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USAID GUATEMALA FY 1987-1988 ACTION PLAN

ANNEX ONE - CARE FY 1987-1989 TITLE II OPERATIONAL PLAN

A. MCH NUTRITIONAL PROGRAM

CARE - GUATEMALA
OPERATIONAL PLAN/AER
USG FY 1987

MCH NUTRITION PROGRAM

Cooperating Sponsor: CARE

Country: Guatemala

Date Submitted: 14 March, 1986

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AER MULTI-YEAR PLAN
INFORMATION CHECKLIST

Country: Guatemala MYP Period: 1987 - 1989
Project: MCH Nutrition Date of Action: 12 Mar., 1986

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AER MULTI-YEAR PLAN

Country: Guatemala Project Title: MCH Nutrition
MYP Period: FY 1987 - 89 Prepared by: Christian A. Nill

I. INTRODUCTION

This ongoing program addresses the excessively high rate of malnutrition among pregnant and lactating mothers and pre-school children in Guatemala. The project is administered by CARE and the Ministry of Public Health (MOH), whose personnel distribute approximately 34 million pounds of PL 480 Title II commodities through health centers and posts to 270,000 needy beneficiaries in all departments of Guatemala including the Petén.

During the new MYP period the MCH Nutrition project will expand upon the SINAPS concept of delivering to the rural poor an integrated package of primary health care (PHC) services that serves as a complement to commodities distribution. This objective will be achieved with the complementary project intervention of Title II Enhancement.¹

II. PROJECT DESIGN

2.1 Statement of Problems

Life expectancy in Guatemala is a low 61 years for ladinos and 45 years for Indians.² Some 20% of rural Guatemalan children die before their fifth birthday; in industrialized countries, only about 2 percent do. Guatemala has a nationwide average infant mortality rate (0 to 12 mos.) of 67.7 per 1000 live births³ and in some

¹ See separate MYP Proposal for Title II Enhancement.

² Ministry of Economics. 1982. Department of Statistics. p. 23.

³ Pan American Health Organization. 1984. Annual Report of the Director.

western highlands, this rate rises to 104-134 per 1000.⁴ Indian child mortality is approximately 1.7 times greater than non-Indian (ladino) child mortality, reflecting the environmental conditions for both groups. All the above statistics signify a tragic loss for Guatemala and represent one of the highest infant-mortality rates in the Latin American Continent.

Approximately seventy-nine percent of the total population lives in poverty; almost eighty-two percent of the rural population and seventy-five percent of the urban population do not have sufficient means to meet their daily nutritional requirements. That shortage causes nutritional deficiency; not an imbalance between calories and protein. There may, however, be shortages of specific micro-nutrients and of protein, especially among the young children. Evidence of serious malnutrition comes from three main sources; estimates of food consumption, anthropometric and clinical studies, and data on child mortality. Food consumption data estimate that half of the population consumes well below suggested daily requirements. In fact, studies show that they are only receiving 62% of their minimum daily caloric requirements and 51% of their protein needs.⁵

In children under five, malnutrition reduces their resistance to diseases, is a major cause of their deaths and impairs their physical and mental development. Government and independent study groups concur that approximately 81% of all Guatemalan pre-school children suffer from malnutrition, and within that group, 25-32% suffer from moderate to severe malnutrition.⁶

Data from government health posts and centers record the high child mortality rates, which reflect the combined effects of sickness and malnutrition. Infections reduce appetite and food intake in several different ways (including the action of intestinal parasites) and they reduce the proportion of nutrients that the body absorbs. In turn, undernutrition weakens the body's immunizing mechanisms, lowers its defenses against the initial infection, while making it more susceptible to further infections, which can ultimately lead to death.

Other statistics reveal that low-income pregnant and

⁴ Council of Economic Planning, Guatemala. 1982.

⁵ Ministry of Public Health. 1982. National Plan of Safety and Development. Guatemala. p. 30.

⁶ Ibid., p. 227.

lactating mothers consume only between 60-65% of the recommended minimum amounts of calories and protein. This finding signifies that the nutritional status of pregnant women is very low, especially during the critical first trimester of pregnancy.

Most malnutrition reflects a shortage of calories, protein, or both; some diets, however, are inadequate because they lack specific nutrients. We know that 20% of pre-school children suffer from a serious deficiency of Vitamin A, leading to poor eyesight, which can undermine educational performance and adult learning power. It also affects growth, skin condition and the severity of other nutritionally related illnesses.

Anemia, resulting primarily from blood loss and too little iron, is another common problem. For example, studies show that 55% of pregnant women, 40% of lactating women and 40% of children under 12 years are anemic due to iron and folic acid deficiency.

Such anemia in pregnant women has other adverse effects, as it can lead to premature birth and a much lower chance of survival for the newborn child. The more children a woman bears, the greater the probability of severe anemia, so adding to the cycle of poverty, high fertility and low rates of child survival.

Guatemala's poor do not have enough income for food and, given the low income growth that is forecast for the poorest people in the foreseeable future, large numbers will remain malnourished for decades to come. This combination of diverse factors results in a problem that is quite complex and difficult to combat. Because of that complexity, more effective measures are required in the feeding program and this project will attempt to address that need.

2.2 Final Goal

Improved the health status of 535,000 rural inhabitants of Guatemala, this number comprising pregnant and lactating mothers as well as children of 0 to five years of age.⁷

⁷ The numerical target was estimated as follows:
Assuming a constant beneficiary level of 270,000 for each FY:
a) 40% are mothers => 108,000 per year;
b) 60% are children => 162,000 for first year;
c) 15% annual turnover in infant beneficiary roles =>
24,300;

Then:

2.3 Intermediate Goals

Intermediate Goal R1: MCH distribution centers effectively and accurately target vulnerable groups in their respective communities. Approximate target dates for achievement:

- End of FY '87: 75% of centers comply (490 centers)
- End of FY '88: 100% of centers comply (650 centers)

Intermediate Goal R2: MCH distribution centers effectively carry out educational and outreach activities in health, nutrition and hygiene, using techniques appropriate to their audiences, in relation to commodities distribution. Approximate target dates for achievement:

- End of FY '88: 10% of centers comply (65 centers)
- End of FY '89: 25% of centers comply (163 centers)

Intermediate Goal R3: MCH commodities distribution is effectively linked to the provision of PHC services. Approximate target dates for achievement: same as in I.G. R2.

Intermediate Goal R4: MCH distribution centers meet action standards for local program administration and beneficiary monitoring. Approximate target dates for achievement:

- End of FY '87: 60% of centers comply (390 centers)
- End of FY '88: 90% of centers comply (590 centers)

2.4 Project Activity Targets

<u>Project Activity</u>	<u>FY 87</u>	<u>FY 88</u>	<u>FY 89</u>
<u>Commodities Distributions</u> (000 pounds)			
1. All PL 480 commodities (000's of kg.)	14,781	14,781	14,781

s The specific commodities which make up each ration may be altered, depending on field monitoring results which, combined with budgetary considerations, will help determine the ideal ration makeup. The current ration consists of 30% NFDM, 30% Cornmeal, 30% Soy-fortified bulgur and 10% vegetable oil. See Appendix "E".

Complementary Activities

2. Educational sessions/demos. at feeding centers re health, nutrition & hygiene. (# of ed. sessions/demos.)	1200	1200	1200
3. Home visits performed by center-based rural health practitioners (000s of RHP visits)	40	40	40
4. PHC consultancies/exams for MCH bens. (000s of consults/exams)	53	53	53
5. Annual Outreach Plans developed and implemented by feeding centers (# of plans)	65	65	130

III. PROJECT OVERVIEW

3.1 Project Development

In Guatemala, the MCH Nutrition project has long been established as a supplementary feeding program through the Ministry of Public Health for pregnant and nursing mothers and malnourished pre-school children. The beneficiaries eligible to be enrolled in this program must attend government health posts and centers to receive a monthly ration of PL 480 commodities designed to supplement their normal daily food intake.

Currently, 270,000 beneficiaries are enrolled in the program throughout all departments of Guatemala, including the Petén. Five years ago it was considered that this program could be made more dynamic and beneficial than in previous years by integrating commodities distribution with the provision of complementary health and educational services.

• The targets for complementary MCH activities such as educational sessions, PHC consultancies and home visits will be measured by using a statistically representative sample of all MCH feeding centers. For the purposes of this proposal, a sample size of 5% was used (33 feeding centers). If the actual sample size upon measuring these PATs is other than 5%, the numerical target will of course have to be adjusted accordingly.

Hence in late 1980 CARE began assisting and implementing the SINAPS program referred to earlier. SINAPS was the result of the combined efforts of the MOH, Pan American Health Organization and INCAP to design, implement and evaluate a program of primary health care in Guatemala. Its basic purpose was to increase the effective coverage of PHC service delivery.

SINAPS tested the hypothesis that it was feasible, considering the prevailing conditions in Guatemala, to implement an effective and efficient primary health care program based on service delivery by health technicians such as auxiliary nurses, rural health promoters and traditional midwives, with appropriate supervision and with the participation of the community.

The program implementation began in three pilot health districts of eastern Guatemala. The specific program objectives were to:

a. Develop an appropriate methodology for:

- training health personnel with special focus on non-professional personnel.
- designing, monitoring, controlling the quality and costs of, and measuring the impact of the primary health care system.

b. Strengthening the development of technical norms for primary health care personnel in Guatemala.

