MEASURE EVALUATION SR-15-118D

Family Planning in Guatemala
The Achievements of 50 Years

April 2015

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USAID FROM THE AMERICAN PEOPLE

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MEASURE Evaluation is funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement AID-OAA-L-14-00004. MEASURE Evaluation, whose staff provided editorial, formatting, and distribution assistance, is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in association with Futures Group, ICF International; John Snow, Inc.; Management Sciences for Health, and Tulane University. The opinions expressed in this publication do not necessarily reflect the views of USAID or the United States government.

April 2015 ISBN 978-1-943364-04-6 SR-15-118D

Preface

This publication is one of eight case studies that were developed as part of a broader review entitled *Family Planning in Latin America and the Caribbean: the Achievements of 50 Years.* As its title implies, the larger review documents and analyzes the accomplishments in the entire region since the initiation of U.S. Agency for International Development (USAID) funding in the early 1960s. The reader of this case study may wish to access the executive summary or the report in its entirety at:

http://www.cpc.unc.edu/measure/publications/tr-15-101

Acknowledgments

We want to thank the individuals who provided invaluable historical insight for this case study including Yma Alfaro, Karina Arriaza, Marisela de la Cruz, Rebeca Guizar, Gustavo Gutiérrez, Luis Hernández, Baudilio López, Mirna Montenegro, Edwin Morales, Claudia Roca, Alejandro Silva, Jorge Solórzano, and Silvia Xinico. In addition, Yma Alfaro, Marisela de la Cruz, Héctor Menéndez and Isabel Stout reviewed a previous version of this case study.

The co-authors owe a debt of gratitude to three individuals who devoted vast amounts of their time and energy to this case study and to the larger main report: Kime McClintock and Jerry Parks (lead research assistants at Tulane University School of Public Health and Tropical Medicine) and Maria Cristina Rosales (editorial assistant in Guatemala). Their dedication in conducting background research, fact checking, verifying references, and editing text greatly enhanced the quality of the final product. In addition, we thank Nicole Carter, Alejandra Leyton, and Maayan Jaffe for their contributions as research assistants to specific sections of the main report and/or case studies. Mirella Augusto and Maria Carolina Herdoiza provided valuable administrative and logistics support to this effort. At the University of North Carolina at Chapel Hill, we thank Erin Luben, Elizabeth T. Robinson, and Nash Herndon for their editorial assistance; as well as Denise Todloski, who designed the cover.

The USAID Latin America and the Caribbean Bureau (USAID/LAC) commissioned this work and provided constructive technical guidance in its development. We wish to thank Kimberly Cole for her skillful management of the process and detailed synthesis of reviewer comments. Other reviewers of this case study from USAID/LAC included Maggie Farrell, Amber Hill, Lindsay Stewart, Verónica Valdivieso and Mary Vandenbroucke. Finally, the authors thank a number of Latin American/Caribbean specialists from within and outside of USAID who reviewed the main report and are acknowledged by name in that document.

Suggested citations:

Bertrand JT, Ward VM, Santiso-Gálvez R. *Family Planning in Latin America and the Caribbean: The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso-Gálvez R, Ward VM, Bertrand JT. *Family Planning in Guatemala. The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

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OVERVIEW
COUNTRY SITUATION

Guatemala is the most populous country in Central America. With an estimated population of 15 million people in 2012 and an annual growth of approximately 2.4 percent, its population doubles about every 30 years.[1] In addition to a growing population, Guatemalans face barriers in access to health and education services, especially in rural and indigenous areas. An estimated 60.2 percent of the population is non-indigenous or ladino (primarily Spanish-speaking persons of mixed Spanish and indigenous heritage) and 39.8 percent is indigenous.[2] The latter includes the Maya with 22 different linguistic communities, the Xinka and the Garífuna. These indigenous groups have distinct cultural patterns and health, economic and social indicators that are well below those of the ladino population.[3] The above factors are evidenced by high maternal and infant mortality rates that are almost 50 percent higher in rural and indigenous areas than in the rest of the country.

Vast income disparities exist in Guatemala, a country listed by the World Bank as a low- to middle-income economy, overall, 53.7 percent of the population lives in poverty and 13 percent in extreme poverty.[4] For the rural population the situation worsens: almost three-quarters (71.3 percent) live in poverty and 21.1 percent in extreme poverty.[5]

As shown in table 1, the total fertility rate (TFR) had declined from 5.5 children per woman in 1987 to 3.6 children per woman in 2008/09 (3.1 for the non-indigenous population and 4.5 for the indigenous population). The contraceptive prevalence rate (CPR) among women married or in union aged 15 to 49 has more than doubled from 23.2 percent in 1987 to 54.1 percent in 2008-2009 for all methods, and from 19.0 percent to 44.0 percent for modern contraceptive methods. However, there are marked differences by place of residence and ethnicity.[6]

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[1] Population Reference Bureau. World population data sheet [poster]. Washington, DC: Population Reference Bureau; 2013. [Note: Other sources, like Guatemala´s National Statistics Institute (INE), duplicate this population estimate that population doubles every 20 to 23 years.]

[2] Instituto Nacional de Estadistica. *Caracterización Estadística República de Guatemala 2012*. Guatemala City: Gobierno de Guatemala; 2013.

[3] The World Bank. *World Development Indicators*. Washington, DC: The World Bank; 2012. Available at http://data.worldbank.org/country/guatemala.

[4] Instituto Nacional de Estadistica. *Encuesta Nacional de Condiciones de Vida –ENCOVI-2011*.

[5] Instituto Nacional de Estadistica. *Encuesta Nacional de Condiciones de Vida (ENCOVI). Principales Resultados 2006*. Guatemala City, Guatemala: United Nations Population Fund; 2006.

[6] Ministerio de Salud Pública y Asistencia Social (MSPAS). *Encuesta Nacional de Salud Materno Infantil (ENSMI) 2008-2009.* Guatemala City, Guatemala:MSPAS; 2009.

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married or in Union, Aged 15-44, Guatemala, 1987-2009

	1987	1995	1998-1999	2002-2003	2008-2009
Total Fertility Rate	5.5	5.1	5	4.4	3.6
Contraceptive Prevalence Rate (%)	23.2	31.4	38.2	43.3	54.1
Modern Contraceptive Prevalence Rate (%)	19.0	26.9	30.9	34.5	44.0
Unmet Need (%)	n/a	28.1	26.8	27.6	20.8

Source: ENSMI data
Note: The data presented in this table were obtained through DHS STATcompiler for the following years: 1987, 1995, 1998-99, 2002-03, and 2008-09. Data on unmet need for 2002-03 and 2008-09 were not available in STATcompiler and instead were obtained directly from Reproductive Health Surveys (RHS).

