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A Qualitative Study on the Work and Challenges Faced by Non-Governmental Organizations Providing Sexual and Reproductive Health Services to Vulnerable Populations in Guatemala

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Abstract

Introduction Non-governmental organizations (NGOs) are key actors in the provision of sexual and reproductive health (SRH) services to vulnerable populations in Guatemala. We conducted an exploratory qualitative study to shed light on the work and challenges faced by these NGOs, which are underrepresented in the scientific literature.

Methods We selected 16 representatives from four SRH-providing NGOs who participated in two semi-structured interviews and four focus group discussions in May–June 2022. The data were analyzed using thematic analysis.

Results All participating NGOs prioritized indigenous women with low socioeconomic backgrounds in rural areas. Participants shared several challenges they face, including the taboo around sexuality, exposure to violence, limitations to their activities caused by the COVID-19 pandemic, unfavorable policy and legal frameworks for SRH service delivery, and limited inter-institutional collaboration on SRH issues.

Conclusions Our results highlight the importance of involving communities and tailoring interventions to the context to ensure successful implementation. Also, an urgent need for changes in the country's political management and regulations to guarantee the full exercise of the sexual and reproductive rights (SRR) of the population, as well as greater inter-institutional collaboration to improve the quality and efficiency of SRH services in Guatemala.

Policy Implications Guatemala needs to develop a national SRH policy to guide and align the work of the different actors providing SRH services and facilitate their accountability. Also, Guatemalan politicians representing the citizenry should continue to promote reforms to the legal framework to facilitate effective fulfillment of the SRR of the Guatemalan population.

Keywords Sexual health · Reproductive health · Sexual rights · Reproductive rights · Guatemala · Vulnerable Populations · Non-governmental organizations

Introduction

In Guatemala, timely access to quality sexual and reproductive health (SRH) services represents a challenge for a large part of the country's population. According to the latest National Maternal and Child Health Survey, conducted in 2014–2015 (ENSMI 2014–2015), only 65% of the women who had given birth in the 5 years prior to the survey were attended by qualified health personnel, and 9% had not had any antenatal care consultation during their pregnancy (Ministerio de Salud Pública y Asistencia Social et al., 2017). The lack of access to health services is also reflected in the unmet demand for modern family planning methods (MFPM), which is experienced by 34% of the population at

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reproductive age (Ministerio de Salud Pública y Asistencia Social et al., 2017). This translates into a higher unintended pregnancy rate than other countries in Latin America and the Caribbean, at 63 per 1000 women aged 15–49 years, on average annually between 2015 and 2019 (Bearak et al., 2022). Also, as a result of barriers to access to HIV diagnosis and treatment, the country has not yet reached the 90–90–90 target set by the Joint United Nations Program on HIV/AIDS (UNAIDS) (Margolis et al., 2016; UNAIDS, 2014; USAID, 2018). In 2022, an estimated 97% of the HIV-infected population in Guatemala knew their HIV status; 77% of those who knew their positive status were receiving antiretroviral therapy, and 71% of these had viral load suppression (UNAIDS, 2023).

In addition to the lack of access to health services, there is a lack of access to comprehensive sexuality education (CSE), which should cover sexual and reproductive physiology, prevention of HIV and other sexually-transmitted infections, contraception and unintended pregnancy, values and interpersonal skills, and gender and sexual and reproductive rights (Monzón et al., 2017). Guatemala has a regulatory framework that establishes that schools must provide CSE, as set forth in the 1999 Law for the Dignification and Integral Promotion of Women, the 2000 Law for the Fight against HIV/AIDS and the Promotion, Protection and Defense of Human Rights in the Face of HIV/AIDS, the 2001 Social Development Law, and the 2005 Law for Universal and Equitable Access to Family Planning Services and their Integration into the National Reproductive Health Program (UNESCO, 2023). However, in 2021, a government agreement was approved stating that sex education should be the responsibility of parents and take place in the family context, which has limited the implementation of CSE in schools and has meant that the country still does not have an official CSE program (UNESCO, 2023). According to a 2015 survey conducted in three departments, only 7% of participating secondary school students had learned on all aspects of CSE according to the United Nations Population Fund definition (Monzón et al., 2017).

The lack of access to both SRH information and services is especially pronounced among the most socioeconomically vulnerable populations, which represent the majority of Guatemala's population (Ministerio de Salud Pública y Asistencia Social et al., 2017). According to the National Institute of Statistics, 60% of the population lives in poverty conditions, with the greatest impact on rural populations, indigenous and Afro-descendant populations, and women (46.2%, 43.8%, and 51.5% of the country's population, respectively) (Instituto Nacional de Estadística de Guatemala, 2018, 2022). According to the 2014–2015 ENSMI, health indicators, including SRH, are worse in the indigenous population than in the non-indigenous population in most cases, especially among the female population. The indigenous population has lower health insurance coverage (lower in women), experiences more problems in accessing health services (higher in women), presents greater unmet need for family planning, less exposure to family planning information, higher stillbirth rate, lower proportion of prenatal and delivery care by skilled health providers, lower proportion of deliveries in health institution, lower early postpartum care, and lower knowledge about HIV (lower in women) (Ministerio de Salud Pública y Asistencia Social et al., 2017) (Table 1). Similarly, if we compare the population living in rural and urban areas, we observe that the rural population has worse indicators of SRH, especially the female population (Ministerio de Salud Pública y Asistencia Social et al., 2017).

Another population with poorer access to SRH services in Guatemala is the migrant population that travels from South and Central American countries and transits through the country on their way to Mexico and the United States of America, which has increased in recent years (International Organization for Migration, 2023). Between April and September 2023, the International Organization for Migration monitored 105,000 migrants in transit through Guatemala (United Nations Office for the Coordination of Humanitarian Affairs, 2023). Among the unmet SRH needs of the migrant population are those derived from acts of sexual violence, which are highly prevalent in this population due to their situation of greater vulnerability (Luna, 2023), and access to MFPM, menstrual supplies, and prenatal care (Letona et al., 2023). In addition, migrants are often discriminated against by public health care providers, making it difficult for them to access SRH services (Luna, 2023).

