish to monitor closely in the process of gradual integration of FP and MCH services is the extent to which there is a perceived problem in having an agency such as APROFAM, whose image is clearly identified with family planning, delivering health services as well. In other words, will the client(s) tend to confuse the negative images that family planning detractors have used with the potential usefulness of immunization or oral rehydration therapy, thereby reducing utilization of the latter. In the Guatemalan context, the question may be real and should be followed during the course of the three-year extension. Other experience in different cultures (Narangwal) suggests that health services tend to increase the recruitment of family planning acceptors, with no sacrifice in quality and quantity of health services. The literature does not shed any light, however, on the effects of family planning on the "recruitment of health service acceptors."

Political Rationale:

In view of the controversial, politicized nature of family planning in Guatemala, it is not surprising that the government has been timid about embracing it and perhaps the corollary, that the Mission has decided to deal with the population growth problem using a predominantly family planning approach, as opposed to a population growth reduction model. It is much more defensible -- for both the host government and USAID -- to cast the program being financed by the U.S. Government as one which supports individual decisions and those of couples to space the births of their children or limit family size. A related matter is the decision by the Mission to promote the integration of family planning into the cluster of "maternal and child health services". If family planning is part of, not separate and distinct from, the rest of the services one receives at the health clinic, it becomes less vulnerable to the violent political swings that may occur in Guatemala.

Family planning as a means to improved health offers the likelihood of lessening the incidence and impact of adverse political factors which are outside the control of project managers and implementing agencies. For example, the Church might well find family planning to be more acceptable if presented as a means to improve the health status of mothers and children. By the same token, opposition political forces might find it less useful politically to attack family planning programs that are presented in this light.

There is little doubt that political factors play an important role in family planning projects in Guatemala. We found many references to the political controversy surrounding the issue and the impact of national politics of family planning initiatives, public or private. It is clear also that Guatemala's political system has been rather unstable, particularly over the last decade. Consistent public policy is hard to elaborate and maintain during period of political instability because of the climate of uncertainty and turnover in political and administrative leadership -- family planning policy has suffered from this instability.

Also, because of the de facto, imposed character of many of the military governments in recent decades they were arbitrary in their policies. We found many reports that family planning policy, which experienced several abrupt shifts, reflected the personal views of the president and his minister of health rather than public preferences or the position of political parties.

B. Areas of Continued USAID Support

USAID should continue to support the three institutional components that are delivering services that is, APROFAM, MOH/FPU and IPROFASA. Special support is needed in the short term for the MOH/FPU in providing systematic improvements to their management systems: logistics, supervision, service data. With the increase by nearly double the number of health areas being served by the FPU, this special support becomes important. The extension design team should look carefully at possibility of expansion of delivery services by the MOH/FPU through additional outreach by a CBD activity involving volunteer promoters such as midwives as well as auxiliary nurses and Rural Health Technicians. These workers would be trained initially to provide acceptors with education on family planning within the context of basic MCH. Subsequently, these workers could be gradually phased into actual distribution services, following an adaptation of the APROFAM model.

Under the project extension, support for the MOH's integrated MCH-FP program, presently largely on paper, should be strengthened in the areas suggested in the Technical Rationale section given earlier. The environment may now be appropriate to begin phased support to the MOH's clinical contraception program, particularly the post-partum surgical contraception and IUD insertion. The latter, IUD insertion, has begun to be implemented slowly in health centers with no political backlash to date.

For APROFAM, expansion of the present CBD outreach carrying a child-spacing MCH message, plus increased numbers of clinics offering "full service" in rural areas should be planned and continued support provided. Expansion of the CBD program should strongly emphasize, perhaps be limited to, the Mayan areas of the country where the greatest unmet need is located. The evaluation shows a strong correlation between increased CBD and clinical outreach and increased acceptors. Hence, we recommend maximum use of these service delivery modes.

With regard to IPROFASA, we encourage the Mission to continue efforts to move the project away from the concepts of "experimental nature" and "financial self-sufficiency". Easing of these conditions on performance will enable IPROFASA to more effectively fulfill its mandate as a social marketing institution. As recommended by PSI in 1987, product diversification should support the institutional image

of IPROFASA as a provider of quality health and health-related products. As with the other implementing agencies, programmatic emphasis should continue on reaching the rural and Mayan segments of the population. Finally, the Mission may also wish to explore the idea of strengthening IPROFASA's capacity to market "concepts", in addition to products.

The original project design cited an estimated 30 small private organizations (PO) which had expressed interest in including FP services in their regular activities. During the evaluation, conversations with persons connected with various project areas indicated that this idea should be reexamined. The Stony Brook study described by USAID staff indicated that an assessment of alternative private sector models for health service delivery to farm workers was carried out and that these results would be available to the extension design team. It is assumed that the Stony Brook study looked at structural and management capacities of a number of existing service delivery mechanisms so that these could be considered in the extension of this project. The extension design team, in addition to reviewing the potential of these private sector delivery arrangements, should also examine the management burden implications on the Mission of entering into agreements with one or more service delivery agencies. Other management options should be considered, such as the use or creation of an "umbrella" PO which could manage USAID funds destined for smaller PO's interested in providing the "integrated service package."

An area which needs to be explored and perhaps addressed in the extension by APROFAM's PIPOM activity is general support for activities of the population subcommittee of the National Health Commission. These influential legislators, mostly physicians, appear to be motivated to learn more about the relationship of population dynamics on economic and social development. A small amount of funding could be provided to finance observation travel by legislators to Guatemala as well as to other countries. Another activity might be a national level seminar to discuss broad health issues which have an impact on Guatemala's development.

Increased acceptance and coverage of Mayan speakers has long eluded the efforts of Guatemalan and foreign donors alike. The remarkable progress made in such a short time in this area by AGES should continue to receive Mission funding support and encouragement. AGES' activities may well be the key to reaching this segment of the population which is in greatest need for education and

for services. Again, as in the case of the service delivery function the experiences of 1982-87 have provided us with greater insights on how to measure progress in this very important area. More carefully kept statistical data by all the service delivery agencies on all population segments is necessary.

C. Technical Assistance Requirements

Technical assistance to the agencies currently being financed by the project should consist of some combination of the following:

- a. A full time IEC consultant with a background in marketing research who will work with all the components on a continuing basis. While the Mission received excellent technical short-term assistance during 1982-87, lack of Mission expertise in this highly complex area prevented optimal development and effective follow-up in this area.
- b. Continued technical assistance, such as is presently being provided on both long-term and short-term basis is considered essential for IPROFASA. IPROFASA is still growing and maturing. With the upcoming market penetration into Mayan areas, this agency will need assistance.
- c. MOH/FPU, with the need to now provide delivery services to the entire country, will be facing many problems. This will require an expansion of their entire logistics system -- ranging from ordering commodities offshore to delivery at health posts and centers. We recommend consultation in the program management areas of: service delivery systems, supervision, statistics and recordkeeping, management and administration.

The Mission may wish to explore the modality of providing UNFPA with financing for this technical assistance. This approach has the advantage of assuring greater emphasis on family planning programs by UN funds, while at the same time assisting the MOH in the areas listed above.

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All of these consultants would be long-term (one year or more). In all probability the need for short-term consultants in specialized areas within the above competencies would become apparent during the project planning exercise.

VI. ANNEXES

ANNEX A

PERSONS INTERVIEWED

<u>Person</u>	<u>Institution</u>	<u>Position</u>
Dr. Roberto Santiso	APROFAM	Director
Dr. Victor Hugo Fernández	APROFAM	Program Coordinator
Dr. Carlos Contreras	APROFAM	Medical Director
Ms. Sara de Molina	APROFAM	Director Community Based Distribution
Mr. Edilzar Castro	APROFAM	Director IEC
Ms. Sara Tercero	APROFAM	Director Communications
Ms. Ma. Cristina Rosales	APROFAM	Video Production Center
Ms. Ma. Antonella Pineda	APROFAM	Director Evaluation Unit
Mr. Roberto Ipiña	APROFAM	Financial Director Supply Section
Mr. Manolo Solórzano	APROFAM	Reproductive Health Program
Mr. Guillermo Flores	APROFAM	Administrative Surgical Contraception Program
Dr. Rubén Velazco	APROFAM	Director Training
Dr. Raúl Rosemberg	MOH/FPU	Director
Mr. Haroldo Vargas	MOH/FPU	Administrative Chief
Lic. Mario Coll	I PROFASA	Board of Directors
Dr. Rodolfo McDonald	I PROFASA	Board of Directors
Lic. Jorge Mario Ortega	I PROFASA	General Manager
Mr. Regino Chávez	I PROFASA	Juarez & Assoc.
Contractor		
Dra. Elvira Ariano	AGES	Training Office Director
Lic. Eugenia Monterroso	AGES	Director
Lic. Gustavo Castellanos	AGES	President of the Board of Directors/Director of Education and Communications
Ms. Liliana Ayalde	USAID	Gen. Dev. Officer
Mr. John Massey	USAID	Hlth/Pop. Officer
Ms. Jayne Lyons	USAID	Liaison Officer
Ms. Barbara Vielman	McCANN ERICKSON	
Mr. Miguel Fitz Patrick	McCANN ERICKSON	
Mr. Eric De Mul	UNDP	Country Representative

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ANNEX E

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**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project
From FY 83 to FY 86
Total U. S. Funding \$8,586,000
Date Prepared: May 28, 1982

