MEASURE EVALUATION

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Family Planning in Paraguay

The Achievement of 50 Years

April 2015

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Jane T. Bertrand, PhD, MBA

USAID FROM THE AMERICAN PEOPLE

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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

Paraguay's population is close to 7 million inhabitants, with a density of 15 inhabitants per square kilometer. Approximately 54 percent of the population lives in urban areas and 46 percent in rural areas, some of them very remote. It is a predominantly agricultural, multilingual, and multicultural country. The national languages are Guarani and Spanish, and most of the country is bilingual.

Considered by the World Bank as a country with a lower middle income economy in 2012, Paraguay ranks as one of the poorest countries in South America. The gross national income (GNI) per capita is estimated at U.S. $3,400.[1] As in other Latin American countries, there are major income inequalities. While the country reported a 13 percent economic growth rate in 2012, poverty afflicts one of three Paraguayans and extreme poverty one of five.[2,3]

While the maternal mortality ratio has decreased from 154 deaths per 100,000 live births in 2004 to 89 per 100,000 in 2011, it is still the fourth leading cause of death in women ages 10 to 54. The main causes of maternal mortality have varied slightly throughout the years, but the presence of unsafe abortion, toxemia, hemorrhages, and sepsis continue to be the most common causes.[4] This gradual decrease in the maternal mortality ratio can be attributed in part to an important increase in institutional delivery, as well as to higher coverage of prenatal care. These advances, together with better access to FP services of women, in particular among the poorest, have contributed to the continued decrease in maternal mortality in Paraguay.[5]

Young people under 15 make up 33.0 percent of the population. Almost two-thirds (63.0 percent) of girls ages 11-19 have been pregnant or have given birth. Adolescent fertility rate in Paraguay in 2011 was 68 births per 1,000 young women ages 15-19.[6]

According to data from the last Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (ENDSSR, National Survey on Demography and Sexual and Reproductive Health), the total fertility rate (TFR) declined from 4.7 children per married/in union woman aged 15-44 in 1990 to 2.5 in 2008 (table 1). Urban/rural differences in TFR have also decreased

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[1] World Bank. World development indicators-Paraguay [Web database]. Washington, DC: World Bank; 2012. Retrieved from: http://data.worldbank.org/country/paraguay.

[2] World Bank, 2012.

[3] Economic Commission for Latin America (Comisión Económica para América Latina) (CEPAL). *Paraguay. Informe Macroeconomico Junio 2012*. Santiago, Chile: CEPAL; 2012. Retrieved from: http://www.cepal.org/publicaciones/xml/7/46987/Paraguay-completo-web.pdf.

[4] Ministerio de Salud Pública y Bienestar Social. *Indicadores Básicos de Salud Paraguay 2013*. Asunción, Paraguay: Ministerio de Salud Pública y Bienestar Social; 2013. Retrieved from: http://www.paho.org/par/index.php?option=com_content&view=article&id=25:indicadores-baisicos-de-salud.

[5] Ministerio de Salud Pública y Bienestar Social. *Plan de Acción para la Disminución Acelerada de la Mortalidad Materna y de la Morbilidad Materna Severa*. Asunción, Paraguay: Ministerio de Salud Pública y Bienestar Social; 2012. Retrieved from: http://www.paho.org/par/index2.php?option=com_docman&task=doc_view&gid=394&Itemid=239.

[6] World Bank. Adolescent fertility rate [Web database]. Washington, DC: World Bank; 2011. Retrieved from: http://data.worldbank.org/indicator/SP.ADO.TFRT?order=wbapi_data_value_2011+wbapi_data_value+wbapi_data_value-last&sort=desc.

in the past 20 years. In 1990, the TFR in urban areas was 3.6, compared to 6.0 in rural areas. However, by 2008 urban TFR had dropped to 2.2 and rural TFR to 3.0.[7]

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/In-Union Aged 15-44, 1987-2008, Paraguay

	1987	1990	1995-1996	1998	2004	2008
Total Fertility Rate	5.4	4.7	4.2	4.3	2.9	2.5
Contraceptive Prevalence Rate (%)	37.6	48.4	55.9	57.4	72.8	79.4
Modern Contraceptive Prevalence Rate* (%)	29.0	35.2	41.3	47.7	60.5	70.7
Unmet Need (%)	n/a	17.4	19.2	17.3	19.7	12.9

Sources: Encuesta de Planificación Familiar (EPF) 1987; Encuesta Nacional de Demografía y Salud (ENDS) 1990; ENSMI 1998; ENDSSR 1995-96, 2004, 2008.[8]

Notes: * MCPR includes MELA (LAM). Standard days method is considered a modern contraceptive method, but it is not collected as such.

n/a = not available.

The data presented in this table were obtained through DHS Statcompiler for the following years: 1990, 1995-96, 2004, and 2008. Data on unmet need were not included in Statcompiler, figures on 1990 and 1995-96 were obtained from 2012 UN MDG Update Report, while data for 1998, 2004 and 2008 were obtained directly from RHS surveys.

The decrease in TFR coincides with the growth in the contraceptive prevalence rate (CPR) (table 1), which increased from 37.6 percent in 1987 to 79.4 percent in 2008. This is mainly due to increased use of modern contraceptive methods (29.0 percent in 1987 to 70.7 percent in 2008). An analysis of the data by place of residence shows that the prevalence gap between rural and urban areas has reduced significantly. In 1990, CPR was 20 percent higher in urban areas than rural areas (53.5 percent compared to 33.5 percent). However, in 2008, CPR was only 0.2 percent higher in urban areas (79.5 percent compared to 79.3 percent in rural areas). The unmet need for modern contraceptive methods in 2008 was 12.9 percent. It was slightly higher for low-income women aged 35-44 years, Guarani speakers, rural residents, and women with a low educational level.[9]

