Family Planning
in Latin America and the Caribbean:
The Achievements of 50 Years

April 2015

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EXECUTIVE SUMMARY

Introduction

Family planning is a lifesaving intervention that benefits individual women, families, communities and nations. By allowing women to delay childbearing, space births, and avoid unintended pregnancies, family planning can prevent as many as one in three maternal deaths. In addition to multiple other benefits, governments and donors have embraced family planning because it saves lives.

This report examines the 50-year period starting in the mid-1960s that witnessed a dramatic decline in fertility and steady increase in contraceptive use in the Latin America and Caribbean (LAC) region. The current contraceptive prevalence rate (all methods) of 74 percent is among the highest of any region in the developing world.

Many factors have contributed to the dramatic decline in fertility in the LAC region over the past 50 years: increased educational levels, improved economic conditions, decreased infant and child mortality, rapid urbanization, political stability, and changing cultural norms, among others. While recognizing the influence of these factors on fertility, what role did use of family planning play in fertility decline in the region? What lessons can be drawn for other developing countries committed to a development path that strengthens family planning services and improves health and living standards for their people?

This report examines the specific role of family planning in accelerating fertility decline in the LAC region. The objectives of our analysis were to:

1. Document the changes in the region in fertility rates and contraceptive use over time, as well as in indicators of health, education, and economic conditions that contributed to these dramatic changes in societal norms and contraceptive practice
2. Provide a historical overview of organizations, events, and the political environment in the early years of the family planning movement
3. Identify key factors that explain the effectiveness of family planning (FP) programs in this region
4. Outline remaining challenges, including high rates of adolescent fertility in many LAC countries and issues of contraceptive security[1]

[1] Contraceptive security is defined as the point at which every person is able to choose, obtain, and use quality contraceptives, condoms, and other necessary reproductive health supplies for family planning and for the prevention of HIV/AIDS and other sexually transmitted infections.

This report examines the sustained efforts of organizations and individuals over five decades to make contraception accessible, affordable, and of high quality for millions of people throughout the LAC region. The two main sources of information consulted for this report were (1) publications and reports from the published and grey literature; and (2) in-depth interviews with over 100 key informants who currently work or who had worked as far back as the 1960s in international agencies, government officials (including ministry of health, social security institute, and other governmental offices), nongovernmental organizations (NGOs), in-country programs, and current and former employees of the U.S. Agency for International Development (USAID) and its U.S.-based cooperating agencies (CAs) among others.

In addition, the report is informed by eight associated case studies that examine the experiences of selected countries of the region: Colombia, El Salvador, Dominican Republic, Haiti, Guatemala, Mexico, Nicaragua, and Paraguay. The case studies drew on the in-depth interviews held in those countries and conducted for this report.

Evolution of Methods, Programs, and Attitudes

The earliest family planning activity in the LAC region dates back to the mid-1960s. In that period, the International Planned Parenthood Federation (IPPF) played a catalytic role in identifying groups of concerned professionals and citizens within countries and encouraged them to form local private FP associations, which later developed into the network of IPPF affiliates. In 1965, USAID established its population program and quickly became the major donor to FP programs in the region, supporting IPPF, its member associations, government programs, and other local organizations. In addition, USAID provided technical and financial assistance through its U.S.-based CAs, which worked closely with those implementing FP at the country level, to address the priority issues facing individual countries.

Family planning programs initially focused on service delivery using a clinic-based approach. However, by the 1970s, it became clear that other approaches would be necessary to reach populations outside cities or in marginalized urban areas. Many countries in the region experimented with community-based distribution (CBD) programs and social marketing to expand reach.

The earliest FP programs offered combined oral contraceptives, intrauterine devices (IUDs), condoms, and spermicides. By the late 1960s, female and male sterilization were also introduced. In later years, additional methods were introduced as they became available: low-dose and progestin-only pills, the Copper-T IUD, contraceptive implants, and injectables by the 1990s; and Standard Days Method/Cyclebeads and emergency contraception (EC) in the 2000s in some countries.

When first introduced, family planning faced opposition from multiple sources on both ends of the political spectrum. The Roman Catholic Church opposed certain methods of modern contraception. In some settings, various university leaders and political movements considered FP an “imperialistic plot” by western countries to further control developing nations. And in many countries in the region, cultural norms favored large families, and many feared that contraceptives would foster promiscuity if women used them.

As most countries in the region achieved low total fertility rates (TFRs), high contraceptive prevalence rates (CPRs), and increasingly equitable levels of contraceptive use across subgroups (including rural populations and the poor), USAID began to withdraw its assistance to FP programs in the region. The first countries to have funding discontinued were Panama (1988), Costa Rica (1996), and Colombia (1997). Mexico, Brazil, and Ecuador followed (2000-2001). More recently, USAID withdrew its FP funding from countries that met pre-established graduation criteria, including Jamaica (2008), Dominican Republic (2009), El Salvador and Paraguay (2010), Nicaragua (2011), Peru (2012), and Honduras (2013). Guatemala and Haiti have yet to meet the criteria established by USAID for graduation and continue to receive assistance. In 2013 the Bolivian government opted to decline all USAID assistance, despite being eligible for continued assistance for family planning.

Factors Contributing to Widespread Use of Family Planning

Despite strong opposition from multiple sources (some of which exists to this day), family planning made impressive strides throughout Latin America and the Caribbean, improving the health of millions of people while advancing women's rights. Our analysis identified 10 key factors that have contributed to the success of FP in the LAC region:

1. The development of strong NGOs that pioneered the family planning movement, tested new FP methodologies, and continue to tackle politically sensitive issues
2. A socio-political environment at the macro level that gradually supported family planning
3. Sustained external support in financial and technical assistance from USAID and other donors
4. Synergistic coordination among governments, external agencies, NGOs, and civil society
5. The development of local expertise in key programmatic, policy, and management areas
6. Improvement in the availability of information as a tool to drive decision making and open doors to new thinking and new approaches
7. Strategically designed, wide-reaching communication activities to support change in individual behavior and social norms
8. Mechanisms to ensure program financing that evolved to fit the times
9. Effective advocacy to achieve major political gains
10. Significant investments in contraceptive commodities and security

Remaining Challenges

Fifty years after the introduction of family planning in the LAC region, several major challenges persist. First, adolescent fertility rates remain at unacceptably high levels. Even most of the countries with near replacement-level fertility (i.e., with a total fertility rate of 2.1) have had difficulties reaching young, often poor, often rural young women who are sexually active but unprotected from unintended pregnancy. Second, countries that have recently graduated from USAID assistance face uncertainties in ensuring contraceptive security for different reasons, including competing demands on limited resources (even where the government had committed to procuring its own contraceptives while donors were present), turnover in trained personnel able to administer contraceptive logistics systems, and changes in priorities when new administrations come into office.

Other challenges relate to closing gaps in contraceptive access for the poor, rural, or ethnic minorities; ensuring continued commitment and capacity for family planning within highly decentralized health systems; continuing development of an appropriate workforce for family planning within the larger sexual and reproductive health (SRH) and maternal health context; and finding a way to continue doing regular Demographic and Health Survey (DHS)-type studies and using the results to inform decision making.

Conclusion

The history of family planning in Latin America reflects impressive achievements over the past five decades in terms of government support, changes in social norms, and adoption of contraceptive use.

Many factors contributed to the successful vision and courage among the pioneers who embraced family planning in the early years: the eventual support of governments as they realized the benefits and need for FP; high levels of sustained external funding and technical assistance by USAID – and to a lesser extent other donors – tailored to the needs of specific countries at different times in the evolution of their programs; and committed health professionals at all levels of the system in government and NGOs who approached FP more as a social cause than just a job. Other factors such as urbanization, rising levels of education, and economic prosperity also fostered changes in societal attitudes regarding family size norms. The trend towards having fewer children in hopes of giving them a better life (a quantity/quality tradeoff) is evident in the fertility decisions of women and men at all levels of society.

The current strength of FP programming throughout the LAC region – with government now taking the lead role in most countries – represents a major achievement in the annals of international development efforts, both in terms of health and women's rights. As countries in various stages of demographic transition, decentralization of health services, and economic development strive to meet the Millennium Development Goals, reduce maternal and child death, and achieve health equity for their citizens, lessons from the LAC region may prove useful.

I. RATIONALE FOR THIS REPORT

Fertility rates in Latin America and the Caribbean have dropped steadily over the past five decades. In the 1960s, the average woman in the LAC region had 5 to 6 children over her lifetime (Saad, 2009). Today the average is 2.2 children (Clifton & Kaneda, 2013). Brazil, Costa Rica, Chile, and nine Caribbean countries have a total fertility rate of less than 2.0 children.

Many factors have contributed to this dramatic decline in fertility, including urbanization and improved quality of life. Reduced infant mortality and other factors have affected the desire for large families. Latin Americans across the socioeconomic spectrum have embraced the idea of having fewer children in hopes of giving them a better life (the "quantity-quality" trade-off). The development and implementation of family planning programming, promoted by visionary leaders and continuously adapted to the local context by dedicated professionals over a 50-year period, has also contributed to this dramatic fertility decline.

The broad societal acceptance of family planning in selected countries worldwide in recent decades has been labeled the "contraceptive revolution," and the LAC region has been at the forefront of this movement (Clifton & Kaneda, 2013). In the 1960s, approximately one in ten women in the LAC region used some form of contraception to avoid unintended pregnancy. Today, 74 percent of married women of reproductive age (MWRA) use contraception, and 67 percent use modern methods to avoid unintended pregnancy. (By way of comparison, the rates for LAC are now approaching those in the United States, which has a contraceptive prevalence rate of 79 percent and a modern contraceptive prevalence rate of 73 percent.) (Population Reference Bureau, 2013).

Overall unmet need in LAC is among the lowest of any region in the world, although important differences exist among and within countries in the region in terms of fertility, contraceptive use, and unmet need. Despite such differences, the whole region benefited from the international family planning movement in ways that were specific to local political and social realities. The evolution of family planning in this region provides a powerful example of how social and political modernization, combined with key technical inputs in family planning programming, can yield dramatic results.

Family planning is a lifesaving intervention that benefits individual women, families, communities and nations. By allowing women to delay childbearing, space births, and avoid unintended pregnancies, family planning can prevent as many as one in three maternal deaths (Smith, Ashford, Gribble & Clifton, 2009). It provides the means for families to achieve the quantity-quality tradeoff: providing a better life for fewer children. It averts the hardship of continued childbearing among older, high-parity women. It allows women the opportunity to participate in the labor force. In addition to the benefits for women and their families, family planning has a positive influence on the ability of nations to educate their populations and provide meaningful labor force participation. Governments and donors, such as USAID and others, have supported family planning for these multiple reasons – particularly the benefits to maternal and infant health.

Many factors have contributed to the dramatic decline in fertility in the LAC region over the past 50 years: increased educational levels, improved economic conditions, decreased infant and child mortality, rapid urbanization, political stability, and changing cultural norms, among others. While recognizing the influence of these factors on fertility, this report explicitly examines the role of family planning in accelerating fertility decline in the region. It recaps the unwavering efforts of organizations and individuals over five decades to make contraception accessible, affordable, and of high quality for millions of people throughout the LAC region.

This report describes how family planning evolved from a virtually taboo subject to a widely accepted practice throughout most of the LAC region. While family planning is still a politically sensitive topic among some groups throughout the region, it is widely accepted by the medical community and by the majority of the population in most nations. The report recounts the pioneering efforts of visionary, dedicated individuals in selected countries who broke down barriers and persisted despite sometimes facing fierce opposition. Based on the experience of more than 30 countries in Latin America and the Caribbean, we identify 10 factors that explain how family planning progressed so effectively in the region. Challenges remain; marked disparities exist among countries in the LAC region and among populations within certain countries. The experience of Latin America yields many lessons potentially applicable to other countries in the world attempting to make similar inroads with family planning.

II. METHODOLOGY

We conducted a qualitative analysis of the evolution of, and factors that influenced, family planning programs and use in the Latin American and Caribbean region, with specific attention to family planning's role in fertility decline, using two main sources of information:

- Material available through peer-reviewed journals, government reports, international agency reports, country reports, Web sites, and grey literature related to family planning in the LAC region
- Key informant interviews conducted in person or by Skype, telephone, or email with persons familiar with different aspects of family planning in the LAC region over the past 50 years, with particular focus on eight countries selected for case studies

The choice of the eight countries selected for case studies (Colombia, Dominican Republic, El Salvador, Guatemala, Haiti, Mexico, Nicaragua, and Paraguay) was determined by USAID in consultation with the authors. The countries were meant to reflect the range of situations occurring in the region: countries that successfully graduated from USAID assistance for family planning (FP), countries that recently graduated from USAID assistance, and countries still receiving USAID funding. Not included were several important countries with equally interesting FP histories, including Brazil (the largest country in the region, which stopped receiving USAID FP funding in 2000) and Chile (a pioneer in demographic and epidemiological research). Our analysis focused primarily on Spanish-speaking Latin America, with occasional references to events in the Caribbean.

We also conducted over 100 interviews (at least five per country, although some also had a regional perspective). Key informants were selected from government (USAID, ministries of health), international agencies, including the International Planned Parenthood Federation (IPPF), the United Nations Population Fund (UNFPA), NGOs, the academic sector, women's groups, indigenous groups, and others who had knowledge about different periods of the history of FP in a specific country (usually their own). Appendix 4 includes a list of key informants interviewed.

In an effort to avoid inadvertently excluding the names of key contributors to family planning in the region, we focused our analysis thematically on organizations, events, and initiatives, instead of on individuals. Similarly, we did not attempt to chronicle or single out the numerous contributions of specific cooperating agencies over multiple decades in many countries.

Text in this report that is not supported by bibliographic citations was derived from the key informant interviews or the authors' analyses.

III. DEMOGRAPHIC CHANGE IN THE CONTEXT OF STEADILY IMPROVING STANDARDS OF LIVING

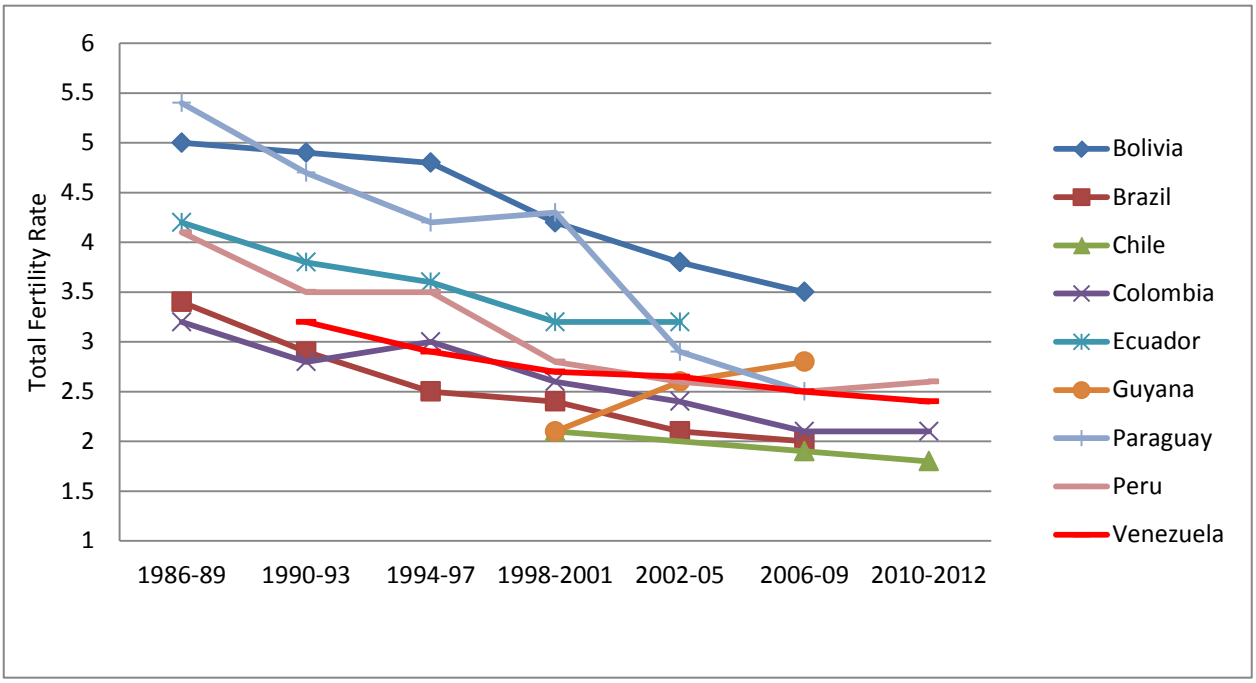
The remarkable progress achieved over the past five decades in the decline in fertility and uptake of modern contraception in Latin America and the Caribbean occurred against a backdrop of generally improving health, social, and economic conditions throughout most of the region. In recent decades, urbanization – which favors a shift toward smaller families – occurred rapidly throughout the region. An improving economic situation over time contributed to improvements in education and health, which also translated to lower fertility norms.

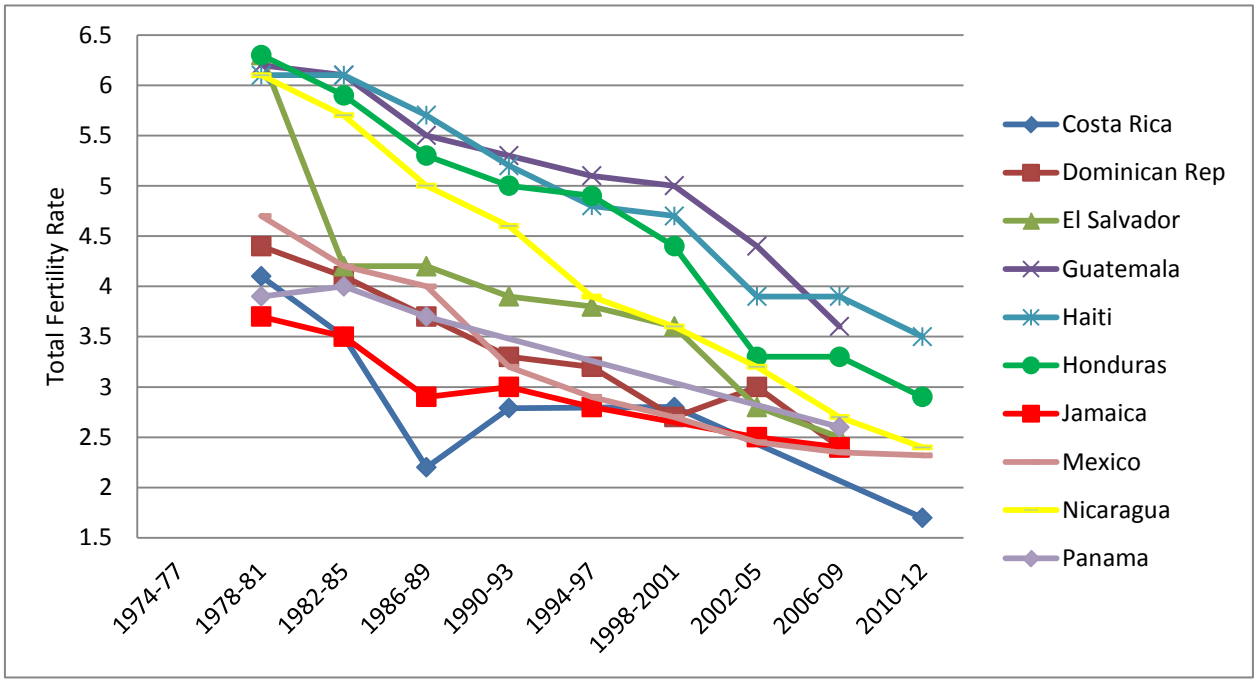
In selected countries, these positive trends have been countered by civil war, political unrest, natural disasters, or other disruptions to the routine operations of society at different points over the past five decades. Yet, as shown in figures 10, 11, and 12, the vast majority of countries in the LAC region have experienced positive gains on social, education, and economic indicators in recent decades.

It is beyond the scope of this report to analyze the *relative* contribution of improved economic, educational, and health indicators on one hand, and increased access to family planning programs on the other, as determinants of fertility decline in Latin America over the past five decades. It is also beyond the scope of this paper to gauge the broader socioeconomic benefits of widespread adoption of family planning. Nevertheless, in assessing the achievements in family planning programming over this time period, we recognize the strides made simultaneously in health, education, and economic conditions.

Demographic Change

The data in figures 1 and 2 illustrate the dramatic decrease in fertility in Latin America since 1966. Some countries began this demographic transition with lower levels of fertility than others. For example, as of the early 1960s, the total fertility rate (TFR) in Chile was at 5.6, compared to the Latin American average of 6 to 7 children per woman in most of Latin America. With a single exception (Guyana), fertility rates have dropped in every country in Latin America and the Caribbean, in most cases by at least three children per woman, over the past five decades.





Sources: DHS, RHS, and national survey reports.

Figure 1: **Total fertility rate over time in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).**

Evolution of Contraceptive Use

A key factor in this dramatic decrease in fertility has been the increased use of contraception in countries throughout the LAC region. The rate of increase in contraceptive use has varied by country, but the increases in contraceptive use have been significant in virtually every country in the region.

Trends data on contraceptive use have been tracked since 1975 through a series of national household surveys projects funded by USAID. The earliest of these was the World Fertility Survey (WFS), begun in 1972, that helped to carry out high quality, internationally comparable surveys in 42 developing countries worldwide, including 13 countries in the LAC region.[2] Next, USAID supported two projects to undertake contraceptive prevalence surveys. One project was implemented through the U.S. Centers for Disease Control (1975-2009); and the other was the Contraceptive Prevalence Surveys (CPS) project, implemented through Westinghouse Health Systems (1977-1985). By 1981, these projects had 22 surveys completed or underway in 11 countries in LAC[3], including separate surveys in 8 Brazilian states. The clustering of surveys in the mid-1980s reflects the start of the USAID-funded Demographic and Health Surveys (DHS) in the region. Begun in 1984 and still ongoing, DHS is the largest of the USAID-supported survey assistance projects, and has 44 surveys completed or underway in 15 countries in the LAC region.[4]

Contraceptive prevalence rate (CPR) is generally reported for women of reproductive age who are married or in union. Reproductive age is defined, depending on the country, as 15 to 44 or 15 to 49 years of age. Contraceptive use is alternatively reported as CPR for all methods (figure 2) or MCPR for modern methods only (figure 3). "All methods" refers to modern and traditional methods (the latter including periodic abstinence, withdrawal, sympto-thermal [Billings] and folkloric/herbs). Modern methods include female and male sterilization (also known as voluntary surgical contraception or VSC), intrauterine devices (IUDs), implants, injectables, oral pills, emergency contraception (EC), male and female condoms, Standard Days Method (SDM)/cyclebeads, lactational amenorrhea method (LAM), vaginal rings, and spermicides (tablets, foam, jelly).[5] Where use of traditional or natural methods is low, the CPR and the

[2] WFS surveys were completed in Colombia (1976), Costa Rica (1976), Dominican Republic (1975 and 1980), Ecuador (1979-80), Guyana (1975), Haiti (1977), Jamaica (1975-76), Mexico (1976-77), Panama (1975-76), Paraguay (1979), Peru (1977-78), Trinidad and Tobago (1977), and Venezuela (1977).

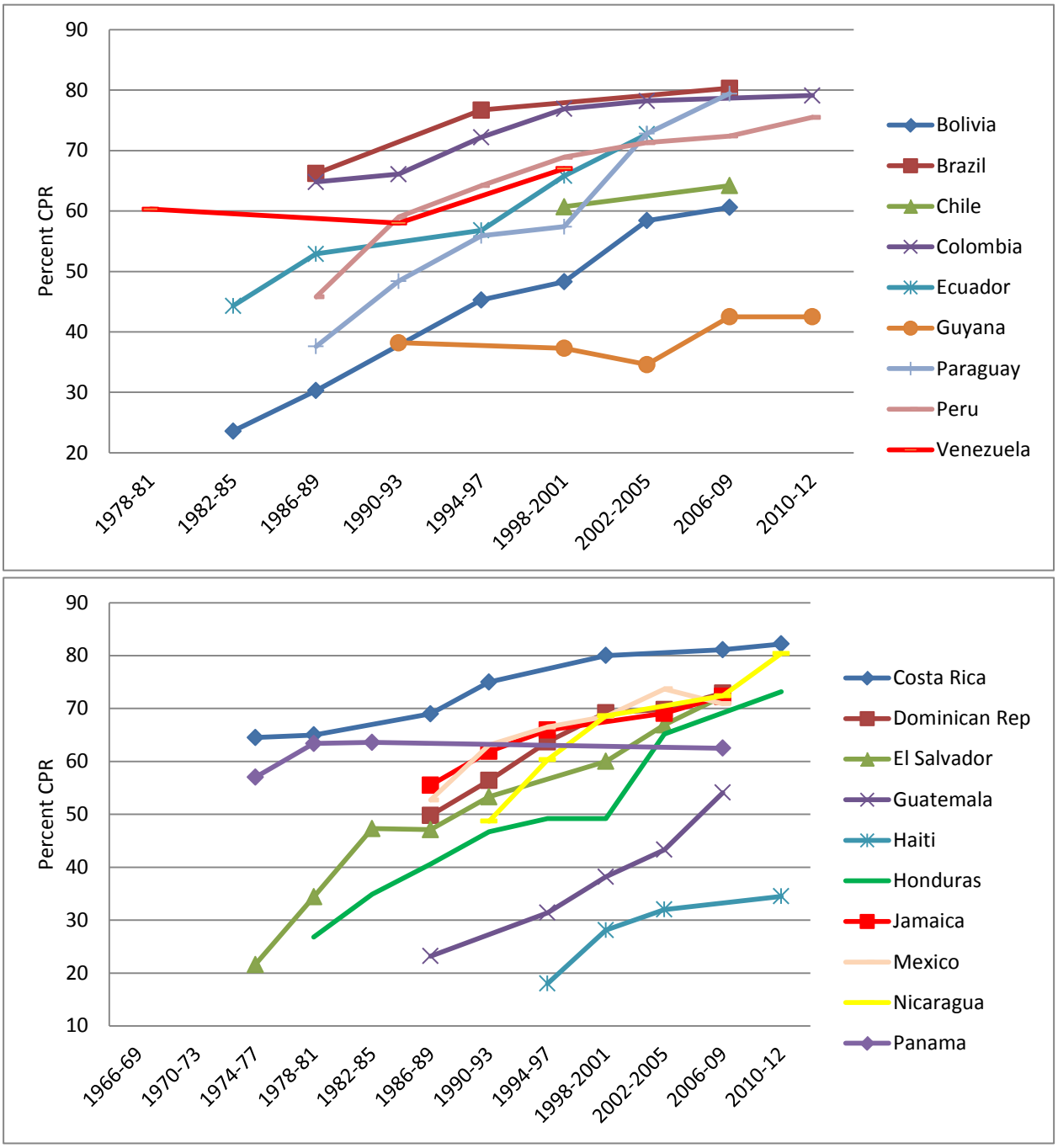
[3] CPS surveys were completed or underway as of 1981 in Barbados (1981), Brazil (1978-1981 in Amazonas, Bahia, Paraiba, Pernambuco, Piaui, Rio Grande del Norte, Sao Paulo, and Southern region), Colombia (1978 and 1980), Costa Rica (1978 and 1980); El Salvador (1975 and 1978), Guatemala (1978), Honduras ((1981), Jamaica (1979), Mexico (1978 and 1979), Panama (1979-80), and Paraguay (1977).

[4] DHS surveys were completed or are underway in Bolivia (1989, 1994, 1998, 2003 and 2008), Brazil (1986, 1991, and 1996), Colombia (1986, 1990, 1995, 2000, 2005, 2010, and 2014-15), Dominican Republic (1986, 1991, 1996, 1999, 2002, 2007, 2013), Ecuador (1987), El Salvador (1985), Guatemala (1987, 1995, 1997, 1998-99, 2015), Guyana (2004, 2005, 2009), Haiti (1994-95, 2000, 2005-06, 2012, 2013), Honduras (2005-06, 2011-12), Mexico (1987), Nicaragua (1998, 2001), Paraguay (1990), Peru (1986, 1991-92, 1996, 2000, 2004-06, 2007-08, 2009, 2010, 2011, 2012, 2013), and Trinidad and Tobago (1987).

[5] The World Health Organization and USAID classify SDM/cyclebeads and LAM as modern methods. However, RHS and DHS surveys have tended to classify them as traditional methods until recently.

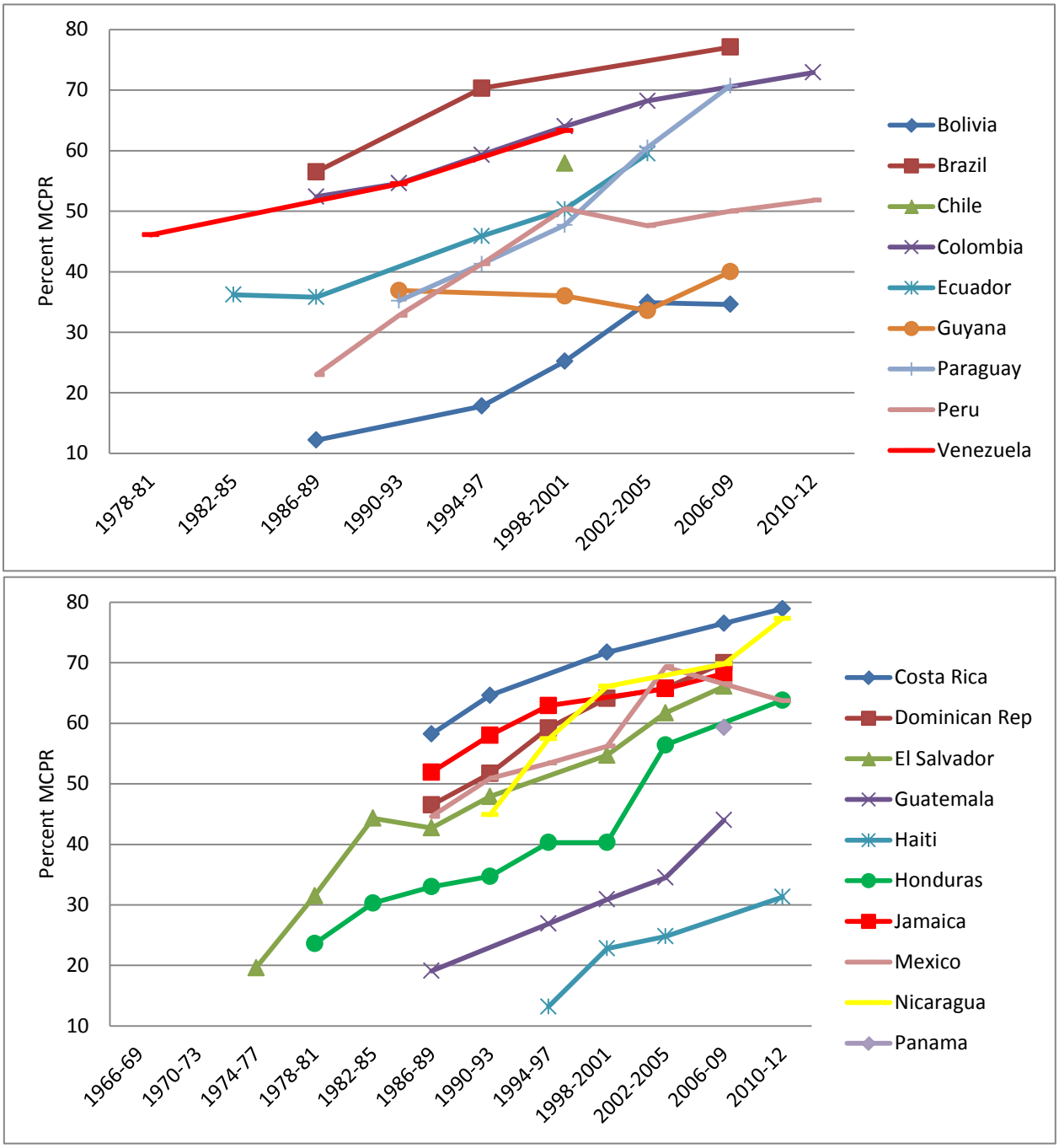
modern contraceptive prevalence rate (MCPR) are similar (e.g., in Nicaragua, 80.4 percent and 77.3 percent, respectively). By contrast, where use of natural methods is relatively high (e.g., Bolivia), the spread between CPR and MCPR is substantial (60.6 percent vs. 34.6 percent).

Figure 2 (CPR) and figure 3 (MCPR) both show a steady increase in contraceptive use in almost every South American and Central American or Caribbean country for the available data points over the past 30-plus years. By the mid-1980s, when national surveys of contraceptive prevalence were available for most countries in the region, there were already marked differences by country in contraceptive prevalence, from a low of 19.1 percent MCPR in Guatemala to a high of 56.5 percent MCPR in Brazil. Yet whatever the starting point, all countries showed increased MCPR, some by as many as 25 percentage points over a period of less than three decades.



Sources: DHS, RHS, and national survey reports, and UN Contraceptive Data Sheet.

Figure 2: **Contraceptive prevalence rates (modern and traditional) for married women of reproductive age in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).**



Sources: DHS, RHS, national survey reports, and UN Contraceptive Data Sheet.

Figure 3: **Modern contraceptive prevalence rate over time in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).**

Currently the countries with the highest MCPR include Costa Rica (78.9 percent in 2010), Nicaragua (77.3 percent as of 2012), Brazil (77.1 percent in 2006), and Colombia (72.9 percent in 2010). By contrast, those with the lowest MCPR are Guatemala (44.0 percent in 2008-09) and Haiti (31.3 percent in 2012).

Method mix (the percent distribution of contraceptive methods among married current users) differs somewhat by country. Of 20 countries in Latin America and the Caribbean included in a recent analysis of contraceptive method mix worldwide, female sterilization was the leading method in 11 countries. In two countries – Dominican Republic and Mexico – more than half of all users rely on female sterilization. However, this same analysis found that LAC had the lowest proportion of countries of any region in the world with a skewed contraceptive method mix (defined as having over 50 percent relying on a single method) (Bertrand, Sullivan, Knowles, Zeeshan & Shelton, in press).

