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An Analysis of the Role of the Guatemalan Private Sector in the (New) Project "Improved Family Health": Concept Paper

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Cover

AN ANALYSIS OF THE ROLE OF THE PRIVATE SECTOR IN THE (NEW) PROJECT "IMPROVED FAMILY HEALTH"

EXECUTIVE SUMMARY

This concept paper explores the potential role of private sector organizations (PSO) in the implementation of a new project, "Improved Family Health" (IFH) in FY1988. The specific objectives of the project will be to increase contraceptive prevalence and reduce infant mortality through the five interventions of the Child Survival Program (CSP): Oral Rehydration Therapy (ORT), Expanded Program of Immunization (EPI), Acute Respiratory Infections (ARI), Monitoring Growth and Development (MG&D) and Birth Spacing (BS). The participation of PSO's in this project is seen as a supplementary effort to the services delivered by the Ministry of Health (MOH) and by the Guatemalan Social Security Institute (IGSS).

The rural population working in export related crops production seems to be the most appropriate one to be served by PSOs in this project for three reasons: a) it constitutes a population at risk with low living standards and health status (high infant and maternal morbi-mortality); b) it has difficult access to - and thus low utilization of - services delivered by the MOH and IGSS networks of facilities; and c) the recurrent costs of the CS program could be financed by the economic production for which they work, either directly or through social security, providing for the sustainability of the program once the project is finished. Thus, the agricultural workers of

coffee, sugar cane, cardamom, cotton and banana plantations, and their families could benefit from the IFH project on an ongoing basis. Between the permanent and the migrant population they reach an estimated 2.5 million people.

The implementation of the IFH project through PSOs could start nationwide or in a specific region where a high concentration of workers takes place, like the South-Western Region. It comprises the southern part (or all) of the following Departamentos: San Marcos, Quetzaltenango, Retalhuleu, Suchitepequez, Solola, Escuintla, Chimaltenanao, Sta. Rosa and Jutiapa. It covers the southern coastal plains and slopes of the highlands. The implementation of the IFH project through PSOs should start in these two regions and expand, later-on, to other areas not served by public sector health services. There are several reasons for this approach: concentration of the target population, relatively greater accessibility and a larger proportion of farming land allocated to export crops.

However, the most important justification lies in a recent IGSS decision: IGSS is in the process of expanding two of its programs to these Departaments. Given the resistance of finca owners and their workers to IGSS (primarily due to the lack of an adequate model to answer the needs of the rural workers and their families) the development of alternative mechanisms for organizing and financing these services could provide an acceptable compromise for both sides.

There are already several PSOs providing health care services to small segments of the identified target population. Among these, there are five or more common or interesting types:

a) Private physicians and pharmacists working out of the nearby towns and villages. Included in this group are medical students doing a semester of social work (Ejercicio Profesional Supervisado or EPS). The medical orientation of residents and EPS physicians is highly curative. Thus, in order for them to participate in the IFH project, their practice would have to be refocused to include the delivery of the generally preventive services of a CS program.

b) Some large plantations have a health service of their own. In such instances, the health facility is usually staffed by physicians and nurses and organized, controlled and financed by the finca owner.

c) Eighteen plantations have an agreement with a PSO, called Agrosalud, by which a preventive and curative program is organized and sponsored jointly by the plantation owner and the organization. This program is entirely financed by finca owners.

d) A public health physician sells a preventive program to a limited number of fincas in the region.

e) A regional coffee trade association, ACOGUA, has organized two health facilities. They provide preventive and curative services to the plantation workers and their families. There are plans to reproduce this approach through the national trade association (ANACAFE) which has decided to set aside part of its member's fees in order to finance the expansion of this health services delivery model.