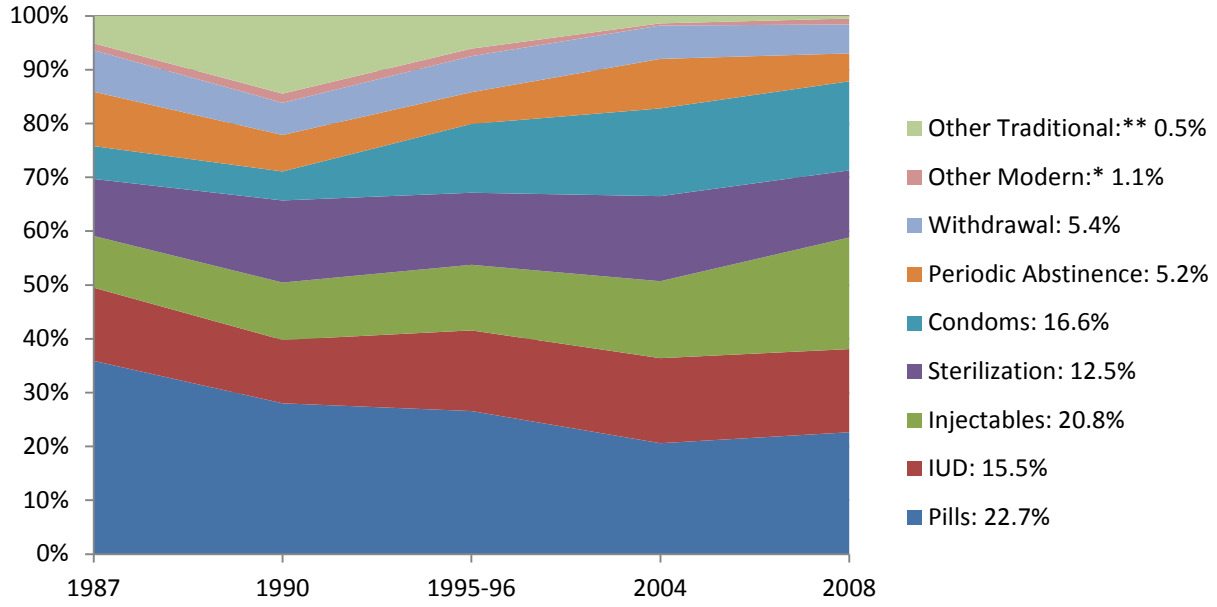
Paraguay method mix is one of the most balanced in the world, with no method representing more than a quarter of the mix (figure 1). According to trends from the FP, ENDS, and ENDSSR surveys from 1995 to 2008, the most common method used by all FP users has been the pill,

[7] Centro Paraguayo de Estudios de Población (CEPEP), 2009. Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (ENDSSR) 2008."

[8] Centro Paraguayo de Estudios de Población (CEPEP). 1989. *Encuesta de Planificación Familiar (EPF) 1987*. Asunción, Paraguay: CEPEP; 1989; Centro Paraguayo de Estudios de Población (CEPEP). *Encuesta Nacional de Demografía y Salud (ENDS) 1990*. Asunción, Paraguay: CEPEP; 1990; Centro Paraguayo de Estudios de Población (CEPEP). *Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (ENDSSR) 1995-1996*. Asunción, Paraguay: CEPEP; 1996; Centro Paraguayo de Estudios de Población (CEPEP). *Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (ENDSSR) 2004*. Asunción, Paraguay: CEPEP; 2005; Centro Paraguayo de Estudios de Población (CEPEP). *Encuesta Nacional de Demografía y Salud Sexual y Reproductiva (ENDSSR) 2008*. Asunción, Paraguay: CEPEP; 2009. Retrieved from: http://www.cepep.org.py/endssr2004/endssr2008/..

[9] ENDSSR 2008.

although its use has decreased from 35.9 percent in 1987 to 22.7 percent in 2008. Injectables are the next most used method and their use has increased markedly from 9.6 percent in 1987 to 20.8 percent in 2008. Female sterilization has remained relatively constant, from 10.6 percent in 1987, increasing to 15.8 percent in 2004, but decreasing to 12.5 percent in 2008. Traditional methods were being used by 11.1 percent of family planning (FP) users in Paraguay in 2008. It is worth noting that access to interval female sterilization in Paraguay has been limited.[10]

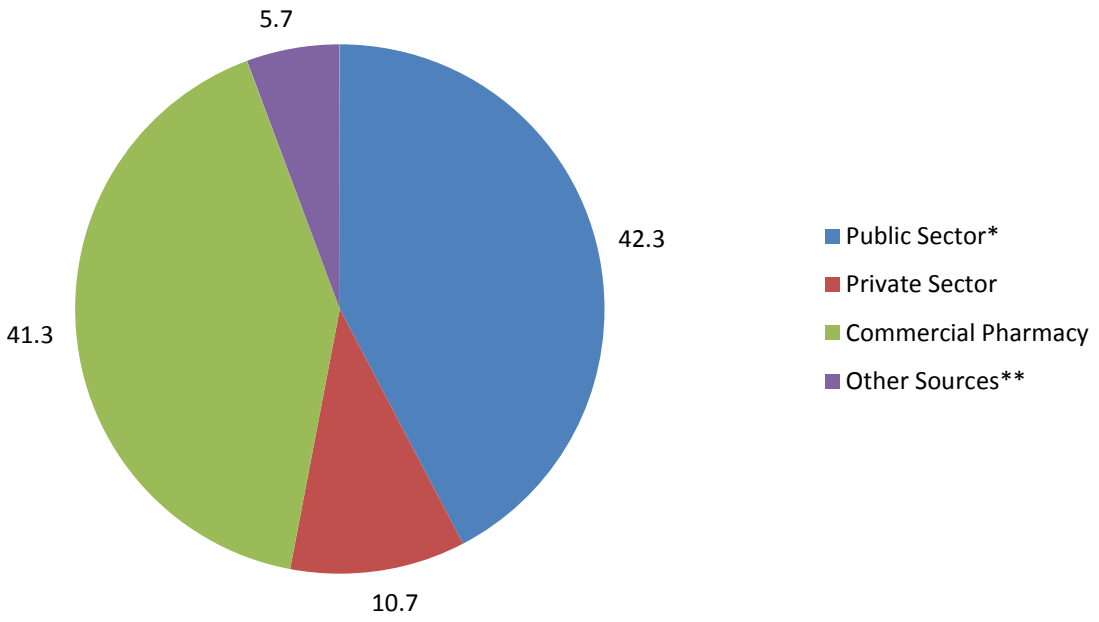


Sources: EPF 1987; ENDS 1990, ENDSSR 1995-96, 2004, and 2008.
Notes: The percentages in the legend refer to the most recent survey (2008).
* Includes male sterilization, vaginal methods and the lactational amenorrhea method (LAM).
** Includes Billings, other folk methods (not Yuyos). The use of herbs (yuyos) as contraception is common practice in Paraguay.

