

USAID Graduation from Family Planning Assistance: Implications for Latin America



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**USAID Graduation from Family Planning Assistance:
Implications for Latin America**

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Executive Summary

The United States Agency for International Development (USAID) has played a pivotal role in international family planning for almost half a century. From the 1960s it has provided financial and technical support to public and private sector programs in developing countries worldwide. Over this 50-year period, the average number of children per woman in the developing world has dropped from around 6 to 2.7. Family planning (FP) has evolved from a politically controversial, socially sensitive topic to a routine part of public health service delivery in many countries.

In 2004 USAID recognized the need to be more strategic in the allocation of its FP funding (to countries with the greatest unmet need) and more systematic in its process of “graduating” countries from FP assistance. The criteria for considering countries for graduation have evolved somewhat since that time. Currently the criteria for “imminent graduation” (2-5 years) include a total fertility rate (TFR) of 3.0 or less and a modern contraceptive prevalence rate (MCPR) of at least 55 percent; additional criteria relate to urban/rural inequities, method mix, and size of the population. This decision affected the region of Latin America and the Caribbean (LAC) in particular because of the number of countries approaching or surpassing this threshold.

At present, four countries in the LAC region are scheduled to graduate: El Salvador (in FY 2010), Honduras (FY 2012), Nicaragua (FY 2011), and Paraguay (FY 2010)¹. One additional country, Peru, was scheduled for graduation in FY 2010, but that decision is currently under review. Two LAC countries ended their programs under the graduation criteria (Jamaica in 2008 and the Dominican Republic in 2009), and three others do not yet meet the graduation criteria (Bolivia, Guatemala, and Haiti). This report analyzes the prospects and challenges of graduation for Honduras, Nicaragua and Paraguay in some detail and briefly describes the situation in Peru. In addition, it reviews the current status of family planning and the need for continued support in the countries not scheduled for graduation: Bolivia, Guatemala, and Haiti.

The role of the Ministries of Health (MOHs) and their support for family planning has changed vastly over the past decade. Currently, the MOHs are generally supportive of FP in the nine countries mentioned above, and the public sector is the major source of contraceptive provision in most of them. With support from USAID, the MOHs have developed the forecasting and logistics capacity to deliver contraceptive services. The International Planned Parenthood Federation (IPPF) member associations – the pioneers for family planning in most Latin American countries dating back to the 1960s – now play a supportive, but reduced, role in FP service delivery.

1. Programs funded in a given fiscal year (i.e. FY2010) actually complete program activities in the following year; thus programs funded in FY 2010 are still ongoing in 2011.

Two key elements for successful graduation are: (1) Government commitment to using its own funds to procure contraceptives on the international market, and (2) The technical and managerial savvy to manage the relatively complex contraceptive logistics process. USAID has worked closely with the MOHs in Honduras, Nicaragua, and Paraguay to strengthen both the commitment and capacity in these areas. While they have been highly successful in strengthening the procurement and logistics capacity, it is less certain whether there will be a sufficiently strong and lasting political commitment to allocating the resources necessary to purchase contraceptives in some of the graduating countries. In June 2010, the eight countries that have participated in USAID’s Regional Contraceptive Security Initiative (Bolivia, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru) attended a meeting on contraceptive security where seven of them (Honduras’s representative was not authorized to sign) reaffirmed their commitment to providing “protected” budgetary resources for reproductive health by signing the Declaration of Punta Cana, a strong statement of support for family planning (*Compromiso Punta Cana*, 2010).

Nevertheless, of the three countries under consideration in this paper that are scheduled to graduate, only Paraguay has convincingly demonstrated its willingness and ability to cover 100 percent of the cost of purchasing contraceptives for the public sector. In Honduras and Nicaragua, the looming question relates to the government’s commitment and ability to purchase contraceptives for the public sector program using funds from the national budget, especially in the face of other fiscal priorities. In the past the United Nations Population Fund (UNFPA) has served as the “safety net” for both countries, but its stated policy is to serve exclusively as a procurement facilitator and to discontinue the donation of contraceptives.



Rebecca Guatafson, USAID

USAID officials in all three countries express the sentiment that “there is no turning back on this decision.” They feel a strong degree of confidence that their counterparts are well-trained and capable of managing all aspects of the contraceptive logistics and procurement process. Moreover, they describe a sense of pride on the part of government counterparts at taking ownership and responsibility for their own programs.

In sum, with USAID assistance Honduras, Nicaragua, and Paraguay have prepared for FP graduation by increasing their capacity in contraceptive procurement, logistics, and management. The MOH service delivery system represents a potentially viable mechanism for getting contraceptives to a large segment of the population, and demand for contraception is strong. However, in two of the three countries there remain a number of uncertainties. The largest question mark – for Honduras and especially for Nicaragua – is the governments’ ability to deliver on their commitments to using their own funds for procuring contraceptives. For 2011, Nicaragua will not be able to meet its commitment from its own income and is negotiating with donors to cover projected shortfalls (Cuadra, 2010). While the outlook seems more positive in Honduras, only time will tell whether they will be able to find the resources locally to meet their contraceptive procurement needs.

The situation in Peru is considerably different in that the Peruvian government is willing and financially able to provide the financing for contraceptives and for the continuous implementation of the Demographic and Health Survey (DHS). However, inconsistent government commitment in the past and the larger health sector reform process that the country is undergoing have increased challenges for the family planning program and assistance may need to be continued for longer than anticipated.

In terms of the three countries that are not yet on the list to graduate (Bolivia, Guatemala, and Haiti), the first two share several traits: (1) A large indigenous population that tends to be poor, rural, uneducated, and more resistant to family planning than their Spanish-speaking counterparts; (2) Large inequities in access to



Angela Rucker, USAID

and use of modern contraceptives, and (3) A legacy of strong opposition from the Catholic Church, which hindered programs in prior decades but has lessened in recent years, focusing instead on specific issues like emergency contraception and abortion. Because of these factors, Bolivia and Guatemala have not yet approached the “threshold numbers” for TFR and MCPR that would put them on the schedule for graduation from USAID FP assistance.

The earthquake of January 2010 in Haiti represents an immeasurable setback to all development activities in that country, including family planning. The U.S. government has pledged one billion dollars to rebuild this country, and FP assistance will be part of that package. In Haiti

there are very significant limitations in family planning service delivery. The camps for internally displaced populations (IDPs), as well as other cities, towns and rural areas remain seriously under-served. Temporary contraceptive methods are available at many hospitals, but there are shortages of trained staff and extremely limited information-education-communication (IEC) activities. While emergency contraception (extremely important in the post-disaster environment) is more widely available than before the earthquake, long-term and permanent methods are unavailable for the most part.

Although international family planning received a higher level of funding (\$648 million) in fiscal year 2010 than ever before in its history, the level of unmet need remains high and USAID must prioritize its support. Despite continuing pockets of unmet need in Latin America, the LAC region – with the exception of Haiti – has far lower fertility and far higher contraceptive use than in sub-Saharan Africa and parts of South Asia. Without a significant increase in funding for FP it is unlikely that USAID will allocate additional funding for LAC.

It is important, however, for Congress and USAID to ensure that the effort to graduate countries in LAC does not imperil the notable progress that has been made in the past few decades. While USAID has taken great pains to maintain contraceptive security, it's imperative to continue to monitor the level of unmet need in graduating countries, particularly among rural, indigenous, and low-income and youth populations, and, if necessary, to offer additional assistance to countries in special need.

List of Acronyms

APROFAM	Asociación Pro-Bienestar de la Familia de Guatemala
ASHONPLAFA	Asociación Hondureña de Planificación de la Familia
BKKBN	National Family Planning Coordination Board, Indonesia
CBD	Community-based delivery
CEPEP	Centro Paraguayo de Estudios de Población
CPR	Contraceptive prevalence rate
CIES	Centro de Investigación, Educación y Servicios de Bolivia
CS	Contraceptive security
CYP	Couple years of protection
DAIA	Disponibilidad Asegurada de Insumos Anticonceptivos
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Surveys
ENDSSR	Estrategia Nacional de Salud Sexual y Reproductiva
FONSALUD	Fondo de Apoyo al Sector Salud
FP	Family planning
FPPEI	Family Planning Effort Index
FP/RH	Family planning/reproductive health
GDP	Gross domestic product
GH	Global Health/ USAID
GH/OPRH	Bureau of Global Health/Office of Population and Reproductive Health
GOG	Government of Guatemala
GOH	Government of Haiti or Government of Honduras
GON	Government of Nicaragua
GOP	Government of Paraguay or Government of Peru
GRUN	Gobierno de Reconciliación y Unidad Nacional
HIV/AIDS	Human Immune-Deficiency Virus/Acquired Immune-Deficiency Syndrome
IADB	Inter-American Development Bank
ICPD	International Conference on Population and Development
IDP	Internally-displaced persons
IEC	Information-education-communication
IGSS	Instituto Guatemalteco de Seguro Social
IHSS	Instituto Hondureño de Seguro Social
INSS	Instituto Nicaragüense de Seguro Social
IPPF	International Planned Parenthood Federation
IPS	Instituto de Previsión Social
IUD	Intra-uterine device
JICA	Japan International Cooperation Agency
LAC	Latin American/Caribbean

MAs.....	Member associations
MCPR.....	Modern contraceptive prevalence rate
MINSA.....	Ministerio de salud/Nicaragua
MOH.....	Ministry of Health
MOHP.....	Ministry of Health and Population (Haiti)
MOSCAFC.....	Model of Community and Family Health
MSH.....	Management Sciences for Health
MSPP.....	Ministère de la Santé Publique et de la Population Haïti
MWRA.....	Married women of reproductive age
NGO.....	Non-governmental organization
OMB.....	Office of Management and Budget
OSAR.....	Observatorio de Salud Reproductiva
PASMO.....	Pan-American Social Marketing Organization
PRB.....	Population Reference Bureau
PROFAMIL.....	Association pour la Promotion de la Famille Haïtienne
PROMESA.....	Promoción y Mejoramiento de la Salud
PROMESS.....	Program of Essential Medicines and Supplies
PSI.....	Population Services International
SOH.....	Secretariat of Health
SSIs.....	Social Security Institutes
SUMI.....	Seguro Universal Materno-Infantil
SWAp.....	Sector wide approach
TFR.....	Total fertility rate
ULAT.....	Unidad Local de Asistencia Técnica
UNDP.....	United Nations Development Program
UNFPA.....	United Nations Population Fund
USAID.....	United States Agency for International Development

USAID Graduation from Family Planning Assistance: Implications for Latin America

I. Rationale for USAID graduation from FP assistance in selected developing countries

The United States is widely recognized for its leadership in international family planning (FP) in the developing world. Since the inception of its program in 1965, population and family planning have enjoyed widespread support in the U.S. Congress (O’Hanlon, 2009). The United States Agency for International Development (USAID) has given financial and technical support to family planning programs in developing countries worldwide. This investment in family planning has contributed to the dramatic decrease in total fertility rates in the less developed world: from over 6 children per woman as of 1960 to the current average of 2.7 children overall and 4.5 children in least developed countries (PRB, 2010). Over the past five decades, family planning has evolved from a highly controversial, politically sensitive topic to a routine aspect of public health service delivery in much of the developing world.

Since the inception of the USAID population program, USAID funding became a mainstay of family planning programs in the developing world, thanks to strong bi-partisan support in the U.S. Congress. Not an implementer of programs itself, USAID provides financial and technical assistance to government, quasi-governmental organizations, and non-governmental organizations (NGOs) in support of the full range of FP programming needs: establishment of facilities, training of personnel, management, contraceptive procurement, logistics and delivery systems, information-education-communication programs, advocacy initiatives, and related activities. A common objective of this assistance has been to increase access to, and quality of, contraceptive services.

In the pioneering years of family planning programs, USAID funding for family planning was plentiful, often outstripping the absorptive capacity and political receptivity of recipient countries. By the 1980s, many developing countries had recognized the latent demand for family planning on the part of its population, and programs – especially in Asia and Latin America – grew quickly, with continued strong support from USAID. By this time many FP programs had extended beyond clinic-based service delivery to include community-based distribution and social marketing of contraceptives. Because the U.S. government gave high priority to family planning for more than three decades starting around 1970, countries came to depend on USAID as a key source of support for their family planning programs. In 1995 (the year after the International Conference on Population and Development [ICPD] in Cairo), funding for international family planning reached the highest point since the inception of U.S. government FP assistance (\$580 million). Funding would subsequently recede back to a relatively steady

level of \$430 million per year until recent increases under the Obama administration (O’Hanlon, 2009).

Despite this strong support for FP in developing countries worldwide, USAID realized that some countries had reached a point at which they would be able to continue their family planning programs without external financial or technical support. South Korea was the first country to lose USAID support for FP (around 1976), followed by Panama in the late 1980s. USAID discontinued FP assistance to six other countries in the 1990s (in chronological order): Tunisia, Thailand, Botswana, Costa Rica, Colombia, and Mexico. Between 2000 and 2004, it ceased to fund FP in Brazil, Ecuador, Turkey, and Morocco. (See Table 1 for exact dates) Although phase-out plans were developed in



World Bank

conjunction with International Planned Parenthood Federation (IPPF), USAID, and national governments in some Latin American countries, there was no uniform process or set of procedures for establishing when a country should graduate or how it should be done. In some cases, FP assistance ceased when USAID, over a 25-year period, closed its missions (O’Hanlon, 2009).

In 2002, USAID Office of Population was reviewed by the Office of Management and Budget under its “Program Assessment Rating Tool,” designed to answer whether a program is demonstrating value to the taxpayer (i.e., whether it has a track record of results and warrants continued or additional resources). This systematic review of the population program examined multiple dimensions including management structure, strategic approach, and results to show for impact, among many others. The program scored very well on all criteria except “strategic use of resources.” Specifically, the review concluded that USAID did not allocate its resources to the countries with greatest need, which, in the case of family planning, are found in sub-Saharan Africa and South Asia. Because the agency budget for FP remained stagnant over this period, the action implicit in this recommendation was to decrease funds going to Latin America.

In response to this review, the Office of Population contracted a private sector agency to develop a strategic budgeting model to assess country need for FP assistance, which incorporated a number of factors including modern contraceptive prevalence and trends, number of high-risk births, number of women with an unmet need for family planning, and population density relative to arable land and water resources. Other factors also affect budget decisions, including absorptive capacity, country stability, country commitment, and other donor contributions. USAID began using this model to inform budget allocation decisions in 2003. The leadership

quickly realized that instead of cutting funds abruptly to Latin America and the Caribbean (LAC), they instead needed to develop a graduation strategy, based on defined criteria, which would be implemented over a period of several years.

A. Establishment of a systematic graduation process

In 2004 the USAID Office of Population² created a “FP Graduation Working Group,” to analyze the experience of recently-graduated countries, develop criteria and a technical approach, review the graduation process, and update the list of countries scheduled for graduation (O’Hanlon, 2009). The intent was to actively plan and manage a transition process of two to six years, or if necessary, up to 10 years (depending on what state of transition a given county is in) to help countries achieve long-term sustainability in their FP programs (USAID, 2008).

To support this process, the Bureau of Global Health/Office of Population and Reproductive Health (GH/OPRH) commissioned a study on the consequences of graduation in the countries where it had already taken place. The authors were not able to find appropriate data on consequences, and instead focused on the processes and lessons learned from graduation in countries (Cromer et al, 2004). This report provided useful guidelines to the FP Graduation Working Group as it moved forward with its formalized mandate to graduate countries that met specific criteria.

The FP Graduation Working Group presented its recommendations in a *Technical Note: Approach to Phase-out of USAID Family Planning Assistance* (USAID, 2006). It reiterated the premise that all USAID assistance programs in developing countries should be designed and implemented with the expectation that the host country program will eventually no longer require or receive direct support from USAID or other donors. The original criteria for graduation established by the FP Graduation Working Group have evolved slightly in the past four years. Currently, two types of graduation criteria apply: one for imminent graduation (in 2-5 years), and a second for near-term graduation in 3-6 years (see Appendix B). The criteria for “imminent graduation” (2-5 years) are as follows (Farrell, 2010):

- Total fertility rate is less than 3.0;
- Modern method contraceptive prevalence is greater than 55 percent of married women of reproductive age (MWRA);
- At least 80 percent of the population can access at least three FP methods within a reasonable distance (may be farther than 5 km. for long-term and permanent methods);
- No more than 20 percent of family planning products, services, and programs offered in the public and private sectors are subsidized by USAID; and
- Major service providers (public sector, NGO, private commercial sector) meet and maintain standards of informed choice and quality of care.

² Later renamed the Office of Population and Reproductive Health (OPRH).

USAID adopted the approach outlined in this report, which included the following steps for recipient countries of FP assistance that were approaching the specified criteria (USAID, 2008).

As countries begin to approach these threshold levels, USAID is required to:

1. Conduct an initial assessment of the actual program strengths and weaknesses and the main challenges to successful graduation, and begin the development of a phase-out plan. Representatives from GH/OPRH and health staff from the appropriate regional office work with Mission staff on this assessment.
 - a. The areas of key interest in this assessment include the following:
 - National commitment to programs;
 - Adequate financing of programs;
 - Contraceptive security;
 - Adequate human resources, including sustainable leadership and technical skills;
 - Quality of information and services;
 - Appropriate engagement of the private sector; and
 - Attention to access of underserved populations.
2. Prepare a phase-out plan for each recipient country of FP assistance once that country begins to approach the family planning/reproductive health (FP/RH) graduation thresholds; the plan should:
 - a. Articulate a process to reinforce the national commitment to and existence of adequate financing, sustainable skills and leadership, and attention to underserved populations; and
 - b. Describe ways of continuing relationship with former counterparts.

The phase-out of funding for FP may or may not be accompanied by the phase-out of funding for other health programs (which may or may not have achieved the same level of maturity). Whereas “zero” funding is the objective to phase-out, in some cases USAID has opted to provide small amounts of funding post-graduation for specific activities, such as the demographic and health surveys (DHS), or in response to short-term emergency situations.

II. Experience of countries (worldwide) that have graduated to date

Successful graduation from USAID FP/RH assistance means that FP service delivery continues to support the level of contraceptive prevalence achieved before graduation and inequities in

access to services do not increase (USAID, 2006). Criteria for evaluating successful graduation include:

- A sustained or increasing modern contraceptive prevalence rate (CPR);
- In-country technical, administrative and programmatic capacity capable of maintaining FP service delivery, and adapting to changes as appropriate;
- On-going financing of essential aspects of FP service delivery and products, including contraceptives; and
- Services directed to remaining pockets of unmet need.

Table 1 lists the countries that have graduated from USAID assistance and the year of their graduation. (Note: this list does not include some 24 countries in which USAID closed its Missions, primarily in West Africa, over a 25-year period)

A. The process of negotiating graduation from FP assistance

The graduation experience occurred under different circumstances in different countries. Among the earlier “graduates,” the negotiations for the phase-out of USAID FP assistance generally occurred when these countries reached a certain level of contraceptive prevalence and were considered ready to continue the FP programs on their own. In most countries this process involved discussions between USAID/Washington and the USAID Mission in question, then with members of the government and other stakeholders (e.g., the IPPF member association) in country. The nature of these negotiations varied by country based on the leadership in place, the level of dependency on USAID funding, and the perceived feasibility of maintaining a strong FP program post-graduation.

For example, the phase-out of FP assistance in Mexico in 1999 took place after in-depth negotiations involving Mexican officials and two different directors of the Office of Population who were directly engaged in the process. Because of the proximity of Mexico to the United States, the Latino Caucus of the U.S. Congress became involved, and the Director of the Bureau of Global Health at USAID, Dr. Duff Gillespie, traveled to Texas to discuss the phase-out with Congressional representatives from that border state. In the end, the Mexicans were “resigned and sad, but not hostile” (Gillespie, 2010).

The graduation process in other countries occurred over a multi-year period in which USAID worked closely with local implementing partners to ensure a gradual and smooth transition of technical and financial input to the program. Although small setbacks may have occurred, overall the process occurred in a climate of mutual support and respect, often culminated by a well-publicized “celebration” of this event involving local stakeholders and U.S. officials. The Morocco experience with graduation followed this model (Hajji and Bertrand, 1999).

However, the graduation has not always proceeded smoothly. In the case of Indonesia, there was considerable resistance on the part of USAID staff and local government and private sector counterparts to the concept of graduation (which occurred in 2007). Moreover, it coincided with the period of health sector reform in Indonesia, marked by a major decentralization effort. Since much of the success of the Indonesia program to that point had been orchestrated from the offices of the National Family Planning Coordination Board (BKKBN) in Jakarta, many questioned if the program could be maintained at then-current levels if USAID were to withdraw FP assistance. Indeed, one population expert knowledgeable about the FP program in Indonesia reported that FP is declining in many districts. Specifically, norms have not been established, medicalization is creeping back (e.g., trained midwives may not be allowed to insert implants), and only 20 percent of districts have a full complement of BKKBN offices. USAID has provided some technical assistance post-graduation in order to address the most pressing issues facing the program (Radloff, 2011). The upcoming DHS will confirm the extent of this backsliding, if indeed it is occurring (Rimon, 2010).



Marcin Szczepanski, University of Michigan

Since USAID instituted an official policy in 2004 with a systematic process for the graduation of countries from family planning, additional countries shown on the bottom half of Table 1 have also graduated from USAID FP assistance (Jamaica and the Dominican Republic) or are scheduled to graduate this year (Peru and El Salvador). It is too soon to know the long-term effects of this phase-out on contraceptive use.

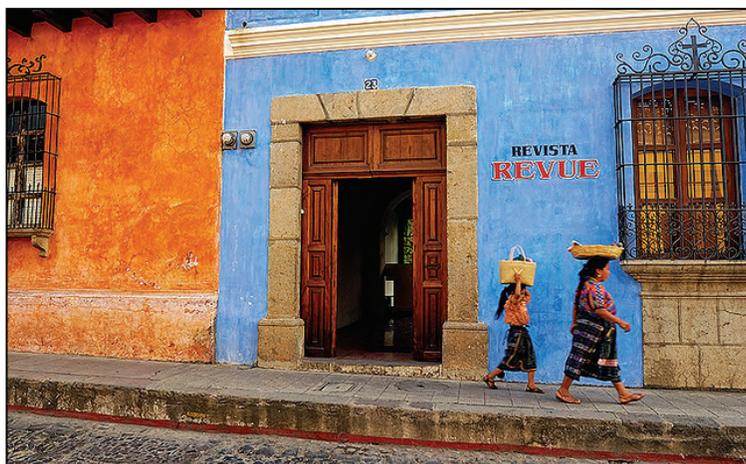
B. The impact of graduation in selected countries

To date, no systematic analysis has been undertaken of the impact of graduation on the countries that have gone through the graduation process (Cromer et al, 2004). It is important to recognize that USAID funding is only one of many factors in the success of a national FP program; the total fertility rate (TFR) or CPR are influenced by changes in economic conditions, a functioning health delivery system, social status of women, the legal status of abortion, natural disasters, political turmoil, and related macro-level factors.

It is beyond the scope of the current report to conduct an in-depth analysis of the consequences of graduation in the countries that have completed this process and have national-level survey

data in the post-graduation years. Nonetheless, it is interesting to analyze the trends in contraceptive prevalence in the countries in which graduation has occurred and national-level data (such as the DHS) are available. Figure 3 in the annexes shows modern contraceptive prevalence in four LAC countries that graduated by 2001 and have data on modern CPR before and after graduation. The arrow shown on the line graph for each country indicates the year of graduation.

