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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
Washington, D. C. 20523

GUATEMALA

PROJECT PAPER

EXPANSION OF FAMILY PLANNING SERVICES

Amendment 2

AID/LAC/P-438  
CR P-82-09 & P-381

Project Number: 520-0288

UNCLASSIFIED

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PROJECT DATA SHEET

1. TRANSACTION CODE

**C** A = Add  
C = Change  
D = Delete

Amendment Number  
2

DOCUMENT CODE  
3

2. COUNTRY/ENTITY

Guatemala

3. PROJECT NUMBER

520-0288

4. BUREAU/OFFICE

LAC

05

5. PROJECT TITLE (maximum 40 characters)

Expansion of Family Planning Services

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY  
1 2 3 1 9 1

7. ESTIMATED DATE OF OBLIGATION  
(Under 'B:' below, enter 1, 2, 3, or 4)

A. Initial FY 88 B. Quarter 3 C. Final FY 91

8. COSTS (\$000 OR EQUIVALENT \$1 = )

A. FUNDING SOURCE	FIRST FY <u>88</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1,250	6,545	7,795	4,243	27,088	31,331
(Grant)	( 1,250 )	( 6,545 )	( 7,795 )	( 4,243 )	( 27,088 )	( 31,331 )
(Loan)	( )	( )	( )	( - )	( - )	( - )
Other U.S. 1.						
Other U.S. 2.						
Host Country				-	8,925	8,925
Other Donor(s)				-	-	-
<b>TOTALS</b>				4,243	36,013	40,256

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	440	440		12,116		14,945		27,061	
(2) CS	513	510				4,270		4,270	
(3)									
(4)									
<b>TOTALS</b>				12,116		19,215		31,331	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

450 490 563

11. SECONDARY PURPOSE CODE

444

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

The purpose of the project is to expand the utilization of family planning services and information provided by public, private and commercial sources through integration of maternal health services and selected child survival interventions which are designed to reduce the reproductive risks of women in fertile age.

14. SCHEDULED EVALUATIONS

Interim MM YY 0 8 8 9 MM YY 0 9 9 0 Final MM YY 0 8 9 1

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000  941  Local  Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment)

This PP amendment will increase the project's DA grant funding by \$19.215 million and extend the PACD by three years to the end of CY 91. The project amendment will finance the continuation and extension of activities currently carried out by three private sector grantees and the Ministry of Health, and initiation of activities of a new component to work with the private sector.

I have reviewed the methods of implementation and financing of this project and certify that they are in agreement with payment verification policy implementation guidance.

17. APPROVED BY

Signature: Anthony J. Gaferucci  
Title: USAID Mission Director

Date Signed MM DD YY  
07 22 88

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

PROJECT AUTHORIZATION

Amendment No. 3

Name of Country/Entities: Guatemala: Government of Guatemala; APROFAM; IPROFASA, S.A.; AGES; and, other eligible private organizations.

Name of Project: Expansion of Family Planning Services

Number of Project: 520-0288

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Expansion of Family Planning Services Project, for Guatemala and participating public and private organizations, was authorized on August 27, 1982. The Authorization was amended on September 25, 1986, and July 31, 1987. The Authorization is hereby further amended as follows:

a. Paragraph 1 is deleted in its entirety and the following inserted in lieu thereof:

"1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Expansion of Family Services Project for the Guatemalan Ministry of Health ("MOH"), the Guatemalan Family Welfare Association ("APROFAM"), Importers of Pharmaceutical Products, S.A. ("IPROFASA"), the Guatemalan Association for Sex Education ("AGES") and other eligible private organizations, involving planned obligations of not to exceed Thirty One Million Three Hundred Thirty One Thousand United States Dollars (\$31,331,000) in grant funds ("Grant") over an eight (8) year period from the date of authorization subject to the availability of funds in accordance with the AID OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is nine (9) years and four (4) months from the date of initial obligation".

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2. Except as hereby amended, the Authorization remains in full force and effect.

*Paul E. White*

Paul E. White  
Acting Director

July 22, 1988  
Date

Drafted: GC/LAC: <sup>CMS</sup> MJ Williams

Clearances:

OHRD: LAyalde	<u><i>Ayalde</i></u>	Date	<u><i>4/15/88</i></u>
PDSO: CHSchoux	<u><i>CHSchoux</i></u>	Date	<u><i>July 15, 1988</i></u>
PRM: Mott	<u><i>MCD</i></u>	Date	<u><i>7/18/88</i></u>
OEPA: SSkogstad	<u><i>MCD</i></u>	Date	<u><i>7/15/88</i></u>
CONT: JHill, Jr.	<u><i>JHill</i></u>	Date	<u><i>7/21/88</i></u>
A/DDIR: CHSchoux	<u><i>CHSchoux</i></u>	Date	<u><i>July 21, 1988</i></u>

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I. SUMMARY AND RECOMMENDATIONS

A. Summary and Recommendations

The Project Committee recommends authorization of an additional grant of \$19,215,000 and a three-year extension of the Expansion of Family Planning Services Project to December 31, 1991. Of the requested LOP increase of \$19,215,000, \$14,945,000 will be from the Population Planning (PN) account and \$4,270,000 from the Child Survival (CS) account. With the addition of the proposed new grant funds, total life-of-project funding for the project, which was initiated in 1982, will be \$31,331,000.

It is planned to obligate \$7,795,000 (\$5,035,000 PN; \$2,760,000 CS) in June and July 1988 as follows:

--APROFAM (OPG Amendment) - \$4,504,000 (\$2,397,000 PN; \$1,301,000 CS; and \$806,000 CS "set-aside" for new private sector initiatives).

--Ministry of Health (Grant Agreement) - \$1,724,000 (\$1,071,000 PN; \$653,000 CS).

--I PROFASA (Cooperative Agreement Amendment) - \$879,000 (PN only).

--AGES (OPG Amendment) - \$688,000 (PN only).

The Project Committee has reviewed all aspects of the proposed \$19,215,000 amendment to the Expansion of Family Planning Services Project and finds that it is financially, economically, technically, socially, and administratively sound, and consistent with the development objectives of the Government of Guatemala, the private sector health and family planning community, and USAID.

This Project Paper Amendment was developed with the assistance of the following individuals:

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B. Project Summary

High fertility is one of the major development problems confronting Guatemala. Continued population growth at the present rate will severely strain the capability of the Government of Guatemala (GOG) to provide adequate social services, as well as the capacity of the economy to permit an adequate livelihood for the majority of the population.

There is a significant unmet demand for family planning services. According to the 1987 Demographic and Health Survey (DHS) of women of reproductive age in union who do not use any contraception, 49.8% desire no more children and 28.9% want to space the births of any additional children by at least two years. This Project will expand the current level of services to help meet some of this demand for family planning.

The contraceptive prevalence was 25% in 1983; in 1987, prevalence was found to be 23%. The apparent drop in prevalence is caused by an increase in the number of women in the reproductive age group, such that even as the absolute number of users increased, it did not keep pace with the increasing number of fertile-aged women. This situation is likely to continue because 50% of the population is below age 15. Thus, the FY89-90 Action Plan target of 35.3% prevalence by 1990, based upon an earlier projection, must be adjusted in light of the more recent data.

The target of the Project is to add a cumulative 1,000,000 couple-years-of-protection (CYP) in the next three years which represents about a 34% increase in the rate of CYP per year achieved during recent years by the Project. (See Annex F for a definition of CYP.) Because of the different contribution to CYP of the various contraceptive methods, this indicator has no precise equivalent in prevalence rates, but might signify a 27% prevalence by 1991. Even this seemingly modest increase will require the additional inputs and continued expansion of activities called for by this Amendment.

The Project Amendment extends the current Project for three years to the end of CY91, and will serve as a bridge to a successor project dealing with the health of the Guatemalan family as a whole. This new project will combine the current family planning, child survival and maternal health activities. This Amendment accelerates the process begun in mid-1987 of integrating family planning and child survival and in preparing the implementing agencies for a fully integrated "family health" project to be designed in 1991.

(D)

The purpose of this Project is to expand the utilization of family planning and child survival services through public, private and commercial sector activities. Achievement of the project purpose will be reflected by an increase in the number of users equivalent to 1,000,000 couple-years-of-protection. The key strategies to accomplish this include:

- 1) integration of family planning into maternal and child health services, targetted to younger mothers wishing to space births;
- 2) strengthening or expansion of existing implementing agency services with more emphasis on services to the Mayan population and more educational and informational materials for the Mayan and non-literate segments of the population; and,
- 3) use of an umbrella mechanism to promote the utilization of existing private sector providers as a means of expanding the number of service outlets and generating greater institutional support for family planning programs.

C. Project Components

The following Project Components will be implemented during the 1989-1991 period:

1. Association for Family Welfare (APROFAM)

APROFAM is the Guatemalan affiliate of the International Planned Parenthood Federation. It has been the family planning leader in Guatemala since its founding in 1967 and has a proven record over several years in successful accomplishment of AID and other donor projects. During the extension period, APROFAM will continue and expand its activities of:

- a) Community-based distribution (CBD) of contraceptives;
- b) Clinical services, including voluntary surgical contraception (VSC), insertion of intrauterine devices (IUD) and maternal-child health (MCH) services;

- c) Information, education and communication (IEC) activities to promote family planning within a maternal and child health context;
- d) Supplying and training other contraceptive service providers such as private sector physicians, peasant organizations, industrial health plans and other organized groups.

APROFAM will play the major role in accomplishing the purpose of the Project. Under the Amendment, APROFAM will receive funding for technical assistance, commodities, equipment, audits, evaluations and program support.

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

The MOH has the largest health care delivery infrastructure in Guatemala: it operates 35 hospitals, 214 Health Centers and 755 Health Posts throughout the country. There are also thousands of volunteer rural health promoters and traditional birth attendants (TBA's) trained by the MOH.

The MOH has recently reorganized the maternal-child health department to change the formerly vertical, isolated nature of the Family Planning Unit: the Head of the Family Planning Unit now also directs the Maternal Health Section, which will lead to the integration of family planning activities with the maternal-child health program of the MOH.

Project activities will increase the training, supervision and supplying of MOH facilities, thus increasing service delivery capacity. Staff, vehicles and technical assistance will be provided to the FPU to aid in the expansion of service outputs. Efforts to furnish all Health Centers with equipment, training and supplies for IUD insertion will continue under the Amendment. Finally, the Association for Voluntary Surgical Contraception (AVSC), through a buy-in arrangement, will assist the MOH with equipment, training and technical assistance in the provision of permanent reproductive risk reduction methods at the hospital level in response to progressive increases in demand for such services.

## 3. Guatemalan Association for Family Life Education (AGES)

AGES will continue and expand its information, education, communication and training activities in family life

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education in five departments of the country. Its activities will include new initiatives in developing original Mayan language educational materials along with culturally sensitive and customized approaches to a sample number of Mayan communities. These IEC materials will also be supplemented by operations research in a select number of Mayan communities to determine what service delivery mechanisms are most likely to work in different cultural environments. The information acquired by these activities will be made available to other implementing agencies, including an umbrella organization which is proposed as a means of working with private sector health care providers in both Mayan and Ladino areas.

In order to handle the expanded workload, AGES will receive technical assistance and financing for increased staffing and management improvements.

#### 4. Importers of Pharmaceutical Products (IPROFASA)

IPROFASA will continue its social marketing of contraceptives and expand the number of products and channels. Revenues from sales will in part serve to expand its operations and prepare for increasing sales to Mayan communities. This organization will continue to receive technical assistance from the Project in short, task-specific increments, rather than the long-term assistance provided to date under an institutional contract with Juarez and Associates.

#### 5. New Initiatives

The diverse nature of the cultures in Guatemala and the highly dispersed population (16,000 communities have 500 or fewer inhabitants) limit the effectiveness of a single national top-down delivery system for family planning and health services. There are about 300 private organizations providing some kind of health service in the country, and these organizations have existing staff, financing and outreach of varying quality and coverage.

The strategy is to contract an experienced, qualified firm or PVO which can serve as an "umbrella organization" to identify local groups interested in expanding their activities in Child Survival, Family Planning and Maternal Health. Once identified, the umbrella organization would fund, promote, develop, train, supply with health commodities, contraceptives and monitor a number of such providers meeting certain criteria. This umbrella mechanism

would therefore help expand delivery channels while reducing the proliferation of agreements which USAID would have to manage.

The umbrella mechanism can begin with providers such as ANACAFE and AGROSALUD, which currently provide services to employees of some large farms on Guatemala's South Coast region and elsewhere in the country. The PVO or firm contracted to serve as the umbrella mechanism can also assist some of the many small providers working with Mayan groups in the Highlands. This organization will identify effective and efficient models of delivery and serve as a clearinghouse of information regarding health care resource optimization to both donor and provider agencies and institutions involved in service delivery activities in key geographic areas and cultural groups. Finally, this organization would identify and develop the local capacity necessary to eventually serve as "broker" and intermediary for and manager of USAID health/family planning grant funds.

#### D. Summary Financial Plan

Under the terms of the amended project grant agreements, AID will provide additional grant funds of \$19,215,000. This is in addition to the \$12,116,000 original project grant obligation making total life of project funding of \$31,331,000. Of the additional \$19,215,000 project grant funds, \$14,945,000 is derived from the population account and \$4,270,000 is derived from the child survival account. The new funds will be committed to the following implementing agencies in the following manner: APROFAM (\$10,430,700), the Ministry of Health (\$2,143,100), AGES (\$2,214,200), IPROFASA (\$2,885,700), and the New Initiative with the private sector (\$1,541,300). Funds will be provided in the project in the amount of \$1.4 million for centrally-procured contraceptives. Counterpart contributions total \$6,811,700 of which \$268,800 will be contributed by IPROFASA, \$2,167,600 by MOH and \$4,375,300 by APROFAM.

## II. PROJECT BACKGROUND AND RATIONALE

### A. Health Status and Demographic Trends

#### 1. Health Trends and Projections

Health problems in Guatemala follow a pattern which is typical of developing countries. Table II.1 below presents selected indicators.

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TABLE II.1

Health and Demographic Indicators for Guatemala

Birth rate (1984)	43/1000
Infant mortality rate (1984)	79.82/1000
Child mortality rate, ages 1-4 (1983)	15.5/1000
Crude mortality rate (1984)	10/1000
Life expectancy (Est. 1985)	62 years
Maternal mortality rate (1983)	10-17/1,000 live births
Fertility rate (1984)	186/1000 women 15-44
Annual population growth rate (1985)	3.3%

Source: World Bank Indicators (1983)

Child Health Indicators

Child health indicators are poor. In the 1987 Demographic and Health Survey (DHS), mothers reported that 10.2% of children under five years had experienced a diarrheal episode within the last 24 hours, and 16.5% within the last two weeks; oral rehydration solution (packaged or homemade) was administered to only 17.5% of those children. One fourth of all deaths in Guatemala occur among infants, and another quarter among children 1-15 years. The main causes of death for children under five are enteritis (408/100,000 children), upper gastro-intestinal infections (220/100,000), measles (121/100,000), pertussis (69/100,000), and malnutrition (44/100,000), all of which are responsive to child survival technologies.

Immunization coverage rates are generally low compared with other Central American and Latin American countries. The percentage of children fully immunized by one year of age indicates the risks of contracting immuno-preventable diseases (Table II.2).

TABLE II.2

Comparison of Percent of Children Receiving Specific Immunizations by Age One

<u>Immunization</u>	<u>Guatemala</u>	<u>Central America</u>	<u>Latin America</u>
BCG	67	65	56
DPT	16	59	53
Polio	16	82	68
Measles	15	67	59

Source: Westinghouse/IRD: Child Survival; Preliminary data from 1987 Guatemala DHS

Maternal Health Indicators

Abortion is the second leading cause of maternal death and the fifth leading cause of hospital admissions in Guatemala (1987 Health Sector Assessment).

Related to this is the low (34.4%: 1987 DHS) percentage of women receiving professional pre-natal care, and the low (29.3%: 1987 DHS) percentage of births assisted by a either a physician or nurse. This latter figure compares poorly to the average of 53% in the other Central American countries and 64% for Latin America as a whole.

Another indication of risks to newborns is low birthweight, which is strongly associated with pre-natal care. Low birthweight occurs in 18% of births with recorded weights in Guatemala, compared with about 10-11% in the rest of Latin America. Percentage of births assisted by trained birth attendants is also an indication of safe birthing practices. Within Guatemala, large ethnic and geographic disparities exist in utilization of both pre-natal care and trained birth attendants (see Table II.3). In general, the rural and Mayan segments of Guatemala are significantly underserved.

TABLE II.3

Utilization of Pre-natal Care and Trained Birth Attendants  
1987

	<u>Received pre-natal care</u>	<u>Birth assisted by trained attendant</u>
Urban	56.1%	57.7%
Rural	26.3%	18.8%
Ladina	47.5%	44.0%
Maya	16.5%	9.5%

Source: 1987 DHS

Lactation in Guatemala has a long average duration. Lactation is related to post-partum amenorrhea, which contributes to increased birth spacing by delaying the

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mother's return to fertility. For the young child, lactation also reduces the risk of malnutrition, diarrhea and infection.

In general, the maternal and child health problems which afflict Guatemalans are amenable to low-technology, cost-effective family health programs.

## 2. Demographic Trends and Projections

Guatemala's population in 1988 is estimated at 8,500,000. About half of this population is under 15 years of age, about 18% is under five, and about 22% is made up of women of child-bearing age (15-44 years). The Maternal-Child Health (MCH) target population (women aged 15-44 plus children aged 0-4) represents 38.2% of the total population. Roughly 60% of the population lives in rural areas, half in villages of 500 or fewer inhabitants.

The Guatemalan birth rate, annual population growth rate, and fertility rates, while continuing to drop, are all relatively high and consistent with rates seen in less developed countries. The current Total Fertility Rate (TFR) is 5.6, compared with an average of 3.9 in the rest of Latin America and 4.7 in the rest of Central America and Panama. In the last decade this rate has dropped from 6.1 children per woman (1978) to 5.8 (1983) to 5.6 (1987). The data available from the 1983 Family Planning and Maternal/Child Health Survey, however, demonstrated large urban-rural differences in TFR among Ladinas (urban: 4.2; rural: 5.5), while the rural Mayan TFR was even higher (7.2). These patterns may be assumed to be the same in the 1987 DHS data.

Of the total population, there are some 1,877,000 women in the fertile age group of 15-44. The total number of contraceptive users increased between 1983 and 1987 by approximately 40,000 women (237,600 to 277,000). Despite this increase in total number of women using contraception, the contraceptive prevalence rate actually dropped from 25% to 23% during the same period. The explanation for this phenomenon is in the fact that females now in the 1-14 year old age group are sufficient in number to continue to swell the population of fertile age women, even as fertility rates drop. Thus, approximately 337,000 more women were of reproductive age in 1988 than in 1983, and this trend will continue at least through the year 2,003.

It is largely the level of success in raising contraceptive prevalence among cohorts of women entering

fertile age which determines fertility and therefore total population. Other key factors include lowering the age at which contraception is first practiced and expanding the use of temporary methods, thereby lengthening intervals between births.

During the period covered by the current Project (1983-1987), approximately 1,235,060 CYP were provided, or an average of 247,012 per year. A rough estimation can be made that women 15-44 in union increased an average of 44,686 per year during the same period. Thus, on a gross order of magnitude, perhaps one-fifth of all CYP were offset by increases in the number of women of reproductive age in union.

Given current contraceptive prevalence, these demographic trends will continue. A comparison of the number of women currently in the reproductive age bracket of 15-44 years with those in the 10-39 year age bracket indicates that in the next three years the number of women in reproductive years will have increased by another 234,000 to 2,121,000, an average increase of 75,000 per year.

The nationwide proportion of reproductive age women in consensual union in 1983 was 66.3%. In rural areas, the proportion was 64.9% of Ladinias and 73.5% of Mayas. With a higher proportion of women in consensual union, and a much lower rate of contraceptive prevalence (5.5% versus 34% for Ladinias), the Mayan population is increasing at a significantly higher rate than the Ladino population.

### 3. Unmet Family Planning Needs

Overall contraceptive prevalence was estimated at 23% of women in union in the 1987 Demographic and Health Survey (DHS). Estimates of current contraceptive users for 1988 are approximately 288,000. The DHS also indicates that 14% of all fertile age women in union want to have a child in the near future. The estimated target population of women in need (fertile age women in union exclusive of women wanting children soon), assuming constant proportions, is therefore approximately 1,251,000 in 1988, and will increase to 1,406,000 by 1991, representing 155,000 additional women in need of family planning services during the three-year Project extension period.

To simply maintain the current level of contraceptive prevalence, therefore, the Project would have to add about 35,000 new users. To achieve 30% prevalence, a total

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of 134,000 new users must be reached by 1991. This would represent an increase of 68%, an increase which is greater than the current level of output of the APROFAM community-based distribution (CBD) program, the largest single delivery subsystem in the Project. These rates of growth are shown in Table II.4.

TABLE II.4

Women of Reproductive Age, In Union, and In Need (000's)

	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Women 15-44	1680	1746	1815	1887	1962	2040	2121
Women in union	1114	1158	1204	1251	1301	1352	1406
Want children soon	160	167	173	180	187	195	202
Women in need	954	991	1031	1071	1114	1157	1204
Users (from DHS)	267	272	277	288			
Users (25% prevalence)					325	338	351
Users (30% prevalence)					390	406	422

Reaching a greater number of users presents a challenge, especially women of ages appropriate for birth spacing. Users reached in the past several years of Project activity can be assumed to have been the easiest to reach, both logistically and culturally.

Mayans represent about 48% of the population. The percentage of Mayan women in union is higher than that of rural Ladinas (74.3% versus 64.9% in the interior), while the percent of those women using contraceptive methods is far lower (5.5% versus 34%). It is estimated that of the population in need, approximately 60% are Mayan women. This group, more diverse and disperse and with lower educational levels, is in greatest numerical need and is the most difficult target population to serve.

USAID's FY89-90 Action Plan sets a target of 35.3% contraceptive prevalence by 1991. This same Action Plan

projected a prevalence of 27.7% by 1987, or a percentage increase of 2.7% over 1983, although, in fact, prevalence declined by 2% due to the dynamics discussed above. This extension will provide a total of nearly one million couple-years-protection (CYP) between 1989 and 1991. This level of output will contribute to raising the level of contraceptive prevalence, though the target of 35.3% will not be reached by 1991 through Project activities alone. It will be necessary to adjust the Mission's Action Plan target for contraceptive prevalence in light of the new data provided by the 1987 Demographic and Health Survey (DHS).

B. Rationale for Integration

Given the historically controversial and politicized nature of family planning in Guatemala, it has become clear that its viability has been threatened in the past by its separation from maternal and child health services. This vertical separation, especially in the Ministry of Health and given the often "privileged" status family planning implementing units have enjoyed, has caused counterproductive intra- and inter-institutional rivalries.

Another factor necessary to enhance the political sustainability of family planning activities in Guatemala is increasing the "constituency", both in sheer numbers of users and in family planning provider organizations. By "bundling" family planning and maternal-child health services, it will be easier to add service organizations whose recognition and respect in Guatemala reduces their vulnerability.

Family planning as a means to improved health offers the likelihood of lessening the incidence and impact of adverse factors-political, religious and cultural, which are outside the control of Project managers and implementing agencies.

Experience and carefully controlled studies have shown 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. The literature also demonstrates that program efficiency (lower costs per unit of service) increases with integration.

Common sense also suggests that if health services are "packaged" or provided in such a way as to deal with the entire family -- or at least the mother and her children -- at the same time and in the same clinic setting, that efficiencies

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would accrue both for the mother (who 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 periods of her reproductive life and at desired intervals between pregnancies; (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.

Recent research and experience clearly indicate 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 for reaching maturity and achieving 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. Approximately one-half of maternal deaths are abortion-related; these deaths can be significantly reduced as a result of family planning.

C. Institutional Situation

1. General Background

Family planning programs, particularly in the public sector, have had a cyclical and occasionally stormy history in Guatemala since the first AID-financed project began activities in 1965. This early project with APROFAM was quickly followed by an agreement signed with the GOG in 1967, which sought to integrate family planning into the programs of 75 health centers and some hospitals. Initially, these programs in the MOH were operated as vertically distinct programs, which occasionally met with strong political resistance. This opposition led to a virtual abandonment of these services by the public sector on a temporary basis in the mid-70's, and again in 1979 and early 1986. Programs in the private sector, on the other hand, have shown sustained growth; their coverage, however, until recently has been limited primarily to urban and Ladino populations.

2. AID Support of Existing Agencies

As of the current PACD of December 31, 1988, financial support of approximately \$12.1 million will have been provided to four Guatemalan organizations, in the following proportions:

<u>Organization</u>	<u>Share of Financing</u>
Association for Family Welfare (APROFAM)	62.6%
Importers of Pharmaceutical Products (I PROFASA)	23.7%
Guatemalan Assoc. for Family Life Education (AGES)	7.9%
Ministry of Health (MOH)	5.9%

The recent Project evaluation (January 1988) contained estimates of agency contributions to couple-year-protection (CYP), which indicate that APROFAM and the MOH are the major providers of family planning services, with some 97% of the CYP attributable to these two agencies, 93.1% APROFAM and 4.0% MOH. The 1987 Demographic and Health Survey (DHS) reports the MOH as the source for some 5.5% of contraceptive users in the country. I PROFASA shows an increasing contribution to CYP. AGES does not provide clinical services.

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APROFAM, the local affiliate of the International Planned Parenthood Federation (IPPF), has a national level network of ten full-service (permanent and reversible methods) family planning clinics and approximately 1,800 community-based distributors (reversible only). In addition, mass media, educational materials production and training programs are carried out throughout the country. The recently completed evaluation gave APROFAM high marks for its management, service delivery and IEC programs.

The Ministry of Health, through its Family Planning Unit (FPU), is the only public sector agency being financed by this Project. The current agreement provides funding for contraceptive distribution, medical supervision of family planning activities and a large training program. The MOH has more than 1,000 outpatient health service facilities scattered throughout the country, into which the FPU is gradually integrating family planning as part of routine maternal and child health services programs. There is currently minimal direct participation of MOH hospitals in the provision of family planning services, through either permanent or reversible methods.

The Guatemalan Association for Family Life Education (AGES), through a variety of funding sources, has been providing family life education services since 1978. AID funding has supported educational services for young adults, parents, teachers, church groups, community leaders and schools since 1985. In 1986, the AID grant agreement with AGES was amended to include a pilot female education program to facilitate completion of at least three years of primary education among Mayan Indian girls. AGES operates a headquarters in Guatemala City and sub-centers in small cities in five of the country's 24 departments. The recent evaluation (January 1988) indicates that AGES has been remarkably successful in developing relationships and working with Mayan communities.

I PROFASA is a private, for-profit company founded with AID funding in 1982 for the purpose of carrying out social marketing of contraceptive products. The current Project finances contraceptive acquisition, sales, distribution, training and advertising/promotional activities. At present, contraceptive sales are taking place in approximately 750 of the country's 1,200 pharmacies. An evaluation of I PROFASA performed in 1987 indicated that this Project component is well-managed and progressing satisfactorily.

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An analysis of the family planning and maternal-child health needs indicates that the number of providers in the private sector should be expanded. These needs are particularly evident for rural populations, and especially for the Mayan communities among whom the contraceptive prevalence rate is only 5.5%.

There are 309 private voluntary organizations listed by the MOH as providers of health-related services, 179 health-related non-governmental organizations, and 5,000 active private physicians, many of whom have private clinics. There are also agricultural producer organizations such as ANACAFE and AGROSALUD that provide health services to their workers. Thus, the number of private providers is large, although their current coverage may be minimal in family planning, child survival and maternal health services.

This Project will utilize existing channels by identifying or establishing an organization which will provide the financing, technical assistance, training and commodities to expand the scope of services of some of these providers. An umbrella mechanism would permit AID and other donors to assist many providers without proliferating the number of organizations with which donors must directly deal. The details of this proposed mechanism are provided both in the Detailed Project Description section and the Administrative Analysis Annex.

#### D. Relationship to AID Policies and Strategies

The first AID-financed five-year bilateral project (Population and Family Planning No. 520-0237) provided \$1.0 million in grant assistance and ended in 1980. This project was followed by a \$2.3 million three-year project (Integrated Family Planning Services No. 520-0263), which ended in February 1983. Several evaluations of both projects provided AID with enough guidance to develop a major new initiative with the public and private sectors and, as a result, the current Project (520-0288) was designed in 1982 and initiated in 1983, providing \$8,686,000 in AID grant funds.

In July 1987, AID approved an amendment to the authorization extending the PACD to December 31, 1988, and adding \$3.4 million in grant funds to the Project for a total of \$12.1 million. The additional funds were obligated in APROFAM's Operational Program Grant. The 1987 amendment added limited child survival and maternal health components to the Project. This amendment, therefore, began the process of

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integrating family planning and maternal-child health services. Parallel to this Project, the USAID Child Survival Project (520-0339) directly addresses the needs of the child side of the mother-child diad, while recognizing the importance of maternal health per se.

Thus, the current Project extension will further "bridge" the child survival and "mother" survival activities, leading to an integrated sector-wide health project by 1992. At that time, the goal of achieving family health through a unified project will be addressed.

AID centrally funded and managed intermediaries such as the Association of Voluntary Surgical Contraception (AVSC), the Pathfinder Fund, Family Planning International Assistance (FPIA), Population Council, Family Health International, Johns Hopkins University, The Futures Group, Development Associates and others have or continue to provide financial and/or technical support to Guatemalan family planning information and service providers. The major recipient of this assistance has been APROFAM. Currently, the MOH is receiving technical assistance from Development Associates in the area of training. Financial data show that the total budget for centrally-funded assistance to Guatemala was \$260,000 in FY84, \$1,047,000 in FY85, and \$345,000 in FY86.