Most of these types of arrangements serve primarily the permanent plantation population. Apparently there are no

specific programs designed for the migrant agricultural workers and their families while they reside and work in the plantation. The living and health status of the migrants is even lower than that of the permanent population. Delivery of CS interventions by PSOs to this migrant population would require the development of new, innovative arrangements. These arrangements would have to overcome language and cultural barriers as well as ensure the continuity of health programs in the farms and in their home communities. One possibility to explore is to have a health promotor migrating with the group, from the community to the finca and back. While in the fincas, these health promotors would coordinate their activities with the primary care system that regularly serves the permanent population. The contractor, the enganchador or the capataz should also be explored as possible human resources in this health liaison/watcher/promotor role for the migrant population.

At present the effective extension of coverage to this population probably would require the participation of a number of PSOs. The management, supervision and coordination of the PSOs implementing the IFH project would be difficult. There are two very different structures by which to organize these activities: a) one would have as many management agencies as types of PSOs participating in the project, with one coordinating body made up of their representatives, the other b) would have a single overall management/supervising agency, completely autonomous from the PSOs implementing the project. Although more difficult to administer, the first alternative seems less risky. It would help assure a more successful implementation by limiting

potential failures, by minimizing inter-institutional friction and by accommodating more easily to preferences of participating agencies. For either approach, it would be essential to distribute the project's budget among the participating agencies beforehand and to avoid delays caused by disputes over resource allocation.

Given the characteristics of the target population, the IFH project delivered through PSOs would expand its benefit package to include: a) some basic curative services for adults, particularly workers; b) a referral arrangement with backup institutions for higher levels of care, and c) complementary interventions to each one of the CS instruments. The latter, financed through other AID projects or other donor agencies, are important to ensure that improvements achieved in infant health status are long lasting.

The recurrent costs should be borne mostly by the plantation owners. Given the political environment of Guatemala, farm owners may be induced/motivated to increase their expenditures for the well being of their workers and their workers' families because such expenditures can be expected to: a) increase productivity; b) enhance their social and political image, and c) obviate the threat of government intervention. In particular, it should be emphasized that the timing of such an initiative and that of IGSS's effort to extend coverage in the south western region is opportune and the projects have considerable overlap which can and should be taken advantage of. The project can foster the development of PSOs that are more acceptable to owners

and workers and which could become efficient providers of IGSS financed services. IGSS could provide a solution to the thorny issue of sustainability by shouldering from the beginning the recurring costs of the CS interventions for its beneficiaries. Several policy changes that should be adopted by the GOG to facilitate the implementation of a private sector strategy are identified in the paper.

INTRODUCTION

This concept paper explores the role that private sector organizations may play in the implementation of a new project "Improved Family Health" (IFH) to be started in FY1988. The specific objectives of this project will be to increase contraceptive prevalence and reduce infant mortality through a Child Survival Program.

I. USAID/GUATEMALA STRATEGY AND OBJECTIVES

A. Strategy

The Mission's Action Plan for 1985-87 contained the basic program goals pursued during that period: a) an economic stabilization program and b) a return to a pattern of long-term real economic growth, emphasizing greater participation of the poor in the benefits of growth.

B. Objectives

The Mission strategy for 1987-89 will strengthen these basic goals through the pursuit of eight specific objectives. For the purposes of this paper the following are relevant:

Objective #2 Strengthen the private sector.

Objective #8 Increase contraceptive prevalence from 25% to 35.3% by 1989.

Objective #10 Reduce Infant Mortality from 79.8 per 1000 live births in 1984 to 61.5 per 1000 live births in 1989.

II. IMPROVED FAMILY HEALTH PROJECT (IFH)

A. An Overview

Besides the continuation of several projects aimed at objectives No. 8 and 10, the Action Plan incorporates a new project. It will use a sectoral approach encompassing Health, Child Survival and Population functional accounts and will be implemented through sub-agreements with public and private sector health and family planning agencies. Over a five year period, US$20 million will be spent to assist these agencies in carrying out services and information delivery which will significantly improve the health status of Guatemalan families, with emphasis on women and children. Public and private sector agencies (including PVOs and others like prepaid plans) will implement Child Survival (CS) interventions, including: Oral Rehydration Therapy (ORT), Immunization (CPI), Growth Monitoring (GsD), Acute Respiratory Infections (ART) and Birth Spacing (B.S.). The project will assist the institutions involved in improving the management support systems necessary to ensure efficient and effective implementation of a National Child Survival Program.

