

**USAID/GUATEMALA BEST Action Plan
For Family Planning, MNCH, and Nutrition**

Best Practices at Scale in the Home, Community, and Facilities

(August, 2011 version for public distribution)

Acronyms

CAIMI	Integrated Maternal/Child Health CareCenter (Spanish acronym)
CARSI	Central America Regional Security
CAP	<i>Permanent Care Center (Spanish acronym)</i>
CDCS	Country Development and Cooperation Strategy
COCODE	Community Development Council
DAS	Health Area Directorate
DMPA	Depo-Medroxy Progesteron Acetate
DMS	Municipal Health Directorate
ENSMI	National Maternal and Child Health Survey (Spanish acronym)
FTF	Feed the Future
FFP	Food for Peace
GCC	Global Climate Change
GOG	Government of Guatemala
HBB	Helping Babies Breathe
HCI	Health Care Improvement
IGSS	Guatemala Institute for Social Security (Spanish acronym)
ISO	International Standards Organization
LAPM	Long Acting and Permanent Methods
LQAS	Lot Quality Assurance Sampling
MAIS	Integrated Health Care Model (Spanish acronym)
MIFAPRO	Mi Familia Progresá
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH/FP/N	Maternal, Neonatal, Child Health/Family Planning/Nutrition
MSPAS	Ministry of Public Health and Social Affairs (Spanish acronym)
PEC	Extension of Coverage Program (Spanish acronym)
OSAR	Reproductive Health Observatory (Spanish acronym)
REDMISAR	Network of Indigenous Women for Reproductive Health (Spanish acronym)
SBCC	Social and Behavior Change Communication
SCMS	Supply Chain Management Project
WRA	Women of Reproductive Age

Executive Summary

Guatemala is a focus country for a number of US Presidential initiatives, including Feed the Future (FTF), the Global Health Initiative (GHI), the Central America Regional Security Initiative (CARSI) and Global Climate Change (GCC) and the USAID Mission is in the process of developing a new five-year Country Development and Cooperation Strategy (CDCS) that addresses the challenge of program integration while respecting the priorities and guidance of this diverse set of initiatives. The BEST action plan presented in this document outlines planned activities aligned with the GHI and FTF strategies for the country, which are in turn aligned with the Government of Guatemala's priorities in health, nutrition and family planning. The action plan is based on multiple consultative meetings with key stakeholders and discussions internal to USAID, a process that was launched with a visit of a BEST team from USAID/Washington in January 2011 (see Appendix 2 for the team visit schedule.) That visit coincided with the presence in Guatemala of teams from the Washington offices of Food for Peace and USDA, as well as a technical team working on the Feed the Future strategy development. This felicitous overlap of several of the USG agencies and initiatives developing nutrition and health programs for Guatemala for the next five years provided an excellent opportunity to establish a basic consensus on how the USG government will work together to achieve significant results in food security, nutrition, health and family planning in the coming years.

Since the Guatemala GHI strategy was approved by Washington in January 2011, USAID has continued its planning process for the implementation of GHI in Guatemala. Under the new CDCS (2012-2016), USAID/Guatemala has taken the decision to integrate resources and efforts from all sectors to achieve economic and social development results in one geographic focus area of the country – the five highest-need departments of the largely indigenous and rural Western Highlands. With the addition of another, contiguous, rural indigenous department for maternal and neonatal health and family planning interventions, the BEST plan will be carried out in six departments of the country (see map in Appendix 3.) In order to achieve the objectives laid out in the GHI and FTF strategies, the health program has made a firm commitment to substantially shift its focus and effort to working with communities and local governments to provide information, promote behavior change and provide basic and essential services in place of current efforts to prop up the Ministry of Health's (MOH) Expansion of Coverage Program (PEC). (See discussion of the PEC and a new MOH model in the section on The Health System below.)

Key to this approach will be mobilizing communities to actively engage in health and nutrition promotion and the improvement of their health care; strengthening local health authorities' (Health Area Directorates) capacity to coordinate, regulate and supervise basic, essential health care (including commodity distribution and reporting); and engaging municipal governments to comply with their responsibilities for ensuring that all communities have access to basic services. USAID is currently supporting the evaluation of alternative service delivery models to the classic PEC approach, such as the "Jalapa model" and the "unidades minimas" established

by local governments in their underserved communities, to potentially replicate these models in the new community-focused efforts of this BEST action plan.

Background

Health Context

Almost 40% of Guatemala's 14.3 million people (2010¹ estimate) are categorized as indigenous Maya. Although the country is classified as a lower middle income country, based on a per capita income of \$4839², wide disparities in wealth quintiles leave 50% of the population living in poverty and among this group, 15% are living in extreme poverty. Almost 75% of indigenous people live in poverty, compared with 36% of non-indigenous, and these large disparities also exist between rural and urban residents. While 46% of the total population live in rural areas, a disproportionately large number of rural residents, 72%, are extremely poor.

Not surprisingly, health and education indicators reflect the gaps in income and opportunities between the indigenous and non-indigenous. For example, the average time in school among indigenous people is only 3.8 years while it is 6.5 years among the non-indigenous. And according to the 2008-09 Demographic and Health Survey (ENSMI by its initials in Spanish), among indigenous women of reproductive age (15-49) only 3% completed secondary education and 1.7% completed higher education; among non-indigenous the figures are 9.7% and 8.1% respectively.

Ranked as the tenth most vulnerable country in the world for climate change, Guatemala is prone to earthquakes, tropical storms and other natural disasters. Natural disasters and extreme climate events disproportionately affect poorer rural, indigenous populations when their marginal living conditions, subsistence agriculture, and cash crops are destroyed. Young children and women in these communities are often the most adversely affected, as they are more vulnerable and often have poorer nutritional and health status.

In Guatemala, the greatest threat to a child's survival and potential intellectual and future economic productivity is the extremely high rate of chronic malnutrition (as measured by height for age, stunting), particularly in children under age two when growth of bones and brain development are at their most critical stage. With 50% of children under five years stunted, Guatemala ranks fourth for chronic malnutrition in the world and has the highest rate of stunting in the western hemisphere.

¹ <http://www.ine.gob.gt/index.php/demografia-y-poblacion/42-demografiaypoblacion/211-poblacion>

² <http://www.indexmundi.com/guatemala/>

Family Planning, Health and Nutrition Status and Service Coverage

Table 1

Indicators	ENSMI Results 2002			ENSMI Results 2008-9		
	Total	Indigenous	Non-Indigenous	Total	Indigenous	Non-Indigenous
Contraceptive use for women of reproductive age –WRA – in union	43.3%	23.8%	52.8%	54.1%	40.2%	63.3%
Modern contraceptive use WRA in union	34.4%	16.6%	43.2%	44.0%	28%	54.2%
Delivery attended by medical personnel	41.4%	19.1%	57.0%	51.6%	29.5%	70.2%
Infant mortality rate (deaths per 1,000 live births)	44	49	40	34	40	30
Neonatal mortality rate	23	26	22	18	21	15
Full immunization coverage (BCG, Polio 3, DPT 3, Measles)	68.6%	65.4%	71.1%	71.2%	71.9%	70.5%
Acute respiratory infection (ARI) among children <5 in previous 2 weeks	18.2%	18.3%	18.2%	20.1%	21.0%	19.4%
Diarrhea prevalence among children < 5 in previous 2 weeks	22.2%	24.2%	20.8%	22.5%	22.6%	22.4%
Prevalence of stunting among children < 5	49.3%	69.5%	35.7%	49.8%	65.9%	36.2%
Anemia in children 6-59 months	39.7%	41.9%	38.2%	47.7%	49.5%	46.3%
Underweight (weight for age)	22.7%	30.4%	17.5%	13.1%	16.8%	10.1%
Acute malnutrition	1.6%	1.7%	1.6%	1.4%	1.3%	1.5%

Statistics generated by the 2008-09 National Maternal and Child Health Survey or ENSMI (Spanish acronym) show some progress when compared with the previous survey carried out in 2002 (Table 1). These data also demonstrate significant gaps in some indicators when comparing indigenous and non-indigenous population groups.

These ENSMI data show that in the area of **Family Planning and Reproductive Health**, modern contraceptive use among women in union aged 15-49 years (women of childbearing age, WRA) increased from a prevalence of 34% in 2002 to 44% in 2008/9. Among indigenous women, contraceptive use increased substantially, from 24% to 40%; however there was still a significant gap between indigenous and non-indigenous women in modern method use in 2008-09, with 28% of indigenous women compared to 54% of non-indigenous women using modern contraceptives. This gap is also reflected in the 2008-09 unmet need for family planning among

indigenous women (29.6%) that is nearly double that of non-indigenous women (15.1%). Patterns of use of contraceptive method type also differ between indigenous and non-indigenous women, which likely signal differing cultural attitudes as well as variable access to family planning services. For instance, while female sterilization is the leading method for all women at 18.9%, (of which 25 % are non-indigenous) only 8.9% of indigenous women use this method, behind Depo-Medroxy Progesteron Acetate (Depo-Provera® or DMPA) at 14.4 % use and natural methods (rhythm and withdrawal) at 11 % use among indigenous women in union. Implant use is very low, about less than 1.1% overall. For all women IUD use is low and has been declining from 2.6 % in 1995 to 1.3% in 2008-09. Clearly there is work to be done to improve the acceptability and access to information about all methods including long acting and permanent methods, particularly among indigenous women, indicating the importance of a continued focus on family planning in Guatemala

The Ministry of Health is the major provider of family planning methods at 45% of all FP methods sourced in the public sector , followed by APROFAM (Guatemala's IPPF affiliate) at 14.1% , 12.3% provided through pharmacies, communes and communities and the Guatemalan Social Security Institute (IGSS) at 1.9%, despite covering some 14% percent of the population.

