

IMPROVING FAMILY PLANNING PROGRAMS
IN THE HIGHLANDS OF GUATEMALA

A Report Prepared By:
SHELDON ANNIS, M.A.

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CONTENTS

	Page
I. OVERVIEW OF THE STUDY	1
II. PROFILE OF QUICHÉ	3
III. PRIVATE COMMERCIAL DISTRIBUTION OF CONTRACEPTIVES	7
Recommendations	14
IV. DIRECT DISTRIBUTION OF CONTRACEPTIVES BY THE MINISTRY OF HEALTH	18
Recommendations	28
V. APROFAM'S COMMUNITY-BASED DISTRIBUTION PROGRAM	29
Recommendations	41
VI. DELIVERY OF FAMILY PLANNING SERVICES BY HEALTH-RELATED PRIVATE VOLUNTARY ORGANIZATIONS	43
Recommendations	56
APPENDIX: Schematic Comparison of Family Planning Delivery Systems in Quiché	58

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Sheldon Annis, M.A.
Consultant
American Public Health Association

Elena Hurtado
Guatemalan Counterpart
APROFAM

IMPROVING FAMILY PLANNING PROGRAMS IN THE HIGHLANDS OF GUATEMALA

I. OVERVIEW OF THE STUDY

A. INTRODUCTION

This report is the result of an investigation into Indian utilization of family planning services in the Highlands of Guatemala. The purpose of the investigation was: 1) to collect data on family planning delivery systems and how Indians make use of them, and 2) to make recommendations which will result in improved utilization of family planning.

Data was collected in the Department of Quiché, an 86% Indian Department which has been notably unresponsive to the introduction of family planning. Four types of family planning delivery systems in Quiché were examined: 1) private commercial distribution through rural pharmacies, 2) direct distribution through Government of Guatemala rural health posts, 3) APROFAM's Community-Based Distribution Program, and 4) distribution of contraceptives by health-related private voluntary organizations. Each of these delivery systems is discussed separately in a chapter of this report. Key elements of the four systems are summarized in a comparative fashion in Appendix A. Recommendations for improvement of delivery of family planning systems are presented for immediate improvement of existing programs, for expansion of programs presently underway, and ideas for untried approaches.

B. BACKGROUND

This report comes at a time when APROFAM is faced with an important decision in regard to its future programs. It is clear that there is a discrepancy in receptivity towards family planning between the Indian and Ladino areas and that cost per acceptor is far higher among Indians than Ladinos.¹

How, then, should APROFAM allocate its resources? On the one hand, APROFAM has had good success in the Ladino area in recent years, particularly along the south coast and in the metropolitan area. Programs have grown rapidly and a functioning delivery system has been installed. The existing infrastructure offers good prospects for investment, new programs, and expansion.

¹ Most recently, See La Situación Cambiante Respecto a la Planificación Familiar en Areas Rurales de Guatemala: 1976 a 1978, Center for Community and Family Studies, University of Chicago. In press.

On the other hand, in the Indian areas, roughly half the country, programs have moved slowly and have been met with resistance. Is that a rationale for more investment -- or less? Is there a threshold take-off point which has just been reached in the Ladino areas-- and could be reached in the Indian areas? Or is it best to leave a reluctant population alone?

These questions are not answered in this report. There is information provided, however, on the workings of family planning in one particularly conservative Indian area, the Department of Quiché.

C. METHODOLOGY

The methodology employed in this study was described in detail in the Workplan presented to APROFAM in September, 1978. That document contains all of the research instruments that were employed in the study. In addition, each of the four major sections of this report contains a description of its own methodology.

The decision was made to study Quiché since APROFAM has had particular difficulty in that area and specifically requested that the study be carried out there. The rationale was: we might as well choose the toughest area, since things can only be better elsewhere. Necessarily, a limitation of the study is that it lacks comparative data on Indian areas that are somewhat more receptive to family planning than Quiché; e.g., most of the Cakchiquel-speaking region, and the urban or modernizing Indian areas around Quetzaltenango and San Marcos.

Emphasis was placed on problems of existing programs (supply) as opposed to cultural factors that affect acceptance and utilization (demand) for family planning services. One reason for this focus is that APROFAM -- for whom this technical assistance is intended and to whom it is responsible -- wanted it that way. APROFAM's concern was that a study of demand, perhaps a more classically "anthropological" study, might produce a report which would be overly academic and of less immediate use in decisions of program management and expansion. Instead, the study was designed to look at Indian culture but through the filtering screen of existing programs. An objective was to keep the programs -- and Indians -- in simultaneous focus, hopefully arriving at conclusions that would be "programmable".

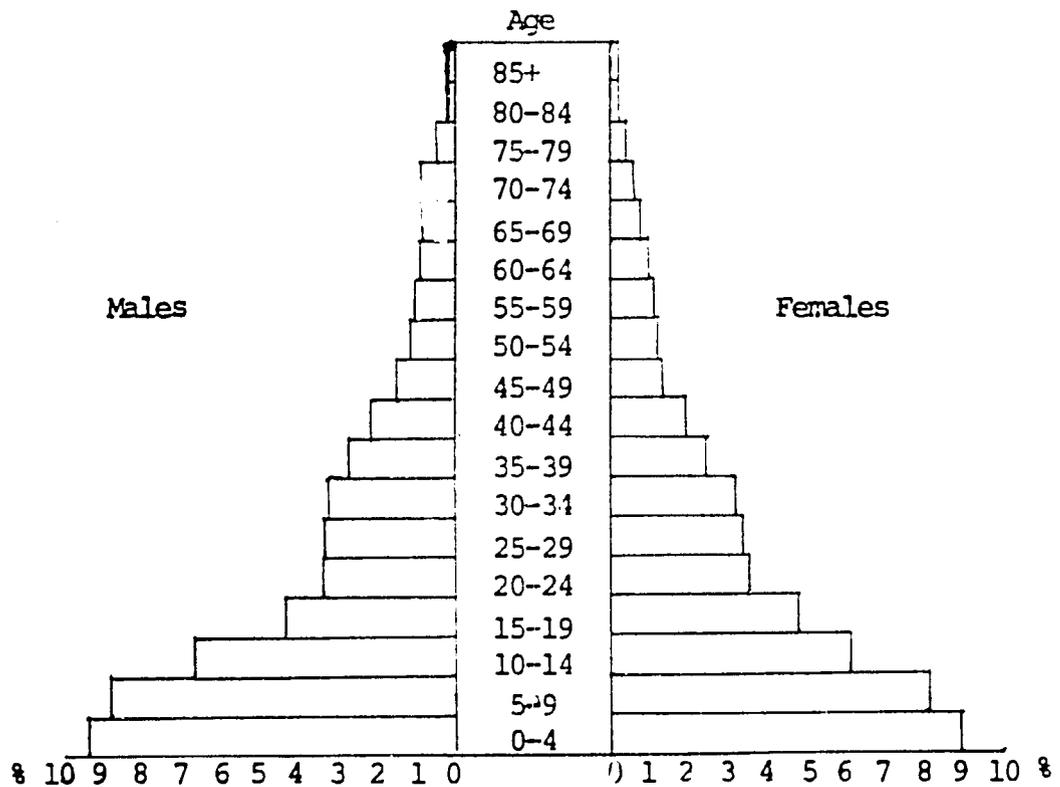
II. PROFILE OF QUICHÉ

A. POPULATION, ESTIMATED AND PROJECTED, 1950-2000 (in thousands)

<u>1950</u>	<u>1964</u>	<u>1973</u>	<u>1978</u>	<u>1990</u>	<u>2000</u>
188.4	259.1	327.6	366.5	488.6	596.4

Source: R. Fox and J. Huguet. Population and Urban Trends in Central America and Panama, Inter-American Development Bank, 1977 and Guillermo Poitevin, Departamento de el Quiché, Población Calculado Año, 1972-1980, Unidad de Estadística, Ministerio de Salud Pública.

B. AGE-SEX POPULATION PYRAMID FOR THE DEPARTMENT OF QUICHÉ, 1978



Note: Female population ages 15-44 = 72,181 or 39% of the total female population.

Source: Drawn from data contained in Poitevin, op. cit.

C. PRESENT ANNUAL RATE OF NATURAL INCREASE: 3%

Source: Poitevin, op. cit.

D. URBANIZATION

Urban population: 12% (Towns over 2,000 pop.)
Rural population: 88%

Source: Census, 1973. Dirección General de Estadística.

E. ETHNIC COMPOSITION

Indian: 86%
Ladino: 14%

Quiché is the dominant Indian language, but at least four other languages, and several dialects of Quiché, are spoken in the department. The basic unit of social, as well as geographic and political, organization is the municipio. There are no "tribes". Although they are sometimes called "the Quiché", they are not a unified and discrete social group.

Source: Census, 1973.

F. URBANISM AMONG INDIANS

Urban Indian population: 8%
Rural Indian population: 92%

Source: Census, 1973.

G. LITERACY

According to the 1973 Census, Quiché has the second lowest literacy rate of the 22 departments in the nation. The highest literacy rate is in the department of Guatemala (Guatemala City), 76%. The lowest is in neighboring Alta Verapaz, 14%. Literacy increased from 13% to 17% between 1964 and 1973.

H. LITERACY OF RURAL INDIAN POPULATION

	Rural Indian women	Rural Indian men
Age, 18+	2%	13%
Age, 7-17	8%	18%

Source: Calculated from Census data.

I. FAMILY INCOME

We estimate that average family income in rural Quiché is now about \$400-600 per year. This is based on the current wage of an agricultural worker of \$1.50 per day. This estimate is considerably higher than most other recent figures, e.g., the Guatemalan Health Sector Assessment or US AID/Guatemala Program Office. Wages have nearly doubled in the last two years. This reflects inflation, not a real rise in standard of living.

J. ECONOMIC ACTIVITY OF RURAL WOMEN

Only 3 to 4% of married, rural Indian women, ages 15-44, are classified by the Census as being "economically active" (working for a wage, either cash or in-kind; self-employed; or participating, on a cash or non-cash basis, in a family business). The rest are working in non-remunerative domestic activity, i.e., weaving for personal consumption and sale, raising poultry, braiding reed fibers for hats, marketing, etc.

K. LIFE EXPECTANCY

Indian	49.9 years
Ladino	54.3 years

Source: Jorge Arias de Blois, La Población de Guatemala, 1974.

L. INFANT MORTALITY

Vital statistics at the departmental level are too unreliable to be reported here. The Dirección General de Estadística for 1973 estimates an infant mortality rate at 70.8/1000 for Indians. This undoubtedly misrepresents the actual case, due to under-reporting of infant deaths in the rural area. The Institute for Nutrition of Central America and Panama (INCAP) estimates an Indian infant mortality rate which may be as high as 100/1000 in the rural area.

M. BIRTH, ATTENDANCE AND PLACE OF DELIVERY

	<u>Birth Attendant</u>				<u>Place</u>		
	<u>MD</u>	<u>Trained Midwife</u>	<u>Untrained Midwife</u>	<u>None</u>	<u>Hospital</u>	<u>Midwife Facility</u>	<u>Home</u>
Quiché	1%	0.5%	98%	0.3%	1	0.2	99
National Average	16%	16%	62%	7%	18	2.0	80

(cont. p.6)

Note: Quiche has the highest rate of birth attended by untrained personnel and the highest rate of home births in the country.

Source: Dirección General de Servicios de Salud, Unidad de Estadística, 1978.

N. LEADING CAUSES OF MORBIDITY

Enteritis and other diarrheal disease, acute respiratory infections, avitaminosis and other nutritional deficiencies.

O. OBSTETRICAL HISTORY OF A SAMPLE OF 143 RURAL INDIAN WOMEN, 1972-74 (Santa María Cauqué, Chimaltenango)

Age	Number of Pregnancies		No. of Abortions*	No. of Still-borns	No. of Child Deaths	No. of Live Children	% of Loss
	Conceptions	Fetuses					
20	2.6	1.6	0.3	0.1	0.2	1.0	38%
25	5.0	4.0	0.4	0.2	0.9	2.5	38%
30	6.9	5.9	1.2	0.3	1.1	3.3	44%
35	9.8	8.8	1.3	0.3	2.1	5.1	42%
40	11.0	10.0	1.8	0.4	2.1	5.8	42%

* These figures do not distinguish between spontaneous and induced abortion. Dr. Urrutia reports that induced abortions are attempted; i.e., by massages, heavy exercise, teas, and herbs; but never by internal mechanical means.

Source: Dr. J.J. Urrutia and Snra. Berta García, INCAP, unpublished figures (permission granted for citation).

III. PRIVATE COMMERCIAL DISTRIBUTION OF CONTRACEPTIVES

A. INTRODUCTION

Data on the private commercial distribution of contraceptives was collected in 28 rural pharmacies. It was found that, despite higher prices, the rural pharmacies accounted for almost as many users as does the Ministry of Health, and considerably more than the Private Voluntary Organizations or APROFAM's Community-based Distribution program. One way to reach a potentially large number of users might be to offer a low-cost brand-name contraceptive in rural pharmacies eventually in rural tiendas (general stores).

B. BACKGROUND

It is sometimes assumed that because the rural Quiché population is dispersed that it is also isolated. This is not necessarily the case. In fact, since pre-Columbia times the area has been integrated -- both socially and economically -- by a complex, highly evolved, constantly changing regional marketing system.

The marketing system of Quiché presents a textbook case of what, in the economic anthropological literature, is often called a "solar marketing system". Markets are organized in such a way that communities are linked into a system of interdependent, rotating marketplaces, somewhat analagous to a solar system. At the center is a major market which is in daily operation. Through the market runs a vertical flow of modern-sector goods from the exterior and an outward flow from the interior of agricultural goods. Surrounding the major market are smaller marketplaces which have fixed weekly or bi-weekly market days. These "satellite" markets tend to specialize in an agricultural commodity or handicraft product and carry a reduced selection of the goods available in the central market.

No household or village is entirely self-sufficient. Rather, communities are generalized consumption and specialized production units. By rotating within the satellite markets -- or by buying from a vendor whose profession it is to trade within the system -- a household can buy everything it needs and sell everything it produces.

This marketing system is still very much intact in rural Quiché. Modern entrepreneurship has adapted to the traditional system rather than visa versa. Manufactured goods, which are brought in from the capital by pick-up, often flow horizontally by foot and mule. Settlements which are near-vacant six days a week come to life on market day. It is estimated (C. Smith, 1972) that even in the most remote areas, one member of the household visits some marketplace at least once every two weeks, and most households claim at least weekly visits. Spatially, the system is so arranged that there are

virtually no families who are beyond a two-hour walk from some marketplace -- which is to say, that since all marketplaces are temporally connected to each other, theoretically at least, everyone in Quiché has reasonably convenient access to everything he needs.

Contraceptives, of course, are not yet a staple household good and do not fall into the range of "everything someone needs". At the lowest rungs of the marketing hierarchy -- the village marketplace or its increasingly popular functional analog, the rural tienda -- no contraceptives are sold. Folk contraceptive techniques -- for example, herbs and teas -- are not generally known or openly available. At the present time, modern-sector contraceptives have filtered downward only so far as the rural pharmacy. The rural pharmacy, however, is functionally linked to both the external manufacturing sector and the local population. In Quiché, any central supply source can serve as a wholesaling and re-distribution point for lower-order commercial centers; i.e., the large pharmacy in Santa Cruz buys drugs in the capital and sells to the smaller rural pharmacies; the rural pharmacies, in turn, can sell to tiny aldea tiendas or even self-taught village-level health promoters.

C. METHODOLOGY

The findings reported upon here rely mostly on data obtained in a questionnaire for private and municipal pharmacies. This interview included questions on the sale of contraceptives, brands, distributors, prices, users, preferences for methods, and relations with APROFAM.

There are two kinds of pharmacies in Quiché, private and municipal. Private pharmacies are small, usually family-run, Ladino-owned businesses. Municipal pharmacies are non-profit and public, operated on behalf of the municipality and supplied with low cost basic medicines by the National Pharmacy (Droquería Nacional). Both are typically located in the cabecera municipal (roughly the equivalent of a US county seat). Altogether, 28 pharmacies were interviewed by the consultants, as follows:

	<u>Total in Quiche (Estimated)</u>	<u>No. in Sample</u>
Private Pharmacies	30	25
Municipal Pharmacies	8	5
Total:	38	28

In all, there are 19 cabeceras municipales, in Quiché. Thirteen (68%) of them were covered in the sample. Twenty-one of the 23 private pharmacies and all of the municipal pharmacies are located in cabeceras municipales.

D. FINDINGS

The principle findings of the field study are summarized below. More detailed information has been presented in an early draft of this report and is available.

1. Prevalence of contraceptives. The sample covered by the interviews encompasses a geographic area that contains most of the population of Quiché. In this area there is a surprisingly widespread prevalence of contraceptives. Twenty-one of the 23 private pharmacies (91%) queried reported selling at least one type of contraceptive.

<u>Number Of Types Of Contraceptives Sold</u>	<u>Number Of Pharmacies Selling</u>	<u>% Of Pharmacies Selling This Number</u>
5 or more	3	13%
4 types	8	35%
3 types	5	22%
2 types	1	4%
1 type	4	17%
none	2	9%

Of the 23 private pharmacies: 19 offered the pill; 17 offered condoms; 16 offered vaginal tablets; 11 offered injectables; and 2 offered creams and jellies. (Of the two pharmacies not carrying contraceptives: one did not because they had no cash to re-order depleted supplies and the other because they are simply too small and had not yet found a way to order.)

Of the five municipal pharmacies queried, three carried contraceptives. Pills were the only method in stock. Two reported interest in receiving some other type.

2. Prevalence of brands. There is a wide range of commercial contraceptive brands available on the market in Quiché. Altogether 53 different brands of contraceptives were identified. These included 23 different brands of pills (including two brands of the once-a-month pill); 19 brands of condoms; three types of vaginal tablets; 3 types of injectables; 2 suppositories; and two creams.

