

MIDTERM EVALUATION
DEVELOPING MAYAN-BASED HEALTH CARE FOR
RURAL WOMEN AND CHILDREN

COOPERATIVE AGREEMENT NO. 520-A-00-97-00060-00

PROJECT CONCERN INTERNATIONAL

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ACRONYMS AND FOREIGN TERMS

| | |
|-------------|---|
| ACOMASMI | <i>Asociación de Comadronas Mayas de Salud Materno Infantil</i> (Association of Mayan Traditional Birth Attendants for Maternal and Child Health) |
| ADEMI | <i>Asociación de Mujeres Ixpijakok</i> (Association of Ixpijakok Women) |
| AIEPI | <i>Atención integrada de las enfermedades prevalentes de la infancia</i> (see IMCI-integrated management of childhood illness) |
| AIN | <i>Atención Integral de Niño</i> (Comprehensive Child Management) |
| APROFAM | <i>Asociación Pro-Bienestar de la Familia</i> (Association for the Welfare of the Family) |
| APROSAMI | <i>Asociación de Promotores de San Miguela Ixtahuacán</i> (Association of Promoters of San Miguela Ixtahuacán) |
| ARI | Acute respiratory infection |
| ASOCVINU | <i>Asociación de Comadronas de Ixcán “Vida Nueva”</i> (“New Life” Association of Traditional Birth Attendants of Ixcán) |
| ATI | <i>Asociación Toto Integrado</i> (Integrated Association of Totonicapán) |
| CMM | <i>Consejo de Mujeres Mayas</i> (Council of Mayan Women) |
| GOG | Government of Guatemala |
| IEC | Information, education and communication |
| IMCI | Integrated management of childhood illness |
| IR | Intermediate Result |
| LLR | Lower Level Result |
| MCH | Maternal and child health |
| MEDS | Monitoring, Evaluation, and Design Support Project |
| MOH | Ministry of Health |
| MSPAS | <i>Ministerio de Salud Pública y Asistencia Social</i> (Ministry of Health and Social Assistance) |
| NGO | Nongovernmental organization |
| ORT | Oral Rehydration Therapy |
| PAHO | Pan American Health Organization |
| PCI | Project Concern International |
| PVO | Private voluntary organization |
| Quetzal | Guatemalan currency |
| RFA | Request for applications |
| SIAS | <i>Sistema Integral de Atención en Salud</i> (Integrated System of Health Care) |
| SO | Strategic Objective |
| USAID | United States Agency for International Development |
| USAID/G–CAP | United States Agency for International Development/Guatemala–Central American Programs |
| USAID/G–HN | United States Agency for International Development/Guatemala–Health and Nutrition |

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EXECUTIVE SUMMARY

In September 1997, Project Concern International (PCI) was awarded a competitive four-year cooperative agreement by USAID/Guatemala–Central American Programs (USAID/G–CAP) to support the Mission’s Strategic Objective (SO), “Better Health for Rural Women and Children.” Under the terms of this agreement, PCI proposed to extend health services in USAID/G–CAP’s five priority departments (San Marcos, Quetzaltenango, Totonicapán, Sololá, and Chimaltenango), as well as the municipalities of Ixcán and Barillas.

The mechanism defined by PCI for accomplishing results under the SO was the identification and strengthening of 10 or more Mayan nongovernmental organizations (NGOs), which would provide basic health coverage to their own and other communities. PCI proposed that as a result of the project, these NGOs would develop the capacity to “provide primary health care services, particularly reproductive health services, in approximately 20 targeted municipalities with a total catchment area of up to 1 million people.”

The purpose of this external evaluation was to conduct a midterm review of project activities and assess progress toward accomplishing the results and objectives specified in the PCI agreement.

To date, PCI has established strategic alliances with six Mayan NGOs. Of these, five are currently receiving funding, training and technical assistance to improve their institutional and technical capacity to deliver health services. During the first year and a half, PCI activities were directed to NGO identification, strengthening administrative and financial procedures and NGO hiring of personnel who would manage service delivery (usually nurses) and work with community volunteers (usually educators). The project’s Mayan partner, *Rxiin T’namet*, also conducted introductory training for NGO staff in the project’s main clinical areas (e.g., reproductive health and child survival) and introduced strategies for adult education. Clinical services began under the project in March 1999; the NGOs working with PCI currently cover a population of 67,369.

The project has a number of strengths. PCI’s Guatemala office has good relations in the field and especially with MOH leadership in departments where the project currently works. It also has strength in management and administration, for which demand exists, and in some other technical areas that are promising, including the community pharmacies. The project also has a good baseline from which to evaluate future results and it has a new project director who has personal credibility with USAID partners and Guatemalan health officials in the MOH and rural areas.

Overall, however, the project has not performed as both PCI and USAID expected. An analysis of activities carried out in the first two years indicates that it has not made

significant progress in any of the Intermediate Results (IRs) and Lower Level Results (LLRs) specified in the agreement. The project currently has little programming specific to the community or household, access to clinical services has not increased significantly, and there are no indicators to suggest that quality of services has improved. It has also been unable to report much progress on most project indicators; even indicators for which there are data fall far below the anticipated annual targets. These findings are disappointing, especially in light of the project's size and budget.

The reasons for the lack of progress on the project's results and indicators are complex. Certainly, the project had a number of operational and management problems during the first two years, which had a strong negative impact on its ability to obtain results. Two other factors also contribute significantly:

- There were problems with PCI's program approach, which assumed that the successful, long-term relationship which it had with *Rxiin T'namet*, its Mayan NGO partner, constituted a model which was replicable with other Mayan organizations. PCI also assumed that this replication was feasible as a strategy to meet program objectives. In fact, probably neither was accurate, for reasons which were both particular to the PCI-*Rxiin T'namet* partnership and characteristics of *Rxiin T'namet* as an organization; and,
- The PCI country team restricted itself when it defined selection criteria for NGOs with which it would work, limiting counterparts to women-oriented and women-managed grassroots Mayan NGOs in indigenous rural communities.

These decisions had long-range implications for performance. Even if PCI had been successful in identifying and strengthening 10 NGOs as it had originally proposed, the project could never approach the coverage goals described in the proposal, nor could it make much progress on the agreement's results and indicators. PCI's current NGOs still require major investments in creating or upgrading technical skills and are still far from the competency levels necessary for providing quality health services, even in small populations.

Given the performance of the project to date, the main recommendations from the evaluation are related to options or combinations of options which PCI could use to set priorities and restructure activities to achieve results within the remaining time frame and budget. These include continuing the current program, albeit with more realistic expectations about results; modifying the original strategy to increase coverage but retaining the focus on Mayan NGOs; expanding the program to focus on service delivery; and, expanding activities in prevention and family health, while retaining some clinical and administrative activities. Specific recommendations for PCI consideration (regardless of how the project may be restructured) are presented.

I. BACKGROUND

In September 1997, Project Concern International (PCI), a U.S. private voluntary organization (PVO), was awarded a competitive cooperative agreement (No. 520-A-00-97-00060-00) by the United States Agency for International Development (USAID)/Guatemala–Central American Programs (USAID/G–CAP). The purpose of this agreement was to support the Mission’s Strategic Objective (SO) in health, “Better Health for Rural Women and Children.” The life of this activity is four years (September 1997 to September 2001); total funding is \$6,340,878 from USAID/G–CAP and \$3,810,294 (cash and in-kind contributions) from PCI.

The objectives of this agreement are to:

1. Develop and promote integrated approaches to improving women and children’s health, especially in the departments of San Marcos, Quetzaltenango, Totonicapán, Sololá, Chimaltenango and the municipalities of Ixcán, Quiché, Barillas and Huehuetenango;
2. Enhance the empowerment of women and communities and engage them fully in health-related decision-making;
3. Create/sustain partnerships among public and private sector entities with the aim of increasing the coverage and quality of health services in underserved areas; and,
4. Increase the programmatic, financial and social sustainability of local health programs.

As a key partner in activities to support the SO, PCI agreed to extend services in maternal health, child survival, reproductive health and family planning, as well as community and household prevention activities in the geographic areas noted above. The main implementation vehicle for this work was the recruitment and assistance to nongovernmental organizations (NGOs) that would, in turn, provide these basic health services at the community level. A client/Mayan focus, gender perspective and community problem solving approaches, which were specified by USAID as central to achieving the results desired under the SO, were also to be major elements in the PCI program approach.

This strategy of supporting NGOs to extend health services to communities with little or no other access to care is similar to that adopted by Guatemala’s Ministry of Health (MOH) (*Ministerio de Salud Pública y Asistencia Social* [MSPAS]) for its rural outreach program, the Integrated System of Health Care (*Sistema Integral de Atención en Salud* [SIAS]). PCI’s program was designed to complement this work.

PCI's success in carrying out this program was to be measured by progress on Intermediate Results (IRs) and Lower Level Results (LLRs) and indicators spelled out in the cooperative agreement. The Results Framework of the agreement is presented in Table 1.

Table 1: USAID/G-CAP Results Framework

| |
|--|
| <p><u>Intermediate Result 1 (IR1): More Rural Families Use Quality Maternal and Child Health Services</u></p> <p>LLR1.1 More households in priority areas adopt better health care practices. LLR1.2 More community agents provide quality care. LLR1.3 More health facilities provide quality services.</p> <p><u>Intermediate Result 2 (IR2): Maternal Child Health Programs are Better Managed</u></p> <p>LLR2.1 Supplies and equipment are continuously available. LLR2.2 Improved financial and administrative systems to support decision-making. LLR3.3 Communities actively participate in decision-making. LLR2.4 Program planning, monitoring and evaluation are based on quality data.</p> <p><u>Intermediate Result 3 (IR3): Greater Local Advocacy for Improved Access to Health Care, Especially for Women</u></p> <p>LLR3.1 Local-level entities facilitate advocacy activities. LLR3.2 Documentation and dissemination of lessons learned at the local level. LLR3.3 Linkages/partnerships formed with national-level advocacy activities.</p> |
|--|

PCI's annual work plans for achieving the desired results require USAID approval each year. In addition, the agreement also specified that PCI would develop and submit a monitoring and evaluation plan for measuring progress on the proposed indicators. This plan would include specific numerical and non-numerical targets and benchmarks by which progress toward the IRs and LLRs could be tracked. (See Annex A, PCI Program Approach and Proposed Activities, for a complete description of the SO, the Results Framework and proposed indicators for activities to be carried out under the cooperative agreement.) Semi-annual performance reports were to monitor and report on a core set of indicators and targets, as well as accomplishments and future plans.

II. PURPOSE AND METHODOLOGY OF THE EVALUATION

A. PURPOSE OF THE EVALUATION

The purpose of this external evaluation was to conduct a midterm review of the PCI project as it completed the second year of in-country activity (See Annex B, Midterm Evaluation Scope of Work). This report is intended to further assist PCI's and USAID/G-CAP's planning for the last two years of project activity.

This evaluation report

- Outlines the current status of the PCI/Guatemala program,
- Reviews the current strengths of PCI/Guatemala,
- Summarizes PCI/Guatemala's overall progress to date on the results in its agreement and the Mission's SO,
- Analyzes major problems that impeded progress toward these results,
- Reviews financial and sustainability issues, and
- Makes a series of recommendations in two areas:
 - Program options for modifying the project's objectives and activities, and
 - Concrete changes that PCI/Guatemala should consider, regardless of the options or combination of options it, in consultation with USAID/G-CAP, chooses.

B. EVALUATION METHODOLOGY

The external evaluation of the PCI cooperative agreement (No. 520-A-00-97-00060-00) was carried out between September 6–28, 1999, by a two-person team. The evaluation was conducted through the centrally funded Monitoring, Evaluation and Design Support (MEDS) project.

Major activities of the evaluation team included briefings by both USAID/G-CAP and PCI/Guatemala, as well as meetings with other USAID partners and Guatemalan professionals who participate in the implementation of the Mission's SO. Extended meetings were held with individual members of USAID and PCI/Guatemala, the government of Guatemala (GOG) representatives of the SIAS program and MOH personnel in San Marcos, Totonicapán, and Ixcán. In addition, field visits were conducted

to the PCI/Guatemala office in Quetzaltenango, the *Rxiin T'namet* training center in Santiago Atitlán and three project sites of PCI NGO partners, the *Asociación Toto Integrado* (ATI) and *Consejo de Mujeres Mayas* (CMM) in Totonicapán and the *Asociación de Comadronas de Ixcán “Nueva Vida”* (ASOCVINU) in Ixcán.