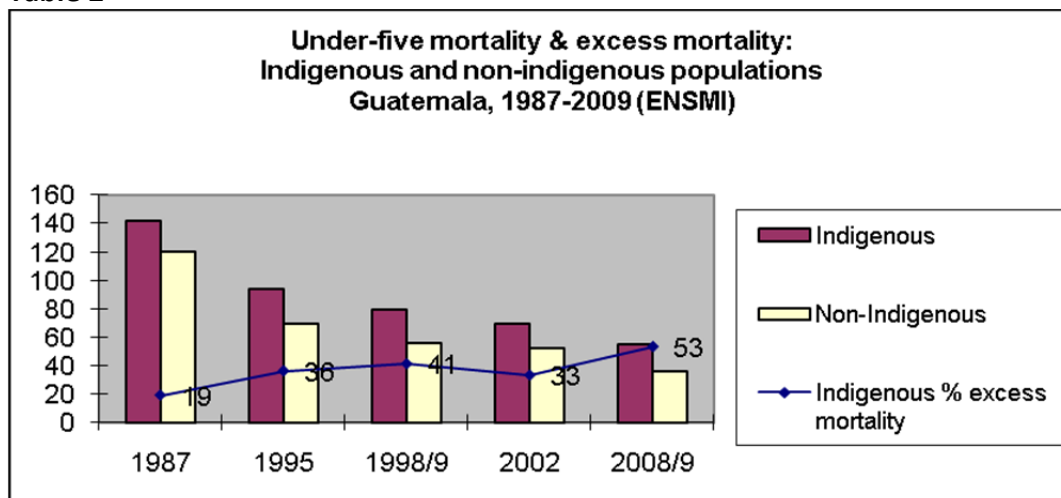
In the area of **Maternal Health**, attendance of births by skilled personnel increased from 42.1% to 51.2% between the 2002 and the 2008-09 surveys. However, delivery care by institutional personnel shows an important gap - 70% of births by non-indigenous women are attended by doctors and/or nurses, compared with only 29% of births by indigenous women. This gap is reflected in the maternal mortality ratio (MMR), the number of maternal deaths per 100,000 live births. Guatemala's MMR was 139.4/100,000 in 2007: 211/100,000 among indigenous women compared to 70/100,000 among non-indigenous women.³ Most maternal deaths result from complications during childbirth and the first 24 hours thereafter, with hemorrhage and obstructed labor accounting for the most common causes of maternal deaths. Iron deficiency and maternal malnutrition contribute to maternal mortality and are more prevalent among indigenous women.

In the area of **Child Health**, under-five, infant and neonatal mortality have all decreased from the rates identified in the 2002 ENSMI survey. However, at 34 infant deaths per 1,000 live births, of which 18 deaths per 1000 live births occur within the neonatal period, Guatemala still has the highest infant mortality rate of any Central American country. While the declines in neonatal, infant, and under-five mortality have included both indigenous and non-indigenous children, the rates of death show that the gaps between indigenous and non-indigenous populations are widening. At 40/1,000 live births, indigenous infant mortality is one-third greater than non-indigenous, and at 55/1,000, indigenous under-five mortality is more than 50% greater than mortality among non-indigenous children (Figure 1). According to the

³ SEGEPLAN 2006: "*Hacia el Cumplimiento de los Objetivos de Desarrollo del Milenio en Guatemala [Fulfilling the Millennium Development Goals in Guatemala]*." Final report to be officially released in May, 2011.

Ministry of Health and Social Welfare (MSPAS), the most frequent causes of post-neonatal and child death are acute respiratory infections and diarrheal illnesses, with malnutrition as the underlying cause in at least half of cases. Since the prevalence of diarrhea and respiratory infection, documented by the ENSMI are (and have been in previous surveys) essentially the same in indigenous and non-indigenous children, the disproportionately higher rates of mortality among indigenous children appear to reflect both the higher prevalence of malnutrition and lower access to services among indigenous children.

Table 2



Note: excess mortality refers to the number of deaths above the number expected by survey data for the population as a whole. In post-disaster situations, excess mortality are those deaths that can be attributed to the disaster.

The ENSMI data (Table 2) show the rate of under-five mortality to be significantly associated with shorter birth intervals: in the 2008-09 survey, under-five mortality was 71/1,000 for births with intervals of less than two years, compared to a rate of 30/1,000 for intervals greater than three years, indicating the important impact of a strengthened family planning on child health.

In the area of **Nutrition**, the 2008-09 ENSMI found overall half of Guatemalan children under age five are stunted and this rate rises to an alarming level of two-thirds among indigenous children. This overall prevalence is essentially the same as that documented by the ENSMI in 1995 (49.7%), while 2008-09 stunting rates are higher among indigenous children (65.9%) than in the preceding survey (2002), particularly in some departments where activities under the BEST action plan will focus (e.g. Totonicapan - 82%; Quiche - 72%). Although progress has been made during the past decade in improved weight for age levels (underweight), the current declines will not overcome the huge burden of stunting for two decades, as evidenced by reviews⁴ conducted of the DHS surveys and the National School Height Census, indicating the need for more focused targeting of interventions and effective action by multiple sectors from the policy level to the operational and household levels. In the area of maternal nutrition,

⁴ Delgado, H. *Bases para el Mejoramiento de la Situación de Desnutrición Crónica en Guatemala, 2011* and *Situación y Tendencias de la Desnutrición Crónica en Guatemala, 2010*.

almost one-third of mothers on a national level and almost half (48.3%) of indigenous women fall below the critical height of 145 centimeters, which is related to obstetric complications, and reflects the need for improved nutrition in childhood for girls as well as women.

Anemia is worsening in both reproductive age women and young children: the 2008-09 ENSMI survey found 29% of pregnant women and 47.7% of children under five are anemic – both these levels represent substantial increases over 2002 levels when they were 22.1% and 39.7 respectively. Anemia among indigenous women and children living in rural communities is the result of a combination of factors including: high prevalence of soil transmitted helminthes that remain as a widespread and neglected public health concern, lack of access to iron-rich food, limited consumption of iron fortified food, and poor coverage and quality of supplementation programs. USAID will implement evidence base interventions such as fortification at the household level of food staples with micronutrients in the form of sprinkles, supplementation with iron to pregnant women and children according to national and international standards, systematic deworming, and hygiene and eating behavior change.

The Health System

Limited resources, infrastructure, personnel, and supply levels pose profound challenges within the health care delivery system, especially for the more remote, rural Mayan areas. These challenges in large part reflect government underfunding: despite its relatively high per capita income, Guatemala provides only about 1% of its GDP for health care expenditures, the lowest level in Central America. Revenue collections from taxes are low, in part because the general population's confidence in the government's ability to solve problems is low, and the government has not aggressively pursued measures to increase tax revenues.

Guatemala's healthcare system has three components: public, private, and social security. Traditional medicine is practiced but not in coordination with the other three components of the system. The public system is run by the Ministry of Health (MSPAS), consisting of the central level, departmental health areas (DAS), and municipal health districts (DMS). The MSPAS system is in the process of decentralization but with limited coordination among levels of care and across facilities, as well as weak referral mechanisms. In most rural areas, services for the underserved, vulnerable populations are offered largely through the public sector. The Guatemalan Social Security Institute (IGSS), with a network of 24⁵ hospitals around the country provides health care to approximately 17.4%⁶ of the population, who are affiliated with the formal sector workforce. Another 8.1% of the population use private sector health facilities, 2.5 % military facilities and 4% covered by non-governmental organizations.

A critical component of public sector services in rural areas is the MSPAS's Extension of Coverage Program (PEC) covering over 4 million people in 22 departments. This program was

⁵ http://www.igssgt.org/subgerencias/Informe_Anual_Labores_2009.pdf

⁶ *Ibid.*, pg. 37

initiated, following the signing of the Peace Accords in 1996, to provide basic health services to the rural, largely indigenous populations that lacked such services. The PEC provides monthly services from an itinerant health team that includes health and nutrition education, growth monitoring, and family planning (counseling, services, and referrals) by mobile teams of educators. A cadre of community health workers, typically a “community facilitator”, a “mother-educator” and a traditional birth attendant (*comadrona*), in each community receives a small stipend and limited training to assist with education and promotion efforts. The MSPAS implements PEC through agreements with NGOs at a cost of \$8-\$9 per capita. Initially supported by funds from the Inter-American Development Bank and other donors including USAID, the funding for basic PEC services has become the responsibility of the MSPAS with limited support from donors. As a result, the program is subject to national budget limitations and fluctuations and deficiencies in drug and commodity procurement and logistics, as reflected in the recent failures by the MSPAS to pay PEC NGOs for their services resulting in stock-outs of vitamin A and pentavalent vaccine. As a partial response, a World Bank loan is being used to provide a \$4 per capita plus-up to the amount from the MSPAS to NGOs providing PEC services in a few areas of the country. This World Bank program ends in late 2011 and is not expected to be continued.

Originally designed to be a stop-gap measure of itinerant services until health care facilities could be constructed and staffed in all rural communities, 15 years after its creation the PEC is still only providing healthcare for the majority of its communities once a month (barring transportation or funding interruptions), rather than access to even modest facility-based services on an ongoing basis. This is in sharp contrast with other Central American countries, which have progressively extended institutional services to the majority of their rural populations. As a result, 95% of low-income populations and 91% of the indigenous population in Guatemala still must travel over an hour to reach a health facility.⁷ Furthermore, despite the fact that the PEC has expanded the geographic coverage of its mobile health, nutrition and family planning services over the years, in 2009 an estimated 14% of the Guatemalans still did not have even this level of access.⁸

Difficult geographic access is not the only reason that indigenous populations are underserved by the Guatemalan health system. Many indigenous people do not seek out western, bio-medical health services because they are seen as culturally inappropriate and socially unwelcoming, preferring traditional medicine practitioners including local, untrained midwives (*comadronas*). Quality of care – both technical and client-perceived (including the lack of respect for cultural practices, particularly in maternal, family planning and child health and nutrition) – is an issue in health care services, both in fixed facilities and the mobile outreach units. Several model experiences in Guatemala have demonstrated that improving quality of

⁷ Gagnolati and Marini. *Health and Poverty in Guatemala. Policy Research Working Paper No. 2966*, LAC Region, World Bank, Washington, D.C., 2003.

⁸ World Bank, *Expanding Opportunities for Vulnerable Groups Project*, 2009; project appraisal document on proposed loan.

services and increasing their cultural accessibility have a positive effect on the use of services by indigenous populations. Lessons from these experiences will be applied to the new approaches under BEST.

In 2009, the Guatemalan government instituted a conditional cash transfer program (“*Mi Familia Progresada*,” or MIFAPRO) aimed at linking use of health and education services to receipt of cash and food supplements. This program targets much of the same vulnerable population targeted by the PEC program and other MSPAS public health services; however, because of funding limitations, it does not cover all eligible families in targeted communities. The continuity of this program is somewhat dependent on which political party takes control of the GOG after 2011 presidential elections; however, USAID will seek to coordinate and collaborate with MIFAPRO in the focus municipalities of the GHI and FTF strategies.

The MSPAS recently (April 2011) unveiled a new health system concept, the Integrated Health Care Model (MAIS for its initials in Spanish), that may change the way that public sector services are provided throughout the country and particularly in semi-rural and rural communities where USAID will be working over the next five years. Details of how the MAIS will be operationalized are lacking; however one of the central concepts is that it will be up to local departmental and municipal governments and the local health area authorities (Dirección de Área de Salud – DAS) to ensure that they have an adequate, integrated structure and system serving all of their communities – the principle of “territoriality”. It is unclear what the impact of this new model will be on the PEC but there is general consensus that the program will eventually be phased out in favor of fixed facilities with full time health staff. As it has been described, the MAIS fits well with the approach that USAID will be taking to strengthen services in the Western Highlands, namely supporting community and local government engagement in improving health and nutrition outcomes as well as assisting Health Area Directorates in their planning, programming, commodity distribution, supervision and reporting roles. However, as there are no details on how the new model will operate, the assumption is the model will include a community-based component; otherwise, the MOH decision could jeopardize the implementation of vital interventions where community participation is a key element to achieve planned results.

