Guatemala, Reproductive Health and the UNFPA (Part A)

Dr. Raul Rosenberg leaned back in his chair while sipping a dark blend of Guatemalan coffee. He arrived at the UNFPA office earlier than normal on an overcast July 2000 morning in hopes of sorting out the thoughts swimming through his head. Early in January of 2000, he was named as the Director of Reproductive Health for the UNFPA office in Guatemala. He had spent the past few months mulling over the reproductive health situation in Guatemala in hopes of creating a strategy that would enable the passage of reproductive health legislation. In 1993, reproductive health legislation was approved in the crucial, third meeting of the Congress of the Republic, but was eventually vetoed by President Jorge Serrano Elias due to strong opposition from conservative groups. With the exception of the 1993 initiative, the last decade had brought little advancement in policy for reproductive health in Guatemala. The coming weeks would be critical for Dr. Rosenberg in evaluating the reproductive health situation, especially the political situation surrounding reproductive health. He had scheduled a meeting at the end of July with Hendrik VanderPol, the head official for the UNFPA in Guatemala, to decide on the next steps for passing a new law.

Once again, Dr. Rosenberg reviewed the health situation facing Guatemala.

Health and Social Indicators

Guatemala's unstable and tumultuous history, beginning in the days of the Spanish conquistadors and lasting throughout the devastating 36-year civil war ending in 1996, has permeated every aspect of Guatemalan life. Health and social indicators are no exception.

Guatemala is the most populous country in Central America and has a unique ethnic division; 55% of the population is Mestizo/Ladino (mixed Amerindian-Spanish or assimilated Amerindian) and 43% Amerindian or indigenous population. The population growth rate in 2001 was estimated at 2.6%, demographically represented by a large percentage of individuals between the ages of 0-14 years (42.11%). The life expectancy in Guatemala continues to be lower than most Central American countries, with men living to an average of 63.85 years and women living to an average of 69.31 years.

For many developing nations, population growth and poverty go hand-in-hand. In 2000, the World Health Report ranked Guatemala 159th of 191 countries in terms of health care distribution and equity. The National Study on Living Conditions conducted in 2000 reported that 57% of the Guatemalan population lives in poverty (less than two dollars a day), 27% of the population lives in extreme poverty (less than one dollar a day), and a large percentage of the Guatemalan population faces high rates of social discrimination.[1] There are distinct differences in the quality of life and health

[1] ENCOVI Reportaje 2000

This case study was prepared by Beth A. Knowlton at the Harvard School of Public Health under the supervision of Dr. Raul Rosenberg at the UNFPA office in Guatemala, and Professor Michael R. Reich at the Harvard School of Public Health. Funds for preparation of this case were provided by the Saltonstall Population Innovation Fund at the Harvard Center for Population and Development Studies and the UNFPA.

and social indicators between the Ladino population and the indigenous population. Poverty is especially prevalent in rural areas where mostly indigenous people live; in 1989, 93% of the indigenous people lived in poverty, while 91% lived in extreme poverty.[2] By contrast, 66% of the Ladino population lived in poverty, and 45% lived in extreme poverty.

Guatemala also has one of the highest maternal mortality rates in Latin America, 190 per 100,000 live births, and infant mortality rates, 46 per 1,000 live births. In fact, Guatemala is surpassed by only Bolivia and Haiti for the highest rates of infant and maternal mortality in the Southern Hemisphere. The high maternal mortality and morbidity rates are influenced by the above-average fertility rate (an average of 5.1 children per mother, 6.2 children per mother in rural areas, and 3.8 children in urban areas), low levels of education, limited access to information on reproductive health issues, the small percentage of married women between the years of 15-49 who use some method of family planning (38%), and an unmet need for family planning services among reproductive age women (26%). In addition, limited access, scarce coverage and rudimentary offerings of basic health services also influence the high maternal and infant mortality rates.

Why high fertility?

High fertility in Guatemala is attributed to a variety of factors. Indigenous people living in rural areas oftentimes desire many children. Low education levels and lack of demand and usage of contraception also contribute to high fertility rates.

Guatemala lacks government sponsored social security, which encourages parents to have more children as a means of survival and income in their later years. Many indigenous children begin work at an early age in formal and informal sectors by selling food and goods. In addition, indigenous families living in rural areas, where agriculture is the way of life, require additional assistance in the fields to meet specific crop goals and deadlines. Younger female children are often required to take care of the other children in the household, while male children and adults work in the fields. Larger families promise both a greater source of income and a safety net for parents.

Cultural norms and expectations in indigenous communities also foster high fertility rates. Male heads of households with large families consisting of many sons are highly regarded by community members. Men, over spousal objections, oftentimes prohibit their wives from seeking family planning methods. In fact, men will sometimes abandon their wives if they try to seek family planning services. An article printed in the Guatemalan *Free Press* (*Prensa Libre*) highlights this issue. The article entitled "Women without power decide"(Mujeres sin poder decider) narrated the experience of a 38 year-old woman who had borne 11 children and undergone three abortions. Another pregnancy for this woman could mean death because her body could no longer handle the "weight" of childbearing. The mother was aware of reproductive health programs offered by the government, but she was afraid to seek services fearing that her husband would not approve of them and abandon her. These fears have contributed to a variety of her reproductive health problems.[3]

[2] Country Health Profile Guatemala 1999 from http://www.paho.org/english/HSA/prflgut.htm
[3] "Mujeres sin poder decider," *Prensa Libre*, 21 January, 4.

