

Contraceptive Security in Paraguay: Assessing Strengths and Weaknesses

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USAID/LAC/RSD-PHN
Regional Contraceptive Security Feasibility Study

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Abbreviations

| | |
|----------|--|
| CAFAPAR | Paraguay's Pharmacy Association |
| CEPEP | Paraguay's Center for Population Studies |
| CS | Contraceptive security |
| FP | Family planning |
| GDP | Gross domestic product |
| IMI | Commodity Movement Report |
| IPPF | International Planned Parenthood Federation |
| IPS | Social Security Institute |
| IUD | Intrauterine device |
| LAC | Latin America and the Caribbean |
| MSP y BS | Ministry of Public Health and Well-Being |
| NGO | Nongovernmental organization |
| PAHO | Pan American Health Organization |
| PNSSR | National Sexual and Reproductive Health Plan |
| PROMESA | Social Marketing NGO |
| SPARHCS | Strategic Pathways to Reproductive Health Commodity Security |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |

The results of the contraceptive security (CS) assessment conducted in Paraguay in March 2004 show that although there are still many challenges to be faced, the Paraguayan government is well-positioned to achieve contraceptive security. One of the key challenges has been the changing political climate for family planning (FP) since the public health system started providing FP services in the 1970s. Fortunately, today the political environment and commitment to family planning are strong among national leaders, and Paraguay has completed many “firsts” on the path to contraceptive security. In 2003, President Nicanor Duarte Frutos took office, and under his administration, political support for family planning has continued. The new Minister of Health approved the National Plan for Sexual and Reproductive Health for 2003–2008, which clearly identifies family planning as a priority.

The Paraguayan population’s growing demand and use of contraceptives is clearly a positive trend. However, high unmet need, particularly among the poor, is a serious concern. Donor investments in family planning during the 1990s produced rapid increases in overall contraceptive prevalence and equally rapid reductions in total fertility. Between 1990 and 1998, contraceptive prevalence (all methods, women in union) increased from 44 percent to 57 percent, while total fertility fell from 4.6 to 4.3 births per woman. In 1998, Paraguay’s unmet need for family planning was 17 percent among all women in union and as high as 60 percent among women in the two lowest income quintiles. Despite this fact, no official strategies are in place by the Ministry of Public Health and Well-Being (MSP y BS) to target FP services to those most in need, and while the MSP y BS infrastructure is strong, stockouts appear to be an issue affecting access to FP services.

The strong role of the private sector in the segmentation of the Paraguayan FP market is a clear advantage for contraceptive security. In 1998, the private sector accounted for 60 percent of the market, with pharmacies serving 43 percent of contraceptive users. Paraguay’s pharmacies include commercial and social marketing brands that span a wide price range, making them affordable to most consumers. In 1998, the MSP y BS had 27 percent of the contraceptive market share, providing free contraceptives to its clients, but charging a small fee for the consultation. The relatively large role of the private sector should make it easier for the MSP y BS to target its resources to those with unmet need.

There are important advancements as well as major challenges in terms of financing of contraceptives. In 2002, for the first time in Paraguay, the MSP y BS established a line item in its budget for reproductive health service, and this line item included an earmark for contraceptives. However,

although this line item was approved by Congress, due to a serious budget deficit, the budget has never been fully funded. MSP y BS funding and purchasing of contraceptives in future years will need to increase rapidly to meet growing contraceptive requirements, particularly in the face of USAID phaseout, anticipated within the next five years, and low levels of United Nations Population Fund (UNFPA) funding in Paraguay.

Overall, the MSP y BS has little experience in procuring contraceptives and will have to strengthen its contraceptive procurement skills. However, MSP y BS does have experience procuring non-contraceptive drugs and supplies for vertical programs such as those for tuberculosis and malaria. Paraguay's procurement laws appear to be relatively flexible, giving the MSP y BS several alternatives for contraceptive procurement.

Paraguay's contraceptive logistics system is centralized within the MSP y BS, and staff appears to be well trained in using the appropriate logistics management instruments. The logistics system does show, however, a breakdown in coordination and information use at the central level, translating into inadequate supplies being sent out, and ultimately resulting in stockouts. There is a need to improve coordination and use of information among different MSP y BS offices and programs at the central level. This also contributes to the fact that MSP y BS has consistently requested insufficient quantities of contraceptives from UNFPA, which then are supplemented by emergency procurements from USAID. Despite the seemingly heavy reliance on donors for contraceptive supplies, the actual value of contraceptives donated to Paraguay by donors in a single year has never exceeded \$500,000, suggesting that it may be feasible for the Paraguayan government to replace these subsidies in the near future.

