Family Planning in Haïti

The Achievements of 50 Years

April 2015

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PREFACE

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

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

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OVERVIEW
COUNTRY SITUATION

Haiti is the poorest country in the Latin America and Caribbean (LAC) region, with nearly 80 percent of the population living on less than U.S. $2 per day and 54 percent living on less than U.S. $1 per day. According to the World Bank, in 2013, Haiti´s gross domestic product (GDP) was U.S. $8.5 million,[1] making it one of the poorest nations in the world.[2] Real per capita GDP declined by 30 percent between the 1960s (when family planning [FP] programs began) to the 2000s.[3] A slight upward trend in GDP began in the 2000s, but it has been modest. Economic growth is slow due to already wrenching poverty, corruption and lack of basic infrastructure.

Extreme political instability and rampant violence during much of the last 50 years has affected Haiti´s economic and social development, as well as its ability to meet the health and family planning needs of the population. Ecological degradation in the countryside and vulnerability to national disasters, including earthquakes, hurricanes and flooding, are especially problematic in Haiti. Hurricanes, tropical storms and resultant flooding recur frequently and pose persistent challenges for the country as a whole and the health system in particular. The devastating earthquake of 2010 which killed an estimated 250,000 people, injured 300,000 and left at least one million homeless was a recent watershed event that has had a major effect on Haiti´s current situation.[4]

The current population of 10.1 million (July 2013 estimate) is 95 percent black (African descent) and 5 percent mixed or white. Life expectancy at birth is 64 years for women and 61 years for men. About 53 percent of the population lives in an urban environment. Port-au-Prince was built for a population of 200,000 and currently more than 2 million people call it home.[5]

French and Haitian Creole are the official languages of Haiti and are taught in the schools. Haitian Creole is spoken by 100 percent of the population. While no data on Creole literacy rates are available, a much smaller proportion of the population can read and write in Creole.

Haitian women experience high levels of gender-based discrimination. Rural women in particular have little access to education and must work extremely long hours.[6] In the urban areas women have been described as ¨the backbone of the informal economy¨ but are often excluded from the more highly-paid formal sector. In the city, the high levels of unemployment generally

[1] World Bank. Country data – Haiti [Web page]. Washington, DC: World Bank; nd. Retrieved from: http://data.worldbank.org/country/haiti#cp_wdi.
[2] World Bank. Country overview—Haiti [Web page]. Washington, DC: World Bank, nd. Retrieved from: http://data.worldbank.org/country/haiti
[3] Taft-Morales M. *Haiti Under President Martelly: Current Conditions and Congressional Concerns*. Washington, DC: Congressional Research Service; 2012.
[4] Kent MM. *Earthquake Magnifies Haiti's Economic and Health Challenges*. Washington, DC: Population Reference Bureau; 2010.
[5] Kent, 2010.
[6] Haiti Net. Gender in Haiti [Web page]. Boston, MA: Haiti Net, Northwestern Univeristy; 2012. Retrieved from: http://www.northeastern.edu/haitinet/gender-in-haiti/.

mean that women find it particularly difficult to find work. Cultural and societal norms still dictate that women do all of the childcare and housework.[7]

Forty-one percent of Haitian households are headed by women,[8] and the average household size is 4.4 people. Labor migration is particularly high among Haitian men, many of whom go to the Dominican Republic or to the U.S. for extended periods to work. The high percentage of female-headed households may contribute to women´s childbearing decisions, particularly in rural areas. An ethnographic study conducted in rural Haiti theorized that the absence of men led women to have more babies because children become an important source of additional labor in the women-headed households.[9]

In Haiti, childbearing patterns are correlated with the kind of union in which a woman is engaged. Formal marriage *(marye*) is practiced primarily by the elite due to the costs involved with a church ceremony. The most common kind of union is the *plasaj*; this kind of union tends to be stable and enduring, but costs less than a church marriage. *Plasaj* unions are explicitly based on economic agreements in which men agree to provide for women and children. In addition, there are more loosely formed unions (*vivav'ek*, r*emen* and *menaj)* in which there is cohabitation and differing levels of ties, but no formal agreement of economic support. It has been observed that women in the less formal types of unions may have more children. These women are generally poorer and may be more likely to have children in order to cement the relationship and ensure economic support for themselves and their children.[10]

Chronic and acute malnutrition and food insecurity are serious problems in Haiti with 81 percent of the national population and 87 percent of the rural population lacking the minimum daily ration of food defined by the World Health Organization. High levels of poverty and lack of access to education and health care have contributed to a high infant mortality rate of 59 deaths/1,000 live births. However, infant mortality has decreased markedly from the 2007 rate of 79 /1,000 live births. The under-5 mortality rate is 88 deaths per 1,000 live births, and the estimated maternal mortality ratio (MMR) is 380 deaths/100,000 live births.[11]

OVERVIEW OF CONTRACEPTIVE USE AND UNMET NEED IN HAITI

Haiti's total fertility rate (TFR) remains the highest in the Latin America and Caribbean region, although it has decreased from 4.8 in 1994 to 3.5 in 2012 (table 1). Women with higher education (secondary education and above) have an average of 2.6 children compared with 5.4 children for those who have less than a secondary education. Household wealth is inversely

7 Haiti Net, 2012.
8 Ministère de la Santé Publique et de la Population (MSPP). *Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-V) 2012*. Calverton, MD: MSPP, ICF International; 2012.
9 Schwartz TT. *Fewer Men, More Babies: Sex, family, and Fertility in Haiti*. Lanham, MD: Lexington Books; 2009.
10 Maynard-Tucker G. Haiti: unions, fertility, and the quest for survival. *Soc Sci Med.* 1993. 43(9):1379-1387.
11 World Health Organization (WHO). *Maternal Mortality in 1990-2013*. Geneva, Switzerland: WHO; 2013. Retrieved from: http://www.who.int/gho/maternal_health/countries/hti.pdf?ua=1.

correlated with fertility; women in the lowest wealth quintile have almost three times as many children (5.7) as women in the highest wealth quintile (1.9).[12]

Haiti's modern contraceptive prevalence rate (MCPR) increased substantially from 13.2 percent in1994 to 31.3 percent in 2012. Nevertheless, the MCPR remains the lowest in the LAC region. Unmet need remains at one of the highest levels in the world, 35.3 percent. Supply issues, socio-economic factors, and socio-cultural issues around fertility and childbearing all contribute to persistent elevated levels of unmet need.

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/In-Union Aged 15-44, Haiti, 1994-2012

	1994-1995	2000	2005-2006	2012
Total Fertility Rate	4.8	4.7	3.9	3.5
Contraceptive Prevalence Rate (%)	18.0	28.1	32.0	34.5
Modern Contraceptive Prevalence Rate (%)	13.2	22.8	24.8	31.3
Unmet Need (%)	44.7	39.6	37.3	35.3

Sources: Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS) data, obtained via DHS Statcompiler.[13]

The three most common methods of contraception used in Haiti (figure 1) are injectable hormonal contraception (Depo-Provera), condoms, and oral contraceptives. The use of injectable contraceptives has increased dramatically in recent years; in 1994 injectables accounted for only 2.7 percent of contraceptive use, while in 2012 over half (56.2 percent) of contraceptive users opted for injectables. The obvious benefits of the three-month injectables (do not require partner involvement, do not require taking a daily contraceptive pill, and can be used discreetly) may be the principal reason for the high level of utilization. However, this high level of reliance on a single method is potentially problematic for several reasons: women may not have access to a wide range of methods due to supply issues or provider promotion of specific methods; reliance on a single method increases the program´s vulnerability to procurement problems related to that method; and the need for relatively frequent re-supply of injectables may put an undue burden on women and represent higher costs for the health system as compared to more long-acting methods such as the IUD, hormonal implants and female sterilization.[14] The Ministère de la Santé Publique et de la Population (MSPP – Ministry of Public Health and Population) and USAID are instituting measures to expand availability and promotion of a broad range of methods through measures described in sections below; this will improve real access to a wider range of methods.