Guatemalan behaviour is also influenced by religious orientation. The majority of individuals living in Guatemala follow Roman Catholicism, Protestantism, or traditional Mayan beliefs. Religious traditions can also influence desired fertility for both indigenous and Ladino individuals. Many people see the number of children they conceive as a reflection of "God's will" reasoning that their family is blessed with fecundity. Many women also do not believe in family planning methods due to religious, especially Catholic, influences.

Social factors like socio-economic status and education are also associated with fertility. Cross-sectional studies from the Demographic and Health Surveys in over 60 nations have shown the link between more schooling and lower fertility.[4] For example, women in Kerala, India, continue to live in economically poor surroundings, but have an exceptional educational system in which women are not only taught about various reproductive health methods, but also about their value as human beings and the importance of investing in their children. As a result of increased and improved female education, Kerala has lower fertility rates than any other region in India (TFR = 1.8, compared to average TFR in India = 3.06).[5] Guatemala, on the other hand, demonstrates the other spectrum of the relationship between education and fertility. According to the CIA World Factbook in 2000, over 40% of Guatemalan women are illiterate and primary school enrollment rates are considerably lower for females than for males. Illiteracy rates are even higher and more pronounced for indigenous women living in rural areas. In 2001, the TFR in Guatemala was an average of 5.1 children, with an average of 6 or more children in rural areas. Women are unaware of the availability of contraceptives and uninformed about the advantages of having smaller families in order to invest in the education and upbringing of their children. A great deal of ignorance, especially concerning modern methods of contraception, exists in the country. Many women continue to believe that the birth control pill is a form of abortion because members of the church and other groups have printed this misinformation in newspapers.[6]

Overall, Guatemala has an extremely low contraceptive prevalence rate. In 1995, it was estimated that out of the total population of women at reproductive ages, 5% were using traditional methods while 26% were using modern methods of contraception; female sterilization was surprisingly the preferred method of contraception, 14.5%, while only 5.7% of women chose to use contraceptive pills and condoms.[7] The best candidates for family planning services or contraceptive methods have proven to be the groups of women with the lowest education levels, primarily indigenous women. When Indian women were surveyed in 1983 concerning their form of contraception, 48% of these women cited a lack of knowledge or ability to obtain contraceptive methods as their reason for non-use. In contrast to indigenous women, the most frequent response for non-usage by Ladino women was fear of contraceptive side effects or a general fear of contraception.[8]

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[4] Monteith, Richard, Oberle, Mark. "Contraceptive Use and Fertility in Guatemala," *Studies in Family Planning*, 16-5(September-October 1985): 282.
[5] CIA World Factbook from http://www.cia.gov
[6] "Planificacíon familiar," *Prensa Libre*, 20 January 2000, 10.
[7] "Guatemala con tasa màs alta de fecundidad en América," *Cronica de Guatemala*, 23 January 2000, 34.
[8] Monteith, Richard, Oberle, Mark. "Contraceptive Use and Fertility in Guatemala," *Studies in Family Planning*, 16-5(September-October 1985): 282.

Guatemala also has a large unmet need for family planning and contraceptives. Overall, there is a 23.1% average of unmet need for contraception or family planning methods in the country. The breakdown is as follows: 26.9% unmet need for rural areas, and 18% unmet need in urban areas, while there is a 30.2% unmet need for indigenous populations and a 19.8% unmet need for Ladino populations.[9] This unmet need for family planning can be attributed to a lack of supply of contraceptives, especially in rural areas, and is also caused by the long distances that women must travel between rural and urban areas to access family planning services. Men tend to dominate women's reproductive lives, leaving them with a discrepancy between their desired and actual family planning needs. The unmet need for contraception has had a devastating effect on the lives of the women and children of Guatemala, especially since women in reproductive ages and younger than 18 years old constitute 2/3 of the total population of women.[10]

Why are women and children dying?

According to the ENSMI (National Statistics Institute) study conducted in 1998/1999 only 47.5% of pregnant women have the financial resources and capability of seeking pre-natal care from a physician, while 12.1% seek care from a nurse and the other 26.7% seek care from a mid-wife. This lack of physician accessibility and professional care has contributed to the major causes of both maternal and child mortality in Guatemala. Maternal mortality is caused by diseases or complications that can easily be remedied; haemorrhages (40%) account for the largest percentage of maternal mortality, while complications from abortions (21%), sepsis (17%), toxemia (14%), and unknown reasons (8%) are also contributors. Guatemala also has high rates of teenage pregnancy. The study also showed that 44.3% of 19 year-olds were pregnant, with only 9.2% of them finishing their secondary education. It is well documented that both maternal and infant mortality rates increase when births take place at very young and old ages, and when birth spacing is shortened.

Guatemalan children also face high levels of malnutrition and other curable diseases that routinely go untreated, leading to an above average amount of child deaths. The leading causes of infant mortality in 2001 were in conditions in the perinatal period (50.5%), pneumonia (17.0%), diarrehea (8.8%), and malnutrition (2.3%).[11]

Past Experiences with Reproductive Health and Population

In the 1960s, reproductive health and family planning programs were developed only in the private sector of Guatemala, mainly due to effective opposition against including these services in basic public health programs. Overall, these private services had little support and limited impact. Furthermore, in the last thirty years, the topic of population was only briefly mentioned in various laws or national plans for development as a means to an end. International organizations like USAID believed that population control was necessary for developing countries to advance economically, and reproductive control was viewed as the means to achieve population reduction.