Within the Latin America and Caribbean (LAC) region, contraceptive security has become an increasingly important issue. While USAID and many other international donors have supported family planning for more than three decades, donor investment is now declining, and contraceptive donations have been or are being phased out in many LAC countries. At the same time, the demand for contraceptives continues to grow as the region's predominantly young population passes through its reproductive years.

It is in this climate that USAID and UNFPA country offices are working with host governments and NGO recipients to address contraceptive security. To support these efforts, USAID's Bureau for Latin America and the Caribbean (LAC/RSD-PHN) conducted a regional contraceptive security assessment to guide future policy and programmatic decisions at the regional and country levels. USAID's DELIVER and POLICY II projects implemented the assessment in Bolivia, Honduras, Nicaragua, Paraguay, and Peru. The assessment was designed to address the following issues:

- What are the priority CS issues shared by most USAID-assisted countries in the LAC region?
- What are the most promising regional interventions to address these issues?
- How should future regional assistance be structured to maximize benefits?
- What are the national-level issues that should continue to be dealt with in-country, and why are they not appropriate for "regionalization"?

These activities were initiated in July 2003 during a regional CS conference in Nicaragua designed to raise awareness about contraceptive security and stimulate dialogue. During this meeting, representatives from each participating country formed a Contraceptive Security Committee designed to take the lead on CS issues and serve as a liaison in the CS assessment in those countries that formed part of the regional study. The CS assessment was conducted in Paraguay in March 2004.

Paraguay's population of 5.9 million is predominantly urban, with 57 percent living in towns and cities. Approximately 57 percent of the population in Paraguay lives in poverty. Women of reproductive age constitute 25 percent or 1.46 million of the population. Despite a weak economy, the government's spending on health increased during the late 1990s and, as a result, health and FP indicators improved. However, this positive trend ended in 2000, and between 2000 and 2001, government health spending declined. If this trend continues, it is likely to have a negative impact on the government's ability to maintain and increase its spending on family planning.

Paraguay's public health system has provided FP services since the 1970s. Although the FP program has had a checkered history over the past 30 years, today the political environment and commitment to family planning are strong among national leaders. In 1979, the Paraguayan government suspended the provision of contraceptive methods to its population. For nine years, the national FP program consisted only of educational efforts and promotion of the Billings method. Nongovernmental organizations (NGOs), such as Paraguay's Center for Population Studies (CEPEP), Paraguay's International Planned Parenthood Federation (IPPF) affiliate, continued to provide modern methods during this period. Given their small scale, however, they were unable to achieve national coverage.

In 1988, the MSP y BS created the National Program of Maternal and Infant Care, which reestablished the provision of FP services. From 1988 to date, international organizations such as UNFPA, Pan American Health Organization (PAHO), and USAID, through various projects and endeavors, have actively supported services related to reproductive health, including family planning, pre- and postnatal care, institutional delivery, and reproductive cancers. Through their efforts, and particularly with contraceptive donations from UNFPA and USAID, FP services have been incorporated into all MSP y BS establishments.

In 1998, following the inauguration of a conservative government, public sector efforts in family planning were suspended again. However, the government and the hostile environment lasted only seven months, at the end of which FP programs were reinstated, and support for family planning has continued since. In 2003, President Nicanor Duarte Frutos took office, and political support for family planning continued on the upswing. The new Minister of Health approved the National Plan for Sexual and Reproductive Health 2003–2008, which identifies family planning as a priority.

Family Planning Services in Paraguay

The Paraguayan government provides contraceptives and condoms to the population through the MSP y BS, the Social Security Institute (IPS), the armed forces, national police, and the National University of Asunción. In contrast to other countries in Latin America where the Ministry of Health plays a dominant role, in 1998 the MSP y BS was serving only 27 percent of all FP users. The IPS covers 14 percent of the country's population but only 1 percent of contraceptive users. IPS services are available to employees in the formal sector and their dependents, and its health establishments are primarily located in cities and towns. IPS provides contraceptives only in the central IPS hospital in Asunción, and these commodities are received free from the MSP y BS. The armed forces receive most of their contraceptives from UNFPA, whereas the national police and the National University of Asunción receive their contraceptives through the MSP y BS but serve only 2 percent of FP clients.

