



AN ASSESSMENT OF AID'S
BILATERAL POPULATION PROGRAM
IN GUATEMALA
1977-1979

AMERICAN PUBLIC HEALTH ASSOCIATION
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PREFACE

The authors would like to gratefully acknowledge the contribution of the many people who shared their time and insights with the evaluation team. In particular, a debt is owed to Dr. Roberto Santiso and the staff of APROFAM for their cooperation, patience and enthusiasm. The support of Scott Edmonds, Neil Woodruff and Marilda de Cruz of USAID/Guatemala is most appreciated.

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EXECUTIVE SUMMARY

Under the 1977-79 AID Bilateral Program, the government of Guatemala directed APROFAM, the IPPF affiliated private family planning organization, to implement a major portion of the national population program. APROFAM was asked to carry out a national mass media campaign, establish community-based distribution of contraceptives, and provide logistic support to government health facilities. This evaluation team found that the major objectives of the AID Bilateral Program were successfully met: By 1979, the Contraceptive Logistic Program was supplying contraceptives on a regular basis to 580 government clinics (90 percent of existing facilities). An intensive nationwide media campaign had been successfully implemented which included a well-done pre- and post-test of family planning knowledge, attitudes, and practice to evaluate the campaign. In addition, a metropolitan community-based (CBD) program was well on its way to achieving its ambitious three-year goal of 25,000 active users. Several rural CBD programs, after a period of start-up problems, had taken hold and a rural CBD infrastructure was in place. Nevertheless, efforts to reach the rural indigenous population using these approaches had been slow because of significant differences between this group and "mainstream" Guatemala. In response to this problem, programs designed specifically for indigenous groups are being developed.

In addition to its AID bilaterally-funded activities, APROFAM also successfully carried out a number of other projects which were funded by AID through various private agencies during the 1977-79 period. For example, the team was positively impressed with APROFAM's clinical services, their extensive education program and their recent training efforts. It is suggested that taken together the bilateral and intermediary programs carried out by APROFAM had significantly helped to increase contraceptive usage in Guatemala during the past three years. And, indeed, according to a recent prevalence survey done by the Center for Disease Control, contraceptive usage has increased rapidly during this period.

The evaluators were favorably impressed with APROFAM's overall management system and organizational capacity. APROFAM staff is dedicated and capable. APROFAM has been able to solve management problems which resulted from rapid expansion during the past few years.

The team's arrival coincided with the Minister of Health ordering all government clinics and hospitals to cease family planning activities. Although this did not hinder severely evaluation of performance under this AID bilateral contract, it gave urgency to development and assessment of recommendations for future AID support.

Given the current political environment and the demonstrated organizational capacity of family planning agencies in Guatemala, the team recommends that the Mission expand APROFAM's program through both the public and private sector to increase national coverage from 11 percent to 30 percent of currently married women by 1984. APROFAM should expand in the following ways: (a) increase urban CBD to 36,000 active users, (b) double rural CBD coverage to 160,000 active users, (c) capacitate some 500 Indian distributors, (d) double the percentage of sterilized

women in the 15-44 age group, (e) expand the capacity of the recently established training unit to meet the needs of a rapidly expanding program, and (f) augment information and education efforts to support enlarged CBD and sterilization activities. In order to achieve these goals more effectively, APROFAM should decentralize or "regionalize" its administration to facilitate management of its expanded program.

APROFAM should continue its role of advocacy by encouraging both government and private agencies to study all aspects of the population "problem" in Guatemala. Cooperation and support must be strategically sought from universities, research centers, newspapers, labor unions, industry, commerce, agricultural cooperatives, women's groups, and political parties, to name a few. Involving these groups in population activities will help to build popular support, a necessary ingredient for any national population program.

I. INTRODUCTION

At the request of Scott Edwards, the USAID Population Officer in Guatemala, the American Public Health Association arranged for four consultants to evaluate AID's 1977-1979 Bilateral Population/Family Planning activities in Guatemala and to make recommendations regarding future activities. Working in Guatemala for three weeks (June 10-28, 1979) under the guidance of the USAID Population Officer, the consultant team reviewed available data and documents, interviewed key persons, made site visits and prepared this report. Before setting out for Guatemala the team met for one day in Washington, D.C. for orientation by the staff of the Latin American/Caribbean Bureau and the Office of Population. A one-day debriefing for the same Washington staff was held after the field work was completed.

The evaluation team focused on monitoring several family planning (FP) service delivery programs, assessing their relative output; and analyzing their cost effectiveness. Furthermore, an assessment was made of the overall organizational capacity of APROFAM, the Guatemala private family planning agency which is the primary executing agency of this AID Bilateral Program.

The evaluation team was unable to interview the staff of the Ministry of Health because on June 8, 1979, a few days before this consultancy began, the Ministry of Health stopped family planning activities in all government hospitals and clinics. Although this action only minimally hampered the assessment of APROFAM's past performance, it was indeed difficult to judge the feasibility of future activities with the Ministry of Health, or other ministries. In summary, the present central government's lack of commitment to family planning made the team's work more complex and difficult. This was especially true with regard to analyzing the relationships among various ministries, international family planning agencies, local voluntary organizations and cooperatives, and APROFAM in order to suggest ways to strengthen these relationships so as to increase coverage and acceptance of family planning.

II. HISTORY OF FAMILY PLANNING IN GUATEMALA: BACKGROUND TO AID BILATERAL INVOLVEMENT 1977-1979

The Asociacion Pro-Bienestar de la Familia (APROFAM) has been a leader in the promotion and delivery of family planning services since 1965. The organization, an affiliate of the International Planned Parenthood Federation, opened its first family planning clinic in Guatemala City in January, 1965. During its first year of operation, the clinic served 1,661 users. During the last 14 years, APROFAM has steadily expanded its efforts to provide family planning to the citizens of Guatemala.

The first years of the program were devoted to assessing the feasibility of family planning services in Guatemala and establishing delivery systems in the capital. By 1967, APROFAM had had sufficient experience to expand services to other areas of the country. In fiscal year 1968, the Government of Guatemala (GOG), the Agency for International Development (AID) and APROFAM entered into a funding agreement whereby APROFAM would assume the responsibility for providing family planning services to rural Ministry of Health (MOH) clinics.

In 1969, the Ministry of Health created a Division of Maternal, Infant, and Family Health (DMIF) with a Department of Child Protection and Family Orientation responsible for national family planning programs. APROFAM and the Ministry developed a subsequent agreement whereby APROFAM would continue to administer the capital's clinics and the MOH would assume responsibility for the provision of family planning in its rural health centers. In addition, the MOH, with financial assistance from AID, hired auxiliary nurses for rural health posts who received APROFAM training in family planning. A Joint Office of Information was established in order to avoid duplication of education and training efforts.

MOH assumption of responsibility for family planning services in rural areas did not prove to be successful. The rural clinics previously supported by APROFAM returned to a lower level of family planning acceptors. The specially trained auxiliaries were absorbed into the general health system and spent little time on family planning. By 1975, only 126 of 522 rural clinics were offering any organized family planning services; only 3,000 users were reported. In FY 1975, USAID reduced its support to the GOG by 40 percent and, with MOH agreement terminated its support in FY 1976.

In FY 1976, with AID financial support, APROFAM assumed total responsibility for the Information and Education Program at the national level. By August 1976, APROFAM had developed relationships with five national and 25 Department radio stations, 16 newspapers, and three TV stations. A collaborative program was developed with the Ministry of Defense to educate and train army personnel in family planning.

In 1976, APROFAM also received AID support for distributing contraceptive supplies to MOH rural health clinics. By the end of FY 1976, the number of centers

with family planning supplies had increased to 275, more than double the number achieved by the MOH after seven years of effort.

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Additionally, APROFAM, with AID support, began to experiment with cost-effective community-based distribution programs, in both urban and rural areas. Local community leaders received family planning training to provide contraceptives directly to the users with a minimal amount of clinical backup.

The 1977-1979 AID Bilateral Program was developed not only to intensify the capacity of APROFAM to deliver family planning information and services, but also to demonstrate the feasibility and acceptability of family planning to top-level policymakers in Guatemala. Significant utilization of APROFAM services in the three-year period would not only demonstrate the grassroots acceptability of family planning to policymakers but would also serve the immediate service needs of many thousands of Guatemalans. The success of APROFAM's program between January 1977 and June 1979 is reviewed in detail in the following section.

III. IMPLEMENTATION OF THE 1977-1979 BILATERAL POPULATION PROGRAM

A. Contraceptive Logistics Program

The Direct Distribution Program, DDP, (referred to as Contraceptive Logistics Program in the PP) was designed to "assure the constant availability of contraceptives in MOH clinics". In June 1976, family planning services were offered in 126 of 552 MOH rural health centers and health posts.

As of December 1978 four APROFAM detail men were supplying contraceptives on a regular basis to 580 MOH clinics (90 percent of existing facilities and nearly 100 percent of those willing to offer FP services). In FY 1978 the DDP served approximately 40,000 user years at a delivery cost of \$1.04 per user year.

DDP accounted for 38 percent of the new users and 19 percent of total user years, generated by the total APROFAM/MOH program in 1978. The program utilized only 12 percent of APROFAM's financial resources.

DDP's success was not without problems: (1) Department-level MOH directors had to be convinced on an individual basis, (2) medical students doing required rural internships were (and still are) opposed to family planning and (3) logistic and reporting obstacles had to be overcome (Montieth Trip reports 2/77 and 10/77).

The greatest barrier to this program has just occurred. Monday, June 12, 1978, (the evaluation team's arrival date) the Minister of Health sent a telegram to MOH facilities stopping all family planning activities. The Minister has named a commission to study MOH's involvement in family planning. APROFAM will not be permitted to resupply MOH clinics until the Commission submits its report. In the meantime, our evidence suggests that only a three-month supply of contraceptives exists at MOH clinics. An alternative means of serving those in need should be found.

DDP has, however, demonstrated the feasibility of establishing a low-cost distribution system for the rural poor through the MOH with logistic and training support from APROFAM. If the political situation permits continuation of DDP, several issues require careful consideration.

1. Enrollment of MOH staff into APROFAM training programs.
2. Programming of sufficient time for detail men to "motivate" MOH clinical staff.
3. A cost/benefit analysis of continued logistic support services to clinics/outposts with marginal utilization of FP service.
4. Tightening inventory control and reporting system between outposts, APROFAM, AID.

