"We can help poor families build a better future. We can insist that all people have the opportunity to learn about contraceptives and have access to the full variety of methods... The goal here is really clear: universal access to birth control that women want. And for that to happen it means that both rich and poor governments alike must make contraception a total priority."

Melinda Gates *(2012)*

FORO LAC
Aseguramiento de Insumos de SSR

On the occasion of July's Family Planning Summit, hosted in London by DFID, the Bill & Melinda Gates Foundation, and other partners, 15 members organizations of the **Latin America and Caribbean (LAC) Forum (LAC Forum)****, under the auspices of the Reproductive Health Supplies Coalition, formed an advisory group. The group assembled key messages on sexual and reproductive health and rights (SRHR) with the aim of increasing the visibility of the region at the Summit, and drawing attention to unmet needs. Three key messages stand out:

- It is essential that the international community recognize the right to family planning (FP) and prioritize access by those most vulnerable and at greatest risk of adolescent pregnancy, maternal mortality and unsafe abortion.
- Donors should consult with national governments and civil society on major needs and gaps. Together, they should develop strategies for transitioning towards sustainable national ownership of the health sector through targeted technical and financial support.
- The role of civil society remains key. Civil society is increasingly prepared to help governments fulfill their commitments, demand accountability, and carry out joint advocacy activities. Strengthening the relationship between civil society and government is critical for ensuring good governance, adequate spending on health, and strong national ownership.

The paradox of development: Economic growth, the burden of inequity and its impact on sexual and reproductive health in the LAC region

Inequity

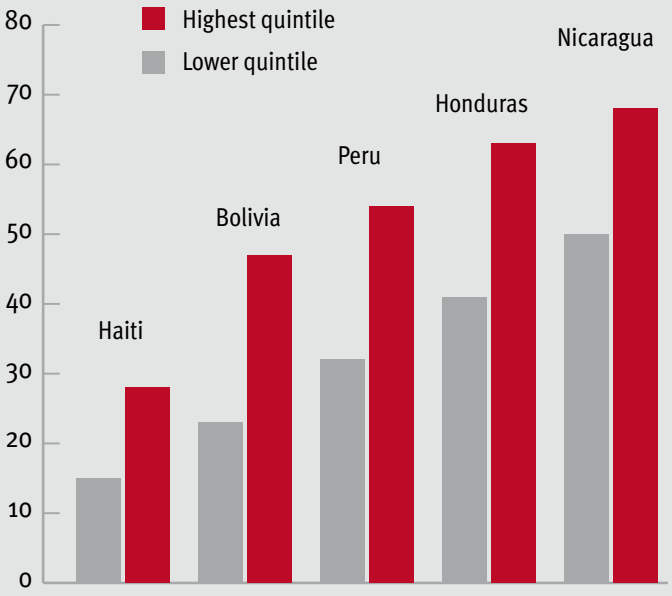
Latin America and the Caribbean (LAC) is a region of contrasts. Despite two decades of continued democratic development and the existence of various middle income countries, there remain large health disparities not only among countries but also within them.

Many of those who struggle to obtain even the most basic health care services rendered invisible by what is often viewed – certainly compared to other parts of the world – as relative prosperity. Acute inequities in access to health care systematically marginalize the socially disadvantaged: the poor, women, ethnic minorities and the geographically remote. This inequity

translates into unacceptably high rates of maternal mortality and morbidity, unsafe abortions and adolescent pregnancies. Strong correlations exist between income distribution, education and access to health supplies and services, including Sexual and Reproductive Health SRH.[1] In Guatemala and Bolivia, for example, contraceptive prevalence averages about 40% for women without education and 70% for those who have at least started high school. In Ecuador, the averages are 50% and 80%, respectively.[2]

Total fertility rate by level of education (2008)[3]			
Country	No education	Elementary	High school
Bolivia	6.1	4.7	2.8
Colombia	4.3	3.2	2.0
Guatemala	5.2	3.8	2.3
Honduras	4.9	3.8	2.2
Nicaragua	4.4	3.2	2.0

Contraceptive prevalence (%) by income quintile



Source: WHO. Global Health Statistics, 2012.

The tyranny of averages

The degree to which seemingly good macroeconomic indicators mask pockets of poverty represents a "tyranny of averages". This tyranny offers an impression divorced from the true reality on the ground – an impression that effectively denies women who do not want to get pregnant, from access to contraceptives and other SRH services and to information and recognition of their SRHR.

Social gaps and inequalities persist and may even worsen without targeted support. Rights-based approaches should take the needs of these very different populations into account and look beyond country and regional averages to address the real problems at hand with adequate support and funding.

Maternal mortality ratio: maternal deaths per 100,000 live births[4]	
LAC region	80
Chile	25
Uruguay	29
Honduras	100
Guatemala	139
Dominican Republic	150
Bolivia	190
Guyana	280
Haití	350

The determinants of development assistance, therefore, must look beyond national levels of income. They should be informed instead by indices of poverty, human development and social exclusion. Blanket approaches that fail to take this regional reality into account will derail progress made so far.