[9] ENSMI Reportaje 1998/99
[10] Planificacion familiar" *Prensa Libre*,20 January 2000, 10.
[11] Country Health Profile-Guatemala from http://www.paho.org/english/HSA/prflgut.htm

With the growing concern about population explosion issues in developing countries in the 1970s, USAID provided financial support for family planning services in Guatemala through APROFAM (Asociacíon Pro-Bienestar de la Familia), a local NGO, in hopes of initially covering urban areas and then expanding reproductive health services to rural areas. Despite reproductive health/family planning media campaigns and financial backing from international organizations, family planning and other reproductive health services still only covered 12% of married women in reproductive ages in the year 2000.[12]

In the 1970s, the Ministry of Health included family planning programs as part of Maternal and Child health programs. These services had limited coverage, principally due to the lack of institutional support, scarce promotion, and limited reproductive health services in relation to other basic health services that were provided. Although these services provided limited coverage, the increased offering and incorporation of family planning and reproductive health services into Maternal and Child health programs created an opportunity to implement integrated health programs for women. Then during the 1980s, development plans and programs created by SEGEPLAN (Secretary of Planning and Programming for the President) initiated the incorporation of population into the analysis of national problems.

The advances made in the 1980s created an environment where a population and development initiative might be started that could include reproductive health and population issues. For example, the Commission of Intersectoral Education and Population (CIEP) was formed by civil society groups in 1992. With the support of the Catholic and Evangelical churches, CIEP was a success, and population issues, including some reproductive health education, were included in the Guatemalan educational system. In the 1980s, the reputation and the involvement of the UNFPA in national affairs continued to improve. In 1993, a reproductive health and population initiative was created with the support of the UNFPA and other traditionally supportive groups. The Congress of the Republic approved the initiative in the third session, yet the initiative encountered strong opposition by powerful organizations like the Catholic and Evangelical Churches, (as much opposition from the Catholic as from the Evangelic) lay religious groups and conservative sectors of civil society that considered the law to be outside the realm of the state. Although the law was approved in the third meeting of Congress, the law was immediately vetoed by Jorge Serrano Elias, the President of the Republic. The reputation of the UNFPA suffered after the initiative was rejected, and the Guatemalan government and churches looked upon the organization as a threat, concerned only with reproductive goals and not human development.

The success of groups opposed to reproductive health legislation had a significant impact on the decision making capacity of the government towards population themes, especially reproductive health. Opus Dei, Pro Vida, and other conservative organizations continued to influence the government when making political decisions. One of the most important effects in this process was the lack of support and representation of the Guatemalan government in the 1994 ICPD accords in Cairo. The ICPD accords were viewed by members of the Catholic Church, Opus Dei, Bioetica and other groups within Guatemala as a means of opening the door for abortion.

[12] Country Health Profile-Guatemala from http://www.paho.org/english/HSA/prflgut.htm

Within the government, many advances made in the 1980s were lost during the 1990s. Population themes were practically eliminated from the process of planning, and population data were only used for statistic references. The activities of family planning within the Ministry of Health were reduced significantly, and reproductive health services were limited to pregnancy and post-pregnancy issues.

The Peace Accords of 1996

From 1960 to 1996, Guatemala faced a gruelling civil war which affected almost all citizens living in Guatemala. The population was divided between poorer working classes in rural areas and rich individuals in urban areas. Throughout this period, the Guatemalan army used scorched earth tactics to burn entire indigenous communities, killing a large percentage of the general population, to identify the rebels involved in the anti-government activities. A series of military dictatorships and coups characterized the 1980s and 1990s. At the end of the war, over 200,000 Guatemalans had been killed, a million made homeless, and untold thousands had disappeared.

On December 29, 1996, the Peace Accords, known as "A Firm and Lasting Peace Agreement," were signed ending the 36-year civil war. The Peace Accords emphasized the importance of development and human rights, opening the discussion and the incorporation of population themes and reproductive health issues into the government agenda. Maternal mortality reduction was a specific goal of the Peace Accords, along with the provision of integrated health services for women and the improvement of women's educational levels. The Peace Accords also included specific recommendations to reduce gender inequalities in economic, social and legal areas.

Using the 1996 Peace Accords as a point of reference, changes in legislation and governmental work plans began to include population themes. In the health field, the 1996 revised health code focused on the creation of integrated services to improve women's health, activities of reproductive health, and family planning services offered within public health settings. The new health law had important advances for gender relations and the civil code modified articles that discriminated against women in the area of the administration of family welfare and the child responsibility. Furthermore, the civil code created a law for the advancement of women and detailed a plan of equality for women's opportunities. In the education field, CIEP (Commission of Intersectoral Education and Population) was legalized through government agreements, and population activities were included in the primary level of public schools.

After the national elections in December 1999, the government included in its work plan the need to support the right of women's integrated reproductive health services. One of the first actions announced by the Minister of Health in 1999 was the promotion of information and education in reproductive health and family planning to be implemented with the help of international aid. The government's agenda specifically stated that the reduction of maternal mortality and the organization of reproductive health services was a national goal; national health coverage would be a means to achieve this goal. Furthermore, Zury Rios, the daughter of former President Ríos Montt, and a respected women's advocate, was appointed as the vice president of the

Congress of the Republic. With these changes in government, an opportunity emerged for a reproductive health strategy to be implemented.