B. Purpose of the Concept Paper

The aim of this paper is to present and analyze several options for implementing the IFH project - in part - through private sector organizations (PSOs). In addition, it will identify mechanisms and/or institutions that may play a coordinating/management role vis-a-vis these private agencies in the implementation phase, to ease the management burden of the Office of Human Resources Development.

The strategy used to carry out this task was first to identify a target population where private sector involvement in CS activities is likely to occur and succeed on an on-going, self-sustained basis. Second, the issue of geographic location of the target population is discussed in order to analyze whether or not the participation by private agencies could or should be limited to one region. Third, the potential participating institutions are identified and analyzed based on their experience in delivering primary care services. The target population is divided into two groups with different cultural and economic background and which may therefore require different types of private providers. This possibility, in turn, gives rise to additional complications, including the need for an overall management supervisory agency discussed below. Fourth, taking into consideration the most important health needs of the population to be served, the basic benefit package is discussed in terms of additional services that could or should be added to it. Finally, some options for financing recurrent costs are identified and discussed.

III. SELECTION OF TARGET POPULATION

The population group(s) to be served by private organizations in the IFH project were identified following three criteria:

a. Largest health needs in terms of infant and maternal morbidity and mortality.

b. Lowest availability or accessibility to existing primary care facilities and services.

c. Linkage to a productive segment of the economy, in order to attract and sustain private initiative and ensure sustainability of the program after the project phase.

Three groups of people were identified:

1. Periurban poor in Guatemala City and in other cities and towns, heads of Departments and Municipalities. Although Guatemala is still a predominantly rural society, the migration from rural to periurban areas is a growing phenomena.

2. Indigenous communities living in the highlands. Semi-isolated in terms of geography, culture, and language and with limited means of production in terms of the quantity and quality of farming land and technology, these large groups of people have very low incomes and large health needs.

3. Agricultural workers and their families that labor full or part-time in plantations of export crops, particularly coffee, cotton, sugar cane, cardamomo and banana. There are two kinds of farm workers: a) the permanent or "colono" who lives on the plantation with his family year-around, and b) the migrant or "cuadrillero", who comes in groups, mainly from the highlands, for short-term work during the harvest seasons. Although the living and health standards of both groups are low, the latter has the greatest health problems, partially attributable to the concomitants of migrant worker status. The number of the permanent and migrant workers and their families was estimated in 1977 at around two million, that is 36% of the total Guatemalan population. Assuming that this proportion has fallen to 33% in 1986, with population growth the absolute size of this group is

now estimated to be 2.5 million people.

The agricultural workers and their families - both colonos and cuadrilleros - best fulfill the target group selection criteria specified above. Assuming that all high risk-low access and utilization groups have similar availability and accessibility to primary care services and similar health needs, this is the only group with a link to a relatively highly productive structure; i.e. the only one that fulfills the third criteria. Moreover, the plantation's economy can become a financial resource, on a self-sustaining basis, to the private sector component of the IFH project. To some extent this is already true: some export crops have already become a source of funds since some plantation owners and/or their workers, are already paying voluntarily for health care which is usually curative in nature. Moreover, one of the regional trade associations of coffee growers, ACOGUA, already sponsors and partially finances a health center.

IV. SELECTION OF GEOGRAPHICAL LOCATION

Although farms of export crops are located throughout the country they show a higher concentration in the southern area towards the pacific coast. About 80% of the production of coffee (the largest crop), sugar cane, cotton and cardomomo comes from two regions: the South Coastal Lowlands (Region Suroccidental) and the South Coastal Highlands (Region de Boca Costa).

Since the permanent agricultural workers (colones) live in the plantations, their geographical location coincides with the distribution of the farms. Therefore, they too concentrate in

these two regions. The migrant workers, on the other hand, come from the Highlands, particularly from the Departments of Huehuetenango, Quiche and San Marcos.