Figure 1: Method mix (Paraguay, 1987-2008).

In 2008, for the first time in Paraguay, the public sector as a whole surpassed private pharmacies as the main source of contraceptive supplies for women married or living in union, although private commercial pharmacies remain an important source (figure 2). Between 2004 and 2008, the percentage of women receiving contraceptives from the public sector increased from 31.7 percent to 42.3 percent, representing a relative percentage increase of 17 percent, a significant increase.[11] Pharmacies saw a small decrease in their participation as a source of contraceptive provision from 43.4 percent in 2004 to 41.3 percent in 2008. The rest of the private sector represented by private hospitals, private clinics and doctors are the third source of provision with 10.7 percent participation and very little variation from 2004. Other sources mentioned (5.7 percent of the contraceptive demand) refer to partner, spouse, or neighboring countries such as Argentina or Brazil.[12]

[10] ENDSSR 2008.
[11] MOH (37.3%), Instituto de Prevision Social (IPS) (3.5%), other public sources (1.5%)
[12] ENDSSR 2008.



Sources: ENDSSR 2008.
Notes: *MOH facility, social security facility, military and police facilities, Red Cross.
** Includes partner, spouse, or neighboring countries such as Argentina and Brazil.

Figure 2: Method source (Paraguay, 2008).

Paraguay has effectively segmented the market by economic income quintile: the public sector primarily serves the two poorest quintiles, whereas users with the ability to pay tend to obtain methods from pharmacies.[13]

Increase in use of the public sector is due in part to greater and more reliable availability of contraceptive methods at Ministry of Health (MOH) service delivery points, particularly in rural areas. Contraceptive availability increased at MOH facilities between 2005 and 2011 due to the strengthening of the logistics system and the empowerment of MOH personnel in the facilitation of access to services and estimation of contraceptive needs. Additional information, education, and communication (IEC) activities and counseling were also important to the increase of the CPR in Paraguay. All of these activities received substantial financial and technical support from the U.S. Agency for International Development (USAID) and were part of the FP graduation plan that is discussed below in greater detail. Another reason for the increase in the use of the public sector was the elimination of the fee for FP consultations at all service delivery points in 2007.[14]

Paraguay has made significant progress in expanding family planning and reproductive health (FP/SRH) services, and has increased support and political will in this area. However, there are still barriers to contraceptive use which require on-going efforts for FP/SRH to remain a public health priority.

[13] USAID/DELIVER Project. *Paraguay: Avances y Retos-Informe Final*. Arlington, VA: John Snow, Inc.; 2012a. Retrieved from http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/PY_AvanReto.pdf; ENDSSR 2008.
[14] USAID/Deliver Project, 2012a; ENDSSR 2008.

THE EARLY YEARS (1960-1980)

As in other Latin American countries, FP was introduced in Paraguay in the 1960s, in response to the concern of medical groups, demographers, and other experts for the serious deficiencies in maternal and child health care and the perceived need to address the issue of population in a more systematic way. The Centro Paraguayo de Estudios de Población (CEPEP, Paraguayan Center for Population Studies) was created in 1966, with the purpose of conducting demographic studies, raising awareness, and informing the public about the benefits of responsible parenthood and FP.

According to FP experts who have lived and worked in Paraguay, CEPEP began creating demand for FP services in Paraguay's urban areas, which caused conflict with conservative groups. Given the lack of government action to provide these services and after intense awareness-raising campaigns, CEPEP began offering FP information and services at its clinics, establishing itself as a pioneer in FP programming. Use of any contraceptive method was not authorized in the country at the time, but by the end of the 1960s, the MOH allowed promotion of the Billings Ovulation Method, a natural FP method that consists of identifying the woman´s fertile period, based on the consistency of cervical mucus, and avoiding intercourse during that time period.

USAID began providing technical and financial support for FP in Paraguay in the late 1960s. Because the government did not support FP, USAID's assistance was directed primarily to CEPEP. Initially, in the early 1970s, this funding supported surveys on fertility, which later expanded to include demography and FP under the guidance of the U.S. Centers for Disease Control and Prevention. USAID also provided assistance for producing IEC materials and counseling.

CEPEP became an associate member of the International Planned Parenthood Federation (IPPF) in 1969 and a permanent member in 1971.[15] This enabled CEPEP to strengthen FP services, since IPPF not only provided financial support, but also donated modern contraceptives, which the government did not have at that time.

In 1970, the MOH established the Family Protection Program, which included FP as a means to promote family welfare. In 1972, USAID, MOH, CEPEP, and the United Nations Population Fund (UNFPA) signed an agreement to provide FP information and services. This agreement initiated a government program which operated with CEPEP-trained personnel and volunteers.

During the 1970s, the government was ambivalent about population policy and FP for several reasons: Paraguay was a country with low population density; human resources were considered valuable to the development process; and conservative groups opposed FP. However, as

[15] International Planned Parenthood Federation (IPPF). Paraguay [Web page]. London, United Kingdom: IPPF; 2013. Retrieved from: http://www.ippf.org/our-work/where-we-work/western-hemisphere/paraguay.

mortality decreased and high fertility patterns persisted, the age structure showed an increasing dependency ratio, which attracted the government´s attention.[16]

From 1954 to 1989, Paraguay was under the dictatorship of Gen. Alfredo Stroessner. In 1979, the MOH FP program was shut down for nine years by executive order. CEPEP was not able to provide national coverage; however, it continued to receive small grants from USAID, despite its limited participation in Paraguay during this time.[17]

PROGRAM CONSOLIDATION (1980-2000)

In the early 1980s, CEPEP provided training for clinical staff to offer contraceptive services using natural fertility awareness methods. This trend continued until the fall of President Stroessner. From mid to late 1980s, CEPEP also provided FP commodities, principally oral contraceptives (OCs) to associated private providers, including doctors and midwives. CEPEP also offered training and conducted research on population and women's health.