Project Title & Number EXPANSION OF FAMILY PLANNING SERVICES - PROJECT 520-0288

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Sector Goal: The broader objective to which this project contributes: Improve socio/economic welfare of poor by increasing access to F.P. services information.</p>	<p>Measures of Goal Achievement: Decrease of birth rate from 41 per 1,000 to 36 by end of project.</p>	<p>National studies to be done in 1982 and 1986 based on 1978 National Contraceptive Usage Study data.</p>	<p>Assumptions for achieving goal targets: The population perceives the importance of F.P. as a basic need.</p>
<p>Purpose: Expand availability of family planning services through public, private, commercial sector activities.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status. Current family planning users in activities funded by project increase to 500,000. GOG, APROFAM, and Private Sector coordinating family planning effort. Acceptance of family planning in rural areas increases in proportion to urban.</p>	<p>National Contraceptive Usage Studies in 1982 and 1986 providing analysis by Urban & Rural Areas. Service statistics by private and public sector participating institutions.</p>	<p>Assumptions for achieving purpose: GOG support of family planning as part of the National Health Plan and consequent GOG willingness to participate actively in F.P. Private sector organizations continue to participate in F.P. activities.</p>
<p>1. F.P. services and counseling available in all MCH health facilities. Family based F.P. services established in rural areas not having access to MCH fixed clinics. 2. Contraceptives readily available at affordable prices in retail outlets throughout the country. 3. Information on family planning available through mass media.</p>	<p>Magnitude of Outputs: 1. 650 MCH facilities, 8 APROFAM clinics, 500 community based distributors and 30 identified PD's providing F.P. services. 2. Contraceptives available at reduced prices in 1,200 commercial pharmacies and 5,000 retail sales outlets. 3. 95% Ladino and 85% Indian populations aware of F.P. services available in their area.</p>	<p>1. MCH statistics APROFAM statistics. 2. CRS Sales Records. 3. MCH management info. system. 4. Routine reports of APROFAM Indian monitors.</p>	<p>Assumptions for achieving outputs: 1. All facilities providing services are staffed by trained personnel and receiving necessary MCH support. 2. No GOG curtailment of information campaigns. 3. No major disruptions in commercial sector.</p>
<p>Contribution Contribution Donors</p>	<p>Implementation Target (Type and Quantity) AID - SERVICE \$ 6,681,000 IEC \$ 1,925,000 AVS \$ 1,243,000 IPPF \$ 1,937,000 UNFFA \$ 1,952,000 GOG \$ 3,550,000 Others (combined) \$ 2,001,000</p>	<p>Review of project financial records. AID project agreements; other donor project agreements.</p>	<p>Assumptions for providing inputs: Inputs are made in a timely fashion. Continued other donor willingness and capacity to meet commitments.</p>

ANNEX D

- 1) Chart on CBD Distribution Points
- 2) Number of New Acceptors - CBD Program
- 3) Total Distribution of Contraceptives by method - CBD Program
- 4) Couple Years of Protection - CBD Program
- 5) Home Visits CBD Promoters
- 6) Couple Years of Protection - Direct Distribution Program
- 7) New Users of Clinical Services
- 8) Couple Years of Protection - Clinical Services
- 9) Couple Years of Protection - Surgical Contraception
- 10) Total number of Surgical Contraceptions Performed
- 11) Total New Users - Temporary and Permanent - Male and Female
- 12) Total New Users - All Programs
- 13) Total New Users by Year
- 14) Couple Years of Protection - IPROFASA
- 15) Couple Years of Protection - All Institutions
- 16) Organization Chart for CBD Unit

