

Family Planning in
Colombia

The Achievements
of 50 Years

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Preface

This publication is one of eight case studies that were developed as part of a broader review entitled *Family Planning in Latin America and the Caribbean: the Achievements of 50 Years*. As its title implies, the larger review documents and analyzes the accomplishments in the entire region since the initiation of U.S. Agency for International Development (USAID) funding in the early 1960s. The reader of this case study may wish to access the executive summary or the report in its entirety at:

<http://www.cpc.unc.edu/measure/publications/tr-15-101>

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OVERVIEW

COUNTRY SITUATION

Colombia is the third most populous country in Latin America (47 million people) and one of the most urbanized (76 percent live in urban areas). The population is composed of Mestizos (a mix of European and Amerindian, 49 percent), white/European (37 percent), Afro-Colombian (11 percent), and Amerindian (3 percent).¹ The vast majority of Colombians (80 percent to 90 percent, depending on the source) define themselves as Roman Catholic.

Although the international media has tended to highlight the turbulence caused by armed conflict and drug trafficking throughout the past 40 years, the political situation has stabilized significantly over the past decade. Moreover, Colombia has made steady improvements in the living standard of its population, as reflected by measurable improvements in education, health, and economic indicators. Such indicators have been positively correlated with the increase in family planning. The gross domestic product (GDP) per capita (in 2005 constant dollars) rose from \$1,818 in 1970 to \$4,252 in 2012, though income inequality remains a major issue in Colombia. The percentage of women completing primary school has increased from 38 percent in 1970 to 100 percent in 2012. Contraceptive prevalence has also improved. Colombia represents a textbook example of what is often called “the quantity/quality trade-off”, in which societal norms and individual decision making have come to favor smaller family size in hopes of giving a better future to one’s children.^{2,3} Rapid urbanization within this “country of cities” has also favored smaller families.

Colombia has served as a model for other countries in Latin America and the Caribbean (LAC) region since the mid-1960s. The data in table 1 demonstrate the steady progress in family planning over the past four decades. The contraceptive prevalence rate (CPR) (all methods) for women ages 15-49 who are married or in union was estimated at less than 20 percent in 1969. Since then, it has gradually increased to 79 percent (in 2010), which is among the highest in the LAC region, after Costa Rica (82 percent in 2010) and Brazil (80 percent in 2006), and equal to Paraguay (79 percent in 2008).⁴ Similarly, the percent of married/in-union women using modern contraceptive methods (73 percent as of 2010) is also among the highest in the LAC region.

The steady increase in CPR has been matched by: (1) a corresponding decrease in unmet need, which reached a low of 8.0 percent in 2010: 3.6 percent for spacing and 4.4 percent for limiting; and (2) a decline in the total fertility rate (TFR), from an estimated 7.0 children in 1960-65 to 2.1 children per woman as of 2010 (replacement level fertility). The TFR for women living in rural

¹ Departamento Administrativo Nacional de Estadística (DANE) (National Bureau of Statistics). *National Census: Socio-demographic Information on Colombian Families*. Bogotá, Colombia: DANE; 2014.

² Becker G. An economic analysis of fertility. In: Becker GS, ed. *Demographic and Economic Change in Developed Countries*. Princeton, NJ: Princeton University Press; 1960: 135-187.

³ Becker G, Lewis H. On the interaction between the quantity and quality of children. *J Polit Econ*. 1973. 81(2):S279-S288.

⁴ Rizo A, Roper L. 1986. The role of sterilization in Colombia’s family planning program: a national debate. *Intern Fam Plann Perspect*. 1986. 12(2):44-48.

areas has declined markedly since 2005, from 3.4 to 2.8. The decline was negligible in urban areas, already reporting replacement level fertility (2.1 to 2.0).

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/In-Union Aged 15-49, Colombia, 1986-2010

	1986	1990	1995	2000	2005	2010
Total Fertility Rate	3.6	2.8	3.0	2.6	2.4	2.1
Contraceptive Prevalence Rate (%)	64.8	66.1	72.2	76.9	78.2	79.1
Modern Contraceptive Prevalence Rate (%)	52.4	54.6	59.3	64.0	68.2	72.9
Unmet Need (%)	n/a	13.7	11.4	10.0	8.6	8.0

Sources: Encuesta de Prevalencia, Demografía y Salud (EPDS) (1986, 1990);⁵ Encuesta Nacional de Demografía y Salud (ENDS) (1995, 2000, 2005, 2010)⁶ obtained via DHS Statcompiler.

Despite declining fertility rates among married women of reproductive age, fertility among adolescents aged 15-19 is relatively high (84/1000). In Latin America, only three other countries have higher rates (Nicaragua, Guatemala, and Guyana). According to the Demographic and Health Survey 2010 for Colombia (DHS-2010), 19.5 percent of adolescents (15-19 years old) are already mothers or pregnant with their first child. Among adolescents, sexual debut is often early and unprotected, putting these young women at risk of sexually transmitted infections, including HIV, and early pregnancies before they complete their physical development or education. The health, economic, and social consequences are grave for these young women, their children, their families, and society. Several large nongovernmental organizations (NGOs) (e.g., Profamilia, Fundación Bien Familia, Partners of the Americas) have programs designed to reach adolescents, and UNFPA has provided substantial support for teen pregnancy prevention. Nonetheless, adolescent pregnancy remains a significant social and public health problem in Colombia.

Among women of reproductive age, married or in union, and using a contraceptive method, the most common method is female sterilization (44.1 percent), followed by the injectable (11.6

⁵ Asociación Probienestar de la Familia Colombiana Profamilia. *Encuesta de Prevalencia, Colombia. Demografía y Salud 1990*. Calverton, MD: Institute for Resource Development, Macro International Inc.; 1991. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR9/FR9.pdf>.

⁶ Asociación Probienestar de la Familia Colombiana Profamilia. 2011. *Encuesta Nacional de Demografía y Salud 2010*. Calverton, MD: Macro International Inc.; 2011. Retrieved from: <http://www.measuredhs.com/pubs/pdf/FR246/FR246.pdf>.

