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TECHNICAL REPORT

USAID'S LEGACY OF FAMILY PLANNING TECHNICAL ASSISTANCE TO THE GUATEMALAN PUBLIC HEALTH SECTOR:

Over a Decade of Success through USAID's Calidad en Salud and Health Care Improvement Projects

JANUARY 2012

This case study was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Luigi Jaramillo and Catherine Howell of URC for the USAID Health Care Improvement Project (HCI). HCI is made possible by the generous support of the American people through USAID.

On the cover: A women receives family planning counseling using contraceptive method cards developed by USAID's Calidad en Salud project. The cards greatly improved the quality of information provided to clients during counseling sessions.
Photo credit: Elena Hurtado, URC

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DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ABBREVIATIONS

APROFAM	Association for Family Welfare of Guatemala
BCC	Behavior Change Communication
CBD	Community-Based Distribution
CC	Convergence Center
CDC	Center for Disease Control and Prevention
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DHS	Demographic and Health Surveys
ENSMI	National Survey of Maternal and Child Health
FP	Family Planning
GTI-IEC	Inter-Institutional Technical Group on Information, Education, and Communication
HCI	Health Care Improvement Project
HR	Human Resources
IEC	Information, Education, and Communication
IGSS	Guatemalan Social Security Institute
INE	National Institute of Statistics
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
LAN	Local Area Network
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MIS	Management Information System
MOH	Ministry of Health
MSPAS	Ministry of Public Health and Social Assistance
NCSC	National Contraceptive Security Committee
NGO	Non-Governmental Organization
NRHP	National Reproductive Health Program
PD3	USAID Policy Determination 3
QI	Quality Improvement
SIAS	Integrated Health Care System
SIGSA	Health Management Information System
UNFPA	United Nations Population Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Through the Calidad en Salud (Quality in Health) I and II (2000-2004, 2005-2009) and Health Care Improvement (HCI, 2009-2012) projects, managed by University Research Co., LLC (URC), the United States Agency for International Development (USAID) has provided more than a decade of support to the Guatemalan Ministry of Health (MOH). These projects have improved the quality of and broadened access to clinical health services in the country, particularly for traditionally underserved populations in the remote highland regions. A primary component of this work has been to support the MOH and other Guatemalan institutions in providing quality family planning (FP) information and services, particularly for indigenous populations in rural areas.

Over the 12 years of project work, the Guatemalan FP program has shown dramatic improvements. The contraceptive prevalence rate (CPR) grew at an average of 1.6 points per year between 1998 and 2008 (much faster than any other region of the world during that time), and the fertility rate declined from 5.1 children per woman in 1998 to 3.6 children per woman in 2008.

Expanding and improving the FP program in Guatemala were necessary due to sustained high population growth in the country. Already-stretched resources were unable to meet the growing demand for food, health, and other social services brought on by the fast-growing population. To meet the clear need for widespread FP services, USAID, through Calidad en Salud, assisted the MOH in building the country-owned National Reproductive Health Program (NRHP) in 2001. A major component of the NRHP is the nationwide FP program that provides services free-of-charge to all Guatemalans at more than 2,000 service delivery points. These services include the provision of barrier and hormonal contraceptive methods, intrauterine devices (IUDs), male and female sterilization, and brochures and counseling on FP options and the use of FP methods.

In order to support the national FP program, Calidad en Salud developed a strategic framework, designed to effectively leverage financial, political, technical, and human resources provided by USAID and the MOH.

The program is supported by a robust system of tools and interventions, including a) policy and advocacy for FP service development, b) guidelines for FP delivery, c) a human resources (HR) development strategy, d) a behavior change communication (BCC) strategy, e) gender equality activities, f) a logistics management information system (LMIS) for contraceptives, g) monitoring and evaluation (M&E) teams, h) research studies and technical notes, and i) a quality improvement (QI) plan. Further details on each program component are provided as follows.

Calidad en Salud worked closely with Guatemalan stakeholders, including government officials, women's groups, private employers, the media, and non-governmental organizations (NGOs) to advocate for and influence policy decisions regarding FP. Advocacy efforts contributed to the formulation of the Universal Access to Family Planning Law and to the creation of the National Contraceptive Security Committee. In addition, advocacy helped to educate Guatemalan society on reproductive rights and to prompt hospital directors to expand FP services in their facilities.

In order to standardize the provision of quality FP services, Calidad en Salud assisted the MOH in developing guidelines based on scientific evidence to provide staff with step-by-step guidance on FP service delivery. Project staff also ensured the training of all FP personnel in FP service delivery and counseling at all MOH service delivery points; more than 15,000 physicians, nurses, and health workers were trained.

Calidad en Salud also contributed to the development of the first national BCC strategy for FP and supported the strategy by reviewing existing BCC materials; leading the design, pretest, and production of new materials; and coordinating the logistics of their distribution. Messages focused on raising awareness of FP services and methods were included on posters, videos, radio spots, and brochures. In addition, Calidad en Salud provided technical support to the MOH to implement activities designed to change men's attitudes about FP and to promote their use of contraceptives. These activities, including FP counseling targeted toward men, BCC materials promoting FP practices for males, and training for FP providers on FP messaging for men, have proven effective. For example, since the start of the national FP program, more than 650,000 men have sought free condoms from the MOH.

To ensure that contraceptives are available for distribution through the national FP program, Calidad en Salud provided technical assistance to the MOH in designing and implementing a simple, user-friendly LMIS and trained more than 8,000 people from around the country in logistics management. As a result, stock-outs of contraceptives decreased from 45% of health posts without adequate stock levels in 2000 to only 18% by 2008. Calidad en Salud also built capacity in the MOH to monitor and evaluate overall program results, helping to build a management information system (MIS) for monitoring, to determine indicators, and to train staff in use of the system.

Calidad en Salud also conducted studies and developed technical notes to inform Guatemalan FP policies and processes. Using evidence from these studies, Calidad en Salud was able to directly address policy, social, medical, and institutional barriers to a stronger FP program. One study, for example, showed that the MOH saves $14.32 for every dollar that it invests in FP. Other studies include research on the implications of rapid demographic growth on socio-economic variables, a market segmentation study to determine demographic characteristics of potential contraceptive users, and formative research studies on barriers to vasectomy and IUD use.

Through the HCI project, USAID built on the Calidad en Salud work and assisted the MOH to improve the quality of FP services and to motivate providers to give the best services possible according to evidence-based standards. HCI used improvement collaboratives (groups of service providers who identify gaps, test changes for improvement, and measure their achievements) and other proven QI methods to improve the availability of FP services, the technical capacity of FP staff, client relations for FP service providers, and the organization of services for more efficient delivery.

The successes documented here stem from strong political backing for FP from the MOH and through USAID support. In order to continue the progress made to date, the MOH will need to coordinate with political leaders, civil society groups, and other NGOs to maintain political support for FP and to continue to educate new FP practitioners and inform the public of FP methods and services available. If the FP program remains strong and the current trend in birth rate decline continues, Guatemala will reach its demographic transition (in which birth and mortality rates are equal) by the year 2040 instead of the previously-projected 2060, avoiding a population increase of 17 million people.