Figure 4 shows similar data for three other graduated countries outside of Latin America. In all cases these graduated countries were able to maintain or increase their levels of modern contraceptive prevalence in the years following the phase-out of USAID FP assistance. However, it is important to note two characteristics of these countries: most of these countries were middle- or low-middle income countries, and in most cases outside of Latin America, the government was the major provider of family planning services – not an NGO.



Abe Kleinfeld

In sum, at least in terms of maintaining contraceptive prevalence at its previous levels, the data in Figures 3 and 4 support the decision of USAID to graduate them. However, to date there has not been a systematic study of the effect of graduation on fertility rates and contraceptive prevalence in all countries. There is some indication that while overall contraceptive prevalence has risen and fertility rates have

continued to decline, this is not universally the case for more vulnerable population groups. In Brazil and Colombia fertility rates among the 15-19 year-old population have actually increased in recent years (Rodriguez Vignoli, 2010). There is also a need for a more thorough follow-up of what happens with women in the lowest income quintiles.

A forthcoming study on Peru's experience suggests that the family planning program there has been highly vulnerable to political trends in the country, with an overall tendency towards greater inequities (LaRamee, 2010). An ambitious program of health reform and decentralization with many functions devolving to regions and municipalities poses new challenges to the sustainability of the family planning program, especially for vulnerable groups. The 2009 Peru DHS reports that modern contraceptive prevalence has hovered at or below the level it was in 2000 (50 percent). There are strong indications that the program does not currently have the capacity to provide contraceptives in a sustainable manner. At this writing, USAID is considering a postponement of the graduation date for Peru (Stewart, 2011).

C. Recommendations for preparing for graduation

In 2003 the USAID Bureau of Latin America and the Caribbean (LAC) supported a year-long regional study to determine how contraceptive security planning in LAC countries could be more effectively addressed and strengthened. The study focused on Bolivia, Honduras, Nicaragua, Paraguay, and Peru, and included secondary data analysis for El Salvador and Guatemala (DELIVER and POLICY Projects, 2004). Recommendations from this study for ensuring that contraceptive security could be maintained after the phase-out of USAID donations were as follows:

- Develop comprehensive contraceptive security plans and phase-out schedules among USAID, the government, and NGO recipients of USAID-donated contraceptives;
- Work to increase budgets for contraceptives (including a budget line item);
- Conduct market segmentation analyses for strategic targeting of subpopulations in the future;
- In the short-term, procure commodities through the United Nations Population Fund (UNFPA) or the United Nations Development Program (UNDP) to take advantage of lower prices than through commercial pharmaceutical companies;
- Promote reproductive health and contraceptive security as essential aspects of economic development; and
- Integrate and continue to strengthen contraceptive logistics through capacity building, proper equipment, and adequate supervision.

USAID Missions that have successfully graduated FP programs have provided valuable guidance on this process (USAID, 2006), noting:

- A need for careful, consistent and honest communication with host country counterparts and other assistance partners (including discussion of timelines);
- The importance of encouraging and publicly recognizing the host country counterparts for the steps they have taken to improve program performance and sustainability; and
- The value of celebrating the success inherent in graduation by publicly acknowledging the contributions made by leaders at USAID and the host government.

III. Graduation status of Latin American countries from family planning assistance

The current report looks specifically at graduation in the context of Latin America. Countries in Latin America that have received USAID FP assistance fall into three categories vis-à-vis graduation:

- Have already graduated (either before or after the 2004 graduation strategy was instituted):
 - Brazil, Colombia, Costa Rica, the Dominican Republic, Ecuador, Jamaica, México, and Panamá.
- Are scheduled to graduate between FY2010 and FY2013:
 - Honduras, Nicaragua, Paraguay and Peru.³
- Are not on the list to graduate:
 - Bolivia, Guatemala, and Haiti.

The levels of USAID FP assistance to the three countries definitely scheduled for graduation appear in Figure 7 located in the Annexes.

IV. Status of contraceptive use and family planning programs in Latin American countries that have not yet graduated

In this section we review the current status of family planning in the six countries above that have not yet graduated and which have definite graduation plans. Tables 2-6 present the most updated information available on key family planning indicators for each country. Tables 7 and 8 describe how FP services and programs are organized in each country. In addition, we have provided data on Belize, where available.⁴ These data provide context for our analysis of the prospects and challenges of graduation for Honduras, Nicaragua, and Paraguay (sections VI-VIII below). They also reflect the continuing need for USAID support for FP in the three remaining countries (Bolivia, Guatemala, and Haiti), discussed in sections IX-XI.

Tables 2-10 present the data on the countries, grouped by graduation status:

- Those scheduled to graduate by 2013: Honduras, Nicaragua, and Paraguay;
- Those not yet scheduled for graduation: Bolivia, Guatemala, and Haiti; and
- Belize (where data are available).

From Table 2 showing the gross domestic product (GDP) for this set of countries, one can observe that GDP is not a criterion. Guatemala – with the highest GDP of \$2,848 – is not slated for graduation, whereas Nicaragua – ranking fifth out of these six countries in GDP (at \$1,228)

³ Peru is an anomalous case. It is scheduled to graduate in FY2010. At the time of this writing, this decision is under review and is dependent on the availability of funds in the beleaguered USAID budget currently before the U.S. Congress. Should funding be available Peru will graduate in FY2013.

⁴ Note: Belize was included in the scope of work for this report, as one of seven countries to be covered. However, USAID has never given significant FP assistance to Belize, and thus we have excluded it from the discussion in most sections of this report.

is. Not surprisingly, Haiti – with the lowest GDP of \$717 (measured in 2009) – is not scheduled for graduation. With the lowest modern contraceptive prevalence rate in the Western Hemisphere, Haiti would not have been a likely candidate for graduation, and the earthquake in January 2010 dramatically increased its dependence on international funding sources for all areas of development for many years to come.

A. Contraceptive prevalence among married women of reproductive age (MWRA)

Given that modern contraceptive prevalence rate (MCPR) is one of the criteria for selecting countries to graduate, it is not surprising that the three countries slated for graduation have a higher MCPR than those not scheduled for graduation. Paraguay (71 percent), Nicaragua (70 percent), and Honduras (56 percent) are much higher than Bolivia (35 percent), Guatemala (55 percent), and Haiti (25 percent); see Table 3. As of 2010, MCPR was 67 percent for Latin America and the Caribbean as a whole, 69 percent for South America, and 63 percent for Central America (Population Reference Bureau, 2010). (Note: the lower MCPR for Caribbean countries – at 55 percent - decreases the MCPR for the LAC region.) In comparing these percentages from Central and South America to the MCPR in the United States (72 percent), one realizes the strides that Latin America has made in terms of contraceptive use.

However, Table 3 also reflects another important phenomenon. The three countries scheduled for graduation show less of a gap between the use of modern methods (MCPR) and the use of all methods (CPR) than do the other countries. Specifically, the soon-to-graduate countries show a gap between these two measures of 2-9 percentage points. By contrast, the three countries not on the graduation list show a gap of 7 to 26 percentage points, with Bolivia having the greatest difference. From these data, one can infer that the countries scheduled for graduation have been more successful at reaching married women of reproductive age (MWRA) with effective contraceptive methods than the other three countries.

B. Method mix

Method mix refers to the distribution of contraceptive methods used by women reporting contraceptive use. It answers the question: What methods are most popular among users in a given country?

Method mix is important for several reasons (Sullivan et al, 2006). Although there is no “ideal” method mix and the current-day emphasis is on giving women what they want in terms of method, in fact, program managers and donors often prefer to see a varied method mix, indicating that women have access to different contraceptive options. In a country where the majority of clients use a single method (e.g., two-thirds of users in the Dominican Republic have undergone female sterilization), there may be a suspicion of provider bias. However, a

competing explanation relates to social norms in a given community: “If everyone else chooses this method, it’s probably the best for me.”

A second reason that a method mix is important is that some methods are more effective than others in controlling fertility. Countries with a high prevalence of use of female sterilization and intra-uterine devices (IUDs) are likely to have fewer unintended pregnancies than countries relying on condoms or the pill, which require constant vigilance to achieve fertility control. Although the promotion of long-term methods became politically charged around the time of the Cairo Conference – based on the suspicion that pressure to achieve high couple years of protection (CYP) would result in provider bias or attempts to increase CYP at the expense of client free choice – many countries have now returned to promotion of such methods both due to client demand and their potential cost-effectiveness.

A third implication of method mix is cost. Some methods are much more expensive than others. For example, an IUD is relatively inexpensive because the device itself is inexpensive and once inserted represents little additional cost. By contrast, injectables – which have gained dramatically in popularity over the past decade in countries worldwide – require a new dose of the product every one to three months.

Table 4 presents the method mix for each country. What is striking from this table is the lack of pattern in terms of “preferred method,” although the injectable comes closest, being either the first or second in terms of preference across the six countries. Female sterilization – which used to be the leading contraceptive method in Latin America – is number one in Guatemala and Honduras, but toward the bottom of the list are Paraguay and Haiti. The pill, highly popular in earlier days of family planning, is the preferred method in Paraguay, but ranks far lower in Bolivia, Guatemala, and Haiti. Condoms, not traditionally a popular method of FP except where HIV prevalence is high, rank low in all countries except Haiti. And traditional methods, which usually represent a low proportion of use, are number one in Bolivia, reflecting the influence of the indigenous medical traditions in the country.



Hilary Thomas

In sum, if one can find any pattern regarding method mix in these data, it is that injectables and female sterilization are the top two methods in three Central American countries: Guatemala, Honduras, and Nicaragua. We will return to the issue of method mix in discussing the sustainability of FP programs post-graduation as clients show an increasing preference for injectable contraceptive methods. A promising new alternative, which costs up to 60 percent less than other implants, Sino-implant (II), is gaining increasing acceptance in the region.

C. Source of contraceptive supply

The source of contraceptive supply is useful to understanding the dynamics of a given country for at least two reasons. First, it explains an important aspect of the dynamics of contraceptive use in a given country. Second, it allows one to understand the role of government in the provision of services in a given country.

Table 5 presents the data on source of contraceptive supply for all six countries except Haiti, for which this information is not available.⁵ In five of the six countries (all except Paraguay), the public sector is the primary supplier of contraceptive methods in the country. In Guatemala, the data are not disaggregated between the Ministry of Health (MOH) and the Social Security Institute, but anecdotal evidence suggests that the pattern is probably very similar to what is found for Bolivia, Honduras, Nicaragua, and Paraguay, which is that the Social Security Institute is the source for less than 6 percent of contraceptive users. The section below will discuss the role of the Social Security Institutes in the countries scheduled to graduate.

In the early days of family planning in Latin America, International Planned Parenthood Federation (IPPF) played a pioneering role in the promotion of contraceptive use. IPPF member associations (MAs) were often more proactive in increasing access to contraception than were the governments in many of these countries. Only after IPPF MAs demonstrated the latent demand for contraception did governments come to embrace it. In recent years USAID has directed a greater portion of its FP assistance to the governments of each country, rather than to the IPPF member associations. For example, in Guatemala, APROFAM (La Asociación Pro Bienestar de la Familia) for many years was the primary source of contraception. However, by 2008 the public sector had assumed that role.

The data in Table 5 reflect this trend of a diminished role for IPPF member associations in the provision of contraception to MWRA. In the four countries that separate out the percent of use corresponding to the IPPF member association, it ranges from 5 percent in Nicaragua, 8 percent in Bolivia, 11 percent in Paraguay, and 25 percent in Honduras.

Pharmacies and other commercial outlets contribute significantly to the provision of contraceptive services. In the three countries where the data are broken out separately for pharmacies and other commercial outlets (Bolivia, Honduras, and Paraguay), at least one quarter of users obtain their contraception from this source. The high percentage in Paraguay (41 percent) that uses pharmacies may be due to the community pharmacies distributed around the country and is consistent with the popularity of oral contraception in the country.

⁵Data are available for Haiti on source of contraceptive supply by method, but not for all methods combined, as is shown in Table 5.

D. Unmet need

Unmet need refers to the percent of MWRA that do not want a pregnancy now or in the next two years but are not currently using a contraceptive method (Population Reference Bureau, 2010). This variable is constructed from answers given by respondents in the DHS to several different questions.

Table 6 shows the percent of MWRA that have an unmet need for contraception in the six countries of interest. The data indicate that unmet need is lower (ranging from 7-17 percent) in the three countries scheduled to graduate than in the three countries not slated for graduation (where the range is 20-37 percent). In fact, Guatemala and Bolivia (with 20-21 percent unmet need) are only slightly higher than one of the countries to graduate (Honduras, at 17 percent). By contrast, Haiti is truly an outlier with over one-third of MWRA having unmet need for contraception, and these data predate the earthquake in Haiti.



Julio Pantoja, World Bank

While great strides have been made in all countries in increasing access to the middle and upper classes, there are still significant unmet needs among the poor. The data on unmet need by level of wealth are striking in the consistency of the findings (see Table 7). For all countries, women with the least resources had the greatest unmet need, without exception.^{6,7} The gap between the highest and lowest levels of wealth was smaller for the countries

scheduled to graduate (only 3 percentage points in Paraguay, 6 in Nicaragua, and 12 in Honduras) than in the two countries not on the graduation list (13 points in Haiti and 25 in Bolivia). The high level of unmet need in Haiti and disparity between rich and poor on unmet need in Bolivia are further reasons why these two countries are not yet slated for graduation.

E. The Family Planning Program Effort Index, 2009

The data presented in the previous section (Tables 3-7) comes from national surveys with representative samples. The Family Planning Program Effort Index (FPPEI) is an entirely

⁶Guatemala did not present data by wealth quintiles but rather by ethnic group and education level. The patterns were similar, with the greatest level of unmet need among those with the least education. Also, unmet need was higher among the Mayan population than among the non-Mayan population.

⁷ Some countries presented the data for 3 groups, others as quintiles. For the sake of comparison, we reduced the quintile data from five to three categories.

different source of data. It represents an attempt to collect data on the strength of family planning programs in a large number of developing countries over time based on responses from key informants. The FPPEI now includes six cycles of data collection for the years 1972, 1982, 1989, 1994, 1999, and 2009 (Ross and Smith, 2010). Whereas contraceptive prevalence measures the outcome of family planning programs, the FPPEI measures the inputs into those programs. Higher FPPEI scores are associated with stronger FP programs.

As shown in Table 8, the three countries scheduled for graduation tended to score higher on the FPPEI (between 46 and 50 percent of the maximum possible score) than did the three countries not listed for graduation (which scored from 33 in Haiti to 49 in Bolivia). In fact, five of these six countries fall in a similar range on this index with Haiti being the strong outlier.

The FPPEI also scores each country on four dimensions: policy, services, evaluation, and access to contraception. All of the countries except Haiti tended to score slightly higher on two of the dimensions – access and evaluation – than on policies and services. Interestingly, although Haiti scored much lower than the other five countries on this index, its highest score for a single dimension was on policy, suggesting a country that perhaps had the right ideas but was unable to implement them.

F. Organizations involved in FP service delivery

Table 9 provides information on the three of the primary providers of FP services in each of these countries. It does not include pharmacies or other commercial outlets, which are important in some countries, as shown in Table 5.

In all six countries under discussion, the MOH plays a major role in FP service delivery. Data from the “Contraceptive Security Index – Governance Indicator” (USAID/DELIVER, 2009) reflect how favorable the MOH in each country is to family planning; the maximum score is 30. The three countries scheduled for graduation fell within a surprisingly tight range: Paraguay (10.8), Nicaragua (11.5), and Honduras (11.8). However, Bolivia (10.6) and Guatemala (11.7) were in this same range. Only Haiti (8.2) was lower than the others.

The USAID/DELIVER report (2009) also rated the strength of service delivery of the Social Security Institute (SSI) in each country. The Social Security Institute provides health insurance for government employees, as well as some others in the formal sector. They are supposed to provide contraceptive services to their beneficiaries, but anecdotal evidence suggests that this model has not been as successful as anticipated. Indeed, all six countries received a rating of “weak” on this dimension.

In May 2010, USAID sponsored a regional technical working meeting for MOHs and SSIs in order to promote an increase of the SSIs' provision of FP services and commodities. This strategy is designed to shift SSI subscribers from the over-burdened MOH services, hopefully freeing the MOH services for those in greater need such as the rural poor and those employed in the informal sector not covered by social security.

As a result of this increased advocacy for the SSI's role in contraceptive security (CS) strategies, some MOHs in the LAC region are increasingly collaborating with SSIs to help expand FP coverage. Despite this progress, much remains to be done to ensure all service providers – public and private – take advantage of economies of scale in procuring reproductive health commodities, that policy norms and procedures are followed and implemented at all levels of the supply chain and service delivery points, and that systems and organizational planning for contraceptive security are managed in a cohesive fashion among all health sectors, including SSIs.

The IPPF member associations (described above as pioneers in the FP movement in Latin America) play very different roles in the six countries. Whereas they are no longer the primary source of contraception in any of the six countries, they do remain a key player in Honduras (ASHONPLAFA, Asociación Hondureña de Planificación de la Familia), Guatemala (APROFAM), and Bolivia (CIES, the Centro de Investigación, Educación y Servicios), both for the services they provide and for the



USAID

visibility they bring to family planning/reproductive health services in these countries. At present, four of the six countries receive USAID funding for the provision of FP services (Bolivia, Guatemala, Haiti, and Honduras). Honduras is the only country scheduled to graduate in which the IPPF MA receives any USAID funding. According to ASHONPLAFA, the funds received from USAID currently make up only 5 percent of their operating budget (Morlacchi, 2010). Among countries not scheduled for graduation, CIES in Bolivia receives significant funding from USAID, APROFAM in Guatemala receives a small amount of funding, and PROFAMIL (Association pour la Promotion de la Famille Haïtienne) in Haiti does not receive USAID funding.

Social marketing programs

As shown in Table 10, all six of the countries have social marketing programs that sell contraceptives at subsidized prices. Population Services International (PSI) has programs in five of the six: Haiti, Guatemala, Honduras, Nicaragua, and Paraguay. The program in the three Central American countries operates under the name of PASMO, or the Pan-American Social Marketing Organization. The PSI/PASMO social marketing programs initially focused on the sale of condoms for HIV/AIDS prevention, but in recent years they have expanded to include a wider range of contraceptives (pills, IUDs, and injectables) in the PSI/PASMO programs above except in Honduras.

APROFAM in Guatemala and ASHONPLAFA in Honduras also operate social marketing programs as part of their effort to provide sustainable services. In Bolivia, PROSALUD operates a system whereby it provides contraceptives at competitive prices to pharmacies and commercial outlets. And in Paraguay, the social marketing program PROMESA (Promoción y Mejoramiento de la Salud, an NGO affiliate of PSI) operated successfully until USAID's support ended and is currently experiencing difficulties with sustainability.

V. Prospects and challenges of graduation for Honduras

Three countries in Latin America are definitely scheduled to graduate before FY2013. In this section we review the situation in Honduras to assess its readiness for graduation. The subsequent two sections will focus on Nicaragua and Paraguay, respectively.

Family planning in Honduras enjoys support from the Secretariat of Health as one of the pillars of the successful and highly valued safe motherhood program in this country (known as RAMNI, or the Reducción de la Mortalidad Materna, Infantil y de la Niñez). It has made impressive gains in contraceptive prevalence in recent years, suggesting a strong level of demand on the part of the population.

A. GOH's acceptance of graduation from USAID FP Assistance

As early as 2000 USAID began discussions with the Government of Honduras (GOH) about assuming a larger role in the procurement of contraceptives for the public sector. Initially, the GOH showed little ownership in this issue, which resulted in the absence of a national budget for funding supplies, inadequate storage and distribution facilities, a lack of a logistics management information system, donor dependency for supplies, and no mechanism for procuring contraceptives independent of donors (USAID/DELIVER, 2007).

Negotiations regarding graduation from FP assistance between USAID and the government of Honduras (under the administration of President Manuel Zelaya) began in 2007. Local officials

were initially apprehensive about taking on this responsibility, given their “comfort level” over USAID playing such a key role in FP for so many years. One particular concern was the limited access to contraception in the rural areas. Yet, officials in the government recognized the importance of family planning, and this plan to work toward self-sufficiency in family planning fit with their own plans for health reform and decentralization of health services.

Thus, in 2007, the GOH and USAID signed an agreement whereby the GOH committed to assuming responsibility for its own FP program by the end of 2012. In this accord the GOH agreed (*inter alia*) to:

- Ensure access to FP to vulnerable populations and in rural areas;
- Consolidate FP service delivery within the public sector;
- Procure contraceptives for the public sector program (gradually increasing to 100 percent by 2012);
- Strengthen pre-service training; and
- Finance the in-country costs of the DHS.

USAID in turn agreed to continue its assistance to the MOH⁸ and ASHONPLAFA (though with decreasing amounts each year as the graduation date neared), to fund technical assistance for strengthening contraceptive procurement and logistics, and to cover the technical assistance costs of the DHS.

Work on implementing the graduation plan was in full swing when in June 2009, Honduras experienced a coup d'état that ousted President Zelaya and brought in a provisional president, Roberto Micheletti. The U.S. government stopped all support to the government of Honduras. Not surprisingly, the new government began its operations in an environment of turmoil, confusion, and uncertainty. Commitments from the previous administration carried no guarantees.

Honduras held free elections in November 2009, which ushered into office President Porfirio Lobo Sosa in January 2010. One year after the coup, some normalcy began to return to public life in Honduras. The plan to phase out USAID FP assistance remains in place, although the deadline has been pushed back to 2013.

B. Contraceptive demand, access, and equity

Honduras has made tremendous strides in the past decade in increasing contraceptive use. However, the level of MCPR, the equity in urban/rural access, and the method mix are all potential factors for concern. Of the three countries scheduled to graduate, Honduras has the

⁸ The MOH in Honduras is known locally as the Secretariat of Health (SOH). However, for purposes of consistency it will be referred to as the Honduran MOH in this report.

lowest CPR and by far the lowest MCPR (56 percent), as shown in Table 3. Moreover, there is considerable divergence in MCPR by wealth quintiles and by urban/rural status. Only 51 percent of women in rural areas currently use a modern contraceptive method compared to 62 percent of women in urban areas (DHS, 2006). Honduras also has the biggest gap between rich and poor in terms of unmet need (shown in table 7). Adolescent fertility rates in Honduras are also among the highest in the region, with large gaps between rich and poor adolescents (Rodriguez Vignoli, 2010).

Regarding method mix, one-third of users in this country opt for female sterilization, which is a highly effective and cost-effective method. However, the second and third most widely used methods are the injectable and the pill, which require constant resupply. Moreover, the injectable is not as cost-effective as female sterilization or the IUD, representing an additional challenge to Honduras as it seeks to become self-sufficient in contraception.

C. Government support for family planning



Hector Medrano, USAID

The MOH has shown strong support for family planning, linking it directly to the national initiative to reduce maternal mortality, which has served as an engine for health reform in Honduras. Family planning is included in the package of guaranteed health services at the primary level, which currently covers one million low-income residents in rural areas and is scheduled to scale up to cover three million.