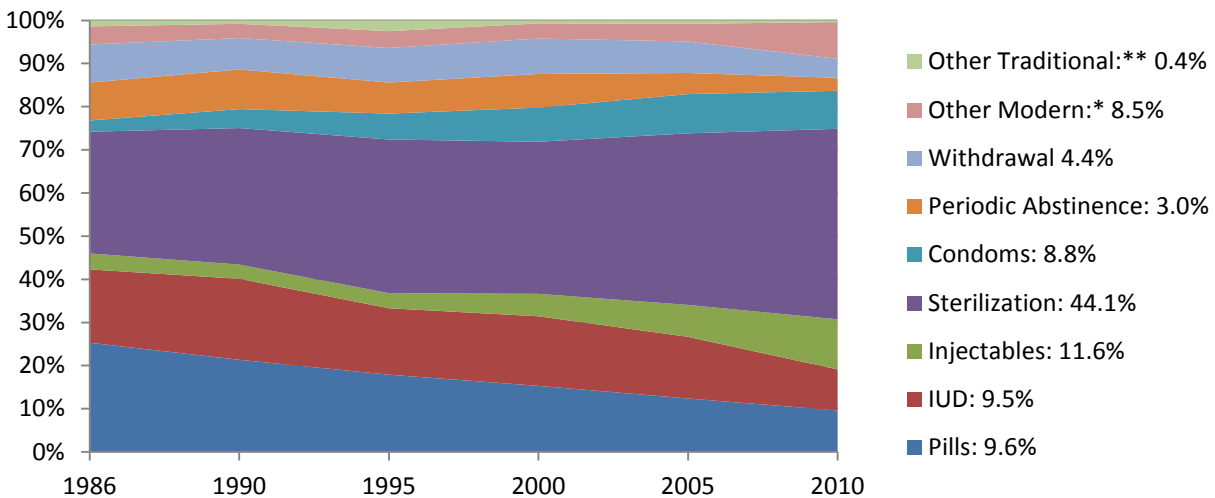
Asociación Probienestar de la Familia Colombiana Profamilia. 2005. *Encuesta Nacional de Demografía y Salud 2005*. Calverton, MD: Macro International Inc.; 2005. Retrieved from: <http://www.measuredhs.com/publications/publication-FR65-DHS-Final-Reports.cfm>.

Asociación Probienestar de la Familia Colombiana Profamilia. *Encuesta Nacional de Demografía y Salud 2000*. Calverton, MD: Macro International Inc.; 2000. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR114/FR114.pdf>.

Asociación Probienestar de la Familia Colombiana Profamilia., 1995. *Encuesta Nacional de Demografía y Salud 1995*. Calverton, MD: Macro International Inc.; 1995. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR65/FR65.pdf>.

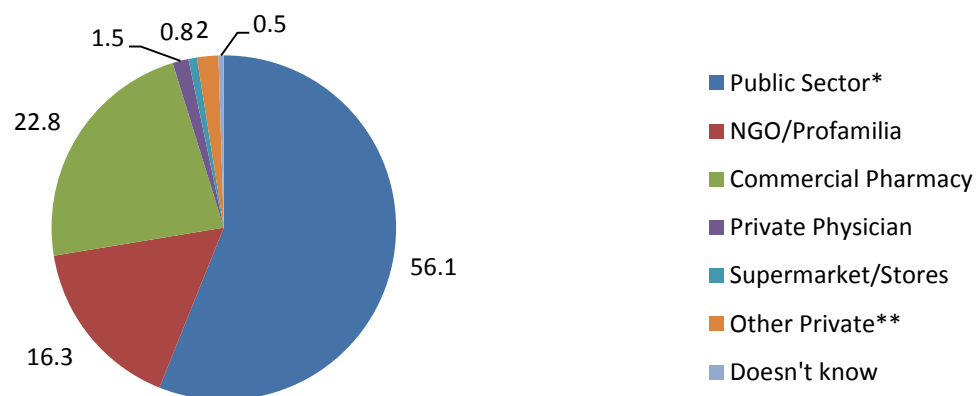
percent), pill (9.6 percent), the intrauterine device (IUD) (9.5 percent), and condom (8.8 percent), according to DHS-2010 (figure 1).

As of 2010, more than half of users obtained their contraceptives from the public sector (56.1 percent), followed by pharmacies (22.8 percent) and NGOs/Profamilia (16.3 percent); see figure 2. The trend in Colombia is similar to that of numerous other Latin American countries, in which an early dependence on private family planning associations later gave way to reliance on the public sector. In Colombia, the distinction between public and private is less clear-cut than in the past, as a result of health sector reform in the mid-1990s; private insurance schemes now support social programs, and the public sector contracts with private NGOs to deliver services.



Sources: EPDS (1986, 1990), ENDS (1995, 2000, 2005, 2010); percentages in the legend are from the 2010 ENDS.
 Notes: *Male sterilization, implants, vaginal methods and LAM.
 **Folk methods.

Figure 1: Method mix (Colombia, 1986-2010).



Source: ENDS (2010).
 Notes: * Hospital, clinic, institution, health post.
 ** Church, friends, health promoters, traditional healing.

Figure 2: Method source (Colombia, 2010).

THE EARLY YEARS (1965–1980)

In their chapter *Against All Odds: Colombia's Role in the Family Planning Revolution*, Measham and Escobar-Lopez provide an insightful summary of the factors that allowed Colombia – one of the most conservative and religious countries in Latin America – to become the first nation on the continent to promote widespread availability of family planning methods: (1) leadership and determination of well-placed, highly committed individuals to the cause of family planning; (2) academic rigor and strategic use of data in support of family planning; and (3) external assistance in support of national leadership, for which there was no substitute.⁷ In addition to financial support, the technical partnership formed between U.S. Agency for International Development (USAID)-funded cooperative agreements (CAs) and Colombian institutions contributed to the development of a family planning program that has gained widespread acclaim for its innovative approaches and impressive results.

Interest in family planning began in Colombia in 1965.⁸ By the 1960s, high rates of induced abortion indicated a need on the part of the Colombian population, especially the poor, to have access to methods of pregnancy prevention. Research from this period pointed to a sizable gap between desired and actual family size. Yet, serious obstacles existed to family planning and the development of a population policy: nationalism, pro-natalist cultural norms and traditions, a powerful Roman Catholic Church, Marxist political movements, bureaucratic rigidities, a shortage of trained health personnel, and inadequate government infrastructure in rural areas.⁹ Events on the international scene combined with a nascent interest among a small group of pioneers in Colombia to establish family planning services.

The public statements of Colombian leaders broke the silence on the issue of family planning. In 1965 Alberto Lleras Camargo, past president of Colombia and the influential editor of a weekly news magazine, testified to a U.S. Senate committee that rapid population growth in Latin America “is fostering misery, revolutionary pressures, hunger and many other potentially disastrous problems...the only solution is demographic control”.¹⁰ The president of Colombia, Carlos Lleras Restrepo (1966-70), echoed these statements that unchecked population growth would negatively impact education, housing, and employment. Such statements paved the way for a group of seven Colombian physicians to use their personal stature, reputations, and social networks among fellow elites to introduce family planning service delivery to the country, primarily through the Asociación Colombiana de Facultades de Medicina (ASCOFAME, the Colombian Association of Medical Schools) and Profamilia.¹¹

⁷ Measham AR, Lopez-Escobar G. *Against the odds: Colombia's role in the family planning revolution*. In Robinson WC, Ross JA, eds. *The Global Family Planning Revolution*. Washington, DC: The World Bank; 2007: 121-136.

⁸ Simmons AB, Cardona R. Colombia: stages of family planning and adoption, 1964-1969. *Stud Fam Plann*. 1974. 5(2):42-49.

⁹ Measham & Lopez-Escobar, 2007.

¹⁰ Simmons & Cardona, 1974.

¹¹ Measham & Lopez-Escobar, 2007.