5. Increasing MOH share of sales revenue (as additional incentive factor).
6. Improving working conditions for APROFAM detail men.

B. Community-Based Distribution (CBD)

The bilateral program included provision for only two CBD projects, one in Guatemala City and another in rural areas with a local campesino league. During 1977 and 1978, AID intermediaries also began a series of pilot CBD projects which when deemed successful, were absorbed into the bilateral program. A brief evaluation of all CBD projects receiving some bilateral support during the period is presented below along with recommendations for the future.

1. Metropolitan Guatemala

APROFAM, with financial assistance from IPPF, initiated a pilot CBD project in Guatemala City in October 1975. During 1976, 40 newly trained distributors enrolled 5,406 new acceptors. In 1977, plans were made for USAID/G to support the expansion of this very cost-effective program over the next three years. Since 1977, growth has been steady with respect to number of distributors, geographical coverage (zones), number of new acceptors and number of active users (Table 1). APROFAM will come close to achieving its ambitious three-year goal of 25,000 active users.

A highly motivated staff, under the very competent supervision of Sra. Sara de Molina, has successfully penetrated the poorer areas of Guatemala City, despite opposition from parish priests, government doctors and private physicians, including those employed by APROFAM. Logistics and record keeping are in place. Referrals when necessary, are made to 30 cooperating physicians for problem cases, pap smears, IUDs and sterilization.

The major need identified for this rapidly expanding program is more comprehensive training of the distributors and promoters. APROFAM's training unit is conducting refresher courses for distributors and a more comprehensive curriculum is being developed to train new distributors. Regular training efforts should be used to improve the distributors' network and to address operational problems. For example, it could be pointed out to the distributors during training sessions that the average distributor captures only about 1.5 new acceptors per week and makes very few referrals to available sterilization services. Needless to say, the promoters will also need to work on these problems during regular supervisory visits. At this time, the metropolitan CBD program is under serious attack by the Ministry of Health which believes that contraceptives should only be distributed under strict medical supervision. One of the roles of the newly established MOH commission is to investigate the adequacy of APROFAM's medical backup. It is hoped that this commission will draw conclusions which would support the program.

TABLE 1

RESULTS OF URBAN CBD PROJECT, 1976-1979

<u>Year</u>	<u>ZONES</u>	<u>DISTRIBUTORS</u>	<u>PROMOTORS</u>	<u>NEW ACCEPTORS</u>	<u>ACTIVE USERS</u>
1976	2	40	2	5,406	4,306
1977	4	75	4	6,008	9,500
1978	6	105	5	8,339	12,274
Mid 1979	15	24	12	na	na

2. Campesino League (Ligas Campesinas) CBD Project

This pilot education project began in May 1976. After a series of lengthy discussions, the National Campesino League Federation and their local leagues accepted the idea of a CBD project. Seminars, lectures and conferences were held during the remainder of 1976. In all 90 conferences were held with 4,500 persons in attendance. By the end of 1976, FP information and contraceptives were being distributed through some 10 community distribution posts in Jutiapa.

Plans were made for AID/G to finance with bilateral funds the expansion of this project into seven departments. Unfortunately, problems between AFRCFAM's Information and CBD Units slowed implementation. The Information Unit placed excessive emphasis on information activities and distribution posts were slow in opening. (As of May 1977, only 16 of the 73 targeted distribution posts had opened in Jutiapa and only 14 of the 25 targeted had begun in Escuintla). This relatively poor performance continued through 1977. Funds for expansion were withdrawn and a less expensive, more concentrated effort initiated in 1978 under the supervision of the CBD unit.

During 1978, three promoters and 75 distributors working in two departments (Jutiapa and Escuintla) successfully enrolled 1,491 new acceptors, thereby surpassing the goal of 1,400. The monthly results for January through May 1979, suggest the 1979 goal of 2,000 new acceptors will also be met.

Overall, the number of new acceptors per distributor per week was low, less than one in 1978 (1,491/75/52). Although the target population is quite disperse in these rural areas, this performance can be improved since some of the more active distributors are now enrolling one to three new acceptors per week. The current retraining effort may be helpful in this regard. Furthermore, attention should be given to high drop-out rates. In some three-month periods drop-outs exceed new acceptors.

3. Other Bilateral Community-Based Projects

Although not included in the original project paper, several rural community-based projects received bilateral funds between 1977 and 1979. Most of these

began as pilot projects with the financial assistance from AID intermediaries such as Columbia University and FPIA. The results of these projects are reviewed briefly below.

a. Person-to-Person (Suchitepequez)

In 1976, the University of Chicago recommended that APROFAM develop an experimental program using community and clinic workers to complement an intensive mass media campaign. In 1977, a pilot person-to-person project was begun in Suchitepequez under the supervision of the IE&C department.

Experience during the first year proved the basic fallacy of the original premise. It was evident by the end of the year that most new acceptors were primarily the result of the efforts of the community workers and that it was the media campaign that had played the supporting role. In 1978 the program was expanded to two more departments with an emphasis on community organization supported by media. Goals for the program were 90 active distributors and the development of educational materials specific to the local region.

The program encountered numerous obstacles which hindered its implementation. In three departments, lack of available family planning services destroyed the program. In Huehuetenango, the MOH area health chief refused to support the project and it was never started. In Totonicapan, the program had begun to be developed when it was cancelled by the Ministry of Health. In Quetzaltenango the program was slowly being implemented but ran into serious opposition from local MOH physicians and medical students.

The project was implemented in Suchitepequez. Between June 1, 1977 and December 1978, three promoters and their distributors enrolled 1,917 users, 51.6 percent of the goal. In 1979, the Suchitepequez project was absorbed by the overall CBS program. With AID bilateral funds, it continues successfully with three promoters and 26 distributors.

b. Community-Based Distribution with
Agricultural Cooperatives (FECCAR)

In July 1977, a series of motivational seminars for cooperative directors, extension workers, promoters and potential distributors were held to launch the project. Training was provided to each group. At the end of one year (June 1978), 160 distribution posts were established (60 more than targeted), yet the project had inscribed only 800 new acceptors or one-quarter of the goal of 3,000 acceptor target. Distribution of contraceptives had been hampered by religious opposition, supply problems, organizational difficulties and the resistance to family planning among the Indian population. In addition, in one department, a newly-appointed MOH area health chief rejected the project in spite of previous support by his predecessor (Isaacs, 1978).

By April of 1979, significant improvements had occurred: a reported 183 distribution posts were operating in six departments under the direction of seven

promoters. Three thousand one hundred eight users entered the program between December 1977 and April 1979 (Cabrera, et al., 1979). A comprehensive evaluation was carried by APROFAM and Columbia University indicating some important steps to be taken to further improve the program.

c. Cotton-growers Association CBD Project

This project was initially planned to serve migrant workers during the harvest period when they would be concentrated in a few fincas and, therefore, "easier" to reach with family planning information and supplies. In fact, the migrant workers did not accept contraceptives, even when they were offered free. Apparently due to the extremely poor living conditions, the migrants receptivity to family planning was low. An abbreviated program will continue to provide information and services to the permanent population (colonos), and this project will be integrated into the larger CBD program.

d. Training for CBD Distributors

Education for distributors is being implemented by a recently formed training unit. In the first half of 1979, 13 courses for distributors, two for promoters, and one for program heads have been held. The principal objectives of the distributor course are to analyze both the positive and negative aspects of being a distributor, to develop a feeling of identification with APROFAM, to increase distributor knowledge and understanding of contraceptive delivery, and to train distributors to complete the statistical reports required by the program. A pre-test post-test of the distributors knowledge is used to evaluate the program. The final evaluation concentrates heavily on proper use of the pill (7 out of 11 questions) to assure distributors' understanding of contraindications.

The first day of a training course for FECOAR distributors was observed in Jutiapa. Twenty-one distributors, who had been working from 3 to 10 months, were present, as well as their two promoters. Prior to this course, distributors had received only individual instruction from the promoters. The course was taught by three instructors from the training unit who appeared to be well trained and comfortable with the material they were presenting. The course lasted for four days. A mixture of didactic sessions, small group exercises, and case studies were used. Subjects covered included the nature of APROFAM programs, the importance of family planning, contraceptive methodology, rumors about contraceptives, and the contraindications and effectiveness of various methods. This curriculum is standard for these courses.

Certain concerns may be raised. Less than half of the distributors in the area attended the course. It is recommended that the promoters actively encourage their distributors to attend all courses. This may mean arranging transportation, and eliminating other barriers to attendance. Courses should optimally be offered before a distributor begins working in the community. The course should set aside time for active distributors to share their experiences, questions, and concerns.

The course needs to add a section on the role of the distributor in the community. Because the promoters only visit each locale monthly, the distributor needs to be encouraged to do outreach in the community. At minimum, techniques for announcing the service to the community should be addressed. However, it seems feasible to train the distributors to give group talks on family planning to their neighbors.

e. Summary

Community-based distribution has been a new activity for APROFAM, especially in the rural areas. Initial progress may have been slow because APROFAM began too many small CBD projects, funded by a variety of donors, each with their own interests and biases. A larger single effort may have been more successful. Steps are now being taken to integrate many projects into a unified program which will maximize past experiences. The following are the major difficulties identified:

1. Lack of uniform criteria for selecting distributors and distributor posts.
2. Limited training of new distributors and in-service training for old distributors.
3. Need for systematic spot checking and verification of number of acceptors.
4. Specification of operational targets at the local level.
5. Low motivation of distributor.
6. Inadequate project planning.
7. Low penetration into Indian areas.
8. The need to develop regional specific educational materials.

Although the project paper did not envision a comprehensive rural CBD project, APROFAM has made significant progress towards the establishment of a rural system despite problems. The 1977-79 bilateral funds in the CBD area have been well invested. Conversely, intermediary funds have been used as high risk investments which will pay off only if a comprehensive rural CBD program can be implemented over the next three to five years. APROFAM should be capable of synthesizing the lessons learned from the experimental projects into a dynamic, far-reaching CBD program.

C. Information, Education, Communication

1. Mass Media

a. Description 1977-79

A major goal of the 1977-1978 bilateral program was the provision of family planning information to the entire Guatemalan population. Information and communication programs were budgeted to receive \$430,000 during the 1977-79 project period.