A debriefing on the major findings of the evaluation was held for USAID/G–CAP staff. A complete agenda and list of contacts is included at the end of this report as Annexes C and D. A list of documents provided by PCI, USAID and others is included as Annex E.

III. MAJOR FINDINGS

A. PCI/GUATEMALA PROGRAM RESULTS

Current Status of the PCI/Guatemala Program

In its original proposal, PCI proposed a "...four-year program of focused technical assistance to assist 10 or more selected NGOs develop the capacity necessary to provide primary health care services, particularly reproductive health services, in approximately 20 targeted municipalities with a total catchment area of up to 1 million people."

As part of this proposal, it identified a Mayan, women-managed NGO, *Rxiin T'namet*, as a major implementing partner, which would be primarily responsible for training. *Rxiin T'namet* has a community health outreach program in Santiago Atitlán similar to that proposed by PCI in its response to the USAID request for applications (RFA). The two organizations also had a long history of previous collaboration.

At present, PCI is halfway through its four-year agreement. The project employs a staff of 28, and has a main office in Guatemala City (14 employees). It also has a regional office in Quetzaltenango (10), and small offices in both Huehuetenango (2) and Ixcán (1), in addition to a training center operated and staffed by *Rxiin T'namet* in Santiago Atitlán (1).

Major project activities to date have included a survey (by questionnaire) of potential NGO partners, the completion of a comprehensive collection of baseline data, and subcontracts with five Mayan NGOs who currently participate in the PCI/Guatemala program. (Selection criteria developed by PCI for inclusion of NGOs in the project are found in Annex F. An update of activities subsequent to the evaluation team's work in Guatemala has been provided by PCI and can be found in Annex G) Under the terms of their subcontracts, participating organizations receive technical and financial support from the PCI agreement to develop their institutional capabilities to provide health services to communities in their catchment areas.

The five participating NGOs and their major areas of interest are described below.

1. ***Asociación Maya Pro-Salud (APROSAMI)***: This Mayan NGO is located in San Miguel Ixtahuacán, department of San Marcos, and has been in existence for about 10 years. Its membership is composed of health promoters and traditional birth attendants. Its expected coverage in 1999 is 12,743, approximately 43 percent of the total population in its catchment area.
2. ***Asociación Toto Integrado (ATI)***: ATI works in the rural areas of Totonicapán to improve the health of women and children through the

- integration of public health services and modern medicine with Mayan health values. The organization works primarily through traditional birth attendants (*comadronas*), traditional healers (*curanderos*), and spiritual guides (*guías espirituales*). In addition to health services, they provide clients with medicinal plants and other traditional treatments. ATI's expected total coverage in 1999 is 4,891, approximately 5 percent of the total catchment area.
3. ***Asociación de Comadronas de Ixcán “Nueva Vida” (ASOCVINU)***: This is a women's organization of approximately 250 traditional birth attendants representing 42 communities in the municipality of Ixcán, Quiché. The total population covered in 1999 is estimated to be about 9,290, about 19 percent of the catchment area.
 4. ***Asociación de Comadronas Mayas de Salud Materno Infantil (ACOMASMI)***. This is an organization of traditional birth attendants located in Todos Santos Cuchumatanes, Huehuetenango. It is currently working in 41 small communities, in conjunction with 4 physicians who receive some support from project funds. The total population covered in 1999 was 11,088, approximately 46 percent of the total catchment area.
 5. ***Consejo de Mujeres Mayas Para el Desarrollo de San Cristobal Totonicapán (CMM)*** CMM is a group of traditional birth attendants providing midwifery services in nine communities. It has been trained previously by the Pan American Health Organization (PAHO). This is a relatively urban NGO, and will have an estimated 1999 coverage of 22,666, or 67 percent of the total population in the area it covers.

Agreements with ACOMASMI and CMM are quite recent. PCI also had an agreement with a sixth NGO that was recently terminated. ***Asociación de Mujeres Ixpijakok (ADEMI)*** was formed to assist widows of Guatemala's civil war and provided support to rural communities surrounding Santa Apolonia, Chimaltenango. The estimated population covered by this NGO is 8,938.

More complete information on these partners is available from PCI/Guatemala.

PCI/Guatemala Program Strengths and Accomplishments

A number of definite strengths in the PCI/Guatemala program were identified. These provide a base from which PCI/Guatemala can build new program elements, where necessary, that will lead more directly to the results required under the agreement.

- The project's infrastructure is already in place and is adequate to support a quick restart of activities once the necessary management and program decisions to address some of the project's problems have been made;

- PCI/Guatemala has good relations in the field, and especially with MSPAS leadership (Area Director) in departments where the project currently works;
- The SIAS program, which has objected to the project in the past, is willing to initiate new work with PCI/Guatemala if areas of collaboration can be concretely defined;
- The project has strength in assisting NGO management and administration, for which demand exists, and other technical areas that are promising, especially the community pharmacies;
- PCI has a good baseline from which to evaluate future results and potentially provide the Mission with information that might not otherwise be available on the efficacy of NGO-based health services projects; and,
- The new project director has personal credibility with USAID partners and Guatemalan health officials in the MOH and rural areas.

With these strengths, PCI and the Mission should be able to develop an improved program strategy for the future.

PCI/Guatemala Progress on the Results Framework and Objectives

Tables 2 through 7 below summarize the project’s overall progress toward accomplishments specified in the agreement.¹ There is a table for each IR and its related LLRs (Table 2, for example) followed by a separate table for the indicators for each IR (Table 3, for example). This information was drawn from PCI reports and other documents provided to the evaluation team by PCI/Guatemala. (Some of these documents were in draft form and may have contained incomplete data.) Conclusions regarding progress on results and indicators and clinical coverage based on available data are in section IV. A short discussion of work conducted in Barillas and Ixcán, which are geographic areas mandated in the PCI agreement, is contained in section V.

Table 2: Intermediate Result 1 (IR 1): More Rural Families Use Quality Maternal and Child Health Services

| Indicator | Numbers | Accomplishments |
|-----------|---------|-----------------|
|-----------|---------|-----------------|

¹ Reporting Difficulties with Project Results: It is difficult to definitively describe PCI progress on results because reporting documents do not consistently use the IR, LLR and indicators format. Information is usually narrative, and often does not include quantitative figures. In addition, PCI has tabulated considerable information that does not correspond to the indicators, so it cannot be used for the purpose of reporting on results. For example, PCI reports number of volunteers trained in educational messages for mothers, but number of households or mothers that have received the messages are not consistently reported. In clinical coverage, prenatal care is reported, but not according to first or second prenatal visit, or visit in the third trimester, as the indicator requires. Treatments for acute respiratory infections are reported, but not percent of pneumonia cases of children under 5 treated at health facilities, as required by the indicator. Given these reporting difficulties, it is possible that PCI has made somewhat more progress on the results and indicators than was able to be determined during this evaluation.

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| LLR 1.1 More households in priority areas adopt better health care practices | No reporting standard | <ul style="list-style-type: none"> ▪ The PCI information system reports only on the number of cases that receive some type of clinical treatment, not the number of households benefited. ▪ Number of educational talks by educators and volunteers are reported sporadically, but there is no information linking these to changes in households or better health practices. |
| LLR 1.2 More community agents provide quality care | No measures related to result | <ul style="list-style-type: none"> ▪ 5 NGOs currently have 404 volunteers; these have received some training through NGO educators, but cannot yet be considered fully trained to provide quality care. In September 1999, 114 of these volunteers received additional training to manage 57 community pharmacies (2 volunteers per unit). |
| LLR 1.3 More health facilities provide quality services | No measures related to result | <ul style="list-style-type: none"> ▪ The result here depends on the definition of what is to be considered “health facilities” and “quality services.” ▪ One NGO (ATI) provides clinical services at its headquarters some days of the week. Mostly, NGO nurses and educators visit and provide some clinical services to approximately 66 small communities at community-defined meeting places (<i>centros de convergencia</i>). These cannot be considered “quality services” because coverage is incipient and provider training is not complete. ▪ There are also 4 physicians providing health services through ACOMASMI in Todos Santos, Huehuetenango. The quality of the service has not been evaluated or documented. ▪ If the 57 community pharmacies are considered “health facilities,” then 57 were initiated in September but no information about quality yet exists. |

Table 3: Indicators for IR 1

| Indicator | Number of Cases Treated (reported by NGOs) |
|---|---|
| Percent of women with obstetrical complications or danger signs who arrive at appropriate health care facilities. Target: 20% annual increase | No data |
| Percent of births with interval of 2 years or greater. Target: From 70 to 73 by 2001 | No data |
| Percent of women completing 2 prenatal care visits (at least one in the last month of pregnancy). Target: 100% increase by year 2001 | 441 visits for prenatal care reported |
| Vaccination coverage of children aged 12–23 months (polio, measles, DPT3, BCG; each separately and percentage of fully immunized children). Target: Increase to 80% by 2001 | 7,734 doses of vaccine provided |
| Percent of diarrheal episodes in children under 5 years treated with oral rehydration therapy (ORT). Target: Increase to 80% by 2001 | 428 cases treated |
| Percent of pneumonia cases of children under 5 years treated at health facilities. Target: Increase to 75% by 2001 | 221 cases of IRA treated |
| Percent of children exclusively breastfed for first 6 months. Target: Increase to 65% by 2001 | No data |

Table 4: Intermediate Result 2 (IR2): Maternal Child Health Programs Better Managed

| Indicator | Number | Accomplishments |
|--|--|---|
| LLR 2.1 Supplies and equipment are continuously available | 57 community pharmacies | 57 community pharmacies have been established in September 1999. No results are available yet. |
| LLR 2.2 Improved financial and administrative systems to support decision-making | 5 NGOs | 5 NGOs have been trained and have, as of September 1999, a functional administrative system. |
| LLR 2.3 Communities actively participate in decision-making | -- | Some meetings between the NGO, PCI and the communities are reported. There is no systematic reporting of these meetings or linkage of the meetings that do occur to a decision-making result. |
| LLR 2.4 Program planning, monitoring and evaluation are based on quality data | 5 NGOs use baseline survey data and census data for planning | The baseline surveys were used in the induction training of the 5 NGOs. Information from the community censuses is used by PCI and the NGOs to plan activities. |

Table 5: Indicators for IR 2

| Indicator | Number |
|---|---|
| Number of days of stockouts of vaccines, contraceptives and clortrimoxazole | <ul style="list-style-type: none"> ▪ Not reported as such. No contraceptives are being managed logistically to date. Vaccine is being provided by MOH at the local level; documentation of vaccine availability has not been implemented. ▪ Clortrimoxazole is now available in the 57 community pharmacies, but there is no information yet available about use or resupply. |
| Percent of facilities with adequate (between the minimum and maximum range) stock | Same as above |
| Percent of participating communities using participatory methodologies for maternal and child health (MCH) services, including problem solving, implementation and monitoring/ evaluation modules | Not reported |
| Percent of participating communities using participatory surveillance/ monitoring plans (based on key health indicators) for decision-making | Not reported |
| Number of local maternities established by community members with support from the MOH and local NGOs | None to date |

Table 6: Intermediate Result 3 (IR 3): Greater Local Advocacy for Improved Access to Health Care, Especially Women

| Indicator | Number | Accomplishments |
|---|-----------------------|--|
| LLR 3.1 Local-level entities facilitate advocacy activities | No data | No data |
| LLR 3.2 Documentation and dissemination of lessons learned at the local level | -- | 5 NGOs share lessons learned of administrative systems |
| LLR 3.3 Linkages/partnerships formed with national-level advocacy activities | None reported as such | None reported as such |

Table 7: PCI's Proposed Indicators for Advocacy

| First Set of Indicators Proposed by PCI | |
|---|---|
| Indicator | Data |
| Percent of NGO personnel of Mayan descent | 40% |
| Percent of NGO personnel that are female | 85.7% |
| Percent of NGO board members that are female | 33% reported initially; number has increased over 2 years |
| Number of Mayan-based health NGO conferences held | No data |
| Number of NGO members in a Mayan health alliance | No data |
| Number of advocacy initiatives identified and enacted by a Mayan health alliance | No data |
| Additional Indicators Proposed by PCI in the Second Monitoring Plan | |
| Indicator | Data |
| Number of female volunteers | 77.7 % |
| Number of new projects, initiatives, actions executed by Mayan health alliance | No data |
| Number of experiences exchanged between 2 or more NGOs | The administrative experience of the 5 NGOs has been shared |
| Number of volunteers mobilized to participate actively in the strategic planning of health activities | No data |
| Number of plans and strategies elaborated for health activities | 1 work plan per NGO has been elaborated |
| Number of NGOs that have events, meetings to analyze/evaluate health situation | Not systematically documented or presented |

PCI Coverage and Service Delivery

As suggested by the above tables, PCI/Guatemala shows little progress on meeting Intermediate and Lower Level Results and Indicators over the first two years of project activity. Some of the low numbers and/or the lack of reported progress might be due to inconsistent reporting standards and the fact that there is not yet a monitoring and evaluation system functioning adequately. Still, these results do not represent a performance effort consistent with PCI's own projections for this four-year project, nor do they approach USAID/G-CAP's performance expectations, as suggested by the indicators in the agreement.

