STRATEGIC OBJECTIVE CLOSE OUT REPORT (SOCR)

A. Strategic Objective (SO) Name: Better Health for Women and Children

B. Number: 520-003

C. Approval Date:

On March 13, 1997, USAID/W approved the USAID/G-CAP bilateral strategy 1997-2001 (later extended to 2004), including the health SO "Better Health for Rural Women and Children," (later re-named "Better Health for Women and Children.")

D. Life of SO Funding (by USAID funding accounts):

$84,804,098 ($34,556,297 CSH; $3,165,000 OH; $46,353,801 POP; $729,000 AIDS).

E. Completion Date: March 31, 2005

F. Counterpart Contributions:

The targeted counterpart contribution during the strategy period was $29,077,622.00. The actual cost-sharing provided surpassed this projection. By the end of the strategy period USAID's main partners *Asociación ProBienestar de la Familia de Guatemala* (APROFAM), Project Concern Internation (PCI), Ministry of Health (MOH) and Pan-American Health Organization (PAHO) contributed with $37,384,111.03 as counterpart.

Counterpart contributions during the first phase of the health bilateral Agreement reached a total of $4,299,661.10, in-kind and cash contributions. According to PIL No. 9 dated August 28, 2000, counterpart contributions from the MOH were required in cash only for the second phase of the Agreement. Through March 2005 the MOH achieved 100.01% of its planned cash contributions ($7,019,700,00). The actual MOH total reported for the strategy period was $7,019,700,00 in cash and $4,139,634.14 in-kind counterpart contribution.

G. Geographic Impact Area:

The work in family planning and immunization had a national scope; the strong focus on increased use of Maternal and Child Health (MCH) services in the rural western highlands of Guatemala (the seven departments of San Marcos, Sololá, Totonicapán, Quetzaltenango, Chimaltenango, El Quiché and Huehuetenango) was to bridge the enormous gap between rural Mayan populations and the rest of the country. To follow up MotherCare interventions, the Maternal and Neonatal Health activity included Suchitepéquez and Retalhuleu.

H. Principal Implementing Partners:

MOH; Guatemalan Social Security Institute (IGSS); Abt Associates; Academy for Educational Development (AED); AmeriCares; APROFAM; *Arevalo Perez, Iralda & Asocs.* (Pannell Kerr Forster - PKF – Guatemala); EngenderHealth, Quality Assurance Project,

INCAP, JSI/FPLM, JSI/Deliver; Centers for Disease Control (CDC); Development Associates; Family Health International (FHI); Futures Group; *Importadora de Productos Farmacéuticos S.A.* (IPROFASA); Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO); John Snow Research and Training Institute Inc. (JSI); LTG Associates, Inc.; Management Sciences for Health (MSH); Pan-American Health Organization (PAHO); Population Council; PCI; and University Research Corporation (URC).

I. Summary of Overall Impact at SO and Intermediate Result (IR) Levels:

SO Level: The SO made a major contribution towards better health for women and children in Guatemala as measured by significant reductions in the two major SO indicators - **Infant Mortality** and **Total Fertility** - in the 2002 National Maternal and Child Health Survey (ENSMI) conducted by CDC and co-funded by UNFPA, UNICEF, UNDP, the MOH, the European Union, and Swedish SIDA. Between 1999 and 2002, infant mortality declined from 45 to 39 per 1,000 live births, a 50% bigger drop than expected (to 41). During the same time period the Total Fertility Rate (TFR) was reduced from 5.0 to 4.4, three times the expected drop (to 4.8).

IR1: Increased Use of Quality MCH Services and Better Household Practices
The **National Contraceptive Prevalence Rate (CPR)** rose from 38.2% in 1999 to 43.3% in 2002. The increase in contraceptive prevalence in the indigenous population from 12.6% to 23.8% was much greater than the increase in the ladino population from 49.9% to 52.8%. As a result, the indicator for the **Reduction in the Gap between the Mayan and Ladino Populations** showed a greater than expected decrease in the ladino rate from being 4.5 times higher in 1995 to 3.9 times higher in 1999, and 2.2 times higher in 2002, against the targeted decline of 3.0 times higher, thus amply meeting the SO's goal of narrowing the access gap. The **Reduction in the Gap in CPR between the Urban and Rural Populations** basically achieved the targeted decline with the urban rate being reduced from being 2.5 times higher in 1995, to 1.9 times higher in 1999, and 1.6 times higher in 2002 against the target of 1.5. There were 279,465 **New Family Planning Users** from January to September 2004 compared to the target of 237,185 and the baseline of 117,178 in 1998. During the life of the SOAG (1997-2004), USAID partners accumulated 3.946 million Couple Years of Protection (CYP), with the MOH as the major service provider since 2003. The SO achieved 531,187 **CYP** from January to September 2004, exceeding the target of 480,045 and achieving a 187% increase from baseline in 1997. The immunization program was also a remarkable example of equity and success in increasing rural coverage; there were no differences between rural and urban coverage in ENSMI 2002 for the **Complete Vaccination Coverage of Children Aged 12-23 months** indicator with 63% of children in this age group fully immunized per household interviews, compared to 43% in 1995 and 60% in 1999. The indicator of **Met Need for Essential Obstetric Care** at 58% in 2003 fell short of the target of 68% but was still a significant increase over 19% in 1997. The poor performance is attributable entirely to the Totonicapan hospital's poor performance, which was due to political reasons beyond the SO's control and forced a withdrawal of USAID assistance for maternal and neonatal health interventions in that health area. When this poor performing hospital is excluded, the indicator rises to 65%, which is satisfactory.

IR2: Public Health Programs are Well-Managed

The percentage of MOH and IGSS family planning service delivery sites that report no **stockouts** of contraceptives during the six-month period prior to being interviewed is a key measure of well-managed programs. Data from the 2002 Stockout Survey indicated that the MOH achieved 59% vs. their 72% target and IGSS achieved 79% vs. their 83% target. The MOH fell short of the ambitious target, but improved significantly since the indicator was last measured in 2000, when it only achieved 37% absence of contraceptive stockouts. Hard to reach rural health posts and frequent staff turnover continued to be a challenge for reducing MOH stockouts. Following these poor results, in 2003 the contraceptive logistics systems and stock levels of around 1,500 service delivery points of the MOH and IGSS were strengthened through norms, manuals, information systems, and national inventories. At the end of 2004, the stock out indicator at the time of the visit improved from 40% in 2000 to 14%. As a result of an intense effort by the MOH, IGSS, and APROFAM to increase access to family planning, the **Number of (14) Medical/Institutional Barriers to Family Planning Services Removed** was decreased to five, exceeding the target of four. The indicator "**National HIV/AIDS Surveillance System Provides Annual Seroprevalence Data**" was met and the national HIV/AIDS surveillance system was significantly strengthened by MERTU-CDC.

IR3: Increased Guatemalan Commitment to Integrated Women's Health

The indicators of **Cumulative Number of Campaigns Advocating Women's Participation** and **Number of GOG plans that Use Information Provided by Policy Project** were met with 41 campaigns from January through September 2004 and seven GOG plans. The **Policy Environment Score** increased from 45 in 1997 to the target of 60 in 2003.

J. Summary of activities used to achieve the SO and their major outputs:

IR1: Increased Use of Quality MCH Services and Better Household Practices

To improve the health of women and children, USAID's program responded to the principal causes of maternal and child morbidity and mortality as well as high fertility in Guatemala by assisting public and private sector service providers to increase the use of quality reproductive and child health and nutrition services and to improve health and nutrition practices. Assistance from USAID focused on rural Mayan highland populations to bridge the enormous health gap between these groups and the rest of the country. USAID's family planning and immunization assistance, in contrast, were national programs.

In 2004, the program met or exceeded all its targets toward increasing use of quality MCH services and better household practices, most notably family planning services, integrated maternal child health and nutrition community-based services with food aid as an integral component, and essential maternal and neonatal care. The program was implemented by the highly committed and effective Guatemalan MOH, through their National Reproductive Health Program, and the IGSS, both of which received support from the *Calidad en Salud* project implemented by URC. During the first part of the strategy, from 1997 to1999, USAID's reproductive health program had to maintain a low profile with the then conservative government. However, the administration that came to office in January 2000 showed an unprecedented commitment to reproductive health. The MOH's National

Reproductive Health Program was launched in 2001; the legal basis for family planning was solidified with the passing of the Social Development Law in October 2001 and the policy for implementing the law was issued in April 2002. The current government which came to office in 2004 has continued the program. *Calidad en Salud* provided the MOH, its partner non-governmental organizations (NGOs), and the IGSS with the tools and skills required to improve the quality of and access to basic health services and to stimulate demand for these services. The improvement in health services was not only in the quality of attention but also in extension of coverage. The MOH is committed to community involvement and has made major advances by contracting out health care coverage under its rural health service delivery model, the Integrated Health Care System (SIAS), to grassroots NGOs that are attuned to local needs and promote community participation through the selection by each community of its own health volunteer. The *Calidad en Salud* program, with USAID support, further strengthened community participation in the MOH program by introducing a four-step process the NGOs use which includes: (1) identification of key actors in the community; (2) health status data collection and sharing in community forums; (3) guided analysis of the health situation by the community, including causes, solutions and action plans (community situation room); and, (4) implementation, monitoring and evaluation of action plans by the community. All community health volunteers have been trained in the four-step methodology and the mothers and other caregivers are mobilized through the monthly child weighing sessions.

