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Baudilio López, USAID|Guatemala CTO

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Table of Contents

1	Introduction/URC'S Approach.....	1
2	Major Achievements and Approaches.....	3
2.1	Major Achievements: Summary Data.....	3
2.2	Selected Results.....	6
2.3	Project Strategies.....	3
3	Results by Component.....	15
3.1	Maternal and Neonatal Health.....	15
3.2	Nutrition Interventions for Women and Children.....	21
3.3	Child Health.....	24
3.4	Integration of Child and Reproductive Health Services.....	27
3.5	Sexually Transmitted Infections and the Human Immuno-deficiency Virus.....	28
3.6	Family Planning and Contraceptive Security.....	31
3.7	Better Management of Public Health Programs.....	34
3.8	Information, Education, and Communication for Behavior Change – IEC/BCC.....	39
4	Lessons Learned/Challenges and Opportunities.....	41
4.1	Lessons Learned.....	41
4.2	Challenges and Opportunities.....	42
5	Annexes.....	43
5.1	Performance Monitoring Plan Indicators.....	46
5.2	Operations Plan Indicators.....	55
5.3	Training Report.....	60
5.4	Research and Technical Reports Produced by USAID Calidad en Salud Project, Years 2004 – 2009.....	61
5.5	Guatemala IEC/BCC Materials Produced by USAID Calidad en Salud Project, Years 2004 – 2009.....	64
5.6	Project Deliverables Met by USAID Calidad en Salud Project, Years 2004 – 2009.....	64
5.7	Calidad en Salud Inventory.....	64

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome	MHU	Minimal Health Units
AIEPI-AINM/C	Integrated Care of Women and Children at the Community Level	MNCH	Maternal, Neonatal, and Child Health
AMTSL	Active Management of the Third Stage of Labor	MNH	Maternal and Neonatal Health
BBC	Behavior Change Communications	MSM	Men who have Sex with Men
CAIMI	Integrated Maternal and Child Health Care Center	MSPAS	Guatemala Ministry of Health
CAP	Permanent Health Care Center	NGO	Non-governmental Organization
CCTP	Conditional Cash Transfer Program	OP	Operation Plan
CQI	Continuous Quality Improvement	PMP	Performance Monitoring Plan
CRS	Catholic Relief Services	PNI	National Immunization Program
DHS	Demographic Health Service (also known as the National Maternal and Infant Health Survey)	PNSR	National Reproductive Health Program
ENRDC	National Strategy for the Reduction of Chronic Malnutrition	POA	Plan of Action
ENSMI	National Maternal and Infant Health Survey	ProCONE	Promotion and Essential Obstetric and Neonatal Care strategy
FP	Family Planning	PVO	Private Volunteer Organization
HCI	Health Care Improvement Project.	QMAS	Quality Management Assurance System
HIV	Human Immuno-deficiency Virus	SDM	Standard Days Method
HP	Health Posts	SESAN	Secretariat for Food Security and Nutrition
IEC	Information, Education and Communication	SIGSA	Health Management Information System (Sistema de Información Gerencial en Salud)
IMCI	Integrated Management of Childhood Illness	STI	Sexually Transmitted Infections
IPC/C	Interpersonal Communication and Counseling	TBA	Traditional Birth Attendant
ISO	International Organization for Standardization	UNFPA	United Nations Population Fund
LAM	Lactational Amenorrhea Method	URC	University Research Co., LLC
LQAS	Lot Quality Assurance Sampling	USAID	United States Agency for International Development
		VCT	Voluntary Counseling and Testing
		VICITS	National STI and HIV Sentinel Surveillance System

Tables and Figures

- Table 1: Selected improvements in family health based on 2002 and 2008-2009 DHS data
- Table 2: Selected improvements in family health based on LQAS studies, 2008 and 2009
- Table 3: Selected family health achievements, based on self-monitoring, 2006 and 2009
- Table 4: Preliminary results of the QMAS implementation
- Table 5: Changes *Calidad* helped make to MSPAS communications, by state of the BCC process
- Table 6: MSPAS objectives and their activities, scope, and results
- Table 7: Percentage of deliveries attended by trained health personnel in San Marcos, 2007 and 2008
- Table 8: Mayan auxiliary nurse midwives, San Martin Jilotepeque, Chimaltenango
- Table 9: *Calidad* nutrition objectives and their activities, scope, and results
- Table 10: Child health objectives and its activities, scope, and results
- Table 11: Improvements in indicators of integrated child care in seven health districts, South Guatemala Health Area, 2008
- Table 12: Vaccination coverage at the national level, 4 vaccines, 2005-2008
- Table 13: Improvement in vaccination coverage after six weeks of intervention in six health areas, 9/22–11/7, 2008
- Table 14: *Calidad* objectives related to STIs and HI and the activities, scope, and results of those objectives
- Table 15: Family planning and contraceptive security objectives, activities, and results
- Table 16: Changes in the use of specific methods during the project
- Table 17: Better management objectives, activities, scale/local, and results
- Table 18: Results of efforts to improve logistics management through training
-
- Figure 1: Compliance with AMSTL, three health centers and two hospitals in San Marcos
- Figure 2: Basic ProCONE Expansion Phase
- Figure 3: Compliance with criteria for AMSTL, pilot phase in San Marcos, 8/2007-9/2008, and expansion phase in other health areas, 1-5/2009
- Figure 4: Maternal deaths classified by cause of delay, San Marcos, 2008-2009
- Figure 5: New Users and Couple Years of Protection, 2004-2009
- Figure 6: Contraceptive supplies in health facilities, nationwide, 2001-March 2009
- Figure 7: Post-test VCT, selected health centers, 10/2005-9/2009
- Figure 8: Compliance with indicators for STI evaluation, diagnosis, treatment, and referral, 34 health centers, 9/2008-7/2009
- Figure 9: Communication Program Cycle
- Figure 10: WHO framework for health systems strengthening
- Figure 11: *Calidad* framework for health systems strengthening
- Figure 12: Four steps to quality improvement
- Figure 13: Compliance with norms for partograph use, 5 health providers (2 permanent care centers, 1 center for IMCI, and 2 hospitals) in San Marcos, 8/2007-9/2008
- Figure 14: Compliance with criteria for partograph use, pilot phase in San Marcos, 8/2007-9/2008, and expansion phase in other health areas 1-5/2008
- Figure 15: Compliance with criteria for AMTSL, pilot phase in San Marcos, 8/2007-9/2008, and expansion phase in other health areas, 1-5/2009
- Figure 16: Compliance with criteria for routine newborn care, pilot phase in San Marcos, 8/2007-9/2008, and expansion phase in other health areas, 1-5/2009
- Figure 17: Compliance with prenatal care indicator in 22 health centers, 1-8/2009, compared to 79 health posts and 53 municipal health units, 5-7/2009, San Marcos
- Figure 18: Pregnant women who could name at least 3 danger signs during pregnancy, 22 districts in San Marcos
- Figure 19: Pregnant women who could name at least 3 danger signs in the newborn, 22 districts in San Marcos
- Figure 20: Pregnant women who had an emergency plan, 22 districts in San Marcos
- Figure 21: Compliance with child immunization indicators, 16 municipalities, 2-5/2009
- Figure 22: Changes in method mix, 2005-2009
- Figure 23: Example of the redesigned process for personnel hiring
- Figure 24: Achieving time standards in purchasing, nationwide
- Figure 25: Achieving time standards in issuing payments, nationwide
- Figure 26: Image from the Hospital Logistic Administration Tool
- Figure 27: Improvement in drug supply, 10 hospitals, Feb. – Aug., 2009
- Figure 28: Sample of *Calidad*-supported MSPAS materials

I. Introduction/URC's Approach

Calidad en Salud II was a five-year (2004–2009) TASC2 Global Health contract awarded by the United States Agency for International Development (USAID) to the University Research Co., LLC (URC), to support Guatemala's Ministry of Health (MSPAS) and its partner non-governmental organizations (NGOs) in increasing the demand for and strengthening the delivery of quality health services. *Calidad* has had impact on such health indicators as fertility and infant mortality rates and percentage of births attended by qualified personnel. The project initially focused on eight highland areas of the country's 29 health areas: Chimaltenango, Sololá, Totonicapán, Quetzaltenango, San Marcos, Huehuetenango, Quiché, and Ixil. Alta Verapaz was added in January 2009.

Project components reflected the services targeted by the contract, including:

1. Family planning and contraceptive security,
2. Maternal and neonatal health (MNH),
3. Child health,
4. Nutrition interventions for women and children,
5. STI/HIV prevention and STI treatment,
6. Integration of child and reproductive health services,
7. Better management of public health programs, and
8. Behavior Change Communication/Advocacy and Community Action for Health.

During *Calidad's* last year, support was also provided to the management of public health programs through the addition of the Gestion de Calidad (quality management) component and the integration of technical support represented by the expansion of the Health Care Improvement Project into Guatemala. The quality management component had three cross-cutting subsystems: advocacy and policy development, health information systems, and the development of human resources.

The URC *Calidad en Salud* team has provided high quality technical assistance to MSPAS to strengthen its capacity to offer quality health services; actively engage communities; manage partnerships; and scale up proven, successful interventions. The team worked closely with Guatemala's Government to develop a mutually developed implementation program that ensured

that the strategies and achievements were sustainable and institutionalized in the health system. This close collaboration was achieved despite repeated changes in the Ministry's senior management team and the January 2008 change of the entire government.

The URC team undertook the following series of actions (detailed immediately below) to ensure desired results:

- Focus on the institutionalization and sustainability of program successes;
- Partner with MSPAS, other agencies, and other sectors;
- Invite the participation of communities, clients, health workers, and managers;
- Emphasize achieving results by using quality assurance and continuous improvement across integrated strategies;
- Scale up successful activities to more communities, health centers, and hospitals while emphasizing underserved areas; and
- Foster leadership among health care providers, managers, and communities.

Institutionalization and sustainability: URC developed and promoted a framework that identifies the essential elements that must be in place for institutionalization to occur. The framework provides a roadmap for establishing and maintaining an innovation as an integral, sustainable part of a health system. *Calidad* used the framework to assist MSPAS in assessing and planning how best to incorporate different innovations into day-to-day operations. *Calidad* also supported MSPAS in involving NGOs, professional schools of health, and other entities to meet their health sector priorities. *Calidad* also supported advocacy at all levels to build wide support for MSPAS priorities.

Partnership: The *Calidad* team stressed working in close partnership with key Government counterparts and fostered relationships with such counterparts. The project worked closely with national and health area-level managers, maintaining regular and open communications and participating in planning and strategy sessions. *Calidad* advisors developed productive relationships with MSPAS counterparts to provide quality technical assistance across multiple departments/units and with health area-level management teams.

Participation: The *Calidad* team promoted the use of innovative techniques to encourage and engage the participation of Government staff in the identification of issues, the design of new care processes and systems, and the development of practical solutions to improve care. This enabled health workers to assess their own facility's performance and work in teams to develop solutions. For example, facility and health area-level workers established systems to use local data to create plans, make decisions, and evaluate improvements. Thus, health workers and their supervisors—independent of URC staff—developed, implemented, and integrated continuous quality improvement and monitoring approaches as part of their routines.

Emphasis on achieving results: *Calidad* supported MSPAS in developing a shared vision and integrated approach to sustained improvement in the quality of care. We helped the Ministry strengthen health worker competence in critical technical and clinical areas through coaching and supervision, thus ensuring compliance with standards. Monitoring quality of care, initiating clinical and support services and processes, and the continued promotion of integrated service delivery all worked together to enhance clinical performance.

Scale up: In order to support the systematic scale up of key interventions, the URC team supported MSPAS in identifying and evaluating the most successful approaches, methods, and materials that had been developed under *Calidad en Salud* and other programs. This is illustrated by the Ministry's decision to scale up AIEPI-AINM/C (Integrated Care of Women and Children in the Community) to expand the reach of community-based health interventions. Another example is the success of the Basic ProCONE (Promotion and Essential Obstetric and Neonatal Care) improvement collaborative, which allowed

health facilities to share innovative practices and support mutual learning.

Leadership: Improving access to health care and the quality of care with system-wide changes requires strong and visionary leadership. Leaders at all levels—in communities, health care settings, and management teams—were afforded opportunities to acquire essential leadership skills and experience. Practitioners who had demonstrated their leadership abilities served as “champions” of quality and later led an expansion phase, accelerating scale-up, fostering empowerment among local staff, and building ownership among those staff of improvement approaches.

This report summarizes *Calidad's* achievements over the past five years. It is organized into four main sections that describe *Calidad's* positive impact on the Guatemala public health system, the strategic and program approaches applied, lessons learned, and challenges faced and overcome. After this introduction to *Calidad en Salud* and URC's approach, the second section, “Major Achievements and Approaches,” highlights results and summarizes the two major strategic approaches *Calidad* used: health systems strengthening and quality service improvement. The third section, “Results by Component,” further details each technical area and related program issues, describes the specific focus under each project health component, and summarizes the key activities implemented by component. The fourth section synthesizes the key lessons learned over the past five years and describes the challenges and opportunities for future programs.

The annex includes a Performance Monitoring Plan (PMP), Operation Plan (OP), summary of training completed, IEC/BCC materials, and a list of publications.

2. Major Achievements and Approaches

2.1 Major Achievements: Summary Data

To measure major achievements, the *Calidad en Salud* project used different sources of data, including Demographic and Health Survey (DHS) data (preliminary results are available as of the date of production of this report), self-reported data from monitoring and analysis based on lot quality assurance sampling (LQAS), and other self-reported data.

Field studies used LQAS to monitor the results of USAID's health programs in selected departments. The LQAS sampling approach and analysis tool originated in industry to facilitate quality monitoring and is increasingly used in international health programs by USAID and its partners: *Calidad en Salud* worked with the FANTA Project in January 2008 to undertake the first study. A firm hired to perform the study in September 2008 and 2009 reported the results in Table 2.

Table 1: Selected improvements in family health based on 2002 and 2008–2009 DHS data

Indicator	2002	2008–2009
Total fertility rate (children per woman)	4.4	3.6
Infant mortality rate (per thousand live births)	39	30
Chronic malnutrition in children 3–23 months	44.0%	38.4%
Contraceptive prevalence rate	43.3%	54.1%
Births attended by qualified personnel	41.4%	51.3%
Vaccination coverage (DPT) of children 12–59 months	1 dose: 94.1% 3 dose: 81.7%	1 dose: 96.8% 3 dose: 86.4%

Source: V Encuesta Nacional de Salud Materno Infantil 2008–2009, November 2009, Guatemala: DHS.

Table 1 presents achievements as measured by DHS data. The improvements surpassed expectations. The target for infant mortality was 36/1000, while 30/1000 was achieved. The global fertility target was 3.8 children per woman, while 3.6 was achieved. Chronic malnutrition, still too high, fell significantly more than expected: to 38% instead of 42%. Contraceptive prevalence rose to 54% rather than 49%, and the percentage of births attended by skilled personnel rose to 51% rather than 45%.

Table 2 shows important improvements in indicators related to MNH, especially in family planning: Greater use of contraceptives—from 28% to 40%—confirms the above-cited DHS results. More newborns (53%) received essential care than had before the previous year (35%). On the other hand, indicators related to women who could name at least three ways to protect themselves or their baby during pregnancy and who had knowledge of HIV decreased.

From the project-based monitoring *Calidad* is presenting some results of indicators in aspects not included in the previous tables.

Table 2: Selected improvements in family health based on LQAS studies, 2008 and 2009

Technical Area	Indicators	Year 2008	Year 2009
		Percentages (95% Confidence Interval)	
Maternal and child health	Women who have a postpartum checkup with qualified health personnel within three days of giving birth	27.0 (10.7–43.3)	34.0 (25.7–42.2)
	Newborns who receive essential care	35.1 (29.1–41.2)	52.5 (45.1–60.0)
	Women who can name three ways to protect her health and that of her baby during pregnancy	8.6 (4.4–12.7)	5.3 (1.6–2.2)
	Children 12–24 months who received their third DPT dose (or pentavalente) at 12 months, as indicated on the mother's identification card or report	88.6 (82.7–94.6)	91.4 (87.1–95.7)
	Children 0–6 months who were exclusively breastfed in the last 24 hours	43.4 (31.1–55.8)	52.1 (44.5–59.8)
	Children 1–60 months with cough and difficulty breathing in the past two weeks who received medical care from a health provider	57.5 (46.8–68.1)	67.6 (61.2–74.1)
	Women who took iron/folic acid throughout the pregnancy	7.3 (3.3–11.2)	10.8 (6.2–15.4)
Family planning	Women who were aware of the birth control pill	29.9 (20.5–37.8)	33.3 (25.4–41.3)
	Women of reproductive age, married or having a partner, who use, or whose partner uses, a modern contraceptive method	27.8 (10.2–45.4)	39.5 (32.3–46.7)
HIV/STIs	Women who were aware of HIV	69.6 (52.2–87.0)	63.6 (56.3–70.9)
	Women who could name at least one means of HIV transmission	53.0 (26.0–80.0)	54.1 (45.9–62.3)

Note: Figures in parenthesis show range.

Source: Annual Outcome Monitoring Survey of USAID-funded Health Services and Projects in Guatemala (DAS: Ixil, Quiché, San Marcos, Huehuetenango, Quetzaltenango) for 2008-2009. USAID/Calidad en Salud.

Even though norms in Guatemala do not conform to international standards, main improvements are in two indicators: a) “newborns who receive a medical check-up in their first 28 days” and b) “mothers who have a medical check-up in the 40 days after delivery”; these results are consistent with those presented in subsequent sections.

Table 3: Selected family health achievements, based on self-monitoring, 2006 and 2009

Indicators	2006	Sept. 2009
Percentage of children under age 2 who participated in monthly growth monitoring sessions at the institutional level (national figures)	15%	21%
Percentage of children 6–59 months old who received iron as needed by those under 5 years	4%	16%
Percentage of children from 6–59 months who received folic acid as needed by those under 5 years	4%	16%
Percentage of pregnant women who received a first prenatal care checkup	60%	70%
Percentage of pregnant women whose first prenatal care checkup was during the first 12 weeks of pregnancy	16%	22%
Percentage of pregnant women who attended three medical checkups	20%	37%
Percentage of new mothers who have a medical checkup within 40 days after delivery	39%	58%
Percentage of newborns who receive a medical checkup during their first 28 days	32%	53%

Table 3 presents data that *Calidad* collected as part of its routine data collection. On their face, these data indicate steady improvement, although *Calidad* was expecting higher figures in the last column. Not to be overlooked, however, is the leave-behind: Staff who never before considered the importance of the numbers underlying their work now have the means for determining how to generate better outcomes.

Results for all indicators that *Calidad* tracked through the PMP are in Appendix I. URC’s operations research studies were reported in a series of technical reports, listed in Appendix 4.

2.2 Selected Results

In this section we present key results achieved by MSPAS with the support of USAID's *Calidad en Salud* project. The next section offers results by component.

2.2.1 Maternal and neonatal health

Calidad introduced an **essential maternal and neonatal integrated health care model** that links the demand side (pregnant women, their families, traditional birth attendants, community organizations) with the provider side (outpatient and delivery services and a new cadre of health personnel) by focusing on improved quality and cultural appropriateness of health care processes, a quality management system, behavior change communications, community action and advocacy, and referral and counter referral.

The model, *ProCONE* (Promotion and Essential Obstetric and Neonatal Care), was initially implemented in San Marcos Health Area with great success in improving normal outpatient maternal and neonatal care. Figure 1 shows the improvement achieved in the active management of the third stage of labor (AMTSL) in San Marcos facilities that attend births.

In the demonstration or pilot phase in 22 health facilities in San Marcos, indicators of quality of prenatal, postpartum, and outpatient newborn care improved and stabilized above 80%, as did use of the partograph, AMTSL, and routine newborn care in five delivery services. The successful completion of the demonstration phase allowed the project to expand to 132 first-level facilities in San Marcos and 165 health centers in seven other health areas.

Figure 1: Compliance with AMTSL in three health centers and two hospitals in San Marcos

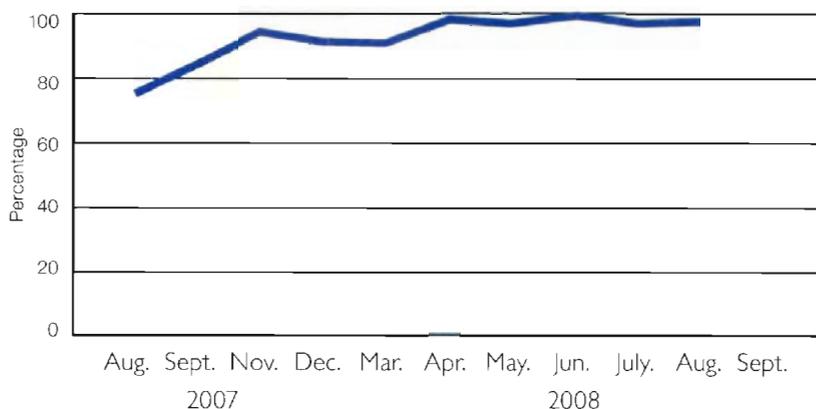
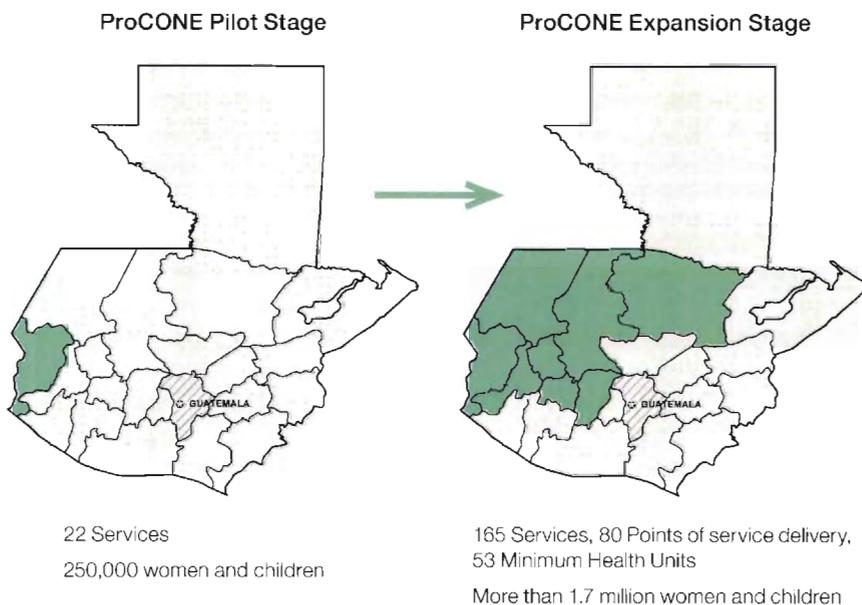


Figure 2 shows the geographic expansion of basic maternal and neonatal care.

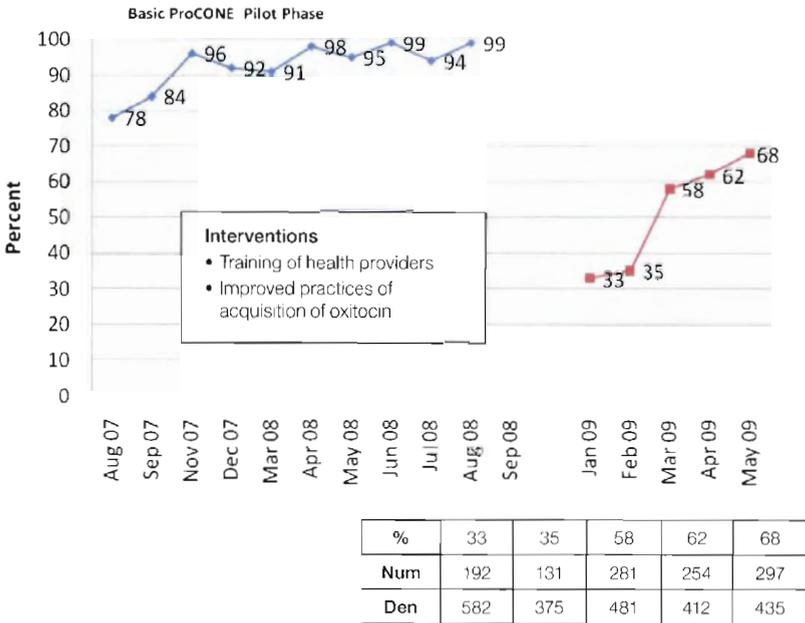
Figure 2: Basic ProCONE Expansion Phase



In the expansion phase, measurements of the indicators are approaching acceptable performance ($\geq 80\%$) more rapidly than they had in the pilot phase, as can be seen in Figure 3.

Community ProCONE: In the pilot phase of the community dimension of the model in San Marcos, indicators for pregnant women's recognition of danger signs and emergency planning improved. Also, 85% of prioritized communities have a health committee with an emergency plan. Figure 4 shows maternal deaths classified by the delay implicated in their occurrence. The overall number of deaths fell from 27 in 2007 to 16 in 2008 and 11 as of 11/15/2009. The percentage of maternal deaths occurring due to the first delay (failure to recognize danger signs) fell substantially, while the percentage of deaths due to the fourth delay (appropriate management of complications) increased somewhat. These data suggest that the implementation of community dimension was successful in reducing the first community delay.

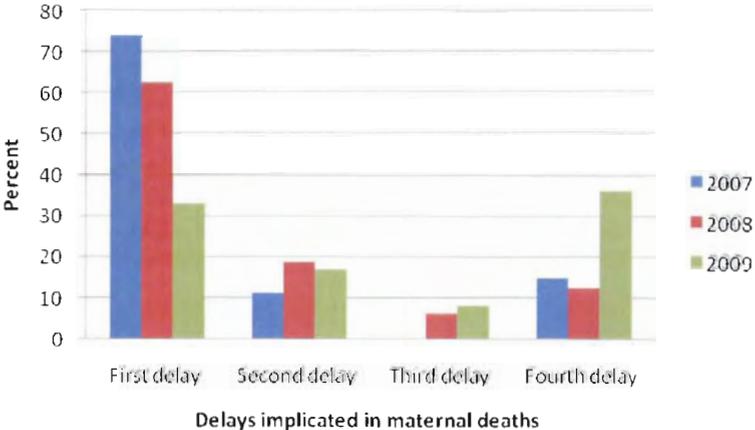
Figure 3: Compliance with criteria for AMTSL, pilot phase in San Marcos, 8/2007–9/2008, and expansion phase in other health areas, 1–5/2009



The overall number of deaths fell from 27 in 2007 to 16 in 2008 and 11 as of 11/15/2009.

Figure 4: Maternal deaths classified by cause of delay, San Marcos, 2007–2009

Trend in maternal deaths occurring in San Marcos in years 2007, 2008 and 2009 according to delays* implicated in their occurrence



Note: The delay classifications are:
 1) failure to recognize danger signs,
 2) failure to take decision to seek care outside the community,
 3) lack of opportune transportation of woman with a complication, and
 4) inappropriate management of complication.
 The first three delays occur in the community and the fourth in health services.

Auxiliary nurses qualified in maternal and neonatal care: To bridge the gap between health services and rural communities of predominantly Mayan descent, *Calidad* supported MSPAS' National School of Nurses in the selection and formation of 129 Mayan auxiliary nurse midwives who mostly work in the MSPAS Extension of Coverage Program as part of basic health teams in remote communities. Their performance is reflected in the increased coverage of ambulatory obstetric and neonatal care and in the significant number of lives saved.



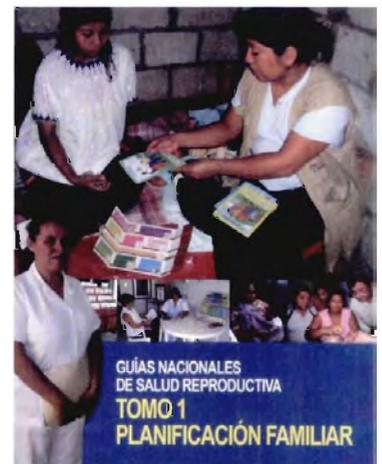
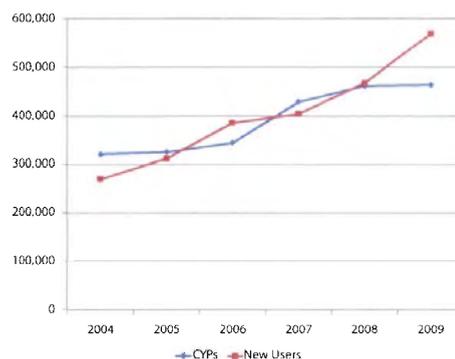
Community members work together to implement a community emergency plan to help a woman reach the hospital in time.

