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INCREASING ACCESS TO FAMILY PLANNING AMONG INDIGENOUS GROUPS IN GUATEMALA

DECEMBER 2008

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EXECUTIVE SUMMARY

This report describes an initiative to promote equitable access to family planning and reproductive health services (FP/RH) among indigenous women in Guatemala. The lessons learned from this approach and its application in five districts can be applied to other settings.

In Guatemala, the USAID | Health Policy Initiative, Task Order 1, has worked to foster an enabling environment for the implementation of adequately financed, effective, sustainable, and culturally appropriate FP/RH programs. To achieve this, the project has focused on supporting indigenous leadership, policy dialogue, and advocacy (building on previous work by its predecessor, the POLICY Project).

In partnership with the Ministry of Public Health and Social Welfare (MSPAS), the Guatemalan Institute for Social Security (IGSS), and the Association for the Wellbeing of the Family (APROFAM), the Health Policy Initiative (1) collected and analyzed information related to access to services and unmet need for FP among indigenous groups; (2) discussed the findings with key stakeholders and supported policy dialogue to identify strategies and service delivery practices to address the issues identified; (3) tested the strategies and practices; (4) conducted follow-up interviews with program implementers; and (5) identified lessons learned that can guide future work to make FP/RH services more accessible to disadvantaged groups. This report discusses the background and rationale for this work, reviews efforts to reach the underserved, and describes the process of identifying barriers and implementing the recommended strategies. The final section provides lessons learned and recommended actions for other countries to reduce barriers to access and use of FP/RH services among poor and marginalized groups.

To better conceptualize the policy framework, the project reviewed existing research and policies to identify the factors affecting access to FP/RH services. The project then conducted 108 in-depth interviews with service providers, 22 group interviews with 168 indigenous women, and 11 group interviews with 69 community educators and traditional midwives in three departments (Quiché, Sololá, and Totonicapán) of Guatemala. Based on the research findings, the project identified six major barriers that limit access to FP/RH services among indigenous groups:

1. Provider bias toward indigenous women
2. Unsuitable conditions in facilities providing FP services
3. Lack of appropriate information, education, and communication materials
4. Limited integration of community-based providers in the community
5. Community beliefs regarding family planning
6. Restrictive social and familial environments

During stakeholder workshops at the national and community levels, project staff presented these findings; and participants from the MSPAS, IGSS, and APROFAM, as well as civil society organizations, developed a set of service delivery practices that could improve access to services. These practices were then incorporated into operational guidelines that were pilot-tested in five districts in Quiché. The districts were selected because of their high maternal mortality ratios and low contraceptive prevalence.

The Health Policy Initiative helped the Departmental Office of Health in Quiché develop a list of 10 locally appropriate service delivery practices. These practices involved providing services and information in the local language or through a qualified interpreter, orienting providers to local conditions, and making a private area available for FP consultations. Following the collection of baseline information on the status of the 10 priority service delivery practices, the Quiché team trained service providers in the new guidelines through a series of one-day workshops. The team then monitored implementation of the guidelines in five pilot districts. After one month of implementation, the Health

Policy Initiative interviewed stakeholders to gauge feasibility and ease of implementation. The stakeholders reported that the guidelines were feasible and would help to improve the quality and coverage of FP services. Four of the five districts had implemented some part of the guidelines, such as ensuring that services were provided in indigenous languages, finding a private place for FP consultations and services, and removing signs that called attention to the facility as a source of FP services (thus discouraging potential clients who feared stigma and disapproval from family and community members). One district health team developed and broadcast television spots about family planning in indigenous languages.

The project also interviewed program implementers to capture lessons learned and best practices. For national agencies (e.g., the MSPAS) and external agencies providing technical assistance, it is important to apply a systematic process to ensure that the recommended actions are applied effectively to the local context. These agencies should do the following:

- *Understand the dynamic policy environment*. Policymakers and health program managers must think beyond enacting policy statements and consider how concrete guidelines can actually be implemented. Because the positions and interests of stakeholders frequently change, continuous advocacy and targeted actions are needed to keep the issue high on the policy agenda and to influence policy decisions.
- *Support an evidence-based, country-driven process*. Service providers, the main institutions providing healthcare, and the targeted population should be fully involved in identifying barriers and formulating service delivery practices to address them.
- *Use a comprehensive approach involving multiple stakeholders*. The involvement of public and private agencies as well as potential beneficiaries helps to ensure that the approach addresses local needs and conditions.
- *Involve the indigenous population in identifying problems and designing solutions*. The perspective of indigenous people was essential to development of the guidelines, as service providers were unaware of some factors that inhibited indigenous women from seeking FP services.
- *Conduct equity-based monitoring and evaluation*. Once a change in service delivery is implemented, it is important to ensure that the target population is actually benefiting from it. Factors such as the quality of the counseling, accuracy of information provided, and the extent of community outreach need to be assessed regularly.

The Health Policy Initiative worked with the MSPAS, IGSS, APROFAM, USAID, United Nations Population Fund, and the Population Council to continue dissemination of the research findings. It also formed a central-level working group to draft the National Family Planning Strategic Plan. The plan incorporated several of the recommendations developed as a result of this work, including promoting family planning among indigenous populations; incorporating community personnel in FP programs; and distributing FP information that addresses myths and misconceptions of family planning to the general population. The process used in the project's work was adopted to implement a similar study among non-indigenous women and to guide technical assistance work in FP/RH.

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

ABBREVIATIONS

APROFAM	Association for the Wellbeing of the Family
DFID	Department for International Development (United Kingdom)
FP	family planning
IGSS	Guatemalan Social Security Institute
MSPAS	Ministry of Public Health and Social Welfare
NGO	nongovernmental organization
OSAR	Reproductive Health Observatory
PAHO	Pan American Health Organization
RH	reproductive health
SIAS	Comprehensive Health Care System
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

I. INTRODUCTION

In Guatemala, the USAID | Health Policy Initiative, Task Order 1, has worked to foster an enabling environment for the implementation of adequately financed, effective, sustainable, and culturally appropriate family planning and reproductive health (FP/RH) programs. To achieve this, the project focused on supporting indigenous leadership, policy dialogue, and advocacy (building on previous work by its predecessor, the POLICY Project).