[12] MSPP, 2012.

[13] EMMUS-V, 2012; Ministère de la Santé Publique et de la Population (MSPP). 2006. *Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-IV) 2005-06*. Calverton, MD: MSSP, ICF International; 2006. Ministère de la Santé Publique et de la Population (MSPP). *Enquête Mortalité, Morbidité et Utilisation des Services (EMMUS-III) 2000*. Calverton, MD: MSSP, ICF Macro; 2001.

[14] Bertrand JT, Sullivan T, Knowles EA, Zeeshan MF, Shelton J. Contraceptive method skew in low- and middle-income countries: continuing concerns despite modest improvement. *Intern Perspect Sexual Reprod Health.* 2014. 40(3).

Condom use has remained stable (14.5 percent of users in 1994-95 and 14.8 percent in 2012) while the use of oral contraceptives has declined by more than half, from 17.8 percent in 1994-95 to only 8.1 percent of total contraceptive use in 2012. Observers note that the majority of women have shifted from oral contraception to injectables, a phenomenon that has been documented in other countries in the region.[15]

Use of the least reliable methods is low (4.6 percent for rhythm, 3.2 percent for withdrawal and 1.4 percent for other traditional). Withdrawal has declined sharply from 13.0 percent in 2006 to 3.2 percent in 2012.

Despite efforts to increase access to and use of female sterilization in the 1980s, the method still only represented 17.3 percent of all method use in 1994-95 and has declined steadily in later surveys. Potential reasons for this include service provision -related factors such as inadequate provider training and lack of promotion of the method.[16] Demand-related factors such as low levels of knowledge of the method and myths around the effects of female sterilization appear to play a role in limiting use of this method, but knowledgeable respondents indicate that the supply limitations may be more relevant. There are extremely low levels of IUD use (0.3 percent) as well, and again it is suspected the lack of provider training and promotion have played a major role in limiting use of this method. Male surgical contraception has been the least used and remains extremely low in 2012 (only 0.1 percent of contraceptive use).

In 2012, the public sector hospitals and health centers provided only 23 percent of contraceptives used in the country (figure 2). Numerous private sector channels provided 58.4 percent of all contraceptives, including a relatively large percentage (14.7) that is provided by non-medical organizations.[17] Community health workers (CHWs), in both the public and private sector, delivered 11.8 percent of contraceptives.

As can be seen in table 2, adolescent fertility has declined from 86/1000 births in 2000 to 66/1000 births in 2012. Impressively, utilization of modern contraception among women 15-19 in union increased more than threefold, from 7.1 percent in 2000 to 24.0 percent in 2012.[18] However, this increase in CPR has had little effect on unmet need among this age group. The 2012 Demographic and Health Survey (DHS) reports that unmet need for 15-19 year olds in union is 56.6 percent, down only very slightly from 58.4 percent in 2000. This large increase in use and stable levels of unmet need may suggest that family-size desires are shifting, but knowledge of methods and access to contraceptive methods have not kept pace. The government's efforts to improve promotion and access to address unmet need are described in the sections below.

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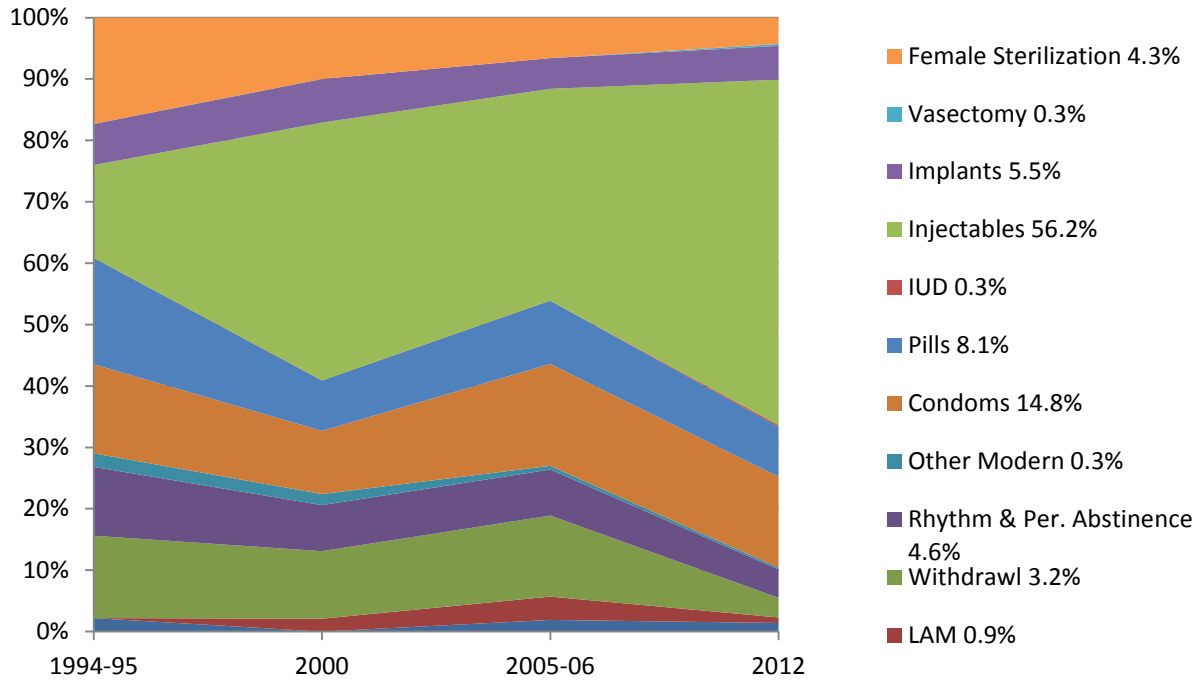
15 Sutherland EG, Otterness C, Janowitz B. 2011. "What happens to contraceptive use after injectables are introduced? an analysis of 13 countries. *Intern Perspect Sexual Reprod Health.* 2011. 37(4):202-208.

16 Haiti seminar discusses voluntary sterilization. (Research Triangle Park, NC: Family Health Inernational.) *Nework.* 1984. *5*(2):6.

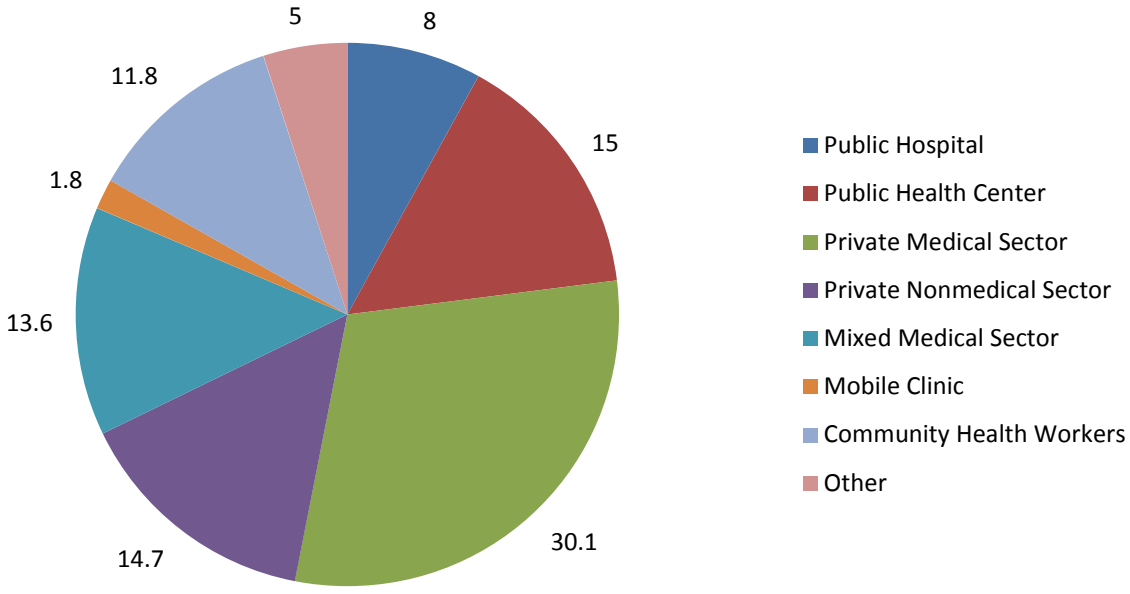
17 Almost half of all condoms used in Haiti are obtained from private non-medical organizations, as part of condom-promotion programs related to HIV prevention.