Goals and Objectives of USAID Programs

As a designated Global Health Initiative (GHI) Plus country, Guatemala’s **GHI strategy** was submitted and approved in Washington in January 2011, with the following three focus objectives for the 2011-2015 strategy period : 1) Improve access to and quality of health services in Guatemala with an emphasis on rural, indigenous and other vulnerable populations to reduce inequitable health outcomes¹; 2) Prevent chronic malnutrition for children under two years of age with a focus on rural and indigenous populations; and 3) Strengthen the collection and use of information for action at all levels of the health system. Guatemala is also a priority country for the US government’s Global Hunger and Food Security Initiative, also known as **Feed the Future (FTF)**, which is focusing efforts and resources to increase food security and

reduce chronic malnutrition rates among rural, indigenous populations in five departments of the Western Highlands under the FTF Multiyear Strategy (2011-2015), approved in Washington in April 2011. USAID's health and nutrition program, as well as the Food for Peace Title II program, are responsible for implementation of activities under FTF to address chronic malnutrition as the complement to the agriculture activities that address food insecurity and poverty, demonstrating a close and synergetic relationship between GHI and FTF. In order to provide an integrated package of basic health services to the target FTF communities, the majority of USAID's maternal and child health and family planning resources will also be programmed according to this geographic focus. Additionally, maternal and child health activities will be implemented in one other high-need department, Alta Vera Paz, where maternal and neonatal mortality rates are among the highest in the country and where current USAID support to improve the quality of obstetric care has shown promising results

USAID/Guatemala is finalizing a new five-year Mission-wide strategy, the Country Support and Cooperation Strategy (CDCS), for the period 2012-2016. In recognition of the coinciding objectives of the GHI and FTF strategies, the CDCS is designed to concentrate the majority of resources from all Mission programs - economic growth, democracy and governance, health, nutrition and education – in the Western Highlands region of the country with the purpose of achieving greater economic and social development impact in the targeted rural Mayan communities through cross-sectoral program integration. In addition to the integrated development efforts in the Western Highlands, the CDCS targets a smaller amount of resources to improve transparency and institutional capacity of the Guatemalan government to better respond to the needs of its citizens, a development objective to which health and nutrition funds will contribute for the purpose of strengthening Ministry of Health systems and policies. The goals and objectives of the Guatemala BEST action plan are responsive to these three strategies, GHI, FTF and the CDCS, all of which have been developed in consultative discussions with the Guatemalan government and other key stakeholders.

Guatemala's Millennium Development Goals (MDG) target for maternal health aims to decrease the MMR from the present 139.4 maternal deaths/100,000 live births to 55/100,000 live births and to increase skilled attendance at birth from the present 51% nation-wide to 60% and from 30% among indigenous women to 45%. GHI targets, reflecting a sub-national geographic focus, aim to decrease the MMR from 139.4 maternal deaths/100,000 live births to 100/100,000 and increase skilled attendance at birth among indigenous women from 30% to 50%. The MDG, to which GHI will contribute, are to reduce under-five mortality from the present level of 42/1,000 live births to 37/1,000 and to reduce infant mortality from the present 34/1,000 to 24/1,000. In family planning, the GHI goal is to raise the contraceptive prevalence rate (CPR) from the present 54% to 64% nation-wide and among indigenous populations, from 40% to 55%. The GHI strategy goal for nutrition coincides with the FTF strategy goal to contribute to a reduction of national chronic malnutrition levels among children less than five years from the current 49.8% to 43.52% and, specifically among indigenous children in the targeted Western Highland region, from the present level of 63.3% to 52.0% by 2016. The MDG goal for Guatemala is to reduce the number of underweight children for the country as a whole to 29% by 2015. FTF, BEST and GHI are contributing to

Guatemala achieving this MDG by focusing and concentrating efforts on chronic malnutrition in rural areas of the country that are most affected.

Relationship of USAID investments to National Priorities and Plans

The Government of Guatemala (GOG) lacks a long term strategic plan for health that transcends political changes from one administration to the next. However, when it took office in 2008, the current government launched a multi-sector strategy to reduce inequality and extreme poverty, aimed at providing integrated support to extremely poor families, particularly in rural areas. The aforementioned conditional cash transfer program (*MIFAPRO*) is at the core of the strategy. Its objectives are to ensure (through conditionality): that poor households send children to school; that they obtain health care by trained providers; and that they increase their consumption of nutritious foods. Its stated objective is to promote investment in education, health and nutrition by Guatemalan families who live in extreme poverty who are obliged as their part of the conditionality to take their children to health facilities for regular check-ups and enroll them in public school. This demand-side program has been scaled up very rapidly to 307 of Guatemala's 333 municipalities, benefitting over 917,330 families.⁹ However, the program has aggravated the mismatch between increased demand for services and inadequate attention to the supply-side issues of access, quality, and cultural adequacy of health and education services, due largely to severe budget constraints as well as a lack of consistency in operational approaches.

The Ministry of Health of the current government prepared, in 2008, a National Health Plan for its period in office which laid out its priorities as: 1) improve governance and leadership; 2) increase institutional capacity, including stronger attention paid to "*interculturalidad*" (sensitivity to specific cultural and linguistic needs and values); 3) reduce maternal, infant and child mortality; 4) reduce chronic malnutrition; 5) improve information systems; and 6) increase the percentage of national GDP spent on the healthcare system.

Goals of the FP/MNCH/N Program in BEST

The GHI strategy for Guatemala encompasses all USG-supported health, population and nutrition activities in a whole-of-government effort to support national health priorities and requires close coordination among USAID, CDC, the DOD, USDA and the Peace Corps. The BEST action plan covers the family planning, maternal, neonatal and child health and nutrition (FP/MNCH/N) activities USAID is programming for the period 2011-2015. Under the BEST action plan, USAID will build upon its close partnership with the Ministry of Health (MSPAS), other donors, the private (for profit) sector, local civil society groups (, and community-based advocacy groups), as well as U.S.- based partners, to support improvements in the Guatemalan health system as part of four major goals:

⁹ Official data on the MIFAPRO website as of 25 April 2011.
<http://www.mifamiliaprogresas.gob.gt/joomla/cobertura.html>

Expand access to and use of health care and nutrition services by populations most in need, supporting Guatemala's national priorities and progress toward MDG's through:

Increasing adoption of improved health practices;

Increasing the availability and sustainability of quality health and nutrition services in health facility and community-based programs that includes changes to improve patients' perception of service quality; and

Supporting efforts for more transparent and efficient government management of public resources and service delivery.

Barriers to achieving goals

USAID's programs in Guatemala face a number of significant barriers that need to be overcome for accelerated progress in maternal and child health, family planning and reproductive health, and nutrition. Some are within the capacity of the USAID program to address and will be prioritized:

Coordination. One of these relates to the previous poor coordination among USG agencies and programs that have different modes of programming for MCH and nutrition interventions, preventing synergies that could have resulted from consultation and coordination. Major USG investments in Guatemala include USAID's MCH, nutrition and family planning programs funded through USAID's Global Health Child Survival (GHCS) funds; a large Food for Peace (FFP) program using food assistance and monetization of those foods to support nutrition and health programming; USDA programs that target improved food security and school feeding; and several CDC-funded activities to strengthen surveillance systems for nutrition, maternal mortality and selected infectious diseases, including support for improved laboratory services and a number of small health studies. To date these programs have operated with little coordination, in different geographic areas, with approaches that are at times inconsistent with each other and without taking advantage of lessons that can be learned from cross-fertilization of experience.

- *Response:* Recent in-country consultations among FFP, USDA, and USAID's MCH/FP/nutrition teams produced agreement to re-focus all three programs on five high-need regional departments in the Western Highlands, populated primarily by indigenous Maya, and to develop common or complementary coordinated programming approaches. Additionally, efforts have begun to create closer ties between the Peace Corps programs in family health education and youth development and USAID's health and nutrition program, with new volunteers being placed in this same region of the country and coordination of volunteer training activities.

- The GHI strategy development team brought together representatives from all USG agencies to harmonize approaches and increase the sharing of information and lessons learned among USG agencies and with GOG programs. CDC activities in maternal health and nutrition surveillance will be well-integrated with interventions under BEST.

In the past, this same lack of coordination of technical assistance and program support has existed among the programs and technical approaches of various donors and UN organizations. The lack of national plans for health to prioritize investments and interventions have resulted in duplication and uncoordinated donor support, leading to less than optimal progress and inconsistent inputs at the operational level.

- *Response:* During the past year, USAID and other donors have strengthened mechanisms for coordination among themselves through regular donor coordination round tables, specific topic sub-committees and regular meetings with the government. Although the level of coordination is still not optimal, communication and transparency have increased. USAID will continue to press for greater coordination among the donors through a common platform with key agreed upon “asks” of the government in health and nutrition, to be negotiated with all the major political parties in this year’s presidential elections. USAID and partners will also plan technical fora on evidence-based programmatic approaches to establish consensus with government and partners regarding strategies for confronting key health and nutrition challenges.

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Quality of health care. Overall, assessments of Guatemala’s health services at all levels have identified variable and often low technical quality of those services. In addition, for the indigenous population, low “perceived quality” of services, neither offered in indigenous languages nor with culturally adapted approaches, represents a substantial barrier to utilization.

Response: USAID-supported activities over the next five years will contribute to addressing quality of health care in MSPAS facilities in six departments of Guatemala by improving the delivery of family planning services, particularly for long-acting and permanent methods (LAPM); obstetric services, particularly infection control, active management of third stage of labor, and resuscitation and warming of new-borns; and pediatric services, particularly improved management of diarrhea and pneumonia. Additionally, and perhaps most important for increasing use by indigenous families, the USAID program will support citizen advocacy and monitoring groups to work with health facilities to continue to address cultural, linguistic and social barriers that have traditionally made public sector health facilities unfriendly the indigenous poor.

Transportation and hospitalization costs. A significant proportion of the rural population live in isolated, mountainous areas where, even if they are visited once a month by the itinerant PEC teams, they have difficulty accessing health facilities when they need them because of limited public transport and accessible roads; where transport to clinical services exists, its cost

– along with the substantial costs associated with having a family member die in hospital – are also significant barriers.