Chart No. 1

Total Puestos

de DCA

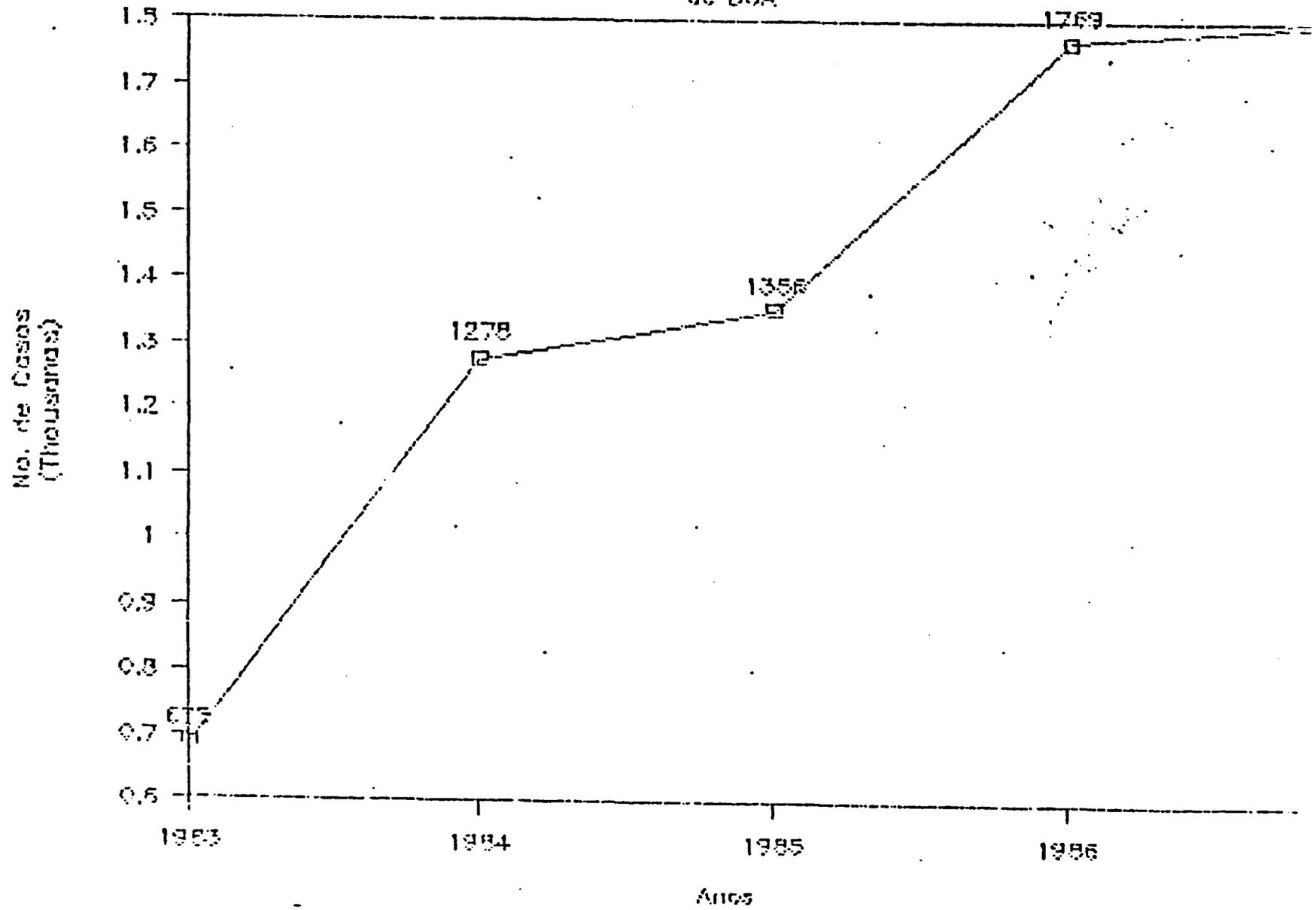


Chart No. 2

Numero de Nuevas Aceptantes

de DCA

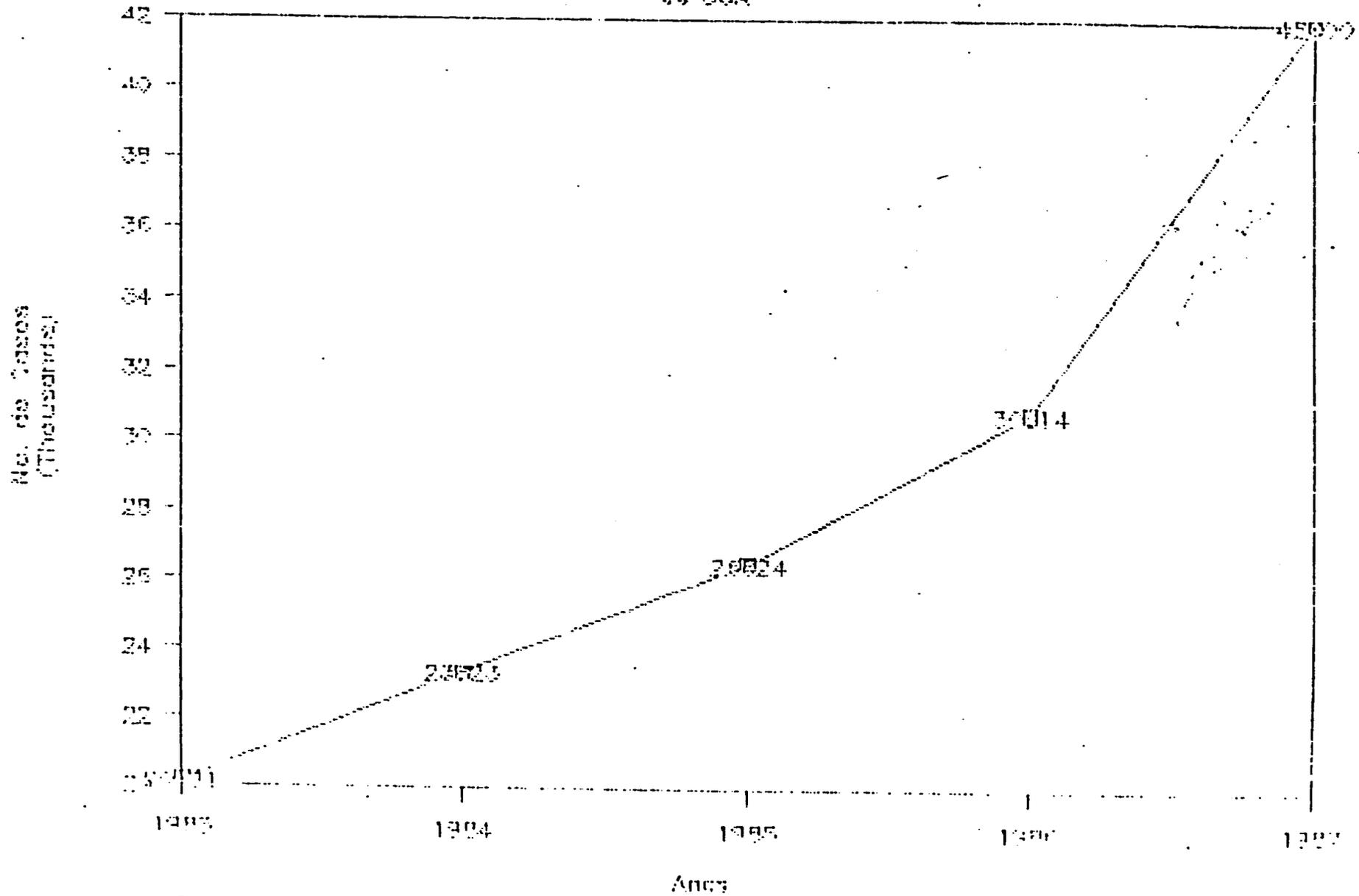
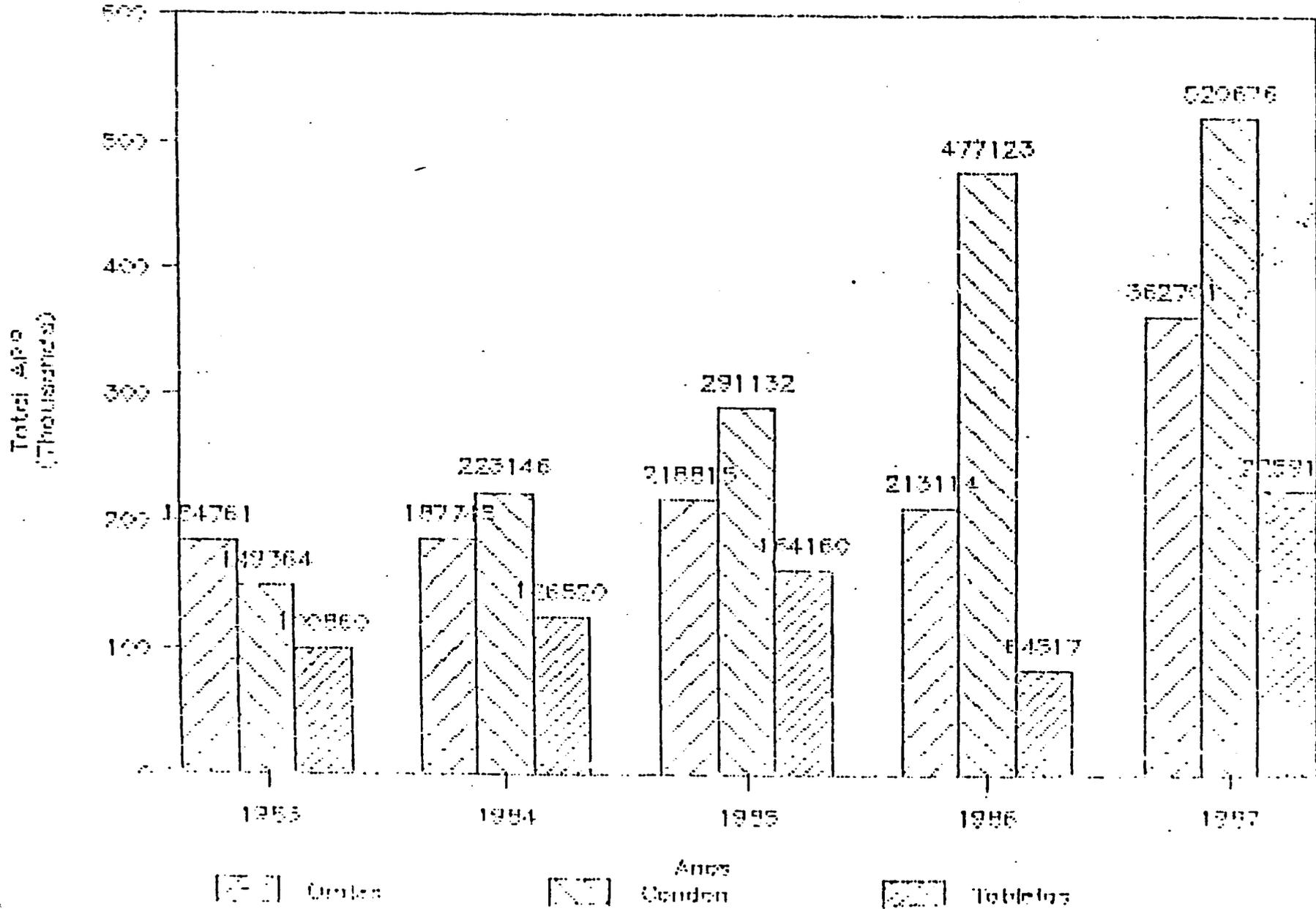


