RFTOP No. 520-P-04-055
Attachment No. 1

Scope of Work
TASC 2 Task Order
Child and Reproductive Health Program
USAID/Guatemala

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TASC2 Scope of Work – Child and Reproductive Health Program, USAID/Guatemala

I. Introduction

This TASC2 Request for Task Order Proposal (RFTOP) is being issued by USAID/Guatemala for the purpose of contracting a technical assistance team to support the Central America and Mexico (CAM) Regional Strategy Strategic Objective 3: Investing in People: Healthier, Better Educated People in Guatemala. Specifically, this RFTOP consolidates and extends the work previously carried out in Guatemala for USAID by a series of Cooperating Agencies (CASs) in the areas of family planning, maternal and neonatal health, child health, nutrition, and prevention of sexually transmitted infections and human immunodeficiency virus (STI/HIV) and STI treatment. This will be a five-year Task Order with a date of award expected on or before September 30, 2004

A. Background

1. Government of Guatemala Health Strategy and Programs

As the Berger government took office in January, 2004, the new team at the Ministry of Health (MSPAS) is still in the process of defining its priorities, but preliminarily they have identified three areas of focus:

- Strengthening and extending health care coverage to the entire population of Guatemala.
- Strengthening Level 2 services (Health Centers and District Hospitals) as a mechanism for improving access to care and relieving the stress on tertiary level hospitals.
- Strengthening the managerial capacity of the Health Areas.

In the initial stages of pursuing these objectives, MSPAS is carrying out some specific activities, which include:

- An evaluation of present health care coverage.
- A revision of basic indicators for the information system.
- The consolidation of 19 program areas into 8-9. This includes the consolidation of the various programmatic areas of Reproductive Health.
- Reviewing existing organizational contracts and commitments made by the prior administration to determine their eventual financial impact on the budget of the MSPAS.
- And more generally, clarifying the financial situation of the MSPAS, including its growing debt obligations.

B. USAID CAM Strategy & Guatemala Country Plan FY 2004-2008

The CAM Regional Strategy marks a major shift in how USAID development assistance is provided. First, the strategy focuses on contributing to achievement of national level impact. Second, the strategy requires each Mission to make strategic choices that focus each program on

a select number of approaches and interventions. Third, the CAM Regional Strategy gives greater focus to implementation of sound policies that address the key constraints to development. Good governance is a crosscutting theme and an essential part of each objective. Fourth, it provides a single framework, strengthening the linkages between regional and bilateral efforts. The strategy maximizes operational efficiency through fewer management units, streamlined procurement, and a regional services hub in El Salvador.

The CAM Regional Strategy provides the framework for regional and country-specific programs leading to achievement of the overarching regional goal of a more democratic and prosperous Central America and Mexico, sharing the benefits of trade-led growth broadly among their citizens. The new regional strategy narrows the focus of USAID investment to a limited number of results within the three performance "arenas" established in the Millennium Challenge Account (MCA): Ruling Justly, Economic Freedom, and Investing in People. The Guatemala Country Plan builds on USAID experience and supports the three strategic objectives (SO) of the CAM Regional Strategy: more responsive, transparent governance (SO1); diversified, expanding economies (SO2); and investing in people: healthier, better educated people (SO3). Despite the enormous development needs and challenges, significantly reduced USAID resource levels for Guatemala necessitate a narrower programmatic focus than prior strategies. This TASC2 Statement of Work is designed to support only Strategic Objective 3.

C. SO3: Investing in People: Healthier, Better Educated People

Development Challenge. Although health trends are promising, Guatemala lags far behind nearly every other country in the region. Child health (under five years) has improved steadily, but there is still much to be done, especially at the community level. Guatemala's infant mortality rate of 39 per 1,000 live births is the highest in Central America and the third highest in the region after Haiti and Bolivia (Graph 1). With 49% of children under five years of age chronically malnourished, Guatemala has the highest rate of stunting in LAC. These national-level statistics mask the even worse health status of the indigenous rural population. For example, stunting among indigenous children reaches a staggering 69%. Guatemala's maternal mortality ratio of 153 per 100,000 live births is one of the highest in the region. The percentage of births attended by a physician or nurse is only 41% -- the lowest in LAC.

The former Portillo government's commitment to reproductive health made possible a quantum leap in terms of increasing use of contraceptives and lowering fertility by launching the National Reproductive Health Program in January 2001. Nevertheless, Guatemala's total fertility rate of 4.4 is still one of the highest in Latin America and the Caribbean (Graph 2). The contraceptive prevalence rate of 43% among women in union, ages 15-49, is the second lowest in the region after Haiti, and the unmet demand for family planning is growing. The HIV epidemic is concentrated in populations with high risk behaviors, and untreated STIs in these same populations are contributing to the spread of HIV.

The public financing needed to address Guatemala's health problems is substantial; 2002 government health expenditures amounted to only 1.30% of GDP, compared to the very modest Peace Accords' target of 1.32%. This is far less than the public investment needed for universal coverage of basic services and is well below health spending of other Central American

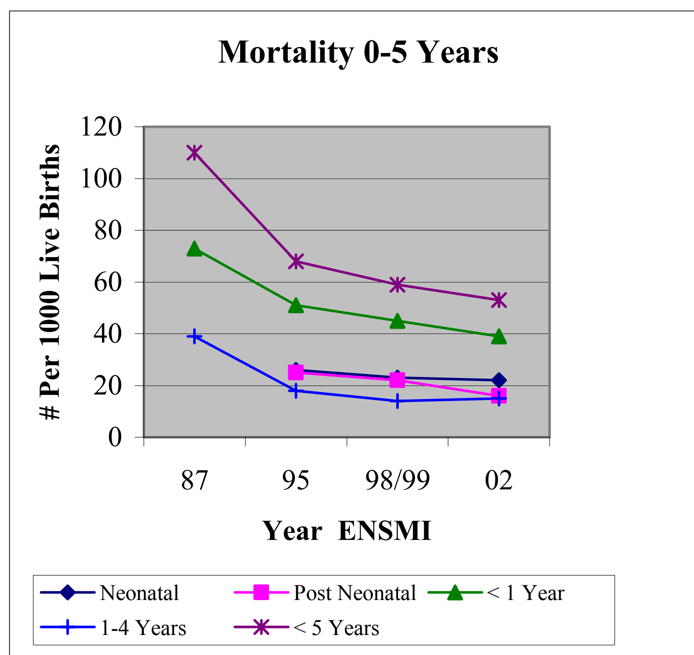
governments, but shows marked improvement over pre-Peace Accords levels (0.92% for health in 1996). Greater targeting of health funding is also needed to promote equity and transparency. In 1997, the Ministry of Health (MSPAS) implemented a major health reform -- the "extension of coverage" (SIAS) program, by contracting out to more than 100 NGOs to provide a basic package of health care to more than 3 million people. It is a testimony to the success of this program that it has been continued by the MSPAS since its inception, despite changing political parties in power. Nevertheless, approximately two million rural inhabitants continue to lack health care due to resource constraints. Available funds could be used more efficiently by better management and financial planning in the MSPAS. Too much public sector spending supports curative hospital care, while much less is spent where it could have the greatest public benefit, i.e., in underserved smaller cities, rural areas, and on preventive health programs.

Results Expected in Guatemala under this Task Order for Achieving USAID's CAM Strategy SO3: USAID assistance will improve health care to respond to the principal causes of maternal and child morbidity, malnutrition and mortality, as well as high fertility and STI/HIV. Working through the MSPAS and its NGO partners, technical assistance under this Task Order will support the MSPAS to increase access to and use of reproductive and child health and nutrition services and to improve health, nutrition and hygiene practices.

The Health-related Strategic Objective 3 Results Indicators include:

- Reduced Infant Mortality Rate (from ENSMI 2002 and 2007)

Graph 1

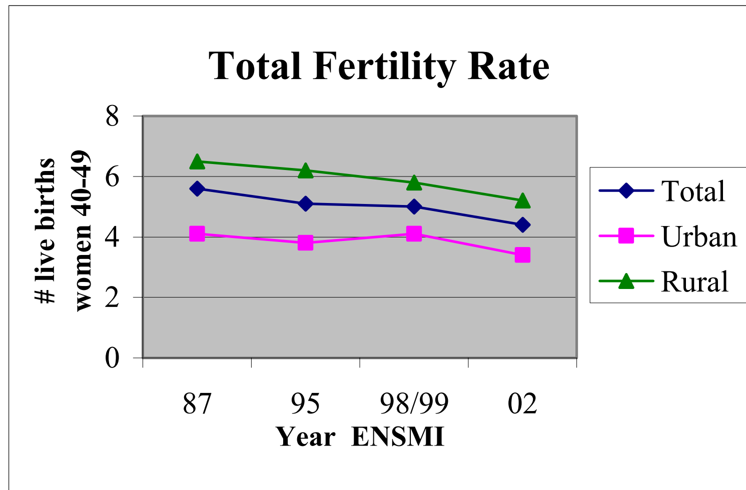


All indices of mortality of the < 5 year age groups have been reduced since 1987. Nevertheless, child mortality (<5 years) remains high at 53/1000 live births. Infant mortality is 39/1000 live births, but more than half of all deaths are neonatal, which also represent more than 40% of

deaths < 5 years. For this reason the USAID program will focus on neonatal activities to significantly reduce deaths in the first month of life, which have remained near the same level for more than 15 years.

- Reduced Total Fertility Rate (from ENSMI 2002 and 2007[1])

Graph 2



Graph 2 above demonstrates that total fertility is gradually reducing, but hides the fact that there exist population groups with high levels of fertility, including uneducated women, Mayan women, and couples settled in the North, North-West, South-West and Petén regions. These regions contain the groups that are the most difficult and important to reach to significantly reduce total fertility in Guatemala.

- Reduced Chronic Malnutrition or Low Height for Age in Children 3-23 months (from ENSMI 2002 and 2007)

At the **Intermediate Result** Level, This Task Order will contribute primarily to achieving Intermediate Result 3.3 of the CAM Strategy Strategic Objective 3, namely:

Intermediate Result (IR 3.3): Increased Use of Quality Maternal-Child and Reproductive Health Services

IR3.3 includes four lower-level results:

3.3.1 Improved and expanded family planning services and information/education
3.3.2 Improved and expanded maternal child health care and information/education
3.3.3 Better nutrition and dietary and hygiene practices
3.3.4 Increased use of prevention practices for STI/HIV and of STI treatment

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[1] Encuesta Nacional de Salud Materno Infantil

The indicators for measuring progress toward these results include:

- Contraceptive prevalence rate (from ENSMI 2002 and 2007)
- Couple years of protection (CYP- national MSPAS sources)
- Percentage of births attended by skilled health personnel (from ENSMI 2002 and 2007)
- Global malnutrition rate (low weight for age) in children from 3-23 months of age (from ENSMI 2002 and 2007)
- Immunization rate: DPT3 (national MSPAS sources)
- Number of MSPAS clinics implementing improved STI syndromic management protocols (annually starting 2006)

By working to assist the MSPAS to implement better-managed public health programs, policy and management reforms, and systems strengthening from the national level down to the health district level, the Contractor will also contribute, but to a lesser degree, to achieving Intermediate Result 3.1 of the CAM Strategy Strategic Objective 3:

Intermediate Result 3.1: Increased and Improved Social Sector Investments

And the following lower-level results:

3.1.1 Increased and more efficient expenditures (including procurement processes) by Ministries of Health and Education (Task Order to assist MSPAS only)

3.1.2 Increased and more effective decentralized investments in health and education (Task Order to focus only on health)

The Indicators for measuring progress in these areas include:

- Total budget actually spent by MSPAS as a percent of programmed budget
- MSPAS annual contraceptive purchases as a percent of total MSPAS annual needs

The components of this Task Order are designed to specifically contribute to achieving these lower level results as measured by the above indicators.

Development Hypothesis/Proposed Program: Building on success, USAID will continue expanding and improving the quality of reproductive and child health services and information, education and communication (IEC), especially at the community level via the integrated program known as AIEPI AINM-C (see Annexes 1 and 2), which focuses on prevention and promotion as well as on integrated case management of childhood illness, and includes maternal and child health and nutrition care, growth monitoring/promotion, IEC to improve dietary, health and hygiene practices, and family planning. This program was launched in 2003 in all municipalities in the seven highland departments, which are the geographic focus of USAID's current health strategy and will continue to be focus departments in the new CAM strategy and in this Task Order (San Marcos, Quetzaltenango, Totonicapán, Sololá, Quiché (includes separate health area – Ixil Triangle), Huehuetenango and Chimaltenango). This is the poorest area of the country, with lagging health and nutrition indicators and the greatest concentration of indigenous populations, and around 25% of the total population of Guatemala. The Contractor will build on

prior USAID health investments and successes in these departments and consolidate and institutionalize program improvements, transferring these to the new government officials.

The four PL-480 Title II NGOs are actively involved in the AIEPI AINM-C program and striving to improve food security for at-risk Guatemalans by integrating food aid for targeted supplementary feeding for 6-36 month-old children and pregnant/lactating women in target municipalities with high chronic childhood malnutrition (See annex 5 for list). A significant proportion of total PL-480 Title II resources will complement funding under this Task Order to achieve greater impact on reducing malnutrition.

Expanding access to essential maternal and neonatal care will be an integral part of USAID's assistance in the seven departments. Effective STI/HIV prevention and STI treatment services, currently concentrated in the capital, will be established in MSPAS facilities that serve high HIV prevalence populations in geographic areas with high HIV prevalence. Family planning assistance to the MSPAS will be national. The program builds on current investments in operations research, development of IEC materials, training, logistics systems, management information systems, and provision of necessary commodities and supplies. Community health services and IEC will be carried out through the traditional MSPAS infrastructure and with NGOs under contract to the MSPAS. Management reforms will be implemented to increase access to, and efficiency and quality of, MSPAS services.

The program will encourage greater male participation in health activities supported by USAID, including, but not limited to the following: family planning use and promotion, lengthening the interval between pregnancies, birth preparedness and emergency readiness at the family and at the community level, gender equity, improved child feeding and women's nutrition practices, removing barriers to family planning access by women and reducing unmet demand and STI/HIV prevention and STI treatment.

Not through this Task Order, but complementing it, USAID intends to provide $12 million in financial support to the MSPAS at the rate of $3 million per year to finance basic health care coverage for an additional 500,000 to 1,200,000 people for four years in the eight focus health areas, starting in calendar year 2005 and continuing through 2008, through the MSPAS' contracts with NGOs, conditioned on leveraging an equal amount of MSPAS funds to cover the above-mentioned population. The size of the final population to be covered via co-funding by the MSPAS and USAID will depend on the per capita health care cost set by the MSPAS. Through this leveraging, combined with similar efforts by the IDB and World Bank, it should be possible to finally achieve universal access to health care in Guatemala. USAID's first priority will be to get the MSPAS to assume financial responsibility for the health care coverage of the 317,000 people served by local NGOs that are directly supported in USAID's current strategy by John Snow Research and Training Institute (JSI) and AmeriCares in the Pro-Redes Salud program. In 2009, the MSPAS is expected to fully finance the additional populations covered without USAID support.

II. Statement of Work

A. Overall Statement of Work

1. Task Order Objectives

USAID is issuing this RFTOP to contract the services of a single Offeror to provide a range of long and short-term Technical Assistance to the MSPAS to increase use of child and reproductive health and nutrition services in order to reduce maternal and child morbidity, mortality and malnutrition, as well as total fertility in Guatemala. The Contractor will also be responsible for a limited amount of participant training and procurement of materials and equipment related to project execution.

The objective of this Task Order is to build on past activities and advances to increase use of quality child and reproductive health and nutrition services. Much has been accomplished with USAID health assistance in the past five years, and a major focus of the new strategy is the consolidation and support for continuation and expansion of those activities, particularly in the sense of institutionalization. The Contractor shall support the MSPAS to strengthen current interventions and expand them nationally using the MSPAS' regular human and financial resources. The Contractor is not expected to implement the interventions directly by itself, but rather to build on current MSPAS strengths, personnel and existing infrastructure, for instance the NGO extension of coverage program. While some activities will be new, they too essentially represent a new stage and extension of past USAID health activities with the MSPAS.

USAID is issuing this Task Order as a cost-effective means of reducing the number of USAID health partners currently working with the MSPAS in order to reduce costs and USAID's management burden. These current activities include principally: Calidad en Salud executed by the University Research Corporation, the Maternal and Neonatal Health Project executed by JHPIEGO, the Pro-Redes Salud program executed by the John Snow Research and Training Institute (JSI) and AmeriCares, and IMPACT executed by Family Health International.

In order to integrate the various components and activities included in this Task Order, as well as reduce costs and promote competition, USAID would prefer a single Contractor rather than a consortium composed of various CAs and sub-contractors. Offerors may propose sub-contracts, but must justify their reason for doing so, and explain how coordination will be ensured and costs not increased over those of a single firm. Any additional firm should bring unique technical contributions of the firm and not just serve as an employment agency for Task Order Advisers and Consultants.

2. Technical Focus

The Activity consists of seven components, which are closely linked and mutually supportive:

- Family Planning and Contraceptive Security
- Maternal and Neonatal Health
- Nutrition Interventions for Women and Children

- Child Health
- STI/HIV Prevention and STI Treatment
- Integration of Child and Reproductive Health Services
- Better Management of Public Health Programs

These components are described in some detail in Section B. In general, most of the activities envisioned are a follow-on to those undertaken by USAID/Guatemala in its current strategy from 1997-2004 (ending September 30, 2004), and will build on the results of the USAID health program to date. There are, however, four significant modifications, which must be taken into consideration:

- There will be much more emphasis on nutrition in the Child and Reproductive Health Program than in the past. Nutrition is considered to be a weak link in the MSPAS' basic package of health services contracted out to NGOs to deliver in the extension of coverage program (see Annex 3), as well as in MSPAS programs in general, and has taken on a higher visibility and priority with the new government's War against Hunger program (Frente contra el Hambre), chaired by the First Lady of Guatemala. The AIEPI AINM-C strategy, with community-based growth monitoring and promotion at its core, offers an excellent opportunity to strengthen nutrition interventions in the public health sector (refer to Annexes 1 and 2 for a description of the AIEPI AINM-C approach). This additional emphasis will take the form of expert policy advice, as well as an improved and expanded maternal child nutrition program at community level.

- While the AIEPI AINM-C package of interventions has been introduced in the seven western highland focus departments in USAID's current strategy in more than 2,000 villages, even more emphasis will be placed on expanding it in the future, not only to MSPAS facilities and contracted NGOs yet to implement AIEPI AINM-C, but in particular to geographical areas where access to institutional care is limited. In general, the models and educational and training materials have been developed.

