

USAID/G-CAP

**FAMILY AND COMMUNITY HEALTH
STRATEGY**

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June 9, 1995

ACTION MEMORANDUM FOR THE MISSION DIRECTOR

June 8, 1995

FROM: C/PDM, Elizabeth Warfield ^{EBW}
THROUGH: DDIR, Bambi Arellano ^{EBW for}
SUBJECT: Family and Community Health Strategy (520-0420)

ACTION REQUESTED: Your approval is requested to authorize the documentation for Phase I of the Mission's new Family and Community Health Strategy (520-0420) at a \$30 million funding level during a five year period timeframe.

BACKGROUND: USAID/G-CAP volunteered to participate as an experimental laboratory for the Agency's reengineering efforts. Specifically, the Mission worked in refining its "Smaller, Healthier Families" Strategic Objective. The reengineering efforts focused on improving results through a stronger client focus and teamwork with partners. By defining a results framework based on client needs and expectations, the Mission intends to improve program responsiveness and effectiveness over the short term.

Under this sectoral strategy, USAID will support private and public sector efforts to improve the health of Guatemalan women and children, especially those living in rural Mayan communities. This Strategic Objective contributes directly to the Agency's goal of Stabilizing Population Growth and Protecting Human Health. By slowing the population growth, it also contributes indirectly to the goals of Protecting the Environment and Broad Based Economic Growth.

One of the first steps in developing this new strategy was the formation of a broad team for reengineering the health sector. Participants included technical personnel, policy makers from the public and private (NGO) sectors and USAID grantees. This team completed detailed problem/constraints analysis pertaining to children's and women's health. After analyzing why past efforts to improve health status in rural areas met limited success, the team concluded that the new approach needed to focus simultaneously on all three locations where health related decisions and behaviors (practices) occurred: the home, the community, and health facilities. This approach will promote the development of culturally appropriate models of integrated service delivery which will be the basis for improving results of USAID/G-CAP's effort in the Health Sector during the next ten years in Guatemala.

DISCUSSION: The Strategic Plan was reviewed on May 23, 1995. Previously, the draft Reengineering Package, including the Results Framework, Client Service Plan and Annexes was sent to Washington for review/input. The following decisions were made at the review:

1. Strategic Balance: The Strategy establishes targets for the resource split among Results Packages and GOG/NGO partners, but the actual distribution of funds will depend on continuous impact evaluation. The relative emphasis between the Results Packages (including the sub-division between child survival and reproductive health approaches) and the division of resources outlined in the Strategy respond directly to the Mission's priorities and to the country's needs and demands for services in the health sector.
2. Obligation/Implementation Arrangements: STATE 124000 that approved Delegation of Authority to Country Experimental Labs cites the Agency's delegation to Mission Directors of the CELs to negotiate, execute and implement strategic objective agreements, loans, grants, memoranda of understanding, and other ancillary agreements with foreign governments, any agencies and subdivisions thereof, and public international organizations, including the authority to deviate from Standard Provisions.

The Mission has started discussions with the Ministry of Health (MOH) for signing a Handbook 3 Agreement to obligate the FY 1995 funds available for child survival and population activities. It is also the Mission's intention to sign a memorandum of understanding with the MOH to demonstrate mutual agreement and support for this strategic approach.

To support the transition between the current health projects (Family Health Services and Immunization and ORT Services for Child Survival) and the implementation of the new joint strategy, the Mission will sign a one-year contract with Clapp and Mayne to continue providing technical assistance to the MOH throughout 1996 in the areas of management, decentralization, information systems, and service delivery. As a bridge between the current Child Survival Project and this new contract, both the PACD and the Clapp and Mayne contract under Project 520-0339 will be extended by approximately three months. Early in FY 1996, the Mission will start working on an RFP to contract a firm to provide longer term technical assistance beginning in FY 1997.

Sub-obligations with APROFAM and other partners will take place during late FY 1996 and early FY 1997 through the signature of HB 13 Cooperative Agreements.

3. Phased Authorization: Due to an Agency decision to limit Congressional Notifications at this time to activities of no longer than five years and no more than \$30 million, only Phase I of this Strategy will be authorized at this time. However, the ten-year Strategy remains valid and will be reflected in obligation documents, though formal commitments will be within the five-year, \$30 million limit.

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INITIAL ENVIRONMENTAL EXAMINATION: An Initial Environmental Examination (IEE) recommending categorical exclusion was signed by the Mission Director in March, 1995 and approved by LAC Chief Environmental Officer on April 18, 1995.

CONGRESSIONAL NOTIFICATION: A Congressional Notification was sent to LAC in April 1995. Due to complications in negotiating a new CN format, that Notification was not processed. A revised CN, reflecting the old format, was submitted on 8 June. No obligations under this Project will be incurred until LAC formally notifies the Mission that the CN has expired.

AUTHORITY: STATE 12400 dated May 20, 1995, delegates to Mission Directors of post with CELs the general authority to obligate funds under USAID/W approved Strategic Objective Plans. The Mission's approved Action Plan is USAID/W's concurrence with the Authorization of this Strategy which is a necessary step to negotiating, executing, and implementing an SO Agreement.

RECOMMENDATION: That you sign below and sign the attached Authorization, thereby authorizing the Family and Community Health Strategy (520-0420) for a total life-of-project funding of \$30 million over an approximate period of five years.

Approved William Stacy Rhodes Date June 29, 1995
William Stacy Rhodes, DIR

I certify that the methods of payment and Audit plan are in compliance with the Payment Verification Policy.

Gary Byflesby, Jr.
Gary Byflesby, Controller

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SCórdoba
PO'Connor
1st draft review
PMiller
of

Date 6/09/95
Date 6/9/95
Date 6/9/95
Date 6/12/95
Date 6/12/95

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STRATEGY AUTHORIZATION

Name of Country: Guatemala
Name: Family and Community Health Strategy
Number: 520-0420

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Phase I of the Family and Community Health Strategy with a total projected funding level of \$30 million with a planned completion Date of July 30, 2000.
2. The Strategy objective is to improve the health of Guatemalan women and children, especially those living in rural Mayan communities. The long term goal is to improve the health status of women and children throughout the country and, by focusing efforts on the highlands region, to bridge the gaps between rural, Mayan populations and the rest of the country.
3. The Strategic Objective Agreements and Sub-Agreements, which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with USAID regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as USAID may deem appropriate.

3.1. Source and Origin of Commodities, Nationality of Services

Commodities financed by USAID under the Strategic Objective shall have their source of origin in the United States (Country Code 000), except as USAID may otherwise agree in writing or as provided in paragraph 3.2 below.

The suppliers of commodities or services shall have the United States as their place of nationality, except as USAID may otherwise agree in writing or as provided in paragraph 3.2 below.

Ocean shipping financed by USAID under the Project shall, except as USAID may otherwise agree in writing, be financed only on flag vessels of the United States. Air transportation services financed under the Project shall be on U.S. flag carriers except to the extent such carriers are not "available" as such terms is defined by the U.S. Buy America Act.

3.2. Local Cost Financing

Local cost financing, totaling \$40 million, is authorized only to the extent permitted by the Agency's Buy America policy as outlined in 90 State 410442 and in Handbook 1B, Chapter 18. If necessary, individual waivers may be processed for procurement of goods and services which are outside the exemptions to the Buy America Policy but necessary to Project implementation, under the criteria stated in Handbook 1B, Chapter 5.

APPROVED William Stacy Rhodes Date 6/29/95
William Stacy Rhodes, DIR

Drafted:	PDM, SAlvarado	<u>SAlvarado</u>	Date <u>06/08/95</u>
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FAMILY AND COMMUNITY HEALTH STRATEGY

1. Statement of Strategic Objective

"Improving the health of Guatemalan women and children, especially those living in rural Mayan communities".

This strategic objective contributes directly to the Agency's goal of Stabilizing Population Growth and Protecting Human Health. It also contributes indirectly to the goals of Protecting the Environment and Broad Based Economic Growth. The strategy will support public and private sector institutions to strengthen the delivery of reproductive and integrated child health services, especially in rural Mayan areas.

The long term goal of USAID/G-CAP strategy is to improve the health status of Guatemalan women and children throughout the country and, by focusing efforts on the highlands region, to bridge the notable gap between rural, Mayan populations and the rest of the country.

The time frame for achievement of the strategic objective is eight to ten years. The following performance indicators will be used to measure success:

- o Infant Mortality Rate
- o Child (Aged 1-4 Year) Mortality Rate
- o Neonatal Mortality Rate
- o Perinatal Mortality Rate
- o Maternal Mortality Ratio
- o Total Fertility Rate

The 1995 Demographic and Health Survey (DHS) will permit establishment of the baseline (1995) as well as the mid-term (2000) and final (2005) targets for each indicator. The DHS will provide national level measures of these indicators. By oversampling selected areas, the DHS has also been designed to establish baseline and target measures for the principle Mayan linguistic groups (Q'eqchi', Kaqchikel, Mam and K'iche), with the exception of maternal mortality which will only be measured at the national level. It is expected that the results of the DHS will be available by September, 1995.

2. Background

Unlike many other Latin American countries, Guatemala has yet to experience the demographic and epidemiological changes that are known as the health transition. The population is young, growing rapidly and still primarily rural. A recent World Bank survey shows that approximately 75% of Guatemala's people live in poverty and over 55% of the population lives in extreme poverty and isolation in rural areas. Female literacy among rural Mayan women is one of the lowest in the entire Western hemisphere at less than 20%.

Despite a forty percent reduction over the past 20 years, Guatemala has the highest infant mortality rate in Central America. According to official data, the infant mortality rate in 1991 was 54 per thousand, although other estimates suggest a rate over 60. In all areas of the country the rate is higher in the rural population than in the urban population and higher in the Mayan as opposed to the non-Mayan population. The child mortality rate in Guatemala is 10 times higher than in Costa Rica (10.9 per 1,000 versus 1 per 1,000) and is declining at a fraction of the pace of other Latin American countries. PAHO estimates that approximately one third of infant mortality in the country occurs in the neonatal period (first 28 days of life); perinatal deaths and neonatal deaths combined are estimated to constitute up to one half of infant deaths. Pneumonia causes about 19% of infant deaths and diarrheal disease another 17%. Twenty-eight percent of child mortality is from diarrheal disease, 22% from pneumonia, 20% from measles, and 8% from malnutrition. Approximately 70% of the deaths of children aged 1 to 4 years are due to the preventable causes of acute respiratory infections (ARI), diarrhea and malnutrition.

A series of rapid assessments conducted in 15 health areas by the Ministry of Health with USAID technical assistance have demonstrated overall poor coverage rates among children for immunizations and drastic differences between the predominantly Mayan areas and the non-indigenous areas. Coverage rates for children under 1 year ranged from 23% and 31% in Ixcán and Solola, respectively, to over 70% in Amatitlán (73%), Zacapa (76%), and El Progreso (77%).

Guatemala has the highest percentage of malnourished children in Latin America. In contrast to most other countries, nutritional conditions have not improved over time. According to a 1987 national survey, 33.6 percent of children under the age of 3 years were underweight (suffering from a weight-for-age deficit). Stunting (height-for-age deficit) was found in 56.9% of children nationwide.

Guatemala has consistently reported very high maternal and neonatal mortality levels. The Ministry of Health estimates that the maternal mortality ratio is 248/100,000 live births. In most rural areas, especially among Mayan women, maternal mortality is notably higher than in urban areas. For example, the maternal mortality ratio in the predominantly indigenous Departments of Solola and Totonicapán is 446 and 289, compared to 84 in the Department of Guatemala.

The majority of women in rural areas of Guatemala give birth at home with the help of a traditional birth attendant (TBA). According to 1992 Ministry of Health statistics, 77% of women deliver outside of health facilities while only 23% deliver health facilities with trained providers. In the highlands, TBAs may deliver over 90% of the births. Coverage of tetanus toxoid is very low in all areas of the country. Sixty percent of lactating women suffer from anemia.

The 1987 Demographic and Health Survey showed that the desired fertility was estimated at 3.8 births; however, the observed rate was 5.6. Moreover, 35.4% of married women stated they did not want to have any more children and an additional 26.9% did not want to have a child for at least the next two years. Yet, only 23% of married women were practicing some form of family planning. This demonstrates the need for contraceptive services by many Guatemalan women. In 1994, the national contraceptive prevalence rate was estimated to be only 30%,

however, the rate among Mayans may be as low as 5%.

It is unlikely that most health indicators will improve unless there are fundamental changes in the way the both the Ministry of Health and non-governmental organizations (NGOs) approach the problem. To date, most efforts have promoted a western, highly medicalized model of service delivery without sufficient regard for the local cultural context. Most donors, the Ministry and the NGOs have emphasized facility-based services. Yet, most Guatemalan women and their children have very limited access to health services. SEGEPLAN/INE estimate that the Ministry of Health provides health services to only 27% of the population, IGSS 15% and the private sector 12.5%, leaving 45.5% of the population uncovered. Only one third of Guatemalan women have ever had a gynecological examination. Consultation rates are under 1 per person per year in each of the country's 22 departments, compared to the World Health Organization's recommended norm of 2 consultations per person per year. These low rates of service utilization suggest that the services that are being provided are not what is demanded by the public.

3. Development of the USAID/G-CAP Strategic Approach

3.1. Introduction

The strategic objective and performance indicators described above were developed by a team of USAID/G-CAP staff and health professionals from the public and private sectors. Team membership included some 20 representatives from partner organizations: the Ministry of Health, the Guatemalan Social Security Institute (IGSS), local non-governmental organizations, U.S. private voluntary organizations, and two U.S. institutional contractors. This large team divided itself into two working groups, with one group assuming responsibility for the problem/constraints analysis related to women's health, and the second group handling the same issues for integrated children's health. Based on these analyses, USAID/G-CAP then developed a results framework that specifies the kinds of results that will be required over time in order to achieve the strategic objective.

The first step was the elaboration of a conceptual framework for discussing the health status of Guatemalan children under five and women of reproductive age. This technical analysis can be found in Annex A. After analyzing why past efforts to improve health status in rural areas have met with limited success, USAID and its partners concluded that the new approach must focus simultaneously on all three locations where health related decisions and behaviors (practices) occur: the home, the community and health facilities.

Home-based Care

Home-based care includes both the preventive and curative actions that are taken inside the home, as well as making the decision to seek care outside the home. The primary

preventive behaviors in the home revolve around breastfeeding and weaning, hygiene, child-spacing, and child-birth. Mothers' practices and decisions are influenced by personal beliefs and experiences as well as the beliefs and experiences of relatives and other influential community members. While there is considerable knowledge of women's health behaviors, there is generally poor understanding of how to promote improved home-based care. For example, numerous studies have identified improper initiation of breastfeeding, delayed/inadequate weaning, and non-use of family planning methods despite a desire to space births as fairly common problems in rural communities. Yet, almost no health education programs have successfully promoted behavior change.

The primary preventive interventions sought by caretakers outside of the home are immunizations, prenatal care, family planning, and care for complicated deliveries. Of these, the two interventions which have changed the most over time are deciding to seek immunizations for children and family planning services. With respect to immunizations, coverage seems to vary more according to the government's ability to organize local immunization programs, than culturally driven fears about injections. In fact, both Mayan and ladino cultures generally promote a positive view of injections.

The process of providing curative child health care in the home starts with the mother, when she notices signs in the child that make her recognize illness. Although some minor ailments are not treated at all, most commonly, the mother will start treating the symptoms in the home with what she thinks or knows is good for the suspected illness. Sometimes her mother, mother-in-law and/or female neighbors comment on possible causes of the illness and advise the mother on specific remedies. Remedies usually include a mix of herbal preparations (infusions) and low cost store medicines dissolved in the infusions.

A woman usually tells her husband that a child is ill, particularly if the condition lasts more than one day. Sometimes she suggests that he go out to buy medicine (even a specific medicine), or she might ask him for the money to buy the medicine herself. If the mother has suggested an action, the husband usually agrees because, according to the culture, she is the person responsible for the health of the family. If the mother does not suggest anything, the husband might tell her what should be done and/or recommend a treatment.

Most of the signs that worry the mother (such as the child refusing breastmilk or other food, persistent fever, convulsions, persistent cough, "hervor de pecho", alterations in breathing, sunken eyes) and worry them sufficiently to seek outside care are not too different from the danger signs identified by biomedical practitioners for care seeking. Also, despite the difficulties that mothers face when seeking care outside the home, especially from the formal health system, there is evidence that mothers do seek it. The fact that they generally wait for several days before seeking outside care reflects their hope that the condition will improve or disappear or that they underestimate the severity of the signs or symptoms.