The information available on clinical coverage, which began in March 1999, also indicates that the project has made little headway in extending access to basic health care to rural families, although the reporting system may understate it somewhat. Tables 5 and 6, which represent the only summarized information available on clinical services at the time of the evaluation, illustrate some of the reporting problems, but allow some crude estimates of clinical outreach to be made.

Table 8 reports activities by time period (March–August 1999) but includes information from only three NGOs: ATI (Totonicapán), APROSAMI (San Miguel Ixtahuacan), ACOMASMI (Todos Santos, Huehuetenango). The data on CMM (San Cristobal

Totonicapán), ASOCVINU (Ixcán) and ADEMI (Chimaltenango) are not reported. Table 9, below, reports activities by geographic area, not by NGO, but does not include Ixcán. It does not state a reporting period, although it presumably represents coverage from March–June 1999, as it was included in the project’s semi-annual report for January–June 1999. Since the numbers in the two tables do not coincide, they must reflect differences in time periods or different geographic coverage, or both.

Table 8: Clinical Services Provided by ATI, APROSAMI, ACOMASMI During March–August 1999

| Activity | Number |
|--|-------------|
| Prenatal care | 441 |
| Postnatal care | 91 |
| Children immunization | 7,734 doses |
| Pregnancy tetanus toxoid | 1,183 doses |
| Treatment of diarrhea | 428 |
| Treatment of acute respiratory infection (ARI) | 221 |
| Treatment of pneumonia | 68 |
| General morbidity | 935 |
| Emergencies | 21 |
| Growth control | 40 |
| Clinic consultations | 984 |
| Case follow up | 43 |
| E.E. control (not explained) | 38 |
| Referrals | 14 |

Table 9: Clinical Services in Totonicapán, San Miguel Ixtahuacán, Chimaltenango and Todos Santos

| Clinical Care | Number of Cases |
|------------------------|-----------------|
| Prenatal care | 278 |
| Postnatal care | 36 |
| Diarrhea treatment | 37 |
| Treatment of pneumonia | 15 |
| Treatment of ARI | 140 |
| General attention | 722 |
| Emergencies | 11 |
| Growth control | 21 |
| Birth spacing control | 18 |
| Clinic consultations | 657 |
| Case follow up | 37 |
| Referrals | 13 |
| TOTAL | 1,989 |

Source: *PCI Informe Semestral Enero – Junio, 1999* (First Semester Report of PCI Covering January–June, 1999), Annex 1, page 10, *Cuadro de resultados vinculados con el Plan Operativo Anual*

Average monthly vaccination coverage calculated from Table 8 results in an average of 429 vaccines for children per month per NGO from March through August 1999, and 65.7 tetanus toxoid for women per month. Based on Table 9 (assuming that it covers the four months from March through June 1999 and that each of the four geographic areas represents an NGO), each NGO averaged 124 clinical encounters a month. These

figures, although estimates, are quite low when compared with the results and indicators in the PCI agreement.²

In terms of non-clinical coverage, PCI reports offer some information, particularly on volunteer contacts with mothers and other community members. However, these figures tend to be inconsistent and overlapping so that it is not possible to estimate an average level of contact apart from clinical encounters (which may include both counseling by volunteers and the provision of a service, such as an immunization). Nevertheless, these numbers are of the same order of magnitude as the coverage numbers discussed above and, overall, are small relative to the anticipated accomplishments of the project.

PCI's progress on results and indicators, as well as the low estimates of coverage, can be partially explained by the fact that the project was in start up and that it encountered a number of implementation problems (discussed below) which affected performance. These numbers, however, cannot be expected to increase substantially as the project's NGOs become more proficient at service delivery, primarily because of the size of the NGOs, their coverage areas and institutional capacities. This has implications for the project's accomplishments in the long term, as health services delivered through PCI NGOs, however calculated or defined, will still only reach a small percentage of the anticipated coverage of the rural population. If coverage is to be increased significantly and the project is to make progress consistent with the size of PCI's agreement with USAID/G-CAP, other strategies must be considered.

Barillas and Ixcán

Notwithstanding PCI/Guatemala's specific mandate to develop activities in Barillas and Ixcán, the project results can be reviewed briefly.

- **Barillas:** PCI has not yet developed any activities in Barillas, largely because of difficulties with the SIAS coordinator in Huehuetenango. Now that this coordinator has left, the project is actively looking for opportunities to work in the area.
- **Ixcán:** PCI started activities in Ixcán in May 1999 with ASOCVINU. PCI chose to work with this NGO apparently because it was composed of women, it had legal status, and it had a certain degree of independence from the big NGO associations in Ixcán. The group is small and works in extremely isolated communities, often under very adverse conditions. ASOCVINU has no real infrastructure and the likelihood of expansion is minimal.

² In the future, PCI should consider improving the way clinical services are reported, including the definitions of clinical categories. Categories such as case follow up, referrals, clinical counseling, emergencies, general attention, and morbidity need to be expanded to include a diagnosis, where possible, and should be assigned to categories that contribute to the result and indicators. It is also important that each NGO report the same clinical categories so the numbers can be consolidated and aggregated. Finally, PCI should consider standardizing its reporting by time, geographic period and NGO so that types of coverage, as well as coverage trends, could be reported accurately.

Ixcán does, however, offer interesting possibilities for possible PCI involvement in the future. The degree of community organization in Ixcán is very strong and, for a variety of reasons, none of the large NGO associations has been willing to work with SIAS. Nevertheless, the head of MOH activities (Area Director) in Ixcán is currently negotiating with these groups and hopes they will be willing to apply for SIAS support in the future. He is particularly interested in PCI, and has asked (as have other health areas) if the organization could administer SIAS funds. (The possibilities of PCI entering this type of arrangement with the GOG to administer SIAS are discussed as an option for future activities under Option 2, in the recommendations.)

In conclusion, PCI/Guatemala progress toward the IRs, LLRs and indicators specified in the cooperative agreement may be judged as poor. It is also unlikely, given the current status of activities and the fact that only two years remain in the agreement, that PCI will be able to meet even a small percentage of its original coverage goals. A discussion of the major problems identified by the evaluation team that have affected performance to date follows.

B. PCI/GUATEMALA PROGRAM STRATEGIES

The original PCI proposal, upon which the cooperative agreement was based, is well written and ambitious. At the time of the award, the organization had a long-term relationship with a Mayan NGO, *Rxiin T'namet*, which was implementing health services at the community level. PCI's activities worldwide also suggested that it had the experience to implement this activity at scale. Finally, the proposal was attractive in its willingness to collaborate strongly with the MOH's SIAS program and for its emphasis on using local technical experts.

PCI has not been able, however, to translate these positive features into an effective program strategy for reaching the public health goals desired by the SO. The reasons for this are complex, but many of the project's biggest problems arise from assumptions made by the PCI program approach in the original proposal and choices made by the country team in defining the NGO selection criteria. This resulted in a country strategy which was at odds with the basic objectives of the Mission's SO and which could not possibly meet the results defined in the agreement.

Difficulties with the Program Approach

In its proposal, PCI made a basic assumption that its successful, long-term relationship with *Rxiin T'namet* constituted a model which was replicable with other Mayan NGOs. This is a compelling strategy, as *Rxiin T'namet* typifies many aspects of NGO development that PCI wished to replicate through this agreement. It is a successful, indigenous organization that is directed and managed by Mayan women. PCI also assumed that this replication was feasible as a strategy to meet project objectives. In fact, neither supposition was probably accurate, for reasons which were both particular to the PCI-*Rxiin T'namet* partnership and characteristics of *Rxiin T'namet* as an organization. Some reasons for this are:

- PCI's relationship with *Rxiin T'namet* had extended over 23 years. The amount of support and degree of interaction probably varied over time, but the roots of the partnership were deep and built on a certain amount of mutual trust and support. It was unlikely that the main characteristics of such a relationship could be distilled and transferred to other Mayan organizations within a four-year project.
- The sustainability/self-reliance process which PCI showcases so heavily in its proposal and which starred *Rxiin T'namet*, is a long and complicated process. Four project years is not enough time to make serious inroads on this objective, especially given the kinds of organizations PCI sought as partners.
- As an organization, *Rxiin T'namet* has many elements which make its experience highly individualistic. These include a relatively well-defined geographic area and population, accessible communities in an area of Guatemala that has seen development and infusions of foreign money not available to most rural areas, international attention and support for its activities, and a history of dynamic Mayan women in leadership positions.
- The area and population covered by *Rxiin T'namet* is relatively small. The organization is also quite small and the relationships among staff members are highly personalistic. Size alone would suggest that it is not a model for large-scale expansion into rural areas.
- The PCI proposal suggests that *Rxiin T'namet*, as a Mayan institution, will facilitate its relationships with other NGOs. However, interviews suggest that this assumption was not accurate. The strong alliance between these two organizations was probably a deterrent that kept some Mayan NGOs out of the PCI program.

In addition to these assumptions, the PCI country team chose to interpret the cooperative agreement's emphasis on a Mayan gender focus restrictively when it defined the selection criteria for the NGOs with which it would work. These criteria (see Annex F), which are suggested in the proposal and detailed in the January 30, 1998, quarterly report, sharply limit PCI counterparts to women-oriented and managed grassroots Mayan NGOs in indigenous rural communities.

These selection criteria were defended strongly by the PCI country director and some members of his team, in spite of clear reservations expressed by USAID/G-CAP managers about the size and abilities of organizations that PCI initially identified as partners using these criteria. Despite the fact that these same criteria were later described to other organizations and the SIAS program as the restrictions that USAID had placed on the project (and as such, became the excuse for PCI's inability to collaborate more fully with the MOH and others), PCI itself had defined the strategy.

The decision to implement the project by strengthening Mayan grassroots organizations, such as *Rxiin T'namet*, was based on PCI's interpretation of the Mission's request for applications (RFA), not a requirement of that document. PCI chose its own model for providing health services and set its own criteria for NGO participation. Obviously, these decisions had long-range implications for performance. Even if PCI succeeded in identifying and strengthening the 10 NGOs that it had originally proposed, the project would never approach the coverage goals described in the proposal, nor could it make much progress on the indicators outlined in the agreement.

Lack of Strategic Plan or Framework to Achieve Results

Project documents show that PCI never had a comprehensive strategic plan for implementing the Guatemalan program. Within the proposal itself, training and other activities are not systematically linked to results. There is also no clear sense that PCI appreciated the complexity of program elements they proposed, particularly in technical areas where neither PCI nor *Rxiin T'namet* had expertise (e.g., implementation of IMCI or strategies for improving perinatal and neonatal care). Similarly, the timetables proposed for many activities were unrealistic (e.g., identification of NGO partners, establishment of basic clinical services). Even some management-related activities where PCI has much experience (e.g., logistics systems for supplies, escalation of NGO counterpart contributions, assumption of managerial self-sustainability) are proposed without reference to the need for planning, logistics, and in some cases, extended negotiations with NGOs and partners.

