



USAID
FROM THE AMERICAN PEOPLE

GUATEMALA HEALTH SYSTEM ASSESSMENT 2015: PRIVATE SECTOR ASSESSMENT OF FAMILY PLANNING, ANTENATAL CARE, AND DELIVERY

December 2015

This document/publication was produced for review by the United States Agency for International Development. It was prepared by Cindi Cisek, Chloé Revuz, and Christina Kramer for the Strengthening Health Outcomes through the Private Sector (SHOPS) project.



Recommended Citation:

Cisek, Cindi, Chloé Revuz, and Christina Kramer. December 2015. *Guatemala Health System Assessment 2015: Private Sector Assessment of Family Planning, Antenatal Care, and Delivery*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Download copies of SHOPS publications at: www.shopsproject.org

Cooperative Agreement: GPO-A-00-09-00007-00

Submitted to: Marguerite Farrell, AOR
Bureau of Global Health
Global Health/Population and Reproductive Health/Service Delivery Improvement
United States Agency for International Development

Yma Alfaro
Health Project Management Specialist
United States Agency for International Development, Guatemala



Abt Associates Inc.
4550 Montgomery Avenue, Suite 800 North
Bethesda, MD 20814
Tel: 301.347.5000 Fax: 301.913.9061
www.abtassociates.com

In collaboration with:
Banyan Global • Jhpiego • Marie Stopes International
Monitor Group • O'Hanlon Health Consulting

GUATEMALA HEALTH SYSTEM ASSESSMENT 2015: PRIVATE SECTOR ASSESSMENT OF FAMILY PLANNING, ANTENATAL CARE, AND DELIVERY

DISCLAIMER

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

TABLE OF CONTENTS

Acronyms	vii
Acknowledgments	ix
Executive Summary	11
1 Introduction	17
1.1 Antecedents	17
1.2 Scope of Work.....	17
1.3 Key Concepts - Definitions	18
2 Methodology.....	20
2.1 Approach	20
2.2 Sources of Information	21
2.2.1 Literature Review and Background	21
2.2.2 Market Segmentation Analysis.....	21
2.2.3 Field Work	21
2.3 Timeline	22
2.4 Limitations	22
3 Current Health Context in Guatemala.....	24
3.1 Background.....	24
3.2 Health Seeking Behaviors	25
3.2.1 Overview	25
3.2.2 Family Planning	27
3.2.3 Current Use of Contraception	29
3.3 Maternal Health	31
3.3.1 Antenatal Care.....	32
3.3.2 Delivery	33
3.4 Health Financing and Out-of-Pocket Expenditures	34
4 The Guatemalan Health Sector and the Role of the Private Sector	37
4.1 Health Sector Overview.....	37
4.1.1 Ministry of Health and Social Welfare	39
4.1.2 Guatemalan Institute for Social Security	41
4.1.3 Private Sector	42
4.2 Market Segmentation	43
4.2.1 Family Planning	43
4.2.2 Antenatal Care.....	48
4.2.3 Delivery	49
4.2.4 Summary of Market Segmentation Findings	52
5 Findings.....	55

5.1 Overview	55
5.2 Enabling Environment	55
5.2.1 General Policy and Regulatory Review	55
5.2.2 National Health Council	57
5.2.3 National Commission for Contraceptive Security	57
5.2.4 Other Key Advocacy Organizations	58
5.3 Public Sector Organizations	58
5.3.1 MSPAS	58
5.3.2 Guatemalan Institute for Social Security	62
5.4 Nongovernmental Organizations	63
5.4.1 APROFAM	63
5.4.2 PASMO/Red Segura	66
5.4.3 WINGS	67
5.5 For-Profit Private Sector	68
5.5.1 For-Profit Private Providers	68
5.5.2 Social Health Enterprises	69
5.5.3 Health Insurance and Microinsurance	70
5.5.4 Corporate Social Responsibility	71
5.5.5 Worker Health and Well-Being	73
6 Recommendations	74
6.1 Health System stewardship	74
6.2 Service Delivery	74
6.3 Demand Side	76
6.4 Supply Side	76
6.5 Human Resources for Health	77
Annex A: Stakeholders Interviewed for PSA	78
Bibliography	81

LIST OF TABLES

Table 1: Guatemala Global Health Indicators.....	25
Table 2: Guatemalan Population's Accessibility to MSPAS Service Delivery Points.....	25
Table 3: Guatemala Family Planning Indicators, 2008.....	27
Table 4: Primary Source of Family Planning for WRA Knowing Where to Source a Family Planning Method (%).....	31
Table 5: Guatemala Maternal Health Indicators.....	31
Table 6: Number of ANC Visits	33
Table 7: Personnel Attending Deliveries, 2013 (%).....	33
Table 8: Health Financing by the Numbers.....	35
Table 9: Overview of Health Sector Stakeholders.....	37
Table 10: MSPAS Health Infrastructure by Facility Type.....	40
Table 11: IGSS Programs 2015 Operations Plan.....	42
Table 12: Number of Private Health Facilities by Type, January 2015	43
Table 13: Source Providing Each Type of Family Planning Methods - Countrywide.....	45
Table 14: Sources of Injectables According to User Profile (N=1,905).....	47
Table 15: Sources of Sterilization According to User Profile (N=2,433).....	47
Table 16: Place of Delivery and Place Where ANC Was Received (%)	49
Table 17: Place of Delivery According to User Profile (N=2,433)	50
Table 18: Legislation Related to Sexual and Reproductive Health in Guatemala 2001-2012	56
Table 19: APROFAM's Leading Social Programs	65

LIST OF FIGURES

Figure 1: Steps in a Private Health Sector Assessment.....	20
Figure 2: Mortality Rate in Central American Countries (Children Under 5) - 2013	24
Figure 3: Health Seeking Behavior at Time of Illness- Western Highlands - 2011.....	26
Figure 4: Place of Treatment - Western Highlands - 2011	26
Figure 5: Total Fertility Rate in Guatemala, 1987-2008.....	27
Figure 6: Family Planning Method Use by Type in Guatemala (%)	28
Figure 7: Evolution of Modern CPR in Guatemala (%) WRA in Union.....	28
Figure 8: Evolution of Modern Contraceptive Method Mix for WRA in Union (%).....	29
Figure 9: Type of Modern Method Used among WRA in Union, Countrywide vs. Western Highlan ds (%).....	29
Figure 10: Maternal Mortality Rates in Latin America and the Caribbean, 1990-2013.....	32
Figure 11: Health Expenditure Per Capita (Constant 2005 International \$)	35
Figure 12: Human Resources for Health Indicators in Selected Latin American Countries	38
Figure 13: Changing Market Share for Family Planning Products - All Methods.....	44
Figure 14: Source of Family Planning Methods by Region (All WRA) (%)	44
Figure 15: Socio-Economic Characteristics of Modern Method Users (All WRA) (%).....	45
Figure 16: Source of Modern Contraceptives by Wealth Quintiles (%)	46
Figure 17: Place Where ANC Is Received (%)	48
Figure 18: Source of ANC by Wealth Quintile (%)	49
Figure 19: Place of Delivery According to Wealth Quintiles - Countrywide	51
Figure 20: Place of Delivery According to Wealth Quintiles - Western Highlands	51
Figure 21: Place of Delivery According to Wealth Quintiles - Guatemala City	52

ACRONYMS

ANC	Antenatal care
APROFAM	<i>Asociación Pro Familia</i> , IPPF Affiliate of Guatemala
BEOC	Basic Essential Obstetric Care
CABEI	Central American Bank for Economic Integration
CAIMI	<i>Centros de Atención Integral Materno Infantiles</i> , Centers for Integrated Maternal-Infant Care
CAP	<i>Centro de Atención Permanente</i> , Permanent Care Center
CAT	<i>Comadrona Adiestrada Tradicional</i> , trained traditional birth attendant
CentraRSE	<i>Centro para la Acción de la Responsabilidad Social Empresarial en Guatemala</i> , Center for Corporate Social Responsibility
CEOC	Comprehensive Essential Obstetric Care
CDCS	USAID Country Development Cooperation Strategy
CNAA	<i>Comisión Nacional de Aseguramiento de Anticonceptivos</i> , Contraceptive Security Committee
CPR	Contraceptive Prevalence Rate
CSR	Corporate Social Responsibility
DRACES	<i>Departamento de Regulación, Acreditación y Control de Establecimientos de Salud</i> , General Directorate for Health Regulation, Vigilance, and Control
ENCOVI	<i>Encuesta Nacional de Condiciones de Vida</i> , National Survey on Living Conditions
ENSMI	<i>Encuesta Nacional de Salud Materno Infantil</i> , National Survey on Maternal and Child Health
EPSS	<i>Empresa de Promoción de Servicios de Salud</i> , Enterprise for Promotion of Health Services
GDP	Gross domestic product
IDB	Inter-American Development Bank
IGSS	<i>Instituto Guatemalteco de Seguridad Social</i> , Social Security Institute of Guatemala
IPPF	International Planned Parenthood Federation
MSPAS	<i>Ministerio de Salud Pública y Asistencia Social</i> , Ministry of Health and Social Welfare
NGO	Nongovernmental organization
OSAR	<i>Observatorio de la Salud Reproductiva</i> , Reproductive Health Observatory
PASMO	Pan American Social Marketing Organization, created by PSI
PEC	<i>Programa de Extensión de Cobertura</i> , Program for Extended Coverage, MSPAS policy (1996-2014)
PPP	Public-private partnership

PSA	Private Sector Assessment
PSI	Population Services International
REDMISAR	<i>Red de Mujeres Indígenas por la Salud Reproductiva</i> , Network of Indigenous Women for Reproductive Health
RH/FP	Reproductive Health/Family Planning
SBA	Skilled birth attendant
SHOPS	Strengthening Health Outcomes through the Private Sector Project (USAID-funded; 2009-2015)
TBA	Traditional birth attendant, also called <i>comadrona</i>
TFR	Total Fertility Rate
UNAIDS	United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHIP	Western Highlands Integrated Program
WHO	World Health Organization
WRA	Women of Reproductive Age

ACKNOWLEDGMENTS

The authors thank Baudilio López, Yma Alfaro, and Romeo Menéndez from USAID/Guatemala for their generous support and clear guidance throughout this assessment. They also thank Martha Mérida and Eugenia Monterroso for their valuable participation in the planning and data gathering phases of this report, as well as being available for clarifications. Leslie Miles and Linda Moll also provided detailed, thoughtful input to finalize this report. And finally, the authors thank colleagues on the SHOPS project who gave technical input at critical moments, especially SHOPS Deputy Director Caroline Quijada.

EXECUTIVE SUMMARY

PURPOSE OF THE ASSESSMENT

The Strengthening Health Outcomes through the Private Sector (SHOPS) project conducted a private sector assessment (PSA) in Guatemala at the request of USAID/Guatemala in order to identify the strengths and weaknesses of the private health sector and solicit recommendations from private sector stakeholders to strengthen health system efforts in the country. The findings and recommendations of the PSA will serve as a resource for public sector, private sector, and international stakeholders as they work to improve health outcomes in Guatemala. The PSA focused on the private sector's current role in family planning and maternal health services and identified ways to mobilize untapped private sector resources to increase supply and demand of services.

METHODOLOGY AND LIMITATIONS

Following the model that SHOPS has used in over 20 PSAs, the assessment team began by clarifying the scope of work with USAID and reading the literature that was pertinent to the assessment topics. Next, they conducted a market segmentation analysis, conducted in-depth interviews with key informants within the country, and submitted a draft report for feedback from USAID. After addressing USAID's comments, SHOPS finalized the report.

The scope for this assessment was limited to family planning, antenatal care, and safe deliveries. The PSA team limited its scope to assess source and use of the private sector, without addressing quality of services. Commodity supply was purposely excluded from the scope because it has been covered through other assessments.

A challenge in data analysis stemmed from the data sources, which were dated and from different time periods and different regions. The team used the latest available data to conduct secondary analyses. These data existed in several national databases (*Encuesta Nacional de Salud Materno Infantil* (ENSMI) conducted in 2008-2009;¹ National Health Accounts, conducted in 2014; *Encuesta Nacional de Condiciones de Vida* (ENCOVI), conducted in 2012) as well as a database from USAID's Western Highland Integrated Program (WHIP) baseline from 2013 used by the agency to measure the impact of its integrated programs. Additionally, the differences in sampling for ENSMI 2008-2009 (presenting data at the national level, with a possibility to disaggregate at the departmental level) and for the WHIP baseline database from 2013 (focusing on USAID priority municipalities in the Western Highlands) make it impossible to directly compare the two surveys. The team did not conduct quintile analysis at the departmental level due to inadequate sample sizes and thus it was not possible to identify variations across departments in the country.

And finally, the assessment occurred at a time when the Guatemalan government, including the Ministry of Health and Social Welfare (MSPAS), was experiencing a severe political crisis, which introduced a level of uncertainty among the informants. It also made some of them reluctant to go into much depth with the interviewers.

¹ ENSMI 2008-2009 is synonymous with the Demographic and Health Survey. Although the resulting report was authored by MSPAS in 2010, throughout this report, "ENSMI 2008-2009" is used to refer to the study.

KEY FINDINGS

Guatemala has a strong regulatory framework that guarantees access to maternal health, reproductive health, and family planning services, providing a legal basis to guarantee and defend the right to these services. Nonetheless, there is still strong ideological opposition from both religious and political entities that challenge the family planning program. For more than a decade, advocacy organizations have been working to increase awareness of the importance of contraceptive security, to advocate for a multisector approach, and to address key policy and programmatic gaps. In 2009, the National Commission for Contraceptive Security (CNAA) was officially created to be led by the MSPAS' National Reproductive Health Coordinator. Despite important legal and regulatory advances, stakeholders report that there are still budget shortfalls for contraceptives and limited competitive procurement options to ensure efficient use of resources. In addition, a high percentage of funds that are dedicated to reproductive health/family planning services are not effectively executed; budget allocations are received late; funds are poorly spent or not spent at all. Many of these issues still require constant advocacy to ensure that they are appropriately addressed with each annual budget law. In late 2013, CNAA published its Market Segmentation Strategy for contraceptives, which recognizes the importance of a sustainable, total market approach. The strategy outlines different scenarios for reducing unmet need and shifting method mix, but does not define specific actions to achieve the scenarios. In March 2015, the CNAA was planning to hold a workshop to discuss how to take the market segmentation strategy to the next level.

Guatemala has a strong legal framework that facilitates access to sexual and reproductive health services and family planning. MSPAS, IGSS, and APROFAM are the largest service providers.

The private sector represents a large and growing segment of the health system. Many Guatemalans, regardless of their income levels, seek health services in the private sector even though this requires out-of-pocket spending.

MSPAS is currently facing a severe financial crisis that is not likely to be resolved in the short term. As seen in the secondary analysis, MSPAS' share of the provision of family planning, antenatal, and maternal health services has increased over time, in some cases significantly, contributing to an increasing financial deficit for MSPAS and underlining the need for a more balanced, sustainable total market. As reported by stakeholders, there are widespread stock outs of essential medicines including vaccines. In the Western Highlands, second-level facilities that serve as maternity centers report stock outs of anesthesia and other supplies that inhibit their ability to provide caesarian deliveries so all non-vaginal deliveries are being referred to second- and third-tier hospitals, overburdening these facilities as well. Stakeholders report that budgets for contraceptive supplies fall short of the demand for services. There are stock outs of family planning commodities at all levels.

The Guatemalan Social Security Institute (IGSS) is the second largest health service delivery institution in the country. There is evidence that a large percentage of IGSS beneficiaries and their dependents are seeking family planning services at non-IGSS facilities. Many of these users are going to MSPAS, creating additional burden for that financially struggling institution. IGSS' family planning program is institutionalized under Resolution No. 1165; stakeholder interviews suggest that there is not widespread knowledge of IGSS policy to provide family planning services, and contraceptives are not widely available. In addition, Resolution 1165 includes some key policy barriers to family planning access, including stating that beneficiaries and affiliates are only eligible for family planning services up to 26 weeks postpartum, requiring a written request for sterilization services by the beneficiary, and requiring that women have at least two living children. Despite these shortcomings, almost all stakeholders recognize that IGSS has a critical role to play and must be a key player in ensuring a more balanced, sustainable market.

Guatemala has several NGOs that have and can play important roles in service delivery, including the International Planned Parenthood Federation affiliate, APROFAM, which is the second largest provider of family planning methods after MSPAS. APROFAM's mobile units are the only ones in the country that are equipped to provide laparoscopic voluntary surgical contraception. These social programs will continue to require significant subsidy given the costs associated with reaching remote areas. APROFAM also has an underutilized capacity for delivery services, which could be used to ease the volume of clients at MSPAS.

Guatemala's private sector represents a large and growing segment of the health care market, including high-end tertiary hospitals, small specialty and general clinics and hospitals, individual practices, pharmacies, and traditional providers. Regardless of income level, many Guatemalans seek care in the private sector, and although the use of private sector providers involves out-of-pocket payments, many households use the private sector as their first point of care. For example, Guatemala's second largest city, Quetzaltenango, has a very strong network of private hospitals and lower-level facilities, both for general medicine as well as a wide variety of specialties. After Guatemala City, Quetzaltenango has second largest conglomeration of private facilities, and the private health care market in Quetzaltenango municipality is becoming saturated. There is an opportunity to explore what types of incentives would encourage new private sector providers to expand in other medium-size cities in the Western Highlands. Private health insurance represents a small segment of the Guatemala health care market, with less than 5 percent of the Guatemalan population covered by a private health insurance scheme (MSPAS 2010). Interviews with representatives from the insurance industry suggest that the segment is growing and that over 90 percent of the population covered resides in Guatemala City. Nonetheless, there are interesting trends in health insurance targeted toward lower-middle and middle-income groups.

RECOMMENDATIONS

Health System Stewardship

Stewardship that engages multiple private sector players

Guatemala's MSPAS is charged with stewardship or governance (*rectoría*) of the overall health sector. However, in practice, coordination and communication among sectors is limited, particularly concerning IGSS and the private sector. At the same, various commissions for multi-sectoral dialogue exist in Guatemala, yet there is little engagement of the for-profit private sector in these fora. The PSA team recommends that MSPAS continue to look for opportunities to engage new private sector players, including the for-profit sector. This would include participation of the for-profit sector, including the pharmaceutical industry as well as professional medical associations, such as the College of Physicians and Surgeons, Association of Obstetricians and Gynecologists, Association of Pediatricians, and others.

Advocacy to improve market inequities

Despite important legal and regulatory advances, Guatemalan advocacy organizations report that there are still budget shortfalls for contraceptives and limited competitive procurement options to ensure efficient use of resources. In late 2013, CNAA published its Market Segmentation Strategy for contraceptives, which recognizes the importance of a sustainable, total market approach. The strategy outlines different scenarios for reducing unmet need and

The Guatemalan health system can be strengthened by:

- Increasing cross-sectoral coordination, including the private for-profit sector
- Advocating to improve market inequalities
- Expanding options of services
- Expanding health insurance and micro insurance to cover the middle-income segment
- Promoting synergies between the commercial sector and private for-profit companies
- Creating a professional midwife cadre to assist births outside medical facilities

shifting method mix, but it does not define specific actions to achieve the scenarios. The market segmentation analysis conducted by PSA team suggests that there are still important inequities in the delivery of FP, ANC, and delivery services, and the potential to move upper health quintiles toward private sector channels.

The team recommends that the CNAA strengthen the engagement of the for-profit private sector as part of a sustainable health market, as well as identify specific next steps for all sectors. CNAA should also consider the comparative advantages of NGOs and the for profit sector to expand access to ANC and delivery services.

Service Delivery

IGSS to increase its provision of FP, ANC, and delivery services

The Guatemalan Social Security Institute is the second largest health service delivery institution in the country. There is evidence that a large percentage of IGSS beneficiaries and their dependents are seeking family planning services at non-IGSS facilities. Many of these users are going to MSPAS, creating an additional burden for that institution. Stakeholder interviews suggest that there is not widespread knowledge of IGSS policy to provide family planning services, and contraceptives are not widely available.

We recommend that IGSS' stakeholders conduct a review of Articles 4 and 5 of Resolution #1165 to ensure that it is consistent with Guatemala's law on universal access to FP services.

IGSS plays a very small role in ANC services, even among the highest wealth quintiles. The PSA team recommends that IGSS strengthen provision of ANC services as well as delivery services outside of Guatemala City. Given its infrastructure and resources, IGSS is the organization that will have the most immediate and significant impact on strengthening RH/FP and MH services.

The PSA team recommends continued high-level advocacy with IGSS to ensure that IGSS realizes its role as a strategic player in ensuring a more balanced, sustainable market for FP, ANC, and delivery services, sharing facilities and resources, and avoiding an unnecessary duplication of facilities and services.

APROFAM to identify its comparative advantages and commit to strengthen and subsidize high priority areas

APROFAM is in a critical time striving to maintain its leadership position as the 2nd largest provider of FP services in the country, while streamlining operations and increasing its overall sustainability. APROFAM's mobile units represent an important comparative advantage for the organization since they are the only ones in the country that provide laparoscopic surgical sterilization. However, APROFAM should seek to strengthen coordination, promotion and dissemination of these medical outreach activities with other key stakeholders to ensure that they are optimizing number of people who can benefit from services. Additionally, APROFAM's hospitals, particularly in the Western Highlands, report underutilized capacity for delivery services, which through appropriate targeting and demand-side financing (e.g., vouchers) could be used to improve MH indicators in that region.

The PSA team recommends that APROFAM determine what social programs are essential to its mission and then continue its full commitment to their success, using the STF to cross-subsidize high priority activities.

Red Segura to consider targeted expansion of geographic coverage and MH services

Red Segura has proven to be a successful model for increasing IUD and implant use through private providers. Given the network's success in rapidly expanding provision of long-acting

methods in the private sector, there are opportunities to consider for targeted expansion to priority geographic areas and to incorporate additional MH services among participating providers, particularly among middle-income users that are largely using the public sector for ANC and delivery services.

The team recommends that PASMO/Red Segura develop its sustainability strategy, identifying which elements of the provider network are essential to long-term access to key FP, ANC, and delivery services in the for-profit private sector. It should also identify opportunities for expanding geographic access and providing broader MH services.

Enterprise for Promotion of Health Services (EPSS) as a sustainable and scalable private sector health care model

The EPSS represents an innovative, sustainable private sector health care model. EPSS management is open to exploring options for increasing access to reproductive health, family planning, and maternal health services among its network of private providers. EPSS' proven business model and large network of enrolled members represents a very interesting opportunity for large-scale expansion of family planning and reproductive and maternal health services, such as including family planning services in the health insurance policies that are focused specifically on women, e.g., Banrural's Vivo Segura. The PSA team recommends exploring opportunities to expand access to RH/FP and MH services, building on EPSS' sustainable and scalable service delivery health model.

The PSA team recommends exploring opportunities to expand access to RH/FP and MH services, building on EPSS' sustainable and scalable service delivery health model.

Demand Side

Targeted demand generation among underserved groups

The team recommends that the country engage in demand generation activities that recognize important differences within the population, for example, urban/rural, ethnic groups, age, and levels of wealth. Donors and other stakeholders could contribute to this effort by supporting behavior change communication activities on family planning and safe motherhood through its partners in the WHIP. The behavior change communication campaigns should include information on how to access private providers and NGOs, including locations and services available.

Supply Side

Health insurance and micro insurance to expand access among middle income

Private health insurance represents a small but growing segment of the Guatemalan health care market. The PSA team recommends exploring strategic partnerships with insurance agents to expand access to RH/FP and MH services for middle-income populations. The strongest potential for growth in insurance products is within middle income populations in large urban centers.

Corporate social responsibility and private partnerships to create strategic synergies

Guatemala's for-profit commercial sector has a strong, sophisticated base of corporate engagement and social responsibility in health. Many of these organizations are already supporting RH/FP and MH services through their existing programs.

The PSA team recommends exploring strategic partnerships that focus less on financial leveraging and more on identifying added-value and comparative advantage among organizations.

Human Resources for Health

Cadre of skilled birth attendants to address non-facility based births

The majority of women countrywide and in the Western Highlands deliver either in their own home or in the home of a TBA, and many TBAs are illiterate and not qualified to manage emergency cases. The team recommends creating a professional midwife cadre either as a specialization within the nurse cadre or as a separate category. Similarly, the team recommends that Guatemala recognize SBAs in the formal sector and standardize their qualifications and scope of practice. And finally, the team recommends increasing the number of SBAs through training.

1 INTRODUCTION

1.1 ANTECEDENTS

Guatemala suffers high levels of inequality and widespread poverty, with more than half of its 15 million inhabitants living below the national poverty line and 14 percent living on less than US\$1.25/day (UNICEF, 2013a). Life expectancy is short, at 72 years for both sexes (WHO, 2014a), and maternal mortality is high at 113 per 100,000 live births in 2013 (MSPAS, 2015), among the highest in Latin America and the Caribbean along with Bolivia, Guyana, Haiti and Honduras (UNICEF, 2013b). Overall, the country is ranked 125 of 187 in the 2013 Human Development Index, only above Honduras, Nicaragua, and Haiti in the Latin America and Caribbean region.²

More than half of Guatemala's 15 million inhabitants live in extreme poverty. Despite recent improvements in health outcomes, many challenges remain, especially in the Western Highlands where many rural and impoverished indigenous people live.