The 2008-2009 Encuesta Nacional de Salud Materno Infantil (ENSMI) found that among the indigenous population, the contraceptive prevalence rate was 40.2 percent for all methods, but only 28.4 percent for modern methods. Women in urban areas used some type of contraception at higher rates (65.7 percent) than those living in the rural areas (45.6 percent). The desired number of children per woman in urban areas was lower (2.3) than the actual rate (2.9). In rural areas, the pattern was similar, but the numbers were slightly higher: 3.5 (desired) in comparison to 4.2 (actual). Unmet need for family planning (FP) was 20.8 percent nationwide, but if analyzed by ethnicity, unmet need was much higher among indigenous women (29.6 percent) than among non-indigenous or *ladino* women (15.1 percent).[7]

Approximately one-third of the population of Guatemala is between the ages of 10 to 24.[8] Among women married or living in union, the youngest were the most vulnerable. Only 28.1 percent of 15 to 19 year olds use modern contraceptives. Multiple factors contribute to the difficulties experienced by this group: poverty, ethnic discrimination, gender inequality, lack of opportunity for education and employment, and pressure for early marriage/motherhood. Once mothers, these young women often bear the major responsibility for raising their children. Additionally, their low social and economic status makes them vulnerable for gender based violence (GBV). Guatemala is among the countries in Central America with the highest levels of GBV.[9]

High fertility rates (97 per 1,000 women aged 15-19) puts Guatemala as a country with the third-highest fertility rate in Latin America.[10] According to data from the 2008/09 ENSMI, 9.5 percent

[7] ENSMI, 2008-2009.
[8] Instituto Nacional de Estadistica. *Población en Guatemala* [demografía]. Guatemala City, Guatemala: Instituto Nacional de Estadistica; 2011. Available at http://www.ine.gob.gt/np/poblacion/
[9] Ministerio de Salud Pública y Asistencia Social (MSPAS), 2010. "Lineamientos Estratégicos en Salud Integral de Adolescentes y Jóvenes para Orientar los Planes Estratégicos Territoriales en Salud Periodo 2010-2015."
[10] The World Bank. *Data Catalog*. Washington, DC: The World Bank; 2012. Available at http://datacatalog.worldbank.org/.

of women aged 15 to 24 reported having been pregnant for the first time before age 15; 48.5 percent between ages 15 and 17 and 25 percent between ages 18 and 19.

According to the Programa Nacional de Salud Reproductiva (PNSR, National Reproductive Health Program), pregnancies at ages 10 to 19 account for 20 percent of all deliveries in health facilities.[11] Maternal mortality among adolescents and young adults (aged 10 to 24) represents 33.8 percent of the maternal deaths. According to monitoring data from the Observatorio de Salud Reproductiva (OSAR, the Reproductive Health Observatory), 4,354 adolescents aged 10 to 14 and 59,058 adolescents aged 15 to 19 years gave birth in 2013.[12] From a legal standpoint, pregnancies between the ages of 10 and 14 are considered to be the result of rape, often committed by family members, and now considered a criminal offense in Guatemala. The Judicial system has intensified its efforts to enforce this law and prosecute those perpetuating this crime.[13,14] The OSAR is a 21-member multidisciplinary body that performs a watchdog function for policies and programs related to sexual and reproductive health (SRH), contraceptive security, safe motherhood, and neonatal health. It gathers data on indicators to monitor proper compliance with the reproductive health (RH) political and legal framework in Guatemala. OSAR has played a key role in denouncing this type of situation that has afflicted the country for many years, but this problem is rarely exposed to the public scrutiny.

As far as preference for specific methods, the most recent available data show that female voluntary surgical contraception (VSC) is the most prevalent contraceptive method among contraceptive users at 34.9 percent, followed by the three-month injectable Depo Provera (27.2 percent). Figure 1 shows the evolution in the contraceptive method mix from 1987 to 2009.

According to 2008/09 ENSMI data, the use of female VSC is greater among women with higher levels of education and income.[15] The use of injectables had increased markedly, from 10.2 percent in 1998 to 27.2 percent in 2009, with slightly higher use in rural than in urban areas.

Although the government has offered FP for many years, until about 2000 the private/nongovernmental organization (NGO) sector was the main provider of modern methods, covering 70.4 percent of the market (figure 2).[16] However, since the government began to provide more systematic support to FP starting in 2000, the roles have reversed. Use of public sector services has increased to 60.2 percent of users: the health ministry (50.9 percent) and the Instituto Guatemalteco de Seguridad Social (IGSS, Guatemalan Social Security Institute) (9.3 percent). Conversely, the private/NGO sector had dropped markedly as a source of

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11 Ministerio de Salud Pública y Asistencia Social (MSPAS). *Lineamientos Estratégicos en Salud Integral de Adolescentes y Jóvenes para Orientar los Planes Estratégicos Territoriales en Salud Periodo 2010-2015.* Guatemala City, Guatemala: MSPAS; 2010.

12 Observatorio en Salud Reproductiva (OSAR). *Registro de Nacimientos por Edad de la Madre*. Guatemala City, Guatemala: OSAR; 2013. Available at: http://osarguatemala.org/userfiles/Partos%20por%20edad%20de%20la%20madre%20ano%202013.pdf.

13 Congreso de la República de Guatemala. Ley Contra la Violencia Sexual, Explotación y Trata de Personas, Decreto Número 9-2009, Artículo 28. 2009.

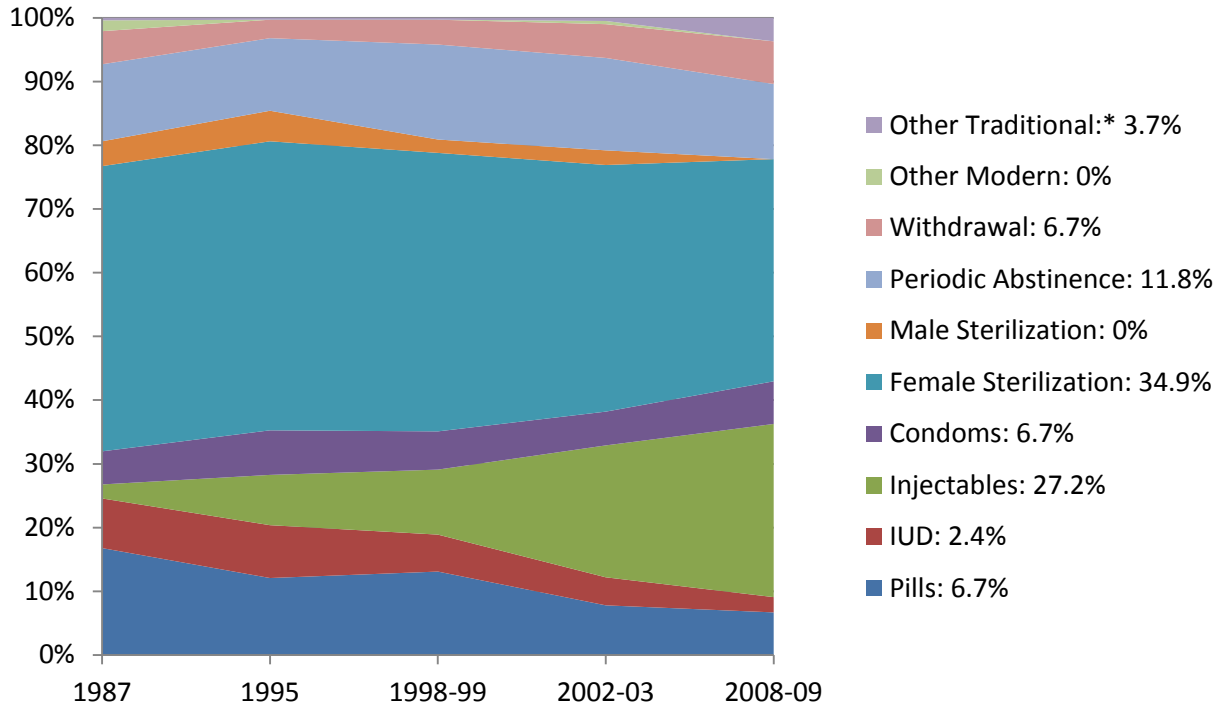
14 Observatorio en Salud Reproductiva (OSAR). *Partos en Niñas Y Adolescentes, una Deuda Social en Guatemala. Monitoreo del Primer Semestre del 2012.*" Guatemala City, Guatemala: United Nations Population Fund; 2012.