INTRODUCTION

The United States Agency for International Development (USAID) has provided substantial support to improve the quality of and broaden access to clinical health services in Guatemala, particularly for traditionally underserved populations in the country's remote highland regions. Three major USAID-funded projects in Guatemala are the Calidad en Salud (Quality in Health) I and II projects, implemented in 2000-2004 and 2005-2009 and managed by University Research Co., LLC (URC), and the global USAID Health Care Improvement (HCI) project (functional in Guatemala from 2009 through 2012), also managed by URC. A primary component of the work carried out by the Calidad en Salud projects was the support of Guatemalan institutions, including the Ministry of Health (MOH), its partner non-governmental organizations (NGOs), and the Guatemalan Social Security Institute (IGSS), to focus on strengthening the capacity of the health care system to provide quality family planning (FP) information and services, particularly for indigenous populations in isolated rural areas. In particular, the Calidad en Salud projects supported the MOH's Extension of Coverage Program, a program designed to deliver health and family planning services to rural settings through the participation of local NGOs. The HCI project continued to provide technical assistance to the MOH by using quality improvement (QI) approaches to enhance access to FP services integrated within the MOH's maternal, neonatal and child care programs.

Over the 12 years that USAID has been strengthening the capacity for FP in Guatemala, the FP program has shown dramatic improvements. The Guatemalan contraceptive prevalence rate (CPR) – the percentage of women ages 15 to 49 who use any form of contraceptive – grew at an average of 1.6 points per year between 1998 and 2008, much faster than any other region in the world during the same period (as shown in Table 1).[1] Today 97% of women at reproductive age have knowledge of at least one contraceptive method, an increase from 72% in 1987.[2]

Table 1. Comparative Change in the Contraceptive Prevalence Rate in Guatemala and Other Regions of the World (1998 – 2008)

Region	1998	2008	Change	% Change
World	57%	62%	5 points	9%
South America	66%	73%	7 points	11%
Central America	62%	68%	6 points	10%
Africa	23%	28%	5 points	22%
Asia	60%	67%	7 points	12%
North America	71%	73%	2 points	3%
North Europe	73%	81%	8 points	11%
East Europe	71%	62%	-9 points	-13%
Guatemala	**38%**	**54%**	**16 points**	**42%**

Source: 1998 Guatemala information from ENSMI 1998/99. 2008 Guatemala information from ENSMI 2008/09. 1998 world regional information from "1998 World Population Data Sheet." 2008 world regional information from "2008 World Population Data Sheet."

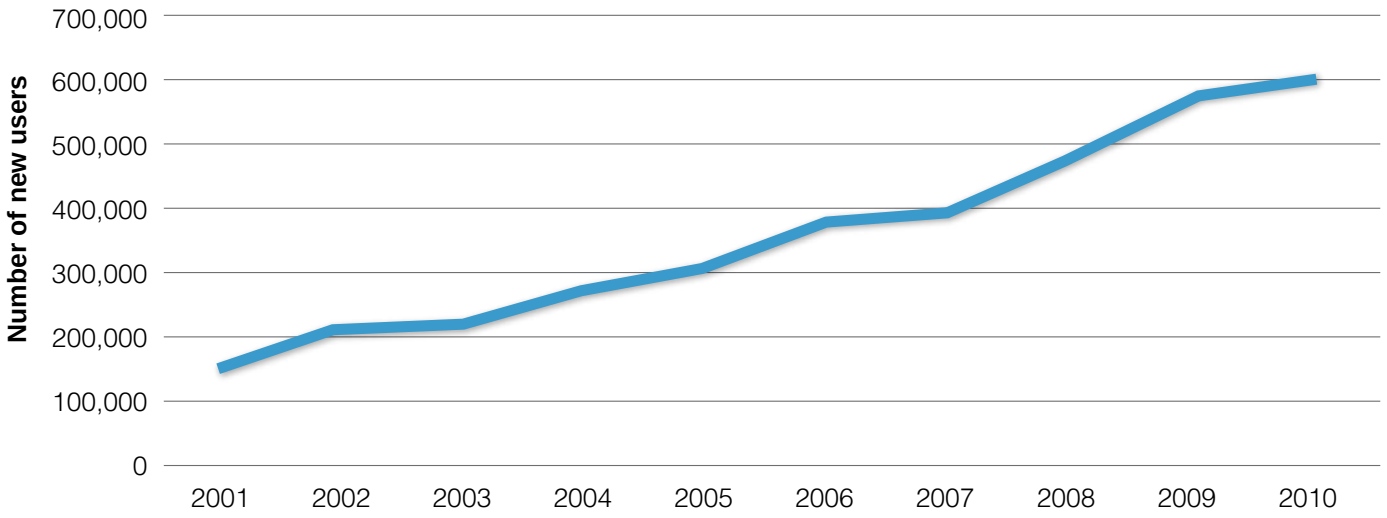
1 1998 Guatemala information from: National Institute of Statistics, Ministry of Public Health and Social Assistance (MSPAS), Macro International, Inc, and Measure DHS, Guatemala: National Survey of Maternal and Child Health, 1998-1999 (ENSMI 98/99), 1999. 2008 Guatemala information from: MSPAS, National Survey of Maternal and Child Health (ENSMI 2008/09), MSPAS, National Institute of Statistics (INE)/Center for Disease Control and Prevention (CDC), Guatemala, 2010. 1998 world and regional information from: "1998 World Population Data Sheet," Population Reference Bureau, Washington, DC, 1998. 2008 world and regional information from: "2008 World Population Data Sheet," Population Reference Bureau, Washington, DC, 2008.

2 ENSMI 2008/09.

In addition, more new clients sought FP services from the MOH, as seen in Figure 1, including large numbers of indigenous people living in rural settings, who had previously largely lacked access to these services.[3]

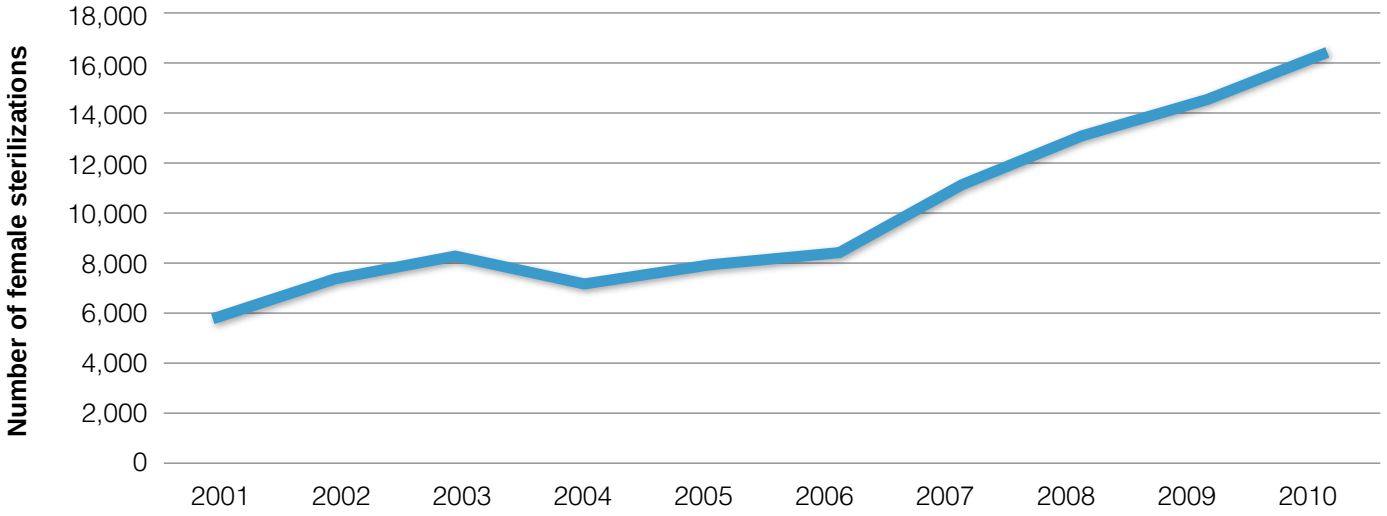
The provision of female sterilization procedures also increased by 195%, from 5,559 sterilizations in 2001 to 16,404 sterilizations in 2010, as seen in Figure 2.[4]

Figure 1. Trend in New Users Seeking Contraceptive Services at the MOH (2001 – 2010)



Source: SIGSA databases provided quarterly to Calidad en Salud for project reporting between 2000 and 2010.