Pharmacies and pharmacy outlets, which are present in all cities and towns and remote rural areas, constitute the primary source for drugs and medicines in Paraguay, including contraceptives (both socially and commercially marketed). In 1998, pharmacies served 43 percent of all FP clients.

In general, NGOs account for a very small share of Paraguay's FP market, and they cater primarily to the middle-higher end of the market. CEPEP provides services through four directly-owned clinics and seven associated clinics and includes a network of community-based distribution volunteers. Another NGO, PROMESA, implements a social marketing program. PROMESA's main focus is pharmacies, where it markets its products at social marketing prices. Private health providers in Paraguay include private physicians and nurses and privately run clinics and hospitals and, in 1998, accounted for 17 percent of contraceptive provision consisting mainly of IUD insertions.

Until 2001, UNFPA and USAID constituted the only source of contraceptives for the MSP y BS. In 2002 and 2003, they accounted for 90–95 percent of all MSP y BS contraceptive commodities. Currently, UNFPA is the principal donor of contraceptives for the MSP y BS. However, these donations have been insufficient to meet the demand of public sector clients, leading to serious stockouts at facilities. USAID donations to MSP y BS have occurred on an emergency basis when there are shortfalls in supplies. However, in the past few years, these emergency donations have become routine but have still failed to cover total needs. In addition, USAID donated contraceptives to CEPEP until 2003 and continues to supply PROMESA with condoms. USAID also provides condoms for the MSP y BS HIV/AIDS program, whereas UNFPA provides condoms for its FP program. IPPF also provides supplies to CEPEP, providing “in-kind” assistance to its affiliate. Despite the seemingly heavy reliance on donors for contraceptive supplies, the actual value of contraceptives donated to Paraguay by USAID, UNFPA, and IPPF in a single year has never exceeded \$500,000.

Findings from the Contraceptive Security Assessment

The DELIVER/POLICY team used the Strategic Pathways to Reproductive Health Commodity Security (SPARHCS) Framework to guide the assessment. The key findings from each element of the framework are described below.

Environment

Although political support for reproductive health and family planning is strong in Paraguay, economic factors pose a threat to contraceptive security. Since 1995, the country has been facing an economic crisis that has resulted in reduced tax revenues and a growing fiscal deficit. As a result, Paraguay's public sector expenditure on health as a percentage of GDP is declining, negatively impacting the government's funding for reproductive health and family planning.

In 2002, for the first time ever, the MSP y BS budget included a line item for the Sexual and Reproductive Health Program. In the following years, however, the funding allocated and approved for the line item was only a fraction of 2002 levels. More important, due to the growing fiscal deficit, the actual amount of funds transferred in 2003 to the Reproductive Health Program by the Ministry of Finance was only 30 percent of the approved budget. These economic problems do not bode well for contraceptive security efforts.

Furthermore, there is a clear intent to decentralize within the health sector, and some actions are underway. For example, the MSP y BS budget for 2004 has for the first time separate line items for contraceptives at the regional level. It is unclear at this juncture how these funds will be allocated and managed by the health regions, and some decisions on family planning are on the verge of being decentralized. Such reforms, when fully implemented, may weaken the MSP y BS's ability to manage its FP services as funding and program responsibilities are transferred to 18 health regions. All of these factors are beyond the direct control of FP managers, but they must be considered and addressed in order to achieve contraceptive security.

Client Demand and Use

The Paraguayan population's growing demand and use of contraceptives clearly shows a positive trend. However, existence of high unmet need, particularly among the poor, is a serious concern. Donor investments in family planning during the 1990s produced rapid increases in overall contraceptive prevalence and equally rapid reductions in total fertility. Between 1990 and 1998, contraceptive prevalence (all methods, women in union) increased from 44 percent to 57 percent, while total fertility fell from 4.6 to 4.3 births per woman. Use of modern contraceptive methods showed equally dramatic gains, increasing nationally from 35 percent to 47 percent, and jumping from 26 percent to 41 percent in rural areas.