18 EMMUS 2001 and EMMUS 2012



Source: EMMUS 2012.
Percentages in legend refer to most recent survey, 2012.

Figure 1: Method mix (Haiti, 1994-2012).



Source: EMMUS 2012.

Figure 2: Method source (Haiti, 2012).

Table 2: Trends in Contraceptive Use and Unmet Need for Adolescents Aged 15-19, Married or In Union, and Adolescent Birth Rate, Haiti, 1994-2012

	1994-1995	2000	2005-2006	2012
Birth Rate per 1000	76	86	68	66
Total Fertility Rate	4.8	4.7	3.9	3.5
Contraceptive Prevalence Rate (%)	10.7	16.4	28.5	25.6
Modern Contraceptive Prevalence Rate (%)	7.7	7.1	20.2	24.0
Unmet Need (%)	61.1	58.4	52.4	56.6

Source: EMMUS.

According to Haiti's 2012 DHS, 14 percent of young women ages 15-19 in union have already begun child-bearing. The median age at first birth for all women age 25-49 is 22.7 years, which is comparable to many other countries in the region. Historically in Haiti, the gap between adolescent birth rates in urban and rural areas has been wide, and recent data fail to show improvement in this trend. In 2012, the urban adolescent birth rate was 49/1000 girls 15-19 years old; in rural areas it was 78/1000 girls.[19] Access to health services in some rural areas continues to be inadequate.[20]

THE EARLY YEARS (1960-1979)

Reports of rapid population growth in Haiti were first published in the late 1950s, when the country's population was approaching three million.[21] Following the first census conducted in 1950, Haitian demographers proposed the inclusion of FP as an essential component within community health programs. Community leaders, physicians, FP activists, and government representatives joined forces to build government support for FP initiatives, which resulted in the establishment of the National Council of Family Planning in 1964. Shortly thereafter, an official government statement was issued supporting FP and the national council. The council held regular informal meetings to discuss family planning, thus marking the beginning of the FP movement in Haiti.

In the 1960s, there was considerable enthusiasm and momentum in Haiti around the idea of family planning; private and public sector leaders were discussing a national strategy.[22] By 1965, 17 facilities were providing FP in Haiti, reaching a little over 7,000 people in the capital city by 1967.[23] These activities were integrated into existing maternal and child health activities in

[19] EMMUS 2001; EMMUS 2012.
[20] Urrutia R et al. Unmet health needs identified by Haitian women as priorities for attention: a qualitative study. *Reprod Health Matters.* 2012. 20(39):93-103.
[21] Moral P. 1961. *Le Paysan Haïtien: Étude sur la Vie Rurale en Haïti*. Paris, France: G.P. Maisonneuve & Larose; 1961.
[22] Moral, 1961.
[23] Bordes A, Couture A. *For the People, For a Change: Bringing Health to the Families of Haiti*. Boston, MA: Beacon Press; 1978.

private clinics and were largely funded by international organizations. In 1969, the government of Haiti suggested a pilot project, beginning in an urban and a rural zone. The plan was to gradually extend FP throughout the country, while developing the necessary infrastructure to meet the needs of the people. The national program was designed to complement the private programs that were already providing FP services.

Haiti has historically been predominantly Roman Catholic country although currently approximately half of the population (54.7 percent) is Roman Catholic.[24] Most of the rest of the population is protestant, of various denominations. Historically, numerous Catholic priests have been involved in Haitian politics, although there is no state religion.[25] Key informants report that while there was some overt opposition to family planning by the Roman Catholic Church in the 1970s, this has diminished.

In 1971, following the death of Francois "Papa Doc" Duvalier, the country's president, and the appointment of his son Jean Claude "Baby Doc" Duvalier as president, Haiti's Council of Ministers approved a FP policy which provided for the integration of FP into maternal-child health programming. The Haitian Parliament restructured the MSPP, creating a division of Family Hygiene (now called the Direction de la Santé de la Famille – Family Health Directorate), which was responsible for supervision and coordination of all public and private activities concerned with child health, including family planning.

Since 1973, the U.S. has been Haiti's primary donor for FP assistance.[26] In the early to mid-1970s, USAID's program included support to the government to strengthen its maternal and child health (MCH) and FP program, as well as support to nongovernmental organizations (NGOs) that provided such services. Several new organizations were created that focused on community health initiatives and FP.[27] In 1974, Centre de Développement et Santé (CDS, Center for Health and Development), a private nonprofit organization, was founded by a former minister of health. CDS and received funding from USAID to implement FP services. CDS began its work in Cité Soleil (an impoverished section of Port-au-Prince) and still provides health and social services throughout urban and rural Haiti.

EFFORTS TO BUILD A PROGRAM DESPITE INSTABILITY (1980-1999)

Haiti experienced increased political instability and violence in the early 1980s. In 1986, Jean Claude "Baby Doc" Duvalier was ousted. The National Family Planning Council was also dissolved in 1986, and a year following Duvalier's departure, the U.S. government discontinued assistance to the government of Haiti. The public sector FP outreach project was terminated. Due

[24] Institut Haitien de Statistique et d'Informatique. *Présentation Générale des Résultats*. 2003. Retrieved from: http://www.ihsi.ht/rgph_resultat_ensemble_population.htm.

[25] U.S. Department of State. *International Religious Freedom Report*. Washington, DC: U.S. Department of State; 2003. Retrieved from: https://www.osac.gov/pages/ContentReportDetails.aspx?cid=14000.

[26] U.S. Department of State. Fact sheet: U.S. relations with Haiti [Web page]. Washington, DC: U.S. Department of State; 2013. Retrieved from http://www.state.gov/r/pa/ei/bgn/1982.htm.

[27] U.S. Department of State, 2013.

to the widespread corruption and political instability, international organizations and local NGOs became the main suppliers of services and contraception by the mid-1980s.[28]

The Association pour la Famille Haitienne (PROFAMIL) was founded in 1984 and soon became an important local provider of FP services. By 1986, PROFAMIL had become part of the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR) and in the late 1980s USAID began to channel funds through IPPF/WHR to PROFAMIL and other smaller NGOs to do FP and HIV-prevention work in the country.

The Fondation pour la Santé Reproductive et l' Education Familiale (FOSREF, Foundation for Reproductive Health and Family Education) was founded in 1988 and became another major provider of FP and HIV services. Initially funded by USAID through IPPF/WHR, FOSREF later developed the management and accountability structures necessary to receive direct PEPFAR (U.S. President's Emergency Plan for AIDS Relief) support and to serve as a sub-contractor on USAID projects. FOSREF continues to work in Haiti to the present.