Despite significant improvements in the last decade, the country is still facing major challenges in health. The conditions are acutely worse in regions with predominantly indigenous, rural, and poor populations. In collaboration with the Ministry of Health and Social Welfare (*Ministerio de Salud Pública y Asistencia Social*, MSPAS), USAID identified the Western Highlands as its focus region for its 2012-2016 Country Development Cooperation Strategy (CDCS). In this region, which faces particularly severe challenges in health, more than 60 percent of the population is indigenous, compared to 29 percent at the national level, and 49.6 percent of children under five suffer malnutrition (USAID, 2012). USAID's CDCS concentrates its activities on 30 municipalities in five departments (Huehuetenango, Quetzaltenango, Quiché, San Marcos, and Totonicapán) through an integrated effort to reduce poverty and chronic malnutrition, improve health and nutrition, and increase health service utilization.

1.2 SCOPE OF WORK

USAID/Guatemala requested that the Strengthening Health Outcomes through the Private Sector (SHOPS) project conduct a private sector assessment (PSA) of the Guatemalan health sector to identify strengths and weaknesses and provide recommendations to strengthen the health system and inform the development of its next CDCS. The assessment was designed to determine the private sector's role in family planning, antenatal care (ANC), delivery, and maternal and child health and to identify ways to mobilize untapped private sector resources.

The PSA focused on private sector service delivery trends both at the national level and within USAID's focus areas of the Western Highlands. Simultaneously, USAID asked the Health Finance and Governance project to conduct a Health Sector Assessment in the country. Together, the reports provide USAID and other stakeholders with an overview of the Guatemalan health sector and summarize challenges and opportunities for stakeholders to strengthen the health system.

The PSA was designed to determine the current role, coverage, and use of the private health sector in Guatemala for family planning and selected maternal health services (specifically, ANC, delivery, and newborn care), to address gaps in public services and provide opportunities

² Human Development Index, <http://hdr.undp.org/en/countries/profiles/GTM>

to increase the private sector's role. The assessment was designed to answer the following questions:

- What is the general role of the private sector in delivering family planning and maternal health services, especially in the Western Highlands?
- Where is the population currently sourcing its family planning and maternal health services?
- How could the private sector be more engaged or play an increased role in the delivery of family planning and maternal health services? To what extent and under what circumstances would independent private providers be interested in providing family planning or maternal health services?

1.3 KEY CONCEPTS - DEFINITIONS

For the purposes of this assessment, the following definitions are applied consistently throughout the report:

BEOC/CEOC: Basic Essential Obstetric Care (BEOC) and Comprehensive Essential Obstetric Care (CEOC) are the globally recognized levels of care that must be available to meet obstetric needs and are vital in reducing maternal mortality and morbidity.

Comadrona: *Comadrona* is the Guatemalan traditional birth attendant (TBA). While the attendant is an important player in the Guatemalan health sector, attendant profiles and skill levels vary. A *comadrona* can be either non-specified, trained (*Comadrona Adiestrada Tradicional*), or empirical. See “skilled birth attendant” in this list for more discussion. Throughout the report, TBA will be used to refer to the *comadrona*.

Health care provider: SHOPS considered health cadres that were present in the latest Demographic and Health Survey (*Encuesta Nacional de Salud Materno Infantil* (ENSMI), 2008-2009). The health cadres involved in family planning and maternal health services are doctors, ambulatory doctors, nurses, TBAs, health promoters, health guardians, and traditional healers.

IGSS: The Guatemalan Social Security Institute (*Instituto Guatemalteco de Seguridad Social*, IGSS) is a hybrid institution funded through public and private (employers) channels to cover workers in the formal sector. As of the 2011 IGSS Annual Report, the most recent year for which data are available, IGSS covers 17 percent of the Guatemalan population.

Key health stakeholder: A key health stakeholder is an individual or group which can affect or is affected by an organization, strategy, or policy in health. Annex A lists the key health stakeholders interviewed for this PSA.

Maternal health: For this assessment, SHOPS limited its definition of maternal health issues to ANC, delivery, and trends related to access and availability in the public and private sectors.

Private health sector: The private health sector in Guatemala comprises for-profit commercial entities as well as nonprofit organizations, such as NGOs and corporate entities dedicated to health. The private sector is engaged in provision of health services, products, or information as well as advocacy and behavior change.

Public-private partnership (PPP): A PPP in health is any formal collaboration between the public sector (national and local governments, international donor agencies, bilateral government donors) and the nonpublic sector (commercial and nonprofit, traditional healers, midwives, or herbalists) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communications, or education (Barnes, 2011).

Public sector: The public health sector in Guatemala comprises MSPAS and IGSS. MSPAS is the sector's overall governing body and the largest provider of health services in Guatemala, with a network of local, regional, and national health facilities.

Skilled birth attendant (SBA): While discrepancies exist among countries regarding the profile of SBAs, the World Health Organization (WHO) advocates for deliveries to be assisted by accredited health providers who have been “educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (WHO, 2004). Guatemala has not yet completed training or accreditation of professional midwives, so most skilled birth attendance is provided by nurses and obstetrician/gynecologists (OB/GYNs) and general practitioners. Additionally, the *comadronas*, (TBAs), often lack any training and education and are not accredited as providers.

Skilled health professional: This professional is a provider accredited by MSPAS for the provision of care. Health professionals in Guatemala have the legal obligation to be affiliated with a corresponding college (such as the College of Physicians and Surgeons, or the College of Pharmacists and Chemists).

Total market approach: A total market approach is a coordinated effort incorporating the public and private sectors to increase access to family planning (or other health products/services) in a given country. The objective of a total market approach is to better use the comparative advantages of public and private sources of health goods and services to increase access to and sustainability of priority health products (Crosby et al., 2010).

Traditional birth attendant (TBA): The WHO defines a traditional birth attendant as a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or serving as an apprentice to other TBAs. Guatemalan TBAs are usually called *comadronas*.

2 METHODOLOGY

2.1 APPROACH

The SHOPS project has conducted over 20 PSAs around the world, providing useful recommendations to major stakeholders on how to better integrate the private health sector and reach sustainability. Throughout the years, the project developed the five-step PSA methodology summarized in Figure 1 that emphasizes collaboration and engagement with local stakeholders in order to ensure accuracy and buy-in for the key findings and recommendations.

FIGURE 1: STEPS IN A PRIVATE HEALTH SECTOR ASSESSMENT



Source: Assessment to Action, SHOPS Project, 2014

The SHOPS LAC Regional Director managed the whole PSA process and contributed to the report. The PSA assessment team consisted of five key people: a team leader, researcher/analyst, and two public health experts who assisted in interviewing and data collection. This core team was supported by SHOPS' expert technical staff at headquarters for specific questions.

In Guatemala, the PSA team used a mix of quantitative and qualitative methods to assess the role of the private sector in the areas of family planning, determine the legal and regulatory framework governing the private sector, and identify PPP opportunities. Among other sources, the team used data from ENSMI 2008-2009, the Western Highland Integrated Program (WHIP) baseline survey, and the National Survey on Living Conditions (*Encuesta de Condiciones de Vida*, ENCOVI) 2011, to understand contraceptive prevalence, unmet need for contraception, contraceptive method mix, and source of family planning, and to quantify the size and role of the private health sector in the country and in USAID's focus region of the Western Highlands.

The PSA team then conducted about 50 in-country interviews both in the capital city and in the Western Highlands. Combining quantitative and qualitative approaches allowed for validation, verification, and triangulation of private health sector data.

Key steps included:

1. Clarification of the scope of work with USAID to understand the priority points
2. Receipt of recommendations from USAID on whom to interview
3. Literature review
4. In-depth interviews in Guatemala
5. Market segmentation analysis
6. Submission of draft report submitted to USAID for feedback
7. Revision and finalization of report and recommendations (September 2015)

After finalizing the scope of work with USAID, the assessment team used the PSA approach outlined in Figure 1. Throughout the five steps of the approach, the team emphasized collaboration and engagement with local stakeholders to ensure accuracy and buy-in for the key findings and recommendations.

2.2 SOURCES OF INFORMATION

2.2.1 LITERATURE REVIEW AND BACKGROUND

A complete bibliography of documents reviewed for this PSA is found in Annex B. The SHOPS team analyzed data from the ENCOVI 2011, and service delivery statistics from the National Statistics Institute to inform development of assessment questionnaires. The SHOPS team also used data from the National Health Accounts (NHA) exercise conducted in Guatemala to analyze health trends and behaviors.

2.2.2 MARKET SEGMENTATION ANALYSIS

To inform this PSA, the team conducted a market segmentation analysis. Data analyzed for this exercise came from the sources below:

- The series of ENSMIs, also known as Demographic and Health Surveys, conducted periodically by MSPAS, the latest dating from 2008-2009, and
- USAID's WHIP baseline study, conducted in 2013 in USAID's focus area of the Western Highlands.

The segmentation analyzed sourcing patterns for family planning, ANC, and delivery according to users' profiles, particularly their residence or wealth quintile.

2.2.3 FIELD WORK

See Annex A for a complete list of the individuals and institutions that provided information and their perspectives to this assessment. SHOPS interviewed representatives from the following organizations:

For-profit private sector

- Network of private providers
- Private facilities (hospitals and clinics)
- Private insurance companies
- Banking institutions

Nonprofit private sector

- Corporate foundations and groups engaged in social responsibility
- Social enterprises (e.g., microcredit institutions, social insurance schemes, pharmacies)

IGSS

- Representatives from the management team
- Representatives from the board of directors
- IGSS health facilities director at the local level

Public sector

- MSPAS
- Professional councils
- Public facilities

Development partners

- International donors
- Multilateral organizations (e.g., Pan American Health Organization, Inter-American Development Bank)
- International project implementers

The stakeholders were identified and purposively sampled in coordination with USAID and its partners in Guatemala. The team compiled an initial list before arriving in Guatemala and finalized it with USAID upon arrival. The initial list was supplemented using snowball sampling during the course of the assessment, with teams asking interviewees for the names and contact information of additional stakeholders to interview. Throughout the report findings are stated as the composite opinion from the many stakeholders interviewed during the assessment.

2.3 TIMELINE

- December 2014: Finalized SHOPS scope of work
- January–February 2015: Conducted data analysis on ENCOVI and NHA data, literature review and prepared for field visits
- February 23–March 7, 2015: Conducted interviews with key stakeholders in Guatemala City, Quetzaltenango, Huehuetenango, and Totonicapán
- March 2015: Conducted market segmentation analysis
- March–June 2015: Developed PSA draft report
- July 2015: Submitted PSA draft report to USAID for review
- September 2015: Finalized PSA report

2.4 LIMITATIONS

While the PSA provides an overview of the private health sector in Guatemala, several factors might limit its generalizability. Due to the limited timeframe to conduct the assessment and interview stakeholders in country, the team sampled key organizations and providers, thus potentially missing some important stakeholders in the private sector. Some institutional stakeholders (particularly at IGSS and MSPAS) were reluctant to respond to an interview and/or had limited time to speak with interviewers. In addition, the assessment occurred in the midst of an institutional crisis at MSPAS as well as during an election year. At the time of the interviews, there were many changes being implemented within the health system.

The team used the latest available data (ENSMI, 2008-2009; NHA, 2014; ENCOVI, 2011; and the WHIP baseline database, 2013) to conduct secondary analyses. Guatemala's major source of family planning and reproductive health data, ENSMI 2008-2009, is dated, and the results of

the next survey might present a different picture of private sector health trends. Additionally, the differences in sampling for ENSMI 2008-2009 (presenting data at the national level, with a possibility to disaggregate at the departmental level) and for the WHIP baseline database from 2013 (focusing on USAID priority municipalities in the Western Highlands) make it impossible to directly compare the two surveys. While the data in the WHIP baseline seem to present improvements in family planning and maternal health indicators from the 2008-2009 ENSMI, the 2015 version of the ENSMI would need to be analyzed to confirm any trends. It should also be noted that for the market segmentation analysis, the team did not conduct quintile analysis at the departmental level due to inadequate sample sizes and thus it was not possible to identify or explore possible variations across departments in the country.

The PSA team limited its scope to assess source and use of the private sector in family planning and selected maternal health services and did not address any other health area that might be included in the USAID/Guatemala portfolio, such as nutrition. Additionally, in the areas considered, the team did not address quality of services. For example, the team did not evaluate the quality of ANC and cannot make any judgement on its impact on reducing maternal mortality. Finally, it should be noted that USAID directed the PSA team to exclude analysis of commodity supplies for family planning and maternal health as other assessments have already documented these issues.

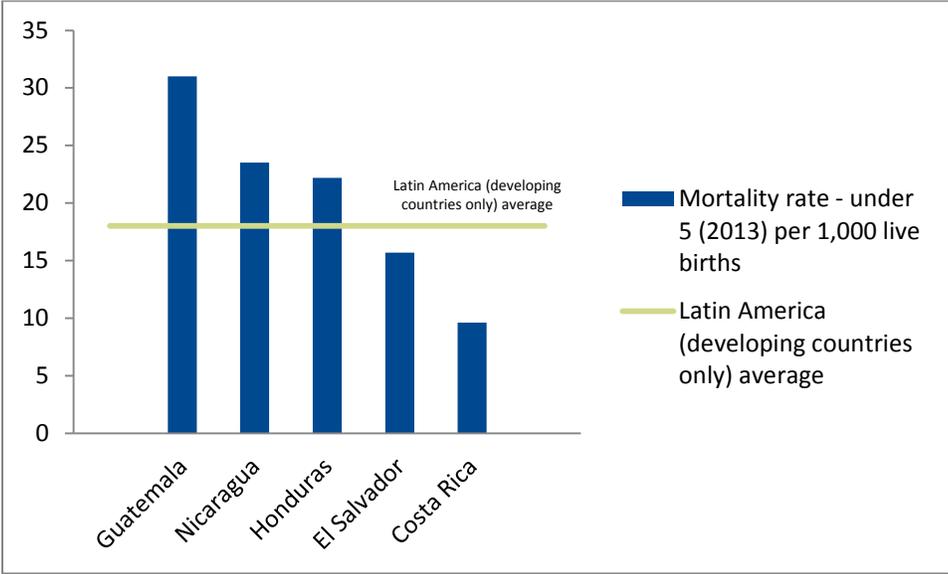
3 CURRENT HEALTH CONTEXT IN GUATEMALA

3.1 BACKGROUND

Guatemala faces numerous health and health system challenges: For example, prevalence of communicable diseases has dropped in the past 25 years, and mortality from these diseases has decreased, from 31.5 percent in 2001 to 19 percent in 2012. Nevertheless, mortality due to non-communicable diseases such as diabetes and cardiovascular diseases has increased from 9 percent to 23 percent in the same timeframe (MSPAS, 2014). In 2015, maternal mortality remains high and the double burden of malnutrition (chronic malnutrition especially for children under five as well as overweight and obesity) represents an additional challenge to the delivery of health services. As previously mentioned, population groups who are poor, living in rural areas, and/or are indigenous suffer the highest burden. In addition, Guatemala’s health indicators tend to be worse than other countries in the region; for example, the children under five mortality rate is the highest in the Central American region as seen in Figure 2. Table 1 presents several other indicators related to the country’s the health status.

The sudden cancellation of the Extended Coverage Program (PEC) has left many inhabitants of the Western Highlands with limited or no access to health services. PEC’s termination has had the greatest negative effect on poor indigenous populations and rural communities.

FIGURE 2: MORTALITY RATE IN CENTRAL AMERICAN COUNTRIES (CHILDREN UNDER 5) - 2013



Source: World Bank, 2015.

TABLE 1: GUATEMALA GLOBAL HEALTH INDICATORS

Indicator	Value	Date
Total population	15,083,000	2012
Population living in urban areas	51%	2013
Life expectancy at birth (both sexes)	72	2012
Population under 15	40.4%	2013
HIV prevalence rate (among adults 15-49)	0.6%	2013

Source: WHO Global Health Observatory Data Repository: <http://apps.who.int/gho/data/node.country.country-GTM?lang=en>

At the time of the PSA, approximately 4 million residents of rural, indigenous areas had insufficient or no access to health services, due largely to an institutional crisis at MSPAS that resulted in the cancellation of the Program of Extended Coverage (*Programa de Extension de Cobertura*, PEC); PEC allowed MSPAS to contract-out the delivery of primary health care services to NGOs in areas that lacked access to public facilities (Avila et al., 2015). Remote location, poor public transportation infrastructure, cost of travel, and frequent impassability of roads in inclement weather make distances to the closest public health center or public hospital major obstacles to the indigenous populations who live in remote areas (Chomat et al. 2014). In 2015, the USAID Health Financing and Governance project conducted an analysis with the USAID GeoCenter and presented the population’s accessibility to MSPAS health centers before and after the cancellation of PEC. Table 2 presents findings of the analysis. The reduction in accessibility, with 1.7 million more Guatemalans now being more than five kilometers from a health facility, is most acutely felt in Alta Verapaz, Quiche, Petén, and Huehuetenango. Regardless of the issues that existed with the PEC network, the loss of over half of the service delivery points in the country will have an impact on access to health services.

TABLE 2: GUATEMALAN POPULATION'S ACCESSIBILITY TO MSPAS SERVICE DELIVERY POINTS

With PEC in Place			Without PEC in Place		
Accessibility (kilometers)	Population with Access	%	Accessibility (kilometers)	Population with Access	%
0-5 km	12,924,050	85.5	0-5 km	11,214,075	78.1
5-10 km	1,227,045	8.5	5-10 km	2,407,356	16.8
10-20 km	184,560	1.3	10-20 km	634,408	4.4
> 20 km	38,873	0.3	> 20 km	111,127	0.8

Source: USAID GeoCenter, 2015, Avila et al., 2015

Closing the access gap between population groups is the main priority of the MSPAS team in charge of monitoring completion of the Millennium Development Goals (Secretaría de Planificación y Programación de la Presidencia República de Guatemala, 2010). However, lack of funding is preventing improving the availability of quality services.

3.2 HEALTH SEEKING BEHAVIORS

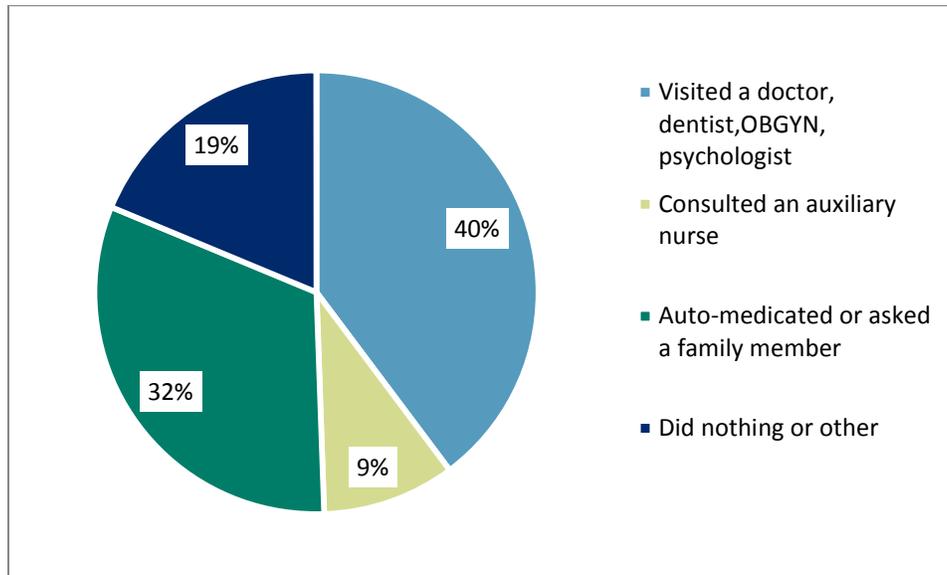
3.2.1 OVERVIEW

According to ENCOVI 2011, only half (49 percent) of Guatemalans visit health providers for any kind of service when experiencing a health problem. Twenty-nine percent self-medicate or ask a family member for help, and 22 percent do nothing. This behavior is consistent

1. Health-seeking behavior varies greatly by wealth quintile. The lowest quintiles are less likely to seek skilled care, suggesting differences in behavior and potentially unequal access to health care. Culture is an important factor that influences health-seeking behavior, especially among Guatemala’s diverse ethnic groups.

countrywide, including in the Western Highlands, where 51 percent self-medicate or do not seek care, as shown in Figure 3.

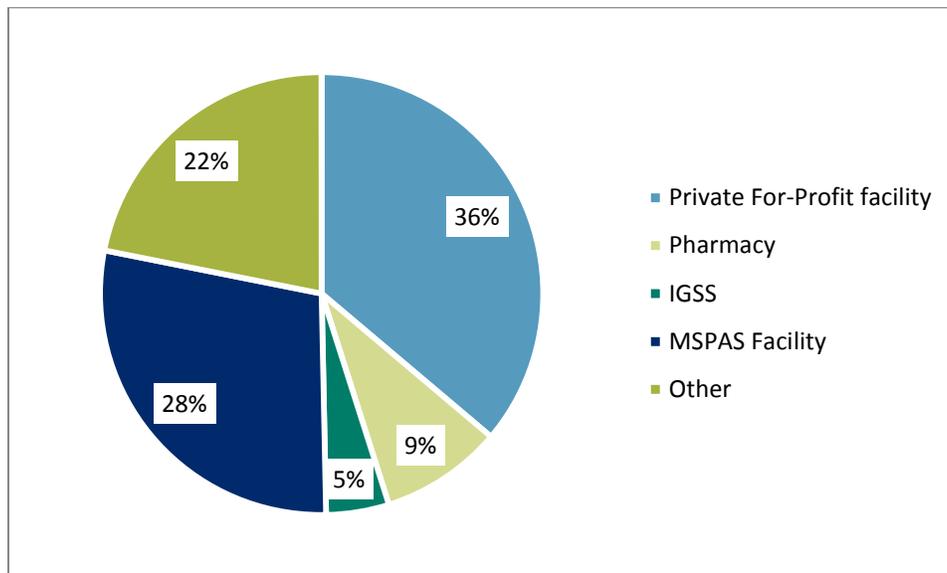
FIGURE 3: HEALTH SEEKING BEHAVIOR AT TIME OF ILLNESS- WESTERN HIGHLANDS - 2011



Source: ENCOVI 2011

ENCOVI 2011 also found that at the national level, people who do seek treatment go to private for-profit facilities (34 percent), pharmacies (9 percent), and IGSS facilities (7 percent). Public (MSPAS) facilities represent a quarter (28 percent) of all the places where people seek care. Again, behavior in the Western Highlands reflects the countrywide breakdown, as seen in Figure 4.

FIGURE 4: PLACE OF TREATMENT - WESTERN HIGHLANDS - 2011



Source: ENCOVI 2011

Health seeking varies greatly by wealth quintile; lower quintiles are less likely to seek qualified care, which suggests behavioral difference and potentially unequitable access to health.

Additionally, culture is an important factor influencing care seeking in Guatemala, with its large indigenous population and various ethnic groups.

3.2.2 FAMILY PLANNING

Guatemala faces significant challenges in improving the sexual and reproductive health of its citizens. Table 3 provides an overview of indicators on family planning.³

TABLE 3: GUATEMALA FAMILY PLANNING INDICATORS, 2008

Indicator	Value
Total fertility rate (TFR)	3.6
Contraceptive prevalence rate (CPR) for women of reproductive age (WRA) married or living in union, all methods	54.1%
CPR for WRA in union, modern methods	44.0%
Contraceptive prevalence rate (among girls 15-19%)	14.6%

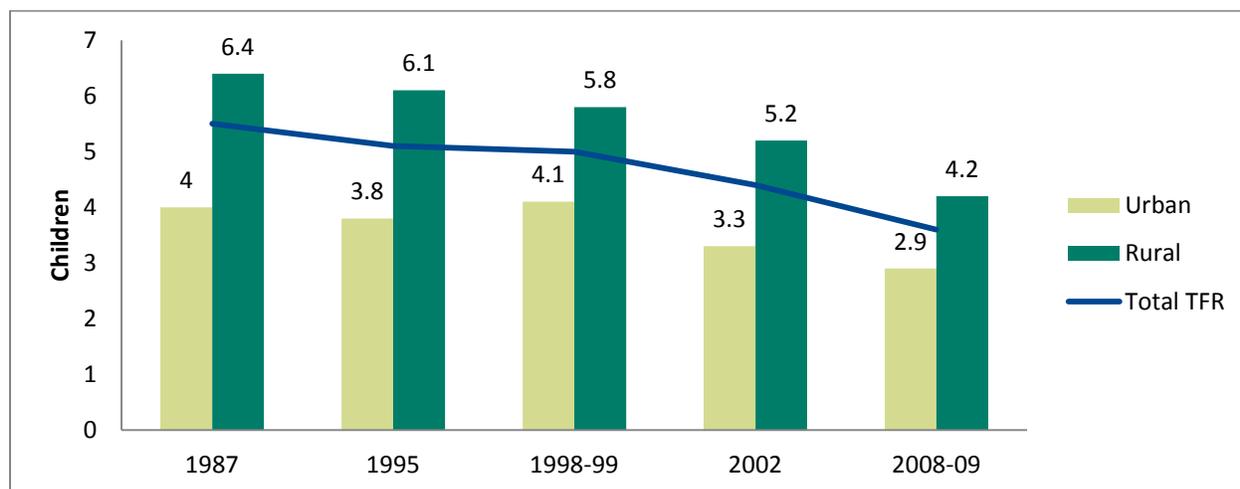
Source: ENSMI 2008-2009

Guatemala has a high TFR of 3.6 births per woman. Although Guatemala's TFR decreased 35 percent between 1987 and 2009, it remains higher than in all other Central American countries, and for the region as a whole, whose average TFR is 2.1 (WHO, 2012). As Figure 5 shows, the decrease in TFR in Guatemala is mostly due to TFR reduction in rural areas, which accelerated between 2002 and 2009. However, a gap between rural areas and urban areas remains. On average, women in rural Guatemala still have 1.3 more children than women in urban areas: the rural TFR is 4.2, whereas the urban TFR is 2.9.