Response: USAID is exploring with the MSPAS, in collaboration with other donors such as UNICEF and Sweden working in the same Western Highlands departments, the piloting of a conditional cash transfer program for pregnant women in poor rural communities where the condition on receiving the extra cash is attendance at regular antenatal check-ups and giving birth at a facility. The long-term sustainability of such an initiative would depend, however, on the GOG taking over the payments from the donors after the pilot period. USAID-supported efforts described above and in sections below on interventions would aim to improve the quality of maternal and neo-natal care at these same facilities.

Ability of the Ministry of Health (MSPAS) to provide and oversee health services for its rural population. Challenges that the MSPAS faces in establishing sustainable, quality health care in rural communities have been laid out above. The sustainability of the USAID-supported interventions over the next five years to strengthen health, family planning and nutrition services in the Western Highlands is directly dependant on the engagement of the local MSPAS structures and systems in addressing the barriers (deficiencies in commodity logistics, data gathering and reporting, technical capacity of health professionals, number and capacity of community health workers and regular monitoring and supervision) and in ownership of the solutions.

Response: A key component of all USAID activities under BEST is assisting the Health Area and Health District Directorates (DAS/DAD) to do their job better: ensure availability of contraceptives, micronutrient supplements, basic antibiotics, vaccines, clean birth kits and other essential commodities; accurate and timely reporting of health statistics to the central MSPAS level; and coordination and oversight of all facility and community services in their jurisdiction. The MSPAS has yet to lay out the operational details of the new Integrated Health Care Model (MAIS) for the country (see previous discussion under Health System) and thus the form of this USAID assistance to local health system is still to be determined.

Government of Guatemala policies and health budget. Other barriers involving Guatemala's own policies, programs, and investments are less susceptible to direct USG resolution, but will be the target of policy dialogue, part of the diplomatic agenda of the US Embassy, and will shape USAID's program approaches. The lack of a long term national vision is connected with significant politically-motivated discontinuity of programs in the health sector; each new government tends to repudiate the programs of its predecessor and start new programs and priorities.

The country's relatively successful experience with the Extension of Coverage Program (PEC), and an associated focus on reducing chronic malnutrition under the previous government (2004-200), have been given substantially lower priority by the present government. The low level and inconsistency of funding from the national budget have especially affected the

program, which relies on government funding to NGOs to provide services for vulnerable populations who otherwise have none. In the past year, NGOs failed to receive payment several times, leading to loss of personnel and breaks in service; these factors in turn have affected the quality of services under the PEC. Since nutrition and increased access to services are mutually agreed upon GHI goals with the GOG, the USG will press for more resources and attention to achieve our shared goals and to ensure country ownership.

As mentioned in the Background section of this paper, funding for health (as a proportion of GDP, and in absolute numbers) is one of the lowest in the Americas, despite Guatemala's status as a lower middle income state. The country recently passed laws that effectively require purchase of locally produced, more expensive pharmaceuticals, significantly increasing the cost of health services within what is a small and fixed funding envelope from the GOG. Also, Guatemala was recently suspended from the PAHO rotating fund for vaccines (on which the immunization program depends) because of failure to pay its accumulated debt to the fund. The USG will join forces with other bilateral and multilateral donor agencies to change laws and improve policies and regulations regarding the procurement of essential health and nutrition commodities.

Lack of program evaluation. Finally, lack of rigorous evaluation leads to the inability of government and partners to know and prove the effectiveness of major programs such as the PEC, the conditional cash transfer program, and others. This lack of evidence from evaluation also renders programs unable to defend themselves in the face of government budget cuts or decisions to discontinue programs. This was one of the factors in the planned phase-out of the World Food Program's nutrition supplement program (*Vitacereal*). The USG will address this in FTF, GHI and BEST programs through an intensified effort to evaluate the impact of interventions supported with USG resources, such as the PEC. The task, however, for the other non-USG supported programs is a much larger endeavor and beyond the scope of USG resources.

Although USAID and the USG do not control many of these factors, they will be important issues for the BEST plan to address to ensure success of planned interventions. For example, as described below in key interventions, health system improvements, cost-efficient procurement of essential health commodities, the need for an increased health budget and for national plans that outlive political cycles will be among the targets for USAID's policy dialogue and the USG political and diplomatic agenda, as well as for donor coordination. Systematic, independent evaluation will be an area of emphasis under BEST, as will replication of models of culturally adapted services proven to be successful.

Successes to build on

In the face of these obstacles, investment in population, health and nutrition programs in Guatemala has provided some important successes on which to build. As noted above, Guatemala has achieved significant progress in reducing infant and child mortality and

increasing contraceptive prevalence, as well as more limited progress in reducing maternal mortality and improvement of child undernutrition, as measured by weight-for-age.

Expanding access through to rural communities. Despite its limitation as essentially an outreach program, the PEC has been a major contributor to improvements in health outcomes. Although a rigorous impact evaluation of the PEC will not be carried out until late in 2011, limited qualitative evaluations indicate that the program is successful in delivering episodic interventions such as immunization and vitamin A. Success in interventions that require more continuous presence – such as treatment of illness, promotion of family planning, and especially reduction of stunting – has been more limited.

In response to the limitations of this outreach-based model, several initiatives are providing permanent health services in PEC communities. The NGO implementing PEC in the Department of Jalapa, for example, has used basic PEC funding plus a \$4 per capita increment (funded by a World Bank loan) to contract health personnel to provide a permanent presence for basic MCH, family planning and reproductive health and nutrition services in its communities. Separately, according to the Strategic Planning Unit of the Ministry of Health, over 50 mayors (*alcaldes*) throughout the country have used part of their government-provided social development funds (distinct from health funds) to build and staff “*unidades minimas*,” which are small health posts operating under norms established by the Ministry of Health. Under BEST, USAID will support systematic evaluations of both of these approaches for possible replication in other communities with no health facilities.

Training of Mayan nurses, nurse-midwives and community workers. USAID developed an innovative program that combines Western medicine and Mayan culture — a scholarship training program for 120 Mayan Midwives. To qualify, applicants must be Maya, be proficient in the language spoken in communities she serves, and reside near communities with high maternal mortality. They must also commit to serving as midwives for two years after completing the training. Mayan auxiliary nurses were trained during an eight-month period in basic obstetrics, after training they were hired by the MOH and returned to their communities. Another excellent experience is the one of *Cooperativa el Recuerdo*, an NGO that has developed an alternative model for PEC where an auxiliary nurse provides permanent services to around 2,000 inhabitants, working with four “community facilitators” performing duties mostly in the community. At the very grass root level “mother-educators” meet with their peers to educate them on preventive nutrition and health interventions, including exclusive breastfeeding, weaning foods, hygiene and growth monitoring and promotion. This NGO operates with the same funding levels of other NGOs associated with PEC with a plus up from the World Bank. These programs will be evaluated for possible incorporation into the new community approach of the BEST action plan

Financial sustainability of a local FP NGO. USAID has provided long-term technical, management and resource support to APROFAM, Guatemala’s IPPF affiliate and a non-government private sector provider of family planning and reproductive, maternal and child health services. This USAID support has aimed to expand coverage of these services through an

increasingly sustainable approach. In the past five years APROFAM has become entirely financially self-sufficient, providing a full range of family planning and other services, including treatment of child illness, through community-based delivery by trained providers plus clinics and centers that include provision of long-term and permanent contraceptive methods. Recently APROFAM has been contracted by both the Ministry of Health and the social security system, *Instituto Guatemalteco de Seguridad Social* (IGSS), to provide long-term and permanent contraceptive methods. Beyond its important role in service delivery, APROFAM provides a good example of the success of continuity of donor support with an eye toward organizational maturation, quality services, and sustainability.

Post-obstetric FP services. Building on the apparent success of post-partum and post-abortion FP services – including access to female sterilization, IUD and other methods that include good counseling materials at the *Centro de Atencion Integral Materno Infantil* (CAIMI) and *Centro de Atencion Permanente* (CAP) secondary health service level and at hospitals that receive technical assistance supported by USAID- the BEST program approach will seek to ensure integration of FP with post-obstetric and reproductive health services in priority departments where these services are weak at the secondary and tertiary levels. Based on experience in existing facilities, FP services will also be integrated with pediatric outpatient services to minimize missed opportunities to reach women of childbearing age. Mobile outreach will be expanded to bring long acting and permanent methods to communities that have no fixed facilities to complement the community-based distribution of short term methods. This will be coordinated with the PEC outreach services.

Renewed focus on nutrition and food security. The GOG has placed food security as a political priority, triggering renewed efforts by the international community to focus on nutrition and specifically address the country's severe chronic malnutrition problem. While the USG's Food for Peace (FFP) Title II program continues to implement a food assistance approach for the most vulnerable families, it has also used health and nutrition promotion and education activities to complement the food assistance that is the heart of that program. Over the years, Title II partners have developed educational materials on such topics as diet diversity, kitchen gardens, breastfeeding, growth monitoring, and immunization for use in low-resource and low-literacy settings in Guatemala and this experience will enrich the social and behavior change communication (SBCC) efforts under FTF and BEST to improve breastfeeding, complementary feeding practices in children 6-23 months and other community health and nutrition interventions.

Additionally, according to FFP guidance for the new cycle of Title II projects to be awarded in 2012, FP counseling, education and referral for services will be provided as part of implementing partners' programs, representing an important opportunity to expand access to FP among some of the most vulnerable communities in the Western Highlands. Title II communities will be linked with mobile FP services supported by USAID's health program to ensure that there is a ready response to the demand for family planning created by Title II partner activities.

Quality improvement. USAID has assisted the MSPAS in quality improvement of service delivery, with several foci. One has been support for the Ministry's successful efforts to receive international (ISO) certification of its administrative and financial management systems and to increase confidence in its use of resources. This approach has also been adapted to health centers, extending the general ISO requirements to include clinical service performance in accordance with national norms. One health center (San Pedro Sacatepequez) has already received ISO certification with ten others awaiting review. These efforts represent an important shift away from direct USAID support for service delivery to assisting the MSPAS to assume its responsibilities in ensuring quality of service delivery.

USAID quality improvement support has focused on institutional maternity services with documented improvement in management of labor using partographs and in prevention and management of post-partum hemorrhage, the major cause of maternal mortality.

In addition, a growing number of facilities serving indigenous populations have undertaken cultural adaptation of services, providing Mayan language speakers, allowing family members and traditional birth attendants to enter maternity services with women in labor, and allowing delivery in non-supine positions. These adjustments have been associated with increased uptake of institutional deliveries in areas where the population is virtually entirely indigenous. These innovations have now been endorsed by the MSPAS ("*interculturalidad*") as an institutional response to the demands of indigenous women.