- The IEC component of the current program has focused on the development of strategies, training materials, interpersonal and mass media campaigns. Those materials now exist, and the challenge is to apply them, particularly at the community level.

- The management component will include a focus on upgrading the capacity of the MSPAS to carry out financial strategic planning and budgeting, two priority areas critical for long-term success in all program components, as well as priorities for the MSPAS. Included in the Contractor's tasks for achieving better managed programs in the MSPAS are also efforts to combat corruption, including strengthening the drug/contraceptives logistics system, and improving the information system. In the case of the logistics system, it is recognized that while a principal objective is to assure the presence of contraceptive methods throughout the country, the logistics system for contraceptives in the MSPAS is integrated with essential drugs and vaccines and must not be treated as a vertical system. Contributions to the information system of the MSPAS will be primarily in the form of improved indicators, and collection and analysis of information. It is not anticipated that much assistance will be provided for computerized databases of the

MSPAS, except in terms of recommendations for improvements in data collection, indicators, analysis and using data for decision-making, and automated reports.

Note that while most program activities have been identified, and support the current priorities of the MSPAS, the Contractor is expected to establish a flexible rapid response fund because priorities are likely to shift somewhat from year-to-year during the implementation of this Task Order. Annual implementation plans, developed jointly with the MSPAS, will reflect these changes, and will be subject to review and approval by USAID. Amendments to annual implementation plans, to be approved by USAID, will be used by the Contractor to formalize unanticipated activities in response to MSPAS' requests.

3. Geographic Focus

The geographic focus varies somewhat between activities. The greatest health needs are found among the indigenous populations of Guatemala's western highlands. For this reason, USAID's efforts will primarily be focused in eight Health Areas (of 26 nationally) in the seven focus departments of the western highlands (San Marcos, Quetzaltenango, Totonicapán, Sololá, Quiché (includes Quiché Health Area and separate Health Area – Ixil Triangle), Huehuetenango and Chimaltenango).

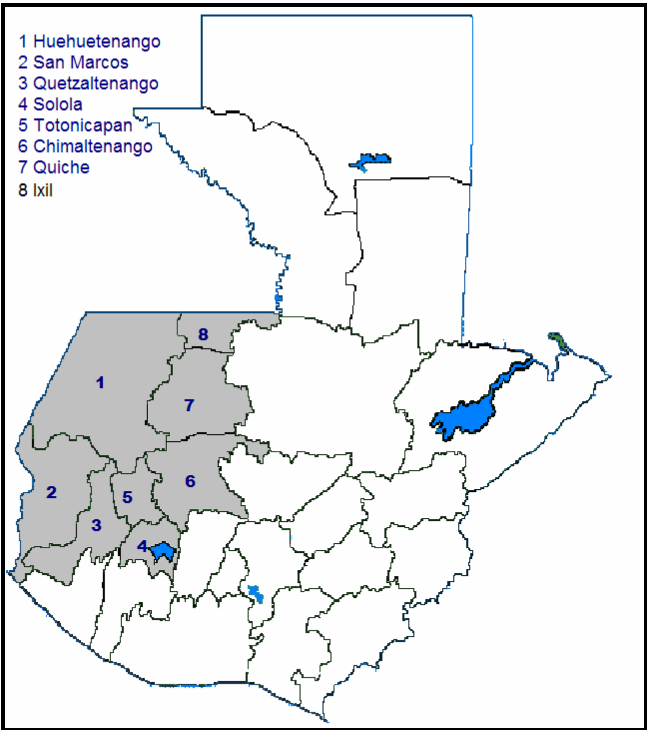
Activities have been initiated in all of these Health Areas. However, the maternal and neonatal care package, in contrast to other interventions, has been implemented to date as a smaller scale demonstration program in only about one third of the facilities and will be scaled up significantly under this Task Order in the seven departments. The Contractor will work with the MSPAS to maintain the current momentum in family planning activities (despite change of government) and seek further improvements at the national level, while helping the MSPAS expand the maternal and neonatal and AIEPI AINM-C components in the seven focus departments. Simultaneously, USAID-assisted technologies and innovations, e.g. AIEPI AINM-C, should be transferred by the Contractor to other donors, local and international NGOs and other organizations to further expansion nationally, working closely with the MSPAS. This transfer of technology would presumably include the training-of-trainers who would then independently initiate the transfer to other areas but would probably exclude other types of material support. The Contractor should conduct proactive policy dialogue with the MSPAS to promote adoption of USAID-assisted technologies and innovations as national norms.

With reference to assistance to strengthen STI/HIV prevention and STI treatment, Guatemala has a concentrated HIV/AIDS epidemic that is growing among core groups (especially Men who Have Sex with Men (MSM) and Commercial Sex Workers (CSW) in urban areas along the major transportation corridors. Therefore, this component will focus on serving these core groups in 26 existing MSPAS facilities in selected cities (outside the capital) with high STI/HIV prevalence, near to ports and borders and along major transportation and trucking routes. See Annex 4 for an illustrative list of the 26 MSPAS health facilities to be strengthened for STI/HIV services. The Contractor will need to select the actual sites to be strengthened in consultation with the MSPAS.

Managerial support will be provided to the eight focus Health Areas down to the health district level, focusing on developing procedures, models, systems and training to improve the planning and management skills of MSPAS personnel, which could then be applied by the MSPAS to other Health Areas of the country. Managerial support will also be provided to strengthen central MSPAS systems and strategic financial planning at national level, particularly to strengthen the Department of Strategic Planning.

The impact of the AIEPI AINM-C, Maternal and Neonatal Health, and Management Components will be concentrated in the eight Health Areas shown on the map below. Nevertheless, it is intended that some of the interventions will have a national impact, as well, particularly in reference to norms and the financial planning, logistics and information systems of the MSPAS.

Map of Eight Priority Health Areas for USAID Program



4. Level of Focus

In support of MSPAS' priorities and decentralization policy, much of the focus of technical assistance activities will be at the Health Area level. The ultimate goal, however, is that the specific interventions reach and are successfully implemented in the lower levels of the health system, that is: the District Level, the individual service delivery and training units, and importantly, at the community level. Management interventions will focus on both the Health Area Level and the Central Level.

5. Customers and Partners

There are two primary levels of customers in this program. The first are the women and children in the USAID Target Health Areas, particularly those in under-served geographic areas.

The other customer is the MSPAS, particularly at the Central level, the Health Area level, the Health District level, and the service delivery level, in terms of enhancing its ability to plan and deliver quality, cost-effective services.

Partners in this effort primarily include:

- The MSPAS itself in terms of delivering services
- Communities in which programs are developed
- International organizations such as PAHO and UNFPA
- Bilateral programs and projects of other donors
- Associations of professional health-care staff such as physicians, nurses, obstetricians and gynecologists
- Local NGOs, particularly the health-delivery network contracted by the MSPAS
- Other Government-wide programs, such as Frente Contra el Hambre
- Civil Society advocacy groups
- Local IEC business partners

6. Tangible Results of Task Order

Tangible Results to be obtained from this Task Order include:

- Increased use of quality MSPAS-delivered family planning services nationally as measured by CYPs, but particularly in those geographic areas presently under-served by the existing MSPAS health delivery system.
- Contraceptive prevalence increased, particularly among the rural indigenous population, and the percentage of short birth intervals decreased.
- Unmet demand for family planning services reduced, particularly among the rural indigenous population.
- A sustainable mix of contraceptive methods available at all MSPAS facilities.
- The contraceptive logistics system improved nationally, and as a by-product, procedures and skills transferred which will enhance the MSPAS' integrated logistics system.
- Improved capacity in the MSPAS to determine, program and procure its contraceptive needs, including enhanced contraceptive security in the long-term.
- Demonstrated improved child nutritional status in the USAID target areas through effective community-based growth monitoring and promotion and micronutrient supplementation programs. This includes significantly increasing the percentage of children under two years that regularly attend monthly weighing sessions.
- Complete implementation of models of extension of care using integrated packages of Maternal, Neonatal, Child Health and Nutrition inventions throughout the USAID target

health areas; and models proactively promoted and technology transferred for replication elsewhere.
- High quality and effective integration achieved in child and reproductive health services provided by the MSPAS throughout the USAID target areas.
- A wide range of existing, effective IEC materials supporting child and reproductive health activities, developed by USAID partners in the last 5 years, available and in use.
- Increased community demand for and use of child and reproductive health services.
- Integration of reproductive health activities at each level of the health care delivery system.
- Improved financial planning for child and reproductive health interventions, and the transfer of methodologies and procedures for financial analysis of health programs to appropriate MSPAS Central and Area Level personnel.
- An improved capacity for financial and logistics management at the Health Area level of the targeted health areas.
- A performance-based budgeting system designed and implemented in the MSPAS.
- Syndromic management of STIs expanded and strengthened in 26 MSPAS health facilities for high prevalence groups (CSW, MSM) and Persons Living with HIV/AIDS (PLWHA).
- Voluntary counseling and testing (VCT) for HIV strengthened for high prevalence groups (CSW, MSM) and Persons Living with HIV/AIDS (PLWHA) in 26 MSPAS health facilities.

B. Components

This section describes the technical services required under this Task Order with Performance Measures (PM) and Benchmarks for each component. The Performance Measures will be used to measure accomplishment of major tasks by the Contractor which contribute to achieving the CAM SO3 results in Guatemala. Benchmarks are quantified, periodic achievements that USAID expects to result from the Contractor's work at various stages of the Task Order in order to achieve the Performance Measures and Intermediate Results. The Benchmarks described are illustrative and not limiting. Offerors should feel free to propose additional or alternative Benchmarks, not to exceed 30 Benchmarks, provided that such adjustments do not significantly alter the substance or objectives of USAID's CAM S03 and Intermediate Results 3.1 and 3.3 and lower level results, as stated above.

1. Family Planning and Contraceptive Security

a) Background

During the past five years Guatemala's policy environment towards reproductive health, particularly family planning, improved considerably. The high commitment of the GOG (Portillo administration) was evidenced in the launching of the National Reproductive Health Program (NRHP) in January 2001. The legal foundation for family planning was strengthened with passage of the "Social Development Law" in 2001 and the "Social and Population Development Policy" to implement the law, approved in May 2002. Furthermore, Guatemala has a favorable regulatory framework for family planning including the Constitution and various

international conventions and declarations (e.g., Convention to Eliminate all Forms of Discrimination against Women, and the Universal Declaration on Human Rights).

As a result of launching the NRHP the MSPAS has become the largest single contributor of family planning as measured by Couple Years of Protection (CYPs), delivering 44% of all CYPs in 2003, with APROFAM the private family planning association (IPPF affiliate) now in second place at 36% of CYPs, and IGSS in third place with 14%. Currently the entire MSPAS network, including hospitals, health centers and health posts, offers family planning services. The achievements in family planning are directly associated with the support provided by USAID/Guatemala and the priority placed by the MSPAS on making family planning information and services more accessible in rural areas.

At the community level, NGOs (both those contracted by the MSPAS and others working in health with USAID assistance through Pro-Redes Salud) began providing family planning services in 2003, yet, their outputs are still minimal. Also during 2003, a comprehensive family planning counseling strategy was implemented throughout the entire national health network by the University Research Corporation and the Population Council. Although IEC materials have been developed and are used by health providers to counsel clients, the program still needs to improve IEC materials distribution and handling to ensure systematic use with family planning clients.

As shown in Table 1, use of family planning increased considerably during the past five years. Approximately 30,000 new acceptors are seen each year at IGSS, with the balance at MSPAS.

Table 1: Number of new acceptors by method and year, MSPAS and IGSS combined

FP Method	1999	2000	2001	2002	2003
Depo-Provera	25,567	58,670	104,282	145,115	153,191
Condom	12,126	18,474	24,384	34,992	28,046
IUD	2,917	4,580	4,197	5,109	5,799
Norplant	0	1,582	2,543	880	175
Oral pills	16,142	32,245	37,196	41,933	39,816
AQV male	0	694	444	358	385
AQV female	8,060	11,262	12,741	14,353	15,276
Naturals Methods	0	0	0	0	8,026
Total new users	64,821	127,507	185,787	242,740	250,714

Table 1 demonstrates several features of the current family planning landscape. First of all, more than 60% of all new acceptors utilizing the MSPAS and IGSS opt for Depo-Provera injections, including 67% in the eight USAID priority areas. Indeed, the annual CYP targets for both the

MSPAS and IGSS for 2003 were achieved primarily through injections (46%) and female voluntary surgical contraception (AQV 37%). This highlights the relative weakness of the other methods, which contributed only 17% of CYPs. While there is an obvious preference for Depo - Provera by women, its popularity relative to other methods is in part due to a preference (bias) by health providers for convenience as compared with insertion of an Intrauterine Device (IUD) and persisting misinformation and doubts on the safety of the IUD.

One of the challenges facing the family planning program in Guatemala is to make it sustainable within the MSPAS, which began paying UNFPA for a small percentage of its contraceptive needs in 2002 and is scheduled to procure 40% of its needs by 2005. Depo-Provera, the present method-of-choice of Guatemalan women, is relatively expensive, and could prove to be unsustainable in large quantities, when USAID and UNFPA donations cease. Although considerable training and equipment have been provided to increase access to IUDs, contrary to pills, injections, and sterilization, which are all well-known family planning methods, the IUD as a method is known by only about half the women of reproductive age.

The unmet demand for family planning is growing. For women of reproductive age in union demand has risen to 28% from 23% in 1999, and represents the success of the program in increasing demand, but also the urgent need to respond by increasing access to MSPAS family planning services in rural areas, especially clinical services. Unmet demand is greater among rural women (32%) and indigenous women (39%), and among those lacking formal education (38%). Unmet demand is actually higher when considering that the present policy of the MSPAS is to achieve pregnancy spacing of 3 to 5 years, consistent with overwhelming international evidence on the health benefits of longer intervals, and because 66% of Guatemalan births have intervals less than three years.

Contraceptive Security: Since 2001 USAID has worked with partners who receive USAID-donated contraceptives to increase self-reliance. For over 20 years, USAID was the sole contraceptive donor in Guatemala. However, the demand for contraceptives is increasing rapidly as a result of the GOG commitment to reproductive health and already exceeds USAID resources. This problem has been solved for now by the donation from UNFPA of contraceptives to the MSPAS and IGSS for the first time starting in 2002 with funds from the Canadian International Development Agency CIDA. The UNFPA agreements provide for the MSPAS and IGSS to gradually buy an increasing portion of their own contraceptives from 2002-2005, with IGSS reaching 100% by the end of their agreement and the MSPAS reaching 40%. The monies provided by the MSPAS and IGSS will be invested by UNFPA to create a trust fund for the MSPAS to be used from 2006 onwards to buy a portion of the required commodities. Still the MSPAS will have to provide additional resources or continue with donor support to secure 100% of its contraceptive needs from 2006 onwards. A National Contraceptive Security Commission (pending endorsement by Governmental Decree) comprised of public and private service providers, academic institutions, women's groups, social marketing organizations, the commercial sector, and the donor community is discussing various needs and planning to increase contraceptive self reliance. Involving the commercial sector in contraceptive security through the Commission is necessary, but new in Guatemala (other than prior USAID support to the contraceptive social marketing organization, IPROFASA, now graduated from USAID assistance).

b) **Tasks to be Performed**

➢ **Performance Measure: Achieving optimal inter-pregnancy intervals of 3-5 years made a major theme in health education and promotion of family planning**. Both short and long inter-pregnancy intervals have been found to increase the risk of various adverse perinatal outcomes, such as low birth weight, preterm delivery, stillbirth, and neonatal death. Short intervals are associated with higher infant mortality and chronic malnutrition. Yet in Guatemala, 66% of all births after the first born have intervals shorter than three years and health professionals as well as the general population are not aware of newer information that a two year birth interval is not long enough. The Contractor will support the MSPAS and other relevant organizations and local providers for IEC for the general population and youth on the benefits of 3-5 year inter-pregnancy intervals and of delaying initiation of sexual activity and first pregnancy, improving breastfeeding practices to lengthen the interval, and increasing access to and understanding of the benefits of temporary family planning methods to plan and space pregnancies.

➢ **Performance Measure: Unmet demand for family planning decreased and coverage and quality of family planning services increased**. Unmet demand for family planning is high in Guatemala. For some people unmet demand is a stage that they pass through, when they have recognized a need to limit their fertility, but have not yet taken action. Others, as in the Guatemalan case, are ready to take action but face impediments to using contraception such as inadequate access to good quality services, worry about health and side effects, lack of information, or opposition from family members. The Contractor will work with central and local health authorities to achieve increased access to and use of family planning services for men and women who wish to limit or space their pregnancies, and to eliminate medical barriers to family planning. NGO performance could improve considerably; health centers and especially health posts have the potential to increase current coverage by improving counseling, quality of services and client satisfaction. The focus of the Contractor's work in this area will be on advocacy, policy formulation, and design of cost-effective strategies for increasing coverage.

As part of the general strategy of satisfying unmet demand, the Contractor will be expected to address the following:

- **Decrease bias against IUDs.** Considering the extensive infrastructure and location of its service facilities, the Ministry of Health has much untapped potential to meet the demand for clinical methods such as IUDs and male and female voluntary surgical contraception. According to the MSPAS service statistics, health centers insert on average less than one IUD per month. Only seven of the twenty six health areas reported more than four insertions per month in 2001. This figure is very low considering that each health area has on average eleven health centers. Provider bias and lack of MSPAS capacity to offer the IUD (trained personnel, equipment) are limiting client's choice and access to this method, which is safe, cost-effective and long lasting. The Contractor shall work with local health providers to dispel misinformation and make them aware of the advantages of the IUD and the need to include it in the method mix offered in response to client needs/preferences. Special efforts are required so that IUD insertion services will be available at every public hospital and health center and at selected health posts via trained auxiliary nurses. The IUD could also increase the range of effective modern methods available at the community level. Each NGO

contracted by the MSPAS has at least one physician or nurse that could be trained to become a proficient provider of IUD.

- **Decrease bias in favor of Depo-Provera.** Injectables are the first contraceptive choice of Guatemalan women and the program should continue to be responsive to client preferences. However, since the MSPAS does not charge for any contraceptive and the worldwide price paid by USAID and UNFPA for their donations of Depo-Provera are below commercial market value of injectables in private pharmacies by an order of twenty-fold, bias toward this high recurrent cost, heavily subsidized method is creating an increasing financial burden on the MSPAS' budget that will be impossible for the MSPAS to support in the future once donations end. The Contractor will work to assure that providers do not favor this method to the detriment of others. Policy dialogue and work with the MSPAS on beginning to charge actual cost for contraceptives to those with ability to pay and to better target its free services to the poor would be very desirable. An undesirable consequence of poor targeting of free MSPAS family planning services is a cannibalization of APROFAM's sales of contraceptives and its sustainability, because as MSPAS services grow in rural areas, people who once went to APROFAM and were willing to pay now go to the MSPAS for free Depo-Provera.

