USAID FROM THE AMERICAN PEOPLE | Nutri-Salud COMMUNITY NUTRITION AND HEALTH PROJECT

URC UNIVERSITY RESEARCH CO., LLC

Nutri-Salud QUARTERLY REPORT

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QUARTERLY REPORT

QUARTER 2, FISCAL YEAR 2015

January 1, 2015 – March 31, 2015

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Acronym List

AMTSL	Active Management of the Third Stage of Labor
AOR	Agreement Officer's Representative
APRECIE	*Aprendizaje Colaborativo e Intercambio de Evidencia y Experiencia* (Collaborative Learning and Evidence Exchange)
BID	*Banco Interamericano de Desarrollo* (Inter-American Development Bank)
CBD	Community-based Delivery
CHW	Community Health Worker
COCODE	Community Development Council
COMUDE	Municipal Development Council
COP	Chief of Party
CY	Calendar Year
DAS	*Dirección de Área de Salud* (Departamental Health Area)
DMS	*Distrito Municipal de Salud* (Municipal Health District)
ENA	Essential Nutrition Actions
FANTA	Food and Nutrition Technical Assistance III Project
FOG	Fixed Obligation Grant
FP	Family Planning
FY	Fiscal Year
GMP	Growth Monitoring and Promotion
GOG	Government of Guatemala
IDB	Inter-American Development Bank
IMCI	Integrated Management of Childhood Illnesses
INCAP	Institute of Nutrition of Central America and Panama
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and evaluation
MNCH	Maternal, neonatal, and child health
MOH	Ministry of Health
MSPAS	*Ministerios de Salud Pública y Asistencia Social* (Guatemala Ministry of Health)
NGO	Non-Government Organization
NS	Nutri-Salud
ONG	Organizacion no-gubernamental
PEC	*Programa de Extension de Cobertura* (Extension of Coverage Program)
PMP	Performance Management Plan
PROEDUSA	*Departamento de Promoción y Educación en Salud* (Department of Health Promotion and Education)
QI	Quality Improvement
RRF	Rapid Response Fund
SA	Supervision Area
SBCC	Social and Behavior Change Communication
SIAS	*Dirección General Del Sistema Integral De Atención En Salud* (Integrated Health System Directorate)
SIGSA	Guatemala Health Management Information System
SMT	Senior Management Team
TISA	*Tienda de Salud* (rural health store)
TOT	Training of Trainers
URC	University Research Co., LLC
USAID	United States Agency for International Development
USG	United States Government
WHIP	Western Highlands Integrated Program

Resumen Ejecutivo

Nutri-Salud: el Proyecto Comunitario de Nutrición y Salud de Guatemala, financiado por la Agencia de los Estados Unidos para el Desarrollo Internacional (USAID) y manejado University Research Co., LLC (URC), es un Proyecto de cinco años (2012-2017) cuyo objetivo del es mejorar la nutrición comunitaria y la salud de mujeres y niños, en 30 *municipios* de cinco departamentos del altiplano occidental de Guatemala, donde la población es predominantemente rural e indígena Maya.

Nutri-Salud tiene tres objetivos principales: 1) mejorar el estado nutricional de las mujeres en edad reproductiva y de los niños menores de cinco años centrándose en la ventana de los mil días; 2) fortalecer los servicios esenciales de atención en la salud materna neonatal e infantil y planificación familiar a nivel comunitario; y 3) involucrar a las comunidades en las soluciones activas de sus necesidades de atención en salud.

Hay cuatro principales componentes técnicos del Proyecto: 1) prevención de desnutrición crónica; 2) atención obstétrica, neonatal e infantil mejorada; 3) servicios de planificación familiar basados en la comunidad y 4) movilización comunitaria y vínculos con los gobiernos locales.

AF 2015, Trimestre 2

Durante el segundo trimestre del año fiscal 2015, el proyecto Nutri-Salud continuó trabajando en un ámbito complejo en lo cual una gran parte de la población objetivo de Nutri-Salud quedo sin acceso directo a servicios de salud del primer nivel por la falta de recursos y por la decisión del Ministerio de Salud de suspender el Programa de Extensión de Cobertura (PEC). La pérdida de las ONG PEC, causó una reducción de un 72% en número total de servicios de salud en el área del USAID WHIP. Nutri-Salud ha estado utilizando los fondos de respuesta rápida para trabajar con el Ministerio de Salud y el Banco Interamericano de Desarrollo (BID) en una propuesta de reestructuración de la organización del primer nivel de salud y en la prestación de servicios del primer nivel de salud. El proyecto también ha proporcionado apoyo a los gobiernos locales y las Áreas de Salud del Ministerio de Salud para hacer frente a las necesidades de atención de salud locales en ausencia del Programa de Ampliación de Cobertura.

En febrero del 2015, a la luz de la decisión del Gobierno de Guatemala de suspender el Programa de Extensión de Cobertura (PEC), USAID informó Nutri-Salud de su decisión de modificar la descripción del programa y pidió que Nutri-Salud continuó con una disminución de implementación, centrándose en cuatro actividades básicas mientras USAID desarrolle una nueva descripción de programa.

Las cuatro actividades básicas durante este trimestre incluyen: apoyo al ministerio de salud para llevar a cabo el conteo poblacional (censo) en las zonas rurales de los *municipios* del USAID WHIP; apoyo a al esfuerzo para desarrollar una propuesta de un modelo alternativo de atención de salud del primer nivel en Guatemala en colaboración con USAID, el Banco Interamericano de Desarrollo y la Alianza para la Nutrición; apoyo a la implementación de un curso certificado (diplomado) en la nutrición materna e infantil (ejecutado conjuntamente con FANTA, INACAP y otros proyectos de la USAID); y capacitación y apoyo a las Áreas de Salud (DAS) y los Distritos Municipales de Salud (DMS) con el objetivo de mejorar los conocimientos y habilidades de los proveedores de salud de primer nivel que trabajan en puestos de salud y unidades mínimas. El proyecto también siguió apoyando 7 ONG bajo sub-convenios para la implementación de actividades para promover la movilización de la comunidad para la salud y un mejor conocimiento de la salud sexual y reproductiva.

Executive Summary

Nutri-Salud: Guatemala Community Nutrition and Health Care project, funded by the United States Agency for International Development (USAID) and managed by University Research Co., LLC (URC), is a five-year (2012-2017) project, which aims to improve community nutrition and health of women and children in 30 municipalities in five departments of the Western Highlands of Guatemala, where the population is predominantly rural and indigenous Maya.

Nutri-Salud has three major objectives: 1) improve the nutritional status of women of reproductive age and children under five, with a focus on the 1,000 Day Window of Opportunity; 2) strengthen essential maternal, neonatal, and child health (MNCH) care and family planning services at the community level; and 3) engage communities in determining active solutions to their health care needs.

The project has four major technical components: 1) prevention of chronic malnutrition; 2) improved obstetric, neonatal, and child health care; 3) community-based family planning and reproductive health services; and 4) community mobilization and linkages to local government.

FY 2015, Quarter 2

During the second quarter of fiscal year 2015, the Nutri-Salud project continued to work within a complex implementation environment in which the weakened MOH health service delivery at the first level of care and the MOH decision to discontinue the Extension of Coverage Program (PEC) has left much of the Nutri-Salud target population without direct access to primary health care. The loss of the PEC NGOs, caused a reduction by 72% of the total number of service delivery points in the WHIP area. Nutri-Salud has been using Rapid Response funds to work with the MOH and Inter-American Development Bank to a proposal to restructure the organization and delivery of primary health care. The project has also provided support to local governments and MOH Health Areas to address local health care needs in the absence of the Extension of Coverage Program.

In February, 2015, in light of the GOG's decision to terminate the PEC NGO program, USAID informed Nutri-Salud of its decision to amend the Program Description and requested that Nutri-Salud continued with scaled-back implementation, focusing on four core activities until a new Program Description could be completed.

The four core activities during this quarter included: support for the MOH's population count (census) in rural areas of the WHIP *municipios*; support to the joint USAID – IDB – Nutrition Alliance effort to develop a proposal for an alternative primary health care model in Guatemala; support for the implementation of a certificate course (diplomado) in maternal and child nutrition (jointly implemented with FANTA, INCAP and other USAID projects); and, capacity-building support focused on the Health Area (DAS) and Health District (DMS) levels, with the goal of improving the knowledge and skills of first level health care providers working in health posts and minimum units. The project also continued to support 7 sub-grantees as they implement activities to promote community mobilization for health and improved knowledge of sexual and reproductive health.

Introduction

Nutri-Salud, the Community Nutrition and Health Project, receives strategic guidance and funding from the United States Agency for International Development (USAID) under Cooperative Agreement AID-520-A-12-00005. A five-year (2012-2017) project, Nutri-Salud is implemented by a collaborative team led by University Research Co., LLC (URC) with sub-partners Mercy Corps, the Institute of Nutrition of Central America and Panama (INCAP), The Manoff Group, and Cloudburst Group. Consistent with the United States Government (USG) Global Health and Feed the Future initiatives, and in collaboration with the Government of Guatemala's (GOG) Zero Hunger Pact, the goal of Nutri-Salud is to improve the health and nutritional status of Guatemala's rural and indigenous populations. Target beneficiaries include children under five years of age, with emphasis on children under age two, and women of reproductive age who are served by the country's primary health care system (known in Guatemala as the "first level of care").

The Nutri-Salud project objectives are to:

- Improve the nutritional status of women of reproductive age and children under five by implementing seven Essential Nutrition Actions (ENA), focusing on "the first 1,000 days" (i.e., during pregnancy and the first two years of life);
- Strengthen essential maternal, neonatal and child health care and family planning services at the community level with a constant health care presence in target communities; and,
- Engage communities in active solutions to their health care needs through community mobilization and linkages to local government structures.

The project has four technical components, which were designed to be implemented in an integrated manner within a continuum of care framework for integrated maternal, neonatal, and child health with a focus on the First 1,000 Day Window of Opportunity:

Component 1: Prevention of Chronic Malnutrition

Component 2: Improved Obstetric, Neonatal, and Child health Care, Including Community-Based Integrated Management of Childhood Illnesses (IMCI)

Component 3: Community-Based Family Planning and Reproductive Health Services

Component 4: Community Mobilization and Linkages to Local Government for Improved Health and Nutrition

From 2012 – 2014, one of Nutri-Salud's core strategies was to work with the MOH to strengthen the quality and coverage of the first level of care in the USAID Western Highlands Integrated Program (WHIP) area consisting of 30 municipalities in 5 departments (34 health districts – DMS – and 6 health areas – DAS). The project provided integrated technical support in three spheres of action: health service delivery (health posts, unidades minimas, and community convergence centers), local government engagement, and community and household level action. Project strategies included technical and financial support to GOG-contracted NGOs under the Extension of Coverage (PEC) program as well as other local NGOs, continuous quality improvement (QI) and collaborative learning among first level providers (both PEC NGOs and MOH services), improved logistics, social and behavior change communication (SBCC) tools, private sector alliances, monitoring and evaluation (M&E), and gender equality and cultural pertinence.

Until the end of CY 2014, Guatemala's primary health care system in the WHIP area included 595 service delivery points. Of these, 28% were the health posts and unidades mínimas (minimum health units) operated by the MOH, often with municipal and/or private sector support). The other 72% of facilities were community convergence centers operated by PEC NGOs. The PEC program was the country's core strategy for providing basic health care services in rural areas for most of the past two decades. However, in January, 2015, the PEC program was cancelled by the GOG. Between January and March, 2015, the MOH communicated its intentions to reorganize the first level of care, strengthen facility-based care, and establish mobile teams linked to community health workers. However, as of the end of the second quarter of FY 2015, the MOH was only beginning to contract the additional personnel required to operationalize its new model for primary health care, and was still in the process of defining the geographic

territories to be covered by each health post and/or minimum unit with its mobile teams and community health workers.

The delayed receipt of its FY 2014 funds led USAID/Guatemala to request that Nutri-Salud temporarily scale-back implementation between October 2014 and January 2015. In February, 2015, on the heels of the GOG's decision to terminate the PEC NGO program, USAID informed Nutri-Salud of its decision to amend the Program Description and requested that Nutri-Salud continued with scaled-back implementation, further narrowing the focus to four core activities until a new Program Description could be completed. The four activities include: support for the MOH's population count (census) in rural areas of the WHIP *municipios*; support to the joint USAID – IDB – Nutrition Alliance effort to develop a proposal for an alternative primary health care model in Guatemala; support for the implementation of a certificate course (diplomado) in maternal and child nutrition (jointly implemented with FANTA, INCAP and other USAID projects); and, capacity-building support focused on the Health Area (DAS) and Health District (DMS) levels, with the goal of improving the knowledge and skills of first level health care providers working in health posts and minimum units. In February 2015, Nutri-Salud made the final payments to 18 PEC NGOs after closing out the program in December 2014. Four community mobilization sub-grants and three reproductive health sub-grants continued during the reporting period, and will be closed out in the third quarter of FY 2015 (or June 2015, latest).

On February 17, 2015, two members of the U.S. House of Representatives visited the rural community of Tizate in Quetzaltenango. With support from the Bill and Melinda Gates Foundation, CARE organized a "learning tour" for Representatives Diane Black of the 6th Congressional District of Tennessee and Renee Ellmers of the 2nd District of North Carolina so they could see how US foreign assistance is helping to transform the lives of Guatemalan women and children. The Representatives were accompanied by a CARE board member and several CARE staff, a Gates Foundation representative, journalists from CNN International, and staff from USAID/Guatemala, USAID/Washington and the Nutri-Salud project. The visit to Tizate gave the Representatives a chance to see firsthand how auxiliary nurses and families are working together to prevent chronic malnutrition by focusing on the 1,000 day window of opportunity with support from Nutri-Salud's home visiting and counseling program, the "Wheel of Practices for Better Living." The Wheel is a visible guide (wall poster) that helps pregnant women and mothers of children under two years of age adopt healthy practices related to nutrition/feeding, care, household hygiene, and use of health services and micronutrients.

Updated Profile of the Health Service Delivery Network in the WHIP Area

The closure of the PEC NGO program in January 2015 represented an immediate curtailment of the MOH's capacity to deliver basic health services at the first-level of care. A year earlier, at the beginning of 2014, there were 525 service delivery points across the 34 Health Districts (DMS) supported by Nutri-Salud in six Health Areas. Of these, 376 were community convergence centers operated by PEC NGOs, 134 were health posts, and 14 were minimum units receiving joint support from the MOH and municipal governments. The loss of the PEC NGOs, caused a reduction by 72% of the total number of service delivery points in the WHIP area.