The insufficient SRH resources provided by governmental institutions, including the Ministry of Health and Social Assistance of Guatemala (MSPAS) and the Ministry of Education, and the low purchasing power of the majority of the country's population, which prevents people from paying for SRH services in private facilities that charge users fees, leave a large part of the population in Guatemala far from SRH services and information. In this situation, the private non-profit sector represents for many the only available option to meet their SRH needs. For practical purposes, we will use the term non-governmental organizations (NGOs) to refer to all mission-driven, non-profit, non-political, and non-governmental advocacy or service organizations working in Guatemala, regardless of their legal constitution (Harvard Law School, 2022).

Despite the great support that NGOs provide to Guatemala, they face an increasingly difficult context for working in the country. On the one hand, the government is increasing restrictions and control over NGOs operating in Guatemala. In response to appeals from the church and conservative politicians in power, in 2020 the government canceled the permit given to Planned Parenthood to work

Table 1 Selected indicators related to sexual and reproductive health from the 2014–2015 Guatemala National Maternal and Child Health Survey

Indicator	Women				Men				Population
	Indigenous*		Non-indigenous		Indigenous*		Non-indigenous		
	%	Total *n*	%	Total *n*	%	Total *n*	%	Total *n*	
Without health insurance	93.1	11,938	81.4	13,973	84.5	4476	70.3	5389	15–49 years
At least one problem in accessing health services to meet their needs**	78.3	11,938	70.5	13,973	-	-	-	-	15–49 years
Unmet need for family planning	17.4	7073	10.8	7948	-	-	-	-	Married or cohabiting women 15–49 years old
No exposure to family planning messages in the media in the last few months***	49.1	11,938	37.9	13,973	37.7	4476	35	5389	15–49 years
Stillbirth rate	79	6562	56	6099	-	-	-	-	Fetal deaths per 1000 pregnancies of 7 or more months' duration in the 5 years prior to the survey
Prenatal care with a skilled provider	88.8	4767	93.8	4820	-	-	-	-	Women aged 15–49 with live births in the 5 years prior to the survey
Births in health facility	49.9	6487	81.3	6012	-	-	-	-	Live births in the 5 years prior to the survey
Births attended by skilled health personnel	50.3	6487	82.1	6012	-	-	-	-	Live births in the 5 years prior to the survey
Postnatal care in the first two days after delivery	73.2	2493	82.5	2294	-	-	-	-	Women 15–49 years old with births in the 2 years prior to the survey
Have heard about HIV/AIDS	82.2	11,938	97.6	13,973	91.8	4476	98.4	5389	15–49 years
Comprehensive knowledge about HIV****	15.6	11,938	35.3	13,973	17.2	4476	30	5389	15–49 years

*Self-identification; **Getting permission to go for treatment, getting money for treatment, the distance to the health facility, or having no one to accompany her; ***Radio, television, and print media; ****Knows that consistent condom use during sex and having only one uninfected partner can reduce the risk of contracting HIV; knows that a person who appears healthy can have HIV; and rejects the two most common misconceptions about HIV/AIDS transmission or prevention (people can become infected with HIV from mosquito bites and people can become infected with HIV if they share dishes and eating utensils with a person who has HIV)

in the country due to its support for voluntary pregnancy termination (Cuffe, 2020). Following this issue and disagreements with other NGOs working in the country, in 2021 the Guatemalan government implemented a reform of the NGO Law, whose regulation strengthens government control over all NGOs established in the country and allows their cancelation by unilateral decision of the state (Deutsche Welle, 2021). One of the main concerns in the NGO sector is that this law can potentially be used by the government to attack and penalize civil society groups that are not aligned with the aims and priorities of the current administration (Hite & Beltrán, 2020).

Moreover, the government has exponentially reduced MSPAS resources allocated to NGOs providing health services in the country. In 2014, the Guatemalan government ended the Coverage Extension Program (PEC), in place since 1996, which outsourced basic healthcare services to local NGOs for the population living in marginalized areas of the country. This occurred after enacting a new law prohibiting the outsourcing of health services from the MSPAS to NGOs in 2013, citing the lack of transparency and inefficiency of the NGOs participating in the PEC. Since then, many Convergence Centers, the facilities where government-supported NGOs provided their services, were forced to close due to lack of resources (Ávila et al., 2016; Gutiérrez, 2021).

NGOs play an important role in the provision of SRH services to the population in Guatemala, especially for those in vulnerable situations, with a single NGO representing the third main SRH services provider after the MSPAS and the Guatemalan Social Security Institute (Cisek et al., 2015). However, evidence capturing the voices of NGOs providing SRH services to vulnerable populations in the country is still very scarce, with only one study identified in our literature search (Rivera, 2022). In order to fill this information gap, we conducted this qualitative study assessing the scope of work of NGOs providing SRH services to underserved populations in Guatemala and the challenges they face in their daily work.

Methods

Study Design

Initially, we conducted a mapping study of private actors working to provide SRH services to vulnerable populations in Guatemala. This was part of a broader study on the role of the private sector in the SRH of vulnerable populations in the Latin America and the Caribbean region. From a total of 103 identified actors in the private sector, 25 NGOs directly provide SRH services. We selected four of these to conduct an exploratory qualitative study on the scope of work and challenges these NGOs face in Guatemala.

Participants

The inclusion criteria for the participating organizations were (1) more than 10 years working in Guatemala; (2) broad geographic and demographic impact of their work in the country; and (3) broad network of collaborating organizations, including private and public institutions. To ensure the richness of the information, organizations with diversity in their management, financing and areas of influence were purposively selected.