This lack of planning and a realistic time frame for activities in the proposal carried over into the country program. As a result, PCI's quarterly and semi-annual reports and the work plans produced during the first two years are largely process oriented and rely on descriptions of activities either implemented or planned, rather than progress toward results. While the project did have some accomplishments during its early phases (e.g., the baseline surveys and identification of some partners), planning was not linked to outcomes and indicators, and the strategy, such as it was, relied strongly on "targets of opportunity." Given this, most activities reflected fairly short-term goals, which were vulnerable to changes in the fluid political and social environment around health sector activities in Guatemala. Nowhere in the documents that were produced up to the departure of the first PCI project director in July 1999, is there a vision of what the project needs to do to accomplish the tasks which it had set out for itself. Lacking this, it fell into an early pattern of blaming others for externally defined objectives, which the project was unable to achieve.

Role of Differing Institutional Objectives

Despite initial assumptions of partnership, USAID/Guatemala and PCI brought very different institutional perspectives to the project. Based on its health strategy, the Mission viewed PCI's activities as one partner among many to reach the objectives of the SO. PCI, on the other hand, is a U.S. PVO with its deepest roots in broad community development, although its international activities usually have a sector focus. Its approach is strongly weighted to activities which lead to development of local identity,

creation of infrastructure and management systems, adequate reporting and, ultimately, self-sufficiency. Further, much of its international work has been performed under cooperative agreements, mechanisms which allow recipients great flexibility for implementing activities, but which give funding agencies little role in management and almost no enforcement ability.

Many of USAID's criticisms about the PCI project stem from these basic organizational differences and PCI's inability to respond flexibly to what were probably new emphases and requirements for the organization. PCI's previous work in Guatemala's health sector was limited, and it was not well prepared to move aggressively into the delivery of services and the extension of coverage, as it had promised and as USAID expected. PCI also had little experience with Results Packages and probably did not understand, or take seriously, the implications of having its performance evaluated against a well-articulated Results Framework and indicators. Nevertheless, PCI did understand very well the cooperative agreement mechanism, and when problems occurred, PCI was able to use the agreement's protective structure as a shelter for nonperformance in areas that USAID considered critical.

Institutional Strengthening Versus Service Delivery

PCI's decision to work with extremely small NGOs is not surprising, but the size of NGOs chosen insured that they must make substantial project investments in institutional strengthening—a process which PCI understood well. The delivery of health services and the strengthening of clinical skills for organizations with little experience became a secondary focus.

At present, PCI/Guatemala maintains that the five NGOs are about halfway through an elaborate institutional strengthening process, which, if successfully completed, would presumably take them to self-sufficiency. While the assumptions about overall progress to sustainability might be questioned, PCI/Guatemala has invested heavily in this process, which could be carried out without strong clinical or technical staff, which the project generally lacked in the first two years. Strategically, however, this strengthening process delayed, rather than supported, the extension of health services. While some of these activities are good and may be the roots of work PCI can carry to scale in a revision of the project, this has been an expensive investment, and was certainly at odds with USAID/G-CAP expectations.

Client Focus and Household Prevention Strategies

Under the terms of its original proposal, PCI had identified community and household promotion as a critical program area in response to the Mission's strong emphasis on mothers, families, households and communities. Twenty-one months into the program, however, the key personnel position which would have supervised such activities remains vacant and this aspect of the program has not been developed. This may be one of the most serious problems with PCI's ability to meet lower level results, especially in IR1, which specifically addresses the needs of clients.

Based on the documentation PCI/Guatemala provided to the evaluation team, past programming for the lowest (and arguably, most important) level of the client hierarchy—the mother and the household—are summarized as follows:

- There is an implicit assumption that benefits to the NGO will eventually accrue to the community and, finally, to the individual. This puts households and families at the bottom of the pyramid of activities.
- Current informational training (which assumes that individuals will act appropriately on the basis of information) for educators (*educadoras*), volunteers (*voluntarios*), and health guardians (*vigilantes de salud*) is thought to compose a sufficient community-based strategy for addressing family health issues.
- There is a presumption that the same strategies for community mobilization (e.g., community-level plans for obstetrical emergencies) can be used to motivate and change the behavior of individuals at the household level (e.g., exclusive breastfeeding).

These assumptions have led PCI/Guatemala away from programming that targets the client and/or the household, or emphasizes prevention as a strategy to protect or improve health status. This is an important missed opportunity, as PCI/Guatemala does have strengths and experience at the community level that would facilitate such a focus. It is also an area that could offer the project a niche where it could complement, rather than compete with, other programs.

Advocacy

The document that describes PCI/Guatemala's approach to advocacy, as well as the indicators used to measure it, suggest little progress in defining and implementing this important part of the project. The currently proposed approach, as well as the advocacy indicators in the monitoring and evaluation plan, lacks definition and clarity, and is not technically sound.

To develop this IR, PCI/Guatemala would need to hire new staff and identify external consultants with experience in advocacy who could provide technical assistance to address these issues and develop a coherent and effective strategy. Current PCI staff members do not have this expertise; to continue their efforts in an area they do not seem to understand is a poor use of time and resources.

As this technical area is one of the weakest in the PCI organization, it should be considered carefully in the reformulation of the project. USAID/G-CAP and PCI may wish to redirect efforts expended here into areas that would have higher long-term benefits for both organizations.

C. CLINICAL AND NON-CLINICAL SERVICES

Clinical Services

The PCI/Guatemala–supported clinical system is based on strengthening the institutional and health services systems of small NGOs that meet the project selection criteria and whose members are already providing some type of health service (e.g., traditional birth attendants). Ideally, the project then provides the financial and administrative support to extend its existing expertise to other health areas and enlarge its community outreach. The NGO health services system that flows from this support is based on a cascade model, which assumes that each level of personnel trains, and to some degree supervises, the level subordinate to it.

Through its agreement with PCI/Guatemala, the NGO hires clinical personnel (usually a professional or auxiliary nurse and several community educators) who subsequently receive training from *Rxiin T'namet*. In some cases, PCI has also assisted organizations to develop or improve a small clinic at their headquarters and/or provide partial support to physicians to improve outreach and service quality. Nurses and educators work directly with communities to identify and recruit volunteers, who agree to be responsible for up to 20 families. Volunteer duties include such tasks as identification of pregnant women, assuring that children are fully immunized, and encouraging women to attend the periodic meetings that the NGO holds in the community for educational talks and/or to provide some basic clinical services.

PCI/Guatemala's system for delivery of clinical services is in the very early phases and cannot be said to work well in any component, or to provide much in the way of quality services. The major shortcomings are:

- Clinical services offered by the NGO do not yet extend much beyond what the organization offered in the first place, although its outreach may be greater. This may be partially related to an NGO's time in the program, but it also reflects other faults in the clinical strategy.
- Clinical skills of most hired staff are very basic and will need upgrading; the training provided by *Rxiin T'namet* over the past year was an introduction to clinical services and adult education strategies, and not intended to increase the clinical skills of participants or to improve their ability to train others in clinical areas.
- Only NGO nurses and educators receive training; there are no plans to train volunteers directly in clinical areas, with the exception of the volunteers who manage the community pharmacies and there are no plans for imparting or improving clinical skills of community workers beyond periodic training by educators.

- There is no monitoring or supervision strategy for the delivery of clinical services by nurses, educators, or the volunteers they train, nor does PCI/Guatemala yet have a functioning evaluation system.

For the PCI service delivery model to work effectively and to provide quality clinical services, the NGO staff and the volunteers need extensive training and strengthening of their clinical skills. Standards of care and all the other crucial elements of a quality service delivery model currently do not exist and would have to be developed and placed in the system. The costs associated with these efforts will be considerable, and it is unclear if, even with large technical and financial inputs from PCI, these NGOs would be able to deliver quality care to a population size that would justify the expenditure.

What must be defined in the short term is the exact package of services that these NGOs can and should provide. Once this is established, quality checks can be inserted into the system. Finally, once there is a clear definition of that package of services, an appropriate monitoring and evaluation system can be developed or adapted.

Non-Clinical Services Strategies

PCI has two services strategies that might be called non-clinical, although one, the community pharmacies, will probably carry a major share of the curative caseload of the project, if they are successful. This strategy, and the use of other volunteers, is summarized below.

PCI is one of many organizations in Guatemala, including the MOH, which supports the distribution of medicines to rural areas through community pharmacies. In September 1999, the first sets of community pharmacy items were delivered to project volunteers after training through the *Fundacion Dolores Bedoya*, which PCI had subcontracted to train 30 educators/nurses and 114 volunteers in their use and management.

When this evaluation was carried out, the community pharmacy items had just been handed out and it was too early to evaluate their operation. However, considering that these are the volunteers that have higher competency levels than the rest of the project volunteers, it has been considered that the volunteers that manage community pharmacies can become the second level of clinical care that the project can provide at the community level.

The five NGOs working with PCI at present have a network of 402 volunteers contacted to date (114 are working with community pharmacies). The other 288 volunteers were selected by the community and have received some training through the educators, who are also responsible for their supervision and monitoring. Each volunteer is responsible for 20 families in his or her community. It is not yet clear how the volunteers are performing these tasks, or what the effectiveness of this approach has been.

D. TRAINING; INFORMATION, EDUCATION AND COMMUNICATIONS (IEC) ACTIVITIES; AND BEHAVIOR CHANGE STRATEGIES

PCI activities in training, IEC and behavior change were developed as a single program component, without a comprehensive strategy or coherent approach. The project never defined behavioral objectives or goals for activities carried out in these areas, and project documents suggest that there was much confusion about what these strategies involved (e.g., PCI reporting often treats training materials and IEC as synonymous). The end result was that much of the completed work was ineffective. Here, as in other technical areas, the lack of senior staff to oversee and guide implementation had strong negative effects on the program's direction and shape.

Training

Training was a major program output during the first two years. Between November 1998 and May 1999, six training courses for NGO clinical staff (auxiliary and professional nurses, educators and, in some cases, physicians and administrative personnel) were organized by *Rxiin T'namet* and PCI/Guatemala. PCI documents refer to these courses as clinical training, but they were not, in fact, training which would impart or improve clinical skills. Rather, they were designed as an introduction to key messages (*mensajes claves*), to familiarize NGO personnel with the main topics in each clinical area. Clinical skills would, presumably, be taught in later training sessions.

Participants in these courses were the clinical personnel of the NGO partners who would oversee the extension of services to the communities, including auxiliary and graduate nurses, educators and, in some cases, physicians and administrative staff. The overall strategy was to train the same personnel in all areas, so participants were, ideally, the same ones for all courses. This did not happen often because NGO partners changed, as did staff members.

The main training methodologies used in these courses were based on adult and continuing education, and materials used in the above courses were supplied by *Rxiin T'namet*. The most complete sets are in the area of family planning, but at the time of the evaluation, other materials were under development, including a manual for child survival. No materials from other USAID projects were used, although the director of *Rxiin T'namet* reports that that was the original intention. Trainees were also provided with copies of some materials from other sources.

Overall, these training courses have many deficiencies. They were held before a needs assessment was conducted for either participants or communities. They are primarily targeted to NGO educators, without any follow-up strategy for supervision and monitoring to insure their understanding and management of course content. There are no provisions for monitoring the follow-up training of volunteers or ways to assure service quality at that level. The most significant weakness in this training strategy, however, is that NGO personnel who participated were no more prepared to do the project's primary work—the delivery of health services—at the conclusion of the training than they were when the courses began.³

³ *The Role of Rxiin T'namet*. While it would be easy to fault *Rxiin T'namet* for the lack of specific accomplishments in light of its central role in the project, PCI's problems cannot easily be attributed to this

Administrative Training for NGOs

PCI does have one training initiative that is an exception to the points above—its training in administration for NGOs. These courses, begun in July 1999, seem well organized, focused and results oriented. The purpose of the training activities is to ensure that these organizations will be able to assume full responsibility for the management of annual budgets. At present, based on the three workshops that have been completed, all participating NGOs are managing their own funds, with ongoing PCI oversight and technical assistance. These latter are expected to diminish as NGOs gain experience and confidence in their ability to manage the budget process.