Calidad en Salud worked successfully with the MOH to launch an effective program to respond to faltering growth, micronutrient deficiencies and health problems at an early stage in women and children under two years. The Integrated Management of Childhood Illness (IMCI) Program with a strong community-based, maternal child health/nutrition prevention component, known in Guatemala as the AIEPI AINM-C Program, was officially launched by the MOH in 2001, and is currently up and running in more than 2,150 rural communities in the seven departments of the western highlands where USAID's health program was focused. Under AIEPI/AINM-C, 1,187 community health center providers and 12,763 promoters were trained and equipped and are conducting monthly weighing sessions for more than 100,000 children under two years. Clinical services are being provided by 487 health centers and posts and 191 mobile doctors (*médicos ambulatorios*). As a result, the quality of child health care is high: 95% of providers verified the existence of illness and health danger signs, 91% of children were provided antibiotics when needed, and 93% of health providers verified appropriate food intake in children. A major accomplishment in 2004 was the successful transfer of the IMCI program to the new government and its continued expansion. The objective of the MOH is to scale up the AIEPI AINM-C strategy to the national level through the SIAS system, which has been further strengthened through the adoption of the key service delivery model innovations that were jointly developed under the USAID NGO Networks project (*Pro Redes Salud*) and *Calidad en Salud*. The MOH is using its counterpart contribution to buy equipment, training and education materials for expanding it to cover 46,000 more children in addition to the 110,405 enrolled in FY 2004. Whereas more than 60% of children under two years were not gaining adequate weight when the program started in 2002, by 2004, 60% of children weighed did gain adequate weight. Through USAID's advocacy, AIEPI AINM-C has also been embraced as a top priority by Guatemala's First Lady and the government's "War Against Hunger". They re-named the program "*Creciendo Bien*" (Growing Well) and are working with the MOH to expand it by

40% in the 102 poorest municipalities with the most childhood stunting. The European Union, PAHO, and Plan International are also financing the scale-up of AIEPI AINM-C in other geographic areas beyond the USAID Western highlands seven focus departments.

The AIEPI AINM-C program was also implemented by many private sector NGOs, mostly local, contracted under the MOH's program to extend coverage of basic health services, or that received assistance through the NGO health programs of Population Council and PCI, as well as the NGO Health Networks Program (*Pro Redes Salud*) implemented by JSI and AmeriCares. The Population Council provided technical assistance to institutionally strengthen 24 NGOs providing IMCI and oral dehydration for diarrhea (ORS) services; quality care during pregnancy, delivery and post-partum; and family planning services which achieved 2,898 new users. The PCI program provided coverage to 222,872 inhabitants through ten NGOs in 379 communities in six departments. *Pro Redes*, which started in September 2001, worked with nineteen NGOs and eight NGO health networks, including all the NGOs previously assisted by Population Council and PCI, covering a total estimated population of 317,000 in rural areas where no reproductive and child health (RCH) services were previously available; a 23.4% increase in RCH coverage in the seven highland departments. Family planning and community IMCI were integrated into service delivery through 19 grantee NGOs and 52 NGOs funded by SIAS, as well as the other NGO members of the eight grantee networks. All the NGOs working in the seven highland departments were included. It is a major accomplishment towards sustainability of this SO that we were able to successfully negotiate with the MOH to continue health care coverage for 317,000 people via MOH-financed contracts to NGOs, before *Pro Redes* ended in September 2004. The Cooperating Sponsors for the PL 480 Title II program (CARE, CRS, SHARE and Save the Children) are playing a key role in implementing the AIEPI AINM-C program in their target areas with food aid as a complementary component, and are helping the MOH to train other providers in the expanded program.

An umbrella network, the *Asociación Nacional de Redes de ONGs en Salud en Guatemala* (ASOREDES) which has a national presence, was formed in 2004 as a product of the *Pro Redes Salud* project. It is made up of seven NGO networks and an estimated 130 NGO members. This is the first NGO network federation in Latin America, i.e., a third tier entity consisting entirely of networks. ASOREDES has immense potential for effective non-governmental health work in Guatemala. Another accomplishment of the *Pro Redes Salud* project is the fact that the networks participating in the project were given seed funds to establish revolving drug funds for all communities where health services were provided. The medicines were sold at PROAM (government) replacement cost plus 35%, and by July 2004, the original seed funds had increased on average by 166%. In 2004 the networks were assisted to convert the revolving drug funds into *botiquines comunales* or *ventas sociales* (rural low-cost pharmacies) affiliated with PROAM. This allowed them to continue to provide their NGOs with basic medicines without additional outside funding, while also providing income for the network.

The very positive family planning performance has already been commented on in Section I. The methods contributing the most to CYP were voluntary surgical contraception followed by Depo-Provera injections. The MOH continued the position it gained for the first time in history in this strategy as the largest single contributor to CYPs, providing 44% of the total,

with APROFAM continuing in second place with 38% of CYPs. APROFAM had historically been the biggest provider, filling the gap left by a passive MOH prior to 2001. This was a desirable shift in roles as the MOH was able to capitalize on the extensive infrastructure that only it had to reach the poor in isolated rural areas. Family planning services delivered by NGOs, including *Pro Redes* and MOH-contracted NGOs, increased significantly from 2003, but still represented only 2% of all CYPs in 2004. The SO Team needs to continue to work on increasing the delivery of family planning services by NGOs or reconsider whether this is a worthwhile strategy. All USAID partners met their CYP targets except IGSS, which fell short by 16% of its target. This shortfall is largely due to deliberate, conservative restrictions in IGSS during 2004, which denied family planning services to all beneficiaries and their dependents except during the 45 days postpartum, in conflict with the Social Development Law. In response to multiple advocacy processes carried out by USAID-supported programs, IGSS reinstituted the family planning program in 2005.

A comprehensive family planning counseling strategy was implemented by the MOH nationally with URC assistance, with a focus on lengthening pregnancy intervals to the optimum 3-5 years, as well as implementation of improved national family planning norms and protocols that allowed the MOH to decrease medical/institutional barriers to family planning access by clients. Family planning information, referral and services are part of the AIEPI AINM-C program. At the request of the MOH, women's groups have reviewed the norms and protocols to assure gender sensitivity. Per the 2002 ENSMI, the program's family planning information, education and communication (IEC) efforts are having an impact as knowledge of modern contraceptive methods among Guatemalan women improved from 81% in 1999 to 91% in 2002. APROFAM was the star among USAID's partners in terms of making the most significant progress in reducing medical/institutional barriers to family planning between 1999 and 2003. A plan to further reduce remaining medical barriers to family planning was developed by the MOH, IGSS and APROFAM. The Committee formed to guide the medical barriers studies conducted in 1999 and 2003 has been institutionalized to continue as a steering committee for follow-up and future studies. Three hundred sixty six MOH auxiliary nurses in twenty departments have been trained and are now providing intrauterine devices (IUDs) for the first time in health posts closer to where rural women live; the IUD used to be available only from physicians at distant health centers. Similarly, APROFAM has trained rural educators in IUD insertion to bring services closer to their rural clientele.

During the strategy period, APROFAM and IPROFASA were large, competent private sector partners of USAID, focusing mainly on family planning service delivery and contraceptive social marketing. USAID was as equally interested in seeing APROFAM survive and increase its self-sufficiency as in improving the health service capacity of MOH and IGSS. APROFAM provides a high quality, affordable package of reproductive and child health services in both urban and rural areas and is a good complement to the GOG, especially in times when the government does not proactively provide family planning services. Given the MOH's offer of free family planning services to some of the same rural paying customers of APROFAM, work to advance the self-sufficiency of APROFAM has been a challenge. There is a tendency for new family planning users to go to APROFAM for a thorough, initial check-up and good advice, but then to go to the MOH to re-supply their selected family planning method for free. With Field Support from the MSH's Management

and Leadership Project, USAID assisted APROFAM to redesign its Rural Development Program to better define its market segment vis-à-vis the new proactive MOH which provides free services and should therefore be target the poorest. Marketing efforts also extended employer-based family planning/reproductive health care services in partnership with leading corporations in Guatemala, including a successful alliance with GUATEVISION TV station for free airspace for APROFAM spots on prevention of uterine cancer. It is impressive to note that APROFAM has already achieved 86% institutional self-sufficiency, up 23 percentage points since 1998. The Rural Development Program, operating in remote and poor villages has reached 64% sustainability. APROFAM bought its own condoms for the first time in 2003.

Helping APROFAM achieve 100% self-sufficiency is a key management goal for the new CAM SO3. However, Mission plans to start a new Cooperative Agreement with APROFAM in October 2004 were thwarted when the APROFAM Board abruptly dismissed the APROFAM Executive Director in July 2004 without USAID approval. Dismissing key personnel requires prior USAID approval under the Cooperative Agreement, and the actions of the APROFAM Board constituted a breach that led USAID to postpone the new agreement until a series of requirements were met by APROFAM. The requirements were formalized through a six-month unfunded extension and include: a) hiring a new Executive Director approved by USAID, b) intensive technical assistance on governance issues for the Board and the membership via GH Field Support to MSH's Management and Leadership Project, c) additional financial and programmatic reporting requirements, and d) the creation of a trust fund to protect the financial reserves of the organization. The Board invited USAID to participate in the selection of the new Executive Director, who is now on the job, and to be an "ex-officio" Board member. APROFAM is also in compliance with the other requirements. The developments of the past six months within APROFAM underscore the need to invest in the leadership of the organization even at the expense of using resources intended for the sustainability trust fund.

USAID culminated 20 years of collaboration with IPROFASA in June 2003 but has continued periodic coordination meetings with the organization, and is receiving sales reports for *Perla* oral contraceptives and *Scudo* condoms on a quarterly basis. The principal objective of USAID support to IPROFASA was to expand the sale of low-priced condoms and oral contraceptives through the commercial sector. This objective was pursued through USAID financing, on a declining basis, to support IPROFASA's social marketing program. USAID donations of condoms and oral contraceptives were repackaged locally as *Scudo* and *Perla* respectively, and technical assistance through the centrally-funded social marketing program SOMARC was provided. All the contraceptives distributed through IPROFASA in over 1,500 retail outlets nationwide were estimated to have provided approximately 490,000 CYP. A phase-out of assistance to IPROFASA began in 1999 and by 2003, IPROFASA had achieved financial self-sufficiency and was procuring replacement stocks from private suppliers. It also had agreed to maintain the low price of *Scudo* and *Perla* (adjusted for inflation), thus assuring a continued commercial source of low-priced condoms and oral contraceptives.