When the SINAPS program failed due to budgetary and organizational problems discussed earlier, it left behind some noble initiatives but at the same time a vacuum of assistance for the continued promulgation of integrated primary health care/supplementary feeding.

In 1982, the Ministry of Health approached CARE regarding the possibility of assisting in the extension of the SINAPS concept into the three highland departments of San Marcos, Totonicapán and Sololá. This program is called Integrated Community Systems of Health and Nutrition with Attention to Primary Health (APS). It was designed as part of the Government mandate to accelerate and improve basic health delivery systems in rural areas.

The APS program never came to fruition. CARE held several planning sessions during the course of 1983-84 with MOH planners, yet despite their assurances that the final plan was upcoming, nothing materialized -- perhaps in large measure due to the GOG's incipient fiscal crisis at that

time.

SINAPS and APS nonetheless serve to demonstrate the GOG's continued interest in providing integrated PHC services along with supplementary feeding. These precedents warrant the renewed efforts in this direction, albeit with a different focus, which will be undertaken by the MCH Nutrition project, only now, in the new MYP period, with the special resources which the complementary "Title II Enhancement" project will have to offer.

3.2 Project Strategy

3.2.1 General

Project strategy is to use PL 480 commodities as an aid to economic and social development, particularly related to improving the nutritional and health of the most vulnerable and neediest groups in Guatemala. This will be achieved by attempting to promulgate the delivery of integrated MCH/primary health care services.

3.2.2 Consonance with MOH policy

The MOH is cognizant of the need to improve its health services delivery system and is interested in including the following activities in the regular MCH program:

1. Scheduled medical check-ups, primary health care and basic immunizations.
2. Maintenance of health monitoring charts for each child.
3. The provision of regular demonstrations for participating mothers in the health centers and posts on subjects relating to health, nutrition, and sanitation.
4. The concept of health "outreach" as an essential PHC service.

Project Strategy is to assist the Government in its efforts to improve the health status of the people and, at the same time, also collaborate in outreach interventions that are effective in terms of their impact on health indicators, particularly infant mortality.

Emphasis will be placed on the prevention and management of those factors that are the main causes of infant mortality and disability, and for which effective health interventions are available in a relatively short time. Those factors are grouped by the MOH as follows:

1. Diseases preventable through vaccination (whooping cough, neonatal, tetanus, measles, poliomyelitis and tuberculosis);
2. Dehydration due to diarrhea;
3. Perinatal health related problems;
4. Severe malnutrition;
5. Early weaning;
6. Short birth interval;
7. Poor environmental sanitation.

3.2.3 The Role of Rural Health Practitioners

The Rural Health Practitioner (RHP) and the Traditional Midwives are responsible for delivering the first level of health services with the supervision and support of the Rural Health Technician (RHT) and the Auxiliary Nurse assigned to local health posts.

Most of the activities performed by the RHP are of a preventive nature and related to promoting active community participation in delivery of health services. For example, immunizations and measurement of arm circumference are generally performed by the RHT. The role of the RHP is to provide information to the community to insure high coverage of these activities. For each activity of the RHP and midwife there are clearly written indicators describing when a patient should be referred to the closest health service.

The participation of the community is an essential component of the program. All sectors of the community participate in the recruitment and selection of RHPs. The RHT is required to seek candidates recommended by civil authorities, community committees, religious and social groups, indigenous health practitioners and persons identified as representatives of the community. Given the rural location of most training centers (e.g., many training centers are actually schools, churches, promoters' homes), community members are also encouraged to attend and participate in all training exercises. The responsibility for service delivery, however, remains with the assigned volunteer.

Finally, the community participates in the evaluation of services. For example, if the provision of services is inadequate or of poor quality, the community is free to select a substitute. Where service coverage is low, the RHT is required to visit the community and poll residents on the

reasons for low utilization. The basic notion is that, rather than having a single health committee responsible for the quality of service delivery, the community should have multiple channels for participation.

3.2.4 PL 480 Commodities as Incentive Tool

The PL 480 commodities are used as a resource by the MOH health personnel to enroll needy families in the program; they use the distributions as opportunities to provide improved understanding of nutrition, health and hygiene. PL 480 commodities are also used in a very important way to incentivate beneficiaries to make more routine use of PHC services at the feeding center. During the present MYP period this incentive value of supplementary feeding will be reinforced and used to maximum advantage in order to provide beneficiaries with truly integrated health services.

3.2.5 CARE Supervision and Host Agency Support

National CARE field staff will continue their tri-monthly supervision and evaluation visits of each health post and center. But in this MYP period, the mission will attempt to create a more meaningful role for its field supervision staff: an improved MCH field monitoring system, to be developed by the complementary Title II Enhancement project, will try to focus on those key indicators of project performance at the feeding center and beneficiary levels, in order to generate statistical profiles that show 1) general tendencies and patterns of MCH service delivery; and 2) performance over time for specific feeding centers. MOH will provide infrastructure and equipment, warehousing, health personnel, medicine and vaccines, and complementary programs such as anti-tuberculosis, anti-malaria, and vaccination campaigns. They will also participate directly in the planning and management of MCH enhancement activities.

The MOH covers CARE's local administrative costs, as well as transportation of all commodities from the port to the warehouses and onward to the health centers.

The government also absorbs a number of other costs including all port charges and import taxes, and provides free internal postage and telegraph service to CARE. No special conditions are imposed regarding admission, storage, transport, distribution, utilization or loss of commodities.

3.2.6 Clustering with other CARE Interventions

Because of its nationwide coverage this project will

cluster with almost all of this mission's proposed as well as ongoing interventions, significant among these, the Rural Health Services Enhancement project, Environmental Sanitation, and Water, Women and Health. Copies of the Multi-Year Plan for these projects are available upon request.

Also, as mentioned earlier, this project will be directly complemented by the Title II Feeding Enhancement project. (The Multi-Year Plan for this project appears as Appendix "A".)

3.3 Project Impact

This project may be expected to have some form of impact on the entire beneficiary family; not only those members of the family who are specifically targeted by the MCH Nutrition project. Two examples of how this will happen:

1. The linking of PHC services to commodities distribution at each feeding center may improve the access to and routine use of such services not only by the targeted MCH beneficiaries, but also the rest of the family members, by example.

2. Educational and extension services provided by the PHC unit will improve sanitary conditions, and subsequently health status, for the whole family, too.

In many communities these types of impacts may extend, through the example that beneficiaries show their neighbors, to other non-beneficiary families, even though they don't receive PL 480 food supplements.

3.4 Project Continuity

Supplementary feeding: Given the reality of the Government's limited resources, we expect this intervention to continue for many years.

Complementary MCH activities: There is indeed an opportunity for the MOH to replicate many of these activities in its other ongoing projects that address rural primary health care. We especially hope that the example of CARE's improved field monitoring system, to be developed during the life of the project, will be utilized by the MOH to monitor and evaluate many of its ongoing projects that do

not necessarily have a supplementary feeding component.

3.5 Project Potential

A most significant aspect of this project is the expected improvement in primary health care delivery systems throughout Guatemala. The community outreach services concept is an opportunity to maximize health support services in rural areas.

The project policy is to improve health and nutrition through sectoral interventions, such as the former SINAPS and APS programs, which emphasize improved PHC health delivery systems providing growth monitoring of children, pre- and post-natal nutrition, supporting environmental health measures, and promoting proper infant feeding practices.

This approach to primary level health care is replicable under the routine working conditions of the MOH and many key elements are being extended to other health district programs. The long-term success is not the adoption of the entire SINAPS model, but the utilization of similar methodology, decision-making process and criteria for the design of primary health care services in other areas of the country.

3.6 Project Constraints

A major constraint to continued participation could be a reduced availability of PL 480 foods. A strategic element of the MCH program is the use of PL 480 commodities as encouragement for attendance at the health clinics for essential curative medical care and control.

A constraint previously experienced in the regular MCH program had been the language barrier. In isolated rural communities, few of the Indian mothers spoke Spanish and few of the health personnel communicated in the local dialect. This situation is slowly changing as more indigenous children attend school and learn Spanish. But more importantly, this constraint will be minimized by actively promoting the use of appropriate teaching techniques which serve to cross these cultural and linguistic barriers. Also, in the Outreach Services Program the health promoters and midwives will be recruited and trained to serve in their own communities, which is instrumental in breaking down these barriers.

IV. PROJECT IMPLEMENTATION

4.1 Pre-Implementation Conditions

- a. Signing of CARE/GOG agreement by the beginning of the project year, delineating responsibilities of all parties. In general, the Government of Guatemala is responsible for providing infrastructure, equipment, transportation, medicines and vaccines, etc.
- b. Submission to and approval by USAID of an Operational Plan and AER.
- c. Development of an improved MCH monitoring system based on key indicators (as an activity of the complementary "Title II Enhancement" project).

4.2 Implementation Plan and Schedule

The following schedule describes the sequence of activities to be carried out during each fiscal year of project implementation:

- a. Transportation on a quarterly basis by the Government of PL 480 food to all health posts and centers implementing the MCH program.
- b. Reporting on a monthly basis by MOH personnel of food consumption, supervision and inventory.
- c. Ongoing monitoring and supervision by CARE.

4.3 Logistics Plan

4.3.1 Port Facilities

The volume of commodities to be handled by this project in USG FY 1987 does not vary significantly from quantities handled in FY 86. Port facilities are excellent, with ample warehouse space for interim storage.

