

**The Stymied Contraceptive Revolution  
in Guatemala**

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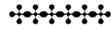
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# **The Stymied Contraceptive Revolution in Guatemala**

**By:**

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**Abstract**

Guatemala has the second lowest contraceptive prevalence (38 percent) of any country in Latin America, despite the active program of the private family planning program for over 30 years. This article analyzes the reasons for the low level of acceptance of family planning in terms of demand for children and supply of family planning services. The leftist movements of the 1960s and early 1970s set the stage for an unfavorable political climate, and to this day the major university in the country has resisted training doctors and nurses in contraceptive service delivery. However, the three primary reasons for Guatemala's low contraceptive prevalence are the ethnic composition of the population, the civil unrest that peaked in the 1980s, and the pervasive influence of the Catholic Church. Catholicism *per se* does not present an insurmountable obstacle to family planning unless Church and State unite in their opposition, which has been the case in Guatemala over much of the past three decades. Despite these obstacles, family planning groups persevered in their efforts to promote family planning. The authors conclude on a note of guarded optimism for family planning acceptance in the future.

## The Stymied Contraceptive Revolution in Guatemala

### I. Overview

Over the past three decades the contraceptive revolution has taken hold firmly in the majority of Latin American countries. Birth rates have dropped from an average of 6 children in the 1960s to 2.9 in the late 1990s. Contraceptive use has edged up steadily, to the point where a number of Latin countries have a contraceptive prevalence level approaching that of the United States (75%). This list includes Brazil (77%), Costa Rica (75%), Colombia (72%), Mexico (65%), Peru (64%) and the Dominican Republic (64%); (Population Reference Bureau, 1999). By contrast, Guatemala has not kept pace with other Latin American countries, even its neighbors in Central America, despite the efforts of an active family planning (FP) association for over 30 years (see Figure 1).

Family planning began in Guatemala as it did in many Latin American countries: as a response of a group of concerned physicians, nurses, sociologists, and social workers to unwanted pregnancy. In Guatemala, the most alarming sign of this trend was clandestine abortion, which resulted in serious health problems and in some cases death to women, many of whom were high parity, low income, and desperate to prevent another birth (Martinez, 1963; Santiso, 1964; Santiso, 1966). This interest in the health and welfare of individual women and their families coincided with burgeoning awareness over rapid population growth in developing countries worldwide. In 1964 this small group of concerned health professionals organized as an affiliate of the International Planned Parenthood Federation (IPPF) under the name of the Asociación ProBienestar de la

Familiar<sup>1</sup> (APROFAM). The first APROFAM clinic opened in Guatemala City in 1965. The key events related to family planning in Guatemala since that time are summarized in Table 1.

This scenario was not unlike the start-up of family planning in other Latin American countries. Yet as contraceptive prevalence progressed steadily upwards and birthrates dropped for Latin America as a whole, Guatemala traveled a different road. At present, its contraceptive prevalence of 38 percent (INE, 1999) is the second lowest in Latin America, trailed only by Haiti at 18 percent (Population Reference Bureau, 1999). This article examines the multiple reasons that family planning has not had the same dramatic success in Guatemala as in other Latin countries.

## **II. Supply and Demand: Factors that Explain the Effectiveness of FP Programs**

In the early days of the international FP movement (the 1960s), there was relatively little variation among developing countries in their levels of fertility and contraceptive prevalence. With a few notable exceptions, fertility was “high” (total fertility rates of 6 or more children per woman), and contraceptive prevalence—although rarely measured systematically—was presumed to be “low” (under 10 percent); (Bongaarts et al. 1990). However, that situation has changed dramatically over the past 30-40 years; currently, fertility and contraceptive use vary markedly by country, even within the same region of the developing world. What explains these differences?

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<sup>1</sup> Translated: the Association of Family Well-being

Much of the early work (1960s and 1970s) on the determinants of fertility focused heavily on “demand” variables, that is, the social, economic, political, and cultural factors that influenced desired family size. In 1983 Easterlin summarized the work to date in a “synthesis framework” that traced the influence of modernization and cultural factors on the supply and demand for children, which in turn influenced the “proximate determinants” (including deliberate fertility control) and ultimately number of children ever born.

In the 1980s, the role of programs became more prominent. Although it was widely recognized that structural factors (e.g., socio-economic conditions, levels of education, urbanization, etc.) were a key determinant of fertility, there was growing awareness of the role of family planning programs in influencing fertility. Specifically, FP programs were seen to play at least two key functions: to provide the means for pregnancy prevention to couples already motivated to space or limit births, and to influence the social norms on family size. The volume commissioned by the National Research Council on family planning effectiveness (Lapham and Simmons, 1987) emphasized that family planning programs have an effect on contraceptive use and fertility independent of the effect of social or economic development. Figure 2 depicts the parallel roles of demand for children on one hand and the policies and programs designed to reduce fertility (otherwise known as the family planning supply environment) on the other, as determinants of contraceptive use and levels of fertility.

Guatemala is a textbook case for illustrating the influence of structural factors on the demand for children and on the family planning service environment. Certain of the factors that impede progress in Guatemala are common to developing countries around the world: widespread poverty, relatively high rates of infant mortality, and low status of women, to name a few. Yet there are three aspects of the “general environment” that are particular to Guatemala: the ethnic composition of the population, the political violence that ravaged the country during the 1980s, and the pervasive influence of the Catholic Church. This article explores how the constellation of these three factors has worked against family planning in a way that is unique to this one country. The double arrow in Figure 2 that connects “social and economic factors” to “political-administrative systems” translates into a powerful linkage between Church and State that has persisted over the past 35 years to the detriment of contraceptive service delivery and practice in this country.

### **III. Background**

#### **A. Population Size and Composition**

The population of Guatemala is 12.3 million (PRB 1999). It is growing at a rate of 2.9 percent per year and even higher (4 percent a year) in major urban areas due to migration from rural areas. Close to two-thirds of the people live in rural areas, and of this group 80 percent live in settlements of fewer than 500 inhabitants (PAHO, 1998).

Guatemala is composed of two primary groups: the Mayans and the *ladinos*. The Mayans, constituting some 40-60 percent<sup>2</sup> of the total population, are descendents from the ancient Mayan civilians of Central America. *Ladino* is the term used to describe the Spanish-speaking majority that has occupied positions of influence and power since colonial times. In common usage, “*ladino*” simply means non-Indian. It includes a small Caucasian elite, a large *mestizo* sector, and those Indians who no longer wear *traje* (traditional dress), speak a native language, or consciously identify themselves as indigenous people (Barry, 1992). Although the term Mayan is used to describe the indigenous population of Guatemala, in fact there are at least 22 different Mayan linguistic groups, many of which are mutually unintelligible. Approximately one-third of the indigenous population speaks only a Mayan language (PAHO, 1998).

## **B. Type of government**

Contemporary political history of Guatemala begins with the overthrow of the Ubico dictatorship in 1944, followed by an unusual period of experimentation with democracy, social reforms, and economic modernization. This period ended abruptly a decade later in 1954 with a violent coup—supported by the CIA, right wing politicians, the Catholic hierarchy, and the oligarchy—which ushered in the 30 years of military control, guided by an ideology of anti-communism and national security (Barry, 1992). The military governed the country from 1954-86 (with one exception), gaining international notoriety (or infamy) for its role in suppressing guerilla movements that began in the mid-1960s

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<sup>2</sup> It has proven extremely difficult to establish an exact percentage of the population that is Mayan, given the difficulty of defining “Mayan” (indigenous) in a census or survey. The Mayan-*ladino* distinction is cultural rather than racial; one cannot classify a person as “indigenous” based on physical appearance alone.

and lasted into the 1990s. This period of *la violencia* resulted in the massacre of tens of thousands of peasants and the disappearance of entire villages in the highlands (Enge and Martinez-Enge, 1993).

The elections of 1985 brought the civilian government of Vinicio Cerezo to power. Many Guatemalans hoped for social and economic progress under this new administration. Instead, they encountered unprecedented inflation, cuts in social services, eroded purchasing power, and amplified concentration of wealth and land. Disillusionment set in over corruption, collaboration with the military, human rights violations, exacerbated poverty, and expanded guerilla activity (Barry, 1992).