Guatemala's total fertility rate (TFR) of 3.6 births per woman is higher than the regional average. In rural areas, the TFR is higher (4.2) than in urban areas (2.9). Approximately half of women of reproductive age use contraceptives. Injectables and female sterilization are the most commonly used methods.

Most women in the Western Highlands seek contraceptives in the public sector, and most urban women obtain their methods in pharmacies.

FIGURE 5: TOTAL FERTILITY RATE IN GUATEMALA, 1987-2008



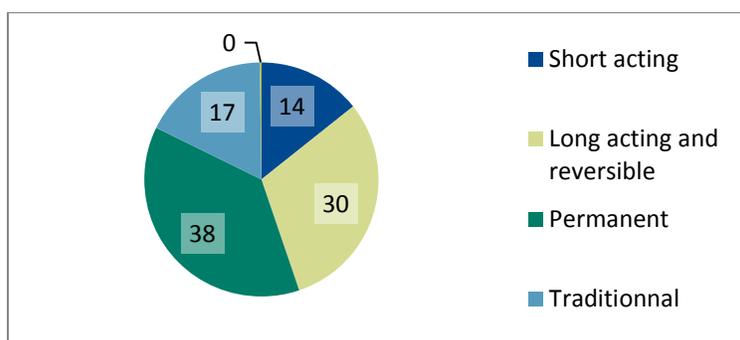
Source: ENSMI 1987 through 2009-2009

As illustrated in Figure 6, permanent methods are the most common methods in Guatemala, followed by long-acting and reversible methods. Short-acting methods needing resupply (such

³ It is important to note that Guatemala is implementing a Demographic and Health Survey in 2015, and data from this survey could differ from the indicators in this report.

as pills and condoms) are not preferred. Traditional methods are still used by 17 percent of users at the national level.

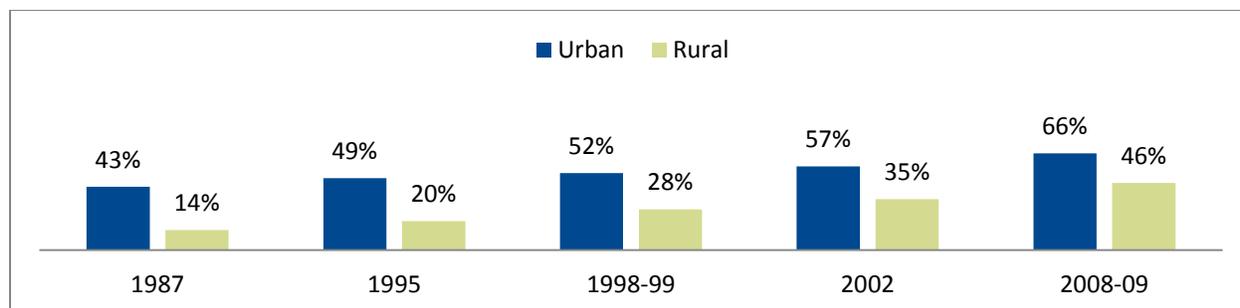
FIGURE 6: FAMILY PLANNING METHOD USE BY TYPE IN GUATEMALA (%)



Source: ENSMI 2008-2009

As Figure 7 illustrates, there was steady growth in the use of modern methods between 1987 and 2009, with the greatest gain seen in rural areas. However, the modern methods CPR in Guatemala remains lower than that of its regional counterparts, with modern contraceptives used by only 44 percent of married WRA in 2008. The urban-rural gap shrank by a third between 1987 and 2008, but it persists, with modern methods CPR 20 percentage points higher in urban areas than in rural areas. The gap between total CPR and modern methods CPR also increased slightly, from eight percentage points in 2002 to 10 percentage points in 2008-2009 ENSMI. This suggests that more women are adopting family planning practices, but not necessarily a modern contraceptive method.

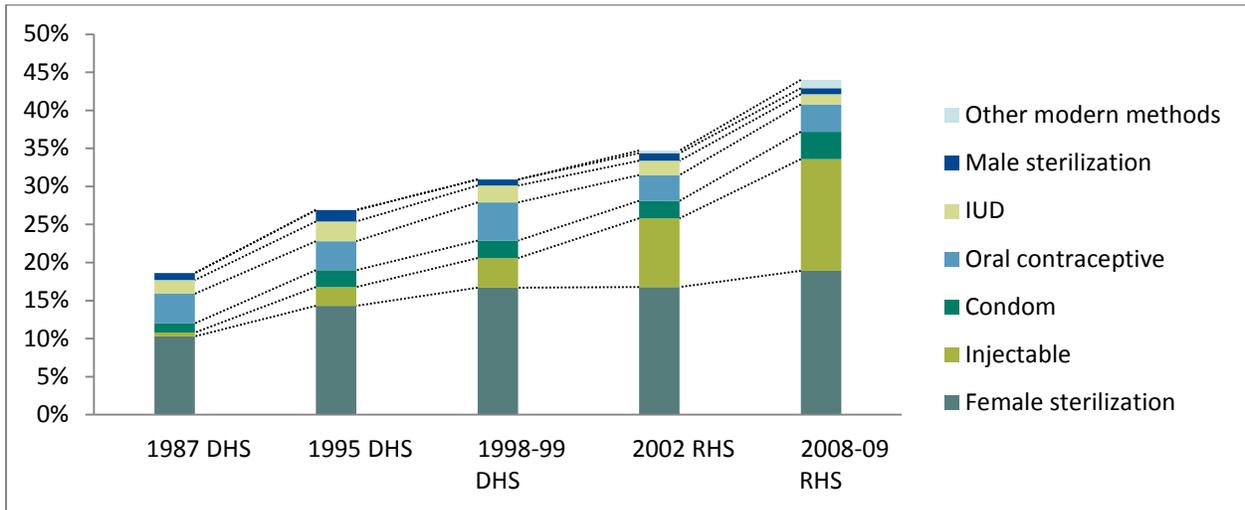
FIGURE 7: EVOLUTION OF MODERN CPR IN GUATEMALA (%) WRA IN UNION



Source: DHS, <http://www.statcompiler.com/>

Changes in the contraceptive method mix for WRA in union in Guatemala since the late 1980s have been primarily driven by increased use of injectable contraceptives and female sterilization (Figure 8). Female sterilization has had a historically large share of the market, growing from 10 percent in 1987 to 19 percent in 2008. The market share of injectable contraceptives also grew during the period, from 0.5 percent to almost 15 percent. Use of other methods remained relatively constant (e.g., CPR for male sterilization went from 0.9 percent in 1987 to 0.8 percent in 2008, and for oral contraceptives went from 3.9 percent to 3.6 percent). Though the utilization rate is still low, CPR for condoms doubled, from 1.2 percent in 1987 to 3.2 percent in 2008.

FIGURE 8: EVOLUTION OF MODERN CONTRACEPTIVE METHOD MIX FOR WRA IN UNION (%)

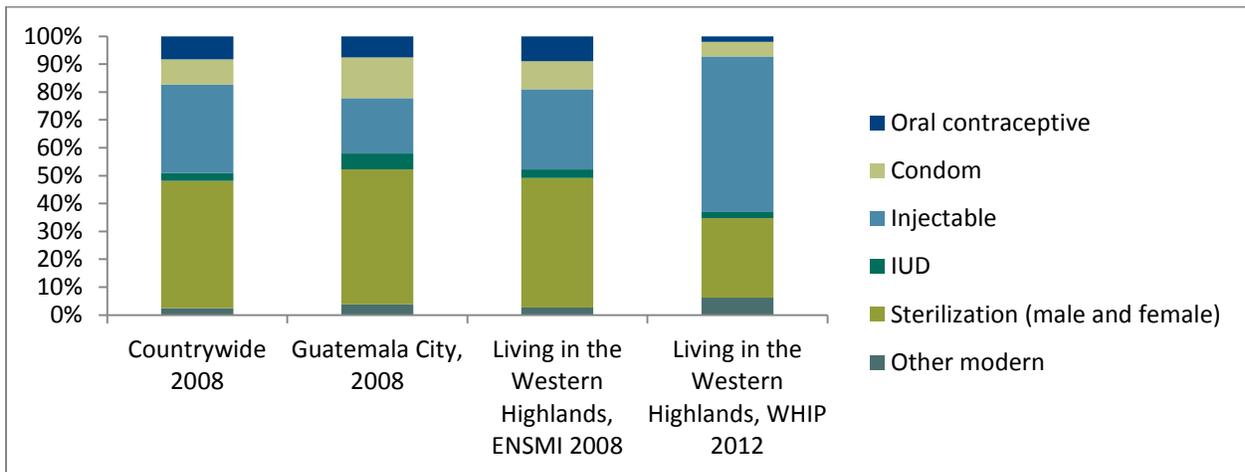


Source: DHS, <http://www.statcompiler.com/>

3.2.3 CURRENT USE OF CONTRACEPTION

According to ENSMI 2008-2009, total contraceptive use by women in union is 54.1 percent and a high proportion of family planning users in Guatemala City and the Western Highlands report using traditional methods (17 percent and 20 of total CPR, respectively). Figure 9 compares overall modern method prevalence nationally and in the Western Highlands using 2008-2009 ENSMI data. In 2008-2009, injectables and female sterilization were the most commonly used modern methods, both countrywide and in the Western Highlands region. A historical trend also indicates a decrease in sterilization and an increase in injectables. In 2008-2009, Condom and oral contraceptive use was slightly higher in the Western Highlands region compared to countrywide, while injectable use was lower in the Western Highlands than countrywide. Fewer than five percent of women countrywide and in the Western Highlands reported using IUDs.

FIGURE 9: TYPE OF MODERN METHOD USED AMONG WRA IN UNION, COUNTRYWIDE VS. WESTERN HIGHLANDS (%)



Source: ENSMI 2008-2009, WHIP 2012

Total contraceptive use reported by men in union age 15-59 at 59.2 percent is close to the percentage reported by women, and 13.7 percent report using a traditional method. As with women, men in urban areas, especially in the capital city, are more likely to use modern methods of contraception, at 58.1 and 63.2 percent, respectively. Female sterilization is an essential method of family planning in Guatemala, but the share of vasectomies is limited, reaching only 0.7 percent of men married or in union in 2008 (MSPAS, 2011). In the youngest age groups, male condoms are the second most used modern method, after injections: condoms are used by 4 percent of 15-19 year olds; 6.4 percent of 20-24; and 8.2 percent of 25-29 year olds.

For the Western Highlands, data are also presented from the 2012 WHIP survey. While methodological differences make it difficult to directly compare the 2008-2009 ENSMI data for Western Highlands to the 2012 WHIP data, it is notable that the more recent WHIP survey revealed higher levels of injectable contraceptive use among modern method users in this region, with an estimated 56 percent of all modern method users choosing this method. That is a substantial increase from the 29 percent share found in the 2008 RHS. The second most common modern method reported in the Western Highlands in 2012 was sterilization (male or female) at 28 percent.

While some women use resupply methods (oral contraceptives, condoms, or injectables), not all WRA know where to procure family planning methods, and regional disparities remained for women to know where to source their method. In 2008, 89 percent of WRA in Guatemala City knew of a family planning source, compared to just 66 percent of women living in the Western Highlands (MSPAS, 2010). WRA living in the Western Highlands most commonly cited the public sector as a family planning source (74 percent), whereas WRA living in Guatemala City mentioned pharmacies the most (35 percent), as illustrated in Table 4. Both at the national and regional level, as the respondent got older, APROFAM, the International Planned Parenthood Federation (IPPF) affiliate of Guatemala, was increasingly cited as a source and pharmacies were less cited. The youngest group vastly cited private pharmacies as a source, perhaps because of the lack of access to public health services. Additionally, they are also the biggest users of condoms, the method that is most commonly purchased in private pharmacies, as reported by 88.2 percent of male respondent in the 2008 DHS (MSPAS, 2011).

Interestingly, only 1 percent of respondents, including in Guatemala City, cited IGSS as the primary source where they knew they could procure family planning methods. Actual sourcing patterns for family planning methods will be discussed later, in the market segmentation analysis (Chapter 4).

TABLE 4: PRIMARY SOURCE OF FAMILY PLANNING FOR WRA KNOWING WHERE TO SOURCE A FAMILY PLANNING METHOD (%)

	Public Sector / MSPAS	IGSS	Private For-Profit	APROFAM	Private Pharmacies	Other
Residence						
Countrywide	62	1	1	12	22	1
Guatemala City	33	1	2	27	35	0
Western Highlands	74	0	1	7	16	2
By age						
15-19	52	0	1	6	40	1
20-24	62	0	1	11	23	2
25-29	70	1	2	13	13	1
30-34	67	1	1	16	13	2
35-39	70	0	2	17	10	1
40-44	67	0	1	19	11	2
45-49	66	2	0	23	8	1

Source: ENSMI 2008-2009

3.3 MATERNAL HEALTH

Maternal health remains a challenge in Guatemala, especially in the Western Highlands and among the most vulnerable populations. Table 5 summarizes maternal health indicators.

TABLE 5: GUATEMALA MATERNAL HEALTH INDICATORS

Indicator	Percent
Births attended by skilled health personnel	51.0*
Births attended by skilled health personnel, among girls aged 15-19	92.6*
Antenatal care coverage (at least one visit)	93.0
Rate of exclusive breastfeeding of infants under 6 months	49.6**
% of WRA with anemia	30.4**
% of infants born with low birth weight	11.4**
% of C/sections	16.3
% of women with a height <145 cm with children <5 years	31.2
% of women with children <5 years of age with an body mass index of 30.0 or more	15.4
% of women with children <5 years of age with an body mass index of between 25.0 and 25.9 (overweight)	35.0

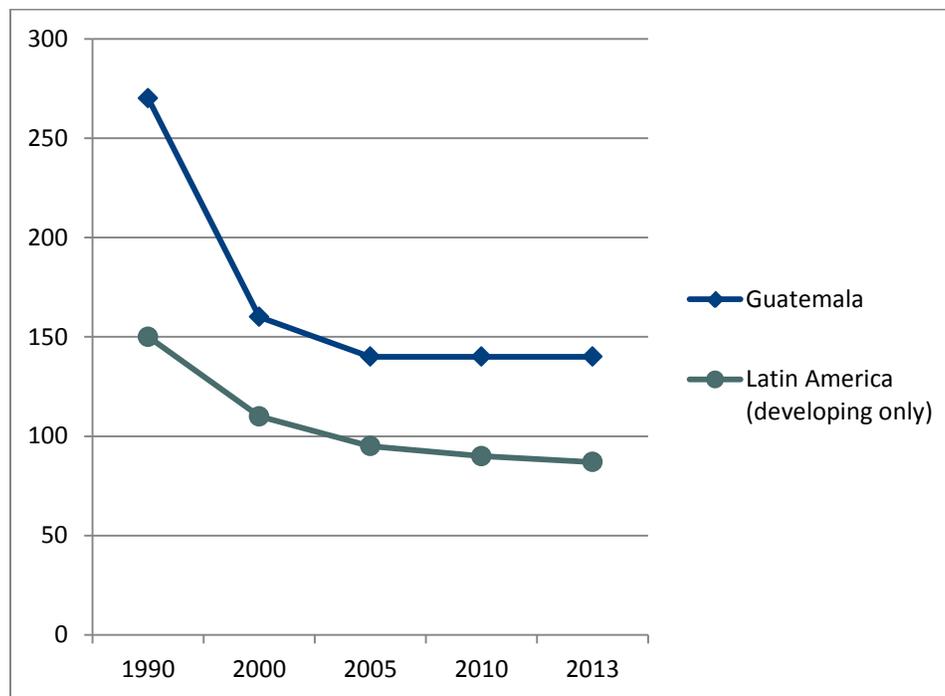
Sources: All data points come from ENSMI 2008-2009 except for those indicated with (*) that come from WHO 2012 and (**) that come from the World Bank Group World Development Indicators databank.

Maternal mortality is high in Guatemala and has slowly declined since 2007 reaching 113 maternal deaths for 100,000 live births in 2013 (MSPAS, 2015). Although there are discrepancies in the reporting of maternal mortality rates, Guatemala's trend is far above the regional average for developing countries in Latin America and the Caribbean of 87 per 100,000 live births (World Bank, 2015) (Figure 10). Among women of all ages, the top causes of death were hemorrhage (41 percent) and eclampsia and pre-eclampsia (25 percent). That these are preventable

Forty-eight percent of deliveries occur at home or with a traditional midwife rather than in a health center with skilled birth attendants.

conditions highlights the need for improved access to timely and high-quality obstetrical care, which is likely exacerbated by the frequency of home delivery (48 percent) and/or birthing with a traditional birth attendant (TBA), rather than in a health facility with skilled birth attendants.

FIGURE 10: MATERNAL MORTALITY RATES IN LATIN AMERICA AND THE CARIBBEAN, 1990-2013



Source: World Bank Development Indicators, 1990-2013

3.3.1 ANTENATAL CARE

ANC coverage is high in Guatemala. According to ENSMI 2008-2009, 80 percent of pregnant women overall had received at least four ANC visits, the WHO standard for ANC care, and 93 percent had received at least one visit. However, it is important to remember that number of visits and quality of care are not necessarily related. ENSMI 2008-2009, for instance, reports a decline in tetanus toxoid immunization coverage from ENSMI 2002, from 49.7 percent of pregnant women receiving at least two tetanus toxoid shots in 2002 to 42.7 percent in 2008, although they made the same number of visits. Most women received their first ANC visit during the second trimester of their pregnancy, with little variation by region. About 77 percent of women in the Western Highlands received their first ANC visit between 20 and 25 weeks, compared to 81 percent of women nationwide.

The community plays an important role to ensure that pregnant women receive antenatal care. Traditional midwives or other community-based workers visited about one fourth of pregnant women in the Western Highlands.

More recent data from the Western Highlands shows that 98 percent of women saw a skilled health professional for at least one of the ANC visits. Additionally, the data suggest that women consult providers several times during their pregnancies (Table 6). According to the WHIP, 63 percent of women indicated having received ANC in the course of their first trimester and 17 percent within the fourth month of pregnancy.

TABLE 6: NUMBER OF ANC VISITS

Number ANC visits (N=3740)	% WRA (n=3740)
Fewer than 4	18
4 or more	80
Did not know / did not respond	2
Total	98

Source: WHIP baseline survey 2012

The role of the community to reach out to women to provide ANC is important. Twenty-two percent of women from the Western Highlands interviewed during ENSMI 2008-2009 reported that somebody came to their homes to provide care during the pregnancy. However, 91 percent of those visitors were TBAs, suggesting that the quality and services provided were not likely to meet recommended standards of care, due to uneven training levels among TBAs.

3.3.2 DELIVERY

In 1999, at the International Conference on Population and Development + 5, Guatemalan representatives concurred with the international target of 90 percent of deliveries to be attended by skilled health professionals. Currently, the country reaches this goal only for births among girls age 15-19, and the WHO World Health Statistics report (2014b) indicates that Guatemala ranks second to last in the Latin America and Caribbean region with only 51 percent coverage of deliveries by skilled health professionals.

The holistic approach that guides the Mayan medical system is not integrated into the formal health care system, which is based on Western medicine.

An estimated 43 percent of deliveries countrywide take place at home, with no skilled providers present (MSPAS, 2010). Teen mothers (age 15-19) is the group that is most apt to deliver in a health facility (MSPAS, IGSS, APROFAM) and, at the national level, institutional delivery reaches 97 percent of the age group. The proportion is smaller in the Western Highlands, where only 36 percent of teen mothers had an institutional delivery.

However, the WHIP baseline survey indicated a change in trends; its data show that the majority of deliveries (70 percent) in 2012 were attended by skilled personnel (Table 7 below). Unlike in the 2008-2009 ENSMI, where the youngest group exhibited a different behavior from the older groups, age of women is not a major differentiator: 67 percent of deliveries for women 15-19 were attended by medical personnel, but not necessarily within institutional facilities, as 53 percent delivered at home (Angeles et al., 2014).

TABLE 7: PERSONNEL ATTENDING DELIVERIES, 2013 (%)

Age of pregnant women (%)								
Type of Personnel	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Average
Medical personnel	67	71	67	66	83	72	60	70
Other personnel	33	29	33	32	17	26	40	29
No one	0	0	0	2	0	3	0	1
Total	100	100	100	100	100	100	100	100

Source: WHIP Survey 2013

The State of the World's Midwifery (WHO, 2014c) projects that Guatemala will need enough midwifery services to cover 63.1 million ANC visits, 9.9 million births, and 39.8 million postnatal care visits between 2014 and 2030.

Strong regional differences exist in women's behaviors at the time of delivery, and interviewees cited cultural context, geographic isolation of the communities, and lack of availability of services as potential reasons for women to deliver their children at home. This sentiment was repeated in the PSA interviews. The holistic approach that guides the Mayan medical system is not integrated into the official health care system based on Western medicine.

This barrier is particularly significant for delivery, and in 2008, the rate of indigenous women delivering at home was 2.5 times higher than that of non-indigenous women (67 percent of women delivering at home are indigenous, as opposed to 26 percent who are not). Through the PSA interviews, informants highlighted various barriers for safe deliveries in rural Guatemala. Among these were difficult access to health facilities from remote communities, lack of funds to transport the women to the nearest health facilities, cultural barriers in health facilities that are not designed for the integration of the community, and lack of training that leaves TBAs unable to recognize danger signs quickly and seek referral. Data from the 2013 WHIP baseline survey indicate that in order to prepare for delivery, 75 percent of patients had saved money, 55 percent of them had secured transportation, but only a small proportion of them (7 percent) had identified blood donors. Additionally, WHIP baseline survey data indicate that a third of deliveries were C-sections, which is extremely high and suggests the reasons for this rate should be examined.

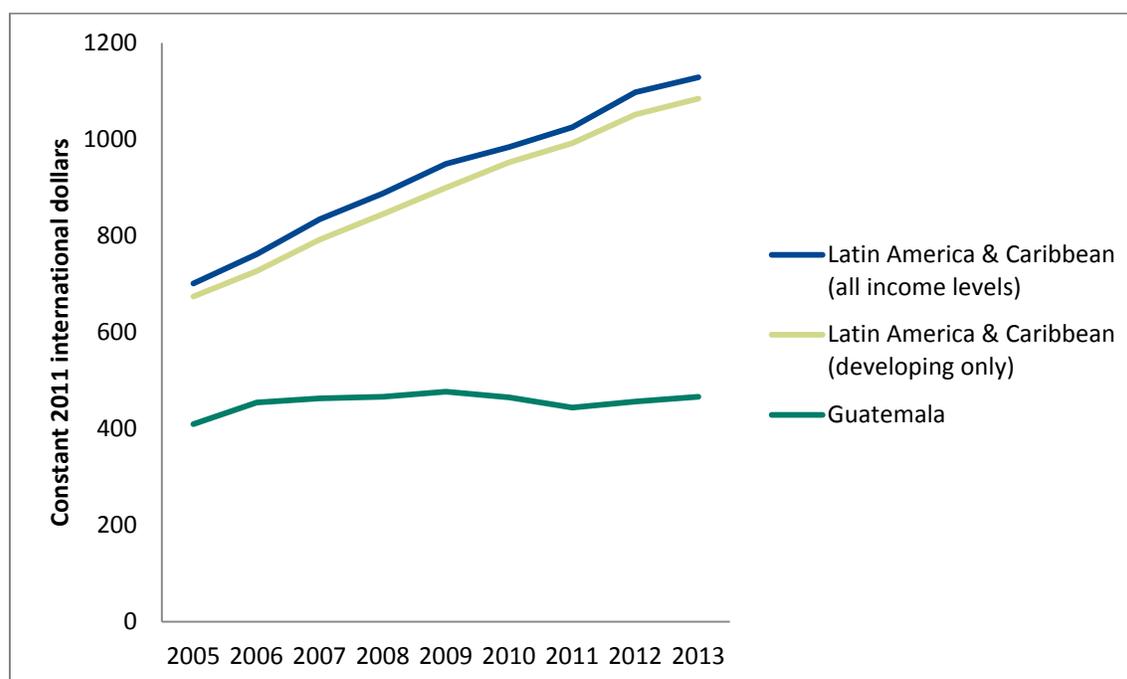
Currently, no professional midwifery training is carried out in Guatemala. MSPAS, in partnership with the Guatemalan Universidad da Vinci and the Peruvian Universidad de San Martin de Porres, is implementing a new midwifery training program based on a Peruvian model. This training is to be implemented in Huehuetenango in the Western Highlands and is designed to strengthen the supply of skilled attendants by recruiting students from the local communities, anticipating increased retention. It is not clear if this training will be the gateway for more courses and if it will substantially increase the number of SBAs. There needs to be a doubling of skilled attendance by 2020 in order to increase met need to 90 percent by 2020 (WHO, 2014c). If professional midwives are not trained, then accredited post-graduate courses for nurses in midwifery skills, will be essential.

3.4 HEALTH FINANCING AND OUT-OF-POCKET EXPENDITURES

Guatemala suffers from inadequate funding in health. Unlike other countries in the Latin American region that have seen their health expenditures grow in the last decade, health expenditures have stagnated in Guatemala, far below the amount spent per capita in the region, as illustrated in Figure 11.

Out-of-pocket payments account for fifty-seven percent of the total health expenditure in Guatemala. These payments go toward basic health commodities, medical consultations, and access to private hospitals.

