BEST PRACTICES in SCALING UP CASE STUDY

GUATEMALA

Pro Redes Salud:

Rapid scale-up of primary health care through NGOs

INTRODUCTION

After a generation of civil war, in 1996 the Guatemalan Peace Accords called for a spirit of reconciliation and a move toward more democratic systems of governance. At the time, health indicators revealed the need to focus efforts in Guatemala's Mayan highlands. One approach involved contracting indigenous non-governmental organizations (NGOs) to implement a *standard service delivery methodology* and provide a *standard set of primary care services*. This approach was first used in Central America by the U.S. Agency for International Development (USAID)/El Salvador's PVO Maternal Health and Child Survival Project (PROSAMI, 1990-1998) to achieve rapid scale-up of critical health services in areas of conflict.

The project's success attracted the attention of neighboring countries, including Guatemala, which sent a team to El Salvador in 1995. Following that visit, in 1996 the Ministry of Health (MOH) designed an NGO granting program and by 2000, the MOH program had contracted 52 NGOs to assist 1.6 million inhabitants at-risk in the Mayan highlands alone, with a nationwide coverage of over 3 million. The Guatemalan NGO Networks project (*Pro Redes Salud*, 2001 to 2004), was a $10 million effort funded by USAID and implemented by JSI Research & Training Institute, Manoff Group, Project HOPE, and AmeriCares.

When the project began, over 300,000 people in the 7 Mayan highland departments (states) still lacked access to care, particularly in the most remote mountainous areas. The MOH national granting program was interested in bringing services to those areas, and also in testing innovations in service delivery to improve the program. To meet these objectives, *Pro Redes Salud* implemented strategies to achieve rapid scale-up of geographic coverage including testing innovative approaches to improve community involvement, quality of care, supervision, and monitoring and evaluation through NGO networks.

Why It Mattered

Before the project began, 300,000 remote rural inhabitants in the Mayan highlands lacked basic primary care, the NGO civil society in health lacked cohesion, and the MOH NGO granting program needed revising. From 2000 to 2004, the NGO Networks Project implemented a grants program that helped form networks of NGOs, strengthening health services and testing innovations in service delivery, and improved monitoring and evaluation. As a result, by 2004, high-quality services had been extended to 317,000 rural people and surveys showed significant improvements in health care coverages, NGOs had been unified into networks, a national NGO federation had been formed, and innovations had been adopted by the MOH for improvements in the national MOH NGO program.

RESULTS

Measuring Progress and Determining Impact

Progress was measured by a community-based monitoring system designed to analyze community integrated management of childhood illness (IMCI) and reproductive health data. **Impact** was measured through the implementation of baseline and final household surveys conducted by an external firm. The project also worked with the MOH and other partners on an operations research activity comparing the results of the project's service delivery innovations with the service delivery method being used by the MOH NGO program.

Process-Level Results

- Rapid expansion of critical health services to 317,000 people through 8 NGO networks and 18 NGOs, a 23.4% expansion of MOH NGO coverage in the Mayan highlands.
- Programs targeted the most vulnerable populations and communities: 92% of 38 priority districts were served by networks and NGOs strengthened and funded by the project.
- 573 training events (1-15 days duration) were held for the financial and technical staff from 8 NGO networks, 116 NGOs, 1,058 community health workers, 12,563 community volunteers, and 96 traditional birth attendants.
- 8 networks, 116 NGOs were supplied and equipped to provide care—including establishing 317 community health centers and also revolving drug funds.
- Program sustainability was achieved through transfer of innovations, NGOs, and project communities to the MOH NGO program. The MOH Coverage Extension program now provides grants to NGOs to extend coverage to hard-to-reach areas.

Household surveys were conducted in local languages.

Impact-Level Results

When reviewing impact-level results, it is important to keep in mind that patient care was *provided by community health workers* using simplified protocols, and drugs and family planning methods were sold at subsidized prices. Vaccines were free and were applied by nurse and physician supervisors.

The project implemented two NGO grant funding rounds. Household survey results were as follows:

Immunizations	*Baseline Survey*	*Final Survey*
DPT 3 coverage, children 12-23 months		
First round NGOs	76.4%	80.0%
Second round NGOs	64.7%	85.7%
BCG coverage, children 12-23 months		
First round NGOs	92.1%	90.0%
Second round NGOs	61.3%	90.0%
MMR coverage, children 12-23 months		
First round NGOs	56.6%	65.0%
Second round NGOs	13.7%	78.3%
Full vaccination coverage, children 12-23 months*		
First round NGOs	50.8%	63.4%
Second round NGOs	18.5%	76.1%

* The recent introduction of the MMR vaccine and its relatively low coverage rates lowered full vaccination coverage rates in both funding rounds.

