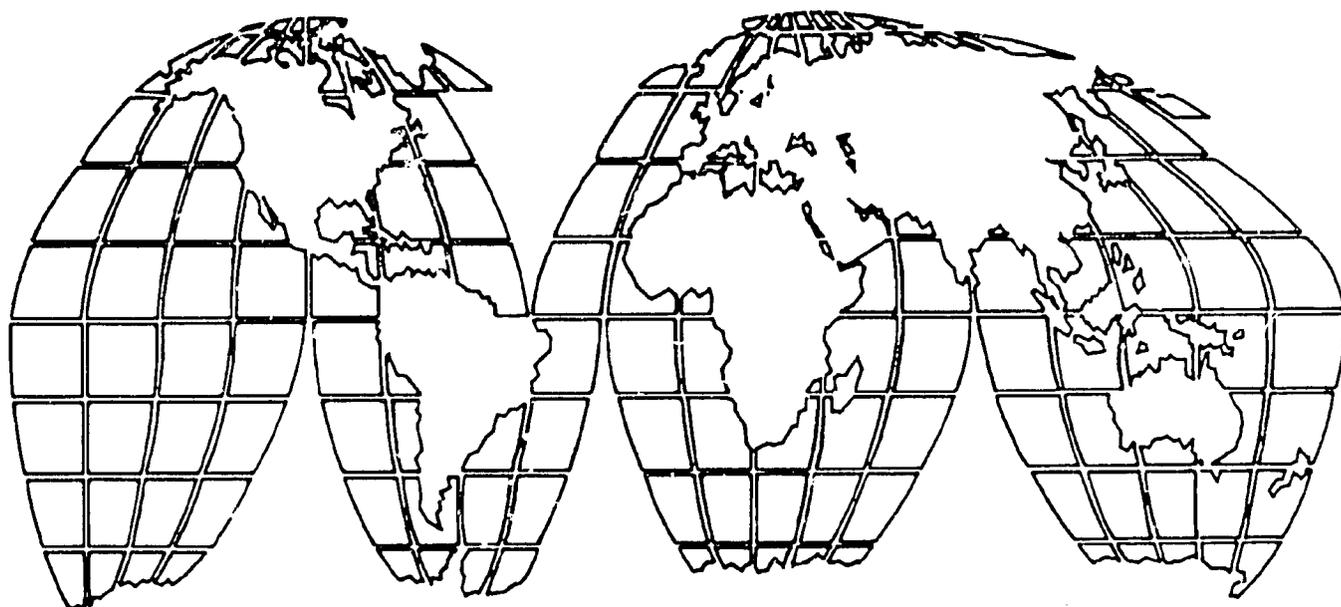

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Sustainability of U.S.-Supported Health, Population, and Nutrition Programs in Guatemala: A Review of Family Planning (1957-1987)



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Sustainability of U.S.-Supported Health, Population, and Nutrition Programs in Guatemala: A Review of Family Planning (1957-1987)

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1. OVERVIEW

The first family planning clinic was opened in Guatemala in 1965 by the Guatemalan Association for Family Welfare (APROFAM), a private affiliate of the International Planned Parenthood Federation (IPPF). A.I.D.'s first family planning project agreement was signed in 1967, and the Government of Guatemala began offering family planning services through the Ministry of Health in 1969. IPROFASA, a for-profit, private sector commercial retail sales program, began service to commercial outlets in June 1985. Another family organization receiving A.I.D. support in Guatemala is the Guatemalan Association for Family Life Education (AGES). AGES was founded in 1978 but did not begin receiving support from A.I.D. until 1985. A.I.D. assistance for family planning has continued uninterrupted up to the present. Table E-1 lists the A.I.D. projects through which family planning funds were channeled.