With the loss of 182 community convergence centers, representing 79% of facilities, Huehuetenango has been the most affected of the six Health Areas. San Marcos saw a reduction of 70 facilities (69%); Quiché lost 67 facilities (74%); Totonicapán lost 36 facilities (78%); and Quetzaltenango and Ixil were the least affected losing 11 and 10 facilities, respectively.

The six Health Areas have addressed the challenging situation using their available resources and management capacity. The Ixil Area, for example, has supported delivery of first-level of care services- across its three *municipios* using various modalities: the Spanish government supports the Modelo Incluyente de Salud (MIS) in Chajul; the municipal government of Cotzal began covering salaries of former PEC staff in January, 2015; and, the Health Area is using MOH resources to support service delivery in the municipio of Nebaj.

The Departmental Health Area (DAS) Quiche reassigned some its existing staff to form mobile teams and is hiring additional staff to cover some areas previously supported by PEC NGOs and to convert some community centers into health posts.

In Quetzaltenango, the Project covers two *municipios*: San Juan Ostuncalco y Concepción Chiquirichapa. In the former, the Municipal Health District office (DMS) received some support from the municipal government to open four unidades mínimas as part of the MOH service delivery network. In the latter, the DMS is supporting a mobile team through IDB loan funds.

In addition to the closure of the PEC program, San Marcos has had a 50% reduction in institutional staff, especially health educators. Recently, DAS San Marcos began hiring addtional staff to support the implementation of the MOH's current service delivery model based on mobile teams.

The loss of 79% of the facilities in Huehuetenango by the closing of the PEC program has been aggravated by labor issues, strikes and management challenges, including lack of an Area Director for extended periods of time. The situation remains critical and the majority of the rural population remains unattended by first-level providers.

And finally, in Totonicapan there have been no significant/visible efforts to reestablish service delivery where the PEC program no longer exists. In fact, salary support for institutional staff has actually been reduced and hiring of new mobile teams is delayed.

Component 1
Prevention of Chronic Malnutrition

This project component promotes a multi-pronged approach to prevent chronic malnutrition. Working at the institutional level, the project promotes the expanded use of evidence-based interventions while also raising awareness among key stakeholders (such as local governments, social action networks, and local leaders) and supporting families to adopt healthy practices.

Results 1.1–1.3: Maternal and child feeding practices (breastfeeding and complementary feeding) to prevent onset of chronic malnutrition improved; Maternal and child essential nutrition actions (ENA) to prevent onset of chronic malnutrition improved; Maternal and child hygiene and care practices to prevent the onset of chronic malnutrition improved

Strengthening health services at the first level of care

Nutri-Salud provides technical assistance and capacity building through training and facilitative supervision to first level health providers to strengthen their competencies in health service delivery, including essential nutrition actions (ENA). Nutri-Salud technical assistance also includes on-site monitoring and facilitative supervision at first level health care facilities (health posts, community convergence centers and minimum health units).

Implementation of certificate course on maternal and child nutrition (Diplomado)

All diplomado activities are coordinated with FANTA, INCAP, PlanFam and the MOH (SIAS, Plan Hambre Cero). In January 2015, eight Nutri-Salud field team managers and technical advisors completed a training program provided by FANTA and INCAP to become facilitators qualified to support the training of MOH facilitators. Using a training of trainers' (TOT) methodology, from March 23-27, 2015, the newly trained Nutri-Salud facilitators were joined by FANTA and INCAP facilitators to train DAS and DMS staff (primarily nutritionists and nurses) as diplomado facilitators. The effort was fully supported by SIAS and PROEDUSA. A total of 41 MOH staff members completed the workshop, including eight district coordinators who can now replicate the workshop in their local areas. The MOH required all participants to sign a letter of commitment to guarantee course completion and later replication.

In the first half of the training course, the group of FANTA/INCAP/Nutri-Salud trainers facilitated eight learning sessions on essential nutrition actions and nutrition

"The course reminded us of topics we had forgotten; now we all share the same information and will be able to conduct home visits and counseling in the same way. After completing the course, I shared the information with my six field teams in order to have more trainers ready to support me with the next step of implementing the course with first level health providers."

— Chief nurse, CAIMI de Cuilco, Huehuetenango

A hands-on activity to learn about appropriate complementary feeding according to the child's age.

Each participant received an electronic version of the course, along with printed materials.

During the self-esteem module, participants explore perceptions about themselves.

sensitive actions which have been shown to be effective in reducing chronic malnutrition during the 1000 day window of opportunity. Topics included; nutrition and care during pregnancy, breastfeeding and complementary feeding, and caring and feeding of the sick child. The program also included a module on self-esteem. During the second half of the week, the emphasis shifted toward learning the training methodology to be used when replicating the course. Participants completed practical exercises in groups, integrating the concepts learned in the first part of the course into the methodology, with an opportunity to comment on and evaluate the way other groups used the methodology.

All participants completed the course reported being motivated and enthusiastic about replicating it. Ready to be the trainers in their districts, the facilitators will train auxiliary nurses at health posts as well recently hired members of the MOH's new mobile teams.

Capacity-building for improved quality and coverage of primary (first level) care

Workshop on Growth Monitoring and Promotion (GMP)

With the objective of enhancing the abilities of DAS/DMS staff to monitor, supervise and improve the quality and coverage of first-level health services, Nutri-Salud supported them in developing a training methodology for skills-building workshops designed for auxiliary nurses on how to appropriately conduct growth monitoring and promotion activities.

Nutri-Salud supported the MOH in developing a methodological guide for carrying out standardized GMP workshops (see annexes 6 and 7). The workshops help build the capacities of frontline MOH staff working in health posts and unidades minimas. They use a participatory approach based on practical exercises on resolving cases, group discussion and socio dramas. Participation in the workshop gives MOH staff a deeper understanding of the role of growth promotion in preventing chronic malnutrition. The workshops enable staff to enhance their skills in anthropometry and especially in determining a child's nutritional status. The workshops covered the ENA within the framework of the 8 steps for GMP, consistent with the diplomado

"This training is important. Although we did growth monitoring and promotion [before the training], we did not know about the 8 steps required to do it properly. We were not doing individual counseling. We just gave a general chat - but now we know how to tailor counseling to the specific nutritional status of each child. That's how this workshop reinforced out understanding of this topic."

— Assessment of the course by a participant in Cotzal, Ixil

GMP Workshops in Quiche and Huehuetenango

GMP workshops in Huehuetenango and Totonicapán

mentioned earlier in this report. A focus on counseling based on the ACCEDA approach helped participants move beyond the less effective but more common approach in Guatemala of conducting simple growth monitoring based only on anthropometry without individualized counseling and growth promotion. The last section of the workshop are the individual commitments made to reduce chronic malnutrition, building in continuity and sustainability. As shown in Annex 2, the DMS carried out 18 workshops with a total of 267 women and 182 men staff.

As follow-up to the workshops, Nutri-Salud and DMS staff provided facilitative supervision through tutoring visits to individual health posts in the six areas. The visits showed that MOH front line providers are able properly weigh and measure children. Sometimes relying on the checklist provided in the workshops, health post staff are able to calibrate scales and know they should undress children as much as possible before weighing them. The health posts have the inputs necessary for GMP including the child's personal health card and the SIGSA 5-1 form. The GMP session is now more personalized, with proper recording of the data and the delivery of tailored counseling for each child. It was noted however, that counseling skills could be further refined to focus more specifically on the age-based recommendations. The visits also revealed that there are some errors when classifying children. For example, if weight for age is normal, staff sometimes assume that height/age will also be normal; sometimes they do not take the time to review the child's trajectory/trend. Among the limitations faced by health post personnel are the lack of counseling cards/ materials to support the delivery of educational messages to low-literacy mothers and the limited physical space available for GMP in the health posts.

Enhancing competencies of medical and nursing students in key topics related to the 1000 day window of opportunity.

At the end of their final programs of study, medical and nursing students in Guatemala are required to do a practicum in a health facility, where they serve as frontline providers under the supervision of a professional nurse or a physician.

Health population count (census) in rural areas of the 30 focus *municipios*

Nutri-Salud has supported the MOH to develop a methodology and carry out a community mapping (croquis) and population count in the 30 *municipios* (33 DMS) across the project's 6 health areas. For training and implementation purposes, the MOH divided the six health areas into two groups: Group I includes the DAS of Totonicapán, Quetzaltenango and Ixil. Group II includes DAS of Huehuetenango, Quiche and San Marcos.

In the first quarter of FY 2015, the project supported the MOH to edit and update the data collection forms for the census and assisted with the design of a data entry and migration process to incorporate the new data into existing data bases. In December, Nutri-Salud trained the appropriate DAS and DMS staff in the methodologies for either conducting the population count (including producing a community sketch) and/or certification in 8 DMS in the Group I Health Areas. (NB: as part of the former PEC NGO program, many rural areas already have a recent population count, which the MOH/SIAS plans to update and certify rather than disregard and start over).

In March, the MOH central level issued guidelines to regulate the use of the official form to be used to collect data on the household and family members and/or to certificate croquis and population count (census).

During this quarter, staff from Totonicapán and Quetzaltenango, trained in December, replicated the training at the health district level for first level providers and are now ready to proceed with the population count and then request the certification process. Nutri-Salud has also provided support to produce the community sketches (maps) in four of the recently created territories in the Ixil area, where territories and communities have been georeferenced.

Before the PEC program closed, a population count had been recently completed in many rural areas. These population counts can be updated/validated and then certified, without re-doing the entire process. With the objective of identifying the requirements/steps need to update and certify the existing population counts, Nutri-Salud helped to carry out a rapid assessment in San Marcos. Fourteen of 34 health services already had completed a population count (using the MSPAS's earlier data collection instruments). The next step is to

Nutri-Salud supported skills building of 184 students assigned to first-level in San Juan Ostuncalco and Momostenango as well as two *municipios* in San Marcos and two *municipios* in Huehuetenango:

		Participants			
Students	**Date**	**Male**	**Female**	**Total**	**Topics Covered**
Medical students from the Universidad Landívar, Quetzaltenango campus	12-15 January	4	4	8	• Essential Nutrition Actions • Growth Monitoring and Promotion and Counseling • The Wheel of Behaviors for Better Living • Mapping and risk groups
Medical students from the Universidad San Carlos, Quetzaltenango campus	16-18 March	36	36	72	• Essential Nutrition Actions • Growth Monitoring and Promotion and Counseling • Mapping and risk groups • Maternal and neonatal health
Nursing students from the Escuela Nacional de Enfermeras Profesionales in Quetzaltenango	11-12 March	15	89	104	• Care of the healthy newborn • Bonding and exclusive breastfeeding • Clean birth and Helping Babies Breathe • Active Management of the Third Stage of Labor (AMTSL)

Facilitative supervision in Huehuetenango to improve health dashboards

validate if these existing data comply with the MSPAS guidelines for certifying them. If not, the population count will need to be repeated.

During the first week of the third quarter (April 7-10), Nutri-Salud provided technical and financial assistance to key MOH staff from Group II, training them on the population count, including the production of sketches, and the certification process.

Result 1.4: Maternal and child cases of severe acute malnutrition identified and treated

As mentioned in the above sections, Nutri-Salud supported the MOH in implementing standardized GMP workshops, during which participants carried out practical exercises to determine and analyze nutritional status of children under two. As acute malnutrition is part of the indicators used to classify nutritional status, this was also included in the contents for these workshops. Along with the workshops, in this quarter Nutri-Salud continued to support local health area teams to analyze the deaths that had resulted from severe acute malnutrition, following the "critical link" methodology. These discussions are an opportunity to identify weaknesses and provide suggestions to implement preventive measures, such as the fact that in all health areas the availability and correct use of child registries to monitor growth and services provided needs to be reviewed and may benefit from trainings in the correct use of these. For example, NS emphasized the need conduct home visits to all children under two and especially to those identified as growth faltering, and follow up children with acute malnutrition to prevent complications. This was also emphasized during the GMP training workshops.

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Activities Planned for Next Quarter

Subject to change once the revised program description is approved)

- Diplomado: In April, Nutri-Salud will offer the newly trained MOH facilitators a refresher workshop, after which point each facilitator will be responsible for managing a study circle of auxiliary nurses in their respective DMS. The implementation of the diplomado is expected to run from April-July or August, 2015.
- MOH Capacity-Building: Nutri-Salud will continue to support 6 DAS and 33 DMS to complete a full round of GMP workshops and tutoring/facilitative supervision to health posts
- Population Count: Technical assistance to health areas and districts to complete the population count and sketches in order to obtain certifications. Nutri-Salud will also provide the forms and documentation required for these and basic inputs for data collection

Component 2
Maternal, Neonatal, and Child Health Care

Under this component, the project works to improve the quality of obstetric and neonatal care in health posts, and other primary care facilities by strengthening the competencies of MOH staff as well as community health workers. A community-based obstetric and neonatal health care approach complements clinical management of maternal and birth complications. In Huehuetenango, nine rural health stores (TISAs), have been helping to bridge the gap created by the absence of PEC NGOs. TISAs provide basic supplies and medicines at the community level, bringing medicines closer to people. Nutri-Salud is working to strengthen coordination between TISAs and local MSPAS health districts and first level providers.

Workshop on Integrated Women's Health in Huehuetenango

Result 2.1-2.2: Access to obstetric and newborn health care improved; Access to infant and child health care improved

Capacity-building for improved quality and coverage of primary (first level) care

Guatemala ranks third in maternal mortality in Latin America. In the WHIP area, the rate is even higher. To support frontline health workers to better address this situation, Nutri-Salud worked jointly with DAS and DMS to enhance the availability of standardized training on integrated care of women during pregnancy, delivery and post-partum. The training includes improvement of knowledge and development of skills related to ENA for women, strategies for preventing maternal death, and counseling. To build the skills of DAS and DMS trainers, Nutri-Salud co-facilitated workshops for 201 women and 161 men who are frontline providers. (See Annex 2)

Health Dash-Boards

As mentioned above, Nutri-Salud and DMS staff provided facilitative supervision through tutoring visits to individual health posts, following the completion of the capacity-building workshops on GMP and integrated care of women. During these visits, the MOH and Nutri-Salud teams also verified the existence and use of health "dash-boards" (sala situacional), with a special emphasis on verifying the quality of the data related to nutritional status, presented in these dashboards. In most sites visited, health dashboards are produced–but are not being used for decision making; information on how and when to use these was provided in the visits. Services don't use the information to identify high risk cases that need special attention and follow-up and dashboards are not accompanied with a list of these cases identified in each community.