The APROFAM information program is one of the few scientifically designed family planning mass media programs in Latin America. The key elements of the program included baseline research, field testing, monitoring, and evaluation. In 1976, the University of Chicago conducted a comprehensive research study of the need for family planning information in Guatemala. That study provided baseline data on the knowledge and attitudes of both Ladinos and Indians and identified barriers to the acceptance of family planning services. Based on this research, APROFAM carried out a national family planning communication program targeted to both the Ladino and Indian rural communities. Radio spots, pamphlets, posters, newspaper articles and television spots were designed, field tested and distributed.

The thoroughness of the development of the information campaign is applauded. Key components of an ideal information strategy were utilized. Planning and programming were supported by the participation of Dr. Jane Bertrand, of the University of Chicago.

Approximately 63 radio spots were designed. After field testing, 40 spots have been aired. Eighteen announcements were designed in accordance with the research findings to reach the Indian region and translated into Quiche and Kekchi. After being field tested, 10 were selected for airplay. Creative support for their development relied heavily on the outside assistance of Dr. Bertrand.

By the end of 1978, the goal of nationwide radio coverage was complete. Six urban stations and 37 rural stations were playing the spots a minimum of three times daily. Messages were developed directed at the general public, men, women, and married couples. The tagline referred listeners to the closest health clinic for more information and services. Over 60,000 spots were broadcast in 1978 at a cost of approximately \$70,000. The majority of the radio stations play a certain number of free spots daily.

Pamphlets and posters were also developed as part of the information campaign. Eight posters were designed during 1977-79, three specifically targeted at Indian families. Nine pamphlets have been produced during this period, including a basic 12-page "Usted puede planificar su familia". The posters are attractive and professional. The pamphlets are clearly and simply written, although for the most part lack style and a convincing motivational message.

It is important to note that many of the older pamphlets are more cleverly designed and interesting to readers. Observers have noted that pretesting materials may mean that they become understandable to all and interesting to none. (Annis and Hurtado, 1979).

In 1978, 190,000 pamphlets were distributed. Direct distribution detail men have reportedly distributed pamphlets and posters to all MOH clinics. Pamphlets are also said to be distributed at APROFAM clinics, CBD posts and education courses. However, none of the CBD points visited by the evaluation team had a supply of pamphlets.

The 1978 Ag called for the development of television spots centered on urban problems and adolescent fertility. Advertisements were developed; however, the adolescent spot was never aired because the pretest proved it to be too controversial. Two spots were played for four months. The TV spots were found to have little yield for the high expense, and were dropped.

Other Pro Ag activities also did not turn out as envisioned. (The radio campaign was to be integrated with the CBD program). Radio spots were to be changed to allow for local participation directing listeners to services in the community. This proved to be unfeasible due to the perceived controversial nature of the CBD program, and ads continued to direct people to the closest MOH clinic. Because of the recent Ministry of Health directive, the tagline now directs people to the local family planning clinic. Optimally to be truly effective spots should direct people to the MOH clinic, pharmacy, or "APROFAM sign in your community".

b. Evaluation

The principal evaluation of the mass media program was conducted by the University of Chicago and APROFAM in 1978. The very study was a partial replication of the 1976 study to "determine whether the expected changes had indeed taken place in these Ladino and indigenous communities during the intervening two-year period". (Bertrand and Pineda, 1978). The evaluation indicated that the program had been very successful in the rural Ladino areas, and had had little demonstrative impact in the Quiche and Kekchi regions. Almost 70 percent of those interviewed had heard a family planning message on the radio; 95 percent of those said that they heard a spot daily. Twenty-five percent of the Ladinos recalled seeing a poster and 17-18 percent had seen a pamphlet. Less than 4 percent of the Indians recalled seeing a poster and none mentioned a pamphlet.

General knowledge of family planning had increased in all groups but the Quiche. Over 92 percent of the rural Ladinos had heard of family planning and on the average could mention between 6 to 7 methods, compared to just over three known in 1976. Conversely, information on specific methods had decreased in both the Indian populations studied.

Both the Ladino and Indian populations experienced favorable changes in attitudes towards family planning. Seventy-five percent of the Ladinos,

38 percent of the Quiche and 23.8 percent of the Kekchi indicated approval of family planning. The overall Indian resistance to family planning dropped from 75 percent to 53 percent. Principal reasons for Ladino opposition are religious beliefs and concerns about women's health. Among the Indian groups, religion is the major cause for opposition, although 16.7 percent of the Quiche indicated that it was because they did not know about the program or methods. (However, with 10 cases in this cell, one hesitates to generalize from this information).

Most important, the evaluation study indicated that the communication campaign had led to an increase in contraceptive use in the Ladino area. The increase in Ladino's knowledge and favorable attitudes had translated into a significant increase in the use of reliable methods. No such increase was noted in either Indian population despite an increase in general knowledge and a reduction in the proportion who disapproved of family planning.

This study clearly indicates that the mass media communication strategies played an important role in increasing the number of family planning users among the Ladino population. Further, posters were a useful tool for promoting family planning. It seems reasonable to conclude that the nationwide campaign was in some part responsible for the growth in family planning users in Guatemala during the project period.

Based on the success of this program, it is recommended that a national information program be continued in the coming years. Although one might argue that the required change in attitudes has already occurred among the rural Ladino population, the still low levels of contraceptive usage indicate the need for continued use of media to support the service delivery program. Messages should be developed that will (a) continue to legitimize the use of family planning, (e.g., "family planning is deciding when and how many children to have. It's your right to decide. It's your choice"), (b) address the perceived risks to a woman's health especially the ubiquitous belief that the pill causes cancer, and (c) if politically possible, identify local sources of contraceptives. Further, campaigns directed at males in order to increase sterilization and condom use and at young people to reduce adolescent fertility should be considered.

In the capital area, a large scale radio campaign seems unnecessary at this time. Given current political realities, APROFAM should consider using the media to strengthen support for its programs. This would essentially mean developing two types of spots. The first would be aimed at improving the image of APROFAM as a non-profit organization dedicated to helping the people of Guatemala have happy, healthy and wanted families through the provision of information and voluntary family planning services. A pamphlet underscoring these messages would be useful for distributing to the PVO's, community organizations, press and other groups with which APROFAM works. The second radio spot should be directed at legitimizing family planning as a way of improving maternal and child health and individual family circumstances. These spots might be more effective without an APROFAM designation.

The information should place an increased emphasis on the development of educational materials. Specifically, educational materials such as posters, flip-charts, and diagrams should be developed for use by CBD distributors and promoters. Simple pamphlets, with an emphasis on motivational messages for use and continuation, should be developed. Distribution of these pamphlets should include rural clinics, pharmacies, and, if found useful, CBD points. Simple posters, relying on few words, but aimed at specific concepts should be developed. For example, a poster on pill use or on sterilization would be useful at both clinics and CBD points.

Other possibilities should be considered. These include the development of a guide to family planning for pharmacists and one for auxiliary health professionals. Further, the possibility of a shorter, simpler guide for distributors than the one currently in use should be considered. Lastly, if pamphlets are deemed inappropriate for widespread use in rural areas, some type of simple three or four point instructions should be included with all contraceptives. As much as possible, these instructions should be integrated within the program packaging.

c. Indian

As described above, APROFAM attempted to reach the Indian population with specifically designed radio messages and posters. The 1978 University of Chicago-APROFAM study clearly indicated that these efforts had been unsuccessful in motivating Indians to use family planning programs. In addition, AID supported an anthropological study in the highlands of Guatemala (ANNIS, 1978) and the development of a how-to guide for family planning workers in Indian communities.

With the support of AID, APROFAM began a demonstration project in two distinct Indian areas in 1979. Four bilingual Indians were hired by APROFAM to work in male-female pairs in two villages. They received an intensive, one-month training course in health and family planning. At this time, they have been in the field for approximately one month. The initial objectives of the program were to promote family planning through talks with community leaders and residents, and recruit and supervise local contraceptive distributors. In July, the four promoters will return to the city to assist with the development of educational materials for the Indian population. This project will be evaluated at the end of one year, and then possibly replicated in other villages. First year AID support for this project is \$20,759.00.

Pathfinder is also participating in this project. They have granted APROFAM \$15,000 to develop educational materials for the Indian population. A conference concerning educational materials for the indigenous areas was held in February 1979. Key recommendations of the conference included the development of materials for (a) health paraprofessionals working in the Indian area, (b) village-level health promoters, and (c) the individual family. It was stressed that the materials developed needed to incorporate Indian concepts and value systems. Indians must be directly involved with the preparation and distribution of the material. The need for an intensive information and education campaign

with the Indian population is obvious. The development and implementation of a comprehensive program will be difficult and costly. The 1979 pilot project, while likely to be somewhat successful, appears to be extremely expensive to replicate. However, the need for community-based information sources and delivery points seems to be an essential component of any strategy to increase contraceptive use among the Indians. Delivery points should include the local pharmacies.

The experiences of the Basic Village Education Project (BVE) should be considered in designing an information/education project for the Indígena community. This project supported by AID in 1974-1977, was a three-year demonstration program for rural areas of Guatemala. The objectives were to develop a non-formal education program to improve agricultural practices and to evaluate the effectiveness of various combinations of media and educational techniques on agricultural knowledge, attitudes, and practices.

A carefully controlled study of both Ladino and indigenous areas was implemented. Messages were tailored to the distinct cultural and agricultural needs of the two areas. Information/Education combinations were radio alone, radio and community monitor, monitor alone, and radio-monitor and agronomist. All of the media combinations were found to have some positive effect on agricultural knowledge and practices. As might have been hypothesized, changes were greatest in the Ladino areas. The areas with the lowest levels of technical sophistication were found to require a highly concentrated program (radio-monitor-agronomist) for significant behavioral change to occur. This combination is essentially replicable in family planning through the use of radio-distributor-promoters.

Nevertheless, radio alone had some demonstrative effect in the Indian area. The radio messages were able to introduce new ideas and to reduce the farmer's perceptions of danger regarding the implementation of new practices. The BVE found that radio messages were most effective when targeted to the individual farmer through the use of personalized messages, linked to other community programs, and sensitive and tailored to cultural needs. A radio novel with continuing characters was found to be effective in both Ladino and indigenous areas. It was important that these messages be integrated into a wider context of community programming with ample opportunity for community feedback and input.

