

***Calidad en Salud***

**Better Health for  
Women and Children**

**Quarterly Report  
Second Quarter, 2003**

For:  
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# Acronyms

AA-MC	AIEPI AINM-C, Manejo de Casos
AA-PP	AIEPI AINM-C, Promoción y Prevención
ABRES	Análisis del Balance, Requisición y Envío de Suministros
ACCEDA	Atender, Conversar, Comunicar, Encaminar, Describir y Acordar próxima cita
AEC-ONG	Ampliación de la Extensión de Cobertura en Organizaciones No Gubernamentales
AEC-PS	Ampliación de la Extensión de Cobertura en los Puestos de Salud
AIEPI	Atención Integrada a las Enfermedades Prevalentes de la Infancia
AINM-C	Atención Integrada al Niño y la Mujer a Nivel Comunitario
AMMG	Asociación Guatemalteca de Mujeres Médicas
APROFAM	Asociación Pro-Bienestar de la Familia
AQV	Anticoncepción Quirúrgica Voluntaria
ATR	Asesor Técnico Regional
BRES	Balance, Requisición y Envío de Suministros
CC	Centro Comunitario
CP	Community Participation
CRN	Centro de Recuperación Nutricional
CPT	Contraceptive Procurement Table
CTA	Comité Técnico Asesor
CYP	Couple Years Protection
DAS	Dirección de Área de Salud
DHS	Demographic Health Survey
DRVCS	Dirección de Regulación, Vigilancia y Control de la Salud
EA	Enfermera Ambulatoria
EBS	Equipo Básico de Salud
ETIO	Equipo Técnico de la Investigación Operativa
ETL	Equipo Técnico en Logística

ETANA	Equipo Técnico Asesor Nacional de AIEPI
FA	Facilitador de Área
FC	Facilitador Comunitario
FI	Facilitador Institucional
FP	Family Planning
GAS	Grupos de Acción en Salud
GMP	Growth Monitoring and Promotion
GTI	Grupo Técnico Interinstitucional
IEC	Información, Educación y Comunicación
IGSS	Instituto Guatemalteco de Seguridad Social
IMCI	Integrated Management Childhood Illness
INAP	Instituto Nacional de Administración Pública
INCAP	Instituto de Nutrición para Centro América y Panamá
INTECAP	Instituto Nacional de Tecnología y Capacitación
IPC/C	Interpersonal Communication and Counseling
IRAS	Infecciones Respiratorias Agudas
IUD	Intra-Uterine Device
LMIS	Logistics Management Information System
LORF	Local Operations Research Facilitator
MA	Médico Ambulatorio
MCH	Maternal Child Health
MEW	Minimum Expected Weight
MIC	Manejo Integrado de Casos
MNH	Maternal Neonatal Health
MOH	Ministry of Health
MSPAS	Ministerio de Salud Pública y Asistencia Social
NFP	Natural Family Planning Methods
NGOs	Non-Governmental Organizations

OR	Operations Research
PEC-ONG	Ampliación de Extensión de Cobertura en Organizaciones No Gubernamentales
PF	Planificación Familiar
PNI	Programa Nacional de Inmunizaciones
PNUD	Programa de las Naciones Unidas para el Desarrollo
POA	Programación Operativa Anual
PROEDUSA	Programa de Educación y Saneamiento
PROSAN	Programa de Seguridad Alimentaria y Nutricional
PVO	Private Voluntary Organizations
QAP	Quality Assurance Project
SAMIG	Sistema Automatizado de Monitoreo Institucional y Gerencial
SIAF	Sistema Integrado de Administración Financiera
SIAS	Sistema Integral de Atención en Salud
SIGER	Sistema de Información Gerencial
SIGSA	Sistema de Información Gerencial en Salud
SLAN	Sociedad Latinoamericana de Nutricionistas
SMN	Salud Materna Neonatal
SUI	Sistema Unificado de Información
TOT	Training of Trainers
TSR	Técnico en Salud Rural
UE	Unidad Ejecutora
UNFPA	United Nations Fund for Population Activities
UPE	Unidad de Planeación Estratégica
UPS1	Unidad de Provisión de Servicios I
UPS2	Unidad de Provisión de Servicios II
UPS3	Unidad de Provisión de Servicios III
USAID	United States Agency for International Development
USME	Unidad de Supervisión, Monitoreo y Evaluación

UTI	Uterine Tract Infection
VS	Vigilante de Salud

# 1. EXECUTIVE SUMMARY

## 1.1. Result 1: Increased Use of Maternal Child Health Services Provided by the MSPAS and Associated NGOs

### Family Planning

The following is a summary of monitoring results including couple years protection (CYP) and new acceptors of family planning (FP) methods both nationwide and in the eight priority areas.

#### CYPs Nationwide and in 8 Priority Areas

Overall, 45.2% of the target for CYPs in the second quarter of 2003 has been achieved (Table 1), 43.9% for the MOH and 48.7% for IGSS. The MOH's cumulative percentage for CYPs is -6.1 percentage points below the goal, while IGSS is -1.3 percentage points below its goal at 48.7%.

The total amount of CYPs is less than projected due to a persistent delay to provide in time information; we expect to get over the goal when all areas provide information to SIGSA.

During the second quarter of 2003, the PNSR and *Calidad en Salud* (CS) worked together to introduce a comprehensive package of AQP services in the health centers, health posts and hospitals. The increased access to AQP services will ensure that those who are in need receive services and that follow-up of treatment is enforced.

**Table 1: Number of CYPs nationwide by target achieved, MOH & IGSS, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
Total	97,519	96,221.32	98.7%	97,519	7,9963.1	82.0%	390,076	176,184.4	45.2%
MOH *	72,519	72,088.32	99.4%	72,519	55,374.1	76.4%	290,076	127,462.4	43.9%
IGSS	25,000	24,133	96.5%	25,000	24,589.0	98.4%	100,000	48,722.0	48.7%

\*Only 9/26 areas reported in June

#### In the 8 Priority Areas

46.8% of the annual target has already been achieved at the end of the second quarter (Table 2). The increase in CYPs in the 8 priority areas is related to improved promotion and availability of FP methods in health centers and posts. The CYPs for the MOH accounts for acceptance of injectables (56%).

**Table 2: Number of CYPs in 8 priority areas by target achieved, MOH, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
MOH *	23089.283	23,689.71	102.6%	23089.283	19,569.72	84.8%	92357.1	43,259.4	46.8%

\*Only 5/8 areas reported in June

The number of CYPs by method for MOH in the 8 priority areas also was measured (Table 3) 56% of CYPs came from injectables, followed by female AOV acceptance. Also it shows a small increase in IUD from 956 CYPs in first quarter to 1,008 in second quarter. This result was preliminary and could change when all data are available.

**Table 3: Number of CYPs in 8 priority areas by method, MOH, 2003**

FP Method	MOH		Total
	Q1	Q2	
Depo Provera	12,470.3	10,909.5	23,379.8
Condom	819.0	698.7	1,517.63
IUD	955.5	1,008.0	1,963.5
Oral pills	777.0	606.6	1,383.6
AOV male	0	44.0	44
AOV female	8,668.0	6,303.0	14,971.4
Total CYPs	23,689.7	19,569.7	43,259.4

This report includes preliminary data; only 9 of 26 MOH areas have been reported June to SIGSA. The number of CYPs by method for MOH and IGSS nationwide was measured (Table 4). The 50.3% is accounted for acceptance of injectables, followed by AOV-female acceptance (33%). Even these are preliminary data shows a small increase in IUD for both institutions.

**Table 4: Number of CYPs by method, MOH & IGSS, 2003**

FP Method	MOH		IGSS	
	Q1	Q2	Q1	Q2
Depo Provera	34,572.0	27,873.8	5,624	5,475.0
Condom	3,159.0	2,614.6	1,215	1,175.0
IUD	3,398.5	3,549.0	1,869	1,992.0
Norplant	-	-	305	287
Oral Contraceptives	3,535.8	2,746.7	841	919
AOV-male	99.0	187	1,023	726
AOV- female	27,324.0	18,403.0	13,101	13,882
Total CYPs	72,088.3	55,374.0	23,978	24,456

**New FP Acceptors Nationwide and in 8 Priority Areas**

Nationwide, the goal for new FP acceptors was 44.7% (Table 5). Nationally, some 66.2% of new acceptors prefer Depo Provera nationwide, and 51.6% in the eight priority areas. The MOH is at -6.1% of its target while IGSS is at +0.5% of its target.

**Table 5: New FP acceptors nationwide provided by the MOH and IGSS, second quarter, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
Total	65,604	78,171	119.2%	65,604	39,109.0	59.6%	262,416	117,280.0	44.7%
MOH *	58,104	70,764	121.8%	58,104	31,373.0	54.0%	232,416	102,137.0	43.9%
IGSS	7,500	7,407	98.8%	7,500	7,736.0	103.1%	30,000	15,143.0	50.5%

\*Only 9/26 areas reported in June

In the 8 priority areas, the MOH exceeded its new acceptor goal by 4.1% (Table 6). The number of new acceptors will continue to increase during 2003 as the community level component of family planning is rolled-out and IUD support and hospital services are advanced.

**Table 6: Number of new acceptors in 8 priority areas by target and actually achieved, MOH, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
MOH *	18,044	20,715	114.8%	18,044	12,415.0	68.8%	72,175	33,130.0	45.9%

\*Only 5/8 areas reported in June

The number of new FP acceptors by method for MOH and IGSS was measured (Table 7 and 8). Both tables show an increase in the amount of new acceptors by institution and by method.

**Table 7: Number of new acceptors by method and year, MOH & IGSS, 2003**

FP Method	MOH		IGSS	
	Q1	Q2	Q1	Q2
Depo Provera	48,547	20,646	3,414	3,457
Condom	6,953	3,376	1,414	1,586
IUD	773	612	534	569
Norplant	-	-	87	82
Oral Contraceptives	12,030	5,049	541	613
AQV-male	9	17	93	66
AQV-female	2,472	1,673	1,191	1,262
Total New Users	70,764	31,373	7,274	7,635

\*Only 9/26 areas reported in June

**Table 8: Number of new acceptors by method and year, MOH & IGSS combined, 2003**

FP Method	2003
Depo Provera	76,064
Condom	13,329
IUD	2,488
Norplant	169
Oral pills	18,233
AQV male	185
AQV female	4,379
Total CYPs	114,847

### **Integrated Child Health-Immunization Coverage**

During the second quarter of 2003, Clinical IMCI component activities focused on: 1) the design and application of the established collaborative methodology by Health Area teams, and 2) the monitoring of IMCI implementation.

The activities carried out under the IMCI collaborative learning included:

- Analysis of the results of the evaluation of the initial stage of IMCI and the identification of the processes to be improved
- Definition of relevant indicators for improving the quality of care in IMCI
- Organization and identification of tasks to be undertaken by the collaborative teams
- Establishment of the district and inter-district teams and national coordinating team. There are two district teams per health area, made up of staff from the district health center: doctor, professional nurse and the person responsible for IEC in the center. The inter-district team consists of the IMCI coordinators of the 8 areas listed in the *Convenio*. The national coordinating team is comprised of the SIAS Director, the USME/URGE coordinator, the IRA Program Coordinator, the AIEPI AINM-C Coordinator, the Coordinator for *Salud Integral de Niñez y Adolescencia* (Integrated Child and Youth Health), a technician from Promotion and Education for Health (PROEDUSA), the Development Coordinator for Health Services, UPS1 and UPS2 Coordinators, the Head of IMCI in the PNSR, and the IMCI Coordinator for *Calidad en Salud*.
- Meeting with national coordinating team to submit proposal and obtain approval for implementation of the collaborative learning approach
- Launching of the first collaborative learning session with area and district collaborative teams June 9-13. This first learning session was attended by representatives of two districts from each of the 8 Health Areas of the *Convenio*, with the exception of Ixil, which was represented by 3 districts. Participating areas were Chimaltenango, Sololá, Quiché, Ixil, Quetzaltenango, Totonicapán, San Marcos and Huehuetenango.
- Follow-up coordination meetings with MSPAS/SIAS on June 17 and June 21

The activities carried out related to monitoring the IMCI implementation included:

- Continuation of the *tutorías* and the monitoring of activities related to clinical IMCI component. From these activities it was discovered that of the 143 providers who received *tutorías*, 54% of health post

assistants, 69% of health center assistants, 76% of professional nurses and 89% of health center doctors adequately apply the strategy.

- Site visits (as part of the *tutorías*) were conducted to 59 health posts. 32 posts (55%) had all the basic medicines required for IMCI, as did 27 health centers (55%).
- Evaluation of the supply of IMCI clinical support materials in the 108 services visited for *tutoría* from April to June 2003. Of the 59 health posts visited, 31 of them (63%) had all IMCI clinical support materials; likewise, 32 (65%) of the 49 health centers had all the clinical support materials.

Other activities conducted under the Clinical IMCI component during this quarter included:

- Support for and participation in planning activities for the vaccination campaign conducted during the *Semana Latinoamericana de la Salud*, June 2-7
- Logistical support for the mobilization of vaccines and MSPAS personnel during the vaccination campaign

### **Micronutrients**

- Coordination, funding and development of the official launching activity on May 9 for the three new technical norms updated by PROSAN (Weekly Supplementation of Iron and Folic Acid, Monthly Growth Monitoring and Promotion (GMP) and Breastfeeding Friendly Service Initiative), as well as the production and distribution of technical brochures regarding these norms and a back-up CD
- Coordination with Dr. Fernando Viteri, an international micronutrient advisor, to technically strengthen PROSAN in its ability to respond to reactions to the new norm regarding Weekly Supplementation of Iron and Folic Acid
- Support to PROSAN for evaluating activities related to “Women’s Health Month”, preparing for “World Breastfeeding Week”, and follow-up to the implementation of the Breastfeeding Friendly Service Initiative
- Incorporation of the new technical norms in the training of 9,685 members of the PEC basic health team

### **AIEPI AINM-C Integrated Case Management (AA-MC)**

- 727 members of the basic health teams from the eight DAS were trained, including new staff of PEC providers and administrators (MAs, EAs, FIs and FCs)
- Standardization of the content of training materials and job aids, including some aspects of balanced counseling (*consejería balanceada*) and the use of the verbal test (*prueba verbal*) for ruling out pregnancy
- The *Unidad Ejecutora* has now taken responsibility for the reproduction of the women and children’s registration sheets (*hojas de registro de mujer y de niñez*), referral forms and advise flyers for sick children (*hojas de consejos para niña o niño enfermo*) in order to ensure that members of the basic health team will have these tools available for use in the future
- Monitoring indicators for the AIEPI AINM-C strategy were established through teamwork process

### **OR on AEC-PS**

- Institutionalization of the AEC-PS variant through the official opening of the provision of services in the three jurisdictions involved and the programming of additional funds to ensure continuity of the services once research has been finalized
- Meetings for coordination, information and evaluation at the central level (USAID, SIAS, UPS1, *Pro Redes* and *Calidad en Salud*), at area and district levels

- Development of community maps and census in the 59 communities of the three jurisdictions participating in the operations research on AEC-PS
- Training of trainers in modules I and II of Promotion and Prevention (PP)
- Training of 18 FCs and 400 VSs in Module I of PP (growth monitoring)
- First growth monitoring sessions of children under two were held by 400 VS
- Agreement between *Pro Redes*, UPS1 and *Calidad en Salud* on the monitoring indicators for the operations research

## 1.2. Result 2: Improve Household Health Practices

- Excellent coordination was achieved with FRONTIERS/Population Council to develop and conduct initial training of trainers (TOT) in balanced family planning counseling, including the final development, printing and distribution of the new algorithm, the TOT guide, training materials, and handouts for participants. Packages distributed to date total 1,538 for TOT's at the Health Area level and for the replicas. FRONTIERS (Irma Ramos from Perú) and members of the *Calidad en Salud* IEC/CCC directly participated in the training of 64 trainers including the FAs from 8 priority Health Areas, the ATRs and nurses responsible for family planning. The cost of printing was covered by FRONTIERS through the AMMG. Health provider trainers and health providers participating in the cascade replica trainings are receiving copies of the new algorithm. By the end of the year, it is anticipated that all health providers involved in FP will be using the balanced counseling method and algorithm.
- Most AIEPI AINM-C Promotion and Prevention IEC materials were printed and 12,463 bags with IEC materials for *vigilantes de salud* have been distributed during training. All of the 12,463 bags have been sent to either the IEC coordinator or the extension of coverage coordinator in each Health Area, who subsequently decide who receives the materials and when. Distribution to NGOs is based on training dates.
- Coordination with the *Unidad Ejecutora* allowed for the printing of extra quantities of IEC FP, IMCI and AIEPI AINM-C materials needed to effectively implement strategies. Approximately \$162,152 (US) were dedicated by the UE.
- Coordination with GTI-IEC member organizations has led several of them to print materials together with *Calidad en Salud*. (To date, *Pro Redes Salud* has printed approximately 3,600 sets of laminas, Merci Corps 25 sets, Fundazúcar 25 sets; CRS 700 sets of *láminas* and *vigilante* notebooks. Save the Children, HOPE and CARE had printed before and are using "old" sets of *láminas*. IEC members are also ordering flipcharts.)
- Monitoring of AIEPI AINM-C training and of *vigilantes'* performance in initial GMP sessions at the community level has been conducted in Huehuetenango, Quetzaltenango, Sololá and San Marcos. The Ixil OR instruments have proven useful for this purpose.
- The IEC/BCC team has started a round of monitoring in 30 selected health services facilities, which includes an in-depth interview with the IEC Health Area and District Coordinators, observation of the presence and use of IEC materials, observation of IMCI and FP counseling, and interviews with users as they exit services to check on counseling and the distribution of IEC materials.
- To support the re-launching of the IUD strategy the IUD flyer and radio spots were distributed. 400 cassettes with radio spots were distributed to all health districts throughout the country, and the flyers also went to all areas and were used in May during the Women's Health Fairs.

- The main achievement for IGSS was technical assistance and training provided to the new Chief of the IEC/BCC Health Communication Section, Ana Isabel Arévalo, that was established within the Communications Directorate of this institution on January 23, 2003.
- Technical assistance was also provided to IGSS for the development of a poster dealing with FP after an obstetric event, and an infant and child feeding guide.

### **1.3. Result 3: MCH and NGOs are Better Managed**

#### **Logistics**

- Continued training in logistics administration
- Finalizing the development of the logistics manuals for IGSS
- Continued implementation of simplified computerized logistics information modules for the MSPAS and IGSS
- Implementation of technical support field visits to the logistics personnel from the DAS
- Continuing activities that form part of a contraceptive security initiative in Guatemala
- Linking with other organizations and units within the MSPAS, such as FNUAP, HIV/AIDS, UPS1, SIGSA-SUI, and the POLICY project

#### **Monitoring and Evaluation**

- Development of the provision of services and logistics modules of SAMIG was completed and are now in the process of being tested
- Agreement and approval by MSPAS counterparts to test 34 indicators of monitoring and evaluation was achieved
- Testing of the flow of information for the AIEPI AINM-C monitoring system has begun
- Initiation to reactivate the use of the *sala situacional* as a forum to discuss the main health problems and how to resolve them was reactivated
- Preliminary report for the baseline of the *Investigación Operativa* (IO) was finalized and submitted
- Support to develop a cost study proposal of the IO was provided

#### **Planning and Programming**

*Calidad en Salud* and the *Unidad Ejecutora*, together with the *Programa Nacional de Salud Reproductiva* (PNSR) and the *Dirección de Regulación, Vigilancia y Control de Salud* of the MSPAS, have worked towards implementation of the 2003 *Convenio* plan with the MSPAS programs. The purpose of the plan is to institutionalize the future actions of the strategic plan of 2000-2003 and the extension plan of 2002-2004.

With the help of an international consultant, *Calidad en Salud* prepared a plan to strengthen the managerial capacity of staff of the 8 priority Health Areas, with a focus on quality in the Health Districts. The goal of the plan is to better understand the current managerial capacity and to then identify the areas which require strengthening the most, such as: planning for appropriate decision making; use of programming tools; increased understanding of administrative procedures; improved management processes; increased cost awareness; and, the ability to generate and make use of resources.

To date, implementation of the *Programación Operativa Anual* (POA) 2003 in the Health Areas has been completed with varying degrees of success according to the technical, programmatic and financial guidelines of the Reproductive Health Unit components in family planning, clinical and community AIEPI-AINMC and the various support systems (IEC/CC, logistics, planning, supervision, monitoring and financial-administrative).

- *Calidad en Salud* and the *Unidad Ejecutora* have provided follow-up of the POAs of the first and second quarter of 2003, involving the PNSR in the review of technical and financial actions implemented, focusing on the eight Health Areas of the seven departments of the western *altiplano*
- *Calidad en Salud*, the *Unidad Ejecutora* and PNSR held meetings with the Strategic Planning Unit of the MSPAS, in order to integrate the components of the *Convenio* into a central, health area planning operation
- *Calidad en Salud* developed a proposal to support the UPE and general management and to offer support for improving the planning and budgeting processes. The proposal was developed into two stages: 1) preparation of a draft *Programación Operativa Anual* (POA), including the budget for 2004, 2) development of the whole process with the hopes of getting it approved by 2004, by designing the health plan for 2004-2008, and the POA and budget for 2005 and subsequent years
- Technical and financial performance in the Quiche, Ixil, Chimaltenango and Huehuetenango Health Areas was monitored to evaluate performance in implementation of the actions of each component at the district and hospital levels

#### **Supevision – Facilitation**

- Consuelo Juárez, a consultant from EngenderHealth, provided a short term technical assistance in May 2003 to improve the institutional supervision system and to improve the design of a community level system
- Version of the institutional supervision system was finalized
- Community level supervision proposal was prepared

#### **Finance and Administration**

- Allocation of government funds in the amount of Q. 661,276 to UNFPA to administer and manage funds for the purchase of a variety of contraceptive methods
- Visits to eight Health Areas to review supporting documentation on expenses incurred with counterpart funds
- Definition of the technical norms needed to design and establish an intranet accounting system together with the UE

### **1.4. Result 4: Community Participation and Empowerment**

#### **Community Participation Model**

- Development of the follow-up plan for the strengthening of community participation within the AIEPI AINM-C strategy in coordination with the corresponding technical units of the MSPAS, UPS1 and PROEDUSA.
- Training of 7,845 VVs and 600 FCs in Module 1 of AIEPI AINM-C training manual that includes the four-step community participation methodology.

- Provision of technical assistance to the AIEPI AINM-C training team in the Ixil Health Area in the four-step community participation methodology, given that this Area had not yet conducted the training. The focus was in the role of community participation in the analysis of growth monitoring data.

