The UN COVID-19 Response and Recovery Multi-Partner Trust Fund (UN COVID-19 MPTF)

Proposal Template

Proposal Title: Support to the Guatemalan Humanitarian Response Plan to COVID-19: protecting healthcare workers and vulnerable groups and promoting a human rights-based quarantine

Amount: USD 1,000,000

I. Immediate Socio-Economic Response to COVID-19

- The first case of COVID-19 in the country was reported on 13 March 2020 (imported case). As of 21 April 2020[1], Guatemala's Ministry of Public Health and Social Assistance (MSPAS) had carried out molecular tests on 3,572 personas, of which 313 were confirmed with COVID-19. From 240 confirmed cases with available data, 97 (40%) had declared having travelled abroad in the 14 days prior to symptoms onset. The median age of confirmed cases was 34 years old (ranging from 0 to 93 years), 62% of them were men and 10 had died.

- Responding to the global coronavirus pandemic represents a challenge for Guatemala, due to initial deficiencies in the health system, subpar coverage and quality of health service and feeble epidemiological monitoring. More specifically, main health sector challenges and needs include: i) epidemiological surveillance: rapid response teams and health facility-based surveillance activities need to be strengthened to carry out case investigations and contact tracing, data management and analysis, and timely reporting; ii) laboratory testing capacity: supply and distribution of reagents, tests, and other supplies and services in tandem with the changing demand; iii) case management: procurement of appropriate medical supplies, including personal protective equipment (PPE), and equipment for treatment, training personnel (at all levels, including pre-hospital), and strengthening referral systems; and iv) infection, prevention and control: availability of PPE to reduce human-to-human transmission in healthcare facilities, as well as training and refresher training in PPE usage at all levels (public and private healthcare networks). Healthcare facilities will need to be reorganized with a focus on improving triage and isolation to facilitate the flow of patients and reduce healthcare-associated infections. To date, there is

[1] Latest data available at the time of drafting this proposal.

also a gap in the establishment of streamlined logistics for COVID-19 dead body management, including body bags and proper PPE for management and transport. A particular need in Guatemala is adopting risk communication using culturally appropriate media channels, presentation methods and language, all informed by evidence. Considering that Guatemala is a multi-ethnic and multilingual country, there is a need to adapt communications on the risk of people to contract the virus and the prevention practices recommended to be implemented by WHO, to culturally sensitive language and presentation, and to ensure that these messages are disseminated through widely used mass media communication channels.

- Guatemala has great inequities in health and social security, gaps which have long been manifested in high rates of maternal mortality and infant mortality. According to recent data reports of the Ministry of Health (2015), the estimated Maternal Mortality Ratio was 108x100,000 live births, the Infant Mortality Ratio was 30x1,000 live births and the Neonatal Mortality Ratio was 18x1,000 live births, associated with the lack of recognition of the problem, difficulty in accessing health services, and limited number and quality of services. The current emergency has exacerbated this situation due to the lockdown and closure of some health services and the overall lack of adequate facilities to provide safe and quality treatment.

- Guatemala has the highest out-of-pocket health expenditure in Latin America and the Caribbean, and low public investment in health (2% of GDP). As such, its vulnerability is national in scope. Despite the country´s emergency preparedness mechanisms being activated since January 2020, WHO ranked Guatemala at the start of March as having a preparedness level 2 (<40%). Moreover, the prevalence of stunting in children under 5 is of 46.5% (DHS, 2015), rendering this population particularly vulnerable. High poverty and adjusted inequality indexes, together with low subnational human development indexes in rural areas (comprised mostly of indigenous communities), make them also vulnerable due to difficulties in accessing health care, and the overall low coverage.

- Of the 384 cases registered as of 23 April 2020, 70 were related to returned/deported migrants both by air and land, which is why it is required to establish and strengthen temporary monitoring centers to test, isolate and monitor returned migrants. Guatemala does not yet have adequate spaces or protocols to assist irregular returned migrants. This poses health risks for all parties involved. As of February 2020, 15,564 people returned to the country (19% more than February 2019)[2]. Since March, there have been "*ad hoc*" irregular returns of Guatemalans, Salvadorans and Hondurans through the Guatemala-Mexico border. Honduran and Salvadoran returnees face dire conditions at the Honduran border.

- Prior to the first confirmed COVID-19 case, initial guidelines directed that returned migrants should pass a verification process undertaken by MSPAS to detect symptoms, followed by a 14-day quarantine at home[3]. However, given the risk of asymptomatic cases, the Ministry of Foreign Relations (MINEX) and the Guatemalan Migration Institute (IGM) developed alternative strategies for extra-domicile quarantine and coordinated with the Directorate General of Civil Aviation (DGAC) to accommodate returnees at the main International Airport to have 24-48 hours of observation, where MSPAS is implementing COVID-19 surveillance/monitoring.

- On April 17, the guidelines and procedures for the reception and transport of returnees were changed and Monitoring Centers were established. Initially, MINEX proposed establishing two centers: i) "Ramiro de Leon Carpio" sports complex for those returning by air; and, ii) a center to be established at Coatepeque Municipality (Quetzaltenango province) for those returned by land (process still ongoing). In the case of unaccompanied children, the Secretariat of Social Welfare of the Presidency (SBS) and the Attorney-General of the Nation (PGN) developed a procedure to facilitate family reintegration. While the families of the returned unaccompanied minors are being located, children remain under the care of the SBS in two centers: i) "*Nuestras Raíces*" ("Our Roots") in Quetzaltenango, for those returning by land; and, ii)

[2] https://mic.iom.int/webntmi/guatemala
[3] http://epidemiologia.mspas.gob.gt/informacion/coronavirus-2019-ncov/descargas-coronavirus-covid-19?download=78:actualizacion-guia-epidemiologica-por-covid-19-al-6-de-abril-de-2020

a center located in Guatemala City for those returned by air. An additional annex was opened in Guatemala City, given the large number of children and adolescents being returned. In the case of the provinces (*departamentos*) of Huehuetenango and Quetzaltenango, observation/monitoring centers are also being managed by the IGM.[4] All these monitoring centers have needs both in terms of basic personal water, sanitation and hygiene (WASH) kits and other protocols related to their health and well-being.