Extrapolating from this experience to a family planning information campaign must be done cautiously; however, certain principles and methodologies may be applicable. Indigenous areas with little previous experience in family planning will need an intensive combination of media and personal educational efforts. Nevertheless, a sensitive personalized radio campaign may be used to introduce unfamiliar concepts such as control over family size and spacing of children. In addition, the radio messages can be used to legitimize family planning in general and to address concerns about health. However, it must be emphasized that a radio program can only be viewed as support for an interpersonal educational program and service delivery.

The monitor was a critical element in the BVE program. Identification and training of indigenous contraceptive communicators/distributors seems essential.

Training should occur in short sessions, but communicators should receive some training on an ongoing basis. Instructions about specific contraceptives should receive some training on an ongoing basis. Instructions about specific contraceptives should only be a part of a total training program that would include methods to reach the community with family planning messages, educational strategies and outreach techniques.

Educational materials should be developed to support the program. As discussed in the mass media section, educational materials for use by the distributor should be available. These should be designed consistent with the values of the Indian culture. These might include posters, flip-charts, film strips and diagrams. Appropriate simple posters should be designed using people in Indian dress to announce the availability of services.

Perhaps most importantly, APROFAM should assure that Indians are directly involved in every aspect of this project. The hiring of Indians to work directly with this program is deemed appropriate and necessary.

Lastly, it is recommended that initial evaluations of this project be process rather outcome oriented. A large increase in the number of users in the first year is unlikely. Rather educational programs in the Indian area must be viewed as an investment in future behavioral changes.

d. Education

Education activities have not received support under the bilateral programs. Nevertheless, because of its impressive scope of activities, any evaluation of APROFAM would be incomplete without a discussion of the educational unit. Further, possible future support for this program should be considered.

The "Educacion para la Vida Familiar" is one of the major programs of the Education unit. The 1979 program has a \$36,773 budget supported by IPPF. The major objectives of the program are to present courses in sex education and family planning, to provide a library service on family planning, and to educate instructors in sex education techniques.

The program has been successful in reaching a large number of organizations. In 1978, 37,000 people, including 12,000 adolescents attended 606 seminars. Over 70 institutions, including factories, business, prisons, religious groups, the army, community groups and youth organizations have participated in the program. Further, cooperative arrangements have been established with the Ministry of Education, Nursing Schools, and other private organizations. The program has been able to break down some of the medical school's traditional resistance to family planning by assisting them in obtaining materials on anatomy and reproductions.

A major activity of this program is the sex education of young people in Guatemala City. Approximately 40 percent of the courses involve school age children. Each month, secondary school students from ten schools in the city

attend seminars. Approximately 100 schools annually participate in this program. It is estimated that 4,000 students have attended sessions.

The development of the courses assures their acceptability. APROFAM first conducts a meeting with the teachers from the school in order to gain their support and to discuss their role in sex education. Parents of potential students are invited to attend a five-session course on the sex education of their children and to answer their concerns. At that point, courses begin for the students. Three 45-minute sessions are usually held.

The instructors for these courses and talks are trained by APROFAM. Daily two-hour classes are held for 6 to 8 weeks. The newly trained instructor then gives talks under the supervision of a more experienced instructor. Approximately 250 instructors have been trained since 1969. The curriculum for this course appears to be comprehensive. Currently there are 50 instructors with the "Vida Familiar" program.

The "Vida Familiar" program has not been formally evaluated. An evaluation of the program is anticipated, but has not yet been developed. Such an evaluation should be encouraged. The one observed session at a factory concerned the subject of Responsible Parenthood. The one-and-a-half hour session included didactic material, a movie, and a lively discussion.

The "Vida Familiar" program has been supported as an urban program. Ninety-five percent of the courses and talks are held in the capital. Only the factory program has made any incursions into the rural areas. It appears that the large amount of experience gained implementing this program could be utilized to develop a similar program in the rural areas. The director of the Education Unit has expressed interest in this expansion. It is recommended that a rural program modeled on the successful urban approaches be considered.

In October 1977, IPPF began supporting a Youth Program with the goal of educating young people to be resources for human sexuality and family planning information. These young people are selected by their schools as peer leaders. Between 20-40 students are selected per school to participate in the program. to gain their support and assistance.

Courses last three days and are usually held at the school itself. Courses are taught by an interdisciplinary team which includes a teacher, sociologist, psychologist, and medical professional. Subjects discussed include anatomy, reproduction, adolescent development, preparation for marriage, venereal disease, responsible parenthood, and family planning. A mixture of didactic sessions and effective learning experiences are used. Students are encouraged to stay in touch with APROFAM for any resources they might need and to report of their activities. A mailing list has been maintained and information has continued to be provided. A booklet on adolescent sexuality has been developed as well as 13 fact sheets on topics of interest to adolescents ranging from alcohol to VD. A cursory review of this material indicates that it is well prepared and relevant to the needs of adolescents.

The first two years of the program have been successful. Seven hundred students have taken the course at 29 schools. A follow-up study indicated that 37 percent of the trained students have become active peer counselors. Six schools were selected for an intensive study of changes in knowledge, attitudes, and practices. In all but one school, significant positive changes were noted. A review of the curriculum indicates that the course is well planned and constructed. The one observed session was well taught. Total budget for the program is \$15,918.

A Pharmacy project was started in 1978 under the auspices of the Pathfinder Fund. The 1979 budget is for \$37,925. Three-day workshops are given for pharmacists to explore their role in the community with an emphasis on their participation in the delivery of family planning services. A poster has been developed for use in these pharmacies, "Tambien aqui vendemos anticonceptivos". At this time, 720 persons have attended 24 workshops throughout the country. Basic and refresher courses are given. In addition, a one-day course for 40 owners of pharmacies will be held.

A formal evaluation has been designed for this project. Support for this evaluation is being requested but has not as yet been approved. A contraceptive display unit is planned. Four groups of pharmacies will be analyzed on the basis of number of contraceptives sold. The pharmacies will be stratified into four groups: 1) the pharmacist has taken the course, 2) pharmacies with displays only, 3) pharmacies with course attendance and displays, and 4) pharmacies where no support has been given. The evaluation is expected to begin in July and be completed by January 1980.

Certain suggestions can be made. Many of the observed sessions contained some factual misinformation. It is suggested that the instructors be evaluated annually on their knowledge of family planning and sexuality information. If warranted, refresher courses should be offered. Many of the programs do not contain outreach components but are dependent on requests for educational services. This is partially due to personnel, time, and fiscal constraints, but the scope of educational services could be improved by greater emphasis on creating a demand. At the present time the majority of the educational activities are centered in the capital. Diversification to the rural areas will assist the program in supporting service delivery components. The need for funds for additional materials, such as books, movies, and pamphlets, is evident and should be considered.

A more active relationship with the "Program de Desarrollo Humano" of the Universidad del Valle should be encouraged. The current directors of the two programs indicate they are now sharing resources and extending invitations to participate in each other's meetings and conferences.

The consideration of a joint Resource Center/Clearinghouse on population, sexuality and family planning is recommended. Both organizations are now responding to a demand for these types of resources. APROFAM is currently requesting additional funds under the "Vida Familiar" program for a Documentation Center.

A comprehensive jointly sponsored program could serve several purposes. It would be a resource for educators trained by both APROFAM and Valle and would provide materials for the training courses offered by both organizations. Active outreach to others involved in family planning and sexuality education, such as youth groups, churches, and community organizations, would both assist these individual activities and build a nationwide constituency. The mailing list of the clearinghouse could be used to disseminate new materials and resources. A nationwide constituency of persons active in the family planning and sex education field would be a valuable support throughout the country for family planning service delivery programs.

D. Clinical Program

APROFAM began providing clinical services in Guatemala City in 1965 and has continued to do so ever since. As APROFAM began to expand its clinical programs outside the city, it was thought that a nationwide clinical service not utilizing MOH facilities would create an extremely costly, parallel rural health system. It was, therefore, decided that APROFAM would concentrate on Guatemala City and the MOH on all non-capital city clinical services.

At the beginning of this project paper, APROFAM, which operated eight clinics in Guatemala City, decided to increase its community-based program in Guatemala City and to reduce its clinic program to just four clinics. Today, these clinics in addition to attracting their own patients are providing (1) medical support to APROFAM CBD activities, (2) training to private and public medical and paramedical personnel, and 3) research opportunities in family planning.

With the reduction in the number of clinics, the number of new acceptors in the clinical program has also decreased over the past three years from 13,374 in 1976 to 11,618 in 1977 to 9,925 in 1978. Old acceptors have remained around 20,000 per year. Moreover, during this transition period average production per clinic has remained high. First, the total number of visits per medical and paramedical in 1977 was third highest in the western hemisphere. Second, among the private associations the average number of new acceptors per clinic was also third highest in the western hemisphere (IPPF Overview, 1977).

At the same time, APROFAM has not only increased its capacity to provide sterilization services and training within its own facilities, but has also attempted to expand sterilization to 14 regional hospitals of the MOH. Unfortunately, some of the regional hospitals had to be closed in 1978 because of poor performance. Now, with the recent order of the MOH to stop family planning activities, the other seven regional hospitals are at a standstill. Meanwhile APROFAM is seeking to provide sterilization services through, for example, mobile clinics and private hospitals and clinics. When APROFAM officially inaugurates services in its new buildings, hopefully by August 1979, its capacity to deliver sterilization should be greatly increased.

E. Ministry of Defense

In July 1976, APROFAM began an innovative family planning program in coordination with the Ministry of Defense (MOD). The primary objectives of the project were to: (a) train MOD personnel to teach family planning and venereal disease information to soldiers; (b) train medical and para-medical personnel in the 48 MOD health clinics; (c) provide contraceptives to career soldiers and recruits; and, (d) design and provide family planning posters and pamphlets to support the MOD program. The 1977 bilateral grant included \$24,197 for support for this program through 1977. The program received an additional \$3,596 from the Pathfinder Fund to continue activities through June 1978.

The Evaluation Unit of APROFAM, with the assistance of Dr. Jane Bertrand, prepared a quantitative evaluation of this program. From July 1976 through the first quarter of 1978, 96,504 condoms were distributed. A clever poster and pamphlet featuring the picture of two soldiers were designed; 48,411 pamphlets were distributed; 920 posters were displayed at every military base and military hospital. The display of the posters and the number of condoms distributed may indicate that family planning services were being provided at each base.