3. Price. The prices of contraceptives in the private pharmacy sample varied considerably, as follows:

- a) Pills, \$1.08 to \$3.10 (mean, \$2.00 for 21 and 28 day cycles; \$3.90 for once-a-month)
- b) Condoms, 5¢ to 40¢ (mean, 19¢)
- c) Vaginal tablets, \$1.06 to \$1.95 (mean, \$1.46)
- d) Injections, \$4.17 to \$5.83 (mean, \$5.00)

Not surprisingly, one of the cheaper brands of pills (Anovulatorio, produced by McKesson) is also the best selling. Price was frequently cited by pharmacists as an explanation of why users, particularly Indians, did not practice family planning in greater numbers. This is certainly the case with injections. At \$4.17 to \$5.83 per 3-month injection they are beyond the means of all but the wealthiest and/or most desperate women.

It is worth noting that the price of private pharmacy pills, on the average, is about 13 times higher than those sold at the health posts and by CBD distributors (15¢ per cycle) and about nine times higher than those sold at the municipal pharmacies (20¢ to 25¢). Condoms, on the average, are about eight times more expensive at private pharmacies. Geographically, private pharmacies and health posts are usually equally accessible, both typically being located in the cabecera municipal. The rural Quiché population is notably price-conscious. An agricultural worker earns about \$1.50 per day. Average family income is roughly \$400-500 per year. Nevertheless, despite the wide price difference between public and private sources, the population is still willing to buy contraceptives at the high-price private pharmacies.

4. Number of users. Estimating the number of contraceptive users from reported pharmacy sales volume is risky. Most rural Quiché pharmacists appear to neither keep track of their sales nor are particularly anxious to report them to interviewers. Accurate data on sales volume was difficult, sometimes impossible, to obtain. Nevertheless, on the basis of collected data, average monthly sales per pharmacy is estimated as follows:

- a) Pills 7 cycles per month
- b) Condoms 12 per month
- c) Injections. 1 per month
- d) Vaginal tablets 3 boxes per month (usually Rendells's which contains 12 tablets per box)
- e) Suppositories, cream, jellies . . . Negligible

These sales would be approximately equivalent to 14 users per pharmacy. There are about 27 private pharmacies in Quiché that offer contraceptives or a very approximate total of 378 users. The breakdown by contraceptive method is approximately as follows:

Pills	189 (50%)
*Condoms	81 (21%)
Injections	27 (7%)
Vaginal tablets	81 (21%)
Suppositories, creams, and jellies	0 (0%)

In municipal pharmacies, the average monthly reported sales of pills (the only contraceptive available) was 46 (with a range of 2 to 125 cycles per month). Although it is certainly true that the lower price of municipal pharmacy pills (mean of 22.5c vs. \$2.00) encourages a higher sales volume, it is probable that that high sales figure of the highest reporting pharmacy (125/month) is exaggerated, thus inflating the overall average.

On the basis of common sense, an "educated guess" is that there are probably altogether 100 users in Quiché supplied by the municipal pharmacies -- or about 478 pharmacy users in total.

It is interesting to note, then, that despite their high prices the pharmacies appear to provide -- at virtually no cost to APROFAM -- almost as many users as does the Ministry of Health and more users than either the Private Voluntary Organizations or the Community-based Distribution program.

5. Use by Indian/Ladino. In response to the question, "Who buys more contraceptives, Indians or Ladinos?" the majority (9) responded "the same", six responded "more by Ladinos", and four responded "more by Indians". Considering that the population of Quiché is about 86% Indian, it is obvious that there is a disproportionate acceptance of family planning among Ladinos. Nevertheless, pharmacists frequently noted that Indian awareness and use of contraceptives is increasing. Remarks were made such as, "Now Indians are buying everything; it's not like it used to be", and "Now Indians know something about family planning."

* To calculate the number of condom users per month we divided monthly condom sales by four. This is based on Glittenberg's finding (1976) of coital frequency among Indians of 3.82 times per month (Patzún, Chimaltenango) and among Ladinos, 4.26 times per month (Zaragoza Chimaltenango). This probably underestimates the number of condom users, since many men are undoubtedly not using a condom during each coitus -- for example, those using condoms in conjunction with the rhythm method.

6. Factors affecting use and preference. Several pharmacists commented that the directions for the pill were considered difficult, thus discouraging use by Indians. There is a widespread often repeated fear that "the pill causes cancer". In all likelihood the vast majority of people -- including users, APROFAM distributors, and most pharmacists -- actually believe that the pill is genuinely dangerous to a woman's health. Indians, in particular, are prone to make a distinction between danger from chemicals that are ingested vs. chemicals that are injected into the body. Throughout the Highlands, curanderos, health promoters, auxiliary nurses, pharmacists, and persons called injectionists routinely inject their neighbors with large, costly, and probably useless quantities of vitamins, antibiotics, and revitalizers. In many areas, a body of lore has evolved which explains the efficaciousness of these remedies in terms of traditional "hot/cold" concepts of disease classification ("it burns and stings when it goes in, therefore it must be good for such-and-such 'cold' sickness"). Vitamin pills, on the other hand, are scarcely used. There is a general reluctance to take pills, particularly if there is no outward symptom of disease or if there is no immediate relief from pain. The common notion that the pill is taken after intercourse corresponds with the familiar experience that an aspirin is taken after a headache appears.

Many pharmacists pointed out that injections are potentially the most popular contraceptive method. It is their high price and occasional extreme side-effects limit their practical use.

Condoms have the advantage that the principle on which they work is easily understood. They make sense within the Indian's mechanistic view of human anatomy and physiology, which often sees disease (of which pregnancy is an analogy, if not an example) as a by-product of interaction of physical forces. Condoms are considered to "avoid damage" to the woman's health, which is inevitably associated with the pill.

Condoms are not widely used by Indian males according to the pharmacists. No explanation emerged other than, "They don't like them", which is equally true among males of other ethnic groups. A factor which may be related to the low acceptance of condoms is that many Indian males have learned about them in the army or as migratory laborers on the south coast. Condoms readily evoke associations of prostitution and venereal disease and do not seem consistent with stable, moral married life. The visible display of the condom through the clear plastic Tahiti package is doubtlessly offensive to Indian aesthetic and moral sensibilities. Interestingly, two druggists volunteered that the matchbook type wrappers of Protex were highly saleable, even though they are far more expensive than other condoms, because of the attractive (or perhaps more discrete) packaging.

In the sample there was a relatively high sales volume of vaginal tablets, although no other local method; e.g., creams and/or suppositories, were reported used. Certainly the high cost of creams (\bar{x} , \$7.14) is a factor which discourages their use. Several pharmacists said that both Indians and Ladinos report that the tablets cause irritation.

Among Indians, a factor which probably limits acceptance of vaginal methods is the self-shame/embarrassment involved in touching ones genitals. Indian women seldom altogether remove their skirts (cortes) -- when sleeping, bathing, urinating, having sexual intercourse, or giving birth. The physical handling required by vaginal methods probably runs against behavioral norms.

7. Supply and distribution of contraceptives to pharmacies. Private pharmacies are presently provided with contraceptives in three ways: 1) traveling salesmen who work for the larger pharmaceutical houses and drug importers, 2) direct purchase from wholesalers or drugstores on buying trips to Guatemala City, and 3) purchase from the two largest drugstores in Santa Cruz (one owner). For the most part, rural druggists do not keep records of their stock and have difficulty remembering where they bought what. On the basis of incomplete data, the most important distributors in Quiché are the salesmen from Scherring and McKesson (in the case of the pill) and the droguerías Colón, Merced, and Refasa en Guatemala City. Two drug wholesalers interviewed in Guatemala City said that there are no special promotional campaign, sales materials or sales strategy that are used for the rural area.

All the municipal pharmacies in the sample are supplied with pills by the Droguería Nacional. AID and APROFAM have within the past year made efforts to expand the services and number of municipal pharmacies providing contraceptives.

8. Relations with APROFAM. Fourteen of the 23 private pharmacies and three of the five municipal pharmacies had had some contact with APROFAM. Most of these contacts were invitations to attend the APROFAM training course held in Sololá. Several of the 16 had received a short APROFAM questionnaire which is being distributed for the purpose of compiling a directory of pharmacies in Guatemala. Six persons (four from private pharmacies and two from the municipal pharmacies) had attended the August, 1978, APROFAM training course in Sololá. Nearly all pharmacists were favorable to the idea of the course. Time loss and distance were given as explanations by some as to why they did not attend. In response to the question, "What other support would you like to receive from APROFAM?", several expressed interest in other courses (preferably closer than Sololá), promotional campaigns in the communities, increased radio promotion, and distribution of posters and pamphlets in the pharmacies themselves.

9. Characteristics of the pharmacists. Twenty-five of the 28 pharmacists were Ladinos. All were favorable to family planning. None expressed criticism or negative feelings toward APROFAM. Although level of education was not explicitly included in the questionnaire, interviews indicated that most of the pharmacists appeared to have minimal formal education and less formal training in pharmacology. For many, the pharmacy was a longstanding

family business. Practically speaking, many of these pharmacists are practicing medicine. It is likely that many of them maintain a higher "patient load" than do the local health posts.

E. CONCLUSIONS AND RECOMMENDATIONS.

Commercial distribution of contraceptives clearly offers several advantages. First, it utilizes channels of distribution and commercial locations that are already established and thus is cheaper to operate. Second, practically the entire rural population has access to and is familiar with these locations -- more so, if rural tiendas could be incorporated in the distribution network. Third, the present pharmacy owners are personally receptive to family planning and, for the most part, enjoy the respect and confidence of the community. And finally, pharmacists (or tienda owners) are less sensitive to political or ideological opposition to family planning than the MOH or Private Voluntary Organizations, thus improving the likelihood of continuity in delivery of services. For these reasons, the following recommendations support the idea of improvement and expansion of family planning activities through commercial distribution.

K. RECOMMENDATIONS

1. Improvement of existing programs.

a. THAT COMMERCIAL DISTRIBUTION OFFERS GOOD POSSIBILITIES FOR IMPROVED FAMILY PLANNING PROGRAMS IS HARDLY NEWS TO APROFAM. THE ASSOCIATION HAS BEEN WORKING SERIOUSLY FOR SOME TIME IN THIS AREA -- AND WITH GOOD RESULTS. THE DIRECTORY OF PHARMACIES, TRAINING SEMINARS IN FAMILY PLANNING FOR RURAL PHARMACISTS SHOULD BE CONTINUED.

b. THERE IS PRESENTLY AN EFFORT UNDERWAY TO SUPPLY THE MUNICIPAL PHARMACIES WITH CONTRACEPTIVES THROUGH THE DROQUERÍA NACIONAL. THIS SHOULD BE CONTINUED SO THAT ALL MUNICIPAL PHARMACIES ARE SUPPLIED WITH AT LEAST PILLS, CONDOMS, AND VAGINAL TABLETS.

2. Expansion of present types of programs.

a. BEGIN PREPARATION OF EDUCATIONAL AND PROMOTIONAL MATERIALS SPECIALLY DESIGNED FOR USE IN RURAL PHARMACIES. THESE MATERIALS SPECIALLY DESIGNED FOR USE IN RURAL PHARMACIES. THESE MATERIALS COULD INCLUDE THE FOLLOWING:

- 1) A SIMPLE GUIDE FOR PHARMACY WORKERS ON HOW TO ADVISE CUSTOMERS ON THE NEED FOR AND USE OF CONTRACEPTIVES, E.G., REASONS FOR FAMILY PLANNING, FAMILY PLANNING AND FAMILY HEALTH, HOW EACH METHOD WORKS, ADVANTAGES AND DISADVANTAGES OF EACH METHOD, CONTRAINDICATIONS, AND THE USE OF THE MEDICAL REFERRAL SYSTEM.

2) POSTERS APPROPRIATE FOR DISPLAY IN RURAL PHARMACIES. LIKE THE PRESENT HEALTH POST POSTERS, THESE WOULD SHOW RURAL PEOPLE, ESPECIALLY INDIANS, IN RECOGNIZABLY LOCAL DRESS.

3) PAMPHLETS AND EDUCATIONAL FLYERS TO BE DISTRIBUTED FREE TO CUSTOMERS IN RURAL PHARMACIES. THESE PAMPHLETS AND FLYERS WOULD DEAL NOT ONLY DIRECTLY WITH FAMILY PLANNING, BUT WITH RELATED SUBJECTS. I.E., NUTRITION, RESPONSIBLE PARENTHOOD, VISIT-YOUR-HEALTH POST, AND VACCINATION. SIMPLE INSTRUCTIONS FOR THE RHYTHM SYSTEM WOULD BE GOOD POLITICS, IF NOT GOOD FAMILY PLANNING. AGENCIES SUCH AS CARITAS, WORLD NEIGHBORS, DIMIF, AND THE PROYECTO LINGUISTICO FRANCISCO MARROQUIN MIGHT BE CALLED UPON TO COLLABORATE IN THE PREPARATION OF THESE MATERIALS.

b. ASSIGN TO THE PRESENT APROFAM "MEDICAL VISITOR" THE RESPONSIBILITY OF MAKING PERSONAL CONTACT WITH ALL THE PHARMACIES IN HIS GEOGRAPHIC AREA. HE SHOULD THEN DISTRIBUTE PRESENTLY AVAILABLE POSTERS AND EDUCATIONAL MATERIALS AND NEW MATERIALS, AS THEY BECOME AVAILABLE.

c. EXAMINE THE FEASIBILITY OF CREATING ONE OR MORE MOBILE TRAINING AND PROMOTION UNITS WITHIN APROFAM. THESE UNITS WOULD BE STAFFED BY ONE OR TWO FULL-TIME PEOPLE AND WOULD HAVE RESPONSIBILITY OF PROVIDING CONTINUAL TRAINING AND RETRAINING FOR THE DISTRIBUTORS AND PROMOTERS IN THE COMMUNITY-BASED DISTRIBUTION PROGRAM, PERSONNEL IN THE HEALTH POSTS AND HEALTH CENTERS, HEALTH WORKERS IN PRIVATE VOLUNTARY ORGANIZATIONS, AND WORKERS IN PRIVATE AND MUNICIPAL PHARMACIES. A REGULAR FULL-TIME TRAINING PROGRAM WOULD BE ESTABLISHED; THESE MOBILE UNITS WOULD BE GIVEN RESPONSIBILITY FOR BRINGING TRAINING TO THE RURAL AREAS. PROVISIONS WOULD BE MADE FOR EVALUATION OF THE EFFECTIVENESS OF THESE UNITS.

d. IN ADDITION TO THE PRESENT PROMOTION OF FAMILY PLANNING WHICH IS DONE BY RADIO, ADDITIONAL RADIO PUBLICITY SHOULD INDICATE THAT CONTRACEPTIVES ARE AVAILABLE AT SPECIFIC LOCAL PRIVATE AND MUNICIPAL PHARMACIES.

e. ESTABLISH AN AGREEMENT WITH PRIVATE AND MUNICIPAL PHARMACIES -- OR AT LEAST KEY PHARMACIES PARTICIPATING IN THE PROGRAM -- WHEREBY THEY KEEP TRACK OF VOLUME OF SALES, METHODS USED, BRANDS, AND NUMBER OF USERS. THESE DATA ARE ESSENTIAL FOR ACCURATE EVALUATION OF CHANGES AND IMPACT OF PROGRAMS.

3. A new method for commercial distribution of contraceptives.

a. CARRY OUT A FEASIBILITY STUDY TO DESIGN A NEW PROGRAM FOR COMMERCIAL DISTRIBUTION. THE PURPOSE OF THIS PROGRAM WOULD BE TO INTRODUCE A LOW-COST,

MASS-MARKET, BRAND-NAME CONDOM AND POSSIBLY PILL. THE INITIAL FEASIBILITY STUDY FOR THESE PRODUCTS WOULD INCLUDE THE FOLLOWING:

1) SIMPLE MARKETING EXPERIMENTS TO DETERMINE PREFERENCES OF THE RURAL POPULATION IN REGARD TO BRAND-NAMES. POSSIBLY THERE WOULD BE BOTH INDIAN AND LADINO BRANDS. IN EXPERIMENTS FOR CREATING AN IDENTITY FOR AN "INDIAN BRAND", NAMES SHOULD BE SOUGHT IN COMMON WORDS IN MAYAN LANGUAGES (MANY COMMON TERMS, ESPECIALLY CONCEPTS RELATED TO THE HOME AND FAMILY, ARE MUTUALLY INTELLIGIBLE IN SEVERAL LANGUAGES). OTHER NAMES/IDENTITIES MIGHT BE SOUGHT USING FAMILIAR NATIONAL-INDIAN SYMBOLS, E.G., TECÚM/UMÁN, THE QUETZAL, THE GRAPHIC DOUBLE-HEADED EAGLE. IN THE EXPERIMENTATION AND SELECTION OF SUITABLE BRAND NAMES CARE SHOULD BE TAKEN TO ENCOURAGE POSITIVE ASSOCIATIONS WITH FAMILY PLANNING, E.G., HAPPY FAMILY, PROSPEROUS FAMILY. FOUR OR FIVE "BRAND NAME MODELS" SHOULD BE DEVELOPED. MARKETING FIELD TESTS SHOULD SYSTEMATICALLY TEST THE ACCEPTABILITY AND CONNOTATIONS OF EACH.

2) MARKETING EXPERIMENTS TO DETERMINE THE PREFERENCES OF THE TARGET POPULATION IN REGARD TO PACKAGING TYPE, LOGO, AND GRAPHIC APPEARANCE. AS A STARTING POINT THESE TESTS SHOULD PAY PARTICULAR ATTENTION TO THE MATCHBOOK-TYPE PACKAGES NOW USED BY PROTEX FOR CONDOMS. ARTWORK FOR THE PACKAGES SHOULD TAKE INTO ACCOUNT PHYSICAL APPEARANCE OF INDIANS (AND LADINOS) AND "GOOD TASTE" IN REGARDS TO THE DISPLAY OF CONDOMS AND SEXUALLY-RELATED SUBJECT MATTER. VISUAL THEMES SHOULD BE DEVELOPED IN CONJUNCTION WITH BRAND-NAMES.