15 ENSMI, 2008-09.

16 Ministerio de Salud Pública y Asistencia Social (MSPAS). *Encuesta Nacional de Salud Materno Infantil (ENSMI) 1995.* Guatemala City, Guatemala: MSPAS; 1995.

contraceptives, accounting for only 38 percent of the market, including: APROFAM (15.9 percent), private pharmacies (11.9 percent), private clinics and hospitals (5.4 percent), private doctors (3.6 percent), and other private sources (1.2 percent). Other sources made up 1.8 percent.[17] A recent survey (publication forthcoming as of 2014) of 30 municipalities in the western highlands of Guatemala with predominantly poor, rural, and indigenous populations shows that 80 percent of contraceptive users obtain their methods from health ministry facilities.[18]

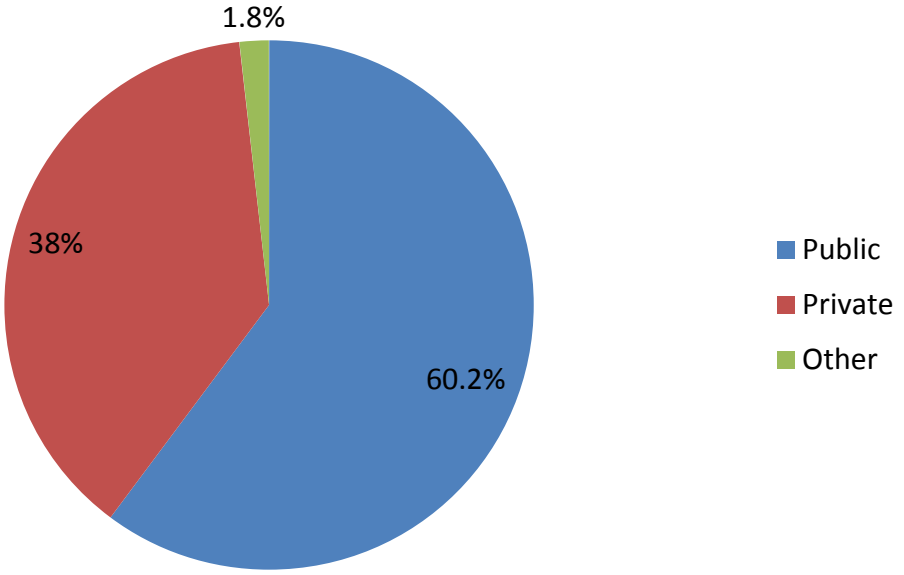
Guatemala faces an ongoing challenge to improve coordination among different FP providers in an effort to eliminate the existing inequities in regard to access to services based on educational, ethnic origin and income level, particularly in rural areas.



Source: ENSMI data; percentages in legend refer to the most recent survey (2009).
Note: * Includes other folkloric methods. Periodic Abstinence refers to rhythm and Billings methods. ENSMI considers these three methods "natural" methods.

Figure 1: Method mix (Guatemala, 1987-2009)

[17] ENSMI, 2008-09.
[18] MEASURE Evaluation. *Encuesta de Monitoreo y Evaluación del Programa del Altiplano Occidental, Línea de Base 2013*. Chapel Hill, NC: MEASURE Evaluation; in press.



Source: ENSMI data.

Figure 2: Method source (Guatemala, 2008-2009).

THE EARLY YEARS (1960-1977)

As in other Latin American countries, FP began in Guatemala as an initiative of a group of doctors, nurses, sociologists and social workers concerned about the high rate of maternal mortality largely due to a high number of unsafe abortions.[19]

The Asociación Pro Bienestar de la Familia de Guatemala (APROFAM, the Guatemalan Association for Family Welfare) was founded in 1964 as a private entity created by the first FP champions in the country. It opened its first clinic in 1965 in the Latin American Hospital of Guatemala City. A doctor, a nurse, and a social worker offered FP counseling and supplies including oral contraceptives, barrier methods, (vaginal creams, tablets, and condoms) intrauterine devices (IUDs), and natural methods. In 1965, IGSS opened a FP clinic that offered contraceptive methods and counseling as part of its maternal and child health service. APROFAM became an associate member of the International Planned Parenthood Federation (IPPF) in 1969 and a permanent member in 1971.[20]

The first tripartite agreement among the U.S. Agency for International Development (USAID), the Ministerio de Salud Pública y Asistencia Social (MOH), Ministry of Health and Social

[19] Galich L, Santiso-Gálvez R, Goldsmith A, Ferguson J. El Problema del aborto hospitalario en Ciudad de Guatemala [conference paper]. International Fertility Research Program, (AID/csd 2979), Pregnancy Termination Series No. 77, presented at the Fifth National OBGYN Congress in Guatemala; 1975.

[20] International Planned Parenthood Federation. Guatemala [Web page]. Available at http://www.ippf.org/our-work/where-we-work/western-hemisphere/guatemala.

Welfare, and APROFAM was signed in 1967, authorizing APROFAM to establish FP services in 20 MOH centers.[21]

During the 1960s and 1970s, donor support for FP came mainly from USAID and its cooperating agencies, although there were other donors, such as IPPF. FP efforts focused on the non-profit private sector, primarily APROFAM.

USAID's support for FP in the early years included major efforts to train staff in counseling and service delivery for male and female temporary and permanent contraception; donate contraceptives and surgical supplies; and provide technical assistance to design and develop information, education, and communication (IEC) materials.[22]

During the early 1960s, the Roman Catholic Church began to analyze the FP situation worldwide, and in 1968 the Vatican published the encyclical *Humanae Vitae*, in which it stated its opposition to the use of contraceptive methods other than "natural" methods.[23] This resulted in attacks against FP in general and APROFAM in particular. The Catholic Church opposed FP in Guatemala and exerted influence on government authorities in this respect. Bowing to these pressures, in 1968 IGSS imposed tight restrictions on access to FP services. [24,25]

In an attempt to measure public receptivity and interest in FP, several studies in urban and rural areas were undertaken with USAID support, which confirmed the existence of demand for services, even though the majority of the population identified itself as Catholic. The increasing rate of induced abortion also served to illustrate the extent to which women desired to control their fertility.[26]

The government reorganized the MOH in 1969 and created a special section for FP within the División de Salud Materno-Infantil y Familiar (Maternal, Child and Family Division), and an integrated office composed of both MOH and APROFAM personnel which included FP among its services. The MOH allowed APROFAM to continue providing services in its clinical units, but did so with great caution, downplaying the provision of FP services by its health centers. From a human resources standpoint, it was a difficult time for APROFAM's staff since some physicians within the public network of health services were opposed, on religious grounds, to the clinics served by APROFAM.

The MOH directly administered USAID funds for FP services from 1967 to 1975. In 1970, provision of FP was extended to 450 facilities, while maintaining a low profile. APROFAM distributed contraceptive methods and provided training to MOH staff until 1975, when the

[21] MSPAS-USAID-APROFAM, 1967. Project No. 520-0189, Population and Rural Health.
[22] MSPAS-USAID-APROFAM, 1967.
[23] Pope Paul VI. *Humanae Vitae*. *Encyclical Letter on the Regulation of Birth.* Vatican State: Tipografia Poliglotta Vaticana; 1968.
[24] Santiso-Gálvez R, Bertrand JT. Guatemala: The Pioneering Days of the Family Planning Movement. In Robinson W. Ross JA (eds.). *The Global Family Planning Revolution.* Washington, DC: The World Bank; 2007:137-153.
[25] Santiso-Gálvez & Bertrand, 2007:139.
[26] Burski C. Family planning in Guatemala [consultant report]. Guatemala City, Guatemala: Burski; 1977.