The overall quality of these activities needs to be measured in results, and although PCI/Guatemala claims that the organizations are now able to manage their budgets, time will be the real test, as the training is still in process. In some reports, the trainers actually seem to outnumber the trainees. Nevertheless, all of the components of a good training program are found here. Given the critical need for financial and administrative strengthening in Guatemalan NGOs generally, this may be one of the areas that PCI should consider formalizing and adapting for use in somewhat larger institutions.⁴

Information, Education and Communications (IEC) Activities

The PCI project never had a specific IEC strategy although it did, through *Rxiin T'namet*, commit resources for the development of materials in relation to training activities. IEC is a topic discussed in many of the project's reports, but responses to queries about specific activities were usually vague. Among NGOs, however, there seems to be a lively interest in having more and better materials for community education. While there may be some methodological debate about whether top-down messages from health volunteers is the best way to change community or individual behavior, the fact remains that they are the main contact with the project's clients. Better support for their efforts, including materials and (where practical) equipment, would seem to make sense, especially if it supported work in prevention.

Behavior Change Strategies

small organization. *Rxiin T'namet* clearly saw the project as an opportunity to expand its sphere of influence and activities. It agreed with PCI to develop, staff and operate a training center, as well as to help support the institutional strengthening activities. There is also little doubt that *Rxiin T'namet* was a full partner in many of the project's major decisions. The definition of criteria and selection of the participating NGOs, the development of new training materials and the dilution of clinical training to more informational courses which could be easily managed by *Rxiin T'namet* staff probably all reflect some opinions of that organization's competent director. Ultimately, however, it was PCI that was responsible for the project's decisions, not a small NGO that accepted a role it may not have well understood and which was probably beyond its institutional capabilities.

⁴ These comments should not be taken to apply to the entire package of institutional strengthening activities that has been defined by PCI. Most of these activities are not relevant to the larger issues of health service delivery at this time, and they distract significantly from the main objective—the delivery of health services.

It is very difficult to know if PCI had accomplishments in the area of behavior change at the household or individual level. Certainly the project had no explicit activities, and project staff generally does not distinguish between the behaviors or actions of the community and the individual, suggesting that they may be seen as the same thing. More significantly, there are no client-focused activities independent of volunteer training.

Community and household programming and prevention were, however, an emphasis of the original PCI proposal and it is probably also an institutional strength of the larger PCI organization. After two years, the project now has good rural and community experience, despite many of its other problems, and it should try to capitalize on this experience. This may be an excellent time to reconsider some aspects of its former strategy and see if this experience might be leveraged into some prevention and behavior change activities.

E. MONITORING AND EVALUATION

Monitoring and Evaluation Plan for 1998

The first monitoring and evaluation plan was submitted to USAID/G-CAP in March 1998 and was approved for the year, with the understanding that a revised plan would be submitted in 1999 for the remainder of the agreement period. The 1998 plan incorporated the IRs and LLRs, but it was not complete and lacked a clear and detailed strategy. The only indicator data that were to be obtained directly from the communities and/or households were for IR 1, by a population-based household survey. All other indicators were to be measured at the level of the NGO's tasks or activities.

The NGO as a measuring unit for these indicators was the easiest way to obtain the information, but it assumes that the NGO activity successfully reaches or benefits communities, households, mothers, and children. However, process indicators in institutions that provide services do not translate automatically into benefits for the population.

In 1998, the project's implementation strategy and concrete activities to archive the IRs and LLRs were not yet clear and this lack of clarity is reflected in the initial performance and monitoring plan.

Monitoring and Evaluation Plan for 1999

A draft revised monitoring and evaluation plan was submitted in August 1999. USAID/G-CAP provided PCI with lengthy comments on the plan and it was not approved. It has not been resubmitted, nor should it be until there is consensus about the activities to be pursued for the remainder of the agreement.

The draft monitoring and evaluation plan was based on the work plan, its objectives and IR3. It includes indicators of results, products, process, and impact. The plan includes many of the required elements, but as presented, they are rather disconnected and appear to lack a logical or functional framework.

The data for IR1 are to be collected by the different service providers, volunteers, educators, and clinical staff. The instruments for reporting have been made simple. However, the system has not yet been piloted and validated to find out if it really works for the volunteers. The investment in time, training, supervision, quality checking, and consolidation of the information as it is currently conceptualized might easily overburden volunteers and educators and cause the system to fail.

Most activities regarding IR2 and IR3 and the LLRs are to be reported by the NGOs. A series of process indicators are described, but they are not constructed so that the summary of the process indicators feeds logically into product and impact indicators. They appear as an isolated recording of activities. The manner in which the indicators and the procedure to obtain the information are described is neither systematic nor very clear. This lack of clarity is probably the consequence of the lack of a clear and precise work plan, in which all activities are linked to precise results, products and indicators.

In theory, the plan is similar to the health information systems that have been traditionally used by the MOH, other big NGOs or the SIAS today. It is based on the assumption that it will be managed by well-trained, capable, well-supervised personnel who will have enough time and skills to fill out all the forms and present clean data in the consolidated forms. This assumption, however, has not produced very positive results with other institutions. For example, the SIAS system that works with similar indicators and similar personnel with its NGOs is already facing problems of quality and quantity of data. Also, it is not clear if the information generated in its present form is compatible with the basic SIAS indicators that the MOH would like to be used and reported at the national level.

The indicators used for IR3 (advocacy) need improvement. Discussions with USAID partners that have specific technical experience with these kinds of interventions and their measurement are likely to be useful.

It was clear that PCI made a significant effort in recent months in developing the revised plan. However, the vague strategies for the overall project directly affected the evaluation plan. If the activities are not clear, the evaluation plan cannot be clear. Therefore, if the main activities of the project are restructured, the evaluation plan should be adapted or redesigned accordingly.

F. MANAGEMENT

The PCI project has suffered from serious management problems since its inception. As noted earlier, some of the poor management performance stems from misguided assumptions about project strategy, rigid and unnecessary selection criteria for NGOs, and little or no planning in critical areas. These exaggerated the normal difficulties associated with any project start up, but they were also compounded by two other factors: poor project leadership and inability to keep technical staff who might have helped overcome these issues.

Many of PCI's management problems in the first two years are directly attributable to its choice of a country project director. The organization has now addressed this problem with the hiring of an experienced Guatemalan physician. It is important to note, however, that the former director left a legacy of few accomplishments, negative relations with important national and international players, and a staff that is ill-equipped for a major re-start of the PCI country program. The new project director will need a great deal of assistance and support from both PCI headquarters in San Diego and USAID/G-CAP to redirect the project towards its original goals.

The most important management issue that the new project director will have to address will be staffing. In the past, PCI did identify and hire a number of skilled Guatemalan professionals but, for the most part, they stayed with the project for only a short time. As a result, many key technical staff positions were vacant or filled by subordinates for long periods of time, with concomitant negative effects on the program. The project does not currently have the number and type of qualified technical staff to mount a new program and carry it through to success. However, there is staff potential, especially in the Quetzaltenango and Ixcán offices, and the project has some solid, experienced professionals who would find a role in new initiatives. Overall, PCI needs a solid technical and management team, many of whom will have to be new hires. This is the single most important action that can be taken to redirect the project and it needs to happen soon.

G. COORDINATION

In general terms, the previous management style of the project did not facilitate or seek the coordination and cooperation of the other U.S. PVO partners of USAID or the public sector. The result is that almost no coordination, cooperation or joint activities were carried out in the project with other PVOs or the MOH. However, the communication and relationship of the current director and field staff with the area directors (*jefes de area*) where PCI is currently working are good; they all expressed their desire for PCI to continue to work and expand its activities in their departments.

Partnerships

Population Council

Some exploratory visits with this partner have been conducted. No specific or concrete coordination or activities are being carried out jointly. The Council's Guatemalan project director did not believe that there were obvious areas of collaboration, as it already had adequate resources and a well-developed, successful program. The program director of NGO activities, however, expressed willingness to exchange experiences with PCI and to provide PCI with copies of its materials.

APROFAM

Some exploratory visits to this partner have been conducted. No specific or concrete coordination or activities are being carried out jointly yet. APROFAM considered PCI to have resources and established community connections that could be very valuable for

future cooperation and coordination, especially in remote areas, such as Ixcán and Barillas.

MotherCare Project

Some of the materials that have been developed by the MotherCare project have been used in some training activities by *Rxiin T'namet*. No further interaction between these two USAID-funded partners has occurred.

Policy Project

The PCI proposal described the Policy Project as the main technical resource and partner for developing the advocacy activities required in the PCI agreement, but this collaboration has not occurred. Two or three meetings have been held with Policy, the first one facilitated by the Mission's PCI project officer. The management and coordination style of the previous PCI project director did not allow this coordination to prosper.

Relationship with SIAS

The SIAS coordinator expressed to the evaluation team that SIAS has always been open to collaboration with PCI. However, PCI never presented a concrete plan of action with geographical specifications, so no concrete mechanisms for coordination were established. SIAS is willing to cooperate and coordinate with PCI under the new directorship of the project.

H. FINANCIAL MANAGEMENT

Budget and Expenditures

The total funding for the PCI project is \$6,340,878 from USAID/G-CAP and \$3,810,294 (cash and in-kind) from PCI, for a total of \$10,151,172 available for the four-year project (September 1997 to September 2001). Through June 1999, USAID obligated \$4,039,362 for the project and PCI expended \$1,429,136 of it, leaving \$2,610,226 of USAID funding obligated but not spent for this project.

The rate of expenditures has been approximately \$80,000 per project month for the past 12 months. Spending for July, August and September could be approximately the same, although expatriate costs have been lower since the former project director left and the new director has put some of the project activities on hold (e.g., training). One new expenditure that has occurred in those last months has been subcontracting to the Dolores Bedoya Foundation for training volunteers in the management of community pharmacies and the procurement of the initial stock of medicines for the community pharmacies.

The largest line item budgeted for the duration of the project was NGO subgrants, in the amount of \$4,909,640.

The counterpart contributions in the agreement were 37.5 percent of the total. To date, PCI has contributed in-kind support and counterpart funds in the amount of \$233,053, which is 14.0 percent of the total amount expended. PCI is lagging behind in its counterpart contributions. It will be difficult for PCI to raise this amount of counterpart resources locally from the small NGOs with which it is working. Assistance from PCI/San Diego to support the local PCI project in this important matter should be one of the items discussed in meetings between USAID/G-CAP and PCI.

Sustainability and Cost Issues

PCI is currently working with very rural, dispersed Mayan populations in conditions of extreme poverty and with little or no access to health services. A sustainability and cost-recovery strategy for health services for such a population is very difficult. Some NGOs in the PCI program are successfully charging very small amounts (1 Quetzal) for providing consultations with the consent of the communities. This fee-for-service strategy is probably very useful for increasing the value of services in the mind of the client, and it may also help keep volunteers in a system if they benefit in some way from this nominal charge. It cannot, however, turn an NGO into a self-sufficient organization.

If one of PCI's main strategies for small NGOs is to be self-sufficient in two or three years when this project ends, much of the time and resources of these organizations will be spent looking for additional or future funding for their continuation. This emphasis on institutional strengthening already seems to have affected the process of implementing the delivery of health services. If it continues, it will likely distract time and effort from the community work that is a major focus of the project.

PCI should analyze its current efforts and consider adjustments as it formulates plans for the final project years. Certainly, NGOs can and should be open to receive other sources of funding, but this effort should not be a main activity. An exception to the decrease in emphasis on sustainability and cost recovery is the recently initiated community pharmacies. These pharmacies provide basic medicines at a very low cost, and will be sustainable if the revolving fund mechanism is managed appropriately. As the pharmacies also provide a small margin of gain to the health promoter, this also provides an incentive for the community health worker to stay active and remain in the system.

The institutional strengthening that PCI has developed in NGOs will, hopefully, make them eligible to obtain funding from other donors and from SIAS, provided that the SIAS strategy continues after the 1999 presidential elections. If, due to a change in government, the SIAS does not continue, all NGOs currently providing health services through SIAS funding will face financial problems. In any case, it is hoped that as PCI moves to extend coverage in the project, it will recruit institutions that will not need the intensive strengthening that has been necessary with its current partners.

