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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: A (A = ADD, C = CHANGE, D = DELETE)

PP

2. DOCUMENT CODE: 3

3. COUNTRY/ENTITY: PARAGUAY

4. DOCUMENT REVISION NUMBER:

5. PROJECT NUMBER (7 digits): 526-0305

6. BUREAU/OFFICE: A. SYMBOL: LA; B. CODE: 03

7. PROJECT TITLE (Maximum 40 characters): Population II

8. ESTIMATED FY OF PROJECT COMPLETION: FY 82

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 79; B. QUARTER 2; C. FINAL FY 81

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. LOC	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. LOC	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL	445		445	1,013		1,013
(GRANT) P	445		445	1,013		1,013
(LOAN)						
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY		796	796		3,044	3,044
OTHER DONOR(S)	2,800		2,800	3,800		3,800
TOTALS	3,245	796	4,041	4,813	3,044	7,857

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 79 F. GRANT	E. 1ST FY 79 G. LOAN	FY 80 H. GRANT	FY 80 I. LOAN	FY 81 J. GRANT	FY 81 K. LOAN
(1) P	444	440		445		[illegible]		[illegible]	
(2)									
(3)									
(4)									
TOTALS				445		[illegible]		[illegible]	

A. APPROPRIATION	N. 4TH FY ___ G. GRANT	N. 4TH FY ___ P. LOAN	O. 5TH FY ___ H. GRANT	O. 5TH FY ___ Q. LOAN	F. GRANT	G. LOAN
(1) P					1,013	
(2)						
(3)						
(4)						
TOTALS					1,013	

FUNDS ALLOCATED: 013,810

13. DATA CHANGE INDICATOR: WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PIP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 (1 = NO, 2 = YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Abe M. Peña

TITLE: Mission Director, USAID/Paraguay

DATE SIGNED: MM MAR DD 22 YY 1979

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 03 DD 26 YY 79

AID 1330-4 (3-76)

PROJECT PAPER

PARAGUAY POPULATION II

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ANNEXES

LIST OF PRINCIPAL ACRONYMS USED IN PROJECT PAPER

AID	Agency for International Development
CEPEP	Paraguayan Center for Population Studies
CDC	Center for Disease Control
DA	Development Associates
DEPROFA	Department of Family Protection
DGEC	General Directorate of Statistics and Census
EDENPAR	Paraguayan Demographic Survey
EPAP	Paraguayan Contraceptive Prevalence Survey
FEMRURAL	Socio-Economic Survey of Rural Women
FP	Family Planning
GOP	Government of Paraguay
IDB	Interamerican Development Bank
IERH	Institute for the Study of Human Reproduction
IFRP	International Fertility Research Program
IPPF	International Planned Parenthood Federation
IPS	Institute of Social Security
IUD	Intra-Uterine Device
MCH	Maternal and Child Health
MSPyBS	Ministry of Public Health and Social Welfare
PIEGO	Program of International Education in Gynecology and Obstetrics
POP	Population
SENASA	National Environmental Sanitation Service
SENEPA	National Malaria Eradication Service
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	Agency for International Development Mission to Paraguay
VHC	Voluntary Health Collaborator
WFS	World Fertility Survey

I. PROJECT SUMMARY AND RECOMMENDATIONS

A. Project Paper Facesheet

B. Recommendation

USAID/Paraguay recommends the authorization of a three-year grant to the Government of Paraguay (GOP) to carry out this project at the following funding levels ($000):

	1979	1980	1981	Total
Oral Contraceptives	100	120	140	360
Bilateral	345	148	160	653
Total	445	268	300	1,013

C. Description of the Project

The purpose of this project is to expand the availability and use of family planning services by assisting the Ministry of Public Health and Social Welfare (MSPyBS) to extend health coverage to the rural population. USAID will provide contraceptives for use in all MSPyBS facilities. It will also assist in the establishment of a low-cost integrated maternal/child health and family planning delivery system in Health Regions I, III, and VII, which include the Departments of Cordillera, Paraguarí, Misiones, Ñeembucú, Itapúa, and part of Central.

The project will include the following components:

1. Training of MSPyBS personnel in the three health regions;

2. Selection, training, and supervision of rural Voluntary Health Collaborators (VHCs);

3. Purchase of basic health supplies, contraceptives, and transport; and,

4. Evaluation of project impact through surveys and data systems.

D. Summary Findings

In the judgment of USAID/Paraguay, the Population II project is sound and will meet its objectives. The 1977 Contraceptive Prevalence Survey (EPAP '77) has indicated in very clear terms that there are significant rural/urban differences in fertility, abortion, and use of effective means of family planning. The authors of the survey recommended that programmatic efforts be concentrated on rural areas where 87% of the women in greatest need of family planning services reside. USAID believes that the MSPyBS has the technical and administrative capability to carry out the activities enumerated above.

In consonance with the Congressional Mandate, the primary beneficiaries of the project will be poor rural families. The project will create a new low-cost health/family planning services delivery system to serve rural families who have limited access to existing health services. One thousand VHCs will be recruited, trained, and supervised over the three-year life of the project.

The project meets all applicable statutory criteria.

E. Project Issues

1. Lack of GOP Commitment to Reduction of the Rate of Population Growth

While the GOP has no official population policy, it is clear that the unofficial policy is to increase the population of Paraguay. The fundamental population concern is to populate the open

spaces of Paraguay through internal migration or international immigration. The development strategy of President Stroessner's regime includes a heavy reliance on colonization of sparsely settled areas of the country. The GOP does not appear to be concerned about the consequences of rapid population growth on achievement of its development objectives. The lack of GOP commitment to reduction of the rate of population growth means that there is no sense of urgency about dealing with problems related to high fertility. Moreover, any overt attempt to reduce the high birth rate will be considered "control de natalidad" (birth control) which is unacceptable to GOP authorities. The proposed United Nations Fund for Population Activities (UNFPA) project will devote millions of dollars to population studies and data collection to assist the GOP to develop a comprehensive national population policy. For this reason, the USAID project will concentrate on increasing the availability of family planning information and services.

2. GOP Attitudes About Family Planning

GOP attitudes about family planning are ambiguous. The authorities have tolerated the provision of family planning services to improve maternal and child health. The MSPyBS with USAID assistance has gradually expanded family planning services throughout its network of health services over the past nine years. Unfortunately, the MSPyBS health network is inadequate for the provision of either health or family planning services. Moreover, other GOP Ministries have not been willing to participate in the provision of family planning information

and services since problems related to human reproduction are considered as health problems. Health authorities do not wish to publicize family planning services because they fear political controversy over the "control de natalidad" issue. They will not allow the development of innovative delivery systems for contraceptives for the same reason. Given the limitations of the MSPyBS health services, it is not surprising that organized family planning services have not reached significant numbers of women in the fertile ages. Stripped of any demographic rationale, the provision of family planning services remains a low-priority health service. This means that USAID must assist the MSPyBS to develop more effective integrated delivery systems to ensure the widespread availability of family planning services.

3. Limited Role of the Voluntary Health Collaborators (VHCs) in the Delivery of Family Planning Services

The MSPyBS is attempting to overcome its financial and personnel constraints by designing programs which rely heavily on community support for services. The MSPyBS strategy for expansion of the coverage of health services revolves around the creation of thousands of VHCs. USAID proposes to assist the MSPyBS in three of the nine Health Regions. Although USAID believes that the project will increase the availability of family planning services in rural areas, we are disappointed that the MSPyBS will not allow the VHCs to distribute contraceptives. We have convinced the MSPyBS to allow the paramedicals and auxiliaries who are to supervise the VHCs to distribute contraceptives in rural communities when performing supervisory travel.

4. Lack of Publicity About Family Planning

The MSPyBS has been reluctant to publicize its role in the provision of family planning services, particularly through the mass media. There have been well-publicized PAP-smear campaigns to attract patients, but almost a total absence of campaigns to motivate Paraguayans to plan their families. USAID has recommended that the MSPyBS start low-key Information, Education, and Communication (IE&C) efforts to inform the public about this important health service. The MSPyBS has declined to do so to date.

The proposed project does offer a good opportunity to provide information about family planning in rural communities through the VHCs.

II. PROGRAM BACKGROUND AND DETAILED DESCRIPTION

A. Background and Strategy

1. Demographic Situation

Paraguay cannot be considered an overpopulated country. The overall population density is about seven persons per square kilometer which is among the lowest in Latin America. The population is very unevenly distributed over 406,752 square kilometers. The Chaco region in the Northwest, where livestock production predominates, contains 61% of the land area of Paraguay but only 3% of the population. The Central region around the capital, Asunción, which is a region of minifundia agriculture, has a population density of about sixty persons per square kilometer. In contrast to most countries in Latin America, there is no large rural to urban migration. The urban population has

increased only from 35% of the total in 1950 to 38% in 1979. The slow rate of urbanization is influenced by the availability of arable land and the large-scale GOP colonization programs that have distributed land to peasants.

The latest population census, in 1972, showed 2,357,955 inhabitants. By 1979 the population is estimated to have reached 2.9 million inhabitants. The population is growing extremely rapidly, at about 3% per year, due to a birth rate of about 39 per thousand and a death rate of about 9 per thousand. Estimates of the number of Paraguayans who may have emigrated to Argentina and Brazil during the past two decades range from 500,000 to 1,000,000, but there is evidence that emigration has tapered off considerably. Some observers feel that Paraguay is now gaining population through international migration. They observe that, 1) Paraguayans are returning in ever-increasing numbers from neighboring Argentina, which is experiencing serious economic difficulties, and 2) that many Brazilian farmers are finding raw land more available and less expensive in Paraguay than in Brazil and are buying, occupying, and clearing a great number of new farms. The economic outlook for Paraguay is bright, and it is doubtful that Paraguay's rate of population growth will be substantially diminished by international emigration. There is every reason to predict that there will be substantial internal migration to new settlements established under the GOP's colonization programs and to the areas along the Paraná River where the world's largest hydroelectric project at Itaipú and the smaller project at Yacyretá are being developed.

Table 1 presents some summary statistical data about Paraguay's population. For Paraguay, two demographic features stand out. Firstly, the country is characterized by a high rate of natural increase (excess of births over deaths) related to mortality rates that have been declining for several decades and fertility rates that have remained high. Secondly, there is a wide difference in fertility between the Asunción area and the rural areas of the country. According to analysis of the data collected by the 1977 Contraceptive Prevalence Survey (EPAP '77), Total Fertility Rates (TFR) range from 2.7 births per woman in Asunción to 8.5 births per woman in rural areas. This means that women in Asunción will produce an average of 2.7 children during their lifetime, while rural women will produce over three times as many children. Two other recent surveys, the 1977 EDENPAR Survey and the 1978 Survey of Socio-Economic Status of Rural Women (FE-RURAL), obtained rural TFRs of 6.4 and 9.2 respectively. Although the sample sizes of the three surveys were not large enough to make precise estimates of demographic rates, it is reasonable to conclude that rural women tend to give birth to an average of 6-9 children during their reproductive history.

This urban/rural difference in fertility is closely related to patterns of contraceptive use and abortion experience which will be discussed later in this part of the Paper. It is also related to aspects of social and economic structure that influence the proportions of fertile-aged women in union (marriage or consensual arrangement), the participation of women in the labor force, and the education

Table 1

POPULATION

Summary Statistical Data. Paraguay

Estimated 1979 Midyear population (000s) 1/	2,900
Rural (62%)	1,800
Urban (38%)	1,100
Females 1977 ages 15 to 44 (000s) 2/	655
Crude Birth Rate per 1,000 population 3/	39.79
Crude Death Rate per 1,000 population 3/	8.87
Total Fertility Rate 1976 2/	6.82
Asunción 1976 2/	2.7
Rural Population of Paraguay 1976 2/	8.5
" " " " 1976 4/	6.4
" " " " 1977 5/	9.2
Females 1977 ages 15 to 44 (000s) using effective contraceptive method 2/	101.4
Contraceptive Prevalence Rate (%) 2/	15.5
Married Women 1977 ages 15 to 44 (%) using effective contraceptive method 2/	23.7
Asunción 2/	44
Rural Population of Paraguay 2/	17
Infant Mortality Rate per 1,000 live births 1973 6/	84.8
Population Density per Km^2 6/	7
Life Expectancy at Birth (1970-75) 6/	61.82

Sources:

1/ Projection from 1972 Census.

2/ EPAP Survey 1977.

3/ Technical Planning Secretariat.

4/ EDENPAR Survey - CELADE 1977.

5/ DGEC/USAID Survey of Socio-Economic Status of Rural Women (FEMRURAL) 1978.

6/ MSPyBS National Health Plan 1975.

of women. These aspects will be discussed within later sections of the Paper.

The Futures Group, an AID Contractor, has prepared a draft report entitled, "Paraguay - The Effects of Population Growth on Development" (Report 364-122-02/02 - RAPID Project). The report points out that even if Paraguayan fertility were to drop today to replacement level (about two children per family), Paraguay's population would continue to grow for about 40 years. In order to demonstrate the effects of population growth on development in Paraguay, the Futures Group prepared three alternative population projections. All the projections assume that life expectancy will increase to 65 years by 1985 and to 70 years by 2000, and that there will be zero net international migration. Projection "A" assumes that fertility remains constant at 6.2 births per woman. Projection "B" assumes that measures are taken now that will cause fertility to gradually decline to an average of three children per woman by 2000. Projection "C" assumes that a two-child average is reached by 2000. Table 2 indicates these population projections under different fertility assumptions. Table 3 compares the population profiles of Paraguay in 1975 and 1995 assuming that fertility drops to replacement levels today.

The Futures Group concludes that a current reduction in fertility means that future requirements for education, health services, and new jobs would be smaller and more easily met. The changing age structure of the population resulting from fertility reduction would cause an increase in the size of the productive population relative to

Table 2

POPULATION UNDER DIFFERENT FERTILITY ASSUMPTIONS

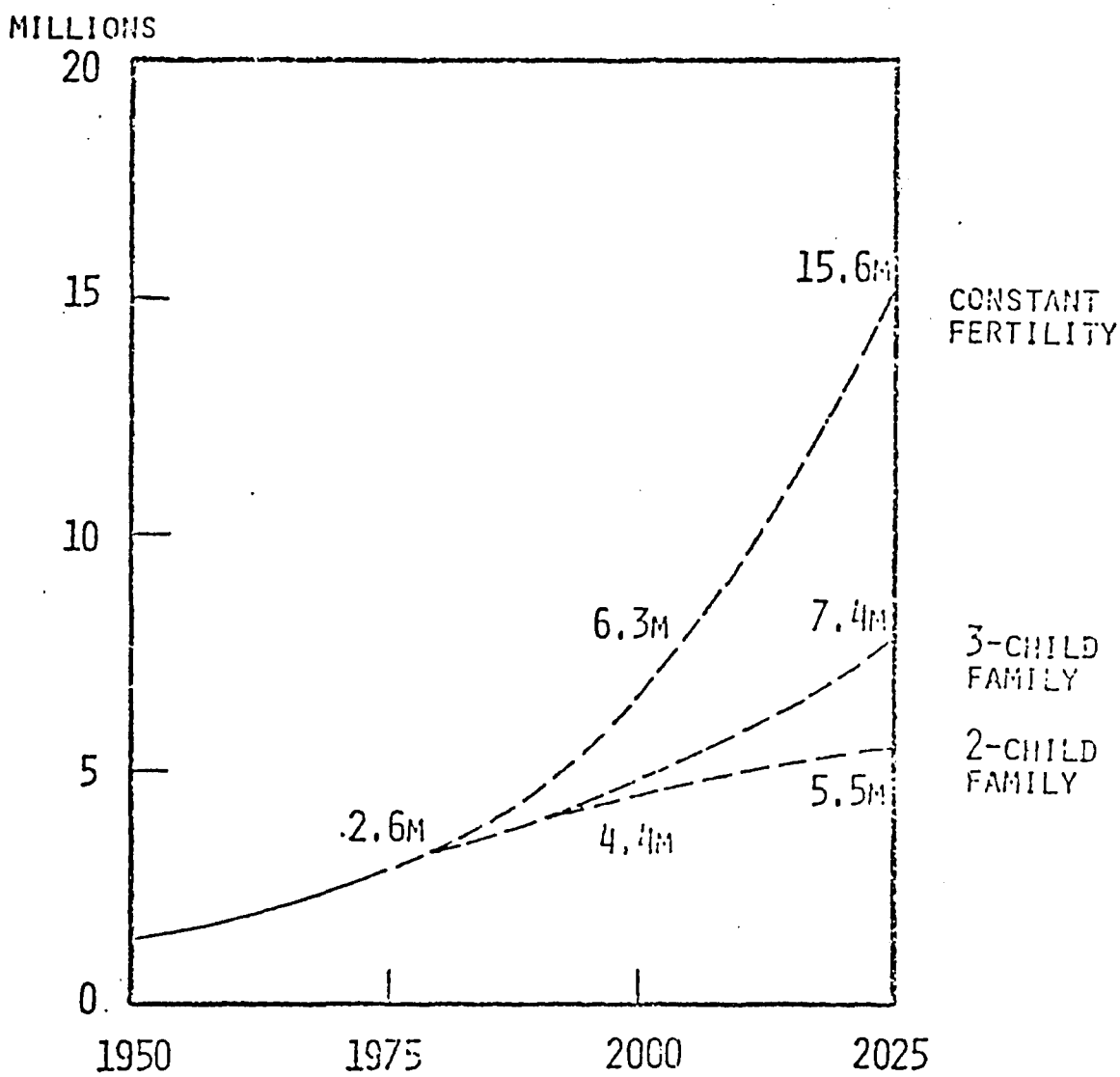
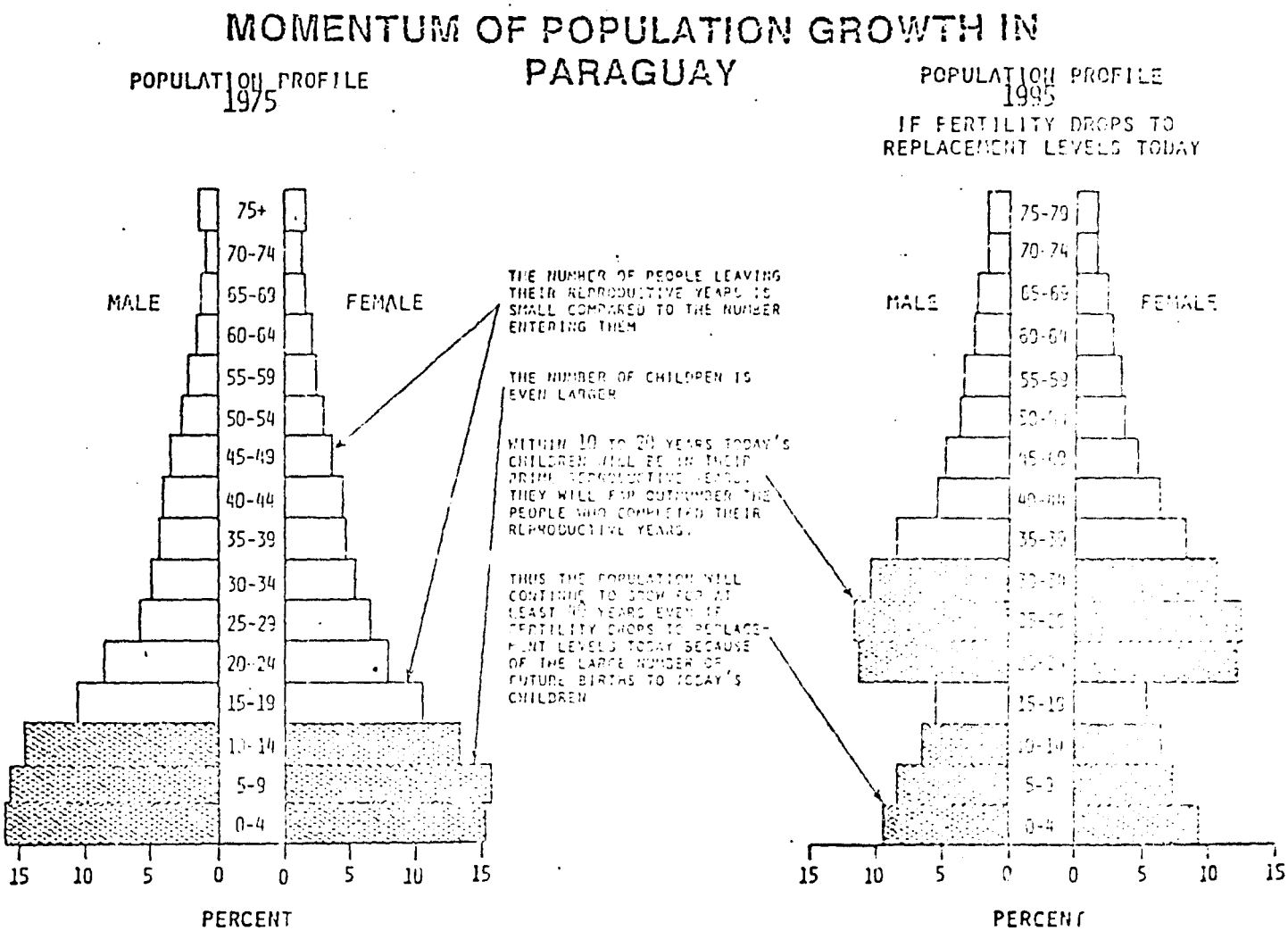


Table 3


MOMENTUM OF POPULATION GROWTH IN PARAGUAY
POPULATION PROFILE 1975
POPULATION PROFILE 1995
IF FERTILITY DROPS TO REPLACEMENT LEVELS TODAY
MALE
FEMALE
75+
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
15 10 5 0 0 5 10 15
PERCENT
THE NUMBER OF PEOPLE LEAVING THEIR REPRODUCTIVE YEARS IS SMALL COMPARED TO THE NUMBER ENTERING THEM
THE NUMBER OF CHILDREN IS EVEN LARGER
WITHIN 10 TO 20 YEARS TODAY'S CHILDREN WILL BE IN THEIR PRIME REPRODUCTIVE YEARS. THEY WILL FAR OUTNUMBER THE PEOPLE WHO COMPLETED THEIR REPRODUCTIVE YEARS.
THUS THE POPULATION WILL CONTINUE TO GROW FOR AT LEAST 70 YEARS EVEN IF FERTILITY DROPS TO REPLACEMENT LEVELS TODAY BECAUSE OF THE LARGE NUMBER OF FUTURE BIRTHS TO TODAY'S CHILDREN

the dependent population. Paraguay is a country with large untapped resources, chiefly land and hydroelectric power. It undoubtedly can support a much larger population than 2.9 million. The high rate at which Paraguay's population grows and the increasing dependency ratios resulting from continued high fertility will affect Paraguay's efforts to achieve both its long and short-term development goals. In every case a reduction in fertility would make it easier to achieve these goals. A full discussion of the effects of population growth on development in Paraguay can be found in the draft Futures Group report which is available through DS/POP/PPD of AID/W.

2. Description of Population/Family Planning Activities

a. Historic Overview

Population activities began in Paraguay in 1966 with the establishment of the Paraguayan Center for Population Studies (CEPEP) to study population, growth, and its social, moral, economic, and political implications. In 1968, CEPEP initiated organized family planning activities in Paraguay by opening a planned parenthood clinic within the University Hospital at the National University of Asunción. In 1969, CEPEP became an affiliate of the International Planned Parenthood Federation (IPPF).

USAID assistance for population/family planning activities began in 1969. The Institute for the Study of Human Reproduction (IERH) was created through an agreement between the Faculty of Medical Sciences of the National University of Asunción, the Ministry of Public Health and Social Welfare (MSPyBS), and USAID.

IERH was developed within the Faculty of Medical Sciences to a) carry out medical, socio-economic, and demographic research studies, and b) teach POP/FP subjects. USAID also entered into an agreement in 1969 with the Dr. Andrés Barbero Institute and the MSPyBS to train nurses, midwives, social workers, and physicians in POP/FP through in-country seminars and participant training.

During 1970-71 USAID entered into a number of agreements with private and public agencies including the Technical Planning Secretariat in order to study POP/FP-related subjects, and to thereby demonstrate the need for a population policy and FP services to the GOP leadership. The USAID-financed research included:

(a) A study of the effects of the Papal Encyclical Humanae Vitae on the attitudes and practices of members of the Catholic faith in Paraguay;

(b) A study of the effects of different population growth rates on Paraguay's economic and social development through the year 2000;

(c) A demographic sample survey of 1,000 households to obtain demographic data for planning purposes;

(d) A demographic sample survey of 2,000 households to measure internal and external migration and the socio-economic and cultural implications;

(e) A demographic sample survey (FEPA) of 2,000 households in five cities to measure fertility, abortion, and use of contraceptives:

(f) A study of the commercial sales of contraceptives; and,

(g) A study of the attitudes of civilian, military, and religious leaders regarding family planning and population growth.

In 1970, USAID assisted the MSPyBS to establish the first six public FP clinics in Paraguay under the supervision of the

MSPyBS Department of Maternal/Child Health (MCH). In the following year six additional clinics were established. The MSPyBS determined that the MCH Department was not recruiting many FP acceptors because delivery of other types of health care was given more priority than FP services. Moreover, the MSPyBS realized that the MCH Department's in-service training, supervision, reporting, and acceptor follow-up activities were inadequate. As a result, in May 1972, the MSPyBS with USAID assistance established an autonomous Department of Family Protection (DEPROFA) to implement all MSPyBS FP activities and to supervise all FP activities carried out by other private or public institutions. From the outset of USAID assistance to the MSPyBS, USAID paid almost all the costs of implementing FP activities, and the MSPyBS contributed only its existing health infrastructure.

During 1970-72, USAID entered into agreements with the General Directorate of Statistics and Census (DGEC) of the Ministry of Finance to assist the DGEC to carry out the 1972 Population Census and Household Survey.

In 1974, a four-member Paraguayan delegation participated in the World Population Conference held at Bucharest, Romania. The Conference produced a World Population Plan of Action which was adopted by 136 countries including Paraguay and the United States. The Plan of Action recognizes that "population and development are interrelated: population variables influence development variables and are also influenced by them". The Plan of Action also declares that "population measures should be integrated into comprehensive

social and economic plans and programmes and this integration should be reflected in the goals, instrumentalities, and organizations for planning within the countries".