4.3.2 Transportation

The GOG covers all costs of inland transport of commodities to CARE's warehouse in Guatemala City, and onward to distribution centers located in 22 departments of the Republic. The GOG's transport contractor has over the years provided consistently excellent service, with minimal commodity losses. The

government for its part places high priority on this feeding program, and thus has managed to meet payments with its contractor even in the worst of financial times.

4.3.3 CARE Warehouse Facilities

These facilities are currently being utilized at approximately 70 percent capacity. No problems are foreseen in the interim storage of MCH commodities for USG FY 1987.

4.3.4 Field Warehouse Facilities

These facilities are on the whole adequate for the volume of commodities to be stored. CARE's field supervisors are constantly visiting all feeding centers to insure, among other things, that each center's warehouse meets all requirements for safe and sanitary storage of commodities. Wherever a feeding center does not meet these requirements, its beneficiary level is readjusted downward so that it can accommodate the incoming food, or, in isolated cases of incorrigible negligence, the center is culled from the program.

4.3 Technical Considerations

Not applicable.

4.4 Procurement Requirements

Not applicable.

4.5 Personnel Requirements

4.5.1 International Personnel

This project will continue to be managed by one CARE Project Manager, Heather Nesbitt, who will devote approximately 50 per cent of his/her time to same.

4.5.2 National Personnel

Please refer to Appendix "D", attached. The field supervisors referred to on that list will be directly responsible for overseeing the distribution of commodities as well as supervising and periodically reporting on each feeding center's administration of the MCH Nutrition project.

V. PROJECT EVALUATION

5.1 Final Goal

Improve the health status of 535,000 rural inhabitants of Guatemala, this number comprising pregnant and lactating mothers as well as children of 0 to 5 years of age.

Indicator: Reduction of infant mortality by 15% in the participating communities.

5.2 Intermediate Goals

I.G. #1: MCH distribution centers effectively and accurately target vulnerable groups in their respective communities.

Indicator 1: MCH distribution center beneficiary roles show a turnover rate for infant beneficiaries (0 - 5 years of age) that is 15% per year.

Indicator 2: Field validation of distribution center beneficiary roles shows that beneficiary mothers are indeed pregnant or lactating and belong to low-income, high-risk groups.

I.G. #2: MCH distribution centers effectively carry out educational and outreach activities in health, nutrition and hygiene, using techniques appropriate to their audiences, in relation to commodities distribution.

Indicator 1: MCH distribution centers carry out center-based educational activities on average three times a month.

Indicator 2: MCH Rural Health Practitioners carry out field extension in health/nutrition education, in the amount of 100 home visits per month.

Indicator 3: 75% of beneficiary mothers regularly attend 75% of center-based educational sessions on distribution days (i.e., once a month).

Indicator 4: MCH distribution centers' analyses of changes in sanitary and food preparation habits among beneficiaries reveal significant changes in 50% of beneficiary families.

I.G. #3: MCH commodities distribution is effectively linked to the provision of PHC services.

Indicator 1: Feeding center records show that 75% of MCH beneficiary mothers obtain PHC pre- and post-natal consultancies with the frequency recommended for such visits.

Indicator 2: 90% of MCH feeding centers have at least one MOH worker who is judged as qualified to provide PHC consultancies and diagnoses.

Indicator 3: Feeding center records 75% of beneficiary children of 0 - 5 years of age receive PHC exams on at least a semi-annual basis.

I.G. #4: MCH distribution centers meet action standards for local program administration and beneficiary monitoring.

Indicator 1: Percent of distribution centers that maintain up-to-date beneficiary roles as well as clear, organized reports and records of commodities movement.

Indicator 2: Percent of distribution centers that maintain organized and up-to-date beneficiary case histories for each MCH ben., using formats recommended for this purpose.

Indicator 3: Percent of distribution centers that measure beneficiary children's growth (height and weight) in an accurate and timely manner.

Indicator 4: Percent of distribution centers that receive an acceptable rating with respect to program administration, based on a "scorecard" evaluation applied by CARE's MCH field supervisors and validated independently.

Indicator 5: Number of MCH distribution centers that develop "Annual Outreach Plans" which draw together in one operating document: 1) community needs assessment; 2) a PHC action plan designed to address those needs, with specific targets for achievement; and 3) analysis of resources available to implement the plan.

VI. PROJECT FUNDING

TYPE	AMOUNT	SOURCE
<u>FY 1987</u> (firm)		
Infrastructure, equipment, warehousing, health personnel, technical assistance, medicines, vaccines, transport, and administration.	\$2,200,000	MOH ¹⁰
PL 480 Commodities	\$3,347,004	USAID
Freight Value	\$1,212,000 ¹¹	
CARE Personnel & Operations	\$ 238,000	MOH
TOTAL	\$7,339,440	
<u>FY 1988</u> (projected)		
Infrastructure, equipment, warehousing, health personnel, technical assistance, medicines, vaccines, transport, and administration.	\$2,200,000	MOH
PL 480 Commodities	\$3,680,000	USAID
Freight Value	\$1,333,000	
CARE Personnel & Operations	\$ 262,000	MOH
TOTAL	\$7,853,000	

¹⁰ Ministry of Health.

¹¹ Based on an average of eight recent Bills of Lading (June to December, 1985). Average = \$ 82.00/metric ton.

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TYPE	AMOUNT	SOURCE
<u>FY 1989</u>		
(projected)		
Infrastructure, equipment, warehousing, health personnel, technical assistance, medicines, vaccines, transport, and administration.	\$2,200,000	MOH
PL 480 Commodities	\$4,050,000	USAID
Freight Value	\$1,466,500	
CARE Personnel & Operations	\$ 288,000	MOH
TOTAL	\$8,398,500	

VII. PUBLIC RECOGNITION

All commodities will be distributed in packaging that clearly identifies them as a contribution of the people of the United States of America.

VIII. USE OF CONTAINER FUNDS

Most feeding centers will use discarded containers (particularly the five-gallon pails used to package vegetable oil) in order to raise local funds for feeding center use to implement activities that are related to the program's goals. These activities will include those which are outlined in Section 2.4 of this document. Ministry of Health field staff will be responsible for all accounting procedures in relation to the use of these funds.

APPENDIX A

MULTI-YEAR PLAN

TITLE II ENHANCEMENT

MYP PROJECT PROPOSAL:

Country: Guatemala

Project Title: Title II Feeding
Enhancement

MYP Period: 1987 - 89

Prepared by: Christian A. Nill

I. INTRODUCTION

For twenty-three years CARE-Guatemala has been implementing a Mother-Child Health (MCH) feeding program in collaboration with Guatemala's Ministry of Health (MOH) using Title II commodities. For some years this mission has tried to inculcate among MOH managers and field personnel at distribution centers the idea of a "whole" MCH program which should involve the provision of certain services that are integrated with and complement mere commodities distribution. To date, however, CARE's intervention in the promotion of this idea has taken a somewhat passive form; there has been no concerted effort to adequately prepare MOH feeding centers² so they may be able to provide this integrated package of goods and services to project beneficiaries. At the same time, as we ask more critical questions regarding the implementation of the MCH program at the field level, this mission has begun to recognize all the more acutely the shortcomings of our present monitoring system in providing concrete and timely indicators of project performance trends and profiles.

The present Title II Feeding Enhancement proposal aims to address these problems in MCH project strategy. Hence the beneficiary target group contemplated by this project is essentially identical to the target group of our MCH project: that is to say, 270,000 pregnant and lactating mothers and pre-school

¹ Submitted to CARE Headquarters, February, 1986.

² "Feeding center", "distribution center", "MOH center" and "PHC clinic or center" will be used more or less interchangeably in this proposal, unless it is contextually understood otherwise.

children who receive PL 480 food supplements in approximately 650 health and nutritional rehabilitation centers in all of Guatemala's 22 departments. The goal of the project is to impact on all of these feeding centers, through the development of an improved field monitoring system that will allow this mission to measure more accurately each feeding center's compliance with certain "action standards" which are seen as essential to the achievement of goals and objectives within the MCH program. Subsequent project activity in specific areas of MCH enhancement will concentrate on approximately ten per cent of the feeding centers as a "nucleus of change", with the expectation that this nucleus will plant the seeds of change which may be replicated in other MCH feeding centers beyond the life of this project. Moreover, it is hoped that Guatemala's MOH will utilize the principles of project monitoring to be perfected through this intervention in many of its other ongoing health and nutrition programs.

A formal process of assessment of program enhancement requirements within the MCH program has essentially never existed. For this reason the point of departure for the Title II Enhancement project shall consist in precisely this initial phase, only now by using the novel approach of employing market research principles to discern those requirements. Upon completing this important diagnostic exercise, we hope to obtain two products: 1) a finely tuned MCH monitoring system which will enable this mission to identify and respond to specific feeding center problems in a more timely, holistic and cost-effective manner as well as obtain useful diagnostic profiles of project trends at any given time; and 2) a prioritization of those enhancement requirements in the MCH program which will require the intervention of this project. The remainder of this project will then devote itself to those priority interventions which are indicated as a result of this assessment phase.

