USAID FROM THE AMERICAN PEOPLE | Guatemala

Improving Family Planning by Creating Community—Service Provider Partnerships in Guatemala

The Ixil Triangle lies deep in the highlands of western Guatemala. Its three largest villages-which form the shape of a triangle on the map below-are large only in relation to surrounding hamlets. This isolated area is home to the Ixil Maya, who make a living from their farms and looms.

Ixil's very remoteness and near-invisibility on the national stage made it a target during Guatemala's civil war (1960-1996). A rebel group established its headquarters there. Hundreds of civilians lost their lives. Not surprisingly, the people of the Ixil Triangle have learned to be wary of outsiders. At the same time, the disconnect between them and social services has exacted a toll: people here are poorer, less educated and at greater risk of many health problems than the Guatemalan population as a whole.

Save the Children USA's Maya Salud project worked carefully to bring high-quality sexual and reproductive health (SRH) services to the doorsteps of Ixil families by fostering partnerships between community members and service providers. Using a methodology that Save the Children calls Partnership Defined Quality or PDQ, representatives of 88 communities and of the health system jointly examined and improved SRH services in a manner that met the aspirations of service users. By the end of the four-year Maya Salud project, the number of couples using safe and effective family planning (FP) methods had more than doubled, and the contraceptive prevalence rate had surpassed 33 percent.

Introduction

The Ixil Triangle has some of the poorest education, economic and health indicators in Guatemala. More than 60 percent of girls do not attend school and a mere 20 percent complete their primary education.[i] Without education, and with few opportunities to earn an income, children have little chance of breaking the cycle of poverty that affects some 80 percent of families in this remote part of the western highlands.[ii] Maternal mortality is estimated at 277 deaths per 100,000 live births[iii] (the national average is 153[iv]); infant mortality rates reach 66 deaths per 1,000 live births[v] (versus 47 nationally[vi]); and 82 percent of residents live on less than two dollars a day (52 percent nationwide).[vii] In Ixil, girls marry young—some as young as 12—and experience an average of 10 pregnancies before the end of their reproductive years.[viii] Most girls and boys enter their reproductive lives with little or no knowledge about how their bodies work, pregnancy, or childbirth. Studies from earlier this decade revealed that just 20 percent of women in Ixil had healthy birth spacing,[ix] and only 28 percent were using any form of effective contraception even though 56 percent did not want to become pregnant in the next year.[x] Just 13 percent received information on SRH during visits to their closest health post—which in some instances was as far as 38 miles from home.[xi]

Providing women and their partners the information, counseling and health services they need to make informed decisions about childbearing has a tremendous impact on quality of life for all family members. But it is equally important that women and men feel comfortable seeking these services. Often, health workers in rural Guatemala are trained to dispense contraceptives upon request, but they have not learned to counsel and inform, or to consider cultural taboos, the sensitivity of the issue, and the gender divide between the (typically) male service provider and the (typically) female contraception seeker.

CORE Group

Approach

The *Maya Salud* Project

Save the Children USA's *Maya Salud* (Mayan Health) project sought to bridge the gap between those who wanted information, counseling and services in SRH in their communities and those charged with providing these services but who often lacked the knowledge, skills, and resources to do so effectively.

Maya Salud did this by fostering partnerships between communities and health service providers. The project's—and the partnerships'—aim was to improve SRH service delivery for 51,985 women and men of reproductive age in 95 communities across the three municipalities of the Ixil Triangle: Nebaj, Cotzal and Chajul. A four-year project (2005-2009), *Maya Salud* was funded through a subgrant from USAID's Flexible Fund.

The methodology that Save the Children applied to reach its goal was its own Partnership Defined Quality (PDQ).

To achieve its aims, *Maya Salud* engaged a range of constituents as equals in a process that built local capacities to improve and monitor the quality of SRH services:

- Community members,
- Ministry of Health (MOH) representatives,
- Community Health Workers (CHW), MoH volunteers who receive a stipend to provide certain health services in rural communities,
- Cooperativa Todos Nebajenses or Cooperative of the People of Nebaj (COTONEB)

Partnership Defined Quality

Save the Children's PDQ is a field-tested methodology that engages community members in improving and monitoring the quality of their health services. PDQ was appropriate for Maya Salud because central and national efforts to improve health services by equipping facilities and training staff failed to create lasting changes in the quality of services at the community level. This was largely because the central strategies failed to consider that *solutions to health service problems might lie outside the formal health system.*

In Guatemala, MoH strategies also failed to address the cultural gap between health workers (who are usually not from the communities they serve) and clients, leading to a lack of common understanding of concepts as basic as health and illness.