#### **AIEPI AINM-C Promotion and Prevention (AA-PP)**

- Training of 7,845 *vigilantes de salud* (VSs) and 600 community facilitators (FCs) in Module I (Monitoring and Promotion [GMP]) of the Promotion and Prevention Component of the AIEPI AINM-C Training Manual
- Execution of tutorial monitoring to improve the performance of trainers in health areas, districts and provider NGOs
- Interinstitutional coordination so that the training nucleus – including Area, District and NGOs key staff - monitor performance of community personnel using a tutorial approach
- Interinstitutional coordination for review and definition of indicators and goals
- Review of tools for supervision-facilitation
- Testing and design of the community volunteer’s Training Manual (VS and FC)
- Distribution of training and IEC materials
- Refresher training in the use of the methodological training guide for VS and FC and in the use of the GPM MEW table to train groups in the health areas, districts and provider NGOs

### **1.5. Result 5: Increased Use of MCH Services by IGSS**

#### **Family Planning**

- 67% of the services offer natural methods as new options for spacing pregnancies
- Strengthening of the programs for contraception following an obstetrics intervention was started in four IGSS hospitals
- 24 resident doctors from the postgraduate *Gineco Obstetricia* program were trained in counseling and use of the guidelines and provision of services manual
- Seven *tutorías* were implemented in various care facilities to improve and increase the provision of services
- Together with the University of Georgetown and EngenderHealth, visits were made to observe progress in the offering of natural methods and in offering male sexual and reproductive health

#### **IMCI**

- The IMCI *Cuadros de Procedimientos* Manual was approved as the official guidelines for pediatric care within IGSS
- 87% of services providers of childcare were trained in the application of the IMCI strategy
- 77% of community level service providers in Suchitupéquez comply with the technical guidelines
- 99 new members of staff in Escuintla and Suchitupéquez, as well as students from the IGSS nursing school, were trained in the application of the strategy

- The basic training package for the implementation of community-IMCI was prepared

## **IEC**

- 100% of services have IEC materials in family planning, and 75 percent have IMCI materials
- The following Manuals were officially delivered to IGSS management: “*Normas y Procedimientos de Logística de Anticonceptivos del IGSS*” and “*Marco Conceptual para el Sistema de Administración Logística de Anticonceptivos del IGSS*”
- The family planning guidelines manual was printed; distribution to management levels and care facilities was also started
- 20,000 cards for follow-up of family planning services users were reprinted and distributed
- Final artwork of the poster for promotion of contraceptive methods following an obstetrics intervention was prepared and approved

## **Support Systems**

- IGSS made its first payment for contraceptive methods (condoms and oral contraceptives) to the FNUAP
- The steps needed to design and schedule the module to analyze logistics information on contraceptives was finalized
- Projected procurements of contraceptives methods were submitted to the management and technical normative levels of IGSS, with an emphasis on the benefits of a continuous and well managed family planning program
- 53 social workers and Maternal-Child Health (MCH) supervision staff were trained in supervision-facilitation and the subject was introduced to 41 management and technical normative staff, with the technical support of consultant Consuelo Juárez
- The three MCH doctors were trained in the use of the contraceptive procurement tables and the Pipeline tool

## 2. MSPAS RESULTS

### 2.1. Result 1: Increase in the Use of Mother and Child Health Services provided by the MSPAS and its Partner NGOs

- Community Health Agents Provide Quality Care
- Health Facilities Provide Quality Maternal Child Health Services
- Innovative Approaches for Improving the Quality and Coverage of Maternal Child Health Services are Adopted

#### 2.1.1. Family Planning Results

The following is a summary of monitoring results including couple years protection (CYP) and new acceptors of family planning (FP) methods both nationwide and in the eight priority areas.

##### CYPs Nationwide and in 8 Priority Areas

Overall, 45.2% of the target for CYPs in the second quarter of 2003 has been achieved (Table 9), 43.9% for the MOH and 48.7% for IGSS. The MOH's cumulative percentage for CYPs is -6.1 percentage points below/above the goal, while IGSS is -1.3 percentage points below its goal at 48.7%.

The total amount of CYPs is less than projected due to a persistent delay to provide in time information; we expect to get over the goal when all areas provide information to SIGSA.

During the second quarter of 2003, the PNSR and *Calidad en Salud* (CS) worked together to introduce a comprehensive package of AQV services in the health centers, health posts and hospitals. The increased access to AQV services will ensure that those who are in need receive services and that follow-up of treatment is enforced.

**Table 9: Number of CYPs nationwide by target achieved, MOH & IGSS, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
Total	97,519	96,221.32	98.7%	97,519	7,9963.1	82.0%	390,076	176,184.4	45.2%
MOH *	72,519	72,088.32	99.4%	72,519	55,374.1	76.4%	290,076	127,462.4	43.9%
IGSS	25,000	24,133	96.5%	25,000	24,589.0	98.4%	100,000	48,722.0	48.7%

\*Only 9/26 areas reported in June

##### In the 8 Priority Areas

46.8% of the annual target has already been achieved at the end of the second quarter (Table 10). The increase in CYPs in the 8 priority areas is related to improved promotion and availability of FP methods in health centers and posts. The CYPs for the MOH accounts for acceptance of injectables (56%).

**Table 10: Number of CYPs in 8 priority areas by target achieved, MOH, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
MOH *	23089.283	23,689.71	102.6%	23089.283	19,569.72	84.8%	92357.1	43,259.4	46.8%

\*Only 5/8 areas reported in June

The number of CYPs by method for MOH in the 8 priority areas also was measured (Table 11) 56% of CYPs came from injectables, followed by female AQV acceptance. Also it shows a small increase in IUD from 956 CYPs in first quarter to 1,008 in second quarter. This result was preliminary and could change when all data are available.

**Table 11: Number of CYPs in 8 priority areas by method, MOH, 2003**

FP Method	MOH		Total
	Q1	Q2	
Depo Provera	12,470.3	10,909.5	23,379.8
Condom	819.0	698.7	1,517.63
IUD	955.5	1,008.0	1,963.5
Oral pills	777.0	606.6	1,383.6
AQV male	0	44.0	44
AQV female	8,668.0	6,303.0	14,971.4
Total CYPs	23,689.7	19,569.7	43,259.4

This report includes preliminary data; only 9 of 26 MOH areas have been reported June to SIGSA. The number of CYPs by method for MOH and IGSS nationwide was measured (Table 12). The 50.3% is accounted for acceptance of injectables, followed by AQV-female acceptance (33%). Even these are preliminary data shows a small increase in IUD for both institutions.

**Table 12: Number of CYPs by method, MOH & IGSS, 2003**

FP Method	MOH		IGSS	
	Q1	Q2	Q1	Q2
Depo Provera	34,572.0	27,873.8	5,624	5,475.0
Condom	3,159.0	2,614.6	1,215	1,175.0
IUD	3,398.5	3,549.0	1,869	1,992.0
Norplant	-	-	305	287
Oral Contraceptives	3,535.8	2,746.7	841	919
AQV-male	99.0	187	1,023	726
AQV- female	27,324.0	18,403.0	13,101	13,882
Total CYPs	72,088.3	55,374.0	23,978	24,456

## New FP Acceptors Nationwide and in 8 Priority Areas

Nationwide, the goal for new FP acceptors was 44.7% (Table 13). Nationally, some 66.2% of new acceptors prefer Depo Provera nationwide, and 51.6% in the eight priority areas. The MOH is at -6.1% of its target while IGSS is at +0.5% of its target.

**Table 13: New FP acceptors nationwide provided by the MOH and IGSS, second quarter, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
Total	65,604	78,171	119.2%	65,604	39,109.0	59.6%	262,416	117,280.0	44.7%
MOH *	58,104	70,764	121.8%	58,104	31,373.0	54.0%	232,416	102,137.0	43.9%
IGSS	7,500	7,407	98.8%	7,500	7,736.0	103.1%	30,000	15,143.0	50.5%

\*Only 9/26 areas reported in June

In the 8 priority areas, the MOH exceeded its new acceptor goal by 4.1% (Table 14). The number of new acceptors will continue to increase during 2003 as the community level component of family planning is rolled-out and IUD support and hospital services are advanced.

**Table 14: Number of new acceptors in 8 priority areas by target and actually achieved, MOH, 2003**

	Quarter 1			Quarter 2			Total		
	Target	Achieved	%	Target	Achieved	%	Annual Target	Achieved	%
MOH *	18,044	20,715	114.8%	18,044	12,415.0	68.8%	72,175	33,130.0	45.9%

\*Only 5/8 areas reported in June

The number of new FP acceptors by method for MOH and IGSS was measured (Table 15 and 16). Both tables show an increase in the amount of new acceptors by institution and by method.

**Table 15: Number of new acceptors by method and year, MOH & IGSS, 2003**

FP Method	MOH		IGSS	
	Q1	Q2	Q1	Q2
Depo Provera	48,547	20,646	3,414	3,457
Condom	6,953	3,376	1,414	1,586
IUD	773	612	534	569
Norplant	-	-	87	82
Oral Contraceptives	12,030	5,049	541	613
AQV-male	9	17	93	66
AQV-female	2,472	1,673	1,191	1,262
Total New Users	70,764	31,373	7,274	7,635

\*Only 9/26 areas reported in June

**Table 16: Number of new acceptors by method and year, MOH & IGSS combined, 2003**

<b>FP Method</b>	<b>2003</b>
Depo Provera	76,064
Condom	13,329
IUD	2,488
Norplant	169
Oral pills	18,233
AQV male	185
AQV female	4,379
Total CYPs	114,847

In the second quarter of 2003 considerable progress was made in family planning (FP), especially in support of the FP norms in service provision. A comprehensive counseling strategy was developed and is being implemented throughout the national health network, in close collaboration with and the support of the Population Council. The delivery of surgical equipment to health centers and posts, particularly for IUDs, was improved. Finally, with the strengthening of the logistics component, the supply of contraceptives was improved.

#### **Organization of Reproductive Health and Family Planning**

During the second quarter of 2003, the Minister of Health announced the 2002 DHS results that reflect a tremendous increase in access to FP services during the last three years. The announcement was followed by a message from the Minister encouraging all MOH personnel to continue working towards the provision of mother and child health services throughout Guatemala, particularly focusing on the 8 priority health areas. The current strategies are intended to improve workforce performance, and to increase the right of all Guatemalans to use family planning services through an improved scheme of integrated referrals from community-level facilities to hospitals.

#### **Ongoing Technical Assistance to the PNSR**

*Calidad en Salud* FP staff continued to provide organizational and management assistance related to planning next year's FP client centered program that will include: management based on accurate information, team building; and updating AQV norms, referral systems, promotional strategies and mass media messages; the transfer of methodologies; and projections of needed supplies.

#### **Performance Monitoring of Trained Family Planning Providers**

During the second quarter of 2003, *Calidad en Salud* provided technical assistance and support to assess the performance of trainers who provide family planning services. An evaluation of the trainers was conducted, observing three types of family planning services in particular: child health, pre-natal and post-partum. The data collected will be taken into consideration in revising and improving future training plans, contents, materials, and methodologies. *Calidad en Salud* will continue to collect data during all of 2003, to monitor improvements in compliance with new FP norms. This assessment will be compared to the same evaluation of last year's compliance with new FP norms. The gathering of preliminary data was recently completed. Once the statistics are calculated, FP advisors will have more information, upon which to base future FP decisions. Results will be included in the next quarterly report.

## Norms and Guidelines

On June 18, 2003, the new FP guidelines were launched. The new guidelines include: improved methods to less medical barriers, increased access to FP methods, and, valuable information on logistics and information systems.

During this quarter, *Calidad en Salud* provided technical assistance to develop a set of documents to regulate FP service provisions for teenagers and women over 35 years of age. The documents were reviewed by a technical committee and are in the process of being modified and approved by the decision-making personnel from the MOH and PNSR. A document on the AQP National System was completed during this quarter and an AQP Compliance Surveillance and an FP Provision Handbook (mini-guide) including post abortion and post partum guidelines, are in the process of being edited and formatted.

## Training (See Annex C)

Personnel were trained in service delivery improvement, focusing on early detection of illness and management of side effects, technical support for immediate delivery of the method of choice and FP tools. During this year, professional health trainers will be ready to coach community health providers in the new counseling methodology, developed in close coordination between *Calidad en Salud's* FP and IEC/BCC teams and the Population Council, based on Operations Research conducted by the Population Council. (See Result 2 for additional discussion.) Also, FP promoters will begin to provide user-friendly guides to manage FP programs at the district level, encouraging the use of local statistics and to immediately address the needs at the community level.

A total of 269 health professionals and community health workers were trained in FP related topics (34 physicians, 98 auxiliary nurses, 59 nurses and 78 others). A trainer's (facilitator) guide for FP post partum and post abortion services, and a mini-guide for the provision of FP services were produced and are currently being edited and formatted to eventually for publication.

During this quarter, in-service training in the delivery of FP services was provided to staff from 20 hospitals, 37 health centers and 36 health posts.

During the XXXI *Congreso Nacional de Ginecología y Obstetricia* of Guatemala, *Calidad en Salud* provided support to 30 physicians and 6 nurses to participate in the conference. *Calidad en Salud* also supported the *Congreso Nacional de Residentes de Ginecología y Obstetricia* in Quetzaltenango, in which some 35 ob-gyn residents from the southwest region participated. Two of *Calidad en Salud's* technical advisors spoke on the importance of the participation of adolescents and men in reproductive health. The presentations of the two lecturers were well received and generated many questions and comments.

AQV: Eight physicians and 12 nurses were trained to provide comprehensive FP services and a female sterilization program at the local level. The training methodology consisted of *tutoría* (tutorials), utilized in two hospitals (Coatepeque and Quetzaltenango). Staff at twenty hospitals received follow up tutorial training on AQV.

IUD: 150 auxiliary nurses from 7 health areas (Alta Verapáz, Baja Verapáz, Ixcán, Suchitepéquez, Retalhuleu, Petén and Guatemala), have been trained in IUD insertion.

Balanced Counseling Strategy (*Consejería Balanceada*): 65 medical students in their final year of education from the University of San Carlos located in Guatemala City were trained in the new balanced approach to FP counseling. An agreement was signed to guarantee follow-up on activities at the sites where the students are doing their practice during the course of the year. (See Result 2 for additional discussion.)

In coordination with the Population Council, who provided job aids, algorithms and cards to improve client oriented (*Consejería Balanceada*) comprehensive FP information, 251 professionals nurses, TSRs and auxiliary nurses were trained as trainers (TOT). The trained cadre of professionals will replicate the course nationwide starting in July.

## **Increasing Access to IUD Strategy**

IUD insertion rates have increased, especially in the priority health areas in Guatemala where the number of IUD insertions increased from 56 in January to 124 in April. With new equipment and IUD insertions done by auxiliary nurses, an increase of 5% in IUD insertion rates has been witnessed from December 2002 to May 2003. The new strategy will be supported by a radio advertisement campaign and by promotional leaflets, especially designed for Mayan and Ladino populations.

## **Applying Quality Assurance Methods: Improving Client Satisfaction**

During the second quarter, *Calidad en Salud* provided technical assistance and support to design a quality improvement strategy in order to provide better FP services to the entire country. The first step to improving quality assurance was to conduct a client survey to learn more about what clients perceive of the services that they receive. The results of the survey will be utilized as a preliminary assessment of client satisfaction that the MOH and PNSR will use to help in the development of an improved quality assurance strategy. The gathering of data was recently finished and once the statistics are generated, FP promoters will have new and improved information to help in decision making. An update of the strategy will be included in the next quarterly report.

## **Teenager's Clinic at San Juan de Dios Hospital**

*Calidad en Salud* continues to provide technical assistance and support to running a teenager's clinic at *San Juan de Dios* Hospital that opened in January. The clinic provides FP services for teenagers age 10-19. A professional team runs the clinic. The number of patients that attended the clinic during the second quarter was 1,316. The most commonly attended health problems included: first menstruation problems (440 cases), *vulvovaginitis* (263 cases), *dermatitis* (200 cases) and UTI (150 cases). *Calidad en Salud*, in coordination with PNSR, is developing a set of norms to provide FP methods at the clinic. During the second quarter, the clinic provided FP services to teens ages 12-19. The clinic reported 34 new acceptors of FP methods (13 of injectables, 9 of condoms, 9 of oral pills and 3 of Copper T).

## **Equipment for Family Planning During 2003 (second quarter)**

*Calidad en Salud* provided 2 IUD insertion kits to San Felipe Retalhuleu, Escuintla, Palín; and 4 AQV surgical kits to Cobán Hospital (2), Huehuetenango Hospital (1) and San Pedro Necta District Hospital (1).

Some auxiliary equipment such as "Goose Neck Lamps", sterilization pots, small propane stoves, transport stretchers and oscillating fans were donated to 5 hospitals, 21 health centers and two health posts (see annex E, Equipment Delivery). These donations were made to improve the capability of the FP services provision units to answer the increase in demand for family planning services created by radio promotion and by the training of health personnel in interpersonal communication and counseling for FP promotion.

End User Monitoring (See Annex E): *Calidad en Salud* developed a survey of the 14 health areas, 14 Hospitals and 58 Health centers. The results of the survey show that almost all the donated equipment is in place. In one case where it was not, *Calidad en Salud* personnel immediately reported the situation to the Health Area Director in order to take the necessary actions to solve the problem. The next time equipment is delivered, it will be better documented using incoming inventory and personnel responsibility cards. During June 2003, the SIAS Director sent a memo ordering all Health Areas to provide a complete set of documentation acknowledging receipt of the donated equipment.

*Calidad en Salud* is still assigning equipment during this quarter.

## Limitations

- The FP Program of the MSPAS needs to be strengthened in order to improve the management of FP activities. At the present time, most FP activities rely on technical assistance provided by *Calidad en Salud*.
- Leadership for the FP component of reproductive health has not been stable since the launching of the PNSR; the PNSR requires strong political and management support in order to ensure that funds are properly allocated and that the national reproductive health program is well structured and capable of delivering services to meet a growing demand. Lack of human resources devoted at the central and local levels to family planning services has caused serious threat to the continuation of a smoothly running FP program.
- Although substantial improvements are being made in the logistics system, low stocks of contraceptives at the lower level facilities continue to be a barrier for new acceptors (Depo-Provera & Copper T).
- The gathering and data processing of the MOH-SIGSA information system need to be fully revised in order to provide accurate and up-to-date information for decision-making.
- Some medical and paramedical personnel have strong religious and personal beliefs against the use of family planning services; as a result, medical barriers continue to exist making it difficult for Guatemalans, especially women, to access services (e.g. consent needed from husbands to use AQVs, Copper T not given to unmarried women).

### 2.1.2. Child Health (Clinical IMCI) Results

The focus of the clinical IMCI component during this quarter includes two activities:

- Design and application of the collaborative methodology by Health Area teams
- Monitoring IMCI implementation.

Details of these two activities are given below.

#### I. Application of the Collaborative Methodology by Health Area Teams

Having evaluated the initial stage of IMCI and *tutorías* conducted by trained staff, a gap in the quality of care IMCI-related services has been identified, and is summarized below:

- 36% of trained staff received *tutorías*
- 25% of trained staff do not comply with the four care processes
- 20% of staff do not evaluate the four general signs of danger
- 50% do not carry out all procedures for evaluating prevalent illnesses
- 30% do not classify or treat adequately according to IMCI standards
- 45% do not carry out integrated counseling.
- As for services, 28% lack the medicines which are crucial for IMCI
- 50% of mothers fail to remember recommendations regarding medicines, food, liquids and when to return to the health service centers for follow-up on treatment

Given these results, the MSPAS, with the support of *Calidad en Salud*, proposed to strengthen the process for implementation of the strategy by applying a Collaborative Learning Process. A Collaborative Learning Process methodology was designed, with the technical support of URC's Quality Assurance Project (QAP), working in close collaboration with the IMCI Advisor and the Director of *Calidad en Salud*. An initial Collaborative workshop was held with 64 participants, between June 9-13, with follow-up coordination meeting with SIAS on June 17, June 24 (and July 23).

The characteristics of the process are explained in further detail below.

### **1. Aims of the Collaborative Learning Process:**

- To reduce child mortality
- To increase the satisfaction of families using IMCI services

### **2. Objectives of the Collaborative Learning Process**

#### *General Objectives*

The general objectives of the Collaborative Learning Process are:

- To improve the quality of IMCI implementation through the formation of collaborative teams and the application of collaborative methods
- To analyze the care process within the services and to better organize these services

#### *Specific Objectives*

The specific objectives of the Collaborative Learning Process are:

- To improve the performance of health providers of child care using the IMCI algorithm
- To transfer the use of improvement tools and changes for decision making to national, inter-district and district collaborative teams, using information in an environment that promotes team spirit
- To document changes in indicators of the set of processes to be improved for IMCI implementation
- To develop a strategy for communicating achievements

### **3. Working Methodology of the Collaborative Teams**

The purpose of collaborative learning is to achieve the adaptation and dissemination of knowledge throughout Guatemala emphasizing the eight priority areas, with three main objectives:

- Dramatic improvement in the quality of care and expected results in a short amount of time
- Sharing of strategies for services improvement between teams participating in the collaborative learning
- Planning to extend the new learning process to other districts in Guatemala outside of the 8 priority areas listed in the *Convenio*

Generally, between 15 and 20 improvement teams will be set up in different geographical areas to work on the same issue or problem. These teams will share their experiences, achievements, difficulties and lessons learned in a continuous manner, without the need for central coordination.

The period of collaborative learning will be divided into three or four learning sessions, each lasting for two days, where participants will receive the theoretical and practical knowledge necessary for improving performance in their areas. In each session, teams will report on their improvement activities, methods used, results and lessons learned. The training encourages rapid learning, allows for institutional support and creates stimulation to further change and improve current processes and practices.

There will be a space of two months, called the “action period” (*período de acción*), between each learning session during which the teams will be in their working areas implementing improvements. It is at this time that the process of change will take place with the application of the 4 steps on how to improve clinical IMCI implementation: planning, execution, field testing and action.

One very important aspect for the successful implementation of the strategy is to organize the necessary support for frequent communications between all the improvement teams and between the teams and the coordinating group in order to share experiences and results during the *período de acción*. Several means of communication will be used for this, including phone, fax, email and observation visits between the teams.

Once the plan has been carried out using this collaborative approach, a meeting will be scheduled to share the results with other interested parties who did not initially take part in the pilot strategy.

Those involved in this first collaborative pilot strategy will become agents for change and advisors for the new teams which may decide to implement this strategy in their own working areas.

#### **4. Clinical IMCI and Child Survival**

There are many ways to care for ill children, from the time they become sick at home until they are referred to a health service center. Initial care is generally given in the home, followed by the mother or guardian seeking care from a health provider. This may begin within the community, looking for either private or public informal services, and ending with referral to formal health services, such as health posts, health centers or hospitals. Given the important role played by the many providers along the “road to child survival”, a decision has been made that the collaborating teams will become familiar with each of the steps along the way.

#### **5. Identification of Processes and Indicators to be Improved**

Three care processes and 8 indicators for children between the ages of 1 week and 2 months, and 8 indicators for children between the ages of 2 months and five years were developed

##### **Process I: Every child under 5 years of age receives integrated care according to the IMCI algorithm**

##### **Component for Evaluation of Signs and Symptoms of Prevalent Childhood Illness**

##### **Indicators for General Danger Signs**

1. % of children between the age of 1 week and 2 months who were assessed on the registration sheet showing signs of possible serious bacterial infection
2. % of children between the ages of 2 months and five years who were assessed on the registration sheet showing general danger signs

##### **Indicators for General Danger Signs, Treatment and Referral**

3. % of children between the age of 1 week and 2 months with a possible serious bacterial infection who received adequate treatment prior to referral
4. % of children between the ages of 2 months and five years showing general danger signs who received adequate treatment prior to referral

### **Indicators for Food and Nutrition**

5. % of children between the age of 1 week and 2 months evaluated for problems with food and/or low weight
6. % of children between the ages of 2 months and 2 years whose food and nutritional status were assessed

### **Indicators for Classification of Prevalent Childhood Illness**

7. % of children between the age of 1 week and 2 months for whom according to correct evaluation all classifications were adequately carried out
8. % of children between the ages of 2 months and five years for whom according to correct evaluation all classifications were adequately carried out

### **Indicators for Treatment of Prevalent Childhood Illness**

9. % of children between the age of 1 week and 2 months who did NOT require antibiotics according to classification but WERE nevertheless prescribed it
10. % of children between the ages of 2 months and 5 years who did NOT require antibiotics according to classification but WERE nevertheless prescribed it
11. % of children between the age of 1 week and 2 months who were identified as requiring BCG and received it
12. % of children between the ages of 2 months and 5 years who were assessed as to what immunizations were required and received them

## **Process II: Registration Sheets for Children Under Five Contain Complete and Adequate Information**

### **Indicators for Adequate Completion of Registration Sheets**

13. % of children between the age of 1 week and 2 months whose registration sheets are fully and correctly filled in
14. % of children between the ages of 2 months and 5 years whose registration sheets are fully and correctly filled in

## **Process III: Every Child under Five Who is Prescribed Medicine Receives it at the Health Service**

### **Indicators for Compliance with Medicine Delivery**

15. % of children between the age of 1 week and 2 months who required antibiotics, were prescribed antibiotics, but did NOT receive them
16. % of children between the ages of 2 months and 5 years who required antibiotics, were prescribed antibiotics, but did NOT receive them

## **6. Organization and Tasks of the Collaborative Teams:**

The district and inter-district teams and national coordinating team were established during this quarter. There are two district teams per health area, made up of staff from the district health center: doctor, professional nurse and the person responsible for IEC in the center. The inter-district team consists of the IMCI coordinators of the 8 areas listed in the *Convenio*. The national coordinating team is comprised of the SIAS Director, the USME/URGE coordinator, the IRA Program Coordinator, the AIEPI AINM-C Coordinator, the Coordinator for *Salud Integral de Niñez y Adolescencia* (Integrated Child and Youth Health), a technician from Promotion and Education for Health (PROEDUSA), the Development Coordinator for Health Services, UPS1 and UPS2 Coordinators, the Head of IMCI in the PNSR, and the IMCI Coordinator for *Calidad en Salud*.