Diarrheal disease and pneumonia	*Baseline Survey*	*Final Survey*
Children under 5 with diarrhea who received ORS or increased liquids		
First round NGOs	50.2%	84.6%
Children under 5 with pneumonia or acute pneumonia who received antibiotics		
First round NGOs	*	98.0%

* This indicator cannot be collected from a household survey; results are from monitoring data.

Growth monitoring and nutrition	*Baseline Survey*	*Final Survey*
Children under 2 who attended growth monitoring		
First round NGOs	2.0%	47.4%
Second round NGOs	28.8%	48.0%
Children under 2 attending growth monitoring who were growing well		
First round NGOs	47.2%	87.7%
Caretakers of children under 2 attending growth monitoring who received individual counseling		
First round NGOs	55.6%	100%
Children under 2 who received vitamin A		
First round NGOs	29.8%	79.8%
Second round NGOs	39.1%	80.1%
Women exclusively breastfeeding their children under 4 months of age		
First round NGOs	42.2%	57.8%

Integrated reproductive health	*Baseline Survey*	*Final Survey*
Pregnant women receiving at least one prenatal care visit		
First round NGOs	50.5%	91.1%
Second round NGOs	90.4%	89.7%
Postnatal women receiving at least one postnatal visit		
First round NGOs	63.6%	89.5%
Second round NGOs	64.5%	86.1%
WFA using family planning		
First round NGOs	14.3%	29.0%
Second round NGOs	16.4%	28.9%
WFA receiving a Pap smear during the past year		
First round NGOs	12.3%	23.0%
Second round NGOs	10.5%	18.0%

STEPS IN THE SCALE-UP PROCESS

The most important steps were as follows:

STEP 1: ***Negotiating an MOU*** with the Ministry of Health outlining the responsibility of each partner through the end of the project.

STEP 2: ***Working with the MOH and NGOs to:***

- Identify the geographical areas and communities most needing assistance.
- Determine the contents of the standard package of care and the supporting protocols and information/education materials to be used.
- Determine the standard service delivery structure and innovations to be tested.
- Determine the per capita amount to be used as the basis of all grants.
- Negotiate the project exit strategy and sustainability of community efforts.

STEP 3: ***Implementing an open, transparent network and NGO selection process in two stages:***

The first stage was pre-selection of NGO and network grantees. It included a national bidder's conference to explain the project and distribute the proposal forms and selection criteria, and the formation of 8 departmental-level selection teams. Networks and NGOs were allowed one month for proposal development. Once proposals were received, a pre-selection workshop was held at the national level with all selection teams. The workshop included an independent rating of all proposals for each department by each committee member (without discussion), calculation of average scores for each proposal, and a pre-selection of two or more proposals by each departmental team. The second phase was the final selection based on selection team field visits to pre-selected NGO network offices to look at the administrative/financial set-up, and to field operations to look at the provision of services by the NGO in the areas in which they were currently working. Final selection of grantees was made by each team, with a written decision signed by all team members.

The *Pro Redes Salud* project's approach was characterized by:

- Substantial MOH and NGO involvement
- An open and transparent two-stage selection process
- Funding of NGOs through NGO networks
- Targeting grantee projects to highest risk populations
- Extension of care into geographical areas not covered by services
- Implementation of a standard package of care, standard structure and methodology of service delivery with innovations
- Direct provision of primary care by community health workers based on standard protocols and the use of revolving drug funds

STEP 4: ***Setting up and mobilizing communities:***

Once selected, the project:

- Assisted grantee networks and NGOs to develop plans and budgets.
- Signed agreements and funding began to flow;
- Set-up network and NGO offices, hired staff and equipped offices—including motorcycles for field staff.
- Held NGO community assemblies to present the project, determine community interest, and select health workers and volunteers.
- Assisted NGOs in conducting community mapping and census and identified locations for community health centers.
- Developed, field tested, and finalized a baseline household survey instrument, and collected baseline data.
- Set up community health centers with all necessary supplies and equipment, including pharmaceuticals and bicycles for community workers and volunteers.