➢ **Performance Measure: Contraceptive security ensured in both public and private organizations.** The Contractor shall assist MSPAS authorities to carry out the financial planning necessary to ensure that the MSPAS is able to fully finance 100% of the acquisition of modern methods required to satisfy the demand of their clients by the beginning of calendar year 2009, the last year of the USAID strategy. The Contractor will train and work with MSPAS staff to increase their expertise to assume full responsibility for supplying adequate contraceptives at the service delivery level. Furthermore, the Contractor is expected to work with both the MSPAS and private sector family planning providers, such as USAID's major partner, APROFAM, as well as with bilateral and multilateral donors, to establish functioning mechanisms with economies of scale through which service providers will procure the required commodities for the family planning program. To date the best potential source of procurement for contraceptives based on cost and quality is UNFPA, but no Guatemalan organizations have yet procured from UNFPA to test this potential. The recently formed Contraceptive Security Commission will continue to need the Contractor's technical assistance to build capacity of the MSPAS and other family planning service providers to address different elements of contraceptive security: estimating needs, securing funding, effective procurement processes, distribution systems, market segmentation, and alliances between public and private sector service providers along with the commercial pharmaceutical sector.

c) Benchmarks

- By the third quarter of the Task Order, the Contractor shall review the existing IEC and training materials prepared by Calidad en Salud, and submit to USAID/Guatemala an update of these materials as necessary to stress the message "3-5 years pregnancy spacing saves lives" and options for family planning clients to act on this message.

- By November 30, 2005, the Contractor will submit for USAID/Guatemala's approval a Contraceptive Security Plan for Guatemala, with a detailed description of the role and

tasks of each agency and the phases (making projections, securing financing and doing procurement). The plan should be endorsed by all the agencies that need to carry it out. Furthermore, the plan should specify the steps the MSPAS will take so that by 2009 it buys 100% of the contraceptives needed to supply demand in all MSPAS facilities.

2. Maternal & Neonatal Health

a) Background

In 2002, the MSPAS, with support from the international community, carried out a study to determine the magnitude of maternal mortality and found that for the year 2000 in Guatemala. the maternal mortality ratio –MMR- was 153 x 100,000 live births. However, among indigenous women the MMR was 211 x 100,000 live births, one of the highest levels of maternal mortality in the Western Hemisphere. Half of all maternal deaths occurred during the first twenty-four hours after delivery, and half of the deaths occurred at home. Of those women who died, 65% delivered with unskilled attendants. In recent years, neonatal mortality (0 – 28 days) contributed more than a half of infant deaths. Early-neonatal mortality (0 – 7 days) represents 77 % of neonatal mortality. The main causes of newborn deaths are: infection, birth asphyxia and low birth weight (< 2500 grams) due to either intrauterine growth retardation or prematurity.

To address these problems, USAID, through the Maternal and Neonatal Health Project implemented by JHPIEGO, has provided support to the MSPAS in essential maternal and neonatal health care (EMNC) to enhance the capacity of health service providers to resolve problems related to birth at appropriate levels of the system. Procedural manuals have been developed, staff trained, and equipment provided to 154 facilities including hospitals (10), maternity hospitals (3), health centers (44), and health posts (97). These represent about 35% of MSPAS institutions in the eight USAID priority health areas.

In 2003 all participating facilities were evaluated using quality standards. Every facility demonstrated dramatic improvements in performance and quality of basic maternal and neonatal care. In general, performance indicators rose from less than 20% compliance in 2001 to about 80% in 2003. Eighteen health facilities, including two hospitals, reached an 85% level of quality standard satisfaction. This quality improvement process also motivated visits between health facilities resulting in cross fertilization of problem-solving ideas, exchange of low-cost technology, increased motivation towards improved quality, peer-to-peer education, and improvements in the referral system. As a result, an effective performance quality improvement (PQI) model has been implemented. The capacity exists to gradually extend this model to all health care delivery points in the eight areas of emphasis, and, through the MSPAS, other donors and organizations, to other regions of the county over the coming years. In fact, NGOs and other donors including the European Union have begun replicating the PQI effort carrying out baseline assessments in 221 additional facilities in six additional health areas.

Simultaneously, effective life-saving committees have been established by JHPIEGO in 93 communities. Their main mission is to increase demand for emergency obstetric care, and to organize communities and individuals to access timely referrals to services in case of obstetric emergencies, making transport arrangements, etc. The committees enhance family and community awareness of maternal and neonatal health problems, birth preparedness and

emergency readiness. They also promote culturally appropriate interventions to improve home-based care and more timely use of health services.

Under the current EMNC strategy, innovative traditional birth attendant (TBA) training has included recognition of danger signs and timely referral, and the formulation of birth preparedness and emergency readiness plans. No traditional training in safe delivery and handling obstetric complications has been supported for TBAs, based on lessons learned from the failed impact on reducing maternal mortality of prior programs focused on training TBAs to manage such emergencies. The Contractor will continue the effective EMNC strategy and no traditional TBA training in safe delivery will be included under this Task Order. However, TBAs shall be recognized as an integral part of the community-level health team and they shall be trained to gradually assume new supportive roles in counseling, identification of complications, timely referrals, and in some cases, as care-givers in MSPAS facilities.

Major future challenges include:

- Extending the EMNC model will require a sustained effort, not only to train and equip health care personnel, but continual supervision to assure quality of care.
- Better coordination and an improved referral system are needed between the various levels of care.
- One of the key elements for success is community support. The model for achieving this has been developed, tested, and proven acceptable and of great utility. The challenge is to extend it to hundreds of additional communities, especially in isolated areas.
- The EMNC model needs to be enhanced by integrating a stronger neonatal care component to reduce neonatal deaths during delivery and in the period immediately following birth, when most deaths occur and through the first critical month of life.
- Physical and cultural access to health services remain barriers in the geographic areas with the worst maternal mortality indicators. New models must be developed to increase access to skilled attendants at birth for isolated, rural and indigenous populations
- Increasing the number of women receiving post-partum care, currently at only 20%, is essential.

b) Tasks to be Performed

The following activities should be expanded throughout the seven USAID focus departments, as other USAID-assisted health interventions have already been, and not remain limited to a small geographic area as has been the experience to date.

➢ **Performance Measure: Increased proportion of deliveries attended by skilled personnel.** From 1999 to 2002 in ENSMI the proportion of deliveries attended either by a physician or nurse remained almost stagnant (40.6% vs. 41.4%), placing Guatemala as the

country with the worst safe delivery attendance in LAC. In Guatemala, skilled providers are not available to cover deliveries for a large segment of the population. The Contractor shall work with the MSPAS to define and introduce affordable and feasible models for skilled delivery coverage in rural areas. In doing so, the Contractor will consider existing capabilities in communities, training capacity in national nursing schools and clinical training experts to teach professional, certified, midwifery skills, as well as other strategies such as mobile teams, maternity centers, additional health facilities, etc.

- **Performance Measure: Increased number of Mayan professionals trained to become certified nurse midwives who provide skilled attendance at birth in rural areas of high maternal mortality.** This will be achieved by a participant training scholarship program to be managed by the Contractor for training Mayan professionals at Guatemalan nursing schools to become certified nurse midwives in one or two-year degree programs. This training program will begin in 2005 and contribute to the USAID Guatemala Country Plan's cross-cutting focus on indigenous empowerment and youth. The Contractor will work with GOG and MSPAS high middle and local-level authorities on the selection of approximately 120 scholarship recipients. The MSPAS will need to assure that the newly trained professional midwives will have MSPAS positions in rural areas with high maternal mortality in which to fulfill a two-year post training service requirement providing prenatal, delivery and postnatal care. The Contractor will negotiate with the MSPAS accordingly. The MSPAS will be requested to mobilize its resources to improve use of quality maternal and neonatal health care in isolated geographic areas. The Contractor will work with the MSPAS to define the role of this new cadre of professional personnel including possibly: supervising health clinics run by traditional birth attendants, or serving as members of the MSPAS-contracted NGOs' health service delivery teams doing deliveries in rural NGO community health centers, as staff in the MSPAS' health centers or posts on permanent call to attend deliveries at home, or attending deliveries in MSPAS type B health/maternity centers with appropriate but currently non-operational infrastructure.

- **Performance Measure: Newborn care integrated into safe motherhood and child health programs.** Newborn care should be an integral part of safe motherhood because factors that cause maternal morbidity and mortality also affect the fetus and newborn. The Contractor shall work with the MSPAS to strengthen and integrate newborn health care into existing maternal and child health programs at the facility and community level.

- **Performance Measure: Increased access to and use of quality basic Essential Maternal Neonatal Health Care (EMNC).** The Contractor will strengthen the work already done in this area by USAID'S partners and the MSPAS, and increase the number of facilities that provide quality EMNC care for mothers and newborns. The Contractor will support the MSPAS's performance quality improvement efforts in EMNC facilities networks for: prenatal, delivery, post partum and basic neonatal care. Management of post-abortion complications should be included as an integral part of quality improvement interventions.

- **Performance Measure: Improved linkages between levels of care.** Each level of the health system requires protocols defining its role in the process of providing EMNC, with careful attention to the capacity of the facility and its personnel. The various levels need to be linked from primary to tertiary so that each level provides the range of interventions it is responsible for, and refers the patient to the next level for further attention, if necessary. The Contractor

shall assist the MSPAS in defining and strengthening the roles at each level, creating links in the chain of health services in the eight target health areas, and ensuring that the referral and counter-referral system is functioning adequately.

➢ **Performance Measure: Strengthen community level interventions.** Active participation of the community is essential to improve maternal and neonatal outcomes. Birth preparedness and emergency readiness plans at the family and at the community level are essential to rapidly detect and refer complications to quality EMNC facilities. Culturally appropriate interventions for indigenous populations to improve home-based care of the mother and the newborn have been developed, tested, and proven acceptable and useful for improving care, identifying problems, and assuring that women with reproductive health problems reach the proper level of services. The Contractor will scale up this model of community participation, perhaps as an extension of the activities of the large network of "vigilantes" already present in the communities, in conjunction with TBAs and working with NGOs that deliver health services. This should be a major thrust of IEC under this Task Order.

➢ **Performance Measure: Increased access to Post-Partum Care.** Post-Partum care is currently provided to only 2 in 10 women giving birth. The postnatal period is one of high vulnerability for the mother and her baby, and thus post-partum services represent an important element in protecting the lives and well-being of women and newborns. At the same time, the post-partum visit represents an opportunity for family planning counseling, particularly in reference to birth spacing. The Contractor is, therefore, expected to promote increased access to and use of post-partum care for the mother's health, as well as to promote pregnancy spacing and family planning.

c) Benchmarks

- By the second year of the Task Order, the EMNC quality of care model should be implemented in an additional 40% of MSPAS facilities in USAID priority health areas.

- Two years after the Task Order is signed, the Contractor will have expanded mobilization processes to at least 200 additional communities, focusing on municipalities with high maternal mortality.

3. Nutrition Interventions for Women and Children

a) Background

Despite efforts to improve nutrition in Guatemala over the last half century, maternal and child malnutrition remain contributing factors to many health problems and child deaths. Guatemala has the highest chronic malnutrition rate in the Western Hemisphere (49%) in children 3-59 months of age. This national figure masks an even worse situation among Mayan children, 69% of whom are stunted. This chronic problem requires immediate attention to prevent recurrence of a rural, acute malnutrition crisis, such as the one that occurred recently when an economic downturn led to further dietary gaps and pushed already seriously deprived, stunted children into life-threatening wasting or low weight for height.

Several years ago USAID conducted a study on "**Stunting in Guatemala: analyses of change over 15 years"**. The major findings which Offerors should take into account were: 1) Stunting and not wasting is the chief form of child growth retardation in Guatemala; 2) Stunting develops prior to age two years and is the product of both prenatal and postnatal growth retardation; 3) Guatemala has one of the highest rates of stunting of any country in the world, although the decline since 1987 is faster than average for developing countries; 4) Stunting is more common among Mayans than Ladinos and it will take 80 years to eliminate stunting among Mayans compared to 20 years among Ladinos at the current rate of change; 5) Maternal education and socioeconomic status are powerful, independent predictors of stunting; 6) The benefit of family planning services for reducing stunting is seen in the consistent positive relationships between lower birth order, use of contraceptives and longer birth intervals with lower stunting; 7) Appropriate child feeding practices are predictive of lower rates of stunting; 8) The faster rate of decline in stunting among Ladinos compared to Mayans is explained by their faster rate of socioeconomic progress and improved access to education and health services.

Recommendations from the aforementioned study include:

1) **Focus on mothers and very young children** Programs should focus on mothers and children under two years in order to accelerate progress in addressing the problem of child malnutrition. In addition, there must be access to basic health services, including family planning, along with primary and secondary education. Improved nutrition education and counseling are needed to achieve the following behavior changes for reducing stunting rates:

- Improve intrauterine growth via improved diet in pregnancy
- Increase exclusive breastfeeding in the first six months
- Improve complementary feeding

2) **Improve the plight of Mayans** Although many Ladinos are poor and malnourished, Mayans are much worse off and deserve special attention.

3) **Increase income while improving health and nutrition** Programs to promote economic development and programs to address childhood malnutrition should be viewed as mutually reinforcing, complementary strategies, rather than as competitors or trade-offs. The USAID strategy will address income generation through SO2.

Unfortunately, but understandably given the multi-sectoral nature of the malnutrition problem, a number of voices have been heard in Guatemala in debates over food security strategy, not all of them consistent, and not all providing useful information and recommendations based on research evidence. This lack of a sound, unified food security policy has been recognized by the new government by appointing a Hunger Commission and launching the War on Hunger at Presidential level.

Availability and absorption of micronutrients in children suffering from chronic diarrhea and food shortages are serious problems. Fortunately, supplementation and sugar fortification with vitamin A and salt iodization have greatly reduced deficiencies of these micronutrients, but other major deficiencies exist. Perhaps the most critical is the deficiency of iron and folic acid among Guatemalan women and children. Iron deficiency is common and contributes to poor women's

health and pregnancy complications and negatively affects learning ability, physical coordination and emotional development in children. Folic acid deficiency, also common, causes neural tube defects in the newborn. Recent international research findings on improved iron absorption were used to launch new norms under the current strategy in which all women of reproductive age receive one iron and folic acid tablet per week, instead of daily supplementation limited to pregnant and lactating women. More work is needed to put these norms into practice, assuring that adequate supplies of supplements are available, and promoting participation and compliance by women and children.

A promising growth monitoring and promotion strategy, incorporated into AIEPI AINM-C in USAID's eight target health areas, includes community-based monthly weighing of children under two years to detect those who are not growing as expected, counseling to improve feeding practices, micronutrient supplementation, and timely treatment or referral in case of infection. Monitoring is done by about 12,527 "vigilantes" in 2,150 communities, each of whom is responsible for working with mothers and children in 20 families. Weight gain is reviewed in monthly meetings during which the community itself helps individuals to overcome nutritional problems. The poorest communities and families may still require food aid and supplementary feeding, but remarkable results have been achieved through improving feeding practices and health care alone.

Community members appreciate and are able to implement growth monitoring and promotion themselves, including collecting, recording, reporting and analyzing information, and better counseling caregivers with IEC materials and tools developed by the University Research Corporation under the current strategy. Training materials have been developed and used to train health center and health post staff and community health workers ("vigilantes"), who have also been equipped with weighing scales, growth charts and other materials to implement AIEPI AINM-C.

The four PL 480 Title II food aid cooperating sponsors (PVOs) working in maternal child health with USAID in Guatemala (CARE with 27,550 food aid beneficiaries, CRS with 90,000 beneficiaries, Share with 50,000 beneficiaries, and Save the Children with 6,201 beneficiaries) are also implementing AIEPI AINM-C. Their continued involvement in the new strategy will make it possible to integrate food aid for targeted supplementary feeding for 6-36 month-old children and pregnant/lactating women in a sub-set of communities in which USAID will be assisting with AIEPI AINM-C in five of the seven priority western highland departments, as well as in four additional departments in northern and eastern Guatemala. The Contractor will work closely with these PVOs. See Annex 5 for a list of the municipalities by department where each of the four PVOs is carrying out the food aid program.

b) Tasks to be Performed

- **Performance Measure: Nutrition policy support provided**. The Contractor will provide expert nutrition policy support to the MSPAS and the GOG's Hunger Commissioner and War on Hunger, at the request of these organizations. This could be done through either a local adviser or through short-term international technical assistance.

- **Performance Measure: Interventions strengthened and expanded to reduce chronic and global malnutrition in children under two years**. The Contractor will work with central and local health authorities to further strengthen and expand the community nutritional component of AIEPI AINM-C through the MSPAS, the Guatemalan First Lady's welfare secretariat (SOSEP), PL 480 Title II PVOs and other interested parties. This activity is considered to be a major thrust of the Task Order. In addition to long-term impact on nutritional status indicators collected in ENSMI surveys, the Contractor should measure monthly impact using indicators of increased percentage of children under two years attending monthly weighing sessions and gaining adequate weight, and with improved breastfeeding and complementary feeding practices and work with the MSPAS to ensure that such indicators are incorporated into the MSPAS health information system. Again, the Contractor is not expected to carry out the activities itself, but rather provide policy guidance, technology transfer, and training of trainers to local groups that wish to scale up the intervention to other regions of the country, availing of MOH and other infrastructure.

- **Performance Measure: Increased use of iron and folic acid as well as Vitamin A supplementation**. The Contractor will promote the necessity of micronutrient supplementation for women and children with both the MSPAS and the Hunger Commissioner. It will also assist the MSPAS to include iron and folic acid supplementation in the basic package of AIEPI AINM-C care, and promote supplementation at institutional and community level, while strengthening the integrated logistics system of the MSPAS to ensure the availability of adequate supplies of supplements throughout the country. While the Vitamin A megadose supplementation program for children is well developed, work is still needed to improve coverage, including policy dialogue to permit community health promoters to administer the Vitamin A, as well as iron and folic acid supplements.

c) Benchmarks:

- By the end of the third quarter of the first year of the Task Order, the Contractor will present to USAID/Guatemala a data-base and nutrition surveillance system designed by the MSPAS with oversight of the Contractor. This system will report both at the local and at the central level at least three monthly related nutrition indicators for children under two years: (a) percentage of children in the community who do not grow well (i.e. have not gained minimum expected weight in two consecutive weighing sessions); (b) percentage of children in the community who gain adequate weight; and (c) percentage of children in the community who attend the monthly weighing sessions.