Although Paraguay's upward trend in prevalence is a positive force for contraceptive security, unmet need for family planning continues and will increase as demand for contraceptives rises. In 1998, Paraguay's unmet need was 17 percent among all women in union, and as high as 60 percent among women in the two lowest income quintiles. Despite this fact, there are no official strategies in place by MSP y BS to target FP services to those most in need. Many government facilities, however, do have a social worker in place to identify poor clients and exempt them from paying consultation fees for FP visits.

Paraguay's method mix slightly favors oral contraceptives but overall is evenly distributed among different long- and short-term methods. Condom use doubled between 1990 and 1998. Despite the presence of very high unmet need among the poor, the proportion of women using female sterilization fell between 1990 and 1998. This can probably be attributed to provider bias and fear based on the interpretations of the penal code, which classify a harm to the reproductive system as a punishable crime. Nonetheless, Paraguay is the only country in the region where emergency contraception is accepted by all organizations, including the MSP y BS.

Services

While the MSP y BS infrastructure is strong, stockouts appear to be an issue affecting access to FP services. The MSP y BS provides FP services in all its facilities, which include 17 regional hospitals, 18 district hospitals, 120 health centers, and 634 health posts. Staff at all levels have received FP training. Frequent contraceptive stockouts at these facilities, however, pose a serious barrier to access and quality. A recent rapid assessment of 22 health establishments found that 15–20 percent of those establishments were experiencing stockouts of one or more methods at the time of the visit. IUDs and injectables were most frequently out of stock, but condoms and pills were also affected. Surprisingly, there was also evidence that some methods (Depo-Provera) were in stock in the central warehouse while others (IUDs and pills) had expired in large quantities. The emergency contraceptive, Postinor2, is distributed through the MSP y BS health facilities and faces no opposition from any groups. However, demand at health facilities is low, and there is a significant overstock at all levels.

There clearly seem to be bottlenecks associated with getting products from the central level to the regions in adequate quantities and in a timely manner, indicating problems with the central distribution system. MSP y BS stockouts at public health facilities have led to an increased reliance on pharmacies, even by low-income clients, and have contributed to unmet need and method discontinuation. Other barriers to access also exist. For example, MSP y BS consultation fees for FP visits serve as a deterrent to poor women, particularly because these fees are charged for revisits as well. Anecdotal evidence also suggests that there are provider biases against female sterilization and that young women with low parity are often denied access to this method.

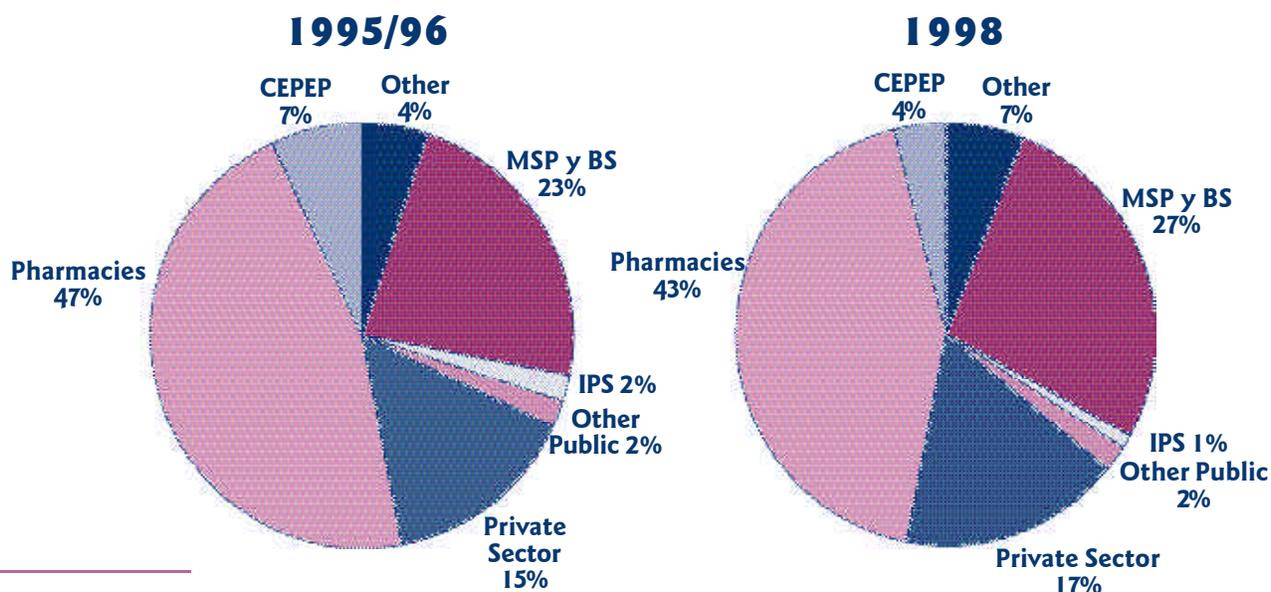
Social pharmacies constitute an innovative approach to providing basic drugs and medicine at affordable lower-than-commercial prices to low-income populations. Currently, in Paraguay, there are 51 social pharmacies operating in the Department of Itapúa. They are financed through rotating funds initiated with seed capital from the regional governments and are sometimes housed within MSP y BS facilities. Contraceptives are available at some of these pharmacies. Expanding the network of social pharmacies to the national level and increasing their role and consistent supply in the contraceptive market is an option that merits further investigation.