STEP 5: ***Training:*** As the *Pro Redes Salud* approach to rapid scale up involved implementation of a standard technical package of care and a standard method of

service delivery by all grantee NGOs, it was important that all grantees—from staff through to community health workers and volunteers—be trained in the technical contents of the service delivery package and use of protocols and IEC materials. This ensured that all NGOs were updated in national norms and would deliver standardized, high-quality services in a similar way. It also ensured that the NGO programs and personnel would be recognized by the MOH departmental staff and included in referral systems.

Community volunteers weigh children to monitor growth.

STEP 6: Provision of care: The standard package of care implemented by all networks and grantee NGOs included:

- *Integrated Child Health:* Detection, case management, and referral of diarrheal disease in children under five; detection, case management and referral of respiratory infections in children under five; growth monitoring and counseling of children under two; micronutrient supplementation (vitamin A, iron) among children under two.
- *Integrated Reproductive Health:* Prenatal and postnatal care; promotion of exclusive breastfeeding and infant nutrition; family planning; detection and referral for breast cancer; screening and referral for cervical cancer; prevention and referral of STDs.

All networks and grantee NGOs implemented a standard structure and methodology of service delivery with innovations that were designed by the project and the MOH and with technical assistance from the NGOs. To ensure that the model with innovations could be replicated by the MOH, certain parameters were held constant: grant amounts to NGOs were held to the per capita payment based on the total population to be served of US$5, job titles and salaries were maintained, and patient care was based on the national norms and protocols.

To improve the national MOH NGO program, the following innovations were tested:

- The total population and number of volunteers under each community health worker were reduced to 1,000 (167 households) and 8 volunteers.
- Preventive and curative services were limited to children under 5 and women of fertile age.
- The principal responsibility for case management was given to the community health worker based on the simplified community-based IMCI and reproductive health protocols approved by the MOH.
- Each volunteer was responsible for a "sector" of the population corresponding to 20 households and given the responsibility for growth monitoring, counseling and case referral.
- Community health worker training was extended to 3 weeks with hands-on practice in health centers and hospitals.
- Community health worker pay was increased to reflect increased responsibility:

community health worker supervision was strengthened by using nurses (1 for every 5 community health workers) and a methodology of weekly supportive supervision and a checklist.

- The quality of community health centers was improved through a quality assurance process.
- All community health workers and community health centers were provided with a revolving drug fund consisting of a limited supply of basic drugs and contraceptives as established in the community-based IMCI and reproductive health protocols.

- Care was systematized in the community health centers through mapping, labeling of households, opening of folders containing patient records which corresponded to the household number on the community map, development of a simple system for tracking and patient follow-up.
- Growth monitoring and counseling were improved through the development of guidelines and new IEC and training materials.
- A new community-based information system for IMCI and reproductive health was developed for community health workers, consisting of a standard set of field reporting forms, a computerized database, monthly and quarterly data analysis based on a set of key indicators of coverage and quality of care, and electronic reports given on a regular basis.

Community health workers counting respiration to detect pneumonia.

Funding was provided to NGO grantees on an advance basis monthly, with monthly liquidation of expenses.

WHAT WORKED

- The transparent, inclusive NGO selection process implemented by the project resulted in the receipt of hundreds of proposals—including many previously unknown but excellent NGOs—and gave the final selection of grantees credibility among all involved—NGOs as well as government.
- Including a list of specific high-risk communities in the process ensured that all final grantee projects were implemented in those communities and to populations most needing assistance.
- The approach to NGO granting based on a standard service delivery structure and methodology and standard package allowed the project to achieve both rapid scale-up of critical health care services in high-risk areas and significant health impact in a short time.
- The standardized approach provided an opportunity to broadly test innovations through NGOs. The innovations that worked included:

reducing the population ratio to one community health center per 1,000 population (approximately 167 families) attended by a community health worker and 8 volunteers;
focusing preventive and curative services primarily on children under 5 and women of fertile age;
giving the principal responsibility for case management to the community health worker based on the use of simplified community-based IMCI and reproductive health protocols;
extending training of community health workers to 3 weeks with hands-on practice in health centers and hospitals; using distance training methods for new personnel;
employing nurses as supervisors for community health workers using a methodology of supportive supervision and a standard checklist;
improving community health centers through a quality assurance process;
systematizing care in community health centers through mapping, labeling households, opening folders containing patient records which corresponded to the household number on the community map, developing a simple system for tracking and patient follow-up;
improving growth monitoring and counseling through new guidelines, IEC, and training materials; and
improving monitoring through a new community-based information system for IMCI and reproductive health.