Implementation of the IFH project through PSOs for the identified target population could proceed in two ways: a) at the national level with the aim of reaching as many farms as possible regardless of their location, or, b) in a subnational strategy, it could focus on the two southern regions where most of the agro-export farms are located.

The national approach has the advantage of reaching a larger segment of the agricultural population and thus, obtaining a larger impact, but it has the disadvantage of higher costs due to diminishing marginal returns. In regions where farms are more dispersed, the cost to extend the services would be higher than in regions where farms for export crops are more concentrated. The regional approach has advantages and disadvantages that are essentially the converse of those of the national strategy. A reasonable compromise could be achieved by implementing the IFH project through PSOs on a stepwise basis, starting with those Departamentos or even Municipalities within the southern regions, with the highest concentrations of farms, and proceeding on a region-by-region basis to eventually embrace the entire nation.

The stepwise alternative has several advantages. First, it avoids unfair competition within the same type of production, which would otherwise constitute a potentially serious obstacle to successful implementation. The IFH project will require additional expenditures on health services by owners and workers, without an immediate, discernible economic return generated by

increased worker productivity. A stepwise approach will limit this effect and thus reduce resistance by the plantation owners. Second, it avoids a task that may be too large to grasp for the project management team. The stepwise approach allows to start implementing the project through existing organizations in locations of relatively easy access and concentration of farms and moving later into harder to reach areas.

An additional advantage of this approach is that it enables coordination of the implementation of the IFH project with the extension of coverage of two programs of the Instituto Guatemaltico de Seguro Social (IGSS). IGSS has made a decision and is elaborating operational plans to expand its MCH and Health Care Programs to the South Western Region. This is the region with the highest concentration of farms whose workers and families could be served by the IFH project through private providers. The interaction between IGSS and the private organizations implementing the IFH project in the same geographical area will be discussed later, in the section about financing.

V. POTENTIAL PRIVATE IMPLEMENTING AGENCIES

A variety of private organizations could be invited to participate in the implementation of the IFH project. The following were mentioned: a) service clubs: Club de Leones o Club de Rotarios; b) cooperatives acting either individually or through federations; c) insurance companies; d) prepaid plans for health care services like Salud Total, La Medica Guatemalteca and

Agrosalud; e) private voluntary organizations (PVOs) of which there are almost two hundred in health related activities in the country; f) trade associations like the Asociacion Nacional del Cafe (ANACAFE), some of them already active in the health field and g) private practitioners like doctors, pharmacists, rural health technicians, rural health promotors, hospitals, etc.

The identification of agricultural workers in the export crops and their families as the target populations for this component of the project, suggests the particular private organizations that might be best qualified (by experience) and most willing and able to participate in the project. Institutions without experience in providing health services to this population would require additional effort to become effective participants in the project. If, as is recommended, the project is to avoid these start-up costs, the types of organizations identified in (a), (b) and (c) should not be considered viable alternatives. Of the prepaid plans only Agrosalud has experience with rural populations. Prior successful experience in the delivery of health services to the agricultural population indicating the willingness to act in this field and acceptance by owners, workers and families, seem to be the most important criteria for selection.

A. <u>For the Permanent Population.</u>

There are several private organizations or types of providers (some are individuals) that have experience in providing health services to the colono population and their families.

1) Medical doctors, dentists and pharmacists, working out of nearby towns, provide health services under contractual arrangements with plantation owners. Particularly interesting, in terms of their potential for the IFH project, are the medical graduates performing their half year of social service called Ejercicio Profesional Supervisado (EPS) which is mandatory before licensing. For the most part, services are curative and delivered through regular visits (weekly, bimonthly) for the finca, where the physician offers consultations.

2) In some fincas there is a permanent nurse auxiliary or a formally trained rural health promotor, who provides preventive and basic curative services. They work on an individual basis, that is, not as part of an organization providing support, supervision, supplies, technical guidance, etc. Their presence in a finca does not exclude the arrangement with a private doctor as described in (1).