2.2.2 Family Planning

The project supported MSPAS to meet the increasing demand for family planning services in the country; the results are significant, as seen in Figure 5. The number of women who received MSPAS family planning services for the first time increased 210%, while couple years of protection increased by 144%

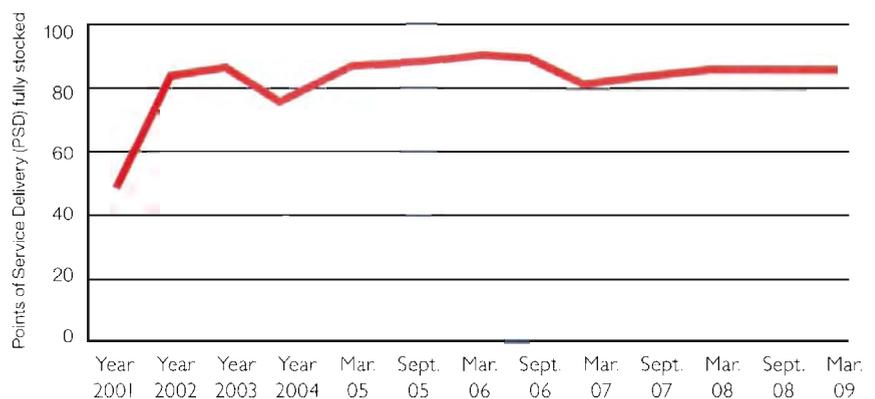
Also, implementation of the subsystem for logistics administration resulted in a large increase in the supply of contraceptives nationwide at ambulatory service delivery points. Supply has been maintained above 80% since March 2005 (Figure 6). The availability of contraceptives is an inherent part of the quality of MSPAS services; its purpose is to raise user satisfaction and ensure the continuation of services, which are quality of care indicators. Institutionalization of these achievements in health areas and hospitals, as well as in the MSPAS Logistics Unit, will guarantee work continuity and results sustainability

Figure 5: New users and couple years of protection, 2004–2009



Another important achievement was the development and updating of standards of care in different components, including family planning.

Figure 6: Contraceptive supplies in health facilities, nationwide, 2001–March 2009



2.2.3 Improvements to MSPAS efficiency and transparency

PriceWaterhouseCoopers performed an institutional assessment of MSPAS in 2005 and found a lack of efficiency and transparency, as reflected in: 1) a lack of standard norms and procedures, especially in the administrative and financial processes; b) inadequate procurement, accounting, and budgeting management; c) lack of auditing; and d) insufficient technological support for management of MSPAS resources.

To strengthen the Ministry's processes and internal structures in accordance with ISO 9001:2008 norms, a Quality Management Assurance System (QMAS) was designed and a comprehensive plan developed and implemented. Some preliminary results from the QMAS implementation are shown in Table 4.

The standardized procedures for acquisitions, client services, internal audits, management of



What is missing for MSPAS ISO Certification?

- Maintain process implementation
- Carry out internal audits
- Implement improvements derived from internal audits

documents, warehousing and inventory, budgeting, general services, preventive and corrective maintenance, and improvement management were approved in August 2009 by a Ministerial Decree (as seen in the photo above).

This Ministerial Decree guarantees the institutionalization of the QMAS processes and obligates all 82 MSPAS administrative units to implement them. It allows the Ministry to maintain the ISO approach, underpinning the continuity and sustainability to the achievements.

Steps towards ISO Certification

- Understand and learn norms
- Situational analysis to document compliance with norms and gaps
- Plan and design Quality Management System
- Design and document processes
- Train internal auditors
- Train 100% of personnel in ISO 9000

Table 4: Preliminary results of the QMAS implementation

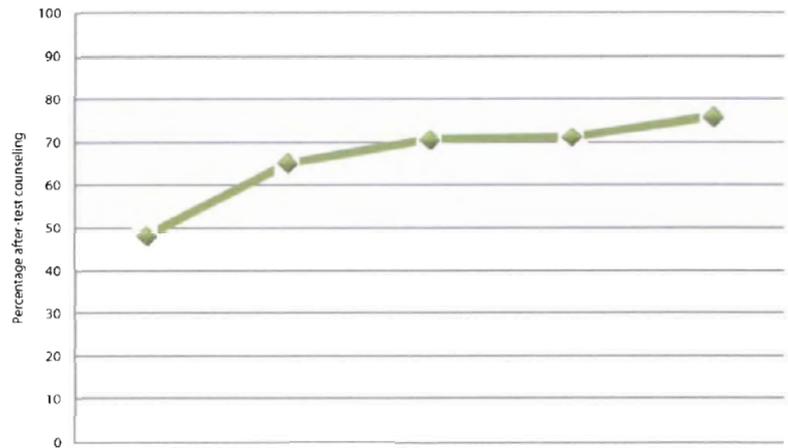
Process	Before	After
Personnel administration	No integrated human resources management system	Redesigned procedures for selecting and contracting, personnel actions, and performance assessments
Procurement	Mixture of normative and operative functions; lack of manuals; inadequate warehousing	Developed procedures for direct and comparative price purchasing, bidding, open contracting, receiving, warehousing, and distribution of supplies and drugs
Accounting System	Inadequate technological support for accounting system; lack of centralized tools to monitor budget execution	Established procedures for all accounting functions, including for decentralized budgeting
Budgeting	Spending decisions taken outside MSPAS; Annual Operational Plan inoperative	Redesigned procedures for all aspects of budgeting
Planning	Inadequate participation of staff; lack of management indicators that permit ongoing monitoring	Extensive capacity building of staff at central and area levels in the new management system, which includes monitoring indicators
Auditing	Lack of adequate internal auditing system	Produced manual for the internal auditing unit, including functions and procedures

Building MSPAS capability to address STIs, including HIV

The project supported MSPAS in 34 health centers to improve the detection and treatment of STIs and voluntary testing and counseling for HIV. Technical assistance provided to the MSPAS AIDS Control Program accomplished the objectives of improving the quality of STI/VCT services, increasing the promotion of and demand for such services, integrating these services with reproductive health services, and strengthening STI/HIV surveillance and monitoring systems. Two figures illustrate the work carried out, presenting results of indicators related to the quality improvement of the services provided. Figure 7 shows that the provision of VCT increased 58% from October 2005 to September 2009 in the 34 health centers where the project worked.

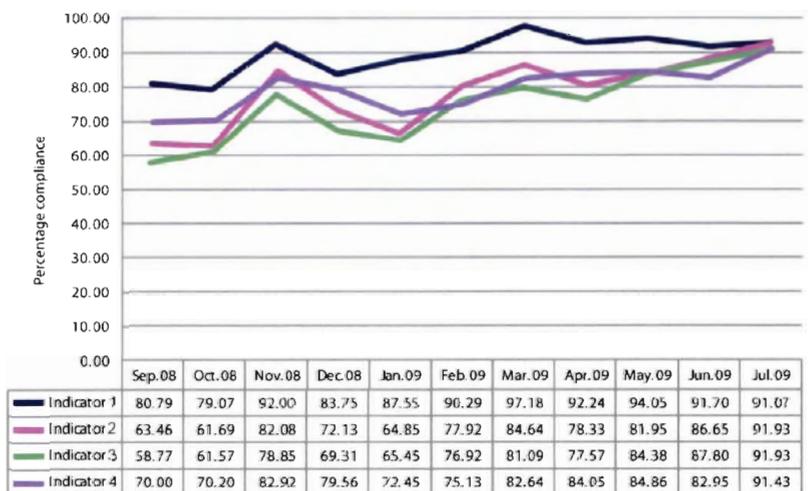
The Continuous Quality Improvement Collaborative resulted in significant improvements in compliance with service delivery norms, as shown in Figure 8. It shows four indicators (evaluation, diagnosis, treatment, and service referrals) that reflect improvement in the management of STIs; all surpassed 80%, acceptable performance.

Figure 7: Post-test VCT, selected health centers, 10/2005–9/2009.



	Year 2005	Year 2006	Year 2007	Year 2008	Oct.08-Mar.09
% after-test counseling	48%	65%	71%	71%	76%
Denominator	4,067	5,868	9,034	10,848	7,746
Numerador	1,959	3,826	6,387	7,734	5,896
# Sites	13	18	15	19	21

Figure 8: Compliance with indicators for STI evaluation, diagnosis, treatment, and referral, 34 health centers, 9/2008–7/2009



Note: Indicator 1 is STI evaluation; Indicator 2 is STI diagnosis and classification; Indicator 3 is STI treatment; and Indicator 4 is referral and counseling

Source: Consolidated database from the 34 health centers participating in the STI Improvement Collaborative.

Table 5: Changes *Calidad* helped make to MSPAS communications, by state of the BCC process

Stage of the BCC process	Before	After
Analysis	A structure for health promotion and education was visible only at the central level	The structure for health promotion and education was strengthened at the area and district levels, with an IEC Area Coordinator, IEC/Reproductive Health Facilitator, IEC District Representative, and community teams
	Coordination is lacking between MSPAS entities undertaking communication	Coordination was improved between PROEDUSA, the Social Communication Unit, and the Programs' Communication Unit
Planning	There is no strategic planning guide for BCC	Various strategic documents and <i>IEC a la Carta</i> guide BCC strategies at the area and district levels. Materials are used by other agencies and NGOs
Materials development	In 2001, quality IEC materials for health providers, other change agents, and the population were few	The materials development process was improved, and numerous high-quality materials are available for major programs' components. <i>Calidad</i> IEC graphics are reproduced by MSPAS, NGOs, and others
	Implementation	A traditional focus on "educational plan" was common
Monitoring/evaluation	Traditional training was conducted in "health education"	Training in BCC includes theories, trials of improved practices, strategic planning, processes, monitoring, and evaluation
	There were no clear logistics for communication products	Logistics have been defined and improved (quantities, storage, forms, and routes)
	Supervision and monitoring of IEC activities did not occur	Developed a supervision and monitoring system for areas, districts, and communities. Monitoring forms are used in family planning, vaccination, and Community ProCONE

Results that contribute to the Improvement of MSPAS capability to change behaviors of the population

Working with MSPAS, *Calidad* followed the Communication Program Cycle in Figure 9 to develop and implement various IEC/BCC strategies for the different project components, implemented numerous work tools, and distributed many materials among the general population. The project provided IEC/BCC technical

assistance, training, materials development, and dissemination tailored to each technical area to health staff at primary, secondary, and tertiary levels.

Table 5 reports the situation before and after the *Calidad en Salud* project, arranged by major stages in the communication process.

Efforts from the IEC/BCC strengthening and implementation process are reflected in the rest of components' results.

Figure 9: Communication Program Cycle



Samples of IEC/BCC material

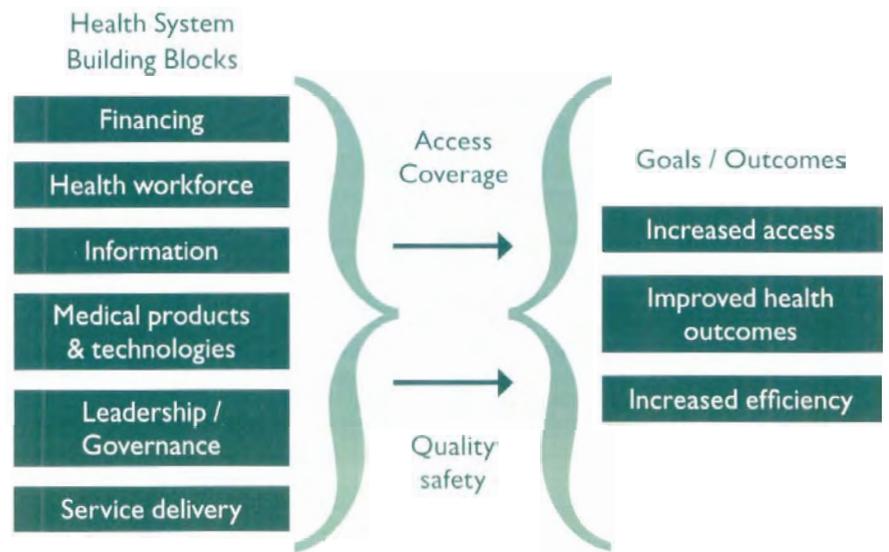
2.3 Project Strategies

The project used two important strategies to guide the implementation of its activities: a holistic approach to health system strengthening and the use of quality assurance methods. These strategies were integral to all *Calidad* activities and were applied to the components listed in the Introduction and described in Section I.

2.3.1. Health System Strengthening

The *Calidad* scope of work provided an opportunity to not only focus on improving different project components and support systems, but also to ensure that all interventions supported the strengthening of the greater health system. The WHO framework for health systems strengthening (Figure 10) has six building blocks that together comprise a health system. *Calidad* focused on both supporting needed improvements in the system building blocks and on initiating

Figure 10: WHO framework for health systems strengthening



Source: *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: WHO, 2007.

Figure 11: *Calidad* framework for health systems strengthening



large-scale changes in the way the existing system functioned. Thus, investments in capacity building, equipment, updating clinical norms, information systems software, etc. were coupled with the introduction and/or expansion of far-reaching redesign and improvement.

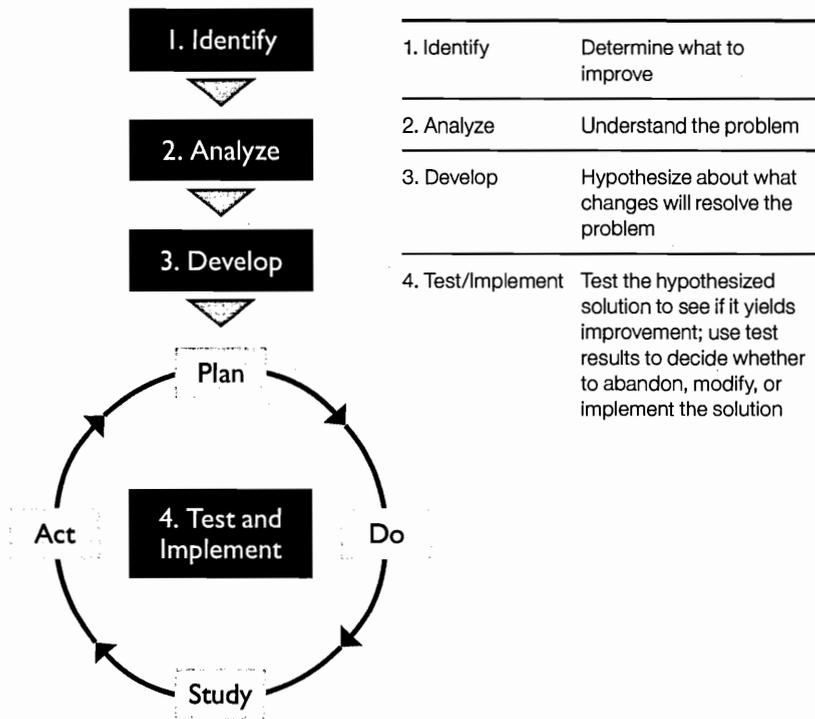
2.3.2 Quality assurance methods

Continuous improvement of quality of health services: To establish a culture of quality through which the Ministry would be able to both redesign systems and improve systems processes, *Calidad* introduced a quality assurance focus on a broad scale. Quality services are those delivered in accordance with evidence-based norms; they respond to the needs and demands of users and families and are delivered efficiently.

Calidad promoted the use of data for decision making, a core approach to improvement. The project taught facility-based quality improvement teams and MSPAS managers to follow the four steps to improvement (Figure 12) and to document both their results and the path they followed to get them. Run charts were introduced to display trends over time in providers' compliance with norms. Other important data are those generated by the Health Management Information System (SIGSA), as well as other monitoring tools promoted by URC, such as those applied in logistics monitoring systems.

Calidad also strengthened MSPAS and NGO staffs' clinical, management, and communications skills: We assisted MSPAS to use an evidence-based approach¹ to adapt or develop standards, bringing together key national and, when necessary, international experts. We supported MSPAS in developing the capacity to monitor and analyze data: given that measurement is critical in improving and sustaining quality care and should serve

Figure 12: Four steps to quality improvement



as the basis for evaluating performance and knowing whether an intervention really resulted in improvement. This technical assistance strengthened MSPAS capacity at all levels to monitor compliance with standards. NGOs were similarly increasingly able to assess their performance in achieving desired results.

Calidad's efforts results in improved care and improved care environments: The project fostered ongoing improvement at all levels of care and with all workers. They learned by doing and by working together across facilities to collaborate on clinical areas commonly needing improvement. These providers and managers learned how to test changes to make sure improvements resulted from them. They also learned to measure the effect of multiple changes to identify best practices and performance in the context of quality indicators common to all participating

sites. URC's experience elsewhere was confirmed in Guatemala: Synergy emerged when multiple facilities worked on the same improvement area. Mutual learning and shared results minimize duplication and facilitates rapid change. The approach used most intensively was the improvement collaborative.

An *improvement collaborative* is a time-limited quality improvement strategy that brings together a large number of teams from different facilities to work and learn together how to rapidly achieve significant improvements in a specific area of care; the intention is to spread the lessons these teams learn to other sites through phased scale-up.

Facility-based quality improvement teams participating in a collaborative devise and test ways to operationalize their best practices and overcome barriers

¹ An "evidence-based approach" in the provision of medical services based on evidence is the "conscious, explicit, and reasonable use of the best evidence available to make decisions with respect to patient care." Gardner y Altman. 1986. Confidence intervals rather than P values: Estimation rather than hypothesis testing. *British Medical Journal*, 292:746-50.

to making such practices work in their settings. Each team collects data on a set of indicators, such as those in Table 3, that are common to all facilities. The data indicate whether the changes each team makes improve the indicator rates. Teams share their results with other teams at *learning sessions*, which are meetings where representatives of each team explain their innovations, best practices, results, etc. Thus, teams learn from each others' experiences and avoid "re-inventing the wheel" in discovering successful changes.

Improvement collaboratives typically have three phases: a demonstration phase, an expansion phase, and a phase when best practices are spread and institutionalized in all health facilities in the targeted system. *Calidad* implemented improvement collaboratives for MNH primary care, community-level Integrated

Management of Childhood Illness (IMCI), and STI/HIV. Selected results are presented in the following section. Collaboratives sought to:

Reorganize systems that provide care:

An important *Calidad* focus was its promotion of integrated service delivery, its improvement in the continuity of care and referral and counter-referral systems, its strengthening of preventive and health promotion services, and its promotion of integrated clinical services and support systems. These system-level reorganization efforts are described in Section 3.

Reorganize management support systems:

Section 3 describes the new Quality Management Assurance System being implemented in the Ministry; it will lead to the first of a series of ISO 9001 certifications in early 2010.

Institutionalize quality care and quality management systems: *Calidad* made close collaboration with counterparts a cornerstone of its work. Health area management teams are leading quality improvement efforts; the Ministry has trained auditors to monitor compliance with new systems and is taking steps to ensure improvements; a new website with up-to-date information on norms, ministerial decrees, performance results, as well as an intranet site, allows easier access and more transparency to decision making and involvement by health personnel and the public. The Administrative Vice Minister is the leader in the implementation of the Quality Management Assurance System, and a Ministry Decree obliges 82 MSPAS administrative and financial units to implement new norms and procedures.

3. Results by Component

3.1 Maternal and Neonatal Health

Table 6 presents information by objective on the activities, scale, and results achieved by the strategy for the Promotion and Essential Obstetric and Neonatal Care (ProCONE). This section describes the activities and notes their geographic scale. It also provides key results on indicators measured by the facility-based quality improvement teams.

The ProCONE strategy aims to improve maternal and neonatal care in Guatemala. It has three components: specific health promotion and communication interventions to improve demand and access to health services (Community ProCONE); cost-effective interventions, proven and accessible to provide quality maternal and neonatal ambulatory care (Basic ProCONE); and quality management of the most prevalent obstetric and neonatal complications (Complications ProCONE). Actors involved in these components used the improvement collaborative approach: Facility-based teams in each participating health facility or community worked together to measure previously defined indicators and implement changes to improve those indicators.

3.1.1 Basic ProCONE

This component seeks to improve the quality of MNH services, especially those concerned with detecting and providing initial management of complications. The goal is to reduce maternal and neonatal deaths. Basic ProCONE improved the processes of 1) prenatal, postpartum, and neonatal outpatient care; 2) normal

Table 6: MNH objectives and their activities, scope, and results

Objective	Key activities	Geographic scale and population	Results
Introduce an essential maternal and neonatal health care model	Developed and implemented ProCONE, which had three components: Community ProCone, Basic ProCone, and Complications ProCone	San Marcos: 794,951 inhabitants; 250,000 women and children under 5	In the Basic ProCONE demonstration phase indicators of pre- and postnatal and neonatal outpatient care and normal delivery care reached 80% and became stable Acceptable but insufficient results were obtained for the community component Unacceptable results were obtained for deliveries with complications
Expand quality MNH services (Basic ProCONE) at the first and second levels to MSPAS highland facilities	Basic ProCONE and the collaborative methodology were expanded from San Marcos to seven other health areas The Basic ProCONE Collaborative was further expanded to 79 health posts and 53 minimal health units in San Marcos	Alta Verapaz, Chimaltenango, El Quiché, Totonicapán, Huehuetenango, Quetzaltenango, Sololá In San Marcos, expansion from the 29 initial sites to include all health posts: 161 health facilities in total Over 1.7 women and children under 5	Baseline measurements in 165 health centers in expansion areas started lower than those in San Marcos; subsequent measurements are rapidly approaching acceptable levels for most indicators Interventions were documented
Consolidate Community ProCONE	Learning sessions and action periods conducted Strengthened documentation of Community ProCONE to prepare for expansion	San Marcos: 250,000 women and children under 5	Recognition of danger signs and emergency planning reached acceptable levels (>80%) 85% of prioritized communities had emergency plans
Develop ProCONE for management of obstetrical and neonatal complications	Conducted first two learning sessions Performed baseline measurements	16 hospitals in same health areas	Completed baseline measurements: Most indicators were at 0%
Train Mayan auxiliary nurse midwives	Carried out initial negotiations with MSPAS, including Extension of Coverage Negotiated agreement with National School of Nurses Developed selection criteria, curriculum, practical training (internship/residency), and diploma requirements Implemented training	NGOs of the Extension of Coverage Program in Alta Verapaz, Chimaltenango, El Quiché, Totonicapán, Huehuetenango, Quetzaltenango, Sololá, and San Marcos	108 AECAMN graduated; last group of 21 to graduate in December 2009 Evaluation showed that midwives comply with standards of outpatient prenatal, postnatal, and neonatal care, and normal deliveries, but have little opportunity to perform deliveries; together with TBAs they have helped save more than 500 lives

deliveries, including the use of the partograph for decision making; and 3) the active management of the third stage of labor (AMTSL).

Key activities: During a preparation stage, activities included revising MSPAS norms, defining standards of care based on norms, developing indicators to measure standards, and forming quality improvement teams at the MSPAS, health area, and district levels. The implementation stage engaged participating teams in a series of learning sessions and action periods. During action periods MSPAS and health area teams provided support and tutoring, facility teams made changes following the four steps in Figure 12, documented changes made, and communicated among themselves to share problems and solutions, establishing a friendly, competitive spirit.

Results: The teams measured Basic ProCONE indicators for standards of care during pregnancy, delivery, and postpartum and for the newborn. The most significant results were improvements in partograph use, AMTSL, and care for the newborn. Significant progress was also made in the quality of prenatal and postnatal care and outpatient care for newborns. Figure 13 shows improvements in partograph use during the San Marcos pilot phase.

Expansion of quality MNH services to MSPAS facilities in the highlands

The Basic ProCONE expanded to improve the quality of MNH services in a greater geographical region. The program increased from 29 facilities in San Marcos to 165 facilities in the health areas listed in Table 6, Row 2 (previous page). In addition, in San Marcos, Basic ProCONE was expanded to include 132 first-level health facilities: 79 health posts (HPs) and 53 minimal health units (MHUs), which are funded by their municipalities.

Key activities: Workshops were held with new quality improvement teams where sessions on standards, indicators, measurements, and the collaborative

approach were presented. San Marcos participants took an active role in presenting their best interventions and lessons learned, so that the new teams could benefit from the San Marcos pilot-phase experience.

Results: Figures 14-16 compare data from the Basic ProCONE pilot in San Marcos and the Basic ProCONE expansion in

the other health areas. In general, the ProCONE expansion areas' baseline measurements started lower than those of San Marcos, in part due to the use of more stringent indicators (e.g., all criteria had to be met in order to comply with an indicator). The expansion areas made significant improvements in the indicators in a shorter period than San Marcos had, and these areas are rapidly

Figure 13: Compliance with norms for partograph use, 5 health providers (2 permanent care centers, 1 center for IMCI, and 2 hospitals) in San Marcos, 8/2007–9/2008

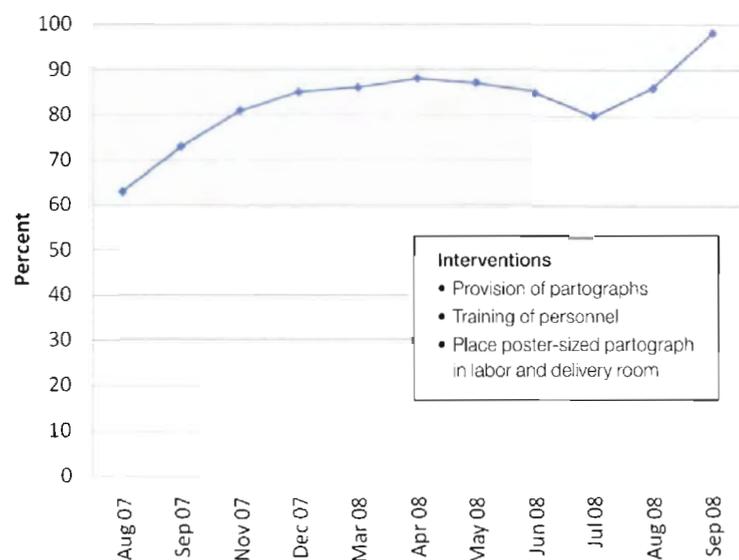
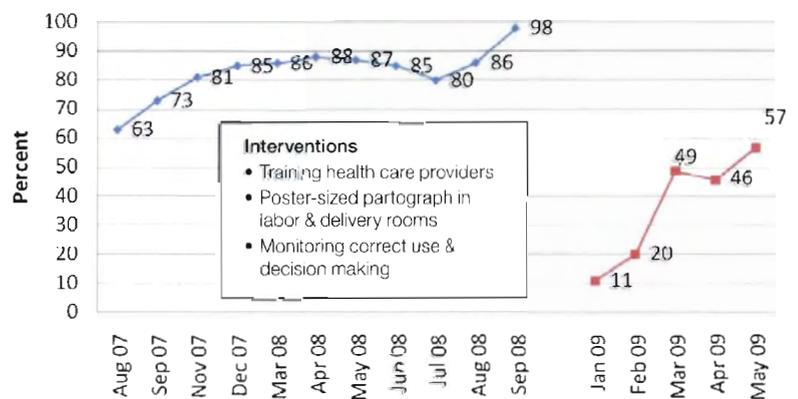


Figure 14: Compliance with criteria for partograph use, pilot phase in San Marcos, 8/2007–9/2008, and expansion phase in other health areas, 1–5/2009



%	11	20	48	56	57
Num	59	82	237	164	237
Den	526	411	487	357	419

approaching San Marcos's achievements. Interventions conducted in the pilot phase are documented on the graphs. Expansion sites are similarly documenting their interventions, and comparisons with San Marcos's interventions will be part of the follow-up Health Care Improvement (HCI) Project.

Expansion of Basic ProCONE to first-level facilities in San Marcos and links to Community ProCONE

The Basic ProCONE in San Marcos expanded starting in March 2008 from 22 health centers to 70 HFs offering first-level care and 53 MHUs. Participating were auxiliary nurses and community

health volunteers (health promoters) who also participated in the Community ProCONE. Figure 17 compares the health centers against the HFs and MHUs in the prenatal care indicator. The latter are below the health centers but rising rapidly by means of such interventions as: home visits to reach new users and new cases, improvements in equipment and the availability of micronutrients, training providers in interpersonal communication and counseling (IPC/C), and improved filling of clinical records. This type of information is also available for post-partum and neonatal care.