In terms of a woman's own health, it is often the lowest priority of the family. This is reflected in day to day actions and conversations. Women are much more informed and feel more comfortable talking about their children's health, even their husband's health, than their own health. Often a woman only seeks care for herself when the condition is so severe that she cannot take care of her family (or other obligations). She often feels that by addressing her own ailments she would be putting herself first - which implies giving up or setting aside her other priorities within the household.

Additionally, women are not well informed about reproductive health issues. Unlike other illnesses/complications, women do not speak freely with their husbands, sisters/brothers, mothers-in-law and/or female friends about women's health issues. Moreover, little information regarding reproductive/women's health is available in the community and/or at health facilities in rural areas. Women need to be informed about how actions they can take at home as well as when/where to seek care outside the home.

The process of care-seeking starts in the home with remedies prepared by the mother. As stated in the previous sections, the husband, female relatives and neighbors may advise and help the mother, but she is the main person responsible for action. It is unusual that mothers seek care outside the home without first having tried a remedy at home. When care is sought outside the home, the health providers that are available to the families come both from the popular/ traditional/informal and from the biomedical/modern/formal health systems. Their availability and accessibility are different in a small village than in a larger town.

The fathers are usually involved in care seeking outside the home when the child's condition is perceived as serious, and particularly when care is sought from providers outside of the immediate community. Fathers provide money for treatment and in many cases accompany the mother to facilities outside of the community.

Community-based Care

The options that families in small communities have when seeking care are the stores (which frequently sell some minor drugs), traditional healers, midwives, and health promoters. Store medicine is usually bought to prepare remedies in the home. It is not common that store vendors provide advice to the mother, usually she knows what medicine she wants to buy.

There are an estimated 15,000 midwives (traditional birth attendants - TBAs) and 10,000 health promoters, and an unknown number of other traditional healers who provide a wide range of services at the community level. Some have received training courses from the MOH or any of a large number of NGOs. These individuals are often the first and sometimes the only source of health care for most rural residents. Yet, communication with health facilities and formal providers is limited, except for specific temporary interventions such as immunization campaigns or containing epidemic

outbreaks such as cholera, measles, etc.

Traditional healers and midwives are sought mostly for "folk illnesses" (or culture-bound syndromes) such as "empacho" (anorexia), "ojo", "susto", sunken fontanel. Mothers recognize that "doctors" do not know how to treat these illnesses while traditional healers have specific remedies for them which fit cultural expectations. For example, in the case of "empacho" massages are performed on the abdomen and oral solutions prepared by the healers are administered. In the case of "ojo", medicinal plants or an egg is passed over the sick child's body while prayers are said.

Health promoters do not receive support or respect from formal providers, but these individuals are often respected community leaders who can communicate effectively and affect the attitudes and behaviors of others. These individuals have been recognized as a valuable resource but few organizations, both public and private, have been able to establish and sustain functional and mutually beneficial relations with them over an extended period of time.

Increasingly, health promoters are no longer recognized by their communities as a source of health care nor are they consulted. The decline in their popularity and use is related to their lack of curative resources. They are regarded as mostly able to provide advice. They are not even regarded as good channels of referral because health promoters are at the bottom of the formal health system ladder and, in the past, their referrals have not translated into prompt or better care for those referred.

Facility-based Care

In Guatemala, particularly in the highlands, facility-based providers confront numerous problems. They have established procedures to provide services and have their own perceptions of the people they serve. A large number of service delivery problems exist because of incongruence of provider and community attitudes/experiences, and the relative power to affect changes in the service provision system. It is not a simple matter of changing either provider or client attitudes, but instead an accommodation should be reached.

Many providers feel that the reason people do not seek services is because of their own traditional beliefs and poor understanding of the benefits of western medicine. Furthermore, most providers feel that the attitudes of the population, especially ethnic Mayans, must change, and that the providers are doing a good job (or at least the best they can) under difficult circumstances. For example, they believe that midwives and other empirical practitioners should give up their "ineffective or dangerous" practices and be trained using the western model. There is little recognition of the fact that many community practices are quite beneficial or simply neutral. In terms of service provision, most facilities are open during days of the week and hours to suit the providers, not the clients. Providers generally feel that clients should come to the facility, and few facilities have active community extension programs. Many attempts

have been made to have providers visit homes to give immunizations, distribute temporary contraceptive methods (pills, condoms, vaginal tablets), treat diarrheal disease or ARI, and provide information on disease prevention and reproductive health. Most of these efforts have been abandoned because providers have no real incentives to go beyond the clinic. Transportation, per diem and time constraints make such efforts relatively ineffective.

Although some providers feel they have all the knowledge and skills necessary, many providers feel they need additional training. Observational studies of technical procedures and testing of providers' knowledge show that considerable efforts should be made to train personnel. The areas where knowledge and skills have been found to most inadequate is all aspects of reproductive health.

In terms of community perceptions of facility-based care in Guatemala, research shows that the most common problems expressed are the long and time consuming distances to reach services, language barriers, limited and inconvenient service hours, services focusing on specific medical problems and not the person, no consideration of the entire family, lack of medicines and laboratory facilities/supplies, inhuman treatment, lack of follow-up, and the general inability of providers to adequately treat the client's condition or resolve problems.

The conceptual framework identifies two target populations: children under five years and women of reproductive age (WRA). It focuses on particularly vulnerable groups in rural Guatemala such as pregnant women and newborn children. It identifies the key steps related to health seeking behavior: when/why do people take actions in their homes, seek assistance from community personnel (both nonformal and formal providers) and/or visit a public or private sector facility. It identifies the determinants that influence women's/caretaker's behavior and the interventions required to improve the quality of preventive/curative services at all levels.

3.2. Problem/Constraints Analysis

The problem and constraints analysis focused on partners' experiences in implementing USAID projects as well as key issues. The process produced four key issues. First, many partners have found that the USAID project design system is inflexible and too lengthy. Hence one of the principle goals of the problem analysis was to replace the traditional project design system with a new approach centered on obligating to the strategic objective and developing flexible, results oriented agreements with individual organizations. The new health sector strategy identifies intended results over the medium to long term, but leaves enough flexibility to shift resources on an annual (or semi-annual) basis according to lessons learned and problems encountered, individual organization's abilities to achieve planned results, and new technical developments.

Second, the team also concluded that the current system is weighted too heavily on implementing generic, high-impact interventions without sufficient regard for the local cultural context and client involvement in all stages of the process. In the past, most efforts played lip service to

community involvement, limiting the focus to learning about local beliefs and customs but not really empowering communities to actively participate in all stages of program development and implementation. Client involvement is a key challenge for the USAID re-engineering effort, but one that is absolutely fundamental to its success.

Third, the team recognized that the Guatemalan health sector has overemphasized vertical programs - such as family planning, immunizations, control of diarrheal disease and treatment of ARI. Vertical programs facilitate development of technically sound interventions and training programs, and can be appropriate when initiating new programmatic areas. However, they are difficult to implement at lower levels of the health system. Many health posts are staffed by one professional or para-professional who tends to compartmentalize activities given his/her training and reporting requirements. Clients, however, do not compartmentalize health issues; they need and expect integrated and comprehensive care.

The fourth set of issues analyzed by the team focused on the the roles and relationships among self care in the home, community-based care (i.e., TBAs and promoters) and facility-based care. There is limited understanding of health seeking behavior in Guatemala. In order to improve the relationship between providers and families/communities, past and current efforts should be carefully studied, and new approaches should be built on these experiences. For example, in Guatemala, service provision is highly medicalized and based on norms that mitigate against effective service delivery. Decisions are generally made by physicians and graduate nurses. Auxiliary nurse and rural health technicians play secondary and more minor roles, yet these are the providers who have the most contact with care seekers and have a better understanding of their problems. Whenever new programs or innovations have been proposed, physicians have generally been opposed to giving more training and/or responsibility to low level personnel. The attitude is that only the physician has the training and experience to provide adequate medical care. An appropriate service delivery model for rural, highland Guatemala must tackle these issues by strengthening the relationship between the family/community and formal services.

3.3. Key Assumptions Made During the Elaboration of the Strategic Objective and Results Framework

The most fundamental assumption underlying this strategy is that this conceptual framework is a valid tool for identifying the relevant public health actions that are required to achieve desired results in the Guatemalan health sector. More specifically, the following assumptions were made during the elaboration of the conceptual framework and results framework:

- o Effective strategies and specific interventions can be identified through USAID/G-CAP's ongoing program of operations research and qualitative studies on client needs/wants, especially in rural Mayan areas.
- o The MOH and NGOs can change their organizational cultures to enhance client

focus and consequently, improve results.

- o Over time, the GOG will increase political and financial support for family planning and community health care.
- o USAID/G-CAP at least maintains its current level of budget support for reproductive/maternal-child health (R/MCH) activities.
- o Other donors are willing to work with USAID to integrate the series of vertical national R/MCH programs (immunizations, diarrheal disease/acute respiratory infections, family planning, etc.) into a coherent system with all necessary elements (training, supervision, monitoring, evaluation, etc.) for improved results
- o The process currently underway to update service delivery guidelines is successful, and that the MOH and NGOs are willing/able to implement standardized guidelines.
- o Professional training school curricula can be modernized

3.4 General Strategic Approach

Development of Innovative Approaches for Rural Mayan Areas. When new solutions are required, as they are in the case of the Guatemalan health sector, concentrating the developmental phase of activity in a relatively small area is advisable. USAID/G-CAP is using this approach with considerable success in the area of maternal health. In 1989, the Health Area, with technical assistance provided by INCAP and financed by USAID, initiated a demonstration project. From 1994 to 1996, USAID is providing additional resources to the Ministry of Health to scale up project activities to cover an additional three Health Areas. USAID is also working with the MOH and NGOs to test strategies to incorporate family planning into the program.

Applying this approach to other interventions in women's and children's health, makes it possible for USAID/G-CAP and its partners to develop greater understanding of the current obstacles to improving health indicators, and to design and test innovative solutions before making substantial investments. The identification of two to three versus only one pilot area requires greater investment of resources but it could also result in greater creativity as local teams share ideas and feed off of the natural competition to produce results. USAID/G-CAP will work with both NGOs and the public sector on these innovative approaches.

Continued Support at the National Level. While working toward the improvement of the health situation in the altiplano, USAID/G-CAP will continue to work at the national level through both the public and private sectors to improve women's and children's health. The program will focus on strengthening the public sector's overall capacity to provide and manage health services at all levels. Support for NGOs will focus on improving the technical quality of services,

program management and sustainability.

Participation. USAID/G-CAP and its partners will make every attempt to actively involve formal health service providers and managers, the Mayan communities and other development representatives in the process of identifying and removing the barriers to access and quality of health care that affect the Mayan population. In this way, all of the potential stakeholders will feel greater ownership of the interventions that are developed and, therefore, be more ready and able to assist in their replication in other areas. Participation should be built into:

- * Planning
- * Operations research
- * Social audit/monitoring with community participation

Strengthening Mayan Organizations and Professionals. USAID will make training opportunities available to Mayan leaders and professionals. USAID will attempt to strengthen its relationships with Mayan organizations or organizations with Mayan staff when contracting for project services or making project subgrants. In this way, Mayan organizations and associations will grow and be able to provide important, culturally appropriate services into the future.

4. Results Framework

The results framework outlines the strategic approach that USAID/G-CAP and its partners will implement over the next 8 to 10 years to improve results. This approach will promote the development of culturally appropriate models of integrated service delivery. Three guiding principles were applied during the development of the results framework:

- 1) the need to organize the activities that USAID and its partners undertake into logical results packages for which indicators of success over the short to medium term (up to 5 years) can be identified;
- 2) the need for a transparent system of assigning USAID resources based on demonstrated ability of the partner organizations to achieve results (accountability for results);
- 3) the need to involve local communities in the design and delivery of health services so that their beliefs and needs are met to the greatest degree possible.

By applying these principles, it is hoped that the results framework serves as a decision-making and management tool that will allow USAID/G-CAP to make programmatic and funding decisions to enhance the results and client focus.

Results will be measured in terms of specific desired outcomes related to women's and children's health. The two principle results, "improved women's health" and "improved children's health" are considered "medium-term"; that is, demonstrable impact can be achieved within five years.

The key people-level indicators that will be used to measure success are described below:

Improved Women's Health:

- o improved birth spacing (% of women whose births ≥ 2 years apart)
- o increased contraceptive prevalence rate
- o decrease percentage of unwanted/unplanned pregnancies
- o decrease percentage of high risk pregnancies (women < 18 or > 34 years)
- o reduced maternal mortality due to: secondary effects of abortion, sepsis and toxemia
- o decreased use of oxytocin outside the hospital

Improved Children's Health:

- o decreased percentage of low birth weight
- o decreased specific morbidity/mortality (diarrhea, pneumonia, measles, tetanus)
- o decreased case fatality rate for diarrhea and ARI
- o improved coverage of immunizations, use of ORT
- o improved nutrition/breastfeeding practices (exclusive breastfeeding through 4 to 6 months and percentage of children aged 6 to 9 months who are receiving breast-milk and supplemental foods)
- o improved birth spacing (% of women whose births ≥ 2 years apart)

The baseline and target measures for most these indicators will be established by September, 1995, in large part from the results of the DHS. In other cases, geographically targeted surveys may be carried out by individual partners.

Strategic Objective: Indicators of Success

Improved Health of Guatemalan Women and Children, Especially in Rural Mayan Areas
(Five and ten year targets to be set)

Indicators:

- * Infant Mortality Rate
- * Child Mortality Rate
- * Neonatal Mortality Rate
- * Perinatal Mortality Rate
- * Maternal Mortality Ratio
- * Total Fertility Rate

Improved Reproductive Health
(Two to Five Year Targets)

- * Improved Birth Spacing
- * Increased Contraceptive Prevalence Rate
- * Decrease Percentage of unwanted/unplanned pregnancies
- * Increase Tetanus coverage
- * Decrease percentage on high risk pregnancies
- * Reduced maternal mortality (abortion, sepsis, toxemia, hemorrhage)
- * Decrease use of oxytocin outside hospitals

Improved Child Health
(Two to Five Year Targets)

- * Improved Birth Spacing
- * Decrease percentage low birth weight
- * Decrease case fatality rate (diarrhea/ARI)
- * Decrease mortality (diarrhea, pneumonia, measles)
- * Improve immunization coverage (DPT3, polio, measles)
- * Improved ORT coverage
- * Improved breastfeeding practices

The achievement of results in a sustainable way is contingent on improving health practices, especially in the home, and on strengthening health service delivery, at both the community and facility levels. The public health actions and interventions that are required to achieve improvements in health status have been organized into results packages. Each "results package" focuses on the lower level results that are logically linked to the achievement of the strategic objective. Section 6 below presents the detailed results framework.

In identifying the results packages, the re-engineering team sought to answer the question: what do we need to do in the short to medium term to demonstrate measurable progress toward the achievement of the strategic objective?

Results Packages:

In contrast to the current planning and implementation system, the following results packages are more flexible, more responsive to client and partner concerns regarding women's and children's health, require less up-front documentation and are more focused on the delivery of results. It is understood that USAID/G-CAP will negotiate a specific plan (agreement/contract) with each partner organization; the plan will describe specific activities for given results packages, a timeline, and indicators of short (up to one year) and medium (up to five years) term success. Annex B contains an illustrative list of the indicators that could be used by partner organizations to monitor progress toward short and medium term results. Specific indicators will be agreed upon by USAID and its individual partners on an annual or semi-annual basis, depending on the following:

- o the programmatic area(s) covered by the partner (reproductive or integrated child health, or both);
- o geographic area covered and client characteristics/needs
- o past performance (status of the organization vis-a-vis) the results packages)

One of the goals of the USAID/G-CAP reengineering effort is to eliminate large and highly structured projects and replace them with results-based contracts with specific organizations. Therefore, each potential partner must be evaluated in terms of its potential to achieve results by incorporating the community into the planning, delivery and monitoring of services. Proposals on how the community will be involved in improving and becoming active partners in delivering services will be developed; realistic goals and concrete measurable results will be incorporated into the design process. Indicators to monitor implementation will be identified, and the service provision strategy must be sufficiently flexible to permit adjustments and restructuring in response to problems and lessons learned.

The three principle results packages that USAID/G-CAP and its partners have identified as the fundamental organizing principles of the new health sector strategy are:

- o **improved health practices and service delivery**
- o **sound program management**

o a policy environment conducive to improving women's and children's health

The re-engineering team identified various interrelated sub-results within each results package. For example, the "health practices and service delivery" results package will be measured at three interrelated levels: improved household practices; the availability and use of quality care in the community; and the availability and use of quality care at health facilities (including hospitals, health centers, health posts, pharmacies, etc.). The achievement of these three results is contingent upon lower level results in four programmatic areas: improving service quality, coverage and access; strengthening information, education and communication programs (IEC); developing appropriate human resources; and ensuring that supplies and equipment are available.