FIGURE 11: HEALTH EXPENDITURE PER CAPITA (CONSTANT 2005 INTERNATIONAL \$)



Source: World Bank Databank 2015

The Guatemalan health system is mostly financed by private funds, as presented in Table 8. Notably, the share of government expenditures on health has decreased in the last five years while the share of private expenditures on health has steadily increased. Out-of-pocket expenditures are high and have remained roughly at the same share of total private expenditures on health since 2010 (81.3 percent in 2010, 81.2 percent in 2013).

TABLE 8: HEALTH FINANCING BY THE NUMBERS

	2010	2011	2012	2013
General government expenditure on health as % of total health expenditure	40.8	37.8	38.0	37.4
Private expenditure on health as % of total health expenditure	59.2	62.2	62.0	62.6
GGHE as % of General government expenditure	20.3	17.6	18.3	17.0
Social security funds as % of GGHE	45.6	48.3	52.5	43.7
Private insurance as % of PvtHE	4.4	4.7	4.8	5.2
Out of pocket expenditure as % of PvtHE	81.3	80.6	80.7	81.2

Source: WHO <http://apps.who.int/nha/database/DataExplorerRegime.aspx>

Total health expenditure as a percentage of gross domestic product (GDP) is low in Guatemala, reaching 6.5 percent of GDP in 2013, below the average for Latin America and the Caribbean of 7.6 percent (World Bank, 2015).

Public expenditures on health represent contributions from central government and municipalities. Combined, these entities spent Quetzals (Q) 5,105 million (US\$650 million) in 2013, which represents only 19 percent of total health expenditure and was equivalent to 1.2 percent of GDP, similar to the percentage they spent in 2005. In recent years, public expenditures have fluctuated: government expenditure was Q4,287 million (US\$546 million) in 2012, increased in 2013, declined in 2014, and increased again, to Q5,400 million (US\$687 million), in 2015. These increasing expenditures are attributable to MSPAS despite reductions to health spending by municipalities. The annual per capita expenditures from MSPAS was approximately one-fifth (Q184 or US\$23) of what IGSS beneficiaries received (Q841 or US\$107) in 2013 (Avila et al., 2015).

Private expenditures by employers are their contributions to the IGSS and private insurance, and their direct financing of the provision of medical services and workplace care. Private health insurance in Guatemala accounted for 11.4 percent of total health expenditures in 2013 (Q2,804 million, US\$357 million), equivalent to 0.6 percent of the GDP (Avila et al., 2015).

The inadequacy in government funding for health has resulted in an increasing share of total health spending in the form of out-of-pocket payments, an unwieldy burden for households. Currently, households are the main source of health financing in Guatemala. Fifty-seven percent of the total health expenditure in Guatemala comes from out-of-pocket spending. These private payments go toward commodities, medical consultations, and access to private hospitals.

Guatemala mobilizes resources for health sector from a dedicated tax. Since 2004, the Tax Law on Distribution of Alcoholic Beverages (Decree21-04) has guaranteed that 15 percent of tax income would be dedicated to financing reproductive health and family planning, as well as the prevention of alcohol consumption and smoking. However, the disbursement and amounts have varied over the years, affecting the execution of the reproductive health program. Tax collection from alcoholic beverages and tobacco amounted to Q431 million (US\$55 million) in 2013, out of which Q46.2 million (US\$5.9 million), or 11 percent, was collected specifically from alcoholic beverages. The percentage spent of this specific tax (the execution rate) was 86 percent in 2013 and 72 percent in 2014. The 15 percent of the tax allocated to health programs was Q6.1 million (US\$781,000) in 2013; the amount declined to Q5.3 million (US\$679,000) in 2014.

4 THE GUATEMALAN HEALTH SECTOR AND THE ROLE OF THE PRIVATE SECTOR

4.1 HEALTH SECTOR OVERVIEW

Many key health stakeholder groups operate in the Guatemalan health sector (Table 9). During the PSA field work, the team interviewed a number of these stakeholders; Annex A lists the informants by name and organization.

MSPAS is the main health care provider in the country, and IGSS is the second largest.

A large percentage of Guatemalans also seek care in the private sector through private health insurance or out-of-pocket payments. They go to private hospitals, clinics, or pharmacies.

TABLE 9: OVERVIEW OF HEALTH SECTOR STAKEHOLDERS

Public Sector	For-profit Private Sector	Nonprofit and Faith-based Private Sector	Donor Countries, and Implementing Partners	Multinational Donors and Cooperation/ Reimbursable Cooperation
<ul style="list-style-type: none"> Ministry of Public Health and Social Welfare (national and local levels) Guatemalan Social Security Institute Military Health Service (limited involvement in health) 	<ul style="list-style-type: none"> Private pharmaceutical laboratories: <ul style="list-style-type: none"> -Bayer HealthCare -Pfizer -ABL Pharma Private pharmacies Private for-profit providers Private health facilities 	<ul style="list-style-type: none"> APROFAM Pan American Social Marketing Organization (PASMO) Medical college Pharmaceutical college Universities 	<ul style="list-style-type: none"> Donor countries: <ul style="list-style-type: none"> -USA -Spain -Japan -Sweden -Canada Population Services International University Research Co., LLC Futures Group John Snow, Inc. Medicus Mundi 	<ul style="list-style-type: none"> Inter-American Development Bank World Bank Group (including International Bank for Reconstruction and development) Central American Bank for Economic Integration (CABEI) United Nations Development Assistance Framework (UNDAF): <ul style="list-style-type: none"> -UNDP -UNICEF -UNFPA -UNESCO -UNAIDS Global Fund to Fight AIDS, Tuberculosis and Malaria

Guatemala's public health sector includes multiple government entities that provide care to different segments of the population. MSPAS is the overall steward of the Guatemalan health system; as such, it is responsible for policy formulation and resource mobilization. In addition, MSPAS provides health care services to the general population—it is Guatemala's largest

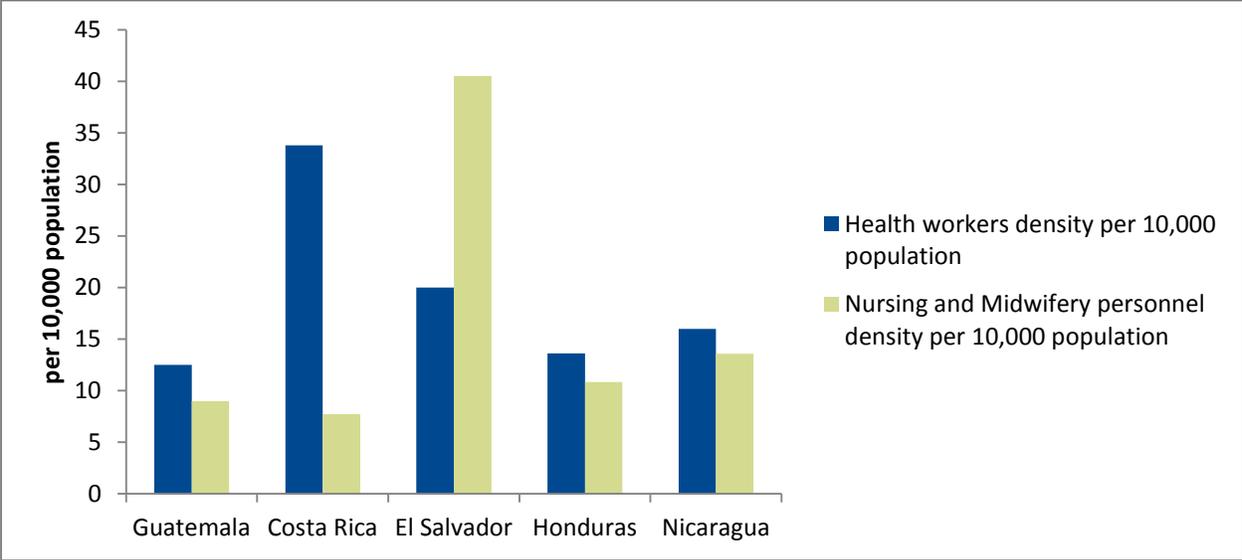
health care provider, providing approximately 71 percent of all health care services. The Ministry of Defense has its own health care network and covers service members and their dependents, approximately 0.5 percent of the population. Both of these entities have their own network of hospitals, health centers, and health posts, with little coordination between them.

The IGSS is a public-private entity that covers formally employed workers and their dependents. Although the Guatemalan Constitution states that all citizens have a right to social security services, only 18 percent of the population is covered through IGSS. Those who are employed in small companies or self-employed have limited enrollment in the IGSS system.

Additionally, a large percentage of the Guatemalan population seeks care through the private sector, both for-profit and nonprofit. The private sector, comprising private hospitals, clinics, pharmacies, and other facilities, provides services for people who either have private insurance or pay out-of-pocket (MSPAS, 2012). MSPAS oversees private sector facilities through the General Directorate for Health Regulation, Vigilance, and Control (*Departamento de Regulación, Acreditación y Control de Establecimientos de Salud, DRACES*), which is responsible for overall regulation and licensing of for-profit private sector facilities. Finally, traditional medicine practices and various community-based health services (such as those provided by TBAs, or *comadronas*) complement the more formal elements of Guatemala’s health system.

Human resources for health in Guatemala are insufficient, as measured by health worker density, the most commonly use indicator. Figure 12 illustrates health worker density in five Central American countries. With a ratio of 12.5 health workers (physicians, nurses, others) per 10,000 inhabitants (MSPAS/PAHO, 2013), Guatemala has the lowest health worker density in the region. The ratio is also well below WHO recommendation of 22.8 health workers per 10,000 inhabitants as the bare minimum for a functional health system (Avila et al., 2015).

FIGURE 12: HUMAN RESOURCES FOR HEALTH INDICATORS IN SELECTED LATIN AMERICAN COUNTRIES



Sources: PAHO, 2013 (health workers density); WHO Global Health Repository: <http://apps.who.int/gho/data/node.country.country-GTM?lang=en> (nursing and midwifery personnel – latest available data).

Health professionals in Guatemala are well organized according to their health profession. To practice, they are legally obliged to be affiliated with their corresponding college (College of Physicians and Surgeons, College of Pharmacists and Chemists, etc.). Other, non-mandatory

associations exist, such as the Guatemalan Association of Female Physicians and the Guatemalan Association of Obstetrician and Gynecologists, with local sections throughout the country.

Findings from the PSA regarding each of the groups of actors are discussed in Chapter 5. The following sections discuss the three major health care actors—MSPAS, IGSS, and the private health sector—in more detail below.

4.1.1 MINISTRY OF HEALTH AND SOCIAL WELFARE

Guatemala's Health Code establishes that MSPAS shall “*formulate, organize, and direct the execution of policies, plans, programs and projects for the delivery of health services to the general population*” and that MSPAS is charged with stewardship or governance (*rectoría*) of the health sector. As stated in the introduction to this section, MSPAS is Guatemala's largest health care provider, providing 71 percent of all health care services. It also is the major provider of modern family planning methods: its role increased from 32.2 percent in 2002 to 50.9 percent in 2008 (ENSMI 2002/2008). It is the major provider of Guatemala's two most widely used family planning methods: 77 percent of all injectable users and 42 percent of sterilization users receive services from MSPAS. Given that a high percentage of women still receive ANC and delivery services in their homes, MSPAS is the second largest provider of these services as well as the largest provider of facility-based care.

MSPAS is the primary supplier of the two most widely used family planning methods in Guatemala, providing 77 percent of injectables and 42 percent of sterilizations. In the Western Highlands, the availability of services is limited. More than 89 percent of facilities are first-level facilities, and 11 percent are secondary facilities.

MSPAS facilities are located in urban and rural areas. They range from basic primary care posts to high-end tertiary hospitals—although hospitals are located mostly in urban areas. These facilities provide services free of charge, with the exception of some hospitals that take donations.

MSPAS categorizes its service delivery infrastructure into three different levels, with various types of service delivery facilities at each level. Family planning, however, is provided at all levels. The first level of care has 1,492 facilities, representing 74 percent of all facilities; they are 1) convergence centers (covering fewer than 1,500 inhabitants), which are storage points for medicines and meeting points for outreach personnel, 2) health posts (covering 2,000 inhabitants), which serve as a link to the health network and are normally staffed by a nurse assistant (*auxiliar de enfermería*) to provide basic health services, and 3) strengthened health posts (approximately 5,000 inhabitants), which provide basic health services and refer more complex health issues to MSPAS health centers.⁴ In 2002, the General Decentralization and Municipal Code Law delegated the responsibility for establishing and administering public health services to municipalities.

The second level of care (representing 23 percent of all facilities) comprises: 1) health centers, 2) Type A health centers (with inpatient care and housing 30-50 beds), providing pediatric and emergency care, 3) Type B health centers, which focus on promotion, prevention, recuperation, and rehabilitation services, 4) Permanent Care Center (CAP) dedicated to provision of normal deliveries, 5) Ambulatory Care Centers (CENAPA) which provide outpatient care only, and 6) Centers for Integrated Maternal-Infant Care (CAIMI), which attend both normal and high-risk deliveries and have operating theaters. The government has expanded CAPs and CAIMIs to more rural areas, but there are still significant gaps in infrastructure, personnel, and resources. Health Area Directorates (DAS) and Municipal Health Districts (DMS) are responsible for local

⁴ <http://www.mspas.gob.gt/index.php/en/mspas/red-de-servicios.html>

implementation. The assessment team was not able to collect data on the availability of MSPAS facilities at the departmental or district level through stakeholder interviews or MSPAS' website.

The third level of care with 51 facilities (3 percent of all facilities) is focused on specialized hospital services, which are referral points for first- and second-level facilities. It includes 1) departmental hospitals, 2) regional hospitals, and 3) referral hospitals. In terms of MSPAS' budget, the majority of resources are allocated to the hospital network. Not surprisingly, these specialized services are concentrated in urban areas with higher income levels, leaving rural populations vulnerable and without access to specialize services.

TABLE 10: MSPAS HEALTH INFRASTRUCTURE BY FACILITY TYPE

Level of Care	Type of Establishment	Number of Establishments
First	Convergence center	2,220*
	Health post	1,302
Second	Health center	902
	Health center with specialties	21
	Mobile clinic	379
Third	Hospital level 1	13
	Hospital level 2	32
	Hospital level 3	6

Source : MSPAS Strategic Plan, 2014-2019

* Convergence centers, rudimentary health posts operated by NGOs under contract with MSPAS (MSPAS, 2014) will likely be closed from the cancellation of PEC and the organizational crisis at MSPAS, leaving many in the rural population without access to public health care, a situation which is only beginning to be addressed in mid-2015 (Avila et al., 2015).

In the Western Highlands, the availability of MSPAS health facilities is limited. More than 89 percent of all facilities represent first-level facilities and 11 percent are secondary facilities (Angeles et al., 2014). Health care professionals are concentrated in second-level facilities (CAIMIs) and permanent care centers.

Only 19 percent of health facilities report having adequate roofing, walls, windows, and floors. Twenty-six percent possess all essential utilities and equipment: electricity, drinking water, a refrigerator, and an instrument sterilizer. Thirty-seven (37 percent) percent of facilities have an in situ pharmacy (Guatemala National Statistics Institute, Municipal censuses 2008-2011).

MSPAS monitors the health sector via a Health Management Information System (*Sistema de Información Gerencial en Salud, SIGSA*), which tracks health information by demographics, socioeconomic, deaths, illnesses and risks, resources, access and coverage.⁵

⁵ <http://sigsa.mspas.gob.gt>

4.1.2 GUATEMALAN INSTITUTE FOR SOCIAL SECURITY

The IGSS, created by law⁶ in 1946 as an autonomous entity, is the second largest health service delivery institution in Guatemala. Its beneficiaries are public and private sector workers and retirees. In 2013, IGSS reported a total beneficiary population of 2.643 million people (or about 17 percent of the population) including direct beneficiaries, spouses, and children under seven years of age. IGSS has a service delivery network of 123 medical units, of which 23 are hospitals, located in all departments. Forty of the medical units are in Huehuetenango, Quetzaltenango, Quiché, San Marcos, and Totonicapán, which MSPAS and USAID have declared as priority areas for integrated development activities in 2012-2016. According to IGSS representatives, the current infrastructure is insufficient to meet the needs of the insured population and its beneficiaries. IGSS is finalizing construction of the Regional Hospital of Quetzaltenango, which will serve as a referral center for multiple Western departments. Within the next five years, IGSS plans to build a new complex of four specialty hospitals.

According to IGSS representatives, the current infrastructure is insufficient to meet the needs of its beneficiaries.

The governance of IGSS is delegated to the Board of Directors, which oversees administration and management. IGSS provides coverage for its members based on a public group insurance system. Membership in the IGSS health insurance plan is compulsory for employees in the formal sector and is financed through contributions from workers and employers. The rate of contribution is specified by law and based on the worker's salary level.

Decree 295 establishing IGSS stated that the system must be financed by three parties: employees (25 percent), employers (50 percent), and the State (25 percent). The portion from the State must be financed by taxes created for that purpose and, while collected by the government, must be available as exclusive property of the Institute. Nevertheless, the government of Guatemala stopped giving resources to IGSS in the mid-1950s when a contra-revolution regime was established. By December 2014, the total State debt to IGSS amounted to Q27.8 billion (US\$3.6 billion). In February 2015, President Otto Perez Molina signed an agreement with IGSS authorities to pay the debt as an employer to IGSS, which accounts for Q5 billion (US\$649.7 million). The amount was to be paid in installments. The agreement did not cover the remaining Q22.8 billion (US\$2.9 billion) of the debt.

In 2013, IGSS health expenditures totaled Q4.7 billion (US\$600 million), close to the Q5.1 billion (US\$650 million) spent by MSPAS, which covers far more people (Avila et al. 2015). Table 11 lists the main programs provided to IGSS beneficiaries.

⁶ Decreto N° 295 -Ley Orgánica del Instituto Guatemalteco de Seguridad Social

TABLE 11: IGSS PROGRAMS 2015 OPERATIONS PLAN

Program	Population and Type of Coverage
IVS (Disability, Retirement, and Survival)	<p>Protects the insured for permanent disability (disability) or when the condition ends or acquires retirement upon reaching a certain age.</p> <p>Provides protection for surviving beneficiaries, providing medical care and pecuniary benefits.</p>
PROCAPI (Program of Special Protection for Domestic Workers)	<p>Provides protection for maternity and accidents for domestic workers and their children under five since September 2009 and currently covers women who work in Guatemala Department. Services are provided only in IGSS-owned medical units.</p>
EMA (Programa de Enfermedad, Maternidad y Accidentes)	<p>Provides medical assistance to the insured member and family, and economic assistance to the member who is temporarily incapacitated and unable to work.</p> <p>Provides maternity medical-surgical, preventive, and curative care in prenatal, delivery, and postnatal period for beneficiaries; full (100 percent) salary paid to insured during maternity leave.</p> <p>Provides specialized care for adolescents under 19 in the capital who are cared for by traditional midwives; deliveries may be conducted in the home or in an IGSS facility.</p> <p>Includes accident medical care for any event that caused an injury or functional disorder and provides temporary financial benefits in the event of temporary incapacity of the member.</p>

Source: PSA team interviews with IGSS officials

4.1.3 PRIVATE SECTOR

Nongovernmental organizations

Guatemala has a multitude of NGOs working in the health sector, many of them working at the regional and departmental levels. The majority of NGOs focus on preventive health programs, education, and some also provide clinical services. This report highlights the two largest NGOs for family planning and maternal health with nationwide coverage. Please see Section 5.5 for more information on NGOs.

According to DRACES, there are more than 9,000 private health facilities in Guatemala. APROFAM and PASMO are the two largest NGOs in family planning and maternal health with national coverage.

For-profit private sector

Guatemala's private sector represents a large and growing segment of the health care market, including high-end tertiary hospitals, small specialty and general hospitals (95), clinics for specialized medicine (2,927), clinics for general medicine (1,103), and laboratories (1,373), representing approximately 60% of all registered facilities. According to DRACES, there are well over 9,000 private facilities related to health in Guatemala (Table 12).

TABLE 12: NUMBER OF PRIVATE HEALTH FACILITIES BY TYPE, JANUARY 2015

Facility Type	Number
Health clinic	1,103
Specialized clinic	2,927
Dental clinic and laboratories	1,651
Alternative medicine center	241
Hospital (including outpatient only facilities)	135
Laboratories (various)	1,688
Other (including sports facilities and nursery homes)	1,808
Total	9,553

Source: General Directorate for Health Regulation, Vigilance, and Control (DRACES) interview, 2015

As stated above, the private for-profit sector is a key player in health services in Guatemala, even though, as the following market segmentation analysis shows, its market share in terms of provision of family planning, ANC, and delivery services is limited.

4.2 MARKET SEGMENTATION

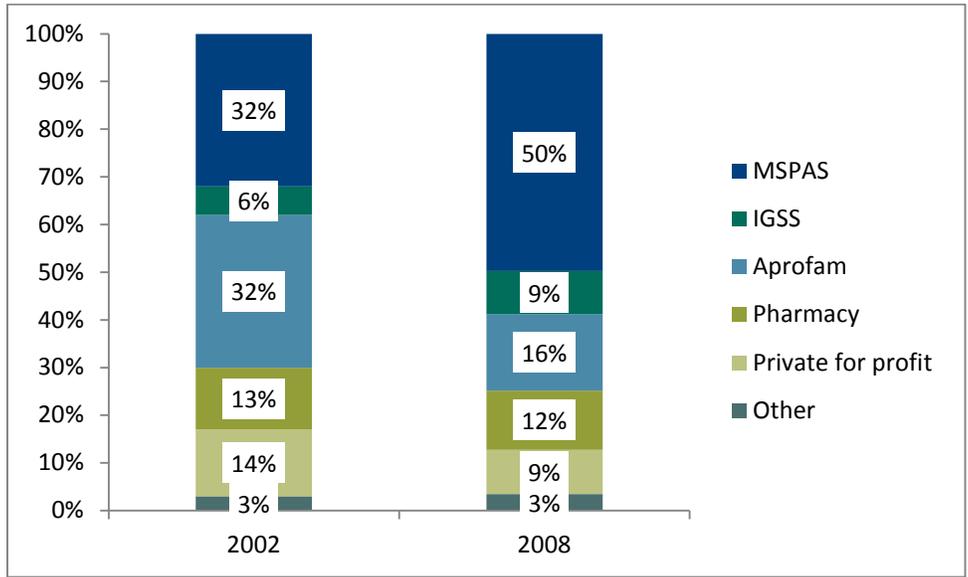
SHOPS conducted a market segmentation analysis of family planning, ANC, and delivery service provision to understand sourcing and behavior by wealth quintiles of clients accessing these services. While the market segmentation analysis of sourcing by quintile group has been used extensively for family planning services, it is increasingly being used to understand and improve equity of services in other health areas. To our knowledge, this is the first such analysis of ANC and delivery services in Guatemala.

4.2.1 FAMILY PLANNING

Sources of Services and Products

In Guatemala, the public sector has long history been the most important provider of family planning products/services. Figure 13 presents a breakdown of market share for all family planning products between 2002 and 2008, during which time MSPAS' role increased from 32 percent to 50 percent. In the same period, IGSS' share increased slightly from 6 to 9 percent, and APROFAM's share dropped from 32 percent in 2002 to 16 percent in 2008. Pharmacies remained a stable source of services and products at about 10 percent of the market in both 2002 and 2008.

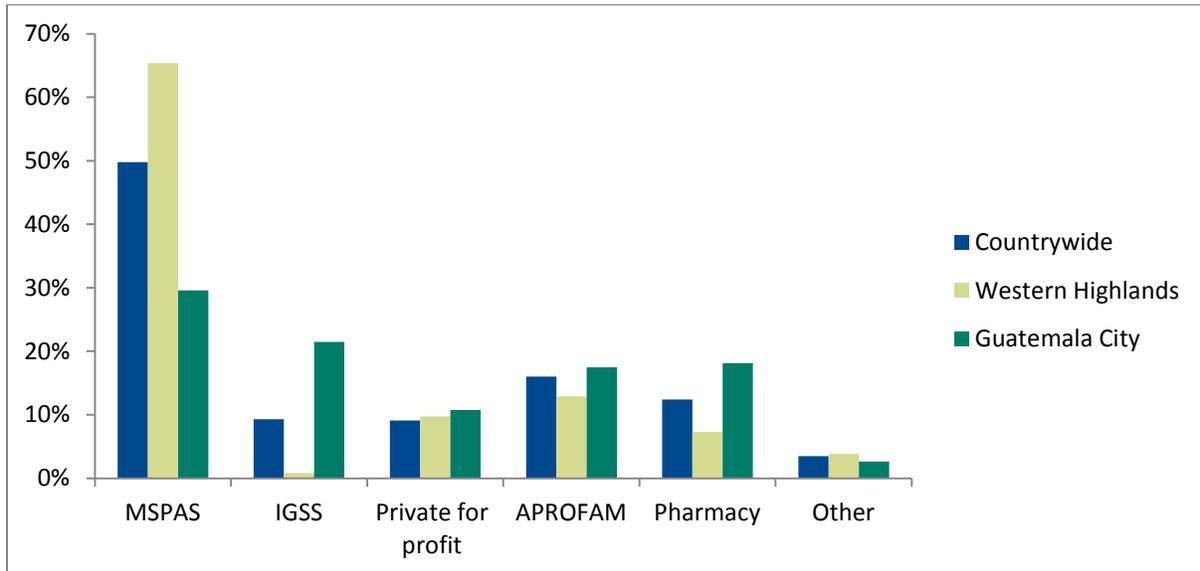
FIGURE 13: CHANGING MARKET SHARE FOR FAMILY PLANNING PRODUCTS - ALL METHODS



Source: ENSMI 2002, 2008-2009

Figure 14 shows the source of family planning methods in different geographic areas. The public sector (MSPAS) is the primary source of family planning methods countrywide and in both Guatemala City and the Western Highlands region. In Guatemala City, IGSS is the second most common source of family planning methods due to a larger share of the formal employment sector in that area. In contrast, both countrywide and in the Western Highlands, the second most common source of family planning methods is APROFAM. The use of pharmacies is slightly higher in Guatemala City than the national average or Western Highlands.