The district collaborative teams were chosen using the following criteria: 1) desire to participate, 2) possession of extension of coverage/Ability to extend coverage, 3) non-participant in the San Marcos operations research, 4) currently receiving *tutoría*, 5) high rate of morbidity and mortality from prevalent childhood illnesses.

The main tasks of the collaborative teams include the follows:

- **District Teams:** improvement of the indicators for the processes identified, documentation of changes achieved and activities carried out, analysis of information, decision making and exchange of information with other participating teams both within and outside their own health area
- **Inter-district Teams:** technical support for the district collaborative teams for improvement of indicators. They are the link between the district team and the national coordinating team
- **National Coordinating Team:** leadership, training, and support to the districts for analysis and decision making for improving indicators in the processes identified

## **7. Meeting with the National Coordination Team**

A workshop presentation to executive staff of the MSPAS on the Quality Assurance (QA) Institutionalization Plan to strengthen health services was held in May. The Director of the SIAS, the Director of the *Regulación, Vigilancia y Control para la Salud*, the technical coordinator for *Programas de Atención a las Personas*, the IMCI national coordinator, the Development Coordinator for health services, the UPS1, 2 and 3 coordinators, the USME coordinator, the director for reproductive health and a representative from MSPAS human resources were present. The MSPAS authorities approved implementation of the plan, including the collaborative methodology, and the national coordination team was established, its members defining the processes and indicators to be improved in clinical IMCI.

## **8. Collaborative Learning Sessions**

After a consensus was reached by the national coordinating team regarding the package of processes and indicators to be improved, four collaborative learning sessions were defined. The first session focused on the socializing and agreement of the following elements of the method with the inter-district and district teams: i) the package of processes and indicators to be improved, ii) establishing a base line, iii) work to be carried out during the *periodo de acción*, iv) documentation of improvements achieved, and v) commitment to provide continuity and take part in the next learning session. The second and third learning sessions focused on sharing experiences with all the districts, strengthening QA, programming continuous monitoring, attending the third learning session, and using the methodology to make better use of information. The fourth session will serve to evaluate achievements, consolidate learning, to expand to other districts and to share the success of this pilot strategy.

### **First Learning Session of the Collaborative Learning Process**

This first learning session was held between June 9 and June 13, attended by representative of each of two districts from each of the 8 Health Areas of the *Convenio*, with the exception of Ixil, which was represented by 3 districts. Participating areas were Chimaltenango, Sololá, Quiché, Ixil, Quetzaltenango, Totonicapán, San Marcos and Huehuetenango. The following table shows the districts that made up the collaborative teams in each of the eight health areas.

**Table 17: Districts with collaborative teams per health area**

<b>Health areas</b>	<b>Participating Districts per Health Area</b>
Chimaltenango	Poquíl
	Comalapa
Sololá	Sololá
	Santa Lucía Utatlán
Quiché	Chichicastenango
	Chicamán
Ixil	Nebaj
	Cotzal
	Chapul
Quetzaltenango	San Martín
	Coatepeque
Totonicapán	Totonicapán
	San Cristóbal
San Marcos	Tejutla
	Tacaná
Huehuetenango	Barillas
	Aguacatán

The MSPAS had a total of 64 participants, represented by the IMCI Area coordinators, doctors, professional nurses and personnel responsible for IEC in the health center of each district, the national technical coordinator for AIEPI AINM-C and 12 participants from *Calidad en Salud*.

Matters discussed related to quality, clinical IMCI and collaborative learning. A commitment to participate in the measurement and improvement of the indicators was made by district representatives. It was also agreed that the same staff attending the first session would participate in the second session.

#### **Follow-up of the First Session and Preparation of the Second Learning Session**

Communications between the districts were tested using the list of phone numbers supplied by the eight priority health areas. All the districts also received the final draft of processes and indicators to be improved. Telephone monitoring was carried out with the districts to answer questions, and direct visits were scheduled to the districts prior to the second collaborative learning session, which is scheduled for July 29-30, 2003.

## **II. Monitoring of IMCI Implementation**

In the second quarter of 2003 institutional clinical IMCI has continued with *tutorías* and monitoring activities. Results related to performance, supply of medicines and clinical support materials are detailed below.

## **Staff Performance**

From April to June 2003, a *tutoría* was implemented to work with 143 health providers from health posts and health centers, of which 59 were *auxiliares de puestos*, 49 *auxiliares de centros*, 18 *médicos de centros* and 17 professional nurses.

Of the 143 providers who received the *tutorías*, 54% of *auxiliares de puestos*, 69% of *auxiliares de centro*, 76% of professional nurses and 89% of health center doctors apply the strategy correctly.

## **Supply of Medicines**

Supply of basic IMCI medicines was evaluated in the 108 services visited for *tutoría* from April to June 2003. Of the 59 health posts visited, 32 of them (55%) had all basic IMCI medicines; as did 27 health centers (55%).

## **Clinical Support Materials**

Supply of IMCI clinical support materials was evaluated in the 108 services visited for *tutoría* from April to June 2003. Of the 59 health posts visited, 31 of them (63%) had all IMCI clinical support materials; likewise, 32 (65%) of the 49 health centers had all the clinical support materials.

Additional vaccination related activities conducted under the Clinical IMCI component included:

- Support for and participation in planning activities for the vaccination campaign conducted during the *Semana Latinoamericana de la Salud*, June 2-7
- Logistical support for the mobilization of vaccines and MSPAS personnel during the vaccination campaign

Unfortunately, data related to national vaccination coverage was not made available to *Calidad en Salud* by MSPAS in time to include in this quarterly report. A summary table will be prepared and submitted to USAID.

## **Limitations**

### **IMCI Collaborative Teams**

One of the major limitations relates to communications considering that a majority of the districts have access to phone facilities, but not to fax or email. Communications for sending information will be by phone to the districts and by phone, fax and email to the health areas.

### **2.1.3. AIEPI AINM-C Case Management (AA-MIC) Results**

The Integrated Case Management (MIC) component of the AIEPI-AINM-C strategy contributes directly to the achievement of Result One, which is defined as increase in use of Maternal Child Health (MCH) services. This component provides the basic health teams ((MAs or EAs, FIs and FCs) working in the community centers with the tools needed to integrate, standardize and improve quality management of the cases they attend. The two main population groups accessing the services include: women of reproductive age and children under five. (See additional discussion of the AIEPI AINM-C strategy under Results 2 and 4.)

This component is closely linked to health promotion and prevention of illnesses, as well as community participation, given that both are essential in order to achieve the overall objectives:

- To decrease mother and child mortality and morbidity
- To ensure that serious cases are referred to the proper care level

The main results of this component in the second quarter of 2003 include:

- Standardization of all training materials and job-aids, including certain aspects of *consejería balanceada* on family planning
- Continuation of the training process of FAs, FCs and new staff from health service providers and administrators (MAs and EAs) in the 8 Health Areas
- Participation in the process of defining indicators for the AIEPI AINM-C strategy
- Coordination of funding by the Unidad Ejecutora of part of the reproduction of the *hojas de registro de mujer y de niñez*, the *hoja de consejos para la niña o niño enfermo*, growth cards (carnets), and referral forms (*boletas de referencia*)

### **Institutionalization**

The process for institutionalizing the MIC component was strengthened in the second quarter in the following manner:

- Counterpart funds from each DAS were used to carry out training in Integrated Case Management of FC
- Officialization by UPS1 of the norms for technical coordination of the AIEPI AINM-C strategy, and the form for collecting information on the current situation of Integrated Case Management (MIC)
- Use of counterpart funds by the *Unidad Ejecutora*, to reproduce the *hojas de registro*, *carnets*, and *boletas de referencia* and *hojas de consejos para la niña y niño enfermo* which are required for the extension of coverage in the 8 DAS.

### **Planning and Coordination**

Regarding planning and coordination, the following results were achieved: a) adaptation of training and counseling materials to include basic aspects of balanced FP counseling, with the help of *Pro Redes*; b) design and testing in the Ixil area of the form and instructions for gathering information relating to the current situation of Integrated Case Management, together with *Facilitadores de Area*, *Facilitadores del primer nivel*, UPS1, logistics components, family planning, IEC and the normative technical coordinator of the strategy and c) strengthening of coordination with FAs and *Facilitadores del primer nivel*, receiving and providing feedback to improve MIC processes at the local level.

### **Materials**

During the second quarter of this year work was done on various aspects of the MIC materials, the most significant including the following: a) modification of the input algorithm, the *hoja de registro* and the protocol for integrated case management of women, including a *prueba verbal* for ruling out pregnancy prior to offering further family planning services; b) delivery to the *Unidad Ejecutora* of the latest version of the MIC registration sheets for their reproduction; c) distribution of 1000 sets of MIC training materials to the 8 DAS, for training of FC and new staff and d) delivery of 4500 *hojas de registro de niñez* and 4500 *hojas de registro de mujer*, as well as instruments for monitoring the current situation of MIC in the community centers participating in the operations research study (OR) in San Marcos.

### **Equipment**

Delivery to the *Direcciones de Área de Salud* (DAS) of hand-held lamps for throat examination bearing the MIC logo was completed. Distribution has coincided with the number of *Facilitadores Comunitarios* being trained as MIC providers. A total of 1,023 lamps have been delivered in this quarter.

## **Training (See Annex C)**

The training of *Facilitadores Comunitarios* as MIC providers continued during this quarter in the eight *Direcciones de Área de Salud* (DAS). Given that some providers or administrators of the NGOs changed, new staff including MA, EA, and FI also had to be trained. A total of 727 health providers were trained in this period, including FCs (524), MAs and EAs (104) and FIs (93).

### **Tutoría Following Training**

In order to strengthen performance of trained staff, a proposal was prepared to adapt the *tutoría* instruments following the MIC training. This proposal will cover integrated case management of both children and women was submitted to the normative technical coordinator of the strategy.

Consensus was achieved on what instruments to use for monitoring MIC. A follow-up training visit, however, was made to the Ixil area together with UPS1, and as a result, a number of important issues were identified: 1) MAs in the Ixil are not performing Integrated Case Management because they are working under Cuban funds, 2) all necessary medicines were not available in community centers throughout the area, although there was sufficient supply of FP methods, and 3) all the classifications noted on the registration sheets were not being registered on the SIGSAS 3 P/S nor were all the medicines being dispensed were being reported.

In view of the above, the 24 MA working under Cuban support were trained and two agreements were reached: 1) the methodology and jobs aids for Integrated Case Management would be used and, 2) *tutorías* would be given to FCs. Likewise, the UPS1 representative took all of the necessary actions to improve the situation.

Through follow-up activities carried out by the central level AIEPI AINM-C team with the area training teams, it has been found that there are certain aspects which must be addressed in order to improve the implementation of MIC, including the following: a) lack of *hojas de registro*; b) lack of medicine supplies; c) inadequate *tutorías* by the DAS on how to replicate training and, d) inadequate use of the training guide by some of the trainers. Certain measures have already been taken to address these issues, such as the reproduction of the *hojas de registro* with funds from the *Unidad Ejecutora*, and coordination with the logistics team for support in the supply of medicines.

### **Monitoring and Supervision**

The AIEPI AINM-C team continued to build consensus in defining monitoring indicators for the strategy (see Result 3). The instrument and instructions for gathering information on the current situation of Integrated Case Management were designed with technical support from *Calidad en Salud*'s logistics, family planning and IEC teams, *Facilitadores de Área* and *Facilitadores del primer nivel* in close collaboration with UPS1 and the normative technical coordinator of the strategy. The instrument was tested together with UPS1, adjustments were made and the form was then made official. This instrument will be used by *Facilitadores de Área* and *Facilitadores del primer nivel* to assist them in coordinating the gathering information. The measuring unit is the community center. Information will be gathered during the month of July.

### **Limitations for AIEPI AINM-C Integrated Case Management (AA-MIC)**

- The changes to the materials for interpersonal communications and counseling have resulted in a delay in the final design for care protocols, both for children and for women
- The technical normative coordination team for the strategy has not yet evaluated the proposal for the modified *tutoría* instruments following training, and these have therefore not been applied as of yet
- The DAS teams are not using the monitoring tool in a systematic way to replicate training, and thus not all activities have been documented
- The changes in health service providers and administrators have meant a delay in implementation of the MIC component, since new staff has had to be trained.

- New NGOs contracted by the MOH have not yet received their initial funding, so provision of services has not yet begun
- Seven out of the 8 DAS did not comply with the programs and plans contained in the POA regarding reproduction of the *hojas de registro de niñez y de mujer*, making it difficult for MIC to be implemented
- The agreement between APROFAM and MSPAS whereby FP methods would be handed over to extension of coverage NGOs is not functioning properly; therefore there is a lack of supply of FP methods in some community centers

#### 2.1.4. Micronutrients Results

During the second quarter of the year, work was done systematically, together with the *Programa de Seguridad Alimentaria y Nutricional* (PROSAN), to officially adopt and to begin implementation of the three service delivery norms: Weekly Supplementation of Iron and Folic Acid, Monthly Growth Monitoring and Promotion (GMP) and Breastfeeding Friendly Service Initiative. The outcomes of work implemented during this quarter include:

- Organization, funding and development of the official activity of socialization of the norms
- Preparation, together with IEC, of a proposal regarding content, design, diagrams and reproduction of three technical brochures and a CD containing the technical basis for the norms
- Coordination with Dr. Fernando Viteri to technically strengthen PROSAN in its ability to respond to negative reactions to the new norm on Weekly Supplementation of Iron and Folic Acid
- Coordination with the monitoring and evaluation component to include information to SIGSA related to the new norms

#### **Institutionalization**

During the second quarter the institutionalization process was strengthened with the official adoption of the three new norms on May 9, 2003. In this respect, PROSAN has organized and supported, with other funds, local activities in order to integrate the new norms in those DAS which are not part of the USAID *Convenio*. Likewise, the UPS3 has included in its objectives support for the implementation of the Breastfeeding Friendly Services Initiative and Weekly Supplementation in hospitals.

#### **Planning and Coordination**

During the second quarter of 2003, the outcomes of planning and coordination in the micronutrient component were aimed at achieving official adoption and implementation of the new norms of Weekly Supplementation of Iron and Folic Acid, Monthly Growth Monitoring and Promotion (GMP) and Breastfeeding Friendly Service Initiative.

Results include:

- Inter-institutional coordination for integration of the norms with the *Programa de Seguridad Alimentaria y Nutricional* (PROSAN), the *Secretaría Presidencial de la Mujer* (Presidential Secretariat for Women) and the Division for Social Communication of the Ministry of Health. This was the first “scientific” activity within the official program of the “Women’s Health Month” (May) with the theme “*Mejorando la Salud y Nutrición de la Mujer de Hoy y del Mañana*” (Improving the Health and Nutrition of Women Today and in the Future). There were more than 200 participants, with representatives from the 26 *Direcciones de Área de Salud* and 38 hospitals that specialize in Maternal Child Health (MCH) care, as well as institutions that work with women, donor agencies and other institutions

- Support for PROSAN in the evaluation of the “Women’s Health Month” and preparation for the upcoming “World Breastfeeding Week”, the theme of which will be “Breastfeeding and World Globalization”. The new norms will be integrated into this activity as well.
- Technical assistance to UPS3 and PROSAN to develop the follow-up plan for the Breastfeeding Friendly Service Initiative.
- Coordination with Dr. Viteri to technically strengthen PROSAN in its ability to respond to negative reactions to the norm on Weekly Supplementation of Iron and Folic Acid

## **Materials**

In regards to the materials for the micronutrients component, the following outcomes were achieved in this quarter: preparation, reproduction and distribution of 2000 technical brochures on the new norms; reproduction and delivery to the UPS3 of 40 copies of the self-evaluation form for Baby Friendly Hospitals, and production of a CD with all the presentations made in connection with the activity of fully integrating the new norms, i.e. the technical basis of each and the norm itself.

## **Training (See Annex C)**

The contents of the three new norms have been included in the training materials for the AIEPI AINM-C strategy, both for integrated case management and for promotion and prevention. During this quarter a total of 9,685 members of the PEC basic health team were trained in the new norms. (See strategy trainings result 1 and result 4).

## **Limitations for Micronutrients**

- In some health areas and some community centers there is a lack of availability of iron and folic acid for implementing the new norm of Weekly Supplementation, since no funds have been available for purchasing these medicines
- Proper registration of Weekly Supplementation of Iron and Folic Acid in children under five and women of reproductive age is currently not possible through SIGSA.
- The MSPAS lacks the necessary funding to provide follow-up on the Breastfeeding Friendly Service Initiative norm.

### **2.1.5. OR on AEC-PS Results**

The following is a description of results and on-going plans for the *Calidad en Salud* supported operations research on the Extension of Coverage Model of the Population Assigned to Health Posts (AEC-PS) or “*Extendiendo la Cobertura de Salud y Nutrición a través de la Prestación de Servicios Comunitarios en Guatemala*”. The purpose of the study is to test and compare the relative costs and effectiveness of three extension of coverage models: AEC-*Puesto Salud* (new model being tested), AEC-ONG (*Pro Redes*), and PEC-ONG (SIAS).

## **Results**

One of the main results is the institutionalization of the AEC-PS variant, carried out by the ministerial office, which officially opened the variant simultaneously in the three jurisdictions, with the participation of local health authorities, the municipalities and community staff. The necessary arrangements were also made so that the provision of services could be guaranteed in the year 2004 with counterpart funds, once research is finalized.

## **Staffing**

The local operations research facilitator (LORF) resides in San Marcos and works directly with the local area, district and jurisdiction health staff.

## **Timeline**

The work plan has been adjusted accordingly with the following requirements:

- Finalizing the sketch and census of the 56 communities in the three AEC-PS jurisdictions
- Carrying out a *tutoría* for the first growth monitoring of children to be taken by the VS
- Reaching agreements on indicators for services production with *Pro Redes*, *Calidad en Salud* and UPS1
- Defining a methodology for a cost study

## **Communication**

Communication is of vital importance for obtaining the support of all those involved in the operations research. As a result, the following activities have been implemented:

- 12 meetings at the district level, with the technical team of the districts and staff from the institutional EBS; this has allowed progress to be evaluated and necessary adjustments to be made in the implementation of the AEC-PS
- Weekly meetings with the DAS technical team from San Marcos which is supporting implementation of the variant
- Presentation to the DAS teams of Quetzaltenango and Totonicapán of the variant of the extension of coverage model being implemented in San Marcos, with emphasis on the importance of support from these DAS in providing the necessary information for the operations research
- Weekly meetings with the *Calidad en Salud* team to coordinate support for the various components of the operations research
- Monthly meeting with UPS1 staff, to provide them with information on progress in the implementation of the variant of the model and of the OR study
- Meeting with the *Equipo Técnico* of the operation research (ETIO) to present progress on implementation and receive relevant feedback (only one out of the three meetings planned was held)
- Second meeting of the *Comité Técnico Asesor* (CTA) of the operations research, where it was agreed that each participating institution would circulate instructions that staff representing them in the ETIO should attend the monthly meetings starting July 14. The next meeting of this committee is scheduled for September 16, 2003

## **Operational Activities**

The Extension of Coverage Model of the Population Assigned to Health Posts (AEC-PS) variant was officially launched on June 4, 2003 in three health districts of the department of San Marcos: San Marcos, San Pedro Sacatepéquez and San Pablo. These simultaneous events boasted the participation of municipal and community authorities, staff from the Ministry of Health (at the district, area and central levels) as well as enthusiastic members of the new ambulatory teams for health services provision (professional nurses, assistant nurses, institutional

facilitators, community facilitators and more than 400 VS). The main implementation activities for this variant implemented in the quarter include:

### **Training activities**

- Training of 6 VS trainers in Module I and II of PP
- Training of 18 FC and 400 VS, in 22 different groups, on the following subjects: integration of the basic health team, community mapping and census, and Module I of PP (growth monitoring)

### **Tutoría activities**

- The EA were established in each jurisdiction to implement *tutorías* at the health post level to FC and to identify and “condition” (or physically prepare) the community centers (CC) with the help of deputy mayors and families from the community.
  - San Antonio Sacatepéquez: 7 FC received *tutorías* and 14 CC are already functioning
  - San Cristóbal Cucho: 6 FC received *tutorías* and 12 CC are already functioning
  - San Pablo: 6 FC received *tutorías* and 10 CC are already functioning

### **Provision of Services**

- The FI and managers organized to support the FC and VS in the preparation of the sketch and census for each sector and for consolidation of the 59 communities in the three jurisdictions. This activity was finished in June
- The first growth monitoring of children by VS was implemented in June with support of the FC, FI and managers
- The EA are carrying out MIC and supporting the VS in their respective areas in the preparation and consolidation of the sketch and census

### **Investigation Component**

The investigation component is comprised of three activities: baseline survey, monitoring, and comparative cost study. The Local Researcher is directly responsible for the component, with support from the Principal Investigator, Operations Research Manager and local consultants.

Baseline Survey (3 variants): The output tables for the first draft of the baseline report were prepared and the results presented to the CTA for the OR study. A program has been prepared to socialize the results at the central level and for each DAS.

Monitoring: Agreements have been reached with *Pro Redes* and UPS1 on indicators, frequency, sources and gathering tools. Training meetings have been set for the coming quarter in the three DAS (Quetzaltenango, Totonicapán and San Marcos), on the use of the tool for gathering information on the PEC-ONG.

Cost-effectiveness Study of 3 Variants: The principal investigator developed the methodology for the cost study and prepared the terms of reference for the recruitment of an economic expert on local health. The aim of the study is to provide information on the relative costs of the three variants of the extension of coverage model in order to come up with a standard package of services. The study will include: measurement of the cost of providing the services on a monthly basis and measurement of the managing units on a quarterly basis. The comparative analysis of the 3 variants will be carried out on a cost per capita basis, cost per service provided and cost for the standard package of services.

## OR Budget

Regarding the budget, an increase of Q. 200,000 was obtained from counterpart funds to cover the costs of training for the AEC-PS variant. Furthermore, Q. 450,000 were allocated to cover operating costs for the three jurisdictions from April to December 2004.

A review of the budget will be carried out with *Pro Redes*, UPS1 and UE in July in order to make similar adjustment made to the results of the census carried out by the VS, since some of the communities have a much larger population than was estimated.