Several landmark events occurred during the 1960s:

- ASCOFAME played a pivotal role in introducing and legitimizing family planning in Colombia. In 1964, it established the Division of Population Studies (DEP) that conducted research on a range of topics related to fertility and the felt need among Colombian women to prevent pregnancy. Because ASCOFAME had a network of seven medical schools throughout the country, it was able to train physicians in family planning (FP) service provision, define norms for service delivery, and pilot family planning programs.¹²
- Independently, but in parallel, Profamilia was established as a private family planning organization in 1965. It expanded service delivery from one clinic in 1965 to 42 clinics by 1975 (later peaking at 48 clinics in 1995). It began by providing pills and IUDs, later incorporating almost all types of contraceptive methods as they became available on the international market. Profamilia would go on to become one of the best-known and most highly regarded NGOs in the international family planning movement, based on its pioneering innovations in family planning, strong focus on quality services, and willingness to take risks in the name of bringing family planning services to Colombian couples.¹³
- In 1966, USAID and the government of Colombia signed an agreement to provide training to medical doctors. Upon signature of the agreement, the Colombia Ministry of Health (MOH) contracted ASCOFAME to develop a wide-ranging training program on demography, its implications for socioeconomic development, and methods to regulate high levels of fertility “without mentioning in its vagueness the still unpronounceable expression ‘family planning’.”¹⁴ This program was intended to lay the groundwork for transferring the delivery of services to MOH, despite the reluctance of MOH to publicly embrace family planning. In 1967 — a “tempestuous year for FP” — the Catholic Church and conservative political factions openly attacked the agreement and succeeded in suppressing some nascent programmatic activity; nonetheless, the Colombian president continued to endorse publicly the concept of providing women in poverty with options to avoid unwanted childbearing.^{15,16}
- By 1969, the MOH had established a Maternal and Child Health (MCH) Division and took over the FP service delivery program from ASCOFAME. It provided pills and IUDs, followed in later years by a wider range of contraception. In contrast to Profamilia, the MOH took a highly medicalized approach to family planning in the early years, by focusing on the reproductive health risk of another pregnancy rather than the woman’s

¹² Echeverry G. *Contra Viento y Marea: 25 Años de Planificación Familiar en Colombia*. Santa Fe de Bogotá, Colombia: Profamilia; 1991.

¹³ Seltzer J, Gomez F. *Family Planning and Population Programs in Colombia 1965 to 1997* [POPTECH Report No. 97-114-062]. Arlington, VA: Population Technical Assistance Project; 1998.

¹⁴ Echeverry, 1991.

¹⁵ Echeverry, 1991.

¹⁶ Royco Ott E. 1977. Population policy formation in Colombia: the Role of ASCOFAME. *Stud Fam Plann*. 1977. 8(1): 2-10.

stated desire for contraception.¹⁷ Eventually the MOH would reach clients through a network of 1,200 health centers and posts nation-wide and in 30 regional hospitals.¹⁸

During this period, the Colombian government never issued an official population policy but indicated its general support for family planning through public statements and actions. This decision to keep family planning out of the headlines allowed both Profamilia and MOH to continue expanding service delivery activities without direct confrontation with the opposition.

The strong leadership shown by Colombian individuals and organizations in the mid-1960s was quickly matched by external funding and technical support. The Ford Foundation and Rockefeller Foundation — already active in the international population field — provided early assistance to ASCOFAME. In 1966, USAID funded both ASCOFAME and the International Planned Parenthood Federation (IPPF) to support Profamilia. IPPF funded salary and administrative costs for Profamilia starting in 1967. The United Nations Population Fund (UNFPA) began providing funding to the MOH in 1974. (For a complete accounting of funding sources through the 1990s, see Seltzer and Gomez, 1998). Several cooperating agencies (CAs) — also recipients of USAID funding — became major contributors to projects aimed at improving the delivery of reproductive health and family planning services. The presence of technical advisors from each of these CAs working in Colombia is considered to have been highly effective.¹⁹ The strong influx of economic support for family planning led to some criticism and concern that foreign powers were meddling in the affairs of the country. However, this external funding proved invaluable in jumpstarting the Colombian program.

The social and economic context in Colombia was ripe for the entrance of Profamilia in the 1960s. Government was very centralized, with few local institutions and no local elections. When Profamilia began to arrive in communities where no government officials had previously been, the population reacted favorably. Moreover, Profamilia brought to women in these communities something they wanted but had previously been unable to access: a means of deciding the timing and number of their children.

While communities were appreciative of these early programs, they met with staunch opposition from the Roman Catholic Church.²⁰ During the mid-1960s there was speculation in Colombia and around the world that the Vatican might reconsider its opposition to the use of “artificial contraceptive methods.” However, the Papal Encyclical *Humanae Vitae*, issued in 1968, firmly reiterated the opposition of the Church to all methods except natural methods.²¹ Bolstered by the issuance of the Papal Encyclical, the Roman Catholic hierarchy in Colombia reiterated its strong stance against artificial contraceptive methods. Yet at the community level, local priests and

¹⁷ Rizo & Roper, 1986.

¹⁸ Measham & Lopez-Escobar, 2007.

¹⁹ Measham & Lopez-Escobar, 2007.

²⁰ This opposition continues to the present day, though is now directed to specific issues such as emergency contraception and abortion rather than family planning in general.

²¹ McLaughlin L. *The Pill, John Rock, and the Church: The Biography of a Revolution*. Boston, MA: Little, Brown & Company; 1982.

nuns were often sympathetic to their parishioners' problems and turned a blind eye to their contraceptive use.²²

From the start, Profamilia placed a high value on quality of services at low cost for two reasons. First, this strategy reduced its institutional risk in an environment with opponents such as the Roman Catholic Church, leftist groups, and others. Second, satisfied users were an effective means of generating further demand. Profamilia took the stance that services should be low cost but not free, because women would value the product more if they paid something for it. Further, women choosing to pay for contraception could be seen as evidence of their free choice. Profamilia took the bold step in 1969 to use radio stations with national reach to broadcast short spots explicitly announcing family planning services and locations, instead of resorting to euphemisms that were then common in other Latin America countries. At that time, fellow IPPF organizations criticized Profamilia for advertising FP as if it were a commercial product; yet, 20 years later these same organizations regularly requested funding for such radio programming.²³ Profamilia also relied heavily on community level educators in addition to satisfied users to generate demand.

By 1969, Colombia had an active family planning program that was fast expanding across the country, through Profamilia clinics and MOH facilities, with a range of methods including the pill, the IUD, and barrier methods.²⁴ Vasectomy was added in 1970 and female sterilization in 1972.²⁵ However, Colombia's FP leadership realized that to meet the demand for services throughout the country, including in rural areas, it would need to expand its service delivery beyond the clinic walls.²⁶ Thus began a decade of programmatic innovation that would further solidify Profamilia's reputation not only as a pioneer in family planning, but as a model for the region, albeit with challenges and setbacks along the way.