Activities Planned for the Next Quarter

(Subject to change once the revised program description is approved)

- Follow-up to trainings on integrated care of women during pregnancy, delivery and post-partum, through facilitative supervision/coaching
- Support for the maintenance of updated data contained in community mapping/surveillance of pregnant women, deliveries, postpartum women and newborns (improved service network)
- Practical training of medical and nursing students in key areas of health and nutrition during the 1000 day window of opportunity
- Logistics support to primary care facilities by monitoring the supply of inputs and drugs and updating logistics databases as needed by DAS and DMS to support the 1000 day window of opportunity

Component 3
Family Planning

Family planning has positive effects on maternal, neonatal and child health outcomes and is an important part of an integrated strategy to reduce chronic malnutrition and improve community health. From 2012 – 2014, Nutri-Salud promoted community-based reproductive health and family planning services through strengthening of program planning, strengthened community participation and built the capacity of community organizations to distribute family planning methods at the community level. During this quarter, activities were scaled back per the request of USAID. Nutri-Salud focused primarily on the activities carried out through three Fixed Obligation Grants (FOGs) implemented by local NGOs as well as strengthening the rural health stores (TISAs). In coordination with DAS, two of the stores are now selling condoms.

Result 3.1-3.3: Effective CBD programs for family planning services implemented, including preventive services for adolescents; Community participation and advocacy for family planning and reproductive health increased; Capacity of selected local organizations to guarantee the quality of community-based distribution of family planning services guaranteed

This quarter, Nutri-Salud promoted community-based reproductive health and family planning services through technical assistance to the formal health care sector to improve counseling and service delivery through grants to local organizations that are working on sexual and reproductive health programs focused on youth and adolescents. The grants focus on behavior change communication among the youth and their parents through mass media campaigns emphasizing rights, gender and cultural relevance. Other activities include building the technical capacities of a team of youth facilitators to promote sexual and reproductive health and to promote the social and economic development of organized youth.

Reproductive Health Sub-grant: Pies de Occidente (Quetzaltenango and Totonicapan)

During the quarter, Pies de Occidente's achievements included:

- The formation of a team of 24 youth/ adolescents facilitators who host educational sessions. This team of facilitators continues to receive training and have participated in 10 of the 12 planned training sessions.
- A program of sexual and reproductive health education for students in public high schools and a module aimed at parents were developed. Both are being taught at educational establishments (4 *municipios*) to a total of 2,754 students representing 100% of the school population.
- The design and development of the brochure "My body, my choice: I live my sexuality responsibly," which will be used with adolescents and youth in the next quarter.
- Broadcasting of 12 radio programs involving youth/ adolescents, parents/mothers to promote the importance of sexual and reproductive health.

Reproductive Health Sub-grant: ACODIHUE in San Antonio Huista and Cuilco, Huehuetenango

During the quarter, ACODIHUE's achievements included:

- Educational sessions, forums, and health fairs that promote knowledge of sexual health were attended by 975 adolescents and young students from public and private schools in the municipalities of San Antonio Huista and Cuilco
- The hosting of community meetings about responsible parenthood that were attended by 743 parents. These meetings covered topics such as maternal and child nutrition, healthy birth spacing, and the need for sexual and reproductive health education among adolescents.

- Supporting the development of life plans with 858 adolescents and young people using the "Train of Life" methodology to plan for the future: study, travel, work, friends and family. Commitment letters were signed by teachers to monitor life plans. By the end of the quarter, 318 life plans had been developed.
- Couples counseling was conducted for young couples and adolescents to promote the health formation of a family. Counseling was personalized and through home visits and topics covered were: family planning methods, decision making, and self-esteem, sexual and reproductive rights. 675 were reached through these counselling sessions
- 24 radio programs were broadcast in local languages to promote evidenced based decision making concerning sexual and reproductive health.

Reproductive Health Sub-grant: Red Cross in San Marcos

During the quarter, Red Cross achievements included:

- Educational workshops benefitting 1628 adolescents and youth were implemented. This goal was surpassed thanks to advocacy by teachers who have identified the importance of sexual and reproductive health activities and who have asked Red Cross volunteers to work with their students using the "I love myself, I decide, I participate" methodology which teaches on issues of self-esteem and sexual and reproductive health.
- 3,936 adolescents (students and youths not in school) received education in sexual and reproductive health. Red Cross volunteers implemented short workshops with youths by visiting the homes of young people and conducting group activities. This quarter, the Red Cross took advantage of entertainment events such as sporting events, movie nights, and in some communities, embroidery sessions to attract youth. The activities have achieved greater attendance are sports events and movie nights. The events were well received by community leaders.
- Because of the recent change of authorities in communities, the Red Cross worked to promote the "I love myself, I decide, I participate," methodology by electing a community health promotor in each community.
- Through the use of information kiosks located in parks, schools, sports fields, fairs and other places where youth spend time, balanced counseling was provided to 1345 youths and adolescents. This activity was particularly attractive to young people of both sexes and very rewarding for volunteers who made this strategy work.

Activities Planned for Next Quarter

- Continued supervision and close-out of family planning sub-grants

Component 4
Community Mobilization

The purpose of this project component is to increase the effective participation of local governments (including municipal and community development councils), community action groups/social networks, and community leaders such as traditional authorities in improving community health and nutrition. From 2012-2014, the project sought to raise awareness among citizens, community leaders, municipal authorities and members of municipal and community development councils about the causes of chronic childhood malnutrition and other poor health outcomes, and to strengthen municipal investment and collective local action in health promotion and prevention activities that contribute to reducing the prevalence of chronic malnutrition. Because of scaled back implementation during the current quarter, Nutri-Salud was not active in community mobilization except through the four local NGO sub-grantees working in 12 *municipios* in the Health Areas of Quiche, San Marcos, Ixil, Quetzaltenango and Totonicapán.

Result 4.1 Strengthening community organization to improve nutrition and health

As part of the technical assistance to the local NGOs, Nutri-Salud supported them to develop Project sustainability plans. The plans include the development of (1) a guide and supporting educational materials for training and certifying community leaders and (2) signed community commitments detailing the community's role in continuing the community health and nutrition plans. Another key input for sustainability planning is the ongoing work to incorporate the priority community projects into municipal development plans by coordinating with the Municipal Planning Departments who are well poised to help identify financial and other support in the future. The associations that were formed will provide ongoing support to the established networks of men and women through their projects and/or by connecting them with other local actors.

Highlights of Activities

Community Mobilization Sub-grant: APEDIBBIMI (Chajul, Cotzal and Nebaj in the Ixil Area)

- During the quarter, APEDIBBIMI trained 200 COCODES, 1,608 men and women in 54 communities in health and nutrition.
- Community assemblies were used to analyze progress in implementing community health and nutrition plans. Seventy percent of the communities have implemented actions to improve the health outcomes for women and children. Examples of the actions include: garbage collection, cleaning water collection/distribution tanks, using water filters (distributed by other projects), community clean-up campaigns, and fencing animals to separate them from family space.

Community Mobilization Sub-grant: ECO (Sibinal, San Rafael Pie de la Cuesta, San Lorenzo, San Pablo and El Rodeo in San Marcos)

- ECO trained 383 women leaders about the importance of citizen participation and the effects of women's leadership in communities. ECO also held a youth encounter for 25 young leaders from the communities in San José el Rodeo
- A total of 18 strategic plans in Health, Nutrition, Water and Sanitation were presented during community assemblies as well as to COMUDES and Municipal governments in Sibinal, San Lorenzo, San Rafael Pie de la Cuesta y San Rafael el Rodeo. These strategic plans were incorporated into municipal development plans for their future implementation/follow-up.

Community Mobilization Sub-grant: ASDECO (Chichicastenango, Quiche).

- 56 members of the COCODE for the second level completed a training program on family planning and healthy maternity.
- 56 communities held assemblies to prepare project results to be presented to municipal governments

Diplomado: "Leaders promoting healthy lifestyles", in Chichicastenango

for incorporation in municipal development plans. Sixty percent of the communities have implemented specific action to improve community health and nutrition including expanding water systems and/or improving water purification systems.

- In February ASDECO completed the training of 366 COCODE representatives and women's groups in Chichicastenango, through the Diplomado called "Leaders promoting healthy lifestyles", which reviewed several topics that reinforce the capacity building efforts that NS has done with both health providers and community members. Topics reviewed include the conceptual framework of chronic malnutrition, 1000 WOP, family planning and health motherhood as well as the Wheel of Practices for better living. Participants have replicated the trainings with members of their communities, surpassing the expected target of people trained. The training is part of the community mobilization actions that ASDECO promotes and has resulted in community leaders getting involved in developing health and nutrition plans for their communities.

Community Mobilization Sub-grant: Pies de Occidente: San Juan Ostuncalco and Concepcion Chiquirichapa in Quetzaltenango and Momostenango and Santa Lucia La Reforma in Totonicapán

- 493 women who belong to community-based women's groups participated in workshops to develop inputs to municipal agendas. They were also trained in health, nutrition and citizen participation.
- 190 community leaders and 833 COCODE members from a total of 74 communities in 4 *municipios* participated in workshops to help them identify their roles and responsibilities in health, nutrition, water and sanitation.

Result 4.2: Municipal investments in water and sanitation services, and other health and nutrition actions increased

In the first half of this quarter, before further scaling back the work plan, Nutri-Salud continued its ongoing support for several activities to promote municipal investment in water and sanitation services. Among these:

- San Marcos. The project supported four municipalities in San Marcos (San Lorenzo, San Miguel Ixtahuacan and Tajumulco) in the design of a project to install hipocloradores in 38 communities. The documentation was submitted to the corporate social responsibility unit of AMANCO – a construction company. If funded, the projects will be implemented jointly with the health area.
- Totonicapan. As a result of the training of the Momostenango municipal council on safe water, the council members committed to the task of surveillance of water quality and working with community members in promoting the use of safe water at the household level.
- Nebaj. Together with WHIP projects working in Nebaj, Nutri-Salud supported the municipality in completing an information and communication plan to promote safe water activities. The plan which includes radio spots has a total budget of approximately $3,000, for which funding is still not available.

Special Activities

Development of alternative models for primary care service delivery

Jointly developed and implemented by USAID/Nutri-Salud, the Inter-American Development Bank (IDB) and the Guatemalan private sector's Alliance for Nutrition, this activity aims to develop a proposal to restructure the organization and delivery of primary health care. The proposal is being generated from the lessons learned garnered by assessing national and international models/standards for primary health care delivery systems followed by a review of epidemiological profiles in Guatemala, costing studies of various models/approaches, staffing plans and options for organizational structures and delivery systems, among others. In this quarter the following specific activities were completed:

1. Define the optimum package of services for the first level of care in Guatemala, including: i) defining the set of interventions that should be offered by the MOH network of facilities as well as the complementary responsibilities of organized civil society groups, communities themselves, and municipal governments. The package was also grounded in a literature review of the most cost-effective interventions, considering the legal framework in which the MSPAS and municipal governments operate; ii) estimates of the 2015 population (by age groups based on a life cycle approach) to be covered by each intervention; and, iii) an estimation of demand by specific causes of morbidity, based on prevalence data generated by the national health information system.
2. Define the gap which exists between the optimum package of services and the current MSPAS capacity to respond to the population's needs for health services. Nutri-Salud and its partner INCAP are supporting the analysis of data collected at the beginning of 2015 on the status of first level health facilities including physical infrastructure and equipment, availability of supplies, knowledge of current MSPAS service delivery norms, and use of data. Current MSPAS capacity will be compared to the minimum capacity that would be needed to deliver the optimum package of services to reach universal coverage (at least 80% of the population) with the pre-defined interventions.
3. Other products generated included a technical review of the draft inputs for the costing component of the draft proposal as well as a proposal of functions/responsibilities that will be required of institutional and community-based staff.

Analysis of Municipal Investment in Health

According to the Guatemalan Municipal Code, local governments are responsible for generating the conditions required to guarantee a healthy environment. Hence, in coordination with the MSPAS, municipal governments should ensure that conditions exist for the appropriate delivery of health services. During the quarter, Nutri-Salud initiated an analysis of the role that local governments currently play in the delivery (or support for the delivery) of health services. Specifically, the study examines health investments made by the 30 municipal governments in the WHIP area and documents four specific examples of strong municipal performance/leadership in this regard.

The analysis identified four categories of municipal investment: Strengthening the network of facilities; water and sanitation; healthy enabling environments; and, improved physical access to health facilities. Specific examples for each of the four categories were identified among the 30 *municipios* (see table on page 19). The first two categories are considered "direct" investments, while the other two categories are "indirect" investments in health. The analysis conducted includes the percent of municipal funds invested in 2014 in health-related activities in each of the 30 *municipios*. Annex 5 contains a graphic depiction of investments in each municipio. San Pablo, San Marcos had the highest investment while San Lorenzo, San Marcos had the lowest. The study will be completed in the next quarter.