In 1991, Guatemala experienced the first transfer of power between elected civilian officials in four decades. During the administration of President Jorge Serrano (1991-93), structural adjustment programs bolstered some economic indicators, but created further economic hardship for the poor. Promises in “social investment” were never realized. In 1993 Serrano was forced to step down after he attempted to dissolve Congress and the Supreme Court. Congress elected Lic. Ramiro de Leon as provisional President. He remained in office for three years, during which time he established the groundwork for the Peace Accords with the guerillas.

In January 1996 President Alvaro Arzú assumed power, and in December of the same year he signed the historic Peace Accords. There was widespread hope that the Peace Accord would bring a new era to Guatemala, with a major investment of funds in

improving socio-economic conditions: health, education, employment, housing. During this administration, the government privatized key industries, including telecommunications, utilities, and the railroad. It conducted major reconstruction projects of highways, health centers, and schools. However, Guatemala experienced a severe economic crisis, consistent with the international economic crisis, resulting in high levels of unemployment. By the time of elections in late 1999, only half of the agenda outlined in the Peace Accords had been accomplished. Arzú's party was not able to retain power, and as of January 2000 the new government of President Alfonso Portillo took over.

Between the time that APROFAM opened its first clinic and the present day, there have been 11 presidencies and three coup d'états, reflective of political instability that is a reality in Guatemala.

### **C. Levels of living**

Guatemala has a per capita GNP of approximately \$1500, below that of Costa Rica, Belize and El Salvador, but above that of Honduras and Nicaragua (World Bank, 2000). However, as Enge and Martinez-Enge (1993) report, "by any measure, its population...continues to be among the most ill-fed, uneducated, and unhealthy in the region." Seventy percent of the population lives in poverty. Total unemployment has remained steady at around 37 percent. A third of the adult population is illiterate (PAHO, 1998). There is a dramatic inequality on the distribution of income, which accounts for the high illiteracy rates, poor health conditions, and desperate poverty (Enge and Martinez-Enge, 1993).

#### **IV. Factors that have Affected the Supply of and Demand for Contraception**

While other Latin countries worry about problems of sufficient access to contraception and quality of services available to interested FP clients, Guatemala continues to wrestle with much more fundamental problems that affect both the demand for children (and thus the demand for contraception) and the supply of family planning services. Three factors are key in understanding the dynamics of family planning in Guatemala: the ethnic composition of the population, the political violence of the 1980s, and the pervasive influence of the Catholic Church. Taken alone, none is unique to Guatemala. Four other Latin countries—Bolivia, Ecuador, Mexico, and Peru—have sizable indigenous populations (Terborgh et al., 1995). El Salvador and Nicaragua also experienced bloody civil wars during the 1980s. Bolivia is another country in which the close relationship between Church and State has worked to the detriment of family planning. Yet it is the convergence of these three factors within a single country that has stymied family planning acceptance in Guatemala. A fourth impediment—the staunchly conservative position of the major local university—might be relegated to a historical footnote, were it not for its deleterious effect over time on the human resource pool. The situation at the Universidad de San Carlos three decades ago set the tone for what was to follow.

##### **A. Left Movements in Latin America and the Universidad de San Carlos**

The late 1960s and 1970s was a decisive period for the development and expansion of family planning programs in many Latin American countries. Without exception, governments were driven by the desire for social and economic development; debate

abounded on how best to achieve it. Conference, seminars, and other structured dialogue focused on the role of rapid population growth in socio-economic development. International development agencies (notably USAID and UNFPA<sup>3</sup>) and private foundations (e.g., Ford and Rockefeller) were eager to sponsor conferences that promoted this dialogue and to support pilot efforts to experiment with FP service delivery (Harkavy, 1995).

The “Western” position—that slowing population growth is advantageous to socio-economic development—was strongly opposed by leftist groups throughout Latin America and elsewhere. In Guatemala, the nucleus of opposition emanated from the Universidad de San Carlos, the leading university in the country. Family planning was seen as part of an imperialistic plot by the United States to “control the masses” of its developing country neighbors. Moreover, it was viewed as counterproductive to revolutionary goals, if it substituted for more sweeping social and economic reforms such as redistribution of land and income to the needy (Dept. of State/USAID, 1980).

The Universidad de San Carlos has played a determining role in its opposition to family planning that has left traces on the program even to the present day. In the early years of family planning, the San Carlos remained categorically opposed to any investigation related to contraception; moreover, it refused to incorporate into its curriculum any of the evidence of the benefits of birth spacing for maternal child health. One manifestation of this extremist position related to promotion procedures; professors in the School of

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<sup>3</sup> United States Agency for International Development, and the United Nations Fund for Population Activities, subsequently renamed the United Nations Population Fund.

Medicine being reviewed for promotion had to submit to questions on their views toward family planning, which affected the outcome of the decision. In short, the leftist movements in Central America considered demographic pressure to be a desirable condition to bring revolution to a head.

The leftist opposition to family planning was considerably weakened by a series of events in the 1970s and 1980s. Russia changed its view toward birth control and began promoting family planning. In 1979 China announced its one-child policy in an effort to curb population growth. Cuba authorized abortion on demand for social, economic, and health reasons. Leftist ideologues were forced to abandon their systematic opposition to family planning but they continued to insist that it was not the solution for socio-economic development of the country.

The opposition from San Carlos had profound effects of the evolution of family planning at two levels. First, it reinforced the position of the government in strong opposition to family planning efforts. Second, it hindered the development of a cadre of doctors and nurses with the knowledge and skills to provide contraceptive services. The dearth of clinicians with appropriate training has resulted in significant medical barriers: clinicians have outdated knowledge of contraceptive technology, they require unnecessary lab tests, they limit contraceptive choice because they are not competent to administer certain methods. In the 1980's, the Universidad de San Carlos did allow for APROFAM in collaboration with JHPIEGO to develop extra-curricular coursework in reproductive health, which was particularly useful to graduating medical students who would need the

knowledge and skills during their mandatory rural year of service (*año rural*). However, this subject matter has never been incorporated into the permanent part of the curriculum.

### **B. Ethnic Composition of the Guatemalan Population**

The ethnic composition of Guatemala is a major factor in understanding the low levels of contraceptive prevalence. The vast majority of Mayans live in mountainous rural areas, many without access to health services, education, electricity, and other modern amenities. For centuries they have worked the land using subsistence farming techniques that have resulted in degradation of the soil. Plots of land handed down from one generation to the next have become increasingly smaller, leaving Mayans with *minifundios* (small farms) that are insufficient to support their families even at the most modest standard of living. As a result, nearly a million Mayans from the Western highlands are forced to migrate annually to the southern coastal areas of the country on a seasonal basis (3-4 months a year) to harvest coffee, cotton, and sugar cane, taking their families with them (PAHO, 1988). This has proven very disruptive to the education of the children involved in this process and has perpetuated their low educational status. According to Enge and Martinez-Enge (1993), “although all sectors of the Guatemalan population have been affected by political violence and continuous economic deterioration, the indigenous peoples have borne the brunt of brutality and suffering in terms of rapidly deteriorating quality of life.”

There are multiple reasons why Mayans have resisted the adoption of family planning (Ward et al., 1992; Bertrand et al., 1979). A large number of children, especially sons, is

beneficial in an agrarian society. High rates of infant and child mortality leave parents uncertain that all their children will survive. After centuries of marginalization and oppression at the hands of the Spanish conquerors and colonial leaders, these Mayan groups have grown highly skeptical of things foreign to their own culture, and they resist change in an effort to preserve their cultural heritage. Many see overtones of genocide in the “enthusiasm” of family planning groups to promote fertility control in their communities. Residence in isolated areas and linguistic barriers, especially for women, have reduced their exposure to new ideas as well as their access to health services, including family planning. Indigenous society is highly structured, and the decision-making processes are carried out at the community level through *xamanes* (traditional priests), the elders, and the male members of the community. In the past little importance has been accorded to education, especially of girls.