The key exceptions to the widespread support for family planning in Honduras have occurred in relation to emergency contraception and services to adolescents. Shortly after the coup, the Secretary of Health of the interim government announced that emergency contraception could not be provided in either private or public settings. This prohibition is currently being challenged in court and many feel that it will not be upheld.

While this situation has not affected the larger FP program and there is strong support for family planning at the technical level, it signals a growing force in Honduran politics against sexual and reproductive health and family planning. Highly placed individuals in the legislature actively sought to restrict the work of the MOH on family planning information and services for adolescents and emergency contraception, but have not at this point sought to limit other FP services.

D. Public sector capacity (MOH and Social Security) to deliver FP services

The public sector in Honduras supplies approximately half of all contraceptive users: the MOH supplies 42 percent and Honduran Social Security Institute (IHSS) 6 percent, while the IPPF MA supplies approximately 25 percent. The remainder is supplied by the for-profit private sector and social marketing programs. These numbers reflect in part the important role that ASPHONPLAFA has historically played in this country. Moreover, ASHONPLAFA performs many of the female sterilizations, the most widely used method in the country.

The Social Security Institute, IHSS, is responsible for providing its beneficiaries (workers and their families) with a range of services, including family planning. However, IHSS facilities have not developed strong technical capacity in this area, and instead IHSS tends to encourage its beneficiaries to seek out services from ASHONPLAFA, the MOH, or elsewhere. This same pattern – seen by some as a shirking of its responsibility – appears to occur throughout Central America, with the exception of El Salvador.

With support from the USAID-funded Health Care Improvement Project, the World Bank, and the Inter-American Development Bank (IADB), in the past few years the MOH has implemented a mechanism for extending health care services into rural regions of the country through a decentralized mechanism of service delivery (or third party) contracts. Local government and NGOs are eligible to bid on these contracts. These *convenios* (agreements) include a series of quality indicators, and payment by the government for services provided depends on maintaining a certain level of quality. Assuming family planning remains a part of the basic package of services for the Secretariat of Health, this system of *convenios* will help to extend services to the rural areas.

Public sector FP service delivery lost ground because of the coup. Some services became increasingly hard to obtain, such as voluntary surgical contraception. Although most services seem to be back on track, several informants have expressed concern that the upcoming DHS results might indicate a detrimental impact on FP.

The government is about to issue new norms and guidelines on service delivery in the health sector, which will include family planning. Key topics include strategy, quality of care, logistics, monitoring and evaluation, among others. The FP section will cover such topics as the administration of injectables by community workers, standardized training, and counseling guidelines. These service delivery guidelines are intended to standardize and improve the delivery of health services (including FP) in almost 1,400 services around the country, including 28 hospitals. This document reflects the central position of family planning in the GOH health services delivery.

E. Role of commercial private sector and NGOs in service provision

The commercial private sector (including social marketing programs) is the source of FP for one-quarter of users in Honduras. Given the continuation/expansion of the PASMO activity in Honduras, graduation should not have a large negative effect on this sector. PASMO/Honduras receives funding for HIV/AIDS from USAID and funding for broader sexual and reproductive health work from KfW Bankengruppe (a German development bank) and an anonymous donor.



Tulane University

As mentioned above, ASHONPLAFA has been a leader in FP service provision for over 40 years. It has struggled to become self-sufficient over the past decade, as both USAID and IPPF have reduced their funding levels dramatically. Currently, USAID and IPPF provide approximately 5 percent each of ASHONPLAFA's operating budget. ASHONPLAFA has responded to the challenge of remaining sustainable by developing and offering new services to its low middle-to-middle class clientele (e.g., such as dental services, eye care, mammograms, pediatrics, and internal medicine) to subsidize its FP services. At present, it has reached 97 percent self-sufficiency, running on a very tight budget. In the past, USAID has supported ASHONPLAFA's community-based distribution program as a means of extending the reach of FP services to rural areas; however, this funding has tapered off in recent years and will end in 2011. As a result, the number of community based delivery (CBD) posts has dropped from 2,500 to just over 1,500 for lack of an alternative funding source. ASHONPLAFA has also had a small social marketing project to promote pills, condoms, and the injectable under the brand names *Guardian* and *Piel*, but it finds it difficult to compete with PASMO's social marketing efforts.

APHONPLAFA remains an important provider of FP services and should be able to maintain its seven urban clinics after the country graduates from FP assistance. It is expected to play a key role in rural areas as well, as a third party subcontractor to the GOH under the new decentralized mechanism of public/private partnerships. It might also be tapped for other tasks, e.g., training. If this does not come to pass, the phase-out of USAID funding to ASHONPLAFA could have negative consequences on contraceptive access in rural areas.

F. Contraceptive security

Contraceptive security is a key objective in all countries committed to providing FP services to their population. Contraceptive security exists “when every person is able to choose, obtain, and use quality contraceptives and condoms for family planning and for the prevention of HIV and AIDS and other sexually transmitted infections” (USAID/DELIVER PROJECT, 2010). It requires the capacity to forecast contraceptive needs, procure contraceptives on the international market at competitive prices, warehouse products upon delivery, distribute them efficiently to service delivery points, monitor supplies to guard against stock-outs, and manage the entire process. In the past, USAID has played a major role in this process. From 1995-98, it was the sole donor of contraceptives; from 1998-2003 it provided 83 percent of contraceptive donations to this country. Thus, for Honduras to be ready for graduation, the GOH needed to make a financial commitment to procuring its own contraceptives and to strengthening its technical capacity in contraceptives logistics.

In terms of procuring its own contraceptives, the GOH began to do so in 2002 by purchasing condoms and injectables, and by 2003 it was contributing \$200,000 toward the purchase of IUDs and oral contraceptives. With the agreement for graduation signed in 2007, the GOH committed to annually increasing its share of the purchase of contraception for public sector service delivery, until 2010 when it would assume 100 percent of the cost, a goal it has not been able to meet.

The new national plan is to restructure the budget to provide resources for the district and municipal levels. The current allocation for 2011 for contraceptives is \$1.3 million. According to one USAID official, the problem is not the level of funding, but the ability of the government to plan and accurately estimate its needs, and to implement and monitor the necessary logistical system.

In terms of technical capacity to manage all aspects of contraceptive logistics, USAID agreed to provide technical assistance through Management Sciences for Health’s (MSH) local office ULAT (Unidad Local de Apoyo Técnico). In 2007 this office began working closely with MOH counterparts in building their capacity in the multiple aspects of contraceptive logistics and procurement, with a focus on leadership, management, and sustainability. From this point onward, projections for contraceptive needs were based on “real numbers,” not just historical data. ULAT also worked with ASHONPLAFA and the IHSS.

The GOH was making strong progress in developing its contraceptive logistics systems prior to the coup in June 2009. They worked on these processes in tandem with health system reform that gave more power to service delivery points in the regions. In recent months, as normalcy has returned to public life, counterparts in the MOH have again engaged in this process, although the

outbreak of dengue fever and other pressing health issues have diverted some attention elsewhere.

The technical advisor for ULAT feels confident that the country can take over the FP program and maintain the current level of functioning if the GOH follows the current plan for execution. Of all the provisions in the plan, the most important is the financing of the contraceptives. Thus, there is great interest in the ultimate fate of the *líneafija* (fixed line item) in the national budget for this purpose. In addition, there are other important considerations, such as training and equipment. The biggest threat to graduation, in the advisor's opinion, would be if the budget structure were to change.

According to one USAID/Honduras official, "The political will for graduation is there." USAID and the new government have a shared vision on the need to move Honduras toward self-sufficiency in family planning, even if at times it is "scary to think of ending this long relationship."

UNFPA/Honduras staff had some reservations about the current status of the logistics system, feeling that it still requires some work to function optimally. Nevertheless, they felt that this would soon be achieved.

G. The role of the Contraceptive Security (DAIA) Committee

In July 2003, with support from UNFPA and USAID, the ministries of health in various Latin American and Caribbean countries met in Managua, Nicaragua, to launch an initiative known as Disponibilidad Asegurada de Insumos Anticonceptivos, or DAIA (Assured Availability of Contraceptive Products). Each participating country developed its own national committee. In the case of Honduras, members of the DAIA include the Secretariat of Health, ASHONPLAFA, PASMO, USAID, and UNFPA. The USAID Office of Population, Latin America/Caribbean (LAC) Division has provided key technical assistance to this initiative through the DELIVER project.

In 2004 this group of countries convened in Lima, Peru, for a forum on "DAIA-Regional Initiative in Latin America and the Caribbean." They defined four key components to strengthen the DAIA strategy: (1) Political commitment and leadership; (2) Market segmentation; (3) Procurement and financing; and (4) Logistics in the era of health reform. The actions of the local committees were intended to prepare countries for the gradual withdrawal of USAID funding for contraceptive procurement.

According to USAID/Honduras, the DAIA is playing an important role in keeping the different organizations involved in FP service delivery focused on issues of forecasting, procurement,

distribution, and monitoring. Moreover, it is coordinating market segmentation. That is, the DAIA is ensuring that all segments of the population in all areas have access to contraception from the different organizations represented and from the commercial sector.

As with many activities in Honduras, the DAIA lost some momentum after the coup. One informant commented that the meetings of the DAIA seem directed primarily to the needs of the government and less so to other stakeholders. Nonetheless, the DAIA appears to be critical to the GOH's attempts to ensure contraceptive security as it moves toward graduation.

While the government of Honduras attended the regional conference of the DAIA and



John Donaghy

Ministers of Health held in June 2010 in the Dominican Republic, it was the only country at that meeting that did not sign the Punta Cana Declaration reaffirming the government commitment to take action on contraceptive security.

H. Role of UNFPA

At the global level, UNFPA became heavily involved in contraceptive procurement in 1995-96. It established a special unit for procurement of contraceptives and devised a mechanism to bid on and procure a range of contraceptives at highly favorable prices, based on high volume purchase. It has been a win-win situation because it has decreased the price of contraceptives for countries that tap into this mechanism while assuring them the timely delivery of quality products. The extent of use of this mechanism differs by country. It is particularly appropriate for countries that have the funds available to purchase contraception but may lack procurement savvy.

In recent years, UNFPA has played a key role in contraceptive procurement. In the year prior to the coup, the GOH had committed \$1 million to the procurement of contraceptives. In May 2009 UNFPA/Honduras forecast a shortage. UNFPA headquarters agreed to provide a one million dollar donation on an exceptional basis to cover this emergency, and these funds covered contraceptive procurement starting in 2010 and carrying over into 2011. However, looking forward, the situation is very complex. The Ministry of Finance is clearly struggling to cover other essential goods and services (e.g., the salaries of teachers and nurses), not to mention unexpected emergencies, such as the dengue fever outbreak. Given the financial situation of Honduras, it appears difficult for the government to commit to a new line item for contraception.

As one official from UNFPA opined, “The country may be theoretically ready, in terms of technical know-how, but given the government crisis, it is very difficult for the government to accept this new line.”

UNFPA thought it was supplying a \$1 million donation of contraceptives on a one-time basis, but now speculates that it may be asked to step in again. In principle, UNFPA/Honduras appears to be willing to be a potential “safety net,” but cautions that it may not be possible to continue doing so. It is the organization’s policy to serve as a facilitator and procurement mechanism, not a contraceptive donor. It remains unclear if continued donations would be authorized by headquarters or whether money will be available.

I. Ongoing relationship between the GOH and USAID

In the *Technical Note* regarding graduation, USAID stresses the value of maintaining ties with the FP programs of graduating countries even if it does not provide financial support. One informant in Honduras indicated that he saw a value in continuing the relationship with USAID, “even if the contract is only for \$1.00.” His point was that having a relationship with USAID gives the local organization *respaldo* (support or backing) and serves as a sort of protection in dealing with government officials on family planning issues.

J. Impressions of USAID staff toward the prospects of graduation

USAID officials made it clear that “there is no turning back” on the decision for Honduras to graduate from FP assistance. They appear cautiously optimistic. The work by ULAT in strengthening all aspects of contraceptive procurement and delivery makes them confident from a technical point of view that the GOH is ready to assume the task of running its own FP program.

However, there is an underlying uneasiness related to the fragility of the new government, coupled with the financial crisis in Honduras and worldwide. Although progress was made in including a *líneafija* in the new budget for contraceptive purchases, there is a fear that in the event of an emergency, the government might use these funds to cover other “more pressing” needs. If this were to happen, there is an implicit expectation that UNFPA might step in (again) to supply the country with contraceptives on an emergency basis.

A second (smaller) area of concern is in-service training for medical and nursing personnel, where little progress has been made in recent years, possibly related to general disarray in the educational sector in Honduras, according to one informant.

The previous government had agreed to fund the in-country costs for the 2011 DHS (\$2 million) through a protected line item in the national budget, with USAID funding the costs for technical assistance. This was viewed as a significant achievement at the time, but given the budget shortfalls in the wake of the coup, the new government can no longer honor this commitment and the Inter-American Development Bank (IADB) has agreed to assume this funding responsibility. Although USAID would have preferred to have the government fund the DHS, they are nonetheless pleased that someone else is funding it. It is unclear what the long term solution will be to funding the DHS.



Mark Garten, UN Photo

USAID obviously wants to see Honduras avoid any setbacks in its FP program, and it plans to monitor the situation closely. It has invested heavily in family planning in this country and would not want to see all the hard work in this sector unravel. There was a sense that if the situation did deteriorate post-graduation, USAID/Honduras might agree to step in to fund discrete items on an exceptional basis.

At the same time, USAID/Honduras seems to have mixed emotions regarding the readiness of UNFPA to step in if needed in the area of contraceptive procurement. As one official mentioned, “When USAID announces its plans to phase out in five years, this should be the responsibility of the countries involved” rather than another donor.

Despite the uncertainties surrounding this process, one USAID informant wouldn’t favor going back on the plan for graduation in 2013. “We are too far into this to even have that discussion. It would be detrimental and counterproductive [to revisit the decision].” Although she did not rule out renegotiating pieces of the agreement, she added that it is not strategic to engage a government in a planning process and then change course. “It’s easier to be dependent, but people [in Honduras] want the pride of being in control. And that’s what we’re here for: to assist them to not need this aid moving forward.”

K. Other

Confidence in the government’s capacity to manage the transition is not universal. One of the respondents expressed concern that a donor pullout would lead to a reduction of the MCPR and an increase in the fertility rate. There also exists a concern that conservative factions in the

legislature will succeed in changing the government's current supportive policies related to family planning.

VI. Prospects and challenges of graduation for Nicaragua

The Gobierno de Reconciliación y Unidad Nacional (GRUN, the government of national reconciliation and unity) under the administration of President Daniel Ortega considers health, as well as education, to be a factor in development and a human right. Thus, the government of Nicaragua (GON) has invested strongly in human capital as a means of improving quality of life and contributing to the productivity of the country. It strives to ensure this right to health through prevention and integrated health services that are free, of acceptable quality, and tailored to the multiple ethnic, cultural, religious, and social realities of the country (Comité de DAIA-Nicaragua, 2009). The Ortega administration has espoused a strongly populist model based on an ethos of empowering the population to take a greater role in decision making.

Nicaragua is one of the few Latin American countries in the initial round of test countries included in the accords of the Paris Declaration on Aid Effectiveness. This accord, designed to streamline aid operations, calls for coordinated efforts between donors and recipient governments in health and other development areas. Nicaragua has been successful at developing and implementing a Sector Wide Approach (SWAp) for the health sector. Under this model all development assistance is channeled through the



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government which takes increasing responsibility for development activities. Nicaragua's commitment to this model has led it to mainstream family planning as part of its family health and maternal mortality reduction plans.

Nicaragua is a poor country (46 percent of its population lives in poverty) that has nonetheless made impressive strides in recent years in macro-level indicators, with input from the international community. The TFR dropped from 3.9 children per woman in 1998 to 2.7 in 2006-07 (DHS, 2007).

Since 1991, USAID has invested over \$200 million in the health programs of Nicaragua, one-third of which has gone to family planning and reproductive health. Today, family planning is considered one of the most successful programs in Nicaragua.

A. GON's acceptance of graduation from USAID FP assistance

In 2005 USAID began negotiations with the GON regarding the phase-out of FP assistance. A team from USAID/Washington came to Nicaragua to develop a plan with the Mission and local stakeholders.⁹ In fact, Nicaragua was the last country to be visited on a list of seven, reflecting some resistance on the part of local stakeholders. Some didn't believe that USAID was serious about pulling out of family planning in their country, but as one USAID/Nicaragua staff member commented, "No country wants to graduate. It means finding funds in a budget that doesn't increase."

USAID and the GON, under the administration of President Enrique Bolaños, signed a *convenio* in 2005 that covered contraceptive donations only. The plans for assuming greater control over the FP program fit with the ambitions of the new Ortega government for health reform. President Ortega came to office in January 2007 and the change in administration has not affected the plans for graduation.

Nicaragua will continue to receive support from USAID for its other health activities, with a strong emphasis on reducing maternal mortality. This funding represents an indirect support of family planning, given that the GON considers FP a vital component to reducing maternal mortality.

B. Contraceptive demand, access, and equity

For a low-income country, Nicaragua has shown impressive gains in contraceptive prevalence. As of 2006-07, 72 percent of MWRA used contraception and 70 percent of MWRA used modern contraception. The most widely used contraceptive method is female sterilization (25 percent), followed closely by the injectable (24 percent). Other methods include the pill (14 percent), condoms (4 percent), the IUD (4 percent), and other methods (4 percent). Over one quarter (28 percent) of MWRA used no contraception. The increasing popularity of the injectable signals a concern for the future, given that the injectable is a relatively expensive method, and clients prefer the monthly injectable over Depo-Provera (the less expensive alternative administered every three months). However, there is some hope that the injectables will come down in price as the new implant, Sino-implant (II), gains in acceptance.

⁹ Coincidentally, one of the USAID/Nicaragua staff interviewed for this paper was part of that team.

Also impressive, Nicaragua has reduced the urban/rural difference in contraceptive prevalence from previous years. Currently, it is relatively small, with a CPR of 75 percent in urban areas versus 69 percent in rural areas.

In contrast, adolescent pregnancy remains a major challenge. While fertility among 15-19 year-olds declined in the last decade, Nicaragua has the third highest rate in the region (after Haiti and Guatemala) and adolescent fertility among the poorest youth has actually increased in the last decade (Rodrigues Vignoli, 2008). As of 2006-07, unmet need had dropped to 7 percent which is down from 15 percent in 2001. However, the data show geographical differences in unmet need, with the highest levels found in Jinotega, RAAN, Matagalpa, and Madriz. Given the strong emphasis that the GON places on equity in access to health services, these are likely to be targets for more intensive programming in future years.

C. Government support for family planning

Consistent with the fifth Millennium Development Goal (to reduce maternal mortality and achieve universal access to reproductive health, including family planning), the GON has numerous policies and decrees that strongly reinforce its support for family planning as part of the basic health services of the country. Through its Modelo de Salud Familiar y Comunitario (model of community and family health, MOSCAFC), it seeks equity in health, to guarantee access to health services, and to reduce the inequalities in health care for marginalized populations, with a strong focus on sexual and reproductive health. In Nicaragua, as in Honduras, family planning is seen as a key component in reducing maternal mortality.

The National Strategy for Sexual and Reproductive Health (ENSSR) promotes equity, healthy sexuality, contraceptive availability, reduction in maternal mortality, and attention to HIV/AIDS. It seeks “to promote informed and responsible decision-making in the selection and use of contraceptive methods that are safe and effective, through the provision of accessible, quality FP services.” Moreover, this strategy includes the specific objectives of:

- Increasing MCPR from 64.1 percent in 2003 to 75 percent in 2015;
- Reducing unmet need for women with partners aged 15-19 from 19.8 percent in 2001 to 17.5 percent in 2015; and
- Reducing unmet need for women with partners aged 20-24 from 17.0 percent in 2001 to 15.3 percent in 2015 (DAIA-Nicaragua, 2009).

Political support for family planning has been historically strong in Nicaragua. However, at the urging of the Catholic Church, the government has taken extreme legislative action on abortion, prohibiting all abortions even to save the life of the mother (IPPF WHR, State of the Association Update, Nicaragua 2009). This legislation has created tension between the government,

international donors, women’s groups, and sexual and reproductive health organizations. While the controversy over abortion has not directly affected family planning services, the extremely close relationship between the Ortega government and the Catholic Church creates a precarious environment for family planning.

D. Public sector capacity (MOH and Social Security) to deliver FP services

The Ministry of Health¹⁰ plays the predominant role in the delivery of health services, including family planning in Nicaragua. Approximately 70 percent of users obtain their contraception from a public sector facility: 66 percent from the MOH and 4 percent from the INSS. While it is promising that the government has shown such commitment to the delivery of FP services, this strong reliance on an under-funded public sector may not be sustainable over the long run. Moreover, it would represent a major setback for family planning should the government withdraw its support or a government less favorable to FP comes into power in the future.



Elaine Faith

The Nicaraguan Social Security Institute (INSS) has not been a major player in FP service provision. The INSS contracted with service providers to cover its population and most providers covered by INSS did not offer FP services. Because of this, INSS beneficiaries would seek services from the MOH or elsewhere. The INSS has not been able to subscribe a sufficient number of workers from the formal sector (and almost none from the informal

sector) in its system. This inability to finance its services has greatly limited coverage of its beneficiaries in general and has affected its ability or willingness to provide FP services. However, this situation appears to be improving. Some reports suggest that INSS is now providing close to 15 percent of the contraceptives in the public sector, and the goal is for INSS to provide one-third of all public sector contraception by 2015. INSS has a strong working relationship with UNFPA, and it is working to be able to purchase its contraceptives through the UNFPA global procurement mechanism.

¹⁰ The MOH in Nicaragua is known locally as the *Ministerio de Salud* or MINSa. However, for purposes of consistency, it will be referred to as the Nicaraguan MOH in this report.

E. Role of the commercial private sector and NGOs in service provision

Although a commercial private sector exists in Nicaragua, most of the purchase of contraceptives through pharmacies is related to contraceptive social marketing. PASMO, a regional organization established with USAID funding, began its activities in Nicaragua in 1997. It has worked closely with the government in promoting its programs to improve service coverage in the rural areas and empower populations toward improved health. Pharmacies that sell both commercial and socially marketed contraceptives constitute the source of contraception for 23 percent of users.

PROFAMILIA, formerly known as the Asociación Demográfica Nicaragüense, was a pioneer in family planning dating back to the 1970s. With considerable investment from USAID, PROFAMILIA attempted to become sustainable by developing diversified services and serving as a subcontractor to the INSS. While this effort was largely successful in terms of sustainability, this sustainability came at the cost of a loss of focus on family planning and other sexual and reproductive health services. In 2005, USAID withdrew its funding from PROFAMILIA and the organization began a process of re-building its SRH programs with funding from IPPF and various European donors. Today PROFAMILIA struggles to remain financially self-sufficient, but continues to support two dedicated family planning programs, a youth program and community-based distribution (CBD). The organization also provides some services in its 17 clinics and advocates for family planning issues. Its role as a supplier of contraception has continued to decrease in recent years, down to approximately 5 percent of the market. PROFAMILIA has played an important role in the provision of female sterilization; as of 2006/07, more than 40 percent of women that had opted for this method obtained this service from PROFAMILIA (DHS, 2007). However, since then the numbers of operations performed by PROFAMILIA has dropped by more than half, presumably because the MOH is providing this service free of charge, whereas clients must pay at PROFAMILIA.