The four organizations selected were initially contacted by e-mail to present the study and were asked to recruit members to participate voluntarily in it. The organizations provided the contacts of the persons interested in participating, who were contacted by the principal investigator and enrolled in the study after granting their informed consent to participate. All the individuals proposed by the organizations enrolled in the study, totaling 16 participants, an average of four per participating organization (Table 2). The majority of participants were male (62.5%), of Guatemalan nationality (87.5%), and with university studies (68.8%). The most common positions held in their respective organizations were director (31.3%), coordinator (18.8%), and

Table 2 Sociodemographic characteristics of the participants

	n = 16	
	%	*n*
Sex		
Male	62.5%	10
Female	37.5%	6
Nationality		
U.S.A	6.3%	1
Peru	6.3%	1
Guatemala	87.5%	14
Last school grade completed		
Secondary	25.0%	4
High school	6.3%	1
College	68.8%	11
Organization		
1	12.5%	2
2	31.3%	5
3	31.3%	5
4	25.0%	4
Position		
Coordinator	18.8%	3
Community health worker	12.5%	2
CSE facilitator	18.8%	3
Director	31.3%	5
Manager	12.5%	2
Researcher	6.3%	1
	Median	**Interquartile range**
Age	38	32.8–44.3
Years with the organization	7.5	3.8–10.5

CSE comprehensive sexuality education, *U.S.A.* United States of America

facilitator of CSE (18.8%). The median age of the participants was 38 years (interquartile range 32.8–44.3 years), and time in the organization was 7.5 years (interquartile range 3.8–10.5 years).

Data Collection

The study included two individual interviews and four focus group discussions (FGDs), which were conducted in May and June 2022, until saturation was reached. In one of the organizations, only two people were able to collaborate and it was decided to conduct individual interviews due to the different availability of both participants. Three of the FGDs comprised members of the same organization, and one comprised representatives of all participating organizations. FGDs had an average number of six participants. Both the interviews and the FGDs lasted 60 to 90 min and were conducted by the principal investigator (a male researcher with 7 years of experience in conducting mixed-methods public health research and no prior relationship with the interviewees) in Spanish, except for one interview conducted in English. Different semi-structured guides were used for interviews and FGDs with members of the same organization and for the inter-organizational FGD (Supplementary File 1). All FGDs and interviews were conducted virtually using Zoom or Microsoft Teams. This was due to the resource limitations of the research team, which prevented us from traveling to the offices of the different organizations.

The virtual sessions were recorded and transcribed using Sonix software. After transcription, only the excerpts included in the manuscript were translated into English by a native English speaker with Spanish proficiency.

Data Analysis

Transcripts were analyzed with the aid of Dedoose v.9.0.62 software using the thematic analysis methodology described by Braun and Clarke (Braun & Clarke, 2013). We opted for this methodology due to the research team's knowledge and extensive experience with it, as well as its greater accessibility compared to other qualitative analysis methodologies (Nowell et al., 2017). We first proceeded with data familiarization, which consisted of repeated reading of the interview/focus group transcripts to begin to identify elements that might be relevant to the objective of the study. After initial familiarization with the data, the coding stage consisted of identifying fragments of the transcripts that matched the research question and assigning labels (or codes, consisting of one or a few words) that captured the essence of the fragment. The principal investigator and the senior author independently coded a subset of interviews. Discussion between the two researchers of the codes found led to a consensus codebook that was applied to the entire dataset. After coding, by examining the coded data and using an inductive approach, we identified a number of patterns relevant to answering our research question that materialized into themes. The themes were reviewed and refined by the entire research team until a satisfactory result was obtained. The authors adhered to the 32-item Consolidated Criteria for Reporting Qualitative Research Studies (COREQ) checklist, which can be found in Supplementary File 2.

Ethical Considerations

This study was performed in line with the principles of the Declaration of Helsinki. Ethical approval for this study was obtained from the Ethics and Research Commissions of the National Institute of Public Health of Mexico (CI1415-2016) on September 6, 2016. All four participating organizations approved the participation of their members in the study, and all participating professionals gave informed consent before participation in the interviews and FGDs.

Results

The findings of the analysis are presented under eight themes, three of which relate to the characteristics of the participating organizations and five to the challenges experienced by these organizations in implementing their SRH interventions. Some themes consist of multiple sub-themes, all of which are listed in Fig. 1.

Characteristics of Non-Governmental Organizations

Catchment Area and Target Population

Three of the four participating organizations focus on rural Guatemala, and one has a broad presence in both rural and urban areas of the country. The geographic scope varies among the organizations, with their presence ranging from 3 to 17 departments of Guatemala. Half of the organizations focus solely on SRH, while the other half also provide health services not directly related to SRH. All participating organizations attend to any individual who may require their services, regardless of their socioeconomic background or health insurance status. Due to the greater presence of NGO services in marginalized areas and the fact that most services are provided free of charge, the majority of service users have low socioeconomic background and