3) EXPERIMENTS IN THE PREPARATION OF SIMPLE AND EFFECTIVE INSTRUCTIONS FOR THE USE OF CONDOMS AND PILLS, TAKING INTO ACCOUNT THAT THE POPULATION, IN LARGE PART, IS ILLITERATE, NOT ALWAYS FLUENT IN SPANISH, EASILY OFFENDED BY TOO-GRAPHIC DISPLAY OF SEXUAL ORGANS, AND IN GENERAL, DOES NOT UNDERSTAND ABSTRACT GRAPHIC ABSTRACTIONS (SUCH AS SCHEMATIC OUTLINES OF HUMAN SEXUAL ORGANS). THESE INSTRUCTIONS WOULD BE INTENDED FOR INCLUSION IN THE CONDOM AND PILL PACKAGES.

4) DETAILED FINANCIAL ANALYSIS ON COST AND PRICING FACTORS. THIS WOULD INCLUDE START-UP COSTS, PACKAGING COSTS, RADIO AND OTHER PROMOTIONAL COSTS, DISTRIBUTION COSTS, MARK-UPS FOR COMMERCIAL DISTRIBUTORS, ADMINISTRATIVE AND OPERATIONAL COSTS. ON THE BASIS OF THIS ANALYSIS, MAKE RECOMMENDATIONS ON RETAIL PRICING, KEEPING IN MIND THE 1) SOCIAL CEJECTIVE OF MAKING THESE CONTRACEPTIVES ACCESSIBLE TO THE FOOREST GROUPS, 2) IMPACT ON THE PRIVATE MARKET OF A VERY LOW-PRICED CONTRACEPTIVE, AND 3) IMPACT ON THE COMMUNITY-BASED DISTRIBUTION AND DIRECT DISTRIBUTION PROGRAMS SUPPORTED BY APROFAM.

5) ANALYSIS OF THE DISTRIBUTION ALTERNATIVES. WHAT WOULD BE THE RANGE OF DISTRIBUTION ALTERNATIVES AVAILABLE FOR THE NEW, LOW-PRICED COMMERCIAL BRAND -- WOULD IT BE HANDLED BY A NEW DEPARTMENT WITHIN APROFAM? AS PART OF EXISTING DEPARTMENTS? A NEW SEMI-INDEPENDENT PRIVATE CORPORATION? CONTRACTUAL AGREEMENT WITH AN ESTABLISHED DRUG WHOLESALER? A CONSUMABLE PRODUCT DISTRIBUTOR; E.G., ASPIRINS, BEER, OR COUGH REMEDIES? WHAT ARE THE POSSIBILITIES FOR USING MORE THAN ONE DISTRIBUTOR?

6) PREPARE A DETAILED IMPLEMENTATION PLAN EXPLORING HOW THE PROPOSED COMMERCIAL DISTRIBUTION PROJECT WOULD CONCRETELY BE CARRIED OUT AND COORDINATED WITH EXISTING PROGRAMS.

IV. DIRECT DISTRIBUTION OF CONTRACEPTIVES BY THE MINISTRY OF HEALTH

A. INTRODUCTION

This section of the report concerns direct distribution of contraceptives provided by the Government of Guatemala in rural health posts. Data was collected at 15 rural health posts in Quiché. Although direct distribution through the Ministry of Health (MOH) is the major delivery system in Quiché, it was found that family planning is a very low priority, occupying on the average about 1 to 3% of the work time of a single auxiliary nurse in each health post. There are several obstacles to the direct distribution program, including lack of support from the Ministry itself, half-hearted involvement by health post personnel, and reluctance by the local population to use the government facilities.

B. BACKGROUND

Provision of government health services in rural Guatemala is relatively recent. No MOH health facilities existed in the rural area prior to 1968. Within recent years, however, there has been a shift in policy in favor of primary rural health care. In part, this is due to the encouragement and availability of funding from international lending agencies. The Inter-American Development Bank (IDB) has been the most active, most notably with a Rural Health Services loan of \$28 million in 1976. AID has made three major loans (totaling about \$8 million) and several grants (totaling about \$3 million) since 1971. These funds have been used to build, staff, and equip basic rural health infrastructure. It is projected that by 1980 there will be about as many rural as urban health facilities in the country, although the population is still 64% rural. (Urban/rural is defined as a place above/below 2000 inhabitants.)

In 1977 there were about 666 MOH health facilities in the country -- 470 health posts, 159 health centers, and 37 hospitals. The health post, the core of the rural health infrastructure, is located in municipalities of 200-2,000 people. It is staffed by a minimally trained auxiliary nurse, and, since 1974, by a rural health technician (a middle-level paramedic with two years of medical and public health training). The higher order facility, called a health center, contains beds and a doctor and/or last year medical student.

Despite their increase in number and the obvious health needs of the rural population, MOH facilities are not necessarily heavily utilized by local people. One study of 18 municipios showed an average of only .07 medical consultations per inhabitant for the year 1976 -- with utilization as low as .0015 in several of the municipios.¹ The Ministry competes -- not always

1 "Situación de Salud y Analisis de una Area Piloto, Departamento del Quiché". Edgar Rolando Muñoz P. Tesis para la Facultad de Ciencias Médicas, Universidad de San Carlos de Guatemala, 1977.

favorably -- with self-prescribed pharmacy cures, self-prescribed home cures, pharmacy-prescribed cures, traditional curanderos, and private clinics.²

Family planning was introduced into the Ministry of Health in 1967 in an agreement whereby APROFAM, with AID support, helped the MOH to bring family planning services to 40 MOH rural clinics and 16 mobile clinics. This agreement was terminated in 1970, largely because of problems of payment and responsibility of personnel in the clinics. In the same year a new agreement integrated APROFAM's work with the Maternal and Child Health Division (DMIF) of the MOH. Auxiliary nurses were trained in family planning by APROFAM and eventually absorbed into the expanding rural health system. The APROFAM-AID joint program was terminated in 1975, in part because of lack of high level MOH support for family planning in the clinics. In 1976 another agreement -- the present direct distribution program -- was signed whereby APROFAM would provide contraceptives, technical information, and promotional materials for health facilities. The entire country -- except for Guatemala City, which is supplied directly by APROFAM -- is covered by this program.

The project began in May, 1976, with the training of field personnel. Thirteen months later, 324 of the 500 clinics to be included had been incorporated into the program. By 1977 there were 408 clinics covered; and as of June, 1978, according to APROFAM, there are 524 clinics covered -- or 88% of the total of 593 clinics. In all, there are nearly 17,000 users at health posts -- or an average of 33 users per clinic.

It was hoped that the Minister of Health appointed by the newly-elected Lucas administration would provide high level support for family planning. In September of 1978, however, the new Minister, Dr. Requelino Recinos, was widely quoted in the Guatemala press as categorically opposing family planning activities, and announced that the new administration would neither participate with nor support APROFAM-related programs. Since the initial flurry, an agreement has quietly been drawn up between APROFAM and the MOH in which certain groundrules are established or clarified. It is agreed that family planning will continue along all present lines through the MOH with -- from the Ministry's point of view -- somewhat stricter control on medical aspects.

Direct distribution of contraceptives through the MOH began in Quiché in 1976. A centralized storage area was established in the departmental health headquarters. This arrangement did not work well, and in November, 1977, it was replaced by a system whereby an APROFAM-employed "medical visitor" would visit and directly supply health posts. The Quiché program was stymied by lack of a reliable all-weather vehicle. Additionally, the first medical visitor did not work out well and was replaced four months ago.

² See, for example, "Alternative Curing Strategies in a Changing Medical Situation", Clyde Woods. *Medical Anthropology*, 1:3, 1977; or "Decision-Making and Medical Care in Highland Guatemala", Sheila Cosminsky. PhD dissertation, Brandeis University, 1972.

Under the direct distribution program, 40% of the profits from the sales of contraceptives may be used by the clinic to purchase medical materials. Total contraceptive sales during the first year of the program are about \$214. About \$138 in purchasing credit has been made available to the health posts.

C. METHODOLOGY

Most of the data used in this part of the study was generated by a two-part field-tested questionnaire administered in 15 Quiché health posts. The first part contained questions on the personnel, services, and priorities of the health post; the second part contained specific questions on family planning.

In addition, useful data was also obtained by: 1) unstructured informal interviews with six Quiché Rural Health Technicians, 2) an extensive family planning questionnaire administered to four American Peace Corps nurses working in MOH health posts in Chimaltenango, and 3) analysis of raw data produced by the Guatemalan Academy of Sciences in its Evaluation of the Rural Health System. A short questionnaire was also prepared for Quiché doctors and the last year medical students who are required to work at rural health posts. For political reasons, however, APROFAM preferred that the questionnaire not be administered.

The distribution of health posts interviewed is shown below:

	<u>Health Centers</u>	<u>Health Posts</u>	<u>Total</u>
Number in Quiché	12	16	28
Offering Family Planning	12	8	20
Consultants' Sample	11	4	15
% of Total	92%	25%	54%
% of Those With F.P.	92%	50%	75%

Actually, the sample's coverage is somewhat better than that which is implied in the table. Many of the smaller health posts are not supplied directly by APROFAM, but indirectly by the larger nearby health center, 92% of which were interviewed. These smaller health posts order contraceptives and report their users through the health centers; therefore, almost all the actual MOH contraceptive users are included in the sample.

D. FINDINGS

1. Health post personnel, services, and priorities. The number of type of

personnel working in the health posts and centers interviewed is shown below:

	<u>Number</u>	<u>Average per facility (n=15)</u>
Doctors	5	.3
Graduate Nurses	4	.3
Last-year Med Students (EPS)	9	.6
Auxiliary Nurses	31	2.1
Rural Health Technicians	18	1.2
Social Workers	1	.1
Sanitary Inspectors	5	.3
Dentists, Denistry Students, Technicians	0	0
Trained Midwives	not determined	---
Village Health Promoters	not determined	---

Of the fourteen health services studied, only two have some type of in-patient care. The major service provided is general medical consultation (dressing of wounds, prescription of simple medicines) and maternal child care. Vaccination campaigns are carried out from time to time, and some facilities surveyed are distribution points for CARE PL-480 food programs, a factor which has undoubtedly stimulated overall utilization of the health facilities.

The health facilities were asked to list their priorities. Maternal-child care was first. Family planning, out of nine choices, was last.

2. Personnel involved with family planning. Fourteen of the 15 health facilities interviewed had family programs. The following table lists characteristics of the persons actually delivering family planning services:

Position of person in charge of Family Planning.	Auxiliary Nurse 13 Graduate Nurse 1
Sex.	Women 11 Men 3
Age.19-56 years, range 33 years, (\bar{X})
Education.8.75 years, \bar{X} (NOTE: 5 attended 6th grade or less)
Time at this health post5 months to 26 years, range: 6.5 years, \bar{X}
Attended APROFAM training courses.Attended 1 course 9 Attended 2 or more courses 2
Place of residenceIn the community 10 Outside the community 2
Ethnic groupLadinos 14 Indians 0
Speak Indian language of the communityYes 4 No 10
Salary*.\$113 to \$175 per month, range \$120 per month, \bar{X}

The auxiliary nurse is not only the key person in the family planning program, but she is the work backbone of the health post. Usually, she has been there the longest. Although not well educated, she has years of direct contact and practical experience. Typically, she sees her job as difficult and underpaid. The older nurses, in particular, tend to view themselves as being burdened with mountains of paperwork, "wet-behind-the-ears" supervisors, and a not particularly grateful clientele.

The younger auxiliaries are generally better educated and more mobile than their older colleagues. Increasingly they are concerned with the image of their profession. In the past, the auxiliary nurses have not always been

* 1976 data. Muñoz, op. cit.

viewed as "good girls" by the communities. They are generally unmarried; they are not usually church goers; they espouse progressive ideas and social change (e.g., vaccination programs, latrinization); and they are known to be comfortable with touching, viewing and discussing the human body. To the conservative, gossip-prone Indians, the nurses are a source of entertainment and speculation (the nurse and the Ladino schoolteacher? .. the nurse and the telegraph operator?).

The younger nurses, in particular, resent this less-than-prestigious position. Invariably they wish to upgrade and professionalize their work and status within the community. Training and cursillos (courses) help. For most, their two-day APROFAM training course has been a significant and memorable professional experience; and, in fact, it represents a significant addition to their total formal health training.⁴ On the other hand, family planning itself is of dubious moral status. Unfortunately, it reinforces the bad-girl image. For this reason, even though they are not themselves opposed and although they have received training which they enjoyed and took seriously -- many auxiliaries, particularly the younger ones -- will not actively promote family planning in their day-to-day work.

To date, Rural Health Technicians (TSR's) in Quiché have played no significant role in family planning (although a female TSR runs the program in one Chimaltenango clinic). Informal interviews with six TSR's indicated no serious ideological opposition to family planning, although all the TSR's were familiar with the political issues ("family planning is no answer to rural poverty; it's a gringo plot", etc.). For the most part, the TSR's interviewed were reasonably convinced of the need for family planning; their concern was primarily in its safety. This would seem to be a matter of education. To some extent, they view themselves as the loyal opposition to the MOH. They are young, relatively well educated, progressive, from rural backgrounds; and unlike the future-doctors, they are willing to live and work in the rural areas. A primary job of the rural health technician is to coordinate and support community and health post projects; e.g., potable water, latrinization, etc. TSR's work with community activists and opinion makers. Unlike any other member of the health post, they also work with men. Moreover, they have responsibility for recruiting and training village health promoters, who educate and provide some primary health care in the remote aldeas.

3. Amount of health post time devoted to family planning. The interviewed auxiliary nurses reported that on the average they devote one and a half hours a week to family planning. Generally, they claim to spend 30-45 minutes with a patient. It is clear that for the most part they prescribe family planning techniques to patients who come into the clinic requesting them.

4 This fact is noted by Muñoz, op cit, who though opposed to family planning himself, points out that it is practically the only public health-related training that health post personnel have had.

There is practically no promotion or educational outreach.

According to the schedule established by the Ministry, an auxiliary nurse works 44 hours per week. Therefore, on the average, one nurse per participating health post spends 3.45% of her time devoted to family planning. This, of course, does not include all the other auxiliary and graduate nurses who do not do family planning nor the other health post personnel.

Data collected by the Guatemala Academy of Sciences in its evaluation of the Rural Health System in Quiché corresponds to this estimate. Raw data was analyzed from seven health facilities in Quiché. The range of time devoted to family planning by participating auxiliary nurses was .2% to 2.8% of a 1000 hour work semester -- or, on the average, about 3% of her work time per week.

4. Pamphlets and posters in the health post. APROFAM posters were visibly displayed in 10 of the 15 health posts visited. Small wooded holders for APROFAM-DMIF (División Materno Infantil) pamphlets were visible in about half the health posts, although only four actually had pamphlets. Most of these materials were provided to the auxiliary nurse during the APROFAM training course in November, 1977. The medical visitor, who is the regular contact with APROFAM, has not brought new materials.

The usefulness of these materials is limited by the fact that 98% of rural Indian women over 18 years of age are illiterate (calculated from the 1973 census data); nevertheless, the posters create some interest because they show women who are recognizably Indian by their dress.

5. Number of family planning acceptors. There were 610 family planning acceptors reported in the sample. This number includes acceptors at many of the smaller health posts that were not directly interviewed; therefore, most of the MOH acceptors not in Quiché would be included. Actually, the number is probably somewhat inflated since many of these acceptors are not active. Data is too unreliable to adjust the number with any accuracy.

598 (98%) of the reported 610 users are women. 12 men users were reported. Possibly this number is too small, since there are no control cards for men. The nurse who reported most of the men users indicated that condoms are actually purchased in the health post by the wives.

The average number of users per health post is 44, which is somewhat higher than the national average of 33 (probably because the national average includes many health posts which are not directly covered, but are actually supplied by nearby health centers -- this slight bending of the truth being done to meet the program goal of "full coverage" of health posts by the end of this year). The largest number of users (264, or 43% of the total) is reported at the health center in the departmental capital, Santa Cruz del Quiché. This disproportionately high number is largely due to the efforts of one older auxiliary nurse, who has been something of a family planning zealot for many years. The second highest number of users (78) is reported at the health post in Uspantán. In fact, the health center at Uspantán is

not particularly interested in family planning; however, a nearby private program which itself does not want to dispense contraceptives regularly refers patients, thus accounting for the high number of users.

6. Methods used. The contraceptive methods found in the health posts studied are: pill (14), condom (13), vaginal tablets (9), foam (6), and jelly (4). IUD;s are inserted in the health centers in Santa Cruz and Uspantán.

Although the data is not altogether reliable, it is estimated that 98% of the acceptors (580 women) are using the pill. Injections have been discontinued by the Ministry. Local methods are not frequently encountered -- probably because they are somewhat more expensive, because they require an amount of physical handling of the genitals which is "shameful" to most Indian women, and because the pill is the method best known to the auxiliaries.

An interesting side note is that in one health center only the condom is sold. In this health center the auxiliary is a man. The users are the town's Ladino schoolteacher, the nurse, and several of his friends.

7. Obstacles to expansion of services by the MOH.

a) Social/cultural. In general, health posts are not "culturally comfortable" places for most Indians, particularly men. Their languages are not spoken and they are usually treated in a patronizing manner (doñacita, tu, mi'ja -- a contraction and diminutive of mi hijo(a) -- roughly, "my boy", or "my dear child" -- favored by city women addressing their maids and health post nurses addressing their patients, who then are expected to reply seño, "teacher", derived from the verb enseñar). Judged by male utilization rates, Indian men are not prone to discuss or allude to their sexual lives with female, Ladino auxiliary nurses. Indian women are shy about undressing or pelvic exams -- so much the worse if the examiner is a male doctor.

b) Physical/geographic. Although the direct expense of a medical consultation is low, there is some significant opportunity cost involved in time/work loss in a trip to the health post. Health posts are viewed as places to go when one is sick; i.e., to request contraceptives requires considerable motivation.

c) Institutional/political. The major obstacle to expansion of services at the health post is the lack of support from the MOH itself. This has been the major obstacle for ten years; it is nothing new. The Ministry establishes policy, and although policy may not be accurately understood at the health post operational level, at least the general tone and intent of the Ministry is. This field investigation took place in the weeks immediately following the widely publicized announcement (at least 7 newspaper articles) that the Ministry would not support family planning. No one interviewed at the health posts seemed to be aware of the announcement in Guatemala City, or

in the subsequent reversal of the decision. Nevertheless, people were very aware that there is little enthusiasm for family planning that emanates from the top. It is APROFAM's association with DIMIF, to some extent largely symbolic, that is taken as a sign that there is tacit support by the Ministry. Without this sign, there would be no, as opposed to the present level of almost-no, family planning.