In the early 1980s, the first cases of HIV infection were diagnosed in the Western Hemisphere. Haiti's initial response to the epidemic (in 1982) included the creation of the Groupe Haïtien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO, The Haitian Group for the Study of Kaposi´s Sarcoma and Opportunistic Infections). GHESKIO was dedicated to providing service, research and training to combat HIV and continues to be the principal provider of services in collaboration with the MSPP and with funding from PEPFAR. GHESKIO developed a model of comprehensive care for HIV/AIDS and related illnesses. Central to the GHESKIO model is the concept that an individual at risk or already infected with HIV should be quickly identified and provided access to a package of services including voluntary counseling and testing, management of sexually transmitted infections, tuberculosis screening and treatment, reproductive health services (including FP), HIV care including antiretroviral therapy, and services to prevent mother to child transmission of HIV.[29] According to observers, by the late 1980s HIV/AIDS- related funding had outstripped family planning funding, as the government of Haiti and its national and international partners struggled to contain the rapidly-growing epidemic.

One uniquely Haitian project attempted to use the widespread practice of *voudoun* (voodoo), a religion that worships a series of domestic spirits, to promote HIV prevention and FP. A large segment of the population (anecdotal evidence suggests well over half) practices *voudoun*. A USAID-funded project implemented by PROFAMIL relied on voodoo specialists as change agents to promote FP and HIV messages.[30] *Voudounists*, those who practice voodoo, prize having multiple sexual partners, so HIV prevention messages were particularly important to reduce HIV transmission. Anecdotal reports suggest that the voodoo specialists were an important channel of communication for both health and FP messages.[31] While that project

[28] Maternowska MC. *Reproducing Inequities: Poverty and the Politics of Population in Haiti*. New Brunswick, NJ: Rutgers University Press; 2006.
[29] GHESKIO Centers. Integrated primary care for HIV and related diseases [Web page]. Port-au-Prince, Haiti: GHESKIO Centers; 2013. Retrieved from: http://gheskio.org/wp/?page_id=16.
[30] Barker K.2004. Diffusion of innovations: a world tour. *J Health Comm.* 2004. 9(S1):S131-S137.
[31] Popline Working with voodoo, reaching wut: Haiti. *Forum.* 1995. 11(2):3-4.

ended, it has been a model for other projects that have involved voodoo specialists to promote HIV prevention and FP methods that are meaningful for target populations.[32]

Social marketing of condoms began in Haiti in 1989 with the introduction of the *Pantè* condom, followed by a series of other products over the years. In 1996, *Pilplan*, an oral contraceptive, and *Confiance*, an injectable, were introduced. USAID support has been crucial to developing the social marketing efforts and to building local capacity among NGOs to brand, market, and advertise contraceptives and other health products.[33]

In 1991, Haiti's military staged a violent coup d´état, ousting then President Jean Bertrand Aristide. The newly formed repressive military government provided minimal levels of support to public health, resulting in even more drastic decreases in access and quality of services for Haiti's poor. The United Nations imposed a trade embargo on Haiti to push for the restoration of democracy. Three years of economic embargo further worsened the provision of health services.[34] By 1994, when Aristide was re-instated as president, the MSPP health services were largely non-existent, and donors were reluctant to provide funding to the fragile government.[35] This situation continued for most of the next decade.

SLOW PROGRESS (2000-2009)

Haiti's repeated political upheavals and continuing economic weakness in the decade of the 2000s continued to affect efforts to improve the health and lives of the Haitian people in general and reproductive health and family planning in particular. While in most Latin American and Caribbean countries the 2000s saw some consolidation of gains in health status, progress in Haiti was limited by the political situation.

Jean-Bertrand Aristide was re-elected president of Haiti in 2001 amidst tremendous political controversy. In January 2004, Aristide was overthrown in the thirty-third coup d'état since its independence in 1803. That same year, the United Nations established the MINUSTAH (United Nations Stabilization Mission in Haiti) to help ensure rule of law and support human rights. The election of a new administration in 2005 allowed for limited efforts in the health arena, but the years of upheaval had taken a severe toll on the capacity of the MSPP and on donor enthusiasm for investing in the country. There was limited progress in health, including FP.

In 2008, the USAID/Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment reported that the FP program in the country suffered from severe management problems, inadequate provider knowledge, poor quality of care, limited contraceptive method mix, frequent and prolonged stock-outs and problems with access to services due to insufficient

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[32] Fort S. Modern health care groups collaborate with voodoo priests to help identify the HIV-positive [Web page]. Washington, DC: International Consortium of Investigative Journalists; 2006. Retrieved from: http://www.icij.org/projects/divine-intervention/modern-health-care-groups-collaborate-voodoo-priests-haiti-help.

[33] U.S. Agency for International Development)/Haiti. *USAID/Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment*. Cambridge, MA: Management Sciences for Health; 2008. Retrieved from: http://pdf.usaid.gov/pdf_docs/PDACP887.pdf.

[34] Farmer P, Fawzi MC, Nevil P. Unjust embargo of aid for Haiti. *The Lancet*. 2003. 361(9355):420-423.

[35] Maternowska, 2006.

and poorly-located service delivery points. The FP program was described as the ¨poor stepchild of the MCH program¨ and contrasted this with well-funded HIV/AIDS efforts. The report concluded that FP was a ¨largely neglected programmatic area.[36]

One notable exception to the lack of progress in reproductive health was the area of HIV. Access to HIV prevention and care improved in the 2000s with funding from PEPFAR and other sources, including the Global Fund for AIDS, Tuberculosis, and Malaria. Other health services (including maternity care and FP) remained woefully inadequate. A Haitian ministry official reported in 2004 that the ministry had sophisticated equipment and supplies for assessing viral loads of HIV positive patients, but lacked basic laboratory services needed for safe pregnancy and childbirth.[37]

THE 2010 EARTHQUAKE AND ITS AFTERMATH (2010-2014)

Haiti's already fragile economy and lack of basic infrastructure was severely impacted when the massive earthquake (magnitude 7.0) struck in January 2010. The epicenter of the earthquake was located approximately 20 kilometers outside the capital city. Estimates are that 250,000 people were killed and at least 1 million were internally displaced. The earthquake was assessed as the most damaging in the region over the last 200 years.[38]

Prior to the 2010 earthquake, estimates of the number of NGOs operating in Haiti ranged from 3,000 to as many as 10,000. In the wake of the 2010 earthquake, there was a major influx of international aid as well as the creation of new NGOs. Donor countries pledged billions of dollars to contribute to Haiti's relief and rebuilding efforts. Immediate assistance arrived in Haiti, along with outpouring of support from the international community. Initial efforts were focused on rescuing survivors and providing basic necessities (water, shelter, security, and medication).[39]

The MSPP was incapable of providing any services in the immediate aftermath of the disaster, due to the destruction of much of the infrastructure in Port-au-Prince, including its main offices. International organizations and local NGOs (those not badly affected by the disaster) stepped in and provided emergency relief, including trauma care. Organizations specializing in emergency humanitarian aid, such as International Rescue Committee and Doctors without Borders, quickly responded and provided emergency medical care under the coordination of the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA).

USAID headed the U.S. government's response to the earthquake, which involved relief missions by all branches of the U.S. military in the initial aftermath of the quake as well as donations of food and shelter. The agency implemented a large-scale recovery strategy that has involved multiple sectors (housing, energy, economic and food security, health, education and

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36 USAID/Haiti, 2008.

37 Bongaarts J, Cleland J, Townsend JW, Bertrand JT. *Family Planning Programs for the 21st Century: Rationale and Design.* New York: The Population Council; 2012.

38 United Nations Stabilization Mission in Haiti (MINUSTAH). *Background.* New York, NY: MINUSTA; 2013.

39 Klarreich K, Polman L. 2012. The NGO republic of Haiti: how the international effort to help the devastated country has left out its people." *The Nation.* 2012. 295(21):11. Retrieved from: http://www.thenation.com/article/170929/ngo-republic-haiti.

disabilities). USAID´s major health projects continued to operate, providing commodity support and services throughout the post-earthquake period.