The immunization program was a remarkable example of equity and success in increasing rural coverage; there were no differences between rural and urban coverage in ENSMI 2002

with 63% of children 12-23 months fully immunized per household interviews. Measles eradication efforts have been effective with no measles cases reported. Per MOH statistics, immunization coverage with Mump Measles and Rubella (MMR) vaccine reached 72% by the end of September 2004 and should be over 90% by year's end. Coverage with MMR, the last vaccine a child receives in the first year of life, is a good proxy for complete vaccination coverage. Guatemala's immunization program has successfully achieved sustainability. USAID contributed technical assistance through PAHO to strengthen the program, which ended in September 2003, and some equipment purchases, but the MOH financed most of the program, including the vaccines.

To spur action to address the findings of the 2000 baseline maternal mortality study that documented Guatemala's high maternal mortality ratio of 153 per 100,000 live births, a Maternal Health Monitoring Group comprised of the MOH, USAID, and other local and donor organizations drafted and published National Strategic Guidelines to Reduce Maternal Mortality. To increase availability of Essential Maternal and Neonatal Care (EMNC), the MOH has implemented a Performance and Quality Improvement Process (PQI) with assistance from GH Field Support to the Maternal and Neonatal Health (MNH) Program of JHPIEGO in more than one-third of the MOH's health facilities in USAID's seven focus departments in the Western Highlands (154 of 395). Alliances with other private organizations and the MOH made possible the expansion of PQI to 318 health facilities in 10 other health areas. In 2004, the new MOH authorities questioned the maternal and neonatal health approach taken by USAID and MNH, and we provided technical assistance to the MOH to conduct an evidence-based review. A final decision by the MOH to scale up the MNH work is still pending. Some examples of improvements in quality of maternal and neonatal care should be noted. Adequate sterilization of instruments improved from 0.0% in 2001 to 100% in 2003. Hospitals with adequate supplies and equipment for EMNC in their labor and childbirth rooms increased from 28% in 2001 to 63% in 2003. Use of the partograph to diagnose obstructed labor, reduced use of episiotomy in first deliveries, immediate skin-to-skin contact of babies with their mothers after delivery, and active management of the third stage of labor in vaginal births to prevent postpartum hemorrhage all improved greatly in participating hospitals and maternity clinics. These procedures have been included in the national norms and standards. Four clinical-training centers have been strengthened for EMNC as well as eight public and private nursing schools. The AIEPI AINM-C program implemented by various USAID partners also includes prenatal care and iron/folic acid supplementation for women of reproductive age as basic services.

The Behavior Change Component of the MNH work emphasized community organization to effectively respond to obstetric emergencies and increase demand for EMNC services, including "Life Saving Plans." One-third of the women in program communities reported having a plan for transportation in case of an obstetric emergency vs. only 12% of women in control communities. The percentage of women who reported having set aside money for an emergency was significantly higher at follow-up (74%) than at baseline (7%) in program communities and 26% at follow-up in control communities. The percentage of women who believed a woman should receive skilled care for childbirth rose from 42% at baseline to 78% in program communities. Men in the program reported similar positive changes.

IR2: Public Health Programs are Well-Managed

The health program also worked to improve health services management by the MOH, the IGSS, and NGOs. Improved management of public health programs was achieved with strengthened HIV/AIDS surveillance and contraceptive logistics systems, removal of medical barriers to family planning services, and an institutional assessment of the MOH, which advanced the Mission's cross-cutting anti-corruption theme.

The contraceptive logistics systems and stock levels of around 1,500 service delivery points of the MOH and IGSS were strengthened through norms, manuals, information systems, and national inventories. Updated information on contraceptive stockouts is now available as a result of a logistics system activity now institutionalized: a national level, twice yearly, physical inventory of contraceptive methods. Other on-going logistical improvements included: training in logistics administration for 100% of staff working on contraceptive logistics; the development of manuals and management information system; quarterly field visits to all service levels; and intensive inter-institutional coordination. A unique public-private partnership was formed in 2002, when MOH signed an agreement with APROFAM for the latter to act as the delivery agent for USAID-donated contraceptives to the 90 NGOs under contract to the MOH in the most remote parts of the country. These NGOs were receiving the contraceptives for the first time so that they could offer family planning as part of the basic health services package in SIAS. APROFAM also trained the NGOs in contraceptive logistics and monitored their performance. With APROFAM as the delivery agent for contraceptives to NGOs, the number of NGOs/health promoters with no stock-outs exceeded targets. MOH contraceptive stock-outs at the time of monitoring visits decreased from 18% in 2003 to 15% in March 2004. The use of Kardex has been maintained at 100%. The MOH, APROFAM and IPROFASA are now independently using the contraceptive management tool "Pipeline" to prepare contraceptive projections and tables. The MOH's automated-logistics information system has been preliminarily accepted by the new administration.

The national contraceptive security initiative is advancing. The MOH paid UNFPA their contribution for 20% of their 2003 contraceptive needs, and will pay a progressively greater share each year. IPROFASA started buying 100% of its contraceptive needs upon graduation from USAID assistance. APROFAM bought its own condoms for the first time in 2003 and is self-sufficient for contraceptives since 2005. However, the new MOH-administration has not agreed to continue the national Contraceptive Security Commission started by the prior government. The MOH and IGSS have shown real commitment to fight corruption and increase transparency in the use of contraceptives; reports from MOH monitoring of contraceptive leakage have led to investigations by the Public Ministry and the application of administrative sanctions by the MOH. The percent of commercial pharmacies with leakage of donated Depo-Provera was reduced from 14% in 2000 and 8% in 2002, to 6% in 2003.

The Automated Monitoring System software (SAM) developed with USAID assistance under URC/*Calidad en Salud* was used by the MOH for the first time in 2002 to evaluate all the NGOs with contracts to extend health services coverage in USAID focus areas. SAM uses technical, financial and administrative data to measure performance and certify or

decertify the NGO, contributing to more transparent MOH decisions. From 2003-2004, the MOH implemented an operations research activity to compare the innovative service delivery model designed by *Pro Redes* (AEC NGO) with the national Extension of Coverage model (PEC NGO) and the model of service delivery through health posts implemented by MOH with assistance from URC/*Calidad en Salud* (AEC PS). In mid-2004, the MOH informed *Pro Redes* of its interest in including some of the key project innovations in the national Extension of Coverage program. These innovations had been transferred to the MOH by the end of the project. They included: changes in the organizational structure of the program and personnel roles to a model similar to that of *Pro Redes,* with a community facilitator (FC), community center and eight volunteers (VS) for each 1,000 inhabitants (167 families); a change in the role of the FC to provide direct patient care based on the protocols of the IMCI program with a strong community-based, maternal child health/nutrition prevention component (known in Guatemala as the AIEPI AINM-C program); supervision of the FCs by nurses; the community-based information system including the forms and electronic database; the checklist and methodology for supportive supervision of community personnel; the checklist to ensure the quality of community centers; the modified training modules for training the FCs in AIEPI and AINM-C in an integrated manner that include practice in health centers and hospitals; and, the use of the new distance training modules for AIEPI AINM-C for refresher training and training of new personnel.

The release of the 2002 ENSMI survey reports contributed greatly to the result of solid decisions based on quality data. This major undertaking, which for the first time contained a module with a gender focus, provides USAID, other donors and, most importantly, the GOG with vital, reliable, demographic, health, nutrition, education and gender violence information to measure progress since the 1998/99 ENSMI. A nutrition advocacy tool called Profiles has been updated with the latest ENSMI data. The national HIV/AIDS surveillance system was strengthened with bilateral assistance by MERTU-CDC and continues to provide annual seroprevalence data. From FY 2004, assistance, has continued at a reduced scale under USAID's regional HIV/AIDS program. The bilateral health program now focuses on work with the MOH and NGOs to prevent HIV/AIDS in the most at-risk populations (female sex workers and men who have sex with men) through behavior change communication (BCC) interventions, voluntary counseling and testing (VCT) and syndromic management of sexually-transmitted infections (STI) via the Global Health (GH) Field Support to FHI IMPACT. The new MOH authorities endorsed and carried out the USAID plan in FY 2004 in four MOH facilities in geographic locations with high HIV prevalence, starting in the capital and expanding to Izabal. Remodeling with the MOH's own funds of the main MOH clinic for STI/HIV work in the capital to convert it to a national training center for syndromic management of STIs and VCT was been slow due to the change of government, but should be completed soon. Meanwhile training of health providers is proceeding without the center. A strategy for BCC was developed which includes the establishment of an inter-agency group to coordinate and advise on the design of national and local level HIV/AIDS and STI prevention campaigns and materials. Three NGOs received assistance to carry out BCC activities with high HIV prevalence populations.

In FY 2004, USAID/G-CAP completed its assistance through the GH Field Support to the Inter-Agency Agreement with CDC for the Field Epidemiology Training Program in Guatemala conducted by San Carlos University (USAC) Medical Sciences Faculty and the

MOH. The program produced 73 applied epidemiology specialists, 14 Master's level epidemiologists, and more than 600 local health staff updated in epidemiology. Initially with Hurricane Mitch reconstruction funds and then continued through regular USAID funds, the regional epidemiology training program achieved institutionalization by the MOH and USAC and now is implemented by the GOG with minimal assistance from CDC.

IR3: Increased Guatemalan Commitment to Integrated Women's Health
Advocacy for women's health by the SO was outstanding with the assistance through the GH Field Support POLICY II Project of the Futures Group International. An increased Guatemalan commitment to integrated women's health has been achieved through strengthened civil society organizations, especially women's groups, and many successful advocacy campaigns to get women's health on the agenda during the 2003 elections and thereafter with the new government.