A major component of the program was the training of mid-level army officials in delivering family planning information to their troupes. During the project period, 41 army officials participated in the instructor training program. At the time of the evaluation, 21 of these trained officials were giving lectures on family planning and venereal diseases at 14 military bases. During the period studied, 409 lectures were given; they were attended by over 13,000 army personnel. APROFAM both supervised and participated in these seminars. In 1978, in addition to these activities, APROFAM presented one course to the wives of army officials, three courses at military institutes, and one at the Sanidad Militar.

Despite the formal termination of this program in June 1978, the MOD continues to provide family planning education and services with APROFAM support. Pamphlets and posters continue to be available. APROFAM provides the MOD with movies, books, and other support for their lectures. In addition, APROFAM staff present lectures to the MOD troupes under the "Vida Familiar" program.

IV. COST ESTIMATES OF SERVICE DELIVERY PROGRAMS

Although research findings are not available on the exact continuation rates for each contraceptive method in Guatemala, we have estimated average years of protection using the following conversions:

Table 1

<u>New Clinical Acceptors</u>	<u>Years of Use</u>
Pill	2
IUD	3
Barrier	1
Injection	2
Sterilization	15
<u>New CBD Acceptor</u>	
Pill	1.5
Condom	.75
<u>Continuing Clinic Acceptors</u>	
Pill	1
IUD	1
<u>Continuing CBD Acceptor</u>	
Pill	.75
Condom	.75

The relative output during 1978 of four programs expressed in years of protection is displayed below in Table 2.

Table 2

PROGRAM	Couple-years of protection	%
Sterilization-APROFAM	90.510	43.3
Clinical Services-APROFAM	51.433	24.6
CBD APROFAM	27.031	12.9
Direct Distribution MOH	30.878	19.1
TOTAL	208.852	100.0

The costs in 1978 of these four programs are shown in Table 3

Table 3

Program	Total Project Cost	Fees Collected for service	Net Cost per year of protection
Sterilization	175,974	18,000	1.74
Clinical - APROFAM	220,491	32,000	3.44
CBD - APROFAM	112,050	16,000	3.55
Direct Distribution-MOH	65,290	24,000	1.04

Operational costs to APROFAM excluding costs of contraceptives. 10 per cent administrative cost included.

The seemingly low costs of the direct distribution program cost can in part be explained because costs to the Ministry of Health were not included, only the costs to APROFAM. Neither are the funds provided to the Ministry of Health by international donor agencies for the overall health system included.

It is a well-known fact that small programs, rural programs and new programs are generally more costly. APROFAM experience bears this out. For example, the larger, older, and urban CBD program in Guatemala City was quite cost effective at \$1.14 per year of protection use. Meanwhile, a fairly new, rural CBD program with FECOAR was more costly, at \$10.73 per year of protection use. The newest rural CBD program (Algedoncens) plagued by design problems, was unacceptably costly, at \$25.64 per year of protection. Each of these programs can be modified to achieve greater cost effectiveness.

As can be expected, the sterilization program is quite cost effective, at \$1.74 per year of protection use. Although the cost per case is approximately \$26, there are steps that could be taken to increase the number of procedures per clinical session. This is especially true for the mobile sterilization project, where long, tiring, and difficult trips are sometimes made for only five or six patients. The scheduling could be modified so that 10 or 12 patients are served at each session and then cost per case would be reduced.

Besides its cost effectiveness the mobile sterilization program is strategically very important. The program has obvious demographic impact, but, moreover, each satisfied patient has a multiplying effect on demand.

Unfortunately, the sterilization program has suffered several "political" setbacks. Regional governmental hospitals had performed so poorly that activities were suspended in 50 percent of the hospitals. More importantly, and more recently, the suspension of family planning services in MCH facilities obviously stops sterilization activities. This is most unfortunate considering the strong demand for sterilization service that exists in Guatemala.

Finally, with regard to CBD programs, it is important to emphasize outputs other than the program's own acceptors. For example, the CBD program recruits patients for the sterilization program, helps expand the political base of family planning, carries forth family planning information, and helps to organize the local communities to deal with their own problems.

V. ADDITIONAL AID SUPPORTED FAMILY PLANNING ACTIVITIES, 1977-1979

A. APROFAM's Intermediary Activities

APROFAM has carried out in the last three years a number of activities with the financial and technical support of AID intermediaries. Objectives of the projects and their approximate funding levels are presented below to indicate the broad scope of APROFAM's activities. Such an impressive list displays not only the intermediaries' confidence in APROFAM's implementation capacity but also their difficulties in finding and funding effective Guatemala organizations in the family planning field. Within the LAC region, funding to a family planning association from such a variety of services is unusual.

1. Production of Educational Materials for the Indian Population (Pathfinder, \$32,769.00).

This project will produce a variety of educational materials for use in the indigenous areas by indigenous communicators. These materials will be a key element in APROFAM overall program to provide Indians with family planning information and services.

2. Family Planning Training for Auxiliary Nurses (Pathfinder), \$12,884).

APROFAM will train approximately 72 auxiliary nurses working for the same number of MOH health centers throughout Guatemala to insert IUD's and prescribe orals.

3. Adolescent Care Center (Pathfinder \$36,970).

This project will establish a teen center to counsel adolescents in the areas of social and psychological well-being, health, and reproduction.

4. Family Planning Training for Drugstore Employees (Pathfinder \$37,924).

This project provides basic instruction on contraception and family planning techniques to 480 drugstore employees so that these employees can counsel their customers with regard to family planning. Refresher courses have been held for 240 drugstore employees previously trained by Pathfinder.

5. Movimiento Campesino Independiente (Pathfinder \$12,000).

This CBD project seeks to enroll 2,880 new acceptors of oral contraceptives and 3,000 new acceptors of condoms during its second full year of Pathfinder support.

6. Expansion of male and female Voluntary Sterilization Service and Training Program (Association for Voluntary Sterilization \$438,242 - Maximum for 1977/78).

Funds in 1978 and 1979 will be used to perform 10,000 voluntary sterilization procedures, train 15 physicians and 20 nurses in laparoscopy, mini-laparotomy and vasectomy, and continue to conduct an extensive public information and education program in support of voluntary sterilization programs. Prior to 1978 AVS had funded a large voluntary sterilization program with APROFAM for a number of years totalling half million dollars.

7. Sugar Growers (FPIA, \$49,821).

To provide family planning services to migrant and non-migrant workers of sugar plantations, 30 distributors will be trained to distribute contraceptives to 1,500 new users.

8. Rural Male Motivation (Pathfinder, \$9,752).

This project attempts to reach rural men with the family planning message at their place of work.

9. Postpartum/Post-Abortion IUD Services (IPPF \$70,000).

Government physicians working in seven department hospitals would be trained to insert IUD's among postpartum and post-abortion patients.

10. TAC/TIC (World Neighbors \$2,600).

Working with an indigenous population, the project provides training in health and hygiene in order to introduce family planning in the context of integrated community development.

11. Marginal Areas (World Education/IPPF \$7,828).

Project will identify methodology to involve community in integrated family planning programs.

12. Leaders Seminars (Battelle \$14,950).

In order to make the population problem more apparent to community leaders such as area health chiefs, governors, union leaders, journalists and majors, a series of conscious-raising seminars were held.

13. Resource Development Unit (IPPF \$11,700).

The project establishes a resource development unit to raise funds locally from businesses and elite private citizens as well as improve the public image of the association.

14. Evaluation Unit (IPPF \$4,245).

This project provided four weeks of concentrated training for the evaluation staff from throughout Central America under the direction of Drs. Bertrand and Roy.

15. Training Family Planning Personnel (Development Associates \$141,000).

The following excerpt was taken from a report by Development Associates (DA) for 12/77 through 11/78:

"DA provided funding for several Guatemalan institutions and activities during 1977/78. APROFAM, which received the largest amount of program support, continued its series of family planning courses, begun in 1977, for MOH personnel in rural areas. They also hosted an international seminar for leaders in population program development. With DA and the University of Chicago, APROFAM and the Guatemalan MOH co-sponsored a month-long course in family planning communications for 42 international participants."

In line with Guatemala's growing population effort, nine administrators received advanced management training during this period with DA support. Three others were sent on observation tours to Profamilia in Colombia in order to increase their knowledge of large-scale CBD and other family planning programming.

Third country training done during this year included vasectomy training for two Central American physicians at APROFAM clinics and three courses in Human Development and Sex Education given at the Universidad del Valle. Fifty-four international grantees attended these courses under DA sponsorship.

16. Building Construction (IPPF \$190,000).

Assist FPA to replace building destroyed by earthquake.

17. Youth Leaders (IPPF \$9,500).

To create youth multipliers to identify and help solve problems related to adolescent sexuality.

18. Job and Salary Evaluation (IPPF \$8,000).

With technical assistance from a Price Waterhouse consultant, this project developed job descriptions and salary scales for APROFAM personnel.

19. Training Unit (IPPF \$26,800; Development Associates \$9,000).

Create a national family planning training unit for APROFAM and various Ministry staff.

20. International Year of the Child (IPPF \$2,500).

Involve lawyers and other professionals to search for solution to legal problems of Guatemalan children in collaboration with University Rafael Landivar.

B. Valle University

The "Programa de Desarrollo Humano" of the Universidad del Valle has been instructing primary and secondary school teachers in sex education techniques since 1968 with the assistance of USAID. During the last 10 years, 3,234 Guatemalan teachers have attended their basic sex education training course. In addition, the program has developed curricula and teaching guides for human development courses and supported sex education material.

The first phase of the program was completed in 1975. Fifty-six Intensive Basic Sex Education Courses were held for Guatemalan teachers. The program received assistance from the Ministry of Education in selecting schools and teachers and legitimizing the need for such courses.

The second phase of the program began in 1976. The courses for national teachers continued on a reduced level, and emphasis was placed on providing courses for professionals from other countries in Latin America. Seven regional courses have now been held. This change in emphasis was partially due to the program's commitment to sharing their successful experiences with other Latin American countries, and in response to the need to obtain financial support from other organizations. In addition, during the second phase, a separate course was developed for school guidance counselors.