FIGURE 14: SOURCE OF FAMILY PLANNING METHODS BY REGION (ALL WRA) (%)



Source: ENSMI 2008-2009

Sources of family planning commodities change according to the type of method (short-acting, long-acting, and permanent). As illustrated in Table 13, MSPAS is the largest provider of

short-acting and permanent methods, at 58 percent and 42 percent of the market, respectively. APROFAM dominates the market for long-acting methods (mostly implants), providing 58 percent of the services. Interestingly, the pharmacy sector provides only 24 percent of the short-acting contraception overall, far less than MSPAS. IGSS participation in short- and long-acting methods is limited, and is not significant in permanent methods.

TABLE 13: SOURCE PROVIDING EACH TYPE OF FAMILY PLANNING METHODS - COUNTRYWIDE

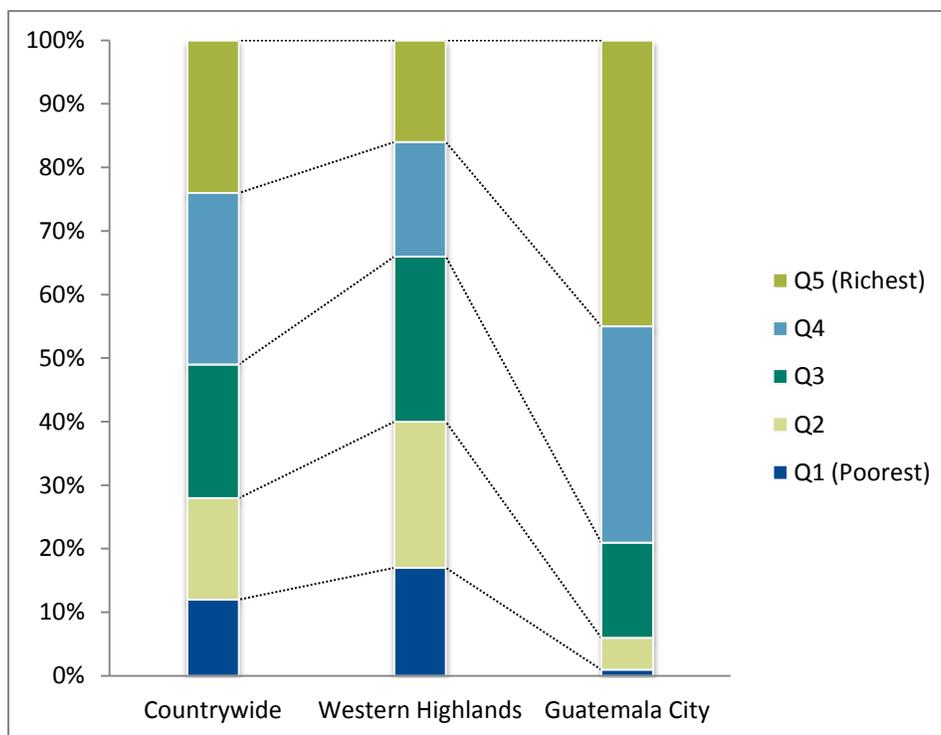
Source	Short-acting	Long-acting	Permanent
Public sector	58	26	42
IGSS	3	2	17
Private for-profit	3	12	15
APROFAM	7	58	25
Pharmacy	24	0	0
Other	5	2	2
Total	100	100	100

Source: ENSMI 2008-2009

Socio-Economic Analysis of Family Planning Users

The quintile analysis for use of modern methods across geographic regions is shown in Figure 15. In the Western Highlands, modern method users from the different wealth quintiles are represented relatively equally, whereas users from the two wealthiest (4th and 5th) quintiles largely dominate the group of modern method users in Guatemala City.

FIGURE 15: SOCIO-ECONOMIC CHARACTERISTICS OF MODERN METHOD USERS (ALL WRA) (%)

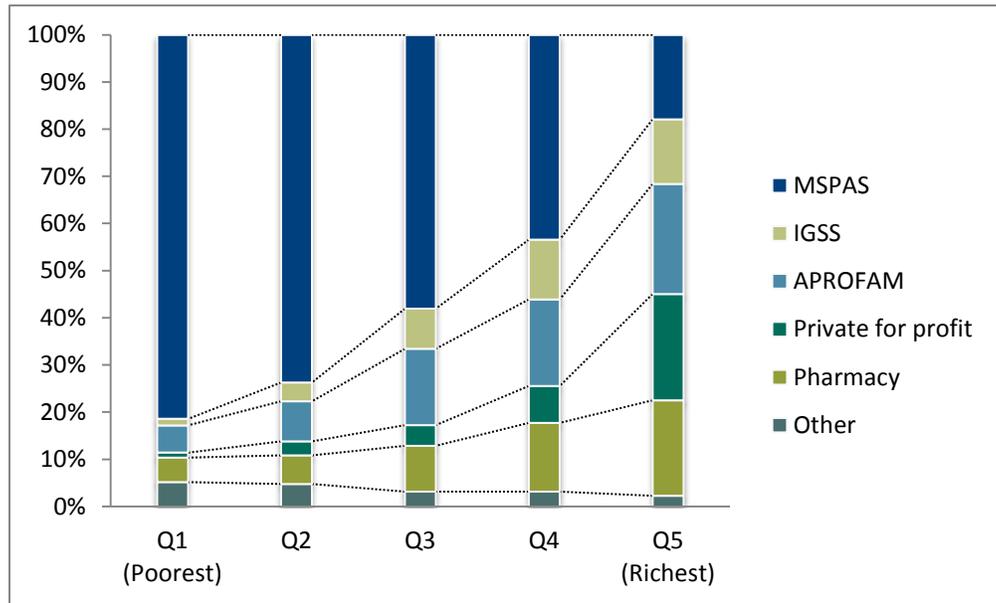


Source: ENSMI 2008-2009

As seen below, there are wide variations in sourcing across wealth quintiles. The public sector is the predominant source (81 percent) of modern contraceptive methods for wealth quintiles 1-

3, but provides just 43 and 18 percent of modern contraceptives to quintiles 4 and 5, respectively (Figure 16). APROFAM, for-profit providers, and pharmacies are the predominant sources for the two wealthiest quintiles. More than 82 percent of users sourcing from the private for-profit sector are from those quintiles, as are 66 percent of APROFAM users and 71 percent of pharmacy users (data not shown).

FIGURE 16: SOURCE OF MODERN CONTRACEPTIVES BY WEALTH QUINTILES (%)



Source: ENSMI 2008-2009

SOURCING AND QUINTILE ANALYSIS OF MOST WIDELY USED MODERN METHODS

Injectables

The public sector is by far the largest provider of injectable contraception (Table 14). Our market segmentation analysis indicates that the majority of income quintiles (1-4) source their injectable products from MSPAS. Only 18 percent of IGSS beneficiaries obtain injectable contraception at IGSS facilities; 52 percent of them source their injectable contraception from MSPAS. Interestingly, another 18 percent of IGSS beneficiaries purchase their injectables from private pharmacies. Only the 5th quintile is diversified in its sourcing patterns for injectable contraception, with 64 percent sourcing from pharmacies, private for-profit providers, and APROFAM.

TABLE 14: SOURCES OF INJECTABLES ACCORDING TO USER PROFILE (N=1,905)

	Public		Private				Total
	MSPAS	IGSS	Private for-profit	APROFAM	Pharmacy	Other	
According to residence (% of users)							
Countrywide	77	3	3	4	8	4	100
Western Highlands	83	0	2	2	7	6	100
Guatemala City	56	10	8	9	13	5	100
According to IGSS coverage (% of users)							
IGSS beneficiaries	52	18	4	5	18	3	100
Others	82	0	3	4	7	5	100
According to wealth quintile (% of users)							
Q1 (poorest)	92	0	0	0	2	5	100
Q2	89	1	0	1	4	5	100
Q3	80	2	1	5	6	5	100
Q4	69	7	3	8	11	3	100
Q5 (highest)	27	5	20	11	33	4	100

Source: ENSMI 2008-2009

Sterilization

The public sector is a major provider of female sterilization throughout the country (Table 15). MPAS is the primary source for sterilization for quintiles 1-4. Only a small percentage of IGSS beneficiaries (34 percent) seek sterilization services from IGSS' facilities; approximately a quarter of the IGSS-eligible population is sourcing either from MSPAS and APROFAM. Only the 5th quintile is diversified in its sourcing patterns for sterilization services with 30 percent sourcing from private for-profit providers and 27 percent from APROFAM.

TABLE 15: SOURCES OF STERILIZATION ACCORDING TO USER PROFILE (N=2,433)

	MSPAS	IGSS	Private for-profit	APROFAM	Pharmacy	Other	Total
According to residence (% of users)							
Countrywide	42	17	15	25		2	100
Western Highlands	55	2	20	23		2	100
Guatemala City	26	36	17	21		1	100
According to IGSS coverage (% of users)							
IGSS beneficiaries	26	34	15	24		1	100
Others	47	11	15	25		2	100
According to wealth quintile (% of users)							
Q1 (poorest)	71	4	3	19		3	100
Q2	63	9	7	19		3	100
Q3	49	16	7	27		1	100
Q4	41	20	12	25		3	100
Q5 (highest)	21	21	30	27		0	100

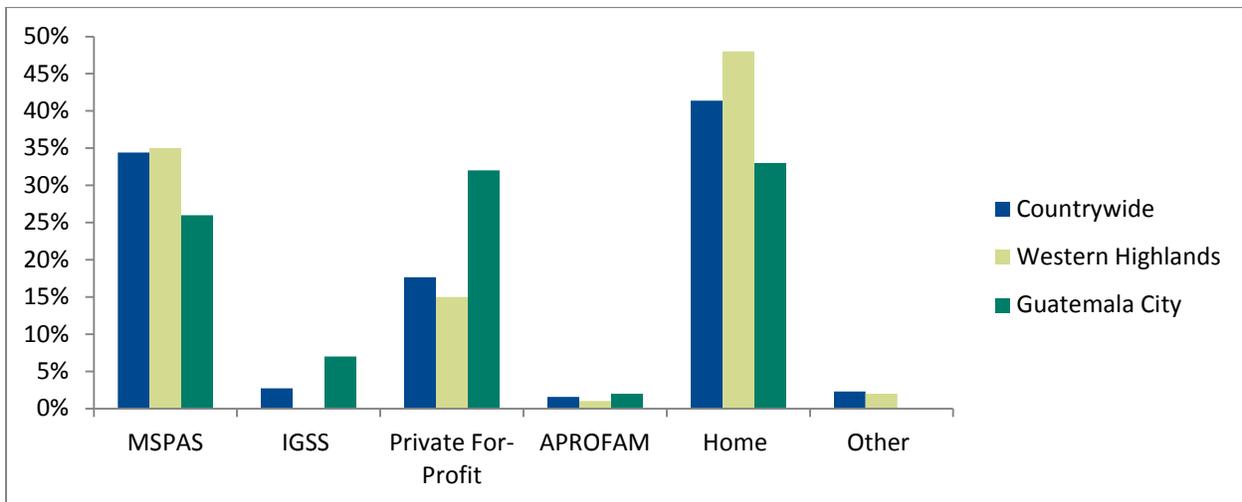
4.2.2 ANTENATAL CARE

Sources of Services

The major source of ANC across all geographic regions is home-based care at 41 percent countrywide (Figure 17). Even in Guatemala City, where the availability of health services and IGSS coverage is high, there is a high percentage of women who report home-based care. In fact, although IGSS has a constitutional mandate to provide health care at a nationwide level, its participation in providing ANC is very low in Guatemala City (<10 percent), lowest countrywide (<5 percent), and practically non-existent in the Western Highlands where the most vulnerable population lives. TBAs are the major provider (81 percent) of home-based care (MSPAS 2010), and TBAs are also key players when women seek ANC outside of their homes: 46 percent reach out to them, while 52 percent visit skilled providers and 2 percent visit other community-based personnel. In Guatemala City, the for-profit private sector is an important provider of ANC services.

Sources of ANC differ by wealth quintile. All wealth quintiles use home-based care for ANC services, although use of home-based care gradually decreases as wealth increases. The role of the private for-profit sector is highest in top two wealth quintiles.

FIGURE 17: PLACE WHERE ANC IS RECEIVED (%)



Source: ENSMI 2008-2009

The sourcing pattern for ANC changes slightly when considering the number of visits to each provider. The three main sources remain the public sector (41 percent), home ANC (36 percent), and private for-profit (16 percent). Interestingly, the WHIP data present a different reality for the Western Highlands in 2012, where the public sector appears to be almost the only source of ANC (84 percent of visits). Additionally, WHIP data indicate that 86.2 percent of ANC care was performed by a physician or nurse (Angeles et al., 2014).

While the place of ANC could potentially have an impact on the place of delivery, the place of ANC does not necessarily lead to delivery in the same sector. Health sector institutions that provide ANC retain women for delivery in approximately one out of three cases. MSPAS retains 36 percent of its ANC patients for delivery, IGSS retains 35 percent, and the private for-profit sector retains 33 percent. Many women change sectors and receive ANC services at IGSS or private for-profit clinics but deliver at public facilities (44 percent and 46 percent respectively).

TABLE 16: PLACE OF DELIVERY AND PLACE WHERE ANC WAS RECEIVED (%)

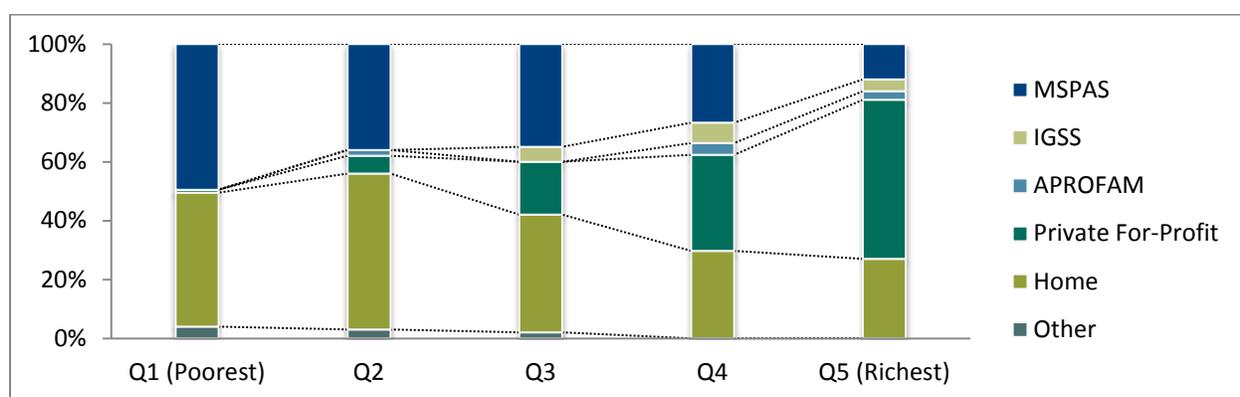
Place where ANC was received	Place of delivery					
	MSPAS	IGSS	Private For-Profit	Private House (own / TBA)	Other	Total
MSPAS	36	3	2	57	1	100
IGSS	44	35	14	7	0	100
Private for-profit	46	6	33	12	3	100
Private house (own / TBA)	25	7	2	66	1	100

Source: ENSMI 2008-2009

Socio-Economic Analysis of ANC Users

As illustrated in Figure 18, sources of ANC differ according to wealth quintiles. Interestingly, all wealth quintiles use home-based care for ANC services, although it gradually decreases as wealth increases. The role of the private for-profit sector increases significantly in the fourth (33 percent) and fifth (54 percent) quintiles. IGSS and APROFAM play a small role in ANC services, with IGSS playing no role in the two poorest quarters.

FIGURE 18: SOURCE OF ANC BY WEALTH QUINTILE (%)



Source: ENSMI 2008-2009

4.2.3 DELIVERY

Sources of Services

The majority of women countrywide (48 percent) and in the Western Highlands (64 percent) deliver either in their own

In the lowest wealth quintile, home births are most common in the lowest wealth quintile. In the highest wealth quintile, the largest proportion of births (37 percent) occurs in the private for-profit health sector. The National Health Council, CNA, OSAR, and REDMISAR under the leadership of MSPAS constitute an effective framework to advocate for and achieve multisectoral coordination and optimization of major service providers.

home or in the home of a TBA, followed by facility-based delivery at MSPAS at 38 percent countrywide and 28 percent in Western Highlands (Table 17). Only in Guatemala City are facility-based deliveries the primary source for delivery—with MSPAS at 43 percent. Also in Guatemala City, IGSS is the second source of delivery services (30 percent). The for-profit private sector is the third most important source of facility-based deliveries in Guatemala City and countrywide. APROFAM plays a very small role in delivery services.

TABLE 17: PLACE OF DELIVERY ACCORDING TO USER PROFILE (N=2,433)

Place of delivery according to residence (%)						
	Public Sector	IGSS	Private For-Profit	APROFAM	Private House (own / TBA's)	Other
By residence						
Countrywide	36	8	7	1	48	0
Western Highlands	28	1	5	1	64	0
Guatemala City	43	30	16	2	10	0
According to IGSS coverage (% of users)						
IGSS affiliates	27	42	20	3	7	0
IGSS beneficiaries	28	42	14	2	13	0
Not covered by IGSS	40	4	7	1	48	0
According to wealth quintile (% of users)						
Q1 (poorest)	23	1	0	0	76	0
Q2	37	4	1	0	56	1
Q3	50	8	4	1	36	0
Q4	51	23	12	2	13	0
Q5 (highest)	33	21	37	3	5	0

Source: ENSMI 2008-2009

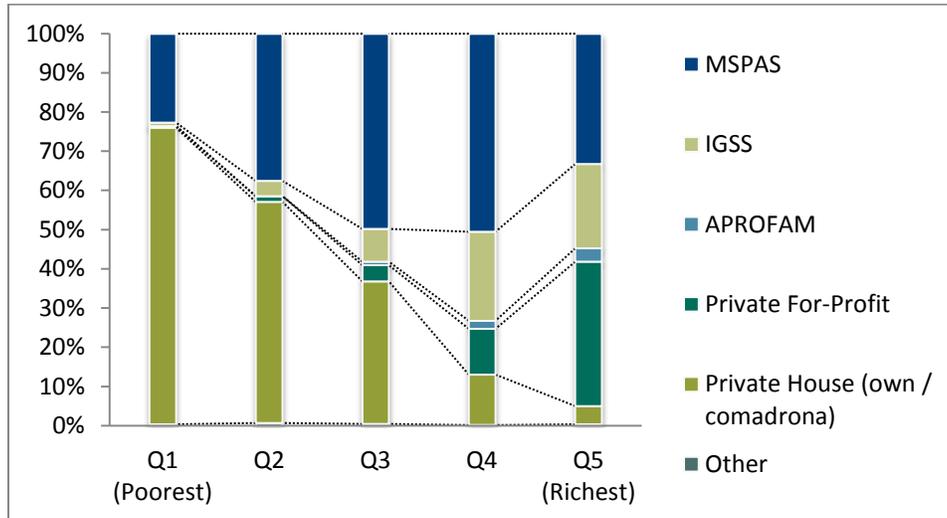
Socio-Economic Analysis of Women Delivering

As illustrated in Figure 19, a significant proportion of all wealth quintile groups countrywide seek delivery services from the MSPAS, with the share highest in the middle-income groups (Q3 and Q4). Public sector delivery is proportionately the lowest in the first quintile, which is dominated by home delivery. The private for-profit represents the largest share of the market for the fifth quintile with 37 percent of deliveries.

As illustrated in Figure 20, in the Western Highlands, a significant proportion of all wealth quintiles have home-based deliveries. MSPAS is the second most important provider of delivery services, gradually increasing in quintiles 1-4. Interestingly, in the fifth wealth quintile there is a dramatic increase in the percentage of women who seek delivery services in the for-profit private sectors.

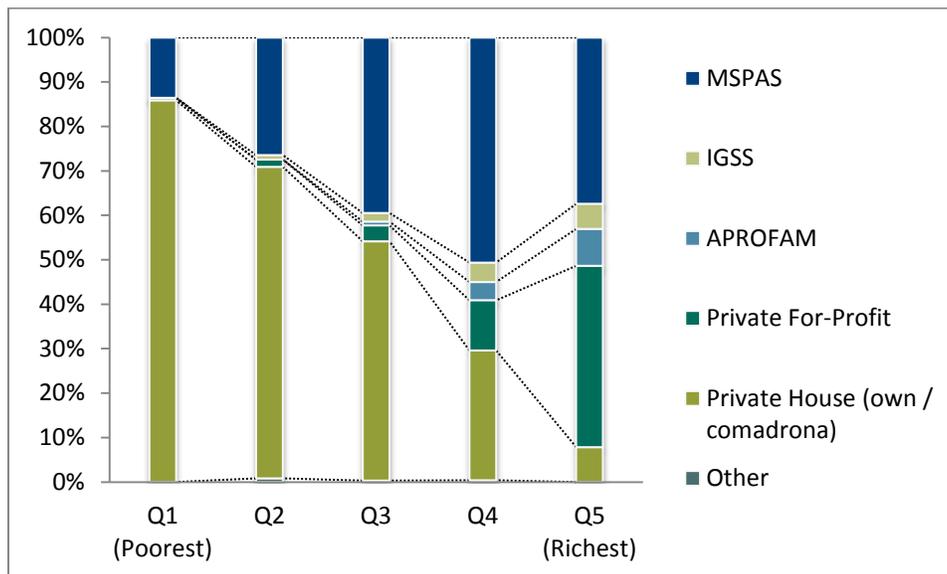
As illustrated in Figure 21, in Guatemala City, the share of home delivery is lower than anywhere in the country. IGSS share reaches a higher amount than anywhere in the country at 20 percent, 40 percent and 30 percent for Q3, Q4 and Q5 respectively.

FIGURE 19: PLACE OF DELIVERY ACCORDING TO WEALTH QUINTILES - COUNTRYWIDE



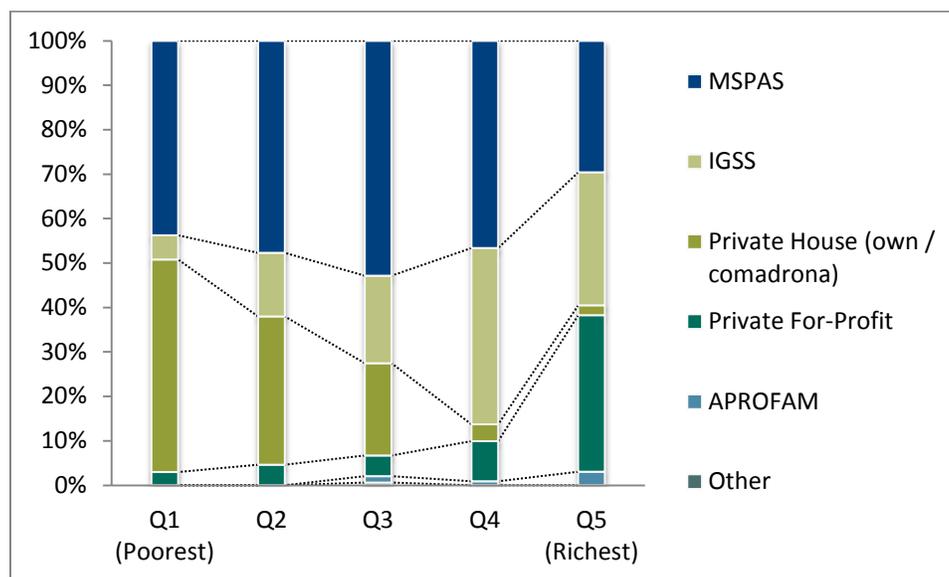
Source: ENSMI 2008-2009

FIGURE 20: PLACE OF DELIVERY ACCORDING TO WEALTH QUINTILES - WESTERN HIGHLANDS



Source: ENSMI 2008-2009

FIGURE 21: PLACE OF DELIVERY ACCORDING TO WEALTH QUINTILES - GUATEMALA CITY



Source: ENSMI 2008-2009

4.2.4 SUMMARY OF MARKET SEGMENTATION FINDINGS

Family Planning

- In USAID's 30 focus municipalities within the Western Highlands, 39 percent of WRA interviewed reported using a modern method of family planning (Angeles et al., 2014). Short-acting methods requiring resupply were the most popular, followed by permanent methods. As in the 2008-2009 ENSMI, long-acting methods other than permanent methods were low, at 5 percent of users.
- MSPAS is by far the major provider of family planning products and services for both short-acting and permanent methods. MSPAS' provision of modern family planning methods increased significantly, from 32.2 percent in 2002 to 50.9 percent in 2008 (MSPAS, 2010). MSPAS is the major provider of family planning for all wealth quintiles except the fifth quintile. MSPAS is also the largest provider for Guatemala's two most widely used methods: injectables (79 percent) and female sterilization (43 percent) services.
- APROFAM's role in the provision of family planning services has decreased significantly from 32 to 16 percent from 2002 to 2008, although APROFAM continues to be the second most important source of family planning. It is the most important provider in the private sector. In 2008, APROFAM was also the largest provider of implant services. APROFAM's role in family planning and maternal health services will be further discussed below in the NGO section, including its network of clinics and its community-based distribution program.
- While IGSS is the second largest health care provider in the country and serves a large beneficiary population, it provides only 9 percent of family planning services (an increase from 6 percent in 2002). Only in Guatemala City is IGSS the second most common source

of family planning. Interestingly, only a small percentage of IGSS beneficiaries seek their services from IGSS facilities. They use the public sector (28 percent), the private for-profit sector (10 percent), APROFAM (17 percent), or pharmacies (17 percent). For injectable services, 52 percent of IGSS beneficiaries source their method from MSPAS. For sterilization services, 26 percent of IGSS beneficiaries go to MSPAS, 24 percent go to APROFAM, and 15 percent go to the for-profit private sector.