Providing key sexual and reproductive health (SRH) and FP services to displaced people living in internally displaced persons (IDP) camps was a major challenge following the earthquake. Family planning is frequently ignored in disasters, but this did not occur in Haiti. USAID-supported organizations and the IPPF member associations (MAs), PROFAMIL, were providing FP services within days of the quake. An IPPF MA in the Dominican Republic worked closely with IPPF/WHR and the International Federation of the Red Cross (IFRC) to ensure that PROFAMIL could provide services in the immediate aftermath despite the death of its executive director as a result of the earthquake.

UN OCHA coordinated all the bilateral, multilateral, and international NGOs involved in the relief effort. Interviewed humanitarian aid professionals reported that this was the largest relief effort ever mounted. Each sector met independently and a specific cluster on SRH was created to oversee the provision of SRH services.[40] Haiti's government was not familiar (nor prepared) with the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations and was unable to implement the program post-earthquake. The MISP is a series of activities developed in order to manage key areas in reproductive health at the onset of a crisis, namely minimizing consequences of sexual violence, preventing maternal and newborn morbidity/mortality, and reducing HIV transmission.[41] Despite a lack of government preparedness, international NGOs coordinated by the United Nations Population Fund (UNFPA) worked to implement FP and other components of the MISP package.[42]

In October 2010, Haiti was again struck with a disaster; a cholera epidemic broke out in the central plateau of the country. Haiti had never experienced a cholera outbreak in its history and it caused massive confusion, panic, and fear. Cholera spread to all districts in the country; as of March 2014, it had killed over 8,500 people. Already plagued with disaster, the cholera outbreak set back Haiti's reconstruction and rebuilding efforts ten-fold according to a UN report.[43]

Although humanitarian relief organizations aim to provide reproductive health services during crisis, a gap in funding and services typically emerges between the crisis period and implementation of long–term development programs. Two challenges emerged for Haiti's rebuilding and reconstruction efforts: many countries that had pledged funding to the efforts did not follow through fully on their commitments; and by the one year anniversary of the earthquake, available funds for rebuilding and development were not being utilized effectively

[40] Krause S, Heller L, Tanabe M. *Priority Reproductive Health Activities in Haiti. An Inter-Agency MISP Assessment Conducted by CARE, International Planned Parenthood Federation, Save the Children and Women's Refugee Commission*." New York, NY: Women's Refugee Commission; 2011.

[41] Reproductive Health Response in Crisis Consortium (RHRC). *Minimum Initial Service Package for Reproductive Health in Crisis Situations*. New York, NY: RHRC; 2011 Retrieved from**:** http://misp.rhrc.org/**..**

[42] USAID/DELIVER Project. *Task Order 4: Annual Report October 2011-September 2012*. Arlington, VA: John Snow, Inc.; 2013.

[43] United Nations (UN). *UN Fact Sheet: Combatting Cholera in Haiti*. New York, NY: UN; 2013. Retrieved from: http://www.un.org/News/dh/infocus/haiti/haiticholerafactsheet-december-2013.pdf.

according to many reports.[44] Some of the disaster response groups had moved on or were fully occupied with the cholera epidemic. By the end of 2012 only 54.7 percent of funds pledged by governments and multilaterals such as the development banks had been disbursed.[45] Health funding was not fully utilized; only U.S. $108 million of the U.S. $315 million promised for health had been disbursed by the end of 2011.[46] While official data on funding for the family planning program is not available, program managers indicate that family planning program funding had also diminished from the 2010 high. USAID funding for population was back to its pre-earthquake levels in 2011 and other actors, such as IPPF/WHR, were having trouble funding its services.

In May 2011, Haiti elected a new administration with Michel Martelly as president. Top priorities for the new government included stabilizing the country, providing security and safety, providing homes/shelter for displaced families, and rebuilding after the earthquake. Since 2011, the government has focused many of its efforts on rebuilding earthquake-safe structures, establishing new homes for displaced families, and creating new opportunities for economic growth. Given the massive needs in other areas, health and sexual reproductive health were not initially seen as principal priorities by the Martelly government.

The cholera epidemic that erupted in 2010 remains an ongoing challenge for the health system and continues to affect the health system´s ability to rebuild and strengthen other areas. While the number of cholera cases has dropped, the need to focus on improving water, sanitation and hygiene remains urgent for the government and for donors.

In the years immediately following the earthquake, humanitarian and other international NGOs continued to be a major source of family planning and other reproductive health services. However, since 2012 the MSPP has made progress in reinvigorating the FP program with a new Plan Stratégique National de Santé de la Reproduction et Planification Familiale (National Strategic Plan 2013-2016), a Campagne Nationale de Planification Familiale (National Campaign on Family Planning) and a Résolution du Conseil des Ministres (Ministerial Decree) which is strongly supportive of family planning efforts. These three policy milestones are described in the section on policy and governance.

Violence in general and violence against women in particular is highly problematic in Haiti. Official statistics are lacking, but observers familiar with post-quake conditions reported a pervasive culture of rape. A study conducted by the grassroots organization Komisyon Fanm Viktim Pou Victim (KOFAVIV or Commission of Women Victims for Victims) found 230 incidents of rape in 15 camps in the two months following the earthquake.[47] Rape, among other

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[44] Khan C. Haiti aid groups criticized as money sits unspentunpsent [radio broadcast]. *National Public Radio Special Series, Haiti: A Year Later*. Washington, DC: National Public Radio; 2011. Retrieved from: http://www.npr.org/2011/01/11/132807059/haiti-aid-money-lies-unspent-drawing-criticism.

[45] United Nations Office of the Secretary-General's Special Adviser on Community-Based Medicine & Lessons from Haiti. *Summary*. New York, NY: United Nations Office of the Secretary-General's Special Adviser on Community-Based Medicine & Lessons from Haiti; 2013. Retrieved from: http://www.lessonsfromhaiti.org/assistance-tracker/.

[46] Provost C. Haiti earthquake: where has the aid money gone? *[The Guardian Datablog.]* London, United Kingdom: The Guardian; 2012. Retrieved from: http://www.theguardian.com/global-development/datablog/2012/jan/12/haiti-earthquake-aid-money-data.

[47] Institute for Justice & Democracy in Haiti. *Our Bodies Are Still Trembling: Haitian Women's Fight Against Rape*. Boston, MA: Institute for Justice & Democracy in Haiti; 2010. Retrieved from: http://www.madre.org/images/uploads/misc/1283377138_2010.07.26%20-%20HAITI%20GBV%20REPORT%20FINAL.pdf.

crimes, continues to be under-reported due to a lack of confidence in a justice system viewed as corrupt and apathetic when it comes to rape.[48] A 2012 UN survey showed that of 62 rape complaints filed over three months, only one made it to court.[49] Furthermore, authorities often do not explain the importance of or provide access to a medical examination within 72 hours of the rape, which is detrimental to health outcomes and the chance that a case will go to trial.[50] The high incidence of rape and violence affects women's mobility and ability to access services.[51] Female community health workers may also find it difficult to work in some areas due to threats of violence. In recent years, local NGOs as well as UNFPA, the United Nations Development Fund for Women (UNIFEM), Human Rights Watch and Amnesty International have called for increased attention to the issue of gender-based violence in Haiti.[52]

There have been efforts by USAID and UNFPA to increase attention to adolescent reproductive health and gender violence. Haiti's current educational system is largely privatized, and only 20 percent of youth attend public schools. This poses special challenges for health education programming as it is difficult to implement a universal curriculum in health education and sexual reproductive health.[53] Sexuality education and peer education provided through local NGOs has expanded in recent years.[54]

Much remains to be done in reproductive health and family planning. The unmet need of 35.3 percent for all women and 56.6 percent for adolescents in union reported in the 2012 DHS is evidence of a profound need for expanded FP services. Qualitative studies with women indicate that accessing affordable contraceptives and general healthcare remain a major concern for many.[55] USAID and other international donors have worked closely with the MSPP to improve SRH and FP in recent years, as described in greater detail in the section on the health system below.