Although the logic behind this process may preclude detailed a priori descriptions of the enhancement activities which are to follow as a result of needs assessment, the mission considers that some combination of the following broad areas of intervention will probably be pursued:

- the development of an improved field monitoring system to be utilized by CARE-Guatemala, and which shall relate

the key indicators of MCH performance to CARE's ongoing policy decision-making process aimed at fine-tuning of the MCH project;

- promotion of improved field educational activities in health and nutrition;
- upgrading the administrative and monitoring capabilities and performance of feeding center personnel;
- enhance the MCH program's capability to dynamically target nutritionally vulnerable groups.
- improving the quality of project information management for the purposes of ongoing monitoring as well as future analyses of impact;
- providing the necessary resources and guidance to effectively link health/nutrition education and Primary Health Care (PHC) services to the distribution of PL 480 commodities.

II. PROJECT DESIGN

2.1 Statement of the Problem

CARE-Guatemala's MCH program has concentrated for years on the distribution of Title II commodities. This fact becomes patently obvious upon taking but a brief look at MCH PATs at least since 1980. While empirical evidence would seem to indicate that this fairly exclusive project focus has nonetheless improved the nutritional status of many mothers and pre-school children, the potential for any lasting impact on these target groups, as well as the potential for effective project continuity, are somewhat limited.

These limitations may be illustrated on the one hand by the

example of the pre-schooler whose nutritional status is effectively rehabilitated through consumption of MCH food supplements, and who later develops an acute case of nutrient-depleting gastrointestinal dehydration due to poor sanitary conditions at home as well as the parents' ignorance of those simple measures such as homespun ORT which could alleviate the child's condition. The point here of course is to integrate supplementary feeding with sanitary and nutritional education sessions at the feeding center, within the community itself through home visits, and as a regular part of routine PHC consultancies.

On the other hand, the limitations that an exclusive focus on commodities distribution imposes on project continuity may be illustrated by the example of the feeding center that effectively rehabilitates a number of food recipients, upon accomplishing this dutifully removes the from beneficiary roles to make room for new individuals from high-risk groups, and thus dissolves all contact with the rehabilitated individuals. Supplementary feeding can of course only save beneficiaries from the imminent danger of malnutrition; only through periodic PHC consultancies during and after MCH enrollment will beneficiaries receive the adequate attention they need so as not to "lose ground" once again.

To be sure, a number of MCH feeding centers have taken their own initiative to undertake educational sessions in health and nutrition in conjunction with commodities distribution; some others have made efforts to assure that MCH beneficiaries are accurately targeted and receive primary health care along with the food, or have taken significant strides towards perfecting their own administration and local monitoring of the MCH program. But these positive (and very particular) features of the MCH program do not belie the facts that, on the whole:

1. Except for a promising but short-lived adventure in sectoral primary health care (the SINAPS program of the

early 1980s), CARE has to date encouraged this integration of MCH goods and services only on paper, even while local resources and technical know-how are admittedly insufficient to actually achieve this integration at every feeding center;

2. Even those educational sessions delivered with the best of intentions are in many cases failing to effectively reach their audiences, due to the formidable cultural and linguistic barriers which most PHC staffers are not trained to deal with;

3. Even those PHC staffers who offer regular consultancies to MCH beneficiaries are often unaware of the ways in which these consultancies can be combined with "one-on-one" health and nutrition education for the patient/beneficiary;

4. In the last analysis, those MCH feeding centers which have taken special initiatives in one or more of these areas are very few. CARE's field supervision of the MCH project reveals clearly that most feeding center personnel are overly occupied with the paperwork and mechanics of food distribution, without recognizing "the big picture" -- i.e., the provision of integrated MCH services;

5. Finally, CARE's project monitoring system is inadequate to distinguish which MCH feeding centers are meeting those action standards for the provision of integrated MCH services.⁴ Our present field monitoring does not provide the key information needed to determine which feeding centers require special

³ Refer to the MCH Nutrition Project Proposal that corresponds to this MYP period for more details on this program.

⁴ What are CARE's "action standards" for the provision of integrated MCH services? What do we mean by "integrated"? See Appendix A.1 for a first approximation towards answering these important questions.

assistance in this regard, nor which centers should actually be culled from the project; much less can it provide us with periodic profiles of project performance that could enable CARE to make informed decisions.

2.2 Final Goal

Effectively enhance CARE-Guatemala's MCH Nutrition project with respect to its field monitoring system, and in as many of the following program areas as may be indicated by an initial assessment of priority enhancement requirements:

- targeting of nutritionally vulnerable groups;
- feeding center administration and monitoring of beneficiaries;
- health, nutrition and hygiene education, both in the feeding center as well as in the field;
- feeding center PHC services;
- feeding center management of resources for commodities distribution and the provision of related services;
- MCH impact, in terms of beneficiary weight/height parameters as well as general health status.

The improvement of field monitoring will impact on 270,000 MCH beneficiaries during the life of this project, by providing CARE with a more efficient response mechanism to specific feeding center problems. The general program areas described above will be expected to directly impact on 27,000 MCH beneficiaries during the life of this project. With the replication of these activities at other feeding centers, however, it is expected that these program areas too will impact over the longer term on the total MCH beneficiary population of 270,000.

2.3 Intermediate Goals

Some of the following intermediate goals may be subject to subsequent refinement or possibly elimination, depending upon the results of a prior assessment of enhancement requirements within the MCH Nutrition project. This assessment will help determine those MCH program areas to which Title II Enhancement funds might best be applied. This assessment exercise is referred to in I.G. #1; it is described in more detail in Section 4.1 (Pre-Implementation Conditions).

Intermediate Goal #1: Complete initial survey of 10 % of all MCH feeding centers in order to develop and pre-test new field monitoring system and to establish priority program enhancement requirements to be addressed by this project. Approximate target date for achievement: April, 1986.

Intermediate Goal #2: Mission adopts and effectively utilizes improved field monitoring system which employs marketing techniques to monitor MCH Nutrition project. Approximate target date for achievement: June, 1986.

Intermediate Goal #3: MCH distribution centers effectively and accurately target vulnerable groups in their respective communities. Approximate target dates for achievement:
End of FY '87: 60% of centers comply (390 centers)
End of FY '88: 90% of centers comply (590 centers)

Intermediate Goal #4: 65 MCH distribution centers effectively carry out educational activities in health, nutrition and hygiene, using techniques appropriate to their audiences, in relation to commodities distribution. Approximate target date for achievement: June, 1988.

Intermediate Goal #5: MCH commodities distribution in 65 feeding centers is effectively linked to the provision of PHC services. Approximate target date for achievement: June, 1988.

Intermediate Goal #6: 65 MCH distribution centers meet action standards for local program administration and beneficiary monitoring.

2.4 Project Activity Targets

The comment which appears at the beginning of Section 2.3 will be seen to apply as well to the definition of this project's principal activities which follow. Also, it will be noted that the three fiscal years identified below correspond to the three-year duration of the Title II Enhancement grant; only FY 1987-88 fall within CARE's MYP planning period. The inclusion of information that pertains to FY 1986 is essential since it involves important activities that will be precursors for those that follow in FY 1987-88.

<u>Project Activity</u>	<u>FY 86</u>	<u>FY 87</u>	<u>FY 88</u>
Preliminary survey to assess priority MCH enhancement requirements:			
1. Define key project decisions & action standards as basis for survey design. (1 report)	1	-	-
2. Complete survey of 65 MCH distribution centers to test new monitoring system and determine priority enhancement requirements. (1 survey)	1	-	-

Title II Enhancement activities will then include some combination of the following, depending on priority enhancement requirements identified in (2.), above:			
3. CARE staff training re new monitoring system (# of pers/days)	48	24	-
4. MOH field personnel training re appropriate educational techniques in health/nutrition (# of pers/days)	-	650	650

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5. Educational sessions/demos. at feeding centers re health, nutrition & hygiene. (# of ed. sessions/demos.)	1170	2340	2340
6. Home visits performed by center-based rural health practitioners (000's of RHP visits)	39	78	78
7. Quality of instruction in educational sessions/demos. rated as effective. (% of such sessions which receive satisfactory rating by independent validator)	30%	75%	75%

8. MOH field personnel training re linkage of PHC services to food distribution. (# of pers.-days)	-	260	260
9. PHC consultancies/exams for MCH beneficiaries (000s of consults./exams)		53	106
106			

10. MOH field personnel training re development of "Annual Outreach Plans" for each feeding center. (# of pers.-days)	-	390	390
11. Annual Outreach Plans developed (# of plans)	-	65	65

12. Data Management System (DMS) developed for tabulation and analysis of monitoring information, this data to be treated statistically to indicate performance profiles and trends on a site-specific, regional, and national basis. (1 DMS)	1	-	-

13. Monitoring information from MCH feeding centers stored on DMS. (# of feeding centers)	65	420	650
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III. PROJECT OVERVIEW

3.1 Project Development

3.1.1 Development of the Concept

In mid-1985 CARE headquarters signed a grant agreement with USAID for the purpose of enhancing CARE's Title II MCH feeding programs. Guatemala was one of four CARE missions selected to participate in MCH enhancement activities under this grant. The original rationale for this selection was based on the mission's express interest in the "evaluation of the communications component of the MCH program with the objective of developing an overall educational strategy and some specific educational materials for general child care"s.