Figure 15: Compliance with criteria for AMTSL, pilot phase in San Marcos, 8/2007–9/2008, and expansion phase in other health areas, 1–5/2009

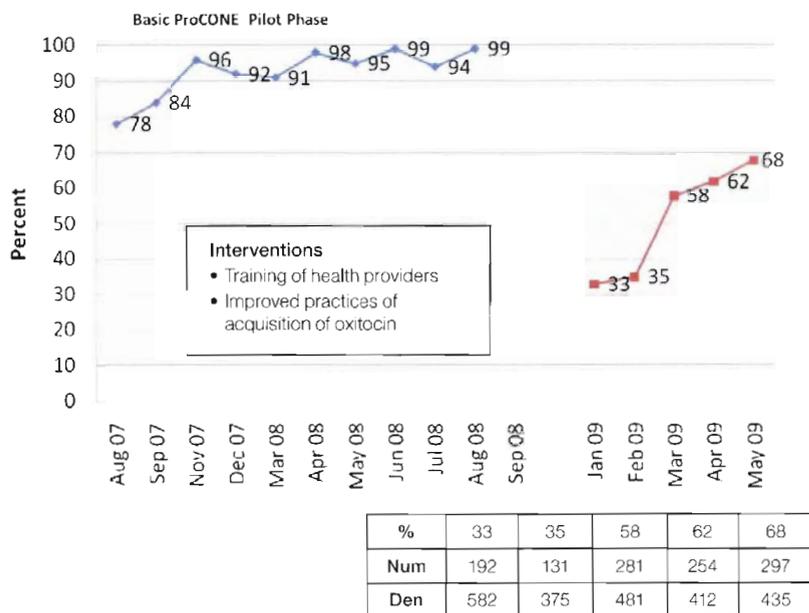
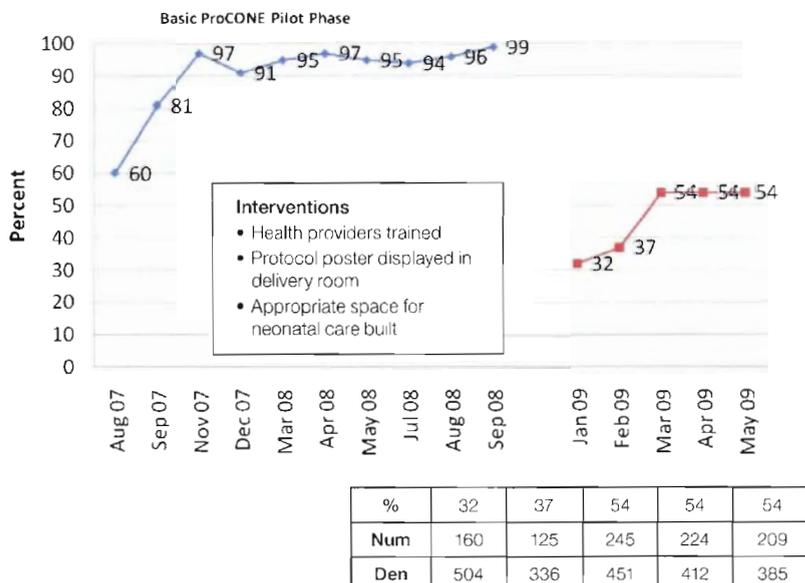


Figure 16: Compliance with criteria for routine newborn care, pilot phase in San Marcos, 8/2007–9/2008, and expansion phase, in other health areas, 1–5/2009



3.1.2 Community ProCONE

The community component of the ProCONE strategy focused on increasing the demand for and access to MNH services. It has taught pregnant women, families, and TBAs the danger signs—during pregnancy, delivery, and the postpartum period and for neonates—that should prompt immediate care in second-level facilities following a family emergency plan drawn ahead of time. Also, to facilitate transportation for complications, Community ProCONE has promoted the formation of health committees in priority communities and urged them to have a community emergency plan.

Key activities: Quality improvement teams were formed and included the area and district coordinators for behavior change communications (BCC), health educators, representatives of the Extension of Coverage Program basic health teams, and TBA representatives. The standards, indicators, and measurement instruments were defined and conveyed in a learning session with community improvement teams. During the pilot phase in San Marcos, teams conducted a series of activities designed to: 1) increase the recognition of danger signs, 2) augment the decision to seek care for complications outside the community, 3) ensure transportation to reference health facilities, and 4) increase humanized and culturally appropriate practices in delivery care. The next phase, starting under the

Figure 17: Compliance with the prenatal care indicator in 22 health centers, 1–8/2009, compared to 79 health posts and 53 municipal health units, 5–7/2009, San Marcos

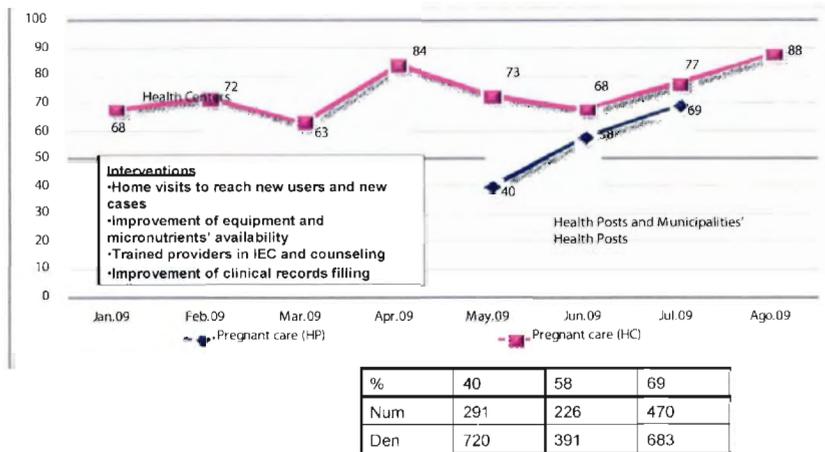


Table 7: Percentage of deliveries attended by trained health personnel in San Marcos, 2007 and 2008

Year	Deliveries	Institutional (attended by trained personnel)	Percentage
2007	27,395	4,976	18%
2008	26,429	6,454	24%

HCI Project, will expand the Community and Basic ProCONES to selected districts in seven health areas.

Results: Figure 17 compares Group 1, 11 districts in the highlands of San Marcos, and Group 2, 11 districts mainly in lowlands (in all 29 municipalities). Districts in Group 1 were prioritized based on their higher maternal mortality rates and started the Community ProCONE Collaborative in October 2007. Seeing good results, the health area director asked that all health districts participate, so Group 2 joined the collaborative in May 2008. Group 2 districts caught-up with those in Group 1 in January 2009, rising to the 80%+ level much more quickly than Group 1 districts had. Compliance percentages above 70% were obtained for recognition of danger signs and emergency planning by pregnant women. Also, health committees with emergency plans were formed or strengthened in 85% of prioritized communities. Also, the cultural

adaptation process was initiated in two hospitals, one Integrated Maternal and Child Health Care Center (CAIMI), and 12 out of 14 (86%) Permanent Care Centers (CAPs).

Interventions to improve maternal knowledge of danger signs during pregnancy and for the newborn included: team work involving health promotion coordinators, reproductive health teams, and NGOs; training all health personnel on IPC/C; training, using participatory, methodology on the four delays that lead to maternal and neonatal deaths; use of mimic and dramatization with groups of pregnant women groups; and involving community health educators in talks and participatory sessions (see Figures 18 and 19).

To increase the number of pregnant women with an emergency plan, all services received ample quantities of emergency plans. They were used in individual counseling and group talks and

given, with training on how to use them, to Extension of Coverage Program basic health teams and TBAs (see Figure 20).

Of health committees in 439 prioritized communities in San Marcos, 373 (85%) now have an emergency plan. Interventions on this indicator were: the development and implementation of a training of trainers for facilitators who train health committees; provision of community emergency plan booklets; coordination with the Disaster Reduction Council and other institutions (police, fire department, and NGOs); and financial support from the Departmental Development Council and municipalities.

Finally, regarding the humanization and cultural adaptation of delivery services, 2 out of 12, or 17%, of CAPs that attend deliveries comply with all six criteria defined by the CAPs themselves during workshops. Three CAPs have started to measure user satisfaction using pictorial forms. Interventions included: developing a strategy and training all personnel; having TBAs train physicians in traditional birthing positions; posting pictures of traditional birthing positions in labor and delivery room so that the woman can indicate the desired position; and financial support from the Departmental Development Council to train TBAs.

In San Marcos, the percentage of deliveries attended by trained health personnel increased from 2007 to 2008 (Table 7), in part due to the CAP promotion component of the Community ProCONE.

Finally, the San Marcos health area administration has analyzed all maternal deaths from the past three years and classified each according to one of four delays:

1. The recognition of danger signs,
2. Decision making,
3. Opportune transportation, and
4. Quality management of complications.

The number of deaths decreased from 2008 through 2009, and a dramatic shift occurred in the percentage of deaths

Figure 18: Pregnant women who could name at least 3 danger signs during pregnancy, 22 districts in San Marcos



Figure 19: Pregnant women who could name at least 3 danger signs in the newborn, 22 districts in San Marcos

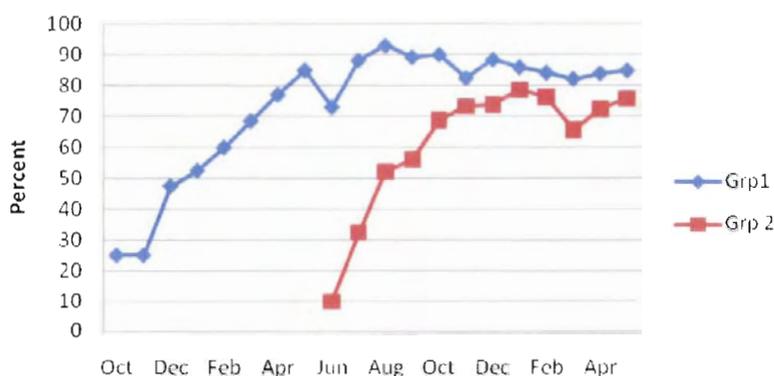
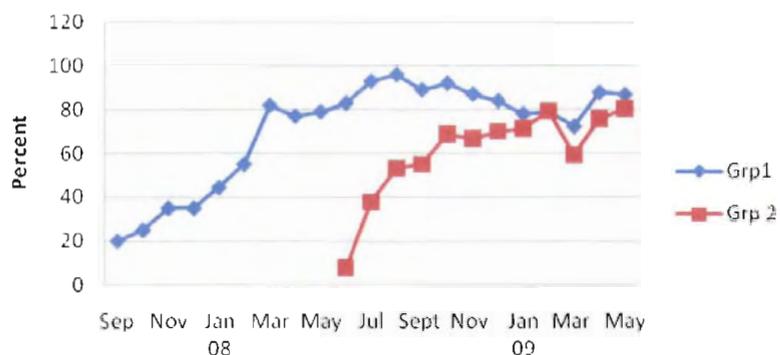


Figure 20: Pregnant women who had an emergency plan, 22 districts in San Marcos



classified as having occurred in the first three (community) delays to those classified in the fourth delay (inadequate management of complications), which is an independent endorsement of the Community ProCONE.

3.1.3 ProCONE for obstetrical and neonatal complications

The ProCONE component addressing complications focused on strengthening the management of the most prevalent obstetric and neonatal complications (hemorrhage, sepsis, and preclampsia in the mother and asphyxia, prematurity/low birth weight, and sepsis in the neonate) through the formation of quality improvement teams with staff from obstetric and pediatric departments of participating hospitals.

Key Activities: Norms were revised to identify standards, indicators, and criteria for management of the main causes of maternal and neonatal death. The work involved experts from teaching hospitals and participating hospitals. Although measurements started in two San Marcos hospitals, to foster both collaboration and competition, Calidad negotiated to have the Complications ProCONE implemented in more, and 16 hospitals from seven health areas participated. Indicator measurements for the management of complications began in August 2009, with most values starting at 0% (all criteria in each indicator must be met in order to qualify as complying with the indicator). This work will continue under the HCI Project.

3.1.4 Training of Mayan auxiliary nurse midwives

Developing a cadre of Mayan auxiliary nurse midwives was a *Calidad* mandate. MSPAS was initially opposed, but an agreement was reached to develop this new cadre. The program was implemented through close collaboration involving the Extension of Coverage Program, which provided field experience for students and hired course graduates; the National School of Nurses, which conducted training and monitored

activities; and *Calidad*, which provided scholarships, supported training, and provided ongoing monitoring.

Results: The work of these midwives shows favorable results as can be seen by the indicators listed in Table 8, covering those working in the Asociación Xilotepeq in San Martín Jilotepeque, Chimaltenango, since January 2008. While it is difficult to distinguish the midwives' contributions from those of the rest of the basic health team, results like these are common. In the absence of other changes in these NGOs, improvement has been attributed to the midwives (see box).

Other results: Community organization: Preceding the Community ProCONE activities described above, the formation of health committees and training in emergency planning were piloted in Cuilco, Huehuetenango, and El Estor, Izabal—where the first two CAIMIs were implemented. According to a September 2006 inventory, taken two years after contract signing, at least 365 health committees were found to have functioning community emergency plans at some level in municipalities in areas other than San Marcos. This represented 121% of the *Calidad* target to strengthen 300 community emergency plans before that date. Health committee participants reported some strengths in the initial phases of the community emergency plan effort: organization, analysis of problems, and planned solutions. Weaknesses were reported in implementation, monitoring, and participative evaluation. On May 30, 2007, *Calidad* delivered to USAID a detailed report on the inventory of health committees and some of their

Box 1: Case study of San Martín Jilotepeque

General Information

Population: 78,500 residents living in 160 communities

Population served to by NGOs: 60% in 96 communities divided into four jurisdictions (of ~10,000 inhabitants each)

There are two auxiliary nurse-midwives; each one covers two jurisdictions.

Table 8: Mayan auxiliary nurse midwives, San Martín Jilotepeque, Chimaltenango

Indicator	2007	2008	Increase
Pregnant women who attend first prenatal visit	224	312	39%
Pregnant women who have two prenatal visits	616	877	42%
Pregnant women who have three prenatal visits	495	704	42%
Home visit to new mother	550	688	25%
Taking of Pap smears	575	1165	102%
Delivery of Pap smear results	456 (79%)	1107 (95%)	142%
Women who use family planning	15%	49%	34%

characteristics. In addition, formative research on community perspectives and organization was carried out in Totonicapán.

Proportion of deliveries attended by trained personnel: Official data (SIGSA I) indicate that the proportion of deliveries attended by trained personnel has been increasing in the health areas covered by the project. From 2005 to 2008 the proportion covered rose from 13.1% to 19.6% in the highland health areas.

Coverage of postpartum care: Since implementation of the ProCONE strategy and its expansion, positive results have

been observed in the Extension of Coverage Program in *Calidad's* eight health areas. Coverage of postpartum care increased from 28.5% in September 2006 to 45.4% in September 2008, which surpasses the MSPAS goal of 44%. As of December 2008, postpartum care at the national level in the Extension of Coverage Program was 57%. Although there is no SIGSA data prior to 2008, for that year postpartum care coverage at institutional services was reported to be 57.1% in *Calidad* health areas.

3.2 Nutrition Interventions for Women and Children

Calidad's nutrition component, originally planned for three years, provided technical assistance to the MSPAS during four years, from October 2004 to September 2008. Actions focused on preventive and curative aspects as highlighted below. In the final year, nutrition activities have been integrated into support to improve quality of care and BCC activities in the Conditional Cash Transfer Program, with emphasis on growth promotion through IPC/C on exclusive breastfeeding and complementary feeding.

Table 9 presents information by objective on the activities, scale, and results achieved by the strategy to improve nutrition for women and children. This section describes the activities and notes their geographic scale and provides key results.

3.2.1 Institutionalization of AIEPI AINM-C

Developed in 2002, the preventive component of the Integrated Care of Women and Children in the Community strategy (AIEPI AINM-C but hereafter "AINM-C") was aimed at growth promotion and illness/ malnutrition prevention at the community level. Although for different, primarily political, reasons, direct support to the MSPAS Extension of Coverage Program (through NGOs working at the community level) was limited, the strategy was institutionalized within that program. Furthermore, project staff participated in the development of a World Bank project that provides additional technical and financial support

Table 9: Calidad nutrition objectives and their activities, scope, and results

Objective	Key activities	Geographic scale and population coverage	Results
Improve and expand programs related to nutrition; in particular, growth monitoring and promotion at the community level	Institutionalization of the growth monitoring component of the Integrated Care of Women and Children at the Community Level Program (AIEPI-AINM/C) Monitoring and evaluation of growth promotion component of AIEPI-AINM/C	Nationwide: extension of coverage to first-level services	AINM-C contents, training, IEC materials, and indicators are official Monitoring and evaluation of AINM-C results serve as the basis for a World Bank project
Support updating of existing nutrition policies and new policies and norms	Supported National Strategy for the Reduction of Chronic Malnutrition (ENRDC) in the form of formative research and development of a BCC strategy	Nationwide	Vitacereal trials of improved practices and recipes implemented; 17 recipes were disseminated BCC strategy and materials developed and used
Identify innovative and integrated approaches to reduce chronic malnutrition in children	Operational research on sprinkled micronutrients for children 6–69 months and soluble zinc tablets for sick children	Three municipalities in Alta Verapaz	Based on research results, this intervention has been expanded to 45 priority municipalities covered by CCTP BCC strategy and materials adopted Improved logistics for micronutrients
Promote optimal breastfeeding and appropriate complementary feeding practices	Supported and monitored compliance with baby-friendly strategy Disseminated messages through IPC/C and mass media Integrated breastfeeding and family planning (FP) messages	Nationwide	Limited results of baby-friendly strategy: accreditation of only 2 hospitals (9%) and 4 maternities (80%) Results of BCC strategy will be evaluated through the National Maternal and Infant Health Survey (ENSMI) in 2009
Strengthen human resources in nutrition	Developed and implemented distance education course on Food and Nutrition Security for health personnel	13 health areas	>500 health personnel trained Catholic Relief Service staff trained Other institutions trained Secretariat for Food Security and Nutrition (SESAN delegates)
Establish a nutritional surveillance system to enable monitoring and evaluation of the public's nutritional status, planning to solve problems, and providing early warning	Revised the "grows well" indicator in the Extension of Coverage program Modified SIGSA 5 A into a child notebook Prepared a manual to accompany the child notebook	Nationwide: the child notebook is being used in most health services	A complete nutritional surveillance system is still inoperative
Provide rapid response during nutritional emergencies	Provided equipment Nutritional surveillance and interventions in cases of emergency BCC strategy and materials	45 priority municipalities	33 hospital equipped for management of severe acute malnutrition Case detection and intervention

to AINM-C implementation. The strategy is an important part of the content, training, and activities of the basic health teams working under NGOs in the Extension of Coverage Program, the World Bank project, and USAID partner PVOs. All project materials are official MSPAS materials being used by health providers, including new community health educators, and AINM-C indicators are part of the Extension of Coverage information system. Evaluation results of the AINM-C strategy carried out with USAID partner PVOs and independently have been incorporated in present projects. As part of the support to a longitudinal nutritional information system, the SIGSA 5 A register was turned into the *Cuaderno del Niño y de la Niña* (Child Notebook), now used in most health services for registering weights, micronutrient supplementation, and vaccination in children under 6.

3.2.2 Support to the National Strategy for the Reduction of Chronic Malnutrition

The Secretariat of Food and Nutrition Security presented the national strategy for the Reduction of Chronic Malnutrition (ENRDC) in 2004. *Calidad* provided continued support to MSPAS in the development and communication of this objective. A key intervention was the distribution of a food supplement, Vitacereal, to pregnant women, lactating mothers (up to 6 months postpartum), and children from 6 months to 3 years of age. The project participated in studies on the acceptability of Vitacereal (although preparation suffered a last-minute change without new acceptability tests) and in the development of the BCC strategy for its positioning and distribution, including promotion materials. The project also conducted research on the inclusion of Vitacereal in 17 complementary food recipes that facilitate consumption by young children.



How to feed children under 2 years of age BCC poster

3.2.3 Innovative and integrated approaches to reduce chronic malnutrition in children

The project supported innovative and cost-effective intervention that can contribute to the reduction of micronutrient malnutrition. It supported MSPAS in implementing research on micronutrients in powder form, which are easily sprinkled onto foods prepared in the home (Sprinkles or *Chispitas*) and soluble zinc tablets used to treat pneumonia and diarrhea. The project helped with proposal development, research in three municipalities in Alta Verapaz, logistics, development of training and counseling materials, and recall materials for mothers, monitoring, and evaluation. MSPAS is now implementing this form of home fortification under CCTP in all eight municipalities in Totonicapán and expanding it to the other priority municipalities. The project also helped improve the MSPAS logistics for micronutrients.

3.2.4 Promotion of breastfeeding and infant and young child complementary feeding

The project supported the baby-friendly services initiative through the monitoring of compliance with 10 steps (indicators) and the promotion of

breastfeeding, one of the most cost-effective interventions to reduce neonatal and child mortality. Self-evaluation and training were conducted in 23 hospitals and 5 maternities, and 8 hospitals and 5 maternities were also evaluated externally. Breastfeeding committees were formed at 23 hospitals, but only two hospitals (9%) and four maternities (80%) had been accredited as baby-friendly as the project approached closure. In addition, through work supporting the MSPAS and the USAID partner PVOs, specific recommendations, messages and materials on complementary feeding were developed and disseminated. Above is a sample of a material on complementary feeding supported by the *Calidad* project.

3.2.5 Strengthening human resources in nutrition

A six-module distance education course on food and nutrition security for health personnel was developed and implemented with the MSPAS and accredited by the Rafael Landívar University. Thirteen departments and 500 second-level health care providers (HCs) participated. In 2008, Catholic Relief Services (CRS) trained its technical personnel using this course. In addition, hospital and health area nutritionists participated in continuous education

workshops in nutrition; medical and nutrition students from major universities attended MSPAS training in nutrition supported by *Calidad* technically and financially.

3.2.6 Nutritional surveillance system

Calidad attempted to implement a nutritional surveillance system that could enable MSPAS to monitor and evaluate nutritional status, plan to solve problems found, and provide early warning before nutritional crises arise. The adequate weight gain indicator ("grows well") was added to the Extension of Coverage Program information system and the child notebook for institutional health services. However, the quality of the data was unacceptable, and MSPAS prefers independent surveys using the weight-for-

height indicator of acute malnutrition (and the Nabarro table). Despite numerous meetings and planning, institutions that must cooperate—SESAN, MSPAS, Ministry of Education (height census of first-grade students), and the Ministry of Agriculture—never agreed on a nutritional surveillance system.

3.2.7 Rapid response to emergencies

Among the responses to emergencies, the following can be highlighted:

- Equipment and support was provided to 33 hospitals for treatment of severe acute malnutrition during the nutritional crisis.
- After the Hurricane Stan emergency, the project helped develop and install a provisional nutritional

surveillance system to prevent acute malnutrition through the provision of food distribution, micronutrient supplementation, and counseling, thus averting a major nutritional crisis. At the same time, detection of cases of acute malnutrition for referral for treatment in hospitals and nutritional recuperation centers was conducted.

- Immediate and opportune responses were provided at other times when communities were declared in "nutritional alert." Specifically, support to MSPAS nutritional evaluations was crucial to detect cases requiring treatment.

3.3 Child Health

For the child health component, *Calidad* focused on one objective: to contribute to the prevention of illness and the reduction of infant and child mortality. Table 10 presents the activities, scale, and results achieved, and the text and figures that follow present that information in detail, including indicators measured by the facility-based quality improvement teams.

3.3.1 Demonstration collaborative on integrated child care

A health care improvement collaborative focused on IMCI was implemented in seven health districts in the South Guatemala Health Area. The aim was to better integrate infant and child care for children under five using the IMCI algorithm: identification of general danger signs, evaluation, classification, treatment, and prevention and counseling.

Key activities: *Calidad* helped MSPAS and other stakeholders revise child care norms, define standards and indicators, and provide clinical records and forms to enable monitoring. Collaborative teams formed in each participating health facility and attended *Calidad*-conducted learning sessions. The teams measured indicators under the guidance of *Calidad*-provided mentoring during “action periods” (periods of team work between learning

sessions). Results were presented at the national and health area levels and at selected conferences.

Results: Presented here in Table 11, results show improvement from the baseline to the second and third measurements. General identification of danger signs improved 49 percentage points, from 38% to 87%. Integrated evaluation of the child improved of 25 percent points, from 59% to 84%. Classification was high to start with (84%) and did not vary. Treatment improved from 64% to 83%. Counseling also improved (20 percent points overall), but not in a linear way. Interventions to improve the situation were the training of health personnel to standardize their work in providing integrated child care and recording care on clinical records, posters reminding them about standards and indicators, and periodic monitoring of indicators and discussion of percentages of compliance. Reasons for the lack of continuous improvement in the prevention indicator were: vaccination is not conducted opportunistically, micronutrients are not always available, and growth promotion counseling is not always conducted.

3.3.2 Child vaccination coverage

Calidad supported the MSPAS throughout the project in order to achieve adequate immunization coverage in the country. The project provided support to 1) the introduction of the Pentavalente vaccine, instead of DPT, for children under one year and 2) an extraordinary campaign to vaccinate individuals 7–39 years old against measles and rubella. Finally, the project conducted an immunization campaign in selected municipalities.

Key activities: *Calidad* held strategy meetings periodically with the National Immunization Program (PNI). It also supported the BCC strategy design, implementation, and monitoring; materials were developed and distributed. *Calidad* also helped conduct rapid monitoring of coverage in the six priority health districts listed in Table 13 before the 2008 national health week vaccination campaign.

Table 10: Child health objective and its activities, scope, and results

Objective	Key activities	Geographic scale and population coverage	Results
Contribute to the prevention of illness and the reduction of infant and child mortality	Demonstration collaborative on integrated child care	South Guatemala Health Area (7 health districts): 98,281 children under 5	Four out of five indicators reached acceptable levels above 80%
	Strategies to improve vaccination coverage	Nationwide	More than 95% vaccination coverage was achieved for all vaccines for children 12–23 months
	Collaborative on timely child immunization	16 priority health districts in seven health areas: North Guatemala, Huehuetenango, El Quiché, Totonicapán, San Marcos, and Izabal: 91,322 children under 5	Providers' knowledge reached 70% or more Caregiver indicators improved, but not above 70% 50% of participating health districts have adequate coverage of trace vaccine polio/ Penta3
	BCC strategy and use of IEC materials	Nationwide	Contributed to improved vaccination coverage (greater than 95% in ordinary vaccination campaigns and in measles and rubella vaccination for people 7–39 years old)

Results: Adequate vaccination coverage (>95%) was achieved at the national level in 2008 in all vaccines that are administered to children 12–23 months old. Previous years had less success (Table 12), when two or three of the vaccines did not reach adequate coverage (grey-shaded areas).

After the rapid monitoring survey revealed low coverage in six health areas, 13,610 children who had not been vaccinated. Data on the OPV/Penta3 coverage are in Table 12 and show that on the final measurement, all participating health areas had 95% coverage or above.

3.3.3 Improvement Collaborative on Child Immunization

Achievements notwithstanding, *Calidad* helped identify municipalities and communities with chronically low immunizations coverage. To correct the problem in selected health districts, *Calidad* initiated a Child Immunization Improvement Collaborative in 16 health districts in six health areas. These health districts had shown persistently low vaccination coverage (percentages).

Key activities: A preparation phase stimulated stakeholders to participate in and support the collaborative. The collaborative defined indicators relative to: 1) opportune vaccination, 2) provider knowledge of child vaccination programs, 3) availability of vaccines, 4) BCC activities focused on child vaccination, 5) mothers or other caretakers knowledge of ages for child vaccination, and 6) radio messages about vaccination for mothers and other caretakers. During the collaborative, *Calidad* conducted learning sessions and provided technical assistance during action periods with monitoring of indicators and the rapid improvement cycles.

Table 11: Improvements in indicators of integrated child care in seven health districts, South Guatemala Health Area, 2008

Indicator	Baseline n (%)	2nd measurement n (%)	3rd measurement n (%)
Identification of general danger signs	53 (38)	94 (67)	122 (87)
Integrated evaluation	83 (59)	94 (67)	118 (84)
Classification	118 (84)	122 (87)	119 (85)
Treatment	90 (64)	140 (100)	116 (83)
Prevention (counseling)	66 (47)	66 (85)	94 (67)

Note: Percentages are based on 140 clinical records reviewed each quarter by seven health facilities.

Table 12: Vaccination coverage at the national level, 4 vaccines, 2005–2008

Vaccine	Year			
	2005	2006	2007	2008
BCG	97	96	98	98
OPV 3	93	92	93	95
Pentavalente 3	95*	91	93	95
MMR	94	94	94	96

Note: In 2005, DPT coverage was achieved through the administration of DPT3 and Pentavalente 3 (56% and 39%, respectively).

Table 13: Improvement in vaccination coverage after six weeks of intervention in six health areas, 9/22–11/7, 2008

Health Area	Initial coverage (%)	Final coverage (%)
Alta Verapaz	89	98
Baja Verapaz	96	100
El Progreso	98	100
Izabal	79	96
Petén norte	93	96
Petén suroriental	81	95

Results: Figure 21 shows the percentages of compliance with the six indicators.