IV. RECOMMENDATIONS

A. PROGRAM OPTIONS

PCI/Guatemala and the Mission now face a major task of setting priorities and restructuring project activities in response to the remaining budget and a more limited time frame (the original cooperative agreement is scheduled to end in September 2001). This will probably include substantial modification in the project's technical focus, performance objectives and activities.

The major options for reorganizing the project are described below, although the elements are interchangeable and should be to create a program that both PCI and the Mission can support. These have been discussed generally with the new project director, but do not necessarily represent his views on the project's future. Of these options, Option 4 offers PCI the best opportunity to create a place for itself in the complex network of organizations that support health activities in Guatemala. It would also provide the greatest benefit to the Mission's health portfolio, as it would target activities to areas where, at present, there is not as much focus as there is on the health service delivery system.

Option 1: Continue the Current Program

Under this option, PCI would modify, but generally continue the strategy outlined in the original PCI proposal submission. This would include an expansion of the total number of Mayan grassroots NGOs who receive PCI assistance to 10 or possibly more, and continue emphasis on small, service delivery networks supported by an institutional strengthening agenda, albeit a more realistic one.

Under this option, the coverage requirements of the project, as well as estimates of accomplishments on results, would have to be adjusted sharply downward. However, it is unlikely that the Mission would believe that such lowered expectations were acceptable, given the financial investment. This option would also probably encounter resistance from the SIAS, which believes that, at the least, PCI should expand service coverage to something consistent with its large budget.

Option 2: Modify the Original Strategy to Increase Coverage but Retain the Focus on Mayan NGOs

Under this option, PCI could continue some of its current strategy, recruiting smaller Mayan NGOs, especially in areas where the project is already active, and work actively to help these partners expand their coverage with more staff and resources. PCI could also augment clinical coverage through direct hiring of physicians and professional nurses to help these NGOs cover rural areas and increase quality of care.

In addition, PCI could look for complementary activities, especially in areas where they already have capacity and experience, which could directly or indirectly support the service delivery initiatives of others. These latter might include direct management and administrative assistance to the SIAS and, in some cases, technical assistance to SIAS NGOs. When PCI has more experience with the community pharmacies, this might also be an area of modest expansion through direct collaboration with other programs (e.g., managing their pharmacy activities) or technical assistance.

Under this scenario, coverage requirements would also have to be adjusted downward and expected results under IR1 and IR2 would have to be modified. PCI could probably meet some or all of the targets under IR2, but few in IR1, which relies on direct involvement in the delivery of services and/or community/household programming.

The SIAS would be supportive of such a strategy from PCI, especially if the project used its own resources to assume some of the administrative burden at the level of the health area. There are, however, contracting and double-counting issues which the project and USAID would have to consider carefully. This option is also less attractive in that it essentially commits additional Mission funding, albeit through the lens of PCI institutional costs and overhead, for the SIAS program. This reduces USAID's flexibility regarding major GOG strategy changes that might occur in the upcoming national elections.

Option 3: General Program Expansion Focused on Service Delivery

Through Option 3, PCI could enlarge the kind and number of NGOs with which it works, while retaining the relationship that it has with the five already in the program. Under such a plan, the project would try to recruit both Mayan and non-Mayan NGOs, and help to improve their health service outreach in the Mission's targeted geographic areas with clinical training, institutional strengthening and other strategies. Most of the program levels currently offered through the PCI strategy would be retained, and primary emphasis would still be on direct extension of clinically oriented (curative) services through promoters, educators and community volunteers.

Under this option, PCI activities would essentially parallel and replicate the SIAS organization and, for grassroots organizations, might play a role in strengthening them sufficiently that they could become members of SIAS (which, as funding becomes less available, would become more attractive). PCI would probably continue to focus program efforts in geographic areas that SIAS does not currently cover well, and additionally, would seek broader collaboration with other PVOs and international donors, as well as USAID partners. In this latter area, it might support technical activities that could help organizations provide a full complement of health interventions (i.e., child survival training and materials to organizations that specialize in family planning or technical assistance in administration and financial management). The SIAS would be supportive of these efforts, as it would provide additional coverage.

This model represents, in essence, a shrinking and refinement of PCI's former efforts, while still trying to expand total coverage and improve performance on IR1 and IR2. If

adopted, expected coverage and performance figures would have to be reduced, but the project would try to respond in all of the results areas formerly proposed. This option most closely represented the original thinking of the new PCI project director, although he did envision an enhanced clinical role for the community outlet (*botiquin comunitaria*) and the promoter or volunteer who managed it. While this option would probably be acceptable to all stakeholders (PCI, USAID, SIAS, and others), there are some issues that should be considered.

Although this is the general model that PCI has been trying to use in the past, the word “trying” is important, since the program did not have much success. Neither PCI nor the Mission should assume that this option would allow them to quickly initiate an expanded program using past experience as a base. Because PCI worked with such small organizations and had some serious management problems, there is relatively little in the organization’s past work which can serve as a platform for continuation of this strategy. Clinical training strategies, institutional strengthening, identification and management of relations with partners would all have to be rethought. PCI will also have to consider how to better manage program elements it plans to keep, regardless of new directions (i.e., logistics for supply of the *botiquines*, formalization of the management training curriculum). PCI would not be starting over entirely, but major new groundwork would have to be laid to go forward with this strategy.

Option 4: Expand PCI Activities in the Areas of Prevention and Health at the Household and Individual Levels, while Continuing Some Clinical and Administrative Work

Under this scenario, PCI could continue support to the NGOs with which they are currently working. More generally, however, it would look for alliances with other, larger programs already implementing NGO-based health service extension. Through these alliances, PCI could offer technical assistance and support in areas in which they already have capability and experience (administration, management and the *botiquines comunitarios*), and they could also work within the framework of these programs to help them strengthen prevention programming and family health at the household level. The SIAS and APROFAM are obvious partners for this, but there may be others.

PCI does not currently have a particular capability in this area, although it was a major emphasis of the original proposal. It does, however, have a number of advantages that could help it get started quickly. These include the recent experience of the new project director in developing community- and household-level prevention activities, some existing staff with community experience (including at *Rxiin T’namet*), strong networks at the local level, and an existing urgent need to hire new senior staff in this area to improve the community-level work of volunteers.

There are also several other reasons for recommending this as an approach:

- Excellent materials to support part of this agenda were developed in Guatemala during 1997–98 by the BASICS project, which was directed locally. The materials have yet to be used by a program at scale, although external technical review judged them as excellent. These materials are in the

area of child survival, but it is likely that complementary materials in maternal health also exist through local projects or in Honduras, through that country's national *Atención Integral de Niño* (AIN) community health program.

- PCI could help to fill a niche in the USAID strategy which is currently not receiving the attention it should, based on the Mission's SO (particularly IR1). Most of the efforts of current USAID partners are directed towards improving service delivery. And, with the exception of APROFAM and the Population Council's NGO project, none is working directly at the household level. Most partners do have prevention elements in their program, but there is no focused effort in this area.
- A PCI support strategy that complements the work of major partners, rather than competes with them, is likely to be a more comfortable place for a project that has had a very difficult two years. Here is an opportunity to collaborate and coordinate with partners and to offer assistance in an area that they may perceive as a need. This was not a part of PCI's agenda in the past.

This is not to imply that the adoption of such a strategy would be easy. It is a new area for PCI and it would take considerable investment. However, anything the project chooses to do will probably require the same amount of work. As a concept, it would also have to be marketed to SIAS and other partners with some care and, in the case of SIAS, would probably require that PCI make some technical and financial commitments in other areas as well. Finally, PCI has a credibility problem with partners, and it would take effort to overcome their current lack of expectations about PCI abilities.

It is not recommended that PCI adopt prevention and household focus to the exclusion of other activities. However, it is an important area, and PCI should consider this option (or some version of it) carefully. If the project is willing to make the commitment, it could succeed and this success would constitute an important contribution to the larger panorama of bringing effective health care to Guatemala's Mayan communities.

B. SPECIFIC PROGRAM RECOMMENDATIONS

In addition to the above options, a number of concrete recommendations should be considered by PCI/Guatemala, regardless of what strategy or combination of strategies are used to implement the program in the future. Briefly, these are:

1. Begin work immediately on a complete strategic framework for the project and, as soon as possible, develop detailed plans for the implementation of major components. Clear objectives and goal-oriented activities will avoid many of the problems that occurred in the past.
2. Request from USAID that the submission of a new monitoring and evaluation plan be tied to the completion of Recommendation 1. This task will be much easier once the project figures out what it is really trying to accomplish.

3. Develop, in conjunction with SIAS, a specific plan to support its activities. PCI should be flexible and act quickly to accommodate SIAS' suggestions. (within reason and within a reasonable budget).
4. Make project staffing a priority, and conduct national or Central America-wide searches to find the right people. Make internal staffing changes as soon as possible, before the project agenda or activities deeply involves existing personnel and complicates changes. The addition of new, technically qualified staff is the single most important action that PCI can take to support the new director and create the necessary conditions to reorient the project towards its original goals.
5. Consider better ways to define "coverage" in the project, and engage the Mission in a realistic discussion of what results are feasible for PCI to accomplish in the project's remaining two years. Also, consider requesting that USAID eliminate or help PCI redefine activities under IR3, advocacy.
6. Incorporate the client or end-user directly into program planning. Try to assess the needs and capabilities of individuals and households, as well as the demands of the service delivery system, in the design of activities. Add prevention as a specific component of the PCI program, regardless of what program option that project may choose.
7. Define, for the short term, an exact package of services that NGOs currently in the PCI/Guatemala program can and should provide. Move quickly to put this package in place so that clients are receiving acceptable, quality services while adjustments are made in the larger program.
8. Begin immediate consolidation of technical packages, which include training, educational and behavior change materials that will support PCI's proposed interventions (e.g., prevention, clinical services, and household outreach). These should be drawn from existing sources and adapted as little as possible. Consider innovative strategies (i.e., distance learning, community programs based on adaptations of the AIN model) and spend enough of the project's resources to make sure that every trainee, regardless of subject matter or level, has adequate materials to take home and use on the job. Put as much material as feasible and appropriate in the hands of *voluntarios* and even *vigilantes de salud*, who probably have the most impact on community health status.
9. De-emphasize or eliminate self-sustainability and activities related to it in future work with NGOs. It is not a reasonable goal in the time left to the project. Also avoid, however, support for strategies that are clearly non-sustainable (e.g., hiring physicians and/or professional nurses to work in isolated areas), if there is no possibility for continuation of such services when the project is over. Make sure that proposals for hiring such clinical

personnel are fully discussed with the SIAS, particularly the implications for continuing services when the project ends.

10. Engage PCI/San Diego and PCI regional personnel more directly in the project and solicit more help from headquarters, especially in difficult areas where the new project director has little or no experience. The whole issue of counterpart funding falls here, and PCI headquarters should take this on.