The budget from the International Planned Parenthood Federation (IPPF), for its affiliate in Guatemala, APROFAM, was \$537,000 in FY84, \$309,000 in FY85, \$352,300 in 1986, with \$577,723 in 1987, and \$446,000 projected for 1988.

E. Relationship to GOG Policies/Strategies:

Article No. 47 of the 1985 Constitution guarantees Guatemalan couples the right to space the births of their children and limit family size. This article provides the legal basis for the Government of Guatemala's (GOG) National Maternal-Child Health (MCH) Plan. The MCH Plan, prepared in March 1988, bases its strategy upon activities focused on high risk population groups, specifically women of reproductive age and children. Among service activities for women of reproductive age are included education for reproductive life, pre-natal care and breastfeeding, family planning, responsible parenthood, early detection of cervical and breast cancer, appropriate assistance during the birth process, and attention to the newborn. Emphasis is placed upon reduction of reproductive risk, through a combination of training of community level personnel, educational activities, and, in the

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case of family planning, the delivery of contraceptive methods in accordance with demand. These activities are consistent with AID's child survival strategies.

The MOH seeks to expand coverage, by 1991, of pre-natal and delivery care by increasing absolute service coverage through an increase in trained community-based personnel, especially traditional birth attendants (TBA's). The MOH will attempt to train TBA's to detect and refer high risk pregnancies for proper care and treatment. This GOG policy is appropriate given the current situation in Guatemala, where 66% of births do not receive professional attention. Equally appropriate is the MOH's reproductive risk strategy, which emphasizes prevention, detection, treatment and referral of women at high risk. The incorporation of these maternal health strategies within the MCH context now receives strong support within the MOH, and rightfully places family planning within a broader health perspective.

The MOH also seeks to expand the variety of temporary and permanent contraceptive methods available to couples. Both intra-uterine devices and surgical contraception represent relatively new methods the MOH will make available upon demand.

The AID strategy fully complements that of the GOG, and thus an important opportunity now exists for substantial progress in the area of maternal health and family planning in the public sector. Indeed, the current project will greatly assist the GOG to operationalize the services already ratified by the law.

#### F. Relationship to Other Donors

The other major donor in population has been the United Nations Fund for Population Activities (UNFPA) through its implementing agency, the Pan American Health Organization (PAHO). Major assistance in Maternal-Child Health/Family Planning from the Fund began in 1983, designed to strengthen the MCH services of the MOH through the training of midwives and rural health promoters. Community participation, information/education and communication, natural family planning methods, training in population education, a demographic survey, and population and development policy activities have also received support from the Fund. The total UNFPA budget during CY81 to CY87 was \$2.240 million, and \$1.5 million is planned for 1988-91. An initiative is underway by UNFPA to assign a regional MCH and Family Planning Advisor to be located in Guatemala.

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At the present time, there is a close working relationship between UNFPA and USAID. Major initiatives by each agency are thoroughly discussed with the other and complementary actions are frequently taken to optimize the use of resources.

### III. CURRENT PROJECT STATUS

#### A. Introduction

The recent evaluation of the Expansion of Family Planning Services Project found that all planned numerical goals for the Project had been met or exceeded. Positive unplanned changes were also noted, especially the favorable political climate for family planning activities.

Two areas of weakness were noted. First, the Information, Education and Communication (IEC) components of all the agencies have shown improvement, but family planning messages are still not reaching Mayan speakers and people with low literacy skills. And second, institutional weakness were noted for some of the implementing agencies. Areas needing improvement are noted below.

Progress has been made: preliminary data from the 1987 Demographic and Health Survey suggest a declining tendency in the birthrate. Also, user statistics from the agencies show increased use of all methods except voluntary surgical contraception (VSC). In 1987, however, VSC procedures began to increase and by the first quarter of 1988 had almost risen to prior year levels.

#### B. Project Components

##### 1. Association for Family Welfare (APROFAM): Operational Program Grant (OPG)

The 1988 evaluation of 520-0288 found that APROFAM had exceeded the goals proposed in the 1982 Project Paper for clinic establishment, CBD posts and CBD users. The integration of new maternal-child services began in 1987 and is now a priority activity for all APROFAM departments.

Integration of MCH services, clinical family planning services and CBD services is currently being tested in two of the 10 departmental clinics. This marks APROFAM's first step towards a decentralization of services and administrative support functions.

APROFAM's direct distribution program that supplied MOH centers and posts in 11 health areas in the past has now been turned over to the MOH. A new department and improved system for supplying clinics and CBD's have been established with stronger commodity controls and an identification process established which prevents commercialization of AID-donated goods.

The IEC focus has shifted to include the production of materials and training for Mayan speakers and for people with low literacy skills. Clinics have bilingual personnel in areas with Mayan populations to ensure that all FP clients receive understandable information and counseling on FP methods.

2. Ministry of Health/Family Planning Unit (MOH/FPU): Grant Agreement

The MOH was described in the 1987 extension as "providing services at modest levels of coverage to about half of the country and anticipated working in the rest of the country in the near future". In late 1987 and early 1988, the 11 health areas formerly supplied by APROFAM were transferred back to the MOH. An additional 4 medical supervisors were hired to work in these areas. The supervision and training activities carried out by the FPU have been extremely well received by the MOH, and maternal-child health components have been incorporated into both.

Under the Cerezo administration, the FPU has been able to expand its coverage, provide more training and integrate itself into the MOH system more effectively than in prior years. Data collection from centers and posts has improved, due to improved supervision, but this area of program management remains weak for the Unit and for the MOH as a whole.

3. Guatemalan Association for Family Life Education (AGES): Operational Program Grant (OPG)

AGES provides educational programs for young people, teachers, church groups and others in the broad area of family life education. Initially, the AGES program was limited to Guatemala City. Expansion of AGES began in 1986 with the establishment of three sub-centers in the interior of Guatemala. In 1987, two more centers were opened and a pilot female education project was initiated. This pilot project is currently providing scholarships for approximately 500 girls in eight Mayan communities.

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AGES has surpassed its numerical goal for the provision of information and educational services. The association now has bilingual staff in all five centers and has developed Mayan language curriculum for various family life education topics.

In 1986, AGES successfully carried out a young adult survey in Guatemala City with Centers for Disease Control (CDC) assistance, which provides a solid basis for working with youth in urban areas. The association is currently starting a needs assessment in six Mayan communities with technical and financial support from the Population Council. Although this research component of AGES is recent, it appears to be a very valuable tool for exploring knowledge, attitudes and practices about family planning and MCH in Mayan areas.

Institutional shortcomings identified in AGES by the 1988 evaluation are being addressed through a contract with a management firm which is providing technical assistance to AGES in planning its institutional growth, personnel policies, procurement and other administrative functions.

4. Importers of Pharmaceutical Products  
(IPROFASA): Cooperative Agreement

IPROFASA continues to gain larger market shares for both its brand of condom, Scudo, Lirio, a contraceptive vaginal tablet, and Perla, an oral contraceptive. IPROFASA's products are now being marketed through 775 commercial outlets, including a chain of 24-hour convenience stores. The company has developed a comprehensive marketing plan for 1988 and is engaged in anthropological research in four linguistic areas to find more effective ways to reach the Mayan population. IPROFASA is anxious to move into marketing other health-related products in order to achieve greater financial self-sufficiency, and is currently exploring which products may be appropriate and how this should be done.

The 1988 evaluation recommended that AID support be continued until IPROFASA can absorb more of its operational costs, in order to stimulate IPROFASA to develop innovative strategies to reach rural Ladino and Mayan populations.

#### IV. DETAILED PROJECT DESCRIPTION

##### A. Project Goal and Purpose

The goal of the Project is to improve the quality of life of mothers and children in Guatemala. This represents a revision in the original project goal which was: "improvement in the socio/economic welfare of the poor by increasing access to family planning services and information." The new goal is consistent with the 1988 Action Plan which seeks to integrate family planning into a maternal-child health context.

The purpose of the Project is to expand the utilization of family planning services and information provided by public, private and commercial sources through integration of maternal health services and selected child survival interventions which are designed to reduce the reproductive risks of women in fertile age.

By the end of the Project, significant steps will have been taken to integrate family planning into maternal-child health services, and vice versa, by expanding the number of available channels for delivery of birth spacing services and information to largely rural acceptors, at an earlier point in their childbearing age. The major outputs will include: a total of 994,000 Couple-Years-Protection to be provided by all agencies; 416,000 MCH service encounters (264,000 through CBD programs and 152,000 through clinical services); 213 new service delivery points in the private sector for birth spacing and other child survival services established; 2,200 active community-based distributors; 6,350 persons trained in MCH subjects, reproductive risk management, and family planning; 183,900 clients receiving family life education; and a total of 1,050 pharmacies and other retail outlets supplied with contraceptives.

These outputs will be generated by Project elements which will address the areas of: (1) intensified delivery of family planning services and information in Mayan areas; (2) strengthening of selected services for the mother (e.g., pre-natal, post-natal); (3) continued integration of selected child survival services into family planning programs; (4) development of new private sector mechanisms for delivery of birth spacing and child survival services to unserved and underserved populations; and (5), improved program supervision and logistics systems.

The Project will continue to build upon and

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strengthen the ongoing information and service delivery programs developed thus far under the Project in APROFAM, the Ministry of Health, AGES and IPROFASA. Approximately 75% of Project resources under this amendment are dedicated to strengthening or expanding ongoing programs. The remaining 25% of the resources will directly finance child survival activities and a, New Initiatives component, which is expected to be an effective means of extending the coverage of AID-financed birth spacing and child survival service delivery in rural areas.

In broad terms, this Project can be characterized as addressing "Mother Survival" problems in the same sense that the USAID/Guatemala Child Survival Project (520-0339) deals with improving the health and survival of Guatemala's children. In systematic, programmed ways, the Project Amendment will finance programs which can help women make decisions and take actions concerning their fertility and reduce reproductive risks. For women who become pregnant, this Project will also help to improve the safety of the pregnancy, delivery and post-partum periods for both mother and child.

This Project, then, is a key element in the overall two-part Mission Strategy for assistance to Guatemala in solving the health problems of women and children. In 1992, these two parts -- the Child Survival and the Family Planning Projects -- will be joined into a single integrated, sector-wide project which addresses the health problems of the Guatemalan family in its entirety.

#### B. Strategy

Analysis of the available data indicates that, to achieve the Project purpose of expanding the utilization of family planning services, the Project must seek to reach significantly greater numbers of new users with the following characteristics: rural, largely Mayan women who are relatively young and have two or fewer living children who would be most receptive to temporary reversible birth spacing methods. The strategy requires that existing service provider channels, both public and private, be strengthened and expanded so as to reach further into areas presently accepting family planning services. In addition, new service provider delivery channels need to be established, recognizing that no single model is capable of reaching the culturally diverse and geographically disperse populations in Guatemala. Both existing and new service provider channels must carry an integrated package of

maternal-child health services in a manner which is comprehensible and culturally acceptable to both the Ladino and Mayan segments of the population.

The above strategies are being pursued for a variety of social and technical reasons. Increasing the number of integrated family health service provider organizations broadens and strengthens the constituency for family planning programs, in an environment which now appears more conducive to seem to permit such programs. The beneficiaries are the individual couples who are able to make free decisions about family size and spacing of their children. It is particularly important in Guatemala that women have the opportunity to make these kinds of decisions before they reach high parity with the concomitant risk of poor maternal health and infant deaths. Finally, the proposed project extension will provide the GOG with a transition period to operationally define what has been approved in law.

1. The Mayan Focus:

The Mayan population has tended to be resistant to and mistrustful of services which are introduced into their communities and are not necessarily clearly relevant to their social or cultural sphere. Other social services such as health and education which are available to Mayans have been underutilized by this group. Increasing the level of utilization among this population will continue to be difficult and costly relative to urban, Ladina populations.

Through the activities to be carried out under this extension, family planning and maternal health services will be provided to the Mayan population in a variety of configurations which are intended to increase utilization and acceptance while promoting more positive perception and behavior related to child spacing. There are a number of ways in which new approaches can positively affect utilization. For example, it has been shown that family health workers who are able to provide some basic medicines, such as ORS or parasite medicine, gain greater acceptance than workers offering only contraceptives.

Staff in all delivery agencies will be trained in integrated family health specialty areas. APROFAM community-based promoters will provide basic medicines in addition to temporary reversible contraceptives, along with individual talks on family health issues. IEC tactics will emphasize messages directed toward non-literate, non-Spanish

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speaking audiences. AGES will expand integrated family health programs into new Mayan communities, to increase its understanding of the dynamics of acceptance and utilization of social services.

## 2. Expand Existing Provider Channels

As mentioned, this Amendment continues the process of strengthening and expanding family planning services and information provided to the rural areas. The Ministry of Health will add several hundred new health centers and posts as service delivery points primarily in rural, semi-rural areas. These facilities will provide a full range of temporary, reversible methods to women wishing to space their births. On a case by case basis, the Amendment will finance limited improvements to hospitals wishing to provide voluntary surgical contraception services (VSC). The Amendment will also support an increase in the number of APROFAM community-based distributors, to approximately 2,200, primarily in rural, Mayan areas of the country.

I PROFASA will implement marketing strategies in rural and Mayan areas which use traditional sales outlets such as the various types of pharmacies -- approximately 1,000 such sales points will be reached. To the extent possible, I PROFASA will also incorporate non-pharmacy sales outlets. The MOH will establish referral relationships with rural mid-wives, through training and limited supplies.

The Information-Education-Communication strategy will include messages designed to inform and motivate potential users of birth spacing services, inform current users regarding normal secondary effects of contraceptives and encourage maintenance of use, locations of services and image-building for participating agencies. Special emphasis will be given to promoting the perception that family planning is a conscious decision couples can make throughout the reproductive life of the mother, and not only at the end of this period through sterilization. Culturally appropriate messages in local languages which minimize the need for literacy skills will be emphasized.

## 3. Create New Provider Channels

The USAID Mission faces a series of important issues in expanding the provider network for family planning and maternal-child health services. The MOH, for historical, political and bureaucratic reasons, has had difficulty expanding

its service coverage in the country. APROFAM and IPROFASA have efficient, top-down service delivery systems and the capacity to expand their own operations; it may not be appropriate, however, for these agencies to help other health care providers expand their service coverage. Lastly, there is the management burden on USAID which would result from a large number of agreements with small service providers in the private sector.

The Project will provide financing for a contract with an experienced firm or PVO which will assist existing or new health service providers in the private sector by offering financial and technical assistance for the delivery of one or more of the child survival services, including birth spacing. The contractor will also serve as a clearinghouse of lessons learned from other providers, as well as a means of diffusing new knowledge obtained from AGES' work in the Mayan community. The contractor will provide training, develop project proposals, and monitor performance of the new grantees. An essential task of the contractor will also be to develop local capacity to assume the role as intermediary between USAID and the health PVO community. It is expected that funding equivalent to 10-15 small grants (\$10,000 or less) and four large grants (over \$100,000) will be executed by the end of the extension period in 1991.

APROFAM will continue to expand its work with small health clinics, labor groups and trade associations in the provision of birth spacing services and information. Small logistic support grants, accompanied by educational services as appropriate, will be provided to these organizations.

C. PROJECT COMPONENTS

1. APROFAM (\$10,430,700)

a. General Description

The Project extension will continue to support APROFAM in clinical services, community-based distribution (CBD), information, education and communication (IEC), and a number of special programs in the area of family planning and maternal-child health. These activities will continue to be enhanced and expanded, while developing and pursuing strategies to reach new target groups, such as the Mayan population.

b. Program Elements

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### Community-Based Distribution (CBD)

The CBD program will continue to be the largest single provider of CYP. The cadre of community level promoters will be increased from the current 1,850 to 2,190 by 1991. The increases will take place primarily in the interior of the country, in Mayan areas, and in previously unserved areas. It is estimated that the CBD program will recruit 185,000 new family planning users, and will conduct 540,000 home visits, another 54,000 group talks, and will provide 206,000 CYP.

Basic child survival activities have already been introduced into the CBD program. These will be enhanced through training of all field personnel, and the inclusion of MCH and child survival topics in all community, group and individual talks. ORT, breastfeeding, and child spacing will be integrated into the CBD program. Referrals will be made to APROFAM or other clinics for Maternal-Child Health as well as specific family planning needs. CBD will become more thoroughly integrated with the clinical services program through managerial reorganization and decentralization.

Personnel turnover will be reduced by gradual salary adjustments which approach pay scales in similar organizations, non-monetary incentives such as status enhancement and perquisites, and through improved supervision.

### Clinical Services

This department will continue to expand, after catchment area and demand studies have been completed, with the addition of two new clinics. MCH and FP will continue to be integrated at the clinical level through the addition of a pediatrician and nurse educator at all clinics and the retraining of all clinical personnel. Demand creation will be supported by IEC and CBD elements.

Three regional medical labs will be established to provide cytological, hematological and fecal examinations, which are currently lacking or available only at APROFAM's central facilities. Clinical services will be provided to 14,335 new family planning users, providing a total of 505,462 CYP. In addition, 152,500 MCH service contacts will be made.

Following the model tested successfully by the Enterprise Group in Mexico, twenty-five young, unemployed physicians will be recruited, trained, equipped and located in rural and marginal urban areas to set up private practice,

including the delivery of primary health care and family planning services. These physicians will sign no-pay contracts with APROFAM to serve for specified lengths of time, in return for the training and logistic support received to set up practice. This service modality addresses both the maldistribution of physicians manpower and their apparent oversupply in Guatemala. A full review of this activity is scheduled for 1990 to effect program adjustments.

Finally, CBD staff will continue to develop new mechanisms to deliver reversible methods and education through health plans in industrial complexes such as the Maquila, as well as through small, private clinics in the community.

#### Information, Education and Communication (IEC)

The Communications Unit will continue to raise public awareness of family planning issues and practices. A major new focus of the Unit will be to direct attention to the interrelatedness of child health and birth spacing by targeting messages to couples between the ages of 25-40 with 3 or more children and 3 years or less of formal education. Special emphasis will be placed on reaching Mayan couples with these characteristics. The Unit will do extensive pre- and post-testing of new materials. The Unit will also expand its personnel by adding a specialist in non-literate materials development.

The Training Unit will continue training for all new and existing staff in non-clinical topics. The Unit will also focus attention on expanding its curriculum to include MCH information. This will be directed to CBD promoters as well as to clinical services personnel. A total of 3,950 persons will be trained by the bilingual staff of the Unit during the LOP. Courses in FP training methods which are currently offered to two private institutions will be expanded to include MCH training, and these courses will be provided to up to eight additional private institutions.

APROFAM's IEC program will continue to provide mass and targeted family health education through print and broadcast media. The Training Unit will provide initial and continuing training to all existing and new field personnel in family health objectives and methods.

The PIPOM (Population Information for Policy and Opinion Makers) program provides information on population issues through monthly publications, individual interviews and

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seminars for educators, women's groups, rural advisory groups, and other key entities. This will continue to be a pivotal element in the strategy to create an increasingly favorable environment for family planning in the national Congress, the National Population Commission, and in other high-level political circles.

#### Support Units

These units (evaluation, administration, and management information system) are crucial to the success of the Project extension. Upper management training is planned and a decentralization process to defer administrative tasks to regional and department clinics and field supervisors will be part of the service expansion. Management information will be enhanced through the development of an integrated management information system (MIS), with local and regional data transferred from the field to the central MIS at APROFAM headquarters. The MIS development activity will be carried out in collaboration with IPPF. The evaluation unit will continue to monitor quantitative achievements, while placing a new emphasis on managerial and supervisory evaluations, and on pre- and post-testing of IEC materials and impact.

#### Institutional Development

APROFAM is a well-managed and administered organization. As APROFAM expands its services to more areas of maternal and child health, however, it is necessary to provide senior APROFAM management with systematic analyses of the various elements of the organization which will be most affected by these expansions. The analyses should include reviews of the workload, organizational structure, decentralization issues, improved coordination of clinic and community distribution efforts, the possibility of creating regional administrator posts and improvements in planning and budgeting. This review will be initiated during 1988 by management consultants financed by the Project, in close collaboration with IPPF.

#### Other Activities

Several other APROFAM activities will also be supported by the Project. These include the Regional Center for Audio-visual Education (CREA), an AIDS-oriented Sexually Transmitted Diseases program, and an educational program promoting condom use by military personnel.

c. APROFAM Outputs \*

<u>Community-Based Distribution</u>	
New FP users	185,000
Home visits	540,000
Active Distribution posts	2,190
CYP	206,000
<u>Clinical Services</u>	
New users	14,335
CYP	505,000
MCH/CS contacts	152,560
Number of integrated clinics	12
Number of rural physicians in the field	25
<u>Training</u>	
Number of persons trained	3,950
Number of courses	51
<u>Education of leaders (PIPOM)</u>	
Number of booklets printed	156,263

\*Note: Outputs based upon financing provided by both new and previously obligated funds.

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AFREXAM  
SUMMARY BUDGET

figures in US Dollars, rounded to nearest hundred

LINE ITEMS	1969		1970		1971		1972	COUNTERPART
	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART		
SALARIES	528.5		1,188.5		1,478.5		2,157.5	
TECHNICAL ASSISTANCE	111.0		257.8		248.2		1,151.1	
TRAINING	93.0	91.7	153.1	103.9	170.7	118.2	791.5	2,10.3
TRAVEL/TRANSPORTATION	108.6		271.4		322.9		703.8	
UTILITIES	0.0		184.5		200.7		318.2	
EQUIPMENT/VEHICLES	0.0		181.5		135.9		237.5	
PROMOTION AND PUBLICITY	271.9		731.4		985.6		1,543.8	
ADMINISTRATIVE COSTS	0.0	572.6	149.1	753.2	173.3	822.1	701.3	1,227.1
SUPPLIES	97.4		114.3		133.4		317.2	
EVALUATIONS/AUDITS	0.0		21.6		111.6		133.2	
SPECIAL PROGRAMS	153.9	663.4	58.1	518.0	58.2	576.2	270.3	1,777.8
OVERHEAD	277.8		360.6		428.2		1,015.5	
<b>SUB-TOTAL</b>	<b>1,642.1</b>	<b>1,433.7</b>	<b>3,572.0</b>	<b>1,375.1</b>	<b>4,279.2</b>	<b>1,566.5</b>	<b>9,450.5</b>	<b>4,518.0</b>
CONTINGENCIES	152.2		178.6		214.0		544.8	
INFLATION	0.0		178.6		214.0		352.6	
<b>SUB-TOTAL</b>	<b>152.2</b>		<b>357.2</b>		<b>427.9</b>		<b>897.4</b>	
<b>TOTAL</b>	<b>1,794.3</b>		<b>3,929.2</b>	<b>1,375.1</b>	<b>4,707.2</b>	<b>1,566.5</b>	<b>10,347.7</b>	<b>4,578.0</b>

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2. Ministry of Health/Family Planning Unit (\$2,143,100)

a. General Description

The MOH plays an important role in the overall Project strategy because it operates the largest health care delivery system in the country with the greatest potential service delivery to the rural population, including Mayan areas. The Family Planning Unit now provides supplies and supervision to some 944 health centers and posts within the MOH system. The MOH plans to increase access to a wider variety of FP methods than currently provided (oral contraceptives, condoms and vaginal tablets) and to establish an effective referral system among the different levels of the MOH and community level health providers, especially traditional birth attendants (TBA's).

A significant change in the component is that FP services will become increasingly integrated within the MOH's overall maternal-child health strategy, rather than the vertical, isolated orientation of the FPU in prior years. In preparation for the future family health project mentioned earlier, this component will carry out specific, management-oriented studies to examine structural and administrative issues which will facilitate or hinder the integration of Maternal-Child Health and Family Planning. These studies will be closely coordinated with the activities of the Child Survival Project (520-0339) technical assistance in this area.

The Project extension will continue to support these ongoing activities through the FPU's training programs in the reduction of reproductive risk targeted at MOH personnel at the hospital, health center, health post and community levels. The Project extension will also support equipping and some upgrading of selected health facilities in order to meet minimal surgical standards for the provision of permanent and temporary family planning methods and the training of MOH personnel in these methods. Finally, AID support will be provided in order to strengthen FPU administration and to consolidate improvements in the management information system to assist the FPU with its expanded role in logistics, service delivery and supervision.

b. Program Elements

Reducing reproductive risk is a priority for this component. Worldwide, mortality risks for mother and child are

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highest after four births, when births are spaced less than two years apart, or when the mother is under age 18 or over 35. High parity and inadequate spacing interact synergistically to increase risk. All of these factors are common in Guatemala.

#### Training of MOH and Community Personnel

During the current Project, one hundred health centers will have been equipped with IUD insertion kits, and the physicians and graduate nurses who staff these centers will have been trained. The Project extension will continue this effort at a rate of 50 new centers per year. A total of 900 health post personnel (auxiliary nurses) will also be trained in reproductive risk prevention, detection, management and referral, with special emphasis on improving their link to TBA's in the community and improving pre- and post-natal maternal health care. At the hospital level, training of approximately 300 physicians and graduate nurses will also focus on the reproductive risk reduction strategy. Because of the introduction of methods essentially new to the MOH, quality of service delivery will receive special attention through training and intensified supervision. A buy-in with the Association for Voluntary Surgical Contraception (AVSC) is planned to provide the full range of the technical assistance requirements and commodity procurement support for this activity.

Although training activities experienced a marked increase in quantity and effectiveness during 1987-1988, the Project extension will enhance the quality and impact of these activities through the development and distribution of improved training materials. Technical assistance, training and curriculum development will contribute to this effort. Concise, targeted manuals will be developed, with technical assistance, for health personnel at the hospital, center, post and community levels.

The MOH recognizes that the TBA's provide the majority of pre-natal and delivery care in Guatemala, but that training and minimal equipment are required to improve delivery techniques and for the detection and referral of high risk pregnancies. Close coordination is planned for these activities with UNFPA, UNICEF and AGES. The latter will assist in developing improved training methods and content for this level of health worker.

The nature and extent of MOH activity financed by the Project in the area of training of TBA's will be determined

by a careful, "state-of-the-art" study of existing knowledge and experience in this area in Guatemala. The study to be financed from non-Project funds, will take place in the Fall of 1988 and will lay the basis for preparing and scheduling MOH training activities, as well as further studies to be undertaken by AGES. Tentatively, the overall plan includes: 900 auxiliary nurses trained in reproductive risk management, and equipped with appropriate training materials and TBA kits. These auxiliary nurses, in turn, will identify and train an average of four TBA's each in basic principles of asepsis, the use of the kits, and detection and referral of high risk pregnancies and improved pre-and post-natal maternal health care. In order to effectively reduce maternal risk while establishing an on-going relationship between the auxiliary nurse and the TBA. The Project will coordinate with UNFPA in the provision of iron supplements for distribution by the auxiliary nurses through the TBA's to their patients. These incentives, combined with progressive improvements in the MOH reproductive health referral system, significantly enhance the probability of success in this outreach effort.

Although contraceptive distribution is not expected to form an important part of the TBA's activities, the improved relationship between the formal and informal health sector should lead to greater awareness of contraceptive alternatives and their availability at different levels of MOH facilities.

#### Supervision and Logistics

The 1988 evaluation of the Project expressed concern about the adequacy of staffing levels in the FPU, particularly with regard to the increased supervision and supply functions of the Unit. The Project extension addresses this issue by providing an assistant to the administrator, two additional medical supervisors, and a communications-oriented psychologist. Finally, six four-wheel drive double cabin pickups will be provided to replace the aging fleet of supply vehicles, whose maintenance is both costly and problematic.

#### Improved Management

The recently acquired micro-computer system currently supports the FPU in the use of the CDC Contraceptive Procurement Tracking System (CPTS). The Project extension will expand the management information system in terms of hardware (establishment of a Local Area Network, or LAN, for a multi-user environment), and software will be developed to deal

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more effectively with issues of planning, programming, contraceptive logistics, supervision, finance and reporting. Technical assistance will be provided for this component, and software development will be contracted as required.

Specific Programs

Limited Project funds will be used to support MOH activities in cervical cancer detection, support of selected activities presented in the annual work plan of the National AIDS Commission, the provision of offshore training and reproductive health training materials, and in-country and offshore staff development training for the School of Nursing. An amendment to AVSC's central contract with AID/Washington will provide funds for the limited equipping and upgrading, as required to meet minimum surgical standards, of up to 15 MOH hospitals in support of the reduction of reproductive risk strategy, on an on-request basis. AVSC will also provide technical assistance in specialized areas of reproductive risk management and periodic technical and quality evaluation of this program.

c. MOH Outputs \*

CYP provided by:

1. Orals	28,500
2. Condoms	9,000
3. Vaginal tablets	7,500
4. IUD	120,000
5. VSC	90,000
Total	255,000

Training:

1. Number of MOH personnel trained	1,805
2. Number of courses	54
Number of facilities providing VSC	15
Number of facilities providing IUD	150
Number of TBA's equipped	3,600

\*Note: Outputs based upon financing provided by both new and previously obligated funds.

d. MOH Budget Summary

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MOH  
SUMMARY BUDGET

figures in US Dollars, rounded to nearest hundred

LINE ITEMS	1989		1990		1991		TOTAL	
	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART
ISALARIES	102.2	55.9	103.8	61.5	105.2	67.7	311.2	185.1
ITECHNICAL ASSISTANCE	70.3		35.5		0.0		105.8	
ITRAINING	2.2	271.0	24.9	298.1	23.5	328.0	50.6	697.1
IPER DIEM/TRANSPORTATION	95.3		132.0		126.7		353.9	
ICOMMODITIES	26.5		36.6		39.8		102.9	
IEQUIPMENT/VEHICLES	214.4		125.0		150.0		489.4	
IPROMOTION AND PUBLICITY	0.0	238.2	0.0	261.5	0.0	267.7	0.0	767.4
IADMINISTRATIVE COSTS	11.2	90.0	47.2	99.0	34.9	109.0	93.3	298.0
ISUPPLIES	78.7		73.0		88.7		240.4	
IEVALUATIONS/AUDITS	5.0		5.0		5.0		15.0	
ISPECIAL PROGRAMS	37.8		71.0		75.0		183.8	
I OVERHEAD	0.0		0.0		0.0		0.0	
SUB-TOTAL	646.6	655.1	654.0	720.1	647.7	792.4	1,948.3	2,157.6
ICONTINGENCIES	64.7		32.7		32.4		129.7	
IINFLATION	0.0		32.7		32.4		65.1	
SUB-TOTAL	64.7		65.4		64.8		194.8	
TOTAL	711.3	655.1	719.4	720.1	712.5	792.4	2,143.1	2,167.6

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3. Guatemalan Association for Family Life Education (AGES)  
(\$2,214,200)

a. General Description

AGES will expand its ongoing activities during the Project extension, developing community-based, culturally appropriate communications strategies for the delivery of family life education with a maternal-child health focus to Mayan groups as well as urban marginal ladinos. The Project extension will assist AGES to include five additional communities in its educational service delivery component, reaching a total of 183,900 persons during LOP, training 2,000 new youth counselors, and granting 1,935 scholarships to young Mayan girls. An educational curriculum will be developed for non-school attending Mayan girls and their families who will receive special courses in family life skills. Research activities will be conducted on incorporating culturally specific MCH components into the family life curriculum, the feasibility of developing TBA training methodologies and on the use of innovative, non-traditional communications methods to promote child survival products and services. The provision of technical assistance in institutional development will assist AGES to achieve these outputs.

b. Program Elements

AGES will continue to work in the eight Mayan communities in five departments (Chimaltenango, Huehuetenango, San Marcos, Quetzaltenango and Alta Verapaz) where it currently provides family life education and information services. The Project extension will provide for the inclusion of five additional communities located in the same Departments. The activities AGES conducts in those communities consist of the Family Life Education program, a program based on counseling methodology, and a scholarship program aimed at school-aged Mayan girls. A total of 183,900 persons will be reached through these programs.