Unfortunately, the IPS capacity for providing FP services is also severely limited. The majority of IPS establishments do not have contraceptive commodities to distribute to clients. As a result, IPS only serves 1 percent of FP clients, and the only alternative for IPS beneficiaries is to obtain contraceptives at MSP y BS facilities and pharmacies.

Market Segmentation

Paraguay's contraceptive market is well-segmented, with the private sector playing a predominant role (see Figure 1). In 1998, the private sector accounted for 60 percent of the market, with pharmacies serving 43 percent of contraceptive users. Paraguay's pharmacies include commercial and social marketing brands that span a wide price range, making them affordable to most consumers. In 1998, the MSP y BS had 27 percent of the contraceptive market share, providing free contraceptives to its clients, but charging a small fee for the consultation. In a loose form of targeting, some users may be exempt from the payment if a social worker determines that they are unable to pay.

Figure 1. Changes in Sources of Contraceptives and Condoms



Source: ENSMI, 2 years

The role of private medical practitioners in Paraguay's contraceptive market is largely limited to the insertion of IUDs. Use of the private sector prevails across all income groups, but is significantly higher among the top three quintiles. In the highest income group, 79 percent of users go to the private sector, and only 7 percent rely on the MSP y BS. Even in the poorest quintile, where 52 percent rely on MSP y BS facilities, as many as 40 percent of users relied on pharmacies and private providers. It is also important to note that 19 to 26 percent of middle and upper-middle income clients, many of whom can afford commercial sector prices, rely on the MSP y BS for their contraceptives. Redirecting these clients to the private sector could free up resources so that the MSP y BS could focus on meeting unmet need among the poor.

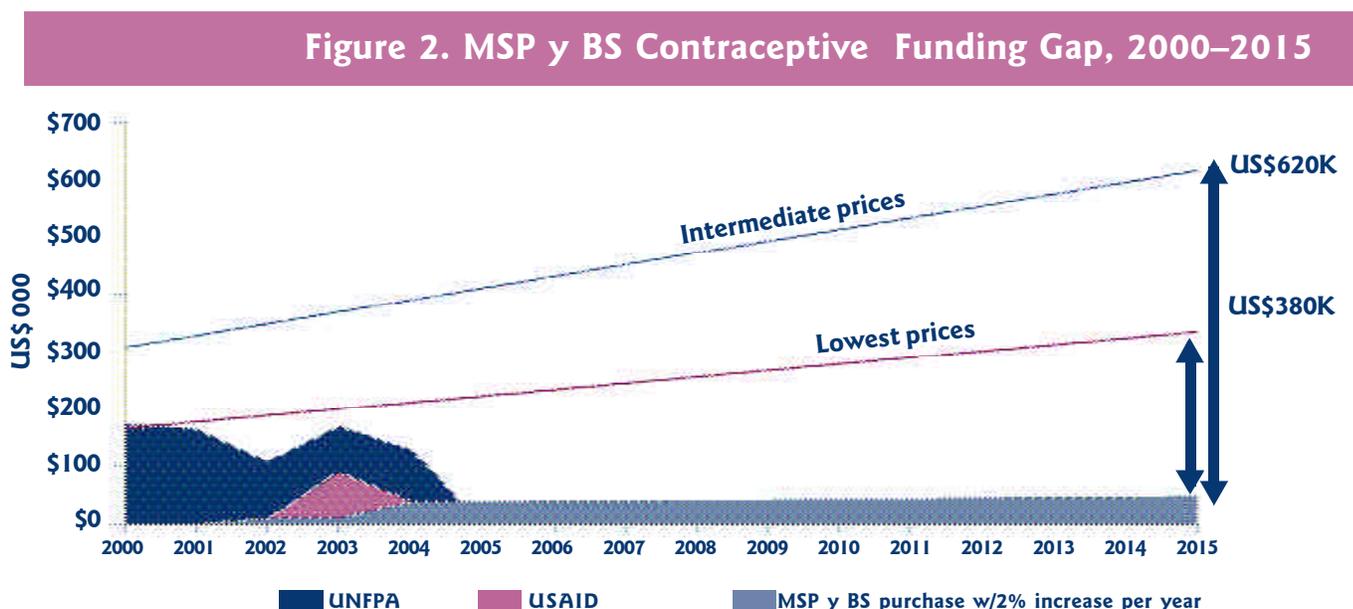
The role of NGOs in Paraguay's contraceptive market is small and is dominated by CEPEP and PROMESA. Both NGOs serve middle to high income groups and have few options for expansion because of sustainability requirements. Their reliance on donor commodities is low.