Save the Children developed the PDQ approach in 2000, and has since implemented it in more than 18 countries as part of maternal, newborn, child survival, HIV/AIDS, FP and youth SRH projects. Save the Children is now working with The CORE Group to build regional expertise in the use of PDQ.

Save the Children invites interested readers to download the PDQ manual a facilitator's guide for a four-day training of trainers; and monographs describing PDQ application in 11 countries from **www.savechildren.org** or **www.coregroup.org**.

In Ixil as elsewhere around the world, a failure to examine community perspectives about the quality of care means that what a client considers good service may not match what the service provider considers good service. Such gaps and disconnects can be a major factor in underuse of available services, including SRH services. The PDQ process brings together health service providers, users and non-users of health services to define and meet SRH needs within a community. It does so with a central focus on *quality*.

PDQ takes community and service provider groups through four empowering phases:

Phase 1: Building Support

The PDQ is collaborative and requires commitment from key members of communities and the health system. In the *Building Support* phase in Ixil, Save the Children staff held a series of meetings with residents who could represent their communities' concerns to the health system, and with local, district and even national service providers including the MoH and COTONEB. In all, *Maya Salud* achieved acceptance of the PDQ process in 88 communities (or 92 percent of target) over the life of the project.

Phase 2: Exploring Quality

The five *Maya Salud* field staff guided community groups and service provider groups—separately—to explore their perceptions of what constitutes a quality health service, particularly in matters of SRH. Each group developed its own definition of quality by considering its members' needs, resources, rights and responsibilities, and cultural heritage.

Also during this phase, each group explored the benefits of a partnership between community and health workers. This was especially important because health workers were not accustomed to working with community partners and vice versa. Both groups often needed assurance that the PDQ would benefit everyone involved.

The findings from these meetings were then organized for presentation during the PDQ's third phase.

Phase 3: Bridging the Gap

In each community, the residents' group and the health workers' group brought their definitions and characteristics of quality health care to a joint forum. They presented their own and heard each other's ideas and perspectives. In each case, *Maya Salud* staff guided the two groups to form a team and develop a shared vision of quality.

Together, each team then identified and prioritized problems and constraints that made it difficult to achieve quality health services within the community. This step and these activities were the beginning of the *partnership* necessary for subsequent activities to improve SRH service quality. The participants established Quality Improvement Teams (QITs) composed of a subset of community members and health workers. Each of the 88 participating communities had its own QIT.

Phase 4: Working in Partnership

At the end of the *Bridging the Gap* workshop, the QITs understood various viewpoints, had a shared vision of what quality in health care meant for their communities, and saw the gaps they needed to fill to achieve that vision. The QITs then moved from identifying problems to solving them. Through dialogue and analysis, the QITs explored the root causes of inadequate quality of services and identified appropriate, feasible solutions for reaching the desired level of quality.

The results of the QITs' analyses were their Quality Improvement Plans. The plans delineated actions to fill gaps in knowledge, skills or attitudes at two levels: community/client (service demand) and community/provider (service supply). The QITs also established goals, and identified indicators to monitor progress and determine when a goal had been achieved.

In Phase 4, the PDQ process was in the hands of the QITs. The *Maya Salud* staff, MOH representatives and COTONEB stepped back, but did provide technical assistance and inputs to the QITs' work as needed.

Partnerships in Action:

Building Demand

This section and the one that follows describe just some of the activities that the QITs undertook in their Quality Implementation Plans.

- Peer networks called *Amigas/Amigos* (friends) were established in participating communities. QITs recognized that most women and men were encouraged to use modern FP methods for the first time by someone they knew, like a friend, with whom they could speak openly yet confidentially about SRH. Amigas and Amigos learned the basics of FP, including modern methods, peer counseling, and referral (and sometimes accompaniment) to health facilities.
- *Maya Salud* developed and distributed a Contraception Sample Kit to help the *Amigas/Amigos*, MoH service providers and CHWs show which methods were available, what they looked like and how they worked. The kit helped demystify contraception for new users who could touch, see, and ask questions about methods in an informal environment.

The photos below show the "Contraception Sample Kit" developed by the Maya Salud project for use by local Ministry of Health staff and Community Health Facilitators, Quality Improvement Teams, and Amigas/Amigos to create awareness among women and men of reproductive age of the variety of existing contraception methods as well as to use them as visual aides in educating them about how they function.