AGES will expand its successful Family Life Education Program begun in 1986. Parent-teacher committees will continue to work with AGES to develop socially, culturally and linguistically appropriate family life education material for school-aged children.

Approximately 2,000 additional youth counselors will be trained during the extension in order to significantly increase program coverage of family life education services.

To further test the hypothesis that female education through the primary grades affects fertility, maternal and infant health, AGES will expand its ongoing scholarship program. Approximately 1,935 scholarships will be granted over the three-year Project extension period. Q15 per month will be awarded to girls between 8-15 years of age to encourage them to remain in school and hopefully postpone early marriage and pregnancy. Additionally, technical assistance will help AGES develop a life skills training curriculum for non-school attending Mayan girls and their families. These activities respond to the lower contraceptive prevalence and higher rates of early marriage and pregnancy in unemployed and under-educated Mayan women reported by the 1983 Contraceptive Prevalence Survey. Female education programs such as this have been successfully carried out by USAID/Pakistan and Bangladesh where similar social, educational and employment characteristics among the female populations are found.

AGES will also develop and test materials and hypotheses relating to the following: maternal-child health curriculum to integrate with their Family Life Education Program, urban youth awareness of AIDS risks and preventive measures, methodologies to train TBA's in integration of MCH/FP strategies, and new communications methods in AGES communities to promote child survival products and services.

The systematization, validation and refinement of community training methods and communications strategies for the Mayan community will allow AGES to play an important developmental role during the Project. The resulting Information, Education and Communication (IEC) resource base will help the organization to work more effectively in new communities, and serve as a potential information resource for other organizations that will be shared by AGES in their on-going monthly inter-institutional meetings.

Project funds will assist AGES in implementing the recommendations of a recent institutional management study conducted to develop a long-term organizational plan, clarification of job descriptions and establishment of an equitable pay scale. In order to accommodate AGES' expanded activities, regional responsibility and decision-making authority will be enhanced, permitting the Director to more effectively address global institutional and strategic planning issues.

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c. AGES Outputs

Number of clients served	183,900
Scholarship recipients	1,935
Supervisors' trained	78
Number of persons trained	2,400

AGES  
SUMMARY BUDGET

figures in US Dollars, rounded to nearest hundred

LINE ITEMS	1989		1990		1991		TOTAL	
	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART
ISALARIES	201.8		311.9		334.5		848.2	
ITECHNICAL ASSISTANCE	76.7		82.0		82.0		240.7	
ITRAINING	2.0		8.4		8.4		18.8	
IPER DIEM/TRANSPORTATION	85.5		194.3		123.5		403.3	
ICOMMODITIES	0.0		0.0		0.0		0.0	
IEQUIPMENT/VEHICLES	4.6		12.2		12.2		29.0	
IPROMOTION AND PUBLICITY	0.0		0.0		0.0		0.0	
IADMINISTRATIVE COSTS	3.0		36.4		38.8		78.2	
ISUPPLIES	58.6		73.2		61.6		193.4	
IEVALUATIONS/AUDITS	20.9		25.0		5.0		50.9	
ISPECIAL PROGRAMS	33.8		58.3		58.3		150.4	
IDOVERHEAD	0.0		0.0		0.0		0.0	
<b>SUB-TOTAL</b>	<b>486.9</b>		<b>801.7</b>		<b>724.3</b>		<b>2,012.9</b>	
ICONTINGENCIES	48.7		40.1		36.2		125.0	
IINFLATION	0.0		40.1		36.2		76.3	
<b>SUB-TOTAL</b>	<b>48.7</b>		<b>80.2</b>		<b>72.4</b>		<b>201.3</b>	
<b>TOTAL</b>	<b>535.6</b>		<b>881.9</b>		<b>796.7</b>		<b>2,214.2</b>	

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**4. Importer of Pharmaceutical Products (I PROFASA)**  
**(\$2,885,700)**

**a. Ongoing Activities**

The Project will continue to support I PROFASA's contraceptive social marketing functions, which have had a marked impact on FP activities in Guatemala to date. Of all current agencies involved in the Project, I PROFASA shows the greatest strength in a number of areas which will contribute to Project objectives. The company has developed a market research approach to developing strategies, rather than simply entering a given area and promoting a product. I PROFASA is also strong in management and accountability of supplies, as all supplies are tracked and reported through a computerized inventory and accounting system, minimizing the risk of contraceptive inventory leakage. I PROFASA generates funds from its sales which contribute to its operating budget. I PROFASA has also contributed in a very skillful manner to shifting the climate towards family planning in the country, through its public information and advertising efforts. A final consideration is that consumer markets, once established, have a strong tendency to continue.

Through the continuation of current activities, it is anticipated that I PROFASA will contribute about 65,000 CYP during the three years of the Project extension. By 1991, I PROFASA will annually be providing contraceptives to an estimated 1.85% of fertile age women in union. If in that year contraceptive prevalence increases to 30%, I PROFASA will be supplying around 6% of CYP; at 25% prevalence the contribution would be slightly over 7%.

**b. New Activities**

**Product Diversification**

New contraceptive products, such as the low-dosage oral contraceptive Norquest and a popularly-priced condom recently introduced, will broaden the line I PROFASA handles, gaining both new markets and greater sales for the company.

I PROFASA activities will expand into non-contraceptive markets, as diversification of products is essential to the long-range stability and self-sufficiency of the company. Part of an estimated \$1 million of projected revenues will be invested in development of non-contraceptive

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product lines during the extension. Guidelines have been developed by USAID which define the types of product lines which IPROFASA may handle. In general, new products which are consistent with and contribute to the image of IPROFASA as a provider of quality health and family planning products will be included in product lines. Standard market research procedures will be followed to select products which are economically viable business ventures. Specific new products and activities will be approved by an Executive Committee composed of representatives from the firm and by USAID/Guatemala. Diversification will also move IPROFASA into marketing sales activities and services to other companies.

#### Activities in the Mayan Area

Another important area of activity under the Project extension will be the penetration of Mayan markets, employing a marketing approach based on studies of the cultural underpinnings of acceptance, purchase, and related consumer behavior. IPROFASA has carried out a preliminary study among Mayan groups to define parameters in terms of knowledge, attitudes, and practices in relation to family planning and contraceptive products. A follow-up operational research project is presently being designed that will test various strategies for penetration of this market segment. A fully operational component focusing on this segment is planned for introduction during the first quarter of 1989.

#### Other New Activities

IPROFASA will evaluate the feasibility of providing condoms to organized groups at reduced or wholesale prices. This must be coordinated with the sex education programs APROFAM will be providing to such groups, which is specifically provided for in the APROFAM budget. IPROFASA will also provide information in the area of AIDS education as it relates to the promotion of condom use for safe sex.

#### c. Adjustments to the Project Agreement

With respect to the original Project target of self-sufficiency by 1988, it is clear that this is not yet feasible. With the breakeven point well beyond 1991, the real possibility of a self-sufficient social marketing company at a future date, while not discounted into the current value of investment, enhances the potential returns on support of IPROFASA. It is important for the Project that IPROFASA continue to provide satisfactory yearly increases in CYP, as a condition for continued funding.

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An Executive Committee will be established to provide a rapid means of making decisions on certain predetermined types of issues, such as the use of revenues from sales.

I PROFASA  
SUMMARY BUDGET

figures in US Dollars, rounded to nearest hundred

LINE ITEMS	1989		1990		1991		TOTAL	
	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART
ISALARIES	153.8	26.6	237.3	29.8	289.7	33.2	680.9	89.6
ITECHNICAL ASSISTANCE	46.2		65.8		66.8		179.8	
ITRAINING	0.0		0.0		0.0		0.0	
IPER DIET/TRANSPORTATION	34.8		50.0		60.0		154.9	
ICOMMODITIES	73.0		102.0		106.0		281.0	
IEQUIPMENT/VEHICLES	8.3		9.1		10.0		27.4	
IPROMOTION AND PUBLICITY	285.0		312.0		252.0		849.0	
IADMINISTRATIVE COSTS	55.8	53.2	78.5	59.6	81.5	65.4	215.8	179.2
ISUPPLIES	0.0		0.0		0.0		0.0	
IEVALUATIONS/AUDITS	1.3		3.9		4.6		9.7	
ISPECIAL PROGRAMS	75.0		75.0		75.0		225.0	
IDOVERHEAD	0.0		0.0		0.0		0.0	
<b>SUB-TOTAL</b>	<b>733.2</b>	<b>79.8</b>	<b>944.6</b>	<b>89.4</b>	<b>945.6</b>	<b>99.6</b>	<b>2,823.4</b>	<b>288.8</b>
ICONTINGENCIES	73.3		47.2		47.3		167.8	
IINFLATION	0.0		47.2		47.3		94.5	
<b>SUB-TOTAL</b>	<b>73.3</b>		<b>94.5</b>		<b>94.6</b>		<b>262.3</b>	
<b>TOTAL</b>	<b>806.5</b>	<b>79.8</b>	<b>1,039.1</b>	<b>89.4</b>	<b>1,040.1</b>	<b>99.6</b>	<b>2,885.7</b>	<b>288.8</b>

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5. New Initiatives (\$1,541,300)

a. The Rationale

The rationale for entering into a New Initiatives modality (NIM) is the need for a mechanism to expand health and family planning services through a number of different delivery models to the Coastal Plain, the Mayan communities and other underserved segments of the population by utilizing existing service providers without proliferation of USAID agreements. In addition, it helps leverage more international and domestic resources for health services by working with more donors. The NIM can also provide a clearinghouse of information for more effective means of providing services including types of information and communication with Mayans that will be forthcoming from the AGES experience or from other organizations. The NIM will also help to expand the number of health and family planning providers thus increasing the constituency for family planning.

Three separate reports by different authors and at different times have recommended the creation of an umbrella organization to deal with various private sector providers of health services (See SUNY Stony Brook Health Care Financing Study, Hofmann Report on Services to Mayan Population, and the Project Evaluation of January 1988).

This Project extension plans the contracting of an experienced, qualified firm or private voluntary organization (PVO) to initially serve as the umbrella intermediary organization to establish mechanisms for identifying, developing, monitoring and evaluating performance of private sector grantees in delivery of child survival services, including birth spacing.

c. The Program

During the first half of 1989, the contractor will carry out series of steps including development of the detailed organizational design for its operations, identification of potential grant recipient organizations and create the various management systems needed by the organization.

The contractor will carry out an inventory of relevant private voluntary organizations (PVO's) in early 1989, followed by a thorough organizational design later in the year. The contractor will develop the planned structure,

functions, population to be served, objectives, and relationships with donors and grantee providers. The budget summary is contained in this Section and the more detailed description and justification is contained in the Administrative Analysis Annex.

Operations are scheduled to begin in mid-1989 and by year's end the NIM should have executed one major grant estimated at \$100,000 and one small grant of \$10,000. Thereafter, the number of grants increases each year as shown in the Program Budget. Large and small grants have been set arbitrarily at \$100,000 and \$10,000 merely for the convenience of estimation. In reality, grants can and should be varied in amount to reflect the specific objectives and circumstances of each provider.

The program budget represents funds needed for grants, audits, evaluations and other direct costs in support of the grantees. These are distinguished from the operating costs which include salaries and other administrative costs such as audits, evaluations and technical assistance for the internal administration of the NIM. It is contemplated that funding needs will be smaller in 1989 while the NIM is establishing its organization, procedures and relationships. The number of grants per year have been set arbitrarily to fit the funds available but the organization should be able to handle more grants than budgeted. As the NIM gains experience, it may solicit "shelf" proposals from PVO's for funding from additional Child Survival funds available in subsequent years. Subsequent evaluations (scheduled in 1990 and 1991) will indicate what adjustments are appropriate. Hence, the program budget below is illustrative of the needs, to be confirmed by the detailed operating plans drawn up in 1989 and subsequent years.

NEW INITIATIVES  
SUMMARY BUDGET

Figures in US Dollars, rounded to nearest hundred

LINE ITEMS	1987		1990		1991		TOTAL	
	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART
ISALARIES	58.0		112.3		164.4		332.7	
ITECHNICAL ASSISTANCE	36.0		0.0		0.0		36.0	
ITRAINING	0.0		0.0		0.0		0.0	
IPER DIEM/TRANSPORTATION	9.1		18.2		18.2		45.5	
IECONOMITIES	20.0		30.0		35.0		85.0	
IEQUIPMENT/VEHICLES	20.0		1.0		1.0		22.0	
IPROMOTION AND PUBLICITY	0.0		0.0		0.0		0.0	
IADMINISTRATIVE COSTS	29.0		73.2		77.2		179.4	
ISUPPLIES	0.0		0.0		0.0		0.0	
IEVALUATIONS/AUDITS	0.0		22.5		22.5		45.0	
ISPECIAL PROGRAMS **	210.9		197.0		257.0		664.9	
I OVERHEAD	0.0		0.0		0.0		0.0	
<b>SUB-TOTAL</b>	<b>391.0</b>		<b>455.0</b>		<b>576.1</b>		<b>1,422.1</b>	
ICONTINGENCIES	26.1		22.8		28.8		77.7	
IINFLATION	0.0		22.8		28.8		51.6	
<b>SUB-TOTAL</b>	<b>26.1</b>		<b>45.6</b>		<b>57.6</b>		<b>129.3</b>	
<b>TOTAL</b>	<b>407.1</b>		<b>500.6</b>		<b>633.7</b>		<b>1,551.4</b>	

## V. FINANCIAL PLAN AND ANALYSIS

### A. Project Budget

The activities planned under the PP Amendment are a continuation of ongoing project activities and an integration and expansion of child survival and material health activities. This project will be combined with the Child Survival Project (520-0339) into a family health project to be implemented after 1991. During this bridge period, funding for the Expansion of Family Planning Services Project will come from both the Population and Child Survival accounts.

The total additional budget for the three year project extension, for the period December 31, 1988 to December 31, 1991, will be \$19,215,000, exclusive of counterpart budget. Table V.1 presents a summary by input budget line item for this three year extended period. The total counterpart contribution totals \$8,925,000 of which \$6,811,700 is being added as part of this amendment which will be made available during the three year extension period. The counterpart contribution represents 28.4% of the total life of Project funding. In addition to the \$19.215 million in new funds, it is estimated that approximately \$2.8 million will remain from the current project pipeline as of December 31, 1988. This estimated amount will be utilized by the implementing agents under which the funds were previously committed during the three year project extension. This estimate is based on there being a remaining pipeline of \$4.7 million as of March 31, 1988 and an estimated requirement of \$1.9 million needed to complete activities during CY 1988 (\$4.7 million less \$1.9 = \$2.8 million). Table V.III contains a breakdown of the foreign exchange (18%) and local currency (82%) requirements under the project.

On an annual basis, each implementing institution will submit an annual budget submission for estimated resource requirements for the follow on year. The annual budget will be presented to the project manager at the beginning of each year in the format presented below. The project manager will use the budget as a basis for approval of the follow on activities in the subsequent fiscal year. The format for presentation of the annual budget by each implementing organization is shown in Table V.I as follows:

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ANNUAL FINANCIAL PLAN  
BY INSTITUTIONAL INSTITUTION

PROJECT CATEGORY	LIFE OF PROJECT INVEST				PREVIOUS TOTAL APPROVED		CURRENT COMMITMENTS		FINANCIAL PLAN		TOTAL NEW APPROVED	
	ORIGINAL	NEW	TOTAL	CONTRIBUTION	THRU 12/31 OF PRIOR YR	REMAIN	THRU 12/31 OF C/YEAR	REMAIN	CONTRIBUTION	REMAIN	CONTRIBUTION	THRU 12/31 OF FOLLOWING CY
GRANTS												
TECHNICAL ASSISTANCE												
TRAINING												
PER. DEV./REORGANIZATION												
EQUIPMENTS												
WORKSHOP/SEMINARS												
PROVISION & PUBLICITY												
ADMINISTRATIVE COSTS												
STARTUPS												
MANUFACTURING/PLANTS												
SPECIAL PROGRAMS												
OTHERS												
<b>SUB-TOTAL</b>	<hr/>											
CONTRIBUTORS												
INFLATION												
<b>SUB-TOTAL</b>	<hr/>											
<b>TOTAL</b>	<hr/>											

TABLE V.1

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ALL INSTITUTIONS  
SUMMARY BUDGET

figures in US Dollars, rounded to nearest hundred

LINE ITEMS	1989		1990		1991		TOTAL		% AID CONTRIB	% TOTAL PROJECT
	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART	AID	COUNTERPART		
SALARIES	1,040.4	92.5	1,953.9	91.3	2,332.3	100.9	5,326.5	274.7	28%	22%
TECHNICAL ASSISTANCE	340.2		442.1		389.0		1,171.3		5%	5%
TRAINING	97.1	362.7	166.4	402.0	202.6	446.2	466.2	1,210.9	2%	6%
TRIP DIEM/TRANSPORTATION	336.2		675.9		651.2		1,663.4		9%	6%
COMMODITIES	119.5		353.1		390.5		853.1		4%	3%
EQUIPMENT/VEHICLES	247.3		248.9		309.1		805.2		4%	3%
PROMOTION AND PUBLICITY	556.8	238.2	1,043.4	261.5	1,117.6	257.7	2,717.8	787.4	14%	10%
ADMINISTRATIVE COSTS	99.0	821.8	394.5	911.8	405.7	1,027.5	897.2	2,761.1	5%	14%
SUPPLIES	236.7		260.5		283.7		781.0		4%	3%
EVALUATIONS/AUDITS	27.2		77.9		148.7		253.8		1%	1%
SPECIAL PROGRAMS **	511.4	653.4	460.2	518.0	524.3	596.2	1,496.0	1,777.6	6%	13%
OVERHEAD	277.8		360.6		428.2		1,066.6		5%	4%
<b>SUB-TOTAL</b>	<b>3,989.8</b>	<b>2,168.6</b>	<b>6,427.3</b>	<b>2,134.6</b>	<b>7,172.9</b>	<b>2,458.5</b>	<b>17,490.0</b>	<b>6,811.7</b>	<b>91%</b>	<b>93%</b>
CONTINGENCIES	365.0		321.4		358.4		1,045.0		5%	4%
INFLATION	0.0		321.4		358.6		680.0		4%	3%
<b>SUB-TOTAL</b>	<b>365.0</b>		<b>642.7</b>		<b>717.3</b>		<b>1,725.0</b>		<b>9%</b>	<b>7%</b>
<b>TOTAL</b>	<b>4,254.8</b>	<b>2,168.6</b>	<b>7,070.0</b>	<b>2,134.6</b>	<b>7,890.2</b>	<b>2,458.5</b>	<b>19,215.0</b>	<b>6,811.7</b>	<b>100%</b>	<b>100%</b>
% PER YEAR AID SOURCE	22%	32%	37%	32%	41%	36%	100%	100%		

% COUNTERPART CONTRIBUTION

35%

\*\*NOTE: INCLUDES \$120,000 FOR 1989 CENSUS, NO CONTINGENCY OR INFLATION CALCULATED FOR THIS EXPENSE.

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EXPANSION OF FAMILY PLANNING SERVICES  
PROJECT 520-0229

CURRENCY UTILIZATION

TABLE V. III

LINE ITEMS	1969				1970				1971				TOTAL			
	AID		COUNTERPART		AID		COUNTERPART		AID		COUNTERPART		AID		COUNTERPART	
	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC
FEES	100.0	946.4	0.0	82.5	100.0	1,033.9	0.0	91.3	100.0	2,237.3	0.0	100.9	300.0	5,024.3	0.0	274.7
HEALTH ASSISTANCE	313.0	75.2	0.0	0.0	315.0	127.1	0.0	0.0	315.0	74.0	0.0	0.0	943.0	228.3	0.0	0.0
INSURANCE	45.0	52.1	0.0	362.7	45.0	121.4	0.0	402.0	45.0	137.6	0.0	446.2	135.0	331.2	0.0	1,219.9
RENT/TRANSPORTATION	45.0	291.2	0.0	0.0	45.0	630.9	0.0	0.0	45.0	606.2	0.0	0.0	135.0	1,328.1	0.0	0.0
DUTIES	119.5	0.0	0.0	0.0	353.1	0.0	0.0	0.0	380.5	0.0	0.0	0.0	853.1	0.0	0.0	0.0
EQUIPMENT/VEHICLES	200.0	47.3	0.0	0.0	200.0	48.9	0.0	0.0	200.0	109.1	0.0	0.0	600.0	205.2	0.0	0.0
TRAVEL AND PUBLICITY		356.8	0.0	232.2		1,043.4	0.0	261.5		1,117.6	0.0	297.7		2,717.8	0.0	787.4
OPERATIVE COSTS		99.0	0.0	823.8		304.5	0.0	711.8		405.7	0.0	1,027.5		669.2	0.0	2,761.1
FEES		236.7	0.0	0.0		260.5	0.0	0.0		283.7	0.0	0.0		781.0	0.0	0.0
STIPENDS/AUDITS		27.2	0.0	0.0		77.9	0.0	0.0		120.0	0.0	0.0		133.8	0.0	0.0
OTHER PROGRAMS		511.4	0.0	663.4		460.2	0.0	510.0		524.3	0.0	352.2		1,493.9	0.0	1,777.6
GRAND TOTAL		277.8	0.0	0.0		360.6	0.0	0.0		428.2	0.0	0.0		1,066.6	0.0	0.0
SUB-TOTAL	824.5	3,065.3	0.0	2,169.6	1,059.1	5,369.2	0.0	2,184.6	1,205.5	5,967.4	0.0	2,438.5	3,028.1	14,401.9	0.0	4,811.7
AGENCIES	22.5	282.5	0.0	0.0	52.9	269.5	0.0	0.0	60.3	250.4	0.0	0.0	193.6	849.4	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	52.9	269.5	0.0	0.0	60.3	250.4	0.0	0.0	113.2	566.8	0.0	0.0
SUB-TOTAL	22.5	282.5	0.0	0.0	105.8	536.9	0.0	0.0	120.6	506.7	0.0	0.0	306.8	1,416.2	0.0	0.0
GRAND TOTAL	907.0	3,347.8	0.0	2,169.6	1,164.9	5,906.1	0.0	2,184.6	1,326.1	6,474.2	0.0	2,438.5	3,398.9	15,818.1	0.0	4,811.7

TABLE V. III

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B. Source of Funding

Of the total, an estimated \$14.945 million will support Family Planning activities and \$4.27 will support Child Survival activities.

C. Other Project Activities

Census

A contribution of \$120,000 will be made through a Limited Scope Grant Agreement (LSGA) to the National Institute of Statistics (INE) to support the 1991 decennial Census in Guatemala. The principal donor for the Census is UNFPA, through grants to INE. The precise nature of this assistance will be specified through a PASA arrangement with BUCEN which will develop a scope of work for the LSGA.

D. Sustainability of the Project

This project has one component -- IPROFASA -- which is designed for eventual self-sufficiency. Other elements will continue to generate limited self-financing, such as APROFAM and AGES. The Ministry of Health has the capacity to continue activities without continuous USAID support. However, it is anticipated that USAID support will be prolonged, and that the level of support described in this document will continue after PACD of 12/31/91.

E. New Funds Required

Table V.2 below shows the amount of new funds required for project activities.

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TABLE V.2  
ADDITIONAL FUNDS REQUIRED  
FY 1989 - FY 1991 - (US\$000s)

	ESTIMATED PIPELINE AVAILABILITY	NEW FUNDS REQUIRED	TOTAL
SALARIES	589.2	5,326.5	5,915.7
TECHNICAL ASSISTANCE	311.0	1,171.3	1,482.3
TRAINING	100.7	466	566.9
PER DIEM/TRANSPORT	134.6	1,663.4	1,798.0
COMMODITIES	384.3	853.1	1,237.4
EQUIPMENT/VEHICLES	325.6	805.2	1,130.8
PROMOTION AND PUBLICITY	490.7	2,717.8	3,208.5
ADMINISTRATIVE COSTS	314.6	889.2	1,203.8
SUPPLIES	0.0	781.0	781.0
EVALUATION/AUDITS	98.1	253.8	351.9
SPECIAL PROGRAMS	49.2	1,496.0	1,545.2
OVERHEAD	0	1,066.6	1,066.6
CONTINGENCIES	0	1,045.0	1,045.0
INFLATION	0	680	680.0
TOTAL	2,798.0	19,215.0	22,013.0

Amounts to be obligated in FY88, by functional account are as follows: \$5.035 million from Population Planning and \$2.760 from Child Survival. Table V.3 below presents the proposed FY 1988 obligations by Component:

TABLE V.3  
FY88 OBLIGATIONS, BY COMPONENT (AGENCY) AND FUNCTIONAL ACCOUNT

COMPONENT	PN	CS	TOTAL
Ministry of Health	1,071	6,53	1,724
I PROFASA	879	-0-	879
AGES	688	-0-	688
A PROFAM	2,397	1,301	3,698
NIM	-0-	806	806
TOTAL	5,035	2,760	7,795

Table V.4 below presents the projected expenditures by implementing agency and year:

TABLE V.4  
SUMMARY  
PROJECTED EXPENDITURES  
BY AGENCY AND YEAR  
(\$'000)

Implementing Agency	1989	1990	1991	Total
A PROFAM	1,794.3	3,929.2	4,707.2	10,430.7
MOH	711.3	719.4	712.5	2,143.1
AGES	535.6	881.9	796.7	2,214.2
I PROFASA	806.5	1,039.1	1,040.1	2,885.7
	497.1	500.5	633.7	1,541.3

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## VI. AUDIT AND EVALUATION PLAN

### 1. Audit and Evaluation Plan

APROFAM, AGES, MOH and IPROFASA will be audited on a yearly basis by an independent local accounting firm which has been contracted specifically for this task. The MOH, as part of the GOG, is also audited periodically by the Contraloría de Cuentas, the official GOG Audit Institution. AID funding for audit activity has been included in the project budget. These audits will be supervised and reviewed by the USAID Controller's office to ensure conformity with sound fiscal management practices.

Evaluations will be carried out for the purpose of improving the ongoing project management process and assessing the extent to which planned goals, purposes and outputs/inputs are being achieved. Four types of evaluations are planned under the extension: (1) focused evaluations of specific elements of implementing institution programs; (2) an overall evaluation during the third year of the extension to assist with new project development; (3) "mini-surveys" in follow-up to the 1987 Demographic and Health Survey carried out by INCAP/Westinghouse, and (4) management evaluations of the implementing institutions. An illustrative budget for project evaluations is included as Annex N.

#### a. Evaluation of Specific Elements of Grantee Programs

Evaluations limited to specific elements of Grantee programs will be carried out by both external and local evaluation experts. A total of \$180,000 is set aside for these types of evaluations and is included in the respective agency budget. Estimated timing is given, if known:

#### APROFAM

Periodic "Quality Assurance" evaluations of the VSC program will be conducted, including spot checks of medical, administrative and educational dimensions of the program. Elements of the Tulane Voluntarism studies will be repeated for trend analysis.

Program review of communications strategy implementation with special emphasis on the Mayan elements and non-literate Ladino population will also be conducted.

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MOH

An intensive review of: (a) training activities; (b) integrated supervision of MCH and Family Planning services; (c) management information system in support of logistics, supervision, project accounting and other applications; and (d) analyses of service coverage will be conducted.

AGES

To guide expansion, a communications strategy assessment to address the quality of family life educational materials and progress made in developing a vocational education program in AGES' Mayan communities will be conducted.

I PROFASA

A management evaluation in 1989 will be conducted to assist in further institutional development.

New Initiatives

Interim formative evaluations of New Initiatives to be funded by the Project will be undertaken to assist in facilitating implementation.

b. Overall Evaluation of the Project

An overall evaluation of the Project is scheduled for March 1991 to guide designers in the preparation of the PID in May 1991 of the new project, Family Health (520-0357). Implemented by external evaluators, this evaluation will assess the overall results and impact of the current Project, as well as provide a realistic basis for planning, management and implementation of the new project. Although implemented by external evaluators, this activity will be carried out in close collaboration with relevant counterpart agencies in the public and private sector. A total of \$60,000 is set aside for this activity and is included in the APROFAM budget.

c. "Mini-Surveys" on Selected Topics

A principal outcome of the 1987 National Demographic and Health Survey (DHS) are data which permit measurement of trends in contraceptive prevalence, fertility rate changes, indicators of maternal and child health status and usage of health services, and other demographic variables.