This report summarizes the work of the Health Policy Initiative to identify and address barriers that limit access to FP/RH services among indigenous people in Guatemala. In partnership with the Ministry of Public Health and Social Welfare (MSPAS), the Guatemalan Institute for Social Security (IGSS), and the Association for the Wellbeing of the Family (APROFAM), a national nongovernmental organization (NGO), the project (1) collected and analyzed information related to access to services and unmet need for FP among indigenous groups; (2) discussed the findings with key stakeholders and supported policy dialogue to identify strategies and service delivery practices to address the issues identified; (3) tested the strategies and practices; (4) conducted follow-up interviews with program implementers; and (5) identified lessons learned that can guide future work to make FP/RH services more accessible to disadvantaged groups. This report discusses the background and rationale for this work, reviews efforts to reach the underserved, and describes the process of identifying barriers and implementing the recommended strategies. The final section provides lessons learned and recommended actions for other countries to reduce barriers to access and use of FP services among marginalized groups.

II. BACKGROUND ANALYSIS

Poverty Among Indigenous People

Nearly two in five (38%) Guatemalans are from indigenous groups, including the Mayan, Xinkan, and Garifunan. Two-thirds (68%) of the indigenous population live in rural areas (Guatemala National Statistics Institute, 2006; United Nations Children's Fund, 2008). Great inequalities exist between indigenous and non-indigenous populations. Three in four (75%) of indigenous people are poor, compared with slightly more than one-third (37%) of the non-indigenous population (see Table 1). More than one in four (27%) indigenous people live in extreme poverty, defined as being unable to cover the minimum cost to purchase food (Guatemala National Statistics Institute, 2006; International Organization for Migration, 2008).

Table 1. Level of poverty by ethnicity

Ethnicity	Level of Poverty			
	Extreme Poor	Poor	Not Poor	Total
Indigenous population	27%	48%	25%	100%
Non-indigenous population	8%	29%	64%	100%
Total population	15%	36%	49%	100%

Source: Guatemala National Statistics Institute, 2006.

Policy Environment

The government of Guatemala is committed to addressing poverty and inequality, particularly among the indigenous population, and sees this initiative as critical to the country's development. Across several ministries and other public agencies, the government continues to fine tune its strategies to better reach

the poor and marginalized, including the indigenous population, with a broad range of health and social services. In addition, Guatemala continues to undergo health sector reform, presenting many opportunities to ensure more efficient and effective health service delivery, particularly in rural and remote areas where the majority of the indigenous population live. While much progress has been made in reducing maternal mortality and birthrates and increasing life expectancy, indigenous people remain vulnerable and underserved, continuing to face barriers in accessing services, including FP/RH services.

Following the 1996 Peace Accords, the Guatemalan government began a series of health reforms known as the Health Services Improvement Program, financed by the Inter-American Development Bank and implemented by MSPAS (PAHO, 2007). The program called for the MSPAS to (1) provide free healthcare to people without sufficient resources, (2) increase public expenditure, (3) improve the efficiency and equity of services, (4) increase decentralization, and (5) increase community participation. The act also emphasized the need to expand coverage of the underserved, particularly the rural poor and indigenous population (Gragnolati and Marini, 2003). Within the Health Services Improvement Program, MSPAS implemented a strategy known as the Comprehensive Health Care System (SIAS) to bring basic services to indigenous rural populations. SIAS contracts with NGOs and other entities to provide basic primary health services to the poor.

During 2001–2005, with support from the POLICY Project, the government developed several policies and plans, including the Law of Social Development (Population and Development). Ratified in October 2001, the law served as the first legal framework for work in population and development in Guatemala, giving significant RH protections and services to the entire population. At the government's request, the POLICY Project assisted with developing a comprehensive policy to facilitate implementation of the law in the field of FP/RH. This policy, known as the Social Development and Population Policy, was approved by the Social Cabinet on April 8, 2002.

Other notable legal achievements during 2001–2005 were

- Creation of the Program for Reproductive Health by Ministerial Resolution SP-M-239-2004 (Article I of the resolution established the National Reproductive Health Program as one of the key programs intended to care for individuals); and
- Passage of the Law of Universal and Equitable Access to Family Planning Services and its integration into the National Sexual and Reproductive Health Program.

The Health Policy Initiative provided follow-up technical support for the creation of the Reproductive Health Observatory (OSAR), an oversight board to monitor and evaluate laws and policies, including the Law of Social Development, the Social Development and Population Policy, and the Family Planning Law. The OSAR partnership is led by the Guatemalan Congress, civil society organizations, professional associations, and universities.

The Guatemalan government has remained committed and motivated to address poverty and inequality, particularly among the indigenous population. Guatemala's policy reforms and creation of a legal framework have created a favorable environment for increased access to services by indigenous populations. However, it is not evident that the policy and financial reforms have increased equity and access to health services among poor, indigenous women.

Market

Supply

The MSPAS is the largest provider of health services in Guatemala, followed by the IGSS, which has 43 facilities that provide health services. APROFAM, a national NGO, charges fees for its services, which are available through a network of 30 clinics and 11 hospitals.