It should also be pointed out that the last year medical students (EPS's) are usually opposed to family planning, quite independently of the Ministry's position. This reflects their training at San Carlos, the national university. Here they are exposed to almost no public health courses and only minimal training in medical aspects of family planning. They are, however, well grounded in the political, moral, and ideological aspects of the issue.

At the health post program level, it should be noted that the activities of the medical visitor (visitador médico) are not yet fully in operation. This is certainly not the fault of the present visitor, who is new to the job. However, ten of the health posts reported that a visitor had come only twice since July, or once every two months. According to the auxiliary nurse in Nebaj, a bumpy five-hour drive from the departmental capital, the visitor has not been to Nebaj, which is barely accessible by pick-up, it is nearcertain that he has not been to Pulay, Tzabal, and Salquil Grande, which are all-but-inaccessible dependent aldeas, listed in APROFAM's reports as being covered by the direct distribution program. According to nurse informants, the visitor's visits are short and devoted strictly to taking orders and collecting money. No one reported that pamphlets, posters, or additional information about family planning were provided. Of the 12 health posts that had been visited, seven nurses said they were satisfied with these visits, four said they were not, and one said she didn't know.

d) Economic. Contraceptives are inexpensive at the health post -- 15¢ for a cycle of pills, 30¢ for a dozen condoms. Cost does not appear to be a factor in restricting sales of contraceptives.

An interesting question is to what extent does the 40% profit that stays at the health post act as an incentive to the auxiliaries? Presently, purchasing credit "earned" by all the health posts in Quiché totals about \$138 for the year -- or an annual average of about \$6 per health post. Not a large amount of money. Nevertheless, many nurses were still aware that "they" had earned something. Several expressed concern that possible competition from the Community-based Distribution program might cut into their profits. Even though the profits are largely symbolic, they do appear to exist in the minds of the nurses.

E. CONCLUSIONS AND RECOMMENDATIONS

The situation with the MOH Direct Distribution in Quiché is not bright. The program in the health posts is operating far under its capacity to actually

deliver services. Whether this is because of lack of demand on the part of the local population or lack of interest at the health post is a complicated question. Certainly the answer is that it is a combination of both. Obviously people are not banging on health post doors for family planning, but the people are not banging for any MOH services in Quiché.

The programs in Quiché can hardly be said to be more than just beginning. What is perhaps most impressive about the program is that there are as many users as there are, given the fact that the services are offered neither courteously nor enthusiastically. The only two examples of successful family planning programs in Quiché are in the departmental capital and in Uspantán. In both cases a single person -- in the first case a veteran auxiliary nurse, and in the second case an independent paramedic who does not work for the MOH but refers patients -- has caused a program to attract users. In both cases, there is genuine teaching, reassurance, and interest in the patient.

If the situation is not bright, neither is it hopeless. In the first place, the MOH in Quiché is expanding; the system of rural health services can be said to only be just beginning. In the second place, the auxiliaries, the backbone of the system, are responsive to training. They enjoy courses and need training in public health. They are sensitive to measures which will increase their professional competence and esteem. As it happens, the basic auxiliary nurse training facility, the school in Jutiapa, was financed by AID.

Furthermore, the TSR's are a still-untried possibility in improved delivery of family planning services. Whereas the auxiliary nurses will obviously have better luck with women, the male TSR's may very well be able to bring family planning to the men, who are all but unreachable by the present program. Furthermore, the TSR's may very well be able to bring family planning to the men, who are all but unreachable by the present program. Furthermore, the TSR's have good and are developing better interaction with village health promoters, who could be a positive force in village-level family planning education. There is presently some family planning in the TSR curriculum at the school in Quirigua (also financed by AID); however, the amount of family planning could be greatly expanded, or better yet, integrated into existing units of the TSR curriculum.

Problems with the medical students and the lack of support from the Ministry are serious. Lack of Ministry support not only undermines the potential of the Direct Distribution program, but as pointed out in the following section of this report ("Delivery of Family Planning Services by Health-related Private Voluntary Organizations"), it also limits the extent to which private voluntary organizations are willing to provide family planning.

RECOMMENDATIONS

1. Improvement of existing programs.

a. CONTINUE EFFORTS OF RAPPROCHEMENT WITH THE MINISTRY OF HEALTH.

b. RE-EVALUATE THE RESPONSIBILITIES AND ACTIVITIES OF THE MEDICAL VISITOR. HE SHOULD BE ADEQUATELY PREPARED IN BOTH THE MEDICAL AND SOCIAL ASPECTS OF FAMILY PLANNING. IN EACH HEALTH POST ASSIGNED HIM, HE SHOULD BE RESPONSIBLE FOR PROMOTION AND EDUCATION OF THE HEALTH POST STAFF AS WELL AS SUPPLYING CONTRACEPTIVES. THE VISITOR SHOULD DISTRIBUTE POSTERS AND PAMPHLETS FOR USERS AND COPIES OF TIMELY TECHNICAL ARTICLES FOR THE STAFF. HE SHOULD KEEP TRACK OF THE 40% PROFIT AT EACH HEALTH POST AND SHOULD BE RESPONSIBLE FOR PROMPT DELIVERY OF MATERIALS AND SUPPLIES THAT ARE ORDERED.

2. Expansion of present types of programs.

a. EXPAND THE FAMILY PLANNING COMPONENT NOW INCLUDED IN THE TSR TRAINING CURRICULUM AT QUIRIGUA. EMPHASIZE COMMUNITY EDUCATION AND FAMILY PLANNING FOR MEN. ENCOURAGE THE TSR'S TO TEACH FAMILY PLANNING TO VILLAGE HEALTH PROMOTERS.

b. INCLUDE FAMILY PLANNING IN THE AUXILIARY NURSE TRAINING CURRICULUM AT THE SCHOOL IN JUTIAPA. THIS WOULD INCLUDE IMPROVED TRAINING ON THE MEDICAL ASPECTS OF FAMILY PLANNING, FAMILY PLANNING WITHIN THE CONTEXT OF PUBLIC HEALTH, AND SENSITIZING NURSES TO CULTURAL DIFFERENCES AND THE SOCIAL PROBLEMS INVOLVED WITH THE DELIVERY OF FAMILY PLANNING SERVICES.

c. IMPROVE EDUCATIONAL MATERIALS. THIS WOULD INCLUDE SIMPLE BROCHURES INTENDED FOR INDIAN WOMEN (ALSO FOR USE IN THE COMMUNITY-BASED DISTRIBUTION PROGRAM), FLIP-CHARTS FOR USE IN FAMILY PLANNING CLASSES, PAMPHLETS FOR INDIAN MEN, AND "A FAMILY PLANNING GUIDE FOR THE HEALTH PROFESSIONAL", INTENDED FOR THE AUXILIARY NURSE AND THE TSR.

d. IMPROVE THE SYSTEM OF TRAINING AND RE-TRAINING OF PRESENTLY EMPLOYED AUXILIARY NURSES. THIS MIGHT BE DONE THROUGH A SPECIALLY CREATED MULTI-PURPOSE MOBILE TRAINING UNIT.

3. A new possibility.

CREATE A MONTHLY APROFAM-DMIF NEWSLETTER TO BE SENT TO ALL GRADUATE NURSES, AUXILIARIES, TSR'S AND PRIVATE VOLUNTARY ORGANIZATIONS. THIS NEWSLETTER WOULD HAVE TWO EQUALLY IMPORTANT FUNCTIONS: 1) TO INCREASE INTEGRATION WITH THE MINISTRY, TO PUBLICALLY EMPHASIZE THE APROFAM-DMIF TIE, AND INCREASINGLY PRESENT APROFAM AS AN ORGANIZATION CONCERNED WITH PUBLIC HEALTH PROBLEMS RATHER THAN POPULATION CONTROL, AND 2) PROVIDE PERSONNEL WORKING IN PUBLIC AND PRIVATE CLINICS THE UP-TO-DATE INFORMATION ON FAMILY PLANNING TECHNOLOGY, FEATURE ARTICLES ON SUCCESSFUL GUATEMALAN HEALTH PROGRAMS, NEWS ON HEALTH/FAMILY PLANNING IN OTHER DEVELOPING COUNTRIES, AND NEWS ABOUT MINISTRY AND VOLUNTARY PERSONNEL WORKING IN PUBLIC HEALTH AND FAMILY PLANNING. PERHAPS AN AGREEMENT COULD BE REACHED WITH THE AMERICAN PUBLIC HEALTH ASSOCIATION (APHA) WHEREBY SUCH A NEWSLETTER WOULD BE DISTRIBUTED WITH SALUERITAS, AN APHA NEWSLETTER.

V. APROFAM'S COMMUNITY-BASED DISTRIBUTION PROGRAM

A. INTRODUCTION

This section of the report deals with APROFAM's program in Community-Based Distribution. For the study, virtually all of the promoters in the country, all of APROFAM's distributors in Quiché, and a small sample of CBD family planning users were interviewed. It was found that the program has been slow to attract Indian users and is expensive to operate. Nevertheless, a potentially significant village-based health and family planning delivery infrastructure is being established. It can be argued that there is a high social benefit in training village people, particularly Indian women, in basic health and family planning. The program is still in experimental stages. Suggestions are made for improving and extending the program.

B. BACKGROUND

Community-Based Distribution is the only family planning delivery system in Quiché which is entirely operated by APROFAM. To a certain extent, the program is modeled on CBD concepts which have been employed in other countries.

In establishing the national CBD program, APROFAM has experimented with various institutional bases for village-level distribution. To date, component programs include: the Metropolitan area project (1 supervisor, 12 promoters, 130 distributors, about 15,000 users); the Cooperative project, developed with FECOAR (Federacion de Cooperativas Agrícolas), of which the Quiché Program is one part (supervisor and 8 promoters, covering 6 departments); the Campesino League Project in Escuintla (1 supervisor, 3 promoters, 60 distributors, and about 700 users within the first few months of the project), the Cotton Growers Project, in Tiquisate and Coffee Growers project; and the Independent Campes Movement project in Nuehuetenago, which is just starting but has produced about 300 users in its first month.

The program in Quiché was begun in July, 1977. Support was obtained at the national level from FECOAR (a cooperative umbrella organization which has been supported by AID since its inception in the early 1970's). FECOAR has five regional member coops, including El Rey Quiché. Each regional coop is a federation of local village chapters.

After initial FECOAR-APROFAM meetings at the national level, a meeting was called in Quiché of 52 local cooperative leaders to solicit their support and encourage them to become APROFAM distributors. Initially, 47 of the 52 leaders were opposed to the program. Eventually, however, they were convinced and 25 distributors were selected among them. A promoter for Quiché

was hired to coordinate their work. In November, 1977, a two-day training session was given, and the program was begun.

The promoter job is a full-time position. He is paid a relatively high salary (\$110/month, \$25 for gasoline, and \$60 for travel expenses). In addition, APROFAM helps him with bank financing of a small motorcycle, which is indispensable to his work. The promoter visits each of the distributors about once a month. They receive no salary, but instead "earn" 40% of the profits from their sales of contraceptives, which even by rural Quiché standards, is a near-insignificant monthly amount--on the average, about 42¢. Being a distributor is considered volunteer community work. They are encouraged by APROFAM to make it known that they sell contraceptives, to speak on a person-to-person basis, and encourage their neighbors to use them. An additional incentive to some distributors is simple medicines-- aspirins, antidiarrheal medicines, etc. -- which they sell in addition to contraceptives.

C. METHODOLOGY

These findings are based on three sets of questionnaires: 1) a promoter questionnaire, 2) a distributor questionnaire, and 3) a contraceptive user questionnaire.

Interviews with APROFAM's promoters were carried out at a meeting of promoters which took place in late August, 1978. The questionnaire covered: personal characteristics of the promoters, their work, community attitudes toward family planning, problems they have encountered and their ideas for solutions, satisfaction with APROFAM, and the distributors they supervise.

Using data obtained from the promoters, a distributors questionnaire was designed. It is certain that village-level distributors are key persons in the CBD program; yet the problems in physically reaching them were considerable, given the rain and state of the roads in Quiché during September. For this reason, a two-day meeting was arranged in Sta. Cruz to which all distributors were invited and paid \$5 per day for their attendance. The purpose of the meeting was to allow person-to-person interviewing with each distributor and create a situation which would also allow group discussions. So that the distributors would themselves profit from the meeting, APROFAM provided lectures, training, and films. The APROFAM Quiché promoter assumed responsibility for arranging a meeting place, contacting the distributors, refreshments, etc. One difficulty with this arrangement was that the training and motivation sessions tended to bias questionnaire results by teaching the distributor "right answers". For this reason, all the results from the questionnaire are not included in this report. Several distributors were not able to attend the meeting; therefore, interviews were also carried out with several distributors in their homes.

A topic of particular importance to the study was the economic and social characteristics of contraceptive users who are supplied by the CBD program. Who are these people? What sets them apart from others who are not family planning users? What motivates them? Are they satisfied with the services they receive?

Getting first-hand answers to these questions proved to be the real methodological challenge of the consultancy. It was far simpler to design an extensive questionnaire, one containing all the questions, than it was to decide how to administer it. First, simply obtaining an accurate list of names and locations of users proved to be a complicated task; finding them would in many cases require a jeep and a guide, and it would have been unrealistic to anticipate more than one or two interviews per day. Furthermore, many roads in September are all-but-impassable; many of the informants do not speak Spanish; most of them regard their use of contraceptives as a secret and are not willing to discuss it with strangers; and any stranger in a woman's house is visible to the community, causes gossip and is a source of embarrassment to her. Furthermore, the important questions, i.e., landholding, wealth, sexual behavior, are sensitive and difficult to discuss under the most humane conditions, much less in a surprise, half-hour questionnaire-type interview.

It was too much for us. As an alternative, we redesigned the original questionnaire to a barebones minimum and took advantage of the distributor meeting to train the distributors to act as our interviewers. This works reasonably well, although communications lags in Quiché caused us to get back only 24 questionnaires, or 15% of the 155 users, before the end of the field collection of data.

D. FINDINGS

1. Personnel in the CBD Program. The following table shows characteristics of APROFAM's promoters. For purposes of this report, promoters have been divided into three groups: Indian promoters, Rural Ladino promoters, and Metropolitan promoters. The Quiché is shown separately (and is also included among Indian promoters). (page 32)

It is frequently claimed that one reason that so few Indians are found in supervisory positions in programs, even in Indian areas, is that it is impossible to find people who are qualified. It is interesting to note, therefore, that the level of education of rural Indian promoters is somewhat higher than rural Ladino promoters.

Characteristics of distributors are summarized in the following table. Data on four distributors new to the program are shown separately, since the September meeting was their formal initiation to the program.
(page 33)

<u>CHARACTERISTICS</u>	<u>RURAL INDIAN (n=10)*</u>	<u>RURAL LADINO (n=13)*</u>	<u>LADINO MET. AREA (n=12)*</u>	<u>TOTAL (N=35)*</u>	<u>QUICHÉ PROMOTER (n=1)*</u>
SEX					
Male	5 (50%)	7 (54%)	0	12 (34%)	male
Female	5 (50%)	6 (46%)	12 (100%)	23 (66%)	
AGE					
\bar{X} Years	23.4	30.6	26.6	27.5	28
CIVIL STATUS					
Single	4 (40%)	3 (23%)	6 (50%)	13 (37%)	married
Consensual/ Married	6 (60%)	8 (62%)	6 (50%)	20 (57%)	
Divorced	0	2 (15%)	0	2 (6%)	
CHILDREN					
No	5 (50%)	3 (23%)	5 (42%)	13 (37%)	yes
Yes	5 (50%)	10 (77%)	7 (58%)	22 (63%)	
LIVE CHILDREN	2.0 (5)	2.8 (10)	2.3 (7)	2.4 (22)	1
RELIGION					
None	1 (10%)	1 (8%)	1 (8%)	3 (9%)	Catholic
Catholic	8 (80%)	11 (85%)	10 (83%)	29 (83%)	
Protestant	1 (10%)	1 (8%)	1 (8%)	3 (9%)	
SCHOOLING					
\bar{X} Years	8.8	7.2 (12)	10.8	8.9	7
TIME WORKED					
\bar{X} Months	11.8	8.1	17.8	12.5	12
AREA POPULATION					
Mostly Indian	8 (80%)	2 (15%)	0	10 (29%)	mostly Indian
Mostly Ladino	0	2 (15%)	3 (25%)	6 (17%)	
Both	2 (20%)	9 (69%)	9 (75%)	19 (54%)	

* The number in brackets represents the number of cases included.

<u>CHARACTERISTICS</u>	<u>DISTRIBUTORS (OLD, n=19)</u>	<u>DISTRIBUTORS (NEW, n=4)</u>	<u>TOTAL (N=23)</u>
SEX			
Male	14	3	17 (74%)
Female	5	1	6 (26%)
AGE \bar{X} Years	29.4	23.3	28.3
CIVIL STATUS			
Single	4	3	7 (30%)
Consensual/married	15	1	16 (70%)
CHILDREN			
No	5	3	7 (30%)
Yes	14	1	16 (70%)
LIVE CHILDREN, \bar{X}	4.07 (14)	7 (1)	4.3 (15)
CHILDREN WHO HAVE DIED, \bar{X}	0.21 (14)	1 (1)	0.3 (15)
ETHNIC GROUP			
Indian	13	4	17 (74%)
Indian Women	0	1	1 (4%)
Ladino	6 (5 fem.)	0	6 (26%)
SPEAKS QUICHE			
No	5	0	5 (22%)
Yes	14	4	18 (78%)
RELIGION			
None	1	0	1 (4%)
Catholic	17	4	21 (91%)
Protestant	1	0	1 (4%)
SCHOOLING \bar{X} Years	4.26	4.0	4.2
CAN READ	19	4	23 (100%)
CAN WRITE	19	4	23 (100%)

Most of the male distributors are small farmers cultivating their own land (35%), and in one case, family land. There are also two albaniles (unskilled masons), a tailor, and a floorloom weaver. Of the old women distributors, three are housewives, one operates a tienda, and one is a high school student.