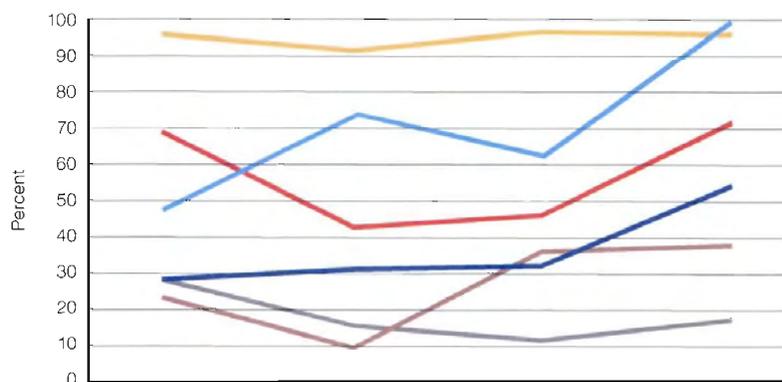
The availability of vaccines was high throughout (>90%), and providers' knowledge remained at 70%. Opportune vaccination increased from 28% to 53%. BCC activities on child vaccination increased from 48% to 100% compliance in participating health districts (i.e., at the end, all health districts were conducting IPC/C and airing mass media messages). However, the percentage of mothers or other caretakers who mentioned correct ages for bringing their child in for vaccination did not change (<25%), and the percentage of mothers and other caretakers who reported having listened to radio messages about vaccination did not reach acceptable levels, although it rose from 24% to 38%. It appears that the question of specific ages for child vaccination is difficult for mothers to remember.

Eight out of 16 priority health districts (50%) had adequate coverage (> 95 %) of vaccine OPV/Penta3, considered a trace vaccine.

3.3.4 BCC strategy and materials.

The project supported MSPAS in the design, pretesting, production, and distribution of various IEC materials focused on child care and vaccination (shown below). Among these materials the following are noteworthy: vaccination brochure, child vaccination scheme poster, and reproductive-age women vaccination poster, radio spots on vaccination, a video on vaccines (produced with PNI). Also provided were brochures and posters on diarrhea and pneumonia prevention. All materials were distributed with training and were accompanied by user guides. Thus, it can be stated that IEC/BCC must have contributed to improved vaccination coverage

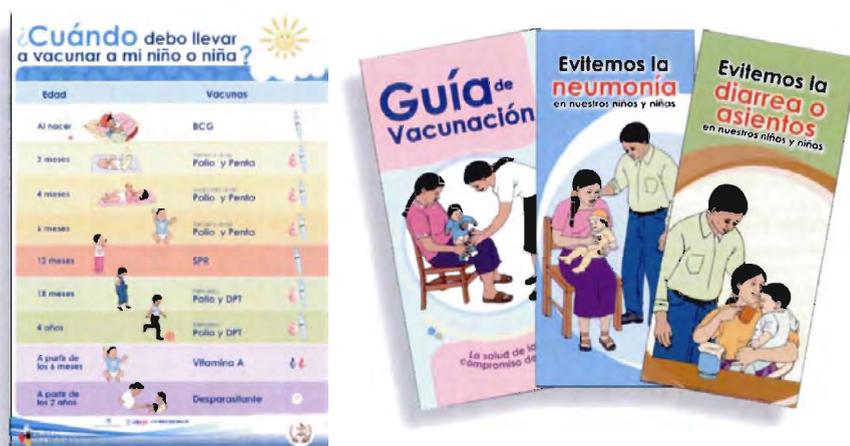
Figure 21: Compliance with child immunization indicators, 16 health districts, 2–5/2009



Indicador	Feb. 2009	Mar. 2009	Apr. 2009	May 2009
First	28	31	33	53
Second	69	43	46	71
Third	97	92	96	96
Fourth	48	75	63	100
Fifth	29	16	12	17
Sixth	24	10	36	38

Note: The indicator numbers in the figure align with the list of indicators in the "key activities" text above.

Sample BCC materials developed and distributed by Calidad



3.4 Integrating Child and Reproductive Health Services

Integrating child and reproductive health services was conceptualized as a strategy to improve the organization of health systems to improve efficiency, services, and client satisfaction. Four lines of action were identified to develop this component: 1) integrate program teams, service provision units, and others at the central level; 2) integrate horizontally prevention and care services; 3) integrate other services vertically; and 4) integrate clinical services and support systems.

Implementation strategies and results

The project developed a set of strategies that guided the implementation of the other project components. The strategies included:

- Integrated service delivery for women of reproductive age and children under five;
- A system of referrals and counter-referrals;
- Prevention and health promotion services offered at all times, including during curative service delivery;
- Availability of essential drugs, contraceptives, and IEC materials in all health facilities; and
- A functioning, facilitative supervision system.

Integrated service delivery

The Project made several major inroads in integrating the delivery of primary care services. Neonatal health was integrated into the Essential Obstetrical Care Service Delivery Package. Second, support to MSPAS in its co-responsibility in the CCTP includes improving preventive prenatal, postpartum, neonatal, and child care. Third, family planning services were integrated into the 34 STI/HIV clinics; FP is also being integrated in the MNH improvement collaboratives in the eight priority health areas and in support to the CCTP preventive services. Fourth, growth monitoring is part of preventive child care in all health services. Next, voluntary counseling and testing is being

integrated into maternal health service. Sixth, the integrated AINM/C strategy is undergoing continued strengthening throughout the country. Also, the new norms (to be launched in November 2009) have been developed following the life-cycle approach, where actions from all programs are integrated. Lastly, the concept of "counseling in the continuum of care" was put forward and has been integrated into norms.

System of referrals and counter-referrals

Improvements to the referral and counterreferral system: With participation from technical personnel at the central level and the health areas of El Quiché, Huehuetenango, Izabal, Jutiapa, San Marcos, and Sololá, *Calidad* developed a referral and counterreferral system having ten components: regionalization; portfolio of services; coordination; management of documentation; patient management; transport or transfer of patients; communication; information technology; supervision, monitoring, and evaluation; and technical and administrative norms and standards. To begin implementation, the technical teams in the health areas of Petén Norte, Petén Sur Occidente, Petén Sur Oriente, Zacapa, Chiquimula, Jalapa, Jutiapa, and Alta Verapaz were inducted into the system. A baseline was also carried out at the San Marcos Hospital.

Calidad helped develop clinical records by life-cycle stages to facilitate the application of standards of maternal, neonatal, and child care. Based on article 81 of MSPAS regulations (Reglamento Orgánico del MSPAS), a referral and counter-referral system was developed with participation from personnel at the central and local levels. Implementation was validated and tested in the health area of San Marcos. The test identified a need for technical rules and a procedures manual, which are currently being developed.

Prevention and health promotion services are offered at all times, including during curative service delivery

Integrated care is offered for mothers, neonates, and children whether the child comes in sick or healthy. Integrated care follows the clinical record and includes preventive services (immunization, growth monitoring, micronutrient supplementation, de-worming) and counseling. Also, in the 34 health centers *Calidad* supports to offer STI and VCT services, providers are routinely offering FP services; when a high-risk woman is pregnant, prenatal services are offered. Integrated services are also offered to the general public, with special attention to high-risk groups.

Availability of essential drugs, contraceptives and IEC materials in all health facilities

The logistics strategy has been working to support MSPAS to improve the availability of contraceptives at all delivery points in the country. Between 2001 and 2009, contraceptives availability increased from less than 50% to more than 85%. Consequently, MSPAS decided to monitor other essential drugs, especially those used to provide maternal and child services; results are less favorable than those seen in contraceptives, due mainly to budget restrictions.

IEC materials for all major programs and integrating maternal, neonatal, and child behavior messages were designed, pre-tested, produced, and distributed. *Calidad* helped develop a booklet on the CCTP for health workers so as to include preventive care norms, standards, and indicators being measured through *Calidad* collaboratives.

Functioning facilitative supervision system

Due to frequent changes in the MSPAS Monitoring, Supervision and Evaluation Unit, implementation of the facilitative supervision system developed during the previous URC contract (*Calidad en Salud I*) was discontinued; nevertheless, several monitoring activities were reinforced in each *Calidad* component.

Table 14: *Calidad* objectives related to STIs and HIV and the activities, scope, and results of those objectives

Objectives	Key activities	Geographic scope	Results
Improve the quality of STI and HIV services	Situational analysis Capacity building Continuous quality improvement Infrastructure improvement	34 health services in 9 health areas and the central level	Screening of clients for STIs reached 90% Compliance with service delivery norms increased from 60% to 80% Staff in all 34 sites now provide quality STI, VCT, and family planning services in an integrated approach The number of VCT tests doubled between 2005 and 2009 Developed MSPAS capacity to diagnose Chlamydia and gonorrhea Strengthened biosecurity program
Promote and increase demand for STI and HIV services	Developed a national strategy to address stigma and discrimination Developed training manuals Conducted study visits to clinics offering high-quality integrated services to stigmatized groups Contributed BCC materials	34 health services in 9 health areas and the central level	Staff of 34 health centers and hospitals were sensitized about stigma and discrimination Demand for services has increased Clients who received post-test counseling increased from 48 to 78% BCC materials were developed in cooperation with MSPAS
Integrate HIV/STI within reproductive health services	Close coordination between the National Reproductive Health Program (PNRS) and PNS Integrate messages on all FP and HIV/AIDS IEC materials Integrate counseling training	34 health services in 9 health areas and the central level. FP is nationwide	FP services are routinely offered to STI and HIV clients and vice versa At least three centers have reorganized to provide a general waiting area where all clients are routinely offered all available services
Strengthen HIV-STI surveillance and monitoring systems	Coordinated with the PNS and CDC in the implementation of VICITS Implemented PACE 2 Improved data collection	Central level, Puerto Barrios, Escuintla, and Quetzaltenango	Three improved sentinel surveillance sites are functioning SIGSA SIDA (HIV component of the health management information system) implemented

3.5 Sexually Transmitted Infections and the Human Immuno-deficiency Virus

Table 14 presents information by objective on the activities, scale, and results achieved by the strategy to improve services for people with sexually transmitted infections (STIs) or the human immuno-deficiency virus (HIV). This section describes the activities and notes their geographic scope and provides key results.

3.5.1 Quality of service delivery

The National AIDS Program (PNS) and the project team conducted a structured needs assessment to document the state of syndromic management and voluntary counseling and testing (VCT) services. Second, capacity building was addressed in training sessions, facilitative supervision visits, during study visits to a model clinic, and/or during learning sessions related to continuous quality improvement activities.

As in the overall *Calidad* strategy, staff supported relevant MSPAS structures and personnel to plan and implement all capacity-building exercises, greatly enhancing sustainability.

Calidad launched continuous quality improvement (CQI) in its STI/HIV component in July 2007 with a demonstration phase that included nine centers in the department of Guatemala. An expansion phase that included the rest of the 34 project health centers ran from September 2008–September 2009. CQI teams at each facility typically included the physician, nurses and auxiliaries, the data analyst, social worker, secretary, and others, as appropriate. All teams convened every few months in learning

sessions to monitor results against indicators, share strategies, and solve problems.

The project contributed to infrastructure

improvements by providing a one-year supply of 8,000 rapid HIV tests, 350 confirmatory tests, reagents, and supplies needed to bring VCT and STI counseling, testing, and lab services closer to the

population. *Calidad* also developed a user's manual and oriented relevant health center staff to Pipeline, a projection tool meant to improve supply continuity. Another activity was to provide technical support for clinic redesign to enhance the provision of STI/HIV services, particularly to improve privacy and confidentiality. Staff facilitated architect site visits as well as the necessary government and donor paperwork. The difficulty of meeting some requirements, such as verification of government ownership of the land where the clinic is located, delayed rehabilitation in several sites until 2010.

Support included updating HIV reporting norms and guidelines to better align with national and international indicators; arranging four workshops, financed by the Pan American Health Organization, for national rollout of the updated, electronic HIV component of the health management information system (SIGSA-SIDA).

Biosecurity

Calidad worked with the national HIV/AIDS program to help develop curricula for the implementation of training workshops for physicians, paramedics, and laboratory personnel; training focused on management of needles, syringes, and sharp material; management of body fluids and laboratory equipment, and on strengthening the use of protection and hygiene practices to reduce the risk of infections. A total of 228 service providers, including physicians, nurses, paramedics and laboratory personnel received biosecurity training during the project.

3.5.2 Promoting and increasing demand for HIV and STI services

Technical assistance was directed at identifying the degree of stigma and discrimination among the MSPAS service providers and at developing and implementing a strategy for reducing both stigma and discrimination. The findings of this effort can be summarized as follows:

- Breaches in patient privacy and confidentiality and other stigmatizing and discriminatory behaviors of

- which providers were unaware were problematic.
- Requests had been made by high-risk groups, particularly men who have sex with men (MSM), for a reporting and sanction system for abusive and discriminatory service provision.
- There was a lack of supplies and facilities that would ensure universal precautions, proper waste disposal, and equal access to testing services.
- Discrimination occurred between client groups themselves, especially against MSM, underscoring the difficulties this group faces in any public acknowledgment of their sexual diversity (including attending an STI/HIV clinic).

Results: The stigma and discrimination interventions are just beginning to create an impact on demand for and use of services by vulnerable groups. Practices such as reporting positive HIV serostatus to brothel owners or other employers, marking serostatus on health cards, and discouraging pregnant commercial

sex workers from working without the offer of a viable alternative have been reduced according to reports from service providers. Health workers are beginning to understand that such practices divert sex workers—particularly HIV-positive ones—to private STI control services that do not offer VCT, so they will not be identified or reported and could be fired.

3.5.3 Behavior Change Communications

Calidad supported the MSPAS's development of an IEC/BCC strategy for STI/HIV and a range of behavior-focused materials for commercial sex workers, MSM, persons with HIV/AIDS, and owners of entertainment establishments (Annex 5.5 has a list of materials).

The overall impact of the project technical assistance has been the improvement in MSPAS capacity to provide quality service delivery.

All materials followed good design principles, focused on desired behaviors, were tested and validated with their

HIV and STI BCC/IEC materials



specific audience, and reprinted by the project. Working in technical committees to plan and produce materials took time but helped ensure relevance, use, and even defense of materials. A sampling of HIV and STI BCC materials is shown on the previous page.

Integrating HIV/STI within reproductive health services

This was the first project in the experience of national HIV/STI program leaders to address STIs comprehensively and integrate them with HIV and other reproductive health services.

3.5.4 HIV/STI surveillance and monitoring systems

Calidad improved 1) laboratory and reporting capacity at the 34 project sites and 2) national norms and systems

for capturing STI/HIV service statistics through rollout of SIGSA-SIDA. The project also integrated medical record forms and provided assistance in the development of MANGUA for reporting integrated HIV treatment services.

The project also supported improvements in the national STI/HIV surveillance system. An effective partnership of national health agencies, the Centers for Disease Control and Prevention, and *Calidad* succeeded in adding rapid diagnosis and testing of gonorrhea and chlamydia to a national reference laboratory at the Zone 3 health center in Guatemala City, strengthening its role as a national resource for both STI/HIV service delivery and surveillance. *Calidad* equipped the center with PACE 2 diagnostic

equipment, supervised its installation, trained staff in the testing process, and provided necessary reagents and supplies. This is the only such equipment in the country.

The partners also worked to expand the national STI and HIV sentinel surveillance system (VICITS) to three health centers in addition to the Zone 3 center (Puerto Barrios, Escuintla, and Quetzaltenango). The Foundation for AIDS and Society (Fundación Sida i Societat) supported the development of the site in Escuintla.

objectives was nationwide. Subsequent text provides detail on these topics.

The Ministry of Health, with the support from *Calidad*, has achieved significant advances in its efforts to meet an increasing demand for family planning services, becoming in the process, the leading provider of contraceptives in the nation.

3.6 Family Planning and Contraceptive Security

Calidad had four overall objectives in the area of family planning and contraceptive security, ranging from increasing demand for products and services to enabling financial security on the part of MSPAS to ensure both will be available to the people of Guatemala for the long term. Table 15 lists the objectives and provides key activities and results for each. The geographical scope for all

3.6.1 Increase in the use of family planning services

Calidad provided technical assistance that contributed to a significant increase in the levels of provision and institutionalization of family planning services to men and women. An unprecedented number of people received MSPAS family planning services during *Calidad*'s implementation: During the project's first year, 2004, MSPAS provided FP services to 270,907 new users; in 2009 this figure was 569,101,

a 210% increment. In addition, couple years of protection (CYPs) rose from 321,288 in 2004 to 463,619 in 2009, a 114% increase. The project consistently met and surpassed annual targets for both indicators, resulting in USAID's raising project targets.

Key activities: *Calidad* achieved these results by starting with training: MSPAS staff were trained in contraceptive technology, family planning counseling, sensitizing, and birth spacing. This was followed by the donation of equipment for IUD insertion and sterilization procedures. *Calidad* contributed to the institutionalization of service provision, seeking to have FP services offered on an equal basis with curative services. A postpartum FP program was implemented at 20 of the country's 43 hospitals. *Calidad* stressed the need for the use of data for planning and resource allocation, taking every opportunity to explain the role of data in decision making to as many MSPAS staff as possible. Throughout, *Calidad* contributed to efforts to strengthen the logistics management system for contraceptives and to the design and production of educational materials, such as posters and brochures. *Calidad* also contributed to updates to the MSPAS family planning guidelines to reflect the latest international evidence.

Table 15: Family planning and contraceptive security objectives, activities, and results

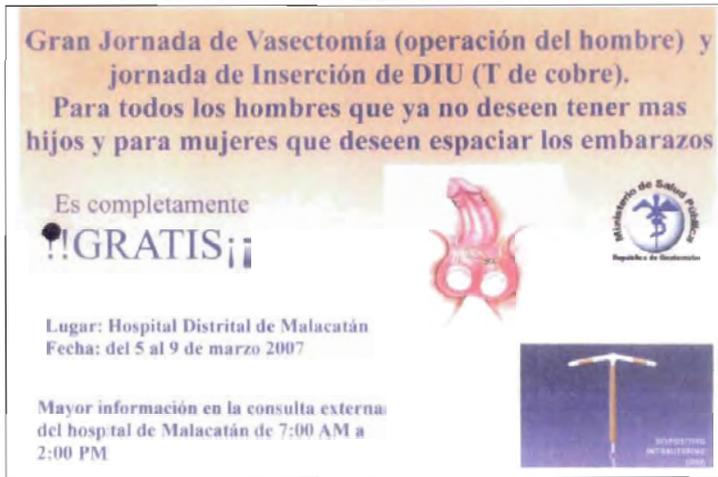
Objective	Key activities	Results
Increase the demand and supply of family planning services	Designed IEC materials to promote FP services Strengthened MSPAS capacity to provide services	Increase in the number of new users Increase in the number of couple years of protection (CYPs)
Reduce medical and institutional barriers to family planning	Developed IEC material Sensitized staff about FP benefits and legal framework Advocacy Improved logistics for contraceptives Involved schools of future health providers Updated of FP guidelines	Norms updated to reflect latest scientific evidence Staff trained in FP topics Logistics systems strengthened
Change method mix	Trained in IUD insertion Promoted orals Jadelle implant introduced in Peten and is being expanded in the capital. Developed materials to involve Males in FP	Significant increase in IUD and female sterilization Increase in the use of natural methods (LAM and SDM)
Increase MSPAS capacity to project and finance contraceptives in the future	Trained of MSPAS staff in forecasting methodologies and using data for decision making Implemented Pipeline software Participated in advocacy forums Implemented a market segmentation study	Staff trained in and using forecasting methodologies Improvement in data reporting and analysis Pipeline software updated frequently

3.6.2 Reduction of medical and institutional barriers to family planning

Medical barriers in Guatemala curb demand for family planning: 40% of providers still request a client's partner's approval before offering services. *Calidad* provided technical assistance in the design of a sensitizing curriculum. It was included in every FP workshop, reaching 4,983 participants during the project. Changes indicating greater support for family planning include:

- Hospitals have committed to providing FP services 24/7.
- Hospitals in Izabal, Quetzaltenango, San Marcos, Chimaltenango, Amatitlán, Coatepeque, Antigua, and Sololá have

Poster explaining that vasectomies and IUD insertions are free in the District Hospital of Malacatán



opened spaces dedicated to family planning.

- Some sites have developed and posted in waiting areas posters declaring the legal right to FP information and services.
- The project worked closely with MSPAS and the national schools of nursing to train students in family planning and its benefits.
- Twenty hospitals used local resources to develop large posters to explaining male and female sterilization methods.

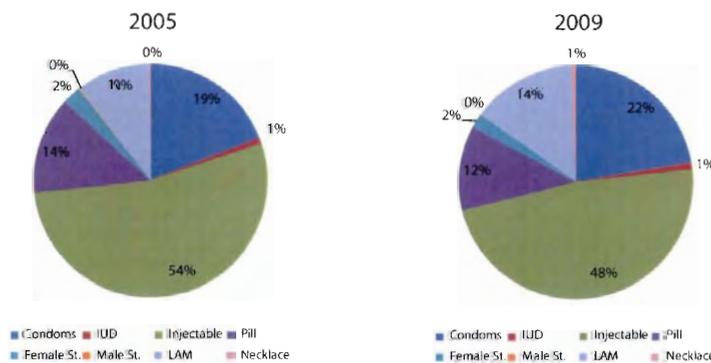
3.6.3 Changes in the method mix

Activities: Postpartum FP program staff were trained in IUD insertion and sterilization procedures. As noted

above, medical equipment for IUD and sterilization procedures was donated. Hospitals promoted IUD and sterilization services, and a sterilization procedures manual was developed. Providers were instructed to offer all methods.

Results: Despite efforts to promote all contraceptive methods, Guatemalan women choose the three-month injection for personal and cultural reasons and for the discretion and privacy this method affords. Like other countries (53% of Japanese and 59% German women, respectively, prefer condoms and orals), Guatemala’s method mix has generally changed little and centers on one or two methods (Figure 22).

Figure 22: Changes in method mix, 2005–2009



Note: Proxy based on method preference by total users.

Nonetheless, the use of traditional methods such as the lactation amenorrhea method (LAM) and the necklace (cycle beads) has increased (see Table 16). Although the proportions of IUD insertions and female sterilizations have changed little, the demand for these methods in terms of new users has increased significantly over the course of the project.

3.6.4 Increase MSPAS capacity to project and finance future demand for contraceptives

Each year, the project provided technical assistance to MSPAS in the implementation of workshops on methodologies for forecasting future needs of contraceptives, ranging from those based on historical data on consumption to more advanced methodologies based on population characteristics. The project worked closely with MSPAS in the preparation of the annual contraceptive procurement tables, using the Pipeline model to allow MSPAS to review current stock levels and shipments in transit against consumption trends. As a result, MSPAS has achieved high levels (above 85%) of stock of contraceptives throughout the country’s network of warehouses during the past five years. At MSPAS’s request, the Pipeline model was extended with project technical assistance beyond the National Reproductive Health Program to include the national HIV and immunization programs. Calidad implemented a market segmentation study and helped direct contraceptive supplies to where they are needed most.

The market segmentation study found a Guatemalan family planning market of 2.7 million people and that the unsatisfied demand for birth spacing in this market is 26% in urban areas and 74% in rural areas. Of the women of reproductive age and not using contraceptive methods, 36% have more than five children. A copy of the report was delivered to USAID on December 5, 2005.

Table 16. Changes in the use of specific methods during the project

Method	2005	2006	2007	2008	2009	% Change
LAM	32,756	56,030	56,994	68,855	82,755	252%
Necklace	520	819	1,703	2,017	3,492	671%
Female sterilization	7,712	10,11	12,965	12,999	11,104	144%
IUD	2,685	2,774	2,827	2,914	5,489	204%

Note: 2009 figures were projected based on first nine months of the year.

Source: SIGSA, PNSR Logistics System.

3.6. 5 Update IEC materials to address needs of men and promote optimal birth spacing

Materials to involve men in family planning (see above) were designed to promote their support for FP and provide information on vasectomies and condoms. Nonetheless, involving men as family planners requires specifically designed strategies targeted to men. The use of vasectomy is still very low within the MSPAS network of services.

Also developed were materials to promote birth intervals of three to five years. These materials were based on formative research conducted in 2007 (report submitted January 30, 2008). In addition, workshops with international FP experts were held as part of provider training. A technical note was also developed. Promotion of optimal birth spacing has been part of all training workshops. Additionally, the latest international evidence on the advantages and contribution of birth spacing and for reducing maternal and infant mortality as well as improving nutritional status of both mother and child were included in the national family planning guidelines and all project-developed counseling IEC materials.

Compliance with U.S. legislation regarding FP assistance

Ensuring compliance with U.S. laws regarding FP was an essential project activity. In all FP training workshops during the project, including those on counseling, sensitizing, contraceptive technology, and surgical contraception, participants were

advised of restrictions on the provision of financial and technical assistance: 4,983 participants, including physicians, professional and auxiliary nurses, MSPAS directors, and administrative staff learned: a) no targets for FP other than operational should be established for providers, b) no incentives should be given to providers to induce FP, c) no incentives should be given to patients to induce adoption of a family planning method, d) patients should not be coerced to accept a method, and e) complete information and services on all methods should be offered to patients for an informed and voluntary decision.

Hospitals received special attention due to their capacity to provide surgical contraception and its implication for

Poster promoting vasectomy at the National Hospital of Mazatenango



ending fertility. Of 44 Guatemalan hospitals, 43 were visited to ensure that all sterilization clients had signed informed consent forms kept in files. The visits found the practice to be institutionalized: 821 sterilization patients' clinical records were reviewed: two lacked informed consent forms, but follow-up home visits to the patients confirmed that they had signed such form. Both patients offered to sign a replacement.



A woman receives family planning counseling.

3.7 Better Management of Public Health Programs

Calidad provided considerable technical assistance to enable MSPAS to make managerial changes in its organization and functions. These upper-level advancements will prevent lower level problems, such as stock-outs, and ensure better quality services. Table 17 presents the five objectives of this effort and the key activities, scale or locale, and results of each.

3.7.1 Quality management system

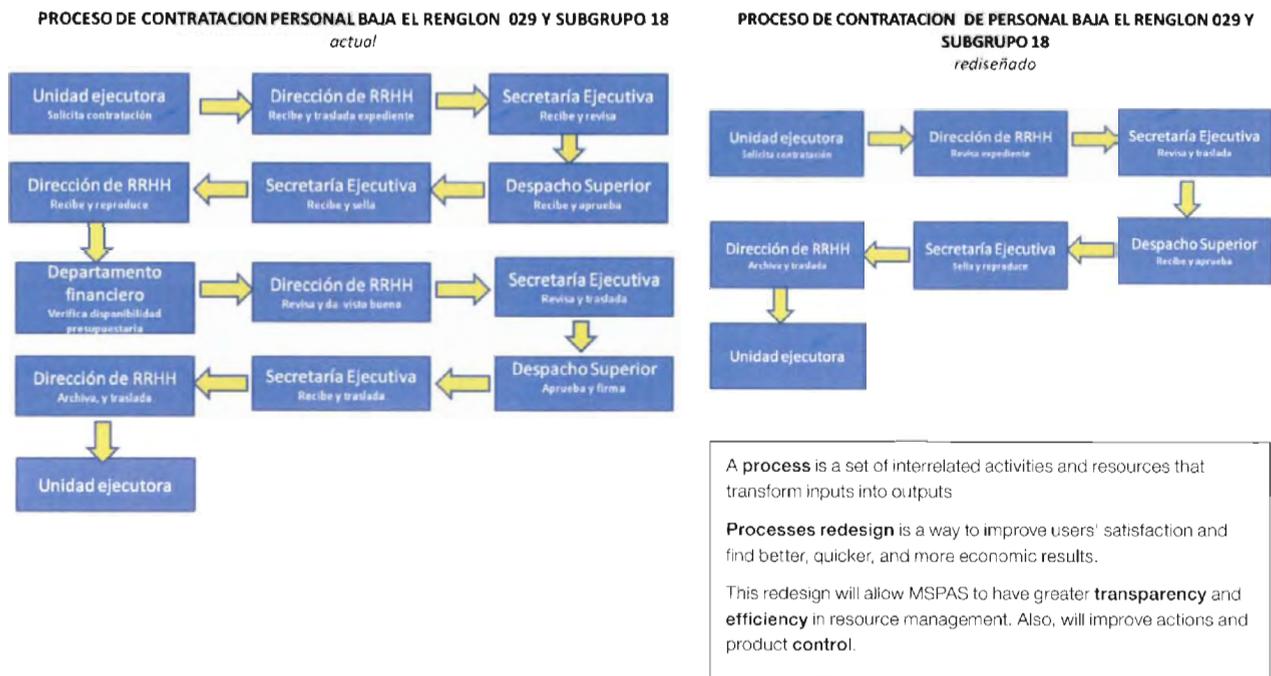
The Government installed in January 2008 asked *Calidad* to undertake a comprehensive plan to strengthen and certify the Ministry's processes and internal structures in compliance with ISO 9001:2008 norms. This far-reaching endeavor has taken hold and will, if continued, foster growth and continuous improvement of the institution. The Quality Management Assurance System (QMAS) was initiated after the 2005 completion of a comprehensive organizational audit by PriceWaterHouseCoopers. This audit documented major problems in Ministry functioning, serious inefficiencies, and lack of transparency in major management and procurement processes. With USAID funding, URC continues to provide support for the roll-out of this process and certification, expected in 2011.