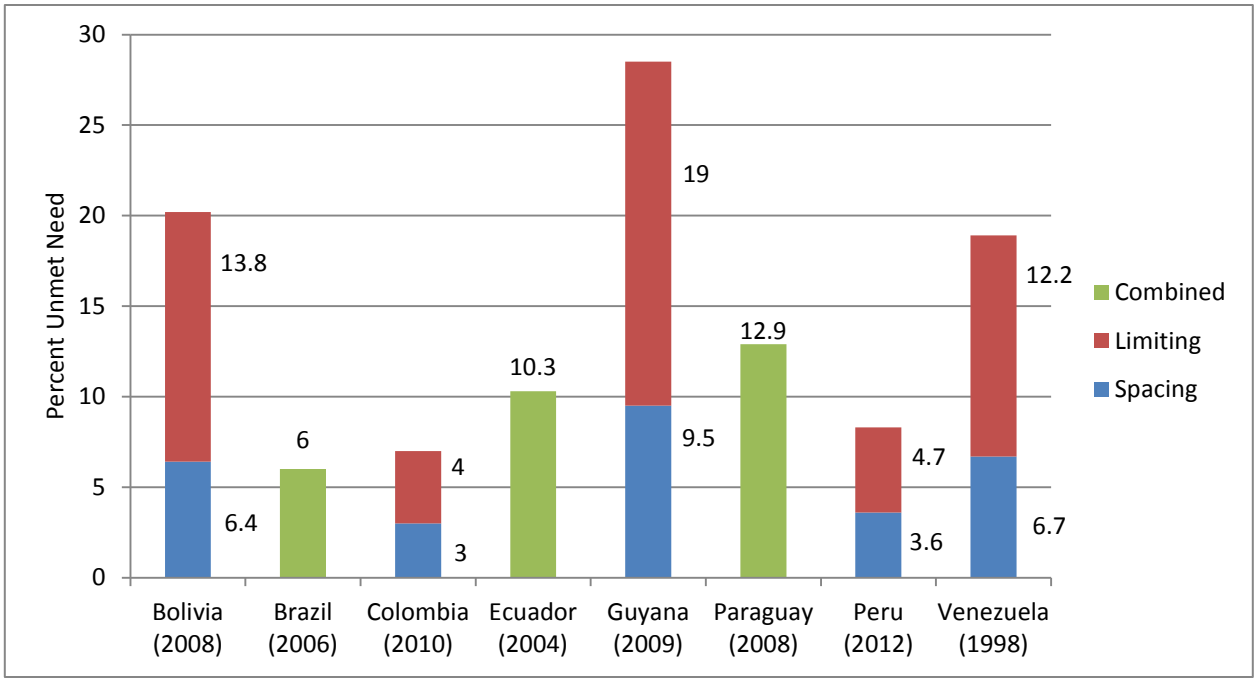
Unmet Need for Contraception and Continuing Disparities

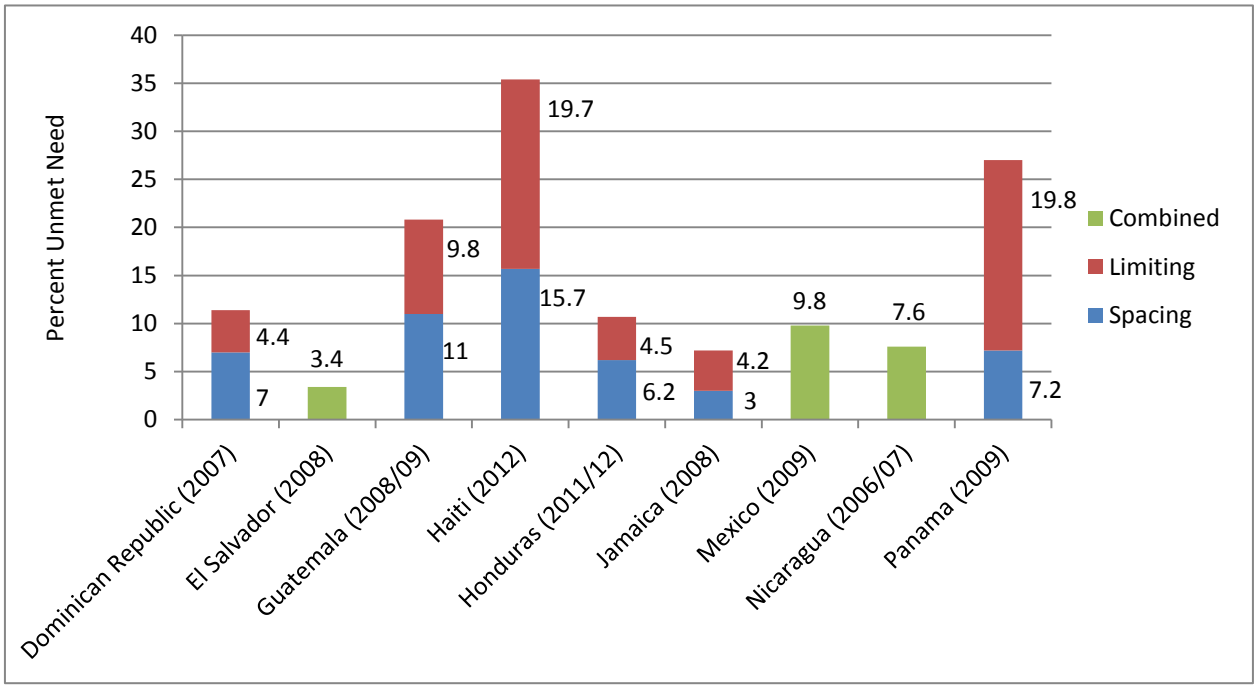
Unmet need refers to the percentage of women – often reported among MWRA – not using contraception who either want to cease further childbearing (unmet need for limiting) or who want to postpone the next birth at least two more years (unmet need for spacing) (Westoff, 2006). In general, as contraceptive prevalence increases, the percent of women with unmet need decreases. However, the relationship is not linear, since women with little knowledge of and access to contraception may accept continued childbearing; thus they do not express a wish to avoid pregnancy and are not counted as having unmet need. Unmet need is a politically useful indicator, because it carries no judgment of what CPR should be in a given country but rather reflects the voice of the women of that country in terms of their stated fertility desires.

Unmet need differs by county in the LAC region, ranging from 35.4 percent in Haiti to 3.4 percent in El Salvador (figure 4). Data differentiating unmet need by limiting and spacing were available for 11 of the 17 countries. Within that group, eight of the 11 have a higher unmet need for limiting than spacing. Where differentiated data are not available, they are presented for unmet need for both.

Despite the high levels of contraceptive use throughout the region and relatively low levels of unmet need (by global standards), there are still notable disparities in terms of urban/rural residency, wealth quintile, and ethnic group. Ideally, a country wants to reach high MCPR and low unmet need among all segments of the population, regardless of urban/rural residence, income level, or ethnicity.

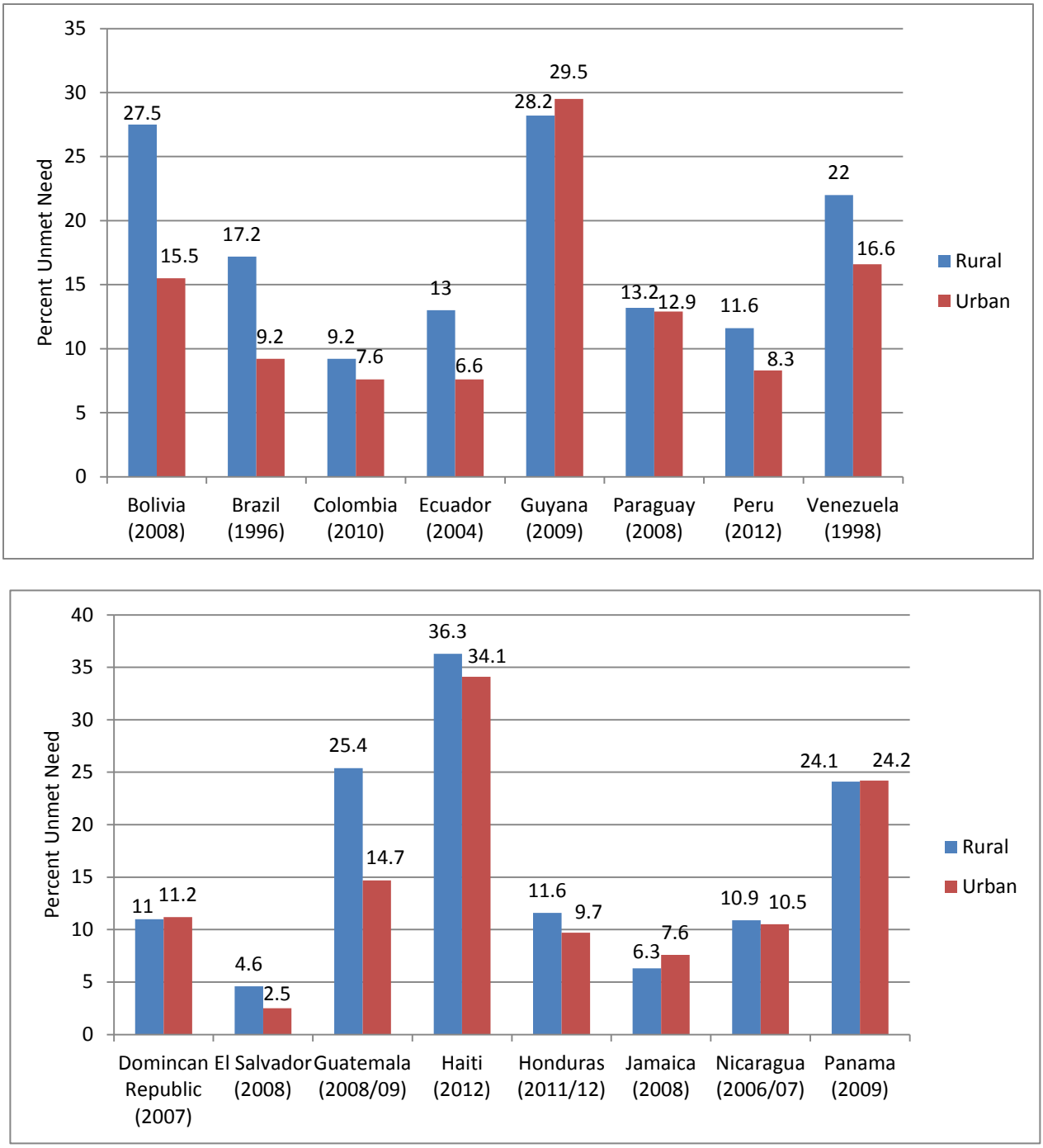
Almost half of the countries in the region with available data have similar levels of unmet need in urban and rural areas (figure 5). For example, unmet need differs by less than 2 percentage points between urban and rural areas in Colombia, the Dominican Republic, Honduras, Guyana, Jamaica, Nicaragua, Panama, and Paraguay. By contrast, in two countries – Bolivia and Guatemala – there is greater disparity with unmet need at least 10 percentage points higher in rural than urban areas.





Sources: DHS, RHS, and national survey reports.
Notes: Unmet need in Brazil, Ecuador, and Paraguay (top) and in El Salvador, Mexico, Nicaragua (bottom) is only available as a combined total.
Data on unmet need are not available for Chile.

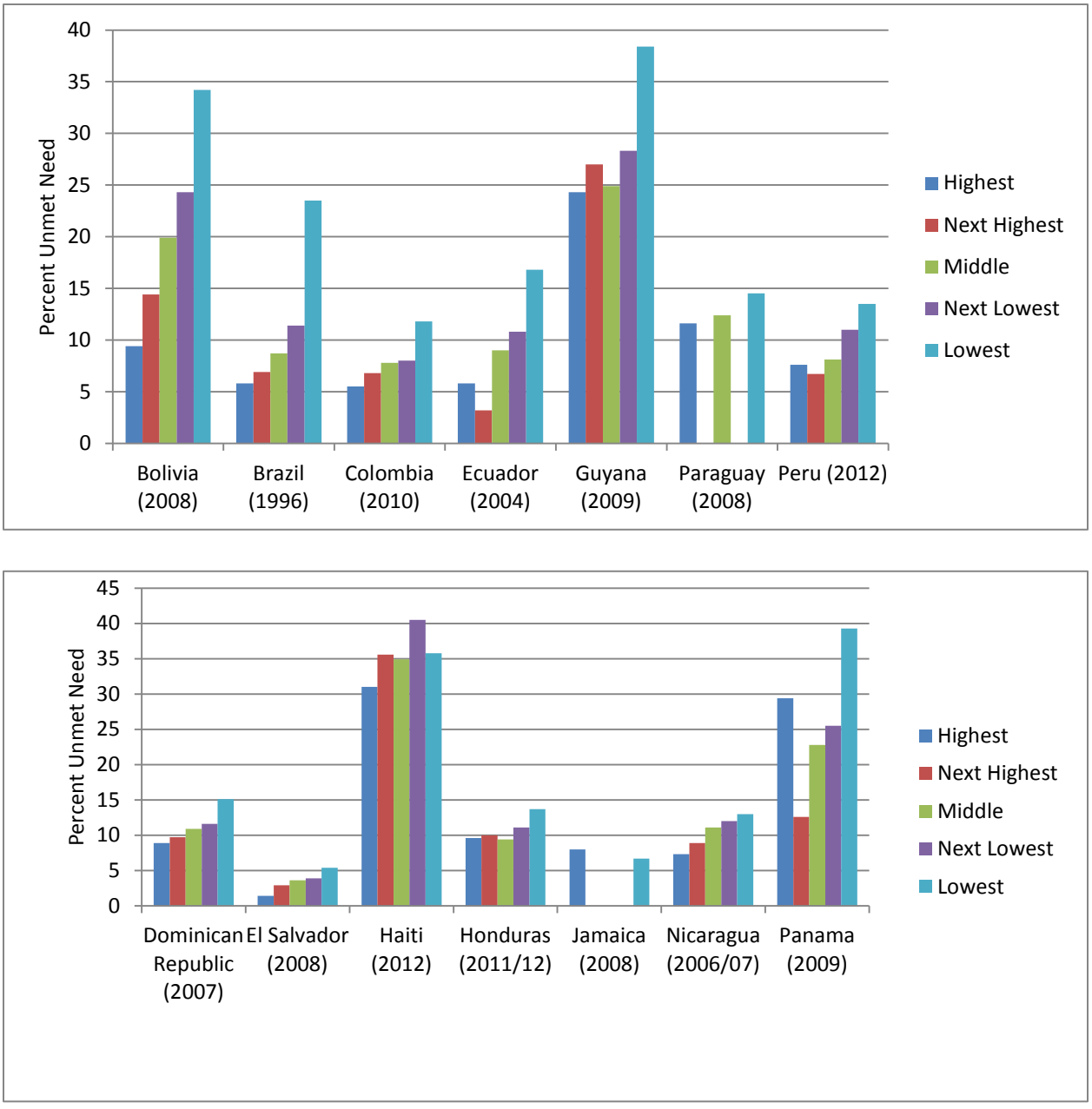
Figure 4: Unmet need for family planning (including for limiting vs. spacing) in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).



Sources: DHS, RHS, and national survey reports
Note: Data for unmet need in Chile and Mexico were unavailable.

Figure 5: Urban/rural disparities in unmet need for married women of reproductive age (MWRA) in selected South American countries (top) and in selected Central American and Caribbean countries in selected Central American and Caribbean countries (bottom).

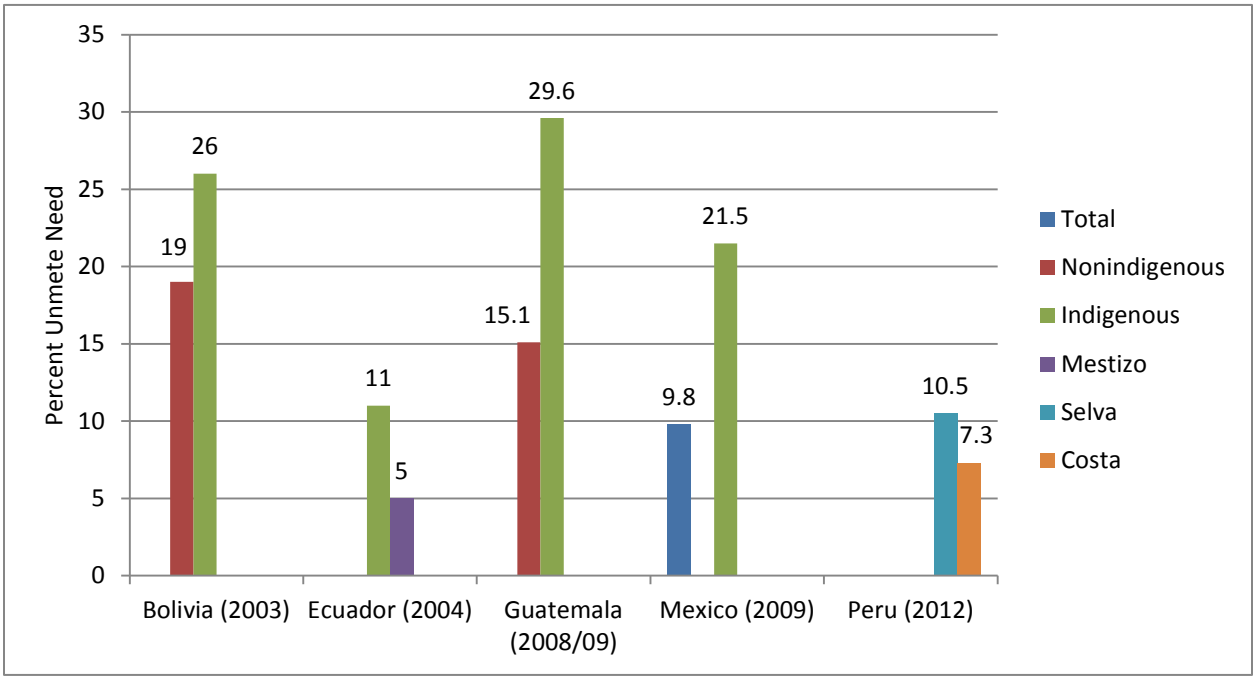
Unmet need is strongly related to wealth quintiles, even in countries with no urban/rural disparity. As shown in figure 6, unmet need increases as wealth quintile decreases, leaving the poorest with the greatest unmet need. (The data for Panama deviate from this pattern, for reasons that remain unclear.)



Sources: DHS, RHS, and national survey reports.
Notes: Data for unmet need by wealth quintile in Chile and Venezuela are unavailable.
Data for Jamaica in 2008 are broken down as employed vs. unemployed.

Figure 6: Disparities in unmet need for married women of reproductive age by wealth quintiles, in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).

Ethnicity is another factor underlying health disparities in the five Latin America countries with substantial indigenous populations: Bolivia, Ecuador, Guatemala, Mexico, and Peru. In contrast to urban/rural residency or wealth quintile, the categories of ethnicity differ by country. The data in figure 7 reflect the categories available on each country's survey; this variable was not available in the latest survey from Peru. In the four countries where "indigenous" is a category, unmet need is far higher among the indigenous population than the non-indigenous population. The greatest gap is in Guatemala, with almost a 15 percentage point difference in unmet need between the indigenous (29.6 percent) and their Ladino counterparts (15.1 percent).



Sources: DHS; RHS; national survey reports; and UNFPA, 2013.

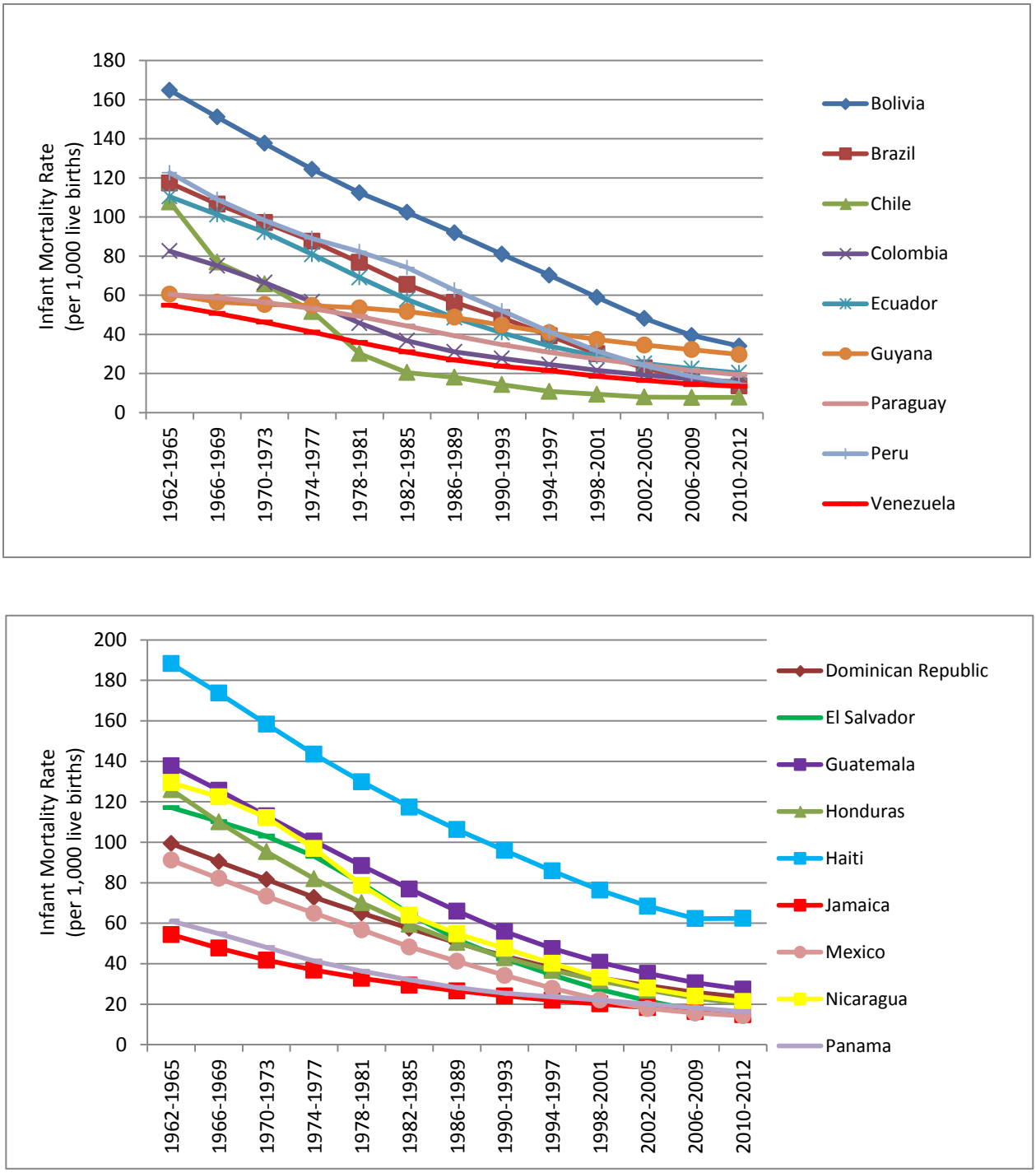
Figure 7: Disparities in unmet need for married women of reproductive age by indigenous and nonindigenous populations in five LAC countries.

Infant Mortality and Maternal Mortality Trends

Infant mortality rate (IMR) – the number of deaths of children less than one year of age per 1,000 live births – measures premature mortality and is a powerful determinant of life expectancy in population groups in addition to serving as a proxy for the overall health status within the groups (Mcguire, 2001). In the LAC region, there has been a constant decline in the IMR since the 1950s. From the early 1950s (1950-1954) to early 2000s (2000-2004), Latin America recorded an 80 percent drop in its IMR, from 128 deaths per 1,000 live births to 26 per 1,000 live births (Guzmán, Rodriguez, Martínez, Contreras & González, 2006). Reduction in IMR was recorded for all countries, and it has been linked to economic growth, the development of primary health care (e.g., vaccination and the use of oral rehydration therapy to avoid death caused by infectious and parasitic diseases), and the presence of lower fertility rates (e.g., decrease in short birth intervals, reduction of the percentage of young mothers) (Palloni, 1989).

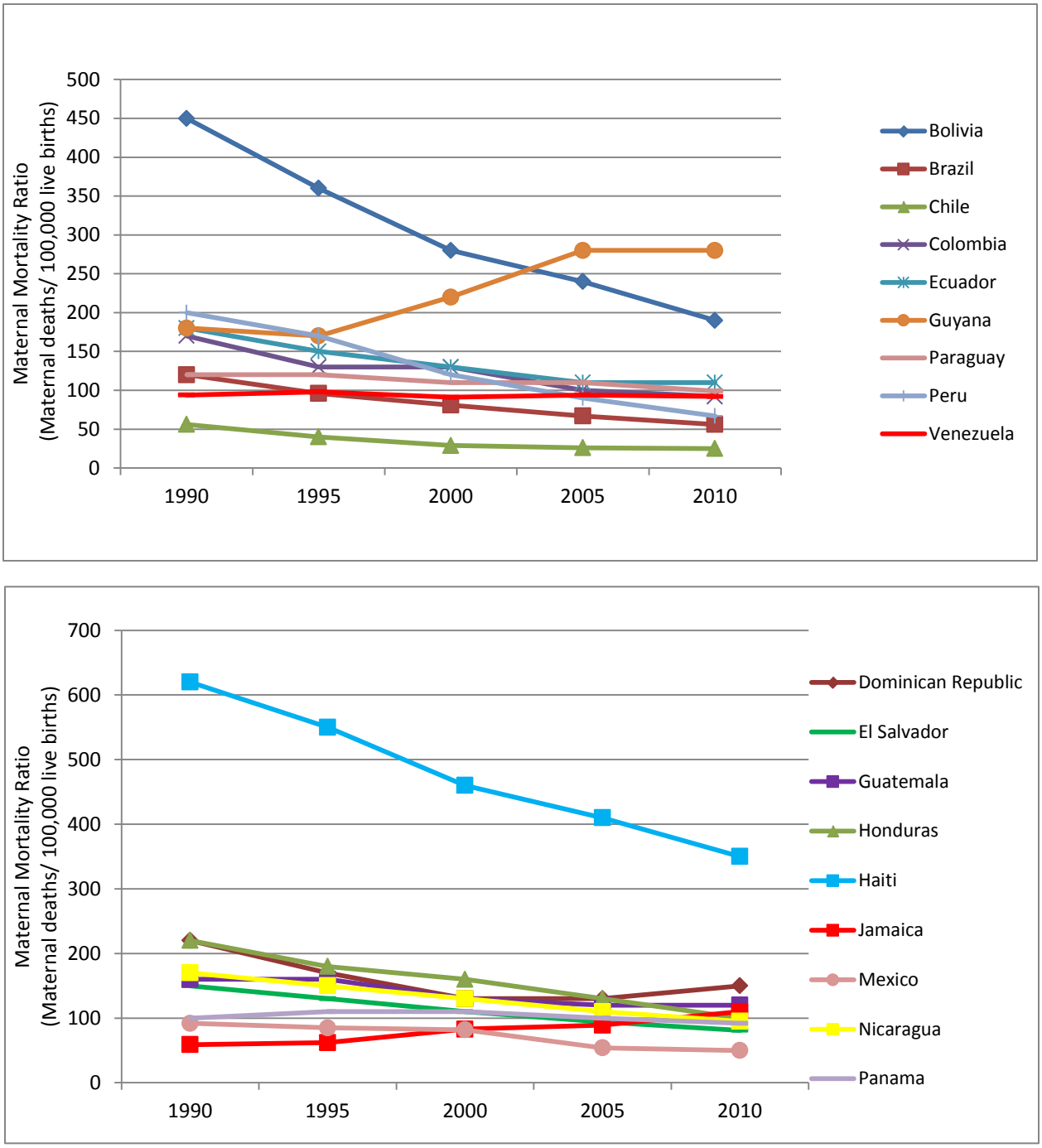
The maternal mortality ratio (MMR) measures the number of maternal deaths (excluding accidental or incidental causes) per 100,000 live births during the same time period. In Latin America, the risk of a woman dying from pregnancy or complications of childbirth decreased by 54 percent between 1970 and 1989 (Brea, 2003). Tracking trends in maternal mortality has been a challenging task because of the relatively scarce number of cases, the presence of hidden cases, inadequate vital registration systems, and the difficulty identifying the precise cause of death. Therefore, estimates for most countries have only been available since 1990. Figures 8 and 9 demonstrate the improvements achieved by LAC countries over the last 20 years in both infant and maternal mortality.

Estimated abortion rates in LAC have also declined: from 37 per 1,000 women ages 15-49 in 1995 to 31 per 1,000 in 2003, a period which saw rapid increases in contraceptive use (Marston & Cleland, 2003; Sedgh et al., 2012).



Source: World Bank, 2013a.

Figure 8: Trends in infant mortality rates 1962-2012 in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).



Source: World Bank, 2013a.

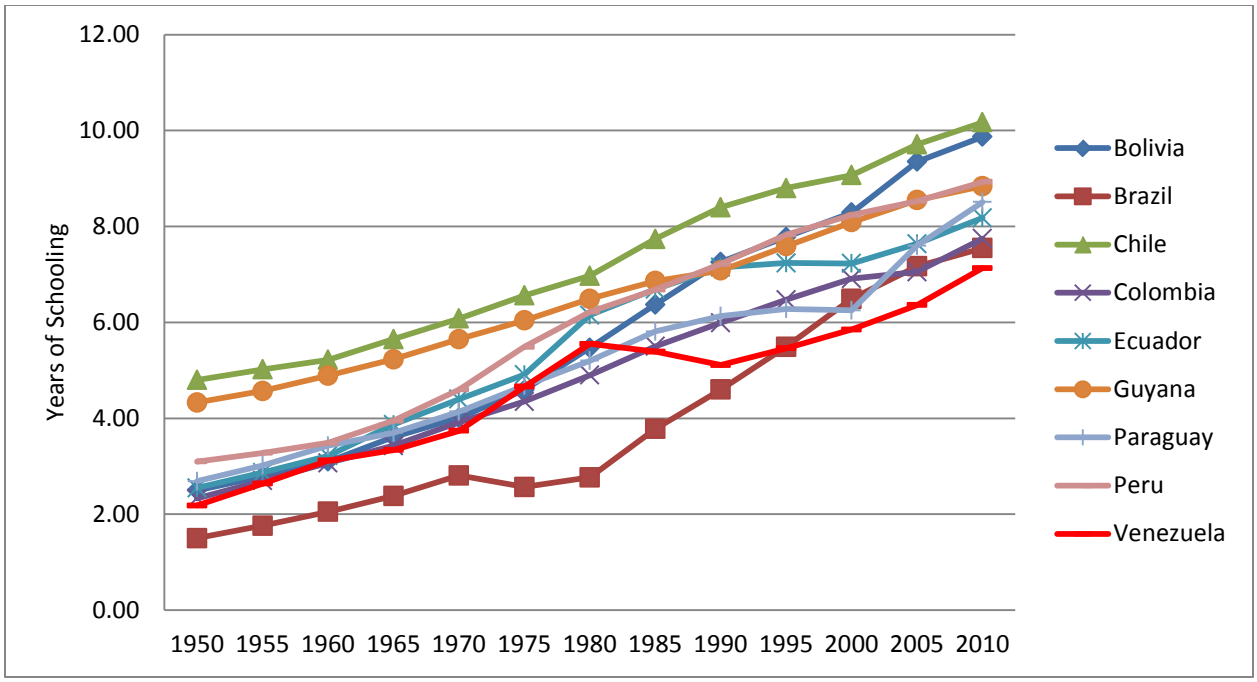
Figure 9: **Trends in maternal mortality ratios 1990-2010 in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).**

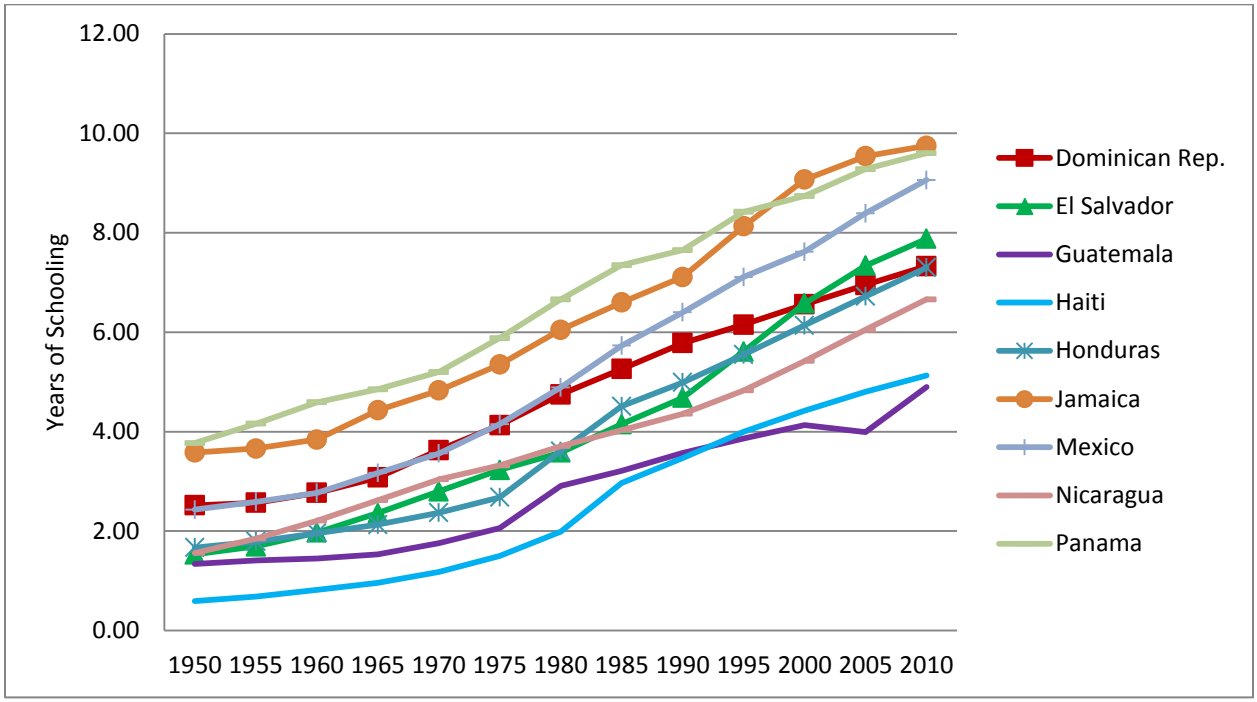
Educational Achievement

Education is one of the strongest determinants of contraceptive use worldwide: not only does it provide women with exposure to new ideas and better mastery of concepts, but more importantly, it gives them aspirations for a better life.