In 1988, the MOH restored the provision of FP services through its National Maternal and Child Health (MCH) Program, and USAID resumed its FP assistance to the government to provide information on fertility awareness-based methods, which helped created a favorable political environment for FP.

During the following years, USAID provided technical and financial assistance to CEPEP to launch new service delivery models such as community-based distribution (CBD) and social marketing. In 1996, social marketing was provided through a USAID-funded project that later became independent, Population Services International/Paraguay (PSI/Paraguay) and then through the nongovernmental organization Promoción y Mejoramiento de la Salud (PROMESA, Health Promotion and Improvement). Mass media was a large component of this work, focusing on increasing the use of contraception among adolescents and young adults.

With increased government support, programs were strengthened and FP gained prominence as both an essential health program for Paraguayans and an approach to reduce maternal mortality. The MOH provided FP services for the most vulnerable populations, although there were problems with the quality of care, providers' technical qualifications, and contraceptive stock-outs, particularly in rural areas.

During the 1980s and 1990s, CEPEP provided information and contraceptive methods through a network of more than 20 clinics, 100 health professionals, and 600 field workers, seeking to reach the most marginalized groups. CEPEP has continued to share its experience as a pioneer FP nongovernmental organization (NGO) in the country, supporting and promoting equity and access to information and services as a human right.

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[16] Ministerio del Interior, Secretaría Técnica de Planificación de la Presidencia de la República, Comité Interinstitucional de Población (CIP). *Política de Población*. Asuncion, Paraguay: United Nations Population Fund; 2005. Retrieved from: http://www.unfpa.org.py/download/Politica_de_Poblacion_PY.pdf.

[17] Bertrand JT. *USAID Graduation from Family Planning Assistance: Implications for Latin America*. Washington, DC: Population Council, Inc.; 2011. Retrieved from: http://www.populationinstitute.org/external/files/reports/FINAL_LAC_Report.pdf.

The MOH began offering modern contraceptive methods in Paraguay in 1989, with support from USAID, UNFPA, and the Pan American Health Organization (PAHO). PAHO provided technical assistance for training activities and IEC materials; it also supported the establishment of technical guidelines on standards of care, as part of larger quality improvement efforts in the government health system.

During the years of program consolidation, USAID was one of the main donor agencies providing financial and technical assistance to increase voluntary use of reproductive health services. USAID supported the development of FP norms and protocols, training of service providers, provision of modern contraceptive methods, counseling, development and distribution of educational materials, computers, vehicles, medical equipment, and management systems. This funding helped to greatly improve availability and access to contraception nationwide.

Changes in government resulted in setbacks for multiple reasons: the influence and pressure exerted on political candidates by conservative groups that oppose FP; the uncertainty regarding the position of a new government towards FP; and the lag time between the election and the inauguration of new governmental authorities. The volatility of political support for FP, depending on the leaders in power, negatively impacted the budgeting and implementation of FP programs.

POST CONSOLIDATION OF THE PROGRAM (2001-PRESENT)

During the last years of USAID financing for FP in Paraguay, successful IEC campaigns were designed and implemented, in collaboration with UNFPA and PAHO. USAID also provided training for FP/SRH counseling throughout the country. These activities contributed to women's empowerment in terms of their reproductive rights and to greater involvement of men in this subject. Political advocacy also helped to create a more favorable environment for FP, with civil society participation, particularly of community groups and women's organizations.

THE GRADUATION PROCESS

In the first decade of the 21st century, maternal and child health was a central priority in Paraguay's health policies. The commitment to women's health on the part of two female ministers of MOH was notable. In addition, the work of women's NGOs that fought for reproductive rights of individuals, to decrease the high rates of maternal mortality, and international commitment to the United Nation's Millennium Development Goals were all highly influential.

In March 2005, USAID developed criteria for scaling down and eventually ending its economic assistance to several countries that had made significant progress in their FP programs.[18] Paraguay's 2004 ENDSSR showed a TFR of 2.9 children per woman and a modern

[18] U.S. Agency for Inaternational Development (USAID). *Techincal Note: Approach to Phase-out of USAID Family Planning Assistance*. Washington, DC: USAID; 2006.

contraceptive prevalence rate of 60.5 percent. Therefore, according to the established graduation criteria, the country was ready to graduate from the USAID financing for FP.

The graduation process took place over a five year period (2006-2010). However, when USAID first announced its graduation plan, MOH authorities and the Instituto de Prevision Social (IPS), as well as local Mission employees, were somewhat concerned; the country depended almost completely on USAID for FP funds and technical assistance and feared for long-term sustainability.

A high-level MOH, USAID/Washington, and USAID/Paraguay team, along with input from other national and international actors, first conducted a situational analysis and then developed a graduation plan. The findings indicated that that access for the poor was limited, due to widespread stock-outs in the public sector; by contrast, private sector access was adequate. As a result, the phase-out effort focused on increasing access to methods in the public sector to achieve greater equity for the poor.

The plan, tailored to the Paraguayan context and need, called for continued FP funding for Paraguay through FY 2010, with activities continuing into FY2011 in accordance with USAID's funding cycle. The vision was to leave Paraguay well-positioned to provide quality FP services and contraceptives nationwide. Thus, the plan identified three critical areas for continued support prior to the termination of funding: (1) strengthening the contraceptive procurement and logistics management system; (2) advocacy activities, including community mobilization for health and support for decentralization; and (3) increasing access to voluntary surgical contraception (VSC). The latter resulted from a realization that, although the MOH offered post-partum female sterilization, there were obstacles to access to interval female VSC procedures.[19]

The graduation process was closely supported by USAID, through several projects that helped to strengthen the health system. These projects focused on empowering communities and MOH staff at all levels to improve service quality, expand coverage, and properly handle the logistics and information systems.

IEC and counseling activities were tailored to different target groups. Emphasis was given to coordinating with other actors to avoid effort duplication, and promoting lobbying and advocacy strategies, which led to important policy decisions needed for Paraguay to take ownership of the process and eliminate existing barriers to access.[20]

A key component of the graduation strategy was an agreement signed by the MOH, USAID, and UNFPA to gradually reduce the donation of contraceptives, while government funding would increase to cover the needs. This agreement helped the MOH to transition from 100 percent dependency on donations for contraceptives supplies to total self-sufficiency over a four year timeframe.