At the same time, members of the international community expressed grave concerns at the reproductive health situation in Guatemala. "The human right of every person to access family planning services and information has been affirmed by the international community at UN conferences beginning in 1968," said Katherine Hall Martinez, Deputy Director of the International Program at the Center for Reproductive Law and Policy (CRLP) at the UN Human Rights Conference in New York City. She continued, "It is deplorable that the government's lack of political will to address this right continues to be at issue over 30 years later."[13] The United Nations Human Rights Committee stated on August 1, 2001 that Guatemala should legalize abortion. "The committee complained that the criminalization of abortion creates serious problems, mainly in light of uncontested information on the high incidence of maternal mortality, of clandestine abortions, and the lack of information on family planning."[14] The important role of the UNFPA throughout this debate was emerging.

Reflecting on the problems of Guatemala, Dr. Rosenberg took a deep breath. His own life experiences had been shaped by the events of the last thirty years in Guatemala. He had received his medical training in obstetrics/gynecology in Guatemala during the height of the civil war, and then worked as an obstetrician/gynecologist in Brazil (1982) and Mexico (1983-85). In 1986, Dr. Rosenberg returned to Guatemala to work as the Secretary of Reproductive Health for the Guatemalan Ministry of Health until 1992. In December of 1992, he was hired by UNFPA/UNESCO as a consultant for education and population topics. At the beginning of his consultancy, Dr. Rosenberg worked closely with three other UNFPA officials, identifying 20 civil society institutions involved in education issues, including the Catholic and Evangelical churches. From January to April in 1992, the UNFPA created strategies and arguments to approach members of the churches and sensitize them to population/reproductive health issues. In 1993, the Minister of Education officially recognized the efforts of the UNFPA and other civil society institutions, giving these institutions the responsibility of executing, evaluating and creating the curriculum for population education in the country. At the end of 1994, the Commission of Intersectoral Population and Education (CIEP) was approved by Ramiro de León Carprio, the interim President of the Republic. These experiences working as a consultant for the UNFPA in the early 1990s and then in Ministry of Health taught Dr. Rosenberg the importance of political processes in formulating health and education policy agendas. He hoped to draw on these experiences to address obstacles he foresaw with the reproductive health agenda in Guatemala.

Dr. Rosenberg wanted the reproductive health agenda to include reproductive health as part of a more comprehensive population law that would address less controversial

[13]"Family Planning in Guatemala Falls Woefully Short," *CRLP Press*, 30 November 2000, from http://wwww.crlp.org/pr_00_1130guatre.html

[14]"Family Planning in Guatemala Falls Woefully Short," *CRLP Press*, 30 November 2000, from http://wwww.crlp.org/pr_00_1130guatre.html

issues like education, migration and disaster prevention. Dr. Rosenberg thought that the following changes were what Guatemala needed for reproductive health:

- create a national reproductive health program by expanding reproductive health services to rural areas and also increase reproductive health services in urban areas
- enhance obstetric emergency services, family planning services, cervical cancer and other cancer screenings
- increase reproductive health information to both men and women throughout the country
- require clinics to teach safe motherhood classes throughout the country
- improve reproductive health information on reproductive issues and decrease reproductive health misinformation
- create a national prevention program, including educating the population, for HIV/AIDS

He considered a new law on reproductive health but one that would not include any language that would support or approve abortion, due to the strong conservative nature and influence of the Catholic Church within Guatemala.

Dr. Rosenberg identified the following problems with this approach, based on past experiences with reproductive health legislation.

1. Past experience showed that population and reproductive health proposals had only been created with the participation of traditional allies, like USAID and APROFAM, and had not been successful. The opposition sectors, especially the Catholic and Evangelical Churches, rejected every proposal presented in this manner and undermined efforts to approve a new law in 1993.

2. In the past, attempts had been made to gain agreement from polarized groups, but Opus Dei and Bioetica had refused to work with feminist organizations or groups like APROFAM that promoted family planning services. The polarization around principles and ideologies made it difficult to bring these groups to the table for negotiation.

3. There existed a strong perception that institutions promoting the themes of population had a double agenda. This climate of mistrust affected the level of social participation and institutional support. The government and religious organizations were highly suspicious of the population activities of groups like USAID and APROFAM, and did not want to work with them on population goals.

4. Some indigenous groups, such as Coordinadora Nacional de Viudas de Guatemala, believed that organizations like USAID and UNFPA were trying to exterminate their heritage by forced family planning measures that would limit their population growth.

5. The interventions of international agencies in Guatemala seemed to produce a rejection of proposals at all levels of society. This was mainly due to the

widespread belief that international involvement and foreign proposals did not respond to national interests.

6. With the exception of the 1993 proposal, the Guatemalan Congress of the Republic had expressed little interest or political will with reproductive health legislation. In addition, the Guatemalan President of the Republic had the ultimate power to veto potential legislation, despite the rulings of Congress.

In order to address the above problems, Dr. Rosenberg listed important institutions that could be involved in a process of mobilizing support for policy changes (see list of players). He would need to work with these groups, especially the Congress of the Republic, to make any progress. The question was, how could he accomplish this? While thinking about his strategy, Dr. Rosenberg created a series of slides he could use to discuss the importance of maternal and infant mortality to these civil society organizations (see attached slides).

Case Study Questions:

1. What were the main problems associated with reproductive health in Guatemala in the 1990s?

2. What contributed to these problems?

3. What change improved the chances of reproductive health legislation in the late 1990s? What could Dr. Rosenberg do to enhance the political feasibility of his proposal?

