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**HEALTH POLICY
INITIATIVE**

INCREASING ACCESS TO FAMILY PLANNING SERVICES AMONG INDIGENOUS GROUPS

Indigenous groups—such as the Mayan, Xinkan, and Garifunan—constitute about 40 percent of Guatemala’s total population and 75 percent of its poor. Most indigenous people have limited access to healthcare services, including family planning/reproductive health (FP/RH). The effects of poverty and limited healthcare are reflected in large disparities between indigenous and non-indigenous women on key reproductive and maternal health indicators, such as the maternal mortality ratio, total fertility rate, and unmet need for family planning. According to the 2002 National Maternal and Child Health Survey, 39 percent of married indigenous women ages 15–49 indicated an unmet need for family planning—that is they want to have no more children or delay the next birth by at least two years. Contraceptive use among indigenous women is roughly half that of other women; 24 percent of indigenous women were using contraceptives, compared with 53 percent of the non-indigenous women, according to the 2002 survey.

The benefits of family planning for the health and welfare of individuals and families have been amply demonstrated. Family planning enables women and men to decide how many children they want and when to have them, thereby serving to improve maternal and child health. Nevertheless, many people still lack access to FP/RH services due to various economic, sociocultural, and geographical barriers.

To help increase access to FP/RH services among Guatemala’s indigenous populations, from April 2006–April 2008, the USAID | Health Policy Initiative, Task Order 1, identified barriers to access among indigenous groups and worked with Guatemala’s major health service providers to design and implement effective strategies and service delivery practices to overcome the barriers—thereby ensuring that policies and programs respond to the FP/RH and maternal health needs of indigenous groups. Specific objectives included identifying barriers related to service provision as well as attitudinal and socio-cultural constraints.

IDENTIFYING THE BARRIERS TO ACCESS

The Health Policy Initiative selected three major health service providers in Guatemala to participate in the activity: the Ministry of Public Health and Social Assistance (MSPAS in Spanish), the National Institute for Social Security (IGSS in Spanish), and the Association for the Wellbeing of the Family (APROFAM in Spanish). These agencies were selected because of their strategic position in FP/RH program implementation and information dissemination. The first two providers are government agencies supported by tax revenue and the latter is a nongovernmental organization (NGO) supported by nominal fees charged for its FP/RH services.

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In collaboration with the three major health service providers, the Health Policy Initiative completed a five-step process:

I. Information gathering and analysis. First, the Health Policy Initiative and its partners reviewed research and data related to access to services and unmet need for FP among indigenous groups. Then the project team conducted a formative study designed to understand the FP/RH and maternal health situation of Guatemala's indigenous populations, as well as barriers they face in accessing services (see Box 1). The study was conducted in three Guatemalan departments with a high proportion of indigenous populations: Quiché, Sololá, and Totonicapán. Researchers conducted in-depth interviews with 108 health service providers as well as 33 group interviews with 168 indigenous women who were users and non-users of FP methods as well as 69 community educators and traditional midwives.

Box 1. Barriers to use of family planning faced by indigenous women

Six major barriers hinder indigenous peoples' access to FP services. Four of these barriers relate directly to the provision of services and two relate to the socio-cultural context:

1. *Bias of providers toward indigenous women.* Some providers doubt the ability of indigenous women to use specific FP methods and therefore do not recommend those methods. For their part, indigenous women think that providers discriminate against them and do not understand their needs and problems.
2. *Unsuitable conditions where FP services are provided.* Both providers and indigenous women stated that the lack of privacy for counseling and inability to communicate due to language barriers hampered service delivery. The indigenous women also mentioned the long waiting times and inconvenient hours at health facilities.
3. *Lack of appropriate information, educational materials, and counseling for indigenous populations.* Nearly all providers speak Spanish during FP consultations and ask bystanders to serve as translators. Consequently, indigenous women receive little information from providers, and even this information is often incomprehensible. The available educational materials are mostly in Spanish and require literacy skills. These materials are not useful for indigenous women and do not address their concerns regarding contraceptive side effects.
4. *Limited integration of community-based providers in the community.* The community facilitators and health promoters employed by MSPAS are not well integrated into the community. They lack systematic training on FP issues and thus perpetuate the same myths and concerns about FP that the community holds.
5. *Beliefs within the community regarding family planning and associated behavior.* Indigenous women face community and familial pressure to refrain from using FP methods, since such conduct is not considered socially acceptable.
6. *Restricted social and familial environments.* The indigenous community is heavily influenced by the opinion of community elders and religious beliefs. Women's autonomy to make decisions about using FP is highly restricted, especially since spouses and parents also support community customs and traditions.