F. Contraceptive security

Prior to 2006, international donors (primarily USAID) provided 100 percent of contraceptive supplies for the MOH and, in large part, for NGOs working in family planning and other government agencies (e.g., the Army and the National Police). Starting in 2006, the MOH first assigned a budget line item to contraceptive procurement, and the amount has increased since then, consistent with the national policy to guarantee free and universal coverage of this service.

In 2001, USAID announced that it would begin to gradually reduce its contraceptive donations to Nicaragua. Through the DELIVER and POLICY projects it sought to provide technical assistance to Nicaragua in all aspects of contraceptive security. In 2007, the GON and USAID signed an agreement for a gradual reduction in contraceptive donations to the public sector starting that year. According to this document, contraceptive donations (especially Depo-

Provera) would end in 2009, and simultaneously the MOH would gradually increase its contribution.

While the Ministry of Health has consistently maintained its political commitment to covering a gradually increasing percentage of the cost of contraceptive procurement for the public sector, in actuality this has not materialized. From 2002-05 it continued the historical pattern of accepting contraceptive donations from USAID and UNFPA with the USAID portion being almost double that of UNFPA until 2005 when they were near equal. However, from 2006-2009, the percent contribution from the MOH has varied depending upon the availability of donated contraceptives. The highest level of expenditures on contraceptives took place in 2008, when the MOH provided 37 percent of the overall expenditure (approximately 3 times their 2007 expenditure). However, the proportion provided by the MOH decreased to 12 percent in 2009 and in 2010 was still only 20 percent of the total contraceptive expenditure required. Staff of USAID's DELIVER project point out that these low percentages may not be a good gauge of the government's commitment, since the government has never been in the position of not having a donor providing for the remaining need.

There are strong indications that the government may not have sufficient commitment to increase funding to 100 percent any time soon given other priorities (and the availability of donor funding from UNFPA for contraceptives). In 2010, the total contraceptive budget was approximately \$1.4 million dollars and the MOH will presumably require a similar amount for 2011. As of December 2010, approximately 50 percent of the projected funding needed was included in the government's 2011 budget and the MOH was negotiating with donors to see who would provide for the shortfall. According to the MOH's representative to the DAIA Committee, the government will not be able to pay for contraceptives and will be hard pressed even to come up with the 50 percent currently budgeted. The GON is currently negotiating with FONSALUD (Fondo de Apoyo al Sector Salud, a Common Basket Fund created by bilateral and multilateral donors for the purchase of essential medicines and other basic health expenditures) for some of the funding required. According to the MOH representative to the DAIA Committee, "Family planning is a priority, but there are lots of other priorities," (Cuadra, 2010).

For the Nicaraguan government, procurement through UNFPA ensures low prices and reliable supplies. Contraceptives are part of the list of essential drugs that the GON purchases, thus guaranteeing continued government support to their purchase.

The current strategy toward contraceptive security entails:

- A greater role for the INSS in FP service delivery;
- More emphasis on the private sector (presumably pharmacies and social marketing);
- More efficient purchase of contraceptives through UNFPA; and
- Greater emphasis on long-term methods.

G. The role of the DAIA committee

Nicaragua hosted the regional meeting that launched the DAIA initiative in 2003. It formed its own DAIA committee, which the MOH coordinates. Other members include INSS, PASMO, PROFAMILIA, UNFPA, USAID, and several USAID contractors (DELIVER, PRONICASS, FamiSalud, and HCI). The objective is to promote support and collaboration among the key actors in family planning, to guarantee the contraceptive requirements for the country, and maintain or increase the levels of supply and coverage of contraceptives in the country.

In 2005, the MOH produced a *Plan para la Disponibilidad Asegurada de Insumos Anticonceptivos en Nicaragua 2005-08*, which was ratified in 2006. This plan has served as the guideline for the subsequent work of the DAIA.

In April 2009, the DAIA conducted an evaluation of the 2005-08 plan for the purposes of developing a follow-on plan for 2009-2011. It assessed the results on eight indicators, as follows (DAIA-Nicaragua, 2009):

- Completely met (6 indicators): high levels of contraceptive coverage, decreased levels of unmet need, acceptable access to mix of methods, MOH allocation of funding to contraceptive procurement, and market segmentation;
- Completely met (1 indicator): functioning of the DAIA committee (apparently the strategy for reaching hard-to-reach populations was not totally implemented); and
- Partially met (1 indicator): efficient contraceptive logistics system.

According to various sources, the DAIA Committee in Nicaragua is functioning very well with strong commitment on the part of the participating agencies. In 2010, it expanded its area of activity to focus on the adolescent population, especially sexually active adolescents and IEC for SRH. The DAIA Committee has also expanded membership, including an NGO that works with youth and AMNLAE (Asociación de Mujeres Nicaragüenses Luisa Amanda Espinoza, a Nicaraguan women's organization) as members. It has also begun to work with the Ministry of Education on sexuality education in schools (Arauz, 2010).

H. Role of UNFPA

UNFPA has provided financial and technical assistance in the development of the logistical system for contraceptive procurement, as well as advocacy for contraceptive security. It has also contributed to developing the norms and guidelines for FP service delivery. UNFPA considers the Nicaraguan case one of its reproductive health commodities securities success stories (UNFPA, 2009).

In terms of contraceptive procurement, UNFPA's contribution has fluctuated markedly by year. For instance, from 2002 to 2008, UNFPA's contribution represented 34 percent, 31 percent, 34 percent, 48 percent, 69 percent, 46 percent, and 28 percent, respectively, of contraceptive costs. In 2009 Nicaragua was identified as a priority Global Programme "Stream 1" country and UNFPA provided increased support for contraceptives to the GON.

In addition, UNFPA has provided financial and technical support to a series of other initiatives in support of sexual and reproductive health, involving policy, service delivery guidelines, IEC, sexuality education, advocacy, and capacity building. It has also supported safe motherhood, family planning, prevention of cancer in the reproductive organs, HIV/AIDS prevention, adolescents, and strengthening of management systems of medical products (DAIA-Nicaragua, 2009).

I. Ongoing relationship between the GON and USAID

USAID/Nicaragua staff mentioned in passing that they would like to find a way to stay involved in family planning after graduation "in some small way."

J. Impressions of USAID staff toward the prospects of graduation

The USAID/Nicaragua officials were strongly supportive of the graduation process, even when one stated that this meant "losing her job" (though presumably she will be reassigned to another area within USAID). Reportedly, the Mission Director and other top level USAID officials are committed to the phase-out of FP assistance. They gave high marks to the GON for its health policies and for its achievements in improving primary health care, reducing maternal mortality, and getting health services (including FP) to the rural areas. It seems to have made good on the slogan "*Con menos, hacemos mucho mas,*" which translates to, "With less, we are doing much more."

However, the weakness relates to the financial and logistics aspects of ensuring an adequate supply of contraception, not to mention the products and equipment needed for other areas of health care delivery. Whereas USAID/Washington is focused on the issue of these systems vis-à-vis family planning, locally the counterparts are concerned about the systems as they apply to the entire health sector ("It's the same computers...").

A second concern is the financial situation of the country. Nicaragua is a low-income country with a relatively weak infrastructure and is currently facing many challenges. In recent years, bilateral and multilateral agencies have invested heavily in Nicaragua, a priority country for numerous European donors. However, the economic crisis in Europe and a number of missteps

on the part of the Nicaraguan government are causing development budgets to shrink. In addition, the Chavez government in Venezuela has provided a substantial influx of resources for development, but there is considerable speculation that this will be highly dependent on oil prices. Given the current and likely economic difficulties, will the government make good on a commitment to fund contraceptives?

A third issue of concern is funding for the DHS. There is widespread recognition of the importance of the DHS for tracking progress on key fertility and health indicators. Yet, will the government be able to sustain it in the future?

When asked if CPR would drop post-graduation, one USAID/Nicaragua staff member said no. Increases in literacy in recent years have helped to support both increased CPR and reduced maternal mortality. The implication is that demand for contraception is very solid. What remains critical is ensuring supply. USAID/Nicaragua staff indicated that local counterparts now view graduation from FP assistance as a source of pride: “Despite being a poor country, we are able to take this on; we’re not just holding out our hand.” On the day of graduation, there will be a big “congratulations.”

K. Future directions

The 2009 evaluation conducted by the DAIA in Nicaragua gave the country strong marks for progress but identified a number of areas for improvement in the future (USAID/DELIVER, 2009):

- Increase participation from civil society and new actors;
- Continue to implement and automate the logistics system;
- Increase the INSS as a source of contraceptive procurement;
- Improve the mechanisms for procurement;
- Promote the use of long-term methods;
- Improve conditions for the provision of long-term methods and the IUD;
- Promote the dual use of condoms; and
- Intensify programming to reach adolescents.

VII. Prospects and challenges of graduation for Paraguay

Paraguay has a population approaching 7 million and a total fertility rate of 2.5. It is a bilingual culture (Spanish/Guaraní) with 59 percent of the population reporting Guaraní as the first language used in the home. It is one of the poorest countries in the Southern Cone with a GDP per capita of \$4,600. The first USAID family planning assistance project was implemented in 1968, but a lack of dedication and support from the government of Paraguay (GOP), then under

the Stroessner dictatorship, caused the project to shut down ten years later. Although USAID continued to fund the local IPPF member association, CEPEP (Centro Paraguayo de Estudios de Población), with small grants, it remained largely inactive in the family planning arena until after the 1989 overthrow of the 35-year dictatorship. A new constitution was ratified in 1992 and Article 61 recognized the right of all citizens to freely and responsibly decide the number and spacing of the births of their children, as well as the right to receive education and access to adequate family planning services. With the support of the new government, USAID resumed its family planning assistance to Paraguay in 1995 and it has been an integral part of the sector since (FP Graduation Strategy, 2005).

A. GOP's acceptance of graduation from USAID FP assistance

Paraguay's 2004 Reproductive Health Survey (ENDSSR) showed a total fertility rate of 2.9 and a modern contraceptive prevalence rate of 60.5 percent. In March 2005, USAID's Health Sector Council approved a *Technical Note: Approach to Phase-Out of USAID Family Planning Assistance*, which defined the two main criteria for graduation as an MCPR of at least 55 percent and a TFR of less than 3.0. Thus, Paraguay was immediately slated as a candidate for "imminent graduation" (Avila et al, 2005).

As in other Latin American countries, Paraguay had come to depend on strong support from USAID for family planning. When USAID first announced its plan to withdraw FP funding from Paraguay, local officials were surprised and apprehensive, especially about the timeline. However, once it became apparent that USAID would be withdrawing its FP assistance, government officials recognized their responsibility and the need for action (Avila, Personal Correspondence, 2010).

A team including staff from USAID/Washington, USAID/Paraguay, and other key Paraguayan and international stakeholders was assembled to develop Paraguay's family planning graduation plan. As such, Paraguay became the first LAC country to model and implement a graduation plan under the new *Technical Note*. USAID FP funding to Paraguay was scheduled to be discontinued by September 30, 2010 (though USAID funding cycles would allow some activity to extend into 2011), the earliest graduation date of the countries addressed in the report.

The graduation was set in two phases: Phase one, *Immediate Phase-Out* (2006), discontinued funding for three programs that USAID felt had met their objectives, in order to direct efforts towards achieving long term sustainability of the FP/RH Program post-graduation. Phase two, *Phased Graduation* (2006-2010), emphasized three areas of priority to help Paraguay's FP program reach permanent self-sufficiency: (1) Procurement and logistics strengthening; (2) Advocacy including community mobilization for health and support for decentralization; and (3) Increasing access to voluntary female sterilization (Avila et al, 2005).

USAID has developed strong relationships with its local counterparts in Paraguay and the graduation process has remained a collaborative effort. The hope is that this partnership, program, and graduation will stand as a model for current and future USAID FP projects.

B. Contraceptive demand, access, and equity

Of the four countries set to graduate, Paraguay has both the highest CPR (79 percent) and MCPR (71 percent) (see Table 3). Paraguay also has the lowest gap in the CPR between high-income and low-income MWRA (79 percent versus 77 percent). This drop to a gap between high- and low-income women from 16.8 percentage points in 2004 to only 2.3 percentage points was dramatic, especially when compared to the gaps in CPR between rich and poor in other countries (e.g. 25 percentage points in Bolivia). Similarly, the gap in CPR between urban and rural women dropped from 9 percentage points in 2004 (ENDSSR, 2004) to just 0.2 percentage points in 2008 (79.5 versus 79.3).

Paraguay's predominant indigenous group, the Guaraní, represents 80 percent of the lowest income quintile and has historically had a very low CPR. The 2008 data showed that this traditional gap was closing: CPR was 75 percent among Guaraní-only speakers compared to 80 percent among bilingual women. There was one noteworthy regional gap in CPR. The Northern Area of the country, which is traditionally the poorest and least educated region, also had the lowest contraceptive use (CPR of 75 percent, MCPR of 68 percent), which indicates a need for targeted services to the north to reduce regional disparities. Overall, however, the 2008 ENDSSR data reflected that Paraguay had made tremendous strides in achieving a high level of CPR and in reducing disparities between urban/rural women and between the Guaraní and Spanish-speaking population.

Paraguay has a well distributed method mix, as shown in Table 4. No single method represents more than a quarter of the method mix: pill (23 percent), injectables (21 percent), condom (17 percent), IUD (15 percent), female sterilization (12 percent), traditional (11 percent), and other (1 percent).

In contrast to other Latin countries, the percent of MWRA using female sterilization is low. The Ministry of Health¹¹ facilities only provide female sterilization on a post-obstetrical basis, and there are often age barriers to receiving the method. According to the 2008 ENDSSR, one-third of women that do not want more children would be interested in female sterilization. Their reasons for not getting it included, in order of importance, are high cost, age (too young), fear of the operation or its side effects, and doctor's refusal to perform the operation.

¹¹ The MOH in Paraguay is known locally as the Ministerio de Salud Pública y Bienestar Social (MSPBS). However, for purposes of consistency, it will be referred to as the Paraguayan MOH in this report.

In light of these findings, Paraguay's graduation plan lists increasing access to female sterilization as a priority. USAID has been working with CEPEP (the IPPF member association) to try and add voluntary surgical sterilization to their line of services. However, MOH regulations apply to public sector clinics and hospitals, not to NGOs such as CEPEP. Thus, the project has encountered a number of obstacles. CEPEP did receive approval for providing the procedure in its San Lorenzo clinic, but this change has not yet had any population-level effect. In the first year of the program, 2008, only ten operations were performed, including three male sterilizations (CEPEP-Paraguay, 2009).

C. Government support for family planning

The Stroessner dictatorship, which ruled over Paraguay from 1954-1989, contributed to a rocky beginning for family planning initiatives in the country. However, the democracy that replaced it has provided a very favorable political environment for FP. The first major action taken by the GOP to promote sexual and reproductive health was the formation of the National Council for Reproductive health in 1994. The Council includes all government institutions dedicated to reproductive health and family planning, CEPEP, the IPPF MA, women's NGOs, professional organizations of obstetrics and gynecology and other physicians, the Chamber of Pharmacies of Paraguay, and other private sector agencies. Another major landmark for FP in Paraguay came in 2002 when it became one of the few LAC countries to include a direct line item in their national budget specifically for contraceptive procurement (USAID/DELIVER, 2006).



Jan Pešula

The MOH has also taken an active role in the DAIA process by assembling a special task force to develop and pass the *Strategic Plan for the Assured Availability of Contraceptive Products 2006-2010*, which established indicators to monitor and evaluate progress toward achieving sustainable contraceptive security in Paraguay following USAID withdrawal. The report recognized that establishing a sustainable funding mechanism for FP programs represented “an urgent need,” especially in the wake of government cutbacks on healthcare spending from 1998 to 2004 (DAIA, 2006).

In May 2006, Paraguay's congress passed a groundbreaking law entitled *Funding of Reproductive Health Commodities and Safe Birth Kits*. The law directly allocates funds to procure contraceptives and other reproductive health commodities, and guarantees this funding based on projections of future need (as opposed to the historical trends), which in the context of

growing demand represents a tremendous step towards assuring sustainable contraceptive availability. The absence of similar laws in Nicaragua and Honduras is an important consideration.

The MOH has also taken a strong position in meeting Millennium Development Goal Five, which calls for a three quarters reduction in maternal mortality between 1990 and 2015. Given the relatively high levels of maternal mortality among married women in the 15-19 age range, the MOH made concerted efforts to increase CPR for married women aged 15-19. The results of the DHS showed an increase in CPR among 15-19 year-olds from 61 percent in 2004 to 71 percent in 2008 (DHS, 2008).

D. Public sector capacity (MOH and Social Security) to deliver FP services

The public sector provided contraceptives to 41 percent of users in 2008, up from 27 percent in 2004. This public sector provision includes 37 percent coming from the MOH and 4 percent from the Social Security System (Instituto de Previsión Social or IPS) (see Table 5). The IPS is generally regarded as having underperformed in the provision of FP services. In 2004, among IPS beneficiaries using contraceptives, 88 percent received their contraceptives from other sources: 47 percent from pharmacies, 17 percent from the MOH, 3 percent from CEPEP, and 2 percent from private sources (DELIVER, Paraguay, 2007). IPS's lack of involvement in the provision of contraceptives is a major source of concern for Paraguay's success post-graduation. Establishing the IPS as a reliable source of contraceptives for its beneficiaries could open up resources to target poorer populations, thus reducing unmet need.

Prior to 2001, international donors (like USAID) provided 100 percent funds for contraceptives distributed through the public sector. As of 2003, the MOH began supplying 5 percent. In May 2006, the MOH signed an agreement with the UNFPA under which UNFPA would procure the entire supply of public sector contraceptives at favorable rates on the international market, with the GOP accepting full financial responsibility by 2009 (DELIVER, Paraguay, 2006). The successful implementation of this agreement has meant a remarkable transition from almost complete dependence to full independence in contraceptive procurement in less than five years.

E. Role of commercial private sector and NGOs in service provision

Paraguay is the only country within the scope of this report whose primary contraceptive supplier is not the public sector (see Table 5). Rather, the private sector (commercial and NGO) supplied 52 percent of contraceptive users in 2008. Pharmacies provided a majority of that supply, accounting 41 percent overall distribution with the IPPF member association CEPEP providing the remaining 11 percent.

CEPEP has a relatively small role in the supply of contraceptives. However, as of 2008, contraceptive services represented only 13 percent of its service mix, meaning it focused largely on the provision of other reproductive and sexual health services. CEPEP has been working in the FP sector in Paraguay for over forty years and has increased the scope of its work in the last five years to include additional sexual and reproductive health services such as prenatal, gynecological, and pediatric attention. CEPEP services are available to individuals of all socioeconomic classes, although its primary users are from within the middle and higher income levels (USAID/DELIVER, Paraguay, 2006). As with other IPPF associations, CEPEP has added additional paid services to help subsidize its FP services. In addition, USAID has identified CEPEP as a potential provider of female sterilization and has provided some funding to explore this option (Avila et al, 2005). To date only one CEPEP clinic has begun offering the procedure in limited numbers, but now with initial MOH approval and a business plan in place, there is an expectation that CEPEP could scale up its service delivery and become a significant source of voluntary female sterilization.



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The NGO PROMESA (Promoción y Mejoramiento de la Salud), which works under the PSI umbrella, began operations in Paraguay in 1996 with USAID funding. Its emphasis has been using mass media social marketing to increase contraceptive use among adolescents and young adults. Unlike CEPEP, its users generally represent the lower- and middle-income segments of the population

(USAID/DELIVER Paraguay, 2006). It also distributes a significant volume of contraception through the commercial sector, and in 2009 its condom line *PANTE* and oral contraceptive *Segura* each represented a 20 percent share of their respective markets (PSI, 2010). The relatively low price of its products and successful marketing campaign to adolescents may contribute to the overall strength of the commercial sector in Paraguay. However, USAID has withdrawn funding from PROMESA-Paraguay, rendering its social marketing program unsustainable. There is also concern that without further USAID contribution, PROMESA will not be a strong source of contraceptives in the future. (USAID/DELIVER Paraguay, 2007).

F. Contraceptive security

As of 2010, the GOP is financing 100 percent of contraceptives distributed through the public sector. With UNFPA securing low-cost FP commodities on the international market and providing the GOP with assistance in need and budget forecasting, it appears probable that the GOP self-sufficiency will be sustainable.

The stability and sustainability of the private commercial sector in Paraguay is of key concern, given the relatively large market share for contraceptives that it represents in Paraguay. Pharmacies often receive client referrals from health centers during stock-outs, and contraceptive security depends on their ability to meet these shortfalls. National production of contraceptives is limited, with the largest national producers of contraceptives, *Recalcine*, *Lascar*, and *Indufar*, reaching only the private commercial sector (USAID/DELIVER, Paraguay, 2006). Additionally, international pharmaceutical companies offer the same products for varied prices in different countries. Paraguay's private sector could gain stronger negotiating power with pharmaceutical companies by exchanging price information with organizations and companies working in other countries, or by taking advantage of various LAC regional procurement initiatives.

Paraguay's public sector has a history of contraceptive stock-outs at the regional and local levels, making the strength of contraceptive distribution channels one of the greatest concerns regarding the future of contraceptive security. With tight budgets at the local level, resources are often not available to transport products from the central and regional warehouses to local hospitals and clinics. This results in frequent stock-outs of one or more contraceptive methods, often with facilities closer to distribution points remaining well stocked while more remote locations have no supply. Contraceptive rationing occurs frequently, which is especially problematic for patients who travel long distances only to obtain a single cycle of pills (Avila et al, 2005). Both the USAID graduation plan and the DAIA plan have made improved logistics and more even distribution a high priority. The two groups have been successful in helping to strengthen the logistics system, train employees, and target distribution to those with the greatest unmet need. However, with both plans ending in 2010, it will be essential to evaluate the progress that has been made and implement new contraceptive security strategies to ensure the furthering of these gains. Close monitoring will also be needed during the transition to ensure that no segments of the population see reduced or interrupted access to contraceptives.

G. The role of the DAIA committee

Following the launch of the DAIA initiative in Latin America in 2003, the MOH formed its own DAIA committee in order to implement the initiative in Paraguay. This committee became a new

sub-committee under the National Council for Reproductive Health, which was established in 1994. The MOH management team, comprised of the Minister and Vice Minister of Health, the Director of the Sexual and Reproductive Health Program, and the Managing Director of Health Programs, appointed top officials from the IPS, USAID, CEPEP, UNFPA, PROMESA, and DELIVER to serve on the committee. In April 2006, the team published the *Strategic Plan for the Assured Availability of Contraceptive Products 2006-2010*, which was approved by the National Council for Reproductive Health the following month.