Chart No. 3

Total de Metodos Distribuidos

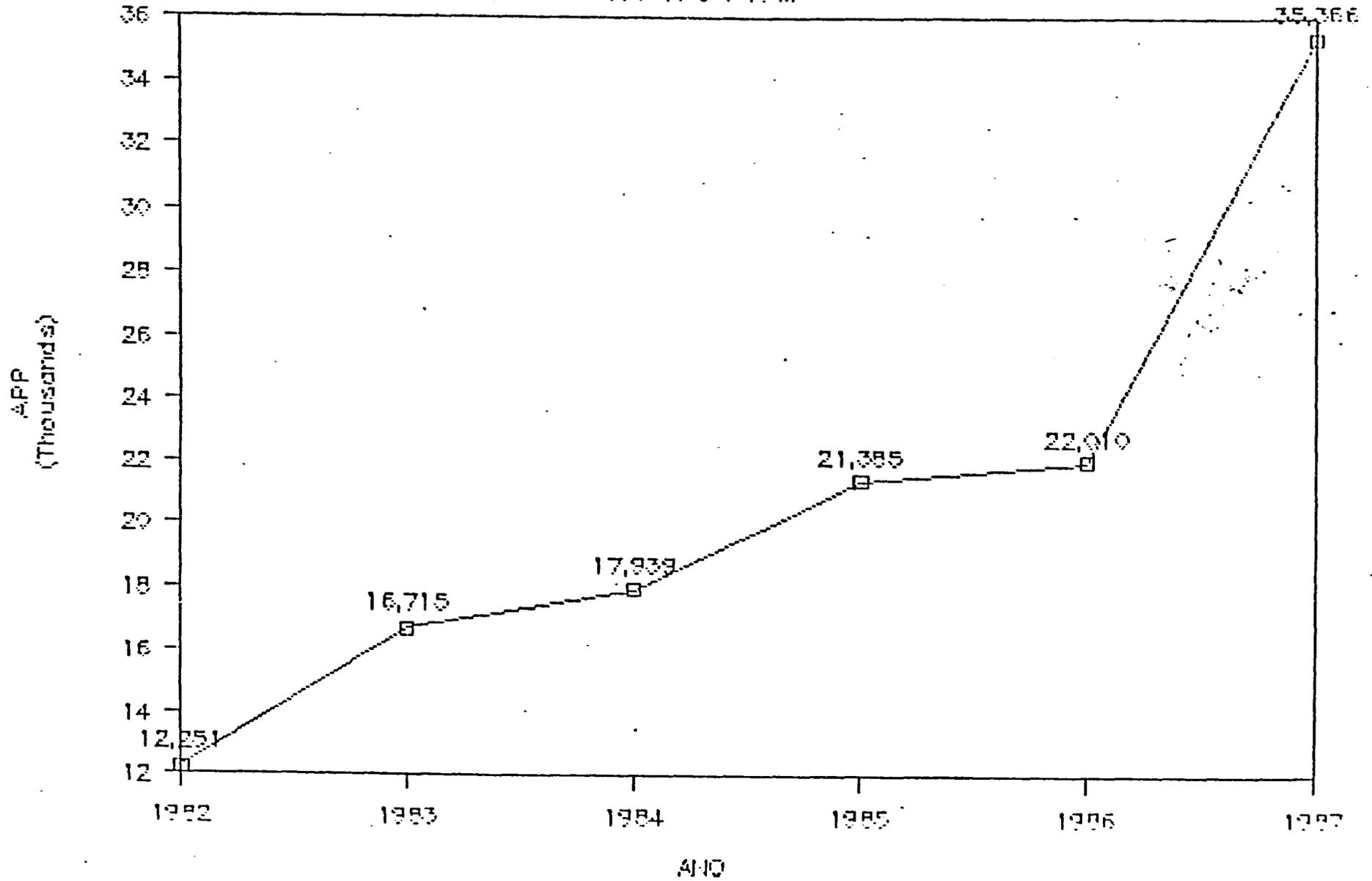
DCA



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AAP DEL PROG. DE DCA

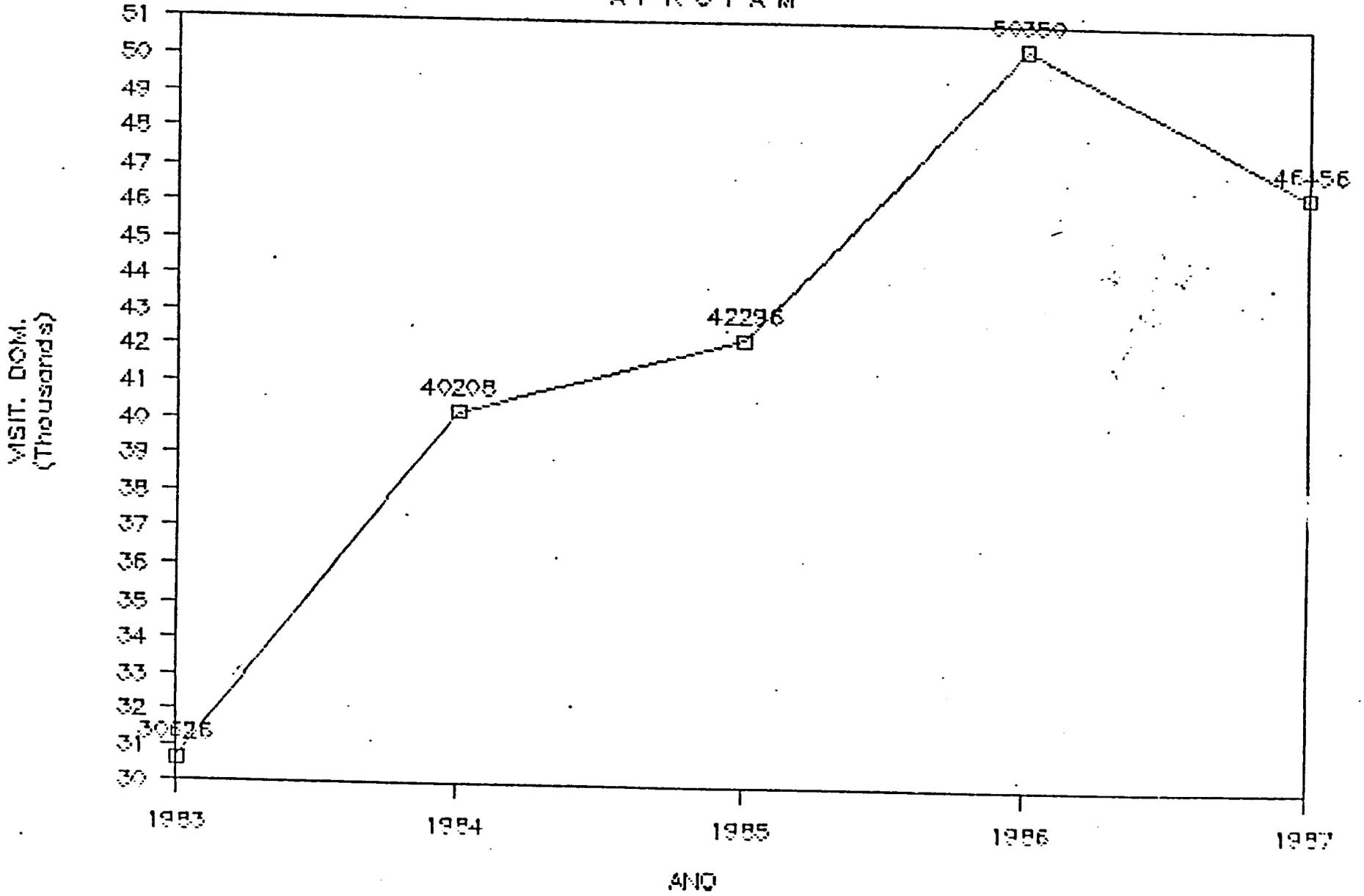
A P R O F A M



69

Chart No. 5

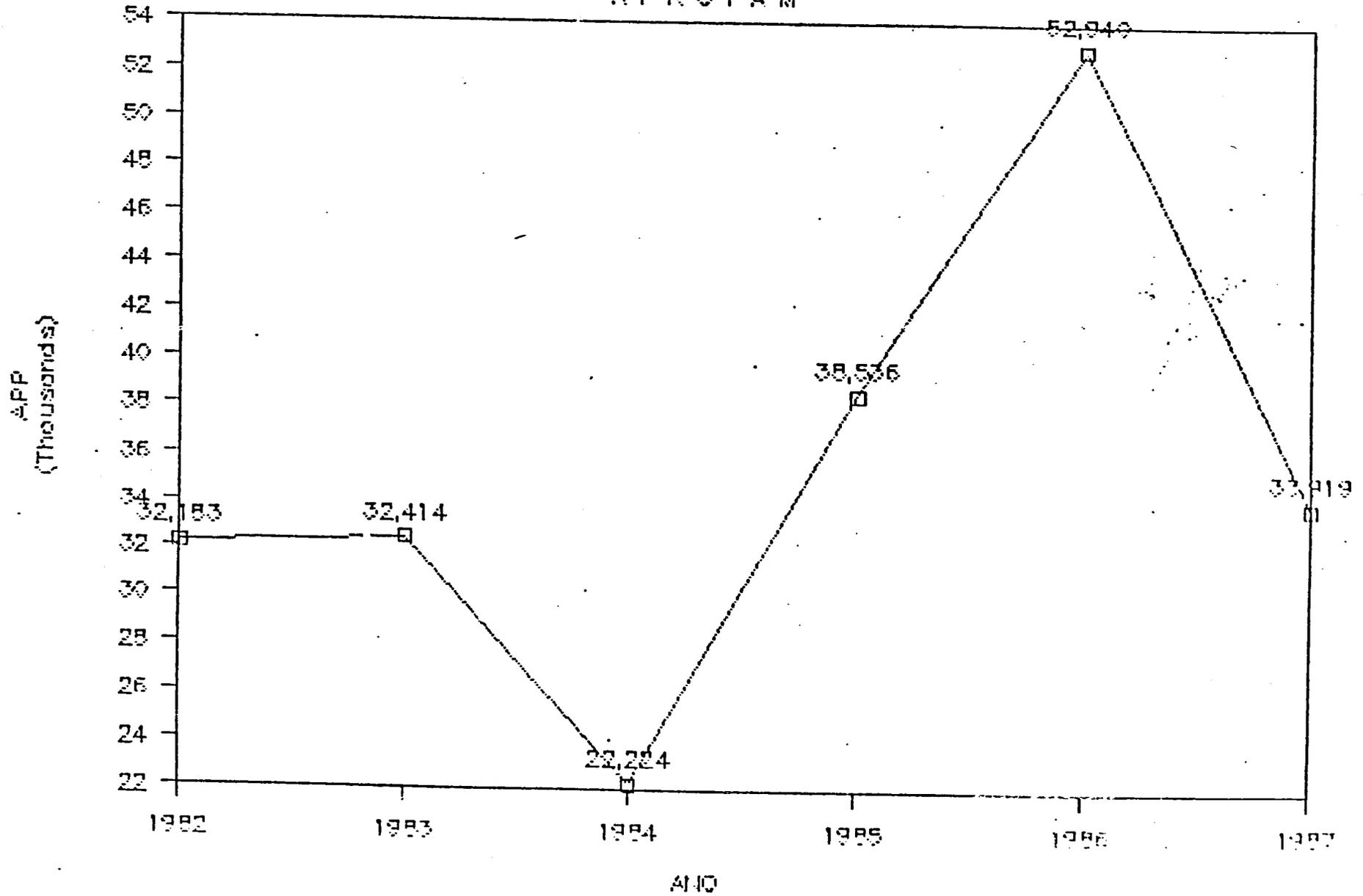
VISITAS DOMICILIARIAS DEL PROG. DE DCA A PROFAM