Figure 2. Trend in Female Sterilization Procedures within the MOH's Postpartum Family Planning Program (2001 – 2010)



Source: SIGSA databases provided quarterly to Calidad en Salud for project reporting between 2000 and 2010.

3 MOH's Health Management Information System (SIGSA) databases provided quarterly to Calidad en Salud for project quarterly and annual reporting between 2000 and 2010.

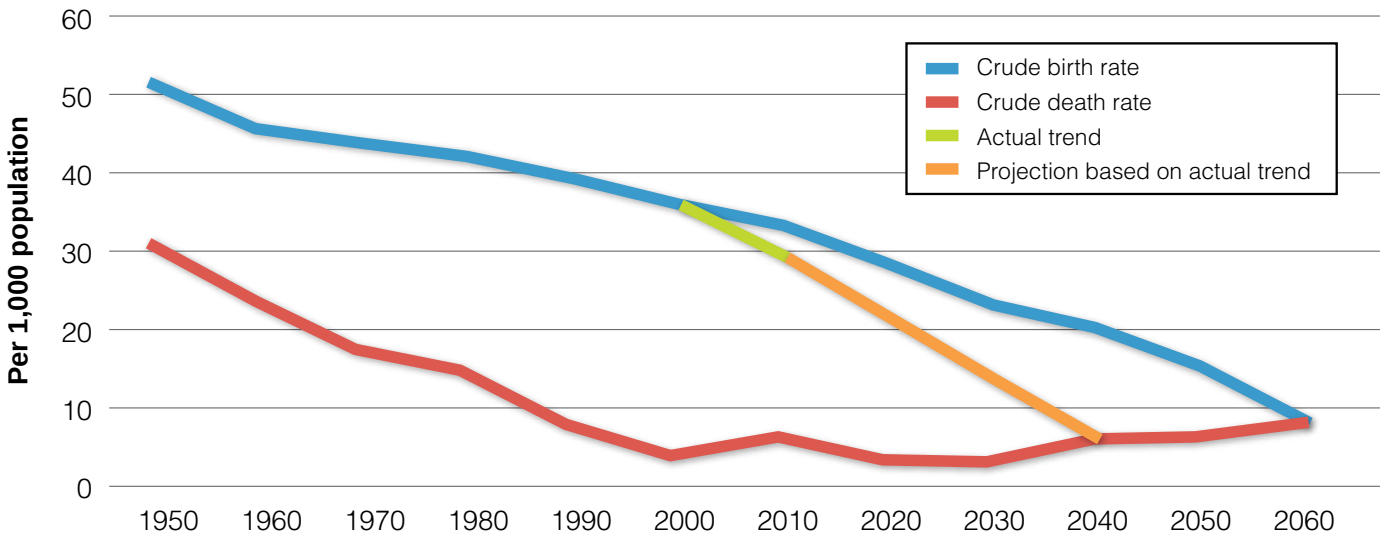
4 SIGSA databases provided quarterly to Calidad en Salud for project reporting between 2000 and 2010.

Over the 12 years that USAID has been strengthening the capacity for FP in Guatemala, the FP program has shown dramatic improvements.

Thanks to the advances in FP coverage by the public sector, the country witnessed a reduction in fertility rates: the average number of children that women of reproductive age have during their lives declined from 5.1 children on average per woman in 1998 to 3.6 children by 2008.[5] This decline is a significant achievement; if the current trend continues, Guatemala will reach its demographic transition (in which birth and mortality rates are equal) by the year 2040 instead of the projected 2060, avoiding a population increase of 17 million (shown in Figure 3).[6]

This report details USAID's legacy of successful technical assistance in FP provided to the Government of Guatemala through the Calidad en Salud I and II and HCI projects from 2000-2012. The work described here occurred during a time in which the Guatemalan national FP program experienced a period of dramatic and unprecedented growth and development. This report also presents the challenges encountered in expanding the FP program and presents lessons learned that could be applied to other projects working to successfully establish or enhance FP programs in other settings.

Figure 3. Demographic Transition in Guatemala: Trend before the Year 2000 vs. Trend after 2000



Source: Crude birth rate and death rate from: United Nations, Department of Economic and Social Affairs, Population Division (2007). World Population Prospects: The 2006 Revision, vol. I, Comprehensive Tables (United Nations publication, Sales Co. E.07.XIII.2).

5 ENSMI 2008/09.

6 Crude birth rate and death rate from: United Nations, Department of Economic and Social Affairs, Population Division (2007). World Population Prospects: The 2006 Revision, vol. I, Comprehensive Tables (United Nations publication, Sales Co. E.07.XIII.2).

BACKGROUND

Need for Family Planning in Guatemala

During the last four decades of the 20th century, Guatemala had one of the highest rates of population growth in the region, with total fertility rates above 5 children per woman.[7] This situation was in part due to the limited availability of family planning services. The population most affected by the gap between supply of and demand for contraceptives—demand met with caution and ambivalence by the private sector—was poor, rural women: in 2002, 32.3% of rural women did not wish to become pregnant at the time and/or in the future but were not using contraception, as opposed to only 20.2% of women in urban areas.[8]

As a result of high fertility rates, in particular among the poor and rural segments of the population, the country's population grew much faster than all neighboring countries, as shown in Table 2. Already-stretched resources were unable to meet the growing demand for food, health, and other social services brought on by the fast-growing population.

To address these issues, Guatemala needed a government-supported national FP program tasked with satisfying growing demand for contraceptive information and services. To develop and sustain such a program, FP services needed support at the same level given to other national health priority programs, such as immunization, and to be made as widely available as other services.

History of Support for Family Planning Programs

Since the 1960s, Guatemala's FP program has received different degrees of technical and financial support from the donor community. During the 1960s and 1970s, support was mainly focused on the private sector, in particular on the Association for Family Welfare of Guatemala (APROFAM), an NGO affiliated with the International Planned Parenthood Federation (IPPF), which pioneered the delivery of voluntary FP services in the late 1950s and 1960s and today contributes 38% of the national coverage.

Support shifted to the public sector in 1984, when the Family Planning Unit was created within the MOH's Maternal and Child Health Program, through technical and financial assistance from USAID. Today, the MOH provides more than 60% percent of available contraceptives services.