Key activities: *Calidad* started by selecting the processes to include in QMAS essential management support processes: planning, storage, inventory, purchasing, budgeting, general services (e.g. warehousing, inventory, maintenance support), internal and external communications, health information systems, human resources, health education, and customer service. In keeping with the mandate to foster integration and ensure that management systems serve the Ministry's ultimate purpose, public health service delivery, *Calidad* linked the improvement process for management support systems to priority health services: prenatal care, delivery care, postnatal care, and newborn and child care. QMAS started within the Ministry itself, while the improvement of management of MNCH services was piloted first in San Marcos.

Table 17: Better management objectives, activities, scale/locale, and results

Objective	Key activities	Scale/locale	Results
Develop and implement a quality management system based on the requirements of ISO 9001:2008	Sensitized the central level and San Marcos Health Area staffs Analyzed gap for priority management support processes and priority maternal, newborn and child health (MNCH) services Re-designed and standardized processes Documented processes and sought MSPAS approval Upgraded MSPAS technology platform for QMAS	MSPAS central level San Marcos Health Area	53 new and 27 improved processes have been standardized and are being implemented in 82 MSPAS units 50 internal auditors were trained Two Ministerial Decrees were issued institutionalizing new norms and procedures
Promote use of strategic and operational tools for planning and budgeting	Strengthened plan of action (POA) Improved programming electronic sheet	Nationwide	POA was reformulated Personnel and contracts were added to electronic sheet
Introduce performance-based budgeting	Developed quarterly spending plans according to POA	Nationwide	Quarterly programs with spending plans were implemented
Improve capacity for financial planning of child and reproductive health interventions	Defined a strategic planning system Identified cost-effective interventions in MNH Defined coverage goals and interventions Estimated cost of interventions Designed health territorial plans	Nationwide Health areas of Chimaltenango, Quetzaltenango, San Marcos, Sololá and Totonicapán	Drafted National Health Plan and territorial plans for Chimaltenango, Quetzaltenango, San Marcos, Sololá, and Totonicapán health areas
Improve capacity for financial and logistics management	Developed a logistics module for health areas and another for hospitals Developed tools for supply-needs projection	Nationwide 14 health areas 41 hospitals	Logistics module implemented in 14 health areas and 41 hospitals Created MSPAS Logistics Unit Produced contraceptive procurement tables produced

Figure 23: Example of the redesigned process for personnel hiring



In the first stage, more than 1,000 people at the central level and in the San Marcos Health Area were introduced to the QMAS principles and implementation plan. Together *Calidad* designed 53 new processes and re-designed 27 that had been in place and then documented all 80. *Calidad* next trained staff in these process on a large scale. Next, 50 national level auditors were trained and training was initiated with another 50 at the local level, thus ensuring sustainability. The processes were made official through Ministerial Decrees and made available on the MSPAS website. An example of the redesigned process for personnel hiring is presented in Figure 23.

3.7.2 Developing strategic and operational tools for planning and budgeting

Action: *Calidad* supported work to reformulate the POA by technicians from different health programs, in accordance with the most recently approved version of care standards. The procedure relating to classification and calculation of electronic sheets was revised to include

expenditures relating to human resources and contracts. SIGSA is developing a version based on data from the current electronic programming sheet. Work is still needed to develop intermediate results to connect strategic planning with operational programming.

The project also supported the start of implementation of Business Objects, a tool that enables databases from different sources to be connected to enable more in-depth multivariate analysis and facilitate access to Internet-based reports. URC provided Business Objects licenses to MSPAS and trained SIGSA personnel to use it. In addition, the project helped set up the first analyses, during which an initial exercise was to form a universe of databases from different sources, including population projections from the National Statistics Institute and births and deaths from SIGSA. This exercise served as hands-on training. Results were excellent and disseminated among Ministry personnel and those who have more recently promoted implementation with MSPAS.

3.7.3 Performance-based budget

Following the presentation of the performance budgeting document, which suggested the need to program every three months with corresponding expenditure plans, MSPAS introduced a quarterly purchasing cycle to schedule purchasing and expenditures as POA develops. The expenditure plan is not completely accepted by the health areas, in part because tools are lacking to facilitate distribution of the annual program in three-month components that take into account seasonal variations in the use of each type of health care service.

3.7.4 Capacity for financial planning of child and reproductive health interventions

Calidad has been working with MSPAS, especially the Strategic Planning Unit and the group driving the National Health Plan, to delineate a strategic planning system that supports development of a holistic model for care and management and strategic plans focused on institutional priorities. Within this plan, cost-effective, evidence-based MNH interventions were

Figure 24: Achieving time standards in purchasing, nationwide

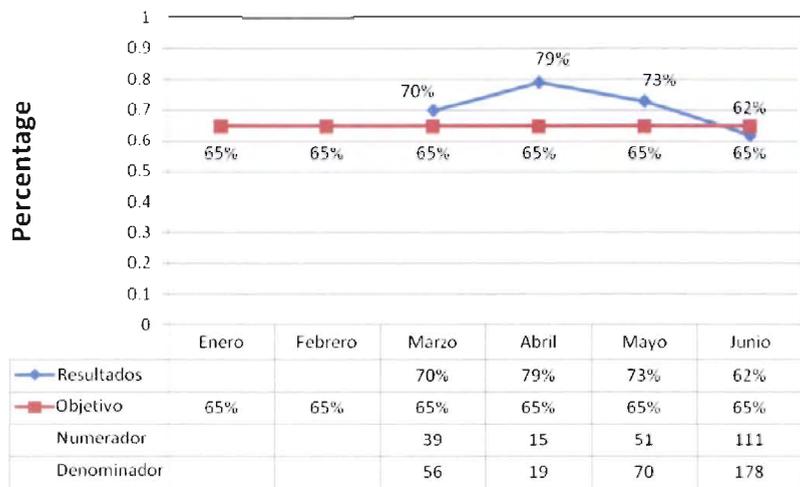
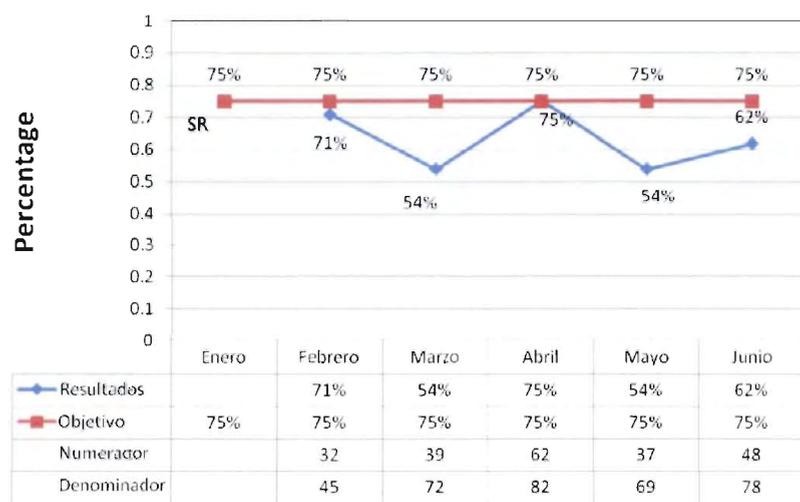


Figure 25: Achieving time standards in issuing payments, nationwide



identified and coverage goals defined for up to 2012. Strategies to implement them were set for these interventions. Using national MSPAS coverage rates and projected changes in population growth, the levels of interventions that will be needed in the next few years were calculated and costs estimated. In addition, technical assistance was provided to Chimaltenango, Quetzaltenango, San Marcos, Sololá, and Totonicapán health areas to develop plans for 2010.

3.7.5 Capacity for financial and logistics management in the health area directorates; logistics champions trained in selected areas and at the central level

The supply level of medicines and the ability to project supplies needed to effectively implement the purchasing and financing processes has been a great challenge in the MSPAS network. With support from *Calidad*, MSPAS has been training "logistics champions" in the health areas and at the central level. At the central level, the project's support led to the creation of the Logistics Unit, which has personnel and resources dedicated

to improving the availability of medicines and contraceptive products. Designed and developed with technical support from *Calidad*, the logistics module has been implemented in 14 health areas. We engaged the coordination and cooperation of the logistics unit SIGSA staff to expand and support it, institutionalizing this important activity within MSPAS. The development of contraceptive purchasing tables contributed to good coordination with the National Reproductive Health Program (PNRSR) and UNFPA in order to calculate deliveries and payments. Table 18 (next page) presents some of the achievements to date.

Completion of annual contraceptive inventories: National inventories of contraceptives and trace medicines have been implemented and institutionalized. Inventories were taken twice a year during *Calidad's* five years. Improvements in logistics are reflected in the high levels of supplies of contraceptives, exceeding 85% during the project.

Contraceptive purchasing tables delivered to USAID: Using the PipeLine tool to produce these tables has contributed significantly to MSPAS capacity for financial and supply planning. The tables were delivered to USAID in April and September of 2005 through 2009, each time with greater autonomy on the part of MSPAS.

Hospital Logistics Administration System: The Vice Minister for Hospitals and SIGSA, with *Calidad* support, designed an informatics tool that allows automating drug and pharmacy warehouse inventories in hospitals. This system covers Guatemala's entire hospital network with the exception of its two biggest hospitals. Figure 26 presents an image of the tool.

Figure 27 shows the improvement achieved by 10 hospitals in drug supply. The goal is to have hospitals with 85% drug provision. The figure shows that from May to August these hospitals accomplished and surpassed the goal. This achievement was made possible by such interventions as financial resources assignment, drug exchange among hospitals, and drugs purchases.

List of materials designed and used during the period in order to implement the health management model in at least 15 health areas: The project worked on a new health area management model, which holds that the service network exists to satisfy the health needs of the citizenry and that the health area directorates exist in order to attend to the needs of the service network. With this model, the health area directorates are meant to be capable of meeting essential public health functions, with geographic analysis and a general direction focused specifically on health determinants (surveillance and public health control). This new model takes a systemic focus based on the processes needed at that level and focused on the results expected from the network of services in the health area directorate. This means that the functions of risk, service, and resource management met by the health area directorates have been determined. It allows the necessary organizational structure, and the positions to make it operational have been identified. Thirteen health areas participated or have finished reorganizing to adapt to the new organizational structure.

3.7.6 Health information systems

The project provided extensive technical support to MSPAS to strengthen all stages of information systems: design, development, processing, training personnel, and expanding health areas. Support was given to redesign the modules that make up SIGSA; to review and update SIGSA forms; and to make the system modules a cost-effective, open-source, Microsoft compatible platform with no licensing fees. The updated modules include SIGSA 1 births, SIGSA 2 deaths, SIGSA 3 control of consultations, SIGSA AIDS, and the vaccination module.

In addition to supporting the strengthening of information systems both at the central and program levels, technical and financial assistance was provided to update computer equipment, ranging from powerful servers to administer the central

Table 18: Results of efforts to improve logistics management through training

Percentage of cost of contraceptives supplied by the MSPAS	60% in 2008 100% targeted for 2009
Number of logistics champions in health areas and at the central level	29
Number of health areas that have implemented the logistics module	14

Figure 26: Image from the Hospital Logistic Administration Tool

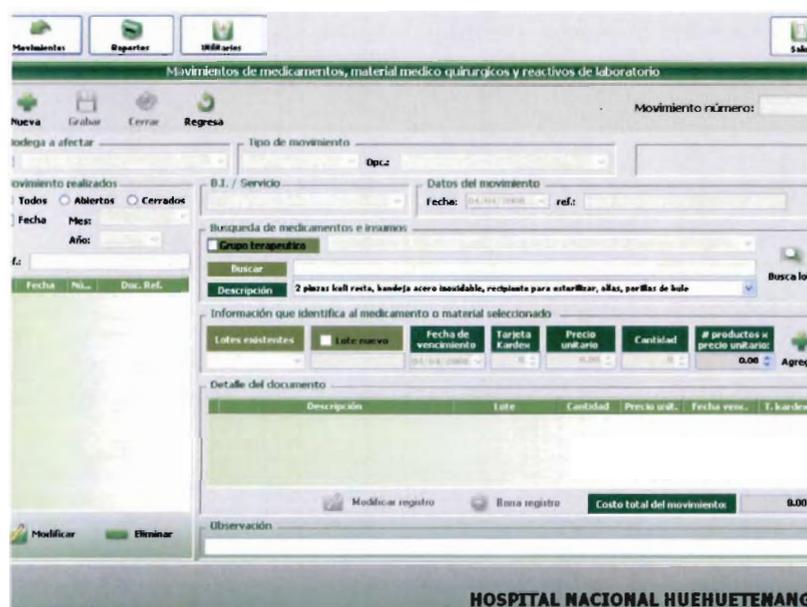
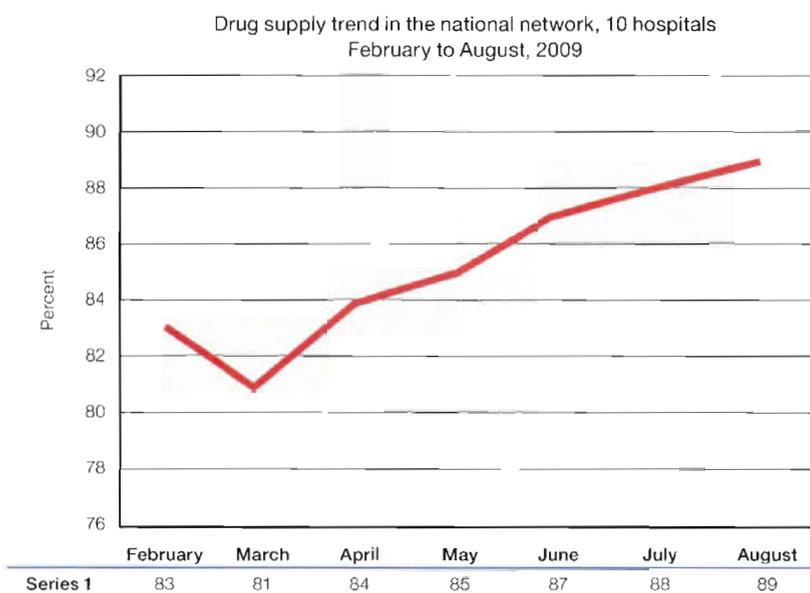


Figure 27: Improvement in drug supply, 10 hospitals, Feb. – Aug., 2009



network to the wiring of the central office; to the wiring of Department of Care Programs headquarters; to expansion of email; and to the supply of desks, laptops, and printers. In all, 39 computers were donated.

3.7.9 Human resources development

QMAS includes an action line on human resources to reinforce such aspects as attitudinal change, organizational development procedures, alignment of organizational structures and processes, and tailored training plans for each position and person. 85 position profiles were developed in Tejutla and San Pedro health centers in the San Marcos Health Area. These profiles cover maternal, neonatal, and administrative positions in San Marcos Hospital and the health area directorate and maternal and neonatal positions in San Juan de Dios General Hospital. This work has identified needs for personnel training, and a training plan will be designed to improve professional and service capabilities and eventually

achieve users' satisfaction and better service quality. These profiles, which are based on competencies, will allow MSPAS to improve staff skills to provide quality services.

3.7.8 Bio-security

During the project, actions to improve bio-security within the MSPAS network of services included training service providers in bio-security norms/ best practices and monitoring and supervision of service providers' adherence to the norms, in particular with regard to: a) proper disposal of sharps, b) proper use of disinfectants, and c) availability waste containers for contaminated supplies.

Monitoring and evaluation ensured proper implementation of bio-security standards. Monitoring was implemented quarterly in a sample of health posts, centers, and hospitals. A total of 64 service delivery posts received supervisory visits, revealing a generally adequate use of sealed and properly labeled containers for disposal of sharps (90% of posts visited).

Nonetheless, the use of disinfectants is not yet institutionalized: Only 40% of posts were using disinfectants.

Additionally, as part of the quality improvement strategy, an assessment on bio-security issues was implemented for health centers in San Marcos. The results of the assessment led to important Ministry-initiated activities, including:

- In coordination with the department of waste management at San Juan de Dios Hospital, guides for storage of bio-infectious waste and disinfection of facilities were developed.
- *Calidad* technical assistance supported the development of an MSPAS Plan for Bio-infectious Waste Management.

Additionally, at the local level in San Marcos, the health area created a special area for temporary storage of bio-infectious waste in the CAP of San Pedro, and actions are underway to improve the process of separating and labeling of bio-infectious waste.

A woman receives family planning counseling.

3.8 Information, Education, and Communication for Behavior Change

To achieve the project's objectives, the cross-cutting component—information, education and communication/behavior change communications (IEC/BCC)—provided communication guidelines and support to the project's five technical components. This component also helped improve the integration of reproductive health services; family planning; and maternal, neonatal, and child health. This component's achievements are reflected in cross-cutting activities as well as in assistance provided to the other project components.

Through its advisors, USAID's *Calidad en Salud* project was influential in helping establish certain facets of the MSPAS health promotion and education structure. At the central level work was conducted with the Ministry's Department of Health Promotion and Education and the Social Communication Units of the MSPAS and health programs. In the health areas, the IEC/BCC component helped strengthen the functions of the health area promotion coordinators, IEC reproductive health facilitator, district promotion coordinators, and health promotion teams.

The IEC/BCC component also developed and made available to health staff nationwide a strategic planning guide for IEC/BCC initiatives (*IEC a la Carta*) and oriented health staff at various levels in how to carry out advocacy and public relations activities. The project provided IEC/BCC technical assistance, training, and materials development and dissemination specific to each of the technical areas to



Through its advisors, USAID's Calidad en Salud project was influential in helping establish certain facets of the MSPAS health promotion and education structure.

health staff at primary, secondary, and tertiary levels of health service delivery. Also, the logistics used to deliver IEC materials were defined and improved.

In the area of **family planning** and contraceptive security, the communication strategy was revised in 2005 and again in 2007. The systematic offer of family planning services and balanced family planning counseling in order to provide the same initial information on all contraceptive methods was an important focus. Numerous materials (Figure 28) were designed, pretested, and produced. Distribution was conducted along with training in how to use the materials to improve family planning/birth spacing counseling. Two rounds of monitoring were conducted by health area promotion coordinators in selected health centers in 2006 and 2007.

In the area of **maternal and neonatal health**, the communication strategy focused on the four delays that lead to

maternal and neonatal deaths: recognition of danger signs, the decision to seek care, obtaining transportation to an appropriate health service, and receiving quality care. Anthropological studies were reviewed and two studies conducted to better understand these delays. Of particular concern was increasing families' recognition of maternal and neonatal danger signs and immediate care-seeking in response. The IEC/BCC component was linked to the ProCONE strategy, providing communication guidelines and materials to each of its line of actions: community, basic, and complications.

IEC/BCC efforts in the area of **women and children's nutrition** largely centered on growth promotion and malnutrition prevention in AINM-C through breastfeeding, infant and young child complementary feeding, and women's and children's micronutrient supplementation. Studies were conducted on the acceptance of the complementary food *Vitacereal* and a specific BCC strategy and materials were developed. Counseling training guides and materials were provided for Sprinkles micronutrient supplementation for children. Technical assistance and training were provided to USAID's PVO partners, especially in the area of BCC and trials of improved

Figure 28: Sample of *Calidad*-supported MSPAS materials



practices related to infant and young child feeding. AINM-C materials were revised before PVOs printed them. Lastly, in response to the Hurricane Stan emergency, the IEC/BCC component led the development of materials and training about safe water and sanitation.

Support to the annual immunization campaign—including vaccinating people aged 7 to 39 against measles and rubella—was a major IEC/BCC contribution to the project's *child health* component. Campaign strategies were developed; training activities conducted; and numerous materials designed, pretested, produced, and distributed. Monitoring surveys were conducted at various campaign stages. In addition to vaccination, materials were developed that focus on diarrhea and respiratory/pneumonia prevention, safe water, and other preventive health behaviors. A series of 26 mini-videos on key preventive behaviors was recently produced.

For *STI and HIV prevention and treatment*, the IEC/BCC component assisted with the design and development of a communication strategy to reach vulnerable groups, and materials were developed for these specific target audiences and the health personnel who serve them. The IEC/BCC component participated in a study on stigma and discrimination toward these groups and in the development and implementation of the ensuing communication strategy. In addition, a manual and counseling cards on management of emotions after a positive HIV test and about feeding infants of HIV-positive mothers were produced and distributed.

The *advocacy and communication* component was introduced in 2007 to influence other audiences and civil society. Informative sessions with local media were conducted in Quiché,

Tonicapán, Huehuetenango, and San Marcos. This work sensitized the media about the importance of promoting healthy behaviors in rural communities, emphasizing maternal and neonatal care, breastfeeding, and prevention of H1N1 influenza. The process of municipal intersectoral sessions was assessed, and despite several achievements, documentation was found lacking.

Added to the project in January 2009 was the *public relations and communication* component, which documented 24 success stories and testimonials and prepared 24 technical notes and other reports with the collaboration of technical personnel in the project and the IEC/BCC component. Selected products are in Annex 5.5.

4. Lessons Learned / Challenges and Opportunities

4.1 Lessons Learned

This section first reports on the lessons learned from the past five years of the *Calidad en Salud* Project. It then explores the remaining challenges and finally the opportunities that will support overcoming those challenges.

Involvement of Ministry of Health staff

Active participation and leadership from health managers: It is essential that all program activities be planned in close collaboration with counterpart staff. The project has been particularly successful in recent years in providing technical training to health managers at area, hospital, and national levels so that these managers and their staffs implement activities in their respective services. Project technical staff played the role of coach and technical advisor, staying in the background as appropriate and taking a more assertive approach when the situation called for it.

Expansion of best practices was implemented by the area-level health management team, including planning, organizing, holding learning sessions, and conducting coaching visits. An opportunity exists to explore the level of institutionalization of best practices and required management and leadership in each component to identify what kind of support would be most appropriate next year.

Better communication between different levels of service delivery and between area management teams and hospitals: The collaborative learning and implementation of best practices that the project supported in 34 STI/HIV clinics and that is underway in eight health regions in maternal and neonatal health services have demonstrably improved ongoing communication between different levels of the health service. Growing recognition of improved quality of care raised the level of confidence for referral and mutual support.

Physical proximity of technical assistance and MSPAS counterparts: Placing the ISO 9001 technical assistance team within the Ministry instilled confidence and facilitated access during a difficult transition. Housing the whole project in the Ministry was not successful.

Power of using the systems approach

Using the systems approach: From the beginning and for all technical assistance components of the project, using the systems approach has enabled the project to offer an integrated vision. The approach has facilitated the integration of cross-cutting components as well as a more holistic approach to strengthening health services. It has allowed for an objective assessment of the status of any subsystem and needed improvement.

The roll-out of IEC as an integral focus across components rather than separated by technical health topic has begun to build greater competence among health workers and their managers and has allowed them to quickly transfer skills learned within one health component (such as interpersonal communication) to another.

Success of quality improvement

Creating a culture of quality takes time: Using innovative approaches, including the improvement collaborative, and the introduction of ISO 9001 as an approach to standardize subsystems have rapidly built the capacity of a larger cadre of health staff and managers in improving the quality of care. Their involvement in the project and participation in solving problems and improving outcomes create a sense of empowerment, which is further strengthened by the use of innovative approaches and ideas.

Situational analyses must include quality of care indicators and measurements

Using the improvement collaborative approach facilitated staff creativity in working in service delivery and support systems and greatly enhanced their participation in problem solving using existing resources. The approach has begun to change staff attitudes, including better and more consistent use of data for decision-making.

Cross-visits (where staff from one health facility or region visit another) were an effective way to exchange experiences, overcome resistance to change, and stimulate rapid improvement.

Involve civil society and communities:

Involving civil society fostered discussion around major public health issues and has begun to strengthen community engagement to find solutions and take responsibility for health. Working with mass media garnered reporting that stimulated discussions about health issues in public fora.

4.2 Challenges and Opportunities

Challenge	Possible Solution
Limited capacity of public health staff to continue implementing best practices due to continuous high turnover among Ministry staff	<p>Continue to strengthen capacity of the MSPAS Supervision and Evaluation Unit, including in continuous quality improvement and how to update and disseminate evidence-based best practices.</p> <p>Continue to expand the e-learning options available on the MSPAS Web site.</p> <p>Promote certification process of MSPAS staff to stimulate self-learning.</p>
Lack of institutionalized process to train newly appointed staff; lack of system for continuous education	<p>Establish package of core competencies for staff at different levels of health system.</p> <p>Provide regular refresher training opportunities offered and coordinated with donor resources, e-learning resources, and links to an incentive system for health staff.</p> <p>Conduct a study on the feasibility of establishing continuous education for medical staff.</p>
Referral system still in initial stages	<p>Ensure that norms and standards for the referral system are firmly established in the MSPAS.</p> <p>Continue to support efforts to strengthen referral systems and institutionalize monitoring of compliance with referral norms by area and district management teams.</p>
Lack of system to share and disseminate health information system data within MSPAS	<p>Emphasize the use of SIGSA data for routine decision-making.</p>
Absence of regular mechanisms to measure and monitor population-based results and impact of public health activities	<p>Develop norms and mechanisms to ensure regular measurement of population-based results and impact of public health activities.</p>
Lack of policy for internal and external communications within the MSPAS	<p>Complete ISO 9001: 2008 implementation of the MSPAS communications system</p>
Insufficient inter-institutional coordination	<p>Establish clear mechanisms and standards for necessary sharing of information.</p> <p>Establish mechanisms to coordinate all MSPAS-provided external support.</p>
Inadequate financial resources for the MSPAS	<p>Advocate for additional resources and mechanisms to ensure optimal use of same.</p>

Opportunities

Calidad has set a foundation that leaves several opportunities for continued strengthening of public health services and of MSPAS to exercise its normative, regulatory, and service delivery functions. Among these opportunities are:

- Continuing major activities under the Health Care Improvement Project will allow best practices in maternal and neonatal health and family planning to be expanded to more areas of the country.
- More capacity can be built in the MSPAS to reach ISO 9001 certification for major management systems.
- Excellent relations with counterparts at all levels of the health system facilitate access and strong commitment to assume leadership for planned activities.
- The Conditional Cash Transfer Program affords possibilities to reach more of the at-risk population, enabling continued efforts to reduce persistent malnutrition among children under two.
- Areas and facilities where quality improvement was introduced will have more capacity to solve problems and improve the quality of service delivery.
- The work carried out with hospitals in clinical improvement, information systems, logistics, and management has built a platform for continued work to improve service delivery.

5. Annexes

- 5.1 Performance Monitoring Plan Indicators
- 5.2 Operations Plan Indicators
- 5.3 Training Report
- 5.4 Research and technical reports produced by USAID|Calidad en Salud project, years 2004 - 2009
- 5.5 Guatemala IEC /BCC Materials produced by USAID|Calidad en Salud project, years 2004 - 2009

5.1 Performance Monitoring Plan Indicators — Family Planning

Objetivo estratégico 3: Invertiendo en personas más saludables y mejor educadas												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado	Meta	Dato Reportado							
Tasa Global de Fecundidad (1)	4.4	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	4.0	3.6	
Porcentaje de desnutrición crónica en niños/as entre 3 y 23 meses (1)	49%	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	44%	38.4%	
Tasa de mortalidad infantil (1)	39 x 1000	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	38 x 1000	30 x 1000	

Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva**Sub Resultado: 3.3.1. Mejoramiento y expansión de los servicios de planificación familiar e IEC**

Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Prevalencia de uso de métodos anticonceptivos (métodos modernos y tradicionales) (1)	43.3%	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	46.6%	54.1% (total)	
Prevalencia de uso de métodos anticonceptivos modernos (píldora, DIU, AOV, inyectable, condón), distribuidos por el MSPAS (2)	ND(A)	12%	7.86%	12.6%	9.92%	13.6%	12.04%	14.9%	12.75%	17%	13.70%	
Años Protección Pareja (APPS) (3)	280,180	294,190	245,066	347,186	336,854	364,547	394,063	382,773	446,115	401,911	499,188	Reporte incluye servicios de Extensión de Cobertura
Nuevas usuarias de planificación familiar (4)	260,000	270,000	236,809	290,000	379,841	320,000	398,215	340,000	467,402	360,000	565,133	Reporte incluye servicios de Extensión de Cobertura

Fuente de Datos: (se identifican con números)

(1)= ENSMI 2008-2009. Noviembre 2009

(2)= Reporte de APPs generados anualmente (sin incluir métodos naturales). Población 15-49 años: Proyecciones INE anuales

(3)= Reporte consumos de DAS a nivel nacional (reporte BRES consolidado) para condones, orales, inyectable y DIU. SIGSA 6 mensual para AOV, MELA y MDF. Reportes incluyen servicios de Extensión de Cobertura. Año 2005: sólo se reporta 9 meses. Años 2006-2008: Octubre a septiembre. Año 2009: Octubre 2008 a Agosto 2009. Datos preliminares. Septiembre 2009, proyectado de acuerdo a comportamiento de primeros 11 meses.