The plan defined 20 activities targeted to meet the four pillars of the DAIA strategy: political commitment and leadership, market segmentation, procurement, and financing and logistics. Each activity was delegated to one or more of the various organizations represented on the DAIA committee. While each activity had its own separate objective and expected results, five principal indicators were identified:

1. Percent annual required investment covered by MOH funds – to reach a level of 100 percent by 2010;
2. Percent unsatisfied family planning need – to decrease from 11 percent to 7 percent by 2010 (not considering use of traditional methods as unmet need);
3. Percent IPS beneficiaries using FP, receiving FP services from IPS – to increase from 0 percent in 2004 to 50 percent by 2007 and 100 percent by 2010;
4. Adequate supply- to maintain a minimum of 80 percent of establishments stocked between minimum and maximum on all basic contraceptive methods (IUDs, oral contraceptives, injections, condoms); and
5. Contraceptive Prevalence Rate – to increase CPR from 72.8 percent in 2004 to 76 percent by 2010.

A final report on DAIA progress has not yet been released but an evaluation of the latest data available on the progress of the indicators shows both successes and continued room for improvement. Indicator one has been achieved; the 2010 USAID Contraceptive Security Assessment revealed that in 2008 the GOP spent \$539,537 on contraceptives, exceeding by 1 percent the 67 percent government procurement goal (DELIVER, Measuring CS Security, 2010). Indicator two has also seen marked success, with the 2008 ENDSSR survey indicating 4.7 percent unmet FP need. Indicator three has not progressed: the IPS only represents 3.5 percent of contraceptive supply in 2008, with 100 percent of its contraceptives donated by the MOH. The data to accurately estimate the progress of indicator four is not available, though reported stock-outs remain frequent. The fifth measure has seen remarkable success, as the contraceptive prevalence rate had already surpassed the goal of 76 percent by 2008 (at 79 percent).

Since its founding, the DAIA committee has met either biweekly or monthly to discuss its operations, and has been a successful mechanism for communication and collaboration among

the key FP stakeholders in Paraguay. DELIVER's *Final Country Report 2007* commended the DAIA for being a cohesive group with committed members and for having achieved important advances. Continued collaboration of committee members following the completion of the 2006-2010 DAIA Plan will be an important factor in the advancement of FP in Paraguay following USAID graduation. Furthermore, the GOP has decided to utilize the FP supply chain model for all its commodities. This integrated commodities supply chain will hopefully become a model for the other countries (Stewart, 2011).

H. Role of UNFPA

Historically, UNFPA has provided technical support and logistics strengthening in Paraguay. Budget limitations have made UNFPA only a minor, and at times unreliable, source of contraceptive donations. UNFPA has a member on the DAIA committee, and the organization has worked closely with the committee to try to complement the activities of others (Avila, 2010).

UNFPA signed an agreement with the MOH, which authorizes UNFPA to procure public sector contraceptives on the global market using GOP funds. As public sector contraceptives were previously purchased in the local market at much higher prices, this contract has been an important step towards assuring contraceptive security and sustainability of FP programs post USAID graduation. As Paraguay has no experience purchasing contraceptives in the international market, UNFPA's established mechanisms for contraceptive procurement have been an important resource for the public sector. UNFPA has played a key role in providing information and training on selecting the safest and most cost effective-products, forecasting and calculating purchase volumes, and evaluating vendors and bids (DELIVER, *Contraceptive Procurement Policies, Practices, and Options: Paraguay*, 2006). Their continued presence and support will be especially important following USAID withdrawal.

I. Ongoing relationship between the GOP and USAID

The family planning program currently represents USAID's only health program in Paraguay. USAID linkage to host countries post-graduation is often facilitated through other health program staff that remains in country. The absence of further health personnel on the ground will make post-graduation monitoring a greater challenge in Paraguay. Subsequently, as part of the phase-out plan USAID/Paraguay is soliciting funds from USAID/Washington to help conduct the scheduled 2013-2014 Reproductive Health Survey (similar to the DHS). Proper funding of this survey will be essential to ensuring that Paraguay's FP achievements are maintained or improved (Avila et al, 2005).

J. Impressions of USAID staff toward the prospects of graduation

USAID Paraguay recognizes the important contribution made by USG financial and technical support to Paraguay, but that it is time for the country to take over (Avila, Personal Correspondence, 2010). The fact that no health programs will remain in Paraguay post-FP graduation is a concern, and there have been appeals to USAID/Washington to establish a defined mechanism for collaboration, should problems arise.

Currently the relationship between the United States and Paraguay within the FP/RH sector is one of donor and recipient. The goal is to establish a “partnership of equals” post-graduation, “whereby each party enhances the other’s ability to perform its role as a leader in international efforts to address population issues” (Avila et al, 2005).



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To mark the end of USAID FP assistance in Paraguay, plans are underway to compile a history of the partnership. Additionally, in the months leading up to graduation a series of press articles and events will draw attention to their achievements over the years. The graduation ceremony, scheduled to take place in March 2012, will likely be a celebration of this very successful partnership.

VIII. The prospects and challenges of family planning in Peru

As mentioned earlier in this report, Peru is the one country in Latin America whose graduation status is uncertain at this point. Should funding become available, USAID will consider continuing some form of assistance to the family planning program.

A. History and status of family planning in Peru

When plans for graduation of LAC countries were being made in 2003 and 2004, Peru’s most recent DHS showed a TFR of 2.3 in urban areas and 4.3 in rural areas. Modern contraceptive prevalence was 50.4 percent and total contraceptive prevalence was 68.9 percent among women in union in 2000 (DHS-Peru, 2000). The country indicators were just high enough to be included in plans for graduation.

The previous government of Alberto Fujimori had been highly criticized for not ensuring informed consent in sterilization and possibly engaging in coercion. Right-wing politicians in the United States subjected USAID to intense scrutiny, including two official audits, and discovered no USAID involvement in the overzealous practices of the Fujimori regime. USAID shifted its funding to more closely monitor the Peruvian family planning program.

In 2003, two highly conservative Ministers of Health were appointed in Peru. In addition to attacking emergency contraception, they partially dismantled the family planning program and placed ultra-conservatives in high-level positions in the MOH (Chavez and Coe, 2007). By 2004-05, contraceptive prevalence had dropped to 47.1 percent (DHS-Peru, 2004/5).

While the administration of Alan Garcia was not opposed family planning, it appears that none of the actors in Peru – not the government, the donors, or civil society – have made promotion of family planning a priority. Civil society and even the MOH have worked together to combat right-wing attacks on emergency contraception, but access to other methods of family planning



Thomas Quine

has not been a rallying point. The women's groups who once espoused a woman's right to contraception have been defending other key issues such as violence against women and access to emergency contraception.

Disturbingly, the modern contraceptive prevalence rate in Peru is back to the level it was in 2000, although when traditional methods are factored in, total CPR is 73.2 percent (4.3 percent more than in 2000). Periodic abstinence or rhythm is the method most frequently

reported. Not surprisingly, given the distrust of the method and the lack of physicians willing to perform it, use of female sterilization has declined from 12.3 percent in 2000 to 9.4 percent in 2009 (DHS-Peru, 2009).

B. Procurement, financing and logistics issues

As part of the health sector reform process, there has been a strong emphasis on decentralization with much of the responsibility for health services devolving to the regional and municipal governments. USAID supports technical assistance and training to the government in this process, focusing its support on work at the policy level, quality improvement (including logistics strengthening), and a project to increase demand for and supply of family planning.

USAID discontinued the donation of contraceptives in 2004 except for the one-time exception. Since 2004, the government has been largely responsible for its own procurement efforts, with

support from UNFPA. Approximately 69 percent of contraceptives are provided by the public sector.

In contrast to some of the other countries slated for graduation, the current administration in Peru has shown its willingness to allocate resources to purchasing contraceptives. Of more concern is the lack of an effective and sustainable logistics supply chain. While decentralization is perceived by USAID as successful, there is little doubt that the regions do not yet have the capacity to implement all previously vertical programs – such as family planning – in an integrated structure. Restructuring and rotation of logistics staff to other assignments have decimated the procurement and logistics capacity at the central level (Aspilcueta, 2011). Furthermore, complicated bidding procedures have caused widespread contraceptive stock-outs, including stock-outs of condoms. In 2010, USAID provided a one-time donation of condoms and IUDs because the government was not able to procure the supplies (Janowsky, 2011).

C. Continuation of the Demographic and Health Survey

The government of Peru (GOP) is very aware of the importance of the DHS surveys, and Peru was the first country to introduce a “Continuous DHS” in which data are collected on an annual basis, rather than every five years.

D. USAID Perspective on Peru’s Graduation

USAID staff are concerned that 2011 is not an appropriate moment for graduation. The Peruvian government is making important progress in decentralization, but the regions are not yet prepared to take on the challenge of promoting family planning or ensuring FP commodities on site. According to one USAID official, the health sector reform effort provides an opportunity for a re-vitalization of the family planning program. The 2009 law of Universal Access to Health Care includes family planning as part of the package of essential medicines paving the way to make family planning a vital part of the regions’ programs (Janowsky, 2011). Yet with all of the challenges the government faces in meeting its goals regarding equity and solidarity, continued support for family planning would help ensure that the opportunity is not squandered.

IX. The status of family planning in Bolivia

Despite steady improvement, Bolivia lags behind other Latin American countries in family planning progress. Actual use of any contraceptive method among MWRA hovers at about 60 percent, but modern contraceptive prevalence is only 35 percent. This means that only one-third of all married women in Bolivia use highly effective contraceptive methods, and 25 percent rely on less effective traditional methods. Moreover, Bolivia is a country with high levels of inequity and this is reflected in family planning and reproductive health indicators. The MCPR among the lowest two education levels, no education and some primary education, is 22 percent and 30

percent, respectively, compared to 44 percent among those with the highest level of education. The lowest two wealth quintiles also present low levels of MCPR, at 23 percent and 27 percent, compared to 47 percent for those in the highest wealth quintile. Similarly, there is a 15 percentage point gap in the MCPR between MWRA in urban and rural areas.

A. History and Support for FP Programs in Bolivia

Family planning programs in Bolivia began in the 1980s, later than in neighboring countries. Before this time, Bolivia was not favorable towards family planning. This was due, in part, to the strong presence of Catholicism and ties between the Church and the Bolivian government. In the 1970s, American Peace Corps workers were expelled from Bolivia after being accused of conducting involuntary sterilizations although these allegations were never proven. In the 1980s,



Szymon Kočański

NGOs were prohibited by the Bolivian government from distributing contraceptives. Even today, the Catholic Church continues to thwart certain family planning efforts. CIES, the IPPF member organization in Bolivia, reported an incident in which the Catholic Church tried to convince indigenous leaders to expel USAID and organizations that worked with them in the Chuquisaca region (IPPF State of the Association Update, CIES, 2009). However, such incidents are uncommon, and there are high levels of

political support for family planning in general.

In 2002, the Bolivian government passed a law, *Seguro Universal Maternal Infantil* (SUMI), which guarantees universal healthcare to mothers and their children. In 2005, this was expanded to guarantee family planning services to all women of reproductive age. While in theory this law provides universal FP access to all women, its execution has been flawed and its sustainability after donor phase-out of funding is questionable.

The public sector provides 69 percent of all family planning services. Because of SUMI, these services are subsidized and “available” to all women of reproductive age. However, most hospitals and clinics are located in urban and peri-urban locations and few are accessible to those living in rural areas. This means that those living in urban areas, and often those in higher wealth quintiles, can readily access these subsidized family planning services while those living in rural areas (and often those in lower wealth quintiles) cannot.

The private sector and NGOs have worked to provide low-cost FP services in Bolivia, and their efforts currently make up 35 percent of the market. The two largest NGOs, who both receive USAID funding, are CIES and PROSALUD, the largest social marketing program in Bolivia. In order to increase sustainability, both organizations have begun to charge small user fees, but still provide contraceptives and services at an affordable rate for middle-income users. CIES in particular has made an effort to reach rural populations through Mobile Health Units that travel to rural areas to provide family planning services and contraceptives. CIES hopes to work more closely with the Ministry of Health to increase this practice.

B. Contraceptive Security

Contraceptive security is fragile in Bolivia. While the contraceptive security committee (also known in Bolivia as the DAIA committee) has existed since 2004, it does not have legal status and its activities and progress have been erratic. As of 2008, the committee was not meeting due to changes in Ministry of Health policies.

As of 2008, Bolivia had not yet procured contraceptives for its public sector program at the national level. Almost all contraceptives distributed in Bolivia are donated. UNFPA and JICA (Japan International Cooperation Agency) have been the primary donors, as well as DFID (Department for International Development, United Kingdom) and USAID. All contraceptives distributed in the public sector, as well as those distributed by NGOs, are from international donors. Bolivia has never been responsible for any large-scale procurement. To further complicate the situation, the health system in Bolivia is largely decentralized. Healthcare is dealt with on the municipal level and procurement is expected to occur at this level as well. Each municipality is expected to allocate 10 percent of its budget to health, which includes contraceptives. Each municipality is also expected to procure contraceptives without a larger body governing the process. There are no local producers of contraceptives. Therefore, municipalities must purchase these contraceptives in small quantities and at extremely high prices.

Both situations pose challenges for Bolivia. Municipalities will not be able to sustainably provide contraceptives through individual procurement. In the absence of a larger body able to achieve economies of scale, decentralized contraceptive procurement is not sustainable. It may be necessary to incorporate contraceptive procurement into a more centralized process in order to ensure sustainability. Moreover, Bolivia must begin to take responsibility for procurement if donor presence continues to decrease in order to avoid a major shortage in contraceptive availability.

C. Ethnic Disparities in Bolivia

Ethnic disparities exist in Bolivia across almost all health, social and economic indicators. Approximately half of Bolivia's nine million inhabitants are classified as indigenous. They traditionally do not speak Spanish, but rather Aymará, Quechua, or Guaraní. In the past two decades, through political activism, the Bolivian government has granted its indigenous populations increased constitutional rights. In 2005, the first indigenous president, Evo Morales, was elected. Despite these gains, Bolivia's indigenous population continues to experience high levels of inequity in all spheres. It is estimated that approximately 40 percent of Bolivia's population resides in rural, hard-to-reach locations. The majority of this 40 percent is indigenous. Bolivia's indigenous population is also more likely to experience poverty and less likely to attain high levels of education. Inequality in family planning and reproductive health follows this same pattern.

McNamee (2009) analyzed DHS data to demonstrate the ethnic disparities in relation to fertility and family planning. TFR has been consistently higher among indigenous women (4.3) compared to non-indigenous (3.1). MCPR is also very low among indigenous women at 27 percent compared to 61 percent among non-indigenous women. It is often assumed that this is due to higher fertility preferences among indigenous populations and cultural opposition to family planning. However, indigenous women's approval of family planning is only slightly lower than non-indigenous (83 percent versus 95 percent, respectively), and desired family size is actually lower among indigenous women (at 1.5 children) compared to non-indigenous women (1.7). McNamee concludes that the differences in TFR can be attributed in large part to unwanted fertility and unmet need. These data indicate that many challenges still remain to achieve equity in reproductive health in Bolivia.

D. Need for Continued Family Planning Assistance in Bolivia

While indisputable progress has been made, Bolivia continues to struggle with low levels of modern contraceptive use and extreme inequities in MCPR related to place of residence, education, and ethnicity. The large gap between CPR and MCPR represents an opportunity to move women to more effective means of contraception. The data on desired family size provide support for continued/expanding funding for programs to reach the indigenous populations. One major challenge that must be addressed before donor phase-out is the lack of a centralized procurement process; municipalities will not have the human or financial resources to ensure contraceptive security, and could become overwhelmed in the process, resulting in the potential for widespread stock-outs.

X. The status of family planning in Guatemala

Despite progress in recent years, Guatemala has the highest total fertility rate and lowest contraceptive prevalence rate in any Spanish-speaking country in Latin America. Furthermore, it has the highest adolescent fertility rate in the region except Haiti. The data on CPR reflect a growing but somewhat fragile demand for modern contraceptives. As of 2008, Guatemala had attained a CPR of 54 percent and a modern CPR of 44 percent. The ten percentage point difference between CPR and MCPR indicates that one in four users relies on a less effective contraceptive method. Moreover, the 44 percent CPR masks tremendous urban-rural differences (urban=66 percent, rural=46 percent) and ethnic differences (Ladino=63 percent, Mayan=40 percent). Since much of the Mayan population lives in rural areas, there is considerable overlap in these two indicators of inequity. Furthermore, only one-third (33 percent) of women in union aged 15–19 use a contraceptive method and only 44 percent of women in union 20–24 years of age do so.

A. Reasons for low contraceptive prevalence in Guatemala

Santiso-Galvez and Bertrand (2004) analyzed the low levels of contraceptive use in Guatemala and identified four main reasons:

1) Anti-imperialistic leftist movements of the 1960s and 1970s

During the pioneering years for family planning in Latin America, efforts to launch FP activities in Guatemala were hindered by the strong leftist, anti-American movements that prevailed among certain institutions, such as the universities. Although this factor was not unique to Guatemala, it had lasting effects, even to the present day, in terms of the quality of pre-service training for physicians and nurses in family planning.

2) *La Violencia* during the 1980s

Civil strife in Guatemala intensified during the decade of the 1980s. Focused largely in the rural western highlands of Guatemala, it resulted in massacres and “disappearances” of thousands of innocent people, including anyone appearing to show any leadership traits or to convene groups of community members for whatever purpose exposed themselves to great danger. As a result, many development organizations virtually ceased operating in this area for nearly 10 years, further hindering any preventive health or family planning interventions.

3) Relationship between the Catholic Church and the government of Guatemala in terms of family planning

This strong relationship that persisted from the early 1970s through 2000 between Church and State had a dramatically negative influence on the evolution of family planning services. Catholicism is not generally a barrier to contraceptive use, as shown by very high levels of CPR throughout Latin America. However, it does become a hindrance when the Catholic Church and the government work together to actively block family planning in a given country as has been the case in previous years in Bolivia, Guatemala, and the Philippines. Fortunately, since President Alfonso Portillo took office in 2000, the tight link between the Catholic Church and the Guatemalan government in opposition to family planning has diminished to a great extent and the Church has focused more attention on other issues such as abortion and comprehensive sexuality education. In the past decade, the government, assisted by other organizations, has made tremendous strides in providing family planning services to the low-income population of Guatemala including in rural areas.

4) Marked differences by ethnic groups

Guatemala has the largest indigenous population of any Latin American country: approximately half of its population is culturally Mayan and speaks one of the 21 different Mayan languages. Historically, this group has been politically and economically oppressed. Mired in poverty and suspicious of outsiders, especially those promoting family planning, the Mayans have remained on the outside of Western medical service delivery for decades. Not surprisingly, the Mayans have some of the lowest social and health indicators in the hemisphere.



John Olsson, UN Photo

Significant strides, however, have been made in the past 20 years. The contraceptive prevalence rate among the Mayans (all methods) has increased from 23 percent in 1987 to 40 percent in 2009 (DHS-Guatemala, 2009). In recent years, MOH and NGO services have increasingly reached the towns and rural communities of Guatemala, increasing access to contraception for these populations. However, Guatemala, more than any other country in Latin America, displays the income and ethnic inequities in access to and use of modern contraception, a factor that USAID takes into consideration in considering countries for graduation.

In sum, three of the four barriers to contraceptive use cited by Santiso and Bertrand (2004) are now historical relics. The fourth – the large portion of the population that is Mayan, often illiterate, and living in rural areas of the country – continues to contribute to low contraceptive prevalence in Guatemala.

B. Current situation regarding family planning

1. Policies and political climate

Possibly because of the outright hostility to family planning and political attempts to block service delivery in the past, advocates of family planning in Guatemala have worked aggressively to pass laws and policies that guarantee access to family planning services. Three such laws/policies include:

- *La ley de desarrollo social y población* (the law for social development and population) 2001;
- *Ley de las Bebidas Alcohólicas de 15 percent* (the law of 15 percent of alcoholic beverages) 2005, designed to raise funds to reach the rural poor with services and to reduce dependency on external donors, it stipulates that at least 15 percent of taxes collected on alcoholic beverages will be dedicated to family planning as well as reproductive and mental health services in Guatemala; and
- *Ley de acceso universal y equitativo a los servicios de la planificación familiar y su integración en el programa nacional de salud reproductiva* (the law of universal and equitable access to family planning) 2005, which requires the Ministry of Health and IGSS (Instituto Guatemalteco de Seguro Social) to provide universal FP coverage and quality services and promotes the DAIA (the law for which was passed in 2009). Vetoed in 2005, the law was then approved by congress in 2006, motivating conservative groups to react, thus commissions were formed to study the viability of the law.

When and if these laws are fully implemented, they should help to create a more favorable political climate for family planning. The current government in Guatemala (under the administration of President Alvaro Colom Caballeros) is generally supportive of family planning. Presidential elections are planned for late 2011.

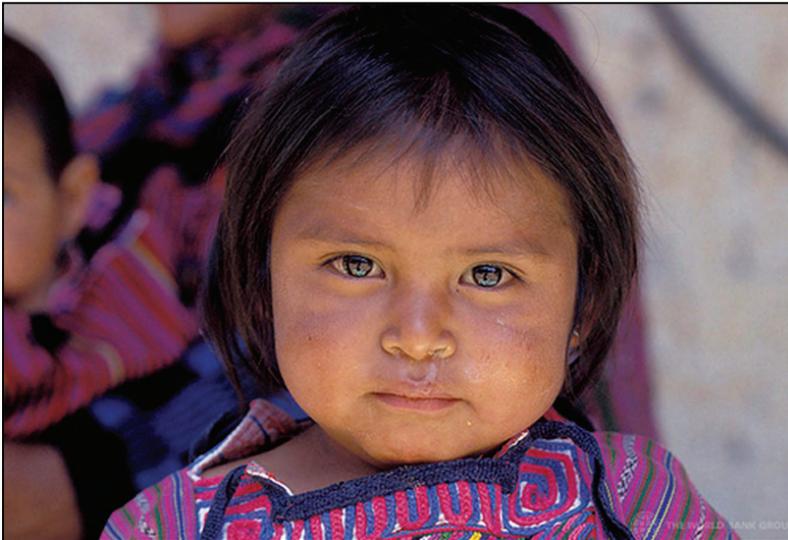
In sharp contrast to previous administrations that were politically opposed to linking demographic trends to development goals, the current administration has in fact requested that demographic analysis form part of development planning. The President speaks of the “demographic dividend” (the benefits that can accrue to a country by rapidly

decreasing population growth and improving economic efficiency). He clearly recognizes the close link between family planning and development.

However, as elsewhere in the region, the government may have other priorities. The 2011 budget for sexual and reproductive health services was slashed by 25 percent. It is unclear whether any donor will be available to make up this shortfall and what programs will be cut as a result (Simon, 2010).

2. Improved family planning service delivery in MOH facilities

Guatemala has experienced a remarkable turnaround in the government's position and in MOH service delivery in the past 10 years. As shown in Table 9, Guatemala scores in a very similar range with the three Latin American countries scheduled to graduate in terms of having a supportive MOH. The results of the MOH efforts in family planning service delivery are evident from Table 5, indicating that 58 percent of users obtain their methods from an MOH facility. Historically, APROFAM (the IPPF member association) was the primary source of family planning service provision in this country, but in the past



Curt Carnemark, World Bank

decade the MOH has won this distinction.

Nevertheless, according to reproductive health professionals working in Guatemala, there remains much to be done as the government clinics still experience frequent stock-outs and do relatively few sterilizations (historically, a popular method in Guatemala) compared to APROFAM.