- On 17 April 2020, the Office of the Human Rights Ombudsperson (*Procuraduría de los Derechos Humanos)*, following investigations carried out by the Ombudsman for Migrants (*Defensoría de las Personas Migrantes)* at the facilities at the International Airport in Guatemala City (*La Aurora*), issued recommendations to the institutions responsible for assisting returned migrants[5] calling for strengthening the practice of solidarity, considering actions taken to date by the institutions of the central government, and urging for respect for the human rights of the returnees.

II. Solutions proposed

Based on the Guatemalan Humanitarian Response Plan to COVID-19, the Joint Program is focusing on two key issues for the country context, framing the proposal in two components: C1) ensuring health service provision by protecting and training healthcare workers (HCW) and enhancing surveillance and laboratory capacities, including health services for women; and, C2) guaranteeing a human rights-based approach for quarantining returned migrants (since deportations have continued during the pandemic), given that most COVID-19 cases in Guatemala so far have been imported, including from returned migrants.

C1 - Ensuring health service provision by protecting and training healthcare workers and enhancing surveillance and laboratory capacities, including health services for women

- **Infection, prevention and control for COVID-19 (IPC) and case management.** Activities to reduce human-to-human transmission are essential to protect healthcare workers at all levels. Indeed, infections of COVID-19 in healthcare workers have been reported in other countries, further straining the capacity of national health systems to care for the overflow of patients during an outbreak. Therefore, to help reduce human-to-human transmission in health facilities, PAHO/WHO COVID19 online and IPC verification lists will be employed to guide the re-organization of health services and ensure adequate provision and training for PPE. Also, healthcare workers' (HCW) management of healthcare associated infections (HAI) will be strengthened by means of water, WASH interventions, as well as surveillance assessments and interventions. In addition, healthcare quality will be enhanced by strengthening the local health system capacity, including training and refresher training for HCW at all levels of the integrated healthcare services network.

- **Surveillance and laboratory**. National capacities need to be brought up to scale quickly to train, implement and supervise the active observation of isolated cases and contact tracing of all COVID-19 cases. Significant work will also be needed to collect and analyze surveillance data, including analysis of disaggregated data (gender, disability, age, ethnicity) for targeted information and response. It is vital that such capacities are taken to scale because their absence would otherwise have a detrimental impact on maintaining surveillance for other epidemic-prone diseases such as influenza, yellow fever, dengue and Zika. To this end, early detection of COVID-19 cases will be supported through existing surveillance systems to inform and improve analysis and decision-making, including reducing the fragmented flow

[4] https://www.mspas.gob.gt/index.php/noticias/covid-19/casos
[5] https://www.pdh.org.gt/61-20-el-procurador-de-los-derechos-humanos-jordan-rodas-andrade-al-pueblo-de-guatemala-manifiesta/

of information to promote timely data management for monitoring of cases and tracing of contacts, including for healthcare workers with high-risk exposure. Furthermore, the capacity of the National Health Laboratory will be strengthened for differential diagnosis and confirmation of COVID-19 cases through the required tests, reagents, and human resources to ensure the continuity of services. Logistic and testing capacity will be scaled up as more cases are detected.

- Improvement of women's access to health services. Technical assistance will be provided to MSPAS to strengthen regulations and norms, and their application in health services, in order to provide safe, relevant and culturally appropriate spaces to assist pregnant women, women in labour, post-partum, and their newborns, as well as for victims and survivors of sexual violence. These activities will be carried out with the support of the Observatory of Sexual and Reproductive Health (OSAR), under the auspices of the Association for Community Health Services (ASECSA). Complementary to these activities, actions will be undertaken to strengthen the work of doulas, midwives and local emergency committees, women community leaders, and women health providers, by training them and their community-level clients, including about referral systems from the community to institutional services and by providing them with PPE and supplies.

C2 - Guaranteeing a human rights-based approach for quarantining returned migrants

- Humanitarian assistance. Considering conditions of returning migrants and given the need to take account differing needs for responding to women, pregnant women, children and men, mechanisms will be identified to ensure an efficient distribution of hygiene and cleaning kits, warm clothing kits, and health and PPE supplies, beneficiaries will be informed about their human rights. Analysis will be carried out to estimate the quantities and types of supplies required for distribution when returnees enter the Monitoring Centers and when they return to their communities of origin. For the latter, provision of transportation is foreseen.

- Psychosocial assistance. To ensure compliance with official measures and to guarantee ordered treatments for cases testing positive or negative, clear, trustworthy and culturally appropriate information will be made available and distributed in line with national protocols for coronavirus response. Individual orientation will be provided based on crisis psychology and evidence, to support the emotional stabilization of those requiring such assistance, and to follow the steps for self-protection. In addition, service providers will be given psychological support and training on effective communication[6] with local authorities and receiving communities to reduce stigmatization and discrimination against returnees.