- Pharmacies are the primary source of oral contraceptives (34 percent) and condoms (72 percent), which is common for resupply methods, and representing overall 12 percent of family planning supply. Private for-profit providers supply 9 percent overall, primarily for IUDs, implants, and sterilization services. Interestingly, pharmacies are a source of supply for all wealth quintiles, including a small percentage of the lowest quintiles. Pharmacies and for-profit providers account for a larger percentage of the highest wealth quintile, reaching 20 percent (pharmacies) and 23 percent (private for-profit providers).

Antenatal Care

- The major source of ANC across all geographic regions is home-based care. Even in Guatemala City, where the availability of health services and IGSS coverage is high, a high percentage of women report receiving home-based care. TBAs are the major provider (81 percent) of home-based care, and they are also key players when women seek ANC outside of their homes. ENSMI 2008-2009 reports that TBAs cover 33.2 percent of ANC services nationwide. However, the most recent data from the WHIP indicate that 86 percent of ANC care was performed by physicians or nurses.
- Women who seek ANC at MSPAS or in their homes are most likely to delivery at home (57 percent) or in MSPAS (36 percent). Women receiving ANC from a private for-profit provider are most likely to deliver at MSPAS (46 percent) or in a private for-profit facility (33 percent), and are less likely to have a home delivery (12 percent). Women receiving ANC services from IGSS are most likely to delivery at MSPAS (44 percent) or an IGSS facility (35 percent), and least likely to delivery at home (7 percent).
- There is a potential to increase the role of IGSS for ANC and encourage WRA to remain with IGSS for delivery, as 44 percent of women receive ANC at IGSS.

Delivery

- The majority of women countrywide (48 percent) and in the Western Highlands (64 percent) deliver either in their own home or in the home of a TBA. MSPAS is the second most important provider of delivery services, gradually increasing in quintiles 1-4. at 38 percent countrywide and 28 percent in Western Highlands, is the second highest source of delivery services.
- Only in Guatemala City are facility-based deliveries the primary source for delivery—with MSPAS at 43 percent. Also in Guatemala City, IGSS is the second source of delivery services (30 percent). The for-profit private sector is the third most important source of facility-based deliveries in Guatemala City and countrywide. APROFAM plays a very small role (2 percent) in delivery services.
- Countrywide, a large proportion of all wealth quintiles seek delivery services from the MSPAS, with the share highest in the middle-income groups (Q3 and Q4). Public sector delivery is proportionately the lowest in the first quintile, which is dominated by home delivery (86 percent). The private for-profit represents the largest share of the market for the fifth quintile with 37 percent of deliveries.
- In the Western Highlands, a significant proportion of all wealth quintiles have home-based

deliveries. MSPAS is the second most important provider of delivery services, gradually increasing in quintiles 1-4. In the wealthiest quintile there is a dramatic increase in the percentage of women who seek delivery services in the for-profit private sectors.

5 FINDINGS

5.1 OVERVIEW

This chapter reports findings about key public sector organizations' engagement with the private sector, key activities of leading NGOs, the for-profit sector, corporate foundations, and social responsibility organizations. In this chapter, we also identify opportunities for strengthening overall private sector engagement, building on the comparative advantage of existing organizations, and identifying new opportunities for scalable and sustainable private sector initiatives.

5.2 ENABLING ENVIRONMENT

5.2.1 GENERAL POLICY AND REGULATORY REVIEW

Guatemala has a strong legal framework that guarantees access to maternal health, reproductive health, and family planning services, providing a legal basis to guarantee and defend the right to these services and products (Table 18). In 2001, the Law on Social Development was approved, defining reproductive health (Article 10) as a right of the Guatemalan population, which includes “effective access for persons and families to information, orientation, education, provision, and promotion of reproductive health services, including family planning services, prenatal care, delivery and post-partum, prevention of cervical and breast cancer, treatment during pre-menopause and menopause, diagnosis and treatment of prostate illnesses, diagnosis and treatment in infertility, sexually transmitted disease, HIV/AIDS, and attention for adolescents.”⁷ In 2004, the Tax Law on Sale of Alcoholic Beverages guaranteed 15 percent of tax income would be dedicated to financing reproductive health and family planning and prevention of alcohol consumption and smoking. In 2005, the Law on Universal and Equal Access to Family Planning was approved; however, Catholic Church opposition to regulation tied to the law delayed its implementation until 2009. In 2010, the Law for Health Maternity was approved, establishing budgeting minimums for reproductive health programs and commodity procurement.

⁷ Compendio de Leyes para la Accion en Salud Reproductiva en Guatemala, August 2014.

**TABLE 18: LEGISLATION RELATED TO SEXUAL AND REPRODUCTIVE HEALTH IN GUATEMALA
2001-2012**

Year	Law	Implication
2001-2002	Law on Social Development and Policy on Population and Social Development	Article 10 defines people's right of access and responsibility of government to provide reproductive health, maternal health, and family planning services.
2004	Tax Law on Sale of Alcoholic Beverages	Guarantees that 15% of all tax income is dedicated to financing RH/FP and other health services.
2005	Law on Universal and Equal Access to Family Planning	Law is approved, but not put into effect until 2009 when regulation is approved.
2009	Regulation on the Law on Universal and Equal Access to Family Planning	Required MSPAS, IGSS, and other public and private institutions to make modern contraceptives available.* The National Commission for Contraceptive Security (CNA) is officially installed.
2010	Law for Healthy Maternity Decree 32-2010 Decree 19-2010 approves a budget expansion that excludes an exception to the requirements in Decree 72-2008.	Article 27 establishes a minimal allocation of 15% for reproductive health programs and of 30% for the purchase of contraceptives. Approval allows MSPAS to transfer funds to UNFPA for the purchase of contraceptives.
2010	MSPAS and UNFPA sign a new agreement to continue procurement of contraceptives.	MSPAS uses funds from the 15% tax to purchase contraceptives, creating the framework for the procurement of contraceptives in future years.
2012	Regulation for the Law for Healthy Maternity Governmental Accord 65-2012	The approval of the regulation allows for implementation of the law and the requirement to spend at least 30% of the tax on the purchase of contraceptives.
2013	Law for the General Budget of Income and Expenses of the State for the 2013 Fiscal Exercise	Includes an article that allows the transfer of funds and upfront payment of contraceptives through UNFPA.

* <http://www.ipsnews.net/2009/11/Guatemala-sex-education-family-planning-finally-available/>

Political Commitment for Family Planning and Maternal Health

Despite a strong legal framework in Guatemala, there is still significant opposition to the family planning program from religious and political entities. For example, as noted above, implementation of the Law on Universal and Equal Access to Family Planning was delayed for four years by legal challenges from the Catholic Church. In addition, Guatemala has had several presidential administrations with strong religious affiliations and opposition to family planning. For example, when the PEC began in 1996, it did not cover family planning services.

Legislation Mentioning the Private Sector

The Law on Universal and Equal Access to Family Planning Services and the Healthy Maternity law both recognize the important role of the private sector in providing these services. While various multisectoral commissions exist in Guatemala, coordination across sectors is still limited and there is no mechanism in place to ensure appropriate reporting of health statistics. IGSS, for example, is particularly averse to sharing its reproductive health/family planning (RH/FP) data, and reporting of private sector activities is limited. As discussed below in Section 5.3.3, the

recently passed Decree 13-2013 prohibits NGOs from receiving and directly managing government resources, though it does not strictly prohibit contracting with other private players. Given the recent cancellation of the major contracting-out mechanism for non-facility-based services through the PEC, the government appears to be wary of mechanisms that directly finance NGOs. As a result, some of the positive experiences and lessons learned from the PEC experience will be lost—primarily the opportunity to increase and strengthen community participation and integrate contracting out and performance-based financing. Prohibiting contracting out to NGOs and other private entities is viewed by some experts as a major setback in advancing public-private partnerships and improving performance-based results.

5.2.2 NATIONAL HEALTH COUNCIL

MSPAS is the main regulatory agency, responsible for governance of the health sector and the country's Political Constitution asks that IGSS and the ministry be coordinated (Art. 100). The National Health Council was established in 2001 as an Advisory Body with the broad goal of strengthening development of an integrated health system in Guatemala and more specifically to promote coordination among health sector entities.⁸ According to the initial government decree, the members include the MSPAS; IGSS; National Association of Municipalities (ANAM); Coordinator for Commercial, Industrial, and Financial Associations (CACIF); Assembly of Professional Medical Associations; University of San Carlos of Guatemala; Ministry of Education; and private universities, as well as any other institution deemed necessary to serve temporarily. While the National Health Council provides a forum for dialogue among representatives of the public health sector, professional and academic associations, and the organized private sector, it lacks the regulatory power to issue agreements or resolutions with binding authority over any segment of the public health system, including MSPAS and IGSS, making it in essence a discussion forum with no power of enforcement.

Within the last year, with renewed leadership by MSPAS, the council has started meeting more regularly. Its existence does provide an opportunity for the interchange of information regarding institutional priorities and programs, which may be taken into account as each institutional actor individually develops and implements its own health-related programs. Several PSA interviewees suggested that if it continues with strong MSPAS leadership and political commitment it could represent an opportunity to strengthen multisector participation, suggesting that the National Health Council and MSPAS be empowered to effectively coordinate the delivery of public health care services across sectors.

5.2.3 NATIONAL COMMISSION FOR CONTRACEPTIVE SECURITY

In Guatemala, a number of USAID's cooperating agencies and other organizations advocate strongly for measures to achieve contraceptive commodity security. In 2009, the National Commission for Contraceptive Security (*Comisión Nacional de Aseguramiento de Anticonceptivos*, CNAA) was officially established and coordinated by MSPAS' Coordinator of the National Reproductive Health Program. Other government and nongovernmental agencies, such as the Presidential Secretariat for Women, Office for the Defense of Indigenous Women, IGSS, APROFAM, and the Association of Guatemalan Female Physicians, participate in the CNAA. In late 2013, CNAA published its Market Segmentation Strategy for contraceptives, which recognizes the importance of a sustainable, total market approach, and the need for an increased role for the private sector. The strategy outlines different scenarios for reducing unmet need and shifting method mix, projections and scenarios for Guatemala's three primary family planning providers, MPSPAS, IGSS, and APROFAM, through 2015, but does not define

⁸ Acuerdo Gubernativo No. 68-2001.

specific actions to achieve these scenarios. Nonetheless, there are still some important barriers to sustainable access to contraceptive commodities, including insufficient budget, legislation that requires special exemptions to allow for international procurement, limited engagement of the private sector. IGSS also has official representation within CNAA, but it provides limited information on its family planning program; stakeholders commented that IGSS' participation in CNAA is noncommittal, which precludes important synergies for health care services. In 2015, CNAA is planning to develop more concrete actions based on the market segmentation strategy. Commercial commodities providers are not included in the discussion.

5.2.4 OTHER KEY ADVOCACY ORGANIZATIONS

To counter a generally conservative environment, there are a number of Guatemalan advocacy organizations that monitor public policy related to reproductive health. The Reproductive Health Observatory (*Observatorio de la Salud Reproductiva*, OSAR) is a consortium designed to monitor implementation and fiscal management of public policy related to reproductive health. Member organizations of OSAR include the Congress of Guatemala, Faculty of Medicine from San Carlos University, Faculty of Medical Sciences and Health from Mariano Galvez University, University Institute of Women (*Instituto Universitario de la Mujer de la USAC*), the Women's Health and Development Entity, the College of Physicians and Surgeons, the Guatemalan Association of Female Physicians, and the Guatemalan Association of Obstetrician and Gynecologists. OSAR is dedicated to the systematic follow-up and collection of data and indicators regarding the advancement and performance of health policy implementation. The Network of Indigenous Women for Reproductive Health (*Red de Mujeres Indígenas por la Salud Reproductiva*, REDMISAR) is a network of indigenous women's organizations that started in 2009 and has been involved in monitoring at the service delivery level. REDMISAR conducts monitoring visits every six months using a checklist to assess infrastructure, cleanliness, availability of health personnel, health and family planning commodities, and other aspects of service delivery. In Quetzaltenango there are 25 member organizations, 20 in Totonicapán. Several PSA interviewees stated that MSPAS does not currently have a formal position on the role of TBAs in the health sector. Traditional community-based organizations among indigenous peoples, as well as the various community-based organizations and networks of community health facilitators and TBAs, constitute important elements of the country's health system that have not been successfully integrated into the national health system.

5.3 PUBLIC SECTOR ORGANIZATIONS

5.3.1 MSPAS

MSPAS, which plays the dual role of “rector” (overall senior authority, or *rectoría*) of the country's health system, and provider of publicly financed health services including the largest network of local, regional, and national health service providers. In practice, coordination and communication among sectors is limited, particularly concerning IGSS and the private sector. The PSA assessment took place at a time when Guatemala was facing notable challenges to its leadership in the political and social spheres, as well as facing potential transitions with the upcoming elections in the fall of 2015.

According to some interviewees, is too early to know whether MSPAS's new strategy can adequately replace the services previously provided under PEC or achieve the objectives of comprehensive primary health care.

Based on interviews with ministry staff at central, regional, and departmental levels, it appears that MSPAS needs to strengthen its oversight of the health sector and engagement with other sectors. While various commissions for multi-sectoral dialogue exist in Guatemala, there is little

engagement of the for-profit private sector in these fora and no mechanism by which the ministry can ensure all health system entities report health statistics so that the ministry can coordinate governance efforts in an informed way. This would include participation by the for-profit sector, including the pharmaceutical industry as well as professional medical associations, such as the College of Physicians and Surgeons, Association of Obstetricians and Gynecologists, Association of Pediatricians, and others.

Nearly all informants mentioned the institutional crisis that MSPAS is currently facing, which is linked to recurring insufficient budgets and weakened infrastructure for providing basic care. Stakeholders reported widespread shortages of essential medicines, including vaccines and family planning commodities as well as vital supplies for delivery services.

Program for Extended Coverage

Over the past 20 years, NGOs have been contracted by MSPAS to provide health services in rural areas, and they have played a major role in the expansion and improvement of health services throughout the country. This began with the signing of the Peace Accords of 1996, which provided a new impulse for the health system, mandating increased public expenditure for health and specifying that the funds should be used to extend health services to marginalized rural areas. Faced by many challenges to expanding its services directly, MSPAS elected to contract NGOs to expand coverage more rapidly through the Extension of Coverage Program (*Programa de Extensión de Cobertura*, PEC). The PEC system contracted private providers and administrators to provide health services to populations without access to a health post. PEC implementers included many types of organizations, from NGOs that provided health services, to savings and loan cooperatives, and other enterprises.

PEC did not initially cover family planning services and products. Its incorporation of these services and products (condoms, oral contraceptives, and injectables) into its basic health services package in 2003 increased family planning coverage significantly. Through PEC, MSPAS expanded services from 4,400 community health centers, 380 basic health teams, and 23,000 community facilitators⁹ to hard-to-reach communities throughout the country. The basic health teams visited convergence centers at least once per month to provide medical consultations, including family planning, growth monitoring and screening, vaccinations, and provision of vitamins and minerals. However, the PEC program suffered from poor implementation, including weak performance objectives and services, limited oversight and monitoring, and limited financing (including late payments) for implementing NGOs. In 2013, amidst criticisms and accusations of inefficiencies and lack of accountability of PEC contracts, Guatemala's Congress passed Decree 13-2013, which sought to improve efficiency and transparency of the resources in the health sector and prohibited NGOs from managing government resources. The law provided a three-year period for MSPAS to phase out the PEC program, but at the end of 2014 MSPAS cancelled the program without having an alternative strategy in place. The abrupt cancellation was due to irregularities in implementation and resource management by some NGOs as well as lack of MSPAS resources to continue funding PEC. Some PSA interviewees suggested that, in addition to the above reasons, the PEC was dismantled due to the severe financial debt accrued by MSPAS in paying for these contracts, compounded by even more limited financial resources than in prior years. Regardless of the issues that existed with the PEC network, the loss of over half of the service delivery points in the country will have a negative impact on access to health services.

⁹ <http://mspaspas.gob.gt/salud/web/index.php?limitstart=260>

Strategy for the Institutional Development and Strengthening of the Primary Level of Care

For many stakeholders the failure and cancellation of the PEC program highlighted the magnitude of unmet need. MSPAS faces intense pressure to develop and implement an alternative strategy to provide health access to those populations covered through PEC, many of whom now are without access to basic care. In March 2015, MSPAS outlined an alternative strategy, which is focused on strengthening the first level of care, primarily health posts, to continue to support existing community convergence centers. Its components include:

- Strengthening of the health human resources, equipment, facilities, and medicines
- Promotion of family health and health education
- Monitoring, physical growth and promotion of good nutrition, and monitoring during the window of 1,000 days from conception to two years of age
- Zero Hunger Plan (*Plan de Pacto Hambre Cero*) health care with emphasis on neonatal and reproductive health
- Traditional alternative medicine
- Drinking water, and household and environmental sanitation
- Prevention and control of endemic diseases
- Diagnosis, treatment, and referral services

The new strategy, which was planned to start in early 2015, will use existing personnel currently based at health posts as well as recruit mobile health teams of community outreach specialists, including one nursing assistant, six community facilitators, 10 midwives, and one data specialist. These additional personnel are expected to be recruited from former PEC staff. As provided by MSPAS, the estimated cost of each mobile health team is Q104,500 annually (US\$13,600) however the assessment team was not provided with a detailed analysis of how these costs were estimated (MSPAS, 2015). The total strategy is projected to cost about Q123 million (US\$16 million) versus the estimated Q430 million (US\$56 million) the PEC would have cost. The population to be covered will include one health post, 2,000 to 2,500 inhabitants per sector, a maximum of 5,000 inhabitants per territory. Stakeholders interviewed for the PSA were unclear as to whether the new strategy will be able to reach the same number of people and whether MSPAS will be able to provide the significant funding it will need. It is still too early to tell whether this new strategy will adequately replace the services formerly provided by the PEC in a timely fashion, or achieve the lofty goals of comprehensive PHC.

Municipal-Level Partnerships

According to the Municipal Code (Decree No. 12-2002 as amended by Decree 22-2010), the Municipal Council is required to appoint several commissions including one on Health and Social Assistance; these commissions can make proposals to improve efficiency in municipal public services and management (Arts. 36 y 37). Furthermore, consistent with the objectives of decentralization, a municipality may be delegated the authority, based on its administrative capabilities, to deliver selected public services including compliance with sanitary control regulations governing the production, distribution, and consumption of food and beverages in order to guarantee the health of the municipal population (Art. 70) (Avila, 2015).

Several municipalities of the Western Highlands developed innovative partnerships with MSPAS to confront the health needs of their citizens.

Because of limited access to health services and the failure of existing systems, several municipalities in the Western Highlands have entered into innovative partnerships to address

the health care needs of their populations, including agreements between municipalities and MSPAS at the departmental level. In these partnerships, MSPAS and municipalities share the responsibility for funding personnel, medical supplies and commodities, and training. One example is the municipality of La Esperanza (Quetzaltenango Department), which has 33,000 inhabitants and 22 Development Councils (COCODEs) that are designed to guarantee the participation of indigenous groups in community development. Proposals and development projects are presented by the councils, reviewed and approved, and then financed by the municipality, but the process can take several years to complete given the need for local-level advocacy and planning and government funding cycles. Through this type of partnership, La Esperanza built a health center on municipal property that will be managed by MSPAS personnel. The municipality pays the salary of one medical coordinator, one professional nurse, one nurse assistant, one secretary, and one part-time environmental inspector. The health center has a family planning department that offers reversible contraception, and an agreement with APROFAM to provide permanent methods at the health center. While these partnerships demonstrate the resourcefulness of local communities to address their healthcare needs, they generally take several years to develop, are often under-funded, and not systematically developed or monitored.

Summary of Findings for MSPAS:

- MSPAS is charged with stewardship or governance (rectoría) of the health sector, however, in practice, coordination and communication among sectors is limited, particularly concerning IGSS and the private sector, and while various commissions for multi-sectoral dialogue exist in Guatemala, there is little engagement of the for-profit private sector in these fora.
- In addition to leaving a large percentage of the population without access to health services, the recent legislation prohibiting contracting out to NGOs and cancellation of the PEC will also inhibit the health sector's ability to explore new opportunities for public-private partnerships and integrate alternative models for achieving performance-based results.
- For more than a decade, MSPAS, donor-funded projects, and advocacy organizations have been working to increase awareness of contraceptive security and have made important advancements, including establishment of the CNAA. Nonetheless, there are still some important barriers to sustainable access to contraceptive commodities, including insufficient budget, legislation that requires special exemptions to allow for international procurement, as well as limited engagement of the private sector in the CNAA committee.
- The market segmentation analysis demonstrates that MSPAS is by far the major provider of family planning products and services for both short-acting and permanent methods. MSPAS' provision of modern family planning methods increased significantly, from 32.2 percent in 2002 to 50.9 percent in 2008 (MSPAS, 2010). MSPAS is the major provider of family planning for all wealth quintiles except the fifth quintile. MSPAS is also the largest provider for Guatemala's two most widely used methods: injectables (77 percent) and female sterilization (42 percent) services.
- Countrywide, a large proportion of all wealth quintiles seek delivery services from the MSPAS, with the share highest in the middle-income groups (Q3 and Q4). Public sector delivery is proportionately the lowest in the first quintile, which is dominated by home delivery (86 percent). In the Western Highlands, a significant proportion of all wealth quintiles have home-based deliveries. MSPAS is the second most important provider of delivery services, gradually increasing in quintiles 1-4.
-

5.3.2 GUATEMALAN INSTITUTE FOR SOCIAL SECURITY

IGSS has a service delivery network of 123 medical units distributed in all departments, of which 23 are hospitals. Forty units are located in the USAID focus areas of Huehuetenango, Quetzaltenango, Quiché, San Marcos, and Totonicapán. According to IGSS representatives, the current infrastructure is insufficient to meet the needs of the insured population and their beneficiaries. IGSS is finalizing construction of the Regional Hospital of Quetzaltenango, which will serve as a referral center for multiple Western departments. Within the next five years, IGSS plans to build a new complex of four specialty hospitals in Guatemala City.

Nearly all stakeholders recognize that IGSS plays a critical role and must be a key actor to ensure a more balance and sustainable market.

IGSS has been contracting private providers to expand the coverage of services. Since 2002, IGSS's insured population was assigned to a membership medical unit; these units were in charge of a referral system to private providers. These contracted services allowed IGSS to expand coverage of ambulatory services while reducing the number of health posts it operated and gain in efficiency.

Regarding sexual and reproductive health services, IGSS provides services for the early detection of cervical cancer, breast cancer, prostatic cancer, menopause, health education, and promotion of family planning. IGSS' family planning program is institutionalized under Resolution No. 1165 (August 2005). According to ENSMI 2008–2009, IGSS covers 10 percent of the market for family planning, making it a key player for the health system in Guatemala and a source of supply of products and services to its policyholders and beneficiaries. However, this percentage may have declined in recent years. The market segmentation analysis using 2008-2009 ENSMI data suggests many IGSS users seek family planning services at MSPAS. More recent data (for 2012), from the CNAA Market Segmentation Strategy, suggest that IGSS provided only 7 percent of all family planning services.

Resolution 1165 requires IGSS to budget sufficient resources for reproductive health and family planning services. However, during interviews with IGSS stakeholders, it was stated that contraceptive procurement is not being done at the central level; this function has been delegated to the region based on demand. However, in some departments, service sites had no commodities and were not familiar with Resolution 1165.

Stakeholder interviews suggest that there is not widespread knowledge of IGSS policy to provide family planning services, and contraceptives are not widely available. Informants pointed out that Resolution 1165 includes barriers to family planning access, including requiring that women have at least two living children to receive sterilization. According to interviews with advocacy groups, IGSS needs to address several institutional policies to harmonize norms and regulations regarding family planning with the Law of Social Development, Law on Universal and Equitable Access to Family Planning, Law for Healthy Maternity for Maternal and Neonatal Health issues, and other gender rights policies.

Interviews made it clear that providers, beneficiaries, and affiliates are not aware of the availability of family planning services through IGSS facilities. Employers do little to demand better quality and access to health services for their employees.

Despite these shortcomings, almost all stakeholders recognize that IGSS has a critical role to play and must be a key player in ensuring a more balanced, sustainable market.

Summary of Findings for IGSS

- IGSS' family planning resolution #1165 requires that IGSS budget for sufficient resources for reproductive health and family planning services; however, PSA interviewees suggested

that contraceptive procurement is not being conducted at central levels, and this function has been delegated based on demand.