In 1976, USAID phased out its budget support to IERH. During a period of seven years IERH was totally dependent on USAID funding. USAID constructed and equipped IERH's two-story building and financed salaries, commodities, and participant training. There were predictions that IERH would die when USAID funding ended, but IERH is prospering. IERH has been receiving ever-increasing funds from the GOP budget and has been undertaking a variety of research and training projects with the assistance of donor agencies. It remains the predominant Paraguayan research institution in the field of POP/FP.

In 1976-77, USAID experienced difficulties in obtaining a two-year extension of the Population Project which was to expire on 12/31/76. AID/W was reluctant to approve the extension because of the inadequate GOP financial commitment to the MSPyBS DEPROFA program. The USAID Director and U.S. Ambassador to Paraguay had numerous conversations with GOP officials. After USAID obtained firm commitments from the MSPyBS about increased GOP funding for DEPROFA, beginning in 1977, AID/W authorized the requested extension. The March 2, 1977, Action Memorandum for the Acting Administrator which approved the extension contained specific guidance for the Mission. A paragraph under the heading PPC Comment states: "This project was started more than ten years ago. The attention of the Agency has since turned from ensuring that family planning concepts and programs were started to

one where emphasis is directed to concentrate on, among other things, working with the host government to incorporate family planning within their institutional framework. While this may take time, it should receive primary emphasis in those projects where family planning efforts have been in existence for some time. The terminal extension of this project must form the bridge within which time the USAID and Government of Paraguay agree on a strategy on how and when to absorb the remaining family planning activities within their budget. This dialogue should be started -if not already begun- since no further project extensions will be considered. A new project should be constructed within the framework of the past accomplishments of this project but should set new targets and purposes in line with the accomplishments achieved under its predecessor."

During the course of 1977, USAID discovered that the MSPyBS was unable to make its financial contribution to the project as specified in the 1977 Project Agreement. USAID considered whether to immediately suspend further disbursements to the MSPyBS or to develop jointly with the MSPyBS a plan for the progressive absorption by the MSPyBS of recurring local costs of the DEPROFA program during the remainder of 1977 and 1978. USAID decided to take the latter course of action. The MSPyBS agreed to absorb approximately $5,000 in DEPROFA costs during the remainder of 1977, and in November 1977, negotiations began between USAID and the MSPyBS over the progressive absorption by the MSPyBS of recurring local costs in 1978.

The largest component of the Population Project in recent years had been salary payments or supplements to MSPyBS employees

for performing FP duties. In mid-1977 approximately 150 MSPyBS employees were receiving either full salary or salary supplements through this project. USAID and the MSPyBS agreed that 1978 would be the last year of USAID budget support for the DEPROFA program. The 1978 Project Agreement between USAID and the MSPyBS states, "The Ministry and USAID agree that 1978 will be a year of transition in which the Ministry progressively absorbs local costs of DEPROFA's activities. The Ministry agrees that it will absorb with its own funds all local costs of DEPROFA's activities beginning on January 1, 1979." The Project Agreement budget included $100,000 as the 1978 USAID contribution. Of the USAID contribution, 73% was devoted to payment of DEPROFA Central Office staff, DEPROFA Cytology Laboratory staff, and MSPyBS staff at 32 large Health Centers. The Project Agreement divided the USAID salary payments into quarterly disbursements of $31,700, $18,800, $12,600, and $9,700, while the MSPyBS disbursements for salaries were to be $11,470, $20,050, $23,035, and $25,195. The MSPyBS, under considerable pressure not to dismiss employees from their posts, found the money to pay salaries and eliminated salary supplements to personnel already collecting a MSPyBS salary. The progressive absorption went smoothly throughout 1978.

In 1979, the MSPyBS is paying the salaries of program personnel. Approximately three hundred medical, paramedical, and auxiliary personnel who provide FP information and services at health centers/posts are being paid out of MSPyBS monies budgeted for the country's nine Health Regions. DEPROFA Central Office and Laboratory

staff are baing paid out of the 1979 budget of ₲4.9 million allocated to DEPROFA. The DEPROFA budget is three times as large as in 1978.

USAID followed the AID/W guidance expressed in the March 2, 1977, Action Memorandum and is pleased that we were able to successfully transfer the financial responsibility for family planning activities from USAID to the GOP within the short period of two years.

b. Coverage of Family Planning Services

The best source of data about contraceptive prevalence in Paraguay is the 1977 Contraceptive Prevalence Survey (EPAP '77) which was designed and analyzed by the U.S. Center for Disease Control (CDC). The survey found that 15.5% of women in the fertile ages of 15-44 were using an effective means of contraception. Of ever-married women in the fertile ages of 15-44, 23.7% were using an effective method of contraception. The urban/rural difference in contraceptive use parallels the fertility differentials discussed in a previous section of this Paper. Over 40% of ever-married women were using contraception in Asunción and other urban areas, compared to 17% in rural areas. Contraceptive use also appears to be associated with education of women. Approximately 19% of ever-married women with less than primary education were using effective means of contraception, while 47% with more than primary education were doing so.

The EPAP Survey provides estimates of contraceptive users obtaining supplies from organized family planning programs and the commercial sector. Of the 655,000 women aged 15-44 years in Paraguay, 101,400 were found to be using an effective contraceptive

method. Table 4 gives the number of users of each contraceptive method, and Table 5 gives the number of users by each source of supply. Sterilization is included in the totals of each table, but it is not an approved method of family planning in any of the organized programs. Over 43% of the acceptors of contraceptives were using oral contraceptives. This method is by far the most popular in Paraguay. Over 75% of the active users of the MSPyBS organized family planning program were using oral contraceptives.

The MSPyBS was found to be the largest single provider of contraceptives in the country. In rural areas of the country 54% of contraceptive users obtained supplies through the MSPyBS, while only 26% obtained supplies through the commercial sector. In Asunción only 21% of contraceptive users obtained supplies through the MSPyBS, while 53% obtained supplies through the commercial sector. The MSPyBS program is apparently having its biggest impact in the rural areas.

The MSPyBS currently offers family planning services through 77 Health Centers and 96 Health Posts throughout Paraguay. USAID estimates that the MSPyBS has 35,000 active FP users, not including sterilizations. USAID has supplied most of the contraceptive needs of the MSPyBS since the inception of MSPyBS activities in FP. (See Annex 1 for contraceptive supply analysis.) Family planning services are delivered by the same health personnel who deliver all health services within the health facility. There has been a growing tendency to delegate responsibility to paramedical and auxiliary personnel. Auxiliaries and paramedicals are permitted to distribute

Table 4

Estimated Number of Current Users of Contraception by Method: Paraguay, 1977

Method	No. of Users	Percent
Oral contraceptives	43,900	43.3
Rhythm and Withdrawal	18,300	18.0
IUD	13,700	13.5
Sterilization	11,800	11.6
Other methods: condom, injection, foam, jelly, vaginal tablets and diaphragm	13,700	13.5
	101,400	100.0

Table 5

Estimated Number of Current Users of Contraception by Source of Supply: Paraguay, 1977

Source	Number
Organized Programs:	
Ministry of Public Health and Social Welfare	37,500*
C E P E P	8,000
Other	3,600
Commercial Sector	34,000
No source, rhythm and withdrawal	18,300
	101,400

* Includes 6,000 sterilization cases. Since sterilization is not a program method, the MSPyBS has 31,500 FP users.

oral contraceptives, the most popular method. Many paramedicals and auxiliaries have been trained to insert IUDs and are inserting IUDs. The largest constraint to the widespread availability of family planning services through the MSPyBS is the limited coverage of the health delivery system in rural areas. In 1974, the MSPyBS had the capability of reaching only 56% of the population, while in that same year, Asunción with only 16.5% of the population had 77.2% of the doctors, 79.6% of the dentists, and 89.2% of the nurses. Despite MSPyBS willingness to utilize paramedical and auxiliary personnel as the primary distributors of family planning services, there is little outreach of family planning activities beyond the confines of the health facilities. The inadequate rural network of health facilities coupled with the inadequate rural network of roads means that many rural families do not have reasonable access to family planning services. The new project proposed in this Paper is an attempt to partially overcome these deficiencies in three Health Regions.

The private International Planned Parenthood Federation affiliate, the Paraguayan Center for Population Studies (CEPEP), offers services through 27 clinics. CEPEP was the most important provider of family planning services until the mid-70s when the MSPyBS family planning activities began to expand. The EPAP Survey estimated that CEPEP had only 8,000 active users in 1977. The CEPEP data system appears to be notoriously inaccurate because of the failure of CEPEP management to purge inactive cases from the client record system. USAID analysis of the EPAP Survey results and the current distribution

of contraceptives by CEPEP indicates that CEPEP has an estimated 10-15,000 active users. USAID does not feel that CEPEP will be an important source of family planning services to the rural population. Although the CEPEP Executive Director is an innovative and capable man, CEPEP is unlikely to be more innovative than the MSPyBS because of political constraints.

The MSPyBS and CEPEP have the largest organized family planning programs. The Social Security Institute (IPS) does offer family planning services to an estimated 1,500 women with five or more children for medical reasons. This is in contrast with the MSPyBS and CEPEP who offer services to any woman who requests them. The Friendship Mission, a religious voluntary agency affiliated with the U.S. Disciples of Christ, has an estimated 1,000 active users in the Asunción area. The MSPyBS and CEPEP have assisted the military and police health services to offer family planning services to their members in a few locations. The user figures are included within the totals for the MSPyBS and CEPEP.

The EPAP Survey estimated that there were 11,800 women who were protected from pregnancy through sterilization. Sterilization is not considered to be a program method in either the MSPyBS or CEPEP programs, but sterilizations are routinely performed for medical reasons. In the past three years physicians from all the major public, private, and military hospitals in Asunción have received U.S. and third-country training in advanced techniques of fertility control including instruction in either laparoscopy or mini-laparotomy.

The Faculty of Medical Sciences at the National University of Asunción will be organizing courses in 1979, for physicians from the interior for training in obstetrics and gynecology including advanced techniques of fertility control. The MSPyBS is interested in obtaining training for MSPyBS physicians stationed in Health Centers outside of Asunción through the Program for International Education in Gynecology and Obstetrics (PIEGO) and will make the necessary applications to PIEGO.

A high proportion of women included in the EPAP Survey reported having had at least one spontaneous or induced abortion. Women residing in Asunción and women in the highest educational categories had greater abortion experience than other women, a finding which may suggest that induced abortion is an important component of all abortions reported. Almost 23% of ever-married women aged 15-44 reported a history of abortion. The percentages ranged from 20% in the rural areas to over 36% in Asunción. Almost 43% of the women reporting an abortion history required hospitalization after their most recent abortion, and over 60% of the women required some medical attention. The high levels of abortion experience, spontaneous or induced, are related to high complication and hospitalization rates, which indicates that abortion is a large-scale public health problem in Paraguay.

The EPAP Survey also found significant urban/rural differences in the proportions of fertile-aged women in union (married or consensual union). The percentage in union is lower in Asunción at every age, particularly between the ages of 20 to 29 when fertility is

highest. Overall, 48% of fertile-aged women are in union in Asunción compared to 64% in the interior. Fewer women in Asunción are exposed to pregnancy.

According to the EPAP Survey, the wide urban/rural differences in fertility are related to consistent differences in contraceptive use, abortion history, and proportions in union.

The EPAP Survey found that 65% of women in union did not desire pregnancy at the time of the survey. Of the women not desiring pregnancy, only 34% were using an effective method of contraception. 25% of the rural women not desiring pregnancy were using an effective method of contraception, while over 63% of the urban women were using an effective method. The authors of the EPAP Survey estimated that there were 163,000 women 15-44 years of age who were in need of effective means of fertility control and not presently using an effective means. A woman was characterized as in need of services if she stated she was not pregnant and did not currently desire to become pregnant and she was either using an ineffective method or was using no method and could not give an adequate reason for not using an effective method. 141,000 or 87% of the 163,000 women characterized as in need of effective means of fertility control live in rural areas. It is clear that USAID and the MSPyBS must concentrate their programmatic efforts on the rural areas of Paraguay.

The challenge is to find an effective means of delivering family planning services to the 141,000 rural women in need. The MSPyBS has a policy that family planning services should be

completely integrated with the public health system. However, the public health network currently reaches only a small percentage of the rural population and is not an effective vehicle for either health or family planning services. The next section of the Paper will present the proposed USAID response to the challenge.

c. Rationale for Current Project

Despite a decade of USAID assistance to population and family planning activities, most rural families do not use an effective means of contraception. Rural women, on the average, give birth to between six and nine children. Rural families also suffer from high levels of morbidity and mortality. Both health and fertility may each be regarded as a determinant as well as a consequence of the other. There is a growing body of evidence, according to Taylor, Newman, and Kelly*, that shows that patterns of high fertility are associated with health hazards to individuals, families, and communities, leading to the strong conclusion that family planning is one of the most important health measures available.

There is abundant international evidence showing that high parity directly affects childhood mortality. Stillbirth, infant mortality, and child mortality increase with parity beyond the fourth birth. Rapid childbearing without proper child-spacing has an adverse

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* Taylor, C.E., Newman, J.S., and Kelly, N.U., "Interaction Between Health and Population", Studies in Family Planning, Vol. 7 No. 4, April, 1976.

effect on child survival. Evidence from the Indian Punjab indicated that neonatal, infant, and second-year mortality were highest when the birth interval was less than one year and tended to decline progressively with longer intervals up to four years. The association of high parity and short birth intervals with child health problems and mortality is well known.

High parity and short birth intervals also affect maternal morbidity and mortality. Higher maternal morbidity due to toxemia, placental disorders, malpresentations, and hemorrhage occurs with grand multiparity even where high quality obstetrical care is available and maternal mortality rates are low. When obstetrical care is minimal as in Paraguay, parity directly affects maternal mortality, with a steady and sharp increase in risk after the third birth. There are increased risks to women under 20 years of age or over 34 years of age who give birth. There is a strong medical justification for limiting births to the maternal ages of 20-34.

Our Sector Goal is to improve the health and well-being of poor Paraguayan families. Our Project Purpose is to increase the availability and use of family planning services. Although the argument could be made that Paraguay needs a family planning program to reduce its rapid rate of population growth which threatens the attainment of development objectives, USAID does not choose to make that argument as the rationale for this project. We would rather dwell on the relationships between fertility and family health. We believe that there are compelling reasons for not justifying our family planning assistance to the GOP with a demographic rationale.

Firstly, a demographic rationale is not convincing to the intended beneficiaries of our assistance. The women who are using family planning services do so because they are concerned about their own health and welfare and that of their family members. They do not do so because they are concerned about Paraguay's rate of population growth. We believe that rural Paraguayan families will adopt the practice of family planning in ever-increasing numbers as they become aware of the health and welfare benefits. Health is a basic human need, and family planning is an important means to achieving improved health.

Secondly, a demographic rationale is not convincing to the GOP leadership. The GOP has not articulated a national population policy. There is no official concern about the projection that Paraguay's population will double in approximately 22 years. Many of the GOP leaders have been quoted in the press about their conviction that Paraguay needs to grow more rapidly. The United Nations Fund for Population Activities (UNFPA) has developed a multi-million dollar package of demographic and socio-economic research studies to assist the GOP develop a national population policy. When the proposed UNFPA assistance to the National Council of Social Progress was announced, the President of the Council stated that Paraguay needed more population and that UNFPA would be helping the GOP to develop policies to achieve this goal. USAID efforts to convince the GOP economic planners at the Technical Planning Secretariat through similar studies in the early 1970s that high fertility and a rapid rate of population growth

were injurious to Paraguay's development led to no perceptible changes in the attitudes of the GOP leadership. USAID intends to concentrate its assistance on the provision of information and family planning services. UNFPA will devote much larger sums of money to population policy development.

Thirdly, a series of articles about birth control appeared in Asunción's leading daily, ABC Color, in 1978. The articles (see Annex 2) were critical of attempts to reduce the population of Paraguay and singled out CEPEP, the private IPPF affiliate, for special condemnation. No mention was made of the fact that the MSPyBS also had a family planning program. The sharply worded and often inaccurate articles have caused everyone concerned with family planning services to assume a low profile. The articles demonstrate the risks of using a demographic rationale for family planning activities in the present political climate.

Fourthly, the MSPyBS is committed to the provision of family planning services as a component of health services. The Minister, the Director General of Health, and other high health officials have expressed their personal conviction of the importance of family planning services to the health of women and children. The MSPyBS will not implement a highly publicized family planning program because it fears an adverse political reaction. The MSPyBS has established no demographic targets for the family planning program, and any talk of reducing the birth rate makes MSPyBS personnel very uncomfortable.

The U.S. Congress has repeatedly reaffirmed its position that AID should integrate its assistance in health, family planning, and nutrition whenever possible. Despite the instruction that AID should develop low-cost integrated delivery systems, Congress continues to establish separate funding accounts for health and population. USAID is in complete accord with the Congressional Mandate and feels that there are compelling reasons for pursuing an integrated approach in this project. Firstly, the MSPyBS has adopted a policy of integrating family planning services into the health services. Secondly, the MSPyBS will not pay the additional costs of maintaining a vertical family planning service network. Thirdly, the MSPyBS has requested USAID to assist in development of a low-cost integrated delivery system that will extend the coverage of health services to the rural poor. Fourthly, the MSPyBS has stated frankly that it will not allow any other public or private Paraguayan organization to undertake non-clinical distribution of contraceptives at this time. Fifthly, USAID believes that integrated maternal/child care services including family planning are more acceptable to rural Paraguayans than isolated family planning services. Sixthly, USAID believes that reduction in infant mortality will lead to a reduction in fertility when parents perceive that their children will survive and the means to regulate the size of their family are made available. Finally, the integrated approach offers the opportunity to extend availability of family planning services to rural people.

The MSPyBS has not requested USAID for further assistance to DEPROFA. The MSPyBS is attempting to strengthen the nine

Health Regions and has delegated increased authority for implementation of programs to each Health Region. In discussions with both the United Nations and USAID, the Director General of Health has indicated that DEPROFA would soon be integrated with the Department of Maternal and Child Health and possibly other Departments of the MSPyBS. The MSPyBS has requested the United Nations Fund for Population Activities to provide two consultants in 1979, to assist with the preparation of an integration plan. Whatever form the MSPyBS re-organization takes, it appears to USAID that DEPROFA has already relinquished operational control of the family planning services to the Health Regions. In that respect, DEPROFA has come to resemble all other MSPyBS Departments which characteristically do not operate health services programs. DEPROFA has become a horizontal program rather than a vertical program.

The MSPyBS has requested USAID to provide additional contraceptives for the nine Health Regions and to assist the MSPyBS to expand the availability of family planning services by expanding the health delivery system in three Health Regions. USAID does not view this project, which is described in detail in the next section of this Paper, as an ideal family planning project. USAID strongly recommended to the MSPyBS that the Voluntary Health Collaborators (VHCs) be trained to distribute health supplies including contraceptives in their rural communities. The MSPyBS did agree that the VHCs should be fully trained in family planning to provide information and to refer patients to health facilities, but the MSPyBS would not agree to non-clinical distribution of contraceptives by VHCs. The MSPyBS also did agree to

allow trained nurses and auxiliaries from Health Centers/Posts to distribute contraceptives in the rural communities while supervising the activities of the VHCs. The MSPyBS is fully aware of the effects of high fertility on health and the desirability of extending family planning services into rural communities without ready access to Health Centers/Posts. USAID believes that the refusal to permit community-based distribution of contraceptives through VHCs reflected fear of possible political consequences rather than medical judgment.

Despite this shortcoming, USAID does believe that the project will result in greater availability of family planning services and improved maternal/child health. Additional personnel at Health Centers/Posts will receive family planning training and provide family planning services. Those Health Centers/Posts which are not presently providing family planning services will provide them under this project. The VHCs will receive family planning training and will motivate residents of rural communities. The paramedicals and auxiliaries who will train and supervise the VHCs will distribute contraceptives during supervisory visits to communities served by VHCs. Moreover, USAID feels that the project will assist the MSPyBS to build a non-clinical network of basic health services that will eventually include the distribution of contraceptives by VHCs.

The August 19, 1977, cable (STATE 197334) which approved the PID (Annex 3) for this project states, "Alternative approaches that will involve the GOP and improve the actual delivery of services to the poor need to be explored. To propose a continuation

of the same approach with the vague expression of increased support from the GOP will make PP approval difficult, at the very least. New methods for the expanded delivery of services and additional organizations that will support family planning will be useful to include in the PP." (Annex 4). This project is an alternative to the former DEPROFA approach which neither USAID nor the MSPyBS wants to continue. The MSPyBS will support the new approach, and the new approach will improve the delivery of FP services. We feel that we have explored all possible alternatives and that the approach outlined in the next section of this Paper is the best possible project that we can achieve at this time.

B. Detailed Description of New Project

The three general objectives of the National Health Plan are to increase life expectancy, to extend coverage of health services to all the population, and to contribute to economic growth and social harmony. The MSPyBS is placing its highest priority on a program of interrelated projects with external funding to extend the coverage of health services from 77% of the population to 83% during the period 1976-80. In the rural localities of less than 2,000 inhabitants the coverage of health services will be extended from 51% to 64% of the population. The extension of coverage will be accomplished through the following actions:

(a) Construction of new rural Health Posts to be staffed by health auxiliaries;

(b) Equipping of new rural Health Posts;

(c) Training of personnel who work in the Health Centers and Health Posts of the Country's nine Health Regions;

(d) Creation of a new cadre of Voluntary Health Collaborators (VHCs) selected from rural communities on the periphery of Health Centers and Posts; and,

(e) Provision of technical assistance to improve the administration of MSPyBS programs which impact on rural areas.

The purpose of this USAID population project is to expand the availability and use of family planning services through modest grant assistance to the MSPyBS program for extension of health services. USAID will concentrate its assistance in the First, Third, and Seventh Health Regions (see map, Annex 5). The project will include the following components:

(a) Technical assistance to the MSPyBS in curriculum development, training techniques, supervision, logistics, data systems, survey design, and evaluation;

(b) Training of MSPyBS personnel of the three Health Regions;

(c) Selection, training, and supervision of rural Voluntary Health Collaborators (VHCs) in the three Health Regions;

(d) Purchase of basic health supplies, contraceptives and transport for the three Health Regions;

(e) Project evaluation through sample surveys and development of new data systems; and,

(f) Purchase of contraceptives for MSPyBS programs throughout the country.

A number of other donors including the Interamerican Development Bank (IDB), the United Nations Fund for Population Activities (UNFPA), and the United Nations Children's Fund (UNICEF), will be assisting the MSPyBS Extension of Coverage Program in other Health Regions. These activities are described in the Other Donors Section. The MSPyBS Director General of Health will coordinate donor activity to avoid duplication of effort.

The First, Third, and Seventh Health Regions of the MSPyBS contain 102 Health Centers and Posts which have the responsibility of providing health services to an estimated population of 870,645. This project is designed to improve the availability of low-cost basic health services including family planning by assisting the MSPyBS to create an improved delivery system for the rural population. Existing health facilities within the three Health Regions are unable to discharge their responsibilities adequately because of a number of easily identified constraints. Firstly, health staff, particularly auxiliary personnel assigned to rural Health Posts, are in short supply and often have not received adequate training or supervision. Secondly, Health Centers and Posts invariably lack basic medicines and vaccines necessary for primary health care. Thirdly, health facilities are concentrated in the larger towns, and there are large numbers of the rural poor living in sparsely populated areas beyond the reach of the health facilities. Fourthly, there are few health outreach activities organized by health workers who are accustomed to wait for people to come to the health facility. MSPyBS budgetary limitations preclude

the establishment of Health Posts in every rural community. The MSPyBS instead has decided to improve the services at the existing 102 Health Centers and Posts and to recruit, train, equip, and supervise approximately one thousand Voluntary Health Collaborators (VHCs) in the First, Third, and Seventh Health Regions.

As a condition of a $4.9 million IDB loan entitled Program for Expansion and Improvement of the Rural Health Service, the MSPyBS has established an Executing Unit of 23 persons to implement the activities financed by IDB. The organization chart and composition of the Executing Unit are shown in Annex 6. Although the Executing Unit is primarily concerned with the IDB loan, USAID has consulted with members of the Unit in the design of this project. We anticipate frequent contact with the Unit as the IDB and USAID projects are implemented. The Director General of Health is responsible for relations with donor agencies who are interested in developing projects which will result in the expansion of health services in rural areas. This USAID project was designed in collaboration with the Director General and members of his staff. The Office of the Director General will be responsible for the planning and evaluation of the project and will share responsibility for implementation with the First, Third, and Seventh Health Regions.

USAID will provide short-term technical assistance to both the MSPyBS Headquarters staff and the three Health Regions throughout the life of the project. USAID-financed consultants will assist the MSPyBS to develop curriculum for training courses, training and

supervision manuals, and evaluation systems. A MSPyBS Training/Supervision Team will be established to train one Regional Training/Supervision Team in each of the Country's nine Health Regions.

The MSPyBS Training/Supervision Team will be composed of representatives of the following MSPyBS Departments: Rural Health, Family Planning, Maternal and Child Health, Nutrition, and Nursing. The First, Third, and Seventh Health Regions each will designate six people to serve as members of their respective Regional Training/Supervision Teams. Each Regional Training/Supervision Team will receive ten days of training related to the VHC program. The Regional Training/Supervision Teams will train existing Health Center and Post personnel within their respective Health Regions through a series of ten-day courses. There will be seven courses involving 200 persons in the First Health Region, five courses involving 80 persons in the Third Health Region, and five courses involving 80 persons in the Seventh Health Region. The courses will provide 3,600 person-days of training to Health Center and Post personnel. USAID and the MSPyBS feel that it is essential to re-orient existing health personnel so that they may effectively play their roles in the new system for delivery of rural health services. Nursing or auxiliary personnel assigned to the 102 Health Centers and Posts will be responsible for the VHCs in their area. There will be approximately ten VHCs under the supervision of each Health Center or Post. Members of the Regional Training/Supervision Team will assist the Health Centers and Posts to recruit, train, and supervise the VHCs.