- Management of Monitoring Centers. Support will be provided in terms of personnel, structures and coordination required to ensure that the Monitoring Centers for returning migrants run by the Government are enabled to carry out the following activities: a) epidemiological surveillance; b) emergency treatment; c) communication and training; d) basic water and sanitation (e.g. availability of gender-separated bathrooms); e) hygiene and cleaning protocols (including the establishment of a process for recording information on returnees who leave the Monitoring Center to facilitate epidemiological follow-up at the level of host communities, in line with national guidelines regarding the arrival, follow-up and duration of returnees' quarantine);[7] and g) advice and support to public institutions for their compliance with treatment standards in different situations. Support will also be provided to staff training them on conduct identification and referrals of returnees who cannot return to their homes or communities due to myriad reasons associated with violence, including gender-based violence (GBV), gang violence, violence against children, and violence against LGTBIQ+, among others.

- Support for returns to communities of origin. In order to ensure a gender and culturally appropriate focus, all proposed actions will develop differentiated

[6] https://www.paho.org/es/documentos/covid-19-orientaciones-para-comunicar-sobre-enfermedad-por-coronavirus-2019-0
[7] http://epidemiologia.mspas.gob.gt/informacion/coronavirus-2019-ncov/descargas-coronavirus-covid-19

methodologies to provide appropriate assistance, especially for children, adolescents, women, and expectant mothers. Concrete actions will be promoted to prevent GBV, especially sexual violence and trafficking of girls, adolescents, women and children. In addition, support will be provided to children who are unable to return to their communities of origin due to situations of violence, through capacity building to PGN and SBS personnel so as to enable them to prepare, accompany and provide follow-up to family and community re-integration, as well as the delivery of support kits to the families of children undergoing quarantine in their communities.

III. What is the specific need/problem the intervention seeks to address?

- **IPC and case management.** Patients with COVID-19 that present symptoms of respiratory problems may require an invasive procedure (e.g. sampling, intubation, mechanical ventilation, or suction). These procedures generate aerosols and might play a role in disseminating the virus in healthcare facilities. Therefore, healthcare providers should comply with standard precautions and proper use of PPE to stop transmission. This is currently not the case in Guatemala. In addition, there is not an adequate training available to HCW to improve knowledge and practices regarding infection control and case management. There is no HAI surveillance programs nationwide. Finally, health infrastructure and provisional COVID-19 care centers are limited or outdated; access to safe water, sanitation and hygiene is inadequate, and training opportunities for HCW and supplies are limited.

- **Surveillance.** The flow of information is currently fragmented, with national information systems not yet having the ability to collect s disaggregated data systematically, hence the dearth of sound analysis to support decision-making. Surveillance field teams need reinforcement to conduct case investigation, contact tracing, and management of quarantined and isolated persons to better respond to vulnerable populations at risk of unequal access to health services. In addition, there is no decentralized capacity for the differential diagnosis or confirmation of COVID-19 cases, given limited tests, reagents, and human resources.

- **Maternal and neonatal health services and services to respond to sexual violence**. In the context of the COVID-19 pandemic, these services have been negatively affected and have become points of additional risk of contagion for women, newborns, and healthcare providers, potentially contributing to increased maternal and neonatal morbidity and mortality. It is critical to identify, assist and refer cases of women who are victims and survivors of sexual violence. To minimize the impact of the COVID-19 pandemic while accessing these services, and to reduce such risks during service delivery, safe and secure spaces must be guaranteed –in maternal and neonatal health services, for integrated responses to sexual violence, gender, culture, community, institutional settings, among others.

- **Gaps in the intervention strategy for returned migrants**. Despite actions implemented to address the coronavirus emergency (implemented by MINEX, IGM, SBS, PGN and SOSEP)[8], it is clear that the intervention strategy continues to exhibit operational gaps with respect to protecting human rights of returned migrants, fulfillment of their basic necessities, including psychosocial and health needs, and the adequate identification of those who cannot return to their homes or communities due to violence, including GBV, gang violence, violence against children, and violence against LGTBIQ+, among others. Up to the present, the provision of essential services to the returnees staying in the Monitoring Centers established in Guatemala City has been scarce and mostly spontaneous; for example, food has been provided through donations by government and civil society organizations and there is a lack of hygiene supplies and a lack of support for cleaning and disinfection of the facilities. In addition, the provision of direct assistance for returnees' psychosocial needs, effective epidemiological surveillance, and the development of information and communication processes related to COVID-19 prevention and warning signs, are found wanting. Finally, it should be noted that significant effort is still required to effectively implement the existing protocols to prevent sexual and GBV and human rights violations in the interactions among beneficiaries and between beneficiaries

[8] Ministry of External Relations (MINEX), Guatemalan Institute for Migration (IGM), Secretariat for Social Welfare (SBS), Secretariat for Social Work of the First Lady (SOSEP), and Attorney General of the Nation (PGN).

and service providers.

- **Stigma and the rejection of migrant returnees**. Migrants returning to their communities often face stigmatization and rejection. For this reason, it is important to ensure a safe and dignified return, and to ensure that those returning are placed in home-based quarantine. The local health system should support local authorities and indigenous leaders to enable them to welcome returnees, and to ensure that returnees remain in their home-based quarantine under the supervision of the public health system. This implies consideration of special support to those unaccompanied children and adolescents who are reunified with their families, and to their families.

IV. How does this collaborative programme solve the challenge? Please describe your theory of change

The incidence of COVID-19 –and of its humanitarian and socio-economic impact will depend on the containment measures implemented, including the epidemiological surveillance capacity to identify new cases, carry out complete contact tracing to control transmission chains, and the infection prevention and control measures during the management of light, moderate, serious and critical cases. As Guatemala already has the highest out-of-pocket healthcare expenditures in Latin America and the Caribbean, and as it has the lowest health-related public investment rate (2% of GDP), the country faces a significant degree of vulnerability. It is thus foreseeable that there will be an increase in the vulnerability of groups, including children under 5 years, people with underlying health issues, those who are immune-compromised, the elderly, and expecting mothers, as well as migrants, internally displaced populations, and poor and extremely poor rural and indigenous communities with limited access to health services.