Policies, Leadership, and Governance

The MSPP of Haiti is led by the minister of health who is advised by a cabinet of health advisors. The director general is the second in authority with the role of leading, coordinating, and managing the various departments within the ministry.

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48 United States Department of State Bureau of Diplomatic Security. *Haiti 2013 Crime and Safety Report*. Washington, DC: United States Department of State Bureau of Diplomatic Security; 2013. Retrieved from: https://www.osac.gov/pages/ContentReportDetails.aspx?cid=14000.

49 United Nations Stabilization Mission in Haiti (MINUSTSAH). *A Profile of Police and Judicial Response to Rape in Port-au-Prince*. Port-au-Prince, Haiti: MINUSTSAH; 2012. Retrieved from: http://www.minustah.org/a-profile-of-police-and-judicial-response-to-rape-in-port-au-prince/.

50 MINUSTSAH, 2012.

51 Human Rights Watch. *World Report 2014: Haiti*. New York, NY: Human Rights Watch; 2014. Retrieved from: http://www.hrw.org/world-report/2014/country-chapters/haiti.

52 Human Rights Watch, 2014.

53 United Nations Childrens Fund (UNICEF). Les défis [Web page]. New York, NY: UNICEF; 2011. Retrieved from: http://www.unicef.org/haiti/french/education.html

54 JSI Research & Training Institute. *A Long Wait: Reproductive Health Care in Haiti*. Arlington, VA: John Snow Inc.; 2009. Retrieved from: http://www.rhrc.org/resources/jsi_haitireport_2009_compressed.pdf.

55 Urrutia et al., 2012.

Throughout the 1980s and 1990s, the Haitian government did not have an official population policy. Some observers suggest that this was due in part to a belief that family planning should only be provided within a broad development context, while other observers felt that there was simply a lack of commitment to FP on the part of the government. In 2000, with technical assistance and support from USAID, the MSPP established a new position, titled the secretary of state for population, to develop and implement population policy. This position was eliminated in late 2012. Population activities are currently overseen by the directeur de la direction santé de la famille (director of family health program) at the MSPP.

The pre-earthquake national family planning strategy noted the importance of FP to protect maternal health, while avowing that people should procreate in accordance with local sociocultural norms.[56]

In May of 2013, a presidential decree established a strong family planning policy, which states that provision of free FP services is required in all health institutions, including workplace infirmaries. Any institution that cannot meet the requirement must refer patients to an institution that does. It also stipulates that failure on the part of institutions to provide family planning services would be grounds for sanctions and mentions types of sanctions that could be used. In addition, health providers are required to encourage women with more than two or three children to consider a long-acting contraceptive method. It requires that voluntary surgical contraception be performed only when a woman provides written, informed consent. The decree also requires the MSPP to develop and implement a FP education program, as well as provide health worker training on contraceptive technologies. Furthermore, mass media outlets are required to provide airtime for FP messages. The decree also specifies that three ministries must work together to carry out the decree: the MSPP, the Ministry of Women´s Affairs, and the Ministry of the Interior.[57]

USAID works to ensure voluntarism and informed choice in the context of service provision. USAID also ensures that governmental partners such as the MSPP are aware of such policies, and provides informational sessions to staff on them. USAID expects that the implementation of this decree will be in a manner that guarantees that every woman makes a truly informed and free choice regarding whether to use contraception and what type of method to use.

The National Strategic Plan for Reproductive Health and Family Planning for 2013-2016 provides a much stronger framework for family planning, with family planning as one of its two objectives:

- Reduce, by 2016, the maternal mortality ratio (to 400 per 100,000 live births) and neonatal mortality rate (to 20 per 1,000 live births) by offering basic obstetric and neonatal services to approximately 2.6 million women of reproductive age, especially the 250,000 to 300,000 pregnant women of whom 30,000 suffer from obstetric complications and who would benefit from appropriate care and supervision by qualified personnel.

[56] Ministère de La Sante Publique et de la Population (MSPP). *Manuel de Normes en Planification Familiale et en Soins Maternels*. Port-au-Prince, Haiti: MSPP; 2009. Retrieved from: http://unfpahaiti.org/pdf/web_SR/Doc6_normes_SM_et_PF_final.pdf.

[57] Government of Haiti. Résolution #1 du Conseil des Ministres du 30 Avril 2013. 2013. *Le Moniteur* 168 (84).

- Offer integrated reproductive health services provided by qualified personnel, including information and advice on family planning issues, prevention of maternal-child HIV transmission, treatment for gender-based violence against women and girls, all of which is to be undertaken with gender and cultural sensitivity.

The National Strategic Plan for Reproductive Health and Family Planning envisions reproductive health interventions organized along three complementary axes: service provision, communication and advocacy, and governance and communication. The plan outlines key results related to each of these programmatic areas, focusing attention on increasing the availability of life-saving maternal care and family planning.

The regulatory and operational framework for implementing the 2013 decree is not yet fully in place, but there are advances in the development of FP education curricula and health worker training supported through USAID and its partners.

According to observers of the current situation of family planning in Haiti, there is strong support within the current MOH for FP. However, other sectors of government, such as the fiscally important Haiti Ministry of Economy, have shown little interest in FP. Furthermore, the Haiti Ministry of Education — vital to the introduction of sexuality education — does not currently actively engage with the issue.

Haiti's existing policy framework provides a strong basis for the country to continue to strengthen its family planning program, but much needs to be done to realize its goals.

Family Planning and the Health System

Historically, Haiti's health care system was comprised of public hospitals and clinics funded by the state, as well as a large number of private clinics run by doctors or small NGOs. As Haiti's political and economic situation declined in the1980s and 1990s, the state became increasingly incapable of providing the people of Haiti sufficient health care. Private, non-profit (local and international) and for-profit organizations partially filled the gaps in service provision.

Service Delivery

Haiti's health system is organized in three levels: (1) primary health facilities, (2) departmental hospitals, and (3) four university hospitals. Almost half of Haiti's health facilities are located in the capital city of Port-au-Prince, and access to quality health services is extremely limited for those living outside of the city. State funded hospitals have limited resources and charge fees for services (with the exception of maternal child health services, which are provided free of charge). They tend to be understaffed and provide low quality health care services.[58]

[58] World Health Organization (WHO). *Haitian Health Care: A Follow Up*. Geneva, Switzerland: WHO; 2011. Retrieved from: http://www.who.int/features/2011/haiti/en/.

Prior to the earthquake USAID provided family planning services through performance-based contracts with local NGOs. In the period immediately after the earthquake USAID contractors were essential to maintaining access to FP commodities, and humanitarian organizations stepped in to provide FP and other health services for internally displaced populations (IDPs).

A 2011 assessment of MSPP hospitals at the district level found considerable gaps in their capacity to provide FP services. Since then, USAID has supported several large-scale efforts to strengthen the service provision capacity of the MSPP. USAID support has also been critical to strengthening the health referral systems.