Municipal Investment in Health, by Category			
Strengthening the Network of Health Facilities	Water and Sanitation	Enabling Environment	Improved Physical Access to Health Facilities
Infrastructure (health facilities)	Community water systems	Healthy Schools and Markets	Rural Roads to improve access to health facilities
Contracting of human resources	Drinking water treatment	Household/community environment which allows for healthy development of family members	Facilitate emergency transportation mechanisms
Incentives for community health workers	Projects to address human waste disposal	Creating healthy spaces for health and nutrition	Promote local transportation systems for pregnant women
Provide equipment and furnishings for minimum health units or health posts	Management of solid waste	Support to community networks engaged in health promotion	Support community emergency plans
Municipal pharmacies	Project for healthy homes	Incorporate health and nutrition topics in art and culture projects	Set up early warning systems

Activities Planned for Next Quarter

- Complete the study on municipal investment as well as the four case studies on municipal innovation and leadership in health investments
- Finalize the health facility assessment
- Complete a community mapping exercise to identify the actors involved in health service delivery at the national, departmental and municipal levels
- With IDB and the Alliance for Nutrition, support the development of the first draft of a proposal for the restructuring of first level care in Guatemala
- Design consultative workshops on the draft proposal, engaging with a broad range of actors

Challenges to Implementation and Solutions

Challenges	Solutions
MOH reorganization of the first level of care: In January 2015, the MSPAS cancelled the PEC NGO program and began to reorganize the first level of care based on a plan to establish mobile teams to cover communities that had benefitted from the PEC NGOs. The MOH updated/redefined geographical units (territories) based on estimated population, created new positions and began a process of selecting/contracting additional staff.	The various health areas have responded to the reorganization in different ways, and Nutri-Salud has worked at the local level to support the DAS and DMS to find creative ways to support community health during the transition from PEC to mobile teams. In San Juan Cotzal, for example, the mayor hired 35 people to compensate for the loss of PEC. N-S is supporting DAS/Ixil and the DMS to train and support the new staff (many of whom are former PEC NGO workers). In San Juan Ostuncalco, Nutri-Salud helped establish a new minimum health unit. And finally, Nutri-Salud is helping the DAS and DMS to build the capacities of new staff as they are hired through standardized trainings on priority topics (diplomado, growth monitoring and promotion, and integrated care of pregnant and post-partum women).
The APRECIE methodology was implemented in only 21 supervision areas in Quiche and Ixil. The reorganization of first level of care (referred to above) interfered with the use of APRECIE in other areas.	Although the APRECIE approach for continuous quality improvement is suspended for the time being, pending the conclusion of the ongoing process of reorganizing the first level of care and the identification of updated/new supervision areas, Nutri-Salud is prepared to reinitiate support for this proven methodology in the third or fourth quarter of FY 2015. Reinstating the approach will require aligning the sampling methodology to the new territorial organization of the MOH.
Potential politicization of local governments leading up to national and local elections.	Nutri-Salud staff are sensitized as to the risks that some mayors and local candidates may try to use the health sector reorganization and closure of the PEC program as electoral topics.
Revised Program Description is pending: Nutri-Salud was informed by USAID in February that the project scope would be changed, with details to follow by the end of March (a target date later pushed back to May). Pending the formal modification of the Cooperative Agreement, USAID has authorized Nutri-Salud to work on only 4 core activities (population count, certificate course on nutrition, development of alternative models, and MOH/DAS/DMS capacity-building around the 1000 day window of opportunity), without acquiring any commitments beyond the end of May, making coordination/planning with the DAS/DMS and other USAID project challenging. The project's PMP is no longer valid and the project's direct contribution to USAID's WHIP goal of an annual 2% decrease in chronic malnutrition has decreased.	Nutri-Salud will respond as required to the upcoming modification of the Cooperative Agreement included (as appropriate/needed) a technical proposal, revised PMP, revised strategic plan, revised SBCC strategy, staffing plan and organization structure, and revised budget. Once the new Program Description is approved, Nutri-Salud will be in a position to update plans and coordination mechanisms with DAS, DMS and other USAID projects.

Project Management

Sub-Grants

Nutri-Salud supports community level maternal, neonatal, and child health service delivery, community-based reproductive health and family planning activities, and the active participation of community actors in health and nutrition activities through sub-grants to local non-governmental organizations. During this quarter, Nutri-Salud closed out 18 sub-grants with local PEC NGOs which had completed their activity implementation during the previous quarter. In addition, Nutri-Salud managed 4 community mobilization grants focused on strengthening the community development council system for improved participation in health and nutrition activities and three grants to improve sexual and reproductive health services for youth.

These sub-grants, with a total value of $1,901,491.41, are administered as Fixed Obligation Grants (FOGs) based on technical deliverables that are submitted by sub-grantees on a quarterly basis. Technical monitoring of sub-grant implementation is done by Nutri-Salud's Public Health Managers who lead Nutri-Salud's field teams. The review and approval of sub-grant deliverables is coordinated by Nutri-Salud's Grants Manager.

PEC Sub-grants

During the quarter, the final close-out of the eighteen sub-grants was completed. As reported in the previous quarter, these grants were terminated early based on the lack of core MOH budget resources which were needed to sustain their central operations. Without these resources, it was not possible for the sub-grantees to meet their scheduled deliverables. Nutri-Salud reimbursed them for expenses incurred in their efforts to meet deliverables prior to the termination of the grant.

Community Mobilization and Reproductive Health Grants

The seven sub-grantees that are implementing Community Mobilization and Reproductive Health sub-grants were monitored this quarter and deliverable submissions were reviewed by Nutri-Salud's grants management team. Details on the technical implementation of these sub-grants can be found in previous sections of this report.

Monitoring and Evaluation

APRECIE Implementation

With the loss of health providers in community convergence centers the areas previously under the PEC program, there are far fewer providers covering the target communities. This means that there are also fewer staff available to form the Quality Improvement Teams which implement APRECIE. Although Nutri-Salud plans to promote the methodology once the MSPAS has completed its reorganization and mobile teams are functioning, two health areas have continued to implement APRECIE. Twenty-one of the prior supervision areas in the Quiche and Ixil Health Areas completed the 8th APRECIE measurement. The results are described in detail in Annex 5.

Institutional Communication and Knowledge Management

As part of the knowledge management efforts, the project held several internal meetings, as well as workshops with project partners. Knowledge management activities and events in this quarter include:

Weekly reports

Nutri-Salud continued to inform USAID on the achievements through the Weekly News & Activities Report, and the Activities Calendar.

Non-PEC NGO training

A workshop with the seven sub-grantees implementing Community Mobilization and Reproductive Health sub-grants was held in March in an effort to help them prepare for the close out of these awards, in the next quarter. The workshop began with discussions on the progress and results to date of these awards, followed by a working session to develop project sustainability plans which will include a guide and supporting educational materials for training and certifying community and signed community commitments. The need to incorporate the priority community projects into municipal development plans was also discussed and should be done before projects end. The workshop ended with a session on the branding and marking requirements for sub awards, followed by a Q&A time.

Tiahrt Amendment

In this quarter, NS completed the annual Tiahrt Amendment training for all project staff. In an effort to monitor Tihart Amendment compliance, in this quarter, local project teams conducted seven interviews to first level health providers and eight Fammily Planning users in four municipalities. The interviews provided evidence that providers are offering all FP methods available, without being subject to quotas or receiving incentives. Although all providers provided counseling on FP, in many cases providers don't have job aids and not all of them had all the methods available. Users interviewed referred having received counseling and being able to freely choose their methods, without the pressured from health providers.

Methodological Guides. As mentioned under Components 1 and 2

Nutri-Salud supported the MOH in developing two methodological guides to carry out standardized training workshops on GMP and Integrated Care of women during pregnancy, delivery and post-partum (see Annexes 6 and 7). The training includes improvement of knowledge and development of skills related to ENA for women, strategies for preventing maternal death, and counseling. These documents are part of the MOH's efforts to enhance the abilities of DAS and DMS staff to monitor, supervise and improve the quality and coverage of first-level health services.

Rapid Response Funds

The Nutri-Salud Project includes a Rapid Response Fund (RRF) which allows the Project to quickly and efficiently respond to unanticipated issues or to design program activities in response to opportunities that were not foreseen or anticipated but that offer high pay off within any of the components under the Cooperative Agreement. In September 2014, USAID approved the use of RRFs to contract one or more national experts in primary health care service delivery. The experts are to support USAID, the Inter-American Development Bank (IDB) and the private sector's Alliance for Nutrition to develop alternative approaches for community-based health service delivery in rural areas. The initiative responds to the need for a viable approach to ensuring quality services are available to poor families living in rural areas, especially given the Guatemalan Government's decision to terminate NGO sub-contracting before having developed a new model or transition plan.

The RRF has enabled Nutri-Salud to hire an expert consultant (see above section on consultants) who is working closely with the IDB and the Alliance for Nutrition in a review primary health care models and the development of alternatives for Guatemala going forward. By June 2015, a draft proposal will be ready for discussion with the Ministries of Health and Finance, civil society actors, political parties, academics and others. After the proposal is updated based on the feedback a multi-year plan for its implementation will be developed.

Activities Planned for Next Quarter

- Complete the draft proposal for alternative models of primary health care in Guatemala, disseminate the draft for feedback with a wide array of actors, and develop a multi-year work plan outlining the steps required to implement the model
- Close-out of four community mobilization sub-grants and three reproductive health sub-grants
- Depending on the content of the revised program description and the completion of the reorganization of first level services, explore options for re-instating the APRECIE methodology with DAS and DMS in the project area

Staffing and Administration

Local Consultants

The following local consultants were under contract in the first quarter

Ivan Mendoza

During this quarter, the consultant focused on three objectives: (1) support the joint efforts of USAID, IDB and the private sector Alliance for Nutrition to develop a proposal for providing health care services to rural communities in Guatemala in anticipation of the closure of the PEC program by 2017; (2) assess the quality and focus of Nutri-Salud's activity planning and implementation to maximize results achievement; and, (3) facilitate a new community level initiative to strengthen nutrition health promotion activities across the USAID WHIP portfolio of projects. The first objective is funded with Rapid Response Funds and the inter-agency team expects to have the proposal for a new service delivery model ready by June 2015 so it can be discussed in national workshops with health experts, civil society groups, and political parties. The second is funded with regular project funds. The third objective was recently added to the consultancy agreement (and deliverables have not yet been submitted).

Deliverables Objective 1 (Rapid Response Funds)

- Technical inputs for the development of a new service delivery model for first-level care, identifying interventions according to the life cycle approach (for women and children)
- Proposal for forming the basic health teams, including a profile for each team member, place of work, role and responsibilities, and performance profile

Deliverables Objective 2 (Regular Project Funds)

- Training plan for Nutri-Salud field staff based on the revised work plan submitted to USAID in December 2015
- Strategy and short-term work plan to strengthen the quality and coverage of services provided by health posts, consistent with the revised work plan submitted to USAID in December 2015
- Proposal for improved coordination by Nutri-Salud with other donors, other USAID WHIP projects and GOG entities
- Facilitated the development by Nutri-Salud local field teams of a new six-week work plan for mid-February through March 31, 2015

Deliverables Objective 3 (Regular Project Funds)

Will be reported next quarter

Silvia Escobedo

Administrative and project management support

Deliverables

- Project filing system routinely maintained
- Weekly news summaries and activities reports submitted to USAID
- Weekly senior management team (SMT) meetings organized, with agenda and minutes
- Field trips for COP organized and travel claims processed
- Assisted with preparations for the USAID financial review
- Assisted with meeting arrangements and document preparations with the Ministry of Health and other actors

Annex I
Performance Indicators, Targets and Results

Service indicators are analogous to those collected through population-based surveys and are used to monitor progress of project activities towards achieving key milestones and results related to project objectives at the primary health care facility level. As shown below, indicator targets for which there are data were not met this period due to circumstances beyond the project's control; primarily because of shortages and interruptions in the availability of micronutrients and supplies from the MOH as well as the lack of first level health providers to cover areas that had been under the PEC Program. [NB: Nutri-Salud will develop a revised or a new PMP based on the upcoming modification to the Program Description, linking specific indicators with the updated results framework].

	Indicator*	Target	Q1	Q2	Performance >90%
Result 1.2: Improved Maternal and Child Essential Nutrition Actions					
Q1	% of pregnant women seen at supported health facilities who were supplemented with folic acid	50%	25%	33%	X
Q2	% of children 6-59 months of age seen at supported health facilities who were supplemented with folic acid or vitamins, minerals, or micronutrient powder	60%	30%	21%	X
Q3	% of pregnant women seen at supported health facilities who were supplemented with iron	50%	24%	24%	X
Q4	% of children 6-59 months seen at supported health facilities who received iron or vitamins, minerals, or micronutrient powder	60%	30%	21%	X
Q5	% of children 6-59 months seen at supported health facilities who were supplemented with vitamin A	45%	29%	14%	X
Q6	% of women who are malnourished during pregnancy	0.4%	0.5%	0.3%	X

* Q1-Q6 reflect data from all first level facilities. Q7-Q10 reported in previous reports cannot be included as they were only for PEC NGOs.

Annex 2
Trainings and Workshops

	M	F	T
1 Chronic Malnutrition Prevented			
Growth Monitoring and Promotion Comprehensive Women's Health (Pregnancy, Delivery and Post-partum)	**177**	**255**	**432**
Huehuetenango	20	29	49
Barillas	13	15	28
La Democracia	7	14	21
Quetzaltenango	47	81	128
Concepción Chiquirichapa	11	44	55
Quetzaltenango	36	37	73
Quiché	70	54	124
Chajul	16	12	28
Cotzal	34	15	49
Nebaj	15	9	24
Quiche	5	18	23
San Marcos	30	69	99
San Lorenzo	5	10	15
San Miguel Ixtahuacán	15	26	41
San Rafael Pie de la Cuesta	4	24	28
Tajumulco	6	9	15
Totonicapan	10	22	32
Santa Lucia la Reforma	10	22	32
2 Improved Neonatal, Child and Maternal Health			
Helping babies breathe	**8**	**44**	**52**
Quetzaltenango	8	44	52
Quetzaltenango	8	44	52

	M	F	T
Project Management			
Tiahrt Amendment	**18**	**17**	**35**
Quetzaltenango	18	17	35
Quetzaltenango	18	17	35
M&E			
Population Count and Certification	**57**	**103**	**160**
Quetzaltenango	47	81	128
Concepción Chiquirichapa	11	44	55
Quetzaltenango	36	37	73
Totonicapan	10	22	32
Santa Lucia la Reforma	10	22	32
Total general	**260**	**419**	**679**

Annex 3
Financial Report

Period: January 1, 2015-March 31, 2015

Cooperative Agreement No AID-520-A-12-00005

Total Estimated USAID Amount	$31,781,525
Cost Sharing Amount	$6,356,305
Total Program Amount	$38,137,830
Current Obligation	$16,156,793.31

Cost Element	Total Estimated Cost	Cumulative Expenditures to Date	Expended This Period (1/1/2015-3/31/2015)	Remaining Funds
Community Nutrition and Health Care Project	$24,671,528	$11,159,317	$1,341,502.10	$13,512,211
Procurement	$370,119	$433,088	$114.49	$(62,969.12)
Training	$3,000,035	$696,932	$5,696.35	$2,303,103
Indirect Costs	$3,739,843	$2,232,707	$208,666.73	$1,507,136
Total Federal Funds	**$31,781,525**	**$14,522,044**	**$1,555,979.67**	**$17,259,481**
Cost Share Amount	$6,356,305	$5,670,879		$685,426
Total Program Amount (+Cost Share)	**$38,137,830**	**$20,192,922**	**$1,555,979.67**	**$17,944,908**

Obligated Amount	$16,156,793.31
Obligated Spent to Date	$14,522,043.88
Obligated Amount Remaining	$1,634,749.43

Annex 4
Implementation of APRECIE

Nutri-Salud could not actively support the implementation of the APRECIE methodology in the 30 prioritized *municipios* because of the MOH reorganization that is underway which is changing the supervision areas. However, some health providers in Quiche and Ixil decided to continue using the methodology. Despite the financial restrictions, APRECIE reports were received from 18% of the supervision areas (21 out of 117), as shown in Table 1.