FP service delivery through the MOH continued to be limited, however; strategic planning and program management capabilities were limited. Dr. Julio Garcia Colindres, current Maternal and Neonatal Advisor to the MOH, explained the issue: "Prior to the year 2000, the family planning unit within the MOH did not have the necessary human and financial resources to

Table 2. Population Growth in Selected Central American Countries (1995 – 2000)

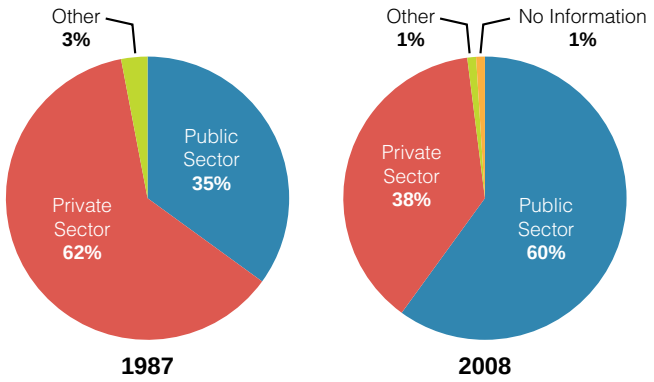
Country	Births per year	Deaths per year	Net migration per year	Population change per year
Guatemala	**396,000**	**73,000**	**-78,000**	**245,000**
Honduras	197,000	36,000	-36,000	125,000
El Salvador	163,000	35,000	-15,000	113,000
Costa Rica	79,000	14,000	26,000	91,000
Nicaragua	148,000	27,000	-32,000	89,000

Source: World Population Prospects: The 2006 Revision, vol. I.

7 World Population Prospects: The 2006 Revision, vol. I.

8 ENSMI 2008/09.

Figure 4. Comparison in Family Planning Service Provision by the Private and Public Sectors in Guatemala in 1987 and 2008

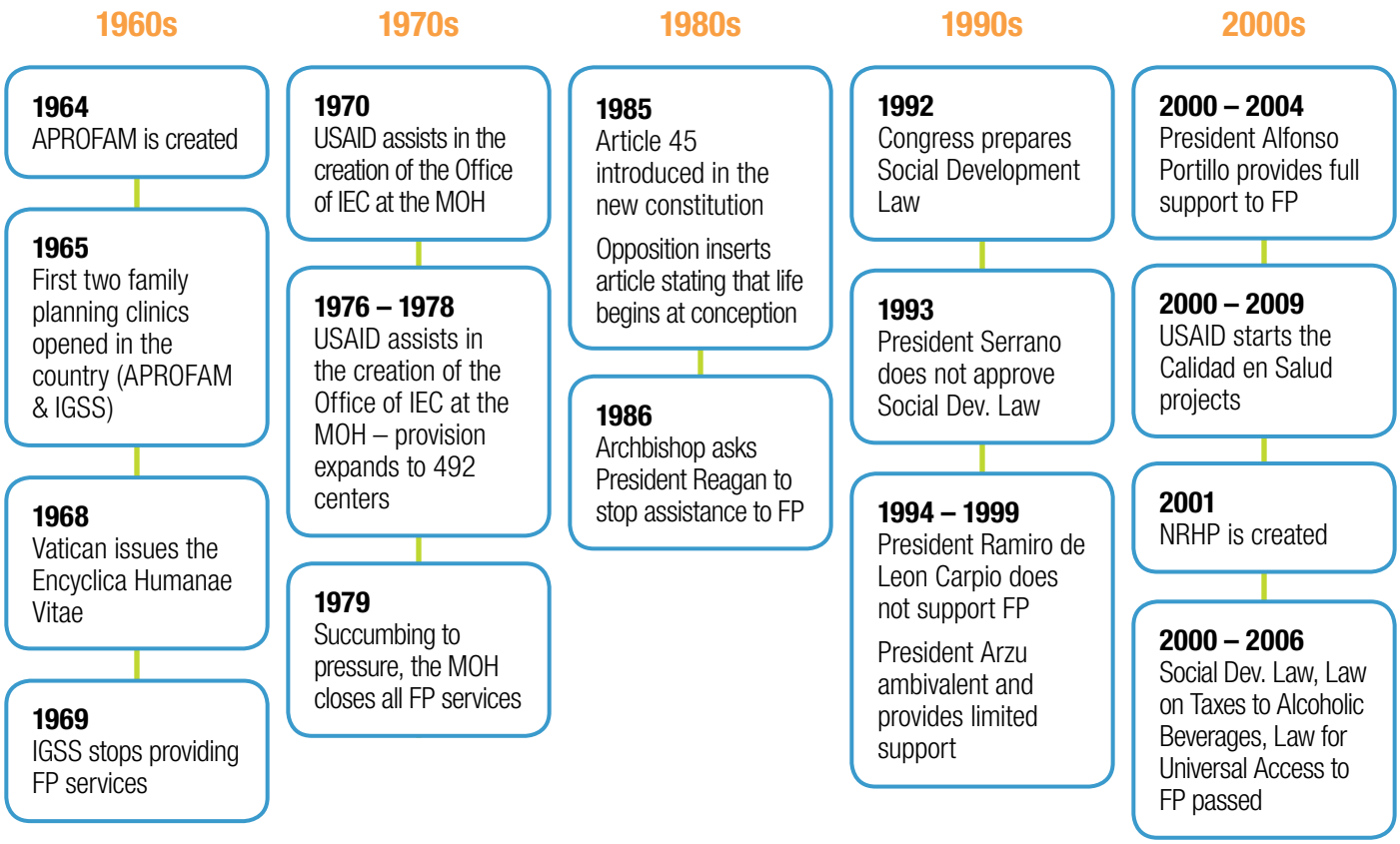


Source: ENSMI 2008/09.

manage a program of that size. Funding came from a larger maternal and child health budget, and securing dedicated funds for FP was a challenge, especially given the increasing demand for curative services. Furthermore, logistics systems for contraceptives were weak or non-existent."

Political will to support FP was also absent, as FP services were considered controversial and opposed by powerful religious and conservative groups. Although Guatemalan women were changing their views about ideal family size (54% of women who had two children in 1998 did not want more[9]), they continued to have limited access to FP services. Those opposed to providing FP services exerted strong pressure on politicians to withhold much-needed political and financial support.

Figure 5. Important Milestones in the Guatemalan Family Planning Movement



Source: Santiso-Galvez, Bertrand and Janet T. Bertrand. "Guatemala: The Pioneer Days of the Family Planning Movement." The Global Family Planning Revolution: Three Decades of Population Policies and Programs. Ed. Warren C. Robinson and John A. Ross. World Bank, 2007.

9 ENSMI 1998/99.

By 2000, however, the political climate regarding FP practices in Guatemala was shifting. Women-centered civil society groups organized to advocate for the provision of contraceptive information, FP services and improved policy with regard to reproductive health; and pressure mounted on government officials to support FP programs. Responding to this change in perception, USAID, through Calidad en Salud, assisted the MOH in building the National Reproductive Health Program (NRHP) with a strong FP component. The NRHP was officially created in July 2001, and the interventions described in this report were implemented through USAID's support to the NRHP through the Calidad en Salud I and II and HCI projects.

Principles Guiding Family Planning Technical Assistance to Guatemala

USAID'S technical assistance to Guatemalan FP is based on the recognition of FP as a basic human right and respects the rights of men and women to make voluntary and informed decisions on the use of FP methods. Furthermore, USAID, through Calidad en Salud, supported only those program elements that fully adhered to Guatemalan law and ensured that recipients of USAID's technical and financial assistance in FP strictly followed US government policies and regulations. Calidad en Salud staff developed curricula and provided annual training to USAID's partner organizations on the Guatemalan and US legal frameworks regarding the provision of FP services and technical assistance. These trainings focused on the Tiahrt Amendment, which protects voluntary and informed decisions regarding contraception. Partner organizations were also instructed on the Mexico City Policy, regarding the provision of support to organizations engaged in advocacy or delivery of abortions, and on USAID's Policy Determination 3 (PD3), which complements the Tiahrt Amendment. These policies and regulations are explained in more detail in Table 3.