2. Dissemination of the findings and policy and strategy development. The Health Policy Initiative held a central-level workshop to share and discuss the research findings with leaders of the three service delivery organizations, civil society organizations, and other key stakeholders. The workshop participants developed a strategy and a list of service delivery practices to address the identified barriers to use of FP/RH services. This list served as the basis for operational guidelines to ensure that FP/RH services are offered in accordance with the needs and perspectives of indigenous women.

3. Pilot testing. The next step was to test the operational guidelines in health facilities serving indigenous women. MSPAS facilities in five districts of Quiché department were selected as the sites for the pilot test. The Quiché team selected 10 locally appropriate service delivery practices to reduce the identified barriers and conducted a baseline assessment in the five pilot districts in order to measure progress in implementing the guidelines. Each district identified priority actions, such as hiring translators and training FP providers.



Health center in Chichicastenango. Photo courtesy of Liz Mallas.

4. Feasibility assessment. After the guidelines had been implemented for one month, the project team conducted follow-up interviews with program implementers in the five districts to determine whether the guidelines were appropriate and feasible. Four of the five districts had made changes, such as arranging for client consultations in the local language, setting aside an area for private counseling, and providing appropriate information materials in local languages about available FP methods. One district had broadcast television spots on FP in the local language.

5. Documentation of lessons learned. In collaboration with partner agencies and other stakeholders, the project team identified lessons learned that can guide future work to make FP/RH services more accessible to disadvantaged groups.

POLICY-RELATED OUTCOMES

Replication of the activity's approach. Recognizing the importance of understanding barriers to FP/RH services, in September 2006, MSPAS used the conceptual framework and methodology of this activity to identify factors limiting access to family planning for *non-indigenous* populations. The Health Policy Initiative provided MSPAS with the instruments and original concept of the activity and reviewed the instruments, UNFPA provided funding, and the Population Council provided technical assistance. The MSPAS developed and implemented the tools for the complementary analysis with limited external assistance, demonstrating the government's commitment and capacity. One of MSPAS' goals is to reduce the unmet demand for family planning nationally by identifying the main barriers that limit access to FP services and defining interventions to address those barriers.

Continued use of the research findings. At USAID/Guatemala's request, University Research Co., LLC also used the results from the project's work to guide its technical assistance in service delivery in Guatemala.

Development of the National Family Planning Strategic Plan. The National Program of Reproductive Health of the MSPAS used the results from the original and expanded studies to develop its strategic plan to reduce unmet demand for FP services nationwide. Developed during August–October 2007, the plan incorporated several of the recommendations developed as a result of this work, including promoting family planning among indigenous populations, incorporating community personnel in FP/RH programs, and distributing FP/RH information that addresses myths and misconceptions about FP to the general population. The plan has been incorporated down to the departmental level, where operational guidelines have been adopted to address barriers to access faced by indigenous groups. Key stakeholders now have a better understanding of these barriers at all levels of FP service implementation. Department-level staff are now implementing the guidelines, providing training, and addressing the questions of nurses and users.

Improved coordination. Participation of the three major FP/RH service providers in this activity strengthened relationships among their high-level leaders as well as operational staff—thus improving coordination and creating an environment for sharing experiences. Stakeholders involved in drafting the National Family Planning Strategic Plan stated that the process was less complicated and more substantive than previous collaborations because of the relationships fostered through the activity implementation process.