National governments in the LAC region have made access to education a priority across the socioeconomic spectrum for men and women. At the start of the 20th century, levels of literacy remained low in most LAC countries. However, by the middle of the century, national governments committed funding for the establishment of public schools, with additional support from external donors. Starting in the 1950s, years of schooling began to rise steadily in all countries in the region (as shown in figure 10), including for women and the poor (Reimers, 2003; UNESCO, 1997; Schiefelbein, 2007). Over a 50-year period, almost all countries increased the mean years of schooling by five to six grades. Similarly, female literacy rates for the LAC region increased from 74 percent in 1970 to the current level of 98 percent (World Bank, 2013a).

While access to the primary level is now close to universal, repetition and dropout rates for primary and secondary education continue to pose challenges, and the actual quality of education for many children in LAC remains poor (UNESCO, 2012; Schiefelbein, 2007). Importantly, expansion of the educational system in most settings occurred in the context of fiscal austerity, so while access to education expanded, quality diminished.



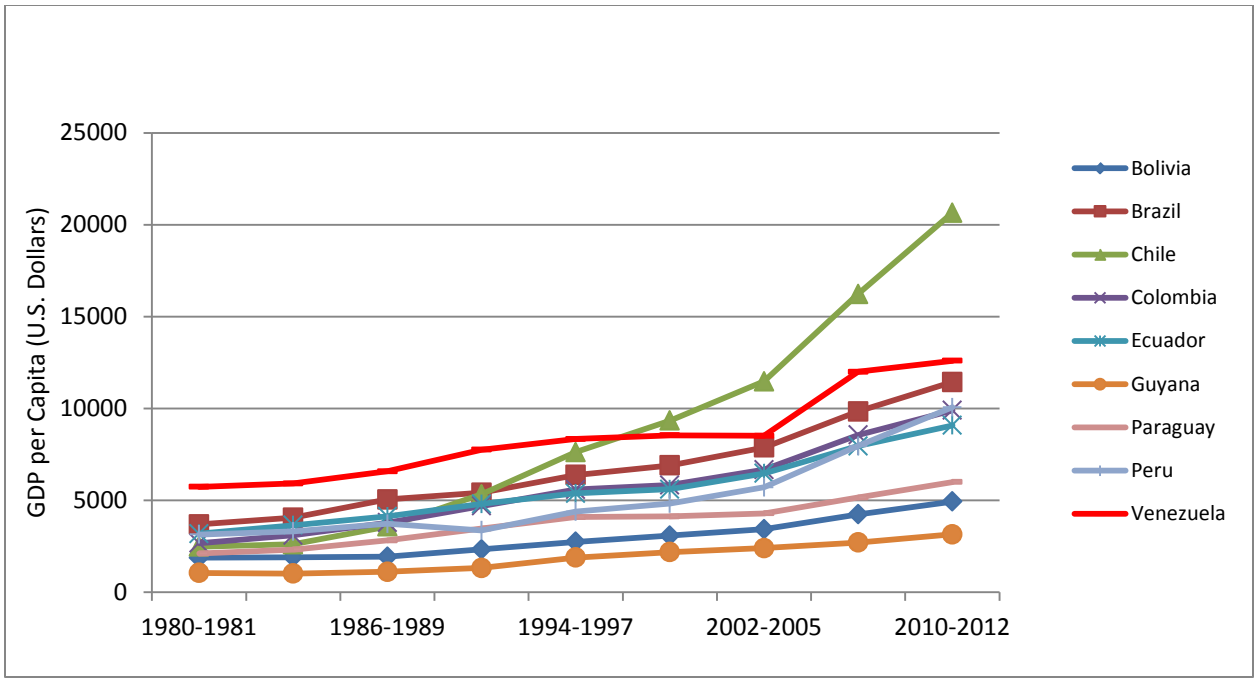


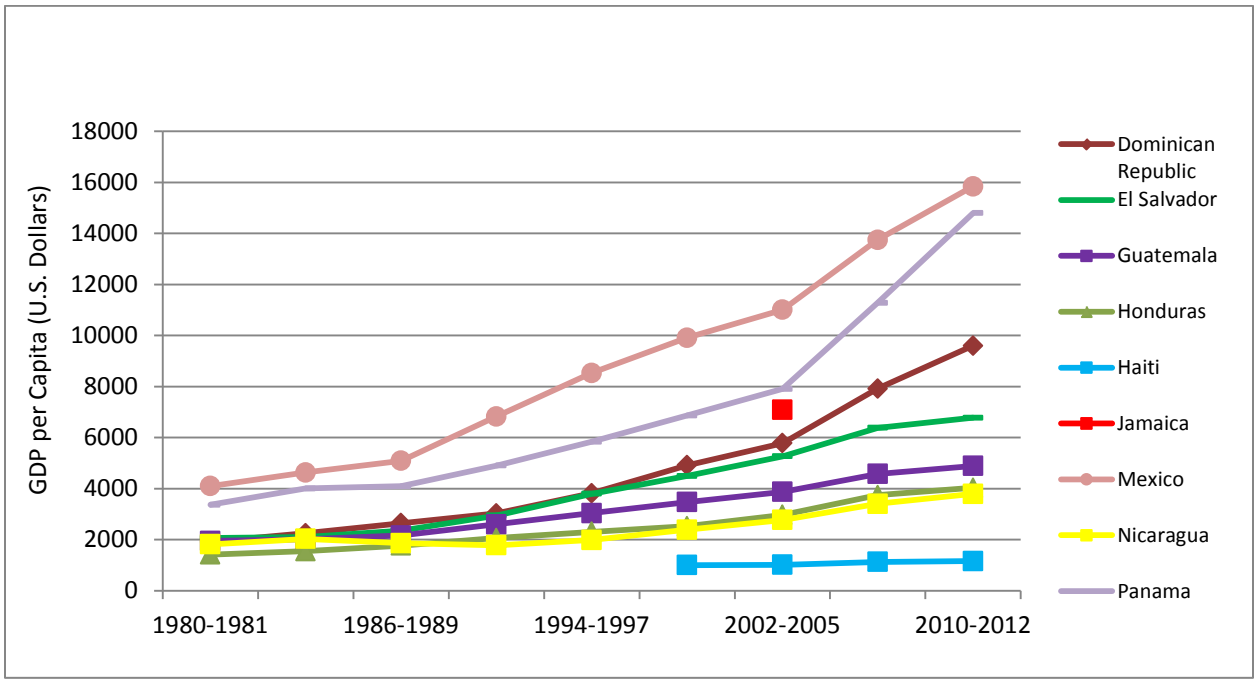
Source: Barro & Lee, 2013.

Figure 10: Trends in average years of total schooling (years) 1950-2010 in selected South American countries (top) and in selected Central American and Caribbean countries (bottom).

Economic Trends and Income Disparity

In recent decades, most of the countries of Latin America and the Caribbean have experienced strong economic growth after overcoming previous economic shocks and crises. The region temporarily managed the global shocks of the 1970s with abundant and inexpensive external borrowing. In the early 1980s, the region experienced a debt crisis which caused a period of slow, unstable growth and macroeconomic instability known as "the lost decade" for the region (Gasparini & Lustig, 2011). A new cycle of external borrowing began in the early to mid-1990s, with the adoption of market-oriented policies (e.g., reduction of fiscal deficits, implementation of tax reforms, decreases in import tariffs, privatization of state owned companies). From 2003 to 2007, Latin America experienced a period of resurgence marked with strong growth and low inflation (see figure 11). Prudent macroeconomic policies and important structural reforms have been the cornerstone of improved performance. Additionally, abundant, inexpensive financing and large persistent increases in the prices of the region's commodity exports have been important factors in these economic trends. While the impact of the 2008 global financial crisis was less severe in Latin America than on other continents, negative effects were still observed, including a decline in the volume of international trade and a sharp deterioration in the terms of trade for commodities (Porzecanski, 2009; Canuto & Giugale, 2010; Ocampo, 2009).





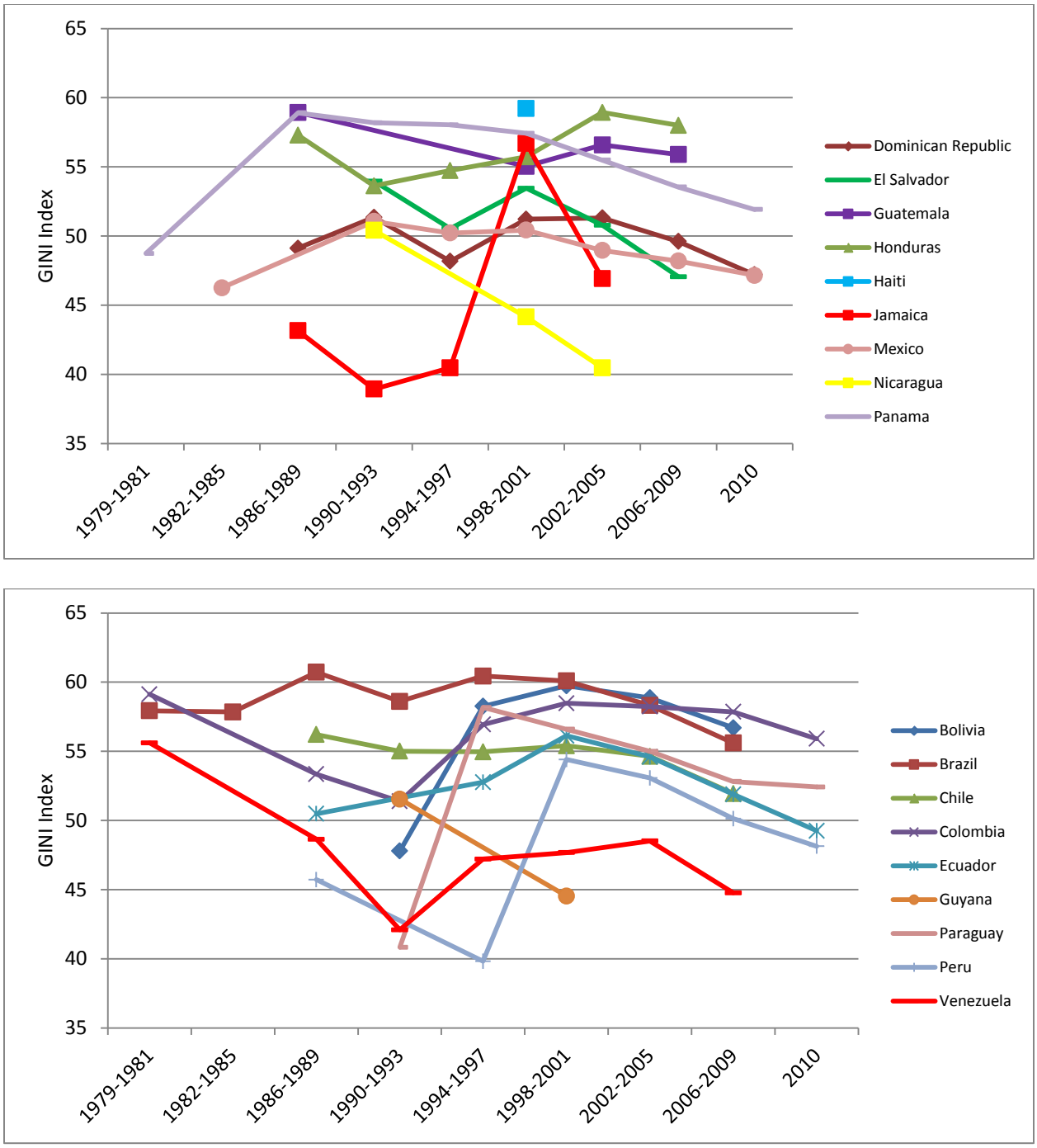
Source: World Bank, 2013a.

Figure 11: Trends in gross domestic product per capita 1980-2012 in selected South American countries (top), and in selected Central American and Caribbean countries (bottom).

Despite impressive attainments in the standard of living, economic and social inequalities persist in the LAC region. According to the World Bank, in the 1970s, the LAC region had the greatest disparity between rich and poor anywhere in the developing world; the income share of the bottom 20 percent in Latin America equaled 2.9 percent of total income, compared to 40.1 percent among the richest 10 percent (de Ferranti, Perry, Ferreira, et al, 2003). The macroeconomic crisis of the 1980s further aggravated inequality, since the poor were less able to protect themselves from high, runaway inflation. Moreover, the fiscal adjustment reforms of the 1990s frequently hurt the poor and the middle-income population disproportionately.

These disparities in the distribution of income (as measured by the Gini index) finally began to decline in the 2000s.[6] Two phenomena account for this improvement: a fall in the earnings gap between skilled and low-skilled workers, caused by expansion of coverage in basic education, and an increase in government transfers targeted to the poor (López-Calva & Lustig, 2010). These trends are captured by the Gini index shown in figure 12.

[6] Gini index is a measure of statistical dispersion intended to represent the income distribution of a nation's residents. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality.



Source: World Bank, 2013a.

Figure 12: Trends in Gini index 1979-2010 in selected South American countries (top), and selected Central American and Caribbean Countries (bottom).

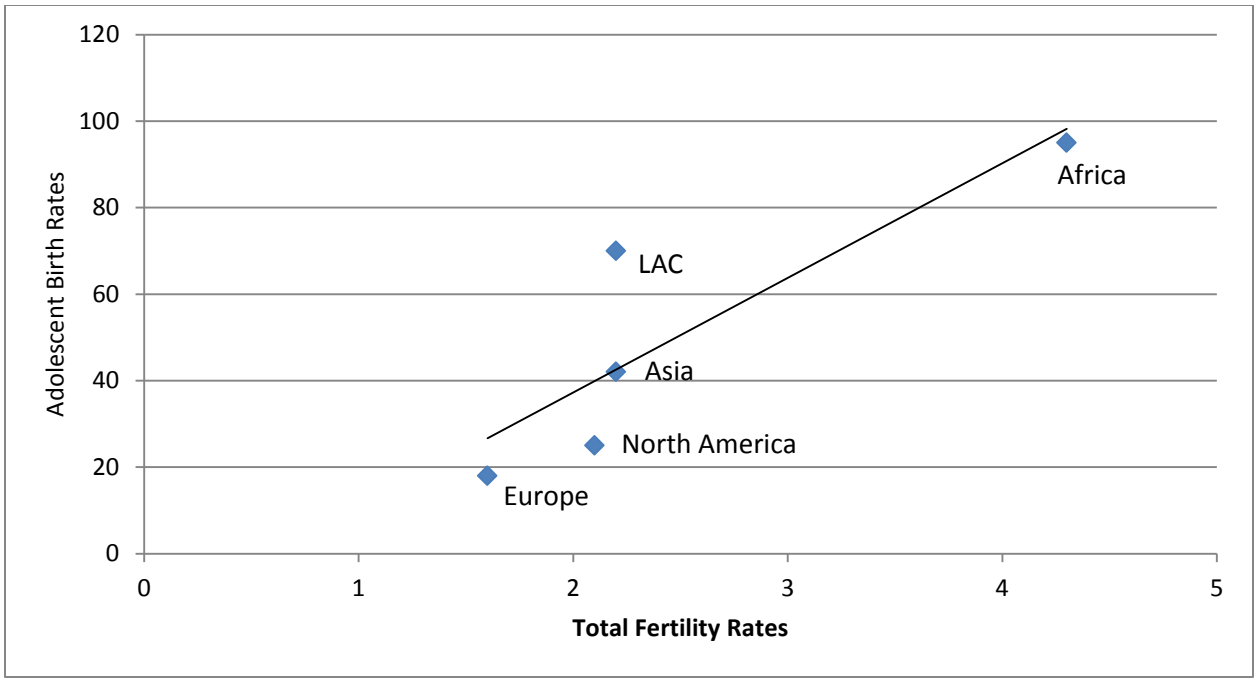
IV. ADOLESCENT FERTILITY, CONTRACEPTIVE USE, AND UNMET NEED

The population of the LAC region is young: nearly one in four is considered to be an adolescent, by the World Health Organization's definition (10-19 years old) (UNFPA, 2013). In this report, however, the term "adolescents" refers to those aged 15 to 19, since the data sources used (DHS and Reproductive Health Survey [RHS]) do not include respondents younger than 15 years of age. Adolescent fertility and contraceptive use in the LAC region present several paradoxical situations:

- In contrast to the sharp decline in TFR over the past four decades, census data reported by UNDP show that in the LAC region, the adolescent birth rate (ABR) remains high at 79 births per 1000 women aged 15-19; it is higher than any other region of the world, except sub-Saharan Africa, and is projected to exceed Africa if current trends hold (Rodriguez, 2011).[7]
- The proportion of adolescents who give birth under age 18 (18 percent) is similar to the global average of 19 percent for developing countries (UNFPA, 2013).
- Although births to adolescents have declined in some LAC countries, the overall adolescent fertility rate remains high.
- Countries that have experienced the greatest decline in ABR (e.g., Honduras and Nicaragua) still have among the highest adolescent fertility in the region.
- Education levels continue to rise, yet this has not had the expected effect of curbing ABR in all countries.
- In recent decades, the gap has narrowed between rich and poor in terms of family size, yet among adolescents, there are glaring differences between the highest and lowest wealth quintiles in terms of early childbearing.
- Contraceptive use among adolescents has increased in all countries in the region in the past decade, yet the impact on adolescent fertility rates has not been as strong as expected.

It is instructive to consider adolescent fertility in the LAC region with a global perspective. Figure 13 charts the actual and expected relationship between ABR and TFR using data from five regions of the world. Given the TFR of 2.2 children per woman for the LAC region, the ABR of 79/1000 is markedly higher than would be expected. LAC is the only region that falls well above the line; Asia and Africa are very close to it; Europe and North America are below the line (implying even lower ABR relative to their TFR).

[7] The adolescent birth rate measures the annual number of births to women 15 to 19 years of age per 1,000 women in that age group. It represents the risk of childbearing among adolescent women 15 to 19 years of age. It is also referred to as the age-specific fertility rate for women aged 15-19.



Source: United Nations Department of Economic and Social Affairs, 2010, as cited in Rodriguez, 2011.

Figure 13: Total fertility rates by adolescent birth rates for global regions.

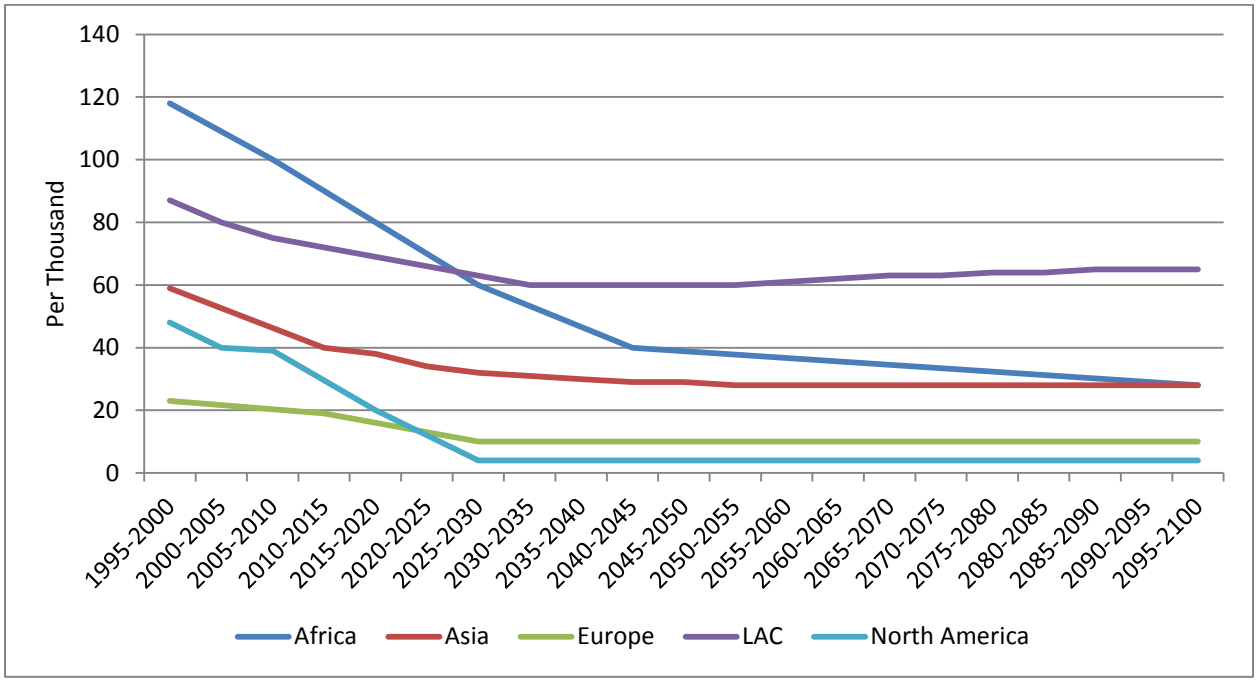
Figure 14 projects worldwide trends in ABR for the period 1995 to 2010. Currently, the LAC region is second highest in adolescent fertility, surpassed only by Africa (Rodriguez, 2011). If the adolescent fertility trends of the last 30 years were to continue, by the period 2015-2030 and for all subsequent years, Latin America would have the highest ABRs of any region in the world (Rodriguez, 2011).

We examined the trends within the LAC region in adolescent fertility and contraceptive use, as well as country-specific data (see figures 13, 14, 17, and 18, compiled with data from DHS and RHS). Valuable as these survey data are, they have several limitations: (1) These surveys did not collect data among 15 to 19-year-olds who were not married or in union, limiting what can be said about unmarried youth, and only one country (Colombia) had data from two points in time on non-married youth; (2) Surveys were conducted at different intervals and in different years depending on the country; and (3) With the discontinuation of USAID population assistance to certain countries in the past decade, surveys have been conducted less frequently in some countries and/or have not used the standard questions.

In an effort to describe change over time on key variables related to adolescent fertility, we compared data from the most recent survey (2005-2012) with data from a survey approximately 10 years previously (1994-2004) for countries where data were available. As such, they reflect changes in the decade prior to the most recent DHS/RHS for the 11 countries with surveys at both intervals. For some variables (e.g., MCPR) we also report the rate for countries where there is only one data point. In addition, for one variable (ABR), data from the United Nation's Millennium Development Goals (MDG) reporting system are used for those countries that do not have RSH/DHS data, thus increasing the number of countries analyzed to 16 for that variable.

We note that the data might not be strictly comparable given that this variable is not limited to women in union as are the RHS/DHS data.

These findings substantiate the main conclusion of this report: that adolescent fertility remains a major challenge for FP in the region, if not the top challenge.



Source: Rodriguez, 2011.

Figure 14: Projected worldwide trends of adolescent birth rates, 1995-2100.

Adolescent Birth Rates

Table 1 shows the ABR (number of births per 1000 women 15-19 years old) for 16 countries in the region that received USAID funding and have available trend data.[8] The ABR declined by at least 15 or more births per 1,000 adolescents between the two periods (1995-2004 and 2005-2012) in eight of the 16 countries with available data: Brazil, Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, Nicaragua, and Paraguay. It declined by a lesser number (8-14 births per 1,000 adolescents) in two other countries (Chile and Haiti). By contrast, the ABR showed little variation in the decade prior to the most recent survey in Bolivia, Colombia, Panama, and Peru.[9] And in Ecuador, the ABR increased by nine births per 1,000 adolescents

[8] ABR from DHS/RHS does not include only adolescents in union. ABR is the number of births to women 15-19 as reported by women 20-24 in union. Thus, even if the respondents were in union, they may not have been when they had a birth during the 15-19 year period. The denominator is not limited to adolescents in union. Since the ABR is one of the Millennium Development Goals indicators, it is available for most countries including those that do not have national survey data. Where no survey is available, the ABR is based on census or vital registration data.

[9] The time period for Peru was slightly longer: 2002-2012.

between 1994 in 2004. As of the most recent year for which data are available, the countries with the lowest ABR are Chile (54/ 1000), Mexico (70/1000) and Jamaica (72/1000). By contrast, Honduras has the highest ABR in the region: 101 per 1,000 adolescents.[10]

Table 1 also examines urban/rural differences in adolescent fertility. Without exception, all countries in the LAC region showed higher ABRs in rural areas than in urban areas. These data reflect the cultural norms and social pressures for early childbearing experienced by rural women, as well as more limited access to education, economic activity, and contraception.

Although the ABR is higher in rural than urban areas, the ABR has declined faster in rural than urban areas for nine of the 12 countries with available data (Colombia, Dominican Republic, El Salvador, Haiti, Honduras, Guatemala, Nicaragua, Paraguay, and Peru). This finding may indicate both increased program effort and changing sociocultural norms around age of first sex and/or age at first union in rural areas. In Colombia and Peru, ABRs decreased in the rural areas and increased in urban areas, which has been attributed by some to high rates of rural-urban migration with new migrants behaving in ways similar to their rural counterparts. By contrast, in Bolivia the ABR changed relatively little in the ten-year interval (decreasing by 1/1000 in the urban and increasing by 3/1000 in the rural).

Proportion of Adolescents in Union Who Are Pregnant or Have Had a Child at the Time of the Survey

The proportion of women in union 15-19 years old who are pregnant or have had a child captures the current dynamics of adolescent fertility (as compared to the retrospective ABR). For both indicators, women are asked only about live births; as such, they underestimate total pregnancies to this age group, as miscarriages, abortions, and stillbirths are omitted from the total.

Figure 15 shows changes over time by country in the proportion of young women 15-19 who were pregnant or already had one or more children. Of the 10 countries with available data on this indicator, four showed decreases. El Salvador and Jamaica showed the most dramatic decreases, with Nicaragua and the Dominican Republic experiencing decreases to a lesser degree. By contrast, Colombia, Ecuador, Honduras, and Peru remained stable. Brazil and Bolivia showed increases on this indicator.

[10] Ecuador follows closely with an ABR of 100/1000 adolescents, but the most recent survey (2004) is now dated. The data on ABR in the table are obtained from married women 20-24 years old who are asked about childbearing in the 15-19 year-old period. While respondents are married at the time of the survey, it is not known whether they were married of in union in the 15-19 year-old period.

Table 1: Adolescent (15-19) Birth Rates and Percentage Differences over Time in Latin America and the Caribbean

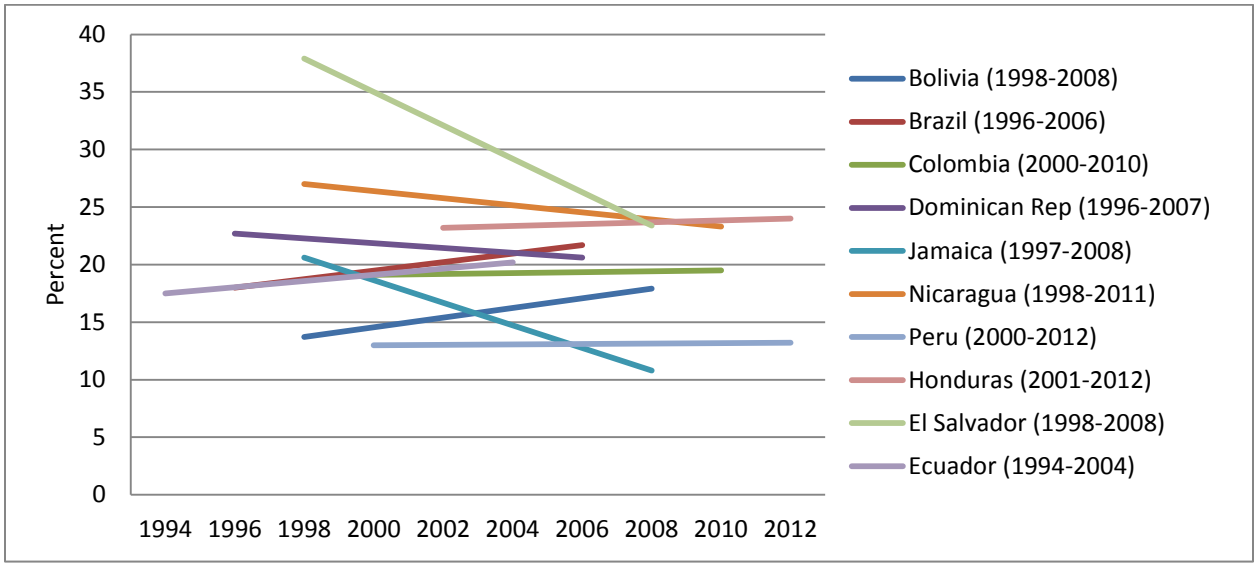
Country *(Years)*	1995-2004			2005-2012			Difference		
	Total Births /1000	Urban	Rural	Total Births /1000	Urban	Rural	Total	Urban	Rural
Bolivia *(1998 and 2008)*	84	68	135	88	67	132	+3	-1	+3
Brazil* *(1996 and 2006)*	86	78	112	78.4	-	-	-8		
Chile* *(1998-2008)*	65.6	-	-	54.0	-	-	-11.6		
Colombia *(2000 and 2010)*	85	71	134	84	73	122	-1	+2	-12
Dominican Republic *(1996-2007)*	112	87	160	92	83	117	-20	-4	-43
Ecuador *(1994-2004)*	91	76	112	100	87	119	+9	+11	+7
El Salvador *(1998-2008)*	116	87	150	89	73	108	-27	-14	-42
Guatemala *(1998/9 and 2008/9)*	117	86	139	98	78	114	-19	-8	-25
Haiti *(2000 and 2012)*	80	61	100	66	49	78	-14	-12	-22
Honduras *(2001 and 2011/12)*	137	114	162	101	81	123	-36	-33	-39
Jamaica† *(1997 and 2008)*	112	82/114	133	72	51/83	174	-40	-31	+41
Mexico* *(1998 and 2009)*	84.7	-	-	70.4*	63.9	82.5	-14.3		
Nicaragua *(1998 and 2011)*	139	115	181	92	74	117	-47	-41	-64
Panama* *(2000 and 2010)*	89.5*			85.7*			-3.8		
Paraguay *(1998 and 2008)*	87	51	140	63	47	85	-24	-4	-55
Peru *(2000 and 2012)*	66	45	118	64	49	109	-2	+4	-9

Sources: DHS, RHS, and national survey reports.
* MDG Development Indicators http://unstats.un.org/UNSD/MDG/Data.aspx.
† For urban Jamaica birth rates, the data are broken down into "Kingston" and "other urban".

Economic status remains a strong determinant of early childbearing, and inequities persist between the rich and the poor. Although the proportion of adolescents who were pregnant or had given birth has decreased or remained stable in the past decade in most LAC countries, marked disparities exist between the highest and lowest wealth quintiles with respect to early childbearing.

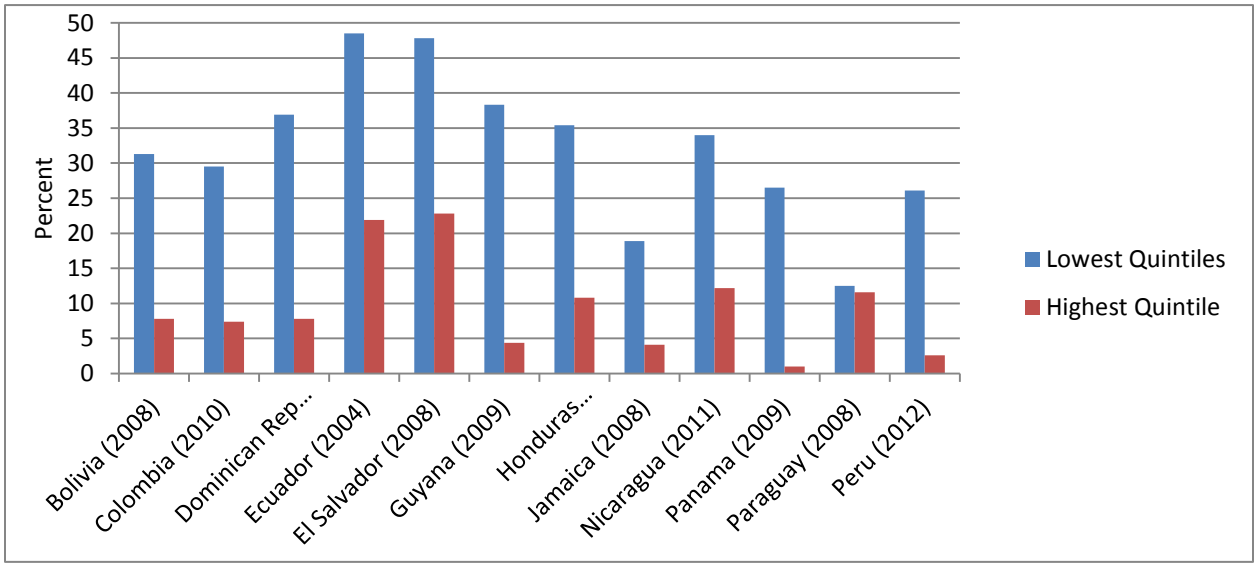
As can be seen in figure 16, in all but one country with available data, adolescents in the lowest wealth quintile were most likely to be pregnant or have given birth. Paraguay is the notable

exception, showing similar percentages of adolescent mothers for the highest and lowest quintiles. Panama shows the highest level of inequity on this variable: only 1 percent (among the highest wealth quintile) versus 26.5 percent among lowest having been pregnant or mothers. In fact, these data from Panama may actually slightly underestimate the gap since one of the indigenous groups with high fertility and low age at union did not participate in the survey (Panama Ministerio de Salud, 2009).



Sources: DHS, RHS, and national survey reports.

Figure 15: Percent of women 15-19 years who were pregnant or had a baby at time of survey.