The MSPAS oversees a central administrative level, eight regions, 27 health areas, and a three-tiered delivery system:

- The first tier is at the community level and is typically located in remote, rural areas; it provides preventive and primary health care, as well as some curative services. These facilities are the simplest within the system (community centers) and health posts and staffed by trained community volunteers, an auxiliary nurse, and, occasionally, a rural health technician. Doctors and health technicians visit community centers monthly to provide curative and more complex care.
- The second tier of facilities includes two types of health centers known as Type A and Type B facilities. Type A facilities are used primarily for maternity care and have some beds for patients. Type B facilities operate without beds and provide ambulatory care. Health centers are usually staffed by a doctor, nurse, auxiliary nurse, rural health technician, administrative personnel, and, occasionally, a laboratory technician and dentist.
- The third tier comprises the most advanced level of care and includes general and specialized hospitals that operate in mostly urban areas (PAHO, 2007).

Using the World Health Organization's definition of physically accessible health services (travel time of less than 60 minutes to obtain health services), only 11 percent of the adult population in Guatemala has geographic access to health services (PAHO, 2007). However, the SIAS has made some progress in achieving the goal of improved access for the poor and indigenous populations through expanded services in rural areas. Rural healthcare coverage was extended by nearly 66 percent during 1990–2004 (PAHO, 2007).

Financing and the provision of health services are often linked. If the quality of services in public clinics is perceived as low, even with low user fees, individuals, including the poor, may prefer to go to a private provider for care. This is evident in Guatemala, where the population tends to prefer private rather than public facilities. However, when the poor and indigenous communities cannot afford services, they go without care or seek care within their communities (Gragnolati and Marini, 2003).

Demand

While the SIAS was successful in expanding geographic coverage of services, inequities between indigenous and non-indigenous populations remain.

According to the 2002 National Survey of Maternal and Infant Health, indigenous women are less knowledgeable about FP methods than non-indigenous women. Among married women of reproductive age, contraceptive prevalence among non-indigenous women is more than double that of indigenous women, even though more indigenous women express a need for family planning to limit or space births than non-indigenous women (see Table 2). Two in five (39%) indigenous women have an unmet need for family planning—that is they would like to have no more children or delay the next birth by at least two years—but they are not using an FP method. In contrast, one in five (22%) non-indigenous women are in this category.

Table 2. Knowledge and use of FP methods, family size, unmet need for FP by ethnicity among married women of reproductive age

	Indigenous	Non-Indigenous
Aware of any FP method	84%	98%
Aware of a modern FP method	83%	98%
Use of modern FP method	17%	43%
Use of traditional FP method	7%	10%
Total fertility rate[1]	6.1	3.7
Unmet need for FP	39%	22%

Source: MSPAS, 2003.

Indigenous women have less access to FP services and information. Of those indigenous women who are not using a family planning method, nine in 10 (92%) reported that they had no contact with a family planning provider in the previous 12 months, compared with 87 percent of the non-indigenous women (MSPAS, 2003). Only one in four (25%) indigenous women had heard a message about family planning from print materials or communication discussion groups, compared with more than half (58%) of the non-indigenous women (MSPAS, 2003).

The patterns of contraceptive use and unmet need for family planning among indigenous women are reflected in the data for poverty. According to the 2002 National Survey of Maternal and Infant Health, women in the lowest two economic quintiles are less likely to use an FP method than women in the two highest economic quintiles. In addition, unmet need for family planning is much higher among women in the lowest two economic quintiles (41% and 37%), compared with those in the highest two quintiles (17% and 9%) (Guatemala MSPAS, 2003).

In regard to demand for health services, consumers generally prefer private healthcare providers because public primary care services are perceived to be of low quality. Many poor people would prefer to use private services that are closer in proximity or have perceived better quality services, but most cannot afford private services. Even the lower costs of public health services may be beyond their means, taking into account transportation costs and time away from work. Their healthcare needs are left unmet, or they rely on household members or self-medication (Gragnolati and Marini, 2003).

Finance

Like many developing countries, public health spending in Guatemala is skewed toward those in higher economic quintiles. A World Bank study found that the poorest 40 percent of the population receives 35 percent of the total net health subsidy (public spending on health), while the richest 40 percent receive 42 percent (Gragnolati and Marini, 2003). One reason for this difference is that the rich use public health services, especially hospitals, more frequently than the poor. The richest 40 percent accounts for 56 percent of visits to all health facilities, whereas the poorest 40 percent make only 26 percent of such visits. The World Bank study concluded that if the government of Guatemala wanted to do more to meet the needs of the poor, it has two policy options: (1) shift resources from hospitals to community centers, health posts, and health centers; and (2) introduce a sliding fee scale based on user income levels (Gragnolati and Marini, 2003).

[1] The total fertility rate is the average number of births a woman would have during her lifetime at current rates of childbearing.

Health financing affects access to health services on the supply side by ensuring that essential services are adequately financed and delivered and on the demand side by reducing financial barriers to access and by ensuring that funds are raised and service delivered equitably (Pearson, 2002). For a health financing system to be considered pro-poor, it must (1) ensure that the costs borne by households are proportional to their ability to pay; (2) protect the poor from the financial shocks associated with severe illness; and (3) enhance the accessibility of services to the poor (in regard to perceived quality and geographic services) (Bennett and Gilson, 2001). Financing mechanisms should increase access to health services and, at the very least, not impose additional barriers to access (Menotti et al., 2008). High levels of out-of-pocket financing for health services can impede access to services and fail to provide financial protection for the population against the financial consequences of ill health (La Forgia, 2005).

The extent to which different financing mechanisms interact affects the degree to which the financing system as a whole is pro-poor (Bennett and Gilson, 2001). In many Latin American countries, formal sector employees are covered by social health insurance schemes (e.g., the IGSS in Guatemala). Healthcare for those employed outside the formal sector is funded by tax-based financing and user fees, which may generally result in limited and possibly lower quality services (Bennett and Gilson, 2001).

Because public payers are often a main source of financing for services used by indigenous populations, it is essential to understand how public resources can be made pro-poor, as well as other financing mechanisms, such as user fees, to ensure that cost is not a barrier to indigenous people in accessing services (Pearson, 2002).