(4)= Reporte SIGSA 6 mensual; este reporte incluye los servicios de Extensión de Cobertura. Año 2005: sólo se reporta 9 meses. Años 2006-2009: octubre a septiembre. Datos preliminares.

Abreviaturas:

N.A.: No Aplica

N.D.: No Dato

Llamadas: (se identifican con letras)

(A)= Una aproximación a la tasa de prevalencia anticonceptiva será calculada con base en el total de APPS generado y su relación con el total de mujeres en edad fértil.

Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado: 3.3.1. Mejoramiento y expansión de los servicios de planificación familiar e IEC												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado	Meta	Dato Reportado	Meta	Dato reportado	Meta	Dato Reportado	Meta	Dato Reportado	
Necesidad insatisfecha para planificación familiar (1)	28%	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	25%	20.8%	
Intervalo intergenésico entre 3 y 5 años (1)	34%	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	39%	pendiente	
Actualización de materiales de IEC para incluir espaciamento de 3 o más años	NA	Enviado el 30/06/05	Enviado	N.A	N.A	N.A	N.A	N.A	N.A	N.A	N.A	
Desabastecimiento de métodos anticonceptivos en centros y puestos de salud, y servicios ambulatorios de hospitales en el momento de la medición (visita o autoinventario) (6)	20.7%	19%	Mar.12.97% Sept. 13.00%	18%	Mar.6.40% Sept. 13.60%	17%	Mar. 19.25% Sept. 15.29%	16%	Mar. 13.01% Sept. 13.71%	15%	Mar. 13.26%	
Tablas de adquisición de anticonceptivos preparadas por el MSPAS (7)	NA	Enviado en Abr. y Sep.	Enviado	Enviado en Abr. y Sep.	Enviado	Enviado en Abr. y Sep.	Enviado	Enviado en Abr. y Sep.	Enviado	Enviado en Abr. y Sep.	Enviado	
Plan y presupuesto de aseguramiento de anticonceptivos	NA	Enviado el 30/11/05	Enviado	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	

Fuente de Datos: (se identifican con números)

(1)= ENSMI 2008-2009. Noviembre 2009

(5)= Reportes auto-inventarios PNSR. Base de datos Unidad de Logística. Período: Marzo y Septiembre de cada año.

(6)= Documentos del MSPAS con planes de Adquisición anual

Abreviaturas:

N.A.: No Aplica

Performance Monitoring Plan Indicators — Maternal and Neonatal Health

Objetivo estratégico 3: Invertiendo en personas más saludables y mejor educadas												
Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado Intermedio 3.3.2 Mejoramiento y expansión de atención materno neonatal e IEC												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado	Meta	Dato Reportado							
Porcentaje de partos atendidos por personal profesional (médicos o enfermeras) (1)	41%	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	43%	51.3%	
Cobertura de vacunación (DPT3 o Pentavalente 3) en niños/as menores de 1 año (DAS priorizadas) (2)	94%	94%	89.12%	95%	88.25%	95%	91.12%	95%	93.12%	95%	96.00%	Reporte del nivel institucional, el porcentaje de enero a septiembre 2009 esta basado en el 72% de cobertura que alcanzaron las DAS priorizadas sobre la meta acumulada de 75% para septiembre
Cobertura de vacunación (DPT3 o Pentavalente 3) en niños/as menores de 1 año (Nivel Nacional) (2)	94%	95%	92.16%	95%	91%	95%	93%	95%	95%	95%	94.67%	Reporte del nivel institucional, el porcentaje de enero a septiembre 2009 esta basado en el 71% de cobertura que se alcanzó a nivel nacional sobre la meta acumulada de 75%. Para septiembre
Porcentaje de niño/as 12 a 23 meses de edad, que han recibido todas las dosis de DPT o Pentavalente (1)	94%	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	95%	85.2%	
Número de EOM (enfermeras obstétricas mayas atendiendo partos o/y apoyando) trabajando en las comunidades del área rural del altiplano (3)	NA	10	10	60	54	120	85	120	88	120	120	
Porcentaje de servicios (puestos de salud, centros de salud, maternidades) en los cuales se presta la atención obstétrica esencial básica (4)	35% (154 servicios)	37%	N.D.	46%	21.82%	57%	21.82%	67%	24.78%	75% (330 servicios)	88.64%	La cobertura de servicios entre el año 2005 y 2008 es de 440 servicios. En el año 2009 se incorpora la DAS de Alta Verapaz por lo que se incrementa a 590.
Número de hospitales en los cuales se presta la atención obstétrica esencial integral (4.a)	N.D.	1	6	3	N.D.	4	2	6	2	8	16	La cobertura de hospitales entre el año 2005 y 2008 es de 13. En el año 2009 se incorpora la DAS de Alta Verapaz por lo que se incrementa a 16.
Porcentaje de proveedores que cumple con las normas de atención prenatal, al nivel de puestos y centros de salud (5)	N.D.	10%	N.D.	15%	3%	30%	18%	40%	N.D.	55%	N.D.	

Fuente de Datos: (se identifican con números)

(1)= ENSMI 2008-2009. Noviembre 2009

(2)= Reporte acumulado de Vacunación SIGSA 5C, de enero a diciembre del año reportado. Datos preliminares. DAS Ixil no reporta para diciembre 2008. Año 2009: Se reporta de enero a septiembre 2009. Datos preliminares.

(3)= Registros UPS 1. Reportes de pago de becas por el proyecto. En el año 2006 hubo deserción de 3 estudiantes y candidatas posteriores no cumplieron el perfil.

(4)= Año 2005: en proceso (dato reportado en informe anual del proyecto). Año 2006 y 2007: dato reportado en informe anual del proyecto en el 2006. año 2008: servicios de San Marcos involucrados en Proceso de Mejoramiento continuo de la calidad. (fase demostrativa, incluye puestos de salud) Año 2009: Servicios de DAS priorizadas involucradas proceso de mejoramiento continuo de calidad (fase de expansión) en la cual se tiene 523 servicios involucrados (pendiente expansión a puestos de salud, para el período fiscal 2010)

(4.a)= Año 2005: Dato reportado en informe anual del proyecto. Año 2006: Dato reportado en informe anual del proyecto. Año 2007 y 2008: Hospitales y CAIMI de San Marcos involucrados en Proceso de Mejoramiento continuo de la calidad. Año 2009: Hospitales de DAS priorizadas involucradas proceso de mejoramiento continuo de calidad (fase de expansión)

(5)= Año 2005: en proceso (dato reportado en informe anual del proyecto). Año 2006: Dato presentado en porcentaje de proveedores que cumplen las normas de atención prenatal en PS y CS. Base de datos Cumplimiento de normas del DRPAP año 2006 (línea basal); año 2007: Segundo monitoreo del cumplimiento de normas de atención prenatal en PS y CS. Base datos cumplimiento de normas del DRPAP.

Abreviaturas: N.A.: No Aplica, N.D.: No Dato

Objetivo estratégico 3: Invirtiendo en personas más saludables y mejor educadas												
Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado Intermedio 3.3.2 Mejoramiento y expansión de atención materno neonatal e IEC												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Porcentaje de proveedores que cumple con las normas de AIEPI AINM-C, al nivel de equipo básico (MA, EA, FC) (6)	ND	10%	80%	15%	N.D.	30%	N.D.	40%	N.D.	55%	N.D.	
% de Púérperas con un control en los primeros 40 días (A) (7)	N.D.	N.E.	N.D.	N.E.	39.00%	N.E.	41.61%	N.E.	58.15%	N.E.	N.D.	Reporte de 8 DAS priorizadas
Porcentaje de madres y recién nacidos con atención de posparto (1)	20%	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	26%	25.6%	
Número de comunidades que están implementando un plan de emergencia comunitario, por fase (8)	93	100	110	150	365	320	365	320	N.D.	320	N.D.	
Número de comunidades con comités para una maternidad segura (8)	99	100	110	300	365	300	365	320	N.D.	320	N.D.	
Número de comités en etapa I			110				115					
Número de comités en etapa II							89					
Número de comités en etapa III							78					
Número de comités en etapa IV							51					
Número de comités en etapa V							32					
Número de comunidades en las cuales se ha expandido la estrategia de AIEPI AINM-C (9)	N.E.	N.E.	3,333	N.E.	3,420	N.E.	8,596	N.E.	N.D.	N.E.	N.D.	

Fuente de Datos: (se identifican con números)

(1)= ENSMI 2008-2009. Noviembre 2009

(7)= Base de datos Programa de Extensión de Cobertura, reporte de 8 DAS priorizadas. El sistema inició a partir del año 2006. No se dispone de reporte acumulado del año 2009.

(6)= Año 2005: Dato reportado en informe anual del proyecto Datos tomados de las fichas clínicas de mujeres y niños del sistema de información del Programa de Extensión de Cobertura, así como de actividades de supervisión del mismo.

(8)= Año 2005 y Año 2006: Datos reportados en informe anual del Proyecto. Año 2007: Informe de monitoreo de la estrategia de comisiones /comités de salud con planes de emergencia comunitario, realizado por el proyecto.

(9)= Año 2005 y 2006: Dato reportado en reporte anual del proyecto. Año 2007: Reporte de Extensión de cobertura de 198 municipios (8,596 comunidades) cubriendo 4.1 millones de habitantes (incluyendo adultos).

Abreviaturas:

N.A.: No Aplica

N.D.: No Dato

N.E.: No Establecido/a

Llamadas: (se identifican con letras)

(A)= Se presenta como indicador equivalente de los siguientes: "Porcentaje de púérperas con un control en los primeros 15 días después del parto, por MA, EA y FC" y "Porcentaje de púérperas con visitas posparto (en 15 días) en el último nacimiento, nivel comunitario"

Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado Intermedio 3.3.2 Mejoramiento y expansión de atención materno neonatal e IEC												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado	Meta	Dato Reportado							
% de servicios desabastecidos de medicamentos para atención de la niñez (10) (B)	N.D.	N.E	N.D.	N.E.	Sep. 59.51%	N.E.	Mar. 83.35% Sep. 70.91%	N.E.	Mar. 59.27% Sep. 65.00%	N.E.	Mar. 78.78%	Datos a partir del año 2006, con la Creación de la Unidad de Logística. Reporte a nivel nacional (incluye DAS priorizadas por el proyecto)
% de servicios desabastecidos de medicamentos para atención materna (C/S B, CENAPA; P/S, UM) (10) (B)	N.D.	N.E	N.D.	N.E.	Sep. 34.7%	N.E.	Mar. 40.96% Sep. 42.98%	N.E.	Mar. 31.43% Sep. 47.36%	N.E.	Mar. 49.84%	
% de servicios desabastecidos de medicamentos para atención de ITS (10) (B)	N.D.	N.E	N.D.	N.E.	Sep. 61.67%	N.E.	Mar. 92.84% Sep. 89.53%	N.E.	Mar. 89.49% Sep. 87.27%	N.E.	Mar. 94.42%	
% de servicios desabastecidos de vitamina A (10) (B)	N.D.	N.E	N.D.	N.E.	Sep. 19.44%	N.E.	Mar. 32.05% Sep. 21.46%	N.E.	Mar. 23.09% Sep. 30.22%	N.E.	Mar. 24.48%	
% de servicios desabastecidos de micronutrientes (hierro y ácido fólico) (10) (B)	N.D.	N.E	N.D.	N.E.	Sep. 35.57%	N.E.	Mar. 70.02% Sep. 45.31%	N.E.	Mar. 40.64% Sep. 43.82%	N.E.	Mar. 47.15%	
% de servicios desabastecidos de vacunas (10) (B)	N.D.	N.E	N.D.	N.E.	Sep. 65%	N.E.	Mar. 66.13% Sep. 62.25%	N.E.	Mar. 49.44% Sep. 43.20%	N.E.	Mar. 71.03%	
% de Puntos de entrega de servicios desabastecidos de métodos anticonceptivos en servicios de ONG's (10) (C)	N.D.**	N.E	Mar. 34.36% Sep. 38.54%	N.E.	Mar. 23.96% Sep. 25.00%	N.E.	Mar. 25.00% Sep. 13.83%	N.E.	Mar. 17.03% Sep. 18.78%	N.E.	Mar. 17.14%	
% de embarazadas en primer control prenatal en extensión de cobertura (7) (D)	N.D.	N.E.	N.D.	N.E.	60%	N.E.	55.68%	N.E.	69.96%	N.E.	N.D.	El sistema de información del Programa de Extensión de Cobertura inicia a partir del año 2006. No se dispone del reporte acumulado para el año 2009
% de embarazadas captadas antes de 12 semanas de embarazo en extensión de cobertura (7) (D)	N.D.	N.E.	N.D.	N.E.	16.18%	N.E.	17.54%	N.E.	22.46%	N.E.	N.D.	
% de embarazadas con tres controles médicos en extensión de cobertura (7) (D)	N.D.	N.E.	N.D.	N.E.	20.30%	N.E.	26.24%	N.E.	37.31%	N.E.	N.D.	
% recién nacidos con 1 control antes de los 28 días (7) (D)	N.D.	N.E.	N.D.	N.E.	31.69%	N.E.	39.53%	N.E.	52.88%	N.E.	N.D.	

** Esta información va a ser útil para que el MSPAS tome decisiones de mejoría, pero los logros pueden ser limitados, dado que el proyecto ni USAID tienen control sobre el manejo de medicamentos en el país.

Fuente de Datos: (se identifican con números)

(7)= Base de datos Programa de Extensión de Cobertura, reporte de 8 DAS priorizadas. El sistema inició a partir del año 2006. No se dispone de reporte acumulado del año 2009.

(10)= Base de Datos, monitoreo de la disponibilidad de medicamentos, por paquetes de atención, Unidad de Logística, auto-inventario nacional. Este reporte toma como abastecidos aquellos servicios que disponen con todos los insumos evaluados; si le falta al menos uno o más, se toma como desabastecido. Período: Marzo y Septiembre de cada año, a partir de septiembre 2006

Abreviaturas: N.A.: No Aplica, N.D.: No Dato, N.E.: No Establecido/a

Llamadas: (se identifican con letras)

(B)= Se presentan los indicadores de desabastecimiento por paquete de atención, como equivalentes al indicador "Porcentaje de servicios de Puestos y Centros de Salud con desabastecimiento de medicamentos en los últimos 6 meses"

(C)= Se presenta el indicador de desabastecimiento de métodos anticonceptivos a nivel de ONGs, como equivalentes al indicador "Porcentaje de servicios de ONG's con desabastecimiento de medicamentos en los últimos 6 meses"

(D)= Se presentan indicadores adicionales de Atención Materno Infantil, reportados dentro del Programa de Extensión de Cobertura.

Performance Monitoring Plan Indicators — Nutrition

Objetivo estratégico 3: Invertiendo en personas más saludables y mejor educadas												
Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado Intermedio 3.3.3 Mejor nutrición, dieta y prácticas de higiene												
Monitoreo de Crecimiento												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado	Meta	Dato Reportado	Meta	Dato reportado	Meta	Dato Reportado	Meta	Dato Reportado	
Porcentaje de desnutrición global en niños/as de 3 a 23 meses (peso para edad) (1)	26.8%	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	24%	19.30%	
Sistema de base de datos y vigilancia nutricional diseñado para el MSPAS	NA	Enviado el 30/06/05	Enviado	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	
Porcentaje de niños/as menores de 2 años que inician sesiones mensuales de monitoreo del crecimiento a nivel institucional (2) (A)	N.D.	N.D.	N.D.	N.D.	N.D.	N.E.	6.22%	N.E.	6.53%	N.E.	5.37%	Consolidado a nivel nacional (incluye DAS priorizadas por el proyecto), a nivel institucional. Este indicador se inicia a reportar por parte de las DAS a partir del año 2007, con el reporte del SIGSA 5 C de Seguridad Alimentaria (Monitoreo de Crecimiento)
Porcentaje de niños/as menores de 2 años que participan en sesiones mensuales de monitoreo del crecimiento a nivel institucional (2) (A)	N.D.	N.E.	10.50%	N.E.	15.00%	N.E.	14.49%	N.E.	21.37%	N.E.	21.26%	Consolidado a nivel nacional (incluye DAS priorizadas por el proyecto), a nivel institucional. Todos los indicadores de monitoreo de crecimiento, tienen como fuente de información el SIGSA 6 de Seguridad Alimentaria en el año 2006. A partir del año 2007 se cambia el reporte, teniendo como fuente de información el SIGSA 5 C de Seguridad Alimentaria (Monitoreo de Crecimiento)
Porcentaje de niños/as menores de 2 años con ganancia esperada de peso a nivel institucional (2) (B)	N.D.	N.E.	10.38%	N.E.	92%	N.E.	86.47	N.E.	88.17	N.E.	86.60	
Porcentaje de niños/as menores de 2 años con ganancia de peso inadecuada a nivel institucional (2) (C)	N.D.	N.E.	N.D.	N.E.	8%	N.E.	13.53%	N.E.	11.83%	N.E.	13.40%	

Fuente de Datos: (se identifican con números)

(1)= ENSMI 2008-2009. Noviembre 2009

(2) = Año 2005: Datos reportados en Informe Anual del Proyecto. Año 2006: Reporte SIGSA 6 mensual de Seguridad Alimentaria, nivel nacional, Enero a septiembre. Año 2007-2009: Promedio Nacional a partir del Reporte SIGSA 5C ,Seguridad Alimentaria (Monitoreo de Crecimiento) Año 2007: enero a septiembre 2007. Años 2008 y 2009: octubre a septiembre. Datos preliminares

Abreviaturas:

N.A.: No Aplica

N.D.: No Dato

N.E.: No Establecido/a

Llamadas: (se identifican con letras)

(A)= Se presentan como indicadores equivalentes al indicador "Porcentaje de niños/as menores de 2 años que participan en sesiones mensuales de monitoreo del crecimiento"

(B)= Se presentan como indicador equivalente al indicador "Porcentaje de niños/as menores de 2 años con ganancia esperada de peso"

(C)= Se presentan como indicador equivalente al indicador "Porcentaje de niños/as menores de 2 años con ganancia de peso inadecuada"

Objetivo estratégico 3: Invirtiendo en personas más saludables y mejor educadas												
Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado Intermedio 3.3.3 Mejor nutrición, dieta y prácticas de higiene												
Micronutrientes												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Porcentaje de puérperas vistas en servicio suplementadas con hierro (2) (D)	N.D.	N.E.	85.75%	N.E.	94%	N.E.	95.67%	N.E.	97.67%	N.E.	98.12%	Promedio Nacional (incluye DAS priorizadas por el proyecto), a nivel institucional. Estos indicadores tienen como fuente de información el SIGSA 6 de Seguridad Alimentaria, en el año 2006. A partir del año 2007 se cambia el reporte, teniendo como fuente de información el SIGSA 5 C de Seguridad Alimentaria.
Proporción de puérperas en relación a población (nacidos vivos) suplementadas con hierro (3) (D)	N.D.	N.E.	N.D.	N.E.	3%	N.E.	3.53%	N.E.	4.55%	N.E.	3.82%	
Porcentaje de puérperas vistas en servicio suplementadas con ácido fólico (2) (E)	N.D.	N.E.	84.75%	N.E.	94%	N.E.	96.17%	N.E.	95.06%	N.E.	96.93%	
Proporción de puérperas en relación a población (nacidos vivos) suplementadas con ácido fólico (3) (E)	N.D.	N.E.	N.D.	N.E.	3%	N.E.	3.48%	N.E.	4.31%	N.E.	3.73%	
Promedio de niños vistos en servicio entre 6 y 36 meses que reciben vitamina A (4) (F)	N.D.	N.E.	47%	N.E.	48%	N.E.	29%	N.E.	54%	N.E.	44%	El dato de niños suplementados con vitamina "A", es un promedio a nivel nacional (incluye DAS priorizadas). Dato reportado del año 2009 proyectado.
Proporción de niños menores de 1 año en relación a población (nacidos vivos) suplementados con vitamina A (4) (F)	N.D.	N.E.	70%	N.E.	74%	N.E.	45.53%	N.E.	77.70%	N.E.	66.81%	
Proporción de niños de 1 año a < de 2 años en relación a población (niños de 2 años) suplementados con vitamina A (4) (F)	N.D.	N.E.	41%	N.E.	42%	N.E.	26.29%	N.E.	48.40%	N.E.	39.42%	
Proporción de niños de 2 años a < de 3 años en relación a población (niños de 2 años) suplementados con vitamina A (4) (F)	N.D.	N.E.	29%	N.E.	27%	N.E.	16.37%	N.E.	36.10%	N.E.	27.12%	

Fuente de Datos: (se identifican con números)

(2) = Año 2005: Datos reportados en Informe Anual del Proyecto. Año 2006: Reporte SIGSA 6 mensual de Seguridad Alimentaria, nivel nacional, Enero a septiembre. Año 2007-2009: Promedio Nacional a partir del Reporte SIGSA 5C, Seguridad Alimentaria. Año 2007: enero a septiembre 2007. Años 2008 y 2009: octubre a septiembre. Datos preliminares

(3) = Año 2005: Datos reportados en Informe Anual del Proyecto. Año 2006: Reporte SIGSA 6 mensual de Seguridad Alimentaria, nivel nacional, Enero a septiembre. Año 2007-2009: Promedio Nacional a partir del Reporte SIGSA 5C, Seguridad Alimentaria. Año 2007: enero a septiembre 2007. Años 2008 y 2009: octubre a septiembre. Población nacidos vivos: Reporte de Vacunación 5C. Datos preliminares

(4)= Reporte acumulado de Vacunación SIGSA 5C, de enero a diciembre del año reportado. Datos preliminares. DAS Ixil no reporta para diciembre 2008. Año 2009: no se dispone de información, pues ya no se incluye este dato con el consolidado nacional de vacunación trabajado por SIGSA, por lo que se hace una proyección basada en el reporte de los años anteriores (promedio del año 2005 al año 2008)

Abreviaturas: N.A.: No Aplica, N.D.: No Dato, N.E.: No Establecido/a

Llamadas: (se identifican con letras)

(D)= Se presentan como indicadores equivalentes al indicador "Porcentaje de mujeres que han tenido su parto en los últimos 6 meses y que reciben hierro"

(E)= Se presentan como indicadores equivalentes al indicador "Porcentaje de mujeres que han tenido su parto en los últimos 6 meses y que reciben ácido fólico"

(F)= Se presentan como indicadores equivalentes al indicador "Porcentaje de niños/as entre 6 y 36 meses que reciben vitamina A"

Objetivo estratégico 3: Invirtiendo en personas más saludables y mejor educadas

Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva

Sub Resultado Intermedio 3.3.3 Mejor nutrición, dieta y prácticas de higiene

Micronutrientes

Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Proporción de de niños/as entre 6 y 59 meses en relacion a población (menores de 5 años) que reciben hierro (5) (G)	N.D.	N.E.	N.D.	N.E.	4%	N.E.	7.79%	N.E.	16.29%	N.E.	10.04%	Estos indicadores tienen como fuente de información el SIGSA 6 de Seguridad Alimentaria, en el año 2006, donde se reporta el promedio nacional. A partir del año 2007, se tiene el reporte acumulado a nivel nacional (niños < 5 años con esquema completo), siendo al fuente el SIGSA 5 C anexo.
Proporción de de niños/as entre 6 y 59 meses en relacion a población (menores de 5 años) que reciben ácido fólico (5) (H)	N.D.	N.E.	N.D.	N.E.	4%	N.E.	7.65%	N.E.	15.41%	N.E.	18.63%	
Porcentaje de embarazadas vistas en servicio suplementadas con hierro (2) (I)	N.D.	N.E.	N.D.	N.E.	87%	N.E.	94.12%	N.E.	96.97%	N.E.	96.38%	Promedio Nacional (incluye DAS priorizadas por el proyecto), a nivel institucional. Estos indicadores se inician a reportar en el año 2006, del SIGSA 6 de Seguridad Alimentaria. A partir del año 2007 se cambia el reporte, teniendo como fuente de información el SIGSA 5 C de Seguridad Alimentaria.
Proporción de embarazadas en relación a población (nacidos vivos) suplementadas con hierro (3) (I)	N.D.	N.E.	N.D.	N.E.	11%	N.E.	7.07%	N.E.	7.61%	N.E.	6.98%	
Porcentaje de embarazadas vistas en servicio suplementadas con ácido fólico (2) (I)	N.D.	N.E.	N.D.	N.E.	88%	N.E.	93.03%	N.E.	93.28%	N.E.	93.85%	
Proporción de embarazadas en relación a población (nacidos vivos) suplementadas con ácido fólico (3) (I)	N.D.	N.E.	N.D.	N.E.	11%	N.E.	6.81%	N.E.	7.14%	N.E.	6.64%	

Fuente de Datos: (se identifican con números)

(2) = Año 2005: Datos reportados en informe anual del Proyecto. Año 2006: Reporte SIGSA 6 mensual de Seguridad Alimentaria, nivel nacional, Enero a septiembre. Año 2007-2009: Promedio Nacional a partir del Reporte SIGSA 5C ,Seguridad Alimentaria. Año 2007: enero a septiembre 2007. Años 2008 y 2009: octubre a septiembre. Datos preliminares

(3) = Año 2005: Datos reportados en informe anual del Proyecto. Año 2006: Reporte SIGSA 6 mensual de Seguridad Alimentaria, nivel nacional, Enero a septiembre. Año 2007-2009: Promedio Nacional a partir del Reporte SIGSA 5C ,Seguridad Alimentaria. Año 2007: enero a septiembre 2007. Años 2008 y 2009: octubre a septiembre. Población nacidos vivos: Reporte de Vacunación 5C. Datos preliminares

(5)= Año 2005: Sólo se tiene datos de niños suplementados en relación a vistos en servicio (para hierro el dato es de 38.88% y para ácido fólico es de 35.5%), no se tiene datos de población. Datos reportados en informe anual del Proyecto. Año 2006: Reporte SIGSA 6 mensual de Seguridad Alimentaria, nivel nacional, Enero a septiembre. A partir del año 2007 se reporte el acumulado a nivel nacional del reporte SIGSA 5C anexo (niños < 5 años con esquema completo) Año 2007: enero a septiembre 2007. Años 2008 y 2009: octubre a septiembre. Datos preliminares. Población <5 años: Proyecciones INE

Abreviaturas:

N.A.: No Aplica

N.D.: No Dato

N.E.: No Establecido/a

Llamadas: (se identifican con letras)

(G)= Se presenta como indicador equivalente al indicador "Porcentaje de niños/as entre 6 y 59 meses que reciben hierro"

(H)= Se presenta como indicador equivalente al indicador "Porcentaje de niños/as entre 6 y 59 meses que reciben ácido fólico"

(I)= Se presentan indicadores adicionales de suplementación de embarazadas con hierro y ácido fólico, a nivel institucional.

Performance Monitoring Plan Indicators — HIV/ITS

Objetivo estratégico 3: Invertiendo en personas más saludables y mejor educadas												
Resultado Intermedio 3.3: Incremento en el Uso de los Servicios de Calidad en Salud Materno Infantil y Salud Reproductiva												
Sub Resultado Intermedio 3.3.4 Incremento en la utilización de prácticas de prevención para ITS/VIH y de tratamiento de ITS												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado	Meta	Dato Reportado	Meta	Dato reportado	Meta	Dato Reportado	Meta	Dato Reportado	
Evaluación de necesidades, guías y políticas nacionales de los servicios y del programa de manejo sintomático de ITS y PVC en el MSPAS	NA	Enviado el 30/09/05	Enviado	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	
Plan detallado de trabajo 2006-2009 para ITS y PVC incluyendo actividades, estrategias y métodos/ herramientas para recolección y uso de datos	NA	Enviado el 31/10/05	Enviado	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	
Número de clínicas del MSPAS implementando protocolos aprobados de manejo sintomático de ITS para H/M (TCS, HSH, PVS)*	ND	8	8	20	24	34	34	34	34	34	34	
Número de clínicas del MSPAS implementando servicios certificados de PVC (TCS, HSH, PVS)* (A)	ND	N.E.	N.E.	8	24	20	34	34	34	34	34	
Ayudas de trabajo e IEC/CC para ITS y PVC con enfoque de género	NA	N.A.	N.A.	Enviado el 31/03/06	Enviado	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	

* Sujeto a evaluación de los avances hasta Junio de 2005.

Performance Monitoring Plan Indicators — Management and Integration

Resultado Intermedio: Sistemas de Apoyo												
Gerencia e Integración												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Porcentaje del presupuesto ejecutado sobre lo programado (1)	85%	85%	97.57%	90%	97.05%	90%	98.15%	90%	97.11%	100%	71.43%	
Porcentaje de supervisión facilitadora hacia los puestos y centros de salud (2)	ND	10%	15%	40%	N.D.	60%	N.D.	80%	N.D.	80%	N.D.	
Porcentaje de supervisión facilitadora hacia los Centros Comunitarios (3)	ND	10%	40%	40%	N.D.	60%	N.D.	80%	N.D.	80%	N.D.	
Sistema de información: Uso de información para la toma de decisiones	NA	Enviado el 31/10/05	Enviado	Enviado el 31/10/06	Enviado	Enviado el 31/10/07	Enviado	Enviado el 31/10/08	Enviado	Enviado el 30/09/09	Enviado	
Avances en la integración de servicios de Salud Reproductiva y de la Niñez	NA	Enviado el 31/10/05	Enviado	Enviado el 31/10/06	Enviado	Enviado el 31/10/07	Enviado	Enviado el 31/10/08	Enviado	Enviado el 30/09/09	Enviado	

Fuente de Datos: (se identifican con números)

(1)= Registros MSPAS y Ministerio de Finanzas SICOIN (Sistema de contabilidad integrado). Año 2005 al 2008: ejecución anual. Año 2009: Ejecución a septiembre 2009.