In addition to these barriers that are common in impoverished societies, the Mayans have a cosmovision of their world that further mitigates against family planning. They believe that God has created a world in which man is meant to live in harmony with his natural environment, and they pride themselves on being “*los naturales*.” When faced with illness, they seek natural remedies that use medicinal plants, massages, vapor, water and air. Their sources of health care include midwives, local priests, and traditional healers, among others. The rites that surround the birth of a baby have deep social, biological and cosmic significance: the ceremonial cutting of the cord, the burial of the placenta, the celebration of the birth, the use of the *temazcal* (vapor bath) after the birth, special dietary rules, among others. These acts derive from the signs of the Mayan

calendar “Tzulkin” and are passed from one generation to the next by a council of elders that form an integral part of the community. To procreate is to obey the laws of nature and to contribute to the propagation of the Mayan identity. To deny the birth of children already destined to be born is to violate the will of the Supreme Being. Thus, the use of modern contraceptives goes against the basic philosophy of allowing Nature to take its course, and it requires use of a Western medical system that is foreign to the culture (Epinoza, 1999; Velasquez, 1993).

Even for Mayan women interested in using family planning, the barriers are great. Given high levels of social disapproval of contraceptive use, many would not want to be seen at the family planning clinic. MOH or APROFAM clinics often lack bi-lingual personnel to explain the services and put Mayan clients at ease (Ward et al, 1992). Mayan women (many of whom for reasons of modesty give birth wearing their long-flowing skirts) are not accustomed to undergoing a gynecological exam. Clinical schedules are often inflexible, and Mayan clients who have traveled a great distance to reach them may be turned away (if they are late, if they are not menstruating, if personnel opt not to see them, etc.) Women may have little access to cash resources needed for transportation or the purchase of supplies.

In short, the ethnic composition of the country has great importance for the adoption of family planning for two reasons. First, approximately half of the population is Mayan, the majority of whom live in extreme poverty that is reflected in high levels of illiteracy, high levels of infant and child mortality, and low status of women. Second, there are

strong cultural factors (the cosmovision of the Mayans) that further impede the acceptance of family planning among these groups.

The importance of ethnicity is illustrated in Figure 3. The contraceptive prevalence of 38 percent among married women of reproductive age in Guatemala as of 1998 conceals the marked disparity by ethnic group, with 50 percent of *ladino* women reporting contraceptive use, in contrast to only 13 percent among Mayans. Moreover, among Mayan women living outside the two principal cities (Guatemala and Quetzaltenango), is still lower: less than 7 percent as of 1995/96<sup>4</sup> (Bertrand et al, 1999).

### C. Civil Unrest

Civil unrest is another factor that has had a major impact on society in general and on social programs (including family planning) in particular in Guatemala.

The civil war in Guatemala started in the mid-1960s and lasted into the mid-1990s, resulting in an estimated 100,000 deaths and 50,000 displaced persons (many to southern Mexico, some to the United States). It was triggered by fear of the “mounting communist influence” and guerrilla movements that had become active in rural areas (Enge and Martinez-Enge, 1993). All of Guatemala suffered, but the greatest impact was felt in the highland areas (home to thousands of Mayans) where entire communities disappeared as a result of the civil war. The extreme brutality of this period was captured in the highly controversial book *I, Rigoberta Menchu* (Menchu, 1983), required reading for thousands

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<sup>4</sup> The sample in the Mini-DHS in 1998 is not large enough to calculate this percentage; thus, we include the findings from the 1995/96 survey.

of college freshman in campuses across the United States. Although some critics have questioned the factual validity of all incidents described in the book, the basic elements of massacres, genocide, and disappearances have been well documented elsewhere (Tomucshat et al., 1999).

Armed conflict reached its most violent point in the 1980s; the capital city was threatened by the guerillas. In the rural highlands the army distributed weapons to community groups who became *patrullas de auto defensa civil* (self-defense civil patrols). As part of a government program dubbed “*Frijoles y Fusiles*” (beans and guns), these patrols were intended to combat the guerillas. Instead, they became vigilantes who took the law into their own hands, committing major abuses and violations of human rights. There were repeated incidences of “disappearances” of people from rural highland communities, causing many to migrate to other areas of the country and to the south of Mexico. Community leaders (who had been the backbone of development efforts in the highlands after the 1976 earthquake) were at greatest risk of assassination, and many were obliged to flee for their lives.

The entire country was affected by terrorist acts perpetrated against roadways, bridges, electric energy plants, telephones, water sources, transportation systems, and so forth. However, the political violence was greatest in areas of the Western highlands inhabited by Mayans. Social services—education, health, housing, and employment—were brought to a virtual standstill; neither government nor the private sector could operate effectively in these areas. All construction of health units was suspended, and the few that existed

further deteriorated for lack of maintenance. Training and retaining clinical personnel became extremely difficult, given attacks against civilians travelling on the highways and the theft of equipment and supplies from clinical facilities. Not surprisingly, few health personnel were willing to relocate to these areas of armed conflict. The chronic shortage of nurses and doctors became even more acute during this period, especially in rural areas and Mayan communities.

The effects of the armed conflict were even more pronounced for family planning than for health services in general. If family planning was never a strong priority of the MOH, it was even less so under these circumstances. Mayans developed a deep-seated suspicion of anyone “foreign” to their community and were understandably reluctant to congregate for health education talks that civil authorities might misinterpret as a political gathering. Health promoters and nurses stopped making home visits, since local families considered such visits as a potential threat to their personal security. Any fears of genocide that family planning programs had sparked in the past were only magnified by the widespread massacres of entire Mayan communities during this period.

Many international agencies shut down their development projects in the highlands for security reasons. Other NGOs continued to work in these regions, but they paid the price for doing so. In the case of APROFAM, guerilla groups sent threatening messages to the staff, from the director to the local community workers and their families. One APROFAM staff member died in an assault along the highway, another “disappeared,” and a third was taken out of the country under the protection of USAID.

By the 1990s, the threat of violence decreased markedly, and APROFAM's relations in these communities improved considerably with the introduction of more integrated maternal child health services. Nonetheless, APROFAM continues to be viewed with skepticism in many Mayan communities.

#### **D. The Pervasive Influence of the Catholic Church**

Catholicism is the major religion of Guatemala, and its Catholic Church has been classified as one of the most conservative in Latin America. Approximately two-thirds of the Guatemala population report being Catholic, although for many, this identification is more cultural than doctrinaire. Despite the major conversion to fundamentalist evangelicalism among large segments of the population over the past 20 years, Catholicism remains the dominant religion among the politically powerful. Moreover, the Church Catholic has assumed the role for itself as society's moral authority. Although the Church has functioned as a social advocate with regard to certain issues, "strict hierarchical control, rigid dogma, and an elite priesthood limit the church's ability to respond to social need" (Barry, 1992).

When family planning first became available through APROFAM in 1965, the Catholic Church was in the process of reexamining its position on birth control (in response to the emergence of the pill as a viable means of birth control). At the international level there was guarded optimism that the Vatican commission studying the issue of family planning might come up with recommendations favorable toward or at least tolerant of the use of

modern contraception (McLaughlin, 1982). However, Pope Paul VI's unequivocal declaration of opposition to modern contraception issued in *Humanae Vitae* in 1968 represented a major setback for family planning worldwide.

The position of the Vatican on this issue came to be the guiding force in decision-making regarding family planning in Guatemala. Many of the high-ranking officials within the Guatemalan government were and are members of religious orders that staunchly uphold the position of the Vatican, including the Jesuits and *Opus Dei* (literally translated "Works of God"). Despite changes in presidential leadership over the past 30+ years, the opposition of the different administrations to family planning has varied little over time.<sup>5</sup>

The linkage between Church and State has been further cemented over the past 15 years by the work of Mercedes Arzú de Wilson, founder of the Family of the Americas Foundation, located in Covington, Louisiana. For over 20 years she has championed the cause of natural family planning methods (the Billings ovulation method in particular) both in the United States and in her home country of Guatemala. In 1984 she organized a Conference of the Americas on Natural Family Planning Methods in Guatemala, attended by Mother Therese of Calcutta, India.