## Limitations

There are several limitations in implementing the OR study:

- The OR study is dependent upon materials, equipment and funds from the UE, MSPAS/DAS and *Calidad en Salud*. If there are delays in receiving these inputs, then the OR study is delayed. For example, the DAS in San Marcos has not paid local staff and has not repaired motorcycles required for the transportation of EA and FI. On the other hand, the OR study has the advantage of not being directly responsible for producing training, IEC, supervision, and logistics materials.
- The Principal Investigator is off-site and spends limited time in Guatemala. There is not enough in-country time allocated to afford a thorough knowledge of what is happening, what's working and what's not working. Consequently, it is difficult to address and solve outstanding problems with the Operations Research Manager and other *Calidad en Salud* staff.

## 2.2. Result 2: Adoption of Health Practices within the Home which Favor Child Survival and Reproductive Health

- Increased capacity of the MSPAS and its partner NGOs to design, plan, implement and evaluate behavior change interventions
- Improved health practices in the home through behavioral change interventions

### 2.2.1. Summary of IEC/BCC Objectives and Strategies

Result 2 corresponds with the IEC/BCC support system of *Calidad en Salud*, with two major objectives, one at the MSPAS and partner NGO central level and the other at the operative (Health Area, health services and community) level. The first objective, to increase the capacity of the MSPAS to design, plan, implement and evaluate behavior change interventions, focuses on institutionalizing a strategic multimedia approach to communication interventions for health and health-related behavior change. Although some progress has been made, meeting this objective will probably not be fully attained in 2003. During this quarter, *Calidad en Salud's* IEC/BCC team has continued to work closely with two specific communication-related units, various programs of the MSPAS, and through an inter-institutional and inter-agency group known as the GTI-IEC<sup>1</sup>, providing technical assistance, administrative coordination and financial support for the development of IEC materials and the execution of strategies. The GTI-IEC has met monthly during the second quarter of 2003 for planning and reviewing materials under production as

<sup>1</sup> GTI-IEC members include the Communication Unit, and the Promotion and Health Education Department of the MSPAS, other MSPAS programs as needed, *Unidad Ejecutora*, ADEJUC/ Promasa, American Red Cross, APROFAM, CARE, Celsam, CRS, *Cruz Roja Guatemalteca*, HOPE, IGSS, JHPIEGO/ MNH, Population Council, *Pro Redes Salud*, Save the Children, SHARE, UNICEF and *Calidad en Salud*.

well as user's guides. Finally, technical assistance to PROEDUSA, to PROSAN for the production of new norms regarding iron and folic acid supplementation, growth monitoring and baby-friendly services, and to the National Immunization Program (PNI) for its 2003 promotion plan, required that *Calidad en Salud* IEC/BCC team also work individually with these MSPAS programs.

The second objective, improved health knowledge, attitudes and practices of women of reproductive age and mothers of children less than 5 years in the home through behavior change interventions, is being addressed through technical assistance to the MSPAS in the design and execution of three inter-related IEC/BCC strategies for family planning, IMCI and, especially, AIEPI AINM-C (which combines two distinct components - integrated case management and promotion and prevention). Through the GTI-IEC, *Calidad en Salud* is also influencing the programmatic focus of its member organizations. At the institutional level the IEC/BCC strategies for FP and IMCI focus on improving interpersonal and intercultural communication and counseling (IPC/C) between providers and users in hospitals, health centers, health posts and community centers. These IEC/BCC strategies also support national campaigns scheduled by the MSPAS and special events during international and national celebrations, such as the International Breastfeeding Week in August. The community promotion and prevention component of the AIEPI AINM-C strategy is based on all six IEC/BCC tactics that have been developed under *Calidad en Salud*'s integrated communication strategy: 1) mass media (radio), 2) IPC/C between community providers and caregivers during both growth monitoring and promotion (GMP) sessions and home visits, 3) group communication during group and community sessions, 4) special campaigns designed and scheduled by the MSPAS, but requiring local adaptation, 5) educational entertainment during local events and festivities, and 6) community mobilization and participation linked to *Calidad en Salud* Result 4. These IEC/BCC sub-strategies or tactics have been described in detail in manuals and previous reports.

One of the main achievements for this quarter was the excellent coordination achieved with FRONTIERS/ the Population Council to develop and conduct initial training of trainers (TOT) in balanced family planning counseling, including the final development, printing and distribution of the new algorithm, the TOT guide, training materials, and handouts for participants. Packages distributed to date total 1,538 for TOT's at the Health Area level and for the replicas (see Result 1 and training annex on family planning).

Most Promotion and Prevention AIEPI AINM-C IEC materials were printed and 12,463 bags with IEC materials (first set of counseling cards, *vigilante*'s notebook, recall leaflets, and child card) for *vigilantes de salud* have been distributed to Health Areas IEC or Coverage Extension Coordinators, who have distributed them NGOs; 7,845 have been distributed to *vigilantes* during training. Good coordination with the *Unidad Ejecutora* has allowed for the printing of extra quantities of IEC FP, IMCI and AIEPI AINM-C materials needed to effectively implement strategies. Also coordination with GTI-IEC member organizations has led several of them to print materials together with *Calidad en Salud*.

The IEC/BCC advisor has participated in monitoring of AIEPI AINM-C training and of *vigilantes*' performance in initial GMP sessions at the community level and has emphasized the inclusion of the community participation methodology within the AIEPI AINM-C strategy. The IEC/BCC team has started a round of monitoring in 30 selected health services, which includes an in-depth interview with the IEC Health Area and District Coordinators, observation of the presence and use of IEC materials, observation of IMCI and FP counseling, and interviews with users as they exit services to check on counseling and the distribution of IEC materials. Finally, to support the re-launching of the IUD strategy the IUD flyer and radio spots were distributed and used in May during the Women's Health Fairs.

Under the IEC/BCC component of Result 5, the main achievement for IGSS was technical assistance and training provided to the new Chief of the IEC/BCC Health Communication Section that was established within the Communications Directorate of this institution. Tutoring and monitoring revealed that 75 percent of IGSS maternal-and-child health services have IEC IMCI materials. Technical assistance was provided for the development of a poster dealing with FP after an obstetric event, and an infant and child feeding guide.

## 2.2.2. General IEC/BCC Capacity Building

### General

During the second quarter of 2003, the IEC/BCC team worked closely with all MSPAS counterparts to follow-up on the proposal to establish a Communications for Social and Behavioral Change Unit within the MSPAS, that could breach the gap between the Social Communication and Public Relations Unit presently in charge of public relations and mass media and the Department of Health Promotion and Education (PROEDUSA) mostly focusing on community organization and participation through Municipalities. This is proving very difficult to attain and will probably not be completed this year. As mentioned in the previous report, PROEDUSA had started to independently train IEC Health Area Coordinators in a strategy known as “Municipalities for Development” (formerly “Municipalities for Health and Peace”), which involves the IEC Area and District Coordinators working with a newly legalized structure of Municipal Councils, Municipal Planning Offices (formerly, Municipal technical units), Municipal Health Commissions (health is one of nine commissions), and Health Action Groups (*Grupos de Acción en Salud* or GAS).

A strategy to incorporate *Calidad en Salud* IEC/BCC approach into PROEDUSA’s training program proved successful. *Calidad en Salud* IEC/BCC team provided technical assistance to PROEDUSA to include the IEC/BCC process and community participation methodology in the inter-institutional one-day workshops being held with Health District and Municipality teams in all 26 Health Areas. Specifically, *Calidad en Salud* designed three (of five) training sessions to deal with teamwork as a quality principle, behavior change communication (BCC) and the 4-step community participation methodology (activation, assessment, analysis and action). For the BCC session, *Calidad en Salud* has prepared, as it were, communication plans a la carte, which are simplified three-page communication plans on different health problems (e.g. low vaccination rates, dengue, high incidence of diarrhea or respiratory infections, low use of public health services/ family planning, high rates of child malnutrition) that health commissions within Municipalities can pull out according to epidemiological profiles and to conduct health communication activities as part of Municipal efforts to tackle these problems. Samples of IEC audio and printed materials available are also being provided to Municipalities.

Although, *Calidad en Salud* would have preferred to provide assistance only at the central level, PROEDUSA required the *Calidad en Salud* Director to sign an agreement to insure that the IEC/BCC team would conduct actual training of inter-institutional teams. Therefore, the IEC/BCC team has had to conduct direct training in Zacapa, Chiquimula, Quiché, Huehuetenango, and Baja Verapáz. These training activities have significantly altered IEC/BCC work plan, delayed the completion of several products, and increased the number of IEC materials required to cover these audiences.

Together with the Social Communication Unit, *Calidad en Salud* IEC/BCC team revised and finished the policy for modifying and reprinting of IEC materials and progress has been made towards finalizing the IEC Area Coordinator’s functions manual. *Calidad en Salud* IEC/BCC team also participated in planning meetings with the MSPAS units and programs, such as the Health Services Provision Units 1 (UPS1), the National Reproductive Health Program, the National Immunization Program (PNI), and the Nutrition and Food Security Program (PROSAN) to review IEC FP and AIEPI AINM-C materials and obtain their approval before printing.

Technical assistance was provided to several programs in the MSPAS for the preparation of IEC strategies and materials. The PNI was assisted in the design of its promotion plan for 2003, including the dummy of a vaccination flyer; while the Social Communication Unit received assistance to develop a brochure on dengue and malaria. Assistance was also provided to PROSAN in preparing three booklets on new norms regarding: 1) iron and folic acid supplementation, 2) monthly growth monitoring at the community level (including the use of the minimum weight gain table) and 3) breastfeeding-friendly maternal and child health services (based on the revitalization of the joint WHO/UNICEF baby-friendly hospitals initiative). The IEC/BCC component was in charge of developing the growth monitoring booklet, conducting extensive editing of the other two booklets, taking photographs included in each booklet, laying out the booklets, and generally overseeing the production and distribution process. Two thousand of each type of brochures was printed. *Calidad en Salud* participated in the launching of the new norms on

May 9, 2003, which included a presentation of the GMP Operations Research as the technical basis of the new growth-monitoring norm.

As mentioned, the FP and AIEPI AINM-C sub-groups of GTI-IEC continued with monthly, or more frequent, meetings during this quarter. New printed material for FP and AIEPI AINM-C and the design for new materials and strategies were presented and individual technical advice was given to several members of GTI-IEC: to APROVIME/ Population Council for the design of an IUD poster with the steps to conduct insertion, to the Population Council regarding a flip chart to be used by midwives to advise men on increasing their participation in reproductive health, and to the JHPIEGO/MNH project regarding the community emergency plan booklet and four radio spots. One new issue of the GTI-IEC Actual newsletter was put out during this quarter summarizing new evidence on the 3-5 years interval between births and quantitative and qualitative research on this recommendation. Implications for IEC/BCC activities, messages and materials were discussed. Coordination with *Pro Redes Salud* and USAID NGO partners continued, especially for the printing and use of the AIEPI AINM-C materials.

The GTI-IEC decided that as part of the development process of the adolescents' reproductive health communication strategy, it will organize and hold a fair of the Health and Education Ministries' programs and NGOs projects that have worked or are presently working in adolescent reproductive health. PASMO (Panamerican Social Marketing Organization), with experience in adolescent project in Honduras and elsewhere in Latin America, has joined the GTI-IEC for the adolescent reproductive health IEC strategy development process. The GTI-IEC will develop a list of criteria for the inclusion of projects in this fair, and consider the exhibition of all their training and IEC materials. The MSPAS Social Communication Unit will be in charge of officially convening adolescent programs and projects. The expected product will be the identification of "best practices" and "lessons learned" in IEC/BCC to influence adolescent reproductive health practices, including the identification of quality training and IEC materials that the GTI-IEC could modify and/or reproduce and use. The fair is scheduled for August 12, which is Adolescents' Day. The *Calidad en Salud* IEC team has been leading the work of the GTI-IEC in the analysis phase of strategy development (collecting documents, reports, and inventorying materials), but increasingly the Social Communication Unit and SINA (the Integrated Child and Adolescent Health) program of the MSPAS are taking the lead. Also, there are international organizations such as PASMO, the American Red Cross and Save the Children who have plans and funds to conduct projects in adolescent reproductive health. In addition, to completing the set of 10 FP methods brochures, a new one on abstinence has been drafted and will be presented to the GTI-IEC..

As in previous years, *Calidad en Salud* IEC component has offered University students in Guatemala and abroad the possibility to conduct supervised practices or thesis in topics of interest to the project. This summer two Emory University School of Public Health students are conducting their practices on a) the men's involvement in reproductive health and b) balanced family planning counseling leading to selection of IUD, respectively. The Population Council and *Calidad en Salud* are conducting supervision jointly, since both students are working within the former ongoing research projects. A graphic arts student of the Rafael Landívar University conducted her thesis with assistance from the IEC/BCC team on the revision and analysis of child cards that have been or are being used in Guatemala. This revision was useful in the design of the new child card.

The IEC/BCC Advisor is participating as a facilitator of a distance education course on Health Communication organized by the Guatemalan Nutritionist Association (ANDEGUAT). The course is based on the Academy for Educational Development (AED) Manual "A Tool Box for Building Health Communication Capacity" and is leading 150 health and communication professionals (including several of the new Health Areas IEC Coordinators in Sololá, Quetzaltenango, San Marcos and Ixil, two of them sponsored by individuals in *Calidad en Salud*) through the process of designing a health communication strategy. Seven lessons requiring the presence of participants are being conducted from May through November on a monthly basis (on Saturdays), during the one-month interval between sessions, participant's study and complete exercises in one of six participant's modules. The experience will be useful for the completion of the URC/*Calidad en Salud* manual on Behavior Change Communication and Quality tools.

### **Area and Community Level**

Technical support to MSPAS Area-level staff responsible for health promotion and communication activities through meetings with the IEC Health Area Coordinators has continued this quarter. However, workshops with all

26 IEC Health Area Coordinators and with 8 IEC Health Area Coordinators in eight priority Areas did not take place this quarter. The MSPAS has been reluctant to schedule these workshops due to the IEC Coordinators concentration in the PROEDUSA's Municipality strategy. However, monitoring activities scheduled for the second quarter of 2003 have started with joint (IEC/BCC central and area level) visits to selected health services in Chimaltenango, San Marcos, Huehuetenango, Quiché, and Ixil. Monitoring activities include an in-depth interview with the IEC Health Area and District Coordinator. Observation of IEC materials, FP and IMCI counseling, and exit interview instruments are being used in 30 health services selected based on the sample of the upcoming IEC survey (one service per cluster). Only 27 percent of this sample was visited during June 2003 due to the other activities undertaken by the IEC/BCC team. Furthermore, of eight services visited half of them were closed on the day of the visit, which was unannounced. Therefore, monitoring visits will continue throughout July 2003 and a report will be ready next quarter

The IEC/BCC team has participated in several workshops with IEC District level coordinators as requested by social workers (Area level IEC coordinators). Likewise, the IEC/BCC team has continued to participate in monthly meetings of first-level *Calidad en Salud* facilitators to discuss IEC/BCC accomplishments and future plans, to identify problems and solutions, and to identify successful experiences and original ideas and in monthly ATR (Regional Technical Advisers that focus on FP activities in non-priority health areas) meetings to provide them with standard guidelines regarding the distribution and use of FP materials. Participation of ATRs in PROEDUSA's Municipality strategy in non-priority areas is envisioned during next quarter. Training related to the IEC sub-strategies, activities and materials carried out by the *Calidad en Salud* IEC/BCC team, the IEC Coordinators and the first-level facilitators in the Areas are included in Annex C.

### 2.2.3. Specific IEC/BCC Results for Family Planning

#### **IEC/BCC Strategies and Materials for FP**

The IEC/BCC FP strategy designed at the beginning of the project at the central level has been adapted at area and local levels for its implementation. As mentioned in previous report, the IEC/BCC team had started to work with the GTI-IEC in the preparation of two strategy workshops that were scheduled for the second quarter of 2003: one focusing on increasing male participation in reproductive health and the other on adolescents, specifically abstinence, delaying first sexual relations and avoiding unwanted pregnancies. Due to numerous competing activities by the IEC/BCC team of *Calidad en Salud* and other GTI-IEC members, strategy workshops were not conducted this quarter. However, some advances were made.

Regarding increased male participation, the GTI-IEC is assisting and following closely the Population Council's project in Patzún to train midwives to advice men during prenatal visits. A public health student has been incorporated to review the literature on male participation, conduct interviews and document/ evaluate the midwives training process in Patzún. Also, modifications suggested to a flipchart for men that will be printed by the Population Council were made. To aid in the process of developing the adolescents' reproductive health IEC/BCC strategy, the GTI-IEC will organize and hold a fair of programs and projects working in adolescent reproductive health. The expected product will be the identification of "best practices" and "lessons learned" in communication influencing adolescent reproductive health, including the identification of quality training and IEC materials that the GTI-IEC could modify and/or reproduce. Also, the GTI-IEC will participate in reviewing a brochure on abstinence as a method for delaying the onset of sexual activity in adolescents

One of the most important results under FP/IEC/BCC during this quarter was finalizing the development of the balanced counseling algorithm in coordination with the Population Council/ FRONTIERS and the Female Physicians Association of Guatemala (AMMG) Following *Calidad en Salud* recommendations and further pre-testing of the algorithm, significant modifications were included. In May, 6,000 copies of the algorithm and companion cards were printed. Also, a TOT guide was developed *Calidad en Salud*'s IEC/BCC Advisor, together with the training materials (cards and overheads) and handouts, which are presently being distributed to trainers of the "training cascade". One handout includes a comparison between the 6-step counseling previously promoted (ACCEDA) and the new algorithm, so as to assure providers that the new algorithm makes the ACCEDA framework specific to family planning.

FP IEC/BCC materials in press include the FP flipchart (6,000) to be used in health services nationwide and two FP *sala situacional* posters for graphing the cumulative percentages of contraceptive methods used and new FP users. In support of the IUD re-launching strategy, the IUD promotion flyers – 125,000 for Mayan and 125,000 for Ladino populations – were printed and, together with radio spots, some were distributed as part of the Women’s Health Fairs conducted in May and June.

The production of FP mini-videos - three of them on services and methods offered by the MSPAS and two regarding IPC/C between providers and users- is underway. The last version of the video scripts was produced and the first takes) are being made.

An exhibition of IEC FP materials was set up for the Obstetrics and Gynecology Congress held in May 7 and 8. Congress activities included a presentation on Health Communication for Family Planning, given by *Calidad en Salud*’s IEC/BCC Advisor.

Both *Calidad en Salud* and the *Unidad Ejecutora* are now re-printing the two distinct sets of 10 individual methods FP brochures (200,000 sets of each Mayan and Ladino version for a total of 400,000 sets. This production will insure that there are enough IEC FP materials through the beginning of 2004 and that materials will reach community centers and health workers as part of AIEPI AINM-C strategy.

### **IEC/BCC Training for FP**

During the first week of May, the IEC/BCC team together with FRONTIERS consultant, Irma Ramos, participated in the development of the methodology for the TOT on Balanced FP Counseling. Five physicians from the AMMG also participated in the first week of training. *Calidad en Salud* documented each session of this training and later developed a brief TOT manual to guide trainers in their workshops to guarantee consistency and quality in the replication of training. *Calidad en Salud* also reviewed other training materials and handouts.

Subsequently, between May 12 to 16, *Calidad en Salud* and FRONTIERS conducted two TOT workshops in Quetzaltenango to enable MSPAS, IGSS and *Calidad en Salud*’s field staff to train service providers on the use the balanced counseling strategy. A total of 64 participants were trained including *Calidad en Salud*’s ATRs, FAs, FIs plus central-level MSPAS and IGSS personnel and representatives from 8 Health Areas. During the following four months, workshop participants will in turn train an estimated 6,000 MSPAS and IGSS health providers on the new counseling procedure. The initial training of trainees (64 participants) was paid for by FRONTIERS/Pop Council through AMGG. *Calidad en Salud* is distributing the IEC/counseling material and our FAs and ATRs, who participated in initial course, are conducting TOTs at the areas. Members of *Calidad en Salud*’s IEC team are monitoring trainings in Chimaltenango and San Marcos. This project is a good example of positive inter-institutional collaboration involving USAID CAs - *Calidad en Salud* and FRONTIERS. Although AMMG had originally planned to hire four associated physicians to conduct follow-up trainings, this did not transpire. Consequently, *Calidad en Salud* has taken a major lead role in ensuring that trainings are taking place throughout the country, with the support of four nurses hired by AMMG.

To ensure the full participation of the IEC/BCC component in the balanced counseling training process, the IEC/BCC team has conducted additional training of IEC Area Coordinators (who were not included in the Quetzaltenango workshops) and of GTI-IEC member organizations. To date, *Calidad en Salud* IEC/BCC has distributed 1,538 balanced counseling packages, supported by FRONTIERS through AMMG, including the FP algorithms and cards, TOT guides, training materials and handouts. The rest of the algorithms and accompanying materials will be distributed in the following months. The “Ask me about family planning” buttons produced last quarter are being given to participants, together with a diploma, at the end of the balanced counseling training as the badge of a good FP counselor.

The training for trainers’ manual (TOT) on IPC/C for FP was revised for the last time to include USAID and URC comments (that were pending) and will be printed next quarter. The text of the manual, overheads and handouts will be included in a companion compact disc.

## **IEC/BCC Monitoring and Evaluation for FP**

As planned, the IEC/BCC team has started its first round of monitoring this year in 30 selected health facilities; selection was random in each of 30 clusters drawn for the IEC survey to be conducted next quarter. Monitoring in FP/IEC/BCC includes an in-depth interview with the IEC Health Area Coordinator, observation of presence and use of family planning IEC materials, observation of FP counseling and an exit interview to determine systematic offering of FP services and adequate end-point distribution of materials (for example, brochure of method selected if applicable). A monitoring instrument has been developed by IEC/BCC for the balanced FP counseling, but it will not be used until the training of health personnel is completed. In the mean time, monitoring will continue with the ACCEDA checklist instrument while the new instrument is being pre-tested by an Emory public health student.

### **2.2.4. Specific IEC/BCC Results for IMCI**

#### **IEC/BCC Strategies and Materials for IMCI**

The original IEC/BCC strategy for IMCI was designed (prior to launching AIEPI AINM-C) to address both the institutional component and the original version of the community component of IMCI. The institutional component focuses on strengthening provider client interpersonal communication and counseling (IPC/C) regarding the preparation and administration of medicines, the use of liquids and feeding during illness, as well as danger signs that should prompt re-consultation. Several materials have been developed for use during counseling and as recall for mothers and caretakers, but monitoring at the beginning of this year showed that most health services did not have them.

To improve on the shortage of IMCI IEC materials, after much negotiation with Health Areas and a long administrative process, this quarter the *Unidad Ejecutora* is printing significant additional quantities of IEC IMCI materials programmed with counterpart funds. The materials that are being printed include: 673,000 recall leaflets for the sick child; 312,000 infant and child feeding guides; 292,000 vaccination guides; 2,800 danger signs poster; 2,800 infant and child feeding and weighing posters.

Negotiations between the IEC/BCC team and a private bottled-water company (*Embotelladora Salvavidas*) were initiated, to include the company logo and a message on clean water to prevent illnesses on the vaccination brochure. However, consensus has not been reached between all parties on the inclusion or not of a message on chlorinated water that the bottled water company did not agree with. The printing of the vaccination brochures would be important for the second National Health Week in August, which includes the vaccination campaign. The IEC/BCC team will continue to explore the possibility of obtaining private sponsors for this and other IEC activities and materials.