3) Some large fincas, with a permanent population of one thousand or more have a health center, usually staffed by a resident doctor and an auxiliary nurse or a rural health promotor. It is said that few fincas have such elaborated health facilities and services. Little is known about the orientation of these services.

4) A limited number of fincas have made an arrangement with a physician with formal training in Public Health. The physician performs preventive activities on site, on a monthly basis and a minimum number of office visits. For curative services, he refers the patient to a nearby clinic or doctor, private or public. The physician's fees and expenditures are

paid by the plantation owner.

5) A more numerous, though limited, number of fincas have contracted primary care services with an organization named Agrosalud. Preventive and some basic curative services are provided by rural health promotors, formally trained, supervised and supported by the organization. Payment is made by the owner on a per capita basis.

6) A smaller number of coffee fincas are served by health centers (with permanent physicians and outreach rural health promotors) organized by a regional coffee trade association named ACOGUA (Asociacion de Cafetaleros del Oriente de Guatemala).

Operating expenditures for the staff and medicines are paid by IGSS. Another regional coffee trade association, in the Western Highlands, has created a similar health center, under the guidance and promotion of ACOGUA.

7) There are several other providers of which little is known by this consultant at this point. Among them, deserving mention is la Liga de Salud del Pueblo, which provides (or used to provide) mostly curative services through mobile units.

Of all these arrangements and types of providers, only those mentioned in (1) and (2) cover a significant proportion of farms. However, there are organizations and individuals [identified as (4), (5) and (6)] that provide a more appropriate response to the health needs of the colono population, although their number and coverage is limited.

Thus, it is the opinion of this consultant that the IFH

project could try to deliver its services through existing institutions, if they are re-oriented in terms of their scope of services and expanded in order to increase coverage. As well, this consultant is of the opinion, that a multi-institutional approach should be used, to suit the preferences and traditions of owners and workers. All of them should have a strong commitment to deliver the benefit package of a Child Survival Program. Given this array of existing providers there appears to be four major types of organizations or arrangements that could become private sector implementers of the IFH project.

1. The Trade Associations, nationally or regionally, can develop primary health services along the lines of ACOGUA. In fact ANACAFE has formally proposed to IGSS the development of as many centers as needed, nationwide, to provide coverage to all the coffee plantations. This proposal was approved by a meeting of the General Assembly of ANACAFE in November of 1986 and, according to IGSS authorities, is being implemented. The estimated expenditure for 1987 of ANACAFE in this program is one million quetzales. Although another trade association has had a negative experience with the same approach, namely cotton producers, a coordinated approach by IGSS, the GOG and international donors may convince them to try again.

2. Some of the physicians that serve as finca doctors are in their period of social work (EPS). Their work for the fincas however, is not part of the EPS program. Instead, it evolved from the need of the physicians to supplement their income and the need of the plantation owner to provide locally some health

services to the permanent population. The doctors' work for the fincas could be expanded along the lines of activities performed by the Public Health Physician described in (4) above. Institutions like the Colegio Medico or the Medical Schools with the support of this Public Health physician or some other resource, could become a focal point for appropriate training and supervision of these physicians in a modified EPS program. The financial arrangements could remain as presently are (that is, on an individual basis), or could be organized through a cooperative of providers, created for this purpose. Locally resident physicians may also participate in a program of this type either individually or through a cooperative approach. The creation of one or several cooperatives would facilitate the the management of the IFH project itself.

3. Agrosalud could be expanded and/or replicated by enticing other PVOs (Agrosalud developed in connection with the Behrhorst Foundation) to develop a similar type of organization. Limited funds to train and locate needed staff, particularly health promotors and supervisors, as well as to carry out effective marketing, seems to have been the major causes for the limited growth of Agrosalud. From the point of view of the technical orientation of its services and their acceptability by owners and workers, Agrosalud seems to be well suited to implement, on a large scale, the IFH's Child Survival program.