Since Guatemala's preparation and response capacity to the coronavirus is defined by WHO as being at level 2 (<40%), national capacities need to be strengthened rapidly to train, implement and supervise the active monitoring of suspected cases and the follow-up of all the contacts of confirmed COVID-19 cases. This situation also requires significant effort to collect and analyze COVID-19 surveillance data. Because of their work overload and their continuous lack of supplies and personnel, integrated services are extremely limited (including sexual and reproductive health services, care for elderly women, care for pregnant and lactating women, women living with HIV, care for those with disabilities, and services for LGTBIQ+), as are programs for mental health and psychosocial assistance.

On the other hand, one of the groups most affected by the present pandemic are returned migrants due to their high degree of vulnerability and the stigmatization and rejection they face upon returning to their communities, and before that in the Monitoring Centers, where essential supplies and services are lacking, this jeopardizing the respect of their human rights.

In this context, the Guatemalan Humanitarian Response Plan to COVID-19 (HRP) -prepared by the UN Humanitarian Country Team- prioritizes actions in the health sector: prevention, containment and response plan for the health sector, protection for health personnel, strengthened isolation and quarantine, including returned migrants, strengthened response capacity and better functioning of the health services network, epidemiological and community surveillance, and strengthened capacity for timely and quality diagnosis. This plan also includes multisectoral interventions: actions to address food security, nutrition, GBV, other gender issues, education, social protection and WASH.

The actions proposed for this Joint Program aim to support the implementation of the HRP and fall under Window 1 of the call to implement actions to suppress the transmission of the virus, focusing particularly on two key issues in the Guatemalan context: i) ensuring health service provision by protecting and training healthcare workers and enhancing surveillance and laboratory capacities, including health services for women; and, ii) guaranteeing a human rights-based approach for quarantining returned migrants (since deportations have continued during the pandemic), given that most COVID-19 cases in Guatemala so far have been imported, including from returned migrants.

The methods proposed for the interventions include direct support to the government in the form of technical assistance, financing of essential services (interrupted or non-existent) to cope with the emergency, as well as direct service delivery to affected populations, as described in section II.

Consequently, the theory of change for the Joint Program is as follows:

IF, adequate equipment for healthcare workers, organization of services, prevention and control of infections as well as strengthening of capacities are guaranteed; and IF, early detection of cases and their isolation together with contact tracing via strengthened epidemiological surveillance are guaranteed, and diagnostic capacity through an extended laboratory network to effectively and timely manage cases -adapted to living conditions of each case- are strengthened; and IF, access to culturally appropriate health services is guaranteed for expecting mothers, women in labour, post-partum, their newborns and for victims and survivors of sexual violence, establishing safe and secure spaces for providing attention, improving coordination, referral and information systems for decision-making; and IF, government institutions protect the human rights of migrants by satisfying their basic needs, their transportation, their psychosocial needs, and the need for epidemiological surveillance according to national and international standards and ethnic and gender appropriateness; and IF, service providers in the Monitoring Centers and other sites proposed by the government promote dignified assistance to returnees by systematizing information as the basis for action, by acquiring the technical capacity to improve service quality, promoting self-protection, and providing appropriate security measures to prevent contagion; and IF, local communities prepare themselves to receive returnees, supported by local authorities (including indigenous authorities) and with evidence-based information; and IF, Monitoring Centers adequately identify returnees who cannot return to their homes or communities for various reasons related to violence and provide these returnees with advice and assistance so they can complete their quarantine in a dignified and safe manner (including for non-Guatemalan's transiting the country). THEN, it will be possible to save lives, protect healthcare workers, strengthen epidemiological surveillance systems and reduce the transmission of COVID-19 in the most vulnerable populations in Guatemala, including returnees, providing dignified treatment, free of discrimination and stigma, and with adequate protection mechanisms. The implementation of the Joint Program, in addition, will support the achievement of SDG 3 (Good health & well-being), SDG 5 (Gender equality), and SDG 10 (Reduced inequalities).

The main assumptions of the theory of change focus on government leadership, which is consolidated at the national and local level through the governance structure led by MSPAS for the health response, along with the availability of medical supplies and equipment; and, on the other hand, the MINEX and IGM regarding actions for returned migrants. The risks associated with the implementation of the Joint Program are, therefore, operational, political and organizational in nature, regarding: i) global market depletion of PPE and other essential supplies; ii) high turnover of health authorities and interruption of technical cooperation processes; and iii) institutional weaknesses for defining the management of Monitoring Centers for returned migrants. Both components of the proposal will be implemented following a human rights-based approach.

The Joint Program follows the "build back better" principles as it aims to support the restoration/introduction of critical services potentially on a halt during the pandemic (health services and attention to returned migrants, respectively), that will play a critical role in coping with the effects of the emergency for key groups (healthcare workers) as well as vulnerable populations (including women who are most affected), and therefore the restoring or improving of livelihoods and health.

V. Documentation

On 6 April 2020, Guatemala presented its Humanitarian Response Plan to COVID 19 (*Plan de Respuesta Humanitaria COVID-19*). This plan was formulated with the humanitarian clusters which were activated in response to the pandemic, including sectors such as: health, social protection, shelters, gender, early recovery, WASH, nutrition, food security

and education. These clusters comprise UN agencies, funds and programs (AFPs) and non-governmental organizations (NGOs), with participation of the Guatemalan Government. The three objectives of the HRP are: i) to strengthen the capacity of the MSPAS to contain the health emergency; ii) to respond to the humanitarian needs of the population derived from COVID-19; and iii) to put in place the basis for the socioeconomic recovery in the medium and long term.