Guatemala's policy reforms and the creation of a legal framework have fostered a favorable environment for increased access to services by indigenous populations. However, it is not evident that policy and financial reforms have increased equity and access among poor, indigenous women. Indigenous women still face a high unmet need for family planning, and the lowest economic quintiles remain less likely than the wealthiest quintile to use FP services. Furthermore, as Guatemala strives to increase equity among the indigenous and non-indigenous populations, several supply and demand issues affect use of FP services, including affordability and social and cultural beliefs.

III. INFORMATION GATHERING AND ANALYSIS

In collaboration with MSPAS, IGSS, and APROFAM, the Health Policy Initiative collected information on indigenous groups' access to health services and commodities. The project originally planned to do a national market segmentation and unmet need analysis, but this was not possible due to the paucity of disaggregated data and information on the indigenous population in Guatemala. However, the project and its partners were able to conduct a formative study designed to understand barriers to FP/RH services among indigenous populations.

The study included interviews with indigenous women and healthcare providers in three easily accessible departments (*departamentos*[2]) with large indigenous populations—Quiché, Sololá, and Totonicapán. The project conducted 33 group interviews with the following characteristics:

- 8 group interviews with 69 indigenous women users of modern FP methods who obtain services from MSPAS or APROFAM
- 14 group interviews with 99 indigenous women not using any FP method, separated into those who either obtain or do not obtain health services for their families
- 11 group interviews with 69 community health educators (*promotores*) from APROFAM and SIAS and traditional midwives (*comadronas*)

[2] *Departamentos* are administrative districts similar to states in the United States.

The project also conducted in-depth interviews with 108 health service providers, including doctors, nurses, auxiliary nurses, and community educators (51 in Quiché, 31 in Sololá, and 26 in Totonicapán) in MSPAS, IGSS, and APROFAM facilities. Because the subjects were selected through a convenience sample, the study findings cannot be generalized neither to the overall population of indigenous women nor to service providers in the three departments. Nevertheless, the study provides new information that can be used in program planning and implementation.

The following sections discuss the findings of the provider interviews and group interviews. Table 3 summarizes the six key barriers identified in the study.

Table 3. Barriers to FP Services

	Barrier	Description
Barriers to Service Delivery	1. Provider bias toward indigenous women	• Providers doubt the capacity of indigenous women to understand information about FP services and methods • Providers do not recommend some FP methods to indigenous women • Women perceive that the services are of poor quality because they are discriminated against as indigenous, rather than non-indigenous
	2. Unsuitable conditions in facilities providing FP services	• Consultations do not take place in physically appropriate settings (lack of privacy) • Providers use inappropriate interpreters during FP consultations • The hours of operation and waiting time for health services are not convenient
	3. Lack of appropriate information, education, and communication materials	• Materials are not in indigenous languages and providers do not have specific guidance in providing appropriate care to indigenous populations • Indigenous women do not receive sufficient information regarding the use and side effects of FP methods
	4. Limited integration of community-based providers in the community	• Community providers lack access to systematic knowledge of FP • Community providers fear rejection by their communities and are therefore reluctant to discuss FP within their community
Socio-Cultural Barriers	5. Community beliefs regarding family planning	• Community members think that women who use FP methods are unfaithful to their spouses and are not fulfilling their role to their marriage and family • Communities emphasize the benefits of FP in relation to others, money, and household spending, rather than the health benefits to women and their children
	6. Restrictive social and familial environments	• Patriarchal culture and machismo limit the autonomy of women to make decisions about FP methods • The majority of family members and the community have a negative opinion of FP and of those who use FP methods • Religious beliefs and messages that FP is a sin

Barriers to Service Delivery

1. Provider bias toward indigenous women

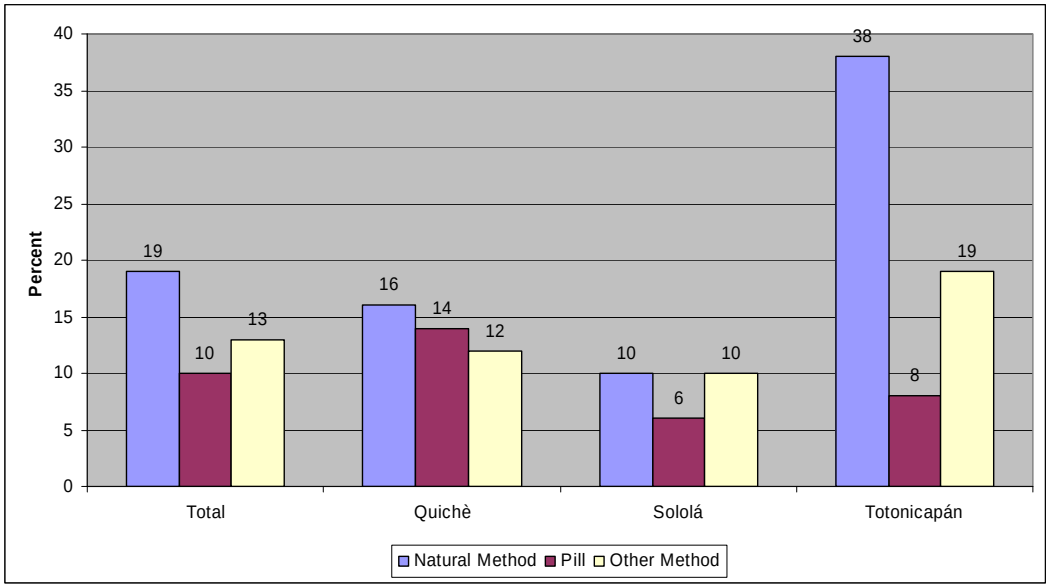
Providers' attitudes can affect the amount and quality of information given to clients, resulting in a lack of informed choice and options as well as the alienation of clients, who may feel that they are treated poorly by health providers. Many indigenous women who participated in the group interviews reported that providers discriminated against them and treated them badly because of their ethnicity and inability to speak Spanish fluently. As a result, indigenous women do not feel comfortable with the providers and lack confidence in the services and information they provide. Women who do not use family planning say that the health providers do not understand their problems and pay more attention to *ladinos* (non-indigenous people) than to them.