Table 3. Government Policies and Regulations Regarding USAID Support for Family Planning

Tiahart Amendment	• The setting of targets with regard to the number of FP users or users of a specific method is prohibited. This clause exempts indicators and goals used for planning, budgeting, and reporting. • Incentives, financial rewards, or anything of value must not be used to encourage clients to accept an FP method or to encourage program personnel to achieve a target numbers of births, FP users, or users of a particular FP method. • Benefits or rights must not be tied to the acceptance of an FP method. • Complete information on all contraceptive methods must be provided. • Experimental contraceptive methods may be provided only within the context of a scientific study. Complete information on possible adverse effects must be conveyed to volunteers in the study.
Mexico City Policy	• USAID is prohibited from providing technical assistance or financial resources to NGOs that provide counseling or information related to abortion or that are engaged in advocating with foreign governments for the legalization of abortion.
USAID Policy Determination 3 (PD3)	• Clients must provide informed consent for sterilization. Informed consent is defined as the "voluntary, knowing assent from the individual after being advised of the surgical procedures to be followed, the attendant discomforts and risks, expected benefits, the availability of alternative FP options, the purpose of the operation and its irreversibility, and the option to withdraw consent at any time prior to the operation." • Where voluntary surgical contraception services are made available, other means of FP should also be readily available at a common location, thus enabling choice on the part of the client. • The payment of incentives to induce clients to accept sterilization is prohibited.

Calidad en Salud developed curricula on US Government policies and regulations regarding support for family planning.

Aware of the sensitivity surrounding male and female sterilizations due to alleged mass non-consensual female sterilizations in other countries, Calidad en Salud designed, tested, and implemented use of the "Informed Consent for Voluntary Surgical Contraception" form used today by the MOH network of services. The project monitored the availability of informed consent forms through supervisory visits in coordination with staff from the NRHP and provided training and refresher training to clinical staff to explain the necessity of the document and ensure its use.

Calidad en Salud operated through a country ownership approach, which enabled Guatemalan stakeholders to take the leading role in creating the FP program. USAID's FP technical assistance in Guatemala placed FP within a broader comprehensive reproductive health framework, emphasizing a woman- and girl-centered approach and integrating other healthcare services such as HIV/AIDS and maternal, newborn and child health. USAID ensured that the reproductive rights of both men and women are protected and recognized in the national MOH FP guidelines, policies, and legislation.

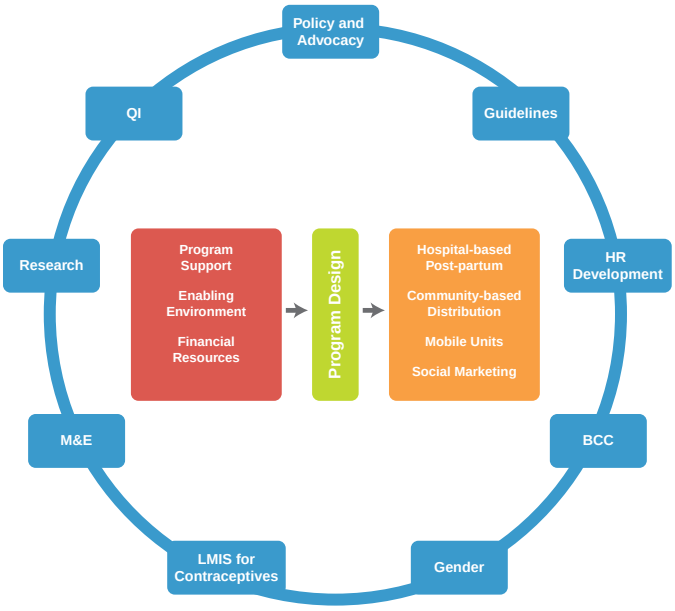
USAID'S FAMILY PLANNING TECHNICAL ASSISTANCE PROGRAM IN GUATEMALA

Program Design

Calidad en Salud developed a strategic framework to support development and implementation of the MOH's FP program, designed to effectively leverage financial, political, technical, and human resources provided by USAID and the MOH. An overview of the framework is shown in Figure 6.

The new nationwide FP program included hospital-based post-partum care and FP counseling, community-based distribution (CBD) of contraceptives, mobile units to provide FP services outside of clinics, and social marketing to generate demand for FP and educate providers. The program is supported by a robust system of tools and interventions, including a) policy and advocacy for FP service development, b) guidelines for FP delivery, c) a human resources (HR) development strategy, d) a behavior change communication (BCC) strategy, e) gender equality activities, f) a logistics management information system (LMIS) for contraceptives, g) monitoring and evaluation

Figure 6. Guatemala's Nationwide Family Planning Program Design and Implementation Framework



A staff member from the MOH's Extension of Coverage program provides FP counseling during a home visit.
Photo credit: Elena Hurtado, URC

(M&E) teams, h) research studies and technical notes, and i) a QI plan. Calidad en Salud's and HCI's team of experts collaborated closely with MOH staff to establish all of the necessary components for successful FP program implementation. Further details are provided in subsequent sections of this report.

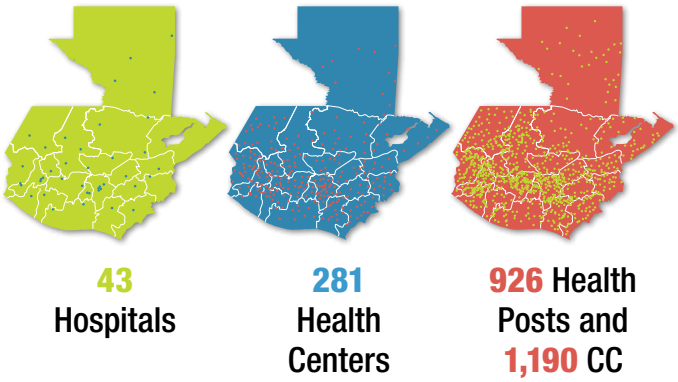
In order to enhance transparency and ensure responsible use of financial resources, Calidad en Salud also led the creation of the Reproductive Health Budgetary Unit, which provides funding oversight of FP program activities. Dr. Carlos Morales, the MOH's current Family Planning Advisor, explained the significance of the newly-created unit: "Before Calidad en Salud, the FP unit within the MOH had no direct line of authority, no decision making power, and no control over a budget for operations. Things changed with Calidad en Salud when the Reproductive Health Budgetary Unit was formed."

Calidad en Salud also helped to organize the team in charge of leading the nationwide program. The team was composed of staff from the NRHP, Guatemala's Integrated Health Care System (SIAS) program, and Calidad en Salud, as well as other regional health area facilitators. The slogan of the program, "Your Health, Your Decision, Our Future" ("Tu Salud, Tu Decisión, Nuestro Futuro"), was selected through a nationwide contest and presented at the inauguration of the NRHP.

Program Services

Assisted by Calidad en Salud, the MOH built a nationwide FP program to provide services throughout the regions managed by the 29 health area directorates in the country. FP services are available at more than 2,000 service delivery points, including 43 hospitals, 281 health centers, 926 health posts, and 1,190 community-based convergence centers (CCs). Services provided free of charge to all Guatemalans include the provision of barrier and hormonal contraceptive methods, intrauterine devices (IUDs), male and female sterilization, and brochures and counseling on FP options and use of FP methods.