Table 1. Number and percent of Supervision Areas (SAs) that submitted reports for the 8th measurement (March 2015)

Health Area	Total SAs	Number SAs submitted	Percent SAs submitted
Grand Total	**117**	**21**	**18%**
Huehuetenango	42	0	0%
Ixil	17	17	100%
Quetzaltenango	4	0	0%
Quiché	23	4	17%
San Marcos	22	0	0%
Totonicapán	9	0	0%

Health promotion indicator results

Many of the supervision areas (SAs) reached the minimum of 80% of coverage (as per LQAS), i.e. a correct response for each question and each indicator was received in 13 out of 19 interviews, which is expected to have a positive impact in the level of knowledge of mothers with a child 0-23 years.

According to the results in Table 2, the percentage of mothers with a child aged 0-23 months who recognize at least three newborn danger signs has decrease slightly. In December 2014, 91% of the SAs showed positive results for this indicator; currently, 86% of the SAs (18 out of 21) reached the expected level of coverage. With respect to mothers who have prepared their emergency family plans and can show evidence of using them, the indicator value decreased from 32% to 10% (2 out of 21), of the SAs that reached the expected level of coverage.

Table 2. Percent of Supervision Areas in Ixil and Quiche that achieved or passed the threshold established for each indicator

Indicator	Measurement 7 Dec 2014 N=22*	Measurement 8 March 2015 N=21*
1. % who report children's adequate feeding according to their age	100	86
2. % who report taking their children to the monthly growth monitoring session (data from vaccination card)	100	95
3. % who recognize at least three danger signs during pregnancy, delivery, and postpartum	91	86
4. % who recognize at least 3 newborn danger signs	86	81
5. % who mention key moments for hand washing	100	95
6. % of household with a child 0 to 23 months of age that have a place with supplies for hand washing (inside or outside the house)	100	95
7. % who recall having been oriented in ENA by community health staff in the last month and mention at least one specific topic.	95	90
8. % who have emergency family plans that show evidence of use	32	10
9. % who know about the recommended number of years for spacing their pregnancies (3 to 5 years)	91	90
10. % who report that a CHW offered or gave her any modern family planning method	100	90
11. % who report children's intake of iron (sprinkles) during the last week	95	85

* Number of supervision areas that reported

The same downward tendencies are obtained when comparing the number of mothers who were interviewed in December 2014 and March 2015 (Table 3). In December 2014, 349 out of 418 (83.5%) of mothers interviewed remembered at least three newborn danger signs, compared to March 2015, when 320 out of 399 interviewed mothers (80.9%) remembered them correctly. This trend of slightly decreased is observed for each indicator measured. All the figures are representative of only Supervision Areas from Quiche and Ixil.

Table 3. Percent of women with a child 0 a 23 months of age who answered correctly according to the criteria for each indicator

Indicator	Measurement 7 Dec 2014 N=418*	Measurement 8 March 2015 N=399*
1. % who report children's adequate feeding according to their age	90.9	80.7
2. % who report taking their children to the monthly growth monitoring session (data from vaccination card)	87.8	87.5
3. % who recognize at least three danger signs during pregnancy, delivery, and postpartum	89.7	83.5
4. % who recognize at least 3 newborn danger signs	83.5	80.2
5. % who mention key moments for hand washing	99.0	92.5
6. % of household with a child 0 to 23 months of age that have a place with supplies for hand washing (inside or outside the house)	93.1	93.2
7. % who recall having been oriented in ENA by community health staff in the last month and mention at least one specific topic.	93.5	86.2
8. % who have emergency family plans that show evidence of use	45.5	31.6
9. % who know about the recommended number of years for spacing their pregnancies (3 to 5 years)	87.8	83.2
10. % who report that a CHW offered or gave her any modern family planning method	96.4	89.0
11. % who report children's intake of iron (sprinkles) during the last week	92.6	80.7

* Total of interviews carried out in the assessment

Chart 1. Percent of mothers with a child 0 a 23 months of age who answered correctly

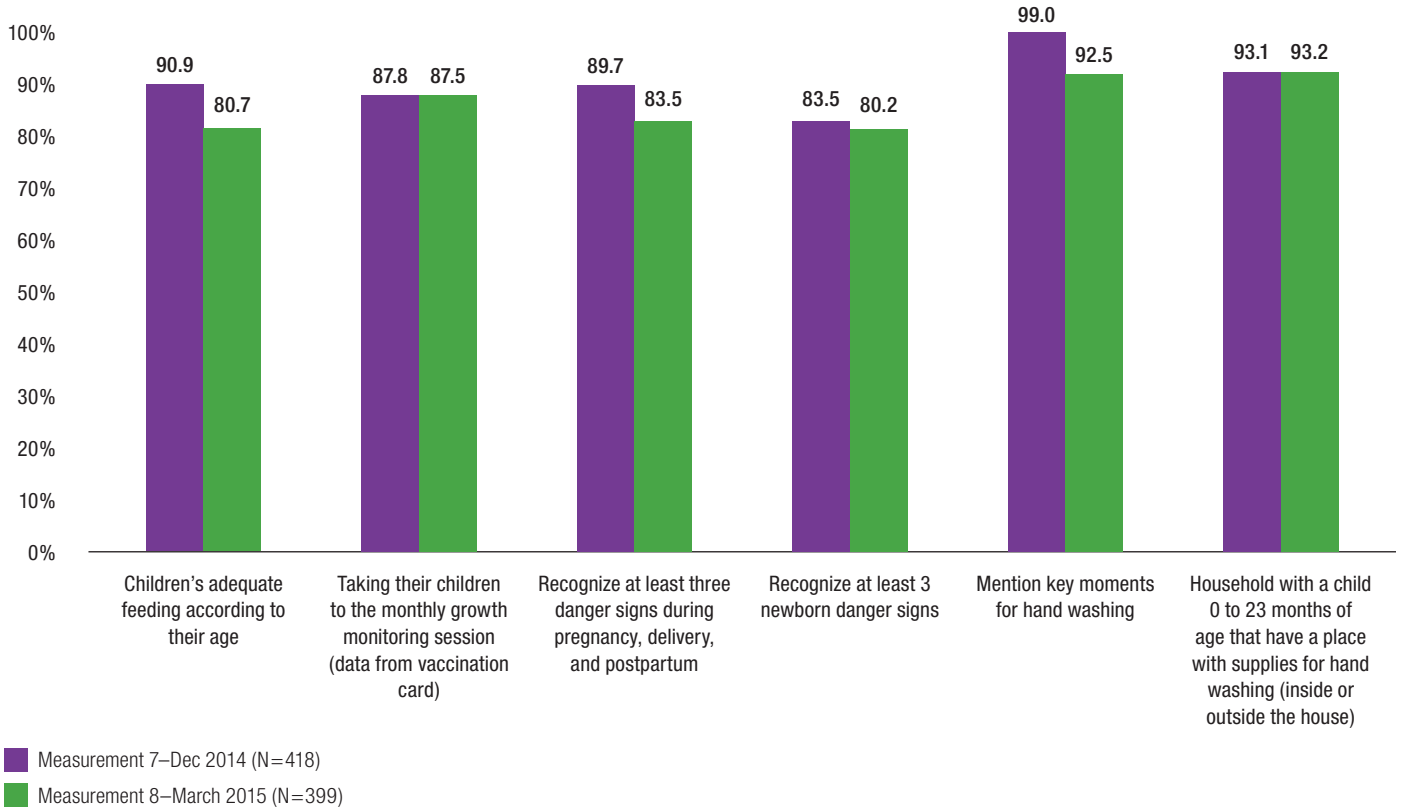
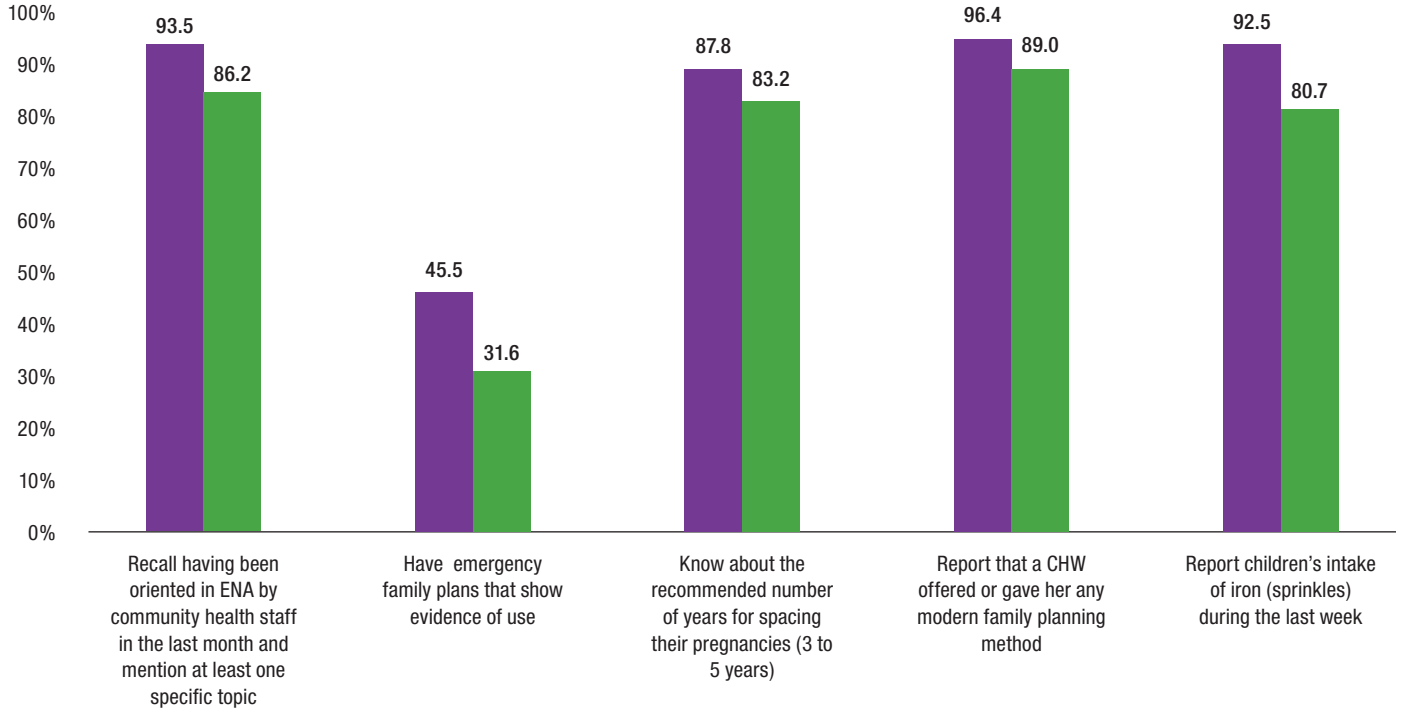


Chart 2. Percent of mothers with a child 0 a 23 months of age who answered correctly



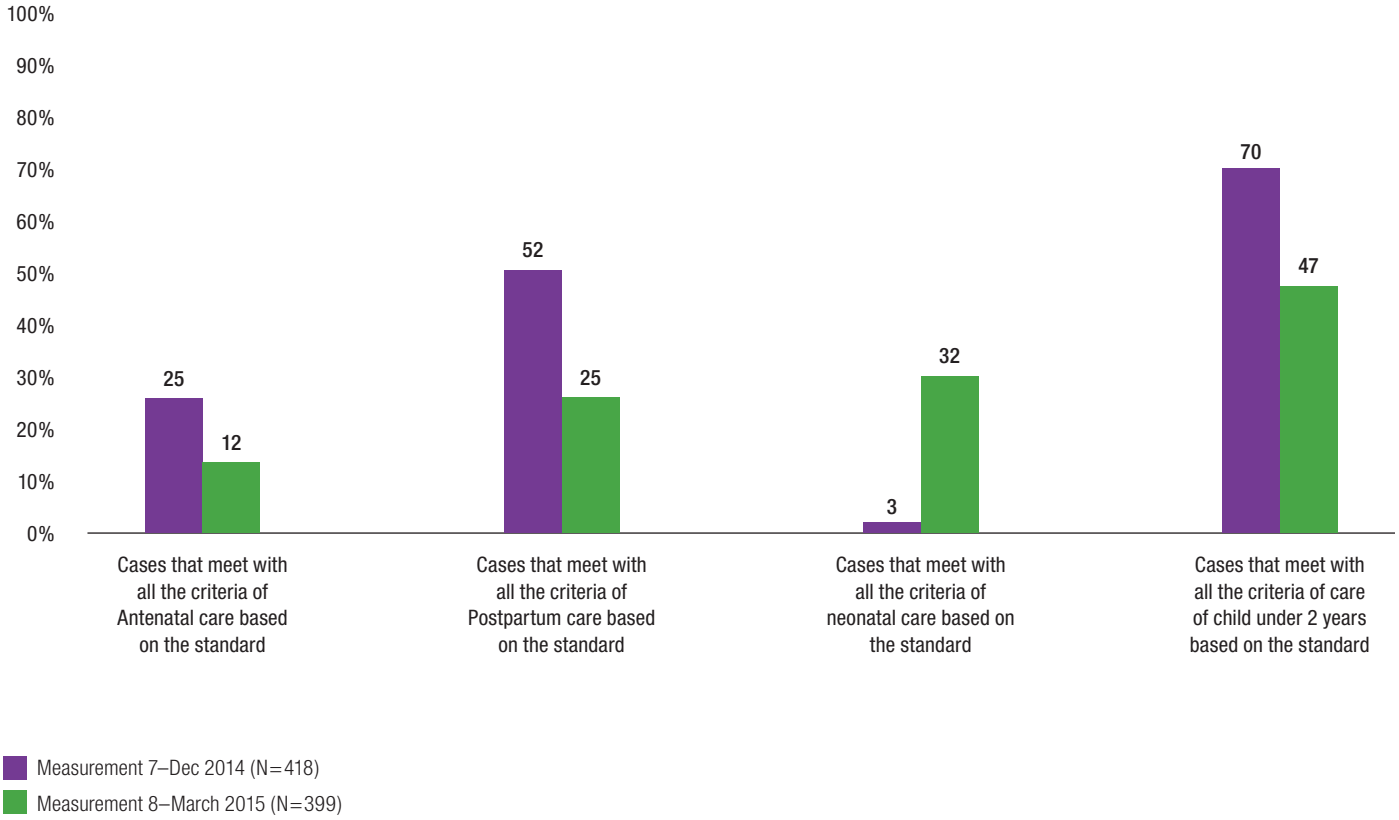
Health service delivery indicator results (pregnant women, post-partum women, newborn, and children less than 2 years of age)

Comparing the last two measurements completed in Quiche and Ixil, the decrease of compliance in the indicators related to prenatal, postnatal and children under two years is significant (Chart 3). The decrease is related to the decreased numbers of health providers and the lack of inputs needed (Tables 4, 5, 6, 7). Only the neonatal care standard improved, due to the availability of Hepatitis vaccine, passing from 3% in December 2014 to 32% of compliance in March 2015.

