

**USAID/Guatemala**  
**Community Nutrition and Health Care Project**  
**BACKGROUND INFORMATION**  
**(October 2011)**

**Health and Nutrition Data**

**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%
	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%

In the area of **Family Planning and Reproductive Health**, modern contraceptive use among women aged 15-49 years (women of childbearing age, WRA) increased from a prevalence of 34% in 2002 to 44% in 2008-09. Among indigenous women, contraceptive use increased substantially, from 24% to 40%; however, there is still a significant gap between indigenous and non-indigenous women in modern method use, with 28% of indigenous women using modern contraceptives compared to 54% of non-indigenous women. This gap is also reflected in the 2008-09 unmet need for family planning among indigenous women (29.6%) that is nearly double than 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%, only 8.9% of indigenous women use this method. Other long-term methods are low among all women: implant use is less than 1.1% nation-wide and IUD use has been declining over the years, from 2.6 % in 1995 to 1.3% in 2008-09. Clearly there is work to be done to improve access to information and services for all methods, particularly among indigenous women, indicating the importance of integrating family planning information and services into CNHC activities.

The Ministry of Health and Social Welfare (MOH) 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 nation-wide 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. Guatemala's maternal mortality ratio (MMR) was 139.4/100,000 in 2007: 211/100,000 among

indigenous women compared to 70/100,000 among non-indigenous women.<sup>1</sup> Most maternal deaths result from complications during childbirth and the first 24 hours thereafter, with hemorrhage and obstructed labor the most common causes of maternal deaths. Iron deficiency and maternal malnutrition contribute to maternal mortality and are more prevalent among indigenous women as well.

In the area of **Child Health**, national under-five, infant and neonatal mortality rates have all decreased from the rates identified in the 2002 ENSMI survey. While the declines in neonatal, infant, and under-five mortality have included both indigenous and non-indigenous populations, these rates show that the gaps between these two groups 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. According to the MOH, 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 insufficient access to services among indigenous populations.

The ENSMI data 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 half of Guatemalan children under age five are stunted and this rate is at 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 CNHC will focus (e.g., Totonicapán - 82%; Quiché - 72%). Although progress has been made during the past decade in improved weight for age levels, the current declines will not overcome the huge burden of stunting for at least another two decades, as evidenced by reviews<sup>2</sup> conducted of the ENSMI surveys and the National School Height Census. In the area of maternal nutrition, 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 has a direct correlation with 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 found 29% of pregnant women and 47.7% of children under five are anemic – both these levels

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<sup>1</sup> SEGEPLAN: “Estudio Nacional de Mortalidad Materna 2007”, Ministerio de Salud Pública y Asistencia Social. Borrador 2011.

<sup>2</sup> 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*.

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: lack of access to iron-rich food, limited consumption of iron fortified food, poor coverage and quality of supplementation programs and high prevalence of soil transmitted helminthes that remain as a widespread and neglected public health concern.. It will be critical for CNHC interventions to address this issue, both in direct community interventions and linking with other efforts to ensure 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 the adoption of safe hygiene and eating behavior.

### **The Guatemala Health Care System**

The MOH is the government’s authority on health matters. The MOH is exclusively responsible for regulation and management and, along with other governmental and nongovernmental institutions, shares responsibilities for insurance, delivery of services, financing, and essential public health functions. The system of service provision in the country tends to be fragmented and segmented, with little functional integration or separation of functions between subsystems, each serving specific population groups that have access to different services. Only one percent of the national budget is devoted to providing health services through the public sector, the lowest proportion of all countries in Latin America.

The for-profit private sub-sector is made up of hospitals, nursing homes, clinics, pharmacies, and laboratories authorized by the MOH. The nonprofit private sub-sector consists of health facilities run by nongovernmental organizations (NGOs), which currently total more than 1,000.

Education and training of health professionals takes place in the universities. Five of the country’s 11 universities train physicians and surgeons, with the national public university offering medical and nursing degrees in the capital and in the western part of the country. Three private universities provide training in the capital while one also has a branch campus in the western region.

As a part of a health reform process undertaken by the GOG after the 1996 Peace Accords, priority-program standards were set for all three levels of care: primary health care in local health posts and health centers, second-level care at regional hospitals and tertiary care at reference hospitals, most of which are located in the capital. These standards were updated in 2009, and in 2011 disseminated through a directive to all staff responsible for direct patient health care in first- and second-level services.