Additional, smaller surveys designed to study in greater depth selected variables in specific geographic areas may be scheduled during the extension. The results of these surveys will be used to assess the effectiveness of the current Project in increasing knowledge of family planning, increasing contraceptive usage, and efficient changes in fertility rates. The surveys will also provide additional baseline data for the design of the new project, Family Health (520-0357), planned for obligation in FY91.

These surveys will be carried out by APROFAM, AGES, Westinghouse, CDC or other qualified research institutions. A total of \$60,000 is set aside for these activities and is included in the APROFAM budget.

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VII. IMPLEMENTATION PLAN

A. Implementation Arrangements

This Amendment is a continuation of ongoing activities, so that no major changes to the existing disbursement and procurement arrangements are foreseen. The dominant methods of financing will be direct payment, advances and reimbursement. No deviation from the disbursement procedures established under the original Project are anticipated. Funds will be disbursed to implementing institutions upon presentation of monthly vouchers in the required format, indicating that expenditures were made in conformance with the Project financial plan. The detailed annual budget will serve as a basic guide to monitor the flow of Project funds.

An estimated 67.3% of total expenditures in the budget is composed of line items which disburse smoothly or are one-time disbursements. The table presented below contains estimated funding, by line item, which are stable, recurrent costs or are procurements over which AID has high degree of control. The total of almost \$14.0 million, therefore, represents the aggregate funding which is believed to pose no expenditure problem for the grantees.

Estimated Funding, by Line Item  
of Stable Recurrent Costs  
(\$000's)

<u>Line Item</u>	<u>Approx. Amount</u>	<u>% of Total</u>
Salaries	5,326.5	30.4
Technical Assist.	1,171.3	6.7
Perdiem/Trans	1,663.4	9.5
Commodities	853.1	4.8
Equipment	805.2	4.6
Admin. Costs	889.2	5.1
Evals./Audits	253.8	1.5
Special Prog.	800.0	4.6
Overhead	1,066.6	6.1
Sub total	12,829.1	NA
Contingency/ Inflation	1,160.1	NA
TOTAL	13,989.2	67.3

In addition to the above and barring unforeseen events, there is the fact that approximately 75% of the funding is

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destined to implementation of ongoing programs in strengthened and expanded form. Thus, the usual start-up delays in projects of this type will be minimal. It should also be noted that APROFAM, a good performer along lines of "planned vs. actual expenditures", has approximately 66% of the total budget assigned to it.

Past experience has shown that the private sector agencies participating in this project, although affected by the occasional negative political swings, tend to maintain stable expenditure patterns. The ratio of private to public sector proportions of the budget is 89:11, suggesting that expenditures will approximate those projected for the life of project. Finally, expenditures (including accruals) for the Project as a whole were \$1,189,000 for the third Quarter of FY 1988. This rate projects to an annual expenditure of almost \$5 million, making an annual rate of \$7.0 million quite reachable.

Annex E contains an analysis which presents total expenses during the life of the project for all implementing agencies which are covered by new funding and pipeline. The total projected expenses, \$22.0 million is composed of \$19.215 million in new funding and \$2.8 of pipeline. The table in Annex E shows pipeline estimates by line item as a separate column to the right. This same table presents an estimate of total spending by project year, which averages approximately \$7.3 million.

TABLE VI.1  
Methods of Implementation and Financing

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EXPANSION OF FAMILY PLANNING SERVICES  
PROJECT 520-0255

METHODS OF IMPLEMENTATION AND FINANCING

LINE ITEMS	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	APPROXIMATE AMOUNT (000)
ISALARIES	HC - FSC	Advance/Reimbursement	5,726.5
ITECHNICAL ASSISTANCE	Profit Contractors	Direct Pay	1,171.0
ITRAINING	IC - Profit or Non-Profit Contractors	Advance/Reimbursement	465.0
ISPER DIET/TRANSPORTATION	HC - Procedures	Advance/Reimbursement	1,620.4
ICOMMODITIES	AGD/USA Procurement	Direct Pay	553.1
IEQUIPMENT/VEHICLES	HC - Procedures Purchase Orders	Direct Pay	608.2
IPROMOTION AND PUBLICITY	IC - Profit or Non-Profit Contractors	Advance/Reimbursement	2,717.8
IADMINISTRATIVE COSTS	CC - Profit and Non-Profit Implem Instit	Advance/Reimbursement	319.2
ISUPPLIES	HC - Procedures Purchase Orders	Advance/Reimbursement	780.0
IEVALUATIONS/AUDITS	CC - IGC and Profit Making Contractors	Direct Pay	255.5
ISPECIAL PROGRAMS	GPE - PVD	Advance/Reimbursement	1,456.0
IOVERHEAD	CC - Profit and Non-Profit Implem Instit	Direct Reimbursement	1,085.6
SUB-TOTAL			17,470.0
ICONTINGENCIES	Various	Advance/Reimbursement	1,045.0
INFLATION	Various	Advance/Reimbursement	620.0
SUB-TOTAL			1,725.0
TOTAL PROJECT			19,215.0

The USAID/Guatemala Controller has reviewed and approved the detailed assessment of the methods of implementation and financing for the activities included in this project paper supplement as summarized above.

Andrew A. Peters  
Acting Controller, USAID/Guatemala

Date

B. Implementation Schedule

Key Events of Project

<u>Event</u>	<u>Responsible Inst.</u>	<u>Date</u>
PP Supplement Approved and authorized	USAID	June 1988
Agreements signed with Implementing Agencies	USAID and counterparts	June/July 1988
Institutional Devel Plan for APROFAM	APROFAM/contractor	Oct. 1988
New PSC on duty	USAID	Jan. 1989
Results of Mayan Market Research	I PROFASA	Sept-Oct 1988
Review Contraceptive Logistic MIS	APROFAM, MOH & TA from CDC	Nov. 1988
TA contract signed	USAID	Nov. 1988
Contract for NIM signed	USAID	Nov. 1988
Market Strategy for rural areas	I PROFASA	Dec. 1988
Approve Implementation Plans for 1989	USAID & Counterparts	Dec. 1988
Inventory of PVO resources completed	NIM Contractor	Jan. 1989
Initiate MCH materials development	AGES/APROFAM	Jan. 1989
Management Improvement Process begins in AGES and APROFAM	USAID/AGES/APROFAM	Sept-Dec 1988
Review/Approval of CY89 Workplans	USAID	Dec. 1988

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Sign Contract for TA	USAID/Contractor	Dec. 1988
External Audits of grantee fiscal mgmt.	USAID/Contractor	various times
Initiate Vocational Educ. Program	AGES	Jan.
1989 Complete design of Proposed NIM structure	NIM Contractor	Feb. 1989
Initiate IEC Strategy Phase II	APROFAM	Feb. 1989
Sign first NIM Grant Agreement w/local PVO grantee	USAID, Contractor & PVO grantee	June 1989
Initiate Phase II Mayan Strategy	AGES	Feb. 1989
Evaluations of Grantee programs under Project	USAID & Contractors	Aug-Sep 1989
Approve annual plans and budgets for 1990	USAID & Grantees	Dec. 1989
Evaluate Inst. Develop.	AGES	Dec. 1989
External Audits of grantee fiscal mgmt.	USAID Contractor	various times
Evaluations of Grantee programs	USAID & Contractor	Aug-Oct 1990
Initiate analysis of Mayan strategy	AGES	Dec. 1989
Approve annual plans and budgets for 1991	USAID & Grantees	Dec. 1990
Write PID for new Family Health Project	USAID & Contractor	Feb. 1991
External Audits of grantee fiscal mgmt.	USAID Contractor	various times
Final overall eval. of Project.	USAID & Contractor	Aug-Oct 1991
Complete PP for Family Health	USAID & Contractor	Nov. 1991

C. Technical Assistance Plan

A total of 78.5 person-months of technical assistance is programmed for the three-year period, all of these to be short-term inputs, i.e., less than one year duration per task. The long-term resident advisor position for IPROPASA will be converted to a series of short-term consultations.

The volume and variety of technical requirements will necessitate a contractor to procure the various inputs according to the specifications and timing of the Project. The Contractor will be selected by competitive procurement and maintain a home office coordinator to respond to Mission and Project needs. There is no need for the Contractor to maintain a resident representative in Guatemala.

Two Agencies -- APROFAM and AGES -- have the capacity to procure their technical assistance directly, subject to the approval of the USAID Mission. Hence, their technical inputs will not be handled by the main Contractor and are budgeted at a lower overhead rate than that of the main Contractor.

The detailed technical assistance requirements of each agency are presented Annex E, Technical Assistance.

The technical assistance requirements for each of the agencies involved in the Project are detailed below.

1. APROFAM

A. Community Based Distribution Program: This program will receive a total of five months of TA in the following areas:

- (1) To develop a child survival protocol for use by promoters, which can be followed in covering the fundamental activities and topics, elements of individual education, and indications for referrals. (0.5 months)
- (2) Skills development related to the integration of maternal and child health with family planning in overall community education strategies. (1.0 months)
- (3) To develop a task-specific supervision system; will identify models to increase effectiveness and efficiency of supervisory contacts. (2.0 months)

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- (4) Develop strategies to integrate reporting and tracking systems between CBD and clinical services. (1.5 months)

B. Clinical Services Department

Technical assistance for clinical services will consist principally of setting up systems for decentralization of administrative responsibilities. Additional technical assistance not included in this budget will be provided by AVSC in the areas of quality assurance. (4 person-months)

C. Evaluation Department

Internal evaluations during the extension period will emphasize content and impact of supervision, communications, and CBD activities. TA is required during the evaluation planning phase each year to design evaluation activities with key personnel in the respective departments, and to provide timely input into the analytical stage of these evaluations. (4.5 person-months)

D. Management Information System (MIS)

Technical assistance will be provided to revise and coordinate reporting forms between CBD, clinical services, evaluation and support units, and to ensure proper database management and reporting and systems. (1.5 person-months)

E. IEC Department

Assistance in the integration of Family Planning and Maternal Child Health IEC messages and strategies will be provided to assist in focusing on the targeted population of married couples with 3 or more children. Birth spacing will be the predominant theme. (2 person-months)

IEC will also receive assistance in the development of literacy materials in family planning and maternal-child health. (4 person-months)

2. MOH

A total of seven person-months of short-term

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technical assistance will be provided to the MOH/Family Planning Unit in the following areas:

- (1) Supplementary support to the CDC-provided logistics technical assistance will be provided to assist the FPU in managing supply, storage, distribution and reporting aspects of the logistics system. (2 person-months)
- (2) Assistance in the development of training materials to enhance the quality of the MOH training program will be provided. Specifically, assistance will be provided in the development of manuals for distribution to medical, paramedical and community-level personnel. (3 person -months)
- (3) Technical assistance will be provided to guide the overall design of the management information system, so as to insure maximum compatibility with software and reporting formats used by the other agencies. Most software for the MOH will be developed on a contract basis. (2 person-months)

### 3. AGES

A total of 16.5 person-months of technical assistance activities will be conducted:

- (1) Assessment/modification of institutional development plan. The assistance will occur one year following central-regional office decentralization, in order to modify roles and functions of personnel and major program components. (2 person-months)
- (2) Development of maternal-child health curriculum to integrate with existing family life education program. Material will be linguistically, culturally and educationally appropriate for major Mayan language groups. (4 person-months)
- (3) Evaluation and modification of currently used curriculum material and the development of non-formal education/training methods. Modification of existing materials particularly in the Family Life Education For All Program as well as innovative strategies for non-readers will take place. (4.5 person-months)

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- (4) An occupational training program will be developed for non-school attending young Mayan women. Program will include a pre-vocational component, a community assessment tool to determine curriculum needs and guidelines for program implementation. (2 person-months)
- (5) Development of alternatives for new income generation to assist AGES in gaining a greater degree of self-sufficiency. (0.5 person-month)
- (6) Assistance in Applied Survey and Ethnographic Methods and Analysis to strengthen AGES' research capacities. Funding will be sought through the Population Council or similar group. (3 person-months)

#### 4. I PROFASA

A total of 24 person-months of technical assistance to I PROFASA will accomplish the following:

- (1) Design, develop, test and implement marketing strategies for Mayan areas. (4.5 months)
- (2) Develop yearly marketing plans. (4.5 months)
- (3) Assist in the systematic incorporation of non-contraceptive products into the product line. (3.0 months)
- (4) Develop, test, select and incorporate maternal and child health products and respective advertising. (3.0 months)
- (5) Develop and test market segmentation strategies. (4.5 months)
- (6) Develop and test additional market research activities analyzing specific product marketing channels, pricing models, and consumer preferences. (4.5 months)

#### 5. New Initiatives (NIM)

Technical assistance will be contracted as part of a larger contract with a firm or PVO to serve as an "umbrella" organization in the following areas:

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- (1) Organizational Design of NIM: Develop detailed organizational plans for the NIM which specifies objectives, project selection criteria, functions, structure, relationship to external donors and grantees, and budget. (3.5 person-months)
- (2) Management Systems Develop procedures for the planning, project appraisal, monitoring, budgeting, evaluation and reporting procedures, both from grantees and to donors. (2 person-months)

3. Person-Month Summary

Project Technical Assistance

	Person-months			1989-91	
	1988	1989	1990	1991	
<u>Total</u>					
<u>USAID</u>					
PSC(local) Mos.	12.0	12.0	12.0	12.0	36.0
PSC(non-local) Mos.	0	12.0	12.0	12.0	36.0
Resident Advisors	12.0	24.0	24.0	24.0	72.0
Short-term Offshore		23.5	14.5	12.0	50.0
Short-term Local		12.0	6.0	5.5	23.5
Short-term AID/W support		2.0	1.5	1.5	5.0
Total Short-term		37.5	22.0	19.0	78.5

3. Budget Summary

Project Technical Assistance Budget (Dollars)

	1989	1990	1991	Total
<u>AID Procured TA</u>				
Long-term (PSC) *	151,000	151,000	151,000	453,000
Offshore TA	220,000	100,000	70,000	390,000
Local TA	66,000	33,000	30,250	129,250
Total AID Procured TA	437,000	284,000	251,250	972,250
<u>Agency Procured Advisors</u>				
APROFAM *	225,880	135,360	115,900	477,140
AGES	96,440	82,060	82,060	260,560
Total Agency Procured TA	322,320	217,420	197,960	737,700
GRAND TOTAL	759,320	501,420	449,210	1,709,950

\* The two long-term PSC advisors are included in the APROFAM summary agency budget for technical assistance.

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D. Procurement and Contracting Procedures

Contraceptive procurement for all the agencies will be done by USAID/Guatemala through AID/Washington. These procurements are guided by the Contraceptive Procurement Tables (CPT), prepared annually by Centers for Disease Control consultants. Contraceptive specifications, including IUD's, are developed by AID/Washington (ST/H).

As Operational Program Grantees (OPG's), APROFAM and AGES will carry out all local procurement of goods and services in accordance with standard handbook procurement procedures. These two grantees will also carry out procurement of off-shore technical assistance, in consultation with USAID/Guatemala.

For the MOH, USAID/Guatemala will provide procurement services for vehicles and TA. Contraceptive equipment (including surgical and IUD equipment and supplies) will be procured for the MOH by AVSC, through a Mission buy-in to an existing AID/Washington contract with this organization. All other MOH procurement will be local.

USAID/Guatemala will perform all offshore procurements (TA and commodities) for IPROFASA and the New Initiatives Modality (NIM). All local procurements will be handled by these agencies.

### VIII. Monitoring Plan

The monitoring of this Project will be the primary responsibility of the Mission Population Officer. This officer will be assisted on a day-to-day basis with implementation and monitoring by two Project Liaison Officers (PSC's) who will be Project-funded (See Annex K for Scope of Work and Qualifications). In addition, these three officers will receive overall guidance from the Project Committee consisting of the Chief, Office of Human Resource Development (OHRD), one representative each from the Project Development and Support (PDSO) and Program (PRM) offices, and a financial analyst from the Controller's office.

The monitoring of implementation by Mission staff will be supplemented by the technical assistance contracted in specific areas of technical expertise. Briefly, the areas of technical assistance are management and institutional development, training, materials development, IEC, management information systems, logistics and evaluation.

The Project will also receive short-term technical assistance from AID/Washington-funded intermediary contracts. The Association for Voluntary Surgical Contraception (AVSC) will continue supervision of the VSC program with APROFAM in Guatemala; AVSC will also carry out technical assistance activities in implementation of the new VSC program in the MOH; Development Associates will continue assistance in the area of training; and, from CDC/Atlanta, assistance will be provided in the areas of contraceptive procurement and quality control. As needed, AID/Washington will provide selected technical assistance in specialized areas of Project implementation. With concurrence from the Mission, representatives of intermediary-funded projects will travel to Guatemala as required to assist with implementation and monitoring of the Project.

Mission representatives will hold regular implementation meeting with key officers in each implementing institution. With APROFAM and AGES, the meetings will be held with the Executive Director of these agencies; MOH, with the Chief of the Family Planning Unit and when necessary, with the Head of Maternal and Child Health, Director of Applied Programs and the Director General of Health Services; and for IPROFASA, with the General Manager, Resident Advisor and as necessary, with the company's Board of Directors.

USAID staff will undertake regular field visits to directly observe Project activities. These visits will occur on a monthly basis, as other Mission business permits.

Quarterly reports including family planning service statistics will be submitted to USAID by each of the grantees for analysis and assessment of Project progress.

AB

IX. SUMMARY OF PROJECT ANALYSES

A. Technical Analysis

1. Demographic Impact

Guatemalan health status is among the worst in Latin America, both maternal and infant mortality rates are unacceptably high. These important indicators are highest among rural Mayan segments of the population. The public health sector is underfunded and services are inadequate. Almost 50% of the total population has no access to modern health care. Given this situation, the strategy of providing family planning services within a maternal child health program appears extremely sound.

According to preliminary data from the Demographic and Health Survey, the Mayan population has shown no increases in the use of family planning or maternal health services in the past ten years. Studies have shown that health messages and services are not reaching this group. This large population, almost 50% of the total population, thus remains marginalized and underserved.

The prevalence rate of 1983 was 25% and the rate in 1987 was 23%. The decline in prevalence occurred despite an increasing number of users because the number of fertile age women increased faster than the number of new users. This relative increase in the number of fertile age women will continue through the end of the century, as these cohorts of women have already been born.

A better indicator is perhaps couple-years-protection (CYP) in order to distinguish between users of methods of different intrinsic duration (i.e., sterilization versus IUD or oral contraceptives). The cumulative target for 1989-91 is 994,000 CYP which translates to an average of 331,000 CYP per year compared to an average of 247,000 CYP per year since 1983. This increase of 34% is realizable if the inputs and managerial improvements are made in the existing implementing agencies and another organization is utilized to expand the number and size of current health service providers.

The FY89-90 Action Plan target of a 35.3% prevalence by 1991 is not considered feasible. The CYP target of 994,000 has no exact equivalent in user rates but a rough estimation of prevalence achievable by the PACD is about 27%.

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This constitutes an increase of 4 percentage points from 1987 to 1991, which is a substantial increase. Nonetheless, this target is considered obtainable given the assumptions stated above. The level of funding for this Project almost doubles from \$12.1 million during 1983-87 to \$22 million during 1988-91. These inputs and the revised strategy using a maternal health focus make achievement of the target feasible.

2. Contraceptive Technologies

The Project will continue using the various medically acceptable contraceptive methods already in use in Guatemala and elsewhere. Contraceptive providers are or will be trained in the use of oral contraceptives, voluntary surgical sterilization methods, IUD's and the various barrier methods. No problem is foreseen in the continued use of these proven methods. The MOH and APROFAM will be encouraged to provide advice on natural methods (withdrawal, Billings, etc.) as alternatives for those who wish to use these methods.

3. Integration of Maternal-Child Health and Family Planning

An important technical consideration under this amendment is the strong emphasis that is being placed on integrating child survival, mother-related services into the ongoing family planning program of the various agencies currently in the Project. As described in earlier sections, there is a clear technical basis for this integration, as well as a strictly political rationale. For more details, see Section II B.

B. Administrative Analysis

APROFAM is a proven performer and carries the largest portion of the delivery of family planning services in the country. The Project will finance the continued (or, accelerated) expansion of the organization into maternal and child health. Fully 2/3 of the new funding is allocated to APROFAM, an agency presently spending at an annual rate of approximately \$2.4 million. An increase in APROFAM's annual spending rate to \$4.0 is considered feasible. The proposed expansion of the program will require increases in both staff and service points and will impose a managerial burden on the organization. APROFAM successfully managed a tripling of its budget in 1977-79 and has continued to improve its management and administration.

To deal with forthcoming expansion, however, a comprehensive review of APROFAM's institutional development

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process will be carried out. It is contemplated that a plan will be developed with technical assistance in the Fall of 1988 for presentation as part of the 1989 Implementation Plan for approval by USAID for the 1989 budget.

Despite startup problems, the Family Planning Unit of the MOH will have only an estimated \$80,000 of the original \$712,000 in the agreement. The remaining pipeline, about 10% of total funding, is considered within acceptable limits. The MOH is undergoing a process of reorganization and staff changes. The provision of additional staff, vehicles, improved management information systems, and technical assistance is directed at increasing the managerial capacity of the Unit. It is believed that these changes will strengthen the organization adequately for its expanded workload and expenditure requirements.

AGES is already spending at a rate which is at or near the levels required under the extension. Thus, disbursements are not seen as a problem for AGES under the proposed increased funding. AGES is currently being assisted by a management firm to strengthen its organizational structure, position descriptions, salaries and plans for decentralization. During the extension, AGES will receive technical and managerial assistance, additional managerial staff to support the Director. In addition, assistance will be provided in the design and development of a management information system. Technical assistance will be provided to AGES to include maternal and child survival communications in its program. With these inputs, AGES will be prepared for its expanded activities.

I PROFASA has been strengthened through a long-term technical assistance contract. All administrative systems are fully functional. Some additional improvements will be made to the information system. I PROFASA is spending at an annual rate of approximately \$700,000. The proposed financing under the amendment requires a spending rate of \$900,000, which is considered feasible given I PROFASA's management capacity. Otherwise, no significant administrative changes are planned for the period ahead.

The proposed new initiatives component contemplates contracting an U.S. firm or PVO in late 1988 or early 1989 for the purpose of establishing an umbrella organization which is prepared to identify, develop, and execute grant agreements with local health agencies in the private sector which are interested in expanding their child survival program

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activities, including provision of birth spacing services. The proposed design is based on lessons learned from the evaluation of ASINDES, a similar organization in function but which will relate to health PVO's in Guatemala. It incorporates technical assistance in developing all essential management systems, in addition to a careful design of the basic structure and functions of the organization.

### C. Economic Analysis

In the early 1980's, Guatemala began to experience serious economic problems. Per capita income in 1987 was 20 percent less than in 1980, and open unemployment rose to nearly 20 percent. This deterioration is related to several factors, including adverse economic and political events in the region.

Guatemala is characterized by high rates of fertility. It is important to remember that in a high fertility society, the age structure will be younger and the demands made upon resources to feed, clothe, house, educate, and equip the increasing numbers, will be greater than in a low fertility society.

A slower growth in numbers would mean that a lower proportion of public expenditure will be required to provide each added person with the average amount of physical infrastructure and social services, and so more is available to increase the amount per person.

Rapid population growth has made many of Guatemala's problems harder to solve. Population growth has contributed significantly to inequality, while making social targets such as universal literacy or full employment, much harder to attain. Population growth has slowed down improvements in health and nutritional standards. In short, population growth has been an important cause of poverty.

Guatemala's extremely high dependency ratio (98.4%) will be reduced by the Project; this will provide better opportunities for increasing the savings rate and so lead to increased investment and faster economic growth.

In Guatemala, 75 percent of the employed labor force earns less than Q200 (\$80) per month. The rate of open unemployment is presently estimated at around 20 percent, compared with 8 percent in the early 1980's. According to the Ministry of Labor, underemployment, mainly in rural areas, affects an additional 20 percent of the labor force.

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Since alternatives to the capital-intensive technology currently used and favored in Guatemala may be very limited, it is not surprising that the growth rates of the labor force offer a challenge that is difficult to meet. Measures must be taken to reduce the pace of population growth, if unemployment and underemployment are to become manageable in the near future.

Reducing the fertility rate will lower the amount of funds that must be invested in health, education, housing, food imports, and other public utilities simply to maintain current standards of living. The resources saved in this way can be channelled to investment activities, increasing productivity and enhancing standards of living.

An average of Q198 (\$79.20) in education expenditures per school-aged child is budgeted by the Government of Guatemala for 1988. Using the Horlacher figure of 17,000 births averted per year, approximately Q3.5 million (\$1.4 million) will be saved in educational outlays during the first year of Project. Without adjusting for an increased number of births prevented in subsequent years of the Project, these savings, projected linearly, would amount to \$4.2 million for the three years of the Project, or \$15.4 million through the end of the 1990's.

The GOG's 1988 health budget provides for an annual health care cost per child (aged 0-14) of Q46 (\$18.40). Savings generated by births averted amount to Q818,000 (\$327,000) during the first year of the Project, and thus become available to increase child care. Nearly \$1 million will be saved for the three years of the Project, and at least \$3.6 million through the next decade.

The annual per capita housing cost is an estimated Q80 (\$32). When multiplied by the cumulative number of births prevented during the first year, a total saving of Q1.4 million (around \$570,000) is obtained. This amounts to \$1.71 million for the three years of the Project and \$6.27 million through 1999.

The total savings during the first year of Project extension attributable to education, health and housing is therefore Q5.7 million or \$2.3 million, \$6.9 million by 1991, and \$25.3 million by 1999.

These estimates are for savings in three areas based upon the minimum number of births prevented which would be

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attributable to Project activity. A more thorough analysis would reveal further savings on a broader range of social services, as well on food and food imports and other items which affect the national economic profile.

D. Social Soundness Analysis

Guatemalan health status is among the worst in Latin America, both maternal and infant mortality rates are unacceptably high. These important indicators are highest among rural Mayan segments of the population. The public health sector is underfunded and services are inadequate. Almost 50% of the total population has no access to modern health care. Given this situation, the strategy of providing family planning services within a maternal child health program appears extremely sound.

Important social consequences can occur if this project is successful. Use of FP and MCH services should increase among the Mayan speakers leading to overall lower fertility rates and possibly impacting on maternal and infant mortality rates over the long-term (10 years or more). Mayan speakers will become better informed about FP and MCH services and able to make decisions about family health, a positive move away from the fatalism that can arrest action.

The role of women can be expected to change if family planning services and information are made available to them. Traditionally women have been excluded from decision making in many important aspects of daily and national life. By providing the means to control fertility, women can make decisions regarding childbearing. This power of control over their reproductive lives makes it possible for women to complete their education, participate in economic activities, space their children, and avoid high risk pregnancies. Age of first union will go up if girls remain in school longer and a delay in childbearing should also result.

Overall, if FP and MCH services rates increase, it can be expected that in the long run, family health will improve, population growth at the national level will slow and a reduction in maternal mortality and infant mortality will occur. New opportunities for women will emerge once they are able to take control of their reproductive lives and are freed from the burden of high fertility and mortality.

X. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

A. Covenants

1. On an annual basis no later than December 1, all Grantees will prepare and submit detailed Workplans (including procurements of goods and services) and budget for the upcoming year. The budget submission will include detailed estimated counterpart contributions from applicable Grantees, including such items as rent, utilities, operating expenses for vehicles (gas, oil, etc.) and others as appropriate. The budget will be submitted in a standard format contained in Annex O.

2. In conjunction with the Annual Workplan submission during the month of November, USAID and each Grantee will perform an intensive review of project performance to include, but not be limited to:

-Actual versus planned expenditures, by major budget line items;

-Achievements of prior year Workplan;

-Accomplishment of quantitative outputs, cumulative and year under review;

Subject to the outcome of the performance review, USAID/Guatemala reserves the right to decrease or increase funding in individual grantee agreements. IPROFASA must demonstrate satisfactory increases each year in couple-year-protection, both in absolute numbers and in geographic distribution.

3. In addition to the above, the MOH will also present for approval as part of the Annual Workplan, evidence satisfactory in form and substance that the GOG is taking steps to establish positions and gradually absorb recurrent costs of salaries and other operating expenses, as described below:

Year 1: 3 medical supervisors  
1 administrator

Year 2: 4 medical supervisors  
1 assistant administrator

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Year 3: 3 medical supervisors  
1 warehouseman  
1 social communicator

4. Grantees will provide service and information statistics on a quarterly basis which reflect departmental and regional program activity.

5. IPROFASA will present for USAID approval in December 1989, a plan for achieving self-sufficiency with decreasing participation of USAID in financing annual operating costs.

B. Negotiating Status

The proposed Project Amendment has been developed in close collaboration with each of the Grantees and all issues were discussed and resolved with respective Grantee during the design process. No serious problems are anticipated in negotiating the grant agreements. It is expected that obligation signatures can be obtained shortly after the amendment is authorized.

The target date for authorization is June 1988, with obligation of funds for IPROFASA and the Ministry of Health taking place in June; obligation for APROFAM, AGES and New Initiatives is planned for July.

The mechanism for obligation of the majority of the amendment funds is to amend each of the existing agreements as follows:

<u>Grantee</u>	<u>Type of Agreement</u>
APROFAM	Operational Program Grant
New Initiatives	(Within APROFAM's OPG)
AGES	Operational Program Grant
IPROFASA	Cooperative Agreement
MOH	Grant Agreement

The contribution to the 1991 Census of \$120,000 will be obligated in a Limited Support Grant Agreement with the National Institute of Statistics (INE).

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**ANNEXES**

SC(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?