The health care providers in health posts, in this quarter, also had to serve populations without coverage.

Percentages for each indicator and service delivery criteria do not represent levels of coverage, but compliance with the standards and their respective criteria as per the verification of medical records in primary health care facilities.

Chart 3. Percent of Supervision Areas that reached the threshold[1] established for the indicator



1 Supervision Areas where at least 13 of 19 interviewers answered correctly to the questions related to a specific indicator.

Table 4. Percent of cases that meet all the antenatal care criteria, per the standard

Indicator	Measurement 7 Dec 2014 N=418*	Measurement 8 March 2015 N=399*
Percent Total	**25%**	**12%**
1.1 Assessed signs and symptoms of danger	86	74
1.2 Measured the blood pressure	86	74
1.3 Classified nutritional status	80	67
1.4 Assessed fetal heart rate, 20 weeks or more of pregnancy	79	69
1.5 Conducted Leopold maneuvers, from week 36 of pregnancy	79	67
1.6 Urine test strip in every antenatal visit	44	32
1.7 Determined how many weeks of amenorrhea, gestational age	86	74
1.8 Provided ferrous sulphate	79	68
1.9 Provided folic acid	86	73
1.10 Administered Td vaccine (Vaccination section)	74	43
1.11 Provided a delivery plan	78	63
1.12 Provided family emergency plan	81	72
1.13 Provided a family planning folding leaflet (counselling section)	81	70
1.14 Provided material with information on feeding practices or exclusive breastfeeding during pregnancy (applicable to the quarter)	85	45

Table 5. Percent of cases that meet all the postpartum care criteria, per the standard

Indicator	Measurement 7 Dec 2014 N=418*	Measurement 8 March 2015 N=399*
Percent Total	**52%**	**25%**
2.1 Postnatal care after 48 hours of childbirth	72	49
2.2 Assessed signs and symptoms of danger	84	65
2.3 Measured the blood pressure	84	65
2.4 Measured the temperature	84	66
2.5 Assessed the presence of vaginal hemorrhage	84	63
2.6 Provided ferrous sulphate	78	61
2.7 Provided folic acid	83	64
2.8 Administered Td vaccine	70	47
2.9 Provided a family planning folding leaflet	83	55
2.10 Provided material with information on exclusive breastfeeding (counselling section)	78	49

Table 6. Percent of cases that meet all the neonatal care criteria, per the standard

Indicator	Measurement 7 Dec 2014 N=418*	Measurement 8 March 2015 N=399*
Percent Total	**3%**	**32%**
3.1 Evaluated the newborn during the first 24 hours of life	73	51
3.2 Assessed general signs of danger (IMCI register)	84	69
3.3 Assessed the presence of infection (IMCI register)	84	67
3.4 Assessed malformations or abnormalities (IMCI register)	83	70
3.5 Classified nutritional status (Weight)	83	69
3.6 Administered the Hepatitis vaccine	4	42
3.7 Provided counselling on exclusive breastfeeding	84	67
3.8 Provided counselling on newborn care	84	68

Table 7. Percent of cases that meet all the criteria for the care of children under 2 years, per the standard

Indicator	Measurement 7 Dec 2014 N=418*	Measurement 8 March 2015 N=399*
Percent Total	**70%**	**47%**
4.1 Weighed	85	65
4.2 Classified weight for age	85	64
4.3 Measured the length/height in the first consultation or at least once every 6 months for children less than 2 years of age	84	64
4.4 Classified height/age (or chronic malnutrition) as per the growth curves	85	62
4.5 Provided counselling according to the age (counselling section)	82	62
4.6 Administered Vitamin A, from month 6	78	55
4.7 Provided iron, from month 6, or provided multi-vitamin Powder	80	55
4.8 Provided folic acid, from month 6, or provided multi-vitamin powder	81	55
4.9 Verified and ensured the administration of vaccines according to the age	77	62

Next Steps

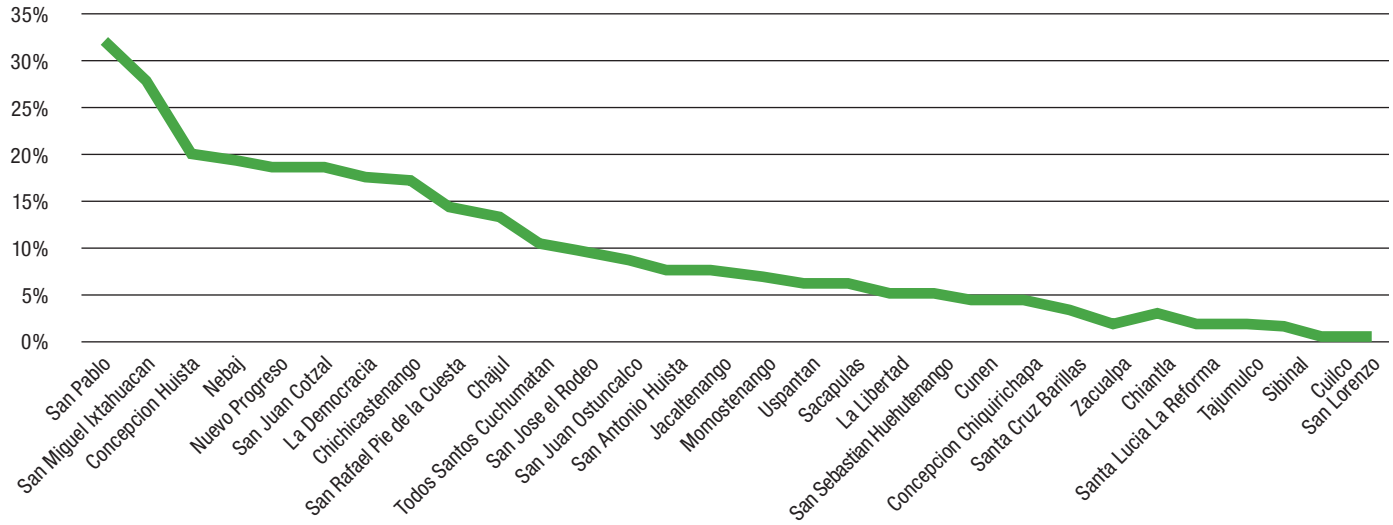
Given the current situation, Nutri-Salud plans to reinstate its support for the APRECIE methodology in Q3 or Q4 of FY 2015, depending on the timing of the completion of the MSPAS's reorganization of first level services. Sampling/supervision areas will be reconfigured and training will be conducted to bring new MSAPS staff on board.

Annex 5
Analysis of Municipal Health Investments

Health Area	Municipio	Annual Health Budget 2014	Investment in Health 2014	Investment in Direct Categories	Investment in Indirect Categories
Ixil, Quiche	Nebaj	Q10,080,788.85	30.04%	19.46%	10.58%
	San Juan Cotzal	Q5,143,730.18	19.31%	18.15%	1.17%
	Chajul	Q10,568,016.89	29.40%	13.13%	16.27%
Quiche	Sacapulas	Q2,709,567.36	6.11%	6.11%	0.00%
	Uspantan	Q3,895,082.17	9.62%	6.18%	3.44%
	Cunen	Q1,646,573.72	5.34%	4.43%	0.91%
	Zacualpa	Q485,236.06	2.49%	2.49%	0.00%
	Chichicastenango	Q9,202,757.23	17.22%	17.22%	0.00%
San Marcos	San Jose el Rodeo	Q2,379,525.03	9.39%	9.39%	0.00%
	Nuevo Progreso	Q3,690,119.31	19.95%	18.74%	1.21%
	San Lorenzo	Q20,000.00	0.13%	0.13%	0.00%
	San Miguel Ixtahuacan	Q71,636,878.94	34.92%	27.41%	7.51%
	San Pablo	Q8,870,836.64	32.07%	32.07%	0.00%
	San Rafael Pie de la Cuesta	Q2,601,316.92	14.14%	14.14%	0.00%
	Sibinal	Q242,429.74	1.07%	1.07%	0.00%
	Tajumulco	Q5,151,346.12	19.89%	1.37%	18.52%
Huehuetenango	Jacaltenango	Q2,604,397.62	9.15%	7.26%	1.89%
	Chiantla	Q13,235,790.34	28.11%	2.46%	25.66%
	San Sebastian Huehutenango	Q5,383,074.02	24.48%	5.23%	19.25%
	Todos Santos Cuchumatan	Q11,106,465.54	45.43%	10.14%	35.29%
	Santa Cruz Barillas	Q3,051,007.05	6.78%	3.17%	3.62%
	Cuilco	Q9,920,194.55	28.42%	0.50%	27.92%
	Concepcion Huista	Q12,638,555.88	80.58%	19.94%	60.64%
	San Antonio Huista	Q6,378,519.17	35.99%	7.49%	28.50%
	La Libertad	Q1,617,743.26	5.64%	5.39%	0.24%
	La Democracia	Q7,180,069.43	29.07%	17.64%	11.44%
Totonicapan	Momostenango	Q4,249,760.94	7.28%	6.85%	0.43%
	Santa Lucia La Reforma	Q8,763,320.35	20.43%	2.00%	18.43%
Quetzaltenango	San Juan Ostuncalco	Q3,645,712.77	9.66%	8.64%	1.02%
	Concepcion Chiquirichapa	Q9,652,358.09	32.89%	4.30%	28.59%

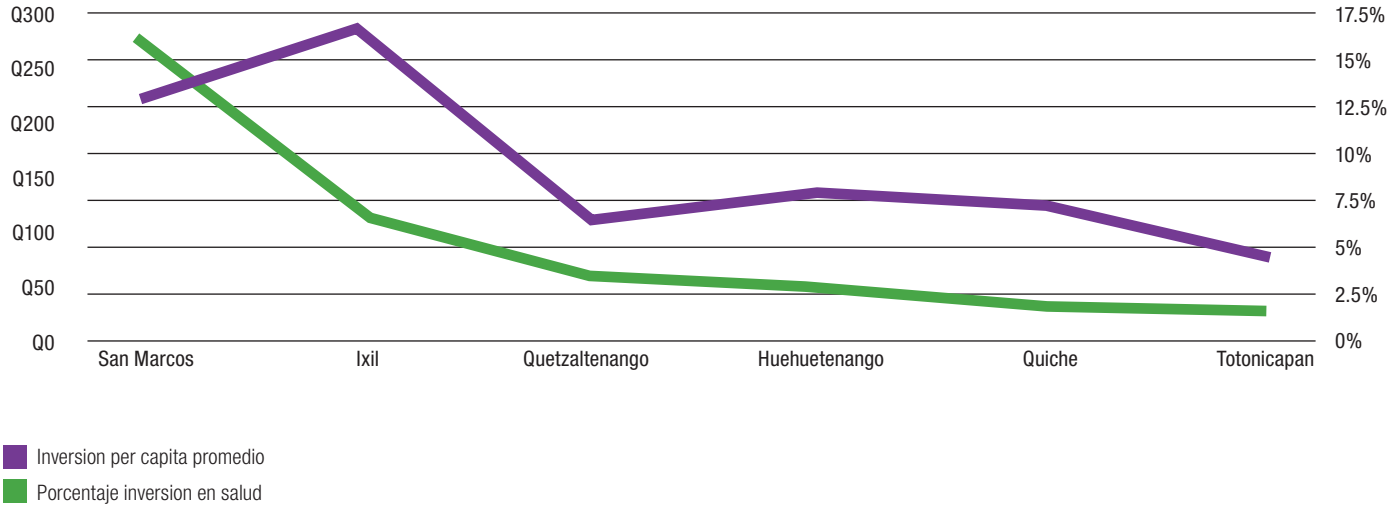
Graph 1 shows the percentage of municipal funds invested in health in 2014. This investment is specifically for those expenditures that are considered direct costs related to health, which include salaries of health providers, infrastructure for health posts, community water and sanitation investments. The graph shows that municipal investments range from 0% to 32% approximately of their total annual budget. Although the investment varies considerably among the 30 municipalities of the project coverage area, the data show that there is a considerable municipal funding available for health that can be used wisely in the provision of quality health services, especially now that the PEC program has ended.

Graph 1. 2014 Municipal Investment in health (in direct costs) – percentage of total municipal budget



Graph 2 shows the comparison between the per capita investment in health and the percentage of funds invested in health by health area in 2014. It clearly shows that San Marcos and Ixil health areas have the highest per capita investment in health, and a higher percentage of municipal budgets are dedicated to health. Per capita investment varies considerable among health areas, ranging from Q36 to Q270, whereas the percentage of budget invested in health varies from almost 5% to 13%.

Graph 2. Per capita investment in health compared to percentage of funds invested in health by health area (data are averages from municipalities in that health areas), 2014



Annex 6
Draft Training Guide for Capacity Building: Growth Monitoring and Promotion

Guía Metodológica

Taller para el fortalecimiento de capacidades en Monitoreo y Promoción del Crecimiento (MPC)

Lugar: _____

Fecha: ___/___/___

I. Introducción

La presente guía tiene como propósito orientar la capacitación del personal de salud del primer nivel de atención en el tema de Monitoreo y Promoción del Crecimiento, con la intención de fortalecer los conocimientos, habilidades y destrezas, así como que adquieran el compromiso de mejorar la atención que brindan a la población de niños/as menores de cinco años, con énfasis en los menores dos años, en aspectos de promoción y prevención.

Como su nombre lo indica, esta es solo una "guía" para facilitar el trabajo de capacitación, la cual usted como "facilitador" podrá adaptar según su audiencia, el tiempo y los recursos con los que cuenta. Las actividades están orientadas a requerir de un alto grado de participación de los asistentes; reduciendo al mínimo las conferencias tradicionales de la educación formal.

Usted, como facilitador, deberá dirigir y estimular las discusiones que se den en los ejercicios y casos incluidos en el material, por lo que es conveniente que conozca muy bien el material con anterioridad. Es necesario, que el facilitador tenga conocimientos básicos de alimentación y nutrición.