Figure 7. Locations Providing Family Planning Services through the National Family Planning Program (2011)



Policy and Advocacy

Calidad en Salud worked closely with Guatemalan stakeholders, including the ministers for health, education and finance; congressional committees; women's groups; private employers; NGOs; and members of the media and scientific communities to advocate for FP programs. In advocating to the government, Calidad en Salud worked to clearly demonstrate the relationship between FP and decline in fertility rates, which helped to obtain much-needed political support for FP.

Initially, Calidad en Salud's work focused on creating government policy to establish the NRHP. The project's FP and BCC advisors participated in public forums, television talk shows, and meetings with key politicians and produced publications that contributed to the

formulation of the Universal Access to Family Planning Law and to the creation of the National Contraceptive Security Committee (NCSC) to ensure adequate stocks for the national program. Calidad en Salud also argued for the consideration of FP and demographic variables in overall MOH and national development planning.

With the NRHP in place, the project's FP and BCC advisors worked closely with the media, drafting press releases to spread knowledge about the benefits of birth spacing and FP and marking important dates, such as Women's Day and HIV/AIDS day. They distributed important educational materials, including brochures, condoms, and information on where to seek FP services. The renowned national television talk show "Libre Encuentro" ("Free Encounter") invited Calidad en Salud's FP Advisor to discuss FP and sexual education.

Calidad en Salud also used training to advocate for FP in the national schools for doctors and nurses, training practicing and graduating students on a yearly basis in FP. Courses sensitized them to the importance of FP in reducing maternal and child mortality rates and improving nutritional status of mothers and children.

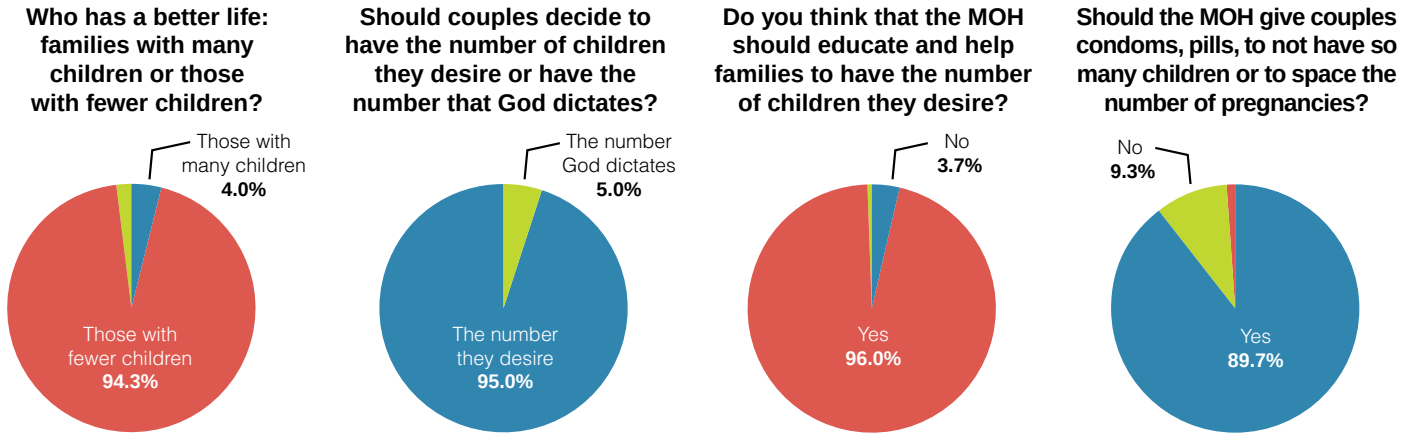
Although advocates for FP met a great deal of opposition, their efforts to educate Guatemalan society on reproductive rights and sexual behavior were effective. While the political battle over reproductive rights was ongoing, nationwide polls indicated that the overwhelming majority of Guatemalan citizens wanted FP services: in 2005, 96% of respondents indicated a desire for FP services through public health facilities, and 94% of respondents believed that families with fewer children have a better life than those with more children.[10]

Calidad en Salud also reached out to Guatemalan communities, working in close coordination with municipalities in priority health areas. Promotional campaigns for local FP services involved radio stations and newspapers. Project staff also advocated for FP resources and contraceptive services in local hospitals. Hospital directors instituted FP services in a variety of ways, including creating FP units, assigning staff to provide FP counseling services, and requiring service provision seven days a week.

Guidelines

In order to standardize the provision of quality FP services, Calidad en Salud provided technical assistance to the MOH for the development of guidelines based on scientific evidence to provide staff with step-by-step FP service processes. Guidelines developed included those on contraceptive technology, male and female sterilizations, IUD insertion, and balanced FP counseling. Furthermore, guidelines were also produced to standardize procurement, warehousing, distribution, and overall logistics management processes. Throughout the Calidad en Salud I and II and HCI projects, guidelines were updated in order to reflect the latest scientific research, in particular with regard to FP method eligibility

Figure 8. Results of a 2005 Nationwide Poll on Family Planning



Source: Vox Latina, Telephone Poll, "Family Planning," Guatemala, December 2005.

10 Vox Latina, Telephone Poll, "Family Planning," Guatemala, December 2005.

Family planning guides were developed with Calidad en Salud's technical assistance.

criteria. Calidad en Salud also ensured that FP providers were trained on all appropriate guidelines: more than 5,000 providers were trained.

Human Resources Development

The Calidad en Salud projects also contributed significantly to the national FP program by ensuring training of FP personnel at all MOH service delivery points, including health area directorates, hospitals, and other clinics and health centers. Technical areas for training included contraceptive technology, FP counseling, logistics management, monitoring and evaluation, surgical sterilization procedures, IUD insertion, and QI processes. Training was also provided in leadership and program management and administration.

To train staff across the country from more than 2,000 service delivery points, a total of 14 training centers were established at seven health area offices and at seven hospitals known for surgical contraception training. More than 15,000 people have been trained in FP provision and counseling since 2000: 5000+ physicians, 7,000+ nurses, and 3,000+ health workers engaged in the Extension of Coverage Program. Furthermore, through the work of Calidad en Salud, refresher trainings were provided on topics based on the results of annual assessments. The project

Calidad en Salud staff provide hands-on training in IUD insertion.
Photo credit: Luigi Jaramillo, URC

also developed a variety of interactive training DVDs, which included recorded sessions by Calidad en Salud's FP team.

Behavior Change Communication

In 2000 the Inter-Institutional Technical Group on Information, Education, and Communication (GTI-IEC) was formed with participation from the MOH, the IGSS, and organizations working on FP in Guatemala, most notably APROFAM and the Population Council. The GTI-IEC strategy development workshop in July 2000, involving technical assistance from Calidad en Salud using the Communications Intervention Cycle developed by URC and shown in Figure 9, resulted in the first national BCC strategy for FP.

The BCC strategy aimed to increase the use of contraceptive methods in people of reproductive age, especially rural and indigenous women. Calidad en

Salud supported the review of existing FP materials; led the design, pretest and production of new materials; and coordinated the logistics of their distribution to clients through MOH facilities and personnel, which included the production and distribution of wooden brochure display carts. Initially, materials included posters, videos, radio spots, and brochures explaining FP services and the FP methods available. Materials were published in indigenous languages to ensure wide usability. Messages were focused on raising awareness of FP services offered at health facilities free of charge and explaining that a personal decision to use FP could be made without coercion. Calidad en Salud also developed training manuals and job aids for providers, including posters, flipcharts, and counseling cards for each FP method offered.