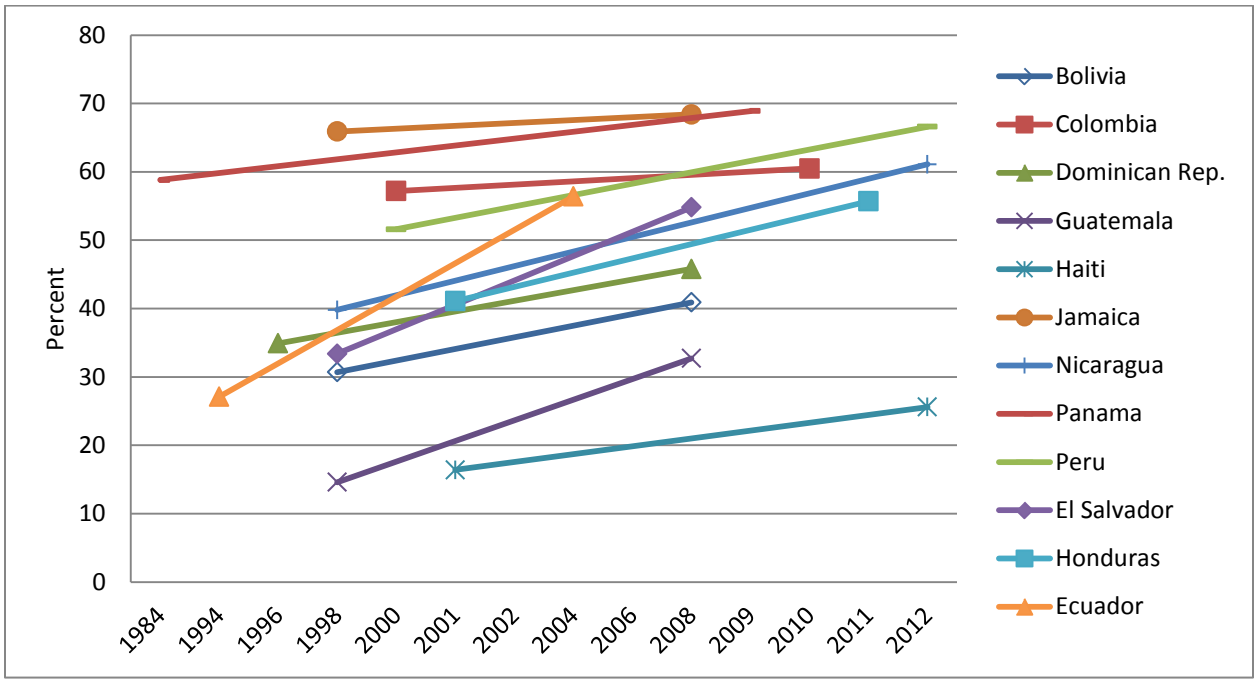


Sources: DHS, RHS, and national survey reports.

Figure 16: Percent of women 15-19 years who were pregnant or had a baby at time of most recent survey, by highest and lowest wealth quintile in select Latin American countries.

Contraceptive Prevalence Rates among Adolescents

Figure 17 shows CPR for 15-19 year olds married or in union. Jamaica and Peru have the highest CPRs with 68.4 percent and 66.6 percent, respectively. Jamaica's and Colombia's CPRs remained fairly stable in the period, but most countries experienced increases.

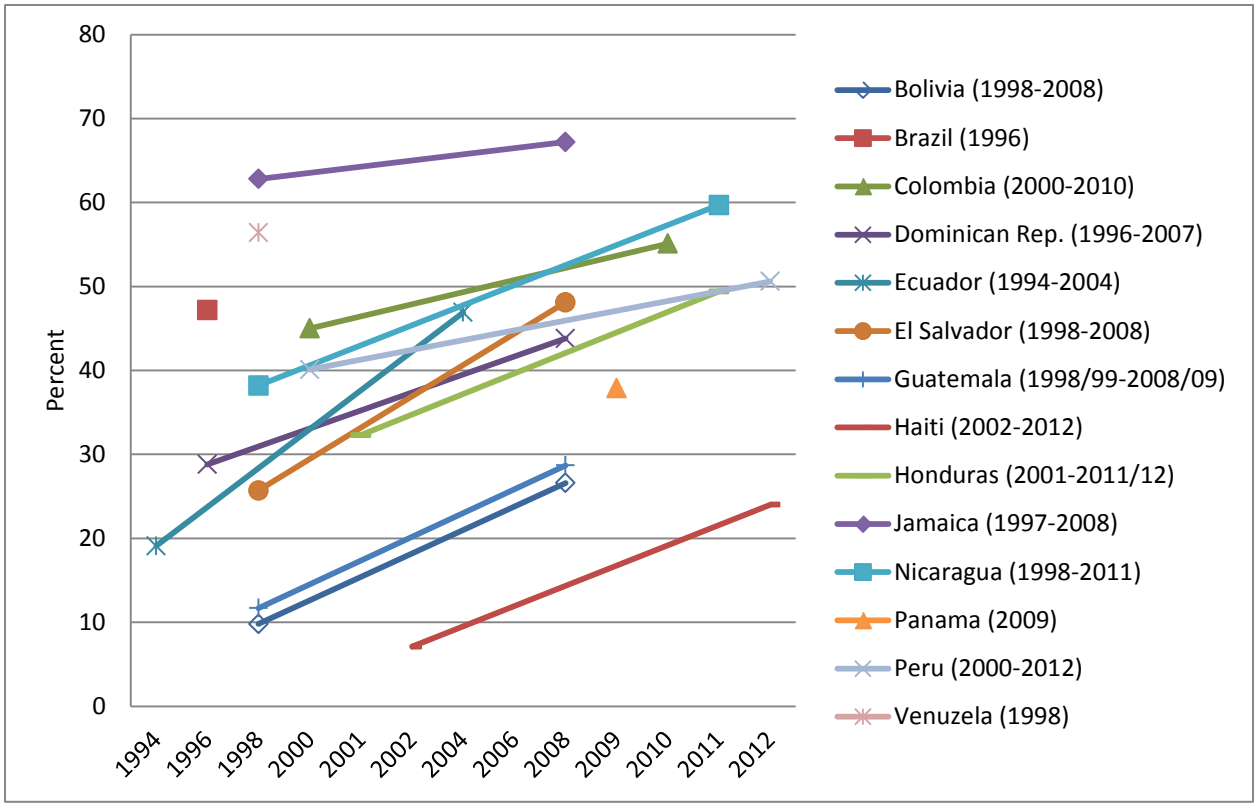


Sources: DHS, RHS, and national survey reports.

Figure 17: Trends in contraceptive prevalence rate among women 15-19 years married or in-union, selected countries over time.

As can be seen in figure 18, adolescent MCPR varies from a high of 67.2 percent to a low of 24.0 percent, based on surveys conducted since 2005. The countries with the MCPR of over 50 percent are (in descending order) Jamaica, Nicaragua, Colombia, Peru, and Honduras. By contrast, the four countries with the lowest MCPR among adolescents are Bolivia, Guatemala, Haiti, and Panama.

In the 11 countries with data from at least two surveys conducted in the last 20 years, MCPR increased over time. Ecuador, El Salvador and Nicaragua experienced the greatest increases (27.8, 22.4 and 21.5 percentage point increases, respectively). Honduras, Haiti, Guatemala, and Bolivia also experienced increases of over 15 percentage points from the earlier survey to their most recent one.



Note: Countries represented by single data points (Brazil, Panama, and Venezuela) did not have data on this indicator from multiple surveys.
Sources: DHS, RHS, and national survey reports.

Figure 18: Trends in modern contraceptive prevalence rate among women 15-19 years, married or in-union, in selected countries from most recent survey and one decade earlier.

In most countries worldwide, increased contraceptive use is associated with decreased fertility. Curiously, this relationship is not systematically true among adolescents in all countries in the LAC region (adolescent MCPR shown in figure 18, ABR in table 1). Although MCPR has increased in most countries in the region, ABRs have been stagnant or even increased for some countries (including in countries where MCPR has increased). To take specific examples, in Bolivia the MCPR among adolescents increased by 16.8 percentage points, yet the ABR also increased during the same period of time. Peru's ABR stagnated despite an increase of 15 percentage points (from 51.6 percent to 66.6 percent) in MCPR. Jamaica´s already high MCPR did not increase substantially in one decade, while ABR dropped dramatically. For Jamaica, other factors such as delayed childbearing may have had more of an effect on adolescent pregnancies, given the already high levels of contraception at the beginning of the period.

However, there are some countries in which the expected relationship was found; that is, MCPR increased as ABR decreased: Colombia, the Dominican Republic, Haiti, and Nicaragua.

Demographers studying the region have noted that adolescent MCPR (especially among married adolescents) may not be a good predictor of fertility among LAC adolescents. Possible explanations include the following:

(1) Due to numerous cultural and access issues, LAC adolescents often access contraceptive methods only after their first child (Rodriguez, 2009).
(2) Decreases in age of sexual debut may be offsetting increases in MCPR (Ali and Cleland, 2005).
(3) Increases in MCPR among adolescents have been disproportionately related to increases in condom use (a less effective method of pregnancy prevention) (Rodriguez, 2011). Cross-sectional, multivariate analyses have found that 15-19 year olds using contraception are more likely to be mothers (possibly because it is only after they are mothers that they are able to access contraception easily) (Rodriguez, 2009; Di Cesare & Rodriguez, 2006).

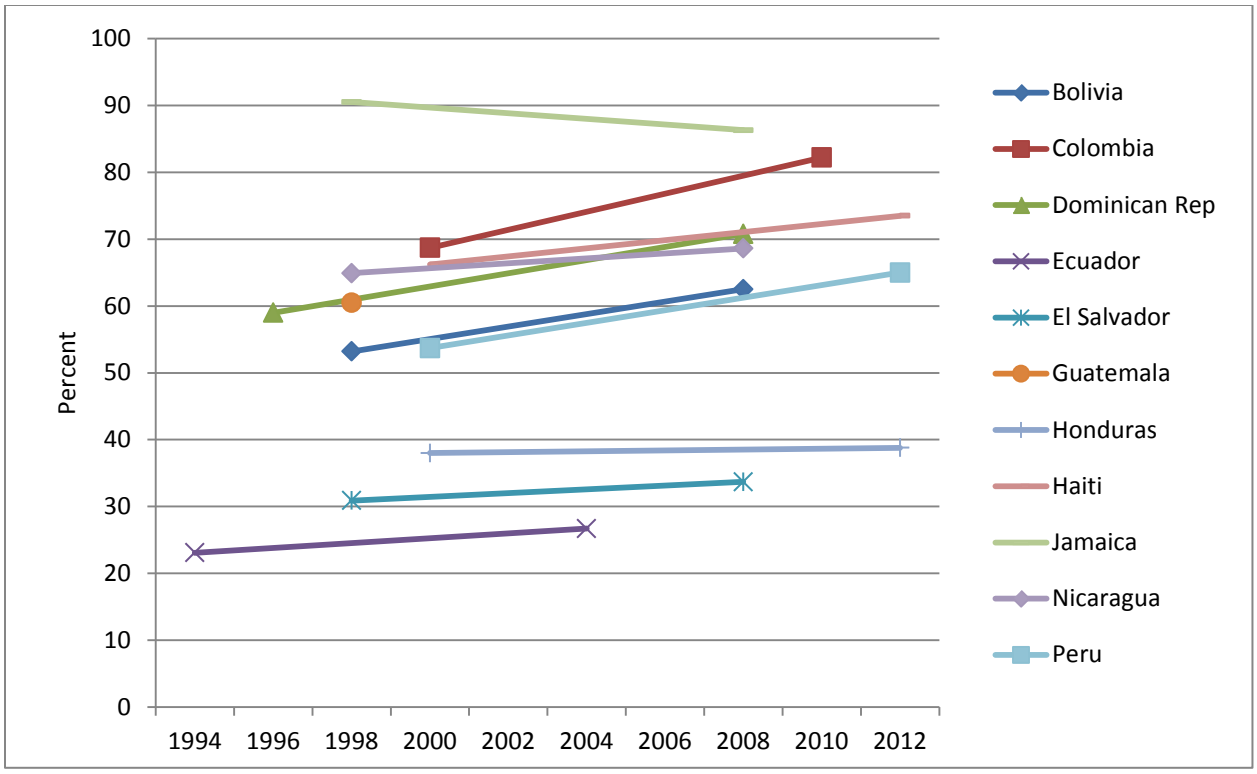
Even if MCPR does not show a consistent (inverse) relationship with ABR, it is still a useful indicator for other reasons. Specifically, it reflects demand for contraception, availability of methods, and access to contraception.

Early Sexual Debut and Very Young Pregnancy

The age of sexual debut potentially influences pregnancy rates among young women; thus, the proportion of young women who have sex as adolescents is an indicator of interest. Figure 19 shows that in seven of the 10 countries where data were available for two surveys, over 50 percent of women had had sex before age 20. In descending order based on the most recent survey, the seven countries are Jamaica, Colombia, Haiti, Dominican Republic, Nicaragua, Bolivia, and Peru. By contrast, the three countries in which less than 50 percent had experienced sexual debut before age 20 were Ecuador, El Salvador, and Honduras.

Figure 19 also reflects changes over time in the percentage that had initiated sexual activity. Changes in early sexual initiation may explain why the ABR and MCPR are not always inversely related. For example, Peru and Colombia decreased ABR only modestly, despite increasing the MCPR by 10 percentage points, and Bolivia's ABR increased despite a 16.5 percentage point increase in MCPR. Jamaica´s decrease in proportion of women having sex before age 20 may explain how they were able to reduce ABR despite a minimal increase in the already high MCPR (only 4.4 percent in the 10-year period).

DHS and RHS data from 1997-2011 have shown that births to girls under 15 years of age constitute a small proportion of total births (3 percent in all developing countries and only 0.5 percent of births in LAC). However, LAC is the only region in the world that saw an increase in births to girls under age 15, and projections suggest that this trend will continue (UNFPA, 2013). Factors contributing to this increase include earlier ages at menarche and earlier age at first sex.



Sources: DHS, RHS, and national survey reports.

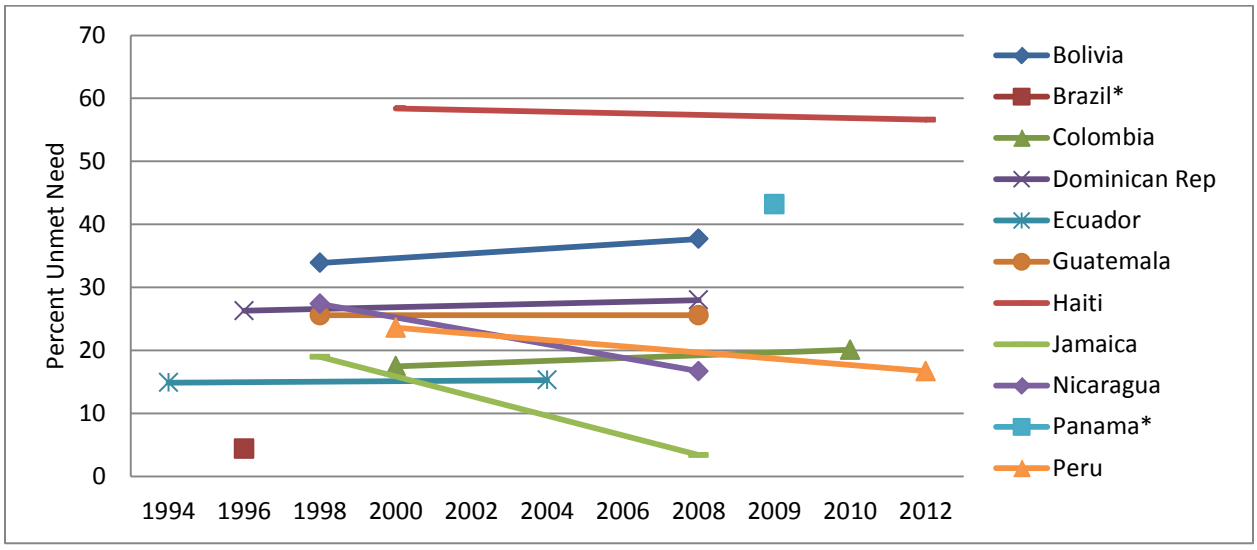
Figure 19: Percent of women 20-24 years who report having had sexual intercourse before age 20 over time in select Latin American countries.

Unmet Need for Contraception among Adolescents

Unmet need for contraception among adolescents is the proportion of 15-19 year olds who are not using contraception and do not want to get pregnant within the next two years or never want to become pregnant.

Figure 20 shows the unmet need among adolescents in union for 10 countries for which this information is available. In five of the 10 countries, 20 percent or less of female adolescents have an unmet need for contraception. In descending order, these are Colombia, Ecuador, Nicaragua and Peru, with Jamaica having the lowest unmet need (at 3.7 percent). LAC countries in the middle range of unmet need (from 25 percent to 40 percent) include Bolivia, the Dominican Republic, Guatemala, Guyana, and Panama.[11] The country with by far the greatest unmet need for contraception among female adolescents is Haiti (at 56.7 percent).

Figure 20 also indicates how unmet need has changed over the approximately 10-year period between surveys in the 10 countries with available data. Three countries achieved sizable decreases in unmet need among adolescents: Jamaica, Nicaragua, and Peru. Most other countries showed either no change or slight increases in unmet need.



Note: * Countries represented by single data points (Brazil and Panama) did not have data on this indicator from multiple surveys.
Sources: DHS, RHS, and national survey reports.

Figure 20: Unmet need among women 15-19 years in union over time in selected countries.

[11] Panama's high level of adolescent unmet need (43.9 percent) is an anomaly, in this country with high per capita gross domestic product for the region and relatively high educational attainment (92 percent of the population has completed primary school and the average number of years of completed schooling is 9.3 [UNESCO, 2012]) According to SRH experts in the country (including one of the authors), reasons for these high levels of unmet need include: persistent stock-outs of contraceptives in the public sector, little current investment in FP promotion or health worker training, and no systematic sexuality education in the schools. Furthermore, both public and private sector providers routinely refuse to provide FP counseling and services to youth under the mistaken impression that parental consent is required (this is a misinterpretation of the policy).

Educational Attainment and ABR

As discussed above, the LAC region has significantly improved educational attainment with near universal primary school attendance and increased levels of secondary school attendance. There is strong evidence that in some countries (e.g., Ecuador and Panama) education has contributed greatly to decreases in adolescent fertility; however, there does not appear to be a direct linear relationship between education and declines in adolescent births in all countries (Rodriguez, 2011; Rodriguez & Cavenaghi, 2014).

Given the widely recognized and well-documented positive association between education and fertility (Bongaarts, 2003), a key question emerges from this analysis: Why hasn't adolescent fertility declined more rapidly in the region?

Some health professionals working in the region offer one possible explanation for this anomaly of high adolescent fertility in the presence of increasing educational attainment – a significant subset of adolescents in the LAC region might want to become pregnant. Cultural norms remain strongly pronatalist, and early pregnancy may be viewed as desirable. However, data from the DHS/RHS show that desirability of early motherhood is declining and that the most common reasons given for not using contraception at first intercourse relate primarily to lack of access (real or perceived) and situational factors, rather than desire for pregnancy (Rodriguez, 2011). While sexual activity is increasing among adolescents, access to contraceptives is not improving (ECLAC, 2011).

Another explanation of this anomaly may relate to the declining ability of educational attainment to protect against early fertility. Researchers analyzing the relationship between fertility and education (measured as the number of years of education attained), using 2010 census data in LAC countries, found that while having no education is clearly related to increased fertility, increased numbers of years of education are not associated with continuous declines in adolescent fertility until after the seventh year of schooling. Interestingly, this has changed over time; data from the 2000 census showed a positive effect beginning at the fifth year of schooling (Rodriguez & Cavenaghi, 2014). According to Rodriguez and Cavenaghi (2014), given that the labor market has not kept up with greater numbers of educated women, early motherhood remains an attractive option for women unless they can complete secondary or university level education.

In short, the LAC region has experienced dramatic declines in fertility rates over the past 50 years and substantial increases in modern contraceptive use. Urban/rural differences have diminished markedly for both fertility rates and contraceptive use among the population as a whole. Yet, during the same period, adolescent fertility has remained high, with marked disparities by wealth quintile and place of residence. As we reviewed data in preparing this report, we therefore examined factors that contribute to continued high levels of adolescent fertility, as well as the persistent barriers to contraceptive use for young people.

V. HISTORICAL OVERVIEW: EARLY YEARS IN THE FAMILY PLANNING MOVEMENT

Concern over rapid population growth in the developing world arose in the 1950s, with a particular focus in Asia. Both political and humanistic motivation fueled this concern. In a period of fervent anti-communist sentiment in the United States, the potential destabilization of countries unable to manage the growing demands of their own people was viewed as a potential a threat to U.S. security. Others felt the need to curb rapid population growth to minimize the human suffering of children born to parents unable to provide them with the basic necessities of life (McLaughlin, 1982). Landmark events during this period included the establishment of a family planning program in India in 1951, as well as establishment of IPPF in London and the Population Council in New York.

In the 1960s, interest in family planning emerged on the national agenda in the United States. The U.S. Food and Drug Administration (FDA) approved a contraceptive pill in 1960, which was welcomed by the population community as a means to slow population growth and by feminists and others in the general population as a means of determining the number and spacing of children. USAID was established in 1961 and, for many years, its international family planning programs enjoyed bi-partisan support in the U.S. Congress (Radloff, 2013).

In 1962, the United Nations General Assembly adopted a resolution establishing the role of family planning in decreasing rapid population growth. The U.S. government and agencies such as the World Bank were increasingly convinced that population was a key factor in economic development. A 1969 USAID report on its Population Assistance Program begins with a strongly worded discussion of the "the population problem," quoting World Bank President Robert S. McNamara as saying "no achievable rate of economic growth can be sufficient to cope with an unlimited proliferation of people on our planet" (USAID, 1969).

USAID support for family planning began in the early 1960s; it established its Population Program in 1965. Population assistance grew dramatically from $2.1 million in 1965 to over $45.1 million in 1969 (USAID, 1969). While the first large population programs began in Asia (India, Pakistan, and Sri Lanka), Latin America emerged as a priority region by the end of the 1960s due to having the fastest population growth rate at that time (USAID, 1969).

Catalytic Role of the International Planned Parenthood Federation in Latin America

As in other parts of the developing world, in the 1950s, Latin America had high birth rates while also experiencing decreasing levels of mortality, as a result of greater availability of antibiotics, pesticides for vector control, the introduction of potable water and sanitation, vaccination programs, parasite control, and generally improved medical care and living conditions. In most countries, the income disparities between rich and poor were marked, resulting in a great number of impoverished families struggling with the burden of raising large families. With increased urbanization, more families fled to the cities in hopes of improving their economic lot. By the 1960s, the plight of women with high fertility – including rates of maternal death and disability – was becoming increasingly evident to concerned physicians, nurses, and social workers. Their

desperate need to limit unwanted or unintended births resulted in alarming rates of abortion, despite the practice being highly restricted and socially stigmatized in the region. Moreover, for the first time in history, safe contraception methods were available that would make it possible to address age-old issues of unwanted high fertility and high abortion rates. This situation triggered some countries to develop FP programs to save lives as an alternative to abortion.

IPPF began an initiative in the early 1960s to encourage interest in family planning in Latin America. Dr. Ofelia Mendoza, one of the pioneers in this effort, visited the majority of Latin American countries over several years, searching out groups of doctors, nurses, social workers, businessmen, and concerned citizens, helping them to articulate the negative impact of unintended pregnancy at both a societal and individual level (Echeverry, 1991). By 1966, IPPF had helped to develop private family planning associations (FPAs) in 14 Latin American and Caribbean countries, which soon thereafter became member associations (MAs) of IPPF: Argentina, Brazil, Colombia, Costa Rica, Curaçao, El Salvador, Mexico, Panama, the Dominican Republic, Saint Vincent, Paraguay, Cuba, Uruguay, and Nicaragua.[12] In addition, IPPF sponsored several regional meetings to raise awareness of the problems of rapid population growth, unintended pregnancy and maternal mortality, and to identify programmatic solutions to these issues. This process of identifying and affiliating private family planning organizations to IPPF continued through the 1970s, resulting in a total of 17 countries in the LAC region with an established IPPF member association by 1975 (see table 2). In most countries, the local IPPF MA established its headquarters in the capital city and began to provide FP services in this and other urban areas. USAID support for IPPF began with a grant of $3.5 million in 1968, and its continued support was vital for the work of the organization in the region during the 1970s and beyond. Furthermore, many of the MAs in the region received additional USAID financial assistance during this time period.

In the 1960s and 1970s, family planning was a controversial topic in the LAC region for multiple reasons. In most countries, the population predominantly self-identified as Roman Catholic. In 1968, the Vatican reiterated its opposition to all non-natural methods of contraception in the papal encyclical letter *Humanae Vitae*. Additionally, many in the region considered the number of children born to each woman as a matter of divine will. There were also social, political, and economic barriers to modifying fertility, similar to those in other parts of the developing world. High fertility norms prevailed in all countries, especially in rural areas that depended on children to assist with agricultural production. Machismo led many men to equate having large numbers of children with manliness, sometimes without a corresponding sense of responsibility to care for these women and children. Some husbands feared that contraceptive use would allow their wives to engage in promiscuity. Finally, the preference for male children drove many couples to continue childbearing until they achieved this goal. With few alternative occupational roles, women tended to define their role in society as housewives and mothers, often with a large number of children.

[12] These organizations, initially known as family planning associations and often referred to as IPPF "affiliates," are legally member associations (MAs), the term used throughout this report.

Table 2: IPPF Membership in Latin America and Caribbean Countries

Country	IPPF Association	Year of Associate Membership* (Full Membership)
Argentina	Fundación para la Salud del Adolescente	2010
Barbados	The Barbados Family Planning Association	1957 (1957)
Belize	Belize Family Life Association	1992 (2008)
Bolivia	Centro de Investigación, Educación, y Servicios (CIES)	2001 (2008)
Brazil	Associação Pro Bem-Estar Familiar	1967 (1971)
Caribbean Family Planning Affiliation	Caribbean Family Planning Association Ltd.	1973 (1992)
Chile	Asociación Chilena de Protección de la Familia	1965 (1965)
Colombia	Asociación Pro-Bienestar de la Familia Colombiana	1968 (1971)
Costa Rica	Asociación Demográfica Costarricense	1967 (1971)
Dominican Republic	Asociación Dominicana Pro-Bienestar de la Familia	1969 (1971)
Cuba†	Sociedad Científica Cubana Para el Desarrolla de la Familia (SOCUDEF)	1980
Ecuador	Centro Ecuatoriano para la Promoción y Acción de la Mujer de Guayaquil, Ecuador	2007
El Salvador	Asociación Demográfica Salvadoreña	1969 (1971)
Guatemala	Asociación Pro-Bienestar de la Familia de Guatemala	1969 (1971)
Guyana	Guyana Responsible Parenthood Association	1990 (2008)
Haiti	Association pour la Promotion de la Famille Haïtienne	2001
Honduras	Asociación Hondureña de Planificación de Familia	1965 (1975)
Jamaica	Jamaica Family Planning Association	1957 (1957)
Mexico	Fundación Mexicana para la Planeación Familiar, A.C.	1967 (1971)
Nicaragua	Asociación Pro-Bienestar de la Familia Nicaragüense	1975 (1992)
Panama	Asociación Panameña para el Planeamiento de la Familia	1969 (1975)
Paraguay	El Centro Paraguayo de Estudios de Población	1969 (1971)
Peru	Instituto Peruano de Paternidad Responsable	1982 (1998)
Puerto Rico	Asociación Puertorriqueña Pro-Bienestar de la Familia	1954
Suriname	Stitching Lobi	1990 (2000)
Trinidad and Tobago	Family Planning Association of Trinidad and Tobago	1960 (1971)
Uruguay	Iniciativas Sanitarias	2013
Venezuela	Asociación Civil de Planificación Familiar	1995 (2004)
	Members of the Caribbean Family Planning Affiliation (CFPA)	
Anguilla	Anguilla Family Planning Association-The Primary Health Care	(1992)
Antigua	Antigua Planned Parenthood Association	(1992)
Aruba	Foundation for the Promotion of Responsible Parenthood (Aruba)	(1992)
Bahamas	Bahamas Family Planning Association	(1992)
Bermuda	Teen Services	(1992)
Curacao	Foundation for the Promotion of Responsible Parenthood (FPRP)	1992 (1992)
Dominica	Dominica Planned Parenthood Association	(1992)
Grenada	Grenada Planned Parenthood Association	(1992)
Guadeloupe	Association Guadeloupéenne pour le Planning Familial	(1992)
Martinique	Association Martiniquaise pour l'Information et l'Orientation Familiales	(1992)
Nevis and St. Kitts	Nevis Family Planning Association	(1992)
St. Lucia	Saint Lucia Planned Parenthood Association	1969 (1992)
St. Vincent	St. Vincent Planned Parenthood Association	(1992)

* This is the year that each member became an associate member; several countries have since become full members.
† Cuba is considered to be outside the Western Hemisphere Region by IPPF and is handled by IPPF's London headquarters.
Source: IPPF/WHR.

The majority of Latin American governments during the 1960s were hesitant to become involved in the delivery of a service that was politically sensitive, socially controversial, and likely to create conflict with the Roman Catholic Church. Moreover, many viewed population growth in a positive light: as a source of manpower, economic strength, and national pride. In some countries the government vehemently opposed the efforts of private MAs to develop and expand service delivery. In others, they simply ignored this development. In this environment, the local IPPF MAs were trailblazers; they demonstrated the felt need for family planning, especially among the poor, and developed local technical expertise in FP service delivery.

In the 1970s, several governments became more open to delivering family planning services, often as part of maternal and child health (MCH) services. In such countries, family planning became available in the hospitals and health centers operated by the country's ministry of health (MOH). In addition, in some countries, a national Instituto de Seguridad Social (Social Security Institute) provided services to employees in the government or formal sector, often on a more limited scale. USAID provided bilateral support to 16 LAC countries for population activities in the 1970s.

Evolution in the Models of Service Delivery

In the early days of family planning in the LAC region, FP services were highly medicalized. Doctors, midwives, and nurses conducted medical exams and provided contraceptive services to clients in established clinics, while social workers often assisted with counseling.

Given the sensitive and highly politicized environment surrounding contraceptive use in those years, the early FP programs were cautious. They delivered services in a carefully controlled environment to avoid any negative incident which may have attracted unfavorable public attention. The early FP clinics had a more limited range of contraceptive products available than is the case today: combined oral contraceptive pills, the IUD (including the Dalkon Shield before it was removed from the market), male condoms, and spermicides (creams, vaginal tablets such as Neo-Sampoon). Despite initial opposition, permanent methods (male and female sterilization) were introduced in the late 1960s and early 1970s in a number of countries including Brazil,[13] Colombia, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Mexico, and Panama, and became increasingly popular in the decades to follow.

By the early 1970s, the limitations of the clinical model became clear to program leadership in numerous countries. Clinics operated primarily in urban areas, yet a large portion of the population lived in rural areas. Moreover, programs did not have the resources to build and staff the number of locations needed to meet the demand for FP services of the entire population. Other developing countries had begun to experiment with alternative means of reaching large segments of the population, either through community-based distribution (CBD) (e.g., in Tunisia and Indonesia) or contraceptive social marketing (in Thailand) (Altman & Piotrow, 1980). A

[13] Female sterilization was illegal in Brazil until 1997. To get around this law, sterilizations were often performed after deliveries, something that helped account for the large percentage of births in Brazil via Caesarian (Potter, Perpétuo, Berquó, Hopkins, Leal & Souza, 2003).

number of LAC countries followed suit by adapting these service delivery modes to local circumstances.

Community-based distribution used community workers, often volunteers without formal clinical training, who received a short training involving how to deliver a limited number of contraceptive methods (e.g., pills, condoms, spermicides). These workers would then sell contraceptives from their homes, small stores, hair salons, and other locations throughout the community. Training included the use of a checklist to identify contraindications to the oral contraceptive pill, in which case the potential user was counseled on other methods or referred to a nearby health facility. This model of service delivery allowed programs to reach the most remote areas of a country, increasing access to contraceptives for many populations. Profamilia/Colombia (Asociación Probienestar de la Familia/Colombia) was the first LAC organization to experiment with this model, and it became widely adopted among NGOs and some public programs (e.g., in Mexico), despite initial resistance from the medical community.

While the CBD model helped to ameliorate disparities in access to contraceptives between urban and rural residents, it did have some drawbacks. Studies conducted under USAID's operations research (OR) project suggested that, due to high turnover and high training costs, CBD programs were not cost-effective in most countries. Many NGO programs moved away from traditional CBD to social marketing-type programs, while the public sector integrated community workers into rural clinics. Programs generally moved away from CBD by the late 1990s, although some continued beyond that (Foreit & Raifman, 2011). The high costs of CBD programs could often be attributed to the challenges of training volunteers and supervising them, especially over large geographical distances (Foreit & Raifman, 2011). CBD requires a high level of coordination, which proved difficult in some settings in the LAC region. Nevertheless, this model is largely acclaimed for achieving increased access to remote areas (USAID, 2012a).

Social marketing of contraceptives also emerged in the 1970s as an alternative to the clinic model, to expand coverage and address unmet need (Altman & Piotrow, 1980). Often subsidized by USAID (especially in the early phases), social marketing programs approached contraception using a consumer-centered marketing approach which involved the "four Ps" (product, price, promotion, and place). The programs designed attractive packaging and tested for consumer preferences, although the contraceptives were usually the same ones (except for packaging) available free or at a lower cost through public sector services. Such programs appealed to consumers who preferred the convenience of purchasing supplies at local shops or other outlets, rather than visiting a medical setting. Furthermore, they provided greater anonymity, which was especially important for young people. Many users considered these products "superior" to the available government-sector commodities and enjoyed the status of buying a more attractively presented product in lieu of receiving free government contraception. These social marketing models were later applied successfully to condom social marketing efforts as part of the response to the HIV epidemic.

Both CBD and social marketing met with criticism from various stakeholders. In some countries the medical community reacted negatively to the delivery of a health service by community-level personnel with no formal medical training (Kols & Wawer, 1982). Others complained that the social marketing of contraceptives diminished the value of health services, equating their sale to

that of chewing gum or toothpaste. In some countries, the pervasive marketing that accompanied such campaigns elicited public statements from the Roman Catholic Church, and, in some cases, formal requests to end those campaigns (e.g., in El Salvador in the late 1970s). Despite the controversy and criticism that CBD and social marketing provoked, by the late 1970s, numerous LAC countries had implemented one or both of these models of service delivery.