- *Maya Salud* trained 1,000 QIT members to mobilize their peers and community members to promote social change. Likewise, 1,000 QIT members learned the basics of FP and modern contraceptive methods so they too could promote them and counsel others in their use.

Building Supply

- The MOH and COTONEB trained more than 200 health workers in the Ixil Triangle in FP and SRH counseling.
- Eighty CHWs learned the basics of SRH and modern contraception, counseling and information dissemination. In the most remote communities, the CHWs dispensed condoms, pills and quarterly injections to new users who did not have the time, resources, or confidence to travel dozens of miles to seek contraception from the nearest health facility.
- One community built a new post, and three more rehabilitated their posts to provide comfortable, confidential FP services. In one case this involved building a wall to create more privacy; in others, painting interiors and building basic furniture. Some clinics changed their operating hours to better suit the needs of clients who worked long days in the fields.
- QITs and Maya Salud partnered with APROFAM (the Guatemalan branch of International Planned Parenthood Federation) to bring five mobile clinics to the most remote of villages. The clinics offered voluntary tubal ligations and vasectomies, Jadelle® implants, and gynecological exams including pap smears. Such services had never before been offered in these far-flung hamlets.
- Maya Salud staff gauged client satisfaction with SRH services via exit interviews, monitored contraceptive stocks, and observed service delivery to clients as appropriate. Staff shared the results with the QITs as a way to ensure consistent application

Key Findings

Save the Children's final evaluation of Maya Salud (2009) measured a number of indicators and contrasted them to the project's baseline (2006), revealing that PDQ had improved access to and use of FP, and that users appreciated service quality.

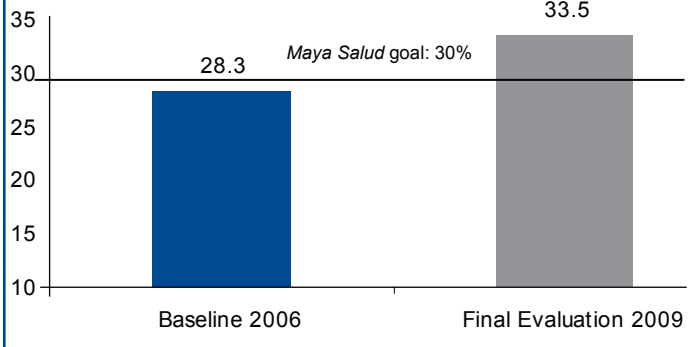
Knowledge and Sources of Information

% of couples who discussed FP, by place:	2006	2009
Nebaj	44	46
Cotzal	39	56
Chajul	36	50

- In the final evaluation, 56 percent of women indicated that they had discussed birth spacing and desired family size with their partner in the previous year, in marked contrast to 2006 when only 37 percent of women did so.
- 72 percent of women of reproductive age surveyed could name three or more FP methods in 2009, up from 52 percent in 2006.
- In 2006, the single greatest source of FP information for women (41.5 percent) was friends, family and neighbors. By 2009, the most commonly cited source (36 percent) was the local health post. In fact, the percentage of women who said that their local health post/health center was a source for FP information and methods quadrupled from 15 to 60 percent.
- 21 percent of women of reproductive age received a home visit by a health care provider who spoke with them about FP in 2009, up from 5 percent in 2006. And 51 percent of such women received FP information during their last visit to their local health post in 2009, up from 13 percent in 2006.

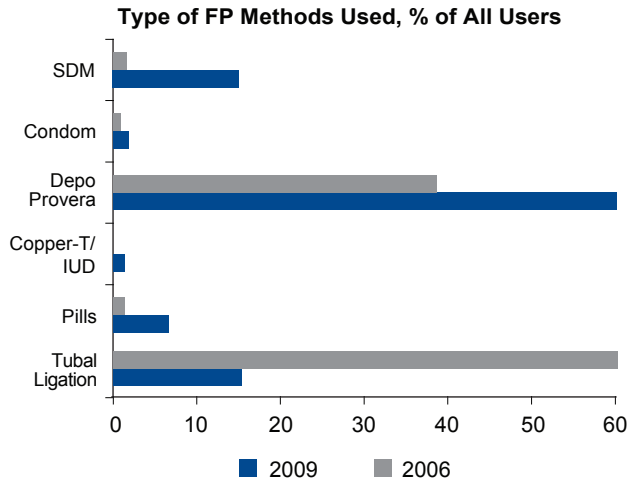
Contraceptive Use

- According to monitoring data, the number of new FP users rose from 2,087 (in 2006) to 5,638 (in 2008)—a 270 percent change after only about three years.