Table E-1. A.I.D. Projects That Provided Support for Family Planning Activities, 1967-Present

Year	Project No.	Project Title	Amount (dollars)
1967	520-0189	Population and Rural Health	2,642,246
1973	0189 extended	Population and Rural Health	2,171,754
1976	520-0237	Population and Family Planning	2,921,000
1980	520-0263	Integrated Family Planning Services	2,476,000
1983	520-0288	Family Planning Services	8,586,000
1987	0288 extended	Family Planning Services	3,434,000

2. PRIOR CONDITIONS AND PROJECT INPUTS

A.I.D.'s support for family planning projects developed out of concern over the high rate of natural population increase and the maternal and child health consequences of high rates of fertility, pregnancy, and illegal abortion. Although the Guatemala population was growing very rapidly in the mid-1960s, largely because of falling mortality rates, domestic support for family planning is overwhelmingly justified in terms of mother and child health and the right of couples to choose the number of children they wish to have, a right guaranteed by the Guatemalan Constitution of 1985.

The Government of Guatemala has never adopted a population policy, although the current administration of President Vinicio Cerezo has created an interministerial commission to develop a policy on population and development (USAID 1987 5). In view of the absence of a demographic rationale, A.I.D. has gradually adopted a strong family planning justification for its projects. Although fertility rates have dropped, population growth remains high due to decreases in mortality and relatively low rates of contraceptive use, even for Latin America.

A.I.D.-supported family planning activities in Guatemala have been implemented by both public and private agencies. Although the preferred mode for implementing family planning activities has been the Ministry of Health, political factors (discussed in Section 3.1) have frequently prevented effective public sector implementation of A.I.D.-supported family planning activities. APROFAM, a leader in the Guatemalan family planning movement, APROFAM, has been the most important and consistent recipient of A.I.D. funds for family planning.

The Ministry directly administered A.I.D. funds for family planning services from 1967 to 1975 when the USAID mission withdrew its support because of poor project performance (Project Appraisal Report, Project 0189, November 18, 1976). In 1979, the Ministry eliminated even APROFAM-supplied services from its facilities. Family planning services were resumed on a limited basis in 1982. Currently, the Ministry is directly responsible for supplying family planning services in 11 of the 23 health areas of the country, and APROFAM is responsible for the remainder. Officials from the Ministry, APROFAM, and A.I.D. agree that the program would be stronger if the Ministry were directly responsible for family planning throughout the country. The Cerezo government, with A.I.D. support, plans to implement full integration of family planning services.

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3. SUSTAINABILITY

Early A.I.D. Project Papers frequently implied that the sustainability of family planning projects in Guatemala was possible. For example, Project Revision Paper No. 1 (February 28, 1968) of the Population and Rural Health project states that "The project should be terminated in FY 1972 on the assumption that the Government of Guatemala and private sources will be responsible for all future costs." And a later project appraisal reports that by 1977 the Ministry would contribute 100 percent of recurrent costs. The Project Paper for the Population and Family Planning project predicted that by 1981, APROFAM would reach a cash flow level "sufficient to enable it to continue an expanded program without A.I.D. support."

Recent Project Papers have been more cautious and avoid a commitment to sustainability. The most recent paper, which proposes an extension of the Family Planning Services project, states that "Continued progress in the family planning sub-sector in Guatemala is ... considered to be highly unlikely without the solid and continuous presence of A.I.D. support" (A.I.D. 1987, 4). This perspective is entirely consistent with that of our informants, none of whom consider it realistic to believe that family planning could become self-sustaining in Guatemala, given the political climate.

Given the improbability of family planning projects achieving sustainability, the remaining task of this appendix is to explore why this is so and to assess how external assistance has contributed to the expansion of family planning in Guatemala.

4. CONTEXTUAL FACTORS

Contextual factors beyond the control of project designers and managers are important determinants of the fate of family planning projects in Guatemala. Although they set rather fixed parameters that cannot be manipulated, it is possible to fit effective, if not sustainable, projects within the Guatemalan context. The discussion in here is limited to those contextual factors that were discovered to have had a demonstrable effect on family planning projects.