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[19] Pilz K, Vandenbroucke M, Avila G. *Mid-Term Assessment Report on Phase-Out Plan for USAID Assistance to Paraguay in Family Planning/Reproductive Health*. Washington, DC: USAID; 2008.

[20] USAID/DELIVER Project, 2012.

The graduation process was greatly facilitated by the creation and intervention of the interagency contraceptive security committee named Comité para la Disponibilidad Asegurada de Insumos Anticonceptivos (DAIA, Committee to Ensure Contraceptive Availability). It was established in 2005 with USAID support. The DAIA designed and implemented an initial action plan (2006-2010) that focused on reproductive rights and concentrated on five objectives: political commitment and leadership, contraceptive financing and procurement, resource allocation, contraceptive logistics and management, and demand and use of services.[21]

Initially, the government did not formally recognize the DAIA Committee, although MOH logistics personnel were active participants. However, in 2011, the Minister of Health mandated its formal recognition. Therefore, the DAIA's 2011-2015 Strategic Plan, approved by the government, could include the purchase of condoms for dual protection (to prevent HIV/STIs and pregnancy).

The work of the DAIA benefited greatly from having a multidisciplinary committee that was very committed to the population in general and to women in particular. It emphasized both women's rights and the rights of all people to sexual and reproductive health. With USAID support initially, this interagency committee has become a model for other countries in the region. Its members now include the MOH and IPS, CEPEP, UNFPA, PAHO, PSI Paraguay and, until 2010, USAID, among others. Among other achievements, the DAIA was influential in persuading Congress to earmark funds for contraceptive purchases, which augured well for sustainability post-graduation.

UNFPA also supported this process from the outset, providing technical assistance for training, production of IEC materials, and the purchase of medical equipment and instruments. In addition, UNFPA served as the agent for MOH contraceptive procurement. Through the DAIA, UNFPA helped to implement the national condom supply strategy for dual protection, and to increase access to interval and post-partum VSC at the MOH.

Paraguay's graduation from USAID funding for FP has had many successes: the government has taken over 100 percent of contraceptive procurement costs; modern methods are more readily available; and stock-outs have been reduced to one percent according to the DAIA Committee. However, the country still faces significant challenges that need to be addressed decisively.

Among these challenges is the financing of the next ENDSSR survey. Since the 1970s, and every four to five years, ENDSSR surveys had been conducted in Paraguay by CEPEP, with USAID technical and financial support. These surveys are an important source of progress indicators that have been instrumental for decision-making.[22]

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[21] USAID/Health Policy Project. *Promoting Country Ownership through Latin American Contraceptive Security Committees—Paraguay Case Study*. Washington, DC: Health Policy Project; 2013. Retrieved from: http://www.healthpolicyproject.com/pubs/131_ParaguayBrief.pdf.

[22] ENDSSR 2008, 2004, 1995-96; Encuestas Nacional de Demografía y SSR (ENDS),1990; Encuesta de Planificación Familiar (EPF) 1987.

The most recent survey was conducted in 2008. However, due to lack of financial resources, no ENDSSR surveys have been conducted since then. As of mid-2014, negotiations were still underway with a potential donor to obtain financial support to conduct a new ENDSSR.

Policies, Leadership, and Governmance

Political support for FP in Paraguay has vacillated greatly over the past 50 years. There was no legal backing for FP, despite the activities of the NGO sector and later the government itself, until 1992, when a new Constitution of Paraguay was adopted. Article 61 recognized the right of all citizens to decide freely and responsibly the number and spacing of their children, the right to FP education, and adequate access to FP services. The constitution also stated that life begins at the moment of conception. This argument has been used by groups opposed to famly planning to label all contraceptives, incorrectly, as abortifacients.

The Consejo Nacional para la Salud Sexual y Reproductiva (CNSSR, National Council on Sexual and Reproductive Health) was created in 1994. It included members from all government institutions that worked in FP and reproductive health, as well as CEPEP, women's NGOs, professional organizations of obstetricians and gynecologists and other physicians, the Chamber of Pharmacies of Paraguay, and other private sector agencies. It played an important role in coordinating efforts and resources, as well in defining FP/SRH policies; however, it has not been regularly convened in recent years.

The National Policy on Comprehensive Women's Health Care, developed jointly by the MOH and the CNSSR, was adopted in 1999. This policy represented major progress in ensuring actions to promote women's health, including FP. Technical guidelines for FP service delivery were also updated. The 1999-2003 National Health Plan incorporated national commitments to FP/SRH made by Paraguay at global conferences and summits.

Finally, in 2011, Law 4.313 was enacted, and the MOH initiated contraceptive procurement through UNFPA. This law is an improvement over Law 2907 in that it facilitated the purchase of contraceptives through international agencies, it mandated IPS to purchase contraceptive products with its own funds, authorizing it to acquire them under the same conditions as the MOH, and it exempted such purchases from taxes.

Overall, Paraguay has shown that it has the political will to support FP and the technical, scientific and human resources needed to improve the country's health situation. The MOH has implemented three different sexual and reproductive health plans since 1997. These plans have established goals, strategies, indicators and expected results; in addition, they have facilitated development of operational plans at local and regional levels. Significant emphasis has been given to the issue of "rights" in all plans.

Gradually, Paraguay has developed a culture that defends sexual and reproductive rights, particularly those of women; knowledgeable observers indicate that it will be difficult to stop its momentum despite opposition from conservative groups. Reproductive health receives considerable attention as part of policy dialogue, but not at the operational level. Despite the existence of a favorable legal and legislative framework, there is uncertainty for FP and

reproductive health programs every time a new administration takes office. Continued advocacy is required to maintain political support.

Family Planning and the Health System

The health system in Paraguay is made up of the public sector (MOH, IPS, Military Hospital, Police Hospital), and the private sector that includes NGOs providing FP clinical services, private doctors, traditional midwives, social marketing, and the private commercial sector, which includes pharmaceutical distributors and pharmacies.

The MOH FP program provides FP information, contraceptive supplies, and free services at delivery points in a network of centers in 18 health regions and about 1,300 health facilities nationwide.