The table above demonstrates the increase of married or united women who use a modern family planning method.

- The overall use of FP methods among married/united women increased from 28.3 percent to 33.5 percent, surpassing the *Maya Salud* goal of 30 percent.
- The number of women who chose tubal ligation as a method of contraception plummeted as less invasive, less costly and less risky methods became readily available. Meanwhile, Depo Provera surged in popularity.



The table above shows the dramatic increase in usage of modern family planning methods. It also demonstrates how women, as they learned more about existing family planning methods, changed their preferences for contraception. In the beginning of the project, before injectables were available, 60% of women were having tubal ligation. As the project progressed, this percentage decreased to 15% while the percent of women using injectables increased significantly.

Quality

How would you rate the service that you received today?	2008 (%)	2009 (%)
Excellent	14	17
Very good	60	79
Normal	20	3
No response	5	1

When Save the Children compared the results of user satisfaction surveys from the third and fourth years of the *Maya Salud* project, it was apparent that perception of quality had risen.

Lessons and Recommendations

Save the Children learned several lessons from its work in the Ixil region of Guatemala, and intends to incorporate these into future project designs to yield improved, sustained impact on the quality of SRH services at local and national levels.

Invest First in Trust

Generally speaking, the Ixil culture is one that appreciates open discussion and values collective action to solve common problems. Yet people were wary of

outsiders after their tremendous suffering during Guatemala's civil war. Save the Children found it vital to invest time in building trust between community members and outsiders, such as MoH service providers, in the PDQ's Phases 1 and 2.

The *Amigas/Amigos* networks proved an ideal bridge between the project and the people. The volunteers effectively functioned as extensions of the project staff by promoting information and social acceptance of modern FP in their communities. But they also lent social credibility to the project and its goal of increasing the use of SRH services in ways that project staff alone may not have been able to achieve. And, of course, the network extends *Maya Salud's* impact by continuing to serve as a local source of information beyond the life of the project.

Tailor Your Communications and Schedules

It is imperative to consider local literacy and culture when selecting ways to train and present information. In Ixil, Save the Children found that problem trees which map out causes and effects of barriers to improved health service delivery, were excellent tools for helping QITs conceptualize the concept of quality. Similarly, the 'Traffic Light Analysis' allowed QITs and project staff to easily communicate the monitoring findings to the rest of the community by using a color code: green = meets quality goals; yellow = improvement needed; red = requires follow-up or reconsideration. Standardized training materials for groups with shared cultures and experiences also helped the PDQ process: facilitators used such materials to track their progress through themes and topics, and to structure meeting and workshop content.

It is likewise imperative to consider local livelihoods. Save the Children scheduled meetings and other events around work hours and important seasonal activities such as sowing or harvesting crops.

Engage QITs in Monitoring and Evaluation

In Ixil, QIT members were involved in some aspects of monitoring the effects of their Quality Implementation Plans, but it was the Maya Salud staff who led the process and took responsibility for analyzing and presenting the information to the QITs. Because the underlying goal of PDQ is to empower service users and providers to take collective action for their joint benefit, Save the Children realizes that users must also learn to develop and apply monitoring and evaluation tools, and to analyze and act upon the results. Future PDQ work in Guatemala will take this into account.

Promote Learning and Engagement among National Stakeholders

Save the Children cannot overemphasize the importance of keeping MoH officials at all levels informed of activities and results. Project management must establish and reinforce mechanisms for sustaining MoH engagement—

The Quality Improvement Team of the community of Batzuchil standing in front of the old community health post before they built a new one - as part of their Quality Improvement Plan for increasing access and utilization of local reproductive and sexual health service.

and have the resources to do so. In Guatemala, this meant periodic meetings with MoH and stakeholder groups; documentation and dissemination of learnings and results; and advocacy for the replication of successful models in other parts of the country. Without these, there will be no broader impact and overall improvement in national capacity to affect lasting change for citizens.

Conclusion

Save the Children's application of PDQ was very effective in the Ixil Triangle. It fostered an increase in demand for and supply of SRH services by bringing the services closer to clients and engaging community members in the promotion of modern contraception use.

Perhaps most importantly, PDQ brought service users and service providers together for the first time to negotiate perceptions of quality in health service delivery, and to provided them the structure and support they needed to improve. Using PDQ, Maya Salud set the stage in 88 communities for dialogue about improved SRH service delivery, and for grass roots mobilization, social change, and collective empowerment.

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