Improved information management. USAID has supported the government in developing an integrated information software platform that brings together official data (e.g. budget, expenditures, key geographic, output and impact data on service delivery) of the Ministries of Health, Education, and Finance, as well as national census data, with a long-range goal of turning over the entire system to the GOG General Secretariat for Planning (SEGEPLAN) for wider use in planning, tracking and reporting on national resources. This "*Plataforma*" allows selection and interaction of desired data from any of these data bases, including GIS application, permitting situation and trend analysis down to the level of individual health areas, municipalities, and health centers. Ongoing work will allow the adaptation and inclusion of additional data bases and improvement of routine health service data, to allow real-time analysis for management, program improvement and policy development. The *Plataforma* is open to all users, promoting transparency. USAID's support has made this model one of the most advanced available for such data. As a result, it has been officially adopted by the GOG and exported to other countries, including El Salvador, Peru, South Sudan, and Uganda, for use by their governments.

Citizen advocacy. The design of several USAID programs have incorporated models of civil society mobilization to focus on maternal survival, HIV/AIDS, and family planning through networks and alliances of civil society organizations and public and private sector providers, reaching community, municipal, departmental, and national policy levels. Two major networks supported are the "Reproductive Health Observatories" (OSARs) and the "Network of Indigenous Women for Reproductive Health" (REDMISARs). These organizations focus on

political advocacy at the national and local levels for women's health; the OSAR has negotiated agreements with the National Guatemalan Congress to track the Executive Branch's compliance with GOG commitments to health issues. The indigenous women's groups have become institutionalized under the Office of the Ombudsman for Human Rights in Guatemala, with members having official status that permits them to enter health facilities to evaluate conditions and services using standardized instruments and to negotiate with government representatives. These women's groups have proven extremely effective in political advocacy: they played a major role in getting a line item in the national budget for public sector purchase of contraceptives. They also helped pass laws regarding the right of all women to maternity services and access to family planning. These groups have expressed willingness to expand their advocacy to child nutrition and health. Some have also taken on the characteristics of "mothers' clubs" in their communities, organizing around health promotion and education efforts; their members would likely be good candidates for the "community facilitator" positions recognized by the MSPAS health system to provide essential community health services, education, promotion and distribution of short term contraceptives.

Alliances with the business sector. Among donors, USAID is unique in its work with the commercial private sector, creating alliances with professional and business associations including those of coffee growers and sugar producers. Through these connections, USAID is providing technical support and limited operational resources that leverage private investment in health services, training of health personnel, and education and behavior change communication programs. These private sector partners have also engaged in strategic planning, including a multi-sectoral conference in 2010 on poverty reduction. They have expressed interest in expanding their work in these areas, focusing on most vulnerable populations, supporting an objective, data-based social development "watchdog" function and participating in policy dialogue and capacity building for health and nutrition at both national and local government levels.

Key Interventions

Building on the progress that has been made and keeping in mind the challenges to continued progress as described above, key interventions are laid out here for the BEST action plan in terms of priority levels (highest priority, high priority and medium priority), corresponding to different funding scenarios over the BEST action plan period. USAID will **focus geographically**, implementing the majority of FP/MNCH/N program interventions in the five highest-need, almost exclusively indigenous, departments already identified as focus areas for Feed the Future and one other, contiguous, department with high maternal and neonatal mortality rates. With limited resources, USAID's best chance to contribute to national impact is to concentrate its resources and support achievement of impact in these underserved parts of the country.

The proposed community nutrition and health care approach

At the heart of USAID's health, nutrition and family planning program under the BEST action plan is a new community nutrition and health care (CNHC) activity to be implemented throughout the five targeted departments of the Western Highlands, in conjunction with the areas where the FTF agricultural production and income generation activities will be implemented. Together, the CNHC activity and the new rural value chain program (RVCP) from the economic growth sector, supported by the local governance program from the democracy and governance sector will be responsible for achieving USAID/Guatemala's goals of reducing poverty, food insecurity, chronic malnutrition and poor health status in 50-60 municipalities of the Western Highlands. The number of communities to be served by this new nutrition and health care activity will depend on the level of resources received over the five-year period. While resources will largely be channeled through NGO partners (international and local) working in the communities, this new activity has been discussed with the MSPAS and will be carried out in close coordination with the Health Area Directorates and Health District Directorates in the target departments in support of whatever model for health care that the MSPAS has in place. (This will initially be the PEC which may later transition to the newly proposed Integrated Health Care Model – see the discussion above of The Health System.) The CNHC activity will be complemented by efforts of other USAID partners working in the same target departments in a) community and facility based family planning and reproductive health services; b) quality improvement of maternal, neonatal and child health in MOH facilities; c) citizen advocacy and monitoring; and d) engaging the private sector (corporate, universities, professional organizations) in improving and expanding health and nutrition services and products.

Based on the twin principles of a) engaging individuals, families and communities in taking action to improve their nutrition and health status and b) ensuring that an integrated package of basic maternal, neonatal and child health, family planning and nutrition services is readily available, the approach relies heavily on the mobilization efforts of community leaders, associations and community health workers (CHW), referred to typically as "community facilitators" and "mother-educators". These CHW are part of the MSPAS rural health model, whether through health posts and health centers or through the PEC outreach services. Title II implementing partners and other NGOs also typically have a similar cadre of CHW, sometimes supplemented with nurse auxiliaries and health educators. The CNHC activity will increase the training and supervision of CHW in the selected communities for improved implementation of the community-based interventions outlined below. Planning, supervision and reporting of CNHC activities will be carried out with the local health authorities and municipal governments to foster GOG ownership of the program and ensure its survival. The CNHC activity will also provide assistance to the Health Area and Health District Directorates to improve logistics management for contraceptives, micronutrients, vaccines and other essential drugs necessary for community services and reporting health and nutrition data up to the MSPAS central level.

Family Planning

Highest Priority:

Ensure an expanded method mix and continuous supply of contraceptives in BEST communities and

Improve the quality of services to indigenous communities through culturally sensitive approaches, appropriate materials, and behavior change communication specifically designed to enable understanding of the service, promote male participation, and engender confidence in providers and increase method use.

Rationale: While the PEC program has extended access to basic family planning methods, (combined oral pills, condoms and DMPA), behavior change communication (BCC), counseling and demand side activities in rural indigenous highland communities are weak and limited methods are only available once a month. Indigenous communities currently have very limited access to long acting and permanent methods. These limitations in counseling, education, and supply have resulted in missed opportunities to address cultural barriers to FP acceptance and to address myths, misperceptions and rumors with technically sound information, communicated in appropriate ways to non-Spanish speakers. A wider method mix needs to be included in counseling and education at the community level. Better counseling is needed to promote child spacing and longer birth intervals that result in healthier, better nourished children. Counselors need to provide BCC and materials that are comprehensible to indigenous women that speak one of 23 Mayan languages and are designed for low literacy populations with very little education. Comprehensive and balanced education and counseling on all of the methods including the lactation amenorrhea method (LAM), the Standards Day method, as well as long-acting and permanent methods (LAPMs) will ensure greater uptake of services.

Maternal Health

Highest Priority

Intensive, culturally appropriate community organization and behavior change activities to promote birth planning, recognition of complications, timely care-seeking, and avoidance of harmful practices by traditional birth attendants and

Enhanced promotion of iron/folic acid supplementation through community action and health services, including provision of supplements through community providers and antenatal care with assurance of supply (avoidance of stock-outs)

Join efforts with MSPAS to train an additional number of Mayan nurses and nurse mid-wives and create a more enabling environment for them to operate in the rural communities.

High Priority

Removal of cost and logistic barriers to care-seeking

Expand the successful quality improvement experience with Active Management of the Third Stage of Labor and use of the partograph to all birthing centers in USAID-supported program areas and

Improve the quality of facility obstetric care, including evaluation and expansion of successful, culturally adapted models

Rationale: The planned focus of GHI, FTF and BEST on the indigenous highlands is appropriate for maternal survival program efforts, since the 2007 maternal mortality (RAMOS) survey confirmed that 70 per cent of maternal deaths occurred among indigenous women even though they make up half or less of the population of women of reproductive age. The major cause of maternal death was identified as hemorrhage (42%), followed by hypertensive disorders (18%) and infection (16%). The high (increased from 2002) prevalence of anemia among pregnant women (29%; 32% among indigenous women [ENMSI, 2008-09]) contributes to risk of death during and after childbirth, especially from hemorrhage. Almost half of deaths detected by the RAMOS survey occurred at home (46%) or in transit to a health facility (6%); a recent USAID/HCI-supported study¹⁰ of deaths occurring in Huehuetenango Department from January to July 2010 found that 80% of delays associated with maternal death were delays in recognition of danger signs and seeking care.

Neonatal Health

Highest Priority

Expand support for essential newborn care (warmth, safe delivery, recognition of danger signs, and need for referrals, immediate and exclusive breastfeeding) at all levels of the health system through community mobilization and training

Ensure that certified birth attendants (“comadronas”) are trained in safe delivery, warmth, infection prevention, management of asphyxia, have access to clean birthing kits, and follow-up postnatal care within 24 hours and three days of birth and

Scale up the Helping Babies Breathe (HBB) Initiative in the USG geographic areas of emphasis, with both community and facility interventions for newborn resuscitation

High Priority

Improve quality of care at the facility level for neonatal services, including resuscitation as a standard component of basic emergency and obstetric care

Expand newborn infection management at all levels of care and

¹⁰ Jarquin, D. *Evaluación del Sistema de Vigilancia de la Mortalidad Materna e Implementación de casos con la Metodología de Eslabones Críticos en Guatemala*. August 2010

Kangaroo mother care for low birth weight infants

Rationale: Although post-neonatal and child mortality make up a larger fraction of under-five mortality among indigenous (62%) vs. non-indigenous groups (55%), neonatal mortality is the largest single share of under-five mortality - and over half of infant mortality - in both groups. Therefore, reducing neonatal deaths will be an important focus of USAID's program. The 2008-09 ENSMI survey indicates that 70% of births among the indigenous population occur at home, although improved access to and perceived and real quality of institutional care are expected to increase deliveries in facilities somewhat (the biggest barrier to institutional births being cost and lack of transport.) Thus, a substantial part of newborn care efforts will come through USAID's support for community organization and action, such as promoting institutional births, ensuring that family emergency action planning is in fact carried out, and increasing knowledge and skill levels of *comadronas* in home births. Interventions to address the cost of transportation to facilities include encouraging the MSPAS to consider transportation vouchers for institutional births.

Facility births, however, do not assure newborn survival: recent USAID-supported studies in highland hospitals indicate that the major cause of newborn death in those facilities is asphyxia, indicating significant problems with quality of obstetric and newborn care. In facilities, the priority will be to improve the quality of obstetric care, especially monitoring of birth to reduce asphyxia and introducing newborn resuscitation.