MOH temporarily suspended FP services due to internal administrative problems within the MOH.[27]

During the 1970s, Guatemala was in the midst of an internal armed conflict that lasted over 30 years (1960-1996). During this time, the Guatemalan army and guerilla groups fought against each other, leaving over 200,000 people dead. The war's effects were felt most strongly in rural areas, where the indigenous population was caught in the middle of the conflict and fell victim to widespread massacres. As such, the conflict left deep scars and distrust among its population. Contraceptive use was already low because of cultural and religious opposition and limited access to services. According to experts who worked in Guatemala during those years, the internal conflict increased the local populations' apprehensions towards the ideological and political motives of FP.

On February 4, 1976, Guatemala suffered an earthquake that killed 25,000 people and destroyed large parts of the country, including much of the MOH infrastructure. The MOH closed its Information, Education and Training Office and devoted itself to rebuilding its infrastructure, delegating further implementation of the agreement with USAID to APROFAM. In spite of innumerable problems, APROFAM continued to work closely with the MOH; it was the prime promoter of population and FP activities in Guatemala, and designed a direct distribution system to provide logistic contraceptive support to the MOH. As of 1977, the system had expanded the program from 126 to 324 MOH clinics, and by January 1978, 500 health facilities were offering FP services.[28]

YEARS OF CONTINUED CONTROVERSY (1978-1999)

Between 1978 and 1979, pro-natalist groups opposed to FP launched a series of attacks against the IUD because they considered it an abortifacient. The MOH, yielding to pressure from the Catholic Church, interrupted the FP program and ordered the removal of all IUDs from FP users of the MOH program; it also suspended VSC services and temporarily discontinued collaboration with APROFAM.[29]

Toward the end of 1979, a group of representatives from the private sector met with the Minister of Health and persuaded him to continue the FP program and renew the MOH's relationship with APROFAM. FP services were later resumed, but on a limited basis. The program experienced an additional setback, when the MOH mandated that FP services could only be delivered by specific medical personnel, but not through trained nurses as had been done in the past.

When the MOH created the Family Planning Unit and Maternal Health Program in 1984, international aid began flowing to the public sector. APROFAM coordinated USAID's and IPPF's assistance to IGSS for provision of reversible methods, equipment and training for medical and paramedical personnel. Assistance in training in administrative and operational

[27] U.S. Agency for International Development (USAID). Project no. 189. Evaluation report. Guatemala City, Guatemala: USAID; 1976.
[28] Burski, 1977.
[29] Santiso-Gálvez & Bertrand, 2007.

processes and technological support at the national level was provided through APROFAM, until IGSS launched its own FP program as part of MCH service delivery during the 1990s.[30]

In the early 1980s, APROFAM started an information and advocacy campaign to counter the attacks on FP and raise awareness among opinion leaders, decision makers, and the general public about the impact of rapid population growth on development. The campaign also positioned FP as a means to improve maternal and child health. This campaign – which received technical and financial support from USAID and IPPF – used multiple communication channels (newspapers, radio programs, radio and TV soap operas, television spots, and documentaries) and won several national and international awards.

In the 1980s, APROFAM also organized a contest for journalists and the media, giving awards for the best reporting on population and development, population growth, responsible parenthood, sexual education, HIV/AIDS, and FP. The contest fueled the interest of journalists and gained significant media coverage. It also generated controversy, pitting media outlets that supported FP against those that defended the conservative position. Advertisers who opposed FP withdrew their advertisements from media supporting FP. However, the APROFAM contest continued well into the mid-2000s and became a widely recognized and prestigious award among journalists and communicators.

In 1986, the Archbishop of Guatemala wrote a letter to President Ronald Reagan requesting the suspension of U.S. FP aid based on allegations of mass sterilization of indigenous women without their consent. President Reagan sent a delegation to Guatemala, which concluded that the allegations were unfounded. The program continued; however, both the MOH and APROFAM strengthened their counseling, information efforts, and staff training to improve the quality control of services and ensure that APROFAM fully complied with the requirement of informed consent, particularly for VSC.

In the late 1980s and early 1990s, various organizations and individuals (in particular women) worked to raise awareness on population and FP issues among officials in the legislative and executive branches and to develop a position on the Program of Action of the International Conference on Population and Development (ICPD) held in 1994.[31] However, at the conference, the Guatemalan delegation acted in accordance with the instructions of President Ramiro de León Carpio and voted consistently with the Vatican.

After decades of civil unrest, the Peace Accords were signed in 1996 between the government and the guerrillas. The accords established the government's commitments for the future development of Guatemala, in the areas of health, education, and human rights. The Peace Accords addressed the status and rights of women and indigenous peoples, prioritizing their

[30] USAID/Healthcare Improvement Project. *USAID´s Legacy of FP Technical Assistance to the Guatemalan Public Health Sector: Over a Decade of Success through USAID's Calidad en Salud and Health Care Improvement Projects*. Bethesda, MD: University Research Co., LLC; 2012. Available at https://www.usaidassist.org/sites/assist/files/guatemala_legacy_of_fp_assistance_jan2012.pdf.

[31] Ministerio de Desarrollo Social (MIDES) & Secretaria de Planificacion y de la Presidencia (SEGEPLAN). *Informe Nacional de la Encuesta Mundial de Avances del Programa de Acción de la Conferencia Internacional sobre Población y Desarrollo*. Guatemala City, Guatemala: United Nations Population Fund; 2012.

needs. During this period international support to FP, primarily on the part of USAID, continued unabated.

Between 1996 and 1997, President Álvaro Arzú launched a survey among opinion leaders and policy makers in order to find out their position on FP, thus intensifying the debate between those who supported it and those who opposed it. At the end, the MOH FP program continued, but with limited government support. In this period, civil society participation to promote policies and legislation in support of FP/SRH markedly increased.

At the end of the 1990s, in an effort to decentralize services and to promote preventive medicine, the government launched an initiative to extend health coverage nationwide, especially to indigenous populations, via local NGOs. This was known as the Extensión de Cobertura Program (Coverage Extension), but did not include FP until years later.

PROGRAM CONSOLIDATION (2000-2013)

In 2000, the political climate surrounding FP began to change. Noteworthy is the role that women have played over the past 15 years. With a rights-based approach as the foundation of their advocacy efforts, organized groups of women fought to defend their reproductive rights. Women members of Congress, supported by professional, political and women's groups from the civil society, promoted legislation in support of FP/RH and advocated for the provision of contraception. They also helped improve policies regarding SRH within the overall legal framework developed over the decade. Media coverage and FP experts who lived the experience recount the episodes of women marching in the streets, protesting in front of the Presidential Palace, and organizing their communities – all to overturn access barriers to FP. These women, indigenous and non-indigenous, coordinated with Congress, signed agreements with the Human Rights Ombudsman, petitioned mayors, went public with their requests, interviewed presidential candidates, and involved their families and communities in an effort to defend their rights to health and FP.

President Alfonso Portillo responded to these demands and offered political support for FP, promoting MOH services and facilitating the training of personnel nationwide. The Programa Nacional de Salud Reproductiva (PNSR, National Reproductive Health Program) was officially created with USAID technical and financial support during the Portillo administration (which ran from 2000 to 2004). The civil society led a major effort to improve the policy environment for FP/RH, HIV, and maternal health. The projects supported by USAID combined awareness raising, promotion of civil society leadership, policy dialogue, and policy formulation for a wide range of RH issues, promoting multisectoral involvement in policy development processes. Thus began the consolidation of FP in Guatemala. During this administration, MOH became the major provider of family planning services in the country, a position that it still held as of 2014.

The MOH, its NGO partners, and IGSS received significant technical and financial support from USAID and other donor agencies (e.g., the United Nations Population Fund, UNFPA) to

strengthen the capacity of the health care system and provide greater access to clinical services, particularly for indigenous people in isolated rural areas of the highlands.[32]

In 2001, USAID notified the government of Guatemala and IGSS of its impending withdrawal of financial support for the procurement of contraceptives and, jointly with UNFPA, established a gradual withdrawal plan that called for both MOH and IGSS to take responsibility for contraceptive procurement. This was fully achieved in 2010, as discussed below. However, in contrast to other countries in the LAC region, this did not signal the discontinuation of population assistance to the country.