It is important to note that the HRP takes into consideration the needs expressed by the Government in its Health Sector Plan for Prevention, Containment and Response (supported by PAHO/WHO) to contain the COVID-19 crisis and the National Emergency and Economic Recovery Program (Phase 1) prepared by the Economic Cabinet. The latter contributed to establishing the basis for a multi-sectoral response focusing on seven priority areas: health, social protection, GBV and gender inequality, food security, nutrition, education, and WASH. At the same time, the HRP served as the basis for the preparation of this Joint Program, which considers government's proposed short-term actions to save lives, protect healthcare personnel, continue epidemiological and community surveillance, strengthen the capacity for timely and quality diagnosis, strengthen health services (including sexual and reproductive health, maternal and neonatal health, institutional and community capacity, and services for the victims and survivors of sexual violence), and provide dignified quarantine for returned migrants, prioritizing those regions of the country most affected and where the majority of inequities are found in terms of services and development.

The WHO Partners Platform was presented and discussed initially with the Office of the Vice President, which identified *Secretaría Nacional de Ciencia y Tecnología (SENACYT*) as the focal point for the adoption of the platform in Guatemala. PAHO/WHO, with the support of WHO Geneva Headquarters, facilitated training on the use of the platform with SENACYT´s focal point on March 27, 2020. Subsequently, SENACYT´s focal point presented the platform during a meeting of the MSPAS Emergency Operations Center (EOC), during which the EOC manager supported its use and suggested that local administration of the platform to be transferred from SENACYT to a focal point identified within the MSPAS Department of International Cooperation. Currently, PAHO/WHO is facilitating the training of the new MSPAS focal point and is starting to upload information to the platform, which will be presented during the next Health Cluster meeting.

VI. Target population

This Joint Program supports implementation of actions contained and prioritized in the Guatemalan Humanitarian Response Plan to COVID-19 which, as mentioned in the previous section, was developed by the UN AFPs, NGOs and the Government. In addition, for the definition of the target population of this Joint Program, the Government was consulted in order to guarantee that the UN support will reach those populations most affected by the pandemic, with the primary objective of saving lives and containing the transmission of the coronavirus. The target populations for each component of the Joint Program are spelled out below.

C1 - Ensuring health service provision by protecting and training healthcare workers and enhancing surveillance and laboratory capacities, including health services for women

The target population is healthcare workers (approx. 700) and the catchment population (13.4 million) of 25 prioritized hospitals spread across 12 provinces (Guatemala, San Marcos, Huehuetenango, Quetzaltenango, Quiché, Petén, Alta Verapaz, Izabal, Chiquimula, Jutiapa, Zacapa y Escuintla) to save lives and reduce transmission, including vulnerable populations, such as indigenous communities, persons with disabilities or at risk for gender-based violence, migrants, accompanied and unaccompanied children, among others.

In addition, this component seeks to improve the services provided for pregnant women by institutions in at least 16 health centers, which have the capacity to provide support for births and newborns, guaranteeing the safety of healthcare staff and strengthening their capacity to provide safe and quality services. Specifically, the program will work

with 1,000 traditional birth attendants (*comadronas*), equipping them for their protection and that of their patients. In addition, the program will work with at least 24 local emergency committees to facilitate timely referral in at least 3 priority municipalities in 3 provinces (*departamentos*), which register the greatest number of COVID-19 cases to date: Guatemala, Sacatepequez and Chimaltenango.

C2 - Assuring a human rights-based approach to quarantining returned migrants

The target population will comprise returned migrants (adults, unaccompanied children, and family units) who will make use of the Monitoring Centers established by the Government in the provinces (*departamentos*) of Guatemala and Quetzaltenango[9], as well as the centers for the reception and protection of unaccompanied children and families. Using data and trend information from 2019, it is estimated that the target population will be distributed as follows: 14.7% will be women and 18.7% will be children and adolescents. If the 2019 patterns hold for 2020, it is estimated that approximately 200 people will require shelter each week in each of the 6 Monitoring Centers and, thus, that the total population of beneficiaries will be approximately 7,000 people (this figure includes irregular migrants returning back to Guatemala, as well as those transiting Guatemala to return to their own countries of origin). In addition, the personnel managing the Monitoring Centers and the receiving communities will benefit indirectly by the improvements in the conditions and management of these Centers and the interventions designed to improve self-care and communication to prevent the stigmatization of returnees. Geographically, assistance to unaccompanied children will be provided mainly in the provinces (*departamentos*) of Guatemala and Quetzaltenango at the time of their return to the country, and the support for family and community reintegration will focus principally on the provinces (*departamentos*) of Huehuetenango, San Marcos, Solola and Quiche.

VII. Who will deliver this solution?

The Recipient UN Organizations (RUNOs) of the Joint Program will be PAHO/WHO (C1 leader), UNFPA (C1), IOM (C2 leader) and UNICEF (C2). They all have accumulated experience, previous solid work, and specialized staff related to the areas of intervention described in this Joint Program. It is important to stress that the RUNOs are already providing some specific support and technical assistance to the Government in responding to the COVID-19 emergency, and that this Joint Program will allow the implementation of complementary efforts and will guarantee an integrated response of greater reach.