4. What problems do expect Dr. Rosenberg to encounter with his new strategy? How could he overcome these problems?

5. How could problems of implementation be addressed?

Guatemala, Reproductive Health and the UNFPA (Part A)
EXHIBITS

Players as of July 2000

Academic Institutions (*Universidad de San Carlos, Universidad Rafael Landivar, Universidad de Valle, Universidad Mariano Galvez*)-These academic institutions are interested in promoting and participating in development issues.

Alfonso Portillo-Alfonso Antonio Portillo was elected as President of the Guatemalan Republic and assumed office on January 14, 2000 as part of the Guatemalan Republican Front (FRG) party. He is the chief of state and the head of the Guatemalan government.

APROFAM (*Asociación Pro-Bienstar de la Familia de Guatemala)*-A Guatemalan NGO that is actively involved in family planning services; this groups is considered to be suspicious by the government.

CACIF-A large and very powerful cooperation between national business in Guatemala; this group has a lot of financial power and connections in every sector of the government.

Association of Gynecology and Obstetrics-This organization is combined mainly of physicians and is in favor of reproductive health legislation.

CODEDENA-A conservative Catholic organization that opposes any form of reproductive health legislation.

Ministry of Education-The Minister of Education favors education policy, and is willing to incorporate sexual education into regular school curriculum.

UNFPA-A prominent international organization very involved in development issues in Guatemala. The reputation and the involvement of the UNFPA in Guatemalan affairs have increased over the past few years.

Indigenous groups (*Coordinadora Nacional de Viudas de Guatemala, CENOC, Academia de las Lenguas Mayas*)-Indigenous groups generally feared reproductive legislation, believing that the government wanted to exterminate the indigenous population.

Catholic Church, CEG (Episcopal Conference of Guatemala)-The CEG is opposed to abortion issues, and somewhat hesitant to discuss reproductive health issues with civil society groups.

Evangelical Church-The Evangelical Church wants to promote individual free will and choice, not forced decisions; this philosophy also applies to reproductive health choices.

Juan Reyes- The Vice President of the Republic, elected at the same time as President Portillo and took office on January 14, 2000.

Women's organizations (*Secretaría de Presidencial de la Mujer, Converencia Cívico Política de Mujeres*)-These are very vocal organizations about women's health and rights; these groups also have a good relationship with Zury Ríos, the Vice President of Congress.

Opus Dei/Pro Vida- A conservative Catholic group that has traditionally held a lot of power in Guatemala due to family ties with the government. This group is opposed to all reproductive health legislation. Mercedes Wilson is a vocal member of Pro Vida.

Ríos Montt-He is a former President of the Republic who took power during a military coup in 1982; he formed the FRG party, and is now the current President of the Guatemalan Congress.

Zury Ríos Montt- She is Ríos Montt's daughter, and the current Vice President of Congress. She is a dynamic leader, with a lot of power and political intentions in Congress. Ms. Ríos is a women's issue activist.

Minister of Health – Mario Bolaños, the MOH, is extremely interested in promoting reproductive health issues during his time in office.

SEGEPLAN-The Secretary of Planning for the President (SEGEPLAN) is the counterpart to the UNFPA in Guatemala; this organization will promote reproductive health legislation in the country.

USAID-USAID has a large and influential presence in Guatemala dating back to the 1970s. Although this organization is interested in promoting reproductive health issues, USAID is not trusted by some Guatemalan church leaders and government officials.

*INDICATORS RELATED TO ICPD & ICPD+5 GOALS**

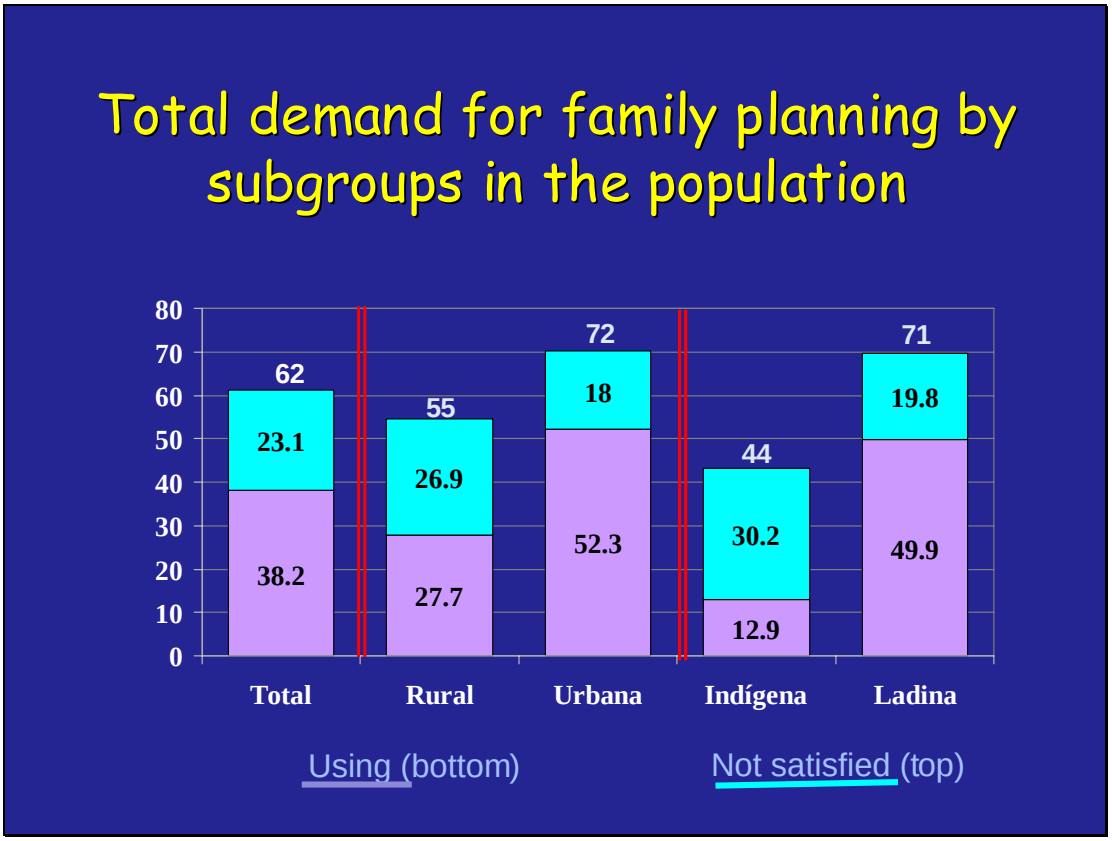
		Thresholds*
Births with skilled attendants (%)	35	≥60
Contraceptive prevalence rate (%)	31	≥55
Proportion of population aged 15-24 living with HIV/AIDS (%)	1.04	≤10
Adolescent fertility rate (per 1,000 women aged 15-19)	119.3	≤65
Infant mortality rate (per 1,000 live births)	46	≤50
Maternal mortality ratio (per 100,000 live births)	190	≤100
Adult female literacy rate (%)	57	≥50
Secondary net enrolment ratio (%)	83	≥100