It is interesting that among the 25 original distributors there was not a single Indian woman. Recently a 20 year old unmarried Indian girl was selected as the first and only female Indian distributor in Quiché.¹

One of the initial surprises of the investigation was that the champion distributor, in terms of number of users, turned out to be a 16 year old Ladino high school girl. This ran quite contrary to expectations of who would make the best distributors. On closer examination, it turned out that it was not the girl but her mother who was acting as distributor. The mother was interested in family planning and took it upon herself to discuss it with her friends and recommend it to customers of her small business.

This was an important finding; for we soon learned that many of the distributors who were answering our questionnaires were not necessarily the de facto distributor. The initial 25 distributors were recruited by the coop. An effort was made to choose local leaders under the assumption that they would be both progressive and influential. But to put it simply; many of them were pressured into it. They accepted with the reassurance that there really was not much work to do and that they would have little actual responsibility.

Few of these coop leaders appear to have done much with the responsibility other than pass it along to their wives. Not all wives were interested, of course; but several did take it upon themselves to suggest family planning to relatives and friends.²

In fact, this was a better arrangement. It is theoretically expected of the distributors that they will inform their neighbors of the benefits and techniques of family planning at meetings and in house-to-house chats. In fact, this is unrealistic. In the first place, family planning -- at least an undiluted exposition -- is not acceptable subject matter at a public meeting. Distributors (and the promoter) repeatedly emphasized that it is necessary to speak of family planning in euphemisms and with roundabout

¹ APROFAM has concluded that for distributors to satisfactorily carry out their work they must, at a minimum, speak Spanish and be literate. Whereas it would obviously be desirable to have older married Indian women as distributors, it is no easy task to find ones who are literate, speak Spanish, favor family planning, and willing to work without pay. The 1973 census lists only 999 rural Indian women in Quiché over 18 as literate (about 2%). The situation is not so extreme in other Indian areas.

² From the small user sample it appears that 33% of the users are relatives, 43% are friends, and only 24% are acquaintances or persons with whom the distributor has had no dealings.

logic; e.g., the shortage of land, the poverty that we face; the cost of educating, clothing, and feeding children; responsible parenthood, etc. It is doubtful that a Quiché distributor ever simply addressed a public meeting by saying: "Now I'm going to tell you how not to have children in case you don't want any for awhile."

On the other hand, there is no real medium for a frank person-to-person, heart-to-heart talk, particularly a male distributor talking to a potential female user. To the conservative Indians, it is improper for a man to talk privately to a woman not his wife, much less to talk about her sex life.

The Quiché expression for adultery, "kinch'ab'ej jun ixoq" translates "I speak to a woman" or "to a man", jun achi. Informal house-to-house visiting of any sort is not a common element of Indian social life. There is no coffee klatch or its equivalent. Neighbors rarely visit unless there is a good reason to do so ("your chicken is in my yard"). Men work in the fields or appear in a public capacity at religious/civic meetings. Women work in their homes; they interact with close relatives, particularly members of the extended family who live within the same housing compound; they gossip and exchange news while carrying water or washing at the public pila; and they talk about prices and the weather while doing marketing.

So, the shifting of responsibility from the husband to the wife was not entirely shirking, but an adaptive response to the realities of the Quiché cultural situation. If there were to be any communication within established village channels, it would be men talking to other men in their oblique and metaphoric fashion at public meetings and women concretely explaining how it works to relatives in the house and friends at the pila.

As the investigation progressed, it also became apparent that there was more than one kind of distributor. Four fairly clear types began to emerge:

(1) The Ladino Distributors. The Ladino women tended to be second generation distributors, that is, they have been recruited since the first round was chosen by the coop. In an analysis of the "best distributors", measured simply by actual number of users, it turned out that the Ladino women were on top. In absolute number of users, all were above the mean. In part, this reflects the fact that they tend to live in nucleated or at least slightly more dense settlements than do the Indians, and they are far less constrained in discussion of sexual matters.

(2) Indian Community Activists. Ladinos, even in the rural areas, tend to identify with and be linked into national society. Indians, on the other hand, traditionally have almost no supra-village organization. Their social and political sphere tends to be restricted to the municipio. Within any municipio there is a network of committees, associations, community betterment projects, political parties, religious groups, and cooperatives. Many of these are recent outgrowths from assistance received from private voluntary organizations or foreign-assisted government programs. A common trait of outside programs is that they wish a popular community-base for their programs; they seek out -- and in a sense create -- a class of persons who become known as líderes. ("What do you do for a living here in Pachalún?" Yo soy un líder.)

Such people play the important role of fronting for the community, keeping in touch with whatever program opportunities develop. These people maintain their primary allegiance and identification within the community, but they also learn to intervene and represent the community in the outside world. Understandably, these were the first generation of APROFAM's distributors. Most of these people -- who tend to be older men with 5-6 children and 4-5 responsibilities similar to that of APROFAM distributor -- acquired their role in family planning not so much out of interest, but as part of a subtle strategy to keep the community in touch with anything that might develop from the program.

(3) Amatuer Health Promoters. There is a growing demand for modern-sector health services. Despite the expanded number of MOH health posts, the rural area can hardly be said to be covered by health services.³ Most curing is still done in the home. Pharmacies and traditional curers continue to be of great importance. Within recent years, a common phenomenon in many communities is that one or two people take it upon themselves to learn about simple medicines, especially injections, and purchase small quantities of drugs which they dispense at a few pennies profit. Increasingly, health promoter training is becoming available through private voluntary organizations and through the TSR's assigned to Ministry health posts. Training is welcome. It is probably no exaggeration that Dónde No Hay Doctor is on the rural Quiché bestseller list. Predictably, some of these people were attracted by the APROFAM CBD program. In these cases, the incentive is not so much to distribute contraceptives -- to which most health promoters are luke-warm -- but to simply obtain medicines inexpensively and have an opportunity for training in health and medicine. In the sample of distributors, seven persons turned out to also be health promoters (6 give injections, 2 claim to sell simple medicines from house to house, and one has opened a tiny pharmacy in his home -- two small wooden tables with neat piles of remedios, handwritten health messages on the wall, and a dog-eared copy of Dónde No Hay Doctor).

(4) Opportunity-seekers. Several of the distributors are simply intelligent under-employed young men who are looking for a way, any way, to improve their lives. Most are sufficiently educated to be dissatisfied with the prospects of raising a family at \$1-2 a day as an agricultural laborer; but they are too under-educated, with connections, and without financing to do much about it. They are restless, ambitious, and unhappy. To them, the APROFAM promoter is a model of someone who has "made it". He is, after all, an Indian, a person of similar education and background, who now has a responsible job, a motorcycle, and an enviably high income of close to \$200 per month. It is well known that he has worked in one or another foreign-financed program for 7-8 years. It is also known that several young Indians, including women in their early 20's, have recently been hired for \$180/month as bilingual education promoters, which from the local point

³ The present Quiché population is about 386,000. About 88%, or 339,600 people, live in settlements less than 2000. Assuming an average size for these settlements of roughly 400 persons, there would be about 850 of these aldeas or caserios. Presently there are health posts -- which is to say, an auxiliary nurse and a TSR -- in about 10 of these settlements, or less than 1%.

of view appears to be a very soft and well paid job. Where does one find such opportunities? Some people just have luck, but another answer is simply to keep in touch with whatever is happening, even to the extent of accepting an unpaid position such as distributor in APROFAM's CBD program.

2. Users. After about a year of implementation, the full-time promoter and 25 distributors have managed to attract about 155 users for the program -- that is, approximately 6 users per distributor (range of 0-37).

The productivity of the Quiché program compared to the program at the national level can be seen in the following table:

Area	PROMOTERS	DISTRIBUTORS		USERS	
	Total	Total	Distrib./ Promoters	*Users/ Promoter	Users/ Distrib.
In Indian or mixed area (inc. Quiché)	10	160	16	141 (n=5)	9
In Ladino area	13	221	17	242 (n=13)	14
In the Guatemala City metropolitan area	12	144	12	707 (n=3)	59
In Quiché only	1	25	25	155 (n=1)	6

*This data is based on reports by those promoters who responded to this question on the promoter questionnaire. The number of responding promoters, n, is indicated.

The distribution of users by sex and contraceptive method is shown below:

	<u>Male Users</u>	<u>Female Users</u>	<u>Total</u>
SEX	59 (38%)	96 (62%)	155
METHOD USED	condoms 59 (100%)	Pill 70 (73%) Foam 16 (17%) Vaginal tablets 10 (10%)	

About 79% of the users are Indians (72 of the 91 users for whom the distributors provided this information on the questionnaire). Interestingly, the Ladino distributors do fairly well even among Indians; they responded that 58% of their users are Indians and 42% Ladino.

The following table gives basic data on characteristics of the users who were interviewed. It is not claimed that this data is highly reliable or perfectly representative. As indicated in the methodology section, accurate data on users was difficult to collect.

<u>CHARACTERISTICS</u>	<u>USERS</u>	<u>TOTAL (n)</u>
SEX		
Male	3 (12%)	24
Female	21 (88%)	22
AGE \bar{x} Years	26.6	22
ETHNIC GROUP		
Indian	17 (71%)	24
Ladino	7 (29%)	
MARITAL STATUS		
Single	5* (22%)	23
W/spouse	18 (78%)	
LIVING CHILDREN \bar{x}	2.8	21
CHILDREN WHO HAVE DIED \bar{x}	0.64	23
WHAT MORE CHILDREN		
Not sure	2 (10%)	
No	3 (43%)	
Yes	10 (47%)	
If so, how many more \bar{x} ?	2	
RELIGION		
None	2 (90%)	23
Catholic	21 (91%)	
Protestant	0 (0%)	
METHOD USED		
Pill	12 (52%)	23
Tablets	10** (43%)	
Condoms	1 (4%)	
TIME USED \bar{x} MONTHS	4.14	22
PAST USE		
No	15 (65%)	23
Yes	8 (35%)	
IF SO, WHICH METHOD		
Pill	4	8
Injections	3	
IUD	1	

*This information is inexact. At least two women, who are clearly living with a spouse and have been for several years were reported as "single" on the basis of the fact that they have not yet been able to bear children (which lends some insight into the values of Indian culture). In fact, both these women are taking the pill with the idea of increasing their fecundity.

**Two men are reported as using tablets. Presumably they are giving them to their wives rather than swallowing them.

Contrary to expectations, the interviewed users do not appear to have large families (\bar{X} , 2.8 live children). It will be seen that the more children they have, the fewer additional children they tend to want:

<u>DO YOU WANT ANOTHER CHILD?</u>	<u>AGE</u>	<u>NUMBER OF LIVE CHILDREN</u>
No 9 (47%)	26.6 years	3.8
YES 10 (53%)	24.8 years	2.4

Those who indicated that they wish to have more children have, on the average, 2.4, and report that they wish 2 (\bar{X}) more -- indicating an ideal family size of about 4.4 children, which is fairly close to the mean (3.8) of those reporting that they wish to have no more children.

An important aspect of the CBD program that needs further investigation is continuation rate among users. Reliable data was not obtained during the course of field study; but on the basis of impressions it appears as if the average continuation rate could easily be as low as 2-3 months. It certainly can be argued that: 1) the program is only a year old and, therefore, the continuation rate could not possibly be high, 2) the drop-out rate for first-time users is usually high, and 3) most women family planning users typically experiment and start-stop before settling into a stable use pattern. Nevertheless, it is possible that the continuation rate here is unusually low, even taking these considerations into account. Keeping in mind that short-term use of the pill is known to increase fertility in some women it is possible that the program may have had the short-term effect of causing more births that it has prevented. This is not an argument for discontinuing the program, just that close attention should be paid to the quality of services that are being offered.

Although it is questionable whether referral of users to the MOH for pap smears and annual exams is synonymous with offering of "quality" family planning services, it is nevertheless now the contractual obligation of APROFAM to do so. Distributors are provided with referral coupons which their users are supposed to take to the nearby health post. No instance was found in which this had actually been done, in either the MOH or CBD segments of this study.

3. Obstacles/limitations to family planning services.

a) Social/cultural. Family planning is a topic about which, traditionally, men talk to men and women talk to women in the village. The number of situations in which such talk is appropriate is limited, even man-to-man, woman-to-woman. The present reliance on men and female Ladino distributors makes communication to the target population, Indian women, difficult.

The low level of literacy makes it difficult to find distributors and prepare education materials.

The Catholic church stridently opposes family planning in Quiché; but perhaps the church is more a rationale for not using family planning than the real reason. Quiché Indians have thoroughly demonstrated their capacity to ignore priests when they want to.

Despite the increasing popularity of the health promoter concept, it should also be taken into account that there are still many people who do not necessarily trust their neighbors. To many, a neighbor is the last, not the first, person to whom one would turn for advice on family planning. Use of a family planning methodology is usually kept a secret. A woman who does not regularly conceive is the object of gossip -- Is she infertile? or is she "doing something"? Therefore, many women would much prefer an impersonal relationship with a pharmacist or health post nurse.

b) Physical/geographic. The rural population in Quiché is exceptionally disperse; many settlements are of a non-nucleated type. It is not realistic that distributors will go far beyond their homes. In most cases, the opportunity cost in doing so is undoubtedly higher than the potential economic gain. Therefore, most distributors have access to only a very small pool of potential users.

c) Institutional. At the regional level, the program is more easily installed and operated if it makes use of a pre-existing institutional base, e.g., agricultural cooperatives. Unfortunately, most of the suitable institutions are either against or indifferent to family planning. Most do not have direct contact with the primary target population, rural Indian women.

The program requires an exceptionally high investment in supervision, training, and management, given the relatively small number of actual and potential users.

d) Economic. There is a high investment required for each distributor and a comparatively low potential user productivity. The present economic work incentive to the distributors -- 42¢ per month, on the average -- cannot be considered an adequate incentive to motivate the distributor to actually carry out those activities that APROFAM wishes. The level of social consciousness among village distributors may be higher but it is not much higher -- than that of APROFAM or AID professionals; i.e., they don't get paid. In a systematic review of 32 experiments that tested the use of a particular type of personnel in family planning delivery systems, Cuca and Pierce observed, "The most conclusive finding to emerge was that the recruitment of acceptors was most successful when workers were offered some incentive or bonus for each person recruited."⁴

⁴ Robert Cuca and Catherine Pierce. Experiments in Family Planning: Lessons from the Developing World, World Bank, 1977.

E. CONCLUSIONS AND RECOMMENDATIONS

In truth, the CBD project in Quiché can hardly be said to be more than an experiment. So far, the experiment has been slow to attract users and relatively expensive to install. Nevertheless, it is not fair to prematurely conclude that the experiment -- or at least the concept -- is a failure.

The problem at this point is not the low number of users but the low number of "the right" distributors. At present, the most basic principle of community-based distribution -- delivery of services by peers -- is not being fulfilled. What has been learned for certain from the experiment is that male agricultural cooperative leaders and 20-year old, under-employed males do not make good distributors of contraceptives to Indian women. What is not certain is whether adult rural Indian women, who are about 98% illiterate, can be recruited, motivated, and then trained to be distributors -- and then whether they will make good distributors.

RECOMMENDATIONS

1. Improvement of existing programs.

a. REVISE THE LIST OF PERSONS DISTRIBUTORS, AND UNLESS THERE IS A VERY GOOD REASON NOT TO DO SO, EXCLUDE THE YOUNGER MALES AND THE OLDER COOP LEADERS.

b. REMIND THE PROMOTER AND THE DISTRIBUTORS OF THEIR RESPONSIBILITY TO REFER USERS TO THE MOH FOR PERIODIC EXAMINATIONS.

2. Expansion of programs along present lines.

a. STARTING FROM SCRATCH, SYSTEMATICALLY DESIGN A TRAINING CURRICULUM ESPECIALLY FOR INDIAN WOMEN. DESIGN A TRAINING CURRICULUM FOR THEIR TRAINERS. THE CURRICULUM MUST NECESSARILY TAKE INTO ACCOUNT THE LOW LEVEL OF LITERACY AMONG WOMEN. CREATE A PILOT PROJECT WHICH CONSISTS OF ALL INDIAN WOMEN. THIS SHOULD BE DONE IN A DEPARTMENT WHERE THIS IS A WOMAN INDIAN PROMOTER. EXPAND THE CURRICULUM TO INCLUDE, IN ADDITION TO TRAINING IN FAMILY PLANNING, TRAINING IN NUTRITION, USE OF BASIC SIMPLE MEDICINES. SEVERAL AGENCIES; E.G., INCAP, BERHORST FOUNDATION, MIGHT BE CALLED UPON TO ASSIST IN THE DESIGN OF THE PROGRAM.

b. DEVELOP EDUCATIONAL MATERIALS WHICH WILL BE SUITABLE FOR USE IN THE INDIAN AREA. THIS PROJECT SHOULD EVALUATE THE POTENTIAL FOR SEVERAL KINDS OF MATERIALS; E.G., AUDIO CASSETTES, FLIP-CHARTS, PAMPHLETS, FILM STRIPS. PRODUCE, FIELDTEST, AND EVALUATE THE EFFECTIVENESS OF THESE MATERIALS.

c. EXAMINE THE FEASIBILITY OF AFFILIATING WITH ARTEXCO, A FEDERATION OF ARTISANAL COOPS, FOR AN INSTITUTIONAL BASE FOR A PROGRAM. THE ARTISANAL COOPS HAVE A MUCH HIGHER REPRESENTATION OF WOMEN AMONG THE MEMBERS THAN DO THE AGRICULTURAL COOPS. ALTHOUGH MANAGEMENT IS MOSTLY MALE, MANY LOCAL CHAPTERS ARE PREDOMINATELY FEMALE. ARTEXCO MAY BE ABLE TO PROVIDE AN INSTITUTIONAL BASIS WITH A BETTER REPRESENTATION OF WOMEN.