Achieving "sound program management" will be achieved by getting lower level results in four areas: having functioning financial and administrative systems; having functioning monitoring systems; improving program sustainability; and using operations and evaluation research findings to support decision-making.

The third results package, "a policy environment conducive to improving women's and children's health" is linked to the first two results packages. Greater high-level political commitment to primary health care will be required if Guatemala is to improve women's and children's health indicators at the national level, and bridge the gaps between urban and rural areas and/or between indigenous and non-indigenous populations.

Strategic Objective

Results Framework

Improved Health of Guatemalan Women and Children, Especially in Rural Mayan Areas

Results Packages

Result 1
Improved Health Practices and Service Delivery

Improved Household Practices

Improved Quality of Care in Communities

Improved Quality of Care in Facilities

Result 2
Participatory Sound Program Management

Result 3
Policy Environment Conducive to Improving Women's and Children's Health

Results Sub-Packages

Result 1.1
Improved Quality, Coverage and Access

Result 1.2
Strengthened Information, Education and Communication (IEC) Programs

Result 1.3
Development of Appropriate Human Resources

Result 1.4
Supplies and Equipment Continuously Available

Result 2.1
Functioning Financial and Administrative Systems

Result 2.2
Functioning Monitoring Systems

Result 2.3
Greater Program Sustainability

Result 2.4
Operations Research and Evaluation for Better Decision-Making

Result 3.1
Increased Investment in Women's and Children's Health

Result 3.2
Leadership and Policy Development

Result 3.3
Advocacy for Women's and Children's Health

Results Package No. 1: Improved Health Practices and Service Delivery

USAID/G-CAP will dedicate the majority of its resources on this results package because it has the most direct relationship to the strategic objective performance indicators. For the past several decades, USAID assistance to the health sector has focused on improving service delivery at the facility level, with a secondary focus on community-based care. Almost no resources have been assigned to improving household practices for improved health. In order to achieve this results package, USAID resources and technical assistance will be provided simultaneously at all three levels where health care is provided, and will promote greater contact among the levels.

USAID/G-CAP will work with selected partners in the highlands to develop innovative strategies to achieve results at all levels of care. Based on lessons learned in implementing these new approaches, partners will expand these efforts to provide additional geographic coverage. At the same time, USAID/G-CAP will continue its work with the public sector and NGOs at the national level where existing activities will be altered so as to strengthen their client focus and to integrate delivery of various high impact interventions previously supported in separate programs. Integration of services will focus, at least initially, on "family planning and reproductive health" on the one hand and "integrated management of the child" on the other. Integrated management of the child includes preventive aspects of care (such as immunizations, breastfeeding promotion and growth monitoring) as well as curative care (standard case management of ARI and diarrheal disease). Each of these programs will focus on the technical side (such as the development of norms and protocols) as well as ensuring the availability of necessary materials and supplies. USAID/G-CAP will facilitate the incorporation of proven innovations at the national level whenever possible.

Given the importance of improving health practices in the home while also improving community-based and facility-based services, results will be monitored at all three levels. The discussion provided below explains the rationale for working simultaneously at these levels of care.

Improved Household Practices

Household practices related to care of women and children has received very little emphasis in Guatemala. Yet, because of the current limited amount of contact between most families and the health system (including both formal and nonformal providers), most health care delivery takes place in the home. It is essential that understanding of current health practices be increased, so appropriate practices can be taught and promoted as necessary. USAID/G-CAP will promote the development of simple diagnostic tools that health workers can use to identify key household practices that should be modified. Based on these diagnostic results, information, education and communication (IEC) activities will be developed, implemented and evaluated. The IEC campaigns will address a limited number of key health behaviors.

With few exceptions, past efforts to change health behaviors through information, education and communications (IEC), have had little or no impact. There are reasons to believe that: 1) messages and materials have been designed without sufficient attention to linguistic and ethnophysiological considerations, or as is frequently mentioned, the Mayan worldview (cosmovision); 2) messages are not always clear because materials are so full of information that the key information is lost; and, 3) well-designed materials are only sporadically available to those community workers who are in a position to deliver messages in local languages.

Because of their geographical and cultural closeness to families, traditional health workers such as TBAs, health promoters, community-based distributors, food distribution centers, and community groups of all kinds are well positioned to carry out IEC activities, especially fac-to-face communication. The goal is to get materials--materials that are in the local language, that reflect the population's concepts of health and illness, and that focus on changing a few key behaviors--into the hands of the individuals who are most likely to be able to use them effectively with families, especially women.

Quality Care in the Community

The options that rural families have for seeking care in their communities include stores (that often sell some drugs), traditional healers, midwives and health promoters. As a first step in defining "quality care in the community", USAID/G-CAP and partners will develop a simple methodologies/tools for conducting a community health diagnosis, carrying out inventories of local resources that are (or potentially could be) involved in health care delivery at the community level, and planning interventions. These diagnostic activities will be carried out with substantial community involvement. Based the results of these assessments, community personnel will be trained/organized to deliver appropriate preventive and curative services. The USAID program will promote the application of adult learning methodologies and standardized training curricula for key areas (integrated management of the child and key reproductive health interventions, including community-based distribution of family planning methods). The methodology would also include tools for monitoring and evaluating progress over time.

In the 1970s, both the Guatemalan public sector and NGOs made a big push to train health promoters. However, due to a variety of reasons, many health promoter programs proved unsustainable. Promoters often did not have a continuous supply of necessary drugs and materials, they rarely received supervision, and they had few incentives to remain active. USAID/G-CAP and partners will examine the lessons learned from these local experiences and develop more sustainable approaches to improving promoter trainins, supervision and credibility in the community. For example, strategies for promoter self-sufficiency for supplies will be developed and tested (e.g., fees, drug rotating funds and incentives).

Another key category of community personnel is midwives. In Guatemala, midwives are

an important source of both women's and children's health care. In four health areas, USAID is working with the ministry of Health to develop a training program and to enhance the image of midwives among formal health care workers. Based on lessons learned in training midwives in selected areas of the country (1995-96), USAID and partners will expand these programs to additional areas of the country.

Quality Care in Health Facilities

To date USAID and most other donors have supported the delivery of various high impact interventions - such as family planning, immunizations, oral rehydration therapy and control of acute respiratory infections. Each of these "programs" focused on the technical side (such as the development of norms and technical training) as well as provision of supplies. However, USAID has only recently begun to analyze how these various programs and interventions can be integrated at the point of service delivery to enhance client satisfaction and service utilization and to improve providers' abilities to provide and monitor services. Integration of services will focus, at least initially, on "family planning and reproductive health" on the one hand and "integrated management of the child" on the other.

In Guatemala, especially in rural areas, the referral system is another key area for improvement. Providers at lower levels of the health system - such as TBAs and promoters are often not accepted by "formal" providers at health centers and posts; there is no formal system for referring complicated cases, nor for any follow-up once the patient returns to the community.

Result Subpackage 1.1 Improved Quality of Care, Coverage and Access

Quality of care is a key element of USAID's global approach to improving women's and children's health. At the household level, improved quality of care centers on women's abilities to provide appropriate preventive and curative care. This includes seeking outside care when required. Thus, the USAID/G-CAP strategy focuses on improving knowledge and understanding of home-based care and enabling women to change their practices as required to improve their health and the health of their children.

The USAID/G-CAP re-engineering team based much of its analysis regarding improved service delivery (community and facility-based care) on Judith Bruce's 1990 framework on quality of care. The framework has six key elements which are largely reflected in this results package (although selected elements can be found in other results packages): choice of methods, information given to clients, technical competence, interpersonal relations, continuity mechanisms, and constellation of services (appropriateness and acceptability of services).

Although Bruce's framework was designed to strengthen family planning programs, it has broad applicability for integrated child health as well as safe motherhood programs (especially for first level referral facilities). USAID/G-CAP will work with its partners to improve quality of

reproductive and child health care so that more Mayan families have access to and use appropriate services.

Improved access to services includes physical/geographical access as well as cultural/linguistic and economic access. Past research has shown that the relationship between physical access to services and utilization of those services is not as strong as might expected. Other intervening variables that have been shown to be important in Guatemala include limited service hours, providers' poor interpersonal skills, inadequate supplies at facilities, low technical quality of services, high costs (transportation, drugs, etc) as well as language and other cultural barriers. USAID and its partners will improve accessibility by strengthening local resources (such as health promoters and TBAs) and the linkages/interface between these resources and public/private sector facilities.

Service provision in Guatemala is highly medicalized and uses norms that paradoxically limit access to services. Physicians and graduate nurses are given authority to make most decisions; auxiliary nurses, rural health technicians and promoters are usually relegated to secondary roles - yet they have far more contact with the care seekers and have a better understanding of their problems.

Cultural distance between local community members and institution-based service providers can be addressed in part through better selection, training/supervision and incentive systems. In addition, community level personnel such as traditional birth attendants (TBAs) and promoters and their clients have often been rejected by western facilities, a situation that must be changed for the achievement of the strategic objective.

Result Subpackage 1.2 Strengthened Information, Education and Communication (IEC) Programs

Given the emphasis that USAID/G-CAP and its partners are placing on improving women's abilities as caretakers of their own reproductive health and the health of their children, effective IEC programs are a fundamental element of the strategy. IEC program development will be centered on greater community participation in program design and implementation. Short term results include diagnostic studies and development of IEC plans. Over the medium term, IEC activities seek to change knowledge and behavior related to reproductive health, including prenatal, pregnancy and post-partum care; care of the newborn; and standard case management (SCM) of ARI and diarrhea.

Result Subpackage 1.3 Development of Appropriate Human Resources

The development of appropriate human resources entails a series of inter-related aspects including selection and assignment of personnel (institutional and community), technical training, adequate supervision systems and managerial/leadership training. In Guatemala, critical areas for technical training include reproductive health/family planning and management of obstetrical emergencies.

Community personnel rarely receive support and/or respect from formal providers, yet community personnel are often respected community leaders who can communicate effectively and affect the attitudes and behaviors of others. It is crucial to the success of the program that both private and public sector partners establish and sustain functional and mutually beneficial relations with community-level personnel over an extended period of time.

Result Subpackage 1.4 Supplies and Equipment are Available

One of the critical issues for quality of care and coverage at all three levels is ensuring that the necessary supplies and equipment are available. These include contraceptives, vaccines, syringes, antibiotics, ORS and other supplies. Good logistics management ensures that the right quantity of the right quality goods are sent to the right place at the right time and at the right cost. Without supplies and equipment quality care cannot be provided.

Results Package No. 2 Participatory Sound Program Management

While building the technical and human capability to deliver culturally appropriate services in Guatemala is central to the USAID/G-CAP strategy, it is also recognized that improved institutional capacity to manage programs is key to the achievement and sustainability of the strategic objective. It is also important that local participation be a key feature of program design, management, monitoring and evaluation.

Result Subpackage 2.1 Strengthened Financial-Administrative Systems

It is the role of program managers to guide service delivery efforts toward the successful achievement of their planned outputs. The USAID/G-CAP strategy focuses on two parallel processes: a) financial planning based on equity and b) the development and utilization of financial and administrative systems to support program implementation. Few USAID/G-CAP partners are currently focused on the highlands, yet this area has the poorest health indicators. Program managers need to improve the planning process to ensure that underserved areas have adequate access to quality services. Key to this process is better access to and use of current financial and administrative systems (personnel, inventory, budget, etc.) at all levels - district/local to central. During the first year of the program, USAID/G-CAP will provide technical assistance to the Ministry of Health to incorporate family planning and reproductive health into the existing management information system (logistics, personnel, budget, service statistics, etc.), and to decentralize the system to the district level.

Result Subpackage 2.2 Functioning Monitoring Systems

Sound program planning and management are fundamentally linked to information. Managers and technical staff must have access to current information to make decisions about how to operate of their institutions and/or programs. USAID will support partners in the design and implementation of decentralized monitoring systems that support the decision-making needs of

managers and technical staff at all levels of an institution. Both manual and computerized systems will be developed. These systems will permit better monitoring of program implementation and the results (service statistics, coverage data, etc.).

Result Subpackage 2.3 Greater Program Sustainability

Sustainability has been defined by the re-engineering team in both financial and programmatic terms. Financial sustainability focuses on improving efficiency of service delivery as well as greater cost recovery. The former applies to both the public and private sector, whereas the latter applies to the private sector (since the current legal framework prohibits much cost recovery in the public sector). Programmatic sustainability refers to the ability of partners, individual facilities, and/or communities to carry out program over the long term, after external assistance disappears.

USAID/G-CAP and the Ministry of Health made notable progress in the past few years in decentralizing the capability to manage and deliver child survival services to the health area (departmental) level. However, these efforts have been limited to the internal financial and administrative systems of the MOH and have not been built around client participation. As part of the new strategy, decentralization will be pushed to the district (municipal) level and will begin with greater community involvement in the design and delivery of services.

Result Subpackage 2.4 Operations Research and Evaluation for Better Service Delivery and Program Management

The re-engineering team felt that partners need to strengthen their research and evaluation capabilities in order to improve program performance. The focus of this results subpackage is on the ability to generate data relevant to managers' information needs and to meaningfully utilize research and evaluation findings in program planning and management decision-making. Operations research and evaluation play a supportive role to better service delivery and program management.

Results Package No. 3 Policy Environment Conducive to Improving Women's and Children's Health

"Policy" in its broadest sense reflects the principles upon which decisions are made and actions are taken. The policy environment not only includes the official policies that are created and enforced by governments, but also private sector standards/policies as well as the social and cultural norms which, though perhaps unwritten, prescribe actions of people at large. The policy environment includes those factors that influence service delivery that are beyond the full control of program managers. The policy environment affects most functional areas of women's and children's health programs - service delivery, IEC, training, cost-recovery/sustainability, access, etc.

Policy development will be based on an assessment of the current policy environment in relation

to program needs and the resources available to develop effective programs. Over the short to medium term, policy development activities will be based on strengthening political support for family planning and reproductive health (by targeting opinion makers and grass roots advocacy groups) as well as greater government investment in primary health care programs.

Result Subpackage 3.1 Increased Investment in Women's and Children's Health

The Guatemalan health sector confronts two serious overriding limitations: first, the overall investment in health is among the lowest in Central America. Investment in health has declined in real terms since 1980 and is now less than one percent of gross domestic product. Second, between seventy and eighty percent of the health sector budget goes to hospitals, leaving very little for primary health care. USAID will work with other donors and the GOG to increase the overall investment in health to two percent of GDP by 2000, and will also promote greater investment in primary health care.

Result Subpackage 3.2 Leadership and Policy Development

As part of its efforts to promote a supportive health policy environment, USAID/G-CAP and its partners will support the development of stronger leadership for women's and children's health. This includes increasing policy makers' knowledge of key health and demographic issues; increasing the number of women leaders; improving the quality of formal GOG policies that specifically support women's and children's health initiatives and activities; increasing the number of opinion and policy makers who support reproductive and child health; and improving the quality of media coverage about women's and children's health. USAID and partners will continue with the efforts already underway to reduce medical and other barriers by improving the maternal-child health norms.

Result Subpackage 3.3 Advocacy for Women's and Children's Health

In Guatemala, there is increasing public acknowledgement of the importance of improving women's and children's health. A recent study of 271 Guatemalan non-governmental organizations found that 35% of them are engaged in family planning activities (training, research and/or services); 73% are interested in working in this area. Efforts will also focus on increasing the number and diversity of community-based organizations and nonformal associations that have access to technically sound information on women's and children's health so that they can contribute to the growth of a positive policy environment.