As part of the decentralization process of Paraguay's health reform, approximately 704 Unidades de Salud de la Familia (USF, Family Health Units) have been created in 234 districts of 18 of the country's departments, where vulnerable populations and those with the highest poverty levels reside. All these units offer FP services and products.

USAID support has played an important role in this initiative through capacity building efforts around health advocacy and community mobilization to enhance the ability of communities and local governments to ensure provision of FP services. This success of this activity, implemented by a local NGO, Centro de Información y Recursos para el Desarrollo (CIRD, Resource and Information Center for Development), received strong support from government authorities who have subsequently sought to expand this model to the national level.

The MOH faced three major challenges after USAID discontinued funding and other donors decreased support to FP: ensuring quality of services, strengthening logistics and information system efficiency, and updating standards and protocols.

The IPS covers about 20 percent of the Paraguayan population and has become increasingly involved in FP service delivery since 2006. IPS started as a small office that lacked systematic management and depended on donations from the MOH for contraceptive procurement. Now, it has FP clinics throughout its service network of more than 100 hospitals and clinics. Contraceptives are included in its list of essential medicines, and it has a guaranteed budget for procuring all contraceptive supplies, purchased with its own funds since 2010.[23]

USAID provided support for the training of key IPS personnel in contraceptive technology, counseling, and logistics. IPS participated jointly with the MOH in a broad national IEC strategy to improve the quality of care in services delivered to the most vulnerable population groups, including adolescents. The DAIA committee has played an important role in this effort.

[23] USAID/DELIVER Project. *Estudios de Caso: la Disponibilidad Asegurada de Insumos Anticonceptivos en Institutos de Seguridad Social, En Cinco Países de América Latina*." Arlington, VA: John Snow, Inc.; 2008. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/policypapers/LAC_CSSociSecu.pdf.

Although some issues have yet to be resolved and challenges lie ahead, increased IPS participation is considered a major achievement in Paraguay.

CEPEP continues to offer clinical FP services, although its role as a source of contraceptive provision has diminished. Until 2006, CEPEP received contraceptives as a donation from USAID. This allowed it to maintain a CBD program, which operated primarily in rural areas and in northern Paraguay. CEPEP discontinued its CBD program as MOH and IPS coverage increased.

In the last 10 years, CEPEP expanded its services into other MCH/RH areas such as prenatal care, gynecology, pediatrics and others through its four clinics. Today CEPEP struggles to finance its own activities, since USAID support to this institution ended as part of the graduation process. CEPEP receives donated contraceptives from IPPF and offers them at subsidized rates after paying for shipping, customs and clearance fees. In 2013, CEPEP was able to cover 70 percent of its costs with its own funds. However, this process has not been easy and a contingency plan exists to cut all expenses, including personnel, if necessary.

In earlier years, social marketing consisted of offering FP methods at affordable prices, which were distributed by promoters mainly in peri-urban and remote rural communities. However, this approach has all but disappeared, now that the MOH offers contraceptives free of charge nationwide.

Nonprofit social marketing has contributed to market segmentation, ensuring affordable access to contraceptives for intermediate economic quintiles of the population. As mentioned before, PSI/Paraguay is a social marketing organization that was initially funded by USAID. PSI/Paraguay provided oral contraceptives and male condoms through pharmacies during many years. In 2004, PSI/Paraguay launched an emergency contraception (EC) product that is distributed through pharmacies. This organization utilizes provider behavior change materials and consumer product inserts to increase knowledge and use of EC, as well as communication activities directed towards students, teachers and parents.

The private commercial sector (consisting of local and international pharmaceutical manufacturers and distributors, as well as private physicians) provides products and services to higher economic quintiles of the population. Community pharmacies that use revolving funds and include FP were part of the reform in rural villages.

Human Resources for Health and Family Planning

In earlier years the government of Paraguay had not adequately attended to the development of human resources for health in Paraguay. In 2010, the country had a total health workforce of 54,598 professionals, which included 10,390 physicians, 15,341 auxiliary nurses, a little over 10,000 nurses and nursing assistants, 1,964 midwives, and 1,944 obstetrical assistants, among others. However, this health workforce was not evenly distributed geographically. Although there were 22.5 health personnel for each 10,000 inhabitants at the national level, 70 percent of them were concentrated in Asuncion and vicinity, where only 30 percent of the population resides. Moreover, there was a shortage of health workers, particularly those required for primary

health care. Contracts in the health sector did not provide long-term security, and many health workers migrated to neighboring countries.[24]

Recently, however, the MOH has developed policies and plans to improve the technical capacity and distribution of health personnel, to improve working conditions as a means of enhancing morale, and to strengthen linkages between educational institutions and service provision. As of 2011 (the most recent data available), the MOH health services had the following numbers of health professionals per 10,000 inhabitants: medical doctors: 11.7, obstetricians 2.1, professional nurses, 5.0, auxiliary nurses 12.0.[25]

As in other countries in Latin America, the high turnover of personnel working in health programs is an issue of concern for FP/SRH administrators and champions, due to the large investment that training of personnel represents.

As part of the graduation process, USAID provided assistance to the MOH to strengthen technical capacity, improve the quality of the data for contraceptive forecasting, empower personnel at the central and regional level to maintain the logistics system, and track progress, with the aim of achieving contraceptive security.[26]

USAID helped to establish a team of champions that is involved and committed to FP/SRH, in the MOH, in IPS, and in the private NGOs sector. The existence of this team in these positions is particularly important because they provide continuity from one administration to the next.

Information Systems

At the beginning of the millennium, MOH data and information were divided among different programs; logistics were managed vertically and in parallel systems; internal controls were weak; supplies occasionally expired, disappeared or were damaged; donated contraceptives were found to be on sale at private pharmacies; and stock-outs were frequent.

As stated above, one of the objectives of the graduation process was to strengthen the logistics information system in relation to the full range of functions: forecasting of needs, procurement, storage, transportation and distribution of supplies, with proper supervision and monitoring and evaluation of results, and then using those results for decision-making to ensure access in the public sector for the poor, rural and indigenous.

With USAID and its implementing partner's support, the MOH developed the Sistema de Información para la Administración Logística (SIAL, Logistics Management Information System), which generated essential information for decision making. Later, the MOH automated

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[24] Global Health Workforce Alliance. Paraguay-building a national health sector career sector [fact sheet]. Geneva, Switzerland: World Health Organization, Global Health Workforce Alliance; 2011. Retrieved from: http://cdrwww.who.int/workforcealliance/countries/ccf/CCF_Poster_Paraguay.pdf.