A detailed breakdown of the project components and costs can be found in the USAID budget under Part III.B.2.a.

During the first year activities will begin in the First Health Region, during the second year activities will begin in the Seventh Health Region, and during the final year activities will begin in the Third Health Region. As a result, the project will run for three years in the First Health Region, two years in the Seventh Health Region, and one year in the Third Health Region. It is anticipated that lessons learned from evaluation of the implementation of the project in the First Health Region will lead to modifications in implementation in the other Health Regions. Prior to the beginning of VHC activities, USAID will fund a sample survey to measure selected health indicators including infant mortality and selected fertility indicators including incidence of abortion and prevalence of contraceptive use. The survey will be repeated approximately two years later. The design, field work, and data analysis of the two surveys will be conducted by a qualified organization not involved in the implementation of the project.

The project will create a rural health infrastructure of approximately 1,000 VHCs which will be closely linked to the existing system of 102 Health Centers and Posts. The project's initial emphasis will be on achieving maximal coverage of the rural population with a limited number of high priority, basic services. Although the range of services provided by the project will be relatively small, a major objective of this approach is to establish an infrastructure which

will permit the expansion of services in the future. Moreover, the basic services will impact upon the major health problems of the rural poor.

In order to produce a model that can potentially be replicated on a large scale, the project will provide simple services with small training requirements. Each trainee will be thoroughly instructed in the proper and safe use of all the medicaments and contraceptives provided by the project. Within each Health Region there will be layers of field supervision to assist the VHCs carry out their duties in a competent and effective manner. In order to understand how the VHCs will relate to the existing health delivery system, it is necessary to give a brief description of that system.

1. The Existing MSPyBS Health Delivery System

The first service level consists of a Health Post (a consulting room without hospitalization facilities) staffed by one auxiliary in nursing or obstetrics. The MSPyBS often is unable to provide fully trained auxiliaries to rural Health Posts and must make do with a local resident who has not received formal training as an auxiliary (six to nine months). The Health Post auxiliary is expected to provide first aid, immunize patients (when vaccines are available), distribute simple medicaments (when medicaments are available), and refer patients with complications to the next level of health services. If the auxiliary has taken a course in obstetrics, he or she can also help with normal childbirth. Approximately half the Health Posts are currently distributing contraceptives. The MSPyBS intends that all

Health Posts within the First, Third, and Seventh Health Regions will distribute contraceptives during this project. The Health Posts are usually located in towns with less than 2,000 inhabitants.

The second level in the regional health delivery system is the Health Center. Health Centers are usually located in towns with 2,000 to 20,000 inhabitants and have hospitalization facilities with six, nine, or nineteen beds. They are usually staffed by one or two physicians, one or two graduate nurses, a part-time dentist, and several health auxiliaries. Health Center staff supervise a group of Health Posts and provide a variety of curative and preventive services such as family planning, pre and post-natal care for women, child care, minor surgery, immunizations (when vaccines are available), and first aid care. Most hospitalizations are related to childbirth and extreme dehydration in children. Almost all Health Centers provide family planning services. The MSPyBS intends that all Health Centers in the First, Third, and Seventh Health Regions will distribute contraceptives during this project.

The third and highest level in the regional health delivery system is the Regional Health Center. Each Health Region has one Regional Health Center which is usually located in the principal town of the region. The staff usually includes medical, dental, nursing, obstetrical, laboratory, X-ray, pharmaceutical, service, and maintenance personnel. Regional Health Centers have hospitalization facilities with between 30 and 50 beds. Patients requiring highly specialized or complex surgical attention are referred to Asunción.

2. The Voluntary Health Collaborator Program

The 1,000 VHCs will be selected from both sexes according to criteria to be developed by the MSPyBS. There will be 400 VHCs in the First Health Region, 300 VHCs in the Third Health Region, and 300 VHCs in the Seventh Health Region. They will include recognized community leaders, voluntary collaborators of the Malaria Prevention Service (SENEPA), and granny midwives (parteras empíricas). In the selection process emphasis will be placed on the willingness of each candidate to actively promote the specific services included in the project. Since the coverage achieved by the project will be largely determined by the location of VHCs, the selection process should be designed to achieve a wide distribution of VHCs throughout the area. To facilitate this process, the location of each VHC will be recorded on maps of rural 'compañías'.

a. Training

Training of the VHCs will take place at selected Health Centers/Posts within each of the three Health Regions. Over the three years of this project, there will be 85 training courses for VHCs involving 10,400 person-days of VHC training. The major causes of sickness and death among the rural poor, diarrheas, parasite infestation, anemia and pregnancy-related problems, can be prevented or cured through the application of simple technology. The VHCs will be given simple, task-oriented instruction in preventive and curative measures to reduce the incidence of these health conditions. The VHCs will be trained to provide information about environmental sanitation and

personal hygiene to their communities. The use of properly constructed and properly located latrines will reduce the presence of parasites in the soil and improve the quality of drinking water. Encouragement of breast-feeding and use of proper weaning foods will contribute to the lowering of infant mortality. The encouragement of family planning to achieve birth intervals of two-three years between children and to reduce unwanted fertility will pay important health dividends, particularly to mothers and young children. The application of anti-parasitic tablets will remove intestinal parasites which retard the development of young children. Although the children will be reinfested unless environmental sanitation is improved, semi-annual deworming is considered beneficial. Oral rehydration solution will save the life of an infant severely dehydrated through diarrhea. Iron tablets will reduce anemia among pregnant or lactating women.

The First and Seventh Health Regions will schedule initial courses of five days for their VHCs. Approximately one year after the initial training, refresher courses of five days will be scheduled. The VHCs will receive instruction related to topics presented in the initial training and instruction in additional subjects which the MSPyBS may wish to add to the curriculum after evaluation of the first year of project operations. The Third Health Region will combine the initial and refresher courses into a single course of ten days. VHC training in the Third Health Region will not begin until the third year of the project, and there is not sufficient time to schedule two series of courses. Moreover, the Third Health Region will have the

benefit of experience gained by the two other Health Regions in order to modify the curriculum prior to the VHC training.

The initial course will stress the following subjects:

(a) The use of the medicaments that the VHCs will receive;

(b) Simple concepts in health education and community organization;

(c) Family planning;

(d) Techniques for home visits; and,

(e) The relationship between the VHC and MSPyBS staff.

The contents of the course will be limited to allow the instructors to a) repeat every subject area several time, b) obtain the active participation of every student, including informal evaluation of the ability of each student to apply his training in the field, and c) a formal, recorded evaluation of each student. Thus, for every skill included in the course there will be an explicit, written definition of competence. For example, for the treatment of infant diarrhea this would include the ability of the VHC to a) prepare a rehydration solution correctly, b) explain its use, c) describe appropriate follow-up and the criteria for referral to the local Health Center or Post. The responsibility of the instructor is not merely to give a lecture on the subject, but rather to bring each VHC to a satisfactory level of competence in each skill.

b. Supplies

During the initial training course each VHC will receive a manual of basic health skills, and at the successful completion of the course, each VHC will receive a kit consisting of the following:

(a) Oral rehydration salts	30 each
(b) Anti-parasitic tablets	30 treatments
(c) Iron tablets	200 each
(d) Aspirin	200 each
(e) Merthiolate	1 4-oz. bottle
(f) Gauze pads	30 each
(g) Adhesive tape	2 rolls
(h) Cloth bag with shoulder strap	1 each
(i) Sign with MSPyBS logo	1 each

Each Health Center and Post participating in the project will receive a supply of tetanus toxoid for administration to pregnant women referred by the VHCs. Each Health Center and Post will receive contraceptives to distribute to their regular patients and patients referred by the VHCs.

An efficient logistics system is a necessary condition to project success. USAID will provide technical assistance to assist the MSPyBS to adapt its existing logistics systems to serve the Voluntary Health Collaborator Program. New procedures will have to be developed to move commodities from the port to each VHC operating in the field. The commodities will flow from the MSPyBS Warehouse to the Health Centers and Posts participating in the program and thence to the VHCs. USAID and the MSPyBS experienced difficulties in managing project commodities purchased under the former Population Project. An AID Area Auditor General audit was performed in 1977 to establish the reasons for irregularities in management of project commodities and to

make recommendations for improved management. The audit recommendations have been followed to the letter and there has been a marked improvement in the management of commodities. However, the proposed project will require considerable modification of the logistics system established under the previous project. It is proposed that an expert in logistics visit Paraguay in the early stages of the project to prepare recommendations which can be implemented before the project commodities arrive.

c. Voluntary Health Collaborator Duties

The VHC will affix the sign with the MSPyBS logo to the exterior of his house. He will store the medical supplies in a cloth bag which the project will issue for use as a medical kit. The VHC will carry the medical kit when visiting rural households. Whenever the need arises to dispense medicaments to patients, he will do so at no charge. The VHC's stock of supplies will be replenished by his supervisor during periodic field visits. If the VHC's stock runs low before the supervisor's anticipated visit, the VHC can obtain more supplies by visiting the Health Center or Post where the supervisor works.

The MSPyBS expects each VHC to perform an average of two consultations daily to members of his community. The VHC should be a promotor of good health practices and must take the initiative to inform his neighbors how to prevent disease. Health education through both personal contact and presentations at community meetings should be a major activity. He will provide first aid to accident victims. He will refer the seriously ill to the appropriate health facility. The VHC should routinely visit households in his area to seek out

persons in need of his services. Community residents should be instructed by the VHC to come to his house whenever they have a health problem.

Although the VHC should try to assist anyone who needs his services, his VHC training will prepare him to perform only a few basic health interventions. His training will emphasize maternal and child health care. Pregnant women should be encouraged to visit the nearest health facility for tetanus toxoid inoculation and pre-natal care. Iron tablets should be distributed to pregnant and lactating women. Anti-parasitic tablets should be distributed to children under five years of age because parasitic infestation is almost universal in rural Paraguay. The VHC should prepare oral rehydration solution for infants suffering from diarrhea and refer the child to the appropriate health facility. The VHC should inform women about the advantages of breastfeeding and nutritious weaning foods. Mothers should be encouraged to visit health facilities with their children for periodic check-ups and immunizations.

The VHC has an important role to play in family planning. All couples should be informed about the health benefits of child spacing and the availability of a full range of family planning methods at MSPyBS Health Centers and Posts. The VHC should try to motivate all pregnant women to seek family planning services after the birth of the baby. All women with young children should also receive motivational visits from the VHC. The VHC should inform visiting supervisory personnel about families in need of family planning services

or families who are interested in obtaining contraceptives. The supervisors should try to motivate the individuals identified by the VHCs and supply contraceptives to those who desire them.

Initially, the VHCs will not distribute contraceptives. The auxiliaries and nurses who are to supervise the VHCs will be required to make regular supervisory visits to the communities served by VHCs. Persons who desire to obtain contraceptives may obtain them from the nurses or auxiliaries during their supervisory trips t the community or by visiting a Health Center or Post. Although USAID and AID/W Consultant Dr. James Heiby attempted to persuade the MSPyBS to allow the distribution of contraceptives through VHCs, the Director General of Health stated categorically that conditions would not permit it at this time. Nevertheless, the project will result in a greater availability of family planning services for the following reasons: (a) Health Posts which are not currently offering family planning services will offer them after their auxiliaries receive training under this project; (b) The VHCs will provide information about the health benefits of family planning and motivate couples; (c) Rural Paraguayans will learn that family planning services are available and where they may obtain them; and (d) Contraceptives will be distributed within the communities during the supervisory visits. The project will establish a low-cost health services delivery system which will benefit the rural poor who do not use MSPyBS health services at present. Over the past decade the MSPyBS has gradually adopted more liberal policies regarding the provision of family planning services. As recently as 2 1/2 years

ago, the MSPyBS offered services only through 32 urban Health Centers and required that every woman submit to a pelvic examination by a physician before allowing her to receive contraceptives. At present, most family planning patients are attended by paramedical or auxiliary personnel. Trained paramedicals and auxiliaries are permitted to distribute oral contraceptives and insert IUDs. USAID predicts that the MSPyBS will ultimately decide to allow the VHCs to distribute contraceptives. This could occur as soon as the MSPyBS is convinced that the VHC program is firmly established and that VHCs have earned a good reputation. In the meantime, the expansion of family planning services within the framework of basic rural health services justifies the expenditure of Title X funds.

d. Supervision

The MSPyBS with technical assistance from USAID will develop a supervision manual with guidelines for supervisory activities. During frequent field visits to communities served by VHCs, supervisory personnel will provide services to community residents, re-train the VHCs, re-supply medicaments, solve problems, and collect data. Each VHC should receive at least one visit per quarter, and USAID will defray the travel expenses of the VHC supervisors during periodic field visits. To receive payment, the supervisor will be required to complete a standard supervision form. This form will include the following activities: (a) Evaluation of the VHCs knowledge and skills; (b) follow-up of a sample of interventions by the VHC; (c) a random sample of households in the community to determine the effectiveness of the

VHC in detecting health problems; (d) the quantity of supplies distributed per month; and (e) a summary of problems identified and steps taken by the supervisor to correct them.

The MSPyBS will develop general guidelines to concentrate visits among VHCs with inferior performance, and to a lesser extent, among VHCs with unusually good performance. The objective of supervision will be to improve the output of less successful VHCs and learn the techniques of outstanding VHCs, rather than simply achieve a number of visits. The Regional Training/Supervision Teams will also periodically supervise the VHCs and local supervisors. During the three years of project life, USAID will finance 10,380 person-days of supervision by Health Center and Post personnel and by the Regional Training/Supervision Teams.

To facilitate VHC supervision, the VHCs will be required to maintain a brief record of their interventions, including the name of the person treated, the medicament provided, and the result of follow-up. The VHC will maintain a listing of all FP users and will record the names of all persons referred to a Health Center or Post for FP services. The VHC will also maintain a listing of currently pregnant women, including the outcome of the pregnancy. The Health Centers and Posts will maintain client record cards for family planning acceptors. Each health facility participating in the program will submit a quarterly report summarizing the supplies distributed to each VHC. These quarterly reports, together with individual supervision reports will form the basis for planning supervision.

3. Provision of Contraceptives

USAID will procure contraceptives for use in all MSPyBS health facilities in Paraguay which offer family planning services. The MSPyBS offers the following contraceptive methods: oral contraceptives, IUDs, condoms, and contraceptive foam. USAID has provided all the above contraceptives to the MSPyBS through the former Population Project. USAID will procure $470,000 worth of oral contraceptives, IUDs, and contraceptive foam under this project. USAID and the MSPyBS have decided not to order more condoms. The condom has not proved to be a popular method in Paraguay, and there are supplies in the pipeline sufficient to meet any anticipated increase in demand over the life of the project.

C. Anticipated Other Donor Activities

1. The Interamerican Development Bank (IDB)

During 1979 the IDB and GOP signed an agreement under which the IDB will provide a $4.9 million loan for expansion and improvement of the rural health services. The loan will be disbursed over a four-year period beginning in 1979. Over 95% of the loan funds will be utilized to finance the construction and equipping of health facilities within the Second, Fourth, Sixth, and Ninth Health Regions. A small percentage of the loan funds will be utilized to fund part of the costs of training personnel who will work in the four Health Regions. Of particular interest to USAID is the IDB intention to finance certain costs related to the training of 2,000 Voluntary Health Collaborators. It should be noted that the training of VHCs to be

partly financed by the IDB will take place in Health Regions which are not included in the USAID project. The IDB loan will finance the following:

(a) Construction and equipping of 81 Health Posts and nine Health Centers;

(b) Expansion of facilities at the Sixth Regional Health Center;

(c) Equipping of the Second, Fourth, and Sixth Regional Health Centers;

(d) Training of 485 auxiliary personnel presently serving in Health Posts and Centers of the four Health Regions;

(e) Training of 2,000 Voluntary Health Collaborators within the four Health Regions; and,

(f) Provision of a health kit to each of the 2,000 VHCs.

In addition to the $4.9 million loan, the IDB has agreed to provide $402,200 in grant funds to finance 60 person-months of technical assistance and 25 person-months of fellowship training. The funding will cover the following:

a. Technical Assistance

1) Supply Systems - 3 months;

2) Organization and Methods - 4 months;

3) Accounting and Budget Control - (2) at 6 months;

4) Information Systems - 2 months;

5) Health Planning and Administration - 12 months;

6) Nursing Services - 12 months;

7) Hospital Administration - 3 months;

8) Building Maintenance Systems - 5 months;

9) Community Development - 3 months; and,

10) Training - 4 months.

b. Fellowships

1) Supply Management - 4 months;

2) Hospital Administration - 6 months;

3) Building Maintenance - (3) at 3 months; and,

4) Drug Inventory Control - 6 months.

The technical assistance and fellowships are targeted to the operation of health facilities rather than the VHC Program.

2. The International Planned Parenthood Federation (IPPF)

IPPF has budgeted $375,000 in cash and commodity support for the Paraguayan Center for Population Studies (CEPEP) in 1979. It is reasonable to expect that IPPF will provide approximately that level of assistance during each of the three years that the USAID project will be active. IPPF will meet the contraceptive requirements of CEPEP and provide over 80% of the money for the CEPEP operating budget. CEPEP organizes a number of informational and educational programs as well as operating a network of family planning services.

It is difficult to assess CEPEP's performance because of the unreliability of their service statistics. The 1977 Contraceptive Prevalence Survey (EPAP '77) estimated that CEPEP had only 8,000 active users of contraceptives enrolled in its programs as of March/April 1977. At the same time, CEPEP was claiming more than 32,000 active users. The authors of the EPAP Survey analyzed CEPEP's 1976 service statistics and concluded that CEPEP would have required 2 1/2 times as many oral

contraceptives than actually distributed to support the number of active users of oral contraceptives claimed by CEPEP. Recent analysis of CEPEP's data leads USAID to the conclusion that CEPEP has between 10,000 and 15,000 active users.

3. Development Associates, Inc. (DA)

During the period May 1972 through November 1978, DA trained the following numbers of Paraguayans:

	Short Term Trainees			Long Term Trainees		
	Programmed in:			Programmed in:		
TOTAL	The USA	Puerto Rico	In-Country, LA & Other	The USA	Puerto Rico	In-Country, LA & Other
2,016	95	31	1,884	2	4	-

It is no exaggeration to suggest that DA has been and probably will continue to be the most important donor in terms of population/family planning training. Over two thousand Paraguayans belonging to a variety of public and private institutions have attended DA-sponsored courses in Paraguay, other Latin American countries, the USA, Puerto Rico, and elsewhere in the world.

During the period December 1977 through November 1978, DA signed five contracts with three Paraguayan entities. Contracts were for these projects:

a. A contract with the Institute for the Study of Human Reproduction (IERH) for training in sex education and family planning for students at the Instituto Superior de Educación (ISE), at the national schools for nursing, midwifery, and social work, as well as for physicians. A total of 1,120 participants were included in these courses.

b. DA sponsored a week-long refresher course for 45 physicians working in CEPEP's program.

c. A contract with the Department of Family Protection (DEPROFA) of the MSPyBS, provided for the training of 50 nurses and auxiliary nurses working in the MSPyBS family planning program.

d. DA contracted with the Society of Public Health Nurses for a 4 1/2-week course for 36 alumni of the Society's school for mid-level midwives (graduates of a two-year course) to make them proficient in IUD insertion, pill distribution, etc. Prior to the course's initiation, DA's training specialist worked with the school's staff on curriculum development.

e. Under a contract with DEPROFA for the training of MSPyBS personnel in seven sanitary regions, 120 participants will be trained before June 1979. One course for 15 participants was held in December 1978.

4. Program of International Education in Gynecology and Obstetrics (PIEGO)

PIEGO has trained 14 Paraguayan physicians in the United States during the period 1976-8. Thirteen of the physicians attended the course which incorporates the latest techniques in obstetrics and gynecology including laparoscopy, while the fourteenth attended a course for administrators of family planning programs. All but two of the trainees are employed by hospitals in the Asunción area. During the next few years PIEGO will select candidates from institutions in other areas of the country.

5. International Fertility Research Program (IFRP)

Ms. Christina Colven visited Paraguay in November 1978, to make arrangements to receive data from the MSPyBS, the Institute of Social Security (IPS), the National University Faculty of Medical Sciences, and CEPEP. We understand through sources in the MSPyBS that they are preparing research data sheets related to IUD insertion for IFRP. USAID understands that IFRP is studying proposals from the IPS and the Medical School which would document the incidence and consequences of illegal, induced abortion.

6. Pathfinder Fund

Pathfinder has granted $27,746 to enable the Institute for the Study of Human Reproduction (IERH) to conduct a follow-up study to the 1971 CELADE demographic research study originally financed by USAID. Information to be obtained from 2,500 women in seven urban locations includes: place of birth, present residence, length of residence, date of birth, marital status, age at marriage, number of marriages or unions, amount of education, employment status, number of children (living, born dead, or died after birth), knowledge and practice of abortion, method used to space children, knowledge and use of various family planning methods, source of information on family planning and date first practiced, reason for discontinuation if applicable, and various questions about sexual practices.

Pathfinder has granted $30,828 for a three-year program of family planning and demography instruction at the Faculty of Medical Sciences of the National University of Asunción. Approximately 180

medical students and 40 obstetrical nursing students will receive the training in 1978-9. When funding expires in February 1979, Development Associates, Inc., will fund this activity for at least one more year.

In recent years Pathfinder Fund has provided the financing for two pilot rural maternal/child health and family planning projects through the MSPyBS and CEPEP.

7. The United Nations Children's Fund (UNICEF)

The MSPyBS has requested UNICEF to assist the expansion of rural health services in the Departments of Alto Paraná (Health Region IX), and Caaguazú and Canendiyú (Health Region VI) by financing the following:

(a) A course for 20 Trainers of Health Center/Post personnel ($4,[illegible]);

(b) Courses for 121 Auxiliaries in Health Centers/Posts ($[illegible]);

(c) Courses and supplies for 645 VHCs in Alto Paraná ($[illegible]);

(d) Courses and supplies for 355 VHCs in Caaguazú and Canendiyú ($85,115); and,

(e) Stipends ($[illegible]).

The MSPyBS request to UNICEF is similar to that made to USAID, but involves different Health Regions. UNICEF will be supplementing the efforts of IDB in Health Regions VI and IX.

Year		Anticipated UNICEF Funding
1979		$[illegible]
1980		116,287
1981		86,415
	TOTAL	$293,405

8. The United Nations Fund for Population Activities (UNFPA)

UNFPA has designated Paraguay as one of the priority countries in Latin America for population assistance. The National Council of Social Progress, a group composed of representatives of GOP Ministries, is coordinating the requests of various GOP institutions for UNFPA assistance during 1979-82. UNFPA has not yet finalized its proposed project which is expected to begin in mid-1979 and to disburse approximately $5 million over a period of four years. The major thrust of the proposed UNFPA assistance appears to be demographic and social science research to assist the GOP to formulate a national population policy for Paraguay. Among the areas of proposed assistance are includes the following:

(a) A National Census of Indians;

(b) The 1982 Population and Household Census;

(c) A National Employment Survey;

(d) A Socio-Economic Survey of Urban Women;

(e) A Vital Registration Project in Alto Paraná;

(f) A Study of Migration in Paraguay;

(g) Studies related to Colonization Programs;

(h) An Abortion Study; and,

(i) Maternal and child health activities.

USAID learned from MSPyBS sources that the $1.2 million request to UNFPA from the MSPyBS has been substantially reduced by the National Council of Social Progress. It appears that a minor part of UNFPA assistance will be devoted to the provision of family planning

services. UNFPA and UNICEF had previously funded a pilot MCH/FP project (MAMIPAR) in the First Health Region, but it appears that this activity will not be continued under the proposed UNFPA project. The $1.2 million MSPyBS request to UNFPA contained substantial funding for training, supplying, and supervising VHCs in the Second, Fourth, Sixth, and Ninth Health Regions, but it is unclear how much of the VHC activity will be submitted to UNFPA by the GOP. The anticipated UNFPA assistance which will be reviewed in New York in June 1979, does not appear to duplicate any elements of the proposed USAID project.

9. World Fertility Survey (WFS)

The core costs of the WFS are jointly funded by AID/W and UNFPA. The costs of doing the survey in Paraguay are funded by AID/W. The survey will provide information on fertility, maternal and child health, contraceptive prevalence, and many other topics. Planning for the WFS in Paraguay began in 1978, and the interviewing of 4,500 households began in February 1979. The International Statistical Institute, the MSPyBS, and the General Directorate of Statistics and Census (DGEC), are collaborating on the survey. The WFS will be an excellent source of population and health data.

10. The International Confederation of Midwives (ICM)

ICM Field Director Agnes Lima visited Paraguay in 1978 to work with the Nursing Department of the MSPyBS in the preparation of curriculum for a workshop. The Workshop will be held from April 9 to May 17, 1979.

III. PROJECT ANALYSES

A. Technical Analysis

This project is designed to improve the basic health conditions of the rural poor through the provision of appropriate technology. The GOP cannot allocate sufficient budgetary resources to build and staff a nationwide network of fixed health facilities. There are not enough trained physicians, nurses, and midwives to assign to a nationwide network of fixed health facilities. Recognizing that there are financial and manpower constraints to the provision of health services in rural areas, the MSPyBS had devised a health services delivery system that depends on health auxiliaries and community volunteers. This delivery system takes advantage of the fixed clinics currently in place as both points of origin for mobile training/supervision personnel and as referral points for Voluntary Health Collaborators (VHCs) working in rural communities. Training and supervision at all levels of activity has been designed into the program. Motorcycles or mopeds will be purchased to facilitate supervision of VHCs by Health Center/Post personnel.

The project will train, supply, and supervise rural community residents in order to reduce the basic health problems of the poor. MSPyBS statistics indicate that parasitosis, diarrheas, anemia, respiratory diseases, and problems related to childbirth are the principal health problems in rural Paraguay. The project intends to utilize halth education to motivate the rural population to prevent disease by taking specific steps such as building a latrine or digging

a well. Health education will cover topics such as waste disposal, personal hygiene, safe water, breastfeeding, nutritious foods, and family planning. The project will also cure disease through the provision of basic medicaments. Both approaches utilize low level technology. The basic health problems will tend to recur unless preventive measures are taken. Nevertheless, USAID believes that the curative measures should be included in the project.