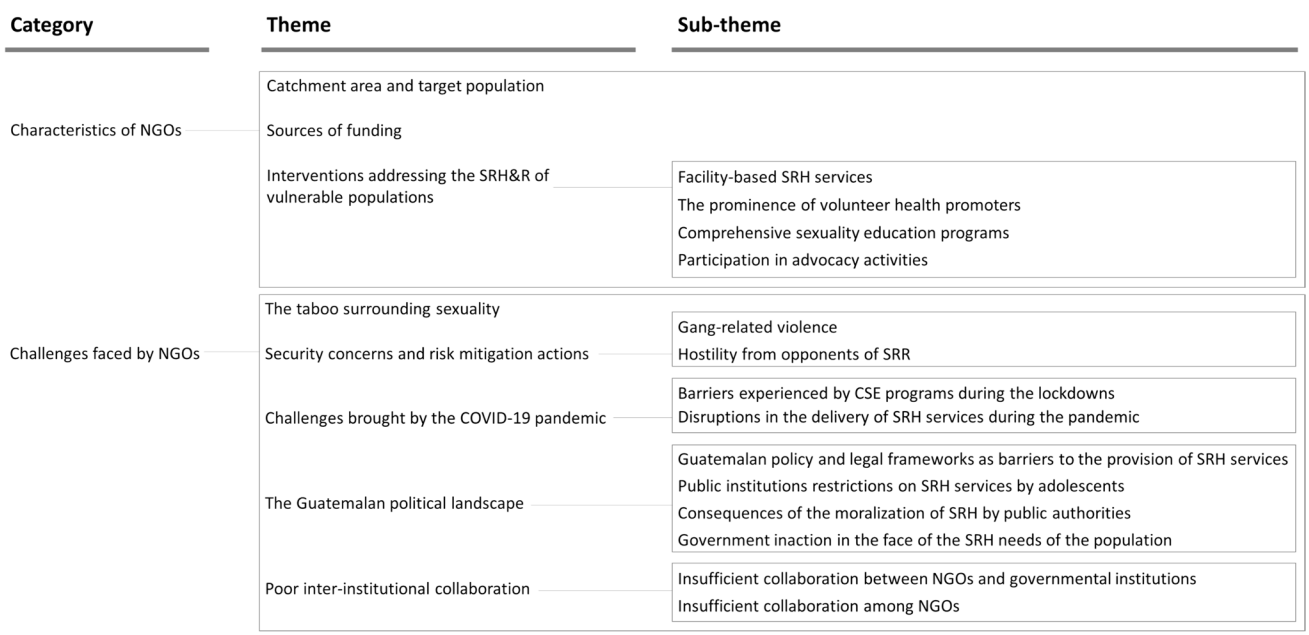

Fig. 1 Categories, themes, and sub-themes identified in the thematic analysis. SRH&R: sexual and reproductive health and rights; SRH: sexual and reproductive health; SRR: sexual and reproductive rights; CSE: comprehensive sexuality education; NGO: non-governmental organization

do not have health insurance. Overall, priority is given to adolescent and adult indigenous women with low literacy and income levels due to the greater vulnerability faced by this social group. In some cases, prioritization of population niches responds to the demands of the communities served:

> *"The community approached us; they are the ones who first identified that there was a high rate of teenage pregnancies and they needed to make some kind of intervention."* (Male manager)

Sources of Funding

Funding sources vary among participating NGOs. Reported sources of funding include fees for service, individual donations, donations and grants from foundations, donations from agribusiness, and grants from multilateral and bilateral cooperation agencies. All organizations rely on more than one source of funding, but in different proportions. One of the participants relayed about his organization's funding,

> *"Through the clinics and hospitals we generate income to sustain the operation of the organization. We also have funding from donors to be able to give continuity to the social mission.* […] *The community distribution strategy has been sustainable over time because it generates its own funds."* (Female coordinator)

Interventions Addressing the Sexual and Reproductive Health and Rights of Vulnerable Populations

Facility-Based Sexual and Reproductive Health Services

All of the organizations have their own health facilities or collaborate with government facilities to provide comprehensive antenatal, childbirth and postpartum care, short- and long-term MFPM and counseling, Pap smears, and diagnostic and treatment of sexually transmitted infections. Three of the organizations also have mobile medical units to bring some of the services provided in permanent facilities to the most marginalized populations.

One of the NGOs commented that, despite having invested in constructing and equipping a birthing center, the facility has been inoperative due to a lack of qualified personnel,

> *"We have not been able to get the local hospital's obstetrics and gynecology department to rotate their residents or faculty to our birthing center to train our nurses as nurse-midwives. This has prevented us from opening our birthing center."* (Male director)

The Prominence of Volunteer Health Promoters

All participating organizations are supported by volunteer health promoters, who belong to the communities in which

they work and act as a link between the organization's facilities and the supported populations, facilitating access to some of the services and supplies provided in the health facilities directly at home:

> *"These volunteer promoters can distribute short-acting contraceptive methods and have a basic list of medicines. This, because we know that many times women have to invest in order to get from their communities to a health center and hospital, and they find that there are no contraceptives because there is a shortage of supplies, or they do not have the economic possibilities because the payment for transportation is very expensive."* (Female manager)

The most common SRH-related tasks of the health promoters are the provision of information on family planning and services available at the clinics, as well as short-term MFPMs. Two of the organizations sell the MFPMs to the volunteer health promoters at a minimal cost and allow them to resell them to the population at a profit margin. In some cases, volunteer health promoters also provide follow-up care to pregnant and postpartum women, as well as education for the prevention of sexually transmitted infections.

Comprehensive Sexuality Education Programs

Three of the organizations have conducted CSE interventions with adolescents and youth. The curriculum varies among the three organizations, as all three draw on different educational models and external counselors. However, all participants agreed that CSE programs must be adapted to the context of implementation, which differs even within the departments of Guatemala. As one participant recounted,

> *"We have adapted the CSE program culturally to the area. The first year we implemented it, we worked with the teenagers in the area. We have an advisory group made up of fourth and fifth graders, and they helped us update the language and activities so that they would be attractive to them. In addition, we worked with the religious leaders, parents and teachers so that they could give feedback on how the program could be improved without affecting its essence."* (Male manager)

Participation in Advocacy Activities

All of the organizations have participated in advocacy activities related to SRH, mainly through their participation in national roundtables on issues such as HIV prevention in the workforce, prevention of adolescent pregnancy, and ensuring access to MFPMs. Some participants highlighted the importance of participating in these spaces as an opportunity to give visibility to the work of their organizations and to share their positioning with other key actors:

> *"What we have been doing is getting involved in national and regional roundtables. It has been a very important space because we have been able to coordinate among all of us, but also as civil society, to make our contributions and also to point out some of the gaps that exist between the guarantee of rights and access to services and the reality of the communities."* (Male director)

Challenges Faced by Non-Governmental Organizations

The Taboo Surrounding Sexuality

Some participants noted that, especially in rural areas, some community members feel uncomfortable addressing SRH issues and in some cases, even oppose NGOs' activities on this topic. Informants cited misinformation, machismo, and cultural constructs as causes behind the taboo and myths around sexuality present in some communities. Most of these difficulties are found in interventions aimed at adolescents and youth, such as CSE and SRH promotion activities, as they sometimes encounter opposition from parents and teachers of adolescents. One of the NGOs providing CSE reported that in some schools, although they accept the classes, directors limit their curricula:

> *"Many times the management does not allow the topics to be addressed as established by the organization. So it is as if they want us to talk about certain topics, but when it comes to talking about contraceptive methods or sexual diversity, they do not want us to address them."* (Female coordinator)

One participant commented on how they sometimes encounter teachers who believe they cannot talk about SRH with their students, so they have to show instructors the regulatory framework in Guatemala that provides for access to CSE as a right:

> "*It has happened to us that we go to schools and raise the issue of CSE and they tell us we can't talk about that, that's for parents to talk about. However, sometimes we have had to take our compendium of laws and tell the directors, 'Look, this law establishes it, and tells us that it is our responsibility to*

provide these topics.' And then they tell us that they did not know it." (Female manager)

Security Concerns and Risk Mitigation Actions

Gang-Related Violence

Two of the four participating organizations serve vulnerable populations living in urban areas. Participants from these organizations expressed concern about insecurity in Guatemala City, Guatemala's capital, due to the presence of gangs—known locally as "maras"—in some neighborhoods. Sometimes, even if the violence is not against the organization or the civilian population, conflicts between gangs can put service providers and users at risk:

"*We have had cases in some maternity hospitals where there is a gang presence, for example; so we go to zone 18, we go to zone seven, and many times these people arrive from one zone to another and there can be certain conflicts, and we have also had some friction there.*" (Male director)

To mitigate risks, the two NGOs working in urban areas are designing security protocols, including escape routes, so their staff can know how to act in case of security issues. These security concerns have hindered the expansion of these NGOs into new urban areas.

Hostility From Opponents of Sexual and Reproductive Rights

Security concerns are not limited to gang activities, but also include violent opposition by members of the supported communities to the SRR advocacy efforts of the participating organizations, whose workers have received lynching threats in some cases. To mitigate risks, one of the organizations explained that all youth volunteers involved in their SRH promotion program receive comprehensive training before participating in activities in public spaces to advocate for SRR, such as marches, including how to deal with possible threats and aggressions from opponents. One participant mentioned the importance of meeting with youth volunteers away from areas with a high prevalence of violence and preferably in neutral locations during mentorship and group discussions:

"*We go with the young volunteers to places that are safe for us as well. We know that there are places where we cannot enter because of the levels of violence, so what we do is that we can have the activities outside that perimeter. We meet with them in a mall or in a restaurant, as these are neutral places that allow us to be careful with the safety of the adolescents, youths and our facilitators.*" (Male coordinator)

Challenges Brought by the COVID-19 Pandemic

Barriers Experienced by Comprehensive Sexuality Education Programs During the Lockdowns

Three of the organizations that participated in the study have a CSE program. One of the main challenges during the COVID-19 pandemic was that, due to fear of infection of beneficiaries and providers, and mandatory lockdowns and safe-distance regulations, sessions had to undergo modifications to adapt to the new situation. The poor accessibility to information and communication technologies experienced by large parts of the populations served posed a barrier to adapting programs to distance learning formats. These limitations were not exclusive to rural environments; as one participant pointed out,

"*In terms of access, it seems that young people in the area of the capital city have better access to the Internet, to information. But we have to take into account that since they are not economically active, many of them do not even have the money to buy a phone card to be able to connect the Internet to their phone and participate in these processes.*" (Male CSE facilitator)

Thus, when online sessions were not an option, paper-based SRH teaching materials were provided to students with the expectation they would read them at home and complete a series of assignments. However, when classes in public schools were canceled, many parents forced their children to work on plantations, in family businesses, or on household chores. With little time left to study, students often gave priority to subjects other than CSE, since it was not included in the official curriculum, and therefore, its grades were not reflected in students' official grades.

One of the participating organizations shared that since some of the supported schools had established technological channels of communication between teachers and students, they decided to provide access to recorded sessions and assignments through a chat application. However, the unfamiliarity of many of the students with the use of this technology presented a challenge, in addition to the fact that students missed the face-to-face support of the instructors:

"*The videos were useful because they seemed more attractive to them. However, they still need the component of having someone in person to answer their questions, because they feel a greater connection. Even though we even have channels, either through What-*

sApp or e-mails where we can communicate, they still need that component." (Male manager)

Overall, informants who had participated in both virtual (due to the health emergency) and face-to-face CSE sessions perceived that the educational programs were more relevant to the students when the sessions were conducted in person.

Disruptions in the Delivery of Sexual and Reproductive Health Services During the Pandemic

Aside from the impact on the CSE, all participating organizations shared some form of disruption in the provision of SRH services during the pandemic. In some cases, these disruptions were associated with a reduction in resources; some donors reduced support to health areas that were not directly related to health needs caused by the pandemic, as the COVID-19 became the first health priority. Due to both reduced resources and restrictions on local mobility to reduce potential encounters with SARS-CoV-2, many activities in health facilities with health workers from outside the communities and mobile health units had to be canceled or limited. These activities were mainly related to the application and withdrawal of long-term MFPMs. In these circumstances, some organizations were still able to rely on volunteer health promoters from the served communities. The promoters were still able to offer family planning counseling and provide short-term MFPMs:

"*This network of volunteer promoters are basically community leaders who have some contraceptive methods in their homes but only short-term methods—that is, pills and injections—and they can distribute or give the services in their homes to people in their community. And that's what sustained a lot of this work in the pandemic while we were getting back into the field with long-term methods, like IUDs* [intrauterine devices]*, implants and surgeries.*" (Male director)

The Guatemalan Political Landscape

Guatemalan Policy and Legal Frameworks as Barriers to the Provision of Sexual and Reproductive Health Services

Participants agreed that a major limitation to their work is the lack of a unified national SRH policy, due to its fragmentation into multiple specific thematic policies, such as adolescent pregnancy, maternal mortality, or gender-based violence. According to participants, this situation hinders the work of stakeholders working on SRH in the country.