Mercedes Wilson has had close ties with members of the Republican Party in the United States, and she successfully lobbied the administration of President Ronald Reagan to give greater importance to natural methods in its international family planning programs.

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<sup>5</sup> The administrations under which family planning operated with least opposition were those of the only two Evangelical presidents: Jose Efraim Rios Montt (1982-1983) and Jorge Serrano (1991-1993).

Evidence of her effectiveness is that in the mid-1980s, USAID issued a request for proposals for a global contract with a near exclusive focus on natural family planning methods. In addition, USAID required its existing contractors to find ways to give greater importance to natural methods in ongoing programs. Ironically, the contract for natural family planning methods was awarded to another group (not to the Family of the Americas). The work under this contract has created greater awareness that natural methods have a place in the so-called “cafeteria approach” to family planning service delivery, yet it has not changed the priority given by the international population community to modern contraception.

Mercedes Wilson exerted influence not only in Washington, but also in the high levels of government in Guatemala. Concurrent with her lobbying efforts in Washington, she remained actively involved in Guatemala in promoting the Billings method and ensuring a “pro-Catholic” stance of the government on all issues relating to modern contraception, sterilization, and abortion. As personal envoy of the Vatican, Mercedes Wilson wielded considerable influence over the Guatemalan delegations to several landmark international events, including the International Conference on Population and Development in Cairo (ICPD, 1994) and the Conference on Women in Beijing (in 1995). One assumes her influence reached its maximum during the presidency of her brother, Alvaro Arzú, from 1996-99.

## V. The Intricate Relationships of Church and State

Catholicism *per se* does not constitute an insurmountable obstacle to family planning. Indeed, a number of the Latin countries with levels of contraceptive use similar to those of the United States are predominantly Catholic. However, Catholicism can play a powerful role in impeding the progress of family planning when Church and State unite to block the implementation of FP services.<sup>6</sup> This relationship appears as part of the conceptual framework on Figure 2, as the two-directional arrow linking “social and economic structures” and the “political-administrative systems.” This linkage has translated into a series of critical incidents in which Church and State have joined together in opposition to family planning.

### A. The Population and Development Conference at San Carlos

In the late 1960s the School of Economics, Universidad de San Carlos, collaborated with CELADE (the regional demographic center for Latin America) to sponsor a seminar on the subject of Population and Development, a topic much in vogue at the time. The proceedings from this seminar were openly negative toward family planning. Although the Catholic Church was not officially represented at the seminar, it later received copies of the conclusions and sent congratulatory messages to the organizers for their excellent work. This event foreshadowed the rocky road for family planning in Guatemala over the subsequent three decades.

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<sup>6</sup> Bolivia was a clear case in point through most of the 1970s and 1980s; in the early 1990s, the government adopted a population policy favorable to family planning (Schuler et al, 1994).

**B. Establishment of Article 47, but not without Article 3**

In 1984-85 a Constitutional Assembly was formed to undertake the ambitious task of drafting a new constitution. Proponents of family planning argued effectively to incorporate “Article 47” into the new constitution. This article stipulated that the government would promote (*inter alia*) responsible parenthood and the right of persons to freely decide the number and spacing of their children. However, representatives of the Catholic Church were equally successful in incorporating another article, stating that “life shall be protected from the earliest moment of conception.” This Article 3 led to repeated efforts to prohibit the distribution of all forms of modern contraceptive methods, on the grounds that they were abortifacients. A decade of confrontation and debate on this subject ended in the mid-1990s in a stalemate. Whereas the opponents to family planning were not successful in removing these commodities from circulation in Guatemala, this debate consumed vast amounts of time and energy that might otherwise have been invested in improving the delivery of services.

**C. Accusations of mass sterilization**

During the presidency of Vinicio Cerezo (1986-91) the Catholic Church mounted an aggressive campaign against family planning. This began in 1986 with a letter from the Archbishop (whose personal physician had close ties to the Minister of Health) to President Ronald Reagan, denouncing APROFAM for massive sterilization among the indigenous population and demanding an investigation of the situation with suspension of economic aid to this program. The Ministry of Health in turn threatened to close down APROFAM and its network of clinics. However, public reaction to these threats was

swift and strong. In a few days more than 10,000 signatures were collected to demand that the Ministry of Public Health guarantee family planning services. A demonstration lasting several days was staged in the central plaza of Guatemala City, in which more than 8,000 people showed support for APROFAM.

President Reagan named a commission to investigate these allegations. The commission was formed by the Director of the USAID Office of Population and a lawyer serving as the personal representative of President Reagan. The commission concluded that the allegations were false. Although APROFAM voluntarily took additional measures to strengthen informed consent procedures in the program, again the best efforts of the organization went to political survival rather than improved service delivery.

#### **D. Guatemala's position on issues at the ICPD**

As a means of developing consensus among the international population community prior to the actual ICPD conference in Cairo in 1994, a series of preparatory committee (PrepCom) meetings were held in New York in March 1991, May 1993, and April 1994.

The background work for Cairo was begun in Guatemala under the administration of President Jorge Serrano, who had been relatively favorable toward family planning. The Technical Committee was composed of persons with technical expertise and programmatic involvement. For example, the head of the MCH program (representing the government) and the Executive Director of APROFAM (representing the NGO community) attended PrepCom II. When Serrano was forced to step down in 1993,

Ramiro De León became President during a transitional administration. He attacked the preparatory work for Cairo, despite the fact that Guatemala had publicly endorsed a pro-Cairo position in sub-regional PrepCom meetings held in El Salvador and Antigua, Guatemala. De León then proceeded to nominate his own team to represent Guatemala at PrepCom III and at the Cairo Conference. All delegates were strong adherents to the views of the Vatican, which created a public outcry from the press, women's groups, and other NGOs. At Cairo Mercedes Wilson played a dual role of working with the Guatemalan delegation and representing her own NGO, Family of the Americas. President de León instructed the Guatemalan delegation to oppose all mention of reproductive rights, sexual rights, reproductive health, fertility regulation, sexual health, sexual education, services for adolescents, abortion (all aspects), contraceptive distribution, and safe motherhood. Not surprisingly, Guatemala was one of the handful of nations that sided with the Vatican and refused to endorse the Plan of Action at the ICPD.

In the five years following Cairo, there was continued dialogue between the government on those promoting women's reproductive health. Those in technical positions reached a tentative agreement to revise Guatemala's position, which went against the wishes of civil society as well as some of the government's own initiatives in different sectors. However, in the end President Arzú maintained his opposition. The official Guatemalan delegation to the Cairo +5 meetings in The Hague and in New York reiterated its disagreement with the Cairo Plan of Action. Rather, the delegation focused on the education of women, especially indigenous women, and their integration into development activities. In short, the delegation staunchly supported the Vatican position.

### **E. Efforts to Establish an Official Population Policy**

In the past five years the government has shown some recognition of the needs for Guatemalans to have access to contraception. The administration of Alvaro Arzú included two camps: one favorable, one opposed to family planning. Vice President Luis Flores was part of the first group, and he worked actively to develop support for an official population policy. His office commissioned a study of leaders' attitudes toward reproductive health issues, which documented a strongly supportive stance among the vast majority of those interviewed, except religious and Mayan leaders (Secretaría General de Planificación, 1997). However, the second camp from the Arzú administration mobilized support against the creation of a population policy. The question became increasingly politicized, and the Arzú administration showed no inclination to spend political capital on this issue. As a compromise measure, family planning and reproductive health services were integrated into the newly developed SIAS program (*Servicio Integral de Atención en Salud*), which was expected to make reproductive health services more accessible to the population but at little political cost. The official population policy never came to pass.

### **VI. The Resilience of the Family Planning Movement**

Despite the adverse political climate for family planning and reproductive health programs in Guatemala over the past 30 years, family planning proponents have persisted

in their attempts to make contraception available throughout the country. In this section we examine the factors that have contributed to contraceptive use in Guatemala.