BORRADOR

II. Participantes:

Adjuntar planilla de asistencia.

III. Objetivos

Que los auxiliares de enfermería:

1. Comprendan la importancia de realizar adecuadamente el MPC.
2. Se sensibilicen ante las consecuencias para el niño, la familia y la sociedad de la desnutrición crónica
3. Conozcan los aspectos conceptuales y técnicos para realizar el MPC
4. Reforzar el cumplimiento de la norma para mejorar los proceso de atención

Guía metodológica: El siguiente cuadro presenta la guía metodológica que el facilitador debe seguir para llevar a cabo la capacitación:

TIEMPO SUGERIDO	CONTENIDO ACTIVIDAD	METODOLOGÍA	RECURSOS
5 minutos	Tomar asistencia	Prepare una mesa a la entrada del salón con hojas de asistencia, lapiceros y una persona encargada de entregar un gafete con el nombre para identificar a los participantes	Hojas de Asistencia Lapiceros Gafetes, ganchos o *masking tape*
5 minutos	Bienvenida y objetivos	Pida al jefe de distrito o la persona con mayor rango que dé la bienvenida a los presentes y que lea los objetivos.	Cañonera Objetivos
5 minutos	Reglas del taller	En un papelógrafo y con apoyo de los participantes anote las reglas del taller	Rotafolio, Papelógrafos, marcadores

55 minutos	**1. Importancia del MPC:** • Prevención de la desnutrición crónica • Oportunidad para: - Captación temprana de niños sano y enfermos - Brindar consejería	Actividad 1: **Sensibilización** Parte I (55 minutos) Coloque el cartel con las figuras de los 3 niños (con edades tapadas) y pregunte: • ¿Qué ven en estas fotos? • ¿Qué edad creen que tienen estos niños? Después de que los participantes digan lo que ellos creen o DESTAPE LAS EDADES Y DÍGALAS. Forme 3 grupos y reparta los sobres con información estadística nutricional de cada municipio, entregue papelográfos. Pida que organicen los datos y comparen. Luego deberán analizar y establecer las causas que producen esos datos, pida que escriban las causas en un papelógrafo y que nombren a un representante para presentarlo. Escuche a los representantes de cada grupo y reflexione sobre la importancia del peso de los niños. Pregunte: ¿El retardo del crecimiento es un problema? ¿Cómo se puede evitar? Previamente habrá colocado en las paredes del salón, un mapa de cada uno de los municipios participantes con las figuras de los niños que representará el índice de desnutrición crónica de cada lugar. Destape los mapas y diga que si un niño no crece bien, su cerebro no se desarrollará bien y en el futuro no tendrá las mismas oportunidades que los demás niños. Mencione que los niños con desnutrición crónica, son también más vulnerables a las infecciones.	Papelógrafos con figuras de los 3 niños, con las edades y tamaños (deberán estar tapadas para la actividad) uno que no ha crecido bien • Sobres con información estadística nutricional de cada municipio. • Mapa de cada municipio con el índice de niños desnutridos crónicos con figuras de niños.

		Termine enfatizando en la importancia de detectar temprano las fallas en el crecimiento, a través del MPC: • Prevención de la desnutrición crónica • Es una oportunidad para poder indagar, identificar problemas/obstáculos, hacer compromisos con las madres para mejorar la alimentación y cuidados del niño • Es una oportunidad para captar tempranamente a un niño que está falto de crecimiento, y darle un seguimiento cercano mes a mes (o más frecuente si fuera posible a través de visitas domiciliarias)	

BORRAD

TIEMPO SUGERIDO	CONTENIDO ACTIVIDAD	METODOLOGÍA	RECURSOS
3 horas 05 min	**2. Aspectos conceptuales y técnicos para realizar el MPC**	**Contenidos:** . Conceptos técnicos para realizar el monitoreo del crecimiento. I. Qué es y para qué sirve el Monitoreo y promoción del crecimiento II. Vigilancia del desarrollo infantil (Evaluación y clasificación del desarrollo infantil) III. Medidas antropométricas básicas IV. Estado y evaluación del estado nutricional V. Índices o indicadores antropométricos VI. Gráficas de crecimiento infantil para cada indicador VII. Desnutrición Crónica y Aguda VIII. Acciones esenciales 2. Instrumentos antropométricos para monitorear el crecimiento, sus componentes y su manejo. • Balanza tipo salter • Balanza infantil • Tallímetro • Infantómetro 3. Técnicas y pasos para el monitoreo del crecimiento, registro, procesamiento y uso de la información para la toma de acciones: • Entrevistar a los padres y revisar el carnet • Elegir las gráficas de crecimiento infantil a utilizar	Papelógrafos Papelógrafos con las preguntas acerca de los conceptos técnicos básicos de MPC Normas de Atención Integral en Salud MSPAS Mensajes clave en grande y los dibujos asociados a cada acción esencial Presentación en Power Point sobre los Instrumentos antropométricos para monitorear el crecimiento, sus componentes y su manejo. Equipo antropométrico (Balanza tipo salter, balanza infantil, tallímetro, infantómetro) Casos de MPC para el trabajo de grupos (para grupo 2 con los 8 pasos para el MPC; información y técnicas) Cartel con los 8 pasos del MPC. Lista de chequeo para observar los casos (Para el grupo 3)

		• Realizar la evaluación antropométrica • Interpretar y clasificar el estado nutricional y anotar en instrumentos oficiales • Realizar acciones de promoción del crecimiento • Brindar consejería efectiva a los padres • Programar el próximo monitoreo • Registrar la información en instrumentos oficiales ***Café (15 min)*** **Actividad I: Conceptos básicos (20 min)** Divida a los participantes en 6 grupos, cada uno de los cuales trabajará un tema de los conceptos técnicos de MPC: 1. ¿Qué es y para qué sirve el MPC? 2. ¿Qué es la evaluación y clasificación del desarrollo infantil? y ¿Cuándo se aplica? 3. ¿Qué es el estado nutricional?, ¿Para qué sirven los índices o indicadores antropométricos? ¿Cómo se hace la evaluación del estado nutricional? 4. ¿Qué es y para qué sirve el análisis e interpretación de índices antropométricos? 5. ¿Para qué se usan las gráficas de crecimiento infantil? ¿Por qué es importante relacionar las gráficas de cada indicador? 6. ¿Cuál es la diferencia de la desnutrición Crónica y Aguda? Pida que nombren a una persona del grupo para que exponga los aportes en la pizarra o papelógrafo. Si es necesario, refuerce la forma correcta de la toma de medidas antropométricas y análisis e interpretación de índices antropométricos.	1 Juego de registros oficiales para ejemplos: 1. Cuaderno 5ª, 2. Carnet del niño(a) 3. Registro diario de consulta (SIGSA 3p/s o 3 c/s) 4. Reporte semanal de vigilancia epidemiológica (SIGSA 18) 5. Ficha clínica. 6. Listados de niños con desnutrición crónica (nuevo) y 7. Cuadernillo 5DA en caso de desnutrición aguda y llenar el formulario de notificación obligatoria.

Haga una breve reflexión de los comentarios, resalte los aspectos clave:

- El MPC es un medio no un fin en sí mismo; se complementa con la consejería.
- Relación con las Normas de Atención en Salud Integral MSPAS – Norma II para lactante y niño menor de 5 años Pags. 136 y 199 del documento.
- El MPC deberá abordar de forma integral los aspectos nutricionales y de salud del niño /a. (toman medidas, consejería, micronutrientes y vacuna)

Actividad II: Acciones esenciales

Coloque los mensajes clave en grande y los dibujos asociados a cada acción esencial y péguelos en la pared

Pida a los participantes formar un semi círculo o media luna.
Pegue el primer dibujo de la primera acción esencial y pregunte a los participantes qué ven ahí y qué mensajes darían ellos a las madres, escuche dos o tres respuestas.

Refuerce pegando a la par de los dibujos, los rótulos de los mensajes clave, pida apoyo de voluntarios para leerlos con la finalidad de reforzar los conocimientos.

Brinde un espacio para resolver dudas, comentarios u observaciones.

		Pregunte ¿Cuál será la aplicación de estas acciones esenciales en sus servicios de salud? Escuche tres o cuatro comentarios. Refuerce la importancia de la suplementación, indicando que aunque localmente hay muchos esfuerzos por brindar una alimentación adecuada, la dieta guatemalteca no es suficiente en todos los nutrientes que el niño/a necesita y que por eso es importante la entrega, consejería y adherencia de micronutrientes. **Actividad III: Presentación magistral (30 min)** Utilice la presentación en PP sobre los Instrumentos antropométricos para monitorear el crecimiento, sus componentes y su manejo. **Actividad IV: Sociodrama 8 pasos para el MPC (2 horas)** Forme 3 grupos. Al grupo 1 se le entregará una hoja con un caso para trabajar el MPC; pida que realicen una dramatización realizando las acciones que usualmente llevan a cabo durante este procedimiento El grupo 2 también recibirá una hoja con un caso para trabajar el MPC, pero en esta hoja aparecen los 8 pasos de MPC. Pida que realicen el procedimiento usando cada uno de estos pasos. Cada grupo puede utilizar el equipo antropométrico que se le facilitará. Ninguno de estos dos grupos sabrá qué información tiene cada hoja del caso.	

		El grupo 3 recibirá una lista de chequeo para evaluar a los demás grupos cuando pasen a realizar el socio drama. Mientras los dos grupos se preparan, ellos rotarán en cada uno de los grupos observando los preparativos. Al finalizar la presentación de los dos grupos, el grupo 3 tendrá 5 minutos para evaluar cada presentación y luego tendrá un tiempo para presentar los resultados con base en la lista de chequeo. Además deberán utilizar el cartel con los 8 pasos para explicar cómo lo realizó el grupo 2. Si es necesario, brinde retroalimentación de cada uno de los pasos. Refuerce el paso número 8, recordando los instrumentos oficiales en donde se debe asegurar el registro de la información obtenida en MPC: 1. Cuaderno 5ª, 2. Carnet del niño(a) 3. Registro diario de consulta (SIGSA 3p/s o 3 c/s) 4. Reporte semanal de vigilancia epidemiológica (SIGSA 18) 5. Ficha clínica. 6. Listados de niños con desnutrición crónica (nuevo) y 7. Cuadernillo 5DA en caso de desnutrición aguda y llenar el formulario de notificación obligatoria. Haga una síntesis y reflexionen a cerca de: • La importancia de cada uno de los 8 pasos del MPC • Las oportunidades que se presentan en cada uno de los 8 pasos Brinde un espacio para comentarios y resolución de dudas	

TIEMPO SUGERIDO	CONTENIDO ACTIVIDAD	METODOLOGÍA	RECURSOS
3 horas 30 min	3. Cómo brindar consejería para la promoción del crecimiento: Acciones esenciales de nutrición focalizadas (E)	Contenido: 1. Consejería de cambio de comportamiento como parte del MPC 2. Aspectos a observar en la consejería 3. Cualidades y habilidades del consejero 4. Consejería con ACCEDA 5. Barreras para la consejería **Actividad I: Lluvia de ideas (20 min)** Con la técnica de lluvia de ideas, abordar el tema de MPC y su complementariedad con la consejería. Escuche las ideas y anótelas en fichas de colores y péguelas en el Sticky Wall. Haga un breve resumen enfatizando los puntos importantes: • ¿Qué es consejería? • ¿Se puede hacer MPC sin consejería? • ¿Cómo se relaciona y complementa la consejería con el MPC? • ¿Qué oportunidades debe aprovechar al aconsejar? *–si los participantes no lo mencionan, recuérdeles: Captación temprana con retardo del crecimiento, seguimiento del niño desnutrido enfermo, compromisos con la madre, la familia, la comunidad, para mejorar la alimentación y cuidados del niño/a*	• Sticky Wall, fichas de colores • Presentación en Power Point "Consejería efectiva" • Papelógrafos con las preguntas de reflexión Actividad II, Parte II. • Pasos de ACCEDA impresos para cada grupo • 4 casos de consejería efectiva • 1 Caja de cartón grande (Ej. De aceites o jabones) • 1 Caja de cartón pequeña (Ejemplo; vacía de medicamentos) • Fósforos o clips • 1 Rollo de masking tape • Carta modelo del compromiso

		Actividad II: Consejería efectiva (40 min) **Parte I Presentación magistral (20 min)** Haga una presentación utilizando el Power Point "Consejería efectiva" que incluye: 1) Consejería, MPC y Cambio de comportamiento 2) Aspectos a observar en la consejería 3) Cualidades y habilidades del consejero 4) ACCEDA 5) Barreras para la consejería efectiva **Almuerzo (1 hora)** **Parte II Ejercicio de reflexión (20 min)** Con los 4 grupos formados, realice la siguiente actividad: De un papelógrafo a cada grupo, para que lea las preguntas que ahí aparecen y que reflexionen y respondan: Grupos 1 y 2 ¿Qué recomendaría a mis compañeros del servicio para dar una buena consejería? Grupos 3 y 4 ¿Qué cualidades y habilidades del consejero poseo y cuales debo reforzar?	

		Actividad III: Sociodrama (1 hora 30 min) Formar grupos para realizar sociodramas, utilizando los casos que se acompañan en esta guía (4 casos). Entregue con cada caso, la hoja con los pasos impresos de ACCEDA. En cada caso deberán practicar la consejería siguiendo los pasos de ACCEDA y abordar las barreras que le sean presentadas. **Actividad IV: Reflexión de Cierre y Compromiso:** Coloque una caja pequeña y una grande en paralelo, brinde fósforos o clips a los participantes y pida que, situados a dos metros de las cajas, lancen la mitad a la caja grande y la mitad a la caja pequeña. Al terminar, se habrán dado cuenta que dada la dificultad, la caja grande tendrá abundantes objetos adentro, mientras la pequeña tendrá la mayor parte regados alrededor por no haber podido entrar. Pregunte al grupo: ¿Dónde se les facilitó más? Explique la analogía y reflexione junto con ellos acerca de la caja grande y la pequeña, la grande representa la amplitud de oportunidades con que cuenta un niño adecuadamente nutrido, mientas que la pequeña representa la estrechez de oportunidades que afronta el niño desnutrido crónico. Pregunte, a manera de reflexión, ¿Cómo podemos ampliar las oportunidades de los niños de nuestro país? Reflexione sobre la importancia del monitoreo y promoción del crecimiento y motive a asumir compromisos en el sentido de realizar adecuadamente el MPC, dar consejería y seguimiento.	