4. Finally, there will be some large producers, particularly those that already have a health facility and/or services of

their own, that would be willing to make the necessary arrangements to participate in the implementation of the IFH project. Although somewhat similar to model #1, it is conceivable that some producers would prefer to maintain their health services independently, aside from outside organizations, even if those are of the trade association to which they may belong.

B. For the Migrant Population

The provision of primary care services to migrant workers and their families presents a more difficult problem than for the colonos. Their presence in the plantation is generally limited to an average of one month. Moreover, only a third of them come with their families. Third, the plantation owner feels less committed to the social well being of the migrant population. Fourth, there are language and cultural barriers that for the most part, are not present with the colono population. Fifth, their health needs are more severe and somewhat different (diseases caused by the changing environment like IRA or depression or by their heavy physical work like muscle problems). Sixth, the major concern of the migrant workers is raising enough income to sustain their families back in their base community.

Despite these difficulties there are two strong reasons for trying to organize CS services for the migrant population. First, they constitute the largest segment of the agricultural labor force in the export crops. They out number the colonos in a proportion of four to one. Second, their work for the plantation relates them, on a contractual basis, with a source of

funding which is stronger than the economy in their base communities. In other words, their work for the plantations is one of the few options they have, to increase their participation in the benefits of economic growth.

There are two basic options to look after the migrant workers in the context of the IFH project:

a) By the primary care system adopted by the plantation, among the four models specified above, for its colono population.

b) By an extension of the primary care system of the base community to which they belong.

The second option seems more appropriate because it would have previous experience with each migrant group in overcoming the cultural and language barriers. As well, it could provide better psychological support to the migrant population than the other. However, not all the indigenous communities from which migrant populations are derived, have a system of delivering effectively primary health services. If it does, then the IFH project could be implemented through a rural health promotor, linked to the primary care system provided in the community, that travels and stays together with the migrant group. It would serve as a source of primary care services, with special emphasis on CS instruments during the entire travel period.

The contractors of migrant workers should be induced to play an important role in this regard. The Ministry of Labor already regulates some aspects of the contractors activities, including the registration of the contract with the Ministry. The Ministry could establish that contractors can hire migrant workers, only

if a provision for primary care coverage for they and their families, while traveling and working in the plantation, is included in the contract. Who will be empowered to make a decision in terms of the options specified above and what will be the financial incentives/disincentives, are items that should become part of this policy initiative.

C. Supervising/Management Agencies

The management and supervision of the private sector component of the IFH project would face an increasing level of difficulties as the number of types of providers increase.

If there are several institutions and/or arrangements, there appears to be two alternatives for solving the management/supervision issue:

a) Engage several management agencies, each one in charge of a particular model of delivery: these could be ANACAFE, the Consejo Nacional de Algodon and the Asociacion Nacional de Caneros for the trade associations model; the Colegio Medico for the EPS model and/or the Physician Cooperative; the Asociacion de Servicios Communitarios en Salud (ASECSA) for PVO models. They could act independently of each other, relating directly to AID or through a Coordinating Council made up by representatives of the different associations as well as from IGSS and the MOH.

b) Have one management agency, nationwide, for all private sector institutions, implementing the project. It should not be related to any of the associations or groups involved, although it should have the capability of relating with each one

appropriately. This consultant was not able to identify an organization that is strong enough or with a mandate to be active in this field that could play this role.

Both alternatives have advantages and drawbacks. The former is more participatory, will ease out political or institutional rivalry and will minimize the risk of weak management since much of it would be given to the implementing organizations themselves. However, the coordination of so many institutions with diverse interests will slow implementation. The second alternative should be more expedient but it may be unacceptable for the participating institutions or associations. In both instances an important involvement by the Mission staff organizing and supervising the project, would be required.

In both approaches it may be unavoidable to put together and develop a technical body in charge of acting as a management support unit (MSU). In both cases the relationship between the MSU and the implementing PSOs becomes a difficult issue that has to be clearly addressed and solved in the structure of the project.