A National Campaign on Family Planning designed to reposition family planning was launched by the MSPP in 2013 with support from USAID. The National Campaign objectives include to:

- educate the population, especially the 80 percent who are young people, about their sexual and reproductive health rights specifically in terms of FP and the methods and services that are available;
- ensure the availability of FP services in at least 90 percent of health institutions;
- organize a system for FP services in 100 percent (five total) of university hospitals;
- offer long-acting reversible or permanent methods in 100 percent of departmental hospitals (DH), community referral hospitals (CHR), in emergency obstetric care institutions, and in private practices;
- install in each health department at least four fixed locations for FP services in the community; and
- assure the training or retraining of 100 percent of provider staff, including midwives and community health workers, so that they can offer FP as part of their services.[59]

USAID provides FP support to 164 clinics through its service delivery projects. In addition, USAID and the U.S. Centers for Disease Control and Prevention (CDC) provide support to approximately 300 institutions, with CDC providing mainly HIV services. Two thirds of the 300 clinics are MSPP sites, while the rest are run by NGOs. UNFPA is currently providing contraceptives to 300 clinics in the country.

In an effort to decentralize FP services and expand at the community level, the MSPP, with support from USAID, has revamped and expanded its CHW program, the agents de santé comunitaire polyvalents (multi-purpose community health agents). These CHWs provide MCH, nutrition, and reproductive health services. The CHWs are trained to provide pills, condoms, and follow-up injectable contraception, and are also able to refer clients to the nearest health center for follow-up care if necessary.

As shown in figure 1, utilization of long-acting and permanent methods of contraception has declined since 1994-95 despite overall increases in MCPR. The method mix is worrisome to some observers, as the need for continuous re-supply of contraceptives is costly for both women

[59] Ministère de la Santé Publique et de la Population (MSPP). *Campagne Nationale de Planification Familiale*. Port-au-Prince, Haiti: MSPP; 2013.

and the government services. Recently, efforts have been made to ensure that essential supplies and training are in place to provide IUDs or sterilization when women request these methods.

Behavior change communication activities are being planned and implemented through the National Family Planning campaign. These communications activities will provide women with more information on the advantages of these methods for those interested in a long-term solution to their contraception needs. They also include communications activities directed towards young people. The social marketing project has already had some modest success in re-kindling interest in IUDs according to local observers.

FP Workforce

Haiti suffers from a major shortage of health care professionals in both urban and rural areas. Human resources for the health sector remain an area where little progress has been made in Haiti. USAID historically supported public health training for Haitian doctors, creating a cadre of qualified public health professionals. However, qualified professionals frequently emigrate to find better jobs and schooling opportunities for their own children. Those who remain find more attractive opportunities with the many in-country international NGOs rather than in the public sector. This dynamic has greatly limited the availability of Haitian professionals for work in the public sector or in underfunded Haitian NGOs. This perennial problem was exacerbated in the immediate aftermath of the earthquake as Haitian health care professionals left their jobs with Haitian organizations to work for international organizations, thus decimating the public sector.

In addition, the MSPP is affected by an imbalance between administrative staff and health care providers in the public sector. For example, between September 2010 and February 2011, the MSPP hired a total of 1,159 people who filled 768 administrative/support posts but only 391 for direct health care service delivery posts.[60] Key informants report serious deficiencies in human resources. Other important challenges include improving the career paths and status of health care providers, instituting a policy for competitive selection of candidates, and developing a clear policy for remuneration of health care providers. The issue of retention of health providers needs to be addressed by the MSPP. International NGOs frequently offer higher pay and better working conditions, thus limiting the MSPP´s ability to retain qualified staff.[61]

In recent years, USAID-supported projects have trained thousands of health workers in Haiti in an ongoing effort to strengthen the capacity of the health system. Management, leadership, and governance training have focused on strengthening the MSPP´s ability to manage the health commodities supply chain, including for FP commodities.

[60] Pan American Health Organizationn (PAHO). 2013. *Health in the Americas: Haiti.* Wasington, DC: PAHO; 2013. Retrieved from: http://www.paho.org/SaludenlasAmericas/index.php?option=com_content&view=article&id=38&Itemid=36&lang=en.

[61] WHO, 2011.

Information Systems

Since 1994, USAID has funded and supported the DHS in Haiti, which has been conducted approximately every five years. USAID has also provided extensive support to the improvement of the Systeme d'Information Sanitaire d'Haïti (HSIS, Haiti Health Information System) since 2001. Prior to the earthquake the HSIS included information from 750 MSPP facilities, although reporting was inconsistent. Furthermore, there were other specialized systems for the Expanded Program on Immunization (EPI) and for collecting information from HIV-infected patients.

Following the earthquake, a multi-agency working group was created to assist with information systems. The MSPP's Master Health Facility List (MHFL) was improved with USAID support to provide needed resources to facilities that were providing immediate relief following the disaster.[62] The MHFL prior to 2010 consisted only of government health facilities, excluding private institutions, NGOs (both local and international), and community based primary health facilities. The lack of a concise and complete list of facilities offering health services post-earthquake posed a challenge to the MSPP.

The multi-agency coordinating committee has been maintained and is currently chaired by the MSPP. Moving forward, the MSPP plans to strengthen and integrate the multiple information systems. Local observers report that it now has much better information regarding services provided in reproductive health than it did prior to the earthquake, in part as the result of extensive USAID investments in strengthening information systems.

Commodities

In Haiti, contraceptive commodities for both public and private-sector programs are supplied by USAID and UNFPA.

The Program for Essential Medicines (PROMESS) is a multi-donor project created and administered by the Pan American Health Organization (PAHO) since 1992, which has received support from USAID. It provides centralized supply storage and management for UNFPA-supplied commodities and serves both the public and private NGO sector in Haiti. The health minister presides over its management board. Currently, hospitals, agencies, and private organizations obtain contraceptive supplies via PROMESS free of charge. Organizations and agencies are required to report the amount of contraceptives distributed on a monthly basis in order to be resupplied, based on demand and services provided.[63]

With the aim of improving health commodity security, the government of Haiti is establishing a new national central commodity management mechanism for all essential medications, including reproductive health commodities, as well as other essential commodities. The MSPP will now manage this national system of commodities; its steering committee members include USAID, UNFPA, WHO, and UNICEF. The role of this commodity management mechanism is to

[62] MEASURE Evaluation. *MEASURE Evaluation in Haiti* [fact Sheet]. Chapel Hill, NC: MEASURE Evaluation; 2011. Retrieved from: http://www.cpc.unc.edu/measure/publications/fs-11-53.

[63] JSI Research & Training Institute, 2009

facilitate distribution of commodities, construct a national warehouse and regional warehouses, and assure commodity availability.[64] USAID has supported recent and ongoing efforts to strengthen the Haitian government´s supply chain and logistics management systems.

There is evidence that contraceptive supply in Haiti has improved in recent years. According to the UNFPA, the number of service delivery points reporting "no stock out" of contraceptives in the last 6 months increased from 24.4 percent in 2011 to 42.6 percent in 2012.[65]

Financing

The national health system is currently 100 percent donor supported, and most of the public sector family planning program is funded by USAID and UNFPA. USAID remains the principal donor for FP and reproductive health in the country with UNFPA also donating a large proportion of contraceptives. The IPPF/WHR is the third largest donor active in the country, funding its member association PROFAMIL. Knowledgeable observers within both the donor community and local NGOs feel that it is likely that Haiti will require donor assistance for health and FP for the foreseeable future.

LOOKING TO THE FUTURE

While the achievements and advances of the last decades are noteworthy, great challenges remain ahead for Haiti in the area of family planning.