For example, the principal causes of rural morbidity and mortality, environmentally-related parasitic and diarrheal diseases, will recur after treatment unless conditions of environmental sanitation are improved. The VHCs will attempt to improve environmental sanitation by educating their neighbors. While this process is underway, there is still the need to save the life of a severely dehydrated infant through the application of oral rehydration solution or to rid a young child of intestinal parasites which are retarding his development through the application of anti-parasitical tablets. The list of medicaments and contraceptives to be utilized in the project was prepared by James Heiby, M.D. MPH. Dr. Heiby, a former public health physician at the U.S. Center for Disease Control and current employee of DS/POP, recommended medicaments which have proven to be effective against the common health problems of rural Paraguay. Dr. Heiby recommended the inclusion of anti-parasitical tablets for semi-annual de-worming of children. Regardless of the likelihood of reinfestation, Dr. Heiby feels that semi-annual de-worming will be beneficial for the children. Aspirin will be used to reduce fever, and iron tablets will

be distributed to anemic pregnant and lactating women. Merthiolate will be used to disinfect wounds, while oral rehydration salts will be used for infants suffering severe diarrhea. The project medicaments have shown few side-effects under rigorous testing and are thought to be suitable for distribution by minimally trained VHCs. Tetanus toxoid will be administered to pregnant women who are referred to health facilities for pre-natal check-ups. The contraceptives provided under this project all have FDA approval.

The World Health Organization and UNICEF sponsored a 1978 International Conference on Primary Health Care in Alma-Ata, USSR. The World Health Organization has identified five principles essential to the success of primary health care. Primary care should:

(a) Relate closely to the life patterns and perceived needs for the community;

(b) Maximize the use of local resources and promote health self-reliance through education, so health care remains as inexpensive as possible;

(c) Integrate health services including prevention, treatment, promotion and rehabilitation;

(d) Undertake health interventions at the most peripheral level practicable by the worker most simply trained for this activity;

(e) Redesign other health service echelons to support the peripheral level and furnish technical help, referral facilities, supervision, and supplies.

The five principles of primary health care recommended by WHO are the principles of the proposed project.

The Office of International Health of the U.S. Department of Health, Education, and Welfare has prepared a two-volume analysis entitled AID Integrated Low Cost Health Projects. According to the authors, "The most rapidly growing category of health assistance is the development of low cost health delivery systems which bring together health services, family planning and nutrition interventions, areas nominally separate in AID, but integrated in these projects. Integrated services can be more effective than separate health, nutrition or family planning projects."

In order for this project to be successful the MSPyBS must be able to recruit VHCs who are willing and able to perform the proposed duties. We do not believe that this will be a problem. The MSPyBS has had a particularly favorable experience with community health volunteers in the past. The Malaria Eradication Service (SENEPA), successfully utilized volunteers in its program against malaria. The SENEPA program is probably the most successful public health activity ever undertaken in Paraguay and one of the world's most successful malaria eradication programs. Malaria no longer is a significant public health problem in Paraguay, and according to MSPyBS sources, the SENEPA volunteers deserve much of the credit. The network of SENEPA volunteers is still intact, although their success in the control of malaria has left them with diminished duties. The MSPyBS regards the SENEPA network as a valuable asset and intends to recruit SENEPA volunteers as VHCs whenever possible.

The SENEPA volunteers receive no monetary reward, and the MSPyBS has determined that the VHCs will receive no monetary reward.

USAID originally proposed that the VHCs sell their medicaments at subsidized prices. The VHCs would have retained part of the sales proceeds as an incentive payment and the balance would have been returned to the MSPyBS to purchase more supplies. The MSPyBS did not agree to this proposal. The MSPyBS stated that they wanted to recruit rural leaders as VHCs. If they were to pay incentives to the VHCs, the rural communities would nominate people who needed money as candidates rather than the community leaders. The MSPyBS feels that rural leaders will volunteer for the following reasons. Firstly, they want to improve health conditions in their communities. Secondly, they are interested in the training which will improve their skills. Thirdly, they want the prestige that will accompany their selection and association with the GOP. Fourthly, they have time on their hands and will enjoy working a few hours a day as a VHC.

The MSPyBS points to the success of the SENEPA program to justify its optimism about the VHC program. The MSPyBS also refers to the tradition of rural participation in community commissions to raise money for improvements to health centers, schools, water systems, etc. The rural communities presently support the costs of maintaining and operating health centers and posts through fund raising activities and user fees. The MSPyBS often pays only the salaries of health facility personnel, while the local community has to finance the maintenance and operations of the health facility. USAID has worked with many rural commissions in the financing of small projects with Special Development Grant money and can confirm that rural communities are

often capable of extensive self-help efforts. Based on the available evidence, USAID concludes that it should be possible to recruit capable VHCs who are willing to work a few hours per day to serve their communities. We are also convinced that the MSPyBS is capable of managing the VHC program and ensuring VHC competence through training and supervision.

Dr. Kenneth Farr, Director of Health Planning of HEW/OIH, visited Paraguay in April-May, 1978, to assess opportunities for USAID assistance within the health sector. In his trip report Dr. Farr rated a Voluntary Health Collaborator Project as the highest priority for USAID consideration.

USAID is convinced that the project will employ low-level, proven technology which is appropriate for Paraguay. The approach is consistent with approaches recommended in the AID Policy Paper, A Strategy for a More Effective Bilateral Development Assistance Program. The Paper states, "Under the circumstances, our overall efforts should be directed along two parallel, mutually reinforcing lines: (1) expand the provision of safe, effective, affordable, acceptable family planning services, particularly at the village level and, where appropriate, in conjunction with other basic health services; (2) pursuant to Section 104(d) of the Foreign Assistance Act, promote accelerated development of a type which will increase the desire for smaller families, with emphasis on wide primary education, especially for girls, expanded low-cost health facilities with broad rural outreach, strengthened community organizations, and improved opportunities for women (socially, economically and politically)."

The Paraguay Country Development Strategy Statement (CDSS) of January 1979, states "... the best approach for U.S. bilateral assistance is to focus on the problems of resource allocation, institutional capacity and appropriate policy as they can be dealt with in the design and implementation of specific projects." This project will address all three of those problems. By assisting in the provision of basic health services in localities where none now exist, demand will be created that MSPyBS will be required to meet through additional allocation of its own resources. This will be a repetition of the experience under Population I. Building the MSPyBS institutional capacity is the primary purpose of the project. Field personnel will be trained, their supervisors will be trained and both groups will be provided with the tools to make their work effective. The MSPyBS will have a replicable model for expansion nationwide. Finally, the project will promote and institutionalize the developing MSPyBS policy of providing basic health services through local volunteers, with decentralized supervision of their activities. This is a policy which AID is encouraging in several countries. It is particularly appropriate in Paraguay, with large areas of sparse population, a rapid rate of population growth and a low ratio of doctors to population.

B. Financial Analysis and Plan

1. Financial Analysis

The project proposed herein will total $4,961,000 of which $1,013,000 will be in the form of an AID grant. The remaining funds will be provided by the MSPyBS to the three Health Regions

involved in the project. Various donor agencies are involved in related projects with the MSPyBS in other Health Regions, but for the purposes of this analysis their contribution will not be considered because the USAID project is not dependent on the inputs of other donors and should be considered a separate project.

The USAID grant will be disbursed in increments of $445,000, $268,000, and $300,000 over the three years of project life. $82,000 will be devoted to consultant services, $680,000 for U.S.-procured commodities, $115,936 for in-country training, $56,670 for supervision, $40,000 for surveys, and $38,394 for local purchases. $762,000 (75%) will be devoted to foreign exchange costs, and $251,000 (25%) will be devoted to local costs. The cost of U.S.-procured contraceptives, $470,000, is the largest single cost in the project.

The MSPyBS budget has more than tripled in U.S.-dollar terms (Guaranies converted at official rate of ₲126 = US$1) from 1975 to 1979. This increase reflects both the growing GOP revenue collections/expenditures in the public sector and the increased budgetary allocations to the MSPyBS. In 1979 the MSPyBS will receive 4.46% of the general budget revenues, while in 1975 the MSPyBS received only 3.30%. Table 6 gives the MSPyBS budgets over the past five years. The 1979 budget allocation for the MSPyBS will result in an expenditure of $5.15 for every Paraguayan in 1979.

The MSPyBS contribution to this project will be in the form of monies allocated to the First Health Region in 1979, the First and Seventh Health Regions in 1980, and the First, Seventh, and Third

Table 6

Budget of Ministry of Public Health and Social Welfare

Year	$ Amount	% General Budget of Nation
1975	4,826,028	3.30
1976	5,992,490	3.26
1977	6,805,016	3.01
1978	8,575,056	3.06
1979	14,927,785	4.46

Table 7

1979 Data on Health Regions I, III, and VII

	Region I	Region III	Region VII	Total Three Regions
Regional Health Budget	$796,071	$615,621	$423,635	$1,835,327
Population	471,107	249,238	150,30[illegible]	870,645
Per Capita	$1.69	$2.47	$2.82	$2.11
Women aged 15-44	86,608	47,085	27,911	161,604
Children under 5 years	76,346	41,951	24,783	143,080
MSPyBS Health Centers	23	7	11	41
MSPyBS Health Posts	26	18	16	60
Doctors	45	21	22	88
Nurses or Midwives	54	22	17	93
Auxiliaries	122	26	26	174

Health Regions in 1981. According to an analysis prepared by the Interamerican Development Bank, the most important factor in current expenditures of the MSPyBS is personal services. This item accounted for an average of 74% of all spending through 1977. With regard to use of funds spent, the MSPyBS utilized for current costs 98% of funds received in 1974, 96% in 1975, 93% in 1976, and 94% in 1977. Capital expenditures absorbed the remaining funds.

The proposed project does not involve the payment of MSPyBS salaries by USAID. The MSPyBS will contribute the funds necessary for salary payments to personnel in the three Health Regions. It will also provide the funds necessary to operate the existing health service network. USAID will finance the additional costs of extending the coverage of health services in the three Health Regions through the creation of a Voluntary Health Collaborator network. The VHCs will receive no salary, and no future MSPyBS or USAID funds will be necessary to pay them. Other project personnel are already on the MSPyBS payroll. Although the amount of funds required for training, supervision, and evaluation can be reduced to some extent after the VHC program is fully operational, there will be substantial recurring costs, especially for medicaments and other supplies. The MSPyBS understands that USAID will not finance these recurring costs beyond FY 1981. The MSPyBS has agreed to arrange the financing of these costs.

It is the conclusion of USAID that the recurring operating costs of activities to be initiated under this project can be met

by the MSPyBS with Paraguayan and/or other donor resources. By assisting the MSPyBS in this project USAID is not creating a delivery system which requires additional USAID assistance to survive upon termination of this project. For every dollar that USAID will contribute to expansion of health services in the three Health Regions, the MSPyBS will contribute almost four dollars to the health services in the same Health Regions. This projection is based on 1979 MSPyBS budgetary allocations to the three Health Regions held constant over the three years of project life. This projection is very conservative because USAID anticipates that allocations to the Health Regions will increase about 20% annually, in line with the trends in past years. USAID assistance is only a modest portion (approximately 20%) of expenditures for MSPyBS activities in the three Health Regions.

Upon termination of this project in 1982, USAID estimates that there will be recurring costs of approximately $250,000 annually. Approximately $140,000 will be needed to finance the importation of contraceptives for all MSPyBS Health Regions and approximately $110,000 will be needed to finance medicaments, other commodities, training, supervision, and evaluation for the VHC program in the First, Third, and Seventh Health Regions.

2. Financial Plan

a. USAID Budget

	1979	1980	1981
1) PERSONNEL (Total)	$28,000	$38,000	$16,000
a) Consultant in MCH/FP Manpower Development of Paramedicals, Auxiliaries and Volunteers	4,000	6,000	6,000
b) Consultant in MCH/FP Curriculum Development	4,000	6,000	-
c) Consultant in Health Education Techniques	4,000	4,000	4,000
d) Consultant in Clinical and Non-Clinical Data Systems	4,000	6,000	[illegible]
e) Consultant in Clinical and Non-Clinical Logistics Systems	6,000	[illegible]	
f) Consultant in Survey Design and Analysis	6,000	-	6,000
g) Evaluation Team	-	16,000	-
2) COMMODITIES (Total)	$330,000	$169,000	$181,000
a) Medicines/Supplies			
(1) Oral rehydration	40,000	-	-
(2) Anti-Parasitic tablets	50,000	-	-
(3) Iron tablets	15,000	-	-
(4) Aspirin tablets	8,000	-	-
(5) Merthiolate	4,000	-	-
(6) Tetanus toxoid	3,500	-	-
(7) Gauze pads	3,000	-	-
(8) Tape	2,500	-	-
(9) Cytology Laboratory Supplies	9,000	-	-

		1979	1980	1981
b) Contraceptives				
(1) Contraceptive foam		$40,000	$30,000	$20,000
(2) IUDs		10,000	4,000	6,000
(3) Oral contraceptives*		100,000	120,000	140,000
c) Motorcycles/Mopeds including Spare parts		45,000	15,000	15,000
3) OTHER COSTS	(Total)	$87,000	$61,000	$103,000
a) Training Within Paraguay	(Sub-Total)	$36,847	$36,619	$42,470
(1) Region I	(Sub Sub-Total)	($36,847)	($15,107)	-
(a) Training of Regional Training/Supervision Team - 1 Course				
i) Per diem of Regional Training/Supervision Team 6 persons x 10 days x $15		900	-	-
ii) Travel of Regional Training/Supervision Team 6 persons x $10		60	-	-
(b) Training of Health Center/Post Personnel - 7 Courses				
i) Per diem of Regional Training/Supervision Team 6 persons x 7 courses x 10 days x $8		3,360	-	-
ii) Travel of Regional Training/Supervision Team 6 persons x 7 courses x $10		420	-	-

* Centrally procured by AID/Washington.

	1979	1980	1981
iii) Per diem of Health Center/Post Personnel 200 persons x 10 days x $8	$16,000	-	-
iv) Travel of Health Center/Post Personnel 200 persons x $5	1,000	-	-
(c) Training of Voluntary Health Collaborators - 20 Courses 1979 + 20 Courses 1980			
i) Per diem of Regional Training/Supervision Team 2 persons x 20 courses x 5 days x $8 x 2 years	1,600	1,600	-
ii) Travel of Regional Training/Supervision Team 2 persons x 20 courses x $5 x 2 years	200	200	-
iii) Per diem of Health Center/Post Personnel 49 persons x 5 days x $8 x 2 years	1,960	1,960	-
iv) Travel of Health Center/Post Personnel 49 persons x $3 x 2 years	147	147	-
v) Per diem of 400 Voluntary Health Collaborators 20 persons x 20 courses x 5 days x $5 x 2 years	10,000	10,000	-
vi) Travel of 400 Voluntary Health Collaborators 400 persons x $3 x 2 years	1,200	1,200	-
(2) Region VII (Sub Sub-Total)	-	($21,512)	($11,040)
(a) Training of Regional Training/Supervision Team - 1 Course			
i) Per diem of Regional Training/Supervision Team 6 persons x 10 days x $15	-	900	-

	1979	1980	1981
ii) Travel of Regional Training/Supervision Team 6 persons x $12	-	$72	-
(b) Training of Health Center/Post Personnel - 5 Courses			
i) Per diem of Regional Training/Supervision Team 6 persons x 5 courses x 10 days x $8	-	2,400	-
ii) Travel of Regional Training/Supervision Team 6 persons x 5 courses x $10	-	300	-
iii) Per diem of Health Center/Post Personnel 80 persons x 10 days x $8	-	6,400	-
iv) Travel of Health Center/Post Personnel 80 persons x $5	-	400	-
(c) Training of Voluntary Health Collaborators - 15 Courses 1980 - 15 Courses 1981			
i) Per diem of Regional Training/Supervision Team 2 persons x 15 courses x 5 days x $8 x 2 years	-	1,200	1,200
ii) Travel of Regional Training/Supervision Team 2 persons x 15 courses x $5 x 2 years	-	150	150
iii) Per diem of Health Center/Post Personnel 2 persons x 15 courses x 5 days x $8 x 2 years	-	1,200	1,200
iv) Travel of Health Center/Post Personnel 2 persons x 15 courses x $3 x 2 years	-	90	90
v) Per diem of 300 Voluntary Health Collaborators 20 persons x 15 courses x 5 days x $5 x 2 years	-	7,500	7,500
vi) Travel of 300 Voluntary Health Collaborators 300 persons x $3 x 2 years	-	900	900

	1979	1980	1981
(3) Region III (Sub Sub-Total)	-	-	($31,430)
(a) Training of Regional Training/Supervision Team - 1 Course			
i) Per diem of Regional Training/Supervision Team 6 persons x 10 days x $15	-	-	900
ii) Travel of Regional Training/Supervision Team 6 persons x $15	-	-	90
(b) Training of Health Center/Post Personnel - 5 Courses			
i) Per diem of Regional Training/Supervision Team 6 persons x 5 courses x 10 days x $8	-	-	2,400
ii) Travel of Regional Training/Supervision Team 6 persons x 5 courses x $10	-	-	300
iii) Per diem of Health Center/Post Personnel 80 persons x 10 days x $8	-	-	6,400
iv) Travel of Health Center/Post Personnel 80 persons x $5	-	-	400
(c) Training of Voluntary Health Collaborators - 15 Courses			
i) Per diem of Regional Training/Supervision Team 2 persons x 15 courses x 10 days x $8	-	-	2,400
ii) Travel of Regional Training/Supervision Team 2 persons x 15 courses x $5	-	-	150
iii) Per diem of Health Center/Post Personnel 2 persons x 15 courses x 10 days x $8	-	-	2,400

	1979	1980	1981
iv) Travel of Health Center/Post Personnel 2 persons x 15 courses x $3	-	-	$90
v) Per diem of 300 Voluntary Health Collaborators 20 persons x 15 courses x 10 days x $5	-	-	15,000
vi) Travel of 300 Voluntary Health Collaborators 300 persons x $3	-	-	900
b) Supervision (Sub-Total)	$5,980	$18,660	$32,030
(1) Region I (Sub Sub-Total)	($5,980)	($14,200)	($14,200)
(a) Regional Training/Supervision Team			
i) Per diem 6 persons x $8 x days (79-20, 80-50, 81-50)	960	2,400	2,400
ii) Travel 6 persons x $5 x days (79-20, 80-50, 81-50)	600	1,500	1,500
(b) Health Center/Post Personnel			
i) Per diem 49 persons x $2 x days (79-20, 80-50, 81-50)	1,960	4,900	4,900
ii) Travel 49 persons x $2 x days (79-20, 80-50, 81-50)	1,960	4,900	4,900
(c) Regional Headquarters Staff	500	500	500
(2) Region VII (Sub Sub-Total)	-	($4,460)	($10,400)
(a) Regional Training/Supervision Team			
i) Per diem 6 persons x $8 x days (80-20, 81-50)		960	2,400

	1979	1980	1981
ii) Travel 6 persons x $5 x days (80-20, 81-50)	-	$600	$1,500
(b) Health Center/Post Personnel			
i) Per diem 30 persons x $2 x days (80-20, 81-50)	-	1,200	3,000
ii) Travel 30 persons x $2 x days (80-20, 81-50)	-	1,200	3,000
(c) Regional Headquarters Staff	-	500	500
(3) Region III (Sub Sub-Total)	-	-	($7,430)
(a) Regional Training/Supervision Team			
i) Per diem - 6 persons x $8 x 35 days	-	-	1,680
ii) Travel - 6 persons x $5 x 35 days	-	-	1,050
(b) Health Center/Post Personnel			
i) Per diem - 30 persons x $2 x 35 days	-	-	2,100
ii) Travel - 30 persons x $2 x 35 days	-	-	2,100
(c) Regional Headquarters Staff	-	-	500
c) Research (Sub-Total)	$20,000	-	$20,000
(1) Baseline Survey on MCH/FP Conditions	20,000	-	-
(2) Follow-up Survey to Measure Impact of Project Interventions	-	-	20,000

		1979	1980	1981
d) Local Purchase	(Sub-Total)	$24,173	$5,721	$8,500
(1) 1,000 Cloth Bags for VHC Medical Supplies		5,000	-	-
(2) VHC Signs/Emblems		2,500	-	-
(3) Production of 1,200 VHC Manuals		6,000	-	-
(4) Production of 150 Supervisory Manuals		750	-	-
(5) Production of Data Forms		2,500	-	-
(6) Training Materials		3,500	-	-
(7) Reading of PAP Slides		3,923	5,721	8,500
	GRAND TOTAL	$445,000	$268,000	$300,000
	TOTAL THREE YEARS			$1,013,000

b. GOP Budget

	CY 1979	CY 1980	CY 1981	Totals
1) MSPyBS First Health Region	$796,000	$796,000	$796,000	$2,388,000
2) MSPyBS Seventh Health Region	-	568,000	568,000	1,136,000
3) MSPyBS Third Health Region	-	-	424,000	424,000
TOTALS	$796,000	$1,364,000	$1,788,000	$3,948,000

c. Anticipated Other Donor Assistance

1) Interamerican Development Bank	$1,210,000	$2,500,000	$1,000,000	$4,710,000
2) United Nations Fund for Population Activities	1,000,000	1,000,000	1,000,000	3,000,000
3) IPPF	375,000	375,000	375,000	1,125,000
4) UNICEF	91,000	116,000	86,000	293,000
5) Other	124,000	130,000	154,000	408,000
TOTALS	$2,800,000	$4,121,000	$2,615,000	$9,536,000

C. Social Analysis

The principal intended beneficiaries of the proposed project are women in the fertile ages of 15-44 and children under five years of age. Although the project will provide contraceptives for the entire MSPyBS health network, the major thrust of this project is the development of an integrated health, family planning, and nutrition delivery system within the First, Third, and Seventh Health Regions. According to MSPyBS estimates, there are an estimated 161,584 women aged 15-44 and 143,080 children under five years of age. The project will provide information and services designed to improve the health and wellbeing of the 304,664 women and children estimated to reside in the three Health Regions in 1979. The remaining family members will also benefit from the project, but the project interventions are designed primarily to improve maternal and child health.

Table 8

	Population	Children Under 5	Women 15-44
First Health Region	471,107	76,346	86,588
Seventh Health Region	150,300	24,783	27,911
Third Health Region	249,238	41,951	47,085
TOTALS	870,645	143,080	161,584

Source: MSPyBS Department of Bio-Statistics.

USAID believes that the intended beneficiaries merit the proposed assistance. There is substantial evidence that rural Paraguayans have not yet shared the growing prosperity that is reflected in national statistics. Despite impressive growth rates of GNP

and a corresponding increase in per capita national income to $640 in 1976 (according to the IBRD), it is clear that income distribution is highly skewed and that the per capita income figure in no way reflects the extent of poverty in rural Paraguay. In the following paragraphs we will present preliminary data from the 1976 Survey on the Socio-Economic Status of Paraguayan Women (FEMRURAL) to demonstrate that there is ample justification for assistance to the intended beneficiaries. The FEMRURAL Survey of 2,352 rural households was carried out with population funds from the AID/W Determinants and Consequences of Fertility Project. The survey report is being written now and should be available by mid-1979.

The FEMRURAL Survey measured the income of all household members including proceeds from wages and from sales of agricultural products, animals, processed and manufactured goods, and other goods and services. It did not include the estimated value of products consumed by the producer such as on-farm consumption of foodstuffs.* USAID considers a per capita income of $330 in 1977 dollars to be the 1977 indicator of the poverty level in Paraguay. FEMRURAL data indicate that 75.8% of rural households had per capita incomes below $300, while 53.2% had incomes of less than $150 in 1977.

The rural poor are concentrated in five geographic regions. They are: (1) the minifundia region, often referred to as the Central

* According to the Small Farmer Survey and the Small Farmer Subsector Assessment, on-farm consumption represents about 47% of total net farm income in Eastern Paraguay.

Zone, encompassing the older farming areas close to Asunción; (2) the cattle region, a mixed minifundia/latifundia area covering the Departments of Misiones and Ñeembucú; (3) the Itapúa region, a modernizing area undergoing rapid economic expansion; (4) the Eje Norte (Northern Axis), an older settlement area with extensive new colonization areas; and, (5) the new colonization region, covering the Departments along the northeast border with Brazil. FENRURAL data indicate that 49.1% of the households below the poverty level are in the minifundia zone. The First Health Region, which will receive the dominant share of assistance under this project, is located in the minifundia zone. The Seventh Health Region consists of the Departments of Misiones and Ñeembucú, while the Third Health Region consists of the Department of Itapúa. USAID estimates on the basis of FENRURAL data that over 75% of the households who are potential beneficiaries of this project had incomes below $300 per person in 1977.

The principal economic activity of rural households in Paraguay is agriculture. Among the rural families interviewed, 54.4% reported farming as their principal economic activity, followed by manufacturing (home crafts, food processing and small industries) with 15.2%, commerce (storekeepers) 4.3%, agricultural day labor 9.1%, service 3.6%, and other 3%. Of those households that listed farming as the major occupation in 1977, 61.5% received less than $150 per person and 82.2% less than $300. 74.5% of farm households below the $150 per capita level grow cotton as the principal crop. Of farm households in this income group whose principal crop is cotton, 50.8%

cultivated less than three hectares, and 83.9% cultivated less than five hectares.

Farm households below the $150 per capita level cultivated an average of less than three hectares. USAID estimates that with family labor and existing technology, the typical farm family can cultivate about six hectares. Although additional land is available in new colonization areas, many of the rural poor are reluctant to leave the minifundia region where 49.3% of the households who have land available for crops or livestock are located.

Rural households live a very humble existence. 11% of the households had no facilities for human waste disposal, 81% had inadequate outdoor latrines, and only 7% had some type of improved outdoor latrine. Only 6% of the rural population had access to safe water. Among the principal causes of high infant mortality are respiratory diseases and gastrointestinal disorders, the latter resulting directly from inadequate human waste disposal and unsafe water. 81% of rural households cook on the ground, 13% have a mud or wattle stove, and only 6% have a modern or gas stove. Housing is generally inadequate with households averaging four to five persons usually occupying one-room structures with thatched roof and dirt floor. The average educational level for those seven years of age or older in the rural areas is 2.7 years.