The positive results from the 2002 ENSMI can be largely attributed to the improved policy environment and successful reproductive health program launched by the MOH in 2001. Significant policy achievements included enactment of a Social Development Law guaranteeing access to reproductive health services in public facilities and to reproductive health education in public schools. As measured by a composite index on policy reform, reproductive health policies in Guatemala have improved substantially. The **Policy Environment Score** increased from 45 in 1997 to the target of 60 in 2003. The POLICY II Project capitalized on the Strengthened Women's Network for Peace, a reproductive health advocacy group which was influential in shaping public opinion in favor of the Social Development Law, when its passage was threatened by conservative groups. It later presented an advocacy paper to the Guatemalan Congress and organized a public campaign pleading for more resources for the National Reproductive Health Program. Once the Social Development Law passed in October 2001, USAID assisted the GOG and civil society to shape the Population and Social Development Policy for implementing the law, which was approved in April 2002. Other achievements included improved family planning norms published by the MOH, including permitting trained auxiliary nurse-midwives to insert IUDs and not just physicians and nurses to do this, who have limited reach access in rural areas. In a move toward sustainability and assuring contraceptive security, all USAID partners in 2002 funded a portion of their contraceptive requirements for the first time. USAID also leveraged UNFPA to begin donating contraceptives to Guatemala for the first time.

With pre-election USAID support, proactive policy dialogue and advocacy by civil society organizations influenced, at a national level, the political agendas of presidential candidates in favor of reproductive and child health, and increased public spending on health. After the elections, civil society organizations ensured that the new government continued to offer effective reproductive health services and information consistent with the Social Development Law. A key step forward was the decree issued by the Minister of Health of the departing government in January 2004, which made the MOH's Reproductive Health Program an official part of the MOH's permanent organizational structure. Health collaboration with the new government in 2004 was challenging because of the change to a coalition political party, with nationalistic, closed-door policies toward donors, and a first inclination to discard all that was done by the prior government. Under the current GOG administration the SO has succeeded in transferring key tools and models for continuation

and expansion by the MOH. USAID's policy dialogue with the new MOH authorities on evidence-based best practices and lessons learned will continue in 2005, as the MOH updated norms and implemented its health plan in earnest.

Instancia Salud/Mujer, a network of 75 women NGOs, is the principal local women's health advocacy group which POLICY II helped form and strengthen. The *Instancia* hosted pre-electoral for a, developed, and presented the new government with a policy proposal on "Priority Interventions for Women's and Children's Integrated Health, including Reproductive Health: a Civil Society Proposal for Inclusion in the 2004-2007 National Health Plan." This proposal was disseminated through national fora, including one at local level with more than 150 women from eight departments present to endorse it. Press conferences and presentations of the proposal have not only succeeded in generating high-level government support, but also ensured that reproductive health is constantly in the popular media. The *Instancia Salud/Mujer* has established excellent communication with officials of the Berger Administration, including the MOH, Health Commission of the Congress, Planning Secretariat -SEGEPLAN, and Women's Secretariat-SEPREM. Indicative of the high esteem in which the *Instancia* is held is the nomination of their representative to the official GOG delegation to the Economic Commission for Latin America's (CEPAL) regional meeting in June 2004 for the 10-year follow-up on the International Conference on Population and Development. At the meeting, the Guatemala delegation signed the declaration without reserve toward sexual and reproductive health, in contrast to the reserve Guatemala had put to block the original declaration in Cairo. In July 2004, women's health advocacy efforts culminated in the directive by the Guatemalan Congress that 15% of the revenue from the alcoholic beverages tax be transferred to the MOH's National Reproductive Health Program. The Health Commission of the Congress is actively monitoring proper implementation of the Social Development Law.

Inadequate public expenditure on health in Guatemala is one of the key constraints affecting the health sector and will be a major thrust of USAID's new strategy. Several successful initiatives brought this problem to the attention of the mass media, Ministry of Finance, MOH and the political parties including: a) dissemination of data on the current health financing situation and advocacy for higher public expenditures; b) development of a "budget formula" for the MOH to calculate budget projections to cover priority health needs; and 3) dissemination of findings from a study of unit cost of health care services in the MOH's health centers and posts. With USAID and PAHO in the lead, 13 health donors signed a public declaration in 2004, released at a high-level press conference, which called for increases in the MOH's budget, along with improved efficiency, transparency, and equitable distribution of current health spending.

K. Prospects for long-term sustainability of impact and principal threats to sustainability:

SO3 achieved major contributions towards better health for women and children in Guatemala as measured by the significant reductions in the two major SO indicators – Infant Mortality and Total Fertility – as well as in the various impact indicators at the intermediate result level. Much remains to be done but there are many indications that the impact achieved to date is sustainable in the long-term.

The MOH, its partner NGOs, the IGSS, and other private sector service providers, were given the tools and skills required to improve the quality of and access to MCH services and better household practices, most notably family planning services, community-based integrated maternal child health and nutrition services, and essential maternal and neonatal care; and to stimulate demand for these services. They more than rose to the challenge, they exceeded all expectations. The improvement in health services in the quality of attention as well as coverage. The immunization program undertaken by the MOH, with technical assistance provided by PAHO was a remarkable example of equity and success in increasing rural coverage and in achieving sustainability. The MOH financed most of the program, including the vaccines. The reformed rural health care service delivery model, the SIAS, has been rigorously field-tested and strengthened. The objective of the MOH is to scale-up the implementation of the AIEPI AINM-C program to the national level through the SIAS model. This model now incorporates the key service delivery innovations that were the object of operations research under the NGO Networks project and *Calidad en Salud*. An indication of the MOH's commitment to extension of coverage was its decision in June 2004 to assume coverage of the 317,000 persons in the communities covered by the USAID NGO Networks project, The MOH also selected many of the project NGO grantees or members of this same network to be incorporated within SIAS to cover these communities.

The launching of the MOH's National Reproductive Health Program in 2001 quickly underwrote the positive family planning performance achieved under the strategy. By 2002, the MOH was for the first time the largest single contributor of CYPs, and the national MOH comprehensive family planning counseling strategy led to an increase in knowledge of modern contraceptive methods among Guatemalan women, which improved from 81% in 1999 to 91% in 2002. The policy environment score indicator confirms the substantial improvement in reproductive health policies in Guatemala. Contraceptive security has been advanced through UNFPA donations leveraged by USAID and later sales of contraceptives to Guatemala for the first time; and the implementation of annual contraceptive procurement plans. Also, for the first time the MOH and IGSS paid for 20% and 40%, respectively of their contraceptive needs in 2003. IPROFASA is now buying 100% of its contraceptive needs after graduating from USAID assistance, and APROFAM was self-sufficient with their contraceptives by the end of the SO.

Indeed, APROFAM and IPROFASA are themselves sustainability success stories. As a result of reengineering its processes, including its rural development program, the offering of a greater range of services and cost containment, APROFAM has achieved 86% institutional sustainability, up 23 percentage points since 1998. Its rural development program which operates in remote and poor villages has reached 64% sustainability. As mentioned above, by the end of USAID's strategy, it was buying 100% of its contraceptive needs with its own funds. USAID culminated 20 years of collaboration with IPROFASA and its social marketing program in 2003. A phase-out of assistance to IPROFASA began in 1999 when all direct financial and technical assistance ended and USAID assistance was limited to the donation of condoms and oral contraceptives. In 2002, the last condom donation was made and in March 2003, the last oral contraceptive donation. IPROFASA is now responsible for all of its own contraceptive procurement.

Although several trends are promising, including sustainability of long-term impact, Guatemala's health indicators lag far behind nearly every other country in the region. Inadequate public health expenditure in Guatemala is a key restraint and will be a major thrust of USAID's new strategy. Assistance from USAID/Guatemala under the new CAM SO3 "Investing in People: Healthier, Better Educated People" for the period 2004-2008, will focus on increasing and improving social sector investments and transparency.

L. Lessons learned:

The lessons learned during the strategy period are organized around the principal activity groupings.

1. Support to the Ministry of Health and Guatemalan Social Security Institute (*Calidad en Salud*)

- As was to be expected in a program of this nature, the principal challenge was to achieve and maintain the institutionalization of advances made at different stages of each component. The constant change of authorities and personnel at all the different levels within the MOH and IGSS, as well as the recurrent fiscal crises, tended to generate a climate of instability. It negatively affected continuity and availability of sufficient counterpart resources and delayed management processes.
- The onset of general elections and a new administration every four years leads to a general slow-down of activities and a renegotiation of the program with the new authorities. Modifications included changes in areas of focus, renegotiation of counterpart resources, training of new personnel, establishment of new working relationships,
- To develop a FP program in a country like Guatemala requires constant non-partisan political support at the national level. A FP program will only be as successful as its support systems. The unmet need for FP will not be adequately attended without improving the response capacity of the public sector. The necessary technical support at all levels requires that priority be given to the quality and quantity of training programs. The adequate functioning of a national FP program requires strong promotional support in order to successfully deliver the message on the availability of services in the public sector to the population that does not usually use these services.
- The participation of the MOH, the NGOs under SIAS, USAID's NGO partners, and other external cooperation agencies was important for the institutionalization and sustainability of the strategy to date. The replication of the AIEPI AINM-C model at the national level and the improvements that still need to be made in the quality of the provision of health care, especially by the NGOs, will require substantial increases in government health expenditures.
- Child health indicators can be improved by means of the AIEPI (strategy, which allows for an integrated focus at the household, community, and institutional levels through prevention and counseling. The collaborative team model has strengthened health services by providing quality services within an integrated approach at the central area and district level teams, with emphasis on quality assurance. The collaborative learning approach has been most important in decentralizing the improvement process; speeding up the improvements; identifying local leaders to be agents of change; using the relevant

data to make decisions; teamwork; client satisfaction; and a focus on processes and systems without relying on the central level.

- Waiting until pregnancy and postpartum to give iron/folic acid supplements can be too late to prevent and treat anemia effectively. The normal weekly supplement should be given to all women of reproductive age, and enhanced during pregnancy and lactation by doubling the weekly dose of iron.