- Community health workers with a fourth grade education were found to be capable of delivering high coverage and quality primary care based on the use of the simplified protocols.

- The rural population was found to be willing to pay for medicines and contraceptives at subsidized prices—thus providing some cost recovery for the rural program. Quality of care and health coverage were not compromised by the sale of basic drugs or contraceptives.
- Involving the Ministry of Health in the project from the beginning ensured project credibility. As a result, the Ministry of Health made changes in the national NGO program based on project innovations, and assumed direct funding for NGO grants and communities covering a population of 317,000 when the project ended.

WHAT WE LEARNED ALONG THE WAY

- NGOs are often critical of donor grantee selection processes that are biased or do not allow all NGOs to participate. We learned that by implementing a transparent participatory process, the project gained credibility among NGOs.
- Ministries of Health are also often left out of the process during project granting of NGOs. This can lead to mistrust. We found that involving the MOH in the project from the beginning also gained us credibility and allowed the Ministry to ensure that the project would be focused on high-risk areas, priority health problems would be addressed, and that NGOs would follow national norms and protocols. This led to improved communication between the MOH and NGOs as NGOs were seen as partners who were reaching populations that the MOH had been unable to reach alone.
- NGOs generally work with a given population or in specific communities, and have expertise in specific technical areas. For this reason, we were unsure at first if NGOs would be interested in expanding into new populations and new geographical areas, or in learning new technical skills. We learned that NGOs actually welcome geographic and technical expansion and see it as an opportunity for organizational growth as long as they are given the training and resources they need.
- We were at first concerned that the NGOs might reject a standardized approach to grants, but found instead that they appreciated being given a clear idea of the interventions and a basic structure and methodology for service delivery. They also appreciated the opportunity to learn new methodologies and gain experience in new technical areas.
- Because NGOs have their own methods and focus, we were also concerned that the standardized approach would stifle NGO and local creativity. Instead, we found that the approach provided a framework for all NGO projects, but still allowed NGOs to put their individual touches and creativity on their projects based on local needs and organizational strengths.
- We did not know if funding to NGOs would work if it were channeled through networks. Although this proved to be a challenge as it entailed strengthening and organizing the networks in addition to the NGOs themselves, in the end we found the approach to be feasible for NGO granting.
- We were also unsure if community health workers with little education would be able to provide direct patient care using the simplified protocols. When the final survey results were tabulated, however, it became clear that community health workers who are fully equipped, properly trained, and supervised are indeed able to provide quality care. This positive experience with community health workers was an important step forward for Guatemala as it meant that basic care could be accessible to remote rural communities 24 hours a day.
- The standardized approach and joint training of all networks and NGO grantees served to unify the civil society working in health. This led to the formation of a national federation of NGO networks. The federation would not have come about if NGOs and networks had not unified their approaches and visions and come to know each other during the life of the project. The federation, ASOREDES, is comprised of 8 NGO networks with over 150 NGO members working in health nationwide.

CONCLUSION

The *Pro Redes Salud* experience in Guatemala—in collaboration with the Ministry of Health—has shown that it is possible to use participatory methodologies to select diverse local NGOs, focus efforts in the highest risk communities, and strengthen NGOs to provide a unified, standard set of integrated child and reproductive health services.

The provision of these integrated services extended basic primary care in project areas through trained community members using simplified methodologies that included providing antibiotics for pneumonia. The methodology was shown through household pre- and post-surveys to have significantly increased access to quality health care, to have changed key health behaviors, increased coverage and reduced morbidity. This process also served to unify the NGO networks into a much more cohesive civil society that culminated with the formation of the first Guatemalan federation of NGO networks working in health.

Key to this success was the adaptation of an established methodology previously used in El Salvador to involve the MOH, forming a national NGO federation, and transferring project communities and NGOs to direct MOH funding when the project ended. Although each country is different, the methodology used in these projects could be adapted to many other settings. The many important lessons learned from this project should be used to inform the development of MOH-NGO projects and integrated service delivery through community health workers in others countries not only in Latin America, but elsewhere.

The Guatemalan highlands.

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