There seems to be an association between poverty and the use of the Guarani language. Almost 76% of the families interviewed in the FEMRURAL Survey spoke only Guarani. 88% of the households earning

less than $75 per member spoke only Guarani. The poorer the family, the more likely it is to speak only Guarani and the more likely it is to find unfamilarity with Spanish, a factor limiting access to education and other services.

Among the poor, consensual relationships are more prevalent than among wealthier economic groups. 18.5% of rural households are headed by a woman. Rural female-headed households have a median income of $87 per person, while male-headed households have a median income per person of $157.

The FEMRURAL Survey included questions designed to measure contraceptive prevalence and to examine the determinants and consequences of fertility. 16.1% of rural women at risk were found to be using an effective method of contraception. This finding is very similar to the EPAP Survey finding that 17.1% of ever-married rural women aged 15-44 were using an effective method of contraception. The FEMRURAL data indicate that organized family planning programs provided supplies to 69.1% of contraceptive users in rural areas and the commercial sector provided supplies to 26.7% of the users. The EPAP data indicate that organized family planning programs provided supplies to 67.6% of contraceptive users in rural areas and the commercial sector provided supplies to 26.8% of the users. Once again, these findings are very similar and highlight the importance of organized family planning activities in rural areas.

The FEMRURAL Survey found no consistent relation between material possessions and fertility. Socio-economic status, as measured

in the values of consumer goods and household possessions, has no net inverse relation with fertility. FEMRURAL data do suggest that education is inversely related to fertility among women with more than six live births. 40% of women with some primary education, 14.6% of women who had completed primary, 13.5% of those with some secondary, and 8.7% of those who completed secondary school had more than six births. Only 17.4% of women with some primary schooling had one or two live births, while 43.5% of women who had completed secondary school had one or two live births. For women with three to six live births, there seems to be no discernable relation with educational categories. Moreover, there is no association between education and fertility for women fifty years of age and older. FEMRURAL data suggest that there is an association between income and fertility similar to that noted between education and fertility. The proportion of women having more than six live births drops as family income rises. 51% of women from families of the low income group, 38.5% of the wom from the middle income group, and 23.[illegible]% of women from the high income group reported more than six live births. Women reporting one or two live births were more numerous in the middle income group than the lower and in the higher income group than in the middle. Although income level is clearly associated with fertility behavior for women between the ages of 15 and 49, the fertility of respondents over 50 years of age is not closely associated with the income level of the family. FEMRURAL data also indicate that married women tend to have more children than women in consensual unions. Single women have lower fertility than women in consensual or marital unions.

Although preliminary FEMRURAL data suggest that the age, marital status, and educational level of women and the income level of their families are associated with fertility, the relationships are not conclusive, particularly for women over 50 years of age. These factors are conditioned by cultural norms and the availability of family planning information and services. These preliminary findings are consistent with findings elsewhere. A massive study of fertility decline in 94 developing countries from 1965-75 conducted by Tanner Mauldin and Bernard Berelson of the Population Council demonstrated that "on balance, family planning programs have a significant, independent effect over and above the effect of socio-economic factors". Mauldin and Berelson point out that the greatest third world fertility declines have occurred in countries with good development records and strong family planning programs, but argue that in some instances, family planning has been more important than development.

The FEMRURAL data demonstrate that the intended beneficiaries of this project are living in poverty and that almost 85% of women at risk of becoming pregnant are not using an effective contraceptive method. We believe that the absence of an effective delivery system for health services in the rural areas has limited the availability of contraceptives to rural women. USAID efforts in agriculture and education are designed to increase rural income and improve rural educational opportunities. Given the association between income, education, and fertility reflected in FEMRURAL data, it is important that USAID efforts in family planning be supplemented by other USAID

programs in agriculture and education. While the debate over the determinants of fertility behavior continues, there is every justification for USAID to continue a broad-based development assistance program including family planning.

D. Role of Women in this Project

The project will reduce maternal mortality and morbidity. There will be reductions of physical suffering and unnecessary loss of life among the 161,584 women aged 15-44 who reside in the First, Third, and Seventh Health Regions. There will be increased opportunities for women to participate in the labor force if unwanted pregnancies are reduced and the health status of women is improved. The program will employ women as doctors, nurses, midwives, auxiliaries, social workers, health educators, and voluntary health collaborators.

The project offers women a greater opportunity for controlling their own fertility. The medical, psychological, nutritional and economic benefits of child spacing are well known. The high fertility of rural Paraguayan women is associated with high levels of infant morbidity/mortality, malnutrition, and poverty.

E. Economic Analysis

The proposed project contains two principal components, the procurement of contraceptives for all MSPyBS programs and the VHC program in the First Third, and Seventh Health Regions. Each of the components must be analyzed separately in order to estimate the costs of the activities.

1. Procurement of Contraceptives

The project will procure contraceptives worth $470,000 for distribution by all MSPyBS health facilities offering family planning services throughout the nine Health Regions. The $470,000 represents approximately 46% of project funds. MSPyBS family planning service statistics indicate that there were 36,820 active users of contraceptive methods registered at MSPyBS facilities on December 31, 1978. Over 75% of the clients were using oral contraceptives, approximately 14% were using the IUD, and over 1[illegible]% were using other methods. The estimated costs to USAID for contraceptives in sufficient quantity to protect a woman against pregnancy for one year are shown below.

Table 9

Cost of One Year's Supply of Contraceptives

Method	Quantity	Cost
Oral Contraceptives	13 cycles	$2.50
IUDs	1 IUD	.50
Foam	80 ounces	4.50
Condoms	100 condoms	3.00

Given the mix of contraceptives chosen by MSPyBS clients as of 12/31/78, it would cost approximately $2.34 to provide contraceptives to protect one woman against unwanted pregnancy for one year. USAID estimates that the MSPyBS will need to protect the following numbers of women shown in the following table.

Table 10

Estimated MSPyBS Active Users of Contraceptives at Mid-Year and Cost of Contraceptives

1979	38,000	at $2.34	$88,920
1980	43,000	"	100,620
1981	50,000	"	117,000
		TOTAL	$306,540

The above calculations assume that the contraceptive mix and cost of contraceptives will remain constant over the next three years.

USAID has attempted to make a rough calculation of the number of unwanted births to be averted by use of USAID-supplied contraceptives. In Paraguay it is estimated that there are 180 births annually per 1,000 women in the fertile ages. However, there are great differentials in fertility due to differential exposure to the risk of pregnancy. Let us assume that all users of contraceptives through MSPyBS facilities would be exposed to the risk of pregnancy if they were not contracepting. Let us also assume that all users of contraceptives through MSPyBS facilities are in a marital or consensual union. The EPAP Survey found that 60.4% of women in the fertile ages were in union. This means that approximately 40% of women in the fertile ages had limited exposure to pregnancy, particularly women under 25 years of age. In the EPAP Survey 25% of women in the fertile age responded that they were either not sexually active or had a fecundity impairment. If we assume that 25% of all women in the fertile ages will not be exposed to pregnancy, the potential fertility of MSPyBS contraceptive users should be 25% higher than that of all

women in the fertile ages. Keeping these assumptions in mind, we are now ready to calculate the number of births averted.

Table 11

Births Averted

A Year	B MSPyBS Users of Contraceptives	C Births per 1,000 Women	D 25% Factor	E Births Averted
1979	38,000	180	1,710	8,550
1980	43,000	180	1,935	9,675
1981	50,000	180	2,250	11,250
			TOTAL	29,475

This calculation is highly conservative. Another rule of thumb is that one third of all sexually active, fertile women will give birth in one year without some form of contraception. A calculation based on this rule of thumb results in 43,667 births averted. If we assume that it will cost $306,540 for contraceptives to prevent 29,475 unwanted births, it will cost $10.40 in contraceptives for each birth prevented. If we assume that it will cost $306,540 for contraceptives to prevent 43,667 unwanted births, it will cost $7.02 in contraceptives for each birth prevented. The estimates range from $7.02 to $10.40, and USAID believes that the actual cost will be found within this range. However, there is no way of determining how many of the MSPyBS contraceptive users would give birth if contraceptives were not available through the MSPyBS. The women might elect to use methods such as rhythm, withdrawal, or abortion.

USAID is certain that better methodology exists to calculate the costs of births averted. The above analysis is simply a

rough calculation to indicate orders of magnitude. The cost to a family of raising an unwanted child to 15 years of age is at least $2,250 (15 x $150). According to analysis prepared by the Futures Group, an investment of over $7,500 is required to create a new job in Paraguay. We believe this project is cost effective.

2. The Voluntary Health Collaborator Program

If the cost of procuring contraceptives for use in all MSPyBS facilities is excluded, $543,000 of project funds will be available to finance the establishment of a low-cost, integrated delivery system for MCH/FP services in the First, Third, and Seventh Health Regions. Existing health personnel need to be retrained and VHCs have to be recruited, trained, supplied, supervised, and evaluated. There will be 13,780 person-days of training and 10,380 person-days of supervision funded by USAID.

The MSPyBS considers that each VHC should average two health consultations daily. During the three years of project life it is anticipated that the 1,000 VHCs will treat more than one million patients at a cost of $.54 per consultation, not including the operating costs of the ongoing MSPyBS health delivery system. Table 12 indicates the projected number of consultations per year. It should be kept in mind that many of the costs of developing the new delivery system are related to training, supervision, and evaluation. In future years it should be possible to reduce costs per consultation. These costs could be passed on to the communities served by introducing modest charges for medicaments distributed by VHCs. However, the MSPyBS does not want VHCs to charge users for the medicaments distributed under this project.

Table 12

Projected VHC Health Consultations

	Year 1	Year 2	Year 3	Total Consultations	Total Costs
First Health Region	100,000	275,000	290,000	665,000	-
Seventh Health Region	-	80,000	210,000	290,000	-
Third Health Region	-	-	60,000	60,000	-
TOTALS	100,000	355,000	560,000	1,015,000	$543,000

Cost per Consultation: $.54

If the VHCs do actually perform two consultations daily, the VHC program will prove to be extremely cost effective in comparison with other programs. The projected cost of $.54 per consultation does not include the MSPyBS budgetary allocations to the existing health infrastructure of the three Health Regions or MSPyBS headquarters operations. The VHC program will cost the MSPyBS very little additional money during the three years of project life since it will be grafted on to the existing health network. In 1979 the MSPyBS is expected to spend $2.11 per capita for the three Health Regions and $5.15 per capita for its total health operations. The VHC program will cost $.62 per capita for three years or about $.21 per capita annually. The per capita costs of the VHC program are only 10% of the costs of the ongoing program in the three Health Regions. The VHC program costs are modest in comparison to those of the ongoing MSPyBS health services because approximately 74% of the latter costs are for salaries while the VHC program does not pay salaries to the VHCs. Moreover, no fixed health facility is required for the VHCs.

F. Environmental Assessment

USAID determines that the proposed project is not a major Federal action which will have a significant effect on the human environment. The only environmental areas in which this project will have a significant measurable impact are those relating to health status, population, and cultural traditions.

The health status of women and children can be expected to improve as a result of the project. Medicines and contraceptives to

be imported under the project are standard, modern and tested ones, and instructions in the proper use will be provided through training of project personnel to minimize possibilities of any adverse reactions or results from their use.

While population pressures are not currently threatening urban and rural environmental balances, there has been considerable environmental degradation due to exploitation of forests and uncontrolled land clearing. The proposed project activities should help to alleviate future environmental problems by slowing down the rate of population growth.

The cultural changes which might be expected to occur as a result of the adoption of family planning methods and improved health care would be very slight, would not be adverse, and would develop over a long period of time.

G. Helms Amendment

No USAID projects funds will be used to finance abortions or to advocate the practice of abortion.

IV. PROJECT PLANNING AND IMPLEMENTATION

A. Administrative Arrangements

The Paraguayan institution that will implement the project is the Ministry of Public Health and Social Welfare (MSPyBS). The MSPyBS, with headquarters in Asunción, is an organ of the Executive Branch created by Decree Law 2000 of July 15, 1936. The MSPyBS employes 4,3hu persons. Tables 13 and 14 indicate the location and qualifications of MSPyBS employees.

Table 13

	MSPyBS Employees	%
MSPyBS Central Office	842	19
Health Regions	3,502	81
Total	4,344	100

Table 14

	MSPyBS Employees	%
Physicians	474	11
Nurses and Practicioners	203	5
Paramedical Technicians	876	20
Dentists	152	3
Unskilled Aides	613	14
Administrative Employees	848	20
Others	1,178	27
Total	4,344	100

Organization of the MSPyBS encompasses the following agencies:

1. Advisory Agencies. The National Health Coordination Commission and the National Nutritional Council. The National Health Coordination Commission consists of the Minister of Health, the Rector of the National University of Asunción, the Director General of the Social Security Institute (IPS), the Minister of the Interior, and the Health Director of the Municipality of the Capital. This commission has not operated systematically in the past.

2. Executive and Service Agencies. Twelve units are directly answerable to the Office of the Minister. These can be classified into two groups. The first performs general support functions and includes the General Secretariat, Private Secretariat, Press Office, Public Relations Office, Office of the General Counsel and International Relations Office. The second group consists of those units performing executive functions at the national level, such as the National Malaria Eradication Program (SENEPA), National Environmental Sanitation Service (SENASA), Rural Health Department, National Blood Transfusion Service, Office of Surgical Services and Registry of Narcotics and Dangerous Drugs.

3. Six major sections are indirectly answerable to the Minister through the Director General of Health, as follows:

a. Basic Services Bureau, which includes the Mother/Child, Family Protection, Leprosy, Biostatistics, Nutrition, and Dental Departments; the National Epidemiology Service; the Nursing and Obstetrics Section; and the National Tumor Registry.

b. The General Technical Services Bureau, consisting of the Departments of Chemistry and Pharmacy, Architecture and Health Education, the Central Public Health Laboratory and the National Center for Training Nurse Practitioners.

c. The Department of Medical Services, which includes the Laboratory of Pharmaceutical Products, the Professional Control Section and the Manpower Office.

d. The Social Welfare Division is a virtually self-sufficient unit with its own administration. It consists of four sections: Family Welfare, Child Protection, Protection of the Elderly, and Orientation and Private Charity.

e. The Bureau of Administrative Services furnishes support services to the entire MSPyBS structure utilizing the following specialized divisions: Economic Advisory Services and Budget Division, responsible for orienting budget economic studies requested; Audit Division, which establishes the correctness and legality of financial action; Finance Division, responsible for control, receipt and expenditure of funds and for maintaining proper accounting records, including budget control records; Assets Control Division, responsible for maintaining records of buildings, installations and equipment; Health Inventory, which through its local and foreign purchasing sections undertakes procurement, storage, distribution and control of supplies, and Personnel Division, which handles the personnel of the MSPyBS, maintains individual records and prepares payrolls. In addition, the Division of General Services provides cleaning, guard,

maintenance, telephone and filing services, while the Division of Shops and Transportation is responsible for the MSPyBS's fleet of automobiles, their repair and maintenance.

f. Regional Offices. There are at present nine Health Regions functioning at the operating level and answerable to the Director General of Health, which themselves supervise the Health Centers and Posts.

USAID will negotiate and sign Project Agreements with the MSPyBS as soon as the project has received AID approval and funds are available. The MSPyBS will designate a MSPyBS employe to be Project Coordinator for the MSPyBS, and the USAID Population and Public Health Advisor will be the Project Manager for USAID. The MSPyBS Bureau of Administrative Services will open a special checking account to handle project funds. The Bureau of Administrative Services will also clear project commodities through GOP Customs, store the commodities at the MSPyBS, and distribute the commodities to the Health Regions.

B. Implementation Plan

During USAID and MSPyBS project development discussions, the major events in project implementation have been identified. The project funds will be disbursed over a period of three years ending in mid-1982. While the schedule of major events is of a summary nature, the time phasing of activities and their durations is sufficient to give an understanding of the scope and programming logic. USAID will require that the MSPyBS prepare detailed work plans during each year of project activity. USAID will collaborate with the MSPyBS in

preparation of the work plans and will approve the work plans prior to disbursement of funds to the MSPyBS. The work plans will not only serve as guides for on-going project management, but will also provide USAID and the MSPyBS benchmarks for measuring progress and identifying problem areas.

Schedule of Major Events in Project Implementation:

Step	Month	Event
1	(1)	AID review of Project Paper and approval.
2	(1)	USAID prepares draft FY 1979 Project Agreement.
3	(1-2)	USAID and MSPyBS discuss and revise draft FY 1979 Project Agreement.
4	(1-2)	Project Agreement signed by USAID Director and MSPyBS Minister.
5	(1-2)	MSPyBS designates MSPyBS Project Coordinator.
6	(1-2)	MSPyBS opens special checking account(s) for project funds.
7	(1-3)	MSPyBS prepares time-phased Work Plan for initial 12 months of project.
8	(1-3)	USAID prepares documentation for purchasing commodities and consultant services.
9	(1-3)	USAID disburses cash advance to MSPyBS upon satisfaction of conditions precedent.
10	(1-12)	USAID Consultants arrive to assist MSPyBS.
11	(3-6)	Survey on MCH/FP conditions begins.
12	(4)	Training of First Health Region Training/Supervision Team.

Step	Month	Event
13	(5-6)	Training of Health Center/Post personnel of the First Health Region in seven courses.
14	(7-12)	Selection and training of Voluntary Health Collaborators of the First Health Region in 20 courses.
15	(7)	Survey on MCH/FP conditions completed. Analysis of data begins.
16	(12-13)	USAID and MSPyBS evaluation of first year of project.
17	(12)	USAID prepares draft FY 1980 Project Agreement.
18	(12-13)	USAID and MSPyBS discuss and revise draft FY 1980 Project Agreement.
19	(13)	FY 1980 Project Agreement signed by USAID Director and MSPyBS Minister.
20	(13)	USAID prepares documentation for purchasing commodities and consultant services.
21	(13-15)	MSPyBS clears project commodities ordered in year one through Paraguayan Customs and begins distribution to Health Regions.
22	(13)	MSPyBS prepares time-phased work plan for second year of project.
23	(13-14)	USAID disburses cash advance to MSPyBS for second year project expenses. MSPyBS liquidates advances from first year by documenting all cash expenditures.
24	(15-24)	USAID Consultants arrive to assist MSPyBS.
25	(15)	Training of Seventh Health Region Training/Supervision Team.

Step	Month	Event
26	(16-17)	Training of Health Center/Post personnel of the Seventh Health Region in five courses.
27	(18)	Survey report of MCH/FP conditions completed.
28	(18-22)	Selection and training of Voluntary Health Collaborators of the Seventh Health Region in 15 courses.
29	(18-22)	Refresher training of Voluntary Health Collaborators of the First Health Region in 20 courses.
30	(23-24)	Major Project Evaluation by outside Evaluation Team, MSPyBS, and USAID.
31	(24)	USAID prepares draft FY 1981 Project Agreement.
32	(25)	USAID and MSPyBS discuss and revise draft FY 1981 Project Agreement.
33	(25)	FY 1981 Project Agreement signed by USAID Director and MSPyBS Minister.
34	(25)	MSPyBS prepares time-phased work plan for final year of project.
35	(25)	USAID prepares documentation for purchasing commodities and consultant services.
36	(25-27)	MSPyBS clears project commodities ordered in year two of project through Paraguayan Customs and begins distribution to Health Regions.
37	(25-26)	USAID disburses cash advance to MSPyBS for third year project expenses. MSPyBS liquidates advances from second year by documenting all cash expenditures.

Step	Month	Event
38	(27-36)	USAID Consultants arrive to assist MSPyBS.
39	(27)	Training of Third Health Region Training/Supervision Team.
40	(28-29)	Training of Health Center/Post personnel of the Third Health Region in five courses.
41	(28-30)	Follow-up survey on MCH/FP conditions begins.
42	(30-34)	Selection and training of Voluntary Health Collaborators of the Third Health Region in 15 courses.
43	(30-33)	Refresher training of Voluntary Health Collaborators of the Seventh Health Region in 15 courses.
44	(31)	Follow-up survey of MCH/FP conditions completed. Analysis of data begins.
45	(35-36)	MSPyBS clears final shipment of contraceptives.
46	(36)	Survey report of MCH/FP conditions completed.
47	(37)	USAID and MSPyBS final evaluation of project.
48	(39)	MSPyBS liquidates all project cash advances by documenting all cash expenditures. Project close-out.

C. Evaluation Plan

USAID and the MSPyBS will undertake annual evaluations of the project according to the schedule set forth in the Implementation Plan. The MSPyBS Executing Unit under the supervision of the Director General of Health will work with USAID on project evaluations. The first annual evaluation is scheduled to take place one year from the signing

of the Project Agreement with the MSPyBS. A major project evaluation utilizing consultants not involved in project implementation is scheduled to take place after two years of project implementation. Specific project elements will be studied by USAID consultants during all three years of project life. The two sample surveys of MCH/FP conditions which are scheduled to take place during the first and third years of the project will be designed to measure the impact of project interventions.

D. Project Monitoring

The Population and Public Health Division will be responsible for managing this project. Numerous site visits will be made within the First, Third, and Seventh Health Regions.

E. Status of Negotiations

All major project issues have been negotiated with the MSPyBS. Assuming AID approval of the project by March 31, 1979, the Mission would negotiate and sign a Project Agreement with the MSPyBS during April 1979.

ABS

Table 1

Program Analysis for the Oral and Condom Supplies Needed to Achieve Full Availability

	1977	1978	1979	1980	1981	1982
A. "Full Supply" Analysis						
1. Married women of reproductive age - (See Annex A)	422	435	448	462	477	492
2. 65% of line A.1. (Contracepting women required to achieve replacement fertility)	274	283	291	300	310	320
3. 50% of line A.1. (Contracepting women utilizing orals and condoms)	211	217	224	231	238	246
4. Annual stock requirements for "full availability"						
a. Orals - 3/4 of line A.3. x 13 monthly cycles (75%)	2,056	2,115	2,184	2,251	2,320	2,399
b. Condoms - 1/4 of line A.3. x 100 units (25%)	5,275	5,425	5,600	5,775	5,950	6,150
B. Annual New Supply From Non-AID Bilateral Sources						
1. Private Commercial Sector						
a. Orals	358	375	394	414	434	450
b. Condoms	437	437	437	437	437	437
2. Other Donors						
a. Orals	158	255	286	320	355	390
b. Condoms	269	85	95	107	115	120
3. Host Country Government Procurement						
a. Orals	0	0	0	0	0	0
b. Condoms	0	0	0	0	0	0
4. Total In-Country New Supply						
a. Orals	516	630	680	734	789	840
b. Condoms	706	522	532	544	552	557

Table 1 - Page 2
Program Analysis for the Oral and Condom Su[illegible]s Needed to Achieve Full Availability

	1977	1978	1979	1980	1981	1982
C. Gap to be Filled to Achieve "Full Availability"						
1. Orals (line A.4.a. less line B.4.a.)	1,540	1,485	1,504	1,517	1,531	1,559
2. Condoms (line A.4.b. less line B.4.b.)	4,569	4,903	5,068	5,231	5,398	5,593
D. AID Bilateral Supply Objectives						
1. Orals	260	320	420	500	550	600
2. Condoms	115	381	1,440	1,152	864	1,152
E. Total New Supply						
1. Orals (line B.4.a. plus line D.1.)	776	950	1,100	1,234	1,339	1,440
2. Condoms (line B.4.b. plus line D.2.)	821	903	1,972	1,696	1,416	1,709
F. Remaining Supply Gap						
1. Orals (line A.4.a. less line E.1.)	1,280	1,165	1,084	1,017	981	959
2. Condoms (line A.4.b. less line E.2.)	4,454	4,522	3,628	4,079	4,534	4,441
G. People Gap						
1. Orals (line F.1. divided by 13)	98	90	83	78	75	74
2. Condoms (line F.2. divided by 100)	45	45	36	41	45	44
3. Total (line G.1. plus G.2.)	143	135	119	119	120	118

Table 2

AID Bilateral Logistic and Financial Analysis of Orals

A. AID Inventory Analysis

	Calendar Year				
	1978	1979	1980	1981	1982
1. Beginning of year stock	201	281	381	491	541
2. Add: Scheduled deliveries	320	420	500	550	600
3. Less: Expected use	240	320	390	500	550
4. End of Year Stock	281	381	491	541	591

To be completed by AID/Washington

B. Financial Analysis (FY'78)

1. CY 1979 deliveries (Line A.2. above)
2. Estimated cost per unit in FY of purchase
3. Estimated total cost for FY'78 (to be determined by AID/W)

C. Financial Analysis (FY'79)

1. CY 1980 deliveries (Line A.2. above)
2. Estimated cost per unit in FY of purchase (to be determined by AID/W)
3. Estimated total cost for FY 1979 (to be determined by AID/W)

Crónicas de un terráqueo

Jesús Ruiz Nestosa

La probeta y el horno

En los últimos días, el tema obligado de las conversaciones y los comentarios periodísticos fue Louise Brown, el famoso bebé—probeta que acaba de nacer en Inglaterra. A su alrededor se hicieron las suposiciones más descabelladas, las disquisiciones más complicadas y más de uno quiso lucir sus conocimientos científicos, históricos y hasta teológicos. Pero muy pocos se asombraron de lo que muy bien puede considerarse como un triunfo del conocimiento humano.

En el Brasil, un sacerdote escribió sobre el hecho, horrorizándose, claro está. Porque siempre, ante cualquier hecho nuevo queda mejor horrorizarse antes que asombrarse. Así queda menor margen de error aunque la evolución de la ciencia demuestre lo contrario.

Uno de los argumentos para oponerse a este hecho "aberrante" es que a partir de ahora el hombre podrá crear, probeta mediante, una superraza, buscando los óvulos y los espermatozoides que reúnan las mejores cualidades en cierto sentido. No importará ya, según el autor del artículo publicado en un diario brasileño, el interés ni el cariño de los padres, sino nada más la obtención de los resultados deseados.