4.1 Political Environment

There is little doubt that political factors play an important role in family planning projects in Guatemala and are the major reason for the nonsustainability of these projects. The documents we reviewed and the interviews we conducted are replete with references to the political controversy surrounding the issue of family planning and the impact of national politics on family planning initiatives, public or private.

The Guatemalan political system has been rather unstable over the period of U.S. assistance, particularly over the last decade, making consistency in public policy difficult to maintain. There is evidence in the project documents and from our interviews that family planning policy has suffered because of the instability of Guatemalan politics.

The nature of the Guatemalan regimes also impeded the development of strong and consistent family planning programs. For most of the period, the country was ruled by military leaders whose policies were often arbitrary. Our informants consistently reported that family planning policy, which experienced several abrupt shifts, reflected the personal views of the president and his minister of health rather than public preferences (which might have reflected the growing acceptance of family planning during the period) or the position of political parties.

In this context of arbitrary, unstable military rule, the full participation of various interest groups in politics and policymaking was impossible. However, several organized interests were influential in shaping family planning policy. All sources report that the Catholic church has been the principal force opposing policies favoring family planning. Although the Catholic church, which is stronger in Guatemala than in other Latin American countries, has consistently opposed family planning, the impact of its opposition has varied according to the response of the government in power, the personal actions of the local church hierarchy, and the position the Pope. The recently elected Christian Democratic government appears less vulnerable to church pressure and is going ahead with an expansion of family planning activities despite the outspoken opposition of the Archbishop.

Other active opponents of family planning have included a local right-to-life movement with strong U.S. ties, departments and professors in the national university, and others. The most important group supporting family planning is APROFAM. It conducts a variety of educational activities designed to gain acceptance of family planning among the public and to win the support of opinion makers. APROFAM activities have been particularly important in countering opposition to government family planning efforts, such as the particularly heated opposition that was waged in 1985-1986.

Given of the controversial, politicized nature of family planning in Guatemala, it is not surprising that the Government has been timid about embracing family planning programs. Under such conditions, it would be unrealistic to expect current family planning projects to be sustained without external financing. In fact, one informant argued that external financing is politically expedient since it deflects attention from local agencies to external donors. It also seems reasonable to expect that private nonprofit organizations such as APROFAM will continue to play important roles.

4.2 U.S.-Government of Guatemala Relations

We have hypothesized that the sustainability of health projects in Guatemala is affected by the relationship between the United States and Guatemala. Although there is no evidence to directly corroborate a relationship, there does seem to be a correlation between declining official support for family planning in the mid- and late 1970s and growing hostility between the United States and Guatemala over the issue of human rights. Also, there is some evidence to suggest that the U.S. ambassador, by taking a personal interest in the issue, offered some encouragement to local opponents of family planning in the 1985-1986 controversy, which eventually included a White House-appointed task force to investigate the local A.I.D. population program. Other variables in bilateral relations that need further investigation are the policies, personnel, and budgets of A.I.D./Washington and USAID/Guatemala.

4.3 Sociocultural Context

One sociocultural factor that clearly affects family planning programs in Guatemala is the presence of a large, nonintegrated indigenous population. If family planning services are to be effective, they must reach the 43 percent of the population that does not speak Spanish and that is culturally distinct from the dominant ladinos in a variety of ways relevant to family planning and health care delivery. The very low rates of contraceptive acceptance among the indigenous population indicate that family planning programs have not yet reached this population. Major obstacles to the eventual resolution of this problem include the failure of the health care system to penetrate indigenous communities and the high level of suspicion between the indigenous population and health care providers.

Another potentially important sociocultural factor is the growth of the rural wage labor force. This growth offers the possibility that large numbers of rural dwellers, who were previously in the subsistence sector, may now have access to the modern health care system and its family planning services.