In May of 1985 CARE contracted the services of Dr. J. Carlos Manduley of INCS in Washington to visit Guatemala in order to make a diagnostic appraisal of the potential for educational enhancement within the MCH project. Dr. Manduley's reports provided a series of recommendations for such enhancement, starting with the implementation of a series of "model workshops" for MOH rural health practitioners on the theme of low-cost, appropriate

s CARE. 1985. Title II Enhancement. CARE World Headquarters. p. 22.

s Manduley, J.C. 1985. Interim Consultant's Report on PL 480 Title II MCH Project and Development of a Health/Nutrition Education Package for CARE/Guatemala. 68p.

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techniques for health and nutrition communication. Manduley's report at the same time revealed considerable enthusiastic support among key MOH officials for the idea of educational enhancement as part of an integrated package of MCH services. Later, in July of that year, Dr. Manduley came to Guatemala on a second TDY, for the purpose of launching the first of these workshops.

The final report⁷ that related the outcome of these workshop experiences, however, was met with some skepticism by CARE-Guatemala, insofar as it appeared that the biggest challenges of health and nutrition education in Guatemala had been sidestepped: i.e., the challenge of overcoming significant cultural and linguistic barriers that are indigenous to Guatemalan society and which pose a real obstacle to effective health/nutrition communication here, as well as the challenge of linking those educational efforts to the MCH Nutrition project in a meaningful and practical way. This mission then began to rethink whether "educational enhancement" alone is all that is required to make the MCH project more effective as a delivery system for certain goods and services, or whether, perhaps something more unique and more complete could be accomplished with Title II Enhancement funds.

Near the end of 1985 two important conclusions were reached: 1) we do not have an adequate awareness of what specific enhancement requirements exist within the MCH Nutrition project (though we do have untested notions); and 2) our present MCH field monitoring system is inadequate to provide this awareness through the collection of concrete information from which statistical patterns and profiles might be generated that show those deficiencies shared by many feeding centers, in their delivery of integrated MCH services.

These fundamental conclusions represented the watershed out

⁷ Manduley, J.C. 1985. Final Consultant's Report on PL 480 Title II MCH Project and Development of a Health/Nutrition Education and Communication Package for CARE/Guatemala. Parts I and II. (pp. unnumbered).

of which grew the present MYP proposal. It became logical that, to implement an MCH enhancement project, we need to get a better grasp of MCH enhancement requirements; that to get a better grasp of those requirements, we need to count on an effective MCH field monitoring system that will reveal general tendencies and deficiencies among the services that the MCH project aims to provide. And finally, it became logical that in order to obtain a more effective monitoring system, we need to efficiently focus on those key indicators of MCH implementation.

Thus, the point of departure chosen for the Title II Enhancement project was that of developing an improved field monitoring system for the MCH feeding program. In order to obtain a cost-effective monitoring system that really focuses on those key indicators of success of ear delivery of goods and services in the MCH project, it was decided that this mission might best utilize the expertise of a private sector marketing firm. This decision was based on two premises: 1) that a private sector enterprise selling a certain product to a certain public needs to obtain answers to most of the very same questions that CARE needs answers for in its MCH Nutrition project; and 2) a marketing firm, if it is to remain in business, must be able to develop systems to monitor correctly those key indicators of the delivery of goods and services.

The monitoring system to be developed based on marketing techniques will accurately respond to these and other aspects of MCH programming performance. As stated earlier, the results obtained early on from a representative sample of feeding centers will aid in determining those priority enhancement areas which will comprise the focus of this project's attention and activity during the remainder of the implementation period.

3.1.2 Host Agency Role and Interest

The public health sector of the Government of Guatemala has since 1980 given priority to the provision of integrated mother-child health services for the rural poor. This interest was made evident when in the early 1980s the MOH sought and obtained CARE's collaboration for the

development of a Sectoral Integrated Primary Health Care/Nutrition program (SINAPS). This two-year program made very promising advances towards the type of integrated MCH services discussed in this proposal. In 1983 MOH/CARE made plans to expand this program into three more departments of Guatemala under the name "APS"; unfortunately, the GOG fiscal crisis during that year prevented these plans from leaving the drawing board.

SINAPS and APS nonetheless serve to demonstrate the GOG's continued interest in providing PHC services along with supplementary feeding. These precedents warrant the renewed efforts in this direction, albeit with a different focus, which will be undertaken by this project. The recently elected government in Guatemala is not likely to renege on the priority of this health area; on the contrary, it has already shown strong signs of interest in precisely this type of integrated intervention.

What may require more active promotion on CARE's part is the concept of specifically using private sector market principles to develop the monitoring system which in turn will identify the priority enhancement requirements. The MOH is, needless to say, a very large bureaucracy, dedicated at least in part to project monitoring; indeed, it is precisely this bureaucratization of MCH monitoring that has caused all of us to lose sight of those really key indicators of implementation success. Nonetheless, we have had some positive preliminary talks on this subject with GOG health officials and planners, and we are confident of the MOH's general backing for the idea.

3.2 Project Strategy

Project strategy will consist in the following main components:

1. Development of an MCH monitoring system: With the assistance of a private marketing firm, a sample survey of about 10 percent of all MCH feeding centers will be performed, in order to establish those key indicators which best serve to gauge project performance at the feeding

center level, and which also will help generate profiles of project performance in general, in a statistically valid manner. Most importantly, the improved monitoring system will render only that field information which is essential for project decision-making; other field information which may be, obscurely "interesting", but which is not essential to this decision-making process, will not be addressed through monitoring procedures and formats.

2. Identification of priority MCH enhancement areas: These priorities will be established after completing the field testing stage of the improved monitoring system discussed in (1.).

3. Specific activities in the priority enhancement areas: Although the priority enhancement areas to be addressed will only come out of the previous steps outlined above, the strategy to address each of these areas is likely to follow the same generic sequence of activities:

- 3.1 Train key health personnel in the chosen programming area;
- 3.2 Evaluate their response to training over a period of time;
- 3.3 Provide follow-up training in the same programming area; and
- 3.4 Perform final evaluation of the response to enhancement activities in that programming area.

3.3 Project Impact

This project will be expected to have an impact on the entire MCH beneficiary family; not only those members of the family who are specifically targeted by the MCH Nutrition project. Two examples of how this will happen:

1. The linking of PHC services to commodities distribution at each feeding center will improve the access

to and routine use of such services not only by MCH beneficiaries (targeted mothers and children), but also the rest of the family members, by example.

2. Educational and extension services provided by the PHC unit will improve sanitary conditions, and subsequently health status, for the whole family, too.

In many communities these types of impacts may be expected to extend, by beneficiary neighbors' examples, to other non-beneficiary families, even though they don't receive the PL 480 food supplements.

The impact this project will have on women in each participating community is obvious by the very nature of MCH targeting.

Title II Enhancement is not expected to cause any negative impacts.

3.4 Project Continuity

CARE-Guatemala's MCH Nutrition project intervention is expected to continue into the foreseeable future -- at the very least, for the next five years. Its beneficiary level (currently at 270,000) may vary, depending upon the combined factors of detected need, CARE's programming potential, and of course USAID's food programming targets and ceilings.

Nevertheless, the project activities to be implemented under the Title II Enhancement project are expected to be continued by the MOH at the PHC unit level, even after such time as the MCH Nutrition intervention may be discontinued. These activities all involve the effective integration of PHC services -- something that each PHC unit should achieve and continue working at whether or not it runs a supplementary feeding program as well.

The replication of project activities in those PHC units that are not aided during the life of this project will be insured by involving key health officials and planners (including representatives of the health sector of the

government's non-MOH National Planning Secretariat) in all phases of project development, so as to create a nucleus of GOG decision-makers who will be in a position to mandate and guide project activities after the period of CARE's intervention.

3.5 Project Potential

The possibilities of replication of project activities were discussed above in Section 3.4. What we haven't yet emphasized is the strong potential this project has for replication in other CARE countries of the world. While integrated MCH services are not particularly new as a concept -- the idea is in fact at the root of CARE's food programming principles -- the concept of employing private sector market survey principles to monitor the delivery of integrated MCH services to each participating community is indeed innovative, and could serve to improve in significant measure the response capabilities of MCH nutrition projects in other countries where conditions for implementing this type of system permit.

3.6 Project Constraints

1. Turnover/relocation of MOH personnel: As one may appreciate in the PATs described above in Section 2.4, training of MOH personnel will be a major component of this project intervention. The normal turnover of personnel within the MOH, or even their unfavorable relocation, say from a rural PHC clinic to a city hospital ward, may cause some attrition among the trained body of rural health workers that this project aims to create. This project will attempt to forestall too great a loss in this respect by creating a nucleus of key technicians, planners and decision-makers who will be responsible for perpetuating the knowledge gained through these enhancement exercises. These key people will be selected with an eye towards the

6-7. a See CARE's Use of Food Aid: Policies and Guidelines, pp.

likelihood of their prolonged stay within the Ministry, and they will be responsible for the replication of this project's training exercises for new rural health workers that enter the field in the future.

2. Continued GOG support for MCH Nutrition: Over the years CARE's MCH Nutrition project has represented a highly valued component of the GOG's national health sector strategy. The economic crisis of recent years, however, has made the government ever more hard-pressed to put up the cash for MCH project administration. Should its commitment to MCH Nutrition waver in the future, this would have an obvious effect on the potential for Title II Enhancement activities.