Unmet need, maternal mortality, abortion and sexual and reproductive health and rights of adolescents: pending issues in the region

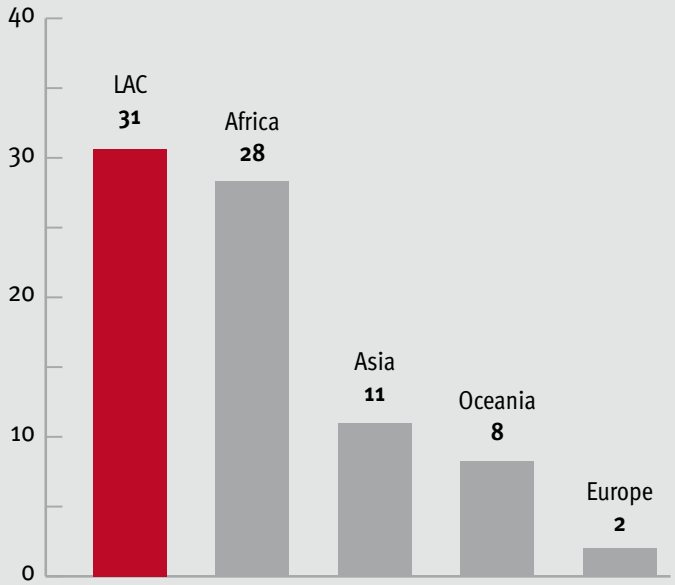
the **unmet need** for modern family planning in the region has fallen marginally from 25% in 2008 to 22% in 2012. Meanwhile, among the region's poorest countries which include Bolivia, Haiti, Honduras and Nicaragua, unmet need has basically stagnated with an increase of only one percentage point in the same period.[5]

At the regional level, rates of **maternal mortality** have declined. But among countries as well as within them, disparities are wide. Among some populations, maternal mortality rates even approach levels in Africa. The differences between countries make for an even more compelling picture. For example, the maternal mortality rate in Chile is 25 per 100,000 live births while in Bolivia it is 190 [6] In Haiti and Guyana, rates of maternal mortality reach a staggering 350 and 280 per 100,000 live births, respectively. As often is the case, the poor, young, indigenous populations and those of African descent carry the heaviest burden.

Unsafe abortion contributes greatly to maternal mortality. The region has about 4.2 million abortions a year, 93% of which take place in unsafe conditions. Both rates are the highest in the world.[7]

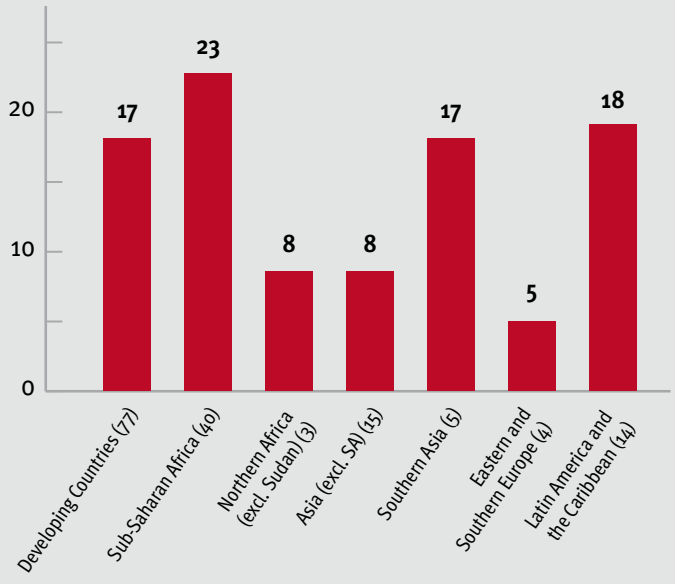
Adolescent pregnancy rates in the LAC region are one of the highest in the world, and in some cases approximate those of sub-Saharan Africa. Approximately 38% of women in the region become pregnant before the age of 20 and almost 20% of

Unsafe abortion ratio
Per 1000 women 15-44 years old



Source: WHO. Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008.

Percentage of women 15-19 years who have initiated childbearing



all births are to adolescent mothers. In some countries including Bolivia, Colombia, Ecuador, and Peru, the adolescent pregnancy rate is growing. And in others, such as Nicaragua, the pregnancy rate among girls aged 10 to 14 has increased faster (47.9% in 2009) than among older teenagers – the probable cause being sexual violence.[8] In Argentina, births among the age group 10-14 years is 1.74 per 1,000 women and, in Panama, it exceeds 3 per 1,000. These levels are likely to remain stable and possibly even increase.[9]

In certain vulnerable populations, **adolescent fertility** has stagnated, and in some cases has even increased, compared to sharp declines at national levels. Socio-economic and educational status is strongly correlated with adolescent pregnancy as well as access to contracepti on and other SRH services. Pregnancy rates are three to five times higher for adolescent girls in poor, indigenous and rural areas. Adolescent pregnancy exacerbates already limited access to education and employment, and intensifies social and gender inequities.