4. Child Health

a) Background

In addition to neonatal health problems and malnutrition, major causes of death in Guatemalan children under five years remain poor management of diarrheal diseases and acute respiratory infections. The prevalence of diarrheal diseases in children under five years was 22 percent and the prevalence of acute respiratory infections was 18 percent in the last two weeks prior to the survey (ENSMI 2002). The prevalence is much higher in rural areas and among those without education.

During the last four years Guatemala has made excellent advances in immunization coverage, surveillance and reporting data quality. Immunization rates in children 12-23 months are high, although they are not always registered on the child's carnet. According to ENSMI 2002, BCG, DPT, and polio vaccinations are above 90% coverage. However, measles vaccinations were only 25%, in part because of the transition to the MMR vaccine in the year of the survey. Therefore, special attention should be paid to increasing coverage of MMR vaccine. No measles, nor poliomyelitis cases, have been reported, and active surveillance is conducted for these diseases nationwide.

The AIEPI AINM-C program is a promising strategy that brings together the best of the Integrated Management of Childhood Illness –IMCI- (WHO model) and the Integrated Care of Children in the community– AIN-. The AIEPI AINM-C program has two complementary components: integrated case management at the clinical level (focused mainly on diarrhea and acute respiratory infection), and a community level prevention and promotion component, which focuses on the nutritional interventions mentioned above, as well as on household management of diarrhea, family planning promotion and prenatal care. The clinical level also focuses on immunizations. For a more complete summary of AIEPI AINM-C, see Annexes 1 and 2. The MSPAS is already implementing the AIEPI AINM-C strategy in its network of services and at the community level in the seven USAID focus departments. At the clinical level, quality of services has improved considerably: immunization rates have increased, and detection and treatment of acute diarrhea, pneumonia and other conditions have also improved.

b) Tasks to be Performed

➢ **Performance Measure: Improved quality and increased coverage of AIEPI AINM-C.** The Contractor shall further strengthen all services for this intervention at both the clinical and community level. The Contractor shall support the MSPAS to disseminate and/or update current norms, policy and guidelines to institutionalize this strategy. Furthermore, the Contractor shall support expanding AIEPI AINM-C to other areas of the country (i.e. by technology transfer and training of national MSPAS teams and other donors and organizations that will implement, monitor, supervise and evaluate implementation and results of the strategy). Policy dialogue with central MSPAS staff shall be carried out to assure proper implementation and support for the strategy, including national norms.

c) Benchmarks:

- In each Annual Progress Report, the Contractor shall present evidence of expansion of AIEPI AINM-C to other areas of the country with participation and support of other donors and organizations.

5. STI/HIV Prevention and STI Treatment

a) Background

Since FY2003, FHI/IMPACT has been assisting the MSPAS to strengthen STI/HIV prevention and syndromic management of STIs in 8 MSPAS facilities in Guatemala City and Izabal

Department, including introducing VCT services. This work includes a behavior change communication (BCC) component to reduce high risk sexual behaviors. The FHI support ends September 30, 2005. The MSPAS STI clinic for female sex workers in Zone 3 of Guatemala City has successfully piloted syndromic management of STIs with selective laboratory screening as necessary. With FHI assistance this clinic will be converted into a national training center for STI prevention and treatment. Starting in July 2005, the Contractor is expected to work with FHI to transition assistance for these activities. From FY 2006-2008, the Contractor will provide follow up monitoring and further strengthening at the 8 facilities previously assisted by FHI, as well as expand STI and VCT services in 26 additional MSPAS facilities by training MSPAS staff from these health centers at the national training center in the capital. Work in 2009 under the Task Order will be to continue follow-up and monitoring of all these 34 facilities.

b) Tasks to be Performed

- **Performance Measure: Expanded and strengthened syndromic management of STIs for high-prevalence groups (CSW, MSM and PLWHA).** The Contractor shall assist the MSPAS to increase access to and use of syndromic management of STIs, especially among high-prevalence groups by training health personnel from 26 MSPAS facilities at the national training center for STI syndromic management. See Annex 4 for an illustrative list of the 26 health centers. The Contractor will need to select the actual sites to be strengthened in consultation with the MSPAS, and with USAID's approval. Training will include appropriate syndromic management for men and women including selective laboratory screening, basic diagnostic services (e.g. rapid HIV and syphilis testing), counseling in risk-reduction behavior, partner management, voluntary counseling and testing for HIV, and provision of condoms. Staff should also receive training in quality assurance and basic monitoring and evaluation of services, and proper procedures for taking, safeguarding, and transporting STI samples. Facilities will be upgraded and equipment provided by the Contractor as needed in these 26 health centers in order to provide high quality STI/HIV services, including selective laboratory screening. The Contractor should assist these STI sites to offer VCT for HIV (see below) and to do effective BCC to encourage clients to determine their HIV status and to take risk-reducing precautions. The MSPAS STI sites should also have strong links with NGOs in their area that work with the principal target populations. It is understood that the MSPAS will buy the HIV and syphilis test kits and reagents as well as drugs to treat STI infections and this will not be the responsibility of the Contractor. The Contractor is expected to provide follow up support to the 8 health facilities assisted by FHI as well.

- **Performance Measure: Voluntary counseling and testing (VCT) for HIV introduced and strengthened for high-prevalence groups (CSW, MSM and PLWHA).** As mentioned in the previous PM, the Contractor will assist the MSPAS to introduce high quality VCT services in the same 26 health facilities to ensure that CSW and MSM know their serostatus and that they receive quality post-test counseling to encourage safe sex practices, whether they are seropositive or seronegative. This includes work by the Contractor to promote use of VCT and STI services at MSPAS facilities. The Contractor will assist the MSPAS to project its needs and budget for the necessary supplies for STI testing and treatment and VCT for HIV. Technical assistance and training under the Task Order will be needed to improve the quality of counseling,

using internationally accepted standards for VCT and STI prevention/treatment. Linkages between STI/HIV VCT services and other HIV care and support services should be fostered.

c) Benchmarks

- By the end of the first year of the Task Order, the Contractor shall present to USAID/Guatemala an assessment of current MSPAS STI syndromic management and VCT services and program needs, national guidelines and policies. The assessment shall include an inventory of facilities working with high prevalence groups, the status of training, counseling, rapid testing, and quality assurance protocols. Particular attention shall be directed to evaluating the performance of the STI/VCT model clinic and training center in Zone 3 in Guatemala City.

- As part of its overall annual implementation plan for the second year of the Task Order, the Contractor shall present for USAID/Guatemala's approval a joint MSPAS-Contractor work plan for FY2006-FY2009, including strategies and service provision standards for VCT to ensure adequate coverage and quality. The work plan shall include, among others, the following key elements:
    - Activities to ensure that the MSPAS will procure and deliver adequate stocks of STI medications, reagents and VCT test kits for participating health facilities.
    - A description of the strategies that will be employed to increase demand for VCT and STI services by individuals with high-risk behaviors.
    - A description of the strategies that will be developed with the MSPAS to implement an integrated STI model of service delivery. For STI/VCT sites, the plan will describe how linkages between the site and other health facilities, other departments within the facility, general staff and care and support services will be fostered to increase cooperation, reduce stigma, and promote cross-referral and follow-up.
    - Methodologies and tools to standardize collection and use of information on use of VCT and STI services.

- By the second quarter of the second year of the Task Order, the Contractor will present for USAID/Guatemala's approval a set of job aides for STI and VCT services, as needed.

6. Integration of Child and Reproductive Health Services

a) Background

Considerable progress has been made in developing an integrated health services delivery model -AIEPI AINM-C- at the community level. The next step will be to extend this integration to other Child & Reproductive Health Services at the secondary and tertiary levels of care. This integration will improve not only service delivery, but also supervision from the Health Area and District Levels, which frequently assign individuals to supervise each individual component of health care delivery in a vertical and less effective manner. The MSPAS is in the process centrally of consolidating the various programmatic elements of Reproductive Health Services into a single Reproductive Health Department. However, the scope and name of such a

department has not been defined yet. The challenge will be to not only locate all of Reproductive Health under one organizational roof, but to insure a true integration of those programs which have historically been in competition.

b) Tasks to be Performed

➢ **Performance Measure: Improved integration of Child & Reproductive Health Services at the clinical and community level**. The Contractor shall continue to promote the existing integration of child and reproductive health services in the AIEPI AINM-C program in terms of case management at the clinical level and prevention/promotion at community level. Simultaneously, the Contractor will promote and help organize the integration of Family Planning and other related Reproductive Health Services (e.g. maternal health) in MSPAS facilities at the clinical level.

➢ **Performance Measure: Improved MSPAS supervision of integrated Child & Reproductive Health Services at the Health Area Level**. The Contractor shall improve MSPAS management and delivery of Child and Reproductive Health Services by developing and/or building on existing models of integrated supervision at the health area and district levels. This will most likely involve activities such as further improving the current system developed by the MSPAS with support from the University Research Corporation and improving reporting forms, training, and communication between staff members, each with his/her own specialty, but the responsibility for supervising and supporting the entire package in a cost-effective manner.

➢ **Performance Measure: Reproductive Health Programs consolidated at the Central Level**. The Contractor shall work with the four central MSPAS Directorates to insure a high degree of integration and collaboration among them. The Contractor will work first with the Directorate in charge of developing guidelines and norms to ensure that USAID-supported activities are officially included in the official MSPAS guidelines and norms of the new government. Second, the Contractor shall work with the Directorate of the Integrated Health Care System (know as SIAS in Spanish) to support them with implementation, supervision, monitoring and evaluation of activities. This Directorate is in charge of implementing programs/interventions throughout the entire MSPAS' network of services. Third, the Contractor will work with the Human Resources Directorate, which is in charge of defining training content and methodology for MSPAS personnel. Finally the Contractor shall work with the Directorate of Finances to insure that programmed activities will receive adequate financial support from the central and local levels of the MSPAS.

c) Benchmarks:

- In each Annual Progress Report, the Contractor shall present evidence of advances in better integrating child, maternal and reproductive health services, while improving quality of services and decentralized management of health services.

7. Better Management of Public Health Programs

a) Background

One of the primary weaknesses of the MSPAS is management. This affects all programs and activities, and has become increasingly critical due to staff and budget reductions versus increasing demands to serve a growing population. It affects the motivation and commitment of personnel and utilization of resources. It affects the ability to effectively decentralize authority to the health area and district levels, as well as to contracted NGOs. Ultimately, it affects the quality and cost-effectiveness of services provided. Another key concern of the Berger administration and USAID is combating corruption by strengthening systems of key Ministries, such as the MSPAS. With funds from USAID, Price Waterhouse Coopers (PWC) is conducting a vulnerability assessment of the MSPAS (as well as the Ministry of Education) to be completed by August 2004, that will recommend MSPAS systems that need strengthening.

Specific management skills directly affect the ability to deliver the services described in the other components above. These include logistics management to insure an adequate completion of the procurement and delivery cycle for contraceptives, micronutrients, and other essential drugs, minimizing leakage and fraud, regardless of the source of those drugs and contraceptives; and financial management to insure the availability of resources to support program objectives. Improved management of MSPAS programs will be critical to insure cost-effective strategies, transparency and more efficient utilization of resources, a key result envisioned under the CAM strategy SO3.

One of the primary objectives of the new regime of the MSPAS is to strengthen management at the Health Area Level, and in general at the secondary level of the health system, to ensure that health staff properly guide activities nationwide. This neglected secondary level is appropriately recognized as the critical level in terms of decentralization. While some attention has been given to strengthening capacities at secondary level, there remains an absence of management "systems" and periodic personnel turnover is a complicating factor.

Likewise, at the Central Level, improving strategic financial planning has become a critical need since the MSPAS is chronically and acutely short of budget. Budgetary shortfalls are critical for the new authorities because they inherited a frozen budget in 2004 at the 2003 level, which was already low, as well as debt servicing obligations. With USAID support, the Partnerships in Health Reform Plus Project (PHR) of Abt Associates has conducted an analysis of financial needs for the MSPAS using a budget formulation tool and a costing study, but there is now a need to formulate cost-effective strategies to respond to health care needs in the face of budget cuts and restrictions. Nor is the MSPAS budget related to achieving Ministry objectives. Rather it is simply a response to accumulated debt and historical funding levels. As a result, tertiary-level hospitals will undoubtedly continue to command the major share of the MSPAS budget, leaving much more cost-effective primary care and public health programs to compete for scarce resources, and two million Guatemalans with no access to health care.

At all levels, the MSPAS is managed by professional health care personnel whose training focuses on the medical or public health aspects of the delivery of health care. While such technical training is essential, so are solid health care management skills which are not provided

in the technical training. For example, contrary to good organizational management and the benefits of teamwork, doctors are taught to diagnose and prescribe – generally alone – rather than involving staff in the process.

The supervisory system of the MSPAS still faces challenges in monitoring access to and quality of health care services, e.g. lack of human and financial resources to supervise with adequate frequency at all levels of the system, dissemination and use of a facilitative supervision approach based on principles of teamwork, empowerment and problem-solving at local level. During the past few years, with USAID assistance, a facilitative supervision system was designed for the MSPAS, and manuals for the health area, district and post levels were tested, developed, and implemented in selected health areas that the Contractor can build on.

Some of the critical areas of management which require attention include:

- Effective leadership styles
- Effective organizational management
- Management by objectives and for results
- Strategic planning
- Budgeting and financial planning
- Management of personnel
- Analysis and use of information for improving decision-making
- Effective integration of programs
- Performance-based evaluation and supervision
- Procurement systems
- Logistics management and control
- Supervision of contracted NGOs
- Facilitative monitoring and supervision

Over the years, workshops have been sporadically given to improve one or another of these areas, but in general, they have not been systematically applied nor affected a critical mass of people in order to make a more effective organizational culture of the MSPAS. Furthermore, the rotation of personnel requires a continual updating of managerial capacities.

While training in each of the above mentioned areas could potentially improve the management of specific aspects of individual programs, it will not be effective unless institutionalized through some formal mechanism. An example of an effective approach is the performance-based evaluation of maternal and neonatal care using performance quality standards and the improvement and accreditation of facilities based on compliance with standards as mentioned earlier. Another might involve the development of budgets based on organizational objectives. A critical area is the monitoring of NGOs as an extension of MSPAS service delivery. Another is financial planning to insure contraceptive security as the MSPAS is required to pay for increasing quantities of its contraceptive needs.

For the past several years, an integrated logistics system, which incorporates essential drugs, vaccines and contraceptives has been designed and implemented with USAID assistance. Warehouse personnel and those responsible for distribution of supplies (primarily nurses) in all

Health Areas have been trained in inventory control, form management for the information system, warehousing, and contraceptive projections. The system is presently much stronger than prior to its commencement when only 53% of MSPAS facilities did not have a stock-out of at least one family planning method at the time of the visit. At present (2003), 80% of facilities have a complete contraceptive supply at the time of the visit. However, with the entrance of the new government and its reorganization of the MSPAS, monitoring groups established for both essential drugs and contraceptives are being dismantled, leaving no mechanism in place to monitor and support logistics management at the Health Area Level. Five of the 26 Health Areas remain quite strong in terms of logistics management, but the others require additional training support.

b) Tasks to be Performed

➢ **Performance Measure: Adequately functioning contraceptive and drug logistics system**. The key task is to assure that the proper quantities of each type of contraceptive are available in constant supply at all program delivery and supply points, and that the skills required to estimate these quantities are passed on to counterparts. Systems should be strengthened to prevent fraud and leakage of pharmaceuticals. Since the MSPAS logistics system is integrated to include contraceptives, essential drugs, vaccines, and other supplies, this also means assuring that the system responds to the needs of each of these items. This task could also include strengthening drug procurement systems.

➢ **Performance Measure: Strengthened Monitoring and Facilitative Supervision System**: The Contractor will help the MSPAS to review and update norms based on the new MSPAS health care management model. The Contractor will provide support to the MSPAS to strengthen the current supervision system, and will propose innovative, feasible ways to implement it at all levels, including NGOs - within the current GOG funding limitations. The most recent supervision manuals developed with USAID assistance will be taken as the starting point.

➢ **Performance Measure: Improved MSPAS information system.** Contributions to the information system of the MSPAS will be primarily in the form of improved indicators, and collection, analysis, and use of information for decision-making. It is not anticipated that assistance will be provided in support of the computerized databases of the MSPAS except in terms of recommendations for modifications for improvements in collection procedures, indicators, and automated reports. It is anticipated that all technical advisers will contribute to improving and utilizing the information generated in their respective fields as follows:

- **Family Planning**. As a means of monitoring the progress of family planning the Contractor will establish a performance-based information system which provides sufficient information to both measure progress and guide managerial and technical decisions. The basis for this already exists within the MSPAS structure, but additional efforts are required for monitoring and evaluating service delivery by NGOs. Assistance should be provided to Central Level and Health Areas in terms of interpreting data and planning interventions.

- **Maternal and Neonatal Care**. The Maternal and Neonatal Health Project has introduced a series of quality-assurance, performance-based indicators for the delivery of Maternal and

Neonatal Health services. These have been used to improve the delivery of these services, and to eventually accredit individual institutions. This system should be expanded and enhanced and the concept of performance quality improvement applied to other interventions.

- **Nutrition.** Community level "vigilantes" are maintaining registers of growth monitoring participation and adequate weight gain of children. This is a manual system, with a vast amount of data, but at present there is no cost-effective way of compiling and analyzing these data. The Contractor shall support the MSPAS to incorporate these data into the health information system to provide continuous monitoring of progress of nutrition interventions as well as the possibility of early warning indicators of impending nutritional emergencies in communities where a large percentage of children continue to not gain adequate weight.

- **Child Health**. The Contractor shall work with the MSPAS to review data collection and reporting of performance-based indicators for AIEPI AINM-C to improve data quality, reporting and monitoring. The information system developed with USAID assistance by the Pro-Redes Salud Project for use by NGOs in the community will be taken as the starting point.

- **Management Indicators.** Each health program/activity executed in the Health Areas and Districts has a series of indicators (many performance-based, including those mentioned above). Collected monthly, they represent far more detail than an Area or District Chief is able to absorb. The Contractor is therefore expected to develop a monthly report for use at the Health Area and District levels, which summarizes a few key indicators of program delivery and institutional activities. These indicators should be chosen to demonstrate whether a particular service or program is functioning adequately or not. If it seems to require attention, then the Health Area or District Chief can seek additional information. A similar format should be developed for management oversight of NGOs contracted and supervised by the Health Areas. Note that these monthly reports could include financial indicators linked to programs as well.

➢ **Performance Measure: Financial analysis applied to other Project Components.** The Contractor will attempt to insure that not only are the program activities achieved in the most cost-effective way possible, but that the skills required to analyze, select, and implement strategies from a financial point of view are transferred to counterparts. Examples are the development of cost-effective strategies to integrate the management and delivery of Child & Reproductive Health Services; financial planning to insure contraceptive security in the future; measurement of cost-effectiveness of IEC strategies; and cost-benefit analysis of different models of service delivery and of assuring access to skilled attendants at birth. Others will undoubtedly arise.