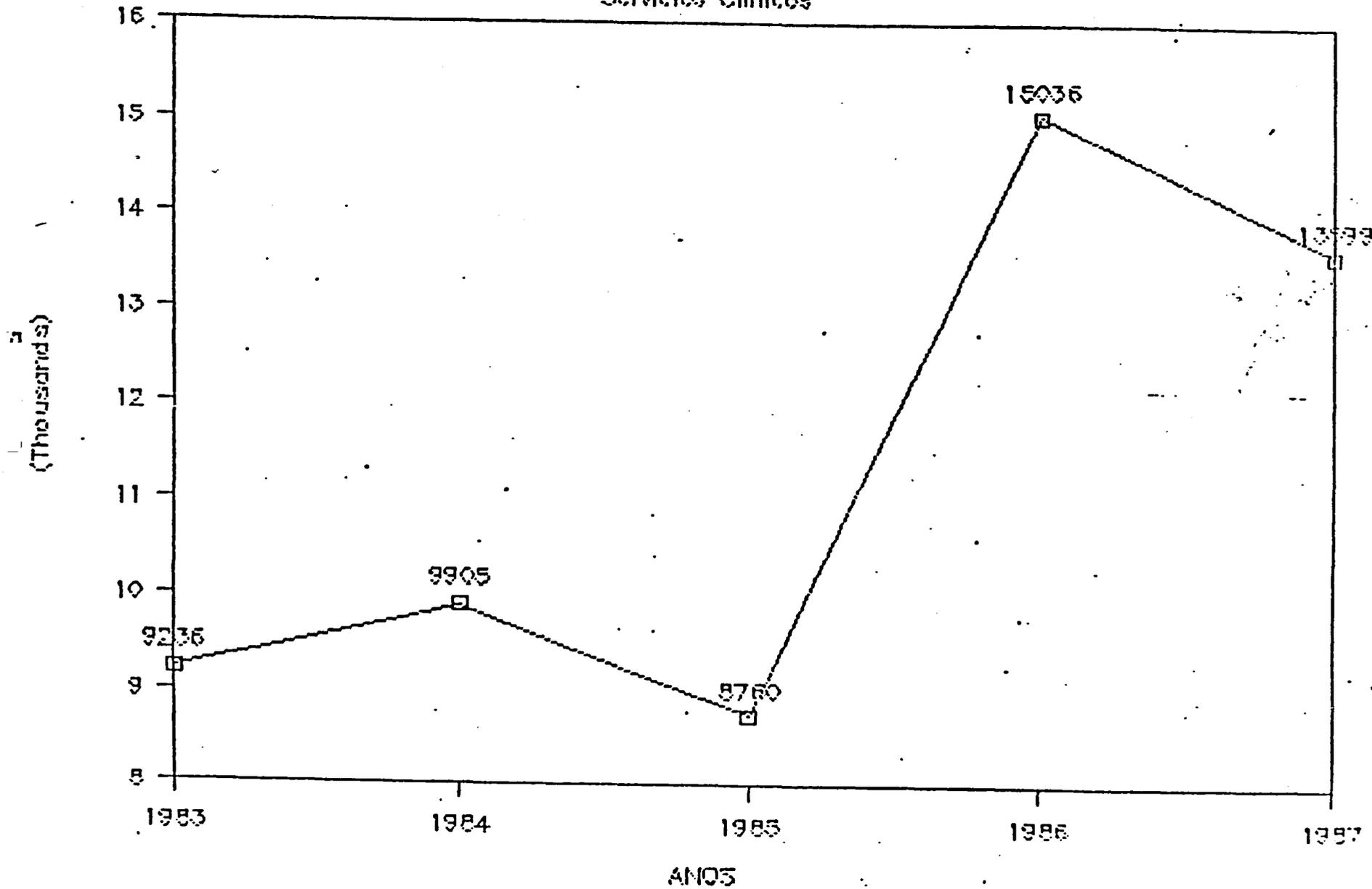
74-

APP DE D.D. Y OTROS PROGRAMAS

A PROFAM



Total de Usuaris Nuevas de Servicios Clinicos

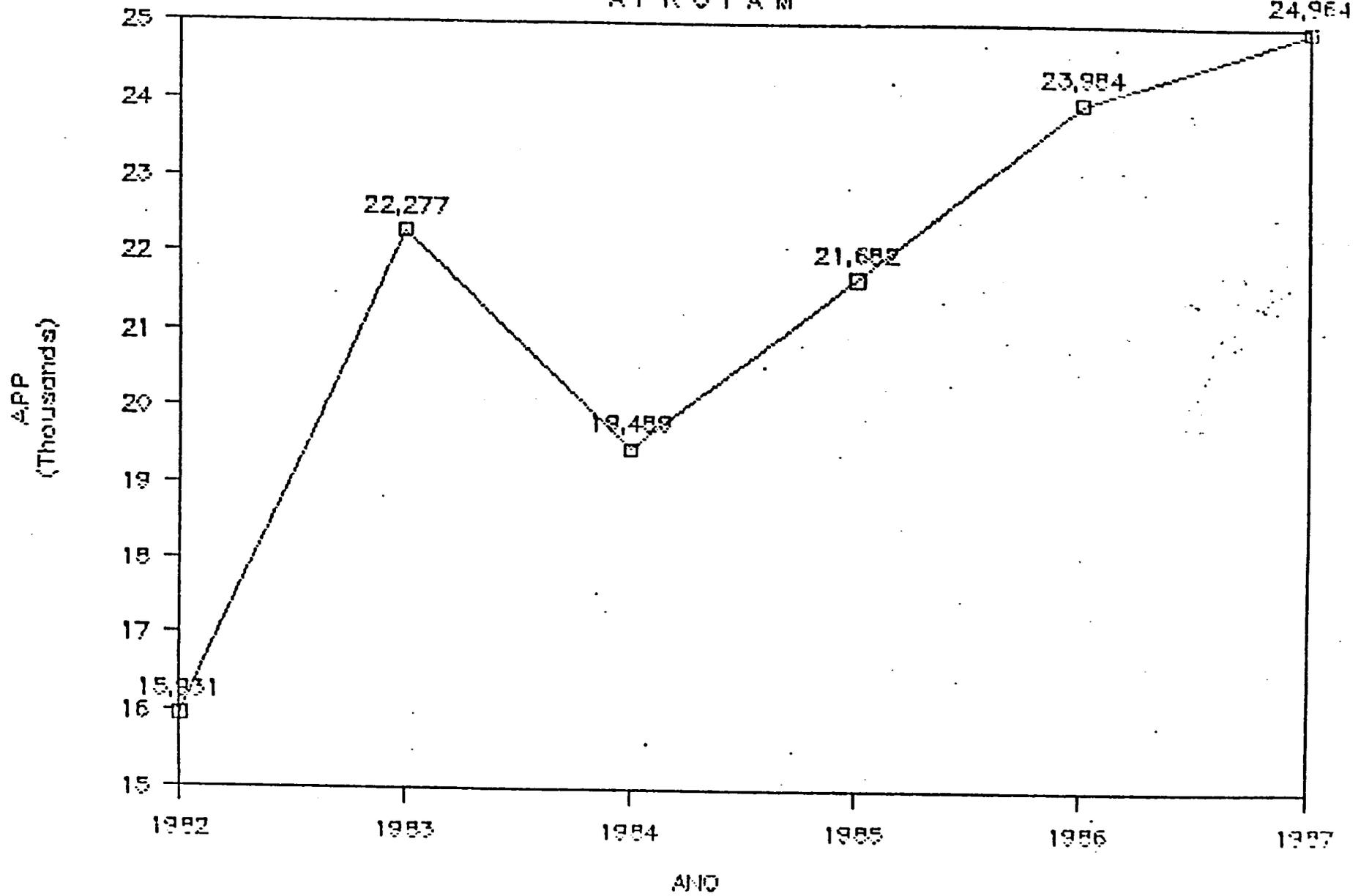


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Chart No. 8

APP DE LOS SERVICIOS CLINICOS