Child Health

Highest Priority:

*Improve capacity of community health agents to provide counseling to mothers and other caretakers to prevent and manage diarrhea, acute respiratory infections
In facilities and, for the PEC teams at the community level, assess and strengthen the quality of health workers' ability to diagnose and correctly manage these illnesses.*

High Priority:

Expand community management of childhood diarrhea, pneumonia, and malnutrition during bouts of illness through training and behavior change communication using trained personnel and culturally sensitive approaches and materials.

Rationale: The services provided under the Extension of Coverage Program (PEC) are generally adequate to deliver episodic child health interventions including immunization and vitamin A (stock-outs of these will be addressed as financing and logistic issues). This program, however, does not provide care for child illness. The government identifies the major causes of post-neonatal and child illness and mortality to be **diarrhea** and **pneumonia**. Expanding community management of child diarrhea and pneumonia, including emphasis on nutritional management during and after illness, will reduce the morbidity and mortality associated with these two childhood diseases.

Nutrition

The focus of the USAID nutrition program will be the management of chronic malnutrition.

Highest Priority:

Behavior change communication to improve immediate and exclusive breastfeeding in the first six months of life and timely introduction of adequate and appropriate complementary feeding for children 6-23 months and

Improve growth monitoring/promotion and follow-up counseling of mothers and caretakers for infants and young children with growth faltering

High Priority:

Improve capacity of community health workers (“facilitador comunitario”) to prevent and manage diarrhea, acute respiratory infections and provide nutrition counseling to mothers and other caretakers,

Improve GOG capacity to ensure that micronutrient supplements are present in all communities for distribution to women and children

Link with USAID’s agricultural program to provide assistance in kitchen gardens and small animal husbandry for diet diversification and improvement, and

Provide technical assistance and an enabling environment (through incentives) to local municipal governments to comply with their responsibility to provide potable water to communities

Medium Priority

Join efforts with the private sector to fortify staple foods with micronutrients and

Management of severe acute malnutrition following national and international standards

Rationale: Malnutrition is one of the greatest health and development challenges in Guatemala. Because of recent food shortages in the country, there has been a high level of press and political attention paid to *acute* malnutrition or wasting. However, despite the high risk of mortality associated with wasting, it only affects 1% of children (ENSMI 2008-09). On the other hand, *chronic* malnutrition or stunting affects almost half of children under age 5, or approximately 1.5 million children, and the prevalence is even higher among indigenous children. It is one of the major contributors to mortality among children, as well as an irreversible individual and national loss of intellectual, physical and productive potential.

The USG’s FTF and GHI strategies have made reduction of chronic malnutrition a shared priority and have set an extremely ambitious goal – a reduction from 66% to 35% among indigenous

children. Since the 1987 ENSMI, the prevalence in that population has declined by only 6 percentage points making this the most urgent, critical health need impeding development and health progress in the country. To achieve this ambitious goal, all relevant USG resources in Guatemala – including health, Title II, agriculture, economic development, education, and governance – will need to maximize their impact on nutrition and leverage other resources through coherent, coordinated programming.

In addition, micronutrient malnutrition is highly prevalent. Although many rural families have the potential of growing vitamin A rich foods, the diet generally fed to children is deficient in vitamin A and twice-yearly supplementation is part of the core package of PEC interventions. However, poor planning and logistics results in frequent stock-outs of vitamin A. The high prevalence of iron deficiency in both women and children makes this another critical target for health and nutrition programming under BEST.

Health Systems Strengthening

Highest Priority:

Policy dialogue with other donors and the government on increasing the GOG budget for health and

Advocacy with GOG policy makers and assistance in developing a national health plan that is used to align USG and other donor programs and that is used to prioritize chronic malnutrition as an intervention among the highest need, indigenous populations
Advocacy with GOG to reformulate laws that currently require local procurement of drugs and other health commodities in favor of more cost-efficient international procurement

High Priority:

Strengthen supply chain management to reduce stock-outs and expand the availability of drugs and pharmaceuticals, particularly in the local Health Area Directorates that service target departments

Build on public/private alliances to expand the resource base for health care and the quality of services provided in Western Highlands

Advocacy for timely and continued GOG financial support for NGOs to provide services in underserved areas, improving performance based financing (in the case that the MSPAS continues with the current form of the Extension of Coverage Program)

Provide assistance to maintain the quality and consistency of data generated by the “Plataforma” (housed in the Ministry of Education but providing real time data for several ministries) and expand access to and use of the data and

Work with USAID's other development sectors (democracy and governance, economic growth) to strengthen local municipal government officials' and town mayors' leadership and governance skills in support of improved health and nutrition

Rationale:

The GOG's investment in health is one of the lowest in the region at just 1.1% of GDP. The USG will engage policy makers in a dialogue to ensure consistency and continuity of increased budget resources. The USG will work at all levels including civil society to mobilize for advocacy and action (expanding the OSAR and REDMISAR activities -and newly formed men's groups) in support of reproductive health, family planning and maternal and neonatal health as well as increased government resources addressing chronic malnutrition. Private sector partners will be mobilized to support this effort. For example, USAID coordinate with private foundations and think tanks to advocate for increased government investments in health and a longer term development vision that includes investing in the health of Guatemala's human capital. Other groups to get involved in advocacy will include mayors, labor unions, civil society, and universities that have organized using the MDGs attainment at the national level as an advocacy tool to increase investment and improve Guatemala's long term economic development vision.

Without a national health plan with estimated costs for highest impact interventions, donor and GOG programs are not coordinated to achieve maximum impact. As discussed in previous sections of this paper, chronic malnutrition is one of the key factors impeding development and the capacity of the population to achieve their physical and intellectual potential. The national health plan must address the staggeringly high rate of stunting among indigenous children through an intensified, coordinated effort of all parties concerned and at all levels of the systems from the household to the national policy level.

Stock-outs and lack of essential drugs in most-at-risk areas continues to plague the health logistics system. The MSPAS has the responsibility to provide commodities for an integrated basic package of services for all Guatemalans. With USAID assistance in family planning commodity logistics, the system functioned well for a period of time until it was later expanded to include all basic health commodities, causing the system to weaken and become less functional.

The Supply Chain Management Project (SCMS), with HIV funding, conducted a rapid preliminary assessment on stock outs for HIV/AIDS commodities recently and will conduct another more in-depth assessment this year that will include stock-out information for key child health, nutrition and family planning commodities. Depending on the assessment findings more support may be needed in this area as stock outs of contraceptives, particularly injectables, are reportedly in short supply in many locations.

The MOH will require some technical assistance on planning for, financing and procuring FP commodities, vaccines and other drugs and pharmaceuticals. Current laws that make local

purchase a requirement for specific health products will need to be addressed to encourage procurement of basic drugs and contraceptives through the UN or regional procurement systems for cost-efficiency sake. A high priority will be placed on efforts to make these changes, with the support of other USAID policy change efforts from the Democracy and Governance Office.

USAID has worked with the private sector project *Alianzas* to include the private sector (in the sugar, banana, coffee, banking, cement and tourism industries) in providing health care services through their social corporate responsibility foundations. These groups will not only be included in advocacy for health issues at the local level as watchdog groups to push for the attainment of the MDG goals but will also be encouraged, through the *Alianzas* project, to expand access and quality of health services through their own resources, leveraging public and donor resources to increase private sector resources.

As mentioned previously, GOG financing to meet contractual obligations to NGOs for their health care services under PEC has not been forthcoming on many occasions. In many remote areas, these are the only health care services available to the indigenous population most in need. The USG and donors will continue to press for consistent support from the GOG and will mobilize other civil society partners to participate in this effort as well.

The development of the information management software platform, the “*Plataforma*”, that provides a real time database unifying the Ministry of Finance, Ministry of Education, Ministry of Planning and Ministry of Health’s information systems and service statistics has been a major accomplishment of USAID’s support to date. All of the data can be accessed and cross-tabulated for analysis and comparison. It also includes mapping of all health and education (public, faith based and NGO) services at the municipal level through Google maps. This is housed at the Ministry of Education. More work is needed to ensure that the health data that is included is of good quality and that the platform is used for decision-making, planning, and resource allocation, as well as monitoring and evaluation.

Strengthening the leadership and governance skills of local municipal and community officials in indigenous areas is of paramount importance to achieving sustained central government attention and support for the health problems facing rural, indigenous areas. Efforts will focus on working with the community and local government through the *alcaldes* (mayors) and social development and health commissions at the municipal and community levels. Some of this work will be implemented through the Democracy and Governance office of USAID. This will help to organize and mobilize communities to participate in planning and influencing local programs and resources to address key health issues such as water, sanitation and responsive health services.

Principal Delivery Approaches

USAID/Guatemala will use a range of delivery approaches to achieve the objectives laid out in this action plan, including facility based and community-based services and services through

mobile teams. At the facility level, partners will focus on quality improvement implementation of MSPAS norms for obstetric and neonatal services, family planning services for long-acting and permanent methods, and integrated management of child illness through infection control, training and supervision of professionals, addressing cultural and linguistic appropriateness of services, improved service organization to reduce patient waiting time and improved counseling and patient education. Targeted sites for quality improvement are the first and second level facilities in the six focus departments. At the community level, the new CNHC activity, as well as the family planning partners and the civil society advocacy partner, will work together to ensure the support for community mobilization efforts and an integrated package of basic nutrition, health and FP services. While community-based distribution of short-term FP methods will be a standard component of CNHC interventions, the family planning partners will also use mobile teams to do regular “*jornadas*” or “health days” to provide long-acting methods and sexually transmitted infection and cancer screening. The delivery approaches are designed specifically to link mobile outreach to community activities and appropriate referral of patients from both mobile and community services to health facilities. Key to the establishment and maintenance of these links is the ongoing planning, coordination and supervision that USAID and its partners will undertake with the ongoing PEC program, the MSPAS local health directorates and the municipal governments responsible for ensuring basic services for their communities.

Additionally, USAID will evaluate and potentially replicate alternate service delivery models like the *unidades minimas* and the Jalapa model to provide continuous services to PEC communities that now are getting once-a-month outreach visits. The MSPAS recently unveiled a new national health delivery system called the Integrated HealthCare Model (MAIS as its initials in Spanish) which has yet to be fully fleshed out, but in essence reorganizes the public sector health network by government administrative units, down to the district level, thereby attempting to better engage local government authorities and structures in improving health care delivery. USAID will work with the MSPAS as these new structures are strengthened and made operational.