Financing

Until 2001, UNFPA and USAID were the only sources of contraceptives for the MSP y BS. In 2001, the MSP y BS established a line item in its budget for reproductive health, and under this line item was an earmark for "chemical and medical products," including contraceptives. Although the line item was not fully funded due to fiscal deficits, it provided an opportunity for the MSP y BS to make some initial, albeit small, purchases of contraceptives. In 2002 and 2003, for the first time ever, the MSP y BS purchased contraceptives using its own funds. The purchases amounted to approximately \$10,000 each year and made up 5–10 percent of total MSP y BS contraceptive procurements for those years. MSP y BS funding and purchasing of contraceptives in future years will need to increase rapidly to meet growing contraceptive requirements, particularly in the face of a USAID phaseout, anticipated within the next five years, and low levels of UNFPA funding.

Given current method and source mixes, financial projections show that in 2015, the public sector will need between \$380,000 (at low prices) and \$620,000 (at intermediate prices) in contraceptives to meet client needs—a seemingly reasonable target for the Paraguayan government (see Figure 2). However, given the low level of current government purchases, this implies, on average, a 35–50 percent annual increase in MSP y BS contraceptive purchases to close the funding gap projected for 2015. Initially, part of these requirements will be met by gradually declining donor funds, but the Paraguayan government will increasingly need to assume more of the burden as donor support declines.

In order to avoid shortfalls, donors and the MSP y BS will need to work closely to estimate and negotiate their respective roles and financial responsibilities. Also important will be making sure that the government finds the lowest possible prices for the contraceptives it purchases and sets in place mechanisms to procure these contraceptives in adequate quantities and in a timely manner. In addition,



the IPS will need to take over the financing of family planning and contraceptive services for its beneficiaries. To achieve contraceptive security in Paraguay, other sources of financing must also be preserved and expanded. Individuals and households contribute significantly to the financing of contraceptives in Paraguay, and their source of product, namely pharmacies and other private sector outlets, need to be supported and included in CS strategies and plans.

Procurement

Overall, the MSP y BS has little experience in procuring contraceptives and will have to strengthen its contraceptive procurement skills. Its limited experience includes procurements of small quantities of Mesigyna at relatively high prices from Schering Paraguay in 2002 and 2003. However, the MSP y BS does have experience procuring non-contraceptive drugs and supplies for vertical programs, such as those for tuberculosis and malaria.

Paraguay's procurement laws appear to be relatively flexible, giving the MSP y BS several alternatives for contraceptive procurement. With the exception of vaccines, most of the supplies/medicines used for the vertical programs are not part of the MSP y BS's List of Basic Drugs, but this does not represent a barrier to procuring these drugs when needed, and the same is true for contraceptives. The MSP y BS's two contraceptive purchases in 2002 and 2003 did not require a tender. The MSP y BS's Family Planning and Reproductive Health Program was able to use budgeted funds and purchase injectables from a local distributor without any legal procurement barrier. It is also understood that, if needed, the MSP y BS could purchase commodities internationally, if the prices and quality of the products offered in country do not meet quality control and registration requirements. In summary, the MSP y BS could either purchase contraceptives locally or internationally, and there seem to be relatively few barriers with these mechanisms.

