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Establishing and Sustaining Government Financing for Contraceptives in Guatemala

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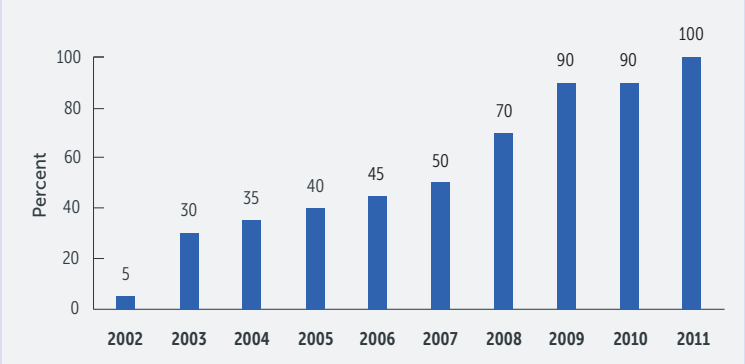
More than a decade ago, Guatemala passed landmark legislation that provided permanent funding to the Ministry of Health's family planning and reproductive health program. While family planning advocates may have thought these resources secure, a member of congress introduced a bill in 2016 to redirect this funding to primary healthcare, citing "poor budget execution," or under-spending, as justification—a common rationale for redirecting public funds. Civil society and government advocates countered the charge by demonstrating that approximately 70 percent of the US$7.3 million assigned for these services in 2016 had been spent; the remaining funds were committed and would be spent when contraceptive shipments entered the country. Working with the Human Rights Ombudsman, supporters convinced the member of congress who introduced the bill to formally retract it (HEP+, 2016; Institución del Procurador de los Derechos Humanos, 2016; Villaseñor, 2016).

This episode showcases the resiliency of Guatemala's longstanding effort to finance public family planning services. In an era of shrinking and finite donor resources, Guatemala provides a heartening example of how civil society and government champions can work together to secure funds for contraceptives. These efforts also helped the government eliminate its reliance on external donor assistance for family planning and reproductive health services, including commodity donations.

Transitioning from Donor- to Government-Financed Contraceptives

In 2001, the government of Guatemala began planning to progressively increase its share of contraceptive purchases, phasing out donations from the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA). The following year, the Ministry of Health, Guatemala's primary public provider of family planning, began to shift from near total reliance on donated contraceptives to fully financing its commodity needs (see Figure 1). The Guatemala Social Security Institute, the country's other public provider of family planning services, was fully financing its contraceptive purchases by 2007. These transitions took place even as the government assumed management of family planning services for most of the country's contraceptive users, especially impoverished, rural, and indigenous populations (Santiso-Gálvez et al., 2015). During the transition period, modern contraceptive use among married women also increased, from 34.5 percent in 2002–2003 to 44 percent in 2008–2009, and continued to rise, with almost 49 percent of women in union using modern methods by 2014–2015 (MSPAS et al., 2017).

Figure 1. Share of Payment for Contraceptives Covered by the Ministry of Health



Sources: De la Cruz, 2016; MSPAS and UNFPA, 2010

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Establishing the Funding Source for Contraceptives

As the government paid for an increasing share of its contraceptive costs, it also passed national laws to ensure more equitable access to family planning and maternal and child health services. Civil society advocates played a critical role in spurring the development and passage of this legislation (Health Policy Initiative, 2012). Notably, in 2004, the government modified the Distribution of Distilled Spirits, Beer and other Fermented Beverages Law to allocate 15 percent of alcohol tax revenue to reproductive health, family planning, and alcoholism programs.

Other laws followed that further strengthened financing for contraceptives. The 2005 Law on Universal and Equitable Access to Family Planning featured two important provisions for financing. One required that the Ministry of Health create a budget line item for the alcohol tax revenue, thus making the funds trackable. A second provision established a Commission for Contraceptive Security to monitor compliance with the law. The commission, with representatives from nine public and private organizations, would monitor resources for contraceptives, identify procurement mechanisms, and help coordinate contraceptive logistics. Further, the 2010 Safe Motherhood Law required that the ministry spend at least 30 percent of the 15 percent alcohol tax revenue on contraceptives each year (Reyes et al., 2013; Santiso-Gálvez et al., 2015).

Addressing Challenges to the 2005 Law and Modern Contraceptives

Since the 1960s, conservative and religious groups have opposed modern contraceptive use in Guatemala. The 2005 Law on Universal and Equitable Access to Family Planning proved especially controversial and was quickly vetoed by the president. Congress overrode the veto in 2006, but multiple legal challenges prevented its implementation. The law would not be enforceable until 2009, when the Constitutional Court dismissed the legal challenges and upheld the law and its operational regulations (Health Policy Initiative, 2012).

Civil society groups and government champions played a major role in defending the 2005 law. Many of these advocates had been trained and supported through successive USAID-funded policy projects. Supporters pressured Congress, the constitutional court, the president, and other senior policymakers. They engaged regularly with journalists and carried out public education campaigns to keep the issue on the policy agenda.