➢ **Performance Measure: Strategic financial planning carried out.** The MSPAS is desperately trying to deliver a full range of health services without adequate resources. This requires the transfer of technical skills in financial planning to analyze the costs and benefits of strategic alternatives, not only in areas served directly by the USAID program, but in general, to ensure that adequate resources will be available for all MSPAS services. This support would focus on the Strategic Planning Department of the MSPAS, transferring capacity to carry out cost-benefit analyses and to use other financial decision-making tools (including the costing

study and budget formulation model developed by PHR+) to compare strategies and make appropriate, cost-effective decisions, not only for individual components, but more broadly across larger competing programs, such as tertiary care versus primary care. The focus of this assistance is strictly limited to more efficient utilization of existing MSPAS funds, and excludes broader efforts to increase public sector health expenditures, which will be implemented by a different partner under USAID's CAM Strategy SO3.

➢ **Performance Measure: Performance-based budgeting introduced.** This activity complements the previous one, and focuses on an effort to shift budget allocation decisions from being made based on simple, historical norms, to a system which determines the cost of achieving MSPAS objectives and is linked to performance. The MSPAS has expressed its serious interest in undertaking this new approach to budgeting. The parameters of the system are left to negotiations between the Contractor and the MSPAS. Ideally, this performance-based approach would serve as the basis for budget allocation to the Health Areas, even if other MSPAS programs are not included initially in the system.

➢ **Performance Measure: Monitoring assistance provided for USAID financial support to the MSPAS to achieve additional health care coverage.** USAID intends to provide matching financial support to the MSPAS to co-finance (50:50) basic health care coverage for up to an additional 1,200,000 people for four years, starting in calendar year 2005 and continuing through 2008, through the MSPAS' contracts with NGOs. The Contractor will assist USAID by monitoring NGO performance with delivering the basic package of health services under this component.

c) Benchmarks:

- By the end of the first year of the Task Order a set of strategic and operational planning and budgeting tools to improve management at the central and at local levels of the MSPAS, developed jointly by the MSPAS and the Contractor, will be presented for USAID/GUATEMALA approval. These tools will be designed to address weak MSPAS systems, taking into consideration recommendations of the PWC vulnerability assessment.

- By second year of the Task Order, the Contractor should have introduced performance-based budgeting in the MSPAS, and annually, thereafter, present evidence that the MSPAS is using performance-based budgeting.

- By the end of the first year of the Task Order, the Contractor will have trained "logistics champions" in selected health areas and at the central level to lead/improve the performance of integrated logistics management; including forecasting, programming, procurement, warehousing and distribution.

- Throughout the life of the Task Order, the Contractor will support the MSPAS to carry out two annual national contraceptive inventories, and reports will be discussed/analyzed and presented to MSPAS central and local level staff.

- Starting in 2005, in April and September of each year of the Task Order, the Contractor shall submit for USAID/Guatemala's review and approval, the Contraceptive Procurement Tables prepared by the MSPAS with minimal oversight of the Contractor.

III. Contractor Requirements

A. Staffing Requirements

1. Long-Term Technical Assistance (TA) Team

The Long-Term Technical Assistance Team will be composed of six highly experienced and qualified advisers, plus a Chief-of-Party. This Task Order is limited to a maximum of one (1) international position, recommended by USAID to be used for the Chief of Party.

Table 2: Long-Term Key Personnel

Adviser	Number of Months
Chief-of-Party	60
Family Planning	60
Maternal, Neonatal & Child Health	60
Nutrition / Community Outreach	60
Logistics Management/Contraceptive Security	24
Health Administration/ Financial Management	60
Sexually-transmitted Infections(STI)/HIV	51

As can be observed in Table 2, all key members of the Technical Assistance Team will be present in Guatemala for the entire length of the Task Order, with the exception of the Logistics Adviser who will be present for 24 months to allow for assistance of two complete cycles of contraceptive procurement, and the STI/HIV Adviser who will not start work until July 2005 (when FHI assistance is ending) and work for 51 months. With the approval of USAID, the tour of the Logistics Adviser may be increased at the request of the Contractor, if necessary, and offset by fewer months of Short-Term Technical Assistance.

The long-term Technical Assistance Team is intended to be highly integrated, with each adviser responsible for a specific area, but providing support to other Project Components. The Chief-of-Party (COP) is responsible for the leadership and coordination of the entire program. Individual responsibilities are clarified below. Note that in the case of the three Management Advisers (including the COP), each is responsible for a particular set of activities. The advisers are not expected to themselves do all of the work required in their assigned areas, but are responsible for coordinating all activities related to their areas. They will draw support as necessary from Short-Term Technical Assistance, and local support staff, both technical and administrative.

Below is a description of the primary activities of each Long-Term Adviser, together with their expected qualifications. In all cases, the following minimum qualifications will apply:

- Demonstrated exceptional expertise in their particular fields
- A minimum of 5 years of experience in a technical assistance role in a developing country, preferably in their assigned subject area.
- Spanish-speaking with the ability to communicate verbally and in writing at the FS3 level or above.
- The ability to speak and write English fluently is not essential, except for the Chief-of-Party, but preferred.
- Experience in Latin-America, with experience in Guatemala preferred.
- Demonstrated ability to work well with other team members and host government counterparts.

Note that no gender restrictions will be applied in the selection of any of these positions.

a) Family Planning Adviser

The Family Planning Adviser (FPA) is expected to advise on and coordinate all aspects of family planning assistance, which include all of the activities described in Section I.B.1 above. To this end, the FPA is expected to promote policies and develop and implement strategies to achieve increased use and quality of family planning services, and the related objectives described in Section I.B.1. The Family Planning Adviser will coordinate closely with the Nutrition/Community Outreach and the Maternal/Neonatal/Child Health Advisers to implement the AIEPI AINM-C package at the community level.

The FPA is also responsible for developing appropriate indicators and monitoring and evaluation systems for both the MSPAS and the contracted NGOs in the USAID target areas; and assisting their staff in interpretation of results and development of tactical strategies related to specific delivery points. To this end, it is expected that much of the assistance will be directed toward the Health Area Level, although the scope of family planning will be national.

The FPA will also be key to achieve the integration of Family Planning, not only into the basic package of care, but into a smoothly functioning Reproductive Health Department/Program at the Central Level of the MSPAS. The FPA will work closely with the Logistics/Contraceptive Security Adviser and will assume responsibility for continuing to advance contraceptive security, as well as for assisting the MSPAS to prepare contraceptive inventories and Contraceptive Procurement Tables, when the two-year term of the Logistics/Contraceptive Security Adviser ends.

In addition to the general requirements above, the Family Planning Adviser should have the following characteristics:

- A university degree in Public Health, Medicine, or related area.
- Be up to date on modern contraceptive technology and counseling strategies.

- Have experience working in a family planning program for at least 5 years, preferably involved with the policy level.
- Have experience working in IEC and counseling for family planning and optimal birth spacing promotion.
- Have demonstrated experience in formulating accurate projections of contraceptive demand.
- Be familiar with internationally utilized family planning indicators.
- Have extensive experience supporting large scale interventions or experience in scaling up interventions with national focus.

b) Maternal/Neonatal/Child Health Adviser

The Maternal/Neonatal/Child Health Adviser (MCH) is the Team member responsible for most of the actions related to the delivery of Maternal, Neonatal and Child Health. Because this is an extremely broad scope, it is not expected that this single adviser will be experienced in all aspects, but will coordinate all of these different interventions, and draw on additionally available Short-Term Technical Assistance to fill in the gaps where s/he has either no time or insufficient expertise.

In carrying out these activities, the MCH Adviser is expected to build on the strategies and procedures already implemented by the Maternal and Neonatal Health Project in the USAID target health areas. This Adviser will also work closely with other Advisers, particularly the Health Administration/Financial Management Adviser to develop cost-effective strategies for extending Child and Reproductive Health services, especially access to skilled attendants at birth in the USAID target health areas.

The MCH Adviser will coordinate closely with the Nutrition/Community Outreach and the Family Planning Advisers to implement the AIEPI AINM-C package at the community level to increase community mobilization and service demand. Furthermore, the MCH adviser will coordinate with the rest of the team to integrate a comprehensive package of services (maternal, neonatal and child health) at the clinical level (MSPAS network of services).

The MCH Adviser will be the chief advocate in terms of policy formulation, advocacy, and ensuring high quality, cost-effective, maternal, neonatal and child health services. S/he is expected to ensure the use of appropriate indicators, and to both help interpret those indicators for decision-making, as well as ensure that MSPAS counterparts at the Central and Health Area levels are able to interpret them adequately.

The MCH Adviser is also responsible for coordinating activities with other Team members for assuring the delivery of an integrated package of child and reproductive health services; as well as creating a support system both at the Central and the Health Area Levels, which will function in a highly integrated fashion. In this effort, S/he will work in close coordination with the Family Planning Adviser and the Nutrition/Community Outreach Adviser.

In addition to the requirements above, the MCH Adviser should have the following characteristics:

- A university degree in Public Health, Medicine or related area.
- Be familiar with "state of the art" interventions in maternal and neonatal health: evidence-based interventions, essential obstetric care, lessons learned from the Safe-Motherhood Initiative and LAC Regional Maternal Mortality Reduction Initiative.
- Have experience in the design and implementation of maternal, neonatal and child health services at primary, secondary and tertiary hospital levels of care.
- Have experience in child survival interventions and/or implementation of the Integrated Management of Childhood Illness (IMCI) Strategy.

c) Nutrition/ Community Outreach Adviser

The Nutrition/Community Outreach Adviser (N/CO) is primarily responsible for developing strategies for applying the AIEPI AINM-C package of services to the community level. It is not expected that this Adviser actually do training at the community level, but s/he should guide the process of community development, and train teams to reach out to communities, to assure effective child growth monitoring and promotion. It is likely that the N/CO Adviser will train trainers to extend this outreach strategy to other parts of the country beyond the USAID target areas.

The N/CO Adviser will also be the resident expert in food security and applied nutrition, paying particular attention to the delivery of the growth monitoring/promotion component in the AIEPI AINM-C package.

S/he will provide expert technical policy advice on nutrition and food security to the MSPAS and the Hunger Commissioner/ Frente Contra el Hambre on a systematic basis to ensure an effective national programmatic response. It is recognized that additional support in this area from international expertise may be necessary, which could be provided through Short-Term Technical Assistance.

As the primary focus of IEC is at the community level, the N/CO Adviser is also the de-facto IEC adviser on effective behavior change, not developing new materials, when appropriate ones already exist, but managing and appliang materials, methodologies and approaches already developed, to assure that appropriate messages reach families at community level.

S/he will develop a cost-effective surveillance system for collecting, processing, analyzing, and using weight gain data emanating from the AIEPI AINM-C growth monitoring/promotion component, as well as assist counterparts in analyzing the data collected.

In all of these efforts, s/he will work closely with the Family Planning and MCH Advisers.

In addition to the requirements above, the N/CO Adviser should have the following characteristics:

- A university degree in Nutrition.

- Have experience working as a nutritionist, preferably at the public health and/or the community level.
- Have considerable experience working at the community level in rural areas of developing countries.
- Be familiar with community-based growth promotion strategies.
- Have expertise in state of the art food security strategies.

d) STI/HIV AIDS Adviser

The STI/HIV AIDS Adviser (STIA) is expected to advise on and direct all work on STI/HIV prevention and STI treatment, syndromic management of STIs, voluntary counseling and testing for HIV (VCT), integration of STI and VCT services and expansion of STI and VCT services for high-prevalence groups (CSW, MSM and PLWHA) per the scope of work. The STIA is expected to promote adequate policies and implement strategies to achieve increased use of quality STI and VCT services by core groups (CSW, MSM and PLWHA).

He/She will also apply effective BCC interventions to promote increased demand for these services and implement quality counseling for sexual risk reduction behaviors. The STIA will coordinate closely with the FPA and MCH Advisers in order to integrate STI-VCT services with reproductive health in facilities in high HIV prevalence cities. He/she will also coordinate with the FPA and MCH advisers to include family planning and maternal and neonatal health information and services for high prevalence populations in the MSPAS facilities offering STI and VCT services under the Task Order.

The STIA is also responsible for recommending appropriate monitoring and evaluation indicators for measuring use of STI and VCT services in the USAID-assisted MSPAS facilities in high prevalence areas and assisting MSPAS personnel in the interpretation of results for decision-making at the local and national levels. It is expected that STIA will work closely with the National STI/HIV/AIDS Program (PNS) of the MSPAS, as well as the Epidemiology Department, and the National Health Laboratory at the central level, but most of his/her assistance will be directed toward the MSPAS health facilities in the high HIV prevalence areas.

In addition to the general requirements above, the STIA should have the following characteristics:

- At least five years experience working in STI prevention and treatment, as well as HIV prevention programs, including VCT, at both policy and service delivery levels.
- Have demonstrated experience in the implementation of STI syndromic management and training.
- Have demonstrated experience in the formulation and implementation of STI and HIV interventions.
- Have experience in the implementation of VCT services for HIV.
- Have experience working with high-prevalence populations specifically CSW, MSM and PLWHA.
- A university degree in Public Health, Medicine, or related area.

e) Logistics/Contraceptive Security Adviser

The primary responsibility of the Logistics/Contraceptive Security Adviser (L/CS) is to assure that the logistics system of the MSPAS functions sufficiently well to guarantee the availability of the proper quantities of contraceptive methods. To the degree possible, it is expected that the programming of contraceptive supplies serves as a model for the programming of other drugs and supplies. Among other things, this means working with operational personnel to program appropriate quantities of each type of contraceptive method; and ensure that the capacity to do so is passed on to a wide number of counterparts to assure the perpetuation of this skill.

Since the MSPAS logistics system integrates contraceptive materials with essential drugs and vaccines, improving all of the other aspects of their reception, warehouse management, inventory management, and distribution, effectively means working with the MSPAS system in general, developing, applying, and improving systems and procedures to all drugs and supplies acquired and managed by the MSPAS. Since the basic systems and procedures already exist, and primarily need to be reinforced, refined, and expanded, the term of the Logistics Adviser is initially limited to 24 months.

Special attention will be paid to logistics management at the Health Area level, as well as insuring that supplies are well managed at the institutional level.

The L/CS adviser will play the lead role in promoting contraceptive security, through improving the capacity of local staff to carry out accurate programming, by reviewing programmed acquisitions and by facilitating the work of the Contraceptive Security Commission. S/he will also work in close coordination with the Financial Management Adviser to assure that MSPAS resources will be available to sustain the Family Planning Program in the medium and long-term.

In addition to the other general requirements above, the Logistics Adviser should have the following characteristics:

- A university degree in Management, Finance, Public Administration, Public Health Administration or a related field.
- Demonstrated experience in all aspects of logistics management of contraceptives and/or pharmaceuticals.
- Demonstrated ability to accurately estimate quantities of contraceptive materials required.
- Experience in contraceptive security. As this is a relative new area of expertise in Guatemala, additional support could be provided through Short-Term Technical Assistance.

f) Health Administration /Financial Management Adviser

The Health Administration/Financial Management (HA/FM) Adviser has a number of distinct, but interrelated roles. While the focus is financial planning in each case, this is essentially a management adviser position with a financial bias.

The first priority is to work with other Technical Assistance Team members and appropriate counterparts to enhance the strategic and activity planning of Child & Reproductive Health interventions by focusing on the cost-benefits of those interventions. This includes assistance to the Logistics/Contraceptive Security and Family Planning Advisers and to the MSPAS and other interested parties, to estimate and plan for financing to insure long-term contraceptive security. The HA/FM Adviser is expected to work with the MSPAS Central Strategic Planning Department to assist them in evaluating strategies for delivering health care in order to promote and give emphasis to the most cost-effective models. In line with the objectives of this project, the initial focus should be maternal neonatal, child and reproductive health and nutrition services. In these efforts, an important focus is to instill financial analysis concepts and practices into the normal work of the Strategic Planning Department and other involved Departments in the MSPAS.

The Health Administration/Financial Management Adviser is also expected to support the other technical assistance Team members in their efforts to improve management at the Health Area level of the target areas. S/he will work with the Health Area Directors to analyze the cost-effectiveness of specific interventions, again using that experience to instill practices of financial analysis in the planning and decision-making processes of the Health Areas. Financial accounting practices should also be reviewed and enhanced to improve transparency of resource allocation. A final major task will be to assist the Planning and Budget authorities of the MSPAS to plan and implement a system of Performance-based budgeting within the MSPAS to be applied at the Health Area level in the target areas.

In addition to the requirements above, the Health Administration/Financial Management Adviser should have the following characteristics:

- A university degree in Management, Finance, Public Administration, Public Health Administration, or some related field.
- At least 5 years experience working in management and finance of health programs in the developing world.
- Demonstrated ability carrying out financial analysis, cost-effectiveness analysis, planning and budgeting of specific health care interventions.

2. Chief-of-Party

The Chief-of-Party is the designated Leader of the Technical Assistance Team. S/he is the principal link between the Contractor, the Technical Assistance Team, USAID, and the MSPAS. S/he is responsible for coordinating all Task Order activities, and for directing and assuring cost-effective results achievement. The COP is expected to have a significant degree of decentralized authority from the Contractor. S/he is also the principal liaison with all other organizations and actors.

The Chief-of-Party works with all TA Team members to insure the quality of their work and support them in their efforts to link effectively with their counterparts. S/he helps them set priorities, resolve problems, and generally facilitates their work. S/he is the principal representative of the program on all formal occasions and meetings with USAID, counterparts,

and related groups. S/he is responsible for the budget execution, accounting, sub-contracting (should this need arise), and reporting on all project activities.

In addition, it is expected that the COP serve a technical function as a management expert, which is estimated to take about 30% of his/her time. In this area, s/he will provide additional support to the Health Administration/Financial Management Adviser on those activities specifically assigned. In addition, the COP will act in a more general fashion as a management expert, providing expert advice on policy, strategies and procedure on specific management areas at both the Central and Area levels. It is likely that within this function, s/he would conduct management training seminars for MSPAS staff.

In addition to the requirements above, the Chief-of-Party should have the following characteristics:

- Formal education in management, public health or an equivalent field at the Masters level (or higher);
- Minimum of 10 years of experience working in health, population and nutrition in developing countries;
- At least five years experience as COP in development projects, preferably in health related projects;
- Demonstrated ability to manage health support programs at central and community levels;
- Ability to effectively communicate both orally and in writing in both English and Spanish;
- Demonstrated ability to create and maintain effective working relations with senior Government personnel, NGO partners, host country citizens, U.S. and foreign government organizations, donor partners, and the private sector;
- Demonstrated ability to manage multiple partner collaborative projects.