Like all the other countries in Table 9, the service delivery by the Social Security Institute (IGSS) is weak. Approximately five years ago USAID discontinued FP funding to IGSS. However, there is now a sense that IGSS can and should play a role in FP service delivery. In the recent past, IGSS has made some improvement in delivering family planning services to its beneficiaries and their spouses.

Interestingly, Opus Dei, a powerful, fundamentalist sect of the Catholic Church, used to dominate MOH positions and further serve to hinder progress for family planning within the Ministry. Opus Dei remains very strong in the private sector in Guatemala and

reportedly in politics, but they no longer appear to have an influential presence in the MOH.

3. Progress towards contraceptive self-sufficiency

In the past, USAID was the sole provider of contraceptives to the Ministry of Health and donated contraceptives to APROFAM, IGSS, and a social marketing program. Historically, UNFPA and USAID shared responsibility for procuring contraceptives in Guatemala. However, the government signed an agreement with USAID, which released the latter from any obligation for contraceptive procurement as of January 1, 2009. Under the agreement, the government would pay 50 percent and UNFPA would pay 50 percent to procure the contraceptives needed for the public sector program in Guatemala. The government portion would come from the 15 percent tax on alcohol.

USAID has assisted the MOH in building its contraceptive logistics capacity through support from the DELIVER project. As part of this assistance, USAID has worked with the MOH and UNFPA on projecting contraceptive needs, using a min/max system. As a result, stock-outs have been rare in MOH facilities in recent years in Guatemala.

With support from USAID, the MOH has developed a very sophisticated information platform that reflects the public/private partnership for FP in Guatemala and allows for tracking of commodities through the system. It allows the MOH to retrieve, process, and interpret services statistics for management purposes.

4. APROFAM, a strong IPPF member association

APROFAM has evolved in the 50 years of its existence. For four decades starting in the 1960s, APROFAM was the driving force for FP in Guatemala. It maintained a very assertive, persistent struggle throughout the difficult years of the 1970s, 1980s, and 1990s, standing up to the government's efforts to curb FP. However, by the mid-1990s, it too needed to evolve into a new model, consistent with the mandate of IPPF for its members associations to become financially self-sufficient. It shifted its focus from one of providing services at little or no cost to low-income populations to becoming more of a provider for low- to middle-income populations with a diversified range of services (similar to ASHONPLAFA in Honduras). It maintains a rural program with 3,400 CBD promoters. Also, it provides FP services through its network of 28 clinics, and its mobile units provide voluntary surgical contraception at sites throughout the country (including at MOH clinics or health centers). However, USAID currently provides only a small proportion of APROFAM's budget. APROFAM, which in recent years has been increasingly self-sufficient, supports FP service delivery through modest grants from

other donors, cross subsidizing the cost of family planning services with clinic users fees, and laboratory revenues. However, as the data show in table 5, APROFAM remains an important force in FP in Guatemala, providing 40 percent of services to contraceptive users.

5. Vigilance from women's groups

Women's groups have ensured that the relatively progressive legislation on family planning was enacted and is being legislated. For example, in 2005 President Berger tried to veto the law of universal coverage. Women's groups, including doctors, reproductive health specialists, Mayan women's groups and others, organized to ensure that his veto did not carry. In 2008, a watchdog agency for reproductive health was created with support from USAID and the Pan American Health Organization. This initiative, the Observatorio de Salud Reproductiva (OSAR), is a government/civil society initiative that tracks government action to ensure that it delivers on its promises that the services are made available to the target populations and that quality standards are met.



USAID

Women's groups have also played a pivotal role in standing up to the media. In the past the Catholic Church has had tremendous sway over the media on family planning issues. However, in recent years, because of the strong input from women's groups, the Catholic Church no longer has free reign over the media on this topic. The press has given these women's groups a space and a voice.

C. USAID support to Guatemala for family planning

Currently, Guatemala receives approximately \$5 million a year from USAID for the following activities:

- Improving the coverage and quality of family planning services;
- Strengthening the systems in MOH and other entities on contraceptive logistics;
- Producing information, education and communication materials; and
- Supporting counseling activities.

D. Need for continued family planning assistance to Guatemala

Although Guatemala has made impressive strides in family planning in the past decade, and the current government is supportive of FP, the statistics on Guatemala signal a continuing need to support family planning:

- A TFR of 4.4 children per woman;
- The lowest contraceptive prevalence rate of any Spanish-speaking country in Latin America: MCPR of 34 percent, CPR of 43 percent (DHS-Guatemala, 2009);
- Marked urban/rural and non-Mayan/Mayan differences in both access to and use of contraception;
- Unmet need for spacing of 11 percent (urban) and 18 percent (rural) and for limiting of 9 percent (urban) and 15 (percent) rural, for a total unmet need of 21 percent among MWRA (DHS-Guatemala, 2009); and
- The highest adolescent fertility rate among Spanish-speaking countries in the region.

Given the relatively recent support by the government of Guatemala, the high TFR, and the continuing inequities in access to and use of contraceptives, USAID support remains critical to future success of FP in this country.

XI. The status of family planning in Haiti

The earthquake of January 2010 dealt a catastrophic blow to Haiti, already the poorest country in the Western Hemisphere. This section will provide an overview of Haiti, its demographic profile, contraceptive use patterns, and FP service delivery environment prior to the earthquake. While the disruption caused to the health system, the massive numbers of displaced and the ongoing cholera epidemic can be assumed to have worsened the situation in the country, it is useful to consider these indicators as a point of reference. This section will also summarize the information available regarding family planning in the months since the earthquake, but it is beyond the scope of the report to give a detailed analysis of the current situation.

A. Haiti's demographic profile prior to the earthquake

Before the earthquake, Haiti had a young and rapidly growing population. The 2003 census put Haiti's population at 8.4 million, with recent estimates closer to 9 million. The annual population

growth rate was 2.5 percent per year and 3 percent per year among 15-19 year-olds. Population growth results exclusively from childbearing, since Haiti's net migration rate is -1.3 migrants per 1,000 (RGPH, 2003).

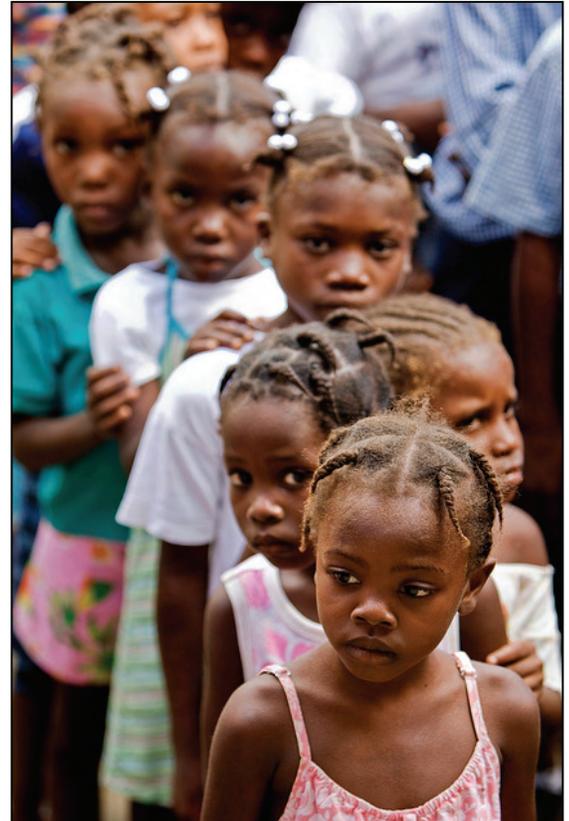
Haiti's health indicators were the worst in the Western Hemisphere, with an annual death rate of 12.2 deaths per 1,000 people, infant mortality at nearly 72 deaths per 1,000 live births, a maternal death ratio of 523 women per 100,000 live births, and an HIV prevalence rate of 4-5 percent of the total population (UNFPA, 2006). As of 2006, average life expectancy was 53 years - 52 years for males and 55 years for females.

B. Fertility in Haiti

Despite some decreases in recent years, Haiti also had one of the highest fertility rates in the Western Hemisphere prior to the earthquake. The TFR was 3.8 children in 2009 with women in rural areas having 5 children on average, compared to 2.8 children for urban women (Cayemittes et al, 2007).

Cultural norms in Haiti dictate that children are an essential element in cementing a relationship between a man and a woman. Haitian men traditionally recognized their responsibility for the care of their children and, for Haitian women, having a child thus represents a claim on a man's resources and one of the few ways for women to access additional resources for themselves and their children (Dejeneand Martin, 2002).

Data gleaned from adult women aged 20-24 in the most recent Haitian DHS indicate that Haitian girls' sexual debut occurred early. By age 15, nearly 15 percent had experienced intercourse, and by age 18 over half had been sexually active (this is similar to other countries in the Latin America/Caribbean region). Where adolescent sexuality differs between Haitian girls and other girls in the region is in the high proportion of young girls in union and bearing children early. By age 17, 11 percent of Haitian adolescents have had a child or are pregnant, and by the age of 19, this percentage climbs to 29 (Population Council, 2009). More than one in four had a second child within 24 months of their first birth (Agma et al, 2008). While sexuality outside of marriage/union was increasingly common prior to the quake, nearly one-third of 15-19 year-olds report being in union, and a full 65 percent of sexually active respondents in the 15-19 age group reported being married or in union (Population Council, 2009).



Marco Dormino, UN Photo

Child spacing tends to increase with the age of the mother, with an overall average of 34 months between births, close to the optimum delay recommended by health professionals. Forty-five percent of births, on average, occur more than three years after that of the next-oldest sibling (Agha et al, 2008).

Education, especially women's education, is closely correlated with both contraceptive use and decreases in fertility. While data on school enrollment are not available in Haiti, only 25 percent of girls who were of secondary school age were enrolled in secondary school according to household surveys (UNICEF, 2010).

These data suggest that adolescents are a key target group for family planning information and services, with an emphasis on delaying childbirth, protecting against sexually transmitted infections (STIs) and HIV, and increasing spacing of births. Women over 35 are a group that would benefit from increased information about and access to long-term methods of family planning, including intrauterine devices (IUDs) and voluntary surgical contraception.

Given the pressure on Haitian women to have children in order to establish a relationship with a male partner, increased income-generating activities for young women and increased education, combined with increased access to reproductive health information and services, would be a potent strategy to increase women's ability to manage their reproductive choices.

C. CPR and unmet need

At the time of the Haiti DHS in 2006, contraceptive prevalence (all methods) was at 25 percent. Contraceptive method use was slightly higher among urban women (28 percent) than among rural women (22 percent). Prevalence increased with age and peaks between 30 to 40 years, after which it declined. Injectables were by far the most widely used method (34 percent), followed by traditional methods (22 percent), condoms (17 percent), pill (10 percent), female sterilization (7 percent), IUD and other (5 percent). Condoms are not seen as a family planning method, but as a method of prevention of HIV and STIs. As such, couples in union tend not to use them, as doing so would be to admit unfaithfulness.

At the time of the 2005/2006 DHS, 38 percent of women aged 15-49 had an unmet need for family planning. Nearly 50 percent of Haitian women in union did not want any more children and more than 30 percent wanted to space their next child by more than two years. The demand for limiting dropped slightly in recent years, whereas the demand for spacing increased slightly, possibly reflecting the lack of access to long-term methods.

Furthermore, only 23 percent of Haitian women used family planning within the first year after the birth of a child, although only 2 percent of these women said they wanted another child within the next two years. Adolescents were even less likely to use FP post-partum; fewer than 15 percent of women aged 15 to 19 years used a contraceptive method in the first year postpartum. Three-quarters of Haitian women recommence sexual activity within 4 to 6 months after birth. Thus, these women have a high risk of becoming pregnant again before they want to do so. Unmet need for spacing and limiting of births reaches 80 percent in the first three months postpartum and over 60 percent by the end of the first year. Among those women who do use contraceptives postpartum, the majority use injectables (Cayemittes et al, 2007).

Multiple and interrelated factors explain the low level of contraceptive use and high level of unmet need. These include: lack of health infrastructure, poor quality of family planning services, lack of access to contraceptive supplies, and a lack of integration of family planning in other health services. Below we discuss these in more detail.

1. Lack of health infrastructure

A large majority of Haitians, particularly in rural areas, lacked access to basic health services prior to the quake. Haiti's health workforce is weak with just three physicians, one nurse/midwife and 13 hospital beds per 10,000 people, compared to global averages of 13 physicians, 28 nurses/midwives, and 25 hospital beds per 10,000 people (Kaiser, 2010).

The MOH¹² operated 752 service delivery points that offered family planning and was active in all 10 departments prior to the quake. These services were provided in health centers and district hospitals clustered in urban areas. Even temporary methods were provided in the hospital services and there is little history of community-based distribution or use of auxiliary medical personnel by the MOH. Only condoms were distributed by other levels of staff through HIV prevention programs and PSI's social marketing programs (Ferguson and Larson, 2009).

2. Poor quality family planning services

Quality of care of family planning services in Haiti prior to the earthquake was poor due to the lack of a strong government strategy, inadequate human resources, and lack of training. (Agha et al, 2008). While the MOH and the Institute for Health and Community Action (INHSACS) conducted periodic training of health providers, there was little attention to ongoing supervision.

¹² The MOH in Haiti is known locally as the Ministère de la Santé Publique et de la Population (Ministry of Public Health and Population). However, for purposes of consistency, it will be referred to as the Haitian MOH in this report.

Services functioned poorly despite significant investments on the part of USAID and other donors. With funding from USAID, MSH and partners such as JHPIEGO and other NGOs were working with the MOH to strengthen services, but a 2009 assessment by JSI found that there were still numerous problems, including long wait times and lack of contraceptives and trained staff (Ferguson and Larson, 2009).

3. Lack of access to contraceptive supplies

Access to drugs and contraceptives has been a persistent problem in Haiti due to a lack of adequate funding and weak technical and managerial leadership to improve access to essential drugs, vaccines, and contraceptives. The chronic stock-outs of essential drugs and supplies at health facilities led to the creation of a parallel procurement and distribution system, PROMESS (Program for Essential Medicines and Supplies). Generally, the PROMESS system worked well to ensure that the MOH, international and national NGOs had adequate supplies of contraceptives at the central level. However, in 2009 a major shipment of contraceptives was stolen, resulting in stock-outs for much of the year at both public and non-profit public sector facilities. Furthermore, there were significant supply-chain problems, with few contraceptives available to rural areas (Ferguson and Larson, 2009).



Logan Abassi, UN Photo

4. Lack of systematic focus on integrating FP services

While family planning counseling appears to be integrated into prenatal consultations (62 percent receive some family planning information during prenatal visits), it is rarely a part of postnatal care. Reports indicate that only 25 percent of mothers were provided with family planning counseling during postpartum check-ups. Furthermore, FP was not systematically addressed in the course of other mother and child contacts with health providers (Cayemittes et al, 2007).

5. Other issues that affect use

The broader issues related to lack of transportation and spotty coverage of contraceptive services and supplies were important factors contributing to the low contraceptive prevalence rates. Furthermore, the frequent and extended periods of unrest and fear of violence may have also been a factor in keeping women from traveling to access services.

While Haiti is a highly Catholic country, this does not seem to be a major barrier to family planning use. Among women not currently using a contraceptive method and who did not intend to use one in the future, 27 percent declared that they feared side effects and 19 percent cited other health issues as the reason for not wanting to use modern contraception. Only 7 percent said they were opposed to FP, 8 percent cited religious reasons, and only 2 percent said their partner was opposed. Other reasons were cited by less than 1 percent of women interviewed for the DHS (Cayemittes et al, 2007).

D. Family planning and the policy environment

Because of high poverty, low literacy levels, and high unemployment, policy makers in Haiti have long been convinced of the need for a family planning program, as well as maternal and child health programs. The government commitment to population programs began in Haiti in the 1970s with the establishment of the Division of Family Hygiene (DHF) (Allman, 1982). The ministry of health in Haiti is in fact called the Ministry of Health and Population (MOHP).

Family planning services were first introduced in Haiti in private-sector health programs in the late 1960s, followed several years later by their introduction in public facilities. The government began to implement family planning/maternal and child programs through public facilities in 1977, which were later expanded to mobile clinics (Allman, 1982). The government worked with multiple partners in the public and private sector to broaden access to modern contraceptive methods. In 2006, the MOH introduced a new initiative to reposition family planning and declared a renewed commitment to FP. Through the repositioning of family planning, MOH officials expressed their commitment to achieve the objectives of the Millennium Development Goals (MDGs), especially MDGs 4, 5, and 6 to reduce maternal, infant, and child mortality.

However, for the last 20 years family planning services have suffered from a range of management and operational problems, including frequent stock-outs, inadequate provider knowledge, and poor quality of care, poor counseling, limited method mix, and limited access due to uneven distribution of services throughout the country (Rivero-Fuentes et al, 2008). Furthermore, Haiti was also the only country in the region that did not allow emergency contraception.

Haiti also has one of the highest seroprevalence rates in the region and the past fifteen years witnessed a huge growth of investment in HIV/AIDS prevention in Haiti. Observers have noted that the emphasis on HIV prevention may have come at the cost of the FP program (Ferguson and Larson, 2009).

E. Family planning services after the earthquake

Haiti has a long history of being hit by hurricanes and flooding which put additional strain on an already fragile health system. However, the January 12, 2010, 7.0 earthquake was by far the biggest natural disaster ever experienced by the island nation and the destruction was devastating. The government of Haiti estimates that more than 200,000 people were killed, with an additional 300,000 people injured. The greatest destruction by far occurred in the high-density



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capital city of Port-au-Prince, where thousands were killed, injured and rendered homeless. More than 5 million people lived in the area directly affected by the earthquake and 1.2 million people were displaced. It was estimated that more than 3 million people out of Haiti's 9 million inhabitants were in need of humanitarian relief, including health care, food assistance, and access to water and sanitation (Eberhard et al, 2010). Many primary health facilities and hospitals collapsed, therefore

health care provision including family planning services were negatively impacted by the natural disaster. One year later, approximately 1 million people are still living in internally displaced persons (IDP) camps (IFRC, 2010).

In October 2010, cases of cholera began to surface in Port-au-Prince and a full-blown cholera epidemic affecting tens of thousands was underway by December 2010. The cholera epidemic, combined with the contested elections and resultant violence, are currently limiting access to health services and family planning.

The priority for the MOH, international agencies and the local NGOs in the immediate aftermath of the earthquake was to handle the flood of trauma cases resulting from building collapses and manage diarrheal and other diseases resulting from substandard living conditions in the tent cities. While there is an increased recognition of the importance of reproductive health services in the aftermath of disasters, it is other reproductive health interventions (emergency obstetric care, services for gender-based violence, and HIV prevention) that are most crucial. Family planning services necessarily took longer to resume after the quake and remain less of a priority than safe obstetric services and services related to gender-based violence.

Whereas public and private sector agencies provided FP services (albeit in a fragmented way) prior to the earthquake, the MOH has now taken a leadership role in ensuring the availability of FP services. The NGO community has pledged to work closely with the MOH to ensure contraceptive services are available. Nevertheless, there are formidable obstacles.

1. Contraceptive supplies and basic infrastructure

There was no interruption in contraceptive supply to the country due to the earthquake, as the PROMESS facility was not damaged by the quake and essential medicines and contraceptives were available to the MOH and NGOs almost immediately afterwards. However, there is evidence to suggest that these have not been a focus at health facilities. The MOH conducted a study of the availability of family planning in community referral hospitals in the country in mid-2010. Nearly all of the 23 community referral hospitals surveyed had some contraceptives in stock, primarily condoms (97 percent), orals (92 percent) and injectables (90 percent). Amounts of stock are small and the study did not assess how many services are being provided at each site. Very few facilities have Norplant, and IUDs are not available at any of the sites. The stock-outs are attributed to poor projections of needs as supplies are available from PROMESS (Viel, 2010).

The same MOH study also mentions that many of the community hospitals have no running water and experience problems with electricity, making the provision of services problematic. While all had gynecological tables, only 20 percent of the community hospitals visited had a private room where contraceptive counseling could take place.

Voluntary surgical contraception is available at only a handful of the community referral hospitals and, even where theoretically available, was only rarely performed. Information, education and communications materials were not available and even basic office supplies were not available at most of the community hospitals (Viel, 2010).

2. Lack of trained human resources

The study of referral hospitals found widespread training needs related to family planning at all of the hospitals. While providers had received some training in contraceptive technology, there was a need for refresher courses and very few had received training in FP counseling and education. The researchers found that knowledge of contra-indications and side effects of contraceptive use is very low among providers (Viel, 2010).

Voluntary surgical contraception was not widely used in Haiti prior to the earthquake and is for the most part still not available, although there are reports that the MOH plans to institute the service. The study of community referral hospitals mentioned above found that providers were

not trained in the method, nor are the equipment and supplies available to provide it (Viel, 2010). The IPPF member association, PROFAMIL, is currently training MOH staff to provide voluntary surgical contraception and it is hoped that the government will organize voluntary surgical contraceptive services in public sector hospitals (Michaud, 2010).

Unlike other countries in the region, Haiti never had a strong community-based distribution network as an integral part of the family planning program, nor have auxiliary nurses been available to provide family planning services. These are two of the modalities that are being proposed under the new post-earthquake family planning program.

3. Services to especially vulnerable populations

The government and its NGO partners face an enormous challenge in providing family planning services to the 1.2 million internally displaced persons (IDPs) living in tent cities in Port-au-Prince. These people are living in extremely precarious conditions and their access to services is further limited by the dearth of public transportation. A recent assessment of 100 IDP camps indicated that less than half (45 percent) of the camps had some kind of family planning service available (Michaud, 2010). The coverage and quality of these services is unknown.

Needs for contraceptive services were already extremely high among the adolescent population prior to the earthquake, and in its aftermath, adolescents are at even greater need. Most schools have been closed since the earthquake and there are extremely limited work opportunities for young people (UNFPA, 2010). Sexuality education and information, education and communications regarding contraception are mostly non-existent in the camps. As of July, UNFPA had organized training and other activities for over 65,000 young people in the camps with plans to continue the activities (UNFPA, 2010). In the aftermath of the earthquake, several international agencies began to work in concert with the MOH and local Haitian NGOs to plan coordinated activities for adolescent sexual and reproductive health. This initiative has developed a strategy and division of responsibilities among the various organizations working with young people in Haiti (Billowitz, 2010).

F. Other barriers to access to FP

Prior to the earthquake, clients had to pay for FP services at most NGO sites and frequently even in the public sector, although services were nominally free-of-charge. After the earthquake, the MOH has decreed that contraceptives and other health services should be universally free. However, the review of referral sites mentioned above found that some providers were charging for injections in order to pay for the syringes and for Norplant to pay for the insertion equipment (Viel, 2010).

G. Future directions for Haiti

While data are not yet available on family planning in post-earthquake Haiti, there are indications that the situation may have worsened in the aftermath of the quake. The pre-earthquake family planning program in Haiti was weak, with serious deficiencies in quality of care, frequent stock-outs at service delivery points, gaps in provider knowledge, and significant lack of infrastructure. Contraceptive use was low, especially among adolescents.

The current lack of family planning services in nearly half of the IDP camps points to the need for a coordinated effort to ensure that FP services are provided in all camps and at other sites in Port-au-Prince and other earthquake-affected areas. The historically low contraceptive prevalence and the present lack of information, education and communications related to family planning suggest the need for a coordinated IEC strategy once services have been organized.