4.4 Economic Context

Given Guatemala's low level of development, its precarious economic position, and the relatively weak fiscal position of the Government, the prospects for the Government's taking on an increasingly larger share of the cost of family planning are not good. A.I.D. has borne almost all of the direct cost of family family planning activities within the projects it supports, and the recently signed project extension does not contemplate a major change in this practice. The external nature of financing may insulate family planning programs from Government austerity programs and other shifts in budgetary priorities.

4.5 Private Sector

None of our informants seemed to feel that commercial firms will be able to make a major contribution to family planning, much less assume responsibility for it, unless their efforts are subsidized through a social marketing scheme. APROFAM, however, is and will continue to be a major force in the family planning movement, as both a provider and a promoter of family planning services.

4.6 Implementing Institution

The Ministry of Health has affected family planning projects in a number of ways. The Ministry's position on family planning has largely been determined by the incumbent minister, and turnover in this position has been frequent. Internal reorganizations and government health sector plans have also affected projects in the past.

4.7 National Commitment to Project Goals

Recent surveys indicate growing acceptance and practice of family planning among Guatemalans, at least in the ladino community. However, there is no evidence that progress in family planning acceptance among the population is reflected in a national consensus that support for family planning should be an official policy of the government. Perhaps a consensus will emerge under the newly inaugurated democratic government, but until it does, family planning projects are not sustainable without external assistance.

5. PROJECT CHARACTERISTIC FACTORS

In contrast with contextual factors, project characteristic factors are considered to be subject to greater control and manipulation by project designers and program managers in reaching project objectives. Since A.I.D. does not expect Guatemalan family planning programs to become sustainable and is continuing to fund these activities, characteristics of projects are reviewed in the context of reaching objectives. Since increased accessibility to family planning services has been the driving force behind A.I.D. support, this review focuses on those project characteristics that we found to have influenced the expansion of family planning programs.

5.1 Project Negotiation Process

Informants report that the of negotiation of family planning projects in Guatemala has been problematic and inconsistent because of its dependence on the personality and

negotiating skills of the A.I.D. population officer. The reduction in A.I.D.'s financial support to the Ministry of Health in 1975 because of dissatisfaction with Ministry implementation of family planning activities, as well as the Ministry's subsequent termination of all family activities in 1976, is evidence of a break down in negotiations.

The provision of family planning services through the Ministry of Health in Guatemala has been fundamentally an A.I.D.-initiated, A.I.D.-driven activity. The Ministry began offering family planning services in 1967 under a grant from the USAID Mission. Although there might have been consensus between the Ministry of Health and A.I.D. at the time the agreements were signed, Ministry performance and compliance with project agreements to expand services were adversely affected by the lack of internal consensus within the Ministry on offering contraceptives through the program, and by changes in key A.I.D. and ministry personnel. The Ministry program has for several years been limited to only 11 of the 24 health zones. Only recently has the Ministry demonstrated an interest in expanding its program to the remaining 13 health zones currently serviced by APROFAM.

In contrast, APROFAM initiated services 2 years before A.I.D. began supporting the agency. Both APROFAM and A.I.D. share similar global objectives, but they seem to have had differences of opinion regarding the direction and expansion of APROFAM's program, particularly to indigenous populations. These differences not seem to have affected A.I.D.'s support of APROFAM, however, which has been continuous since 1967. By and large APROFAM has complied with its agreements with A.I.D. and has achieved or surpassed objectives for expanding coverage.

A.I.D. has also provided support to IPROFASA and the Guatemalan Association for Family Life Education (AGES). Although motivated in part by A.I.D.'s increasing emphasis on private sector involvement, support for these agencies can be viewed, as an informant suggested, as providing options for increasing access to services when negotiations with traditional service delivery agencies did not lead to the desired consensus.