***Source:* Executive Board of the United Nations Development Programme and of the United Nations Population Fund-Guatemala Report, November 21, 2000; 1**

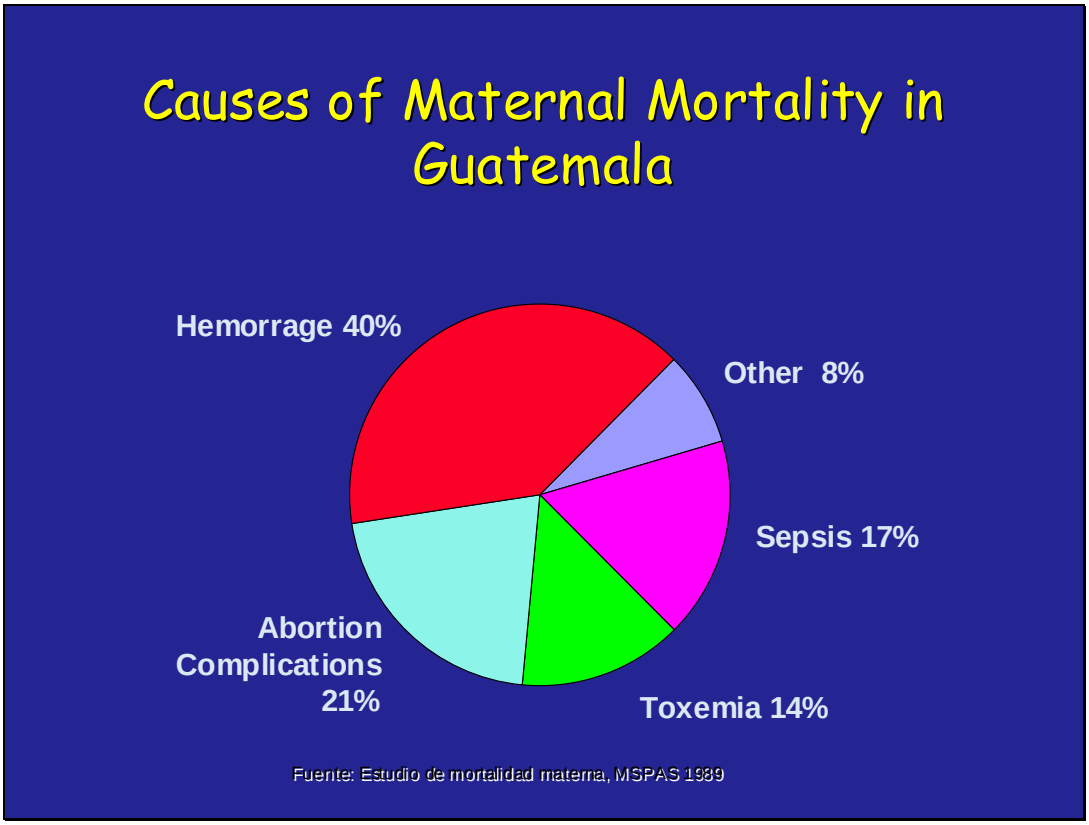
Compared to other Central American countries, Guatemala ranks 4th for GDP per capita; annual GDP growth rates are in parentheses.