5. Detailed Results Framework and Benchmarks

DETAILED RESULTS FRAMEWORK

Key Benchmarks

RESULTS	YEAR 1 (1995-1996)	YEAR 2 (1996-1997)	YEAR 3 (1997-1998)	YEAR 4 (1998-1999)	YEAR 5 (1999-2000)
1 Improved Practices And Service Delivery	<ul style="list-style-type: none"> NGOs and MOH initiate IMC programs in pilot areas at the household, community and facility levels NGOs and MOH strengthen current RH/IMC programs at national level (Years 1-10) USAID/MACRO conducts "situational analysis" of services and demand USAID establishes with partners short, medium and long term targets for Results Package No. 1 (household practices and service delivery coverage) 	<ul style="list-style-type: none"> NGOs and MOH initiate RH projects in lessons learned from OR Expand MotherCare's program to other health areas (Years 2-10) 	<ul style="list-style-type: none"> NGOs and MOH refine/scale-up IMC programs based on lessons learned (Years 3-10) 	<ul style="list-style-type: none"> NGOs and MOH refine/scale-up RH programs (Years 4-10) 	
Improved Household Practices	<ul style="list-style-type: none"> Diagnosis of child health behaviors and needs Diagnosis of reproductive health behaviors and needs 	<ul style="list-style-type: none"> Develop and initiate IEC campaigns for improved home-based management of the child Develop and initiate IEC campaigns for improved reproductive health care in the home 			<ul style="list-style-type: none"> Targets met: <ul style="list-style-type: none"> Home-based IMC practices Home-based RH practices
Quality Care in the Community	<ul style="list-style-type: none"> Develop simple methodologies for community health diagnosis; community resource inventory and program planning for IMC pilot areas Methodology for training/organizing community personnel for IMC intervention is developed/tested 	<ul style="list-style-type: none"> Develop simple methodologies for community health diagnosis, community resource inventory and program planning for RH pilot areas Methodology for training/organizing community personnel for RH is developed/tested NGOs and MOH using adult learning methodology and standardized training curricula for TBAs 	<ul style="list-style-type: none"> CBD programs using adult learning methodologies and standardized curricula to train CBD workers and supervisors CBD programs have standardized counseling messages Strategies for health promoter self-sufficiency for supplies/support have been developed and tested (eg. fees, drug rotating funds, incentives) 	<ul style="list-style-type: none"> In public areas, community personnel (promoters, etc.) are using standardized educational messages to provide IMC at household level 	<ul style="list-style-type: none"> Targets met for provision of community based services (IMC and RH)
Quality Care in Facilities	<ul style="list-style-type: none"> Partners develop tools for assessing and monitoring quality and efficiency for service provision Partners conduct assessment using 	<ul style="list-style-type: none"> Partners use tools to conduct facility and community level assessment, prioritized actions to improve quality and efficiency 			<ul style="list-style-type: none"> Targets met provisions of quality care at health facilities (RH/IMC)

DETAILED RESULTS FRAMEWORK

Key Benchmarks

RESULTS	YEAR 1 (1995-1996)	YEAR 2 (1996-1997)	YEAR 3 (1997-1998)	YEAR 4 (1998-1999)	YEAR 5 (1999-2000)
1.1 Improved Quality, Coverage and Access	<ul style="list-style-type: none"> Each partner develops multi-year action plan to improve quality, coverage and access (including setting targets) and initiates activities Each partner develops multi-year action plan to improve RH quality and coverage (including setting targets) and initiates activities APROFAM clinics have standard prices according to ability to pay MOH, MotherCare establish 3 community maternities Partners assess administrative and cultural barriers to service delivery and utilization and develop multi-year action plan 	<ul style="list-style-type: none"> Adoption of standards of Emergency Obstetrical Care (EOC) at each level of care (hospital, clinic, post, community) Facility and community level providers practice standard case management of ARI and CDD Hospital maternal mortality committees will review maternal deaths Improve detection and management of obstetric complications in MotherCare program areas Increase number women with obstetrical/perinatal complications who utilize medical services in 4 Altiplano health areas Public/private - expand CBD program and commercial outlets in Altiplano 		<ul style="list-style-type: none"> Community and facility based personnel referring clients to appropriate level of care 	<ul style="list-style-type: none"> Improved use of community-based services (CBD, commercial outlets, promoters, TBAs, etc.) Increased use RH/MCH services (hospitals, centers, posts) Public/private institutions have Mayan speaking staff at appropriate sites
1.2 Strengthened IEC Programs	<ul style="list-style-type: none"> IEC campaign on maternal/neonatal health carried out in 4 altiplano health areas Develop integrated community based IEC strategy in IMC (breastfeeding, ARI, CDD, immunizations) in pilot areas 	<ul style="list-style-type: none"> IEC campaign on integrated management of the child carried out in 3-4 altiplano health areas focussing on messages at the family level Develop integrated community based IEC strategy in reproductive health in pilot areas 	<ul style="list-style-type: none"> IEC campaign on integrated RH in pilot areas focussing on messages at household level 		<ul style="list-style-type: none"> Appropriate home-based care being given Appropriate utilization of community providers and facilities
1.3 Development of Appropriate Human Resources	<p>Nationally approved and adopted:</p> <ul style="list-style-type: none"> Training materials for training of TBA trainers Training materials for TBAs in emergency obstetric care 	<ul style="list-style-type: none"> Each partner develops operational definition of "supervision" for all levels of care and multi-year action plan to establish supervisory systems 	<ul style="list-style-type: none"> Partners update personnel policies and job descriptions Partners are actively supervising personnel at all levels Technically competent community and facility based personnel <ul style="list-style-type: none"> - family planning counseling - maternal health care IMC (SCM for ARI/CDD) 		
1.4 Supplies and Equipment Continuously Available	<ul style="list-style-type: none"> MOH maintains cold chain at all levels (central to district) 		<ul style="list-style-type: none"> Central and local levels properly stocking and storing the appropriate amounts of contraceptives and other supplies 		<ul style="list-style-type: none"> Community personnel supplied according to need (contraceptives, ORS, essential drugs, supplies)

DETAILED RESULTS FRAMEWORK

Key Benchmarks

RESULTS	YEAR 1 (1995-1996)	YEAR 2 (1996-1997)	YEAR 3 (1997-1998)	YEAR 4 (1998-1999)	YEAR 5 (1999-2000)
2 Participatory Sound Program Management	<ul style="list-style-type: none"> • APROFAM clinics develop annual sustainability workplan to be integrated into overall APROFAM plan 	<ul style="list-style-type: none"> • Ministry of Health decentralizes delivery/management of RH services 	<ul style="list-style-type: none"> • Each APROFAM clinic is accountable for its sustainability • Partners using support systems for decision-making at levels (planning, management, monitoring) 		<ul style="list-style-type: none"> • Health areas and districts achieve annual targets for budget execution and program implementation
2.1 Functioning Financial-Administrative Systems	<ul style="list-style-type: none"> • Add RH to MOH Management Information System (MIS) (personnel, budget, inventory, etc.) • MOH's MIS decentralized to local level (health centers, posts) 	<ul style="list-style-type: none"> • Central level facility/community-based personnel able to provide up-to-date account of quantities of supplies requested, received, distributed (to users plus losses), in-stock, and stock-outs 	<ul style="list-style-type: none"> • Health districts reporting on current financial position defined as ability to generate information amounts budgeted and expended for major line items (overall and for specific facilities) 		<ul style="list-style-type: none"> • Health districts have systems of checks and balances for handling cash (vouchers, disbursements, verification of accounts)
2.2 Functioning Monitoring Systems	<ul style="list-style-type: none"> • Design and test methodology tools for program monitoring at all levels • Public sector - incorporate RH into HIS 	<ul style="list-style-type: none"> • Develop and test community-level HIS (promoters, TBAs, etc.) • Implement semi-annual review committee meetings in districts (staff at all levels participating) • Central, area, district and community levels able to provide up-to-date account of quantities of supplies requested, received, distributed (users and losses), in-stock, and stock-outs 			<ul style="list-style-type: none"> • Central, area, district, community levels using H/MIS for program planning, management and monitoring
2.3 Greater Program Sustainability	<ul style="list-style-type: none"> • APROFAM/MSH complete 3 year sustainability plan for urban clinics 	<ul style="list-style-type: none"> • IPROFASA sustainable (except for commodities) 	<ul style="list-style-type: none"> • APROFAM urban clinics sustainable 		<ul style="list-style-type: none"> • Local NGOs achieve sustainability targets • MOH establishes cost recovery systems at all levels
2.4 Operations Research (OR) and Evaluation for Better Decision-Making	<ul style="list-style-type: none"> • Five year monitoring/evaluation plan for USAID detailed results framework (baseline, targets) • ARI communications strategy evaluated • Secondary analysis DHS and dissemination of results to local level (area, districts, NGOs) 	<ul style="list-style-type: none"> • Define phase II OR program (1996-2000) • APROFAM, IGSS, MOH, local NGOs implementing new strategies based on phase I OR project (Population Council 1993-96) 			<ul style="list-style-type: none"> • APROFAM, IGSS, MOH, local NGOs implementing new strategies based on Phase II OR Project (1996-2000)
3 Policy Environment Conducive to Improving Women's and Children's Health	<ul style="list-style-type: none"> • Using DHS and other data, POLICY Project develops policy dialogue tools 	<ul style="list-style-type: none"> • MOH/SEGEPLAN/MOF and NGOs use of demographic data (census, DHS) for development planning and resource allocation 			<ul style="list-style-type: none"> • Absence of unwarranted restrictions on family planning service providers/users

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DETAILED RESULTS FRAMEWORK Key Benchmarks

RESULTS	YEAR 1 (1995-1996)	YEAR 2 (1996-1997)	YEAR 3 (1997-1998)	YEAR 4 (1998-1999)	YEAR 5 (1999-2000)
3.1 Increased Investment in Women's and Children's Health			<ul style="list-style-type: none"> Percentage of MOH budget for primary health care increased by 25% 		<ul style="list-style-type: none"> Percentage of GDP for health increased to 2% Percentage of MOH budget for primary health care increased to 50%
3.2 Leadership and Policy Development	<ul style="list-style-type: none"> Assessment/baseline of policy environment 	<ul style="list-style-type: none"> Develop integrated RH/MCH norms Personnel policy on facility staffing (language, assignment/selection, etc.) Active program of awareness-raising events targeted to leaders, journalists, etc. 			
3.3 Advocacy for Women's and Children's Health	<ul style="list-style-type: none"> Community groups identified as potential advocates 		<ul style="list-style-type: none"> 10 groups working together in advocacy 		

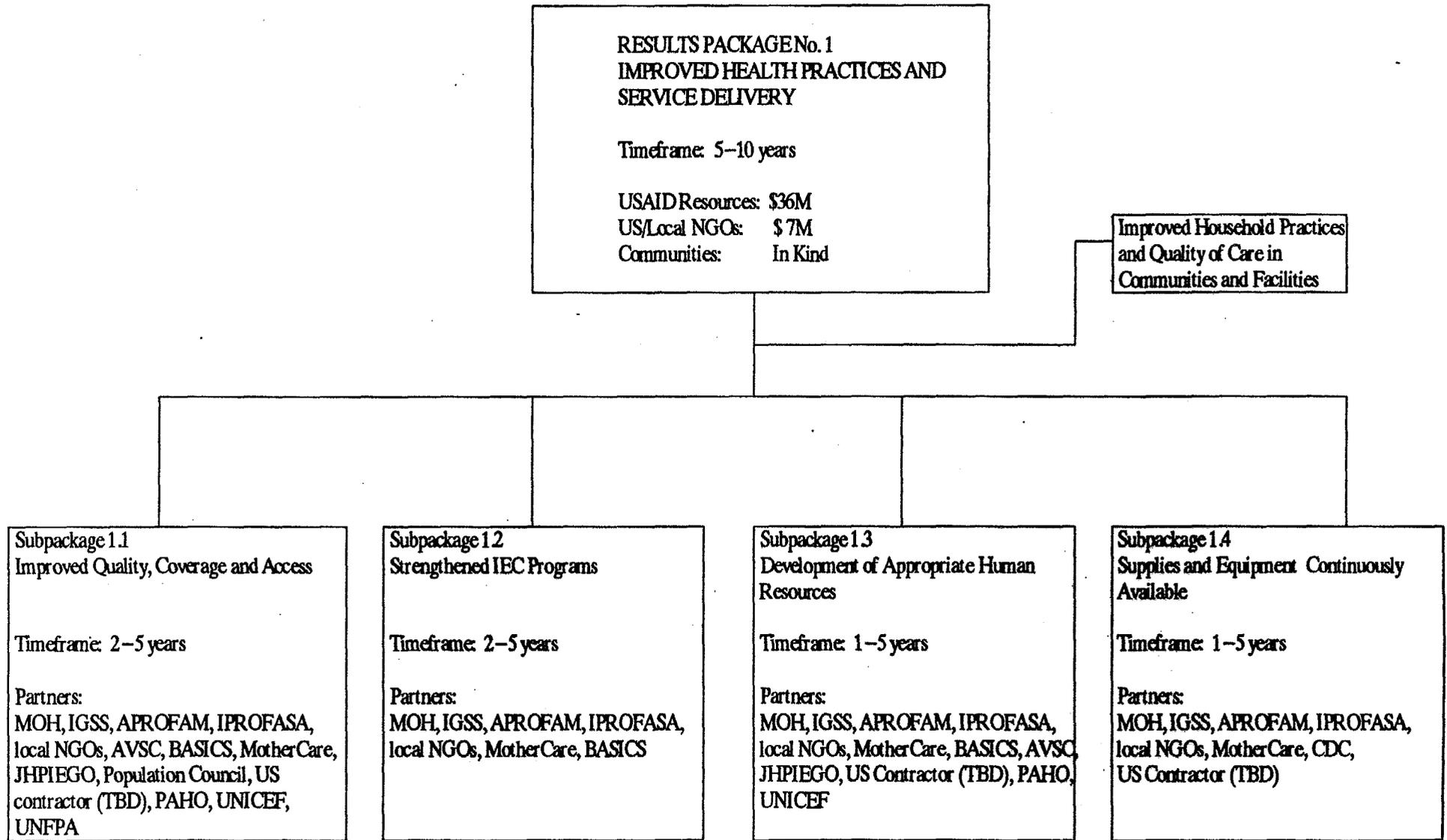
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6. IMPLEMENTATION PLAN

USAID/G-CAP plans to invest \$60 million over a ten year time frame in improving the health of Guatemalan women and children, especially in the highlands. It is expected that the GOG and NGOs together will invest an additional \$20 million in counterpart contributions. In terms of the public sector, counterpart requirements will not focus on salaries but on the procurement of supplies such as vaccines, syringes, oral rehydration salts and selected antibiotics. The following charts show the distribution of USAID, MOH, and NGO resources and the expected partner organizations by results package.

DETAILED RESULTS FRAMEWORK *



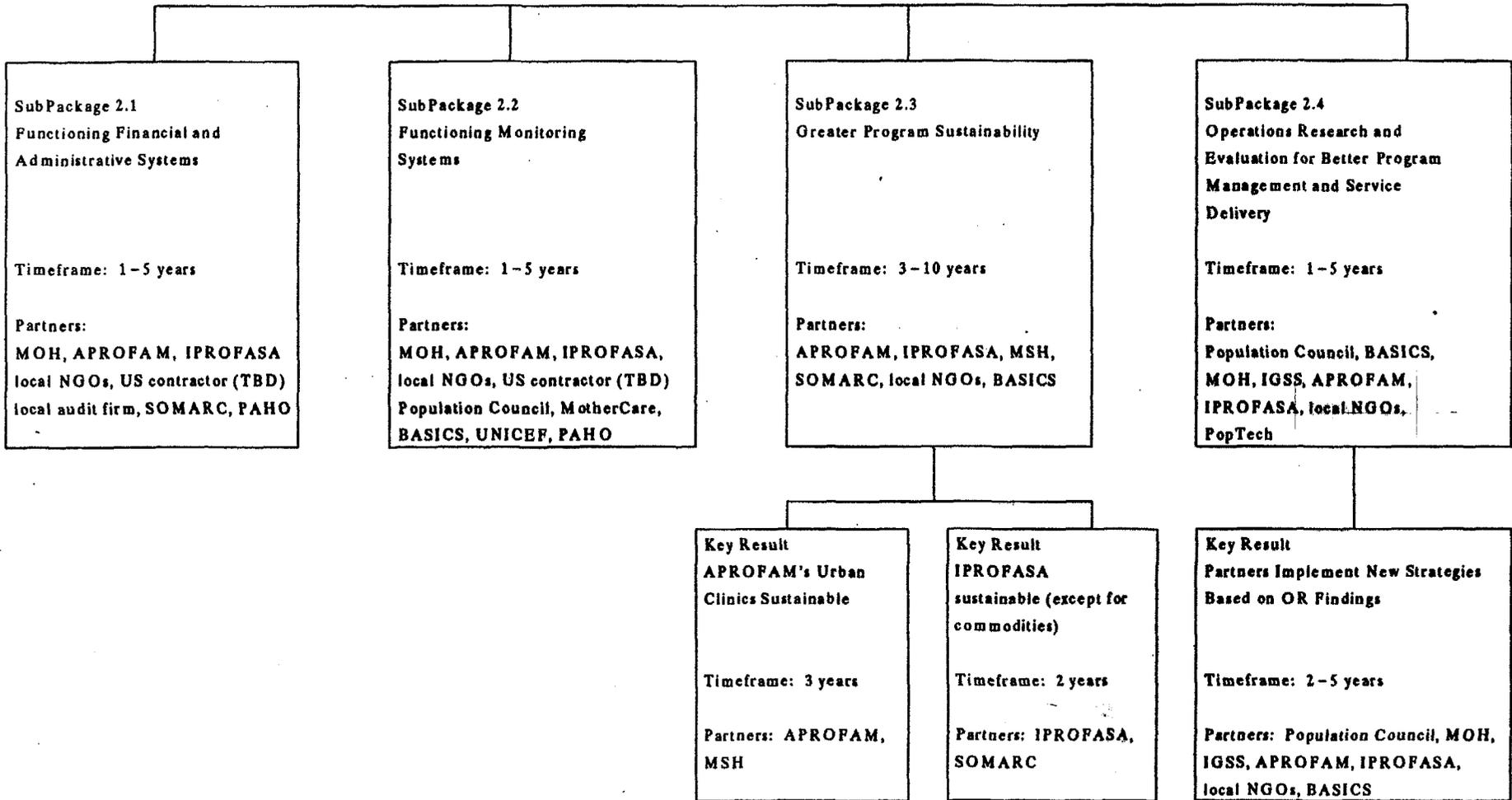
* Critical Assumptions: (1) IDB Health Sector Reform Program (\$25M in technical assistance, \$40M in loans) is successful in increasing GOG investment in health sector.
 (2) Other donors continue to support maternal child health services at the same financial level as 1995.