VI. THE BENEFIT PACKAGE

Like malaria, infant mortality is a health indicator that may deteriorate, if its improvement is based solely on simple technological interventions without a transformation of the living conditions associated with development. Therefore, to ensure further progress in the area of child survival, besides the specific preventive or curative measures, the background causes should be removed. As a result, the five basic

instruments of child survival, which constitute the core of the IFH project, should be supplemented whenever possible, by some additional activities directed towards improving the living conditions of the agricultural workers in the plantations. For each CS instrument, this consultant has identified a cluster of activities, that could be implemented, over a period of time, by the owner and by the primary care system working in the finca.

1. Oral Rehydration Therapy (ORT): Safe water supply, safe waste disposal, better housing arrangements and innovative health education seem to be essential complementary activities to ORT in order to reduce the prevalence of diarrhea. Financing for infrastructure improvements like water systems, latrines and housing could be obtained from several donors including other AID projects.

2. Expanded Plan of Immunization (EPI): Besides the diseases preventible in the EPI program, the rural agricultural workers of Guatemala and particularly their children, suffer a high incidence of the following infectious conditions; malaria, skin infections, intestinal parasites and onchocerciasis. There are inexpensive technologies to prevent the first three and the most important complications of the fourth, that should be included as complements to the EPI.

3. Acute Respiratory Infections (ARI): It is widely recognized the influence of depression, alcohol, heat and humidity, on lowering the resistance of the respiratory tract to infections. The migrant population is particularly prone to these factors. A combination of education, entertainment and appropriate rules to

ensure rest (avoiding alcohol, curfew hours, etc.) could help reduce this problem at a minimum additional cost.

4. Growth and Development (G&D): A most important complement to this instrument is supplemental feeding for lactating mothers and children under five. Their intake showed the lowest values in terms of calorie and protein in relation to recommended allowances. As well, breastfeeding should be promoted and encouraged as much as possible. A difficult problem is posed by pregnant women that migrate and engage in physical work in the plantations. They tend to limit their food intake so that their pregnancy does not interfere with their work. As a result, intranterine growth retardation at birth is a significant public health problem (20-25%). A policy decision would have to be made by the GOH to protect these women and change their eating behavior.

5. Birth Spacing: A strong program of health education about child rearing seems to be an important complementary measure. Children under the age of twelve should be induced to attend formal education, within the finca, provided by the nurse promotor or other educational resource.

Besides these complementary activities the IFH for agricultural workers should include two additional activities:

a) Basic curative services should be offered to all colono and migrant workers, in an accessible way, by the primary care system of the plantation; and

b) Arrangements for referrals and counter-referrals between the plantation primary care system and IGSS centers and hospitals should be established to provide overall health coverage to this

population.

VII. FINANCING

As already mentioned above the IGSS has made a decision to expand its MCH and General Health Care programs to the Southwestern Region where 80% of the agricultural workers live and/or migrate to work. This expansion will imply that social security contributions by owners and workers will increase from 4% (for accidents) to 10% (for all three programs). Most farm owners and agricultural workers complain bitterly against IGSS because it provides services with very limited accessibility to the agricultural community, particularly in the South Coastal Regions. Besides, IGSS recognizes that its health center model of delivery does not fit easily with the location and accessibility problems of the agricultural population. Furthermore, IGSS doubts that it willbe able to reach the workers and their families at the finca level. Therefore, some IGSS authorities argue that the expansion of the two programs in the southwestern region would put IGSS in a difficult situation, since it would be receiving contributions from a working population that it may not be able to serve with a reasonable accessibility. Therefore, IGSS is prepared to consider the possibility of paying private providers, for the delivery of those services that IGSS should, but is unable, to deliver. In addition, IGSS appears to be prepared to offer back up services in its own facilities and receive and return patients from private providers in this rural area, within a pre-arranged referral system.