- Resolution #1165 includes some key medical barriers to FP access, including stating that beneficiaries and affiliates are only eligible for FP services up to 26 weeks post-partum, requiring a written request for sterilization services by the beneficiary, and requiring that women have at least two living children.
- The institutional and budgetary autonomy of IGSS effectively isolates it from anything other than a voluntary coordination or sharing of resources with MSPAS. Protocols for reimbursing MSPAS for services provided to IGSS beneficiaries, sharing facilities and resources, and avoiding an unnecessary duplication of facilities and services should be an immediate objective.
- The market segmentation analysis suggests that only a small percentage of IGSS beneficiaries seek their FP services from IGSS facilities. Instead, they seek their services from MSPAS (28 percent), APROFAM (17 percent), pharmacies (17%), and for-profit private providers (10 percent). In terms of ANC services, IGSS plays a very small role in ANC services, even among the highest wealth quintiles. In Guatemala City, IGSS is the second highest source of delivery services (30 percent) and reaches a higher portion of wealth quintiles than anywhere else in the country at 20 percent, 40 percent and 30 percent for Q3, Q4 and Q5 respectively.

5.4 NONGOVERNMENTAL ORGANIZATIONS

Guatemala benefits from a wide range of international, regional, and local non-governmental organizations that have been instrumental in increasing access of RH/FP and MCH services to underserved populations, including indigenous populations. While the team met with multiple organizations, the PSA report focuses primarily on two of the largest NGO providers and opportunities for building on their comparative advantages to strengthen the overall RH/FP and MH market. The report also provides a brief overview of another smaller regional NGO called WINGS (Alas in Spanish) that focuses on providing family planning and reproductive health services to underserved clients and most remote areas.

5.4.1 APROFAM

The Family Welfare Association in Guatemala (*Asociación Pro-bienestar de la Familia*, APROFAM) is a private, nonprofit organization affiliated with the International Planned Parenthood Federation with more than 50 years providing health services. During these five decades, APROFAM has been a key stakeholder in the delivery of women's and children's health services for lower- and middle-income clients with an emphasis on sexual and reproductive health. USAID provided significant support and investment over the years to help APROFAM achieve its leadership position although APROFAM no longer receives direct USAID-support. APROFAM is the second largest provider of family planning methods (16 percent) after MSPAS (50.9 percent). Between 2002 and 2008, APROFAM's role in the provision of family planning services fell from 32 percent to 16 percent, which likely reflects APROFAM's increasing emphasis on diversifying its services and client base to strengthen financial sustainability in preparation for USAID phase-out.

APROFAM's mobile units are the only ones in the country equipped to provide laparoscopic voluntary surgical contraception.

APROFAM provides comprehensive health services to Guatemalans who lack economic resources and have limited access to other private health services. APROFAM has a presence

in most departmental capitals through its network of 27 clinics spread across the country and through its social programs. Through its clinic network, APROFAM offers general medicine and specialty consultations, laboratory services, diagnostic services, sale of medicines, normal and caesarean deliveries, and short-acting, long-acting, and permanent contraception. Clinic services are financed through user fees, which are tailored to the geographic region and ability and willingness to pay. Services are cross-subsidized with different types of services across clinics because some clinics have higher profit margins.

APROFAM is also playing an important role in maternal health services. Between 2012-2014, APROFAM attended 8,725 deliveries, averaging 2,908 deliveries per year, 65% by cesarean section. In the West there were 1672 births in the last three years, which means 19% of total deliveries by the institution attended. The demand for delivery services in APROFAM both nationally and in the Western Highlands is low, compared to the high demand for ANC. APROFAM currently utilizes approximately 50% of installed capacity for deliveries, suggesting that there is potential for APROFAM to increase its support for skilled childbirth. APROFAM has also diversified its services SSR and has become an alternative in cities where it has established its clinics offering other services to women of reproductive age and affordable more beyond family planning and deliveries. For example, APROFAM averages 75,246 pap smears and 41,265 ultrasounds for pregnant women per year.

APROFAM also supports three main social programs that are subsidized through donor funding and designed to reach the underserved: the adolescent program, the community-based distribution program, and the mobile outreach program (Table 19). APROFAM's mobile units are the only ones in the country that are equipped to provide laparoscopic voluntary surgical contraception and therefore represent a strong comparative advantage. Interviews with stakeholders indicated that MSPAS recognizes APROFAM's major contribution to family planning coverage. These mobile outreach units will continue to require subsidy given the high (and unsustainable) costs associated with reaching remote areas. APROFAM reported that costing of mobile services needs to be adjusted in current agreements with external funders; the current reimbursement scheme is not covering full operating costs given that APROFAM is reimbursed on a per client basis and operating costs for reaching outlying areas may be higher than the total number of clients served. Other stakeholders reported that coordination and promotion could also be improved to ensure that mobile units serve a higher number of clients during their outreach services.

APROFAM has also built a strong network of community volunteers, designed to provide FP services in Guatemala's remote areas. In 2014, APROFAM had 1,861 community promoters, a 13 percent decrease from 2012 levels. In the Western Highlands, in 2014 APROFAM had a total of 376 promoters, a 33 percent decrease over 2012 levels. The gradual reduction in community promoters is related to APROFAM's increasing emphasis on financial sustainability, lack of supervision and follow-up, as well as competition by other NGO programs offering the same products in the same geographic areas, but with higher subsidies.

In 2009, USAID and APROFAM established a memorandum of understanding to develop a Sustainability Trust Fund (STF) to guarantee the continuity and sustainability of APROFAM's social programs. In 2014, the fund had US\$14.3 million, generating approximately US\$1.5 million in interest per year. The agreement stipulated that use of the STF will be overseen by committee, that USAID would participate as a passive observer, and that APROFAM would fund at least one project per year using the STF. In September 2014, SHOPS conducted an assessment of APROFAM's ability to receive direct funds, which included several recommendations on how to best utilize the STF, including reviewing and strengthening APROFAM's community promoter network given that lack of supervision and follow-up has resulted in loss of community promoters and supporting mobile units to continue strategically

targeted provision of long-acting and permanent services in underserved areas in the Western Highlands, and using APROFAM's installed capacity in the Western Highlands to partially subsidize referrals for deliveries.

TABLE 19: APROFAM'S LEADING SOCIAL PROGRAMS

Program	Description	Geographic Coverage	Financial Support
Adolescent program	Peer educators sensitize, train, and promote responsible and informed of sexual and reproductive health and HIV management.	Urban and suburban areas, with some attempts to expand to rural areas	External donor support
Community-based distribution	Volunteers who are recognized in the community as a source of supply of modern contraceptive methods for poor and indigenous women.	Distribution points are located in peri-urban and rural areas to strengthen the distribution coverage of contraceptives to ensure affordable access.	Self-financed by APROFAM, which purchases some commodities and gets others donated by IPPF. In 2013, cost recovery of this program was estimated at 83%.
Mobile health units	These five units are the only mobile units in the country that provide voluntary surgical contraception for men and women. Long-acting methods (insertion and removal of IUDs and implants) are also offered. MSPAS recognizes the importance of these efforts to expand family planning services in remote areas of the Western Highlands and supports coordination and community mobilization.	Coverage includes suburban and rural areas where public health services and private (almost nonexistent) are unable to offer them. The beneficiaries are poor, rural, and indigenous women.	The program is highly subsidized and users provide only a symbolic fee or receive free services. In 2012, cost recovery was estimated at 41%. For services from the two mobile units funded by USAID for the Western Highlands, users do not pay; APROFAM receives financial support through PASMO. For services from the two mobile units financed by Bergstrom, APROFAM charges Q25 per service. For services at the unit financed by APROFAM with its own funds, APROFAM charges Q60 per procedure.

Summary of Findings for APROFAM:

- APROFAM is in a critical time where it is striving to maintain its leadership position as the second largest provider of FP services in the country, while streamlining operations and increasing its overall sustainability through diversification. APROFAM no longer receives direct support from USAID, and it receives minimal external donor funding for specific components of its portfolio.
- APROFAM's mobile units represent an important comparative advantage for the organization since they are the only ones in the country that provide laparoscopic surgical sterilization. MSPAS also recognizes these units to be complementary to its actions and allows APROFAM to collaborate in targeted public sector outreach initiatives. However, APROFAM should seek to strengthen coordination, promotion and dissemination of these medical outreach activities with other key stakeholders to ensure that they are optimizing number of people who can benefit from services.

- APROFAM's social programs providing services to poor and remote areas will always require significant subsidy, and external funding may not cover all costs. APROFAM must decide what social programs are essential to its mission and continue its full commitment to their success. For example, APROFAM's community-based distribution program has reduced its coverage due to the organization's need to streamline activities and the presence of other donor-supported activities in these areas that support similar activities.
- APROFAM's hospitals, particularly in the Western Highlands, report underutilized capacity for delivery services, which through appropriate targeting and demand-side financing (e.g., vouchers) given the urgency to improve MH indicators in that region. As mentioned above, these services could also be partially subsidized by APROFAM's STF.

5.4.2 PASMO/RED SEGURA

Population Services International (PSI) established the Pan American Social Marketing Organization (PASMO) to strengthen social marketing and behavior change communication for HIV/AIDS prevention in the Central America region. Since its founding in 1997, PASMO continues to expand its portfolio in Guatemala to include private- and public-sector interventions. PASMO has a presence in every country in the region and is headquartered in Guatemala. The social marketing organization has grown its portfolio to include a wide range of health initiatives; many of them have achieved self-sufficiency. For example, PASMO's condom social marketing initiative no longer receives donor support as KfW stopped providing financial assistance more than three years ago.

Red Segura has been a successful model to increase the use of IUDs and implants through private providers. Many people from the medium or high income sectors go to MSPAS facilities for family planning and maternal health services. There is an opportunity for the private sector to increase its market share with these clients

Through Red Segura, PASMO developed a strong network of private providers that has increased provision of IUD services among private providers over the last five years. Launched in 2009, Red Segura currently includes 243 private providers, primarily gynecologists (80 percent) and general physicians (20 percent). While the network is national, the majority of providers are located in Guatemala City. Out of 243 providers, only 26 are located in the Western Highlands. Providers must be certified and active members of the Medical College. The network succeeded in recruiting a substantial number of active providers, although recruitment and training of providers are time and cost intensive considering the large attrition rate. PASMO estimates that to date it has recruited more than 900 providers, but many of them later withdrew or were dropped by PASMO due to inactivity, poor performance, or resistance to reporting.

The benefits to providers to participate in the network include: 1) increasing their knowledge and skills in IUD and implant insertion, family planning, and counseling and informed consent, 2) receiving basic equipment, 3) access to affordable methods and other consumable supplies (cotton, gloves, etc.), and 4) receiving support from Red Segura's promoter agents. The network employs one promoter agent per physician (estimated area of five kilometers), and there are approximately 60 promoters for the entire network. There are no established maximum pricing levels since the Guatemalan Colegio Médico does not allow it, but clients are referred to doctors based on their socioeconomic profile. Red Segura estimates that it costs approximately US\$1,000 per provider to recruit and train each physician in the network. There are no fees for doctors to be members of the provider network.

Red Segura has proven to be a successful model for increasing IUD and implant use through private providers (monitoring and evaluation data from Red Segura indicates a 73 percent

increase in IUD distribution between 2010 and 2011 and a 18 percent increase between 2013 and 2014), however PASMO has not yet developed a sustainability strategy that would address long-term operation and management of the network. Nonetheless, given the network's success in rapidly expanding provision of long-acting methods in the private sector, there are opportunities to consider with Red Segura for targeted expansion to priority geographic areas and to incorporate additional MH services among participating providers, particularly among middle-income users that are largely using the public sector for ANC and delivery services. Based on SHOPS' market segmentation analysis of delivery services, even in Guatemala City a large percentage of the highest wealth quintiles are delivering at MSPAS (33%). Since a large percentage of the Red Segura network providers are gynecologists, there may be an opportunity to link the network (or selected providers) to provision of antenatal and delivery services through targeted, demand-side financing. Given that there is limited coverage outside of Guatemala City, the network could explore the feasibility of geographic targeting of new providers in priority regions; Quetzaltenango, for example as the second largest city, has a strong private health market.

Summary of Findings for Red Segura:

- Red Segura represents a strong private network with a comprehensive service delivery model that has successfully increased provision of IUD services among private providers over the last five years. However, PASMO has not yet developed a sustainability strategy for the network and relies heavily on external donor funding.
- Despite the low coverage outside of Guatemala City, there is opportunity to explore geographic expansion of Red Segura providers in priority regions to further increase access to FP services.
- In addition, given that 4th and 5th quintiles (highest) still rely strongly on home-based births and MSPAS, there is an opportunity to expand the provision of ANC and delivery services through the Red Segura network in Guatemala City and Quetzaltenango using targeted, demand-side financing.

5.4.3 WINGS

WINGS, which was founded in 2001, is a small NGO that provides reproductive health and family planning services to Guatemala's most underserved and remote populations. WINGS provides education and access to reproductive health services for rural, indigenous, and low-income populations. Their primary technical areas include family planning services, cervical cancer screening and treatment, and adolescent information and services. WINGS operates one newly established clinic in Antigua, two mobile clinics, approximately 103 community volunteers who provide RH/FP information and services, and agreements with other private hospitals and clinics to provide facility-based services. They are almost exclusively financed through individual and organizational contributions, and they currently receive no financial support from USAID. They maintain institutional alliances with PASMO, APROFAM, SHEVA, and various other public and private hospitals and clinics to strengthen their collaboration and coordination. Given their relatively small structure, their strategic advantage is that they are able to respond quickly to specific needs for information, education, and services throughout the country's most remote and difficult-to-reach areas.

5.5 FOR-PROFIT PRIVATE SECTOR

5.5.1 FOR-PROFIT PRIVATE PROVIDERS

Guatemala's private sector represents a large and growing segment of the health care market. Regardless of income level, many Guatemalans seek care in the private sector, and although use of private providers involves out-of-pocket payments, many households use the private sector as their first point of care. The for-profit private sector includes high-end tertiary hospitals, small specialty and general hospitals (95), clinics for specialized medicine (2,927), clinics for general medicine (1,103), and laboratories (1,373), representing approximately 60 percent of all registered facilities.

MSPAS oversees private sector facilities through the General Directorate for Health Regulation, Vigilance, and Control (*Departamento de Regulación, Acreditación y Control de Establecimientos de Salud*, DRACES), which is responsible for overall regulation and licensing of for-profit private sector facilities. Interviews with DRACES revealed that a fair number of facilities are opening every year, and at the time of the interview, there were 9,553 facilities related to health care registered in the country, with the majority registered in Guatemala City and Quetzaltenango. Most stakeholders interviewed recognized that Guatemala City and the municipality of Quetzaltenango were the two main "hubs" for private sector providers, although data disaggregated by region or department are not easily available.

The requirements and forms for registration are straightforward and easily accessible on the DRACES website. DRACES maintains an Excel database of all private providers, but the database does not allow for analysis by geographic area. DRACES is also responsible for monitoring all private sector facilities, although its resources are limited, and monitoring teams make only periodic visits to outside of Guatemala City. PSA interviews suggested that there are no incentives or credit opportunities available to encourage providers to open private practice outside of major urban areas.

Registration in Guatemala's College of Physicians and Surgeons (*Colegio de Médicos y Cirujanos de Guatemala*, CMCG) is required by law in order for all physicians to obtain their license. CMCG currently has more than 19,000 registered physicians. Although CMCG statutes stipulate that health workers should undergo periodic re-certification and accreditation procedures, the only requirement in practice is for active members to pay their monthly fees (Decreto 72-2001). Thus there is little regulation of health workers once they are graduated and licensed. Professional medical associations also exist at the regional levels. Most providers interviewed agreed that there were no barriers to the establishment of private sector health facilities. Many of these professional medical associations are involved in supporting continuing education, but with limited engagement and awareness of priority public health issues, such as reproductive health, family planning, and maternal health services.

Regarding the for-profit sector's role in the provision of RH/FP and MH services, according to 2008-2009 ENSMI, approximately 9 percent of women seek their family planning services through a private hospital, clinic, or provider, primarily for IUDs (13 percent of private for-profit sector users for family planning) and implants (9 percent of private for-profit sector users for family planning). This percentage is fairly consistent both in Guatemala City and country-wide. The largest percentage in use of the for-profit private sector for FP services is from the highest wealth quintile, however a large percentage of this quintile (approximately half) still use public sector for FP services. In terms of ANC, while all wealth quintiles use home-based care for ANC services, the role of the for-profit sector increases significantly in the higher wealth quintiles (4th and 5th). In Guatemala City, the for-profit private sector is an important provider of ANC services in Guatemala City. In terms of facility-based deliveries, the for-profit private sector is the third

most important source of facility-based deliveries in Guatemala City and countrywide. The market segmentation analysis suggests many women may seek ANC services in the for-profit private sector, but deliver at public facilities. PSA interviews with private providers offered anecdotal evidence to support this trend.

Summary of Findings for For-Profit Private Sector:

- The for-profit private sector infrastructure is strongest in urban areas, and most well-developed in Guatemala's two largest cities, Guatemala City and Quetzaltenango. Given limitations of DRACES' database, it is not possible to assess the availability of private providers in other urban areas.
- Guatemala's medical associations serve as a licensing board for all physicians, public and private. However, the only requirement in practice is for active members to pay their monthly fees so there is little regulation of once they are licensed. Given that many of these associations support continuing education, there is an opportunity to increase their engagement on priority public health issues, such as reproductive health, family planning, and maternal health services.
- The market segmentation analysis demonstrates that Guatemala's highest wealth quintiles are using the for-profit private sector (Q4 – 12 percent and Q5 – 30 percent) for family planning services (more than any other wealth quintiles), but a higher percentage still use MSPAS (Q4 – 41 percent and Q5 – 21 percent) as their main source of family planning. The same trend is true for delivery services, where 12 percent of Q4 and 37 percent of Q5 use for-profit providers, but a higher percentage still use MSPAS (Q4 - 51 percent Q5 – 33%). Interestingly, higher wealth quintiles seem to seek ANC services in the for-profit private sector (Q 4 – 33% and Q5 – 54%) more than other FP or delivery services. These findings suggest that there is an important opportunity to move higher quintiles from MSPAS to other private sector sources for FP, ANC, and MH services.

5.5.2 SOCIAL HEALTH ENTERPRISES

There are several social health enterprises operating in Guatemala that have incorporated health services and insurance models into their structures to meet the needs of their beneficiaries. Several small social pharmacy franchises operate throughout the country, providing discounted medical consultations as well as generic medicines. For example, in Quetzaltenango, the Association for the Potential of Human Development (*Asociación para el Desarrollo del Potencial Humano*) (ADEPH) manages several “social enterprise” pharmacies. The PSA team witnessed firsthand the strong demand that exists for these pharmacies. However, ADEPH representatives stated that their social enterprise faces strong pressure from Guatemala's largest pharmacy chains, and their previous product sources are increasing product prices by 40-60%. Other pharmacy chains known for providing accessible pricing include Farmacias del Dr. Simi, which provides on-site consultations, as well as Farmacias de la Comunidad.

The EPSS health model is an innovative and sustainable private sector initiative. EPSS has established unique partnerships with public institutions, and it has the potential for large-scale expansion of family planning, reproductive health, and maternal health services.

The Enterprise for Promotion of Health Services (EPSS) is a private company designed to increase access to affordable, quality health services for Guatemala's population. The model is loosely based on Colombia's Ley 100, which creates universal access to health services, administered through companies that manage health care consumer and provider networks. The premise is that 90 percent of all health issues can be resolved at the outpatient level. EPSS has operated in Guatemala since 2002 and provides health care services for more than 650,000

families. EPSS administers a large call center that is used to make referrals to a network of primary care providers like general practitioners as well as OB/GYNs and pediatricians, the two most requested specialties. EPSS currently works through an alliance with the Ministry of Education, where teachers have the option of entering the network and paying a premium that is deducted from their salary. EPSS also has an active alliance with Banrural, where its credit card holders may also participate in the primary care network. The EPSS represents an innovative, sustainable private sector health care model. EPSS management is open to exploring options for increasing access to reproductive health, family planning, and maternal health services among its network of private providers. EPSS' proven business model and large network of enrolled members represents a very interesting opportunity for large-scale expansion of family planning and reproductive and maternal health services, such as including family planning services in the health insurance policies that are focused specifically on women, e.g., Banrural's Vivo Segura.

Summary of Findings for Social Health Enterprises:

- Several small social pharmacy franchises operate throughout the country, providing discounted medical consultations as well as generic medicines. Several PSA interviewees reported increasing difficulties in sourcing low-cost products and pressure from large pharmacy chains.
- EPSS' health model represents a highly innovative, sustainable private sector health initiative that has established unique partnerships with both public (e.g. Ministry of Education) and private business (e.g. Banrural). EPSS' model and large network of enrolled members represents an interesting opportunity for large-scale expansion of family planning and reproductive and maternal health services.

5.5.3 HEALTH INSURANCE AND MICROINSURANCE

Private health insurance represents a small, but growing segment of the Guatemalan health care market. Interviews with representatives from the insurance industry suggest that private health insurance is held by approximately 5 percent of the Guatemalan population, and more than 90 percent reside in Guatemala City. In Guatemala, the five private insurance companies with the largest revenues are 1) Seguros G&T, 2) Aseguradora Rural, 3) Seguros El Roble, 4) Seguros y Prevision CHN, and 5) Aseguradora General. Health and accident insurance represented 43 percent of the overall market. Seguros G&T recently launched a maternity policy covering antenatal, delivery, and postnatal check-ups. Expenditures on private insurance plans reached 810 million quetzals (US\$103 million) in 2013, representing only 3 percent of total health expenditure and 0.2 percent of GDP. Most people are enrolled in voluntary plans and most private health insurance plans are supported by employers on behalf of employees and provided by major corporations in the main cities (Avila, 2015).

There are interesting trends in health insurance schemes aimed at the low and middle income sectors.

In addition, there are interesting trends in health insurance targeting lower-middle- and middle-income groups. The Aseguradora Rural, S.A. has been operating in Guatemala for eight years, as a member of the financial group Banrural. Its clients include agricultural workers, housewives, teachers, and micro, small, and medium-sized enterprises. Products include:

- **Medical Insurance:** Intended for individuals, groups, and families to provide coverage to the insured and family (spouse and children). The benefits cover outpatient visits, medications, laboratory tests and diagnosis, hospitalizations, and emergency. The premium is Q26 per month (US\$3.40).

- Hospital Insurance: Offered to employees of a company or individuals and includes benefits for inpatient surgeries, doctor visits, and laboratory tests. The premium is Q36 per month (US\$4.70).
- Vivo Seguro—Collective Cancer and Life Insurance for Women: Aimed at preventing and treating cancer in women. Coverage includes two visits to a gynecologist per year, preventive Pap tests, colposcopy, biopsy, and fine needle breast treatments such as cryotherapy. This insurance also includes: 1) discounts for drugs in the pharmacy network and procedures, examinations, consultations and general medical treatment in the EPSS provider network, 2) compensation for a covered cancer diagnosis in the amount of Q23000 (US\$3,000) when the cancer is diagnosed more than 90 days after the effective date of the policy, and 3) life insurance benefits of Q6,000 (US\$780) for death from any cause. The premium is Q32 per month (US\$4.20).
- Health insurance for microcredit clients: Covers borrower and spouse and children for medical appointments, medications, laboratory tests and diagnosis, hospitalization, and emergencies. This insurance is offered on a mandatory basis to all borrowers. Premiums are included in the loan administration fees. There are about 400,000 insured clients to date.

Other microcredit organizations are also incorporating health services for their affiliated members. In Quetzaltenango, the private foundation, FUNDAP, has been operating for more than 30 years and manages more than 28 microcredit offices throughout the Western Highlands with more than 40,000 affiliates. In 2003, they developed a health component since many women were dropping out of community banks due to unanticipated health expenses. They operate a network of seven clinics at the departmental levels where members have access to free basic preventive and curative services, although FP services are not included. PSA interviewees suggested that this trend was common among microcredit institutions.

Summary of Findings for Health Insurance and Micro Insurance:

- Private health insurance represents a small, but growing segment of the healthcare market, and there are several interesting trends in health insurance attempting to target lower-middle- and middle-income groups and incorporate maternal health and delivery services.
- Microcredit organizations are also increasingly including basic health services for borrowers and dependents since unanticipated medical expenses are cited as one of the main reasons for faulting on microcredit loans.

5.5.4 CORPORATE SOCIAL RESPONSIBILITY

Guatemala's for-profit commercial sector has a strong base of corporate engagement and social responsibility in health, and the team interviewed several groups such as the organization of cocoa producers or representatives from the banana industry.

Among all corporate social responsibility (CSR) actors, the Center for Corporate Social Responsibility in Guatemala (*Centro para la Acción de la Responsabilidad Social Empresarial en Guatemala*, CentraRSE) stands out. Founded in 2003, CentraRSE has more than 100 member companies belonging to more than 20 sectors and subsectors of the country and employing 150,000 families. CentraRSE is a coalition of companies promoting the country's most influential CSR activities. CentraRSE's provides education and training with local and international experts in the field of CSR, evaluation and measurement through established CSR indicators, support in setting priorities and developing action plans, and access to the latest information and trends in CSR. CentraRSE's leadership considers that Guatemala's corporate sector is ready to support the country's underserved

There are many opportunities for donors, implementing partners, and the private for-profit sector to collaborate on health initiatives.

communities as long as these initiatives are designed to improve the existing structures and not create parallel systems.

Many of the country's major corporate foundations are already sensitized to Guatemala's priority health issues and have actively incorporated health, and even RH/FP, into their programs. Fundazucar's program focuses primarily on education, health, and municipal strengthening. The program includes its "*Mejores Familias*," which works with pregnant women in local communities to support them over a 24-month training period to develop proper care, preventive health, and nutrition for their children. Women from the community are trained as leaders, and with program staff they conduct monitoring visits to local homes. Fundazucar also has an existing partnership with the Escuintla Regional Hospital, which operates the hospital's nearby outpatient clinic. The clinic charges patients a nominal fee for its services. In 2013, almost 50,000 consultations were provided in five medical specialties.