Marco Dormino, UN Photo

The fact that over 60 percent of the Haitian population is under the age of 25, the high levels of unmet need among young people, and the small proportion of youth attending secondary school signal a strong need to focus on this population with both sexuality education and services.

Long-term and permanent methods of contraception are still not widely available in Haiti. As a convenient and cost-effective solution for women, efforts to ensure that they are provided, preferably free-of-charge, should be supported.

Haiti's weak pre-earthquake family planning program and the need to focus on other, extremely urgent reproductive health priorities, as well as other health issues, may pose obstacles to making strong progress in family planning in the country. However, the massive influx of donor attention and resources to Haiti, unprecedented levels of joint coordination and planning by the MOH and other actors are positive trends that may generate the momentum to rebuild a much stronger reproductive health program in Haiti.

Conclusions

USAID has played a pivotal role in international family planning for almost half a century. From the 1960s on it has provided financial and technical support to public and private sector programs in developing countries worldwide. Over this 50-year period, the average number of children per woman in the developing world has dropped from around 6 to 2.7. Family planning has evolved from a politically controversial, socially sensitive topic to a routine part of public health service delivery in many countries.

Some FP programs have been met with more success than others. As far back as the 1970s, USAID realized that some countries had outgrown their need for USAID FP assistance. For



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example, USAID discontinued FP funding to South Korea around 1976, to Panama in the late 1980s, and to six other countries in the 1990s. However, in 2003 USAID recognized the need to be more strategic in the allocation of its FP funding (to countries with the greatest unmet need) and more systematic in its process of “graduating” countries from FP assistance. To this end, USAID established a series of criteria for considering countries for graduation, which have evolved slightly over time. The current criteria for “imminent graduation” (within 2-5 years) are a TFR of 3.0, a MCPR of at least 55 percent, and additional criteria related to urban/rural inequities, method mix and size of the population. This decision affected the region of Latin America and the Caribbean (LAC) in particular because of the number of countries approaching this threshold.

Although no in-depth study has been undertaken on the consequences of graduation in the countries that have experienced this process, in general these countries appear to have been able to maintain or increase levels of modern contraceptive use and decrease or maintain fertility levels. One possible exception is Indonesia. Furthermore, recent anecdotal evidence suggests that in Peru oral contraceptives and condoms were not available from the public sector for a period in 2010 (Ward, 2010).

One possible cause for concern is the recent increase in adolescent fertility rates among the poor in some graduated countries in the LAC region such as Brazil, Colombia, and Ecuador. While it is unclear what is driving this phenomenon – and it is hypothesized that some of these increases may be due to changes in wanted fertility – it is clear that unmet need among 15-19 year-olds is

still a concern. Furthermore, it is a population that most governments have been reluctant to address.

At present, the following countries in the LAC region are scheduled to graduate: Honduras, Paraguay, Nicaragua, and El Salvador. Three others do not yet meet the graduation criteria (Bolivia, Guatemala, and Haiti) and are slated for continued FP assistance from USAID. Whether Peru will be granted an extension of its phase-out plan still remains to be seen.

This report analyzes the prospects and challenges of graduation for Honduras, Nicaragua, and Paraguay. It also looks at the situation in Peru. In addition, it reviews the current status of family planning and the need for continued support in the countries not scheduled for graduation: Bolivia, Guatemala, and Haiti.

The role of the MOHs and their support for family planning has changed vastly over the past decade. Currently, the MOHs are supportive of FP in the six countries mentioned above, and the MOH represents the major source of contraceptives in five of the six. Family planning services are embedded in larger health plans for family health and reduction of maternal mortality. The IPPF member associations – the pioneers for family planning in most Latin American countries dating back to the 1960s – now play a strongly supportive role in the delivery of FP services in at least two countries (Guatemala and Honduras) but a markedly diminished role in others (e.g., Nicaragua and Paraguay).

Two key elements for successful graduation are: (1) government commitment to using its own funds to procure contraceptives on the international market, and (2) the technical and managerial savvy to manage the relatively complex contraceptive logistics process, especially in a time of increased decentralization and integration.

In terms of the upcoming graduations in Honduras, Nicaragua, and Paraguay, USAID has worked closely with governments in these three countries to build commitment and capacity for contraceptive procurement, logistics, and service delivery. In Honduras and Nicaragua, family planning is considered integral to the continued success of highly valued initiatives to reduce maternal mortality. All three countries had become very dependent on USAID assistance to support their FP efforts, and initially there was a sense of disbelief that USAID was serious about phasing out its assistance to FP. Yet, the governments in all three countries came to accept this reality and have begun to prepare for USAID's eventual withdrawal of FP funding. In all countries USAID contractors have provided considerable technical assistance to the MOH and (to a lesser extent) to the Social Security Institute and IPPF member association. The JSI-DELIVER Project worked to build capacity in contraceptive security and logistics in all three countries, and (in Honduras only) Management Sciences for Health provided assistance in restructuring organizations and financial systems. As a result, all three countries have developed

considerable capacity in the multiple aspects of contraceptive security: forecasting, procurement on the international market (via UNFPA), procurement in country, the logistics of warehousing and distribution, monitoring stock levels, and managing the entire process. Although this capacity is newly-acquired and weaknesses exist within these systems, all three countries seem ready to take on this new challenge.

Of the three countries scheduled to graduate, only Paraguay has convincingly demonstrated its ability and willingness to cover 100 percent of the cost of purchasing contraceptives for the public sector. As of 2009 it paid the full amount to UNFPA, which purchased them through its global mechanism at competitive prices. However, in Honduras and Nicaragua, the looming question relates to the government's commitment and ability to purchase contraceptives for the public sector program using funds from the national budget (i.e., having a fixed line item in the national budget). In Honduras this *líneafija* (fixed line item) is under discussion in the President's Office. In the case of Nicaragua, the government has included a budget line for 2011 which covers 50 percent of the cost, but is uncertain whether it will be able to fully fund that line. The MOH is negotiating with the FONSALUD (the Common Basket Fund for Health), a vertical fund established by multiple donors, to cover the portion it is not able to cover.

A major concern is that even if the governments commit to a budget line item, will they honor the commitment in the face of a fiscal crisis or other "more pressing issues" (e.g., the dengue outbreak in Honduras)? In the past, UNFPA has served as the "safety net" for both countries, but it is clear that UNFPA will not continue this practice indefinitely. In addition to UNFPA's own funding issues, it does not fulfill the goal of the Paris Declaration and other international commitments to encourage countries to assume responsibility for their own programs.

A related concern is the continued capacity of the Nicaragua government to sustain services to the large number of people living in poverty. Nicaragua has the lowest percent of service provision occurring in the private sector, meaning that the burden falls primarily on the public sector. Can this low-income country sustain this burden, and what would be the fate of public sector health programs, including FP, if a new government with different priorities were to come into office? A second concern that applies both in Honduras and Nicaragua is the growing popularity of the injectable. In contrast to female sterilization and the IUD (long-term methods that are both effective in preventing pregnancy and cost-effective), the injectable requires constant resupply. While the introduction of the Sino-implant (II) at lower costs may help bring prices of the injectable down, the cost of service provision on a monthly or even every three months is always going to be higher than that of longer-term methods.

USAID officials in all three countries express the sentiment that "there is no turning back on this decision." They are confident, from a technical standpoint, that the governments are capable of managing the whole logistics system from procurement to distribution of contraceptives.

Moreover, they describe a sense of pride on the part of their government counterparts at taking ownership and responsibility for their own programs.

In sum, Honduras, Nicaragua, and Paraguay have prepared for FP graduation; they have increased their capacity in contraceptive procurement, logistics, and management. The MOH service delivery system represents an effective mechanism for getting contraceptives to a large segment of the population, and demand for contraception is very strong. The largest question mark (for Honduras and especially for Nicaragua) is the governments' ability to deliver on their commitment to using their own funds for procuring contraceptives. Given the many other priorities facing the governments, it may be difficult to find the resources to meet the increasing need for contraceptives. Time will tell whether the governments are committed to and capable of fulfilling their pledges during times of political or economic adversity.



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With respect to Peru, graduation should be postponed until the family planning program can be reconfigured to work effectively and efficiently within the decentralized health sector structure. USAID support could serve to ensure that family planning is not left off the policy dialogue and to strengthen civil society support for family planning. In addition, continued support on logistics and procurement issues appears to be required in the medium term if the government is to meet the challenge of providing access to contraception.

In terms of three countries that are not yet on the list to graduate (Bolivia, Guatemala, and Haiti), the first two share several traits: (1) A large indigenous population that tends to be poor, rural, uneducated, and more resistant to family planning than their Spanish-speaking counterparts; (2) Large inequities in access to and use of modern contraceptives; and (3) A history of strong opposition from the Catholic Church, which hindered programs in prior decades but no longer does. Because of these factors, Bolivia and Guatemala have not yet approached the “threshold numbers” for TFR and MCPR that would put them on the schedule for graduation from USAID FP assistance. Although not on the list, USAID/Guatemala is already preparing for graduation at a future time. USAID/Guatemala has negotiated for the government of Guatemala to pay a substantial part of the bill for procurement of public sector contraceptives from a tax it imposed on alcoholic beverages and applies to reproductive health programs. USAID has no plans for graduation in these two countries until they begin to approach the threshold numbers. The

current programs focus strongly on increasing FP access among these underserved populations and strengthening health systems.

The earthquake of January 2010 in Haiti turned an already desperate situation into an unfathomably complex situation. The U.S. government has pledged one billion dollars to rebuild this country, and FP assistance will be part of that package. It is too early to know the exact impact of the earthquake on access to FP services. Many aspects of service delivery in Port-au-Prince are now functional, though access to female sterilization is limited. FP services are now available in approximately half of the camps set up to house displaced persons. IPPF will also maintain its presence in Haiti.

Although international family planning and reproductive health received a higher level of funding in fiscal year 2010 than ever before in its history (\$648 million for bilateral and multilateral assistance), these new funds will be allocated based on the areas of greatest need. Despite continuing pockets of unmet need in Latin America, the LAC region – with the exception of Haiti – has far lower fertility and far higher contraceptive use than in sub-Saharan Africa and parts of South Asia. Thus, even the new funding levels under President Obama’s Global Health Initiative are not likely to result in additional funding for Latin America.

Based on this analysis, we offer the following recommendations to USAID:

- 1) Closely monitor the situation in the four graduating countries to ensure that they are able to maintain (if not increase) contraceptive prevalence and equitable FP access to all segments of the population, including the rural poor and adolescents.
- 2) Assist in finding sources of funding for future DHS surveys that will provide valuable data for internal purposes as well as continued tracking by the international community.
- 3) Continue to provide assistance to Bolivia and Guatemala, especially in reaching poor, indigenous, rural populations and adolescents, as well as systematically evaluate the strategies used as a means of better understanding how best to reach the “hard-to-reach” populations.
- 4) Continue to provide much-needed FP assistance to Haiti and use the experience to identify and test strategies for providing FP to internally displaced populations and in emergency settings for use in future emergencies elsewhere in the world.
- 5) Commission an in-depth study of USAID graduation to determine its medium-term effects on TFR and MCPR, especially among indigenous populations, the rural poor, and adolescents.

Table 1. List of countries that have graduated and are scheduled to graduate from USAID family planning assistance

Prior to 2004:	
Country	Year of graduation (USAID FY)
South Korea	(approximately 1976)
Panama	1988
Tunisia	1990
Thailand	1993
Botswana	1995
Costa Rica	1996
Colombia	1997
Mexico	2000
Brazil	2000
Ecuador	2001
Turkey	2002
Morocco	2003
Since 2004:	
Romania	2006
Jamaica	2008
Indonesia	2007
Dominican Republic	2009
Peru	2010**
El Salvador	2010
Egypt	2010
Scheduled for graduation (expected year)	
Paraguay	2010
Nicaragua	2011
Honduras	2012

Source: O'Hanlon (2009), Farrell (USAID, 2010) and Stewart, (2011).

** At the time of this writing the graduation date for Peru is under review.

Table 2: Gross Domestic Product (GDP) per capita by country, 2009

COUNTRY	Bolivia	Guatemala	Haiti	Honduras	Nicaragua	Paraguay	Belize
GDP (\$US)	\$1,723	\$2,848	\$717	\$1,957	\$1,228	\$2,581	\$4,569

Source: UNDP, 2009.

Table 3: Contraceptive prevalence among married women of reproductive age, by country

	Bolivia (2008)	Guatemala (2008)	Haiti (2006)	Honduras (2006)	Nicaragua (2006)	Paraguay (2008)	Belize
CPR (All Methods)	61%	43%	32%	65%	72%	79%	56%
CPR (Modern Methods)	35%	34%	25%	56%	70%	71%	49%

Source: Population References Bureau, 2009.

Table 4: Method Mix

	Bolivia (2008)	Guatemala (2008)	Haiti (2006)	Honduras (2006)	Nicaragua (2006)	Paraguay (2008)
Injectables	19%	27%	34%	21%	32%	21%
IUD	14%	2%	5%	10%	5%	15%
Female Sterilization	11%	35%	7%	33%	34%	12%
Male Condom	7%	7%	17%	4%	5%	17%
Pill	5%	7%	10%	17%	18%	23%
Traditional	43%	18%	22%	14%	4%	11%
Other	1%	4%	5%	1%	2%	1%

Source: Data from most recent RHS/DHS.

Table 5: Source of Contraceptive Supplies for Current Users

	Bolivia (2008)		Guatemala* (2008)	Haiti (2006)	Honduras (2006)	Nicaragua (2007)	Paraguay (2008)
Ministry of Health	43.5%		57.9%	26%	42.9%	67%	37.3%
Social Security System	4.8%			6%	5.9%	4%	3.5%
IPPF MA/NGO	7.7%		40.2%	52%	25.1%	5%	10.7%
Pharmacy/Commercial	27.5%				24.7%	23%	41.3%
Other	16.5%		1.9%	16%	1.4%	1%	7.1%

Source: Most Recent DHS, RHS.

*Guatemala DHS information only separates points of access into public & private

Table 6: Unmet Need among MWRA (at last DHS/RHS)

	Bolivia (2008)	Guatemala (2008)	Haiti (2006)	Honduras (2006)	Nicaragua (2006)	Paraguay (2008)
	20.2%	20.8%	37.0%	16.9%	7.4%	12.1%

Source: Last DHS/RHS.

Table 7: Unmet Need by Wealth Status

	Bolivia (2008)	Guatemala* (2008)	Haiti (2006)	Honduras (2006)	Nicaragua (2006)	Paraguay (2008)
Wealthiest	9.5%		31.6%	12.3%	7.3%	11.6%
Middle	20.0%		36.6%	16.3%	11.1%	12.4%
Lowest	34.2%		44.2%	24.2%	13.3%	14.5%

Source: Last DHS/RHS.

*In the 2008 Guatemalan DHS/2002 Guatemalan RHS, unmet need is not broken down by wealth quintile, only by indigenous/non-indigenous and level of education.

Table 8: Family Planning Effort Index, 2009

FPPEI	Bolivia	Guatemala	Haiti	Honduras	Nicaragua	Paraguay
TOTAL	48.8	42.7	33.2	50.3	47.4	46.4
Policies	46.3	36.1	36.9	49.4	44.2	48.3
Services	46.4	43.8	31.3	49.1	46.8	43.4
Evaluation	50.7	47.2	29.7	54.5	49.3	51.9
Access	55.4	46.1	34.1	52.0	51.4	47.6

Source: USAID/DELIVER Project, 2009.

Table 9: Organizations Involved in FP Service Delivery

	Bolivia		Guatemala		Haiti		Honduras		Nicaragua		Paraguay		
Ministry of Health	Favorable to Family Planning* (Max = 30)	<i>Ministerio de Salud y Deportes (MSD)</i>	10.6	Ministerio de Salud Pública y Asistencia Social (MSPAS)	11.7	Ministère de la Santé Publique et de la Population (MSPP)	8.2	Secretariat of Health (SOH)	11.8	Ministerio de Salud de Nicaragua (MINSA)	11.5	Ministerio de Salud Pública y Bienestar Social (MSP y BS)	10.8
Social Security Institute	Strength of Service Delivery (Strong/Weak)	Caja Nacional de Salud (CNS)	W	Instituto Guatemalteco de Seguridad Social (IGSS)	W	??	W	Instituto Hondureño de Seguridad Social (IHSS)	W	Instituto Nicaragüense del Seguro Social (INSS)	W	Instituto de Previsión Social (IPS)	W
IPPF Member	Receives USAID funding	<i>Centro de Investigación en Educación y Servicios (CIES)</i>	Y	Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM)	Y	Association pour la promotion de la Famille Haïtienne (PR OFAMIL)		Asociación Hondureña de Planificación de Familia (ASHONPLAFA)	Y	La Asociación Pro-Bienestar de la Familia Nicaragüense (PROFAMILIA)		Centro Paraguayo de Estudios de Población (CEPEP)	

* Governance data based on Contraceptive Security Index “Governance Indicator,” USAID/DELIVER 2009.

Table 10: Social Marketing Programs

	Bolivia	Guatemala	Haiti	Honduras	Nicaragua	Paraguay
Name/Type/ Product	PROSALUD (Clinics and provision of contraceptives at competitive prices to pharmacies and commercial outlets)	ASHONPLAFA (distributes socially marketed contraceptives in all pharmacies), PASMO (condoms, technical assistance)	PSI/HAITI (Condoms, distributed through CBD)	PASMO (condoms, technical assistance)	PASMO (condoms, technical assistance)	PROMESA (education, technical assistance, contraceptives)
Status	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	USAID funding ended, not-sustainable