APROFAM

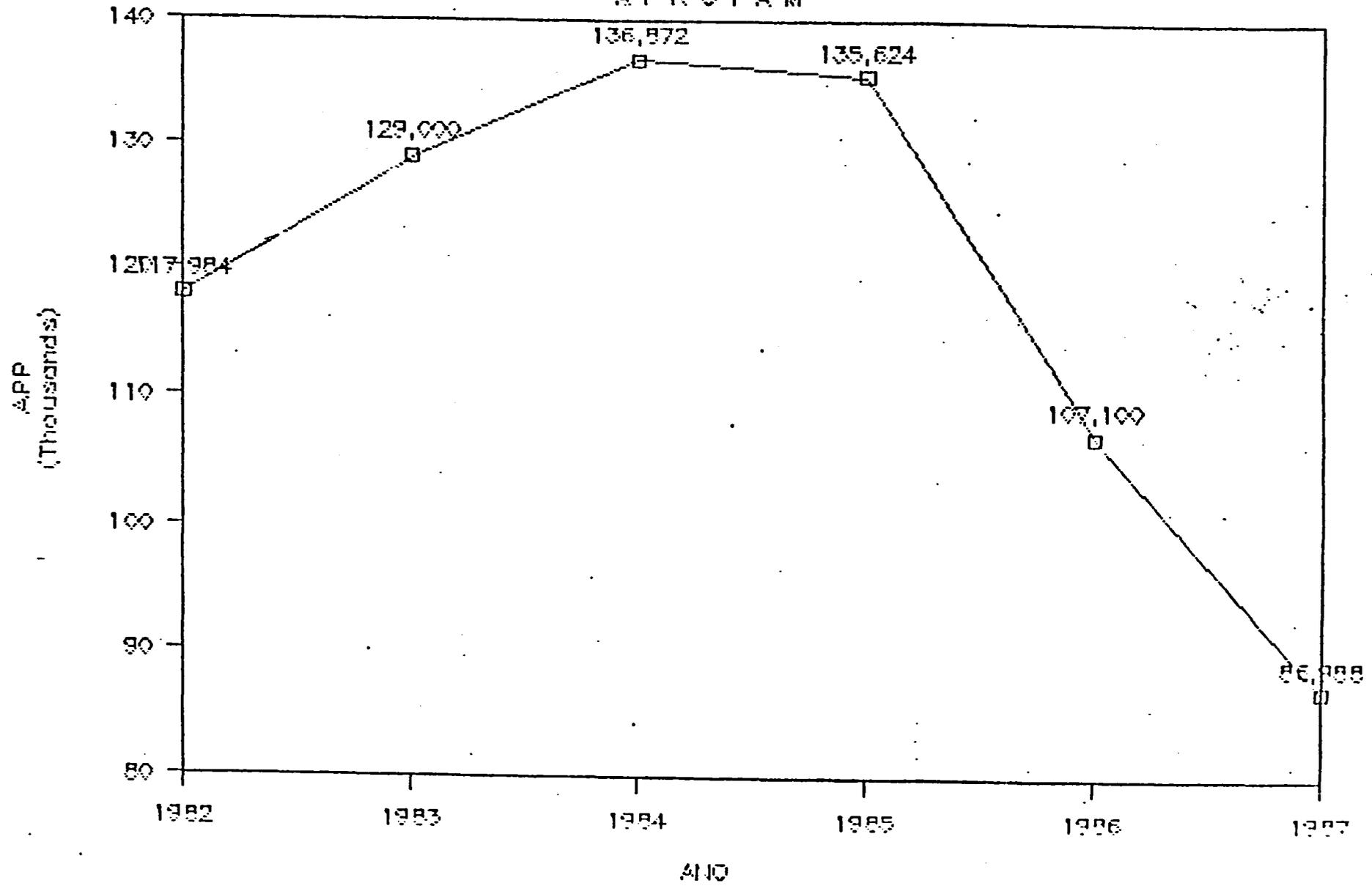


77

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APP DEL PRG. QUIRURGICO

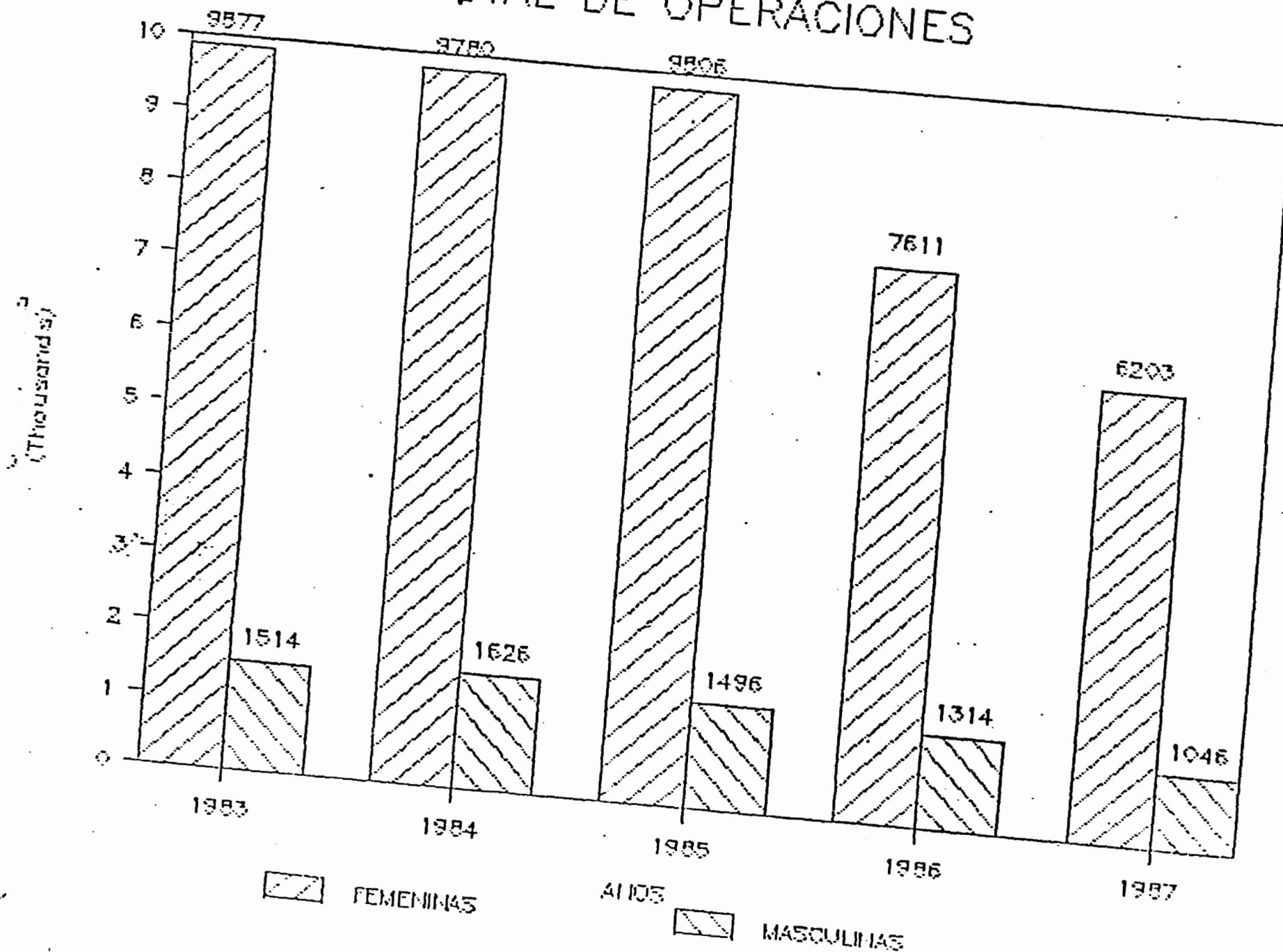
A PROFAM



72

Chart No. 10

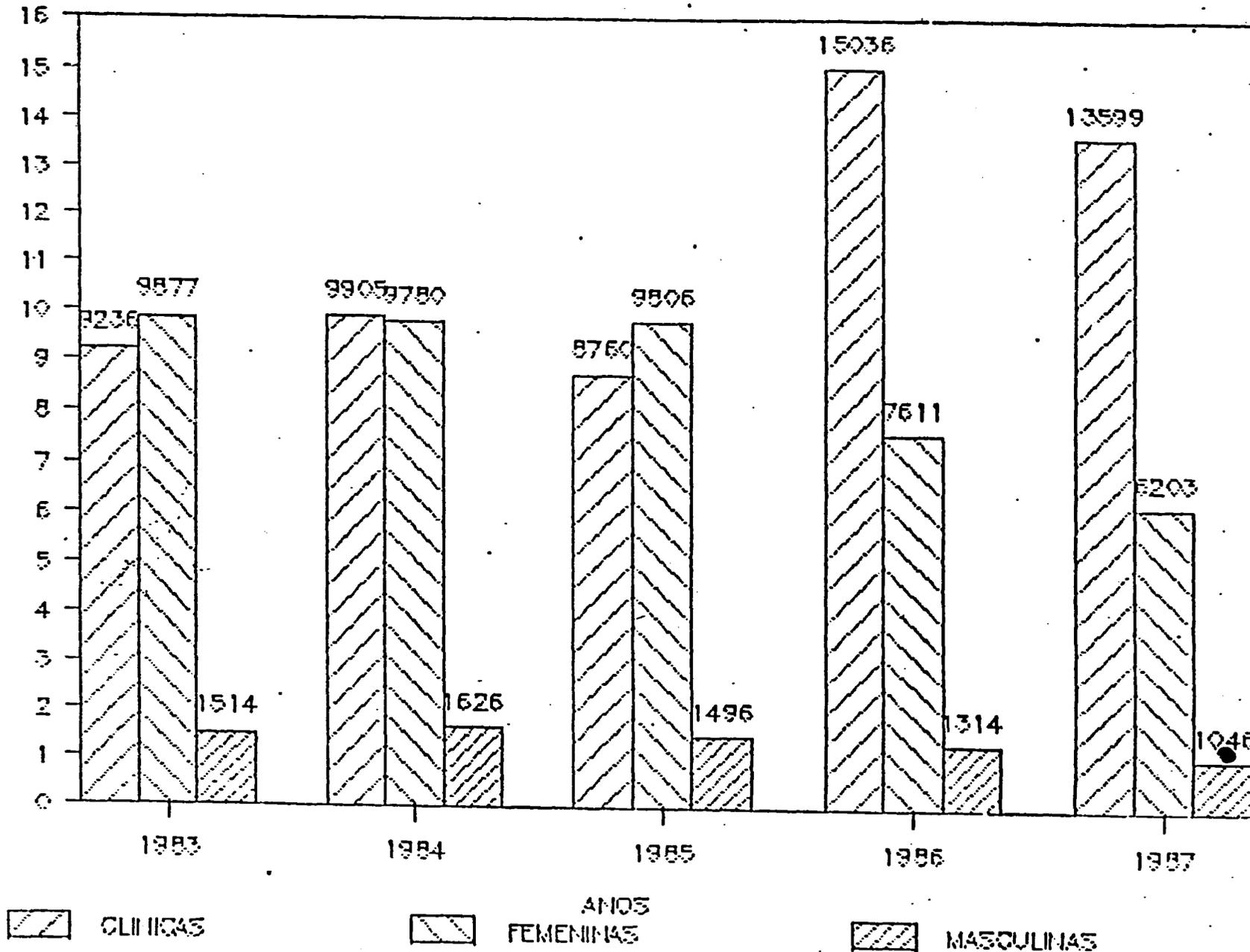