Funcafe is a private, nonprofit organization established in 1994 to represent the social responsibility actions of the coffee sector. Its efforts are focused on the development of the rural populations in the regions where coffee is grown, working primarily in health, education, and food security. Funcafe maintains 16 health centers and health posts in coffee farms and nearby areas to serve more than 125,000 coffee workers and the general population of 13 departments. Service regions include the South Coast, San Marcos, Chimaltenango, Alta and Baja Verapaz, Quiché, and Huehuetenango. Funcafe supports preventive health; general health care; dental, pediatric and prenatal care; training in sexual and reproductive health; family planning; and prevention of cervical-uterine cancer.

There are many foundations that understand the important role of family planning in a woman's overall reproductive and maternal health and incorporate these vital services. Many of these organizations have collaborated recently with donor-supported initiatives, and some expressed donor burnout. Several PSA interviewees mentioned the need for better coordination among donors since so many are working in the private sector. Given the tremendous opportunity to collaborate with these partners on health initiatives, there is a need for better coordination among donors, and approaching and engaging these organizations in a coordinated fashion. Guatemala has the example of the Nutrition Alliance (*Alianza para la Nutricion*), which is an interesting model of corporate engagement where multiple organizations led by several of Guatemala's prominent companies identify common themes and agendas for nutrition programming in order to better coordinate resources and interventions. This example could be a model for reproductive and maternal health engagement with the corporate sector.

Summary of Findings for CSR:

- Guatemala's for-profit commercial sector has a strong, sophisticated base of corporate engagement and social responsibility in health. Many of these organizations are already supporting RH/FP and MH services through their existing programs. There is some sensitivity among these organizations regarding donor coordination, and a stated need for improved coordination and communication among the multiple donors that are interested in engaging with CSR initiatives.
- Guatemala's Nutrition Alliance represents an interesting model of corporate engagement that leverages corporate resources and political support toward common objectives and agendas. While this type of coordinated effort requires strong leadership and time to establish consensus among multiple players, it represents an opportunity to limit duplication of effort and improve coordination of resources.

5.5.5 WORKER HEALTH AND WELL-BEING

A significant number of companies in Guatemala provide health services to their staff through company-owned facilities, on-site clinics, and workplace health programs, and contracted private health services. Many organizations (some with donor support) have established workplace wellness programs focusing on RH/FP, HIV, and general health services. APROFAM has worked for several years to establish partnerships with companies to support worker health, particularly for RH/FP services. APROFAM maintains partnerships with multiple companies to provide access to clinics as well as periodic, on-site services in RH/FP and information, education, and training services. For example, APROFAM has an ongoing agreement with Walmart at the national level to offer free care to its employees through APROFAM clinics.

Summary of Findings for Worker Health and Well-Being:

- Many companies provided supplemental coverage for health services to their employees through on-site clinics and workplace health programs for specialized services—and are willing to make additional investment in these services.

6 RECOMMENDATIONS

Based on key findings from the PSA, this report outlines several key recommendations regarding strengthening stewardship of a balanced, sustainable health market for RH/FP/MH services.

6.1 HEALTH SYSTEM STEWARDSHIP

Stewardship that engages multiple private sector players

Guatemala's MSPAS is charged with stewardship or governance (*rectoría*) of the overall health sector. However, in practice, coordination and communication among sectors is limited, particularly between IGSS and the private sector. The institutional and budgetary autonomy of IGSS allows it to coordinate with MSPAS on a voluntary basis. There are various commissions for multi-sectoral dialogue exist in Guatemala, but there is little engagement of the for-profit private sector in these fora. For example, the CNAA involves the major NGO actors such as APROFAM and PSI, yet there is little engagement of other private sector organizations.

The PSA team recommends that MSPAS continue to look for opportunities to engage new private sector players. This would include participation of the for-profit sector, including the pharmaceutical industry as well as professional medical associations, such as the College of Physicians and Surgeons, Association of Obstetricians and Gynecologists, Association of Pediatricians, and others.

Advocacy to improve market inequities

Advocacy organizations have been working to increase awareness of the importance of contraceptive security, to promote a multisector approach, and to address key policy and programmatic gaps. In 2009, the National Commission for Contraceptive Security was officially created to be led by the MSPAS' National Reproductive Health Coordinator. Despite important legal and regulatory advances, stakeholders report that there are still budget shortfalls for contraceptives and limited competitive procurement options to ensure efficient use of resources. In late 2013, CNAA published its Market Segmentation Strategy for contraceptives, which recognizes the importance of a sustainable, total market approach. The strategy outlines different scenarios for reducing unmet need and shifting method mix, but does not define specific actions to achieve the scenarios. The market segmentation analysis conducted by PSA team suggests that there are still important inequities in the delivery of FP, ANC, and delivery services, and the potential to move upper health quintiles toward private sector channels.

The team recommends that the CNAA strengthen the engagement of the for-profit private sector as part of a sustainable health market, as well as identify specific next steps for all sectors. CNAA should also consider the comparative advantages of NGOs and the for profit sector to expand access to ANC and delivery services.

6.2 SERVICE DELIVERY

IGSS to increase its provision of FP, ANC, and delivery services

The Guatemalan Social Security Institute is the second largest health service delivery institution in the country. There is evidence that a large percentage of IGSS beneficiaries and their

dependents are seeking family planning services at non-IGSS facilities. Many of these users are going to MSPAS, creating an additional burden for that institution. IGSS' family planning program is institutionalized under Resolution No. 1165, but stakeholder interviews suggest that there is not widespread knowledge of IGSS policy to provide family planning services, and contraceptives are not widely available. In addition, Resolution 1165 includes some key policy barriers to family planning access.

We recommend that IGSS' stakeholders conduct a review of Articles 4 and 5 to ensure that Resolution #1165 is consistent with Guatemala's law on universal access to FP services.

IGSS plays a very small role in ANC services, even among the highest wealth quintiles. In Guatemala City, IGSS is the second highest source of delivery services (30 percent) and reaches a higher portion of wealth quintiles than anywhere else in the country at 20 percent for Q3, 40 percent for Q4, and 30 percent for Q5. Country-wide, however, IGSS performs only 8 percent of all deliveries and only 1 percent in the Western Highlands. The PSA team recommends that IGSS also strengthen provision of ANC services as well as delivery services outside of Guatemala City.

Despite these shortcomings, almost all stakeholders recognize that IGSS has a critical role to play. Given IGSS' infrastructure and resources, it is the organization that will have the most immediate and significant impact on strengthening RH/FP and MH services.

The PSA team recommends continued high-level advocacy with IGSS to ensure that IGSS realizes its role as a strategic player in ensuring a more balanced, sustainable market for FP, ANC, and delivery services, sharing facilities and resources, and avoiding an unnecessary duplication of facilities and services.

APROFAM to identify its comparative advantages and commit to strengthen and subsidize high priority areas

APROFAM is in a critical time striving to maintain its leadership position as the second largest provider of FP services in the country while streamlining operations and increasing its overall sustainability. APROFAM's mobile units represent an important comparative advantage for the organization since they are the only ones in the country that provide laparoscopic surgical sterilization. However, APROFAM should seek to strengthen coordination, promotion and dissemination of these medical outreach activities with other key stakeholders to ensure that they are optimizing number of people who can benefit from services. APROFAM's network of community volunteers, once a flagship program for the organization, has gradually reduced the number of its community promoters. APROFAM's hospitals, particularly in the Western Highlands, report underutilized capacity for delivery services, which through appropriate targeting and demand-side financing (e.g., vouchers) could be used to improve MH indicators in that region.

The PSA team recommends that APROFAM determine what social programs are essential to its mission and then continue its full commitment to their success, using the STF to cross-subsidize high priority activities.

Red Segura to consider targeted expansion of geographic coverage and MH services

Red Segura has proven to be a successful model for increasing IUD and implant use through private providers; however, PASMO has not yet developed a sustainability strategy that would address long-term operation and management of the network. Nonetheless, given the network's success in rapidly expanding provision of long-acting methods in the private sector, there are opportunities to consider for targeted expansion to priority geographic areas and to incorporate

additional MH services among participating providers, particularly among middle-income users that are largely using the public sector for ANC and delivery services.

The team recommends that PASMO/Red Segura develop its sustainability strategy, identifying which elements of the provider network are essential to long-term access to key family planning, ANC, and delivery services in the for-profit private sector. At the same time it should identify sources for long-term funding. And finally, it should identify opportunities for expanding geographic access and providing broader maternal health services.

EPSS as a sustainable and scalable private sector health care model

The EPSS represents an innovative, sustainable private sector health care model. EPSS management is open to exploring options for increasing access to reproductive health, family planning, and maternal health services among its network of private providers. EPSS' proven business model and large network of enrolled members represents a very interesting opportunity for large-scale expansion of family planning and reproductive and maternal health services, such as including family planning services in the health insurance policies that are focused specifically on women, e.g., Banrural's Vivo Segura.

The PSA team recommends exploring opportunities to expand access to RH/FP and MH services, building on EPSS' sustainable and scalable service delivery health model.

6.3 DEMAND SIDE

Targeted demand generation among underserved groups

In order for there to be a robust private sector, there has to be sufficient demand. The team believes that if there were more demand for family planning, especially for the full array of methods and for facility-based deliveries, the private sector could play a bigger role in providing services.

The team recommends that the country engage in demand generation activities that recognize important differences within the population, for example, urban/rural, ethnic groups, age, and levels of wealth. Stakeholders could contribute to this effort by supporting behavior change communication activities on family planning and safe motherhood through its partners in the WHIP. The behavior change communication campaigns should include information on how to access private providers and NGOs, including locations and services available.

6.4 SUPPLY SIDE

Health Insurance and micro insurance to expand access among middle income people

Private health insurance represents a small but growing segment of the Guatemalan health care market. However, there are interesting trends in health insurance targeting lower-middle and middle-income groups. The Aseguradora Rural, S.A. has been operating in Guatemala for eight years, as a member of the financial group Banrural. Its clients include agricultural workers, housewives, teachers, and micro, small, and medium-sized enterprises.

The PSA team recommends exploring strategic partnerships with insurance agents to expand access to RH/FP and MH services for middle-income populations. The strongest potential for growth in insurance products is within middle income populations in large urban centers.

CSR and private partnerships to create strategic synergies

Guatemala's for-profit commercial sector has a strong, sophisticated base of corporate engagement and social responsibility in health. Many of these organizations are already

supporting RH/FP and MH services through their existing programs. There is a stated need for improved coordination and communication among the multiple donors that are interested in engaging with CSR initiatives.

The PSA team recommends exploring strategic partnerships that focus more on identifying added-value and comparative advantage among organizations and less on financial leveraging. The Alliance for Nutrition represents an interesting partnership model for engaging multiple private sector partners around a specific health issue, it but requires strong corporate and political leadership to bring key players to the table.

6.5 HUMAN RESOURCES FOR HEALTH

Cadre of skilled birth attendants to address non-facility based births

The majority of women countrywide (48 percent) and in the Western Highlands (64 percent) deliver either in their own home or in the home of a TBA. Many of these TBAs are illiterate and not qualified to manage emergency cases. Currently, there is no professional midwife cadre in Guatemala.

The team recommends creating a professional midwife cadre either as a specialization within the nurse cadre or as a separate category. These professionals would be qualified to attend normal deliveries and refer complicated ones to OB/GYNs. Similarly, the team recommends that Guatemala recognize SBAs in the formal sector and standardize their qualifications and scope of practice. And finally, the team recommends increasing the number of SBAs through training. Donors could help develop curricula within private training institutions to train aspiring students or TBAs who want to upgrade their skills. There should be a scholarship program for students from indigenous and other underserved areas who commit to practicing in those areas after graduation.

ANNEX A: STAKEHOLDERS INTERVIEWED FOR PSA

Organization	Name	Contact information
Public sector		
Municipalidad La Esperanza, Quetzaltenango	Cristian Ximin	
Directora, Sistema Integrado de Atención a la Salud (SIAS), Ministerio de Salud Pública y Asistencia Social	Nicté Ramírez	
Instituto Guatemalteco de Seguridad Social		
Subgerente de Prestación de Servicios de Salud	Byron Arana	
Jefe Dpto Medicina Preventiva	Edwin Cambranes	
Vocal de la Junta Directiva - Representante de los patronos período 2014 - 2016.	Max Erwin Quirín Schoder	
Director Departamental IGSS Occidente	Octavio Cortes	
IGSS - Huehuetenango	Hugo Isaac Sum	
Civil society		
Asociación CDRO Totonicapán	Benjamin Som	salud.dac@asociacioncdro.com
Asociación CDRO Totonicapán	Julia Rodríguez	salud.dac@asociacioncdro.com
Asociación CDRO Totonicapán	Walter Sac Escobar,	salud.dac@asociacioncdro.com
ADEPH (Asociación para el Desarrollo del Potencial Humano)	Obed Velasquez	gere@adeph.org.gt
ALAS	Rodrigo Barillas	director@wingsguate.org rodrigobarillas@wingsguate.org
Alianza por la Nutrición	Jorge Lavarreda	jlavarre@cien.org.gt
APROFAM	Ana Cecilia Fajardo Andrade	
APROFAM	Silvia Palma	spalma@aprofam.org.gt
Asociación de Farmacéuticos ASOFAGUA	Martha Tánchez	martha_tanchez@yahoo.com
Asociación de ginecología y Obstetricia de Guatemala (AGOG) - seccion NorOccidente	Roxanna Ramirez	roxanademoir@msn.com
Asociación de Investigación, Desarrollo y Educación Integral (IDEI)	Janet Ikeda	janet.m.ikeda@asociacionidei.org
BANASA	Bernardo Roehrs	broehrs@agromerica.com
Colegio de Farmacéuticos y Químicos de Guatemala	Sofia Posadas	gerenciaadministrativa@colegiodefarmaceutico syquimicos.gt
Colegio de Médicos y Cirujanos	Porfirio Santizo	info@colmedegua.org
FUNDAECO, Huehuetenango	Julio López	j.lopez@fundaeco.org.gt
FUNDAP	Eunice Martínez	jorge.gandara@fundap.com.gt

Instituto Universitario de la Mujer de la USAC	Patricia Borrayo	miriamusac79@gmail.com
El Instituto de Salud Incluyente	Juan Carlos Verdugo	juancarlos.verdugo@isis.org.gt
Observatorio en salud reproductiva	Mirna Montenegro	mirnam.rangel@gmail.com
PSI/Pan American Social Marketing Organization (PASMO)	Pilar Sebastian	Psebastian@pasmo-ca.org
Red de organizaciones de Mujeres Indigenas para la Salud reproductiva (REDMISAR)	Silvia Xinico	silviaxinico@gmail.com
Red Segura	Karen Steele	ksteele@pasmo-ca.org
Universidad San Carlos de Guatemala - USAC	Adrian Chávez	adrianchavezgarcia@gmail.com
Private for-profit		
EPSS – Empresa Promotora de Servicios de Salud	Rodolfo Muralles	2382-2002
ASEGURADORA GENERAL, S.A	Donald Tijerino	(502) 2331 -1880
ASEGURADORA GENERAL, S.A	Verónica Lainfiesta	(502) 2331 -1880
ASEGURADORA RURAL	Christian Leuthold	23398888- Ext.302690
ASEGURADORA RURAL	José Guillermo López	23398888- Ext.302690
ASEGURADORA RURAL	Oscar Chamalé	23398888- Ext.302690
Asociacion Medica del occidente	José Hasted / Ruby Montes de Oca	77671698
Fundación del Café (FUNCAFE)	Mynor Maldonado	mynor.DMM@funcafe.org
FUNDAZUCAR	María Silvia Pineda	mspineda@azucar.com.gt
Development partners		
DELIVER project	Anabella Sanchez	annabella_sanchez@jsi.com
HEPP project	Herminia Reyes	Herminia Reyes - hreyes@hpp-gt.org
HEPP project	Maricela de la Cruz	Marisela De La Cruz - mdelacruz@hpp-gt.org
IDB	Ian MacArthur	IANM@iadb.org
Iniciativa de Salud Mesoamericana 2015	Jorge Solórzano	jsgua05027@gmail.com
Nutrisalud	Angélica Bixcul	abixcul@nutri-salud.urc-chs.com
Nutrisalud	Ivan Mendoza	ivanmendozagt@gmail.com
Nutrisalud	Jose Eduardo Silva	jsilva@urc-chs.com
Nutrisalud	Melida Chaguaceda	mchaguaceda@nutri-salud.urc-chs.com
OPS/OMS Guatemala	Luis Roberto Escoto	escotoro@paho.org
USAID	Hector Romeo Menendez	hmenendez@usaid.gov

BIBLIOGRAPHY

- Alianzas Project. 2013. *Multi-sector Alliances Program Annual Report: October 1, 2012–September 30, 2013*. RTI International.
- Angeles, Gustavo, Edgar Hidalgo, Roberto Molina-Cruz, Tory M. Taylor, José Urquieta-Salomón, César Calderón, José Carlos Fernández, Mynor Hidalgo, Kristen Brugh, and Martin Romero. 2014. *Encuesta de Monitoreo y Evaluación del Programa del Altiplano Occidental: Línea de Base 2013*.
- Avila, Carlos, Rhea Bright, Jose Gutierrez, Kenneth Hoadley, Coite Manuel, Natalia Romero, and (editor) Michael P. Rodriguez. 2015. *Guatemala Health System Assessment, 2015*. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.
- Badillo D., F. Carrera, M. Castro, V. Guzmán, and J. Menkos. 2009. *Financiamiento de la protección social de la salud en Guatemala*. Guatemala City: CEPAL.
- Barnes, Jeffrey. 2011. *Designing Public-Private Partnerships in Health*. Primer. Bethesda, MD: SHOPS Project, Abt Associates.
- Becerril-Montekio V., and L. López-Dávila. 2011. "The health system of Guatemala." *Salud Publica Mex* 53 (Suppl 2):s197-208.
- Bowser, Diana, and A. Mahal. 2009. *Health Financing in Guatemala: A Situation Analysis and Lessons from Four Developing Countries (Final Report)*. Boston: Harvard School of Public Health.
- Briceño, R. 2008. *Gasto Privado en Salud en Centroamérica. Nicaragua: Estado de la Región en Desarrollo Humano Sostenible*.
- Burleigh, E. 2006. *Pro Redes Salud: Rapid scale-up of primary health care through NGOs*. John Snow Inc.
- Castle S., and P. Hardtman. 2014. *Support for international family planning organizations*. Population Services International midterm project evaluation.
- Catalyst Project. 2004. *Increasing Access through Public-Private Partnerships in Guatemala: Lessons Learned from APROFAM's Employer-Based Reproductive Health/Family Planning Services*. Meridian Group International, Pathfinder International.
- Chary A., Anne Kraemer Díaz, Brent Henderson, and Peter Rohloff. 2013. "The changing role of indigenous lay midwives in Guatemala: New frameworks for analysis." *Midwifery* 29(8):852–858.
- Comisión Nacional de Aseguramiento de Anticonceptivos. 2013. *Estrategia de Segmentación del mercado de anticonceptivos en Guatemala. Estimaciones de la demanda de planificación familiar en el corto y mediano plazo: Alcanzando la equidad en el acceso a servicios para el año 2025*. Guatemala City.
- Congreso De La República de Guatemala. 1997. Health Code. Guatemala.
- . 2002. Código Municipal, Guatemala.
- . 2010. Decree number 32-2010, Ley para la Maternidad Saludable. Guatemala.
- Crosby, D., B. O'Hanlon, and F. Armand. 2010. *Paraguay Assessment Report*. Bethesda, MD: SHOPS Project, Abt Associates.
- De la Cruz A., and N. Beyeler. 2013. *Tiendas de Salud, Guatemala, A qualitative evaluation of a micro-pharmacy franchise*. The Global Health Group, University of California San Francisco.
- Flores, Walter. 2008. *El Sistema de Salud en Guatemala ¿Así... funcionamos?* United Nations Development Program.

- Forgia G. 2005. *Innovaciones en el Sistema de Salud de América Central: Lecciones e Impactos de Nuevos Enfoques*. World Bank Working Paper.
- Foster J., J. Houston, V. Lamprecht, A. Anderson, G. Frenkel, and J. Cohen. 2014. *Midwives for midwives in Guatemala: weaving traditional and professional midwifery*.
- García Gómez O., E. Armendariz, A. Fros, N. Martínez, L. Alonso, M. López Prada, and J.J. Taccone. 2012. *The Bank's country strategy with Guatemala 2012-2016*. Inter-American Development Bank.
- Green T., H. Green, J. Scandlyn, and A. Kestler. February 2009. "Perceptions of short-term medical volunteer work: a qualitative study in Guatemala." *Globalization and Health*.
- Gutierrez E. n.d. *Guatemala 1985-2015, Análisis de tendencias y prospectiva, Documento de insumo sobre los contextos sociopolíticos y económicos para el proyecto, "La construcción social del futuro de la salud y la seguridad social en Guatemala."* Fundación DESC, United Nations Development Program.
- Institute for Reproductive Health, Georgetown University, for the U.S. Agency for International Development (USAID). 2013. *Using Most Significant Change Methodology to Evaluate Impact of a Health Innovation in Four Countries*. Washington, DC.
- Lao Peña, Christine. 2013. *Improving Access to Health Care services through the Expansion of Coverage Program (PED): The Case of Guatemala*. Washington, DC: World Bank.Measure Evaluation. 2014a. *The Western Highlands Integrated Program (WHIP) Evaluation Baseline Survey in Guatemala: A Case Study in Evaluation Practice*.
- MSPAS (Ministerio de Salud Pública y Asistencia Social). 2003. *Encuesta Nacional de Salud Materno Infantil 2002 (ENSMI-2002)*. Ministerio de Salud Pública y Asistencia Social (MSPAS)/Instituto Nacional de Estadística (INE)/Centros de Control y Prevención de Enfermedades (CDC). Guatemala.
- . 2010. *Encuesta Nacional de Salud Materno Infantil 2008 (ENSMI-2008/09). Informe Final: Mujeres*. Ministerio de Salud Pública y Asistencia Social (MSPAS)/Instituto Nacional de Estadística (INE)/Centros de Control y Prevención de Enfermedades (CDC). Guatemala.
- . 2011. *Encuesta Nacional de Salud Materno Infantil 2008 (ENSMI-2008/09). Informe Final: Hombres*. Ministerio de Salud Pública y Asistencia Social (MSPAS)/Instituto Nacional de Estadística (INE)/Centros de Control y Prevención de Enfermedades (CDC). Guatemala.
- . March 2012. *Diagnóstico Nacional de Salud*. Guatemala.
- . 2015. *Estrategia Fortalecimiento y Desarrollo del Primer Nivel de Atención*. PowerPoint. PSA Interview with Dr. Pablo Werner Ramírez, MSPAS. Guatemala.
- MSPAS (Ministerio de Salud Pública y Asistencia Social) Dirección General del SIAS. 2015. *Estrategia de Fortalecimiento y Desarrollo Institucional del Primer Nivel de Atención*. Guatemala.
- MSPAS (Ministerio de Salud Pública y Asistencia Social)/PAHO (Pan American Health Organization). 2013. *Segunda Medición de Metas Regionales de Recursos Humanos para la Salud: Informe Final*. Guatemala.
- Pan American Health Organization. 2007. *Perfil de los sistemas de salud Guatemala: Monitoreo y análisis de los procesos de cambio y reforma*. Third Edition. Washington, DC.
- Peña, Christine Lao. 2013. *Guatemala – Improving Access to Health Care Services through the Expansion of Coverage Program (PEC): The Case of Guatemala*. Universal Health Coverage (UNICO) Studies Series; No. 19. Washington, DC: World Bank.
- Replogle J. 2007. "Training traditional birth attendants in Guatemala." *The Lancet* 369 (9557):177-178.
- Secretaría de Planificación y Programación de la Presidencia República de Guatemala. 2010. *Tercer Informe de Avances en el Cumplimiento de los Objetivos de Desarrollo del Milenio*. Guatemala City.
- UNICEF (United Nations Children's Fund). 2013a. *The State of the World's Children 2013*. New York.

- . 2013b. *Annual report 2013 – Guatemala*.
- USAID. 2012. *Guatemala country development cooperation strategy 2012-2016*. Guatemala City.
- USAID GeoCenter. 2015. *Geographic Analysis of MSPAS Infrastructure and Supply Chains*. With inputs from: USAID HPP Project, MSPAS, SIAS, and Oak Ridge National Lab.
- USAID Guatemala. 2013. *Integration of USAID in the Western Highlands*.
- Valenzuela López, C. 2014. *La cooperación internacional para el desarrollo y las alianzas público-privadas en los servicios públicos de salud en Guatemala*. Guatemala City: Universidad Rafael Landívar.
- Verdugo, J.C. et al. 2002. *Hacia un primer nivel de atención en salud incluyente – bases y lineamientos*. Guatemala: Instancia Nacional de Salud.
- WHO (World Health Organization). 2004. *Making Pregnancy Safer: The Critical Role of the Skilled Attendant*. Geneva.
- . 2012. *Global Health Observatory Data Repository*. Geneva.
- . 2014a. *Guatemala Health Profile*. Geneva.
- . 2014b. *World Health Statistics Report*. Geneva.
- . 2014c. *The State of the World's Midwifery*. Geneva.
- World Bank. 2015. *World Development Indicators*. <<http://data.worldbank.org/data-catalog/world-development-indicators>>.