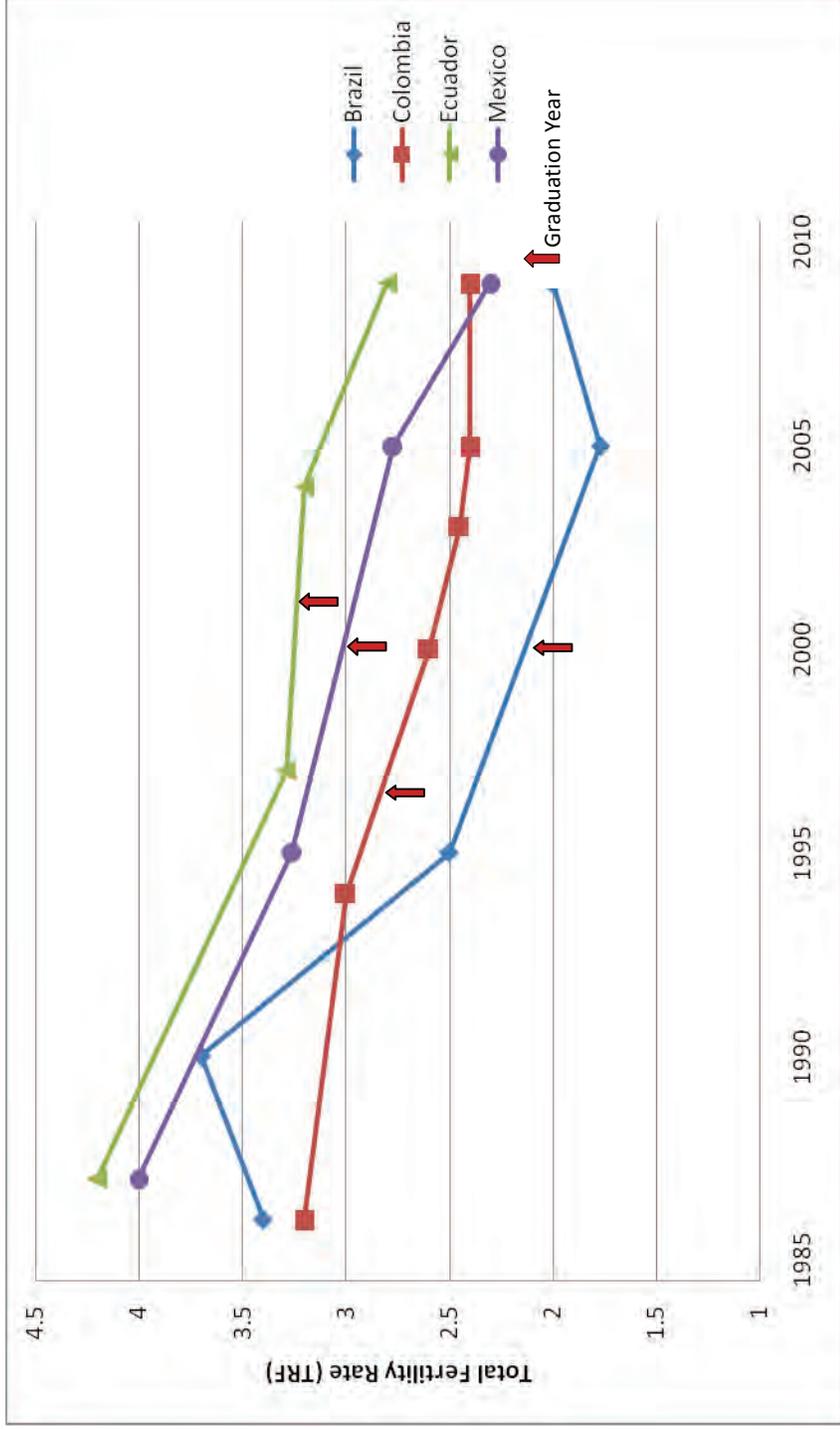


Figure 1: TFR by year: select graduated countries, LAC

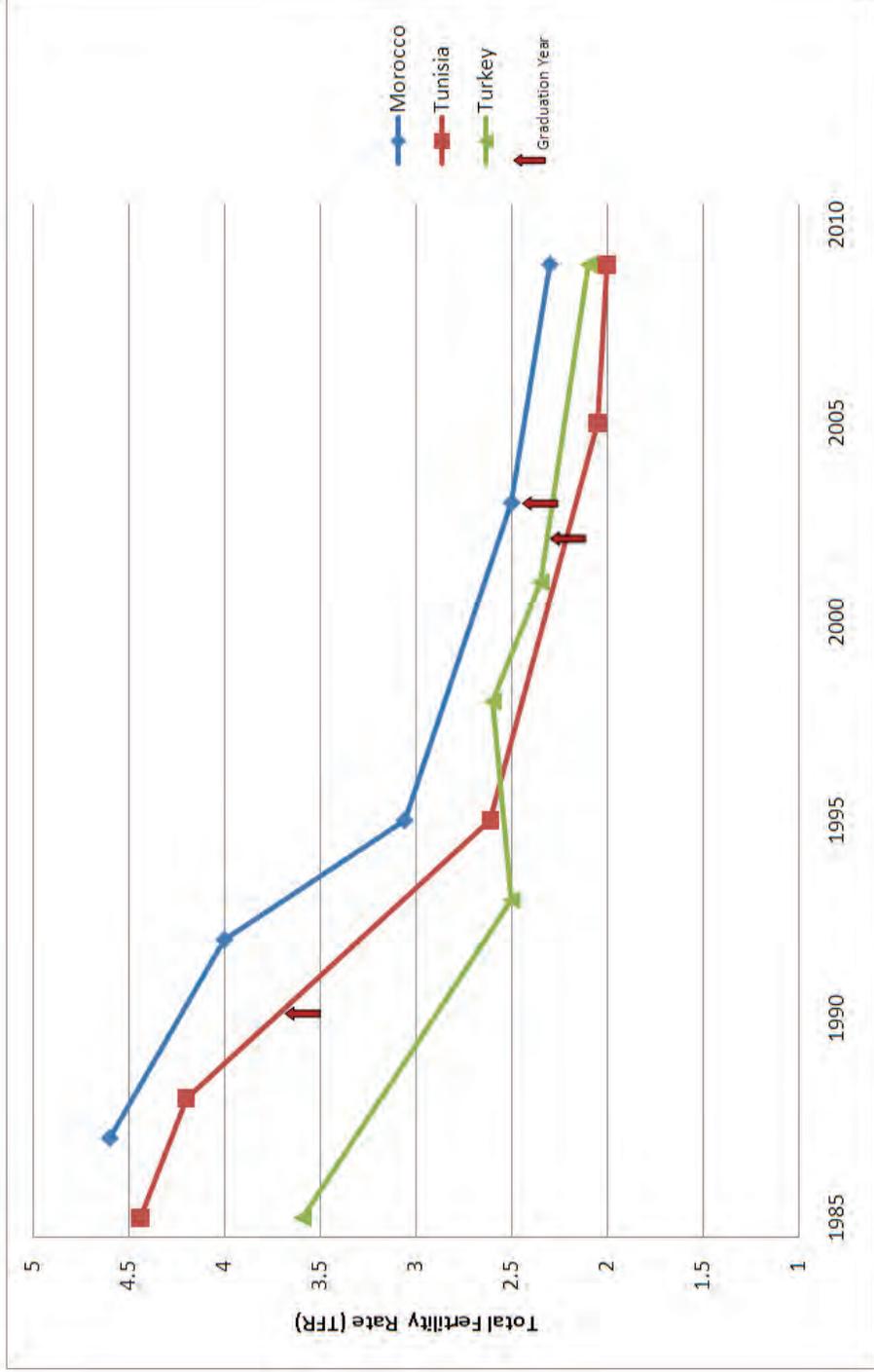


Figure 2: TFR by year: countries from other regions

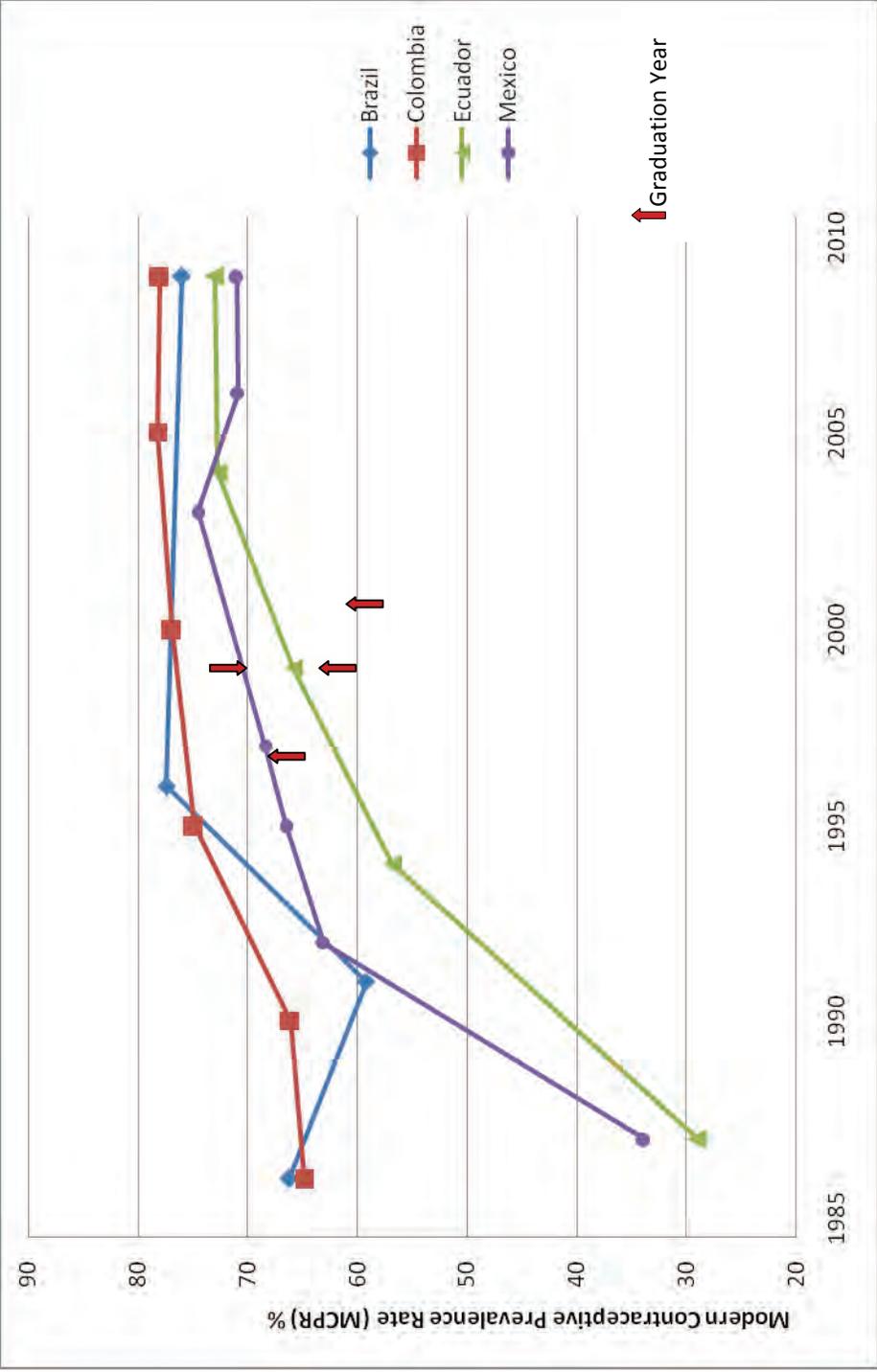


Figure 3: Modern CPR by year: graduated countries - LAC

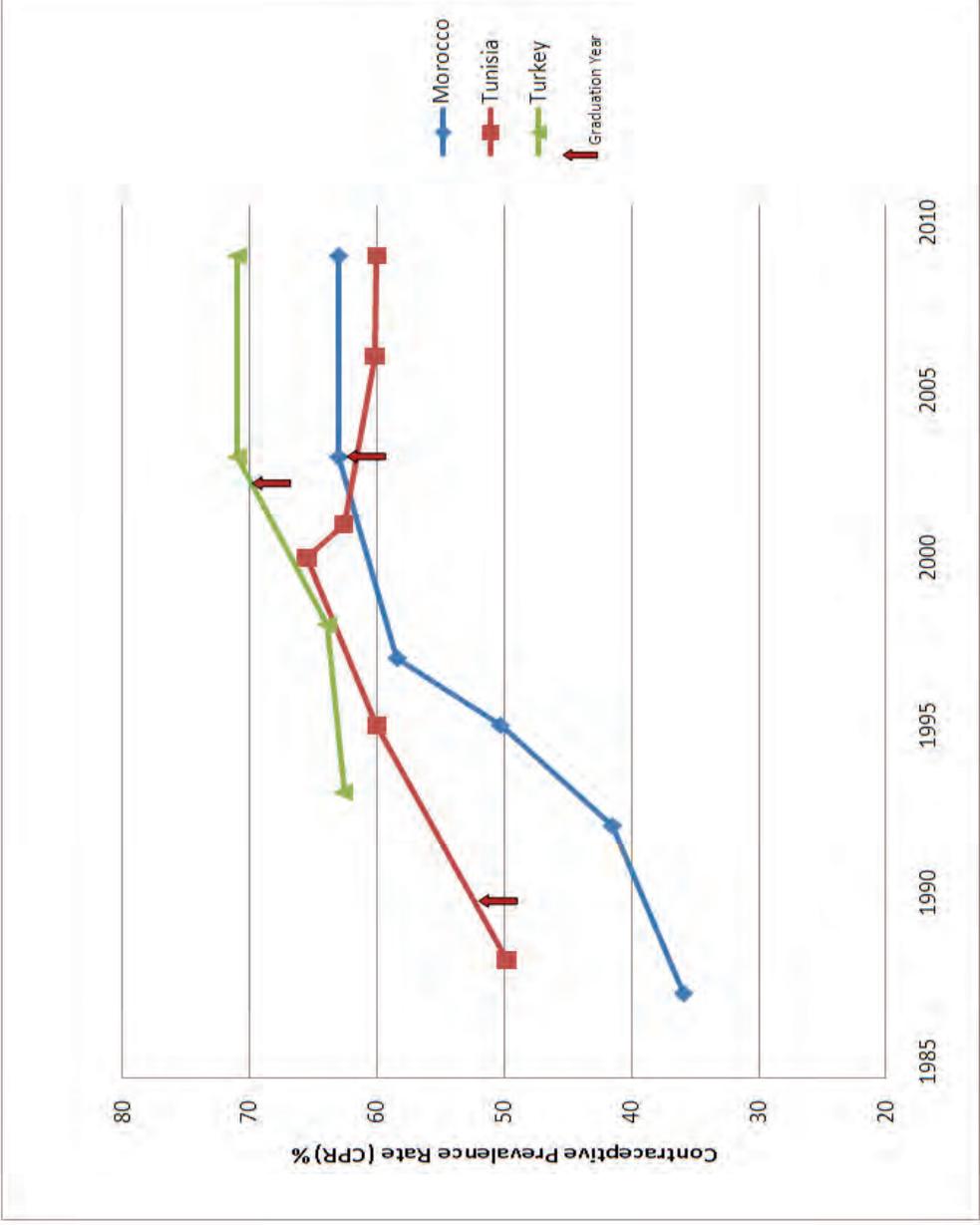


Figure 4: Modern CPR by year: graduated countries - LAC

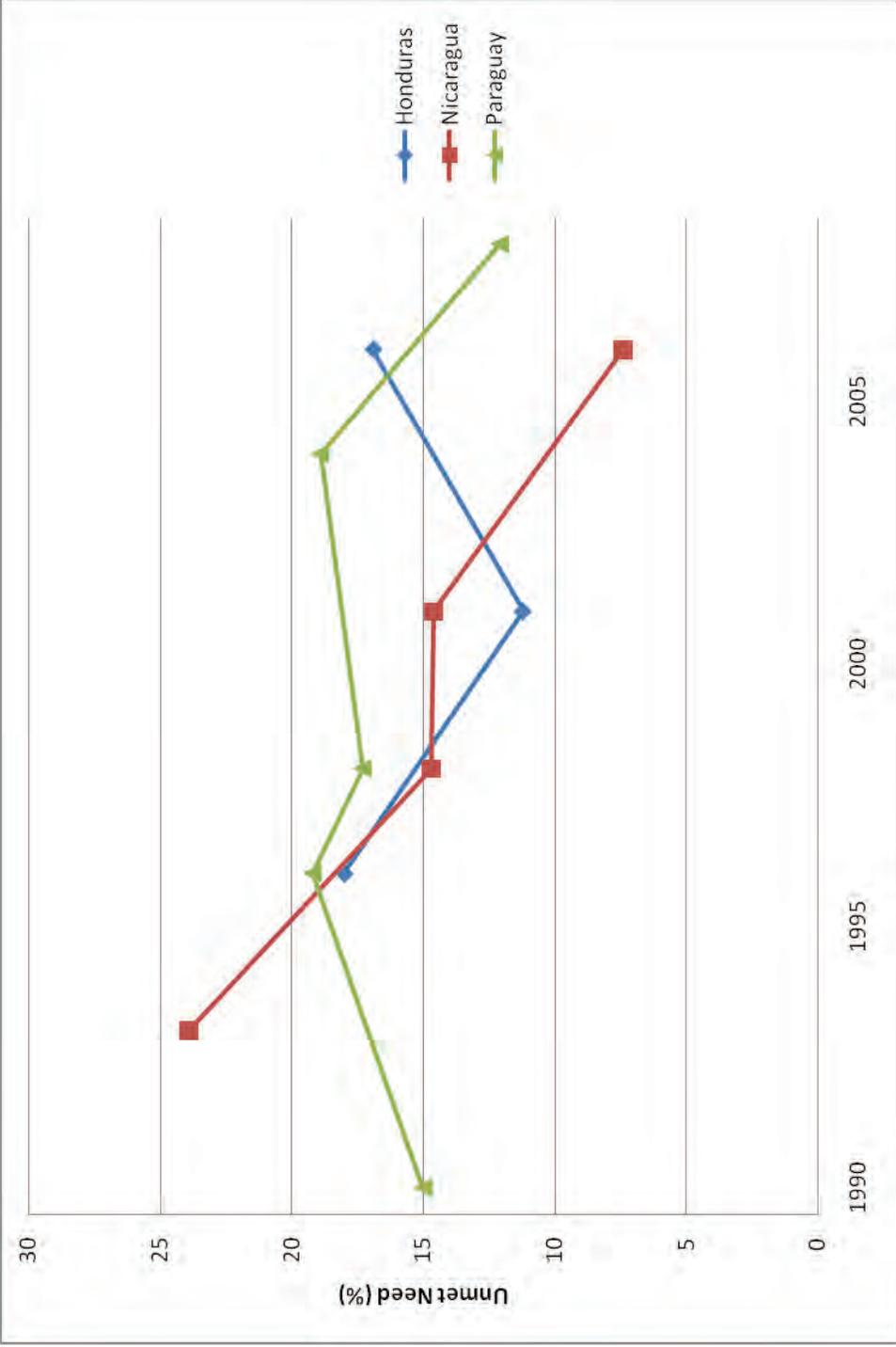


Figure 5: Unmet need by year, LAC countries scheduled for graduation

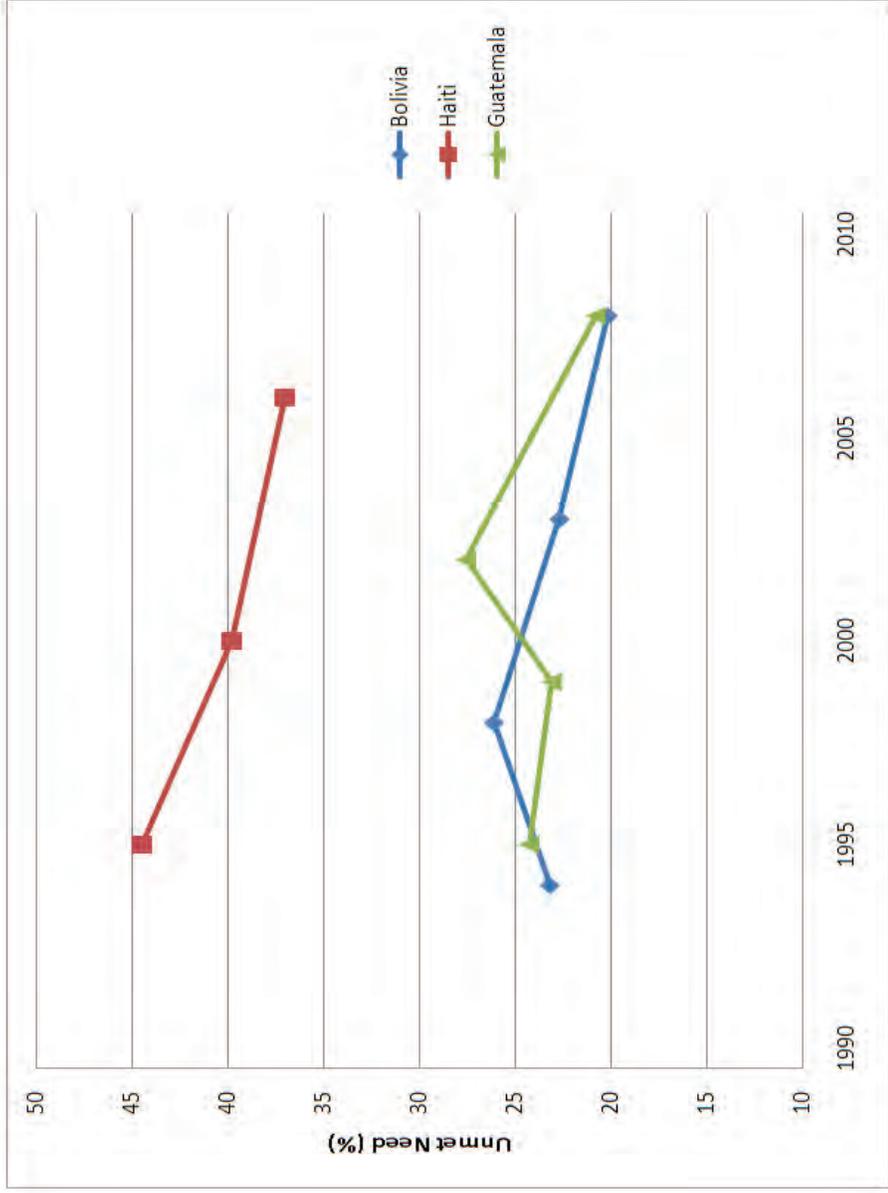


Figure 6: Unmet need by year, LAC countries not yet scheduled for graduation

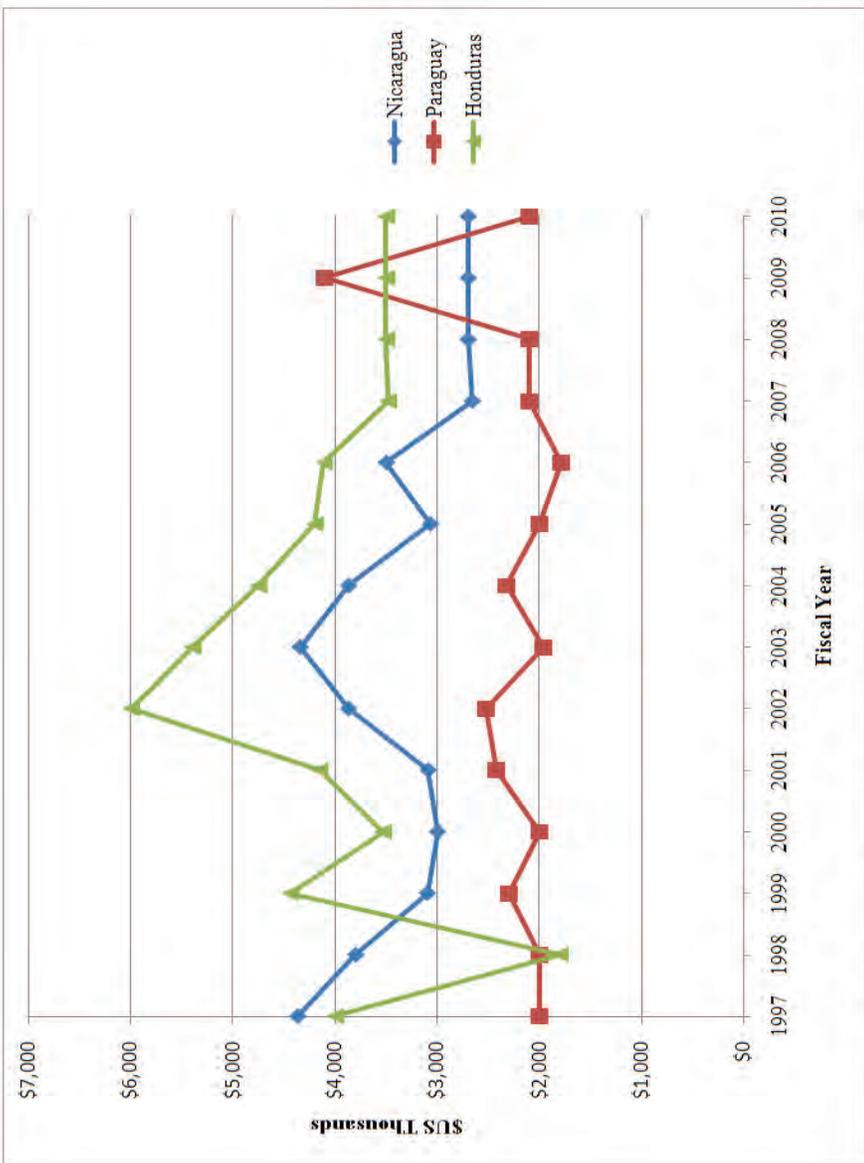


Figure 7: USAID Family Planning Assistance to the 3 “graduating” countries in Latin America 1997-2010

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APPENDIX A. List of persons interviewed

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Marianela Corriols, USAID/Nicaragua

Carolina Arauz, Deliver/Nicaragua
Freddy Cardenas, Profamilia, Nicaragua
Carlos Cuadra, Ministerio de Salud y Población, Nicaragua

Paraguay:

Graciela Avila, USAID/Paraguay

Peru:

Daniel Aspilcueta, INPPARES/Peru
Eric Janowsky, USAID/Peru

APPENDIX B. Criteria for imminent and near-term graduation from USAID FP assistance

The criteria originally established by the USAID FP Graduation Working Group in its Technical Note on Graduation (USAID, 2006) have evolved, based on the experience of USAID with this process. As of 2010, USAID is using the following criteria (Farrell, 2010):

Criteria for imminent graduation from USAID population assistance:

A country's family planning program will be considered a candidate for graduation within a 2-5 year time period when:

- Total fertility rate is less than 3.0
- Modern method contraceptive prevalence is greater than 55 percent of MWRA
- At least 80 percent of the population can access at least three FP methods within a reasonable distance (may be farther than 5 km. for long-term and permanent methods)
- No more than 20 percent of family planning products, services and programs offered in the public and private sectors are subsidized by USAID
- Major service providers (public sector, NGO, private commercial sector) meet and maintain standards of informed choice and quality of care

Achievement of the first two indicators (measurable through surveys) will generally trigger an assessment of the other key aspects of a country's family planning program. Using survey and service delivery data, supplemented with more extensive analysis if needed, USAID should determine the country's status relative to the other three indicators. If the program meets all or most (four out of five) of the criteria above at the country level, it should proceed on an expedited phase-out process over a 2-5 year period.

Extenuating circumstances such as low GNI per capita, populations with over 80 million with a large proportion under 15 years of age, that would make it difficult to address unmet need or other important concerns will be taken into consideration at this time to assess if a longer graduation period is needed. Note: in the Europe and Eurasia region the only graduation criterion will be the modern contraceptive prevalence rate, due to the differing circumstances and rationale for family planning programs in the region due to high abortion rates.

Criteria for near-term graduation from USAID population assistance

A country's family planning program will be considered a candidate for graduation within a 3-6 year time period when:

- Total fertility rate is 3.0-3.4
- Modern method contraceptive prevalence is 48-55 percent of MWRA

- At least 70 percent of the population can access at least three FP methods within a reasonable distance (may be farther than 5 km. for long-term and permanent methods)
- No more than 30 percent of family planning products, services and programs offered in the public and private sectors are subsidized by USAID
- Major service providers (public sector, NGOs, and private commercial sector) generally meet standards of quality of care and informed choice.

Achievement of the first two indicators (measurable through surveys) will generally trigger an assessment of the other key aspects of a country's family planning program. Using survey and service delivery data, supplemented with more extensive analysis if appropriate, USAID should determine the country's status relative to the other three indicators. If the program meets all or most (four out of five) of the criteria above at the country level, it should begin planning for a 3-6 year phase-out.



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