3. Short-Term Technical Assistance

To supplement the Long-Term Team, the Task Order should include approximately 30 months of International Short-Term Technical Assistance, or the equivalent of 6 months per year. The majority of skills required should already be present in the Long-Term Team. To supplement the Long-Term Team, approximately 25 months of additional local Short-Term Technical Assistance may be used. Short-Term Technical Assistance is subject to USAID approval for both the assignment and the person. It is not necessary to specify the use of this resource in the Offeror's technical response to the RFTOP, but it should be included in the Cost Proposal.

4. Local Support

Depending on salary levels, approximately 600 months of local support staff time should be provided in the Task Order. This must include a full-time office manager and/or an accountant responsible for maintaining the budget, accounting, procurement, etc. Other positions are optional, but subject to approval by USAID. They may include office assistants, drivers, direct

hire or Task Ordered local technical staff, trainers, etc. The Contractor should present a preliminary description of the use of this Local Support in its response to the RFTOP.

5. Home Office Support

Offeror's response to this RFTOP should include a discussion of proposed backstopping by corporate headquarters, supervision, and quality control efforts under the Task Order. It should also include provision for the designation of decentralized authority for the COP. It is assumed that approximately six weeks per year of home office support would be used for on-site supervision in Guatemala.

B. Partnerships, Relations, and Roles

1. Contractor Roles and Responsibilities

The Contractor will implement the Statement of Work defined above, with responsibility for its overall management. Offerors will propose how the management responsibilities will be coordinated to ensure an integrated approach to implementation. The Contractor will be responsible for ensuring that all Task Order staff create and maintain effective working relations with host country counterpart agencies, partner institutions, international and national NGOs, donor organizations, and USAID; work in a collaborative and inclusive team-oriented manner; and interact effectively with all partners and customers in the accomplishment of tasks.

The Contractor's performance will be assessed on its ability to develop partnerships and promote teamwork that ensures a more effective contribution to the attainment of results related to CAM SO3. The COP will be authorized to represent the Contractor in all matters pertaining to the execution of the Statement of Work, with the possible exception of Task Order issues and amendments, for which authority will be delegated according to the discretion of the Contractor.

The COP will serve as the Contractor's representative in Guatemala for all purposes of this Task Order, and will be responsible for the activities of all long- and short-term personnel under this Task Order. The COP will work with the USAID Mission to respond to any Task Order questions and formal Task Order obligations. S/he will be responsible for all reports to USAID under this Task Order.

USAID will provide the Contractor with the furniture/equipment listed in Annex 6 to the Scope of Work for the Contractor's use in running the program, and this should be taken into account in the Offeror's budget. In addition to the U.S. Government property to be provided, the Contractor shall be responsible for the procurement of any and all equipment and commodities (not elsewhere specified as USAID or MSPAS procurement) which are procured under the Task Order in order to carry out activities. The Contractor shall submit a procurement plan for the entire period of the Task Order with its proposal. All procurement of goods will be executed in accordance with USAID regulations. The authorized sources for procurement are USAID Code 000 (U.S.A.), and local procurement as authorized by 22 CFR 228.40. Whether commodity procurement will be off-shore or local will depend on timing, cost, and available sources. The Contractor will also be responsible for proper warehousing, inventory, delivery, end-use

monitoring and reporting requirements for all equipment, materials, and commodities purchased under this Task Order.

2. USAID Responsibilities

Task Order Management

USAID/Guatemala assumes the responsibility for overall coordination of SO3 country activities. Collaboration between the Contractor and other USAID implementing partners, and other activities of relevance to SO3, will be fostered through:

- Active participation in coordination mechanisms established by the MSPAS and GOG and other donors and partners;
- Regular meetings in which USAID implementing partners come together to share progress and problems, discuss issues of common concern, identify areas for joint action, and update action plans;
- Joint, local level planning, implementation, and monitoring by USAID implementing partners and other SO Teams, Contractors and partners, for work carried out in the same geographic areas; and
- Communication and sharing of information among partners and with other Missions in the CAM strategy.

The Cognizant Technical Officer (CTO) will be nominated by the SO3 Team Leader and designated by the Regional Contracting Officer (RCO). The CTO will serve as the official USAID representative for the RCO on this Task Order. Daily management of the Task Order will be the responsibility of the CTO and assigned Activity Managers for specific components. The CTO, Activity Managers and other SO3 Team members, as needed, will work with Contractor staff to facilitate implementation. This will include processing matters through USAID for decision, and assisting implementing partners (and USAID) to attain compatibility in information and reporting requirements. USAID will help facilitate the Contractor's relationship with the GOG and relevant donor institutions other than USAID.

USAID's roles and responsibilities under the Task Order will take the form of:

- Ongoing close collaboration in the implementation of activities. The principal mechanism for this involvement will be the review, approval, and monitoring of the annual implementation plans and periodic reviews and updates to assess progress towards achieving Task Order results;
- Approval of key personnel and Short-Term Technical Assistance suggested by the Contractor;
- Review and approval of sub-contracts or sub-Task Orders; and
- Approval of a monitoring and evaluation plan, with clear targets and indicators, which measure whether the Task Order results are being attained, as laid out in a timeframe over the course of the Task Order.
- Approval of all IEC and training materials.

Logistical and Administrative Support for Long-Term TA Staff

USAID will obtain necessary paperwork for customs clearance and visas as the Contractor is required to be covered under the USAID bilateral agreement. Specifically, USAID will:

- Assist in customs clearance and entry into Guatemala of all commodities and equipment for the program, as well as household effects and personal vehicles for long-term expatriate TA staff; and
- Obtain long-term residence and exit visas for long-term technical advisers and their dependents as required.

3. Relationships with Implementing Partners

Since the task of significantly achieving program objectives and their expansion to other geographic areas is well beyond the capacity of this Task Order alone, and depends on partnerships, one of the primary goals of the CAM strategy is *leveraging*. The Contractor will work closely with all partners to enhance the success and expansion of all Program activities. It is, therefore, essential that the Contractor collaborate and coordinate closely with all levels of the MSPAS, the participating communities, other groups related to the GOG, local and international NGOs, international and bilateral donors, and civil society groups.

Special care must be taken to work proactively with other donors in the same technical components in other geographic areas. In many cases, the strategies and materials adopted by the MSPAS have been developed by USAID partners, and form the basis for this present Task Order. In those cases, collaboration is expected to transfer the technologies to these other donors, including MSPAS staff, in parts of the country outside the USAID target areas. At the same time, care must be taken to avoid duplication of efforts when other donors and partners are working in the same departments. This applies, for example, to PAHO which is presently implementing the AIEPI AINM-C package in parts of Huehuetenango and Quiché. A similar situation exists with Advisers from other donors such as PAHO who are working with the MSPAS in related or the same functional themes. An example is a PAHO technical adviser helping the MSPAS improve its capacity in the area of procurement in the logistics system. Advisers are expected to be mutually supportive, but not duplicate or contradict efforts.

4. Budget Guidance for the Task Order

Funding from USAID for this Task Order will come entirely from the Child Survival and Health (CSH) account. A further breakdown to guide implementation of the program is that 51% of the funds should be used for Family Planning/Reproductive Health; 34% for Child Health/ Maternal Health/ Nutrition; and 15% for STI/HIV/AIDS. The Recipient will be expected to follow agency guidance on the use of CSH funds, which can be found at http://www.usaid.gov/our_work/global_health/home/Funding/index.html.

For the purpose of preparing Cost Proposals, Offerors should include in their budgets the following funds for providing material assistance to the MSPAS (excluding technical assistance and related costs and indirect costs and fee):

a) IEC

The design and production of IEC materials may be sub-Task Ordered. A budget of $1,000,000 should be designated for this purpose. The Nutrition/Community Outreach Adviser will be responsible for managing this budget, subject to guidance from the Chief-of-Party.

b) Scholarship program for training professional certified nurse midwives

A budget of $440,000 should be designated for direct use on approximately 120 scholarships for training professional certified nurse midwives. The MCH Adviser will be in charge of this component.

c) Flexible Rapid Response Fund

As mentioned earlier, $500,000 should be set aside to respond to unanticipated requests from the MSPAS.

d) Equipment for the MSPAS

For procurement of basic equipment, supplies and vehicles on behalf of the MSPAS, the Offeror should program $535,000. Specific procurement plans will be developed jointly by the Contractor and the MSPAS as part of annual implementation plans. It is envisioned that procurements will include basic medical equipment and supplies, computer equipment and supplies and vehicles.

e) Training and Program Activities

Most training is expected to be local in Guatemala. To cover costs of training materials, travel and per diem, trainers and other program activities, Offerors should set aside $2,005,000.

C. Monitoring and Evaluation Plan

Based on the Tangible Results, Performance Measures and Benchmarks described in the Scope of Work, the Contractor will be responsible for developing and executing a Monitoring and Evaluation (M&E) Plan, which, at a minimum, includes the relevant standard indicators found in USAID's CAM SO3 regional and Guatemala Performance Monitoring Plans (PMP), which are used to objectively assess the overall progress and impact of activities for achieving the health and education strategic objective. The indicators listed in Section I.C. and again below are the relevant standard indicators from the regional PMP. The Guatemala PMP is still being developed and will be shared with the Contractor in the first quarter of the Task Order. The Monitoring and Evaluation Plan should be submitted to the USAID CTO for approval within 120 days of the award of the Task Order. The Plan should include end of program, as well as annual, indicators and targets for measuring the accomplishment of results and baseline data should be provided when available. Data sources and collection methodologies should also be noted for each indicator.

The Contractor will work together with the MSPAS to measure the results, using scientifically and statistically sound, qualitative and quantitative research methodologies and techniques, so that reported information meets reliability and validity criteria contained in USAID Data Quality Assessment directives. The Contractor is encouraged to use the most cost-effective methods to monitor progress, and measure impact of activities and performance at all levels and to be innovative and creative in order to capture, document, and report all major outcomes of USAID

assistance. The Contractor will work with the MSPAS to transfer technology and know-how to strengthen information systems, which will allow easy tracking and assessment of progress and results compared to agreed targets and facilitate information exchange among the MSPAS, USAID, USAID's partners and the GOG. As part of its work to improve monitoring and facilitative supervision, the Contractor will need to establish a mechanism to monitor skills maintenance following training courses/programs, especially of community health agents and clinical providers. The Monitoring and Evaluation Plan should also define objective measures of quality, behavior change and management improvement, whenever possible.

Offerors should include as an Annex to their Technical Proposal, a preliminary Monitoring and Evaluation Plan, containing a set of indicators, including the following standard regional ones to be used for health components of CAM SO3, with annual and end-of-program targets to measure progress toward each of the intermediate results and their corresponding lower level results:

IR 3.1.1

a. Total budget actually spent by MSPAS as a percent of programmed budget
b. MSPAS annual contraceptive purchases as a percent of total MSPAS annual needs

IR3.3.1

a. Couple years of protection
b. Contraceptive prevalence rates

IR 3.3.2

a. Percentage of births attended by skilled health personnel
b. Immunization rates: DPT3 (National MSPAS sources)

IR 3.3.3

a. Global malnutrition rates (low weight for age in children 3-23 months)

IR 3.3.4

a. Number of MSPAS clinics implementing improved STI syndromic management protocols (annually starting in 2006)

D. Reports

The Contractor shall submit an original and two copies in English of the following reports to the USAID/Guatemala CTO. The need for Spanish versions of these reports will be determined by USAID/Guatemala later during the implementation of the activities.

1. Annual Implementation Plans

Within the first 90 days after the award of the Task Order, the Contractor will submit its first annual (U.S. fiscal year October-September) implementation plan to USAID/Guatemala. This first implementation plan, and fiscal year implementation plans for each subsequent year of the Task Order, will describe the activities and interventions required for achievement of the Statement of Work results. For plans for fiscal year 2006 onwards, annual implementation plans will be due to USAID by October 31 of the same fiscal year. It is envisioned that annual implementation plans will be developed jointly with the MSPAS and include:

- Proposed accomplishments for the fiscal year, and expected progress towards achieving Task Order Tangible Results, Performance Measures, and Benchmarks, tied to the Monitoring and Evaluation Plan;
- A timeline for implementation of the year's proposed activities, including target completion dates;
- Information on how activities will be implemented;
- Personnel required for achieving proposed targets;
- An analysis of possible obstacles hindering achievement of objectives;
- Major commodities to be procured; and
- Detailed budget by the seven components and also by line item showing actual expenditures to date and planned expenditures, including pipeline remaining of unspent funds from previous obligations.

The implementation plan will be developed in close collaboration with the MSPAS to ensure it meets their needs and to coordinate all activities. This will enhance the likelihood that the MSPAS will sustain program interventions beyond the life of the Task Order. Amendments to annual implementation plans, to be approved by USAID, will be used by the Contractor to formalize unanticipated activities in response to MSPAS' requests mid-year for flexible rapid response funds.

In the event of changes in funding during the award period, the Contractor will be requested by USAID/Guatemala to modify its implementation plan in accordance with directives associated with those changes.

2. Joint MSPAS/Contractor Strategic Plan

At the end of the third quarter of the first year of the Task Order, the Contractor will submit to USAID/Guatemala for approval a strategic plan for achieving all of the performance measures and benchmarks during the duration of the Task Order, developed jointly with the MSPAS to ensure it meets their needs and to coordinate all activities. This will enhance the likelihood that the MSPAS will sustain program interventions beyond the life of the Task Order. Furthermore, the Contractor shall describe innovative approaches it will introduce, at a minimum, in the following key areas, all equally important:

- Selecting and training auxiliary nurses to become competent providers of IUDs, including policy dialogue with MSPAS to guarantee that these trained auxiliary nurses are assigned to adequately equipped health posts to provide IUD insertion services.

- Developing and achieving consensus on a Contraceptive Security Plan for Guatemala, with ample participation of the health sector (MSPAS, IGSS, APROFAM, NGOs, OB/GYN Association, women's groups, social marketing organizations, commercial sector and pharmaceutical companies, etc.).

- Building on the quality of care model implemented by JHPIEGO, to expand maternal and neonatal interventions in MSPAS hospitals and community maternities in the USAID

priority health areas. The plan should also include support to culturally appropriate interventions for indigenous populations to improve home-based care of the mother and the newborn, identification of problems needing referral, and care seeking behavior, innovative approaches to facilitate community mobilization via birth preparedness and emergency readiness plans, as well as strategies for increasing the number of women receiving post-partum care.

- Implementation of new, affordable, and feasible outreach models of maternity care to increase access to skilled attendants at birth, particularly for isolated, rural and indigenous populations.

- Lines of action for carrying out policy dialogue with MSPAS and key GOG officials to implement state of the art interventions to reduce childhood malnutrition.

- Expanding AIEPI AINM-C to other areas of the country with participation and support of other donors and organizations, while improving the quality of the intervention in communities already implementing AIEPI AINM-C.

- Enhancing integration of child and reproductive health services, while improving quality and decentralized management of health services.

- Institutionalization of the Facilitative Supervision and Monitoring System piloted by Calidad en Salud in the MSPAS to improve quality of care at the different levels of the health system, including care provided by MSPAS-contracted NGOs.

- Strengthening the MSPAS Information System to improve availability of data for decision-making, as well as for using performance-based indicators for the family planning, maternal and neonatal health, nutrition, child health, and management components mentioned above.

3. Training Plan

The Contractor will submit a training plan to USAID/Guatemala within 90 days after the date of award. Thereafter, the Contractor will submit for USAID's approval an updated annual training plan every year along with the annual implementation plan. This plan shall also include a participant training scholarship program to begin in 2005 to train at least 120 Mayan professionals at Guatemalan nursing schools to become certified nurse midwifes to be employed by the MSPAS in rural areas with high maternal mortality.

4. Quarterly and Annual Progress Reports

The Contractor will provide quarterly progress reports (the last of which each year will be an Annual Report) to document major actions taken during the reporting period. This report should cover all activities proposed in the annual implementation plan, and should inform on progress made in them and plans for the next quarter. It must also specify any problems encountered and indicate resolutions or proposed corrective actions and include feedback from the MSPAS and program beneficiaries. In each quarterly report, the Contractor should include information on

site visits, including an "end-use monitoring report" for donated commodities, equipment and supplies procured for the MSPAS with USAID funds under the contract. The report should include the findings of the Contractor's monitoring of NGO performance delivering the basic package of health services under the additional health care coverage component. The report should identify any weaknesses in the use of contract-funded equipment, commodities and supplies for other than its intended purpose, lost/stolen equipment, and any other anomalies encountered. As part of the quarterly report, the Contractor will be responsible for providing USAID information it needs on participant training for the TraiNet data base.

The schedule for submission of the Quarterly Reports will be 30 days after the end of the quarter and the Annual Report for the fiscal year will be due by October 31 each year. The Annual Report should follow the same format as the Quarterly Reports, but focus on accomplishments, progress and problems toward achievement of Task Order Tangible Results, Performance Measures, and Benchmarks, tied to the Monitoring and Evaluation Plan targets for the entire previous fiscal year, including the 4th Quarter.

5. Financial Reporting

The Contractor will submit to the CTO and USAID/ Controller's office one original financial report on a quarterly basis.

6. Short-Term Consultants Reports

All short-term consultants will prepare reports at the end of their consultancies detailing their activities while in Guatemala, and making recommendations as may be appropriate. Before leaving Guatemala, the short-term consultant will leave copies of either a final or a draft copy of their report with the implementing Contractor. The Final Report is to be submitted to USAID within 30 days after the consultant's departure from Guatemala, unless extended by the CTO.

7. Completion Report

A Completion Report will be provided to USAID/Guatemala 30 days prior to the Task Order completion date. This report will highlight major successes achieved during the Task Order period with reference to established targets, and should also discuss any shortcomings and/or difficulties encountered. An additional function of this report is to outline lessons learned and make recommendations for follow-on activities. The Completion Report will form the substantive basis for the required Final Task Order Report.

8. Final Task Order Report

A Final Task Order Report is required within 60 days of completion of the Task Order, per standard USAID/ADS and applicable regulations.

9. Special Reports

From time to time, the Contractor will be required to prepare and submit to USAID special reports concerning specific activities and topics.

10. Development Experience Clearinghouse

Submission of Development Experience Documents to PPC/CDIE/DI shall be done by the Contractor in accordance with AIDAR 752.7005. USAID Contractors must submit one electronic copy and one hard copy of development experience documentation to the Development Experience Clearinghouse at the following address:

Development Experience Clearinghouse
1611 N. Kent Street, Suite 200
Arlington, VA 22209-2111

Telephone Number: (703) 351-4006, ext. 100
Fax Number: (703) 351-4039
E-mail: docsubmit@dec.cdie.org
http://www.dec.org

11. Annual Inventory of Commodities

In accordance with AIDAR 752.245-70, the Contractor will submit an annual report on all non-expendable property. The form/format to be used in preparing this report may be found in AIDAR 752-245-70.