5.2 Institutional Organizational and Management Characteristics

A.I.D. funds have supported both fixed and recurrent costs as well as incentive payments to key service providers. This policy has led to friction within the Ministry of Health because the money has supported a privileged, vertical structure outside of normal Ministry channels. Because many Ministry health programs do not have adequate equipment, trained staff, and supplies, whereas family planning programs are well supplied, staff discontent and jealousies have developed. Given the general state of health service delivery through the Ministry of Health in the mid-1960s and the cost of supporting primary health care systems, A.I.D. may well have viewed the vertical structure of the Ministry family planning program as an effective and efficient way to expand access to these services. Despite the problems resulting from the privileged nature of the family planning program, informants insist that without this vertical structure, family planning services would not have been provided by the Government.

The stability and strength of APROFAM's leadership has enabled the agency to weather a severe attack from the right in 1986 and to survive in an often hostile environment. APROFAM's management was able to organize its defense through professionally executed media campaigns and technical presentations to policymakers on the implications of rapid population growth. At the same time, APROFAM's management has been able to incorporate changes into its program, such as widening the range of services offered, and to counter political attacks while adopting a strategy it had hoped would bring greater success in servicing indigenous populations.

AGES is headed by the same three people who founded the program. They provide stability and, perhaps more important, continuity to the AGES program. Because there is little in the sex education/family planning literature on successful methodologies for community work with indigenous groups, AGES has had to depend on its experience and trial and error to carry out its work and plan its future expansion, both of which depend on continuity provided by a stable, strong management. Ministry of Health family planning programs, however, have had neither strong leadership nor stable management because of the lack of political commitment to the program.

Guatemala today has a good base of experienced people who could become leaders in family planning if the political climate changes or who might at even be able to influence family planning policy. These people, according to one informant, received training under A.I.D. auspices through the projects reviewed in this case study.

5.3 Financing

Private family planning organizations have been encouraged for several years by donor agencies to assume increasingly greater fiscal responsibility for their program. For example, IPROFASA is expected to reach self-sufficiency while simultaneously expanding its program coverage. Although IPROFASA has not yet achieved that objective, it has recently surpassed the goal set for contraceptives sales (see Table E-2).

Both AGES, through the sale of sex education materials, and APROFAM, by charging fees for a range of maternal and child health services provided in its clinics, are attempting to increase their income. A.I.D. is providing technical assistance to help APROFAM identify strategies for generating income. Nevertheless, there is a consensus among informants that private family planning organizations in Guatemala will not be able to substantially recover costs. At a minimum, they will continue to rely on donations of contraceptive supplies.

APROFAM has conducted studies to identify cost-effective delivery strategies for expanding its services, particularly for its voluntary surgical contraception program. Cost per couple years of protection, a standard measure of the cost-effectiveness of family planning programs, is routinely used by IPPF affiliates as a management tool. Couple years of protection estimates for APROFAM's various service delivery programs are reported in the American Public Health Association's 1977-1979 assessment of the program. The assessment shows that APROFAM's program has been relatively cost-effective, mainly because of the relatively high proportion of sterilizations, which obviously provide significantly more years of contraceptive protection than do other methods.

Table E-2. Program Performance for the
Family Planning Services Project, 1983-1987

Activity	Scheduled		Actual Cumulative to Date (1987)	Percent of Scheduled Goal Achievement
	Goal	Cumulative to Date (1987)		
<u>APROFAM (520-0288)</u>				
Community Based Distribution				
New Acceptors	140,380	100,380	105,209	105.0
Continuing Acceptors	93,585	77,091	73,547	95.0
Home Visits	200,500	153,325	144,047	94.0
New Distribu- tion Posts	990	805	1,245	155.0
Training				
Persons Trained Completed Courses	3,811	2,575	3,292	128.0
	171	98	124	126.0
Education of Leaders (PIPOM)				
TV Spots Transmitted	22	26	25	96.0
<u>AGES (520-0288)</u>				
New Sites	11	4	4	100.0
No. of Persons Served ^a	288,840	22,700	33,653	148.0
Persons Trained	241	44	53	120.0
<u>I PROFASA (520-0288)</u>				
Product Sales	800	408	446	109.0
Couple-Years of Protection	27,700	19,700	24,411	124.0
Introduction of Other Family Planning Products	3	3	1	33.0
Outlets Supplied	1,300	640	742	116.0

Table E-2. Program Performance for the
Family Planning Services Project, 1983-1987 (cont.)