### **A. Perseverance of the Private Family Planning Association, APROFAM**

APROFAM assumed the classic role of an IPPF affiliate: to take the lead in family planning at a time when it was politically controversial and to demonstrate its acceptability to the general public. However, in contrast to many countries where the governments soon took over the lead in providing FP services, APROFAM remained the primary Guatemalan institution in promoting family planning for almost 30 years. As of 1998, it was the largest provider of contraception in Guatemala, although its “market share” had decreased from 41 to 37 percent between 1995 and 1998.<sup>7</sup> Despite the often hostile political climate, APROFAM designed and implemented innovative programs similar to those being carried out in Latin countries with far greater acceptance of family planning: community-based distribution, mobile clinic services, no-scalpel vasectomy, adolescent programs, STD/HIV screening, and mini-clinics in isolated areas staffed by para-medicals, to name the most important. Over the years APROFAM was awarded a number of international prizes for its leadership in quality of care, training, information-education-communication, and management information systems (MIS).

By the mid-1990s, APROFAM faced a situation of declining donor support and growing demand for its services. It responded to this challenge by adopting dramatic cost-recovery moves, and by 1999 it had nearly achieved financial self-sufficiency in its urban

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<sup>7</sup> By contrast, the Ministry of Health was responsible for only 20 percent through its public health facilities and an additional 4 percent through the Guatemalan Institute of Social Security, IGSS.

clinics that serve primarily *ladino* populations.<sup>8</sup> Some would argue that APROFAM has lost some of its “social orientation,” given that it now targets a clientele able to pay (though its fees remain low in comparison to private doctors). Others applaud their adaptability to a changing external environment.

### **B. Sustained Donor Support**

USAID has been the primary donor for family planning and reproductive health activities in Guatemala for over 30 years. Other donors have included IPPF, UNFPA, several bi-laterals (Japan, Sweden, Canada, etc.), and several international private voluntary organizations. Given that donors are under considerable pressure to show results, one wonders if USAID didn’t consider moving its limited resources to other countries or to other areas of development in Guatemala. Instead, it maintained ongoing support despite lackluster results, constant political battles, and occasionally difficult relationships with local program administrators. There is no way to systematically document the effect of this sustained commitment to family planning and reproductive health services, but it unquestionably has played a role in maintaining momentum for a cause that had weak local support.

### **C. Technical Input to Ensure Quality of Services**

As mentioned above, the long-term opposition to family planning of the Universidad de San Carlos had detrimental effects on the human resource base for the delivery of

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<sup>8</sup> Given the fragile demand for the service among Mayan populations, self-sufficiency has not been one of the objectives in that component of APROFAM’s activities.

contraceptive services. Although several of the reversible methods do not require a clinical setting, the long-term methods do. During the many years that political controversy brewed around the issue of family planning, several U.S.-based agencies continued to provide sustained technical assistance, financial support, and equipment to both the public and private sector. AVSC International (New York), JHPIEGO (Baltimore), and the Population Council/Guatemala were particularly key in strengthening the human resource base for the delivery of family planning services and in training local staff to take over this function. In addition, the Population Council conducted a series of operations research projects with local agencies to diagnose shortcomings in the service delivery system and to reorient services to better meet the needs of potential clients.

#### **D. Culturally Appropriate Programs for Mayan Populations**

In the past decade there has been a growing recognition of the special needs and interests of Mayan groups. Moreover, the cessation of civil unrest meant greater access to the rural communities in which the majority of Mayans reside. A number of organizations have developed strong collaborative relationships with Mayan communities or groups for the purpose of jointly identifying more effective strategies to reaching women and men with reproductive health services. The Population Council/Guatemala has worked with a number of groups to test new approaches to service delivery. Through its small grants program, it has supported numerous NGOs in their pursuit of improved programs for Mayans (Population Council, 1999). Project Rxiin Tnamet (formerly supported by Project Concern) in Santiago Atitlan has become one of the most visible NGOs working

in this area, with a female Mayan project director and a predominantly Mayan board of directors. APROFAM through its Programa de Salud Rural continues to test new ways of reaching the Mayan community. CARE International has also played a key role in working with Mayans in the *departamentos* of Alta Verapaz and San Marcos. In short, whereas family planning is over 30 years old in Guatemala, programs specifically designed to address the needs of Mayans are more recent. They hold promise for results in the future.

### **E. Changes in Social Conditions**

It would be misleading to suggest that the changes in contraceptive use have resulted exclusively through the “supply side.” Indeed, a recent analysis by Bertrand et al. (1999) showed that changes in socio-economic conditions have been a major determinant in increased contraceptive use over the past 20 years. Despite the desperate poverty that still afflicts more than half of the Guatemala population, there have been measurable improvements in socio-demographic conditions. Data from the Demographic and Health Surveys (although limited to women of reproductive age) reflect these changes. The percent of women who had attended some level of primary school increased from 35 percent in 1978 to 49 percent in 1995. By ethnic group, this figure rose from 12 to 38 percent among Mayans, and from 50 to 54 percent among *ladinos*. Radio and TV ownership (reflecting both economic status and exposure to outside ideas) also progressed steadily upward over this same period. Among Mayans, the percentage owning a radio increased from 62 to 72 percent; a television, from 2 to 26 percent. Among *ladinos*, radio ownership rose from 81 to 85 percent, TV ownership from 29 to 68

percent. Urbanization is another powerful determinant of contraceptive use, and it remains on the rise in Guatemala.

In sum, both socio-economic conditions (that affect the demand for contraceptive services) and sustained activity of groups promoting family planning (the supply side) have contributed to achieving a mid-range level of contraceptive prevalence, despite the obstacles.

## **VI. The Future**

A statement in a 1980 USAID Project paper reminds us of the caution that should be exercised in predicting the future. It reads: “The Mission thus feels that the government of Guatemala’s historic lack of commitment to the provision of FP services has ended” (Dept. of State/USAID, 1980). In retrospect, their optimism regarding political support for family planning was not well founded. Thus, it is with some hesitation that we advance any conjectures about the future of family planning in Guatemala. Nonetheless, several factors provide some basis for optimism.

Of the three major obstacles to family planning in Guatemala over the past 30 years, one has been resolved: civil unrest in the highlands. A second obstacle—the strong influence of the Catholic Church—should be somewhat mitigated by the presence of Evangelical Protestants in positions of authority in the administration that just took office as of

January 2000.<sup>9</sup> The third obstacle—resistance to family planning among a major subgroup of the population—continues to be a challenge, but multiple organizations are developing better strategies for reaching these groups.

Several actions would improve the prospects for increased contraceptive use in Guatemala. First, the promotion of reproductive health must be expanded beyond a single sector (health, where it has resided in the past); rather, it must become a multi-sectoral initiative to garner a level of political support lacking in the past. Second, the Ministry of Health (MOH) could significantly improve access and quality of services with a series of focused actions: providing basic and refresher training to clinical personnel within the MOH system, diffusing recently-approved service delivery guidelines through the MOH network of clinics, improving the flow of contraceptive commodities (quantity and quality), and strengthening the management information systems for better monitoring of program performance. Third, linkages between the MOH and NGOs need to be strengthened to capitalize on the competitive advantages of each. Fourth, the donor agencies should strengthen efforts to coordinate their activities to avoid duplication and ensure coverage of key initiatives.

Finally, as this article went to press, there was an urgent need for a strong and sustained advocacy initiative in support of reproductive health, directed to top-level decision-makers in the MOH as well as in related sectors. Family planning and reproductive health

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<sup>9</sup> In March 2000, the new government faced its first series of challenges regarding its reproductive health programs in the form of highly visible articles in the local press (*Prensa Libre, Siglo XXI*). To their credit, they held their ground.

continue to be highly controversial in Guatemala, and those responsible for these programs will most likely find themselves under continuous attack. A sustained advocacy effort would help them to stay the course, where previous administrations have lacked the political will to do so.