This consultant does not know how widely accepted within IGSS and the GOG, are these ideas that break away from the traditional delivery model of "hospital or health center based" and "directly and centralized administered" services by the institution. The alternatives discussed in the previous paragraph can be further promoted through an appropriate policy dialogue. The IFH project could be an important leverage in that direction, which will better serve the health needs of the agricultural workers and their families, through the introduction of alternative arrangements between the private and public sectors.

If IGSS expands its MCH and Health Care programs to the South Western Region, then the five major interventions in the CS program and some of the complementary measures, particularly basic medical care and essential drugs, will become the financial responsibility of IGSS both for the worker, his companion and their children up to age five. The recurrent costs of the IFH project for this segment of the population served through private providers should then be paid by IGSS at its own costs. Depending on the specific model adopted by the plantation for its two groups of people, several mechanisms could be developed to make this payment effective.

Even if this policy change by IGSS is not achieved, this consultant believes that most of the private models for implementing the IFH project for the agricultural workers and their families could be implemented for two reasons:

a) They will imply, for most producers, only a limited

increase in their current expenditures for social activities. Moreover, some of the additional expenditures might be financially recovered from the workers.

b) Export crop producers may find that an additional small expenditure, with a large social impact will produce sizable beneficial effects in terms of increased productivity, lower social tension and improved public image.

c) The producers will resist becoming dependent on public or quasi-public sector agencies for the delivery of services. Even at the cost of double spending for the same service, they would prefer the efficiency and reliability of a private provider, particularly if they can exercise some control over it.

Nonetheless, without a policy change from IGSS, the implementation of the IFH project through private providers will be slower and some of the proposed models may never develop or remain quite small.

This consultant will not go into details of the expenditures that the IFH project should budget for all the institutions or organizations that were analyzed in section V. Suffice it to say that some of these organizations have to be created and all need strengthening in terms of logistics, management, supervision and general institutional development. Marketing and operations research are areas that should not be overlooked.

However, there are two items that are of the utmost importance for this shift in the policy of providing primary care services. First, the primary responsibility for assuring the quality of the services remains with the MOH. However, the

Guatemalan MOH has limited capability and experience in controlling the private health sector. Funds should be reserved to expand the MOH's capability in this regard. Second, the IGSS may decide to pay for some of the recurrent costs. In the LAC region, there have been negative experiences with contracting private providers because agreements are signed without developing the needed monitoring systems, both financial and from the accessibility and utilization view point. Abuses, misinterpretations and outright fraud, as they occur, erode the base of support for these type of arrangements and originate a retrenchment of public sector institutions towards their traditional way of delivering services through their own facilities. Thus, the IFH project, or some complementary source of funding, should finance the development by IGSS of its monitoring capabilities to prevent, as much as possible, these negative events from happening.

VIII. CONCLUSION

Private sector organizations, existing or brand new, may become effective and efficient implementing agencies of the IFH project and help it to reach its two overall objectives (increased voluntary contraception and reduced infant mortality) in a very high risk population, like agricultural workers of export crops. Meantime, it can forward another objective of the Mission like strengthening the private sector through new forms of publicly financed social services.

However, some changes are needed before the participation of private sector institutions can take place. There are some major

policy issues to be analyzed and decide upon, by the GOG and by some autonomous agencies like the School of Medicine, the Colegio Medico and the IGSS. There are some groups of individuals, like sparsely distributed health personnel, already in the rural areas, that have to be brought together and organized and whose role has to be expanded or changed. There are organizations like Agrosalud that have to agree to expand and become a model for replication.

REFERENCES

1. USAID/G; Action Plan 1987-89, p. 107.

2. There are several references about the living conditions of farm workers in Guatemala. Though somewhat old, the best account remains that by Gordon, W. "Extension of Health Services to Finca Workers", USAID/Guatemala. Health Sector Assessment, Annex 5.7, November 1977.

3. The Regional boundaries used by IGSS are departmental while those used by Dordon are municipal and cut across departments. Therefore, they do not coincide. However, to a large extent, the South Western Region of IGSS overlaps with the South Coastal Highland and South Coastal lowlands of Guatemala.