1. **Panama-(1.4%) $8,500**
2. **Costa Rica-(0.3%) $5,900**
3. **El Salvador-(1.4%) $4,600**
4. **Guatemala-(2.3%) $3,700**
5. **Belize-(3%) $3,250**
6. **Honduras-(2.1%) $2,600**
7. **Nicaragua-(2.5%) $2,500**

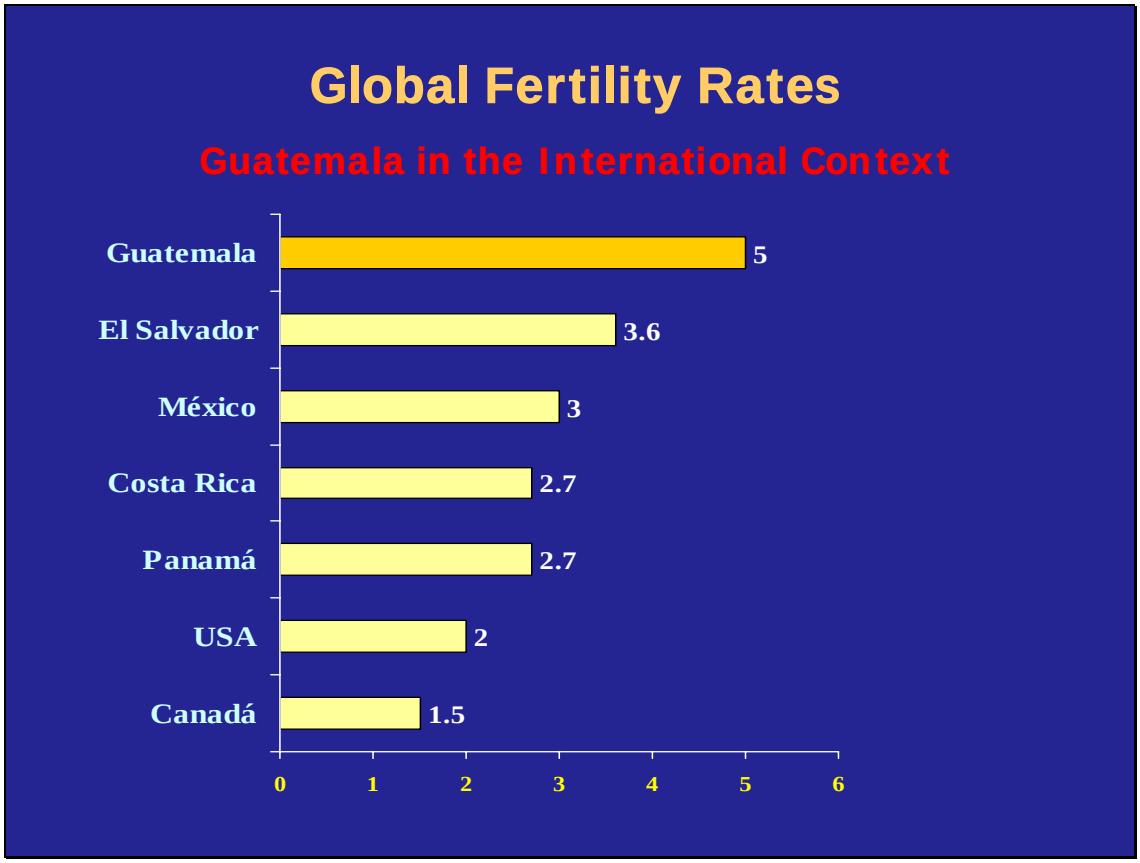
Slide 1


Total demand for family planning by subgroups in the population
80
70
60
50
40
30
20
10
0
62
23.1
38.2
55
26.9
27.7
72
18
52.3
44
30.2
12.9
71
19.8
49.9
Total
Rural
Urbana
Indígena
Ladina
Using (bottom)
Not satisfied (top)