How BEST Aligns with GHI Principles

Integration: Existing Areas

Under the new USAID/Guatemala CDCS, resources from sectors across the Mission will target the same regional departments in the Western Highlands in order to realize an integrated development program addressing economic growth, food assistance, improved access to and use of health and nutrition services, improved formal and non-formal education and strengthened local government institutions and systems in the same selected municipalities. Activities under BEST will thus be integrated into a larger development agenda for each selected municipality. This approach will effectively integrate GHI activities with FTF activities in the same communities.

The current USAID health program has some successful experiences with integration that BEST can build on, both geographically and technically. For example, the Extension of Coverage Program (PEC), working through local NGOs contracted by the MSPAS to extend service delivery via monthly mobile services successfully integrates vaccination, limited FP methods, and infant growth monitoring with community educators presenting educational sessions on health and nutrition promotion. With support from USAID, APROFAM has entered into a partnership with the MSPAS to provide FP/RH services at public sector facilities, an integrated approach that has resulted in increased access to MSPAS clinical family planning services in rural areas including LAPMs, not generally available in MOH service sites. Logistics assistance for HIV/AIDS commodities is being integrated with the PEC systems for drug and contraceptive procurement and will result in overall strengthening of the MSPAS supply chain management system. Program coordination in municipalities where there is co-existence of PEC and MIFAPRO will maximize the effectiveness of counseling and service provision --this effort is in the nascent stage. The OSARs and indigenous women's and men's groups started out with the mandate for reproductive health advocacy and have now integrated other health issues into their platforms such as maternal and neonatal health and nutrition. Further integration of health and nutrition programs and integration of health and nutrition with other sectors would be enhanced by common message platforms and materials targeting behavior change at the community level.

Additional integration opportunities within the sector

Integration of USAID's own health-related programs will in large part depend upon developing a common core model of maternal/newborn/child health, nutrition, and family planning that also responds to MSPAS norms and standards. At present, Food for Peace Title II NGO interventions, USAID health program-supported NGO interventions, and the MSPAS Extension of Coverage Program take somewhat different approaches to implementing the elements of a basic package of health and nutrition services, including variation among individual implementing partners under each of these programs. Meetings among the BEST/PHN team, Food for Peace, and USDA have identified the need to harmonize and better integrate health, family planning and nutrition activities under all of these programs, and the Mission has continued to develop such a shared approach with regular meetings and cross-review of design documents. This effort will be supported by development and use of standardized indicators. In addition, the strengthened focus on community mobilization and action and the work with local government planned under BEST will integrate all focus elements of MNCH, nutrition and family planning/reproductive health as well as successful models used in the HIV/AIDS program to improve quality of care at MSPAS facilities

Rigorous Monitoring and Evaluation

Consistent with the GHI guidance, 15% of USAID's BEST budget will be allocated for research, monitoring and evaluation, both within partner agreements and through a separate mechanism contracted by the Guatemala Mission to carry out program evaluations. USAID/Guatemala will coordinate national program evaluation activities with other donors, such as the Inter-American Development Bank (IDB), and will disseminate USAID supported monitoring and evaluation findings widely in the USG and donor community and within the MSPAS as well as other health providers to create a common understanding of evidence-based approaches and models.

USAID’s health, nutrition and family planning program will not create a parallel system of indicators for BEST but rather will work with the MSPAS and the National Secretariat for Food Security and Nutrition (SESAN) to harmonize and standardize indicators for the basic package of MNCH/FP/N services, and ensure harmonization with the Food for Peace program indicators for the new round of Title II grants , adding FP and delivering a standardized package of services and information. USAID will also work with the World Bank and IDB that support PEC services through loans to the GOG to institutionalize the standardized package of services and service delivery indicators within the MSPAS, and support efforts to enhance quality of local data, and ensure a common understanding of indicator definitions.

Outcome targets

The following outcome targets for the work that USAID’s health program and FFP program will support will contribute to the results as laid out in the Guatemala GHI strategy; however, it should be noted that the USG GHI team will be reviewing the GHI strategy targets for possible adjustment to reflect the decreased geographic focus of USAID’s planned interventions over the next five years. The target numbers provided below for each outcome indicator are for expected results to be accomplished in **six departments where BEST activities will be implemented** (five focus departments of the USAID Mission strategy plus Alta Vera Paz Department.) Because other donors as well as the MSPAS will also be working in these departments to improve health care access and quality, not all results will be attributable to USAID’s efforts. The target numbers are in line with Guatemala’s MDGs and take into account vital interventions that the MOH and other donors such as the World Bank are implementing that include but are not limited to: opening of rural birth centers, training MSPAS facility and community health worker staff. The baseline 2009 figures are the averages of figures for the six departments taken from the most recent National Maternal and Child Health Survey (ENSMI 2008-09). Target figures are based on an expected percentage annual improvement for each indicator.

	2009	2015
Modern method contraceptive prevalence	43.7%	53.2%
Births attended by skilled health personnel	34.2%	43%
Infant mortality rate	38.5%	30.8
Immunization rate (DPT3)	83.8%	93.5%
Chronic malnutrition in children under five	63.3%	51%

Inclusiveness/ Whole of Government Approach and Collaboration with Other Donors

USAID will work with health and non-health partners in the USG, other donors, the private sector and civil society to harmonize and more efficiently coordinate the use of resources and approaches. A detailed list of actions is included in Appendix 1. During the development of the BEST action plan a broad array of stakeholders were consulted including multilateral and bilateral donors, municipal authorities, international development banks, public and private sector service providers and corporate partners as well as civil society groups of men and

women, community members, cultural experts and other technical experts (including those not currently working with USAID).

Country Ownership

Although financial support from the GOG for health services is quite low as mentioned previously, perhaps causing doubt about country ownership of proposed BEST activities, the history of country ownership in Guatemala is quite the contrary. Examples at a variety of levels (national to local) and with multiple stakeholders include: a law passed to collect taxes to support purchase of family planning methods and provide family planning and reproductive health services; Ministry of Health contracting directly with local NGOs for essential health services in rural areas; a vibrant corporate sector entering into partnerships with the GOG for health and education services; laws and policies which encourage civil society groups (OSARs and indigenous women's networks) to inspect and report on the adequacy and cultural appropriateness of public health services; and adoption of an open information system for health and education as well as financial information from other Ministries that increases the transparency of the GOG and has encouraged local municipalities to use their own discretionary funds to support local health services by implementing "*unidades minimas*". USAID's support to strengthen health care in underserved communities under BEST will include a significant component to ensure that implementing NGOs are working hand in hand with local MSPAS health area authorities and structures and using MSPAS service standards and protocols. This will entail support to the MSPAS also to strengthen planning, supervision, commodity distribution and reporting on community service delivery.

Country ownership is critical to BEST and includes "ownership" by the beneficiaries of high impact services. Thus, broadly defined, country ownership involves more than just the government or private sector in delivery of health services. True "ownership" has to begin with the base in order work toward sustainability. Services must meet needs and be valued by communities. Under BEST, to assure that true needs are met, households and communities will be organized and mobilized through a participatory process, starting with women as agents of change to understand health issues and learn how to take action to resolve problems. To accomplish this, successful community mobilization techniques, developed and implemented in Latin America with indigenous and low literacy populations - led by women in communities- will be replicated in Guatemala through modifying existing mechanisms or developing new mechanisms, and in greater collaboration with USG partners such as Peace Corps. This type of community mobilization under BEST complements the GOG's emphasis on increasing use of services through greater intercultural accessibility ("*interculturalidad*").

Research and Innovation

Innovation and research will be essential to improving access and quality of health care. New models for service delivery at the community level and first level care facilities as well as improvements in monitoring and evaluation will require innovative ways of gathering, processing and using data at the primary care level. The lack of an organizational culture that encourages and demands evidence-informed decision making has remained problematic.

In the Guatemalan context the quality of routine data is poor, and health staff and community capacity to analyze data is limited. USAID will apply efforts to develop analytical skills and a culture of evidence-informed decision-making in community health services and among front-line health workers; resources will be invested in enhancing skills and capacities to apply program evaluation and research findings in practice and program improvement. Health providers will be empowered to generate and use data and operations research findings in their planning and decision-making processes. Several innovations, currently in a pilot phase will be validated and scaled up, for instance the Collaborative Methodology implemented by the MSPAS and supported by USAID's Health Care Improvement HCI project in seven departments of Guatemala.

Community based pay-for-performance approaches will be tested and implemented, focusing on improving outcomes. Most health providers are paid the same regardless of the quality of the health care they provide. This produces no financial incentives and, in some cases, produces disincentives for quality. There are an increasing numbers of programs in the world that have started to link payment to performance. Research would be designed to provide empirical evidence of the relationship between explicit financial incentives, managed by community based groups and improvement of health care quality. Research will also provide information to guide implementation of financial incentives and to assess their cost-effectiveness.

An innovative approach will be taken to engage community organizations in finding creative, local solutions to health and nutrition issues, with a willingness to experiment to determine what works in individual communities and taking the time to understand what it takes to scale up new approaches and ideas and address barriers to acceptance. Community health and nutrition committees will be formed under the Community Development Councils (COCODEs) to advocate and liaise with municipal governments for improvements in health care, potable water and hygiene systems.

Community women's groups and men's groups will be empowered and provided support to review local evidence, and to jointly plan, implement, and assess interventions aimed at addressing local family planning and perinatal care issues, thereby increasing coverage of antenatal care and attended deliveries, and ultimately reduction in maternal and neonatal mortality.

USAID will scale up the application of the Kangaroo Mother method for caring for pre-term newborns that was initiated with a small scale training of a few Guatemalan health professionals by the HCI project. Once clinically stable, the preterm infant is placed between its mother's breasts in skin-to-skin contact. Its use is justified by the lack of incubators, cultural beliefs and the high mortality among newborns in Guatemala. There is evidence that babies cared for using the Kangaroo Mother method had shorter hospital stays, adequate oxygenation, higher and stabilized body temperature, fewer episodes of apnea and cried rarely. Furthermore, their mothers breastfed more and felt secure monitoring the health of their own babies. Experience with the method demonstrated reduction in the risk of nosocomial infection and reductions in serious diseases, particularly of the respiratory system 6 months after

discharge. Reductions have been also documented in the risk of dissatisfaction on the part of the mother and of exclusive breastfeeding failure at discharge, while in-hospital weight gain improved

The Helping Babies Breathe (HBB) is an international Initiative from which USAID is an important partner, together with Laerdal Inc. and the American Academy of Pediatrics. An International Strategic Helping Babies Breathe (HBB) conference was launched in Guatemala in February 2011 to roll-out of the HBB strategy and to train a basic cadre of MOH and HCI staff from Guatemala and four other Latin American countries (Ecuador, El Salvador, Nicaragua and Honduras). USAID will support the expansion of the application of HBB methodologies in targeted facilities.