2. NGO Health Networks Project (*Pro Redes Salud*)

- It is important that projects involve the MOH areas and districts in the identification of high risk, uncovered areas for placement of NGO projects. This not only gives the MOH ownership and interest in the project, but also improves the chances that NGOs are placed where it is most necessary.
- NGOs appreciate the opportunity to learn new approaches, new technical areas, and the use of new IEC and training materials, NGOs expect to have clear guidelines from the donor and the MOH on what needs to be done. However, the NGOs should also be involved by the donors and the MOH with regards to new materials and strategies, including those regarding decentralization and the supply of medicines.
- The successful provision of health care by the NGOs depends on such care being systematized. Community members with a fourth grade education can provide direct patient care if they base their actions on the *hojas de registro* and protocols under the supervision of medical professionals. This means that basic RCH care can now be available to remote rural communities 24 hours a day, in contrast to the once-a-month visit of a doctor provided to rural communities under the MOH model of SIAS-PEC. Also, a checklist containing standardized criteria for the establishment of community centers has been established thus improving the quality of the centers and allowing systematized care.
- NGOs organize themselves into informal and formal networks when they feel they have something in common. However, NGO members do not always initially have a clear idea of the benefits they can get from their network, nor does the network always has a clear idea of the benefits it can provide to the members. It gets even more complicated when there is a third level, a network of networks or federation. Sustainability, especially financial sustainability, is an important topic and one that is often unclear to NGOs and networks. This situation can be improved through a needs analysis, network strengthening activities, generating additional sources of funding or revenue generating projects, and learning from the experiences of successful networks elsewhere.
- Learning new approaches and the use of new materials take time and cannot be hurried, if it is to be done well. Training in the area hospitals and health centers, as well as in the community centers that are already using the AIEPI AINM-C strategy, must be based on adult learning techniques and include sufficient time for hands-on practice. The real learning occurs during daily practice, following training. Community centers are located in remote rural areas, making access difficult. It is vital, however, that they continue to receive supportive supervision by NGO technical staff.
- It is important to ensure that, following training, participants have all the equipment and supplies necessary to implement their task. In the community center this includes the AIEPI AINM-C protocols, *cuaderno de vigilante*, hanging weighing scales, IEC

materials, medical supplies, contraceptives, and the necessary forms and paperwork. The lack of any of these affects quality of care.

3. Private, Non-Profit, Provision of Reproductive and Child Health Services through APROFAM (Guatemalan affiliate of the International Planned Parenthood Federation)

- A weakness in the program was the lack of attention paid to the Board of Directors in the strengthening of institutional human resources. APROFAM has advanced at great strides in the past few years to become a modern social enterprise but its Board has lagged behind in the process. Board members tended to be uncomfortable with sustainable approaches, were focused only on the organization's social mission, and did not generate resources to sustain the organization. In March 2004, a new Board of Directors was elected to direct APROFAM. On July 23, 2004 the new Board terminated the long-time Executive Director's contract, key personnel under the agreement, without USAID's approval, thus placing APROFAM in non-compliance with the Cooperative Agreement. The convergence of new leadership, the dismissal of a trusted prior Executive Director and the existence of sizeable assets were all risk factors that justified a decision to place APROFAM in the category of high risk recipient during an unfunded extension of the Cooperative Agreement from October 1, 2004 through March 31, 2005. This extension allowed the APROFAM leadership to prove their ability to guide the organization and produce results before a new Cooperative Agreement was considered by USAID.
- APROFAM needs to generate more income to achieve the remaining 14 percentage points toward 100% sustainability. This challenge will require that APROFAM compete, not only with the public sector, but with the commercial sector. To do so, APROFAM will need to further improve the range and perceived quality of its services, intensify its business approaches, put its reserves to work to purchase contraceptives, invest in new equipment and facilities, and make additional institutional reforms.
- For the development of new business, APROFAM needs to enlarge its capacity and develop new services and products that are compatible with its image and that can bring value added to the organization. An important consideration is putting its installed capacity to use and its financial reserves to work for the organization. Options could include enhanced diagnostic imaging services, conveniently located laboratory sample collection kiosks, optometry services and marketing generic drugs.
- However, increased sustainability cannot be achieved at the expense of curtailing APROFAM's key role in delivering family planning services in Guatemala, increasing prices arbitrarily, decreasing service coverage or abandoning lower-income beneficiaries with no access to MOH or other service providers. There is traditionally a tension between pursuing financial sustainability and serving the poor that APROFAM has managed well in the past and needs to continue to manage well.
- APROFAM needs to select what programs it will subsidize with a view to increasing cost-effectiveness of its services, achieving results that are clearly related to its core mission, and funding programs that can increase use of its clinical services. APROFAM will need to develop clear guidelines to: a) prioritize and select social programs for subsidies, and b) determine how much funding from which source will support these activities.
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- The difficulties experienced in increasing the sustainability of the rural development program, and the need to develop clear guidelines for cross-subsidies now that USAID is no longer providing funding, are well illustrated by the clinic in Ixcan, Quiché, which was inaugurated in May 2001. Persistent problems have included the lack of suitably qualified staff as well as increasing access to the clinic for a population that is 90% rural and only 10% urban. All of its services were subsidized by USAID funding. The highest sustainability rate achieved by the clinic was 39% in 2002, which then decreased to 17% in September 2004.

M. A summary of performance indicators used and an assessment of their relative usefulness for performance management and reporting:

See Annex 1 for the SO Indicator Performance Tables. Significant achievements are discussed in the section summarizing overall impact at SO and IR levels, and the discussion in the subsequent section of the activities used to achieve the SO and their major outputs. In general, the indicators accurately and clearly reflect the focus of technical approaches and program activities under the SO, as well as meeting the criteria of being: direct, objective, practical, adequate, results-oriented, within USAID's manageable interest, useful, easy to communicate and credible. The SO level indicators – Total Fertility Rate and Infant Mortality Rate – reflect the highest level of achievement and program impact for family planning and maternal-child health interventions. In addition, the Infant Mortality Rate is a sensitive proxy for overall socio-economic development in Guatemala. The achievement of results in a sustainable way is contingent on improving health practices, especially in the home, and on strengthening health service delivery, at the community and facility levels. The three intermediate results serve as an organizing tool for the public and NGO health actions and interventions that are required to achieve the SO indicators. Each intermediate result is comprised of a set of lower level results that are logically linked to the processes for achieving the strategic objective. The SO performance management plan allowed for monitoring both short (annual) and medium progress toward the achievement of the SO. By co-financing with the other major donors a periodic national household representative maternal child health survey, the Demographic and Health Survey (DHS) – known in Guatemala as the National Maternal and Child Health Survey (ENSMI) that was conducted in 1998/1999 by Macro International Inc. and in 2002 by CDC, USAID met Agency performance reporting requirements and, at the same time, supported the GOG's need for high quality data for planning purposes. The oversampling of eight predominantly indigenous departments in 1998/1999 coincided with the Zonapaz and included areas of emphasis for implementation of the Peace Accords and the USAID strategy. The 1995/1996 ENSMI data were used as the baseline data. The 2002 ENSMI survey included a male module for the first time on men's reproductive health knowledge, attitudes, and practices.

The following two indicators warrant comments on their relative usefulness in terms of meeting the criteria referred to above:

New Family Planning Users – This indicator tended to overestimate new users because some clients would switch where they went to receive their next dose of continuous contraceptives such as quarterly Depo-Provera injections or monthly oral contraceptives. In these cases, the user would be counted twice, both at the initial facility where they received their first dose and then again as a new user at the later facility where they went for

subsequent doses. Contributing to the decision to change their source of contraceptives was the fact that the MOH and the IGSS delivers contraceptives free of charge, whereas APROFAM and the other NGOs charge a small fee. Some users preferred to go to APROFAM for the high quality of the initial consultation but then switch to the MOH for free subsequent doses.

Met Need for Essential Obstetrical Care – This indicator required complex record-keeping by participating hospitals. The definition of need had to be clearly defined (e.g., to exclude post-abortion complications). The denominator was also problematic because it was the "expected number of women giving birth from the catchment area who have complications." Women who arrived from outside the catchment area to give birth in the hospital, could not easily be excluded from the denominator. The denominator also had two assumptions, i.e., the crude birth rate and the expected percent of women with obstetric complications, which made it less precise. Reported data for this indicator had to be corrected several times using expert technical assistance.

N. A list of evaluations and special studies conducted during the life of the SO:

- Midterm Evaluation of Developing Mayan-based Health Care for Rural Women and Children (Cooperative Agreement No. 520-A-00-97-00060-00 with Project Concern International) dated September 1999, by LTG Associates Inc. and TvT Associates Inc. under MEDS (Monitoring Evaluation & Design Support) Contract No. HRN-I-00-99-00002-00, Task Order No. 7.
- Assessments, investigations and surveys conducted by Development Associates, Inc. under TASCI IQC No. HRN-I-00-98-00030-00, Task Orders No. 800 and 801.
  1. Maternal-Child Health Information, Education and Communication (IEC) Assessment dated May 1999;
  2. An Assessment of the Translation of Health Messages by Bilingual Promoters in Guatemala dated January 2001;
  3. Information, Education and Communication (IEC) Research Summary dated January 2001;
  4. A Communications Channels Survey in Mayan Communities in Guatemala dated January 2001.
- Reproductive Health Education in Indigenous Areas through Bilingual Teachers in Guatemala – Operations Research Final Report, dated April 1997, prepared by *Asociación Guatemalateca de Educación Sexual y Desarrollo Humano* (AGES) and Population Council/INOPAL III project.
- Studies and Investigations supported by JHPIEGO/MNH:
  1. Is active management of third stage of labor cost effective for health facilities? A case-comparison study in Guatemala and Zambia. September 2004.
  2. JHPIEGO/MNH Guatemala Project, Management Review 2001
  3. Impact Report: Maternal and Neonatal Health Program, June 2004.
  4. *Encuentros Video Participativos de Investigación Acción. Elaborado conjuntamente con JHU/CCP. Enero* 2004.
  5. *Informe del estudio de caso. Elaborado conjuntamente con JHU/CCP. Marzo* 2004.
  6. *Estudio de Movilización Comunitaria realizado conjuntamente con JHU/CCP. Febrero* 2004.