Key events of the 1970s included the following:

- In the late 1960s and early 1970s, universities, especially public universities, became the focal point of protests against the country's political and business establishment and its connections with the United States. Protesters saw the rapid growth of FP programs as an imperialistic plot of the "gringos" to control populations within Latin America and to sidestep the larger problems of poverty and development. ASCOFAME was a casualty of these protests. In 1969, ASCOFAME transferred its FP service delivery activities to the MOH. As student unrest heightened in 1972, ASCOFAME curtailed its population-related research activities; new research groups were created to continue the work. It also suspended training of medical students in contraceptive service delivery (through the 1990s), to the detriment of programs in both the public and private sector.²⁷

²² Echeverry, 1991.

²³ Echeverry, 1991.

²⁴ Seltzer & Gomez, 1998.

²⁵ Williams T, Ojeda G, Trias M. 1990. An evaluation of Profamilia's female sterilization program in Colombia. *Stud Fam Plann.* 1990. 21(5):251-264.

²⁶ Echeverry, 1991.

²⁷ Seltzer & Gomez, 1998.

- Profamilia introduced vasectomy to its services in 1970, followed by female sterilization in 1972. Vasectomy represented its first foray into services directed to men. In 1976, it established mobile units that extended voluntary surgical contraception (VSC) services into rural areas and remote parts of urban areas.²⁸
- Recognizing the need to reach rural populations (48 percent of the population in 1970), Profamilia pioneered the community-based distribution (CBD) approach in 1971 through the National Federation of Coffee Growers.^{29,30} The Federation funded Profamilia to bring FP services to the rural coffee farms under its jurisdiction. Profamilia trained and employed field workers responsible for information, education, and communications (IEC) activities within these communities. CBD agents distributed contraceptives (pills, condoms, spermicides) at highly subsidized prices and collected service statistics. The CBD model rapidly expanded to other rural areas as well as to marginalized urban slums by 1973. An evaluation of this novel approach recommended its immediate expansion elsewhere.³¹ Initial opposition from the medical community was silenced by two compelling arguments: such methods were available without a prescription to women of higher economic means in pharmacies throughout the country; and the risks of pregnancy were higher than the risks associated with the use of these methods.³²
- Beginning in 1972, Profamilia experimented with task shifting, such as training nurses to insert IUDs, a procedure previously reserved for physicians.³³ The MOH followed Profamilia's community based model by using their health promoters to make significant advancements in rural areas. The MOH expanded the number of methods offered (including sterilization) and the number of service delivery points throughout the country that stocked contraceptives.
- In 1973, Profamilia established a second nonclinical program to reach a larger segment of the population: contraceptive social marketing (CSM). Originally, Profamilia received its contraceptives as part of an in-kind donation that IPPF provided to its member associations. Subsequently, it shifted to local purchase to take advantage of the fact that Schering manufactured the same products in Colombia, thereby avoiding the effort, expense, and problems (e.g., pilferage in customs) associated with importation. In addition, it purchased contraceptives wholesale and then sold the products to commercial outlets at a reduced price, earning enough profit to subsidize its CBD program. Profamilia developed unique relationships with foreign manufacturers, whereby this NGO became buyer, distributor, and representative for these products within Colombia (e.g., for pills from Germany and vaginal foaming tablets from Japan, condoms from the U.S., and emergency contraception [EC] from Hungary).

²⁸ Williams, Ojeda & Trias, 1990.

²⁹ Vernon R, Ojeda G, Townsend MC. Contraceptive social marketing and community-based distribution systems in Colombia. *Stud Fam Plann.* 1988. 19(6): 354-360.

³⁰ Echeverry G. Development of the Profamilia rural family planning program in Colombia. *Stud Fam Plann.* 1975. 6(6): 142-147.

³¹ Bailey J, Correa J. 1975. Evaluation of the Profamilia rural family planning program. *Stud Fam Plann.* 1975. 6(6):148-55.

³² Seltzer & Gomez, 1998.

³³ Seltzer & Gomez, 1998.

Profamilia's early success can be linked to several key traits: autonomy, a clearly defined mission, rigorous research, highly committed and dedicated managers, financial resources, and an entrepreneurial spirit that continually sought new and better ways of doing things. As a private organization with a clear mission, Profamilia was willing to take political risks that government could not. It maintained a razor-sharp focus on reaching women of all economic strata with simple messages on how they could access and use contraception to limit or space births. It used high-quality data to justify the need for FP programs and to inform programmatic decision making for new initiatives. External donor funding and technical input, much of it from USAID, allowed Profamilia (and ASCOFAME) to push forward with innovative programming and rewarded their early efforts with continuous support.

CONSOLIDATION OF THE PROGRAM (1981-2000)

From the mid-1970s into the 1990s, the socio-political context of the country deteriorated rapidly. The country was ravaged by the *conflicto interno* (internal conflict) caused by hostilities between the army/police, guerillas, and paramilitary groups over control of territories throughout the country. In addition, drug trafficking contributed to kidnappings, killings, and robberies, which created widespread insecurity throughout the country. Colombians outside the areas of highest conflict pushed on with their everyday lives, despite the dangers posed by these negative forces. Whatever political differences were at the root of this conflict, they did not derail the delivery of FP services. As a health institution, Profamilia remained neutral and avoided becoming embroiled in the political sphere; it provided services to all. In some cases, these groups even helped Profamilia, for example, by assisting them in finding selected respondents for their studies. However, government programs were hurt by the corruption in the areas of the country ruled by the paramilitary, which took money from prevention and health promotion programs to finance their activities.

By 1980, Colombia had a fairly mature family planning program. Profamilia supported clinics in most of the capital cities of its 32 *departamentos* (departments or states), eventually expanding to an additional 29 urban areas of the country. It had developed CBD in rural areas, as well as in urban slums. Its CSM program operated with a profit that allowed it to subsidize other elements of the program. By 1980, the MOH was also a full-fledged partner in family planning, offering a range of services through its health centers and posts throughout the country. In 1984, the MOH established norms and specified the state's responsibility for providing FP, including sterilization.³⁴ The private sector also offered a range of contraceptive methods through commercial pharmacies, especially in urban areas. Previously deterred by pressure from the Roman Catholic Church, pharmacies observed the success of Profamilia's CSM and realized they were missing out on potential revenue.

During the 20-year period from 1980 to 2000, the issue of reproductive rights emerged more prominently. In contrast to the early days when women sought out FP with quiet determination despite opposition from the Catholic Church and husbands, family planning as a woman's right became more salient during this period. The political dialogue at the national and international

³⁴ Seltzer & Gomez, 1998.

level around the 1994 Cairo Conference on Population and Development and the 1995 Beijing Conference on Women reinforced the emerging political power of women's groups in Colombia. Given the change in social norms, widespread availability of contraceptives, improving educational levels, and the favorable legal climate, contraceptive prevalence (all methods) reached 72 percent by 1995.