Logistics Management

Paraguay's contraceptive logistics system is centralized within the MSP y BS, and staff appear to be well trained in using the appropriate logistics management instruments. While products are distributed from the central level to the health districts, information flows from health facilities to Regional Health Districts to the MSP y BS centrally. MSP y BS staff managing the central warehouse, staff in the Reproductive Health Directorate, and directors of health facilities have all received training in logistics management, and many have significant experience. Use of logistics instruments, such as the Commodity Movement Report (IMI), at the facility level was consistent and will certainly serve as a strong point in Paraguay's quest to achieve contraceptive security.

The logistics system does show, however, a breakdown in coordination and information use at the central level, translating into inadequate supplies being sent out, and ultimately resulting in stockouts. This problem is largely due to the fact that administration of the central warehouse is independent from the Family Planning Program and the Reproductive Health Directorate, which are the two entities that manage and consolidate consumption and inventory data that come from health facilities. It appears that there is limited flow of information between the entities at the central level. Central warehouse decisions on the quantities of contraceptives to be distributed to each region are often not based on facility-level information, resulting in stockouts at service delivery points. There is a need to improve coordination and use of information among different MSP y BS offices and programs at the central level. The

Reproductive Health Directorate must also use the information on stocks and consumption that it receives from health facilities to forecast contraceptive requirements, which serve as the basis for UNFPA procurements or future MSP y BS purchases. However, there is a tendency to base these estimations on past requests rather than current information, which invariably leads to underestimations of growing demand. As a result, in the past few years, MSP y BS has consistently requested inadequate quantities of contraceptives from UNFPA, which USAID has had to supplement with emergency procurements.

Policy

Paraguay has a well-established policy framework that supports the rights of its citizens to plan their families. At the highest level, the National Constitution guarantees the right of every person to freely and responsibly decide the number and frequency of births, and thereby supports the goals of contraceptive security. The current government has clearly articulated family planning to be one of its priorities. The Government Plan 2003–2008 has as two of its main objectives the reduction of maternal mortality and the expansion of access to family planning, and the National Sexual and Reproductive Health Plan (PNSSR) 2003–2008, approved by the Minister of Health in November 2003, identifies family planning as a priority action area. More important, one of the PNSSR's indicators for measuring improvement in political and economic commitment is the amount of national budget funds spent for purchase of contraceptives.

Leadership and Commitment

The PNSSR is a powerful indicator of the current government's commitment to and leadership in family planning. It is also a document that can be used to hold the government accountable for its actions, or lack thereof, vis-à-vis reproductive health, family planning, and contraceptive security. The current and previous administrations' commitment to reproductive health and family planning is also demonstrated by the existence of a specific line item in the MSP y BS budget for the sexual and reproductive health program along with a sub-item for contraceptives. This commitment, however, has not extended to full-funding of the line item by the Ministry of Finance, in large part due to the dire fiscal situation that Paraguay has been facing in the past seven years, the lack of data to quantify real needs, and the unpredictable funding from donors from year to year.

Coordination

At the policy level, coordination between the MSP y BS and its international partners, USAID and UNFPA, appears to be good. The three institutions, along with most other key stakeholders in the health arena, are members of the National Reproductive Health Council, which was responsible for developing the PNSSR 2003–2008. They also participate on the National Contraceptive Security Committee. Hence, there is clear communication and coordination on policy and programmatic priorities. However, this communication seems to break down in the face of operational functions such as coordinated procurement of contraceptives to avoid duplication and synchronization between the HIV/AIDS and reproductive health programs.

Recommended Strategies and Next Steps

Strategy 1.

Develop strategies to reach populations with the highest unmet need, including poor women, rural residents, youth, and those with low levels of education. Divert those who can afford to pay to the private sector.