Financing for health care in Guatemala comes mainly from out-of-pocket household payments, the GOG national budget, private for-profit companies, NGOs and international donors. The country’s reform process officially began in 1996 with the “Health Services Improvement Program” financed by the Inter-American Development Bank (IDB) and implemented by the MOH. The financial reform has allowed budget allocations and responsibilities for service delivery to be transferred to the sub-national level to the Health Areas Authorities, who are

responsible for programming and execution of the allocated budget, as well as overseeing contractual agreements with local providers and administrators for regulated services.

As part of the 1996 Peace Accords, the Government of Guatemala (GOG) introduced the Extension of Coverage Program (PEC, Spanish acronym) to provide primary care and extend health services to rural indigenous communities, originally intended to be a short-term program until the government could build and staff health centers throughout the country. In this program, government-funded local nongovernmental organizations provide basic maternal and child healthcare services by itinerant medical teams who spend one day a month in individual communities. This primary point of contact can lead to referrals to health centers, regional hospitals, or reference hospitals in Guatemala City. The MOH has established two priority programs to strengthen the PEC during the last decade: 1) the Comprehensive Community-based Care for women and children program to reduce chronic malnutrition; and 2) a program to strengthen secondary care to improve access to institutional births. However, despite these changes, there are still strong barriers to accessing services that affect most rural, indigenous people, especially women. At the facility level, for example, there is a widespread sentiment amongst Guatemala's indigenous population that the public health system "doesn't treat them well". Ongoing language and cultural barriers as well as the cost of getting to health centers and the perception of inadequate services have reduced the impact of GOG attempts to expand health services to rural indigenous communities. The proposed Community Nutrition and Health Care Project will address these gaps in service delivery.

Since the Peace Accords, the GOG has made important commitments for health and social investments: expanding access to free services; intensified efforts to reduce maternal and infant mortality; a focus on reducing chronic malnutrition; improving access to services for HIV/AIDS treatment and prevention; and helping families stay healthy by making family planning and other services available. The immediate priorities of Guatemala's National Health Plan (2008) are: development of health information systems; extending the health service network, particularly in the 125 poorest municipalities of the country; reducing maternal and neonatal mortality and chronic malnutrition; improving supply chain management of essential health commodities; and expanding health financing. The implementation of the National Health Plan (NHP) faces significant challenges. Inadequate health financing by the government has been an ongoing problem and continues to threaten the ability of the public health sector to function. There is a shortage of qualified staff for health facilities in rural locations, especially obstetric nurses and midwives, and the MOH has a chronic high turnover among its staff.

A major assumption, although not made explicit in the NHP, is continuity and strengthening of the PEC. This program is the only existing GOG vehicle to provide health services to 4.6 million Guatemalans. It combines institutional, health center-based services directly administered by the MOH with itinerant health team services contracted out to approximately 88 NGOs. The NGOs are paid an average of \$8 per capita per year and are responsible for providing a package of 32 basic health services to over 400 communities in the most isolated areas of Guatemala. Routinely, GOG payment to the NGOs is in arrears, questioned or suspended. Periodically, the MOH announces plans to replace the NGOs with MOH service delivery models that have yet to be identified and that will require funding levels

that do not exist. The USG and other donors have taken a strong stance to highlight the fact that essential maternal and child health and nutrition services for the majority of rural poor depend on the PEC and reiterate the need to maintain this option while other more efficient models are put in place. [http://www.usaid.gov/gt/docs/informe\\_final\\_calidad\\_salud.pdf](http://www.usaid.gov/gt/docs/informe_final_calidad_salud.pdf). USAID is currently supporting interventions to strengthen and complement the PEC program, through the UNDP-managed “Expansion of the Improved Package of Services Project” which provides training and institutional strengthening to 80 NGOs implementing PEC, and through the Health Care Improvement (HCI) project, which seeks to improve the quality of maternal and child care at first and second-level government health facilities as well as the quality of nutrition interventions at the community level. The proposed Community Nutrition and Healthcare Project will build on the results, structures and relationships established with the MSPS under these two projects.

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. A 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, with a beneficiary base of over 917,330 families.<sup>3</sup>

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<sup>3</sup> Official data on the MIFAPRO website as of 25 April 2011.  
<http://www.mifamiliaprogressa.gob.gt/joomla/cobertura.html>