## REFERENCES

- Barry, T. 1992. *Inside Guatemala*. Albuquerque, NM: The Inter-Hemispheric Education Resource Center.
- Bertrand, J.T., M.A. Pineda and R. Santiso G., 1979. "Ethnic differences in family planning acceptance in rural Guatemala." *Studies in Family Planning*. 10(8-9):238-245.
- Bertrand, J.T., Eric Seiber, and G. Escudero. 1999. "Contraceptive dynamics among the Mayan population of Guatemala: 1978-1998." Seminario Internacional sobre la Población del Istmo al Fin del Milenio, sponsored by the University of Costa Rica and Rand Corporation, Jacó, Costa Rica, October 1999.
- Bongaarts, J., W. P. Mauldin, and J.F. Phillips. 1990. "The demographic impact of family planning programs." *Studies in Family Planning*. 21(6):299-310.
- Dept. of State, Agency for International Development, Guatemala Project Paper. Integrated Family Planning Services. LAC/DR: 80-4. Project number: 520-0263. (1980).
- Easterlin, R. A. 1983. "Modernization and fertility: a critical essay," in *Determinants of Fertility in Developing Countries*, vol. 2, ed. R.A. Bulatao and R.D. Lee. New York: Academic Press, pp. 562-586.
- Enge, K. and P. Martinez-Enge. 1993. "Land, malnutrition and health: the dilemmas of development in Guatemala." In Stonich, S. ed. *I am Destroying the Land!: The Political Ecology of Poverty and Environmental Destruction*. Boulder, CO: Westview Press, pp. 75-101.
- Espinosa, Erick. 1999. *Dimensión Cero, Filosofía Maya, Etnomedicina y Física Moderna*. Guatemala: Editorial Cholsamaj.
- Harkavy, O. 1995. *Curbing Population Growth*. New York, Plenum Press.
- Instituto Nacional de Estadística (INE), et al., 1999. *Guatemala, Encuesta Nacional de Salud Materno Infantil 1998/99, Informe Preliminar*. Guatemala City: INE,
- Lapham, R.J. and G. B. Simmons. 1987. "Overview and framework," in *Organizing for Effective Family Planning Programs*. R.J. Lapham and G.B. Simmons, ed. Washington, DC: National Academy Press, pp. 3-34.
- Martinez, Gustavo, 1963. "Consideraciones sobre Planificación de la Familia Guatemalteca." Tesis de la Facultad de Ciencias Médicas, Universidad de San Carlos, Guatemala.

McLaughlin, L. 1982. *The Pill, John Rock, and the Church. The Biography of a Revolution*. Boston: Little, Brown and Company.

Menchu, R. 1983. *I, Rigoberta Menchu*. New York: New Left Books.

Pan American Health Organization (PAHO). 1998. "Country Profile: Guatemala." *Health of the Americas, Volume II*. PAHO website: <http://www.paho.org>. pp. 204-302.

Population Council. 1999. "NGO strengthening program: processes and lessons learned." Guatemala City: The Population Council.

Population Reference Bureau, 1999. World Population Data Sheet. Washington, DC.

Santiso, Roberto, 1964. "Abortion in Guatemala" First Latin American Seminar on Family Planning, Puerto Rico. IPPF Seminar Proceedings.

Santiso, Roberto, 1966. "Illegal abortion as a health problem" Central American Seminar on Population, Economical Development and Family Planning, Honduras. IPPF Seminar Proceedings, Scap No. 21.

Schuler, Sidney Ruth, Maria Eugenia Choque, and Susanna Rance. 1994. "Misinformation, Mistrust, and Mistreatment: Family Planning among Bolivian Market Women." *Studies in Family Planning* 25(4):211-221.

Secretaria General de Planificación, Secretaria Técnica del Gabinete Social. 1997. "Búsqueda de Consensos en Salud Reproductiva, Informe Fase I." Guatemala City, Gabinete Social, Presidencia de la República.

Terborgh, A., J. Rosen, R. Santiso, W. Terceros, J. Bertrand, and S. Bull. 1995. "Family planning among indigenous populations in Latin America." *International Family Planning Perspectives*. 21(4):143-49.

Tomucshat, Christian, Edgar Balsell, and Otilia L. Cotí. 1999. "Informe de la Comisión para el Esclarecimiento Histórico, Memoria del Silencio," Oficina de Servicios para Proyectos de las Naciones Unidas, Guatemala City, Guatemala. June 1999.

United Nations, 1994. Informe de la Conferencia Internacional sobre Población y Desarrollo, A) Síntesis de los Informes Nacionales sobre Población y Desarrollo; B) Informe de la Secretaría General de la Conferencia Internacional sobre Población y Desarrollo. A/49/482, 6 October 1994.

Velásquez, Leticia. 1993. "Mujer Maya y Salud," Oficina Nacional de la Mujer (ONAM), Guatemala City.

Ward, V., J.T. Bertrand, and F. Pauc. 1992. "Exploring socio-cultural barriers to family planning among Mayans in Guatemala." *International Family Planning Perspectives*. 18(2):59-65.

World Bank. 2000. website: <http://www.worldbank.org/html/extdr/regions.htm>

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**Table 1. Timeline of Significant Events in Family Planning Service Delivery in Guatemala**

Year	Event
1963	<ul style="list-style-type: none"> <li>Colonel Enrique Peralta Azurdia comes to power following a coup d'état in March 1963 (military government)</li> </ul>
1964	<ul style="list-style-type: none"> <li>APROFAM becomes a legal entity.</li> </ul>
1965	<ul style="list-style-type: none"> <li>APROFAM opens its first clinic in Guatemala City.</li> </ul>
1966	<ul style="list-style-type: none"> <li>Julio César Mendez Montenegro assumes presidency (civilian government).</li> </ul>
1967	<ul style="list-style-type: none"> <li>USAID signs first tripartite agreement (no. 520-0189) for "Population and Rural Health" with MOH and APROFAM; APROFAM is authorized to initiate FP services in 23 health centers.</li> </ul>
1970	<ul style="list-style-type: none"> <li>General Carlos Manuel Arana Osorio assumes presidency (military government)</li> <li>USAID agreement is amended to create the "Integrated Office of Information, Education, and Training" within MOH; <ul style="list-style-type: none"> <li>✓ MOH agrees to extend FP services to 450 facilities;</li> <li>✓ APROFAM is responsible for contraceptive commodity distribution and training of MOH personnel.</li> </ul> </li> </ul>
1973	<ul style="list-style-type: none"> <li>USAID extends 1967-73 agreement to 1976.</li> </ul>
1974	<ul style="list-style-type: none"> <li>General Kjell Eugenio Laugerud García assumes presidency (military government)</li> </ul>
1976	<ul style="list-style-type: none"> <li>A USAID evaluation of the project from 1970-76 indicates: <ul style="list-style-type: none"> <li>✓ Satisfactory results on contraceptive distribution and training (by APROFAM);</li> <li>✓ Disappointing results on coverage: FP services available in only 126 of the 450 MOH facilities planned, and only 3000 active users registered in the program.</li> </ul> </li> <li>An earthquake hits Guatemala, killing some 25,000 people and destroying much of the MOH infrastructure: <ul style="list-style-type: none"> <li>✓ The MOH dedicates its efforts to reconstructing the infrastructure;</li> <li>✓ It closes the Office of Information, Education, and Training.</li> </ul> </li> <li>USAID signs second agreement (no. 520-0237) with MOH and APROFAM, to run from 1976-1980: <ul style="list-style-type: none"> <li>✓ APROFAM assumes responsibility for training, commodities distribution, and design of a logistics management system;</li> <li>✓ MOH agrees to offer contraceptive services in its clinical facilities.</li> </ul> </li> <li>APROFAM creates community-based distribution program.</li> </ul>
1978	<ul style="list-style-type: none"> <li>General Romeo Lucas Garcia (military government)</li> </ul>
1979	<ul style="list-style-type: none"> <li>Minister of Health orders all IUDs to be removed from users and FP services at 492 MOH facilities to be closed for concern over inadequate medical supervision; also ordered collaboration with APROFAM to be discontinued (see text); <ul style="list-style-type: none"> <li>✓ Private sector protests vociferously</li> <li>✓ MOH reopens 144 of the 492 facilities (those with a physician in attendance)</li> <li>✓ Access to FP services is markedly reduced</li> </ul> </li> </ul>