7. *Estudio de Linea Basal de Mortalidad Materna. Apoyo a la realización del mismo. Enero* 2004.
8. *Estudio de registro de nacimientos como fuente de información para el monitoreo de la salud materna en Guatemala. Elaborado conjuntamente con* Measure Evaluation *y* GSD. *Mayo* 2001.
9. *Estudio de Linea de Base: "Perspectiva Comunitaria sobre Embarazo, Parto y Post Parto, en los Departamentos de Quiché, Sololá y San Marcos." Diciembre* 2001.

- Investigations developed by Population Council during 2000-2004.
  1. Sololá: Reducing Barriers to family planning in the public sector. September 2001
  2. Achievements and Challenges of Mayan NGOs' New Reproductive and Maternal-Child Health Programs. September 2000.
  3. Capacity Building: Experiences with Strengthening NGOs in Reproductive and Child Health
  4. Findings and Lessons Learned in Delivery of Reproductive Health Care to the Rural Mayan Population of Guatemala from Operations Research and Diagnostic Studies, 1994-1997.
  5. Setting prices for reproductive health services in a public hospital in Guatemala. May 2001
  6. Testing strategies to increase promotional activities by promoters. APROFAM, Guatemala. August 2001
  7. Assessment of the process and impact of operations research in Guatemala: 1998-2000/Frontiers. August 2001.
  8. School-based family life education for indigenous population in Guatemala. October 2001.
  9. Institutionalization of service delivery improvement strategies: a distance learning program/Frontiers. October 2001.
  10. Reproductive health promotion for women victims of violence and rape/Frontiers. October 2001.
  11. Guatemala: Reproductive health care in the post natal period. October 2001.
  12. A willingness to pay study in APROFAM. October 2001.
  13. Situational analysis of post-obstetric event services in public hospitals in Guatemala/Frontiers. February 2002.
  14. Testing a three-phase counseling algorithm with relating job aids and supervision to improve the quality of family planning care in health centers and posts of the Guatemalan MSPAS/Frontiers. November 2002.
  15. Improving client informed choice, continuation in family planning, method mix, and cost-effectiveness at the postpartum/post-abortion clinic of the gynecology-obstetrics hospital, IGSS/Frontiers. December 2002.
  16. Availability and acceptability of IUDs in Guatemala/Frontiers. June 2003.
  17. Informing the medical community in Guatemala about emergency contraception/Frontiers. September 2003.
  18. Effects of IGSS' job aids-assisted balanced counseling algorithms on quality of care and client outcomes/Frontiers. October 2003.
  19. Testing balanced counseling to improve provider-client interaction in Guatemala's MOH clinics/Frontiers. October 2003.
  20. Scaling up a successful counseling model: Guatemala/Frontiers. December 2003.

21. Developing a supervision instrument for post abortion care in Guatemala, Bolivia and Mexico/Frontiers. March 2004.
22. Increasing access to long-term contraceptives in rural areas through the MOH in Guatemala/Frontiers. December 2004.
23. Expanding access to vasectomy services in Guatemala/Frontiers. December 2004.
24. Understanding the lives of indigenous young people in Guatemala; creating opportunities for young people in Guatemala/Gates Foundation. December 2004.
25. *¿Donde esta el hombre en la salud familiar?*/The William and Flora Hewlett Foundation. December 2004.
26. *Entendiendo y respondiendo a la violencia domestica en comunidades mayas*/Moriah. December 2004.

- CDC and MERTU/Del Valle University report dated April 2004: "Informe Final del Proyecto para el Fortalecimiento del Sistema Nacional de Vigilancia Epidemiologica del VIH/SIDA, Guatemala, Junio 2001 – Septiembre 2003" y Anexos.
- Studies and investigations supported by the Policy Project:
  1. Evaluation of Medical and Institutional Barriers to Family Planning: Futures Group International.1999 and 2003.
  2. Evaluation of Policy Environment Score for Reproductive Health/Family Planning: Futures Group International. 1997, 2000 and 2002.
  3. Annual Report on the National Reproductive Health Program: Futures Group International.2001, 2002 and 2003.
  4. *Glosario de Genero y Salud*: in coordination with Population Council, Project Concern International (PCI), *Calidad en Salud*, Maternal Neonatal Health project. September 2001.
  5. *Entendiendo la Salud Integral de la Mujer en Guatemala. Junio de 1999.*
  6. *Recopilación de Leyes, Planes y Programas vigentes en relación con la Salud Reproductiva en Guatemala. Junio de 1999.*
  7. *Declaración Política de las Organizaciones de las Mujeres ante la Implementación del Programa de Acción de El Cairo 2000-2005. Junio de 1999.*
  8. *Población y Desarrollo en Guatemala. Agosto de 1999.*
  9. *GUATEMALA DE CARA AL FUTURO, la relación entre Población y Desarrollo: 27 de Agosto de 1999.*
  10. *SALUD SEXUAL y REPRODUCTIVA: Tema Central del Desarrollo. Septiembre de 1999.*
  11. *Las Encuestas de Salud Materno Infantil: Una Comparación entre 1987, 1995 y 1998/99. 30 de Septiembre de 1999.*
  12. Promoting participation in the context of decentralization to improve sexual and reproductive health in Latin America: the role of the POLICY Project: Futures Group International, May 2000.
  13. *Planificación Familiar y Atención de la Maternidad: Beneficios para la Salud Materna e Infantil: Enero 2002.*
  14. *Desafios en el financiamiento de la salud en Guatemala: Tendencias, Necesidades e Implicaciones. GSD Consultores Asociados 2002.*
- Mayan Family Planning Studies under Measure/Evaluation by Jane Bertrand/Tulane University School of Public Health and Tropical Medicine:
  1. Promoting birth spacing among the Maya-Quiché of Guatemala: May 1999.
  2. The stymied contraceptive revolution in Guatemala: May 2000.

3. Access as a factor in differential contraceptive use between Mayans and Ladinos in Guatemala: July 13, 2001.

- Evaluation of Contraceptive Stockouts: JSI Deliver Project 1998, 1999, 2000 and 2002.
- Guatemala: Decentralization and Integration in the Health Logistics System: JSI Deliver Project and Harvard School of Public Health 2004.
- Building sustainability through better management 1995-2000: Guatemala case study by Management Sciences for Health (MSH) in 2000 under the Family Planning Management Development Project.
- National Maternal and Child Health Surveys (ENSMI) conducted in 1995 and 1999 by Macro International Inc. and in 2002 by CDC.
- Estimates of Maternal Mortality in Guatemala during the period 1996-1998: GSD *Consultores Asociados* and Macro International Inc. March 2000 under the MEASURE/Evaluation project.
- *Elección informada de la esterilización femenina como opción anticonceptiva en Guatemala*: GSD *Consultores Asociados* in February 2001 under the Engender Health project.
- An Unfilled Human Right: Family Planning in Guatemala: The Center for Reproductive Law and Policy (CRLP) 2000.
- Publications by John Snow Inc. under the MotherCare project:
  1. *Audiencia de cuñas de radio sobre señales de peligro en el embarazo en el altiplano de Guatemala: Julio 1998*
  2. *Sesiones participativas con grupos de mujeres: informe de evaluación del proyecto Mothercare/Guatemala: Septiembre 1998.*
  3. *Capacitación tutorial en complicaciones obstetricas y perinatales para medicos: documentación de la experiencia: Enero 1999.*
  4. *Informe de 5 años 1994-1999: Desde su gestación hasta cinco años después: Agosto 1999.*
  5. *Mortalidad Perinatal en Guatemala, un estudio comunitario: Agosto 1999.*
  6. *MotherCare Matters: Boletín trimestral y reseña bibliográfica sobre salud y nutrición materna y neonatal.*
- *Evaluación de QAP en Guatemala: Aplicación e institucionalización de la garantía de calidad*: Center for Human Services 2000 under the Quality Assurance Project.
- Final reports dated December 19, 2003, submitted by Pannell Kerr Foster (PKF)-Guatemala (Arevalo Perez, Iralda & Asociados) under Contract No. 520-I-00-02-00024-00 for 'Strengthened Guatemalan Ministry of Health and Guatemalan Social Security Institute Inventory Internal Control System. MOH-SIAS and other NGOs Inventory Control Systems Assessed and Monitored.'
- Reports submitted by University Research Corporation (URC) under the *Calidad en Salud* project:
  1. Report of urgent response to procure food for 12 hospitals in eight priority areas, Mod 5 (AIEPI)
  2. *Informe de visitas de aprendizaje sobre las experiencias de implementación de la estrategia AIEPI AINMC*
  3. KPC survey report (IEC)
  4. *Reporte de método de días fijo en Chimaltenango (IEC)*

5. *Investigación operativa para mejorar el monitoreo y promoción del crecimiento en el área Ixil (IEC)*
6. *Monitoreo del crecimiento realizado por vigilantes de salud*
7. Operations research protocol for the NHOM
8. Operations research protocol for the NHOM final report
9. Procurement situation analysis
10. Final report of IGSS 2002 contraceptive and essential drug stockout survey
11. *Reporte del diseño para la administración logística de anticonceptivos para el programa de extensión de cobertura del MSPAS*
12. *Estudio de segmentación del mercado en anticonceptivos*
13. *Reporte de inventario físico de anticonceptivos 2002, 2003 y 2004*
14. Monitoring plan on medical wastes as part of the TO, Mod. 4
15. Report of expansion of IUD services to health posts
16. *Encuesta de monitoreo del sistema logístico* – IGSS

- *Impacto económico institucional del programa de planificación familiar del IGSS: preparado por GSD Consultores Asociados y AVSC Internacional* 2000
- Informes Nacional de Salud Reproductiva para los años 2001, 2002 y 2003:
    a. 2001 MSPAS
    b. 2002 MSPAS, APROFAM, IGSS, ONGs
    c. 2003 MSPAS, APROFAM, IGSS, ONGs
- Publications by Ricardo Bitrán/Abt. Associates under the PHRplus Guatemala project:
    1. *Asignación presupuestaria pública para salud en Guatemala: 29 de agosto de 2003*
    2. Models for costing health services package: April 19, 2004
- *Boletines informativos* published by the NGO Health Networks project (*Pro Redes Salud*) implemented by JSI and AmeriCares.
- Building sustainability through better management 1995-2000: report prepared by Management Sciences for Health (MSH) under the Family Planning Management Development Project.