3. New Approaches.

a. RE-DESIGN THE PROGRAM SO THAT TWO DISTINCT TYPES OF DISTRIBUTORS EMERGE: COMMERCIAL DISTRIBUTORS AND FAMILY HEALTH DISTRIBUTORS. COMMERCIAL DISTRIBUTORS WILL BE PEOPLE (ESPECIALLY TIENDA OWNERS) WHO HAVE ACCESS TO FAIRLY DENSE SETTLEMENTS AND WILL TREAT CONTRACEPTIVES SIMPLY AS A SALEABLE ITEM. THESE PEOPLE WOULD BE PROVIDED WITH SALES ASSISTANCE RATHER THAN PUBLIC HEALTH TRAINING. IT IS HOPED THAT THESE PEOPLE WOULD BE A HUMAN INFRASTRUCTURAL BASIS FOR AN EVENTUAL PROGRAM IN PRIVATE COMMERCIAL DISTRIBUTIONS.

FAMILY HEALTH DISTRIBUTORS (PROMOTERS) WOULD HAVE THEIR ACTIVITIES DEFINED IN A MORE GENERAL PUBLIC HEALTH CONTEXT. WHEREVER POSSIBLE, THEY WOULD BE RECRUITED FROM PERSONS WHO ALREADY HAVE SOME PUBLIC HEALTH TRAINING, E.G., MOH VILLAGE HEALTH PROMOTERS. THEY WOULD BE ENCOURAGED IN THE USE OF SIMPLE MEDICINES AND IDENTIFICATION AND MEDICAL REFERRAL OF COMMON DISEASE SYNDROMES, I.E., NUTRITIONAL DEFICIENCIES, INFANT DEHYDRATION.

b. RE-DESIGN THE PROGRAM SO THAT IN PLACE OF A SINGLE DISTRIBUTOR THERE IS A NEW UNIT: A HUSBAND-WIFE TEAM. BOTH THE HUSBAND AND WIFE WOULD BE TRAINED AND EXPECTED TO WORK TOGETHER. THERE IS CONSIDERABLE CULTURAL BASIS FOR THIS SORT OF ARRANGEMENT. MOST INDIAN FAMILIES ARE UNIFIED ECONOMIC PRODUCTION UNITS. AN ADVANTAGE OF THIS ARRANGEMENT IS THAT THERE IS A RELATIVELY HIGHER LITERACY RATE AMONG INDIAN MEN: MEN AND WOMEN COULD MORE EASILY DISTRIBUTE THE RESPONSIBILITIES ACCORDING TO TRADITIONAL SEX ROLES AND EXPECTATIONS.

A REQUIREMENT OF THIS ARRANGEMENT WOULD BE THAT THE ECONOMIC INCENTIVES WOULD BE INCREASED. APROFAM WOULD HAVE TO CONSIDER AND EXPERIMENT WITH VARIOUS ALTERNATIVES.

SMALL SALARIES, BONUSES, OR "TRAVEL EXPENSES" MIGHT BE CONSIDERED. PERHAPS A CREDIT FUND, UNDERWRITTEN BY APROFAM, COULD BE ESTABLISHED FOR PARTICIPANTS. THIS COULD BE USED FOR FINANCING MOTORCYCLES, SMALL BUSINESS PURCHASES, AND MODERATE-PRICED HOUSEHOLD ITEMS.

VI. DELIVERY OF FAMILY PLANNING SERVICES BY PRIVATE VOLUNTARY HEALTH ORGANIZATIONS IN THE HIGHLANDS

A. INTRODUCTION

Health-related Private Voluntary Organizations (PVO's) play a significant role in the delivery of basic health services in rural Guatemala -- particularly in the Indian areas. For this reason the delivery of family planning services by PVO's was examined. Basic data was collected for 33 health facilities in the Highlands, with special attention paid to those facilities in the Department of Quiché.

B. BACKGROUND

For many years Guatemala has benefited from the presence of numerous private voluntary organizations that provide low-cost medical services, especially in the rural areas. Presently there are about 150 such organizations in the country.¹ About 77% of these (115) receive all or most of their funds from outside Guatemala (about half from the US). The largest of these operate about 50 clinics, 6 small hospitals, 21 training programs for health auxiliaries, and over a thousand food distribution and nutrition centers. Collectively, the PVO's spend about \$4.8 million annually on the direct provision of medical services and \$3.5 million for PL-480 food distribution.

The PVO's play an especially important and influential role in rural Guatemala. About 69% of their medical funds are spent in the rural area, where 78% of all PVO's and 84% of all PVO sites are located. The expenditure of the PVO's in rural areas represents nearly half (45%) of the total per capita expenditure in rural health.

The PVO's are especially involved in health care delivery in the Indian areas. Sixty-three percent of the total PVO expenditure is devoted to the Western Highlands. By comparison, 18% of the MOH budget for health is designated for the same geographic area.

In general, the PVO's have provided a type of medical care delivery which differs -- but is now being increasingly emulated -- by the MOH. The MOH has built a physical health care infrastructure, emanating from the urban areas. Its strength is in in-patient referral and specialized care. In

¹ Most of the statistical information contained in the Background section of this report is taken or derived from "Health-Related Private Voluntary Organizations in Guatemala", a study by Charles and Geraldine Keaty, Annex 5.8 of the Guatemala Health Sector Assessment, USAID, November, 1977.

contrast, the PVO's are decentralized. Typically, the PVO field site maintains a small technical staff, educated and financed from the outside, and a larger number of local people trained as auxiliary nurses or health promoters. Emphasis is on basic primary health care and improvement of environmental sanitation. This differing emphasis can be seen in the following chart, which shows distribution of staff among MOH and a sample of 42 HPVO's.

	<u>MD's</u>		<u>RN's</u>		<u>LPN's or auxiliary nurses</u>		<u>Health promoters</u>	
MOH	276	%	186	5%	1,284	36%	1,783	51%
42 HPVO's interviewed	24	2%	50	3%	83	5%	1,373	90%

As a result, the PVO's maintain a high patient productivity, as measured by patient visits:

	<u>Ambulatory care (inc. HPS & HCs)</u>	<u>In-patient facilities</u>	<u>Total facilities</u>	<u>Total patient visits annually</u>	<u>Patient visits/year/ facility</u>
MOH	629	37	666	831,000	1,248
Sample of 42 PVO's	50	6	56	649,694	11,602

Within recent years the MOH has greatly intensified its efforts in the rural areas, in large part through the encouragement and financial support of the major international lending institutions.

To a certain extent, these funds have been used to create and strengthen rural health programs which are based on the PVO model. They include the construction and equipping of dispersed rural health posts; the training and installation of a new middle level health paramedic, the Rural Health Technician; support for training of auxiliary nurses; and support for the training of village-level midwives and health promoters.

In the past, the PVO's have often served best where there have been no health programs by the MOH. Predictably, as the MOH expands its services in the rural areas, the PVO's may increasingly find themselves displaced -- or perhaps will shift toward the provision of more specialized medical services.

In the meantime, however, it is certain that the PVO's are at least as important in the rural (and especially indigenous) areas as is the MOH. PVO's invariably have good relations with the community. Volunteer workers

typically learn local languages -- or at a minimum, hire and train local people who speak them. Service, for the most part, is polite and personal. Although invariably underfinanced, the local site usually has control over its own budget and purchasing, and as a result, is undoubtedly more cost-effective than the highly political and bureaucratic MOH. The PVO's are usually more innovative and experimental in their approach to rural health than the MOH. In general, it appears that where MOH and PVO facilities exist side-by-side, the PVO's consistently attract a higher number of patients and serve them with fewer staff.

In Quiché the PVO's are especially important. For one thing, the PVO's are actually spending more on health in Quiché than the MOH -- the MOH Quiché budget for FY 1977 was \$386,297; the budget for the PVO's was probably in excess of \$500,000. Furthermore, the PVO patient load is probably considerably higher than that of the MOH.²

Given the importance of the PVO's in the area of rural health, it was obviously necessary to learn as much as possible about their activities in family planning in Quiché especially. Three assumptions were made at the onset as to why it would be particularly worthwhile to talk to the PVO's. First, the PVO leadership would include many Europeans and Americans who would very likely be sympathetic to the notion of family planning, and presumably, would have active family planning programs in their clinics. Second, the PVO's would have had experience in the challenging area of family planning education among the Indian population. And third, the PVO's would not be so sensitive to political winds as the MOH and might be viewed as an alternative family planning delivery system in the event of decreased support from the MOH.

C. METHODOLOGY

The findings and recommendations contained in this section of the report rely on: 1) a short family planning questionnaire intended for American nurses attending an annual training meeting (this questionnaire was also administered to several other PVO's in the Highlands); 2) a longer, more extensive questionnaire designed for Highlands PVO's that were known to have family planning programs; and 3) informal visits to several Highlands PVO sites.

The short questionnaire contained questions on the affiliation of the clinic, whether or not they offer family planning, attitude of the informant toward family planning, reasons why the clinic doesn't offer more family planning services. The longer questionnaire contained questions on the services and personnel of the clinic, type of family planning services, cost to patient, number of users by contraceptive type, number of users by Indian/Ladino, utilization and acceptance of services, contacts with and attitudes toward

²The Health Sector Assessment, citing a 1975 PVO study and 1975 MOH patient load data, estimates that about 93,000 patients were served by Quiché PVO's vs. 29,000 by the MOH. This 3:1 ratio probably does not hold true today because of the substantial expansion of MOH services during the past three years.

APROFAM, and suggestions for expansion of services by APROFAM.

Altogether, basic data was obtained for 33 health facilities. Twenty-seven are located in the Highlands. At least twenty-eight serve some or a majority Indian population. Twenty-six of the 33 health facilities are private; seven are Peace Corps nurses associated in some way with the MOH.

An effort was made to identify and interview all health related PVO's in Quiché. Altogether 8 non-Catholic PVO's were identified. Six of these were visited and interviewed. Information on the seventh (which does not offer family planning services) was obtained in Guatemala City. The eight small program operated in a remote northern aldea by two Bible translators, was not visited. The exact number of Catholic parroquial clinics could not be determined, mostly because some are not actually permanent clinics but 1-2 day a week health programs staffed by visiting nurses or doctors.

The sample of PVO's is by no means probabilistic. An effort was made to collect data on as many programs as possible. The approximate representativeness of the sample can be seen in the following comparison between the affiliation of all PVO's in Guatemala and that of PVO's in the sample.

	Guatemalan PVO's	(Non-Guatema- lan) Catholic PVO's	(Non-Guatema- lan) Protes- tant PVO's	(Non-Guatema- lan private, non-sectarian PVO's
In Guatemala, according to the Health Sector Assessment. n=150	23%	48%	13%	16%
In consultancy sample of PVO's. n=26 *	(1) 4%	(7) 27%	(10) 38%	(8) 31%

*Excludes Peace Corps nurses working in MOH

It should be noted that the Highlands area, where most of the interviews were done, probably has a higher proportion of Protestant missionary and private non-sectarian groups than does the country as a whole, which somewhat improves the actual representativeness of the consultancy sample. Nevertheless, there are several obvious biases. First, the sample over-represents American or American-affiliated organizations because of the initial contact with the American nurses training meeting. Second, the sample over-represents the larger, better know, better organized PVO's which were contacted with the assistance of ASECSA, the association of private voluntary organizations.

And third, the sample strongly under-represents Catholic organizations, because they were either not at the meeting or were not willing to fill out any questionnaire concerning family planning. In other words, the sample over-represents those PVO's that have or are likely to be sympathetic to family planning. The picture that emerges is not particularly encouraging to family planning; nevertheless, it is probably somewhat more positive than that which would have been obtained had the sample been more rigorously selected.

D. FINDINGS

The findings of this brief investigation were something of a surprise. In general, the PVO's were neither so active nor receptive to family planning as anticipated. Although individuals are consistently favorable to the concept of family planning, the political climate -- that is, the position of the MOH and the attitude that family planning is "American" or non-progressive -- greatly limits the degree to which the PVO's are willing to provide services.

Presently, most programs are stagnant. There are few experiments in preparing educational materials for Indians or in training health promoters.

There is an irony here: in general, the MOH does not support family planning, but it does it; the PVO's do support family planning, but they don't do it.

1. Personal attitude of respondents toward family planning. Of the 33 people responding to the interviews, all claimed to be in favor of family planning. Four qualified their support as "Billings or natural methods only", but none expressed indifference or opposition to the concept.

It should be noted that several persons received the questionnaire who did not respond. Several of these persons were Catholic nuns who undoubtedly did not respond precisely because of their opposition. Nevertheless, it should also be pointed out that 7 of the 33 respondents (22%) were Catholic nuns or lay missionaries.

2. Prevalence of family planning programs. Altogether, 25 of the 33 informants represent programs that provide some family planning. Of these 4 provide only Billings classes or instruction in other "natural methods". Eight do not provide family planning. Excluding the MOH Peace Corps/nurses, 18 of the 26 private programs (69%) include family planning or 53% excluding Billings/natural.

The breakdown by affiliation of clinic can be seen in the following table:

	<u>Guatemalan PVO's</u>	<u>Catholic</u>	<u>Protestant</u>	<u>Private non-sectarian</u>	<u>Peace Corps</u>	<u>TOTAL</u>
YES	0	3	7	4	7	21 (64%)
BILLINGS OR NATURAL ONLY	0	2	1	1	-	4 (12%)
NONE	1	2	2	3	-	8 (24%)
	1	7	10	8	7	33

Of the 7 who do not provide family planning, the following reasons were given:

- Catholics - Both for religious reasons
- Protestants - One because they had not yet been able to obtain an adequate supply of contraceptives; the other because they are new in the community and are trying to avoid conflict with the local priest.
- Private (including the Guatemalan group) - Because family planning services were available at the local health post; or because, as Americans, they wished to avoid the political onus of family planning.

3. Limitations to extension of family planning services. The reasons given in response to the question of why the clinic does not offer more family planning services than they presently do appears in the following table. (page 49)

To some extent, the response categories presented in the questionnaire were not fully adequate. The category, "religious reasons", for example, was sometimes interpreted to mean their own religious reasons but sometimes they referred to the religious reasons of the Catholics. Similarly, "political reasons" and "lack of acceptable contraceptive technique" were vague categories. "Lack of acceptable contraceptive technique" sometimes meant "religious reasons"; more often, however, it simply meant that when the pill doesn't require counting, people will use it; or, when injections have no side effects, people will accept them. Interestingly, the only category that received no responses was "you are opposed".

Many of the respondents elaborated upon their answers at length, in writing or in conversations. The following paragraphs summarize the major patterns that emerged as to why the clinics do not offer more family planning services than they do.

	<u>Catholics</u>	<u>Protestants</u>	<u>Private non-Denomination</u>	<u>Peace Corps</u>	<u>TOTAL RESPONSE</u>
Lack of acceptable contraceptive technique	2	1	3	2	10
Political reasons	2	1	5	-	8
Religious reasons	3	2	2	-	7
Very little or no demand	2	2	1	2	7
Your boss is opposed	1	2	3	-	6
Lack of resources, e.g., contraceptives, funds	-	2	2	-	4
Lack of trained personnel	-	1	2	1	4
<u>vergüenza</u> of women <u>macho</u> of husbands	-	-	-	2	2
Only provide services not available at health post	-	-	2	-	2
Opposition within the community itself	-	-	1	1	2
Against pressuring people	1	-	-	-	1
Program is just getting started. Have not yet fully begun offering services	-	-	-	1	1
Language barriers (people don't speak Spanish)	-	-	1	-	1
You are opposed	-	-	-	-	0

a) Catholics - The Catholic clinic personnel in this sample were clearly not opposed to the idea of family planning, but they did express disagreement on what constitutes a "sensible approach to family planning". Those interviewed tended to discuss the issue in terms of dangers to the woman's health rather than theological or moral terms. They simply do not believe the pill is safe. Two Maryknolls eloquently made the argument that birth control is no solution to poverty. In general, they were suspicious about what they viewed as the US excessive dedication to family planning. Three made the point that they do not believe the US, BID, and APROFAM, respectively, really favor personal voluntarism in family planning.

b) Protestants - For the most part, the Protestant missionary clinics are the group most active in family planning. Nurses, or those working at the village level tended to be very much in favor. Generally, they favor the pill (the one "lack of acceptable contraceptive technique" answer was given by a Menonite nurse, who was probably incorrectly classified in the Protestant group). Program administrators expressed concern about the political implications of a family planning program, e.g., that they might be criticized by "leftists" in the community. None of the group appeared to have established a reliable working relation with APROFAM. The largest program, which appears to be the second largest private clinic family planning program in the country, did not know that contraceptives could be inexpensively obtained from APROFAM.

c) Independent, non-denominational (including the one Guatemalan program) - The most surprising finding of the study is that the private non-denominational health projects, who are uniformly in favor of family planning and familiar with the technology, are presently not particularly active at the program level. Of the nine programs queried, none has a program which is high priority or actively in the midst of expansion. Berhorst clinic, the largest private program in the country, appears to have reduced its program by about half in the past year. Newer programs are tending to avoid family planning altogether. For the most part, the reasons are political: American programs feel vulnerable to criticism, they wish to maintain a low profile, and thus avoid the potential conflict which might be generated by an aggressive family planning program; or they simply believe that more equitable land and income distribution, not family planning, is the answer to the problems of the rural poor. Common attitudes are "it's better to let the Ministry of Health deal with that," or "we'll provide it if people ask, but it's not our priority".

d) Peace Corps - Seven of the eight Peace Corps nurses who were queried work in MOH programs. With the notorious "Bolivian experience" in mind, they have been advised by the local Peace Corps director to avoid involvement in family planning; therefore, they are involved only to the extent that the Ministry of Health supports family planning.