Yes (May 1988)

HAS STANDARD ITEM CHECKLIST BEEN REVISED FOR THIS PROJECT?

Yes

A. GENERAL CRITERIA FOR PROJECT

1. FY 1988 Continuing Resolution Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?

a. Congressional notification was submitted to Congress on June 17, 1988.

2. FAA Sec. 611 (a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the

a. Yes.  
b. Yes.

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assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

3. FAA Sec. 611 (a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?  
Legislative action is not required within recipient country.
4. FAA Sec. 611(b); FY 1988 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq)? (See A.I.D. Handbook 3 for guidelines.)  
Not applicable.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U. S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?  
Not applicable.
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If  
No. Project is Guatemala specific in terms of private and public organizations involved and in terms of target group addressed.

so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

However, methodologies and information from this project will be informally shared with other countries in the Central American Region.

- a. No, except to encourage use of US produced contraceptives.
- b. Yes, by bolstering the Family Planning activities of APROFAM, a private voluntary organization and by supporting a private commercial retail sales (CRS) program.
- c. Yes, by assisting some of these organizations with Family Planning services in the Community Based Distribution (CBD) project activity.
- d. Yes, by supporting a CRS program which will provide price competition in the local contraceptives market.
- e. N/A
- f. Some labor and trade groups will receive Family Planning services under the project.

Project will make use of US-produced contraceptives, and will in part draw on US-based technical advisors in implementing the project.

Guatemala is providing a substantial contribution to the project in local currency.

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10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No.
11. FY 1988 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? Not applicable.
12. FY 1988 Continuing Resolution Sec. 553. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U. S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? Not applicable.

13. FAA Sec. 119(g)(4)-(6). No. Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? Not applicable.
15. FY 1988 Continuing Resolution. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? Not applicable.

16. FY Continuing Resolution Sec. 541. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? **Yes.**
17. FY 1988 Continuing Resolution Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? **Not applicable.**
18. FY Continuing Resolution Sec. 515. If deob/reob authority is sought to be exercised in the provision of assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified? **Not applicable.**
19. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the a-

greement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1988 Continuing Resolution Sec. 552 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support research that is intended primarily to benefit U.S. producers?

Not applicable.

- b. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.
- a. The project will insure wide participation of the poor in the benefits of development by extending access to affordable maternal and child health and family planning services at the local level. The project will have a special emphasis on the extension of services to the poor rural population.
- b. The role of cooperatives in family planning will be enhanced through their participation in the project as community based distributors of contraceptives.
- c. The project will rely on the local resources and self help of a variety of local public and private agencies in implementing the project.
- d. Women and women's organizations will be direct project beneficiaries. Most salaried and volunteer providers of family planning services will be women.
- e. N/A

- (c. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used? Yes.
- d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses and small incomes of the poor)? Not applicable.
- e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? Yes.
- f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it Yes.

X  
96

be monitored to ensure that the ultimate beneficiaries are the poor majority?

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

The project recognizes the economic necessity and the desire of the people to limit family size, will encourage institutional development of the Ministry of Health unit charged with supervising and coordinating family planning activities, and will provide information and education to enable people to make rational decisions about family planning.

h. FY 1988 Continuing Resolution Sec. 538. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No.

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization?

No.

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part,

No.

to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

- i. FY 1988 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No.

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

No, the voluntary family planning institutions financed under the project offer a broad range of family planning methods and services.

- j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

- k. FY 1988 Continuing Resolution. What portion of the funds will be available only for activities of economically and socially disadvantage enter-

To be determined. Gray Amendment organizations will be given strong consideration in the procurement of services.

X  
98

prises, historically black colleges and universities, colleges and universities having a student body in which more than 20 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

1. FAA Sec. 118 (c). Does the assistance comply with the environmental procedures set forth in A.I.D. regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help and destructive slash-and-burn

Not applicable. This project qualifies for a categorical exclusion as described in Section 216.2 of AID Regulation 16 since it is a program involving nutrition, health care and family planning services.

griculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support and training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) / utilize the resources and abilities of all relevant U.S. government agencies?

X  
100

- m. FAA Sec. 118 (c) (13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity? **Not applicable**
- n. FAA Sec. 118 (c) (14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas? **No.**

- o. FAA Sec. 118 (c) (15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?
- p. FY 1988 Continuing Resolution If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is
- No. Not applicable

X  
102

equitable, participatory, environmentally sustainable, and self-reliant; (b) being provided in accordance with the policies contained in section 102 of the FAA; (c) being provided, when consistent with the objectives such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the

N3

need to protect vulnerable groups; (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics specially to those outside the formal education system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

1515C/1518C

104

AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON DC 20523

LAC-IEE-88-19

## ENVIRONMENTAL THRESHOLD DECISION

Project Location : Guatemala

Project Title : Expansion of Family Planning Services, Amendment 2

Project Number : 520-0286

Funding : \$19,215,000

Life of Project : 3 years

IEE Prepared by : Roberto Figueroa  
USAID/Guatemala

Recommended Threshold Decision : Negative Determination

Bureau Threshold Decision : Concur with Recommendation

Comments : None

Copy to : Anthony J. Cauterucci, Director  
USAID/Guatemala

Copy to : Roberto Figueroa, USAID/Guatemala

Copy to : Frank Zadroga, ROCAP/San Jose

Copy to : Donald Boyd, LAC/DR/CEN

Copy to : IEE File

James S. Hester Date JUN 27 1988

James S. Hester  
Chief Environmental Officer  
Bureau for Latin America  
and the Caribbean

X  
105

INITIAL ENVIRONMENTAL EXAMINATION

PROJECT LOCATION : Guatemala

PROJECT TITLE : Expansion of Family Planning Services (No. 520-0288) Amendment No. 2

FUNDING : \$19,215,000

DESCRIPTION OF THE PROJECT AMENDMENT

The proposed amendment changes the goal of the Project to "improve the quality of life of mothers and children in Guatemala". The purpose is changed to "expand the utilization of family planning services and information provided by public, private and commercial sources through integration of national health services and selected child survival interventions which are designed to reduce the reproductive risks of women in fertile age."

The proposed Project amendment will extend the current Project for three years to the end of CY 91 and will increase the Project's DA grant funding by \$19.215 million. The amended Project will serve as a bridge to a successor integrated family health Project in FY 1992 which will consolidate current Family Planning, Child Survival and Maternal Health activities. The Project amendment will strengthen and accelerate the process of integrating family planning and child survival and prepare the implementing agencies for a fully integrated Family Health Project after FY 1991.

The Project will be implemented by the following agencies: (1) Association for Family Welfare (APROFAM); (2) Ministry of Health (MOH); (3) Guatemalan Association for Family Life Education (AGES); and (4) Importers of Pharmaceutical Products (I PROFASA); and provides for a New Initiatives component with the private sector to be implemented by an umbrella private sector organization. APROFAM, AGES and I PROFASA are private sector grantees which are already implementing the on-going Project.

100

ENVIRONMENTAL IMPACT

As was the case for the original Project, the proposed amendment will not involve activities such as health facility construction, water supply system development or waste water treatment, which significantly affect the physical or natural environment. The activities which will be carried out qualify for a categorical exclusion according to Section 216.2 (C) (2) (VIII) of 22 CFR as "programs involving nutrition, health care or population and family planning services except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.)."

RECOMMENDATIONS

Based on the categorical exclusion discussed above, the Mission recommends that Amendment No. 2 of the Expansion of Family Planning Services Project be given a Negative Determination requiring no further environmental review.

Concurrence:

  
\_\_\_\_\_  
Anthony J. Cauterucci  
Mission Director

  
\_\_\_\_\_  
Date

1512C

107



**ASOCIACION GUATEMALTECA DE EDUCACION SEXUAL, A.G.E.S.**

3a. Calle 3-59, zona 1 Tels. 26648 - 80940 - Ciudad

Guatemala,  
5 de julio de 1988

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(Date later)	

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Sr. Anthony J. Cauterucci  
Director  
AGENCIA PARA EL DESARROLLO  
INTERNACIONAL  
Presente

Asunto: Enmienda al Convenio 520-0288 (A)  
entre USAID/Guatemala y AGES.

Estimado Sr. Cauterucci:

Reciba un cordial saludo de todos en AGES.

Como es de su conocimiento, nuestro convenio el cual fue originalmente firmado en el año 1985 vence el 31 de diciembre del año en curso. Nos sentimos orgullosos de poder reportar que, según la evaluación hecha en enero de este año por USAID, hemos alcanzado o superado todas las metas cuantitativas establecidas en el convenio.

Nuestro programa de Información y Educación para la Vida Familiar ha logrado iniciar y desarrollarse en 5 departamentos del interior del país (Huehuetenango, San Marcos, Quetzaltenango, Chimaltenango y Alta Verapaz). En 8 comunidades mayas de estos departamentos se están realizando estrategias de comunicación basadas en la comunidad y aceptables culturalmente para la entrega de educación para la vida familiar a padres de familia, líderes comunales, maestros y estudiantes. Nuestro personal bilingüe con una metodología de orientación y de bolsas de estudio, han hecho posible la entrada a las comunidades mayas.

El programa a nivel urbano se realiza en la capital y las cinco cabeceras departamentales, caracterizándose por su trabajo con comités de padres y maestros, adultos jóvenes, multiplicadores y reuniones interinstitucionales. A la fecha AGES ha llegado a 173, 111 personas.

Por este medio queremos solicitar que se considere una enmienda a nuestro convenio que extienda la fecha de vencimiento al 31 de diciembre de 1991 y agregue \$2,214.200 de fondos en calidad de donación, sumando un total de \$3,175,200 durante la vigencia del proyecto. Esta extensión y los fondos adicionales permitirá lo siguiente:

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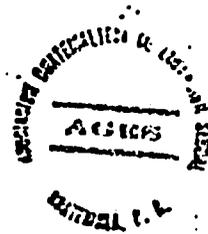
Guatemala, 5/07/88  
Sr. Anthony J. Cauterucci  
Pag. 2

a) Extensión del programa maya a 5 comunidades adicionales; b) Aumentar el programa actual de bolsas de estudio a niñas mayas; c) Desarrollar más la base de métodos de capacitación comunitaria y estrategias de comunicación para integrar los componentes de planificación familiar y sobrevivencia infantil a las comunidades mayas; y d) Reforzar la estructura organizacional de AGES para acomodarse a la expansión institucional y delegar regionalmente la toma de decisiones.

Agradeciendo desde ya la efectiva colaboración que siempre hemos recibido de parte suya para contribuir a la superación de nuestra gente, le saluda.

Atentamente,

ASOCIACION GUATEMALTECA DE  
EDUCACION SEXUAL, A.G.E.S.



*Eugenia Monterroso*  
Licda. Eugenia de Monterroso  
Directora General

cc File AID  
cc Correlativo  
cc Dr. John Massey  
cc Dirección

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MAIL ROOM  
USAID/CONTRAC  
GENERAL

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Ministerio de Salud Pública  
y Asistencia Social

Guatemala, C. A.

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HW

20 de julio de 1988

USA
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Señor  
Anthony Cauterucci  
Director,  
Agencia Internacional para  
el Desarrollo, A.I.D.  
Ciudad de Guatemala

De manera atenta me dirijo a usted, en el sentido de que como ya es de su conocimiento el convenio 520-0288, suscrito entre USAID-Guatemala y este Ministerio, originalmente firmado en 1985, vence el 31 de diciembre de 1988. Tenemos la satisfacción de poder comunicarle que, según la evaluación realizada en enero de este año por USAID, hemos alcanzado la mayoría de las metas cuantitativas establecidas en el convenio.

Nuestro programa de capacitación ha mejorado notablemente en cuanto a la calidad y cantidad de personal que han recibido estos servicios. De acuerdo a la evaluación mencionada en 1987, el programa capacitó mayor número de personal de este Ministerio, que en los cinco (5) años anteriores; en concordancia con Development Associate, creemos en la mejora sustantiva de la capacitación en su calidad e impacto, durante 1987 y en el transcurso de este año hemos asumido la responsabilidad de un programa de racionalización procreacional en todo el país, habiendo incrementado el número de establecimiento de 700 aproximadamente, a casi 1,000, que ahora reciben supervisión y son implementado en forma regular; dentro del convenio actual se ha reclutado adicionalmente 4 médicos supervisores con el fin de conseguir ampliar el programa en forma ordenada y eficiente.

Finalmente este Ministerio se siente complacido, en el sentido de que dentro del programa se ha ejecutado un 89% de los fondos asignados, ya que de acuerdo a la opinión de sus analistas se estima que al 31 de diciembre de 1988 quedarán \$80,000 de los \$712,000 que originalmente fueron incluidos en el convenio.

USAID/GUATEMALA  
MAY 23 1988  
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NUM
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Al contestar dirigirse únicamente al  
Número de referencia de esta nota

Ministerio de Salud Pública  
y Asistencia Social

Guatemala, C. A.

Hoja No. 2  
Sr. Anthony Cauterucci  
Director AID.

Por lo anterior, le solicitamos se considere una enmienda adicional al convenio, que extienda su fecha de vencimiento hasta el 31 de diciembre de 1991 y que se agreguen \$2,143,100 en calidad de donación, para que así ascienda a \$2,855,100 la cantidad total durante la vigencia del proyecto. Esta ampliación en tiempo y los fondos adicionales permitirán, que este Ministerio fortalezca los servicios destinados a la mujer en edad reproductiva, con el objetivo principal de mejorar la salud de este grupo poblacional y reducir así su morbi-mortalidad.

En forma específica le detallo sus objetivos:

- 1- Incrementar la cobertura de servicios de una responsable racionalización procreacional con el sentido que cada familia decida en forma libre el número y la programación de nacimiento de sus hijos.
- 2- Contribuir al incremento de la atención institucional en la racionalización procreacional, control pre y post-natal y atención del parto con enfoque de riesgos, a través de la capacitación del personal de este Ministerio y de voluntarios de la comunidad.
- 3- Fortalecer el proceso de educación en salud y aumentar la comunicación social con énfasis en la educación para la vida familiar, educación sexual, riesgo reproductivo y desarrollo de la mujer.
- 4- Apoyar el proceso de la gestión con carácter técnico-administrativo y la logística de abastecimiento de equipos e insumos clínicos del programa.
- 5- Disminuir la morbi-mortalidad de cancer cervical, apoyando acciones preventivas por medio de la detección oportuna.
- 6- Apoyar actividades de prevención y detección temprana del Síndrome de Inmunodeficiencia Adquirida (SIDA).

AL contestar sírvase mencionar el  
Número de referencia de esta nota.

Ministerio de Salud Pública  
y Asistencia Social

Guatemala, C. A.

Hoja No. 3  
Sr. Anthony Cauterucci  
Director AID

7- Servir de apoyo a la estructura y a la ejecución del sistema único de supervisión y evaluación de los programas de este Ministerio.

8- Realizar investigaciones operativas que por medio de intervenciones oportunas permitan a través de conocer los factores estructurales y administrativos, se establezca un programa de racionalización procreacional.

De acuerdo a los cálculos, el aporte inicial de fondos de este Ministerio como contrapartida de \$272,220 a esta enmienda, equivaldría en quetzáles a fondos ya presupuestados y adicionales para cubrir algunos gastos de funcionamiento y salarios de plazas nuevas.

Tenemos la creencia que este programa engloba un conjunto de actividades con el fin de lograr una mejoría de la salud de la mujer y por ende la familia guatemalteca. Considerando su factibilidad dentro del marco de tiempo y recursos financieros, siempre y cuando sea mantenida la situación administrativa y la política actual de este Ministerio.

Agradeciendo de antemano su colaboración, la que siempre hemos recibido en forma efectiva en la contribución de la salud de nuestra población, me suscribo cordialmente,

  
Dr. CARLOS GEHLERT MATA  
MINISTRO DE SALUD PÚBLICA  
Y ASISTENCIA SOCIAL



CGM/vymadea

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**IPROFASA**  
IMPORTADORA DE PRODUCTOS FARMACEUTICOS, S.A.

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Guatemala,  
16 de junio, 1988

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6/30/88
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(Date initials)
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Sr. Anthony J. Cauterucci,  
Director  
USAID/Guatemala  
Ca Calle 7-EE, Z. 9  
Ciudad de Guatemala

Asunto: Carta de Solicitud para la  
Enmienda al Convenio 520-0288  
entre USAID/Guatemala y IPRUFASA

Estimado Sr. Cauterucci:

Atentamente me dirijo a usted para enviarle un cordial saludo de parte del Consejo de Administración de IPRUFASA y para comunicarle nuestro interés en continuar con el proyecto de Mercadeo Social de Anticonceptivos, en unión de USAID.

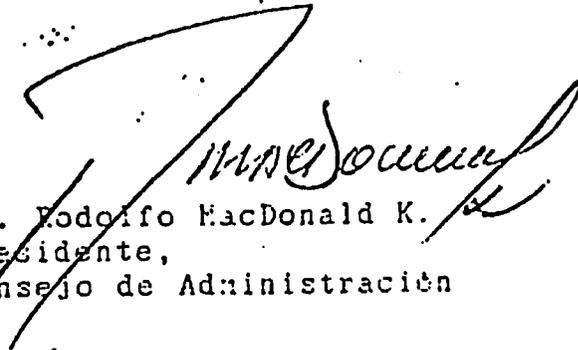
Como es de su conocimiento, nuestro convenio, el cual fue originalmente firmado en el año 1982, vence el 1 de julio del año en curso. Nos sentimos orgullosos de poder reportar que los logros del proyecto han sido muy exitosos y que esto se mostró tanto en la evaluación que se llevó a cabo en Mayo de 1987 como la más reciente en Marzo de este año. Estas dos evaluaciones fueron como resultado la existencia de una buena organización, realizando su labor en una manera eficiente. Asimismo, en el tiempo en que IPRUFASA ha lanzado sus productos al mercado ha cubierto más de 35,000 "Años Protección Pareja" (APP); también, IPRUFASA ha iniciado esfuerzos para penetrar el sector indígena con productos anticonceptivos. Finalmente, creemos que nuestro logro más significativo ha sido el cambio de actitud en el ambiente social, ya que hemos contribuido enormemente a romper tabúes asociados con el uso de este tipo de productos.

Por este medio queremos solicitar que se considere una enmienda a nuestro convenio que se extendía la fecha de vencimiento al 31 de diciembre de 1991 y agregue \$2,685,700.00 de fondos en calidad de donación, sumando un total de (aprox.) \$5,783,700.00 durante la vigencia del proyecto. Esta extensión y los fondos adicionales permitirán lo siguiente: (a) ampliación y fortalecimiento del programa de mercadeo social de anticonceptivos, ya que cubriremos más farmacias, más médicos, y

aumentaremos los APP a más de 60,000 al finalizar el convenio; (b) continuaremos con nuestros esfuerzos educativo-publicitarios y ampliaremos nuestras actividades promocionales para hacer llegar el mensaje de planificación familiar a más consumidores, por medio de distintas empresas; (c) permitir la penetración a otros segmentos de consumidores incluyendo áreas indígenas, y áreas rurales/campesinos; (d) distribución de otros productos para la salud familiar; (e) ampliar la red de canales de distribución para vender los productos anticonceptivos en canales no tradicionales; y (f) fortalecer los sistemas administrativos y financieros para seguir realizando nuestra labor en un manera eficaz manteniendo la política de costo-eficiencia.

Agradeciendo su atención a la presente, me suscribo,

Atentamente,



Dr. Rodolfo MacDonald K.  
Presidente,  
Consejo de Administración

cc: file

**Best Available Document**

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APARTADO POSTAL 1004

TEL: 514001

CABLE: APROFAMGUA

Ref. No.  
1110-88

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Guatemala,  
10 de junio de 1988

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6/24/88
ACTIVO

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Señor  
Anthony Cauterucci  
Director  
MISION INTERNACIONAL AID  
Presente

Asunto: Emiada al Convenio  
520-0288 entre USAID/Guatemala  
y APROFAM

*Handwritten initials: 12/6/2*

Estimado señor Cauterucci:

Como es de su conocimiento, nuestro convenio el cual fue originalmente firmado el 8 de marzo de 1983, vence el 31 de diciembre del año en curso. Nos sentimos orgullosos de poder reportar, que según la evaluación hecha en enero de este año por USAID, hemos alcanzado y superado todas las metas cuantitativas establecidas en el convenio. Aproximadamente 93% de los servicios de planificación familiar medidos por "Años-Protección-Pareja", proporcionados por todas las agencias bajo este proyecto fueron proporcionadas por APROFAM. El programa de Distribución Comunitaria ahora cuenta con 1780 puestos de distribución y esperamos tener 1980 al final del año y contribuyendo con un promedio de 30,000 por año al indicador "Años-Protección-Pareja". Nuestro programa de Servicios Clínicos,

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Sr. Anthony Cauterucci  
 Ref. No. 1110-88  
 Página No. 2

el cual inició el proceso de integración de servicios de supervivencia infantil y para la madre en 1987, ahora tiene 10 clínicas prestando servicios a nuestras usuarias. Este programa contribuye con un promedio de 131,900 por año al indicador "Años - Protección-Pareja". Por último, creemos que a pesar de los ataques fuertes en 1985 y 1986, nuestro programa de Información, Educación y Comunicación ha logrado mantener y mejorar la imagen de APROFAM como institución de servicio a la comunidad.

Por este medio queremos solicitar se considere una enmienda a nuestro convenio que extienda la fecha de vencimiento a 31 de diciembre de 1991 y agregue \$10.4 millones de fondos en calidad de donación, sumando un total de \$17.9 millones durante la vigencia del proyecto. Esta extensión y los fondos adicionales permitirá lo siguiente: (a) ampliación y fortalecimiento del programa de Distribución Comunitaria, haciendo llegar con mayor intensidad la información y los servicios de planificación familiar y supervivencia infantil a las poblaciones indígenas; (b) incrementar los servicios clínicos integrados, tanto de anticoncepción como materno infantiles a través de 12 clínicas.

APART. DO I OSTAL 1004

TEL.: 514001

CABLE: ABOFAMGUA

Dr. Anthony Cauterucci  
R.F. No. 1110-88  
Página No. 3

distribuidas en todo el país; (c) intensificar el programa de información, educación y comunicación para mantener e incrementar la concientización del público sobre planificación familiar, particularmente a parejas en las edades de 25-40 años, que desean espaciar sus nacimientos y líderes de opinión a nivel comunitario y nacional; y (d) fortalecimiento de los sistemas de apoyo gerencial/administrativos (evaluación, informática, financieros, etc.) que asegurarán una ampliación de nuestro programa en forma ordenada y lógica.

Sin otro particular y agradeciendo su atención a la presente, aprovecho la oportunidad para suscribirme de usted,

Muy atentamente,

A P R O F A M

DR. ROBERTO SANTISO GALVEZ  
DIRECTOR EJECUTIVO

RSC/esa

RECIBIDO  
SECRETARIA  
DE ADMINISTRACION  
Y FINANZAS  
1988 JUN 10 10 55 AM

## PROJECT DESIGN SUMMARY

## LOGICAL FRAMEWORK

Life of Project:  
 From FY 1988 to FY 1991  
 Total U.S. Funding \_\_\_\_\_  
 Date Prepared: \_\_\_\_\_

Project Title and Number: EXPANSION OF FAMILY PLANNING SERVICES NO. 520-0288

NARRATIVE SUMMARY INDICATORS	OBJECTIVELY VERIFIABLE VERIFICATION	MEANS OF IMPORTANT ASSUMPTIONS	Assumptions for Achieving Goal
Program or Sector Goal	Measures of Goal Achievement		
Improved quality of life of mothers and children in Guatemala.	Decrease maternal and infant mortality by the end of the project.	National data from Ministry of Health and the Institute of Statistics.	GOG perceives the importance of improving maternal health.
Project Purpose:	Conditions that will indicate purpose has been achieved. End of Project Status.		
To expand utilization of family planning services and info. provided by public, private and commercial sources through integration of maternal health services and selected child survival interventions designed to reduce reproductive risks of women in fertile age.	Total of 994,000 couple-years-protection (CYP) provided by all agencies, including 463 new service delivery mechanisms for birth spacing and other child survival interventions which will be established by the project; Acceptance of family planning in rural areas increases, relative to urban areas.	Service statistics; Mini-demographic surveys; evaluations of elements of the project.	Continued GOG support of family planning within context of maternal child health context and willingness to participate actively in service delivery. Private sector agencies willing to enter into agreements deliver birth spacing and child survival services. Real commitment participating agencies to reach mayan clients.

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**Project Outputs:**

1. Birth Spacing services and counseling available in MOH facilities. Selected maternal health and child survival services available from private sector agencies.
2. Information/training provided on birth spacing, maternal health, reproductive risk management, family life in culturally appropriate manner.
3. Information on birth spacing and maternal health available through mass media.

**Magnitude of Outputs:**

1. 1,000 MOH facilities, 10 APROFAM clinics, 2,200 community-based distributors, 1,000 pharmacies and other retail outlets and 50 private organizations provide integrated MCH/FP services.
2. 944,000 CYP provided, 152,000 maternal and child survival service encounters, 6,350 technicians trained, 183,900 persons receive family life education topics.
3. 95% ladino and 85% mayan populations aware of birth spacing services in their area.

1. MOH statistics  
APROFAM statistics
2. CRS sales records
3. MOH mgmt. info syst.

1. All facilities providing services staffed by trained personnel and receiving necessary logistical support.
2. No unusual curtailment of information campaigns by GOG or other organized groups.
3. No major disruptions in commercial sector.

**Project Inputs**

AID Contribution  
GOG Contribution  
Other Donors:  
AVSC  
IPPF  
UNFPA

**Implementaion Target  
(Type and Quantity)**

AID: Services \$19,692  
IEC \$3,308  
  
AVSC \$ 22  
IPPF \$1,566  
UNFPA \$1,500  
GOG \$2,167

Others

Review of project financial records.

AID Project agreements;  
donor project agreements.

**Assumptions for Providing inputs:**

Inputs are made in a timely fashion. Continued other donor willingness and capacity to meet commitments.