RESULTS PACKAGE No. 2

STRENGTHENED SUPPORT SYSTEMS

Timeframe: 5-10 years

USAID Resources: \$12M
 MOH Resources: \$4M
 US/Local NGOs: \$1M



RESULTS PACKAGE No. 3

POLICY ENVIRONMENT CONDUCTIVE TO IMPROVING WOMEN'S AND CHILDREN'S HEALTH

Timeframe: 5-10 years

USAID Resources: \$ 6M

MOH Resources: \$ 1M

US/Local PVOs: \$0.5M

Subpackage 3.1

Increase Investment in Women's and Children's Health

Timeframe: 3-5 years

Partners: IDB, World Bank, MOH, MOF, SEGEPLAN, IGSS, Policy, US Contractor (TBD), PAHO

Key Result

Percent GDP for Public Health Increased to 2%

Timeframe: 5-10 years

Partners: IDB, World Bank, MOF, MOH, IGSS US Contractor (TBD), PAHO

Key Result

Percentage of MOH Budget for Primary Health Care Increased to 50%

Timeframe: 5-10 years

Partners: IDB, World Bank, MOF, MOH, US Contractor (TBD), PAHO

Subpackage 3.2

Leadership and Policy Development

Timeframe: 2-5 years

Partners: POLICY, MOH, MOF, IGSS, Local NGOs, SEGEPLAN, US Contractor (TBD)

Key Result

Standardized Norms and Service Delivery Guidelines (MCH/RH) for Hospital, Center, Post, Community Levels for RH/IMC

Timeframe: 2-3 years

Partners: MOH, IGSS, APROFAM, USAC, JHPIEGO, POLICY

Key Result

Absence of Unwarranted Restrictions on Family Planning Service Providers and Users

Timeframe: 5 years

Partners: MOH, IGSS, NGOs, JHPIEGO, POLICY

Subpackage 3.3

Advocacy for Women's and Children's Health

Timeframe: 3-5 years

Partners: Policy, Local NGOs and community/women's groups

The distribution of the budget by results package for the ten year period is shown in Table One. An estimated sixty percent of USAID support will be directed to Results Package Number 1 "Improved Health Practices and Service Delivery." At the present time, the public sector and most NGOs have low capability to deliver services in the highlands that meet minimum standards of quality, are accessible to the population, and are culturally acceptable to the end-user. USAID/G-CAP anticipates that it will take several years to develop and pilot test new public-private sector service delivery models that will permit clients to have adequate access to services. USAID/G-CAP will require its partners to establish as medium term results, the often radical changes in service delivery that will be required. Examples of these changes include devolving many responsibilities in the current highly medicalized model to lower levels of the health system, hiring more indigenous personnel at all level of the system, integrating services (including supervision and training systems) and increasing demand through IEC programs. These changes are profound and will require heavy investments in training, development of job aids and design and implementation of IEC campaigns. These IEC campaigns are the principle tool for improving household practices for women's and children's health, and for stimulating demand for health services. For these reasons, USAID/G-CAP estimates that the bulk of its investment will be in this Results Package.

TABLE ONE
FAMILY AND COMMUNITY HEALTH PROGRAM
LOP ILLUSTRATIVE BUDGET
 US DOLLARS (MILLION)

COMPONENT	MOH	%	PRIVATE	%	TOTAL	%
Improved Health Practices & Service Delivery	12.6	35%	23.4	65%	36	60%
Participatory Sound Program Management	7.4	62%	4.6	38%	12	20%
Policy Environment Conducive to Improved Women's & Children's Health	3	50%	3	50%	6	10%
USAID Management	4.5	75%	1.5	25%	6	10%
TOTAL	27.5	46%	32.5	54%	60	100%

In the area of child health, USAID/G-CAP has worked almost exclusively with the public sector and in reproductive health, the Mission has supported only one local NGO, the IPPF affiliate, in a significant way. A central focus of the new strategy is to expand the number of partners and develop a mechanism for channeling resources to a greater number of Mayan NGOs. The current capability of the MOH to achieve desired results in the altiplano is generally low, however, some health districts are highly motivated and can improve health indicators with more training on quality of care and community-based approaches. The Mission will support the development of district- and community-level implementation models, working with those

districts that show commitment to reaching the rural poor through participatory approaches. Given the need to diversify our partners and focus on the local community, USAID/G-CAP anticipates that about 65% of the resources in Results Package Number 1 will be disbursed to NGOs.

It is expected that twenty percent of the resources will be invested in Results Package Number 2, "Participatory Sound Program Management." At the present time, the management and capacity of both the public sector and most local NGOs is weak. Worldwide experience clearly shows that maternal-child health services cannot be delivered in a consistent, sustainable manner if partners do not have the capability to plan, manage, and evaluate their service delivery. USAID will work with both the public and private sector to strengthen critical support systems including financial planning/management, administration (personnel, inventory, etc.), and logistics. The Mission will intensify its ongoing support to the Ministry of Health in the area of decentralization. To date, these efforts have focused on decentralizing management capabilities to the Health Area (Departmental) level; the new strategy will work with districts (municipalities). Hence, USAID/G-CAP will invest approximately 60% of the resources for this Results Package for public sector activities, and the remaining 40% will support NGO partners. Although NGO capacity to manage maternal-child health programs is variable, it is generally poor. USAID will work with these partners to design simplified management, logistics and information systems that will permit them to make timely decisions at all levels of service delivery. The operations research and evaluation activities will guide both Mission and partners' decisions on strategic planning, program design/implementation and resource allocation.

Approximately 10% of USAID/G-CAP's overall budget for the strategic objective will be directed toward activities to strengthen the national policy environment. Based on the current situation, the majority of effort will focus on engendering more support for family planning and reproductive health as valid health interventions. This will be accomplished by supporting grassroots/advocacy activities of NGOs and women's organizations as well as leadership training. This Results Package will also focus on increasing overall national investment in health (currently at less than 1% of GDP) and promoting a stronger role for the private sector. USAID/G-CAP will work closely with the multilateral development banks to promote contracting of NGOs by the public sector to provide services in areas where the MOH capacity is limited.

The remaining 10% of resources will be invested in USAID management activities.

Table Two presents the FY 95 Illustrative budget by results package and type of partner (public sector versus private sector). USAID resources will be completely obligated on an annual basis under a Handbook 3 Agreement with the GOG/MOH. Subagreements with local NGOs, contractors and other organizations will be directly negotiated by USAID/G-CAP on an annual basis based on implementation plans. CY95-96 is considered a transition year between the old system and the full implementation of the new strategic plan. The Mission is phasing out of some of the old models, such as subsidies for urban services over the short term, to increase resources available for the strengthened emphasis on rural services.

TABLE TWO
FAMILY AND COMMUNITY HEALTH
PROGRAM
ILLUSTRATIVE BUDGET 1995-1996
US DOLLARS

COMPONENT	MOH	%	PRIVATE	%	TOTAL	%
Improved Health Practices & Service Delivery	620,000	37%	1,700,000	76%	2,320,000	54%
Sound Program Management	736,892	55%	600,000	45%	1,336,892	31%
Policy Environment conducive to Improved Women's & Children's Health	100,000	31%	225,000	69%	325,000	8%
USAID Management	100,000	34%	195,450	66%	295,450	7%
TOTAL	1,556,892	36%	2,720,450	64%	4,277,342	100%

*USAID/G-CAP will directly obligate an amount of \$550,000 in addition to the amounts included in this table, to support activities directly related to the implementation of the Strategy.

Methods of Financing and Audit Plan

The methods of financing to be used will not deviate from Agency standards. Direct reimbursement will be the norm for all grants and contracts. Federal Reserve Letter of Credit and advances will be used in those cases where a non-profit grantee meets the criteria. No advances are anticipated to for-profit organizations. Bank letters of credit are not anticipated.

Audits will be conducted in accordance with USAID policies. All U.S. organizations will be subject to the Single Audit Act and OMB Circular A-133. Funds will not be included in the agreements for audit. All non-U.S. organizations who receive more than \$100,000 (or whatever threshold is in effect at the time the agreement is signed) in total from all USAID sources will be subject to audit under the Recipient Contract Audit Program. Standard audit clauses will be included in all grants and contracts and funds will be provided, as needed, in all agreements.

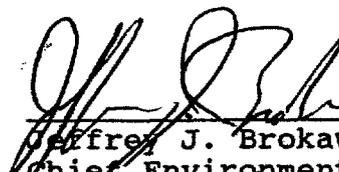


U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

LAC-IEE-95-16

REQUEST FOR A CATEGORICAL EXCLUSION

Project Location : Guatemala
Project Title : Family and Community Health
Project
Project Number : 520-0420
Funding : \$60 million
Life of Project : FY 95-FY 04 (10 years)
IEE Prepared by : Silvia de Cordoba, PDM
Recommended Threshold Decision: Categorical Exclusion
Bureau Threshold Decision : Concur with Recommendation
Comments : None

 Date 4/18/95
Jeffrey J. Brokaw
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

Copy to : William Stacy Rhodes
USAID/G-CAP
Mission Director
Copy to : Wayne Williams, REA/CEN
Copy to : Silvia de Cordoba, PDM
USAID/Guatemala
Copy to : Richard Loudis, LAC/SPM/CAC
Copy to : Ken Ellis, LAC/CEN
Copy to : IEE File

16

**INITIAL ENVIRONMENTAL EXAMINATION
FOR THE DESIGN OF
GUATEMALA FAMILY AND COMMUNITY HEALTH PROGRAM PROJECT
(NO. 520-0420)**

Project location: Guatemala
Project Title: Family and Community Health Project
Project Number: 520-0420
Funding: \$60,000,000
Life of Project: 10 years from FY 1995-2004.

Project Description:

The goal of the project is to assist in the development of Guatemalan programs to improve the health of women and children, especially in rural Mayan communities. Counterparts will work closely with USAID and the Ministry of Health. Current approaches in public health and innovative approaches to health services and policies will be supported. Interactive partnerships in national medical health services will be developed.

End of Project indicators of success will be determined from infant and child mortality rates, neonatal and perinatal mortality rates, maternal mortality ratios, total fertility rate and reduction of chronic malnutrition in small children.

Recommended Environmental Threshold Decision.

Pursuant to 22CFR regulation 216.2 (c), (2), (viii), the project is eligible for a Categorical Exclusion Status and Negative Threshold Decision because the project consists of "...nutrition, health care,...population and family planning services...."

At this time, no physical construction is proposed. However, if during the implementation phase of the project, clinics or other physical construction activities are contemplated, these expenditures will not be approved of without an on-site inspection by the Mission Environmental Officer (MEO), who will be responsible for designing mitigation measures, and if necessary, will submit an amended IEE to LAC Chief Environmental Officer, who will determine the need for an environmental assessment. The MEO shall be responsible for reviewing clinic construction plans, and for inspecting each construction site. The MEO shall develop environmental guidelines, which shall include site-specific mitigation measures, as required, to ensure minimal environmental impacts during and after construction. Environmental guidelines shall be submitted to LAC CEO for approval prior to implementation.

If site-specific mitigation measures are incapable of ensuring minimal environmental impacts, the MEO shall submit an amended IEE to LAC CEO, requesting a positive threshold decision, and an environmental assessment shall be conducted.

Medical wastes from said clinics shall be handled as in the case of the Family Health Services Amendment of Project (520-0357).


William Stacy Rhodes
Mission Director
USAID/G-CAP

Concurred: _____ Date: _____
(LAC/DR/E)

TECHNICAL ANALYSIS

1. Background

Donor assistance to the Guatemalan health sector during the past ten years has focused on improving the technical and management capabilities of the public sector and non-governmental organizations (NGOS) to deliver selected high impact maternal-child health (MCH) and reproductive health interventions. The cornerstones of the USAID/Guatemala program have been improved service delivery (immunization and diarrheal disease initiatives and family planning services) and decentralization of management systems. More recently, USAID began to support interventions to improve pneumonia detection and control in selected geographic areas. The USAID program in Guatemala has been successful in strengthening national programs as measured by coverage rates (immunizations, ORT use and contraceptive prevalence). Nationally, infant mortality and total fertility rates have declined.

In the past several years, USAID and other international organizations have developed, field tested and disseminated case management strategies that use algorithms to diagnose and treat diarrheal diseases and acute respiratory infections (ARI). Likewise, standardized service delivery guidelines have been developed for family planning/reproductive health programs. Progress has also been made in the development of case recognition/management strategies for other childhood illnesses such as pneumonia and malnutrition.

These algorithms and guidelines signify a major technical advance in the field of maternal-child health. However, their implementation in many countries, including Guatemala, has proved problematic. Technical progress in the definition of case management and family planning service delivery exceeds the national capability to implement interventions effectively. Health workers are usually responsible for various interventions. They receive multiple training exercises (ARI, diarrheal disease, family planning, etc.) that are not adequately coordinated or integrated. In addition to the strains that it puts on health workers, vertical programming is usually not appealing to clients.

1.1. Children's Health

In the area of children's health, there is concern that even if multiple disease-specific algorithms were fully developed and implemented, they might not sum to optimal management of the sick child. Recent studies have suggested that a disease-specific case management orientation may not be appropriate where disease syndromes overlap in clinical presentation, diagnostic resources are limited, and many children present with multiple acute and chronic illnesses. In addition, the development of vertical approaches for case management for a growing number of diseases (e.g. diarrhea/cholera, ARI, measles, malnutrition, malaria, etc.) are creating inefficiencies in management, training, and resource utilization for already over-extended health systems and personnel. Conversely, coordination or integration of program support elements (management, training, supervision, logistics, etc.) could produce efficiencies in resource utilization. Similarly, integration of the monitoring and evaluation of children's health services is logical and increasingly essential.

Health worker activities in preventive health care (immunization, health education, breastfeeding promotion, growth monitoring, etc.) also tend to be managed vertically and separately from case management activities. They tend to be given lower priority by health workers given the array of competing priorities and responsibilities. Hence, models for the integrated management of children's health need to be developed and tested. The focus of this effort should be the promotion of "integrated management of the sick child" as well as wellness promotion.

In response to this growing need for integration of programs and services for children, the World Health Organization (WHO) and UNICEF developed an algorithm for case management of sick children at the first level of health facilities. The algorithm promotes appropriate immunization practices as well as recognition and treatment of children with fever, acute diarrhea, dysentery, persistent diarrhea, ARI, malaria, measles, ear problems and nutritional deficiencies. The 1993 World Development Report of the World Bank identified integrated management of childhood illnesses as one of the most cost effective public health actions for developing countries.

1.2 Women's Health

Experience in family planning programs has also shown that demographic goals have been the overriding focus (reducing fertility and population growth). This preoccupation with fertility reduction has adversely affected the design of many programs and the quality of services they provide. International agencies and many service providers have concluded that family planning programs should focus on reducing unwanted childbearing as defined by individuals. The quality and manner of service delivery should be oriented to helping individuals reduce unwanted childbearing safely - by offering the means (services and information) to do so. Family planning programs should be evaluated on the basis of their achievement in responding to the reproductive intentions of individuals and related health issues, rather than on their "net" contribution to fertility reduction. In other words, to increase effectiveness, programs need to be responsive to individuals' desires and preferences.