4. Experiments with teaching family planning in the communities and with educational materials. An important objective of the informal interviews with the PVO's was to learn what kinds of educational approaches have been developed for teaching Indian women about family planning. It turned out that there is very little. For the most part, the PVO's -- like the MOH -- rely on the doctor or nurse to individually explain family planning to the clinic patient. So far, Indian village-level health promoters have not shown themselves to be enthusiastic teachers of family planning. There are virtually no family planning educational materials in use which are specific to the Indian area.

Presently there are several projects underway by PVO's to develop basic materials on health and nutrition education. Only one nurse-educator was located who had actually gone so far as to attempt to develop materials specifically for family planning.

As she pointed out, it is a difficult undertaking because: 1) many Indian women do not understand spoken Spanish, 2) most do not read Spanish, much less read an Indian language, 3) preparation of audio or instructional materials is difficult since many of the languages/dialects are mutually unintelligible, 3) Indian women rarely make house-to-house social visits and there is little precedent for person-to-person educational campaigns (much less sufficient economic or social incentive to the educator), 5) Indian women are busy with domestic work and will not regularly attend classes whose immediate utility is unclear, 6) they will not attend public classes on themes of questionable sexual or religious morality, i.e., family planning, 7) they are not accustomed to and do not understand graphic abstractions such as cutaways of the human body or dream/speech bubbles, 8) they are easily offended by too-direct representation of sexual organs, 9) they enjoy seeing pictures, particularly of Indian women, but they are distracted by "errors" in hair braids or huipil design, 10) similarly, lines used for shading or to indicate clothing folds often confuse the eye not accustomed to print media, and 11) the family planning motivational theme that is probably most understandable to village women, i.e., the scarcity of land, is politically objectionable to many health programs and community leaders.

In short, there is considerable work to be done in developing family planning educational materials appropriate to Indian women. It hasn't yet been done by the PVO's.

5. Characteristics of active family planning programs. Altogether, the longer questionnaire was administered to eight active family planning programs (four in Quiché, four outside of Quiché). These included the two programs which are probably the largest private clinic programs in the country (Berhost Clinic, Chimaltenango, and the Central American Missionary Clinic in Nahualá). Two of the clinics are independent; six are Protestant Missionary clinics.

The clinics are well-established, with a mean number of nine years in Guatemala. They all provide basic primary medical care as well as health education. Five of the eight provide some dental care. Collectively they employ nine doctors, eleven graduate nurses, two last year students in medicine, one last year student in dentistry, twenty-four auxiliary nurses, fifty-seven health promoters, and various technicians in laboratory work, x-ray, dentistry, nutrition, family planning, and health education. Their monthly patient load ranges from 187 to 3,600 -- or a mean of 1,089 patients (587 per month, excluding Berhorst).

On the average, they have been offering some family planning for 5.8 years. In four of the eight clinics the doctor has primary responsibility for delivering family planning services. In four clinics the graduate or auxiliary nurse is also active. There is less reliance on community promoters or clinic trained personnel than might have been anticipated. Berhorst Clinic has a specially trained "family planning technician", a bilingual Cackchiquel Indian woman. She spends two days a week in the clinic and three days in the field. She reports that community promoters are not enthusiastic about family planning, and they discourage her from too active an involvement -- for fear of alienating community leaders and thus jeopardizing other program objectives. She reports that only six of fifty Berhorst trained health promoters are actively promoting family planning in their community work.

The cost of a general medical consultation at the clinics ranges from free to \$2.00. The cost of a cycle of pills ranges from 15c to \$1.00 (the high price, according to the administrator, reflects the high price that the clinic is charged by APROFAM). Excluding the highest price pills (\$1) from the sample, the mean price of pills sold at clinics is 20c. The mean price of IUD insertion is 37½¢; condoms, 3¢; a three month injection, \$1.50. Billings classes are free.

Seven of the eight clinics were able to report their number of users with reasonable accuracy. The range was 4-300; the total, 760; the mean, 109. Note, however, that this sample contains the two private clinics which probably have the largest number of users in the country. Of the 760 users reported, it is roughly estimated at 588 (77%) are Indian and 172 (23%) are Ladino.

Of the clinic users, 99.3% are women. Only five men users were reported. Overwhelmingly, the pills the most widely used method. Injections are popular, but high price and side effects limit their use. A few IUD's are in use; no creams, suppositories, diaphragms, or vaginal tablets were reported. Two of the clinics have made sterilizations referrals this year; one (the Evangelical clinic in Chichicastenango) has performed about a half dozen tubal ligations this year.

Six of the eight clinics report that their services are "under-utilized". Two report that they are at "about capacity". None are "stretched to their limits".

Questions on "attitude of the community" did not generate reliable data since, in reality, most communities are of divided opinion and informants tended to report their own opinions rather than the "communities". In general, however, the clinics reported that their programs were well accepted and there had been no major conflicts. The one exception was the public burning of APROFAM pamphlets in a Chimaltenango aldea (reported by the Berhorst family planning technician).

All the clinics were familiar with APROFAM; some more than others. Six had requested contraceptive supplies from APROFAM. For four of them APROFAM was the regular supplier. One had requested educational materials and one had requested training for an auxiliary nurse, neither of which were provided according to the informants. Two had successfully made laparoscopy referrals through APROFAM.

In general, the clinics were positive about the work that APROFAM is doing. Four reported that "they are doing good work" or that they are "OK". One felt that they were "OK" but were "too pushy" and "represented one-sided information". Three did not comment.

Responses to the question "further support desired from APROFAM?" included the following: none, for fear of causing political problems; cheaper contraceptives; information on the rhythm system; better information for both clinic personnel and users on side effects and contraindications; training for slightly older, married women to be family planning promoters in the communities; training present promoters ("distributors" in the rubric of the APROFAM CBD program) in group dynamics and community organizations; and more contact and work within local government structures.

6. Family planning programs in Quiché. Eight non-Catholic health programs were identified in Quiché. There are about eight or nine Catholic programs, although the exact number was not determined. A guess is that the Catholic programs maintain at least as many patients as do the non-Catholic programs -- probably many more. Where they exist, Catholic programs are well accepted and well utilized.

The Diocesan Priest in Quiché are of the Sacred Heart Order. Almost all are from Spain. They are a conservative order and are unusually adamant in their opposition to family planning. None of the Catholic health programs have formal family planning programs; nevertheless, there is still some support for the idea. Two Quiché priests who were interviewed during the study were openly and strongly in favor of family planning. One private non-denominational clinic reports that it regularly receives referrals from the nearby nuns ("although they never directly use the term family planning or advise the pill, they send them to us to see if we can help them").

Only four of the eight non-Catholic programs have family planning. Altogether, they maintain only about 187 users -- which is to say .3% of the female, fertile age population of Quiché.

Because the numbers are so small, it is probably more useful to present the findings from the Quiché private programs as "case studies" rather than in aggregate statistical form. These cases give a fairly good representation of the characteristics, problems, and attitudes toward family planning of the private voluntary health organizations -- not only in Quiché but throughout the Highlands.

Case 1: An Evangelical missionary clinic affiliated with a fundamentalist US church. They employ two full-time Guatemalan doctors and operate a growing 20-bed hospital. In addition, they operate a Mobile Clinic, in which the doctors travel by jeep and plane to 15 outlying aldeas, some of which also have clinic-trained auxiliaries in residence. The doctors are not enthusiastic about the use of health promoters; for the most part, they deliver medical services themselves, including family planning. Patients rarely come to the clinic specifically to request family planning; rather, the doctors recommend it when they think the medical or economic circumstances warrant it. The doctors have tried but have had little success with educational programs in family planning. According to the administrator, the high cost of contraceptives, which were obtained in one purchase from APROFAM, limits the scope of their program.

Case 2: An Evangelical missionary clinic, which is semi-autonomous but affiliated with the first clinic. The clinic is directed and primarily staffed by a Guatemala doctor, who is also a Quiché-speaking Indian and native of the area. Surprisingly, the clinic does not appear heavily utilized. The clinic has about 30 family planning users, about 25 of whom are Ladino. Pap smears are given at six-month intervals. The doctor is not particularly enthusiastic about family planning. He stressed that a formal program does not exist; services are simply provided to people who come requesting them.

Case 3: An Evangelical missionary clinic, also semi-autonomous but affiliated with the larger clinic. A local person has been trained by the larger clinic as an auxiliary nurse. He is supervised by an American registered nurse, who does not live in the town but visits it regularly. The Guatemalan doctor from the larger mission flies to the town about once a week. The clinic does not have an adequate and inexpensive supply of contraceptives. The nurse does not really have the time, interest, training, or materials to run an active family planning program.

Case 4: A small, non-denominational, very busy clinic. The core staff is local people who have been trained by French and US nurses. Hospitalization and some dental care are provided. Family planning has been an important issue in the clinic. The two French nurses and the young American woman who is administrator are very in favor of family planning. They initiated classes to Indian women in anatomy, reproduction, sex education, and family planning. Women were encouraged to attend, with or without their husband's consent. They also trained a local midwife in IUD insertion. Although the clinic is technically non-denominational and independent, most of the money that supports it comes from US Mormons. The US chairman of the clinic's board of directors visited the clinic recently and strongly objected to the

clinic's intense involvement in family planning. In the ensuing conflict the two French nurses were forced to leave. At present the clinic's family program is greatly reduced (8 or 9 pill users). The administrator, however, is planning to revive the program, despite the conflict that is sure to be generated.

Case 5: An independent, private clinic affiliated with a large international charitable organization that sponsors self-help and community development projects. The organization became involved in the community following the earthquake. The clinic does not want to get involved in family planning in order to avoid conflict with the local health post. Politically, the issue is too sensitive.

Case 6: A small clinic affiliated with a US church (but not a missionary clinic). The US doctor who operates this clinic has worked in Guatemala for several years. For his Guatemalan licensing, he was required by the MOH to do medical service in this town. Following this service he decided to open a clinic, to be affiliated with another clinic that the church operates in the lowlands. The doctor is interested and supportive of family planning, but he is even more concerned with gaining acceptance in the community. The parish priest is suspicious of Americans, particularly non-Catholic Americans. "To start a family planning program" says the doctor, "would be a bombshell. We have enough problems already."

Case 7: A tiny health program in a remote northern aldea operated by two American Bible translators. (This program was not visited directly; information was obtained second-hand in a nearby town.) It was not determined whether or not the two missionaries have formal medical training, but they are passing out medicines and handling medical emergencies in their home. Their concern is religion and primary medical care. It is doubtful that they are offering family planning services (however, missionaries belonging to the same group in another town are).

Case 8: An independent program affiliated with the Berhorst Clinic. The administrator is an American who has no medical school training, but for all practical purposes, is working as a doctor. He practices medicine, actively trains health promoters, and supports several agricultural projects. His wife, a Cackchiquel Indian, formerly operated the family planning program at Berhorst Clinic, Chimaltenango. Both are very much in favor of family planning; nevertheless, they do not offer family planning services. Instead, they strongly support family planning and refer patients to the nearby health center -- which does not appear to be otherwise particularly interested in family planning -- has the second highest MOH utilization rate in Quiché. Mostly, the clinic director is interested in avoiding conflicts with the health post. As an American and as a person practicing medicine without a license, he is in a vulnerable position in the community. It is safer for the clinic, he feels, to not be directly involved in family planning.

E. CONCLUSIONS AND RECOMMENDATIONS

The Private Voluntary Organizations are a small but potentially larger family planning delivery system. They offer an established, self-financed, locally, accepted, and actively functioning health delivery system that is particularly important in the Indian areas.

Unfortunately, the PVO's are not soliciting expanded family planning services from APROFAM. Family planning is not viewed by the PVO's as a high priority matter. They tend to view APROFAM somewhat as a tainted lady and are fearful of guilt by association.

On the other hand, the level of information and support for family planning among PVO clinic personnel is probably much higher than it is in the MOH; and the actual level of activity is probably not much worse.

A full-scale "PVO campaign" is certainly not justified; however, it would seem feasible that APROFAM devote a moderate amount of effort to encouraging the PVO's to increase their participation in family planning. The full potential of the PVO's is as yet still largely unexplored.

RECOMMENDATIONS

1. Immediate improvement of existing programs.

EXAMINE THE PRICES CHARGED PVO'S FOR CONTRACEPTIVES AND STANDARDIZE THE PRICING AND ORDERING PROCEDURES. PVO CONTRACEPTIVE PRICES SHOULD BE THE SAME AS MOH AND CBD PRICES.

2. Improvement of programs along present lines.

a. PREPARE A PAMPHLET FOR DISTRIBUTION TO PVO'S -- BUT ALSO AS A GENERAL PUBLIC RELATIONS TOOL -- WHICH DESCRIBES APROFAM IN TERMS OF THE FOLLOWING THEMES:

1) THAT IT IS THOROUGHLY COMMITTED TO THE PRINCIPLE OF COMPLETE VOLUNTARISM IN FAMILY PLANNING.

2) THAT IT VIEWS FAMILY PLANNING PRINCIPALLY AS A PUBLIC HEALTH QUESTION -- SPECIFICALLY, A PUBLIC HEALTH QUESTION CONCERNED WITH MATERNAL AND CHILD HEALTH. IT DOES NOT SUPPORT FAMILY PLANNING AS A MEANS OF POPULATION CONTROL OR AS AN ALTERNATIVE TO RURAL DEVELOPMENT.

3) APROFAM IS DEDICATED TO QUALITY, NOT QUANTITY OF SAFE AND HEALTH FAMILY PLANNING SERVICES.

4) APROFAM SUPPORTS AND PARTICIPATES IN VILLAGE-LEVEL HEALTH EDUCATION EFFORTS -- NOT ONLY IN FAMILY PLANNING BUT IN NUTRITION AND BASIC MATERNAL-CHILD CARE.

b. ENCOURAGE THE PVO'S TO BECOME INVOLVED IN EXISTING AND FUTURE APROFAM COMMITTEES AND PROJECTS, PARTICULARLY THE PREPARATION OF EDUCATIONAL MATERIALS.

c. A NEW IDEA. HIRE A STAFF MEMBER (FULL OR PART-TIME) WHO WILL HAVE SPECIFIC RESPONSIBILITY FOR PROMOTING AND COORDINATING ACTIVITIES CONCERNING THE PVO'S. IN SELECTING THE PERSON, IT IS STRONGLY ADVISED THAT A WOMAN BE CONSIDERED, PREFERABLY AN INDIAN WOMAN OR A WOMAN WHO HAS WORKED IN VOLUNTARY CATHOLIC HEALTH PROGRAMS. IT IS ESSENTIAL THAT THE PERSON BE ALREADY FAMILIAR WITH THE WORKINGS OF GUATEMALAN PVO'S. THIS POSITION WILL REQUIRE, ABOVE ALL, TACT. IN RECRUITING THIS PERSON IT IS SUGGESTED THAT APROFAM CONTACT THE ASSOCIATION OF PRIVATE VOLUNTARY ORGANIZATION, THE AMERICAN NURSES CONTINUING EDUCATION ASSOCIATION (OCEAN), AND CATHOLIC RELIEF SERVICES (CRS).

THE RESPONSIBILITIES OF THIS PERSON WOULD BE TO:

- a) PREPARE AN UP-TO-DATE LIST OF ALL HEALTH-RELATED PVO'S IN GUATEMALA.
- b) DETERMINE THE ATTITUDE OR POLICY OF EACH OF THESE PVO'S TO FAMILY PLANNING.
- c) ADVISE APROFAM ON CHANGES AND REQUIREMENT OF THE PVO'S.
- d) ESTABLISH PERSONAL CONTACTS WITH THE PVO'S. THIS WOULD ENTAIL REGULAR FIELD-TRIPS AS WELL AS VISITS TO OFFICES IN GUATEMALA CITY.
- e) WORK IN COLLABORATION WITH THE INFORMATION AND EDUCATION DIVISION OF APROFAM TO PREPARE EDUCATIONAL MATERIALS SPECIFIC TO THE NEEDS OF THE CATHOLIC HEALTH ORGANIZATIONS. IT IS FIRST NECESSARY TO REVIEW PRESENTLY EXISTING LITERATURE ON THE RHYTHM METHOD, BILLINGS SYSTEM, AND RESPONSIBLE PARENTHOOD.
- f) ESTABLISH A WORKING RELATIONSHIP WITH THE APROFAM CENTRAL SUPPLY WAREHOUSE (BODEGA CENTRAL) SO THAT ORDERS FOR CONTRACEPTIVES CAN BE HANDLED QUICKLY. THIS PERSON WOULD ACT AS THE ORDERING CONTACT AND THE EXPEDITER FOR THE PVO'S.
- g) ENCOURAGE THE PVO'S TO SEND PERSONNEL, PARTICULARLY VILLAGE HEALTH PROMOTERS AND NURSE AUXILIARIES, TO APROFAM TRAINING COURSES.
- h) SUPPLY HEALTH PROFESSIONALS WITH SCIENTIFIC AND TECHNICAL ARTICLES ON FAMILY PLANNING -- IN PARTICULAR, ARTICLES WHICH DISCUSS THE SAFETY OF CONTRACEPTIVE TECHNIQUES AND THE MEDICAL IMPLICATIONS OF UNWANTED PREGNANCIES.
- i) SUPPLY THE HEALTH CLINICS WITH EDUCATIONAL MATERIALS SUITABLE FOR HEALTH EDUCATION PROGRAMS AMONG THE RURAL, AND ESPECIALLY, INDIAN POPULATION.