[25] Ministerio de Salud Pública y Bienestar Social, 2013.

[26] USAID/DELIVER Project. *Paraguay Overview*. Arlington, VA: John Snow, Inc.; 2012b. Retrieved from: http://deliver.jsi.com/dhome/countries/countrynews?p_persp=PERSP_DLVR_CNTRY_PY.

this system and provided training in management and use of the PipeLine tool at the central level.[27]

From the outset, this system proved successful in reducing stock-outs and facilitating decision-making, to the point that in 2009 the MOH, with support from USAID, decided to use it as a model and integrate it into a single system for medicines and supplies throughout the MOH. The system transition, which began in 2010 and took place over a two-year period, laid the foundation for a new integrated system called Sistema de Información y Control de Inventarios Automatizado del Paraguay (SICIAP, Paraguay Information and Automated Inventory Control System). SIAL, the previous system, had achieved a remarkable reduction in contraceptive stock-outs. However, according to local experts, integration into a single logistics system resulted in a weakening of the FP information platform that persists to this day. This is frequently seen when a system expands from a handful of FP methods to over 650 medical commodities, including contraceptives. Inevitably, adjustments must be made to address this. The logistics department of the MOH is aware of this situation and would like to receive further technical and financial support in this area.

Commodities and Medical Supplies (Contraceptive Security)

Beginning in October 2005, USAID provided technical assistance in logistics management to the MOH FP program in Paraguay. Over three years, contraceptive stockouts decreased from 15 percent (in 2005) to 5 percent (in 2008). In 2006, the government of Paraguay began to procure contraceptives with its own funds (whereas previously the country had received donations from UNFPA and USAID). USAID assisted the MOH to achieve contraceptive security by working to improve the regulatory framework that would facilitate the procurement process and make it sustainable. [28]

In 2006, the Paraguayan government signed a four-year tripartite agreement with the MOH, USAID, and UNFPA to gradually take responsibility for contraceptive procurement. UNFPA continued to donate contraceptives to the MOH through 2009.[29] The procurement mechanism involved co-financing with UNFPA. The percentage procured by the government of Paraguay began at zero in 2006, but increased to 44 percent in 2007, 68 percent in 2208, and 100 percent by 2009. Today, UNFPA acts as a purchasing agent for the MOH and IPS to acquire contraceptives, resulting in significant savings for the country.[30]

Despite this success, some DAIA Committee members have expressed concern over the growing budgetary requirements of the FP program, which could make it untenable, despite the fact that Law 4313 guarantees the financial resources needed for the program. The main reason for

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[27] PipeLine is a Monitoring and Procurement Planning System designed by John Snow Inc.'s USAID/Deliver Project to help program managers monitor the status of their product pipelines and product procurement plans. PipeLine provides information needed to ensure the regular and consistent stock of products at the program or national level.

[28] USAID/DELIVER Project. *La Adquisición de Anticonceptivos en América Latina y El Caribe: Un Análisis de las Opciones Actuales y Futuras en Ocho Países*. Arlington, VA: John Snow, Inc.; 2010. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/policypapers/LaAdquAnticoncept_LAC.pdf.

[29] USAID/DELIVER Project. *Guaranteeing Widespread Access to a Broad Choice of Contraceptives*. Arlington, VA: John Snow, Inc.; 2006. Retrieved from: http://pdf.usaid.gov/pdf_docs/PNADI972.pdf.

[30] USAID/DELIVER Project, 2012a.

concern is that the MOH has not forecast its future financial needs and is not considering how to address these problems in the long term. Demand has increased steadily since the MOH expanded its coverage through free services and primary health care strategies. Ensuring financial sustainability is therefore a crucial challenge for the MOH's FP program.

From 2010 to 2011, USAID provided technical assistance to supplement the DAIA's efforts to improve access to FP services, particularly in IPS, and to promote interest among its members in implementing a market segmentation strategy with a total market approach.

Until recently, there had been political commitment at the highest level in Paraguay; the previous minister of MOH strongly supported promoting sexual and reproductive rights. However, when President Fernando Lugo left office prematurely in June 2012, this minister was removed, leaving an unfortunate vacuum in terms of support for FP and RH.[31] The change of administration in the midst of a political crisis contributed to problems experienced in 2012.

A new government took office in Paraguay in August 2013 and, on December 30 of that same year, approved the 2014-2019 National Sexual and Reproductive Health Plan. This plan was designed under MOH leadership, with PAHO, UNFPA, IPPF, CEPEP, and European Union (EU) participation. Its strategic objective is to improve the sexual and reproductive health of the Paraguayan people, through developing fair, equitable and integrated public policies, taking into consideration aspects of gender, rights and cultural diversity. FP has been recognized as one of the seven strategic areas of this plan; thus, there is optimism in the country for the new government´s support of FP.

Financing

In 2006, Paraguay passed Law 2907, which mandates financial resources for the MOH to procure the contraceptives and delivery kits required by the country. In 2006, the MOH allocated U.S. $261,753 to buy contraceptives; it almost doubled that amount in 2007 (U.S. $551,000). In 2009, it paid U.S. $566,000 and was able to cover 100 percent of contraceptives purchased, thus covering the country's needs for the public sector while supplementing the majority share of FP products and services provided by the private sector, including pharmacies, NGOs, and private doctors (also financed through out-of-pocket contributions).

The government also adopted Resolution 598, which established that all contraceptives delivered through MOH service delivery points would be free of charge. This caused the demand for contraception through the public sector to double in recent years, and markedly increased the funds required annually to cover contraceptive procurement.

As stated before, from 2007 to 2009, the agreement with UNFPA was one of co-financing, combining UNFPA's funds and those of the MOH for purchasing contraceptives and providing technical assistance. However, in 2008, the MOH analyzed the option of procurement from third

[31] Pineda Gadea Z. Avances y desafíos estratégicos para el aseguramiento en insumos en salud reproductiva en la región LAC [presentation]. Informe Regional Del Foro LAC; 2012.

parties and concluded that it offered greater advantages in terms of flexibility and transparency in the procurement processes.