Figure 9. Communication Interventions Cycle

The GTI-IEC revised the BCC strategy in 2005 and 2007 to include more emphasis on gender equality by designing interventions for men and adolescents. New messages and materials were produced, including radio spots targeted to men; banners and billboards, brochures for adolescents; a manual for reproductive health sessions with men; and a video on couple communication. Additional materials were also created to support new FP initiatives and challenges. For example, IUD posters were produced to explain this FP method, and a mini-guide to educate providers on managing IUD side effects and counseling was created.

Calidad en Salud produced numerous FP BCC materials.

Gender

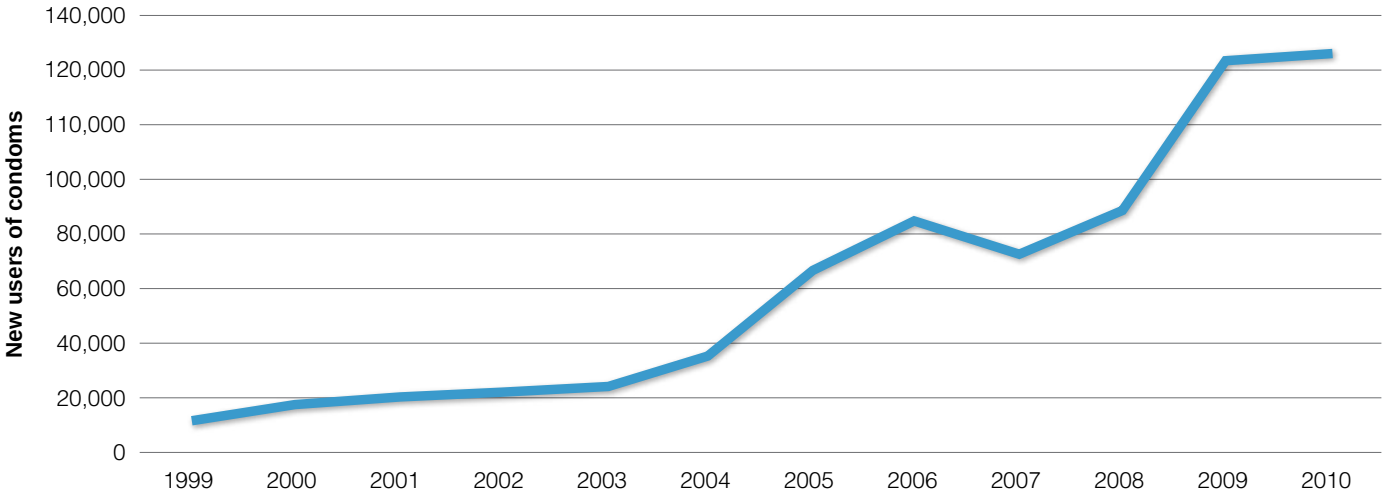
Calidad en Salud provided technical support to the MOH to implement activities designed to foster gender equality by changing men's attitudes toward FP. Men are often considered the household decision-makers, and their opposition to FP contributes to high fertility rates and low CPRs. Activities included the following:

- FP counseling curricula included sections specifically developed to address men's FP needs and promote the use of contraceptives among male clients. In addition, trainings on FP counseling included sessions designed to obtain provider support in supplying male FP methods, such as vasectomy and condoms.
- BCC materials to promote FP among men were designed and distributed at health centers. These materials included brochures on condom use, vasectomy, and male participation in contraception.
- Radio spots targeted male audiences, educating them on the benefits of vasectomy and condom use and dispelling rumors related to the use of contraceptives.
- The revision of the National Family Planning Guidelines for the MOH included a chapter specifically on counseling men.
- At the community level, men were encouraged to play a major role in the promotion of FP services for men and women and in caring for pregnant women.

Staff from Calidad en Salud train MOH physicians in vasectomy procedures. *Photo credit: Hector Chaclan, URC*

Although much work remains to be done in Guatemala to achieve equality among men and women in reproductive health decisions, notable progress has been made. For example, the Guatemala Demographic and Health Surveys (DHS) from 2002 and 2008/2009 showed that men have more knowledge about contraceptives than women. In addition, the desired fertility rate among men was lower than that reported by women. Male demand for contraceptives is also on the rise, as illustrated by the trend shown in Figure 10 on the number of new users of the MOH condom provision service.[11]

Figure 10. Trend in New Users of the MOH Condom Provision Service (1999 – 2010)



Source: SIGSA databases provided quarterly to Calidad en Salud for project reporting between 2000 and 2010.

11 SIGSA databases provided quarterly to Calidad en Salud for project reporting between 2000 and 2010.

Logistics Management Information Systems for Contraceptives

USAID's investment in contraceptives logistics management has been significant in developing an effective and functional contraceptive LMIS, capable of delivering contraceptives to the right places, in the right amounts, and at the right time. Calidad en Salud provided technical assistance to the MOH in the design and implementation of a simple, user-friendly LMIS. This system was designed by the NRHP and by staff working with the MOH's Health Management Information System (SIGSA) and applied state-of-the-art information technology that allows high-level reporting. Once the design was agreed upon, Calidad en Salud provided additional programming resources to build the system under SIGSA's ownership and direction.

Calidad en Salud also trained more than 8,000 people from around the country in logistics management—100% of the logistics staff from the MOH, IGSS, and NGOs working in the Extension of Coverage Program. Approximately one-fourth of those trained were physicians; half were auxiliary nurses and warehouse staff; and one-fourth were community personnel, accountants, ambulatory personnel, and institutional facilitators.

Understanding that the resources to manage a complex LMIS with more than 2,000 service delivery points were limited, Calidad en Salud took the lead in creating a logistics technical team to oversee the LMIS for the MOH. The team involved members from the NRHP, USAID, the United Nations Population Fund (UNFPA), and Calidad en Salud. The team helped to reduce distribution costs, produce educational materials and interactive DVDs for self-learning on logistics, and ensure financing for contraceptive logistics workshops. In a very short time, the logistics technical team generated significant results, including the following:

- Standardization of the distribution process through the development of logistics administration manuals for contraceptives;
- Supervision, monitoring and evaluation of logistics at more than 2,000 service delivery points;
- Development and installation of a computerized LMIS within the MOH's official databases, improving data analysis for decision making;
- Redesign and institutionalization of the logistics forms, now used by 100% of the health areas; and
- Institutionalization of two nationwide inventories of contraceptives per year.

The LMIS was designed and implemented by the MOH with Calidad en Salud.

Logistics management has ensured that delivery of contraceptives through all levels of service provision has improved considerably, helping reduce the gap between urban and rural populations in access to contraceptives. In rural areas, availability of contraceptives has led to an increase in CPRs, from 19.8% in 1996 to 45.8% in 2009.[12] In addition, stock-outs of contraceptives greatly decreased, from 45% of health posts without adequate stock levels in 2000 to only 18% by 2008.[13]

Monitoring and Evaluation

Calidad en Salud worked closely with the MOH and SIGSA to build its capacity for monitoring and evaluating program results, helping to build a management information system (MIS), to determine indicators, and to train staff. The project assisted the MOH in modernizing its MIS to increase monitoring and evaluation capabilities. The project helped tailor-build information system modules within SIGSA and provided the resources necessary for training large numbers of people across the MOH in MIS administration. The

12 ENSMI 2008/09.

13 Results of nationwide annual inventories of contraceptives conducted by the NRHP between 2000 and 2008.

project was instrumental in building the MOH's local area network (LAN) at the central level, providing hardware needs, including servers, routers, cabling, workstations, backup equipment, and printers.