At the present time, the basic course is offered two-three times annually, with an average of 22 teachers attending each course. Courses last for four weeks. The courses are designed to develop the teacher's capacity to integrate sex education and human development within their classes. The curriculum is comprehensive and thorough. Effective education strategies are used to assist the teachers in confronting their own attitudes toward sexuality to assure their ability to teach comfortably and without bias. Basic information about anatomy, physiology, psychology, human development, and family planning is presented as well as educational techniques and strategies for the effective presentation of sex education materials. Formal follow up of teachers who have attended the course has not occurred, principally due to the lack of financial resources. Nevertheless, the program receives at least one letter per week from teachers requesting sex education materials or technical assistance. The program has recently submitted a proposal to Development Associates to conduct a survey of teachers who have attended the Basic Course and to develop refresher courses. A review of the proposal indicates that it is well developed and merits positive consideration. Identification of teachers actively involved in sex education and their more advanced training will result in stronger more effective programs and may be one way to attack the problem of high adolescent fertility.

VI. APROFAM'S MANAGEMENT CAPACITY

A. 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". (Bernhardt, 1976).

Our review of the association's implementation of both the Bilateral Program and other activities confirms this positive evaluation of APROFAM's overall management capability. Despite rapid expansion of activities, APROFAM's overall management capacity, a concept difficult to measure, may have actually improved in the last three years.

APROFAM uses traditional hierarchical administrative systems. Seven department directors who report directly to the executive director, supervise specific projects and activities; supported by a small, centralized administrative staff (Exhibit 1). The recently hired programmer who also reports directly to the executive director will coordinate departmental planning/evaluation activities and serve as the principal liaison with APROFAM project funders. 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 1978, APROFAM's 1.5 million dollar budget supported a staff of 188 persons. Financial assistance was received from 12 different sources including eight international organizations (Table 4). The program implemented 19 distinct project activities, an unusually high number for a private family planning association in the Western Hemisphere Region.

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. Most organizations would have been taxed by such growth; many would have disintegrated under the pressure. APROFAM, in fact, seems to have thrived and learned from the experience.

Several APROFAM organizational characteristics should be highlighted:

1. Staff Motivation. At every level, APROFAM staff are "true believers". Long hours, working weekends and unrelenting dedication are company norms. All management level people have been with APROFAM for at least three years; seven of the top 12 have worked with APROFAM for 10 years, including the executive director. New staff are expected to demonstrate total commitment to the objectives of APROFAM.

Exhibit 1

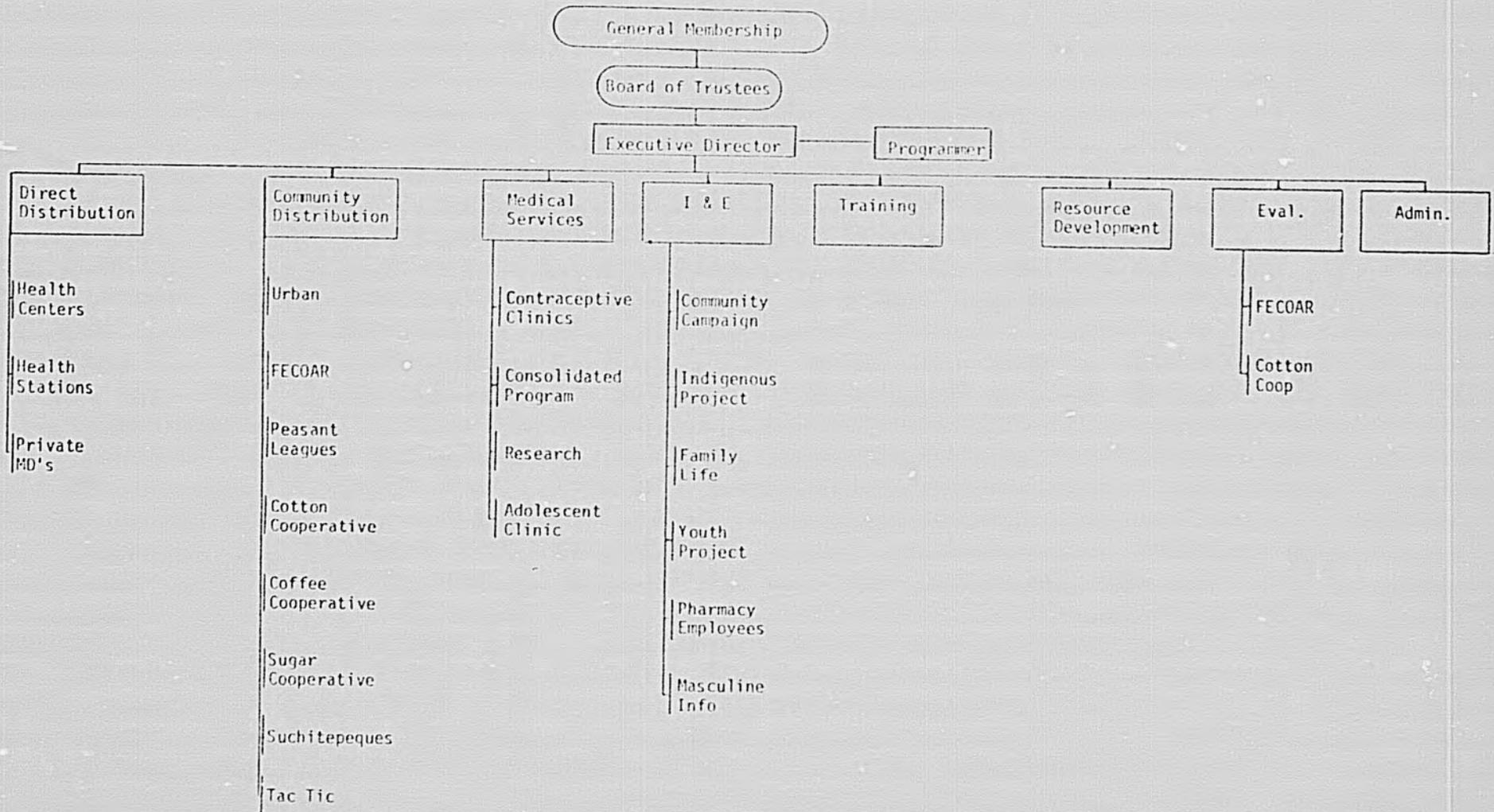


Table #4

APRPFAM STAFF 1978

Information, Education, Communication	18
Clinical/Medical	103
Community Based Distribution	33
Evaluation	4
Administration	21
Executive Director	<u>9</u>
Total	188

APROFAM FUNDING SOURCES -- 1978

AID	369,271
Pathfinder Fund	41,009
World Neighbors	13,814
AUS	179,505
Development Associates	6,507
University of Columbia	29,500
FPIA	17,233
IPPF	336,400
Sales	47,882
Patient Fees	16,151
	55,383
Donations (local)	<u>10,393</u>
Total	1,123,128

2. Technical Competence. APROFAM's management staff understand the organization's mission and have the skills and experience to implement program activities.

3. Political Survival. APROFAM lives from one external political crisis to another. The association's leadership has skillfully developed influential public and private sector allies and coalitions in one of the most difficult environments in Latin America, one in which political will to carry out family planning is lacking. Educational and service delivery activities are continually being developed to expand the association's support base.

4. Institutionalized Learning. APROFAM learns from its successes and failures. Evaluation and consultant reports are reviewed and operational activities/procedures changed when deemed appropriate. Examples are: the training and accounting units, CBS's reorganization and the improvement in the contraceptive logistic system.

5. Outside Advisers. Consultants, advisers and evaluators visit APROFAM in endless procession. The association's leadership has used available external expertise to complement existing organizational capabilities. This is particularly apparent in terms of introducing innovative programs, project evaluation and developing overall administrative capacity.

6. Grantsmanship. APROFAM has demonstrated the ability to capture sizeable quantities of grant money. Under IPPF's "accelerated" program, APROFAM benefited disproportionately, e.g., more than ten projects were funded in a two-year period in addition to increased amounts of basic program support. APROFAM's ability to work with numerous AID intermediaries is noted earlier in this report.

7. Achievement. APROFAM, in spite of numerous political obstacles accomplishes most of its objectives: user knowledge and acceptance is increasing, a community-based distribution system is being put into place virtually nationwide, and community demand for even controversial services such as sterilization has been generated. Donor-supported projects, with some exceptions, have been considered successes.

B. Management Systems

APROFAM has a full range of formal management systems, e.g., payroll, personnel, reporting, internal audit, external audit, inventory supply and control, program evaluation, etc. A procedure manual exists for major administrative tasks. Despite formal, rigid procedures, the association is administered relatively well: payroll is on time; commercial bills are paid regularly; distribution points rarely stock out of contraceptive supplies; donor agencies receive required reports; management data exists and seems to be reasonably accessible and accurate; budget projections have been quite good in the last few years.

It should be emphasized that APROFAM's management structure survived the 1976-79 rapid program growth. In fact, all evidence suggests the association's logistic, planning, supervisory, data collection and reporting capability generally

improved during the 1977-79 grant period. For example, the Direct Distribution Program has responded to external suggestions by implementing a de facto minimum-maximum stock level system and a simple inventory control form.

Overall, new problems were created by rapid growth. Important financial support was provided by IPPF to address management problems: overall organizational design, job descriptions, and salary scales.

1. Data

Staff at all levels are aware of the organization's most important data needs. The supervisory staff is aware of project goals, objectives and progress being made. Management data is available, although not centralized and underutilized by decision-makers. Financial data is reasonably accurate. There is some question about the reliability of utilization data. APROFAM could develop a more sophisticated information system which would have, for example, data on participant characteristics and program costs. Similarly, management data should be centralized and accessible to appropriate decision-makers.

2. Communications

Intra-institutional communication/information flow is a mix of formal systems (e.g., reports, weekly staff meetings) and informal communication among friends/co-workers who share a common vision. The communication "system" does not always function optimally; primarily because everyone is working so intensively on their projects that they have neither time nor energy to share. Nevertheless, one must be impressed with the unanimity of purpose within the organization, the team spirit, the level of understanding among program directors, and the organization's ability to learn from past experience. Persons refusing to work in a team context have left or been asked to leave the organization. Locating all department directors under one roof would facilitate communication. It was suggested that periodically staff meetings be devoted to discussion of general family planning issues (as opposed to daily management concerns).