Providers themselves express difficulties assisting indigenous women. Half of the 108 service providers interviewed said that they doubted that indigenous women have the capacity to understand information regarding FP services. The providers stated that they have to repeat information several times before indigenous women understand it and that they have difficulty finding words and terms that are culturally appropriate for indigenous women. They complained that indigenous women take longer than other clients.

Furthermore, providers expressed negative perceptions of indigenous women and indigenous society. A provider from Quiché said that indigenous women come from small villages that are dirty and that the women themselves are dirty. In Totonicapán, a provider stated that indigenous women are very traditional and are dedicated only to homemaking and having children.

Sixty-four of the 108 providers interviewed do not believe that indigenous women have the same capacity as non-indigenous women to select a contraceptive method. Forty of the 108 providers interviewed stated that indigenous women are only sometimes able to understand the information given during the consultation. Providers stated that they do not recommend some methods to indigenous women because they believe the women are unable to use the method correctly. They are especially reluctant to recommend natural methods and the pill (see Figure 1). A provider in Quiché said that indigenous women have good intentions to use FP but do not know how to use it correctly. In Sololá, a provider stated that indigenous women cannot count and therefore fail to return in three months for follow-up appointments.

Figure 1. Percent of providers who do not recommend specific FP methods to indigenous women, by department



Note: This was a purposive sample and thus not representative of the larger group of health service providers.

2. Unsuitable conditions in facilities providing FP services

Providers and indigenous women interviewed reported that the lack of privacy and inability to communicate hampered service delivery, as did long wait times and inconvenient hours at facilities. Roughly two in five providers stated that the place where they held FP consultations was private and comfortable and contained information materials for clients. Providers in Sololá and Totonicapán were more likely than those in Quiché to label their facility as inadequate. At the community level, the physical environment of health clinics—consultation rooms without doors that close or lack of private areas for consultation—can contribute to the reluctance of indigenous women to seek services that may not be confidential and private. Without privacy, many indigenous women hesitate to inquire about contraceptive methods or ask questions. Sixty-eight of the 108 providers interviewed reported that indigenous women almost never ask questions during FP consultations. Thus, indigenous women lack adequate, accurate information and have limited opportunities to receive clarification about their concerns. Consequently, they do not have the information necessary to make informed decisions regarding FP.

Nine in 10 providers acknowledged that the majority of their clients speak an indigenous language, especially in Quiché and Totonicapán. However, almost all providers interviewed (95 of 108) stated that they normally speak Spanish during FP consultations. For women who only speak an indigenous language, nearly all (93 of 108) providers interviewed stated that they were able to provide services in that language, 12 stated sometimes, and two stated that services were not given in an indigenous language. About one in three providers reported that when a translator is required for an indigenous woman who does not speak Spanish, they ask another client, a family member, or a security guard or maintenance person of the facility to provide translation services. Providers themselves have doubts about their ability to speak an indigenous language and are uncertain if clients really understand them because they are unsure of how to simplify terms in an indigenous language. Furthermore, if a translator was used, providers are unsure of the accuracy of the translation.

Most of the providers (89 out of 108) believed that the hours they offered for FP services were convenient for users, with 88 providers offering services throughout the day, 15 offering services only in the

morning, one provider offering services only in the evening, and two not offering services. When asked for possible reasons that the hours were not convenient for users, all 25 providers from Totonicapán did not give a reason. However, 12 providers in Sololá and nine in Quiché gave various reasons, including that women were busy in their homes or were only available after their hours of operation.

The clients, however, did not agree that the service hours and waiting time met their needs. Women who participated in the group interviews spoke of long waiting times and inconvenient hours of operation. Many women said they are unable or do not want to wait because they fear their husbands will become upset at a prolonged absence from the home. One participant stated that there is a long wait just for an injection.

3. Lack of appropriate information, education, and communication materials

The indigenous women interviewed reported that health providers are their main source of FP/RH information. They rarely mentioned community promoters as sources of information regarding FP/RH, with the exception of APROFAM promoters.

The FP materials available to clients are not culturally appropriate (for example, they feature non-indigenous women or are in Spanish); do not address the myths about FP that are prevalent in communities; and do not explain the side effects of contraceptive methods. Four in five providers interviewed (87 of 108) said that they had never used FP informational materials that are in indigenous languages or targeted toward the indigenous population (43 of 51 in Quiché; 23 of 31 in Sololá; 21 of 26 in Totonicapán).

Roughly one third of the providers interviewed reported that it would be better for materials to be in indigenous languages or preferably in both languages. About half of the 108 providers in the three regions said that print materials are available in K'iche', and about half of the 31 providers interviewed in Quiché said that some print materials are available in Kaqchikel. However, providers do not use these materials because most of the brochures and posters contain mostly text, rather than pictures, creating difficulties because most clients are illiterate in Spanish and their native language. About one in three providers interviewed stated that they needed more audio-visual materials in indigenous languages and better *charlas* (conversation groups), rather than posters and brochures written in Spanish. In addition, providers stated that not having materials tailored to the population hinders the understanding of messages and results in lost opportunities to inform indigenous women about FP and deliver needed services.

Many indigenous women in the group interviews expressed fears and doubts about the long- and short-term effects of contraceptive methods on their health. Common fears cited were negative cultural beliefs regarding the cessation of menstruation (often a side effect of Depo-Provera) and the accumulation of contraceptive pills in their stomach. Slightly more than a quarter of the providers (31 out of 108) stated that they normally clarified client doubts during FP consultations.