Year	Event
1980	<ul style="list-style-type: none"> <li>• USAID signs third agreement with MOH and APROFAM entitled “Integrated Family Planning Services,” to run from 1980-83:               <ul style="list-style-type: none"> <li>✓ MOH takes responsibility for FP (logistics, training, and service delivery) in 11 of 22 health areas of Guatemala;</li> <li>✓ APROFAM responsible for commodities logistics and training in remaining 11 health areas.</li> </ul> </li> </ul>
1982	<ul style="list-style-type: none"> <li>• Coup d’état ousts President Romeo Lucas Garcia; General Efraín Ríos Montt (a strong evangelical figure) assumes power; this military government lasts only 18 months.</li> </ul>
1983	<ul style="list-style-type: none"> <li>• Coup d’état ousts Ríos Montt, puts General Oscar Humberto Mejía Víctores in power (military government)</li> <li>• USAID signs fourth agreement (no. 520-0288) with MOH and APROFAM entitled “New Initiatives for the Rural Area and FP Service Expansion,” to run from 1983-87.               <ul style="list-style-type: none"> <li>✓ MOH establishes a <i>Unidad de Salud Reproductiva</i> (USR, or Reproductive Health Unit)</li> </ul> </li> </ul>
1985	<ul style="list-style-type: none"> <li>• Congress ratifies a new Constitution for Guatemala:               <ul style="list-style-type: none"> <li>✓ Article 3: life shall be protected from the earliest moment of conception;</li> <li>✓ Article 47: ...the rights of persons to freely decide the number and spacing of their children.</li> </ul> </li> </ul>
1986	<ul style="list-style-type: none"> <li>• Civilian government of Marco Vinicio Cerezo Arévalo comes to power</li> <li>• Archbishop of Guatemala accuses APROFAM of mass sterilization of indigenous people without their consent;               <ul style="list-style-type: none"> <li>✓ The Archbishop requests that President Reagan investigate this program and suspend financial support;</li> <li>✓ First Minister of Health under Cerezo attempts to close down APROFAM.</li> <li>✓ President Reagan sends a delegation that concludes the accusations are untrue.</li> </ul> </li> </ul>
1987	<ul style="list-style-type: none"> <li>• Second Minister of Health under Cerezo (Carlos Gehlert) maintains close ties to Catholic Church; nonetheless,               <ul style="list-style-type: none"> <li>✓ He allows family planning within MOH to operate and expand;</li> <li>✓ The number of employees in the USR increases.</li> </ul> </li> <li>• USAID signs fifth agreement (no. 520-0288) with the MOH and APROFAM entitled “Expansion of FP Services,” to run from 1987-92 to continue previous work.</li> </ul>
1991	<ul style="list-style-type: none"> <li>• Jorge Serrano Elías assumes presidency (civilian government).</li> <li>• Preparatory work begins on ICPD (Cairo Conference).</li> </ul>
1992	<ul style="list-style-type: none"> <li>• The Guatemala Congress unanimously approves an “Iniciativa de Ley” for an official population policy.               <ul style="list-style-type: none"> <li>✓ It must appear in official government publication to become law;</li> <li>✓ Catholic Church became aware of implications; lobbied against it;</li> <li>✓ President Serrano faces a myriad of political problems;</li> <li>✓ To avoid further problems, President Serrano never publishes it.</li> </ul> </li> <li>• USAID signs sixth agreement with MOH and APROFAM entitled “Family Health,” to run from 1992-96, later extended to 1999:               <ul style="list-style-type: none"> <li>✓ Government resists assuming financial responsibility for positions of 11 supervisors and 5 administrators in the USR (until 1994);</li> <li>✓ Supervisors refuse to travel to the field because of inadequate per diem;</li> </ul> </li> </ul>

Year	Event
	<ul style="list-style-type: none"> <li>✓ MOH dismisses 11 supervisors from USR;</li> <li>✓ Supervisors win law suit against MOH that is required by law to take them back;</li> <li>✓ MOH deploys 11 supervisors to other branches of MOH;</li> <li>✓ USR has no supervisors; family planning in MOH is paralyzed.</li> </ul>
1992	<ul style="list-style-type: none"> <li>• The Central American Conference “Initiatives for Safe Motherhood” is held in Guatemala.</li> </ul>
1993	<ul style="list-style-type: none"> <li>• Prepcom II takes place in New York. <ul style="list-style-type: none"> <li>✓ Mercedes Wilson (pro-Vatican) confronts representatives from Guatemala.</li> </ul> </li> <li>• President Serrano stages “auto-coup” in May 1993; <ul style="list-style-type: none"> <li>✓ He suspends Congress and the Supreme Court;</li> <li>✓ Serrano in turn is ousted.</li> </ul> </li> <li>• Ramiro de León Carpio assumes presidency (in June 1993); <ul style="list-style-type: none"> <li>✓ Strongly aligned with Vatican position and opposes FP activities in the MOH;</li> <li>✓ Attacks work done to date on Cairo;</li> <li>✓ Names new group of strongly pro-Vatican individuals as the official delegation to PrepCom III and to the Cairo Conference.</li> </ul> </li> <li>• The Guatemalan Social Security Institute (IGSS) initiates its program in family planning.</li> <li>• USAID suspends funding to MOH.</li> </ul>
1994	<ul style="list-style-type: none"> <li>• USAID reinstates funding to MOH under an amendment to Project 520-0357.</li> <li>• ICPD held in Cairo; <ul style="list-style-type: none"> <li>✓ De León instructs Guatemalan delegation to endorse Vatican position;</li> <li>✓ Guatemala does not sign the Cairo Plan of Action.</li> </ul> </li> </ul>
1995	<ul style="list-style-type: none"> <li>• AVSC International assists MOH in establishing supervisory mechanism in USR; FP program is reactivated.</li> </ul>
1996	<ul style="list-style-type: none"> <li>• Alvaro Arzú Irigoyen (civilian) assumes presidency; administration includes opposing camps on FP issue: <ul style="list-style-type: none"> <li>✓ Controversy builds over defining a population policy and expansion of FP services;</li> <li>✓ Vice President Luis Flores (favorable to FP) calls for a multi-level study to develop consensus on FP issues;</li> <li>✓ Strong opposition from Catholic Church, including Mercedes Arzú de Wilson, sister of the President;</li> <li>✓ Government suspends all discussion of official population policy.</li> </ul> </li> <li>• MOH restructures: <ul style="list-style-type: none"> <li>✓ USR becomes integrated into SIAS (Servicio Integral de Atención en Salud).</li> </ul> </li> </ul>
1997	<ul style="list-style-type: none"> <li>• USAID signs new agreement with MOH and IGSS for project entitled “Woman and Child Health in Rural Areas,” to run through 2004.</li> </ul>
1998	<ul style="list-style-type: none"> <li>• USAID signs new agreement with APROFAM for “Better Health for Rural Women and Children” project, to run through 2001.</li> <li>• Improvements within MOH for delivery of FP services: <ul style="list-style-type: none"> <li>✓ Training and technical assistance from AVSC, JHPIEGO, Population Council, University Research Corporation, John Snow Inc.</li> </ul> </li> </ul>

Year	Event
	✓ Elaboration of service delivery norms and procedures, approved by MOH.
1999	<ul style="list-style-type: none"><li>• USAID signs contract with URC and subcontractors (AVSC, JHPIEGO, Population Council and JHU/CCP) to coordinate technical assistance efforts to the MOH and IGSS.</li></ul>
2000	<ul style="list-style-type: none"><li>• Alfonso Portillo (a civilian) assumes the presidency (January).</li><li>• Leading newspapers carry dialogue on reproductive health issues; government defends programs.</li></ul>