E. Participant Training

This provision is applicable when any participant training is financed under the award.

Definition: A participant is any non-U.S. individual being trained under this award outside of that individual's home country.

a) Application of ADS Chapter 253: Participant training under this award shall comply with the policies established in ADS Chapter 253, Participant Training.

b) TraiNet: All USAID-funded training data, including in-country and third-country training, must be reported to Washington through the TraiNet system. Therefore, contractors and grantees must send to USAID their training information on a quarterly annual basis.

c) J-1 Visa: All USAID training participants traveling to the U.S. must obtain a J visa which can only be issued through the USAID Visa Compliance System (VCS). A minimum of eight weeks is now required to process a J-a visa.

d) English Proficiency: Sufficient language proficiency is mandatory for all trainings or conferences in English. USAID/Guatemala may choose to administer the Communicative English Proficiency Assessment (CEPA) test.

F. Period of Performance

This will be a five-year Task Order with a date of award expected on or before September 30, 2004.

G. Gender Considerations

The CAM SO3 framework considers women's participation throughout: in health and education activities, in access to information and reproductive health products, in participation in decision-making, in access to resources for investments in family health and education, and in opportunities for training and leadership in the public health field. In addition, men's role in family health will be included, such as a father's participation in monitoring their children's growth and nutritional status, men's condom use, men's roles in contraception, and men's roles in promoting community health. By actively engaging men and women in both their family and community health, greater success and sustainability will be achieved in reproductive, maternal, and child health. Evidence world-wide demonstrates that improving maternal, child, and reproductive health will have positive impacts on women's productivity and quality of life.

Professional training opportunities will emphasize female participation.
Although the Contractor will not assist civil society groups, it shall consider women's health advocacy groups as allies in working with GOG authorities to improve financing, coverage and quality of reproductive health services, including family planning, in Guatemala. These women's groups have played a key role in advocating for women's rights to family planning services provided by the GOG. These women's groups, among other important contributions, have: (a) Gained political space before the Guatemalan Congress, (b) Launched initiatives advocating for women's health and greater public spending on health; (c) Formed a network of 25 NGOs (Instancia Salud/Mujer) to present proposals to political parties and key decision makers in the new MSPAS administration. In the future, women's groups will continue to play a key role by demanding the continuation and strengthening by MSPAS of reproductive health/family planning services and working to ensure informed choice and access to a range of contraceptive methods, including natural and modern methods.

Offerors will indicate how they plan to incorporate gender considerations in their activities and their M&E plans, following standard USAID guidelines.

H. Coordination and Information Sharing with Other USAID Health Programs and Ministries of Health under the CAM Strategy

Under USAID's CAM strategy, the USAID Missions of Honduras, El Salvador and Nicaragua will be implementing programs very similar to that of USAID/Guatemala under the shared results framework. Increased sharing of information and successful health program approaches and tools between these Central American countries and Guatemala is an expected outcome of the CAM strategy. Therefore, the Contractor should share key technical reports, IEC and training materials from this Task Order with the USAID Health Program Chiefs in these other three countries and invite participation of USAID health staff and MSPAS representatives from these countries to technical meetings or observation visits organized in Guatemala by the Contractor under this Task Order. Furthermore, the Contractor should proactively reach out to

USAID health staff and their implementing partners in these other countries to learn about and adapt successful approaches from elsewhere to Guatemala, including organizing observation visits to other countries, if needed.

ANNEX 1

The Guatemala Program of Integrated Management of Childhood Illness and Health Care for Women and Children in the Community (AIEPI AINM-C):

Clinical Component (Integrated management)

- Integrated management of cases of maternal and childhood illness in health centers, health posts and community centers and via referrals with evaluation and response to the principal signs of illnesses in children, pregnant women and women during the post-partum period.
- Childhood illnesses management protocol (AIEPI) for the most common illnesses, i.e. diarrheal diseases, acute respiratory infections, ear and throat infections and fever (dengue, malaria, measles), as well as malnutrition, feeding practices, immunization, and micronutrient supplementation with iron and folic acid and vitamin A for children under five.
- Maternal health care including prenatal, delivery, postnatal care with recognition of signs and symptoms of shock, management of hemorrhage and sepsis; and development of family emergency plans.
- Neonatal care including management of the newborn with asphyxia, recognition of danger signs and referral, supplementation with vitamin A, folic acid and iron, and breastfeeding promotion.
- Family planning counseling and services.

Community Component-Growth Monitoring and Promotion and Prevention of Illnesses at Household and Community Level

- Monthly growth monitoring/promotion for children under 2 years of age, counseling to improve breastfeeding and complementary feeding practices, immunizations, home visits to those not growing well and referral of complications, micronutrient supplementation with Vitamin A and iron and folic acid.
- Recognition of danger signs (prenatal, during delivery, postpartum and in the newborn) and referral. Counseling on proper diet during pregnancy, breastfeeding, immunization, micronutrient supplementation with iron and folic acid.
- Hygiene and health practices (hand-washing, food preparation, waste disposal, clean water).
- Counseling for household management of diarrhea (without dehydration) and flu and referral of complicated cases.
- Counseling on family planning and referral to the nearest health facility for services.

ANNEX 2

AIEPI AINM-C Strategy

Impressed with the documented impact of the integrated community child health approach, known by it's Spanish acronym – AIN – and aware of the opportunity arising from the 2001 nutritional crisis, the Ministry of Health of Guatemala, with technical assistance from URC/ *Calidad en Salud* decided to formally adopt a variation of this strategy in February 2002. The resulting *Integrated Management of Childhood Illness and Health Care for Children and Women in the Community* (Spanish acronym AIEPI AINM-C) greatly expands the AIN approach by combining it with community IMCI (Integrated Management of Childhood Illness), maternal and neonatal health, and family planning. The overall structure of this strategy was outlined in the Tegucigalpa Declaration, signed by the Minister of Health immediately following a field visit to Honduras by key Ministry and NGO personnel. A proposal for the conceptual basis of the AIEPI AINM-C strategy was developed with the support of *Calidad en Salud*, and then fine-tuned by an interagency taskforce through a consensus building process.

AIEPI AINM-C aims to reduce the morbidity and mortality of women and children, including malnutrition in children, by maximizing access to quality care services among all three levels – communities, health posts and centers, as well as hospitals. The strategy includes two complementary and interrelated components: 1) integrated case management of childhood illnesses and maternal care, and 2) growth monitoring and promotion as well as illness prevention at home and in the community. It complements the Ministry of Health's ongoing Extension of Coverage model by encouraging active community participation in health care delivery, engaging community leaders in the promotion of behavior change, and strengthening the skills of community health agents in the analysis of the nutritional problems and factors that influence nutrition at the community level.

The AIEPI AINM-C integrated case management component focuses on training community facilitators to detect, treat and promptly refer complicated cases of childhood illnesses of children under five years (diarrhea and respiratory disease) to medical professionals in clinics and hospitals. The development of community and family emergency plans for the transportation of complications is also part of this component. Counseling parents and family caretakers to adopt better practices at home so as to treat and prevent illnesses and nutritional problems is equally important. Adding to the traditional elements of community IMCI, this component also includes health care for the neonate as well as family planning and care for women during pregnancy, labor and during the post-partum period. Two protocol/ manuals and several counseling and IEC materials have been developed to guide the integrated case management and counseling of caregivers by community facilitators during consultations to community centers.

The growth promotion and illness prevention component of AIEPI AINM-C aims to strengthen community outreach activities under the Extension of Coverage model. Monitoring and promoting the growth of all children under two years of age is seen as the key intervention. Other interventions such as management of childhood illnesses of children under five years, also contribute to growth promotion. Weighing sessions are designed to bring caregivers from a given sector or community together on a monthly basis, creating opportunities to deliver a combination

of feeding and health education messages through individual counseling, group health talks, demonstration and follow-up home visits. Growth promotion requires advice on breastfeeding and complementary young child feeding, according to the age and growth status of their children, emphasizing the timely introduction and improved combination and preparation of local foods.

This article highlights key elements in the process to implement the AIEPI AINM-C strategy in Guatemala, particularly the growth promotion and illness prevention component. Key elements are not necessarily presented in the order of their importance or chronologically, but all of them have fundamentally contributed to the implementation of this promising approach to improve child health and nutrition in Guatemala.

Political support

Although child malnutrition rates in Guatemala have declined somewhat over the past 15 years, the prevalence of stunting remains the highest in Latin America and the Caribbean. Also, the absolute numbers of malnourished children remain high due to the increase in population. Higher rates, as well as less degree of change, are found among indigenous Maya populations. A nutritional crisis in 2001 made the Ministry of Health recognize the need to focus more resources on prevention strategies and the promotion of healthy behaviors at the community level. The need for a growth monitoring system at the community level that would allow for early detection of nutritional deterioration and prevention of emergencies became evident. The national response to the crisis was to use the Extension of Coverage model as the community platform and to strengthen that model through the adoption of the AIEPI AINM-C strategy.

Structure

In response to the Peace Accords, signed in 1996, and continuing concerns about low levels of health care coverage, especially in rural, isolated communities throughout Guatemala, the Ministry of Health designed and began implementing a strategy to expand basic services through ambulatory medical teams contracted and supervised by local non-governmental organizations (NGOs). This model, known as Extension of Coverage, emphasizes the participation of a cadre of community volunteers and the participation of the community itself in the delivery of services. The system involves providing basic health services through local NGOs under contract by Ministry of Health and basic health teams composed of ambulatory physicians, institutional facilitators, community facilitators, community health volunteers known as *vigilantes*, and traditional midwives. The system now operates nationwide with 116 NGOs and an active network of over 3,000 community centers, 275 ambulatory physicians, 342 institutional facilitators, 1,663 community facilitators and more than 20,000 health *vigilantes*. The population being covered by this model is officially estimated as 3 million people, in a country whose estimated population is 11 million.

Several of the national norms established for of the Extension of Coverage model had to be changed to accommodate AIEPI AINM-C. Notably, growth monitoring and promotion that had theoretically been carried out by institutional facilitators, in now carried out by health *vigilantes* within their community sector (made up of 20 households). Community-based distribution of micronutrients also needed to be established in order to provide an incentive to mothers to bring their children for monthly growth monitoring. *Vigilantes* in each community needed to start

working as a team and in collaboration with traditional midwives to enroll children from birth. These new working relationship required flexibility in the application of existing national norms. For example, family planning, which had not been included in the original basic package of Extension of Coverage services, became and integral part of the counseling provided by all members of the health care team.

Benchmarking

Regional experiences with community IMCI (Integrated Management of Childhood Illnesses) and other strategies were reviewed as part of a "benchmarking" process.

The field visit to Honduras, for instance, was organized for key Ministry of Health and NGO personnel to review that country's successful experience with AIN. This model, which concentrates on training community volunteers to monitor and promote the growth of children under two years of age, had won international attention for its impressive effect on improving a number of knowledge and behavior variables and its potential impact in reducing childhood malnutrition. Benchmarking was also used to identify best practices and lessons learned in and IEC/ behavior change communication strategies and materials and community participation methodologies.

Formative and operations research

The Ministry of Health with support from *Calidad en Salud* reviewed trials of improved practices (TIPs) previously conducted, and designed and conducted new trials in 2001, which subsequently helped to define the contents of young child feeding counseling under the AIEPI AINM-C strategy. Infant and child feeding guidelines include specific advice based on the age and growth (adequate or inadequate) of an individual child, as well as advice on feeding during and after and illness episode.

The suggested change in national policy from focusing on nutritional status indicators such as low weight for age (reflecting total past of the child), to an indicator sensitive to recent changes in the child's health and nutrition such as monthly weight gain encouraged under AIEPI AINM-C, initially generated strong opposition, especially from the Guatemalan nutrition community. In order to help resolve this conflict, the Ministry of Health, in close coordination with and technical support from *Calidad en Salud* conducted an operations research on growth monitoring in an area of the country known as the Ixil Triangle. The aim of this research was to test two alternative methods of classifying children as growth faltering: 1) observation of the growth trend over a two month period to determine failure to gain weight or actual loss of weight, and the b) use of a minimum expected weight table (in use in the AIN programs in Honduras and Nicaragua), whereby children who gain less than a minimum amount in relation to weight the previous month are classified as growth faltering or "not growing well".

The effects of these two growth-monitoring procedures on the proportion of children classified as growth faltering was documented by this research. The performance of health *vigilantes*, their acceptance of these different approaches, as well as the acceptance of mothers were also studied. The operations research demonstrated both the adequacy and acceptance of using a minimum weight gain table for monthly weight monitoring. Additional research conducted by two international consultants recommended a new table specific to Guatemala. Consequently, the

"child card" officially used in Guatemala was modified to reflect these changes. The Ixil Triangle research also provided an important opportunity to pre-test job aids and educational materials for use by community health workers such as the *vigilante* notebook for registering weights, a series of pictorial counseling cards (bound) and specific take-home messages for mothers and caregivers.

Systems approach

A systems approach in the design of the AIEPI AINM-C strategy allowed for the consideration of all the major sub-systems necessary for its successful implementation. These were the following:

- ***Training***. Although training in "cascade" fashion has many limitations, it was deemed the only way feasible to reach the large number of Health Area and Health District personnel, NGOs, ambulatory physicians, institutional facilitators, community facilitators and health *vigilantes*. Manuals for training of trainers, for actual training and participants' manuals were prepared for the two separate components of AIEPI AINM-C –the integrated management component and the promotion and prevention component of the strategy. Three training modules were developed for the growth promotion and illness prevention component – the first one on growth monitoring and promotion, the second one on illness treatment and prevention, and the third one on maternal and neonatal health and family planning – and are being used in training.

  Training sessions for community volunteers in the promotion and prevention component focus on weighing procedures, the use of a minimum weight gain table to classify children as "growing well" or not, plotting weights on a child growth cards, appropriate use of counseling and other IEC materials to promote positive individual and household behaviors (hygiene, immunizations, prenatal care, use of family planning), recognition of danger signs and referral of both women and children to either clinics or hospitals when necessary. In less than one year's time, 12,327 health *vigilantes* have been trained in module 1, most of whom are already conducting weight monitoring sessions.

- ***Behavior change communication***. Three national IEC or behavior change communication strategies that had previously been developed by an IEC-dedicated interagency technical group, with technical support of *Calidad en Salud* (family planning, IMCI and maternal and neonatal health) were integrated into the overall AIEPI AINM-C. Fifty very specific behaviors (not behavior clusters as are defined elsewhere) were identified for mothers and caregivers. Communication tactics for the promotion and prevention component included: a) mass media (radio spots), b) interpersonal communication and counseling between community providers and caregivers during growth monitoring and promotion sessions and home visits, c) group communication during group and community sessions, d) special campaigns designed and scheduled by the Ministry of Health, but requiring local adaptation and implementation during local events and festivities, and e) community mobilization and participation through activation of the community organization, assessment of children's growth, analysis of the growth monitoring data and stimulation of actions to address the problem. In addition, an advocacy and public relations strategy was developed and implemented locally at the Health Area level.

A series of colorful pictorial counseling materials have been designed and tested for use by low literacy community volunteers. In addition, recall leaflets, referral leaflets, and a child card for distribution to caregivers were produced. The process of involving several programs from the Ministry of Health and all major NGOs in the process of designing, testing and producing these materials, has ultimately proved extremely rewarding in terms of the degree of national ownership that has been achieved. This inter-governmental and interagency collaboration, however, has taken a considerable amount of time to achieve, and consensus has not always been easy to arrive at.

- ***Logistics***. For the integrated management component of the strategy the definition and logistical issues related to procuring basic medicines, contraceptives and other supplies was important. For the promotion and prevention component the distribution of weighing scales, one for every four *vigilantes*, was critical to the implementation of the strategy. Even with considerable planning and some external contracted assistance, the distribution of materials has been a difficult process. The lack of personnel specifically devoted to carrying out the process of counting, packaging and transporting educational and counseling materials, for example, has been a constraint. Obtaining information from the field concerning the number of personnel to be trained and establishing training dates has also presented unforeseen challenges.

- ***Information system***. The new promotion and prevention component required the establishment of new national indicators for growth monitoring, such as the percentage of children in the community who "do not grow well" (have not gained minimum expected weight in two consecutive weighing sessions). The establishment of appropriate registration categories in the official information system continues to be negotiated with the National Management Health Information System.

- ***Monitoring and evaluation***. Monitoring of quality of training was the first need identified and addressed. Subsequently, instruments for monitoring the performance of health *vigilantes* were developed. At present, these have been integrated into a national monitoring and supervision system for AIEPI AINM-C. Plans to evaluate the impact on growth/ malnutrition of AIEPI AINM-C are of high priority given that the evaluation of AIN has documented effects in maternal knowledge and behavioral variables only.

- ***Administration and financing***. According to official figures, the Extension of Coverage model requires an inversion of US$17 million a year. Although monthly training of community health workers is included in these figures, funds do not always flow smoothly from the central level to the NGOs and then on to the community health workers, who receive a modest stipend for participating in training and monthly supervision meetings. Funds from other sources have had to be identified to pay for the three consecutive days of AIEPI AINM-C training of *vigilantes* in growth monitoring and promotion. (The training in the other two modules requires six additional days.)

Alliances

From the beginning AIEPI AINM-C has generated and depended upon strong alliance between both the public and the private sector. With the support of many international cooperating agencies, NGOs and the donor community, the Ministry of Health launched AIEPI AINM-C training activities in ten of the 26 Guatemalan Health Areas following an inter-agency training of trainers at the end of 2002. Current plans are to implement AIEPI AINM-C in over 1,000 community health centers and 2,500 communities throughout these ten areas by the end of 2003. More than 14,000 community health workers are scheduled to be trained in the initial stages of implementation. Since the launching of AIEPI AINM-C, *Calidad en Salud* has actively supported the Ministry of Health in the development and implementation of the overall strategy. Also, for over three years an inter-institutional technical IEC group, known as GTI-IEC, has worked on the design, testing and production of training and IEC materials, with administrative and technical support from *Calidad en Salud*.

The anticipated expansion of AIEPI AINM-C on a national level will depend on the new Guatemalan government embracing the strategy. The continuing coordination of financial and technical support of a broad spectrum of international NGOs and donor agencies is also critical to the nationwide expansion of the strategy.