As of 2014, significant USAID technical and financial assistance for FP/RH in Guatemala was continuing at the rate of approximately U.S. $ 6.5 million annually. Through different projects and activities, this support focused on organizing and strengthening civil society participation regarding the right to FP/RH, expanding FP services, improving quality of care, strengthening contraceptive information and logistics systems, producing and distributing behavior change communication (BCC) materials, developing human resources, monitoring and evaluation of FP/RH programs, promoting culturally relevant counseling, and getting men involved in FP/RH.

Although Guatemala has made significant progress in its FP program in the last 12 years, the population has been growing steadily and the demand for social services, including FP, has increased. The indicators used by USAID to initiate the graduation process (total fertility rate, modern contraceptive prevalence rate, disparities by subpopulations) had not improved sufficiently to make Guatemala a candidate for graduation, at least not within the next few years as this document was being written in 2014.

POLICY, LEADERSHIP, AND GOVERNANCE

Guatemala now has a legal framework that mandates universal access to FP services based on international and national standards, as a result of a series of policies and laws enacted over the past 25 years.

In 1985, APROFAM successfully advocated for Congress to include Article 47 in the new Constitution, which would guarantee couples' right to make free and informed decisions regarding the number and spacing of their children. However, opposition groups also succeeded in including Article 3, which states that life begins at the moment of conception, with the aim of attacking contraceptives as abortifacients.

A more favorable policy environment for FP/SRH in Guatemala was glavanized by a series of events, including the 1996 Peace Accords, the ICPD Program of Action, the lobbying and advocacy actions undertaken by the women's movement with USAID and UNFPA support. This resulted in consensus among highly diverse groups and favorably influenced government policy on the subject. In 2001, Congress responded by passing the Social Development Law, Decree

[32] USAID/Healthcare Improvement Project, 2012.

No. 42-201, which constitutes the legal framework for development, including reproductive health.

This law established in its Article 26 "that the Ministry of Health, in coordination with the Ministry of Education, should develop, coordinate, implement and promote a Reproductive Health Program." It specified that one of the components of the SRH program should be FP and decreed that FP methods and services should be available nationwide.[33]

The Social Development and Population Health Policy was created in 2002, establishing a set of goals and actions contemplated in the Law on Social Development.

In 2004, a law was enacted (Decree 21-2004), establishing a tax on the distribution of alcoholic beverages, distilled spirits, beer and other fermented beverages. Article 25 of this law stated that at least 15 percent of the funds raised through this tax shall be allocated to the MOH's FP/SRH and alcohol abuse prevention programs.

In 2005, the law on Universal and Equitable Access to Family Planning Services (Decree 87-2005) was enacted, with final approval in 2006. This law mandates that the government must guarantee financial resources for contraceptive procurement and requires the Ministry of Education to include content on the rights and responsibilities for health promotion, sexuality, and early and unintended pregnancy in the educational curricula. This law led to conflict between conservative groups and the government; its provisions were not adopted until four years later due to appeals filed by those who opposed it, claiming that it was unconstitutional. The law made the government responsible for contraceptive procurement, mandated that the MOH budget should include a line item specifically earmarked for FP, and called for the creation of the Comisión Nacional de Aseguramiento de Anticonceptivos (CNAA, National Committee for Contraceptive Security, similar to a DAIA) that was established in 2009.[34]

The Safe Motherhood Law (32-2010) was enacted in 2010 with five guiding principles: provision of services free of charge, accessibility, equity, respect for cultural differences, and sustainability. Article 27 of this law amended Decree 21-2004, establishing that at least 30 percent of the 15 percent allocated for SRH programs must be set aside for contraceptive procurement. This law also stated that failure to comply with these provisions would result in penal sanctions for public officials and employees, suppliers of services, and partners or spouses (if they impede access to contraceptive use). Congressional Decree 19-2010 was also approved, which allows the MOH to purchase contraceptives through UNFPA or any other international entity that offers the most favorable prices.

[33] The organizations that analyzed and developed the Social Development Bill were the Evangelical Alliance of Guatemala, the Episcopal Conference of Guatemala, the Defender of Human Rights, the National Teachers' Assembly, the Women's Civic and Political Convergence, the Trade Union Federation of Guatemalan Workers, the Gynecology and Obstetrics Association, the Committee of Commercial, Industrial and Financial Associations (CACIF), the Guatemalan Association of Journalists, Rafael Landívar University (Catholic), del Valle de Guatemala University, and San Carlos de Guatemala University.

[34] DAIA is a multi-disciplinary and multi-agency contraceptive security committee that was convened by the MOH with support from USAID.

Civil society has organized itself in groups (both indigenous and non-indigenous) to participate and influence FP/SRH policies. These groups work in close collaboration with the legislative branch of government and the Human Rights Ombudsman in monitoring compliance of the executive branch with the law. They advocated for access to FP and were responsible for pushing Congress to override a Presidential veto to the Universal Access to FP Law. The private sector became more aware of the health and nutrition problems in the country and the connection to population issues, due to the efforts of women's groups. These groups include OSAR, the Alianza Nacional de Organizaciones de Mujeres Indígenas por la Salud Reproductiva por la Nutrición y Educación; (ALIANMISAR, National Alliance of Indigenous Women Organizations for Reproductive Health, for Nutrition and Education), the Asociación Guatemalteca de Mujeres Médicas (AGMM, Guatemalan Medical Women Association), the Instancia de Acciones Políticas por la Salud y el Desarrollo de las Mujeres (Political Actions for Women´s Health and Development), among others.

In short, after years of controversy surrounding FP and RH, the legal framework for FP in Guatemala was robust as of 2014. Civil society had increased participation and the government had earmarked financial resources for FP. USAID continued to support efforts to help the government address potential barriers related to contraceptive procurement and regulatory frameworks. However, careful monitoring of current regulations and procedures are essential to help enforce and guarantee compliance with the existing national laws, decrees, policies, and plans.

Family Planning and the Health System

The health sector is comprised of the MOH, IGSS, the Ministry of Defense, other ministries, secretariats and municipalities, NGOs, and the private sector. Over decades, the public health sector in Guatemala has faced innumerable problems, mainly in relation to human resources, infrastructure, equipment, finances, medical products and coordination across the three levels of attention.

In 2010, Guatemala spent 6.9 percent of GDP on health or $327 per person. Of total health expenditures, 34.9 percent are covered by government, 65.1 percent by private sources (of which the largest portion – 81.2 percent – is "out of pocket"; only 4.8 percent is covered by private health plans).[35] Decreases in government participation in health spending limits access to services for the poorest and threatens the stability of families that live above the poverty line but do not earn enough to support out of pocket health expense.

Between 1996 and 2000, Guatemala began a process of health reform with the introduction of new policies aimed at strengthening primary health care. This process consisted of reorganization, decentralization and modernization of the public health sector, including implementation of new financing, privatization and integration schemes. This process has not been easy and still poses continuous challenges. In particular, the primary health system does not

[35] The World Bank, 2013.

provide adequate reach and coverage to those in the Western highlands where a majority of indigenous population reside.