During the mid-1980s, Profamilia made several changes to its programming. Its CBD program had become less cost-effective; moreover, rapid urbanization had blurred the lines between urban and rural. As a result, Profamilia combined CBD and CSM into a program entitled "community marketing," which sold pills and condoms with a more business-oriented approach. In an effort to become more self-sufficient, Profamilia began the process of diversifying its services to subsidize FP services for the poor; these services focused primarily on other reproductive health problems (e.g., gynecology, urology, Pap smears, pregnancy tests, infertility, and sexually transmitted infections [STIs]) but also included general practice, pediatrics, and dentistry.

The 1990s brought dramatic changes to FP programming in Colombia, due to the dual forces of decreased external funding and Colombian health reform. Key events during this period included the following:

The Transition Project (1992-1997) — In the early 1990s, USAID sent a clear message that it intended to reduce its population assistance in selected (LAC) countries that had reached a certain level of success in FP. To help prepare countries for this eventuality, IPPF/Western Hemisphere Region (WHR) implemented a USAID-funded Transition Project in 10 countries from 1992 to 1997. The objective of the project was to support IPPF member associations to diversify the range of services offered, thus increasing their self-sufficiency. One of the project activities was to remodel Profamilia clinics and acquire equipment to improve its ability to compete in the new market. Although Profamilia was already well along in this process, it further expanded services to include sonograms, VSC for women and men, HIV testing, sex education for adolescents, and legal services, among others (mentioned above). This diversification of services allowed Profamilia to cross-subsidize FP services for the poorest clients; however, it also resulted in catering to a slightly higher income clientele able to pay for these services.³⁵

Passage of *Ley 100 (Law 100)* in 1993 — Described as the "health sector reform law" or "the law to reform social security" in Colombia, the passage of this law made the government responsible for ensuring family planning service delivery. While some had argued against the inclusion of family planning in the list of services, local advocates, with support from UNFPA, succeeded in making it part of the mandated package. The actual changes did not go into effect until 1996.

Prior to the reform, the government financed public hospitals and health centers to provide family planning. Passage of *Ley 100* dismantled the social security and public-sector services system common throughout much of the region, and replaced it with a system in which private

³⁵ Lopez G, Perez I. *Profamilia's Role in Health Sector Reform in Colombia: Case Study Summary*. Bogota, Colombia: CATALYST Consortium; 2003.

and public providers compete for clients. In Colombia's system of universal health insurance, people participate in one of two "regimes" depending on income: the Contributory Regime, which covers workers and their families with monthly incomes above a minimum monthly amount (approximately U.S. \$170 per month), and the Subsidized Regime, which covers those identified as poor through a proxy means test. The contributory regime is financed by mandatory payroll tax contributions (11 percent). The Subsidized Regime is paid from national and local tax revenues and a payroll tax (1.5 percent) as a "solidarity contribution" (that is, a subsidy from those who pay into the contributory regime to help purchase coverage for those in the subsidized regime).³⁶

Ley 100 resulted in the creation of:

- EPS (*entidades promotoras de salud*, literally health-promoting entities, which are health insurance institutions) in the Contributory Regime;
- ARS (*administradora del regimen subsidiado*, or administrator of the Subsidized Regime); and
- IPS (*instituciones prestadoras de salud*, or health provider institutions).

The MOH has a normative function of regulating health care (e.g., establishing quality standards, and prices of services and benefits), the EPS manages the system, and the IPS (clinics and hospitals) provide the services.

In sum, with the passage of this law, the main responsibility for FP shifted from Profamilia to the private and public health insurance institutions operating under this new scheme. Organizations — including Profamilia — have to compete for government and private contracts to deliver these health services (that is, to be selected as IPS). The field expanded to include a range of service providers, including other nonprofit entities and government health facilities. This new approach required business strategies and administrative targets that were new to Profamilia. The leadership debated internally if Profamilia should even continue as an organization, given this new dynamic.³⁷ However, Profamilia studied the new health care coverage laws, trained staff to comply with the new regulations, and conducted market research. As a result, by 2002, Profamilia met 80 percent of its budget by income and revenue-generating sources, compared with 60 percent in 1990.³⁸

Colombia's graduation from USAID population assistance — By 1997, USAID considered that Colombia — with a TFR of 2.9 and a CPR of 72% — was ready for graduation from financial support to its FP program. Profamilia and others had been anticipating this action for over a decade, though many could not imagine that USAID — such a constant partner over 30

³⁶ Giedion U, Uribe MV. 2009. Colombia's universal health insurance system. *Health Affairs*. 2009. 28(3):853-863. DOI: 10.1377/hlthaff.28.3.853.

³⁷ Profamilia decided to continue, based on the conviction that there were other sexual and reproductive health issues (e.g., services for adolescents, abortion rights, inequities of access to SHR, violence against women) that required the presence of a strong institution to succeed.

³⁸ Richey C, Salem RM. *Elements of Success in Family Planning Programming*. Baltimore, MD: INFO Project, Johns Hopkins University Bloomberg School of Public Health; 2008.

years — would discontinue funding FP in Colombia. Profamilia had developed strategies toward sustainability, and the Transition Project further paved the way for self-sufficiency.

As the Transition Project came to a close, and Profamilia prepared for graduation, USAID established an endowment fund of \$6 million for Profamilia. According to the terms and conditions established for the administration and management of the fund, the profits obtained during the first three years were subject to the capitalization of the fund; it was stipulated that from the beginning of September 1999 they would be annually transferred to Profamilia. As of 2001, Profamilia's finance committee established that up to 5 percent of the endowment's three-year market value would be allocated annually in support of Profamilia's operating budget for the following fiscal year. For example, these funds subsidized services for the poor with a special focus on displaced persons in urban areas. This was the first and only such endowment that USAID has given to an IPPF Member Association.³⁹

Although graduation from USAID funding required a great deal of work and fundamentally transformed Profamilia; there are no signs of long-term negative consequences on programming or the use of FP methods. Contraceptive prevalence continued to increase steadily in the three DHS surveys post-graduation.

POST-CONSOLIDATION (2001-PRESENT)

By 2000, family planning was deeply ingrained as a social norm in Colombia. The total fertility rate dropped from 2.6 to 2.1 per woman, while CPR increased from 77 percent to 79 percent between 2000 and 2010.

The most notable achievement of family planning in the past decade has been its institutionalization as part of the Colombian health system, following passage of *Ley 100*. As of 2009, there were 21 EPS operating in the Contributory Regime and 43 different health insurance entities involved in the Subsidized Regime. The percentage of the population with health coverage increased from 24 percent (before 1993) to over 80 percent by 2007, according to the National Health Survey. The increase was especially dramatic among the lowest quintile of the population, rising from 6 percent before the reform to more than 70 percent by 2007. Family planning forms part of the government-mandated health services, and as of 2012 at least 96 percent of the Colombian population was nominally covered.⁴⁰ Despite criticism of this system,⁴¹ a recent analysis confirms that it has increased access for the poor.⁴²

³⁹ Cromer C, Pandit T, Robertson J, Niewijk A. *The Family Planning Graduation Experience: Lessons For the Future* [POPTECH Project Report No. 2004-193-029]. Arlington, VA: Population Technical Assistance Project; 2004.