Increasingly, public health programs are seeking effective strategies to reduce maternal and neonatal mortality. Initial efforts focused on training programs to improve the knowledge of traditional birth attendants (TBAs) who in many cultures are women's first line (and often only) line of care during pregnancy and childbirth. In Guatemala and other countries, these training programs have not had anticipated results. Recent experience in safe motherhood programs has shown that a strengthened ability to detect obstetric complications at the community level and refer them to appropriate higher levels of care must be the cornerstone of program design and implementation. Effective linkages between community level service providers such as traditional birth attendants (TBAs) and clinical/hospital personnel is the most critical element to reducing maternal and neonatal mortality.

1.3. Cross-cutting Issues

Three other dimensions of both women's and children's health programs must be addressed to produce sustained improvements in health status. The first is the strengthening of support systems for health services delivery. MCH programs are plagued by inadequacies and

inefficiencies in management, supervision, training and logistic support.

The second priority results from a growing understanding that behavior of both clients (mothers/women of reproductive age) and providers is critically important for effective programs. In all cultures, an individual's actions related to preventive and curative health are influenced by their individual perceptions as well as community norms - including family and peer related factors - available resources and other circumstances. A behavioral orientation to program/strategy development can help to identify those interventions that are required to facilitate the adoption by clients and providers of desired behaviors.

The third dimension of women's and children's programs is the wider socio-cultural context. It is recognized that program activities exist in a larger policy and program environment that must support and promote the delivery of effective services. Governments should take on stronger roles in structuring health care priorities, formulating equitable and appropriate policies to support these priorities, and the expression of these priorities through effective incentives, regulations/norms, and legislation. Community-based advocacy efforts are another important vehicle for incorporating women's needs and interests into program planning.

2. Conceptual Framework

2.1. Overview

A mutually agreed upon framework that describes the essential MCH program elements can enhance the process of integrating and improving services. Such a framework can guide the development of research questions and assessment tools, interventions, and evaluation strategies. It can also serve as a matrix for collaborative program development.

This document describes a framework that has been developed to support integrated development of reproductive and child health programs - based on a strong client orientation. The framework was originally developed by USAID and the Centers for Disease Control in collaboration with UNICEF and the World Health Organization (WHO), to support integrated management of child illness. USAID/G-CAP has incorporated wellness promotion into this algorithm and developed two additional pathways: integrated management of reproductive health needs, and integrated management of pregnant women and newborns. The emphasis of the three frameworks is on strengthening preventive and clinical care in the home and outside the home in the health system. The health system is comprised on both community services and facility-based services. These efforts should be supported with behavioral, clinical and operations research.

Each framework defines the key action steps related to women's and children's health as subdivided by the three key target populations: the child under five years, the pregnant women and newborn, and women of reproductive age. The frameworks promote a client focus through the identification of the requirements of quality of preventive/curative care both in the home and in the health system. As conceptualized in the framework, the health system is accessed in four ways: informal community services, formal community services, public sector facilities, and private sector facilities.

The framework allows for the identification of the key determinants of the action steps and the kinds of interventions that may serve to influence those actions. These determinants and their corresponding interventions are both behavioral and programmatic. For example, determinants of quality of care in the home or in the facility include, among others, knowledge, motivation, skills, and the availability of essential drugs/supplies.

Home-Based Care: In each framework, those parts of the pathway that lie above the dotted line describe the critical actions for health and survival in the home. In the case of the sick child, these include recognizing the need for treatment, providing appropriate treatment in the home, seeking additional appropriate care, providing continued care after receiving outside assistance, and recognizing the need for further care-seeking if the child's condition worsens. For example, the recognition of diarrheal disease may be relatively simple and appropriate case management frequently may be provided in the home; in contrast, recognition of acute lower respiratory infection may be more difficult and appropriate management may require seeking care outside of the home and subsequently providing ongoing care in the home.

Interface Between the Home and Other Services: Two critical steps relate home-based care to outside-the-home care: seeking outside care and providing continued care after the outside-the-home consultations. The behaviors will vary according to the situation or disease. In all cases, however, the public health actions available to influence these behaviors include defining indications for seeking outside care, providing effective information, education and communications (IEC), assuring availability of drugs and supplies for continued treatment, and improving the relationship between health services and families/communities.

Management Outside the Home: Increasing access to services outside the home should be an explicit objective of reproductive and/or child health programs. For severely ill children or pregnant women, such care can be a critical determinant of survival. Health service outside-the-home are many and varied, and this framework recognizes this diversity by indicating broad divisions of both community and health facility services. In the community, there may be an informal sector (traditional healers, TBAs, etc) providing traditional or hybridized services and a formal sector (physicians, nurses, pharmacists, promoters, drug sellers) providing "western-based" services. Similarly, diversity may exist in health facilities - such as public and private facilities. Research on health-seeking behavior has shown that mothers/women often use multiple services to resolve a single illness problem (a child's diarrhea) or achieve a desired outcome (health pregnancy and delivery). While acknowledging this diversity, the framework promotes standardized definitions or algorithms for "quality of care" based on technical content and a given socio-cultural setting.

Quality of Care in the Community: If a child or a woman of reproductive age (WRA) is attended in the community, the provider must provide quality services with the participation of the caretaker or woman. The combination of care by the community health worker and the caretaker/WRA will often lead to improved health. In instances where improvement does not occur, referral from community health workers to facilities may be required. The definition of quality of care will vary by type of provider, however, the relevant public health actions include training, supervision, incentives, community participation, logistics and commodity support, IEC, and monitoring and evaluation.

Quality of Care in the Health Facility: A facility-based health provider must provide quality care, including effectively advising the caretaker (mother or WRA). The combination of facility based care and subsequent home care lead to improved health and survival. The health worker may recommend follow-up actions to be taken at home (such as medication, feeding/nutrition, contraception, etc.). The health worker must have the skills to effectively communicate indications for follow-up home care, including what should be done if complications occur or if the disease episode worsens. In the case of severe illness or need for services available at a higher level of service delivery (such as surgical contraception), the provider may make a referral. In this case, the caretaker or WRA must have access (physical, cultural, economic, etc.) to that facility and must act on the referral. Referral facility personnel must be trained, motivated, and able to provide quality care.

Social-Cultural-Political-Economic Environment: Health systems do not function in isolation from wider structural and contextual considerations. For example, people's ability to pay to health services geographic accessibility of clinics and hospitals have direct bearing upon health seeking behavior independent of the quality of services offered at individual clinics. Likewise the quality and appropriateness of national norms set the stage for health services organization, training programs and actually service delivery. For example, restrictive norms can limit the effectiveness of family planning programs.

These frameworks acknowledge that most of key actions take place outside the health facilities. Caretaker recognition of illness or reproductive health needs and provision of care are critical components of the pathway to health and survival. In addition, the framework recognizes that the pathways involving facility services may be more heavily utilized by children with severe illness or women with pregnancy/childbirth complications. For these cases, quality care, follow-up, and referral by health workers are also critical. Consequently, the pathways must be examined in their entirety, with the intention of addressing the most critical constraints to improved maternal-child health and survival. The frameworks can be used to facilitate the formulation of more effective national public health/disease control policies and programs.

2.2. Pathway for Integrated Management of the Child

This pathway presents the key decision/action steps that influence the outcomes of preventive care for well children and curative care for sick children. The pathway moves away from the classic division between vertical programs for health promotion and child survival toward the "integrated management of the child". This focus on the child within his/her family and community setting points to the need for good IEC programs that can promote appropriate home-based care. The pathway also provides the basis for integrating services, training programs and support systems (supervision, logistics, etc.).

2.3. Pathway for Integrated Management of Women of Reproductive Age

This pathway illustrates the key decision/action steps related to women's reproductive health. It provides a foundation for developing integrated programs that focus on women's individual needs, rather than promotion of family planning programs to reduce fertility. The pathway shows the importance of health education. This step is placed on the dotted line because women

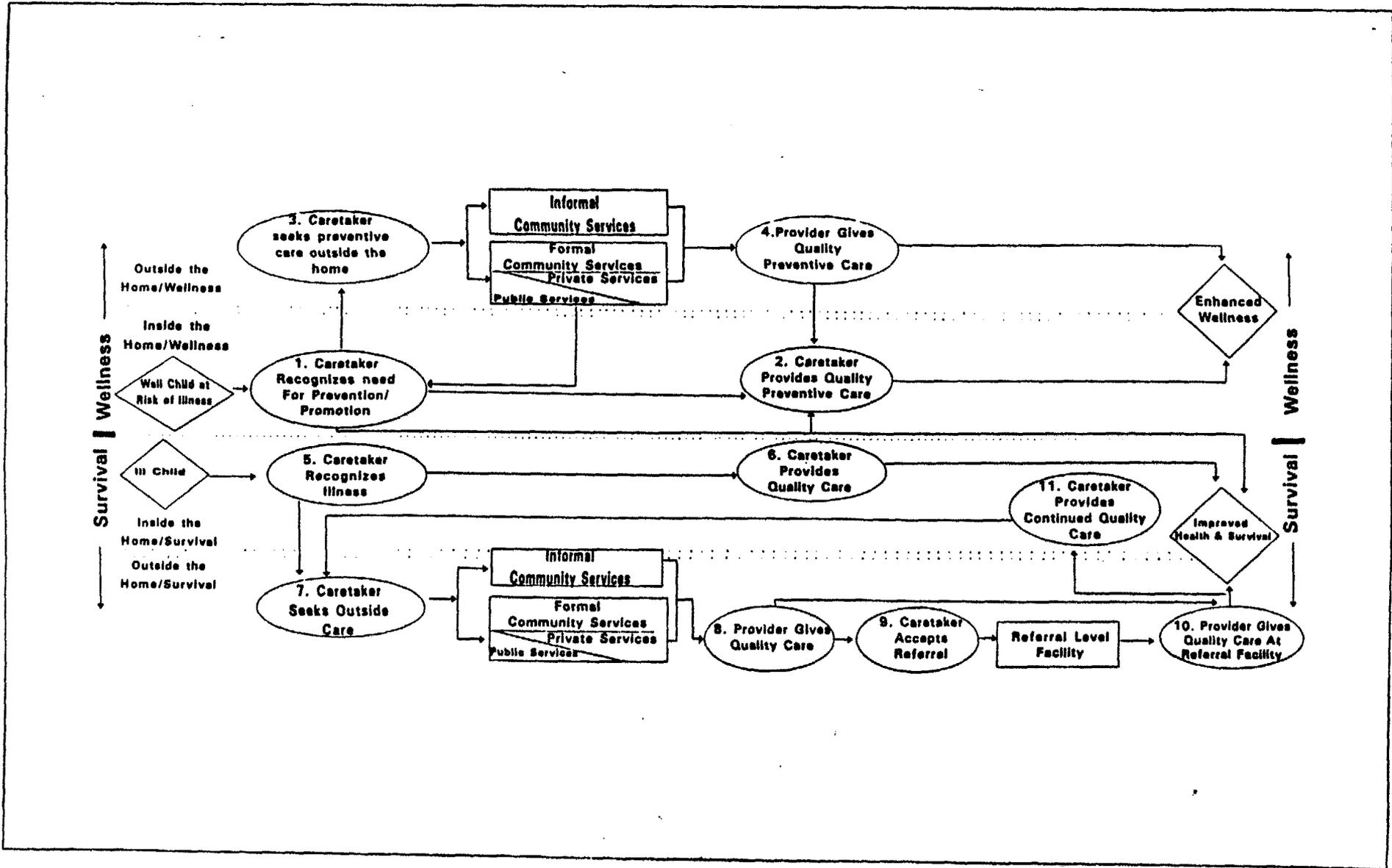
are socialized by their families, peers, and communities in addition to any formal health education that they may receive. The pathway also shows that improved service quality rests on the ability of programs to work at all levels of care, with both nonformal and formal services (including good counseling programs), and to strengthen referral systems. IEC programs are critically important, given the strong role that home-based care plays for women of reproductive age. IEC can lead to improved household practices related to reproductive health and stimulate demand for outside services when necessary.

2.4 Pathway for Integrated Management of Pregnant/Post-Partum Women and Newborns

This pathway shows the key decision/action steps related to maternal and neonatal health. It demonstrates that women may or may not seek care outside the home (prenatal visits, deliveries, post-partum/newborn care). In rural Guatemala, for example, most maternity care is provided in the home or by TBAs (nonformal community-level providers). One of the most important aspects of this pathway is the importance of the referral and counter-referral systems. TBA training programs have very limited effectiveness without a functioning referral system that links community (TBA) services to clinical services. This pathway includes care of the newborn because of the clear relationship between pregnancy and delivery and fetal outcomes/neonatal health status. It is logical to integrate the management of postpartum women and newborns to the extent possible.

INTEGRATED MANAGEMENT OF THE CHILD

SOCIAL-CULTURAL-POLITICAL-ECONOMIC ENVIRONMENT



Integrated Management of the Child (IMC)

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
1. Caretaker knows preventive care	Knowledge and beliefs (caretaker and community)	Effective 2 way communication (based on experiences of caretaker)	Accounting for knowledge/beliefs of caretaker/community and providers in the selection of interventions
2. Caretaker provides quality care in the home	Define concept of health, child and quality care	Development/dissemination of a practical definition of healthy child	Define methodology (How to do it? What to include in the definition? How to limit the definition to what is practical)
	Knowledge of what to do and previous experience	Effective 2 way communication	Analyze successful examples and failures to define communication strategy and content
	Has the possibility of providing care (resources, family support, availability of supplies, drugs, etc.)	Identification of the intervention levels	Identify differences between generations, subcultures, gender, etc.
	Decides to provide quality care (vs. no care or other care)	Base communication program on decision-making process in the home	
3. Caretaker seeks services/care outside the home: immunizations -well baby/child care -food aid -education (breastfeeding, nutrition, etc. -family planning -pre and post-natal care	Knowledge a. recognizes need b. of where to get help c. of what is appropriate care d. previous experience with providers	Effective 2 way communication a. Content b. Strategy c. Capability of services	Communication/education program carried out by credible educators

Integrated Management of the Child (IMC)

CRITICAL POINT		DETERMINANT	INTERVENTIONS	ISSUES
		Access/possibility of doing it: -geographic -economic -family support -socio-cultural and political -medical and other barriers	Redefine service delivery based on client needs and expectations -organization -increased availability -alternative channels	Client perceptions are important in defining quality of care
		Decision to seek care (vs. not seeking care)	Develop/implement interventions	Need to analyze decision-making process (satisfaction, past experiences, perceived quality, cost, social-cultural factors, etc.)
4.	Provider gives quality care	Knowledge and skills	<ul style="list-style-type: none"> - Training that responds to local needs - Redefine/update content and methodology 	Analyze decision-making process (satisfaction, perceived quality, cost, etc.)
		Services and providers have characteristics (eg. language) that respond to needs/expectations of clients	<ul style="list-style-type: none"> - Training that responds to local needs - Selection and assignment of personnel - Modify services as needed -hours -delegation of responsibilities 	<ul style="list-style-type: none"> - Respect for socio-cultural values, beliefs - Political will

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Integrated Management of the Child (IMC)

	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
		Motivation a. current practices b. client/community expectations c. provider expectations d. incentives e. supervision/support f. monitoring	a. Identification of current behaviors and their determinants b. Effective communication and community participation c. Development of norms/standards for well child care d. Monitoring/giving rewards for appropriate practices e. Equipment and materials needed for work/activities, supervision;effective administration/management; functioning referral system; demand creation f. Supervisory and regulatory systems; community participation	<ul style="list-style-type: none"> - Ability to modify norms, standards to align them with well child programs
		Supplies	Identify/test reliable procedures for requesting and supplying delivering supplies a. Public sector b. Local cost recovery c. Private channels	<ul style="list-style-type: none"> - Continuous availability of appropriate educational material, drugs, supplies at the facility - Drug/supply needs of providers and facilities and promoters are defined - Define/implement logistics system - Link supply system for well child care to national supply system - Involve private providers
5.	Caretaker recognizes illness	Knowledge (of caretaker and family/community members)	Effective communication a. Content b. Strategy c. Skills	Identification/selection of the specific illness signs to be treated

Integrated Management of the Child (IMC)