**Figure 1. Contraceptive Prevalence in Guatemala in Contrast to the Region**

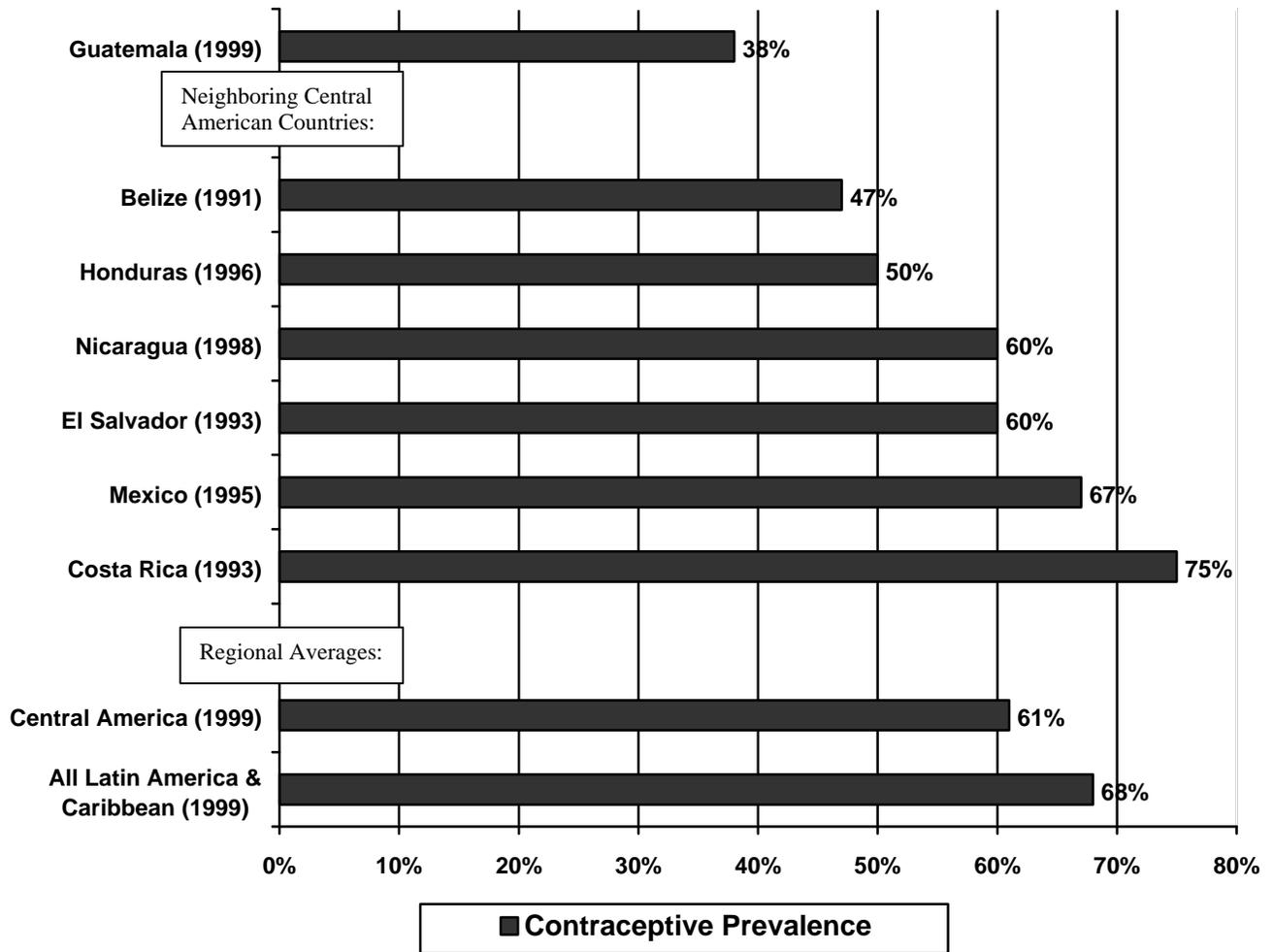
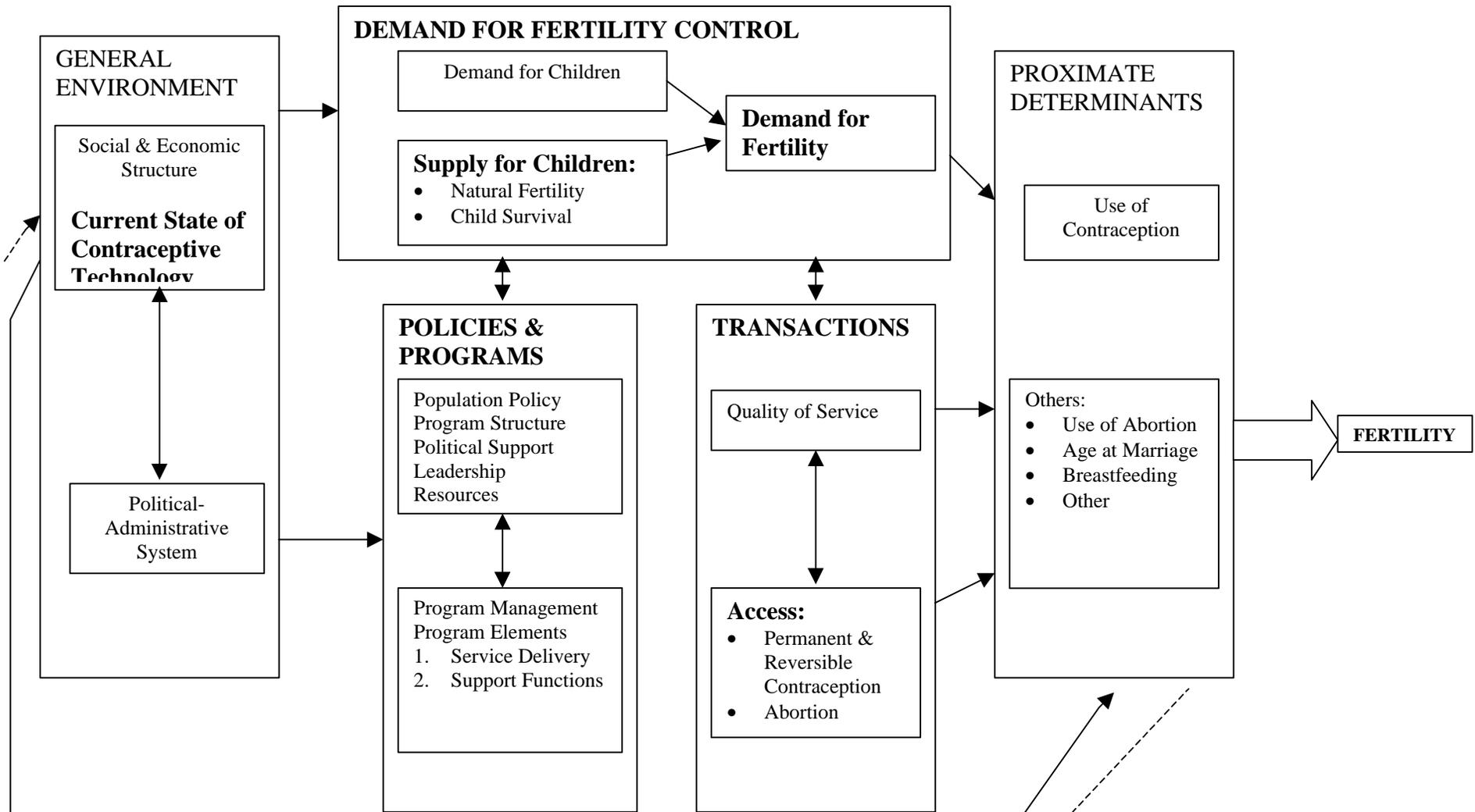


Figure 2. Factors Affecting Contraceptive Use and Fertility<sup>10</sup>



<sup>10</sup>Figure 2 is based on "A Framework for the Analysis of Family Planning Effectiveness" from Lapham and Simmons (1987, p.6), but some of the detail has been omitted to emphasize the main headings.