O. A list of activity close out reports prepared for contracts, grants, and cooperative agreements:

- Cooperative Agreement No. 520-A-00-98-00045-00 (July 16, 1998 to December 31, 2001) with Management Sciences for Health (MSH) to provide technical assistance to *Asociación ProBienestar de la Familia de Guatemala* (APROFAM) in a variety of institutional strengthening areas.
- Agreement No. (July 6, 1998 to July 5, 1999) with the Pan-American Health Organization (PAHO) to strengthen the capacity of health service providers and health service administrators to implement the Integrated Health Care System - SIAS (*Sistema Integral de Atención en Salud*) at the first level.
- Cooperative Agreement No. 520-A-00-97-00060-00 (September 5, 1997 to November 30, 2001) with Project Concern International (PCI) for the recruitment and assistance to NGOs to provide basic health services at the community level.
- Cooperative Agreement No. 520-0357-A-00-4169-00 (September 2, 1994 to February 28, 2002) with The Population Council to (1) conduct operations research towards identifying strategies for the delivery of cost-effective reproductive health services to rural Mayan and

poor segments of the Guatemalan population; and, (2) to strengthen local Mayan NGOs and their maternal and child health programs.

- Cooperative Agreement No. 520-0357-A-00-3222-00 (July 23, 1993 to July 22, 2003) with *Importadora Productos Farmacéuticos S.A.* (IPROFASA) to develop and implement a sustainable, long-term strategy to expand the availability of affordable, temporary contraceptive methods through private commercial channels.
- Cooperative Agreement No. 520-98-A-00-00037-00 (May 22, 1998 to March 31, 2005) with *Asociación ProBienestar de la Familia de Guatemala* (APROFAM) for reproductive and child health services.
- Cooperative Agreements with John Snow Research and Training Institute Inc. (JSI) (Agreement No. 520-A-00-01-00090-00) and AmeriCares Inc. (Agreement No. 520-A-00-02-00220-00) for the NGO Networks Project (*Pro Redes Salud*).
- Task Order No. 800 under TASCI IQC No. HRN-I-800-98-00035-00 (December 13, 1999 to September 30, 2004) with University Research Corporation (URC) in support of the Ministry of Health (MOH) and the Guatemalan Social Security Institute (IGSS) for the *Calidad en Salud* Project.
- Task Order No. 1 under Contract No. 520-I-00-02-00024-00 (December 26, 2002 to July 31, 2004) with Arevalo Perez, Iralda & Asoc. (Pannell Kerr Forster - PKF – Guatemala) to: provide technical assistance to the MOH and IGSS in order to assure timely implementation and monitoring of contraceptive audit and financial review recommendations; and to carry out two surveys of commercial pharmacies to look for possible presence of USAID-donated Depo-Provera.
- Grant 520-G-00-01-00022-00 (August 200 to September 2003) with Pan-American Health Organization (PAHO) to improve immunization rates through Guatemala, especially in communities at high risk of measles and other immune-preventable diseases. Project Assistance Completion Report dated May 2004.

P. Names and contact information of individuals who were directly involved in various phases of the SO:

USAID/Guatemala: Mary Ann Anderson (SO Team Leader); Isabel Stout, Baudilio Lopez, Lucrecia Peinado, and Anabella Sanchez (CTOs).
Ministry of Health: Julio Molina Aviles and Mynor Cordon (Portillo government); and, Hedi Damen, Alfredo Privado and Christina Ramirez (Berger government).
IGSS: Reginaldo Leonardo Garcia and Gustavo Guttierez
IPROFASA (Contraceptive Social Marketing) Jorge Mario Ortega
University Research Corporation (*Calidad en Salud* – MOH/IGSS) Rodrigo Bustamante
PAHO (Immunizations) Irene Leal
APROFAM (Family Planning) Suzette Higueros, Edwin Morales, Edilzar Castro, Zonia Aguilar
John Snow Inc. Research and Training Institute (*Pro Redes Salud* – NGOs) Elizabeth Burleigh, Patricia Taylor
Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) (Maternal Neonatal Health Program) Oscar Cordon

Management Sciences for Health (Management and Leadership Development – APROFAM) Michael Hall, Hector Colindres, Alvaro Monroy
The Futures Group (POLICY II) Lucia Merino
Centers for Disease Control - CDC (HIV Surveillance/MCH Survey) Robert Klein
PHR/Abt Associates (Health Reform) Kathleen Novak
Frontiers/Population Council (Operations Research) Carlos Brambila, Ricardo Veinon
IMPACT/Family Health International (HIV/AIDS) Cesar Galindo
AmeriCares (*Pro Redes Salud* – NGOs) Celina de Sola
Project Concern International – Christopher Bessenecker

Q. Information Sources:

- Procurement instruments and the periodic progress reports, annual reports and final reports submitted by the implementing partners under the various procurement mechanisms.
- 1995, 1999 and 2002 National Maternal and Child Health Surveys (ENSMI).
- USAID/G-CAP annual portfolio review reports and financial management reports.
- Evaluation reports and special studies (see listing in Section N).
- Activity close-out reports (see listing in Section O).

R. Annexes:

Annex 1: Performance Indicator Tables
Annex 2: Analysis of SO funding by implementing partner and funding source.

Annex 1: Performance Indicator Tables

GUATEMALA STRATEGIC OBJECTIVE 3: BETTER HEALTH FOR WOMEN AND CHILDREN			
SO Indicators			
	Calendar Year	Planned	Actual
Total Fertility Rate **Annual Report SO Indicator Table**	1995(B) 1999 2002(T)	5.1 -- 4.8	5.1 5.0 4.4
Infant Mortality Rate **Annual Report SO Indicator Table**	1995(B) 1999 2002(T)	67 -- 41	51 45 39
IR 1 Indicators: More Rural Families Use Quality MCH Services and Better Household Practices			
National Contraceptive Prevalence Rate (CPR)	1995(B) 1999 2002(T)	-- -- 41%	31% 38% 43%
Couple Years of Protection **Annual Report SO Indicator Table**	1997(B) 1998 1999 2000 2001 2002 2003 2004(T)	-- 395,007 414,757 479,163 595,043 480,045* 480,045* 480,045*	376,197 392,430 472,375 566,708 609,581 472,391* 527,885* 531,187*
Unmet Need for Family Planning	1995(B) 1999 2002(T)	-- -- 22%	24% 23% 28%
Reduction in the Gap in CPR Between the Mayan and Ladino Populations	1995(B) 1999 2002(T)	-- -- Ladino rate 3.0 times higher	Ladino rate 4.5 times higher 3.9 times higher 2.2 times higher
Reduction in the Gap in CPR Between the Urban and Rural Populations	1995(B) 1999 2002(T)	-- -- Urban rate 1.5 times higher	Urban rate 2.5 times higher 1.9 times higher 1.6 times higher
New Family Planning Users	1998(B) 1999 2000 2001 2002 2003 2004(T)	-- 123,037 129,189 252,226 237,185* 237,185* 237,185*	117,178 135,663 240,215 301,188 252,906* 301,839* 279,465*

- Fiscal Year Targets and Data January through September.

Complete Vaccination Coverage of Children Aged 12-23 Months	1995(B) 1999 2002(T)	-- -- 70%	43% 60% 63%
ORT or Increased Liquid Intake During Diarrheal Episodes	1995(B) 1999 2002(T)	-- -- 65%	51% 59%
Pneumonia Cases Treated by a Health Provider	1995(B) 1999 2002(T)	-- -- 45%	40% 37%
Percentage of Birth Intervals of at Least Two Years	1995(B) 1999 2002(T)	-- -- 75%	70% 68% 70%
Percentage of Births Attended by a Physician or Nurse	1995(B) 1999 2002(T)	-- -- 45%	35% 41% 41%
Met Need for Essential Obstetrical Care	1996(B) 1997 1998 1999 2000 2001 2002 2003(T)	-- -- 30% 40% 58% 61% 64%* 68%*	10% 19% 34% 56% 58% 55% 58%* 58%*
Infants Under 6 Mo. Exclusively Breastfed	1995(B) 1999 2002(T)	-- -- 50%	46% 39% 51%
IR 2 Indicators: Public Health Programs are Well Managed			
Absence of Contraceptive Stock-outs in selected service delivery points	1998(B) 1999 2000 2002(T)	-- APROFAM-93% MOH-63% IGSS-71% APROFAM-95% MOH-66% IGSS-75% MOH-72% IGSS-83%	APROFAM-89% MOH-60% IGSS-68% APROFAM-94% MOH-73% IGSS-80% APROFAM-90% MOH-37% IGSS-67% MOH-59% IGSS-79%

* Fiscal Year Targets and Data January through September.