The Steering Committee for this Joint Program will include the UN Resident Coordinator and the representatives of the 4 RUNOs, who will meet periodically to make strategic decisions, as well as to discuss with Government counterpart authorities, including the Minister of Public Health and Social Assistance (MSPAS), the Minister of External Relations (MINEX), the Secretary for Social Welfare (SBS), the Secretary for Social Work of the First Lady (SOSEP), the Attorney General (PGN) and the Director of the Guatemalan Institute for Migration (IGM). Considering the characteristics of this Joint Program, the UN team will work in close coordination with government counterparts, and also with civil society organizations, including the Observatory on Sexual and Reproductive Health (OSAR) and the Association for Community Health Services (ASECSA), and other non-governmental partners which are carrying out complementary activities.

The RUNOs will be completely responsible for the administration of the resources detailed in the budget of the Joint Program, in line with its financial rules, norms, policies and administrative procedures. At the technical level, the implementation of the Joint Program will be supported by a technical team consisting of the four RUNOs and will ensure that the planned products and results are reached on time, and will put in place a system for monitoring and evaluation, which will permit follow up on the indicators of the

[9] The Quetzaltenango's center currently operates as a "Sample Collection Center", and the Government of Guatemala is considering transforming it into a "Monitoring Center".

outcomes and outputs included in the Results Matrix. With respect to the joint management of the program, the RUNOs will carry out all their activities in close coordination, which will allow the optimization of resources and minimization of overhead and transaction costs.

OHCHR, UNHCR and UN Women will participate as advisory agencies to the Joint Program. The RUNOs may sign interagency agreements with these advisory agencies for them to provide required technical support. OHCHR will ensure a health and human rights approach to the efforts to suppress the transmission of the virus, with particular attention to disseminating information and creating or enhancing capacity amongst health workers (C1), and will provide technical assistance to government institutions involved in order to ensure cultural appropriateness in their interventions and to ensure that the specific situations and needs of various population groups (children, persons with disabilities, indigenous population, women, people on the move) are addressed from a human rights perspective and in line with relevant human rights standards (C1 and C2). UNHCR will support the design of protocols for the identification and referral of people who cannot return to their homes or communities due to violence (including gender-based violence, gang violence, violence against children, and violence against LGTBIQ+, among others), and will contribute, through its partners, to the identification of these people in the Monitoring Centers (C2). UN Women will provide technical advice for the prevention of stigma, discrimination and gender-based violence, with emphasis on returned migrant women (C2).

Cover Page

<table>
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<tr><td>Description</td><td>The Joint Program will support the provision of an integrated response to the health and humanitarian emergency caused by COVID-19 pandemic, with the main objective of saving lives. The Joint Program proposes the following 2 components:
Component 1. Ensure the provision of health services, protecting and training healthcare workers and improving capacity for surveillance and laboratory analyses, including health services for women. This component will be implemented by PAHO/WHO and UNFPA, and the actions will be implemented through the national health system, the goal is to reach 14 out of the 22 provinces (departamentos) in the country.
Component 2. Provide dignified quarantine to returned migrants with a human rights-based approach, supporting the functioning of six Monitoring Centers, providing humanitarian assistance and psychosocial support to returned migrants, and ensuring a safe return to the communities. This component will be executed by IOM and UNICEF for a target population of approximately 7,000 returned migrants, including men, women, children, adolescents and unaccompanied minors.
The Joint Program will have a budget of US$ 1 million, which will be executed over the next 7 months.</td></tr>
<tr><td>Universal Markers</td><td>Gender Marker: (bold the selected; pls select one only)
a) Have gender equality and/or the empowerment of women and girls as the primary or principal objective.
b) Make a significant contribution to gender equality and/or the empowerment of women and girls;
c) Make a limited contribution or no contribution to gender equality and/or the empowerment of women and girls.</td></tr>
<tr><td rowspan="2">Fund Specific Markers</td><td>Human Rights Based Approach to COVID19 Response (bold the selected): Yes/No
Considered OHCHR guidance in proposal development UN OHCHR COVID19 Guidance</td></tr>
<tr><td>Fund Windows (bold the selected; pls select one only)
Window 1: Enable Governments and Communities to Tackle the Emergency
Window 2: Reduce Social Impact and Promote Economic Response</td></tr>
<tr><td>Geographical Scope</td><td>Provinces (departamentos): Guatemala, Quetzaltenango, Sacatepequez, Chimaltenango, San Marcos, Huehuetenango, Quiche, Solola, Peten, Alta Verapaz, Izabal, Chiquimula, Jutiapa, Zacapa y Escuintla.
Country: Guatemala</td></tr>
</table>

<table>
<tr><td>Recipient UN Organizations</td><td>PAHO/WHO, UNFPA, IOM, UNICEF</td></tr>
<tr><td>Implementing Partners</td><td>Government institutions: MSPAS, SBS, SOSEP, PGN, IGM, MINEX
Civil society organizations: OSAR, ASECSA</td></tr>
<tr><td>Program and Project Cost</td><td>
<table>
<tr><th>Budget</th><th>Agency</th><th>Amount</th><th>Comments</th></tr>
<tr><td>Budget Requested</td><td>PAHO/WHO, UNFPA, IOM, UNICEF</td><td>$ 1,000,000</td><td>Actions in health, gender and assistance to returned migrants foreseen in Components 1 & 2 of this Joint Program.</td></tr>
<tr><td rowspan="3">Co-financing</td><td>UNFPA</td><td>$ 75,000</td><td>Technical assistance and supplies for MSPAS and other institutions serving vulnerable women.</td></tr>
<tr><td>UNICEF</td><td>$ 250,000</td><td>Technical assistance, personnel training and supplies for shelters.</td></tr>
<tr><td>IOM</td><td>$ 172,103</td><td>Support to MSPAS, shelters (SBS), and ground transport for returned migrants from Mexico, and transport for unaccompanied minors.</td></tr>
<tr><td>Total</td><td></td><td>$ 1,497,103</td><td></td></tr>
</table>
</td></tr>
<tr><td>Comments</td><td>The Joint Program will receive advice from UN Women, UNHCR y OHCHR.</td></tr>
<tr><td>Programme Duration</td><td>Start Date: May 20, 2020</td></tr>
<tr><td></td><td>Duration (In months): 7 months</td></tr>
<tr><td></td><td>End Date: December 20, 2020</td></tr>
</table>