By the 1990s, many private sector organizations in the region had built strong social marketing programs (usually with USAID support and technical assistance), some of them verging on commercialization of contraceptives. While not fundamentally different from early social marketing, commercialization programs tended to focus less on mass media advertising and more on product placement through commercial channels (stores, small pharmacies, and for-profit clinics) with higher price points.

In the late 1990s, social franchises emerged as another service delivery model in the region. Under this model, NGOs provided support (including supplies, technical assistance, and common branding) to a network of private clinics. The affiliated clinics collected user fees, which, in some cases, were covered by a third-party payer (such as a social security institute or MOH). In Mexico, the IPPF member association MEXFAM (Fundación Mexicana para la Planeación Familiar) pioneered this model with USAID support. The initial model was successful at expanding access, but it did not prove to be sustainable; a modified version was being tested as of 2014. In 2002, INPPARES Peru (Instituto Peruano de Paternidad Responsible) created a more sustainable model (with initial support from USAID) called Red Plan Salud which currently serves over 600,000 clients a year. Since 2010 PASMO (Pan American Social Marketing Organization) has created the Red Segura (with funding from an anonymous donor) in El Salvador, Guatemala, and Nicaragua. The Red Segura has used a social franchise model to introduce and increase the uptake of long-acting reversible contraceptives (IUDs and implants) through small clinics (Schlein & Montagu, 2012).

In the 1980s, the range of contraceptive methods available in the LAC region greatly expanded, and FP programs began to promote more long-acting reversible (e.g., IUDs), and permanent contraceptive methods (including female sterilization and, to a lesser extent, vasectomy). Improvements were made to reversible contraception during this time. The range of oral pills was broadened to include lower-dose pills (with fewer side effects) and progesterone-only pills (appropriate for lactating mothers). The Dalkon Shield was withdrawn from the market in 1974 because of serious side effects, including sterility, and later replaced by the safer and more acceptable Copper-7 IUD. Many programs also offered training in one or more natural methods, including the Billings method, sympto-thermal method, and rhythm, based on awareness of a woman's menstrual cycle. Meanwhile, the preferred surgical method for female sterilization shifted from laparoscopy to mini-laparotomy, which was simpler, had fewer side effects, and a more rapid recovery. No-scalpel vasectomy was introduced in the region, although numbers of vasectomies performed continued to be low.

Female sterilization became the most widely used contraceptive in numerous LAC countries by the mid-1980s. The increased availability and permanence of the method appealed to women, and some groups made allegations that "mass sterilizations" were being conducted. There were also anecdotal reports that the procedure was done, in some cases, without the knowledge and

consent of the women involved. While such claims were often refuted (for example, in El Salvador) they remained a cause for concern both as a violation of women's human rights and for the political damage they could cause, leading as a result to greater vigilance on the part of groups supporting contraception, such as USAID, to ensure completely informed consent and voluntarism (Bertrand, Landry & Zelaya, 1986).

While the use of injectable contraceptives began in the region in the early 1980s, injectables became widely available in the public sector through USAID commodity donations after FDA approval in 1992. Injectable contraceptives have greatly increased in popularity since 2000 (Sutherland, Otterness & Janowitz, 2011). One benefit of increased use of injectables has been greater access to contraception in rural areas. However, one concern with this method is that if injectables come to replace longer-acting methods, discontinuation rates could increase, because use of injectables requires a return visit to the clinic or pharmacy every one to three months. Also, the cost to governments for injectables in comparison to more cost-effective long-acting methods could limit available funding needed to procure adequate supplies, since most governments in the LAC region (except Haiti) are now responsible for their own contraceptive procurement.

Since 2000, additional methods have become available. In 2002, with support from USAID, the Standard Days Method or SDM (also known as Cyclebeads) was introduced into the method mix as an improved means of practicing periodic abstinence. A second method was a dedicated product for emergency contraception (EC). Although EC using the Yuzpe method (off-license use of standard oral contraceptives) came into use in the late 1990s through the private sector, it wasn't until the 2000s that some LAC governments approved dedicated EC products and included them in their service delivery norms. EC represents a small portion of method mix in any country, but plays a critical role in providing women, especially young women, with greater control against unwanted pregnancy.

Although stock-outs have occurred and continue to occur in some countries for specific methods, historically most of the family planning programs in the LAC region have tried to offer the "cafeteria approach" – giving the client access to a range of contraceptive choices, based on preference.

The Political Climate for Family Planning

By the time the contraceptive pill was approved by the FDA in 1960, there was considerable enthusiasm for family planning in the United States (McLaughlin, 1982). Many influential American policymakers were familiar with the predictions of global calamity due to the population explosion found in Paul Ehrlich's *Population Bomb*, published in 1968, and in similar "doomsday" books. Family planning had bipartisan support in the United States: President Lyndon Johnson appointed the first Committee on Population and Family Planning in 1968, while President Richard Nixon pushed Congress to increase funding for family planning in 1969, later signing Title X of the Public Health Service Act, 1970 into law and laying the foundation for federal funding for these programs in the United States. In 1969, Nixon told Congress that "no American woman should be denied access to family planning assistance because of her economic condition" (Lepore, J, 2011).

From the onset, family planning programs were politically controversial among a variety of groups in Latin America. The Roman Catholic Church and some other conservative religious groups opposed family planning on religious grounds (Opus Dei, n.d.). On the other hand, some political groups, many allied with local public universities, viewed family planning as an imperialistic plot by the United States to control or diminish the population in countries south of its border, to circumvent a social revolution, and to sidestep the problems of underdevelopment. Leaders of indigenous populations, who considered children as a blessing from God and as security in old age, believed that family planning was a threat to the perpetuation of their native culture. Furthermore, many developing countries in the late 1960s and early 1970s resented the abundant USAID resources made available for family planning, when their own development goals focused on nutrition, agriculture, economic growth, or other sectors of development (MacPherson, 2006). At the 1974 World Population Conference in Bucharest, countries of Latin America joined with nations from the rest of the developing world to send a clear message to the developed world that they wanted economic progress, not population control. From this conference the phrase was coined, "Development is the best contraceptive" (Bongaarts, Cleland, Townsend, Bertrand & Das Gupta, 2012).

In the mid-1970s, when most Latin American governments opposed or turned a blind eye to family planning, Mexico demonstrated bold leadership on the issue. Until 1972, when it amended its Constitution to include the right to choose family size, Mexico had been strongly pronatalist, encouraging large families. Yet, in 1974, as demographers and other experts projected the implications of rapid population growth and analyzed its consequences, the government of Mexico, under the administration of President Luis Echeverría, declared a new policy designed to promote family planning and encourage smaller family norms. The Consejo Nacional de Población (CONAPO) was formed to coordinate research and action in the area of population. The government worked with existing NGOs (MEXFAM, FEMAP [Federación Mexicana de Salud y Desarrollo Comunitario], CORA [Centro de Orientación para Adolescentes], and PROSALUD) to increase access to family planning services throughout the country (Bowers & Danart, 2005).

By the early 1980s, the majority of countries in the LAC region had integrated family planning into government health services, although the private FPAs often remained a major source of contraceptives for family planning users and the leading champion for FP in the country. Most Latin American governments espoused the belief that their country would benefit from lower population growth. At the 1984 International Conference on Population in Mexico City, many looked to the United States and other developed countries for increased financial support to their growing family planning initiatives. Although U.S. support for family planning continued, the Reagan Administration seized the political spotlight at that conference to introduce new guidelines that came to be known as the Mexico City Policy. Since 1973, the Helms Amendment had prohibited the use of U.S. foreign assistance to provide abortions as a method of family planning, or to motivate or coerce any person to practice abortion. The Mexico City Policy took this policy one step further by prohibiting the award of U.S. FP assistance to any foreign (non-U.S.) NGOs that conducted *any* abortion-related activities (including education, advocacy, and counseling, as well as abortion procedures), even if these were legal in that country, and even if the funding for these activities were from other sources. This initial Mexico City Policy was in effect from 1985 to 1993, when, on his first day in office, President Clinton rescinded it. In 2001,

President George W. Bush re-instituted the Mexico City Policy, which some referred to as the "Global Gag Rule." Shortly after taking office in 2009, President Obama once again rescinded this policy.

By the early 1990s, family planning was well established in most of the LAC region. The watershed event during this period was the International Conference on Population and Development (ICPD) held in 1994 in Cairo, Egypt. In preparation for the Cairo conference, the Ford Foundation sponsored a series of conferences and workshops in Latin America that focused on a more holistic view of sexual and reproductive health (SRH) based on human rights, a philosophy that became the centerpiece of the ICPD Program of Action. Thus, the Latin American family planning movement was in the vanguard in calling for this new paradigm in Cairo, with most Latin American delegations strongly supportive of the progressive language that was developed there. Furthermore, Latin American feminists, traditionally suspicious of family planning, went to Cairo to work in alliance with family planning advocates to develop a strong Program of Action. The ICPD in Cairo re-defined SRH as a human rights issue, and placed family planning firmly within the context of a broad approach to SRH (McIntosh & Finkle, 1995).

In 1995, the International Conference on Women was held in Beijing, China, and built on the momentum of the Cairo ICPD. Although the range of issues was more wide-reaching, the Beijing conference further confirmed the principles of Cairo in terms of the importance of gender equity, the need for women-centered services, and the centrality of human rights in discussions regarding SRH. This paradigm shift was welcomed in Latin America, where it appealed to a broader coalition of women's and human rights organizations. Following the ICPD, the terminology "sexual and reproductive health" had become widely adopted, and the principles espoused in Cairo and Beijing were frequently cited by advocates and service providers alike. In fact, advocates felt that the ICPD Program of Action and the Beijing Declaration were so important to the SRH movement that they worked actively to scuttle another international population conference that was to have been scheduled in 2004, fearing that it would provide an opportunity for the Bush Administration to seriously reverse the progress made in Cairo and Beijing.

While some aspects of the post-ICPD paradigm took longer to be widely assimilated in the English-speaking Caribbean, others resonated strongly with the region's needs. The increased focus on young people and the provision of contraceptive information within a larger SRH framework were more palatable than contraception alone for those in the largely conservative English-speaking Caribbean and Haiti. The inclusion of men in the sexual/reproductive health and family planning dialogue was also of great interest in the English-speaking Caribbean and meshed well with general efforts to increase male responsibility for their children.

Ironically, despite the paradigm shift that occurred in Cairo and was reinforced in Beijing, international family planning dropped off the global health agenda as a priority area for investment starting in the late 1990s and continuing through 2010.[14] Birthrates had begun to fall,

[14] Since then, three international family planning conferences have been held – in Uganda, Senegal, and Ethiopia; in addition, the FP2020 Summit in July 2012 has given new impetus to the international FP movement.

and many policymakers interpreted the decline to mean that the population problem was resolved. In Latin America, a number of countries had achieved sufficient success in family planning that they were "graduated" from USAID funding (as explained in more detail below). Additionally, the AIDS epidemic took on far greater urgency and captured a large share of donor funding and attention. Nowhere was the diminished priority for family planning more evident than with the establishment of the Millennium Development Goals (MDGs) in the year 2000. Family planning was not included among the 10 most important goals to achieve. This was partially rectified in 2005, when "universal access to reproductive health" was added as MDG indicator 5-b in support of the larger goal of reducing maternal mortality. While this belated recognition of reproductive health and family planning was important, many governments and agencies had already prioritized work on other MDGs and found it difficult to incorporate indicator 5-b into their existing systems.

Financial and Technical Support for Family Planning in Latin America

No history of family planning in Latin America would be complete without acknowledging the role of external support to the development of robust family planning programs throughout the region. Governments in each country contributed to these programs in terms of existing MOH service delivery infrastructure and salaries of personnel, but external funding served to accelerate the introduction and expansion of FP programming throughout the LAC region.

Although multiple donors were involved, USAID was by far the largest and most engaged donor to FP programs in the region. When USAID began its international population assistance in 1965 it gave early support to Bolivia, Colombia, Mexico, and Guatemala, among others. This support took multiple forms: direct financial support to in-country programs, technical assistance across several areas critical to effective family planning programming, and commodity donations. USAID often funded multiple entities within a given country: the MOH, the IPPF MA, and other NGOs. The key informants we interviewed readily reported that the support of USAID was crucial to the creation of both private sector and government family planning programs in many countries. Unfortunately, no detailed reports exist of the exact levels of USAID funding in the LAC region over the full five decades since population assistance began in the 1960s.

Financial support from USAID influenced the development of programs in different ways at different periods of time. In the early days of family planning, it provided resources that allowed fledgling programs to experiment with modes of service delivery at a time when national governments did not yet see investment in family planning as a priority. As programs began to expand in the 1970s and 1980s, USAID funding provided the necessary resources to develop new service delivery models (e.g., CBD, social marketing) and to expand the reach of programs, especially into rural areas. For the two decades leading up to the Cairo Conference in 1994, most Latin American countries participated in recurring cycles of activity to further strengthen their family planning programs in the areas of training, service delivery, information systems, IEC (information, education, and communication, which later came to be known as behavior change communication or BCC), and management.

In the years following the Cairo Conference, USAID focused its assistance strategically toward the Latin American countries in greatest need, as well as in specific areas to promote

sustainability (e.g., contraceptive security). While the agency did not initially adopt the SRH language that became widely used post-Cairo, there were various ways in which USAID adapted to the shifting paradigm in the region and supported local MOHs as they implemented the ICPD Program of Action and the Beijing Declaration. USAID assisted governments in strengthening their ability to provide SRH services by supporting efforts for reaching the poorest of the poor, promoting BCC, and developing technical guidelines.

While IPPF did not contribute at the same financial level as USAID, the influence of its investments and ongoing support is apparent in the strength of private sector programs in many countries. IPPF's core support to its member associations (primarily via donations from European, Japanese, and Australian governments) provided unrestricted funding needed to keep operations functioning as USAID's support for most MAs' services declined during the decade of the 2000s. IPPF originally funded most, if not all, of the budgets for the IPPF member associations; however, this financial contribution waned, and by the 2000s many larger MAs were sustainable, in part due to USAID's capacity building efforts.

Today all of IPPF's Latin American MAs have achieved sustainability with relatively low levels of external funding. (Only two MAs – Argentina and Uruguay – did not survive to the present, and their demise had both internal and external causes.) This was accomplished most easily in countries where the MA generates income through user fees and government contracts for service provision activities. The small MAs of the Caribbean remain much more dependent on IPPF funding, and most have shown relatively less growth than those in Latin America. USAID support in strengthening managerial and technical capabilities through IPPF/Western Hemisphere Region (IPPF/WHR) and a variety of other mechanisms was critical to achieving sustainable programs for most MAs in the region.

While complete data on funding levels is not available, information for specific years reflects the sharp reduction in funding for LAC as a percentage of USAID support for FP worldwide: 30 percent as of the 1960s, 28 percent by 1996, but only 6 percent in 2012 (Radloff, 2013). Over time, the governments of LAC countries have assumed greater responsibility for the financing of family planning. As of late 2013, only three countries in the region – Guatemala, Honduras, and Haiti – still met the criteria for receiving assistance from the USAID Office of Population and Reproductive Health (PRH) in support of family planning. Yet, as many key informants for this report emphasized, the external assistance from USAID to family planning programs in the early years and in subsequent periods of expansion proved critical to the results obtained in a 50-year period. Unquestionably, such support was a catalytic force in the development of programs that contributed to the current high levels of CPR in the LAC region. Highlights of the family planning movement in LAC are listed in table 3.

Table 3: Highlights of the Family Planning Movement in Latin America by Decade (1960s to 1980s)

1960s	1970s	1980s
Approximately 10 percent of MWRA are using a contraceptive method.	The **1973 Helms Amendment** prohibits the use of U.S. government funding for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.	Programs increasingly promote long-acting and permanent methods.
In 1960 the **contraceptive pill is approved** for use in the United States and it became available in Latin America.	In **1973 Mexico reverses its pronatalist policy** and adopts a population policy that advocates family planning and begins public-sector programs (Guzman, Snow & Aitken, 1997).	The U.S. government's **Mexico City Policy (1984)** prohibits awarding USAID money to any non-U.S. NGO that performs or actively promotes abortion as a method of family planning. IPPF/WHR and MAs sign the Mexico City Policy as they did not do any abortion-related work in the 1980s.
Local researchers initiate isolated efforts to study and test new contraceptive technologies (e.g., oral contraceptives and IUDs)	The **1974 ICPD in Bucharest** spurs conflict between the U.S. and other Western nations on one hand and the governments of developing countries on the other, who believe "development is the best contraceptive."	FP services expand rapidly in most LAC countries.
IPPF systematically visits countries throughout Latin America to encourage gynecologists and others to form FP associations.	Community-based distribution of contraceptives begins in Colombia and Mexico.	USAID increases support to natural family planning activities.
NGOs in multiple countries began to provide services, generally in the capital cities.	Social marketing of contraceptives begins in Colombia, Jamaica, El Salvador, and Mexico.	USAID initiates its **Policy Determination 3** regarding voluntary, informed acceptance of surgical contraception in order to ensure voluntarism.
USAID's population assistance activities begin in 1965.	USAID remains the leading FP donor in the region and the world.	USAID remains the leading FP donor in the region, but phases out Panama (1988) from FP assistance.
FP is integrated into MCH services in some countries.		
By the end of the decade, IPPF has 16 MAs in the region.		

Table 4: Highlights of the Family Planning Movement in Latin America by Decade (1990s to 2014)

1990s	2000 to 2014
IPPF MAs begin efforts to increase sustainability under the **Transition Project** funded by the USAID Office of PRH (1992-97)	FP programs throughout the region experience financial constraints (decreasing external funding coupled with increasing demand for services)
The **Mexico City Policy is rescinded** by the Clinton administration in 1992.	Contraceptive security emerges as a pressing issue.
The **1994 ICPD in Cairo** establishes a new rights-based paradigm.	The MDGs initially omit family planning as a central goal or indicator, but in 2005 include "universal access to reproductive health" as a means of decreasing maternal mortality.
The **1995 International Conference on Women** held in Beijing further supports the new paradigm.	The **Paris Declaration on Aid Effectiveness** and the **Accra Agenda for Action** signal donor commitment to strengthening government and intersectoral work.
Many countries in the region promote a new focus on the related issues of SRH rights, women's rights, human rights, choice and client-centered services.	The **Mexico City Policy is reinstated** by President Bush in 2001. IPPF/WHR opts not to sign and loses USAID funding. IPPF MAs in the region still receiving USAID funds sign the Mexico City Policy and are able to retain funding.
The **FDA approves use of Depo-Provera** as a contraceptive method in 1992 and it becomes available in USAID-supported FP programs in LAC through commodity donations.	USAID transitions away from contraceptive donations and phases out three more countries: Mexico, Brazil, and Ecuador.
The U.S. Congress establishes the **Tiahrt amendment in 1998** pertaining to the use of targets, quotas, and incentives, as well as the provision of comprehensible information, in USAID-supported FP service delivery projects.	USAID develops a graduation strategy based on measurable criteria and develops FP graduation plans and graduation dates for the Dominican Republic, El Salvador, Honduras, Jamaica, Nicaragua, and Paraguay.
While remaining the largest FP donor in the region, USAID phases out three LAC countries from FP assistance: Costa Rica, Chile, and Colombia.	USAID focuses on ensuring contraceptive security and sustainable FP programs.
	In response to USAID phase-out of funding, UNFPA increases its role in assisting governments in the region with their contraceptive procurement, increasingly using the countries' own funds.
	HIV programming commands greater donor funding than FP.
	USAID remains very active in monitoring compliance with the Tiahrt, Helms, and other amendments.
	Groups opposed to family planning focus attention efforts on EC.
	As of 2013, 67 percent of MWRA in the LAC region use modern contraception.
	USAID remains the leading FP donor in the developing world.

VI. TEN KEY FACTORS THAT INFLUENCED FP ACHIEVEMENTS IN THE LAC REGION

Family planning programs in the LAC region experienced many setbacks and roadblocks, yet 50 years of persistence in pursuing the goal of increased access to contraception has resulted in high levels of contraceptive prevalence in most countries in the region. An in-depth review of the LAC experience by the authors of this report yielded 10 factors that have contributed to the positive achievements in family planning in the LAC region.

1. The Development of Strong NGOs that Pioneered the Family Planning Movement and Continue to Tackle Politically Sensitive Issues

Without exception, every Latin American country that has a high contraceptive prevalence today boasts of one or more pioneers that blazed the trail in the early days of family planning, often from positions of leadership within NGOs (Robinson & Ross, 2007). This report cannot do justice to all individuals who played leadership roles in all countries; rather, we take the cases of Colombia, Mexico, and Jamaica as illustrative of this leadership.

In Colombia, the pioneering efforts for family planning were spearheaded by a group of medical doctors who had seen first-hand the devastating consequences of unintended pregnancy, especially among the poor (Bejarano, 2009). These individuals assumed positions of leadership from which they promoted the expansion of contraceptive services throughout the country. ASCOFAME (Asociación Colombiana de Facultades de Medicina), the local association of medical schools, developed a series of training programs designed to prepare clinical personnel for the delivery of family planning services. Profamilia systematically rolled out clinical services and community outreach, pioneering efforts which were then spread throughout Colombia and beyond. Research centers in Colombia conducted and disseminated the evidence needed to support these programs. Despite the powerful influence of the Roman Catholic Church, as well as other groups opposing family planning on political grounds, the leadership forged ahead in the face of these seemingly insurmountable obstacles.

The case of Mexico also demonstrates the benefit of visionary leadership with competent technical follow-through. Founded in 1965, the Fundación para los Estudios de Población (Foundation for Population Studies) conducted research on contraceptive use and piloted family planning programs (Reartes & Freyermuth, 2011). There were also significant philanthropic initiatives, such as one that created FEMAP, which allowed for the opening of an FP clinic in the border city of Juarez, Mexico. Reports from USAID representatives in the country suggest that such initiatives were crucial to the expansion of family planning, especially in the 1970s when there was no USAID office in Mexico.

In Jamaica, the Beth Jacobs Family Planning Clinic was opened in 1953 by pioneers who had been involved in the "birth control movement" since the 1930s. This family-run organization became an IPPF member association in 1957 and was a strong advocate for family planning. The

Jacobs family was instrumental in convincing the government to establish a family planning unit in 1966 (one of the earliest in the region to do so) (King et al., 2007).

USAID has supported numerous countries in the developing world that have launched successful family planning programs based largely on government efforts (e.g., Indonesia, Morocco, and Botswana). In contrast, the family planning movement in the LAC region benefited primarily from the strong leadership of NGOs. Primary among them was the network of IPPF MAs. In most LAC countries, the IPPF MAs established the first family planning services and went on to develop innovative strategies for reaching the populations in need of their services. In fact, IPPF MAs are household names in many countries: APROFAM (Asociación Pro Bienestar de la Familia) in Guatemala; ASHONPLAFA (Asociación Hondureña de Planificación Familiar) in Honduras; APLAFA (Asociación Panameña para el Planeamiento de la Familia) in Panama; APROFE (Asociación Pro Bienestar de la Familia Ecuatoriana) in Ecuador; Asociación Demográfica Salvadoreña (ADS) in El Salvador, BEMFAM (Bem-estar Familiar do Brasil) in Brazil, CIES (Centro de Investigación, Educación y Servicios) in Bolivia; MEXFAM in Mexico; Profamilia in Colombia, the Dominican Republic, and Nicaragua; ADC (Asociación Demográfica Costarricense) in Costa Rica; INPPARES in Peru; FPA-Barbados; and FAMPLAN (Family Planning Association) in Jamaica.

In Peru, the Asociación Peruana de Planificación Familiar (AAPF), established in 1966, was shut down in 1972 by the incoming military dictatorship which was vehemently opposed to family planning. Nevertheless, within a period of four short years, the same administration recognized the benefit of family planning and developed a national population policy that included family planning, leading to the reformation of the private family planning organization that became INPPARES, the IPPF member association.

In addition, extremely effective NGOs that were not IPPF member associations also emerged to play an important role in the region. CEMOPLAF opened its doors in 1974 and has become a major source of innovation and service for Ecuador, especially for indigenous populations. FEMAP in Ciudad Juarez, Mexico, serves thousands of Mexican women living along the border with the U.S. and has experimented with numerous forward-looking strategies for youth. ALAS (Wings) in Guatemala has expanded service provision in the highland Mayan communities, including services for youth and men. More specialized NGOs dealing with adolescent SRH have provided valuable educational and clinical services and important models, such as the Center for Orientation of Adolescents (Centro de Orientación para Adolescentes or CORA) in Mexico. Guatemala's Association for Sex Education (Asociación Guatemalteca de Educación Sexual or AGES) has promoted sexual education and family life education for indigenous adolescents, despite resistance from local authorities. In Nicaragua, the NGO Puntos de Encuentro (literally translated as "meeting points") has produced multi-media programming, including popular soap operas that tackled adolescent sexuality and other taboo subjects such as homosexuality and domestic violence.

In recent decades, other NGOs have specialized in social marketing for reproductive health. USAID has supported a number of social marketing programs in the region; PROSALUD in Bolivia, PASMO in Central America, APROPO (Apoyo de Programas de Población) in Peru, PROMESA (Promoción y Mejoramiento de la Salud) in Paraguay, and several of the IPPF MAs

have become important sources of contraceptive and MCH services for the lower-middle income populations.

The role of NGOs has differed from one country to another. In some countries they paved the way for governments to play a greater role and eventually take over family planning service delivery (e.g., in Brazil, Colombia, Ecuador, Haiti, Honduras, Mexico, Nicaragua, Panama, Peru, and most of the Caribbean). In other countries, they represented a major source of contraceptive services for at least two decades before government became fully engaged (e.g., Guatemala and Bolivia). Bolivia's CIES was pivotal in winning over local labor unions to support family planning. The NGOs in the region frequently served as centers for innovation and training for governments.

Being associated with family planning was not without risk. Dr. Rosa Cisneros, a lawyer who took over as executive director of the IPPF MA in El Salvador in 1981, was murdered within two years for causes that have never been satisfactorily established. Her replacement received death threats that caused him to seek exile outside the country. IPPF executive directors in Guatemala and Nicaragua also received threats in the mid-1980s because they continued to promote family planning, and in 1984, the Argentinian FPA was bombed by anti-family planning extremists (IPPF, n.d.a).

As family planning became a widely accepted social norm throughout most of the LAC region, the IPPF MAs and other NGOs turned their energy to new challenges related to sexual and reproductive rights. During the 1980s, these organizations began to support programs to reduce adolescent fertility, also a highly controversial topic in socially conservative countries. In the post-Cairo period, NGOs throughout the region became more involved in such areas as advocacy for comprehensive sexuality education for young people including access to EC, HIV prevention and treatment, abortion, and LGBT (lesbian, gay, bi-sexual and transgender) rights. There has been a notable move towards more progressive policies in all of these areas. Gay marriage has been legalized in Argentina, Uruguay, and Mexico City; abortion has been de-criminalized in Mexico City, Guyana, and Uruguay; and access to EC is becoming more widespread throughout the region, although it is still controversial in many countries and banned in Honduras (CLAE, n.d.).

In 2002, IPPF refused to accept the Mexico City Policy conditions and directed its MAs around the world not to sign the Mexico City clauses. In spite of this, many MAs in LAC retained their USAID funding during the years the Mexico City Policy was in place (2001-2009), due to the specifics of their agreements with USAID. Thus, IPPF's rejection of the Mexico City Policy and subsequent severing of funding relationships with USAID by IPPF/WHR did not have a direct and immediate effect on the funding received by MAs.

Paradoxically, the rejection of U.S. funding did open the way for the IPPF/WHR to become more involved in reproductive rights advocacy and abortion-related activities with funding from private foundations and European governments. While in 2001 only three of the 44 IPPF MAs in the LAC region were working on any programs related to abortion, by 2012 all had pro-choice policies in place and approximately 20 were actively engaged in some abortion-related activities (although most Latin American and Caribbean MAs do not provide abortion services due to the

highly-restrictive legal environments in their countries) (IPPF, n.d.b). As noted above, USAID had no involvement in supporting abortion programs in this area.

From the 1960s to the 1980s, women's groups in Latin America – often forged from leftist movements inimical to population control – were highly suspicious of the family planning movement (Weaver, 1978; Safa, 1990). They focused on economic and social determinants of gender inequalities and often did not include reproductive rights within their mission. This changed markedly in the post-ICPD-Cairo and ICW-Beijing period, as the feminist movement in Latin America became more concerned with reproductive health and rights.[15] Some USAID country missions began to support these new actors with projects such as the Reprosalud project in Peru, which worked with partners from the women's movement and MOH to provide family planning and other reproductive health services within a framework of women's economic and social empowerment (Ferrando, Serrano & Pure, 2002). In the post-ICPD-Cairo period, feminist NGOs began to play an important role in advocating for sexual and reproductive rights and for access to information and services for the most vulnerable. Coalitions of women's NGOs and reproductive health organizations in many countries (Colombia, Guatemala, Dominican Republic, El Salvador, Mexico, Nicaragua, Paraguay, and Peru) have worked together to make important gains in reproductive , in spite of a strong and organized opposition.

2. *The Macro Socio-Political Environment that Gradually Supported Family Planning and Increasingly Progressive Policy Frameworks*

The macro socio-political environment encompasses both institutions and systems (economic, legal, political, educational, and social) that have a major impact on the ultimate effectiveness of public health programs, including family planning. Although socio-political conditions differed by country, improvements in the standard of living have combined with effective family planning programming to reduce fertility and establish family planning as a social and community norm.

Political environments and legal systems in most countries throughout the LAC region have gradually evolved to favor family planning. Latin America was spared the colonial legacy of legislation barring family planning, such as the French law of 1920 that remains on the books in some Francophone African countries (Turshen, 2010). Throughout most of the period in question, reproductive health issues were either not addressed in local constitutions or legislation, or the legislation was generally neutral to favorable. In the past two decades many countries have recognized reproductive health as a fundamental human right in the Constitution itself or by specific laws or policies that ensure access to reproductive health. Moreover, access to modern contraception is promoted as a key strategy in reducing maternal mortality and adolescent pregnancy. Many countries have fully taken over procurement of contraceptive supplies and have introduced a specific line item into the national budget for their purchase (table 5). Less successful have been initiatives to work with the Ministries of Education to introduce sexual education into the curriculum of school-aged children and adolescents, although there are some promising signs of change. In 2013, the governments of the region signed the

[15] Carmen Barroso, regional director IPPF, personal communication, 2013.

Montevideo Consensus on Health and Population which included a commitment to comprehensive, rights-based sexuality education for young people, as well as the provision of SRH services, including modern contraceptive methods for adolescents (CEPAL, 2013). Furthermore, an 11-nation Regional Community of Practice on Sexuality Education has been formed to follow up on the 2008 Ministerial Declaration Education for Prevention (UNESCO, 2013).

Table 5: Public Sector Financing of Contraceptives in Selected Latin American and Caribbean Countries

Country	Year Public Sector Financing Began	Current Acquisition Mechanism
Bolivia	2005	Purchases at the municipal level in the local market
Colombia	N/A	Purchases centrally on the local and international markets
Dominican Republic	2004	Purchases through UNFPA
El Salvador	2002	Purchases through UNFPA
Guatemala	2002	Purchases through UNFPA
Honduras	2005	Purchases centrally but has received some donated commodities from UNFPA and UNDP in recent years
Haiti	N/A	Receives donated commodities from USAID and others
Mexico	1999	Federal Health Secretariat purchases centrally from local and international markets and local Health Secretariats purchase locally
Nicaragua	2007	Purchases through UNFPA
Paraguay	2007	Purchases through UNFPA
Peru	1999	Purchases locally and internationally

The influence of religion on family planning in the region has differed by time period and by country. The Roman Catholic Church in particular has been engaged and influential on family planning issues in the region. The Vatican has not wavered in its unequivocal stance against the use of modern contraceptive methods, which has caused many Catholics around the world to struggle with reconciling the teachings of the Church with their desire to space and/or limit child bearing (Catholic Answers, 2004). In almost every country in Latin America, the creation and expansion of FP programs in the 1960s and 1970s met with resistance from the Catholic Church. Yet as governments integrated FP into MCH programs and contraceptive use became a social norm, opposition tended to subside (with occasional skirmishes lasting into the 1980s, 1990s, and even to the present day in selected countries) (Profamilia, 2012). The Catholic Church continues to oppose EC and sex education in selected countries and has remained vocal in its opposition to abortion (Faúndes, Tavara, Brache & Alvarez, 2007; Martin, 2004). However, the high levels of modern contraceptive use in Latin American countries whose populations are predominantly Catholic indicate that, in the long run, the Roman Catholic Church has not substantially impeded the development of family planning programs or contraceptive uptake throughout Latin America (with the exception of a few isolated cases).

In Guatemala, the close alliance between the government and the Roman Catholic Church on the issue of family planning significantly stymied progress for over three decades, from the mid-1960s through 2000, and continued to play a role in decision making related to contraception. Members of Opus Dei, a powerful conservative arm of the Catholic Church, strongly influenced the government on the issue of FP and were successful in blocking the expansion of governmental FP programming. Similarly, the Catholic Church attempted to block progressive legislation related to contraception and reproductive health, most notably by pushing for laws that protect the embryo from the moment of conception. In particular, their principal rationale for opposing the IUD and EC was the argument that these methods are abortifacients, a belief which a World Health Organization scientific panel concluded is unfounded (WHO, 2012).

Multiple incidents illustrate the influence of the Catholic Church on FP programming in Guatemala over several decades. In 1979, under pressure from the Catholic Church, the government decreed that all women using an IUD had to return to a health facility to have it removed. During the 1980s, the Catholic Church and its political allies tried to close down operations of APROFAM, the IPPF MA. In 1986, the Catholic Church accused the government of Guatemala of conducting a mass sterilization program without the knowledge of clients. The archbishop called on President Reagan to discontinue U.S. government FP assistance to Guatemala. A U.S. government commission headed by the director of the USAID Office of Population traveled to Guatemala to investigate the case and concluded that such accusations were untrue (Santiso-Gálvez & Bertrand, 2004). In 1994, after months of preparation among technical agencies prepared to support family planning at ICPD, the president of Guatemala directed the Guatemalan delegation to vote in line with the Vatican (one of the few LAC countries to do so).