Some of the interviewees expressed concerns about the lack of a legal framework that would allow adolescents with unwanted pregnancies to seek abortion services in health facilities, at least in cases of rape:

"*In Guatemala, when we talk about pregnancies in adolescents and young people, and unintended pregnancies, it is a fundamental challenge because if an adolescent becomes pregnant, even if it is due to rape, she is forced to continue because we do not have a law that guarantees that an adolescent woman can have an abortion safely in a health center or hospital.* [...] *So the women are so afraid that they take herbs, they insert rods, and they put their lives at risk.*" (Female manager)

Despite the restrictive legal framework, some of the participating NGOs shared how they provide whatever support they can within the scope of the law when faced with such cases:

"*We have an institutional model in which we provide counseling and care, which is a model called risk and harm reduction, where we provide women with information based on human rights and the law within the legal framework of Guatemala. And it is a challenge because even when they access this process, just by asking, they are afraid because they do not really know if it is a safe space or if we are going to denounce them or if we are going to expose them because the health providers themselves, when they see that women have undergone this type of process, they denounce them.*" (Female manager)

Public Institutions Restrictions on Sexual and Reproductive Health Services by Adolescents

Despite the fact that Guatemalan law establishes the right to access MFPM and CSE, some participants reported that some schools and health facilities receive orders from the MSPAS and the Ministry of Education to limit access to SRH information and services to adolescents. As one participant recounted,

"*When we visit the health centers, or they lend us their facilities, we find that many adolescents arrive, and we ask them why they have not had access to a contraceptive method before, and they mention that they were told that there is no contraceptive method available at the center. And when we arrive at their warehouses they have the resources, they have the staff to provide the service, but they receive the instruction that the adolescents are not provided with the services because of government situations.*" (Female manager)

Consequences of the Moralization of Sexual and Reproductive Health by Public Authorities

According to some participants, the government is not only limiting adolescents' access to SRH services but through the moralization of SRH is contributing to increased stigma, discrimination, and criminalization toward users of SRH services. One participant related,

> "*This government has been so violent on the issue of the exercise of people's rights, so not only is access to services provided properly limited, but there is a whole series of stigma, discrimination, criminalization... Adolescents' access to health services is violated, because they are questioned, when we have a contraceptive guide for adolescents where we can provide contraceptive services to adolescents aged 14 years plus one day.*" (Female manager)

Government Inaction in the Face of the Sexual and Reproductive Health Needs of the Population

Participants mentioned that the lack of political will to work on SRH issues is reflected in the lack of government-driven campaigns to make SRH services available for key populations, such as victims of gender-based violence, the LGBTQI + community, and adolescents. Also, participants shared that CSE is poorly integrated in the National Base Curriculum (CNB)—the reference document for all teachers in the country—and public school teachers do not receive training on the basic topics related to sexual health and family planning included in the curriculum, so they end up omitting many of these materials. Interviewees shared that all this leads to low awareness among key populations of their SRR and the SRH services provided at public facilities, which negatively impacts demand for and utilization of services. As one informant relayed,

> "*Many adolescents, young people and adults do not know that it is their right to use a method of contraception. They have a high lack of awareness and when we approach them at the workshops and talk to them, give them the educational plan, or do promotional campaigns, it is not unusual to see surprised faces, especially of the adolescents when they come to us and ask us very quietly 'can I get contraception here?' and they say 'but I am a minor,' 'but my mother is not coming.'*" (Female coordinator)

Informants pointed to the lack of government investment in health infrastructure, human resources, and equipment as a major obstacle to meeting the SRH needs of the population. Participants agreed that following the dismantling of the PEC, there was a significant decrease in resources for health in marginalized areas, as many NGOs providing services to the most vulnerable populations in rural areas were forced to discontinue their activities:

> "*The PEC ended after the enactment of the new law in 2013.* [...] *Because of this law, the so-called convergence centers, which were rudimentary health centers managed through the PEC, have stopped receiving support. So the government must now find a new strategy to provide health services to the country's most marginalized communities.*" (Male researcher)

The lack of will and resources invested in SRH by the government concerned participants, who were uncertain of how the SRH needs of vulnerable populations would be met if NGOs disappeared. As one participant put it,

> "*We are often limited in the continuity of the service that we can offer, because the big question here is: what happens if the programs that we implement suddenly disappear? How will the government be able to fill those spaces?*" (Male manager)

Poor Inter-Institutional Collaboration

Insufficient Collaboration Between Non-Governmental Organizations and Governmental Institutions

All participants mentioned the existence of formal agreements between their NGO and the MSPAS. The mode of collaboration differs between organizations; in some cases, the NGO provides services and supplies on-demand from the MSPAS in hard-to-reach areas, while in other cases collaboration is limited to the referral of patients from NGO outpatient clinics to public hospitals or training of government health providers. However, all participating NGOs considered the collaboration between the MSPAS and their NGOs to be insufficient and often perceived a lack of commitment in the points agreed upon by the MSPAS. One participant commented that the fact that NGOs make visible the work that the government is not doing could be behind the MSPAS's reluctance to work more closely with NGOs.

One of the informants shared that, although his organization had previously collaborated with the Ministry of Education on the CSE project, the relationship with this institution worsened drastically after the change of government,

> *"With the Ministry of Education, it has been more complex. With this new government, all the work that had been done in terms of the implementation of the strategy has been set back.* [...] *And we have not been able to concretize a more coordinated work on the issue of CSE, they have been very secretive."* (Female manager)

Insufficient Collaboration Among Non-Governmental Organizations

Some of the participating NGOs mentioned collaboration with other NGOs in Guatemala on SRH issues, but also in other areas of health. For instance, two of the participating NGOs donate free MFPM to the other two organizations interviewed. Some participants reported receiving funds from other NGOs not included in the study. Other NGOs cross-refer patients to other NGOs with expertise in other health areas, such as mental health. According to the participants, in most cases collaborations with other NGOs are in the form of exchanges. All participants agreed that knowledge of the work of other NGOs and collaborative work are still insufficient, and that this should be corrected to avoid duplication of efforts and thus to more efficiently allocate resources:

> *"It is important to identify all the actions that the organizations carry out in order to be able to work collaboratively and not duplicate efforts, and to be able to reach the most vulnerable and excluded populations in the country, who need access to sexual and reproductive health services.*" (Female manager)

Discussion

Our study explored the scope of work of NGOs providing SRH services to vulnerable populations in Guatemala, highlighting their prioritization of adolescent and adult indigenous women with low socioeconomic backgrounds living in rural areas. Also, we saw how all NGOs support the SRH of the population at different levels, including households, schools, health facilities, and national SRH roundtables. We identified a common diversification of funding among the participating NGOs, although the sources varied among the organizations. Finally, participants' work shares a number of challenges, including the taboo around sexuality that prevails in many communities, exposure to violence, constraints caused by the COVID-19 pandemic, the Guatemalan political landscape that hinders the provision and utilization of health services, and limited inter-institutional collaboration on SRH issues.