CRITICAL POINT		DETERMINANT	INTERVENTIONS	ISSUES
6.	Caretaker provides quality care in the home	Definition of appropriate care	Technical definition of appropriate home-based treatment for the principle childhood illness and the resources required to treat them	Develop recommendations for home-based care
		Knowledge	Effective communication a. Content b. Strategy c. Skills	Develop IEC content based on IMC
		Has the possibility of providing care (resources, family support, supplies, drugs, etc.)	Evaluate current availability of resources and identify options to increase availability	Ability to pay and availability of financial resource (of the family)
		Decision to provide appropriate care (vs. no care or some other care) including seeking care outside the home	a. Effective communication b. Promotion c. Reduce barriers	
		Community organization and participation	a. Sensitize about importance of child health b. Participation in community events c. Incentives, motivation, etc.	
7.	Caretaker seeks care outside the home	Knowledge a. Recognizes need for additional care b. Where to seek help c. What is appropriate care	Effective communication a. Content b. Strategy c. Skills	Identification/packaging of key signs regarding when outside care should be sought
		Availability and access	Identify options to increase access to appropriate care a. Organize services to facilitate access (hours, patient flow, etc.) b. Expand current services c. Provide appropriate care through alternative channels (community, private sector, etc.)	IMC as a basis for extending access (a basic service package)

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Integrated Management of the Child (IMC)

	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
		Decision to seek appropriate care (vs. no care or some other care)	a. Analysis of decision-making determinants related to care-seeking (cost, quality, previous experience, socio-cultural factors)	Viability of interventions to convert "inappropriate" care to "appropriate" care by implementing IMC through private sector, NGOs, promoters, etc.
8.	Provider gives quality services	Knowledge/skills	Practical/effective training for IMC for various types of providers	<ol style="list-style-type: none"> 1. Identify content for IMC for promoter/provider training (including reasons for referrals) 2. Develop integrated training and clinical practicums for various types of providers 3. Define process of evaluating current knowledge/skills and base IMC on results of these evaluations
		Motivation <ol style="list-style-type: none"> a. Current practices b. Client/community expectations c. Health system expectations (norms, service delivery guidelines) d. Incentives e. Support systems f. Surveillance 	<ol style="list-style-type: none"> a. Identify current practices and their determinants b. Effective communication and community participation c. Development of norms/standardized service delivery guidelines based on IMC d. Monitoring/giving rewards for appropriate practices (cost recovery, subsidies, loans, etc.) e. Materials and equipment needed to perform duties and for supervision; effective administrative systems; referral systems function f. Supervision; community participation 	<ul style="list-style-type: none"> - Norms/standards can be developed/changed for IMC - Inter-sectoral coordination

Integrated Management of the Child (IMC)

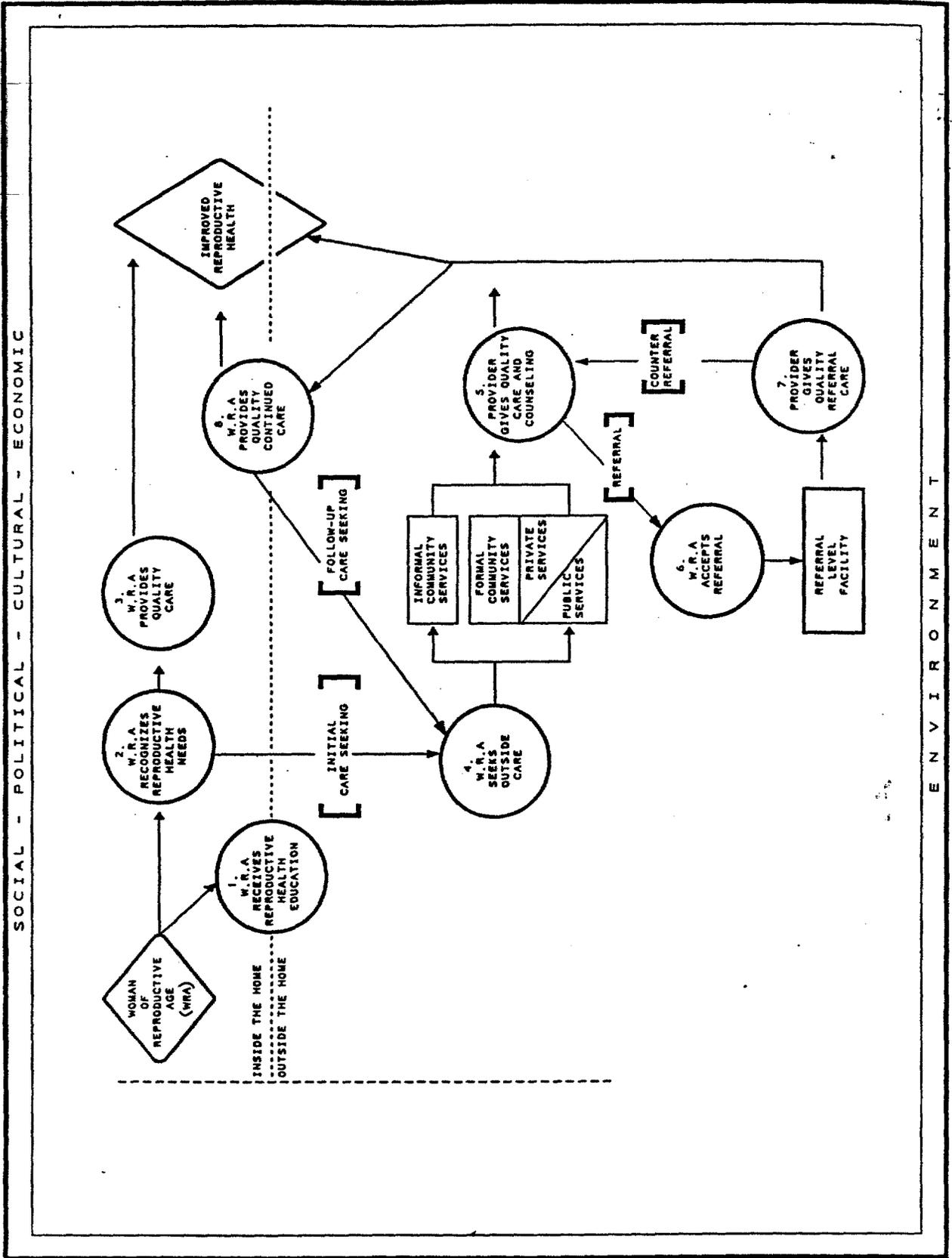
CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
	<p>Previous experience (caretaker and family/community members) with health services (perceived quality)</p> <p>Identify and improve aspects of referral services that affect perceived quality (interpersonal relations, access, availability drugs, hours, etc.)</p> <p>Client focus at referral facilities</p>	<p>Define IMC technical content and required resources for referral level</p> <p>Practical/effective training</p>	<p>Development of integrated and practical training procedures for referral level personnel</p> <p>Define procedures to evaluate current knowledge/skills of promoters previously trained and adapt IMC training to results of the evaluation</p>
10	<p>Provider provides quality care at referral site</p>	<p>Technical content</p>	<p>Adapt/integrate existing referral guidelines (CDD, ARI, etc.) for IMC</p>
	<p>Knowledge/availability</p>		<p>Ability to achieve agreement/standardization between IMC and pediatric practice in Guatemala</p>
	<p>a. Current practices b. Client/community expectations c. Health system expectations (norms, service delivery guidelines) d. Incentives e. Support systems f. Surveillance</p>	<p>a. Identify current practices and their determinants b. Effective communication and community participation c. Development of norms/standardized service delivery guidelines based on IMC d. Monitoring/rewards for appropriate practices (cost recovery, subsidies, loans, etc.) e. Materials and equipment needed to perform duties and for supervision; effective administrative systems; referral systems function f. Supervision; community participation</p>	

Integrated Management of the Child (IMC)

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
	Supplies	Identify/test reliable procedures for requesting and delivering supplies a. Public sector b. Local cost recovery c. Private channels	<ul style="list-style-type: none"> - Continuous availability of appropriate educational material, drugs, supplies - Drug/supply needs are defined - Define/implement logistics system - Link IMC supply system to national supply system - Involve private providers
	In case of referral - Knowledge - Motivation - Availability of supplies	a. Norms/standards b. Communication	Coordination
Caretaker provides continuing quality care	Definition of appropriate care	Technical definition of appropriate home-based care for the prevention and care of principle childhood illnesses and the availability of the resources required to treat them	Develop recommendations for home-based prevention and care
	Knowledge	Effective communication a. Content b. Strategy c. Skills	<ul style="list-style-type: none"> - Develop IEC content based on IMC - Analyse past successes and failures and incorporate lessons learned
	Has possibility of providing care (resources, family support, availability of supplies, drugs, etc.)		
	Decision to provide appropriate care (vs. no care or some other care)	a. Effective communication b. Promotion c. Reduce barriers	
	Health workers' counseling skills	Develop and strengthen effective communication and counseling skills in health workers based on definition of IMC	Identify key danger signs that caretaker should watch for

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INTEGRATED MANAGEMENT OF WOMEN OF REPRODUCTIVE AGE



Integrated Management of Women of Reproductive Age (WRA)

	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
1.	WRA receives reproductive health education (inside and/or outside the home)	Individual/community level knowledge and beliefs are congruent with those of formal health sector	Incorporate information on knowledge and beliefs into design of education programs Two way communication based on daily experiences of client: <ul style="list-style-type: none"> - content - strategy - family capacity 	Credibility/validity of information sources Who? With what degree of credibility/effectiveness? What media?
		Possibilities of obtaining education: <ul style="list-style-type: none"> - resources - geographic access - family situation - socio-cultural-linguistic-political environment - gender - privacy - availability 	<ul style="list-style-type: none"> - Identify levels of intervention - Based on client needs/expectations, reform services (formal/informal) <ul style="list-style-type: none"> - organization - expansion - use of alternative channels 	<ul style="list-style-type: none"> - Differences between generations and individuals <ul style="list-style-type: none"> - modify curricula - modify messages - participatory methodology
		Knowledge/skills of provider	Training that responds to local needs	Modify/revise content and methodology
		Services and providers/educators have characteristics appropriate to needs of client	<ul style="list-style-type: none"> - Selection and assignment of appropriate personnel - Modification of service delivery 	Respect for different/local socio-cultural values
2.	WRA recognizes reproductive health needs	Knowledge, beliefs, attitudes of clients/community	Effective 2 way communication based on daily experiences of clients	Need to take into account the knowledge/beliefs of clients, community and providers in design and implementation of program interventions

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Integrated Management of Women of Reproductive Age (WRA)

CRITICAL POINT		DETERMINANT	INTERVENTIONS	ISSUES
		Pre-socialization of adolescents	Formal and nonformal education	Understand knowledge/beliefs of family, community and adolescents in identification/design of interventions
3.	WRA provides quality care in the home	Concepts of reproductive health and quality of care in the home have been defined	Effective dissemination of the realistic and practical definition of reproductive health	Define methodologies How? What to include in the definition? How to limit (practicality, etc.)
		Knowledge of what to do and past experiences	Effective 2 way communication	Know successful examples and failures to define content and strategy
		Possibility of doing it (resources, family situation, socio-cultural-linguistic-political environment, availability of supplies)	Identify levels of interventions	Differences between generations and individuals
		Decision to act (provide appropriate care vs. no care or other care)	Base communication on process of decision-making at home - effective communication - promotion - reduce barriers	- Partners relationship - Gender
4.	WRA seeks care outside the home - family planning - STDs - pap smear - infertility - sex education - reproductive system pathology - identify reproductive risk	Knowledge/attitudes a. recognize need b. knows where to seek services c. knows what is appropriate d. providers' knowledge and attitudes e. clients' past experiences	Effective 2 way communication - content - strategy - capacity of family/services	Communication/education: - delivered by whom? - What is their credibility?

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Integrated Management of Women of Reproductive Age (WRA)

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
			Analysis of attitudes about reproductive health - women of reproductive age - men of reproductive age - adolescents - community - providers
	Access/possibility of doing it: - geographic - economic - family - religion - medical/other barriers	Modify service delivery based on client expectations - organization - expansion - using alternative channels	Ensuring that services meet clients' ideas/expectations regarding quality of care
	Decision to seek care (vs not seeking care)	Develop interventions	Understand decision-making processes (satisfaction - past experience, perceived quality, costs cultural-religious-political aspects)
5. Provider gives quality care and counseling	Knowledge, attitudes and abilities	Training responds to local needs	Modify/revise content and methodology
	Service and provider attributes meet client needs and expectations	Modify service delivery and selection/assignment of personnel based on client needs	Respect for local values Political will/ability to modify services

Integrated Management of Women of Reproductive Age (WRA)

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
	Motivation a. current practices b. client/community expectations c. provider expectations d. incentives e. supervision/support f. monitoring	a. Identification of current behaviors and their determinants b. Effective communication and community participation c. Development of norms/standards for well child care d. Monitoring/giving rewards for appropriate practices e. Equipment and materials needed for work/activities, supervision; effective administration; functioning referral system; demand creation f. Supervisory and regulatory systems; community participation	Integrated management of reproductive health is not too complicated for providers Variations in existing definitions, norms, etc. for different aspects of reproductive health Norms might have to modified/changed to be consistent with integrated reproductive health Greater need for coordination of different central level and local level departments, etc. for integrated local service delivery
	Supplies	Identify/test reliable procedures to request/receive supplies a. Cost recovery b. Integrated logistics and supervision c. Private channels	Educational materials on reproductive health are available when/where needed
	For referrals when needed: - Knowledge, skills, attitudes, experience - Access - Motivation - Service availability	a. Training b. Norms c. Communications d. Modify service delivery	- Coordination among levels - Redefining roles as needed

3

Integrated Management of Women of Reproductive Age (WRA)

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
6. WRA accepts the referral	Access/possibility of doing it: -geographic -economic -family -socio-cultural-linguistical-political -religion -medical/other barriers	Based on client needs/expectations, modify services - organization - expansion - alternative channels Identify technically appropriate treatment/care that can be provided without referring to higher level	Modify services to meet client needs/expectations Possibility of refining roles and relationships between levels Revise /modify norms/policies as needs Political will to strengthen the local level's ability to solve/manage problems
	Cost - time - resources	Recommend and provide referral care based on clients' needs/possibilities	
	Previous experiences (of the client, family, community and impressions of referral facility (perceived quality))	Identify/improve those aspects of referral facilities that influence perceived quality (interpersonal relations, drugs, supplies, etc.)	
	Perceived need (condition merits a referral)	Effective 2 way communication a. In general <u>and</u> within the community (an understanding of care/treatment that is required) b. Given by provider at time of contact; perceived need (condition warranted a referral)	Define content, strategy and methodologies related to referrals (when, where, etc.)
	Knowledge, attitudes and abilities/skills	Training that responds to local needs	Revision and updating of content and methodology

Integrated Management of Women of Reproductive Age (WRA)