(2) = Año 2005: Registro del MSPAS. Dato Reportado en Informe Anual del Proyecto. A partir del 2006, no se tiene información disponible

(3) = Año 2005: Registros de Programa de Extensión de Cobertura. Dato reportado en Informe Anual del Proyecto. A partir del 2006, no se tiene información disponible

Abreviaturas: N.A.: No Aplica, N.D.: No Dato, N.E.: No Establecido/a

Llamadas: (se identifican con letras)

(G)= 34 clínicas con personal capacitado. Como seguimiento a la certificación se implementó en los servicios la estrategia de mejoramiento continuo de la calidad, equipamiento e incremento de la oferta de PVC.

Objetivo estratégico 3: Invirtiendo en personas más saludables y mejor educadas												
Resultado Intermedio: Sistemas de Apoyo												
Resultado Intermedio 3.1.: Mayores y Mejores Inversiones del Sector Social												
Sub Resultado Intermedio 3.1.1. Mayor y más eficiente ejecución presupuestaria (incluyendo proceso de compra) por el MSPAS												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Responsabilidad que asume el MSPAS (con fondos regulares) para cubrir la demanda de los servicios (anticonceptivos) para hospitales, centros, puestos de salud y ONG (4)	30%	30%	40%	40%	40%	60%	48%	80%	70%	100%	N.D.	En el año 2007 la inversión de anticonceptivos es de 8 millones, de los cuales el MSPAS cubrió 3.8 millones. En el año 2008 la inversión de anticonceptivos es de 4.14 millones, de los cuales el MSPAS cubrió 2.9 millones.

Sub Resultado Intermedio 3.1.2. Incremento y más efectivas inversiones descentralizadas en salud												
Indicadores	Línea basal	Año 2005		Año 2006		Año 2007		Año 2008		Año 2009		Observaciones
		Meta	Dato Reportado									
Presupuestos multianuales aprobados	NA	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	Enviado el 30/09/08	Enviado	N.A.	N.A.	
Diseño y uso de herramientas estratégicas/operativas de planificación y presupuesto para los niveles central y DAS	NA	Enviado el 30/09/05	Enviado	Enviado el 30/09/05	Enviado	Enviado el 30/09/05	Enviado	N.A.	N.A.	N.A.	N.A.	
Presupuesto anual basado en el desempeño funcionando	NA	N.A.	N.A.	Enviado el 30/09/06	Enviado	Enviado el 30/09/07	Enviado	Enviado el 30/09/08	Enviado	Enviado el 30/09/09	Enviado	

Fuente de Datos: (se identifican con números)

(4)= Registros del PNSR.

Abreviaturas:

N.A.: No Aplica

N.D.: No Dato

N.E.: No Establecido/a

5.2 Operations Plan Indicators — Maternal and Neonatal Health

INDICADORES MATERNO INFANTILES - AÑO 2007 - 2009									
INDICADOR	FUENTE	Año 2007		Año 2008		Año 2009		COBERTURA	Observaciones
		Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados		
Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	Institucional (1)	N.E.	262,282	N.E.	526,582	N.E.	678,479	Nacional	Información sobre producción de primera consulta y reconsultas. Reporte 5C (Seguridad Alimentaria), se utiliza a partir del 2007, por lo que en este período sólo se reporta de enero a septiembre. El consolidado nacional incluye DAS priorizadas. Se actualizó el reporte en los tres años, de acuerdo a las actualizaciones enviadas por las DAS a SIGSA, mensualmente. El incremento del reporte en los últimos dos años, se debe a factores como: actualización de reportes por DAS, ampliación de horarios en servicios y Programa de Transferencias Condicionadas.
		137,014	138,647	160,710	180,117	156,657	236,165	8 DAS priorizadas	
	Extensión de Cobertura (2)	109,113	108,769	110,031	91,073	N.E.	141,910	Nacional	Información sobre producción de primera consulta y embarazadas con tres controles médicos. El consolidado nacional incluye DAS priorizadas. El dato reportado cada año, corresponde al reporte acumulado de enero a diciembre del año anterior. El dato reportado al año 2008 es parcial, pues al cuatro trimestre
		N.E.	54,899	N.E.	48,289	48,188	75,821	8 DAS priorizadas	
Number of children reached by USG-supported nutrition programs	Institucional (3)	753,334	841,147	828,667	1,228,350	N.E.	1,561,010	8 DAS priorizadas	Reporte 5C (Monitoreo de Crecimiento), se utiliza a partir del 2007, por lo que en este período sólo se reporta de enero a septiembre. En este indicador se estará reportando el No. de consultas totales, de niños en monitoreo de crecimiento. No se recomienda como referencia, pues un mismo niño puede estar reportado en diferentes meses. Se actualizó el reporte en los tres años, de acuerdo a las actualizaciones enviadas por las DAS a SIGSA, mensualmente. El incremento del reporte en los últimos dos años, se debe a factores como: actualización de reportes por DAS, ampliación de horarios en servicios y Programa de Transferencias Condicionadas.
Number of children reached by USG-supported nutrition programs (mean by consults global annual reported)		N.E.	93,461	N.E.	102,362	53,939	130,084	8 DAS priorizadas	En este indicador se estará reportando el promedio de niños en monitoreo de crecimiento, a partir del total de consultas reportadas. Año 2007: 841,147 consultas. Año 2008: 1,228,350 consultas. Año 2009: 1,561,010. consultas.

Fuente de Datos: (se identifican con números)

(1)= Reporte 5C anexo, Seguridad Alimentaria. Información correspondiente producción de primera consulta y reconsultas. Sólo incluye 8 DAS priorizadas. Año 2007: enero a septiembre 2007 (año anterior se reportaba en SIGSA 6 mensual). Año 2008: octubre 2007 a septiembre 2008 (actualización de datos en todo el período reportado). Año 2009: Octubre 2008 a septiembre 2009 (actualización de datos de enero a junio 2009). Datos preliminares.

(2)= Consolidado Nacional del Sistema de Información del Programa de Extensión de Cobertura, correspondiente a los indicadores 1 (embarazadas por primer control prenatal) e indicador 3 (embarazadas con tres controles médicos). Incluye 8 DAS priorizadas. Año 2007: reporte acumulado de enero a diciembre 2006. Año 2008: reporte acumulado de enero a diciembre 2007. No reporta DAS Quiché, Ixcán, Jalapa, Petén Norte y Petén SurOccidental al cuarto trimestre. Año 2009: reporte acumulado de enero a diciembre 2008. Datos preliminares

(3)= Reporte 5C Monitoreo de Crecimiento. Reporte sólo de 8 DAS priorizadas. Año 2007: enero a septiembre 2007 (año anterior se reportaba en SIGSA 6 mensual). Actualización de datos de todo el año 2007. Año 2008: octubre 2007 a septiembre 2008. Actualización de datos en el trimestre octubre 2007 a diciembre 2007. Año 2009: Octubre 2008 a septiembre 2009. Datos preliminares. Actualización de base de datos de enero 2009 a septiembre 2009.

Abreviaturas:

N.E.: No establecido/a.

INDICADORES MATERNO INFANTILES - AÑO 2007 - 2009									
INDICADOR	FUENTE	Año 2007		Año 2008		Año 2009		COBERTURA	Observaciones
		Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados a septiembre 2009		
Number of people trained in maternal/newborn health through USG-supported programs	Institucional (4)	2,935	2,657	2,054	3,203	1,200	5,471	Nacional	
number of women		1,691	1,737	870	1,835	800	3,315		
number of men		1,244	920	1,184	1,368	400	2,156		
Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs	Institucional (5)	16,956	19,595	17,763	20,519	N.E.	23,714	8 DAS priorizadas	El dato reportado cada año, corresponde al reporte acumulado de enero a diciembre del año anterior. Actualización de reporte en los tres años reportados, basado en consulta enviada por SIGSA a partir de base de datos de Plataforma de Información del MSPAS.
		N.A.	N.A.	N.A.	N.A.	N.A.	16,941	8 DAS priorizadas	Período reportado: enero a septiembre del año 2009. Datos preliminares.
		N.E.	85,915	N.E.	100,994	52,845	95,971	Nacional	Reporte acumulado a nivel nacional (incluye DAS priorizadas por el proyecto). El dato reportado cada año, corresponde al reporte acumulado de enero a diciembre del año anterior. Actualización de reporte en los tres años reportados, basado en consulta enviada por SIGSA a partir de base de datos de Plataforma de Información del MSPAS.
		N.A.	N.A.	N.A.	N.A.	N.A.	59,536	Nacional	Período reportado: enero a septiembre del año 2009. Datos preliminares.
Number of people trained in child health and nutrition through USG-supported health area programs	Institucional (4)	4090	9582	2863	2243	400	1260	Nacional	
Number of women		2785	6093	1950	1458	300	856		
Number of men		1,305	3,489	913	785	100	404		
Number of children less than 12 months of age who received DPT3 from USG-supported programs	Institucional (6)	338,031	307,033	354,932	309,696	316,419	318,059	Nacional	Reporte acumulado a nivel nacional (incluye DAS priorizadas por el proyecto). El dato reportado cada año, corresponde al reporte acumulado de enero a diciembre del año anterior.
		N.A.	N.A.	N.A.	N.A.	N.A.	254,990	Nacional	Período reportado: enero a septiembre del año 2009. Datos preliminares.
Number of children under 3 years of age who received vitamin A from USG-supported programs	Institucional (6)	267,188	497,627	277,789	232,975	244,624	449,815	Nacional	Reporte acumulado a nivel nacional (incluye DAS priorizadas por el proyecto). El dato reportado cada año, corresponde al reporte acumulado de enero a diciembre del año anterior.

Fuente de Datos: (se identifican con números)

(4)= Reporte de capacitaciones del proyecto. Año 2007: octubre 2006 a septiembre 2007. Año 2008: octubre 2007 a septiembre 2008. Año 2009: octubre 2008 a septiembre 2009.

(5)= Reporte acumulado de SIGSA 1, a nivel nacional (incluye DAS priorizadas por el proyecto). Actualización de reporte en los tres años reportados, basado en consulta enviada por SIGSA a partir de bases de Plataforma de Información del MSPAS. Año 2007: Enero a diciembre 2006. Datos preliminares. Año 2008: Enero a diciembre 2007. Datos preliminares. Año 2009: Enero a diciembre 2008. Datos preliminares.

(6)= Reporte acumulado de Vacunación SIGSA 5C, nivel nacional. Incluye 8 DAS priorizadas por el proyecto. Año 2007: Enero a diciembre 2006. Datos preliminares. Año 2008: Enero a diciembre 2007. Datos preliminares. Año 2009: Enero a diciembre 2008. Datos preliminares, Ixil no reporta para diciembre 2008.

Abreviaturas:

N.E.: No establecido/a.

N.A.: No Aplica

INDICADORES MATERNO INFANTILES - AÑO 2007 - 2009									
INDICADOR	FUENTE	Año 2007		Año 2008		Año 2009		COBERTURA	Observaciones
		Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados a septiembre 2009		
Number of evaluations	Institucional	N.A.	N.A.	1	4	1	2		Año 2008: Monitoreo anual con LQAS. Diagnóstico de Monitoreo de Crecimiento en servicios institucionales y extensión de cobertura. MNH monitoring to prenatal care service provision by BBC facilitators, Monitoring of MNH services at the health post level. Año 2009: Monitoreo anual con LQAS. Línea basal de comunidades con transferencias monetarias condicionadas
Number of host country institutions with improved management information systems as a result of USG assistance	Institucional	1	1	1	1	1	1	Nacional	Soporte técnico brindado a SIGSA
5. Number of women receiving active management of the Third Stage of Labor (AMSTL) through USG-supported programs	Institucional (7)	N.A.	N.A.	N.A.	N.A.	3,030	3,382	San Marcos	Promedio del reporte de cumplimiento de MATEP en hospitales, CAP, CAIMI de San Marcos, como parte del proceso de mejoramiento continuo de la calidad.
	Institucional (8)	N.A.	N.A.	N.A.	N.A.	9,630	14,966	DAS Priorizadas	Reporte de cumplimiento de MATEP en servicios de 7 DAS priorizadas (no incluye San Marcos) como parte del proceso de mejoramiento continuo de la calidad (fase de expansión).
Número de recién nacidos que reciben cuidados básicos rutinarios (A)	Institucional (9)	N.A.	N.A.	N.A.	N.A.	N.E.	4,183	San Marcos	Reporte de cuidados rutinarios del recién nacido en hospitales, CAP, CAIMI y Centros de Salud de la DAS San Marcos, como parte del proceso de mejoramiento continuo de la calidad.
No. de niños/as entre 0 a < 60 meses de edad con diarrea en las últimas dos semanas que fueron tratados sueros de rehidratación oral	Institucional (10)	N.A.	N.A.	N.A.	N.A.	112,188	126,646	DAS Priorizadas	Proyección basada en prevalencia de 22% según la ENSMI y población menores de 5 en el 2009. Adicionalmente una cobertura 65.7 % son atendidos de acuerdo al estudio de monitoreo de LQAS del año 2009.
No. de niños/as entre 0 a < 60 meses de edad con tos y dificultad respiratoria en las últimas dos semanas, que fueron llevados con un proveedor de salud apropiado		N.A.	N.A.	N.A.	N.A.	18,371	21,560	DAS Priorizadas	Proyección basada en prevalencia de 18.2% según la ENSMI de IRAS considerando de que por cada 5 casos de IRAS hay uno de neumonía, población menores de 5 en el 2009. Adicionalmente una cobertura 67.6% son atendidos de acuerdo al estudio de monitoreo de LQAS del año 2009.

Fuente de Datos: (se identifican con números)

(7)= Base de datos consolidada de cumplimiento de indicadores de ProCONE básico DAS de San Marcos. Período: enero-agosto 2009. Reporte de partos atendidos en hospitales (no incluye cesáreas), del SIGSA. Período: Enero-septiembre 2009.

(8)= Base de datos consolidada de cumplimiento de indicadores de ProCONE básico DAS de Huehuetenango, Quetzaltenango, Sololá, Quiché, Alta Verapaz, Chimaltenango. Período: enero-agosto 2009. Reporte de partos atendidos en hospitales (no incluye cesáreas), del SIGSA. Período: Enero-septiembre 2009.

(9)= Base de datos consolidada de cumplimiento de indicadores de ProCONE básico DAS de San Marcos. Período: enero-agosto 2009. Reporte de partos atendidos en hospitales (incluye cesáreas), del SIGSA. Período: Enero-septiembre 2009.

(10)= Encuesta ENSMI 2002. Población menos de 5 años: Proyecciones INE. Encuesta de Monitoreo anual con LQAS 2009.

Abreviaturas:

N.E.: No establecido/a.

N.A.: No Aplica

Llamadas: (se identifican con letras)

(A)= No se tiene información para calcular el indicador "Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs" por lo que se presenta como equivalente el siguiente: "Número de recién nacidos que reciben cuidados básicos rutinarios".

Operations Plan Indicators — Family Planning

INDICADORES PLANIFICACION FAMILIAR - Reporte años 2007 al 2009									
INDICADOR	FUENTE	Año 2007		Año 2008		Año 2009		COBERTURA	Fuente de Datos
		Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados		
Couple years of Protection (CYP) in USG-supported programs	Institucional (1)	364,545	394,063	382,773	466,544	446,115	499,188	Nacional	Reportes incluyen servicios de Extensión de Cobertura. Se actualizó el dato reportado en el año 2008, pues consumos de condones, DIU, orales e inyectables, sólo se tenían hasta agosto 2008. Adicional en el año 2009 el PNSR hizo revisión y actualización de consumos de todo el año.
Number of people trained in FP/RH with USG funds	Institucional (2)	723	1644	723	1475	1000	845	Nacional	
Women		578	587	578	917	700	594		
Men		145	1,057	145	558	300	251		
Number of counseling visits for FP/RH as a result of USG assistance	Institucional (3)	391,236	398,215	340,000	467,402	476,750	565,133	Nacional	Reporte incluye los servicios de Extensión de Cobertura.
Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP	Institucional (4)	243	250	343	191	300	199	Nacional	Reporte incluye los servicios de Extensión de Cobertura
Number of new approaches successfully introduced through USG-supported programs	Institucional	N.E.	N.E.	2	2	N.E.	3	Nacional	Año 2008: FP postpartum at hospital level, participatory sessions in FP at the community level (Facilitator manual developed). Año 2009: Coordinación con PASMO para pasantías en inserción de DIU en Guatemala Central y expansión de prueba piloto para introducción de Jadele. Desarrollo de un DVD de capacitación a distancia el PF.
Number of USG-assisted service delivery points providing FP counseling or services	Institucional (5)	1,757	1,730	1,757	1,714	1,757	1,714	Nacional	
Number of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support	Institucional	1	1	1	1	1	1	Nacional	Año 2007: Actualización de Guía de Planificación Familiar del MSPAS. Año 2008 y 2009: En coordinación con el proyecto HPI, APROFAM, se ha brindado asistencia técnica a la Comisión Nacional de Aseguramiento de Anticonceptivos

Fuente de Datos: (se identifican con números)

(1)= Reporte consumos de DAS a nivel nacional (reporte BRES consolidado) para condones, orales, inyectable y DIU. SIGSA 6 mensual para AQV, MELA y MDF. Reporte incluye servicios de Extensión de Cobertura. Año 2007: Octubre 2006 a septiembre 2007. Año 2008: Octubre 2007 a septiembre 2008. Año 2009: Octubre 2008 a Agosto 2009. Datos preliminares. Septiembre 2009, proyectado de acuerdo a comportamiento de primeros 11 meses.

(2)= Reporte de capacitaciones del proyecto. Año 2007: octubre 2006 a septiembre 2007. Año 2008: octubre 2007 a septiembre 2008. Año 2009: octubre 2008 a septiembre 2009.

(3)= Reporte SIGSA 6; este reporte incluye los servicios de Extensión de Cobertura. Año 2007: Octubre 2006 a septiembre 2007. Año 2008: octubre 2007 a septiembre 2008. Año 2009: Octubre 2008 a septiembre 2009. Datos preliminares.

(4)= Reporte de inventario nacional de marzo 2009. Incluye servicios de extensión de cobertura.

(5)= Año 2007: Reporte de Red de servicios del MSPAS (hospitales, centros de salud y puestos de salud):1293 Jurisdicciones: 437. Año 2008: Reporte de Red de servicios del MSPAS (hospitales, centros de salud y puestos de salud):1293 Jurisdicciones: 421. Centros de Convergencia habilitados en PEC: 5801 (entre 10-15 centros de convergencia por jurisdicción). Dato preliminar. Año 2009: Reporte de Red de servicios del MSPAS (hospitales, centros de salud y puestos de salud):1293 Jurisdicciones: 421

Abreviaturas:

N.E.: No establecido/a.

Operations Plan Indicators — HIV/AIDS and STI

INDICADORES VIH/AIDS- Reporte de años 2007 al 2009											
INDICADOR	FUENTE	Año 2007		Año 2008		Año 2009		Observaciones			
		Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados	Meta proyectada	Datos Reportados				
Number of people trained in the provision of laboratory-related activities	Institucional (1)	34	9	34	37	10	7				
Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring	Institucional (2)	N.A.	N.A.	3700	8,654	8,800	11,443	Reporte de 34 servicios fortalecidos por el proyecto. Información de pruebas de laboratorio para VIH.			
					9,470		12,644	Reporte de 34 servicios fortalecidos por el proyecto. Información de pruebas de laboratorio para Sífilis.			
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	Institucional (1)	50	64	50	45	17	27				
· Number of women			37		34		24				
· Number of men			27		11		3				
Number of people trained to promote HIV/AIDS prevention through abstinence and/or being faithful	Institucional (1)	50	64	50	45	17	27				
· Number of women			37		34		24				
· Number of men			27		11		3				
Number of service outlets providing counseling and testing according to national and international standards	Institucional	34	34	34	34	34	34				
Number of individuals trained in counseling and testing according to national and international standards	Institucional (1)	34	64	34	45	17	27				
Number of individuals who received counseling and testing for HIV and received their test results	Institucional (3)	3,500	6,387	3700	7,734	7,060	8,777	Reporte de 34 servicios fortalecidos por el proyecto.			
· Number of women			2,900		5,429		3100		6,342	5,789	7,197
· Number of men			600		958		600		1,392	1,271	1,580

Fuente de Datos: (se identifican con números)

(1)= Reporte de capacitaciones del proyecto de pasantías. Año 2007: Octubre 2006 a septiembre 2007. Año 2008: Octubre 2007 a septiembre 2008 Año 2009: Octubre 2008 a septiembre de 2009.

(2)= Reporte SIGSA 6 laboratorio. Año 2007: Octubre 2006 a septiembre 2007. Año 2008: Octubre 2007 a septiembre 2008. Año 2009: Octubre 2008 a septiembre de 2009. Datos preliminares.

(3)= Reporte SIGSA 6 anexo. Año 2007: Octubre 2006 a septiembre 2007. Año 2008: Octubre 2007 a septiembre 2008. Año 2009: Octubre 2008 a septiembre de 2009. Datos preliminares.

Abreviaturas:

N.A.: No Aplica. La adición al contrato es a partir del año fiscal 2008.

5.3 Training Report

Calidad en Salud Trainings Performed 2004 – 2009

Training	Oct 2005 - Sep 2006	Oct 2006 - Sep 2007	Oct 2007 - Sep 2008	Oct 2008 - Sep 2009
	Quantity Trained	Quantity Trained	Quantity Trained	Quantity Trained
Family Planning	889	1,731	1,699	845
MNH	2,503	1,007	2,270	6,091
Child Health	258	1,964	410	
AECAMN		378	156	
EOM	298	378		
Logistics	978	560	276	417
Nutrition	2,268	7,466	1,959	159
IEC/BCC	2,535	1,151	980	84
IEC/Advocacy			841	2,547
VIH/ITS	507	402	363	1,619
Services Integration	7,428	1,650	127	
Better Management	612	1,142	668	450
Guarantee of Quality	77	120		
QMAS			1,323	2,410
Better Management/Hosp.			56	310
Other	174			
TOTAL	18,527	17,949	11,128	14,932

5.4 Research and technical reports produced during the USAID|Calidad en Salud project. Years 2004 - 2009

Reports and Investigations	Publication Date
Family Planning	
Costo Beneficio de la Planificación Familiar en Guatemala	August, 2008
Exploración del Proceso de la Comunicación y Toma de Decisiones de Planificación Familiar en Parejas Totoncapenses	June, 2007
Planificación Familiar 1996-2006 Un Estudio Comparativo de los Logros Obtenidos por los Programas de Planificación Familiar a Nivel Mundial con el de Guatemala	December, 2006
Segmentación del Mercado de Servicios de Planificación Familiar en Guatemala	June, 2006
El Espaciamiento Óptimo de Embarazos en el Proyecto Calidad en Salud (2004 - 2009)	November, 2005
Maternal and Neonatal Health	
Una Estrategia de Apoyo a la Reducción de la Mortalidad Materna y Neonatal en Guatemala -La Promoción y Cuidados Obstétricos y Neonatales Esenciales (Pro-CONE)	August, 2009
Un Nuevo Recurso que Cambiará la Historia de la Mortalidad Materna y Neonatal en Guatemala: La Auxiliar de Enfermería Calificada en Atención Materna Neonatal (AECAMN)	July, 2009
Evaluación de las Competencias de las Auxiliares de Enfermería Calificadas en Atención Materno Neonatal (AECAMN) en los Cuidados Obstétricos y Neonatales Esenciales Básicos	February, 2009
Intervenciones Identificadas por los Equipos de los distritos de Salud que Contribuyeron al Mejoramiento de la Calidad en Salud Materno neonatal	November, 2008
Perspectiva Maya, Barreras Culturales y del Sistema de Salud para la Atención Posparto y del Neonato: Construyendo la Capacidad Comunitaria para Aumentar la Atención Posparto y Neonatal en Tonicapán, Guatemala	November, 2008
Factores de Riesgo que Influyen en la Mortalidad Neonatal en Hospitales del Ministerio de Salud de Guatemala	October, 2007
Avances en la Implementación de la Estrategia de Planes de Emergencia Comunitarios	May, 2007
Informe del Estudio Cualitativo "Perspectiva Comunitaria sobre el neonato y mortalidad neonatal"	March, 2007
Nutrition	
Evaluación de Proceso: Monitoreo y Promoción del Crecimiento de Niños Menores de 2 Años en la Estrategia AIEPI AINM-C del Ministerio de Salud Pública y Asistencia Social	December, 2008
Diplomado a Distancia de Seguridad Alimentaria y Nutricional (6 módulos)	September, 2007
HIV/AIDS	
Estigma y Discriminación de Proveedores de Salud Hacia Grupos Vulnerables de ITS/VIH en Guatemala: un Estudio de Conocimientos, Actitudes, y Prácticas	August, 2008
IEC/BCC	
IEC and Communication for Behavior Change (IEC/BCC) in the Calidad en Salud II Project	September, 2009
Other	
Levantamiento de procesos de la atención en Chiquimula y Sololá	December, 2007
Estudios de Extensión de Cobertura (UPS-1) (5 Documentos)	April, 2008
Informe Final: 2008 Annual Outcome Monitoring Survey of USAID Funded Health Services and Products in Guatemala	September, 2008

Technical Notes	Date of Publication
Family Planning	
El Espaciamiento Óptimo entre un nacimiento y el siguiente embarazo	June, 2007
Logros y Expectativas en Planificación Familiar	January, 2008
Crecimiento demográfico y desarrollo económico: El rol indispensable de la PF	December, 2008
Maternal and Neonatal Health	
La Estrategia de Promoción y Cuidados Obstétricos Neonatales Esenciales en Guatemala (Pro-CONE)	January, 2008
Salud Infantil: Una adaptación de la Atención Integral a las Enfermedades Prevalentes de la Infancia (AIEPI) en Guatemala para los tres niveles de atención	January, 2008
Evaluation of the Growth Monitoring and Promotion Component of the Integrated Care for Children and Women and the Community Level (AIEPI AINM-C)	May, 2008
Building Community Capacity to Develop a Local Strategy to Increase Access to Maternal and Neonatal Care in Totoncapán, Guatemala	October, 2008
HIV/AIDS	
Atención Integral de ITS y Oferta de la Prueba Voluntaria de VIH con Conserjería	January, 2008
Mejorando los Servicios de ITS/VIH a Través de Trabajar en Equipo: "Si se Puede"	April, 2008
Nutrition	
Principales Estrategias para Abordar el Problema de Desnutrición en Guatemala	January, 2008
Better Management	
La Mejor Gerencia de Programas de Salud Pública como Apoyo al Mejoramiento de los Servicios de Salud a la Población Guatemalteca	January, 2008
Better Management/ Hospital	
Gestión Hospitalaria	January, 2008
Logistics	
Institucionalización en el Ministerio de Salud Pública y Asistencia Social del Sistema de Administración Logística	January, 2008
BCC/IEC	
IEC a la carta para el cambio de comportamientos	November, 2008
La Promoción de Comportamientos Saludables	January, 2008
Other	
Breve Presentación de Calidad en Salud	January, 2008

Success Stories	Date of Publication
Family Planning	
Usuaris de métodos de planificación familiar reportan recibir mejor atención	2008
Guatemala crece 48 por ciento en prevalencia anticonceptiva	2008
94 por ciento de servicios de salud están abastecidos	November, 2007
IEC para incrementar el uso de métodos de planificación familiar	2007
Hospitales de salud pública reciben donación de USAID por 2 millones 850 mil quetzales para estrategia de planificación familiar	2007
Estrategia Post Evento Obstétrico reporta 26.5% de Incremento en Aceptación de Métodos de Planificación Familiar	2007
Expanding Availability of Family Planning Services at the Hospital of Izabal	2005
HIV/AIDS	
A Focused Approach in Guatemala to Incorporating Men into Family Planning Promotion and HIV/AIDS and STI Treatment and Counseling	November, 2008
Maternal and Neonatal Health	
Innovative Care makes Skilled Obstetric Care more Accessible in Remote Guatemalan Communities	January, 2009
Community Organizing and spirit lead change to improve health outcomes in Rural Guatemalan Communities, Boca Costa	May, 2008
Activando los Planes de Emergencia Comunitaria para Salvar Vidas	June, 2008
Auxiliar de Enfermería Obstétrica Maya salva la vida de gemelos y su madre	June, 2007
Auxiliar de Enfermería Obstétrica Maya, una estrategia para reducir la mortalidad materna en Guatemala	June, 2007
Maternal and Infant Care Center Promotes Model to Save Lives	2006
En el CAIMI de Estor se están salvando vidas	2006
Instituciones de gobierno apoyan sus acciones en AIEPI AINM-C	2006
HIV/AIDS	
USAID/Calidad en Salud Strengthens 34 Public Health Centers in Guatemala with HIV/STI Equipment and Laboratory Tests and Supplies	2008
Nutrition	
Una Intervención Integrada Previene Crisis Nutricional que Causaría la Tormenta Tropical STAN	June, 2007
Other	
USAID Engages both Public and Private Sector in National Vaccination Campaign	November, 2007
Combatiendo juntos el Síndrome de Rubéola Congénita	2006
Health Management and Anti-corruption	January, 2007