Activity	Scheduled		Actual Cumulative to Date (1987)	Percent of Scheduled Goal Achievement
	Goal	Cumulative to Date (1987)		
<u>Ministry of Health (520-0288)</u>				
Contraceptive Distribution to Health Centers and Posts				
Orals (cycles)	550,000	305,000	116,103	38.0
Condoms	630,000	325,000	161,931	50.0
Conceptual (tablets)	545,000	400,000	3,633	1.0
No. of Family Planning Training Courses for Minis- try Personnel	48	18	6	33.0
Health Areas Trans- ferred From APROFAM to Ministry	11	9	0	0.0

Note: PIPOM = Population Information for Policymakers.

^aReceived family life education material, participated in family life education activities, or received additional guidance.

Source: USAID/Guatemala 1987.

A.I.D. funding has covered two-thirds of the costs of the family planning projects reviewed in this study. Currently, A.I.D. finances over 95 percent of AGES's expenditures and 50 percent of APROFAM's program expenditures. IPPF funds another 20 percent of APROFAM's program, and the Association for Voluntary Surgical Contraception funds around 10 percent. Both AGES and APROFAM report that A.I.D.'s share represents a greater proportion of their budgets than in the past because of the Agency's increased interest in expanding family planning services to indigenous and rural populations.

With the incorporation of primary health care services into APROFAM's services during the last 4 years (e.g., oral rehydration therapy) and an increased emphasis on reaching indigenous populations, the costs of sustaining APROFAM's program will increase. Whether APROFAM's projects remain as cost-effective as in the past will depend largely on the acceptance of family planning by the target populations and the methods they elect to use. In addition, the kinds of systems (community-based delivery, clinical, social marketing) and delivery strategies (mobile units, house-to-house distribution) selected and the characteristics of subsystems (frequency of supervision and resupply systems) will affect how well APROFAM achieves its objectives and the costs of achieving them.

Although effectiveness and cost-effectiveness are important issues, USAID/Guatemala currently seems to be more concerned with coverage indicators (number of contraceptive users, types of contraceptives distributed, and use prevalence rates) than with cost-effectiveness. Perhaps as the family planning program matures, as it has in Colombia and Brazil, cost-effectiveness and quality of care issues will move to the forefront of A.I.D.'s concerns.

5.4 Project Content Aspects

A.I.D. family planning projects in Guatemala are designed to increase access to family planning services by providing support to a number of institutions in the private and public sectors. This strategy helps insulate project objectives from the influence of uncontrollable contextual factors. These projects are vertically organized, and in the case of Ministry-implemented activities, the projects are managed by personnel outside the normal Ministry structure, whose positions are funded by A.I.D. Project objectives are fairly simple and clearly stated in projects documents. Project designs promote a variety of delivery systems, such as community-based and clinic-based service delivery, which permits service providers to offer a wide range of family planning methods.

APROFAM has supplied Ministry health posts and health centers with contraceptives for several years. A.I.D. has conducted assessments of the logistics systems of APROFAM and the Ministry of Health. A.I.D. has also funded technical assistance to help APROFAM establish an efficient and effective logistics system and to improve its program management and service delivery. Technical assistance has also been provided to the Ministry of Health, but with mixed success. The personalities of technical assistance providers and A.I.D. population officers have played an important role in Ministry acceptance of assistance.

Training is a noteworthy and well-funded component of A.I.D.-supported population projects. Its goal has been to enhance local technical and managerial capability to administer family planning programs. A wide range of professionals and paraprofessionals have received training over the years, including medical doctors and secondary school teachers. Some recipients have been trained abroad (in the United States or Columbia) in fields such as contraceptive technology and demography. Information was unavailable on the total number of people trained under A.I.D. projects since 1965 or on the number of people who have continued to work in the field of population after receiving training.