COMPARISON OF FOUR FAMILY PLANNING DELIVERY SYSTEMS
IN THE DEPARTMENT OF QUICHE, GUATEMALA

PRIVATE COMMERCIAL DISTRIBUTION	DIRECT DISTRIBUTION THROUGH MINISTRY OF HEALTH	DISTRIBUTION THROUGH HEALTH RELATED VOLUNTARY ORGANIZATIONS	COMMUNITY BASED DISTRIBUTION																																												
A. SUMMARY DESCRIPTION OF DELIVERY SYSTEM																																															
<p>30 private rural pharmacies and 8 public municipal pharmacies sell about 50 different commercial brands of contraceptives. No contraceptives, modern sector or "folk", are sold in rural <u>tiendas</u> or Indian markets.</p>	<p>The MOH maintains 28 health posts and centers. 20 of them sell contraceptives supplied by APROFAM. 40% of the profit from the sale of contraceptives remains at the health post.</p>	<p>Health-related Private Voluntary Organizations locally spend more on health care than does the MOH. There are about 7 or 8 Catholic programs, 8 non-Catholic programs, and a missionary mobile clinic that services about 15 remote communities. Although the Catholic clinics do not have formal programs, there is some support for F.P. 4 of the 8 non-Catholic clinics provide F.P. services.</p>	<p>This is a program created and supported by APROFAM. One full-time "promoter" has recruited and supervises about 25 village-level volunteer "distributers". The majority of distributers were recommended by FECOAR, a federation of agricultural co-ops. They have received minimal training from APROFAM. They are responsible for locating, motivating, educating and supplying with contraceptives people in communities.</p>																																												
B. METHODOLOGY FOR COLLECTION OF DATA																																															
<p>Questionnaire administered to 23 of 30 private pharmacies and 5 of 8 municipal pharmacies.</p>	<p>Questionnaire to 15 of the 20 health posts which deliver family planning services.</p>	<p>Questionnaires administered to 27 PVO's in Guatemala and to 7 of the 8 local non-Catholic PVO's.</p>	<p>Questionnaires to all APROFAM promoters in Guatemala; to 23 of the 25 APROFAM distributers; and 25 of the 155 local users.</p>																																												
C. NUMBERS OF USERS																																															
<table border="0"> <tr> <td>Total:</td> <td>478</td> </tr> <tr> <td>(Priv.Pharm. 378)</td> <td></td> </tr> <tr> <td>(Munic.Pharm. 100)</td> <td></td> </tr> <tr> <td>Women</td> <td>83%</td> </tr> <tr> <td>Men</td> <td>17%</td> </tr> <tr> <td>Indians (Est.)</td> <td>50%</td> </tr> <tr> <td>Ladinos (Est.)</td> <td>50%</td> </tr> </table>	Total:	478	(Priv.Pharm. 378)		(Munic.Pharm. 100)		Women	83%	Men	17%	Indians (Est.)	50%	Ladinos (Est.)	50%	<table border="0"> <tr> <td>Total:</td> <td>610[±]</td> </tr> <tr> <td>Women</td> <td>98%</td> </tr> <tr> <td>Men</td> <td>2%</td> </tr> <tr> <td>Indians</td> <td>--</td> </tr> <tr> <td>Ladinos</td> <td>--</td> </tr> </table>	Total:	610 [±]	Women	98%	Men	2%	Indians	--	Ladinos	--	<table border="0"> <tr> <td>Total:</td> <td>166[±]</td> </tr> <tr> <td>Women</td> <td>100%</td> </tr> <tr> <td>Men</td> <td>0%</td> </tr> <tr> <td>Indians</td> <td>70%</td> </tr> <tr> <td>Ladinos</td> <td>30%</td> </tr> </table>	Total:	166 [±]	Women	100%	Men	0%	Indians	70%	Ladinos	30%	<table border="0"> <tr> <td>Total:</td> <td>155[±]</td> </tr> <tr> <td>Women</td> <td>62%</td> </tr> <tr> <td>Men</td> <td>38%</td> </tr> <tr> <td>Indians</td> <td>72%</td> </tr> <tr> <td>Ladinos</td> <td>28%</td> </tr> </table>	Total:	155 [±]	Women	62%	Men	38%	Indians	72%	Ladinos	28%
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COMPARISON OF FOUR FAMILY PLANNING DELIVERY SYSTEMS
IN THE DEPARTMENT OF QUICHE, GUATEMALA

(continued)

PRIVATE COMMERCIAL DISTRIBUTION	DIRECT DISTRIBUTION THROUGH MINISTRY OF HEALTH	DISTRIBUTION THROUGH HEALTH RELATED VOLUNTARY ORGANIZATIONS	COMMUNITY BASED DISTRIBUTION
D. COST OF CONTRACEPTIVES TO CONSUMERS			
<p><u>Private Pharm.:</u> Pills: \$1.08-\$3.10 (x\$2.00) Condoms: 5¢-40¢ (x19¢) Vaginal Tab: \$1.06-\$1.95 (x\$1.46) Injections: \$4.17-\$5.38 (x\$5.00) <u>Municipal Pharm.:</u> Pills: 15¢</p>	<p>Pills: 15¢ Condoms: 30¢/doz. Vaginal Tab: 75¢ --</p>	<p>Pills: 15¢-\$1.00 Condoms: 3¢ -- Injections: \$1.50/3mos. Billings classes: Free</p>	<p>Pills: 15¢ Condoms: 30¢/doz. Vaginal Tab: 75¢ --</p>
E. NUMBER OF YEARS IN DELIVERING FAMILY PLANNING SERVICES			
<p>--</p>	<p>6 yrs. Expansion in last year</p>	<p>8 yrs. delivery of health service 2.4 yrs. delivery of F.P. service</p>	<p>About one year.</p>
F. PERSONS DELIVERING FAMILY PLANNING SERVICES			
<p>Private and Municipal Pharmacists</p> <p><u>Private Pharmacists:</u> 23 were interviewed of which 20 were Ladinos and 3 were Indians. Four had attended the APROFAM 2-day training course.</p> <p><u>Municipal Pharmacists:</u> Five were interviewed - all were Ladinos. Two had attended the APROFAM training courses.</p>	<p>Auxiliary Nurses (DATA ON THOSE INTERVIEWED)</p> <p>14 Auxillary Nurses were interviewed - 11 women and 3 men - all were Ladinos. The mean age of the 14 individuals was 33 years. Education averaged 8.75 years and 11 had received at least one course from APROFAM. (The health post has, on the average, 1 physician or last year medical student, 3 RNs, 2 Auxiliary Nurses, 1 Rural Health Technician, 1 or 2 village midwives, and several village health promoters. Usually one Auxillary Nurse has 1 to 3% of her time devoted to F.P.)</p>	<p>Various (See Below)</p> <p>The Evangelical clinics rely on 2 physicians and a registered nurse. One independent non-denominal clinic relies on 2 foreign PNs who trained promotors and a local midwife. One private clinic refers all patients to the MOH. Several nuns are teaching the rhythm method or referring patients to the MOH.</p>	<p>Promoters and Distributors</p> <p><u>Promoters:</u> One promoter was interviewed. He was a 26 year old male Indian with 7 years of education. He had attended 3 APROFAM courses.</p> <p><u>Distributors:</u> 23 distributors were interviewed. 17 were male and 6 were female with a mean age of 28 years. 17 were Indians and 6 were Ladinos with an average education of 4 years. One had attended an APROFAM 2-day course.</p>

COMPARISON OF FOUR FAMILY PLANNING DELIVERY SYSTEMS
IN THE DEPARTMENT OF QUICHE, GUATEMALA

(continued)

PRIVATE COMMERCIAL DISTRIBUTION	DIRECT DISTRIBUTION THROUGH MINISTRY OF HEALTH	DISTRIBUTION THROUGH HEALTH RELATED VOLUNTARY ORGANIZATIONS	COMMUNITY BASED DISTRIBUTION
G. MOST EFFECTIVE WITH WHICH F.P. SERVICES?			
<p><u>Present Sales:</u> Pill: 50% Condoms: 21% Vaginal tablets: 21% Injections: 7%</p>	<p>98% of MOH acceptors are using the pill. Medical supervision of Pill and Pap smears - nurses are not trained in IUD insertion. TSR's and village health promoters are potential F.P. educators.</p>	<p>Pill: About 75% Injections: About 22% Tubal ligations: 3 to 4% Condoms, foam, tablets: non reported Rhythm method offered in Catholic clinics.</p>	<p>Pill: 45% Condoms: 38% Foam: 10% Vaginal tablets: 6% The continuation rate among CBD pill users appears very low. Some success with condoms and the "personal" female method, i.e., foam and vaginal tablets; undoubtedly because of non-clinical person-to-person methods.</p>
H. COSTS TO APROFAM			
<p>Direct costs: 2-day training program. Indirect costs: Radio campaign.</p>	<p>Program director's salary, secretarial support, and office overhead. Visitador Medico's salary and travel expenses. Training programs for MOH auxiliary nurses. Program planning and evaluation. Posters and pamphlets for health post. (Income from program - 60% of sales price of contraceptives.)</p>	<p>Slight office costs in handling supply of contraceptives. Training of several PVO auxiliaries.</p>	<p>Program director's salary, secretarial support, and office overhead. Field supervisors. Promoters salary. Training for promoters and distributors. Supplies, travel expenses, educational materials, films. Project planning and evaluation.</p>
I. APPROXIMATE COST PER USER			
<p>Negligible</p>	<p>High</p>	<p>Negligible</p>	<p>Very high</p>
J. SOCIAL RELATIONS AND INTERACTIONS WITH INDIAN POPULATION			
<p>Paternalistic. Rural pharmacies are generally family businesses that have operated in the communities for many years. Many rural pharmacists actually serve as "doctors". An impersonal but courteous economic relationship.</p>	<p>Paternalistic. Only 4 of the 15 auxiliary nurses interviewed speak some Quiché. Not usually a first-choice medical service. Rural Health Technicians and Village Health promoters are improving community relations. Busiest on market days. Low utilization by Indian men.</p>	<p>Catholic clinics are usually well accepted and heavily utilized by local population. Private non-Catholic clinics usually employ and train local people; they speak local languages; services are well utilized. Evangelical missionary clinics are well utilized, but distrusted by many because of religious conflict.</p>	<p>Almost all Indian distributors are well-known, well-respected community activists. Rural Ladino distributors are community residents who usually speak Quiché.</p>

COMPARISON OF FOUR FAMILY PLANNING DELIVERY SYSTEMS
IN THE DEPARTMENT OF QUICHÉ, GUATEMALA
(continued)

PRIVATE COMMERCIAL DISTRIBUTION	DIRECT DISTRIBUTION THROUGH MINISTRY OF HEALTH	DISTRIBUTION THROUGH HEALTH RELATED VOLUNTARY ORGANIZATIONS	COMMUNITY BASED DISTRIBUTION
J. SOCIAL RELATIONS AND INTERACTIONS WITH INDIAN POPULATION			
<p>Paternalistic. Rural pharmacies are generally family businesses that have operated in the communities for many years. Many rural pharmacists actually serve as "doctors". An impersonal but courteous economic relationship.</p>	<p>Paternalistic. Only 4 of the 15 auxiliary nurses interviewed speak some Quiché. Not usually a first-choice medical service. Rural Health Technicians and Village Health promoters are improving community relations. Busiest on market days. Low utilization by Indian men.</p>	<p>Catholic clinics are usually well accepted and heavily utilized by local population. Private non-Catholic clinics usually employ and train local people; they speak local languages; services are well utilized. Evangelical missionary clinics are well utilized, but distrusted by many because of Catholic-Evangelical religious conflict.</p>	<p>Almost all Indian distributors are well-known, well-respected community activists. Rural Ladino distributors are community residents who usually speak Quiché.</p>
K. MAJOR OBSTACLES OR LIMITATIONS TO EXPANSION OF FAMILY PLANNING SERVICES			
<p><u>Social/Cultural:</u> Indian women are reluctant to discuss or allude to sexual matters with strange men.</p> <p><u>Physical/Geographic:</u> Pharmacies are in cabeceras municipales, but all cabeceras are not necessarily Indian marketing centers.</p> <p><u>Institutional:</u> Pharmacies do not always have reliable stock of contraceptives. APROFAM has very little direct influence over pharmacies and drug companies may oppose APROFAM involvement in commercial sector.</p>	<p><u>Social/Cultural:</u> The health posts are not "culturally comfortable" place for most Indians, particularly men. Shyness of Indian women about submitting to gynecological exam; reluctance of Indian men to discuss sexual matters with Ladino women.</p> <p><u>Physical/Geographic:</u> Time/work loss.</p> <p><u>Institutional:</u> Support for F.P. in the rural health post will be no stronger than support for F.P. in the Ministry. (Auxiliary nurses will not actively continue F.P. if it is not supported at the Ministry level.) Most of the last year medical students oppose F.P. The supply system via the <u>visitor medico</u> is not fully in operation.</p>	<p><u>Social/Cultural:</u> Strong religious opposition to F.P. in most Catholic clinics and Evangelical clinics are distrusted by many Catholics.</p> <p><u>Physical/Geographic:</u> Small number of clinics for a large, disperse population.</p> <p><u>Institutional:</u> Although individuals are invariably in favor of F.P., private clinics sometimes do not support F.P. because they are concerned about their "image" in community or to avoid conflict with MOH.</p>	<p><u>Social/Cultural:</u> Community members do not necessarily trust and rely on their neighbors for help in medical and personal matters. Sexual matters are not openly discussed; it is considered improper for a woman to discuss such matters with a man not her husband, and vice versa.</p> <p><u>Physical/Geographic:</u> Most distributors have access to a relatively small pool of potential users. Neither social nor economic incentives are large enough to motivate them to go beyond their immediate communities.</p> <p><u>Institutional:</u> Distributors are recruited among "leaders" of the community. (Frequently, these are the people most against family planning.) Substantial motivation, training, and supervision is required by APROFAM.</p>

COMPARISON OF FOUR FAMILY PLANNING DELIVERY SYSTEMS
IN THE DEPARTMENT OF QUICHE, GUATEMALA
(continued)

PRIVATE COMMERCIAL DISTRIBUTION	DIRECT DISTRIBUTION THROUGH MINISTRY OF HEALTH	DISTRIBUTION THROUGH HEALTH RELATED VOLUNTARY ORGANIZATIONS	COMMUNITY BASED DISTRIBUTION
K. MAJOR OBSTACLES OR LIMITATIONS TO EXPANSION OF FAMILY PLANNING SERVICES (CONTINUED)			
<p><u>Economic:</u> Present price of commercial contraceptives is too high for most Indians. If the price were lowered, could create problems with pharmaceutical companies, and could create competition with MOH and CBD programs.</p>	<p><u>Economic:</u> Price of contraceptives is low enough to be affordable to the local population. Average "profit" from contraceptive sale is \$6.00 per health post this year.</p>	<p><u>Economic:</u> Programs are usually very under-financed and do not have adequate staff for F.P. High cost of contraceptives is also obstructive</p>	<p><u>Economic:</u> The cost to APFOFAM for this program is high; the economic incentives to village distributors are low (about 42¢/month income).</p>
L. FACTORS FAVORING EXPANSION OF FAMILY PLANNING			
<p>Pharmacists are uniformly in favor of F.P., are accepted as persons who know about personal and health matters, and are relatively well distributed spatially. The supply and sales infrastructure is presently in place. Training of pharmacists is relatively inexpensive. Condoms could probably be sold in rural <u>tiendas</u>, thus greatly increasing their accessibility.</p>	<p>Services of the MOH are expanding and improving. Health post/community relations are improving with the installation of the TSP and community health promoters. The auxiliary nurses appear to respond reasonably well to APFOFAM training. (To the extent that if there is <u>any</u> F.P. in the health posts, it is a result of APFOFAM training courses.) The TSR's appear favorable to F.P.; they may be able to promote family planning among men, who are otherwise not reached by the MOH, and village health promoters.</p>	<p>The personnel are invariably familiar with, and personally in favor of, F.P. There is a desire to have paramedical staff trained in health-related fields. Catholics in some clinics want information on the Billing's Method and rhythm system.</p>	<p>The distributors are members of the community, sensitive to community problems and attitudes. There is a strong desire for training in health, even if it includes F.P. Distributors can reach population groups, e.g., monolingual women, who do not go to health posts. Husbands and wives have informally started working as teams -- with women talking to other women, men talking to other men. The program is viewed positively by those who would otherwise criticize APFOFAM for "not caring about the communities or education".</p>

COMPARISON OF FOUR FAMILY PLANNING DELIVERY SYSTEMS
IN THE DEPARTMENT OF QUICHE, GUATEMALA

(continued)

PRIVATE COMMERCIAL DISTRIBUTION	DIRECT DISTRIBUTION THROUGH MINISTRY OF HEALTH	DISTRIBUTION THROUGH HEALTH RELATED VOLUNTARY ORGANIZATIONS	COMMUNITY BASED DISTRIBUTION
M. POSSIBLE APROFAM INTERVENTIONS			
<p>Radio campaigns that include mention of local pharmacies. Increased training of pharmacists in F.P., possibly through mobile training units. Educational materials for pharmacists. Educational materials for pharmacy clients. Visual materials (posters) for pharmacies. Introduction of an APROFAM low-price, mass-market brand-name pill and condom into pharmacies. Extension of brand-name condom to rural <u>tiendas</u> and Indian market places.</p>	<p>Continue rapprochement with the MOH. Extend the responsibilities of the medical visitor. Expand F.P. in TSR curriculum in training school at Quirigua. Include F.P. in auxiliary nurse training curriculum at Jutiapa. Provide educational materials designed for Indians for use at health post. Provide educational materials for the continuing education of health post personnel. Strengthen the system of on-going training of auxiliaries, possibly with multi-purpose mobile training units. Create a monthly APROFAM-DMIF newsletter for health posts and PVO's to: 1) publically reinforce the APROFAM-MOH tie, and 2) provide up-to-date information to field personnel.</p>	<p>A half-time or full-time person on APROFAM's staff to maintain regular contact with PVO's, handle PVO contraceptive purchases, facilitate and encourage requests for training, provide educational materials for patients, provide scientific, technical articles, and APROFAM-DMIF newsletter to staff. Prepare information on rhythm and Billings methods for use by Catholic program; explore possibility of work within Catholic organizations, e.g., Caritas. Encourage members of PVO's to participate in APROFAM committees and in project development, e.g., developing educational materials.</p>	<p>Increase the number of promoters/distributors. Increase training and follow-up training for promoter/distributors. Specialization of distributors into two types: Sales agent distributors and health-trained distributors. Increase training in use of simple medicines for "health" distributors. Husband-wife distributor teams in the Indian areas. Development of educational materials specific to the needs of the Indian areas. Increased involvement of Indian women in the program, e.g., recruitment of distributors through artisanal coops. Economic incentives to distributors, e.g., direct subsidies for user continuation, travel expenses, small salary.</p>