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A. All Agencies

Global

Line Items	1989	1990	1991	Total New + Pipe- line	Pipeline Estimates	New Funds
SALARIES	1,604.8	1,953.8	2,332.3	5,890.9	564.5	5,326.4
TECHNICAL ASSISTANCE	631.0	442.1	389.0	1,462.1	290.8	1,171.3
TRAINING	224.6	166.4	202.6	593.6	127.4	466.2
PER DIEM/TRANSPORT	452.2	675.9	651.3	1,779.4	115.9	1,663.5
COMMODITIES	489.1	353.1	380.5	1,222.7	369.6	853.1
EQUIPMENT/VEHICLES	581.7	248.9	309.1	1,139.7	334.4	805.3
PROMOTION AND PUBLICITY	959.9	1,043.4	1,117.6	3,120.9	403.1	2,717.8
ADMINISTRATIVE COSTS	444.9	384.4	405.7	1,235.0	345.9	889.1
SUPPLIES	241.6	260.5	283.7	785.8	4.9	193.4
EVALUATION/AUDITS	134.3	77.9	148.7	360.9	107.1	253.8
SPECIAL PROGRAMS	587.3	460.2	524.3	1,571.8	75.8	1,496.0
OVERHEAD	277.8	360.6	428.2	1,066.6	0.0	1,066.6
CONTINGENCIES	365.0	321.4	358.7	1,045.1	0.0	1,045.1
INFLATION	0.0	321.4	358.7	680.1	0.0	680.1
<b>Total</b>	<b>6,994.2</b>	<b>7,070.0</b>	<b>7,890.4</b>	<b>21,954.6</b>	<b>2,739.4</b>	<b>19,215.2</b>

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B. APROFAM

Line Items	1989	1990	1991	Total New + Pipe- line	Pipeline Estimates	New Funds
SALARIES	994.2	1,188.5	1,438.5	3,621.2	467.7	3,153.5
TECHNICAL ASSISTANCE	376.9	257.8	240.2	874.9	265.9	609.0
TRAINING	169.1	133.1	170.1	472.9	76.1	396.8
PERDIEM/TRANSPORT	185.8	271.4	322.9	780.1	77.2	702.9
COMMODITIES	357.1	184.5	200.7	742.3	357.1	385.2
EQUIPMENT/VEHICLES	320.2	101.6	135.9	557.7	320.2	237.5
PROMOTION/PUBLICITY	674.9	731.4	865.6	2,271.9	403.1	1,868.8
ADMINISTRATIVE COSTS	227.1	149.1	173.3	549.5	227.1	322.4
SUPPLIES	99.4	114.3	133.4	347.1	0.0	0.0
EVALUATION/AUDIT	92.1	21.6	111.6	225.3	92.1	133.2
SPECIAL PROGRAMS	153.9	58.1	58.2	270.2	0.0	270.2
OVERHEAD	277.8	360.6	428.2	1,066.6	0.0	1,066.6
CONTINGENCIES	152.2	178.6	214.0	544.8	0.0	544.8
<u>INFLATION</u>	<u>0.0</u>	<u>178.6</u>	<u>214.0</u>	<u>392.6</u>	<u>0.0</u>	<u>392.6</u>
TOTAL	4,080.7	3,929.2	4,707.2	12,717.1	2,286.5	10,430.6

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C. IPROFASA

Line Items	1989	1990	1991	Total New + Pipe- line	Pipeline Estimates	New Funds
SALARIES	153.8	237.3	289.7	680.8	0.0	680.8
TECHNICAL ASSISTANCE	46.2	66.8	66.8	179.8	0.0	179.8
TRAINING	0.0	0.0	0.0	0.0	0.0	0.0
PER DIEM/TRANSPORT	34.8	60.0	60.0	154.8	0.0	154.8
COMMODITIES	73.0	102.0	106.0	281.0	0.0	281.0
EQUIPMENT/VEHICLES	8.3	9.1	10.0	27.4	0.0	27.4
PROMOTION AND PUBLICITY	285.0	312.0	252.0	849.0	0.0	849.0
ADMINISTRATIVE COSTS	55.8	78.5	81.5	215.8	0.0	215.8
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EVALUATION/AUDITS	1.3	3.8	4.6	9.7	0.0	9.7
SPECIAL PROGRAMS	75.0	75.0	75.0	225.0	0.0	225.0
OVERHEAD	0.0	0.0	0.0	0.0	0.0	0.0
CONTINGENCIES	73.3	47.2	47.3	167.8	0.0	167.8
INFLATION	0.0	47.2	47.3	94.5	0.0	94.5
<b>Total</b>	<b>806.5</b>	<b>1,038.9</b>	<b>1,040.2</b>	<b>2,895.6</b>	<b>0.0</b>	<b>2,885.6</b>

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D. MOH

Line Items	1989	1990	1991	Total New + Pipe- line	Pipeline Estimates	New Funds
SALARIES	102.2	103.8	105.2	311.2	0.0	311.2
TECHNICAL ASSISTANCE	75.5	35.5	0.0	111.0	5.2	105.8
TRAINING	48.3	24.9	23.5	96.7	46.1	50.6
PER DIEM/TRANSPORT	98.3	132.0	126.7	357.0	0.0	357.0
COMMODITIES	39.0	36.6	38.8	114.4	12.5	101.9
EQUIPMENT/VEHICLES	228.6	125.0	150.0	503.6	14.2	489.4
PROMOTION AND PUBLICITY	0.0	0.0	0.0	0.0	0.0	0.0
ADMINISTRATIVE COSTS						
SUPPLIES	78.7	73.0	88.7	240.4	0.0	0.0
EVALUATION/AUDITS	5.0	5.0	5.0	15.0	0.0	15.0
SPECIAL PROGRAMS	113.7	71.0	75.0	259.7	75.8	183.9
OVERHEAD	0.0	0.0	0.0	0.0	0.0	0.0
CONTINGENCIES	64.7	32.7	32.4	129.8	0.0	129.8
INFLATION	0.0	32.7	32.4	65.1	0.0	65.1
<b>Total</b>	<b>955.1</b>	<b>719.4</b>	<b>712.6</b>	<b>2,387.1</b>	<b>243.7</b>	<b>2,143.4</b>

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E. AGES

Line Items	1989	1990	1991	Total New + Pipe- line	Pipeline Estimates	New Funds
SALARIES	298.6	311.9	334.5	945.0	96.8	848.2
TECHNICAL ASSISTANCE	96.4	82.0	82.0	260.4	19.7	240.7
TRAINING	7.2	8.4	8.4	24.0	5.2	18.8
PER DIEM/TRANSPORT	124.2	194.3	123.5	442.0	38.7	403.3
COMMODITIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT/VEHICLES	4.6	12.2	12.2	29.0	0.0	29.0
PROMOTION AND PUBLICITY	0.0	0.0	0.0	0.0	0.0	0.0
ADMINISTRATIVE COSTS	31.9	36.4	38.8	107.1	28.9	78.2
SUPPLIES	63.5	73.2	61.6	198.3	4.9	193.4
EVALUATION/AUDITS	35.9	25.0	5.0	65.9	15.0	50.9
SPECIAL PROGRAMS	33.8	58.3	58.3	150.4	0.0	150.4
OVERHEAD	0.0	0.0	0.0	0.0	0.0	0.0
CONTINGENCIES	48.7	40.1	36.2	125.0	0.0	125.0
INFLATION	0.0	40.1	36.2	76.3	0.0	76.3
<b>Total</b>	<b>744.8</b>	<b>881.9</b>	<b>796.7</b>	<b>2,423.4</b>	<b>209.2</b>	<b>2,214.2</b>

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F. NEW INITIATIVES

Line Items	1989	1990	1991	Total New + Pipe- line	Pipeline Estimates	New Funds
SALARIES	56.0	112.3	164.4	332.7	0.0	332.7
TECHNICAL ASSISTANCE	36.0	0.0	0.0	36.0	0.0	36.0
TRAINING	0.0	0.0	0.0	0.0	0.0	0.0
PERDIEM/TRANSPORT	9.1	18.2	18.2	45.5	0.0	45.5
COMMODITIES	20.0	30.0	35.0	85.0	0.0	85.0
EQUIPMENT/VEHICLES	20.0	1.0	1.0	22.0	0.0	22.0
PROMOTION/PUBLICITY	0.0	0.0	0.0	0.0	0.0	0.0
ADMINISTRATIVE COSTS	29.0	73.2	77.2	179.4	0.0	179.4
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EVALUATION/AUDIT	0.0	22.5	22.5	45.0	0.0	45.0
SPECIAL PROGRAMS	210.9	197.8	257.8	666.5	0.0	666.5
OVERHEAD	0.0	0.0	0.0	0.0	0.0	0.0
CONTINGENCIES	26.1	22.8	28.8	77.7	0.0	77.7
<u>INFLATION</u>	<u>0.0</u>	<u>22.8</u>	<u>28.8</u>	<u>51.6</u>	<u>0.0</u>	<u>51.6</u>
TOTAL	407.1	500.6	633.7	1,541.4	0.0	1,541.4

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Technical Assistance

1. Detailed Technical Assistance by Agency

The technical assistance requirements for each of the agencies involved in the Project are detailed below.

APROFAM

A. Community Based Distribution Program: This program will receive a total of five months of TA in the following areas:

- (1) To develop a child survival protocol for use by promoters, which can be followed in covering the fundamental activities and topics, elements of individual education, and indications for referrals. (0.5 months)
- (2) Skills development related to the integration of maternal and child health with family planning in overall community education strategies. (1.0 months)
- (3) To develop a task specific supervision system; will identify models to increase effectiveness and efficiency of supervisory contacts. (2.0 months)
- (4) Develop strategies to integrate reporting and tracking systems between CBD and clinical services. (1.5 months)

B. Clinical Services Department

Technical assistance for clinical services will consist principally of setting up systems for decentralization of administrative responsibilities. Additional technical assistance not included in this budget will be provided by AVSC in the areas of quality assurance. (4 person-months)

C. Evaluation Department

Internal evaluations during the extension period will emphasize content and impact of supervision, communications, and CBD activities. TA is required.

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during the evaluation planning phase each year to design evaluation activities with key personnel in the respective departments, and to provide timely input into the analytical stage of these evaluations. (4.5 person-months)

D. Management Information System (MIS)

Technical assistance will be provided to revise and coordinate reporting forms between CBD, clinical services, evaluation and support units, and to ensure proper database management and reporting and systems. (1.5 person-months)

E. IEC Department

Assistance in the integration of Family Planning and Maternal Child Health IEC messages and strategies will be provided to assist in focusing on the targeted population of married couples with 3 or more children. Birth spacing will be the predominant theme. (2 person-months)

IEC will also receive assistance in the development of literacy materials in family planning and maternal-child health. (4 person-months)

MOH

A total of seven person-months of short-term technical assistance will be provided to the MOH/Family Planning Unit in the following areas:

- (1) Supplementary support to the CDC-provided logistics technical assistance will be provided to assist the FPU in managing supply, storage, distribution and reporting aspects of the logistics system. (2 person-months)
- (2) Assistance in the development of training materials to enhance the quality of the MOH training program will be provided. Specifically, assistance will be provided in the development of manuals for distribution to medical, paramedical and community-level personnel. (3 person -months)

- (3) Technical assistance will be provided to guide the overall design of the management information system, so as to insure maximum compatibility with software and reporting formats used by the other agencies. Most software for the MOH will be developed on a contract basis. (2 person-months)

AGES

A total of 16.5 person-months of technical assistance activities will be conducted:

- (1) Assessment/modification of institutional development plan. The assistance will occur one year following central-regional office decentralization, in order to modify roles and functions of personnel and major program components. (2 person-months)
- (2) Development of maternal-child health curriculum to integrate with existing family life education program. Material will be linguistically, culturally and educationally appropriate for major Mayan language groups. (4 person-months)
- (3) Evaluation and modification of currently used curriculum material and the development of non-formal education/training methods. Modification of existing materials particularly in the Family Life Education For All Program as well as innovative strategies for non-readers will take place. (4.5 person-months)
- (4) An occupational training program will be developed for non-school attending young Mayan women. Program will include a pre-vocational component, a community assessment tool to determine curriculum needs and guidelines for program implementation. (2 person-months)
- (5) Development of alternatives for new income generation to assist AGES in gaining a greater degree of self-sufficiency. (0.5 person-month)
- (6) Assistance in Applied Survey and Ethnographic Methods and Analysis to strengthen AGES' research capacities. Funding will be sought through the Population Council or similar group. (3 person-months)

I PROFASA

A total of 24 person-months of technical assistance to I PROFASA will accomplish the following:

- (1) Design, develop, test and implement marketing strategies for Mayan areas. (4.5 months)
- (2) Develop yearly marketing plans. (4.5 months)
- (3) Assist in the systematic incorporation of non-contraceptive products into the product line. (3.0 months)
- (4) Develop, test, select and incorporate maternal and child health products and respective advertising. (3.0 months)
- (5) Develop and test market segmentation strategies. (4.5 months)
- (6) Develop and test additional market research activities analyzing specific product marketing channels, pricing models, and consumer preferences. (4.5 months)

New Initiatives (NIM)

Tentative technical assistance has been programmed for the NIM in the following areas, subject to a needs assessment of the organization:

- (1) Design of NIM: Find an existing candidate organization(s) for the NIM or create a organizational plan specifying objectives, project selection criteria, functions, structure, relationship to external donors and grantees, and budget. (1 person-month)
- (2) Management Systems Assist in developing procedures for the planning, project appraisal, monitoring, budgeting, evaluation and reporting procedures, both from grantees and to donors. (2 person-months)

2. Person-Month Summary

Project Technical Assistance

	Person-months				1989-91
	1988	1989	1990	1991	Total
<u>USAID</u>					
PSC(local) Mos.	12.0	12.0	12.0	12.0	36.0
PSC(non-local) Mos.	0	12.0	12.0	12.0	36.0
Resident Advisors	12.0	24.0	24.0	24.0	72.0
Short-term Offshore		23.5	14.5	12.0	50.0
Short-term Local		12.0	6.0	5.5	23.5
Short-term AID/W support		2.0	1.5	1.5	5.0
Total Short-term		37.5	22.0	19.0	78.5

3. Budget Summary

Project Technical Assistance Budget (Dollars)

	1989	1990	1991	Total
<u>AID Procured TA</u>				
Long-term (PSC) *	151,000	151,000	151,000	453,000
Offshore TA	220,000	100,000	70,000	390,000
Local TA	66,000	33,000	30,250	129,250
Total AID Procured TA	437,000	284,000	251,250	972,250
<u>Agency Procured Advisors</u>				
APROFAM *	225,880	135,360	115,900	477,140
AGES	96,440	82,060	82,060	260,560
Total Agency Procured TA	322,320	217,420	197,960	737,700
<b>GRAND TOTAL</b>	<b>759,320</b>	<b>501,420</b>	<b>449,210</b>	<b>1,709,950</b>

The two long-term PSC advisors are included in the APROFAM summary agency budget for technical assistance.

The budget shown above is based upon the following cost factors:

Salary for a second PSC assumes an annual cost for base salary of \$45,000 and all allowances plus transportation of household effects, storage of HHE, a quarters allowance for a spouse and two children, a temporary lodging allowance, a 15% differential, an education allowance for two children, international travel and home leave. This is estimated at \$106,000 per year.

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The foreign technical assistance is based upon short term consultants at the rate of \$269 per day for 24 days a month, plus international travel, per diem for 30 days, overhead of 100% upon direct costs, supporting services and a fee of 10% upon the total. This equals \$20,000 per person month. Based on the type of services, the Technical Assistance cost may vary from \$9,000 to \$20,000

Local technical assistance costs are based upon a daily rate of \$175 for 20 days a month plus an overhead of 35% and supporting services. There is no allowance for travel and per diem. The total is \$5500 per month.

The costs for local procurement by APROFAM or AGES of either foreign or local consultants assumes the daily rate of the respective technicians but with an overhead rate of 12.8%. There is no verified overhead rate for AGES so that the APROFAM rate is used until such time as a rate is established.

Budget Breakdowns

Project Technical Assistance Budget (Dollars)  
By Procurement Agency

<u>AID Procured TA</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
Long-term (PSC)	151,000	151,000	151,000	453,000
Offshore TA	220,000	100,000	70,000	390,000
Local TA	66,000	33,000	30,250	129,250
Total AID Procured TA	437,000	284,000	251,250	972,250
<u>Agency Procured Advisors</u>				
APROFAM	225,880	135,360	115,900	477,140
AGES	96,440	82,060	82,060	260,560
Total Agency Procured TA	322,320	217,420	197,960	737,700
GRAND TOTAL	759,320	501,420	449,210	1,709,950

Technical Assistance Person-months and Costs (\$000's)  
 APROFAM

<u>Foreign TA/Type</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
Clinics	2.0	1.0	1.0	4.0
CBD	2.0	2.0	1.0	5.0
Literacy materials	1.0	0.5	0.5	2.0
Evaluation	1.5	1.5	1.5	4.5
Curriculum development	1.0	0.5	0.5	2.0
Child survival curric.	1.0	0.5	0.5	2.0
<b>TOTAL</b>	<b>8.5</b>	<b>6.0</b>	<b>5.0</b>	<b>19.5</b>
Foreign TA costs	170.00	120.00	100.00	390.00
<u>Local TA/Type</u>				
Instit. development	5.0	0.0	0.0	5.0
MIS	0.5	0.0	0.5	1.0
<b>TOTAL</b>	<b>5.5</b>	<b>0.0</b>	<b>0.5</b>	<b>6.0</b>
Local TA costs	30.25	0	2.75	33.00
TOTAL TA costs for APROFAM	200.25	120.00	102.75	423.00
APROFAM overhead 12.8%	25.63	15.36	13.15	54.14
TOTAL APROFAM	225.88	135.36	115.90	477.14
<u>DAI PAC II (no cost to Project)</u>				
Training methods	1.0	0.5	0.5	2.0

Technical Assistance Person-months and Costs (\$000's)  
 MOH

<u>Foreign TA/Type</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
Educational materials	2.0	1.0	0.0	3.0
Logistics advisor	1.5	0.5	0.0	2.0
<b>TOTAL</b>	<b>3.5</b>	<b>1.5</b>	<b>0.0</b>	<b>5.0</b>
Foreign TA cost	70.00	30.00	0.0	100.00
<u>Local TA/Type</u>				
MIS design	1.0	1.0	0.0	2.0
Local TA cost	5.50	5.50	0.0	11.00
TOTAL MOH	75.50	35.50	0.0	111.00

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Technical Assistance Person-months and Costs (\$000's)  
AGES

<u>Foreign TA/Type</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
Current curriculum development	1.5	1.5	1.5	4.5
Occupation training curriculum	1.0	0.5	0.5	2.0
MCH curriculum	1.5	1.5	1.5	4.5
TOTAL	<u>4.5</u>	<u>3.5</u>	<u>3.5</u>	<u>11.0</u>
Foreign TA cost	80.00	70.00	70.00	220.00
<u>Local TA/Type</u>				
Local mgmt assistance	1.0	0.5	0.5	2.0
Local TA cost	5.50	2.75	2.75	11.0
TOTAL AGES procured TA	<u>85.50</u>	<u>72.75</u>	<u>72.75</u>	<u>230.00</u>
AGES overhead 12.8%	<u>10.94</u>	<u>9.31</u>	<u>9.31</u>	<u>29.56</u>
TOTAL AGES	96.44	82.06	82.06	260.57
<u>Population Council (no cost)</u>				
Operations research	1.0	1.0	1.0	3.0

Technical Assistance Person-months and Costs (\$000's)  
I PROFASA

<u>Foreign TA/Type</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
Maya strategy	1.5	1.5	1.5	4.5
Business development	1.0	1.0	1.0	3.0
Communication strategy	1.0	1.0	1.0	3.0
TOTAL	<u>3.5</u>	<u>3.5</u>	<u>3.5</u>	<u>10.5</u>
Foreign TA cost	70.00	70.00	70.00	210.00
<u>Local TA/Type</u>				
Marketing plans	1.5	1.5	1.5	4.5
Market research	3.0	3.0	3.0	9.0
TOTAL	<u>4.5</u>	<u>4.5</u>	<u>4.5</u>	<u>13.5</u>
Local TA cost	24.75	24.75	24.75	74.25
TOTAL I PROFASA	94.75	94.75	94.75	284.25

Technical Assistance Person-months and Costs (\$000's)

NIM

<u>Foreign TA/Type</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	
Total Organizational design	2.0	0.0	0.0	2.0
Management systems	2.0	0.0	0.0	2.0
TOTAL	4.0	0.0	0.0	4.0
Foreign TA cost	80.00	0.00	0.00	80.00

## Technical Analysis

### 1. Measurement of Impact

The Contraceptive Prevalence Survey of 1983 found that 25% of women in the fertile age group and in consensual union were using some method of contraception. In the 1987 Demographic Health Survey, the prevalence rate had reduced to 23%. There are some 1,877,000 women in the 15 to 44 age group and the number of users increased from 237,600 in 1983 to 277,000 in 1987. The prevalence rate decreased by 2 points because the number of fertile age women is increasing faster than the number of users. Approximately 337,000 more women are of reproductive age in 1988 than in 1983 and this number will continue to increase since 50% of the population is under 15 years of age. The number of users has increased but not as a percentage of the fertile age population.

Couple-Years-Protection (CYP) is an indicator recommended by the Centers for Disease Control (CDC) for using logistics data to estimate active users of a family planning program. It is calculated by applying factors to contraceptive usage data -- units of condoms, cycles of orals, etc. -- to year-equivalents of couples protected from unwanted pregnancy. This method divides the total number of condoms and oral cycles dispensed by 100 and 13, respectively, which are the number of products needed to protect a couple for a year. For surgical contraception, the total number of procedures is multiplied by 10 to estimate the number of years of protection; for IUD's, the multiplier is 2.5.

The CYP calculations assume that clients use the amounts dispensed. For this reason it is best to have data on amounts actually given to clients. Logistics data at levels above the client can actually cause distortions of the true picture. For example, data from higher in the system can cause distortions. For example, data from the highest level in IPROFASA could give erroneous results because of storage of large amounts in wholesaler's warehouses. Other limitations reported by Siragelding, et al, (Evaluating Population Programs, St. Martin's Press, 1983) include:

- a) CYP calculations give equal weight for contraception by women of different ages. However, a year of protection for a woman 22 years of age has a different impact than the same year of protection for a woman 44 years old.

- b) CYP calculations do not account for the differing effectiveness of various methods.
- c) CYP does not take fertility expectations into account, making urban-rural comparisons difficult.

Other distortions can enter the calculations because they take credit for all the years of protection for sterilization and IUDs in the current year.

Despite these problems, CYP represents a reasonable and practical method of estimating users between periodic surveys, and is easier to obtain than often inaccurate service statistics. Research carried out in Guatemala (Bertrand---) has proven its reliability. As an example, during the period 1983-87, the Project provided about 1,235,000 CYPs, or an average of 247,000 per year. This figure corresponds well with the number of users estimated by the 1983 and 1987 surveys (238,000 and 277,000, respectively).

It is estimated that about one fifth of all the CYP provided in the last five years were offset by the increase in the number of fertile age women. In the next three years, the number of reproductive age women will increase an average of 75,000 per year to reach a total of 2,121,000 in 1991.

If we identify the number of women that have expressed a desire not to have more children in the next two years (women in need of family planning services), there is still a very large unmet demand. The following table shows that there are currently 1,114,000 women in this group and they are expected to increase to 1,204,000 by 1991. This group constitutes the target population for this Project.

Women of Reproductive Age, In Union, and In Need (000's)

	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Women 15-44	1746	1815	1887	1962	2040	2121
Women in union	1158	1204	1251	1301	1352	1406
Want children soon	167	173	180	187	195	202
Women in need	991	1031	1071	1114	1157	1204
Users (from DHS)	272	277	288			
Users (25% prevalence)				325	338	351
Users (30% prevalence)				390	406	422

Maintaining a 25% prevalence rate would mean supplying services to 325,000 women in 1989 versus the 277,000 supplied in 1987 -- an increase of 48,000 users. An increase to the 35.3% prevalence rate shown in the Action Plan would mean providing services to 459,253 women in 1989 -- an increase of 182,253. This magnitude of an increase is not considered feasible for the country. The Action Plan target of 35.3% was based upon an earlier study by the University of Chicago Social Development Center which assumed more financing and CYP contribution from the service provider agencies than has actually materialized in Guatemala -- particularly by the GOG.

This Project estimates the target for service coverage in terms of CYP rather than prevalence rate. It is estimated that there will be 1,000,000 cumulative CYP in the period 1989-91 which is roughly equal to a 27% prevalence rate by the end of 1991. In absolute numbers, this means increasing the number of users to 379,600 in three years or an increase of 91,600 over 1988. This CYP estimate of service utilization is at the purpose level rather than output level of the logical framework and is therefore not completely within the control of the various provider agencies in the Project. The target is deemed to be feasible if all the inputs and institutional changes occur as planned. An average of 247,000 CYP for the past five years is estimated to rise to an average of 333,000 CYP per year for the next three years -- or an increase of 34.8% in couple-year-protection.

## 2. Contraceptive Technologies

This Project will provide on oral contraceptives, IUDs, condoms, vaginal tablets, and voluntary surgical sterilization. Referrals to other institutions for "natural" methods (Billings, sympto-thermic observation) will also be provided. This variety of family planning methods responds to the interests and desires for spacing and family-size limitation among Guatemalans. The modern contraceptive methods are no longer experimental and their effectiveness under a variety of field conditions is proven. Since contraceptive failures (pregnancy) result more from human error than from technical shortcomings of the contraceptive, appropriate education and counseling of family planning clients are necessary to ensure correct usage. There is still the need to conduct research into to such areas as preferences in Guatemala for some methods over others, perceptions of secondary effects, reasons for non-continuation, and cultural factors which interfere in successful use of the various methods. Training and seminars for service providers under all

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components of this Project will help to ensure the proper instruction of users. Training materials in Spanish and Mayan languages adapted to Guatemala and tested manuals for correct contraceptive use will be available for all components of this Project.

When proper screening and patient management techniques are undertaken (particularly when compared to the health risks of pregnancy in Guatemala, side effects from contraceptive use are manageable). The relative safety of the various methods depends, in part, on the characteristics of the users, such as age, health, parity, personality, etc. After careful instruction, the user must consider the risks relative to the desired level protection from pregnancy. With the variety of modern methods are offered, by this Project, the user can make a reasonable choice. Trained health personnel will also be available to manage side effects of the chosen method. Often these side effects require only counseling. However, an alternative method can be selected.

Continued use will depend on informed choice of a method and attentive counseling efforts. Special attention will be paid throughout this Project to training appropriate personnel in both these areas. In addition, regular supervision will help to ensure that personnel are giving adequate attention to appropriate method selection and counseling.

#### Voluntary Sterilization

Voluntary sterilization is the most secure, the most requested and the most used family planning method in Guatemala. Laparoscopy, minilaparotomy, and vasectomy will be available through APROFAM clinics and MOH hospitals participating in the Project. The Ministry of Health has specifically requested assistance in this area. The APROFAM IEC program will promote voluntary sterilizations as the method of choice for couples who have reached their desired family size and desire no more children.

#### Intrauterine Devices

IUD's will be provided through APROFAM clinics, MOH health centers, and private physicians. Training will be provided to MOH physicians and graduate nurses in health centers who have not previously received such training. Insertion and removal kits, Copper T's, sterilizing solution and minimal additional equipment will be provided by the Project budget.

### Oral Contraceptives

The project will provide one standard and one low -dose oral contraceptive for distribution in clinics, community -based distribution programs, and the contraceptive retail sales program. The Ministry of Health will provide medical supervision for the distribution of oral contraceptives by non-physicians. Other brands of oral contraceptives will be provided by UNFPA and IPPF to the MOH and APROFAM respectively.

### Barrier Methods

Condoms and vaginal tablets will be provided by the Project for distribution by all providers of family planning services. The IPROFASA publicity campaign will continue with a major promotion of repackaged barrier contraceptives because of the shorter time needed to register these products.

### H. Administrative Analysis

Management Information Systems (MIS) need development in three of the four agencies. Not all data collection can be standardized, but certain elements such as service statistics, distribution statistics, and denominators can and should be. Standardization of data collected and reported across agencies, and the ability to digitally consolidate this information at the Project level, are objectives of the extension.

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1. APROFAM

General Description

In 1976, a study by the Central American School of Business Administration (INCAE) looked at APROFAM's management capability, e.g., personnel policies, staffing patterns, decision making process, financial and administrative controls, internal communications, etc. This study concluded that APROFAM had the "strongest general management capabilities of any of the six IPPF affiliates in Central America". Despite rapid expansion of activities, APROFAM's overall management capacity has improved.

APROFAM uses a traditional hierarchical organizational structure. Five department directors, who report directly to the executive director, supervise specific projects and activities, supported by a small centralized administrative staff. The Program Coordinator, who also reports directly to the Executive Director, coordinates departmental planning/evaluation activities and serves as the principal liaison between APROFAM and donor agencies. Although the administrative structure looks like many in Guatemala, APROFAM's uniqueness is a function of staff dedication to family planning and willingness to seek solutions to management problems as they arise.

In 1988, APROFAM's budget supported a staff of 281 persons plus 1,790 volunteers working as community distributors. Financial assistance was received from six other international organizations for a total of Q2,391,915 apart from AID grants.

APROFAM has demonstrated its ability to successfully implement a wide variety of programs. Between 1977-1979, the Association's operating budget tripled, staff increased correspondingly, and a diverse set of urban and rural activities were initiated. Many organizations would have been taxed by such growth, and others would have disintegrated under the pressure. APROFAM, however, seems to have thrived and learned from the experience. APROFAM employs modern financial and administrative practices which will facilitate expenditure of the funding projected under the extension. This agency, at the time of preparation of the PP supplement was spending at a rate approximately equivalent to \$2.4 million per annum. The extension proposes an increase in spending which averages \$4.0 million per year for APROFAM, or about \$1.6 million more per year in expenditures. In the course of design of this

extension, great care was taken to ensure that programmatic capacities were not being exceeded and that reasonable cost of living increases were factored into the budgets.

### Management Systems

APROFAM has several management systems, e.g., payroll, personnel, reporting, internal audit, external audit, inventory supply and control, program evaluation, etc. A procedural manual exists for major administrative tasks although there is no organization manual describing the functions and responsibilities of each unit nor is there a position description for the key jobs. Despite formal, rigid procedures, the Association is administered well: payroll is on time; commercial bills are paid regularly; distribution points rarely suffer stock-outs of contraceptive supplies; donor agencies receive required reports; management data exist and are reasonably accessible and accurate; and budget projections have been quite good in the last few years.

In early 1989, APROFAM will be enhancing the existing data collection and reporting system. This will begin with a review and revision of reporting forms used in clinics and in the CBD program to ensure that software design supports the informational needs of APROFAM and of the Project.

Hardware and software needs will be met with the purchase and installation of a five node local area network (LAN). This will be an 80286 class system fully compatible with existing hardware and software used in the agency. Directors of the CBD, clinical services, and evaluation units will have nodes in their offices, as will administrative support units. A full time microcomputer and database manager will be added to the staff to handle all phases of data processing.

This MIS will be using a LAN version of dBase III+. During 1990 and 1991, compatible hardware and software will be added in each of the departmental clinics. These sites will assume increasing responsibility for ordering supplies and administering clinics on an ongoing basis. Two or three of these sites will be designated as regional centers and, with the addition of regional laboratories, this will be the main site for tracking and reporting lab work. Data entry will be performed at the clinical level, with raw data uploaded to the LAN at APROFAM central offices. Aggregated reports will also be produced at the clinical level for internal monitoring and management purposes.

The inventory tracking system will be altered with the assistance of CDC to identify aberrations in contraceptive distribution. As just one possible example, this might take the form of flagging outlets deviating more than 2 SD from mean usage. Accountability for supplies, as well as information for rapid procurement and distribution purposes, will be developed as key elements of the system.

The MIS will be used to identify and monitor the broad disparities in service production currently found, both in terms of clinical utilization and in terms of community-based distribution.

#### Ability to Expand

APROFAM's management structure survived the 1976-79 rapid program growth. The Association's logistics, planning, supervisory, data collection and reporting capability has generally improved during this period.

Project activities planned for APROFAM during the 1989-1991 period will nevertheless pose an additional burden of expansion and increased efficiency upon the organization. For example, paid staff will increase from 281 to 398 in 1991 and volunteers from 1,790 to 2,200. Accordingly, a number of actions are planned for the continued development of the institution.

An analysis of the program revealed that at least four clinics of the ten in the field are utilized at a rate below the national average. With a fixed number of clinic personnel, the efficiency of those clinics is below the average. There is an apparent lack of demand for those clinics which needs to be examined to determine whether the promoters and community distributors working in the clinic area are actually helping or hindering the promotion of clinic services. One of the aspects to be examined is whether there is a disincentive for community distributors to refer persons to clinics since they receive their commissions on commodities sold and not on clinic services.

This question raises a more fundamental concern: are the interrelated functions of clinic services, promotion and community distribution properly coordinated at the field level? Presently, clinics and community distributors are managed by separate Departments at the national office with informal coordination at the field level. As field personnel increase and as more administrative functions such as supply

management are delegated to clinics, a basic question emerges whether there should be an Area Chief to handle delegated functions and integrate promotion with clinic services. These questions need to be addressed as part of a coherent institutional development plan that deals with several issues:

- analysis of the forthcoming workload and whether APROFAM needs to decentralize to deal with it.
- critical analysis of decentralization options.
- APROFAM-wide staffing, definition of responsibility and authority delegation.
- the need for a more formal strategic management and project management system.
- the role of the management information system and how it can more adequately serve decision making.
- developing links between the planning, budget and financial management systems.
- executive development of the key personnel at central and field levels.