The challenge of the taboo around sexuality is especially pronounced in rural communities and leads to opposition—sometimes violent—to the NGOs' work by some community members. Guatemala is a country characterized by its cultural diversity and strong faith presence. There are 23 different ethnolinguistic groups in the country, each with its own cultural lineage (Gustavo Arriola Quan, 2019), and the majority of the population self-identifies as Christian (87%) (Oficina International de la Libertad de Religión, 2019). The worldviews of some sectors of society derived from culture and religion can conflict with those embraced by NGOs working in SRH in the country, taking into account that many NGOs are strongly influenced by SRH approaches exogenous to their work context (Sieder & Macleod, 2009). In order to reduce opposition and thus increase the implementability of SRH interventions, some strategies already proven effective in the rural Guatemalan context should be strengthened, such as involving different community stakeholders in the design of interventions and tailoring interventions to the local context, including the utilization of local languages (Rivera, 2022). Another major concern of participating NGOs was that, although Guatemala's legal framework provides for basic SSRs for the population (UNFPA, 2020), public schools and health facilities—following instructions from local and national authorities—violate these rights by denying access to basic SRH services to the population, such as MFPM and CSE to adolescents, as has been reported in other studies (Consorcio por los Derechos Sexuales y Reproductivos, 2022; Monzón et al., 2017). Participants expressed that the moralization of SRH by public authorities contributes to discriminatory treatment by health providers toward users of SRH services, especially adolescents. This discriminatory treatment has been reported toward adolescents but also toward single women and individuals with non-normative sexualities and genders in another study conducted in the country (Consorcio por los Derechos Sexuales y Reproductivos, 2022). This situation could have been further aggravated if the Law for the Protection of the Life and the Family (Law 5272), passed by the Guatemalan Congress in 2022 (Congreso de la República de Guatemala, 2022), had been supported by the Guatemalan president (Gobierno de Guatemala, 2022). The law sought to amend the penal code to criminalize miscarriages and impose prison sentences on providers who facilitate care to these patients. The law also sought to prohibit same-sex marriage and the teaching of sexual diversity and gender equality in schools, and to proscribe criminal prosecution of individuals for discriminating against others based on their sexual orientation (Amnistía Internacional, 2022). Therefore, the enactment of Law 5272 would have represented the officialization of discrimination against members of the LGBTQI + community in the country. Although the future of the country in terms of SRR is uncertain, the new president elected in August 2023, who belongs to the progressive "Semillas" party, has already publicly stated his plans to invest CSE efforts and to combat discrimination against members of the LGBTQI + community (Vílchez, 2023).

Some participants shared their concern that the Guatemalan legal framework prohibits the voluntary termination of pregnancy for adolescents, even in the case of rape, which limits the support that NGOs can provide those facing this situation. In the first seven months of 2023, 1429 girls under

the age of 14 gave birth in Guatemala, where all pregnancies under the age of 14 are considered rape in the legal framework (Observatorio de Salud Reproductiva de Guatemala, 2023). To counteract this situation, in 2018, initiative 5376 was proposed to the Guatemalan Congress for the approval of the Law on Comprehensive Protection, Access to Justice and Dignified and Transformative Reparation for Girls and Adolescent Victims of Sexual Violence, Exploitation and Trafficking, which sought to decriminalize abortion in girls under 14 years of age who are victims of rape. Had it been approved, the new law would have legitimized health professionals to provide the comprehensive care required by this population. However, the Guatemalan Women's Commission rejected the proposal (Babio, 2018), which has led girls who cannot afford safe clandestine abortion services to undergo unsafe abortion practices or to continue with a forced pregnancy until they give birth (Molina et al., 2014).

As mentioned by participants, the country does not have a public policy that guarantees that Guatemalans can fully exercise their SSR, unlike other countries with similar conservative contexts such as El Salvador (Coyoy & Estrada, 2022). The lack of a unified policy generates weak, fragmented SRH programs and misinformation among health providers, teachers, and the overall population (Coyoy & Estrada, 2022). The deficient policy and legal frameworks that protect SRR in Guatemala are reflected in the metrics of the Mira que te Miro observatory of sexual and reproductive health and rights (SRH&R) in the Latina America and the Caribbean region (Mira que te Miro, 2023). This observatory examines compliance with the agreements derived from the Montevideo Consensus on Population and Development, which established the path in 2014 to strengthen the implementation of population and development actions in Latin America and the Caribbean and to which Guatemala subscribed (Comisión Económica para América Latina y el Caribe, 2013). According to the observatory, the country's metrics in SRH&R have been stagnant since 2017, with some of the worst metrics in the region in terms of accountability (39% compliance) and CSE (35% compliance). Guatemala is the country in the region with the fifth worst level of compliance with the Montevideo Consensus agreements (Mira que te Miro, 2023).

Participants mentioned how the COVID-19 pandemic had affected the provision and utilization of CSE and SRH services in their organizations. OSAR, the Guatemalan Observatory on Reproductive and Sexual Health, reported a 30% decrease in access to antenatal care and 70% decrease in family planning from 2019 to 2020, especially in indigenous and poor communities (Lungo & Maldonado, 2022). Restrictions on mobility by local and national authorities made it difficult for the population to access health facilities and schools (Proyecto Mesoamérica, 2023). This situation underscored the importance of volunteer health promoters working for some of the participating NGOs, who were key to not interrupting the provision of short-term MFPM. Also, the new situation led participating NGOs to adapt their CSE interventions to distance learning strategies, with varying degrees of success. Other NGOs in Guatemala focused their COVID-19 response strategy on communication campaigns to motivate service utilization, with special attention to women and adolescents (Asociación Ama, 2020; Lungo & Maldonado, 2022), or on distance trainings to support the provision of SRH services by frontline health personnel during the pandemic (TulaHealth, 2022).