SERVICE DELIVERY MODELS

Clinical Services

FP services are provided primarily by the MOH, IGSS, and NGOs working on FP in the private non-profit sector, the largest of which is APROFAM. The MOH currently provides services in all 29 health areas of the country.[36] Family planning is offered at more than 2,000 service delivery points, including 43 hospitals, 281 health centers, 926 health posts, and 1,190 community-based convergence centers.[37]

MCH services and supplies, which include FP and other SRH services, are provided free of charge to all Guatemalans who request them at the three levels of care and include counseling and IEC materials. Methods offered include barrier methods and hormonal contraceptives (oral contraceptives and injectables), IUDs, voluntary male and female surgical contraception, condoms, and subdermal implants. Information, training, and counseling on natural methods, such as rhythm, Cyclebeads (Standard Days Method), and Lactational Amenorrhea Method (LAM) are also available.[38]

IGSS has 24 hospitals, 30 clinics, 18 first-aid posts and five health facilities attached to national hospitals, which offer the same methods as the MOH. However, there have been irregularities in its provision of FP services because its policies are not clearly defined.[39] Thus, the IGSS participation has been minimal (9.3 percent of the market share) and has not had major impact on access to and use of FP services.

Although oral contraceptives, injectables, condoms, IUDs, and implants are included in the basic list of contraceptives, there are frequent stock-outs for various reasons in different sites, particularly in rural and indigenous areas. While information on various methods is provided, often the desired method is not available upon request.

Extension of Coverage

As mentioned above, the MOH created a health care model that includes both preventive and curative services with the objective of improving access to primary health care services in rural areas, taking services to the community, and creating spaces for community participation,

[36] A health area is a geographical territory that includes health posts, health centers, hospitals as well as any other service provision unit situated under its geographical jurisdiction.
[37] USAID/Healthcare Improvement Project, 2012. Note: "centros de convergencia comunitaria" are health centers run by NGOs with their own personnel, with oversight from the MOH.
[38] USAID/Healthcare Improvement Project, 2012.
[39] Lorenzana Gonzalez M. *Estudio del Papel del UNFPA Guatemala en el Aseguramiento de Insumos de Salud Reproductiva—Sistematizacion de la Experiencia*. Guatemala City, Guatemala: United Nations Population Fund; 2008.

particularly among marginalized rural populations that historically have lacked access to health services. FP services were not offered under this service delivery model until the beginning of the 2000s.

Under this service delivery model that covers an estimated 4.5 million people, the MOH contracts with NGOs to provide primary care services. It operates with participation of MOH primary care personnel; in most cases, a visiting doctor or nurse, and an institutional service provider contracted by NGOs travel to rural-indigenous communities once a month.[40] In 2013, the MOH launched an improved model that provides permanent small health clinics staffed with an auxiliary nurse. This doubled the per capita health investment from U.S. $7 to about U.S. $15 per person per year. The model was transitioning as of 2014, but there was uncertainty about its sustainability since detractors were trying to discredit the approach. Government payments to the NGOs have been a recurrent problem, and donors routinely have had to intervene to facilitate payment. USAID and other cooperating agencies have provided support for this model.

Other NGOs working specifically with indigenous populations to provide FP education and access to SRH services include Alas de Guatemala (WINGS), a charitable organization, Frente de Salud Infantil y Reproductiva (Fesirgua, Front for Child and Reproductive Health), and Rxiin Tnamet, a community-based Mayan organization that works in the Department of Sololá. These and others have received support from USAID as well as other donors.

Most of the Programa de Extension Cobertura organizations have receive FP methods, training, supervision, and monitoring and evaluation from MOH, as well as significant support from international agencies. More recently, however, these organizations have depended upon their own limited financial resources to provide FP services, and have faced stock-outs as well as other problems.

Community-Based Distribution

APROFAM began community-based distribution of contraceptives (CBD) in Guatemala City in October 1975, as a model that was designed to give clients more direct access to contraceptives. Demand for clinical services was high, with long waits in clinics to obtain a contraceptive method. Clinics were operating under limited hours, and personnel were overburdened.

The CBD program grew rapidly and by 1977 more than 7,000 promoters had been recruited. In Guatemala City, CBD workers gave educational talks and sold contraceptives at a nominal cost. The program then expanded into small towns and fincas (large agricultural farms) in the Department of Suchitepéquez and Mazatenango. Distributors were given intensive training and backup support from APROFAM and received 40 percent of the revenue collected from the sale of contraceptives.[41] CBD continues to be a major service delivery model for the MOH and

[40] Ministerio de Salud Pública y Asistencia Social (MSPAS). *Coordinación General de Áreas de Salud, Modelo de Extensión de Cobertura en el Primer Nivel de Atención*. Guatemala City, Guatemala: MSPAS; 2007. Available at http://icosguate.org/files/Extension%20de%20cobertura.pdf.

[41] Burski, 1977.

APROFAM through the community leader network (volunteer promoters), youth multipliers, and mobile health units.

Social Marketing

As in other countries in the region, social marketing began in Guatemala in 1985 through the Importadora de Productos Farmacéuticos, S.A. (IPROFASA, Importer of Pharmaceutical Products), with USAID financial and technical support.[42] Using commercial marketing techniques, IPROFASA received subsidized commodities from USAID; after repacking them for the target population, contraceptives – mainly orals and condoms – were made available and affordable, particularly for urban areas, while linking them to well-designed communication campaigns aimed toward behavioral change. IPROFASA established its own distribution network and used retail shops and pharmacies to make the subsidized commodities available to the public. As of 2014, IPROFASA was active but no longer received USAID support.

The Pan American Social Marketing Organization (PASMO/PSI) initiated its efforts in Guatemala in 1997, focusing on HIV/AIDS prevention with information, behavior change communication, and condom promotion and distribution to people engaged in high-risk behaviors.

In recent years (2009-2013), PASMO has continued promoting and creating demand for long-acting contraceptive methods (particularly IUDs and implants). Through the Red Segura (Secure Network) Project, which was operating through private doctors, quality gynecological services, IUDs, and implants were being offered at affordable prices in compliance with international standards and protocols.

In general, FP service delivery had expanded and significant progress had been achieved in Guatemala, due in part to more information being available and to a growing acceptance of FP within communities. The counseling being offered by the MOH and NGOs working in FP sought to balance the population's needs with a gender-based and multicultural approach, based on the individual´s right to freely decide the number and spacing of their children. Advocacy and lobbying by indigenous and non-indigenous women in different geographic areas and decision-making levels have also been instrumental to this success. The ALIANMISAR, a network of organizations composed of approximately 200 groups of indigenous women, stands out among these groups. With USAID support, it advocates for indigenous women's reproductive health and promotes community-based services.

However, there were important issues in need of resolution. One of the chief complaints related to the shortcomings in the commodity procurement and logistical system. A second challenge related to institutional and medical barriers, such as biases among service providers. Although service providers had been trained, they lacked sensitivity to a woman's right to receive full information tailored to her level of education, ethnicity, and social status. There were important sectors of the population that still had no access to services, and youth SRH education,

[42] McCoy TL, Townsend MC. Continuidad de proyectos de salud financiados con fondos del gobierno de los Estados Unidos en Guatemala, planificación familiar. 1987.

information and services were minimal. Service quality needed to be improved, especially for indigenous populations, which continued to have a large unmet need for FP (nearly 30 percent).

HUMAN RESOURCES FOR HEALTH AND FP

According to the World Health Organization (WHO), the ideal number of doctors to have is 23-25 per 10,000 inhabitants.[43] A study performed by UNFPA in 2008 indicated that Guatemala had 9.9 doctors per 10,000 inhabitants. According to the same study, physician/registered nurse ratio was 1:3 and the registered nurse/nursing assistant ratio was 1:14. Human resources in health were more concentrated in urban areas, with an urban/rural ratio of 4:1 for physicians and 3:2 for registered nurses.[44] At that time (2008), the country had several groups of health specialists with a post-graduate degree in public health. World Bank data for 2009 reported 9,965 doctors in Guatemala, which equaled nine doctors per 10,000 people.[45]

Since 2000, USAID cooperating agencies have provided staff training at all MOH service delivery points on contraceptive technology, counseling, contraceptive logistics management, monitoring and evaluation, voluntary sterilization procedures, insertion of IUDs and implants, and quality improvement processes. They have also provided training in leadership, program management, and administration.