⁴⁰ Lujan F. Colombia: a healthcare system in crisis. *Medical Solutions* [www.siemens.com/healthcare-magazine]. November 2012:1-6.

⁴¹ Ewig C, Bello AH. 2009. Gender equity and health sector reform in Colombia: mixed state-market model yields mixed results. *Soc Sci Med*. 2009. 68(6):1145-1152.

⁴² The World Bank. *Reaching the Poor and Health Services—Colombia*. Washington, DC: The World Bank; 2007.

This system is not without problems. Critics have argued that high co-payments have prevented the poor from gaining access to health services; total health expenditures have skyrocketed without visible improvements in equity; and according to recent studies, efficiency and quality have deteriorated.⁴³ While insurance companies report large profits and high administrative expenditures, many hospitals have gone bankrupt.⁴⁴ Nonetheless, this system has increased contraceptive availability for the majority of the Colombian population, especially those living in urban areas.⁴⁵

Evidence of the shift in service providers is available from DHS data on sources of contraceptives among users of modern methods. In 1995, the private sector — including Profamilia, pharmacies, and private doctors — delivered approximately 72 percent of the services compared to only 27 percent by public sector facilities.⁴⁶ In 2010, the percent of services delivered by the private sector dropped to 41 percent, while those provided by the public sector increased to 56 percent.⁴⁷ Use of pharmacies, which were the source of contraceptives for approximately one-third of users from the mid-1980s to mid-1990s, has also declined in recent decades. This drop is most likely due to increases in usage of female sterilization, obtained in clinical settings, and reduced use of the pill and injections, which were previously obtained primarily from pharmacies.

Despite decades of pioneering work in Colombia, family planning still met with controversy over the introduction of emergency contraception. In the late 1990s, IPPF/WHO selected Colombia to serve as a model for EC introduction in the LAC region. Initially, Profamilia staff were trained in the Yuzpe Regimen of EC. In 1998, Profamilia entered into negotiations to obtain exclusive distribution rights of a levonorgestrel-only product. After considerable delay, the Colombian drug regulation body (Instituto Nacional de Vigilancia de Medicamentos y Alimentos or INVIMA) approved Postinor-2 in 2000. The timing of the announcement of its approval coincided with approval by the U.S. Food and Drug Administration (FDA) of the use of mifepristone for medical abortion, leading to an unfortunate confusion in the media. The Catholic Church in Colombia asserted that Postinor-2 was an abortifacient (contrary to medical evidence) and pressured the INVIMA to review its approval of this drug. Eighteen months after the initial approval, INVIMA issued a statement re-affirming the registration of Postinor-2 as an appropriate contraceptive alternative. Yet this incident reignited the decades-long friction between the Catholic Church and the FP establishment over contraception.⁴⁸

Although the contraceptive prevalence rate in Colombia is one of the highest in Latin America, important work remains to be done. As a result of the *conflicto interno* (internal conflict), over 5.5 million Colombians were displaced from their homes and fled to the relative safety of the

⁴³ Plaza B, Barona A, Hearst N. Managed competition for the poor or poorly managed competition? Lessons from the Colombian health reform experience. *Health Pol Plann.* 2001. 16(Suppl 2):44-51.

⁴⁴ Ugalde A, Homedes N. 2009. Health and equity in Latin America. *Americas Quarterly.* Fall 2009.

⁴⁵ Measham & Lopez-Escobar, 2007.

⁴⁶ ENDS, 1995.

⁴⁷ Asociación Probienestar de la Familia Colombiana Profamilia. *Encuesta Nacional de Demografía y Salud (ENDS) 2010.* Calverton, MD: Macro International Inc.; 2001. Available at <http://www.measuredhs.com/pubs/pdf/FR246/FR246.pdf>

⁴⁸ Heimburger, A., Gras, C., & Guedes, A., 2003. "Expanding Access to Emergency Contraception: The Case of Brazil and Colombia." *Reproductive Health Matters*, 11, 21, 150-160.

nearest cities.⁴⁹ Known as the *población en condición de desplazamiento* (displaced people), these groups live in extreme poverty in marginalized areas of the major cities, with very limited access to social, educational and health services. Under Plan Colombia (1999-2011), the U.S. Department of State gave Colombia both military aid to fight the guerillas and drug traffickers and development assistance for displaced persons.^{50,51} Although “graduated” from FP funding from USAID, Profamilia received over \$13 million dollars of assistance from Plan Colombia between 2006-2011 to provide reproductive health services to displaced persons. The Profamilia leadership during this period described the experience as “turning the clock back 30 years.” Specifically, because this poor, low-literate population has such limited knowledge of and experience with family planning, Profamilia has reverted to the same approaches they had used to reach similar populations in the early 1970s.

With a strong community focus and use of mobile units, programs for displaced populations operated in more than 25 cities throughout Colombia until 2011, when the program was discontinued. Results from baseline-endline surveys of displaced populations showed improvements in use of modern methods among married women of reproductive age, but continued high fertility among displaced adolescents.⁵² Adolescent fertility seems to be tied to deeply rooted problems of poor living conditions, lack of education, violence within families, and other destabilizing factors.⁵³

POLICIES AFFECTING FP IN COLOMBIA

For the first three decades of activity, Colombia achieved its success in family planning in the absence of an official population policy. The government was generally favorable toward family planning and provided FP services through its own network of public sector health facilities. The FP leadership progressed without an official policy because they did not consider it to be necessary to achieve its objectives, and to avoid potential backlash from opponents, including the Roman Catholic Church. However, the various laws passed in the 1990s constitute a *de facto* government policy on contraception in this country.⁵⁴

Three major pieces of legislation have been passed since 1991, unrelated to any work supported by USAID, the first two of which have had a major bearing on family planning in Colombia. The first was the change in the Colombian Constitution in 1991, which recognized the fundamental rights of the individual rather than the *bien común* (common good, which tended to be interpreted as the interests of the state). This constitutional change resulted from the widespread

⁴⁹ Internal Displacement Monitoring Centre. *Global Overview 2012: People Internally Displaced by Conflict and Violence*. Geneva, Switzerland: Norwegian Refugee Council; 2012.

⁵⁰ European Commission Humanitarian Aid Office (ECHO). *Evaluation of ECHO's 2001 Intervention Plan in Colombia*. Brussels, Belgium: Franklin Advisory Services; 2002.

⁵¹ Hernández BA, Gutierrez BML. Vulnerabilidad y exclusión: condiciones de vida, situación de salud y acceso a servicios de salud de la población desplazada por la violencia asentada en Bogotá — Colombia, 2005. *Revista Gerencia Y Políticas De Salud*. 2008. 7(14):145-176.

⁵² Asociación Probienestar de la Familia Colombiana Profamilia. *Surveys in Marginalized Areas Sexual and Reproductive Health, Forced Displacement and Poverty 2000-2001*. Bogota, Colombia: U.S. Agency for International Development; 2011.

⁵³ Profamilia. *Salud Sexual y Reproductiva en Zonas Marginales: Situación de las Mujeres Desplazadas*. Bogota, Colombia: Profamilia; 2005.