4. Limited integration of community-based providers in the community

Implementation of SIAS included community involvement in the delivery of specific, simple health services by community facilitators and health promoters. The community facilitators and health promoters work closely with the community and are supervised by MSPAS personnel. By design, the community facilitators and health promoters should be key actors in the promotion of FP within their communities. However, respondents stated that the participation of community facilitators and promoters was limited, piecemeal, and not integrated into the community. Note that respondents regarded APROFAM promoters differently, stating that they actively promoted the benefits of FP to communities.

Many community facilitators and promoters believe that they lack the training necessary for the promotion of FP services in the community. Consequently, many expressed belief in the same myths

regarding FP that the community holds, as well as many of the same doubts and concerns about the effect of FP methods on their health.

Socio-Cultural Barriers

5. Community beliefs regarding FP

Indigenous women face community and familial pressure to refrain from using FP methods. Within communities, many share the belief that women who use FP methods will be unfaithful to their spouses and are not fulfilling their appropriate marital and familial role to bear children. Consequently, indigenous women fear rejection or ostracism by their community. In about half of the group interviews, indigenous women reported that their communities are critical of women who use FP methods; this view was more prevalent in Sololá and Quiche than in Totonicapán.

In roughly half of the groups, indigenous women stated that the main reason to use family planning is to improve economic conditions for families. Respondents mentioned the cost of providing for many children and the need to have fewer children in order to afford education, food, and clothing. Fewer groups mentioned the benefits of family planning for women's and children's health.

6. Restrictive social and familial environments

The indigenous culture is heavily influenced by the opinion of community elders and religious beliefs, limiting the autonomy of women to make decisions about family planning. In about one-third of the groups, the indigenous women said that women do not use FP methods because of the opposition by community elders. Mothers and mothers-in-law think that using FP methods goes against the customs and traditions of the community. This sentiment was strongest in Quiché, followed by Sololá and Totonicapán. In four in five groups in Quiché and Sololá and three in five groups in Totonicapán, women mentioned spousal opposition as a major restrictive factor.

In addition, many women reported that the majority of religious messages in the community refer to FP use, other than natural methods, as a sin.

IV. POLICY DIALOGUE AND STRATEGY DEVELOPMENT

In May 2007, the Health Policy Initiative presented the research findings to MSPAS, IGSS, APROFAM, civil society organizations, USAID, and other key stakeholders. During this meeting, participants developed a list of service delivery practices to address the identified operational barriers. This list served as the basis for operational guidelines to ensure that FP services are offered in accordance with the needs and perspectives of indigenous women. The project team also presented the research findings to the "Medical Barriers Committee," which was established with support from the POLICY Project, and held workshops for local health providers in the three departments where the data were collected.

The national-level group of stakeholders selected the department of Quiché to serve as the pilot area for introducing the new operational guidelines. Members of the Quiché team selected 10 locally appropriate service delivery practices to reduce the identified barriers:

1. Provide FP services in the indigenous language of the community or ensure that a capable translator is present
2. Train all staff involved in the delivery of FP services semi-annually
3. Train community providers on FP four times a year
4. Require a commitment from FP providers to stay at least 18 months in their job
5. Attend to the indigenous population without discrimination and with respect to indigenous beliefs and cultures

6. Ensure that consultations are conducted in a private area and maintain the patient's confidentiality
7. Provide information on all available FP methods; establish an environment of trust and respect; explain how to use the chosen method, the benefits, and possible side effects; and answer client questions
8. Maintain the hours posted and provide direct access for FP clients
9. Do not identify the facility as offering FP services
10. Conduct information, education, and communication activities in the local language, including information that resolves myths about FP in the community and highlights the benefits of FP.

The Health Policy Initiative then helped the Departmental Office of Health in Quiché develop operational guidelines to improve access to family planning among the indigenous population. The Quiché guidelines provide guidance on service quality, orient service providers to local conditions, and call for the provision of services in the local language or through an interpreter. They were adopted in August 2007 and disseminated to all districts within Quiché for implementation. The team selected five priority districts in Quiché (Chiché, Chichicastenango, Joyabj, San Pedro Jocopilas, and San Antonio Ilotenango) as pilot areas, based on their high maternal mortality ratios and low contraceptive prevalence.

The team analyzed FP services in the five priority districts to develop a baseline assessment. The analysis assessed the 10 service delivery practices listed in the operational guidelines (see Table 4).

Table 4. Baseline assessment of status of FP guidelines in the five pilot districts in Quiché

Service delivery task	CHO	SAI	CHE	JOY	SPJ
1. Provide FP services in the indigenous language of the community or ensure that a capable translator is present	Partially	Yes	No	No	Yes
2. Train all staff involved in the delivery of FP services semi-annually	No	No	No	No	No
3. Train community providers on FP four times a year	No	No	No	No	No
4. Require a commitment from FP providers to stay at least 18 months in their job	No	No	No	No	No
5. Attend to the indigenous population without discrimination and with respect to indigenous beliefs and cultures	Yes	Partially	Partially	Partially	Partially
6. Ensure that consultations are conducted in a private area and maintain the patient's confidentiality	Yes	No	No	No	Yes
7. Provide information on all available methods; establish an environment of trust and respect; explain how to use the chosen method, the benefits, and possible side effects; and answer client questions	Yes	Partially	Partially	Partially	Yes
8. Maintain the hours posted and provide direct access for FP clients	Yes	Partially	No	Yes	Yes
9. Do not identify the facility as offering FP services	No	No	Yes	No	No
10. Conduct information, education, and communication activities in the local language, including information that resolves myths about FP in the community and highlights the benefits of FP	Yes	No	No	Yes	No

Note: CHO=Chichicastenango; SAI=San Antonio Ilotenango; CHE=Chiché; JOY=Joyabaj; SPJ=San Pedro Jocopilas.