The MOH decided to change from the co-financing agreement to a third-party mechanism that would allow it to take advantage of support from the local UNFPA office. Through this collaboration, the MOH was able to develop a direct partnership with the UNFPA Procurement Services Bureau (PSB) in Copenhagen, with the objective of monitoring its orders more closely. The DAIA submitted a bill to Paraguay's Congress that allowed the MOH to use the third party procurement system. It became Law 4313 and currently remains in effect. This has resulted in significant savings for the MOH.[32,33]

Some problems have been identified with this mechanism: problems internal to bureaucratic government payment processes; and manufacturers that do not stock products that meet the Government's specifications and must custom-manufacture the products. Prepayment conditions required by UNFPA previously made it difficult to purchase contraceptives using the government budget, but many of the aforementioned difficulties have been overcome with the new law (Law 4143). Bureaucratic obstacles are currently the main difficulty.[34]

The DAIA has been looking for local providers for purchasing contraceptive supplies, and more efficient and effective procurement mechanisms, but at the time the present system appears to be the best option.

Whereas there is a guaranteed budget for contraceptive procurement, the MOH has an inadequate budget for updating norms and protocols, IEC activities, refresher training, infrastructure maintenance, demographic and reproductive health surveys, and monitoring and evaluation. Paraguay therefore remains dependent on external assistance for these and other activities. The new MOH authorities have started to negotiate funding with a variety of potential donors to cover these expenses.

LOOKING TO THE FUTURE

Paraguay has made significant advances in FP, but seeks to consolidate the progress made to date. There are situations that might lead to setbacks after years of work.

Paraguay has one of the highest contraceptive prevalence rates in Latin America, as well as an effective market segmentation. However, challenges remain, such as the need to reach adolescents with sexual and reproductive health information and services.

This important subgroup will continue to increase in number in the next few years, and high adolescent fertility rates adversely affect maternal mortality rates. MOH statistics to 2009 showed that 63 percent of registered maternal deaths correspond to young women between 15 and 24 years of age. Moreover, unmet need for FP services among non-married sexually active

[32] USAID/DELIVER Project, 2012a.
[33] USAID/DELIVER Project, 2012a; personal communication with DAIA member.
[34] Personal communication with Marguerite Farrell, chair of Family Planning Graduation Workgroup.

young women is 21 percent, compared to 5 percent for young women of the same age who are married or in union. This evidence confirms that Paraguay faces important challenges to increase access to FP services and consolidate contraceptive security.[35] Policies and strategies aimed at adolescents and young women are under development and greatly needed, in light of the growing number of unplanned pregnancies and the spread of HIV at an increasingly early age.[36]

CEPEP offers "friendly spaces" in adolescent centers, where young people can share experiences and receive appropriate guidance for their specific needs. In addition, the MOH is beginning to focus more attention to adolescents. Further research is needed for the MOH to better understand the preferences of adolescents and to provide youth-friendly information and services, as well as contraception and SRH assistance-- although these types of clinics have reported mixed results in other countries. There is a need to learn more about the needs and preferences of adolescents and to develop effective strategies to address them with youth-friendly services. Yet the model of youth-friendly clinics has yielded mixed results in other countries. In addition, actions aimed at preventing gender-based violence and increasing access to emergency contraception are important in preventing unplanned pregnancies in adolescents and other victims of sexual violence.

On January 22, 2014, the minister of MOH presented the 2014-2018 National Plan for Sexual and Reproductive Health to the public in an important ceremony attended by Paraguay's vice president, the MOH minister and vice minister, the vice minister of youth, and other prominent authorities. Also, the government declared November 29 of each year as National Family Planning Day. These actions reflect a high level of commitment to FP/SRH rights by the new MOH minister and his staff, which will be crucial for further progress, particularly in relation to adolescents.

The following are required for continued success for FP/SRH in Paraguay:

- preservation of the achievements to date and continued adequate funding for procurement of contraceptive supplies in an efficient and timely manner (this requires enforcement of Law 4313, guaranteeing that the MOH and IPS will have adequate budgetary resources each year based on actual consumer needs and that funding earmarked for contraceptive procurement will not be diverted to other purposes);
- implementation of an efficient logistics system that monitors the quantity, quality, and continuity of supplies;
- strengthening of other health care providers, such as Military Health and Police Health;
- consolidation of the role of IPS in FP supply, within a market segmentation strategy that emphasizes the total market approach;
- continuity of the DAIA Committee, which has been included in the new National Plan for Sexual and Reproductive Health for 2014 to 2018;

[35] USAID/DELIVER Project. *A Participatory Approach: Using Market Analysis to Improve Access to Family Planning Services*. Arlington, VA: John Snow, Inc.; 2011. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/MarkAnalyFPServ.pdf.

[36] Pineda Gadea, 2012.

- advocacy to support the principle that FP is a right of the people and should remain a priority in future health plans and activities; such advocacy is required not only at the national level, but also at the district, municipal and community levels, especially among political, governmental, financial leaders, religious groups, contraceptive users and suppliers;
- implementation of the new National Sexual and Reproductive Health Plan for the next five years in collaboration with the new government and with the participation of new key government authorities;
- improved SRH services for adolescents, women, indigenous and Guarani speakers, and other vulnerable populations, using a rights-based approach;
- government and international donor support to fund the ENDSSR or similar surveys in order to have adequate and updated information available for decision making;
- strengthened logistics and information systems, including storage equipment and infrastructure, and fully developed human resources to improve the quality of interventions, with appropriate support, supervision, monitoring and evaluation of service delivery processes; and
- continued training of health personnel to maintain coverage with quality services at the central and regional levels and at all service delivery points. This includes training new government officials in technical and logistical matters, monitoring and supervision.

Overall, the FP/SRH situation in Paraguay is favorable. Indicators show significant progress; certain gaps in serving the most vulnerable populations have mostly been eliminated. There is strong commitment to FP/SRH at all levels. A very favorable statutory and legal framework has been established. Key players, such as local and regional health councils, NGOs, and women's organizations, are working together to overcome remaining obstacles in the health system reform process.

Working with all these elements, ongoing political advocacy efforts will be crucial for decision making about where and how to focus public and private sector efforts in the future.

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