Annex 7
Draft Training Guide for Capacity Building: Integrated Women's Health

Guía Metodológica

Taller Salud Integral de la Mujer Embarazada, Parto y Pos parto

Lugar: _____

Fecha: ___/___/___

I. Introducción

Guatemala tiene una RMM de 110 por 100,000 NV, el 3ero más alto de Latinoamérica. En el occidente, se encontró que el 45% de las muertes maternas de 5 los departamentos se dieron en los 30 municipios priorizados para USAID| Nutri-Salud. Del total de casos de estos municipios, el 67.8% se dieron en solo 10 de ellos. Además, el 80% de estos municipios presentó por lo menos 1 MM.

La mayoría de estas muertes ocurren en población indígena, que vive en pobreza y pobreza extrema, con acceso limitado a los servicios de salud. Se conoce que el 57% de las defunciones ocurrieron a nivel de domicilio o en el trayecto y 40% a nivel de servicios de 2do o 3er nivel; varios de los casos eran provenientes del área rural. En cuanto a las causas más frecuentes, el 43% fueron por hemorragia, 24 por pre eclampsia-eclampsia y el 13% por infección. Según reporte del PNSR, más del 80% de estas muertes son prevenibles.

El comportamiento de la MM no es muy diferente en cuanto a su epidemiología con relación a la Desnutrición Crónica en estos municipios, muy vinculados a las mismas condicionantes y determinantes sociales. Es pertinente su abordaje de manera integral, a través de intervenciones basadas en evidencia, con un enfoque de participación comunitaria y pertinencia cultural; enmarcados en la Ventana de Oportunidad de 1,000 días.

II. Participantes

Adjuntar planilla de asistencia.

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III. Objetivos

1. Que el personal de PS (AE) conozca las consecuencias familiares, sociales y económicas que implica la mortalidad materna, lo cual favorece una actitud positiva para realizar las acciones dirigidas a la vigilancia, la prevención de riesgos, y la atención integral de la embarazada y mujer en el post parto.

2. Que el personal del PS (AE) fortalezca sus conocimientos y capacidades para brindar a la mujer durante el embarazo y en el período postparto, los servicios establecidos en la normas de atención con calidad y de manera integral.

3. Que el personal del PS (AE), proporcione mediante sesiones de consejería, información médica y nutricional que contribuya a tener una alimentación adecuada y un embarazo saludable.

Guía metodológica: El siguiente cuadro presenta la guía metodológica que el facilitador debe seguir para llevar a cabo la capacitación:

TIEMPO SUGERIDO	CONTENIDO ACTIVIDAD	METODOLOGÍA	RECURSOS
5 minutos	Tomar asistencia	Prepare una mesa a la entrada del salón con hojas de asistencia, lapiceros y una persona encargada de entregar un gafete con el nombre para identificar a los participantes	Hojas de Asistencia Lapiceros Gafetes, ganchos o *masking*
5 minutos	Bienvenida y objetivos	Pida al jefe de distrito o la persona con mayor rango que dé la bienvenida a los presentes y que lea los objetivos.	Cañonera Objetivos
5 minutos	Reglas del taller	En un papelógrafo y con apoyo de los participantes anote las reglas del taller	Rotafolio, Papelógrafos, marcadores

50 minutos	Consecuencias de la Muerte Materna	**Sensibilización** **Parte I** (25 minutos): Proyecte la presentación sobre la sensibilización de la muerte materna y haga énfasis en las consecuencias sociales, familiares y el rol importante de la atención que ellos hacen para evitar esta. **Parte II** (25 minutos): Presente el video de muerte materna. Al finalizar el video promueva que participen, haciendo las preguntas generadoras: 1. ¿Qué sintieron al ver el video? 2. ¿Se parece a la realidad de nuestras comunidades lo que vimos en el video? 3. ¿Cómo asocia el video con la realidad que vivimos?	Cañonera, portátil, Presentación Video (internet)
2 horas, 20 minutos	**Atención Integral durante el:** **1. Embarazo**	**Contenidos** **I. Acciones Preventivas en el Embarazo** **Vigilancia de la embarazada y los cuatro controles** **Atención a la embarazada** **Parte I:** Instrucciones: (5 minutos) Haga 5 grupos pidiéndoles que cuenten de uno a cinco. Que los 1 formen un grupo, los dos otro grupo y así sucesivamente, hasta completar los 5 grupos. Entregue marcadores a cada grupo y papelógrafo, la ficha de vigilancia de riesgo obstétrico, plan de emergencia familiar y plan de parto Con base en las normas de atención: • El grupo 1: deberá trabajar aspectos generales en la atención a la embarazada y escribirlo en un papelógrafo • El grupo 2: lo qué se hace en un control pre natal antes de las 12 semanas y escribirlo en papelógrafo. • El grupo 3: lo que realiza en el control alrededor de las 26 semanas,	Papelógrafo, Marcadores, Fichas de vigilancia de riesgo obstétrico, Plan de parto y plan de emergencia familiar, Hojas para dar seguimiento a las embarazadas Normas de atención. Círculo de la atención

- El grupo 4: a las 32 semanas y
- El grupo 5: entre las 36 y 38 semanas.

Los grupos tendrán 10 minutos para hacer sus carteles y elegirán a la persona que realizará la presentación sobre lo que el proveedor de salud hace en cada uno de los controles prenatales (cuentan con 10 minutos por grupo, total 40minutos)

Parte II (25 minutos)

A través de lluvia de ideas, **haga un resumen** de lo que se hace en cada control, haciendo énfasis en:

1. La importancia del llenado completo de la ficha de vigilancia de riesgo obstétrico y su uso en el primer contacto con la embarazada.
2. Los factores de riesgo identificados en la ficha de vigilancia de riesgo obstétrico (refuerce la diferencia entre "factores de riesgo" y señales de peligro, para una "Referencia Oportuna")
3. Para dar seguimiento a los factores de riesgo, en el servicio y en la comunidad, debemos actualizar, mensualmente, la Lista de Embarazadas con Fecha Probable de Parto
4. Hacer la vigilancia de la embarazada con la misma lista de embarazadas y entregarla a la Comisión de Salud/ COCODE
5. Manejar la Lista de Embarazadas con FPP en sala situacional
6. Ubicar en el croquis, las embarazadas con Factores de Riesgo
7. La importancia que como parte del examen físico se tome la P/A, lleve el control del peso, se mida la circunferencia media de brazo y/o el IMC para la clasificación nutricional, la altura uterina, las maniobras de Leopold y FCF.

Parte III: Alimentación y nutrición de la embarazada y pos parto (30´)

A) Forme tres grupos pidiendo que se numeren de 1 a 3 y que cada grupo nombre un relator, para el trabajo siguiente cuentan con 10 minutos.

- El grupo 1 escribirá en un papelógrafo las recomendaciones que en la práctica diaria realiza en este tema con las embarazadas

- El grupo 2 lo hará con relación a la mujer pos parto
- El grupo 3: hará una demostración de mezcla de alimentos locales que se recomiendan a las embarazadas y pos parto

B) Cada relator presentará el trabajo realizado a la plenaria dispone de 10 minutos (30 minutos)

C) Refuerce los mensajes claves en la importancia de la alimentación y nutrición en estas dos etapas de la vida y lo importante de la suplementación

Círculo de la Atención 6 pasos para alcanzarlos (15 minutos): Haga una síntesis y reflexionen a cerca de:

- La importancia en la promoción y atención integral de la embarazada y pos parto y
- Las oportunidades que se presentan en cada uno de los 6 pasos

Para tener congruencia con el círculo del monitoreo promoción del crecimiento (Anexo IV)

Café (15 min)

TIEMPO SUGERIDO	CONTENIDO ACTIVIDAD	METODOLOGÍA	RECURSOS
1 horas 20 minutos	**2. El Parto**	**II. Acciones Preventivas en el Parto** **Contenidos:** Atención Calificada del parto comunitario e identificación de factores de riesgo **Parte I** (15 minutos) Integre tres grupos de trabajo. A los grupos 1 y 2, entrégueles el resumen del proceso que les corresponde dramatizar para refrescar los conocimientos y copia de material con que trabajarán: Ficha de vigilancia de riesgo obstétrico, lista de embarazadas, papelógrafo, marcadores, planes de emergencia y de parto: Y al grupo 3 entregue lista de chequeo **Parte II** (65 minutos) **Dramatización**: (25 minutos para los grupos 1, 2 y para el 3 (15 minutos) • Grupo 1: Atención calificada del parto comunitario (auxiliar de enfermería) • Grupo 2: Identificación de factor de riesgo, activación de plan de emergencia familiar. • Grupo 3: Anota lo que observó en cada presentación y lo analiza en plenaria de cómo se llevó a cabo cada proceso dramatizado (15 minutos)	

		Parte III (10 minutos) Felicítelos por la participación, cierre la actividad con la presentación de los 5 procesos para prevenir la muerte materna y neonatal y relaciónelo con los procesos dramatizados y los 1000 días. **(Ver Anexo V)**	

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TIEMPO SUGERIDO	CONTENIDO ACTIVIDAD	METODOLOGÍA	RECURSOS
1 hora 50	**Consejería basada en las Prácticas Para Vivir Mejor**	**Parte I** (30 minutos) Mímica sobre consejería. Instrucciones. (**5minutos**) Pídales que todos se coloquen en un semicírculo sentados en el suelo, (si hay mujeres con vestido o falda, en lugar de sentarse en el suelo pídales que traigan una silla y formen el semicírculo). Cuente las personas presentes, divida al grupo en dos. Indique donde inicia el primer grupo y donde finaliza, donde inicia el segundo grupo y donde finaliza (mitad y mitad) Marque el límite entre un grupo y otro dejando un espacio. Dígales que cada uno de ellos pertenecerá un grupo y que el ganador se llevará un premio. Explíqueles que jugarán mímica y que consiste en transmitir un mensaje a otros **sin utilizar palabras**. Enséñeles la bolsa con papeles, de los cuáles cada uno de los que pase deberá tomar uno y tendrá 60 segundos para que el equipo contrario descubra cuál es la palabra escrita en el papel que tomó al azar. "El Facilitador deberá nombrar a alguien que lleve el tiempo". Si la descubren será un punto para ese equipo, Si no lo hacen, no tendrán el punto. En ambos casos usted colocará en la Sticky Wall la palabra, como si estuviera haciendo una lluvia de ideas. Al terminar las palabras haga el recuento de puntos y felicite a ambos equipos, dele el premio (dulces) al equipo ganador. (Actividad 10 minutos)	Papeles con palabras claves: • Pasos • Consejería • Embarazada, • Saludar • Felicitar • Preguntar • Compromiso • Aconsejar • Neonato • Niño • Visitar • Observar • Mejorar • Presentarse • Explicar • Rueda • • Bolsa de dulces • Sticky Wall • Tarjetas con mensajes claves

		Las palabras que ha colocado en la sticky Wall utilícelas para dar los conceptos básicos sobre consejería y el proceso de consejería, 5 pasos de la consejería. (10 minutos) **Parte II** (50 minutos) Inicie con las preguntas generadoras ¿Qué es consejería? Se puede dar atención integral sin consejería? Basados en las Prácticas para vivir mejor, haremos grupos para dar la consejería a diferentes mujeres. (5 grupos) Reparta a cada grupo uno de los temas listados abajo, para que hagan una dramatización sobre la consejería con mensajes claves del tema asignado. (10 minutos para prepararse) 1. Alimentación, suplementación durante el embarazo 2. Plan de parto y el plan de emergencia familiar 3. Planificación familiar 4. Lactancia Materna Exclusiva 5. Ejercicio y trabajo durante el embarazo (10 minutos por grupo, total 50 minutos para presentar su dramatización.) Entregue las tarjetas con los mensajes claves de cada tema para que no los olviden. **Parte III** (10 minutos) Felicítelos, cierre dando los mensajes claves de cada una de las prácticas para vivir mejor.	"Basados en el 3er paso "aconseje" de las tarjetas de consejería de la Rueda de Prácticas para Vivir Mejor" prepare tarjetas con el mensaje impreso pegado en la parte del paso 3, aconseje

		Actividad IV (20 minutos) **Reflexión de cierre y compromiso** Reflexione en la importancia de la atención integral a la embarazada y pos parto y motive a asumir compromisos en el sentido de brindar una atención de calidad y pregunte: • Estamos dispuestos a brindar una atención integral a nuestras pacientes? • A qué nos comprometemos? (carta modelo de compromiso)	

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Annex 8
Success Story

USAID FROM THE AMERICAN PEOPLE | Nutri-Salud COMMUNITY NUTRITION AND HEALTH PROJECT

URC UNIVERSITY RESEARCH CO., LLC

SUCCESS STORY

Local Government Makes a Difference in Primary Care

At the end of 2014, the Guatemalan Government made a radical shift in primary health care service delivery. For nearly twenty years, the GOG had sub-contracted community health services to local NGOs. However, a government-wide financial crisis coupled with lack of political support for government subcontracting led the Ministry of Health to make an unplanned termination of all subcontracts for health care delivery. In the short term, the transition left as many as 4 million rural Guatemalans without permanent service delivery in their villages while the government establishes a new model for primary care.

This situation was no obstacle for the Municipio of San Juan Cotzal, located in the Mayan Ixil area in the Department of Quiche. Departmental and Municipal health leaders joined forces, and with technical support from the USAIDINutri-Salud project, organized a commission and developed a proposal in which they advocated with the municipal government to support an immediate solution to bring prenatal care, micronutrient supplementation, vaccinations and growth monitoring programs to the 9,963 people living in rural communities in San Juan Cotzal.

In January 2015, the Mayor and the Director of the Ixil Health Area signed a Memorandum of Understanding to formalize the municipal investment of Q400,000

"To invest in health is a way to optimize the local government resources."

— Baltazar Cruz, Mayor of Cotzal

Health Area Director and Mayor of Cotzal signing the Memorandum of Understanding

(approximately US$50,000) to hire local staff including one professional nurse, five auxiliary nurses, 99 traditional birth attendants and 32 community facilitators. All of them have completed a training program facilitated by the health district, to be followed with refresher trainings supported by USAIDINutri-Salud. The Health Area Direction provides the needed supplies, equipment, and basic medicines and supervises service provision.

"We have used the same amount of money to make our patronage festival each year. To invest this in health is a better way to optimize the local government's resources. We cannot leave our communities without health services", said Cruz.

USAIDINutri-Salud is improving the health and nutrition of women in children across the Western Highlands of Guatemala since 2012, through technical assistance to six Departmental Health Areas and 34 Municipal Health Districts.

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