Access to contraception is a limited right. In several countries in the region, adolescents need a prescription to buy condoms and use of health services by minors is not permitted by law unless they are accompanied by an adult.
Mesoamerican Initiative-Foro LAC workshop, 2012

In addition to socioeconomic factors, adolescents also face obstacles in overcoming the limited autonomy afforded them by a society that is, in general, highly conservative[11]. Moreover, this conservatism has had a negative effect on educational policies on SRH, and reinforced legal obstacles that already limit access to contraception, as in the case of emergency contraception.

Achievements and other equally important challenges

The achievements of the region are numerous and undeniable. One is the ability and willingness of regional stakeholders to coordinate and work together. A case in point is the institutionalization of national reproductive health (RH) commodity security committees and the inclusion of SRHR as in public policy. However, despite national ownership of the Cairo agenda by some countries in the region, much remains to be done.

Maternal mortality, unsafe abortion and adolescent pregnancy are confounded by challenges that impede access to quality services. There remains an overwhelming need to strengthen supply systems in a comprehensive manner, address legal and regulatory restrictions, expand the range of modern contraceptives, including emergency contraception, and address the high turnover and poor training of human resources. All these challenges are rooted in the fragility of health systems.

Gaps in health financing

Rapid economic growth in the region, coupled with declining fertility rates, have contributed to a gradual withdrawal of the donor community – often without adequate transition strategies. The region's human and social development indicators remain dire, especially among the most vulnerable including the poor,

indigenous, youth, those of African descent, and rural women. Macroeconomic advances do not automatically lead to general improvement in the quality of life or an equitable distribution of income. Therefore GDP cannot be the sole indicator for making decisions on development aid.

In 2010, only 0.5% of official development assistance aimed at LAC addressed the area of SRH. In 2010, SRHR funding was reduced by 31% to governments and by 20% to civil society organizations.
OECD, 2011

Data indicate that national health expenditures have not kept up with economic growth. In the last decade, LAC countries, despite their economic development, continue to devote an insufficient percentage of their Gross Domestic Product (GDP) to health (7.7%). Approximately 34% of all health expenditures in the region is out of pocket. This is the highest level in the world - higher than that of Africa (32%) and more than double that of the OECD countries (14%). For SRH, out of pocket spending is even higher.[12]

From 2005 to 2010, the region's GDP grew by 73%, while health spending grew only by 12%.
World Bank, 2011

In the face of donor withdrawal, therfore, it is essential that governments assume responsibility for financing health in general and SRHR in general. That, together with attention to education, is essential to take advantage of the region's emerging demographic dividend[13] and produce benefits for present and future generations.

The role of civil society for country ownership

In this scenario, the **role of civil society** is crucial in ensuring that governments take charge of both policy and funding, fight against inequality and corruption and use financial resources wisely and effectively. It is critical, therefore, that the international community support efforts by civil society to advocate with health ministries to address the scarcity of resources, strengthen commitments to SRHR, and focus on programmes for vulnerable groups.

Reproductive Health
SUPPLIES COALITION

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The **LAC Forum is a regional partnership within the Reproductive Health Supplies Coalition that brings together 250 actors from the public and private sector of the LAC region with the aim of facilitating exchange of experiences and technical collaboration, as well as minimizing duplication of efforts through harmonization and coordination. UNFPA LACRO is the current Chair of the Forum.

USAID | DELIVER: Nora Quesada, Anabella Sánchez

1) The Inter-American Development Bank
2) Social Panorama of Latin America 2011, ECLAC
3) CELADE- Population Division of ECLAC, based on demographic and health surveys (DHS) and Centers for Disease Control and Prevention (CDC).
4) Ibid
5) Susheela Singh and Jacqueline E. Darroch, in "Adding it Up Costs and Benefits of contraceptives services estimates" for 2012; Alan Guttmacher, y UNFPA, June 2012
6) Trends in maternal mortality 1990-2010 (UNFPA, WHO, UNICEF, WB)
7) Social Panorama of Latin America 2011, ECLAC
8) Maternal Health Profile ODM5. Nicaragua. MINSA, OPS 2010
9) FLASOG-UNFPA,2011
10) ICF International, 2012, data refer to 1994-2010
http://www.un.org/esa/population/cpd/cpd2012/Keynote%20presentations/CPD45_Keynote_Jejeebhoy.pdf
11) E.g., In Peru, according to Law 28704, sexual relations with adolescents aged 14 to 18 are considered a crime of rape and health service providers are obliged to report these incidents to the authorities.
12) World Bank data http://databank.worldbank.org/ddp/home.do
13) Temporary situation in which dependency rates descend to historic lows, providing the opportunity to increase savings rates and growth of economies. As parents reduce family size, countries can invest more in educating young people who, therefore, will boost productivity and economic growth when they reach working age.