In 2000, the political climate for FP in Guatemala improved with the inauguration of the President Alfonso Portillo, who openly supported FP. The ongoing conflict that existed for more than three decades between the Catholic Church and organized FP diminished, in part in response to the strong advocacy efforts by civil society in favor of family planning and reproductive health (FP/RH). This change in position is reflected in the most recent DHS survey results, showing that the majority of contraceptive users obtain their methods from a government facility. Currently, groups from civil society have created the Observatorio de Salud Reproductiva (OSAR, Reproductive Health Observatory) that monitors government actions and holds the government accountable to its commitments on FP/RH. (See Guatemala case study for further details.) Yet government neglect of family planning prior to the year 2000 unquestionably took its toll on family planning achievement in Guatemala, the country with the second lowest contraceptive prevalence in Latin America. According to observers, changes in the Roman Catholic Church initiated by Pope Francis are seen with optimism by progressive sectors, yet with apprehension from the most conservative groups (e.g., Opus Dei), which continue to organize demonstrations against abortion and sexual education in schools.

Peru also experienced sustained opposition to family planning by the Catholic Church that peaked between 2001 and 2003. In the late 1990s, the Fujimori government undertook an overzealous sterilization campaign which resulted in documented human rights violations (Defensoria del Pueblo, 2006). In efforts to distance itself from the excesses of the Fujimori years, the subsequent government aligned itself with the Catholic Church by taking a hard line

against FP. Two successive ministers of health with strong ties to the Roman Catholic Church attempted to significantly curtail the FP program by refusing to purchase contraceptives, eliminating training programs and declaring EC to be an abortifacient. During this period the Peruvian MOH restructured, as part of decentralization efforts, relegating FP and SRH to a much less prominent place within the Ministry and eliminating most of the staff previously dedicated to the FP program. The Catholic Church in Peru continues to work against access to contraceptives at both the national and local levels. The current Archbishop of Lima is a member of the Opus Dei and highly involved in politics; he is a staunch and active opponent of FP. In contrast to some priests in other countries who turn a blind eye to condoms for disease prevention, the Archbishop of Lima actively opposes condom distribution. According to knowledgeable sources interviewed, Opus Dei continues to exercise influence in political matters through the media. At the local level, Roman Catholic prelates attempt to pressure local MOH staff not to promote contraception. Regardless of the opposition, attempts to pass regulations limiting access to family planning, especially EC, have not been successful in recent years.

3. Sustained Financial and Technical Assistance from USAID and Other Donors

Sustained external support in the form of financial and technical assistance played a crucial role in converting commitment from visionary leaders into actual programming of activities that reached potential family planning users. The high level of external donor support over four decades starting in the 1960s contributed significantly to the family planning achievements of the LAC region today. Although several bilateral and multilateral agencies funded family planning in the region, USAID was by far the largest contributor. In the years leading up to 1996, approximately 30 percent of total USAID FP/RH assistance worldwide went to the LAC region. US FP/RH assistance increased steadily throughout this period, peaking in 1995 (Radloff, 2013).

In addition to its financial contribution, USAID also provided technical assistance across different functional areas of FP programming. Through its CAs, USAID has helped governments, NGOs, universities, and other local organizations build technical capacity in multiple areas that have been essential for sustainable, quality FP services and commodities procurement. Illustrative examples include the following:

- In the area of service delivery, JHPIEGO (an affiliate of Johns Hopkins University) trained clinicians in IUD insertions and in surgical procedures for performing female and male sterilization.
- EngenderHealth (originally Association for Voluntary Sterilization or AVS, then Association for Voluntary Surgical Contraception or AVSC) had two sub-regional offices and worked extensively in training in clinical methods, monitoring quality, and evaluation of services related to long-acting reversible and permanent methods.
- Development Associates had a major contract to collaborate with public and private sector organizations to train clinical staff and community personnel in FP service delivery.
- The University of Chicago (in the 1970s) and the Center for Communication Programs at Johns Hopkins (in later years) worked with governments and NGOs throughout the region to design, test, and implement IEC interventions to support healthy changes in individual behaviors and social norms (Robinson & Ross, 2007).

- Pathfinder International was active in diverse areas of programmatic support across multiple countries: service delivery, curriculum development training, logistics, and contraceptive supply.
- Juarez & Associates provided instruction largely in social marketing, management, and administration.
- The Division of Reproductive Health of the U.S. Centers for Disease Control and Prevention (CDC) delivered technical assistance throughout the region in designing and conducting Contraceptive Prevalence Surveys (later renamed Reproductive Health Surveys), routine health information systems, and client flow analysis.
- ICF International (known in different periods as Macro International, Macro ICF, and ORC Macro) played a critical role in providing technical assistance for the conduct of DHS surveys and information system strengthening that often accompanies them.
- The Population Council's INOPAL project, as well as other efforts launched from their offices, provided OR around many aspects of service delivery, counseling, client ability and willingness to pay for services, as well as a variety of other issues.
- Management Sciences for Health (MSH) collaborated with government and NGOs in strengthening managerial capacity and health information systems and developing plans for sustainability.
- John Snow, Inc. (JSI) has been involved since the late 1990s in strengthening procurement and logistics management systems for contraceptive and reproductive health commodities, which was an essential preparatory step for graduation from USAID funding. JSI has also purchased contraceptives for distribution through USAID FP programs in LAC and worldwide.
- Futures Group pioneered the use of the RAPID (Resources for the Awareness of Population Impacts on Development) methodology, an innovative tool that used then high-tech visual presentations of demographic data and the effects of population growth on other sectors to conduct data-driven advocacy among donors and policymakers. It has also worked in social marketing, market segmentation, policy, and advocacy around issues of reproductive health supplies.
- Population Services International (PSI) has been active in the region with widespread social marketing programs, most recently through its regional affiliate, PASMO.
- CARE pioneered innovative family planning services integrated with both child survival and grassroots community development in several countries in the region.
- Abt Associates has worked with both the private sector (to improve performance and build sustainable markets for contraceptive products) and governments (to institute health reforms favorable to FP and improve financial planning, budgeting, and information use by the health sector).

While this brief description does not capture all the USAID-funded CAs that contributed to building technical capacity in the region, it reflects the wide range of "in the trenches" assistance sponsored by USAID over multiple decades.

It is also important to highlight the role that USAID played as the major provider of contraceptive supplies in the region from the late 1960s through the years 2000 (and still in Haiti). In the early days of USAID population assistance, the director of the Office of Population, Dr. Reinhardt Ravenholt, strongly believed that ready and reliable access to contraception was a

major factor in FP uptake. Under his leadership USAID provided large quantities of a variety of contraceptives to countries throughout the LAC region. From the early 1970s to the mid-1990s, national governments and NGOs worked under the assumption that USAID would continue to provide the required quantities of contraceptives to meet the needs of recipient countries, as long as they were approved by the FDA (Solo, 2011). The term "contraceptive security" had yet to be coined, because many countries assumed that USAID and others would continue to provide contraceptive supplies for the indefinite future. When Depo-Provera became available and was approved by the British regulatory agency in 1974 but not the FDA in the U.S., IPPF stepped in to provide this method to countries until its approval by the FDA in 1992 (FPA, 2010).

The second source of financial and technical support to the region, starting in the 1960s, was IPPF. IPPF began to accept local family planning organizations as members in the late 1960s and early 1970s, and was often the sole or major funder of the local MAs during the startup phase. IPPF's financing included significant USAID unrestricted support, as well as other unrestricted bilateral support from some European countries and Japan. Much of this central funding went to the MAs in the form of core support that they could use to grow their programs. Starting in the 1970s, USAID began funding an increasing portion of the rapidly growing budgets of the MAs throughout the region, either through IPPF or other CAs or directly to the member associations. Until 2001, a large portion of IPPF funding went to support programs in Colombia.[16] More recently, IPPF has been the primary source of funding for its member associations in the Caribbean. Today, the larger Latin American MAs are supported primarily through user fees and contracts with their own governments.[17]

Like USAID, IPPF also provided technical support to the region through its MAs. It contributed to building the technical capacity of these associations in governance, management and leadership, sustainability, financial administration, supply chain logistics, evaluation and information systems. In the 1980s, IPPF's MAs provided support for work in adolescent programming, HIV/AIDS, and improving access to and the quality of service delivery. During this era, IPPF's member associations were sometimes the first organizations in their respective countries to have computerized information systems. However, in the 1990s both USAID and IPPF signaled the impending end to this extensive financial and technical support and began to plan for reduced investments in the region. USAID funded these efforts through the Transition Project, directed by IPPF/WHR from 1992 to 1997. This initiative was designed to assist selected MAs (in Colombia, the Dominican Republic, Guatemala, Jamaica, Mexico, Peru, and Trinidad and Tobago) to become more self-sustaining. Technical assistance focused on sustainability, including cost recovery, marketing of services, and expansion to new services. The project made important achievements in strengthening the capacity of the MAs to assess costs, improve financial administration and implement modern marketing practices (IPPF/WHR, 1997). Those leading the effort realized early on that high-quality services were essential in order to maximize service utilization and income, and they made important advances in quality assurance. The MAs experimented with diversification of their services with varying degrees of success, most coming to a realization that expanding core business and related health-care business (e.g., pediatrics, maternal health including deliveries, diagnostics, fertility assistance and pharmacies) was more

[16] Hernan Sanhueza, former IPPF/WHR regional director, personal communication, 2013.
[17] Felipe Leonardo, IPPF senior finance adviser, personal communication, 2014.

effective than non-health related new businesses. Although not all objectives had been met by the end of the Transition Project, the MAs who participated had greatly strengthened their organizational capacities. While the predicted end of USAID funding did not occur in all cases at that time (as described below), many MAs experienced a decline in funding available for general operating costs and service provision. USAID continued to provide support for specific projects and technical assistance to some of these MAs through various centrally-funded projects in the early 2000s. In addition, some MAs were funded from other sources (e.g., HIV). Profamilia in Colombia received Democracy and Governance funding from 1999 to 2011 for an initiative to provide FP/RH services to displaced populations.

Despite dwindling donor funds after 1999, most of the MAs participating in the Transition Project and other larger MAs continued to grow and expand coverage throughout the 2000s. For most, this meant a shift away from the most disadvantaged to serving lower and middle class clients who could pay for services. Countries used a range of strategies to become more self-supporting. However, MAs in Brazil and Colombia were able to negotiate remunerated contracts with various levels of governments to provide services to poorer sectors of the population. In Brazil, numerous contracts with local municipalities enabled BEMFAM to serve some of the most disadvantaged people in their country for over two decades. One of the major factors contributing to the success of Brazil's and Colombia's MAs was the extensive investment in institutional strengthening made by USAID in the 1990s. These investments positioned BEMFAM and Profamilia/Colombia to advocate successfully for the inclusion of contraception as an essential medicine and to have the administrative and managerial capacity to take on large government contracts at the very beginning of the health sector reform process in those countries. Many other MAs in the LAC region have attempted to replicate these models, but have had limited success in developing extensive public-private partnerships.

The Transition Project also had a profound effect on IPPF/WHR at the regional level beyond the participating countries. By the end of the project, the concept of sustainability was firmly ingrained in the organizational culture of the IPPF. Member associations were required to make sustainability plans and were strongly encouraged to build on the lessons of the Transition Project, due to decreases in funding both from USAID and IPPF centrally. By the mid-2000s, the larger MAs in the region were mostly self-sustaining. As of 2005, IPPF/WHR covered only about 7 percent of the annual budget of the LAC MAs.[18] The IPPF MAs in the LAC region became models for the IPPF globally, and USAID funded a sustainability project at the IPPF Central Office in London to work with member associations in other regions.

As countries became more self-sufficient in the basic delivery of services, USAID extended its capacity building activities to additional areas, which helped national governments and specific NGOs to develop expertise in specialized domains of FP. Later in this section (factor 10 on contraceptive security), USAID-funded efforts to develop and strengthen contraceptive logistics systems in multiple countries of the region are described. USAID also provided support for countries to develop local capacity for conducting DHS surveys, including a continuous DHS survey in Peru (Choi, Lucas, Short, Sarpal & Adetunji, 2011). In Honduras, the MOH received assistance from a local technical group to build capacity and professionalism of their

[18] Felipe Leonardo, IPPF senior finance adviser, personal communication, 2014.

communications team in processes including the design, contracting, and technical oversight of communication campaigns and products to promote health, including FP.

As countries made encouraging progress toward lower fertility rates and increased contraceptive use, USAID began to withdraw its population funding. This occurred outside of LAC in South Korea (around 1976), Tunisia (1990), Thailand (1993), and Botswana (1995). Beginning in the late 1980s, USAID also began to phase out Latin American countries from financial assistance for FP and closed several programs: Panama (1988), Costa Rica (1996), Colombia (1997), Mexico (2000), Brazil (2000), and Ecuador (2001). Beginning in 2004, USAID established a task force to formalize the graduation process. The main drivers of USAID's decision to phase out FP funding in most of the LAC region over the following decade were:

- countries met or approached key indicators of success in family-planning (TFR, CPR, and an equitable distribution of contraceptive use across subgroups including rural and indigenous populations);
- in selected countries the economic situation was improving markedly, meaning that more domestic resources were, in theory, available for health programs;
- there was a relatively much higher need for FP assistance in other parts of the world; and
- the annual ceilings on the Congressionally appropriated FP funding available to USAID for FP programming forced hard choices.[19]

The task force developed criteria for graduation and guidelines for systematically preparing countries for this eventuality (Bertrand, 2011; Cromer, Pandit, Robertson & Niewijk, 2004). The criteria have changed slightly in the years since they were established; the current criteria indicating likely graduation include: (1) a total fertility rate that has declined to 3.0 or less; (2) a modern contraceptive prevalence rate of at least 50 percent for MWRA; and (3) access to family planning that is fairly equitable throughout the country and by income groups. Additional LAC countries that have "graduated" from USAID funding under this formalized process are: Jamaica (2008), the Dominican Republic (2009), El Salvador (2010), Paraguay (2010), Nicaragua (2011), Peru (2012), and Honduras (2013).[20]

UNFPA, established in 1969, has also played an important role in family planning in Latin America. As part of the United Nations system, the role of UNFPA was and still is to support government initiatives. Initially, UNFPA tended to focus on research including national census, development of educational materials, support for MOH participation in conferences and meetings, and the development of guidelines and protocols. Post-ICPD support of programs is designed to integrate gender components into reproductive health programming and work on safe

[19] The issue of "when and how" to graduate countries from USAID assistance was the matter of considerable debate. Some argued that continuing to provide external aid to middle income countries could have the effect of weakening internal political demands on governments to provide the services their citizens needed and wanted. Others argued that, phasing out of assistance is the ultimate goal of development, but it should be managed more gradually in many cases. This experience has highlighted the need for assistance agencies to develop better models for transitioning countries that have depended on foreign aid to support complex service delivery systems (e.g. those required for national FP programs).

[20] The dates noted are the last year of USAID's FP funding in that country; however, the close-out programming typically continues for at least one additional year.

motherhood and youth programming. Furthermore, UNFPA has provided technical support in the region through a variety of implementing partners at the regional and country levels.

Although UNFPA's investments were smaller than those of USAID, in some countries UNFPA has been an important actor. For example, UNFPA has traditionally supported research through CEPAL (Comisión Económica para América Latina y el Caribe, also known as ECLAC or Economic Commission for Latin America and the Caribbean) and CELADE (Centro Latinoamericano y Caribeño de Demografía or Latin American and Caribbean Center for Demography) as well as other regional and local research organizations. In addition, UNFPA has donated contraceptives over the years to numerous countries in the region. In 1996, UNFPA established the Global Contraceptive Commodities Program to assist countries in procuring contraceptives on the international market at favorable prices. This program was later renamed the Global Programme to Enhance Reproductive Health Commodity Security. As USAID reduced its support to contraceptive procurement and initiated the process of graduating countries from its assistance, the role of UNFPA in procuring contraceptives took on greater importance. For example, in 2009, the government of Honduras had committed to procuring its own contraceptives; however, in the wake of the coup that same year, the administration focused on other more urgent priorities. UNFPA donated $1 million for contraceptive commodities to cover the shortfall. In other countries that do not have established systems for procuring contraceptives locally or on the international market, UNFPA has been able to assist by negotiating with major international producers at a more favorable rate than individual countries could get on their own. In recent years, UNFPA has been involved in high level advocacy; it has organized post-ICPD conferences and activities related to monitoring MDGs 4 and 5.

The LAC region has also benefited from external support from other multi-lateral and bilateral donors. World Bank and Inter-American Development Bank (IDB) loans have funded family planning, often very indirectly through health systems-strengthening and under the rubric of reducing maternal mortality. The Japanese government was an active donor through the Japanese International Cooperation Agency (JICA) and Japanese Organization for International Cooperation in Family Planning (JOICFP). Both the British Department for International Development (DFID) and Gesellschaft für Technische Zusammenarbeit (GTZ) of Germany (currently known as Deutsche Gesellschaft für Internationale Zusammenarbeit or GIZ) have provided funding for specific initiatives, as well as to IPPF, although they also have discontinued funding in the region. The Netherlands also provided funding for family planning in LAC during the 1990s as part of their focus on gender equity and reproductive rights. The Canadian International Development Agency continued to fund the Caribbean long after USAID had ended its FP assistance to the islands and still provides some funding there in SRH. Over the last decade, the Spanish government has provided considerable funding for sexuality education in parts of Latin America. Unfortunately, due to economic constraints in Spain, most or all of this funding is being discontinued (SEEK Development, 2012).

Private foundations have also played an important role supporting FP activities in the region, although on a necessarily smaller scale. The Ford Foundation has funded NGOs working on reproductive health, in addition to work in quality of care, adaptation to the post-Cairo agenda, and integration of gender with family planning initiatives. Most recently the foundation has also supported work on sexuality education in the region. The current focus of the Ford Foundation

on migration issues limits its funding for reproductive health to those issues related to migration. The Hewlett Foundation, Packard Foundation, MacArthur Foundation, Bergstrom Foundation, Moriah Fund, Summit Foundation, and a large anonymous donor have been other major supporters to family planning in the region.

While the sustained donor support of financial and technical assistance played a vital role in fostering the expansion of family planning throughout Latin America and the Caribbean, external assistance is a means to an end, not an arrangement that is desirable for its own sake. The ideal is for all countries to be able to provide high quality family planning services/commodities with their own resources, technical and organizational capacity, and political commitment. Indeed, Latin America has made impressive strides to this end.

4. Synergistic Coordination among Governments, External Agencies, NGOs, and Civil Society

The FP movement in LAC was firmly based in each country's own institutions and organizations from the beginning. Yet the coordination among the different entities working in FP in each country has greatly increased access to contraception and uptake of services. Although tensions and disagreements have existed between certain organizations in some countries at different periods of time, mostly governments, NGOs and civil society have worked together to deliver FP services in the region. This type of collaboration has taken multiple forms: various coordinating committees, contracting mechanisms, government coordination initiatives, contraceptive security committees, and recently, the LAC Forum of the global Reproductive Health Supplies Coalition (RHSC). Key informants throughout the region reported that a major contribution of USAID Missions was to facilitate and support the working groups, committees and other coordination mechanisms.

From the early days of family planning, USAID has attempted to ensure that governments and NGOs work together through formal contracting mechanisms. For example, USAID's first project in Guatemala consisted of a tripartite agreement among USAID, the government, and APROFAM. Elsewhere, USAID created umbrella mechanisms to channel technical assistance and resources to NGOs (e.g., PROCOSI in Bolivia and NicaSalud in Nicaragua). In addition to encouraging coordination and collaboration, these groups served to channel funds to smaller NGOs that USAID could not easily manage directly. While PROCOSI was originally only involved in child survival, the organization became thoroughly Bolivian and has expanded to cover SRH and rights.

Meanwhile, in some countries, another model for support was developed in which one local NGO provided contraceptives, technical assistance and funding to a variety of other actors in the country. For instance, in Haiti, the IPPF MA Association pour la Promotion de la Famille Haïtienne (PROFAMIL) channeled support and technical assistance to NGOs in the country from 1988 to 1999. In general, this support strategy has proven more successful when the organization channeling support has the capacity to provide assistance across both technical and managerial areas. Contracting with a larger, more administratively competent organization to channel support to smaller organizations both fosters local collaboration and partnership and enables the agency to support a more diverse set of implementing organizations. Such a practice has proven to provide greater sustainability to programs, as all of the organizations mentioned

above that were created or expanded through USAID are still functioning. In Peru, a local NGO (Prisma) was contracted by USAID to coordinate and provide technical assistance to the MOH and NGOs in the procurement of contraceptives, supply logistics and training throughout the 1990s. Prisma continues to provide logistics support related to supply chain issues for the Peruvian government as well as to other governments and organizations in the region, providing an excellent example of the lasting nature of USAID's investments in local NGO capacity-building.

Starting as early as the 1970s, many countries tried to involve local social security institutes in family planning service delivery. However, the countries where the institutes are the main providers are Mexico and Costa Rica. Countries where they operate with success are El Salvador, Paraguay, and Nicaragua (USAID | DELIVER Project, 2008).

As formal sector employment has increased in recent years, the social security administrations are beginning to play a bigger role in health care provision and consequently in contraceptive services, especially for the middle-income sectors of the population. This change in policy and practice was supported by USAID's role in advocacy and development of contraceptive security committees (disponibilidad asegurada de insumos de anticonceptivos or DAIAs) in many countries as part of the FP graduation process.

Government coordination — In many countries, the proliferation of organizations working in family planning led to efforts to coordinate their work. Various types of coordinating mechanisms were created to improve planning and to channel technical assistance and other resources appropriately. Governments took the lead in these coordinating mechanisms, which also included the major international and national NGOs. For instance, in Bolivia, a National Coordinating Committee on Reproductive Health was created in 1990. This committee developed sub-committees around services, research, training, and IEC. Each sub-committee was supported by one or more of the international contracting agencies operating in the country at the time. The committee and sub-committees were designed to ensure that efforts were planned systematically, that they were not duplicative, and that technical assistance could be channeled appropriately. Local informants described this mechanism as a key element in the success of their activities in the *época de oro* (golden age) from 1995 to 2005, when family planning activities expanded dramatically in the country. Similar coordination mechanisms were created in other countries (e.g., Peru, Nicaragua, Panama), with varying degrees of success. Although these coordinating committees were extremely helpful in the development of strong reproductive health programs, they have proven difficult to sustain over the years, especially with the withdrawal of USAID assistance for FP. Most now rely primarily on governments as the conveners, creating discontinuities when there are changes in administrations. Today, the extent of government involvement in coordination varies markedly by country: in Nicaragua, for example, the government must approve any external funding to NGOs, while in Bolivia two coordinating bodies (one on maternal mortality and another on sexual and reproductive rights) continue to function and have a limited role in coordination. However, in some countries, government coordination has diminished. Even the once-powerful CONAPO in Mexico has lost much of its influence on national policy, most likely reflecting a maturing of the FP movement in Mexico.

***Contraceptive security committees* —** In the past decade, coordination of FP activity in Latin America has focused largely on contraceptive security. Recognition of the impending crisis in contraceptive security in 2001 due to declining external support led to the creation of high-level coordinating committees in several countries, with the aim of ensuring sustainable access to contraceptives. In six countries, multi-disciplinary and multi-agency contraceptive security committees, the DAIAs, were convened by the MOHs with support from USAID. USAID, UNFPA, key NGOs, and private sector representatives have participated in the DAIAs, to increase awareness of the issues of contraceptive security, as well as mobilize public sector support and commitment. The DAIAs have been an important mechanism in the region to ensure that MOHs continue to support contraceptive procurement and a functioning supply chain when governments change. They educate new officials on multiple aspects of contraceptive security (e.g., financing and logistics, and available analytical tools), and they encourage retention of trained personnel in key logistics positions.

The LAC Forum of the global RHSC was established in 2010 to coordinate the supply-related activities of organizations working directly or indirectly on SRH. An integral part of the RHSC, the LAC Forum was developed to address issues facing the LAC region, which increasingly receives little or no donor funding for FP. Led by the RHSC, UNFPA, IPPF, USAID, Ipas, and smaller NGOs that rotate representatives through the LAC Forum's executive committee, the forum provides a space for over 230 organizations to identify priorities and strategies to increase access to contraceptives. USAID has provided support for the RHSC LAC Forum itself as well as for specific activities it has undertaken.

The Pan American Health Organization (PAHO) has been another important player in the constellation of agencies involved in the health sector. PAHO serves as the regional arm of the World Health Organization and provides assistance and support to countries by developing and disseminating international standards of care, research, and technical assistance in implementation. PAHO's Latin American Center for Perinatology, Women's and Reproductive Health (located in Uruguay) conducts research and serves as a clearinghouse for information. PAHO's role has been critical in establishing and disseminating the technical norms and guidelines for service provision. While countries develop their local norms and guidelines, they generally draw on PAHO guidance to do so.

5. The Development of Local Expertise in Key Programmatic and Management Areas

In the early years of family planning in Latin America, it became evident that doctors, nurses or midwives had not studied the delivery of contraceptive services as part of their school curricula. FP was a new concept in the health context; its benefits to maternal and child health were not yet known. In addition, the main universities in the region opposed FP, some based on leftist ideologies, and other due to their strong ties to the Roman Catholilc Church.

FP pioneers – primarily from the IPPF MAs but also from some favorable MOHs – were the first to recognize the need to train medical personnel, nurses, and social workers for clinical FP service delivery. Given the paucity of knowledge in the region in the 1960s and 1970s, U.S. universities were tapped to provide much of this training. From the start, USAID (through its centrally-funded CAs) and others played an important role in developing local human resources

capacity for family planning and reproductive health within the NGO and public sectors. Early training efforts focused primarily on contraceptive technology, design of FP norms and standards, counseling techniques, and production and distribution of IEC materials. USAID's large centrally-funded programs provided in-service training to health personnel throughout the region. Training – often led by external experts – usually took place in workshops or on-the-job training programs for staff, with the objective of increasing knowledge and skills for specific job-related tasks. Over the years, as local expertise developed, country personnel took over the role of training others in basic contraceptive service delivery.

Yet through the 1970s and 1980s, medical personnel traveled to training sites in the United States or other Latin American countries (Colombia, Chile, Peru, Mexico, Guatemala, and Dominican Republic) to receive training in specialized topics, such as modern contraceptive methodology, diaphragm and IUD insertion, mini-laparotomy, vasectomy, and no-scalpel vasectomy. Several countries developed training centers that became valuable tools for FPAs and MOHs in the region. Among these, the Barros Luco Hospital in Chile performed research in contraceptive methodology and human reproduction; Cemi-Camp (Centro de Investigaciones Materno Infantiles of the University of Campinas, Brazil), performed research and training in human reproduction; the Asociación Colombiana de Facultades de Medicina (ASCOFAME) in Colombia, undertook research to validate the benefits of fertility control, performed research in the medical schools and the hospital postpartum FP program, and coordinated reproductive health and contraceptive technology training (Robinson & Ross, 2007). In Guatemala, APROFAM developed one of the first Latin American training centers on surgical contraception techniques.

In addition, health professionals other than clinicians obtained training overseas, primarily in the United States, in a variety of fields (e.g., demography, epidemiology, operations research, program evaluation, communication, management, reproductive health) to support the full range of country needs to implement and monitor FP programs. USAID – both directly and through its CAs – was a major source of this funding; private foundations (e.g., Ford, Rockefeller, Carnegie, Airlie); and universities (e.g., Georgetown University, Johns Hopkins/JHPIEGO, Tulane University, University of California/Santa Cruz, University of Chicago, University of North Carolina) also supported training in the early days. Although statistics are not available on the number of people who benefited from such training, it is estimated that in Colombia alone more than 4,000 health professionals received degree or certificate training in the United States (Bair, 1978).

As demand for FP started to increase and new service delivery models were introduced, personnel training was diversified to address country-specific needs for CBD and social marketing. However, the academic community disapproved of training non-clinical personnel (especially community-level volunteers) to conduct service delivery activities that they believed should be restricted to the domain of medical personnel. In addition to their antipathy toward FP for political reasons, opposition to non-clinical delivery of contraception may explain why universities in the region did not incorporate contraceptive service delivery into their curricula for several decades.

Thus, training of personnel in CBD programs consisted of workshops or on-the-job training by local FP specialists, many of whom had received training themselves outside the country. USAID (through its CAs) and others provided extensive technical assistance to these training programs in the 1970s and 1980s throughout the region. The training of CBD workers – often referred to *promotores* (promoters) – included basic facts about contraceptive technology, side effects, advantages and disadvantages of specific methods, and approaches for motivating potential users. This training allowed the promoters to offer basic methods, such as oral contraceptives, condoms, and vaginal creams and spermicides, which they sold at low cost (subsidized prices) to members of the community as a means of increasing access to contraception. However, promoters were not always accepted by the communities; the turnover rate was often high. By the mid-1980s, research on CBD programs demonstrated that the CBD model was not cost-effective (Vernon, Ojeda & Townsend, 1988); moreover, it remained a source of tension with the medical community and conservative groups, in particular the Roman Catholic Church (Burski, 1977).

Social marketing also required specialized training of the personnel in this program. In the 1970s and 1980s, especially in programs subsidized by USAID, much of the focus was on marketing techniques and product distribution. By the late 1990s, as countries began to move toward self-sufficiency in contraceptive procurement, training in contraceptive logistics took on a new importance, covering all aspects of the process: forecasting, procurement, importation, distribution, monitoring. Local personnel were trained in the total market approach.

In the 1980s and 1990s, the range of training topics expanded to include quality assurance, health administration, gender, training of trainers, OR, youth programming, and new contraceptive techniques, such as no-scalpel vasectomy and mini-laparotomy. More recently, regional workshops have focused primarily on issues related to supply logistics, maternal health, adolescents/youth and BCC, among other areas. Many key informants for this report stressed that these investments in capacity building were one of USAID's lasting contributions to the region, along with several generations of professionals who remain committed to reproductive health and have the skills and knowledge to ensure that policies and programs are implemented.

USAID (before beginning the graduation process) and UNFPA have continued their efforts to get FP incorporated into the curricula of medical schools in Latin America. (It is more likely to be included in nursing school curricula, because of the strong focus on MCH.) To date, these efforts have met with limited success, but this situation is likely to change as schools of medicine and public health seek to address topics of key importance such as HIV/AIDS and sexually transmitted infections. With the current shift in focus throughout Latin America to integrating FP with different aspects of health, including SRH, universities are showing a new interest in incorporating FP/SRH into their medical and nursing school curricula. New technologies and approaches, such as e-learning, virtual courses, and virtual advanced monitoring systems show promise. Universities in various countries (e.g., Nicaragua, Guatemala, El Salvador) are working to develop post-graduate and master's degrees that cover the delivery of comprehensive SRH services, logistics information systems, gender, human sexuality, and research program management.

In Nicaragua, for example, an FP training package known as *maletas pedagógicas* (training packages) for universities and nursing schools was designed, developed, and distributed with USAID assistance. The package is based on the national norms and focuses on logistics, FP counseling, and quality improvement. By September 2013, the package was implemented in seven universities with 17 degree programs. USAID coordinated efforts with two of its partner CAs and the FamiSalud project in this effort (USAID, 2012a). In Mexico, Guatemala and Peru, efforts are underway to train *técnicas universitarias en partería* (university-trained midwives) with special emphasis on improving technical skills and quality of care given to pregnant women. This program links to other preventive initiatives, such as FP.

Another promising approach to strengthening capacity to deliver integrated health care, including family planning, is the Salud Mesoamérica 2015 initiative (SM2015, Mesoamerican Health Initiative 2015). This public-private partnership – launched in 2010 by the Bill & Melinda Gates Foundation, the Instituto Carlos Slim, the Spanish government, and the IDB, in coordination with eight countries – is designed to reduce equity gaps in health throughout the countries of Central America and Chiapas state in Mexico, by increasing poor women's access to health care, including safe childbirth, emergency obstetric care and FP services. The initiative´s interventions are aimed at the poorest 20 percent of the population of Mesoamerica, mainly women and children under five years of age. The initiative introduces a results-based-financing model in which governments and the IDB agree on targets for coverage and quality of services within a given time period. A payment scheme is applied to the health network, based on persons served, days of care, provision of a basic package of services, and user satisfaction. It also includes provision of incentives, such as payment of transportation costs for pregnant women and midwives to health facilities for prenatal care and institutional delivery (IDB, 2013a).

Training of health personnel remains a critical part to the delivery of quality FP services in clinical and commercial programs throughout the region. In the 1960s and 1970s, many health professionals from the region benefited from training outside their countries, either in the United States or other countries in the region. During the 1980s and 1990s, the focus shifted to in-country training in a variety of areas that extended far beyond clinical service delivery, with technical assistance from USAID and others. Training in the past 15 years has focused on strengthening the capacity of country personnel to run all aspects of their programs, with emphasis on contraceptive logistics. Specialists from Latin America now provide TA to developing countries in other parts of the world through south-to-south collaborations (Seltzer & Gomez, 1998).

6. Improvement in the Availability of Information as a Tool to Drive Decision Making and Open Doors

Information has played a key role in strengthening family planning programs over the past five decades, and has taken many forms: population-based studies, routine health information systems, OR, and other special studies. Collectively, the findings from these different sources of information have guided policy and programmatic decision-making in countries throughout the LAC region – as well as donor strategy and investment.

Chile, Mexico, and Colombia provide excellent examples of the power of data to influence policy and inform programs in the early days of the FP movement in the LAC region. One of the most influential research studies was published in Chile, entitled "Condiciones Determinantes del Aborto Inducido" ("Determinants of Induced Abortion"), which provided evidence of the extent of abortion in Chile related to unintended pregnancy (Requena, 1966). It proved pivotal to the policy dialogue in Chile and resulted in the development of the first FP programs through the public sector. As has been observed in the context of multiple countries family planning is considered the lesser evil when compared to abortion (Deschner & Cohen, 2003).

In Mexico, CONAPO became a driving force in the family planning movement. CONAPO is an inter-institutional, governmental entity with private sector participation and was an early partner of USAID in Mexico. Among its broad set of aims, CONAPO implemented a program of research that proved fundamental in guiding population policy; moreover, it coordinated the evaluation of key programs. With support from USAID CAs and eventually from USAID directly, CONAPO's research, leadership and training were vital to both the public and private sector programs and contributed greatly to making Mexico a model for family planning in the region.