⁵⁴ Seltzer & Gomez, 1998.

social movement among Colombians to confront the climate of violence in the country and to promote a “new Colombia.” One such right was for individuals to make decisions about and to control their own “reproductive autonomy,” which further reinforced the rights of Colombian women. It asserted that family planning is a human right: *La pareja tiene derecho a decidir libre y responsablemente el número de sus hijos* (the couple has the right to decide freely and responsibly the number of children they’ll have).⁵⁵ This victory of the Colombian people over the forces of violence had the additional benefit of further strengthening the position of women and men to control their own fertility.

Second was *Ley 100*, described above, which was passed in 1993 to provide a system of health coverage to all Colombians. It declared health to be a right to which Colombian citizens were entitled. This change in law represented a major turning point in the evolution of family planning in Colombia because it made the government responsible for providing family planning services. In addition, the *plan obligatorio de salud* (POS, basic health plan) ensures the implementation of the technical norm to provide family planning services to men and women.⁵⁶

Third, in 2003 the Ministry for Social Protection (today it is known as the Health and Social Protection Ministry) formulated the National Policy on Sexual and Reproductive Health (SRH).⁵⁷ To implement this policy, local authorities developed guiding principles and strategies to address several priority SRH interventions: safe motherhood, family planning, SRH of adolescents, cervical cancer, STIs, and HIV/AIDS. The results of implementing this policy in the coffee growing region of Colombia were published in 2011.⁵⁸

Any description of policies and laws related to sexual and reproductive health would be incomplete without mentioning the legal status of abortion in Colombia. We reiterate that abortion is not a family planning method, and USAID does not and has not supported abortion-related activity or advocacy. Nonetheless, it is relevant to this historical account to note that the constitutional court in Colombia issued a ruling in 2006 that decreed abortion to be legal under three conditions: (1) when pregnancy is a result of rape, incest or non-consensual insemination or implantation of a fertilized egg; (2) when the pregnant woman’s health or life is in danger; and (3) when severe fetal malformations make life outside of the womb unviable. This ruling has been contested by the *procurador general* (similar to an inspector general), who has taken action to hinder its implementation within public sector services. In response, women’s groups from civil society have worked persistently to ensure its implementation, as a means of providing greater access to SRH services for women in Colombia.

⁵⁵ Colombia *Const*, 2012. Art 42, Resolucion 0769 de 2008.

⁵⁶ Colombia *Const*, 2012. Art 42, Resolucion 0769 de 2008.

⁵⁷ República de Colombia. *Política Nacional de Salud Sexual y Reproductiva*. Bogotá, Columbia: Ministerio de la Protección Social y Dirección General de Salud Pública; 2003.

⁵⁸ del Castillo Matamoros S E, Roth Deubel AN, Wartski Patiño CI, Rojas Higuera R, Chacón Barliza OA. La implementación de la política pública de salud sexual y reproductiva (SSR) en el Eje Cafetero colombiano: el caso del embarazo adolescente. *Revista Latinoamericana de Ciencias Sociales, Niñez y Juventud*. 2011. 6(1). Retrieved from <http://www.scielo.org.co/pdf/rllcs/v6n1/v6n1a08>. República de Colombia. *Política Nacional de Salud Sexual y Reproductiva*. Bogotá, Colombia: Ministerio de la Protección Social y Dirección General de Salud Pública; 2003.

FP AND THE HEALTH SYSTEM

Service Delivery

As described early in this case study, Profamilia began service delivery using the medical model, but soon evolved to innovative models of CBD (1971), CSM (1973), and eventually community marketing (1984). It piloted services targeted specifically to males (vasectomy in 1970) and adolescents (1990). In the 1960s, pharmacies shied away from offering contraceptive methods, because of pressure from the Roman Catholic Church. However, when social marketing programs in the 1970s successfully established thousands of sales points in urban areas, the private sector recognized that selling contraception was good business. Over the years, contraceptives became widely available through commercial pharmacies.

Whereas Profamilia was the leader in service delivery, by 1969 the MOH began providing contraception as part of its MCH program. The Instituto de Seguros Sociales (ISS, Colombian Social Security Institute) also provided services to its beneficiaries, though the primary focus of its services was treatment, not prevention. The government closed the ISS in 2012. Today the EPS, called “*Nueva EPS*,” manages health care services, including FP.

In the past two decades, additional providers have emerged with a strong focus on sexual and reproductive health, gender equality, and women’s rights. For example, Sí Mujer (“Yes Woman”) first opened in 1984 and provides SRH services (including contraception, gynecology, medical consultations, endometrial biopsies, psychological services, and counseling and crisis support for victims of sexual violence, among other services). Although their only medical site is in Cali, they provide outreach and education workshops in other locations.

FP Workforce

Starting in 1966, the Ford Foundation, Population Council, and USAID trained personnel in multiple fields (public health, epidemiology, sociology, statistical analysis, service delivery, and communication) through both university degree programs and short-term training to manage service and research programs related to family planning. Over 4000 Colombians received some type of overseas training, largely in the United States, between the 1960s and late 1970s.⁵⁹

In terms of in-country capacity building, ASCOFAME was instrumental in training the first wave of service providers in Colombia through affiliated medical schools. As the programs of Profamilia and the MOH expanded rapidly, the need for trained service providers and community personnel increased dramatically. Colombia’s experience integrating family planning into the training of its medical schools proved to be a disappointment. In 1972 ASCOFAME discontinued training of medical students in contraceptive service delivery, under pressure from the university-based leftist movement. Not until the mid-1990s were attempts made to reintegrate FP service delivery into the medical curriculum. By contrast, nursing students received some

⁵⁹ Seltzer & Gomez, 1998.

orientation to FP as part of their MCH training.⁶⁰ USAID’s financial and technical assistance — primarily through its CAs to Profamilia and to lesser extent the MOH — proved invaluable in filling this gap. The training covered a wide range of areas: service delivery, IEC, commodities, and operations research, among others. “This investment in human resources during the first decade of family planning and population activities has proved to be one of the most important contributions to the Colombian story.”⁶¹

Profamilia established a training unit for its own personnel, as well as those from other Colombian institutions and other Latin American countries. Starting in the 1970s, Colombia hosted a steady stream of participants who came to learn from Profamilia’s model programs. In addition, Profamilia staff provided technical assistance to other countries in the region (e.g., in CSM and program evaluation). In the 1990s Colombia began to participate in the Partners in Population and Development (south-to-south initiative), offering courses on a wide variety of topics (e.g., finance, accounting, research, evaluation, social marketing, and gender).⁶² Through this mechanism, more than 1400 staff from 345 public and private organizations from 20 countries in the region were trained; 13 training modules were developed and used; and 37 technical assistance missions were deployed to 10 other countries.