Olvida, sin embargo, este articulista, que tales experiencias fueron realizadas ya, entre seres humanos, no hace mucho tiempo. Y es posible que él haya sido joven en el mismo momento que se realizaban tales experiencias en Alemania y en Italia, bajo la mirada atenta y vigilante de Hitler y Mussolini. Y entonces no era probeta mediante, sino a través de la relación normal, si normal puede llamarse a este acto totalmente mecanizado, carente del mas mínimo vínculo de afectividad.

Pero hay algo más. Quizá no sea tan grave, en este momento, considerar que tales experiencias se hayan hecho, sino olvidar que se hayan hecho, sobre todo por aquello que significó ese momento histórico para toda la humanidad. Pues el bebé—probeta suscita una ola de protestas, de indignación, de disconformidad. Pero los brotes de aquella ideología que llevó a tantos a pensar que podían construir una raza superior pasan poco menos que desapercibidos y nadie se preocupa de manifestarse en contra.

El viernes a la mañana se podía leer en los diarios un nuevo movimiento surgido en Alemania, entre adolescentes de 15 a 17 años. Se dedican ellos a estudiar todo aquello que tiene relación con el Ejército, el uso de armas y técnicas de estrategia militar. Y se asegura que recientemente esos adolescentes se reunieron en una gran asamblea bajo la dirección de un "joven aprendiz de Führer".

Muchos adultos de hoy deben recordar aún los años treinta y la forma sutil en que comenzó aquel movimiento que iba a tener tan trágico desenlace. Porque los jóvenes se pueden entusiasmar fácilmente con falsos ídolos. Como ejemplo se puede citar a un joven artista paraguayo que semanas atrás, en una entrevista, declaraba su gran admiración a Hitler, al que consideraba un gran orador.

Quizá sería mejor que perdamos algunas oportunidades de mostrarnos brillantes ante los demás; que renunciemos a deslumbrar a una masa de lectores que por otra parte desconocemos y ante la que obramos empujados por la vanidad. Y en su lugar, detengámonos a pensar dos veces sobre el tema que vamos a opinar.

La historia está muy cerca en este aspecto para darnos el lujo de ignorarla. El bebé—probeta no es nada más que algo circunstancial y anecdótico en comparación con esos otros hechos que estamos viviendo y que nos rodean. La alarma no debe cundir ante las nuevas formas de producir vida, sino ante los peligros de que resurjan viejas técnicas de exterminarla. Y lastimosamente hay que reconocer que la imaginación del hombre es mucho más rica y pródiga en este caso que en el primero. Así, ante la probeta y los hornos, es mejor elegir lo primero que lo segundo.

¿Nos conviene el control de la natalidad?

Hace poco la doctora Néstar de Stark, responsable general del Centro Nacional de Pastoral Familiar, hablando para nuestro diario se refirió al control de los nacimientos diciendo que "repercute e influye negativamente en el desarrollo económico del país".

Desde hace muchos años el Centro de Estudios de Población (CEPEP) viene frenando nuestro crecimiento demográfico en una forma demasiado libre y al parecer incontrolable. En algunas naciones organismos similares al CEPEP han sido acusados de esterilizar a la mujer sin su consentimiento. Quizás aquí pudiera haber razones para pensar lo mismo en momentos en que el CEPEP dispone de muy amplias facultades para actuar en todo el territorio del país con una potencia económica al parecer ilimitada.

No hay barrios de la capital, ciudades, pueblos y compañías del interior donde no está actuando alguien del CEPEP "concientizando" con sus modernos equipos portátiles de proyección o directamente con sus médicos, enfermeras, asistentes sociales, etc. procediendo al control en forma descontrolada, de la natalidad.

Erróneamente suele afirmarse que los hijos son una carga para los padres en el interior. Al contrario, son una solución económica. Son una fuerza económica. Son un ahorro en muchos aspectos, puesto que desde los siete u ocho años ayudan ya en las distintas tareas de la casa o de la capuera. Y con un poco más de edad que las señaladas, los hijos trabajan en labores que en otras situaciones sus padres tendrían que pagar a los vecinos.

No se trata de limitar el nacimiento sino de planificar el futuro de los que nacen. No se trata de ponerse en la cómoda posición de pensar que los niños habrán de tener hambre sino en hacer que el hambre no exista creando fuentes de trabajo, mejorando con la misma cantidad de dinero que se destina a impedir los nacimientos las condiciones socio-económicas del país. No sabemos cuánto gasta el CEPEP, pero por lo que aparenta, tiene que ser muchos millones de dólares con los que, pensamos, se podrían construir escuelas agrícolas, financiar equipos mecanizados para el agro, comprar semillas, construir silos, centros de salud, pero con medicamentos que curen, etc. etc.

La política del CEPEP es evitar el nacimiento, es decir, limitar la población del país cuando que no sabemos si el Paraguay necesita de más habitantes o quizás menos. Pero sobre esto no hay un estudio acabado. El Gobierno no tiene en esta materia un criterio muy firme porque carece, al parecer, de estudios serios.

Una vez hechos esos estudios, y nos damos cuenta de que el Paraguay necesita como lo afirma la Dra. Stark de aproximadamente cuatro millones más "para que se produzca un verdadero despegue" ¿Qué vamos a hacer? ¿De cuántos años de actividad del CEPEP tenemos que arrepentirnos?

Una medida prudente sería suspender la actividad del CEPEP hasta que sepamos claramente si necesitamos o no de más población. Por la experiencia de otros países, como la Argentina y el Brasil, colegimos que nos hace falta poblar nuestros desiertos. El desequilibrio poblacional entre nuestros vecinos es demasiado pronunciado y demasiado peligroso.

Economistas y sociólogos deben darse a la tarea urgente de realizar un estudio acabado sobre nuestra población. Hay un consenso general de que necesitamos de más habitantes. Entonces las actividades del CEPEP están de más. Entonces nos resulta demasiado perjudiciales. Y no hablemos de los aspectos morales y religiosos.

Con más datos en nuestro poder, seguiremos con este tema del CEPEP. Procuraremos saber exactamente si su presencia es o no beneficiosa a nuestro país.

Alcibiades González Delvalle

OPINIONES

No un orgullo, un compromiso

Uno de los primeros slogans de Itaipú —debemos convenir que los ha generado al por mayor— ha sido el de "un desafío histórico". Ya se lo escuchaba cuando el tratado estaba en estudio y hoy en día se convirtió en una cantinela que en boca de empresarios y funcionarios suena como la satisfacción del deber cumplido.

Invariablemente cuando la prensa consulta en dichos niveles sobre las perspectivas de aprovechamiento de la energía que generará Itaipú, la respuesta no va más allá de que se tiene ante uno a un desafío... y misión cumplida.

Conste que también existen otras expresiones como "la represa más grande del mundo", "Itaipú será la capital de la energía", el "boom energético mundial", "la palanca para el desarrollo" etc., etc. y todas ellas sirven sólo para exteriorizar un estado de ánimo y el orgullo que significa poseer, una obra que, sin lugar a dudas, es colosal.

Pero tendríamos que convencernos de que Itaipú antes que un honor es un compromiso. Un gran compromiso que muchos parecen no comprenderlo en toda su magnitud e importancia; sólo así podría explicarse el fenómeno de que hasta el momento no se haya establecido o por lo menos iniciado el estudio metódico de la estrategia a seguir en materia de venta o utilización de la electricidad que generará.

Muy pronto el río Paraná será desviado para iniciar las fundaciones de la represa, y no será el caso de que ante una consulta periodística se siga respondiendo que Itaipú es un desafío histórico porque entonces sí ya no será posible disimular la inoperancia que también será histórica.

Hace unos días la ANDE señaló que se superó la barrera de los 100 mil kilowatts de consumo diario de electricidad y si tenemos en cuenta que la parte que nos corresponderá de Itaipú será de más de 6 millones de kilowatts no hace falta calcular mucho para determinar que el camino a seguir es bastante largo.

Hasta el momento no se ha definido qué hacer con la energía y a juzgar por el corto tiempo que queda, el Brasil irremediablemente en la etapa inicial deberá consumir todo lo que produzca la hidroeléctrica. Pero es perentorio estudiar la política nacional en esta materia para que cuando tenga que plantearse la restitución de la parte de energía que le corresponde al Paraguay no tengamos que expresar solamente que ese papel es "un desafío histórico".

Y para esta tarea no será posible depender exclusivamente de la genialidad de unos pocos, pues tendrán que poner su cuota de esfuerzo e inteligencia los distintos sectores oficiales y privados que tienen que ver con el desarrollo económico y social del país. Lo que se haga o deje de hacerse entonces, tendrá repercusiones negativas o favorables —según el caso— en el futuro del país. Es pues entonces el momento de recoger el guante que nos lanza Itaipú.

CARLOS ALBERTO RODRIGUEZ

"Yacyretá camina"

"Yacyretá camina" ha sido la expresión breve y clara sobre el estado actual del proyecto paraguayo-argentino, lanzada por uno de los directores paraguayos del ente. Es la sintética y optimista forma de enfatizar el avance de un proyecto, que es indiscutible, en el camino de su realización que ya ha hallado una serie de obstáculos.

Al decir que "Yacyretá camina" el Ing. Riolas Ortiz, el más alto funcionario compatriota ante el organismo que maneja el emprendimiento, no hizo sino trasuntar una serie de aspectos que han convertido a Yacyretá en algo más que esos largos e interminables estudios.

No se puede dejar de lado ya una cantidad interesante de trabajos preliminares que empezaron a ejecutarse en la zona que se constituirá en villa para toda la gente que de una u otra manera tendrá participación en trabajo de tanta magnitud.

Aparte del estudio de suelo, construcción y pavimentación asfáltica de calles, viviendas, instalaciones sanitarias, y otras tareas, la Entidad Binacional ya ha previsto la construcción de un aeropuerto en Ayolas, y últimamente ha empezado el llamado a licitación para la realización el puente sobre el Brazo Aña Cuá.

Está, además del conocido concurso de preselección de firmas internacionales interesadas en la fabricación y provisión del equipamiento electromecánico para la usina del río Paraná, y la futura licitación para las obras civiles principales del proyecto.

Cuando el mismo Ing. Riolas efectuara la declaración de la que se hizo eco toda la prensa nacional, tampoco dejó de

Rincón Filatélico

Matasellos paraguayos en portugués

Alfredo M. Seiferheld

Desde el momento mismo en que, la "Litografía Nacional Porto" de Portugal, entregó los primeros sellos concesionados que le fueran encargados (3ª serie de pinturas, aparecida el 10.3.1967); la misma ha incurrido ... Portugal. Y aparece tan a menudo sobre nuestros sellos que podríamos coleccionar los sellos y bloques afectados por separado. Aunque no hagan a la intención de esta entrega, vale la pena citar algunas expresiones como "nan portuguesa" por nave portuguesa; "unem" por unen al referirse a una ubicación. Hasta aquí todo estaría encuadrado en el decreto que lo ampara, de no ser que el fechador lleva inserto los nombres de los meses en portugués, con la abreviatura internacional de las tres primeras letras de cada palabra. Por fortuna, tal abreviatura coincide con los nombres castellanos en 7 meses, ... chazar los incorrectos. Alguna representación diplomática debemos tener en Portugal. Y están aquí los entendidos no sólo en lengua española sino también en filatelia y en historia. A través de nuestros ocho años de aparición nos hemos cansado de sugerir cosas al Correo Central, como ser el nombramiento de una comisión filatélica asesora como la había

¿Nos conviene el control de la natalidad? (II)

En relación a nuestro artículo del domingo pasado "¿Nos conviene el control de la natalidad?" hemos recibido del Centro Paraguayo de Estudios de Población un lote de publicaciones que hablan de las actividades e importancia del CEPEP. Nobleza obliga, vamos a ocuparnos primeramente de dichas publicaciones y después de las informaciones que hemos obtenidos por nuestros propios medios. Informaciones que no figuran en las revistas y folletos que nos remitió el CEPEP.

El director ejecutivo del CEPEP, Dr. Darío Castagnino, dijo a un diario local que "El mero crecimiento de la población no es garantía de desarrollo, como tampoco lo es la cantidad de población que pueda llegar a tener un país, sino que su relación debe adecuarse a sus posibilidades de crecimiento económico".

Este concepto es un lugar común entre los defensores del control de la natalidad. Para ponerlo en práctica se valen de las estadísticas — confeccionadas por ellos mismos — y en las que siempre parecen de que estamos demás, de que nuestra capacidad económica no da sino para la mitad de los habitantes. Y si fuésemos un millón, igualmente estarían demás quinientos mil.

Los entusiastas de controlar la natalidad siempre quieren hacernos creer de que actúan de una manera estrictamente científica y humanitaria. Por humanitarios que son procuran no traer más seres que tengan que sufrir hambre y encontrarse sin espacios donde vivir.

Tienen otro razonamiento: el desarrollo de un país no depende de la cantidad sino de la calidad de habitantes. Entonces, como los mejores son los actuales, evitan que vengan otros, porque seguramente no serán buenos. En el fondo de toda esta cuestión lo que hay es un tremendo egoísmo y una inmensa vanidad. Egoísmo al pensar que otros vendrán a comer nuestros alimentos y meterse en nuestras viviendas, vanidad, al creer que no habrá mejores que nosotros y entonces nos hacemos del derecho de evitar los nacimientos.

En base a las estadísticas de que dispone el CEPEP — estadísticas hechas por la misma institución — desde hace doce años se viene aquí controlando la demografía. Para ello utiliza, repetimos, el consabido concepto de la "calidad" sobre la "cantidad" y la relación "producción — población". Conviene aclarar aquí que las cifras y los conceptos son utilizados por el CEPEP exclusivamente como justificación de su tarea en nuestro país y como justificación de los fondos que recibe de los organismos internacionales creados especialmente para evitar los nacimientos en el mundo. Aclaramos también, antes de seguir adelante, de que nos referimos exclusivamente a la situación del Paraguay sin que los casos que podamos dar como ejemplos pudieran servir a otros países en algunos de los cuales, por la superpoblación, quizás haga falta planificar los nacimientos.

LAS RECETAS MAGICAS

En un párrafo del editorial de "Temas de Población" (No. 5), editado por el CEPEP se lee: " En consecuencia, resultan asaz sospechosas aquellas formulaciones que pretenden, sin un estudio previo de la implicancia de la dinámica poblacional, recetas mágicas para promover el desarrollo. En especial, aquellas aseveraciones de que el mero crecimiento de la población es factor fundamental para el desarrollo".

Aparte de que acude siempre al lugar común ya señalado, el CEPEP no cree en "recetas mágicas" ni en el "mero crecimiento" para alcanzar el desarrollo económico. Igualmente — y utilizando las mismas expresiones del CEPEP — podrían resultar "asaz sospechosas aquellas formulaciones que pretenden" que con sólo evitar el crecimiento se obtendría un adelanto económico. Entonces, "la receta mágica" es aplicada precisamente por el CEPEP. Con esta "receta mágica" — las pastillitas — cree que se alcanzará —¿o se alcanzó ya?— el bienestar económico de la familia paraguaya.

Desde luego que no existen "recetas mágicas". Existen estudios serios y propósitos firmes. Pero da la casualidad de que no disponemos de ese estudio serio para saber científicamente si el Paraguay tiene pocos habitantes o está superpoblado. De acuerdo a las estadísticas del CEPEP ya somos demasiado. Pero esas estadísticas están tomadas de acuerdo a nuestra situación actual. Forzando un poco, hasta podríamos decir que de acuerdo a la actual cantidad de viviendas de servicios de luz y agua, de cantidad de panaderías y zapaterías. Tomando así las cosas, con tanta simpleza, desde luego que faltan viviendas y los servicios señalados.

Con este concepto, la ANDE, por ejemplo, tendría que ser un entusiasta de las pastillitas porque evitaría muchos gastos en la compra de los elementos necesarios para extender a un barrio nuevo los servicios de energía eléctrica. Igualmente CORPOSANA y ANTELCO y el Ministerio de Salud Pública, y etc. etc.

Insistimos en que el Estado debe determinar con exactitud de cuántos habitantes precisa nuestro país para el famoso despegue económico. Este trabajo debe estar a cargo exclusivo del Estado Paraguayo y no de un organismo privado con financiación extranjera.

Puesto que no sabemos qué potencialidad económica guarda por ejemplo nuestro subsuelo. ¿ Cómo vamos a planificar el desarrollo económico en base exclusivamente al control de la natalidad, en el supuesto de que ya no damos

POLUCION Y CONTAMINACION

En el mismo editorial señalado, leemos este párrafo: " Asimismo y para hacer frente a un fenómeno de más reciente preocupación, deberá prever también cuestiones ecológicas, incluyendo tasas de utilización de recursos no renovables, polución y contaminación del medio ambiente".

De que el CEPEP es tremendista no cabe dudas. Piensa como si el Paraguay se hundirla de contener un habitante más. En relación a su territorio somos el país menos poblado del mundo y el CEPEP nos quiere asustar ya con cuestiones de polución y contaminación, etc. De que son cosas para no tomarlas a broma, es cierto. Son problemas, y muy graves, para muchos países SUPERINDUSTRIALIZADOS Y SUPERPOBLADOS. El CEPEP nos dirá que llegaron a esa situación porque no se repartieron a tiempo las pastillitas, y aquí estamos en el momento ideal para no llegar a tener tales problemas, con la condición de que se le deje meterse libremente en nuestras cuestiones demográficas.

El problema, lo dijimos en nuestra crónica anterior, no está en evitar nacimientos sino en crear las condiciones socio—económicas con miras al futuro. Y este proyecto puede llevarse a cabo tal vez con el mismo dinero que se destina a la planificación familiar.

Alcibiades González Delvalle

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ANEXO 2

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tiembre y varios profesionales de la especialidad expondrán sobre el tema.

El profesor doctor Luis Valenzuela F. acompañado de los doctores Telmo Aquino y Mariano Bordas, desarrollará el tema: "Accidente Vascular Cerebral Hemorrágico". El 29 expondrán sobre "Diarrea en Clínica" los profesionales Víctor Masi Gorostiaga, Rufino Gorostiaga y Hugo González.

l 30 de agosto hablarán sobre "Bronconeumopatia crónica", los doctores Eduardo Mingo, Raul Gómez y Derlis Martino. Para el 31, se ha previsto la participación del doctor Ricardo Moreno Azorero y miembros delDepartamento de Gastroenterologia para el desarrollo de "Bases fundamentales de la dieta en Clínica".

1° de setiembre se refe- -n sobre "Desequilibrio hidroeléctrico" los doctores Luis Carlos Maas, Carlos A. Oviedo, y Augusto Centurión. Para el dos de setiembre disertarán sobre "Insuficiencia renal" los doctores María Teresa de 'aliente, Luis Carlos Maas y Silvio Rodas Ortiz.

simismo, continuando con programa los doctores Carlos A. Oviedo y Luis Daumas Ladouce expondran el 4 de setiembre sobre "Antibióticos usos y abusos". El 5 del mismo mes, los doctores Osvaldo Real y Alejandro Arce tocarán el tema: "Linfomas: Clasificacion clínica y tratamiento."

Por último, para el 6 de setiembre se ha establecido el relato del tema, "Cardiopatia ezquemica" a cargo de los doctores Silvio Rodas Ortiz, Oscar Lovera, Rubén Darío Molinas, Derlis Martino y Silvio A. Rodas Q

El horario establecido para el desarrollo de las conferencias es de 10 y 30 a 12 horas. Los interesados pueden llamar al telefono 80.311. Tienen de- r a participar los estudiantes d a Facultad de Ciencias Medicas, y especialmente, los graduados en la materia.

¿Nos conviene el control de la natalidad? (III)

Alcibiades González Delvalle

Ligar al Paraguay con "la explosión demográfica" nos parece un absurdo. Historiadores y sociólogos de continuo nos hablan de la sangria poblacional ocasionada por las dos guerras internacionales y las incontables guerras civiles. Hemos descansado de las unas y las otras, pero he aquí que hace su aparición el Centro Paraguayo de Estudios de Población (CEPEP) con su lema de "seamos menos, pero mejores". En las pastillitas descubrió la "receta mágica" para causar el mismo efecto que las grandes conmociones sociales como las mencionadas. Es una especie de aborto poblacional sin dolor.

¿Por qué ser "menos" significaría necesariamente ser "mejores"? ¿No podemos ser más y seguir siendo buenos? El mismo razonamiento de CEPEP que le hace creer (¿creerá?) de que lo que importa es la calidad y no la cantidad -prejuzgando que quienes vendrán serán peores- nos lleva también a creer anteponiendo nuestro optimismo al pesimismo de CEPEP- que podrían ser mejores aquellos que estamos impidiendo nacer. Con el mismo fundamento histórico y científico podemos sostener ambos puntos de vista.

Nosotros podríamos poner como ejemplos -como pruebas- innumerables conquistas, en todos los ordenes, del hombre del siglo XX: el CEPEP también mostrándonos, pese a esas conquistas, a ejércitos de niños pauperrimos sin futuro venturoso, mas otros ejercitos de hambrientos y analfabetos. Se le puede agregar una serie de lacras sociales como la criminalidad, las enfermedades venereas, etc. etc. Aparentemente la lista del CEPEP sería mucho más larga que la nuestra. Entonces el CEPEP nos preguntaría: ¿Es este el mundo que desean? Si tantas calamidades pueden evitarse, ¿por qué no las evitamos?. Déjenos repartir en paz las pastillitas.

Es contra esta formulación simple, tremendista y vaga con la que no estamos de acuerdo. El Paraguay no tiene todavia los problemas, como a diario leemos, de los grandes paises: nuestras ciudades no tienen la misma conformacion social que las de esos mismos paises. Y siendo distintos, nuestros problemas necesitan soluciones distintas. Con el cuento de procurar que el Paraguay no llegue a la situacion de otras naciones, con sus muchos problemas originados de la superpoblación, no podemos permitir que se este frenando en forma incontrolada nuestro crecimiento demográfico.

En cualquier ocasión, el CEPEP repite que tiene por finalidad principal trabajar por el bienestar de la familia paraguaya. ¿Y cuál es el bienestar que le brinda? CEPEP entiende por bienestar la eliminación de aquello que pudiera significar quebrantos económicos. Su preocupación "real" se reduce a que no aparezca una boca más porque esa ha de ser la única culpable de que la familia pierda o no tenga "bienestar".

Al CEPEP no se le ocurre otra solución que evitar el nacimiento de este futuro intruso, de esta especie de parricida que ha de venir a matar de hambre a sus padres.

Al CEPEP nunca se le ocurriría -desde luego que no está en sus propósitos- ayudar financieramente a las entidades que procuran mejores condiciones de vida a quienes YA NACIERON Y HAN DE NACER mediante el mejoramiento de las condiciones socio-economicas del pais. No ayudaría a las Escuelas Agrarias con la donación de equipos mecanizados; a las escuelas y colegios, con útiles y profesores; a las escuelas vocacionales y a tantos organismos que incluso podrian crearse con la finalidad de que se llegue a un autentico bienestar de la familia paraguaya.

EL MOVIMIENTO DEMOGRAFICO

Del 11 al 14 de diciembre de 1975 se realizo en nuestra capital el Foro Nacional de Líderes Femeninos bajo el auspicio -es decir, con la financiación- de CEPEP. En esa ocasión el presidente del consejo directivo de la entidad, Dr. Raúl Mendoza, dijo que el Foro "se encuadraba perfectamente dentro de los objetivos de la entidad, ya que respondía a uno de sus postulados, cual es el de ENCARAR EL ESTUDIO CIENTIFICO DE LA POBLACION PARAGUAYA, POR CONSIDERAR QUE EL MOVIMIENTO DEMOGRAFICO EN EL AREA CONTINENTAL Y MUNDIAL, CON SUS GRAVES IMPLICACIONES SOCIALES, MORALES, ECONOMICAS Y POLITICAS, OBLIGA A ESCLARECER LAS CARACTERISTICAS FUNDAMENTALES DE LA POBLACION PARAGUAYA, SOBRE BASE DE ESTUDIOS METODICOS CON RIGORISMO CIENTIFICO".

Estas palabras del presidente del consejo del CEPEP -sobre las que volveremos varias veces- no deja ninguna duda sobre el propósito que les anima en nuestro país. Parten del "MOVIMIENTO DEMOGRAFICO EN EL AREA CONTINENTAL Y MUNDIAL" para aplicar la misma solución, la misma "receta mágica" -las pastillitas- a enfermedades evidentemente distintas.

"Estudio científico", "estudios metódicos", "rigorismo científico" son algunos de los términos que tienen una sola finalidad: justificar los fondos extranjeros, los propósitos extranjeros, para frenar nuestro crecimiento demografico.

AMIGO LECTOR

¿Nos conviene el control de la natalidad? (IV)

Alcibiades González Delvalle

Un alto ejecutivo de la Federación Internacional de Planificación de la Familia (FIPF), el Dr. Benjamín Viel dijo recientemente en nuestro país en uno de los tantos "seminarios" que financia el CEPEP, que "el trabajo de esta Federación Mundial está basado en la libertad humana, por ambos lados. La libertad de la pareja para elegir el tamaño de la familia. La libertad para aceptar o rechazar los métodos anticonceptivos reversibles"

Dejando de lado de que en muchos países se han denunciado no precisamente los métodos anticonceptivos reversibles, sino irreversibles (como la esterilización de la mujer sin su consentimiento) las expresiones del Dr. Viel no son precisamente muy acertadas. No es cierto que exista la libertad de elección. Veamos por qué.

El CEPEP dispone de modernos equipos de proyección de películas y slides; de folletos, boletines; de especialistas en propagar entre la gente, de convencer a la gente, de la utilidad de aceptar los servicios del CEPEP. Dispone, en fin, de todos los elementos propagandísticos modernos cor ecciona dos por especialistas altamente calificados. Con este arsenal de "comunicación" e "información" se lanza sobre indefensas parejas, totalmente vírgenes en estas cuestiones. Principalmente en el campo este método causa estragos.