Based on the analysis findings, the MSPAS team in Quiché drafted a training agenda for providers in the five priority districts. The training, planned for one eight-hour day, included discussion of the study results, a technical refresher on FP methods, and an explanation of how to implement the new guidelines. The MSPAS team in Quiché conducted the trainings during September 3–13, 2007.

V. IMPLEMENTATION

The Health Policy Initiative (1) provided technical assistance and training to MSPAS in Quiché to create and implement operational guidelines to increase access to FP services among indigenous populations and (2) assisted indigenous leaders with incorporating findings of the analysis into advocacy and policy dialogue activities. The district teams and MSPAS agreed that implementation of the guidelines would be according to the priorities identified by each district and that MSAPS would monitor the process. Implementation of the guidelines in the five districts began during the week of September 17, 2007. In each district, the Medical Director, Chief Nurse, and the FP/RH Supervising Nurse were responsible for ensuring implementation. Each district established priorities for implementation (see Table 5).

Table 5. Priorities identified by each district

Service delivery task	CHO	SAI	CHE	JOY	SPJ
1. Provide FP services in the indigenous language of the community or ensure that a capable translator is present			Hire an individual who speaks the indigenous language of the district	Use a qualified, trusted translator in FP consultations	
2. Train all staff involved in the delivery of FP services semi-annually					
3. Train community providers on FP four times a year	Develop and execute a training plan with FP providers	Plan with the ambulatory nurse training of community providers		Extend FP training for community providers	
4. Require a commitment from FP providers to stay at least 18 months in their job	Modify the duration of assignment	Modify the duration of assignment	Modify the duration of assignment		Modify the duration of assignment
5. Attend to the indigenous population without discrimination and with respect to indigenous beliefs and cultures				Call women who require FP services by their name	
6. Ensure that FP consultations are conducted in a private area and maintain the patient's confidentiality		Assign a private space for FP consultations	Assign a private space for FP consultations		

7. Provide information on all available FP methods; establish an environment of trust and respect; explain how to use the chosen method, the benefits, and possible side effects; and answer client questions		During FP consultations, ask questions about FP needs to better understand the client. Clarify the myths and misperceptions about FP	During FP consultations, ask questions about FP needs to better understand the client. Clarify the myths and misperceptions about FP	During FP consultations, ask questions about FP needs to better understand the client. Clarify the myths and misperceptions about FP	
8. Maintain the hours posted and provide direct access for FP clients		Allow FP users to pass directly to consultations without taking a number	Establish a system for setting hours of operation based on the needs of FP clients		
9. Do not identify the facility as offering FP services	Remove the sign indicating FP services are offered	Remove the sign indicating FP services are offered		Remove the sign indicating FP services are offered	Remove the sign indicating FP services are offered
10. Conduct information, education, and communication activities in the local language, including information that resolves myths about FP in the community and highlight the benefits of FP	Develop information material in the indigenous language that includes clarification of doubts and myths of FP. Develop radio spots in the indigenous language and include information on doubts and myths about FP.		Coordinate with other organizations and indigenous groups		Coordinate with local NGOs to create radio programs with information about FP in the local language

Note: CHO=Chichicastenango; SAI=San Antonio Ilotenango; CHE=Chiché; JOY=Joyabaj; SPJ=San Pedro Jocopilas.

After the guidelines had been implemented for one month, the Health Policy Initiative interviewed the MSPAS Coordinator of Technical Assistance for the Delivery of Primary Services, the IGSS Coordinator of Reproductive Health APROFAM's Executive Director, and the technical teams from the five districts. The purpose of these interviews, conducted during October 22–26, was to determine whether the guidelines were appropriate and feasible.

The interviewees reported that one of the five priority districts (Chiché) did not attempt to implement the operational guidelines. However, the remaining four districts made progress toward implementing the guidelines. Both the technical team from Quiché and the technical teams from the districts stated that the guidelines were feasible to implement and would contribute toward improving the quality and coverage of FP services. Nevertheless, those interviewed also stated that the approved guidelines represented some

challenges, as many facilities lack privacy, and that alternative procedures or models should be developed for facilities that do not have a private space for consultations.

Within a month of receiving the guidelines, four of the districts had a system in place to ensure that a provider or translator was available to provide information in the indigenous language. Three districts had arranged for FP consultations to be provided in a private area. Two districts had instituted a requirement that service providers stay in their jobs for two years. Three districts had removed the sign identifying their facility as offering FP services. One district had broadcast television spots on FP in indigenous languages, and two districts had obtained information material about available FP methods to provide to indigenous women (see Table 6). Also, the Quiché Office of Health reported that auxiliary nurses who participated in FP training sessions are now more interested in FP and ask more questions about it.

Table 6. Results by district after one month of implementation

Service delivery task	CHO	SAI	CHE	JOY	SPJ
1. Provide FP services in the indigenous language of the community or ensure that a capable translator is present	The nurse responsible for FP speaks the local language but uses a local interpreter for speaking. This will continue as the women in the community are accepting of it	The nurse responsible for FP speaks the local language	Although the nurse responsible for FP does not speak the local language, no action has been taken to improve the situation	The providers in the district who speak the local language are men, but the services are accepted by the population. They are trying to identify a qualified translator	The nurse responsible for FP speaks the local language
2. Train all staff involved in the delivery of FP services semi-annually	No activity	No activity	No activity	No activity	No activity
3. Train community providers on FP four times a year	No activity	No activity	No activity	Inclusion of FP information in November training	No activity
4. Require a commitment from FP providers to stay at least 18 months in their job	2 year commitment	2 year commitment	No activity	No activity	No activity
5. Attend to the indigenous population without discrimination and with respect to indigenous beliefs and cultures	No activity	No activity	No activity	No activity	No activity
6. Ensure that consultations are conducted in a private area and maintain the patient's confidentiality	Changed location of FP services to a place with privacy	Assigned a private space for FP consultations and services	No activity	Assigned a private space for FP consultations and services	No activity