#### **IEC/BCC Training for IMCI**

During this quarter, *Calidad en Salud* first-level facilitators have conducted refresher training in IPC/C in IMCI in their health areas, mainly with those in charge of IEC at the District level. The *Aconsejar* (Counseling) module of the IMCI training and the WHO/PAHO/UNICEF manual *Conversando con las Madres* are being used in refresher training and tutoring in IEC for IMCI. Training also deals with the appropriate use of the IEC materials, including a flowchart of counseling and group communication activities in services prioritizing audiences for the distribution of materials (for instance, the vaccination guide is given only to mothers of children who are vaccinated for the first time).

An abbreviated training of IEC Health Area Coordinators and *Calidad en Salud* first-level facilitators on the clinical component of IMCI has not been carried out yet, but will be carried out next quarter.

## **IEC/BCC Monitoring and Evaluation for IMCI**

*Calidad en Salud* contributed several monitoring instruments for the past vaccination campaign, including an observation checklist, key-informant interview guides, and an exit-interview guide for mothers leaving the vaccination post. The IEC Health Area Coordinators and *Calidad en Salud* first-level facilitators used these instruments for monitoring during the National Health Week on April 7-13.

As mentioned, monitoring presence and use of IEC IMCI materials, of counseling activities and of mother's recall started to be conducted in the second quarter of 2003 in eight of a sample of 30 health services (27 percent) and will continue during July 2003. Monitoring instruments include an observation check-list of IMCI materials, observation of counseling during child consultation, and exit interviews with mothers/ caretakers, including observation of recall materials given to them.

### **2.2.5. Specific IEC Results for AIEPI AINM-C**

#### **IEC/BCC Strategies and Materials for AIEPI AINM-C**

The IEC/BCC strategy, with its six IEC tactics, is central to the health promotion and illness prevention component of AIEPI AINM-C. Interpersonal communication and counseling is also important in the integrated case management component of AIEPI AINM-C.

The implementation of the advocacy and public relations plan that was prepared last year for the promotion of the AIEPI AINM-C strategy has started with presentation of the AIEPI AINM-C strategy to Municipalities as part of PROEDUSA "Municipalities for Development" strategy. A total of 331 health district-municipal teams of four are scheduled to hear the presentation, totaling 1,324 persons. Activities targeted to other groups, such as the church/religious, the press, private and political sectors, academic organizations and professional associations have not been carried out yet. The need to develop a brochure on AIEPI AINM-C has been identified and it will be drafted in the coming quarter. Also, there is a need to identify communities where the AIEPI AINM-C strategy is operating well for demonstration and for tours or visits of interested groups and mass media.

AIEPI AINM-C Promotion and Prevention counseling cards (now bound in three sets), recall leaflets (nine), referral leaflet, weight-for-age graph poster, growth monitoring *sala situacional* poster, child card and vigilantes notebook have been printed and are being distributed based and preceding training. A total of 12,463 vigilante bags containing the first set of counseling cards on infant and child feeding, the vigilante notebook, a child card, and a set of nine recall leaflets have been distributed to Health Areas to date, 7,845 of which have been distributed to vigilantes being trained. Other materials distributed include: 50,000 referral leaflets and 112,686 child cards (a mean of nine for each vigilante). Materials being distributed are: the second set of counseling cards (illnesses treatment and prevention); danger signs, infant and child feeding, situational room and weight-for-age graph posters; markers; and pins. The third set of counseling cards (maternal and neonatal health and family planning) will be completely printed by the middle of July when distribution starts for training of vigilantes in the third module (maternal and neonatal health and family planning).

The logistics of distributing all the AIEPI AINM-C materials has proven a challenge for the IEC/BCC team. Although detailed distribution lists have been prepared, the lack of personnel specifically devoted to counting, packaging and transporting the materials has been a constraint. Even with external hired help (from Print Studio), the IEC/BCC team has had to fully participate in the process and to conduct inventories of materials in the *Calidad en Salud* warehouse and at the printing company. In addition, the information coming in from Health Areas regarding number of personnel and dates of training has not always been accurate or on time. These problems have been addressed in several meetings and will continue to be discussed in order to find solutions and streamline the distribution process.

The *Unidad Ejecutora* is printing 531,400 referral leaflets; 273,000 sets of family recall leaflets (nine each set); 700 vigilante's notebooks; 700 community situation analysis room poster and markers; 700 weight-for-age graph poster

and markers; and 700 of each three sets of counseling cards for the AIEPI AINM-C strategy. These will be distributed shortly, following a detailed logistics plan. For the integrated case management component of AIEPI AINM-C, two flipcharts, one on maternal and neonatal health and the other on child health, have been finalized and are being reviewed by the MSPAS and URC. Since the diagramming and graphic design of the algorithms and protocols for women and children case management have required improvements, the IEC/BCC team has become increasingly involved in their development. The register forms and algorithms were finalized and are also being reviewed by the MSPAS and URC before printing.

Coordination with other GTI-IEC members has been achieved so that we benefit from printing IEC materials at the same time. *Pro Redes Salud* and other NGOs have followed the same printing process as *Calidad en Salud* and have obtained lower costs on materials than if they had printed on their own. Another benefit includes the close supervision of the printing process provided by the IEC/BCC team (e.g. colors, paper). The official launching of the materials for the AIEPI AINM-C strategy and materials has not taken place yet and is pending MSPAS authorization.

The IEC Advisor has become more involved in the review of the community participation materials, the situational analysis room manual, and the community participation work plan for the remainder of the project (see Result 4). Communication for community participation has been introduced in the plan, in order to develop audio materials inviting communities to get involved with their local Health Committees to analyze and help solve community health and nutrition problems.

### **IEC/BCC Training for AIEPI AINM-C**

The IEC/BCC team has taken an active role in the monitoring of the training on the AIEPI AINM-C strategy, especially in the Promotion and Prevention component and growth monitoring and promotion (GMP) sessions within that component. The IEC/BCC advisor continued to conduct observations of area level training for ambulatory physicians and institutional facilitators (FIs) in order to monitor quality and update their knowledge regarding GMP procedures, the use of the minimum expected weight (MEW) table to classify children as growth faltering, the child card, and the vigilantes notebook to record children's weights and promotion activities. The Vigilante Manual has been drafted and the IEC team will produce a more polished version for review by *Calidad en Salud*, MSPAS, URC and USAID. The review and final production will be conducted in the coming quarter. (See additional discussion of AIEPI AINM-C activities under Result 4.)

### **IEC/BCC Monitoring and Evaluation for AIEPI AINM-C**

The revision of the *Extensión de Cobertura* information system indicators and forms to include the AIEPI AINM-C GMP indicators has continued with active participation of the IEC/BCC team. In addition, the IEC/BCC team has worked in the development of the monitoring/ supervision model at the community level (with FI supervising FCs and FCs supervising VS) and has provided instruments that were used in the GMP operations research in Ixil, including the observation checklists that are being used to monitor the vigilantes performance. Using these instruments the IEC/BCC team has conducted observations of the first GMP sessions at the community level conducted by *vigilantes de salud*. These observations have shown great variability in the skills of vigilantes and in the organization of work at the community. For instance, limited writing skills makes it difficult for some vigilantes to develop the list of children under two years in their sector; some facilitators have decided to have vigilantes conduct the first GMP sessions at the community center and not in their own sector in order to be able to monitor them more closely. GMP observation instruments have proven useful for the tutoring of vigilantes, and it is expected that they will be made official at the beginning of July.

### **Growth Monitoring and Promotion**

As mentioned, during this quarter the new monthly growth monitoring norm at the community level was made official by PROSAN and a booklet with the norm was published and is being distributed. Meetings held with this program during this quarter led to the following conclusions:

The Nutritional Rehabilitation Centers (CRN) still use the Nabarro table to classify malnourished children and for follow-up. These centers will cease operations by November 2003, after which it will be unlikely that the Nabarro table will continue to be used within nutrition projects.

In hospital, health centers and most health posts, integrated case management is being implemented as clinical IMCI. In these services, children's nutritional status is classified according to NCHS reference curves, specifically  $-2$  SD (low weight-for-age) and  $-3$  SD (very low weight-for-age). This classification will continue to be used, especially when the child does not have current monthly growth monitoring data in his/her card. However, institutional health personnel will be informed about monthly growth monitoring and the classification procedure (based on weight gain each month) at the community level, so that weight information on the child card is used when available. PROSAN will prepare a brief document for health services implementing clinical IMCI asking personnel to take into account data on the child card from monthly growth monitoring at the community expressed as "grows well" (in blue) or "does not grow well" (in red). In this manner, refusals to references made from the community level will be avoided, as well as undermining the work of community health personnel.

In health posts under *extensión de cobertura* (as in the San Marcos OR), community centers and communities monthly growth monitoring will be implemented according to the new norm using the minimum weight gain table or the MEW table in children 0-11 months and observation of growth trajectory in children 12 months and older (which is equivalent to a minimum weight gain of 4 oz for these children). The operational definition of malnutrition is "children who fail to 'grow well' (gain weight according to table) in two successive sessions".

Based on the mean percentage of children expected to be classified as "not growing well" according to analysis presented by URC/ *Calidad en Salud* consultants (Reynaldo Martorell and Rafael Flores) in December 2002, it was proposed to PROSAN that communities with equal to or more than 34 percent of the children "not growing well" would be considered at risk of having its nutritional situation worsen. Consultants and PROSAN judged this proposal adequate, with the following proviso stated by consultants: "according to the results of our simulations (which were summarized in our presentations in Guatemala), and using the proposal that more than 33 percent children not growing well indicates nutritional risk, we would have more than 10.9 percent false negatives (children that were classified as growing well, but are not). This means that a community health worker will strengthen his/her actions when in average s/he surpasses this threshold. This seems adequate from the perspective of preventive health, but these criteria are arbitrary and to date there is no empirical data to support them." It was also concluded that when more than 33 percent of the children in one community "do not grow well in two consecutive weighing sessions" the process of community participation (activation, assessment, analysis and action) needs to be activated or strengthened to look for and implement solutions to the nutritional problem.

Forms were prepared for the community facilitator (FC) to summarize growth-monitoring data for each community under his/her charge. This information will let the FC identify communities at nutritional risk. This information also needs to be part of the community participation strategy of the project, linked to the AIEPI AINM-C, and the FC will summarize it on situational room poster. Finally, an agreement was made by *Calidad en Salud* and PROSAN to promote the analysis of growth monitoring data corresponding to the following quarter (July-September 2003) to serve as the basis for a meeting to evaluate the quality of the data, its usefulness for community participation under AIEPI AINM-C, and the 33 percent criteria, to be held in October 2003. PROSAN and UPS1 should forward an official communication to Health Areas and Districts indicating the need to follow-up and tutor monthly growth monitoring sessions and to collect and analyze growth monitoring data from the first quarter of operations of the Promotion and Prevention component of the AIEPI AINM-C strategy.

There is still some confusion (even in the MSPAS) about the minimum weight gain table and the minimum expected weight table, which are complementary. One or the other can be used to classify children with inadequate growth, but, for vigilantes, the latter is usually easier to use than the former.

Additional analysis of the Ixil data on the number and percentage of communities with more than 33 percent of children less than 2 years "not growing well" in each weighing session and number and percentage of communities with more than 33 percent of children less than 2 years "not growing well in two consecutive sessions" are presented in the table below. As can be observed, no communities met the latter criterion; the percentage of children not growing well in two consecutive sessions in each community ranged from 0 to 23.7 per cent. Twenty-one out of 44 communities (47.7 per cent) had no children not growing well in two consecutive weighing sessions. Also, there

were four communities with more than 33 percent of children not growing well in both sessions. These results underscore the need to conduct data analysis of growth monitoring for the quarter July-September 2003.

**Table 18: Number and percentage of communities with more than 33 percent children less than two years “not growing well” in each session and in two consecutive weighing sessions**

Communities Number (percent)	2 <sup>nd</sup> session	3 <sup>rd</sup> session	Communities Listed in Both 2 <sup>nd</sup> and 3 <sup>rd</sup> Session
>33% children not growing well <sup>2</sup>	12 (27.3)	15 (34.1)	4 (9.1)
>33% children not growing well in two successive sessions	---	0 (0)	

A proposal to have several demonstrative communities of the Promotion and Prevention component of AIEPI AINM-C, including community participation, in each Health Area has been made by IEC/BCC. A coordination meeting was held with PROMASA in the Ixil. Agreements were reached in order to have the Health Area and CRN Coordinator visit the basic units that PROMASA has installed (or improved) in one health promoter house in each community to assess the feasibility of their becoming a growth promotion center at the community level to help with children found with inadequate weight gain in two consecutive sessions. Also, Health Area personnel were to conduct a situational analysis of *Extensión de Cobertura* and an assessment of the training needs of the new administrator NGO (*Cooperativa Todos Nebajenses*). However, given that the new administrator NGO has not yet received funds to start operations and most community facilitators have resigned and vigilantes have discontinued voluntary activities, including growth monitoring, these activities have not been carried out in the Ixil. The late allocation of funds to NGOs continues to be mentioned as a problem by institutional facilitators in other areas where training has been observed. In addition, community centers were reported to be lacking medicines for integrated case management and FCs have not been paid their monthly salary, while the salary of the NGOs accountant has been lowered.

The OR on GMP in Guatemala was accepted for a poster presentation at the 5th International Conference on the Scientific Basis of Health Services: Global Evidence for Local Decisions to be held in Washington in September 2003. It was also accepted for presentation at the Latin American Nutritionist Society (SLAN) Congress to be held in November in Mexico.

### Follow-up Survey on the 2002 Base Line

Although using different samples, results of the baseline survey conducted in San Marcos for the operations research on the expansion of the *Extensión de Cobertura* (OR-AEC) model were analyzed as a picture of present situation and compared to the IEC/BCC baseline survey results in 2001. The results were found comparable regarding characteristics of the sample, but an increase has probably occurred in women’s exposure to health messages, knowledge of family planning methods, and prevalence of use of family planning methods. One of the most interesting OR-AEC findings is that the population with the NGO model is not substantially different or better than that with the other models. This supports the idea that the new sample for the IEC/BCC follow-up survey can be drawn in the same manner as the sample in the previous survey was drawn (cluster sampling representative of the eight priority health areas); that is, there is no apparent reason to select two samples –one representing *extensión de cobertura* communities and the communities outside *extensión de cobertura*. The same questionnaire used in 2001 will be used, with a few additional questions on IEC activities and materials included.

<sup>2</sup> Classified using the Guatemalan Minimum Expected Weight Table

## **Operations Research on the Expansion of the *Extensión de Cobertura***

The IEC/BCC component contributed with an exhibition of IEC materials during the launching of the revised health service delivery model in San Cristóbal Cucho, San Marcos. In addition, training of community health workers and initial GMP sessions are being observed. Finally, institutional facilitators involved in the OR received one-day training on the updated GMP procedures. The OR in San Marcos is experimenting with a child card without the NCHS reference curves, which are unnecessary when the minimum expected weight gain is being used as the classification criterion. A brochure on the new AEC model will be drafted.

### **2.2.6. Specific IEC/BCC Results for IGSS**

The main achievement for IGSS was technical assistance and training provided to the new Chief of the IEC/BCC Health Communication Section, Ana Isabel Arévalo, that was established within the Communications Directorate of this institution. After tutoring and monitoring revealed that only 75 percent of IGSS maternal-and-child health services have IEC IMCI materials there will be renewed effort to have all materials distributed. Technical assistance was provided for the development of a poster dealing with FP after an obstetric event, which was also pre-tested with providers. Since the maternal-and-child department at IGSS does not want to change the child card to include the new approach to growth monitoring (presently the CLAP card is used, but the mother does not keep a copy), an infant and child feeding guide was developed and will be pre-tested, modified and printed next quarter.

### **Limitations for IEC/BCC**

Several limitations have been identified during the second quarter of 2003 include the following:

- The difficulty in the implementation of the IEC/BCC institutionalization plan, especially at the central level continues. Coordination between the Social Communication Unit, the Department of Health Promotion and Education (PROEDUSA), UPS1, the National Reproductive Health Program and the *Unidad Ejecutora* is weak and subject to conflicting interests. Only the Social Communication Unit representative attends GTI-IEC meetings. PROEDUSA is focusing entirely on following the “Municipalities for Development” strategy, working through the Municipal Council, Municipal Planning Office and the Health Commission within that office, and the IEC/BCC team had to insert IEC/BCC inputs into this structure and work plan.
- Although, *Calidad en Salud* would have preferred to provide assistance only at central level, PROEDUSA required that the *Calidad en Salud* Director sign an agreement assuring that the IEC/BCC team conduct actual training of inter-institutional teams. Therefore, the IEC/BCC team has had to provide direct training in Zacapa, Chiquimula, Quiché, Huehuetenango, and Baja Verapáz. This activity has altered our work plan delaying the completion of several projects and has also increased the IEC materials required to cover different audiences.
- Despite the fact that annual planning of all six workshops to be held this year with 26 IEC Area Coordinator was submitted to the MSPAS at the beginning of the year, PROEDUSA has been reluctant to authorize these workshops to have IEC Health Area and District Coordinator focus entirely on the “Municipalities for Development” strategy. The IEC/BCC team has continued providing technical assistance to IEC Area Coordinators through first-level facilitators, monitoring visits and other contacts.
- Although improvements in the distribution of IEC AIEPI AINM-C materials (counseling cards, recall leaflets, referral leaflet, child cards and vigilantes notebook), several problems have been identified, such as incomplete or damaged materials. These problems were addressed in the last Area Facilitators and first-level facilitators meeting and will continue to be discussed in order to find solutions and streamline the distribution process. The lack of personnel specifically devoted to carrying out the process of counting, packaging and transporting materials has been a constraint. Even with some external hired help, the IEC/BCC team has had to participate in the process. In addition, the information coming in from Health Areas regarding number of personnel and training dates is not always accurate or on time.

- As UPS1 signs more contracts with NGOs or modifies existing ones, the initial numbers of community health workers have increased. This has forced the IEC/BCC team to make a requirement to URC to print additional quantities of materials. Exact numbers and quotations from providers have had to be obtained delaying the authorization process.
- A serious constraint in Ixil is that the new NGO administrating extension health services (ASS) has not received funds. This situation has made several community facilitators resign and vigilantes stop conducting weighing sessions. This prevents the establishment of demonstrative areas for the Promotion and Prevention component of the AIEPI AINM-C strategy and the continued analysis of growth monitoring data as desirable.
- Strikes of health workers in some areas have prevented training events to take place (e.g. training of health promotion personnel in FP balanced counseling in San Marcos).
- Some IEC activities at IGSS were halted due to the resignation of authorities at IGSS after a case of embezzlement of funds was discovered. Lack of coordination and communication with the institution's maternal-and-child counterparts has delayed the development of some IEC products (e.g. health educator manuals).
- Another constraint is the political period that Guatemala is starting to experience. We've had a few health personnel strikes which have delayed training (for instance, in San Marcos).

### 2.3. Result 3: MCH Programs and its Partner NGOs are Better Managed

- |   |
|---|
| <ul style="list-style-type: none"> <li>• Management Systems Improvements are implemented to increase effectiveness of MCH Service Delivery</li> <li>• Improved Program Planning, Monitoring and Evaluation through the Use of Quality Data</li> </ul> |
|---|

#### 2.3.1. Logistics Results

During the second quarter of the year 2003, *Calidad en Salud* continued to work together with organizations providing family planning services to Guatemalans, especially with the MSPAS, IGSS and other NGOs that make up the outreach program, in the process of on-going improvement to the logistics systems.

This has been a very productive quarter for the logistics component during which numerous activities and products were successfully finalized and delivered.

During this quarter, the principal accomplishments were: a) continued training in logistics administration, b) finalizing the development of the logistics manuals for IGSS, c) continued implementation of simplified computerized logistics information modules for the MSPAS and IGSS, d) implementation of technical support field visits to the logistics personnel from the DAS, g) continuing activities that form part of a contraceptive security initiative in Guatemala, and i) linking with other organizations and units within the MSPAS, such as FNUAP, HIV/AIDS, UPS1, SIGSA-SUI, and the POLICY project

Because the achievements are numerous and they themselves subdivided into several components, in this report they are organized into seven main areas (support to logistics staff, training, planning and coordination, manuals, logistics management information systems, contraceptive security initiative, and limitations).

## Support to Logistics Staff

Obtaining the support of and commitment from logistics staff at all levels is a crucial element for ensuring an adequate distribution of contraceptives. Within the MSPAS human resources are limited, in many cases the same staff member attends to numerous activities, thus, minimizing the time available for improving logistics management of contraceptives. Our goal has been to promote the importance of contraceptive logistics management in order to obtain better levels of health for Guatemalans. With this goal in mind and in order to improve and promote team work at the central, DAS and health post levels, the following activities were carried out during the second quarter of 2003:

- **Physical Inventory of Contraceptives:** The field work for the first inventory of contraceptives at the national level was completed during the first quarter of 2003. During this quarter, the information was tabulated into a database and the output tables were generated for inclusion into the inventory report. Levels of stock reported were used to update the Pipeline System and in the revision of the 2003 Contraceptive Procurement Tables (CPTs). In previous physical inventories, *Calidad en Salud* provided technical assistance to the PNSR in all phases of the inventory (field work, data entry, data processing, and report generation).
- This time around the goal was to institutionalize the inventory process within the PNSR. All phases of the inventory were managed by the PNSR, and *Calidad en Salud* provided hands-on training in data processing and tabulation utilizing a data manipulation tool called dBase, building the in-house capacity for generating the inventory reports in the future.
- In general, the national inventory of contraceptives revealed a significant improvement in the levels of stock by method and level as described below:

**Table 19: Percentage of warehouses with one or more units of contraceptives by level**

Level/Method	Lofemenal	Condom	Depo Provera	Copper-T
<b>DAS</b>				
Reported	26	26	26	26
With one or more units	21	23	22	21
Percentage Supplied	81%	88%	85%	81%
<b>Central Districts</b>				
Reported	423	423	423	423
With one more units	311	316	321	241
Percentage Supplied	74%	75%	76%	57%
<b>Hospitals</b>				
Reported	21	21	21	21
With one or more units	20	21	20	17
Percentage Supplied	95%	100%	95%	81%
<b>Posts</b>				
Reported	851	851	851	851
With one or more units	763	706	753	49
Percentage Supplied	90%	83%	89%	6%
<b>Total</b>				
Reported	1,321	1,321	1,321	1,321
With one or more units	1,115	1,066	1,116	328
Percentage Supplied	84%	81%	85%	25%

Consensus Building: *Calidad en Salud* takes advantage of every opportunity to make a consensus building presentation to different staff levels within the MSPAS working in logistics of contraceptives. This presentation focuses on the importance of the logistics of contraceptives for an effective and efficient family planning program, stressing the point that “without product there is no program”. In the presentation, the trends in population growth in Guatemala, contraceptive prevalence, and in the decline of fertility were highlighted, as well as the importance of providing safe and good quality family planning services to the population of Guatemala. A perspective on population growth versus the ability of nations to provide basic services to their citizens was included. The curricula utilized for this presentation was developed by *Calidad en Salud*'s logistics team. It was presented on three occasions: a) at an invitation by the DAS of Chimaltenango, b) at the logistics management information system training workshop in Xela, and c) at the events for socializing national and organizational projections of future contraceptive needs for the MSPAS and IGSS staff.

Field Logistics Support Visits: During this quarter, *Calidad en Salud* continued assisting the PNSR in institutionalizing the guide for supervision of contraceptive logistics management, and the use of the Analysis of BREs (ABRES) tool. Fields logistics support visits were implemented to the areas of: Santa Rosa, Peten Norte, Petén Sur Oriental, Petén Sur Occidental, Totonicapan, Chimaltenango, Jutiapa, San Marcos, and Huehuetenango.