Results Framework

Window 1. Component 1. Outcome 1.	Enable Governments and Communities to Tackle the Emergency				Outcome Total Budget
	1.1. Save lives and protect the most vulnerable, including healthcare workers, and reduce transmission				USD 500,000
		Baseline	Target	Means of verification	Responsible Organization
Outcome Indicator	1.1.a. Number of prioritized COVID-19 hospitals with standards in IPC and reorganization of services.	0	22	PAHO/WHO COVID19 online and IPC verification lists	PAHO/WHO
	1.1.b. Number of healthcare workers in prioritized COVID-19 hospitals trained in use of PPE and with adequate supplies	0	700 (female: 455, male: 245)	Attendance roster and hospital equipment supplies calculator	PAHO/WHO
Outputs	1.1.1. Reorganization of health facilities for COVID-19 treatment.				
	1.2.1. Strengthened infection prevention and control in all COVID-19 prioritized hospitals.				
	1.3.1. Reinforced active case finding and enhanced existing surveillance systems to enable monitoring of COVID19 transmission.				
	1.4.1. Strengthened maternal and neonatal health services for pregnant women and their newborns and for women who are victims or survivors of sexual violence, through the provision of safe, secure and quality spaces, reinforcing the work of traditional birth attendants, and applying norms and protocols designed or adapted to reduce the impact of the COVID-19 pandemic on these services.				
Output Indicators	1.1.1.a. Number of prioritized hospitals for COVID19 treatment scoring at least 60% in reorganization standards	0	22	PAHO/WHO COVID19 online verification list	PAHO/WHO
	1.2.1.a. Number of prioritized hospitals for COVID19 treatment scoring at least 60% of IPC standards	0	22	PAHO/WHO COVID19 IPC verification list	PAHO/WHO
	1.3.1.a. Number of prioritized health area directorates with operative COVID19 surveillance systems.	0	15	PAHO/WHO COVID19 surveillance checklist	PAHO/WHO
	1.4.1.a. Number of health services with safe, secure and quality areas where assistance can be provided to pregnant women and their	0	16	UNFPA, MSPAS, and OSAR reports	UNFPA

	newborns.				
	1.4.1.b. Number of tradition birth attendants equipped to provide safe and quality service.	0	1,000	UNFPA, MSPAS, and ASECSA reports	UNFPA
	1.4.1.c. Number of health services with safe, secure and quality areas for providing assistance to women who are victims or survivors of sexual violence.	0	16	UNFPA and MSPAS reports	UNFPA
Window 1. Component 2. Proposal outcome	Enable Governments and Communities to Tackle the Emergency				Outcome Total Budget
	2.1. Returned migrants complete quarantine processes in line with national guidelines and their health condition and are reintegrated with their families and communities.				USD 500,000
		Baseline	Target	Means of verification	Responsible Org
Outcome Indicator	2.1.a. Number of returned migrants who complete a dignified quarantine and return to their communities of origin with certification of their health condition.	0	100%	Certifications of release from Monitoring Centers in line with national norms.	IOM UNICEF Monitoring Centers
Outputs	2.1.1. Unaccompanied minors deported by air and ground transportation are reintegrated with their families and communities safely and with dignity, following health and child protection guidelines established by the Government.				
	2.2.1. Family units – normally comprising mothers and their children – are reintegrated with their families and communities safely and with dignity, following health and child protection guidelines established by the Government.				
	2.3.1 Returned migrants who cannot return to their homes or communities for reasons related to violence (including GBV, gang violence, violence against children, and violence against LGTBIQ+, among others), are identified and assisted to complete a safe and dignified quarantine.				
	2.4.1. Returned migrants received humanitarian and dignified psychosocial assistance in Monitoring Centers and are reintegrated with their communities having completed established procedures and requirements.				
Output Indicators	2.1.1.a. Number of unaccompanied minors who are reintegrated with their families and communities in a safe and dignified manner.	292 unaccompanied minor returnees from 23 March-16 April 2020.	875 unaccompanied minor returnees (boys: 612, girls: 263)	Registry of the SBS	UNICEF
	2.2.1.a. Number of family units who are reintegrated with their families and communities in a safe and dignified manner.	834 returned family units from January to 17 April 2020	600 returned family units	Registry of the SOSEP	UNICEF

	2.3.1. Number of returned migrants who cannot return to their home or communities for reasons of violence and complete a safe and dignified quarantine.	0	245 persons (male: 143, female: 83, LGBTI persons: 19)	Identification registry established in the management protocols for the treatment of these people in the Monitoring Centers.	IOM (with advice from UNHCR)
	2.4.1. Number of returned migrants who received dignified humanitarian and psychosocial assistance in Monitoring Centers.	0	7,000 returned migrants (male: 6,090, female: 910)	Identification registry established in the management protocols for the treatment of these people in the Monitoring Centers.	IOM