The government of Haiti's leadership on reproductive health — The government of Haiti has shown a strong commitment to reproductive health and family planning in recent years and it is important that this continue. The MSPP will need to continue to play a strong role in convening and coordinating the large number of national and international NGOs, donors and other actors involved in the SRH activities in Haiti to ensure a strong and successful program

Translating policy into operational reality — The presidential decree of 2013 which mandates free FP services, a widespread FP education program and the promotion of long acting methods provides a strong basis for the family planning program. The government now has an important opportunity to build the regulatory framework and operational strategies to ensure that the FP program is institutionalized and implemented. Support for the development of a regulatory and normative structure to ensure that FP and reproductive health services are institutionalized within the MSPP should be an integral part of the technical assistance to the country. While policies and norms are not sufficient to ensure change, they will provide a structure which may be more resilient in the face of political changes and should be part of the rebuilding process. USAID´s strategy of strengthening the MSPP in areas of leadership, governance and implementation of programs is important and advances local institution-building.

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[64] United Nations Population Fund (UNFPA). *Progress Profile—Global Program to Improve Reproductive Health Commodity Security*. New York, NY: UNFPA; 2012. Retrieved from: http://www.unfpa.org/webdav/site/global/shared/documents/gprhcs/GPRHCS_Haiti.pdf

[65] UNFPA, 2012.

Strengthening civil society organizations — Lessons from other countries in the region have shown that strong NGOs and private sector approaches can help ensure the long-term sustainability of FP services. NGOs can be important advocates for expansion of family planning, introduction of new methods (e.g., emergency contraception), and monitors of government accountability and transparency. In addition, NGOs and community based organizations are important for the provision of services to highly-stigmatized populations (for instance lesbian, gay, bi-sexual, transgender, or sex workers) or special-needs populations such as people who are physically or mentally challenged. There will be a continued need for the government of Haiti to play a strong role in coordinating and enforcing regulations related to service provision efforts on the part of NGOs and private sector.

Strengthening demand and maintaining access — Post-earthquake programs have appropriately focused on improving the supply and provision of high-quality contraceptive services through the MSPP. Important strides have also been made to improve access to family planning by strengthening the delivery systems and training service providers at all levels. Among the ongoing challenges for the MSPP and the donors who support the program is to ensure that the systems and human resources required to strengthen service provision continue to improve.

Haiti will need an intensive effort to expand the range of available contraceptives to ensure that women have adequate choice among a variety of methods. In addition, if expansion of the provision of long-acting reversible contraceptives (LARCs) and sterilization within the context of voluntarism and informed choice proves successful, the program will be more cost-effective for the government in the long-run. While initial investments in service strengthening may be high, they go hand-in-hand with the strengthening of obstetric care and the general quality of reproductive care and will increase program sustainability as women opt for longer-lasting methods.

Communications programs that promote sexual and reproductive health and family planning are required to increase demand for high-quality FP services. These programs will serve to increase knowledge of family planning´s health benefits for women and children, as well as to promote access to contraception as a right for all people of reproductive age. Other efforts will include extensive audience research to assess the acceptability of and concerns with specific methods of contraception among Haitian women. The influence of social networks and sociocultural norms should be carefully assessed to determine how best to increase demand in ways that are sensitive to Haitian culture.

It is unlikely that the private for-profit sector will become a major actor in impoverished Haiti. However, social marketing approaches included as part of a comprehensive approach to increasing demand for FP and other reproductive health services have shown some promise for condom promotion.

Providing comprehensive sexuality education and contraceptive services for adolescents — While adolescent health has been listed as a priority by the MSPP, most programs are provided by the private sector. USAID´s current service delivery strengthening project (2013-2015) will address this issue by providing the MSPP with support to include youth-oriented programming

and dedicated spaces for young people within its service delivery sites. Materials on sexuality education have been developed recently and will be disseminated on a widespread basis.

Highly participatory youth programming with peer-to-peer interventions, youth clubs and other youth activities are important to successful SRH programs for adolescents. Because young people in Haiti are at high risk of violence, ensuring participants' safety is a necessity for all youth programs.

Learning from what has worked — In many places, the HIV/AIDS field learned from the older population/family planning experiences. In Haiti it might be appropriate to reverse this learning process and learn from the HIV/AIDS successes. HIV prevalence in Haiti was the second highest in the Western Hemisphere in 2012,[66] with approximately 130,000 adults over the age of 15 living with HIV — more than half of them women.[67] However, there has been a downturn in the number of new infections from 10.5 per 100,000 in 2010 to 7.5 per 100,000 estimated for 2014.[68] Haiti´s considerable success with HIV prevention programs attests to the fact that with appropriate funding and the right combination of private and public partners the Haitian health system (with support from donors) can respond to very significant challenges. A detailed study of the elements of success in HIV prevention programming would be of great use in informing FP programming and would greatly support current efforts integrate HIV prevention and treatment into other health efforts.

CONCLUSION

The family planning movement in Haiti began in the 1960s, only a short time after family planning activities had been initiated in many other countries in the Latin American and Caribbean region. Initially, doctors and demographers worked together to encourage government policies around the issue and to begin private sector service provision programs in much the same way early family planning activities occurred elsewhere. Yet, in comparison with other countries within the region, Haiti's progress on reproductive health has been slow.

Haiti´s tumultuous political history and weak economy have been major factors in limiting the ability of the country to advance in the area of family planning. Successive fragile and sometimes corrupt governments did little to tackle the daunting task of providing adequate health care (including family planning) for the largely impoverished country. In this context it is not surprising that Haiti lags far behind other countries in the region. The TFR of 3.5 remains the highest in the region. The maternal mortality ratio is 410 per 100,000 live births (similar to many countries in sub-Saharan Africa), and only 26.1 percent of births are attended by a skilled

[66] The AIDS Healthcare Foundation (AHF). *Haiti: The Epidemic*. Los Angeles, CA: AHF; 2012. Retrieved from: http://www.aidshealth.org/americas/haiti.

[67] Joint United Nations Programme on HIV/AIDS (UNAIDS). *HIV and AIDS Estimates: Haiti*. Geneva, Switzerland: UNAIDS; 2012. Retrieved from: http://www.unaids.org/en/Regionscountries/Countries/Haiti//

[68] Ministère de La Sante Publique et de la Population (MSPP). *Déclaration de L'engagement contra la VIH/SIDA: Rapport National sur le VIH/ SIDA*. Port-au-Prince, Haiti: MSPP, Programme Nationale de Lutte contre le SIDA, Haiti; 2014. Retrieved from : www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/HTI_narrative_report_2014.pdf.

provider.[69] Service delivery and the systems that support it face ongoing challenges related to maintaining strong leadership, strong institutions capable of sustaining services and adequate human resources.

However, given the enormous challenges posed by political instability, frequent natural disasters, ecological devastation, and health emergencies, the fact that there has been progress in recent years is remarkable. Haiti managed to keep contraceptives available even after the earthquake (with considerable support from USAID and other donors). Since the earthquake, the supply system has been further strengthened and the frequency of stock-outs has decreased. The re-vitalized and expanded CHW program is beginning to greatly increase outreach to underserved areas. Haiti´s 2012 MCPR of 31.3 percent is more than double the MCPR of 13.2 percent in 1994/95, with a substantial increase documented since 2006. The policy environment for family planning has improved substantially with strong policy statements, a far-reaching National Strategic Plan for Reproductive Health and Ramily Planning and an ambitious national family planning campaign. Access to maternal and child health care services has improved and free services are offered nationally. HIV prevalence rates have stabilized and antiretroviral treatment coverage has significantly increased.

If Haiti is to build on these achievements and move towards a sustainable sexual and reproductive health program with family planning as a cornerstone, it will require USAID along with its partners to consistently work towards strengthening the MSPP's capacity to lead, manage, and implement programs. USAID´s role in building collaboration and coordination among the many actors (both international and national) working in the country and in strengthening capabilities in the public sector, and in local civil society organizations will be vital in the coming years.

[69] United Nations Statistical Organization. *Millennium Development Indicators.* New York, NY: United Nations Statistical Organization; 2014. Retrieved from: http://unstats.un.org/UNSD/MDG/Data.aspx.

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