Design of a Logistics System for the NGOs: A design of a distribution and information system for medicines and contraceptives was finalized in which the flow of information is defined and the procedures for processing system forms are described. During the training of MA and FI the procedures in the design were re-enforced through a series of exercises.

*Calidad en Salud* will organize a meeting on August 8, 2003. Members from NGOs, UPS1, APROFAM, CS, and the UE will attend the meeting in order to share their experiences to date, giving special attention to their accomplishments and advances while pointing out the challenges they met during the process.

New Warehouse: *Calidad en Salud* has assisted the PNSR in securing a better warehouse for contraceptives. The previous warehouse lacked the adequate capacity, security, and conditions to ensure the quality and safety of the stock. A new warehouse was located after an exhausting process and the move of commodities to the new warehouse was completed.

Supervision: *Calidad en Salud* continues to work on the contraceptive logistics supervision guide. According to Claudia Flores, Supervision Technical Assistant, the guide will not be part of the USME supervision-facilitation integrated guide. USME compared what they want to measure versus what they can measure and from this comparative analysis it was determined that only a select few of the logistics indicators will be included in the USME guide. However, the guide being designed and finalized by *Calidad en Salud* has been used by the PNSR and the Logistics Technical Team during the last three quarterly meetings on supervision in the DAS and several districts and health posts. *Calidad en Salud* hopes to institutionalize the guide at the level of the PNSR considering that it was not possible do so at the level of USME. According to the contract, there is no specific date for the delivery of the guide; however, *Calidad en Salud* is putting the final touches on the guide (fine-tuning, formatting, etc.) in order to prepare an improved instructive manual to be institutionalized in the PNSR. It is hoped that the new guide will be finalized by the end of August provided that there are no unforeseen obstacles that arise between now and then.

## **Training**

This quarter followed the year 2002's intensive training program.

- Training in Logistics Management for *Medicos Ambulatorios* and *Facilitadores Institucionales*: *Calidad en Salud* developed a curricula specifically for the logistics responsibilities of the MA and FI. With close coordination with the UPS1 and APROFAM, *Calidad en Salud* completed training the last batch of MA and FI from all the NGOs associated with the extension of coverage program.
- Training in the use of the Logistics Module for District Level Personnel: *Calidad en Salud* provided technical assistance to the SIGSA-SUI in supporting the training of district level personnel as part of the expansion process of the logistics module of the MSPAS. As of today, the MSPAS with technical

assistance from *Calidad en Salud* and UNFPA has completed training in the new logistics module to district level personnel from 17 DAS.

## Planning and Coordination

*Calidad en Salud* has carried out and coordinated numerous logistics related activities with the following institutions and programs:

- FNUAP: *Calidad en Salud* has taken the lead in monitoring consumption patterns and stock levels of contraceptives within the MSPAS and IGSS and has alerted both organizations to initiate the procedures for transferring funds to UNFPA in order to ensure timely arrival of shipments so that both organizations can maintain the established levels of stock including amounts to meet demand plus buffer stock
- SIGSA/SUI: Coordination of activities for training district level personnel in the use of the logistics module
- *Instituto Guatemalteco de Seguridad Social (IGSS)*: *Calidad en Salud*'s logistics team has worked closely with the IGSS logistics staff in four main areas: a) in continuing an induction process for the new personnel and counterparts that included detailed training in the use of the Pipeline software, b) in the completion of both logistics manuals (see Manuals section), c) in initiating a contraceptive security initiative (see Contraceptive Security section of this report), and d) LMIS development (see LMIS section of this report)
- In addition, *Calidad en Salud* provided assistance to the Maternal and Child Health unit of IGSS in order to set up a document with terms and conditions for borrowing injectables from the MSPAS. The loan and the transfer of injectables has been completed
- HIV-AIDS: *Calidad en Salud* has participated in numerous meeting with staff from the PNSR and HIV-AIDS project in order to develop and implement a pilot distribution plan for the condoms donated by UNFPA and meant to protect against the contraction of STDs and HIV-AIDS
- PKF- International: *Calidad en Salud* coordinated with PKF, internal auditing, USME, and the *Unidad de Monitoreo, Vigilancia y Control de Medicamentos* to follow up in the implementation of the recommendations for improving logistics management of contraceptives and prevent leakage of Depo Provera from the MSPAS program into the private sector
- OPS: *Calidad en Salud* provided technical assistance to OPS and the MSPAS in the design of a strategy for improving the logistics management of medicines

## Manuals

The year 2002 witnessed the culmination of activities for developing logistics management manuals for the MSPAS and IGSS, nonetheless, it was during the second quarter of 2003 that the manuals for IGSS were finally approved, printed, and distributed to directors and unit level personnel. The Conceptual Framework for Logistics Management was officially approved with the management agreement of 10-2003.

### Logistics Management Information Systems (LMIS)

In order to empower decision makers and administrators to make better decisions concerning amounts of contraceptives, *Calidad en Salud* has been working with the SIGSA/SUI of the MSPAS in the development of a simplified logistics management information system (LMIS). During the last year, and in only four months, a system was designed, programmed, and the beta version of it was ready for testing. During the month of February 2003 the system was tested in the DAS of Guatemala and once adjusted based on the experience of the testing stage, the system was decentralized to the DAS level through the implementation of two training workshops. During this quarter, the logistics module was further decentralized down to the district level. *Calidad en Salud* assisted the SIGSA-SUI in the training sessions for district level personnel and has provided logistics management orientation to engineering personnel of the SIGSA-SUI (7 SIGSA-SUI staff members were oriented) so that in the future they can implement similar training and re-fresher training as needed. As of today, 75% of the DAS and their districts have

been trained by the SIGSA-SUI (390 district level staff were trained) in the use of the logistics module. In addition, during the quarter's training sessions several "bugs" or problems were detected and *Calidad en Salud* has been providing technical assistance for properly debugging the logistics module.

Equally, during this quarter, *Calidad en Salud* worked closely with IGSS logistics staff in finalizing the design and programming stages of the logistics module. The logistics module for IGSS has a very specific scope; it has been designed and developed to provide decision makers in the Maternal and Child Health unit with the ability to monitor patterns of consumption and distribution down to the unit level and to assess stock levels at any given point in time.

According to SIGSA SUI personnel, the system will be completely installed in all DAS and will be generating information on September 2003. IGSS has already finished the development stage. IGSS will have the system installed and will be trained during August 2003.

### **Contraceptive Security Initiative**

*Calidad en Salud* began work as part of a Contraceptive Security Initiative in Guatemala during the last quarter of 2002. During the second quarter of 2003, several activities were accomplished despite delays encountered due to the numerous staff changes within the MOH including at the National Reproductive Health Program. These advances are detailed below:

Contraceptive Procurement Tables: During this quarter, *Calidad en Salud* has provided technical assistance to the MSPAS and IGSS in the annual review of the 2003 contraceptive procurement tables. With the objective of institutionalizing the CPT process, *Calidad en Salud* provided hands-on training and guided MSPAS and IGSS staff through all the stages of development and review of CPTs. For the first time, the review was entirely implemented by the local staff, including the upgrading of the Pipeline with consumption data, information on shipments received and in transit, and physical inventories. In addition, *Calidad en Salud* guided both local organizations and UNFPA in the process of transferring funds for covering their contribution of total cost within the agreements with UNFPA.

Financing: Technical assistance was provided to the MSPAS, UE, UNFPA, and USAID for implementing a modification to the agreement between the MSPAS and UNFPA so that the amount of future donations meets the growing demand for contraceptives. Current levels of demand are much higher than the originally projected. Such modification includes the additional funds for procuring contraceptives for the years 2003 to 2005. Proper documentation for the modification was presented to the Department of Public Credit so that the necessary funds could be calculated and accounted for in the budget.

This activity is one of the most important and for that reason one of the most difficult for *Calidad en Salud* to execute given that *Calidad en Salud* only advises and does not direct the activity. Instead personnel from MSPAS are responsible for the majority of the activity. Three months ago, it was agreed, with Francisco Vásquez, Head of the Finance Department, that an Item of expenditure would be created in the SIAF which will have the "convenio" name of the UNFPA; however, this person was removed from the office and unfortunately it was not implemented. Actually, as part of contraceptive security, (in the area of finance) all of the documentation related to the purchase of contraceptives including the document of the MSPAS-UNFPA project was presented to the Department of Public Credit of the Ministry of Finance. The Department accepted and approved the fixed amounts including the additional amounts raised in the addendum of the government commitment before the international cooperation. Additionally, in the POA of 2004 of the PNSR the corresponding amounts of 30% of the contribution of the MSPAS for the purchase of contraceptives were included. As previously mentioned, in the structure of the POA of the PNSR that was presented to the Department of Strategic Planning, a specific budgeted item of expenditure format was not shown for the purchase of contraceptives because it is only accounted for under the heading of administration.

Projections of Contraceptive Needs: With the purpose of guiding family planning program directors, leaders, and decision makers, projections of contraceptive needs were developed for the years 2003 to 2008. Projections were developed for the country as a whole utilizing population and demographic parameters, and for each organization (MSPAS, IGSS, APROFAM, NGOs) based on history of consumption by method. These projections are of vital

importance, particularly for anticipating the amounts required for procurement and for initiating a way to advance the process for securing the necessary funds.

The projections were presented during two separate events to decision makers from the PNSR and from IGSS. The contents of the documents that show projections include: a) a set of global projections, b) implications of unmet need compared to total future demand, c) analysis of distribution of quantities of condoms for the HIV-AIDS program, projections for each organization and an analysis of their contribution to total cost by year under a possible arrangement with donor agencies, and d) an analysis of global projections based on demographic parameters with aggregates of projections by source based on history of consumption.

Contraceptive Security Committee: The Governmental Agreement for the formation of a Contraceptive Security Committee was revised once more based on recommendations made by the department of legal counseling of the MSPAS. The recommendations included the elaboration of a more specific set of objectives (motives) for the formation of the committee which was developed by the POLICY project. Today the new version of the governmental accord is pending a new revision by the *Dirección General de Regulación Vigilancia y Control de la Salud* and the PNSR prior to being forwarded to the Minister of Health.

## Results

Activities implemented during the quarter have lead to significant improvements of the logistics infrastructure of the MSPAS and IGSS. Personnel continue to improve their skills, a fact well demonstrated by their high levels of commitment observed during the implementation of the activities mentioned in this report and as described below:

- Staff from the PNSR for the first time implemented the revision of the 2003 CPTs with limited guidance from *Calidad en Salud*
- Staff from IGSS for the first time implemented the revision of the 2003 CPTs with limited guidance from *Calidad en Salud*
- Staff from the PNSR for the first time, took the lead in the implementation of the March 2003 National Inventory of Contraceptives
- Staff from both the PNSR and IGSS have on their own maintained the Pipeline Software up-to-date and have sent monthly reports to *Calidad en Salud*, UNFPA, and USAID
- Staff from the SIGSA-SUI have taken the lead in the training and installation of the logistics module down to the district level, generating material for the training sessions and developing the training plan. *Calidad en Salud* has accompanied the SIGSA-SUI to several of the training workshops
- The logistics staff from the UE has taken the lead at visiting numerous warehouses and finally identifying an adequate warehouse and completing the transferring of commodities
- The staff at the PNSR have been very involved in processing the Governmental Agreement and have provided valuable input for improving the content of it
- A good working relationship has been established between the staff of the SIGSA-SUI and the PNSR. This has been demonstrated in the implementation of the logistics module
- A good working relationship has been established between the staff of the PNSR and the IGSS. This was demonstrated in the successful lending of injectables from one organization to the other
- Several DAS have begun to show leaders in logistics, such as the case of Guatemala, San Marcos, Santa Rosa, and Sololá. Staff from *Calidad en Salud*, UE, and UNFPA have observed significant changes in the levels of commitment for improving contraceptive logistics among these staff members

- Supervisory guide institutionalized within the PNSR. This guide has been utilized for four quarters in the implementation of logistics field support visits. In addition, it has been provided to the logistics staff at the DAS level for them to implement “cascade” visits to districts and health posts
- Conscience levels have been raised. Very strong participation was observed during the discussions generated by the presentations for building commitment and for presenting the results of the projections of future contraceptive needs (2003-2008)
- Improvements in indicators of stocks as documented by the March 2003 national inventory of contraceptives

### Limitations

- The main constraint to programming and carrying out activities in logistics continues to be the limited availability of resources in local organizations. For this reason, some activities have to be re-programmed, which delays implementation
- The recent changes in the leadership positions within the MSPAS and IGSS have been responsible for the delays in meeting targets and deliverables on time. The reason has been that with the changes, the new personnel has had to be re-trained and re-educated about the plans, progress to date, and upcoming activities
- The new personnel has arrived sometimes without any prior experience in family planning logistics management. Therefore, *Calidad en Salud* has had to educate them and convey to them the importance of the logistics of contraceptives in order to obtain their support
- Supervision continues to be a challenge. The Supervision, Evaluation, and Monitoring Unit of the MSPAS is more virtual than real. The scope of work of the unit is way to extensive and complex for a unit with minimal human resources. The logistics component still cannot count on the unit’s ability to perform on-going supervisory visits to over 1,200 service delivery points and additional warehouses across the country

### 2.3.2. Monitoring and Evaluation Results

During the second quarter of 2003, activities were directed primarily towards the development of the SAMIG module for provision of services and towards reaching an agreement and gaining the approval of MSPAS counterparts to test 34 indicators and the flow of information from the AIEPI AINM-C monitoring system. Simultaneously, the reactivation of the *sala situacional* of the AIEPI AINM-C strategy as a forum to discuss the main health problems and how to resolve them was initiated.

Main activities that took place during the second quarter of 2003 include the following:

- Continued support to the MSPAS (UPS1-SIGSA) to develop and test the SAMIG provision of services and logistics modules
- Obtaining the approval of the MSPAS to implement the AIEPI AINM-C Supervision, Monitoring and Evaluation system and to start utilizing it in the *sala situacional* at the local level
- Review, update and standardization of the monitoring system for program activities and indicators, including extension and the new *Investigacion Operativa*, to improve feedback to the various components for the preparation of reports and reprogramming of resources and activities

## **SAMIG**

During this quarter, support to SAMIG was based on development of the provision of services module and the inclusion of the logistics module, both of which are currently being tested. Modification and adaptation of several of the existing SIGSA modules for use by the Extension of Coverage process was also achieved. Implementation was scheduled for the 3<sup>rd</sup> week in July in order to complete implementation before certifying NGOs in the extension of coverage during the last quarter of the year.

## **SIGSA-SUI**

The process for final review and printing of the “*Manual de Procedimiento para Registro, Generación de Informes y Retroalimentación de Estadísticas del Servicio*” depends on approval by the MSPAS of the AIEPI AINM-C monitoring system. The manual will be finalized once approval is given.

## **Performance Monitoring for *Calidad en Salud***

Due to problems with the licenses of the software used to develop the application for monitoring and evaluation of the implementation of activities, it was impossible to utilize the software in the eight priority Health Areas. As a result, previous formats and procedures used to consolidate the training reports and to apply program indicators will continue to be used.

## **Design of the Monitoring System for AIEPI AINM-C**

As part of the re-designing process of the supervision, monitoring and evaluation system of the AIEPI AINM-C strategy, a set of 34 indicators was developed and divided into three categories: quality (6), supervision (8) and monitoring (20). These indicators were discussed with staff from *Calidad en Salud* and MSPAS counterparts, and final agreements were reached among all parties.

The purpose of the indicators will be to collect information on promotion and prevention (PP) and integrated case management (MIC) activities covering topics such as: maternal child health, community participation, organization and training. There are also indicators for each of the personnel of the *equipo básico de salud* (EBS).

The flow of information gathered and consolidated on the indicators is mainly based on the official, routine forms and procedures implemented by the NGOs, districts and health areas. Information will be obtained from the official SIGSA's *Balance, Requisición y Envío de Suministros* (BRES) and the monthly monitoring form or unit. Consolidation of information at the level of NGOs will be the responsibility of the *médico ambulatorio* (MA) and the *facilitador institucional* (FI) and will be done either manually or electronically on a spreadsheet, designed and developed by *Calidad en Salud*. Consolidation and gathering of information at the area level is the responsibility of the Extension of Coverage Coordinator, and at the central level it is the responsibility of UPS1.

## **Preparation and Systematic Use of the *Sala Situacional* for Decision Making within the Community**

In coordination with promoters of the community participation component, efforts to reactivate the use of the *sala situacional* of the AIEPI AINM-C strategy as a forum to discuss the main health problems affecting the community was initiated. Collected information will be used to develop local plans of action to address these health problems. The work should be connected to the use of the monitoring system of the AIEPI AINM-C strategy.

## **Operations Research**

The preliminary report on the baseline of the *Investigación Operativa* was finalized and submitted. (Please refer to the section on IO AEC-PS for further detail).

Working meetings were conducted with a contracted advisor to develop a cost study proposal of the *Investigación Operativa* (Please refer to the section on IO AEC-PS for more detail).

## Limitations

Although participation of personnel from the MSPAS has greatly improved in order to strengthen activities planned by the project, there are still many limitations (ie. human resources, financial and logistical) to ensure even more effective and efficient participation of MSPAS personnel.

## Future Plans

- Finalize the implementation process of SAMIG in all the NGOs working in the 8 priority areas, together with the MSPAS (UPS1-SIGSA) based on agreements and plans already drawn up with UPS1
- Train staff at different levels in the 8 priority areas to gather, consolidate and use monitoring indicators for the AIEPI AINM-C strategy
- Develop, in conjunction with promoters of the community participation component, a plan to use and analyze AIEPI AINM-C monitoring indicators in the *sala situacional* to prepare local plans of action in order to provide solutions to the main health problems

### 2.3.3. Planning and Programming Results

The objectives of the planning and programming component are:

- To improve the operational planning and programming processes of the MSPAS by unifying implementation of programming of activities and of the MSPAS POA with regular funds for the year 2004
- To achieve institutionalization of the components of the *Convenio*, by systematizing and standardizing guidelines for technical and financial programming, based on the policies, objectives and priorities of the MSPAS
- To provide follow-up on the yearly and quarterly programming and budgeting for 2003 of the activities for each of the components of the *Convenio* and taking corrective measures as required

### Development of Management Capacity Building Plan to Integrate Principles of Quality Management

With the support of *Calidad en Salud*, the MSPAS has established that a key element in the institutionalization and sustainability of the activities supported by the program is the strengthening of the management capacity of the health actors, with emphasis on quality.

For this purpose, *Calidad en Salud* contracted the services of Dr. Bernardo Ramírez to prepare a management capacity building plan, with an emphasis on quality, and a focus on the Health Districts, for staff of the eight priority Health Areas. The following activities were carried out in the course of the consultancy: a) interviews with national directors of the MSPAS and selected staff from the health areas and districts; b) interviews with operational staff of *Calidad en Salud*, regarding their opinion on the management capacity of local teams; c) identification and analysis of management training programs in general and in health management in particular in Guatemala; and d) review of available materials for carrying out this capacity building process, both in training and in monitoring and *tutorías*.

Keeping in mind the current political situation, the length of the program and the opportunity for contributing to institutionalization, this plan will be necessary to capture the actions and progress achieved to date regarding programming, planning, supervision, logistics, monitoring and administration. The objective of the plan is to strengthen the management capacity of health providers at the area and district levels by:

- Improving management capacity of staff in the areas and districts
- Strengthening the capacity of health centers and health posts in the provision of services

- Contributing to the institutionalization of program activities with a focus on quality, by supporting:
- Staff that are well-trained and highly skilled
- Follow-up of Actions
- Sustainability of a “Culture of Quality”

The plan is geared towards the area director and team (epidemiologist, nurse, administrator, statistician, health technician) and the district director and team (*Enfermera Profesional*, person responsible for IEC or health technician) and will initially cover the eight priority Health Areas.

The plan will be designed jointly by staff of *Calidad en Salud*, the Ministry of Health and *the Universidad Rafael Landívar* and will include training, follow-up, *tutorías*, and self-learning and distance learning resources will be made available.

The contents of the plan will be based on the needs of a training assessment of the staff which that plan is geared towards, as well as an analysis of job requirements (what each must achieve) and how the requirements connect to the weaknesses and gaps detected from the assessment (what they know, what they can, and what they want to do). The plan will be adapted and programmed keeping in mind the development of management activities, specifically using the “**Just in time**” approach.

The training component of the plan will be divided into modules which will help in guiding the process, with a focus on quality. An initial draft of the modules includes:

- Planning and Programming
- Organization, Implementation and Negotiation
- Development of Health Services
- Development and Management of Human Resources
- Health Awareness: Supervision, Monitoring, and Evaluation and Control
- Social Participation and Health Promotion
- Financial Management and Administration

In regards to the methodology of the plan, the following can be highlighted:

- Use of various training, support and follow-up methodologies: workshops, *tutorías*, distance learning, CDs, audio-visual means, self-learning materials, and use of the Internet
- *Enfoque Semipresencial*, with 8 or 10 events to be attended, using meetings which have already been planned, such as the area technical committee and practical activities on services
- A “learning by doing” approach, through an experimental method that uses cases and contents to emphasize “how” things are done; materials and tools used will be simplified, without a loss in academic and technical quality
- Participation of institutional teams rather than individuals
- Accompanied training linked to the process of supervision facilitation, directly in the workplace
- Certified by a teaching institution (ie. diploma from the *Universidad Rafael Landívar*), for recognition and sustainability

For the purposes of evaluation, indicators to monitor change and measure the development of the management capacity of participants and their ability to modify the operation and management of health services will be established. This evaluation could be integrated into a permanent system for evaluation of the performance of MSPAS staff, with a link to a system that includes the incentives to improve the level of performance.

### **General planning**

During this quarter, *Calidad en Salud*, the UE and PNSR implemented the following activities, in order to comply with the operational planning objectives of the *Convenio* within the various units and programs of the MSPAS and in the Health Areas. The activities include the following:

- Preparation of a proposal to support the MSPAS planning process in its various stages: the proposal was socialized with a USAID official and the Policy Director and submitted to the Director of the MSPAS Strategic Planning Unit, who recognized the relevance of the proposal. However, given the urgency of presenting a POA 2004 draft, the proposal will only be applied in the second half of the year.
- Preparation of the terms of reference for hiring a consultant on planning and budgeting to support the MSPAS in improvement processes. An offer was submitted to the UPE director and to general management. The purpose of the consultancy is to review the current process for programming activities and budgeting resources within the MSPAS and to provide recommendations on how to improve such processes. Implementation is expected to take place during the second half of the year.

### **Implementation and Execution of the POA 2003**

*Calidad en Salud* and the UE, through *Facilitadores de Área* and *I Nivel*, held meetings and made monitoring visits to the districts together with the area technical teams to evaluate execution of the monthly activities of each of the components of the *Convenio*, with a focus on the institutionalization of the components. The areas visited were Quiché, Ixil, Huehuetenango and Chimaltenango.

### **Monitoring, Evaluation and Control**

A monitoring visit was made to the Ixil Health Area in order to provide assistance for review of the POA. Progress in technical and financial execution for each component was presented and problems, strategies and actions for strengthening implementation of the reproductive health program were identified.

### **Coordination**

*Calidad en Salud* and the UE continued their meetings with partners every two weeks, including the SMN (JHPIEGO) Project and *Programa Nacional de Salud Reproductiva* to plan, coordinate and communicate the various actions carried out by the teams of each component. During this quarter, follow-up of activities programmed for 2003 and the preparation of the draft POA 2004 were analyzed.

### **Institutionalization**

*Calidad en Salud* prepared a proposal to improve the planning, programming and budgetary processes for the MSPAS in the hopes of institutionalizing actions implemented by the project while strengthening the Ministry of Health. The proposal was developed in two stages that include the following: 1) preparation of a draft *Programación Operativa Anual* (POA), including a budget for 2004 and 2) development of an entire process with the goal of making it official in 2004, through the development of the Health Plan 2004-2008 and the POA and budget for 2005 and subsequent years.