Public statement of support. Dr. Alejandro Silva, Director of the National Reproductive Health Program, made a public declaration based on the need to remove barriers at the health service provision level to increase equitable access to FP/RH services and information among the indigenous population. This demonstration of political commitment was an important step, as discrimination faced by the indigenous population in accessing health services is rarely recognized publicly. Dr. Silva's declaration also appeared in the national newspaper, *El Periodico*.

LESSONS LEARNED

Guatemala's experience shows that policies adopted at the central level by government to increase equity and access to services for poor, marginalized, and traditionally underserved groups are not always implemented at the local level. Policymakers and health program managers must think beyond enacting policy statements and consider how concrete guidelines to achieve increased access can actually be implemented. Guatemala's experience also underscores the importance of monitoring policy implementation, ensuring that health providers are committed to addressing barriers to implementation, and engaging civil society organizations and potential service beneficiaries to advocate for continued attention to equitable provision of services.

To foster greater access, national agencies such as the Ministry of Health should apply a systematic process with the following elements:

Understand the dynamic policy environment. The involvement of multiple stakeholders at the district, department, and central levels, as well as from different sectors, can often improve the quality of the practice, promote local ownership of the practice, and ensure that it is culturally appropriate. Continuous advocacy and targeted actions are needed to keep the issue high on the policy agenda and to influence policy decisions.

Support an evidence-based, country-driven process. In Guatemala, the three major FP/RH providers used a systematic process to identify key barriers and develop effective service delivery practices that were pilot-tested at the district level. The main institutions providing healthcare, service providers, and potential beneficiaries were fully involved in the process.

Use a comprehensive approach involving multiple stakeholders. Involving multiple stakeholders, including government institutions and local organizations, ensured that addressing the barriers to access by indigenous women was a multisectoral effort that built on the strengths of each institution.

Involve the potential beneficiaries in identifying problems and designing solutions. In Guatemala, indigenous women were involved from the start of the process, ensuring that the proposed solutions would ultimately be effective and address their needs.

Conduct equity-based monitoring and evaluation. It is essential to monitor program indicators to ensure that the intended beneficiaries are actually being reached. Examples of such indicators are the number of FP/RH community-outreach events organized by community facilitators and health promoters, the accuracy and cultural appropriateness of information provided, and the quality of FP/RH counseling.

Guatemala's experience demonstrated the importance of involving all levels of the health system—from the central to the community level—in the process. In developing a targeted program, local health program managers should consider the following practices:

Identifying barriers

- Involve the targeted population in identifying barriers to service access.
- Interview users and non-users of health services as well as providers to understand why the targeted population is not using services. Use the local language when appropriate. Ask about client perceptions of family planning and explore reasons for use and non-use.
- Incorporate all major service providers in the study.

Planning interventions

- Involve the targeted population in the design, development, and implementation of programs.
- Include all stakeholders, including local leaders, in program implementation.
- Strengthen the relationship between the area, district, and basic health units through the development of technical guidelines for FP services to ensure quality and uniformity of services throughout the system.
- Work with community members to disseminate information that clarifies misconceptions about family planning.
- Train all health center personnel, including non-medical staff, on FP issues.
- Strengthen the commitment of district health officials to family planning.

Advocacy

- Involve representative NGOs in advocacy efforts at the local level to build support and consensus from the community and to promote early involvement of the targeted population.
- Use a multisectoral approach in advocacy efforts. Advocate at all levels—central, district, and community—to build political will and momentum for interventions.
- Promote a continuous process of advocacy, policy dialogue, data sharing, and information gathering and dissemination.
- Involve the right stakeholders—representative NGOs, major service providers, Ministry of Health officials, and district- and community-level health officials—to strengthen commitment to equitable access to FP/RH services.

CONCLUSION

As a result of this activity, the MSPAS used key baseline information to prepare a national strategic plan within its National Program of Reproductive Health. The plan has been incorporated down to the departmental level, where operational guidelines have been adopted to address the barriers that indigenous populations face in accessing FP services. Key stakeholders now have a better understanding of these barriers at all levels of FP service implementation. Also as a result of the activity, coordination and communication among the MSPAS, IGSS, and APROFAM has improved; and department-level staff are now implementing guidelines, providing training, and addressing the questions of nurses and clients.

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