5.5 Guatemala IEC /BCC Materials – *Calidad en Salud 2004 – 2009*

Technical focus

Materials

HIV, sexually transmitted infections (STIs), vulnerable groups

- Instructional guide on condom use
- Brochures and pamphlets for CHWs and men who have sex with men (MSM) on condom negotiation and on STIs
- Brochures for MSM on health services
- Flyer for people with HIV/AIDS (PLWHA)
- Manual on orientation and management of emotions
- Counseling cards for advising HIV-positive mothers on infant feeding
- Poster on stigma and discrimination awareness
- Brochures and posters on STIs prevention
- HIV and STI Prevention Leaflets



HIV and STI Prevention Leaflets

Family planning (FP) methods and use

- Updated manuals, flip charts, and counseling cards for FP providers
- Updated brochures, banners, and leaflets on FP methods
- Updated posters (all methods, postpartum methods)
- Two videos on balanced FP counseling



Updated Family Planning counseling leaflets

Maternal and neonatal health/ birth preparedness

- Brochures, worksheets, posters, and videos on family emergency plans relative to maternity and child birth
- Banners and workbooks on community emergency plans
- Radio spots on the prenatal and postpartum periods
- Gestogram and partogram charts and worksheets for health care providers
- Poster and video on active management of the third stage of labor (AMTSL)
- Traditional birth attendant identification card
- Brochure on prenatal and neonatal care
- Brochures and banners on birth spacing, pregnancy and postpartum issues
- Leaflets and charts on AMSTL
- Leaflet on referrals and counter-referrals
- Backpack, towels, pens, buttons, and clipboards for community health workers
- Flip chart and video on the danger signs of pregnancy and delivery



Home Delivery Instructional Poster



Family Emergency Preparedness Posters

Immunization

- Charts, posters, and brochures on vaccine schedules for infants and children
- Booklet for health staff on measles and rubella vaccination
- Leaflets, booklet, and TV and radio spots on measles and rubella
- Municipality civil registration vaccination worksheets



Vaccination Guide Brochure

Child health

- Posters with reminders and important points in growth monitoring, infant and young child feeding, danger signs in young children, and upper respiratory infection prevention
- Brochures on micronutrient supplementation, diarrhea, malaria, dengue, pneumonia, Vitamin A, etc.
- "Simple solutions that save lives": 26 short videos
- Radio spots (10 on vaccination and 10 on hygiene measures and danger signs)
- Guide on illness prevention and care
- Flip chart on child health and nutrition
- Child and women registers and protocols



Brochure on Avoiding Diarrhea in children

Nutrition

- Brochure promoting Vitacereal
- Brochures, counseling cards, leaflets, manual, posters, and preparation reminder sheets for child and adult nutrition. Booklet on safe food and water
- Guide for nutrition distance learning
- Posters on growth monitoring and promotion
- Posters and guides on infant and young child feeding guidelines
- Brochure and posters on safe drinking water
- Leaflets on Sprinkles (a food supplement) and therapeutic zinc
- Demonstration kits and brochures on breastfeeding
- Growth promotion and nutrition guide for health facilitators
- Health provider activity registration sheet
- Radio spots (10 on infant and young child feeding)
- Nutrition CD-ROM
- Nutrition buttons and towels



Educational Guide for Nutrition



Registration tool for nutritional preventative action

Adolescents and youth

- "Know your body" pamphlet for youth and adolescents
- Five-day teaching guide on sex and sexuality for adolescents and youth
- Brochures on abstinence and condom use

5.6 Project Deliverables – *Calidad en Salud* 2004 – 2009

GSH-1-00-03-00029-00

Project 520-0436

PRODUCTOS/REPORTES	FECHA DE ENTREGA	FECHA DE ENTREGA A USAID	FECHA DE APROBACION USAID
Annual Implementation Plan/ Training Plan	FY05	23-Dec-04	21-Jul-05
	FY06	31-Oct-05	16-Mar-06
	FY07	31-Oct-06	22-May-07
	FY08	1-Oct-07	16-Jan-08
	FY09	31-Oct-08	19-Feb-09
b) Strategic Plan 2005-2009	Una vez	23-Dec-04	5-Sep-05
c) Training Plan 2005-2009	Una vez	23-Dec-04	21-Jul-05
Performance Monitoring and Evaluation Report	Una vez	25-May-05	5-Jul-05
Quarterly Progress Reports	Oct-Dic 04	31-Jan-05	28-Jul-05
	Ene-Mar 05	29-Apr-05	21-Jun-05
	Abr-Jun 05	29-Jul-05	24-Mar-06
	Jul-Sep-05	Informe Anual	
	Oct-Dic 05	30-Jan-06	3-Mar-06
	Ene-Mar 06	28-Apr-06	21-Aug-06
	Abr-Jun 06	28-Jul-06	21-Aug-06
	Jul-Sep-06	Informe Anual	
	Oct-Dic 06	31-Jan-07	9-Apr-07
	Ene-Mar 07	30-Apr-07	17-May-07
	Abr-Jun 07	31-Jul-07	31-Aug-07
	Jul-Sep-07	Informe Anual	
	Oct-Dic 07	31-Jan-08	8-Apr-08
	Ene-Mar 08	30-Apr-08	7-Jul-08
	Abr-Jun 08	30-Jul-08	21-Aug-08
	Jul-Sep-08	Informe Anual	
	Oct-Dic 08	31-Jan-09	23-Mar-09
	Ene-Mar 09	30-Apr-09	18-May-09
	Abr-Jun 09	31-Jul-09	20-Aug-09
	Jul-Sep-09	Completion Report/Final Task Order Report	
Annual Reports	FY 2005	31-Oct-05	10-Feb-06
	FY 2006	31-Oct-06	19-Jan-07
	FY 2007	31-Oct-07	14-Jan-08
	FY 2008	31-Oct-08	19-Nov-08
	FY 2009	Completion Report/Final Task Order Report	
Completion Report	Una vez	August 31, 2009	22-Sep-09
Final Task Order Report	Una vez	November 29, 2009*	
Annual Inventory of Commodities	Una vez	October 31, 2005	18-Nov-05
	Una vez	October 31, 2006	19-Jan-07
	Una vez	October 31, 2007	13-Dec-07
	Una vez	October 31, 2008	19-Dec-08
	Una vez	September 29, 2009*	

* See Project Completion Report

PRODUCTOS/REPORTES	FECHA DE ENTREGA	FECHA DE ENTREGA A USAID	FECHA DE APROBACION USAID
Revisión y envío de una actualización de los materiales de IEC y de capacitación existentes preparados por Calidad en Salud	Una vez	June 30, 2005	9-Nov-05
Plan de Aseguramiento de Anticonceptivos 2006-2009	Una vez	31-Oct-05	19-Jan-06
Presentación de una base de datos y un sistema de vigilancia en nutrición	Una vez	28-Jun-05	20-Oct-05
Evaluación de los servicios de manejo sintromico de ITS y PVC en el MSPAS	Una vez	30-Sep-05	18-Nov-05
Como parte del plan de implementación anual para el segundo año, presentar ante la USAID/Guatemala un plan de trabajo FY2006-FY2009 preparado conjuntamente por el Proyecto y el MSPAS	Una vez	30-Sep-05	20-Jan-06
Presentar para la aprobación de la USAID un juego de job aides para servicios de ETS Y PVC	Una vez	31-Mar-06	12-Sep-06
Set de herramientas estratégicas y operativas de planificación y presupuestación	Una vez	30-Sep-05	12-Dec-05
Introducción del Presupuesto basado en el Desempeño	Una vez	29-Sep-06	19-Jan-07
Capacitación de Campeones de Logística	Una vez	30-Sep-05	24-Oct-05
Inventario Semestral de Anticonceptivos	Semestral (en marzo y septiembre)	Durante la vida del proyecto	La info se refleja en los trimestres siguientes, es decir junio y diciembre.
Tablas de Adquisición de Anticonceptivos		April 30, 2005	21-Jun-05
		September 30, 2005	30-Sep-05
		April 30, 2006	30-Apr-06
		September 30, 2006	5-Oct-06
		April 30, 2007	8-May-07
		September 30, 2007	12-Dec-07
		April 30, 2008	9-May-08
		September 30, 2008	30-Dec-09
		April 30, 2009	5-May-09
		September 30, 2009	
USAID DELIVERABLES (Según Modificación 09)			
Informe de Trabajo Anual ITS-VIH y Mejor Gerencia Hospitalaria	31-Oct-07	31-Oct-07	22-Oct-07
Modelo de atención de ITS y oferta de PVC	30-Nov-07	30-Nov-07	14-Mar-08
Instalación y Mecanismos de funcionamiento del Equipo de Laboratorio	30-Nov-07	30-Nov-07	14-Mar-08
Plan de monitoreo y evaluación de la vigilancia centinela y uso de los reactivos e insumos para ITS y VIH - Plan de monitoreo para el uso de reactivos e insumos para diagnóstico de ITS y VIH	30-Nov-07	30-Nov-07	14-Mar-08
Proceso de adaptación del Sistema de Administración Logística para el Manejo de Medicamentos y Productos Farmacéuticos afines a nivel de Hospitales	30-Nov-07	30-Nov-07	14-Mar-08

5.7 Inventory – Calidad en Salud 2004 – 2009

A. Furniture, Vehicles, and Computer Equipment

FURNITURE INVENTORY

NO.	ITEM & DESCRIPTION	Color	QTY	CURRENT CONDITION	Unit Price US\$	Total US\$	Observation:	Recommendation:
1	Escritorio "E1"	Gris	2	Good	\$675.60	\$1,351.20		Transfer to HCl
TOTAL						\$1,351.20		

Note: All other furniture cost under \$500

VEHICLE INVENTORY

PROJECT*	VEHICLE MAKE & MODEL	Color	YEAR	LICENSE PLATE NO.	Status	Observation	Recommendation
Calidad en Salud 1	Ford Explorer	Red	1993	MI 205	Donated to the Executive Unit of the National Health Reproductive Program	Donation approved by USAID	N/A
Calidad en Salud 1	Chevrolet Blazer	Grey	2000	MI 1269	Donated to UAT Ixil	Donation approved by USAID	N/A
Calidad en Salud 1	Chevrolet Blazer	Grey	2000	MI 2246	Donated to UAT El Quiché	Donation approved by USAID	N/A
Calidad en Salud 1	Chevrolet Blazer	Blue	2000	MI 2248	Donated to UAT San Marcos	Donation approved by USAID	N/A
Calidad en Salud 1	Chevrolet Blazer	Grey	2000	MI 2249	Donated to UAT Sololá	Donation approved by USAID	N/A
Calidad en Salud 1	Ford Explorer, Beige	Beige	1998	MI 387	Donated to UAT Quetzaltenango	Donation approved by USAID	N/A
Calidad en Salud 1	Chevrolet Blazer, Azul	Blue	2000	MI 1639	Donated to UAT TONICAPÁN	Donation approved by USAID	N/A
JHPIEGO	Jeep Cherokee	Dark Green	1995	MI 987	Donated to UAT/Huehuetenango	Donation approved by USAID	N/A
JHPIEGO	Pick Up Ford 250	Dark Green	2001	MI-2377	Donated to UAT/Chimaltenango	Donation approved by USAID	N/A
Consejo de Población	Ford Explorer XL		1997	MI-25 BBG	Donated to Nursing School	See Amendment No. 9	N/A
JHPIEGO*	Ford Explorer XL color	Metallic Green	1997	MI-1879	Not in use; lacks proper documentation		Transfer to HCl for Donation*
Proredes*	Pick Up Ford Ranger XL F711		2001	MI-89BBD	Scrapped	Totalled in accident	N/A
USAID	Ford Explorer	Dark Blue	1998	MI-88BBD	Oficina Calidad en Salud		Transfer to HCl
Calidad en Salud 1	Honda Civic	Silver	2000	MI-87BBD	Oficina Calidad en Salud		Transfer to HCl
PCI*	Dodge Ram 1500	White	1999	MI -86BBD	Oficina Calidad en Salud		Transfer to HCl
Proredes*	Pick Up Ford Ranger XL F711		2001	MI-90BBD	Oficina Calidad en Salud		Transfer to HCl
Proredes*	Jeep Cherokee	Metallic Silver	2004	MI-42BBF	Oficina Calidad en Salud		Transfer to HCl
USAID	Ford Ranger 4x2	Grey	2001	MI-35BBG	Oficina Calidad en Salud		Transfer to HCl
Consejo de Población	Chevrolet Astro Van 2000		2000	MI-98 BBK	Oficina Calidad en Salud	See Amendment No. 9	Transfer to HCl

*Donors in the process of being identified. We welcome USAID suggestions.

CALIDAD EN SALUD COMPUTER EQUIPMENT INVENTORY

NO.	ITEM & DESCRIPTION	SERIAL #	QTY	CURRENT CONDITION	PURCHASE PRICE US \$	Responsible	Recommendation:
1	Laptop Dell Latitude D620	GY1Y6B1	1	Good	\$1,806.00	Clara Zuleta	Transfer to HCI
2	Laptop Dell Latitude D505	0H2049-48643-4BG3691	1	Good	\$1,889.00	Sin uso	Transfer to HCI
3	Laptop Dell Latitude D505	CN0H2049486434BI2129	1	Good	\$1,889.00	Consultora Lily Quintanilla	Transfer to HCI
4	Dell Latitude D620	6T1Y6B1	1	Good	\$1,806.00	Sin uso	Transfer to HCI
5	Notebook Dell Inspiron 6000	TG 6873MB1	1	Good	\$1,800.00	Zonia Pinzón	Transfer to HCI
6	Impresora HP LaserJet 4050 TN	J3113A	1	Good	\$2,025.64	Administración	Transfer to HCI
7	Laptop Dell Latitude D505	CN0H2049486434BI2135	1	Good	\$1,889.00	Coralia Cajas	Transfer to HCI
8	Mouse Optico HP	7330AN3T5B07E	1	Good	\$2,362.57	Susana Avendaño	Transfer to HCI
9	Monitor HP L1706	CNN64626KY	1	Good		Susana Avendaño	Transfer to HCI
10	CPU HP	MXJ6470H1Z	1	Good		Susana Avendaño	Transfer to HCI
11	Teclado HP	B93CB0ADPT0914	1	Good		Susana Avendaño	Transfer to HCI
12	CPU HP	MXJ6470H1X	1	Good	\$2,362.57	Stephanie Williams	Transfer to HCI
13	Monitor HP L1706	CNN64803NC	1	Good		Stephanie Williams	Transfer to HCI
14	Mouse Optico HP	FB330AN3TSAVS9	1	Good		Stephanie Williams	Transfer to HCI
15	Teclado HP	B93CB0ADPT0557	1	Good		Stephanie Williams	Transfer to HCI
16	CPU HP	MXJ74000PV	1	Good	\$974.97	Fely Gonzalez	Transfer to HCI
17	Monitor HP L1706	CNC73606XP	1	Good		Fely Gonzalez	Transfer to HCI
18	Mouse Optico HP	FB7330AN302049J	1	Good		Fely Gonzalez	Transfer to HCI
19	Teclado HP	BC3370BVBURGU3	1	Good		Fely Gonzalez	Transfer to HCI
20	Laptop Dell Latitude D505	ST 9FF761	1	Good	\$1,889.00	Sin uso	Transfer to HCI
21	Impresora HP Color Laserjet 3800n	CNJB07832	1	Good	\$999.99	2do. Nivel (comunal)	Transfer to HCI
22	Fotocopiadora Xerox Workcentre Pro 35	L392205	1	Good	\$8,031.90	1er. Nivel (comunal)	Transfer to HCI
23	Retroproyector Epson PowerLite S1	FWDG4Z8821D	1	Good	\$1,050.00	Andrea Donis	Transfer to HCI
24	Retroproyector Epson PowerLite S1	FWDG4Z8922F	1	Good	\$1,050.00	Andrea Donis	Transfer to HCI
25	Sony Digital Still Camera DSC-F707	1337468	1	Good	\$2,699.00	Andrea Donis	Transfer to HCI
26	Computadora iMac	W873459GX89	1	Good	\$2,814.00	Andrea Chavez	Transfer to HCI
27	Laptop Dell Inspiron 1420	28D8VF1	1	Good	\$1,390.85	Sin uso	Transfer to HCI
28	Laptop Dell Inspiron 1420	48D8VF1	1	Good	\$1,390.85	Sin uso	Transfer to HCI
29	Impresora HP Laserjet P3005n (SGC)	SNJ2R04218	1	Good	\$718.42	SGC	Transfer to HCI
30	Laptop Dell Inspiron 1420	48D8VF1	1	Good	\$1,394.51	Martha Paz	Transfer to HCI
31	Laptop Dell Inspiron 1420	J7D8VF1	1	Good	\$1,394.51	Sara Ruano	Transfer to HCI
32	Laptop Dell Inspiron 1420	98D8VF1	1	Good	\$1,394.51	Pablo Wehncke	Transfer to HCI
33	Laptop Dell Inspiron 1420	B8D8VF1	1	Good	\$1,394.51	José Eduardo Silva	Transfer to HCI

continued next page

CALIDAD EN SALUD COMPUTER EQUIPMENT INVENTORY continued

NO.	ITEM & DESCRIPTION	SERIAL #	QTY	CURRENT CONDITION	PURCHASE PRICE US \$	Responsable	Recommendation:
34	Laptop Dell Inspiron 1420	58D8VF1	1	Good	\$1,394.51	Juan Carlos Mancilla	Transfer to HCI
35	Laptop Dell Inspiron 1420	68D8VF1	1	Good	\$1,394.51	Edwin Martinez	Transfer to HCI
36	Laptop Dell Inspiron 1420	38D8VF1	1	Good	\$1,394.51	sin uso	Transfer to HCI
37	Laptop Dell Inspiron 1420	D7D8VF1	1	Good	\$1,394.51	Victoria Valdez	Transfer to HCI
38	Laptop Dell Inspiron 1420	88D8VF1	1	Good	\$1,394.51	Francisco Gutierrez	Transfer to HCI
39	Laptop Dell Inspiron 1420	18D8VF1	1	Good	\$1,394.51	Silvia Gómez	Transfer to HCI
40	Laptop Dell Inspiron 1420	J5F1TG1	1	Good	\$1,394.51	Miriam Vanessa Castillo	Transfer to HCI
41	Laptop Dell Inspiron 1420	G7D8VF1	1	Good	\$1,394.51	Claudina Rodriguez	Transfer to HCI
42	Computadora Laptop Dell Inspiron 1420	78D8VF1	1	Good	\$1,699.60	Héctor Chaclán	Transfer to HCI
43	Cámara de Vigilancia	NUB1X4B	1	Good	\$827.00	Administración	Transfer to HCI
44	Cañonera EPSON Powerlite S5	JX4F7Y7098L	1	Good	\$745.06	SGC	Transfer to HCI
45	Cañonera EPSON Powerlite S5	JX4F8250I2L	1	Good	\$745.06	SGC	Transfer to HCI
46	Fotocopiadora Xerox Multifuncional WC4150	L99355819	1	Good	\$4,786.18	SGC	Transfer to HCI
47	Computadora Laptop Dell Inspiron 1520		1	Good	\$1,552.91	Carlos León	Transfer to HCI
48	Computadora Laptop Dell Inspiron 1520	TG JQJ2RDI	1	Good	\$1,552.10	Alvar Pérez	Transfer to HCI
TOTAL					\$69,480.79		

B. Miscellaneous Items

MISCELLANEOUS ITEM FOR DISPOSAL OR TRANSFER TO HCI

NO.	ITEM & DESCRIPTION	SERIAL #	QTY	CURRENT CONDITION	PURCHASE PRICE US \$	Recommendation
1	Portable diskette Toshiba PA2611U	127416042	1	Irreperable	Not available	Disposal
2	UPS CDP	VUPR505-050121-1279351	1	Irreperable	Not available	Disposal
3	Color Printer HP 2500C	SG9BCI30K3K3	1	Irreperable	Not available	Disposal
4	Server PowerEdge 1300 (no use)	JXZH00B	1	Good	No disponible	Transfer to HCI for Donation*
5	Electronic Agenda Palm_SI Compaq	1D94CKC3D3XJ	1	Good	\$379.28	Donation*
6	Canon Camera 3876 (Utiliza rollo)	1295	1	Irreperable	Not available	Disposal
7	Sony Digital Mavica MVC-FD73 (Usa diskets)	177723	1	Irreperable	\$2,699.00	Disposal
8	Zip drive 250 IOMEGA	7BE004E3XX	1	Irreperable	Not available	Disposal
9	Laptop Toshiba Satellite	81245318PU	1	Irreperable	\$1,584.49	Disposal
10	Printer Epson LQ1170 P641A	4161096639	1	Good	Not available	Transfer to HCI for Donation*
11	Printer Hp Deskjet 895CXI	MX-9341W178	1	Good	Not available	Transfer to HCI for Donation*
12	Computer Laptop HP NX 6320	CNU6401P0Q	1	Irreperable	Not available	Disposal
13	Laptop Toshiba Satellite A10 SP129	Y3034525H	1	Irreperable	\$1,220.00	Disposal
14	Dell Latitude D505	56QS761	1	Irreperable	\$2,198.00	Disposal
15	Toshiba PS426u-0M151	40587572U	1	Irreperable	Not available	Disposal
16	Lockstation Dell	CN-0T7135-47985-4A0-0361	1	Irreperable	Not available	Disposal
17	Lockstation Dell	CN-0T7135-47985-4A0-0214	1	Irreperable	Not available	Disposal
18	Lockstation Dell	CN-0T7135-47985-4A0-01262	1	Irreperable	Not available	Disposal
19	Lockstation Dell	CN-0T7135-47985-4A0-0821	1	Irreperable	Not available	Disposal
20	UPS Tripplite	BTBDX0124FBE	1	Irreperable	Not available	Disposal
21	Monitor View Sonic	23B013401347	1	Good	\$306.92	Transfer to HCI for Donation*
22	Monitor Dell	MX-01780R-47801-9CI-II096	1	Good	\$1,480.00	Transfer to HCI for Donation*
23	Monitor Compaq	933BE62QXY10	1	Good	Not available	Transfer to HCI for Donation*
24	Monitor View Sonic	DP93802502	1	Good	Not available	Transfer to HCI for Donation*
25	Monitor LG	005ACB7024	1	Good	Not available	Transfer to HCI for Donation*
26	Monitor Dell	8266597	1	Good	Not available	Transfer to HCI for Donation*
27	Monitor ADC	54CS0CA687017	1	Good	Not available	Transfer to HCI for Donation*
28	Monitor de Cámara	JCM-100 J00200013	1	Good	Not available	Transfer to HCI for Donation*
29	Kit de Alarma CK System 238, bocina, detectores de humo (5), sensores de movimiento (4), table de mandos	s/n	1	Irreperable	Not available	Disposal
30	Megáfono Modelo PA-702	s/n	1	Good	Not available	Transfer to HCI for Donation*
31	Printer Epson LX300+	CDUY107913	1	Good	\$225.66	Transfer to HCI for Donation*
32	Laptop Compaq Presario	2V99CLR3R0R2 C/Cargador	1	Irreperable	Not available	Disposal
33	Laptop Toshiba Satellite	Z9329495U-1 S/CARGADOR	1	Irreperable	\$1,584.49	Disposal
34	Laptop Toshiba Satellite	20447855U-1 S/CARGADOR	1	Irreperable	\$1,220.00	Disposal
35	Laptop Dgll Latitude XP	ZOQL5067 S/CARGADOR	1	Irreperable	\$1,889.00	Disposal
36	CPU	C5AAY0262CIA	1	Irreperable	\$360.12	Disposal
37	CPU Dell Dimension	6VY4-D	1	Irreperable	\$360.12	Disposal
38	CPU	84873	1	Irreperable	\$360.12	Disposal
39	CPU	N6SJV0216UJS	1	Irreperable	\$360.12	Disposal
40	CPU	BBT0171NBB	1	Irreperable	\$360.12	Disposal

continued next page

MISCELLANEOUS ITEM FOR DISPOSAL OR TRANSFER TO HCI continued

NO.	ITEM & DESCRIPTION	SERIAL #	QTY	CURRENT CONDITION	PURCHASE PRICE US \$	Recommendation
41	CPU Cybertech	NSCCQ0085QCC	1	Irreperable	\$360.12	Disposal
42	CPU HP	G6-BY4D	1	Irreperable	\$360.12	Disposal
43	Keyboard FC	M1BB017CRBB	1	Irreperable	Not available	Disposal
44	Keyboard Dell Quiet Key	M950248394	1	Irreperable	Not available	Disposal
45	Keyboard FC	90219811	1	Irreperable	Not available	Disposal
46	Keyboard FC	1000 90727601	1	Irreperable	Not available	Disposal
47	Keyboard FC	1000 10499932	1	Irreperable	Not available	Disposal
48	Keyboard FC	1000 1049 9956	1	Irreperable	Not available	Disposal
49	Keyboard BTC	H94400177	1	Irreperable	Not available	Disposal
50	Keyboard FC	KB2002EQCOK	1	Irreperable	Not available	Disposal
51	Monitor View Sonic	C195192756	1	Irreperable	Not available	Disposal
52	Monitor View Sonic	DP01704069	1	Irreperable	Not available	Disposal
53	Monitor View Sonic	DP93802508	1	Irreperable	Not available	Disposal
54	UPS Tripplite	F02011795	1	Irreperable	Not available	Disposal
55	UPS Tripplite	F01827383	1	Irreperable	Not available	Disposal
56	UPS Tripplite	9133AYDSM445701113	1	Irreperable	Not available	Disposal
57	UPS Tripplite	F028733181	1	Irreperable	Not available	Disposal
58	UPS Tripplite	U18509962	1	Irreperable	Not available	Disposal
59	UPS Tripplite	F02011777	1	Irreperable	Not available	Disposal
60	UPS Tripplite	U18536303	1	Irreperable	Not available	Disposal
61	UPS Tripplite	F02011848	1	Irreperable	Not available	Disposal
62	UPS Tripplite	F02110820	1	Irreperable	Not available	Disposal
63	UPS Tripplite	F02011835	1	Irreperable	Not available	Disposal
64	UPS Tripplite	F02875608	1	Irreperable	Not available	Disposal
65	UPS CDP	BUPR 1000040089-1250321	1	Irreperable	Not available	Disposal
66	UPS CDP	BUPR 1000040089-1250611	1	Irreperable	Not available	Disposal
67	UPS Tripplite	OMNI-SMART 450PNP	1	Irreperable	Not available	Disposal
68	Proyector de Acetatos 3M 9700	s/n	1	Irreperable	Not available	Disposal
69	Constestadora telefónica AM300	2320003	1	Irreperable	Not available	Disposal
70	Planta Alcatel	s/n	1	Irreperable	\$2,822.25	Disposal
71	Bipofan FC VCE 4100A	s/n	1	Irreperable	Not available	Disposal
72	Bocinas BNWIN	s/n	1	Irreperable	Not available	Disposal
73	Mouse FC	273123	1	Irreperable	Not available	Disposal
74	Mouse FC	699110104740	1	Irreperable	Not available	Disposal
75	Porta telephone	s/n	1	Irreperable	Not available	Disposal
76	Bocinas CE	QCPASS	1	Irreperable	Not available	Disposal
77	Word processor Brother	C9D527977	1	Irreperable	Not available	Disposal
78	ZIP drive	NWAM33AOMR	1	Irreperable	Not available	Disposal
79	Keyboard Compaq	BOAB30E6ZFW245	1	Good	Not available	Transfer to HCI for Donation*
80	Keyboard Generico	NS\$JE0455EJ\$	1	Good	Not available	Transfer to HCI for Donation*
81	Fax Panasonic	6JBRA008515	1	Irreperable	Not available	Disposal
82	MIMIO	s/n	1	Irreperable	\$500.00	Disposal
83	Printer a Color 2500 N	s/n	1	Irreperable	Not available	Disposal
84	Notebook Toshiba	Y3012943H	1	Irreperable	\$1,220.00	Disposal

*Donors in the process of being identified. We welcome USAID suggestions.