A work plan for the project was also prepared in order to develop guidelines and a planning document for the PNSR in 2004 to make the financial request for Q. 115,000,000 to the Ministry of Finance. A technical meeting will be held in July to discuss this matter at which members of UE and the PNSR will be present.

## Special Activities

### Plan for Strengthening the Quality of Health Services (Institutionalization Plan)

URC/*Calidad en Salud* submitted an institutionalization plan on quality health services to the central MSPAS team (central and area level staff). An information workshop on the plan was organized at the central level, and an initiative was suggested to improve implementation of clinical IMCI using the collaborative learning process in two districts of each the eight Health Areas of the *Convenio*.

The Deputy Director of the Quality Assurance Project (QAP), Dr. Diana Silimperi; the Vice-President of the International Group of the University Research Co., LLC (URC), Dr. Tisna Valdhuyzen and a QAP consultant from Nicaragua, Dr. Oscar Núñez, participated in the workshop.

Visits were simultaneously made to the health areas to present the plan and raise awareness amongst the area directors on the relevance of adopting quality processes to improve the services and to reach their goal of being committed to participate in the implementation of the plan.

The plan approved by the MSPAS was shared with the central and local level staff of *Calidad en Salud*.

### Limitations

- *Calidad en Salud* prepared the terms of reference for the hiring of a consultant to support the MSPAS in the review of current processes for planning and budgeting the resources of the MSPAS; however, it is not possible to hire a consultant until the second half of 2003
- The DRVCS, UE and PNSR were not able to agree with the health areas on how best to implement meetings to monitor programming and to review guidelines, adjustments and progress of the POAs on a quarterly basis; this limited the execution of technical activities and the inputs needed to execute the components of the project
- Lack of involvement of the UPE to define a uniform program of the *Convenio*'s POA and of the program guidelines with regular funds for institutionalization of actions
- Lack of improvement mechanisms in management systems to strengthen the effectiveness of provision of services in MCH as well as in planning, monitoring and evaluation of the programs through the use of quality information

### 2.3.4. Supervision – Facilitation Results

The supervision system has been designed and tested and is ready to be launched again. During this quarter, recommendations from the various levels of the MSPAS and Dr. Consuelo Juárez, a consultant from EngenderHealth, have been implemented. A proposal for a supervision system at the community level has also been developed and is currently being reviewed by a team composed of members from *Calidad en Salud*, USME, UE and UPS1.

### Improvement of the Supervision, Monitoring and Evaluation System at the Institutional Level

The improvements made to the system include:

- Recommendations by the directorates of the Health Areas and epidemiologists to include various management indicators to improve the referral/counter-referral system

- Modification of program indicators (IRA, Diarrhea/Cholera and immunizations) to ensure that they correspond to the age groups included in SIGSA and suggestions for check lists for maternal and child health care
- Recommendations for each of the priority programs of the MSPAS, especially regarding indicators reviewed by the reproductive health program; indicators for the vectors program were also modified according to service guidelines issued by the program for this year
- Redesign of some tools for easier use, such as check lists for supplies, equipment, medicines and storage conditions, in order that they can be individually checked by the responsible party in the district; analysis and solutions matrix was also modified to include a column to facilitate analysis of the causes of the problems discovered
- Inclusion of recommendations by Dr. Consuelo Juárez regarding: the inclusion of a tool for client satisfaction (to be applied two times per year by the health services), introduction of the notion of self-supervision and simplifying the tools used as much as possible in order to make them user-friendly

### **Design of the Supervision, Monitoring and Evaluation System for the Community Level**

A proposal for a supervision system at the community level has been prepared. This proposal was based on previously suggested tools and others used during the *Investigación Operativa* conducted on the use of the Minimum Expected Weight (MEW) table. Support was given by the FA of *Calidad en Salud* in Huhuetenango for organization of the material, adaptation of the tools and final editions made to the tools. The proposal contains:

- A methodological guide of the concepts of supervision-facilitation at the community level and how to implement the guide
- Tools to verify performance in Integrated Case Management (MIC) for MA, EA, and FC
- Tools to verify performance in community participation and promotion and prevention by the FI
- Tools to verify the performance of the VS in growth monitoring and promotion (GMP) and home visits
- Tools to supervise NGOs (PSS or ASS) by the health district

This proposal is currently under review by staff from *Calidad en Salud*, USME, UPS1 and UE before beginning the training process and testing the system at the community level. The process will begin at the end of August. The system will be tested and the results documented during the remainder of 2003.

In San Marcos, an initial field testing of the training methodology and the supervisory tools was implemented, with the participation of FIs, *Gestores*, EA and a district coordinator. This activity has led to improvements in the system at the community level.

### **Follow-up at the Institutional Level (Systematic Registration of Supervision Coverage)**

The eight DAS listed under the *Convenio* have continued to apply the supervision process in a systematic manner. However, reporting on supervision from the DAS to the USME has not been consistent, and therefore, there are no systematic figures at present.

### **Course on Management and Administration of Health Services, with a focus on Supervision, Monitoring and Evaluation**

Following the consultancy by Dr. Bernardo Ramírez, *Calidad en Salud* has decided to provide a broad management course, that will involve various levels of the MSPAS in its design and implementation. Dr. Manuel Zeceña of the USME, having been informed of this approach, has declared a request to support the development of a course that

will allow him to provide the USME team training in supervision, monitoring and evaluation systems with improved and more specialized management practices. It was agreed that a course will be given specifically to USME staff to cover these areas, starting at the end of August. Talks are currently being held with the INAP and the INTECAP, given that these institutions have experience in training on quality supervision and monitoring systems.

### **Consultancy by Dr. Consuelo Juárez of EngenderHealth**

Dr. Consuelo Juárez, a consultant from EngenderHealth specializing in supervision-facilitation and evaluation, visited Guatemala between May 4-17. Dr. Juárez's work in Guatemala focused on: improving the institutional supervision system, including the tools used by the MSPAS; modification of the AVSC (EngenderHealth) manual on supervision-facilitation; visits to health services at the community level to support the preparation of a draft of the supervision-facilitation system for this level; training supervisors of the MSPAS and IGSS on the link between supervision-facilitation and improvement of performance for quality.

The main recommendations made by Dr. Juárez to improve the system for institutionalizing supervision include:

- All indicators proposed to monitor supervision at the district and health posts in the Health Areas should be established, proper registration of data should be verified and information should be sent in a timely manner
- An additional column should be added to the analysis and matrix of solutions in order to register the causes of identified problems to ensure that supervisors always look at the source of the problem and add a further column to register how the results of the intervention will be evaluated and measured while solutions are being monitored
- Include tools to verify the quality of the data recorded and the promptness with which information is sent to improve the supervision of centers and health posts
- Increase the capacity of supervisors regarding decision making and problem solving at area level and in some districts

The recommendations regarding tools have been incorporated and training will be given to supervisors at the central level on the methodologies of problem solving. This training will then be replicated at the local level during the re-launching of the system.

### **Limitations**

Improvements to the supervision, monitoring and evaluation system and tools continue to develop at a slow pace. The USME is distracted by demands from authorities at the central level for reasons such as meetings to develop the URRGE USME strategy which, in turn diverts attention away from the main activities needed to improve implementation of the overall supervision system.

## **2.3.5. Financial Management and Administration Results**

*Calidad en Salud* supported the use of counterpart funds, to ensure financially sound management practices and to strengthen the involvement of the area management teams as well as centrally funded directorates in funding decisions. In order to achieve this, monitoring and supervisory visits were made and technical assistance was provided to technical and administrative-financial staff who in addition received: tutoring, information activities, orientation, feedback and advice on how to refine their skills, and support on how best to settle and request new revolving funds.

The objectives of the financial management and administration component are to:

- Provide technical support to staff of the *Unidad Ejecutora*, the MSPAS and the eight priority Health Areas of the *Convenio*, in order to ensure compliance with the norms and procedures related to administrative and financial processes and the management of government counterpart funds
- Facilitate the development and implementation of an accounting system in order to register and control counterpart funds
- Monitor administrative and financial interventions, at the central and area levels, in conjunction with the UNDP

The activities implemented in order to achieve the above-mentioned objectives are described in further detail below.

### **Supervision and Monitoring**

The supporting documentation of the *Unidad Ejecutora* and the 8 priority Health Areas of the *Convenio* for the purchase of goods and services with counterpart funds using various methods (petty cash, revolving funds and payments through request for administrative action) was reviewed. The most significant results were: failure to define technical specifications; companies quoting prices for required goods and services that in reality, they are not able to provide; errors in the comparison of tables; failure to comply with the steps involved in each process; and lack of proper documentation. Recommendations were given for improving the processes and compliance with established norms and procedures was verified.

Compliance regarding the liquidation of the revolving funds assigned to each Health Area and to the *Unidad Ejecutora* in December 2002 was analyzed. It was discovered that despite the fact that liquidation had been requested in January 2003, to date, some Health Areas have not liquidated funds.

The *Unidad Ejecutora* and *Calidad en Salud* collaborated to monitor the provision of inputs. Monitoring continued of the provision of materials and the recording and control of fixed assets, supplies, fuels and vehicles.

### **Coordination**

Meetings were held with staff from the PNUD, the Public Credit Directorate of the Ministry of Finance, the Financial and Strategic Planning Areas of the MSPAS, the PNSR and the various partner projects, in order to plan, program, coordinate and evaluate actions regarding budget and financial execution within the UE and the eight Health Areas and the purchase of goods and services.

### **Training**

In order to improve the budget and financial execution within the *Unidad Ejecutora* and the eight Health Areas, information and guideline activities regarding norms and procedures for the management of funds were provided. This training involves all aspects of financial management.

### **Financial Management**

Meetings were held with financial and strategic planning personnel from the MSPAS to discuss the management of the second allocation of counterpart funds to the UNFPA, in accordance with the addendum of the MSPAS/UNFPA *Convenio*. Of the counterpart funds, a payment of Q. 661,276.00 was made to the UNFPA.

Meetings were held at the Public Credit Directorate of the Ministry of Finance with financial and strategic planning personnel of the MSPAS and partner projects, with the goal of presenting 2004 donation and counterpart funds budget requirements according to the *Convenio* 520-0428 and of the MSPAS/UNFPA *Convenio*.

## Other Activities

*Calidad en Salud* provided support to the *Unidad Ejecutora* in the following activities:

- Definition of the technical norms needed to design and establish an intranet accounting system
- Review of the process for obtaining 50 refrigerators for the *cadena del frío* from counterpart funds, 40 refrigerators for San Marcos Health and 10 refrigerators for Huehuetenango
- Preparation of the document containing the proposal for the contracting of human resources for the *Programa Nacional de Salud Reproductiva* in the 26 Health Areas starting in 2004
- Preparation of the draft budget for 2004 for the Reproductive Health Unit, submitted by the MSPAS to the Ministry of Finance and to SEGEPLAN

## Limitations

In addition to those mentioned in previous quarterly reports, the main constraints were:

- Failure by some Health Areas to provide the PNUD with evidence of liquidation of revolving funds
- Counterpart funds used to cover services and programs not related to the *Convenio*

## 2.4. Result 4: Greater Community Participation and Empowerment

- |   |
|---|
| <ul style="list-style-type: none"><li>• Community Members Actively Participate in Decision-making Concerning MCH Programs</li><li>• Greater Community Control Over Factors that Determine Health Status</li></ul> |
|---|

Under Result 4, Greater Community Participation and Empowerment, *Calidad en Salud* is currently focused on two major objectives: 1) supporting the active engagement of communities, both in terms of decision making and direct participation, in improving the health of women and children and the overall quality of health care services available to them; and 2) supporting the roll-out of the promotion and prevention component of the AIEPI AINM-C strategy. (See Result 2 for additional discussion of AIEPI AINM-C promotion and prevention activities, especially those related to IEC and behavior change communication, and Result 1 for reporting on the integrated case management component of AIEPI AINM-C.)

### 2.4.1. Community Participation Sub-component Results

In order to achieve the objective of active engagement of communities in health care promotion and delivery, *Calidad en Salud* is providing support for the training of community personnel in basic aspects of social change and management through the four-step community participation methodology. This methodology, developed and refined during the first several years of the program, has been officially incorporated into the training of all extension of coverage community personnel under the promotion and prevention component of AIEPI AINM-C. *Calidad en Salud*'s community participation team is also providing ongoing support for training processes that have already been improved<sup>3</sup>.

During this quarter, the major accomplishments included: participation in the training of 7,845 VSs and 600 FCs in the community participation methodology within the AIEPI AINM-C strategy, focused on the analysis of action

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<sup>3</sup> Strategic Plan

plans designed to address nutritional problems; coordination with UPS1, PROEDUSA, JHPIEGO and FNUAP for implementation of the follow-up plan for community participation within the AIEPI AINM-C strategy; and the provision of technical assistance to the AIEPI AINM-C training team in the Ixil Health Area in the four-step community participation methodology, given that this Area had not yet conducted the training. The focus was in the role of community participation in the analysis of growth monitoring data.

### **Planning and Coordination**

The following meetings served to analyze the role of community participation within *Calidad en Salud*, specifically in those Health Areas covered by the *convenio*.

Presentation of the documented results to the technical teams of *Calidad en Salud*, *Unidad Ejecutora* and the *Unidad de Provisión de Servicios Nivel 1* (UPS1).

Situational analysis of the current *sala situacional* with members of the basic health team (MA, FI, FCs and VSs) of San Martín Jilotepeque, Chimaltenango. Health staff stated in the meeting that there has been very little analysis of the *sala situacional*, and that this is a common problem in other communities and Health Areas covered by *Calidad en Salud*. The aspect of the community participation methodology that has been the most problematic is the follow-up to action plans and solutions for problems that have been identified.

Definition with Level I facilitators of the necessary follow-up actions related to the community participation methodology as presented within the AIEPI AINM-C strategy.

The purpose of these meetings was to gain a better understanding of how to prepare a plan with UPS1 to strengthen community participation within the AIEPI AINM-C strategy and how to negotiate this plan with UPS1; the meetings led to the development of follow-up plan (“*Plan de Seguimiento para el Fortalecimiento de la Participación Comunitaria, dentro de dos Estrategias: AIEPI AINM-C y Municipios Promotores de la Salud y la Paz*”). This strategy will be led by PROEDUSA, and this department will place emphasis on working with the municipalities and with the municipal coordinators of the Health Districts.

### **Training (See Annex C)**

The following training activities were carried out during this quarter:

- Training of 7,845 VSs and 600 FCs in the community participation methodology, which is included in Module I of the promotion and prevention (PP) component of the AIEPI AINM-C strategy. Additional details of this activity are reported below under the promotion and prevention component.
- Eleven FIs in the Ixil Health Area were provided with a refresher training on community participation methodology, with a focus on the analysis of growth monitoring data.

### **Tutoría/Monitoring**

Forty VSs and FCs in Chimaltenango were provided additional follow-up and *tutorías* in the community participation methodology as part of the monitoring of the first training module dealing with growth promotion as part of the promotion and prevention subcomponent of the AIEPI AINM-C strategy. During this monitoring process, confusion regarding the use of the summary growth graph was detected, and feedback was given to the AIEPI AINM-C training team concerning the need to reinforce this skill during the subsequent training modules.

### **Materials**

The impression of the *guía de la sala situacional comunitaria* was delayed in order to make substantive changes to the design. (These design improvements are currently underway.) Following a final review by *Calidad en Salud*, MSPAS, URC and USAID, the guide is expected to be printed at the end of July, 2003. One proposal in the work plan for the community participation component is that several of the graphs of the *sala situacional* be converted to

posters. To date, *Calidad en Salud* has only supported the development and printing of the summary growth chart, but five additional *sala situacional* posters are needed, including vaccination, diarrhea, pneumonia, family planning and maternal/neonatal and infant mortality.

In addition to the five proposed posters, the development of 4 radio spots that promote the active participation of communities in their own health care, have also been included in the work plan.

The layout of the methodological guide for the community participation methodology training under AIEPI AINM-C was adjusted, using the format of the *Calidad en Salud* training guide. This training guide now includes a number of simplified tools (visual aids, participatory exercises and working guides) as recommended by a consultant from JHPIEGO, Amelia Kaufman.

### **Institutionalization**

Currently, this revised methodological training guide is undergoing a technical review by UPS1, *Calidad en Salud* and URC. This standardized guide will be utilized by the MSPAS and a number of non-governmental organizations in training community level personnel in AIEPI AINM-C, including the four-step community participation methodology.

### **2.4.2. AIEPI AINM-C Promotion and Prevention Component Results**

The promotion and prevention (PP) component of the AIEPI AINM-C strategy strengthens the extension of coverage process and is linked to the expected results of *Convenio 520-0428*, through the active participation of the community (*vigilantes de salud*) in activities that promote health and prevent illness.

The working strategies for the promotion and prevention component at the community level revolve around monthly growth monitoring and promotion meetings and follow-up home visits to families with children and to women of reproductive age, especially those who are pregnant, recently delivered, breastfeeding, using or are interested in family planning, or who have health problems.

Accomplishments during the second quarter included the review and redesign of the three-module AIEPI AINM-C promotion and prevention component training manual for community personnel (VS and FC); training in Module I (growth monitoring and promotion [GMP]) of 7,845 *vigilantes de salud* (VSs) and 600 community facilitators (FCs); training in the updated contents of the growth monitoring and promotion (GMP) material for 168 *Médicos Ambulatorios*, 170 *Facilitadores Institucionales*, 71 Rural Health Technicians and Municipal Managers of the districts and 104 people in other areas of specialization (social workers, doctors, nurses, inspectors, and auxiliary nurses).

A total of 34 quality, supervision and monitoring indicators related to the strategy were also defined and reviewed and monitoring instructions and instruments were given to 100% of the trainers in the health areas and districts.

### **Institutionalization**

Activities programmed to develop the strategy from the outset have been led by key personnel of the Ministry of Health and approved by the current staff of the MSPAS.

Development of a plan to implement the strategy continued, with the participation of normative technical staff from the UPS1, PNSR and the UE. They gave technical, administrative and financial guidelines to the health areas on how to comply with the norms for the integrated care of children and women of reproductive age.

### **Planning and Coordination**

Planning and coordination activities were carried out to follow-up on the plan for implementation and strengthening of the two components of the AIEPI AINM-C strategy with the *Departamento de Regulación de los Programas de*

*Atención a las Personas*, UPS1, PNSR, UE, USME, PROSAN and PROEDUSA, JHPIEGO, *Pro Redes Salud*, UNFPA, with the support of *Calidad en Salud*.

These actions resulted in the redesign of the training manual for community personnel, review of the monitoring and supervision facilitation system, review and definition of AIEPI AINM-C tracking indicators and design of the tools for monitoring performance of community personnel in MIC and PP.

### **Development of IEC materials**

During the first quarter of 2003, the training manual for community personnel was designed, and in this quarter it was tested through the training of 20 *vigilantes de salud* in the Choantonio village of Chimaltenango. Staff from the PNSR and the UE participated in this activity. As a result of testing the manual, feedback was given on how to improve the manual for future trainings.

With the technical support of *Calidad en Salud*, the manual was redesigned during this quarter to simplify the contents and include training tools as well as lessons learned during the field test. The normative technical staff of the UPS1 subsequently carried out a technical review, after which they approved the manual for use in the training of community personnel (VSs and FCs).

Lastly, negotiations were made with the *Unidad Ejecutora* for the reproduction of 40 copies of the manual using central level counterpart funds.

This redesigned manual is based upon adult learning theory and is organized in three training modules, each corresponding to one set of counseling cards, each lasting three days. Module I focuses on growth monitoring and promotion, Module II focuses on prevalent childhood illnesses and Module III focuses on family planning and maternal and neonatal care. Each of the modules has its own working tools (working guides, “generator” drawings, participatory exercises, models for visual aids) and supporting text, according to guidelines recommended by the JHPIEGO training consultant, Amelia Kaufman.

In coordination with the UPS1, the *Calidad en Salud* IEC team, Print Studio and the management and administration of *Calidad en Salud*, a strategy was defined to delivery 400 copies of the training manuals and 13,000 packets of *IEC* materials to the eight priority health areas covered by the *convenio*. A schedule for each health area was developed, and an agreement was made to carry out partial deliveries, given the large volume required for each health area and the fact that they do not have large warehouses to store such quantities of material. It was agreed to simultaneously train the training team in the use of all the materials they receive.

### **Training**

In the second quarter of 2003, two workshops were held to update the trainers of the health areas on the AIEPI AINM-C promotion and prevention strategy, with a focus on how to use: the methodological guide to train community personnel (VS and FC), the tools related to the use of the minimum expected weight (MEW) table (a summary chart for the minimum expected weight gain for the coming months, a summary graph, and a *vigilante* notebook), and the child card containing a growth chart, a vaccination record and a record of micronutrients. In the first workshop, a total of 30 people from the health areas of Totonicapán, Huehuetenango, Quetzaltenango and San Marcos participated. Thirty people from the areas of Ixil, Quiché, Sololá and Chimaltenango took part in the second workshop.

The workshops were also used to give financial and administrative guidelines to the representatives and accountants of the NGO health service providers and administrators, and to the directors of the health areas, with the goal of facilitating the training of VSs and supporting all members of the basic health team (VSs, FCs, FIs as well as ambulatory physicians and nurses).

The health area training teams replicated the training they received for a total of 170 *Médicos Ambulatorios*, 168 *Facilitadores Institucionales* and 71 TSR or Municipal Managers of the Health Districts and 104 trainers in other areas of specialization. To date 7,845 *Vigilantes de Salud* and 600 community facilitators have been trained on

Module 1 (growth monitoring and promotion). As follow-up to the training, central level staff (UPS1, PNSR, UE and *Calidad en Salud*) provided tutorials to all of the training teams of the health areas to strengthen their technical capacity as trainers.

### **Supervision, Monitoring and Evaluation**

In coordination with the supervision and monitoring subcomponent of the AIEPI AINM-C strategy, the MSPAS was strengthened to carry out coordination with UPS1, PNSR, UE, USME, PROSAN, PROEDUSA, JHPIEGO, *PRO REDES SALUD*, UNFPA and *Calidad en Salud*, to review and define the indicators and goals of the two components of the AIEPI AINM-C strategy – promotion and prevention and integrated case management. A total of 34 indicators were defined: six for quality, eight for supervision and twenty for monitoring.

The supervision-facilitation subcomponent was given technical support to review information gathering tools for both the promotion and prevention (PP) and integrated case management (MIC) components of AIEPI AINM-C. Recommendations were provided on how to improve these tools before formally submitting them as a proposal to the MSPAS for review and official approval.

### **Operations Research**

Technical support was provided to the San Marcos operations research facilitator for organizing training of the basic health team. Furthermore, monitoring of progress of the operations research in relationship to the AIEPI AINM-C strategy was carried out in the districts of San Antonio Sacatepéquez and San Pablo, San Marcos. (IEC carried this monitoring out in San Cristóbal Cucho.)