An institutional development review dealing with the above issues is scheduled for late 1988. An APROFAM decision would follow with a time-phased plan for implementation. Resources have been allocated during 1989 for technical assistance and staff management training to implement the plan.

#### APROFAM Overhead Rate

In November 1981, APROFAM submitted to the Mission a detailed explanation and computation of their overhead. Based on a review of these calculations and supporting documentation undertaken by Mission financial analysts, an overhead rate equal to 12.8% of direct costs was authorized on November 24, 1981. These calculations were based on 1980 figures. The passage of time and the forthcoming increase in project activities warrant a review of this overhead rate. A recalculation of this overhead rate is recommended for inclusion in the 1989 budget cycle.

#### 2. Ministry of Health

It is considered remarkable that, despite serious political and administrative problems when the original

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agreement was signed in mid-1985, that the FPU of the MOH was able to spend the funding it has. It is estimated that at the current PACD of December 31, 1988, the FPU will have only \$80,000 to \$100,000 remaining in its pipeline unspent. This represents only slightly more than 10% of the original funding. If current political and administrative climates maintain, the increase spending proposed in the amendment is feasible.

During the period of the design process (March-May 1988), the Ministry of Health was undergoing a reorganization and a change in personnel at the Ministerial level. The Family Planning Unit was to be integrated into a Maternal Health Department, with the former Head of Family Planning to become the Chief of the Maternal Health Section. However, the FPU is to retain its identity as a component unit within the Maternal Health Department.

Because of the changes underway within the Ministry of Health, previous analyses of the MOH administration may not be valid. However, the MOH will continue with its large field establishment of 35 hospitals, 214 Health Centers and 755 Health Posts. The FPU organization and staffing are currently as follows:

- Director
- Administrator \*
- Medical Supervisors (8) \*
- Graduate Nurses (2) \*
- Social Worker (1)
- Secretaries (6)
- Warehouseman (1) \*
- Janitor/Messenger (1)

\* indicates personnel financed by this Project.

The Project will increase the Unit with the following personnel:

- Administrative Asst. (1)
- Medical Supervisors (2)
- Communications Spec. (1)

These additional personnel will be financed by the Project. The Maternal Health Section will provide two Ob-Gyn's, one pediatrician and one graduate nurse. In total, the full staffing will number 29.

The current warehouse and manual inventory and supply system was considered as fully adequate by the 1988 evaluation report, and will require no upgrading, except for integration with the MIS, discussed below.

The MOH received four 4-wheel drive Jeep Cherokees under the prior extension. The logistics and supervision duties of the eight medical supervisors are currently supported by another four 1981 pickups. Due to the age of these vehicles, and difficulties in obtaining spare parts, the four pickups are both costly to maintain and unreliable. Given the expanded area and intensity of the FPU activity, additional vehicles will be provided by the Project. These will be 4-wheel drive, double cab pickups, equipped with weatherproof canopies. Road conditions and maintenance considerations strongly suggest that these be six cylinder, gasoline powered trucks.

Data at the MOH/FPU is currently entered manually from health centers and posts and transferred by hand to aggregate sheets. The Management Information System (MIS) envisioned for the three years of the Project will not fundamentally alter the existing paper-based MIS, though forms used for data entry will be altered to allow for codification of health post, health center, or hospital. The MIS will focus on five areas for this interim period:

- 1) Accounting
- 2) Inventory system
- 3) Supervision and logistics
- 4) Service statistics, at all levels of service
- 5) Personnel training

The workup around the supervision recording and reporting system is central to the qualitative changes planned for the MIS. The service statistics subsystem, as well as the personnel training subsystem, will mirror, though not duplicate, those subsystems being developed for the MOH child survival project. The criterion to be followed in actual design of the system are as follows:

- 1) Compatibility with the MOH child survival system and the MIS systems in place or being developed by the other implementing agencies, for purposes of aggregation and analysis by the TA team, by USAID, or by other entities;

- 2) Thorough forms review, in accord with criterion (1) above;
- 3) ability to monitor supervision activities, service delivery activities, and supplies, on a continual basis; and
- 4) efficiency in the flow of data and information for procurement, decision making, and analytical purposes.

A simple though more efficient MIS is needed by the MOH which, far short of providing a sophisticated base for analysis and patient tracking, will facilitate basic reporting and decision making processes, areas in which the MOH is currently weak. A more elaborate MIS, integrated with the overall MOH system, is foreseen for the period after 1991 when the child survival MIS being developed with USAID assistance for the MOH is integrated with the FPU MIS at all levels.

As recommended by CDC/Atlanta, the MOH uses an IBM PS/2 Model 60 with a 44 Mb hard disk, internal 3.5 inch 720K drive and an external 5.25 low density drive. An Epson dot matrix printer completes the FPU's hardware. Hardware expansion should be limited, during the Project period, to a tape cartridge backup system, and four additional microcomputers, compatible with the IBM Model 60, which can be used as data entry workstations through the LAN or independent processing stations. A LAN such as Novell ELS I, with cards for four nodes and sufficient cabling, will satisfy MOH FP needs for the next three years. An additional printer should also be added. As for software, in addition to the LAN software, a multi-user data base system will be added to a LAN. A Spanish language word processing software system is also needed for routine word processing purposes.

Existing personnel will be trained to handle data entry and word processing, with technical support purchased from local sources to provide trouble shooting, special software development, programming adaptations, and similar support activities throughout the three year period.

The MIS is seen as a very simple system, which is merely a precursor to the integrated system which will be installed after 1991, in line with other MOH capabilities. It is felt that, for the period of the current Project, there should be no development which would duplicate the activities of the long-term advisor developing an integrated MIS for the MOH. Short-term technical assistance for programming, training

and support will be purchased locally. CDC will be assisting in the implementation of a procurement and inventory logistics system: interfacing and compatibility with the overall system will require additional technical assistance.

### 3. AGES

#### Administrative Analysis

AGES will be receiving considerably more funding from the Project than in the past. During the last several quarters prior to this PP supplement, however, AGES has been spending at a rate near what will be required during the extension to expend slightly more than \$2.0 million in new funds. The majority of the additional increase will go to more realistic salaries, additional personnel including management personnel to assist the Director General in more effective supervision of field activities, a doubling of incentive educational scholarships to school-aged Mayan girls, the purchase of additional vehicles and limited remodeling of AGES' 6 regional offices.

The 1988 Project Evaluation noted AGES' rapid growth during the last two years and pointed out the need for institutional assistance to support its current and future growth. Issues that the evaluation team and others surfaced included the need to:

1. review and modify the organization plan and structure
2. review and modify job descriptions
3. review salaries structures and inequities especially between central and regional office staff, and
4. review and improve the financial and MIS systems.

In order to respond to these issues, the management consulting firm of Praun Reyes and Aldana was contracted. They have developed an exhaustive organizational plan calling for the decentralization of central and field office activities, a job analysis of each organization position including the weighting of each position by a series of variables based on education and supervision requirements, among others. This will be the basis of a salary review to address overall inequities especially between central and field office staff.

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The decentralization model will be initiated mid-year 1988 with the appointment of a Unit Zone Supervisor to co-ordinate the activities of each of the regional offices. A Chief of Services will also be selected to supervise central office personnel, including the Departments of Training, Sexual Education For All, Counselling, Scholarship and Educational Material Development.

These two new administrative positions will greatly reduce the burden of the executive director with day-to-day operational activities, in order that she can concentrate more on global institutional issues.

An external audit was performed in March 1988. A few minor corrections to accounting procedures have been made, and accounting systems in place are adequate to handle the increased expenditures which will be made during the extension period. Otherwise the financial system is accurate and complete.

Forms being developed for future data collection will need review for appropriateness for research and decision making. Two individuals responsible for micro-computer management are fully competent. An increased quantitative load during the Project extension will require the addition of an additional 8088-class microcomputer for data entry, one additional printer, and replacement parts and supplies. The dBase III+ system in place at AGES is sufficient to meet accounting and database management needs; presentation software and utility software will be added. With these changes, minimal information processing needs will for the extension period will be met. As another source of institutional strengthening, The Population Council will be assisting in the design and development of a Management Information System. This will help AGES with its current and future data collection and will enable more efficient program monitoring and management.

#### 4. IPROFASA

All administrative systems at IPROFASA, including accounting, sales, inventory, and credit collections systems are fully functional. Job responsibilities are well specified and internal staff training is ongoing. A management information system centered around a Local Area Network supports all of these areas appropriately and efficiently. A

focused evaluation of IPROFASA conducted by PSI in 1987, and another review carried out as part of the overall 1988 Project Evaluation, corroborate these assessments.

New funds, totalling approximately \$2.8 million, would require an annual spending rate of \$900 thousand. IPROFASA is now spending at a rate nearly \$700 thousand. The increased activity in product diversification, new markets in the indigenous areas and normal cost of living increases including salaries, suggests that IPROFASA will have no difficulty expending the funds budgetted.

The existing MIS consists of a 4-node LAN with an IBM AT fileserver, and IBM XT remote stations. It is structured along a serial design, such that nodes are connected to each other and to the file server. The LAN version of dBase III+ is currently in use, with modules for invoicing, sales and accounting/credits. Individuals within the corresponding departments are restricted in their access to modules outside their normal needs, and electronic mail will increasingly facilitate inter-departmental communication. The system was installed by an independent programmer/systems manager, who also provides training and support to the full IPROFASA staff. This system was reviewed in the PSI evaluation in 1987, and again in the 1988 evaluation.

Additional requirements are minimal. A tape backup system to ensure longevity of data is needed, as is a higher capacity hard disk drive. Development of customized documentation by which users can follow simple steps for logging on, saving their data, and other fundamental user activities, would lessen dependence on outside technical support. Other than this, no significant modification will be needed in hardware, software or training.

No significant administrative changes will take place during the extension period which would strain IPROFASA's existing and well functioning administrative systems.

##### 5. New Initiatives Modality (NIM)

The following analysis provides a discussion of more of the details and issues involved in establishing the New Initiatives Modality (NIM): the role of the entity in relation to population served, both Ladino and Mayan, and the relationships to other providers; its objectives, functions and structure; and finally the relations to AID and other donors.

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The two geographic client catchment areas which have been most carefully studied and which are likely to receive greatest attention under the NIM are the Coastal Plain and the Highlands. Brief summaries of earlier studies are provided below.

### The Coastal Plain

A study by Stony Brook in 1987 indicated the importance of the Coastal Plain as a potential site for expanded health services. There are over one million inhabitants in the area, including colonos (agricultural workers residing on the plantations), 100,000 Mayans and an estimated range of 300,000 to 600,000 Mayan migrants from the Highlands. The rural area is underserved by the MOH and the Guatemalan Social Security Institute (IGSS) so that some agricultural producers have joined together to provide health services through a variety of means. The two most prominent are the ANACAFE and the AGROSALUD plans, although there are several other providers in the area who should be considered for possible support and expansion. The sugar cane producers are also potential recipients of assistance for health services to their workers.

The area has been the scene of unrest because of the population influx, the underemployment and the seasonal fluctuation in available work. The health services provided by employers therefore is, in part, a response to the need and unrest of the population. Assistance to the providers in the area therefore will probably be welcomed and needed.

The NIM could well begin by exploring support for the major providers in the Coastal Plain, but need not be limited to that area since the Agricultural Associations provide health services to rural areas in other parts of the country. Hence, the Coastal Plain provides a good entry into expanding services to rural areas which are generally less served than the urban areas.

### Mayan Community

The Mayan communities present quite a different challenge for the development of providers of health care services. The AGES organization will work in a sample number of communities during the period 1989-1991 to find what kind of communication and approaches best fit the beliefs, local community structure and needs of the Mayan population. Part of the strategy is to find means of linking area providers with

the needs of the women and children of the communities. The NIM will try to find means of connecting the local community with the available resources including community distributors, clinics, health posts, local charity organizations and other PVO's.

A 1987 study of thirteen providers working with Mayan groups revealed the following:

Knowledge of family planning contraindications	....Poor
Attitudes toward family planning	.....Favorable
Users as percent of clients	.....Very low
Constraints to expansion of services	.....Fear of opposition by husbands or priests
Attitudes towards Mayans	.....Favorable
Special studies to extend services	.....None
Experiments to reach Mayans	.....None
Clinic hours	.....Irregular

The above profile of current providers indicates that a possible program of assistance to providers would include training in family planning services, special information programs for husbands and local priests, demand creation in their catchment areas, expansion of staff and facilities to accommodate increased demand, and increased knowledge of the practices and means of communicating with the community. More experimentation is necessary to find more cost/effective means of delivering health services.

The NIM is not limited to assistance to Mayans and the Coastal Plain. As it gathers experience and obtains funding, it can help fill the gaps in the array of providers wherever it can be more cost effective and where it can attract more outside funding for its purposes.

#### Lessons of ASINDES

An evaluation was conducted recently of a Guatemalan association designed to assist non-government organizations, partially financed by USAID: the Asociación de Entidades de Desarrollo y de Servicio No Gubernamentales (ASINDES). The evaluation reported severe problems with the project and ASINDES. Since the approach is similar to the NIM under consideration, it is worthwhile noting the experience of ASINDES and to incorporate into the NIM design the lessons of the ASINDES experience.

The errors detected with ASINDES are of two kinds: one of design, and the other of implementation. The design error is that the Organization is an association attempting to gain members, represent them and their interests, and at the same time attract resources for the use of its members. There are 400 NGO's in Guatemala, of which 40 are development organizations. Only 24 of these are members of ASINDES. It is natural that a membership organization will become involved with the internal and external politics of the membership, particularly where it concerns attracting and distributing resources. There is inevitably a jockeying for a share of limited funds and a resistance to diagnostic studies of member organizations. The lesson is not to mix membership associations with development organizations who must assign resources on the basis of different criteria. Hence, the HSDO should not be a membership organization.

The implementation errors of ASINDES are clearly failures of management systems and a lack of qualified managers. The evaluation concluded that ASINDES needs: a planning system, a five year plan, procedures to review and monitor grants, analysis of benefits, impact evaluations, improved project proposals, improved technical assistance and training, better accounting procedures and personnel systems. The evaluation proposes a complete change in personnel, restoration of morale, and external audits of ASINDES and its grantees. Clearly, the NIM could benefit from this lesson: provide for good managers and good management systems. This should be fundamental for any organization, but especially one trying to develop other organizations.

#### Organization

Although initially NIM functions will be carried out by an U.S. PVO, the NIM should eventually be legally chartered in Guatemala as a non-profit organization with a Board of Directors. The organization could have the following mission and objectives.

#### **MISSION:**

Its mission should be to assist and develop other organizations providing maternal and child health services to the people of Guatemala.

#### **CRITERIA:**

The criteria for such assistance should specify that the help be given without discrimination for religious,

ethnic, or social reasons and that priority be given to those most in need. The criteria also indicates that providers should provide a balanced set of health services to mothers and children including family planning or any combination of these services both preventive and curative. This helps attract more providers who might prefer work on only one aspect such as family planning or child survival or maternal health rather than all of the foregoing.

**OBJECTIVES:**

An illustrative set of objectives could be as follows:

- Expand the number of providers of maternal and child health services including family planning.
- Expand the amount and quality of services being provided by the recipients of the assistance.
- Give priority to the underserved segments of the population such as the Mayan and rural populations.
- Serve as a clearinghouse of information concerning needs, providers and more effective means of providing health services to mothers and children.
- Increase the number of donors and the amount of resources available for these objectives in Guatemala.
- Identify more effective health delivery systems and providers, including operations research studies, to increase coverage and more cost effective means of delivery.
- Aim at self-sufficiency as an organization to sustain operations if AID funding decreases or is stopped.

**FUNCTIONS:**

Its functions should include: to make grants to other organizations, provide technical assistance and training, provide supplies and equipment, help in identifying donors, providers of health services, help with the preparation of proposals, monitor and report to donors on project progress, and assure proper audits of its own and grantee performance.

### STRUCTURE AND STAFF:

A simple structure would include an Advisory Board charged with policy decisions, appointment of the Executive Director, project selection for grant award and supervision of the conduct of operations.

An Executive Director should have full authority for the conduct of operations. He should be assisted by the Advisory Board mentioned above or a professional, volunteer Committee for Project Selection (CPS) in order to assure fairness and balanced judgment in the selection of beneficiaries. The selection process would be carefully designed, organized and monitored to avoid unusual pressures and criticism from external sources.

Initially, a Financial Officer may be sufficient to assist with the preparation of the proposals, their financial analysis and the financial management of the funds of the NIM. At some point an accountant may be contracted or hired according to the workload. It may also be necessary at some point to add a Program Officer to help with project proposals, presentations and reports to Donors, and with monitoring and evaluation functions.

Contract consultants should be available to the NIM to assist as necessary with project proposals, appraisals, technical assistance, training, evaluations and development of management systems either for the NIM or the grantees.

### Financing

Initial financing can come from AID, but the plan should envisage financing by multiple donors. As the NIM gains acceptance as a useful mechanism for external donors who do not have the expertise and knowledge of the country and its specific needs, it is likely to grow in terms of number of sponsors. The donors could include other governments, other international agencies and banks, private charities, civic charities and religious organizations. AID should aim at providing less than 50% of donor funds so as not to dominate the NIM nor to give it the image of an exclusive instrument of United States policy.

In order to ensure its self-sufficiency, the NIM can charge a fee to the donors to cover its administrative expenses. Over time, this fee should enable the NIM to proceed independently of any subvention for its administrative

expenses. The fee should be adequate for its scale of operation and help it to maintain a quality standard.

### Relationships

USAID can request that the contractor initially send its grant proposals to the Mission for information in order to determine conformity with the criteria and objectives established in the cooperating agreement. Quarterly reports of progress and annual evaluations can monitor progress while submission of annual operating plans in advance of each year can be utilized as means of determining funding and program levels by year.

The NIM should maintain communication with AGES in order to incorporate lessons learned regarding IEC with Mayan communities. No formal agreement is necessary for this but there should be an effective process of interchange of information. AGES is interested in disseminating the knowledge it gains so that the NIM should serve as a channel for this, provided, of course, that AGES gets full credit for its work.

There are 309 PVO's involved with health services and 179 health related non-governmental organizations. Since these figures come from different compilations, there may be some duplication between these categories. In any event, there are many providers of health services in Guatemala and the NIM will be interested in identifying the most effective among them that can help meet its criteria and considering them as possible grantees for assistance.

The PVO's in turn can look to the NIM for a clearinghouse of information, a source of help for their own objectives, a channel to donors -- particularly the large international donors -- who usually have stringent requirements for preparation of proposals, project implementation, auditing and reporting. Thus, the NIM is a valuable facilitating mechanism for securing resources along with training, commodities and technical assistance.

The relationship of the NIM with APROFAM, the MOH and IPROFASA should be a collegial one where it provides complementary services rather than supplanting or duplicating the coverage of the others. The NIM is not an operating organization, so that it may, for example, request APROFAM to provide training or other support services to the some of the PVO grantees. The same can be done with the MOH and IPROFASA where their particular capabilities could be used for assistance to other providers.

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Finally, there is a real opportunity to help coordinate services in specific geographic areas among the key providers in that area. For example, coverage for some Mayan communities might involve requesting APROFAM to extend its CBD Distributors to the community while the MOH expands its health post staff to provide services that supplement what the local provider can do. This kind of horizontal cooperation at the field level can best utilize all existing services for benefit of the population.

## I. Economic Analysis

### 1. Introduction

In the early 1980's, Guatemala began to experience serious economic problems. Output and investment decreased, accompanied by a large balance of payments deficits, while external debt almost tripled. Per capita income in 1987 was 20 percent less than in 1980, and open unemployment rose to nearly 20 percent (see Graph 1). This deterioration could be traced to several factors, including adverse economic and political events in the region, a lack of growth-supportive economic policies, the downfall of the Central American Common Market, and a worsening of Guatemala's terms of trade.

But beyond these immediate shortcomings, Guatemala also faces structural problems of a more long-standing nature: dependence on a few primary exports, wide disparities in income, low investment, and scarce resource mobilization. And last but not least the high rate of population growth in Guatemala which makes these problems ever more difficult to solve.

It is important to remember that in a high fertility society the age structure will be younger and the demands made upon resources to feed, cloth, house, educate, and equip the increasing numbers, will be greater than in a low fertility society. In Guatemala, the dependency ratio--the ratio of the population under 15 and over 65 to the population in the ages 15-64--is one of the highest in the world: 98.4 percent (Encuesta Nacional Socio-Demográfica 1986/1987, National Institute of Statistics, December 1987). A reduced dependency ratio, one objective of the proposed Project, could provide better opportunities for increasing the savings rate and so lead to larger investment and faster growth.

### Population and Public Expenditure

A slower growth in numbers would mean that a lower proportion of public expenditure will be required to provide each added person with the average amount of physical infrastructure and social services, and so more is available to increase the amount per person. In the presence of a high population growth rate, lower investment or public expenditure per person does not necessarily translate into proportionately less for each person. More likely, it may mean that distribution of expenditures is less equitable. One consequence can be higher levels of unemployment, illiteracy, and malnutrition among the poor.

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## Population and Labor

The more rapidly the Guatemalan labor force grows, the more investment will be required to maintain the average capital stock per worker, allowing less of an increase in capital per worker and thereby dampening the growth of productivity. Population growth, also, in increasing the supply of labor relative to other factors of production, restrains the growth of real wages (or reduces them), and increases underemployment. In Guatemala, 75 percent of the employed labor force earns less than Q200 (\$80) per month (Encuesta Nacional Socio-Demográfica, National Institute of Statistics, December 1987; see Graph 2 and Table 1). As in education and unemployment, there seems to be an inverse relation between the rate of natural increase and the level of income. By lowering the dependency burden, lower fertility frees resources from use in child support for use in investment.

Rapid population growth has made many of Guatemala's problems harder to solve. Population growth has contributed significantly to inequality, while making social targets such as universal literacy or full employment, much harder to attain. Population growth has slowed down improvements in health and nutritional standards. In short, population growth has been an important cause of poverty.

### 2. The Problem of Population Growth in Guatemala

In Guatemala, industrialization and trade policies have combined to favor capital-intensive manufacturing activities to replace imports. Therefore the sole recovery of historical patterns of economic growth would be unable to solve the unemployment issue, because in Guatemala, industrialization, extensive agriculture, and trade policies have combined to favor capital-intensive activities.

### Unemployment in Guatemala

The rate of open unemployment is presently estimated at around 20 percent, compared with 8 percent in the early 1980's. According to the Ministry of Labor, underemployment, mainly in rural areas, affects an additional 20 percent of the labor force. Though some 60,000 to 70,000 new workers enter the job market each year, the depressed state which the Guatemalan economy has been in since 1980 has not permitted any substantial increase in absorption of new workers.

Employment and improvement in the economic situation of low income population are limited for two main reasons:

1. Productivity in modern, export-oriented, agriculture is based mainly on extensive methods. This involves substantial mechanization, which contributes to an unusually high marginal capital/labor coefficient. This situation is particularly prominent in the Guatemalan Southern Coast.
2. Industrial development has been equally heavily oriented toward capital-intensive production techniques. This is partly because the existing system of investment incentives favors these more than labor-intensive techniques, and partly because new industrial production has been predominantly destined for the domestic and the Central American Common Market and consisted of goods which were relatively capital-intensive.

According to World Bank estimates, the marginal capital/labor ratio for Guatemalan industry was \$10,700 per new job during 1965-73. During those years, Korea had a similar per capita income as did Guatemala, but the Korean marginal capital/labor ratio was only \$2,300 per new job.

Since alternatives to the capital-intensive technology currently used and favored in Guatemala may be very limited, it is not surprising that the growth rates of the labor force offer a challenge that is difficult to meet. Measures must be taken to reduce the pace of population growth, if unemployment and underemployment are to become manageable in the near future.

Reducing the fertility rate will lower the amount of funds that must be invested in health, education, housing, food imports, and other public utilities simply to maintain current standards of living. The resources saved in this way can be channelled to investment activities, increasing productivity and enhancing standards of living.

#### Savings on Education

The Government of Guatemala (GOG) has budgeted Q476 million for education expenditures during 1988. The estimated number of school-age children (ages 5 to 14), according to latest survey (Encuesta Nacional Socio-Demográfica 1986/1987), is 2.39 million. This means an average of Q198 (\$79.20) in education expenditures per children. If we multiply this number by 17,800 (the Horlacher figure for births prevented per

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year), around Q3.5 million (\$1.4 million) will be saved in education outlays during the first year of Project (or, more probably, the level of education will be enhanced through better training, or better materials, or both). Without adjusting for an increased number of births prevented in subsequent year this savings, projected linearly, would amount to \$4,200,000 for the three years of the Project, or \$15,400,000 through the end of the 1990's. It is important to point out that critical to the success of any development strategy is the existence of an education system which can produce a literate population able to acquire industrial skills quickly. But Guatemala's efforts are still far from adequate to attain this goal.

#### Savings on Health

The GOG's 1988 health budget calls for a total expenditure of Q347 million (\$138.8 million). When we divide this outlay by the total number of children (age 0 to 14), we arrive at an annual health care cost per child of Q46 (\$18.40). If we multiply this figure by 17,800, about Q818,000 (\$327,000) will be channelled yearly to intensify child care, nearly \$1,000,000 for the three years of the Project, and at least \$3,600,000 through the next decade.

#### Savings on Housing

Assuming an average cost of Q20,000 per housing unit (the cost set by banking authorities to apply preferential interest rates under the current banking law), a useful life of 50 years and an average of five occupants per unit, the annual per capita cost is an estimated Q80 (\$32). When multiplied by the cumulative number of births prevented during the first year, we reach a total saving of Q1.4 million (around \$570,000). Again this becomes \$1,710,000 for the three years of the Project and \$6,270,000 through 1999.

Under the above circumstances, the total savings during the first year of Project extension attributable to education, health and housing is Q5.7 million or \$2.3 million, \$6.9 million by 1991, and \$25.3 million by 1999.

These estimates are for savings in three areas based upon the minimum number of births which would be attributable to Project activity. A more thorough analysis would reveal further savings on a broader range of social services, as well on food and food imports and other items which affect the national economic profile.

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As the following table shows, income is distributed quite unevenly in Guatemala among the employed segment of the population. Workers in the largest income bracket (36% of the population) earn between \$20 and \$48 dollars per month; another fifth of the workers earn even less than \$20 per month. Only 3% of the employed population earn over \$240 per month.

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TABLE á  
Income Distribution of Employed Labor Force  
(In Quetzales per Month)

<u>MONTHLY INCOME</u>	<u>TOTAL PERSONS</u>	<u>%</u>
	2,205,653	100.0
0 - 49	418,071	19.0
50 - 119	801,464	36.3
120 - 199	445,247	20.2
200 - 299	239,254	10.8
300 - 399	141,998	6.4
400 - 599	92,590	4.2
600 - 999	41,821	1.9
1,000 - 1,999	17,936	0.8
2,000 - & more	7,272	0.3

SOURCE: National Institute of Statistics, Encuesta Nacional Socio-Demográfica, 1986/1987.  
Guatemala, Dic. 1987

The following page shows two graphs indicating economic difficulties. These indicators are all related to population growth.

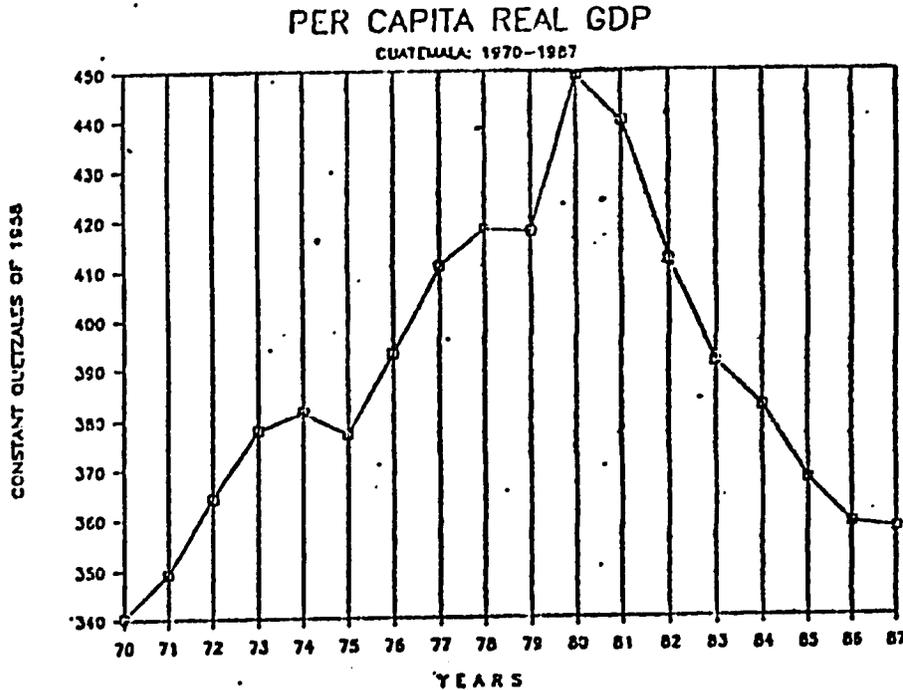
Figure 1 shows the current trend of per capita real gross domestic product (GDP). As a result of the severe economic crisis in the early 80's, combined with increases in the , Guatemala's per capita GDP

now only 80% of what it was in 1972. If we take into account that the recession has been accompanied by a worsening in income distribution, it is no exaggeration to speak of a 15-year setback in economic development.

Figure 2 shows income distribution, another aspect related to population growth and an increasing labor force which cannot be absorbed. In Guatemala, 75 percent of the employed labor force earn less than Q200 (\$80) per month (National Institute of Statistics, Encuesta Nacional Socio-Demográfica 1986/1987).