Fourteen surgical contraception training centers have been established in seven health areas and seven hospitals. Since 2000, more than 15,000 people have been trained to provide FP and counseling services, including more than 5,000 physicians, 7,000 nurses, and 3,000 health providers working in the Extension of Coverage program. Refresher courses have also been held. The program produced interactive training videos and designed and produced numerous information, training and communication materials for behavior change.[46] Several international cooperating institutions, such as UNFPA, Pan American Health Organization (PAHO), and others continued to provide training to service providers. However, turnover of qualified staff and recruitment of new staff contributed, among other reasons, to medical or institutional shortcomings.

Guatemala has a large cadre of community health service providers, including more than 23,000 comadronas (traditional birth attendants) or midwives, of which about 15,000 were registered with the MOH and have been trained with UNFPA support in clean and safe birth attendance. A large segment of the midwives are illiterate and not qualified to manage emergency cases. The MOH has tried to integrate the comadronas as counselors/companions of the birthing process, but that lesser role has not always been acceptable to those who see their profession as an important contribution to MCH in Guatemala.

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[43] Pan American Health Organization. Llamado a la Acción de Toronto, 2006-2015, una década de recursos humanos en salud para las Américas. Reunión Regional de los Observatorios de Recursos Humanos en Salud, 4-7 de octubre de 2005. Available at: http://www.paho.org/mex/index.php?option=com_content&view=article&id=337&Itemid=338.

[44] Lorenzana González, 2008.

[45] The World Bank, 2012.

[46] USAID/Healthcare Improvement Project, 2012.

Nationwide, local midwives attended 42 percent of all deliveries, but their work has not been adequately recognized by the medical community. Although they have been trained to attend normal deliveries, physicians do not regard midwives as qualified staff; they are often barred from working in health centers and their referrals are not always accepted. As of 2014, the MOH was seeking to legitimize the role of midwives within the established services and to improve their relationship with institutional staff.

In 2014, with USAID financial and technical support, the MOH launched a three-year program to train parteras técnicas universitarias (PTU, technical professional midwives), training that would qualify PTUs to work in the health system as skilled technicians. Their participation is very important in the medium- and long-term to improving safe pregnancies and deliveries.

The USAID-funded project PlanFam has been supported through an agreement between USAID and the MOH, to increase use of long-acting FP methods. The implementing CA has provided training, monitoring, and supervision to service providers. Through this project, USAID supported APROFAM for mobile outreach through public sector facilities to strengthen FP services for the Maya population, mainly in the Western highlands.

INFORMATION SYSTEMS

Historically, the health information system to support decision making has been weak in Guatemala. For many years, the MOH – with technical assistance from USAID and other external donors – has tried to improve its management information system, previously known as Sistema de Información Gerencial de Salud (SIGSA, Health Management Information System). However, this system has not been efficient for many reasons, including a lack of trained personnel to manage a complex information system and frequent staff turnover at upper levels that direct information policies and practices. This has resulted in a lack of timely and readily available quality data for decision making.

Under this general information system, a new logistics subsystem has been developed to include all medical products, including contraceptives. In 2002, the MOH, with support from USAID, published the first *Manual on Contraceptive Logistics Standards and Procedures*. This manual was instrumental in the evolution of a logistics information system.[47]

With support from USAID and UNFPA, this process has been complemented by ongoing training on the use of a computerized logistics system, for all those involved in the delivery of commodities – more than 8,000 people nationwide, including physicians, nurse's aides, warehouse staff, community workers, accountants, itinerant service providers, and reproductive health supervisors.[48] According to experts, in the few years since the information system has been developed and has become operational, stock outs have been reduced.

[47] Lorenzana Gonzalez, 2008.
[48] USAID/Healthcare Improvement Project, 2012.

As of 2014, MOH was trying to create a single logistics information system for all medical supplies, including contraceptives, although there was concern that the single system could reduce the efficiency of the current contraceptive information system, according to key informants.

Another important tool for decision making has been the Encuesta de Salud Materno Infantil (ENSMI, Maternal and Child Health Survey), which has been conducted periodically since 1987, with USAID support. The sixth survey (ENSMI 2014) was underway as this document was being written, receiving funding from USAID as well as the governments of Sweden, Spain, and Canada.

COMMODITIES AND MEDICAL SUPPLIES

Contraceptive Security

Contraceptives in Guatemala are provided and distributed by the MOH, IGSS, APROFAM and other NGOs, pharmaceutical companies, commercial distributors, pharmacies, and private doctors.

In 2002, the government made a commitment to finance the cost of contraceptive procurement incrementally until it reached 100 percent in 2010; funding guaranteed by the country's favorable legal and legislative framework. The government has overcome certain challenges and difficulties in the procurement and distribution mechanisms. According to experts working in the field, from 2006 to 2011 more that 80 percent of the tax collected on sales of alcoholic beverages was used to purchase contraceptives.

USAID has supported the contraceptive security initiative since 2003. The CNAA, established in 2009 with USAID support, has multiple functions: to develop national strategies that ensure access by the Guatemalan population to FP services; to coordinate information about contraceptive needs; to ensure accountability in making funds available; and to identify strategies and mechanisms for procuring FP commodities. CNAA has made important strides in its functions, although there are still challenges that need to be faced.

Notwithstanding these advances, procurement, logistics, and distribution processes have not always worked optimally. The existing procurement mechanism has not been as efficient and timely as it should be, and although a procurement budget for the Ministry of Finance has been earmarked and appropriated by law, it depends on the political will of the incumbent authorities to allocate it for this purpose. During 2012, only 38 percent of the 15-percent tax collected on sales of alcoholic beverages was used to purchase contraceptives. However, 2012 was an atypical year, as it was the first year a new administration in the government. To avoid this type of situation in the future, and to guarantee contraceptive security, advocacy is required at different levels, as well as monitoring of legislative provisions. The OSAR has expressed its readiness to monitor the situation and push for transparency in contraceptive procurement to ensure the best outcome for Guatemala.

The role of the CNAA has become more important in recent years. Under the law, CNAA includes representatives from a range of governmental and private entities: the Secretaría Presidencial de la Mujer (SEPREM, Women´s Presidential Secretariat); the ministries of education, public health and social welfare, and finance; the Office for the Defense of Indigenous Women; IGSS; APROFAM; the Guatemalan Association of Women Physicians; and the Instance for Political Action for Women's Health and Development.

Although adequate solutions need to be established in order to have clear, practical, and permanent regulations to facilitate contraceptive procurement, Guatemala has made significant progress in terms of contraceptive security. Since 2011, CNAA, in partnership with civil society (specifically, the OSAR), monitors budget implementation of the alcohol tax for FP and SRH.

As of 2014, CNAA was decentralizing its operations and was completing the legal processes to create regional subcommittees, which were expected to be represented on a central committee. Subcommittees were active in all of the 29 health areas of the country. The main function of these subcommittees is to ensure contraceptive procurement for each of the Departments.

Also, a market segmentation analysis was being conducted with support from USAID, UNFPA, and PAHO. Initial analysis showed marked disparities in access to FP/SRH services. Rural populations, those in the lower wealth quintiles, and girls and adolescents were underserved, and their needs were not being met. Therefore, achieving universal and equitable access to services and information, with emphasis on the most vulnerable sectors – adolescents and youth, rural, marginalized urban and indigenous groups – remain as one of the key challenges.[49]

To succeed in these and other initiatives, CNAA members are committed to FP/SRH and remain very active. They have a clear plan of action and play a key role in designing and implementing mechanisms to ensure contraceptive security and to promote greater access to good quality services.