During the FGD with members of the different participating NGOs, some participants realized that, despite working in the same regions with similar populations and with similar interventions, they did not know enough about each other's work. This represents a great area of opportunity, as learning from each other and collaborating through functional networks of services could open up new funding opportunities, reduce operational costs, and improve the quality and timeliness of the services provided. Also, all NGOs perceived a lack of willingness of public institutions to collaborate on SRH issues, expressed by other NGOs previously (Rivera, 2022), which hinders the work of these organizations and represents a missed opportunity for the MSPAS and the Ministry of Education to attract resources that could help meet the population's needs. The openness of the participating NGOs to collaborate with other NGOs and governmental institutions, as well as the newly elected progressive government that apparently presents a greater willingness to address SRH&R issues, pose a great area of opportunity to create spaces for dialogue that foster interinstitutional collaboration.

Our project is relevant not only for Guatemala but for the entire Latin America and the Caribbean region, due to the prominent role of NGOs in meeting the SRH needs of the most vulnerable populations in other countries in the region and the lack of evidence reflecting the challenges faced by these organizations. As in Guatemala, in other countries in Latin America and the Caribbean, there are NGOs working in the direct provision of services, training of health professionals, education of young people, distribution of supplies, and advocacy related to SRH&R with a focus on vulnerable populations (Nigenda et al., 2023; Rubinstein et al., 2022). The range of NGO operations in each country depends on the structure of the health system and its management, national legislation, and the characteristics of the population. In countries where public institutions are more committed to SRH&R, collaboration between NGOs and the public sector is stronger and NGOs encounter fewer barriers to carrying out their activities, as is the case in Mexico (Berdichevsky, 2020; Centro Nacional de Equidad de Género y Salud Reproductiva, 2022; Secretaría de Salud de México, 2021), Argentina (Karstanje et al., 2020), or Uruguay (López

Scwedt, 2014). On the other hand, in countries where public institutions are less committed to the SRH&R (Mira que te Miro, 2024), NGOs present greater barriers, as in the cases of Belize (United Belize Advocacy Movement et al., 2018), Trinidad and Tobago (Hunte, 2021), or Nicaragua (Ochoa, 2018). These barriers coincide with those described by participants in our study, such as a limiting political and legal framework regarding SRH&R and a lack of willingness on the part of the government to collaborate. In addition, as in the cases described in our study, it is common for NGOs in Latin America and the Caribbean to face resistance from the beneficiary communities themselves to addressing SRH issues. However, several success stories in the region agree on the importance of dialogue with key members of the communities to improve awareness of SRH and overcome taboos (Ivanova et al., 2016; Kendall, 2022), as well as the cultural adaptation of their programs to ensure their implementability. One example is the adaptation of SRH service provision interventions in the Andean region (Gonzales Salguero et al., 2005; Llanque & Blanco, 2021).

Unfortunately, a common denominator among NGOs working in the field of SRH&R in Latin America and the Caribbean is a decrease in their financial resources over the last decade, due to the prioritization of other health areas or other regions of the world (such as sub-Saharan Africa or Southeast Asia) by donors (Nigenda et al., 2023). Studies such as ours highlight the need to continue supporting the efforts of NGOs in the region so that they can continue to bring SRH closer to the most vulnerable populations.

Policy Implications

This study highlights the need for a national SRH policy in Guatemala, which defines the lines of action in SRH for public agencies (mainly MSPAS and the Ministry of Education, but including other ministries that guarantee the implementability of the policy) and represents a framework for the work of civil society organizations, cooperation agencies, and the private sector, thus allowing for the alignment of work among different actors. This national policy should contemplate the development of an official CSE program in the country, which does not yet exist, avoiding relegating the entire burden of this key activity to NGOs. At the same time, the current "Policy for the Protection of Life and Institutionalization of the Family 2021–2032", which states that sex education is the responsibility of parents and limits the implementation of CSE (UNESCO, 2023), needs to be reconsidered. In addition, the national SRH policy should include a monitoring and evaluation plan that allows to control the adherence of the different institutions to the national SRH policy, facilitating the accountability of the different actors involved. In the design of this national policy, Guatemala could take as a reference the efforts in this direction made by other Central American countries, such as Honduras (Secretaría de Salud, 2016) or El Salvador (Ministerio de Salud, 2012).

Moreover, the Guatemalan Congress should continue to promote reforms in the Guatemalan legal framework to ensure the population can effectively fulfill their SRR, such as the failed initiative 5376, which had as its main objective the decriminalization of abortion for girls under 14 years of age who are victims of rape.

Limitations of the Study

One of the main limitations of the study is selection bias. Participants were recruited by the four participating NGOs, which selected individuals according to their own criteria, potentially incurring selection bias. As the interviews and the FGDs were conducted online, this could have left out of the study informants from the selected organizations who were based in areas without access to information and communication technologies. The fact that participants were active employees of the NGOs they were talking about could have limited the information shared by the participants, especially that which could compromise the image of the institution or its relationship with public institutions.

Conclusions

This study sheds light on the scope of work and challenges faced by NGOs providing SRH services to vulnerable populations in Guatemala. Our findings show how these organizations work at different levels, including households, schools, health facilities and advocacy spaces, and underscore their work in CSE and the support of volunteer health promoters to reach the most marginalized populations. On the other hand, we found how the taboo around sexuality, the political and legal framework, violence, and the recent COVID-19 pandemic hinder their work to ensure that underserved Guatemalans can exercise their SRR. Despite these challenges, the new political landscape and the willingness of participating NGOs to collaborate inter-institutionally represent great opportunities for further progress in addressing the SRH needs of the Guatemalan population.

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Data Availability Anonymized data are available from the corresponding author on reasonable request.

Code Availability Not applicable.

Declarations

Ethics Approval This study was performed in line with the principles of the Declaration of Helsinki. Ethical approval for this study was obtained from the Ethics and Research Commissions of the National Institute of Public Health of Mexico (CI1415-2016) on September 6, 2016.

Informed Consent All four participating organizations approved the participation of their members in the study, and all participating professionals gave informed consent before participation in the interviews and FGDs.

Competing Interests The authors declare no competing interests.

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