3. USAID's commitment to food aid programming in Guatemala: CARE has seen the ebb and flow of this commitment in past years. Changes in the total authorized beneficiary level for CARE's MCH Nutrition project, however, may not have an impact on the success or failure of Title II Enhancement activities; USAID's commitment to Title II Enhancement itself most decidedly would.

IV. PROJECT IMPLEMENTATION

4.1 Pre-Implementation Conditions

1. Develop list of key project decisions, decision alternatives and action standards for the MCH Nutrition project. These will serve as a point of departure for the design of a sample survey of MCH distribution centers to be performed by a marketing firm to be contracted by CARE. (This pre-implementation condition has been largely fulfilled, though some further refinement may be required; see Appendices "A" and "B".)

2. Finalize consensus on project strategy to be pursued with key MOH officials and planners. The recent

installation of a recently elected government in Guatemala (formally as of 14 January, 1986) has of course meant many personnel changes within the public health sector. CARE will need to sustain more talks with the new health sector decision-makers in order to win their support for the ideas put forth in this proposal.

4.2 Implementation Plan and Schedule

The implementation of the Title II Enhancement project will consist in basically the following phases:

PHASE 1: Develop an improved MCH field monitoring system based on marketing techniques. This phase will consist in working with a private sector marketing firms to do the following:

1. Design and execute a sample survey of 10% of all CARE MCH feeding centers in order to field test those questions which relate directly to the key project decisions that CARE needs field information for. (See Appendix "B".)
2. Process survey results, and on the basis of these, a.) refine the protocol, procedures and formats for an MCH monitoring system; and b.) establish those priority MCH enhancement requirements that are to be addressed in later phases of this project.

This phase should be completed by April, 1986.

PHASE 2: Train CARE's own MCH field staff in the use of the new monitoring system, and develop a data management system

• CARE-Guatemala has had two very fruitful meetings with one firm of this type -- Gamma Servicios Integrados, Inc. GSI has wide marketing experience in Central America and Mexico. GSI's director, Mr. Derek Steele, is personally intrigued by the potential for applying marketing principles to the monitoring of a development program, and has committed himself to providing GSI's services to CARE on a cost basis.

with CARE's microcomputing facilities, which is capable of organizing the MCH field data so as to generate meaningful reports that will aid in ongoing project decision-making. This phase should be completed by the end of May, 1986.

PHASE 3: Address priority enhancement requirements through project intervention. While the exact nature of this phase will depend entirely upon which enhancement requirements have been identified through Phase 1, the following generic sequence of activities would be implemented,, whether the enhancement focus be on health/nutrition education, feeding center administration/beneficiary monitoring, beneficiary targeting, or linking PHC services to commodities distribution:

1. Train key health personnel from 65 MCH feeding centers, as well as a small number of MOH capital-based health technicians, in the chosen programming area. (One to two weeks.)
2. Use new MCH monitoring system to evaluate their on-the-job response to training over the course of about one year.
3. Provide a follow-up training session concerning the same programming area, and directed at the same health personnel, after approximately one year's time.
4. Conduct final appraisal of the degree of success achieved in enhancing the chosen program area.

4.3 Technical Considerations

None.

4.4 Procurement Requirements

No special procurement requirements for CARE headquarters, as all M&E is planned for local purchase.

4.5 Personnel Requirements

This project will require the services of one project manager, with at least 25% of his/her time assigned to this project.

V. PROJECT EVALUATION

5.1 Final Goal

Effectively enhance CARE-Guatemala's MCH Nutrition project with respect to its field monitoring system, and in as many of the following specific areas as may be indicated by an initial assessment of priority enhancement requirements:

- targeting of nutritionally vulnerable groups;
- feeding center administration and monitoring of beneficiaries;
- health, nutrition and hygiene education, both in the feeding center as well as in the field;
- feeding center PHC services;
- feeding center management of resources for commodities distribution and the provision of related services;
- MCH impact, in terms of beneficiary weight/height parameters as well as general health status.

Indicator: The indicator of achievement of the final goal will of course consist in the sum total of those intermediate goals achieved. Hence this indicator will be subject to refinement only after establishing with greater certainty those priority enhancement areas to

be addressed by this project; each enhancement area will be related to a specific intermediate goal, or series of goals. Below, in Section 5.2, is a series of intermediate goals which reflect this mission's a priori notions of the directions that Title II Enhancement may take.

5.2 Intermediate Goals

I.G. #1: Complete initial survey of MCH enhancement requirements in order to develop and pretest new monitoring system and to establish priority enhancement activities to be undertaken by this project.

Indicator 1: CARE's receipt of final report from private marketing firm on survey and monitoring methodology pretest results, by June, 1986.

I.G. #2: CARE adopts and effectively utilizes improved monitoring system for MCH Nutrition project, employing private sector market principles.

Indicator 1: Training sessions satisfactorily completed for CARE MCH staff re new monitoring protocol, procedures and formats by August, 1986.

Indicator 2: Independent validation of monitoring results is effectively functioning, based on reports rendered by validator (by October, 1986).

I.G. #3: MCH distribution centers effectively and accurately target vulnerable groups in their respective communities.

Indicator 1: MCH distribution center beneficiary roles show a turnover rate for infant beneficiaries (0 - 5 years of age) that is 15% per year.

Indicator 2: Field validation of distribution center beneficiary roles shows that beneficiary mothers are indeed pregnant or lactating and belong to low-income, high-risk groups.

I.G. #4: 65 MCH distribution centers effectively carry out educational activities in health, nutrition and hygiene, using techniques appropriate to their audiences, in relation to commodities distribution.

Indicator 1: 65 MCH distribution centers carry out center-based educational activities at least three times a month.

Indicator 2: MCH Rural Health Practitioners carry out field extension in health/nutrition education, in the amount of at least 100 home visits per month.

Indicator 3: 75% of MCH beneficiary mothers in 65 distribution centers regularly attend 75% of center-based educational sessions on distribution days (i.e., once a month).

Indicator 4: MCH distribution centers' analyses of changes in sanitary and food preparation habits among beneficiaries reveal significant changes in 50% of beneficiary families.

I.G. #5: MCH commodities distribution in 65 distribution centers is effectively linked to the provision of primary health care services.

Indicator 1: Feeding center records show that 75% of MCH beneficiary mothers obtain PHC pre- and post-natal consultancies with the frequency recommended for such visits.

Indicator 2: 90% of MCH feeding centers have at least one MOH worker who is judged as qualified to provide PHC consultancies and diagnoses.

Indicator 3: Feeding center records show that 75% of beneficiary children of 0 - 5 years of age receive PHC exams on at least a semiannual basis.

I.G. #6: 65 MCH distribution centers meet action standards for local program administration and beneficiary monitoring.

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Indicator 1: 65 distribution centers maintain up to date beneficiary roles as well as clear, organized records and reports of commodities movement.

Indicator 2: 65 distribution centers maintain organized and up to date beneficiary case histories for each MCH beneficiary, using formats recommended for this purpose.

Indicator 3: 65 distribution centers measure beneficiary children's growth (height and weight) in an accurate and timely manner.

Indicator 4: 65 distribution centers receive acceptable ratings with respect to program administration, based on a "scorecard" evaluation applied by CARE's MCH field supervisors and validated independently.

Indicator 5: 65 distribution centers develop "Annual Outreach Plans" which draw together in one operating document: 1) community needs assessment; 2) a PHC action plan designed to address those needs, with specific targets for achievement; and 3) analysis of resources available to implement the action plan.

VI. PROJECT FUNDING

6.1 CARE-Managed Inputs

Refer to MYP 1.2, attached.

6.2 Non-CARE-Managed Inputs

<u>TYPE</u>	<u>SOURCE</u>	<u>AMOUNT</u>
FY 1986		
Field health personnel, medicines, vaccines, transportation, administration	MOH	\$ 33,000
FY 1987		
Field health personnel, medicines, vaccines, transportation, educational materials, administration	MOH	\$ 65,000
FY 1988		
Field health personnel, medicines, vaccines, transportation, educational materials, administration	MOH	\$ 65,000
TOTAL		\$ 163,000

MYP 1.2

PROJECTED FUNDING REQUIREMENTS

CARE-MANAGED

Country: Guatemala

Project Title: Title II Feeding
Enhancement

SOURCES	FINANCIAL ¹⁰		IN-KIND
	M & E	P & O	
<u>CARE</u>			
<u>Headquarters:</u>			
FY 1986	0	0	0
FY 1987	0	0	0
FY 1988	0	0	0
TOTAL	0	0	0
<u>Non-Headquarters:</u>			
FY 1986	\$ 25,000	0	0
FY 1987	\$ 125,000	\$ 7,500	0
FY 1988	\$ 100,000	\$ 8,300	0
TOTAL	\$ 250,000	\$ 15,800	0

10 M & E = Material and Equipment
P & O = Personnel and Operations

APPENDIX A.1

KEY PROJECT DECISIONS AND ACTION STANDARDS

FOR MCH FEEDING CENTERS

1991

MCH MONITORING SYSTEM:
KEY PROJECT DECISIONS AND ACTION STANDARDS

1. PROJECT DECISION: Determine whether or not MCH commodities distribution is the best response to rural public health needs in Guatemala.

DECISION ALTERNATIVES

- 1.1 Continue MCH commodities distribution at current level (approx. \$3.06 million per year);
- 1.2 Decrease MCH commodities distribution by "x" percent through selective culling of inefficient or ineffective distribution centers (see Project Decision #7, below), and seek funds for new project to better equip rural health clinics (medicines, vaccines, anthropometric instruments).