USAID will explore with other maternal health donors (e.g. Swedish Cooperation), in coordination with the current GOG cash transfer program, the use of conditional cash transfers to pregnant women. A growing body of evidence demonstrates that health care quality is becoming a policy priority in low- and middle income developing country settings. Most of these quality improvement interventions focus on in-service training of health professionals and supply-side improvements. Few interventions consider the role of households, consumers or patients in improving the quality of care. Being a beneficiary of a large-scale conditional cash transfer program is associated with the receipt of more prenatal care procedures among low-income, rural women in Mexico (Health Policy and Planning 2009; 24:18–25). A recent publication of *The Lancet* (Volume 375, Issue 9730, 5 June 2010-11 June 2010, Pages 2009-2023) shows the results of a conditional cash transfer program in India, providing evidence that payments to mothers were associated with a reduction of 3.7 perinatal deaths per 1000 pregnancies and 2.3 neonatal deaths per 1000 live births¹¹. Additionally the program had a significant effect on increasing the frequency of antenatal care and in-facility births.

What makes the BEST action plan different?

One of the most important strategic choices being made is the Guatemala Mission's decision to re-locate the majority of its resources – including population, health and nutrition (PHN) as well as education, Title II, democracy and governance, and agriculture and economic growth - to the five high-need departments in the indigenous highlands, identified as the focus for Feed the Future: Quiché, Quetzaltenango, Huehuetenango, San Marcos and Totonicapán. (Note that because of the concentration of the HIV/AIDS epidemic among most at-risk populations for HIV/AIDS transmission in Guatemala, the PEPFAR program will continue to focus on a different geographic area, based on the highest prevalence locations.) Additionally, some PHN resources will be directed to one other department, Alta Verapaz, with high maternal and neonatal mortality rates and chronic malnutrition. While the Mission's CDCS strategy focus is on the high-need departments of the Western Highlands, due to funding constraints, resources will target a sub-set of municipalities in these departments, selected by criteria of poverty,

¹¹ [Lancet](#). 2010 Jun 5;375(9730):2009-23

malnutrition, access to health care and capacity for value chain agriculture programs. This integrated, geographic focus is a major shift for the Mission and for activities under the BEST action plan and implies a reorientation of investment and of programming by partners and the phasing out of some successful programs in other areas of the country. However, the focus and the cross-sectoral coordination that will be realized with this focus is intended to accelerate the achievement of GHI, BEST, and FTF goals.

Although USAID will be working in the context of broader government and NGO programs and services that deliver multiple interventions, our limited resources will focus within these programs on highest-need populations and priority problems: availability and use of family planning services for indigenous women; acceptability and quality of maternity services for those women, with an emphasis on preventing or treating hemorrhage and improved birth monitoring (partograph); facility and community newborn care; facility and community diarrhea and pneumonia treatment; chronic (versus acute) malnutrition prevention; anemia and vitamin A. The emphasis will be on applying and adapting, where necessary, best practices from around the world and Guatemala, in particular.

In keeping with the global Scaling Up Nutrition (SUN) effort and the Thousand Days partnership, maternal and child interventions for prevention of chronic malnutrition will focus on the 9 months of pregnancy and the first 24 months of a child's life.

Successful models and approaches (such as facility-based quality improvement) will be simplified to emphasize the basic life-saving elements to make them less "perfect," but more replicable and to achieve wider coverage.

Hard Choices/What are we not doing?

Based on current budget constraints and because of better coordination among donors, other USAID development sectors, and the GOG, the team has made the following resource allocation decisions:

- Other than coordination and evaluation, USAID will no longer provide the same level of technical assistance and support to the MSPAS Extension of Coverage Program, but instead redirect resources to strengthening community and local government engagement to improve outcomes, and on evolution to a permanent model of services.
- USAID will not equip hospital maternity services.
- Contraceptives financing and procurement will continue to be the responsibility of the GOG and UNFPA; however USAID will engage in efforts with other donors to change the government rules on local purchase of contraceptives and drugs, for cost-efficiency sake . USAID will not purchase vaccines but through donor and GOG engagement at the policy level, exert pressure on the GOG to meet this responsibility.
- USAID will not provide (expensive) general support to information and logistic systems but instead, target strategic aspects of those systems.
- Despite political and press interest and attention, USAID will not work on acute malnutrition nor newborn milk banks unless a disaster is declared and USAID/OFDA is able to respond.

Examples of Opportunities for Collaboration within USAID Development Sectors and with Other Donors/Partners

With Other USAID Development Sectors

- Democracy and Governance office: Work with local municipalities to spend more on priority health investments; evaluate current practices such as *unidades minimas*; work with MOH to create incentives for water chlorination. Work with departments, municipalities, Community Development Committees (COCODEs), and local mayors to create more responsive health systems that meet communities' needs.
- USDA and USG Feed the Future Initiative: (McGovern Dole) Work with 4H groups and parent-teacher associations (PTAs) as well as child to child education activities connecting USDA programming with the harmonized package of USG , other donor and MOH nutrition and health approaches. This approach may be extended to Feed the Future work in value chain, microloans, and agricultural extension including male involvement with health and FP. BEST will assure nutrition links into the work that FTF is subsidizing.
- Establish technical and communication messages and consensus on the approach to reduce chronic malnutrition in coordination with FTF.
- Food for Peace Title II program: Work with the Food for Peace program to harmonize a basic set of health and nutrition interventions including FP at the community level, taking advantage of new Food for Peace guidance which promotes FP services within implementing partners' programs; this represents an opportunity to share materials and a common FP approach between Feed the Future and the GHI through BEST.

With Other USG Agencies

- CDC: Link CDC's planned support to the GOG nutrition surveillance system with nutrition program process and outcome monitoring. OSARs have a system linking the communities to municipalities or local health system. Build upon this system to link nutrition status surveillance with monitoring of process and program indicators.
- CDC: Link CDC's planned support to the GOG maternal surveillance system and other MCH studies with the design and implementation of BEST programs.
- Peace Corps: Coordinate work with Peace Corps' "Healthy Families" and "Youth Development" programs, placing new volunteers in appropriate communities in the focus geographic areas of the Western Highlands to provide family and youth education, including child-child and PTA activities, on nutrition, hygiene and other health matters.

With Other Donors and the GOG

- All donors and the GOG: Establish technical and communication messaging consensus on the approach to reduce chronic malnutrition with all donors working in nutrition and FTF.
- All donors and the GOG: Policy work to ensure local laws allow international procurement to secure the best quality and prices.

- The Inter-American Development Bank (IDB) has recently done a qualitative assessment of the PEC strategy and plans a quantitative evaluation soon. They have agreed to share the findings of this evaluation with USAID and to work together on a harmonized strategy for primary health care with the MSPAS that will include a nutritional component.
- Gates/Slim Foundation and IDB: Harmonize the MCH/FP/N package for the upcoming loan to the GOG from Gates, the Slim Foundation, and the Inter-American Development Bank.
- IDB: Work to ensure coordination with the Mesoamerican Initiative (A Gates and Slim-funded Central American regional initiative that the IDB will administer.)
- IDB: Help disseminate and learn from the results of the evaluation of the conditional cash transfer program (MIFAPRO) that IDB is conducting through the *Instituto Nacional de Salud Publica* in Mexico. Link health programming to the MIFAPRO program based on the findings.
- GOG and UNFPA: Coordinate the government's contraceptive purchase from UNFPA and promote 10% donation of contraceptive commodities through UNFPA.
- GOG: Ensure that the MSPAS purchases *Sinoplant* (an implant contraceptive) and that UNFPA allows the government to purchase intra-uterine devices (IUDs).
- UNFPA: Coordinate with UNFPA support to the Ministry of Education and the MSPAS to institute a family life education curriculum in basic and secondary levels of schooling. It is not clear who will support the government's efforts to implement the teacher training for the curriculum.
- UNFPA: Work closely on maternal health issues to avoid duplication with UNFPA's work in this area.
- PAHO: Develop maternal, neonatal, and family planning clinical norms based on WHO eligibility criteria and standards with the MSPAS as well as facility norms that are being finalized. USAID will support the dissemination and implementation of these norms in the five priority departments, including support for community treatment of pneumonia, diarrhea, and recognizing the need for early intervention of risks for pregnant mothers.
- The anonymous donor: Through PSI/ PASMOS (a locally registered NGO) support was provided to work with the public sector to train general doctors, nurses and auxiliary nurses to insert IUDs and implants providing very low cost IUDs (Copper T 380A) and *Jadelle* (an implant contraceptive) commodities. This model proved very successful in increasing IUD uptake through repositioning and revitalizing the IUD due to increased access from training providers and increased information and BCC. Due to MSPAS restrictions on charging for commodities, the strategy has now shifted to working through a network of private physicians providing commodities, support, outreach, marketing and training. USAID/Guatemala will explore continuing this work through the public sector to reach Mayan communities with LAPMs.
- UNICEF and FAO: UNICEF donates Vitamin A micronutrients and, is now exploring the option of running its nutrition programming through USAID and will provide funding for a USAID-UNICEF combined strategy using evidence-based programming.

- World Bank and IDB: USAID will also coordinate with the World Bank and IDB that support PEC services through loans to the MOH to institutionalize the standardized package within the MSPAS.
 - GOG: Promote the use of the “*plataforma*” and enhance quality of local data, making sure everyone understands indicator definitions and that they are using the same indicators utilized for intermediate monitoring of the “*plataforma*” routine data for system-based information. Quality of data collection, reporting and use for decision making is an area that GHI is prioritizing.
 - GOG: Promote the use of the LQAS methodology annually to monitor performance in specific programs or for population-based data.
 - All Donors and the GOG: Collaborate with other development partners and the GOG to assure that the past lack of evaluation (an obstacle to improving and continuing programs) is overcome and provides input into the political process as well.
 - GOG and other donors: Improve monitoring of interventions at the field level, including supportive/facilitative supervision with tools such as checklists to be developed for use with NGO and MSPAS staff within local health posts and among NGO supervisors.
 - Local health officials: Engage the Health Area staff in supervision e.g. the RH Director for FP supervision on a regular basis.
 - Other donors and the GOG: Evaluate promising models of service delivery and reorganization of PEC programs that lack evaluation, e.g. PEC, *unidades minimas*, maternity waiting rooms near services and the Jalapa PEC model run by the Cooperative Recuerdos.
 - GOG: Develop innovative models and test existing approaches that address the barriers to access of institutional service delivery for indigenous populations including psycho-social, cultural, gender, transportation, opportunity costs and financial barriers to receiving services. USAID/Guatemala will also evaluate the models that incorporate *interculturalidad* (sensitivity to cultural norms and practices) or indigenization of services such as those that allow *comadronas* (traditional birth attendants) and husbands in the delivery site and include vertical birth and other culturally sensitive approaches to service delivery.
-