During this period, a strong coalition of support for family planning took shape. Prominent country advocates included the Network of Women for Peace, the National Alliance of Indigenous Women for Reproductive Health, the Organization for Women's Health and Development, and the Guatemalan Association of Female Physicians, among others. These advocates, seasoned and media-savvy following years of challenges to family planning, recruited allies in Congress. In 2006, advocates spurred the creation of the contraceptive security group mandated in the 2005 law, an important accountability mechanism. Also, 2008 marked the inception of another "watchdog," the National Reproductive Health Observatory, comprised of members from government and civil society. The following year, the National Commission for Contraceptive Security was legally established. In subsequent years, local affiliates of the two accountability mechanisms formed at the subnational level as well (Health Policy Initiative, 2012; Santiso-Gálvez et al., 2015).

Funding Generated from the Alcohol Tax Revenue

From 2006 to 2016, the Ministry of Health received US$56.6 million from the alcohol tax revenue for reproductive health, family planning, and anti-alcoholism programs (Ministerio de Finanzas, 2017). During this period, the amounts the ministry received and spent on contraceptives can be tracked for most years (see Figure 2). The data suggest considerable variation in annual contraceptive purchases, even after the 2010 law passed that required 30 percent of the 15 percent tax revenue be spent on family planning commodities. In 2011, 2014, and 2015, spending on contraceptives was approximately US$1.2 million, US$915,000, and US$1.3 million, respectively—below the 30 percent target mandated by law. But in 2012, 2013, and 2016, annual spending on contraceptives exceeded the target. Since a balance from one year may be paid the following year, it is difficult to monitor adherence to the annual target. In total, since the 2010 law passed, the Ministry of Health has spent approximately US$11.7 million on contraceptives from 2011 to 2016, or 32 percent of tax revenue received.

Figure 2. Ministry of Health Alcohol Tax Revenue Allocations and Contraceptive Spending

Notes: Figures are rounded; annual average exchange rates used for each year; data unavailable for 2008 and 2010 (Ministerio de Finanzas, 2017).

Although funds were available from alcohol tax revenue in 2008, the Ministry of Health was unable to pay UNFPA for contraceptives (Santiso-Gálvez et al., 2015). Thanks to a Ministry of Finance representative on the Contraceptive Security Commission, commission members learned of a law regulating the transfer of public funds to nongovernmental organizations. Originally intended to control public spending on infrastructure projects, this Ministry of Finance decree constrained the government from purchasing health commodities from international agencies such as UNFPA, the World Health Organization (WHO), and the Pan American Health Organization (PAHO). These agencies offer health products at below-market prices because they purchase in bulk and are exempt from value-added taxes. The contracting law prevented cost-efficient purchases of not only contraceptives, but also vaccines, antiretroviral drugs, and micronutrient supplements (Health Policy Initiative, 2012).

Purchasing contraceptives through UNFPA meant substantial cost savings (see Table 1). In 2009, based on the purchase amounts needed, the UNFPA price for injectables and pills was around US$1.1 million—approximately $2.8 million less than the open market price. Procurement through UNFPA would enable the Ministry of Health to finance its contraceptive purchases with alcohol tax receipts (Santiso-Gálvez et al., 2015). Each year from 2010 to 2014, the Contraceptive Security Commission, the Congressional Health Committee, and civil society advocates successfully campaigned for an exemption to the contracting law to allow procurement of contraceptives and other commodities through international agencies. In November 2015, Congress amended the law permanently to require that contraceptives and essential drugs be purchased from the lowest cost provider regardless of source (Health Policy Initiative, 2012; Health Policy Project, 2016).

Table 1. Ministry of Health Savings from Purchasing Injectable and Oral Contraceptives from UNFPA in 2009 (US$)*

	UNFPA PRICE ($)	OPEN MARKET CONTRACT PRICE ($)**	AMOUNTS PURCHASED	TOTAL UNFPA PRICE ($)	TOTAL OPEN MARKET PRICE ($)	DIFFERENCE ($)
Injectables	.782	2.19	1,298,532	1.0 million	2.8 million	1.8 million
Oral contraceptives	.299	2.42	455,159	136,000	1.1 million	965,000
Total				1.1 million	3.9 million	2.8 million

** Exchange rate from 2009 = US$1 to GTQ8.2*
*** Mechanism for national purchases used by government institutions. Totals for UNFPA and open market prices are rounded.*
Source: Authors' calculations based on UNFPA and government data on contraceptive needs and prices.

Lessons in Sustaining Government Financing for Contraceptives

Guatemala has had remarkable success in mobilizing public resources for family planning and reproductive health. Even as the government transitioned off of donor assistance for contraceptives, it has been able to meet the needs of a growing population of clients that include the most impoverished people in the country (Santiso-Gálvez et al., 2015; Health Policy Project, 2016). A key lesson learned is that a strong legal framework for financing services and supplies, while critical, may not be sufficient to sustain government funding. Health programs exist within competitive public financing environments. In Guatemala, several key interlocking components have been instrumental in helping sustain contraceptive financing: motivated civil society organizations, effective advocacy, policy dialogue, long-term donor technical support, strong policies and regulations, and joint civil society-government monitoring of policies.

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