Una de las películas de las tantas y muy eficaces que se proyectan en las reuniones se trata de un cajero de bar que tiene a su disposición todo el bienestar que el CEPEP desea para las familias paraguayas; es decir, una hermosa mansión, automóvil último modelo, anda siempre sonriente, no tienen ningún problema económico de ninguna índole. El otro personaje del film es el mozo del bar de situación económica totalmente opuesta al cajero: es muy pobre, sufre el tormento de no tener vehículo propio, nunca tiene ganas de sonreír, etc. etc.- La razón es muy sencilla. El cajero tiene solamente dos hijos y el mozo tiene cinco. El cajero tiene la cantidad de hijos que su presupuesto es capaz de soportar; en cambio el mozo es un irresponsable que tiene más de lo que su situación económica le permite.

Termina esta película, y viene la "charla" explicativa, la moraleja, o mejor, el mazazo final: los cálculos económicos. Resulta que un hijo hasta la edad de 18 años cuesta algo así como tres millones de guaraníes contando desde el primer mes de gestación. Entonces los padres tienen que distraer otras cuestiones -renunciar a su bienestar- para criar ese hijo por cuya culpa sus progenitores no tienen casa propia, ni automóvil, ni televisor, ni instrumentos de labranzas, ni nada que pueda hacer "el bienestar de la familia paraguaya".

Después de esta sesión, los pobres campesinos salen como arrepentidos de haber traído siquiera un hijo en este mundo. Porque aparte de que les muestra se les demuestra supuestamente de que por culpa de ese hijo no tienen "bienestar" además lo trajeron para sufrir hambre, enfermedades, analfabetismo, ser un criminal, etc. etc.

Y después de todo este lavado de cabeza, todavía les queda humor para decir que existe en la pareja toda la libertad de elección. ¿Qué libertad puede tener cuando de esta forma se les seduce? ¿De qué libertad se hablar cuando con estos medios se induce a la gente a hacer lo que nosotros queremos que hagan? Con estos atropellos armados de los más modernos medios de comunicación -tan mortíferos cuando se los utiliza como venimos indicando- es una burla cruel hablar de que existe libertad de elección. Armado de un proyector y de un film científicamente estudiado para su realización y efecto se es tan poderoso como disponer de un ejército bien equipado.

"NO NOS PREOCUPA LO DEMOGRAFICO"

El mismo Dr. Viel dijo en Asunción que "Dejamos bien claro que la FIPF al nacer y en el momento actual no tiene preocupaciones demográficas. La mujer, si llega a tener solamente los hijos que desea, eso mismo producirá una reducción en el crecimiento de la población, sin que nosotros nos preocupemos del fenómeno demográfico. Lo estudiamos, lo analizamos. Repartimos la información que existe sobre este problema. Pero nuestra preocupación fundamental no es la demografía, sino el derecho humano".

En estas expresiones encontramos algo muy feo. Hasta nos parece un cierto cinismo. Claro, yo no le mité a ese individuo, sólo le clavé el puñal en el corazón, señor juez. No tienen preocupaciones demográficas cuando lo único que hacen es frenar la demografía. Es más, ni siquiera se preocupan de eso, total ocurrirá sin falta.

NECESITA DE MAS CONTROL

Hace doce años que el CEPEP actúa en nuestro país. Y actúa demasiado libremente. Por su cuenta está frenando nuestro índice demográfico. Por su cuenta decide cuántos tenemos que ser en el Paraguay. Por su cuenta realiza campañas "concientizadoras" con instrumentos que pudieran perjudicar sicológicamente a nuestra gente. Por su cuenta recorre todo el país y elige el sitio en donde debe hacer más pronunciada su campaña de "promoción" pastillera.

No hay dudas de que el CEPEP debe ser controlado -en sus equipos médicos y propagandísticos- por el organismo estatal correspondiente. Es más, su actuación debe ser ya prohibida por lo menos hasta que el Estado Paraguayo disponga de un acabado estudio sobre si conviene o no el control de la natalidad. Y este estudio debe hacerse lo antes posible en base a nuestras posibilidades económicas. Pero tampoco disponemos de un estudio serio sobre estas posibilidades, en momentos en que no sabemos qué potencialidad económica guarda nuestro subsuelo.

Y mientras se cumplan los trámites tendientes a esta prohibición de actuar el CEPEP en nuestro país, creemos que se debe poner todo el cuidado en controlar los "medicamentos" que ponen al alcance sobre todo de los campesinos. Tenemos informaciones -sobre las que nos explayaremos en una próxima nota- de que el CEPEP estaría utilizando píldoras que, por ejemplo en los Estados Unidos, han sido prohibidas; incluso se nos estarían enviando píldoras para su experimentación o que ya han caducado. Cuestiones son éstas demasiado serias sobre las que se debe tomar una inmediata y enérgica medida.

El papel de la juventud

La Segunda Semana Social Paraguaya organizada por la Universidad Católica "Nuestra Señora de la Asunción" tendrá

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¿Nos conviene el control de la natalidad? (V)

Alcibiades González Delvalle

Con el título de "La empresa privada y la planificación familiar" el Boletín Nº 6 del CEPEP, correspondiente al pasado año, trajo una información que nos resultó sorprendente: que la Azucarera Paraguaya S.A. y el CEPEP trabajan juntos en Tebicuary.

Comienza la crónica diciendo que: "Los resultados satisfactorios que se han logrado en nuestro país mediante la aplicación de los programas de planificación familiar, comprometen la activa concurrencia del sector empresarial para aunar esfuerzos en bien del mejoramiento del nivel y de la calidad de vida de los obreros y sus familias, manifestó el ingeniero Rodi Hoechle, alto ejecutivo de la Azucarera Paraguaya S.A. en el Ateneo Científico organizado por el CEPEP".

Y finaliza la crónica: "Estamos muy cierto —dijo finalmente— (el Ing. Hoechle) de que con la creación del programa del CEPEP se han logrado, hasta hoy, resultados satisfactorios que comprometen nuestra participación activa al lado de esta institución; y de nuestra parte aunaremos esfuerzos y voluntades para que su labor se vea coronada por el mejor de los éxitos en cada uno de los rincones de nuestra patria".

Estas expresiones del más alto ejecutivo de la mayor empresa azucarera del país no dejan ninguna duda. Está firmemente dispuesto a ayudar para que la política demográfica del CEPEP "se vea coronada por el mejor de los éxitos en cada uno de los rincones de nuestra patria". En el supuesto de que haya otros rincones disponibles, es decir, tierra libre del CEPEP.

Entendemos demasiado bien qué quiere decir "el mejor de los éxitos". ¿Pero nos conviene que el CEPEP siga teniendo "el mejor de los éxitos" en nuestro país? ¿El éxito del CEPEP no estaría postergando más éxitos para el Paraguay?

La política poblacional encarada por cuenta exclusiva del CEPEP y de los organismos internacionales a los que representa, puede conducirnos a una total indefensa frente a nuestros dos poderosos vecinos que cada día aumenta su índice demográfico. Y hay más. ¿Quién nos asegura que el CEPEP no esté respondiendo al deseo de algún grupo de países de que el Paraguay sirva de reserva para después —cuando ya no haya espacio en otras latitudes— llenen nuestro territorio de "sobrantes"? Para pensar así hay argumentos muy firmes. Japón y Corea —tenemos pruebas— por ser países superpoblados concedían a sus súbditos toda suerte de ayuda para establecerse en otros territorios; para "despejar" sus respectivos países. Y aquí los tenemos.

Estos hechos forman una contradicción muy pronunciada. Por un lado el CEPEP limita nuestro crecimiento demográfico "porque es mejor ser menos pero buenos". Y por otro, recibimos en cantidad extraordinaria a inmigrantes orientales sobre cuya calidad desearíamos conocer la opinión del CEPEP. Esta contradicción hace porque el país no cuenta con un estudio acabado sobre nuestra verdadera situación demográfica. Si somos muchos, como afirman las estadísticas del CEPEP, para que la familia paraguaya goce de bienestar, ¿por qué recibimos a tantos inmigrantes, que ni siquiera son productores como los coreanos? Y si somos pocos, y necesitamos de más habitantes, ¿qué hace el CEPEP con su política de frenar nuestro crecimiento poblacional?

AYUDA DE LA EMPRESA PRIVADA

Está visto, entonces, que el CEPEP no sólo recibe ayuda de organismos internacionales, sino también de empresas privadas paraguayas, como el caso señalado de la Azucarera Paraguaya S.A.

La región del Guairá, donde está asentado dicho ingenio, es la mayor del país en cuanto a producción de caña dulce. Allí está concentrada también la mayor cantidad de cañeros, la mayoría de ellos con muy pequeñas parcelas. Para que tengamos idea de la superproducción de caña dulce, conviene recordar que cuando la gran helada del año 1975 quemó el 65% de la producción, igual no faltó materia prima a los ingenios.

En nuestras dos series de "Amarga caña dulce" hablamos de la causa parte de los problemas que aquejan a los cañeros del Guairá.

Monocultivo y minifundio; bajo precio para sus productos [illegible] y alimentación deficientes; un casi trato [illegible] a sus cañeros en las características principales en [illegible] Azucarera Paraguaya S.A. a los propósitos del CEPEP se confirma lo que sentimos decir de [illegible] Es más: el reparto de las parcelitas, evitar los crecimientos, que tormar una estructura para mejorar las condiciones de vida.

No creemos que la solución para Tebicuary sea que haya menos cañeros sino diversificar la producción. Es cierto que los cañeros están pidiendo siempre algo: que quieren mejor precio, que quieren créditos oportunos, que quieren caminos, que quieren arreglar las básculas, que no quieren que haya discriminación en la entrega de sus productos, que quieren esto y que quieren lo otro. Pero creemos que la solución no sería diversificar [illegible] cañeros. A fin de cuentas, y para propio [illegible] se necesita de cañeros pobres. Como [illegible] que [illegible] Pero, que [illegible] por su población [illegible]

Hay que ver la forma de frenar los [illegible] del CEPEP de meterse en todo su poderío económico, [illegible] cualquier parte donde crece que algún [illegible] nada, como en "el bienestar de la familia [illegible] tarea mínima, como en el caso de los cañeros [illegible] cia una plan que tienda a diversificar la producción y de una enseñanza integral sobre cuestiones agrarias [illegible] dignifiquen mejoramiento social y económico.

¿Nos conviene el control de la natalidad? (VI)

Alcibiades González Delvalle

Una entidad que se denomina Centro Paraguayo de Estudios de Población parecería dedicarse al estudio de la población. Sin embargo del CEPEP —siglas del Centro Paraguayo de Estudios de Población— no se conoce que haya realizado una labor así. Los datos que maneja corresponden a la Dirección de Estadísticas y Censo y a organismos internacionales. Esta circunstancia, una vez más, da muestras de que el CEPEP disfraza sus verdaderos propósitos o no cumple acabadamente con los organismos que financian sus actividades.

Este incumplimiento —por lo menos parcial— nos induce a tener en cuenta dos aspectos muy importantes: Que la denominación pudiera ser un "camuflage" para algo mucho más serio de lo que aparenta o que los fondos no son totalmente utilizados para sus fines originales.

Tenemos noticias de que el CEPEP habría cambiado, en un año, como media docena de contadores, sabemos de muchos funcionarios que están muy disgustados por la forma en que son tratados por la familia que maneja el CEPEP. En este aspecto, desde luego, el CEPEP es conocido como un organismo manejado a nivel familiar. Y también sobre esto el CEPEP estaría sirviendo otros intereses.

Se nos sugirió que propongamos se solicite a la familia Castagnino una declaración de bienes. Parece ser que hay una diferencia muy notable de antes del CEPEP —hace doce años— y después del CEPEP.

El problema fundamental, en un caso mucho más amplio y en definitiva más importante, es saber la función real del CEPEP. Puesto que no es lo que su denominación lo hace aparecer —el estudio de la población— entonces no queda dudas de pensar lo que venimos refiriendo: que recibe fondos, parte de los cuales se destina exclusivamente a frenar nuestro índice demográfico.

El CEPEP también dispone de otros fondos: todas sus clínicas —diseminadas por el país— cobran por lo menos 100 guaraníes por consulta. El presupuesto de médicos, enfermeras y medicamentos está cubierto totalmente por los organismos extranjeros.

Toda esta situación, más otras que iremos relatando, hace que exista un control sobre las actividades del Centro Paraguayo de Población que, de cumplir realmente con su finalidad de hacer "el bienestar de la familia paraguaya", sería un organismo importante con la condición de que ese bienestar nazca de financiar proyectos que mejoren la vida socio—económica de la población.

Biblioteca agrícola

A los efectos de contar con una estructura de información y documentación que permitan recoger, organizar y colocar a disposición de organismos y personas usuarias, datos agrícolas, técnicos paraguayos y extranjeros estudian un proyecto para la formación de la Primera Biblioteca Nacional de Agricultura. Un programa totalmente estructurado sobre el particular se encuentra en el Ministerio de Agricultura y Ganadería.

En esa secretaría de Estado se [illegible]

seducción polivalente

Algunos se empeñan en llamarme "la múltiplo".
Otros se empecinan en decirme "la polivalente".
Y todo porque tengo tantos dispositivos, que me consideran "varias máquinas en una sola".
A mí, me da igual.

Olympia

- 6 -

Annex 2

También es cierto que cada vez que se quiere poner un ejemplo típico de esta situación, se recurre siempre a Isabel Sarli, quizá como el símbolo sexual más representativo, como la figura innegable que encarna todos esos valores, o antivalores, todo depende de qué lado de la cámara estemos.

Debe ser por eso que en numerosas oportunidades pasamos por alto la misma historia que se repite con harta frecuencia en la prensa, en entrevistas con chicas que no alcanzan ni remotamente a la fama de Isabel Sarli, pero que sin embargo, no son menos tímidas, ni menos vergonzosas, ni menos hogareñas, ni tampoco menos desprejuiciadas, llegado el momento.

Tales pensamientos vienen a raíz de una entrevista aparecida días atrás, en donde una conocida bailarina y profesora de danzas de nuestro medio se declaraba amante de las flores, del jardín y de escribir poemas en sus momentos libres. Todo ello a pesar de una sugestiva fotografía en colores que acompañaba el artículo de marras.

No hay lugar a dudas que a los hombres nos gusta ver tal tipo de fotos, y aun de espectáculos, lo mismo que al glotón le gusta deleitarse con las propagandas de comidas que aparecen en las revistas ocupando llamativas páginas en colores. Lo único que no comprendemos por qué esa necesidad de autocalificarse. Dicen que es una manera efectiva de tapar a las "leguas—largas". Vano intento. Porque quien necesita alimentarse de la honra ajena para poder vivir, difícilmente renunciará a su manjar favorito. Y por otro lado, la única manera de desmentir rumores, es con la actitud. Y para ello no hay madre acompañante suficiente para lograrlo.

Parecería ser que en el fondo — así como los varones soñamos en un momento de nuestra vida ser bomberos, aviadores, marinos o vendedor de helados— parecería ser que en el fondo de las chicas hay un secreto deseo de ser bataclanas. Es fácil comprobarlo después de haber visto el desfile de las ya tradicionales "chiroleras" en la inauguración de los juegos universitarios de anoche.

Es probable que en muchos hogares, esta mañana no sea posible retirar el polvo de los muebles, porque ayer por la mañana fueron sacrificados los plumeros para aprovechar las plumas en algún llamativo traje que debía lucirse por la noche.

Es divertido ver con qué desenfado, con qué libertad, con que falta de prejuicios se puede salir frente a un público multitudinario llevando nada más que lo mínimo, en ocasiones tan mínimo, tan mínimo, que nada impide que se llamen "prendas menores". Pero no tenemos interés de sentar una prédica moral, ni pedir que se alarguen las ropas ni se cubran los brazos ni se escondan los muslos.

Lo único que deseamos es que en el momento preciso se reconozcan el contento y la alegría que les produce poder expresarse de este modo y exteriorizar su desenfado de este modo. Lo molesto es que en el momento preciso nos declaren su timidez, su inocencia y, sobre todo, que sienten verdadera pasión por la poesía, ya que en sus momentos libres se dedican a escribir poemas de amor. ¡Por favor, esto no!. Porque de seguir por este camino todavía nos van a decir que Gabriela Mistral gustaba de bailar con un traje lleno de plumas en sus momentos libres o bien que Pablo Neruda saltaba al ritmo del can—can en sus momentos de ocio.

A la poesía lo que es de la poesía y a las bataclanas lo que es de plumas, pero no mezclar las dos cosas que por allí puede haber un escritor alérgico a los plumeros y termine estornudando, o bien una bataclana iletrada que no haya ido más allá de "En el cielo las estrellas, en el campo el amambay..".

Crónicas de un terráqueo

Jesús Ruiz Nestosa

Entre poetas y bataclanas

Infaliblemente, cada vez que Isabel Sarli es entrevistada por algún periodista, surge la autodefinición de la artista que se considera "tímida, hogareña y vergonzosa". Pero ni bien surge la posibilidad de rodar una película bajo la dirección de su amigo Armando Bo, las auto-definiciones se tiran por la borda y las ropas también para poder tomar un desprejuiciado baño en las Cataratas del Yguazú, mientras el Pombero acecha entre el follaje.

¿Nos conviene el control de la natalidad? (VII)

Sabido es que la función principal del CEPEP es el control de la natalidad en nuestro país a través de sus clínicas diseminadas en la capital e interior. Sabido es también — por las insistentes informaciones que aparecen en los diarios y las revistas— del efecto negativo que pudiera tener en la salud de la mujer que, en forma indiscriminada, consume las píldoras anticonceptivas. Sobre esos efectos vamos a consultar oportunamente con los profesionales correspondientes.

Mientras tanto creemos conveniente referirnos hoy a si esos efectos son estudiados o controlados por los médicos del CEPEP, si solamente sus clínicas reparten las píldoras — previa "lavada de cabeza"— y luego se desentienden de sus pacientes; si el CEPEP busca únicamente evitar los nacimientos sin importarle el problema de la salud de la mujer. Por las informaciones que poseemos, el CEPEP, una vez que haya "concientizado" a la mujer para que opte por las píldoras u otros métodos anticonceptivos, se desentiende ya de los efectos que pudieran sobrevenir. Y esto es totalmente creíble en momentos en que las clínicas del CEPEP no disponen de médicos suficientes que también pudieran atender estos casos. A este respecto, algunos médicos del CEPEP nos dijeron que la institución paga muy poco como para que también pudieran dedicarse a una actividad "extra" como la de atender a cada paciente en cuanto a los efectos de las píldoras.

Se estaría, entonces, ante dos casos muy graves: 1) que el CEPEP, por su cuenta, esté frenando nuestro índice demográfico y 2) que atente contra la salud de la mujer. En este caso, estaría desmintiendo el propósito del CEPEP de trabajar "por el bienestar de la familia paraguaya".

Entendemos que trabajar "por el bienestar de la familia paraguaya" va mucho más allá que la simple planificación familiar. Y aquí usamos "planificación familiar" en el mismo concepto utilizado y practicado por el CEPEP. Es decir, el hecho compulsivo — a través de su arsenal propagandístico — de limitar los nacimientos.

El CEPFP, con sus cuatrocientos mil dólares anuales — aproximadamente sesenta millones de guaraníes— más medicamentos, equipos e instrumentales de todo tipo, realmente pudiera hacer mucho por el bienestar de la familia paraguaya. Si tanto dinero y equipos pusiese al servicio de la salud de la población mucho se estaría haciendo por el bienestar de la familia.

Para nadie es un secreto que la salud es factor gravitante en el proceso de desarrollo; tampoco es ningún secreto que nuestros campesinos tienen encima, frenándolos en muchos aspectos, ese problema de la salubridad. Por razones culturales muchas veces, por factores económicos casi siempre, los "médico ñana" proliferan como hongos en el campo. En los casos leves es muy poco lo que pueden hacer, y en los casos graves, nada. Y aquí nace una ironía que mucho da para pensar. Que el médico — el universitario— por falta de instrumentos de laboratorio, de equipos clínicos, de medicamentos, en una palabra, por lo casi desmantelado que tiene su "Centro de Salud", su participación profesional tiene casi el mismo efecto que la del "médico ñana" para los pacientes. Y suele haber una ventaja en favor del "médico ñana" que sus pacientes, por veinte guaraníes, pueden tomar alguna infusión que por allí hasta puede curar una enfermedad leve. En cambio el médico, el universitario, nada puede hacer con la sola expedición de la receta, que suele terminar arrugada y sucia en el bolsillo del paciente cuando en la farmacia le informaron el precio del medicamento. Un té de amba'y con jagua rundi puede curar una tos. Pero una receta, o su sola expedición, no curaría un simple malestar estomacal.

Claro que es demasiado obvio lo que estamos diciendo, como sería demasiado obvio que no hay ningún fundamento en la afirmación de que para conseguir "el bienestar de la familia paraguaya" basta con evitar los nacimientos.

El tipo de Centros de Salud que hemos mencionado, y de los que tantos hay en nuestro país, vería con mucho agrado que el CEPEP les ayude con su decisión de dedicarse A LA SALUD de la familia paraguaya antes que A SU LIMITACION numérica.

El convencimiento del CEPEP — ¿ convencimiento?— de que "cuanto más pocos, seremos mejores" nos parece una formulación demasiado simple ante una cuestión tan importante como la demografía. De todas maneras la otra cuestión — somos pocos y tenemos que ser más— es igualmente simplista. Esto nos conduce a la necesidad de tener un estudio acabado, científica y honestamente hecho, para que después, y solamente después, el Estado Paraguayo decida sobre este asunto.

Alcibiades González Delvalle

OPINIONES

En busca

En los últimos días todos los
cardenales de todo el mund...
próximo encierro "cum clavi"
Pero, al mismo tiempo, de la
diversas informaciones en torno
peculaciones sobre los candidat
propia Iglesia, pasando por las
entienden que conlleva la elecci
formación vaticana, resaltamos
la atención.

El cardenal Leo Suenens, pri
tonantes declaraciones sobre la
Iglesia. El primado belga —
buenos dolores a la Iglesia —
especie de Senado, que esta
colegiada. La proposición, en
Iglesia, resulta magnífica, pe
limitados. La información no
las características mismas de l
dogma, por su origen de inspir
las discusiones humanas. En
cial. En otros campos, en car
realidad, ya ha comenzado en
darse y con acierto. Un buen
administrativa, cuyos mane
secreto. ¿Por qué no debería
criterio de las cuentas claras?
puede ahondarse la democrat
dogma, la Iglesia debe adecua
vida— que en un comienzo ex
través de sus más autorizad
con la dignidad del hombre.

Monseñor Lefebvre —
cambiar el rumbo de la barca
desaprovechó la ocasión de
no aceptará al nuevo Papa.
que en su elección no parti
pasado los 80 años de edad,
tini. Como se recordará, éste
dio muestras de gran pacien
viaciones del francés. Quizás
que la muerte le sobrevino a
un cardenal norteamericano
pondrá a Lefebvre fuera de la

Mientras el obispo de Ecô
un miembro del sector inte
enviado suyo— buscaba e
grandes electores. ¿Qué
tores afines del cuerpo cardi
Lefebvre? ¿O pretende una
Muchas otras informac
la elección del nuevo Pedro
aspectos más variados. Y
de una institución que es
existencia se acerca ya a los

Moder... del Fe...

Nuevamente no fueron
fijada, los estudios de fact
tro sistema ferroviario. Y
más, para contar con dich
acuerdo firmado entre los
abril del año pasado. Tal vez
correspondientes análisis
seguir respecto al proyecto
Durante la última vis
cionarios superiores de
lugar a principios del pres
los documentos para el
propio presidente del Dir
López" hizo los anuncios
los estudios y nos queda
nuevo anuncio.

Los primeros contactos
autoridades ferroviarias
capital en noviembre
tunidad fueron entrega
boración de los document

Rincón filatélico

[illegible]

ACTION: PO

INFO:
DIR
ASST DIR
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~~ADM~~
ADM
CHRON

Annex 3

TELEGRAM

UNCLASSIFIED STATE 197334

Classification

8/19/77

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FM SECSTATE WASHDC
TO AMEMBASSY ASUNCION 5564
BT
UNCLAS STATE 197334

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AIDAC

E.O. 11652: N/A

TAGS:

SUBJECT: POPULATION PID 526W305

1. SUBSEQUENT TO LA BUREAU REVIEW, PHA/POP HELD A TECHNICAL PID REVIEW ON AUGUST 10 FOR PROJECT 0305. THE PID WAS AGREED TO WITH TWO (2) RESERVATIONS. THESE RESERVATIONS MUST BE TAKEN INTO CONSIDERATION WHEN PREPARING THE PROJECT PAPER (PP), DUE IN JUNE OF 1978.

2. THE GOP MUST INCREASE THEIR REAL CONTRIBUTION TO AT LEAST 25 PERCENT OF THE TOTAL COST OF THE PROJECT. THIS DOES NOT HAVE TO BE IN THE FORM OF GUARANI'S OR DOLLARS, BUT THEY MUST BE IN A FORM THAT SHOWS GENUINE COMMITMENT ON THE PART OF THE GOP. IF THIS COMMITMENT IS NOT CLEARLY EXPRESSED AND DEMONSTRATED IN THE PP, WE HAVE STRONG INDICATIONS THAT THE PP WILL NOT BE APPROVED.