Guatemala is part of a sub-regional initiative promoted by the Consejo de Ministros de Salud de Centroamerica (COMISCA, Central American Health Ministers Council), aimed at facilitating joint negotiation by Central America and the Dominican Republic for purchase of essential medical products, including contraceptives. A strategy has been outlined for Guatemala, and hopefully will be refined to provide MOH more efficient tools to negotiate with large pharmaceuticals for more cost-efficient procurement.[50]

FINANCING

During the period from 2002 to 2006, the MOH purchased contraceptive commodities through a co-financing agreement with UNFPA, under which the government would gradually increase its allocation from public resources, from 5 percent in the first year to 100 percent within nine years.

[49] Comisión Nacional de Aseguramiento de Anticonceptivos (CNAA). Estrategia de Segmentación del mercado de anticonceptivos en Guatemala [working paper]. Guatemala City, Guatemala: CNNA; 2013.

[50] USAID | DELIVER Project. *Llevando Medicamentos a toda la Población: Alianza para Sistemas Logísticos de Salud*. Arlington, VA: John Snow, Inc.; 2013.

Funds allocated by the government were combined with those from the Canadian International Development Agency (CIDA) and the Netherlands. As of 2010, Guatemala no longer received international funds for procuring contraceptives and has fulfilled its commitment to take over procurement costs incrementally, although this has not been easy for reasons both external and internal to the process.

A budgetary line item earmarked for RH has been included in the majority of annual health budgets since 2006. In 2007, however, the Ministry of Finance instructed agencies using public funds to refrain from making further fund transfers to national or international NGOs (Decree 66-2007). As a result, in 2008 the MOH was not able to pay its bill for contraceptives delivered by UNFPA in a timely manner, although it had the funds in hand, collected through the tax on alcoholic beverages. The bill was finally paid by the government of Guatemala, but not without disruptive delays.

As a result of the advocacy and lobbying efforts by the civil society and the CNAA, and with support from the president of the Congressional Health Committee, an exception for contraceptive procurement was made in the annual budget law. In 2009, MOH was able to cover 100 percent of the cost of contraceptives with the proceeds of the alcohol tax (U.S. $1,325,301). The MOH and UNFPA signed a new procurement agreement in 2010.[51]

The IGSS negotiated its contraceptive procurement with UNFPA in 2002 through an agreement similar to that of the MOH, with incremental contributions for five years, starting with 20 percent the first year to covering the full cost of contraceptives at the end the fifth year. However, the IGSS FP program did not function during 2004-2005 and this procurement agreement between IGSS and UNFPA was suspended. The FP program at IGSS was resumed in 2007 but contraceptive procurement was contracted with local commercial sources, not through UNFPA.

APROFAM completed a phase-out plan in 2004 when it received its last donation of Depo-Provera. As of 2014, it has been purchasing contraceptives directly from local and international manufacturers and through IPPF, and was distributing them at affordable prices.[52]

LOOKING TO THE FUTURE

Family planning and reproductive health now form part of Guatemala's national agenda. Demand and services have increased; the newest challenge is to tailor services to increase access and meet the needs and preferences of potential clients, especially young people and members of indigenous groups. As the number of services increases and access advances, it will be important to improve the quality of services (e.g., assuring that they are user-friendly and culturally

[51] USAID | DELIVER Project. *La* Adquisición de Anticonceptivos en América Latina y el Caribe,*Un Análisis de Opciones Actuales y Futuras en Ocho Países.* Arlington, VA: John Snow, Inc.; 2010.

[52] USAID | DELIVER Project. *Políticas, Prácticas, y Opciones para la Adquisición de Anticonceptivos: Guatemala*. Arlington, VA: John Snow, Inc.; 2006. Available at: http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/GT_PoliPracOpciAdqu.pdf.

appropriate). Existing medical and institutional barriers must be removed and users must be able to demand quality care as a human right.

By law, the Ministry of Education is instructed to provide age-appropriate information on SRH to students, as has been stated before. However, this has not always happened. Although the ministry is included in the CNAA and has received support from UNFPA to produce IEC materials, these have not been included in the school curricula due to lack of support from high level authorities. Institutional coordination between the MOH and the education ministry was being improved through *mesas técnicas de trabajo* (technical working groups) with USAID technical and financial assistance.

Guatemala has relied on USAID's technical and financial assistance for FP. In its 2012-2016 Country Development Cooperation Strategy, USAID/Guatemala included continuing support for the health program. In the U.S., the Obama administration requested U.S. $74 million in aid to Guatemala for 2014, of which U.S. $14 million (19 percent) was to be allocated for health, including U.S. $6.4 million for FP and reproductive health and U.S, $4 million for maternal and child health. At the end of USAID's 2014 fiscal year, Guatemala and Haiti were to be the only two LAC countries that continued to have bilateral health programs, including FP.[53]

The CNAA has begun a series of estimates and projections to propose a market segmentation strategy[54] that would follow a total-market approach.[55] This strategy was expected to include both FP and STI/HIV prevention, and should meet the needs from the most vulnerable groups of population. Implementing an evidence-based strategy could eliminate the unmet need for FP by 2020.[56] This very important analysis will require close monitoring and follow through.

To sustain its progress toward universal, equitable and free FP/RH services, Guatemala must:

1. maintain firm political will and commitment to ensure equitable provision of user-friendly and culturally appropriate FP/SRH services to the entire population, particularly vulnerable sectors, such as adolescent and indigenous populations, according to the specific needs of each group;
2. strengthen and improve the procurement, distribution, logistics, warehousing, and delivery of contraceptives nationwide;
3. eliminate medical and institutional barriers that impede equal access to quality services;
4. improve the SIGSA information system and the new logistics information system to enable the MOH to provide reliable and timely statistics;

[53] Devex. USAID-Guatemala partnership [Web page]. Washington, DC: Devex; 2013. Available at: https://www.devex.com/en/news/usaid-guatemala-partnership/81520?mem=ua&src=biz_insight.

[54] In FP, market segmentation is used to divide the FP market into groups based on choice of method and provider, and ability to match clients with sources based on need and ability to pay. See USAID/Reproductive Health Supplies Coalition. *Market Development Approaches Working Group. Market Segmentation Primer*. Washington, DC: Abt Associates; 2009. Available at: http://www.rhsupplies.org/fileadmin/user_upload/MDA_Documents/MDAWG_Market_Segmentation_Primer_FINAL_doc.pdf

[55] USAID/Reproductive Health Supplies Coalition, 2009.

[56] CNAA, 2013.

5. foster decentralization of the health system, public participation and partnerships with civil society organizations and women's groups in order to expand service coverage and ensure transparent and efficient compliance with the provisions of the Law on Universal Access to Family Planning; and
6. permanently eliminate existing legal barriers for international contraceptive procurement, finding new mechanisms and suppliers that will result in savings for the country.

The multicultural and multilingual composition of Guatemala´s population poses additional challenges for implementation of development programs. Specific needs must be addressed with distinct approaches and strategies. Despite social, political, and economic conditions in Guatemala that affect health, tremendous strides have been made in FP and SRH services since 2000. External cooperation has been key to progress made. Contraceptive security, improved logistics and information systems, better skilled health care providers, new communication tools and materials, and active participation from the civil society are advances that seemed unattainable at the beginning of the new millennium. These improvements have been realized, thanks to active participation of different public and private sector organizations and individuals, and to technical and financial support, in particular from USAID. Yet continued commitment and sound decision making at the national level will be essential to maintain the achievements to date and continue progress toward improved health outcomes.

MEASURE Evaluation

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