2. PROJECT DECISION: Fix ideal ration size, based upon the degree to which the current ration is actually reaching targeted groups (i.e., pregnant/lactating mothers and children of 0 to 5 years of age).

DECISION ALTERNATIVES

- 2.1 Maintain ration size at current level (10 lbs./ben./mo.);
- 2.2 Overall ration increase up to 15 lbs./ben./mo.;
- 2.3 Selective* ration increase up to 15 lbs./ben./mo.;
- 2.4 Selective ration decrease to 8 lbs./ben./mo.;
- 2.5 Alternatives 2.3 and 2.4 together;
- 2.6 Ration size tailored individually to the size of each beneficiary's family;

* Selection criteria pending determination.

3. PROJECT DECISION: Fix ideal ration makeup, based upon the degree to which current ration makeup is accepted and actually consumed by target groups.

DECISION ALTERNATIVES

- 3.1 Maintain current ration makeup as follows:

30% NFDM
30% Soy-fortified bulgur
30% Cornmeal
10% Vegetable oil

- 3.2 Alter ration makeup as follows:

50% NFDM
20% S.F. bulgur
20% Cornmeal
10% Veg. oil

- 3.3 Alter ration makeup as follows:

50% NFDM
25% S.F. bulgur
25% Cornmeal

- 3.4 Alter ration makeup as follows:

30% NFDM
20% Cornmeal
20% "NEW PRODUCT"*
10% Veg. oil

4. PROJECT DECISION: Determine what human and material resources will be required in order to make feeding center educational efforts in health/nutrition more effective, particularly in those areas where language or cultural barriers may present special obstacles.

DECISION ALTERNATIVES

???

* "NEW PRODUCT" may consist of rice, CSM, or other commodity whose field acceptability is indicated and whose cost to project is acceptable.

5. PROJECT DECISION: Determine whether or not the expansion of the MCH program into more inaccessible areas is feasible on a logistical as well as cost basis.

DECISION ALTERNATIVES

- 5.1 Do not expand MCH program into any new feeding centers that are more than _____km from the capital city;
- 5.2 Expand MCH program to include 30 to 50 new feeding centers in areas of difficult access in two to three pilot departments on a one-year trial basis. ("Difficult access" shall mean feeding centers that are more than _____km from the capital city.)

6. PROJECT DECISION: Adjust beneficiary levels in any given feeding center, so that ben. level will be in accordance with:
- community needs (i.e., total potential ben. population);
 - project commodity resources available;
 - community receptivity;
 - feeding center's ability to manage the program effectively and to target vulnerable groups.

DECISION ALTERNATIVES

For each individual feeding center:

- 6.1 Leave current beneficiary level as is;
- 6.2 Increase beneficiary level by "x" bens.;
- 6.3 Decrease beneficiary level by "x" bens.

7. PROJECT DECISION: Continuation or discontinuation of the MCH feeding program in specific distribution centers, based upon each center's ability to:
- effectively target vulnerable groups;
 - effectively administer commodities distribution and related record-keeping;

- provide adequate infrastructure for commodities storage and transportation;
- effectively rehabilitate beneficiary children's nutritional status;
- provide educational services as a corollary to product distribution;
- effectively impact on beneficiaries' routine use of other PHC services.

DECISION ALTERNATIVES

For each individual feeding center:

- 7.1 "GO"
- 7.2 "NO GO"
- 7.3 "CONDITIONAL CONTINUATION": Provide special assistance to enhance the abilities of personnel at the distribution center, so that they may perform better any tasks in which they are found deficient. "Definitive" continuation ("GO") would depend upon re-inspection results at 3 to 6 months after special assistance is provided.

STANDARDS FOR A "GOOD" MCH FEEDING CENTER:
A FIRST APPROXIMATION

1. Targeting of vulnerable groups
2. Impact
3. Administration and monitoring
4. Infrastructure
5. Education
6. Primary Health Care (PHC) services

* * *

1. Targeting of vulnerable groups

- 1.1 Beneficiaries are among the poorest in the community;
- 1.2 Beneficiary adult women are indeed pregnant or lactating;
- 1.3 Beneficiary children are indeed 0 - 5 years of age (not older);
- 1.4 Beneficiary children actually suffer malnutrition;
- 1.5 Disqualified bens. (i.e., mothers who are no longer lactating and children who age above 5 years) actually leave beneficiary roles.

2. Impact

- 2.1 Feeding center has demonstrably rehabilitated at least 75 per cent of ben. children, as measured by Gomez chart parameters;
- 2.2 Infants born to ben. mothers show higher live weights at birth than in the general population.
- 2.3 Beneficiaries show higher rate of routine use of feeding center's PHC services, in comparison with the population

in general (see [4.5], below);

2.4 Beneficiaries' sanitary habits at home actually change as a result of educational efforts (see [5.5], below).

3. Administration and monitoring

3.1 Adequate medical charts kept for each MCH beneficiary (see currently recommended medical chart format; with comments, in Appendix "A");

3.2 Feeding center personnel measure ben. children's growth (height and weight) in an accurate and timely manner;

3.3 Feeding center personnel accurately measure food rations for distribution;

3.4 Feeding center director is interested in program objectives, and is willing to devote his/her own as well as his/her personnel's time to meet these;

3.5 Monthly reports sent to CARE in an accurate and timely manner (see sample monthly report in Appendix "B");

3.6 "Disqualified" beneficiaries (as defined in 1:5, above) are actually discharged from program on a timely basis, and new, qualified replacement beneficiaries added to ben. roles.

3.7 Feeding center funds raised from "beneficiary quotas" are used exclusively for purposes related to the objectives of the MCH program (e.g., for costing of education sessions for beneficiaries, medicines and supplies, office supplies directly related to program administration, commodities transportation to sub-distribution points, warehouse improvements, etc.)

3.8 In general, feeding center follows CARE guidelines for program administration (see Appendices "C" and "D").

4. Infrastructure

4.1 Food storage facilities are adequate for the volume of food commodities that the feeding center manages (adequate in terms of space, ventilation, structural impermeability, presence and use of tarimas, and protection from rodents);

4.2 Equipment and physical plant are adequate to carry out

education and PHC services, as described in (5) and (6), below (i.e., teaching space available, space for clinical attention available, teaching aids available, medicines and vaccines available);

- 4.3 Adequate transportation funds and facilities available to guarantee safe and timely transport of commodities to sub-distribution points (generally from health centers to subordinate health posts in the same district);
- 4.4 Characteristics (4.1) and (4.2) apply to sub-distribution points as well as to health centers.

5. Education

- 5.1 Feeding center personnel regularly undertake education sessions in health, nutrition and food preparation, aimed at MCH beneficiaries on distribution days;
- 5.2 Feeding center personnel conduct additional education sessions in the field, as an outreach activity;
- 5.3 Feeding center personnel utilize appropriate teaching techniques to effectively deliver their message to their audience;
- 5.4 When necessary, health/nutrition messages are communicated in local dialect, or interpreter is used;
- 5.5 Feeding center personnel monitor changes in habits as a result of educational exercises.

6. PHC services

- 6.1 Feeding center personnel is adequately trained to provide PHC services;
- 6.2 Vaccines available or readily obtainable from the Ministry upon request;
- 6.3 Basic medicines available in quantities adequate to serve the target population (including ingredients for the ORT suero casero):
- 6.4 At least a modicum of basic equipment available to perform PHC consultancies and exams (e.g., stethoscope, camilla, rectal and oral thermometers, etc.):
- 6.5 PHC consultancies are adequately documented on case history formats for each beneficiary.

APPENDIX B

PROJECT MONITORING:

CARE'S PLANNING, IMPLEMENTATION AND EVALUATION REPORT

(Trimestral)

ANNUAL IMPLEMENTATION PLAN

AIP 1.2

Country: Guatemala 042

FY 1987

PCN 01

Title: MCH Nutrition

	1st TRIMESTER		2nd TRIMESTER		3rd TRIMESTER		TOTAL	
	Plan	Actual +/-	Plan	Actual +/-	Plan	Actual +/-	Plan	Actual +/-
INPUTS:								
CARE Managed								
1. Financial								
a. PL 480 shipments received at port (000,000s of lbs)								
b. PL 480 shipments distributed to project sites (000,000s of lbs)								
c. Payment of GOG administrative recovery (\$000s)								
2. Personnel								
NON CARE Managed								
1. Personnel								
PROJECT ACTIVITY TARGETS:								
Commodities Distribution								
1. All PL 480 commodities (000,000's of lbs)								
COMPLEMENTARY ACTIVITIES								
2. Educational sessions/demos. at feeding centers. (# of sessions/demos.)	400		400		400		1,200	
3. Home visits performed by center-based rural health practitioners (RHP visits)	13,000		13,000		14,000		40,000	