Local Maternity Centers Established by Community Members (cumulative) **Reported through 1999**	1995(B) 1996 1997 1998 1999(T)	0 2 2 4 6	1 2 2 4 6
National HIV/AIDS Surveillance System Provides Annual Seroprevalence Data	2002(B) 2003 2004(T)	Yes Yes Yes	No Yes Yes
Number of (14) Medical/Institutional Barriers to Family Planning Services Removed **Annual Report SO Indicator Table**	1999(B) 2003(T)	-- 4 (10 barriers remain)	0 (14 barriers remain) 5 (9 barriers remain)
IR 3 Indicators: Stronger Guatemalan Commitment to Integrated Women's Health			
Cumulative Number of Campaigns Advocating Women's Participation	1999(B) 2000 2001 2002 2003 2004(T)	3 5 19 20* 35* 41*	4 10 17 30* 37* 41*
Policy Environment Score	1997(B) 2000 2002(T)	-- 52 60	45 52 60
Number of GOG Plans that Use Information Provided by Policy Project	1999(B) 2000 2001 2002 2003 2004(T)	-- 5 10 8* 10* 7*	9 9 10 20* 12* 7*

* Fiscal Year Targets and Data January through September.

Annex 2: Analysis of SO3 funding by implementing partner and funding source

Code 520-	Implementing Partner	CSH	OH	AIDS	POP	TOTAL
	Bilateral Obligations					
357.0	APROFAM Overhead	-	-	-	650,000	650,000
357.2	Pop. Council	3,431,399	-	-	3,939,000	7,370,399
357.2	USAID Mgt.	31,000	-	-		31,000
357.3	IPROFASA	-	-	-	23,000	23,000
428.0	**SOAG**					
	URC/*Calidad en Salud*	7,357,300	-	-	7,429,600	14,786,900
	Management/Audits	1,122,000	-	90,000	1,114,000	2,326,000
	Center Human Services	1,000,000	-	-	500,000	1,500,000
	EngenderHealth/AVSC Int'l.	-	-	-	650,000	650,000
	PAHO/IMM	600,000	-	-	-	600,000
	JHPIEGO	-	-	-	300,000	300,000
	HHS/Qualipharm	196,800	-	-	-	196,800
	PAHO/SIAS	100,000	-	-	-	100,000
428.3	APROFAM	5,918,000	145,000	-	11,305,000	17,368,000
428.4	MSH	441,398	-	-	550,000	991,398
428.5	Project Concern Int'l. (PCI)	2,880,000	-	-	1,949,362	4,829,362
428.6	TASC-Devel. Associates	100,000	-	-	73,788	173,788
428.7	Management/Audits	398,400	-	-	440,300	838,700
428.8	John Snow (JSI)	3,478,000	-	-	3,418,751	6,896,751
428.9	PASCA (CONCASIDA)	-	-	25,000	-	25,000
	Sub-Total USAID/Guatemala	**27,054,297**	**145,000**	**115,000**	**32,342,801**	**59,657,098**
598-0825	LAC/PAHO	-	245,000	-	-	245,000
	Sub-Total LAC/PAHO	**-**	**245,000**	**-**	**-**	**245,000**
	Field Support					
3024.01	POP TECH	111,000	-	-	92,000	203,000
3030	INOPAL/Pop. Council	-	-	-	100,000	100,000
3038.01	FPLM/CDC	130,000	-	-	160,000	290,000
3038.02	FPLM/JSI	-	-	-	700,000	700,000
3055	FPMD	-	-		225,000	225,000
3057	Central Contraceptive Procurement	-	-		5,781,000	5,781,000
3068	Engender Health/AVSC	-	-		600,000	600,000
3069	JHPIEGO	-	-		500,000	500,000
3070	POP Leaders	7,000	-	-	-	7,000
3078	Policy II/Futures Group	810,000	162,000		2,421,000	3,393,000
3079	Family Health Int'l.	-	-		337,000	337,000
3082	Linkages/AED	230,000	-	-	-	230,000
3083.01	DHS/Measure	200,000	-		440,000	640,000

3083.02	Measure Evaluation	100,000	-	-	100,000	200,000
3083.05	Measure BUCEN	-	-	-	50,000	50,000
3083.06	Measure CDC/DRH	-	-	42,000	-	42,000
3086	Frontiers/Pop. Council	-	-		1,259,000	1,259,000
3089.01	Deliver/JSI	-	-		190,000	190,000
3090.02	IMPACT	-	-	522,000	-	522,000
3090.04	Synergy	-	-	50,000	-	50,000
3092	Maternal Neonatal Health/-JHPIEGO	3,248,000	1,155,000		106,000	4,509,000
3099	Management & Leadership Development/MSH	162,000	-		297,000	459,000
3100	CDC IAA	456,000	770,000		-	1,226,000
3104.01	PHR PLUS/Abt.	196,000	100,000		28,000	324,000
5966	Mother Care II/JSI	550,000	214,000		-	764,000
5970	CEDPA/TAACS	764,000			600,000	1,364,000
5974	Partnership for HP/PHR/Abt.	75,000			25,000	100,000
5992	Quality Assurance/URC	234,000				234,000
5994	Environmental Health	35,000				35,000
6006.01	Institutionalizing CS/-BASICS	194,000				194,000
5966.10	MotherCare III/JSI		374,000			374,000
	Sub-Total Field Support	**7,502,000**	**3,020,000**	**614,000**	**14,011,000**	**25,147,000**
	Total Funding SO3	**34,556,297**	**3,165,000**	**729,000**	**46,353,801**	**84,804,098**

USAID Guatemala
Peace Strategy
US thousands

SO	Obligated FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	TOTAL
Democracy								
DA	2,000	2,000	2,800	2,300	2,850	2,000	2,000	15,950
ESF						1,000		1,000
Sub-total	***2,000***	***2,000***	***2,800***	***2,300***	***2,850***	***3,000***	***2,000***	***16,950***
Education								
CS	2,790	2,000	2,650	3,035	2,529	0		13,004
DA						2,750	4,550	7,300
Sub-total	***2,790***	***2,000***	***2,650***	***3,035***	***2,529***	***2,750***	***4,550***	***20,304***
Health								
PN	4,564	10,134	5,400	4,500	5,737	9,500	6,528	46,363
CS	6,029	5,354	5,719	5,275	4,376	6,200	5,489	38,442
Sub-total	***10,593***	***15,488***	***11,119***	***9,775***	***10,113***	***15,700***	***12,017***	***84,805***
Income Generation								
DA	3,350	2,615	2,400	3,350	4,780	3,500	4,792	24,787
DCA	0	0	0	220	0	0	394	614
Food Aid	11,827	12,481	23,990	18,356	15,174	21,502	16,673	120,003
Sub-total	***15,177***	***15,096***	***26,390***	***21,926***	***19,954***	***25,002***	***21,859***	***145,404***
Environment								
DA	***2,500***	***4,635***	***5,499***	***3,080***	***3,927***	***4,067***	***3,476.7***	***27,185***
Peace								
ESF	25,011	24,750	25,250	20,000	13,969	9,000	6,449.7	124,430
DA						1,326	1,100	2,426
Sub-Total	***25,011***	***24,750***	***25,250***	***20,000***	***13,969***	***10,326***	***7,549.7***	***126,855.7***
Mitch								
CS	0	0	3,000	0	0	0	0	3,000
CACEDRF	0	0	25,000	500	0	0	0	25,500
Sub-total	***0***	***0***	***28,000***	***500***	***0***	***0***	***0***	***28,500***
	58,071	***63,969***	***101,708***	***60,616***	***53,342***	***60,845***	***51,452.4***	***450,003.4***
Other Activities								
OTI	4,558	1,750	0	0	0	0	0	6,308
SDF - DA	210	0		0	0	0	0	210
AmeriCares						3,189	0	3,189
Basis						25	0	25
Education					350	5	0	355
OFDA (Drought)	0	0	0	0	25		0	25
OFDA (forest fires)		30			0	0	0	30
OFDA (Mitch)	0	0	1,042	0	0	0	0	1,042
Democracy							125	125
PD&L							6.7	6.7
	4,768	***1,780***	***1,042***	***0***	***375***	***3,219***	***131.7***	***11,315.7***
TOTAL	**62,839**	**65,749**	**102,750**	**60,616**	**53,717**	**64,064**	**51,584.1**	**461,319.1**

Summary by Account

Account	Obligations FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	TOTAL
DA	12,414	19,384	16,099	13,450	17,294	13,643	16,313	108,597
CSD	8,819	7,354	11,369	8,310	6,905	15,700	12,017	70,474
ESF	25,011	24,750	25,250	20,000	13,969	10,000	6,450	125,430
Title II	11,827	12,481	23,990	18,356	15,174	21,502	16,673	120,003
CACEDRF	0	0	25,000	500	0	0	0	25,500
Other Activities	4,768	1,780	1,042	0	375	3,219	132	11,316
Total	**62,839**	**65,749**	**102,750**	**60,616**	**53,717**	**64,064**	**51,584**	**461,319**

Data Source

1. LABS, CPs, FMO & PDM Reports

STRATEGIC OBJECTIVE CLOSE OUT REPORT (SOCR)

Srategic Objective (SO) Name: Better Health for Women and Children
Number: 520-003

Drafted by:

LPeinado: _____ Date: _____

Cleared by:

SO Team Leader: JRichards: J Klein B Richards Date: Dec. 2006

PPS: LAlfaro: L. Rmm Date: Oct. 2006

PPS: LMagno: L. Rmm Date: Oct. 2006

FMO:RMorales: RMS. Date: Jan 2010. for substance only. *

PPS:Ernest Rojas: ERMJ Date: 01-20-2010

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* FMO clearance was delaxed because of discrelancies in the financial info. It was not possible to reconcile with Phoenix numbers.

STRATEGIC OBJECTIVE CLOSE OUT REPORT (SOCR)

Srategic Objective (SO) Name: Better Health for Women and Children
Number: 520-003

Drafted by:

LPeinado: _____ Date: 8/11/05

Cleared by:

RP Team Leader:BLópez: _____ Date: 8/16/05

SO Team Leader MAnderson: _____ Date: 8/17/05

PDM:LMagno: _____ Date: _____

FMO:RMorales: _____ Date: _____

~~DDIR:TAmani:~~ _____ Date: _____

PDM: CThompson

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