Calidad en Salud aided SIGSA in designing indicators to monitor new FP users, continuing users, and total number of users by method. Furthermore, in order to monitor levels of protection generated by the FP program, Calidad in Salud also aided the MOH in adopting the couple years of protection (CYP) indicator, which monitors the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. As the MIS improved in data collection capabilities and reliability, other indicators were added to monitor service quality levels through client exit interviews, stock levels of contraceptives, and BCC materials developed and distributed.

Calidad en Salud helped build a culture of information use for decision making at the central and regional levels. Regional meetings were held on a quarterly basis to review FP performance data. Health centers with high performance shared processes and interventions with lower-performing centers, and healthy competition among service delivery centers contributed to increased results.

Research Studies and Technical Notes

Calidad en Salud also conducted research studies and developed technical notes on FP. The results of these studies reached a wide audience, including service providers across all levels, program administrators and directors, policy makers, the scientific community, and international donor organizations. Using evidence from these studies, Calidad en Salud was able to directly address policy, social, medical, and institutional barriers to a stronger FP program. One study, for example, was a cost-benefit analysis of contraceptive service provision within the MOH and compared the cost of contraceptive services with the costs related to prenatal, delivery, and postpartum care for pregnancies that would occur in the absence of FP. The study showed that the MOH saves $14.32 for every dollar invested in FP.[14]

FP research and technical notes developed by Calidad en Salud were numerous and included:

- A market segmentation study to determine demographic characteristics of potential contraceptive users (including age, location, ethnicity, etc.);
- A report on world trends in FP demand and fertility reduction;
- A study on rates of contraceptive use discontinuation;
- A report on comparing FP programs in Guatemala and other countries from 1996-2006;

Table 4. Relationship between Benefits and Cost of Family Planning

Year	Benefit	Cost	Total saved for every dollar spent
2002	$128,483,418	$7,985,184	$16.09
2003	$146,673,535	$9,297,082	$15.78
2004	$154,170,216	$11,444,030	$13.47
2005	$156,343,453	$11,803,672	$13.25
2006	$165,176,994	$11,900,889	$13.88
2007	$205,917,136	$14,383,388	$14.32
Total	**$956,764,752**	**$66,814,245**	**$14.32**

Source: Jaramillo, Luigi and Ricardo Valladarez, Cost Benefit Study of Family Planning in Guatemala, Published by the USAID Calidad en Salud Project for the United States Agency for International Development, Bethesda, MD: University Research Co., LLC (URC).

14 Jaramillo, Luigi and Ricardo Valladarez, Cost Benefit Study of Family Planning in Guatemala, Published by the USAID Calidad en Salud Project for the United States Agency for International Development, Bethesda, MD: University Research Co., LLC (URC).

- A report on the roles of FP in demographic growth and development;
- Formative research studies on barriers to vasectomy and IUD use;
- A formative research study on adolescent views toward postponing sexual relations, pregnancy, ideal family size and use of FP; and
- Technical notes describing the implications of rapid demographic growth on socio-economic variables.

Quality Improvement

HCI used a variety of approaches to improve the quality of FP services and to motivate providers to give the best services possible. These approaches included ensuring that FP service providers had the necessary skills and tools to provide quality services, conducting exit interviews with clients to assess service quality gaps, and utilizing improvement collaboratives (groups of service providers who identify gaps, test changes for improvement, and measure their achievements).

HCI's QI framework focused on four interrelated key elements, shown in Figure 11.

1. Availability of FP Services

HCI worked with the MOH to formulate an official mandate requiring FP services to be made available 7 days a week on demand. Furthermore, several program administrators contracted additional personnel and acquired clinic space for FP. In order to ensure that quality FP services were continuously delivered, HCI also supported the contraceptive LMIS and verified that BCC materials were consistently available. Individual clinics also published information on the availability of FP services in local newspapers and through promotional posters.

Figure 11. HCI's Quality Improvement Framework

Availability of services was advertised in local newspapers and through promotional posters. *Photo credit (newspaper): El Quetzalteco, (picture): Elena Hurtado, URC*

2. Technical Capacity

Through a training program that reached more than 15,000 service providers, HCI ensured that FP workers have the technical capacity to deliver quality FP services. Training helped providers to avoid causing unnecessary pain or infections to clients or ordering unnecessary and costly procedures. The development of BCC materials also enabled counselors to provide a higher level of care, as they guided both staff and clients through FP methods and processes.

A traditional birth attendant studies materials received as part of her training in FP counseling. *Photo credit: Elena Hurtado, URC*

3. Client Relations

HCI worked to train FP service providers in respectful and confidential treatment. The project also ensured that counseling, desired contraceptive methods, and follow-up visits were available to clients.

4. Organization of Services

HCI integrated FP into maternal health and HIVAIDS services so that clients could access FP services more efficiently and require fewer visits to service delivery posts.

CONCLUSIONS AND RECOMMENDATIONS

The Guatemalan FP program has achieved substantial success through the participation of both private and public sector organizations and with strong support from the MOH. Success stemmed largely from strong political backing, encouraged through civil activists and from USAID support through the Calidad en Salud I and II and HCI projects. Without these two elements, widespread public sector FP service delivery would not have been possible. Program strength will continue to increase as demand for FP services among women and men continues to rise and as remaining political opposition continues to dissipate.

Supporters of FP must continue to work toward universal access to FP, advocating for renewed resources, including financial investment for the procurement of contraceptives. The legal framework in favor of FP in Guatemala is very strong, but mechanisms to ensure compliance with the law need to be firmly put in place. The MOH has made great progress in educating its staff with regard to the reproductive rights of Guatemalans. However, as political changes in the government bring changes in staff, the MOH must continually orient new staff in FP, generating new FP leaders and working to eliminate still-present medical and institutional barriers. Furthermore, the MOH must address the gap between desired and observed fertility rates in rural areas, where maternal, infant, and malnutrition rates are the highest.

The following recommendations for expansion of and increased results through Guatemala's FP program are based on USAID's project experience detailed in this report:

- Maintain supportive and close relationships with women's groups and organized civil society to ensure that the provisions of the Universal Access to Family Planning Law are closely followed and monitored.
- Engage the Extension of Coverage Program to raise its level of contribution to the national program through CBD of FP services in rural areas, with mechanisms to transparently monitor its performance.
- Increase depth of understanding of social cultural barriers to FP among rural populations and design services that incorporate traditions of indigenous populations.
- Further engage additional hospitals in the postpartum FP program to increase IUD and sterilization users, as most of the current increase stems from services at only a small number of hospitals.
- Deliver national FP services for adolescents, and continue to work with men, both individually and with their wives and partners, to encourage FP use.
- Continue to support the LMIS, which is heavily criticized when there are stock-outs at service delivery points. These stock-outs are not the fault of the LMIS but are related to lack of funding or problems with pharmaceutical suppliers.
- Ensure training in FP strategic planning, administration, and management.
- Build in-country leadership for FP programs to support their further growth and development.

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