TOTAL DE OPERACIONES



19/

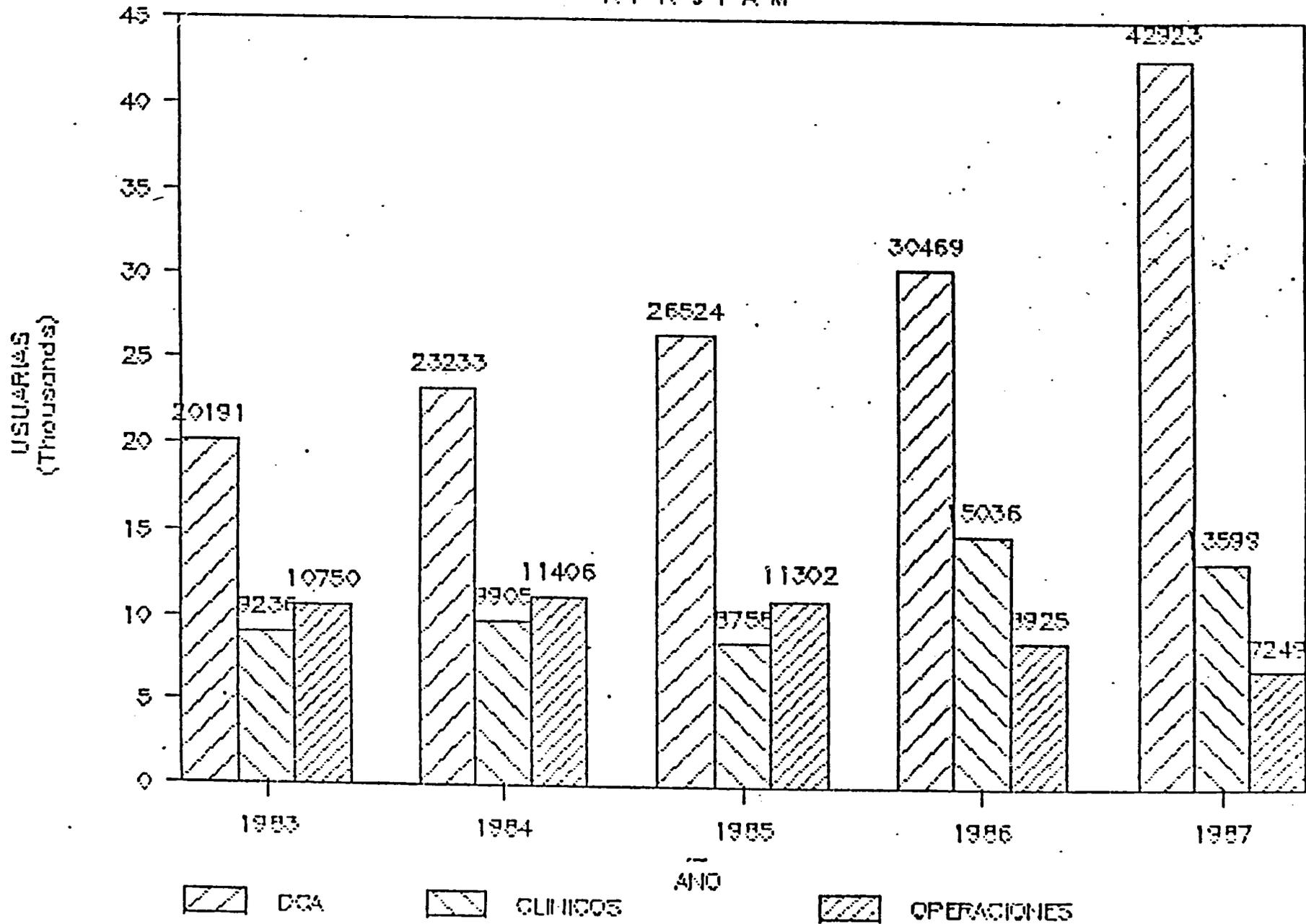
08

TOTAL DE USUARIOS NUEVOS



TOTAL DE USUARIAS NUEVAS POR AÑO

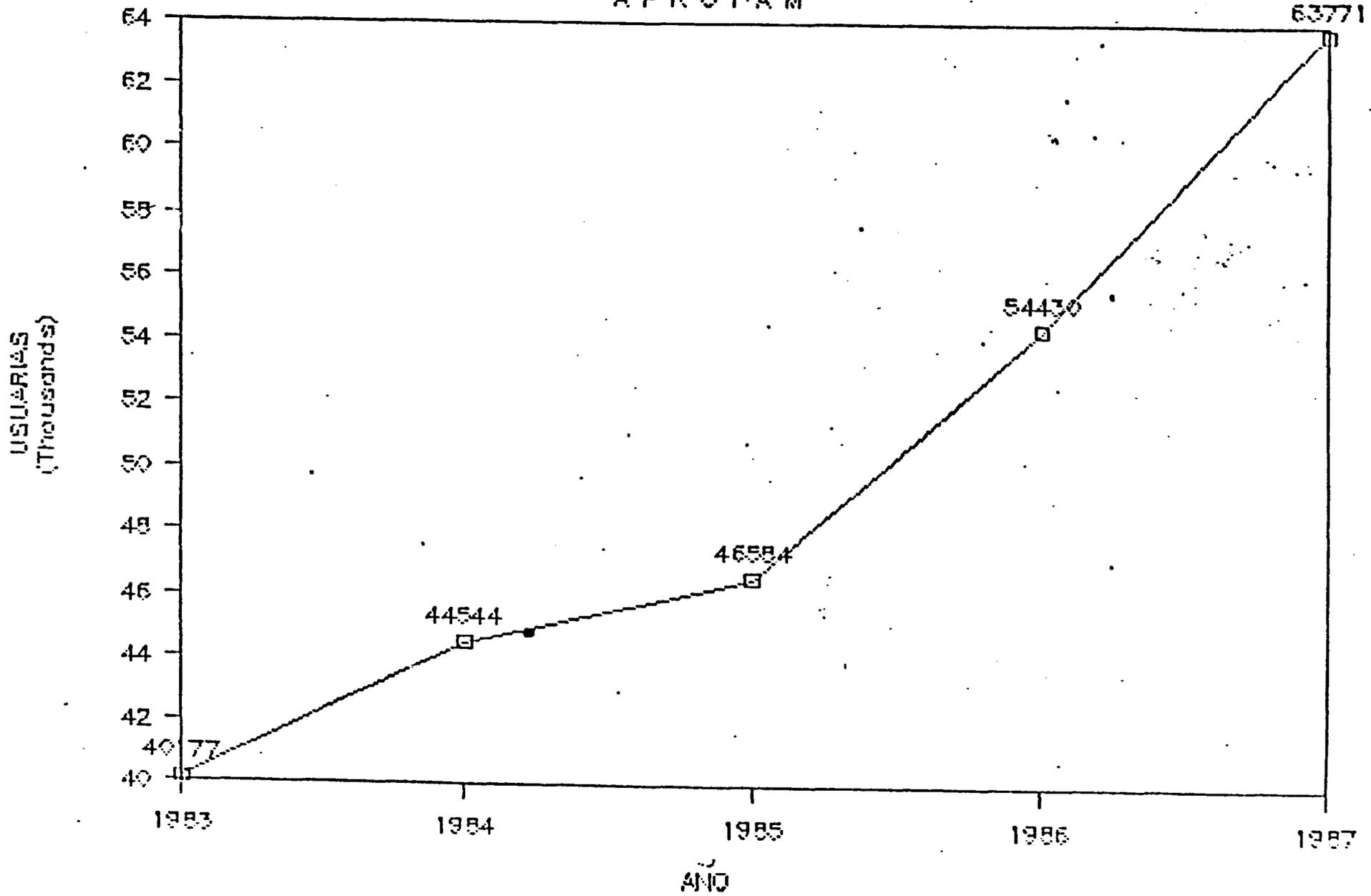
APROFAM



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TOTAL DE USUARIAS NUEVAS POR AÑO