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ANNUAL IMPLEMENTATION PLAN

AIP 1.2

Country: Guatemala 042

FY 1987

PCN 01

Title: MCH Nutrition

	1st TRIMESTER		2nd TRIMESTER		3rd TRIMESTER		TOTAL	
	Plan	Actual +/-	Plan	Actual +/-	Plan	Actual +/-	Plan	Actual +/-
4. PHC consultancies/exams for MCH bens. (# of cons/exams)	17,000		17,000		19,000		53,000	
5. Annual Outreach Plans developed and implemented by feeding centers (# of plans)			30		35		65	
INTERMEDIATE GOALS								
1. MCH distribution centers effectively and accurately target vulnerable groups in their respective communities.								
Indicator 1: MCH center ben. roles show a turnover rate for infant beneficiaries that is 15% per year.								
					15%		15%	
Indicator 2: Field validation of distribution center ben. roles shows that ben mothers are indeed pregnant or lactating and belong to low-income high-risk groups (% of dist. centers that pass field validation appraisal)								
					80%		80%	
2. MCH distribution centers effectively carry out educational and outreach activities in health, nutrition & hygiene!								
Indicator 1: MCH dist. centers carry out center-based educational activities on average 3 times a month (% of feeding centers that comply)								
					80%		80%	
Indicator 2: MCH Rural Health Practitioners carry out field extension in health/nutrition education, at rate of 100 home visits per month. (% of RHPs who meet this standard)								
					80%		80%	

APPENDIX C

DUTY-FREE EXONERATION
FOR IMPORTATION OF FOOD COMMODITIES

(Spanish)

Decreto Número: 26-00

El Congreso de la República de Guatemala

CONSIDERANDO:

Que es obligación fundamental del Estado fomentar el desarrollo de condiciones que conduzcan al bienestar de la colectividad, entendiéndose por dicha condición relativa a la protección y fomento de la unidad del pueblo, que lleven a cabo entidades nacionales o internacionales, para lo cual debe facilitar a éstas el pleno desenvolvimiento de sus actividades;

CONSIDERANDO:

Que "CARE INC." (Cooperativa Americana de Remesas al Exterior) es una organización privada, no lucrativa, integrada por varias entidades de los Estados Unidos de América, cooperativas de asistencia, religiosas, laborales y cívicas, que tiene por finalidad expresar la amistad del pueblo de los Estados Unidos de América hacia la población de otros países, extendiéndoles asistencia directa voluntaria en forma de ayuda, rehabilitación y reconstrucción equipo, medicinas y equipo médico, materiales, alimentos;

CONSIDERANDO:

Que "CARE INC." con la autorización de los ministerios correspondientes coordina sus esfuerzos con los programas de bienestar social del Gobierno de Guatemala y las agencias voluntarias en Guatemala, en favor de los grupos más necesitados de la población de este país, especialmente en lo que concierne a la salud y a la alimentación, por lo cual es indispensable darle las facilidades fiscales y administrativas para el desarrollo de sus trabajos, por el beneficio que reporta al país.

FOR TANTO,

En uso de las facultades que le confiere el artículo 170 inciso 4o. de la Constitución de la República,

DECRETO:

ARTICULO 1o. Se exonera de derechos aduaneros, almacenaje, impuestos, contribuciones, tarifas y demás tasas, impuesto fiscal por timbre, cargos y sobrecargos a "CARE INC." sobre las importaciones que efectúe con destino a los programas de asistencia previstos en sus contratos operativos acordados por el Gobierno de Guatemala.

ARTICULO 2o. También se concede a favor de "CARE INC." la exención de todos los impuestos y cargos a que se refiere el artículo anterior sobre lo siguiente:



- a) los salarios u otras remuneraciones por servicios personales que la citada institución pague a sus representantes y empleados extranjeros residentes en Guatemala; y sobre lo obtenido de residencias, cuyos títulos se expedirán al efecto;

(Decreto Número 16-67)

- b) La importación y exportación del manejo de casa, efectos (ropa, calzado, equipo y suministros que traigan al país en su viaje y durante su trabajo en Guatemala, y la importación de vehículos y sus exportaciones en su caso, para los funcionarios o empleados extranjeros residentes en Guatemala que presten sus servicios a "CARE INC."
- c) El costo de los servicios portuarios, de descarga, muelle, almacenaje y de almacenamiento y transporte, de los artículos, suministros y equipos que se importen, inclusive el manejo de casa y vehículos a que se refiere el párrafo precedente cuando sean proporcionados por empresas portuarias del Estado o por entidades estatales descentralizadas, autónomas o semi-autónomas o por cualquier otra entidad;
- d) Los bienes, propiedades y rentas, de esta entidad, así como sus operaciones y transacciones; los bienes tendrán rotulación apropiada para indicar su procedencia y el modo de empleo; los bienes, propiedades y rentas deben estar destinados a los programas de asistencia;
- e) La reexportación de toda la mercadería, suministros y equipo - que no hayan sido distribuidos y sobre los cuales la organización haya retenido título de propiedad;
- f) Los artículos, equipo y materiales que "CARE INC." adquiera lo suficiente para los programas de asistencia previstos en sus contratos operativos.

ARTICULO 3o. Para gozar de las exoneraciones a que se refiere la presente ley, la institución mencionada deberá firmar, con los ministros que reciben las ayudas, los contratos básicos y operativos que norman la distribución de los mismos; y deberá solicitar en cada caso las exoneraciones, ante el Ministerio de Hacienda y Crédito Público, el que calificará su procedencia e impartirá órdenes encaminadas a su pronta expedición. Cuando se trate de alimentos y medicamentos se dará cumplimiento a los requisitos exigidos por las leyes y reglamentos de Sanidad. Las diferentes dependencias administrativas quedan obligadas a prestar, las facilidades necesarias para la transportación de las importaciones de ayuda, de los puertos guatemaltecos a las centrales de distribución.

ARTICULO 4o. El presente Decreto deroga el Decreto-Ley número 62 y entrará en vigor el día siguiente de su publicación en el Diario Oficial.

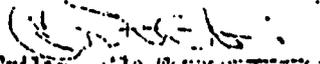
PASE AL ORGANISMO EJECUTIVO PARA SU PUBLICACION Y CUMPLIMIENTO.

DADO EN EL PALACIO DEL ORGANISMO LEGISLATIVO, EN LA CIUDAD DE GUATEMALA A LOS OCHO DIAS DEL MES DE ABRIL DE MIL NOVECIENTOS SESENTA Y NUEVE.



[Handwritten Signature]
 FRANCISCO VILLALBA
 Presidente.

(Decreto Número 16-67)


Emilio Avila Torpou
Primer Secretario


Victor Manuel Marroquin C.
Cuarto Secretario

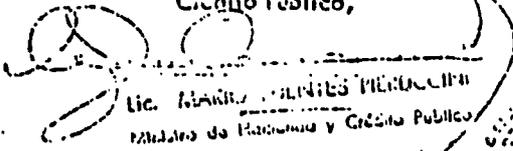


Republica Nacional: Guatemala, VEINTIOCHO de ABRIL de mil novecientos sesenta y nueve.


PUBLIQUESE Y CUMPLASE.

MENDEL MONTENEGRO.

El Ministro de Hacienda y
Credito Publico,


Lic. MENDEL MONTENEGRO
Ministro de Hacienda y Credito Publico



APPENDIX D

CARE-GUATEMALA NATIONAL PERSONNEL

CARE-GUATEMALA NATIONAL PERSONNEL

<u>NAME</u>	<u>POSITION</u>	<u>% ON PROJECT</u>
Avila, Henry	Field Supervisor	
Fuentes, Flavio	Field Supervisor	
Lemus, Roberto	Field Supervisor	
Palacios, Helio	Field Supervisor	
Pérez, Marco Antonio	Field Supervisor	
[New position]*	Field Supervisor	
[New position]*	Field Supervisor	
Rosales, Norberto	Clerk (Feeding)	
Garcia, Carlos	Administrative Assistant	
Chacón, Esteban	Clerk (Feeding)	
Fearon, Roy	Port Representative	
Ericastilla, Rosendo	Warehouse Foreman	
Milián, Nicolás	Warehouseman	
Garcia, Rigoberto	Warehouseman	
Garcia, Daniel	Bookkeeper	
Mazariegos, Victor Hugo	Inventory Clerk	
Arriaga, Rosario de	Accounting Clerk/ Bilingual Secretary	
Flores, Carlos	Vehicle Fleet Assistant	
Cheng, Aidé	Customs Clerk	
Macario, Eusebic	Agroforestry Extensionist	

<u>NAME</u>	<u>POSITION</u>	<u>% ON PROJECT</u>
Zacarias, Victor Manuel	Truck Helper	
Wizel, Eugenia	Exec. Secretary	
Flores, Rodolfo	Administrator	
Alvarez, Rosa Eugenia de	Biligual Secretary	
Barrios, Arelly	Receptionist	
González, Alejandro	Messenger	
Aldana, Octavila	Janitoress	
Midence, Ricardo	Office Clerk	
Enriquez, Efrain	Driver	

* Personnel to be selected by June, 1986.

APPENDIX E

BENEFICIARY RATION MAKE-UP

BENEFICIARY RATION MAKE-UP

MCH NUTRITION PROJECT

<u>COMMODITY</u>	<u>MONTHLY RATION*</u>	
	<u>LBS.</u>	<u>KGS.</u>
Soy-fortified Bulgur	3	1.36
Cornmeal	3	1.36
NFDM	3	1.36
Veg. Oil	1	0.45
TOTAL	10	4.54

* The rationale behind the choice of these commodities is based upon caloric and nutritional values found in the revised PL 480 Commodities Reference Guide. It is worth emphasizing once again that this ration will be under study to determine with greater clarity its acceptability among project bens., dilution, sharing, etc. Please refer to Appendix "A" for more on this.

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