3. ALTERNATIVE APPROACHES THAT WILL INVOLVE THE GOP AND IMPROVE THE ACTUAL DELIVERY OF SERVICES TO THE POOR NEED TO BE EXPLORED. TO PROPOSE A CONTINUATION OF THE SAME APPROACH WITH THE VAGUE EXPRESSION OF INCREASED SUPPORT FROM THE GOP WILL MAKE PP APPROVAL DIFFICULT, AT THE VERY LEAST. NEW METHODS FOR THE EXPANDED DELIVERY OF SERVICES AND ADDITIONAL ORGANIZATIONS THAT WILL SUPPORT FAMILY PLANNING WILL BE USEFUL TO INCLUDE IN THE PP. IT IS ANTICIPATED THAT THE RESULTS OF THE CURRENT RESEARCH AND PREVALENCE SURVEYS WILL PROVIDE SUPPORTIVE DATA THAT WILL STRENGTHEN YOUR PP. VANCE

UNCLASSIFIED

Classification

50161-101

OPTIONAL FORM 161
(Formerly FS-161)
January 1973
Dept. of State

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IDENTIFICATION DOCUMENT FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete)

PID

2. DOCUMENT CODE

3. COUNTRY/ENTITY: PARAGUAY

4. DOCUMENT REVISION NUMBER

5. PROJECT NUMBER (7 DIGITS): 526-0305

6. BUREAU/OFFICE: A. SYMBOL: LA; B. CODE: 05

7. PROJECT TITLE (MAXIMUM 40 CHARACTERS): Population II

8. PROPOSED NEXT DOCUMENT: A. 2 (2 = PRP, 3 = PP); B. DATE: MM 12, YY 77

9. ESTIMATED FY OF AUTHORIZATION/OBLIGATION: a. INITIAL FY 79; b. FINAL FY 81

10. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 = ₲ 126)

FUNDING SOURCE	[illegible]
A. AID APPROPRIATED	2,500
B. OTHER U.S. 1.	
B. OTHER U.S. 2.	
C. HOST COUNTRY	2,000
D. OTHER DONOR(S)	
TOTAL	2,500

11. PROPOSED BUDGET AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. FIRST FY 79 F. GRANT	E. FIRST FY 79 G. LOAN	LIFE OF PROJECT H. GRANT	LIFE OF PROJECT I. LOAN
(1) PH	[illegible]	440		550		2,500	
(2)							
(3)							
(4)							
			TOTAL	550		2,500	

12. SECONDARY TECHNICAL CODES (maximum six codes of three positions each)

450 | 410

13. SPECIAL CONCERNS CODES (MAXIMUM SIX CODES OF FOUR POSITIONS EACH)

BRW | RPOP | DEL

14. ECONOMIC AND POLICY DATA SHEET: -23

15. PROJECT GOAL (MAXIMUM 240 CHARACTERS)

To reduce the national fertility rate.

16. PROJECT PURPOSE (MAXIMUM 480 CHARACTERS)

To expand the availability and use of family planning services.

17. PLANNING RESOURCE REQUIREMENTS (staff/funds)

Any resources required for the PP can be provided by AID/Washington at no cost; these resources will be identified at the PRP stage.

18. ORIGINATING OFFICE CLEARANCE

Signature

Title

Date Signed: MM DD YY

19. Date Document Received in AID/W, or for AID/W Documents, Date of Distribution: MM DD YY

AID 1330-2 (9-76)

POPULATION II 526-0305

I. Summary of the Problem to be Addressed and Proposed Response

Although Paraguay contains only 2.7 million inhabitants, and its population density of six inhabitants per square kilometer is among the world's lowest, the annual rate of population growth is estimated to be as high as 3%. If present trends in population growth continue, the number of inhabitants will double in 23 years. The full implications of Paraguay's rate of population growth on the country's development prospects are difficult to assess because the inadequacy of the demographic data base precludes precise measurement of the problem. According to GOP estimates, the crude birth rate is thought to be 39 per 1,000 population, and the crude death rate, 9 per 1,000 population.

Weaknesses in reporting vital events are compounded by substantial internal migration, emigration of Paraguayans to neighboring countries and immigration of Brazilians to Paraguayan territory bordering Brazil. Migration data are notoriously incomplete, due to inadequate registration of migrants and illegal border crossings. During the last decade, an average of 20,000 Paraguayans per year are thought to have migrated to Argentina, although this outflow undoubtedly has been reduced by the combination of better economic prospects at home and worsened prospects in Argentina. On the immigration side, there has been a substantial influx of unauthorized Brazilian settlers in the past few years. USAID assumes that the loss of population through international migration has been greatly reduced, and that Paraguay is growing more rapidly than in previous years despite a modest reduction in fertility.

Paraguayans who are born in 1977 will not be productive citizens until the 1990's. In the meantime the GOP will have to invest scarce budgetary resources to provide the young with the social services necessary to prepare them for productive roles in society. Forty-five percent of all Paraguayans are estimated to be children under 15 years of age who consume resources which could otherwise be invested in development programs designed to improve the future well-being of the population.

USAID has assisted population activities in Paraguay since FY 1969. In 1972 a Department of Family Protection (DEFROFA) was created within the Ministry of Health to deliver family planning services within established health facilities of the MOH health network. From the outset DEFROFA's central administration was highly dependent on USAID funding, while the MOH counterpart contributions for delivery of services at the clinic level have increased steadily. A large

expansion of family planning services is planned for 1977. DEPROFA provided services in 43 MOH facilities at the end of 1976 with a reported 35,000 active contraceptive users. It plans during 1977 to extend services to an additional 220 health centers and health posts serving dispersed rural communities. In addition, pilot activities in household distribution of contraceptives and community-based distribution of information and services are to be developed in 1977.

Prior to 1977, family planning services were available through only 15% of the MOH health facilities. Patients were required to travel great distances to a clinic where they often waited many hours to see a physician; a physical examination was required and clients had to return periodically for resupply of contraceptives. The 1977 DEPROFA Program, which provides for extension of clinical services to health facilities in dispersed rural communities, increased use of health auxiliaries operating outside of fixed health posts and non-clinical distribution of contraceptives, promises to improve these conditions by extending the limited outreach of family planning services. The key to reduction of unwanted fertility in Paraguay is widespread availability of family planning information and services. As preliminary returns from the 1977 Contraceptive Prevalence Survey indicate, knowledge and use of contraceptives are greatest in localities where family planning services are most available.

The Mission proposes a project which will assist the GOP to develop a national population program designed to reduce the national fertility rate. The principal focus of the proposed Project will be on assisting the Ministry of Health to increase the availability of family planning services. A secondary effort will be directed toward overcoming limited host-country awareness and understanding of population issues. The first objective will be achieved by assisting the MOH to develop:

1. Greater reliance on auxiliaries and community-based distribution of information and services.

2. In-service training courses for clinical and non-clinical personnel to teach the new approaches.

3. A comprehensive logistics system to manage clinical and non-clinical distribution of contraceptives.

4. Simplified clinical and non-clinical contraceptive acceptor record systems which permit accurate calculations of contraceptive prevalence.

5. Evaluation techniques to measure impact of program components and cost effectiveness.

The uncertainty of GOP funding for DEPROFA makes it unclear

whether USAID will continue to work with DEPROFA or with another entity of the MOH. Although the GOP has been reluctant to increase its budget support for DEPROFA itself, counterpart contributions in support of family planning services have been satisfactory. USAID is confident that the MOH intends to provide family planning services throughout its network of health facilities, regardless of the fate of the DEPROFA central office, and we are prepared to work with whatever entity to which the MOH assigns responsibility for family-planning activities.

Availability of family planning services is the key to reduction of fertility and will be given the highest priority within the population sector. However, there are constraints to the effective delivery of contraceptives which can be reduced by non-service activities within the sector. One of these constraints, as identified in the revised DAP, is a general lack of understanding at all levels of society of the effects of rapid population growth. Although family planning is an acceptable health service, demographic factors and consequences are ignored. There is neither a GOP policy on population growth, nor are there official demographic targets. Development planners evidence no concern that rapid population growth may well be undermining their development programs.

To overcome limited host country awareness and understanding of population issues, the Mission proposes to undertake a modest program of research and information diffusion. PHA/POP will be requested to provide consultants to help USAID develop activities such as social science research on the determinants of fertility, population policy formulation, population education, demographic surveys and Information, Education and Communication (IEC) campaigns. One potentially useful study now under consideration is PHA/POP-funded research on women in rural Paraguay, to be conducted during 1977-78, which will provide information on fertility, child mortality, migration and socio-economic conditions. Potential counterpart organizations for research and information-diffusion activities include the General Directorate of Statistics and Census, the Technical Planning Secretariat and the Paraguayan Center for Sociological Studies.

Major assumptions affecting the Project include the following:

1. The MOH will continue to implement an active family planning program with or without the maintenance of DEPROFA in its present form.

2. No other donor plans similar assistance.

3. Qualified consultants are available to work with the project.

Other donor activity in the population sector is supportive of the Mission's objectives without being duplicative. IPPF provides more than $300,000 per year to its Paraguayan affiliate, CEPEP. UNFPA and UNICEF currently are providing $83,000 for a pilot integrated health/family planning project; Pathfinder Fund supports the incorporation of family planning into the Medical Faculty curriculum and a pilot rural community-based family planning activity. Development Associates funds training courses with emphasis on paramedicals, and the Program for International Education in Gynecology and Obstetrics (PIEGO) is training physicians in advanced techniques of fertility control.

There appear to be two alternatives to the proposed Project. The first is to provide increased assistance to the GOP through centrally-funded FHA/POP population intermediaries. However, there is already significant intermediary activity in Paraguay, and it is doubtful that intermediaries could expand their programs to cover all the elements of the Project. The Mission believes that the proposed Project offers distinct advantages in terms of management efficiency and cost effectiveness. In addition, the MOH prefers to receive bilateral assistance through USAID. The second alternative is to develop an integrated rural health project with the Ministry of Health. The Mission plans to undertake a Health Sector Assessment in FY 1978, and until priorities for health assistance are established, we are unable to consider development of an integrated project. At the present time neither of the two alternatives seems preferable to the proposed Project.

The Project's primary beneficiaries will be low-income women in rural Paraguay and, secondarily, their children.

II. Financial Requirements and Plans

The Mission estimates that the total project will cost $2,500,000 over a three-year period, of which $1,500,000 would be A.I.D. grant funds, including AID/W central procurement of contraceptives; $1,000,000 would be a cash and in-kind contribution from the GOP.

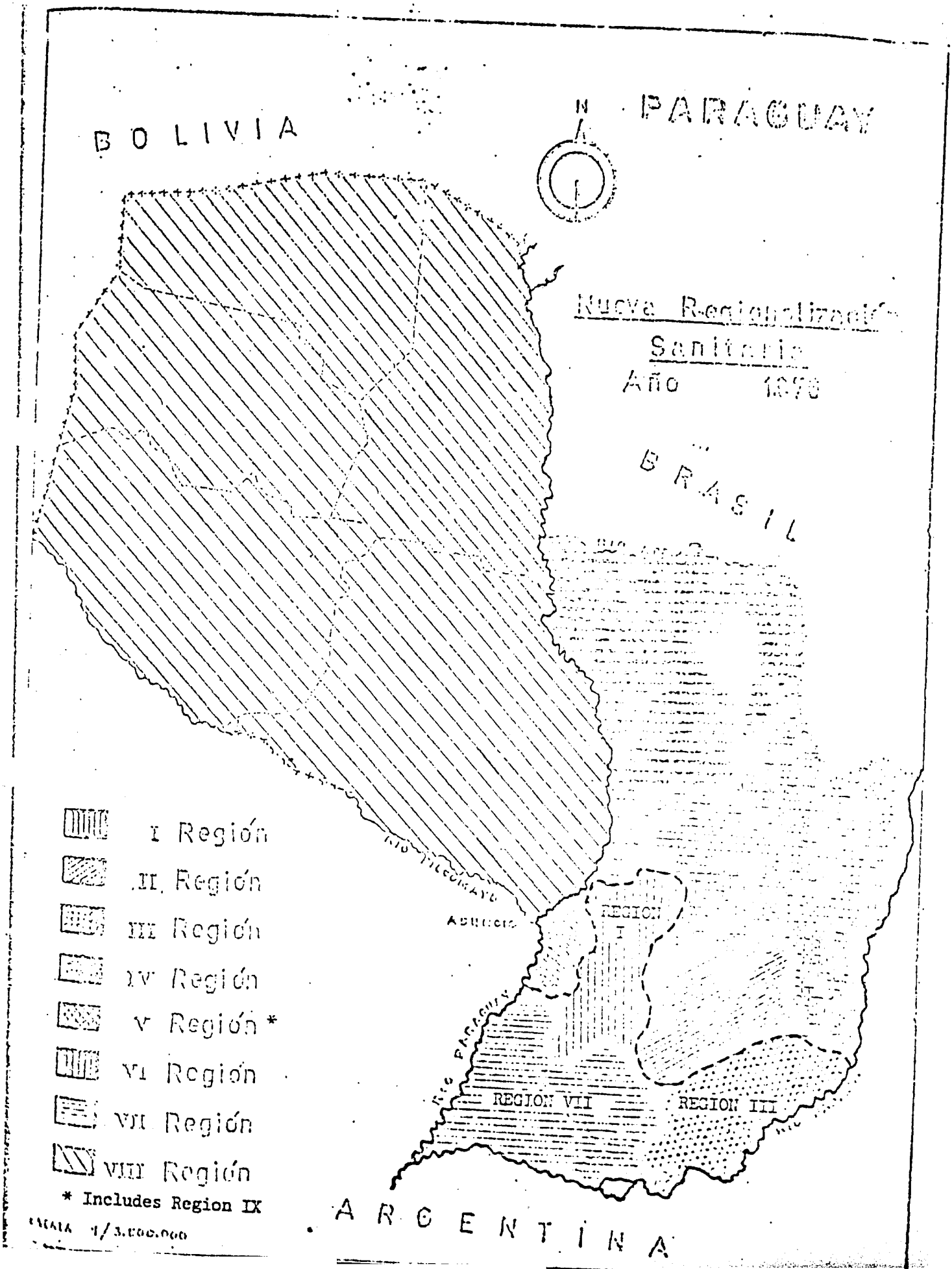
It is estimated that the A.I.D. funding would be utilized as follows ($000s):

	FY 79	FY 80	FY 81
Eighteen months of contract technical specialists	30	30	35
Contraceptives	180	170	195
Medical equipment and supplies	30	20	15
Clinic equipment and vehicles	60	40	50
Local training, supervision and evaluation	250	240	155
	550	500	450

The GOP contribution would cover Project operational and support costs, such as local salaries, physical facilities, local travel, vehicle operation and maintenance, and office supplies.

III. Development of the Project

The Mission Population Office will play the principal role in developing project documentation. In July 1977 DEPROFA will begin the elaboration of a plan to cover its activities during the period 1979-1982. A comprehensive evaluation of population activities and of the proposed DEPROFA plan is to be undertaken by consultants furnished by A.I.D. before preparation of the PRP which is to be submitted in December 1977. It is anticipated that any assistance required in the preparation of the Project Paper, scheduled for submission toward the latter part of FY 1978, will be provided at no cost by AID/Washington either directly or through centrally-funded contract resources.


BOLIVIA
PARAGUAY
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Nueva Regionalización Sanitaria
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BRASIL
I Región
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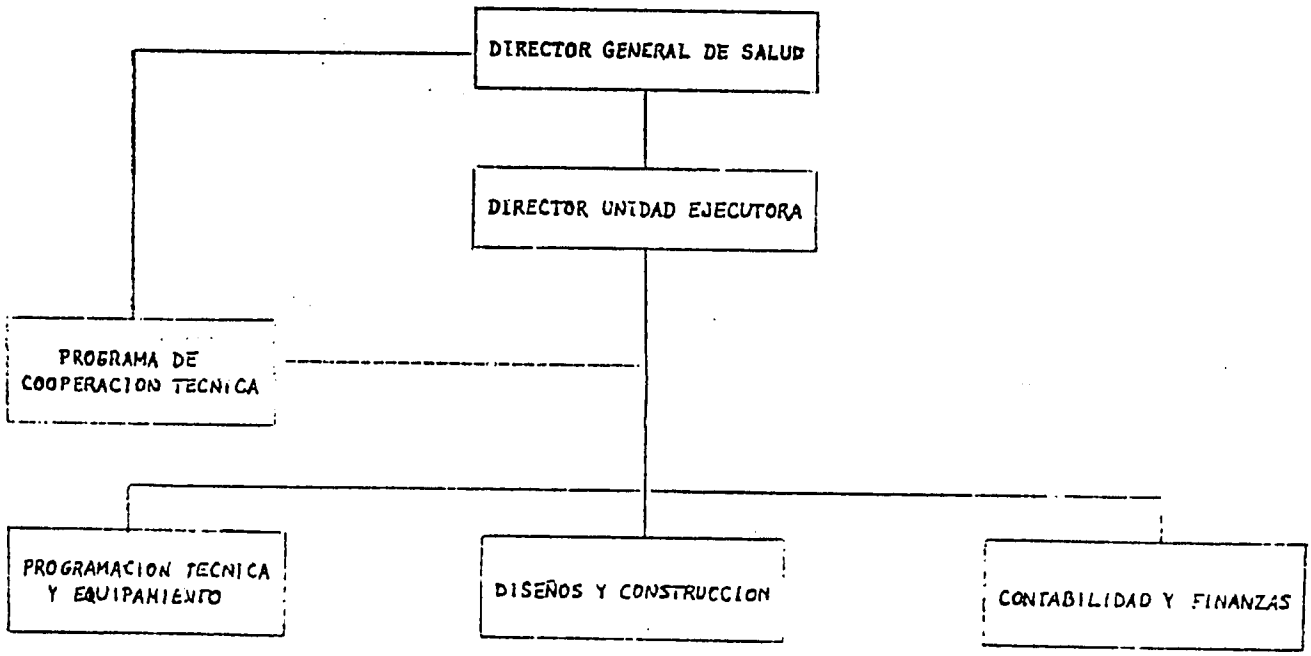
ARGENTINA

UNIDAD EJECUTORA - ORGANIGRAMA



5C(2) - PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a sub-category for criteria applicable only to loans); and Security Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b)

   (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure plus 10%)?

   (a) and (b) This project was part of the Congressional Presentation.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

   2. (a) and (b) Yes.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

   3. No further legislative action is required.

4. FAA Sec. 611(b); Appr. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)?

   4. Not applicable.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

   5. Not applicable.

A.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?

6. Project is not susceptible of execution as part of a regional or multilateral project. It is not expected that this project will encourage regional development programs since it is designed to promote the development of areas wholly within Paraguay.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

7. Not applicable.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

8. Goods and services will be procured in the U.S. The private sector will provide the project commodities to be procured in the U.S. Private firms will be considered as a source of consultant services.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

9. Paraguay is contributing approximately $3.9 million in local currency to the project.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

10. No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

a. The project will create a cadre of Voluntary Health Collaborators. The VHCs will be members of rural communities, and the activity will directly involve the rural poor in the improvement of health conditions in rural communities. The project will assist the MSPyBS to extend the coverage of public health services to the rural poor through the use of community volunteers. The activity will improve the health and wellbeing of actual and potential cooperative members, but will not develop cooperatives.

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(1) [103] For nutrition within the context of an integrated delivery system for health, family planning and nutrition services. It is not designed to directly increase agricultural productivity.

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

(2) [104] The activity is for population planning and health and is designed to extend a low-cost integrated delivery system to provide health and family planning services to the rural poor.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(3) [105] Not applicable.

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(b) to help alleviate energy problem;

(c) research into, and evaluation of, economic development processes and techniques;

(d) reconstruction after natural or manmade disaster;

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

(4) [106] Not applicable.

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(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

(5) [107] Not applicable.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

c. Yes, Paraguay will contribute approximately $3.9 million to the project. This greatly exceeds 25% of the costs of the project.

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

d. No.

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

e. The project will contribute directly to the objectives reflected in items (1), (3), (4), (5). and (6).

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

f. The rural population of Paraguay needs and desires primary health care including family planning. Community members have volunteered to be health collaborators and have demonstrated high capability in their activities. Through training and consultant services MSPyBS personnel and VHCs will undertake institutional improvements to the MSPyBS delivery system for rural health services. The VHCs who participate in the project will be trained to deliver basic health services in the rural areas where such services are not currently available.

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g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

2. Development Assistance Project Criteria (Loans only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds $100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

g. The project gives reasonable promise of contributing to the development of low-cost, integrated public health services through the MSPyBS. The project is related to and consistent with similar projects to be undertaken by other donors in other Health Regions of Paraguay. The project is designed to improve the long-range health and wellbeing of Paraguay's rural poor. The project paper provides information and conclusion on the project's economic and technical soundness.

h. Approximately 75% of U.S. project funds will be spent in the U.S. to obtain U.S. goods and services. The effect on the U.S. balance of payments will be minimal and may be beneficial in the future if the GOP decides to obtain U.S. goods and services with its own resources.

2. Not applicable.

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

3. Project Criteria Solely for Security Supporting Assistance

FAA Sec. 531. How will this assistance support promote economic or political stability?

3. Not applicable.

AID 1020-29 (7-71)
SUPPLEMENT 1

Annex 8

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.)

Project Title & Number: POPULATION II 526-0305

Life of Project:
From FY 1979 to FY 1981
Total U.S. Funding $1,013,000
Date Prepared: March 1979

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: To improve the health and wellbeing of poor Paraguayan families.	Measures of Goal Achievement: In Health Regions I, III, and VII: 1. Decrease in infant mortality; 2. Decrease in maternal mortality 3. Decrease in incidence of gastroenteric and parasitic disease; 4. Increase in intervals between births; 5. Decrease in number of pregnancies to women under 20 or over 34 years of age; 6. Decrease in number of births of fourth or higher order; 7. Decrease in number of abortion reported; 8. Increase in number of consultations at Health Centers/Posts.	1-7 Project sample survey. 8 Health Center/Post records.	Assumptions for achieving goal targets: 1. Increased participation in family planning programs will result in decreased maternal morbidity/mortality, decreased infant morbidity/mortality, and decreased induced abortion. 2. Expansion of organized family planning services will be accompanied by increased use of contraceptives from the commercial sector. 3. The medicaments to be purchased by USAID will be available on a timely basis. 4. GOP policies do not discourage the expansion of family planning services. 5. Effective opposition to family planning does not develop.

AID 1020-25 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: POPULATION II 526-0305

Life of Project:
From FY 1979 to FY 1981
Total U.S. Funding $1,013,000
Date Prepared: March 1979

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: To expand the availability and use of family planning services.	Conditions that will indicate purpose has been achieved: End of project status. a. 10% of women in fertile age in Health Regions I, VII, and III, are using FP services through MSPyBS programs. b. 1,000 Voluntary Health Collaborators trained and functioning as follows: 1) 1st Health Region: 400; 2) 7th Health Region: 300; 3) 3rd Health Region: 300. c. Regional Training/Supervision Teams functioning in the 1st, 7th, and 3rd Health Regions. d. A total of 300 Health Center/Post Personnel trained in FP methods and actively performing as follows: 1) 1st Health Region: 200; 2) 7th Health Region: 60; 3) 3rd Health Region: 80. e. Total Number of Active FP users in all MSPyBS Health Regions at year's end: 1979: 40,000 1980: 45,000 1981: 55,000	a. Health Center/Post records; contraceptive prevalence survey. b. Project records and site visits. c. Project records and site visits. d. Project records and site visits. e. Clinic and supply records; contraceptive prevalence survey.	Assumptions for achieving purpose: 1. Supervisory personnel will distribute contraceptives outside of clinics. 2. MSPyBS personnel will be available for training and employment. 3. Community members will volunteer to be VHCs. 4. The Regional Training/Supervision Teams will train replacements for Health Center/Post personnel who leave the project. 5. The Health Center/Post Personnel who supervise VHCs will recruit and train replacements for VHCs who leave the project. 6. The MSPyBS continues to expand family planning services in all Health Regions.

AID 1020-25 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1979 to FY 1981
Total U.S. Funding $1,013,000
Date Prepared: March 1979

Project Title & Number: POPULATION II 526-0305

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS Magnitude of Outputs:			MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS Assumptions for achieving outputs:
Outputs:	Year 1	Year 2	Year 3		
1. Training - Person Days				Project Records and site visits.	1-4 MSPyBS budget is adequate to allow for expansion of the program.
a. Regional Training/Supervision Team: 1st Health Region	60	-	-		1-2 Consultants are available to assist in the design, implementation, and evaluation of the proposed activities.
7th Health Region	-	60	-		
3rd Health Region	-	-	60		
b. Health Center/Post Personnel: 1st Health Region	2,000	-	-		3 VHCs actively inform community members about health benefits of family planning.
7th Health Region	-	800	-		
3rd Health Region	-	-	800		
c. Voluntary Health Collaborators: 1st Health Region	1,000	3.000	-		4 MSPyBS conclusion that VHCs can treat two patients daily is realistic.
7th Health Region	-	1,500	1,500		
3rd Health Region	-	-	3.000		
TOTAL	3,060	5,360	5,360		
2. Supervision - Person Days					
a. Regional Training/Supervision Team: 1st Health Region	120	300	300		
7th Health Region	-	120	300		
3rd Health Region	-	-	210		
b. Health Center/Post Personnel 1st Health Region	980	2,450	2,450		
7th Health Region	-	600	1,500		
3rd Health Region	-	-	1,050		
TOTAL	1,100	3,470	5,810		
(Cont.)					

AID 1020-25 (7-71)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 1979 to FY 1981
Total U.S. Funding $1,013,000
Date Prepared: March 1979

Project Title & Number: POPULATION II 526-0305

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS Magnitude of Outputs:			MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS Assumptions for achieving outputs:
Outputs:	Year 1	Year 2	Year 3		
(Cont.)					
3. New Family Planning Acceptors:					
1st Health Region	1,500	2,000	2,500		
7th Health Region	-	1,500	2,000		
3rd Health Region	-	-	1,500		
4. VHC Health Consultations:					
1st Health Region	100,000	275,000	290,000		
7th Health Region	-	80,000	210,000		
3rd Health Region	-	-	60,000		

AID 1020-23 (7-71)
SUPPLEMENT I

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: POPULATION II 526-0305

Life of Project:
From FY 1979 to FY 1981
Total U. S. Funding $1,013,000
Date Prepared: March 1979

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS — Implementation Target (Type and Quantity) CY 1979	CY 1980	CY 1981	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs:					Assumptions for providing inputs:
1. USAID				1. Financial Records at USAID.	1. The Host Country Contribution to Health Regions I, VII, and III will be provided at the levels budgeted for 1979 or higher levels.
a. Personnel/Consultants	28,000	38,000	16,000	2. Financial Records at MSPyBS.	
b. Commodities	330,000	169,000	181,000		
c. Other Costs					
1) Training	36,847	36,619	42,470		
2) Supervision	5,980	18,660	32,030		
3) Research Surveys	20,000	-	20,000		
4) Local Purchase	24,173	5,721	8,500		
TOTAL	445,000	268,000	300,000		
2. MSPyBS					
a. 1st Health Region	796,000	796,000	796,000		
b. 7th Health Region	-	568,000	568,000		
c. 3rd Health Region	-	-	424,000		
TOTAL	796,000	1,364,000	1,788,000		