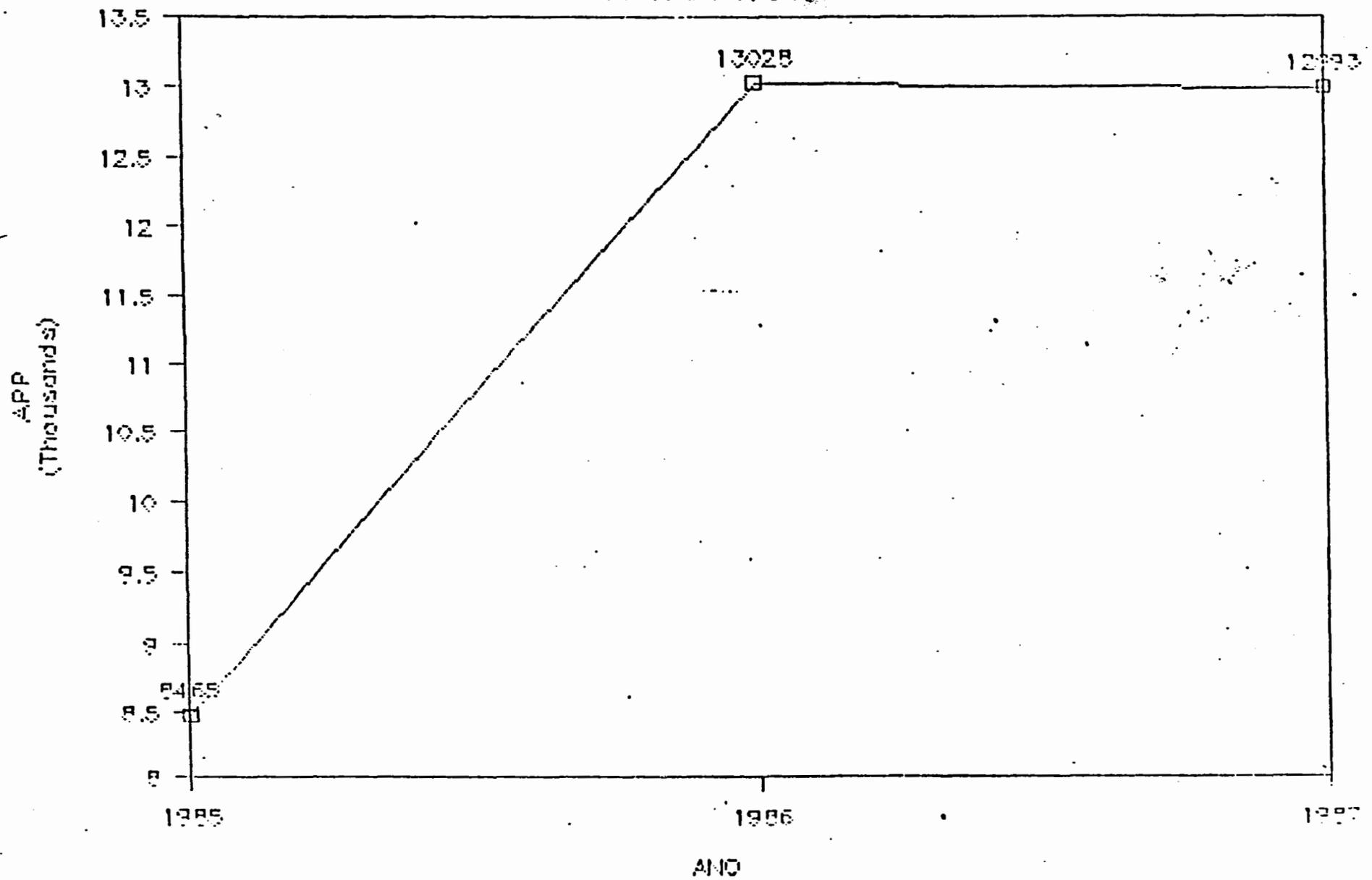
A P R O F A M



7

APP DEL PROYECTO DE MERCADEO SOCIAL

IPROFASA



AÑOS. PROTECCIÓN FAREJA POR INSTITUCIONES
(Acumuladas)AFROFAM

CBD	125,666
Clinicas	129,327
Esterilizaciones	683,568
Distribución Directa (otros programas)	<u>312,216</u>
Sub-Total	1,149,777

<u>IFROFASA</u>	<u>34,386</u>
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Sub-Total	1,184,263
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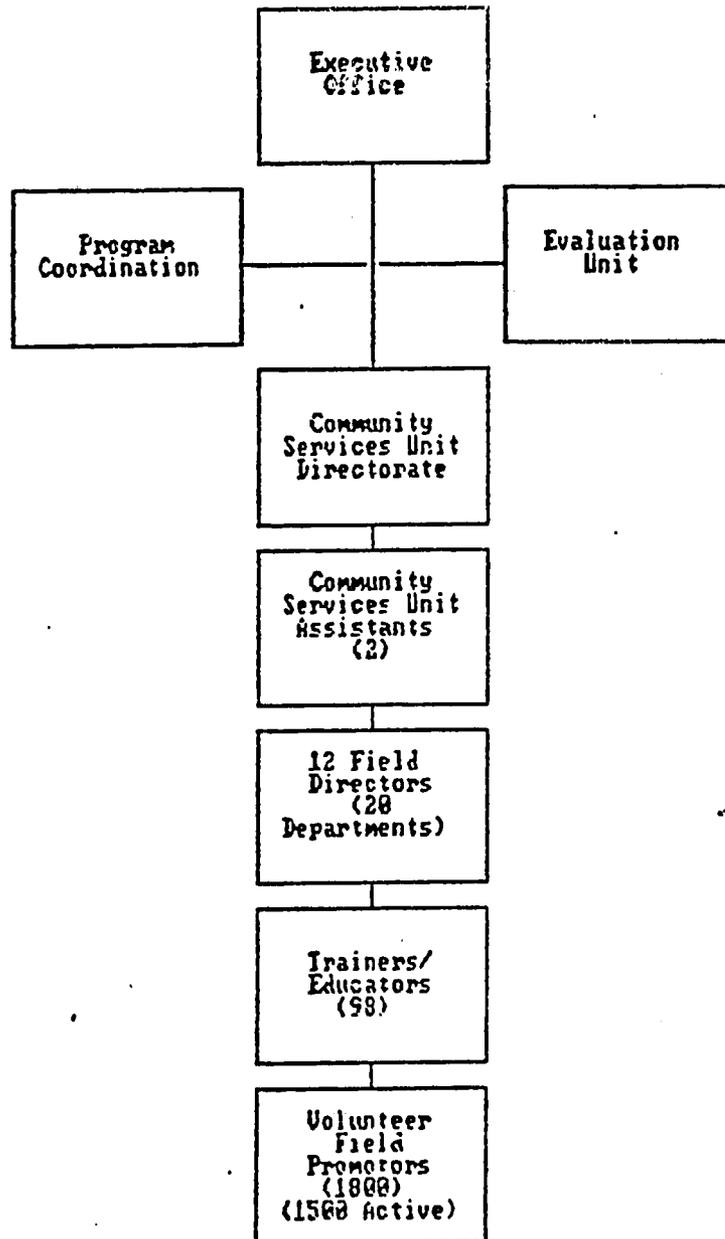
<u>MSPAS</u>	<u>50,797</u>
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Gran Total	1,235,060
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15-84

Chart No. 16

CBD UNIT
APROFAM



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ANNEX F

1987 PRINT MATERIAL

OBSERVATION		RECOMMENDATION
Poster	depicts white upper middle class Guatemalan family - message Happy families	produce posters to show Ladino family and Indian families
Poster	depicts white woman message healthy woman	produce one to show healthy Ladino and Indian woman
Record Cover	Cancion de la Juventud shows university students	produce cover to show other youth populations of Guatemala. Perhaps translate to Mayan dialect.
Brochure	Youth Center - lovely colors again identifiable with higher social groups	produce to show Ladino and Indian culture
Brochure Pink (for women)	Recommendations before and after voluntary sterilization	aimed at a reading audience. Prepare video tape to be shown before and after the operation. Give brochure as backup.
Booklet green and blue	Permanent methods for men and women	aimed at a reading audience. Prepare video tape to accompany manual.

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Booklet	Vasectomy - shows Ladino family with 3 children. Nicely done in fotonovela style	aimed at semi-literate audiences these visuals could be transferred to video tape. Recall with booklet will produce positive results.
Booklet (2)	Responsible Parenthood cover shows working class family with 3 happy children. ID of APROFAM logo approximates color and objective.	methods are explained to a 6th grade reader. Visuals are OK. idem size of letters. Last page has impossible to read menstrual cycle drawing.
Brochure	Natural methods blue and white	aimed at readers. Drawings are difficult to read and understand.
Brochure	Recommendations for males blue and white before and after vasectomy clinic.	aimed at male readers. Should be accompanied by video tape. Shown at
Booklet/ foto- novela	Diarrhea treatment describes signs/symptoms of diarrhea. Preparation of ORT solution. Indications on nutrition and simple hygiene practices.	aimed at semi-literate parents. Pictures are easy to understand. Develop T.V. spots and A.V. support material. This would include a campaign.
Brochure	Resource Center Promotion	aimed at students and professionals interested in population and family planning.
Brochure	IUD (from the POP Council)	aimed at medical personnel

ANNEX G

RESULTS OF MARKETING STUDY MAYAN POPULATIONS

These groups includes Quiche, Cakchiquel, Kekchi and Mam.

General conclusions for these groups included:

- / Misunderstanding about contraceptives.
- Lack of education about organic functions including sex and reproduction.
- Absence of child spacing.
- Large families.
- Price of products beyond their means.
- Negative feelings about the terms "family planning and contraceptives".
- Products and services not geared to include ethnic groups or culture identification.
- Certain products, such as vaginal tablets, contradict group taboos.

Group conclusions:

Quiche

Young people have positive attitudes and feeling for family planning and products but lack education/information on proper use. Pills and condoms would be acceptable products for the Quiche group.

Cakchiquel

These groups are closer to the urban life and identify well with trade and commerce. They heavily criticize urban morals, therefore, much education and information will be needed before they are convinced that the products do not produce poor health.

omen are the key when it comes to encounters. Messages should be aimed at them.

This group also take greater interest in educating their children. Sex education could be incorporated into the curriculum at the proper age taking care not to upset the groups since they are against information without education.

Kekchi

Distribution through midwives seems to be the key to better acceptance for these groups. An incentive for the midwife could be a better supply of vitamins, aspirins, cures for parasites, and equipment that she could use in delivering her services. This plus a percentage of sales of the product. The midwives would require training since they would become the CBD promoters of their villages. The faith healer (curandero) could also serve to bring messages to men.

Mam

Religious influence is very strong among the Mam. However, men who are the decision-makers in these groups, are not against sex education and information as long as it is honest and not misleading. They wish to be communicated to in their dialect and not in Spanish. This groups suggest that products be available in stores and markets where it would be less embarrassing for them to buy.

Recommendations for all groups included:

- Cultural identity of product and program
- Conduct survey by households
- Distribution to include:
 - a. migrant forms
 - b. local markets
 - c. terminal market in Guatemala
- Eliminate vaginal tablets for Indian communities
- Advertising to include ethnic identification

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