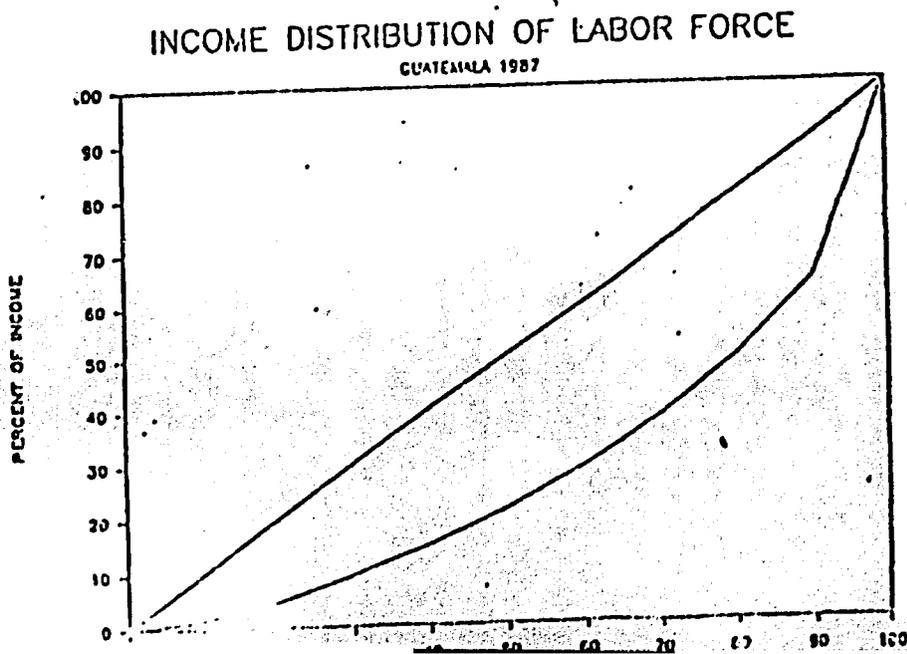
GRAPH 1

Because of the severe economic crisis in the early 80's, Guatemala's per capita GDP has dropped consistently during the last seven years, reaching a low level similar to that of 1972. If we take into account that the recession has been accompanied by a worsening in income distribution, it is no exaggeration to speak of a 15-year setback in economic development.



GRAPH 2

In Guatemala, 75 percent of the employed labor force earn less than Q200 (\$90) per month (National Institute of Statistics, Encuesta Nacional Socio-Demografica 1986/1987).



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TABLE 1

INCOME DISTRIBUTION OF EMPLOYED  
LABOR FORCE (Q per month)

<u>TOTAL</u>		2,205,653
0 - 49.		418,071
50 - 119		801,464
120 - 199		445,247
200 - 299		239,254
300 - 399		141,998
400 - 599		92,590
600 - 999		41,821
1,000 - 1,999		17,936
2,000 - & more		7,272

SOURCE: National Institute of Statistics, Encuesta Nacional Socio-Demografica, 1986/1987. Guatemala, Dic. 1987

## J. Social Soundness Analysis

### 1. Introduction

This extension will be the first family planning project design that has a maternal and child focus. According to the World Bank, Guatemalan health status is among the worst in Latin America (World Bank:16). Maternal mortality in 1981 per 100,000 live births was 110, the highest in the region. The infant mortality rate is also high, 64 per 1,000 live births in 1983. These important health indicators are worse among rural Mayan speakers where the quality of life, in general, is very poor.

A 1982 UNICEF study found the Guatemalan people the poorest in the region. (UNICEF: Dimensions of Poverty in Latin America and the Caribbean, Washington DC, 1982). By combining the Infant Mortality Rate (IMR), life expectancy and literacy rates into one criterion, this report concluded that Guatemala has the lowest "physical quality life" index in Central America and the third lowest in the whole of Latin America after Haiti and Bolivia. Infopress estimated in 1984 (Infopress: 1984) that 76% or 6 million people in Guatemala are poor. Of these 6 million, almost 40% were defined as "extremely poor", or unable to afford the basic food basket sufficient to provide an adequate protein and caloric intake. SEGEPLAN (Dirección General de Estadística, Encuesta Nacional de Ingresos y Gastos Familiares, Guatemala City 1980-81) estimates that by the end of 1985 the percentage of "poor" will have risen to 86% and "extremely poor" to 55%.

#### The Roots of Poverty

A recent letter by the Guatemalan Bishops has concluded that the unequal distribution of land is one of the main causes of the Guatemalan population's impoverishment. This letter traces the Guatemalan pattern of land holding to the colonial era and suggests that agrarian reform is needed to lift this burden of poverty. (El Clamor para la Tierra, Carta Obispal, April 1988, Guatemala).

The minifundia/latifundia land distribution system that has evolved in Guatemala, places large extensions of land in the hands of relatively few where production is for the agro-export sector: coffee, sugar, cotton and cattle. Basic grains are grown on small plots of land primarily in the highlands. Studies conducted by USAID/Guatemala have found

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this agrarian structure to be one of the most unequal and concentrated in the hemisphere. The 1980 study concluded that "nine out of ten people were living on plots of land too small" to provide for their needs. These people, in addition to an estimated 420,000 landless agricultural workers, form the labor backbone for the agro-export sector. These workers migrate from the highlands to the coast to pick cotton and coffee and cut sugar cane. (Painter: 12).

The wealthiest 20% of the Guatemalan population received 47% of the national income in 1970, and this figure rose to 55% in 1980 and 57% in 1984 (Painter:13). The worldwide economic recession at the end of the 1970's had immediate effects on the Guatemalan economy. Economic growth actually went into reverse and much of the growth achieved in prior years was lost. The counter-insurgency program conducted by the Guatemalan military also disrupted and destroyed rural village life throughout the highlands. (PAVA Survey 1984, Montoya:1986).

#### Public Services

Medical and public health services are inadequate. Government spending on health usually represents a small amount of the national budget and far larger amounts are always spent on defense and security. Compared to other countries in the region, Guatemala's spending on public services is low. (Painter:8)

The Ministry of Health (MOH) covers an estimated 30% of the population. The Social Security Systems (IGSS) covers 8%, the private sector 12%, leaving almost 50% without access to some form of modern health care. (World Bank:19)

The MOH has a substandard record of service in the rural areas. Health centers and posts often do not have adequate staff or medicine. Long delays for services, lack of respect and lack of Mayan speaking personnel have lowered the credibility of the MOH in the community.

#### Socio-Political Situation

Since the conquest in the 16th century of Guatemala has been a society dominated by a Spanish speaking minority. This minority has controlled the commercial, political, religious and economic life of the country. The Mayan speaking population was decimated both culturally and physically by the Conquest. From this destruction of their old world, the Mayans

created a new world that syncretized elements from both worlds. During the colonial era there was intercultural and genetic exchange between the Spanish and the Maya. The social system, however, was one of repression and exploitation of the Mayans. The colorful Mayan clothing worn today was imposed during the colonial era as a means of identification and restriction of movement.

Within the colonial Mayan village, communal life was evolving into one that looked in upon itself and viewed the world beyond the village with fear and mistrust. The religious brotherhood, or cofradia, political system became the authority within the village. This "closed corporate" life protected the individual and the village from extreme forms of exploitation during this era.

The Revolution and the introduction of coffee came toward the end of the 19th century and had a profound effect on the society. Coffee production depended on the availability of land and labor, and both were taken by force from the Mayans by the Spanish speaking Ladino. Paid labor was uncommon until the introduction of coffee, and that change pulled the Maya into a money economy based on a world market. Lands held in common by Mayan villages were confiscated by Ladino coffee growers, strengthening the latifundia/minifundia system. Ladinos also moved out into Mayan villages as representatives of the new republic. Ladinos controlled the political life of the village by occupying the jobs of mayor, secretary, schoolteacher and postmaster. They also recruited labor for the coffee growers and gained economic control by establishing new businesses in Mayan areas.

By the 1940's the Mayan village was being pulled more and more into the modern world. Government services were beginning to reach the countryside in the form of new roads. The government of Arevalo and Arbenz (1945 to 1954) brought schools, communications, cooperatives and electricity to a few limited areas in the highlands. Mayan men began to adopt Western dress and learn Spanish. Protestant Christianity found converts in the village and the cofradia organization lost authority as new political forms evolved.

In 1980's the Mayan population was caught in a violent struggle between the Guatemalan military and the armed left. This conflict, once again generated outside the community, pulled the Mayan population into a political dispute of capitalism vs. communism.

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For centuries, the Mayan culture has remained vital and adapted to extreme conditions. And, even though thousands of people have died in the recent violence and entire villages have been destroyed, Mayan people have gained some political voice in Guatemala. The new constitution makes bilingual education a human right and local communities now have control of funds for municipal improvement projects. Centuries of marginalization and exploitation can not be rectified overnight, but medium and long-term plans that address the situation can make important changes occur.

## 2. Target Population and Beneficiaries

### Target Population

Each component of this project has a specific target population. Overall the project is designed to provide MCH services to low income women of fertile age and their children under 5 years of age and to increase acceptability of family planning as a MCH intervention.

### Private Sector

APROFAM will provide MCH services through their clinics, CBD posts, rural physicians and cooperating PVO clinics for low income rural, urban and Mayan families. APROFAM will provide IE&C via mass media and specialized information for decision makers.

AGES will provide family life education through their urban centers, rural bilingual and scholarship programs. These programs are designed to reach parents, students, teachers and community leaders.

I PROFASA will provide contraceptives at low prices to both rural and urban couples through pharmacies and other commercial means, such as small stores and traveling vendors.

INCAP will study communication using patent medicine salespeople to find ways to deliver MCH health messages and products to the urban marginal population and the rural population.

### Public Sector

The MOH will offer family planning services within their framework of maternal health. MOH service delivery personnel will be trained in the concept of "reproductive risk"

to allow them to better ascertain their clients' needs of family planning. Orals, condoms and vaginal tablets will continue to be distributed through the large health post system, and intra-uterine devices will be made increasingly available throughout the health center system. A surgical contraception component will be developed to serve couples who are at high reproductive risk and wish to limit the number of their children.

### 3. Strategy for Mayan Speakers

As described above, the Mayan population is marginalized, extremely poor and traditionally has had both high fertility and mortality rates. The recent DHS survey has shown that virtually no progress has been made in reaching this population since 1978 with MCH and FP services. Evaluations of IE&C material and studies conducted with Mayan groups have found that family planning messages are not being understood and internalized by Mayan people.

Infant mortality rates are so high that Mayan couples feel compelled to have many children to insure that some will live into adulthood. Most Mayan families are not covered by any social security plan that will provide income for their old age and hence must rely on their children to provide for them when they become infirm. Lack of education for Mayan women compounds their situation by limiting their exposure to new ideas and technologies to improve their lives.

This project is designed to provide family life information, FP and MCH services to Mayan speakers that addresses their needs. The strategy for achieving this goal is discussed below.

#### APROFAM

APROFAM intends to establish a new unit in their IE&C department that will develop materials for Mayan speakers and for people with low literacy skills. These materials will be for both for mass media, especially radio, as well as to be used in clinics and CBD posts. Evaluations and studies carried out consistently show that FP and MCH messages are not reaching the target audiences, especially in the rural areas and this materials development strategy addresses this weakness.

APROFAM will strengthen their clinical and CBD service delivery to Mayan speakers in the departments by hiring bilingual staff in areas where Mayan populations are

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concentrated. Every APROFAM clinic serving this population will have a bilingual staff member who can provide FP information and counseling to all Mayan speaking contraception clients to insure informed consent and sensitivity to the needs of the client.

The training unit will continue to expand training activities carried out in Mayan languages and hire additional bilingual staff as necessary. Training schedules will be adapted to insure Mayan participation based on outcomes of current operations research in this area.

#### Ministry of Public Health

The MOH has not devised a separate strategy for Mayan speakers. Their overall strategy will be discussed below.

#### AGES

AGES, through their bilingual program, will continue to carry out field work in Mayan communities in order to develop curriculum for family life education and MCH that are linguistically and culturally appropriate and not mere translations of material developed for urban Ladinos. AGES will also conduct operations research to test options for MCH service delivery in Mayan communities.

The AGES female education program will be expanded to include two Mayan communities for each AGES Center. This component is designed to reach young Mayan girls, their families and their communities. This strategy is based on the assumption that by improving women's educational levels, significant improvement in health status can be attained. Studies have shown that the strongest correlation in reducing infant mortality is to increase maternal education. The recent DHS in Guatemala clearly shows that women who have had some formal education are twice as likely to use modern contraception than women with no formal education. This rate rises by almost 5 times, when women complete primary school. Both the young girls and their mothers will receive family life and MCH education. A retrospective evaluation at the end of this extension will establish what effects this strategy has had on the community, the school, the girls and their families.

#### I PROFASA

I PROFASA plans to reach the Mayan speakers and rural Ladinos by creating new package designs and evaluating their

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pricing for rural areas. A Mayan component will be designed when anthropological field work in four linguistic areas is completed.

#### 4. Strategy for Spanish Speakers (Ladinos)

This project is designed to provide FP and MCH services and information to Ladinos in both rural and urban areas. Each agency has a specific strategy that will be discussed below. Overall, the project extension will utilize mass media to generate demand for FP as a CS and MCH intervention.

##### APROFAM

APROFAM will use their clinics and CBD posts to provide FP and MCH services to Ladinos. Mass media will inform the public about services and educate about reproductive risk and MCH in general. Clinic services will be expanded to include pre- and postnatal care, well baby care (growth monitoring, immunizations and development) ORT and general maternal care (pap smears, diagnosis and treatment of vaginal infections). Clinic hours will be expanded to accommodate these new services.

Clinic sites are located in large departmental towns. Clinic personnel will coordinate with CBD personnel who have traditionally served marginal and rural population to provide back up care for CBD users. A limited program in Guatemala City's marginal areas will be established. MCH clinics will be staffed by an auxiliary nurse who will see CBD clients and provide limited services. It is expected that ORT and FP problems will be main services requested.

APROFAM will place 25 doctors in rural areas. These doctors will receive financial support in order to establish their offices and also receive training in FP and MCH. They will provide primary care in addition to FP and MCH. Limited supplies and equipment will be provided by APROFAM. This strategy is designed for both rural Mayan and Ladino families.

##### MOH

The MOH will continue to educate their personnel on the importance of FP as a maternal-child health intervention. The concept of reproductive risk will be incorporated into all training curriculum of the MOH-FP Unit, and training will be conducted of MOH personnel at the hospital, health center,

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health post and community levels. The school of nursing will receive educational material and human resource development in the area of reproductive risk.

Postpartum FP services will be opened in MOH hospitals to provide methods and information. The catchment areas of the hospitals are geographically large and will cover both Mayan and Ladino clients, even though the hospitals are generally located in the departmental capitals.

Training and equipment for IUD insertion will be provided for the MOH's health centers, providing an important alternative temporary FP method.

At the level of the community, reversible methods will be provided throughout the county at health centers and posts. Auxiliary nursing personnel will be trained to work with local midwives. The MOH will provide limited supplies to the midwife such as prenatal vitamins and mineral supplements and in return the midwives' clients will be accepted into the MOH system on a high-risk referral basis. This community level effort will include both Mayan and Ladina midwives.

#### AGES

AGES will provide family life and MCH education to Ladinos through their departmental centers. Person to person education will be carried out by trained volunteers from the community and group activities will be conducted by paid staff. Mass media will be used to inform the public about AGES and their services. Printed material development will be used to generate income and to complement educational activities.

#### I PROFASA

I PROFASA will provide mass media information on their contraceptive products. These products will be commercialized in pharmacies throughout Guatemala. The addition of new products will allow I PROFASA to expand into rural areas. Contacts with urban businesses and factories will be expanded to reach more low income urban Ladino couples.

#### 5. Strategy for Decision Makers

Three of the agencies working in this project have specific strategies for decision makers.

APROFAM works at the national level with government officials, business, religious and political leaders. APROFAM

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will continue to publish a monthly newsletter for these groups as well as provide information to decision makers through personal visits, use of mass media and presentations to groups of opinion makers. Through their image campaign, APROFAM will maintain a high profile for their new MCH services and emphasize the importance of FP as a MCH intervention.

The MOH will incorporate FP into CS and Maternal Health services. This strategy will reduce the vulnerability of a vertical program financed by AID. The reproductive risk management approach to the MOH strategy makes FP a medically acceptable intervention to improve health. This strategy is more appropriate and politically correct for the MOH personnel and the Christian Democrat government.

AGES works with decision makers at the community level through their scholarship committees and parents groups.

#### 6. Cultural Acceptability

Surveys carried out in Guatemala indicate that couples, both Ladino and Mayan, wish to either limit the number of their children or delay the birth of their next child. In the recent DHS this need was expressed more often by Mayan women than Ladina women even though FP use among Mayan women is very low.

It appears that strategies used in the past have not been successful in reaching the Mayan population nor the Ladina population with low school attainment. The new strategies described above are designed to be culturally sensitive, incorporate community level people, and provide appropriate and linguistically correct material, information and services.

Family planning services will be offered as an integrated part of MCH and no longer offered as isolated services. The concept of reproductive risk will be taught to insure that health providers see FP as the valuable health intervention that it is.

These changes in services, information, training and philosophy should enhance the cultural acceptability in Mayan populations, Ladino populations and among decision makers.

#### 7. Social Consequences

Various social consequences can occur if this project is successful. AGES will facilitate positive changes in the role of women in the rural communities where the scholarship

program operates. Age at first union will go up if girls remain in school longer and a delay in childbearing should also result. It is expected that the quality of life for these girls and their families should improve, this will be seen in higher rates of FP and scholarship recipients compared to a control group.

Use of FP and MCH services should increase among the Mayan speakers leading to overall lower fertility rates and possibly impacting on maternal and infant mortality rates over the long-term (10 years or more) if this initiative is maintained. Mayan speakers will become better informed about FP and MCH services and able to make decisions about family health, a positive move away from the fatalism that can arrest action.

The MOH strategy will make FP more accessible through the MOH and perhaps allow the MOH to gain credibility if these services are well delivered and if the alliance with local midwives allows for entrance into the system for high risk mothers.

Overall, if FP and MCH service rates increase, it can be expected that in the long run family health will improve, population growth at the national level will slow and a reduction in maternal mortality and infant mortality will occur.

Procurement Plan

ANNEX J

1. Summary Procurement Plan

	<u>CY</u> 1989	<u>CY</u> 1990	<u>CY</u> 1991	<u>CY</u>
APROFAM	Contraceptives T.A. vehicles	Contraceptives T.A.	Contraceptives T.A.	
MOH	Contraceptives (6) vehicles Equip Computers VSC and IUD T.A.	Contraceptives Equipment VSC and IUD T.A.	Contraceptives Equipment VSC and IUD T.A.	
AGES	Vehicles (1) T.A.	Vehicles (2) T.A.		
I PROFASA	<u>T.A. (new \$)</u> T.A.	Contraceptives T.A.	Contraceptives T.A.	Contraceptives
NEW ORGANIZATION	Medicines/Equip Contraceptives T.A.	Medicines/Equip Contraceptives	Medicines/Equip Contraceptives	

X  
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## 2. Procurement and Contracting Procedures

Contraceptive procurement for all the agencies will be done by USAID/Guatemala through USAID/Washington. AGES and APROFAM will follow standard handbook 13 (3) procurement procedures using funds from their OPG's. All procurements will be local, except for T.A.

USAID/Guatemala will provide procurement services for the MOH for their vehicles and T.A., VSC and IUD equipment will be procured for the MOH by AVSC through a central contract buy in. All other MOH procurement will be local.

I PROFASA's T.A. will be procured by USAID/Guatemala. All other procurement will be local. All off shore procurement for the New Organization will be handled by USAID through the LOP. Local procurement will be handled by the Organization.

3. Illustrative Scope of Work - PSC

SCOPE OF WORK  
PROJECT LIAISON OFFICER

I. GENERAL:

The incumbent is primarily responsible for serving as Mission liaison with the Importers of Pharmaceutical Products (IPROFASA), the Ministry of Health (MOH) Family Planning Unit and AIDS Commission, and the New Organization components of Project 520-0288, "Expansion of Family Planning Services". The incumbent will report directly to the Population Officer, Office of Human Resources Development (OHRD). He/she will coordinate closely with the PSC Liaison officer assigned to APROFAM and AGES. The duties of this position include, but are not limited to, the following:

A. Implementation/Monitoring Responsibilities:

1. Draft all implementation documents as directed for the various components of the project as assigned, e.g., PIO/T's, PIO/C's, PIL's, Grant Agreements, Amendments, and cables.
2. Examine all project vouchers for accuracy and pass to the Population Officer for approval.
3. Collaborate with implementing agencies in drafting new implementation plans and budgets and adjusting current plans and budgets according to any program modifications.
4. Draft semi-annual reports on progress against goals specified in relevant agreements or implementation plans.
5. Periodically visit program sites throughout the country to monitor the quality and impact of the program as a routine activity and on an emergency basis if the need arises.
6. Maintain contact with all intermediary organizations that are working with host country agencies (e.g. Pathfinder Fund, Development Associates, FPIA, JHPIEGO, CDC, AVSC) and facilitate processing of information flow. Coordinate field visits to Guatemala by intermediary organization personnel.

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7. Provide information and technical support to host country agencies, as necessary.
8. Maintain AID/W informed of major program issues and progress, as deemed necessary by the Population Officer.
9. Prepare other special reports related to Population as required by USAID (e.g. WID).
10. Participate in Project Implementation Meetings and Semi-Annual Reviews.

B. Evaluation and Other Special Studies/Surveys Responsibilities

1. Monitor the progress of ongoing and proposed studies, (i.e. PMS study and the AVSC PSR).
2. Review and make recommendations on the findings of all studies and evaluations. Incorporate these findings into ongoing programs or propose new programs to address the findings.
3. Design new studies, evaluations or surveys as deemed necessary by program performance, AID requirements, or proposals of cooperating agencies.

C. Design Responsibilities

1. Identify appropriate institutions and develop new population activities with these organizations, in accordance with the overall Mission and Project objectives.
2. Assist Mission and contractor personnel in carrying out analyses leading to design of new population activities.

D. Training/Orientation/Supervision Responsibilities

1. Orient, train and provide supervision of the new GDI staff person and other Mission Personnel as directed by the population Officer.
2. Provide intensive orientation to family planning contract staff in the area of Population.

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Logistical Support

The local USAID Mission will provide office space, office supplies, secretarial support and transportation for official in-country trips.

Suggested Qualifications for incumbent:

1. Preferably five years experience as USAID population assistant, monitoring a large national program.
2. Masters in demography, family planning administration; prefer MD with specialization in obstetrics and gynecology.
3. Experience in family planning logistics and supervisory systems.
4. Excellent Spanish (minimum FS-3 or equivalent) and interpersonal skills.

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L. Training Plan

The following offshore training needs have been identified:

- (1) The MOH plans to update the Nursing School faculties capacity to teach current MCH theory and practice, by sending one staff member for long-term training (Masters level) and six staff members for short-term training. \$60,000 is budgeted for the long-term training in CY90-91, and \$40,000 for short-term training in CY90-91.
- (2) AGES and APROFAM will continue to participate in international seminars, workshops and conferences. A family planning management course will be attended by two APROFAM staff members for seven weeks at a total cost of \$14,000. Funds from the agencies' operational program grants will be used to cover the cost and develop an illustrative travel and training plan annually. Training needs for APROFAM's regional personnel will be assessed following job description development and selection of new personnel.
- (3) Under the new organizational initiative, offshore training is contemplated as a possible activity. This will require the development of guidelines and procedures to assess the need for the proposed training and the expected outputs.

M. Illustrative Child Survival Breakout - APROFAM

PRESUPUESTO TOTAL DE ACTIVIDADES DE AID 1989-1991 (QUETZALES)

		1,989	1,990	1,991	TOTAL
-----					
ACTIVIDAD					
I.	D.C.A.	2,638,041	2,334,659	2,851,650	7,824,350
II.	CLINICAS	1,953,390	2,476,536	2,149,608	6,579,534
III	I.E.C.	2,355,951	2,469,362	2,886,609	7,711,922
IV.	ADiestRAMIENTO	551,592	410,638	444,033	1,406,263
V.	ED. A LIDERES	168,616	193,908	222,994	585,518
VI.	EVALUACION	238,833	316,197	278,396	833,426
VII	ENF. DE TRANS. SEXUAL	55,021	205,869	279,132	540,022
VIII	ADMINISTRACION	0	0	0	0
IX.	COMPUTACION	145,493	96,976	137,256	379,725
X.	DIST. EJERCITO	63,129	68,707	79,014	210,850
XI.	PROYECTO INDIGENA	0	0	0	0
XII	CLIN. PERIFERICAS	0	0	0	0
XIII	COMPRA LOCALES DPTALES	0	0	0	0
XIV	MEDICOS COMUNITARIOS	69,936	80,426	46,245	196,607
XV.	C R E A	85,164	609,999	696,211	1,391,374
	SUMINISTROS	200,448	225,558	266,107	692,113
					0
					0
-----					
T O T A L		8,525,615	9,488,835	10,337,255	28,351,705
=====					

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FAMILY PLANNING BUDGET

FP	ACTIVIDAD	1,989	1,990	1,991	TOTAL
I.	D.C.A.	1,418,990	1,283,846	1,560,947	4,263,782
II.	CLINICAS	1,307,580	1,640,842	1,074,804	4,023,225
III.	I.E.C.	1,906,720	2,108,410	2,371,889	6,387,019
IV.	ADIESTRAMIENTO	331,153	268,979	295,226	895,358
V.	ED. A LIDERES	168,616	193,908	222,994	585,518
VI.	EVALUACION	238,833	316,197	278,396	833,426
VII.	ENF. DE TRANS. SEXUAL	55,021	205,869	279,132	540,022
VIII.	ADMINISTRACION				0
IX.	COMPUTACION	145,493	96,976	137,256	379,725
X.	DIST. EJERCITO	63,129	68,707	79,014	210,850
XI.	PROYECTO INDIGENA				0
XII.	CLIN. PERIFERICAS				0
XIII.	COMPRA LOCALES DPTALES.				0
XIV.	MEDICOS COMUNITARIOS	69,936	80,426	46,245	196,607
XV.	C R E A	85,164	609,999	696,211	1,391,374
	SUMINISTROS	200,448	225,558	266,107	692,113
					0
					0
T O T A L		5,991,083	7,099,717	7,308,221	20,399,020

CHILD SURVIVAL BUDGET

		1,989	1,990	1,991	TOTAL
FP	ACTIVIDAD				
I.	D.C.A.	1,219,051	1,050,813	1,290,704	3,560,568
II.	CLINICAS	645,810	835,695	1,074,804	2,556,309
III.	I.E.C.	449,231	360,952	514,719	1,324,903
IV.	ADIESTRAMIENTO	220,439	141,658	148,807	510,905
V.	ED. A LIDERES	0	0	0	0
VI.	EVALUACION	0	0	0	0
VII.	ENF. DE TRANS. SEXUAL	0	0	0	0
VIII.	ADMINISTRACION	0	0	0	0
IX.	COMPUTACION	0	0	0	0
X.	DIST. EJERCITO	0	0	0	0
XI.	PROYECTO INDIGENA	0	0	0	0
XII.	CLIN. PERIFERICAS	0	0	0	0
XIII.	COMPRA LOCALES OPTICAS	0	0	0	0
XIV.	MEDICOS COMUNITARIOS	0	0	0	0
XV.	C R E A	0	0	0	0
	SUMINISTROS	0	0	0	0
T O T A L		2,534,532	2,389,118	3,029,034	7,952,684

N. Illustrative Budget for Project Evaluation

	89	90	91	Total Person Months	Total Cost at \$20,000/month
APROFAM					
-Quality Assurance Evaluation	1	1	1	3	60,000
-Communication Strategy	1			1	20,000
MOH					
-Management System Review			1	1	20,000

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**Annex M**

**Annual Agency Budget Format**

The standard format will include the following 6 elements: (a) budget line items for the year, (b) total LOP approved budget for each line item, (c) total previous year commitments by line item, (d) available LOP budget as of the beginning of the year, (e) projected budgetary requirements required for the current year, and (f) funds available (pipeline) at the beginning of the year.

An illustrative budget is shown below in the expected format for the MOH in year 1990; this budget is provided as an example only, and is not intended to be used in the amounts presented below.

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<b>AGES</b>					
-Communication Strategy Assessment	1	1		2	40,000
<b>I PROFASA</b>					
-Management Evaluation			1	1	20,000
<b>NEW INITIATIVES</b>					
-Program Evaluation			1	1	20,000
<b>OVERALL</b>					
-Project Evaluation			3	3	60,000
-Mini-Surveys	1	1	1	3	60,000
<b>TOTAL PERSON-MONTHS</b>	<b>4</b>	<b>3</b>	<b>8</b>	<b>15</b>	<b>300,000</b>

**G R A N D T O T A L**

	89	90	91	TOTAL
<b>Cost Per Year</b>	<b>80,000</b>	<b>60,000</b>	<b>160,000</b>	<b>300,000</b>

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TABLE IX.1  
Illustrative Yearly Budget: 1990  
MOH (rounded to nearest \$000's)

Line Item	Total Budget	Previous Year Commitments	Available Budget	Projected Requirement Current Year	Projected Available Year End
Distribution & Logistics	290	95	195	90	105
Training	307	78	229	118	111
Forms	10	8	2	1	1
Administ.	473	156	317	156	161
Spec. Programs	236	80	156	76	80
Vehicles	120	120	0	0	0
TBA Kits	180	60	120	60	60
AVSC Agreement	375	100	275	125	150
Nursing School	185	45	140	70	70
Technical Assist.	111	76	36	36	0
Evaluations	<u>20</u>	<u>0</u>	<u>20</u>	<u>0</u>	<u>20</u>
Sub-Total	2,307	818	1,489	732	757
Contingencies	115	41	74		74
Inflation	<u>230</u>	<u>82</u>	<u>149</u>		<u>149</u>
TOTAL	2,652	941	1,711	732	980

5967s

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