- Institute exemption mechanisms for these target groups so that they do not have to pay consultation fees for FP visits. Currently some MSP y BS facilities have informal systems in place where social workers interview clients to determine if they are poor and should receive an exemption. This mechanism could be formalized and instituted officially in all facilities.
- Set in place targeting strategies to charge those in the top three income quintiles who receive free contraceptives from the public sector, and use those revenues to expand services to those with unmet need. For example, the MSP y BS can expand provision of contraceptives through social pharmacies and send non-poor clients to these pharmacies where they will pay out-of-pocket for contraceptives.
- Support and encourage the role of pharmacies as the principal provider of contraceptives in Paraguay by ensuring that the policy and legal environment for commercial sector participation is favorable. The MSP y BS and donors should also fully involve the commercial sector and pharmacy associations in all contraceptive security strategy sessions. Paraguay's primary pharmacy association, CAFAPAR's active involvement in the National Contraceptive Security Committee is a positive step in this direction.

Strategy 2.

Mobilize the IPS's participation in the contraceptive market and thereby ensure that scarce public sector resources are not being spent on those covered by social security.

- Lobby IPS to convince it to incorporate the provision of contraceptives into its service delivery roster, and assume responsibility for using IPS funds to purchase contraceptives, either through the MSP y BS or through its own procurement mechanisms. In order to make this a reality, IPS must include contraceptives in its List of Basic Drugs.
- Assist IPS in estimating contraceptive needs among its clients. An alternative option is to broker an agreement between the MSP y BS and IPS to ensure that the MSP y BS receives adequate remuneration for serving IPS beneficiaries at MSP y BS facilities.
- Invite an IPS representative to be part of the National Contraceptive Security Committee.

Strategy 3.

Ensure that public sector funding adequately covers the contraceptive needs of MSP y BS clients, and identify opportunities to obtain the best value for this funding either through UNFPA procurement or other equally beneficial and reliable mechanisms.

- Work closely with the MSP y BS to ensure that funding requests under the contraceptive purchase line item accurately reflect the projected needs of current and future MSP y BS clients. This will also require advocating for annual budget increments in the order of 35–50 percent to reach self-sufficiency by the year 2015.
- Negotiate with UNFPA and USAID and other external funding sources to secure funding through 2015 to cover the gap between the MSP y BS budget and projected requirements.
- Lobby the Cabinet and the Ministry of Finance to disburse the full amount of funding requested in a timely manner. A one-time disbursement would be ideal because it would enable the MSP y BS to make bulk purchases (economies of scale) and make up-front payment, if required, to obtain the best prices.
- Investigate and test different contraceptive procurement options, always using price and timely delivery of product as criteria. Explore the possibility of procurement through UNFPA to get best prices. It is important to choose a supplier who is also able to accommodate the government's disbursement cycles and lags.

Strategy 4.

Address the issue of stockouts at health facilities by improving logistics coordination at the central level and ensuring that adequate quantities of contraceptive commodities are procured through donors and MSP y BS purchases.

- Set in place mechanisms (information-sharing mechanisms and regular meetings) to improve coordination and flow of information between the Directorate of Reproductive Health and the central warehouse to ensure that disbursement of supplies to regions is based on availability of stock and monthly consumption levels that are received each month from health facilities.
- Use current data on inventories at the central and regional level, consolidated consumption data, and information on unmet need, along with tools such as PipeLine software to forecast realistic contraceptive requirements for the country. This information should be used to request government funding and negotiate with donors.
- Coordinate procurement among the USAID, UNFPA, and MSP y BS to ensure that each source purchases/donates a different method. This avoids duplication, helps maintain a minimum range of methods (one oral, one injectable, one IUD, and one barrier method), and guarantees provision of a minimum full range of methods.



Strategy 5.

Work to ensure that future/proposed health sector and government reforms preserve FP achievements and improve the population's ability to choose, obtain, and use contraceptive methods in the future.

- Analyze all proposed health sector and governmental reforms in the context of the CS framework and lobby for changes to mitigate possible negative effects.
- Provide technical assistance for policy and systems analysis when significant legal or procedural barriers prevent the adoption of a beneficial reform.
- Ensure that individuals who understand family planning and the contraceptive supply chain are on decentralization planning committees and/or that those making reform decisions are informed about contraceptive security.
- Share successful tools and approaches from other reform settings with Paraguay's planners and decisionmakers and provide direct technical assistance for their adaptation and testing, if required.