ANNEXES

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ANNEX A

PCI PROGRAM APPROACH AND PROPOSED ACTIVITIES

**ORIGINAL PROPOSAL TO USAID/G- CAP
JULY 1997**

ANNEX B

**SCOPE OF WORK
MIDTERM EVALUATION
OF THE PCI COOPERATIVE AGREEMENT**

ANNEX C
AGENDA OF THE PCI EVALUATION

MIDTERM EVALUATION: DEVELOPING MAYAN-BASED HEALTH CARE
FOR RURAL WOMEN AND CHILDREN

| Day | Hour | Activity |
|----------------------|------|--|
| Monday 9/6/99 | a.m. | Arrival of Melody Trott in Guatemala |
| | p.m. | Planning meeting of evaluation team, Melody Trott and Barbara Schieber |
| Tuesday 9/7/99 | a.m. | Planning meeting of evaluation team |
| | p.m. | Meeting with USAID Mission, George Garner, Mary Ann Anderson, Edward Scholl, Lucrecia Castillo |
| Wednesday 9/8/99 | a.m. | Meetings with PCI Director, Roberto Aldana |
| | p.m. | Meetings with PCI team |
| Thursday 9/9/99 | a.m. | Meetings with PCI team |
| | p.m. | Meetings with PCI team |
| Friday 9/10/99 | a.m. | Meeting with MOH SIAS Director, Hedi Deman |
| | p.m. | Meeting with Population Council, Maria Ann Burkhard, Marcello Castrillo |
| Saturday 9/11/99 | a.m. | Revision of documentation, meeting of evaluation team, development of |
| | p.m. | outline of evaluation report |
| Monday 9/13/99 | a.m. | Trip to Quetzaltenango via airplane Meeting with PCI staff of the Quetzaltenango office |
| | p.m. | Meeting with Jefe De Area of San Marcos, Alfredo Juarez, Director of SIAS of San Marcos, Dr. Osmin Reina NGO APROSAMI |
| Tuesday 9/14/99 | a.m. | Meeting with Jefe de Area of Totonicapán, Dr. Jaime Rios, Director of Centro de Salud of San Cristobal Totonicapán, Dr. Pedroso |
| | p.m. | NGO ATI from Totonicapán and CMM from San Cristobal Totonicapán Return trip to Guatemala via airplane |
| Wednesday 9/15/99 | | Meeting of the evaluation team, revision of documents, report writing |
| Thursday 9/16/99 | a.m. | Trip to Ixcán via airplane |
| | p.m. | Meeting with PCI staff Ixcán, Christine Almrot NGO ASOCVINU Meeting with Jefe de Area of Ixcán, Dr. Vinicio del Valle, Coordinator of SIAS of Ixcán, Dr. Nicolas Ceron |
| Friday 9/17/99 | a.m. | Return trip to Guatemala via airplane |
| | p.m. | Meeting of the evaluation team Writing of report |
| Saturday 9/18/99 | a.m. | Discussion of field trip findings |
| | p.m. | Writing of report |
| Monday 9/20/99 | a.m. | Trip to Rixiin T'namet, Santiago Atitlán, Sololá |
| | p.m. | Meeting with Rixiin T'namet Director, Leticia Toj Writing of report |
| Tuesday 9/21/99 | a.m. | Discussion of report |
| | p.m. | Writing of report |
| Wednesday 9/22/99 | a.m. | Writing of report |
| | p.m. | Meeting with PCI Director, Roberto Aldana |
| Thursday 9/23/99 | a.m. | Meeting with APROFAM, Dr. Erwin Montufar, Dr. Rebecca Arivillaga |
| | p.m. | Meeting with USAID Mission, Mary Ann Anderson, Edward Scholl, Lucrecia Castillo Writing of report |
| Friday 9/24/99 | | Writing of report |
| Saturday 9/25/99 | | Writing of report |
| Monday 9/27/99 | a.m. | Writing of report |
| | p.m. | Debriefing USAID Mission |
| Tuesday 9/28/99 | a.m. | Delivery of draft version of evaluation report |
| | p.m. | Melody Trott's return trip to Washington |

ANNEX D
PERSONS CONTACTED

USAID Mission

| | |
|-----------------------|-------------------------------|
| Dr. Lucrecia Castillo | PCI Project Officer |
| Edward Scholl | Reproductive Health Sector |
| Dr. Mary Ann Anderson | Health and Education Director |
| George Garner | Mission Director |

Population Council

| | |
|--------------------|------------------|
| Mary Anne Burkhard | Director |
| Marcello Castrillo | Program Director |

Ministry of Health of Guatemala, SIAS

Lcda. Hedi Deman

APROFAM

| | |
|------------------------|--------------------------------|
| Dr. Erwin Montufar | Subdirector APROFAM |
| Dr. Rebecca Arivillaga | Director of Community Programs |

Rixiin T'namet

Leticia Toj

Jefatura de Area de San Marcos

| | |
|--------------------|------------------|
| Dr. Alfredo Juarez | Area Director |
| Dr. Osmin Reina | SIAS Coordinator |

Jefatura de Area de Totonicapán

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| Dr. Jaime Rios | Area Director |
| Dr. Pedroso | District Director, San Cristobal Totonicapán |

Jefatura de Area de Ixcán

| | |
|-----------------------|------------------------|
| Dr. Vinicio del Valle | Area Director |
| Dr. Nicolas Ceron | PAHO, SIAS Coordinator |

ATI, Asociación Toto Integrado, Totonicapán (NGO)

| | |
|--------------------------|----------|
| Eustaquio Domingo Menchu | Director |
| Olivia Guix de Morales | Nurse |
| Rosa Josefina Batz | Educator |
| Teresa de Jesus Menchu | Educator |

GO, CMM, Consejo de Mujeres Mayas de Desarrollo Integral, San Cristobal Totonicapán (NGO)

| | |
|----------------------------|----------------|
| Julia Herlinda Ixcoy | President |
| Santos Pascuala Cuc | Vice-President |
| Mercedes Bernabela Aguilar | Secretary |
| Santos Gregoria Canastuj | Treasurer |
| Victoria Alvarado Chajon | Vocal I |
| Maria Leticia Ola | Vocal II |
| Lidia Alejandrina Say | Vocal III |

APROSAMI, Organización de Promotores Rurales de Salud del Municipio de San Miguel Ixtahacan, San Miguel Ixtahuacan, San Marcos (NGO)

| | |
|-------------------------|----------------------|
| Eligio Aguilar Bamaca | Legal Representative |
| Eugenio Marcelino Lopez | General Coordinator |
| Jose Santos Castañon | Vice-President |
| Jose Florencio Domingo | Secretary |
| Roberto Lazaro Aquilar | Treasurer |

ASOCVINU, Asociación de Comadronas “Vida Nueva”, Ixcán (NGO)

| | |
|--------------------------|---------------------|
| Marta Lidia Garcia | General Coordinator |
| Blanca Eloisa Pangan Sis | Accountant |
| Lidia Cardona Gonzales | Auxiliary Nurse |
| Maria Evangelina del Cid | Educator |
| Ana Maria Muñoz | Educator |
| Maria del Carmen Pinzon | Educator |
| Modesta Escobar | Educator |
| Mildred Maritza Vargas | Educator |

PCI Staff

| | |
|---------------------|--|
| Dr. Roberto Aldana | Executive Director |
| Dr. Edmundo Alvarez | Evaluation and Monitoring |
| Cesar Arroche | Administrator |
| Reina Lopez | Training |
| Christine Almrot | Coordinator, Ixcán |
| Sonia Quixtan | Field director, Quetzaltenango |
| Dr. Jorge Maldonado | Community pharmacies |
| Christy Mund | NGO strengthening |
| Rene Caraballo | Coordinator, Quetzaltenango |
| Juan Gomez | Administration Coordinator, Quetzaltenango |

PCI Field Staff of Quetzaltenango Office

Maria Elena Sucuqui

Paulina Navarro

Marcelina Matias

Victoria Aguilar

Former PCI Staff

ANNEX E
DOCUMENTS REVIEWED

USAID Documentation

USAID Mission, RFA “Better Health for Rural Women and Children”

USAID/G–CAP Health Strategy, 1997–2001, Guatemala, Central America

Diverse written communications between the Mission, PCI, Guatemala, PCI San Diego, MOH

SIAS, Extension de Cobertura Primer Nivel de Atencion, Experiencia Guatemalteca de Alianza Estrategica del Sector Publico con ONGs para la Provision de Servicios de Salud, Guatemala, Junio 1999

Midterm Evaluation. Population Council, Element II, Technical and Financial Assistance to NGOs, USAID/G–CAP Cooperative Agreement No. 520-0357-A-4169-00.

PCI Documentation

PCI Proposal: Developing Mayan-Based Health Care Systems for Rural Women and Children

Cooperative Agreement No. 520 - A00-97-00060-00

Amendments of the Cooperative Agreement

Implementation Plan 1998

Second Annual Work Plan 1999

Revised Second Annual Work Plan

Quarterly Financial Status Report

Month Ending Reports

Revised Performance Monitoring Plan, March 1998

Quarterly Narrative Report, October 1997–December 1997

Semi-Annual Narrative Report, October 1997–March 1998

Technical Report October 1997–March 1998

Technical Report, Second Semi-Annual Report, April 1998–September 1998

Technical Report, October–December 1998

Technical Report, Semi-Annual Report, January–June 1999

Result Framework for the Annual Work Plan

Report of Training Activities, January–June 1999, Administration and Health

Report of Assessment of Training Needs of NGOs

Report of Health Information System

Baseline Survey Methodology and Results

Strategy for Advocacy

Monitoring and Evaluation Plan, Preliminary Version, June 1999

Strategy and Report for the Implementation of the Community Pharmacies, Botiquines

Clinical Services Outline, Preliminary Version

Structure and Information of the NGOs

Agreements, Work Plan for 1998, 1999, monthly and quarterly financial reports of the NGOs

Financial and Administrative Rules and Regulations, Staff Profile and Job Descriptions

ANNEX F

**NGO SELECTION CRITERIA, PCI QUARTERLY NARRATIVE
REPORT, JANUARY 30, 1998**

ANNEX G

**PCI/GUATEMALA “BETTER HEALTH FOR
RURAL WOMEN AND CHILDREN”
PROJECT UPDATE**

SEPTEMBER, 1999

ANNEX H

**PROJECT CONCERN INTERNATIONAL'S
RESPONSE TO THE DRAFT
EVALUATION REPORT**

NOVEMBER 8, 1999

**(Comments and page numbers in this annex
refer to the draft copy of the report)**

Project Concern International

Response to the Mid-Term Evaluation of “Better Health for Rural Women and Children” Cooperative Agreement No. 520-00-97-00060-00

General Observations

Project Concern International (PCI) wishes to extend its appreciation to the Evaluation Team for their efforts in conducting the Mid-Term Evaluation of the Better Health project, especially given that a very extensive evaluation was conducted in a relatively short time period. PCI would like to take this opportunity to provide greater information regarding aspects of the evaluation that were not accurately and/or comprehensively reflected in the draft report provided by the Evaluation Team. PCI views many of the comments and recommendations as valid and have taken them into consideration. However, in other important respects the report does not accurately reflect PCI's work, its progress or the context in which the work took place. Furthermore, comments and observations in the report tend to minimize key processes that are fundamental in strengthening NGOs' capacity to provide health care services in rural areas. The programmatic options for the future of the project as presented in the evaluation report are at times ambiguous and contradictory despite clear discussions between PCI's current Country Director, USAID Mission health officials and the Evaluation Team regarding future project strategies. The options do not accurately describe many of the key elements agreed upon between PCI and USAID.

PCI acknowledges the management problems it faced in Guatemala in the past and the challenges these presented to more successful project implementation. In this respect, it generally agrees with the evaluation team, and has together with the Mission, made significant changes as early as July of this year including a change in directorship. PCI anticipates this progress to continue and has worked closely with the Mission to ensure sound collaboration.

I. Mayan Focus, Gender Focus and Community Participation

(Please refer to Page ii, paragraph 4 of the Executive Summary, Page 15, paragraph 7 and Page 16, paragraphs 1-2 of Section B, "PCI/Guatemala Strategies".)

While the strategies implemented by PCI inherently required a slower start-up of the project, PCI would like to mention that the Mayan Focus, Gender Focus, Community Participation and Advocacy are all key elements to the Better Health strategy **as defined in the RFA, issued in 1997**. The focus of the Better Health project on Mayan populations, increased access to services for women and community participation is not one that PCI invented. Rather, the PCI strategy proposed fits into the framework provided in the RFA, and has been accepted and promoted by USAID through approval of the proposal and first two work plans presented by PCI.

II. Timeline for Project Implementation

(Please refer to Page ii, of the Executive Summary and Page 1, Section I, "Background")

The Chief of Party for the project was not approved by USAID until November 24, 1997, nearly 3 months after the project was awarded to PCI. Until that time PCI was advised in writing to refrain from making expenditures to the grant until the USAID/G-CAP Mission approved a Chief of Party. The Chief of Party moved to Guatemala and lead PCI staff in developing the first Annual Work Plan, submitted in January 1998.

The first Annual Work Plan was approved on May 6, 1998 by means of a letter congratulating PCI on the Plan and the second Work Plan was approved on June 3, 1999. Essentially, the project was implemented according to an approved Work Plan for 16 months: **eight months in 1998 (May-December), and eight months in 1999 (January-August). The report developed by the Evaluation Team failed to not this important contextualization. The reader is led to believe that two years of activities have transpired with little result to show for it.** These were time limitations unforeseen either by PCI or USAID.