SDG Targets and Indicators

Sustainable Development Goals (SDGs) [select max 3 goals]			
☐	SDG 1 (No poverty)	☐	SDG 9 (Industry, Innovation and Infrastructure)
☐	SDG 2 (Zero hunger)	☒	SDG 10 (Reduced Inequalities)
☒	SDG 3 (Good health & well-being)	☐	SDG 11 (Sustainable Cities & Communities)
☐	SDG 4 (Quality education)	☐	SDG 12 (Responsible Consumption & Production)
☒	SDG 5 (Gender equality)	☐	SDG 13 (Climate action)
☐	SDG 6 (Clean water and sanitation)	☐	SDG 14 (Life below water)
☐	SDG 7 (Sustainable energy)	☐	SDG 15 (Life on land)
☐	SDG 8 (Decent work & Economic Growth)	☐	SDG 16 (Peace, justice & strong institutions)
☐	SDG 17 (Partnerships for the Goals)		

Relevant SDG Targets and Indicators		
Target	**Indicator # and Description**	**Estimated % Budget allocated**
Target 3.D. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	3.D.1. International Health Regulations (IHR) capacity and health emergency preparedness	45%
Target 3.1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.2. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births Proportion of births attended by skilled health personnel.	5%
Target 3.2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to	3.2.2. Neonatal mortality rate.	

reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.		
Target 5.1. End all forms of discrimination against all women and girls everywhere.	5.1. Whether or not legal frameworks are in place to promote, enforce and monitor equality and non-discrimination on the basis of sex.	5%
Target 5.2. Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.	5.2. Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence.	
Target 10.7. Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies	10.7.2. Number of countries that have implemented well-managed migration policies.	45%

Risk

Event	Categories Financial Operational Organizational Political (regulatory and/or strategic)	Level 3 – Very High 2 – Medium High 1 - Low	Likelihood 6 – Expected 5 – Highly Likely 4 – Likely 3 – Moderate 2 – Low Likelihood 1- Not Likely 0 – Not Applicable	Impact 5 – Extreme 4 – Major 3 – Moderate 2 – Minor 1 – Insignificant	Mitigating Measures (List the specific mitigation measures)	Risk Owner
Risk1 Global market depletion of PPE and other essential supplies	Operational	3	6	4	• Research and find local providers and international procurement mechanisms	PAHO/WHO
Risk 2 High turnover of health authorities and interruption of technical cooperation processes	Political	3	5	4	• Advocacy with new authorities and continuity with local technical level for strengthening of cooperation.	PAHO/WHO
Risk 3 Institutional weakness of government counterparts (e.g. lack of definition in the administration of the monitoring centers).	Organizational	2	3	3	• Advocacy with political and operational authorities of the Government. • An MoU will be developed with SOSEP and SBS to ensure guarantee the proposed actions. • Meetings to monitor results will be held continuously, providing both political and operational follow up.	UNICEF/IOM

Budget by UNDG Categories

Budget Lines	Fiscal Year	Description	Agency 1 PAHO/WHO	Agency 2 UNFPA	Agency 1 OIM	Agency 2 UNICEF	Total USD
1. Staff and other personnel	2020	National professional consultant, logistician, driver and administrative assistant	$62,000				$87,000
		50% of the salary cost of an expert on child migration.				$25,000	
2. Supplies, Commodities, Materials	2020	PPE, HEPA filters, hospitals air extractors and labs supplies	$216,000				$340,955
		1,000 sets of personal protective equipment (PPE) for traditional birth attendants and their patients.		$27,729			
		7,000 hygiene kits			$88,581	$8,645	
		1,100 warm clothing kits					

3. Equipment, Vehicles, and Furniture, incl. Depreciation	2020	Data entry equipment for health units	$14,000				$14,000
4. Contractual services	2020	Trainings, technical and professional services for health facilities	$118,561				$242,625
		Design and printing of educational materials for community and institutional work on maternal health, GBV and sexual violence		$4,000			
		6 educators y 2 psychologists.			$120,064		
		Food services (for 1 monitoring center)					
		Cleaning services (for 1 monitoring center)					
5. Travel	2020	Per diem and transportation expenses	$10,000				$10,000

		Grant to OSAR and ASECSA to support the implementation of safe health spaces at institutional and community levels		$15,000			
6. Transfers and Grants to Counterparts	2020	Transfer to UN Women for the prevention of stigma, discrimination and GBV, with emphasis on returned migrant women.			$25,000	$200,000	$240,000
		4 workplans with the PGN, SOSEP and SBS to implement 4 temporary centers for unaccompanied minors and family units.					
7. General Operating and other Direct Costs	2020						
Sub Total Programme Costs			**$420,561**	**$46,729**	**$233,645**	**$233,645**	**$934,580**
8. Indirect Support Costs * 7%			$29,439	$3,271	$16,355	$16,355	$65,421
Total			**$450,000**	**$50,000**	**$250,000**	**$250,000**	**$1,000,000**

Budget Summary

Budget Lines	Fiscal Year	PAHO/WHO	UNFPA	OIM	UNICEF	Total USD
1. Staff and other personnel	2020	62,000			25,000	87,000
2. Supplies, Commodities, Materials	2020	216,000	27,729	88,581	8,645	340,955
3. Equipment, Vehicles, and Furniture, incl. Depreciation	2020	14,000				14,000
4. Contractual services	2020	118,561	4,000	120,064		242,625
5. Travel	2020	10,000				10,000
6. Transfers and Grants to Counterparts	2020		15,000	25,000	200,000	240,000
7. General Operating and other Direct Costs	2020					0
Sub Total Programme Costs		**420,561**	**46,729**	**233,645**	**233,645**	**934,580**
8. Indirect Support Costs * 7%		29,439	3,271	16,355	16,355	65,421
Total		**450,000**	**50,000**	**250,000**	**250,000**	**1,000,000**