3. Planning/Budgeting

APROFAM uses IPPF's planning/budgeting system which appears to be understood by all involved in the process. Program objectives and budgets are developed at the department chief level, reviewed and revised by the chief administrative officer (in consultation with the appropriate department chief), and ultimately approved by the executive director and board of directors. (IPPF has provided much technical assistance in this area). Obviously, the process involves several iterations, informal negotiations and mediation by the executive director. At the start of 1977 expansion period APROFAM, with technical assistance from an IPPF supported management consultant, recognized the need to consolidate APROFAM's many discrete projects into a unified and coherent program. New activities were to be undertaken only if they clearly moved the association toward at least one of its major goals. Given multiple funding sources, the association has done a competent job of matching its long-term goals with funders' desires.

There have been no significant project budget deficits (or surpluses) during the bilateral agreement period. Construction costs for the new clinic have exceeded expectations largely due to unanticipated inflation in the construction industry following the 1976 earthquake.

Departmental (project) budgeting probably could be improved by giving department directors additional responsibility for on-going management of their budgets.

4. Accounting and Financial Controls

The Association has an administrator, accountant, internal auditor and annual external audit (by Price, Waterhouse and Co.). In February 1979 APROFAM, with the assistance of IPPF, redesigned their accounting system to improve availability and quality of management information. IPPF expects the changes will upgrade the Association's reporting, planning and daily management capability.

Preview of the two most recent external audits revealed no problems. IPPF indicated satisfaction with APROFAM's financial records and general administrative ability.

5. Reporting System

Major donors are generally satisfied with APROFAM's reporting ability. Required reports are timely and information is considered basically reliable. Raw data collection systems look excessive and somewhat unwieldy, but they seem to produce the desired information. Looking forward to further expansion, the Association recently hired a programmer who, among other things, will be in charge of preparing reports for donors.

As previously mentioned, much work remains in terms of streamlining the reporting systems, as well as maximizing type and use of information contained in the reports.

6. Logistics/Inventory

APROFAM is supplying contraceptive supplies to its own urban clinics, Ministry of Health rural clinics, and APROFAM community distributors in urban and rural areas. Approximately 100,000 active users receive contraceptive services from more than 1,000 clinics, hospitals and community distribution points. Much of the clinic and community-based distribution program has developed since 1977. Given the national coverage and rapid expansion of the program, the absence of serious logistical problems is a noteworthy achievement.

An earlier problem with contraceptive stock-outs has been resolved for the most part. Educational materials continue to be in short supply, but this is primarily a money and production problem. A simple, but sufficient, inventory control system at the distribution point was instituted several months ago. Most community distributors seemed to understand and be able to maintain the inventory control system. To date, the Director Distribution

Program has not implemented a summary control system at the central office. APROFAM should explore means to unify and simplify inventory control systems for all its projects.

7. Supervision

Everyone, donors, evaluators, advisors, staff recognizes the leadership abilities of APROFAM's executive director, Dr. Roberto Santiso Galvez. Less well acknowledged is the important leadership provided by key Board of Director's members and Department Directors.

An organization with strong leadership runs the risk of having too many routine decisions made at the top. APROFAM has not escaped this problem, although the proposed regionalization plans ultimately will force meaningful decision-making at operational levels of the organization.

Department Directors manage three to ten discrete projects, often with financial support from a variety of funding sources. Promoters and detail men are supervised by Department Directors; community distributors by promoters. Ministry of Health personnel are not supervised by APROFAM staff members. APROFAM clinics are supervised by the Medical Services Department.

Department Directors as a group have good supervisory skills. Subordinates are aware of department goals and their performance relative to goals. They are knowledgeable about APROFAM and positively motivated.

Supervision (i.e., motivation) of MOH clinical personnel is an as yet unresolved issue. Plans to train MOH clinical people depend, obviously, on the Ministry's willingness to continue working with the Association.

The Association recognizes a need to improve promoters' supervisory abilities and the recently created training department has initiated training sessions for promoters and community distributors.

To date, little thought has gone into the need to "retool" supervisory skills in order to implement APROFAM's proposed regionalization. This important issue should be addressed before regionalization becomes a reality.

C. Management Issues

The following management issues emerged from our evaluation:

1. Regionalization

APROFAM plans to establish at least four regional centers. The full range of APROFAM family planning services will be offered in each center.

Comment:

Regionalization should be initiated as soon as possible. The process of moving from a centralized to decentralized organization will be difficult and will require special efforts on the part of top-level management. Intensive consulting assistance will be necessary during the transition period. APROFAM leadership will have to work diligently to make sure the regionalization creates a cost-effective service delivery system. It can be anticipated that at least some department directors will resist regionalization and resultant changes in their role within the Association.

2. Integration of Training and Evaluation Departments with On-Going Operations

Dissemination and implementation of evaluation recommendations is not one of APROFAM's strong points. Training Department activities at this time respond to APROFAM's need to train/motivate CBD promoters and distributors.

Comment:

Evaluation Department reports consistently pinpoint important operational issues. The team found, however, these recommendations are all too often ignored. APROFAM's Executive Director should initiate steps to integrate evaluation results into the Association's daily activities.

Similarly, we believe APROFAM should guard against the possibility of training activities moving away from specific Association needs. If CBD expands significantly, the Training Department will have to develop creative methods to achieve economies of scale.

3. Role of Programmer

The Programmer position is new at APROFAM. To date the Programmer has been familiarizing himself with APROFAM operations, particularly information and reporting requirements.

Comment:

We believe the Programmer should be responsible for rationalizing APROFAM's management information system. He should be the focal point for program information between donors and the Association. The Programmer should work with Department and Regional Directors to program, literally, project activities at the national and regional levels.

The two responsibilities just mentioned will give the Programmer considerable organizational power. In the best case, this will free time for the Executive Director and Department directors. This will occur, however, only if the Programmer begins to take on some qualities of a deputy director, a role certain to create some organizational tension and resistance.

4. Personnel Management

APROFAM employs almost 200 people in activities scattered throughout Guatemala. Despite formal personnel policies, salary schedules, and supervisory patterns, APROFAM retains a personalized, informal management style.

Comment:

We believe regionalization and continued program expansion dictate refinement of the Association's system for staff selection, training, supervision and evaluation. In particular, specific criteria should be developed for supervisory activities and staff evaluation at all levels. Professional development programs should be initiated for all top and middle-level management staff.

5. Decision Making and Internal Communications

Although Department directors have considerable decision-making authority, the Executive Director is called on to make many operational decisions and to arbitrate difference among Department directors.

Comment:

Regionalization and program expansion will require improved internal staff communication and a redefinition of decision-making authority. Information flow among Department directors should improve when the Association occupies its new building and everyone is housed under one roof. As the Association grows it will be increasingly important to examine and clarify communication and information flow among the staff.

6. Budget Control

The Administrative director retains control of all operational budget decisions. Department/Program directors have input into developing their own budgets, but as the operational year progresses all budget information is compiled and retained by the Administrator.

Comment:

The existing system functions well in terms of overall budget control and allowing the Executive Director considerable reallocation flexibility. However, the system is frustrating for Department and Program directors. APROFAM should explore ways to give Department directors more information and control over on-going operational budgets.

7. Self-Sufficiency

There is considerable discussion regarding self-sufficiency for at least parts of APROFAM's program. The Association is actively pursuing expansion of programs with the Guatemalan private sector.

Comment:

APROFAM should initiate serious studies of self-sufficiency alternatives. The cost/benefit of activities designed with self-sufficiency as an objective should be examined. The evaluation team believes there are numerous opportunities for collaboration with the private sector in self-sufficiency (or at least cost-efficient) projects.

8. Can APROFAM Manage an Expanded Service Delivery Program?

We believe past performance dictates a YES answer. However, increased services will require operational changes, e.g., regionalization, integration of programmer into the organization, refinements in management information system, strengthening of supervisory system and skills, improved communication among Departments and between Departments and Executive Director.

VII. RECOMMENDATIONS FOR FUTURE AID BILATERAL ASSISTANCE

At the present time, the mission is advised to continue its support to APROFAM who have clearly displayed their ability to perform under what might be labeled difficult conditions. It is unclear whether the government wishes to continue having APROFAM as its sole executing agency. Caution is advised in delegating too much responsibility to new agencies which lack necessary experience, but the need to involve others is obvious. The lack of government commitment to family planning is likely to discourage newcomers to family planning. Therefore, given the present political environment and the demonstrated capabilities of APROFAM, the following programmatic and management recommendations are made.

A. Programmatic Recommendations for APROFAM

1. Community Based Distribution

- a. By 1985, intensify program at national level to cover 30% of the currently married women (1,200,000 currently married)

- b. Guatemala City

By 1985, 50-55% of currently married women will be active users. Four clinics will remain in operation as medical support. 360 active distributors will have approximately 36,000 active users.

- c. Rural

Coverage will double by 1985 so that there are 160,000 active users which will require 3,200 distributors and 160 promoters.

- d. A two year work plan should be elaborated as soon as possible.

2. Sterilization

- a. APROFAM should increase the number of women sterilized to 15%. 100,000 female sterilizations need to be performed in the next five years.

- b. To achieve this goal the following annual targets are suggested: 6,000 in 1979, 10,000 in 1980, 15,000 in 1981, 20,000 in 1982, 25,000 in 1983 and 30,000 in 1984. Assuming that Social Security and private physicians continue to perform at their current annual level of sterilization, and assuming that APROFAM meets the above targets, it can be estimated that in 1984, 150,000 women in the fertile ages will be sterilized.

- c. It is difficult to estimate the costs of this program because it is unclear exactly which proportion of the sterilizations will be done by mobile clinics which are more expensive. But using \$30 per case as our estimate, this program will cost nearly 3 million dollars over the next 5 years. It will most likely need to be funded by intermediaries because of its controversial nature.

3. Indians

- a. Identification and training of well motivated Indian distributors and promoters (500 distributors and 25 promoters). Special effort should be made to train Indian women.
- b. Promoters should indicate target acceptor levels after a one year period.
- c. Indian-specific educational materials and posters should be developed.
- d. Radio messages in dialect and specifically designed to be consistent with Indian values should be used to support any service delivery program. Radio messages should be used as a means of legitimizing family planning and small family size and reducing the perceptions of health and culture dangers.
- e. Indians should be hired to work directly with APROFAM on developing all aspects of this program.