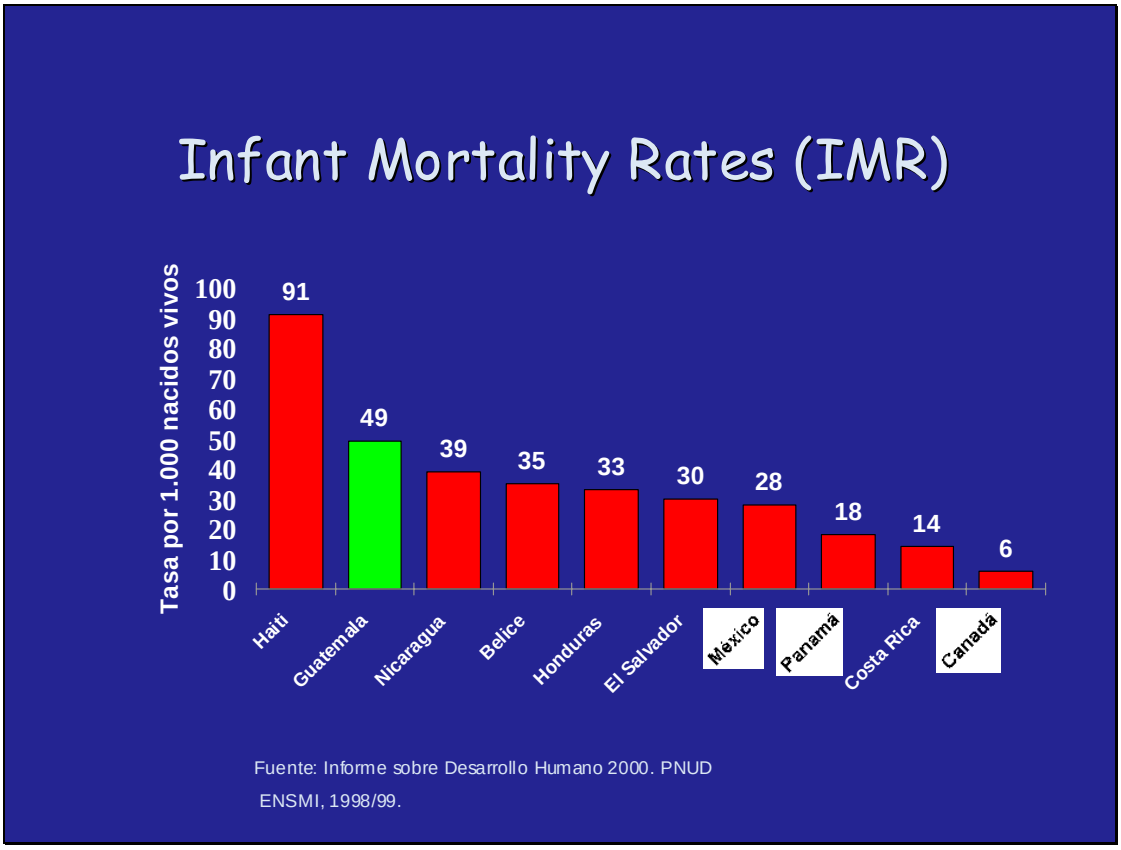
Slide 2


Causes of Maternal Mortality in Guatemala
Hemorrage 40%
Other 8%
Sepsis 17%
Abortion Complications 21%
Toxemia 14%
Fuente: Estudio de mortalidad materna, MSPAS 1989

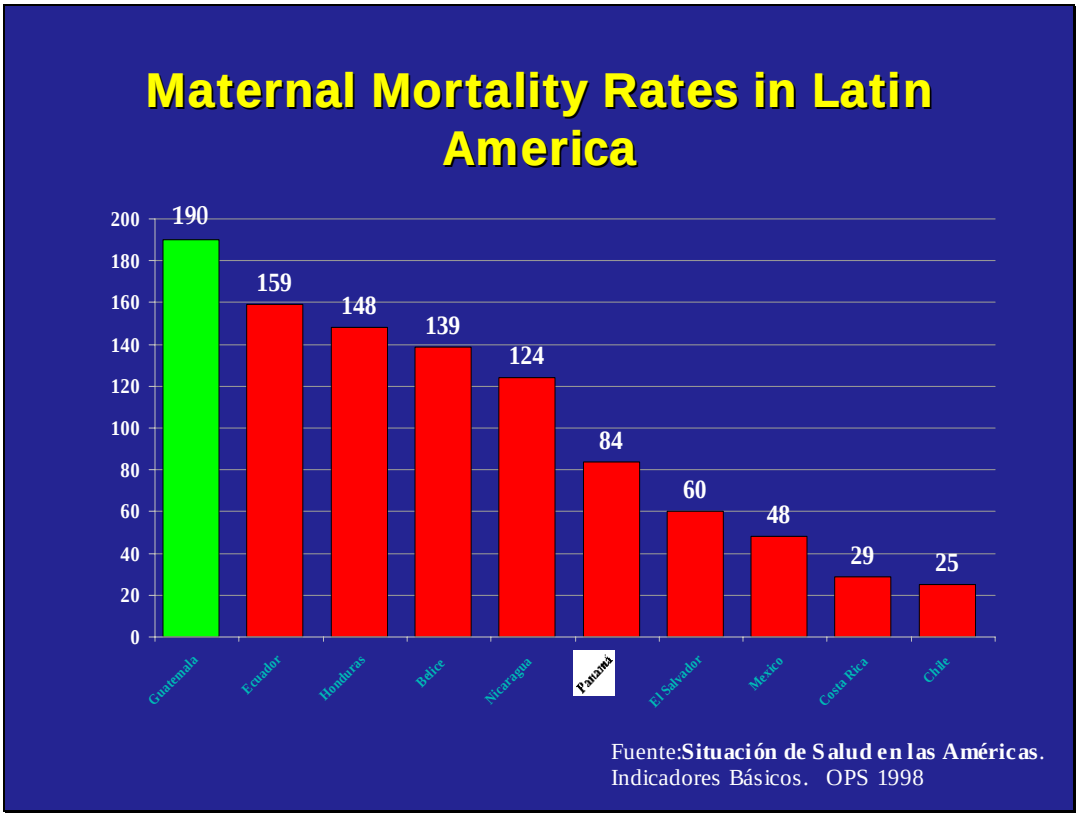
Slide 3


Global Fertility Rates
Guatemala in the International Context
Guatemala
El Salvador
México
Costa Rica
Panamá
USA
Canadá
5
3.6
3
2.7
2.7
2
1.5
0
1
2
3
4
5
6

Slide 4


Infant Mortality Rates (IMR)
Tasa por 1.000 nacidos vivos
100
90
80
70
60
50
40
30
20
10
0
91
49
39
35
33
30
28
18
14
6
Haiti
Guatemala
Nicaragua
Belice
Honduras
El Salvador
México
Panamá
Costa Rica
Canadá
Fuente: Informe sobre Desarrollo Humano 2000. PNUD
ENSMI, 1998/99.

Slide 5


Maternal Mortality Rates in Latin America
200
180
160
140
120
100
80
60
40
20
0
190
159
148
139
124
84
60
48
29
25
Guatemala
Ecuador
Honduras
Belice
Nicaragua
Panama
El Salvador
Mexico
Costa Rica
Chile
Fuente:Situación de Salud en las Américas.
Indicadores Básicos. OPS 1998