7. Provide information on all available methods; establish an environment of trust and respect; explain how to use the chosen method, the benefits, and possible side effects; and answer client questions	No activity	No activity	No activity	No activity	No activity
8. Maintain the hours posted and provide direct access for FP clients	No activity	FP clients already did not have to take a number to receive services	No activity	No activity	No activity
9. Do not identify the facility as offering FP services	Removed sign indicating FP services	Removed sign indicating FP services	The clinic did not have a sign	Removed sign indicating FP services	The clinic did not have a sign
10. Conduct information, education, and communication activities in the local language, including information that resolves myths about FP in the community and highlight the benefits of FP	In coordination with local cable companies, designed and ran television spots about FP in indigenous languages	Equipped clinic with information material about available methods	No activity	No activity	Equipped clinic with information material about available methods

Note: CHO=Chichicastenango; SAI=San Antonio Ilotenango; CHE=Chiché; JOY=Joyabaj; SPJ=San Pedro Jocopilas.

Following the conclusion of active monitoring by MSPAS, the Health Policy Initiative worked with a local NGO to facilitate and monitor implementation of the guidelines. Since the pilot test began, the project has worked with MSPAS, IGSS, APROFAM, USAID, the United Nations Population Fund (UNFPA), and the Population Council to continue dissemination of the research findings.

VI. POLICY-RELATED OUTCOMES

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

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

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

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

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

VII. LESSONS LEARNED AND BEST PRACTICES

Throughout the activity, Health Policy Initiative staff and stakeholders at the central, district, and community levels remained engaged in dialogue, identifying lessons learned and best practices. Their insights and perspectives are applicable to many countries. Most countries have indigenous, poor, and/or marginalized groups that may speak a different language or maintain cultural practices and beliefs that differ from the majority population. These populations may face provider bias, language barriers, or lack of information in understandable and culturally relevant formats when seeking health services. Lessons learned in the Guatemalan context reinforced the need to ensure that all levels—from the central to community level—are actively involved in the process.

In supporting the process of policy change, national agencies (e.g., such as the Ministry of Health) and external agencies providing technical assistance should apply a systematic process to ensure that the recommended actions above are applied effectively to the local context. Key elements of this process are described below.

- *Understand the dynamic policy environment.* The involvement of multiple stakeholders at the district, department, and central levels, as well as from different sectors can often improve the quality of the intervention; promote local ownership of the intervention; and ensure that it is culturally appropriate. In a dynamic policy environment, the stakeholders involved and their positions and interests frequently change. Therefore, continuous advocacy and targeted actions are needed to keep the issue high on the policy agenda and to influence policy decisions (Menotti

et al., 2008). The Health Policy Initiative facilitated policy dialogue and organized planning meetings of stakeholders to reach a consensus on developing interventions to improve access among indigenous women. Policy dialogue helped build consensus, ownership, and commitment within the MSPAS and, more broadly, within the community and district governments (Menotti et al., 2008).

- *Support an evidence-based, country-driven process.* Guatemala followed a systematic, evidence-based, country-driven process to identify key barriers to access among the indigenous population and develop effective interventions. The Health Policy Initiative and its partners, MSPAS, IGSS, and APROFAM, with the leadership of community and departmental governments, evaluated the selected interventions through pilot-testing of the new guidelines in five priority districts. Service providers, the main institutions providing healthcare, and the targeted population were fully involved in the process.
- *Use a comprehensive approach involving multiple stakeholders.* Involving multiple stakeholders, including government institutions and local organizations, ensured that addressing the barriers to access by indigenous women was a multisectoral effort that built on the strengths of each institution. The study team used a comprehensive approach to address the need to increase access to FP/RH among indigenous women.
- *Involve the indigenous population in identifying problems and designing solutions.* Recognizing that policies and programs are often developed *for* a targeted population, such as indigenous women, but not *with* their involvement, the Health Policy Initiative involved indigenous women from the start of the process. Involving the target population in identifying the barriers to seeking and receiving healthcare and how to resolve those barriers ensured that the proposed solutions would ultimately be effective and address their needs.
- *Conduct equity-based monitoring and evaluation.* Monitoring indicators that measure and demonstrate that indigenous women are benefiting from interventions are essential. Evaluating the effectiveness of the intervention could include indicators such as number of FP/RH community-outreach events organized by community facilitators and health promoters; accuracy of information given by community facilitators and health promoters; and whether FP counseling was culturally appropriate.

In developing a targeted program, local health program managers should consider the following practices:

Identifying barriers

- Involve the targeted population in identifying barriers to increasing access to services; ensuring that health policies and programs address the needs of the poor is a vital step in making progress toward reducing poverty and achieving the Millennium Development Goals (PAHO, 2007).
- Interview users and non-users of services as well as providers to understand why the targeted population is not using services
- Use the local language in survey implementation
- Incorporate all major service providers in the study
- Include additional questions regarding FP users' perception of family planning and reasons for use and non-use
- Ensure that the facilitator of focus group discussions is respected by participants
- Train more than one person to conduct interviews
- Provide incentives for group discussion or interview attendance, such as offering snacks

Planning interventions

- Involve the targeted population in the design, development, and implementation of programs to ensure that programs appropriately and adequately address their needs (Menotti et al., 2008)
- Include all stakeholders in implementation of the intervention
- Involve community elders; in many communities, the elders affect the acceptance of family planning in the community
- Strengthen the relationship between the area, district, and basic health units through the development of operational guidelines for FP services to unify criteria for the provision of services at different levels of service
- Work with community members to disseminate information that clarifies myths about family planning
- Train all health center personnel (including non-medical staff) on FP issues
- Strengthen the commitment of district health officials to family planning

Advocacy

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

VIII. CONCLUSION

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

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