PCI provided documentation and verbally pointed out to the Evaluation Team that the project had actually been implemented for only **16 months at the time of the evaluation, not two years as the Evaluation team asserts.** This is one of the reasons why PCI proposed that the evaluation be conducted at a later date.

III. NGO Selection and Strengthening Process

(Please refer to Page 17, paragraphs 3-4, Section B. "PCI/Guatemala Strategies".)

PCI recognizes that the time it would take to identify appropriate NGOs was underestimated in the original proposal. One of the challenges PCI encountered was identifying NGOs with available geographic area to cover, as many NGOs were already working with SIAS funds or under agreements with other USAID funded projects. Given the community-based, Mayan focus of the Better Health project, PCI held NGO meetings in the target departments and had initial contact with approximately 50 NGOs. Of these, PCI selected 25 NGOs with whom to carry out interviews. PCI then visited the communities in which 12 organizations work and eventually six NGOs were selected.

During the first 16 months of the project implementation, PCI's investment in identifying, strengthening and assisting in community organization with grassroots NGOs has contributed to NGOs' increased capacity to provide services. *(Please see attached document entitled "Project Update", describing PCI's achievements in this regard.)* **PCI believes it to be unrealistic and unwise from a development perspective to expect dramatic service delivery results from NGO partners so early into the process without working with NGO partners to organize and lay the groundwork for service delivery.** This preparatory process, described in phases below, took longer with the first NGOs with whom agreements were signed than with NGOs who entered into the Better Health project at a later time, as PCI began systematizing its procedures.

Phases of Organizational Development Start-Up

- PCI disseminates information about the Better Health project to potential stakeholders.
- Interested NGOs complete and submit an organizational questionnaire to PCI.
- PCI makes visits to NGOs' offices and communities in 7 departments.
- PCI and NGOs negotiate letters of understanding first and agreements and development work plans later.
- PCI and NGOs develop project budgets.
- PCI and NGOs socialize work plans among NGOs' Board of Directors, General Assembly, community and health authorities.
- PCI provides NGOs with initial financial management training, monitoring and support.
- PCI supports NGOs in staff recruitment/reorganization for project implementation.
- PCI supports NGOs in community organization (of CHWs, TBAs, etc.) for project implementation.
- PCI supports NGOs in collaboration and dialogue with local health authorities.

While PCI is exploring alternative strategies for reaching a greater number of beneficiaries in a shorter time period, PCI wishes to clarify that the Better Health focus to date has been praised by other stakeholders in the health and development sector, including the Soros Foundation of Guatemala and USAID. It has been expressed that PCI is filling an important role in providing capacity building support with a gender focus to grassroots NGOs in some Mayan communities, as such support contributes to greater community involvement and the formation of more sustainable organizations actively participating in civil society in Guatemala.

This process has not only been proposed by many experts in Guatemala as fundamental to improving access to health in rural communities but is also a fundamental piece of the "democratization" effort of Guatemala as clearly pointed out in the Peace Accord.

IV. Major Project Activities to Date

(Please refer to Page 5, paragraph 4 of Section III. "Major Findings: PCI/Guatemala Program Results".)

Major project activities to date have included much more than a questionnaire of potential NGO partners, the completion of a comprehensive collection of baseline data, and subcontracts with five Mayan NGOs who currently participate in the PCI/Guatemala program, as stated in this section of the report. In fact, PCI has supported its partner NGOs in community organization, initiation of community pharmacies, financial management strengthening and initial preventive health training, among other key start-up activities. *(Please refer to Annex I, "Better Health Project Update", attached, for details.)*

V. Progress on the Results Framework and Objectives

Please refer to Page 7. Section III, "Major Findings: PCI/Guatemala Progress on the Results Framework and Objectives".)

When the Evaluation Team visited Guatemala, neither the Health Information System (HIS) nor the Monitoring and Evaluation Plan (M&E Plan) had been submitted to USAID for final approval, as PCI clearly stated to them. PCI presented rough data regarding services provided to evidence that some level of clinic activity had been initiated. PCI regrets that the Evaluation Team, advised in advance of the quality of such data, has used it as a parameter for the evaluation, especially given the short time period in which services were given and the fact that the HIS was not yet operational.

PCI has and will continue to support service delivery and, upon approval of the HIS and M&E plan, begin to provide systematic information on services provided by partner NGOs as they increasingly begin to meet community demands.

VI. Program Options Proposed by the Evaluation Team

(Please refer to Pages 30-33 of Section IV. "Recommendations: Program Options")

PCI's current Country Director and staff described its proposed future strategies throughout the evaluation process and specifically, in the first meeting held between the Evaluation Team and PCI staff. Such strategies were already under discussion with the USAID Mission as early as July, 1999, and focus on improving the Better Health project in general, and contributing to increased coverage and results in service delivery and behavior change strategies. Despite such clear discussions in meetings between the USAID Mission health officials and PCI's current Country Director, in many of which the Evaluation Team was present and involved, PCI finds it confusing that the options developed and presented by the Team are largely ambiguous, vague and often contradictory. For example:

- In Option 1, the Evaluation Team states that this option would probably encounter resistance from SIAS, which feels that, at least, PCI should expand service coverage to something consistent with its large budget." What is not mentioned and should be included is that SIAS has extensive coverage with a low cost/benefit ratio, however it can't offer the quality that PCI can offer. This quality will determine the demand, use and sustainability of services.
- In Option 2, the Evaluation Team suggests, "PCI could also augment clinical coverage through direct hiring of physicians and professional nurses to help these NGOs cover rural areas and increase quality of care." However, in the "Specific Program Recommendations" section of the report, in Point 9, the Evaluation Team recommends that PCI "de-emphasize or eliminate 'self-sustainability' activities related to it in future work with NGOs." The Evaluation Team specifically uses as an example "hiring physicians and/or professional nurses to work in isolated areas".
- In Option 3, the Evaluation Team states "there is relatively little in the organization's past work which can serve as a platform for continuation of this strategy." This

contradicts the first strength cited by the Evaluation Team, “The project’s infrastructure is already in place and is adequate to support a quick restart once the necessary management and program decisions have been made.”

The options proposed are not satisfactory in PCI’s opinion, nor do they seem to be in accordance with the USAID Mission based on conversations held between PCI’s current Country Director and Mission staff. **For example, the Evaluation Team proposes the elimination of IR3, “Greater local level advocacy for healthcare services, especially for women”, from the project’s strategic framework, as well as the elimination of community participation and the gender focus.** The fundamental premise of the Mission’s RFA which was endorsed by PCI relies on the ability of communities to advocate for their needs. Inherently, the antithesis of community involvement is what has been historically witnessed in the communities where PCI works: extremely marginalized communities with minimal or no access to health services. The key is therefore to “unmarginalize” and empower these communities. Popular participation has been a fundamental strategy and successful approach in achieving sustainable services.

The Evaluation Team also recommends accelerating service delivery, but advises against contracting the professional services of medical personnel.

VII. Coordination with the Ministry of Health at the Central Level – SIAS

(Please refer to Page 27, Section G, “Coordination”)

The health-related results and indicators of the Better Health project are quite similar to those of SIAS, differing primarily in that the Better Health project, **as promoted by USAID in the Request for Applications (RFA), includes the components of advocacy, sustainability, community participation in decision-making and reproductive health.**

PCI has historically attempted to coordinate with SIAS officials at the central and departmental levels, with the close involvement and accompaniment of USAID/G-CAP officials, who encouraged PCI’s proposed strategy for implementing a global SIAS/Better Health initiative. According to this initiative, PCI would have provided SIAS with health information using the Ministry’s “SIGSA” reporting package and PCI’s partner NGOs would have received some funding from SIAS to complement and expand Better Health Funding.

According to the evaluation report, PCI never presented to SIAS a concrete plan of action with geographical specifications. However, PCI records show that on March 3, 1999, the SIAS Director, Ms. Hedy Deman, requested from PCI lists of communities and demographic data for the geographic areas in which the joint initiative would be carried out. On March 19, 1999, PCI presented this information to the SIAS Director, who expressed that such information was never requested and that SIAS funds had been obligated. Furthermore, and in light of past misunderstandings, PCI often sensed SIAS’ unwillingness to collaborate.

At the departmental level, the Ministry of Health has changed and replaced a number of departmental health authorities (*Jefes de Areas*), in some cases many times during the life of the Better Health Project (i.e., Huehuetenango – 3 different Area Chiefs, Ixcán – 3 different Area Chiefs, Quetzaltenango – 2 different Area Chiefs, Chimaltenango – 3 different Area Chiefs). Such staff rotation has caused delays in PCI's negotiations at the departmental level. Nevertheless, PCI has maintained positive, collaborative relations at the departmental level, as the Evaluation Team accurately notes in their report.

VIII. Staff

(Please refer to Page 22, Section VI.B. "Management: Staffing".)

PCI recognizes that the former management styles of the previous director did not place enough emphasis on the technical support and oversight that were necessary to fully implement the project. Technical resources were under-utilized and often misdirected under former management. As a first step in remedying this situation, in July 1999, PCI named a new and highly qualified Country Director with a great deal of experience in public health programs. In addition, PCI has sped up its process of recruiting and hiring more technically qualified staff to fill needs in key areas like clinical service delivery and community outreach and behavior change. Such comments in the report have been helpful to PCI in guiding these decisions.

At the same time, PCI finds it unfounded for the Evaluation Team to make reference to comments from individuals not referenced in the List of Contacts or in the Evaluation Agenda. **For example, the Evaluation Team describes former PCI staff's reasons for leaving PCI and their feelings about PCI. Yet, according to the List of Contacts and Evaluation Agenda, the Evaluation Team did not officially meet with any former PCI staff.**

PCI Guatemala staff, in general meetings and private interviews with the Evaluation Team (all documented in the Evaluation Agenda), expressed their reasons for continuing to work with PCI, although those views are not documented in the evaluation report. Staff views included statements describing their commitment to PCI and the Better Health project because the project design has allowed community members, leaders and women to more actively participate in the definition of priorities in the development process. Staff also acknowledged the need to implement some programmatic and technical changes to accelerate service delivery and community outreach.

IX. Collaboration with the USAID Mission and with USAID Partners

(Please refer to Page 26, Section III.G, "Coordination".)

It is worth noting that while coordination with the Mission and USAID partners under former project leadership could have been more fluid and results-oriented, PCI made strides in improving these relationships in 1999. More collaborative meetings were held with Aprofam and the Population Council, as newer PCI technical staff with a greater understanding of the nuances of national politics began assuming these responsibilities. This is mainly due to the efforts of the current Chief of Party, Dr. Aldana, who joined

PCI staff in April, 1999, as the Technical Advisor for Clinic Services. Dr. Aldana has continued to expand and strengthen ties with these and other important stakeholders in the health and development sectors of Guatemala, including the Ministry of Health, as the strategies he and his staff are developing for increasing coverage and results demonstrate.

Conclusions

As stated throughout this document, the Evaluation Team on several occasions provides valuable observations and suggestions for PCI's future programmatic activities. At the same time, PCI feels strongly that other aspects of the draft evaluation report do not provide an accurate and/or comprehensive reflection of project start-up and implementation to date. First, the draft evaluation report fails to provide important information that contextualizes that project implementation has been in progress for 16 months rather than a full two years. Second, while PCI is in agreement with some of the organizational deficiencies cited, the report does not fully reflect the strength of PCI as an organization. Finally, the evaluation team questions at length the model being implemented by PCI to achieve the results of the Better Health project. This completely disregards the fact that this model was presented by the USAID Mission in its Better Health RFA that called for a Mayan focus, a Gender focus, a focus on Community Participation and advocacy.

PCI would like to thank the Evaluation Team and the MEDS Project for extending to PCI this opportunity to provide feedback regarding the draft evaluation report. PCI is wholly committed to the Better Health project and its future success. At the same time, PCI is also very committed to ensuring that information regarding project implementation to date be as accurate and comprehensive as possible. PCI has worked to improve the health of people living in rural Guatemalan communities for 23 years and it is strongly committed to continuing this objective. For this reason, PCI believes that it is absolutely essential that its efforts be fairly reported as such documents constitute a historical record of the organization's activities.