5.5 Project Effectiveness

The primary objective of A.I.D.-funded family planning projects in Guatemala has been to expand service delivery so that all couples who desire to plan their families will have access to contraceptive information and methods, thus also reducing the high rates of population growth, abortion, and infant mortality. A.I.D. funds have clearly enabled the number of service delivery organizations to increase. Furthermore, because of A.I.D. importation of contraceptives, the availability of contraceptives has remained steady.

Since A.I.D. began funding family planning programs in 1965, some modest demographic changes have occurred in Guatemala. The total fertility rate (the average number of children a average woman will have over her reproductive life) has declined from 6.85 to 5.17. The rate of natural population increase has dropped from over 3.0 to 2.9 percent per year. Infant mortality is estimated to be 68 per 1,000 live births, down from 144 deaths per 1,000 live births in the period 1960-1965. Abortion, although underreported, was the primary cause (about half) of maternal deaths in 1977 (USAID/Guatemala 1987); by 1983, it had dropped to second place. Contraceptives are being used by 25 percent of women in conjugal union who are between 15 and 44 years old, with a much higher rate among urban ladino women (for example, in Guatemala City, 50 percent of women in conjugal union are planning their families). A national demographic and health survey will soon be carried out in Guatemala, which will inform Government and donor agencies of demographic trends since the 1983 survey.

A.I.D. Project Evaluation Summaries show that A.I.D. has been generally satisfied with the family planning projects, but would like more to be done to expand service availability. Coverage and training goals have frequently been surpassed in

these A.I.D.-supported projects, as shown in Table E-2, although it is not clear how these targets were set or how they relate to overall coverage objectives.

6. SUMMARY AND CONCLUSION

Over the years, A.I.D.-supported family planning projects in Guatemala have trained hundreds of health professionals and paraprofessionals in family planning. Four APROFAM clinics built with A.I.D. funds continue to function today, and thousands of pamphlets and other educational materials have been or are being designed, printed, and distributed throughout the country on sex education, responsible parenthood, Acquired Immune Deficiency Syndrome (AIDS), contraceptives, and other related subjects. With A.I.D. management information systems have been developed and new management techniques and administrative procedures have been introduced to family planning organizations in the country. Demographic and other socioeconomic research has been conducted in Guatemala, providing valuable information for health and family planning decision-makers. Another element of A.I.D. support, though less tangible, is the constant promotion of expanded services to indigenous populations as an effective health intervention to reduce infant and maternal morbidity and mortality rates.

Given the highly politicized nature of family planning in Guatemala and the lack of a national consensus in support of an official program, the prospects for significant project sustainability in this area in the event that A.I.D. funding is terminated appear nonexistent. Nonetheless, there are some positive signs. The Ministry of Health is about to expand its program to provide services in the 13 health zones currently covered only by APROFAM. The pattern of A.I.D. funding of Ministry projects has also changed from one of almost complete coverage of all recurrent costs, including personnel incentive payments, to one covering mainly supervisory-related costs, such as transportation and per diem expenses for supervisory visits to the 11 health zones serviced by the Ministry program. Two informants believe that the Ministry of Health could sustain a family planning activity as part of its maternal and child health program with little or no reliance on A.I.D., providing political and other contextual factors were more favorable. Under those circumstances, other donors would supply contraceptives, since they are not manufactured in-Guatemala.

Private voluntary organizations such as APROFAM might be able to reach some level of self-sufficiency in the future through the adoption of viable cost-recovery schemes. However, since the purpose of such organizations is to reach underserved,

poor populations, it is not reasonable to expect cost-recovery schemes to contribute much. Commercial retail sales programs, such as that of IPROFASA, can become virtually self-sustaining as long as commodities are donated. However, commercial programs can become subject to unexpected government import restrictions or price controls, which could undermine their self-sufficiency.