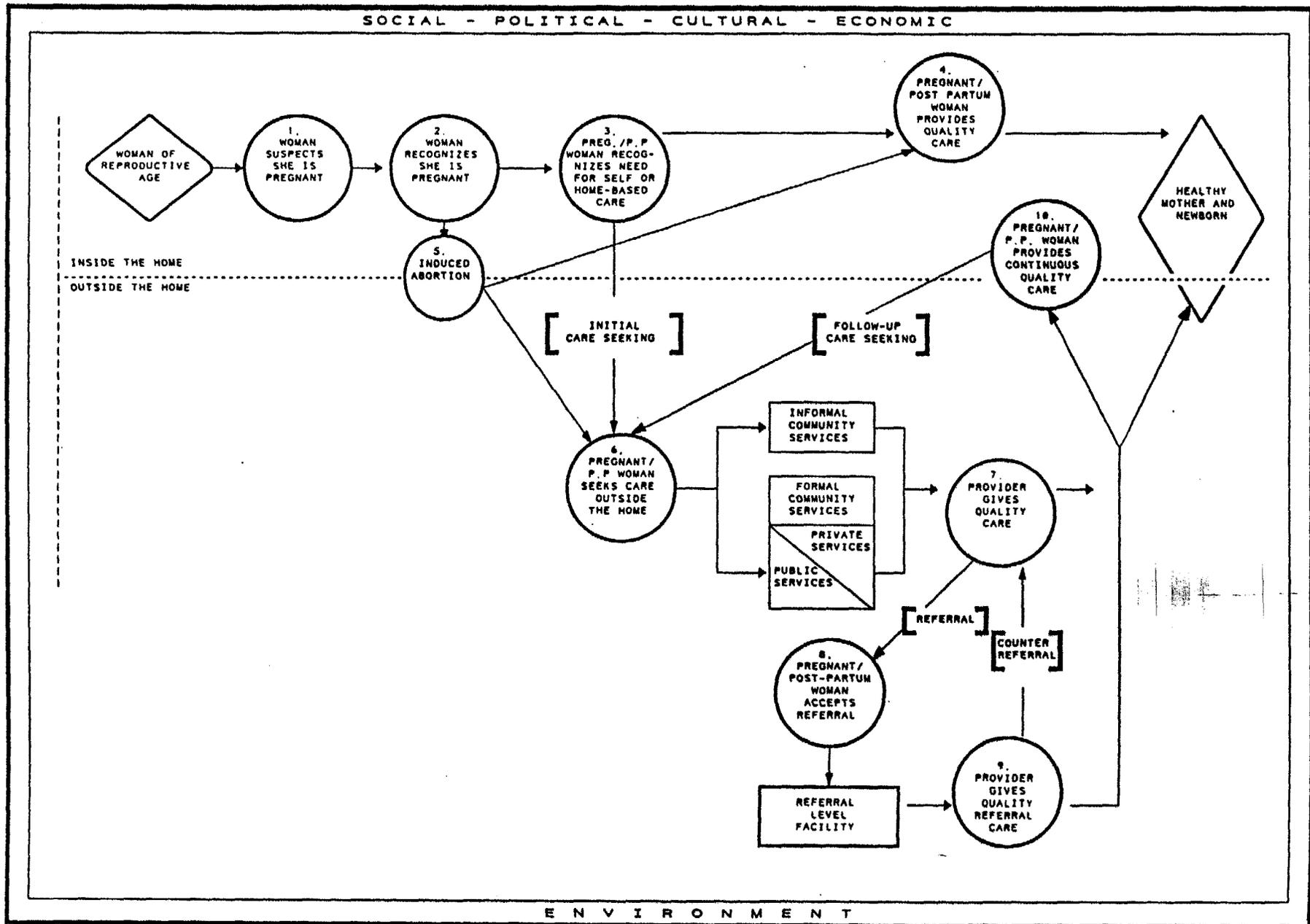
	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
		Services and providers have attributes that meet client needs/expectations	Modify service delivery and the selection/assignment of personnel based on clients needs	<ul style="list-style-type: none"> - Respect for local values - Political will/ability to modify services
7.	Provider gives high quality referral care and counseling	Motivation <ul style="list-style-type: none"> a. current practices b. client/community expectations c. provider expectations d. incentives e. supervision/support f. monitoring 	<ul style="list-style-type: none"> a. Identification of current behaviors and their determinants b. Effective communication and community participation c. Development of norms/standards for well child care d. Monitoring/giving rewards for appropriate practices e. Equipment and materials needed for work/activities, supervision; effective administration; functioning referral system; demand creation f. Supervisory and regulatory systems; community participating 	Integrated management of reproductive health is not too complicated for providers Variations in existing definitions, norms, etc. for different aspects of reproductive health Norms might have to modified/changed to be consistent with integrated reproductive health Greater need for coordination of different central level and local level departments, etc. for integrated local service delivery
		Supplies	Identify/test reliable procedures to request/receive supplies <ul style="list-style-type: none"> a. Cost recovery b. Integrated logistics and supervision c. Private channels 	Educational materials on reproductive health are available when/where needed
8.	WRA providers continuing quality care in the home	Knowledge and skills	Effective 2 way communication	When, where, how

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Integrated Management of Women of Reproductive Age (WRA)

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
	Previous counseling (regarding secondary effects, signals of complications, when to reconsult, etc.)	Adequate provider training	Understanding successful and failed experiences
	Degree of satisfaction with provider, facility and outcome	Modify service delivery based client expectations/needs	
	Possibility of doing of doing it -resources -religion -family situation -socio-cultural-linguistic environment	Identify levels of interventions	Availability of resources at home
	Decision to do it (vs. not doing it)	Base communication on decision-making process in the home	- Relationship of the couple - Satisfaction, past experiences

INTEGRATED MANAGEMENT OF THE PREGNANT/POST-PARTUM WOMAN AND NEWBORN



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Integrated Management of the Pregnant/Post-Partum Woman and Newborn

CRITICAL POINT		DETERMINANT	INTERVENTIONS	ISSUES
1.	Woman suspects she is pregnant	Knowledge and beliefs of the woman, family, community	Effective 2 way communication - signs - what she should/should not do	Understanding different beliefs and taking them into account
		Desired/planned pregnancy	Sexual education	Communication between the partners
2.	Woman recognizes she is pregnant	Knowledge and beliefs previous experience (of the woman, partner, etc.)	Effective 2 way communication	Understanding different beliefs
		Desired/planned pregnancy	Sexual education	Communication between the partners
3.	Pregnant/post-partum woman recognizes need for self-care (or home-based care) related to pregnancy and/or post-partum and/or newborn	Knowledge and beliefs of woman, family and previous experiences	Effective 2 way communication	Ability to identify required care for each phase (pregnancy, post-partum, newborn)
4.	Pregnant/port-partum woman provides quality care in the home	Concepts of quality care have been defined	Effective dissemination of the realistic and practical definition of reproductive health	Define methodologies How? What to include in the definition? How to limit (practicality, etc.)
		Knowledge of what to do and past experiences	Effective 2 way communication	Know successful examples and failures to define content and strategy
		Possibility of doing it (resources, family situation, socio-cultural-linguistic-political environment, availability of supplies)	Identify levels of interventions	Differences between generations and individuals

2

Integrated Management of the Pregnant/Post-Partum Woman and Newborn

	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
		Decision to act (provide appropriate care vs. no care or other care)	Base communication on process of decision-making at home - effective communication - promotion - reduce barriers	- Partners relationship - Gender
5.	Induced abortion inside/outside the home	Unwanted pregnancy	Provide post-abortion family planning services - improve access - organization - alternative channels - health worker training	- Sensitize health workers - Political will and opening to expand services, including community participation
		Possibility of that it happens	- Post-abortion education - Training health workers - Quality management of complication	- Revise/update norms - Adequate training materials (socio-culturally and linguistically appropriate)
6.	Pregnant/post-partum woman seeks care outside the home	Knowledge/attitudes a. recognize need b. knows where to seek services c. knows what is appropriate d. providers' knowledge and attitudes e. clients' past experiences	Effective 2 way communication - content - strategy - capacity of family/services	Communication/education: - delivered by whom? - What is their credibility?

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Integrated Management of the Pregnant/Post-Partum Woman and Newborn

CRITICAL POINT		DETERMINANT	INTERVENTIONS	ISSUES
				Analysis of attitudes about reproductive health - women of reproductive age - men of reproductive age - adolescents - community - providers
		Access/possibility of doing it: - geographic - economic - family - religion - medical/other barriers	Modify service delivery based on client expectations - organization - expansion - using alternative channels	Ensuring that services meet clients' ideas/expectations regarding quality of care
		Decision to seek care (vs not seeking care)	Develop interventions	Understand decision-making processes (satisfaction - past experience, perceived quality, costs cultural-religious-political aspects)
7.	Provider gives quality care	Knowledge, attitudes and abilities	Training responds to local needs	Modify/revise content and methodology
		Service and provider attributes meet client needs and expectations	Modify service delivery and selection/assignment of personnel based on client needs	Respect for local values Political will/ability to modify services

Integrated Management of the Pregnant/Post-Partum Woman and Newborn

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
	<p>Motivation</p> <ul style="list-style-type: none"> a. current practices b. client/community expectations c. provider expectations d. incentives e. supervision/support f. monitoring 	<ul style="list-style-type: none"> a. Identification of current behaviors and their determinants b. Effective communication and community participation c. Development of norms/standards for well child care d. Monitoring/giving rewards for appropriate practices e. Equipment and materials needed for work/activities, supervision; effective administration; functioning referral system; demand creation f. Supervisory and regulatory systems; community participation 	<p>Integrated management of reproductive health is not too complicated for providers</p> <p>Variations in existing definitions, norms, etc. for different aspects of reproductive health</p> <p>Norms might have to modified/changed to be consistent with integrated reproductive health</p> <p>Greater need for coordination of different central level and local level departments, etc. for integrated local service delivery</p>
	<p>Supplies</p>	<p>Identify/test reliable procedures to request/receive supplies</p> <ul style="list-style-type: none"> a. Cost recovery b. Integrated logistics and supervision c. Private channels 	<p>Educational materials on reproductive health are available when/where needed</p>

Integrated Management of the Pregnant/Post-Partum Woman and Newborn

	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
		For referrals when needed: - Knowledge, skills, attitudes, experience - Access - Motivation - Service availability	a. Training b. Norms c. Communications d. Modify service delivery	- Coordination among levels - Redefining roles as needed
8.	Pregnant/post-partum woman accepts the referral	Access/possibility of doing it: -geographic -economic -family -socio-cultural-linguistical-political -religion -medical/other barriers	Based on client needs/expectations, modify services - organization - expansion - alternative channels Identify technically appropriate treatment/care that can be provided without referring to higher level	Modify services to meet client needs/expectations Possibility of refining roles and relationships between levels Revise /modify norms/policies as needs Political will to strengthen the local level's ability to solve/manage problems
		Cost - time - resources	Recommend and provide referral care based on clients' needs/possibilities	
		Previous experiences (of the client, family, community and impressions of referral facility (perceived quality)	Identify/improve those aspects of referral facilities that influence perceived quality (interpersonal relations, drugs, supplies, etc.)	

Integrated Management of the Pregnant/Post-Partum Woman and Newborn

	CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
		Perceived need (condition merits a referral)	Effective 2 way communication a. In general <u>and</u> within the community (an understanding of care/treatment that is required) b. Given by provider at time of contact; perceived need (condition warranted a referral)	Define content, strategy and methodologies related to referrals (when, where, etc.)
		Knowledge, attitudes and abilities/skills	Training that responds to local needs	Revision and updating of content and methodology
		Services and providers have attributes that meet client needs/expectations	Modify service delivery and the selection/assignment of personnel based on clients needs	<ul style="list-style-type: none"> - Respect for local values - Political will/ability to modify services

Integrated Management of the Pregnant/Post-Partum Woman and Newborn

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
9. Provider gives high quality referral care and counseling	Motivation a. current practices b. client/community expectations c. provider expectations d. incentives e. supervision/support f. monitoring	a. Identification of current behaviors and their determinants b. Effective communication and community participation c. Development of norms/standards for well child care d. Monitoring/giving rewards for appropriate practices e. Equipment and materials needed for work/activities, supervision; effective administration; functioning referral system; demand creation f. Supervisory and regulatory systems; community participating	Integrated management of reproductive health is not too complicated for providers Variations in existing definitions, norms, etc. for different aspects of reproductive health Norms might have to modified/changed to be consistent with integrated reproductive health Greater need for coordination of different central level and local level departments, etc. for integrated local service delivery
	Supplies	Identify/test reliable procedures to request/receive supplies a. Cost recovery b. Integrated logistics and supervision c. Private channels	Educational materials on reproductive health are available when/where needed
10	Pregnant/post-partum woman provides continuing quality care in the home	Knowledge and skills	Effective 2 way communication When, where, how

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Integrated Management of the Pregnant/Post-Partum Woman and Newborn

CRITICAL POINT	DETERMINANT	INTERVENTIONS	ISSUES
	Previous counseling (regarding secondary effects, signals of complications, when to reconsult, etc.)	Adequate provider training	Understanding successful and failed experiences
	Degree of satisfaction with provider, facility and outcome	Modify service delivery based client expectations/needs	
	Possibility of doing of doing it -resources -religion -family situation -socio-cultural-linguistic environment	Identify levels of interventions	Availability of resources at home
	Decision to do it (vs. not doing it)	Base communication on decision-making process in the home	<ul style="list-style-type: none"> - Relationship of the couple - Satisfaction, past experiences

ILLUSTRATIVE INDICATORS

(N.B.: Specific indicators will be selected by USAID and each partner institution based on established criteria)

Improved Quality, Coverage and Access

- o Number of contraceptive methods available at specific service delivery points (facilities and community distributors)
- o Percentage of counseling sessions with new family planning acceptors in which provider discusses all methods
- o Percentage of client visits at which providers shows skill at clinical procedures
- o Percentage of clients reporting sufficient time with provider, convenient hours/days
- o Percentage of clients informed of timing and sources for resupply of family planning methods
- o Percentage of contraceptive users by method (method mix)
- o Contraceptive continuation rates
- o Percent of hospitalized pregnant women with hospitalizations correctly managed at the health centers and hospitals
- o Fatality from specific obstetric complications (secondary effects of abortion; sepsis, hemorrhage, toxemia)
- o Immunization drop-out rate in children aged 12-23 months
- o Percentage of mothers/caretakers correctly counseled about SCM at home
- o Case fatality rate for diarrheal disease/ARI
- o Percentage of cases treated with SCM norms
- o Percentage of children < 5 years with integrated management (asked age, immunization history, breastfeeding/nutrition, fever, weight, etc.)
- o Number of women of reproductive age using family planning methods at a given time
- o Percentage distribution of the types of service delivery points by users
- o Percentage of providers who speak Mayan languages
- o Percentage of target population that knows service characteristics (i.e., at least one source of contraceptives and/or ORS)
- o Immunization coverage rates
- o Reduction in the immunization drop-out rate: (DPT1-DPT3)/DPT1
- o Use of oral rehydration therapy
- o Reduction in number of medical/technical and administrative barriers to service delivery (such as restrictive policies/norms on contraceptive methods and/or drug supplies)
- o Percent of referrals
- o Percent of referrals that are followed up in the community

Strengthened IEC Programs

- o Number of communications produced/disseminated, by type, over a given reference period
- o Number of contraceptive methods known
- o Number of acceptors new to modern contraceptives
- o Percent WRA with correct knowledge of obstetric and newborn danger signs and actions to take
- o Percent of mothers/caretakers of children < 5 who know at what age children should be vaccinated against measles
- o Percent of mothers/caretakers of children < 5 years who practice SCM of diarrheal disease and ARI at home

Development of Appropriate Human Resources

- o Number/percent trainees who master relevant knowledge
- o Number of trained health workers with adequate SCM practices (diarrhea/ARI) and/or ability to provide family planning services
- o Number of key health areas with trained community health workers
- o Staff positions of partner agencies are filled by personnel who have the qualifications and competencies required for the position as stated in a position description

10

Supplies and Equipment are Continuously Available

- o Percentage of households with basic supplies for SCM (diarrhea, ARI)
- o Percentage of service delivery points stocked according to plan (contraceptives, vaccines, etc)
- o Percentage of storage capacity meeting acceptable standards (temperature, humidity, ventilation, etc)
- o Frequency of stock-outs
- o Ratio of supplies wasted to the amount issued to clients during a specific time period
- o Percentage of service delivery points stocked according to plan

Functioning Financial and Administrative Systems

- o Improved partner awareness of their current financial position (overall and at specific facilities) defined as the ability to generate information on amounts budgeted and expended for major line items
- o Number/percentage of health units with systems of checks and balances for handling cash including vouchers, disbursements by check, verification of accounts
- o Financial planning focused on equity
- o Key administrative systems operational (personnel, inventory of supplies and equipment, fixed assets)
- o Utilization of a simple planning process for service delivery at the district level
- o Greater community participation in design and delivery of health services

Functioning Monitoring Systems

- o Extent of use of service statistics systems
- o Program-relevant periodic studies (household surveys, qualitative research, etc.)
- o Program staff responsible for logistics management able to provide up-to-date account of quantities procured, in stock, distributed, authorized inventory levels at service delivery points, and stock-outs

Greater Program Sustainability

- o Number/percentage of health facilities that achieve their cost-recovery and planned service goals
- o APROFAM's urban clinics sustainable
- o IPROFASA self-financed (except commodities)

Operations Research and Evaluation for Better Decision-Making

- o Regular conduct of process evaluations
- o conduct of effectiveness, efficiency and impact evaluations
- o Use of operations research and evaluation results for program modification
- o Dissemination of research and evaluation results

Policy Environment Conducive to Improving Women's and Children's Health

- o Number of appropriately disseminated policy analyses
- o Number of awareness-raising events targeted to leaders
- o Percentage of the target population favorable toward family planning programs
- o Greater use of demographic data in development planning
- o Number of statements by leaders in support of family planning and HIV prevention programs
- o Absence of unwarranted restriction on family planning service providers
- o Absence of unwarranted restrictions on users
- o Public sector resources devoted to family planning/MCH as a percentage of GDP
- o Existence of a clear mission among individual USAID partners that contributes to the achievement of the strategic objective
- o Existence of a national population policy and standardized guidelines for reproductive health service delivery
- o Existence of a national policy and technical guidelines on integrated management of the child