In Colombia, in the late 1960s, the government preferred to maintain its distance from family planning, given its controversial nature. Yet early studies showing the latent demand for family planning provided unequivocal evidence of the need for these services. Government officials who might otherwise have refused meetings opened their doors to Profamilia and its evaluation service when they had new data to share and discuss. Eventually, the Colombian government helped fund some Profamilia studies.

As FP programs unfolded, most had some system of collecting routine health information to track number of visits, users in their facilities, distribution of contraceptives, or similar types of information regarding the clients that visited their services and the products distributed. As is often the case in health systems worldwide, these program statistics were typically incomplete or unreliable. Moreover, program statistics do not capture use of methods from pharmacies or use of traditional methods requiring no service visit (e.g., rhythm, withdrawal). Data were available in the region from the World Fertility Surveys (WFS), but these focused primarily on determinants of fertility among married women and yielded little useful programmatic data for family planning purposes. Moreover the results were often issued several years after the data were collected.

Given the pressing need for more accurate data on contraceptive use, the Division of Reproductive Health at CDC worked with USAID/El Salvador in 1976 to design and conduct the first contraceptive prevalence survey or CPS in the world. This survey was nationally representative, collected data on multiple aspects of family planning, and yielded findings more quickly than had the WFS. In the decade to follow, similar studies were conducted in other countries in Latin America and the Caribbean. The CPS evolved into the Reproductive Health Surveys, conducted by CDC and funded by USAID. They also contributed to the development of the DHS, which USAID first put out for bid in 1985. Subsequently, DHS surveys were conducted in countries worldwide. Since the 1980s, countries in the LAC region have conducted either DHS or RHS as a means of establishing contraceptive prevalence, method mix, source of

supply, unmet need, reasons for nonuse, and other key variables for family planning. To date, a total of thirty-four DHS and nine RHS have been conducted in Latin America and the Caribbean, including multiple rounds in most countries. Largely funded by USAID, these nationally representative surveys have served to monitor the progress of FP programs over time. In fact, they are the primary source of evidence for FP achievements. During the 1980s, the Population Reference Bureau conducted a similar set of population-based surveys in eight countries in the Caribbean (Bouvier, 1984). These studies provided important evidence of FP achievement at that time; however, the only countries of the Caribbean with surveys since that time are Haiti and Jamaica (and the Dominican Republic, which is generally included as part of Latin America).

In addition to routine health information systems and population-based surveys, OR played a key role in shaping and strengthening family planning programming throughout the region. Operations research refers to a range of different types of studies, including controlled field experiments, qualitative research, observational studies, and demonstration projects ("test of concept"). The key objective of OR is to test elements of a program or study specific aspects of program design, with the aim of using the findings to strengthen programs. For example, numerous studies were conducted on CBD to determine its effectiveness and acceptability as a model of service delivery. USAID-supported OR studies on willingness to pay, client satisfaction with services, provider training mechanisms, task-shifting strategies, method acceptability, and post-abortion and post-partum contraceptive uptake strategies. These studies contributed to safe, effective service provision in many countries in the region.

Collecting information for decision making in health has been a central and consistent focus of USAID support in selected countries, and its support for these activities has greatly strengthened local information systems in these countries. As part of its efforts to improve contraceptive security, USAID has invested in information systems for forecasting, procuring, distributing and monitoring contraceptive commodities. In some countries (e.g., El Salvador, Paraguay, Nicaragua), the information system for FP commodities was so successful it was scaled up by the governments to cover hundreds of essential health commodities needed in the public sector.

The body of information amassed through these different sources has provided a solid evidence base on which to justify the expansion of FP programs, to further refine programs in operation, and to monitor progress in almost all countries of the LAC region over time. Long before the term "evidence-based programming" came into vogue, FP program directors in Latin America used information to guide and defend their programs. As Miguel Trías, former executive director of Profamilia/Colombia from 1972 to 1994 stated so eloquently: "A day without data is like a minute without oxygen."[21]

7. Strategically Designed, Wide-Reaching Communication Activities to Support Change in Individual Behavior and Social Norms

The use of behavior change communication or BCC has evolved over the past 50 years, and the experience of family planning in Latin America reflects these changes. For 10 years starting in

[21] Gabriel Ojeda, Profamilia director, personal communication, 2014.

the mid-1960s, the promotion of family planning occurred primarily through word-of-mouth and interpersonal communication. The newly formed clinics attracted women with a strong felt need to prevent pregnancy, often referred by concerned physicians and nurses. In addition, interpersonal communication through community educators became an important means of reaching the population. Because of the often-controversial nature of family planning, there was minimal promotion of family planning through the mass media until the mid-1970s, although Profamilia/Colombia first experimented with radio programming on FP in 1969.

During the 1970s, the promotion of family planning became more public for several reasons. In Mexico, the government had openly endorsed family planning through its official population policy. Most IPPF member associations formed their own IEC departments, which were explicitly tasked with creating educational materials for clients and creating awareness among the general population/potential clients. Mexico pioneered the use of "telenovelas" (soap operas) in 1977-78 that promoted family planning and resulted in measurable increases in visits to government family planning clinics. Contraceptive social marketing used the tools of commercial marketing to broadly publicize the availability and desirability of pills and condoms through multimedia campaigns, using radio, pamphlets, and point-of-purchase materials.

In the 1980s, the development of communication campaigns became more systematic and professional. USAID supported a global communication program that provided technical assistance to selected countries throughout the region. The approach drew heavily from marketing techniques (e.g., audience segmentation, consumer-orientation, use of multi-media), but was tailored specifically to the needs of each country and segments of the population. The end of the 1980s ushered in the more widespread use of entertainment education (often called "edutainment"), which was novel at the time but has become the standard for BCC across a wide range of health topics in low- and middle- income countries. For example, in Mexico, pop music sensation Tatiana and Johnny recorded two duets entitled "Cuando Estemos Juntos" ("When We are Together") and "Detente" ("Wait"), which were among the earliest music videos to promote sexual responsibility (USAID, 2011). Developed under a USAID-funded project, these songs were part of an entertainment education campaign to encourage abstinence, but soon gained enormous popularity, topping the music charts in Mexico and Peru and reaching young audiences in twelve Latin American countries (Clift, 1998). This experience demonstrated the power of emotionally compelling communications to draw attention to the issues of SRH. It also provided the lesson that communication products, if sufficiently entertaining, could become self-financing in the private sector.

The influence of radio and television on norms and values in popular culture in the region has been enormous. The vast majority of Latin Americans live in urban centers with access to television; even rural residents generally have some access to television as electrification reaches all but the most isolated areas. Free TV signals reach from 85 percent (Guatemala) to 95 percent or above (in Argentina, Colombia, Mexico, and Panama) (Instituto Brasileiro de Opinião Pública e Estatística, 2012). The mass-marketed telenovelas produced in relatively progressive Brazil and Mexico and aired throughout the region began to show the urban ideal of small families in the 1970s and 1980s. Many observers in Latin America feel that this has had a dramatic impact on family-size norms. Furthermore, the negative aspects of unintended pregnancy were often

openly part of these dramas. USAID capitalized on the popularity of the telenovela and other forms of entertainment-education by funding productions with messaging supportive of FP.

By the 1990s, behavior change communication was a widely used part of family planning programs supported by USAID. One novel project involved the Lilac Tent (Carpa Lila) campaign, launched in Bolivia in 1998, which distributed a wide range of reproductive health materials designed as much for adolescents as for married couples. Lilac-colored tents were set up in rural areas where videos, live music, theater, games, and printed materials served to create awareness of family planning to the thousands of participants lured by curiosity and the dynamism of the health fair event. Local political leaders, health professionals, educators, students, and performers worked together to bring important reproductive health messages and resources to an audience of between 2000-4000 people at each stop (JHU/CCP, 1999).

Also in Bolivia, USAID supported CIES, the IPPF MA, to create a talk show called Naked Dialogue (Diálogo al Desnudo) in which prominent physicians, psychologists and feminists were invited to talk about gender, family planning and other SRH topics. This was one component of a multi-pronged communications approach to create dialogue around family planning and other reproductive health topics. Nicaragua's feminist NGO, Puntos de Encuentro (meeting places), used a variety of communication programs (radio, television, print media) to link community engagement among youth around issues of reproductive health with broader themes of female empowerment, acceptance of gays, and domestic violence. Beginning in 2001, Puntos de Encuentro, produced the first (and only) Nicaraguan soap opera entitled Sexto Sentido (Sixth Sense) centered around a cast of young people to address controversial issues such as sex, abortion, drugs, gender-based violence, and AIDS. Capturing 70 percent of the television audience in Nicaragua, Sexto Sentido was one of the most successful and impactful entertainment education programs addressing adolescent reproductive health in Central America. It drew more than one million viewers in the United States, Mexico, Honduras, Guatemala, Costa Rica, and Bolivia (Howe, 2008).

Source: Strug, 2005.

Figure 21. Lilac Tent campaign illustration.

During the past decade, external financial support for large-scale communication campaigns on family planning has waned as part of a larger decline in support to family planning by international donors in the LAC region (Bongaarts et al., 2012). USAID's global projects for communication have provided little support to BCC for the type of multi-media campaigns for family planning common in earlier eras. The budgets for BCC are very limited, and communication initiatives often lack specialized communication expertise (e.g., evidence or theory-based programming, use of state-of-the-art design and creative approaches including

entertainment education). Because family planning has become a community norm in the large majority of cases, the programmatic emphasis has switched to ensuring sufficient contraceptives to meet the ever-growing demand. In public and private sector programs, basic information for clients during in-clinic visits and promotion/information via community channels has become standard. Some USAID funding has been available from the USAID missions in specific countries (e.g., Haiti, Guatemala) for BCC activities. For example, USAID funded PASMO to support a network of community FP workers that run home visits, FP counseling and referrals to services. In Haiti, FP/RH represents an important part of a new USAID-funded health system strengthening project.

Of various international donors, USAID has been the most consistent in its support for BCC and its commitment to BCC as an integral part of effective family planning programming. In its support of IEC and later BCC, USAID has contributed to developing the techniques of strategic communication that have benefited the field of international public health across various sectors. Much of this experience was gained through projects in LAC, which have contributed to the widespread social acceptance of family planning and contraceptive uptake in the region.

8. Mechanisms to Ensure Program Financing that Evolved to Fit the Times

As a preface to this discussion of financing of FP, it is important to recognize that many of the family planning initiatives in Latin America began as vertical programs in which family planning received a high-level attention, funding, and focus, without any risk of getting "lost" in integrated health service delivery. For example, the IPPF MAs focused largely on family planning in the early years; CBD was often vertical; social marketing focused primarily on contraceptives; efforts to strengthen logistics were aimed primarily at FP commodities; training emphasized clinical service delivery of contraceptive methods; and so forth. As FP service delivery became increasingly incorporated into the MOH activities of each country, it became part of the integrated health services delivered by local health facilities. The concept of separate funding for FP diminished as governments absorbed this responsibility.

In the early years, international donors (USAID in particular) provided the major portion of funding for FP in the LAC region, through grants to governments, NGOs, and other groups. Over the past five decades, mechanisms for financing FP have evolved markedly in different sectors.

Private NGO sector — USAID, IPPF, and other donors initially provided almost all of the funding to the NGO sector working in FP. As external funding declined, the private sector NGOs have struggled to survive; in most countries there are now fewer NGOs working in FP/SRH than there were 10 years ago. Those that provide FP/SRH services (such as the IPPF MAs and others) survived by modeling their clinical services after those of the for-profit sector and developing social marketing or commercialization approaches. In fact, most of the IPPF MAs now talk about their clinics as income-generating operations in contrast to their "social" programs. Service-providing NGOs have instituted a diverse range of non-SRH health services including pediatrics, dentistry, optometry, diagnostics (e.g., lab, x-ray, ultrasound), and pharmacies in order to achieve financial sustainability. In addition, efforts have been made to ensure that the SRH services generate at least enough income to pay for themselves and for the general operating costs of the organization. Social marketing, including sales of contraceptives through commercial channels,

and social franchising schemes have also been implemented to expand both urban and rural coverage and improve sustainability. In many cases, clinics serving a middle-class population are subsidizing services to young people and the poor.

Public sector — In the 1970s and 1980s, ministries of health provided the infrastructure for service delivery and paid the salaries of clinical staff that provided FP among other MCH/health services. Yet external donors often supported the procurement and distribution of contraceptives, training, and technical assistance to support program needs.

Most countries in the region have some form of health coverage for formal sector employees (generally through the national institute of social security). As mentioned previously, social security institutes have become important actors in family planning in some middle-income countries where formal sector employment has increased coverage (Ugalde & Homedes, 2009).

In the past 20 years, most countries in the region have implemented health sector reforms, with a renewed emphasis on service coverage and equity. Through this process, family planning in the public sector has become one component of integrated primary health care services. In most cases, these reforms have also included decentralization of services, devolution of decision making away from the center and some type of health benefits plans to increase coverage for the poor. The role of the MOH at the central level in many countries has evolved into one of a regulator, whereas responsibility for service provision has been assigned to regional or municipal governments. These health sector reforms have had implications for both the financing and implementation of family planning services throughout the region. Many of these reforms have succeeded in improving healthcare coverage (Acuña, 2008; Knaul et al., 2012; Victora et al., 2011). At the same time, there are concerns that FP may become lost in the delivery of a wider range of integrated health services, as is discussed more fully below.

Universal health benefits plans and conditional cash transfer programs — In efforts to attain higher levels of coverage for the poor, many countries in the region have instituted some type of health benefits plans that cover essential services for the poor (World Bank, 2013b; Cubillos, Escobar, Pavlovic & Iunes, 2012). These plans are sometimes called ¨insurance¨ or ¨universal health insurance", although they bear little resemblance to private insurance plans. The term ¨universal¨ does not mean that everyone is covered under a single program. Rather, these public sector health benefits plans cover the segment of the population that is not covered under other public and private sector health services.

Public health benefits plans cover most or all of the cost of contraceptives and other routine reproductive health services for poorer sectors of the population in Bolivia (for pregnant women or those with infants only), Brazil, Colombia, Ecuador, Guatemala, Mexico, and Peru. One study in Bolivia showed that family planning use increased dramatically from 1998 to 2003, a period when contraceptives for everyone were covered by the government's health benefits plan, only to stagnate completely in the period from 2003 to 2008 when they were no longer covered (Silva & Batista, 2010). While there could be other factors at play, the data are highly suggestive of a positive association between contraceptive coverage by health benefits plans and family planning use.

As of 2011, 18 countries in the region had instituted conditional cash transfer (CCT) programs in which low-income families receive cash in return for school attendance and/or for basic health actions such as vaccinations and prenatal care (IDB, 2013b). Family planning services for the poor are generally covered in part under these schemes. It should be noted that none of the CCT programs include FP or fertility decline as a goal, nor as one of the "co-responsibilities" for which incentives are provided. Rather, family planning counseling or services are part of the entitlements provided by the program. While CCT programs have been extensively evaluated in terms of coverage and child health indicators, the information on their success in family planning is not conclusive. Some evaluations of the *Oportunidades* program in Mexico have shown that the program increased contraceptive use (Doskoch, 2009); other evaluations in different years have found minimal impact on fertility (Feldman, Zaslavsky, Ezzati, Peterson & Mitchel, 2009).

Public-private partnerships — Public-private partnerships can be an attractive way for governments to harness capacities in the private sector to further their goals of providing services to their population. A variety of models of public-private partnerships have developed in Latin America, often with USAID or World Bank support. Many health sector reform models in the late 1990s and 2000s included some form of public-private partnerships.

Brazil's health sector reforms of the 1990s decentralized most of the responsibility for health services to the municipal levels. The Sistema Único de Saúde (Unified Public Health System) provided funds for municipalities to manage in order to address health goals defined centrally (Paim, Travassos, Almeida, Bahia & Macinko, 2011). When decentralization first occurred, BEMFAM, the IPPF MA, saw an opportunity and began to market family planning services ranging from contraceptive procurement and supply chain management to training, monitoring and evaluation and other necessary support services. By the mid-2000s, BEMFAM had over a thousand contracts with municipalities and this program was the organization's major source of revenue. These partnerships enabled municipalities to capitalize on the expertise of the private non-profit sector to provide a service they were neither equipped nor sufficiently resourced to provide. BEMFAM's management and training staff (many trained under USAID projects) were able to provide state-of-the-art technical assistance to small and medium-sized municipalities that would not have been able to afford on-site human resources for these functions. Furthermore, by purchasing for multiple municipalities, BEMFAM was able to achieve economies of scale in the purchase of contraceptive supplies and to create efficient supply-chain management structures.

Several other countries have developed mechanisms for public-private collaboration as well. The Colombia case study describes how the government outsources family planning service provision to private service providers (including Profamilia). In Panama, the MOH provides ambulatory and preventive health services (including family planning) to the most remote areas through pay-for-performance contracts with small companies and some NGOs. The Nicaraguan social security administration contracts with NGOs and private clinics for service delivery. For the most part these arrangements are paid for on a "per capita" basis, in contrast to Brazil's fee for service contracts.

9. Effective Advocacy to Achieve Major Political Gains

Political support remains a key factor in the long term sustainability of family planning in a given country, especially in the current period of greatly decreased international donor support. Historically, the policy frameworks in the LAC region have supported family planning more so than in other regions of the world. Even in the early days when FP was often controversial, there were no laws that prohibited the promotion or use of contraception. Governments throughout the region became increasingly supportive of FP. almost all incorporate FP in public sector primary health care programs. However, this political commitment is being put to the test now, as governments are required to support the costs of family planning for their own populations in a "post-graduation" era.

For many years Mexico was the regional leader in terms of population policy. As mentioned above, Mexico established the first population policy in the LAC region in 1974 which explicitly recognized the link between lower population growth and development. This was a dramatic shift from previous pronatalist policies (Nagel, 1978). Simultaneously, the government established CONAPO, which coordinated efforts in the population field in Mexico.

In the late 1970s and 1980s, USAID supported the development of RAPID, an innovative tool for data-driven advocacy for the benefit of policymakers and donors. RAPID used then high-tech visual presentations based on DHS/RHS data to present projections of the consequences of population growth on other sectors. The RAPID project trained reproductive health professionals throughout the region to use this tool, which produced colorful, visually intuitive graphs and provided readily comprehensible presentations of demographic data. While little evaluation was conducted to assess the impact of the project on policy, it has clearly improved the ability of a large cadre of professionals to develop and present data-rich policy-oriented presentations.

In the late 1980s, USAID and other organizations in the field espoused quality of care as a way to ensure that FP programs considered women´s needs (Bertrand, 2011). This emphasis on the client was a precursor to the paradigm shift that occurred at the ICPD in Cairo in 1994 and was institutionalized in countries worldwide that embraced the Cairo Program of Action. In the two years prior to the Cairo conference, the Ford Foundation played a key role in organizing meetings around the region to speak about reframing reproductive health as fundamentally based in human rights and social justice (UNFPA, 1995). This message resonated with both the family planning movement and the women's movement in the region. Most of the Latin American delegates to the ICPD arrived ready to advocate strongly for these issues. In fact, according to some respondents, the principles from the ICPD were already being integrated into the regional programs prior to the conference.

Armed with two powerful international conventions (Cairo and Beijing) signed by nearly all of the countries in the region, the FP movement gradually transformed itself into a movement for SRH. The major organizations in the field – USAID, IPPF, and UNFPA – all embraced the ICPD approach and began to formulate new and more comprehensive programs. Ministries of health began to talk about SRH rather than maternal and child wellness. Such a focus on SRH led to collaborative approach among programs that had previously been handled separately, such as HIV/AIDS, gender, and prevention of gender-based violence. There were some who disagreed,

especially those concerned that this new emphasis on a broader set of issues was coming at a time of overall declines in funding. However, for the most part this paradigm shift was welcomed in the region. Even in Guatemala, which had supported the Vatican position at ICPD, the programs at the country level reflected this new approach.

In 2000, the MDGs were adopted to define the health agenda for countries worldwide; however, family planning was initially omitted. Despite this, IPPF and other civil society groups successfully lobbied to have one FP indicator added to the monitoring framework. Unfortunately, much of the initial work around implementing the MDGs without the FP goals was already well under way in Latin America, as elsewhere. Because the reduction of maternal mortality was one of the MDGs, many governments and programs in the region opted to promote FP in the context of safe motherhood. USAID and PAHO had already been supporting regional maternal health programs during part of the 1990s. Further, reducing maternal mortality was politically more palatable than promoting family planning, and this consolidation eliminated a vertical program.

Most governments in the region have maintained a strong commitment to SRH. Several of the left-leaning and moderate governments in the region (e.g., Ecuador, Bolivia, Peru, and Venezuela) have recently included universal access to reproductive health care as an integral part of the constitution. At the same time, however, a number of governments, like the Dominican Republic, have added or ratified resolutions that acknowledge the right of the embryo from the moment of conception, legal provisions designed to prohibit any relaxation of abortion restrictions.

Despite the relatively positive policy frameworks in the region, in some cases the laws and regulations governing contraception do limit access to specific groups or for specific contraceptive methods. For instance, a number of countries prohibit the provision of contraceptives to minors without explicit parental consent (IPPF, 2010). Others have regulations that require women seeking voluntary sterilizations to get their husband's consent or to meet age or parity requirements. Most countries in the region have regulatory frameworks that limit the procurement of contraceptives from external sources, hamper the registration of products through highly cumbersome procedures and/or limit registration to one "local" distributor. While these regulations are often well-intentioned to ensure quality and the viability of local businesses, there are numerous occasions in which they function mostly to protect the distributors of major pharmaceuticals from "competition" with UNFPA or the local IPPF MA (or as some observers have suggested, enriching those in power through kick-backs).

In contrast to the early days when advocacy efforts tended to rely on personal ties and involved backroom negotiations, with little public debate on the issues, today's policy dialogue is more public and data-driven. Isolated examples of evidence-based programming exist from earlier eras (e.g., research from the 1960s in Chile on the efficacy of oral contraceptive pills, epidemiologic studies on abortion that led to greater acceptance of family planning as an alternative). With the advent of RHS, followed by DHS surveys, in all countries supported by USAID, data became far more available for decision-making purposes. USAID was a major funder for much of this research.

From the 2000s to the present, much of the FP advocacy work has focused on marshaling political commitment to ensure contraceptive security, including a line item in the national budget for contraceptive procurement. Such support has included the development of advocacy initiatives to address contraceptive security, studies regarding the potential effect of withdrawing funding on marginalized groups, planning strategies to mitigate inequities in access for marginalized groups, ensuring the social security institutes provide FP to their members and covered beneficiaries, and collaboration on shared lessons learned with a variety of civil society and public sector partners. USAID has also been a strong supporter in this arena. Advocacy activities ranged from yearly high-level regional contraceptive security conferences to training of grass-roots advocates in support of the 2010 family planning law in Guatemala and ensuring its implementation. Policy assessments and advocacy in El Salvador and the Dominican Republic also helped move forward the policy dialogue around family planning in those countries.

In addition to advocacy for access to contraception (in earlier years) and contraceptive security (in the past decade), recent advocacy initiatives have taken the form of coalitions around specific issues related to reproductive health including safe motherhood, comprehensive sexuality education, contraceptive security, and emergency contraception. Depending on the topic, funding for these coalitions has come from USAID, other donors, or local sources. For example, with support from the LAC EC Consortium, coalitions in Colombia, Peru, and Chile helped make EC legal and available through the public sector. However, a similar coalition in Honduras has failed to achieve this goal (Jacobson, 2012); Honduras still bans EC and has one of the strictest laws against EC globally (International Consortium for Emergency Contraception, 2014). One of the most effective FP/RH coalitions is related to contraceptive security, described in the next section (factor 10).

In Latin America, the leadership of advocacy initiatives currently consists of coalitions of NGOs and international agency representatives, with mid-level public sector officials providing support in some cases. Coalitions have been formed around a variety of issues in the region, in many cases, with support from USAID. Coalitions funded locally or by donors other than USAID have achieved progress in the area of abortion rights by liberalizing abortion restrictions in Colombia and Mexico City (which became the first place in Spanish-speaking Latin America where abortion on demand became available through the public sector). Throughout the region, broad NGO-led coalitions have championed the need for comprehensive sexuality education. These efforts, however, were not without opponents. In Colombia, the Catholic Church was successful at stifling efforts to implement a national policy to support sexual health education during the 1970s and early 1980s. However, with the support of UNFPA, the Colombian Ministry of Education began engaging in sex education programming by the late 1980s and early 1990s (Seltzer & Gomez, 1998).

USAID-funded efforts have adopted the coalition-building methodological approach to advocacy in their work on contraceptive security (described in the next section). Increasingly, advocacy organizations in the region are focusing on monitoring whether governments meet their commitments to provide services. A number of NGOs are tracking government expenditures and disseminating information and analysis of the extent to which they are meeting the commitments they have made (e.g., monitoring stock-outs and service provision to rural/underserved groups). Accountability initiatives at the intra-governmental level, such as the Independent Expert Review

Group (IERG), are mirrored by the "observatories" that monitor local and national level governments and disseminate information to advocates. These advocacy groups (many supported by USAID initially) help ensure the sustainability and continuity of public sector programs. In Guatemala, with USAID funding, OSAR is helping to ensure that indigenous women receive the services they are entitled to through the laws that guarantee rights to FP/RH care. This type of local advocacy has been important for the region's efforts to reduce the disparities in access for marginalized populations.

10. Significant Investments in Contraceptive Security

From the earliest days of FP in the LAC region, the leadership of the FP movement understood that having adequate supplies of contraceptive products was essential for reducing unintended pregnancies. The concept of "no product, no program" was understood well before the phrase became a watchword for the international FP community. From the 1960s to the mid-1990s the region's nascent family planning programs could generally count on the availability of plentiful donations of contraceptives from USAID, UNFPA, or IPPF. There were logistic barriers to overcome in getting the contraceptives into countries and then distributed to service delivery points, but solutions were found within both public and private sector programs to navigate this issue. Starting in the mid-1980s, USAID provided logistics management support to governments and NGOs throughout the region. Getting the contraceptives to the programs (especially in the rural areas) and accurately forecasting supply to limit stock-outs and overstocks was the principal focus in commodities logistics efforts during that period. Moreover, given the popularity of female sterilization in many LAC countries, there were additional challenges in ensuring well-trained staff as well as adequate equipment to perform VSC.

As in other regions of the world, the term "contraceptive security" (CS) did not emerge in Latin America and the Caribbean until the very end of the 1990s. A watershed 2001 conference in Istanbul ("Meeting the Reproductive Health Challenge: Securing Contraceptives and Condoms for HIV/AIDS Prevention") issued dire predictions concerning contraceptive security issues and signaled an alarming funding gap (Solo, 2011). The worldwide family planning movement mobilized around the potential threat of contraceptive scarcity, and the term "contraceptive security" came into widespread use in FP circles. There were serious concerns among USAID and its partners that governments in the region could not afford to provide contraceptives to all of the population in need, given projected increases in contraceptive use and the increasing number of people 15-49 years of age. Furthermore, it was also unclear that governments would have the political will to do so.

A variety of approaches have been utilized in the region to address contraceptive security issues including:

- increased access using the Strategic Pathway to Health Commodity Security (SPARHCS) tool and market segmentation studies;
- development of tools and training in supply chain logistics management;
- research and data collection to increase awareness among policymakers regarding the effects of contraceptive shortages on marginalized populations;

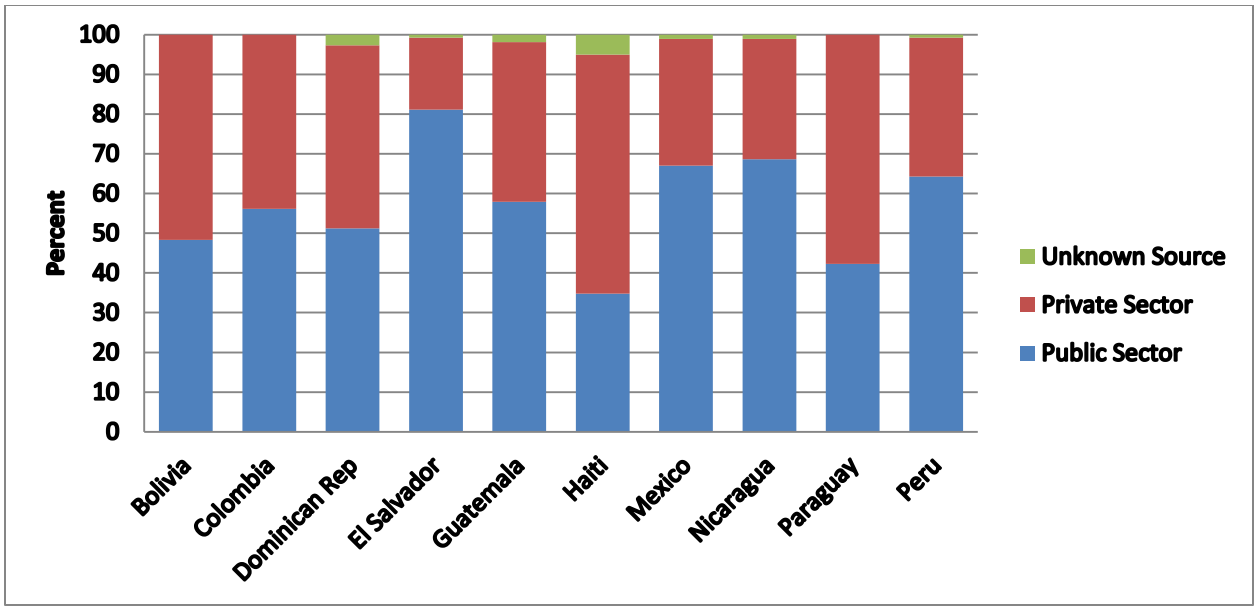
- advocacy to increase government commitment to pay for contraceptives and in some cases to institute legislation mandating a contraceptive line item; and
- creation of multi-agency committees to ensure contraceptive security in a number of countries (DAIA committees).

In response to concern over the inability of governments to meet projected needs, one strategy was to encourage market segmentation and to strengthen the capacity of the private sector and social security institutions to provide contraceptives to the portion of the population that could pay for them. The concept of market segmentation – to conserve public resources to fund services/commodities for the poor – has been an important principle in USAID's approach to FP since the mid-1980s. This approach has the advantage of ensuring that the public sector's share of service provision remains manageable and affordable. Social marketing programs, such as those of PROSALUD, PASMO, and some of the IPPF MAs, benefited greatly from USAID investments in this area in Latin America and from DFID investment in the Caribbean. These social marketing techniques increased the availability of condoms and oral contraceptives to people who could pay for them. When external donations of contraceptive products that clients had come to know and trust ended, the pharmaceutical manufacturers entered the LAC markets with these same products and sold them commercially. In contemporary Latin America, the commercial private sector plays a key role in contraceptive provision.

Figure 22 shows the wide variation in market segmentation across the region. In several countries, more than half of modern contraceptive users obtain their methods from public sector programs (in Bolivia, El Salvador, Guatemala, Nicaragua, Paraguay, and Peru).

By contrast, the private sector provides the bulk of contraceptives in several other countries. In the case of Colombia, a large proportion of contraceptive prevalence is attributed to the private medical sector; however, contraception is covered under the universal health insurance scheme, and the private sector often provides these methods through contracts with the government. In contrast, in the Dominican Republic, Guatemala, Brazil, and Nicaragua, the private sector provides contraception with little or no government subsidy; the users are required to pay full, or nearly full, price.

One of the central concerns of the USAID FP graduation effort was whether governments would accept and follow-through on purchasing contraceptives. In the early 2000s, few governments in the region had a contraceptive line item in their national budget and few were purchasing contraceptives. A central focus of the USAID-supported contraceptive security effort was to increase government commitment to ensuring financing for contraceptives, and this aspect of the graduation process has been a success. A key achievement in the region has been to expand government commitment to purchasing contraceptives. As can be seen in table 5 on government funding for contraceptives (page 54), the majority of governments in the region are now purchasing contraceptives with their own funding. Currently, only Haiti receives significant quantities of donated supplies. USAID support in advocacy and procurement strategies has contributed greatly to this major achievement.



Sources: DHS, RHS, and national survey reports (Bolivia, 2008; Colombia, 2010; Dominican Republic, 2007; El Salvador, 2008; Guatemala, 2008-09; Haiti, 2005-06; Mexico, 2009; Nicaragua, 2006-07; Paraguay, 2008; Peru, 2007-08).

Figure 22: Percentage of contraceptives from private and public sources in selected countries.

UNFPA has been and remains an important contributor to contraceptive security in the region, often working in collaboration with USAID. As can be seen in table 5, the UNFPA mechanism has been useful for many countries. However, the UNFPA requirement that countries must make advance payments for these contraceptive procurements runs up against laws in some countries forbidding advance payments, and problems of regulatory barriers and cash flow related to the timing of government revenue streams in others. DAIA committees in some countries (e.g., Paraguay) have managed to solve this problem through advocacy activities at the legislative level.

The Council of Ministers of Health of Central American and the Dominican Republic (COMISCA) has developed a new sub-regional initiative to facilitate joint negotiation for purchases of essential medications, including hormonal contraceptives. The initiative has made important progress towards joint negotiation, succeeding in agreeing on a list of 79 medications. Many of the medications have been pre-qualified, thus facilitating the national-level registration processes. Once products are pre-qualified, the COMISCA negotiating group establishes a reference price and pharmaceutical companies are invited to bid either through direct negotiation or reverse public tenders. While this is a new mechanism, it has the potential to reduce the cost of contraceptives to smaller nations in Central America and the Dominican Republic by using the increased volume and more agile regulatory processes to improve ministries´ ability to negotiate with pharmaceutical companies. USAID and the Salud Mesoamerica 2015 project of the IDB are working with COMISCA to disseminate this new mechanism more effectively, as to date it has been used only by Costa Rica and El Salvador (USAID|DELIVER PROJECT, 2013).