4. Information

A. Urban

1. A limited radio campaign should be used in the capital. Radio spots should be developed to legitimize family planning and improve the image of APROFAM. These should underscore that APROFAM is a non-profit organization dedicated to the provision of voluntary, safe and effective family planning services and information. Spots promoting family planning concepts in general, without an APROFAM tagline should be considered.

2. A short (4 pages) pamphlet on APROFAM underlining the same points should be developed for distribution to the press, PVO's schools, and organizations with which APROFAM works in the urban areas.

B. Rural

1. Radio should continue to be used. Spots should be directed at legitimizing the concept of family planning, and addressing the concerns about health dangers. If deemed politically feasible, spots should direct people to the clinic, pharmacy, or "APROFAM sign in your community". As deemed necessary, spots should be region-specific.

2. The possibility of reducing the number of spots paid for should be considered. At the present, APROFAM pays for 3 spots daily, and in many areas 6 are broadcast. If only 12 daily spots are paid for and free airplay is donated, coverage can be significant at a lower price.

3. Future information campaigns directed on increasing contraceptive use among males and adolescents should be investigated.

C. Educational Materials

1. Educational materials, including posters, flipcharts, and pictures, should be developed for use by distributors/promoters.

2. A shorter, simpler booklet with pictures for distributors should be developed.

3. Simple pamphlets with motivational messages should be developed. Distribution of pamphlets should assure that they are reaching clinics, pharmacies, and CBD posts in rural areas. Distribution to non-service delivery points, such as stores, factories, etc., should be considered.

4. Posters with method specific education messages should be developed for use in clinics and CBD points.

5. The possibility of integrating 3 or 4 point instructions on method use into contraceptive packaging should be considered.

6. Guides on family planning for pharmacists and para-professional health workers should be developed.

5. Education

A. The Vida Familiar program should be expanded to rural areas. Special emphasis should be placed on programs in factories and business aimed at reaching the male population.

B. Following the results of the evaluation of the pharmacy program, the expansion of the pharmacy training efforts should be considered to include all Type A, B and C pharmacies.

C. The possibility of expanding the Youth Program by adding additional staff should be considered.

D. Support for training more instructors for the Education program should be increased.

E. The development of an APROFAM-Valle nationwide Clearinghouse/Resource Center on population, family planning, and sex education should be considered.

6. Training Unit

A. The new training unit will need to expand its activities very rapidly to train and retrain the promoters and distributors necessary for the expansion of urban, ladino-rural, and Indian-rural CBD programs. Some 3,500 ladino distributors and 500 Indian distributors (see sections 1.A., 1.B., and 1.C. under recommendations to APROFAM) will need to be trained in the next two years.

B. A work plan for this should be elaborated for this training as soon as possible, perhaps with the help of outside consultants.

C. Bilateral funds should be set aside for these efforts and the amount of money necessary will be calculated as part of the work plan. About \$100,000 - \$150,000 per year over the next two years is a rough estimate.

D. Training of CBD distributors should include training in education, counseling and out-reach techniques.

E. Training of rural promoters/distributors should include techniques for working in Indian areas. The Mondloch guide can be used as the basis for this training.

F. The possibility of training BRE promoters in family planning should be considered. (see Appendix D)

7. Evaluation Unit

A. Make better uses of both service statistics and special studies in program planning and evaluation.

1. Use data recently collected by the Center for Disease control to design medium and long range programs as well as to document previous accomplishments.

2. Centralize service statistics to ensure standardization and comparability. More information on user characteristics is needed to further specify targets and results.

B. Hire a competent high-level technician to strengthen the weak evaluation unit. In the long run, this will make the unit less dependent on outside technical assistance. To date, finding appropriate professional at an affordable salary has been a problem.

B. Management Recommendations for APROFAM

1. Hire one management consultant for at least one year to assist the Association with: regionalization, development of Training Unit, implementation of Evaluation Unit recommendations, integration of Programmer into Association operations, and refinement of personnel management system. This person should have good skills in human relations and organizational development.

2. Implement regionalization as soon as possible.

3. Centralize program information in Programmer's office. Develop one reporting format with sufficient input/output data to facilitate breaking out specific donor reports. Data system should include basic information concerning user characteristics and program costs.

4. Concentrate short-term expansion efforts on projects in collaboration with the private sector, e.g. Finqueros, Caficultores, FECOAR.

5. Implement planned staff development program for all staff with supervisory responsibilities. Such a program should include upgrading of supervisory personnel evaluation and communication skills.

6. Allow Department/Program directors more operational control of their budgets.

7. Continue upgrading Evaluation Department skills.

8. Locate all Department directors under one roof as soon as economically feasible. This should facilitate communication/coordination among department.

9. Calculate a realistic overhead rate to be used when developing project and grant proposals.

10. Institute series of quarterly one day "seminars" for senior staff. These seminars should be designed primarily as motivational events and could focus on discussion of such topics as programs in other countries, burning issues in FP, new books/studies in the field.

APPENDIX A

PEOPLE CONTACTED

APROFAM - Guatemala City

Roberto Santiso
Executive Director

Victor Hugo Fernandez
Finance and Administration Director

Rolando Sanchez
Director Distribution Director

Antonieta Pineda
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Blanca Guerra
Resource Development Director

Enrique Soto
Information Director

Rebeca de Montalvan
Education Director

Antonia de Leon
Program Development Director

Sara de Molina
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Emma Munoz
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Judith de Saenz
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Francisco Mendez
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Lilia Oliva
Training Unit

Carlos Chajon
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Promoter (Jutiapa)

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Community Distributor (Llano Grande)

Richardo Snadova1
Teacher (Education)

Edilzar Castro
Youth Program Chief

Manuel Medina
Teacher

Humberto Estrada
Teacher

Julia de Garcia
Teacher

APROFAM - Rural CBD

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Supervisor

Jorge Paiz
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Florencia Calderon
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Jorge Calderon
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Sra. Flores de Calderon
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Robert Halladay
DSB/POP/FPS

Jim Heiby
DSB/POP/R

APPENDIX B

SITE VISITS

Sterilization Clinic, Capital APROFAM, New Headquarters	Haffner, Jaramillo Corno, Jaramillo, Haffner
Escuintla Mobile Sterilization Clinic CBD Posts-Ligas Campesina	Corno, Haffner, Jaramillo
Fabrica	Haffner
Urban CBD Posts	Corno, Haffner
Jutiapa Distributor training Jutiapa promoters Rural CBD distributors	Bloom, Haffner
Mazatenango DIMIF Training Session for Traditional Midwives (MOH)	Jaramillo
Chimaltenango Berhorst Clinic MCI promoter and distributor	Bloom, Haffner
Quetzaltenango FECCAR office FECCAR Distribution Posts Coffee farm; CBD Post	Bloom

APPENDIX C

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APPENDIX D

BASIC RURAL EDUCATION

The Basic Rural Education (BRE) program began in 1976 with the assistance of AID, UNESCO, and UNICEF. The initial goal of the program was to coordinate the rural education activities of several governmental agencies. A National Commission for Non-Formal Education was formed under the Ministry of Education. The seven GCG agencies involved are the MOE, Ministry of Health, Agriculture Services, Community Development, Army Education, INTECAP, and the National Economic Planning Council.

The program uses both radio and field promoters to provide education in the rural areas. As of January 8, 1979, 246 BRE-trained promoters are working in 126 communities. Radio messages are broadcast in 94 communities. The program is currently operating in the Departments of San Marcos, Quetzaltenango, Solola, Sacatepequez, and Chimaltenango. Sixty percent of the population addressed is indigena.

Radio programs have been translated into Spanish, Quiche, and Mam. Distinct cultural messages for the Indigena population have not been developed. Although radio messages are tailored to the agricultural needs of the specific community. Twelve one-half hour programs are produced each week. The range of radio programs also includes short notices, 15-minute spot lessons, and hour long community programs.

Promoters are community people who receive an intensive (125 hours) Basic Training Course. Their principal roles are to organize community working groups, to assist the groups in setting priorities for community needs, and to coordinate the activities of the various outside organizations in meeting these identified needs. Unfortunately, the experience of the program has demonstrated that outside assistance is often minimal, and the promoter must assume the role of technical assistance.

The program was originally concentrated on agricultural education. At this time, radio programs include health, community development, financial affairs, civic and cultural information, and general programming. Supporting educational materials have now been developed for literacy/math programs (34%), home economics (29%), agricultural (23%), health (6%), and community development (7%). Health programs rank fourth in the number of people attending community sessions (behind agriculture, home economics and literacy programs).

The current AID project officer, Gilberto Mendez, has only been with this program for ten months. His reaction to the suggestion of integrating family planning information within this program was receptive albeit cautions. In 1978, APROFAM developed a radio message for this program that was aired for only one week because of extreme negative community reaction. Nevertheless, Mendez believes that it might be possible to slowly integrate family planning into the program. It will first be necessary for the donor agencies to suggest the possibility to the Secretary of the Commission and the Regional

and Departmental heads to ascertain their interest and concerns. It is evident that any proposed integration would have to be very gradual.

The BRE promoters appear to be a valuable educational resource in the five Departments they serve. Four of these departments currently have CBD projects. At minimum, it would seem feasible to include some family planning information into the health section of the Basic Training Course. Minimal information could raise the awareness of the promoters to the existence of the CBD projects in their areas and perhaps encourage them to mention this resource in their maternal and child health talks. More active participation of the promoters in the delivery of family planning education and contraceptive services would be desirable, but appears unlikely at this time.

APPENDIX E

MINISTER OF HEALTH CABLE

ASOCIACION PRO-BIENESTAR DE LA FAMILIA DE GUATEMALA

APROFAM

APARTADO POSTAL 1004

TELS. 81069-81586

CABLE: ASOFAMGUA

Guatemala, 8 de junio de 1979

Dr. Antonio Carias
Director del Hospital
Nacional de Jalapa.

Telegrama No. 4067

Este Depto. ruega a Ud. y a su personal no participar en Programas que no esten contemplados en Plan Nacional de Salud específicamente en actividades de Planificación Familiar por cualquier método, mientras no haga previa consulta éste despacho, responsabilizandolo directamente por las medidas serias que se adopten al desacatar esta disposición, de enterado acuse recibo este mismo día.

Atentamente,

Dr. J. Roquelino Recinos M.
Ministro de Salud Pública y
Asistencia Social.