### **Limitations of the Community Participation and AIEPI AINM-C Promotion and Prevention Subcomponents**

- Little participation by UPS1 staff in the monitoring (coaching) *tutorías* to the training teams of the health areas, districts and NGO providers, given their general lack of human, financial and logistics (ie. transportation) resources. Nevertheless, UPS1 staff participated in areas of closer proximity, such as Chimaltenango and Sololá, with the support of counterpart funds from the *Unidad Ejecutora*.
- Training of *vigilantes de salud* in some of the new NGOs has stopped due delayed funding. Most affected has been the Ixil area since it has a single NGO administrator in charge of all three districts with extension of coverage. To date, they have not yet received the funds they need to operate at full capacity, and, as a direct consequence, training could not continue.
- There have been some difficulties in sending the packages of IEC materials given the large quantities that had to be prepared. Furthermore, individual packaging was outsourced to one company and transported to the health areas by another company, which required additional efforts to coordinate the two companies. Certain materials, including triangles and pencils, were damaged during transport.
- A deficit of materials was experienced in certain health areas, including San Marcos, Huehuetenango, Quiché, Sololá and Ixil, while an excess was reported in the areas of Quetzaltenango and Chimaltenango (due to changing numbers of community, UPS signing additional NGO contracts, etc.).

### **Plans for the Next Quarter (See Annex D)**

Activities in the third quarter will focus on providing technical support to the MSPAS in the form of *tutorías* focused on training community personnel, *tutorías* related to performance of the *vigilantes de salud* in the implementation of the promotion and prevention component, and development of supervision-facilitation and monitoring of the strategy.

Support will continue to be provided to the districts where the operations research is being conducted in San Marcos, related to carrying out the AIEPI AINM-C strategy activities.

### **3. RESULT 5 IGSS: IMPROVED USE OF VARIOUS MATERNAL-CHILD HEALTH SERVICES PROVIDED BY THE IGSS**

#### **Introduction**

During the second quarter, a political and financial crisis within IGSS led to constant changes and a lack of stability in management. The crises in turn led to a lack of decision making and to delays in the processes at the normative technical level needed to comply with the work plans. Despite the crises, the IMCI *Cuadro de Procedimientos* was officially approved by IGSS to serve as guidelines for institutional child care.

In the support systems component, excellent results were also achieved, with the first payment by IGSS to the FNUAP to procure contraceptive methods, in turn institutionalizing the supply of such methods.

As for supply of contraceptives, projected procurements of the methods were submitted to the management and technical normative levels of IGSS, with an emphasis on the benefits of a continuous and well managed family planning program.

The stage of designing and scheduling of the module for analysis of logistical information on contraceptives was finalized.

Despite the financial and political disruptions at services level training, empowerment and quality improvement processes for the provision of family planning and IMCI services continued.

#### **3.1. Sub – Result 1: More families use Maternal-Child Health Services**

##### **3.1.1. Family Planning Results**

Family planning continued to be strengthened, particularly in the areas of provision of family planning services by increasing the offer of natural methods, *tutorías* (in service training) and by improving the information, logistics and supervision systems.

Pursuant to a decision by IGSS management, users of the services must provide evidence of entitlement by means of a work certificate every 3 months, resulting in an estimated 25 percent decrease in visits. This affected all of the Institute's programs, including family planning and IMCI.

Given the above, the MCH managers of IGSS lowered the program targets set for this year to 30,000 new acceptors and the production of 100,000 CYPs (nine percent less than planned).

#### **Indicators**

##### **Production of New Users of the Methods, as Per the 2003 Target**

During the second quarter, 7,736 new couples started to use a method for spacing pregnancies, reaching 50% of the target for the current year. Quarterly injectables continued to be the preferred method, followed by condoms and AQV-female.

**Table 20: New acceptors of FP by method, 2003**

Method	1Q	2Q	Total	Target	%	Mixture
AMP	3,414	3,457	6,871	12,899	53.3	43.0%
Condom	1,414	1,586	3,000	5,197	57.7	17.3%
IUD	534	569	1,103	3,007	36.7	10.0%
Norplant	87	82	169	90	187.8	0.3%
Oral contraceptives	541	613	1,154	2,649	43.6	8.8%
AQV-male	93	66	159	292	54.5	1.0%
AQV-female	1,191	1,262	2,453	4,997	49.1	16.7%
Natural methods	133	101	234	869	26.9	2.9%
Total New Users	7,407	7,736	15,143	30,000	50.5	100.0%

**CYPs Production as per 2003 Target**

AQV-female is the method giving greater CYP, followed by quarterly injectables.

**Table 21: CYPs by Contraceptive Method, 2003**

Method	1Q	2Q	Total	Target	%	Mixture
Depo Provera	5,624	5,475	11,099	21,573	51.4	21.6%
Condom	1,215	1,175	2,390	4,369	54.7	4.4%
IUD	1,869	1,992	3,861	10,525	36.7	10.5%
Norplant	305	287	592	315	187.9	0.3%
Oral contraceptives	841	919	1,760	3,538	49.7	3.5%
AQV-male	1,023	726	1,749	3,212	54.5	3.2%
AQV-female	13,101	13,882	26,983	54,967	49.1	55.0%
Natural methods	155	133	288	1,501	19.2	1.5%
Total CYPs	24,133	24,589	48,722	100,000	48.7	100.0%

### AQV-F Interventions

59% of all AQV-F are carried out post-partum or between pregnancies.

**Table 22: AQV Female**

AQV-female	1Q	2Q	Total	%
Cesarean	486	469	955	40.8
Post-partum	532	612	1,144	44.7
Post-abortion	5	8	13	0.4
In between pregnancies	168	173	341	14.1
Total	1,191	1,262	2,453	100.0

### Natural Family Planning (NFP) Methods

101 new users of natural methods were reported, giving a 2003 total of 234

**Table 23: Natural family planning methods**

Natural Methods	New Users		Total	APP	% APP
	1 Q	2 Q			
MELA	74	46	120	60	20.8
Necklace	59	55	114	228	79.2
Otros	0	0	0	0	
Total	133	101	234	288	100

### IUD Insertions per Services Facility

The following table shows hospitals and *consultorios* where 569 insertions of Copper T 380-A were reported.

**Table 24: Hospitals and Consultorios with IUD reported**

Unit	IUD Insertions		Total	CYPs	%
	1Q	2Q			
Gineco Obstetricia	371	400	771	2,699	69.9%
J.J. Arévalo	38	66	104	364	9.4%
Periférica 5	54	27	81	284	7.3%
Peeriférica 11	4	0	4	14	0.4%
Escuintla	13	10	23	81	2.1%
Mazatenango	5	29	34	119	3.1%
Sacatepéquez	14	2	16	56	1.5%
Santa Lucía Cotz.	4	7	11	39	1.0%
Amatitlán	16	21	37	130	3.4%
Others	15	7	22	77	2.0%
<b>Total</b>	<b>534</b>	<b>569</b>	<b>1,103</b>	<b>3,861</b>	<b>100.0%</b>

### IUD Insertion Care

Calidad en Salud is working on the strengthening of the contraceptives program after an obstetric training focused on IUD post partum. At the moment, Calidad en Salud has a report of the first 34 inserted IUDs.

**Table 25: IUD insertions**

IUD Insertions	New Users		Total	CYPs	%
	1Q	2Q			
In between pregnancies	534	535	1,069	3,742	96.9%
Post-partum	0	31	31	109	2.8%
Post-abortion	0	3	3	11	0.3%
<b>Total</b>	<b>534</b>	<b>569</b>	<b>1,103</b>	<b>3,861</b>	<b>100.0%</b>

### Monitoring and Performance Indicators

Technical support and assistance continued to be provided to the two training centers, *Gineco Obstetricia* and *Dr. J.J. Arévalo* Hospitals and a group of residents of *Gineco Obstetricia* were trained in family planning counseling and guidelines.

Strengthening of the post-partum contraception program began, with an emphasis on IUD insertion following an obstetric intervention in the *Dr. J.J. Arévalo* Hospital; this will be extended to the *Gineco Obstetricia*, Escuintla and Mazatenango hospitals in the next quarter. This activity is supported by a local consultant with extensive experience on the subject.

The target to offer natural methods was met. There are currently 23 facilities with staff trained to offer these new options for spacing pregnancies.

Seven service *tutorías* were implemented in the facilities of IGSS which met the planned target.

All hospitals and *consultorios* have IEC materials, and supervision of the services at local level and monthly analysis of the information continued. Despite the lack of human resources at the central level, there is an interest and a commitment to carry out supervision in order to improve quality in the provision of services.

**Table 26: Monitoring and performance indicators**

Indicator	2003 Target	% Achieved
CYP	109,895	49
New acceptors	32,589	50
Training in counseling, use and application of the FP guidelines manual for <i>Gineco Obstetricia</i> resident doctors and nursing students	100%	50
Quarterly monitoring of the 2 training centers	100%	50
% of services with tutorial	50%	50
% of women who leave with a contraceptive method post partum	50%	NA <sup>4</sup>
% of services offering natural methods	60%	67
Creation of the IEC section in the Public Relations Department of the IGSS	100%	100
% of PF services having IEC materials	100%	100
% of PF services supervised quarterly by central level	75%	10
% of PF services supervised monthly by local level	90%	50
% of PF services analyzing local information monthly	75%	40
% of PF services staff trained in logistics	90%	80
% of PF services having contraceptives	90%	88 <sup>5</sup>

### Organization and Planning

Technical assistance was continued to be provided to the FP technical group of IGSS.

Together with the University of Georgetown coordination continued to develop and put to use training materials and cycle beads in order to offer natural methods. Follow-up of the community level services providers of the Escuintla Regional Directorate was implemented, with good results both for providers and for users of the standard days method<sup>6</sup>.

In coordination with EngenderHealth, a follow-up visit was made to the *Gineco Obstetricia, Dr. J.J. Arévalo* and *Periférica de la zona 5* hospitals, to observe progress in activities related to *salud sexual y reproductiva del hombre* (SSRH) implemented at these hospitals. Good results have been obtained, especially on issues such as greater involvement of men in decision making when Guatemalan couples choose a contraceptive method that best fits their lifestyles. Improvements were also made in education on sexually transmitted diseases.

<sup>4</sup> Final results available 2003

<sup>5</sup> Monitoring survey of the IGSS logistics system, (EMSL) November 2002

<sup>6</sup> Cycle Beads method

## **Training (See Annex C)**

The second group of resident doctors (50 in total) from the postgraduate program on *Gineco Obstetricia* were trained in counseling, use, knowledge and application of the family planning guidelines.

Staff from seven care facilities were trained on how to offer natural methods as new alternatives for spacing pregnancies (Palencia, Santa Leonarda, San Juan, Santa Lucía and the *Gineco Obstetricia, Dr. J.J. Arévalo* and *Unidad Periférica de la zona 5* hospitals).

With the aim of improving staff performance in the provision of services, seven *tutorías* were implemented in the facilities of Siquinalá, La Democracia, Tiquisate, Escuintla, San José Pinula, Chicacao and Patulul. Other objectives of the *tutorías* are to improve the logistics and information systems, to increase promotion and counseling, and to observe proper use of IEC materials.

### **3.1.2. IMCI Results**

For the effective implementation and institutionalization of the application of the IMCI strategy, coordination with Maternal Child Health staff, Human Resources and Medical Audit continued, mainly with the goal to strengthen central and local supervision, and to improve information and logistics systems.

#### **Monitoring and Performance Indicators**

87 percent of childcare staff have been trained in the application of the IMCI strategy. Still to be trained are the *consultorio* of Antigua Guatemala and the extensions of coverage, which will take place in the next quarter.

Evaluation of 77 services providers (*Auxiliares de enfermería* and health promoters) at the community level in the Suchitepéquez Regional Directorate was carried out to verify compliance with the technical guidelines (*Cuadros de Procedimientos*). The findings were that 77 percent of evaluated staff apply the guidelines effectively.

Technical assistance to the training centers continued, and service *tutorías* were given in the *consultorios* of the Departments of Escuintla and Suchitepéquez, receiving 45 percent of the target goal.

75 percent of services have IEC materials, and supplies to continue to be sufficient to reach 100 percent of the target goal.

50 percent of services are supervised at the local level, with the help of IMCI facilitators from IGSS, given that the central level has a lack of necessary human resources.

**Table 27: Monitoring and performance indicators**

Indicator	2003 Target	%
% of childcare services personnel trained to apply the strategy	90%	87
% of trained childcare services personnel who comply with technical guidelines	65%	777
Training in application of the strategy to resident pediatric doctors and nursing students	100%	50
Quarterly monitoring of the 6 training centers	100%	50
Induction on the AIEPI AIMN-C strategy to management level of Maternal Child Health	100%	100
% of staff of the basic health teams trained in the application of the AIEPI AIMN-C strategy	90%	0
% of services with tutorials	50%	45
% of childcare services supplied with IEC materials	100%	75
% of childcare services supplied with medicines	75%	998
% of services supervised quarterly by central level	75%	10
% of services supervised monthly by local level	90%	50
% of services analyzing local information monthly	75%	40
% of complete immunization in children from 12 to 23 months	80%	ND9
% of children under six months who are exclusively breast-fed	50%	15
% of TRO use or consumption of liquids during episodes of diarrhea	75%	75
% of cases of pneumonia treated by service providers	85%	ND10

### Officialization

The IMCI *Cuadros de Procedimientos* Manual was approved as official guidelines for pediatric care by IGSS.

### Organization and Planning

In coordination with the HOPE and JHPIEGO project, a training package for implementation of community-IMCI at in the Departments of Escuintla and Suchitepéquez was prepared.

### Training (See Annex C)

New staff from Escuintla and Suchitepéquez and students from IGSS's Nursing School were trained during this quarter in the application of the strategy. Details are provided in the table below.

<sup>7</sup> As per evaluation carried out at community level in Suchitepéquez.

<sup>8</sup> Monitoring survey for the IGSS logistics system, (EMSL) November 2002.

<sup>9</sup> This IGSS indicator is difficult to measure, since access to immunization services is possible only if the child's parents are working and provide proof of entitlement every four months. Variable population.

<sup>10</sup> Will be measured by central and local supervision and by *tutorías*

### 3.1.3. IEC Results

Technical support continued to be provided to the Department of Social Communication and Public Relations and to the “*Programa Integrado de Difusión de la Seguridad Social y Educación para la Salud por Niveles*” (Integrated Program for the Diffusion of Social Security and Health Education by Levels).

#### **Organization and Planning**

100 percent of services have IEC materials in family planning and 75 percent have IEC materials in IMCI. These materials are being properly used, mainly by nursing staff, social workers and health educators.

#### **Materials, Guidelines and Handbooks**

The “*Manual de Normas y Procedimientos de Logística de Anticonceptivos del IGSS*” and the “*Marco Conceptual para el Sistema de Administración Logística de Anticonceptivos del IGSS*” was officially delivered to the management level of IGSS, and training of warehouse and pharmacy staff in the use and application of the above-mentioned manuals is planned for the next quarter.

The family planning guidelines manual was printed. Distribution to management levels and care facilities has begun. Twenty thousand cards for follow-up of family planning service users were reprinted and distributed.

Final artwork of the poster for promotion of contraceptive methods following an obstetrics intervention was prepared and approved. The Cycle Beads brochure was designed and approved and printing will start shortly. Final artwork for the AIEPI *Cuadro de Procedimientos* was prepared and printing and distribution is planned for the next quarter. The proposal for completing educational materials for supporting the AIEPI strategy (Food guide, medicine reminder and nutrition guide) was submitted to Maternal Child Health for approval.

## **3.2. Result 2: Maternal Child Health Programs are Better Managed**

### 3.2.1. Support System Results

The processes for improving the logistics, information and supervision systems continued.

#### **Officialization**

IGSS made the first payment to the FNUAP for contraceptive methods (condoms and oral contraceptives).

Training on the contraceptive procurement tables (CPTs) and the use of the Pipeline tool (which generates tables for contraceptive projections based on previous consumption) was given to three Maternal Child Health doctors who will be responsible for administrative management of the contraceptive methods.

The supervision-facilitation workshop for supervisors of social workers was facilitated by the Maternal Child Health assistant. As a result, IGSS resources were fortified by a transfer of capacity and skills for institutionalization of the training processes in supervision.

#### **Organization and Planning**

Technical assistance for loans of contraceptives from the MSPAS to IGSS was provided.

As for supply of contraceptives, projected purchases of the methods were submitted to the management and technical normative levels of IGSS, with an emphasis on the benefits of a continuous and well managed family planning program.

Technical assistance was provided to the Internal Audit Department for the first physical inventory of contraceptive methods in all IGSS care facilities that will be generated during the next quarter.

The stage of designing and scheduling the module to analyze logistical information on contraceptives was finalized.

### **Manuals, Guidelines and Handbooks**

The integrated supervision tool for provision of family planning services, which is being used in services *tutorías*, was developed. Hospital and *consultorio* directors made a commitment to carry out monthly supervision with their entire working team.

Technical assistance was provided to the Medical Audit Department for designing their supervision tools. This department now does supervision taking into consideration what they have learned on supervision-facilitation.

### **Training (See Annex C)**

Supervision-facilitation training was provided to supervisors of social workers and Maternal Child Health staff, in order to supervise the provision of family planning and IMCI services.

Introduction and adoption of supervision-facilitation by management and technical normative staff was supported by an EngenderHealth consultant, Consuelo Juárez. By doing this, the objective to raise awareness amongst management staff of IGSS for full acceptance of this supervision approach at the different levels within IGSS was achieved.

### **Limitations**

Due to the political and financial crisis within IGSS (ie. constant changes in management, lack of decision making and a climate of instability) delays have occurred in joint plans. Nevertheless, it was impossible to provide services in order to implement the majority of activities scheduled for the second quarter.

### **Institutionalization**

The IMCI *Cuadros de Procedimientos* manual was approved as the official guideline for pediatric care of IGSS, in effect institutionalizing the strategy.

Payment by IGSS to FNUAP for contraceptive methods shows a process of institutionalization in the supply of contraceptive methods.

Human resources of Maternal Child Health was formed to allow the continuity in training processes on supervision-facilitation, directed towards IGSS's staff, for this important support component.

The Maternal Child Health staff trained in the use of contraceptive procurement tables (CPTs) and use of the Pipeline tool will be responsible for the projections and orders of contraceptive methods to the FNUAP, thereby ensuring good logistical management of the methods.

## Equipment<sup>11</sup>

Purchase of the minimum necessary medical and audiovisual equipment for application of the IMCI strategy was finalized; an official date of delivery to IGSS is still pending. The cost of the equipment is Q.165,570, and this will be used at the community level in Escuintla and Suchitepéquez. It includes scales, King Seller thermoses, sphygmomanometers, and audiovisual and computer equipment for selected facilities, keeping in mind needs and production of services.

## Anecdotes

In the course of the *tutoría* on service provided in the Tiquisate Hospital (Department of Escuintla, south coast of Guatemala), it was found that the person in charge of the pharmacy was not sending information regarding monthly consumption of contraceptive methods to the person in charge of statistics, showing a lack of communication between staff.

*“The tutoría found this weakness while addressing the performance of providers; in the final meeting, the two staff concerned became aware of the importance of team work as a principle of quality, and of the fact that decisions are taken on the basis of accurate and timely information.”*

## Lessons learned

In the Regional Directorate of the Department of Suchitepéquez, a strong working team was selected to monitor and follow-up on the application of the IMCI strategy at the community care level.

As a result of this, the process was decentralized and it is now functioning as an excellent training unit under its own initiative, analyzing information and solving problems as a team. For this team, quality of care and user satisfaction, especially that of children, is the main objective of the service provider.

*“Selecting the persons responsible for bringing about behavioral changes both internally and externally is essential for achieving a good provision of services and good results.”*

## 4. ADMINISTRATION

### *Unidad Ejecutora*

*Calidad en Salud* continues providing technical and administrative support to the UE in the implementation and allocation of counterpart funds, as well as planning workshops for the area levels and procurement procedures for the eight priority areas and the central level.

A more detailed description of *Calidad en Salud*'s support to the UE is included in this report under Result Three.

### *Calidad en Salud*

During this quarter, *Calidad en Salud* continues supporting all components at both the central and area levels in providing funds for training sessions, reproduction of materials, equipment, and all related activities in order to accomplish the established goals by component. Also, during this quarter, *Calidad en Salud* continues providing family planning equipment to the 8 priority areas and the rest of the country.

*Calidad en Salud* started the process of procurement of equipment for IGSS but it is still waiting for USAID approval to distribute the equipment to IGSS clinics for family planning purposes.

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<sup>11</sup> Authorized in the 2003 work plan and budget

On April 21, Ligia Delgado, Logistics Assistant located in the *Unidad Ejecutora* office, reported the loss of a laptop assigned to her. *Calidad en Salud* made an official report of the loss to the *Unidad Ejecutora* and denounced the loss to the Public Ministry.

### **Staffing**

In April 2003, José Say Sarat was hired as the new *Facilitador de Primer Nivel* of San Marcos Area.

On April 21, 2003, Rajni Sood was hired as the new Project Coordinator in Bethesda replacing Dawn Crosby.

In April 2003, Nelly de la Torre resigned as the local facilitator for the OR AEC-PS. In May 2003, Guillermo López y López replaced her.

### **Other**

A consultant from EngenderHealth, Dr. Consuelo Juarez, visited Guatemala from May 4-17 in order to: 1) Provide technical review of the current supervision system instruments; 2) Provide technical assistance in revising the conceptual framework, methodology and tools for the supervision-facilitation strategy; 3) Provide technical assistance in adapting the AVSC/EngenderHealth Facilitative Supervision Manual for *Calidad en Salud*; 4) Provide design support for a preliminary supervision-facilitation system for the community level; 5) Train MSPAS/IGSS supervisors on supervision-facilitation and performance improvement strategies; 6) Conduct a presentation on benchmarking for community supervision-facilitation; and 7) Visit community level health services

A consultant, Dr. Bernardo Ramírez visited Guatemala from May 4-17 to: 1) Conduct interviews with central level MOH representatives, staff from the 8 priority Health Areas teams, and staff from various teams at the district level regarding current practices and capacities in health services management. These interviews should identify possible areas for improvement; 2) Conduct interviews with the operational staff from *Calidad en Salud* regarding their perceptions of what the area and district management teams are capable of achieving and what is needed to improve their management capabilities, focusing on quality management methodologies; 3) Develop a quality management plan which includes training and monitoring. This plan will include activities to be carried out, desired improvements, timelines for activities, resources, and responsibilities; 4) Identify and analyze current management training programs in Guatemala, and in particular, health management training programs; 5) Review available materials regarding monitoring and *tutorías*; and 6) Discuss quality management plan with the director of *Calidad en Salud* in order to ensure that the plan is in line with the goals of the overall program.

Dr. Tisna Veldhuyzen van Zanten visited Guatemala from May 12-24 to: 1) Work with *Calidad en Salud* technical and administrative staff to monitor progress and review deliverables, documentation and staffing; 2) Prepare and hold a one-day working meeting with the MOH to introduce Quality Assurance and to introduce proposed collaborative approach to clinical IMCI; 3) Participate in preparation for and implementation of a two-day working meeting with *Calidad en Salud* staff, including FA and F/IEC to prepare IMCI improvement collaborative scheduled to begin in June; and 4) Prepare IMCI collaborative organization and content.

Dr. Diana Silimperi and Dr. Oscar Núñez visited Guatemala from May 18-24 to: 1) Prepare and conduct a one-day working meeting with the MOH to introduce: Quality Assurance and proposed collaborative approach to clinical IMCI; 2) Participate in preparation for and implementation of a two-day working meeting with *Calidad en Salud* staff, including FA and F/IEC to prepare IMCI improvement collaborative scheduled to begin in June; and 3) Prepare organization and content of IMCI collaborative

Dr. Oscar Núñez made a second trip to Guatemala from June 7-15 to: assist with the first learning session of the collaborative to improve the performance of clinical IMCI. Specific tasks include: 1) Prepare the final content of the first learning session to be held in Sololá for participants of sixteen districts and area management staff. Given the large number of participants for this first session, the group will be divided into two, each receiving two and a half days of learning; 2) Provide major technical support to the first learning session; and 3) Assist in the preparation of the activities and organization of the action period and next learning session.