Finally, some governments are purchasing contraceptives locally. In most Latin America countries, the pharmaceutical companies have responded to the growing demand for

contraception by producing and selling products locally. In the case of Peru, purchases through public tenders use a system through which the maximum allowed is published in the tender, and companies try to provide the lowest bid. If no one bids locally, the government then moves to an international tender. This is a cumbersome process which has led to delays in procurement, according to local observers, but it is expected to improve over time. This has led to the entry of generic manufacturers (e.g., Famy Care, Ltd. in India) into the Latin America market.

VII. REMAINING CHALLENGES AND FUTURE DIRECTIONS

Despite the impressive gains made over a 50-year period, the LAC region continues to face at least six key challenges in the area of family planning and reproductive health.

High Rates of Pregnancy among Adolescent Girls

There is widespread consensus that curbing adolescent fertility is a major challenge. Nearly all of the key informants interviewed in this research effort indicated that improving SRH (including access to contraception) among adolescents is the principal priority for their country or region. However, the political sensitivities around comprehensive sexuality education and provision of contraceptives to adolescents make this a difficult issue in many countries.

The issues related to protecting minors sometimes conflict with the rights of adolescents to contraceptive services. Parental consent requirements serve as a significant barrier to access to contraceptives for youth in many countries in the region. While NGOs and pharmacies around the region have often overlooked these parental consent regulations, it is not something that the public sector can systematically ignore. Some countries in the Caribbean (including Jamaica, St. Lucia, and Trinidad and Tobago) have identified a particularly egregious human rights conflict in their regulations regarding parental consent. The age of consent for sexual intercourse is 16; however, young people cannot access contraceptives without parental consent until they are 18 (IPPF, 2013; IPPF, 2006). Advocates in several countries are trying to change these laws, and Barbados was recently successful in changing the law to enable earlier access to contraceptives.

There are a variety of other barriers to access for adolescents: the high cost of contraceptives in pharmacies; fear of judgmental attitudes of gatekeepers at pharmacies or health services; and prescription requirements. However, pharmacies may provide greater anonymity than the alternatives. Youth often have particular concerns related to privacy, as there may be no way to obtain contraceptives without friends and family finding out that they are sexually active. USAID has supported youth-friendly pharmacies in Mexico and El Salvador which provide greater anonymity to adolescents seeking contraception.

While still representing a relatively small number of births, it is worrisome to public health experts and policymakers that births to adolescents under 15 are on the rise in the region. According to *UNFPA State of World Population 2013*, Latin America and the Caribbean is the only region in the world where births to girls under age 15 are increasing (UNFPA, 2013). Girls giving birth under the age of 15 are at much higher risk of life-threatening obstetric complications (eclampsia, anemia, post-partum hemorrhage) and are more likely to have children who experience low birth-weight and neonatal complications (Neal et al., 2012). There are obviously also legal and human rights concerns related to the extent to which girls under 15 are voluntarily having sexual relations versus being coerced or pressured into having sex. Research shows that girls under 15 are not physically ready for sexual intercourse or childbirth and that most lack the capacity to make informed choices and the power in their communities to ensure that their decisions are respected (Dixon-Mueller, 2008).

The ability to negotiate use of contraceptives and/or condoms for disease prevention is greatly diminished when a girl's partner is much older than she is. Dating or marrying partners who are older (sometimes much older) is a cultural norm that is changing only slowly in the Latin American and Caribbean region. While there is little research on this issue, a recent study which included the Dominican Republic found that, in the previous year, over 10 percent of girls aged 15-19 had had sex with someone at least 10 years older than they were (Kothari, Wang, Head & Abderrahim, 2012). It is likely that a significant proportion of very early sexual intercourse is the result of coercion by the men, as data show that the younger the sexual initiation, the more likely it is to have been forced (WHO, 2012).

While politicians in LAC often decry high adolescent fertility, providing adolescents with the means to avoid unintended pregnancy remains a highly sensitive political issue. Civil society coalitions (often quietly supported by mid-level MOH officials) have made some progress in addressing adolescent access issues. In Peru, misguided legislation that criminalized all sexual relations among minors and limited their access to contraceptives was rescinded after a concerted advocacy effort that united NGOs, the United Nations, and over 10,000 youth. Donor support of NGOs and other civil society groups as well as of the national ombudsman's offices (Oficinas de Defensorias del Pueblo) will be vital to changing policies around access to contraception for minors in the future.

There are some positive signs of change in the region. Youth advocates for SRH and rights are building a vital movement in the region, one that is supported by many of the NGOs that USAID has helped to strengthen over the years. This advocacy movement is generating new leaders who will continue to advocate for SRH, including family planning. The growing number of youth activists and the vibrancy of organizations such as the Network of Youth in Latin America, Youth for Sexual and Reproductive Health and Rights, and the Latin American branch of the Youth Coalition augur well for the future of the region.

Strengthening Comprehensive Sexuality Education in Schools

There is widespread agreement in the SRH community that comprehensive sexuality education is crucial to reducing adolescent pregnancy and that it is most effective if done through the school system (UNESCO, 2011). Historically, governments in the LAC region have shied away from comprehensive sexuality education for numerous reasons. First, many Roman Catholics and some evangelical protestants tend to oppose sexuality education, asserting that it is exclusively the purview of parents and/or religious education. Second, overstretched and underfunded, the ministries of education do not usually prioritize sexuality education. Furthermore, sex education in schools generally requires inter-sectoral collaboration, which is often difficult to achieve. Despite generally supportive legislation (several countries in the region include access to sexuality education as a right within their constitutions), sexuality education is often left to NGOs and churches. This piecemeal approach has created a lack of consistency of curricula and spotty coverage of accurate health education messages. In addition, many teachers are reluctant to talk about sex with their students and not all educators, even with specific training, can provide quality sex education.

In 2008, at the International HIV/AIDS Conference in Mexico City, the region's ministers of health and education signed a landmark agreement to promote comprehensive sexuality education in the schools. The Prevent through Education Ministerial Declaration (Declaración Ministerial Prevenir con Educación) was historic in that it was signed by both ministers of health and of education for 30 countries in the LAC region. The declaration supports widespread comprehensive sexuality education and sets concrete targets for 2015, namely: a 75 percent reduction in the number of schools that currently do not have institutionalized comprehensive sexuality education, as well as a 50 percent reduction of adolescents and young people who currently lack health care coverage to meet their SRH care needs (UNAIDS, 2009). The United Nations and several NGO coalitions have worked to hold governments accountable to this agreement, with partial success. Some countries in the region have adopted comprehensive sexuality education curricula for their schools. However, many others (especially in Central America and the Caribbean) have either ignored the agreement entirely or adopted curricula that focus primarily or exclusively on the biological factors of reproduction and abstinence.

Closing Gaps in Contraceptive Access for the Poor, Rural, and Ethnic Minorities

As noted in the introduction to this report, certain countries in the region have virtually eliminated the urban/rural disparities in MCPR (e.g., Colombia, Nicaragua, Paraguay). However, in other countries these disparities continue to exist (e.g., Bolivia, Guatemala). Likewise, analyses of unmet need show marked disparities by wealth quintile, with the poor quintiles having the greatest unmet need. Five countries in Latin America have significant indigenous populations: Bolivia, Ecuador, Guatemala, Peru, and Mexico. DHS or RHS data provide a breakdown by ethnic group in all of these five except Peru. In the four countries with available data, the patterns remain striking. Indigenous women are far more likely to have an unmet need for contraception than their non-indigenous counterparts. Family planning is not alone in this respect, but rather follows the same pattern as almost all health, education, and economic indicators: a less favorable status for indigenous than non-indigenous.

Governments that have demonstrated and acted upon a strong commitment to reducing urban-rural and income-based disparities in access to FP have succeeded in selected countries. By contrast, no country to date has been able to bridge the gap between indigenous and non-indigenous populations. The health reform that has taken place in most countries of the region is aimed at increasing coverage to all segments of the population which, if effective, works to decrease disparities. By contrast, the decline in donor funding has resulted in a relatively small investment in demand-creation activities (which would educate and motivate clients toward contraceptive use), an integral component of FP programming.

Reducing the inequities in terms of place of residence, wealth quintile, and ethnic group remains a key challenge to many of the countries in the LAC region.

Ensuring Continued Commitment and Capacity for Family Planning within Highly Decentralized Health Systems

Health sector reforms that included decentralization and devolution of functions to regional or municipal authorities began to take place in Latin America in the 1990s and were well underway by the end of that decade in many countries. Early on, there were questions as to whether decentralization would jeopardize reproductive health achievements (Langer, Nigenda & Catino, 2000). The case studies suggest that there are ample grounds for concern.

Decentralization is widely felt to be positive in terms of encouraging local participation in policymaking and management and reduction of bureaucratic inefficiencies. Nevertheless, there are numerous reports that the promised efficiencies of decentralization have not yet been realized. In fact, family planning may have suffered from decentralization processes to date. For instance, in Peru contraceptives are centrally purchased and are free to the user but there remain problems with availability. Stockouts and shortages can occur since local governments are responsible for projecting contraceptive needs and budgeting appropriately for transportation of the contraceptives to the service delivery points. In many cases, and especially during the initial transition, they are often without the capacity to do so consistently; moreover, it is difficult to ensure that all of the regions have this capacity. Similar barriers to care have been reported in other countries. In Bolivia, contraceptive procurement is completely decentralized and municipal governments do not all have the political will to budget for contraceptives, to manage the supply chain appropriately or to ensure that trained personnel are in place to provide counseling. In Mexico, after a decade of decentralization, the Federal Secretariat of Health brought the purchase of some essential medicines (including some contraceptives) back to the federal level.

The decentralization of supervision and control also means that staff responsible for contraceptive and reproductive health supply chain functions are supervised by regional or municipal authorities who typically know little about reproductive health.

In some cases, managers influenced by politicians at the local level may have little interest in or may even be opposed to family planning. This results in uneven programs and lack of access for women living in states or regions where there is political opposition to FP.

Continuing Development of an Appropriate Workforce for Family Planning within the Larger SRH and Maternal Health Context

As in many low- and middle-income nations, there is a shortage of clinical personnel (doctors, midwives, and nurses) trained in FP service delivery in the LAC region and actively working in the area. While the investments made in the past produced a strong cadre of senior-level clinicians and public health administrators with expertise in FP, there is a shortage of front-line staff with this expertise. The degree to which this is the case varies across the region. The English-speaking Caribbean islands experience particularly critical shortages of nurses. Caribbean-trained nurses can obtain U.S., British, and Canadian certification fairly easily, and out-migration is common as demand for nurses in North America and Britain far outstrips supply.

The region's MOHs have continued in-service training to one degree or another. However, due to the high level of rotation, resources are stretched thin and family planning experiences high competition for training time with other health issues. Ministries of health in the region are now well-qualified to manage their own in-service training programs, but in most countries the resources are limited for these efforts and family planning is not a priority.

Similarly, concerns exist regarding personnel to manage the specialized supply chain management functions. Historically, these personnel have been lower-level staff who receive in-service training to handle this specialized function. As governments change, incoming administrations may not understand the highly-specialized nature of this work and may not retain previously trained personnel. While this is an issue that affects all supplies, not just reproductive health supplies, the particular issues around forecasting and long-term procurement of commodities on the international market or through UNFPA make this a threat to the ongoing sustainability of programs.

Information for Programmatic Decision Making

Whereas some programs developed a culture of data-driven decision making almost from the start (e.g., Profamilia in Colombia), a major challenge exists in generating and using information to guide programs. This is particularly true in multicultural, multiethnic, and multilingual countries. Most countries in Latin America now have computerized routine health information systems developed to support the delivery of integrated health services, including family planning. Yet problems persist: lack of adequate data collection systems, data quality, timeliness of data collection, availability of and proper use of existing data for decision making, among others. Even where systems are functioning, the information may not be used for managing programs as efficiently as possible. For example, ministries will collect data but are unwilling to share it publicly. In addition, with the discontinuation of USAID funding throughout much of the LAC region, it is unclear how countries will obtain the advanced technical expertise and high level of funding needed to conduct population-based surveys (e.g., DHS, RHS) that have been so instrumental in tracking progress over time in each country. Peru has developed in-country capacity for conducting a continuous DHS, but depends on external funding (including support from USAID in the past 10 years) to maintain it.

VIII. CONCLUSIONS

The remarkable contraceptive revolution throughout the LAC region over the past 50 years resulted from a confluence of factors: committed leadership, innovative FP programming, gradual improvements in the standard of living, evolving social norms, and sustained financial and technical assistance from external sources. Whereas IPPF created a network of member associations that launched the earliest FP programs, USAID was the largest FP donor in the region and provided valuable resources for over four decades to local leaders and FP organizations throughout the LAC region. The partnerships forged between NGOs, governments, USAID, and others yielded pioneering models of service delivery (CBD, social marketing, franchising), as well as innovations in training, behavior change communication, and information systems. The (near) linguistic homogeneity of the Latin American continent and the multiple opportunities for exchange (e.g., conferences, trainings, workshops) allowed for a cross fertilization and perhaps friendly competition that further advanced FP in the region.

In Latin America and the Caribbean, as in other parts of the world, family planning is not just "one more public health service." Rather, over the past 50 years family planning has evolved into a movement of champions who feel deeply committed to increasing access to affordable contraception and have shown extraordinary leadership in maintaining the course despite many challenges. The rationale for promoting family planning has evolved over time and differs slightly among countries. It includes humanitarian concern over the toll of excessive childbearing and unsafe abortion, interest in decelerating rapid population growth in the name of development and the environment, desire to extend primary care (including family planning) to all, and reproductive rights of women and men to control their own fertility. Currently, with a TFR of 2.2 children per woman for the LAC region, the primary focus has become ensuring SRH for numerous countries in the region.

Despite the remarkable results achieved in a 50-year period, the job is not done. Access to SRH services for adolescents remains a highly controversial topic throughout the region, resulting in high rates of adolescent pregnancy and unsafe abortion. Many countries have achieved equity in access to FP services for urban and rural, rich and poor; yet others have not, especially among indigenous and non-indigenous poor. Will governments faced with competing demands on resources maintain their commitment to support contraceptive procurement and distribution to even the remotest areas of the country? Several countries have long since phased out of USAID assistance and have maintained high levels of modern contraceptive use (e.g., Brazil, Costa Rica, Mexico, and Colombia). Others have recently graduated but face uncertain futures with challenges in contraceptive security (e.g., Honduras, Nicaragua, Dominican Republic, and Peru). Haiti and Guatemala continue to receive USAID FP assistance, given current levels of CPR and disparities in access to services. There are many reasons to celebrate the extraordinary accomplishments in family planning in the LAC region and applaud the contributions of individuals, organizations, and governments in achieving such sweeping change. Still, there remains much to be done, and we must not succumb to apathy or complacency until these challenges are met.

APPENDIX 1. LIST OF CASE STUDIES OF EIGHT LAC COUNTRIES

The authors have also published a series of case studies examining the history of eight LAC countries, listed here in alphabetical order by country:

Bertrand JT, Santiso R, Ward VM. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Colombia*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso R, Ward VM, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Dominican Republic*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso R, Ward VM, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — El Salvador*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso R, Ward VM, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Guatemala*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Ward VM, Santiso R, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Haiti*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Ward VM, Santiso R, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Mexico*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso R, Ward VM, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Nicaragua*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso R, Ward VM, Bertrand JT. *Family Planning Case Studies in Latin America and the Caribbean: The Achievements of 50 Years — Paraguay*. Chapel Hill, NC: MEASURE Evaluation; 2015.

APPENDIX 2. STATUS OF FAMILY PLANNING ASSISTANCE IN LATIN AMERICA AND THE CARIBBEAN

Table A1: List of Countries that Received or Were Currently Receiving USAID Family Planning Assistance, 2014 (with Dates Funding Ended Where Applicable)

Country	Final Year of Graduation (USAID Fiscal Year)	Final Year of Activities (USAID Fiscal Year)
Prior to 2004		
Panama	1988	1988
Chile*	1992	1995
Costa Rica	1996	1996
Colombia†	1997	1997
Mexico	2000	2000
Brazil	2000	2000
Ecuador	2001	2001
Since 2004		
Jamaica	2008	2009
Dominican Republic	2009	2009
El Salvador	2010	2012
Honduras	2013	2014
Nicaragua	2011	2012
Paraguay	2010	2012
Peru	2012	2014
Not Scheduled for Phase Out or Graduation		
Bolivia‡	2012	2013
Ongoing Funding and Programs, 2014		
Guatemala		
Haiti		

Notes: * A phaseout plan was in place from 1992 to 1995 before the Chile Mission closed in 1996.
† Colombia received some funds for family planning activities after 1997 as part of larger democracy initiatives directed toward displaced populations.
‡ The USAID mission in Bolivia closed unexpectedly in 2013.

Source: Stewart, Vandenbroucke & Cole, 2013.

APPENDIX 3. LIST OF DHS AND RHS STUDIES BY COUNTRY

Table A2: List of National Demographic Surveys and Years of Publication

Country	Survey Name	Years of Publication	Survey Type*
Bolivia	Encuesta Nacional de Demografía y Salud (ENDS)	1989, 1994, 1998, 2003, 2008	DHS
Brazil	Pesquisa Nacional sobre Saude Materno-Infantil e Planejamento Familiar (PNSMIPF)	1986	DHS (1996), National survey (1986, 2006)
	Pesquisa Nacional sobre Demografia e Saude (PNDS)	1996	
	Pesquisa Nacional de Demografia e Saude da Crianca e da Mulher (PNDS)	2006	
Chile	Encuesta de Calidad de Vida y Salud	2000, 2006	National survey
Colombia	Encuesta de Prevalencia Demografía y Salud (EPDS)	1986, 1990	DHS
	Encuesta Nacional de Demografía y Salud (ENDS)	1995, 2000, 2005, 2010	
	Dirección de Censos y Demografía (DCD)	2007	
Dominican Republic	Encuesta Demográfica y de Salud (ENDESA)	1986, 1991, 1996, 2002, 2007, 2013	DHS
	Encuesta Experimental se Demográfica y Salud (EEDS)	1999	
Ecuador	Encuesta Demográfica y de Salud Familiar	1987	DHS (1987), RHS (2004)
	Encuesta Demográfica y de Salud Materna e Infantil (ENDEMAIN)	2004	
El Salvador	Encuesta Nacional de Salud Familiar (FESAL)	1975, 1978, 1985, 1988, 1993 1998, 2002-03, 2008	DHS (1985), RHS (1975, 1978, 1988, 1993, 1998, 2002-03, 2008)
Guatemala	Encuesta Nacional de Salud Materno Infantil (ENSMI)	1987, 1995, 1998-99, 2002, 2008-09	DHS (1987, 1995, 1998-99), RHS (2002, 2008-09)
Haiti	Enquête Mortalité, Morbidité, et Utilisation des Services (EMMUS-series)	1994-95, 2000, 2005-06, 2012	DHS
Honduras	Encuesta Nacional de Demografía y Salud (ENDESA)	2005-06, 2011-12	DHS
Jamaica	Reproductive Health Survey	2002-03, 2008	RHS
Mexico	Encuesta Nacional sobre Fecundidad y Salud	1987	DHS (1987), National Survey (2003, 2006, 2009, 2010)
	Encuesta Nacional de la Dinámica Demográfica (ENADID)	2003, 2006, 2009	
	Censo de Población y Vivienda	2010	

Continues, next page

Country	Survey Name	Years of Publication	Survey Type*
Nicaragua	Encuesta sobre Salud Familiar Nicaragua (ENSF)	1992-93,	DHS (1998, 2001), RHS (1992-93, 2006-07)
	Encuesta Nicaragüense de Demografía y Salud (ENDESA)	1998, 2001, 2006-07	
Panama	Encuesta Nacional de Salud Sexual y Reproductiva (ENASSER)	1984-85, 2009	RHS(1984-85), National Survey (2009)
Paraguay	Encuesta de Planificación Familiar (EPF)	1987	DHS (1990), RHS (1987, 1995-96, 1998, 2004, 2008)
	Encuesta Nacional de Demografía y Salud	1990	
	Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (ENDSSR)	1995-96, 2004, 2008	
	Encuesta Nacional de Salud Materno Infantil (ENSMI)	1998	
Peru	Encuesta Demográfica y de Salud Familiar (ENDES)	1986, 1991-92, 1996, 2000, 2004-06, 2007-08, 2009, 2010, 2012,	DHS
Venezuela	Encuesta Nacional de Población y Familia (ENPOFAM)	1998	National Survey

* Whereas the DHS and RHS are "national surveys," the term is used in this table to refer to nationally-representative surveys that included fertility and family planning data conducted under the auspices of mechanisms other than the DHS or RHS.

APPENDIX 4. LIST OF KEY INFORMANTS

Table A3: List of Key Informants

Respondent	Title (Relevant to the Content of this Report)
Bolivia	
Ramiro Claure	National Director, Marie Stopes Bolivia
Rocio Lara	Former Population Officer, USAID
Johnny Lopez	Executive Director, CIES
Bertha Pooley	Founder, CIES Founder, Red NGO
Celia Taborga	Sexual and Reproductive Adviser, UNFPA
Colombia	
Gabriela Castellanos Llanos	Doctor of Discursive Analysis, University of Florida
Amanda Giraldo	Educational Advisor, Si Mujer Foundation
Gabriel Ojeda	Former Head of Evaluation Unit, Profamilia
Diego Palacios	Minister of Social Protection, 2003-2010
Vilma Penagos	Expert in Colombian and Latin American Literature
Martin Alonso Pineda	Former Surgeon, Javeriana University
Maria Isabel Plata	Former Executive Director, Profamilia
Santiago Plata	Deputy Director, The RESPOND Project, EngenderHealth
Catalina Rueda	Member, Provida Foundation
Dominican Republic	
Sonia Britto-Anderson	Director, Capacity Plus Former Director, USAID/DELIVER Project
María Castillo	Technical Advisor, USAID, Profamilia, Mude, MOH
Héctor Eusebio	Former Director General for Maternal Child and Adolescents Health during Graduation, MOH
Sarah Julia Jorge	Executive Director, MUDE
José de Láncer Despradel	Former Director General Maternal Child and Adolescents Health, MOH Former DAIA Committee Coordinator
Sarah Majerowicz	Former Deputy Office Chief, Health Program Specialist USAID
Angela Polanco	National Sexual and Reproductive Health Officer, UNFPA
Ramón Portes Carrasco	Director General, ADOPLAFAM
El Salvador	
José Mario Cáceres	Evaluation and Institutional Development Manager, ADS/PROFAMILIA
Maricarmen Estrada	Regional Democracy Manager (formerly FP and HIV/AIDs Officer), USAID
Beatriz Galán de Alonzo	Consultant, USAID and UNFPA Worked on Graduation Process
Margarita de Lobo	Public Private Partnerships Coordinator (formerly Maternal-Child Health Officer), USAID
Luz Elda Luna	Logistics Consultant, USAID/DELIVER Project
José Ignacio Paniagua Castro	Director of Health Programs, El Salvador ISSS
Esmeralda de Ramírez	Coordinator of FP Components, MOH Sexual and Reproductive Health Team
Sarah Romorini	Program Director, PASMO
Guatemala	
Yma Alfaro	Health and Education Officer, USAID

Respondent	Title (Relevant to the Content of this Report)
Karina Arriaza	Country Representative, RHI / Georgetown University
Marisela de la Cruz	Expert in Reproductive Health Policies, Health and Education Policies Project (HEPP)
Rebeca Guizar	Member DAIA committee, Member of OSAR
Gustavo Gutiérrez	Former Coordinator of the FP/SRH Program, IGSS
Luis Hernández	Executive Director, APROFAM
Baudilio López	Officer in Charge of MOH Program Coordination, USAID
Mirna Montenegro	Technical Secretary, OSAR
Edwin Morales	General Manager, PASMO
Claudia Roca	Country Representative, USAID/DELIVER Project
Alejandro Silva	Population Officer, UNFPA
Jorge Solórzano	Technical Adviser, UNDP
Silvia Xinico	General Coordinator, Indigenous Guatemalan Front for Infant and Reproductive Health (FESIRGUA)
Haiti	
Betsy Brown	Former Consultant, USAID/Haiti
Jean Robert Brutus	Executive Director, Aba Grangou Former Manager, USAID/IPPF Transition Project/Haiti
Francisco DiBlasi	Former Haiti Program Officer, IPPF
Reginalde Masse	Health and Population, USAID
Gadner Michaud	Consultant, PAHO Official, MOH Former Executive Director, PROFAMIL
Shelagh O´Roarke	Former Health Officer, USAID
Mexico	
Gerard Bowers	Former Officer, USAID
Maricela Dura	Executive Director, MEXFAM
Graciela Freyermuth	Director, Observatorio de Muerte Materna
Alfonso Lopez Juarez	Former Executive Director, MEXFAM
Marie McLeod	Former Officer, USAID
Manuel Urbina	Director General, Secretary of Health Former Director, CONAPO
Ricardo Vernon	Former Officer, Population Council
Nicaragua	
Carolina Arauz	Resident Advisor, USAID/DELIVER Project
Guadalupe Canales	Director General, PASMO Former Director of Maternal and Infant Health, MOH
Freddy Cárdenas	Executive Director, PROFAMILIA
Marianela Corriols	Deputy Director, Health Projects Specialist, USAID
Edgard Narvaez	SRH Products Availability Officer, CS UNFPA
Paraguay	
Graciela Avila	Former Health Team Leader, USAID
Adriane Salinas Bomfim	NPO, Sexual and Reproductive Health UNFPA
Margarita Ferreira	National Consultant for Sexual and Reproductive Health, MCH, Gender PAHO / WHO
Noemí Gómez de Rejala	Logistics Director, MOH
Sonia Marchewka	General Manager, PSI

Respondent	Title (Relevant to the Content of this Report)
Cynthia Prieto	Executive Director, CEPEP Former Minister of Health
Bernardo Uribe	Former Chief of Party, USAID/DELIVER Project
Peru	
Carlos Aramburu	Professor, Catholic University Former LAC Director, Pathfinder
Daniel Aspilcueta	Executive Director, INPPARES
Esteban Caballero	Deputy Director, UNFPA Former Representative to Peru
Dr. Lucy del Carpio	Director Sexual and Reproductive Health, MINSA
Jo Jean Elenes	Health Lead, USAID
Maria Rosa Garate	Former Director LAC, USAID
Carlos Gutierrez	Director de Desarrollo Económico, PRISMA
Erik Janowsky	Chief, Office of Health (Guatemala) Former, Health and Population Officer(Peru)
Patricia Mostajo	Independent consultant, Formerly with the Futures Group and Pathfinder
Maria Eugenia Mujica	Program Specialist in Poverty Reduction and Policy Advice, UNDP
Edgar Ramirez	Former Health and Population Officer, USAID
Miriam Roja	Independent consultant Formerly with the Health Policy Project and PRISMA
Grazia Subiría	Sexual and Reproductive Health Adviser, UNFPA
Luis Távara	President of the Board, INNPPARES Committee President, FLASOG
Regional	
Carmen Barroso	Regional Director, IPPF/WHR
Lucella Campbell	Senior Program Adviser for the Caribbean, IPPF/WHR
Maria Consuelo Mejia	Executive Director, CDD (Mexico)
Marguerite Farrell	Chair of FP Graduation Working Group, USAID
Mario Flores	Director for Latin America and the Caribbean, PASMO
Hugo González	Regional Director for Contraceptives in Central America, UNFPA
Alvaro Monroy	Former Transition Project Director, IPPF
Margaret Neuse	Former Chief of Population, USAID
Steven Orr	Former Regional Director, FPIA LA
Alice Payne Merritt	Director of Technical Programs, Center for Communication Programs, Bloomberg School of Public Health
Patricia Poppe	Leader for Latin America and Lusophone Africa, Center for Communication Programs, Bloomberg School of Public Health
Nora Quesada	Regional Director, USAID/DELIVER Project
Maria Cristina Ramirez	Senior Program Adviser in Logistics, IPPF/WHR
Dee Redwine	Regional Director for LAC, PPFA International
Anabella Sánchez	Regional Manager of LAC CS Initiative, USAID/DELIVER Project
Hernan Sanhueza	Former Regional Director, IPPF/WHR
John Skibiak	Director, RHSC Coalition
Ellen Starbird	Former Deputy Chief of Population, USAID (now Chief)
Lindsay Stewart	Former Co-Chair of FP Graduation Committee GWG (See above for MF), USAID
Mary Vandenbroucke	Member GWG of FP graduation committee GH and Lead for LAC, USAID

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LIST OF ABBREVIATIONS

AAPF	Asociación Peruana de Planificación Familiar (Peruvian Association for Family Planning)
ABR	adolescent birth rate
ADC	Asociación Demográfica Costarricense (Costa Rica)
ADS	Asociación Demográfica Salvadoreña (Demographic Association of El Salvador, also known as Profamilia) (IPPF MA)
AGES	Asociación Guatemalteca de Educación Sexual (Guatemalan Association for Sex Education)
APLAFA	Asociación Panameña para el Planeamiento de la Familia (Panama Association for Family Planning) (IPPF MA)
APROFAM	Asociación Pro Bienestar de la Familia Guatemalteca (Association for Family Welfare) (Guatemala IPPF MA)
APROFE	Asociación Pro Bienestar de la Familia Ecuatoriana (Ecuadorian Association for Family Welfare) (IPPF MA)
APROPO	Apoyo de Programas de Población (Support to Population Programs) (Peru)
ASCOFAME	Asociación Colombiana de Facultades de Medicina (Colombian Association of Medical Schools)
ASHONPLAFA	Asociación Hondureña de Planificación Familiar (Honduras Family Planning Association) (Honduras IPPF MA)
AVS	Association for Voluntary Sterilization
AVSC	Association for Voluntary Surgical Contraception
BEMFAM	Bem-estar Familiar do Brasil (Brazil Family Planning Association) (IPPF MA)
BCC	behavior change communication
CA	cooperating agency (USAID-funded)
CBD	community-based distribution
CCT	conditional cash transfer
CDC	U.S. Centers for Disease Control and Prevention
CELADE	Centro Latinoamericano y Caribeño de Demografía (Latin American and Caribbean Center for Demography)

CEMOPLAF	Centro Médico de Orientación y Planificación Familiar (Medical Center for Counseling and Family Planning) (Ecuador)
CEPAL (ECLAC)	Comisión Económica para América Latina y el Caribe (Economic Commission for Latin America)
CFPA	Caribbean Family Planning Affiliation (IPPF association)
CIES	Centro de Investigación, Educación y Servicios (Center for Research, Education and Services) (Bolivia, IPPF MA)
CLAE	Consorcio Latinoamericano de Anticoncepción de Emergencia (Latin American Consortium for Emergency Contraception)
COMISCA	Council of Ministers of Health of Central America and the Dominican Republic
CONAPO	Consejo Nacional de Población (National Population Council) (Mexico)
CORA	Centro de Orientación para Adolescentes (Counseling Center for Adolescents) (Mexico)
CPR	contraceptive prevalence rate
CPS	contraceptive prevalence survey
CS	contraceptive security
DAIAs	disponibilidad asegurada de insumos de anticonceptivos (contraceptive security committees)
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Surveys
EC	emergency contraception
ENDES	Encuesta de Demografía y Salud (Demographic and Health Survey) (Bolivia)
ENDESA	Encuesta Nicaragüense de Demografía y Salud (Nicaraguan National Demographic and Health Survey)
ENDSSR	Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (National Survey on Demography and Sexual and Reproductive Health) (Paraguay)
ENSMI	Encuesta Nacional de Salud Materno Infantil (National Maternal and Child Health Survey) (Guatemala)
EPF	Encuesta de Planificación Familiar (Family Planning Survey) (Paraguay)
FAMPLAN	Family Planning Association of Jamaica (IPPF MA)
FDA	U.S. Food and Drug Administration

FEMAP	Federación Mexicana de Salud y Desarrollo Comunitario (Mexican Federation of Private Health and Community Development Associations)
FESAL	Encuesta de Salud Familiar (National Family Health Survey)(El Salvador)
FP	family planning
FP/RH	family planning and reproductive health
FPA	family planning association
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Agency for Technical Cooperation)
GTZ	Gesellschaft für Technische Zusammenarbeit (former title of the German Agency for Technical Cooperation)
ICPD	International Conference on Population and Development
IDB	Inter-American Development Bank
IEC	information, education, and communication
IERG	Independent Expert Review Group (World Health Association)
IMR	infant mortality rate
INPPARES	Instituto Peruano de Paternidad Responsible (Peruvian Institute of Responsible Parenthood) (IPPF MA)
IPPF	International Planned Parenthood Federation
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IUD	intrauterine device
JICA	Japanese International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
JSI	John Snow International
LAC	Latin America and the Caribbean
LAM	lactational amenorrhea method
LGBT	lesbian, gay, bisexual, and transgender
MA	member association (IPPF)
MCH	maternal and child health
MCPR	modern contraceptive prevalence rate
MDGs	Millennium Development Goals

MEXFAM	Fundación Mexicana para la Planeación Familiar A.C. (Mexican Foundation for Family Planning) (IPPF MA)
MOH	ministry of health
MSH	Management Sciences for Health
MWRA	married women of reproductive age
NGO	nongovernmental organization
OR	operations research
OSAR	Observatorio de Salud Reproductiva (Reproductive Health Observatory)
PAHO	Pan American Health Organization
PASMO	Pan American Social Marketing Organization
PRH	USAID Office of Population and Reproductive Health
PROCOSI	Programa de Coordinación en Salud Integral (Bolivia) (Comprehensive Program of Integrated Health)
PROFAMIL	Association pour la Promotion de la Famille Haïtienne (Association for the Promotion of the Haitian Family, IPPF MA) (Haiti)
Profamilia	Asociación Probienestar de la Familia (Family Welfare Association) (Colombia, Dominican Republic, El Salvador, Nicaragua; IPPF MAs)
PROSALUD	Pro-Health (Bolivia)
PROMESA	Promoción y Mejoramiento de la Salud (Health Promotion and Improvement) (Paraguay)
PSI	Population Services International
RAPID	Resources for the Awareness of Population Impacts on Development
RH	reproductive health
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
SDM	Standard Days Method
SPARHCS	Strategic Pathway to Health Commodity Security
SRH	sexual and reproductive health
TFR	total fertility rate
UNDP	United Nations Development Program

UNESCO	United Nations Economic, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VSC	voluntary surgical contraception
WDI	World Development Indicators
WFS	World Fertility Survey
WHO	World Health Organization

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