ANNEX 3

List of Basic Services in Child and Reproductive Health Care

Child Health

- Vaccinations coverage of children <5
- Growth Monitoring for children < 2
- Micronutrient supplementation (Vitamin A, iron and folic acid) for children <5
- Breast Feeding Promotion and Support
- Counseling to improve complementary feeding practices
- Diagnosis and treatment of diarrheal disease (including ORT) for children <5
- Prevention, detection, case management and referral of Acute Respiratory Infections (ARI) in children <5
- Management of ear-throat infections
- Management of febrile infections
- Care of the Newborn

Reproductive Health

- Prenatal and postnatal care, including tetanus toxoid, iron supplements, folic acid
- Identification, referral and attention to complications during pregnancy, delivery and post-partum
- Family planning counseling , including optimal inter-pregnancy intervals of 3-5 years
- Family planning services and early recognition, referral response to pregnancy and delivery complications
- Iron/ folic acid supplementation for women in reproductive age
- Detection and referral for breast cancer
- Detection and referral for cervical cancer
- Counseling to improve maternal nutrition

Community-Based Responses

- Community health posts
- Community health facilitator and volunteers
- Community revolving drug funds

ANNEX 4

Schedule for upgrading illustrative MSPAS STI-VCT facilities

No.	FHI/IMPACT STI and VCT sites for follow up by the Contractor	FY2006 New Sites	FY2007 New Sites	FY2008 New Sites	Total
1	**Guatemala**: Zone 3 STI Health Center	**San Marcos**: Tecun Uman	**Escuintla**: Pto Sn Jose	**Jutiapa TBD**	
2	**Guatemala:** Zone 6 Health Center	**San Marcos**: Malacatán	**Escuintla**: Tiquisate	**Zacapa TBD**	
3	**Guatemala:** Zone 1 Health Center	**Quetzaltenango:** Coatepeque	**Escuintla:** Santa Lucia Cotzumalguapa	**Santa Rosa TBD**	
4	**Guatemala:** Zone 19 Health Center	**Quetzaltenango:** Quetzaltenango Health Center	**Guatemala**: Amatitlan	**Chimaltenango TBD**	
5	**Izabal**: Puerto Barrios Health Center	**Quetzaltenango: TBD**	**Guatemala**: Villanueva		
6	**Izabal**: Livingston Health Center	**Suchitepequez:** Mazatenango	**Peten:** Melchor De Mencos		
7	**Izabal:** Sto Tomas Health Center	**Suchitepequez: TBD**	**Peten:** Flores		
8	**Izabal**: Puerto Barrios Health Post	**Retalhucleu**: **Retalhuleu**: Health Center	**Peten**: Poptun		
9		**Retalhuleu:** Caballo Blanco	**Peten:** Sayajché		
10		**Retalhuleu**: Champerico	**Peten:** San Benito		
11		**Retalhuleu**: Sta Cruz Muluá			
12		**Retalhuleu: TBD**			
Total	**8 for follow up**	**12**	**10**	**4**	**26 new sites**

TBD = To be determined

ANNEX 5: Location of PL480 Title II Food Aid Program by Municipality/Department/Cooperating Sponsor PVO in Guatemala

Municipality/Department	CARE	SHARE	CRS	SCF
Quiche Dept.				
Sta Cruz del Quiche	X			X
Ixcan			X	
Nebaj				X
Uspantan				
San Pedro Jocopilas	X			
Chichicastenango	X			
Cotzal				X
Uspantan				X
San Andres Sajcabaja				X
San Antonio Ilotenango				X
Patzite				X
Chajul				X
Joyabaj		X		
Zacualpa		X		
Huehuetenango Dept.				
San Mateo Ixtatan		X		
Barillas		X		
Nenton		X		
La Libertad		X		
San Pedro Necta		X		
Todos Santos Cuchu		X		
San Juan Ixcoy		X		
San Pedro Soloma		X		
San Rafael La Indep.		X		
Santa Eulalia		X		
San Miguel Acatan		X		
San Sebastian Coatan		X		
Chiantla		X		
La Democracia		X		
Concepcion Huista		X		
Jacaltenango		X		
San Antonio Huista		X		
Cuilco	X			
Tectitan	X			
Ixtahuacan	X			

Municipality/Department	CARE	SHARE	CRS	SCF
Alta Verapaz Dept.				
Chisec		X	X	
San Pedro Carcha	X		X	
Coban		X	X	
Fray Bartalome		X		
Chahal		X		
Panzos	X		X	
Senahu			X	
Cahabon			X	
Tucuru	X			
San Juan Chamelco	X			
Baja Verapaz Dept.				
Rabinal		X		
Cubulco		X	X	
El Chol		X	X	
Granados		X	X	
Salama			X	
La Tinta	X			
San Marcos Dept.				
Concepcion Tutuapa	X		X	
Comitancillo		X	X	
Tejutla			X	
Tacana			X	
San Jose Ojetenam			X	
Ixchiguan			X	
San Rafael			X	
Sibinal			X	
San Pedro Sacatepequez			X	
Tajumulco			X	
San Antonio			X	
San Pablo			X	
El Tumbador			X	
Nuevo Progreso			X	
San Miguel Ixtahuacan			X	
Sipacapa			X	
San Lorenzo			X	
San Marcos			X	
Rio Blanco			X	
San Cristobal Cucho			X	

Municipality/Department	CARE	SHARE	CRS	SCF
Chimaltenango Dept.				
San Martin Jilotepeque		X		
Comalapa		X		
Santa Apolonia		X		
Tecpan		X		
San Jose Poaquil		X		
Solola Dept.				
Solola	X			
San Andres Semetabaj	X			
Chiquimula Dept.				
Camotan			X	
Jocotan			X	
Olopa			X	
San Juan Ermita			X	
Zacapa Dept.				
La Union			X	

ANNEX 6

Inventory USAID Project No. 520-0428

Better Health for Rural Women and Children
University Research Corporation/Calidad en Salud

ITEM & DESCRIPTION	CPU SERIAL #	Monitor SERIAL #	QTY	DATE PURCHASED	PURCHASE PRICE US $
Impresora HP 1100			1	11-Feb-00	$ 414.15
Monitor Viewsonic 17"	DP93802501		1	29-Feb-00	$ 392.50
Monitor Viewsonic 17"	DP93802508		1	29-Feb-00	$ 392.50
Monitor Viewsonic 17"	DP93802502		1	29-Feb-00	$ 392.50
Monitor Viewsonic 17"	D766907105414		1	29-Feb-00	$ 392.50
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0256CBA	DP94800126	1	02-Mar-00	$ 997.06
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0257CBA	D766907105 414	1	02-Mar-00	$ 997.06
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0255CBA	DP93802502	2	02-Mar-00	$ 997.06
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0249CBA	DP93802507	3	02-Mar-00	$ 997.06
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0258CBA	DP93802508	4	02-Mar-00	$ 997.06

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0262CBA	DP93802501	5	02-Mar-00	$ 997.06
Computadora AMD K7 Athlon de 550 Mhz 64 MB de Ram disco duro de 13.6 GB Kit multimedia 54 x tarjeta de red 10/100 serie	C5AAY0263CBA	DP93802506	6	02-Mar-00	$ 997.06
Combo Powerstation K755015zm, monitor, teclado, bocinas	C5AAY.257CBA	DP94700881	1	07-Mar-00	$ 1,056.73
Combo Powerstation K755015zm, monitor, teclado, bocinas	C5ABC0002YBA	DP94705908	1	07-Mar-00	$ 1,056.73
Combo Powerstation K755015zm, monitor, teclado, bocinas	C5AY025CBA	203B0145D1 326	1	07-Mar-00	$ 1,056.73
Combo Powerstation K755015zm, monitor, teclado, bocinas	C5ABP0004LB	DP99470590 9	1	07-Mar-00	$ 1,056.73
Combo Powerstation K755015zm, monitor, teclado, bocinas	C52AY0256CAA	DP02303726	1	07-Mar-00	$ 1,056.73
Combo Powerstation K755015zm, monitor, teclado, bocinas	C5ABC0005YBA	23B01450016 8	1	07-Mar-00	$ 1,056.73
Monitor Viewsonic 17"			1	31-Mar-00	$ 362.55
Impresora HP Laserjet 4050TN	USCC116666		1	07-May-00	$ 1,867.83
Retroproyector 3M Modelo D2000			1	26-May-00	$ 455.13
Computadora AMD K7 Athlon de 650 Mhz 64 MB de Ram disco duro de 15 GB Kit multimedia 52 x tarjeta de red 10/100 serie, Monitor Viewsonic 17"	FT08A30S0012	DP01705151	1	14-Jun-00	$ 1,575.87

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Computadora AMD K7 Athlon de 650 Mhz 64 MB de Ram disco duro de 15 GB Kit multimedia 52 x tarjeta de red 10/100 serie, Monitor Viewsonic 17"	T08A30S00135	DP01704069	1	14-Jun-00	$ 1,575.87
Computadora Celeron500 Mhz, 32 MB, multimedia 10 GB, Monitor de 14"	C5AFH0723UFA	004AC90190	1	17-Jul-00	$ 719.17
Agenda Electrónica Palm_SI Compaq	1D94CKC3D3XJ		1	02-Sep-00	$ 379.28
Monitor View Sonic E773			1	19-Oct-00	$ 399.70
Sony DVM Digital Camera DCR-VX 2000	1012814 - 00533	Penn Cammera	1	01-Dec-00	$ 2,699.00
Computadora Athlon AMD 64 MB	M1AGM0050UH A	LG 15" S/005ACB70 43	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0036UH A	LG 15" S/005ACB68 12	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0046UH A	LG 15"S/005AC B7024	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0013UH A	LG 15" S/005ACB64 64	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0028UH A	LG 15" S/005ACB66 42	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0059UH A	LG 15" S/005ACB69 39	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0037UH A	LG 15" S/005ACB67 55	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0035UH A	LG 15" S/005ACB67 42	1	12-Dec-00	$ 836.88

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Computadora Athlon AMD 64 MB	M1AGM0023UHA	LG 15" S/005ACB6636	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0054UHA	LG 15" S/005ACB6751	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0010UHA	LG 15" S/005ACB7099	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0060UHA	LG 15" S/005ACB7042	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0058UHA	LG 15" S/005ACB7023	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0011UHA	LG 15" S/005ACB6268	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0057UHA	LG 15" S/005ACB6272	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0005UHA	LG 15" S/005ACB7027	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0004UHA	LG 15" S/005ACB6297	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0009UHA	LG 15" S/005ACB6304	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0012UHA	LG 15" S/005ACB6875	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0022UHA	LG 15" S/005ACB6647	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0056UHA	LG 15" S/005ACB6779	1	12-Dec-00	$ 836.88
Computadora Athlon AMD 64 MB	M1AGM0044UHA	LG 15" S/005ACB6786	1	12-Dec-00	$ 836.88

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Retroproyector 3M Mod D20000	1059239		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059345		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059248		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059251		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059242		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059247		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059240		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059245		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059244		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059246		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059253		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059238		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059250		1	03-Jan-01	$ 450.92
Retroproyector 3M Mod D20000	1059252		1	03-Jan-01	$ 450.92
computadora, con procesador, menoria Dimm 256 MB, motherboard todo incluído			1	04-Jan-01	$ 480.96
monitor View Sonic de 17'			2	28-Jan-02	$ 343.75
Computadoras ATX AMD Duron, 10 GB, monitor 17"			2	10-Jan-01	$ 1,480.00
Computadora ATX AMD Duron, 10 GB, monitor 17"	060SIX7677095 monHOG01500 7		1	15-Jan-01	$ 674.57
Computadora ATX AMD Duron, 10 GB, monitor 14"	000084873 mon S4CS0CA687017		1	13-Mar-01	$ 526.12

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Hub 2COM de 16 Puertos			1	27-Jun-01	$ 345.32
Microsoft Proxy server 2.0			1	12-Jul-01	$ 1,421.60
Norton Antivirus			1	02-Aug-01	$ 59.39
Impresora EPSON LX 300	CDUY107913		1	07-Nov-01	$ 225.66
Servidor, Windows 200 Proxy server 2.0			1	20-Nov-01	$ 410.00
computadora, case ATX , procesador AMD, Ventilador, disco Duro			1	27-Nov-01	$ 413.42
Computadora ATX Middletower 1003 gris, AMD Athlon 1100 MHAz, 60MB S/Monitor			1	04-Dec-01	$ 417.06
Retroproyector 3M, Modelo 2000	78923687322		1	06-Dec-03	$ 523.44
impresora HP 1100			2	11-Dec-01	$ 399.70
Impresora HP 1100			1	11-Jan-02	$ 713.75
Impresora HP 1100			1	11-Jan-02	$ 713.75
Monitor View Sonic E773 17"			1	28-Jan-02	$ 306.92
Monitor View Sonic E773 17"			1	28-Jan-02	$ 306.92
Combo Powerstation K755015zm, monitor, teclado, bocinas			1	15-Mar-02	$ 1,466.15
Fax FC 160 y Protector de voltaje	EM6-010219		1	13-Mar-03	$ 338.45
Monitor View Sonic E773	DP93802506		1	01-Feb-29	$ 392.50
Monitor View Sonic E773	DP94800126		1	02/01/2029	$ 392.50
Monitor View Sonic E773	DP93802507		1	02/01/2029	$ 392.50

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
UPS OMNI Smart 500VA			2	12/20/2001	$ 438.43
impresora a color BJC-250	EJU 47978		1	01/01/1999	$ 110.00
Agenda Electrónica Handspring			1		$ 428.00
Agenda Electrónica Palm Visor de Luxe			1		$ 428.00
Monitor View Sonic E773	DP93802503		1		$ 392.50
Monitor View Sonic E773	DP94705909		1		$ 392.50
Monitor View Sonic E773	DP94700881		1		$ 392.50
Monitor View Sonic E773	DP01704069		1		$ 392.50
Monitor Viewsonic 17"	DP94705908		1		$ 374.35
Monitor Viewsonic 17"	DP94705762		1		
Monitor Viewsonic 17"	DP92002885		1		
Monitor Viewsonic 17"			1		
Impresora Laser HP 4050TN			1		$ 2,025.64
Computadora AMD Athlon Monitor 15"	CPU SD3Q001	MY095WUP4 66321509037	1	20-Mar-02	677.26
Computadora AMD Athlon Monitor 15"	CPU 6P3Q001	MY095WVP4 663215-M-9043	1	20-Mar-02	677.26
Impresora HP 1200			1	25-Mar-02	474.08
Impresora HP 1200			1	25-Mar-02	474.08
Licencias Windows XP Pro Esp Open			21	22-May-02	15,698.74
Licencias Microsoft Office XP Esp Op			25	22-May-02	15,698.74

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Office 2000 and Multimedia Studio Card	450-5802526		1	01-Jul-00	879.00
Visio 2002 Profesional	D39KQ-TJD8G-84QW6-27RYG		1	June 2003	414.95
Adobe Acrobat 5.0 (Full version)	KWW505R7218208-356		1	June 2003	199.95
Freehand 10	FHW100-02832-47245-40865/04034-27246-40885		2		
Symantec Antivirus Corporate Edition	SAVCE09022-34281		25		
Software para presentaciones			1	15-Jul-03	438.59
Charthouse International Training Video			1	January 2001	557.00
Microsoft Project 2000			1	01-Jul-00	185.00
The Power of Visio (video in English)			1	January 2001	716.00
The Power of Visio (video in Spanish)			1	August 2003	905.00
Impresoras HP 1200			5	24-Jun-02	2,204.42
ScanMaker 12 USL			1	01-Jul-00	
Impresora a color 2500 CN			1	01-Jul-00	
Mimio			1	01-Jul-00	499.99
Computadora Compaq EVO D300			11	10-Sep-02	12,289.51
Impresoras HP 1200			5	10-Sep-02	2,050.97
Computadoras	Compaq Evo D3000		5	01-Aug-02	$ 6,000.00

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Monitor Viewsonic Optiquest 17"		70A0247033 92	1	25-Mar-03	$ 145.98
Laptop Toshiba Satellite 2450	PS245UOLQNQP		1	17-Jun-03	$ 1,584.49
Laptop Toshiba Satellite 2450			1	17-Jun-03	$ 1,584.49
Laptop Toshiba Satellite A10 SP129	Y3034525H	Parte PSA10U-OZH6MP	1	20-Jan-04	$ 1,220.00
Laptop Toshiba Satellite A10 SP129	Y3012943H	Parte PSA10U-OZH6MP	1	20-Jan-04	$ 1,220.00
Licencia ArcView GIS 8.3			1	01-Apr-04	$ 1,912.26
Sala de sesiones			1	02/28/2000	$ 2,353.85
Kit de alarma con 16 zonas			1	03/02/2000	$ 2,888.00
Horno Microondas Whirlpool			1	24-Feb-00	$ 644.47
Refrigerador 12" Frigidaire			1		
Planta telefónica y 2 telefonos			1	28-Mar-00	$ 2,822.25
Estufa electrica HotPoint			1	12-May-00	$ 467.49
Retroproyector 3M Mod D20000			1	26-May-00	$ 455.13
Equipo vigilanciaJCM 100 y camara modelo 276	Mod JCM-100		1	16-May-00	$ 744.47
Paneles de división			5	11-Jul-01	$ 5,756.40
Divisiones Modulares				08/23/2001	
TV 21' sony contro remoto	4028393		1	11/28/2001	$ 334.86
Retroproyector 3M Mod D20000	78923687322		1	12/06/2001	$ 523.44
Radio PRO 7150 UHF 403470	LAH25RDH9AA6 A		1	03/20/2002	$ 538.40

ITEM & DESCRIPTION	SERIAL #	SERIAL #		PURCHASED	PRICE US $
Radio PRO 7150 UHF 403470	LAH25RDH9AA6 A		1	04/02/2002	$ 539.86
Detectores de Humo			5	06/19/2002	$ 896.80
		DATE	PURCHA SE	Chasis No	Motor No.
VEHICLE MAKE & MODEL	YEAR/LICENSE PLATE No.	PURCHASED	PRICE US$		
Chevrolet Blazer, Gris	2000/MI 1269	2000	$18,916. 00	1GNDT13W3 Y2157768	NY2157768
Chevrolet Blazer, Gris	2000/MI 2246	2000	$18,916. 00	1GNDT13W9 Y2157709	NY2157709
Chevrolet Blazer, Azul	2000/MI 2248	2000	$18,916. 00	1GNDT13W7 Y2205059	NY2205059
Chevrolet Blazer, Gris	2000/MI 2249	2000	$18,916. 00	1GNDT13W7 Y2157501	NY2157501
Chevrolet Blazer, Azul	2000/MI 1639	2000	$18,916. 00	1GNDT13W4 Y2205326	NY2205326
Honda Civic, Plateado	2000/MI 2250	2000	$14,939. 00	1HGEJ6520Y L500216	D16YZ- 5760416
Dodge Ram 1500, blanco	1999/MI 693	2001	$0.00	3B7HF13Y2X G210890	XG210890