Information Systems (DHS, Routine Health Information Systems, and Others)

Colombia has been a leader in the use of information to drive family planning programming. Studies conducted in the 1960s and 1970s provided evidence that persuaded policymakers of the need for family planning. With funding from USAID, the Ford Foundation and other sources, several research organizations (e.g., Centro Regional de Population; ACEP, Asociación Colombiana de Estudios de Población, Profamilia) produced high quality population-based surveys on demographic trends and family planning needs. These data provided an opportunity for population advocates to demonstrate the need for family planning to government officials and other high-level authorities.

In order to access data for programmatic decision making, in 1973 Profamilia established a routine health information system (RHIS) to collect service statistics. It also designed and conducted studies at the departmental level or below to guide program planning and evaluate results in the medium and long term. In the 1980s, Profamilia was among the first to use computerized information systems in an independent, well-structured program evaluation unit. Since the late 1990s, when family planning became mandated in government health insurance programs, much of the reporting on family planning has occurred through the computerized system known as Registros Individuales de Prestaciones en Salud (RIPS, Information System for Health Services) which tracks performance, more for contractual purposes than measuring family planning output. Between 1990 and 2010, with USAID funding and technical assistance, Colombia conducted a DHS every five years, which is widely used by all levels of government, private entities, donor agencies and others to assess policies and programs. Of note, the DHS 2010 also received technical and financial assistance from the Colombian Ministry of Social

⁶⁰ Seltzer & Gomez, 1998.

⁶¹ Seltzer & Gomez, 1998.

⁶² Seltzer & Gomez, 1998.

Protection, the Colombian Institute of Family Well-being (ICBF), the National Bureau of Statistics (DANE) and Profamilia. In 2011, DANE (the National Bureau of Statistics) evaluated the DHS 2010 and determined that it met international standards for statistical quality.⁶³

Commodities

In the early days of the program, USAID and IPPF provided the bulk of contraceptives used in family planning programs to Profamilia and the Ministry of Health. USAID tended to provide them in-kind; IPPF initially provided them in-kind but shifted to providing the equivalent funds to be used for local purchase. As described above, Profamilia developed innovative mechanisms to ensure a constant supply of contraceptives, by developing independent contracts with international laboratories and becoming the country representative for them in some cases.

By the late 1990s, other commercial entities began to import pills and condoms; the commercial market for contraception was viable, thriving and competitive. Profamilia no longer felt the need to ensure the availability of contraceptives in Colombia. Since the passage of health reform (*Ley 100*), both the public and private health insurance institutions have purchased their own contraceptives, either through local pharmaceutical companies or on the international market. The government is not directly involved in the procurement process, except to issue directives or policies establishing the range of contraceptive methods and services that are part of the basic health plans.

Financing

Because of its strong leadership, commitment, and willingness to take risks, Profamilia was highly regarded by the international donor community for FP for a 30 year period starting in the 1960s. Donors trusted Profamilia, which conducted its operation with a strong sense of mission and integrity. Said one former employee: “We may have been rebels, but we were honest.”

USAID was the first bilateral donor for FP in Colombia and by far the largest donor, providing a total of approximately \$50 million for three decades starting in 1966. In the early years, USAID funded ASCOFAME, IPPF (to support FP in Colombia), Profamilia, and the MOH. Assistance to the government was phased out in the late 1970s, at which point USAID redirected its funding to Profamilia. Much of this funding came through CAs that collaborated in different technical areas with Profamilia (e.g., training, service delivery, IEC, operations research, DHS). USAID provided a solid source of funding to support the continuous innovations of Profamilia, which benefited Colombia and other countries in the region.

IPPF also supported Profamilia, covering salary and administrative costs. In fact, Profamilia received a large share of IPPF funding in comparison to other member associations in Latin

⁶³ Departamento Administrativo Nacional de Estadística (DANE) (National Bureau of Statistics). *Proyecto de Aseguramiento de la Calidad*. Bogotá, Colombia: DANE; 2011. Retrieved from: http://www.colombiastad.gov.co/index.php?option=com_content&task=view&id=1159&Itemid=30.

America. However, the percentage of the Profamilia budget covered by IPPF steadily decreased over the years, currently to approximately 1 percent of its total budget.

UNFPA started supporting activities in Colombia in 1974 and initially directed this funding to the MOH program; later it supported advocacy initiatives that aligned with the ICPD Program of Action. Other donors contributed with lower levels of funding. Early on the Japanese supported CBD in rural areas which also included integrated programming for parasite control, which was later discontinued. Scandinavian countries and Canada also supported Profamilia, often through funding to IPPF globally.

With the passage of *Ley 100* in 1993 and the discontinuation of USAID population assistance in 1997, family planning became part of the basic health plan (POS) covered by EPS and provided by IPS. Currently, the cost of family planning is borne by multiple sources, including both public and private EPS. However, this may change in the future, as there is a bill in Congress to reorganize the health sector.⁶⁴

In sum, Profamilia produced many “firsts” in Latin America, including CBD, social marketing, use of radio and ads in popular magazines to promote family planning, VSC for both men and women, fundraising within Colombia and abroad, and continuous efforts to find the most cost-effective ways to deliver services to the poor. In addition, it introduced the model whereby Profamilia set up contracts with pharmaceutical manufacturers to represent, distribute, and sell their products in country. As such, Profamilia became not only the testing ground in Latin America for these programmatic interventions, but also a training site for family planning professionals from Latin America and beyond who learned and adapted many of the pioneering ideas from the Colombian experience. The program’s success is used to teach others, as demonstrated by the selection of the experience for a case study by The Harvard Business School’s Social Enterprise Knowledge Network.⁶⁵

LOOKING TO THE FUTURE

Family planning has become so deeply entrenched as a social norm in Colombia that it no longer constitutes the special area of interest that it did in the 1960s and 1970s. Nonetheless, challenges remain.

Challenges

Despite its impressive achievements in family planning, Colombia has an unfinished agenda in terms of:

- meeting the current demand for family planning services;
- identifying and satisfying unmet need;

⁶⁴ Lujan, 2012.

⁶⁵ Dario Lobo I, Gutierrez R, Sanabria R. *Profamilia: Planning to Survive*. Boston, MA: Harvard Business School Publishing; 2006.

- improving adherence to/continuation rates of contraceptive methods;
- reducing the number of unintended pregnancies, especially among adolescents; and
- improving the level of information and education for FP and other aspects of sexual and reproductive health.

Emergency contraception continues to be a flashpoint for opponents of family planning in Colombia and across the region. It triggers a dual reaction, because it is seen as an abortifacient and because the primary users are perceived to be young, unmarried women engaged in premarital sex — despite the fact that neither of these views are supported by scientific evidence.

Strengths

Colombia remains a model for the rest of the region and the world in several key areas:

- The government ensures family planning service delivery as a basic right of the Colombian people.
- The separation of Church and State, mandated by the Constitution, has facilitated the introduction and approval of FP methods, including emergency contraception.
- The current health insurance system of EPS and IPS has effectively addressed issues of contraceptive security.
- NGOs complement the government in reaching specialized populations, including adolescents and internally displaced persons.
- The culture of information and evaluation continues to drive FP programming, including population-based surveys, special studies, and service statistics.

MEASURE Evaluation

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